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Article

An Underrecognized Cause of Hindfoot Pain: Outcomes of Accessory Anterolateral Talar Facet Resection in Adolescents and Young Adults

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Abstract

Background/Objectives: The accessory anterolateral talar facet (AALTF) is an anatomical variant associated with talocalcaneal impingement and sinus tarsi pain. This study evaluated clinical and radiological outcomes following isolated AALTF resection in adolescents and young adults. **Methods:** This retrospective series included 13 patients (17 feet) who underwent surgery between 2016 and 2023. Clinical outcomes were assessed preoperatively, at 6 and 12 months, and at final follow-up using AOFAS, VAS, FFI, Oxford questionnaire and PROMIS scores. Radiographic and MRI findings were also evaluated. **Results:** Mean age at first surgery was 15.6 ± 2.6 years, and mean limb-specific follow-up was 16.9 ± 3.7 months. Foot-level AOFAS scores increased from 53.8 ± 15.7 preoperatively to 82.3 ± 12.6 at final follow-up, while VAS scores decreased from 6.1 ± 1.3 to 2.3 ± 2.1. Baseline-to-postoperative clinical comparisons were significant after adjustment (adjusted $p = 0.0037$). Gissane angle decreased from 131.4° ± 3.0° to 125.7° ± 4.1°, which was significant in the patient-level sensitivity analysis (adjusted $p = 0.0079$). Sinus tarsi fat obliteration resolved in 14 of 17 feet. Most improvement occurred by 6 months, with little additional change between 12 months and final follow-up. Residual pain persisted in 12 of 17 feet. **Conclusions:** Isolated AALTF resection was associated with improved pain and function, although complete symptom resolution was not universal. Further prospective controlled studies are needed.

Keywords: accessory anterolateral talar facet; talar facet resection; hindfoot; sinus tarsi syndrome

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1. Introduction

The accessory anterolateral talar facet (AALTF) is an anatomical variant of the talocalcaneal joint, first described by Sewell in 1904, with a reported prevalence ranging from 10.2% to 38% depending on the population and diagnostic method used [1,2]. Although historically considered incidental, recent studies have associated AALTF with mechanical impingement syndromes involving the sinus tarsi and lateral subtalar joint, particularly in patients with rigid flatfoot deformity or hindfoot valgus [3,4].

Anatomically, the AALTF appears as a small facet on the anterolateral aspect of the talus, potentially articulating with the anterior process of the calcaneus [5–7]. This configuration

can change load transmission across the subtalar joint, increasing contact pressure and causing bone marrow edema, subchondral cyst formation and sinus tarsi fat obliteration visible on magnetic resonance imaging (MRI) [1,5]. Clinical presentation typically includes lateral hindfoot pain exacerbated by activity and tenderness in the sinus tarsi region [8]. The accessory facet may occur independently or in conjunction with tarsal coalition, further complicating diagnosis [3,4].

While conservative management is often first-line, persistent symptoms may warrant surgical resection of the accessory facet [9]. Previous case series and observational reports have demonstrated favorable outcomes following isolated excision or combined procedures with realignment osteotomies [8–10]. However, high-quality evidence remains limited, and the clinical significance of AALTF continues to be under-recognized in both imaging interpretation and surgical planning.

This study aimed to describe clinical and radiological outcomes following isolated AALTF resection in adolescents and young adults with symptomatic lateral hindfoot impingement.

2. Materials and Methods

This retrospective study was approved by the institutional ethics committee (approval number: SBA/241138) and conducted at a single tertiary-level orthopedic center. All patients who underwent surgical resection of the AALTF between January 2016 and December 2023 were retrospectively identified from surgical and radiologic archives. Inclusion criteria were: (1) persistent lateral hindfoot/sinus tarsi pain for >3 months that remained refractory to conservative management (activity modification, orthotics, and physical therapy); (2) clinical findings consistent with sinus tarsi-related impingement (localized sinus tarsi tenderness and symptom reproduction with subtalar motion); (3) imaging-confirmed AALTF with supportive MRI findings of mechanical conflict; and (4) availability of complete clinical and radiographic follow-up for at least 12 months. Patients were excluded if they had a history of prior hindfoot surgery ($n = 2$), neuromuscular disorders ($n = 2$), or incomplete clinical or radiological documentation ($n = 1$) (Figure 1).

