Diagnosis, treatment and prevention of ankle sprains: an evidence-based clinical guideline

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ABSTRACT
Ankle injuries are a huge medical and socioeconomic problem. Many people have a traumatic injury of the ankle, most of which are a result of sports. Total costs of treatment and work absenteeism due to ankle injuries are high. The prevention of recurrences can result in large savings on medical costs. A multidisciplinary clinical practice guideline was developed with the aim to prevent further health impairment of patients with acute lateral ankle ligament injuries by giving recommendations with respect to improved diagnostic and therapeutic opportunities. The recommendations are based on evidence from published scientific research, which was extensively discussed by the guideline committee. This clinical guideline is helpful for healthcare providers who are involved in the management of patients with ankle injuries.

INTRODUCTION
In the Netherlands, about 520 000 persons annually have a traumatic injury of the ankle of which about 200 000 are a result of sports.1 Around half of the injuries receive medical treatment and 40% results in chronic instability.1 The average work absenteeism of patients with a functional-treated ligament rupture is two and a half weeks and after six weeks, 90% has returned to work.2 Of the patients who perform sports, around 60–90% resume sports after 12 weeks at the same level as before the trauma.1 About one-third of the total costs due to sport injuries are caused by ankle injuries.1 The prevention of recurrence can result in substantial cost savings. An example from a Dutch study showed mean total costs of one ankle sprain to be about €360.3 With the above-mentioned 520 000 persons with an ankle sprain, Dutch annual sports-related ankle sprain costs can roughly be estimated at €187.2 million. Productivity loss due to absence from paid and unpaid work was responsible for up to 80% of these costs.4 5 Despite the growing body of evidence, international debate shows controversy for best treatment strategies after ankle injuries.4 5 Till date, no international guidelines have been published for the management of acute ankle injuries (International Guideline Library (www.g-i-n.net); US National Guideline Clearinghouse (www.guideline.gov)).

Recently, in the Netherlands, a clinical guideline for acute lateral ankle ligament injury was developed under the auspices of the Royal Dutch Society for Physical Therapy in cooperation with many medical professional associations and patients, following the AGREE criteria.6 Specific goal of this clinical guideline is the prevention of further health impairment of patients (ie, recurrences) by providing recommendations for improved diagnostic and therapeutic opportunities. Other goals are to obtain uniformity of diagnostics, treatment and guidance of doctors and physical therapists and other involved professional groups and to define the framework within which the multidisciplinary care of patients with ankle injuries has to take place. This guideline will also contribute to improved communication between healthcare professionals.

RESULTS
Predisposing factors
Intrinsic and extrinsic risk factors may increase the chance of acute lateral ankle ligament injury or in short lateral ankle injury (LAI). In order to unravel the
importance of extrinsic risk factors for athletes, a specific search was performed for risk factors relating to the type of surface on which to play and the player position during the game.

**Intrinsic risk factors**

Four risk factors are important: strength, proprioception, range of motion and balance of patients older than 15 years with a primary or recurrent lateral ankle ligament injury. The definition of LAI, ADL (activities of daily living) in the literature varied widely. There are indications that limited dorsal flexion and reduced proprioception lead to an increased risk of sustaining an LAI (Level 3). It is plausible that an ankle distortion in the past and reduced balance predispose for LAI, ADL.4–17

**Extrinsic risk factors**

Among a group of 2,016,000 players of all kinds of sports, 14,098 patients with LAI were selected of whom the medical files were available. The highest incidence of ankle injuries was reported due to playing aero ball, in wall climbing, indoor volleyball, basketball and field sports.18 The incidence is dependent on the type of sport, the total number of players and whether a competition is involved (Level 2).18 Among soccer players, playing on artificial grass seems to slightly increase the incidence (Level 2) and defenders and attackers have a higher risk due to contact with opponents (Level 2). In volleyball players, landing after a jump seems to be the most important risk factor (Level 2).

Based on current research data, no recommendations concerning predisposing factors for LAI, ADL can be made for daily practice.

