The Bone & Joint Journal

Supplementary Material

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Table i. Descriptive analysis of statements included in the Delphi survey Round 1.

Statement	Respondent	n	Respondent scoring, n (%)			Median	IQR
			1 to 3	4 to 6	7 to 9		
Definition							
1. ITW is defined as bilateral toe walking that started from initiation of walking and is not associated with any known neurological condition, and persistent beyond the age of two.	All participants	216	6 (3)	29 (13)	181 (84)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	94	4 (4)	13 (14)	77 (82)	8	7 to 9
	Physiotherapists, ANPs	122	2 (2)	16 (13)	104 (85)	8	7 to 9
2. Autism spectrum disorder (ASD) / ADHD are not considered as one of the neurological conditions.	All participants	207	21 (10)	52 (25)	134 (65)	7	6 to 9
	Orthopaedic consultants, fellows, specialists	90	14 (16)	18 (20)	58 (64)	7	5 to 9
	Physiotherapists, ANPs	117	7 (6)	34 (29)	76 (65)	7	6 to 9
Primary referral process							
3. Every referral of ITW should first be seen by an experienced practitioner that can assess, identify, diagnose and refer to a developmental paediatrician/ paediatric neurologist when appropriate.	All participants	218	15 (7)	29 (13)	174 (80)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	95	7 (7)	15 (16)	73 (77)	8	7 to 9
	Physiotherapists, ANPs	123	8 (7)	14 (11)	101 (82)	8	7 to 9

4. Assessment should involve family history, developmental history, basic musculoskeletal and neurological examinations including range, strength, gait.	All participants	218	2 (1)	8 (4)	208 (95)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	95	1 (1)	6 (6)	88 (93)	9	8 to 9
	Physiotherapists, ANPs	123	1 (1)	2 (2)	120 (98)	9	9 to 9
5. Primary assessment should include creatine kinase test.	All participants	208	103 (50)	70 (34)	35 (17)	4	2 to 6
	Orthopaedic consultants, fellows, specialists	95	46 (48)	30 (32)	19 (20)	4	2 to 6
	Physiotherapists, ANPs	113	57 (50)	40 (35)	16 (14)	3	2 to 5
6. Creatine kinase is not required as part of ITW primary assessment.	All participants	207	62 (30)	65 (31)	80 (39)	6	3 to 7
	Orthopaedic consultants, fellows, specialists	93	23 (25)	32 (34)	38 (41)	6	4 to 8
	Physiotherapists, ANPs	114	39 (34)	33 (29)	42 (37)	5	3 to 7
7. In the case of any abnormal / positive findings in the neurological examination, a referral should be made to the appropriate specialist with consideration of further diagnostic tests and imaging.	All participants	218	2 (1)	7 (3)	209 (96)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	95	1 (1)	4 (4)	90 (95)	9	8 to 9
	Physiotherapists, ANPs	123	1 (1)	3 (2)	119 (97)	9	9 to 9
Treatment Decision							
8. The aim of primary treatment is not solely to address toe walking but to manage the symptoms affecting the child who toe walks.	All participants	214	6 (3)	24 (11)	184 (86)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	93	4 (4)	15 (16)	74 (80)	8	7 to 9
	Physiotherapists, ANPs	121	2 (2)	9 (7)	110 (91)	8	7 to 9
9. Passive ankle dorsiflexion in patients with ITW should be measured on the couch with a goniometer.	All participants	218	39 (18)	82 (38)	97 (44)	6	4 to 8
	Orthopaedic consultants, fellows, specialists	95	31 (33)	40 (42)	24 (25)	5	3 to 6.5
	Physiotherapists, ANPs	123	8 (7)	42 (34)	73 (59)	7	6 to 8
10. Passive ankle dorsiflexion in patients with ITW should be measured in weightbearing using a weightbearing lunge test.	All participants	211	78 (37)	87 (41)	46 (22)	5	3 to 6
	Orthopaedic consultants, fellows, specialists	94	51 (54)	32 (34)	11 (12)	3	2 to 5
	Physiotherapists, ANPs	117	27 (23)	55 (47)	35 (30)	6	4 to 7
11. Joint contracture relevant to ITW gait is loss of previously documented range.	All participants	199	48 (24)	76 (38)	75 (38)	6	4 to 7
	Orthopaedic consultants, fellows, specialists	87	26 (30)	36 (41)	25 (29)	5	3 to 7
	Physiotherapists, ANPs	112	22 (20)	40 (36)	50 (45)	6	4 to 7
The following three statements will define joint contracture in children <u>under the age of 8 years old</u>							
	All participants	203	29 (14)	51 (25)	123 (61)	7	5 to 8

