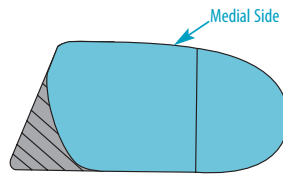


SHELL MODIFICATIONS

Your patients each have biomechanical challenges that benefit from additions and modifications. We allow you, at no extra charge, to customize each orthotic to your patient's specific condition, weight, and activity type by creating the additions and modifications you prescribe. The below are shell modification suggestions and diagrams listed by possible patient conditions. We have included drawings to help you visualize the placement and shape of each modification to the shell. This is not an exhaustive list. Any technical assistance you may need is available by calling Customer Service at 1.888.523.1600.

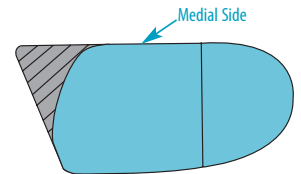
CORRECT FOR IN-TOE

The shell extends laterally to the middle of the 5th digit, changing the gait pattern for in-toeing patients less than 10 years of age. We recommend a pediatric gait plate to correct for in-toe.



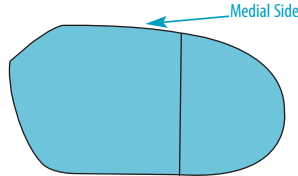
CORRECT FOR OUT-TOE

The shell extends medially to the middle of the 1st digit, changing the gait pattern for out-toeing patients less than 10 years of age. We recommend a pediatric gait plate to correct for out-toe.



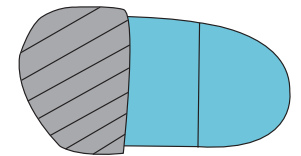
CLIP 1ST MET HEAD

The medial distal corner of the orthotic shell is removed just proximal to the 1st metatarsal head. We suggest this shell modification for Hallux Limitus and Sesamoiditis.



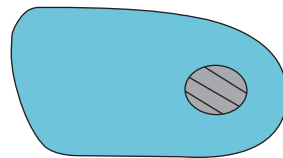
COMPRESSIBLE FF POST TO SULCUS

An EVA forefoot posting is applied to the orthotic extending to the sulcus creating forefoot control on contact. We recommend this for shin splints.



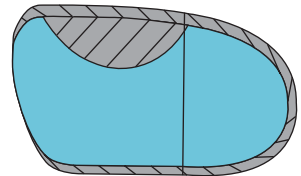
INTRINSIC REARFOOT POSTING

Varus, valgus or neutral posting is ground into the shell of the orthotic device.



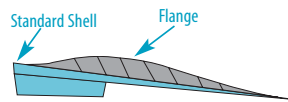
REDUCE BULK

Additional arch filler material is removed and the rearfoot posting is undercut an additional ten degrees achieving a better shoe fit.



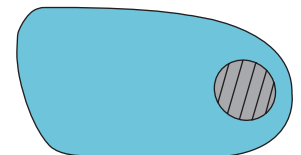
MEDIAL AND LATERAL FLANGES

The medial or lateral border of the orthotic shell extends higher around the sides of the foot, providing greater control. We recommend a lateral flange for lateral ankle instability and a medial flange for over pronation. We recommend a medial flange for posterior tibial tendon dysfunction in combination with deep heel cups.



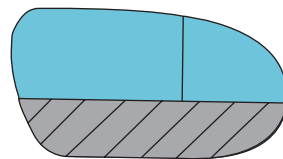
HEEL SPUR CUTOUT

The shell is cut away from the center of the heel and replaced with gel padding. We recommend this modification for heel spurs. In addition to a heel spur cutout, we also suggest heel padding or a U-pad.



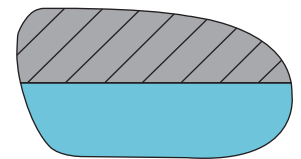
LATERAL WEDGE

An EVA wedge is applied to the lateral plantar surface of the orthotic helping to evert the foot. We recommend this modification for lateral ankle instability in combination with a lateral flange and for over supination.



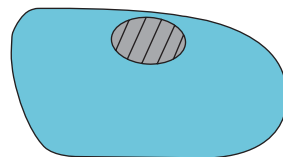
MEDIAL WEDGE

An EVA wedge is applied to the medial plantar surface of the orthotic helping to invert the foot. We recommend this modification for over pronation.



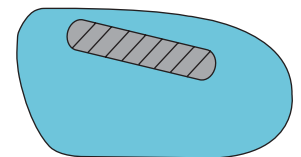
NAVICULAR SHELL ACCOMMODATION

An indentation in the shell of the orthotic is created to provide a "well" for a misplaced navicular.



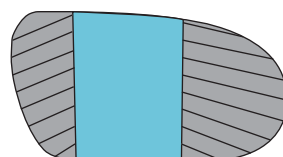
PLANTAR FASCIAL GROOVE

A depression in the shell of the orthotic is created providing relief for the plantar fascia.



EXTRINSIC FOREFOOT AND REARFOOT POSTING

An external piece of EVA material is added to the forefoot or rearfoot of the orthotic to provide varus, valgus or neutral correction. We recommend varus rearfoot posting for over pronation and valgus rearfoot posting for over supination. We recommend varus rearfoot posting combined with deep heel cups for plantar fasciitis.



HEEL CUP DEPTH

$\frac{3}{8}$ " is our standard, $\frac{1}{4}$ " is shallow, $\frac{5}{8}$ " is deep and $\frac{3}{4}$ " is very deep. A deep heel cup provides increased motion control, enhanced proprioception, and better plantar cushion. We recommend this modification for plantar fasciitis (suggest also adding varus rearfoot posting). We recommend deep heel cups for posterior tibial tendon dysfunction in combination with a medial flange.

