Foot and Ankle Pathway (V12) 30.04.2019

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

OUTCOME MEASURES

- MSK-HQ

Referral reason / Patient presentation	Plantar Fasciopathy / Plantar Heel pain *Soft tissue pain in heel / arch provisional diagnosis, Heel pain, plantar enthisopathy, plantar fasciitis*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain (see Spine guidelines for management & guidance) • Absence of neuro or vascular symptoms • Less than 6 week duration • Absence of single traumatic episode Diagnostics: • None **Management (including condition-specific self-care options):** • Patient education • Assessment and advice regarding footwear - avoiding totally flat or high shoes • Calf muscle exercises / stretches • NSAIDs in line with agreed formularies / guidance • Simple analgesics e.g. paracetamol in line with agreed formularies / guidance • Activity restriction • 'Off the shelf' heel pad • Do not inject • Education re natural history, self-management for 6-9 months • Heel Pain Patient info leaflet - \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\1. Heel pain F1.docx

Thresholds for Primary Care to initiate a referral	**Refers to Integrated MSK Podiatry or physiotherapy Service (refer to service with shortest wait on website) if:** • > 6 weeks of symptoms • Failure to create sustained improvement within primary care management • functional impairment • Dry needling (provided by Physiotherapy) **Refer to Integrated MSK Service (Triaged to Advanced Practitioner) if:** • >6 weeks of symptoms with significant functional impairment • Bilateral heel pain • Suspected inflammatory arthropathy • Features of unremitting pain, non-mechanical features. • Non responsive to MSK podiatry/ physiotherapy Co-located with con (where applicable) • Trauma

Management Pathway for the Integrated MSK Service	**1 Patient education and information** • Role of weight management • Appropriate footwear • Patient information leaflet **2 Assessment and Examination (Advanced Practitioner)** • Consideration of differential diagnosis • Neurovascular component **3 Investigations** Consideration of further tests: • Weight-bearing X-ray traumatic (AP, lateral, post Calc view) - query fracture component • Ultrasound pre-referral guided injection • MRI – to exclude sinister pathology **4 Management - Advanced Practitioner:** <u>Stage 1</u> • Suspected spinal component - **treat as red flag** • Explanation with leaflet or diagrams as required, issue with patient info leaflet • Specialised Footwear (self-purchased) and stretch advice • consider air cast boot (info leaflet) for 4 weeks • Home Exercise Program – HEP • Taping • Gait re-training • Orthoses to address mechanical issues • Consider unguided Steroid Injection (if competent) not advisable less than 3 months. –consider risk of fat pad atrophy 1st injection in clinic Ultrasound guided injection if appropriate (please note ultrasound required pre referral) • Blood tests – if inflammatory component <u>Stage 2</u> • Dry needling through physio / pod if offered • ESWT accessed through orthopaedic in secondary care – Guilford. (Extracorporeal Shockwave Therapy) –IP6311 Nice Refractory fasciopathy. **Consider Spine pathway if:** • back component identified **Consider Rheumatology pathway if:** • Suspected ankylosing spondylitis • Consider vascular component **4 Outcome Tools** • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • MSK HQ
Orthotics Thresholds	• Appropriate footwear • Weight management where applicable • 12 weeks of stretching/ strengthening/ gait re-education • Over the counter arch support (self purchase)

	Three quarter length arch support, off the shelf.
Thresholds for referral for Intervention Offer patient choice of provider	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** Day Case / no direct listing
Management pathway for Specialist In-patient care	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has been through stage 1 and 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises **Procedures:** • Gastrocnemius release
Referral reason / Patient presentation	**Hallux Valgus / Bunions** *Bony deformation of the first ray with lateral deviation of the great toe.* *May be asymptomatic, painful in preferred shoe gear, painful affecting walking or debilitating.* *The pain may be deep (bony) or superficial i.e. affecting the skin overlying the bony prominence despite wearing sensible footwear.* *Lesser toe deformity may occur concurrently* *May present with pain impacting on function.* **CEC Thresholds - Hallux Valgus* *(Ctrl and Click)*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude inflammatory disease • Assess preferred footwear

	Diagnostics: • **<u>None</u>** **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education • Consider blood test if Rheumatoid element / inflammatory disease / sero-neg arthropathy / gout is likely • Accommodative footwear • Over the counter orthotics if flat foot • Hallux valgus patient information leaflet - \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\2. Hallux Valgus F1.docx • Patient information leaflet: https://www.versusarthritis.org/media/1252/foot-pain-information-booklet.pdf
Thresholds for Primary Care to initiate a referral	**Refers to Integrated MSK Podiatry if:** • Increasing deformity, especially with family history. • Pain elsewhere in the foot due to altered foot mechanics • Symptomatic Hallux Valgus **Refer to Integrated MSK Service if (Triaged to Advanced Practitioner / Podiatric Surgeon / Orthopaedic Consultant):** • Persistent pain unable to manage through shoe change • Affecting ability to work • Affecting activities of daily living Co-located clinic (geography dependant) • Exhausted conservative treatment pathway outlined in GP letter. • Progressing deformity • Secondary biomechanical issues • Patient open to surgical solution, previously seen and surgery agreed (consider use of DAPOT if applicable) • Ulceration over the Hallux • Non responsive to MSK Podiatry No direct triage to Pod surgeon unless at point of triage, demonstrate CEC compliance
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination (Advanced Practitioner)** • Consideration of Causal Origin (genetic, biomechanical, inflammatory) **3 Investigation & diagnostics:** • Full blood count, ESR, CRP and uric acid required if systemic cause thought likely • Plain film x-ray (weight bearing AP and lateral) **<u>only if</u>**: • surgical opinion required to assist with planning • to identify Rheumatological component **4. Management Advanced Practitioner** • Explanation with leaflet or diagrams as required • Enhanced shoe wear advice

