THE COMPLETE GUIDE TO BUNION SURGERY

Moy Bunion Surgery Website Master Manuscript

Continuous public-facing working draft

This is the website itself in reading order - not a project checklist. It contains the cumulative patient-facing copy developed to date. New approved language should be inserted directly into this manuscript so the public-facing draft remains visible, continuous, and current.

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WORKING COPY - SUBJECT TO CONTINUED EDITING

Bunion Surgery Can Be Different

Before you choose bunion surgery, understand what must be corrected, what recovery can look like, and how to examine the evidence for yourself.

A bunion is not simply a bump on the side of the foot. It is a progressive mechanical deformity involving bone position, joint alignment, the sesamoid apparatus, tendons, ligaments, and the way the entire forefoot bears weight.

Dr. Richard Moy has spent more than 35 years refining an approach designed to restore normal anatomy and function while minimizing unnecessary tissue trauma. Appropriate patients are generally allowed to walk in a protective boot immediately, and Dr. Moy has not routinely prescribed narcotic pain medication following bunion surgery for approximately three decades.

Do not simply take our word for it. Review the written evaluations, watch the patient interviews, examine the X-rays, and decide whether the evidence speaks for itself.

EVIDENCE PREVIEW

Patient evaluations, recovery videos, before-and-after photographs, and weight-bearing X-rays.

Why Are So Many People Afraid of Bunion Surgery?

For many patients, the fear of bunion surgery begins long before they ever enter a surgeon's office. They may have watched a friend or family member struggle through an extremely painful recovery, severe swelling, prolonged immobility, dependence on strong medication, or months of frustration.

After witnessing an experience like that, many people understandably say, "I would never put myself through bunion surgery." Patients who have personally endured a painful or unsuccessful operation may become even more fearful. Some postpone treatment on the other foot for years or decades because they have promised themselves that they will never undergo bunion surgery again.

The concern is not limited to pain. Some patients report that the operated foot never felt normal again. They may remain unable to wear desired shoes, return to previous activities, or walk comfortably. Others develop stiffness, altered balance, transfer pressure, recurrent deformity, or pain elsewhere as the body compensates for a foot that no longer functions normally.

Changing that perception requires more than promises. Patients need to understand why one surgical experience can be very different from another, and they need to see the proof in the people who have already experienced it.

Bunion Surgery Is About More Than Removing the Bump

The visible prominence is usually the effect of a deeper biomechanical problem. As the first metatarsal shifts away from the second metatarsal and the great toe moves in the opposite direction, the joint becomes misaligned. The sesamoids, tendons, capsule, ligaments, and neighboring metatarsals may all be affected.

Simply shaving off the bump may temporarily improve the appearance, but it does not necessarily correct the forces that caused the deformity. Successful correction begins by understanding why the bunion formed and restoring the entire joint apparatus toward a normal anatomical relationship.

What Makes Dr. Moy's Approach Different?

No two bunions are exactly alike. Dr. Moy evaluates the position and length of the first metatarsal, the intermetatarsal angle, sesamoid position, tendon balance, joint motion, arthritis, foot structure, hypermobility, neighboring metatarsal relationships, previous surgery, and the patient's activity goals.

The objective is not simply to create a straighter-looking foot. The objective is to restore alignment, preserve motion whenever possible, maintain balanced weight distribution, reduce recurrence forces, and allow the patient to return to an active life.

A Recovery Designed Around Mobility

Most patients are placed in a protective walking boot and allowed to bear weight immediately. Activity is carefully limited and increased in stages while the correction heals. Many patients can return to sedentary work very quickly, transition to a comfortable athletic shoe at approximately four weeks, and begin a gradual return to higher-impact activity around six weeks when healing is satisfactory.

Evidence Patients Can Examine

This website brings together handwritten postoperative evaluations, patient interviews, before-and-after photographs, weight-bearing X-rays, walking videos, range-of-motion demonstrations, revision cases, and long-term follow-up. The goal is not to ask patients to believe an advertisement. It is to let them examine the record.

Could You Be a Candidate?

Most patients in satisfactory general health can be considered for treatment. Age alone does not determine candidacy. Bone quality, circulation, medical conditions, joint damage, previous surgery, balance, and the ability to follow postoperative instructions all influence the final plan.

Request an Evaluation

Call (949) 837-3338, submit an information request through the website, or schedule a consultation online. Out-of-area patients may begin with a Zoom consultation.

READ PATIENT EXPERIENCES | VIEW BEFORE & AFTER RESULTS | REQUEST AN EVALUATION

UNDERSTANDING BUNIONS

What Is a Bunion?

The visible bump is only the outward sign of a three-dimensional deformity involving the entire great-toe joint.

A bunion is commonly described as a bump on the inner side of the foot near the great toe. That description is incomplete. The prominence develops as the first metatarsal and great toe gradually lose their normal relationship.

The first metatarsal moves away from the second metatarsal while the great toe drifts toward the second toe. The joint becomes misaligned, the sesamoid bones beneath the metatarsal head may shift out of position, and the tendons and ligaments begin pulling along abnormal lines of force.

The bump is therefore not simply extra bone growing for no reason. It is the visible result of altered mechanics and repeated pressure at a joint that is no longer centered.

