Asian Federation of
Foot and Ankle Surgeons
Established in 1993

Volume 2, Dec 2022

Peng-Ju Huang
President, 9th AFFAS meeting

Dear AFFAS members:

I am honored here to announce that the 9th meeting of Asian Federation of Foot & Ankle Surgeons will be held in Kaohsiung, Taiwan on November 24th-25th, 2023.

We all realize that during the past three years, the COVID-19 pandemic has greatly influenced our way of living and career practice. Fortunately the worst seems behind us, and we are confident that there is a big chance for us to hold a face-to-face AFFAS meeting this time.

Kaohsiung is situated in the southern part of Taiwan with an international airport serving south-east Asia. If you take a flight to Taipei, you can arrive in Kaohsiung by high speed rail in 1.5 hours. The weather in Kaohsiung during late November is very pleasant, which makes it the best time for travel.

I am sure we will do our best to make this AFFAS meeting an exceptional event in both academic and social aspects. Please come to Taiwan to experience our local hospitality, meet old friends, and make new ones. The 9th AFFAS meeting is the event you won't want to miss!

Submissions for the event are already open, with the deadline set at April 30, 2023. Details for registration and payment will be available soon.

Best regards,
Peng-Ju Huang
President, 9th AFFAS meeting

9th AFFAS KAOHSIUNG TAIWAN

Asian Federation of
Foot and Ankle Surgeons
Established in 1993

THE 9TH MEETING OF ASIAN FEDERATION OF FOOT AND ANKLE SURGEONS

DATE November 24th - 25th, 2023

VENUE Kaohsiung Exhibition Center, Kaohsiung, Taiwan

TOFAS
Taiwanese Orthopedic Foot and Ankle Society
2005

Asian Federation of
Foot and Ankle Surgeons
Established in 1993

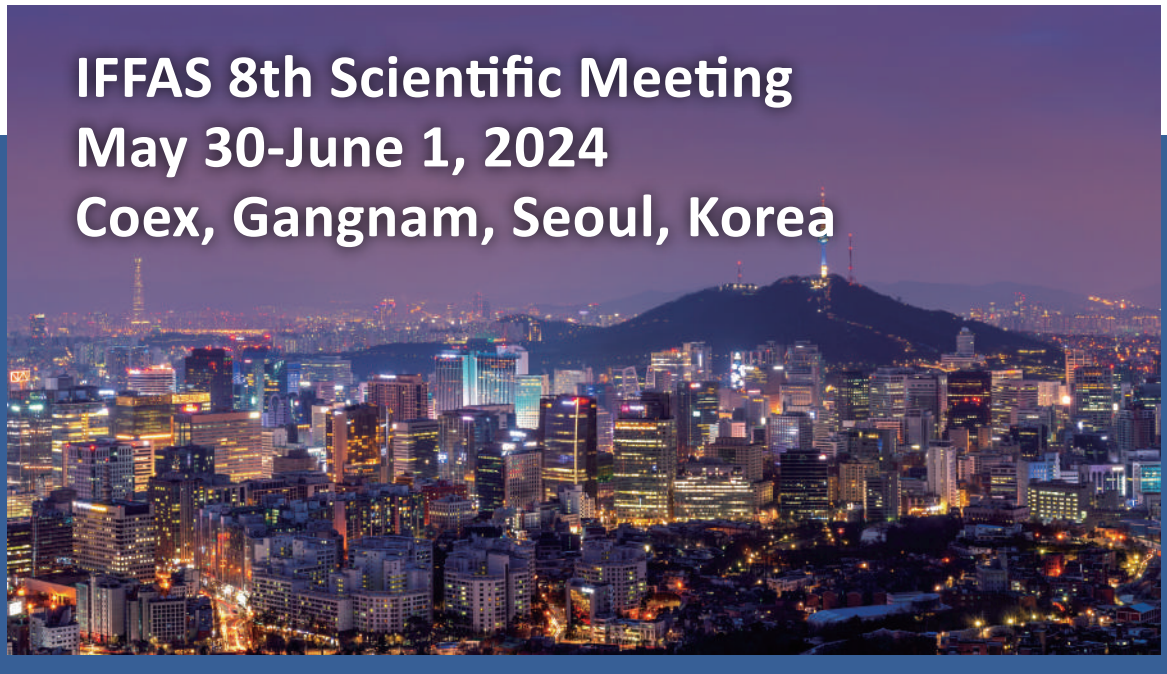
AFFAS 9th Triennial Meeting in Kaohsiung, Taiwan

Open for Submission Now!

