WEIL OSTEOTOMY

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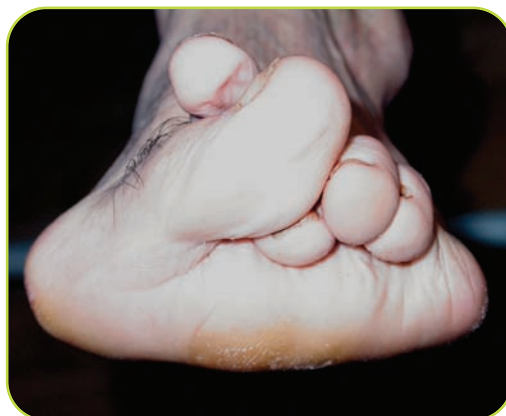
One of the greatest problems encountered in forefoot surgery is management of severe static disorders involving loss of articular congruence in the metatarsophalangeal joints of the lateral toes.

These painful subluxations and dislocations, which are frequently impossible to reduce, are the end result of serious faults in architecture with a prolonged period of abnormal pressures. Even though open surgery on these lesser joints may lead to somewhat unsatisfactory results primarily due to stiffness, it may still be necessary to move metatarsal heads backwards using appropriate fixation.

We wanted to give priority to stability by using a specific screw with a thread that was suited to the spongious bone of these metatarsal heads.

SNAP-OFF SCREW FOR WEIL OSTEOTOMY

L9	*242 440*	L13	*242 444*
L11	*242 441*	L15	*242 445*
		Ref. FH ORTHOPEDICS	



Luxation of metatarsophalangeal joint (claw)

SURGICAL APPROACH

The approach should be as non-aggressive as possible. It is important to:

> pass between the extensor and foot tendons,

> access the joint,

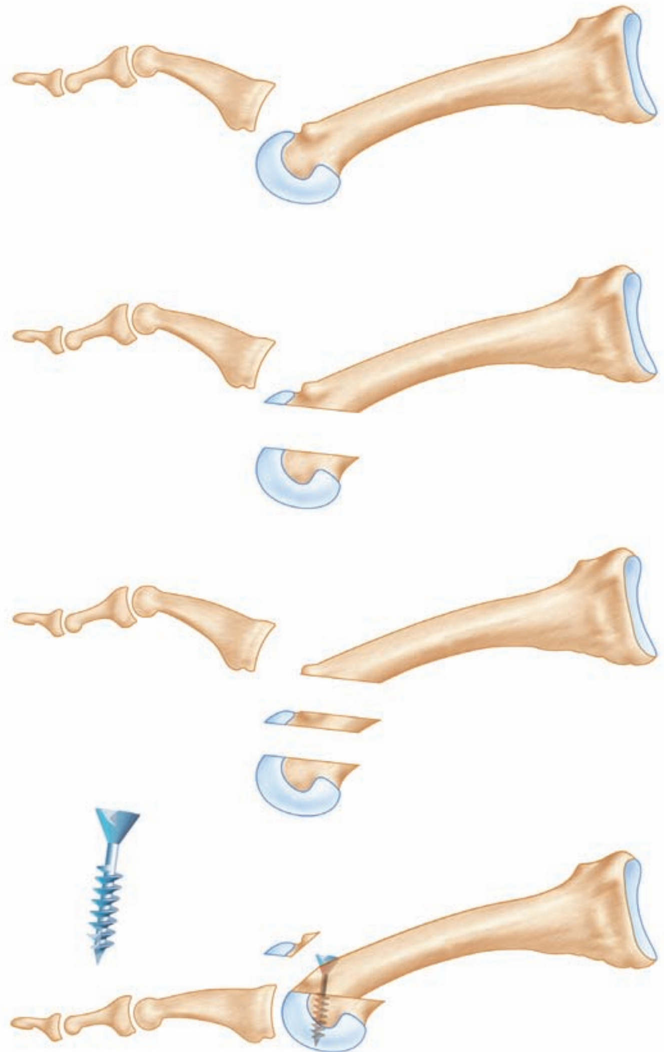
> and avoid compromise of the lateral ligamentous structures.

For this reason we think it is better to avoid any device which requires an extensive exposure which may lead to extra operative difficulties.

THE OSTEOTOMY

The osteotomy, performed with an oscillating saw, begins at the junction of the dorsal cartilage. The line is as horizontal as possible with elevation obtained through the thickness of the blade or better still through resection of a slice of bone. The head is moved backward according to the pre-operative programme.

Reduction in a good position is maintained manually with the toe flexed. The backward movement of the head, any potential lateral shift and good contact between bone surfaces are carefully controlled.



Bony cuts and Weil osteotomy

FIXATION

The site of insertion of the Weil screw is prepared using the conical burr, which makes a cortical starter hole and prepares the site for the head of the screw. The snap-off Weil screw is then positioned manually. Final insertion is completed using the screwdriver.

It is important to ensure that the construct has good compression, since stability is the factor which determines stiffness. If required, the bony procedure is completed by removal of the dorsal cap-shaped prominence.

CLOSURE

Closure is performed step by step and should attempt to reconstruct normal anatomy by closing the capsular plane, followed by the tendinous plane.

This step is important to limit postoperative stiffness.

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