Why Do Bunions Develop?

Dr. Moy views most bunions as the expression of an inherited tendency toward instability, ligamentous laxity, abnormal foot structure, or imbalance within the first ray. Shoes can aggravate pressure and inflammation, but shoes alone usually do not explain why the joint has lost its alignment.

A patient may remember a parent or grandparent with a bunion even when other family members are unaffected. The inherited tendency can appear differently from one person to another and may progress at different rates.

Why Do Bunions Progress?

As alignment worsens, the first metatarsal, great toe, sesamoids, tendons, capsule, and ligaments reinforce the deformity. The joint may remain flexible for years or gradually become more rigid. Shoe pressure can inflame the

prominence, but the deeper problem is the joint's inability to remain centered during weight-bearing and propulsion.

Progression is not identical in every patient. Some bunions remain relatively stable for long periods. Others enlarge steadily, become painful, reduce joint motion, crowd the lesser toes, or change the way pressure is distributed across the forefoot.

Can Nonsurgical Treatment Correct a Bunion?

Nonsurgical care can reduce pressure and temporarily relieve discomfort. Wider shoes, padding, activity modification, anti-inflammatory measures, and selected orthotic devices may make the foot more comfortable.

However, these measures cannot move the first metatarsal and sesamoids permanently back into normal anatomical alignment. They may control symptoms, but they do not straighten the structural deformity. Surgery is the definitive method of correcting the bunion itself.

When Should Surgery Be Considered?

There is rarely a perfect time for bunion surgery. The practical question is when the bunion has become consistently annoying, painful, restrictive, or disruptive enough that correcting it makes sense.

Surgery may be considered when the bunion repeatedly interferes with shoes, walking, work, exercise, sports, travel, or daily comfort; when the deformity is progressing; when the second toe is becoming crowded or unstable; or when nonsurgical measures no longer provide adequate relief.

The decision should be based on symptoms, deformity, examination, weight-bearing X-rays, health status, goals, and the expected benefits and limitations of treatment.

THE MOY APPROACH

What Makes Dr. Moy's Approach Different?

The operation is planned for the individual foot and directed toward restoring the entire first metatarsophalangeal joint as a functional unit.

Correcting the Cause, Not Just the Appearance

The visible bump is only one part of the deformity. A durable correction must address the first metatarsal, great toe, sesamoids, tendons, ligaments, joint capsule, and weight-bearing relationship of the forefoot.

The first metatarsal is repositioned sufficiently to restore the integrity of the joint apparatus. The sesamoid complex is brought back beneath the metatarsal head. Tendon and soft-tissue forces are balanced so that the great toe rests naturally rather than being forcibly held straight.

The great toe should simply want to stay home - in its normal anatomical position.

Preserving the Joint Whenever Possible

The great toe plays a critical role in walking, balance, propulsion, exercise, and athletic activity. Dr. Moy's goal is to preserve and restore the natural joint whenever it can reasonably be reconstructed.

When stiffness, bone spurs, or early arthritic changes are present, treatment may include decompression, removal of obstructing bone, restoration of joint space, treatment of damaged areas, and preservation of as much motion as possible.

Refining the Bone and Soft-Tissue Contour

After the bony prominence is corrected, thickened scarred capsular tissue may still leave the inner side of the joint looking or feeling prominent. Dr. Moy reduces excess and abnormally thickened capsule so the soft-tissue contour more closely resembles a normal foot before the capsule is repaired.

Precise Tissue Handling

Postoperative discomfort is influenced by more than incision length. Tissue handling, bone preparation, nerve and blood-vessel protection, fixation, removal of debris, and the way the soft tissues are balanced all affect the recovery experience.

Dr. Moy emphasizes careful dissection, preservation of neurovascular structures, stable fixation, smooth bone contours, complete removal of loose debris, and repeated assessment of alignment and motion before the operation is concluded.

Immediate Protected Walking

Most patients are placed in a protective walking boot and permitted to bear weight immediately after surgery. Early protected mobility helps patients remain independent while the correction heals. It does not mean unlimited walking, and activity must still be carefully controlled.

No Routine Narcotic Pain Medication

Dr. Moy has not routinely prescribed narcotic pain medication following bunion surgery for approximately three decades. When medication is desired, a short course of prescription anti-inflammatory medication or an appropriate nonprescription medication may be sufficient, depending on the patient's medical history and instructions.

Experience Supported by Visible Evidence

A surgical philosophy should be supported by results that patients can examine. This website presents written evaluations, patient videos, before-and-after photographs, weight-bearing X-rays, walking milestones, range-of-motion demonstrations, revision cases, and long-term follow-up.

PAIN AND PATIENT EXPERIENCE

Is Bunion Surgery Painful?

Bunion surgery has a painful reputation, but the recovery experience is not identical from one surgeon or procedure to another.

Many patients arrive expecting severe pain because they have seen what friends or relatives endured. Some have personally experienced a traumatic bunion operation on the opposite foot and delayed further treatment for years.

Dr. Moy's five-day postoperative evaluation asks a direct yes-or-no question: "Was your surgery virtually painless?" In more than 97% of the patient evaluations currently reported, patients answer yes.

What Happens When the Numbness Wears Off?

