

# The Mona Lisa Bunionectomy (Modified Wilson): *Lineage, Landmarks, and Surgical Control*

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# Why Consider an Office-Based MIS Bunion Procedure?



# What Makes the Mona Lisa (Modified Wilson) Different?

- Performed through 2 mm incision
- No plates, screws, or permanent hardware
- Stable osteotomy design
- Can be performed safely in the office setting
- Allows early protected weightbearing



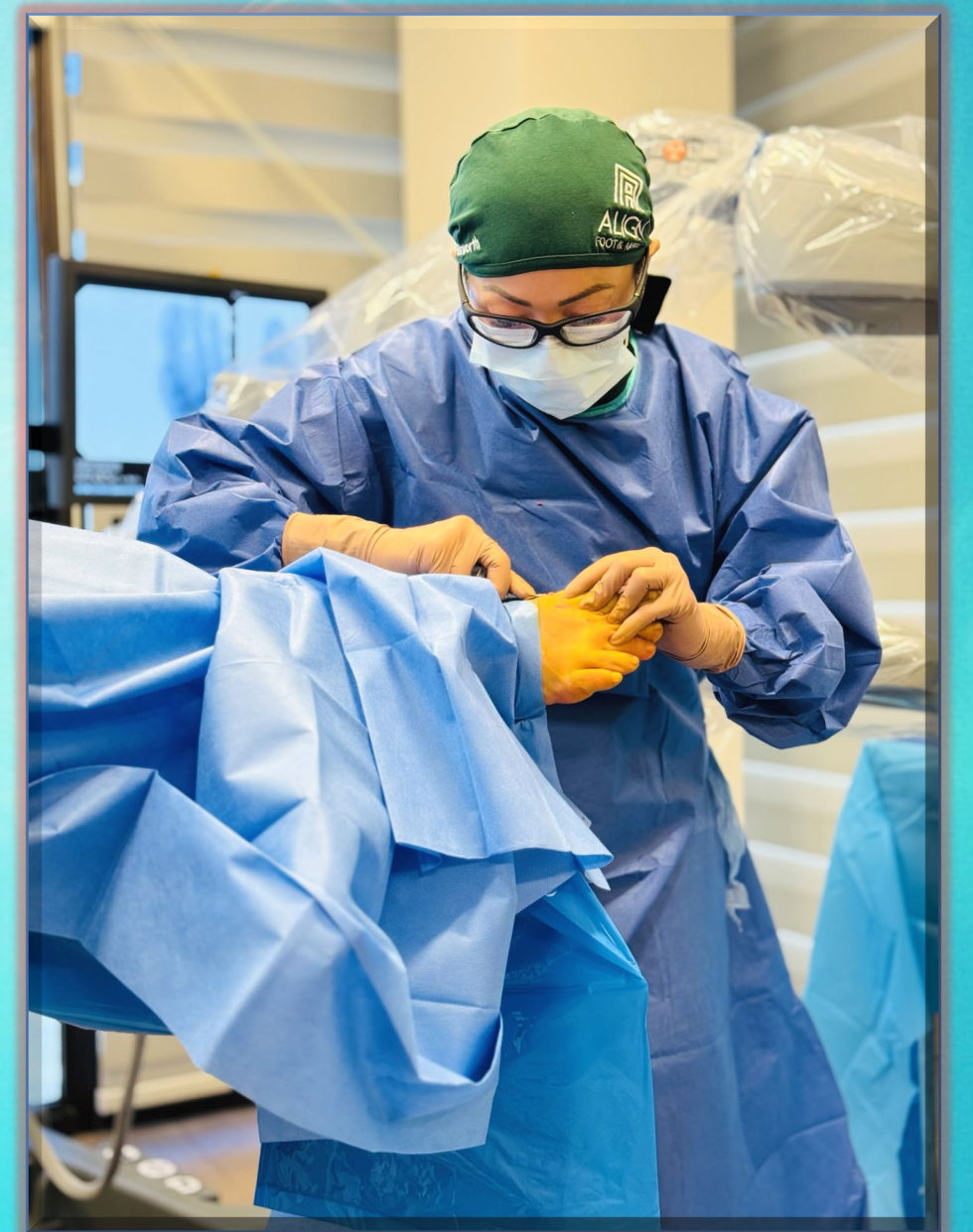
# Advantages for the Patient

- Smaller incision and less soft-tissue disruption
- Reduced postoperative pain and swelling
- Faster return to normal footwear and activity
- No hardware-related irritation or removal procedures
- Lower overall cost of care



