DR SIMON ZILKO
ORTHOPAEDIC FOOT + ANKLE SURGEON

Posterior Hindfoot Arthroscopy

INTRODUCTION

Posterior ankle impingement is pain at the back of the ankle generally caused by a prominent piece of bone. This abnormal bone is usually an unfused bone ossicle (os trigonum) or an enlarged posterolateral talus (Stieda process). Forced or repeated plantarflexion of the ankle causes inflammation of the abnormal bone and surrounding soft tissues, and occurs mainly in AFL and soccer players, ballet dancers and runners. Once impingement is chronic, removal of the abnormal bone and inflammatory tissue is usually effective at relieving pain and allowing return to sport.

THE SURGERY

Posterior ankle arthroscopy involves a number of steps:

- General anaesthetic and IV antibiotics
- Prone position on the operating table
- Tourniquet around the thigh
- Two small incisions (~6mm) over back of ankle
- Insertion of arthroscope (camera) and keyhole surgery instruments to remove the abnormal bone and soft tissue
- Closure of incisions with sutures
- Local anaesthetic block
- Surgical camboot (VACOcast)

GUIDELINES FOR POST-OP RECOVERY

HOSPITAL ADMISSION

- In hospital for 1 night, non-weightbearing on day of surgery

FIRST 2 WEEKS

- Elevate foot and rest
- Full weightbearing as tolerated in surgical boot
- Surgical boot on at all times, including in bed and shower, except for exercises (below)
- From 7 days post-op, may come out of boot for gentle ankle and big toe range of movement exercises (avoid full plantarflexion position)
- Crutches for balance and support
- Dressings to stay dry and intact
- Strong painkillers as required
- Aspirin 100mg and Vitamin C 1g per day

2 WEEK POST-OP APPOINTMENT

- Review by nurse & removal of dressings and sutures

WEEK 3

- Daily scar massage (continue for 4 weeks)
- Podiatry/physiotherapy review (arrange first appointment 2-5 days after 2-week post-op check)
- **REHAB - PODIATRY/PHYSIOTHERAPY:**
  - Joint mobilisation, soft tissue manipulation
  - Transition from boot into supportive gym shoes
  - Modalities for swelling management (tubigrip, elevation, laser) and nerve desensitisation
  - Gait re-training
  - Low-level intrinsic foot strengthening
  - Active ROM (avoid full plantarflexion/impingement position)
  - Protect FHL, protect from overpronation (taping/orthotics as necessary)
  - Stationary bicycle
  - Proprioception re-training
  - Proximal neuromuscular re-training (coordination of hip external rotators, transverse abdominis and adductors)
  - Stretching for gastrocnemius/soleus/FHL muscles

WEEKS 4-5

- **PODIATRY/PHYSIOTHERAPY:**
  - Theraband progressive resistance exercises - emphasise full ROM with high reps/low weight
  - Closed chain plantarflexion exercises (start with PWB and progress to FWB and eccentrics)

6 WEEK POST-OP APPOINTMENT

- Review by Dr Zilko

FROM 6 WEEKS

- **PODIATRY/PHYSIOTHERAPY:**
  - Progress to full strength and endurance
  - Modified return to class/sport from 6 weeks
  - Functional testing from 8 weeks
  - *Ballet*: Pass functional tests for pointe (topple test, airplane test, sauté test)
  - Return to performance/play 9-12 weeks

Full recovery is usually 3-6 months.
Every patient's recovery is individual and depends on the severity of the injury/disease and complexity of the surgery.

FRACS Fellow of the Royal Australasian College of Surgeons
FAORTHA FELLOW of the AUSTRALIAN ORTHOPAEDIC ASSOCIATION

Dr Simon Zilko ABN 35 192 898 398
P 08 6166 3779 F 08 6316 3316
E admin@drsimonzilko.com.au
www.drsimonzilko.com.au

Wexford Medical Centre
Suite 64, Level 4,
3 Barry Marshall Pde,
Murdoch WA 6150

Hollywood Medical Centre
Suite 37, Level 1,
85 Monash Ave,
Nedlands WA 6009