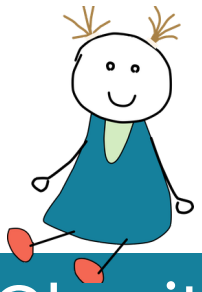
steps

We don't take walking for granted

Clubfoot, a Parent's Guide



Helpful Information from Steps Charity

Contents

How This Booklet Might Help

At Steps, we understand how a lower limb condition can affect individuals, families, and communities. We are committed to helping people understand these conditions, offering reassurance, and working towards a better future through our partnerships with national health services and research projects.

This booklet is for parents with a child diagnosed with clubfoot/talipes. It cannot answer every question about what the future may hold, but we hope it will reassure you. We aim to show that practical help, specialist medical information, emotional support, and signposting to other sources of information are available if needed.

Having this information may help you feel more prepared for the road ahead and better able to ask informed questions about your child's care, treatment, and prognosis.

Help When You Need It

Sometimes being able to contact someone who knows what you are going through can provide much needed encouragement.

Our Family Contact Service can put you in touch with others who have shared a similar experience and can offer advice, support, and practical tips. You can also share your problems and solutions to everyday challenges on our closed Facebook Group for parents. The group is a friendly and safe way of discussing your worries online with other parents, sharing tips, and finding emotional support.

Remember, the Steps team are here to offer information and support in total confidence, and to answer any questions or concerns you may have. This will help you to ask informed questions at hospital appointments or may help to reassure you along the way.

No matter how big or small your concern, please telephone Steps on +44 (0) 1925 750271 or email info@steps-charity.org.uk for support and advice in total confidence.

Social media details and information about how to get in touch with the Steps Family Contact Service can be found on page 25 at the back of this booklet.

About Clubfoot/Talipes

What is clubfoot?

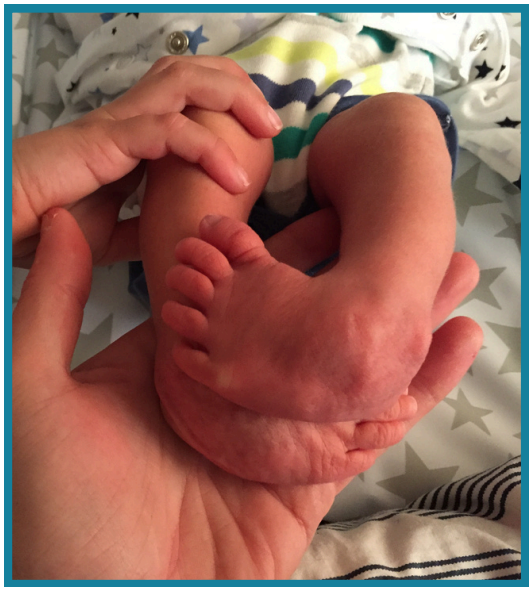
Clubfoot is the common term used to describe congenital talipes equinovarus (CTEV). CTEV is a condition which your baby is born with and is easily recognisable from the position of the foot which is turned in and points down. The severity of the condition can vary.

Congenital talipes equinovarus might sound complicated but, when broken down, it becomes easier to understand.

Congenital – present at birth
Talipes – refers to the foot and ankle
Equino – foot points downwards
Varus – heel turns inwards

Children's orthopaedic specialists may use the term clubfoot or talipes when they are talking about CTEV.

Clubfoot may affect one foot (unilateral) or both feet (bilateral). Often the calf muscle is less prominent on the affected side. Usually the calf muscles on the affected side may remain slightly smaller, but this does not usually prevent good function. Most children who receive treatment achieve a pain-free, functional foot and are able to walk, run and take part in activities like all other children.



Categories of clubfoot

Clubfoot can be classified into a number of different categories, here are the most common:

1. Idiopathic clubfoot is by far the most common type of clubfoot. Idiopathic means of 'unknown cause'. It is a structural deformity, this means that the bones, joints, muscles and tendons of the foot are positioned differently at birth. The exact changes vary from child to child. It is not flexible or correctable without treatment. According to many experts, idiopathic clubfoot occurs in about 1 to 2 per 1000 live births in the UK.

For the purpose of this booklet we will assume that the clubfoot is idiopathic.

