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Approved by	*Podiatry Department*
Prepared by	*Jenny Allen*
Developed by	*Podiatry Department*
Reviewed by	
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Podiatry Services Nail Surgery Care Programme

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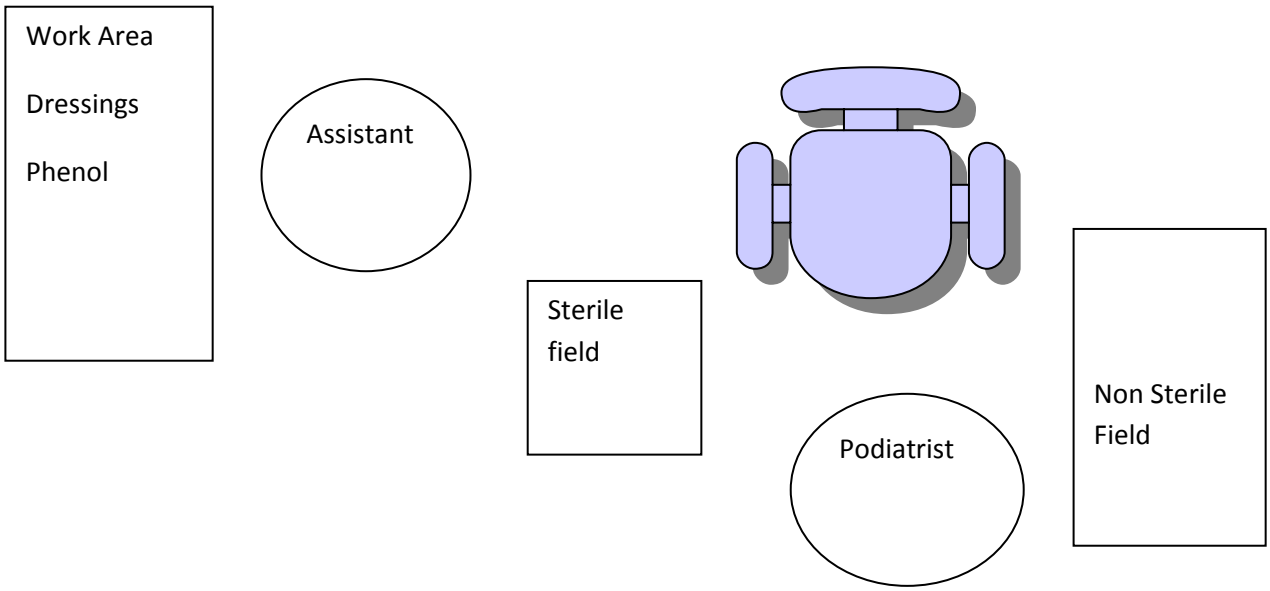
Nail Surgery Care Pathway

Environment and Room Layout



The diagram above is for illustrative purposes only, each clinic will be set up differently, but the basic premise remains the same. Hand washing facilities must be available to health care staff.

Purpose of the Guidelines

The purpose of these guidelines is to help ensure that the referrer provides the podiatry service with sufficient and appropriate information to enable an effective triage to take place. In particular we need to know:-

- **If the nail condition is *acute*, i.e. - there is a visible wound/inflammation because the nail has broken the integrity of the skin in the nail fold.**
- **The medical risk of the patient.**
- **Full medical history.**
- **Full list of medication.**
- **Diagnosis and treatment decided.**

With this information, planning the procedure can commence, with the aim of:-

- Ensuring that acute patients are offered an appointment within 14 days of receipt of referral, locally or at another location.
- Patients who are “at high risk” are treated by the appropriate experienced Clinician.
- Appointments are offered at the most convenient/appropriate venue for the patient, where practicable.

It is not the purpose of these guidelines to lay out the nail surgery procedure, merely to ensure that certain criteria, for example, timing the application of phenol, or the use of PPE, are met in the provision of nail surgery in an equitable manner across the department.

Guidelines for Risk Assessment and Clinical Rationale for this Nail Surgery Care Programme

General Considerations

Informed consent must be obtained. Patients must be provided with clear verbal and written instructions for both anaesthetic and operative procedures.

