How We do It. Trimalleolar Fractures: Fixing the Posterior Malleolus by Posterolateral Approach

Mandeep S Dhillon, Kamal Dureja, Sandeep Patel, Tungish Bansal

ABSTRACT

The understanding of trimalleolar fractures and, in particular, the posterior malleolus fragment has drastically evolved over the last decade. There has been a tilt in favor of fixing almost all posterior malleolus fragment in contrast to the old school thought of the 20th century. The concept of stability offered by posterior malleolus fixation to the syndesmotic stability is well understood now. Posterolateral approach has almost evolved as a gold standard approach for posterior malleolus fixation.

Keywords: Ankle fracture, Posterior malleolus, Posterolateral approach ankle.

INTRODUCTION

In the modern era, trimalleolar fractures are more commonly seen, and have been estimated to constitute 7 to 14% of all ankle fractures.1,2 Isolated posterior malleolus fractures are rare, constituting only 0.5 to 1% of the total. The presence of posterior malleolus fracture is a poor prognostic factor compared with other ankle fractures.3 The management of posterior malleolus fractures has been a subject of debate for a long time now. Previously, the size of the fragment (as seen on lateral radiograph) was taken as the sole criteria to decide whether fixation was needed. One-fourth to one-third involvement of the articular surface and a displacement of more than 2 mm were defined as criteria for fixation.4-6 In recent years, there has been a paradigm shift from this thought process. The importance of posterior syndesmosis stability and fibular notch congruence has been highlighted.7-8 The posterolateral approach has emerged as a viable option for fixation of posterior malleolus.9,10

In this article, we discuss the operative technique for fixation of posterior malleolus through posterolateral approach.

Utility: For internal fixation of the posterior malleolus (Fig. 1, X-ray).

Ideal: For internal fixation of distal fractures of fibula within 5 cm from tip of lateral malleolus.

PREOPERATIVE PLANNING

At the initial presentation, the patients are assessed for local skin condition and distal neurovascular status. Special note is made of any swelling, edema, blisters, or poor skin condition. Standard anteroposterior (AP), lateral, and mortise views of the ankle are obtained. The injuries to medial, lateral, and posterior malleolus are defined and any frank dislocation or subtle subluxation identified. A possible mechanism of injury based on Lauge-Hansen classification11 is identified, as this gives an idea of injury severity and fracture distracting forces. If the skin condition is poor or swelling present, we proceed with application of ankle spanning external fixator (Fig. 2) and wait for the skin condition to improve. Computed tomography (CT) scan of the affected ankle is obtained in all cases (postspanning if external fixator is applied). Standard axial, coronal, and sagittal cuts are obtained (Fig. 3); the axial and sagittal cuts are of most
value. The size of the fragment of posterior malleolus, comminution, and status of the syndesmosis is looked at and noted. The size of the posterior fragment is calculated as percentage area of the total tibial plafond in axial and sagittal cuts. We follow and classify the posterior malleolus as per Bartoníček et al.\(^2\)

**Three-dimensional CT Classification**

Once the skin condition improves and wrinkle sign appears, we proceed with fixation of the fractures. We fix all fractures of the posterior malleolus irrespective of the size of the fragment by open reduction and internal fixation by posterolateral approach to the ankle.

*Patient position:* Prone position (Fig. 4) is preferred, though in exceptional situations semiprone to lateral position is acceptable.

The patients are generally operated under general anesthesia in prone position laid on bolsters. The foot and ankle overhangs the distal edge of table. The knee is slightly flexed and a sterile bolster is placed underneath the legs in such a way that ankle dorsiflexion is not hindered. Proper unhindered AP and lateral views of ankle are confirmed with C-arm before draping. A tourniquet is applied. Posterior superior iliac crest is painted and draped in cases where we anticipate the need for bone graft.

**ANATOMICAL LANDMARKS**

Lateral malleolus is traced along posterior border proximally for 4 to 5 cm.

Lateral border of tendo achilles. These landmarks are marked as shown in Figure 5.

*The incision* is marked midway between lateral border of tendo achilles and posterior border of fibula.

