

DISLOCATION OF THE SUPERIOR TIBIO-FIBULAR JOINT — an unusual soccer injury

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Isolated dislocation of the superior tibio-fibular joint is a rare injury, usually produced by major forces, e.g. parachute jumping (Lord & Coutts 1944). Tenderness over the fibular head is occasionally encountered in sportsmen due to minor degrees of subluxation, but frank dislocations after minor trauma at soccer are unreported.

Case History

C.C., twenty-seven years, Oxford United's centre-back, jumping unchallenged to clear a bouncing ball at Roker Park, fell onto his left leg and experienced a severe pain on the outer aspect of the left knee. On examination there was an obvious prominence two centimetres lateral to the tibial tubercle with the biceps tendon and lateral ligament stretched as tight cords around the external tibial condyle. X-rays revealed undue prominence of the fibular head in an anterior position, with no evidence of shaft fracture. Reduction was carried out under local anaesthesia by fully flexing the knee and applying pressure to the fibular head in an antero-posterior direction; an audible grating was heard as the normal smooth outline of the lateral tibial margin reappeared. Immediately the paraesthesia in the distribution of the peroneal nerve disappeared. The leg was rested in a thick crepe and wool support for twenty-four hours, then a full length plaster including ankle for ten days to allow soft tissue healing. Gentle knee flexion was encouraged at twelve days, and ball kicking with an extended knee at sixteen days. The player took part in an Anglo-Italian match twenty-eight days after the injury, having had one prior reserve outing at twenty-five days. From the start the emphasis was on remedial exercises to maintain muscle bulk and power, and apart from an initial forty-eight hours rest, the player worked hard at physical therapy.

Discussion

Dislocation of the fibular head can occur in anterior, posterior and superior directions (Lyle 1925), although anterior is the most common. Most dislocations are caused by a fall with the leg flexed and adducted, with inversion at the ankle. The rotation of the talus puts stress on the fibular head via the shaft. The resulting torque tears the posterior tibiofibular ligament, and the fibula slips forwards due to the pull of the peroneal muscles and the intact anterior ligament. The key to successful reduction lies in maximal flexion of the knee which relaxes the biceps femoris. If recurrence becomes a problem then screw fixation has been advocated (Dennis & Rutledge 1958).



Fig. 1. The X-ray of the left knee shows the fibular head to be displaced anterior to the tibial condyle. Compare with its more sheltered position on the right.

REFERENCES

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