– Submission Deadline: April 30, 2023

Notification of Acceptance: June 1, 2023

Early Bird Registration Deadline: Aug 31, 2023



IFFAS 8th Scientific Meeting
May 30-June 1, 2024
Coex, Gangnam, Seoul, Korea

Hosted by the Asian Federation of Foot and Ankle Surgeons

Save the Date!

Traveling to Kaohsiung and the event venue

Asian Federation of Foot and Ankle Surgeons
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From Taiwan Taoyuan International Airport (TPE)

Transfer to the Taiwan High Speed Rail (THSR) Taoyuan Station via taxi or the Taoyuan International Airport Mass Rapid Transit (MRT) system. Travel time is approximately 20-25 minutes via either method, although there may be a considerable waiting time for a taxi.

Take the THSR to Zuoying Station. Trains depart approximately every 30 minutes from 6:30 am to 10:30 pm daily. Travel time is about 1 hour and 40 minutes.

From THSR Zuoying Station, take either the Kaohsiung MRT Red Line or a taxi to reach downtown Kaohsiung. The event venue is about a 15-minute walk from the R8 Station of the Red Line.

Direct flight to Kaohsiung International Airport (KHH)

Take either the Kaohsiung MRT Red Line or a taxi to reach downtown Kaohsiung. The event venue is about a 15-minute walk from the R8 Station of the Red Line.

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Fibula autograft in salvage surgery of a massive podagra: A case report on surgical technique.

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Acknowledgment: R Mohd Ali; A Ahmad
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Abstract

Massive podagra with destruction of the 1st metatarsal is a challenge to the surgeon in view of both soft tissue and skeletal reconstructions. These patients often present with soft tissue ulcerations as well as infection, and may end up with amputation. However, in the absence of infection and a motivated patient who has no other co-morbids, surgical excision of the podagra, and reconstruction of the 1st metatarsal/metatarsal phalangeal joint is a viable option. We present a case and discuss surgical techniques in managing a case of a massive podagra with a diseased 1st metatarsal. We utilised a stage surgery where the pathology was excised and managing the dead space with an antibiotic cement spacer. A 2nd stage reconstruction was done with an autologous fibula graft. Patient has had an uncomplicated wound healing and follow up at 6months has shown graft union.

INTRODUCTION

Gout is an inflammatory arthropathy due to an impaired purine metabolism resulting in prolonged, uncontrolled hyperuricemia. This results in deposition of monosodium urate monohydrate crystals within joints. Crystal depositions in joint leads to pain, restriction of movement, deformity as well as complication such as infection and ulceration(1). The most common joint to be affected is the first metatarsophalangeal joint (MTPJ) of foot and this is termed as podagra(2). Chronic gout may progress into accumulation of large amount crystal within joint causing formation of palpable tophi and if left untreated, it may lead to joint and bone destruction(3). Ulcerated tophaceous gouty lesion are susceptible for infection, and this usually ends up with a surgical debridement, or in worse cases amputations. The challenges include debridement, bony stability, wound closure, as well as prevention of infection. We present this report the surgical method of managing gouty tophi with limb salvation.

CASE REPORT

A 52-year-old gentleman presents to our orthopaedic clinic with a 5-year history of progressively increasing gouty tophis over both his feet. The main reason for his visit was difficulty in accommodating shoes as well as non-infective ulcerations on the right foot. The largest ulcerated tophi were located over dorsal right 1st MTPJ measuring 6x8cm. The swelling is hyperpigmented with thinning of the surround skin. While it did not cause any tenderness on palpation, the swelling resulted in a rigid first metatarsophalangeal joint. His uric acid levels were expectantly high with other laboratory investigation unremarkable, with no evidence of infection. Plain

