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Simon Moyes
Consultant Orthopaedic Surgeon

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Simon specialises in arthroscopic and minimally invasive treatment for problems of the knee, shoulder, foot and ankle.

[Book Appointment](#)

9000
Operations to date

270
Patients per month

25%
Surgical strike rate

Simon Moyes specialises in keyhole - or arthroscopic - surgery. This is a highly sophisticated, minimally invasive technique which means you spend less time in hospital and you are more likely to have a quick recovery.

Shoulder 

Foot 

Ankle 



Ankle Arthroscopy

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Ankle Arthroscopy Website

Simon Moyes specialises in keyhole – or arthroscopic – surgery. This site is dedicated to conditions of the ankle joint that are treated by Simon. Patients can find all the information they need about some of the more common ankle problems, while surgeons and medical professionals can find an up-to-date medical resource for those involved in or studying ankle arthroscopy.

Quick Search

Go straight to the specific page you are looking for by using the drop down below:

Specific Condition

Search Site

Patients' Site

An outline of common ankle problems, with information about how the injury / ailment feels, what surgery is likely and the projected recovery time.
[➤ Click here for the Patients' Site](#)

Surgeons' Site

An in-depth resource about all aspects of ankle arthroscopy for medical professionals. Contains highly-referenced documentation of the procedure, citing examples from the early history to current findings.
[➤ Click here for the Surgeons' Site](#)

Simon Moyes | Medico-legal © Simon Moyes 2007 | sitemap | disclaimer

A close-up photograph of a hand holding a patient's ankle. The hand is positioned to examine the ankle joint. The background is a blurred clinical setting.

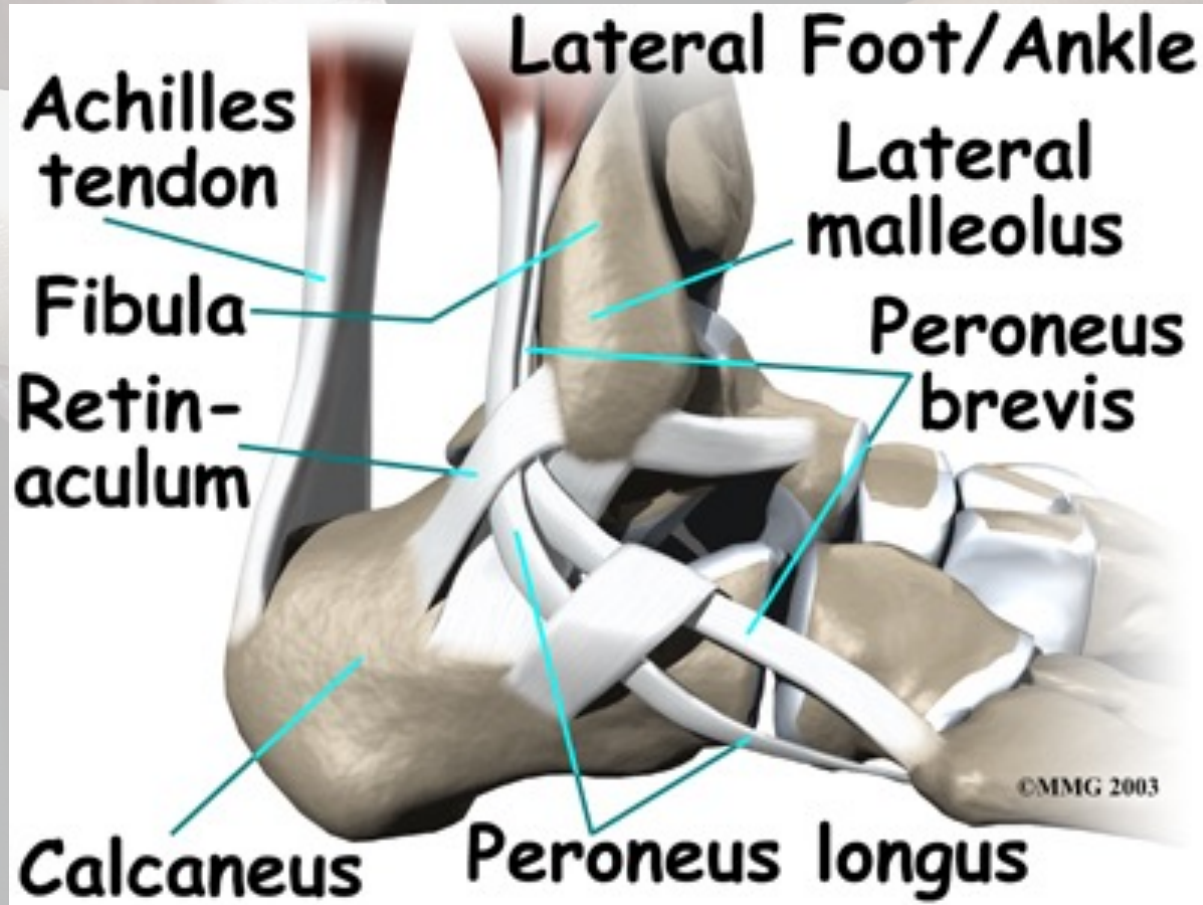
Ankle Instability.

