SUMMARY

Clubfoot is one of the most common congenital deformity, its incidence ranges about 1 to 2 per 1000 live birth, it has a male predominance of 2:1 , and an incidence of bilateralness about 50% .

The deformity consists of fore foot adduction and inversion, heel varus and hind foot equinus .

Many theories exist to explain the aetiology of such deformity with reasonable data to support each of them .

Clubfoot may occur as an isolated disorder or as a part of a syndrome or in combination with other associated anomalies, such as arthrogryposis .

We have discussed the pathogenesis of such deformity and patho - anatomical change that affect the normal anatomy of the foot and that result in such deformity .

Clinically, clubfoot is apparent at birth and the affected foot is usually smaller in size than the apposite normal foot with varying degree of calf atrophy .

Radiographs are useful for diagnosis, assessment of severity, determining the response for conservative treatment, and for planning for operative treatment . The normal values of bony relationship on standing A.P and lateral views of the foot are some what variable and age dependent .

Treatment of clubfoot should begun immediately after birth and consists of manipulation and immobilisation either in adhesive tap or plaster of paris cast to maintain the corrected position .

The equinus deformity is the last deformity to be corrected to avoid the development of a rocker - bottom foot .

The cast is changed weekly and the treatment is assessed at 2-3 months old. It is difficult to assess successful treatment of a clubfoot deformity, since, the criteria for assessment vary in the orthopaedic literature, some depend on radiographic criteria, function, and other depends on clinical criteria .

When to operate is controversial, the guidelines are that a plateau has been reached in the non - operative treatment, the foot is of sufficient size, and the child s general condition is satisfactory .

Recurrent, Neglected and resistant clubfoot that fail to respond to conservative treatment will require extensive posterior, medial and lateral soft tissue releases which can be done with satisfactory results until 5 years old .

Persistent deformity after 5 years old age may require bony procedures, and triple arthrodesis may be necessary for older children which is best done at 10 to 12 years of age .