East Sussex MSK Community Partnership

Foot & Ankle Triage Guidelines

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Plantar Heel pain	**Assessment:** • History – Typical symptoms: ➢ First few steps painful ➢ Eases and reoccurs with sustained activity ➢ Aggravated by standing / hard surfaces ➢ More prevalent with: ○ Standing occupations (NICE 2015) ○ Ages 40-60 ○ Obesity (BMI >30) (Riddle *et al.,* 2003) ○ Athletic overload • Consider location of pain –plantar heel • Exclude: ➢ Inflammatory arthropathy (consider referral to Rheumatology) ➢ Nerve root pain (see Spinal Pathway) ➢ Osteoporosis • Consider trauma / plantar fascial tear: bruising, swelling and altered foot posture • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • X-ray not normally required unless history of trauma or inflammatory arthropathy suspected Please be explicit in your request any history of trauma or concerns around an inflammatory process. • Investigations otherwise unnecessary for diagnosis (ARC, 2004b) **NOTE: Calcaneal spurs do not correlate with symptoms. Significant spurs suggest enthesopathic spondylo-arthrotides** **Management:** • Injection is not recommended as first line management and should only be considered by specialist clinician following assessment • Conservative management **Advice:** • Resolution within 6 months • Activity modification • Reduce standing • Avoid barefoot • Recommend soft shoes with a heel • Consider OTC soft heel pads and insoles • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider Analgesia: ➢ Paracetamol ➢ NSAID: offer PPI for longer duration or add codeine if unsuitable • Encourage self-management • Consider the use of Fit notes if patient is working	**Refer to Podiatry if:** • Mild to moderate plantar heel pain symptoms for self- management advice **Refer to Advanced practitioner:** • Atypical symptoms • Severe heel pain • Suspected plantar fascial rupture • Non resolving to rehabilitation • Imaging or Injection request • Rest pain • Altered foot posture (Urgent) **Literature:** Master Patient Information Document	**Assessment:** **Diagnostics:** • XR only if trauma or inflammatory arthropathy suspected • Investigations otherwise unnecessary for diagnosis (ARC, 2004b) **Management:** • Patient Education • Patient choice following SDM • Comprehensive rehabilitation programme • Footwear advice • Orthotics **Refer to Physiotherapy (from Podiatry, Advanced Practitioner or Orthopaedics) if:** • For consideration of Shockwave therapy only AFTER completing a 3/12 course of rehabilitation **(NOTE: Rupture contraindicates shockwave provision)** **Refer to Advanced Practitioner (from Podiatry or Physiotherapy) if:** • Not improved with comprehensive rehabilitation programme • For consideration of imaging or injection • Altered foot posture **Refer to Orthopaedics (from Advanced Practitioner) if:** • Non resolving to rehabilitation, shockwave and or USGI • Diagnostic imaging confirms fasciopathy • Calcaneal Bone insufficiency / Bone marrow oedema • Injection /shockwave contra indicated • Recalcitrant cases requiring calf release

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Lesser Toe Deformities	**Assessment:**
	• History: often positive family history (Female>Male)
	• Usually bilateral with multiple toes affected
	• May accompany dorsal / apical toe pain with metatarsalgia, callosity or tissue breakdown (non-healing wounds may indicate PAD / neuropathy), nail deformity and Hallux valgus / bunionette deformity.
	• Exclude:
	  ○ Trauma
	  ○ Co existent callosities / wounds (consider co –morbidities)
	  ○ Co existent metatarsalgia
	  ○ Neurology / neuropathic features
	  ○ Compartment syndrome
	  ○ Inflammatory signs (consider referral to Rheumatology)
	• Inspect footwear: size, toe box depth and width
	• Assess for impact upon Activities of Daily living and Quality of Life
	• Assess toes for passive correction (can be passively correctable or rigid)
	
	Diagnostics:
	• Blood tests for inflammatory or neuropathy screen if clinically indicated
	• X-rays not normally required unless presenting with non healing wounds present or with signs of osteomyelitis. Please be explcit about these additional features and request Weightbearing X-Ray AP / Lateral
	
	Management / Advice:
	• Reassure if asymptomatic
	• Footwear
	• OTC toe protectors (silipos gel) or digital splints
	• Non-NHS podiatry for painful nail deformity/ callosities without co-morbidities (low NHS criteria scoring)
	• Refer to NHS podiatry if toe deformity & lesions present with co existent PAD / neuropathy / auto immune disease or if metatarsalgia presents
	• Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service)
	• Consider the use of Fit notes if patient is working
	
	Literature:
	https://www.esht.nhs.uk/wp-content/uploads/2020/07/0834.pdf
		Refer to Podiatry if:
		• Persistent lesser toe deformity & toe pain
		• Lesser toe deformity with metatarsalgia despite self-care advice
		• Progressive deformity and impact upon ADL
		