	<u>Stage 1:</u> • Patient education • Orthoses / foot wear • Orthoses provision – • NSAIDs and paracetamol for episodic pain management in line with agreed formularies / guidance <u>Stage 2**:**</u> • Bespoke footwear <u>Stage 3/4:</u> If **<u>not a surgical candidate</u>**: • Footwear modification including semi bespoke shoes or modifications If **<u>surgical candidate:</u>** • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken – depending on anaesthetics **<u>NOTE - Osteotomy</u>** • 95% operations can undergo regional block (local anaesthetic; GA only at patient's request) • Performed as day case - no Anaesthetist required • Surgery performed by Podiatric Consultant or Orthopaedic Consultant **5 Post-operative management:** • Telephone follow up within 1 week (unless high risk patient) • Face to face follow up at 2 weeks for sutures removal and initiation of exercise programme • Follow up at 6 weeks for x-ray and review (face to face or Skype) **6 Outcome Tools** **4 Outcome Tools** • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • MSK HQ **Hub environment (could be spoke but 10 metre walk way required for all patients)**
Orthotics Thresholds	• Correct footwear • Specific mechanical issues to address
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** Day Case / no direct listing
Management pathway for Specialist In-patient care	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has been through stage 1 and 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited

	• Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • Bunions- follow up at 6/52 for an x- ray, face to face with podiatric surgeon Aseptic Area - dependant on procedure Post Anaesthetic facility Osteotomy to be performed in theatre with adequate lamina flow facilities
Referral reason / Patient presentation	**1st MTPJ pain (vv2) – hallux limitus / hallux rigidus** *Pain/Swelling focused around the 1st MtPJ with or without bony swelling usually associated with increasing ankylosis* *Soft tissue swelling /bursitis* *Stiffness will create possibility of secondary gait changes leading to pain elsewhere* *Presents with or without Hallux limitus*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Assess preferred footwear **Diagnostics:** • Bloods to exclude raised serum urate levels – ***follow Rheumatology pathway for Gout (raised urate does not always = gout)*** **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education and information • Recommend stiffer soled shoes • Over the counter orthotics if flat feet • Patient information on osteoarthritis of the big toe / hallux rigidus – \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\3. Hallux Rigidus F1.docx • Patient information leaflet: https://www.versusarthritis.org/media/1252/foot-pain-information-booklet.pdf
Thresholds for Primary Care to initiate a referral	**Refers to Integrated MSK Podiatry if:** • Non-surgical candidates with:

	○ Persistent pain unable to manage through shoe gear change ○ Pain elsewhere in the foot due to altered foot mechanics/ gait **Refer to Integrated MSK Service Advanced Practitioner if:** • DAPOT • Increasing deformity, especially with family history. • Affecting ability to work • Affecting ADLs • Possible risk to tissue viability • Non responsive to MSK podiatry management • Pain despite appropriate footwear • Co-located clinic (geography dependant) • Listed for surgery in the past • Exhausted Msk pod and iCATS thresholds. Wants to explore surgery • AP to complete CEC process with con in clinic next store.
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination (Advanced Practitioner)** **Hallux Rigidus classification –** \\rdrfs002\rdr-uhf$\JacksonR\7. F&A Pathways\Classification for HR & PTTD.docx • Consideration of Causal Origin (genetic, biomechanical, inflammatory) **3 Investigation & diagnostics:** • Full blood count, ESR, CRP and uric acid required if systemic cause thought likely • Plain film x-ray (weight bearing AP and lateral **only if**: ○ Surgical opinion required to assist with planning ○ (injection undertaken without imaging) ○ Uncertain features **4 Management Advanced Practitioner** • Explanation with leaflet or diagrams as required • Enhanced shoe gear advice **MSK Podiatry** Stage 1 • Patient education • Manipulation • Orthoses provision • NSAIDs and paracetamol for episodic pain management in line with agreed formularies / guidance • Fan taping as "rescue remedy" Stage 2: iCATS • If joint space is swollen and painful consider Steroid injection • If no improvement consider and patient waits for Podiatric Surgeon Vs Orthopaedic Consultant review • Footwear modification including semi bespoke shoes or modifications – rocker sole shoes, MBT probably a better option • Foot wear advice leaflet If **not a surgical candidate:** • Footwear modification including semi bespoke shoes or modifications – rocker sole shoes, MBT probably a better option

	<u>Stage 3/4:</u> • Discuss surgical options including Cheilectomy, arthrodesis, osteotomy, arthroplasty • Forefoot surgery leaflet If **<u>surgical candidate: if appropriate candidate</u>** High risk – ortho Low risk – Pod • Co-morbidity dependent • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken **5. Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire) • MSK HQ
Orthotics Thresholds	• Correct footwear – stiff sole • Two mobilisation exercises (6 weeks) Stretching if indicated
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Direct listing possible**
Management pathway for Specialist In-patient care	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has been through stage 1 and 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • **1/52 telephone follow up post op** • **6/52 face to face follow up post op** **Aseptic Area - dependant on procedure** **Post Anaesthetic facility** **<u>NOTE: Cheilectomy, arthrodesis, osteotomy, arthroplasty</u>** • 95% operations can undergo regional block (local anaesthetic; GA only at patient's request) • Performed as day case - no Anaesthetist required • Surgery performed by Podiatric Consultant or Orthopaedic Consultant **Post-operative management:**

	• Telephone follow up within 1 week (unless risk patient) • Face to face follow up at 2 weeks for sutures removal and exercise programme • Follow up at 6 weeks for x-ray and review (face to face or Skype) • +/- walker boot or rocker shoe
Referral reason / Patient presentation	**Interdigital neuroma / bursitis** *Pain described across the forefoot variable from focused to general across whole forefoot with or without paraesthesia or numbness spreading into toes* *Squeezing the forefoot may reproduce symptoms.* *No trauma* *Trauma did not precede onset of symptoms*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Check shoes for width - tight shoe exacerbate condition, adequate size • Exclude trauma • Patient information on interdigital neuralgia – \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\4. Neuroma F1.docx **Diagnostics:** • **None** **Management (including condition-specific self-care options):** • Patient education and information • Assessment and advice regarding footwear • Over the counter orthotics if flat feet • MTPJ site of pain
Thresholds for Primary Care to initiate a referral	**Refers to Integrated MSK Podiatry if:** • >6 weeks of symptoms • Symptoms progressing **Refer to Integrated MSK Service Advanced Practitioner if:** • 6 weeks of symptoms • Poor foot posture i.e. very flat feet • Numbness paraesthesia • Analgesia advice • For consideration for an injection • Non responsive to conservative management ***Co-located clinic / secondary care thresholds*** • *Exhausted Stage 1 and 2 treatment modalities* • *Unable to inject* • *No response to previous injections.* • *Surgical candidate and wants surgery*