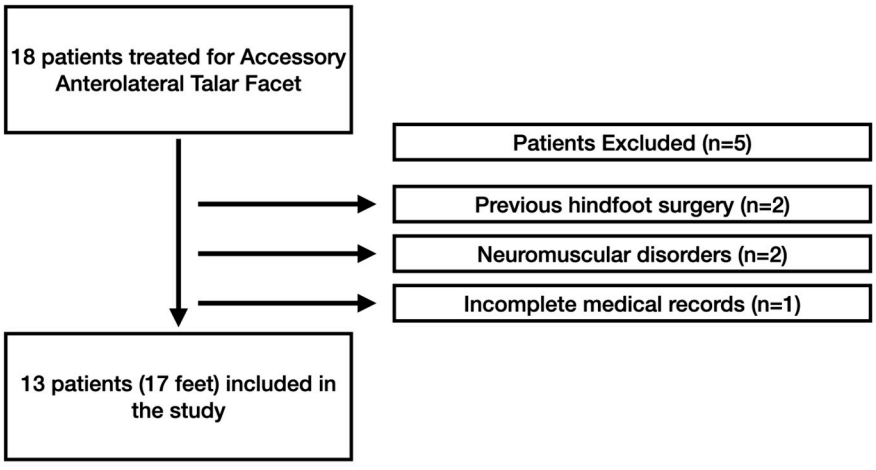


Figure 1. Flowchart of patient inclusion and exclusion.

Preoperative imaging included weight-bearing lateral foot radiographs and MRI in all 17 feet. AALTF was identified as an anterior extension of the posterior talocalcaneal facet articulation of the talus, anterior to the lateral process, with MRI assessment of associated impingement-related changes [1,4,5,8]. Radiographs were obtained at follow-up visits, and the imaging comparison used the 6-month postoperative examination. Gissane angle was

measured on lateral radiographs between the downward slope of the posterior calcaneal facet and the upward slope toward the anterior process. Sinus tarsi fat obliteration was assessed on sagittal and coronal non-contrast T1-weighted MRI before surgery and at 6 months. The angle was an adjunct morphological measurement, not an isolated diagnostic criterion or indication for surgery. CT was obtained when required for operative planning. One postgraduate-year-5 orthopedic resident performed the measurements.

2.1. Surgical Technique and Follow-Up

All procedures were performed by two senior foot and ankle surgeons (M.C.A. and G.Y.) using a standardized anterolateral approach. An oblique incision centered over the sinus tarsi was made. The extensor digitorum brevis (EDB) was identified and elevated to expose the underlying structures. AALTF was identified within the sinus tarsi, located at the most lateral aspect of the posterior talocalcaneal facet. Subtalar inversion and eversion were performed intraoperatively to dynamically assess impingement. The facet was excised using an osteotome and mallet, with resection continued until unrestricted subtalar inversion and eversion were achieved without bony impingement, which was considered the endpoint of adequate resection (Figure 2). The interosseous talocalcaneal ligament and other ligamentous structures of the sinus tarsi were preserved, and no intentional ligament release or reconstruction was performed. The surgical procedure was directed at removal of the osseous accessory facet responsible for mechanical impingement, followed by interposition of the extensor digitorum brevis (EDB) muscle within the resection area. Intraoperative fluoroscopy was used to verify complete resection.