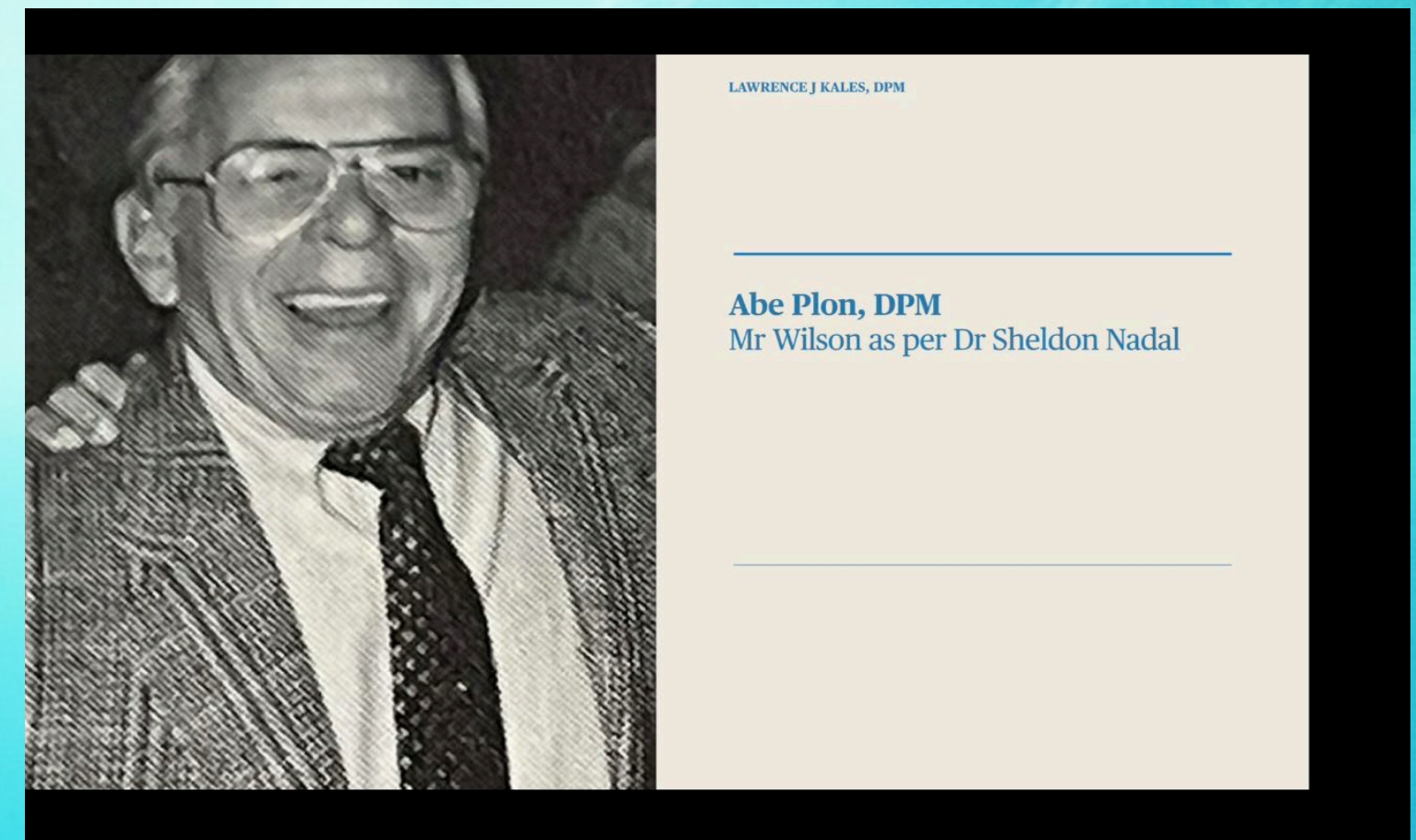
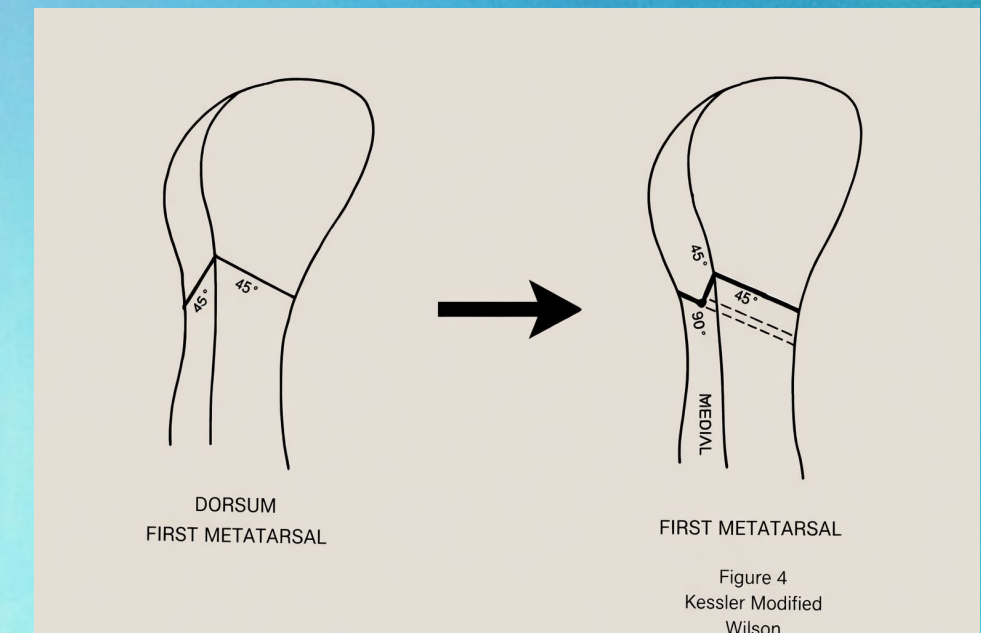
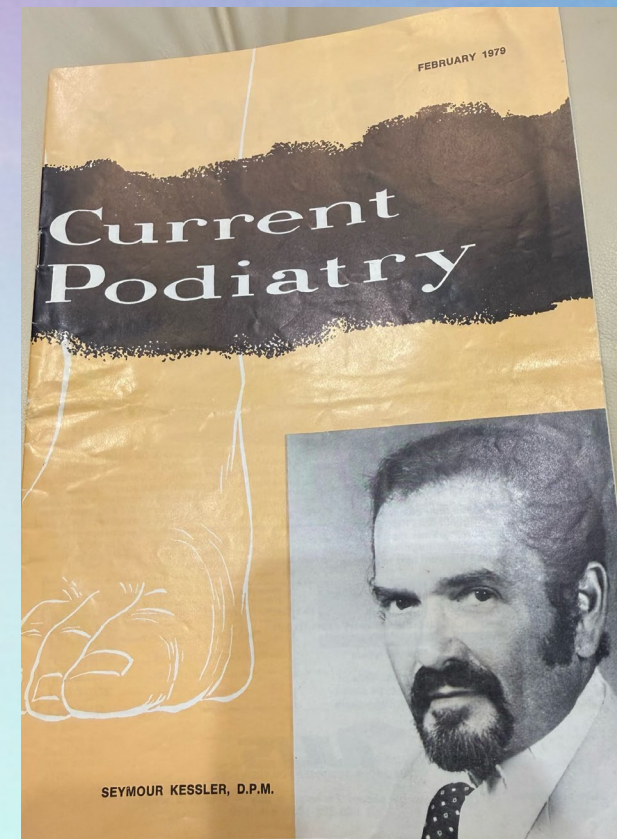
# Advantages for the Surgeon