Management Pathway for the Integrated MSK Service	**1 Patient information and education**
	
	2 Assessment and examination:
	
	• Consideration of differential diagnosis:
	  ○ O/A
	  ○ Stress
	  ○ Tumour
	  ○ Capsulitis/Bursitis
	  ○ Mono-arthritis
	  ○ Tendonopathy, flexor plate pathology
	• Sensation test
	• Mulder click
	• End range grind and drawer tests
	
	4 Diagnostics:
	• X-ray if joint pathology suspected
	• Ultrasound – only if failed injection
	
	5 Management (Podiatrist / Advanced Practitioner / Podiatric Surgeon / Orthopaedic Consultant):
	MSK Podiatry
	<u>Stage 1</u>
	• Enhanced shoe gear advice (wide toe box, low heel)
	• Orthoses with pronation control and metatarsal dome
	• Analgesia in line with agreed formularies / guidance
	
	<u>Stage 2</u>
	• Unguided steroid injection @ 3 months. Consider risk of fat atrophy.
	• Ultrasound guided injection
	• Surgical footwear required
	• Mid Sussex – the Vale
	• Brighton and Hove – Secondary care to Brighton Lab (Ortho hold the budget)
	
	6 Outcome Tools
	• PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure)
	• MSK HQ

Orthotics Thresholds	• Correct footwear • Weight management • Home exercises (including calf lengthening) • Anti-inflammatory gel • Over the counter metatarsal dome or pad
Thresholds for referral for Intervention **Offer patient choice of provider**	**Consider referral if:** • Frank tendon rupture or high grade dysfunction suspected • Conservative measures fail **Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Direct listing possible**

Management pathway for Specialist In-patient care	**1 Listed for surgery based on i.e.:** • Pain • Condition limiting function • Patient has reached stage 2 of the Integrated MSK Service and is confirmed as a surgical candidate **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed Neuroma Management https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/FA-Neuroma-Management.pdf Surgical Procedures – Soft Tissue Surgery https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/1.-Surgical-Procedures-Soft-Tissue.pdf **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • **1/52 telephone follow up post op** • **2/52 face to face follow up post op** • **8/52-12/52 x-rays & face to face follow up** **Aseptic Area - dependant on procedure** **Post Anaesthetic facility**
Referral reason / Patient presentation	**Tibialis posterior dysfunction** **Posterior tibialis dysfunction** **Mostly presents as flat feet** *New onset of pain to postero – medial ankle region, with +/- new onset of flat foot/feet.* *Pain to posterior medial foot and ankle progressing, often a unilateral flat foot.*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management & guidance)*** • Absence of neuro or vascular symptoms • Less than 6 week duration • Single Leg Heel Raise • Too many toes sign, see: orthoinfo.aaos.org • Plain film not indicated

	Diagnostics: • None **Management** (including condition-specific self-care options): • Urgent referral to Integrated MSK Service within 7 days • Tip toe test • Pain, swelling • If not picked up, will result in permanent deformity. • Patient information on PTTD – \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\5. PTTD F1.docx
Thresholds for Primary Care to initiate a referral	**Refers to Integrated MSK Podiatry or physiotherapy Service (refer to service with shortest wait on website) if:** • Unilateral flat foot with pain • Pain affecting day to day activity • Pain with single leg heel raise **Refer to Integrated MSK Service (Advanced Practitioner / Podiatrist) if:** • Urgent -Suspected Tibialis posterior rupture, sudden onset/ traumatic origin. Consider DAPOT (MRI) • Urgent - If bony pathology suspected • Immediate referral to Integrated MSK Service; appointment within 7 days • Routine – secondary mid foot degeneration • Positive tIp toe sign • Weakness of supination/inversion
Management Pathway for the Integrated MSK Service	**1 Patient information and education -** \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\5. PTTD F1.docx **2 Assessment and examination (Advanced Practitioner / Podiatrist):** PTTD classification – \\rdrfs002\rdr-uhf$\JacksonR\7. F&A Pathways\Classification for HR & PTTD.docx • Assessment and examination • Consideration of differential diagnosis • Neurovascular component **3 Diagnostics:** • MRI if other tissues involvement suspected **4 Management (Advanced Practitioner / Podiatrist):** **MSK Podiatry** • Pod MSK Enhanced Shoe gear • Pod MSK Home exercise program - HEP • Pod MSK Taping • Pod MSK Gait re-training • Pod MSK Orthoses to address mechanical issues • Protocol has been revoked • Blood - inflammatory component- FBC,ESR,CRP & RHF (if indicated) • Richie Brace in chronic condition **Integrated MSK ICATS** • ICATS Aircast walker boot