Long-acting local anesthesia commonly keeps the foot numb for approximately 24 to 36 hours. By the five-day postoperative visit, the anesthetic has worn off and the patient has experienced the first several days of recovery.

The survey then asks a separate question: whether the patient experienced any discomfort whatsoever and, if so, how intense it was on a 0-to-10 scale. Many patients record zero, while others describe brief, low-level discomfort. Higher scores can occur, but the exact distribution should not be published until the historical evaluations have been formally counted and verified.

These questions measure different things. A patient may truthfully describe the overall experience as virtually painless while recalling a brief sensation of discomfort as the anesthesia wore off, during increased activity, or when swelling created temporary pressure.

Why the Difference Matters

A statement such as "most patients do not have severe pain" understates the actual question. The patient is asked directly whether the surgical experience was virtually painless. That answer is then supported by a separate numerical report of any discomfort experienced.

No surgical result can be guaranteed for every patient. However, the evaluations preserve the patient's own response shortly after surgery rather than relying only on selected testimonials or distant recollection.

Medication Use

Dr. Moy has not routinely prescribed narcotic medication after bunion surgery for approximately three decades. Patients may be offered a short course of a strong anti-inflammatory medication or may use an appropriate nonprescription medication when needed.

The goal is not simply to avoid narcotics. The goal is to perform the operation in a manner that minimizes unnecessary tissue trauma and reduces the sources of postoperative discomfort.

WALKING AND DRIVING

How Soon Can I Walk and Drive After Bunion Surgery?

Most patients begin protected walking immediately, but the amount of standing and walking must be controlled while the correction heals.

The Day of Surgery

The average patient is allowed approximately 15 total minutes of standing and walking on the day of surgery. That time is divided into brief periods for essential activities such as using the bathroom, moving between a chair and bed, or obtaining food and medication.

The patient should spend most of the day resting with the foot elevated. The protective boot must be worn whenever standing or walking.

Beginning the Following Day

Beginning the day after surgery, the average patient may spend up to approximately 20 minutes of each hour standing or walking. That time should be broken into short periods - one minute here, three minutes there, five minutes there - not completed as one continuous walk.

Standing counts as activity. Showering, preparing food, standing at a counter, and completing household tasks all place pressure on the operated foot.

Weekly Progression

The general progression is approximately 20 minutes per hour during the first week, 25 minutes per hour during the second week, 30 minutes per hour during the third week, and 35 minutes per hour during the fourth week.

These are general limits. Patients with strong bone and secure fixation may progress more quickly. Patients with severe osteoporosis, softer bone, less secure fixation, poor balance, or additional procedures may need partial weight-bearing, additional support, or a slower progression.

Will I Need Crutches, a Walker, or a Knee Scooter?

Most patients do not require crutches. Crutches are generally reserved for severe osteoporosis, substantially weakened bone, complex reconstruction, or another reason to restrict weight-bearing.

A walker may be appropriate for an elderly patient or anyone with poor balance, weakness, or difficulty walking before surgery. A knee scooter is optional and is most useful for patients who must cover long distances, such as students crossing a campus, salon professionals, or employees working in a large facility.

Driving the Following Day

Patients may not drive on the day of surgery because anesthesia and sedation may affect judgment, coordination, and reaction time. After an overnight rest, many patients may be permitted to drive the following day when they are fully alert, are not taking impairing medication, can enter and exit the vehicle safely, and can operate the pedals rapidly and firmly.

An automatic transmission is preferred. Driving a manual or stick-shift vehicle is not permitted during the early postoperative period because repeated clutch use places unnecessary pressure and movement through the foot. Right-foot surgery requires particular caution because the patient must be capable of an emergency stop.

IMPORTANT: The day after surgery is the earliest that driving may be considered. Individual safety and Dr. Moy's postoperative instructions always take priority.

RECOVERY

What Is the Week-by-Week Recovery After Bunion Surgery?

The typical recovery is organized around protected walking, swelling control, early motion, gradual increases in activity, and a return toward normal shoes and exercise over approximately six weeks.

Day of Surgery

The foot is protected in a walking boot. Most patients may place weight on the operated foot immediately, but standing and walking are limited to approximately 15 total minutes for the day. A responsible adult drives the patient home. The dressing remains clean and dry, and the foot is elevated for most of the day.

First Night and Day 1

The foot may remain numb for 24 to 36 hours. Swelling, heaviness, tingling, and mild bruising are expected. The patient should not remove the dressing, touch the incision, walk without the protective boot, or assume that minimal discomfort means unlimited activity is safe.

Beginning the next day, standing and walking may increase to approximately 20 minutes per hour, divided into short periods.

Postoperative Days 2 Through 5

Patients continue protected walking, frequent elevation, icing as instructed, and careful activity control. Swelling and bruising may increase. Temporary numbness can remain present because of swelling and pressure in the tissues.

The office should be contacted for spreading redness, increasing heat, increasing pain, drainage, uncontrolled itching, unusual discoloration, or excessive tightness that does not improve after following the bandage-relief instructions.

First Postoperative Visit: Approximately 3 to 5 Days

Dr. Moy examines the incision, swelling, circulation, sensation, alignment, range of motion, dressing, and activity level. By this time, the long-acting anesthetic has worn off, and the patient completes the written postoperative evaluation.