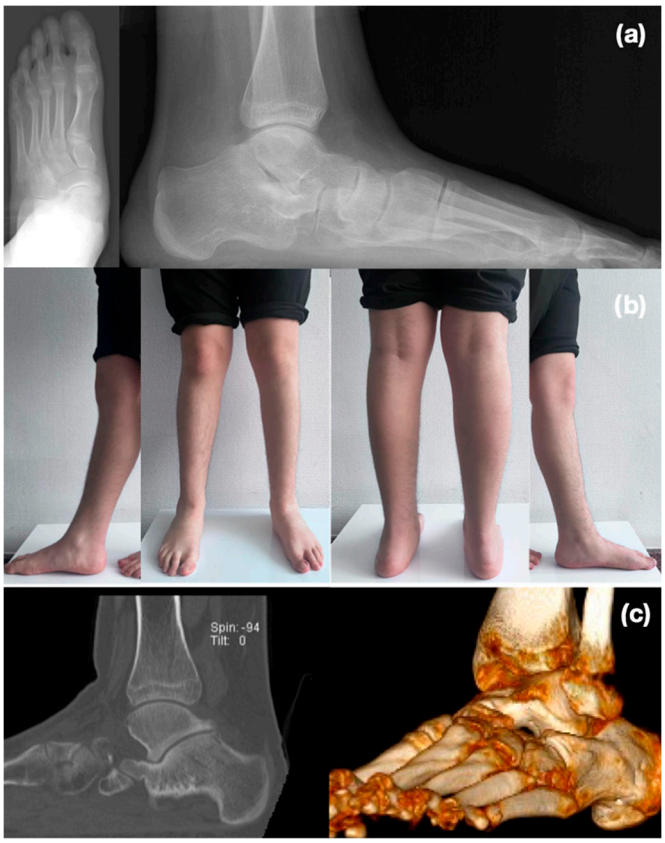


Figure 2. *Cont.*

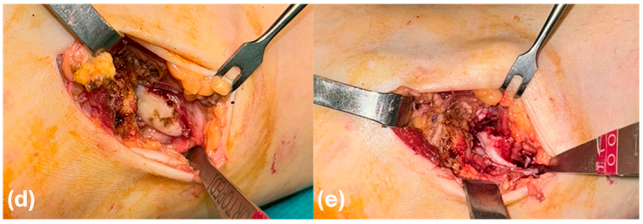


Figure 2. Preoperative imaging and intraoperative photographs of an 18-year-10-month-old male patient with symptomatic accessory anterolateral talar facet (AALTF). (**a**) Preoperative plain radiographs showing hindfoot valgus and joint space narrowing. (**b**) Clinical photographs demonstrating flexible pes planovalgus deformity with flattening of the medial arch. (**c**) CT images confirming the presence of an AALTF with adjacent articular surface irregularity. (**d**) Intraoperative view following soft tissue dissection, revealing the AALTF. (**e**) Macroscopic appearance of the resected facet and joint surface following excision.

All 17 feet underwent isolated AALTF excision with EDB interposition. Calcaneonavicular coalitions were present in five feet in four patients and were left in situ. No coalition resection, calcaneal resection or osteotomy, realignment procedure, or subtalar arthroereisis was performed. Following complete resection of the accessory facet, no bone wax or free fat graft was used. The EDB muscle was mobilized and interposed within the resection area. This technique was applied consistently in all 17 operated feet. The interosseous talocalcaneal and cervical ligaments were preserved. Patients used a non-weight-bearing short-leg cast for 2 weeks, followed by wound assessment, weight-bearing as tolerated in supportive footwear, and active ankle and subtalar range-of-motion exercises. Strengthening and balance exercises progressed at 4–6 weeks. Return to athletic activity was generally permitted at 3–4 months after pain-free single-leg heel rise and symmetrical motion were achieved. Contralateral surgery was staged after painless full weight-bearing, wound healing and recovery of subtalar motion in the first foot.

