which is believed to occur primarily from intrauterine crowding and responds to simple stretching and casting; (2) congenital clubfoot, also referred to as *idiopathic,* which may occur in an otherwise normal child and has a wide range of rigidity and prognosis; and (3) syndromic (or teratologic) clubfoot, which is associated with other congenital anomalies (such as myelomeningocele or arthrogryposis) and is a more severe form of clubfoot that is often resistant to typical treatment.

Classification

The mild, or postural, clubfoot may correct spontaneously or may require passive exercise or serial casting. There is no bony abnormality, but there may be tightness and shortening of the soft tissues medially and posteriorly. The teratologic clubfoot usually requires surgical correction and has a high incidence of recurrence. The congenital idiopathic clubfoot, or "true clubfoot," almost always requires surgical intervention because there is bony abnormality.

Diagnostic Evaluation

The deformity is readily apparent at birth if it has not been detected prenatally through ultrasonography. However, it must be differentiated from some positional deformities that can be passively corrected. Once it is detected, a careful yet comprehensive physical assessment of the affected foot (or feet) should be completed to allow for appropriate decision making regarding treatment plans and prognosis. The affected foot (or feet) is usually smaller and shorter with an empty heel pad midfoot medial crease. When the deformity is unilateral, the affected limb may be shorter and calf atrophy is present. Radiographs of the feet are generally not necessary. A thorough hip examination should be performed for all infants with clubfoot; an increased risk of hip dysplasia is associated with clubfoot deformities.

Therapeutic Management

The goal of treatment for clubfoot is to achieve a painless, plantigrade, and functional foot. Treatment of clubfoot involves three stages: (1) correction of the deformity, (2) maintenance of the