- Procedure can be done in a familiar office environment
- Eliminates OR scheduling delays
- Reduced dependence on hospital systems
- Efficient use of clinic time
- Expands treatment options for patients



# Origins and Structural Evolution

- J.N. Wilson (1963) – Oblique distal osteotomy
  - Lateral translation of capital fragment
  - Risk of dorsal displacement
- MIS Concept was suggested in early 1970's by Lowell Weil Sr to Seymour Kesler, Abram Plon, and Marvin Arnold
- The Modifications:
  - Kessler performed the oblique osteotomy using a Shannon 44 burr via a dorsal incision
  - Plon & Arnold modified the original oblique cut into a V-shaped through a medial incision
    - Provided for more stability
    - Reduced dorsal displacement



# We are Lucky

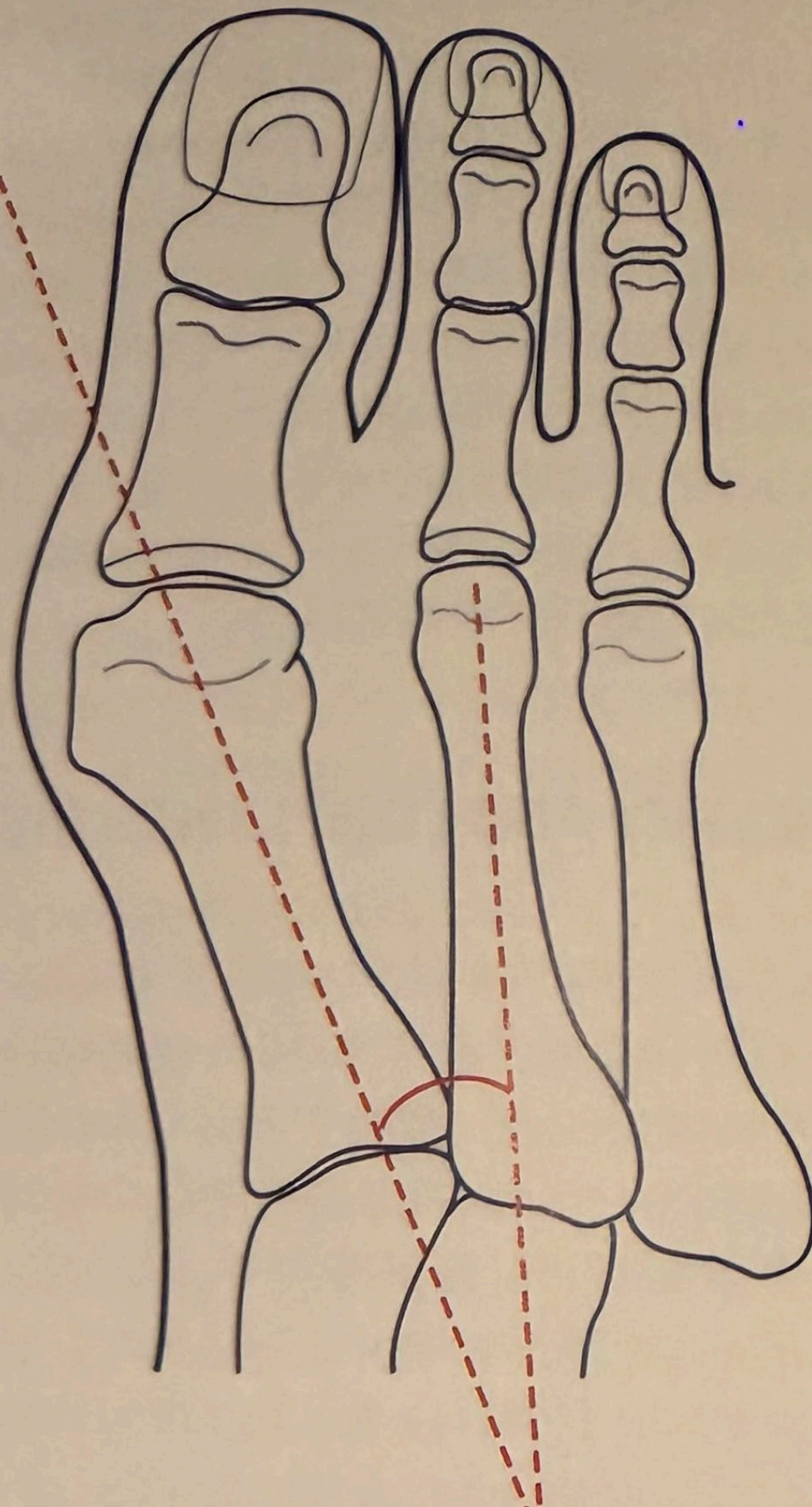
- The pioneers are still teaching
- MIS is collaborative
- The community is different





# Why the Name “Mona Lisa”?

- Represents precision and elegance of the correction
- Memorable for patients and staff
- Helps communicate a less intimidating surgical option
- Reflects the artistic balance of form function