The weight of the patient must be obtained in order to accurately calculate the maximum safe dose of anaesthetic.

Nail Surgery should never be carried out by an individual working alone. A second person, preferably a Podiatry Assistant, should be available to act as Dirty Nurse. Access to Adrenaline is required in case of an anaphylactic reaction to the local anaesthetic agent.

Age Considerations

Upper Age Limit – There is no specific upper age limit; the patient's medical history may however preclude them. In all cases the medical history and current health status should be carefully weighed against the severity of the nail pathology and the patients' wish for surgery.

Children under 12 – Many young children will not have had a local anaesthetic. Clinicians should be vigilant for the risk of anaphylaxis.

(Please note children up to the age of 16 **must** have their consent form signed by a parent or guardian).

Vulnerable Patients

Patients with Learning Disabilities, Adult Mental Health Patients and Alzheimer's Patients

The support of the Learning Disability Specialist Podiatrist or Vulnerable Patients Co-ordinator should be sought here. As the level of disability can vary, the level of understanding of the procedure may also vary, but it must be enough to give consent. It may be necessary for a parent or guardian to be present.

If in doubt, refer to NHS Borders Consent Policy

Specific Medical Conditions

Patients with an Identified Needle Phobia

Patients who have an identified and documented needle phobia can be seen at the DPU (Day Procedure Unit) at the BGH. The Podiatry patients are on the end of the Dental Patient day, so liaison with the Dental team is important to book a slot. **This should be organised through Adam Smith, Diabetes Specialist Podiatrist.**

Items to take for nail surgery at the DPU include:

- Nail Surgery Kit – instruments, dressings, tubinet and mefix.
- Phenol and alcohol
- Local Anaesthetic, with Safety Plus Needle
- Consent Form and Pre-Operative Screening Form
- Patient Advice Sheet
- Dressing Request Form for follow on treatment from nurses.

It should be remembered that as spaces are limited, **it must only be those patients who have an identified severe needle phobia who are treated in the DPU.**

Patients with Epilepsy

The severity and frequency of seizures needs to be established. A patient whose epilepsy is stable should have no problems with local anaesthetic or the procedure. A patient on strong anticonvulsant therapy however, who is unstable should be considered carefully for nail surgery as the drugs can mask the symptoms of toxicity of LA. Depending upon the patient, the input of the Vulnerable Patients Co-ordinator may be helpful/advisable.

Patients with Diabetes

It is essential to be aware of the patients' diabetic control. Raised blood glucose levels can cause impaired healing and increase the chance of infection. Stress may precipitate a hypoglycaemic attack. As a general rule, patients with a chronic nail condition and blood glucose levels at or over 9 should not be treated until their blood glucose has been brought under better control. Such patients should be individually assessed in consultation with their usual Diabetic Support Team and then only proceed if the patient has adequate diabetic control and the local infection has been addressed.

Patients with Peripheral Vascular Disease

Clinical conditions such as Peripheral Vascular Disease, Rheumatoid Arthritis, Scleroderma, Diabetes and Reynaud's Disease require a thorough clinical risk assessment. Many patients with signs of PVD will not be on any specific medication.

Reynaud's Disease/Syndrome is characterised by abnormal vasospastic response of the digital arterioles due to temperature or emotional changes. Nail Surgery should never be attempted during a vasospasm, as the anaesthetic stays in place longer acting as a partial tourniquet. It is often advisable to carry out the surgery in the warmer summer months.

For these patients the following should be confirmed:-

- Are all pedal pulses palpable? If not confirm with Doppler.
- Capillary refill time (nail bed or toe pulp) within 3 seconds.

Cardiovascular Disease

This should include all cases of unstable hypertension, heart murmurs, rheumatic fever (which may need antibiotics prior to surgery), unstable angina, valve implants, bypass or any other vascular surgery. A history of Myocardial Infarction should be assessed individually, depending on the severity.

Warfarin

Patients who are on warfarin should have their INR checked prior to surgery and:

Patients with low risk conditions such as Atrial Fibrillation or Ischaemic Heart Disease who have an INR of 2 or less do not require their warfarin to be stopped.

