American College of Foot and Ankle Surgeons | e - Learning

12SS39: Dueling Techniques Videos

Accreditation Statement:
The American College of Foot and Ankle Surgeons is approved by the Council on Podiatric Medical Education as a sponsor of continuing education in podiatric medicine.

Designation Statement:
The American College of Foot and Ankle Surgeons designates these educational activities for CPME Continuing Education Contact Hours. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Learning Objectives:
At the conclusion of this activity, the participant will be able to:

1. Compare and contrast various surgical treatment for foot and ankle conditions
2. Identify important pearls and pitfalls gleaned from case based discussions.
3. Review the various treatment options for patients requiring foot and ankle surgery.
4. Use the latest evidence to support the indications and contra-indications for surgical techniques presented in this session.

Instructions

1. Watch the online video presentations.

2. Fill in your contact information on the CE Test.

3. Complete the CE Test.

4. Complete the Evaluation form.

5. E-Mail (must have Microsoft Outlook) your CE Test and Evaluation form to:
eLearning@acfas.org

Submit by E-mail
(Must use Microsoft Outlook)

OR

Mail your CE Test and Evaluation form to
American College of Foot & Ankle Surgeons
Nicole Donatello Trefilek, Education Assistant
8725 W. Higgins Road, Suite 555
Chicago, IL 60631-2724

Print Form

6. Please allow 6 - 8 weeks to receive your CE confirmation.

* Please note: the minimum passing score is 70%.

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Questions

1. Which fixation type is the most stable option for an opening wedge osteotomy of the first metatarsal?

a. Single screw
b. Crossed K-wire
c. Single staple
d. Locking plate

2. The osteotomy in the opening wedge technique is typically performed from which approach?

a. Dorsal
b. Medial
c. Lateral
d. Plantar

3. Bone graft options for the opening wedge technique include which of the following?

a. Autograft
b. Allograft
c. No graft
d. Answers a and b
e. Answers a, b, and c

4. The most common cause of a plantar plate tear is:

a. Gout
b. Rheumatoid arthritis
c. Trauma
d. Second metatarsal-phalangeal joint (MPJ) overload
e. Equinus

5. Which of the following can be undertaken to repair the plantar plate rupture?

a. Primarily repair via plantar approach
b. Primarily repair through dorsal approach
c. Secondarily repair by flexor digitorum longus (FDL) tendon transfer
d. MPJ arthrodesis
e. All of the above

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Questions (Cont'd.)

6. A recurrent crossover toe in an elderly patient with a high body mass index (BMI) and low physical demands may be best treated with:

a. Extra-depth shoes and digital bracing
b. Amputation
c. Flexor transfer and repair of plantar plate
d. Arthrodesis
e. Answers b and d

7. The Broström-Gould modification procedure involves which of the following anatomic structures?

a. Posterior talofibular ligament
b. Extensor retinaculum
c. Peroneal brevis tendon
d. Interosseous membrane
e. Tibialis anterior tendon

8. The midline incision for lateral ankle stabilization allows visualization of what commonly injured structure?

a. Medial talar dome
b. Fibular head
c. Fifth metatarsal base
d. Peroneal brevis tendon
e. Deltoid ligament

9. What anatomic structure is in danger of injury during the Broström lateral ankle stabilization procedure?

a. Intermediate dorsal cutaneous nerve
b. Fibular head
c. Extensor digitorum longus
d. Fifth metatarsal base
e. Medial talar dome

10. When considering the management of calcaneal fractures, the following parameters should be addressed:

a. Articular congruity of the posterior facet
b. Height of the calcaneus
c. Varus malalignment
d. None of the above
e. All of the above

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Questions (Cont'd.)

11. One of the considerations for using a small incision technique to manage calcaneal fractures is to:

a. Allow early weightbearing
b. Decrease the rate of post-traumatic degenerative joint disease
c. Increase the inclusion criteria to include smokers, geriatrics, and diabetic patients
d. All of the above

12. The literature suggests that a small-incision technique produces:

a. Poorer outcomes in terms of radiographic parameters
b. Decreased patient functional outcome
c. Increased rate of joint arthrosis
d. Comparable results to those achieved with the lateral extensile approach

13. Second MPJ fusion is not performed for:

a. Avascular necrosis of the second metatarsal head
b. Crossover second digital deformity
c. Infection of the second MPJ
d. Freiberg's infraction
e. Iatrogenic problems of the second MPJ

14. The best fixation option for second MPJ fusion is:

a. Single K-wire
b. Crossed screws
c. Locking plate
d. Suture
e. Crossed K-wire

15. Which of the following statements is *not* true regarding second MPJ fusion?

a. It is often performed in revisional situations
b. It is relatively easy to perform
c. It can be performed as a primary procedure
d. It may need to be supplemented by a bone graft in certain situations
e. It requires the use of orthobiologic products to avoid nonunion

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Questions (Cont'd.)

