JCUH Department of Trauma & Orthopaedics

Ankle Fracture Management

A guide to perioperative management and rehabilitation

April 2019

This guideline has been developed to streamline the management of ankle fractures at the Department of Trauma and Orthopaedics at James Cook University Hospital.

There are preoperative elements as well as suggestions for intraoperative management and postoperative rehabilitation. This document follows the principles of the BOAST for ankle fractures (https://www.boa.ac.uk/wp-content/uploads/2016/09/BOAST-12-Ankle-Fractures.pdf). It forms the default for ankle fracture management except for those with syndesmotic reconstruction, significant neuropathy or open injuries.

Preoperative management

- All patients with ankle fractures must be seen by the on call team, fully clerked and where applicable consented. Their details must be placed onto Bluespier with a contact telephone number. All relevant elements of the history should be placed on Bluespier. Complete the "full clerk" on Bluespier, including fracture classification.
- All patients must have a documented thrombosis risk assessment recorded and appropriate action taken depending on the result.
- All patients that are admitted should be strictly elevated and have a Geko device applied.
- No patients should be made 'nil by mouth' unless immediate surgery is planned.
- All patients placed in a cast must have a radiograph taken following application.
- All patients with fractures involving the syndesmosis and / or the posterior malleolus should have a CT performed preoperatively.

Operative management

- Prompt operating where able is encouraged.
- All ankle fracture operations must be supervised by a Consultant.
- All ankle fractures are to have the skin prepared using TraumaPrep
- All ankle fractures should have an Ioban applied to the skin.
- The use of tourniquet **is not** encouraged.
- All ankle fractures should have the skin closed using interrupted, **not** absorbable sutures. All wounds to be covered with a simple adherent dressing.

- The use of fibula locking plates should be limited to specific indications only and only by consultant decision.
- All patients under 55 should be placed in a below knee resting backslab intraoperatively.
- All patients over 55 should be placed in a below knee resting backslab intraoperatively. They should then be changed to a below knee weightbearing plaster on the second postoperative day.
- All patients must have the immediate and 'on discharge' instructions documented in the operation note and this must include weightbearing plan (unless default) and plans for wound care and anticoagulation.

Postoperative management

- All patients under 55 years of age will be made non-weightbearing in a backslab and discharged on anticoagulation as per trust protocol.
- All patients over 55 will be made weightbearing as tolerated (WBAT) from the second postoperative day once the weightbearing cast has been applied and discharged on anticoagulation as per trust protocol.
- All patients will be seen at two weeks postoperatively in the clinic. Sutures will be removed. Casts will be discontinued and all patients will be placed into a removable boot. WBAT is encouraged for all ankle fractures other than those excluded above.
- No radiographs to be performed at the two-week clinic visit.
- Anticoagulation to continue at clinicians discretion and based upon risk stratification and documented discussion with the patient on an individual case basis.
- All patients to be reviewed at six weeks postoperatively and a radiograph should be taken. Advice should be given regarding return to activities and all patients should be considered for discharge to physiotherapy.
- Any patient with a wound problem at any point in the postoperative course to be reviewed by the consultant in charge of the case or another senior doctor within 48h of diagnosis of a complication. All patients with a postoperative wound issue to be referred into the limb reconstruction / orthoplastic service via Mr Eardley's secretary as per the BOAST guidance on fracture related infection.