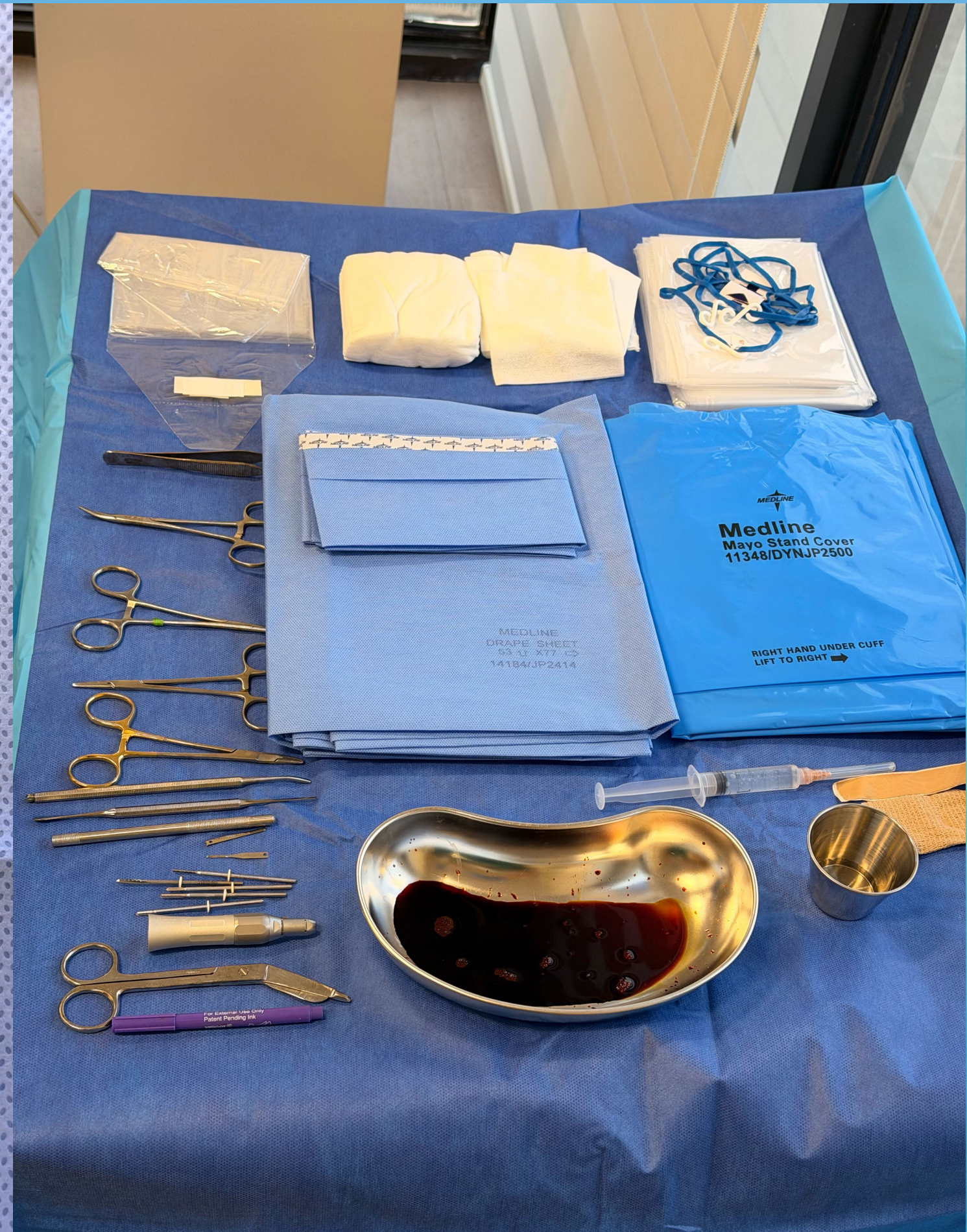


## Indications

- Hallux Valgus
  - Mild – moderate HAV
  - Mild – moderate IM angles
  - Flexible 1<sup>st</sup> MPJ
- Hallux Limitus
  - Not just translation procedure, but joint-preserving decompression tool
  - Select limitus/ rigidus cases as a decompression strategy in combination with dorsiflexory akin osteotomy

# Instrumentation & Setup

- General surgical set-up & Draping
- Low speed, high torque drill
- Beaver No. 64 scalpel blade/handle
- Straight burr - Osteotomy
  - Shannon 44 or Long Isham
  - Short Isham (Proximal Phalanx Akin)
- 3.1 cylindrical burr – Exostosis resection



