APOA Foot & Ankle Council Presents..

Case of the Fortnight

15th September 2022

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Presented by:

Dr. Yuen, chi pan
Honorary Consultant in Orthopaedics & Traumatology, Gleneagles Hospital, Hong Kong SAR

Title:

Simultaneous ankle arthroscopy and hindfoot endoscopy: Single position, usual orientation

Learning Points:

- Concomitant ankle and hindfoot pathology is not uncommon. But it's difficult to address all pathology from a single incision or surgical approach.
- Simultaneous anterior ankle and hindfoot arthroscopic technique is a good option. There are several ways to perform it and here we describe our technique to do it in a single patient position with usual arthroscopic orientation.

*Upcoming Case of the Fortnight on **1st October 2022***

Presented by:

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Orthopaedic Surgeon
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Title:

Correction of a Difficult Forefoot deformity using Minimally Invasive Surgery

Want to present a case? Write to...

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Simultaneous ankle arthroscopy and hindfoot endoscopy: Single position, usual orientation

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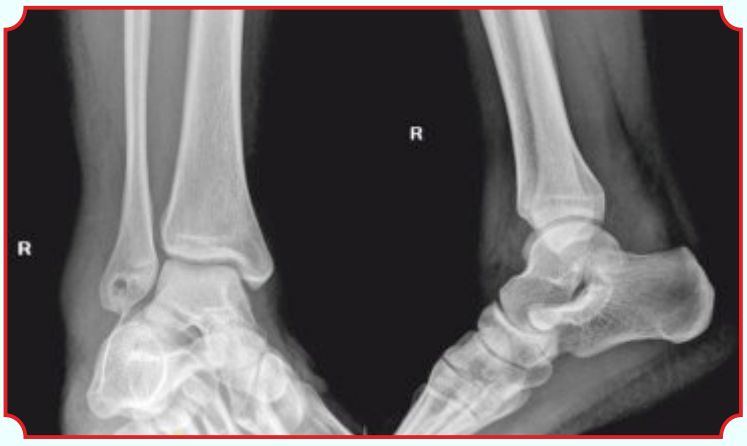
Case

A 34 years old gentleman suffered from ankle sprain and anterior talofibular ligament (ATFL) tear. He was managed by open repair with suture anchor. However he complained of persistent ankle pain and swelling so was referred to us for further management at 6 months after the initial surgery.



(Fig. 1)

Upon assessment, there was a 6 cm linear scar at the distal fibula, healed without sign of chronic infection. There was severe tenderness and swelling over lateral gutter, along flexor hallucis longs (FHL) and hindfoot. Ankle range of movement was limited by pain. Anterior drawer's test showed grade 1 instability.

Xray ***(fig. 1)*** of his right ankle showed healed fracture of the distal fibula and post-operative changes.

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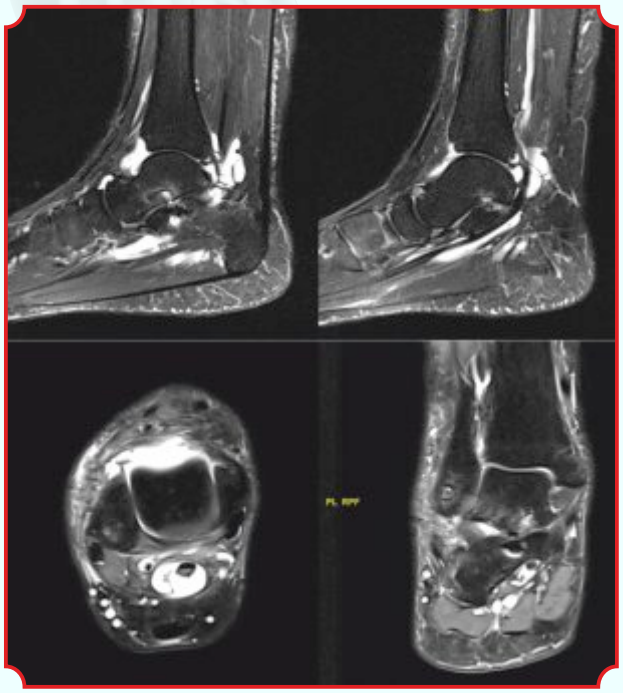

(Fig. 2)

MRI ***(fig. 2)*** showed severe anterior and posterior ankle joint effusion. Increased fluid collection along FHL. Bony channels were seen in distal fibula and lateral part of talus.

After another period of active conservative management included rest, ice therapy, non-steroidal anti-inflammatory drug and regular physiotherapy for 2 months, his symptom persisted so we proceeded to operative management. As there was no tenderness at the syndesmosis, our surgical plan focused on the inflammation over the anterior ankle, hindfoot and along the FHL. If we do it arthroscopically, that involved both anterior ankle arthroscopy and hindfoot endoscopy.

There are several ways to perform simultaneous ankle arthroscopy and hindfoot endoscopy:

- Supine position for ankle arthroscopy then change patient position to prone for hindfoot endoscopy.
- Prone position for hindfoot endoscopy then flex the knee to perform the ankle arthroscopy in an upside down manner.
- Supine position for both ankle arthroscopy and hindfoot endoscopy.

However all the described technique has several potential problems: risks of intraoperative wound contamination while changing position and unusual arthroscopic orientation.

We adopted another technique to address these problem. We first performed hindfoot endoscopy in conventional prone position. Then we hyperflexed the patient's knee and plantarflexed the ankle, while the surgeon standing beside the operating table facing caudally to perform the

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ankle arthroscopy in the usual way. As the operated limb was elevated, we usually needed to stand on working platform. ***(fig. 3)***

There was extensive synovitis around the FHL and latter gutter. Indeed the FHL was encased by a bag of inflamed soft tissue. We performed synovectomy and FHL release. The whole surgery finished in 75 minutes. The patient was discharged on post-operative day one. His wound healed uneventfully. His ankle pain and swelling subsided. He could walk unaided and resumed usual activity.

(Fig. 3)
Patient positioning and theatre setting