12. Joint contracture relevant to ITW gait is defined as ankle equinus (passive ADKE <0).	Orthopaedic consultants, fellows, specialists	88	14 (16)	24 (27)	50 (57)	7	4 to 8
	Physiotherapists, ANPs	115	15 (13)	27 (23)	73 (63)	7	5 to 9
13. Joint contracture relevant to ITW gait is defined as passive ADKE <5-10.	All participants	203	58 (29)	65 (32)	80 (39)	6	3 to 7
	Orthopaedic consultants, fellows, specialists	88	29 (33)	30 (34)	29 (33)	5	3 to 7
	Physiotherapists, ANPs	115	29 (25)	35 (30)	51 (44)	6	3.5 to 8
14. Joint contracture relevant to ITW gait is defined as passive ADKE <10-15.	All participants	203	101 (50)	47 (23)	55 (27)	4	1 to 7
	Orthopaedic consultants, fellows, specialists	87	41 (47)	23 (26)	23 (26)	4	2 to 7
	Physiotherapists, ANPs	116	60 (52)	24 (21)	32 (28)	3	1 to 7
The following three statements will define joint contracture in children <u>over the age of 8 years old</u>							
15. Joint contracture relevant to ITW gait defined as ankle equinus (passive ADKE <0)	All participants	196	22 (11)	44 (22)	130 (66)	7	6 to 9
	Orthopaedic consultants, fellows, specialists	84	9 (11)	23 (27)	52 (62)	7	5 to 8
	Physiotherapists, ANPs	112	13 (12)	21 (19)	78 (70)	7.5	6 to 9
16. Joint contracture relevant to ITW gait is defined as passive ADKE <5-10.	All participants	199	60 (30)	72 (36)	67 (34)	5	3 to 7
	Orthopaedic consultants, fellows, specialists	84	30 (36)	31 (37)	23 (27)	5	3 to 7
	Physiotherapists, ANPs	115	30 (26)	41 (36)	44 (38)	6	3 to 7
17. Joint contracture relevant to ITW gait is defined as passive ADKE <10-15.	All participants	198	100 (51)	46 (23)	52 (26)	3	1 to 7
	Orthopaedic consultants, fellows, specialists	85	35 (41)	26 (31)	24 (28)	5	2 to 7
	Physiotherapists, ANPs	113	65 (58)	20 (18)	28 (25)	3	1 to 6
18. Asymptomatic ITW without ankle joint contracture should not be treated.	All participants	212	54 (25)	54 (25)	104 (49)	6	3 to 8
	Orthopaedic consultants, fellows, specialists	93	22 (24)	21 (23)	50 (54)	7	4 to 9
	Physiotherapists, ANPs	119	32 (27)	33 (28)	54 (45)	6	3 to 8
19. Every ITW should be treated.	All participants	213	137 (64)	32 (15)	44 (21)	2	1 to 6
	Orthopaedic consultants, fellows, specialists	94	68 (72)	7 (7)	19 (20)	2	1 to 4.75
	Physiotherapists, ANPs	119	69 (58)	25 (21)	25 (21)	3	1 to 6
20. An indication for treatment of ITW is pain.	All participants	216	16 (7)	49 (23)	151 (70)	7	6 to 9
	Orthopaedic consultants, fellows, specialists	94	11 (12)	21 (22)	62 (66)	7	6 to 8
	Physiotherapists, ANPs	122	5 (4)	28 (23)	89 (73)	8	6 to 9

