



Information Sheet

Big Toe (Hallux Rigidus)

Hallux Rigidus commonly refers to osteoarthritis of the big toe, the pain and inflammation of which can gradually, over time, restrict movement.

Although not exclusively, this condition is more common in middle-aged men and will often appear in both big toes. Sufferers, as well as having osteoarthritis may well have a bunion as well. If you are identified as having both then in all probability you will be treated for the condition that affects you most.

An examination will help to determine whether you have Hallux Rigidus. Typical symptoms include restriction of a range of motions of the big toe – there may also be the appearance of bony growths on the top of the toe. However, an x-ray will show the extent of the disease and will also help the clinician decide whether surgery is necessary. Other factors will also be taken into consideration including the level of pain, stage of degeneration and the presence of deformity combined with the chance of success against the degree of restriction (following the treatment) will all help the clinician to make an informed decision as to which treatment will be most appropriate for you.

Non-surgical (orthotics). It may be that a non-surgical (orthotic) management may be the most suitable form of treatment for you – the principle is to take the strain off the big toe during walking.

As we walk the front part of the foot acts as a rocker which requires the big toe joint to extend and take the weight. However, by modifying a normal shoe to add a subtle rocker to the sole at the location of the joint, the foot can progress forwards normally with reduced big toe movement.

Surgical - injection/manipulation. This may be useful in the early stages of arthritis but the effects can often just be temporary

Arthroscopic debridement. This is a minimally invasive technique which used for patients who have moderately severe symptoms.

Open debridement. Debridement either by arthroscopic (keyhole) surgery or by the standard 'open' procedure is where surgeons will remove any loose cartilage within the joint and fine drill into small areas lacking cartilage. This allows new, though poor quality cartilage, to form in drilled areas. In addition the excess arthritic bone (osteophytes) which form on the top edge of the joint are removed. This should allow you an increased range of upwards movement.

This procedure is generally performed as a day-case and a rigid bandage is applied afterwards. A physiotherapist will help you get up and around with crutches - you will be allowed to weight-bear as much as is comfortable but will be advised on this.

You will be given an appointment to see a consultant shortly after surgery and you will be also given instructions on exercises to minimise the stiffness that you might experience. The good news is that a gradual return to full function usually happens for most patients.

Kellers/Hamiltons arthroplasty. This is a good option for patients who are less mobile and also for the more elderly patient. This procedure involves the removal of one side of the painful joint. This stops the pain of the arthritic joint but the big toe can sometimes become floppy.

Fusion. In this procedure, the two joint surfaces which generate the pain are removed and the remaining joint fuses as part of the normal healing process following surgery. The joints then fuse together with screws.

Similar to an ankle fusion, the joints each side from the fused joint can takeover some of the original function of the affected joint.

You will need to keep your foot elevated (you will be advised on the length of time) after which you will be given crutches and be allowed to weight bear as comfortable (check with your surgeon first). It normally takes six weeks before you will be able to wear normal shoes.

Replacement. Historically, replacement surgery has not been satisfactory in that previous operations have not been successful in maintaining movement and preserving good mechanical forefoot function. However, this procedure may be worth considering and needs to be discussed in-depth with your surgeon.