SLIDING OSTEOTOMY FOR TAILOR’S BUNION: BRIEF REPORT

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Tailor’s bunion or bunionette are terms used to describe an abnormally prominent fifth metatarsal head. In rare cases, when the deformity is pronounced, with tender plantar and lateral callosities, this prominence can make it difficult to wear ordinary shoes and warrants surgical treatment. This paper presents the technique and results of the osteotomy described by Sponsel (1976) to correct the deformity.

Operation. The neck and distal third of the fifth metatarsal are exposed by subperiosteal dissection through a dorsal incision. The osteotomy is performed with a reciprocating saw and the lateral-distal corner of the metatarsal partially resected with a rongeur (Fig. 1). The metatarsal head is then displaced medially and proximally to bring the prominent lateral surface of the head to the level of the lateral surface of the distal part of the metatarsal. The position is held with absorbable sutures. A below-knee cast is applied for six weeks; partial weight bearing is allowed.

Patients. Thirteen feet in nine patients (six females and three males) operated upon at ages ranging from 15 to 25 years, were reviewed. Prior to surgery, all had pain over the fifth metatarsal head necessitating wide shoes.

Results. At re-examination seven to 30 months (mean 18 months) after operation all the patients were comfortable and could wear ordinary shoes. Radiographs showed that all the osteotomies had united and there was no case of avascular necrosis of the metatarsal head (Fig. 2). Often, however, radiographic union took a considerable period of time, in one case more than six months. The only complication seen was a neuroma in one foot: this needed excision.

Discussion. With a tailor’s bunion the lateral prominence is commonly caused by a combination of lateral bending of the fifth metatarsal and a dumb-bell-shaped metatarsal head. The operation described has the advantage of maintaining the fifth metatarsal head intact while correcting both deformities. The biomechanics of the forefoot is therefore not changed significantly. This probably explains why tender callosities under the fourth metatarsal head or subluxation of the fifth digit, sometimes seen when all or part of the fifth metatarsal head is resected, was not seen in this series (Leach and Igou 1974; Sponsel 1976).

Whether the neuroma seen in one patient was missed before operation or followed the operation is not known. Thul and Hoffman (1985) maintain that tailor’s bunion is often associated with a neuroma which needs to be excised when the deformity is being corrected. It is therefore essential that symptoms and signs of a neuroma be sought routinely before operation.

In summary, the results of this study warrant the conclusion that when the symptoms of tailor’s bunion are sufficient for operation, the sliding osteotomy described gives satisfactory results; it is preferable to total or partial resection of the fifth metatarsal head.

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REFERENCES


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