Low risk patients with an INR of greater than 3 should have their warfarin stopped for a couple of days prior to surgery.

High risk patients, such as those with metal heart valves, should always have their procedure carried out in the DPU (Day Procedure Unit).

Transplant/Prosthesis Patients

Patients who have had recent joint replacement in particular Knee Arthroplasty may require prophylactic antibiotic therapy for the days around the nail surgery procedure. Patients who have undergone, or are waiting to undergo, organ transplant surgery, for example heart, liver, kidney, will most likely be on drugs to control rejection or high doses of steroids. They will have lowered immunity to infection and impaired healing.

Anticoagulants

Anticoagulant Drugs are used to reduce the ability of the blood to clot. Examples include:

Aspirin – Works by reducing the "stickiness" of the platelet cells

Heparin - Works by raising the levels of heparin in the blood, increasing the time it takes for a clot to form. Often used in the breakdown of clots formed in deep vein thrombosis and pulmonary embolism.

Warfarin – Works by interfering with the body's natural chemical cascade of clotting, by targeting vitamin K.

Clopidogrel – Works by inhibiting platelet aggregation, and is used as an alternative for those patients who are intolerant to aspirin.

Dipyridamole – Works by inhibiting thrombus formulation

Phenindione – Vitamin K antagonist – Dindevan

Acenocoumarol – Vitamin K antagonist – Sintrom/Sinthrome

It may be necessary for a patient who is being risk assessed for suitability for nail surgery to stop taking these drugs prior to the nail surgery date, in order to prevent excessive bleeding during or after surgery. This must be done in consultation with the Specialist or GP in charge of the patients' care. *If medication is stopped then the patient must arrange with their Consultant/GP to have medication levels monitored.*

Biological Therapies

For patients who are on biologic therapy for Rheumatoid Arthritis, it is worth noting that one of the side effects of these therapies is an increased risk of infection.

The main classes of biological drugs used within NHS Borders are:

- Anti-TNF drugs such as Infliximag, Etanercept and Adalimumab
    - Works by blocking the action of TNF, a protein found in excessive amounts in the blood and joints of people with RA
    - Taking anti-TNF drugs can occasionally affect the blood count and make the patient more likely to develop infections.
- Anti-CD20 Rituximab
    - Works by removing the antibody-producing white blood cells called B-cells. Antibodies are proteins which are produced by the body in response to germs, viruses or any other substances the body sees as foreign or dangerous. In people with RA, some B-cells produce harmful "autoantibodies" such as rheumatoid factors. The purpose of rituximab is to remove those B-cells. Unfortunately Rituximab also removes B-cells which make useful antibodies, but these return after some months.
    - Infections may be more common after treatment, and a small proportion of people have reaction to the infusion, with fever, wheeziness, rash or a fall in blood pressure.

Blood Borne Infections

These should include all notified incidences of the following:-

- Hepatitis B and C → Refer to Infection Control Manual
- HIV and AIDS → specific Policy and Guidelines regarding
- CJD → these patients

<u>Other factors for Consideration</u>

Hypersensitivity Reactions

- Anaphylaxis – true anaphylaxis is very rare. Varies in severity with progression either rapid or slow in onset. Symptoms include:
    - Angio-oedema

    - Urticaria
    - Dyspnoea
    - Hypotension
    - Laryngeal oedema
    - Change in skin colour – pale/flushed
    - Sense of impending doom
- Central Nervous system – characterised by:
    - Light headedness
    - Apprehension
    - Euphoria
    - Confusion
    - Drowsiness
    - Tinnitus
    - Vomiting
    - Convulsions
    - Respiratory Depression
- Cardiovascular System – usually depressant, causing:
    - bradycardia
    - Cardiovascular collapse
    - Initial symptoms are:
        - Sweating
        - Faintness

Many people have no previous history of local anaesthesia. Should any problems arise, stop injection of Local Anaesthetic immediately, and treat the patient (including emergency resuscitation procedures) as appropriate.