16. Percutaneous Achilles tendon repair:

a. Offers small incisions versus a long single incision for Achilles apposition of tendon ends
b. Can be modified with a mini-incision technique to allow exposure of the tendon ends
c. Offers lower wound complication rates compared with open methods
d. All of the above
e. None of the above

17. Risks of minimally invasive Achilles tendon repair and percutaneous Achilles tendon repair include:

a. Sural nerve injury
b. Significantly higher incidence of wound dehiscence
c. Significantly slower return to sport
d. All of the above
e. None of the above

18. Multiple studies have shown which of the following outcomes for mini-incision/percutaneous repair versus open repair?

a. Quicker return to work and sport
b. Less wound dehiscence and lower infection rate
c. Early range of motion is feasible due to less worry about incision dehiscence
d. All of the above
e. None of the above

19. Factors leading to chronic lateral ankle instability include:

a. Inadequate primary treatment of lateral ankle ligament injury
b. Incomplete healing of lateral collateral ligaments
c. Repetitive trauma with loss of tissue quality
d. Loss of lateral ligament proprioception
e. All of the above

20. Tenodesis procedures should be reserved for:

a. Failed primary ligament repair
b. Acute lateral ankle ligament injuries
c. Ligaments that cannot be repaired due to loss of tissue quality
d. Answers a and c
e. All of the above

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Questions (Cont'd.)

21. All of the following are true regarding the lateral collateral ligaments *except*:

a. The anterior talofibular ligament (ATFL) is the most common injured ankle ligament
b. Ankle and subtalar joint kinematics function best when the ATFL and calcaneofibular ligament (CFL) are oriented 120 degrees from each other
c. The ATFL originates from the anterior aspect of the fibula and is intracapsular
d. The CFL originates from the posterior aspect of the fibula and is extracapsular
e. All of the above

22. In the open Achilles tendon repair, the preferred stitch for tendon repair with minimal soft tissue irritation is:

a. Hoffman stitch
b. Running stitch
c. Over-and-over stitch
d. Bunnell stitch
e. Mattress stitch

23. In the open Achilles tendon repair, the foot is immobilized postoperatively in this fashion:

a. Plantarflexed
b. Neutral
c. Dorsiflexed
d. Inverted
e. Everted

24. After open Achilles tendon repair, physical therapy-assisted weightbearing occurs:

a. 1 week after surgery
b. 4 to 6 weeks after surgery
c. 3 months after surgery
d. Immediately post-operatively

25. The indication(s) for a Lapidus procedure is/are:

a. Hypermobility
b. Large intermetatarsal angle
c. Intercuneiform hypermobility
d. All of the above

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Questions (Cont'd.)

26. Locking plates offer a stronger construct with a compression screw.

a. True
b. False

27. The subchondral plate must be completely removed to get a solid fusion of the metatarsocuneiform joint.

a. True
b. False

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Please type your answers.

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CE TEST

Answers

Question	Answers				
1	☐ a	☐ b	☐ c	☐ d	
2	☐ a	☐ b	☐ c	☐ d	
3	☐ a	☐ b	☐ c	☐ d	☐ e
4	☐ a	☐ b	☐ c	☐ d	☐ e
5	☐ a	☐ b	☐ c	☐ d	☐ e
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21	☐ a	☐ b	☐ c	☐ d	☐ e
22	☐ a	☐ b	☐ c	☐ d	☐ e
23	☐ a	☐ b	☐ c	☐ d	☐ e
24	☐ a	☐ b	☐ c	☐ d	
25	☐ a	☐ b	☐ c	☐ d	
26	☐ a	☐ b			
27	☐ a	☐ b			

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Evaluation

1. The course achieved its learning objectives.

☐ strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

2. The course was relevant to my clinical learning needs.

☐ strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

3. The course was relevant to my personal learning needs.

☐ strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

4. The electronic method of instruction was conducive to learning.

☐ strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

5. The course validated my current practice.

☐ strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

6. I plan to change my practice based on what I learned in the course.

☐ strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

7. Any suggestions for the ACFAS e-Learning program?

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