		Refer to Advanced practitioner:
		• Failed non-surgical management
		• Bespoke footwear
			Assessment:
			Diagnostics:
			• Blood tests for inflammatory or neuropathy screen if clinically indicated
			• Weightbearing X-Ray AP / LAT if non healing wounds present or with signs of osteomyelitis
			
			Management:
			• Podiatry
			• Patient Education
			• Wound Care treatment if indicated
			• Silicone toe splints
			• Patient choice following SDM
			
			Refer to Advanced Practitioner (from Podiatry) if:
			• Exhausted podiatry and self-management
			• To confirm deformity nature and optimal management using SDM
			• To exclude inflammatory / neurological
			• To screen patient suitability for surgical opinion (tissue healing risk, health, and social / occupational status)
			• Not improving with conservative measures
			
			Refer to Orthopaedics (from Podiatry or Advanced Practitioner) if:
			• Persistently problematic
			• High risk foot and persistent toe ulceration (EDGH/ CQH only)
			• Patient wants to be considered for surgical intervention
			
			Refer to Orthopaedics (from Podiatry, Advanced Practitioner or Orthopaedics) if:
			• For consideration of bespoke footwear

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Hallux Abducto-Valgus (HAV) **Bunions**	**Assessment:** • Trauma • Plantar Callosities • Ulceration may indicate Diabetes / PAD • Metatarsalgia • Abnormal Neurology • Inflammatory signs (follow Rheumatology Guidelines) • Inspect footwear. • Quality of Life impact **Diagnostics:** • Blood tests if inflammatory cause or neuropathy suspected • X–Ray only required if considering surgical review: Please be explicit regarding severity of symptoms, pain, altered function or weight bearing status, In these circumstances please request weightbearing XR views AP and lateral • If osteomyelitis is suspected - please include oblique views • Repeat X-ray not required within 18 months unless significant deterioration in symptoms • Xrays not required if referring for physiotherapy, orthotics, rehab podiatry **Management:** **If asymptomatic:** • Advise and reassurance • Educate re: Genetic link • Advise wide / deep Footwear • Provide condition specific information: Master Patient Information Document **If asymptomatic:** • Recommend: ➢ Wide/deep Footwear ➢ Interdigital Toe spacer ➢ Insoles (OTC metatarsal dome / arch support) ➢ Activity modification ➢ Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) ➢ Consider the use of Fit notes if patient is working ➢ Provide condition specific information: Master Patient Information Document	**Refer to Podiatry if:** • Has not tried non- surgical intervention or requires wound care • Declines or is unfit for surgery. **Refer to Advanced practitioner:** • Exhausted non-surgical interventions • Has undergone previous HAV surgery with problematic reoccurrence • Has undergone previous HAV surgery and advised on contra-lateral surgery • High risk foot with ulcer not responding to podiatry input	**Assessment:** **Diagnostics:** • X-Ray • Blood tests where inflammatory cause or neuropathy suspected **Management:** • Patient education • Footwear advice • Patient choice following SDM • Wound care (if required) • Orthotics **Refer to Podiatry (from Advanced Practitioner or Orthopaedics) if:** • Patient Choice • Declines or is unfit for surgery **Referral to Advanced Practitioner (from Podiatry) if:** • Exhausted non-surgical interventions, has a completed SDM and CEC form (create WB AP LAT XR at triage and direct to orthopaedics) • Diagnostic uncertainty **Refer to Orthopaedics (from Podiatry, Advanced Practitioner or Orthopaedics) if:** • For consideration of bespoke footwear **Referral to Surgical appliances (from Podiatry, Advanced Practitioner or Orthopaedics) if:** • Requires bespoke footwear. **Referral to Orthopaedics (from Podiatry or Advanced Practitioner):** **Urgently if:** • HAV with persistent wounds unsuccessfully managed by podiatry team **Routinely if:** • Ensure weightbearing XR views are available and within 18 months. • Past HAV surgery and reoccurrence • Metalwork excision **NOTE: Surgery is only commissioned if demonstrates CEC guidelines:** • Persistent pain affecting ADL • Severe bunion and lesser toe deformities • Has tried non-surgical measures: footwear, ICE & elevation, bunion covers, insoles • Smoking cessation and lifestyle management • High risk of complication including ulceration in presence of diabetes • Referral is NOT for cosmetic reasons • Patient wants surgery

