

METHODS OF REDUCING MEDIAL SUBTALAR JOINT DISLOCATION

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Introduction: Medial subtalar dislocation, accounts for the most frequency based on direction of dislocation, is the result of forceful inversion of the forefoot [1].

Discussion: A 53-year-old lady, whom her left foot slipped and trapped in a drain while walking on a street, presented with painful left ankle and was unable to weight bear. Clinically, her left ankle was grossly oedematous with a puncture wound over the lateral malleolar region, no neurovascular injuries. X-ray (Figure A) confirmed an open medial subtalar (talonavicular) joint dislocation and pseudojones fracture. Emergency wound debridement, open reduction of left ankle and K-wiring was done under spinal anaesthesia (Figure B). Intra-operatively, the wound was connected to the ankle joint, whereby arthrotomy washout was done, reduced spontaneously with axial traction. The ankle was immobilized for six weeks and subsequent follow up her AOFAS, ankle hindfoot score was 69 out of 100.

Conclusion: Majority of medial subtalar joint dislocation can be achieved by closed reduction; axial traction with the knee flexed and eversion of the foot, simultaneously the plantar in flexed position and then dorsiflexed finally [1]. Surgical reduction is rarely necessary; anteromedial approach by dissecting down to the talonavicular joint. Retractors were placed with care to avoid injury to tibialis anterior tendon or superficial peroneal nerve [2]. Anatomical structures include talonavicular joint capsule, extensor digitorum brevis (EDB), buttonholing of the talar head through EBD, dorsalis pedis arterial branches or deep peroneal nerve [3]. Subtalar joint dislocations, though trivial, can cause remarkable complications. Prompt reduction should be done immediately to prevent ankle stiffness and post-traumatic arthrosis.