Ex 405

HERVEY BAY HOSPITAL

SPECIALIST CLINICS - ORTHOPAEDICS

Dictated: 02.06.05
Typed: 09.06.05

SC/ph

Dr G Malherbe
THE BAY SURGERY
PO Box 1124
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Dear Dr Malherbe

RE: P442 - HBH UR

I reviewed P442 in the Outpatient Department at Hervey Bay Hospital on 2 June 2005. He presented with pain in his left foot, mainly complaining of pain underneath the plantar aspect of the left foot where he says that he has two lumps. He initially had claw toes. Asking him about pre-operatively he says that he did not have any pain in the toes; he does not recall any lumps underneath the foot prior to the surgery and denies any pain either in the MTP joints or over the IOP joints. He does say that when he played golf, the toes would push up through the vents in the top of his shoes, but other than this, he does describe being reasonably active. Being a keen table tennis player and frequent golfer, he says that now he is limited by the pain underneath the foot. He is still able to walk long distances, but is unable to play golf and has not done so since the surgery and is also unable to play table tennis. He goes bare foot a lot of the time, and finds it is not as bad then, but sometimes either bare foot or in shoes, he finds he has to walk on the lateral aspect of his foot because it is more comfortable. His wife says he is unable to do a thing, although he does not paint such a gloomy picture. He does however; say that he is a lot worse off than prior to his surgery and that if he had known this was a possible outcome, that he would not have had anything done. Asked why he had the surgery in the first place if he did not have a lot of symptoms. He says that one day his local Doctor noticed them and asked if he wanted to consider having them straightened, to which he said he did.

He was first seen in the Orthopaedic Outpatients Clinic on 31 October 2003, where they noted bilateral hammer toes, more severe on the left side and no callosities at that stage. It was noted that the x-ray showed osteoarthritis. Other than this, the Outpatient notes show a brief but reasonable assessment of the problem.

He was reviewed on 14 November 2003 at the Outpatient Department for consenting and the notes at that time say that he was consented for correction of the hammer toes to the 4 lesser toes and fusion of the MTP joints with K-wires.

He underwent surgery on 28 January 2004, surgery involving excision of the 2nd and 4th metatarsal heads, excision of the POP joints to the lesser four toes, extensor tenotomies and K-wiring. He was subsequently put in a plaster. Outpatient review on 6 February suggested that the wounds were ok. Review on 11 February suggested there was a superficial infection in the 3rd toe, which was treated with oral antibiotics. Review on 19 February, suggested that the toes were viable and there was no evidence of infection. It did note "continue Bactigras dressing at this stage", so presumably there must have been some skin breakdown. It was noted both on 19 February and 27 February that the toes were viable. He was seen on 12 March where the wires were removed, it was also noted on this day that the toes were viable, and that a dressing was applied.

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RE: P442 - HBH UR

He was next seen on 29 March, where he was noted to be happy with his surgery. He was not seen subsequently, but he says that he was unable to attend because of his wife's illness, which meant prolonged periods in Brisbane during last year. P442 tells me that his 2nd toe was black for about three weeks after the procedure.

He was seen on 11 May 2005, where the callosities he currently has were noted and he has been referred for a metatarsal bar to be made in Maryborough. As the Orthotist only comes once a month, he has not yet had this made.

Reviewing his x-rays, films from October 2003 prior to his surgery show dislocation of 4 MTP joints and periarticular erosions which would certainly fit with his known rheumatoid arthritis.

To examine him now, he has intact ankle pulses, his lesser toes do stick up in the air, his PIP joints are fused, but he also has minimal movement in his 2nd and 4th MTP joints, and in fact these may be fully fused. The 2nd in probably 40° extension, and the 4th in possibly 25° extension. The 3rd is painful to touch around the MTP joint; he has large callosities under the 2nd and 4th metatarsal head.

My overall impression is that the first clinical review was reasonable, but it was not noted that he had a history of rheumatoid arthritis, that the MTP joints were dislocated on x-ray, or that they showed rheumatoid changes. The decision making to go ahead with surgery does seem reasonable, and the majority of the procedure would be the right thing to do with the extensor tenotomies, the dorsal incisions, the PIP fusions, and excision of the metatarsal heads. Where there appears to be problems relate to the decision to fuse the MTP joints, the decision to only resect the 2nd and 4th metatarsal head, would potentially cause increased pressure on the 3rd and 5th metatarsal head, although in him this is not the case and also insufficient bone was resected.

I have discussed his options from here, which are basically trying the shoe inserted that he is having or excision of the four lesser metatarsal heads. It is likely that this second opinion would give him significant improvement over his current situation, although I have also indicated that wherever the surgery is done, there is potential for complications. He is going to consider this.

Yours sincerely

(Dictated/Checked/Not signed)

Dr Scott Crawford
Director of Orthopaedics
The Prince Charles Hospital

Date Checked: 10.06.05