Range-of-Motion Exercises

At the conclusion of surgery, many patients demonstrate approximately 90 degrees of dorsiflexion and 45 degrees of plantarflexion. Some motion decreases during the first several days because of inflammation, swelling, early scar formation, and reluctance to move the toe.

When instructed, the patient bends the great toe upward for approximately 30 seconds and downward for approximately 30 seconds, repeating the movement for about five minutes. These sessions are performed regularly as a form of self-directed physical therapy. Moderate, controlled pressure is used; patients should never attempt violent manipulation.

Week 1

The average patient remains limited to approximately 20 minutes of combined standing and walking per hour. The boot is worn during all weight-bearing activity. Desk work may often be resumed quickly when the foot can be elevated and walking remains limited.

Week 2

Standing and walking may increase to approximately 25 minutes per hour. Stitches are generally removed during the early postoperative period according to the individual plan. Range-of-motion exercises and swelling control remain important.

Week 3

Standing and walking may increase to approximately 30 minutes per hour. Swelling commonly peaks around the third week because the patient is becoming more active. A temporary increase in swelling does not necessarily mean that something has gone wrong.

Week 4

Standing and walking may increase to approximately 35 minutes per hour. Many patients transition from the walking boot into a loose, comfortable lace-up athletic shoe when the examination, X-rays, bone healing, fixation, swelling, and motion are satisfactory.

Weeks 5 and 6

Patients gradually increase ordinary walking, work activity, time in regular shoes, and low-impact exercise. High-impact activity should not be resumed solely because the foot feels comfortable. The bone, fixation, capsule, tendons, and surrounding tissues must be ready for greater force.

Many patients may begin a gradual return toward jogging or higher-impact activity at approximately six weeks when healing is satisfactory.

After Six Weeks

The six-week point is an important milestone, but healing continues. Mild swelling after prolonged standing or exercise, continued improvement in motion, and gradual return of strength and endurance may continue through the sixth to eighth week and beyond.

The procedure may be virtually painless, but successful healing still requires patience, protection, and adherence to the postoperative program.

WORK, EXERCISE, SPORTS, AND FOOTWEAR

When Can I Return to Work, Exercise, Sports, and High Heels?

Return to activity depends on the amount of standing, walking, lifting, climbing, impact, and pressure placed through the ball of the operated foot.

Desk and Sedentary Work

Patients with a desk job or another occupation that does not require prolonged standing or walking may often return as early as the day after surgery, provided that they can elevate the foot, wear the protective boot, limit walking, and remain fully alert after anesthesia.

Physically Demanding Work

Flight attendants, delivery workers, police officers, firefighters, longshore workers, construction workers, warehouse employees, healthcare workers who remain on their feet, and others whose jobs require prolonged standing, walking, climbing, lifting, or rapid movement generally require a minimum of approximately six weeks before returning to unrestricted duty.

Modified duty may allow an earlier return when the patient can remain seated and protect the foot.

Exercise During Early Recovery

Patients may begin exercising almost immediately when the activity keeps the foot protected and does not transfer the majority of body weight through the ball of the operated foot. Early exercise should emphasize seated, lying, upper-body, or core activities and should generally keep forefoot loading at approximately half the patient's body weight or less unless otherwise instructed.

Sports and Jogging

Most sports begin gradually at approximately six weeks, with a progression toward normal participation by approximately eight weeks. The patient begins with a short, low-intensity session and increases duration, speed, direction changes, impact, and frequency in stages over approximately two weeks.

High-Heeled Shoes

High heels should generally be avoided for approximately seven to eight weeks. When resumed, the patient begins with a lower, stable heel for a short period and gradually increases heel height and wearing time over approximately two weeks. The shoe must not compress the surgical area or force the great toe into an abnormal position. All work, exercise, sports, and footwear should be resumed gradually according to healing and function - not pain level alone.

RECURRENCE

Why Do Some Bunions Return After Surgery?

A bunion can return when the underlying structural and soft-tissue forces were not fully corrected or when the correction was not adequately protected during healing.

A bunion is not simply a piece of unwanted bone. The visible prominence develops because the first metatarsal, great toe, sesamoids, tendons, capsule, and ligaments are no longer functioning in their proper relationship.

Removing the bump without sufficiently restoring the first metatarsal and the entire joint apparatus may leave the original deforming forces in place.

Restoring the First Metatarsal

A durable correction begins by moving the first metatarsal sufficiently toward its functional anatomical position. Every foot does not have to be forced into one textbook number, but the correction must restore enough alignment to rebuild the integrity of the first metatarsophalangeal joint.

Restoring the Sesamoids

Correction involves two coordinated movements: the first metatarsal is moved toward the sesamoid apparatus, and the mobilized sesamoid apparatus is restored beneath the metatarsal head. These movements counterbalance each other and help rebuild the normal joint relationship.

Neutralizing the Deforming Forces

The intrinsic and extrinsic tendons, ligaments, capsule, and plantar structures must be balanced so the great toe naturally rests in a neutral position. The extensor tendon should be centered over the longitudinal axis of the first ray, and the toe should not demonstrate an easy preference to drift in one direction.