	• Triage /ICATS If suspected spinal component-refer to Spine ESP **Consider Spine pathway if:** • back component Thresholds for referral to Orthopaedics Check for tib post rupture grading system G3 **5 Outcome Tools** • (FAAM) F&A Ability Measure
Orthotics Thresholds	• Correct footwear
Thresholds for referral for Intervention Offer patient choice of provider	**N/A**
Management pathway for Specialist In-patient care	Surgical procedures embedded into the patient information leaflet - \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\5. PTTD F1.docx https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/Surgical-Procedures-–-Mid-Foot.docx
Referral reason / Patient presentation	***Ankle sprain, medial or lateral and peroneal tendinopathy*** *Medial ankle sprain: eversion injury, sprain to the medial deltoid ligament* *Lateral ankle sprain/pain /peroneal tendinopathy: inversion injury or insidious onset of lateral ankle pain.*
Primary Care Management	**Investigation:** • History • Examination and assessment • Functional ability • Consider early treatment at A+E **Diagnostics:** • Lateral ankle • If non-settling and suspect avulsion fracture, consider X-ray • If suspected tibialis posterior rupture, follow the tibialis posterior pathway **Management (including condition-specific self-care options):** • Patient education • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • Advise limitation of exacerbating factors, i.e. sports and work related activities • Over the counter ankle support • Footwear advice • Consider physiotherapy if not settling (6 weeks post injury) • Patient information leaflet on ankle sprains – \\rdrfs002\rdr-uhf$\JacksonR\WEBSITE v2\Conditions\6. Ankle sprains - medial and lateral F1.docx

Thresholds for Primary Care to initiate a referral	**Refers physiotherapy Service if:** • >6 weeks of symptoms post lateral ankle sprain with pain and loss of function. **Refer to Integrated MSK Service (Advanced Practitioner):** • Medial ankle sprain - not improving after 6/52 • Results of diagnostics indicates specialist assessment. • Suspicion of marked tissue trauma • Lateral ankle sprain -not improved with physiotherapy (3 months). • Suspicion of tibialis posterior involvement.
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination (Advanced Practitioner):** • Clinical picture • History • Appearance • Results of any tests / imaging • Check for instability (ligamentous) and muscle/tendon pathology **3 Diagnostics:** • X-ray if considering OCD or degenerative changes. • Ultrasound if peroneal brevis rupture considered / ligament pathology suspected • Consider MRI if: • bone pathology likely but X-ray is NAD and not responding (Occult avulsion # or OCD- Osteochondral defect (medial or lateral) • chronicity has set in and possible impingement **4 Management Advanced Practitioner** • Further rest with bracing • Lateral ankle sprain – boot + leaflet and active monitoring • Management of underlying pathomechanics, cavoid foot effects outcome. • Home Exercise programme • Taping • Consider / Orthopaedic Consultant review if: • Osteochondral defect confirmed • Home exercise programme through physiotherapy service of MSK podiatry **5 Outcome Tools** • MSK HQ
Orthotics Thresholds	**N/A**
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Pod surgeon if no trauma** Lateral ankle instability despite conservative treatment and patient wants to seek a surgical opinion.

Management pathway for Specialist In-patient care	**1 Listed for surgery based on i.e.:** • Recurrent instability • Persistent pain • Functional limitations to ADLs • Confirmed ligament or tendon rupture **2. Surgical pathway: #** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises **Aseptic Area - dependant on procedure** **Post Anaesthetic facility** Surgical Procedures – Mid Foot https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/Surgical-Procedures-–-Mid-Foot.docx Surgical Procedures – Rear Foot https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/Surgical-Procedures-–-Rear-Foot.docx
Referral reason / Patient presentation	**Forefoot Pain** *Pain in the forefoot, generally of non-traumatic origin although it may manifest after surgical rehabilitation; however, stress fracture of MT shaft is not uncommon* *See interdigital neuroma/ bursitis pathway*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Exclude fracture / joint pathology **Diagnostics:** • X-ray if fracture / joint pathology is suspected **Management (including condition-specific self-care options):** • Patient education • Assessment and advice regarding footwear - avoiding totally flat, high or tight shoes. Encourage supportive / cushioning footwear (trainers) • Protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance

	• Reduce overuse of component, activity restriction • Trauma with change in toe shape, reflecting a possible plantar plate tear. • Exclude inflammatory arthropathy • Patient information leaflet: https://www.versusarthritis.org/media/1252/foot-pain-information-booklet.pdf • Patient information leaflet on lesser toe deformities – WEBSITE v2\Conditions\8. Toe Deformities F1.docx
Thresholds for Primary Care to initiate a referral	**MSK Podiatry:** • Persistant forefoot pain **Integrated MSK Service (Advanced Practitioner) if:** • Pain is preventing day to day activity • Frank joint pathology suspected • Failure to create sustained improvement • Symptoms persist > 6 weeks
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination (Advanced Practitioner):** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Check ankle joint for soft tissue and/or bony restriction **3 Management:** • Suspected spinal component **refer to spine** • Enhanced shoe gear • Home exercise programme - HEP • Gait re-training • Orthoses to address mechanical issues • Steroid injection (without Ultrasound guidance) – note: must have x-ray first • Exclude freibergs- Avascular Necrosis and if stress fracture use Ultrasound to confirm • -Osteobleed • Blood - inflammatory component • Consider air cast boot if necessary **4 Diagnostics:** • Consideration of furthers tests: • X-ray if traumatic and query fracture component • Freibergs **5 Further management options:** • Consider Spine pathway if back component • Consider Podiatric Surgeon / Orthopaedic Consultant review if: • Conservative measures fail • Unguided injection fails • Inflammatory disease suspected **6 Outcome Tools** • MOXFQ (The Manchester-Oxford Foot Questionnaire)

	• PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure) • EQ5D • SURE
Orthotics Thresholds	• Biomechanical issues that need addressing • Stretches where indicated
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** **Surgical options:** • Osteotomy • Burstitis • Freibergs
Management pathway for Specialist In-patient care	**1 Listed for surgery based on i.e.:** • Persistent pain • Condition limiting function • Conservative measures and unguided injection failed **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • **1/52 telephone follow up post op** • **2/52 face to face follow up post op** • **8/52-12/52 x-rays (if indicated) & face to face follow up** **Aseptic Area - dependant on procedure** **Post Anaesthetic facility** **Osteotomy to be performed in theatre with adequate lamina flow facilities**

