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TIBIALIS POSTERIOR TENDON RECONSTRUCTION

INTRODUCTION

The tibialis posterior tendon runs down the inside of the ankle and attaches to the middle of the foot. The tendon functions to maintain the height of the arch of the foot and to pull the foot inwards (inversion). Once the tendon becomes dysfunctional, the height of the arch drops and the heel turns outward (valgus). This often results in pain and swelling on the inside of the ankle with time on the outside of the foot as well. Left untreated, the joints of the hindfoot (subtalar, talo-navicular and calcaneo-cuboid joints) become painful and arthritic.

THE SURGERY

Tibialis posterior tendon reconstruction surgery has a number of steps. These include:

- i. nerve block, general anaesthetic, intravenous antibiotics
- ii. lengthening of the tendo-Achilles
- iii. realignment of the heel bone (calcaneus) fixed with screws
- iv. insertion of screw into outside of foot (sinus tarsi screw). This helps to restore alignment of hindfoot and midfoot
- v. check x-rays
- vi. repair of tibialis posterior tendon with neighbouring (flexor digitorum longus) tendon
- vii. stabilisation of midfoot (talo-navicular joint capsule)
- viii. closure of wound with stitches/sutures
- ix. back slab plaster

RISKS OF SURGERY

All surgical procedures carry some risk. The risk of complications with tibialis posterior tendon are low (in the vicinity of 20%). Some of the risks of surgery include:

- Infection
- Problems with wound healing that may require antibiotic treatment, readmission to hospital, further surgery including plastic surgery and/or other treatments
- Nerve injury causing pain, numbness tingling and/or pins and needles
- Ongoing pain
- Complex regional pain syndrome
- Scarring and stiffness
- Deformity recurrence
- Hindfoot arthritis
- Recurrence and over correction of the deformity
- Painful sinus tarsi screw requiring removal
- Deep venous thrombosis/pulmonary embolism. (The risk of DVT increases with smoking, the oral contraceptive pill and hormone replacement therapy, immobility and obesity).
- Insufficient blood flow resulting in loss of toes, foot or limb
- Drug allergy / anaphylaxis
- Further surgery
- Anaesthetic complications including heart attack, stroke and death

GUIDELINES FOR EXPECTED POST OPERATIVE RECOVERY

Keep dressings dry and intact until post operative appointment. Keep foot elevated as much as possible, especially for initial 72 hours.

Removal of stitches/sutures: 10-14 days.

Pain killers may be required for up to 6 weeks.

Xarelto tablets (to prevent deep venous thrombosis): for 6 weeks

Protected weight bearing: up to 6 weeks on crutches

- 10-14 days in back slab touch weight bearing on crutches
- 4 weeks in AirCast walking boot weight bearing as able

Commence physiotherapy: 6 weeks.

Return to most activities: 6-9 months.

Full recovery up to 12 months.

Every patient's recovery is individual and depends on the severity of the injury and the complexity of the surgery.

ANY PROBLEMS

During office hours contact Dr Wines' office on (02) 9409 0563. After hours, please contact the hospital where your surgery was performed.