THE GOLD COAST AND TWEED’S SPECIALIST PODIATRIST
Tweed Health for Everyone
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Dr Butterworth moved from Melbourne to the Gold Coast in 2011, with his wife and 3 children. Dr Butterworth completed his foot and ankle surgery fellowship in 2011 with the Australasian College of Podiatric Surgeons (ACPS). The ACPS is the national organisation responsible for the training and education of podiatric surgeons, including ongoing accreditation. The ACPS is committed to the advancement of knowledge of podiatric surgery, and endeavours to uphold the highest standards in foot and ankle surgical care by podiatric surgeons within the community.

During his fellowship, Dr Butterworth completed residencies at the Great Western Hospital in the UK and Dekalb Medical Centre in the USA, both renowned for their foot and ankle training programs. In 2015, Dr Butterworth was awarded with Fellowship of the Faculty of Podiatric Medicine, Royal College of Physicians and Surgeons of Glasgow, FFPM RCPS (Glasg).

Dr Butterworth is dedicated to research and is currently undertaking his PhD at the Musculoskeletal Research Centre at La Trobe University, assessing the association between obesity and foot pain. A list of Dr Butterworth’s scientific publications and presentations are detailed within this booklet.

Dr Butterworth’s specific expertise is in revision surgery for previously failed foot surgery and the surgical correction of common podiatric complaints such as: Hallux Valgus/Rigidus, digital deformities, Morton’s neuroma and plantar and posterior heel pain. Dr Butterworth consults at:

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Podiatric Surgeons are registered specialists under the National Registration Scheme for health practitioners.

Podiatric Surgeons are unique, devoting their training and careers exclusively to the surgical management of the foot and ankle.

Podiatric Surgeons are podiatrists who have completed extensive, postgraduate podiatric medical and surgical training, which enables them to perform reconstructive surgery of the foot and ankle. Podiatric surgeons are included within both the Health Insurance Act and the National Health Act.

Podiatric Surgeons operate in private hospitals within a surgical team, which includes anaesthetists, medical practitioners, surgical assistants and nursing and hospital staff. Patient care and safety is paramount and the surgical team works closely together to ensure each patient receives the highest quality of care and respect.
Anaesthesia

Foot surgery can be performed under local and general anaesthesia. A specialist Anaesthetist is used for the administration of anaesthesia and intravenous antibiotics to prevent infection. You may be required to fast for 6-8 hours before the surgery and a responsible adult must accompany you home and be available for the first 24 hours after surgery.

Dr Leah Cook lives and works in Ballina on the Northern NSW coast. Dr Cook completed her foot and ankle surgery fellowship in 2008 with the Australasian College of Podiatric Surgeons (ACPS).

Dr Cook operates at Southport Day Hospital with Dr Butterworth and consults at:

Rightfoot Podiatry
80 Crane Street 2a/77 Oxford Street
Ballina NSW 2478 Bulimba QLD 4171
Phone: (02) 6686 9699 Phone: (07) 3395 5300

Dr Viktor Avramov MBBS FRANZCA
Dr Avmarov has been working alongside podiatric surgeons for over 8 years and specialises in day surgery anaesthesia.

Post-operative care

Generally speaking; a post-operative shoe is provided and used for up to 4 weeks. The dressing is changed from 3 to 7 days after surgery. Sterile dressings are then dispensed with after a further 2 weeks. The foot is kept dry for 2 weeks after surgery. At this point in time a compression bandage is used for 4 to 6 weeks to control swelling and the patient is then asked to wear flat lace up shoes until normal foot wear can be used. For further information on foot surgery, please refer to the frequently asked questions section within this booklet, or visit footsurgery.com.au
High patient satisfaction has been reported in patients undergoing foot surgery by podiatric specialists compared to other specialists.

In one study, GP’s were more pleased with the service provided by podiatric specialists than other specialists.

Foot surgery by podiatric specialists improves HRQOL.

Foot surgery by podiatric specialists is associated with low complication rates and is safe and effective.

Substantial financial savings; decreased waiting time for elective foot surgery; increased productivity; improved prevention of co-morbidities; and a quicker return to an improved quality of life are all associated with the service provided by podiatric specialists.


Bunion surgery

Bunions are a frequently observed deformity of the 1st metatarsal and great toe (hallux) and affect women more commonly than men. The condition involves an increase in the 1st metatarsal angle [normal 8-10 degrees] and hallux abductus angle [normal 10-12 degrees]. The condition ascends in grading from stage 0 to 3 (none, mild, moderate and severe).

Causes: genetic predisposition, local and systemic musculoskeletal diseases such as rheumatoid arthritis, ill-fitting footwear and structural anomalies.

Diagnosis

Is made simply through observation although x-rays are used in surgical planning. Clinical assessment involves ascertaining the exact nature of the patient’s symptoms.