2. Atypical clubfoot is a less common and more complex form of clubfoot. It is usually identified at the first assessment and may require treatment by clinicians experienced with atypical clubfoot, or use of modified Ponseti techniques.

3. Syndromic clubfoot is a clubfoot deformity that is associated with an underlying medical condition associated with clubfoot e.g., arthrogryposis, spina bifida. These feet may require additional consideration during treatment due to difference in muscle strength, joint movement or sensation. They can still be treated using Ponseti principles, although the approach may need adapting to the child's individual needs.

You may also have heard of positional talipes, this is not a structural clubfoot. It is managed differently and is covered in Steps' separate Positional Talipes Factsheet to avoid confusion within this guide.

Why does clubfoot happen?

There is no single known cause of clubfoot. It is believed to be multifactorial, meaning it likely results from a combination of genetic and environmental factors affecting how the foot/feet develop during early pregnancy.

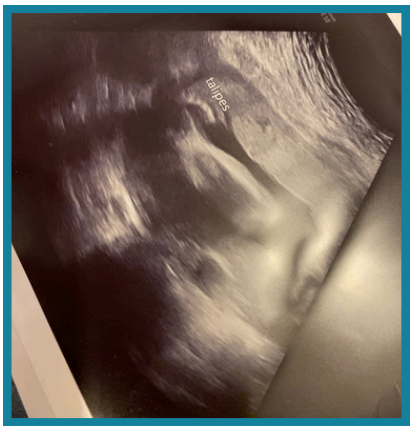
The Global Clubfoot Initiative describes it as follows: *"Clubfoot is a congenital condition (present from birth) where a baby is born with one, or both, feet twisted inward and downward."*

As a baby with clubfoot develops, their calf muscles tend to be smaller and some of the tendons (the tough cords which connect muscles to bone) are tighter and shorter than in other babies. This affects the position of the foot.

Clubfoot affects around 1-2 in every 1,000 babies and is more common in boys than girls. If you have had a child with clubfoot, you have a 4% chance of your next child being born with the condition. Worldwide, the annual figure for cases of clubfoot is in the region of 174,000, and in approximately 50% of these, both feet are affected (bilateral).

All babies diagnosed with clubfoot should have a thorough clinical examination, in line with UK guidance.

How is clubfoot diagnosed?



Clubfoot can often be detected before birth (prenatally) during a routine ultrasound scan, although it is not possible to determine the severity or category of the condition at this stage, and it cannot be treated before birth. Sometimes it is only discovered at birth through a physical examination.

Treatment

How is clubfoot treated?

The Ponseti method is regarded as the gold-standard treatment for clubfoot by healthcare professionals. The treatment begins soon after a baby is born. Long-term studies have consistently shown good outcomes. The aim of treatment is to achieve a pain-free, functional foot by moving the foot into a normal position. Many children achieve excellent outcomes, although some may experience stiffness or differences in function. This may be influenced by the severity of the condition, how well treatment advice is followed, or other factors.

The Ponseti method

The Ponseti method is very effective and is done in three stages. The first stage is manipulation and casting, the second is a minor operation called a tenotomy and the third is the boots and bar stage. Each stage is explained in detail below.

The manipulation and casting stage involves weekly sessions in which a trained Ponseti practitioner manipulates your baby's foot with their hands, gradually correcting the position of the foot.

After manipulation of your baby's feet, a plaster cast is then applied from your baby's toes to their groin to hold the foot in its new position. The cast will be changed weekly and your baby's foot or feet are corrected a little more each time On average, five to six casts are required, but this may vary. Manipulation and casting of the foot are done very gently so they should not hurt your baby.

The cast should be applied by two people, one to manipulate and hold the foot, the other to apply the cast. Many clinics will encourage you to bottle/breastfeed your baby while casting is performed to help relax your baby.

When the plaster cast is first applied, it takes several hours for the plaster to dry fully. Your baby can be dressed and handled normally.

The casting stage takes on average five to six weeks and it is important to follow all the instructions your clinician gives you to ensure your baby is happy and safe, and for the treatment to be successful.

