Dr John Negrine Foot and Ankle Surgeon (To the poor and ignomious)

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Plantar plate repair A "game changer"

John P. Negrine, F.R.A.C.S.
Foot and Ankle Surgeon
Sydney



Foot surgeon's car vs knee surgeon's car

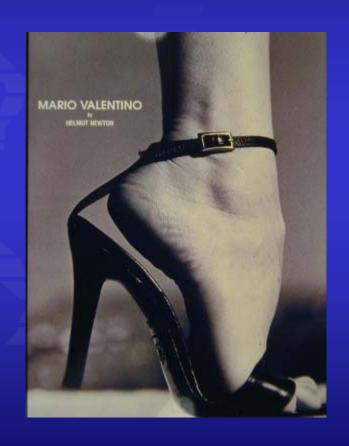






Patient expectations

- Always works on RPA
- The wardrobe full of sexy shoes
- Cosmesis a big issue
- Foot surgery definitely not glamorous!!





Second MTP synovitis 1991







2nd MTP instability

- Very common cause of forefoot pain
- Patients describe walking on a stone
- Swelling
- Deviation of the toe
- Sometimes paraesthesia



There is a general lack of recognition of this condition among GP's, rheumatologists, podiatrists, physiotherapists and the general orthopaedic community.



Second MTP synovitis

- Spectrum from mild pain to marked deformity
- Mostly misdiagnosed initially as 2,3 neuroma
- Much more common in my practice





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Plantar plate

- Thick structure
- Blends with capsule
- From metatarsal neck proximal to articular surface to base of proximal phalanx
- Blends with collateral ligaments medially and laterally





Plantar plate anatomy

- Rectangular or trapezoidal in shape
- Approx 19 x 11 mm
- 2-5 mm thick
- Originated from the plantar aponeurosis and flimsy attachment to the metatarsal neck
- Firm attachment to the base of the proximal phalanx

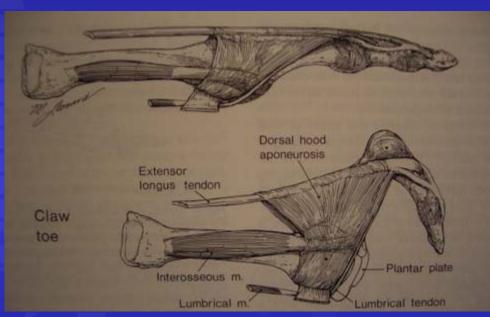






Patho-anatomy

- Once plantar plate ruptures interossei become extensors at MTP joint
- EDL will only extend PIP joint when proximal phalanx is flexed or in neutral
- EDL therefore a significant deforming force when MTP is hyperextended









Is this where hammer toes begin?



Isn't that exciting???





Causes of 2nd MTP instability

- Long second metatarsal
- Hallux valgus
- Impact runners
- Arthritides
- Neuromuscular disease



"Wear and tear"



What is the incidence of plantar plate tears in the normal population?

- 20 specimens
- 6 male average age 56.7
- 14 female average age 71.1
- 14/20 plantar plate tears 70%
- 3/6 males 50%
- 11/14 females 78.6%

(Intervertebral disc, rotator cuff, meniscus)



Lowell Weil Jr. August 2012

Diagnosis

Clinical and usually obvious

• DD: Early arthropathy rheumatoid, Tumours such as PVNS, metatarsal stress fracture, neuroma



65 year old GP

- Avid walker
- Presents with 2nd MTP pain and swelling
- Initial x-rays normal June 2001
- Settled with taping/insole returned to walking





Re-presents 2003

- Pain and swelling 2nd
 MTP joint
- Restriction of movement
- X-rays Freiberg's' infraction
- Adult cases rare but well described in the literature





45 year old lady

- 3 month history of 2nd MTP pain
- Clinically no instability
- MRI Stress reaction proximal phalanx – normal plantar plate – normal metatarsal head





"Doctor do I need an M.I.R.?"

My iridologist said they were real good!!

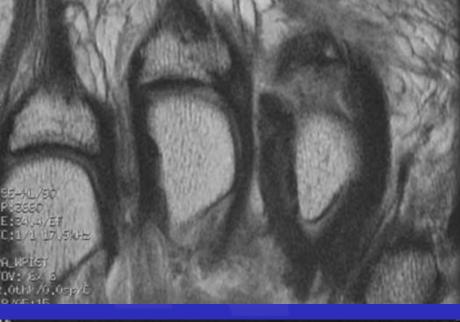


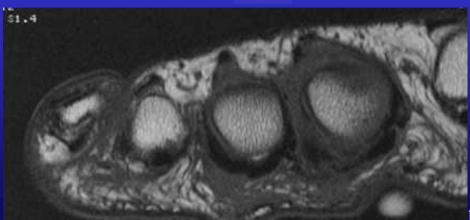
Interpretation is the key



2nd MTP JT capsulitis and lateral plantar plate tear







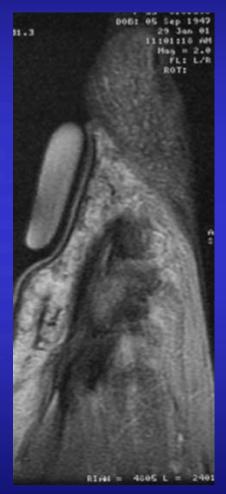






Table 2. Anatomic Grading of Plantar Plate Tears – Coughlin et. al 2011

Grade Patterns of Injury

O Plantar plate or capsular attenuation, and/or discoloration

1 Transverse distal tear (adjacent to insertion into proximal phalanx [<50%]; medial/lateral/central area) and/or midsubstance tear (<50%)