Symptoms

- Medial eminence pain [redness over the bunion with or without bursa formation]. This is likely caused through friction between footwear and the bunion
- Sesamoidal pain. Pain is reproducible upon palpation of the fibular or tibial sesamoid and/or its metatarsal articulation
- Intermetatarsal bursitis. Pain is elicited upon compression of the 1st and 2nd metatarsal or direct compression of the Intermetatarsal space
- Pain on range of motion of the 1st metatarsophalangeal joint, indicating osteoarthritic changes within the joint.

Conservative Management

- Adjusting footwear to accommodate medial eminence pain
- Orthotic therapy may be helpful in offloading sesamoids
- Injection therapy may be a useful treatment in alleviating symptoms associated with Intermetatarsal bursitis.

Surgical Management

Bone limiting joint motion and/or protruding from the joint is removed and the big toe is realigned. Usually a bone cut is made to allow for realignment of the metatarsal bone. Tight soft tissues are released on the inside of the joint and loose soft tissues on the outside of the joint are tightened. A combination of bone and soft tissue procedures allow the big toe to be properly aligned. A pin is used under the skin to hold the bone in its new position. Occasionally these pins need to be removed although this is rare. The majority of these procedures allow for immediate walking after surgery.

A postoperative shoe is worn for 3 to 4 weeks
“BUNIONS HAVE BEEN SHOWN TO REDUCE HEALTH RELATED QUALITY OF LIFE, MAKE FITTING FOOTWEAR DIFFICULT AND INCREASE THE RISK OF FALLS AND BALANCE PROBLEMS”.

“BILATERAL HALLUX VALGUS SURGERY CAN BE PERFORMED SAFELY AS AN OUTPATIENT PROCEDURE IN SELECTED PATIENTS WITH ACCEPTABLE LEVELS OF PATIENT SATISFACTION”.
Hammertoe surgery
Digital deformities of the foot are frequently observed and are commonly termed ‘hammertoes’. The condition involves changes consistent with osteoarthritis in the small phalangeal joints of the toes. Often, the primary cause of discomfort is due to callous build up and footwear irritation.

Causes
May include biomechanical anomalies such as changes in tendon strength and line of pull, ill-fitting footwear, collapsed arches, genetic predisposition and systemic diseases such as rheumatoid arthritis.

Diagnosis
Is made purely through clinical assessment although x-rays may offer further information regarding bone and joint pathology. Digital deformities may include:
- Hammertoes
- Claw toes
- Mallet toes
- Flexible [all of the above]
- Rigid [all of the above]

Conservative Management
- Depends largely on patient expectations
- Initial therapy may be conservative such as adjusting footwear
- Ortho-digital splinting therapy may be helpful in weight re-distribution
- Regular lesion debridement may be useful in alleviating symptoms

Surgical Management
- Minimal incision surgery (Flexor tenotomy) for flexible claw and mallet toes
- Arthroplasty or arthrodesis - Toe arthroplasty refers to removing a small amount of bone from one or more joints of a toe. Sometimes a pin (K wire) is used to maintain the toe in a straight position for 3 to 6 weeks. Toe arthrodesis refers to removing the cartilage within a joint and holding the bones together with a pin so that they become one bone after 6 weeks
- Flexor tendon transfers.
Heel pain

Heel pain is a frequently observed deformity which commonly affects individuals who are active in sport, overweight/obese or have structural anomalies such as high arches or flat feet. The condition involves the plantar aponeurosis/fascia and musculature at its insertion at the heel. The condition may progress from acute to chronic depending on the duration and severity of symptoms.

Causes: Micro or macro trauma leading to fascia tear and subsequent inflammation, genetic predisposition to structural foot anomalies, local and systemic musculoskeletal diseases such as rheumatoid arthritis leading to altered foot structure, ill-fitting footwear and obesity.

Diagnosis: is made through clinical assessment although ultrasonography and x-rays may be useful in ascertaining a diagnosis. Clinical assessment involves determining the exact nature of the patient’s symptoms.

Symptoms

- Insertional fasciitis at the medial calcaneal tubercle. Pain is typical upon rising in the morning [post static dyskinesia]
- Concomitant restriction of the Achilles tendon and excessive tightening of the plantar aponeurosis upon dorsiflexion of the 1st metatarsal or ‘great toe joint’ [windlass mechanism]
- Reproducible symptoms upon range of motion of the 1st metatarso-phalangeal joint
- Heel spur formation evident on a lateral radiograph

Conservative Management

- Orthotic therapy may be helpful in offloading the painful heel
- NSAID/steroid therapy to alleviate symptoms associated with inflammation
- Calf stretching exercise would also be useful for tight Achilles tendons
- Extra Corporal Shock Wave Therapy [ESWT] has been shown to be an effective alternative for those who do not respond to more conservative therapy

Surgical Management

- Plantar fasciotomy
- Heel spur resection
- Tarsal tunnel release.
Morton’s neuroma
Morton’s Neuroma is a frequently observed foot deformity and affects the third interspace more commonly than the second, third or fourth spaces. The condition involves changes consistent with fibrosis of the proper digital nerves. The condition is commonly referred to as a neuroma although this is misleading as it reflects more of a swelling/fibrosis of the nerve rather than a true neuroma.

