Management of an Irreducible Ankle: A Case Report

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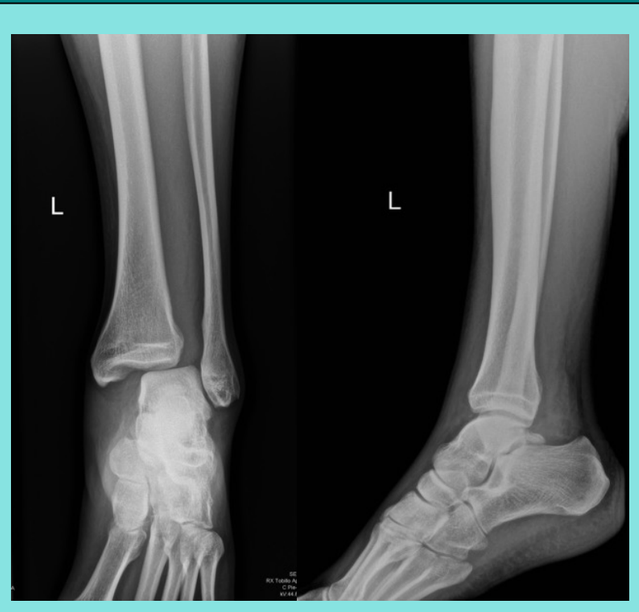
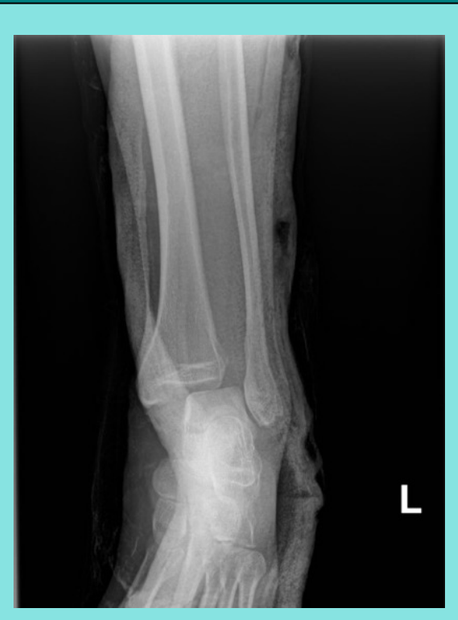
INTRODUCCION

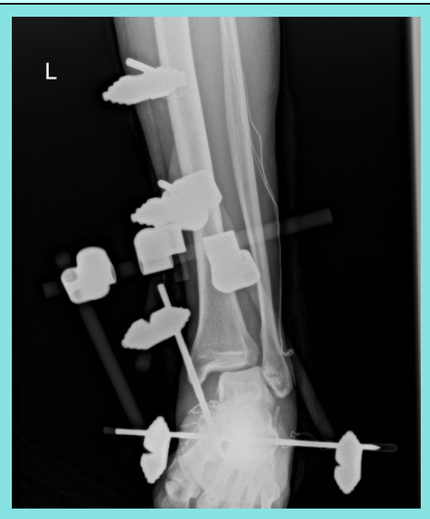
A 44 year old gentleman presented to our emergency department following a high energy workplace accident. He reported severe pain and obvious ankle deformity, intact skin and neurovascular function were observed.

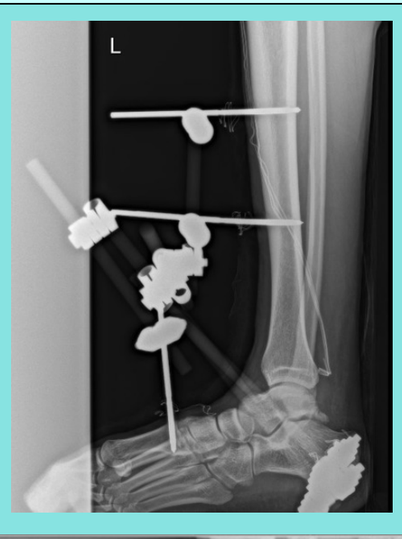
Radiographs showed an ankle dislocation.