21. An indication for treatment of ITW is emotional effects on the patient including their activity participation (subjective).	All participants	216	16 (7)	74 (34)	126 (58)	7	6 to 8
	Orthopaedic consultants, fellows, specialists	94	11 (12)	32 (34)	51 (54)	7	6 to 8
	Physiotherapists, ANPs	122	5 (4)	42 (34)	75 (61)	7	6 to 8
Primary treatment							
22. Non-surgical treatment should always be the first choice of treatment.	All participants	217	16 (7)	21 (10)	180 (83)	9	7 to 9
	Orthopaedic consultants, fellows, specialists	95	11 (12)	12 (13)	72 (76)	8	7 to 9
	Physiotherapists, ANPs	122	5 (4)	9 (7)	108 (89)	9	8 to 9
23. Primary treatment includes education and advice, stretching, strengthening, casting, and day and night splints as decided by the treating physiotherapists based on the clinical examination.	All participants	215	10 (5)	19 (9)	186 (87)	9	7 to 9
	Orthopaedic consultants, fellows, specialists	92	9 (10)	9 (10)	74 (80)	8	7 to 9
	Physiotherapists, ANPs	123	1 (1)	10 (8)	112 (91)	9	8 to 9
24. Primary treatment can be provided by any experienced health practitioner (e.g. physiotherapist, orthotist, plaster technician).	All participants	212	34 (16)	30 (14)	148 (70)	8	6 to 9
	Orthopaedic consultants, fellows, specialists	94	7 (7)	12 (13)	75 (80)	8	7 to 9
	Physiotherapists, ANPs	118	27 (23)	18 (15)	73 (62)	7	4 to 9
25. Stretching programmes can be provided if dorsiflexion range allows heel contact in weightbearing.	All participants	216	17 (8)	46 (21)	153 (71)	7.5	6 to 9
	Orthopaedic consultants, fellows, specialists	95	8 (8)	23 (24)	64 (67)	7	6 to 9
	Physiotherapists, ANPs	121	9 (7)	23 (19)	89 (74)	8	6 to 9
26. Serial casting can be attempted to reduce equinus contractures.	All participants	216	9 (4)	35 (16)	172 (80)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	95	7 (7)	16 (17)	72 (76)	8	7 to 9
	Physiotherapists, ANPs	121	2 (2)	19 (16)	100 (83)	8	7 to 9
27. Heel contact should be achieved in weightbearing casts with wedging as required.	All participants	210	19 (9)	33 (16)	158 (75)	7	7 to 9
	Orthopaedic consultants, fellows, specialists	91	15 (16)	21 (23)	55 (60)	7	5 5 to 8
	Physiotherapists, ANPs	119	4 (3)	12 (10)	103 (87)	8	7 to 9
28. Night splints could be provided if plantigrade or greater in knee flexion.	All participants	214	43 (20)	63 (29)	108 (50)	7	5 to 8
	Orthopaedic consultants, fellows, specialists	94	23 (24)	32 (34)	39 (41)	6	4 to 7
	Physiotherapists, ANPs	120	20 (17)	31 (26)	69 (58)	7	5 to 8
29. Carbon fibre insoles could be offered to reduce toe walking.	All participants	191	69 (36)	71 (37)	51 (27)	5	2 to 7
	Orthopaedic consultants, fellows, specialists	83	36 (43)	26 (31)	21 (25)	4	2 to 6.5

