Orthoses for neurological ankles

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ABSTRACT

Patients with weakness or abnormal posture of their lower leg may benefit greatly from appropriate orthoses. This paper describes the sorts of problems that can be helped in neurological practice and the range of devices commonly used, and also highlights some of the factors influencing selection. With greater understanding of their use, clinicians will feel more confident about referring patients for early orthotic assessment.

INTRODUCTION

An orthosis is a device that supports residual function, whereas a prosthesis replaces that function. Splints and prostheses have been used for thousands of years, for example, on an Egyptian mummy’s foot from 2700 BC. Orthoses are now named according to the joints they work on: I will confine myself to ankle foot orthoses in neurological practice, and not consider diabetic complications, sports injuries and orthopaedic patients.

Orthoses can help many patients with poor control of the lower limb: there is often a biomechanical solution to a biomechanical problem, which can improve safety in standing and walking, while physiotherapy concentrates on motor learning. There has been concern that using an ankle foot orthosis (AFO) early after a stroke may impair recovery of normal muscle control; however, there is now good evidence that this is not the case1 2 and early referral to orthotics service of patients who had a stroke with mobility problems is recommended.3 4

Foot drop in swing phase (while the foot is not in contact with the ground) is the most obvious indication for an ankle orthosis, but some patients may benefit more from improved stability during stance phase (while the foot is touching the ground, during part of which, it is taking all the body weight) by a ‘well-tuned’ AFO. This involves supporting the ankle and hence the knee at the best compromise of angles to stabilise the knee.
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![Figure 4](image1.png) Thin carbon fibre ankle foot orthosis (AFO). Assumes ankle rests in neutral position. Thin lamination, so mild support of dorsiflexion in swing. Stiffer than a plastic posterior leaf spring AFO, so a little more effect in stance.

![Figure 5](image2.png) Elastic foot lifter. Only helps in swing phase. Safe for patients to buy from internet. Works best with lace up shoes. Orthotix.co.uk.

![Figure 6](image3.png) Home made elastic foot lifter. Puppy collar and bungy cord.

![Figure 7](image4.png) Bespoke silicone ankle foot orthoses. Most often bought privately for aesthetic reasons. Dorset Orthopaedic Co Ltd.

![Figure 8](image5.png) Stiff carbon fibre ankle foot orthosis. Assumes ankle rests in neutral position. Thick lamination, much stiffer, so strong resistance to plantarflexion can overcome modest spasticity pulling into plantarflexion and inversion. Strong resistance to dorsiflexion allows ground reaction force to support knee extension in stance and may give some spring at toe-off.

**EVIDENCE TO GUIDE CLINICAL PRACTICE**

When considering orthotic options, the first question is whether there is need for compensation or control during **stance** phase of gait. These functions usually require a bespoke moulded AFO. Only when there is during mid stance phase, while permitting knee flexion at the beginning of swing phase.
no need for this, can one supply a simple stock device to support foot drop in swing phase. (table 1)

Published evidence emphasises the importance of optimising the alignment of AFO and footwear and the stiffness of the AFO for individual patients. Once this has been achieved, the available options may not permit a realistic comparison in a trial, or the patients become so highly selected that the results do not inform clinical practice. The great majority of trials recruit ambulant patients who had a stroke with weak dorsiflexors, relatively normal range of movement, and little or no spasticity. The other group that has been extensively studied is children with cerebral palsy, commonly with crouch gait. Systematic reviews conclude that AFOs work better than nothing, even many years after stroke, and there are similar results with AFO and functional electrical stimulation.

The specific neuropathology causing the biomechanical problem rarely affects the orthotic prescription, other than when the pathology anticipates rapid deterioration. Then, prompt supply of a device that is 80% of ideal is better than a 3-month delay in supply of a device that would have been 90% of ideal when prescribed, but which no longer works as the patient has changed so much in the interim.

**SWING PHASE**

Weak dorsiflexors causing foot drop in the swing phase of gait may be supported by simple elastic foot lifters, stock plastic or carbon fibre AFO of low stiffness, bespoke silicone or Lycra, or functional electrical stimulation. The major factor influencing selection is patient preference among devices that their National...
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Health Service will offer, or what they are prepared to buy privately. Appearance is the most common concern, but also important is restriction of movement that prevents them standing from sitting or getting up if they fall, comfort, feeling too hot, ease of donning and selection of footwear.

Functional electrical stimulation may be preferred over a rigid device because it is lighter, cooler, and does not take up much space in shoes; however, it is not commissioned in all services, so patients may have to travel to supraregional clinics to try this. Functional electrical stimulation does not work with peripheral nerve, muscle or tendon lesions, or with high muscle tone in plantar flexors or inverters. It does not compensate for contractures and does not enhance stability in the stance phase of gait, and requires more competence from the patient to use it than

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**Figure 12** Caliper. External caliper and bespoke footwear for the same patient as figure 10, usable when leg swelling prevents use of close fitting moulded device.

**Figure 13** Turbomed ankle foot orthosis. Worn outside shoe, said to facilitate sports and high activity. Turbomed Orthotics.com.

**Figure 14** Contracture-correcting ankle-foot orthosis. Strong springs in joints beside ankle give powerful dorsiflexion force, but accommodates to voluntary or involuntary plantarflexion, unlike a rigid plaster cast.

**Figure 15** Bespoke dynamic lycra ‘lift up sock’. May improve ankle control if proprioception is facilitated by compression, otherwise only helps in swing phase. DM Orthotics.com.
a mechanical device. Hence, only a small proportion of patients with poor ankle control use it.

**STANCE PHASE**

When an orthosis aims to compensate for loss of normal passive range of movement, to resist higher muscle tone or to control ankle and knee movement during the *stance* phase of gait, a bespoke moulded AFO is usually made. When higher forces are necessary to control the ankle and knee posture in stance, these must be applied over as wide an area as possible. Hence, moulded AFOs are designed to fit closely all around the sole, heel, sides of the foot and back of lower leg.

When the size of the lower leg fluctuates due to oedema or joint swelling, a close fitting moulded AFO should not be used because it cannot expand or contract to accommodate change in size. If oedema can be controlled with a compression stocking or diuretic...
medication, a moulded AFO may fit more of the time, but an external caliper, made for a single pair of shoes, is often the only option.

WHEN TO REFER TO AN ORTHOTICS SERVICE

It is safe for patients to buy or physiotherapists to supply devices to support foot drop during swing phase, as comfort and appearance are the main factors influencing patient satisfaction. However, AFOs to control the limb in stance phase require assessment and prescription by an orthotist due to the much higher forces involved and potential for making the situation worse, with skin breakdown, less stable gait, loss of confidence and musculoskeletal pain.

Referral for orthotic assessment is often late,\(^2^3\) for instance after waiting to see how much improvement occurs with time and physiotherapy. Orthoses may improve the effectiveness of early rehabilitation, for instance by allowing safe weight bearing through a weak limb for transferring with a Rotastand, and reducing the risk of injury during gait training. With greater understanding of their use, clinicians should feel more confident about referring patients for early orthotic assessment.

REFERENCES