Testing the Correction Under Load

Before closure is completed, Dr. Moy simulates loading of the foot and observes where the great toe naturally wants to rest. The toe is gently tested toward varus and valgus. A balanced correction should remain centered rather than snapping back toward the second toe or drifting in the opposite direction.

Protecting the Correction During Healing

A correction that is perfect on the operating table must still be protected. Splinting, postoperative positioning, the walking boot, activity limits, and patient compliance all help maintain the alignment while the bone and soft tissues heal.

A bunion correction should not only look straight at the conclusion of surgery. It should remain stable when the foot is loaded and the toe is tested in both directions.

COMPLICATIONS AND PREVENTION

What Can Go Wrong After Bunion Surgery?

Patients deserve an honest explanation of possible problems, how they develop, and what can be done to reduce the risk.

No surgeon can guarantee that every patient will have an identical recovery or result. Anatomy, health, bone quality, procedure complexity, tissue response, and compliance all matter. Dr. Moy's approach is directed toward anticipating the common failure mechanisms and addressing them before they become permanent problems.

Joint Stiffness

At the conclusion of surgery, the great-toe joint is assessed through its range of motion. Motion can decrease during the first several days because of swelling, inflammation, tightening of the capsule, early scar formation, and the patient's reluctance to move the toe.

Some patients naturally have more elastic connective tissue than others. Patients with hallux limitus, arthritis, preoperative restriction, or a strong biological tendency toward stiffness require particular attention to early range-of-motion work.

The first postoperative visit is an important opportunity to identify excessive restriction before it becomes established. In selected cases, the joint may be locally anesthetized and carefully manipulated by the physician. Patients should never perform forceful manipulation without instruction.

Can Pain Develop Beneath the Second Metatarsal?

Transfer metatarsalgia can occur, but it has been uncommon in Dr. Moy's practice. It develops when the first ray no longer carries its proper share of weight and pressure shifts toward the second metatarsal.

Possible causes include inadequate restoration or hypermobility of the first ray, excessive shortening, elevation or valgus positioning of the first metatarsal, an elongated or plantarflexed second metatarsal, and retrograde pressure from a hammertoe or unstable second toe.

Preventing transfer pain requires evaluating the entire metatarsal parabola and restoring balanced weight distribution across the forefoot rather than treating the great toe in isolation.

Temporary Numbness

Temporary numbness is common and is usually related to the long-acting anesthetic, swelling, pressure from the postoperative tissues, and the bandage. A narrow line of reduced sensation may occur directly along the incision.

During surgery, the neurovascular bundles and the structures associated with the medial marginal vein are identified, protected, and retracted away from the active dissection. Prolonged numbness directly related to surgery has been rare in Dr. Moy's experience. Sensation generally improves as swelling and pressure resolve.

Swelling

Swelling is expected and commonly reaches its highest level around the third postoperative week as activity increases. It generally subsides through the sixth to eighth week, although some patients remain swollen longer.

Pitting edema, varicose veins, chronic fluid retention, venous problems, and certain medications can prolong swelling. Localized swelling over the fixation screw may indicate mechanical irritation or, in a small number of patients, sensitivity to a component of stainless steel.

Hardware Irritation and Screw Removal

The vast majority of patients leave the fixation screw in place because it never causes a problem. A small percentage request removal because they prefer to have it out after healing or because it becomes prominent, backs out, causes localized swelling, or is irritated by shoe pressure.

Dr. Moy developed a minimally invasive removal method using fine-needle localization and guide-wire tracking through the center of the cannulated screw. The screw is removed through a very small opening, generally requiring one stitch and a small dressing. Patients commonly return to a regular shoe the following day.

Infection

Postoperative infection has been extremely uncommon in Dr. Moy's practice. When it has occurred, it has generally been mild and identified early. Concerning signs include spreading redness, increasing warmth, a newly sensitive or painful area, drainage, odor, wound separation, or systemic symptoms.

Patients should keep the dressing clean and dry, avoid touching or scratching the incision, and use the protective shower bag. Intense itching can represent contact dermatitis rather than infection and should be reported rather than treated by removing or probing the dressing.

Blood Clots

Blood clots have been extremely rare in Dr. Moy's bunion patients. Early protected walking promotes circulation and may help reduce the risk associated with prolonged immobility, but it cannot eliminate risk completely.

New calf or thigh swelling, tenderness, warmth, redness, or unexplained soreness requires prompt evaluation and may require ultrasound. Sudden shortness of breath, chest pain, coughing blood, lightheadedness, or fainting requires emergency medical attention.

Complex Regional Pain Syndrome

CRPS is an uncommon condition involving pain that is disproportionate to the expected healing process and may be associated with unusual sensitivity, swelling, skin-temperature or color changes, sweating abnormalities, stiffness, and loss of movement.

Dr. Moy reports encountering several CRPS cases related to traumatic injuries during his career, but none following one of his bunion procedures in more than 35 years. Because it has been exceptionally rare in his experience, it is included here only as part of a complete discussion of uncommon possibilities.

FAILED BUNION SURGERY AND REVISION

When Bunion Surgery Does Not Produce the Expected Result

A failed procedure can create structural, functional, cosmetic, and emotional problems - and many patients delay seeking help because they are afraid of repeating the first experience.

