

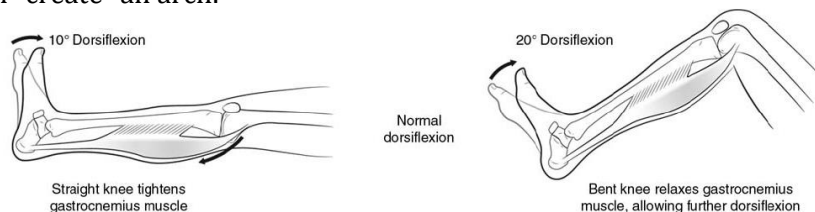
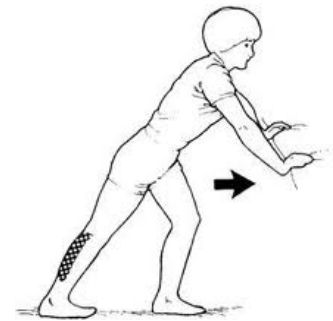
# Flatfeet in Children and Adolescents

Nearly all toddlers have “collapsed archs” upon standing causing the “ankles to roll in” and the feet to “out-toe”. A “flexible” flatfoot is considered a variation of normal in which the arch reappears when the child sits or goes up on his/her tiptoes. Often familial and more common in children with ligamentous laxity, the flexible flatfoot is usually painless and causes no functional impairment with walking or sports. The arch begins to elevate spontaneously by age 5 and adopts the adult position by age 10. However, up to 20% do not outgrow the flatfoot and it will persist into adulthood. Less commonly, the flatfoot may be “rigid”. X-rays, and sometimes a CT or MRI, are necessary to evaluate the possibility of congenital anomalies of the bones, called tarsal coalitions, as this may require surgical intervention.



## Treatment:

Whereas use of orthotics, shoe inserts, or special orthopedic shoes has NOT been shown to “create” an arch, such devices may alleviate arch pain or fatigue pains in the leg when present. The status of the patient’s Achilles tendon cannot be over-emphasized because children and adolescents with flatfeet AND a tight Achilles are prone to developing pain and disability. The Achilles has the potential to tighten during periods of rapid growth, hence the importance of routine stretching. The Achilles tendon is actually made up of 2 muscles; the Gastrocnemius and the Soleus. The former begins above the knee and the latter begins below the knee. Proper stretching of the Achilles tendon requires maintaining the knee in a straight position (i.e. Bending the knee does not allow proper stretch of the Gastrocnemius and it is this muscle that is often selectively tight in growing children). Symptoms of pain and poor activity related endurance often improves once the Achilles is properly stretched. Only surgical intervention can “create” an arch.



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