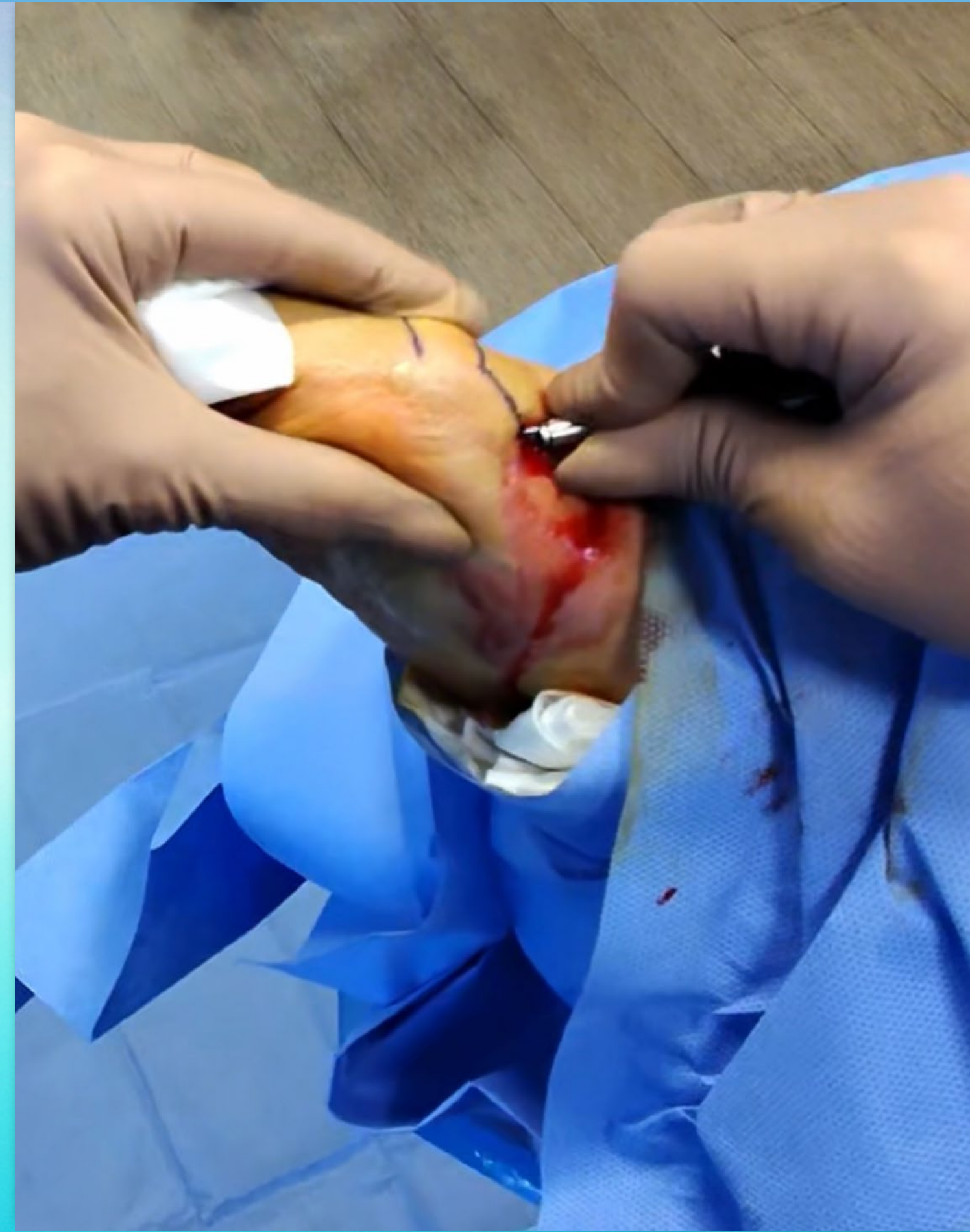


## Landmarks First

- Mark the joint
- Mark the dorsal exit
- Mark fail-safe hole
- Own your landmarks