radiographs show bony erosion over base of proximal phalanx of right great toe and head of first MTPJ (Fig. 1). Surgical intervention was offered to the patient, and a toe salvage procedure was agreed upon. Due to the swelling and bony involvement, a two-stage surgery strategy was utilised. The first stage involved debulking of the tophi, bone resection as well as placement of antibiotic cement. An intramedullary k-wire was used as a temporary stabilizer (Fig. 2). This was done to maintain the length of the medial column as well as to prepare for the 2nd stage. Gross histology revealed irregular chalky white material measuring 90mm in diameter while microscopy showed multiple aggregates of pale eosinophilic amorphous material surrounded by histiocytes and multinucleated giant cells (Fig. 3). Two months later, the 2nd stage was carried out, replacing the antibiotic cement spacer with autologous fibula grafting (Fig. 4). The graft was secured with a locking compression T-plate. His stay in the hospital was unremarkable and his wounds healed well. He was followed up at 7 months of index surgery and his wounds have healed well, and the graft united (Fig. 5).

Fig. 1. Preoperative gross appearance and X-rays.

Fig. 2. 1st stage surgery.

Fig. 3. Histology of excised lesion.

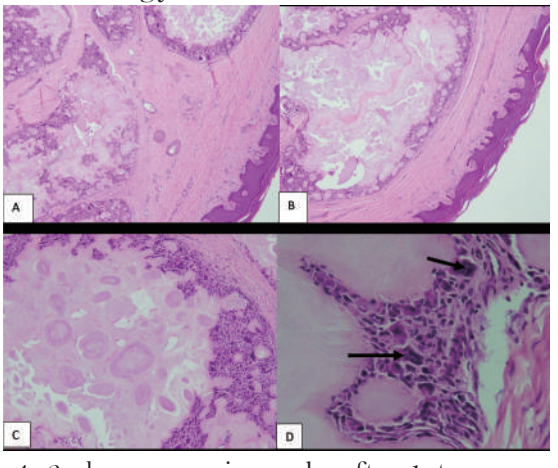

Fig. 4. 2nd surgery, six weeks after 1st surgery.

Fig. 5. Seven months after 2nd surgery.

DISCUSSION

The podagra presents itself as a result of gout in 43-76% of cases. Stewart et all in their meta-analysis report a 79% incidence of 1st MTB erosion on radiographs, along with spur formation (40%), joint space narrowing (39%) as well as sclerosis in 73% of cases(4). This highlights the severity and debilitating effects of the disease. If the 1st MTB is minimally involved, as reported by Tanner et al, a soft tissue excision is usually adequate enough to provide an improvement in the quality of life of the patients(5). In cases of podagra with bony involvement, the decision for surgery is difficult. Stapleton et al utilised a staged procedure similar to our case, utilizing an antibiotic cement spacer with an external fixator to manage the dead space(6). They followed this up by an iliac crest graft and plating. Their patient had complete soft tissue and osseous healing. In cases where there is structural compromise, fibula grafting is a suitable option. Vascularized bone grafts acquired properties which allow the intact endosteal blood supply to initiate, stimulate, and facilitate bony healing but is more technically demanding. The rewards are a very high bony union rates and allow to improve regional circulation, particularly when surrounding tissues have been prone for infection(7). Surgical intervention of a gouty tophus is indicated for functional restoration as well as cosmetic restoration amongst others (8). The goal for patient to undergo surgery is mainly to restore function and permits wearing shoes, control drainage or infection, reduce pain, decompression of nerves and cosmetic restoration

In our patient, his chronic gout had given a huge impact in his quality of life evidenced by having limitation in mobility and being unable to wear footwear. He has no other medical illness (emphasis on non-diabetic and no peripheral vascular disease) besides gout and preferred limb salvaging surgery over amputation. Patient was also able to follow post operative orders and dressing regimes. A detailed risk and benefits discussion was held with the patient pre operatively, with emphasis of wound issues, non-union, as well as possible ischemia or gangrene leading to amputation later. With only limited risk factor and patient foot condition was not infected, arthrodesis and bone graft operation were suitable for him. During the first surgery, we noted total destruction of the distal 1st metatarsal as well as the 1st MTPJ. After resection of the tophi and eroded bone cement spacer was inserted as a temporary void filler to maintain the length of the big toe as well as antibiotic prophylaxis to eradicate any possible local infection. Intramedullary K-wire was inserted instead of external fixation in view of limitation of pin insertion over the distal phalanx. The definitive surgery using the fibula bone graft to replace the bone defect over the metatarsal and proximal phalanx with advantage of restoring toe length, geometrical shape and mechanical strength.