Presented by Mr Simon Moyes

Incidence 1/10,000 people per day



Lateral Ankle Structures



Potential Inversion Injuries

1. Fractures
2. Lateral ligament injuries
3. Peroneal tendon injuries
4. Syndesmosis injuries
5. Talar Dome injuries
6. Any combination of the above

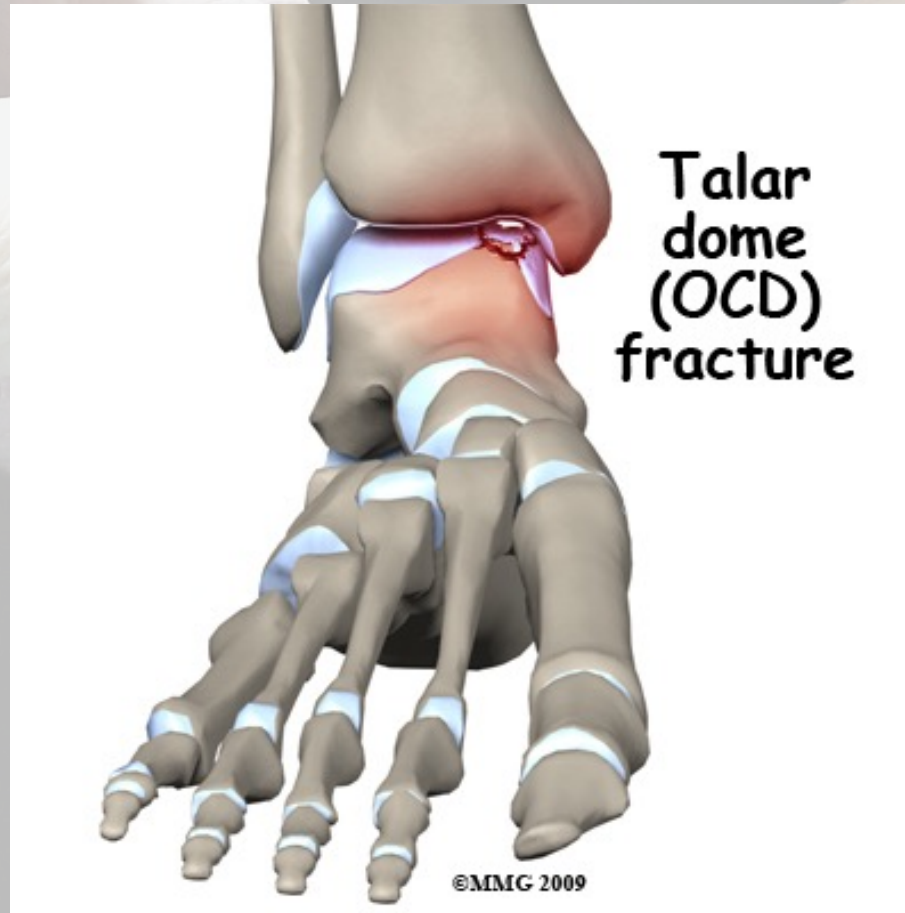
Lateral Ligament Injuries



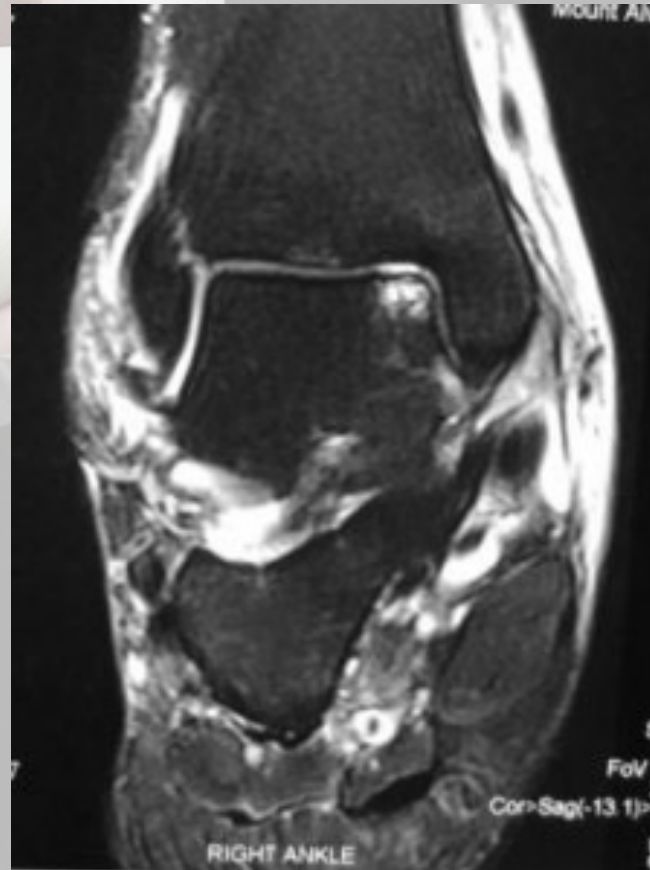
Lateral Ligament Injuries



Talar Dome Injuries



Talar Dome Injuries



Acute Ankle Sprain



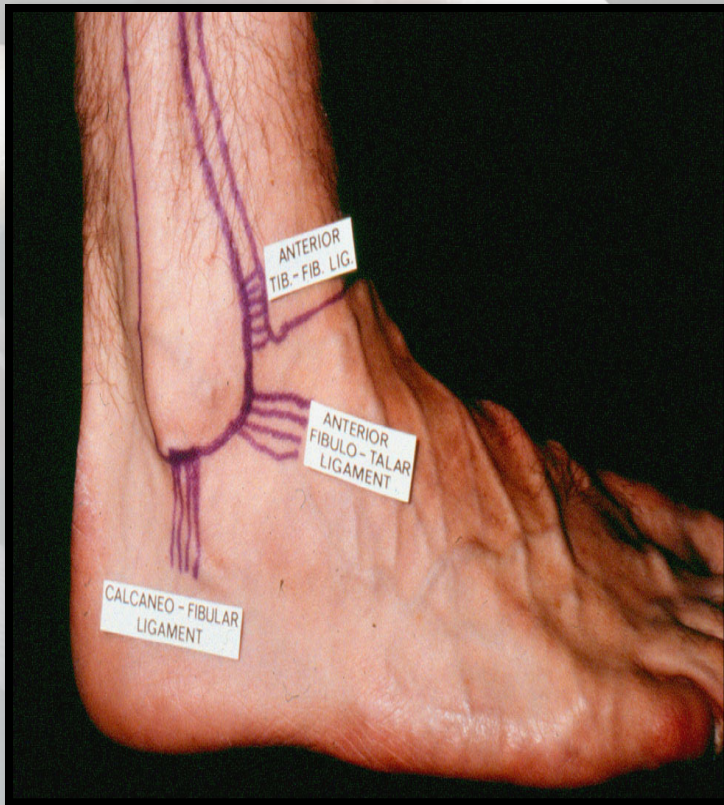
- 14-21% of sports injuries.
- **Grade I:**
painful, but no laxity of uninjured side.
- **Grade II:**
painful with increased laxity.
- **Grade III:**
painful with unstable ankle, painful to wb.

Lateral Ligament Injuries

Acute Management

1. Clinical Assessment
2. X-ray and MR
3. Air cast or Vacoped Immobilisation
4. RICE
5. Physiotherapy/Rehab
6. Conservative Mx successful >90%

'Chronic' Ankle Sprains



'It's OK, it's only a sprain!'

Relevance

- High incidence of persistent symptoms
- Grade III ankle sprains: 25-60% of patients are symptom-free 1-4 years after injury
- Not a benign condition

*Karlsson, Sports Med. 1997
Nov;24(5):337-46*

Examination



- Anterior draw. Suction sign increase 'draw' 20deg plantar flexion. subtle 30N > 60N. (Not a kung-fu manoeuvre!)

(Tohyama H et al. Am J Sports Med 2003)



- The talar tilt test (ankle plantigrade): tilting the hindfoot and observing suction sign or asymmetrical movement.

Investigations



- MRI: No indication of stability!
(Useful for associated pathology.)
- Stress radiography : useful but not always definitive

-anterior draw of 10mm+ or 3mm
cf opp side

-talar tilt of 9° + or 3° > opp side.