**Ottawa ankle rules**

In LAI, ADL, the existence of a fracture is the main red flag. The ability to walk again within 48 h after trauma is an auspicious sign and indicates a good prognosis. The Ottawa Ankle Rules have been developed to rule out fractures after acute ankle injuries. Most patients who visit the emergency room are examined using radiographs to rule out fractures despite the fact that the prevalence of ankle fractures is less than 15%. The Ottawa Ankle Rules consists of a questionnaire and research protocol for examination of ankle and foot. X-ray diagnostics is only indicated in case of pain in the malleoli or middle foot, combined with one of the following findings: palpation pain on the dorsal side of one or both of the malleoli, palpation pain at the bases of the metatarsal bone V, palpation pain of the navicular bone and finally if the patient is unable to walk at least four steps. Among 73 studies concerning Ottawa Ankle Rules, four review studies of importance were identified. Ottawa Ankle Rules seems to be an accurate tool to exclude fractures in the emergency room within the first week after acute ankle injury (Level 1). This finding was acknowledged by results of research from the Netherlands (Level 2). Studies about the use of Ottawa Ankle Rules outside the hospital are missing (Level 4). It seems plausible that the predictive value of the Ottawa Ankle Rules when used in a general practice is reduced due to the lower incidence of serious ankle injuries or ruptures of ligaments of the ankle.

The use of the Ottawa Ankle Rules is strongly recommended in the emergency room of hospitals and in general practice in order to exclude fractures. In the training of healthcare professionals, sufficient attention should be paid to proper application of the Ottawa Ankle Rules.

**Diagnostics**

If a haematoma is present accompanied by local pressure pain at palpation or a positive anterior drawer test is present or both, it is most likely that a (partial) lateral ankle ligament rupture exists. Delayed physical diagnostic examination (4 to 5 days) gives a better diagnostic result than research within 48 h. The sensitivity of delayed physical examination is 96% and the specificity 84% (Level 2). Knowledge about the

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**Table 1** Classification of methodological quality of individual studies

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Diagnostic accuracy of research</th>
<th>Damage or side effects, aetiology, prognosis*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 Systematic review of at least two independently conducted studies of A2 level</td>
<td>Research relative to a reference test (a ‘golden standard’) with predefined cut-off points and independent assessment of the results of a test and golden standard, on a sufficiently large series of consecutive patients who all have had the index and reference test</td>
<td>Prospective cohort study of sufficient size and follow-up, at which adequately controlled for ‘confounding’ and selective follow-up sufficient is excluded.</td>
</tr>
<tr>
<td>A2 Randomised double-blind comparative clinical research of good quality of sufficient size</td>
<td>Research relative to a reference test, but not with all the attributes that are listed under A2</td>
<td>Prospective cohort study, but not with all the features as mentioned under A2 or retrospective cohort study or patient-monitoring research</td>
</tr>
<tr>
<td>B Comparative research, but not with all the features as mentioned under A2 (this includes patient–control research, cohort study)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Not comparative research</td>
<td></td>
<td></td>
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<tr>
<td>D Opinion of experts</td>
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</tbody>
</table>

*This classification only applies to situations in which due to ethical or other reasons controlled trials are not possible to perform. If these are possible, then the classification applies to interventions.
Consensus statement

Table 3* Effects in favour of functional treatment compared with immobilisation in the event of acute ankle injury

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Study Characteristics</th>
<th>Effect Size</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return to work (number of days)</td>
<td>2 RCTs; n=150; RR 5.75 (95% CI 1.01 to 32.71)</td>
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<tr>
<td>Swelling</td>
<td>3 RCTs; n=260; RR 1.74 (95% CI 1.17 to 2.59)</td>
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<td></td>
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<tr>
<td>Medium term (6 weeks–1 year)</td>
<td>2 RCTs; n=123; RR 4.25 (95% CI 1.12 to 16.09)</td>
<td></td>
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<tr>
<td>Patient satisfaction</td>
<td>2 RCTs; n=123; RR 4.25 (95% CI 1.12 to 16.09)</td>
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<tr>
<td>Long term (&gt;1 year)</td>
<td>2 RCTs; n=195; MD 4.88 (95% CI 1.50 to 8.25)</td>
<td></td>
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</tr>
<tr>
<td>Return to work (number of days)</td>
<td>2 RCTs; n=604; MD 8.23 (95% CI 6.31 to 10.16)</td>
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</tbody>
</table>

*The effects per comparison are in favour of the former interventions. MD, mean difference; RCT, randomised controlled trials.

