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Dear Dr

RE:.

Thank you for referring this patient to me for a podiatric biomechanical assessment with regards to his chronic and complex bilateral shin pain.

DIAGNOSIS – Bilateral medial tibial stress syndrome and anterior compartment syndrome.

COMPLAINED OF – 18 month history of bilateral shin pain which is said to have originated following a 3 mile road run which comprised of flat and inclines.

HISTORY OF PRESENTING COMPLAINT – The pain to the anterior muscle is said to be the worse of the 2 pains and he underwent a fasciotomy 6 weeks ago. Since surgery he reports that the pain to this region has lessened, however his MTSS symptoms persist. The anterior pain appears consistent with that of compartment pain and he also experiences paraesthesia to the plantar aspect of both feet. Of note, although he gets his pain with running and increased impact he can also get his symptoms when sitting and also with rowing. He can also experience some lower back pain.

ORTHOSES AND FOOTWEAR – He has been issued with 2 sets of anti-pronatory foot orthoses but neither have reduced his symptoms.

PAST MEDICAL HISTORY – Type 1 diabetes.

CARDIOVASCULAR SYSTEM – Foot pulses palpable.

CENTRAL NERVOUS SYSTEM – Foot dermatomes tested with a 10 g monofilament and nil of note. Reflexes not assessed.

PAIN PALPATION – There was some palpable pain to the lower third of the medial border of the tibia and to the tibialis anterior muscle. There was no positive tinel to the fibula head.

BIOMECHANICAL EXAMINATION REVEALED (all findings bilateral unless stated)

NON WEIGHT BEARING

He has increased external hip ROM with both hips flexed and extended and a high foot to thigh angle was also noted. There was an actual leg length discrepancy with the right leg being shorter by approximately 6 mm. This did not correct when I asked the patient to sit from laying. He had good posterior chain flexibility and demonstrates normal STJ, MTJ and 1st MTPJ ROM. There was callus to the medial 1st MTPJ and IPJ. He had weakness to both tibialis posterior tendons. Of note, there was also some positive neuro-dynamic findings with a positive slump and single leg raise which both reproduced his symptoms to the shins as well as the pins and needles to the plantar aspect of both feet.

WEIGHT BEARING AND GAIT

Resting calcaneal stance position shows a foot posture of plus 3 (normal), although he stands in an externally rotated position as a result of the external tibial torsion and increased external hip ROM. Proprioception is poor and single leg squat shows poor proximal control. Running gait continues to show abduction. He is a heel striker and although rearfoot position is good he shows lateral to medial transition at the forefoot during midstance and into heel lift, where he then rolls off medial through the 1st MTPJ followed by leg circumduction. He has a low cadence and increased foot contact time with a low heel lift. In my experience this is a common gait pattern for those suffering with his diagnosis.

OPINION

Although I certainly feel there could be an element of gait dysfunction that could be contributing to his MTSS I am rather concerned that he experiences his pain with sitting. In conjunction with the history of his complaint and the fact that I could reproduce his pain with neuro-dynamic testing I do wonder how much of this could be coming from his back?

PLAN

I know I have already spoken to you and that you have kindly arranged for an MRI of his lumbar spine to confirm or rule out a central neurogenic cause. I will await to hear the results of this and we can take it from there. Should results of this be clear we can consider orthotic therapy as well as some functional strength exercises

Once again thank you for your referral and should you have any further questions or queries then please do not hesitate to contact me.

Yours sincerely

EV Hannah Yirrell

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Patient