Causes
Biomechanical anomalies such as ill-fitting footwear, collapsed arches and genetic predisposition

Diagnosis
A positive ‘Mulder’s’ Click can indicate the presence of Morton’s Neuroma although both specificity and sensitivity are poorly researched. Ultrasound and MRI provide good predictability although usually a diagnosis is made purely on clinical judgement alone. Differential Diagnosis includes: Plantar plate rupture of the lesser metatarsals, lesser metatarsal capsulitis, peripheral neuropathy, peripheral symptoms associated with sciatica, neuritis/localised digital nerve entrapment.

Conservative Management
- Footwear adjustments
- Orthotic therapy
- Injection therapy

Surgical Management
- Radiofrequency ablation
- Resection of the thickened nerve

Aim
To eliminate pain associated with a benign thickening of a nerve between two toes.

How
The nerve is removed to a level behind the ball of the foot. Most times this is performed through an incision in the top of the foot. However, there are times that an incision is placed in the bottom of the foot.

Where
This procedure is performed as Day Surgery. This may be in a Hospital or a Day Surgery Centre.

For further information on Morton’s neuroma, download the Morton’s neuroma.pdf at footsurgery.com.au.
Ankle disorders

Ankle instability

Chronic ankle instability is a condition characterized by a recurring “giving way” of the outer (lateral) side of the ankle. This condition often develops after repeated ankle sprains. Usually the “giving way” occurs while walking or doing other activities, but it can also happen when you’re just standing. Many athletes, as well as others, suffer from chronic ankle instability.

People with chronic ankle instability often complain of:
- A repeated turning of the ankle, especially on uneven surfaces or when participating in sports
- Persistent (chronic) discomfort and swelling
- Pain or tenderness
- The ankle feeling wobbly or unstable.

Causes

Chronic ankle instability usually develops following an ankle sprain that has not adequately healed or was not rehabilitated completely. When you sprain your ankle, the connective tissues (ligaments) are stretched or torn. The ability to balance is often affected. Proper rehabilitation is needed to strengthen the muscles around the ankle and “retrain” the tissues within the ankle that affect balance. Failure to do so may result in repeated ankle sprains. Repeated ankle sprains often cause – and perpetuate – chronic ankle instability. Each subsequent sprain leads to further weakening (or stretching) of the ligaments, resulting in greater instability and the likelihood of developing additional problems in the ankle.

Diagnosis

In evaluating and diagnosing your condition, the foot and ankle surgeon will ask you about any previous ankle injuries and instability. Then he or she will examine your ankle to check for tender areas, signs of swelling, and instability of your ankle as shown in the illustration. X-rays or other imaging studies may be helpful in further evaluating the ankle.

Non-Surgical Treatment

Treatment for chronic ankle instability is based on the results of the examination and tests, as well as on the patient’s level of activity. Non-surgical treatment may include: physical therapy; bracing; medications.

When Is Surgery Needed?

In some cases, Dr Butterworth will recommend surgery based on the degree of instability or lack of response to non-surgical approaches. Surgery usually involves repair or reconstruction of the damaged ligament(s). The surgeon will select the surgical procedure best suited for your case based on the severity of the instability and your activity level. The length of the recovery period will vary, depending on the procedure or procedures performed.
Peroneal Tendon Injuries
The two peroneal tendons in the foot run side-by-side behind the outer ankle bone. One peroneal tendon attaches to the outer part of the midfoot, while the other tendon runs under the foot and attaches near the inside of the arch. The main function of the peroneal tendons is to stabilize the foot and ankle and protect them from sprains.

Causes and Symptoms of Peroneal Tendon Injuries:
Peroneal tendon injuries may be acute (occurring suddenly) or chronic (developing over a period of time). They most commonly occur in individuals who participate in sports that involve repetitive ankle motion. In addition, people with higher arches are at risk for developing peroneal tendon injuries. Basic types of peroneal tendon injuries are tendonitis, tears, and subluxation.

Diagnosis
Because peroneal tendon injuries are sometimes misdiagnosed and may worsen without proper treatment, prompt evaluation by a foot and ankle surgeon is advised. To diagnose a peroneal tendon injury, the surgeon will examine the foot and look for pain, instability, swelling, warmth, and weakness on the outer side of the ankle. In addition, an x-ray or other advanced imaging studies may be needed to fully evaluate the injury. Dr Butterworth will also look for signs of an ankle sprain and other related injuries that sometimes accompany a peroneal tendon injury. Proper diagnosis is important because prolonged discomfort after a simple sprain may be a sign of additional problems.