Dr. Moy frequently evaluates patients with recurrent or incompletely corrected deformity, increasing pain, unsightly alignment, transfer pressure, second-toe problems, joint stiffness, hardware irritation, chronic swelling, difficulty walking, and fear of undergoing another operation.

How Is the Failure Evaluated?

The evaluation begins with weight-bearing X-rays, including anteroposterior and lateral views. Dr. Moy examines the intermetatarsal angle, hallux alignment, previous surgical site, first-metatarsal length and elevation, sesamoid position, joint congruity, arthritis, healing, and hardware.

He then examines the foot directly and puts the joint and surrounding structures through range of motion to determine how the bones and soft tissues have adapted to the new position. The goal is to identify what anatomy can be mobilized and what would be required to restore the foot toward a normal functional relationship.

Can the Foot Be Reconstructed?

Many failed bunion procedures can be improved when enough usable bone, joint structure, capsule, tendon, ligament, and surrounding soft tissue remain. Revision surgery is based on the anatomy that is still present to work with.

When excessive bone has been removed from both sides of the joint, the natural joint may no longer provide enough structure for Dr. Moy's reconstructive approach. In that unusual situation, he may recommend a surgeon who specializes in another form of salvage reconstruction rather than offer an operation he does not believe can produce meaningful improvement.

What Type of Revision Is Required?

There is no single revision operation. The procedure may require repositioning bone, correcting undercorrection or overcorrection, restoring the metatarsal-phalanx relationship, mobilizing the sesamoids, releasing scar tissue, rebalancing tendons and capsule, removing hardware, smoothing residual prominences, and correcting associated second-toe or transfer-pressure problems.

Is Recovery More Difficult?

Revision surgery may be more complex and time-consuming for the surgeon because the tissue planes are altered, scar tissue is present, anatomy has been changed, and hardware may need to be addressed. Despite that complexity, Dr. Moy reports that the patient's recovery generally follows the same approximate six-week framework as a primary bunion procedure and can still be virtually painless.

Risks and Expectations

The risks and limitations depend on what the first operation changed, what anatomy remains, and what the reconstruction is trying to accomplish. The patient should understand the present condition of the foot, where it needs to go, how the correction will be performed, what obstacles are present, and what degree of improvement can realistically be expected.

The Patient's Role

The surgeon's responsibility is to reconstruct the foot. The patient's responsibility is to allow the reconstruction to heal. Excessive activity, premature pressure, failure to use the boot, and disregard of postoperative positioning or motion instructions can alter the final result.

Dr. Moy's role is to restore the alignment and function of the foot. The patient's role is to protect that work and allow it to heal uneventfully.

FEATURED REVISION CASE

Three-part patient video: failed first surgery, reconstruction, painless recovery, and emotional relief.

HALLUX LIMITUS AND RIGIDUS

Can a Stiff or Arthritic Great-Toe Joint Be Preserved?

Dr. Moy favors preserving the natural joint whenever it can reasonably be decompressed, realigned, and restored to useful motion.

Hallux limitus describes restricted motion of the great-toe joint. Hallux rigidus describes a more advanced condition in which motion is severely limited and arthritis may be extensive. Patients may experience dorsal bone spurs, jamming, pain during propulsion, difficulty with shoes, and loss of normal walking mechanics.

Why Removing Only the Spur May Not Be Enough

The visible dorsal spur - sometimes described as a "shark fin" - is often the result of a joint that remains mechanically compressed and jammed. Removing only the spur may improve the appearance but does not necessarily correct the underlying pressure or restore the joint relationship.

Joint Decompression and Restoration

When appropriate, Dr. Moy may decompress the first metatarsophalangeal joint, remove obstructing bone, restore space, remodel the joint margins, perform peripheral resurfacing, and use subchondral drilling in damaged areas. The objective is to reduce jamming and preserve as much natural movement as possible.

Realistic Limits

No procedure can recreate normal cartilage when advanced arthritis has destroyed the joint surface. The decision depends on the amount of remaining cartilage, location of damage, degree of stiffness, alignment, age, activity, and the patient's goals.

Implant arthroplasty or fusion may be considered when the joint cannot reasonably be preserved, but Dr. Moy does not view fusion as the automatic first choice for every stiff or arthritic great-toe joint.

BEFORE-AND-AFTER RESULTS

What Should Patients Look for in a Successful Bunion Correction?

The goal is a foot that looks, moves, bears weight, and feels as close to normal as possible - not simply a straighter photograph.

A successful result should restore the appearance and function of a normal foot. The great toe should lie flat, appear straight, rest naturally, and move smoothly. The prominence on the inner side should be eliminated, the forefoot should look balanced, and the scar should mature into a fine line that becomes less noticeable over time.

What Should the Joint Feel Like?

The great-toe joint should move smoothly upward and downward without catching, grinding, jamming, or feeling mechanically blocked. The patient should be able to walk, propel, exercise, and wear ordinary shoes without being constantly reminded that the foot was operated on.

The ideal long-term result is simple: "My foot feels completely normal. I do not notice anything abnormal about it, and it works just fine."

What Should the X-Rays Show?