	Physiotherapists, ANPs	108	33 (31)	45 (42)	30 (28)	5	3 to 7
30. Botulinum toxin injection is not indicated in treating ITW.	All participants	190	38 (20)	28 (15)	124 (65)	8	4.25 to 9
	Orthopaedic consultants, fellows, specialists	95	21 (22)	14 (15)	60 (63)	8	4 to 9
	Physiotherapists, ANPs	95	17 (18)	14 (15)	64 (67)	8	6 to 9
31. Botulinum toxin injection can be indicated in treating ITW.	All participants	189	130 (69)	30 (16)	29 (15)	2	1 to 5
	Orthopaedic consultants, fellows, specialists	95	59 (62)	14 (15)	22 (23)	3	1 to 6
	Physiotherapists, ANPs	94	71 (76)	16 (17)	7 (7)	1.5	1 to 3
32. The aim of treatment is to address the indication/ symptom and hence the outcome of the treatment would be whether that goal was achieved.	All participants	212	11 (5)	43 (20)	158 (75)	8	6 to 9
	Orthopaedic consultants, fellows, specialists	95	7 (7)	15 (16)	73 (77)	8	7 to 8
	Physiotherapists, ANPs	117	4 (3)	28 (24)	85 (73)	8	6 to 9
33. There is no need for follow up after successful treatment and patients could be re-referred if needed.	All participants	215	46 (21)	49 (23)	120 (56)	7	4.5 to 8
	Orthopaedic consultants, fellows, specialists	95	24 (25)	13 (14)	58 (61)	7	3.5 to 8
	Physiotherapists, ANPs	120	22 (18)	36 (30)	62 (52)	7	5 to 8
34. There is need for follow up for 12 months after successful treatment.	All participants	213	81 (38)	57 (27)	75 (35)	5	2 to 7
	Orthopaedic consultants, fellows, specialists	94	32 (34)	27 (29)	35 (37)	5	2 to 8
	Physiotherapists, ANPs	119	49 (41)	30 (25)	40 (34)	5	2 to 7
35. There is need for follow up for 24 months after successful treatment.	All participants	211	126 (60)	40 (19)	45 (21)	3	1 to 6
	Orthopaedic consultants, fellows, specialists	93	56 (60)	17 (18)	20 (22)	3	1 to 6
	Physiotherapists, ANPs	118	70 (59)	23 (19)	25 (21)	2.5	1 to 6
36. Following discharge from physiotherapy, patients and families should be advised regarding potential risk factors for recurrence of ITW and how to seek re-referral into services if needed.	All participants	218	1 (0)	11 (5)	206 (94)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	95	1 (1)	8 (8)	86 (91)	8	7 to 9
	Physiotherapists, ANPs	123	0 (0)	3 (2)	120 (98)	9	8 to 9
37. Failure of treatment is defined as the inability to achieve the indication for intervention during an agreed time frame e.g. failure to reach plantigrade stance with 6 weeks of casting.	All participants	210	20 (10)	67 (32)	123 (59)	7	5 to 8
	Orthopaedic consultants, fellows, specialists	93	6 (6)	33 (35)	54 (58)	7	5 to 8
	Physiotherapists, ANPs	117	14 (12)	34 (29)	69 (59)	7	5 to 8
38. Recurrence of ITW is defined as ITW that was previously treated successfully and now lost that improvement in symptoms (range, pain etc.).	All participants	215	5 (2)	29 (13)	181 (84)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	95	2 (2)	13 (14)	80 (84)	8	7 to 9
	Physiotherapists, ANPs	120	3 (3)	16 (13)	101 (84)	8	7 to 9

39. In the case of recurrence following a successful intervention, there is room for another attempt in 'primary' treatment.	All participants	216	11 (5)	36 (17)	169 (78)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	95	10 (11)	17 (18)	68 (72)	8	6 to 9
	Physiotherapists, ANPs	121	1 (1)	19 (16)	101 (83)	8	7 to 9
40. Patients with ITW that have ASD/ADHD should be offered the same procedure with appropriate counselling regarding recurrence rates.	All participants	209	29 (14)	46 (22)	134 (64)	7	5 to 8
	Orthopaedic consultants, fellows, specialists	94	13 (14)	16 (17)	65 (69)	7	6 to 8.75
	Physiotherapists, ANPs	115	16 (14)	30 (26)	69 (60)	7	5 to 8
41. Patients with ITW that have ASD/ADHD should not be considered for the same procedure as they have high recurrence rates.	All participants	203	123 (61)	47 (23)	33 (16)	3	1 to 5
	Orthopaedic consultants, fellows, specialists	92	55 (60)	19 (21)	18 (20)	3	1.75 to 5
	Physiotherapists, ANPs	111	68 (61)	28 (25)	15 (14)	3	1 to 5
Surgical treatment							
42. Referral for surgery is indicated when primary treatment was not successful.	All participants	215	19 (9)	58 (27)	138 (64)	7	6 to 8
	Orthopaedic consultants, fellows, specialists	95	10 (11)	28 (29)	57 (60)	7	5.5 to 8
	Physiotherapists, ANPs	120	9 (8)	30 (25)	81 (68)	7	6 to 9
43. The same indication for referral to primary treatment are valid for surgical treatment.	All participants	206	59 (29)	54 (26)	93 (45)	6	3 to 7
	Orthopaedic consultants, fellows, specialists	94	27 (29)	22 (23)	45 (48)	6	3 to 8
	Physiotherapists, ANPs	112	32 (29)	32 (29)	48 (43)	6	3 to 7
44. Parents should be involved in the treatment decision making.	All participants	218	2 (1)	10 (5)	206 (94)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	95	1 (1)	4 (4)	90 (95)	9	8 to 9
	Physiotherapists, ANPs	123	1 (1)	6 (5)	116 (94)	9	8 to 9
45. Decision of surgery type (Hoke/ Open/ Gastrocnemius) should be made by the operating surgeon based on the clinical findings.	All participants	194	4 (2)	6 (3)	184 (95)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	95	2 (2)	3 (3)	90 (95)	9	8 to 9
	Physiotherapists, ANPs	99	2 (2)	3 (3)	94 (95)	9	8 to 9
46. If other structures need addressing in surgery (e.g. plantar fascia or flexors) it can be added to the procedure.	All participants	160	8 (5)	26 (16)	126 (79)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	91	7 (8)	12 (13)	72 (79)	8	7 to 9
	Physiotherapists, ANPs	69	1 (1)	14 (20)	54 (78)	8	7 to 9
	All participants	194	21 (11)	43 (22)	130 (67)	7	5 to 9
	Orthopaedic consultants, fellows, specialists	94	8 (9)	13 (14)	73 (78)	8	7 to 9