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Hallux Rigidus Osteo-arthritis of the MTPJ1	**Assessment:** • Exclude/Consider: ➢ Trauma ➢ Gait abnormality and Plantar Callosities ➢ Ulceration may indicate Diabetes / PAD ➢ Metatarsalgia ➢ Inflammatory signs (consider referral to Rheumatology) ➢ Inspect for inappropriate footwear. ➢ Quality of Life impact ➢ MTPJ1 joint tenderness ➢ Pain with grind test **Diagnostics:** • Blood tests if suspecting inflammatory cause or neuropathy • X-Ray required to make a diagnosis. Please be explicit regarding severity of symptoms, pain, altered function or weight bearing status, In these circumstances XR views should be weightbearing, AP & Lateral • X-Ray if suspecting inflammatory or osteomyelitis signs • Repeat X-ray not required within 12 months unless significant deterioration in symptoms **NOTE: OA is a clinical diagnosis and imaging is not essential for purely diagnostic purposes** **Management:** If asymptomatic: • Advise wide and stiff soled Footwear • Lifestyle and weight management advice If symptomatic: • Recommend: ➢ Wide and stiff soled footwear ➢ Bunion gel covers ➢ NSAID gel ➢ Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) ➢ Consider the use of Fit notes if patient is working ➢ Insoles ➢ Activity modification -avoid excessive hallux dorsiflexion **Analgesia:** • Paracetamol • NSAID: if in severe distress and offer PPI for longer duration or add codeine if unsuitable	**Refer to Podiatry if:** • Mild / moderate symptomatic hallux rigidus **Refer to Advanced practitioner:** • Severe symptoms • For injection consideration • Unresponsive to podiatry or injection therapy (surgery consideration)	**Assessment:** **Diagnostics:** • X-Ray • Blood tests where inflammatory cause or neuropathy suspected **Management:** • Patient education • Footwear advice • Patient choice following SDM • Wound care (if required) • Orthotics **Refer to Podiatry (from Advanced Practitioner or Orthopaedics) if:** • Has not tried podiatry / non-surgical intervention • Declines or is unfit for surgery /steroid injection therapy **Referral to Advanced Practitioner (from Podiatry) if:** • Exhausted non-surgical interventions • Has not responded to podiatric input • Consideration of steroid joint injection • Diagnostic uncertainty • Severe pain / distress / functional restriction **Referral to Surgical appliances /Orthotics (from Podiatry, Advanced Practitoner or Orthopaedics) if:** • Requires bespoke footwear. **Referral to Orthopaedics (from Advanced Practitioner):** **Urgently if:** • Hallux rigidus with persistent wound unsuccessfully managed by podiatry team (urgent) **Routinely if:** • Ensure weightbearing XR views are available and within 18 months • Contralateral hallux rigidus arthrodesis and request for surgery review • Metalwork excision

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Ankle and hindfoot osteo-arthritis	**Assessment:** • Exclude / Consider: ➢ Trauma ➢ Inflammatory signs (consider referral to Rheumatology) ➢ Inspect for inappropriate footwear. ➢ Quality of Life impact ➢ Leg muscle atrophy and gait disturbance ➢ Irritable ORIF metalwork • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Blood tests if suspecting inflammatory cause or neuropathy • X-Ray required to make a diagnosis:Please be explicit regarding severity of symptoms, pain, altered function or weight bearing status, In these circumstances XR views should be weightbearing, AP & Lateral • X-Ray if suspecting inflammatory or osteomyelitis signs • Repeat X-ray not required within 12 months unless significant deterioration in symptoms **Management:** **If asymptomatic:** • Advise supportive footwear • Lifestyle and weight management advice • Reassurance **If symptomatic:** • Recommend: ➢ Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) ➢ Consider the use of Fit notes if patient is working Lifestyle and weight management advice ➢ Supportive footwear with heel elevation ➢ Ankle bracing ➢ Insoles (arch support) ➢ Activity modification **Analgesia options:** • Consider capsaicin • Paracetamol • NSAID: if in severe distress and offer PPI for longer duration or add codeine if unsuitable	**Refer to Physiotherapy if:** • Mild moderate Symptomatic OA **Refer to Advanced practitioner:** • Severe ankle OA • Unsuccessful physiotherapy • Consideration of injection therapy • Consideration of surgery	**Assessment:** **Diagnostics:** • X-Ray • Blood tests where inflammatory cause or neuropathy suspected **Management:** • Patient education • Footwear advice • Patient choice following SDM • Orthotics **Referral to Physiotherapy (from Advanced Practitioner or Orthopaedics) if:** • Has not tried physiotherapy / non-surgical intervention for 6m • Declines or is unfit for surgery /steroid injection therapy • Patient choice **Referral to Advanced Practitioner (from Physiotherapy) if:** • Exhausted 6m of non-surgical interventions • Consideration of steroid joint injection • Diagnostic uncertainty • Severe pain / distress / functional restriction **Referral Surgical appliances /Orthotics (from Podiatry, Advanced Practitioner or Orthopaedics) if:** • Requires bespoke footwear/ bracing **Referral to Orthopaedics (from Advanced Practitioner) if:** • Ensure weightbearing foot ankle XR views and MRI are available and within 12m • Contralateral ankle arthrodesis and request for surgery review • Metalwork excision