Liver and Kidney Problems

As 85 – 90% of Local Anaesthetic is excreted as metabolites (metabolised by the liver), and the rest unchanged, by the kidneys, hepatic and renal function is important, as any liver disease prolongs the half life of lignocaine (normally 1.5 hours) considerably, allowing damage to occur. Conditions to note are:

- Hepatitis
- Cirrhosis
- Organ transplant

Some medications such as Cimetidine have been shown to slow the metabolism of local anaesthetic agents, and Roaccutane also has an effect on healing, especially skin regeneration.

Pregnant/Nursing Mothers

Phenol can be **genotoxic**, so should not be used on pregnant patients. It is therefore an absolute contraindication if a patient is pregnant. Local Anaesthesia should not be administered until after the first trimester, and while there is no significant evidence that local anaesthetic is excreted in breast milk, a number of drugs are known to be excreted, so it is advisable that mothers should express milk prior to the procedure and only continue breast feeding once 30 hours have elapsed.

Previous Drug Allergy

Previous allergic reaction to LA will almost certainly be repeated with any further exposure to LA. This is a contraindication for the administering of LA.

Local Sepsis

Take care to administer the LA at a suitable anatomical location proximal to the area of sepsis. If possible, delay the procedure until the sepsis has been treated with antibiotics.

Malignant Hyperpyrexia

This is a very rare, life threatening condition, mainly associated with general anaesthesia, where the body temperature rises rapidly. Local anaesthesia is considered safe but if the patient has a history of episodes then consultation with an anaesthetist is recommended.

Marphan/Ehlers Danlos Syndrome

Patients with these hypermobility syndromes often have a higher instance of failure of peripheral nerve blocks with the duration of successful blocks being up to 50% reduced, resulting in a rapid loss of analgesia during any surgical procedures. This may lead to the requirement of a "top up" during the procedure.

Motor Neurological Disease

Patients may experience involuntary spasm of the limb in response to an injection. Care must be taken to reduce risk of needlestick injury. It may be necessary to request pre-op medication from the GP to help reduce or prevent any spasming. Alternatively, it may be that a general anaesthetic may be required.

Porphyria

Mepivocaine is listed as a potentially unsafe drug in patients with Porphyria. Advice must be sought from either the patients' consultant or haematologist.

Symptomatic Bradycardia

This condition is often associated with hypothyroidism, hepatic disease and raised inter cranial pressure. High doses of LA may result in syncope, dizziness, weakness, confusion, chest pain and fatigue. If administering LA do so with the patient in the supine position and use a minimal dose of LA.

Diabetes

Identified risks are peripheral arterial disease, peripheral neuropathy and poor glycaemic control. These may result in delayed or potentially non healing wounds and post operative infection. No clear evidence is available for appropriate HbA1c levels for nail avulsion with phenolisation.

Elevated HbA1c levels may be the result of infection and it may be that removal of the nail could be the stabilising factor.

Immunosuppressed Patients

Some examples of the immunisuppressed patient are listed below.

Endocrine – diabetes

Gastro-intestinal – Hepatic insufficiency, hepatitis, intestinal lymphangiectasia, protein losing enteropathy

Haematologic – aplastic anaemia, cancer, sickle cell anaemia, leukemia

Drug related – Biologics, disease modifying antirheumatic drugs, corticosteroids, cytotoxics, chemotherapy, some anticonvulsants.

Infections – Epstein-Barr virus, HIV, AIDS

Nutritional – Alcoholism, under nourishment

Renal – Renal insufficiency, nephritic syndrome, uremia

Rheumatological – rheumatoid arthritis, SLE

Other – Chromasomal Disorders (Downs Syndrome), chronic illness

Decisions must be made after full consideration is given to the risk factors relatable to each patient on an individual basis. Liaise with other professionals as required to ensure the best outcome for each patient. Ongoing post operative input may be required to ensure a successful outcome.

Nail Surgery Protocol

Objectives

- To provide prompt treatment for patients with acute onychocryptosis.
- To provide surgical treatment for suitable patients with nail pathologies.
- To provide Podiatrists and Students with the opportunity to gain experience in Nail Surgery.

Referral

- Referrals will be accepted from any health professional or from the patient themselves.
- Patients from any age group suffering from an ingrown toenail will be seen and advised, with nail surgery being carried out if appropriate. Ongoing conservative treatment – non surgical – will only be available for patients who are assessed as having a need according to current department criteria.

