How I Treat My Bunion Patients

Chris Hodgkins, MD | Miami, FL

In this interview, Dr. Hodgkins discusses his experience and evolution in treating bunion deformities, specifically his conversion from the Treace Lapiplasty® system to the Arthrex plantar lapidus plate.

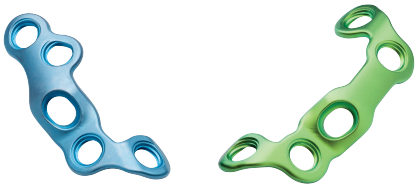
Introduction

The lapidus is a powerful and predictable procedure for obtaining and maintaining long-term correction. However, this procedure tends to be more technically difficult with a longer recovery and longer non–weight-bearing period. Dr. Chris Hodgkins of Miami, FL shared his experiences with various lapidus constructs and how his preferences have evolved. Dr. Hodgkins was previously a user of the Lapiplasty system for some time and now uses the Arthrex plantar lapidus plate and MIS bunion procedure for the majority of his bunion corrections.

Typically, surgeons find the treatment of bunions challenging. These patients tend to have high expectations and are harder to satisfy, as they often dislike scars, swelling, pain, and a long non–weight-bearing period postoperatively. Clinically, these corrections are not easy to achieve and maintain. Deformity recurrence rates and dissatisfaction tend to be relatively high. Nonetheless, there is a large demand, and an ideal technique and product is one that addresses all these issues.

Q. How were you initially introduced to Lapiplasty?

A. I tried a variety of procedures and never settled on one technique I was really happy with, although I was already correcting the triplanar deformity, Lapiplasty had the ability to reproducibly hold correction and allow patients to bear weight early. Additionally, patients were requesting the procedure.



Q. What made you switch to the plantar lapidus plate and what was that process like?

A. Having used the Lapiplasty system for about a year, I noted it was not a perfect system. Lapidus correction with Lapiplasty was not a very cosmetic solution, leaving a noticeable dorsal incision that many patients disliked. Additionally, the procedure can be quite fiddly with the various instrumentation and procedure steps.

Once introduced to the plantar lapidus plate, I immediately appreciated the scientifically proven biomechanical advantage of plating on the tension side.[1] Admittedly, converting to the plantar lapidus plate took some time and initially requires more surgical skill and attention to dial in correction. Having practiced on cadavers, I now make anatomic saw cuts to prep the joint and to obtain my intermetatarsal angle and rotational correction. I use multiple K-wires across the 1st tarsometatarsal joint and from the 1st metatarsal into the second metatarsal to hold the correction while I check it fluoroscopically before I apply the final plate. Once you get it, the procedure is much quicker and easier, and less complicated, than what I had been using previously. The plantar medial incision utilized for the plantar lapidus plate offers a much more cosmetic option for my patients, while still allowing them to bear weight early.

Having used both systems, I trust the biomechanical stability of the plantar lapidus construct to hold my correction and I am able to avoid the fiddly jigs and instrumentation. Additionally, often with my bunion patients, other procedures may need to be done. By switching to the plantar lapidus plate, I now have one company with everything I need–MIS, plantar lapidus, full range of screws, staples, and biologics. I now have one rep with one company, with the best solutions.

Arthrex®

Q. What is your rationale or algorithm for doing a lapidus for your bunion correction?

A. For patients with severe deformity, first-ray instability, arthritic change at the 1st tarsometatarsal joint, or 2nd metatarsal overload I do a lapidus procedure. Otherwise, I am doing an MIS procedure on my bunion patients. For the lapidus cases, I use the plantar lapidus plate, unless the Lapiplasty procedure is specifically requested by the patient.

Q. If Lapiplasty is requested, what conversation do you have with your patients on the procedure to educate them?

A. This really depends on the patient and how much they know. I do not try to talk a patient out of the procedure if they really want it, but I do let them know there is a smaller, minimally invasive surgery option with a quicker recovery if they are a MIS candidate.[2] I'll often show these patients incision images and x-rays if they are interested in a minimally invasive option.

If the patient doesn't know much about Lapiplasty but has heard of the 3D correction, I'll share that the same correction can be achieved with the plantar lapidus plate. Lastly, there are the patients who know a lot about the Lapiplasty procedure. These are not people I want to talk out of their choice, but I will have a conversation with them to find out what is appealing to them and if another option may be best.

Q. How does the MIS bunion correction fit into your practice now?

A. My practice is about 50/50 for lapidus procedures to MIS procedures. I am starting to trend more towards the MIS correction as I might be overtreating first-ray instability. For example, if an older patient who simply wants a quick solution to remove the bump and does not complain of first-ray issues and no 2nd metatarsal joint pain, then MIS might be a better solution. Particularly in my geographical area, the cosmetic benefit and decreased swelling of the MIS approach are huge advantages to offer to my patients. By using the MIS approach, I now have two go-to procedures for all my bunion cases and I have to find a good reason not to do MIS.

Dr. Hodgkins' Post-op Protocols

Lapiplasty

Non-Weightbearing	Weightbearing in a Boot	Walking Out of a Boot
2 Weeks	6-8 Weeks	

Plantar Lapidus Plate

Non-Weightbearing	Weightbearing in a Boot	Walking Out of a Boot
2 Weeks	6 Weeks	

MIS Bunion Correction

Non-Weightbearing	Walking in a Stiff Shoe	Walking in a Tennis Shoe
2 Weeks	6 Weeks	

References

1. Arthrex, Inc. Data on file (APT-0G1049, APT-0G1050). Naples, FL;2018.
2. Lee M, Walsh J, Smith MM, Ling J, Wines A, Lam P. Hallux valgus correction comparing percutaneous chevron/akin (PECA) and open scarf/akin osteotomies. *Foot Ankle Int*. 2017;38(8):838-846. doi:10.1177/1071100717704941

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