Clinical evaluations were performed preoperatively, at 6 months, at 12 months and at final follow-up. All questionnaires were administered in Turkish. Patients younger than 16 years answered with parental reading assistance; those aged 16 years or older answered independently. Assistance did not constitute parent-proxy reporting. Each foot was assessed relative to its own operation, with side-specific pain and functional attribution. General activity items were interpreted in the context of that limb's recovery and may also reflect the contralateral limb. Form and respondent mode were maintained during follow-up for each foot. All 17 feet had complete recorded outcome scores at each nominal assessment. Final follow-up was the last available clinical evaluation at or after 12 months. For Foot 7, the 12-month and final entries represent the same visit; for the remaining 16 feet, the final visit was later. Repeated assessments within a patient were not considered independent observations.

Multiple clinical assessment instruments were included to provide a broader description of postoperative recovery. Although these instruments evaluate overlapping constructs, they differ in their emphasis on pain intensity, foot-specific disability, physical function, and activity-related limitations. They were therefore considered complementary measures of the same underlying clinical recovery rather than independent surgical outcomes. The results were interpreted collectively, with particular attention to the concordance of changes across instruments. No individual scale was prospectively designated as the primary outcome in this retrospective study.

Pain was measured with a single paper 10-cm VAS, anchored from no pain to worst pain, measured with a ruler, and recorded to the nearest whole centimeter [11]. The AOFAS Ankle-Hindfoot Scale assessed pain (40 points), function (50 points) and alignment

(10 points) [12]. The 23-item FFI covered pain, disability and activity limitation [13,14]. Administration records describe a 10-category scale from 0 to 9, with all items answered. The stated total calculation is 100 × (pain raw sum + disability raw sum + activity raw sum)/207; the subscale maxima are 81, 81 and 45. The analysis used the final recorded total percentages. This item-weighted total is distinguished from an unweighted average of the three subscale percentages.

The Turkish 15-item Oxford Ankle Foot Questionnaire for Children (OxAFQ-C) was used [15,16]. Items were scored from 0 (always) to 4 (never), with higher values indicating better function. Physical, School and Play, and Emotional domain percentages used denominators of 24, 16 and 16, respectively; the standalone footwear item used a denominator of 4. All 15 responses were completed. The Oxford composite functional percentage was calculated as 100 × the sum of these four functional raw sums/60, equivalent to 100 minus the corresponding disability percentage. This is a study-specific composite. In four adult feet, School and Play questions were verbally contextualized to university, work or recreational activity; this was not a separately validated adult questionnaire.

The PROMIS assessments were Turkish pediatric (<18 years at surgery) and adult (≥18 years) 8-item physical-function short forms, with complete raw sums of 8–40 and recorded T-scores [17]. The recorded T-scores were retained as secondary numerical outcomes.

2.2. Statistical Analysis

Analyses were performed in Python 3.14.5 with NumPy 2.4.5. Continuous variables are reported as mean ± sample standard deviation and categorical variables as counts and percentages. Foot-level summaries describe all 17 operated feet. Hypothesis tests used the first-operated foot of each patient ($n = 13$), selected by operation date. Within-patient changes were evaluated by two-sided exact Wilcoxon signed-rank randomization tests. Holm adjustment covered 15 baseline-to-postoperative comparisons (five measures at three visits). Weight and recorded BMI associations with final AOFAS, Oxford Physical domain, VAS, recorded PROMIS and FFI scores were assessed using Spearman correlations with Holm adjustment across ten tests. Sex comparisons used two-sided exact permutation Mann–Whitney tests with Holm adjustment across five outcomes. Imaging was summarized for all 17 paired feet, with unadjusted paired t and exact McNemar tests reported for comparison with the original analysis. Patient-level imaging sensitivity analyses used the 13 first-operated feet and Holm adjustment across the two imaging outcomes. Two-sided adjusted $p < 0.05$ indicated statistical significance.

3. Results

Thirteen patients (seven females and six males; 17 feet) underwent isolated AALTF resection. Four patients underwent staged bilateral procedures, and nine underwent unilateral surgery. Calendar age at first surgery, calculated as elapsed days from birth divided by 365.25, averaged 15.6 ± 2.6 years (range, 11.8–20.7). Across all 17 operations, mean age was 15.8 ± 2.9 years (range, 11.8–21.3). There were nine right and eight left feet. Mean limb-specific follow-up was 16.9 ± 3.7 months (range, 12–24); one patient's final assessment was at the 12-month visit (Table 1).

