



Ankle Fractures

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Western Health

Ankle fractures

- Most common fracture treated by orthopaedic surgeon
- Low energy injuries
- Twisting mechanism (similar to ankle sprains)



History and Examination

- Mechanism of Injury – high vs low
- PMHx
 - Diabetes, smoker, neuropathy
- Examination
 - Soft tissue
 - swelling,
 - blisters,
 - Bruising
 - Wounds
 - Special Tests
 - Areas of tenderness
 - Squeeze test
 - Ottawa



Maisonneuve Fracture





Ottawa Ankle Rules:

Order ankle x-rays if acute trauma to ankle and one or more of

- Age 55 or older
- Inability to weight bear both immediately and in ER (4 steps)
- Bony tenderness over posterior distal 6 cm of lateral or medial malleoli
- Sensitivity ~100%
- Specificity ~40%



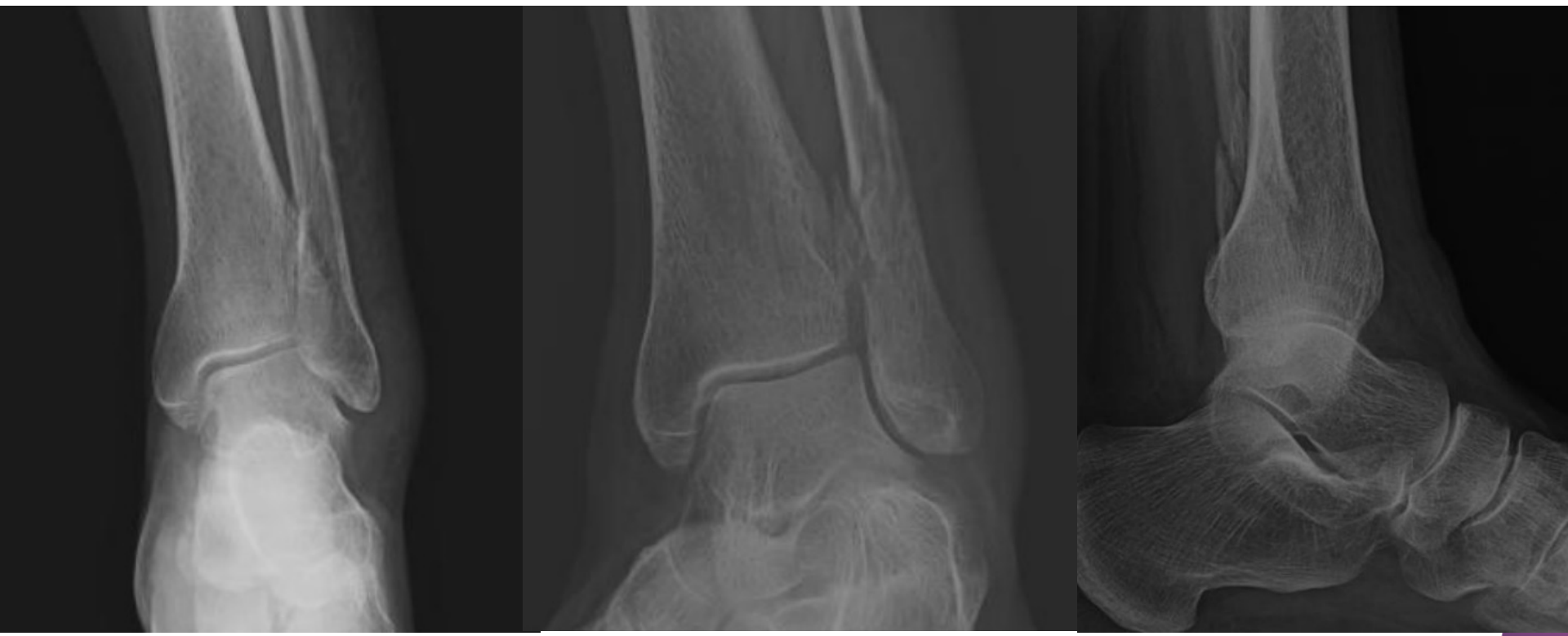
“Walk it off, Billy! It’s just a turned ankle!”