Table 4 Results* of functional treatments for acute ankle injury

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Study Characteristics</th>
<th>Effect Size</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return to work (number of days)</td>
<td>2 RCTs; n=208; RR 0.11, 95% CI 0.01 to 0.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling</td>
<td>1 RCT; n=122; RR 4.19, 95% CI 1.26 to 13.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elastic bandage vs lace-up brace</td>
<td>1 RCT; n=122; RR 5.48, 95% CI 1.69 to 17.76</td>
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<td></td>
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<tr>
<td>Tape vs lace-up brace</td>
<td>1 RCT; n=119; RR 4.07 (95% CI 1.21 to 13.68)</td>
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<td></td>
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<tr>
<td>Return to work (number of days)</td>
<td>1 RCT; n=157; WMD 4.24, 95% CI 2.42 to 6.06</td>
<td></td>
<td></td>
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<tr>
<td>Elastic bandage vs semirigid brace</td>
<td>1 RCT; n=84; RR 9.60, 95% CI 6.34 to 12.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuming sport activity</td>
<td>1 RCT; n=104; RR 8.00, 95% CI 1.03 to 62.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elastic bandage vs semirigid brace (subjective)</td>
<td>Instability 1 RCT; n=84; RR 9.60, 95% CI 6.34 to 12.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complications (ie, skin irritations)</td>
<td>1 RCT; n=84; RR 9.60, 95% CI 6.34 to 12.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elastic bandage vs tape</td>
<td>2 RCTs; n=208; RR 0.11, 95% CI 0.01 to 0.96</td>
<td></td>
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</tr>
</tbody>
</table>

*The effects per comparison are in favour of the former interventions. RCT, randomised controlled trials; WMD, weighted mean difference.

Optimal functional treatment after acute ankle injuries

A systematic review (9 RCTs, N=892) investigated the effect of different functional treatments for acute ankle injuries such as exercise therapy and immobilisation by means of tape or brace (Level 2) (see table 4). Elastic bandages gave fewer complications than tape, but was associated with a delayed return to work and sports. Instability was reported more frequently compared with a semirigid ankle brace. A lace-up brace or a semirigid brace seems preferable to the use of an elastic bandage (Level 2). However, in this review, insufficient data were present to draw definite conclusions from literature.

A lace-up brace or a semirigid brace is preferable and recommended.

Based on consensus in the committee in (professional) sports also the use of tape can be considered.

Exercise therapy after acute inversion injury

Besides three recent RCTs, four systematic reviews of sufficient quality were found on this subject. Exercise therapy seems to prevent a recurrence in patients with LAI (2 RCTs, n=130) (RR 0.37; 95% CI 0.18 to 0.74) on the long term (3 to 12 months) (Level 2). Exercise therapy seems to have no (significant) effect on balance on the medium term (6 to 9 months) (2 RCTs, n=78) (SMD 0.38; 95% CI -0.15 to 0.91) (Level 2).

Exercise therapy should be used in the treatment of LAI.

Exercise therapy can also be applied at home.

Manual mobilisation after acute ankle injuries

Three systematic reviews were identified. The most recent review included all trials from the other two reviews. There are limited positive (very) short-term effects (dorsiflexion, ROM, proprioception) in favour of manual mobilisation of the ankle (6 RCTs, N=224) (Level 2). However, the clinical relevance of these findings is limited since the effects had disappeared 2 weeks after injury.

Manual mobilisation of the ankle has limited added value and is not recommended.

Other therapies after acute ankle injuries

In literature, no effect was found of ultrasound, laser therapy and electrotherapy in the treatment of acute ankle injuries (Level 1). Short-wave therapy also seems ineffective (Level 2).

Ultrasound, laser and electrotherapy have no added value and are not recommended.

use of ultrasound and MRI examination and their diagnostic performance is hampered by lack of research (Level 4). Arthrography within 48 h after an inversion trauma is highly sensitive but not recommended (Level 2).

For a solid diagnosis of an ankle ligament rupture, patients must be re-examined 4 to 5 days after the trauma.

