Surgical Intervention of Chronic Ankle Instability in a Male Collegiate Football Player  
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**Background:** The athlete is a 22 year old male football player. He complained of pain within the left ankle after an ankle sprain during preseason training for the upcoming football season, indicating a feeling of instability. Examination revealed pain along the anterior talofibular ligament (ATFL) along with painful passive and active range of motion. Inversion stress test was positive for pain and laxity. Generalized pain also existed throughout the talocral joint. Despite conservative treatment for a lateral ankle sprain, pain and instability remained unchanged. **Differential Diagnosis:** Chronic ankle instability due to multiple sprains. Peroneal subluxation. **Treatment:** An X-ray was taken two weeks after the start of preseason, which came back negative. The athlete was prescribed NSAIDs to help control his pain. A week later the athlete was casted for an ankle orthosis, but he complained of discomfort, indicating it provided little stability for him. Three days post fitting, the athlete received a cortisone injection in order to further reduce the inflammation. He indicated temporary pain relief, but it eventually returned. Further diagnostic tests were performed to determine the cause of the pain. An MRI was ordered and read by the team physician on August 20, 2009. Findings indicated the following: 1) an osteochondral defect on the lateral talar dome and associated cartilage loss, with no evidence of floating bodies, 2) increased calcification off the bone located on the lateral process of the talus and un-united ossification at the level of the medial malleolus, and 3) evident disruption of the ATFL, and rupture of the anterior tibiotalar ligaments. The signs of osteochondritis dissecans (OCD) and ATFL rupture, along with constant pain, were enough to justify surgery. Surgery included a shortening and suturing of the ATFL, via the Brostrom procedure, debridement of osteochondral spurs, and the insertion of seven pediatric bone plugs into his talus to address the OCD within the joint. The athlete was provided a boot and instructed to be non-weight bearing for four weeks. The athlete was then released to full weight bearing as tolerated while in the boot. Range of motion was the primary focus in rehabilitation at this time. Between seven and eight weeks post-surgery, the athlete was permitted to begin more functional rehabilitation, starting closed kinetic chain proprioception, strengthening exercises, and then more functional activity. The athlete has returned to play his final season. He complains of no pain, and feels increased stability compared to pre-surgery. **Uniqueness:** Athlete’s ankle was extremely unstable due to his torn ATFL, compounded by OCD and osteochondral spurs within the joint. Generally 10% of ankle sprains experience chronic instability and at this time, surgery may be needed. Also, conservative treatment of OCD is often recommended, but bone spurs respond poorly to conservative treatment. Therefore surgical treatment of the OCD was indicated as a result. **Conclusions:** This case illustrates the importance of exploring all possible treatments of an athlete with a history of instability or injury. If improvement is not seen with a given treatment plan, the astute clinician will begin to dig deeper into other possible causes. Since the athlete’s instability and pain was constant with little to no improvement, it would indicate that there is likely an underlying pathology. This case also addresses the importance of knowing the pathology of an injury, rather than simply
treating the symptoms which, unfortunately, can be a common practice in many clinics.

**Word Count:** 576