Non-Surgical Treatment
Treatment depends on the type of peroneal tendon injury. Options include:
- **Immobilization.** A cast or splint may be used to keep the foot and ankle from moving and allow the injury to heal.
- **Medications.** Oral or injected anti-inflammatory drugs may help relieve the pain and inflammation.
- **Physical therapy.** Ice, heat, or ultrasound therapy may be used to reduce swelling and pain. As symptoms improve, exercises can be added to strengthen the muscles and improve range of motion and balance.
- **Bracing.** The surgeon may provide a brace to use for a short while or during activities requiring repetitive ankle motion. Bracing may also be an option when a patient is not a candidate for surgery.

When is Surgery Needed?
In some cases, surgery may be needed to repair the tendon or tendons and perhaps the supporting structures of the foot. Dr Butterworth will determine the most appropriate procedure for the patient’s condition and lifestyle. After surgery, physical therapy is an important part of rehabilitation.
Ingrown Toenail

When a toenail is ingrown, it is curved and grows into the skin, usually at the nail borders (the sides of the nail). This “digging in” of the nail irritates the skin, often creating pain, redness, swelling, and warmth in the toe.

Causes

Causes of ingrown toenails include: heredity; trauma; improper trimming; improperly sized footwear; nail conditions.

Treatment

After examining the toe, Dr Butterworth will select the treatment best suited for you. If an infection is present, an oral antibiotic may be prescribed. Sometimes a minor surgical procedure, often performed in the office, will ease the pain and remove the offending nail. After applying a local anaesthetic, Dr Butterworth removes part of the nail’s side border. Following the nail procedure, a light bandage will be applied. Most people experience very little pain after surgery and may resume normal activity the next day. If your surgeon has prescribed an oral antibiotic, be sure to take all the medication, even if your symptoms have improved.

Preventing Ingrown Toenails

Many cases of ingrown toenails may be prevented by:

- Proper trimming. Cut toenails in a fairly straight line, and don’t cut them too short. You should be able to get your fingernail under the sides and end of the nail.
- Well-fitted shoes and socks. Don’t wear shoes that are short or tight in the toe area. Avoid shoes that are loose, because they too cause pressure on the toes, especially when running or walking briskly.
- Don’t cut a notch in the nail. Contrary to what some people believe, this does not reduce the tendency for the nail to curve downward.
- Don’t repeatedly trim nail borders. Repeated trimming does not change the way the nail grows, and can make the condition worse.
- Don’t place cotton under the nail. Not only does this not relieve the pain, it provides a place for harmful bacteria to grow, resulting in infection.
- Over-the-counter medications are ineffective. Topical medications may mask the pain, but they don’t correct the underlying problem.

RESEARCH SHOWS THAT A SIMPLE IN OFFICE PROCEDURE UNDER LOCAL ANAESTHETIC IS EFFECTIVE IN TREATING INGROWN TOENAILS
A wart is a small growth on the skin that develops when the skin is infected by a virus. Warts can develop anywhere on the foot, but typically they appear on the bottom (plantar side) of the foot. Plantar warts most commonly occur in children, adolescents, and the elderly. There are two types of plantar warts:

- A solitary wart is a single wart. It often increases in size and may eventually multiply, forming additional “satellite” warts.
- Mosaic warts are a cluster of several small warts growing closely together in one area. Mosaic warts are more difficult to treat than solitary warts.

**Causes**

Plantar warts are caused by direct contact with the human papilloma virus (HPV). This is the same virus that causes warts on other areas of the body.

**Symptoms**

The symptoms of a plantar wart may include:

- Thickened skin. Often a plantar wart resembles a callus because of its tough, thick tissue.
- Pain. Walking and standing may be painful. Squeezing the sides of the wart may also cause pain.
- Tiny black dots. These often appear on the surface of the wart. The dots are actually dried blood contained in the capillaries (tiny blood vessels).
- Plantar warts grow deep into the skin. Usually this growth occurs slowly, with the wart starting small and becoming larger over time.

**Diagnosis and Treatment**

To diagnose a plantar wart, Dr. Butterworth will examine the patient’s foot and look for signs and symptoms of a wart. Although plantar warts may eventually clear up on their own, most patients desire faster relief. The goal of treatment is to completely remove the wart. Dr. Butterworth may use curettage or a rotational flap procedure to remove the wart.

Regardless of the treatment approaches undertaken, it is important that the patient follow the surgeon’s instructions, including all home care and medication that has been prescribed, as well as follow-up visits with the surgeon. Warts may return, requiring further treatment. If there is no response to treatment, further diagnostic evaluation may be necessary. In such cases, the surgeon can perform a biopsy to rule out other potential causes for the growth.