Initial Appointment

- Initial appointments are for the assessment and discussion of the treatment options available.
- Patients should be seen within 3 days if there is an acute condition – if the nail has punctured the skin and/or there is infection present.
- Patients should be seen within 4 weeks if non acute.
- A full medical history will be undertaken on the New Patient Assessment Form, paying particular attention to current medication. If possible a GPass Summary Sheet will be included in the notes.
- A pre surgery screening form should be completed, with the pathology described fully, and the treatment options discussed with the patient. The patient should understand what has caused the problem, and realise that the problem may recur unless the causative agent is removed. Where surgery is unlikely to achieve full relief from the symptoms, or where healing may be delayed by impaired circulation or systemic drugs the patient must understand the implications.
- Elderly patients with chronic involution, gryphosis or other non-acute problems who may benefit from surgery should be told what the options and their consequences are. A decision should then be made with the patient on an individual basis.
- Patients with acute onychocryptosis or recurrent sepsis from involuted nails will normally be advised that surgery is the treatment of choice – providing there are no medical, psychological or social contra-indications.

- The Patient must be made aware of all the possible outcomes, from regrowth to post surgical infections that might result from the surgery, and a Consent form must be signed.
- The complete patient record must be sent to the clinic where nail surgery will take place before appointing the patient, with extra labels with the patients name and CHi number on to affix to the patient records.

Surgery

- Surgery will be offered where appropriate:
    - Urgent as soon as possible
    - Non-urgent within 6 weeks of the initial referral
- Surgery will be performed by an appropriately qualified and experienced Podiatrist or Student who **must** have an assistant in the room during the procedure. If a Student takes part in the procedure, an experienced Podiatrist **must** also be present to supervise closely, ensure procedures are followed correctly, and take responsibility for the outcome of the procedure.
- Records of the procedure must be kept on the appropriate form and attached to the patient's record card.
- A letter should be sent to the Patients' GP with a record of the procedure.
- Initial post-operative instructions, for pain relief and dressing regime, should be supplied in writing.

Nail Surgery Procedure

The following sterile, aseptic and safety procedures MUST BE FOLLOWED.

- All work surfaces, including the patients' couch must be cleaned with an approved disinfectant before each procedure.
- A separate nail surgery pack must be used for each procedure and the identification number stuck onto the patients' notes.
- PPE, in the form of hats, gloves, aprons, masks and eye protection (in the form of goggles, plastic visor or prescription spectacles), must be worn. This is particularly important because of the risks associated with the use of phenol.
- Care must be taken to avoid needle stick injuries. No-one must move around the clinic with an unsheathed needle. Once the needle sheath has been removed, no attempt should be made to resheath the needle. Once the syringe is empty, the protective outer should be locked into the safe position, and the unit disposed of in the sharps bin.
- Batch numbers and expiry dates must be recorded for both Phenol and Local Anaesthetic in the patients' notes.
- The toe and cleft should be swabbed with betadine.
- Tourniquet times must be recorded along with a full description of the procedure. Tournicots must not be left on for more than 15 minutes to avoid tissue damage.
- Rubber tournicots must be used with the labels still attached – this is a safety backup to ensure tournicots are not left on once the procedure has ended. They are single use, and should be discarded along with the contaminated waste and **not** used again.
- Clinicians **must** maintain a clean or sterile field, using either the stainless steel trolley or the clinic trolley for the nail surgery pack and unused instruments, and the other for used instruments. Used instruments **must not** be placed back with unused instruments.
- Phenol should be applied for 3 separate 1 minute applications, and the area swabbed between applications.
- Contaminated sharps and used cartridges of anaesthetic should be placed in an approved sharps box.
- All other waste must be disposed of in the clinical waste bin. Swabs etc. used during surgery may be disposed of into a yellow bag that must subsequently be placed into the clinical waste bin.

Dressings

In most cases, a dry dressing should be adequate – such as telfa with tubegauze and mefix. A Haemostatic dressing such as Sorbsan Plus may be useful if there is a lot of post operative bleeding, but should not be used as a matter of course.