Progression over the course of Ponseti treatment

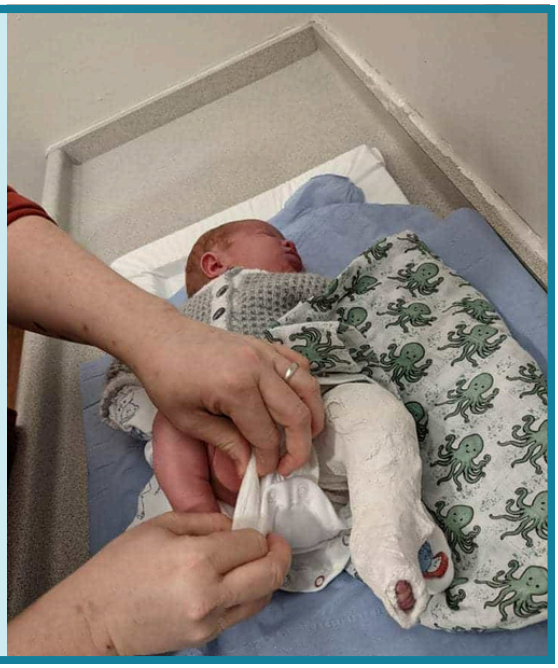
The Pirani score is a way for clinicians to assess clubfoot deformity. It is usual for your child's foot/feet to be given a 'score' prior to treatment beginning – this score should reduce as treatment progresses. The casts progress in a sequence, as shown in the picture.

Key tip before leaving the hospital after casting

Before leaving the clinic, take a clear photograph of your baby's toes and the edges of the cast. This will help you monitor toe position and identify any changes in the cast position. It also makes it easier to show your clinicians what has changed.

When at home

- Check your child's toes to make sure they look normal and feel warm.
- Make sure the toes are exposed and clearly visible at all times.
- Change your child's nappy frequently and fasten it as normal, to avoid soiling the plaster.
- Check the skin around the edge of the cast for any signs of redness or soreness.
- Keep the plaster cast dry at all times.



It is important to contact the hospital immediately if:

- You cannot see your child's toes. This usually indicates that the plaster has slipped. When this happens it will no longer be correcting the feet properly and may cause pressure to the skin at the back of the heel.
- Your child's toes change in appearance or become cold.
- The plaster becomes loose, cracked, or crumbly.

If you can no longer see your child's toes, and they seem to have 'disappeared', contact your clinician immediately as the cast may need to be removed. If you are not able to contact your clinical team immediately it is best to take your baby to accident and emergency to have the cast removed.

Don't forget, you should always talk to your clinician if you are worried about any aspect of your child's treatment, they will be able to answer your questions and advise on the best course of action.

Caring for your child during treatment

- **Use clothing which does not cover the feet**

There are no specific clothing requirements for a baby undergoing treatment for clubfoot. However, babygrows without feet can be useful during the casting stage so that your baby's toes remain visible. Baby clothes without feet are also convenient during the boots and bar stage. You do not need to buy special clothing, simply cutting the feet off standard babygrows works well. Trousers with poppers underneath and dungarees are ideal.
During casting, and while the plaster is drying, your baby can either wear a legless bodysuit/babygrow or have one leg out of the babygrow. The cast should be dry by the time the casting session is finished.

- **Use cushions to help your baby sit comfortably**

A beanbag or large scatter cushion can be useful as it moulds to your baby's shape and helps to keep them comfortable. **Do not** allow your baby to **sleep** on a beanbag or cushion as it is unsafe. Also, babies can overheat easily so it is not advisable to cover your baby in loose blankets or quilts.

- **Look out for signs the cast is rubbing**

Occasionally some parents have found the cast will rub the skin around the edges of the cast. If this happens, inform the clinic/practitioner for advice. Some babies may have disturbed sleep patterns during treatment, especially after the first cast is applied. If your baby wakes, try gently changing their position. Placing a folded towel beneath the legs can sometimes help to adjust their position and make them feel comfortable.

Steps parents say to "trust your gut..."

"There's so much emphasis during a clubfoot journey to follow the plan and as a parent you beat yourself up if this doesn't happen but actually it's also just as important to recognise if your child might be in pain due to a blister forming under the plaster cast, for example."

NB: If the cast is rubbing, loose or becomes very wet, please return to your hospital and seek medical advice. In some cases it might be necessary to remove the cast at home, your clinicans will advise on how to do this.