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Morton's Neuroma	**Assessment:** • Exclude / Consider: ➢ Trauma (MET fracture) ➢ Plantar Callosities ➢ Ulceration may indicate Diabetes / PAD ➢ Abnormal Neurology (exclude Nerve root pathology) ➢ Inflammatory signs (dactylitis, synovitis) - consider Rheumatology referral ➢ Inspect footwear ➢ Quality of Life impact ➢ Occupation ➢ Freiberg's AVN within adolescent females • Clinical tests: • Thumb forefinger Intermetatarsal space squeeze most sensitive with Mulders and Gauthiers test suggestive. **Diagnostics:** • None required in Primary Care **NOTE: History and clinical examination are sufficient for diagnosis** **Management:** • Provide condition specific information: https://www.esht.nhs.uk/wp- content/uploads/2020/05/0797.pdf • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working Lifestyle and weight management advice • Consider NSAIDS (consider prescribing issues) • NOTE: Avoid blind /palpation injection due to fat pad atrophy risk • Recommend self-management strategies ➢ Avoid high heels ➢ Wide cushioned Footwear ➢ Insoles (OTC metatarsal dome support) ➢ Activity modification ➢ Ankle range of motion / Calf stretches	**Refer to Podiatry if:** • Has not tried non- surgical interventions • Early onset or low- moderate symptoms	**Assessment:** **Diagnostics:** • USS confirms MN and sizes lesion for suitability of CSI or surgery • MRI definitive if USS ambiguous **Management:** • Patient education • Footwear advice • Patient choice following SDM **Referral to Advanced Practitioner (from Podiatry) if:** • Exhausted non-surgical interventions • XR to exclude bone /joint pathology • Steroid injection requested • Requests diagnostic imaging • For consideration of imaging and orthopaedic intervention • Refer to spinal AP if abnormal neurology with suspected spinal component **Referral to Orthopaedics (from Advanced Practitioner) if:** • Exhausted non-surgical and injection therapies • Declines Injection therapy • Diagnostic imaging confirms NBC • NOTE: MRI is necessary prior to surgical opinion

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Progressive Collapsing Foot Deformity (PCFD) *Also known as:* *Posterior Tibialis Tendon Dysfunction (PTTD)* - *Adult Acquired Flat Foot Deformity (AAFD)* - New onset of pain to postero-medial ankle regions with new onset of flat foot / feet	**Assessment:** • Exclude neuro / vascular symptoms • Check for “Too many toes sign” • Tip toe test • Check for pain location / any swelling. • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Consider Charcot if patient is diabetic and presents with a red / hot / swollen / deformed foot. **N.B. – diabetic Charcot neuroarthropathy is painless within the insensate foot** **Diagnostics:** • Weight bearing foot and ankle X-ray to exclude other pathology if considering referral to MSK service • Repeat X-ray not required within 12 months unless significant deterioration in symptoms **NOTE: History and clinical examination are sufficient for diagnosis** **Management (including condition specific self-care options):** • Patient education and information • Consider advice on medial arch supports • Consider advice on Ankle Foot Orthosis (AFO) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Podiatry or Physiotherapy if:** • Pain affecting day to day activity • If bony pathology suspected • Progressive deformity **Refer to Advanced Practitioner if:** • Diagnosis unclear • Bony pathology evident on imaging • Severe symptoms affecting function	**Patient education and information** **Assessment and examination:** • **Stage I:** Normal radiographs, able to perform single heel raise, and mild tenosynovitis. • **Stage IIA:** Arch collapse on a radiograph, unable to perform single heel raise, and a flexible flatfoot deformity. • **Stage IIB:** Arch collapse and talonavicular uncoverage (over 40%) on a radiograph, unable to perform single heel raise, flexible flatfoot deformity, and characteristic forefoot abduction or "too many toes" sign • **Stage III:** Subtalar arthritis on a radiograph, unable to perform single heel raise, flatfoot deformity with rigid forefoot abduction, and hindfoot valgus • **Stage IV:** Valgus deformity of the talus in the ankle mortise, visualized on an AP radiograph of the ankle with talar tilt due to deltoid ligament compromise; subtalar arthritis on radiographs; unable to perform a single heel raise; flatfoot deformity with rigid forefoot abduction; and hindfoot valgus. • Consideration of differential diagnosis: Tarsal coalition, Traumatic disruption of mid foot ligaments, Inflammatory arthritis, Charcot Arthropathy, Neuromuscular disease **Diagnostics:** • X-ray if joint pathology suspected +/- traumatic incident leading to symptoms / deformity • Ultrasound • MRI – only if ultrasound inconclusive and symptoms progressive / surgical consideration appropriate • Bloods – if inflammatory component indicated **Management (Podiatrist / Physiotherapy):** • Patient choice following SDM • Consider orthopaedic / protective boot for stage 2+ • Footwear advice / orthosis to address mechanical issues • PTTD braces / taping (Richie brace in chronic conditions) • Gait re-education, home exercise programme (HEP) **Refer to Advanced Practitioner / Ortho (from Podiatry / Physiotherapy) if:** • Failed conservative therapy • Severe pain • Progressive pain • Diagnostic uncertainty • Surgical referral consideration (stage 2/3/4) **Refer to Physiotherapy / Podiatry (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input