Karlsson J et al. Radiographic evaluation of ankle joint stability. CJSM 1991b

Epidemiology Sprains

- Smith and Reischl: 84 college basketball players
56% multiple sprains; 50% residual problems.

AJSM. 1986 Nov-Dec;14(6):465-71

- Munk (1995): 79 patients 9-13 years after sprain
5% pain, 15% structural instability 6% functional instability.

Acta Orthop Scand. 1995 Oct;66(5):452-4

Tendinopathy

Instability

**Chronic
Ankle
Sprain**

?misdiagnosis 5th
met/ lat talar
process, ant
process calcaneus.

Impingement

**Osteochondral
lesion**

Chronic Instability

- Defined: recurrent giving-way > 6 months despite adequate non-surgical therapy.



Lateral Ligament Injuries

Chronic Management

1. Clinical Assessment
2. X-ray and MR
3. Ankle Arthroscopy + Brostrum repair
4. Physiotherapy/Rehab
5. 95% good or excellent results

Diagnostic Examination



The ankle is first distended with approx 30cc of saline.

- The anteromedial portal is established just medial to tibialis anterior at the level of the joint line carefully avoiding the saphenous nerve.
- Then the anterolateral portal is established using transillumination, avoiding the superficial branch of the lateral popliteal nerve. A full diagnostic inspection of the anterior compartment is then carried out.
- Then the posterolateral portal is made, localising the entry point with a spinal needle. A full inspection of the posterior compartment is then made.

Using these three portals, a full systematic ankle examination can be carried out.

Theatre Set-Up



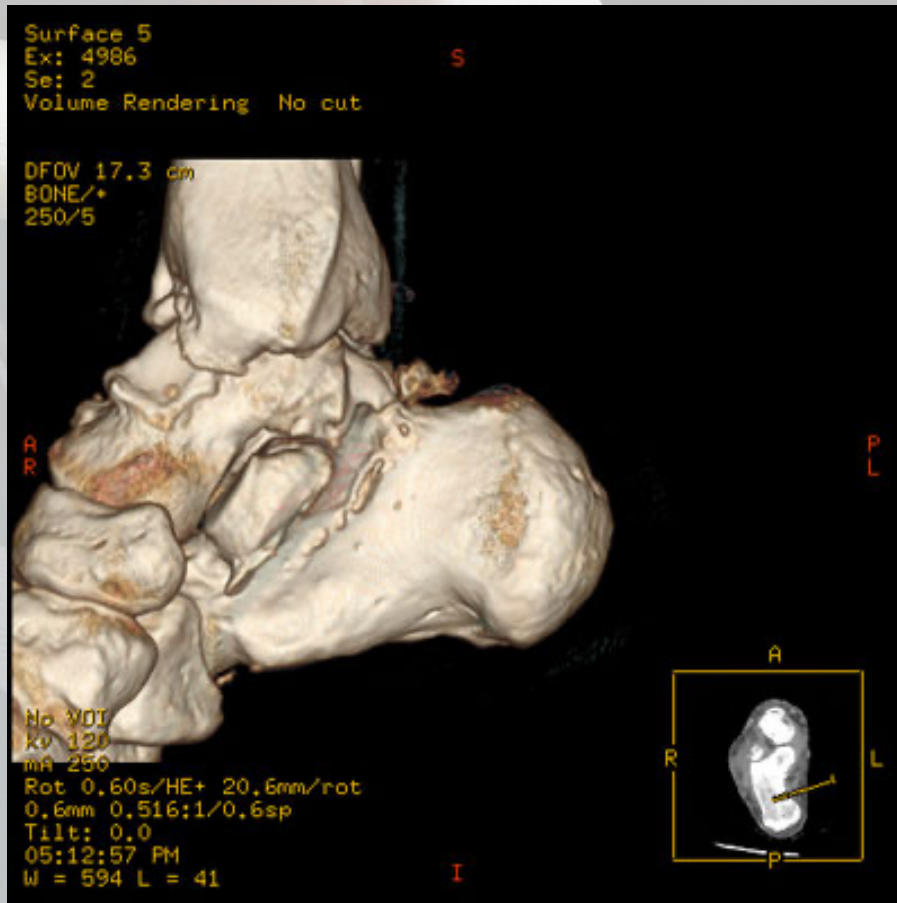
Soft Tissue Lesions

- Patients with such lesions present with a combination of pain, swelling, tenderness, locking and giving way.
- On examination, one finds a combination of tenderness, wasting, swelling, restricted range and instability.
- Traumatic: sprains, fractures, prior surgery
- Excise generalised synovitis
- Excise localised bands
- Excise meniscoid lesions secondary to impingement