Investigations

AP

Mortise

Lateral



15° IR



Reading Xrays

- Lateral malleolus
- Medial malleolus
- Syndesmosis
- Mortice / Talar shift
- Posterior malleolus





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Mortise X-Ray

- ankle in 15-25° of IR



Mortise X-Ray

- **Medial clear space**
 - Between lateral border of medial malleolus and medial talus
 - <4mm is normal
 - >4mm suggests lateral shift of talus



Mortise X-Ray



Mortise x-ray:



Mortise x-ray:



Classification

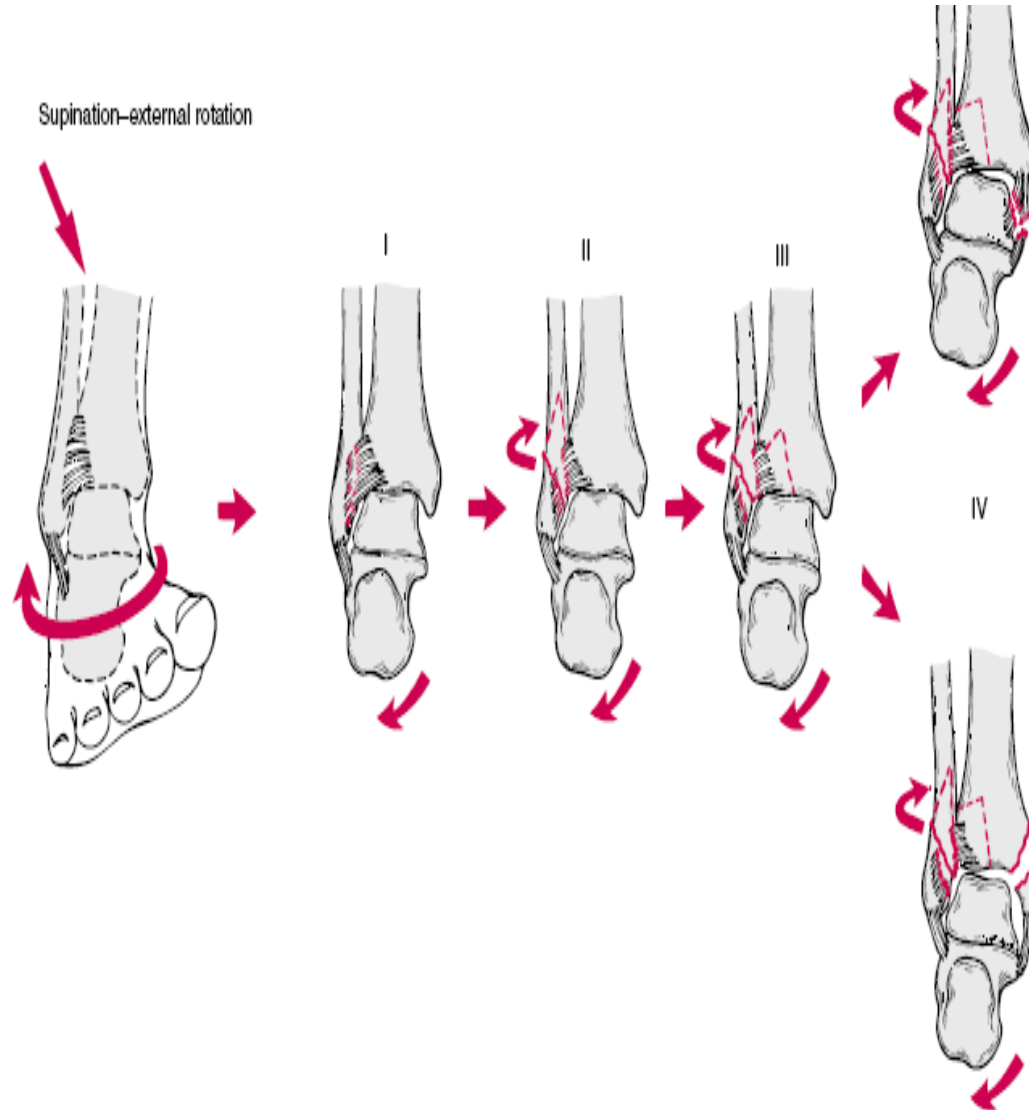
- Lauge-Hansen (1949)
- Weber (1972) - AO



Lauge - Hansen classification

- Mechanism of injury
 - Supination Adduction
 - Supination External rotation
 - Pronation Adduction
 - Pronation External rotation
- Complicated / Hard to Remember

Supination External Rotation





Weber classification

Advantages:

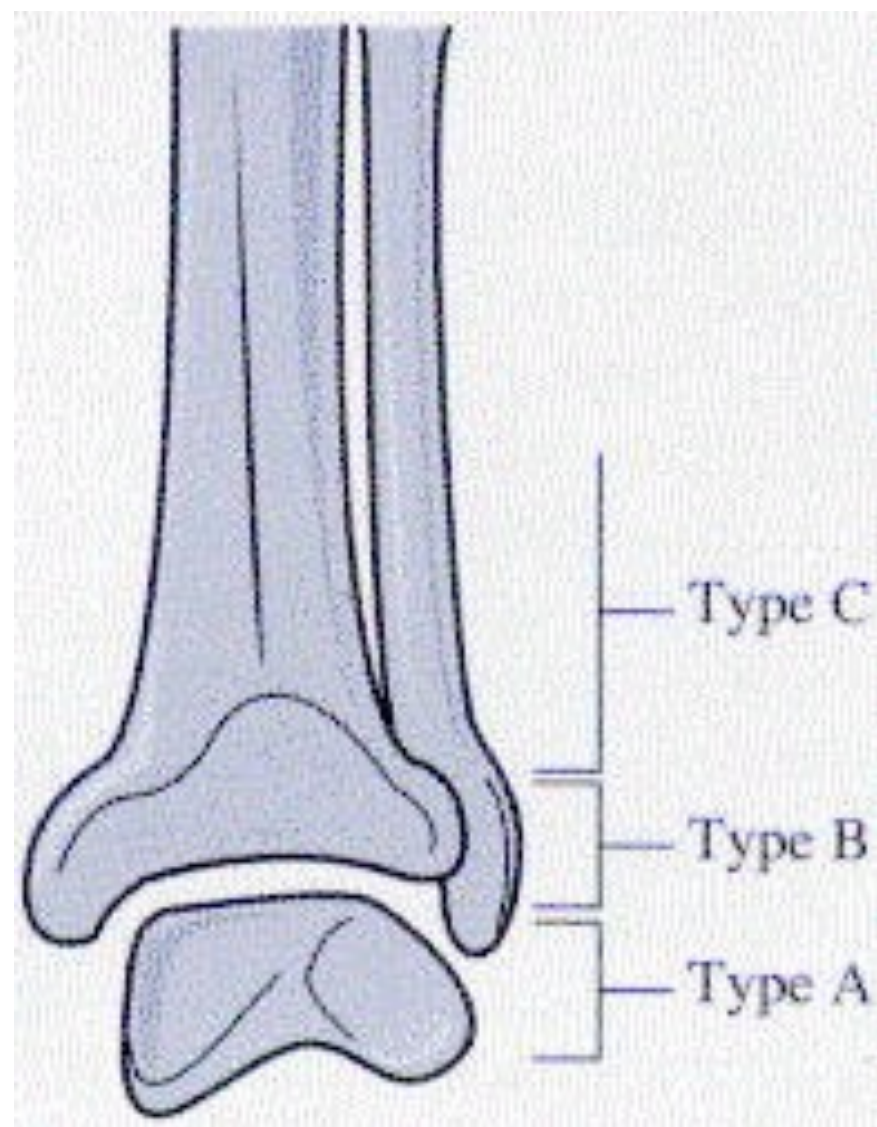
- easy to use
- provides information about fibular

Disadvantages:

- ignores the medial injury

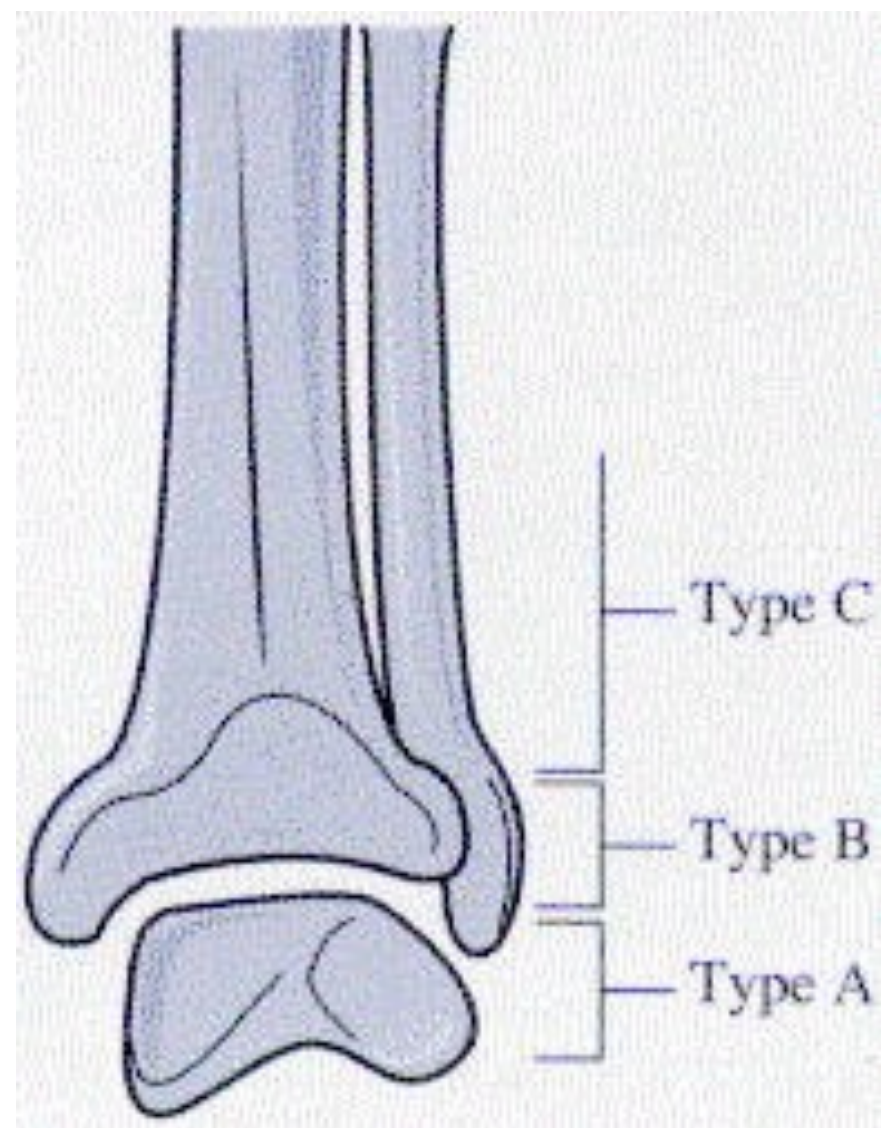
The AO classification system

- Modification of the Weber system
- subdivided on the basis medial or posterior injury