**Variations**

- If only posterior malleolus is to be dealt and CT shows a major part of it medial to midline, incision can be placed closer to lateral border of tendo achilles.
If lateral malleolus fixation is to be dealt, a slight curve toward tip of lateral malleolus distally is helpful.

**Extension**

Though incision can be extended proximally, bulk of deep muscles of posterior compartment do not offer exposure of more than 5 to 6 cm of distal posterior tibia comfortably.

**Dissection**

The skin is incised superficially and subcutaneous plane is dissected by blunt dissection. Short saphanous vein and sural nerve cross the incision in proximal half from medial to lateral side. Both the structures are dissected in a way to be taken along with lateral skinfold to avoid injuring sural nerve.

Deep fascia is divided in line of skin incision.

Deep dissection is internervous plane created between flexor hallucis muscle on medial side (supplied by posterior tibial nerve) and peroneus longus (supplied by deep peroneal nerve) (Fig. 6A).

Sharp dissection is required to elevate flexor hallucis longus (FHL) from its origin from posterior border of distal fibula. The posterior surface of distal tibia is exposed and the posterior malleolar fragment carefully mobilized. Great care must be taken to preserve the posterior inferior tibiofibular ligament.

Loose osteochondral fragments and debris in the joint are removed and the fragment is reduced in an anatomical fashion. The reduction is provisionally fixed with Kirschner wires and checked under image intensifier and under direct vision (Fig. 7). Definite fixation is done by buttress plating preferably using a one-third tubular plate. However, a small fragment can be dealt with two small 2.7 mm or 3.5 mm lag screws passed in posteroanterior direction. The direction of compression screw through the posterior malleolus is posterior to anterior with ankle in 15° internal rotation (this avoids malposition of screw into distal tibiofibular joint).

Sequence of fixation (in a trimalleolar fracture):

- First, posterolateral approach (plane between peronei and FHL) and fixation of posterior malleolus
- Second, posterolateral approach (plane lateral to peronei tendons) and fixation of distal fibula
- Third, fixation of medial malleolus

Note that fixation of fibula is done after posterior malleolus because the plate used to fix distal fibula lies directly over the posterior malleolus fracture line on lateral radiograph and hence hinders in judging the reduction of posterior malleolus.

Next, the associated lateral malleolus fracture is addressed by the same approach but through a window. Dissection is carried out lateral to peroneus tendon and fracture site is exposed and fracture reduced (Fig. 6B). The fixation is done with lag screws and neutralization...
plate. Most surgeons place a syndesmotic screw where possible (Fig. 8), as the addition of a syndesmotic screw also stabilizes the syndesmosis and offloads distractive forces on the posterior malleolus through the posterior tibiofibular ligament (PTFL). The syndesmotic reduction is checked under direct vision and with the help of image intensifier. This has been disputed by some authors who feel that stabilizing the PTFL through rigid fixation of the posterior malleolus may do away with the need for syndesmosis screws.

The medial malleolus fractures are addressed lastly. In the prone position, exposure to medial malleolus is permitted by decreasing the height of the table to the minimum and an assistant holding the leg with the knee in flexion of 90° (Fig. 9). The medial malleolus is now accessed via the standard medial approach and is fixed with two malleolar screws or partially threaded cannulated screws or tension band wiring as per the fracture pattern.

Wound closure is done in layers, deep fascia with 2-0 Vicryl followed by subcutaneous layer with 2-0 Vicryl. Interrupted skin sutures with 3-0 Nylon or Staples are then given (Fig. 10).

**POSTOPERATIVE MANAGEMENT AND REHABILITATION PROTOCOL**

Limb elevation is continued to decrease postoperative swelling. We generally apply a below-knee slab for 1 week with the ankle in neutral position to decrease postoperative pain and better soft tissue healing. Ankle range of motion is encouraged and started as soon as possible. Weight bearing is delayed for 6 to 8 weeks until the fracture consolidates and radiological signs of healing can be seen. The patient is mobilized with crutches with no weight bearing on affected limb. We can also use ankle offloading ankle foot orthosis (e.g., Air Cast walker). Sutures are removed at 2 to 3 weeks depending on the status of the wound.