Post Traumatic Soft Tissue Lesions

- Anterolateral post traumatic synovitis
- Syndesmotic impingement lesions
- Lateral gutter impingement lesion
- Meniscoid bands

Articular Surface Defects



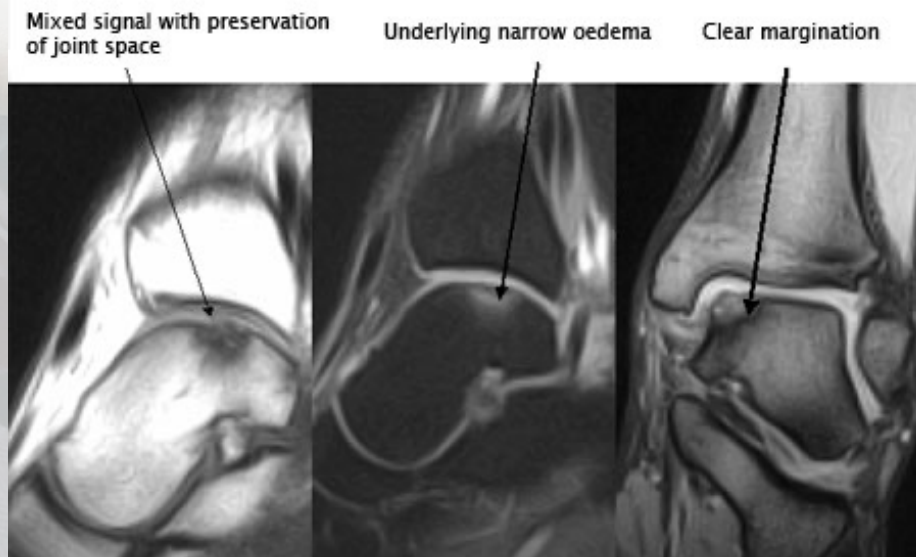
- Arthroscopy is the best way of visualising and treating articular surface defects.

Loose Bodies



- Primary and secondary osteoarthritis can be treated arthroscopically.
- Cheng and Ferkel (87) in 1998 showed that arthroscopic debridement for ankle and subtalar degenerative disease can provide an interim alternative to arthrodesis or ankle replacement, with removal of impinging osteophytes and loose bodies being treated effectively with arthroscopy.

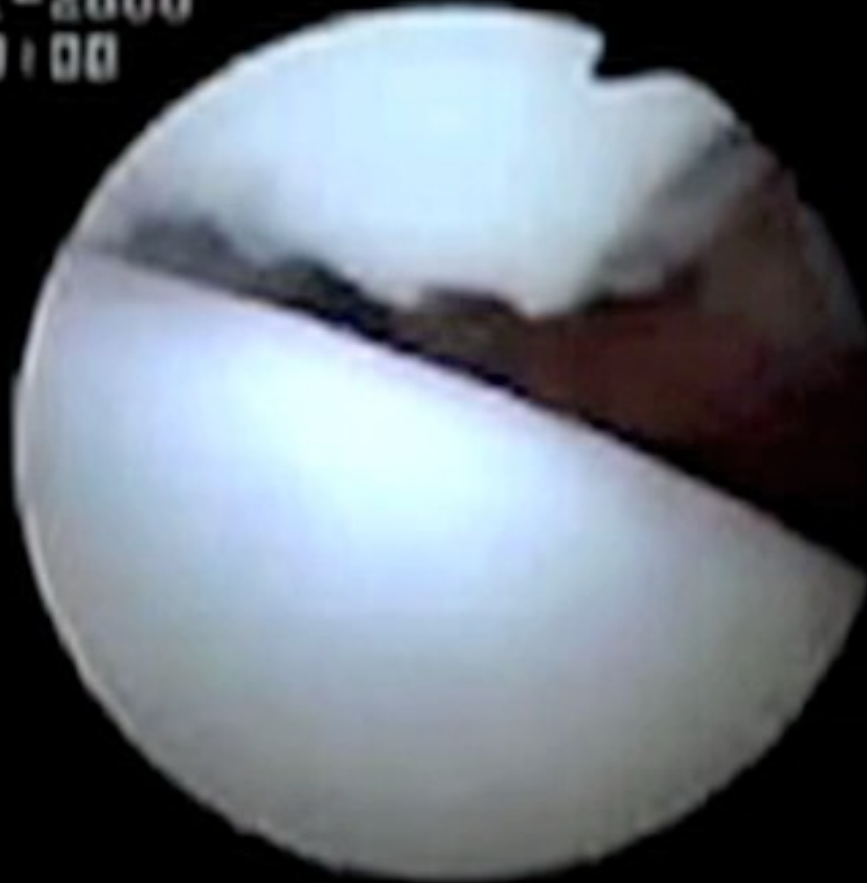
Osteochondral Lesions of the Talus - OLT



- Osteochondral lesions of the talus as such were first described in 1856 by Monro (36) but Konig (37) coined the term ‘osteochondritis’ when he found similar pathology elsewhere in the body and thought the aetiology was osteonecrosis. Kappis (38) in 1922 first applied the term osteochondritis to the ankle joint.