Frequently asked questions about wearing a cast

How are the casts removed?

Your clinic will explain how casts are removed. Many centres now use a cast saw in clinic while some will use a plaster knife, both of which are perfectly safe and commonly used by trained clinicians. Follow the advice given by your own treating team as procedures may vary slightly between clinics. Each week, as your baby is re-cast, it's likely the process will become easier. Many parents find that feeding is the best way of keeping their baby happy and calm during cast removal and re-casting. Breast feeding or bottle feeding can usually be accommodated. Alternatively, you can try distracting them with their favourite toys or music.

Can my baby wear clothes after the casting?

The cast should be dry before you leave the clinic, your team will advise you if any specialist clothes are needed, but this is not usually the case.

What advice would you give to care for my child while in cast?

Bathing will be limited during the plaster stage. Instead, your baby will need a daily wash using a damp cloth (often called 'top and tail') to help them keep clean and comfortable. You may be allowed to bathe your baby at the hospital when they take the cast off and before they apply the new one – please check this with your hospital as provisions vary. The edges of the plaster may be protected by a water-resistant tape which also protects the skin from rubbing, but it is still best to clean these areas with baby lotion or wipes. Avoid using talcum powder as it is harmful if inhaled and can slip down inside the plaster and irritate the skin.

How will I know the casts are working?

At the start of the casting treatment your clinic may have graded your child's feet from 0 to 6 (with 6 being the most severe). This is known as the Pirani score and this score should gradually reduce with each correction. You should see improvement after each casting appointment. Don't be concerned if you don't note the changes straight away, as some parents report that they found this challenging after the first cast, but this soon changed. You will then be surprised by how quickly your baby's foot will begin to appear 'normal.'

When does casting usually start?

Casting typically begins within the first 1–2 weeks after birth, when the baby's ligaments and tendons are most flexible. Starting early often means fewer casts are necessary.

Why are casts long (toe to groin)?

Casts extend from the toes to the groin with the knee flexed. This long cast stabilises the entire lower leg and prevents unwanted movement so that the foot can be corrected gradually and effectively.

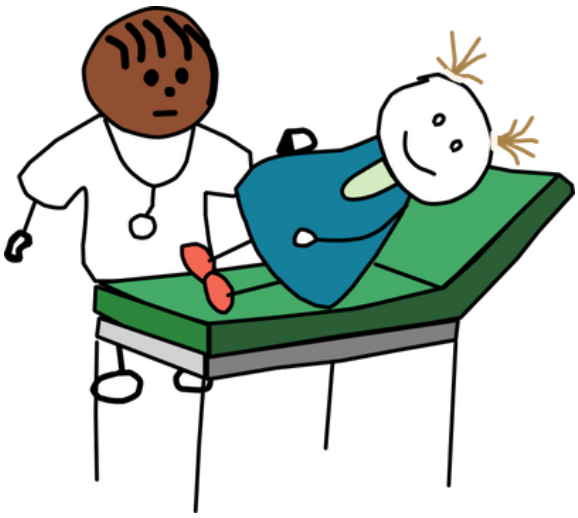
Tenotomy

The second stage of the Ponseti method is a minor operation, known as a tenotomy. This is often needed during treatment for clubfoot to release your baby's Achilles tendon. This is required when the heel has not moved down into the correct position during the casting stage. The procedure is often carried out under a local anaesthetic on an outpatient basis, which means that your baby will not have to stay in hospital overnight; it may even be carried out in a local clinic. In some cases, a general anaesthetic may be used if the clincian decides this is appropriate.

During the procedure, the surgeon will make a small cut in your baby's heel cord to release their foot into a more natural position. After the procedure, your baby's foot and leg will be put in a plaster cast for about two to three weeks to allow the tendon to heal in the correct position.

Before, during or after the procedure, your baby may be upset and feel a little pain but, rest assured that this is also likely because they are objecting to being held.

Any discomfort is very short-lived, your baby will normally settle once the cast is reapplied. Do not be alarmed if there is some bleeding at the back of the heel, but do inform your clinical team immediately so they can reassess. Your clinical team will advise on how to contact them if you are at all concerned.



Tenotomy is successful in approximately 80% of cases; where it is not successful, a second tenotomy may be required.

