Partial Calcanectomy

Pre-Op:

For a partial calcanectomy, prone position in the OR is required. This is a 44 year old gentleman with a spinal cord injury from a fall 13 years ago. He was recently admitted by plastic surgery for excision of sacral ulceration and flap coverage. We have been asked to address his chronic heel ulceration with exposed calcaneus. This ulceration has been present for several years.

His sacral decubitus and flap is now healed.

Incision planning

When planning the incision, look for the obliquity to the soft tissue defect. This particular defect tends to slope from proximal lateral, to distal medial. Do not transect the ulceration, but rather plan the location of the proximal and distal surgical extensions and the location of the two fasciocutaneous flaps off the corners of the defect. The entire chronic ulceration is excised with approximately a 2mm margin.

Distal and proximal extensions

The distal extension will be directed medially, and proximally the extension needs to be located lateral to the Achilles tendon.

2 flaps: A&B

This creates two fasciocutaneous flaps **labeled A & B**. These flaps will rotate, slide, and translate into position to fill and cover the soft tissue defect.

Location of vessels and nerves in distal extension

In planning the distal extension, you must consider the anatomic pathway of the posterior tibial vessels and tibial nerve as it divides into the medial and lateral plantar nerves. The distal extension is drawn, and if further distal extension is needed, the incision will curve away from the neurovascular structures.