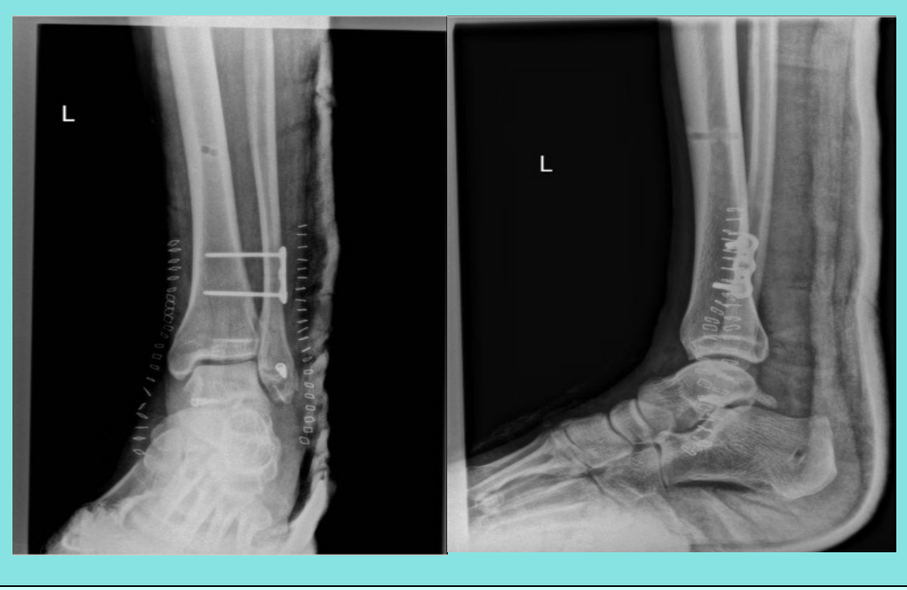
▪1st attempt of close reduction







▪2nd attempt of reduction



▪Postop Rx

DEFINITIVE SURGICAL PROCEDURE

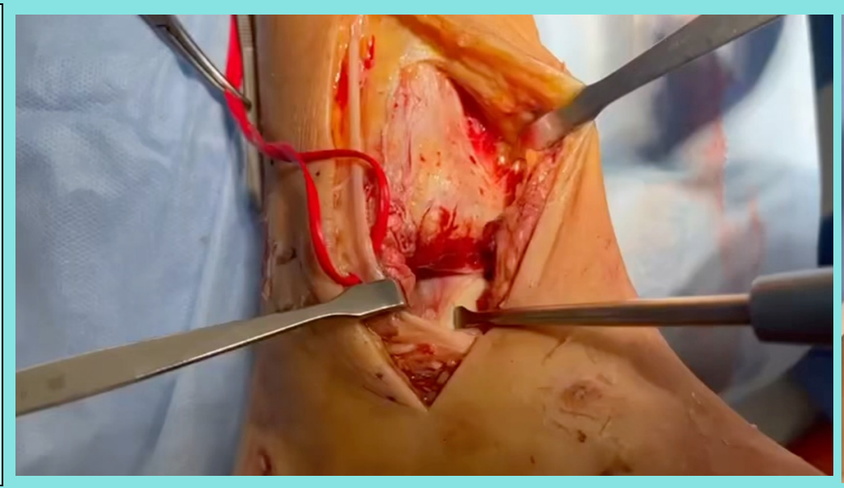
*Ankle arthrotomy was performed through an anteromedial incision. The deltoid ligament was completely detached from the talus and the **POSTERIOR TIBIALIS TENDON** was impeding reduction. The tendon was displaced posteriorly passing through the tibioperoneal syndesmosis to reach the anterior part of the ankle joint, causing lateral traction of the talus.*