AOFAS scores increased from 53.8 ± 15.7 preoperatively to 78.6 ± 9.4 at 6 months and 82.3 ± 12.6 at final follow-up. The Oxford score percentage increased from 59.1 ± 21.1 to 84.8 ± 10.0 and 88.7 ± 10.5, respectively. Baseline comparisons at each postoperative assessment remained significant in the first-operated-foot analysis after Holm adjustment (adjusted $p = 0.0037$ for each comparison; Table 2 and Figure 3).

Table 1. Patient Demographics.

Characteristic	Value
Patients, *n*	13
Operated feet, *n*	17
Age at first surgery, years, mean ± SD (range)	15.6 ± 2.6 (11.8–20.7)
Female/Male, *n*	7/6
Right/Left feet, *n*	9/8
Bilateral operative involvement, *n* (%)	4 (30.8%)
Follow-up, months, mean ± SD (range)	16.9 ± 3.7 (12–24)

Table 2. Changes in Clinical Outcome Scores Over Time.

Clinical Score	Preoperative Mean ± SD	6 Months Mean ± SD	12 Months Mean ± SD	Final Follow-Up Mean ± SD	Holm-Adjusted *p* (Pre vs. 6 Mo)	Holm-Adjusted *p* (Pre vs. 12 Mo)	Holm-Adjusted *p* (Pre vs. Final)
AOFAS	53.8 ± 15.7	78.6 ± 9.4	82.4 ± 12.3	82.3 ± 12.6	0.0037	0.0037	0.0037
Oxford (%)	59.1 ± 21.1	84.8 ± 10.0	88.5 ± 11.1	88.7 ± 10.5	0.0037	0.0037	0.0037
VAS (cm)	6.1 ± 1.3	3.1 ± 1.1	2.4 ± 2.1	2.3 ± 2.1	0.0037	0.0037	0.0037
PROMIS T-score	41.2 ± 4.0	50.6 ± 3.4	52.9 ± 4.2	52.9 ± 4.2	0.0037	0.0037	0.0037
FFI (%)	23.7 ± 16.6	11.8 ± 11.7	10.4 ± 11.4	10.6 ± 12.0	0.0037	0.0037	0.0037

Values are descriptive means ± sample SD for all 17 operated feet at each visit. *p*-values were calculated using two-sided exact Wilcoxon signed-rank randomization tests based on the first-operated foot of each patient ($n = 13$), with Holm adjustment across 15 baseline-to-postoperative comparisons (five outcome measures at three postoperative time points). Identical adjusted *p*-values can arise from the discrete nature of exact tests and the Holm correction and should not be interpreted as indicating identical effect sizes or independent treatment effects. Oxford denotes the study-specific 15-item composite functional percentage (sum of functional raw scores/60 × 100). PROMIS denotes recorded T-scores. FFI denotes recorded total disability percentage. VAS is expressed in centimeters. Higher scores indicate better function for AOFAS, Oxford, and PROMIS; lower scores indicate less pain or disability for VAS and FFI.

Recorded PROMIS scores were 41.2 ± 4.0 preoperatively, 50.6 ± 3.4 at 6 months and 52.9 ± 4.2 at final follow-up. VAS decreased from 6.1 ± 1.3 to 3.1 ± 1.1 and 2.3 ± 2.1, respectively. FFI decreased from 23.7 ± 16.6 to 11.8 ± 11.7 and 10.6 ± 12.0. The largest improvements occurred by 6 months; additional changes between 6 and 12 months were detected for AOFAS, Oxford composite, FFI and recorded PROMIS (Holm-adjusted $p = 0.0234$, 0.0234, 0.0264 and 0.0024), but not VAS ($p = 0.0605$). Between 12 months and final follow-up, AOFAS changed in three feet, VAS in one foot, and Oxford and FFI in one foot; recorded PROMIS did not change. No late comparison was significant (adjusted $p = 1.000$). Final VAS was greater than zero in 12/17 feet belonging to 10/13 patients; positive scores ranged from 1 to 6. Weight and BMI associations were not significant after adjustment (minimum adjusted $p = 0.3694$), nor were sex comparisons (minimum adjusted $p = 0.2418$). Patient-level weight and recorded BMI averaged 71.3 ± 17.4 kg and 24.7 ± 5.3 kg/m^2.