47. Patients with ITW that have ASD/ADHD should be offered the same procedure with appropriate counselling regarding recurrence rates.	Physiotherapists, ANPs	100	13 (13)	30 (30)	57 (57)	7	5 to 8
48. Patients with ITW that have ASD/ADHD should not be considered for the same procedure as have high recurrence rates.	All participants	190	105 (55)	52 (27)	33 (17)	3	1 to 6
	Orthopaedic consultants, fellows, specialists	93	57 (61)	19 (20)	17 (18)	3	1 to 5
	Physiotherapists, ANPs	97	48 (49)	33 (34)	16 (16)	4	1 to 6
49. Every surgical procedure should be followed by day splints as a package treatment.	All participants	200	44 (22)	63 (32)	93 (47)	6	4 to 8
	Orthopaedic consultants, fellows, specialists	94	33 (35)	22 (23)	39 (41)	5	3 to 8
	Physiotherapists, ANPs	106	11 (10)	41 (39)	54 (51)	7	5 to 8
50. Every surgical procedure should be followed by night splints as a package treatment.	All participants	206	52 (25)	53 (26)	101 (49)	6	3.25 to 8
	Orthopaedic consultants, fellows, specialists	95	29 (31)	23 (24)	43 (45)	6	3 to 8
	Physiotherapists, ANPs	111	23 (21)	30 (27)	58 (52)	7	4 to 8
51. Every patient going through surgery should be referred for a gait lab session before and after surgery.	All participants	202	106 (52)	54 (27)	42 (21)	3	1 to 6
	Orthopaedic consultants, fellows, specialists	94	66 (7)	16 (17)	12 (13)	2	1 to 4
	Physiotherapists, ANPs	108	40 (37)	38 (35)	30 (28)	4	3 to 7
52. There is a need for a follow up after surgical intervention for 12 months.	All participants	206	34 (17)	45 (22)	127 (62)	7	5 to 9
	Orthopaedic consultants, fellows, specialists	95	26 (27)	19 (20)	50 (53)	7	3 to 9
	Physiotherapists, ANPs	111	8 (7)	26 (23)	77 (69)	8	6 to 9
53. There is a need for a follow up after surgical intervention for 24 months.	All participants	197	100 (51)	56 (28)	41 (21)	3	2 to 6
	Orthopaedic consultants, fellows, specialists	95	52 (55)	24 (25)	19 (20)	3	2 to 6
	Physiotherapists, ANPs	102	48 (47)	32 (31)	22 (22)	4	2 to 6
54. Outcomes should be measured and documented after any intervention.	All participants	218	3 (1)	6 (3)	209 (96)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	95	3 (4)	4 (4)	88 (93)	8	8 to 9
	Physiotherapists, ANPs	123	0 (0)	2 (2)	121 (98)	9	9 to 9

ADHD, attention deficit hyperactivity disorder; ADKE, ankle dorsiflexion knee extended; ANP, advanced nursing practitioner; ASD, autism spectrum disorder; ITW, idiopathic toe walking.