Although there are many folk remedies for warts, patients should be aware that these remain unproven and may be dangerous. Patients should never try to remove warts themselves. This can do more harm than good.
## Surgical Referral Guidelines for Common Foot Problems

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<th>Condition</th>
<th>Indications</th>
<th>Imaging required</th>
<th>Time off work</th>
<th>Procedures</th>
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<td><strong>Hallux Valgus</strong></td>
<td>Painful 1st MTPJ/Bump pain, Difficult shoe fit, Decreased function, Balance problems</td>
<td>X-rays [AP (weight bearing), Lateral (weight bearing), Medial oblique]</td>
<td>Desk work 1-3/52, Other up to 6/52</td>
<td>Austin/Chevron osteotomy, Release adductor hallucis tendon, Tighten medial capsule</td>
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<tr>
<td><strong>Hallux Rigidus</strong></td>
<td>Painful 1st MTPJ/Bump pain, Difficult shoe fit, Failure of conservative care, Decreased function</td>
<td>X-rays [AP (weight bearing), Lateral (weight bearing), Axial sesamoid]</td>
<td>Desk work 1-3/52, Other up to 6/52</td>
<td>Arthroplasty, Arthrodesis (fusion)</td>
</tr>
<tr>
<td><strong>Tibialis posterior tendon dysfunction</strong></td>
<td>Flat foot, Failure of conservative care, Decreased function</td>
<td>X-rays [AP (weight bearing), Lateral (weight bearing), MRI sometimes required]</td>
<td>6/52 immobilised, 4/52 boot, Normal footwear at 10/52, Desk work 1-6/52, Other 10-14/52</td>
<td>TN arthrodesis (fusion), Sinus tarsi implants, Calcaneal osteotomy with tendon transfer, Gastrocnemius release</td>
</tr>
<tr>
<td><strong>Hammertoe</strong></td>
<td>Painful IPJ, Difficult shoe fit, Failure of conservative care</td>
<td>X-rays [AP (weight bearing), Lateral (weight bearing)]</td>
<td>Desk work 1-3/52, Other 4-6/52</td>
<td>Arthroplasty, Arthrodesis (fusion), Flexor tenotomy</td>
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<tr>
<td><strong>Neuroma</strong></td>
<td>Failure of conservative care</td>
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<td>Desk work 1-3/52, Other 4-6/52</td>
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<td><strong>Ingrown Toenail</strong></td>
<td>Failure of conservative care</td>
<td>AP (weight bearing), Lateral (weight bearing), Rule out subungual exostosis</td>
<td>Immediate return</td>
<td>PNA, Winograd</td>
</tr>
<tr>
<td><strong>Painful corn</strong></td>
<td>Failure of conservative care</td>
<td>AP (weight bearing), Lateral (weight bearing), Rule out exostosis</td>
<td>1-3/52</td>
<td>Syndactyly, Arthroplasty</td>
</tr>
<tr>
<td><strong>Verruca/Skin lesions</strong></td>
<td>Failure of conservative care</td>
<td>N/A</td>
<td>Immediate return</td>
<td>Skin ellipse, Rotational flaps</td>
</tr>
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BEFORE & AFTER

BEFORE

AFTER
Expectation
It often takes people longer to get over their foot operation than expected. This is related to the fact that, unlike the hand that can be protected in a sling, the foot or ankle is below heart level and is often bearing weight during recovery. Swelling and stiffness within the operated foot can often persist for anywhere from 6- to 12- or more months, depending on the procedure performed.
It is important that you ask your surgeon about your convalescence, including healing times and your plan to return to work, activity and lifestyle in the short, mid and long term.

Informed consent
The aim of your foot surgery will be to improve your foot health, pain or function. It is not uncommon for patient’s to present for their 1st post-operative redressing appointment and ask: “So, can you tell me exactly what you did again?” This can be a little disconcerting for the surgeon!
It is very important that you have a sound knowledge of the procedures and processes that are intended for your foot surgery. If you are unable to generally describe what is to be done to a family member or friend, it is likely that you will need to see your surgeon again before the day of the surgery.
No surgery is without risks and the potential for complications, all of which cannot be detailed here but are reviewed thoroughly in a separate informed consent document. General risks with surgery include those associated with anaesthesia, those relating to surgery on bone and joints and then those related to your specific procedure. For all the best will, care and intentions, in a small percentage of cases surgical complications can occur. It is of paramount importance that you understand the risks of these complications. Many surgeons will schedule a pre-operative consultation or interview to specifically discuss the informed consent process, namely the specific procedure and complications.
Please ensure that you discuss and thoroughly understand potential complications with your surgeon before signing an informed consent document.

PREPARING FOR FOOT AND ANKLE SURGERY
Having surgery can be a physical and emotional experience. Information in this guide can help you prepare your mind and body for your upcoming surgery, including things you will encounter during your journey. It can help you learn how to get ready for surgery, prepare for your recovery and provide you with a better understanding of the possibilities of temporary setbacks with the need to seek or employ further treatment along the way.
The professional care, guidance and support from your surgeon and hospital staff will aim to make your surgery experience as comfortable and stress-free as possible.
1. Paperwork
Generally, you will be sent paperwork from the hospital or surgery centre and from your surgeon’s rooms. It is recommended that you read these documents carefully as they will advise you on the most appropriate protocols for the day of the surgery. These will include when to begin fasting, what time to arrive at the hospital and surgeons fees etc.

