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WHAT EVERY PARENT SHOULD KNOW ABOUT IN-TOEING

Many small children toe-in as they are growing up. It is really part of growing up for many toddlers. For these, there is nothing to worry about; and as they get older it will go away.

Some children in-toe because there is a twist to the bone in their leg, either in:

1. Foot. When the twist is in the foot it is called metatarsus varus. Often this can be helped by applying casts to the small child. The cast are changed every week or two gradually straightening the foot. After about 6 weeks the foot is usually straight special shoes are needed for a few months afterwards to keep the foot straight.

2. Shin. When the twist is below the knee, it is called internal tibial torsion. This is something which is made worse by a child sleeping face down, with the feet turned in underneath. It is made worse by a child sitting on his feet habitually. For many children just stopping these habits is enough to allow the condition to get better by itself.

Denis-Browne Splint

For others, with a more marked degree of in-toeing, the problem can be overcome by wearing a night splint for three to six months. This splint holds the feet turned out at night when the bone is growing.

3. Thigh. Some children in-toe because there is a twist between the knee and the hip. This is called internal femoral torsion. It is more common in girls than in boys. Some girls are born with a tendency to this and they find it very easy to sit in the W-position, which aggravates the condition and prevents it from getting better by it self. For some girls, stopping sitting like this will be enough. For more than fifty years, people have been using different kinds of braces and splints and special shoes and special exercises in an attempt to overcome internal femoral torsion. The problem can be made to appear less by putting a child into ballet lesson. Most children show a tendency to improve until the age of eight or ten after which things remain stationary. For the five percent of children who do not improve enough by the age of ten, then remains the possibility of correction by an operation. However, this is hardly ever needed in practice. We do not do the operation at a younger age then ten, because we find that most children grow out of the problem on their own.