Note, before your baby is discharged, your clinic will advise you whether pain relief is needed and how much to give.

Foot abduction braces, commonly known as 'boots and bar'

When the foot is fully corrected once casting and/or tenotomy are complete, your child will be placed in a foot abduction brace. This is the third stage of the Ponseti method. The foot abduction brace consists of two special boots that fit securely onto your baby's feet and are connected by a bar (brace). The bar holds the baby's feet turned outwards, which is essential to maintain the correction achieved during casting.

Boots and bar are fitted immediately after the final cast is removed.

The boots and bar are worn for 23 hours a day for the first three months, (after casting). After this, during sleep (at night and nap times) for 12-14 hours up to the age of five years. Regular footwear may be worn at all other times.

Even after the casts have corrected the position of the feet, there is a risk that the feet could gradually turn back inwards. This is called relapse or recurrence of clubfoot. The boots and bar help to maintain the corrected foot position, prevent the clubfoot from recurring and allow the muscles and tendons to adapt the new position.

Failure to comply with the boots and bar protocol is known to be associated with a higher risk of recurrent deformity (relapse).

This is often considered the most important part of the treatment and therefore, as parents and carers, you will have a vital role to play.

The distance between the boots should be shoulder width, and they should be properly fitted to accommodate growth (both in length and width). The boots will need to be changed, and the bar widened as your baby's feet grow.

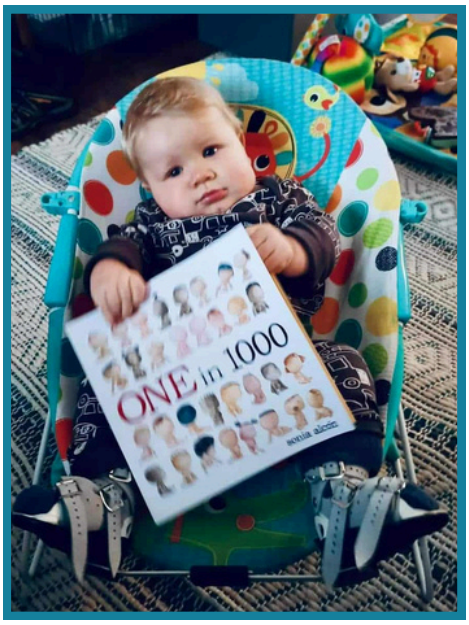
During treatment for clubfoot using the Ponseti method, the boots and bar stage is a crucial part of the process and relies heavily on parental compliance. Removing the boots and bar (even overnight), wearing them for less time than prescribed, or using the boots without the bar can cause the foot to return to its previous position (a relapse). If this happens, your child may need to repeat the Ponseti correction, or in some cases require more complex treatment.

The casting corrects the feet, but it is the boots and bar that maintains the correction long-term. If bracing is stopped at any point during the treatment the following relapse rates can be expected:

- 1st Year: 90%
- 2nd Year: 70 - 80%
- 3rd Year: 30 - 40%
- 4th Year: 10 - 15%
- 5th Year+: - 5%

The boots and bar stage can feel like the most challenging part of the treatment for parents as the feet may well present as being corrected. However, appearances can be misleading, so it is **vital** for the long term success of the treatment that the boots and bar are worn exactly as instructed. Some parents describe it as, “short-term pain for a long-term gain”.

Each child may react differently to the boots and bar, especially during the first few days. It’s usually not due to any pain but because they are new and unfamiliar. Each child will respond in their own way. Some babies adapt quickly and do not mind it, others may take a little longer to adjust. If your child is inconsolable, and you believe they are in pain, contact your clinic. They will be able to advise or reassure you. You should be asked to return to the clinic during the first few weeks after boots and bar fitting, this will be to ensure that everything is working well and that there are no problems.



Don’t be afraid to play with your child while they are wearing the boots and bar. Your child will be unable to move each of his/her legs independently from one another, but they can kick and swing their legs simultaneously with the boots and bar on.

Padding

By padding the bar, you will help to protect your child, yourself, and your furniture. A bicycle handlebar grip or foam pipe insulation covered in fabric or tape works well as padding for the bar. Specialist 'bar bumpers' are available online and the Steps Facebook group is a good forum for finding creative ideas and solutions to everyday concerns.