2 Transverse distal tear (>50%); medial/lateral/central area and/or midsubstance tear (>50%)

3 Transverse and/or longitudinal extensive tear (may involve collateral ligaments)



4 Extensive tear with button hole (dislocation); combination transverse and longitudinal plate tear

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2nd instability treatment

- ??50% can be treated non-surgically
- Tape the toe, toe splint
- Metatarsal dome
- ?Judicious cortisone injection



Non-operative treatment













When plantar plate ruptures pain often subsides but deformity increases



Once the toe no longer touches the ground the only way to bring it down is surgically





Bad operations

- Phalangeal or hemiphalangeal resection
- Isolated metatarsal head resection
- Second toe amputation (except in the very elderly)





Plantar plate repair

- 34 so far (began 21 November 2011)
- 30 female/4 male
- Age Range: 44 84
- Average age 61
- Second MTP 33/Third MTP 1



Associated procedures

- Scarf 22 patients
- First MTP fusion 2 patients
- Akin (phalangeal osteotomy) 1 patient



Plantar plate repair

- New instruments make it possible from "the top"
- Direct repair and advancement is performed
- Morbidity is less



Small pin distractor





McGlamry Elevator





Mini scorpion









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Mini scorpion







Steps of the procedure

- 1. Pass McGlamry elevator to release plantar plate adhesions to metatarsal head
- 2. Weil Osteotomy provisionally fix 1.6mm k-wire
- 3. Place pin in base of proximal phalanx
- 4. Section collateral ligaments
- 5. Expose and debride plate tear
- 6. Put 0-fibrewire sutures in plate
- 7. Drill holes in base of proximal phalanx
- 8. Pass sutures
- 9. Tie sutures
- 10. Replace and fix Weil osteotomy



Technique





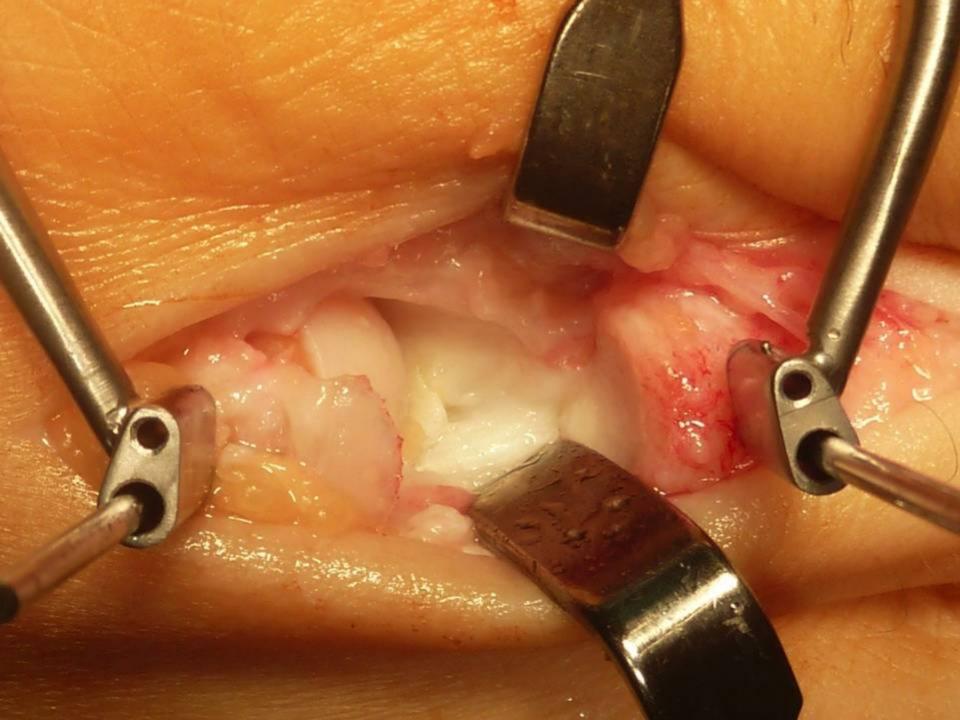


Technique









Plantar plate repair





Dr John Negrine



Passing the suture







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Final steps







Recovery

- 6 weeks in a recovery shoe
- Swelling 6 months
- So far 75% good results in 34 cases follow up < 12 months





Word of caution: The plantar plate is composed of type 1 collagen...we wouldn't repair a meniscus in a 60 year old woman