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Ankle Sprain (Lateral / Medial)	**Assessment:** • History of injury • Examination / assessment • Functional abilities • Exclude potential for fracture / significant soft tissue injury – consider early assessment / treatment via MIU / A+E • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Xray required unless already performed in emergency department • The Ottawa ankle rules suggest ankle and foot Xray (Lateral and AP) should be obtained in the setting of pain in the malleolar region and any of the following: Assessment | Diagnosis | Sprains and strains | CKS | NICE **Management (including condition specific self-care option):** • Patient education and reassurance - Mild to moderate ankle sprains typically have a full recovery in 7-15 days • PRICE (Protect, rest, ice, compression, elevation) • Avoid heat, alcohol, running, massage (HARM) • Advise limiting exacerbating factors i.e. sports and work-related activities as appropriate - All symptoms should be resolved before return to sports • Consider over the counter ankle brace • Footwear advice • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Consider MSK referral if not settling (6 weeks post injury)	**Refer to Physiotherapy if:** • Not improving after 6 weeks • Severely affecting daily activity (ADL) / quality of life (QoL) **Refer to Advanced Practitioner if:** • Results of diagnostics indicates specialist assessment required • Suspicion of significant tendon/ligament injury	**Patient education and information** **Assessment and examination (Physiotherapy / Advanced Practitioner):** • Clinical picture – acute vs chronic. Type of injury • Observations / appearances • Review results of any investigations • Check for any ligamentous instability, possible osteochondral defect/ painful talar dome and review muscle tendon function • If CAI (continuing instability) – enquire what strategies have been tried to date **Diagnostics:** • X-ray if joint pathology suspected • MRI if: ➢ Bone pathology but XR NAD and symptoms persisting ➢ If symptoms chronic and surgical referral being considered **Management (Physiotherapy):** • Review bracing, footwear, activity modification and home exercise programme • Management of underlying Patho-mechanics • Consider referral to physio for supervised course of rehab +/- taping etc • Patient choice following SDM **Refer to Advanced Practitioner / Ortho (from Physiotherapy) if:** • Consider CSI / USGI if inflammatory / OA component • Diagnostic uncertainty • Consider onward referral to orthopaedic consultant if: • Failed conservative therapy • Severe pain • Progressive pain • Failed steroid injection • Suspicion of systemic inflammatory component • Fracture seen and not improving **Refer to Physiotherapy / Podiatry (from Advanced Practitioner) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input

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Meta-tarsalgia	**Assessment:** • Exclude / Consider: ➢ Trauma (Fracture -redirect to fracture clinic) ➢ Plantar Callosities ➢ Ulceration may indicate Diabetes / PAD ➢ Abnormal Neurology (exclude Nerve root pathology) ➢ Neuroma Bursa complex / Morton's neuroma (see Morton's neuroma pathway) ➢ Inflammatory signs (consider referral to Rheumatology) ➢ MTPJ bony swelling may indicate OA ➢ Freiberg's AVN (MTPJ2-3) within adolescent females ➢ Inspect poor footwear ➢ Quality of Life impact ➢ Occupation • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • Blood tests if suspecting inflammatory or neuropathic disease • X-Ray if inflammatory arthropathy, AVN, MTPJ OA, trauma (refer to fracture clinic if confirmed) or osteomyelitis suspected • Repeat X-ray not required within 12 months unless significant deterioration in symptoms **Management:** • Provide condition specific information: https://www.esht.nhs.uk/wp- content/uploads/2020/05/0797.pdf • Advise non-NHS podiatry for painful skin lesions • Advise NHS Podiatry if diabetic or immunosuppressed (high risk) • Consider NSAIDS (consider prescribing issues) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Recommend self-management strategies ➢ Avoid high heels ➢ Wide cushioned Footwear ➢ Insoles (OTC metatarsal dome support) ➢ Activity modification ➢ Ankle range of motion / Calf stretches	**Refer to Podiatry if:** • Mild to moderate symptoms • High risk foot with observable deformity or skin lesion **Referral to Advanced Practitioner:** • Symptoms persist despite appropriate self-help or podiatry • Consideration of injection therapy • Past neuroma surgery	**Assessment:** **Diagnostics:** • X-Ray • Blood tests where inflammatory cause or neuropathy suspected **Management:** • Patient education • Footwear advice • Patient choice following SDM **Referral to Podiatry (from Advanced Practitioner) if::** • Has not tried non-surgical intervention • Patient choice **Referral to Advanced Practitioner (from Podiatry) if:** Exhausted non-surgical and injection therapies • Exhausted non-surgical interventions NOTE: X-Ray not essential • Steroid injection requested • Consideration of boot immobilisation • Requests further investigation • Refer to spinal AP if abnormal neurology with suspected spinal component **Referral to Orthopaedics (from Advanced Practitioner) if:** • Exhausted non-surgical and injection therapies • Diagnostic imaging confirms diagnosis – ensure XR WB AP LAT and MRI are available and within 18 months