Table ii. Descriptive analysis of statements included in the Delphi survey Round 2.

Statement	Respondent	n	Respondent scoring, n (%)			Median	IQR
			1 to 3	4 to 6	7 to 9		
Definition							
2. ASD/ADHD can co-exist with ITW and is not an exclusion to the diagnosis.	All participants	213	6 (3)	33 (15)	174 (82)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	99	1 (1)	19 (19)	79 (80)	8	7 to 9
	Physiotherapists, ANPs, Consultant nurse	114	5 (4)	14 (12)	95 (83)	8	7 to 9
Primary referral process							
5. Initial assessment should always include creatine kinase test.	All participants	203	125 (62)	52 (26)	26 (13)	3	1 to 5
	Orthopaedic consultants, fellows, specialists	100	54 (54)	29 (29)	17 (17)	3	1 to 5
	Physiotherapists, ANPs, Consultant nurse	103	71 (69)	23 (22)	9 (9)	3	1 to 4
Treatment decision							
9. Passive ankle dorsiflexion in patients with ITW should be measured in knee flexion and extension in a consistent manner with the heel in neutral position.	All participants	218	1 (0)	11 (5)	206 (94)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	102	1 (1)	6 (6)	95 (93)	9	8 to 9
	Physiotherapists, ANPs, Consultant nurse	116	0 (0)	5 (4)	111 (96)	9	8 to 9
11. Joint contracture relevant to ITW gait is loss of any expected dorsiflexion range.	All participants	213	19 (9)	47 (22)	147 (69)	7	6 to 8
	Orthopaedic consultants, fellows, specialists	99	11 (11)	25 (25)	63 (64)	7	5.5 to 8
	Physiotherapists, ANPs, Consultant nurse	114	8 (7)	22 (19)	84 (74)	7	6 to 8
The following three statements will define joint contracture in children under the age of 8 years old							
12. Ankle contracture relevant to ITW gait is defined as patient who is unable to dorsiflex to plantigrade.	All participants	213	11 (5)	21 (10)	181 (85)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	99	6 (6)	13 (13)	80 (81)	8	7 to 9
	Physiotherapists, ANPs, Consultant nurse	114	5 (4)	8 (7)	101 (89)	9	8 to 9
13. Ankle contracture relevant to ITW gait is defined as patient who is able to dorsiflex to plantigrade and not beyond.	All participants	212	45 (21)	68 (32)	99 (47)	6	5 to 7
	Orthopaedic consultants, fellows, specialists	98	29 (30)	34 (35)	35 (36)	5	3 to 7
	Physiotherapists, ANPs, Consultant nurse	114	16 (14)	34 (30)	64 (56)	7	5 to 8
14. Ankle contracture relevant to ITW gait is defined as patient who is able to dorsiflex to 10 degrees of dorsiflexion and not beyond.	All participants	212	175 (83)	19 (9)	18 (8)	2	1 to 3
	Orthopaedic consultants, fellows, specialists	97	79 (81)	9 (9)	9 (9)	1	1 to 3
	Physiotherapists, ANPs, Consultant nurse	115	96 (83)	10 (9)	9 (8)	2	1 to 3