Loose Body

01-01-2000
00:00:00



Footballers Ankle

01-01-2000
00:00:00



Arthrofibrosis



Meniscoid band



Synovial Disease



Osteochondral Defects



Comparative studies

- Randomised 42 ankles Chrisman-Snook vs modified Brostrom procedures. Brostrom compared favourably, < complications.

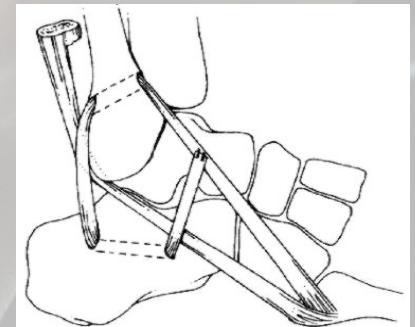
Hennrikus et al AmJSM 1996

- Good results: Brostrom in revision ligament reconstruction 15 ankles.

Kuhn et al FAI 2006

- Anatomic repair superior to tenodesis: < reops, <instability, < stiffness. 106 repairs vs 110 tenodeses

Krips et al Knee Surg Sports tr Arth 2000



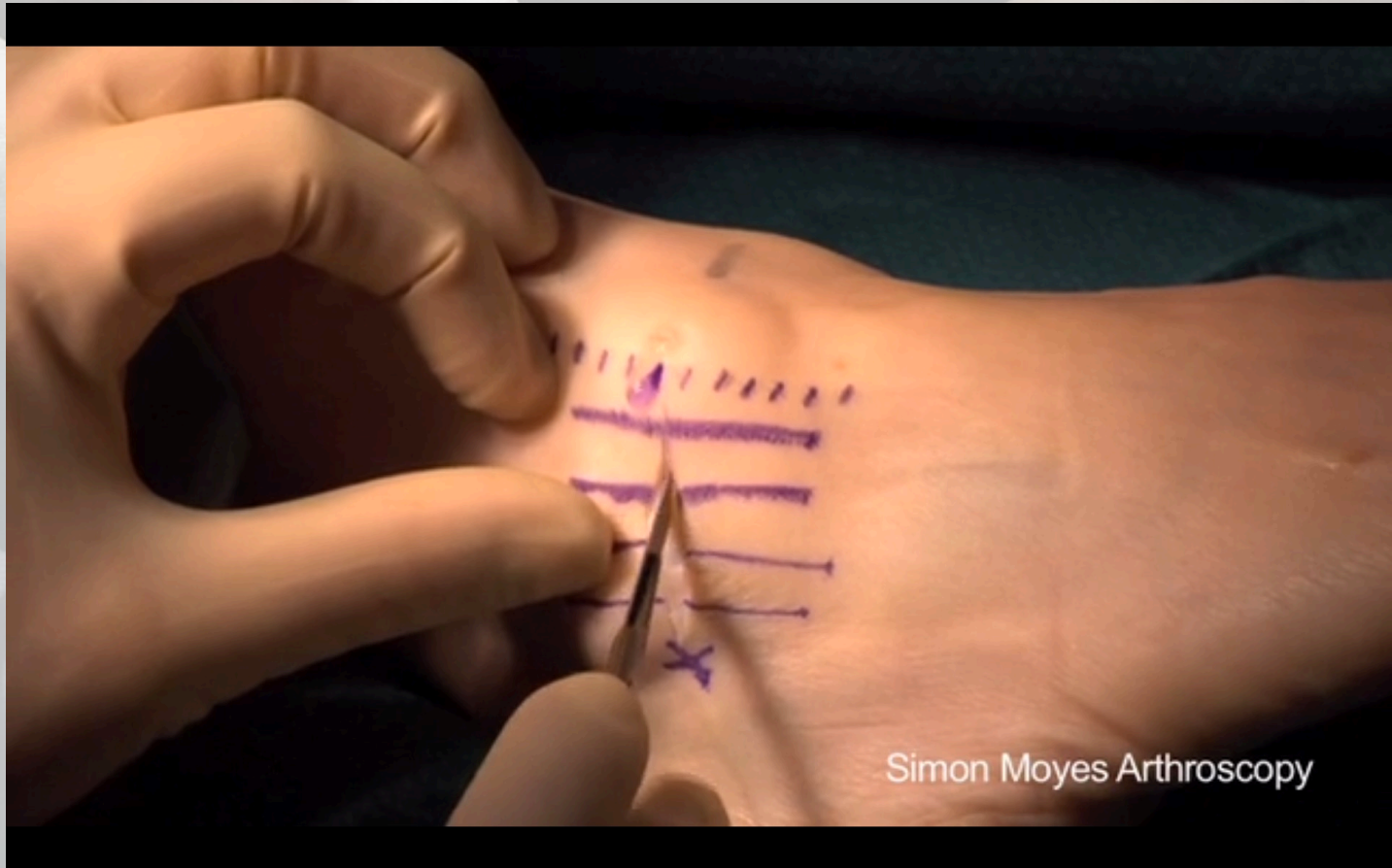
Chronic Instability



- Brostrom-Gould repair. anatomical, 'pants over vest' repair lateral ligaments less morbidity, stiffness.
- Reconstruction: useful for revision surgery, generalised laxity.

