

Fifth metatarsal fracture — postoperative rehabilitation

After surgery for a fifth metatarsal fracture. The main pathway addresses fixation of a Jones or proximal shaft fracture; avulsion fractures and nonunion revision require the modifications described below.

Prepared by Tomasz Poboży — orthopaedic surgeon · Published 19 October 2026

For clinicians, physiotherapists and patients. The individual plan based on the operative report takes precedence over the time ranges on this page.

Essential protection

Weight-bearing

After Jones fracture fixation, an initial non-weight-bearing period of around 4 weeks is commonly followed by cautious progression in a boot. Low pain alone does not justify increasing load; healing must be assessed.

Brace / immobilisation

Initial splint/cast, then a walking boot as prescribed.

Range of motion

Ankle motion after clearance; avoid forced adduction/inversion and early resisted eversion when the tendon insertion has been repaired.

Rehabilitation at a glance

Timings are approximate. Progression requires criteria and clearance for the relevant motion or loading level.

01

Protecting fixation

Weeks 0–4

Protect the wound and a fracture site at increased risk of healing problems.

02

Movement and cautious loading

Usually weeks 4–6

Restore gentle movement and prepare for walking.

03

Walking after healing review

Usually weeks 6–12

Reduce crutch and boot use without recurrent pain.

04

Control and return to sport

From around week 12; criteria based

Return to activity while reducing refracture risk.

Full rehabilitation board

POBOZY.ORG / POSTOPERATIVE REHABILITATION			
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After surgery for a fifth metatarsal fracture. The main pathway addresses fixation of a Jones or proximal shaft fracture; avulsion fractures and nonunion revision require the modifications described below.			
01 Protecting fixation	02 Movement and cautious loading	03 Walking after healing review	04 Control and return to sport
Weeks 0–4	Usually weeks 4–6	Usually weeks 6–12	From around week 12; criteria based
			
Tomasz Pobozy	Tomasz Pobozy	Tomasz Pobozy	Tomasz Pobozy
Non-weight-bearing mobility with two crutches After supervised instruction, place both crutches ahead. Support yourself through the hands and unaffected leg; keep the operated foot off the floor. Avoid long hops. Use a walker or wheelchair if balance is inadequate. Dose / practice: Essential short transfers with rest; no unsupervised stair practice. Watch for: Stop for loss of balance or new pain after accidental loading and contact the treating team.	Gentle active ankle movement Sit with the lower leg supported and the foot free to move. Once removal of the boot is permitted, gently move the foot towards and away from you. Use active movement, without pulling with a towel or having another person force the joint. Dose / practice: Starting dose to individualise: 5–10 slow repetitions, 3–5 short sessions daily, within the permitted range. Watch for: Reduce range and dose for sharp pain, wound tension or increased swelling after the session.	Protected gait training Use the prescribed boot and two crutches. Take short steps, applying only the permitted load through the operated foot. A physiotherapist selects the gait pattern for that restriction; ground contact does not mean full weight-bearing. Dose / practice: Short distances with rests; increase distance before speed. Do not abandon both crutches at once. Watch for: Reduce distance and restore support if limping, pain or swelling increases.	Supported single-leg balance Once full weight-bearing is permitted, stand on the operated leg beside a counter. Keep a hand on it and lift the other foot slightly. Keep the pelvis level and avoid locking the knee backwards. Dose / practice: For example, 3 attempts of 10–20 seconds, initially on a firm, stable surface. Watch for: Return to double-leg stance for pain or loss of control. Do not start on an unstable cushion.
Before starting After Jones fracture fixation, an initial non-weight-bearing period of around 4 weeks is commonly followed by cautious progression in a boot. Low pain alone does not justify increasing load; healing must be assessed. Initial splint/cast, then a walking boot as prescribed. Ankle motion after clearance; avoid forced adduction/inversion and early resisted eversion when the tendon insertion has been repaired. Permission to move ≠ permission for resistance and full loading. Illustrations show selected activities; consult the full protocol for restrictions, criteria and warning signs. Doses are examples to individualise.			

Prepared by Tomasz Pobozy — orthopaedic surgeon

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Illustrations created for this protocol. A later-phase exercise is not permitted merely because it appears on the board.

Exercises — take a closer look

4 phases • technique • dosage • when to stop

Each phase has its own illustration. The descriptions below are the text equivalent of the board. Doses are starting examples to individualise with a physiotherapist and do not override surgical restrictions.