Follow Up Care

- An appointment should be made with the Practice Nurse at the patients' own Health Centre for 24-48 hours after the surgery.
- The Patient should be advised not to drive or go on public transport for 24 hours.
- The Patient should be advised to go straight home and elevate their foot/feet and take it easy for the rest of the day.
- Post operative pain relief should be discussed, and the information sheet on pain relief and dressing regime should be explained and provided.

Safe Working Procedures for Phenol

- Phenol will only be kept in small quantities, usually 10ml. or less.
- Phenol will be contained in a dark glass bottle, and stored away from lig t in a cool, locked cupboard within a secondary container to isolate it from the other contents of the cupboard and to contain possible drips on the outside of the bottle.
- Handling procedure:
    - Protective clothing – gloves, apron and eye protection **must** be worn when decanting the phenol and applying phenol to the toe.
    - No more than 1ml of liquefied phenol should be decanted from the bottle to the gallipot at any one time.
    - Phenol should only be dispensed into a gallipot when required to reduce the risk of spillage and exposure to the vapour or fumes.
    - Phenol should be applied using a black's file, not the dropper, to reduce the risk of spillage or over application.
    - If phenol is used directly from the bottle then the bottle should be disposed of afterwards to prevent the risk of cross contamination. This method may reduce the risk of splashing from decanting the phenol, but may carry an increased risk of spillage and from fumes due to a larger volume being exposed to the atmosphere in a less stable container. The risk of spillage is also increased due to lapses in concentration of the person holding the open bottle for several minutes.
    - Excess phenol should be disposed of at the earliest opportunity. Gallipots used for phenol should be filled with gauze or cotton wool to soak up the excess phenol and then placed in the clinical waste bag. Liquefied phenol is a poison and must not be disposed of down the sink or toilet.
    - **Phenol can be genotoxic and should not be used by pregnant staff or on pregnant patients!**

Emergency and First Aid Procedures

Contact with eye:

- Irrigate with at least 3 litres of water for at least 15 minutes to remove the chemical and report immediately to Accident and Emergency for inspection for epithelial damage.

Ingestion:

- Wash mouth thoroughly with water. Give plenty of water or milk to drink. No not induce vomiting. Obtain immediate medical attention.

Skin Contact:

- Remove contaminated clothing avoiding contamination of unaffected areas. Wash with soap and water, and if any signs of skin damage call for medical help.

Spillage:

- Extinguish sources of ignition. Wear full protective clothing when dealing with spillage. Absorb spillage with paper towels and dispose of these in a polythene bag, which should then be closed firmly by tying before putting into a yellow incineration waste bag. If broken glass is involved the spillage and glass should be placed in a clear 700 gauge polythene bag first. Wash site of spillage thoroughly with water and detergent.

Checklist for Nail Surgery

You have been referred for nail surgery, your appointment is attached, please take note of the following which will ensure a more relaxed and less stressful appointment.

1. **Please make sure you have made a treatment room appointment for 2 days after the surgery**
2. Please bring sandals for after surgery to accommodate dressing
3. Please bring someone to drive you home
4. Ensure you have adequate pain relief – not aspirin based
5. Make sure you have eaten breakfast/lunch prior to surgery
6. Do you need to bring a book/music player for distraction during surgery?
7. As the surgery is warm, can you make sure you are not dressed too warmly, or can remove layers in surgery to avoid overheating.
8. Please inform us if you feel sick or severely stressed by the sight of needles or blood

Thank you

Podiatry

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Podiatry

Staff Requirements

All staff undertaking Nail Surgery procedures should have the following qualifications.

- Current Health and Care Professions Council (HCPC) registration
- Local Anaesthesia Certificate

All staff performing nail surgery should have up to date statutory and mandatory training in

- Basic Life Support
- Anaphylaxis
- Clinical waste and sharps disposal

All staff performing nail surgery should be fully conversant with

- NHSBorders Infection Control Guidelines
- Scottish Executive Health Department: A Good Practice Guide on Consent for Health Professionals in the NHS Scotland
- Society of Chiropodists and Podiatrists Code of Conduct
- Society of Chiropodists and Podiatrists Standards for Clinical Practice