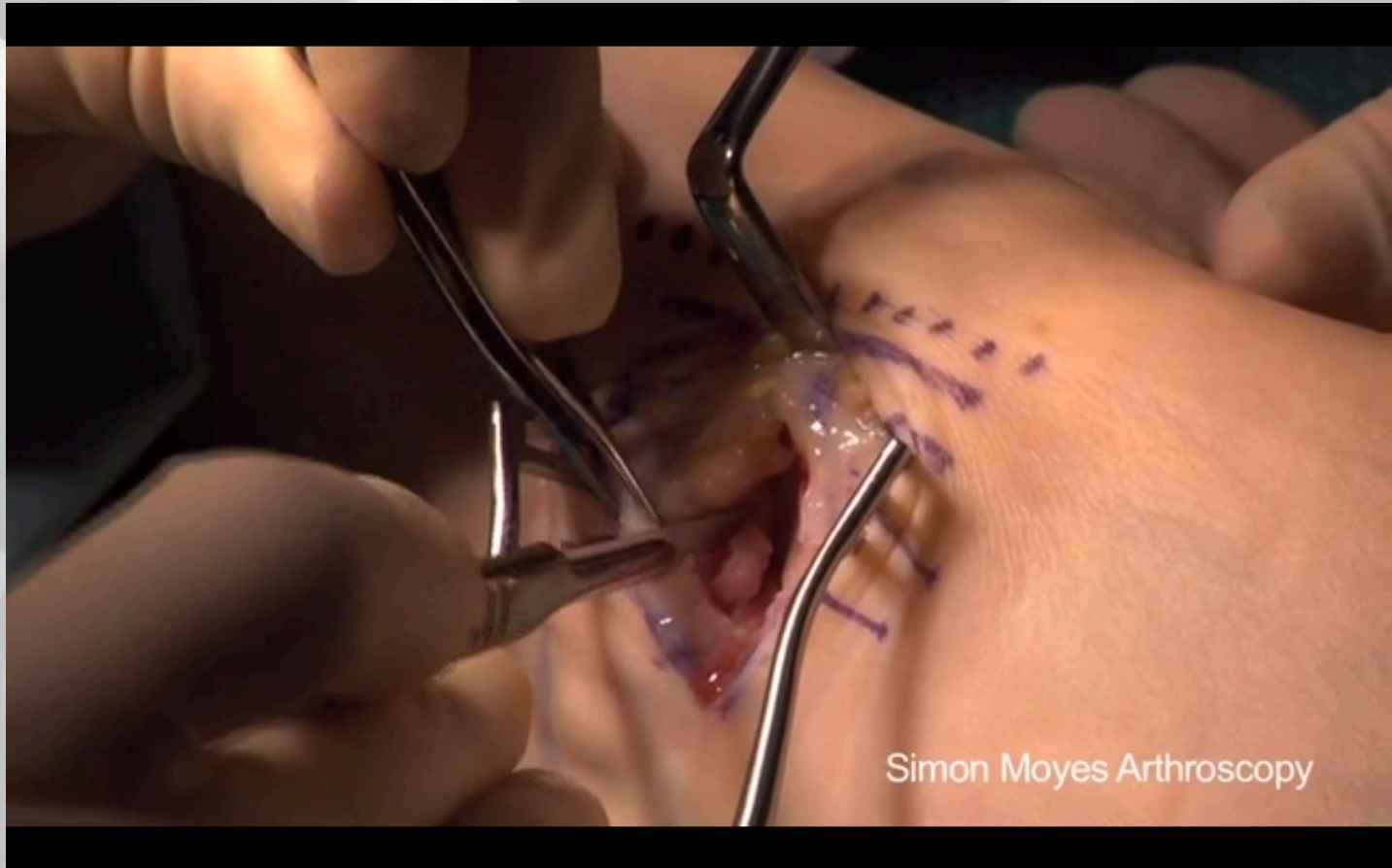
Video: Brostrum Repair

<http://vimeo.com/43535704>



