

A Patient's Guide to a Sprained Ankle

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A PATIENT'S GUIDE TO A SPRAINED ANKLE

THE FOLLOWING INFORMATION SHEET HAS BEEN PRODUCED TO PROVIDE OUR PATIENTS WITH AN OVERVIEW OF THEIR CONDITION AND WHAT TREATMENTS THEY MAY EXPECT. HOWEVER, EACH PERSON IS DIFFERENT AND THE TREATMENT YOU ARE OFFERED WILL DEPEND ON YOUR UNIQUE CIRCUMSTANCES.

What is a sprained ankle?

The ankle is a hinge joint between the leg and the foot. It allows up and down, and side to side movements. The stability is provided by strong ligaments either side of the ankle. The ligaments on the outside of the ankle are called the lateral ligaments. There are three ligaments that make up the lateral ligament complex, and they connect the fibula (the prominent bone on the outside of the ankle) to the talus (ankle bone) and calcaneus (heel bone). They are known as the anterior talofibular ligament (ATFL), calcaneofibular ligament (CFL) and posterior talofibular ligament (PTFL). If the ankle is twisted more than the ligaments allow, the ligaments can become stretched or torn. This is known as a sprained ankle.

What are the grades of injury?

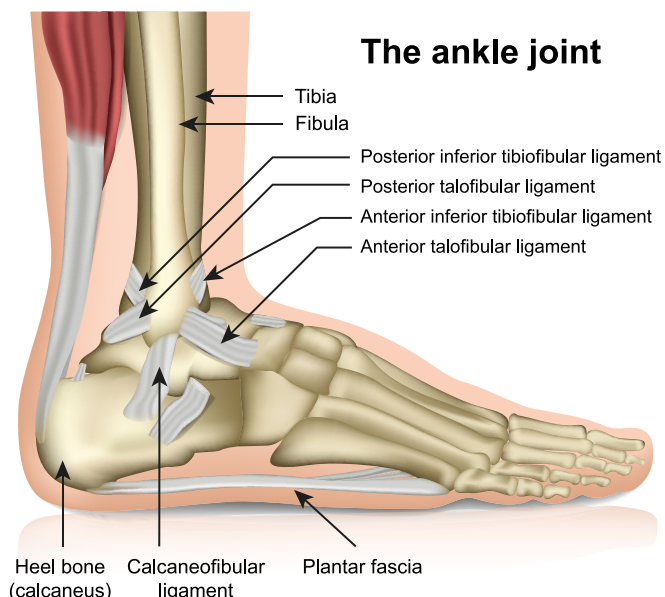
Ankle sprains can be graded I, II or III depending upon how severe the injury is. The majority of sprains are Grade I which means that the ligament is stretched but not visibly torn. The next most common injury is Grade II where the ligament is partly torn. The most severe injury is Grade III which represents a complete tear but fortunately this is also the least common. Although the initial severity is a factor in long-term outcome, there are many other factors such as a history of repeated ankle sprains, underlying joint mobility disorders and adherence to rehabilitation which are equally important.

How is a sprained ankle treated initially?

Most sprained ankles will heal by themselves especially if symptoms are starting to settle within a few days. If you feel the ankle is not improving or is in fact getting worse, it should be looked at to confirm the injury, make sure you have not broken any bones and to start the right treatment.

Early treatment will focus on supporting the ankle and this can be done using either an ankle brace or a special walking boot. This will be influenced by how bad your surgeon feels your injury is and how much swelling and pain you have.

If used, the ankle brace or walking boot will typically be needed for four to six weeks. They keep the ankle in the right position whilst the stretched or torn ligaments start to heal. After this time, exercises or supervised physiotherapy is useful to help 're-train' the ankle. Often the leg will have lost muscle bulk whilst protected in the ankle brace or walking boot, and this needs to not only be built up but regain muscle memory to ensure the ankle does not inadvertently twist and re-injure itself.





How long does recovery take?

Recovery is dependent on many factors. Most ankle sprains will start to feel better within six weeks but some can take months and even longer. Evidence suggests that one in three patients will still have some pain and instability (feeling that the ankle wants to roll over by itself) at one year after an injury.

What happens if my ankle does not get better?

Your surgeon will reassess the extent of injury if your symptoms persist. This will be undertaken by discussing your symptoms and examining you. Occasionally further imaging such a MRI scan is needed but this is not always necessary.