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Phase 1 · Weeks 0–4

Non-weight-bearing mobility with two crutches

After supervised instruction, place both crutches ahead. Support yourself through the hands and unaffected leg; keep the operated foot off the floor. Avoid long hops. Use a walker or wheelchair if balance is inadequate.

Dose to individualise

Essential short transfers with rest; no unsupervised stair practice.

When to reduce or stop

Stop for loss of balance or new pain after accidental loading and contact the treating team.

Check this phase's restrictions and criteria →



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Phase 2 · Usually weeks 4–6

Gentle active ankle movement

Sit with the lower leg supported and the foot free to move. Once removal of the boot is permitted, gently move the foot towards and away from you. Use active movement, without pulling with a towel or having another person force the joint.

Dose to individualise

Starting dose to individualise: 5–10 slow repetitions, 3–5 short sessions daily, within the permitted range.

When to reduce or stop

Reduce range and dose for sharp pain, wound tension or increased swelling after the session.

Check this phase's restrictions and criteria →

Exercises - continued



Phase 3 · Usually weeks 6–12

Protected gait training

Use the prescribed boot and two crutches. Take short steps, applying only the permitted load through the operated foot. A physiotherapist selects the gait pattern for that restriction; ground contact does not mean full weight-bearing.

Dose to individualise

Short distances with rests; increase distance before speed. Do not abandon both crutches at once.

When to reduce or stop

Reduce distance and restore support if limping, pain or swelling increases.

Check this phase's restrictions and criteria →



Phase 4 · From around week 12;
criteria based

Supported single-leg balance

Once full weight-bearing is permitted, stand on the operated leg beside a counter. Keep a hand on it and lift the other foot slightly. Keep the pelvis level and avoid locking the knee backwards.

Dose to individualise

For example, 3 attempts of 10–20 seconds, initially on a firm, stable surface.

When to reduce or stop

Return to double-leg stance for pain or loss of control. Do not start on an unstable cushion.

Check this phase's restrictions and criteria →

Who this protocol is for

After surgery for a fifth metatarsal fracture. The main pathway addresses fixation of a Jones or proximal shaft fracture; avulsion fractures and nonunion revision require the modifications described below.

Excludes nonoperative treatment and Lisfranc injury. Revision, bone grafting or peroneus brevis repair must be reflected in an individual plan.

Before starting, confirm the operation date and extent, fixation, permitted loading, support-removal rules, range of motion and review date. Obtain any missing instruction from the surgeon before progressing.

Full programme by phase

01 · Protecting fixation

Weeks 0–4

Goal	Protect the wound and a fracture site at increased risk of healing problems.
Weight-bearing	Typical Jones pathway: initially non-weight-bearing. Earlier loading is an alternative only when specifically authorised by the surgeon.
Support / immobilisation	Splint or cast, followed by a boot according to the plan.
Motion	Move the hip, knee and unrestricted toes; ankle motion requires permission to remove the support.
Work in this phase	Safe non-weight-bearing crutch mobility, swelling control and thigh activation.
Progression criteria	Wound healing, maintained fixation and clearance for the next level of protection or movement.

See the exercise or activity for this phase →

02 · Movement and cautious loading

Usually weeks 4–6

Goal	Restore gentle movement and prepare for walking.
Weight-bearing	Partial weight-bearing in a boot only when cleared; zone 3 injuries, revision or poor healing progress may require longer protection.
Support / immobilisation	Boot for permitted walking; removal for exercise follows the treating team's instructions.
Motion	Active dorsiflexion and plantarflexion without lateral-foot pain. Avoid sudden twisting.
Work in this phase	Short movement sessions; no heel raises, running, hopping or resisted eversion without clearance.
Progression criteria	Review around week 6 or as scheduled: assess tenderness and imaging before further loading.

See the exercise or activity for this phase →

Full programme - continued

03 · Walking after healing review

Usually weeks 6–12

Goal	Reduce crutch and boot use without recurrent pain.
Weight-bearing	Full weight-bearing and footwear transition require adequate union and clearance. Lack of union means revising the plan, not proceeding by the calendar.
Support / immobilisation	Supportive shoes once cleared; avoid deliberate loading on the inverted outer border of the foot.
Motion	Gradually restore motion and light resistance after assessment of bone and any tendon repair.
Work in this phase	Gait training and double-leg loading tasks within the permitted dose; avoid premature impact exercise.
Progression criteria	No fracture-site tenderness, normal gait, radiographic healing progress and clearance for greater demands.