Referral reason / Patient presentation	**Midfoot pain** Pain in the midfoot, generally of non-traumatic origin.
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Exclude fracture • Trauma, lisfranc fracture **Diagnostics:** • Weight-bearing X-ray if bony / joint pathology suspected **Management (including condition-specific self-care options):** • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Activity restriction • Patient information leaflet: https://www.versusarthritis.org/media/1252/foot-pain-information-booklet.pdf
Thresholds for Primary Care to initiate a referral	**Refers to Integrated MSK Podiatry Service if:** • Mechanical symptoms of Mid foot pain • Symptoms more than 6 weeks **Refer to Integrated MSK Service Advanced Practitioner** • Symptoms more than 6 weeks • Symptoms have not responded to MSK podiatry • Mid Foot persists most of the time • Increased deformity ***NB If neuropathic arthropathy (Charcot) suspected, X-ray and refer urgently to orthopaedics via A&E***
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination (Advanced Practitioner):** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Provocative testing of midfoot joints and extensor tendons **3 Diagnostics:** • Bloods • X-ray if bone joint pathology suspected • Ultrasound if tendon pathology suspected (note: this will show TMT and tarsao-tarsal o/a and capsulitis more clearly than x-ray) • MRI if suspecting a Lissfranc • Diagnostic USGI with local anaesthetic only

	4 Management: • Footwear advice • Protect, rest, ice, compress, elevate (PRICE) • Joint mobilisations • Taping • Orthoses • Steroid injection (Note: x-ray guided is gold standard. 'Blind' injection is not recommended) • Blind injection is permitted, competency dependant. • Consider Orthopaedic Consultant review if: • failed conservative treatment • failed steroid injection • suspicion of systemic inflammatory component • fracture seen and not responding • SEE OVER **5 Outcome Tools** • MSK HQ • Fam S4
Orthotics Thresholds	• Footwear • Home exercise programme for 6 weeks Over the counter arch support
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** Osteotomy Excision of bursa **Podiatry surgery** To consider midfoot fusion **Orthopaedics** • Midfoot deformity • Navicular drop • Plantar prominence • Minimum response to conservative treatment and an injection. **Patient wants to consider surgery and is fit for surgery.**
Management pathway for Specialist In-patient care	**1. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **2. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises

	• After 1 week-phone • 2 weeks face to face • 8 weeks X-ray and face to face • 12/52 follow up Lamina Flow Theatre / Aseptic Area - dependant on procedure Post Anaesthetic facility Surgical Procedures – Mid Foot https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/Surgical-Procedures-–-Mid-Foot.docx
Referral reason / Patient presentation	***Ankle joint /subtalar joint pain*** *Ankle joint/ hind foot pain and stiffness*
Primary Care Management	**<u>Investigation:</u>** • History • Examination and Assessment • Absence of neuro or vascular symptoms • With or without single traumatic episode. • Infection excluded • Rigid flat foot • Decreased subtalar range of movement • Exclude trauma, fracture, Charcot **Diagnostics:** • X-ray including weight bearing views ray if bony / joint pathology suspected **Management (including condition-specific self-care options):** • NSAIDs and simple analgesics in line with agreed formularies / guidance • Supportive footwear • Avoid heat, alcohol, running, massage (HARM) • Activity restriction • Patient information leaflet: https://www.versusarthritis.org/media/1252/foot-pain-information-booklet.pdf
Thresholds for Primary Care to initiate a referral	**MSK Podiatry/Physio:** • Mechanical symptoms of foot pain • Altered foot biomechanics/ foot deformity • Greater than 6 weeks of symptoms • Episodic flare ups of ankle/ subtalar pain • Morning stiffness (have excluded inflammatory component) **Refer to Integrated MSK Service Advanced Practitioner if:** • Persistent pain, despite appropriate conservative treatment. • Suspicion of inflammatory arthropathy • Atypical features for presentation

	Refer to Co-Located Clinic if: - Strong suspicion of TC coalition – consider CT scan (fine slice) or MRI dependent on surgeon preferences.
Management Pathway for the Integrated MSK Service	**.Patient Education and Information** **2.Assessment and Examination** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Bloods – if suspecting inflammatory spondyloarthropathy **3 Diagnostics:** • X-ray if not already done Suspicion of: • Osteochondral Defect (MRI if secondary care management is indicated) • Sinus tarsi syndrome (MRI if secondary care management is indicated) • Occult fracture (MRI) • soft tissue impingement (MRI if secondary care management is indicated) • Os trigonun (Can be seen on XR but if inconclusive and clinically suspected then MRI is indicated or if secondary care management indicated). • Steida Process (Can be seen on XR but if inconclusive and clinically suspected then MRI is indicated or if secondary care management indicated). Strong suspicion of TC coalition but not seen on XR as may be a cartilaginous – consider CT scan (fine slice) or MRI dependent on surgeon preferences. ▪ Can present with c-sign and/or tailor beak. **4 Management:** - Mobilise and exercise. Steroid injection for diagnostic and therapeutic reasons to ankle joint or subtalar joint. - Steroid injection for sinus tarsi syndrome (1st injection blind, 2nd injection guided) - Ankle brace **5 Outcome Tools:** MSK HQ
Orthotics Thresholds	• Correct footwear • Specific mechanical issues to address
Thresholds for referral for Intervention **Offer patient choice of provider**	**Consider podiatric surgeon if:** • Severe joint degeneration – patient considering joint fusion. • Symptomatic os trigonum or Stieda process. *Pod surgeon would perform surgery open, if patient would prefer to have procedure arthroscopically then ref to orthopaedic surgeon.* **Consider Orthopaedic review if:** • Severe joint degeneration – patient considering joint fusion/ replacement/arthroscopy • Osteochondral defect/lesion • Non resolving ankle impingement. • Symptomatic os trigonum or Stieda process. • TC coaliton