2. Day Surgery or Overnight
Whether you return home the same day as your operation or stay overnight or multiple nights depends on many factors, including your overall health, home support status, experiences with previous surgery, the time of day and length of your procedure and how you cope with anaesthesia. Your surgeon should discuss these issues with you and plan for this accordingly.

3. Someone to drive you and to stay with you
You must arrange for someone to drive you to and from the hospital. This cannot be a taxi driver. It is very important you have a responsible adult to make you comfortable at home and stay with you, particularly in the initial 24-48 hours following your surgery. You will often need them to aid with you shuffling to the toilet, preparing or obtaining your medication or meals and assisting in moving about the house or apartment. A family member or friend will also be able to contact your surgeon on your behalf if you have any queries or difficulties in the immediate days after surgery.

4. Medication
A script for post-operative medication will be issued to you on the day of your surgery. Most people having surgery do not often feel up to stopping off at the pharmacy on the way home from their operation. Often, it is recommended that a family member or friend who is responsible for bringing you to the hospital, obtain the post-operative script and purchase your medication for your while you are still admitted in the hospital.

Generally, you can take your regular medication, such as blood pressure medication on the day of surgery with a small sip of water, however, patients taking blood thinning tablets and people with certain disorders such as diabetes, may require special instructions. Your surgeon and anaesthetist will discuss the appropriate medication regime for you during your hospitalisation.

5. Stairs
If your bedroom is on the second floor or mezzanine level, you may want to consider moving in to a spare bedroom downstairs or setting up a bedroom downstairs. Stairs can pose a risk following foot surgery, including falls or disrupting the bone work or fixation performed within your foot, undoing all the hard work and potentially requiring another operation!

6. A cardboard cutout
The sheets and quilts can often place unwelcome pressure on your operated foot at night. A trick to avoid undue pressure is to wear your post-operative shoe to bed or use a cardboard box with one side cut out to allow for your foot placement in bed. The cardboard box can be placed upside down and this will keep the bed covers off your foot or feet.

7. Showering
You will need to keep your foot dry. This can be done with plastic bags and duct tape or gaffer tape. Some companies specialize in producing garments that you can reuse to avoid getting your foot wet. You can often order these over the internet (i.e. www.dricast.com.au) or many pharmacies stock similar garments.

Also, wearing a bag on the end of your operated foot can make you a little unstable in the shower. It is recommended that you consider using a plastic stool, which enables you to sit while showering. This will provide you with stability, safety and relatively less pain than standing while showering.

8. Crutches, Walking sticks and roll-abouts
Your surgery might require you to be non-weight bearing for a short or prolonged period of time. It is a good idea for you to prepare for this by renting crutches in advance and practice using them at home – getting use to using crutches is often not as easy as people might think! For some people, i.e. elderly or overweight or shoulder problem, crutches are not often practical, there exist alternatives to these – a wheelchair or a roll-a-bout may be more appropriate. It is important to discuss this with your surgeon before your scheduled operation so you can organize for these in advance.

9. Stock Up the Fridge!
Most forms of foot surgery will keep you from being able to cook and prepare meals. It is a good idea for you to prepare meals in advance or purchase meals that you can cook easily in the microwave, particularly for the initial 1-2 weeks following your surgery and especially if you are having both feet operated on.

During your convalescence, you will be required to rest, elevate your operated limb/s and spend little time weight bearing (or non-weight bearing). Boredom can creep in quickly! It is essential that you prepare for this by stocking up on books to read, catch up on DVD’s and a pile of magazines. You can catch up on correspondence or perhaps begin those Christmas cards early!
PREPARATION

11. Lap Top and Mobile Phone
Organise your home PC or laptop and mobile phone (including your charger) so that are at hand during your initial recovery.

12. You need a friend!
Schedule for family members and friends to visit during your recovery. This will help to break up your day and they can help with meals and any small tasks that require doing.

13. A timer as guide
Generally, you will be restricted with the amount of time you can spend on your feet following your operation. Your surgeon will guide you on how much time you can spend from hour to hour, from day to day, on your feet. A timer is helpful in this situation to keep track of time and let you know when you need to rest your feet again.

14. Pants, Skirts, Shorts and Jeans
As your foot or leg may be heavily bandaged after surgery, you should wear loose clothing to the hospital and plan for your clothing when you return home. It is not recommended that you wear jeans or tight fitting pants to the hospital as you may not be able to get them back on!