Gissane angle decreased from 131.4° ± 3.0° to 125.7° ± 4.1° at 6 months (17 paired feet; unadjusted paired t = 3.368, df = 16, $p = 0.0039$; preoperative minus postoperative). The mean reduction was 5.71° with paired-difference SD of 6.99°. Sinus tarsi fat obliteration resolved in 14/17 feet and persisted in three (unadjusted exact McNemar $p = 0.000122$). The first-operated-foot analysis showed a 6.47° mean reduction (paired-difference SD 7.34°; t = 3.178, df = 12; adjusted $p = 0.0079$) and resolution in 10/13 feet (adjusted exact McNemar $p = 0.0039$) (Table 3).

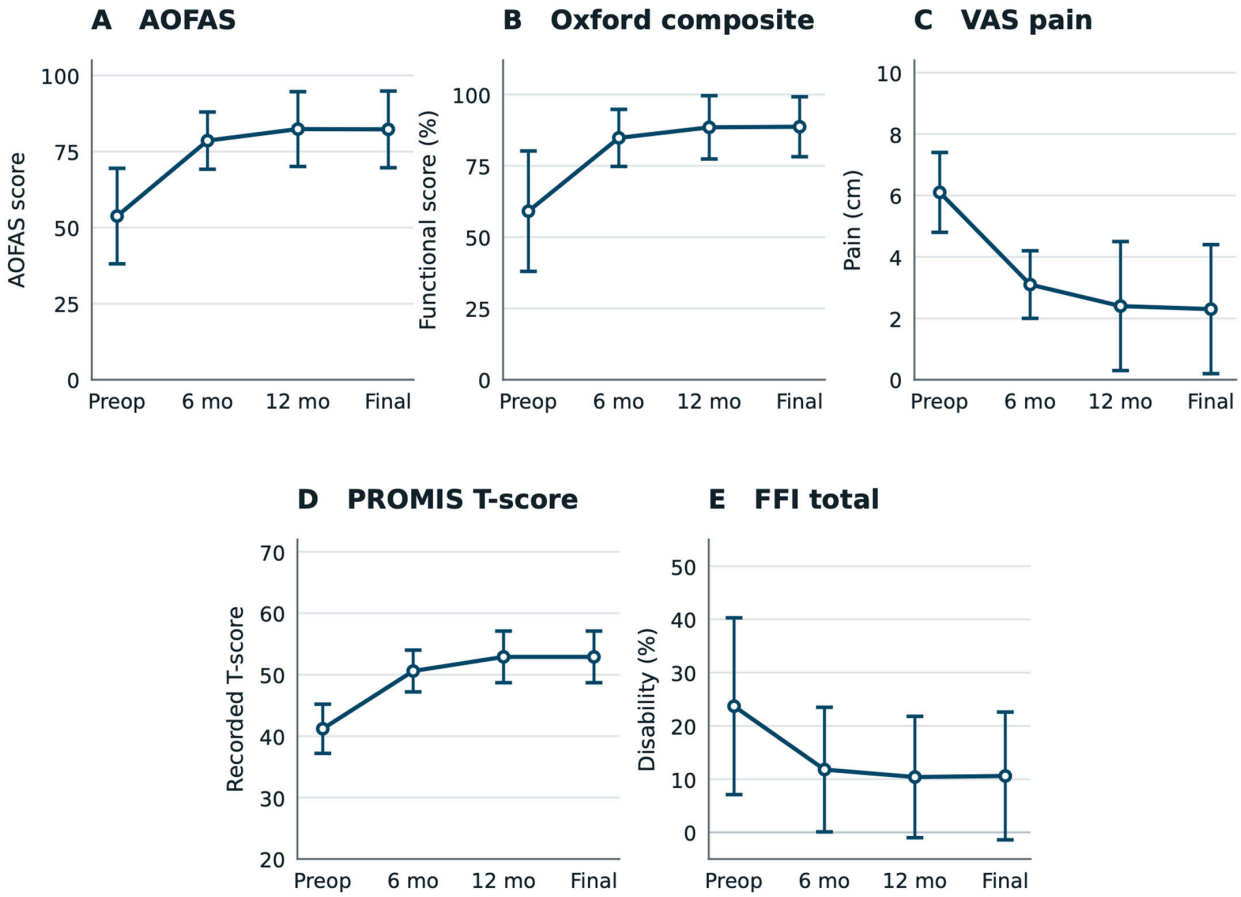


Figure 3. Descriptive mean ± sample SD for 17 feet at preoperative, 6-month, 12-month and final assessments: (**A**) AOFAS, (**B**) Oxford study-specific composite percentage, (**C**) VAS, (**D**) recorded PROMIS T-score and (**E**) FFI total percentage.

Table 3. Radiological Changes Following Surgery.

Measurement	Preoperative (Mean ± SD)	Postoperative (Mean ± SD)	*p*
Gissane angle (°)	131.4 ± 3.0	125.7 ± 4.1	0.0039
Sinus tarsi fat obliteration	17/17 (100%)	3/17 (17.6%)	0.000122

No intraoperative complications occurred. One patient experienced transient lateral foot numbness, which resolved without intervention. There were no cases of wound complications or reoperations.

4. Discussion

This retrospective series found improved pain and functional scores after isolated AALTF resection, with improvements maintained at a mean follow-up of 16.9 months. The findings are consistent with AALTF as a potential source of talocalcaneal impingement and sinus tarsi pain. They do not establish superiority to nonoperative treatment or alternative surgery.

Prior literature has consistently documented the anatomical presence and pathological potential of the AALTF [1,8]. In a large cadaveric study, Hirano et al. identified AALTF in 25% of 44 adult feet and categorized it into four types based on cartilage coverage of the talar and calcaneal sides. Importantly, when articular cartilage was present on both

