The Akin osteotomy was first introduced in 1925 (1). Fixation techniques have evolved from tongue depressors to monofilament Kirschner wires, staples, and screws. Throughout the years, correction placement, orientation, wedge size, and fixation methods have not been extensively studied (2,3). A review of the literature reveals that the Akin procedure has been reported in multiple series with varying results (4). The lateral hinge fracture is a common complication that may occur intraoperatively or postoperatively secondary to bone loss, poor fixation, or significant postoperative swelling (5). The purpose of the study was to assess the incidence of lateral cortical hinge disruption intraoperatively, factors leading to lateral hinge disruption, and the importance of osteotomy stability. Our study was based on a retrospective analysis of all patients who underwent the Akin osteotomy. We aimed to evaluate the lateral hinge integrity, osteotomy orientation, types of fixation employed, lateral cortical hinge integrity, healing time in osteotomy consolidation, and smoking history. Our study found that healing time did significantly change with disruption of the lateral cortex. Patients with disrupted lateral hinge disruptions had a significantly longer healing time than those who did not sustain lateral cortex disruption. Our study has shown that surgical complications can and do occur with the Akin osteotomy, which is common complication that may occur intraoperatively or postoperatively secondary to bone loss, poor fixation, or significant postoperative swelling. The lateral hinge fracture is a common complication that may occur intraoperatively or postoperatively secondary to bone loss, poor fixation, or significant postoperative swelling.