JOURNAL OF CHILDREN'S ORTHOPAEDICS

Special symposium issue: Clubfoot

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Dear Readers,

We are happy to provide you with a Special Issue on Clubfoot – including all topics presented during the EPOS Pre-meeting Course 2019 in Tel Aviv.

The very first description of clubfoot deformity goes back to Hippocrates in 400 BC where he states in his original text that 'most cases of congenital clubfoot are remediable...' and that 'there is more than one variety of clubfoot...'. He assumed that 'the best plan..., is to treat such cases at as early a period as possible, before the defiance of the bones of the foot is very great'.

Today, we still do not fully comprehend why the deformity comes into existence, even if Sadler et al with their paper on 'The genetics of isolated and syndromic clubfoot'[1] give us the opportunity to better understand the background of clubfoot occurrence.

Throughout the centuries, people tirelessly tested and developed different techniques to correct the clubfoot deformity. Repeated manipulations, bandages, special shoes and brace wear, and plaster of Paris casts were used. In ancient Greece the main approach was splinting, followed by plaster during the Renaissance. The tenotomy – first performed in the nineteenth century – can be seen as a breakthrough in clubfoot treatment. Nowadays, the Ponseti technique has finally provided a good solution to reach the goal of a functional, pain free and plantigrade foot. Considered a revolution in clubfoot treatment, over the past 20 years it has become the global standard.

Before starting treatment, the foot length might be one aspect to take into consideration as discussed in Hemo et al's paper on 'The significance of foot length at the initiation of the Ponseti method: a prospective study'.[2]

However, some aspects of the Ponseti treatment protocol still remain a challenge as can be read in Alves's 'Bracing in clubfoot: do we know enough?'[3] or are not yet fully understood, as shown in Hemo et al's paper 'Delayed ossification and abnormal development of tarsal bones in idiopathic clubfoot: should it affect bracing protocol when using the Ponseti method?'.[4] Lööf discusses 'Additional challenges in children with idiopathic clubfoot: is it just the foot?"[5] and van Bosse evaluates the need for modifications in "Challenging clubfeet: the arthrogrypotic clubfoot and the complex clubfoot'.[6]

If you are still looking for an outcome measurement tool for the ambulatory child, the new 'PBS Score' provides a simple and easy-to-use method to assess children of walking age.[7]

Especially in the treatment of idiopathic clubfoot, it is no longer necessary to perform extensive surgery. If recurrent, the first method of choice should always be recasting, if required combined with smaller soft tissue procedures such as re-tenotomy and/or anterior tendon transfer. Nevertheless, we sometimes face our limits in very severe cases and therefore our surgical skills are still needed. Illustrative help is provided in Eidelman et al's 'Treatment of relapsed, residual and neglected clubfoot: adjunctive surgery'.[8]

I hope that we – besides making this issue an enjoyable read – are able to inspire you with some new information and helpful instruments to use in your daily practice. Furthermore, we would like to support your important work in helping children – the world's biggest asset.

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