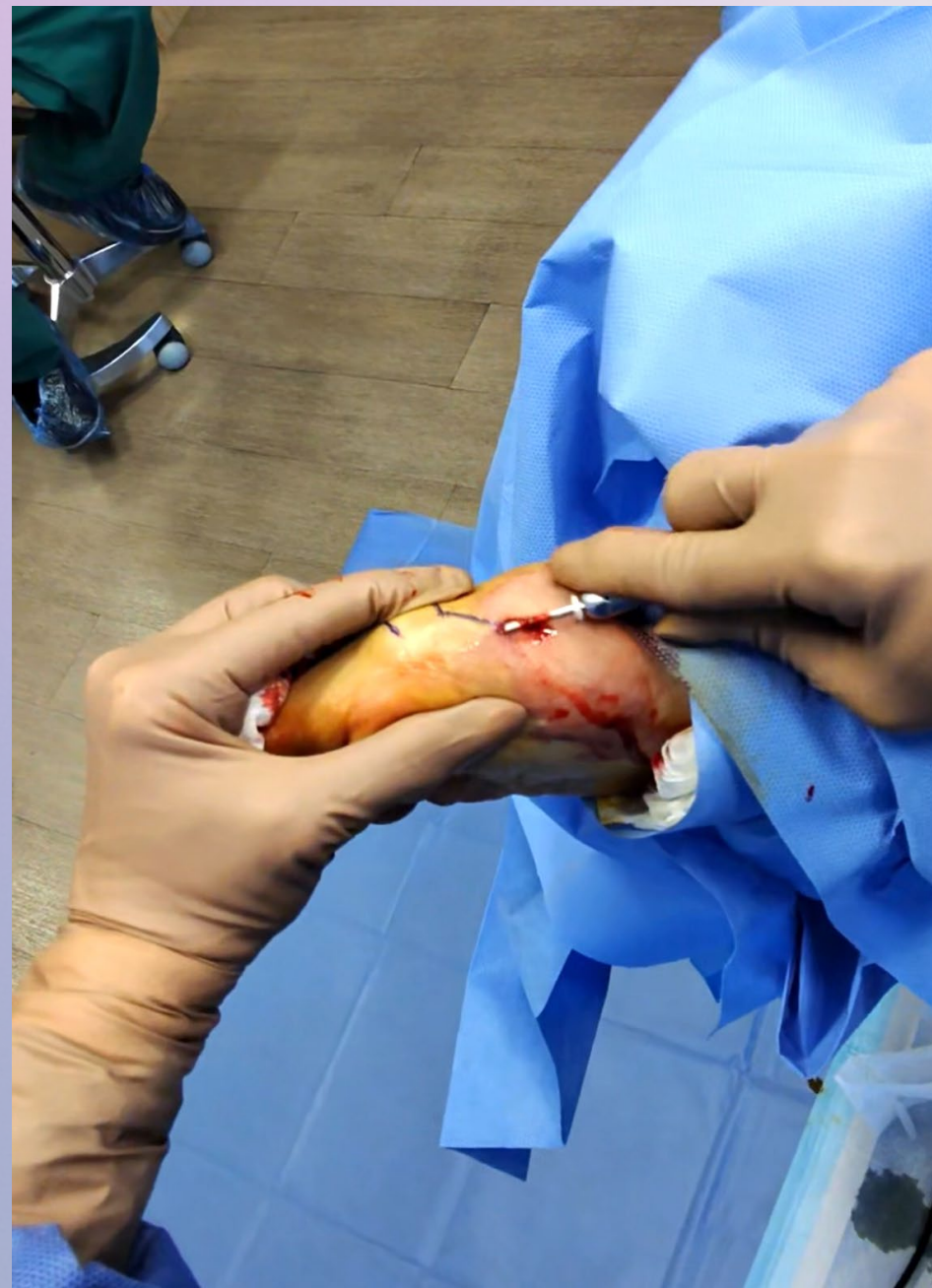
# Your Non-Dominant Hand Matters

- Depth control
- Stability
- Tactile Feedback
- Guides dominant hand



# Medial Eminence Resection

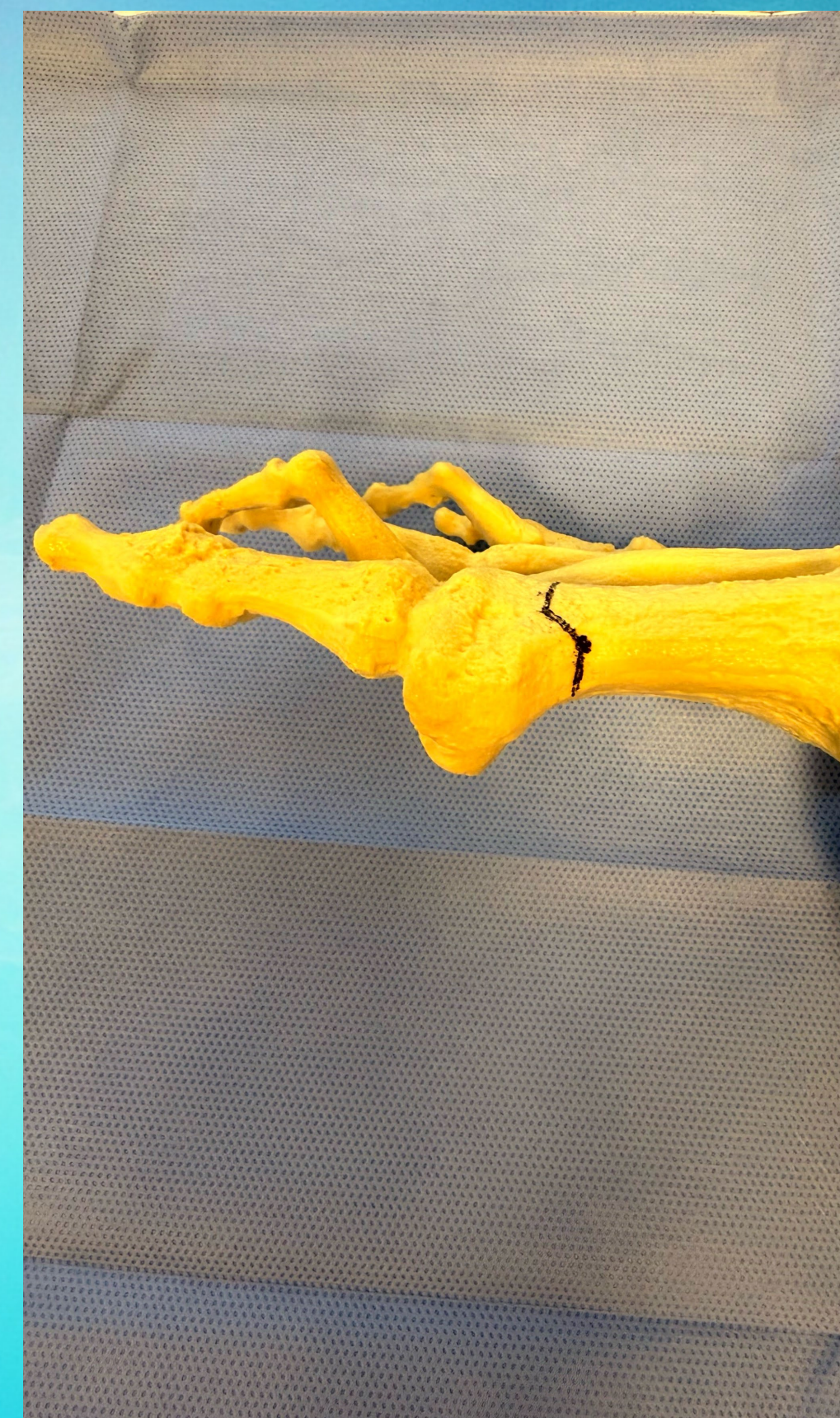
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- Medial incision
  - Proximal to medial eminence
  - Centered at neck between dorsal and plantar cortex
  - Additional dorsal incision optional
- Contour carefully
- Preserve capsular integrity
- Avoid over-resection
- Use hocky-stick hand grip to “scoop” bone
- Use rasps and hemostats to remove residual bone

# The Fail-Safe Hole

- Starting reference of osteotomy
- Incision centered at neck between dorsal and plantar cortex
- Directional control
  - Neutral orientation to 2<sup>nd</sup> metatarsal axis → maintain length
  - More proximal → shortening
  - More distal → lengthening
- Placed at the halfway point of the dorsal and plantar cortex
- Raise your hand slightly to direct the burr plantarly to plantarflex the capital fragment

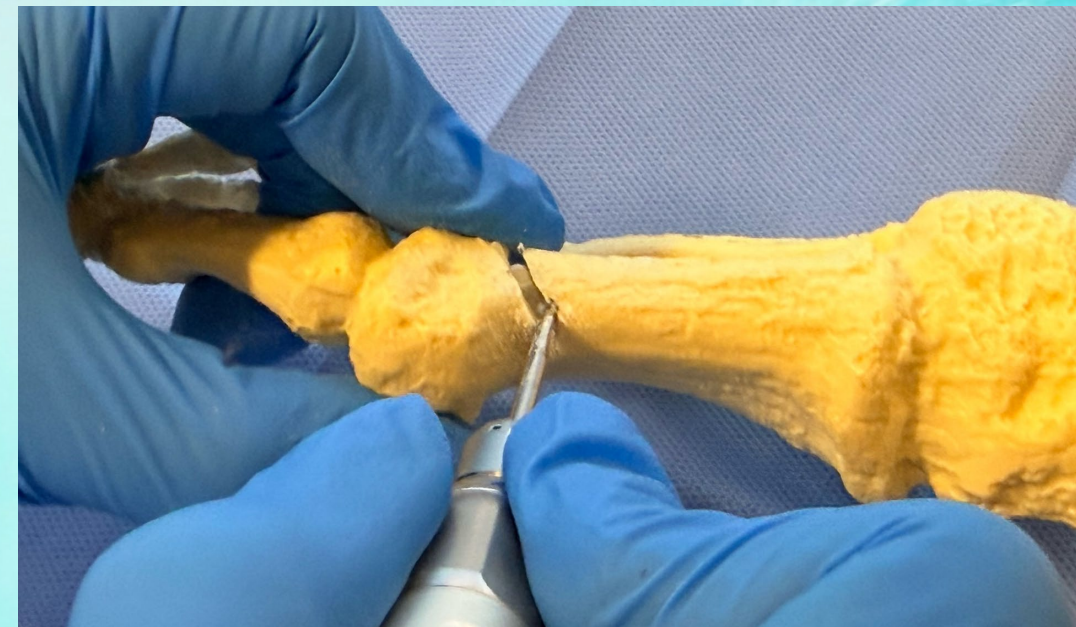


# Osteotomy Trajectory

- Dorsal arm: Initiated through the pilot hole at approximately 45°, directed lateral and dorsal-distal, advancing along the dorsal cortex to exit medially.