	Offer patient choice of provider if patient needs and wants surgery and is fit for surgery. If patient needs and wants surgery but is not fit for surgery, refer to GP for further management Direct listing not possible **http://www.anklearthritis.co.uk/page-t**
Management pathway for Specialist In-patient care	**Surgical pathway for Podiatric surgery:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **2. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises • After 1 week-phone • 2 weeks face to face • 8 weeks X-ray and face to face • 12/52 follow up Lamina Flow Theatre / Aseptic Area - dependant on procedure Post Anaesthetic facility • Patient information leaflet: https://www.versusarthritis.org/media/1252/foot-pain-information-booklet.pdf **Surgical pathway for Orthopaedic surgery:** https://www.bofas.org.uk/ http://www.anklearthritis.co.uk/#home-1
Referral reason / Patient presentation	**Peroneal tendinopathy +/- subluxation** *Pain/dysfunction to the lateral ankle along the line of the peroneal muscle and tendons* See Lateral ankle pain /sprain / peroneal tendinopathy pathway
	Investigation: • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Absence of single traumatic episode

	Diagnostics: • Muscle power testing (note: tendon may be felt to sublux) • Dynamic ultrasound if suspected peroneal subluxation **Management (including condition-specific self-care options):** • Supportive footwear, small heel if appropriate • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Reduce overuse component, activity restriction
	MSK Podiatry: • Mechanical Pain **Refer to Integrated MSK Service (Advanced Practitioner) if:** • Failure to create sustained improvement • Continuing lateral ankle instability (sprains) • Pain preventing day-to-day activity • Symptoms > 6 weeks
	1 Patient education and information **2 Assessment and Examination:** • Muscle power / flexibility testing • Ankle ligament assessment • Sural nerve entrapment • Exclude bone / joint pathology • Painful Os Peroneum Syndrome (Sobel Sign) • Neuro-vascular component **3 Diagnostics:** • X-ray – AP and Lateral • Ultrasound, if considering referral for surgical opinion **4 Management:** • Suspected spinal component • Protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • Taping • Mobilizations • Proprioceptive / strengthening regime • Orthoses / footwear • Steroid injection • Consider Orthopaedic Consultant review if: • Suspected ligament / tendon tear-direct list opportunity • Suspected avulsion fracture • Severe joint pathology-probably orthopaedics • Suspected systemic inflammatory component • Peroneal tear

	5 Outcome Tools MSK HQ
	N/A
	Offer patient choice of provider if patient needs and wants surgery and is fit for surgery **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management**
	1 Listed for surgery based on i.e.: • Pain • Condition limiting function • Conservative measures and steroid injection failed • Suspected ligament / tendon tear or avulsion fracture or severe joint pathology **2. Surgical pathway:** • Patient fasted - food 4 hours prior to procedure, liquid 2 hours • IV Cannula sited • Sedation requirements • WHO surgical safety checklist completed **3. Discharge criteria:** • Neurological checks completed • Pain controlled • Mobile at pre-op level • Medically stable • Provided with appropriate post-operative exercises **Lamina Flow Theatre / Aseptic Area - dependant on procedure** **Post Anaesthetic facility**
Referral reason / Patient presentation	***Non-Insertional Achilles Tendinopathy*** *Pain in the body of the Achilles tendon.*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Absence of single traumatic episode • Trauma / rupture (Refer to A/E) • Patient information leaflet on Achilles tendinopathy – *WEBSITE v2\Conditions\7. Achilles tendinopathy F1.docx* **Diagnostics:** • Muscle power testing **Management (including condition-specific self-care options):**

	• Supportive footwear, small heel if appropriate • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Reduce overuse component, activity restriction • Suspected full rupture of tendon refer to A & E
Thresholds for Primary Care to initiate a referral	• **Triage to MSK (physio)** • **Symptoms > 6 weeks** **Refer to Integrated MSK Service Advanced Practitioner if:** • Greater than 3 months of symptoms
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination:** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Bloods – if suspecting inflammatory spondyloarthropathy **3 Diagnostics:** • Ultrasound if suspected tendon tear or inflammatory cause **4 Management:** • Mobilise and exercise, if no improvement 3-6 months then F&A Advanced Practitioner • Gel sleeve • Cast/immobilise • Orthotics • Extracorporeal Shock Wave Therapy – accessed via secondary care referral • High Volume Injection (not for chronic patients*)* **5 Outcome Tools:** MSK HQ
Orthotics Thresholds	To address poor biomechanics
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management**
Management pathway for Specialist In-patient care	**N/A**
Referral reason / Patient presentation	***Insertional Achilles Tendinopathy***

Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude nerve root pain ***(see Spine guidelines for management and guidance)*** • Absence of neuro or vascular symptoms • < 6 week duration • Absence of single traumatic episode • Trauma / rupture (Refer to A/E) • Patient information leaflet on Achilles tendinopathy – *WEBSITE v2\Conditions\7. Achillies tendinopathy F1.docx* **Diagnostics:** • Muscle power testing **Management (including condition-specific self-care options):** • Supportive footwear, small heel if appropriate • As with any sprain protect, rest, ice, compress, elevate (PRICE) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and simple analgesics in line with agreed formularies / guidance • Reduce overuse component, activity restriction • Suspected full rupture of tendon refer to A & E • Patient information leaflet on Achilles tendinopathy – *WEBSITE v2\Conditions\7. Achillies tendinopathy F1.docx*
Thresholds for Primary Care to initiate a referral	**MSK Podiatry:** **Refer to Integrated MSK Service Advanced Practitioner if:** • None responsive to MSK podiatry/physio (8 weeks of treatment) • Unable to manage in off the shelf footwear
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination:** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Bloods – if suspecting inflammatory spondyloarthropathy **3 Diagnostics:** • Ultrasound if suspected tendon tear or inflammatory cause **4 Management:** • Mobilise and exercise, if no improvement refer to Advanced Practitioner • Gel sleeve • Cast/immobilise • Orthotics • High Volume Injection (not for chronic patients)