**DISCUSSION AND REVIEW OF LITERATURE**

Classification and management of posterior malleolus fractures have been a controversial subject for a long time. Early
studies emphasized that most of the posterior malleolus fractures could be operated nonoperatively. Fractures involving 25 to 33% of articular surface on a lateral radiograph were considered for fixation. Over the years, articular congruity, stability of posterior syndesmosis, and fibular notch congruence have been given their due importance. Langenkuijzen et al emphasized that articular continuity was of utmost importance and recommended fixation for fractures involving more than 10% of articular surface. Jaskulka et al showed that those treated surgically performed better if more than 5% of articular surface was involved. Recent works have highlighted the role of posterior malleolus fixation in maintaining syndesmotic and rotational stability and shown to be at least as good as screw fixation.

Multiple studies have now shown the inadequacy of lateral radiographs to adequately measure the size of the fragment. The first CT-based classification was given by Haraguchi et al who classified posterior malleolus fractures into three types, type I: posterolateral fragment (67%), type II: medial extension fracture (19%), type III: shell fractures (14%) based on axial cuts on two-dimensional CT scans. Bartoníček et al classified these fracture into five types. Type I: extra incisural fragment (intact fibular notch); type II: posterolateral fragment with fibular notch extension; type III: posteromedial two-part fracture with medial malleolus involvement; type IV: large posterolateral triangular fragment; type V: osteoporotic irregular fractures. The authors emphasized on the need of fixation for all fractures except type I, which can be managed conservatively. This observation from the authors where they advise most fractures to be fixed against a smaller fragment. Hence, it makes for a less stable construct; (3) fragments smaller than 15 mm are difficult to fix as all threads of partially threaded cancellous screw will not cross the fracture site and smaller threads do not provide adequate compression; (4) multifragmentary and comminuted fractures cannot be fixed by this approach. As the indications of surgery have become broader over the years, this approach has taken a backseat in popularity with most surgeons.

Another approach for fixation of these fractures is lateral transmalleolar approach. This can only be used in fractures which are Weber type B with fracture line starting near tibial plafond where articular reduction of fibular notch can be looked at by displacing the fracture line. The fractures are ultimately fixed with A to P screws but under direct vision. Kim et al in their study of 36 patients reported good results with this approach with no nonunion, no cases of infection, and similar range of motion compared with the other side. The only advantage this approach provides over indirect reduction with A to P screws is that adequate reduction can be achieved under direct vision. However, this approach cannot be used for multifragmentary and Weber type C fractures.

Posterolateral approach is one of the most viable and widely used options for fixation of posterior malleolus fractures. This approach provides easy access to the fracture site with adequate exposure. O’Connor et al in their study found that patients treated with posterolateral plating by posterolateral approach had better clinical outcomes compared with those treated with indirect reduction with A to P screws. Verhage et al in their study used posterolateral approach for fixation of posterior malleolus and good articular reduction was achieved in all cases; 82% of their cases had a stable syndesmosis after posterior malleolus fixation. Bartoníček et al suggested that Bartoníček and Rammelt type II to IV could easily be addressed by the posterolateral approach. Bartoníček and Rammelt type III fractures may require an additional posteromedial incision, but in most cases posterolateral approach is adequate. Li et al in their study on supination external rotation
injury type IV showed that fixation of sizable posterior malleolar fragments by posterolateral approach provides much better syndesmotic stability compared with A to P screw fixation. Ruokun et al 23 had excellent outcomes in 93% patients using posterolateral approach. Only 3.1% patients developed symptomatic posttraumatic arthritis. Both lag screws and buttress plates can be used for fixation of posterior malleolus fractures. Erdem et al 24 showed good and equivalent results using both lag screws and buttress plates for fixation of posterior malleolus fractures by posterolateral approach and concluded that posterolateral approach is very safe with very few complications. Choi et al 25 in their study on 50 patients noted local wound complications and sural nerve injury to be 4% each. Little et al 26 in their study on 112 patients noted minor wound complications in 9.8%, major wound complications in 2.7% of patients of supination external rotation injury treated with posterolateral approach.

In conclusion, posterolateral approach has evolved to be the gold standard approach in the fixation of posterior malleolar fragment, and each orthopedic surgeon should be well versed with it as they normally deal with ankle fractures.

REFERENCES