- Plantar arm: The 90° component of the cut, advanced lateral to medial from the fail-safe hole to exit plantarly proximal to the sesamoids.



# Capital Fragment Translation

- Palpate and feel that capital fragment moves
- Performed controlled lateral shift
- Maintain length
- Assess rotation and
- Impact head into shaft to stabilize
- Remove overhanging shelf if needed



# Fluoroscopy

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- Use to validate landmarks
- Not a substitute for knowing your anatomy





## Adjunct Procedures

- Akin Osteotomy
- Lateral adductor tendon release
- Optional K-wire fixation
- Taping & splinting

# Post-op Protocol

- **Immediate Post-Op**
- Splinting & Compression dressing
- Protected weight-bearing in post-op shoe or boot
- Elevation & edema control
- Dressings kept clean/dry – dispense shower guard
  
- **Weeks 1–4**
- Suture removal week 1 or 2
- Maintain alignment taping weekly
- Early controlled ROM (if appropriate)
  
- **Weeks 4–12**
- Progressive weight-bearing and nonimpact activities as tolerated
- Transition to supportive shoe
- Continued splinting with spacers
  
- **After 12 Weeks**
- Return to full activities as tolerated
- Continue ROM and supportive shoe gear

## Complications

- Dorsal displacement
- Transfer metatarsalgia
- Malrotation
- Over-Shortening.



# Avoiding & Addressing Complications

Address	Address them early on
Respect	Respect landmarks
Control	Control angulation
Protect	Protect length
Confirm	Confirm angle and cuts
Refine	Refine skills with labs