If a haematoma develops and patients experience local pressure pain at palpation or a positive anterior drawer test is present or both, it is very likely that a ligament rupture exists.

Treatment

The use of ice and compression in the inflammatory phase after acute ankle injuries

In the event of an acute ankle injury, the effect of ice (cryotherapy) is unclear. Ice combined with exercise therapy has a positive effect on the swelling in comparison with heat application. The effectiveness of compression shows conflicting results (Level 2). Intermittent application of ice has a significant effect on short-term pain reduction (difference ± 1 cm in a visual analogue scale) in comparison with standard application of ice. There are no indications that the use of ice only is effective to reduce swelling, increase function and reduce pain at rest in the event of an acute ankle injury (Level 2). The use of ice and compression, in combination with rest and elevation, is an important aspect of treatment in the acute phase of LAI.

Immobilisation after acute ankle injuries

Research from a systematic review (21 randomised controlled trials (RCTs), N=2184) showed that a longer period of immobilisation in a lower leg cast (minimum of 4 weeks) is less effective compared with different functional treatments (Level 2) (see table 3). However, due to great variation in methodological quality, the conclusions from this review should be interpreted with some caution (Level 2). Recent evidence from 1 RCT (N=584) states that a short period of plaster immobilisation (10 days) or rigid support for reduction of pain and swelling can still be considered of help in the treatment of LAI.

A short period of plaster immobilisation or similar rigid support facilitating a rapid decrease of pain and swelling can be helpful in the acute phase of the treatment of LAI.

Functional treatment for 4 to 6 weeks is preferable to immobilisation in a cast.
Communication between healthcare professionals

In order to be able to effectively refine communication between healthcare professionals during referral of patients with LAI, the essential information has been inventoried by consensus of the guideline committee. A distinction was made between the diagnostic phase, the treatment phase and the guidance phase. The available to give a final judgement on the effectiveness of surgery compared with conservative treatment in LAI (20 RCTs, N=2562) (Level 2).65 However, final conclusion from this review was that there are insufficient high-quality RCTs

Table 5 Checklist. Essential information for healthcare professionals during referral of patient with LAI, ADL