Sleeping

Your child may adopt a strange sleeping position. Baby sleeping bags will help with padding and will keep your baby from pulling at the straps and laces. If blistering occurs, this usually indicates that the boot has not been fitted tightly enough and retightening may be required. If the blisters continue or show no sign of healing, contact your clinic.

Feeding

It is possible to breast or bottle feed fairly easily in both cast and boots and bar, though you may need a little guidance from your midwife or health visitor.

Transport

Generally, parents don't find it necessary to buy a special pram/car seat/baby carrier, as many products will work well both with casts and boots and bar.

Note:
It is a good idea to look for a highchair with a detachable or undoable centre strap so that when they are in boots and bar they can still use it.

Parent to Parent Top Tips

Here is some general advice for parents regarding the boots and bar.

• Socks that have a 'grip' on the bottom help keep the boots in place.

• When the clinic fits the boots, make a mark with a biro on the straps (if they have buckles) so you know how tight they need to be in the first days as you get used to taking them off and putting them on again.

• If the boots have laces, knot them in the middle so you only have to re-lace them part of the way when they come undone.

• Use the holes at the back of the boot to check the heel is down. If there is no hole, ask the clinic if they will make one for you.

• It can be helpful to have something to distract your child with (a toy or some food) while boots are being put on.

• You should always ensure the heel is down as much as possible. Note: your clinician is likely to explain that this won't happen at first but will in time. Tip: take a photograph before you leave the treatment room as it will help you to assess if anything has changed.

• Painting the ends of the straps with clear nail varnish aids easy threading.

• If the boots keep slipping off, check they are tight enough (refer to your biro marks). It's also worth checking that the socks are not slipping on the sole.

• In rare cases the foot will slip in the boot if it hasn't fully corrected, so it is important you raise problems with your clinic.

• Sore feet and blisters can be treated with standard medication but do check with your clinic if the blisters form open wounds.

• Ask if there are any special tools needed to adjust the boot's angle or the bar and take them home with you.

• If your child continuously knocks the bar against the cot, safely pad it to prevent damage, ensuring the padding cannot be pulled off.

• Take lots of photos, probably even daily. Your child will change so much and so quickly that it will seem like a blur looking back. As the parent of a child with clubfoot, you'll be so engrossed in the development of the feet that you risk missing out on other details, so taking photos helps you to think about the whole development of your baby.

Frequently asked questions about braces

How should the feet be positioned in the brace?

The affected foot is rotated outward (usually 60–70°). The unaffected foot (if only one foot affected) is rotated slightly outward (around 30–40°). Knees remain slightly bent, not locked straight. Correct positioning ensures proper tendon stretch and alignment.

Will my child be able to move in the brace?

Yes - babies can move their legs, wiggle toes, and kick. The brace should feel snug but not painful. Limited movement is normal and safe. Your baby should be able to turn over in them and also crawl in them.

If my child is uncomfortable, can I remove the bar and use only the boots?

The boots by themselves do not prevent recurrence of clubfoot. The bar maintains the correction by keeping the feet in the corrected position.

Rafferty's Story: My 'Funky Snowboard'

My son Rafferty was born with bilateral clubfoot talipes in August 2015. I discovered his diagnosis at the 20-week scan. I remember feeling scared, confused and tearful. Whilst this was a very upsetting and scary time with much uncertainty, we were very quickly sent to a lovely specialist who answered all our questions and really put my mind at ease.

I contacted Steps after being given their information at the hospital. They were incredibly supportive and it made me feel less alone.

I decided after lots of research that I wanted to make the process as positive as possible. So, I was well prepared for when Raffi was born and saw his '*perfectly imperfect wonky feet*' for the first time, they were utterly adorable.

Raffi was put into cast at 10 days old, and I breastfed him through each casting session. It took a bit to work out how to continue breastfeeding, to find a position that was comfortable for him, but he soon adjusted. I continued to breastfeed until he self-weaned at 13 months, so all through his daytime boots & bar phase too.

Raffi's feet scored 5.5 & 6 (Pirani Score), and whilst not complex or atypical, his feet did resist and needed 13 casts and tenotomy on both feet. There were times when I worried and was concerned for him that his feet were not responding well, but ultimately, they did, they just took a little longer.

