Affinia Health Network

Ankle Pain

Suggested pre-referral evaluation and management guidelines:

1. Radiographs: ankle – non-weight bearing if suspected fracture, weight bearing for all other if possible.
   *Please note: Non-weight bearing radiographs will be repeated as weight bearing radiographs at OAM. Most foot and ankle conditions cannot be accurately diagnosed on non-weight bearing radiographs.
2. If no fracture;
   a. Ankle sprain
      i. If unable to weight bear, controlled ankle motion boot for 1-2 weeks, consider early referral but many improve
      ii. If able to weight bear, ankle stabilizing orthotic and physical therapy for Achilles stretching and ankle proprioception
      iii. Consider orthopaedic referral instead of MRI/CT if further work up seems indicated
   b. Ankle arthritis
      i. Controlled ankle motion boot or ankle stabilizing brace
      ii. NSAIDs (narcotics not recommended)
      iii. Topical diclofenac
      iv. If surgical intervention indicated, smoking cessation required. Ankle arthrodesis and arthroplasty have a high complication/failure rate in smokers
   c. Osteochondral lesions of talus
      i. Controlled ankle motion boot for 6 weeks and non weight bearing is the first line of treatment for nondisplaced without loose body
      ii. Medial osteochondral lesions typically atraumatic and can be bilateral
      iii. Consider early referral if symptomatic, CT/MRI eval depends on the lesion
   d. Chronic instability
      i. Physical therapy for peroneal tendon strengthening, ankle proprioception
      ii. Controlled ankle motion boot or ankle stabilizing brace
      iii. Often associated with cavovarus foot deformities, refer to orthopaedic foot and ankle for discussion of management
      iv. MRI can be indicated to rule out peroneal tendon tears
      v. Often requires orthopaedic foot and ankle referral for discussion of surgery, especially if >6months of symptoms and failure of above
   e. Peroneal tendon injury
      i. MRI ok to order to confirm diagnosis
      ii. Immobilize for 6 weeks in controlled ankle motion boot, protected weight bearing (crutches)
      iii. Commonly lead to surgical repair, consider early referral
   f. Gout
      i. Typically not treated surgically unless erosive changes on radiographs or large tophi present

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ii. If PCP uncomfortable with arthrocentesis for diagnosis, refer to foot and ankle orthopaedic surgeons for arthrocentesis. PCP to resume medical management once diagnosis is made.
iii. Foot and ankle surgeons are happy to perform intra-articular ankle glucocorticoid injections for cases of gout recalcitrant to medical management

Suggested Additional Test/Management:

1. Often appropriate to hold CT or MRI until referral to specialist
2. For instability, physical therapy and bracing should be considered prior to referral

Red Flags:

1. Inability to bear weight
2. Concern for syndesmotic injury (unable to bear weight, higher energy mechanism, more proximal pain)
3. Concern for Achilles tendon rupture
4. Diabetics with neuropathy and concern for Charcot
5. Any fracture

Patient Education:

1. The majority of acute ankle sprains are treated non-operatively. 6 months of non-operative treatment will be pursued prior to consideration of operative treatment for most cases.
2. Operative treatment of ankle arthritis will rarely be entertained in patients who use tobacco and are unwilling to quit. The failure/complication rate is unacceptably high
3. Physical therapy with ankle proprioception and stretching is important to minimize the risk of recurrence of ankle sprains

Appointment Time Frame

We strive to see all new patients within 2 weeks.

Contact

Phone: 231-733-1326
FAX: 231-733-5212

Clinic Location Sites

1400 Mercy Dr., Suite 100
Muskegon, MI 49444

1445 Sheldon Rd., Suite G1
Grand Haven, MI 49417