# Case 1



# Case 2





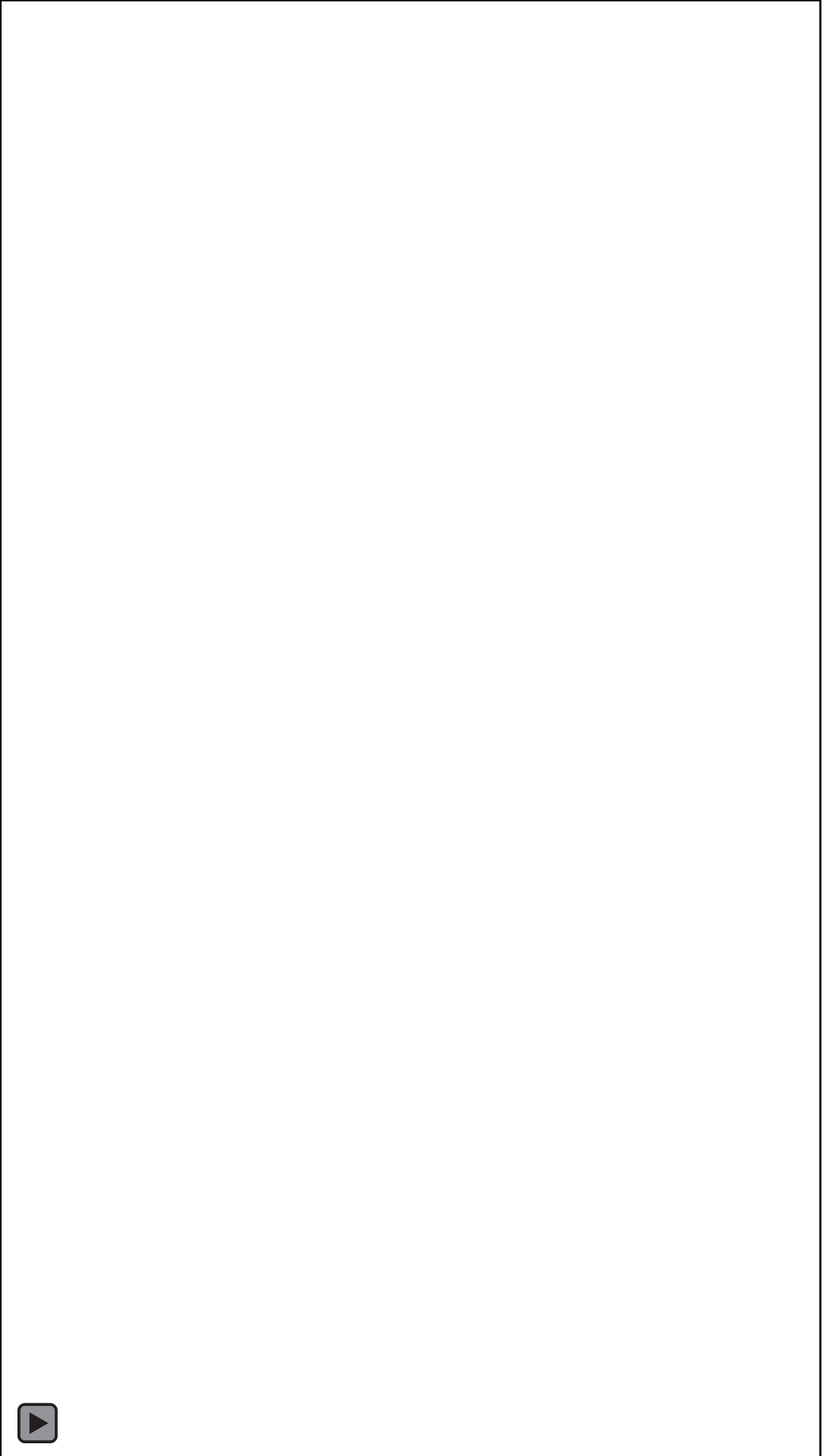
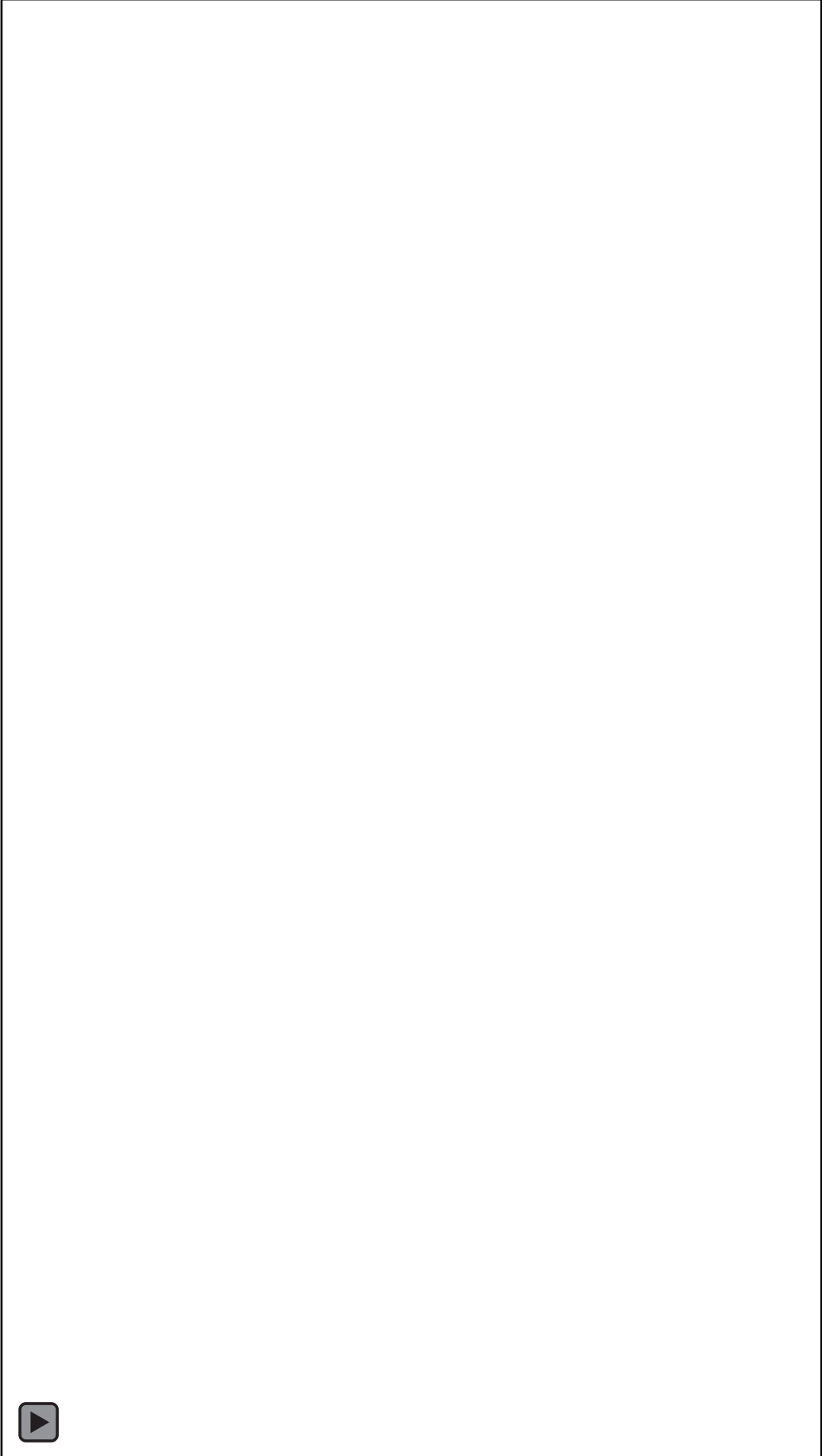
# Case 4



Case 5



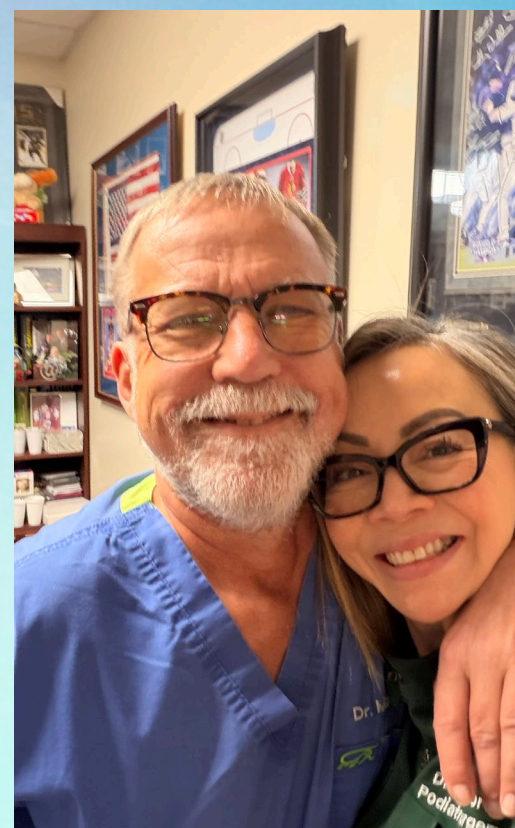
# Case 6



# Modern Bunion Surgery Doesn't Have to Mean Major Surgery



- Effective correction
- Minimal disruption
- Implant-free
- Office-based efficiency
- High patient satisfaction



# With Gratitude

Special thanks to :  
Dr.'s Hartley Miltchin, Sheldon Nadal, Orlando Nunez, Borys Markevych, Stephen Isham



# Thank You!



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