

4.12 Ankle Injuries

X-ray according to Ottawa Guidelines, which specify definite bony tenderness of the

- Posterior sections of both malleoli, or
- The styloid process of 5th metatarsal, or
- Prominence of talus medially, or
- If unable to weight bear.

The common sprain presents as a swelling anterior to the lateral malleolus at the site of the talo-fibular ligament.

- Have a high index of suspicion regarding fractures in the over 65s and any patient who genuinely cannot weight bear.
- Undisplaced fractures can be immobilised in a plaster of Paris back slab and crutches provided, with instructions to elevate and trauma clinic follow up.
- Displaced fractures, or those affecting the ankle joint, should always be discussed with the orthopaedic staff.
- Severe sprains where weight bearing is not possible, though no fracture is identified, should be treated with a double tubigrip and crutches should be provided. The patient should be advised to rest the ankle, apply ice, continue the compression and elevate the ankle. It is reasonable to bring these patients back at 5 to 7 days to A&E returns clinic for reassessment. At this stage a certain number will require a plaster and/or physiotherapy.

Ankle

SITE OF INJURY	LOOK OUT FOR	1e MANAGEMENT	DISPOSAL
Dislocation	distal vascularity	immediate MUA, xray after	Ortho 2C
# lat malleolus	stability of jt, flake off med malleolus	if stable, POP if unstable, Ortho 2C	Ortho TC
# med malleolus	stability of jt	if stable, POP if unstable, Ortho 2C	Ortho TC
Ant talo-fib lig	flake off lat malleolus	if severe pain, cannot WB, POP	A&E RC 2 weeks
Avulsion # talus	os trigonum *	BK POP	A&E RC 2 weeks
bi- or tri-malleolar #	distal vascularity		Ortho 2C

* os trigonum is an anomalous bone (can be misinterpreted as a # of posterior process of talus)

4.12 Calcaneal fractures

- Be suspicious in falls from heights.
- Always be aware of more proximal injuries in these patients e.g knees. Hips. Pelvis, spine etc.
- Plantar bruising is almost diagnostic.
- Admission required more often than realised for treatment of swelling and stiffness. Keep non-weight bearing. Emphasise the need for elevation
- With a collapsed calcaneum with a reduced Bohlers angle the patient will require surgery after CT scan

SITE OF INJURY	LOOK OUT FOR	1e MANAGEMENT	DISPOSAL
Plantar fasciitis		ultrasound, arch support, depomedrone injection if necessary	TRIN
# body/neck talus	avascular necrosis, posterior tibial neurovascular damage	displaced, Ortho2C undisplaced, BK POP	Ortho TC
Avulsion # talus	os trigonum	BK POP	Ortho TC
# calcaneum (os calcis)	subtalar angle	displaced or bilateral, Ortho 2C undisplaced, non-wt-bearing	Ortho TC
Dislocation mid tarsal region	commonly missed	if displaced, MUA, BK POP	Ortho TC
Metatarsal #		BK POP	Ortho TC
Multiple #	swelling, vascularity	elevate, analgesia	TCI Ortho

March fracture

- Stress fracture of 2nd metatarsal.
- Often not visible on XRay, until at least 3 weeks have elapsed. Callus and signs of healing may be the only evidence of previous fracture.
- If diagnosis is in doubt, double tubigrip, NWB, A&E RC 1 week.
- If diagnosis is definite, BK POP (can be WB), A&E RC 2 weeks.

Plantar fasciitis

- Causes focal pain in the sole of the foot. Usually unrelated to trauma.
- Will not usually respond to physiotherapy, and often only resolves with a heel pad and steroid injection.
- May be associated with a calcaneal spur, though this is not considered causal. Refer to returns clinic if severe.

Toes 9D

SITE OF INJURY	LOOK OUT FOR	le MANAGEMENT	DISPOSAL
Toes 2 –4	Dislocation	no x-ray, analgesia, mt pad	ROD
# hallux		analgesia, splint or EP strapping	TRIN