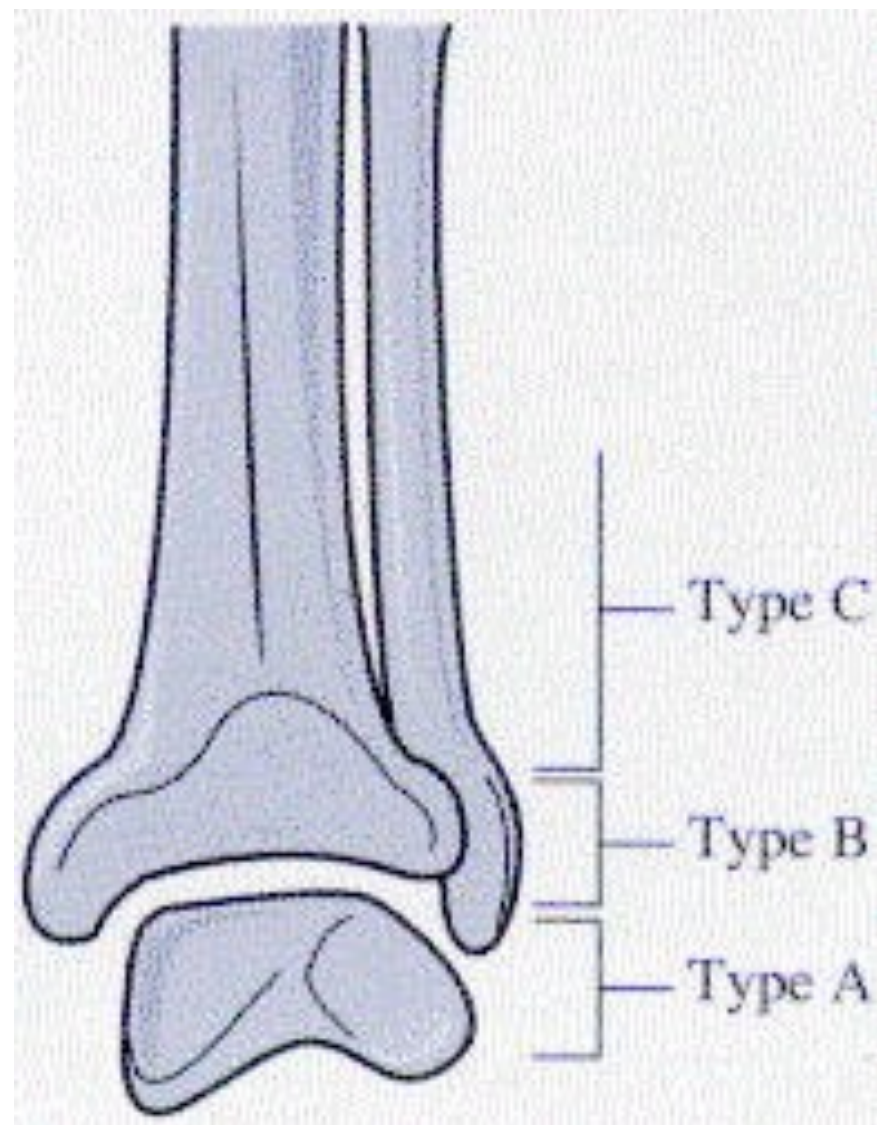


Weber classification



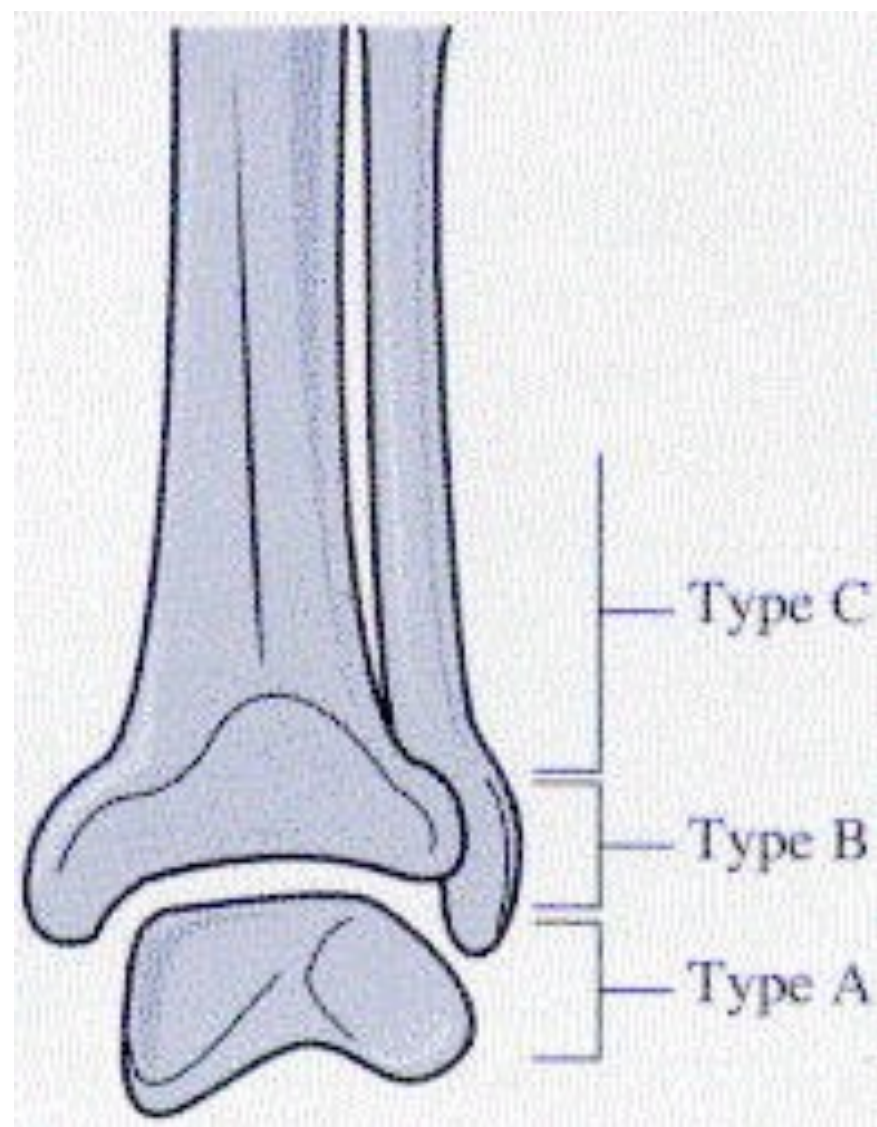


Weber classification





Weber classification



Management priorities

1. Reduce
 - Provisional reduction
 - Care of open fracture
 - Soft tissues
2. Hold
 - Precise definitive reduction
 - Cast
 - ORIF
3. Move
 - Rehabilitation



