NORTHCOAST FOOT AND ANKLE ASSOCIATES, INC.

INDEPENDENT MEDICAL EVALUATION

Examining Physician: Gerard V. Yu, D.P.M., F.A.C.F.A.S.
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Location of exam: East Side Office Facility
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Patient Name: CHRISTINE PIZZUTE **Date:** 27 August, 2002

DOB: 10.24.65 **AGE:** 37 **SEX:** FEMALE

CHIEF COMPLAINT: "Bunion." Shoe size 11

HISTORY OF CHIEF COMPLAINT: Patient indicates she initially had a bunion on the right foot. She underwent surgery in the summer 1999 performed by Dr. Silver and Dr. Rasper with excellent clinical outcome. She's very pleased with the surgery and has had no problems since that surgery.

In September, 2000, she underwent surgical correction of her bunion deformity of the left foot by Dr. Silver/Martin and two other unspecified resident physicians (?). She indicates that she thought it was going to involve one cut in the bone; however it ultimately required two cuts, the use of multiple screws, pins and wires. She indicates she was told that the bone had shifted. She reports a significant amount of aggravation, discomfort and of equal concern the recurrence of her bunion deformity. While the medial bunion prominence is noted as is recurrent deviation of the hallux the primary area of discomfort is more proximal along the metatarsal shaft. She reports varying types of pain in the area but it's mostly sharp in nature. She also reports that the second toe is uncomfortable and she formerly thought it was simply because of rubbing, however she is not sure but does notice the presence of a lesion at the distal end of the toe. She complains that the great toe is significantly shorter on the left than the right. She describes it as though the second toe has replaced the function of the big toe. She denies numbness in the second toe. Each morning upon arising she feels a popping, cracking sensation which sort of sets things in place and by the end of the day she reports swelling. She's receiving no current professional care. She wears comfortable shoes and today is wearing a tennis shoe type of gear. She's unable to tolerate any high-heeled shoes. Weight is not balanced properly. It causes her to walk crooked but not limp specifically.

She has obtained some other opinions. She has seen Dr. Tisdel at The Cleveland Clinic who has offered her revision surgery in the future. A Dr. Lunden (?) basically said revision surgery could be performed but more importantly gave her a scolding for not having seen him in the first place. Her difficulty is compounded by walking on uneven surfaces which makes it very painful. Certain activities that she has noted give it the sensation of vibration within the foot. Her desire is to obtain correction of the deformity and rebalancing of the foot to allow her to weight bear and ambulate without difficulty.

PAST MEDICAL HISTORY:

Illnesses:

1. Hypertension two years duration (originally noted by Dr. Silver and currently under professional care with pharmacologic control)

Previous Surgeries and Hospitalizations:

1. Unspecified vascular tumor medial aspect R knee. Children's Hospital, Akron, Ohio. Surgeon: Unknown. No complications.
2. 1999 surgical correction bunion deformity right foot
3. September, 2000, surgical correction of bunion deformity left foot with bone-healing complications and recurrence

Medications:

1. Prinivil 20 mg. q.d. for hypertension. One year duration. Dr. Bailey
2. Multivitamins
3. Calcium supplement
4. Vitamins E and C supplements
5. Primrose
6. Baby aspirin q.d.

Allergies: NKDA

Social Habits:

1. Denies nicotine consumption.
2. Denies ETOH consumption.
3. Denies use of recreational drugs.
4. Employment: Group sales person for Akron University E.J. Thomas Hall.

Family Hx:

1. Mother living at 58 years of age, good general health.
2. Father living at 60 years of age with previous renal transplant.
3. Two siblings; one brother, one sister.
4. No reported foot problems with the exception of plantar verruca.

REVIEW OF SYSTEMS: Unremarkable and noncontributory.

PHYSICAL EXAMINATION:

General comments: Well-developed, well-nourished female. No acute distress. Articulate and good disposition and affect.

Height: 5'9½" **Weight:** 200 lbs.

Vital Signs: **Temp.:** wnl **Pulse:** 80 **Resp.:** 20 **BP:** 130/74 left arm sitting

LOWER EXTREMITY EXAMINATION:

Dermatological:

Well-healed post-surgical scars dorsal aspect first MTP joint bilateral. Diffuse tyloma distal aspect second digit left foot. Very mild diffuse tyloma sub metatarsal two bilateral (**NOTE:** Patient debrides herself with the use of a pumice stone). Mildly dystrophic fifth digit nail. Nails are otherwise in good order and painted.

Vascular:

Posterior tibial and dorsalis pedis pulses are palpable bilateral. Capillary fill time is slightly delayed in both feet. Slight increased cooling from proximal to distal bilaterally. No evidence of varicosities or veinectasias. Although patient reports edema on the left foot none is present at the time of this evaluation.

Neurologic:

Epicritic sensation is altered in the left foot. Normal on right. Epicritic sensation along the medial aspect of the left foot to the level of the first MTP joint is altered with tactile stimulation. She has decreased light touch and sharp/dull discrimination. The sensory alterations are consistent with altered function of the saphenous nerve primarily and to a much lesser degree the remaining cutaneous nerves on the dorsal aspect of the left foot. Temperature discrimination is intact. She has a slight decreased sensibility to the remaining dorsal and plantar aspects of the foot of no apparent consequence.
Muscle function is grossly intact. In particular, the EHL function is intact on both feet. FHL is intact in both feet but has slightly decreased ability to plantar flex the interphalangeal joint on the left hallux.