See the exercise or activity for this phase →

04 · Control and return to sport

From around week 12; criteria based

Goal	Return to activity while reducing refracture risk.
Weight-bearing	Running and direction changes require confirmed union and strength assessment. In elite athletes or uncertain union, the clinician may request CT.
Support / immobilisation	Activity-appropriate footwear; assess alignment when overload recurs.
Motion	Task-appropriate movement without lateral-foot pain.
Work in this phase	Balance on a stable surface, calf and foot strength, then graded sport loading.
Progression criteria	Union, no pain, sport-appropriate capacity and no next-day deterioration.

See the exercise or activity for this phase →

How to adjust the dose

Increase one element at a time: repetitions, distance, range or resistance. Sharp pain, limping or markedly increased swelling calls for reducing the load. Check symptoms after exercise and the following day; discuss persistent deterioration. Absence of pain does not replace union assessment.

If the surgeon prescribes a kilogram limit, record the value and duration. Do not independently convert “as tolerated” into kilograms. Do not add weights without clearance for resistance.

Everyday activities and return to function

Walking and stairs

Use aids while needed to respect the load restriction and maintain gait quality. Practise stairs with a physiotherapist; choose a safer alternative when support or a rail is unavailable.

Driving

Resume only after assessment of rapid, forceful emergency braking and without medication impairing alertness. Operated side, transmission, bracing and loading restrictions affect the decision; discuss it with the treating team and consider insurance conditions.

Work, rest and swelling

Seated work requires opportunities to change position and elevate the leg; standing or manual work requires loading and task tolerance. Swelling may persist, but new or rapidly increasing swelling requires assessment.

Wound care and prevention

Do not soak an unhealed wound, remove wires yourself or change prescribed thromboprophylaxis. Follow individual medication, dressing, compression and scar-care instructions. Swimming requires complete wound closure and clearance.

Running and sport

Timing follows healing and capacity; it is not a stand-alone criterion. Establish safe gait, strength, balance and task tolerance first, progressing without significant next-day worsening.

Warning signs — when to seek help

Emergency help

Sudden shortness of breath, chest pain, collapse or coughing up blood: call emergency services. Use 112 in the EU; elsewhere use the appropriate local emergency number.

Urgent same-day assessment

New one-sided calf pain and swelling; increasing pain despite rest; fever with wound redness or discharge; wound breakdown; a new injury or pain after accidental loading.

Do not wait for a routine appointment

A cold, pale or blue foot, rapidly increasing numbness, loss of toe movement or severe increasing pain under a cast requires immediate emergency assessment.

Variants and clinical context

- Zone 1: tuberosity avulsion, usually treated nonoperatively. After surgery, protection depends on the fragment and any tendon insertion repair. Do not automatically apply the Jones pathway.
- Zone 2: a Jones fracture at the metaphyseal–diaphyseal junction extending into the fourth–fifth intermetatarsal articulation. Healing risk is higher than with a typical avulsion fracture.
- Zone 3: a proximal shaft fracture, often stress related. Delayed union, nonunion and revision require individually extended protection and risk-factor assessment.
- A distal shaft or neck fracture of the fifth metatarsal is not automatically a Jones fracture. Establish classification from imaging and the operative report.

Related resources

- [First to fourth metatarsal fractures — postoperative rehabilitation](#)
- [Calcaneal fracture — rehabilitation after fixation](#)
- [Avulsion or Jones fracture? — patient article](#)
- [All published foot and ankle protocols](#)

References and evidence

Verified publications and evidence limitations

1. Fifth metatarsal fractures: an update on management, complications, and outcomes. EFORT Open Reviews. 2022. DOI: 10.1530/EOR-21-0025.
2. Republication of “Metatarsal Fractures”. Foot & Ankle Orthopaedics. 2023. DOI: 10.1177/24730114231193428.

Research informs protection and progression decisions; it does not validate every illustrated exercise or example dose. Procedure details, tissue condition and the individual plan determine application.

Glossary

ROM

Joint range of motion. Active movement uses your own muscles; assisted movement uses additional help.

Non-weight-bearing

No body-weight transfer through the operated foot during standing and walking.

As tolerated

Once this pathway is authorised: loading limited by symptoms and movement quality within prescribed protection. It is not permission for unrestricted sport.

Walker

A walking boot is a protective ankle-foot support. A walking frame is a separate mobility aid.

Educational material. Version 19 October 2026. The individual postoperative plan takes priority.

Current online version: pobozy.org - open the protocol

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