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Midfoot Pain **Pain in the midfoot of non-traumatic origin**	**Assessment:** • Examination / assessment • Exclude neuro / vascular symptoms • Exclude fracture / trauma e.g. Lis Franc • Exclude inflammatory pathology • Exclude spinal referred pain (see spine guidelines) • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Check for pain location / any swelling. • Consider Charcot if patient is diabetic and presents with a red / hot / swollen / deformed foot. **N.B. – diabetic Charcot neuroarthropathy is painless within the insensate foot** **Diagnostics:** • Weight bearing X-ray if clinically indicated ie the results will indicate a change in management and bony / joint pathology suspected, Please be explicit regarding severity of symptoms, pain, altered function or weight bearing status. **Management (including condition-specific self-care options):** • Patient education • PRICE (Protect, rest, ice, compression, elevation) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and analgesia in line with agreed formularies / guidance • Activity restriction • Footwear / lacing advice • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working	**Refer URGENTLY to diabetic team if:** • Neuropathic arthropathy (Charcot) suspected (with urgent X-ray) **Refer to Physiotherapy or Podiatry if:** • Joint pathology suspected • Tendon pathology suspected • Failure of symptomatic improvement (>6 weeks) **Refer to Advanced Practitioner if:** • Diagnosis unclear • Bony pathology evident on imaging • If severe symptoms affecting function	**Patient education and information** **Assessment and examination (Physiotherapy / Podiatry / Advanced Practitioner):** • Assessment and examination • Consideration of differential diagnosis • Neuro-vascular component • Provocative testing of midfoot joints and extensor tendons **Diagnostics:** • X-ray if joint pathology suspected • Ultrasound if tendon pathology suspected (note: this will also be helpful in showing TMTJ OA / capsulitis more clearly than X-ray) • MRI if continued suspected pathology but XR inconclusive. Especially if traumatic nature of injury e.g. Lis Franc dislocation **Management (Podiatrist / Physiotherapy):** • Reiterate PRICE / HARM • Footwear advice – heel/rocker sole • Exercise therapy / Manual therapy / taping / orthoses • Patient choice following SDM **Refer to Advanced Practitioner / Orthopaedics (from Podiatry / Physiotherapy) if:** • Consideration CSI / USGI • Diagnostic uncertainty • Consider onward referral to orthopedic consultant if: ➢ Failed conservative therapy ➢ Severe pain ➢ Progressive pain ➢ Failed steroid injection ➢ Suspicion of systemic inflammatory component ➢ Fracture seen and not improving

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Peroneal Tendino-pathy / Non-Traumatic lateral ankle pain **(Peroneal Tendon disorders:** **- Peroneal tendonitis** **- Peroneal subluxation** **- Peroneal tendon tear)**	**Assessment:** • Examination / assessment • Assess ankle eversion strength • Examine for clunking / subluxing tendon • Absence of single traumatic episode – consider ankle sprain pathway if relevant. • Exclude neuro / vascular symptoms • Exclude spinal referred pain (see spine guidelines) • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • None **Management (including condition-specific self-care options):** • Consider advice on supportive footwear / over the counter ankle brace / small heel raise • PRICE (Protect, rest, ice, compression, elevation) • Avoid heat, alcohol, running, massage (HARM) • NSAIDs and analgesia in line with agreed formularies / guidance • Advice on activity modification to reduce overload • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working	**Refer to Physiotherapy or Podiatry if:** • Failure of symptomatic improvement (>6 weeks) **Refer to Advanced Practitioner if:** • Subluxing tendon • Failed physiotherapy • Continuing instability (CAI)	**Patient education and information** **Assessment and examination (Physiotherapy / Advanced Practitioner):** • Assessment and examination • Consideration of differential diagnosis e.g. sural nerve entrapment) • Neuro-vascular component / exclude spinal origin / more proximal neuritis • Provocative testing of lateral ankle muscles and ligaments **Diagnostics:** • X-ray if joint pathology suspected (e.g. avulsion) • Ultrasound if tendon pathology suspected • MRI – if XR / USS inconclusive / surgical consideration indicated **Management (Physiotherapy):** • Reiterate PRICE / HARM • Proprioceptive / strengthening programme (6 months duration even with imaging highlighting peroneal tear) • Manual therapy / taping / orthoses • Patient choice following SDM **Refer to Advanced Practitioner / Orthopaedics (from physiotherapy) if:** • Consideration CSI / USGI • Consider onward referral to orthopaedic consultant if: ➢ Failed conservative therapy ➢ Severe pain ➢ Progressive pain ➢ Failed steroid injection ➢ Suspicion of systemic inflammatory component

