

Hallux rigidus — rehabilitation after cheilectomy

Isolated removal of dorsal osteophytes and impingement at the first metatarsophalangeal joint, without osteotomy, fusion or an implant. The aim is pain reduction and improved function while preserving the joint.

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 isolated cheilectomy, early weight-bearing as tolerated in a postoperative shoe is often allowed. Confirm the discharge prescription; reduce distance if pain causes a limp.
Brace / immobilisation	A stiff-soled postoperative shoe while the wound heals, often around 1–2 weeks; then roomy footwear as tolerated and cleared.
Range of motion	Start gentle big-toe motion early once cleared and with attention to the wound. Do not force a fixed angle.

Rehabilitation at a glance

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

01**Wound care and gentle motion****Weeks 0–2**

Control swelling, protect the wound and limit avoidable stiffness.

02**Motion and footwear****Weeks 2–6**

Comfortable big-toe motion and transition to a roomy shoe.

03**Walking and endurance****Usually weeks 6–12**

Restore everyday walking distances and stairs.

04**Strength and chosen activity****Further progression according to symptoms**

Return to activity compatible with the remaining joint condition.

Full rehabilitation board

POBOZY.ORG / POSTOPERATIVE REHABILITATION			
Hallux rigidus — rehabilitation after cheilectomy			
Isolated removal of dorsal osteophytes and impingement at the first metatarsophalangeal joint, without osteotomy, fusion or an implant. The aim is pain reduction and improved function while preserving the joint.			
01 Wound care and gentle motion Weeks 0–2	02 Motion and footwear Weeks 2–6	03 Walking and endurance Usually weeks 6–12	04 Strength and chosen activity Further progression according to symptoms
			
Tomasz Pobozy	Tomasz Pobozy	Tomasz Pobozy	Tomasz Pobozy
Positioning and swelling control In lying or reclining, support the calf so the foot rests higher. Avoid pressure on the wound over the big toe. Remove the postoperative shoe as prescribed; elevation does not replace permitted movement and short walks. Dose / practice: Short periods of elevation after activity; change position regularly. Watch for: Dressing pressure, numbness, pale toes or increasing pain requires assessment.	Gentle movement at the base of the big toe After instruction, stabilise the first metatarsal just behind the joint and hold the proximal phalanx with the other hand. Gently move the big toe up and down at its metatarsophalangeal joint. Do not pull on the tip or twist it. Start actively; assist only within tolerance and the prescribed limits. Dose / practice: For example, 5 gentle movements, 3–5 times daily. Do not force a particular angle or stretch the wound. Watch for: Reduce the dose and seek advice for sharp pain, bleeding or an increasing joint reaction.	Restoring comfortable walking In roomy footwear, take short steps on level ground. Gradually restore foot rollover without forcing big-toe push-off. Avoid maintaining a gait solely along the outside edge of the foot. Dose / practice: Several short walks rather than one long walk; increase distance if symptoms are no worse the next day. Watch for: Pain causing a limp indicates excessive distance or demand on the big toe.	Supported double-leg heel raise After forefoot loading is permitted, stand in supportive shoes and hold a counter. Raise both heels a small distance and lower them slowly. Avoid rolling onto the outer borders of the feet or bouncing. Dose / practice: For example, 1 set of 6–10 repetitions on alternate days, progressing to 2 sets after checking tolerance. No added weight initially. Watch for: Pain at the base of the big toe or increased swelling the next day indicates excessive loading.
Before starting After isolated cheilectomy, early weight-bearing as tolerated in a postoperative shoe is often allowed. Confirm the discharge prescription; reduce distance if pain causes a limp. A stiff-soled postoperative shoe while the wound heals, often around 1–2 weeks; then roomy footwear as tolerated and cleared. Start gentle big-toe motion early once cleared and with attention to the wound. Do not force a fixed angle. 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

pobozy.org • 19.10.2026 • edition 19 October 2026

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.



Tomasz Pobozy

Phase 1 · Weeks 0–2

Positioning and swelling control

In lying or reclining, support the calf so the foot rests higher. Avoid pressure on the wound over the big toe. Remove the postoperative shoe as prescribed; elevation does not replace permitted movement and short walks.

Dose to individualise

Short periods of elevation after activity; change position regularly.

When to reduce or stop

Dressing pressure, numbness, pale toes or increasing pain requires assessment.

Check this phase's restrictions and criteria →



Tomasz Pobozy

Phase 2 · Weeks 2–6

Gentle movement at the base of the big toe

After instruction, stabilise the first metatarsal just behind the joint and hold the proximal phalanx with the other hand. Gently move the big toe up and down at its metatarsophalangeal joint. Do not pull on the tip or twist it. Start actively; assist only within tolerance and the prescribed limits.

Dose to individualise

For example, 5 gentle movements, 3–5 times daily. Do not force a particular angle or stretch the wound.

When to reduce or stop

Reduce the dose and seek advice for sharp pain, bleeding or an increasing joint reaction.