The hardest part of the journey for me was his tenotomy day. At my hospital I could not go in with him – this varies at all hospitals. Having to pass him over to someone else, so young, knowing he had to have an operation, when I was still full of pregnancy hormones and he had been with me 24/7 since he was born, was gut-wrenching. I cried and paced constantly until he was back in my arms – and to my surprise he was just himself, just desperate for a feed. In fact, whilst this was one of the most upsetting moments – in hindsight it was swift, only 30 mins and he was fine – it was mummy's hormones that weren't. Looking back I can laugh at this now.

Whilst Raffi was in plaster cast I decorated them with sharpie pens to make the experience more fun and positive, it was very therapeutic for me too. Later I had his casts framed to remember his journey, along with some photos.

Raffi took to his boots & bar, or as I called it, his 'Funky Snowboard' really well, he was a little unsettled for two days but settled very well after this. And wearing them 23hrs a day soon became the normal routine. I soon didn't think about life without his boots & bar, it was just a part of our story. Consistency and compliance with the routine was key from the start.

Raffi moved to wearing his 'Funky Snowboard' 18 hours a day after about 3 months and stayed there at 18 hours a day until he was 12 months old and we progressed to overnight wear of 12-14 hours.

During this time, I started my business making bar covers to make the journey more fun, positive and engaging for other families. This led to me writing two books, 'My Funky Snowboard Journey', in a boy & girl version. Since, I have expanded my range to include boot covers, keepsakes,

milestone cards, awareness cards and much more. All born out of the inspiration from my Raffi, his resilience and his 'perfectly imperfect wonky feet'.

Raffi is such an amazing boy, and when it came time to stop wearing his 'Funky Snowboard' on his 5th birthday, he didn't want to stop wearing them. I made a dinosaur boots & bar cake to celebrate his journey, and he asked me to keep his "Funky Snowboard" and get it framed. He still asks if he can put them on now, and he's 10 years old.

His feet are doing very well. He has some residual metatarsus adductus, but nothing that currently needs further intervention, which I'm very grateful for. Especially as Raffi is also autistic, with a PDA profile (Pathological Demand Avoidance, an intense involuntary response to expectations) and severe anxiety. Sadly, since becoming very poorly in 2024 he now also has OCD (Obsessive Compulsive Disorder) and ARFID (Avoidant/Restrictive Food Intake Disorder). So Raffi has many struggles and I'm extremely happy that his feet are ok and one less thing to worry about – which I know was down to the commitment and consistency in wearing his 'Funky Snowboard'.

Whilst the journey to correct his feet was long and certainly upsetting to start with, to see him running, jumping, riding a bike, swimming, and playing like every other child is wonderful and makes every second of the journey worth it.

Rafferty is really active, he loves trampolining and scootering. He's always loved dinosaurs, and is currently very much into Minecraft and Pokémon. We have two cats, Mr Marmite & Mr Marmalade, who he adores, one of which he feels is extra special just like him, because Mr Marmalade now only has 3 legs, but that doesn't stop him being happy and active either.

He is all my inspiration, my Funky Snowboard Hero & a real clubfoot warrior.

Learn more about Raffi and his mum Jen's story at the bootandbarcovers uk website

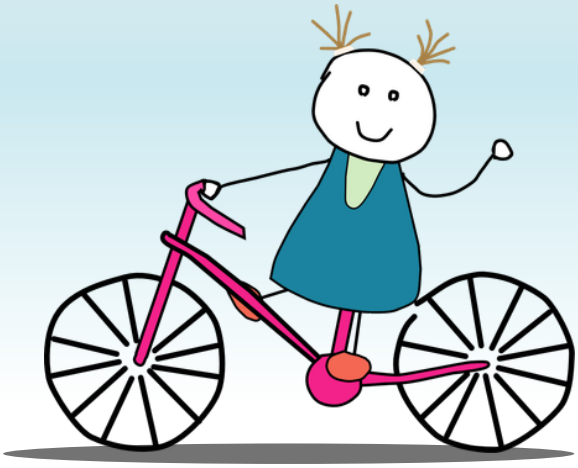
After Treatment

What the future holds

Most children respond well to treatment and go on to fully participate at school, and in sports activities without issue. Nevertheless, your specialist may want to monitor your child until their feet have stopped growing.

