CASE REPORT

Closed posteromedial dislocation of the tibiotalar joint without fracture in a basketball player

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Acute ankle injury is one of the most common problems in sports medicine. Although most are ankle sprains, dislocations are occasionally seen. The case is presented of a closed posteromedial ankle dislocation without fracture which occurred during a basketball match. The literature is also reviewed.

CASE REPORT

A 14 year old boy injured his right ankle while playing basketball in a school match. Physical examination showed a deformed ankle with no evidence of open injury. The foot was medially displaced. Pedal pulses were present and no hypoesthesia. The lateral skin of the ankle was taut and ecchymotic. There were no other injuries. Roentgenograms of the ankle showed a posteromedial dislocation of the ankle joint without fracture or widening of the tibiofibular syndesmosis (fig 1).

An immediate closed reduction of the ankle joint was performed in the operating room under general anaesthesia. Fluoroscopic examination with stress applied to the ankle did not show any widening of the syndesmosis. The ankle was immobilised in a short leg cast. Radiographs showed that the dislocation had been satisfactorily reduced (fig 2). The cast was kept on for eight weeks, and range of motion exercises were then initiated and walking with partial weight bearing. Full weight bearing was permitted at 12 weeks.

The patient had an uneventful treatment course. Two years after the injury, he was pain free. On physical examination, plantar flexion of the right ankle was 10° less than of the left ankle, and there was minimal swelling of the examination. Anterolateral tibiotalar joint instability was not detected on physical examination or on stress radiographs of the ankle joint. Radiographs showed soft tissue calcification under the medial malleolus (fig 3).

DISCUSSION

Posteromedial dislocation of the tibiotalar joint without fracture is an unusual injury. Wilson et al.1 reported 16 cases in 1939, and since then, cases have been reported sporadically. Toohey and Worsing2 have reported the largest series: 19 cases. There are a few references in the literature to closed posteromedial injuries.3

Fahy and Murphy4 classified talotibial dislocations into five types based on the direction of the dislocation: anterior, posterior, medial, lateral, or superior combined. Total superior displacement of the talus is rare.

Talotibial dislocation with an intact ankle mortise and without concomitant fracture may occur if the ankle sustains a combination of inversion and axial loading forces while the foot is in maximal plantar flexion.5 This is supported by the experiments of Fernandes6 who reproduced this form of dislocation in cadavers. He found that the talus could be dislocated medially or laterally without associated tibial or fibular fracture by placing an inversion or eversion stress on a maximally plantar flexed foot. The support structures that were torn during his experiments were the anterolateral aspect of the anterior talofibular and calcaneofibular ligaments. Fernandes postulated that, once the ankle had been dislocated, the talus and the foot were pulled posteriorly by the calcaneal tendon.

Garrick7 reported that 45% of basketball injuries, 25% of volleyball injuries, and 31% of soccer injuries are to the ankle.8 Although most acute ankle injuries in sports medicine are sprains, dislocations are occasionally seen. Ankle dislocations are caused primarily by motor vehicle accidents, particularly motorcycle accidents. The second most common cause is sports trauma.1,9,10 Ankle dislocations are more commonly seen in volleyball and basketball because jumping is a fundamental component of these sports. Closed injuries are reported to be more common. Medial malleolus shortness or lack of coverage of the talus, ligamentous laxity, previous sprains, and weakness of the peroneal muscle are predisposing factors in the pathogenesis of talotibial dislocations.6,10–11 Medial malleolus shortness is the ratio between the length of the medial and the lateral malleolus in a anteroposterior ankle radiograph, and coverage of the talus is evaluated on lateral ankle radiographs as the ratio between two angles (β/α) as described by Elise et al.10 Elise et al.10 reported shortness of the medial malleolus in two cases of ankle dislocation. Rivera et al.11 noted that a patient who experienced a posterior dislocation reported previous ankle sprains and medial malleolus hypoplasia. Rivera et al.11 and Elise et al.10 both reported that coverage of the talus was normal in all their cases. Our patient had no previous ankle injury. In an anteroposterior ankle radiograph, the ratio between the length of the medial (B) and lateral (A) malleolus evaluated by the method of Elise et al.10 was normal (0.58). In the lateral ankle radiograph, the ratio between the β angle, which lies between two lines projected from the centre of the talus through its anterior and posterior articular ridge, and the α angle, which lies between two lines projected from the centre of the talus through the anterior and posterior articular ridge of the tibia, is evaluated as the coverage of the talus. This index was normal (0.59) in our patient.

Most authors recommend closed reduction, cast immobilisation, and several weeks of non-weight bearing in the treatment of both open and closed talotibial dislocations.6,8 In the absence of complications, the reduction must be performed under general anaesthesia to permit complete relaxation of the muscles. An open dislocation permits exploration and repair of the ligamentous injuries, but the repair of disrupted ligamentous structures is more controversial. Colville et al.12 believe that repair of lateral, but not medial, ligaments should be performed in open injuries at the time of initial debridement. Mestdagh and Larzul13 reported that surgical repair of torn ligaments in two cases did not appear to improve their results. Elise et al.10 described seven
patients with open ankle dislocation treated by surgical debridement and ligament repair. Temporary transplantar pinning was required because of instability of the initial reduction in two of the seven patients. Wroble et al., however, state that ligamentous repair does not affect function, and they do not recommend it. Kelly and Peterson and Fahey and Murphy report syndesmotic disruption with these injuries, but neither group recommends any treatment beyond reduction and cast immobilisation.

Complications are rarely seen in talotibial dislocations. Vascular injuries of the dorsalis pedis artery, neurological injuries of the tibial nerve, superficial nerve, and sural nerve are seen occasionally. In addition to neurovascular complications, a 5–10° loss in the range of dorsiflexion, joint stiffness, and capsular calcification can be seen as late complications. Elise et al. reported degenerative arthritis in 25% of cases, especially after open dislocations or if transplantar pinning was used after the initial reduction. Rivera et al. reported numbness on the dorsal face of the hallux and the forefoot in one patient. In the series of Elise et al., the incidence of paraesthesia in the region of the anterior tibial nerve or intermediary cutaneous nerve was 25%. In our patient, no neurovascular complications were seen, but plantar flexion of the right ankle was 10° less than that of the left ankle. Anterolateral talotibial joint instability was not detected on physical examination or on stress radiographs of the ankle joint at follow up. Soft tissue calcification was detected radiologically under the medial malleolus.

The long term prognosis of talotibial dislocations without fracture is good. Emergency reduction and cast immobilisation produces a positive result in most cases. Our patient was playing basketball without any problems with his ankle two years later.

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Accepted 28 April 2003

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