Weight-bearing X-rays should demonstrate adequate reduction of the intermetatarsal and hallux angles, restoration of the first metatarsal toward its functional anatomical position, sesamoids centered beneath the metatarsal head, a congruent joint, stable fixation, healing of the osteotomy, preserved length and elevation, and a balanced relationship with the neighboring metatarsals.

Every patient does not need to be forced into one identical measurement. The alignment must be sufficient to allow the bones, tendons, sesamoids, ligaments, and capsule to function together normally.

How Can Patients Avoid Being Misled?

One impressive photograph is not proof. Patients should look for a broad and consistent body of cases with comparable views, weight-bearing X-rays, clear timing, walking and motion videos, patient interviews, written evaluations, and long-term follow-up.

Photographic angle, lighting, magnification, foot positioning, and X-ray technique can alter appearance. Patients may not be able to determine whether two images truly represent the same foot. The most meaningful safeguard is consistency across many documented patients and the opportunity to hear directly from previous patients.

Talk to Previous Patients

Ask how the anesthesia wore off, what medication was actually taken, how soon the patient walked, whether crutches were required, when the patient drove and returned to work, how long swelling lasted, whether the joint is mobile, whether desired shoes and activities were regained, and whether the patient would choose the same surgeon and procedure again.

An advertisement can be designed. A photograph can be selected. A large body of consistent patient experiences is much more difficult to manufacture.

BEFORE-AND-AFTER GALLERY

Comparable photographs, weight-bearing X-rays, motion demonstrations, and long-term cases.

See the Evidence for Yourself

Patients should not be asked to accept a surgeon's promise without seeing what previous patients actually reported and demonstrated.

How Were the Written Evaluations Collected?

For many years, patients completed a handwritten evaluation at the first postoperative office visit, generally three to five days after surgery. By that time, the long-acting local anesthetic had worn off and the patient had experienced the first several days of recovery.

Each patient recorded answers concerning the operation, including whether it was virtually painless and whether any discomfort occurred. The patient then turned the form over, signed and dated it, and acknowledged that it could be retained as third-party validation of the experience.

The forms preserved the patient's own markings, numerical ratings, comments, signature, date, and contact information as recorded at the time. Public copies should protect identifying information unless the patient has provided appropriate authorization.

Why Did Dr. Moy Begin Collecting Them?

Several years into practice, Dr. Moy began describing his procedure as virtually painless. After that statement was challenged as allegedly false or misleading, he developed a written questionnaire and mailed it to prior patients so their own experiences could be submitted as evidence.

Approximately 45 evaluations were gathered in the initial response. According to Dr. Moy, the Medical Board reviewed the information and took no further action requiring him to discontinue the claim. From that point forward, the evaluation became part of the routine first postoperative visit for every bunion patient.

A Historical Record

During the busiest years of the practice, hundreds of evaluations accumulated annually. Many were scanned and paired with before-and-after cases on the website. Changes in website developers, hosting systems, computers, and storage resulted in the loss or disappearance of parts of the historical collection, so the evaluations currently online represent only part of the archive.

Patient Video Interviews

Hundreds of patients have discussed their experiences on video at different stages of recovery: shortly after surgery, walking in the boot, returning to shoes, resuming activity, and months or years later. These interviews allow prospective patients to hear the patient's voice, observe mobility, see the foot, and understand the recovery in a way that advertising copy cannot reproduce.

Before-and-After Photographs and X-Rays

Photographs demonstrate the visible correction. X-rays show what happened beneath the surface: first-metatarsal realignment, restoration of the great toe and sesamoids, joint congruity, fixation, healing, and maintenance of correction.

Long-Term Follow-Up

Some patients returned more than a year after surgery for an unrelated condition and completed additional long-term evaluations. These cases were not collected at a uniform time and therefore should not be treated as a formal consecutive long-term study, but they provide useful examples of durability, function, footwear, motion, and patient satisfaction over time.

The purpose of preserving these records has always been the same: patients should be able to examine what previous patients reported in their own handwriting, shortly after experiencing the procedure themselves.

PATIENT EVIDENCE LIBRARY

Handwritten evaluations, video interviews, walking videos, recovery milestones, and long-term follow-up.

CANDIDATE SELECTION

Could You Be a Candidate for Dr. Moy's Bunion Procedure?

Most patients in satisfactory health can be considered, but candidacy is determined individually after reviewing the foot, medical condition, bone quality, and recovery requirements.

During more than 35 years of practice, only a small number of patients have been unable to proceed at a particular time because of an underlying medical condition. The average healthy patient who receives appropriate medical clearance can generally be considered for surgery.

Does Age Matter?

Younger patients generally heal more quickly than older patients, but age alone does not determine candidacy. Many older adults are active, independent, and healthy enough to undergo successful correction.

The more important questions are whether the patient is medically fit, whether circulation is adequate, whether bone can support the correction, whether existing conditions are controlled, and whether postoperative instructions can be followed safely.

What About Osteoporosis?

Patients with osteoporosis may still be candidates, but fixation and recovery may need to be modified. Additional internal fixation, partial weight-bearing, a longer period in the boot, assistive devices, closer X-ray monitoring, or a slower activity progression may be recommended.