Professor Ponseti published several long-term outcome studies in his lifetime, following children through to adulthood, specifically looking at the results of his method. His studies showed that the use of his method resulted in no greater severity of foot pain or reduced function in mid-life to those born without clubfoot. These studies have been repeated by other practitioners in recent years and also confirm these outcomes.

The outcomes for children born with clubfoot are overwhelmingly good but sometimes clubfoot can reoccur. This is known as a relapse. Compliance with the boots and bar nightly until the age of five reduces this risk.



Signs and diagnosis of relapsed clubfoot

One of the first signs of a relapse is the loss of the movement of lifting the foot upwards (dorsiflexion).

This happens because of tightness in the large tendon at the back of the heel (Achilles tendon) and can result in walking on the toes or the inability to place the heels flat on the floor when standing. It may become difficult to get the feet down fully into the boots and bar. The heel may also start to tilt inwards (varus), and the front of the foot may appear to lift more on the inside than the outside as the child is walking, so that the weight is taken on the outside border of the foot.

Untreated relapsing feet may gradually become rigid. It is possible that a Pirani score will be used to reclassify feet suspected of relapse.

Treatment for relapsed clubfoot

Treatment for relapsing clubfoot will depend on the severity of the relapse. If the relapse is related to problems keeping boots and bar on for the recommended time, simply addressing the problem and following the treatment protocol closely may be enough to correct the feet. For more severe relapses, it is possible that a clinician may need to manipulate the feet and reapply a plaster cast to maintain the correction. This will be followed by a repeat of the boots and bar stage of treatment. In some cases, surgery to the foot may be required, followed by a plaster cast and again a repeat of boots and bar.

In some cases, a type of surgery called a 'tibialis anterior tendon transfer' (TATT) is required. This is a way of moving one of the tendons on the foot to make the muscles more balanced. The tibialis anterior tendon attaches on the inside of the front of the foot, near the toes. A total tendon transfer will reattach the tendon towards the outside of the foot. The wounds are stitched and will leave minimal scarring. Stitches are usually dissolvable, but a strong, removable stitch may be used to secure the tendon into its new position. A plaster cast will be worn for approximately 6 weeks following the surgery.

It is important, if you think there is a relapse, to have an assessment with a specialist clinician. In the meantime, stretching is really important. If you are able to do effective stretches, especially calf stretches, keep doing so: you should have been shown how to do these, and given some simple exercises, by a physiotherapist.

Always ask for more physiotherapy treatment if you need it.

Exercises to practice may include hopping, walking on heels, balancing on one leg and how to use resistance bands (which help the muscles on the outside of the foot). You will want to keep all the muscle groups strong, particularly around the foot, keeping it as supple and mobile as possible. Work on strengthening the core and leg muscles and keeping good general fitness is recommended but in a low impact way. Cycling, swimming, yoga, when possible, are all low impact activities the whole family can enjoy together and there are some great online resources for children and families readily available.

Impact on the family

How you respond as a family will depend on many different factors, but don't be afraid to seek help or support. Steps is here to support you. More information and links can be found on page 25 of this booklet.

Who are Steps and How Can They Help?

Steps is the national charity working for all those whose lives are affected by childhood lower limb conditions. Everything we do is about valuing and supporting individuals, families and carers affected by conditions which have an impact on the legs, hips or feet.

Contact Steps (confidential)

Call 01925 750271 with any questions you have or email info@steps-charity.org.uk

Facebook discussion groups (private)

There are two pages for members to join:
Steps Charity - Support Group for Parents
Steps Charity - Support Group for Adults

Family contact support service (confidential)

Connecting parents (or adult caregivers) with other families who have been through something similar. Enquire via our contact number 01925 750271 or email info@steps-charity.org.uk. All our Family Contacts are interviewed and given training before they engage with a family, providing a forum for sharing ideas and consulting other parents on day-to-day questions.

Social media

Steps is active on X (@Steps_Charity), Instagram (@StepsCharity) and on YouTube (StepsCharity)

Please note, external websites are not associated with Steps and Steps are not responsible for their content.

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Contributors

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Disclaimer

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We don't take walking for granted

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