surfaces, direct mechanical impingement became more likely, even with subtle hindfoot changes [18]. Similarly, Kurashige described a case of symptomatic AALTF impingement in a patient with tibialis spastic varus foot, showing that impingement may occur even in non-flatfoot deformities [10]. Resection of the facet resulted in complete symptom resolution and restored subtalar eversion.

One of the most comprehensive imaging-based analyses comes from Park et al., who conducted a case–control study comparing 120 symptomatic ankles with sinus tarsi pain to 120 asymptomatic controls [4]. They found that the presence of AALTF, bone marrow edema and sinus tarsi fat obliteration were significantly higher in symptomatic patients [4]. Moreover, smaller Gissane angles and larger inferolateral talar surface angles were also independently associated with pain [4]. These MRI features were strongly predictive of sinus tarsi syndrome when AALTF was present. In the present series, sinus tarsi fat obliteration resolved in 14/17 feet. The postoperative reduction in Gissane angle is an observed radiographic finding, not evidence of calcaneal remodeling: surgery was confined to the talar accessory facet, without calcaneal reshaping. Differences in positioning, projection or subtalar orientation and measurement variability may contribute, but their contribution was not measured. Reliability testing was not performed. Gissane angle is not a validated functional outcome of AALTF resection. The differential diagnosis of lateral hindfoot pain should also include subfibular impingement and anterior talofibular ligament pathology, which may present with overlapping symptoms. Careful clinical examination and imaging assessment are therefore important when attributing symptoms to the AALTF.

