The midfoot

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The midfoot comprises the cuneiforms and the cuboid and related joints. Midfoot arthritis The aetiology is usually not known but the risk factors include microtrauma, rheumatological causes, flat foot, Lisfranc or similar injuries (which may have been missed), Charcot and cavus foot. Patients are best managed non-operatively with orthotics, shoes, analgesia and modifications of their lifestyle. Pain, often with palpable dorsal osteophytes, is the com monest finding. Injections and orthotics are the mainstay of Jean Martin Charcot , 1825–1893, physician, La Salpêtrière, Paris, France. comes. Fusion or interposition arthroplasty of the lateral two TMT joints has a universally poor outcome. Charcot - An acute hot, red, swollen foot (which may or may not be pain - ful) may be indicative of Charcot (often secondary to diabetes, which may as yet be undiagnosed) or other neuropathy . Immediate o ffl oading in plaster and urgent management are - indicated; National Institute for Health and Care Excellence (NICE) guidelines ar e available in the UK. The presence of any unexplained swelling, heat, ulcer or deformity in a diabetic foot mandates an emergency and referral along NICE guidelines; failure to follow such guide - lines can lead to significant sums being paid out by indemnity organsiations. Tendinopathy Rarely , dorsal pain may be due to tibialis anterior tendinosis at its insertion; management is usually non-operative. Injection carries a slight risk of rupture, which is ameliorated by a surgical boot with deep vein thrombosis (DVT) prophylaxis. Ganglions Midfoot ganglions are common and may cause neuralgia over dorsal bosses. Injection/aspiration should be attempted. Surgery may be required but recurrence is high and secondary neuralgia not infrequent. The midfoot

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Revision #1
Created 2025-12-31 15:16:15 UTC by Omar Ayman
Updated 2025-12-31 15:16:15 UTC by Omar Ayman