Goals of Treatment

- Healed fracture
- Ankle that moves and functions normally without pain

Cast vs Internal Fixation

- What is broken?
 - Medial Malleolus
 - Lateral Malleolus
 - Posterior Malleolus
 - Syndesmosis
- Does it need to be reduced?
- Stable vs Unstable



Stable vs Unstable



The ankle is a ring

- Tibial plafond
- Medial malleolus
- Deltoid ligaments
- calcaneous
- Lateral collateral ligaments
- Lateral malleolus
- Syndesmosis

Stable vs Unstable



Fracture 1 part = usually stable

Fracture > 1 part = unstable

Unstable fractures

- Lateral talar shift
- Bimalleolar
- Lateral fractures + medial tenderness
- Syndemosis Injuries
- Maisonneuve



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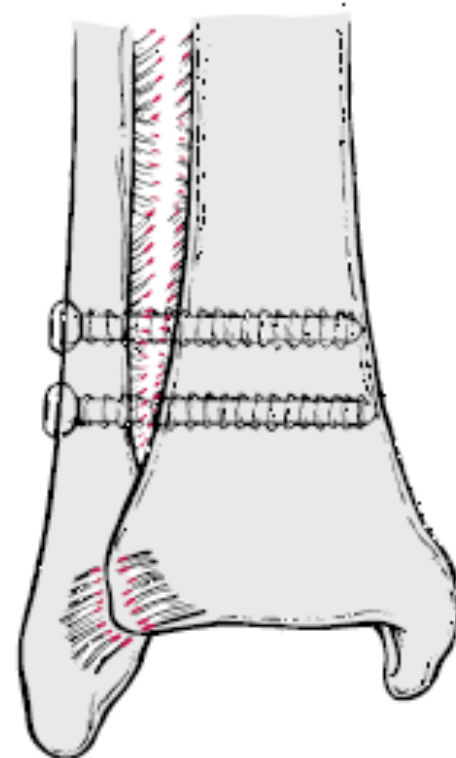
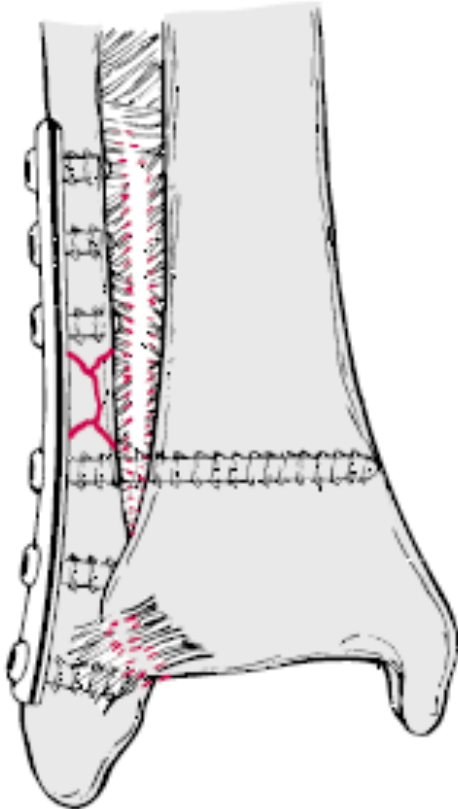
Lateral Shift of Talus

1-mm lateral shift
=
decreased contact area by 42%

3 mm of lateral shift,
=
decreased contact area by 60%



Lateral Shift of Talus



Pilon / Plafond fractures



Pilon / Plafond fractures



- Fracture of distal tibial metaphysis
 - Often comminuted
 - Often significant other injuries
- Mechanism
 - Axial load
 - Position of foot determines injury
- Treatment
 - Unstable
 - X-ray tib/fib & ankle
 - Orthopedic consultation

Tillaux Fracture



Tillaux Fracture



- Occurs in 12-14 year olds
18 month period when epiphysis is closing
- **Salter-Harris 3 injury**
- **Mechanism**
External rotation
Strength of tibiofibular ligament > unfused epiphysis

Tillaux Fracture



- **Management**

Articular injury

Gap >2mm in articular surface

= ORIF

Non-displaced

- NWB below knee cast

Displaced

- surgery



Thank you