Deepak Kumar, ND Kachhap, MM Kumar, Devendra Kumar, Birendra Kumar and Kumar Satyam

Cutaneous Vascular Malformations of the Hand

A comparative study on outcome of ponseti method of clubfoot management in infants and children of more than 1 year of age

Deepak Kumar, ND Kachhap, MM Kumar, Devendra Kumar, Birendra Kumar and Kumar Satyam

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Abstract
Background: CTEV (Clubfoot) is the most common congenital orthopaedic condition of lower limb and being treated worldwide by the Ponseti method. The treatment is started as soon as possible after birth. Still many children come to clinics at relatively higher age. The aim of the study is to compare the effectiveness in terms of outcome of Ponseti method of clubfoot management in infants and children of more than 1 year of age (1 year to 2 years).

Methods: It is a prospective, non-randomised follow-up study conducted on outpatient basis at Department of orthopaedics, Bokaro General Hospital during the period of March 2016-September 2017. The method used for the management was serial manipulation and long leg plaster of Paris casting after getting the Pirani score at every visit.

Results: A total of 40 children (20 infants and 20 children more than 1 year) with idiopathic clubfoot were selected and treated with Ponseti method. Patients from both the groups showed a significant decrease in the mean Pirani score.

Conclusion: Ponseti method in management of clubfoot in older children (1-2 years) gives a good result which is comparable with infants.

Keywords: clubfoot, ponseti method, pirani score, tendoachilles tenotomy, foot abduction brace

Introduction
Congenital idiopathic clubfoot is a common but complex deformity of foot in an otherwise normal child. It is the most common congenital deformity of lower limbs [1]. It is characterized by a complex three-dimensional deformity of the foot [2]. It is estimated that more than 100,000 babies are born worldwide each year with congenital clubfoot. Eighty per cent of the cases occur in developing nations. Globally, neglected clubfoot is the most serious cause of physical disability among congenital musculoskeletal defects [3]. Clubfoot is an obvious deformity which is easily recognized with its four components: forefoot adduction, midfoot cavus, hind foot varus and ankle equinus [4-6].

The deformity in idiopathic clubfoot (CTEV) is both cosmetic and functional. It has become a general rule to start treatment as soon as possible after birth with the initial treatment being non-surgical (serial manipulation and casting) [4, 7-13]. Still many children come to clinics at relatively higher age. The method and its results have been extensively studied in children in their first few months of life [1, 7, 14-19]. However few studies have evaluated this method in children of slightly older age group.

The aim of the study was to compare the effectiveness of Ponseti method of clubfoot management in terms of outcome in infants and children of more than 1 year of age (1 year to 2 years) and to find out answers of
a. Does the late presentation influence the outcome?

b. Does the delay in treatment commencement pose any risk of relapses?

c. Do the patients of different age groups respond differently to the Ponseti method of treatment?
Materials and Methods
A prospective, non-randomised, observational, comparative study was conducted on 40 children (20 infants and 20 children more than 1 year) with idiopathic clubfoot on outpatient basis at Department of orthopaedics, Bokaro General Hospital during the period of March 2016- September 2017.

Group A: Infants (< 1 Year)
Group B: Children of age 1-2 Years

Table 1: Inclusion and exclusion criteria

| Inclusion criteria                  | Exclusion criteria                                      |
|-------------------------------------|---------------------------------------------------------|
| Children with idiopathic clubfoot   | Children with secondary clubfoot                        |
| Infants (Group A)                   | Postural clubfoot                                       |
| Children of age 1-2 years (Group B) | Syndromic clubfoot                                      |
|                                     | Neuropathic clubfoot                                    |
|                                     | Cases with history of previous surgeries                |

The method used for the management was serial manipulation and long leg plaster of Paris casting by conventional Ponseti method after getting the Pirani score at every visit. Children were followed up weekly (till Tendoachilles tenotomy done), then after 3 weeks of tenotomy, they were put in Foot abduction brace. After application of foot abduction brace, children were further followed up at 1 month, 3 months and 6 months and Pirani score was recorded.

Parameters for evaluation
- Number of casts applied
- Improvement in Pirani score
- Recurrence pattern (if any) developing or not
- Prognosis of recurrence pattern
- Skin changes (if any)

Statistical tool
Statistical analyses were conducted with the statistical package for the social science system version SPSS 17.0. Continuous variables was presented as mean ± SD or median (IQR) for non-normally distributed data. Categorical variables were expressed as frequencies and percentages. The comparison of normally distributed continuous variables between the groups was performed using Student’s t test. Nominal categorical data between the groups was compared using Chi-squared test or Fisher’s exact test as appropriate. Non-normal distribution continuous variables were compared using Mann Whitney U test. For all statistical tests, a ‘p’ value less than 0.05 was taken to indicate a significant difference.

Observation and Results
Age distribution and mean age
In Group A most patients were of 0-3 months age group – 15 (75%) with mean age 1.85 months, while in Group B the mean age was 17.75 months with maximum number of patients in 19-21 months age group.
Laterality
There were 14 bilateral and 6 unilateral (4 Right, 2 Left side) cases in Group A and 11 bilateral and 9 unilateral (6 Right, 3 Left side) cases in Group B respectively.