The following* three *statements will define joint contracture in children over the age of 8 years old							
15. Ankle contracture relevant to ITW gait is defined as patient who is unable to dorsiflex to plantigrade.	All participants	215	11 (5)	15 (7)	189 (88)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	100	7 (7)	9 (9)	84 (84)	9	8 to 9
	Physiotherapists, ANPs, Consultant nurse	115	4 (3)	6 (5)	105 (91)	9	8 to 9
16. Ankle contracture relevant to ITW gait is defined as patient who is able to dorsiflex to plantigrade and not beyond.	All participants	213	43 (20)	77 (36)	93 (44)	6	5 to 7
	Orthopaedic consultants, fellows, specialists	98	24 (24)	31 (32)	43 (44)	6	4 to 7
	Physiotherapists, ANPs, Consultant nurse	115	19 (17)	46 (40)	50 (43)	6	5 to 7
17. Ankle contracture relevant to ITW gait is defined as patient who is able to dorsiflex to 10 degrees of dorsiflexion and not beyond.	All participants	213	179 (84)	28 (13)	6 (3)	1	1 to 3
	Orthopaedic consultants, fellows, specialists	100	83 (83)	13 (13)	4 (4)	1	1 to 3
	Physiotherapists, ANPs, Consultant nurse	113	96 (85)	15 (13)	2 (2)	1	1 to 2
18. Asymptomatic ITW without ankle joint contracture should not be treated.	All participants	216	19 (9)	44 (20)	153 (71)	8	6 to 9
	Orthopaedic consultants, fellows, specialists	101	10 (10)	19 (19)	72 (71)	8	6 to 9
	Physiotherapists, ANPs, Consultant nurse	115	9 (8)	25 (22)	81 (70)	9	5.5 to 9
19. Every ITW should be treated.	All participants	215	196 (91)	12 (6)	7 (3)	1	1 to 2
	Orthopaedic consultants, fellows, specialists	102	95 (93)	2 (2)	5 (5)	1	1 to 2
	Physiotherapists, ANPs, Consultant nurse	113	101 (89)	10 (9)	2 (2)	1	1 to 2
20. Lower limb pain can be an indication for treating ITW.	All participants	217	7 (3)	20 (9)	190 (88)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	101	5 (5)	13 (13)	83 (82)	8	7 to 9
	Physiotherapists, ANPs, Consultant nurse	116	2 (2)	7 (6)	107 (92)	9	8 to 9
21. Psychosocial impact can be an indication for treatment of ITW.	All participants	217	15 (7)	68 (31)	134 (62)	7	6 to 8
	Orthopaedic consultants, fellows, specialists	102	7 (7)	32 (31)	63 (62)	7	6 to 8
	Physiotherapists, ANPs, Consultant nurse	115	8 (7)	36 (31)	71 (62)	7	6 to 8
Primary treatment							
24. Primary treatment can be provided by any trained and experienced health practitioner.	All participants	215	2 (1)	10 (5)	203 (94)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	102	1 (1)	6 (6)	95 (93)	9	8 to 9
	Physiotherapists, ANPs, Consultant nurse	113	1 (1)	4 (4)	108 (96)	9	8 to 9
25. Stretching programmes can be provided even if dorsiflexion range allows heel contact in weightbearing.	All participants	218	4 (2)	14 (6)	200 (92)	9	8 to 9
	Orthopaedic consultants, fellows, specialists	102	1 (1)	8 (8)	93 (91)	9	8 to 9
	Physiotherapists, ANPs, Consultant nurse	116	3 (3)	6 (5)	107 (92)	9	8 to 9