Arthrodesis with T-plate permits adequate

number of screws over the distal phalanx and subsequently securing the fibula bone graft, utilizing a bridge plate principle. Patient was followed up on at 7 months of index surgery and his wounds have healed well, and the graft united.

CONCLUSION

The presence of non-infected giant tophi had impaired overall quality of life and function. Amputation, while the easier surgical option, may not always the best option to patient. With a motivated patient and surgeon, limb salvage surgery should be considered instead. A 2-staged surgery offers a good outcome in these instances.

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Original Article

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Current Trends in the Treatment of Acute Achilles Tendon Rupture: Analysis of the Korean Foot and Ankle Society (KFAS) Member Survey

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The Academic Committee of Korean Foot and Ankle Society, 2021

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This study was based on the Korean Foot and Ankle Society (KFAS) member survey and aimed to report the current trends in the epidemiology, diagnosis, and management of acute Achilles tendon rupture (AATR) over the past few decades. A web-based questionnaire containing 34 questions was sent to all KFAS members in October 2021. The questions were mainly related to the clinical experience and preferred management of patients with AATR. Answers with a prevalence ≥50% of the respondents were considered a tendency. Seventy-one (12.9%) of the 550 members responded to the survey. The male sex ratio in AATR was answered mean 78%, and the most common age groups were 30~40 years (n=49; 69.0%), and 40~50 years (n=37; 52.1%), in that order. The most common seasons for the occurrence of AATR were spring (37 cases; 52.1%) and autumn (27 cases; 38.0%). Also, sports-related rupture had an average occurrence of 76.2%. The most important clinical factor to determine the type of treatment was the history of previous injuries, and 75.9% of respondents started conservative treatment in the 2010s. The most preferred protocol of conservative treatment was an orthosis capable of ankle range of motion after casting (68.5%), and 53.7% 'satisfied' and 1.9% 'very satisfied' with conservative treatment. The most preferred surgical method was open repair (80.3%), and the Krackow method (60.6%), and 49.3% of treated patients responded 'satisfied' and 45.1% 'very satisfied' with this treatment. This study gives updated information concerning the current trend of epidemiology, diagnosis, and treatment of AATR in Korea. Both consensus and variation in the approach to AATR were identified using this survey study. This study may raise the awareness of various possible approaches toward AATR and should be used to further establish a standard protocol for the management of this injury.

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A Prospective Study Comparing Steroid Injection and Needle Fenestration for the Treatment of Chronic Plantar Fasciitis

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This study sought to compare needle fenestration with a corticosteroid injection for the treatment of chronic plantar fasciitis. We hypothesized that needle fenestration would be as effective as a corticosteroid injection while avoiding the potential adverse effects of the corticosteroid. Forty female patients with unilateral chronic plantar fasciitis who did not respond to a minimum of 6 months of various conservative treatments were prospectively randomized to receive either a corticosteroid injection or needle fenestration. Visual analogue scale and American Orthopaedic Foot and Ankle Society (AOFAS) ankle-hindfoot score were used for all patients before treatment and at 3-, 6-, and 12-month following treatment. The corticosteroid injection group had a before-treatment average AOFAS Ankle-Hindfoot score of 56.4, which increased to 87.3 at 3 months and 78.2 at 6 months after treatment but decreased to 62.4 at 12 months. The needle fenestration group had a before treatment average AOFAS ankle-hindfoot score of 49.5, which increased to 77.8 at 3 months and 92.1 at 6 months after treatment and remained at a high score of 89.4 at 12 months. There were no complications in either group. In the treatment of chronic plantar fasciitis, needle fenestration is as effective at 3- and 6-month post-treatment as a corticosteroid injection. Also, unlike a corticosteroid, its effect remains until 12 months post-treatment.

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