	• Unable to manage in footwear, consider fast track to orthopaedics. **5 Outcome Tools:** MSK HQ
Orthotics Thresholds	**N/A**
Thresholds for referral for Intervention **Offer patient choice of provider**	**Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management**
Management pathway for Specialist In-patient care	**N/A**
Referral reason / **Patient presentation**	***Tailor's bunion (or bunionette)*** *Bony deformation of the 5th ray with medial deviation of the 5th toe and normally lateral deviation of the 5th metatarsal bone.* *May be asymptomatic, painful in preferred shoe gear, painful affecting walking or debilitating.* *The pain may be deep (bony) or superficial i.e. affecting the skin overlying the bony prominence despite wearing sensible footwear.* *Lesser toe deformity may occur concurrently* *May present with pain impacting on function.*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Exclude inflammatory disease • Assess preferred footwear **Diagnostics:** • **None** **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education • Consider blood test if Rheumatoid element / inflammatory disease / sero-neg arthropathy / gout • Accommodative footwear Over the counter orthotics if flat foot
Thresholds for Primary Care to initiate a referral	**Refer to Integrated MSK Podiatry if:** • Increasing deformity, • Pain elsewhere in the foot due to altered foot mechanics • Symptomatic Tailor's bunion. **Refer to Integrated MSK Service if (Triaged to Advanced Practitioner / Podiatric Surgeon / Orthopaedic Consultant):** • Persistent pain unable to manage through shoe change • Affecting ability to work • Affecting activities of daily living

	Co-located clinic (geography dependant) • Exhausted conservative treatment pathway outlined in GP letter. • Progressing deformity • Secondary biomechanical issues • Patient open to surgical solution, previously seen and surgery agreed (consider use of DAPOT if applicable) • Ulceration over the lateral 5th mtpj. Non responsive to MSK Podiatry
Management Pathway for the Integrated MSK Service	**1 Patient education and information** **2 Assessment and Examination (Advanced Practitioner)** • Consideration of Causal Origin (genetic, biomechanical, inflammatory) **3 Investigation & diagnostics:** • Full blood count, ESR, CRP and uric acid required if systemic cause thought likely • Plain film x-ray (weight bearing AP and lateral) **only if**: • surgical opinion required to assist with planning • to identify Rheumatological component • likelihood of Mtpj 5 OA **4. Management Advanced Practitioner** • Explanation with leaflet or diagrams as required • Enhanced shoe wear advice • Patient education • Orthoses / foot wear • Orthoses provision – • NSAIDs and paracetamol for episodic pain management in line with agreed formularies / guidance • Bespoke footwear • Consider steroid injection to MTPJt 5 (if OA) and risks/benefits understood by patient. If **not a surgical candidate**: • Footwear modification including semi bespoke shoes or modifications If **surgical candidate:** • Patient needs and wants surgery – fitness for surgery, pre-operative assessment, and discharge planning undertaken – depending on anaesthetics **NOTE - Osteotomy** • 95% operations can undergo regional block (local anaesthetic; GA only at patient's request) • Performed as day case - no Anaesthetist required • Surgery performed by Podiatric Consultant or Orthopaedic Consultant **5 Post-operative management:** • Telephone follow up within 1 week (unless high risk patient) • Face to face follow up at 2 weeks for sutures removal and initiation of exercise programme • Follow up at 6 weeks for x-ray and review (face to face or Skype) **6 Outcome Tools** **4 Outcome Tools ??** • PASCOM (Podiatric Audit in Surgery and Clinical Outcome Measure)

	• MSK HQ **Hub environment (could be spoke but 10 metre walk way required for all patients)**
Orthotics Thresholds	• Correct footwear • Specific mechanical issues to address
Thresholds for referral for Intervention Offer patient choice of provider	**Consider Orthopaedic review if:** **Offer patient choice of provider if patient needs and wants surgery and is fit for surgery** **If patient needs and wants surgery but is not fit for surgery, refer to GP for further management** Day Case / no direct listing
Management pathway for Specialist In-patient care	**N/A**
Referral reason / Patient presentation	***Charcot Joint (diabetic and non-diabetic)*** *Neuropathic joints often called Charcot joints are caused by loss of sensation in the joint so that it is severely damaged and disrupted* *Suspect acute arthropathy if there is redness, warmth, swelling or deformity (in particular when skin is intact), especially in the presence of peripheral neuropathy or chronic kidney disease. Consider acute Charcot arthropathy even when deformity is not present or pain is not reported*
Primary Care Management	**<u>Investigation:</u>** • History • Examination and Assessment • Be aware that if person with diabetes fractures their foot or ankle , it may progress to Charcot artropathy **Diagnostics:** Refer the person within 1 working day to the multidisciplinary foot care service. Triage will be within 1 working day. Offload in walking boot until definitive treatment can be started by the multidisciplinary foot care team. If acute arthropathy is suspected, arrange a weight-bearing X-ray of the affected foot and ankle.
Thresholds for Primary Care to initiate a referral	**Refer to MSK Podiatry if:** Non Applicable **Refer to Integrated MSK Service Advanced Practitioner if:** Non Applicable
Management Pathway for the Integrated MSK Service	1. **Patient Education and Information** 2. **Assessment and Examination** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Dopplers 3. **Diagnostics:** Consider an MRI if the X-ray is normal but Charcot arthropathy is still suspected 4. **Management:**

	Refer to the foot care team. https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/AirCast-Boot.pdf **5. Outcome Tools:**
Orthotics Thresholds	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**Consider Orthopaedic review if:** Patient presents with Charcot type foot but is not diabetic **Offer patient choice of provider if patient needs and wants surgery and is fit for surgery. If patient needs and wants surgery but is not fit for surgery, refer to GP for further management**
Management pathway for Specialist In-patient care	The foot care team may recommend a non-removable device because of the clinical or the person's circumstances. • Do not offer bisophosphates to treat acute charcot arthropathy, unless part of a clinical trial. • Monitor the treatment of the acute Charcot arthropathy using clinical assessment. This includes measuring foot-skin temperature difference and taking serial X-rays until the Charcot arthropathy resolves. Acute Charcot arthropathy is likely to resolve when there is less than 2 degree between both feet and when X-ray changes show no further progression. People who have a foot deformity that may be the result of a previous Charcot arthropathy are at high risk and should be cared for by the foot protection team.
Referral reason / Patient presentation	***Fractures*** *Acute fracture should be referred to the fracture clinic*
Primary Care Management	**<u>Investigation:</u>** **Diagnostics:** • Suspicion of a fracture, standing weight bearing X-Ray. Refer to virtual/ fracture clinic. • Up to 12 weeks, refer to virtual fracture clinic/ actual clinic. • Greater than 12 weeks, dealt with on a case by case basis. (management will depend on history, site of fracture, nature and progression of symptoms and imaging findings) • https://www.fracturecare.co.uk/ • https://www.fracturecare.co.uk/bsuh-adult-fracture-clininc-referral/ • https://www.fracturecare.co.uk/care-plans/ae-to-acute-injury-guidlines/
Thresholds for Primary Care to initiate a referral	**Refer to MSK Podiatry if:** Non Applicable **Refer to Integrated MSK Service Advanced Practitioner if:** • If fracture is picked up as part of referral for a separate presentation.
Management Pathway for the Integrated MSK Service	**1. Patient Education and Information** **2. Assessment and Examination** • Consideration of Causal Origin (genetic, biomechanical, inflammatory) **3. Diagnostics:** • Standing weight bearing X-Ray