27. Heel contact should be achieved in weightbearing casts with heel raise to accommodate plantarflexion.	All participants	206	11 (5)	38 (18)	157 (76)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	97	10 (10)	24 (25)	63 (65)	7	6 to 9
	Physiotherapists, ANPs, Consultant nurse	109	1 (1)	14 (13)	94 (86)	8	7 to 9
28. Night splints could be provided to maintain range of motion.	All participants	218	34 (16)	49 (22)	135 (62)	7	6 to 8
	Orthopaedic consultants, fellows, specialists	102	18 (18)	19 (19)	65 (64)	7	6 to 8
	Physiotherapists, ANPs, Consultant nurse	116	16 (14)	30 (26)	70 (60)	7	5 to 8
29. Carbon fibre insoles could be offered to reduce toe walking.	All participants	193	91 (47)	64 (33)	38 (20)	4	2 to 6
	Orthopaedic consultants, fellows, specialists	90	52 (58)	25 (28)	13 (14)	3	1 to 5
	Physiotherapists, ANPs, Consultant nurse	103	39 (38)	39 (38)	25 (24)	5	2 to 6
33. There is no need for follow up after successful treatment and patients could be re-referred if needed.	All participants	218	29 (13)	25 (11)	164 (75)	8	7 to 9
	Orthopaedic consultants, fellows, specialists	102	15 (15)	15 (15)	72 (71)	8	6 to 9
	Physiotherapists, ANPs, Consultant nurse	116	14 (12)	10 (9)	92 (79)	8	7 to 9
34. There is need for follow up for 12 months after successful treatment.	All participants	217	129 (59)	42 (19)	46 (21)	2	1 to 6
	Orthopaedic consultants, fellows, specialists	102	58 (57)	21 (21)	23 (23)	3	1 to 6
	Physiotherapists, ANPs, Consultant nurse	115	71 (62)	21 (18)	23 (20)	2	1 to 5
37. Failure of treatment is defined as the inability to achieve the shared goal for intervention during an agreed time frame e.g. failure to reach plantigrade stance with 6 weeks of casting.	All participants	216	8 (4)	53 (25)	155 (72)	7	6 to 8
	Orthopaedic consultants, fellows, specialists	101	6 (6)	29 (29)	66 (65)	7	6 to 8
	Physiotherapists, ANPs, Consultant nurse	115	2 (2)	24 (21)	89 (77)	7	7 to 8
40. Patients with ITW that have ASD/ADHD should be offered treatment with appropriate counselling regarding recurrence rates.	All participants	216	7 (3)	10 (5)	199 (92)	9	7 to 9
	Orthopaedic consultants, fellows, specialists	101	3 (3)	7 (7)	91 (90)	9	7 to 9
	Physiotherapists, ANPs, Consultant nurse	115	4 (3)	3 (3)	108 (94)	9	7.5 to 9
Surgical Treatment							
42. Referral for surgery is indicated when primary treatment was not successful.	All participants	214	11 (5)	36 (17)	167 (78)	7	7 to 8
	Orthopaedic consultants, fellows, specialists	101	5 (5)	17 (17)	79 (78)	7	7 to 8
	Physiotherapists, ANPs, Consultant nurse	113	6 (5)	19 (17)	88 (78)	7	7 to 8
43. The same indication for referral to primary treatment are valid for surgical treatment.	All participants	206	30 (15)	53 (26)	123 (60)	7	5 to 7
	Orthopaedic consultants, fellows, specialists	101	14 (14)	30 (30)	57 (56)	7	5 to 8
	Physiotherapists, ANPs, Consultant nurse	105	16 (15)	23 (22)	66 (63)	7	5 to 7
	All participants	210	35 (17)	62 (30)	113 (54)	7	5 to 8

49. Every surgical procedure should be followed by day splints as a package treatment.	Orthopaedic consultants, fellows, specialists	102	23 (23)	23 (23)	56 (55)	7	4 to 8
	Physiotherapists, ANPs, Consultant nurse	108	12 (11)	39 (36)	57 (53)	7	5 to 9
50. Every surgical procedure should be followed by night splints as a package treatment.	All participants	209	46 (22)	43 (21)	120 (57)	7	4 to 9
	Orthopaedic consultants, fellows, specialists	102	25 (25)	23 (23)	54 (53)	7	4 to 9
	Physiotherapists, ANPs, Consultant nurse	107	21 (20)	20 (19)	66 (62)	7	5 to 9
51. Every patient going through surgery should be referred for a gait analysis session in a gait lab.	All participants	212	167 (79)	35 (17)	10 (5)	1	1 to 3
	Orthopaedic consultants, fellows, specialists	101	79 (78)	16 (16)	6 (6)	1	1 to 3
	Physiotherapists, ANPs, Consultant nurse	111	88 (79)	19 (17)	4 (4)	1	1 to 3
52. There is a need for a follow up after surgical intervention for at least 12 months.	All participants	209	22 (11)	30 (14)	157 (75)	9	7 to 9
	Orthopaedic consultants, fellows, specialists	101	14 (14)	16 (16)	71 (70)	8	6 to 9
	Physiotherapists, ANPs, Consultant nurse	108	8 (7)	14 (13)	86 (80)	9	7 to 9

ADHD, attention deficit hyperactivity disorder; ADKE, ankle dorsiflexion knee extended; ANP, advanced nursing practitioner; ASD, autism spectrum disorder; ITW, idiopathic toe walking.