Severe, Recurrent, or Previously Operated Bunions

Patients should not assume they are beyond help because the deformity is severe or because a previous operation was unsuccessful. The evaluation determines what anatomy remains, what can realistically be reconstructed, what procedure is required, and what recovery is appropriate.

The First Step

Patients do not have to decide that surgery is right for them before requesting an evaluation. The first step is learning what is causing the deformity, what options are available, and what can reasonably be expected from treatment.

TRAVELING FOR SURGERY

Traveling to Southern California for Bunion Surgery

Patients travel from across the United States and other countries. Most preliminary evaluation and preparation can be completed before the patient leaves home.

Initial Zoom Consultation

The process generally begins with a private Zoom consultation lasting approximately 30 to 45 minutes. The patient discusses symptoms, prior treatment, recovery concerns, and goals. Photographs, medical information, and weight-bearing X-rays may be sent in advance.

X-Rays

Patients may obtain the required weight-bearing X-rays in their hometown and send them to the office. They may also have the X-rays taken after arrival at the radiology office located above Dr. Moy's suite.

Medical Clearance

Appropriate medical clearance is generally completed within approximately six weeks before surgery. Requirements may include a history and physical examination, laboratory testing, an electrocardiogram when indicated, and additional testing based on age, health, anesthesia, and surgery-center guidelines.

Typical Travel Schedule

Out-of-area patients generally arrive on Wednesday and meet Dr. Moy for the in-person examination, X-ray review, surgical planning, consent, preoperative instructions, postoperative instructions, and prescriptions.

Surgery is generally performed on Thursday. The patient returns to the hotel or local accommodation with a responsible adult and follows the same activity limits as local patients.

The first postoperative visit occurs on Tuesday, approximately five days after surgery. After Dr. Moy evaluates the incision, swelling, circulation, alignment, range of motion, dressing, and overall recovery, the patient may generally fly home Tuesday or Wednesday.

Recovering Locally

Several lodging options are located near the office, and patients who prefer to stay near the coast may choose accommodations near the ocean. The trip should be viewed as a planned medical stay rather than an ordinary vacation. Sightseeing and unnecessary walking should be avoided during the early healing period.

Returning Home

Patients should wear the protective boot, use airport wheelchair assistance when helpful, move the ankle and leg periodically, avoid prolonged immobility, elevate the foot when practical, and follow individualized swelling and blood-clot precautions. Follow-up after returning home may include video visits, photographs, locally obtained X-rays, telephone communication, and additional in-person visits when necessary.

The usual plan is to arrive Wednesday, have surgery Thursday, return to the office Tuesday, and fly home Tuesday or Wednesday.

ABOUT DR. MOY

About Dr. Richard R. Moy

More than 35 years of bunion surgery focused on reducing trauma, preserving function, and restoring the foot toward normal anatomy.

Dr. Richard R. Moy is a California podiatric surgeon and Fellow of the American College of Foot and Ankle Surgeons. He has devoted much of his career to bunion surgery, hallux valgus, hallux limitus and rigidus, complex forefoot deformity, and reconstruction after failed bunion operations.

His approach was refined over decades through repeated observation of alignment, joint motion, healing, patient discomfort, return to activity, complications, recurrence, and long-term function. The procedure is methodical, but the magnitude of each step is adjusted to the severity and anatomy of the individual foot.

Dr. Moy's educational philosophy is straightforward: patients should understand what is wrong, what must be corrected, what recovery should involve, and what evidence supports the claims being made.

Patients have traveled from many states and countries for treatment. The practice maintains an extensive collection of patient interviews, handwritten evaluations, before-and-after photographs, radiographs, and recovery videos so prospective patients can examine the experience of those who came before them.

CONSULTATION

Request an Evaluation

The first step is a careful review of the patient's health, symptoms, foot structure, joint motion, weight-bearing X-rays, and goals.

Local patients may schedule an in-person consultation. Out-of-area patients may begin with a Zoom consultation and submit photographs, X-rays, prior operative reports, and relevant medical information before traveling.

How to Contact the Office

Call the office at (949) 837-3338, submit an information request through drmoy.com, email the office through the website, or use the online scheduling link.

What to Bring or Send

Helpful information includes recent weight-bearing X-rays, photographs of the foot, a list of symptoms and limitations, prior operative reports when applicable, previous imaging, current medications, relevant medical history, and the patient's goals for shoes, work, exercise, and activity.

What Happens During the Consultation?

Dr. Moy examines the structure and function of the foot, evaluates alignment and range of motion, reviews the X-rays, explains what is causing the deformity, discusses nonsurgical and surgical options, and describes what can realistically be expected from treatment and recovery.

MEDICAL INFORMATION

Important Medical Information

This website provides general educational information and reflects Dr. Moy's clinical experience and professional opinions. It is not a substitute for an individual medical examination, diagnosis, treatment plan, or emergency care.

Every patient's anatomy, health, bone quality, procedure, healing response, and recovery are different. Recovery milestones and outcomes described on this website are typical or reported experiences and are not guarantees.

Patients should follow their own written postoperative instructions and contact the office promptly with unusual symptoms. Sudden chest pain, difficulty breathing, fainting, or another emergency requires immediate emergency medical care.

REQUEST AN EVALUATION
(949) 837-3338 | drmoy.com | Online consultation and appointment requests available