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Achilles Tendino-pathy (AT): Achilles Tendon pain with functional disability / impaired performance and localised swelling Presentation i) Mid-portion: (2- 6cm from Calcaneum) 60% frequency ii) Insertional disorder (calcaneum - 2cm proximally) 25% frequency)	**Assessment:** Exclusion / Consider: • Inflammatory arthropathy: especially if bilateral (Rheumatology Guidelines) • If presenting with nerve root pain – refer to spinal pathways • Tendon rupture: positive Simmonds triad (declination angle, palpation, and calf squeeze) **- refer to fracture if acute or elective orthopaedics if chronic** • Risk Factors: Diabetes, dyslipidaemia, and fluoroquinolone use • Altered foot posture **- if neuropathic charcot suspected Refer to ESHT MDFT** • Bone stress injury: Osteoporosis / long term steroid therapy • Other tendinopathy: long flexors and peroneal • Calf muscle injury • Ankle / hind foot arthropathy • Compartment syndrome • Vascular insufficiency • Plantar heel pain **Diagnostics:** • XR if trauma or if inflammatory arthropathy suspected, if this will inform a change in management. Please be explicit regarding nature and timescale of injury, severity of symptoms, pain, altered function or weight bearing status. • Blood tests: HbA1c / lipid profile if clinically indicated **NOTE: In the absence of trauma or suspected inflammatory arthropathy, Achilles tendinopathy requires clinical diagnosis without the need for imaging** **Management:** • **Do not inject corticosteroids:** painful with risk of rupture • Manage metabolic factors • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Avoid fluoroquinolones • Encourage self-management: https://www.esht.nhs.uk/wp-content/uploads/2021/01/0891-.pdf • Self-management advice: ➢ Typically resolves (weeks - 12 months) ➢ 12m+ persistence is rare ➢ Resolution within months of initiating Pain and loading protocol ➢ Exercise is the best evidenced intervention, requiring a course of at least 3 months rehab ➢ Temporarily avoid aggravating activity e.g. running ➢ Use footwear with heel elevation ➢ Use heel lifts (OTC) **Analgesia options:** • Paracetamol • NSAIDS: severe distress within acute phase. Not advised in persistent degenerative cases as minimal inflammatory process **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy or Podiatry if:** • No improvement despite advice • > 6-week duration • mild to severe symptoms • Shock wave therapy (requires 3m rehab prior to ESWT) **Referral to Advanced practitioner:** • Unsuccessful physiotherapy • Diagnostic clarity **Refer to Fracture clinic if:** • Acute Achilles injury (acute injury presentation – audible pop, tendon defect, functional restriction, and positive Thompson's / Mattles sign)	**Assessment:** **Diagnostics:** • None **Management:** • Patient education • Footwear and self-management advice • Patient choice following SDM • Minimum of 3 months conservative rehabilitation • ESWT where clinically appropriate **Referral to Physiotherapy (from Advanced Practitioner) if:** • Mild to severe typical symptoms • Has not tried appropriate/at least 3 months of rehabilitation • Electro shockwave therapy (requires 3m rehab prior to ESWT) • Patient choice **Referral to Advanced Practitioner (from Physiotherapy) if:** • Recalcitrant to rehabilitation. • Imaging / injection (HVI) / boot immobilisation request **Referral to Orthopaedics (from Advanced Practitioner) if:** • Has exhausted rehabilitation / ESWT • Chronic Achilles rupture • Explicit request by patient