<table>
<thead>
<tr>
<th>Medical discipline</th>
<th>Diagnostic phase</th>
<th>Acute treatment phase</th>
<th>Guidance phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency physician</td>
<td>Time of accident</td>
<td>(Differential) diagnosis</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Trauma mechanism</td>
<td>Time schedule and treatment plan</td>
<td>Result of treatment</td>
</tr>
<tr>
<td></td>
<td>Age, profession, hobby</td>
<td>Advise follow-up visit</td>
<td>Advise on ADL and sports participation</td>
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<tr>
<td></td>
<td>Man, woman</td>
<td>Duration of rest</td>
<td></td>
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<tr>
<td></td>
<td>Ability to walk after trauma</td>
<td>When normal weight-bearing allowed</td>
<td></td>
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<tr>
<td></td>
<td>Therapy until visit</td>
<td>Thrombosis prophylaxis yes/no</td>
<td></td>
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<tr>
<td></td>
<td>Concomitant symptoms</td>
<td>What to do with deviant drift of symptoms</td>
<td></td>
</tr>
<tr>
<td>Sports masseur, physical therapist</td>
<td>Time of accident</td>
<td>(Differential) diagnosis</td>
<td>Diagnosis</td>
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<td></td>
<td>Trauma mechanism</td>
<td>Time schedule and treatment plan</td>
<td>Result of treatment</td>
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<td>Age, profession, hobby</td>
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<tr>
<td></td>
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<td>Thrombosis prophylaxis yes/no</td>
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<td></td>
<td>Concomitant symptoms</td>
<td>What to do with deviant drift of symptoms</td>
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<tr>
<td>Sports physician, general practitioner</td>
<td>Time of accident</td>
<td>(Differential) diagnosis</td>
<td>Diagnosis</td>
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<tr>
<td></td>
<td>Trauma mechanism</td>
<td>Time schedule and treatment plan</td>
<td>Result of treatment</td>
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<tr>
<td></td>
<td>Age, profession, hobby</td>
<td>Advise follow-up visit</td>
<td>Advise on ADL and sports participation</td>
</tr>
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<td></td>
<td>Man, woman</td>
<td>Duration of rest</td>
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<tr>
<td></td>
<td>Ability to walk after trauma</td>
<td>When normal weight-bearing allowed</td>
<td></td>
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<tr>
<td></td>
<td>Therapy until visit</td>
<td>Thrombosis prophylaxis yes/no</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concomitant symptoms</td>
<td>What to do with deviant drift of symptoms</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic and trauma surgeon</td>
<td>Time of accident</td>
<td>Fracture yes/no</td>
<td>Diagnosis</td>
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<tr>
<td></td>
<td>Trauma mechanism</td>
<td>Treatment options</td>
<td>Therapy</td>
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<td></td>
<td>Age, profession, hobby</td>
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<td>Time schedule and treatment plan/ result</td>
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<td></td>
<td>Man, woman</td>
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<td>Advise on ADL and sports participation</td>
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<td></td>
<td>Ability to walk after trauma</td>
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<td>Advise follow-up visit</td>
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<td></td>
<td>Therapy until visit</td>
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<td>Medication</td>
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<td>Concomitant symptoms</td>
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<td>Prognosis</td>
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<td>Reintegration protocol</td>
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<td>Radiologist</td>
<td>Time of accident</td>
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<td>Diagnosis</td>
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<td>Trauma mechanism</td>
<td>Concomitant pathology</td>
<td>Therapy</td>
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<td>Age, profession, hobby</td>
<td></td>
<td>Time schedule and treatment plan/ result</td>
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<tr>
<td></td>
<td>Man, woman</td>
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<td>Advise on ADL and sports participation</td>
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<td>Ability to walk after trauma</td>
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<td></td>
<td>Therapy until visit</td>
<td></td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td>Concomitant symptoms</td>
<td></td>
<td>Prognosis</td>
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<tr>
<td>Medical officer, insurance medical officer</td>
<td>Time of accident</td>
<td></td>
<td>Diagnosis</td>
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<td></td>
<td>Trauma mechanism</td>
<td></td>
<td>Therapy</td>
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<td></td>
<td></td>
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<td>Reintegration protocol</td>
</tr>
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</table>

ADL, activities of daily living; LAI, lateral ankle injury.

Surgical therapy after acute lateral ankle ligament injury

A systematic review concluded that there was some limited evidence for longer recovery times, and higher incidences of ankle stiffness, impaired ankle mobility and complications after surgical treatment (20 RCTs, N=2562) (Level 2).65 However, final conclusion from this review was that there are insufficient high-quality RCTs available to give a final judgement on the effectiveness of surgery compared with conservative treatment in LAI (20 RCTs, N=2562) (Level 2).65 Functional treatment is preferred over surgical therapy.

Based on consensus in the committee, it is recommended that in (top-professional) sports surgical treatment can be considered on an individual basis.
different disciplines involved in communication are emergency physician, sports masseur and physical therapist, sports physician and general practitioner, orthopaedic and trauma surgeon, radiologist, medical officer for occupational medicine and rehabilitation physicians.

Communication between healthcare professionals involved in the treatment of LAI can be short and effective, if the referring professional takes care to exactly provide the correct information.

The use of the information checklist will refine communication between healthcare professionals involved in the treatment of patients with LAI (table 5) and is recommended.

Prevention

Exercise therapy

Besides one recent RCT,66 one systematic review reports that exercise therapy shows no significant beneficial effect on balance on midterm (6 to 9 months) follow-up in patients with LAI (Level 2) (2 RCTs, N=1577) (SMD 0.38; 95% CI −0.15 to 0.91). Also training coordination and balance have no effect on the prevention of primary (first) inversion injuries of the ankle in athletes (Level 2).11 67 68 However, the results of two RCTs and two systematic reviews suggest that training coordination and balance does prevent recurrence of ankle injuries in athletes up to 12 months postinjury (Level 2).1 13 54 69

After LAI, it is recommended to train balance and coordination, especially among athletes, starting within 12 months after the occurrence of the injury.

Exercise therapy should be included as much as possible into regular training activities or at home to prevent recurrences or both.