All staff performing or assisting with nail surgery act as autonomous practitioners. As such, Podiatrists will:

- Use their professional judgement
- Be accountable for their decisions and actions
- Apply their clinical skills and professional knowledge for each patient
- Be fully conversant of the risks associated with both local anaesthesia agents and phenol
- Keep clear and accurate records, signed and dated in black ink
- Obtain informed consent prior to any procedure
- Give clear and unambiguous information to the patient on the procedure, its' likely outcomes and potential risks, allowing them to make an informed decision
- Work only within their professional capabilities and competencies

DEPARTMENT OF PODIATRY
POST-OPERATIVE NAIL SURGERY ADVICE

Pain relief: It is occasionally necessary to take a painkiller after the procedure in order to ease any discomfort as the anaesthetic wears off. We generally recommend *Ibuprofen* or *Brufen*, however, if you are currently on medication and are not sure which painkiller you would be allowed to take, please contact your GP or discuss it with your Pharmacist. You are advised not to use aspirin.

Dressings: An appointment to see the Treatment Room Nurse at your local health centre should be made either the following day or no later than 2 days after the procedure. This should be the first dressing change. Subsequent dressing changes can be done at home every second day. Guidelines for doing this are set out below. It is strongly recommended that you see the nurse after one week to ensure the wound has not become infected.

The wound: This can take 4 - 6 weeks to heal even when the above advice has been followed. This is essentially due to the effect the Phenol has on the tissues. We advise that, where possible, sensible footwear should be worn and sport or physical exercise is discontinued in order to allow the wound to heal properly. If you have any concerns, please contact your Podiatrist. Try to avoid any trauma to the area and also keep the area dry.

Guidelines for changing your dressings

Remove dressing if easy to do so - if not, soak your foot in a basin of warm salt water to aid removal. Change this water and follow the next steps:

Step 1 ~ Soak foot/feet in a basin of clean, warm, salty water (use approximately 2x handfuls of ordinary salt) for about 10-15 minutes.
Step 2 ~ Dry foot/feet with a clean towel on each occasion taking care not to touch the toe to be dressed - allow it to dry naturally.
Step 3 ~ Once dry, apply a fresh sterile dressing as shown by the nurse.

Please change the dressings every second day. **NOTE: Baths or showers should be taken before changing the dressing.**

THIS IS TO BE READ BY BOTH PODIATRIST AND PATIENT FOR CONSENT PURPOSES

PLEASE ENSURE THE PATIENT FULLY UNDERSTANDS THE PROCEDURE

In order to make your toe better we need to remove a part/the whole of your toenail. To allow us to do this we have to administer a local anaesthetic into your toe to achieve what we call a "Ring-Block". This makes the nerves in your toe become numb and feeling is temporarily lost. The anaesthetic should take approximately 10 minutes to take effect and we can then prepare your toe for the operation.

A tourniquet is placed around your toe, before we begin, to ensure no bleeding occurs throughout the procedure. This is painless, however, we do have to keep an eye on the time the tourniquet is worn. Please understand that the procedure will not go ahead until we are completely satisfied full anaesthesia has been obtained. In some cases a further "top-up" injection is required but this is usually painless due to the anaesthetic already in your toe.

Once the offending nail has been removed, we apply a solution called Phenol to the nail matrix and nail bed for a period of 4 minutes. In doing so, we prevent the nail re-growing and causing a similar problem to recur. The tourniquet is then removed and the toe is dressed.

Post-operative advice will be provided at the end of the procedure

Further reading

A Good Practice Guide on Consent for Health Professionals in NHSScotland http://www.sehd.scot.nhs.uk/mels/HDL2006_34.pdf

Society of Chiropodists and Podiatrist. 2012. Code of Conduct.
http://www.scpod.org/Easysiteweb/getresource.axd?AssetID=6739&type=full&servicetype=Inline

The Standards for Clinical Practice, 2010, Society of Chiropodists and Podiatrists.
http://scpod.org/EasysiteWeb/getresource.axd?AssetID=33365&type=full&servicetype=Inline

Thanks must be given to NHS Greater Glasgow and Clyde Podiatry Service for the use of their Guidelines for Nail Surgery in the updating of this protocol.