

Guidelines and Document format for electronic article submission to the FAOJ

The Foot and Ankle Online Journal has the ability to upload and publish articles within a short period of time by following these simple guidelines. Pre formatting your submitted manuscript will help expedite editing and final formatting so we can publish your manuscript in a timely manner. Please following the following guidelines when using Microsoft Word:

1. Use Microsoft Word version 2007 for submission of all articles.
2. Set 'page layout' to NARROW margins (0.5" all around).
3. Keep manuscript in ONE column.
4. Set Fonts to manuscript.

FONTS:

Title: Garamond (Bold)-22


e.g.

Metatarsal Fracture Allografts: A case report and literature review

Author: Garamond (Bold)-12

e.g.

by William J. Houser, MD¹  , Laura M. Filer, DPM² 

Please add the *number superscript* after each author and use the email image and hyperlink the email address to each author. (you may copy and paste the email image [] from the website. To hyperlink, go to *insert* and *hyperlink* in the MS word toolbar.

Abstract: Times New Roman (Italics)-12

e.g.

*The abstract should be in a new font called Times New Roman using the italics font type at size 12. If there is a **Background, Methods, Results and Discussion** section to your abstract, these words should be placed in **BOLD** font type.*

Key Words: Times New Roman (Italics)-12

e.g.

Key words: Plantar fasciitis, Pain and disability scale, heel pain

Correspondence Address and Titles: Times New Roman-8

e.g.

Address correspondence to: Texas State University, Health Physical Education and Recreation, San Marcos, TX
Email: BuckPhD@yahoo.com

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All authors should have a numbered *superscript* at the beginning of their affiliation listed in order of primary and secondary authors. Please list pertinent information including hospital or clinic name, address, phone numbers and email contacts if applicable.

Body of Manuscript: Garamond -12 (single space)

e.g.

In 2004, a morphofunctional study described a more specific measurement called the “*angle of fourth metatarsal shortening or second-fourth angle*” to quantify the definition of brachymetatarsia.³ Brachymetatarsia is defined as a second-fourth angle of less than 52.2 degrees in males and 50.5 degrees in females.³ Using both techniques, in our case report, the fourth metatarsal measured more than 5mm of shortening from the parabolic line and the second-fourth angle is less than 50.5 degrees respectively (45.2 degrees). (Fig. 1)

All references should be *superscript* at the end of each sentence preferably in listed order within the manuscript.

Figures and Tables: Tahoma -10 (single space)

List figures and tables within the body of the manuscript in parenthesis and abbreviated for figures only.

e.g. (Fig.1), (Table 1)

The figures and tables should be listed at the end of the manuscript in Tahoma-10 font/size as shown in this example.

e.g.

Figure 1 Once the graft is securely in place, the patient’s own platelets and white blood cells are lavaged into the wound. The pin is protected with a Jergen’s® ball at the end of the k-wire and closed prior to application of dressings and a posterior leg splint.

Table 1 Differential diagnosis in PF in a healthy population.

References: Garamond-10

Please use the following example for your reference formats.

e.g.

1. Bennett PJ, Patterson C, Wearing S, Baglioni T. Development and validation of a questionnaire designed to measure foot-health status. *J Am Podiatr Med Assoc* 88 (9):419 – 28, 1998.
2. Digiovanni BF, Nawoczenski DA, Malay DP, Graci PA, Williams TT, Wilding GE, Baumhauer JF. Plantar fascia-specific stretching exercise improves outcomes in patients with chronic plantar fasciitis. A prospective clinical trial with two-year follow-up. *J Bone Joint Surg* 88A:1775 – 81, 2006.
3. Dmitri Luke BS. Plantar fasciitis: a new experimental approach to treatment. *Med Hypotheses* 59(1): 95 – 7, 2002.
4. Fishco WD, Goecker RM, Schwartz RI. The instep plantar fasciotomy for chronic plantar fasciitis. A retrospective review *J Am Podiatr Med Assoc* 90 (2): 66 – 69, 2000.
5. Allmendinger A, Yeghiayan P, Perone R, St. Vincent's Medical Center in New York City: Case of the month. diagnostic imaging 31(1) [\[online\]](#) Accessed February 7, 2009.

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JPEG photos should be sent separately from the manuscript in the same or successive emails.

The following is an example of the all fonts and styles put together and how the document should be sent to picomstaff@hotmail.com or faojeditors@gmail.com :

Plantar Fascial Rupture of the Foot: A case report

by Al Kline, DPM¹ 

Plantar fascial rupture is rarely presented in the literature. Spontaneous rupture of the plantar fascia is commonly preceded by plantar fasciitis. A 60 year old male presents following an acute injury of his foot while playing softball. He presents with acute pain and ecchymosis to the plantar arch of the foot. Plantar fascial rupture was diagnosed clinically and confirmed on magnetic resonance imaging (MRI). This case discusses the clinical evaluation, MRI results and treatment of acute, spontaneous rupture of the plantar fascia. We also describe the MRI differences of plantar fasciitis and plantar fascial rupture.

Key words: Plantar fasciitis, plantar fascial rupture, heel pain, Magnetic resonance imaging

Plantar fascial injuries are a common source of foot pain. Plantar fasciitis is the most common type of plantar fascial injury. The condition is characterized by small tears of the plantar aponeurosis that can cause inflammation and thickening of the plantar aponeurosis. The causes of injury are related most commonly to stress and strain. General injury to the plantar fascia can be divided into three categories: mechanical, degenerative and systemic.¹ Mechanical conditions such as pronation, forefoot varus and rearfoot valgus will often lead to increased tension and strain of the plantar aponeurosis. This may be exacerbated by increased activity and lack of proper shoe and in-step support. It is now widely accepted that degenerative changes can occur within the plantar fascia due to repetitive micro tears and peri-fascial edema termed plantar fasciosis.² This is characterized as a degenerative process of myxoid degeneration without inflammation.²

Case Report

A 60-year old healthy male presented to our office in acute pain. He presented with a limp. He stated that he had been having arch and heel pain of the right foot over the past month. He recently participated in a softball game. He states that while ‘sprinting’ to a base, he felt a ‘pop’ in his arch followed by acute pain and swelling. He immediately stopped playing and placed ice on the arch region of the foot. Clinical evaluation of the foot reveals an extremely tender plantar fascia with localized bruising or ecchymosis (Fig.1).

References

1. Theodorou, D.J., et al.: Plantar fasciitis and fascial rupture: MR imaging findings in 26 patients supplemented with anatomic data in cadavers. *Radiographics*. 20: S181- S197, 2000.
2. Lemont H, Ammirati, KM, Usen N: Plantar fasciitis: A degenerative process (fasciosis) without inflammation. *J Am Podiatr Med Assoc* 93(3): 234 – 237, 2003.
3. Barrett SL, O’Malley R.: Plantar fasciitis and other causes of heel pain. *American Family Physician* 59 (8), 1999.
4. Leach R, Jones R, Silva T: Rupture of the plantar fascia in athletes. *J Bone Joint Surgery* 60A (4): 537 – 539, 1978.

Figures

Figure 1 The plantar fascia shows bruising directly along the arch of the foot. There is extreme point tenderness to this region.

Figure 2 T2 sagittal image shows a central thickening up to 10mm with enlargement and nodular thickening of the plantar aponeurosis.

Figure 3 STIR (inversion recovery image) coronal views also shows intrafascial edema and hemorrhage.

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