Orthopaedic/Musculoskeletal:

On general observation the two feet look similar, however on closer inspection one can appreciate a slight medial bunion prominence on the left foot as well as an elevated and shortened and clinically elevated first ray segment. The hallux is shorter than the second toe on the left in comparison to the right. One can visually appreciate the difference in position of the first metatarsal segment in comparing the two feet. There is some recurrent hallux abductus of the left side with the hallux abutting the second toe: there is no overlapping or underlaying of the hallux and second digits. The right foot demonstrates excellent correction of a reported previous HAV deformity.

Patient has a slight decrease in the range of motion on the left side in comparison to the right by approximately 25-30%. There is pain to end range of motion both in dorsal flexion and plantar flexion on the left but there is no crepitus noted.

On careful palpation of the metatarsal segments one can appreciate an elevated third in both feet in comparison to the second and fourth metatarsal segments. The first ray segment on the left appears to be shorter and slightly elevated in comparison to the second ray, although there is no difference in skin changes beneath the second metatarsal segment of either foot. On careful palpation the metatarsal condyle is more prominent on the right than the left: the left appears to have increased thickening of the plantar soft tissues. This is confirmed by both the examiner and the patient. The significance of this is difficult to ascertain but may be related to a slight increased overload phenomenon of the second metatarsal on the left in comparison to the right. Significant contractures of the lesser toes are not present, although there is definite increase in pressure at the distal aspect of the second toe on the left foot.

Ankle, subtalar and midtarsal joint motions are otherwise equal and symmetrical without pain, limitation or crepitus noted.

Relaxed stance position shows decreased purchase of the fifth digit bilateral. The hallux is nonpurchasing on the left side in comparison to the right. There is a slight exacerbation of the hallux abductus deformity with weight bearing in comparison to nonweight bearing. The third toe is noted to be shorter than the adjacent second or fourth toes of both feet.

The arch configuration of the foot on weight bearing is equal and symmetrical. Patient can perform a heel rise test: she can toe walk and heel walk as well. Some imbalance and maldistribution of weight is reported when toe walking. Her gait pattern is relatively normal, although she does report some sense of imbalance on the left foot.

RADIOGRAPHIC EVALUATION:

Weight bearing dorsoplantar and lateral views are obtained of both feet. The right foot demonstrates a previous distal metaphyseal osteotomy with retainment of one bent Kirschner wire estimated to be 0.045" in diameter. The alignment and position are excellent. There is very mild displacement of the sesamoid apparatus with some remodeling of the medial aspect of the metatarsal head. The joint is congruous. The metatarsal parabola is relatively normal. Some increased stress phenomenon is noted along the shafts of the second, third and fourth metatarsals and the distal diaphysis.

The left foot demonstrates two prior osteotomies; one involving the proximal diaphysis and the other the distal metaphysis. There are four pieces of retained internal fixation hardware consisting of three Kirschner wires two of which appear to be 0.045" in diameter and one 0.062" diameter. In addition, there a retained partially-threaded cancellous screw noted in the diaphyseal area. Both osteotomies have healed completely with excellent remodeling of the medullary canal and otherwise near normal architecture of the bone with malposition. There is an increase in the intermetatarsal angle noted as well as an increase in the proximal articular set angulation. The metatarsus primus adductus appears to be emanating from the prior osteotomy site and the diaphysis of the metatarsal segment as well as the proximal metatarsal cuneiform articulation. The hallux is deviated laterally. The joint is noncongruous and is considered deviated to subluxed. Although well healed, there is significant shortening of the metatarsal segment creating an abnormal metatarsal parabola. A stress phenomenon of the lesser metatarsals is noted. The metatarsal parabola is otherwise satisfactory.

Sagittal plane alignment of the first metatarsal is excellent on the left foot: there is slight metatarsus primus elevatus noted on the right foot.

DIAGNOSTIC IMPRESSIONS:

1. RECURRENT HAV DEFORMITY WITH RECURRENT METATARSUS PRIMUS VARUS LEFT FOOT: OTHERWISE WELL-HEALED DOUBLE OSTEOTOMY OF THE FIRST METATARSAL SEGMENT
2. MULTIPLE RETAINED INTERNAL FIXATION DEVICES, LEFT FOOT
3. STATUS POST CORRECTION WITH RETAINED INTERNAL FIXATION DEVICE, RIGHT FOOT

RECOMMENDATIONS/TREATMENT PLANS:

1. Bilateral pedal x-rays: clinical photographs obtained to accompany report.
2. While specific recommendations for treatment were not made, I did take the liberty of discussing with her options at her request. At this time she advised me the options that have been recommended to her include

some type of lengthening procedure of the first metatarsal segment with revision HAV surgery vs. primary fusion of the first MTP joint. Given her low range of motion of the first MTP joint I advised against lengthening of the first metatarsal segment either by bone grafting or distraction osteogenesis. I would favor revision HAV surgery to include a revision closing wedge osteotomy of the first metatarsal segment and muscle tendon rebalancing at the MTP joint providing the weight distribution can be managed prior with an appropriate balance-mold orthotic device. An alternative option would be primary first MTP joint arthrodesis recognizing the limitation of motion which would be present postoperatively. I have suggested to the patient that appropriate consultation and fabrication of a balance-mold orthotic may be successful in resolving a significant component of her problem: if this proves successful then revision surgery could be undertaken to correct for the recurrent hallux abductus and metatarsus primus varus.

Physician Signature: _____

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Date: 08.28.02

GVY:mid

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