Neumann et al. provided one of the few reports on arthroscopic treatment of pediatric AALTF, treating a competitive gymnast with refractory lateral ankle pain [9]. Their technique involved accessory portals and fluoroscopic guidance for complete facet resection, with excellent short-term outcomes [9]. Similarly, Mui et al. described a case in which untreated nonunion of a talar lateral process fracture led to development of an AALTF, ultimately requiring surgical excision due to secondary impingement [19]. This highlights that AALTF can form as an adaptive or post-traumatic remodeling process, further supporting its relevance in the context of altered biomechanics.

The potential contribution of the soft-tissue structures of the sinus tarsi should also be considered. The interosseous talocalcaneal ligament is an important stabilizer of the subtalar joint, and injury or insufficiency of this structure may contribute to subtalar symptoms and instability. In the present series, however, the operative procedure was directed at the osseous AALTF responsible for mechanical impingement. The interosseous talocalcaneal ligament and other ligamentous structures were preserved, and no intentional ligament release or reconstruction was performed. Therefore, the clinical improvement observed in this cohort was achieved without an additional ligament-directed procedure. Nevertheless, because the integrity of these structures was not systematically graded intraoperatively in this retrospective study, their potential contribution to symptoms cannot be independently assessed. Postoperative rehabilitation may also have contributed to the early improvement observed during the first six months. Because rehabilitation was part of the overall treatment pathway, its independent effect cannot be separated from that of surgical decompression.

The interpretation of these findings should also account for the overlap among the clinical assessment instruments. Although the AOFAS, VAS, FFI, Oxford, and PROMIS scores showed numerical improvement, these measures assess closely related aspects of pain and physical function. Their concordant trajectories should therefore be viewed as complementary descriptions of postoperative recovery rather than evidence of multiple independent treatment benefits. Importantly, residual pain in 12 of 17 operated feet indicates that clinical improvement did not necessarily correspond to complete symptom resolution.

Limitations include the small retrospective cohort and absence of a control group. Residual pain persisted in 12 feet, and long-term durability is uncertain. Five feet had untreated calcaneonavicular coalitions, which may influence symptoms and limit attribution to the accessory facet alone. Skeletal maturity was not formally assessed, and chronological age was used to characterize the study population. Therefore, the potential influence of skeletal maturity on clinical presentation and postoperative outcomes could not be evaluated. Radiographic reader reliability was not tested, and postoperative imaging changes may reflect positioning or measurement variability. The cohort was too small for a meaningful comparison of staged bilateral and unilateral surgery. Objective gait analysis, pedobarography and isokinetic testing were not performed. Subtalar motion was assessed clinically, but standardized longitudinal quantitative motion and performance measurements were unavailable. Rehabilitation may also have contributed to improvement.

5. Conclusions

Isolated AALTF resection was associated with improved pain and function in this small series of adolescents and young adults with symptomatic lateral hindfoot impingement. Most numerical improvement occurred within 6 months, with little subsequent change between 12 months and final follow-up. Complete pain relief was not universal: 12/17 feet had residual pain. These findings support further prospective controlled evaluation with standardized imaging and age-appropriate outcome measures; they do not establish comparative surgical efficacy.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of Hacettepe University (Protocol No.: SBA/241138) on 27 November 2024.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data supporting the findings of this study are not publicly available due to restrictions imposed by the institutional ethics committee to protect patient privacy and confidentiality. Data are available from the corresponding author, U.C.K., upon reasonable request and in accordance with the ethics committee's requirements.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

AALTF	Accessory anterolateral talar facet
AOFAS	American Orthopaedic Foot & Ankle Society
BMI	Body mass index
CT	Computed tomography
EDB	Extensor digitorum brevis
FFI	Foot Function Index
MRI	Magnetic resonance imaging

PROMIS	Patient-Reported Outcomes Measurement Information System
VAS	Visual Analog Scale
OxAFQ-C	Oxford Ankle Foot Questionnaire for Children

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