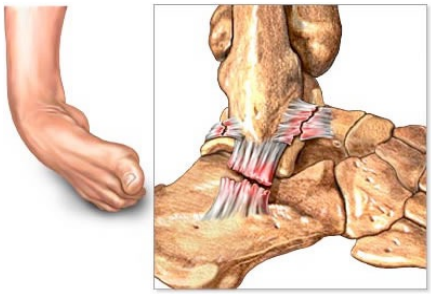
Ankle Instability

Ankle sprains are one of the most common sporting injuries. Usually, the injury recovers with suitable rest and physiotherapy. Ankle instability occurs when the ankle repeatedly gives way during sporting or daily activities. This leads to recurrent ankle sprains, joint pain, swelling, inflammation, and further damage to the ligaments around the ankle. Some people experience intermittent ankle pain which occur with episodes of instability whilst others feel that their ankle aches more often. Recurrent instability episodes can cause damage to the joint surface cartilage, the formation of bony spurs (osteophytes), and eventually arthritis.



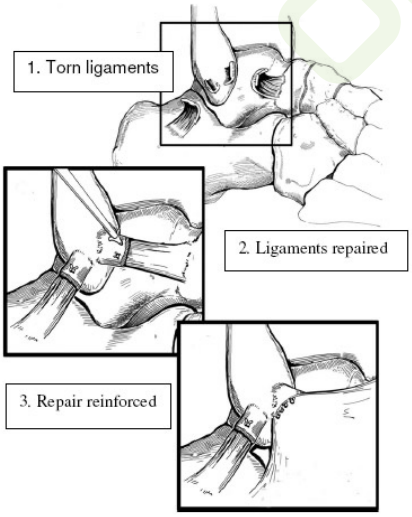
Torn ankle ligaments

Non-Operative Management

The first line of treatment for ankle sprains is rest, ice, compression, elevation with painkillers and anti-inflammatories (if tolerated). Physiotherapy is then useful to regain range of movement, strength, balance and joint position sense (proprioception). An ankle brace may be useful for people who have tried all these measures and experience ongoing problems with sporting or daily activities. Finally, a targeted corticosteroid injection may offer relief from ankle inflammation and help settle symptoms so that physiotherapy can continue.

Operative Management

When all these non-operative measures fail, and recurrent ankle instability becomes an ongoing problem, surgery is usually indicated. The ankle ligaments are assessed clinically and an MRI scan may be necessary to identify any problems within the ankle joint itself or the tendons and ligaments around the joint. There are two components to the surgery. An incision is made over the outside of the ankle where the ligaments have been torn away. The ligaments are then reconstructed in an anatomical fashion and reinforced with overlying tissue (modified Bröstrum-Gould repair). In a small percentage of cases, the ligament quality is not adequate enough to allow a direct reconstruction. In this situation, bony anchors or synthetic devices are inserted to reinforce the repaired ligaments. The tendons running behind the fibula bone (peroneal tendons) are inspected and repaired, if necessary, as injury to these tendons can be an ongoing source of pain and instability. At the end of the operation a backslab (half plaster) is applied to immobilise the ankle and protect both the reconstruction and wounds.



In addition to the ligament repair, an arthroscopy is initially performed through two small incisions at the front of the ankle. The joint surfaces are inspected, inflammatory and scar tissue is removed, and any bony spurs (osteophytes) are trimmed away.

Post-Operative Recovery

As with all reconstructive surgery, rehabilitation and postoperative physiotherapy forms a vital part of your recovery from surgery and return to normal activities. The first tw weeks are dedicated to reducing the swelling with elevation of the foot and mobilising non-weight bearing with crutches to allow the wounds to heal. You will then be required to use a brace or CAM walker for a further four weeks, in which you are permitted to bear weight. Six weeks after surgery the CAM walker is removed for daily activities and an intensive strengthening and balance program begins. An ankle brace should be worn initially for all sporting activities, and you should be able to return to sport 3-6 months after surgery. The ankle may always be a bit stiff compared to the normal side, with a slight reduction in range of motion not uncommon. This is rarely a significant problem.

Risks & Complications

No surgery is completely risk free. The risks and complications will be assessed and discussed with you. There is always a small risk of infection, blood clots, nerve injury and anaesthetic problems and measures are taken to reduce these. There is approximately a 5% chance of experiencing problems with recurrent instability and this is usually due to a fresh injury or sprain. A good outcome is achieved in more than 90% of cases.

Recovery Times

Return to activities	
Hospital stay	1 night
Rest & elevation	7-10 days
Plaster & crutches (non-weight bearing)	2 weeks
Brace or CAM walker as directed (full time) (weight bear as tolerated)	4 weeks
Lace-up brace (training)	6 weeks
Ankle strapping (competition)	12+ weeks

Time off work	
Seated	2-3 weeks
Standing	6 weeks
Heavy physical work	12 weeks

This brochure is a brief overview of the surgical management of ankle instability and not designed to be all-inclusive. If you have any further questions, please do not hesitate to contact your surgeon.

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