Check this phase's restrictions and criteria →

Exercises - continued



Phase 3 · Usually weeks 6–12

Restoring comfortable walking

In roomy footwear, take short steps on level ground. Gradually restore foot rollover without forcing big-toe push-off. Avoid maintaining a gait solely along the outside edge of the foot.

Dose to individualise

Several short walks rather than one long walk; increase distance if symptoms are no worse the next day.

When to reduce or stop

Pain causing a limp indicates excessive distance or demand on the big toe.

Check this phase's restrictions and criteria →



Phase 4 · Further progression according to symptoms

Supported double-leg heel raise

After forefoot loading is permitted, stand in supportive shoes and hold a counter. Raise both heels a small distance and lower them slowly. Avoid rolling onto the outer borders of the feet or bouncing.

Dose to individualise

For example, 1 set of 6–10 repetitions on alternate days, progressing to 2 sets after checking tolerance. No added weight initially.

When to reduce or stop

Pain at the base of the big toe or increased swelling the next day indicates excessive loading.

Check this phase's restrictions and criteria →

Who this protocol is for

Isolated removal of dorsal osteophytes and impingement at the first metatarsophalangeal joint, without osteotomy, fusion or an implant. The aim is pain reduction and improved function while preserving the joint.

If a Moberg or other osteotomy, cartilage procedure, implant or fusion was added, use the relevant extended pathway. A fused joint must not be mobilised.

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 · Wound care and gentle motion

Weeks 0–2

Goal	Control swelling, protect the wound and limit avoidable stiffness.
Weight-bearing	Load as prescribed, usually as tolerated in the protective shoe; keep walking distances short.
Support / immobilisation	Postoperative shoe and dressing; crutches if they help avoid limping.
Motion	Big-toe motion may start in the first few days after clearance. Avoid wound tension and forced extension.
Work in this phase	Rest with elevation, ankle motion and gentle active big-toe movement. Follow wound-care instructions.
Progression criteria	Uncomplicated wound healing; loading and movement do not provoke a marked inflammatory response.

See the exercise or activity for this phase →

02 · Motion and footwear

Weeks 2–6

Goal	Comfortable big-toe motion and transition to a roomy shoe.
Weight-bearing	Gradually increase walking without forced big-toe push-off. Reduce the dose if symptoms worsen the next day.
Support / immobilisation	Wean from the postoperative shoe after wound review; avoid narrow shoes pressing on the top of the joint.
Motion	Short active and gently assisted first-MTP movement sessions. Scar mobilisation only after complete wound closure.
Work in this phase	Big-toe exercises after instruction and rollover training without shifting onto the outer foot border.
Progression criteria	Comfortable footwear, healed wound, smoother gait and no persistent exercise-related flare.

See the exercise or activity for this phase →

Full programme - continued

03 · Walking and endurance

Usually weeks 6–12

Goal	Restore everyday walking distances and stairs.
Weight-bearing	Increase distance before speed. Add cycling and other low-impact activity when footwear, motion and pressure are tolerated.
Support / immobilisation	Choose footwear for the remaining range; a stiffer or rocker sole may help when individually selected.
Motion	Maintain the available comfortable range. Pain relief does not necessarily mean normal motion is restored.
Work in this phase	Gait training and gentle foot and calf strengthening without excessive joint pressure.
Progression criteria	Walking without a significant limp, stair tolerance and no increasing swelling after routine activity.

See the exercise or activity for this phase →

04 · Strength and chosen activity

Further progression according to symptoms

Goal	Return to activity compatible with the remaining joint condition.
Weight-bearing	Introduce heel raises and more dynamic tasks gradually. Running requires push-off tolerance and individual assessment; there is no universal return date.
Support / immobilisation	Comfortable activity-appropriate footwear.
Motion	Do not force a painful end range to meet an angle target.
Work in this phase	Supported double-leg heel raises once cleared, strengthening and work- or sport-specific tasks.
Progression criteria	Activity without persistent flare, safe gait and an informed understanding of residual limitations from arthritis.

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 wound and joint-function 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

- Cheilectomy does not remove all arthritis. Residual motion restriction does not always mean failure, but increasing pain warrants review.
- The phases guide activity selection; they do not impose a mandatory ban on earlier functional recovery. Wound status, symptoms, procedure extent and capacity determine progression.
- Evidence for precise rehabilitation dosing after cheilectomy is limited. Example doses are proposed starting points to individualise, not results of a comparative dosing trial.

Related resources

- [First to fourth metatarsal fractures — postoperative rehabilitation](#)
- [Fifth metatarsal fracture — postoperative rehabilitation](#)
- [Hallux valgus — existing first-metatarsal osteotomy protocol](#)
- [All published foot and ankle protocols](#)

References and evidence

Verified publications and evidence limitations

1. [Foot kinematics in walking on a level surface and on stairs in patients with hallux rigidus before and after cheilectomy.](#)
[Journal of Foot and Ankle Research.](#) 2014. DOI: 10.1186/1757-1146-7-13.

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](#)

PDF prepared on 20 October 2026 from the edition of 19 October 2026.