Tape or brace to prevent inversion injury

The results from three systematic reviews suggest that the use of a brace and tape reduces the risk of recurrent inversion injuries in those who are active in sports (Level 2) (5 RCTs, N=2858) (RR 0.53, 95% CI 0.40 to 0.69).1 70 71 However, it is unclear whether a brace is more effective than a tape (Level 2).1 48 72 The preference for the choice of a brace or a tape depends on the individual situation. Due to considerations about practical usability and evaluation of costs, a brace is initially preferable to a tape.

It is recommended to use a brace or a tape to prevent a relapse.

The use of a brace or a tape is a personal choice. On the basis of practical usability and evaluation of costs, a brace is initially the preferable means of support.

It is recommended to phase out the use of brace or tape in time.

Preventive effect of footwear

Two systematic reviews (3 RCTs, N=3410) found no differences in protective effect of either high-fitted or low-fitted work- or sport shoes to avoid (recurrent) LAI (Level 2).1 70 73

No recommendations can be made concerning the type of shoes to prevent recurrence of ankle ligament injury.

Resuming work

One systematic review (2 RCTs, N=159) concluded that workers who use a semi-rigid ankle brace seem to resume work faster than workers who use an elastic bandage (Level 2) (4.2 days; 95% CI 2.4 to 6.1 days).46 Discrimination between the degrees of injury can support the initial treatment and prognosis in relation to return to work (Level 4).74 A resumption of work strategy and a return to work schedule, which takes into account the task requirements, can contribute to optimise reintegration towards work (Level 3) (table 6).75 76

Workers with LAI should preferably be treated with a brace to speed up work resumption.

Sport resumption

In the Netherlands about 3.5 million athletes annually have a sports injury, of which 1.4 million seek medical treatment. Sixteen per cent of all sports injuries (570,000) are ankle injuries and 26,000 athletes with ankle injuries are treated in the emergency room of a hospital annually.77 Distortion of the ankle as well as a lateral ankle ligament rupture can lead to a disturbance in proprioception through which a functional instability may arise. This disturbance seems to be hosted in the central nervous system above the level of the spinal reflex (Level 2).21 78 79 A delayed response time of the peroneal muscle may occur as a result of (traction) injury of the peroneal nerve. It seems that motor-unit insufficiencies after a distortion are less long lasting than those after LAI (Level 2).80 81

Another effect may be strength reduction of extensor muscles (used in eversion) and other muscles around the ankle. These muscles may benefit significantly from a strength training programme (Level 2).84 85

Rehabilitation of athletes after LAI must be the result of a variety of exercises in which proprioception, strength, coordination and function of the extremity are maintained.

DISCUSSION

A clinical guideline for acute lateral ankle ligament injury was developed under the auspices of the Royal Dutch Society for Physical Therapy by a group including content experts for all specialties involved, methodologists experienced in developing guidelines, health professionals involved in the healthcare process and patients. The idea behind guidelines is to provide a considered, unbiased, evidence-based, accessible, transparent and easy-to-use summary of the implications of current health knowledge for practice, which, if used, should improve the quality of care.89

Guideline development is essential in improving ‘evidence-based practice’, but development is a complex process. Even good guidelines have tended to lie on shelves gathering dust because of the difficulty of distinguishing them from bad ones. At the start of this project, a limited set of relevant questions from daily clinical practice was selected to be answered by the guideline. Consequently, a possible weakness of the guideline is identified in the fact that there are still some issues open for debate. Another possible flaw is that even though the recommendations in this guideline are based on best evidence from literature, ultimately converting the evidence into recommendations was a consensus process among the committee members, leaving room for bias. However, having all relevant health professionals involved in the guideline committee has probably limited this bias.

A definite strength of the current guideline is that essential referral data are now available.
The incidence and trauma mechanism of lateral ankle injury (LAI) are known. A variety of therapeutic interventions is available for restoring stability and diminishing pain and swelling in patients with LAI. There is still no uniform treatment of LAI despite the large number of clinical trials.

This guideline incorporates a perspective from several healthcare professionals and patients with the clinical evidence to formulate a guideline concerning LAI.

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Consensus statement


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