15. Don’t forget your X-Rays!
Please ensure that you bring all your x-rays with you to the hospital. Your surgery may be delayed if you forget these. Often, your surgeon will have these and you will not need to worry, however, should you have any current or previous x-rays or scans please bring them with you.

The surgery
Each hospital has subtle differences in their admission protocols and set up. Generally, a hospital administrator or a nurse will call you in the days or week before your surgery to:
- Review and confirm your health.
- Confirm what time to arrive at the hospital.
- Review what medicines to take/withhold the morning of surgery.
- Answer any last-minute questions you may have.
- Ensure you are appropriately fasted for surgery (This is very important during surgery to reduce the chance of vomiting and/or inhaling it into your lungs. Swallow the pills you are to take the morning of surgery with only sips of water).

The Day of the Surgery
Hospital staff will admit you, ensuring your all your details are correct and all appropriate paperwork is complete. Following this you will be escorted to the day surgery ward or to an inpatient hospital room if you or your surgeon has organized for overnight stay. You will be requested to change into hospital gown and nursing staff will prepare you for surgery.

Surgery Unit
Nursing and hospital staff will then escort you to the surgery unit waiting room or holding area. Depending on the hospital, you will either walk to this room or will be pushed on a trolley bed. The nurses and anesthetist, who care for you before and during surgery will come and introduce themselves to you. You will have an opportunity to ask questions about your care and the type of anesthesia you will be receiving. Please be sure to ask questions and talk about any concerns you may have. The nursing staff and anaesthetist will be with you in the operating room to manage your comfort, breathing, heart rate, blood pressure and any medical issues that might arise.

Your surgeon will visit you in the holding area to answer any last minute questions you might have and ensure you understand the procedure to be performed.

Theatre
In many hospitals, you will be awake when you go to the operating room before your general anesthetic is administered. You may notice that it has beeping machines, lights and is often cool. Blankets will keep you warm and every effort will be made to keep you comfortable by nursing staff and the anaesthetist. You may, however, not be aware of going to the operating room.

In the recovery room
Immediately following your surgery, you will be moved to recovery and monitored for anywhere between 30 minutes to one or two hours. It is often a busy area with many patients being cared for by multiple nurses.

Everybody responds differently to general anaesthetic. You may feel cold and nauseated when you wake up and your mouth may be dry. Your throat may be sore if a breathing tube was used during surgery. Most foot surgeons will inject your foot with local anaesthetic while you are under general anaesthetic and so your foot or ankle will generally be numb when you awake. This numbness is variable from person to person and may last for anywhere between 3 to 18 hours. PLEASE NOTE: If you have a history of post-operative nausea and vomiting you can request of the anaesthetist to have a ‘twilight anaesthesia’ which minimizes this risk.

During recovery, a nurse will check your breathing, heart rate and blood pressure often. It is important that you are comfortable and nursing staff will help you with any nausea or pain you may feel.

Your family will not be able to see you in the recovery room. However, if you are having day surgery, they will be able to join you in the Day Ward or if you are staying overnight in the hospital, your family and friends will be able to join you once you get to your hospital room. The staff at the reception desk will tell or call your family and/ or friends when you are being moved to the ward and direct them to your room.
**Going Home**

Your surgeon will decide whether you are to go home the same day as your surgery or stay in the hospital overnight. Please discuss this with your surgeon during your pre-operative visits. If you are going home on the same day, you will be moved from recovery to the day ward and be monitored by the ward nurses. You will generally be monitored for between 2-4 hours. During this time, nursing staff will educate you and issue you with your specific post-operative instructions. When you are assessed as sound to return home, you will need someone to take you home after surgery that can get you into your home and make sure you are comfortable. For your safety, you will also need a responsible adult to stay with you for at least 24 hours after surgery.

If you are staying in overnight, ward nursing staff will monitor your status and ensure post-operative instructions are issued; surgeon’s orders and medication are followed. The following day, your surgeon will visit with you and discharge you when appropriate.

**DO NOT**

Please DO NOT do any of the following for 24 hours after surgery and/or anesthesia:
- Drive or travel alone
- Drink alcoholic beverages
- Operate machinery
- Sign any legal documents
- Be responsible for another person, such as a child.
Please note: The answers to these questions are merely a guide and do not replace the individual advice given to you by your surgeon.

Q: How long will I be off my feet?
A: Most foot surgery allows patients to be on their feet immediately following the procedure. In those instances, patients are expected to wear a protective post-operative shoe over their bandaging in order to protect the surgical site. In the first 3-7 days, patients are expected to rest as much as possible even when they are able to walk. At your first post-operative review (approximately 7 days following the procedure), Dr. Butterworth will discuss with you your progress and anticipated recovery, as well as your progression into normal footwear such as runners and flat casual shoe gear. For the majority of patients, a return to normal footwear occurs at 3 weeks following the procedure although this does vary from patient to patient.