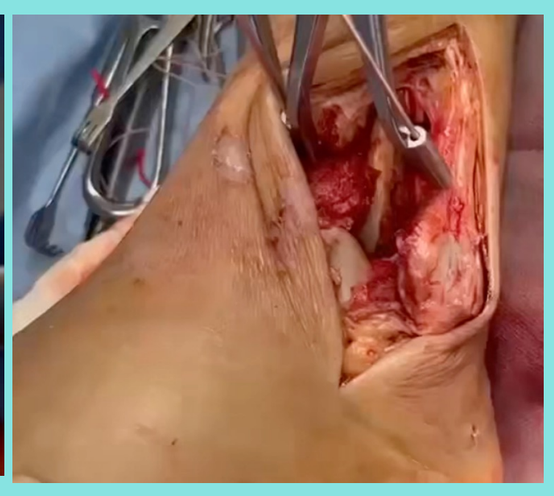
An accessory lateral incision was performed and the anterior syndesmosis was opened.

After joint distraction, the posterior tibialis tendon was reduced with a suture and relocated to its normal position in the retromelleolar groove; this also allowed relocation of the talus in the tibioperoneal mortise.

At this point syndesmosis was stabilized with a plate a 2 syndesmotic screws and 2 suture anchors were placed: one to restore the deltoid ligament and the other to Repair the anterior syndesmosis

▪Intraop Pictures

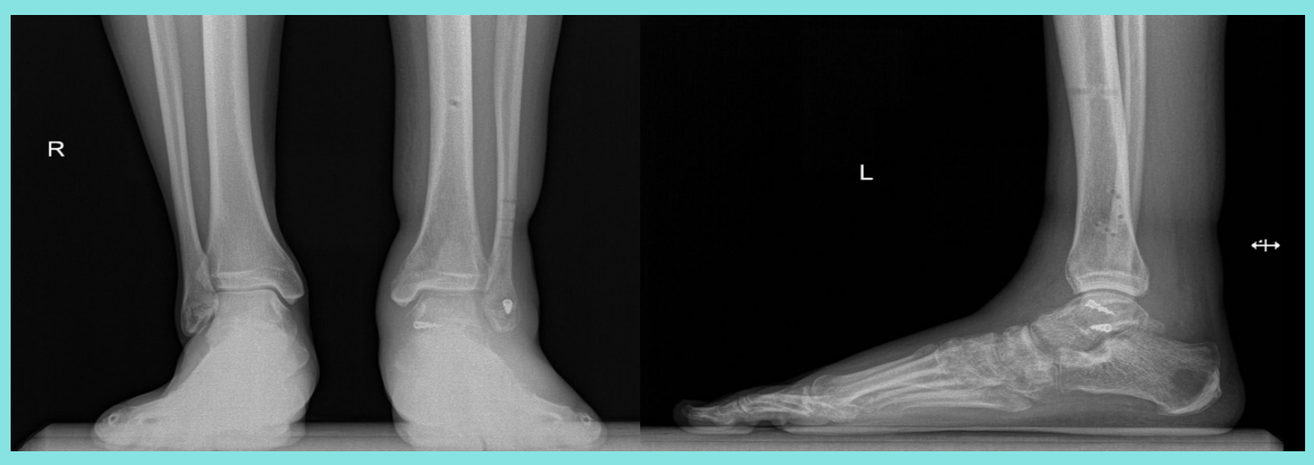




FOLLOW UP

After surgery a below-knee cast was applied and no weight bearing was allowed.

Follow up was completed during a 9 month period. The plate and 2 screws were removed 9 weeks after the definitive surgery. Last follow up was April 2024, pain was minimal and TP tendon is functioning well. Dorsiflexion is almost complete and the patient had returned to his regular activities.



CONCLUSIONS

- Possibility of soft tissue interposition should be considered in persistent ankle dislocations.
- Exact knowledge of the anatomy is required.
- Misdiagnosed can lead to several negative outcomes.