Number of casts required
The total number of casts applied until final correction (at the onset of bracing) among Group A and Group B patients ranged from 3 to 7 (Mean = 5.55) and 6 to 12 (Mean = 8.95) respectively.

Table 2: Average No. of cast required in both Groups
| Age Group | Number of casts (avg.) |
|-----------|-----------------------|
| <1 year   | 5.55                  |
| > 1 year  | 8.95                  |

1 patient of Group A did not require tenotomy, while all the patients of Group B required tenotomy.

Table 3: Average age at tenotomy
| Age Group | Tenotomy Rate | Avg. Age at Tenotomy |
|-----------|---------------|----------------------|
| <1 year   | 95%           | 3.7 months           |
| > 1 year  | 100%          | 20.25 months         |

Pirani score

Table 4: Mean Pirani score in both groups
| Mean Pirani Score | Group A | Group B |
|-------------------|---------|---------|
| At the time of Presentation | 4.425   | 3.8625  |
| After Tenotomy    | 0.3     | 0.225   |
| (Change = 4.125)  | (Change = 3.6375) |
| At 1 Month of FU  | 0.25    | 0.225   |
| At 3 Month of FU  | 0.20    | 0.2625  |
| At 6 Month of FU  | 0.25    | 0.2625  |

Changes in Pirani score

Discussion
We used the classic two hands Ponseti technique for casting but the initial stretching was prolonged to at least five minutes as the soft tissue in elder children were less yielding. End point of manipulation and casting was achieved when no further correction on scoring was noted with CLB (curved lateral border of foot) and LHT (lateral head of talus) score became 0 (the mid foot and hind foot scores seemed corrected enough for tenotomy).

The outcome in Group A is comparable with Lehman et al. [15] who found the Pirani score changed from 4.6 to 0.6 in mean 5.3 casts. In the study by Lourenço AF, Morcuende JA [20], with 17 patients aged 1.9 to 9 years of age, 16/17 corrected. The correction was obtained with a mean of nine casts (7 to 12), but they used a modified Ponseti method with fortnightly change of casts, hence there average duration of immobilization in a cast (3.9 months) was higher than our study.

Recurrence of deformity
During the follow-up visits, some patients showed an increase in the Pirani score in spite of having plantigrade, painless foot. In Group A, both the patients developed forefoot adduction during the follow-up and was managed with manipulation and cast application. In Group B, one patient required repeat TA tenotomy for decreased dorsiflexion of his one foot and manipulation and cast application for his other foot. Other two patients were managed with manipulation and cast application for their forefoot adduction.

Table 5: Cast related complications in both groups

| Complication       | Group A (No. of cases) | Group B (No. of cases) |
|--------------------|------------------------|------------------------|
| Skin Abrasions     | 5                      | 1                      |
| Skin Blisters      | 0                      | 0                      |
| Slippage of casts  | 2                      | 4                      |

Table 6: Patients developed recurrence during treatment
| Group | No. of Patients with increase in Pirani score |
|-------|---------------------------------------------|
| < 1 Year | 2                                          |
| > 1 Year | 3                                          |

Cast complications
There were cast related complications in 6 cases.

Table 7: Patients with recurrence in both groups
| Group | No. of Patients with increase in Pirani score |
|-------|---------------------------------------------|
| < 1 Year | 2                                          |
| > 1 Year | 3                                          |

Changes in Pirani score

Fig 5: Sides affected in clubfoot patients

Fig 7: Mean Pirani score of patients in Group B

Fig 6: Mean Pirani score of patients in Group A
posterior crease was less in children of age group > 1 year than in children of age group < 1 year. Hence, despite severe adduction and cavus deformity the average score for medial crease was lower in the children of older age group. Similarly despite severe equinus in the children of older age group the scores for posterior crease were lower. This remains to be one of the fallacies of Pirani scoring in the older age group. It correlated well with the correction of adduction and equinus deformity. The final Pirani for medial crease and posterior crease were 0 in all the cases post correction. The change in Pirani score between pre and post treatment values was found to be statistically significant.

Parents reported irregular use of the foot abduction orthosis in Patients with increase in Pirani score during the follow-ups. The real impact of this fact was not quantitatively assessed but might have contributed significantly to relapse of the deformity. Recently the bar design of Steenbeek foot abduction brace (SFAB) has been changed and is made straight to reduce the loss of dorsiflexion in the SFAB which can occur when a child happens to stand up in the brace whereby the weight of the child causes the abduction bar to bend flat (losing the dorsiflexion).

Fig 8: Steenbeek foot abduction brace

Conclusion
The use of Ponseti method in management of club foot in older children (1-2 years old) gives a good result which is comparable with infants. Strict adherence to the casting technique helps in successful correction. Higher age of the patient does not mean that they are resistant to correction but may necessitate more prolonged casting period i.e. the number of serial casts may increase. Tendoachilles tenotomy may be needed in a significant no. of these cases and can be safely done in older children with no apparent adverse effect at six-month follow-up. Pirani scoring is an easy method to assess the deformity but its use may be limited in older children as in spite of severe deformity its value may be low. Compliance on the parents’ part in the use of foot abduction orthosis is essential to prevent the relapse of deformity.

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