Q: Is foot surgery painful?
A: Pain is very much dependant on the individual; what one considers painful another may not and there is no simple answer to this question. What is known, is that the minimal incision techniques employed by Dr. Butterworth allow for less swelling and a faster recovery for patients. With most surgery performed as day stay ambulatory surgery, patients are usually mobile following surgery which further decreases swelling and pain. Furthermore, exceptional advances in pain medication both during and after surgery aid in a reduction in post-operative pain for patients undergoing foot surgery.
Q: How much will it cost?
A: Dr. Butterworth has set his fees to be both reasonable and fair for his patients. For exact information on fees, please download the appropriate form on the patient information page.

Q: When can I drive?
A: Generally speaking, no patient should drive a motor vehicle in the first week following surgery. From then on, it is very much dependant on the type of procedure performed. The average time taken off driving for Dr. Butterworth’s patients is 3 weeks.

Please note: The answers to these questions are merely a guide and do not replace the individual advice given to you by your surgeon.

COMMONLY ASKED QUESTIONS

Q: When can I fly?
A: Not in the first week following surgery. From this point on, the decision to fly is made on an individual basis for each patient and is very much dependant on the procedure performed and the needs of the patient. Flying too soon following surgery can prolong swelling and may theoretically increase the risk of blood clots in the legs (deep vein thrombosis).

Q: When can I go back to work?
A: If you work at a desk and there is minimal time spent on your feet you may expect to return to work as early as one week following your procedure although you may be required to elevate your operated foot for a period of 15 minutes each hour in order to reduce swelling. However, if your job involves regular walking, lifting or manual labour, your time off will be considerably longer. It is always beneficial, if possible, that you work from home until you are back into normal footwear and able to walk without discomfort. If sick days are available, it is wise to use these in the weeks following your procedure.

Q: Are there any options other than surgery?
A: Yes. Even if conservative treatment (such as orthoses and physiotherapy) has been unsuccessful, you do not have to undergo elective foot surgery. There is always the option to delay surgery or not have surgery performed if you:
- feel the risk outweighs the benefits
- feel the cost outweighs the benefits
- are able to tolerate your foot problem
- are unable to commit to the post-operative instructions given to you
- cannot take time off work/driving
- have a medical condition that places you at greater risk for complications
- would prefer to try alternative treatments (such as acupuncture)

Q: What are the possible risks of having foot surgery?
A: Elective foot surgery is very safe although there are certain risks that patients must be made aware of, regardless of the rarity with which complications occur. The risks of foot surgery are very similar to those risks posed by having other surgery, such as infection and deep vein thrombosis. There are also risks associated with having certain medicines during and after your surgery, such as the possibility of nausea and vomiting. Any risks associated with surgery are explained to the patient during their pre-operative consultation at which time written consent is given. Absolute care is taken to ensure that consent to undergo surgery is only given once all questions have been answered to the patient’s satisfaction and all possible risks have been explained.
**Scientific presentations**

Butterworth P. Plantar plate rupture - a case study. Australasian College of Podiatric Surgeons scientific conference, Brisbane, August 2005


Butterworth P, Kihm C, Camasta C. Adult acquired flatfoot deformity due to spring ligament rupture. Australasian College of Podiatric Surgeons scientific conference, North Sydney, August 2010


**Injection Techniques for Heel Pain and Inter-metatarsal Neuroma**

Australian Podiatry Association (Vic) Continuing Education Seminar, Melbourne, September 17, 2009
Lower Extremity Dissection Workshop - Instructor
Australian Podiatry Association (VIC), Monash University Medical School, Department of Anatomy, 2010
Butterworth P. Training expectations of podiatric surgical registrars. Australian Podiatry Association Young Podiatrists seminar series, Phillip Island 2010
Butterworth P. Normal radiographic anatomy and normal variants, La Trobe University guest lecture series, April 2011
The association between BMI and musculoskeletal foot disorders – a systematic review. Musculoskeletal Research Centre, La Trobe University. Seminar series, August 2011
The association between BMI and musculoskeletal foot disorders – a systematic review. Australasian College of Podiatric Surgeons annual scientific conference, Perth, August 2011
Butterworth P. Postgraduate pathways in Podiatry. La Trobe University guest lecture series, November 2010 & 2011
Butterworth P. The surgical management of Morton’s Neuroma. Australasian College of Podiatric Surgeons clinical series symposium, Brisbane, August 2013
Butterworth P. Injection techniques for plantar heel pain. Australasian College of Podiatric Surgeons clinical series symposium, Brisbane, August 2013
Lower Extremity Dissection Workshop - Instructor
Southern Cross University, Department of Anatomy, 2014

Scientific publications

GRANTS
“The Cost effectiveness of utilizing podiatrists to manage orthopaedic patients on prolonged waiting lists” January 2013, APERF: $5,000. SCU Approval Number ECN-13-061; HREC/13/QGC 57
“Healthy GC Plus” June 2014: Gold Coast Medicare Local; $15000. Services agreement
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