



**Figure 19-2.** Area where isolated tenderness or swelling occurs that does not require a radiograph.

The pain is often aggravated by sports activity or walking on uneven ground. Clinical examination may find pain on palpation over the coalition, restriction of subtalar or calcaneonavicular joint motion, or tight peroneal muscles that resist inversion. A major sign is the failure of the calcaneus to invert during a heel raise or, in children with flat feet, the failure of the arch to be restored during a heel raise.<sup>4</sup> Radiographs may show the coalition, however magnetic resonance imaging (MRI) is considered to be the investigation of choice in pediatric patients.

Osteochondral lesions mostly occur in adolescents. The mechanism of injury is similar to that of an ankle sprain but with a compressive element such as landing from a jump. Presenting pain is usually in the anterior ankle region and has often built up from intermittent pain to an unremitting ache. It is not unusual for the child's symptoms to deteriorate after an initial period of improvement with correct rehabilitation. Palpation will elicit pain over the talar dome but not over the ankle ligaments. Ankle joint motion, particularly dorsiflexion, is typically restricted. If an osteochondral injury is suspected, MRI or isotope bone scanning should be conducted.<sup>4</sup>

The presence of a cavus foot type in conjunction with recurrent sprains, trips, or falls should result in a thorough neurologic examination. CMT disease, the most prevalent childhood peripheral neuropathy, may present in children for the first time in this way. The peripheral neuropathy causes selective weakness in the lower leg resulting typically in lateral ankle instability and foot posture changes toward pes cavus. Clinical examination may reveal decreased dorsiflexion range of motion,