Possible causes for ongoing symptoms are that the ligament not healed properly, that there is scar or inflamed tissue in the ankle or there is an injury to the cartilage which is the lining of the ankle joint.

The treatment will then be based upon what the problem is, and surgery may be suggested involving either a reconstruction of the ligaments, keyhole surgery (arthroscopy) or both.

What does a ligament reconstruction involve?

This operation is usually performed under a general anaesthetic. An incision (cut) is made over the outside of the ankle. The stretched ligament is cut and then overlapped and sewn together again to restore tension. A thick band of tissue called the extensor retinaculum is sewn over the top, further re-enforcing it. Depending upon your level of function and the quality of your tissues, a synthetic 'tape' may be also inserted for additional security. The operation may be combined with an arthroscopy (see next page). The skin is then carefully sewn up and a plaster cast is applied from below the knee to the ball of the foot. You will typically remain in plaster for two to four weeks and in an ankle brace for up to eight weeks after this.



What does an arthroscopy (keyhole) surgery involve?

This operation is usually performed under a general anaesthetic. Two incisions are made over the front of the ankle. One incision allows a camera to look inside the ankle joint and the other incision allows instruments inside the ankle to perform tasks. Scar tissue, loose flaps of cartilage and inflamed tissue can be shaved away, and bone spurs can be burred. If you have a cartilage injury, small holes may be made in the bone (microfracture) to stimulate formation of new cartilage. The operation may be combined with a ligament reconstruction (see previous page). The skin is then sewn up and if only an arthroscopy has been performed, wool and crepe bandaging will be applied around the ankle. You will typically remain in this for two weeks and then start to get ankle moving more.

Out-patient review

You will be referred for physiotherapy following your surgery, in order to reduce swelling, encourage movement, and regain strength, balance, function and stability. Physiotherapy is an essential part of your treatment. Without this, you have a higher risk of re-spraining your ankle.

Getting back to normal

Returning to work: If your job is mostly sitting, you may be allowed back to work after four weeks, provided you can keep the leg elevated. However, if your job is more physical and involves long periods on your feet, then it may take longer.

Walking: You should be out of dressings/boot/plaster cast and walking with all your weight on the ankle by six weeks. However, this will depend on whether the surgeon has placed any specific restrictions on you and it may take longer.

Driving: If you have an automatic car and have had surgery on the left ankle, you can usually drive by two weeks after your operation. Otherwise, it may take about two months to be able to drive. In order to be safe to drive, you must be able to perform an emergency stop. Also, you must inform your insurance company about the type of operation that you have undergone to ensure that your cover is valid.

Sport: Resuming sporting activity depends on your operation and how quickly your strength, movement and balance recover. Generally you can return to low impact sports between three and six months after your operation, but returning to high impact sports can take up to a year.

Things to look out for

Swelling – you should expect some swelling after your operation. If swelling persists or worsens and you are concerned, call Stanmore Foot and Ankle specialists or your GP for advice.

Infection – all operations carry a risk of infection.

Fortunately surgery for ligament and cartilage injuries is low risk. A small number of patients do develop wound infections and these normally improve after a short course of antibiotics. Rarely, the infection may be more severe and require further surgery to remove infected tissue and administer a longer course of antibiotics.

Blood clots – Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE) are the medical terms to describe a blood clot in the legs or lung respectively. They are uncommon but you should inform your surgeon if you have had a DVT or PE in the past or if you have a family history of clotting disorders. You will be given an anti-embolic stocking to wear on your other leg and daily blood thinning medications if your leg is in plaster.

Numbness or tingling – this can occur at the surgical site(s) if the nerves which are very fine by the stage they reach the ankle are cut or stretched. Symptoms are usually temporary although patchy numbness or sensitised areas may be permanent. In rare circumstances the nerves can become hypersensitive, in a condition called Complex Regional Pain Syndrome. This can lead to severe pain as well as colour and temperature changes in the foot. If this happens, your surgeon will discuss treatment with you.

Wound healing – infections, poor blood supply and underlying health conditions such as diabetes can lead to problems with your wound. If this is the case, more frequent wound dressings may be required to ensure that the wound does not break down.

Scarring – all surgeries will leave a scar and occasionally this can cause pain and irritation. Massaging the wound with either simple creams or silicone gels for scar reduction can be helpful.

Report severe pain, massive swelling, chest pain, excessive numbness or pins and needles.





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