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Ingrown toenail (onycocry-ptosis) / IGTN	**Assessment:** • Screen for: ➢ Signs of spreading infection, symptoms of sepsis (consider use of Sepsis Screening and Action Tool) ➢ Immunosuppression ➢ Poor tissue viability ➢ Ischaemia ➢ Poorly controlled Diabetes ➢ Reduced mental capacity ➢ Inflammatory signs (consider referral to Rheumatology) ➢ Check for signs of localised skin malignancy. • Assess for impact upon Activities of Daily living and Quality of Life **Diagnostics:** • Blood tests if suspecting inflammatory screen or neuropathic disease **NOTE: X-Ray is typically NOT indicated unless features of infection present in blood tests, along with clinical signs e.g., Recurrent tissue breakdown, non-healing wound, progressive change in appearance of toe to exclude tissue abnormality or osteomyelitis**. **Management:** Acute presentation (NICE guidelines): • Advice, reassurance. • Maintaining a clean wound area, saline bathe, and a dry dressing for <2/52 • Checking footwear • Foot hygiene advice • Moderating activity • Obvious signs of infection present, consider antibiotics (as per antibiotic guidelines) **Persistent presentation:** • Refer to podiatry **Do not prescribe antibiotic cover if no signs of clinical infection e.g. wound lacking purulence or tissue inflammation**	**Referral to Podiatry if:** • >6 week of IGTN pain and functional impairment • Nail surgery consideration • Unsuccessful response to anti biotic therapy • Unsuccessful response to self or professional foot care • Has not tried podiatry • Problematic IGTN in conjunction with nil / mild / moderate comorbidities or learning difficulty **Referral to Orthopaedics if:** • Problematic IGTN not resolving with surgical Podiatry input • Problematic IGTN with complex learning difficulty or co-morbidities will need to be referred to an acute NHS Trust	**Assessment:** **Diagnostics:** • None **Management:** • Patient education • Footwear and self-management advice • Patient choice following SDM **Do Not Refer to Advanced Practitioner** **Referral to Orthopaedics if:** • Problematic IGTN in conjunction with criteria: ➢ Severe learning difficulties ➢ Severe cardiovascular disease with non-palpable pedal pulses ➢ Longstanding uncontrolled diabetes ➢ Needle phobia (that requires sedation) ➢ Unsuccessful podiatry management **NOTE: These patients require referral to acute NHS Trust due to medical complexities**

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Charcot Foot	**Assessment:** • Consider risk factors including: ➢ Diabetes ➢ Alcoholism ➢ Renal failure ➢ Leprosy ➢ Syphilis ➢ Syringomyelia • Explore associated condition – ulceration • Exclude ➢ Inflammatory arthropathy (consider referral to Rheumatology) ➢ Presence of cellulitis (follow nice guidelines for acute cellulitis in primary care, sepsis tool kit) ➢ Trauma (without neuropathy) ➢ Critical limb ischaemia • Physical Exam ➢ Active/Acute Charcot will appear swollen, warm (average 2 degrees C warmer than contralateral side) ➢ Erythema, will remain unchanged with elevation **Diagnostics:** • Not required in primary care please refer on urgently **Management:** • Refer within 1 day to Multi-Disciplinary Foot Team for Immediate offloading either casted or walker air cast boot • Advice to rest, reduce activities, complete non-weight-bearing • Driving contra-indicated • Sign off work	**REFER WITHIN 1 DAY to Multidisciplinary Foot team via Primary care Diabetes Foot Referral Form.** **Eastbourne DGH (MDFT)** **Hastings Conquest (MDFT)** **Esht.diabetes.mdft@nhs.net** **For Advice, call:** **Hot Foot Line: 07909907015** **In the absence of diabetes, if Charcot is suspected, please refer urgently to the elective orthopaedic foot and ankle team at EDGH/Conquest Hospital** **OUT OF AREA:** • Patients within Brighton and Hove: Email: bsutr.podiatryroyalsussex@nhs.net • Patient care advisors at HERE: 0300 303 8066 • Patients within west Kent: email kcht.podiatrywestkent@nhs.net or Tel: 0300 123 6756 (Mon-Fri 8.30- 16.30) **Referral to Orthopaedics (URGENT) if:** • Known active Charcot with rocker bottom foot • Increasing risk of infection • Repeated infection • Request from Diabetic Foot Team • Ensure up to date X-ray is available	**If presenting within MSK service, advise and refer as per primary care pathway.**

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Leg Length Discrepancy (LLD)	**History:** • Any previous / recent surgery • Examination / assessment • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • None **Management:** • Consider over the counter heel raise if deemed <2cm for shorter side • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working	**Refer to MSK / Physiotherapy if:** • LLD suspected but unsure if True vs Apparent **Refer to MSK / Orthotics:** • If known LLD (>2cm) and unable to accommodate with in-shoe devices via Podiatry +/- requesting replacement orthotics	**Patient Education and Information** **Assessment and Examination:** • Consideration of differential diagnosis • Clinical assessment measurement of LLD (True vs Apparent) **Management:** • Provision of heel wedge if <2cm • Referral to orthotics for shoe lift / orthosis if >2cm • Gait re-education • Exercise therapy / physiotherapy • Patient choice following SDM **Refer to Advanced Practitioner (from Podiatry / Physiotherapy) if:** • Diagnostic uncertainty