	4. Management: • Manage non displaced fractures with healing on imaging in a walker boot for 4-6 weeks. Patient discharged on active monitoring unless stated otherwise. • Aircast boot and DVT patient information leaflet https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/AirCast-Boot.pdf • If there is malunion, non-union or displacement of a fracture, refer patient to fracture clinic or secondary care orthopaedics where appropriate. **5. Outcome Tools:**
Orthotics Thresholds	• Issue Walking Boot https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/AirCast-Boot.pdf
Thresholds for referral for Intervention **Offer patient choice of provider**	• **Consider Orthopaedic review if:** there is malunion, non-union or displacement of a fracture, refer patient to fracture clinic or secondary care orthopaedics where appropriate. Offer patient choice of provider if patient needs and wants surgery and is fit for surgery. If patient needs and wants surgery but is not fit for surgery, refer to GP for further management
Management pathway for Specialist In-patient care	**N/A**
	Exertional lower limb pain excluding spinal and vascular claudication **Shin Splints** **1. Medial Tibia Stress Syndrome (periostitis)** pain arising from medial soleus fascia attachment to medial border of tibia. But other soft tissues have been sighted as potential source of symptoms. **2. Tibia Stress fracture (progression MTSS)** **3. Compartment syndrome:** *atraumatic exercise induced lower leg pain.* **Acute: Urgent vascular surgical review required:** normally relates to trauma look for 6P's: Pain, Pallor, Paraesthesia, Pulselessness, Paralysis, Poikilothermia. **Chronic:** exercise-induced increase in muscle compartment pressure can affect muscle and nerve function, Symptoms subside when activity stops symptoms include: pain disproportionate to activity, paraesthesia, difficulty moving foot, tightness in muscle which increases on stretching that muscle. **4. Popliteal Artery entrapment Syndrome.** Clinically presents similar to claudication and is more prevalent in younger under 30 males. If this presents bilaterally early vascular review is important. • *Tendinopathy of an anterior or posterior tendon in the distal third of the lower leg*
Primary Care Management	**Investigation:** • History • Examination and Assessment • Absence of neuro or vascular symptoms • With or without single traumatic episode. • Infection excluded • Change in foot biomechanics & or footwear. • Increase in activity.

	Diagnostics: If suspicion of stress fracture and pain does not settle with 6/52 activity restriction / protective loading then consider lateral tibia x-ray. MDT to determine if stress fracture with none breach would be referred fracture clinic or do we manage. If x-ray shows cortical breach referral fracture clinic. If x-ray demonstrates stress fracture with none cortical breach and symptoms are worsening then DAPOT MRI could be considered if there has been clear protective loading. **Management (including condition-specific self-care options):** • NSAIDs and simple analgesics in line with agreed formularies / guidance. ***(check NSAIDs with stress fracture not sure indicated as can affect bone healing).*** • Activity restriction, if indicated protective weight bearing 6/52. Review footwear and biomechanics.
Thresholds for Primary Care to initiate a referral	**Refer to MSK Podiatry if:** Altered foot biomechanics are a contributory factor in presentation. **Refer to physiotherapy if:** There is rehab indicated need: strengthening, balance, kinetic chain loading, education etc. **Refer to Integrated MSK Service Advanced Practitioner if:** • Persistent pain, despite appropriate conservative treatment. • Suspicion of inflammatory arthropathy or deficiency. • Atypical features for presentation.
Management Pathway for the Integrated MSK Service	**6. Patient Education and Information** **7. Assessment and Examination** **8. Diagnostics:** MRI is suspect stress fracture with possible breach anterior cortex. **9. Management:** Stress fracture with none cortical breach 6/52 none weight bearing boot & EC if protective loading failed. **10. Outcome Tools:**
Orthotics Thresholds	**N/A**
Thresholds for referral for Intervention Offer patient choice of provider	**Consider Orthopaedic review if:** **1. MTSS** • If there is soft tissue restriction to reducing loading forces ?soft tissue release of medial compartment. **2. Stress fracture** • MRI shows breach in anterior cortex, or failed conservative management. **3. Compartment** • Acute urgent surgical referral. • Chronic ? surgical review or vascular review if progressively worsening. **4. Popliteal artery entrapment.**

	Offer patient choice of provider if patient needs and wants surgery and is fit for surgery. If patient needs and wants surgery but is not fit for surgery, refer to GP for further management
Management pathway for Specialist In-patient care	**N/A**
Foot and Ankle group 28th March 2018 Hilary, O'Connor, Richard Bell, Imogen O'Callaghan, Lesley Barnes, Rachel Jackson, Mark Sullivan, Tim Harmey, Dylan Anderson, Alex De Sausmarez, Helen Baker, Sally York **Foot and Ankle Group 18th April 2018** Hilary, O'Connor, Richard Bell, Imogen O'Callaghan, Lesley Barnes, Rachel Jackson, Mark Sullivan, Richard Cruse, Stephen Bendall, Tim Harmey, Dylan Anderson, Alex De Sausmarez, Helen Baker, Chloe Stewart, Sally York	