South East ORTHOPAEDIC SURGERY

PATIENT INFORMATION: ANKLE INSTABILITY

Following a consultation with one of our orthopaedic surgeons, you have been diagnosed with an unstable ankle. This leaflet will aim to give you additional information about your condition, the surgery and common risks and complications. If you have any further questions, please don't hesitate to ask a member of the team.

What is an ankle stabilisation?

Otherwise known as a 'Brostrom' reconstruction, it is a repair of the ligaments on the outside of the ankle. It can be done endoscopically using minimally invasive techniques or open using a larger incision.

Why do you need an ankle stabilisation?

An initial injury – 'rolling the ankle' can tear the ligaments on the outside of your ankle. This normally settles with physiotherapy and anti-inflammatories. A small proportion of patients go on to need surgery. This involves exploratory surgery of the ankle using an arthroscopy to look for any changes to the cartilage (osteochondral defect) of the ankle. It is also possible to examine the ankle under anaesthetic to determine if it is truly unstable. We would then proceed with an ankle reconstruction at the same time as your arthroscopy.

What does the operation involve?

Following arthroscopic inspection of the joint surface, a small cut is made over the outside of the ankle. Small divots are made on the end of the fibula and specialised sutures are used to attach the ligament back to the bone. In some instances, the ligaments are badly damaged a tendon from another part of your ankle might be required to reinforce the reconstruction. Alternatively, a synthetic 'internal brace' might be required to support the ankle instead. This is particularly the case in revision surgery.

How long will I be in hospital?

Patients normally go home the same day. Occasionally an overnight stay is required.

Will I need a general anaesthetic?

A general anaesthetic is usually required for the operation. In some circumstances, the procedure may be done under spinal anaesthetic or using nerve blocks. We have specialised anaesthetists who can discuss these options with you and determine the most appropriate anaesthetic for your surgery.

What happens afterwards?

A temporary cast will splint your leg from just under your knee to your toes for two weeks. This is to let the wounds heal without stretching the skin. You will probably be able to partially weight bear using crutches for two weeks immediately following your surgery. We will see you approximately two weeks after your surgery and will remove any sutures and fit you with an ankle brace.

Generally patients can walk while wearing the ankle brace from two weeks after your surgery. You will commence physiotherapy after two weeks for non weight bearing range of motion exercises. We will then see you again six to eight weeks following your operation. If we are happy with the stability of your ankle you can come out of the brace.

You can return to work whilst wearing the ankle brace providing you do not have a labour-intensive job. Heavy labouring may require two to three months off work. Most people are able to drive after they have seen a physiotherapist and are able to move their ankle freely.

When can I play sport?

You can gradually return to sport while wearing the ankle brace. We recommend straight line, low impact sports like walking on flat ground, cycling and swimming from approximately two weeks post-operatively. After your six week review you can consider running on your ankle while wearing a brace. As you gain more confidence, and as directed by your physiotherapist, you can increase the amount of weight you put through your ankle and start to introduce some twisting activities. Generally, people take six months to return to contact sports such as AFL, rugby or basketball. However, this is variable and your physiotherapist will formulate a rehabilitation plan tailored to your needs.

Risks:

Sometimes the repair can be too tight – meaning the ankle is stiff and doesn't fully recovery its flexibility

More commonly, it can be too loose – the ankle remains lax and can continue to give way. This is especially the case in people with generalised ligamentous laxity or heel malalignment

There is a small risk of wound infection or delayed healing. The risk is low and usually settles with dressings and occasionally antibiotics are required. If you are a smoker or a diabetic the risk of a wound infection is much higher. In very, very rare cases and infection can enter the bone and cause chronic infection that is very difficult to eradicate.

There are some small nerves, normally branches of the superficial peroneal nerve, that run close to the ankle where the operation is performed. Approximately one in ten people have some numbness around the scar because of injury to these nerves and in rare cases the sensation to the foot is altered. The majority of cases settle down with time but in very rare circumstances the numbness is permanent.

There is a small risk of blood clots to the legs or lungs following surgery. Some people are particularly at risk of blood clots, including women on the oral contraceptive pill, smokers, very overweight patients and people with a prior history of blood clots. Most patients who are able to weight bear po st-operatively do not require medication to stop them getting blood clots because the risk is the same as someone who has not had surgery. In some circumstances you may require blood-thinning medication and this will be discussed with you prior to your surgery.

If you have any further questions, please contact your surgeon:

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