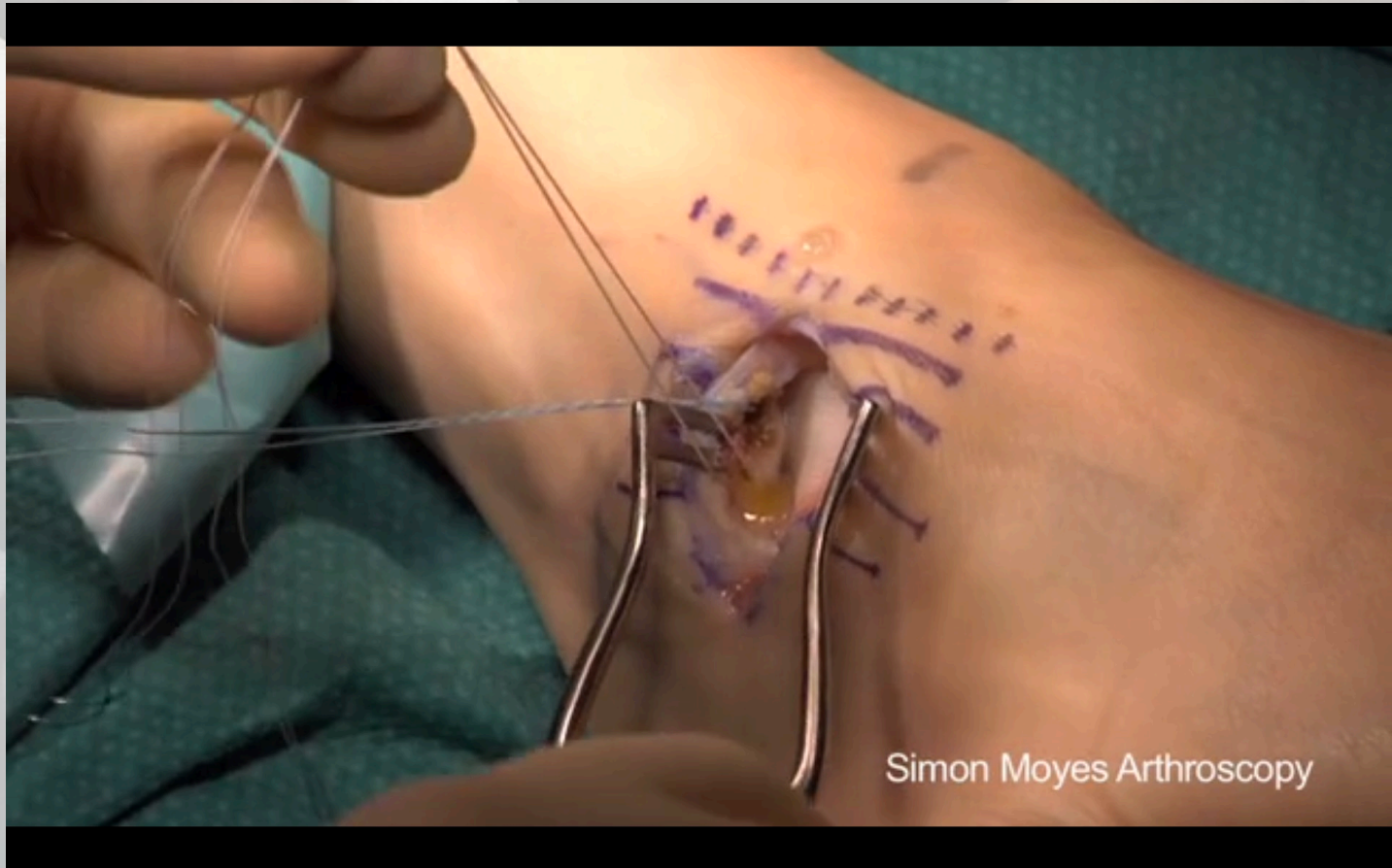
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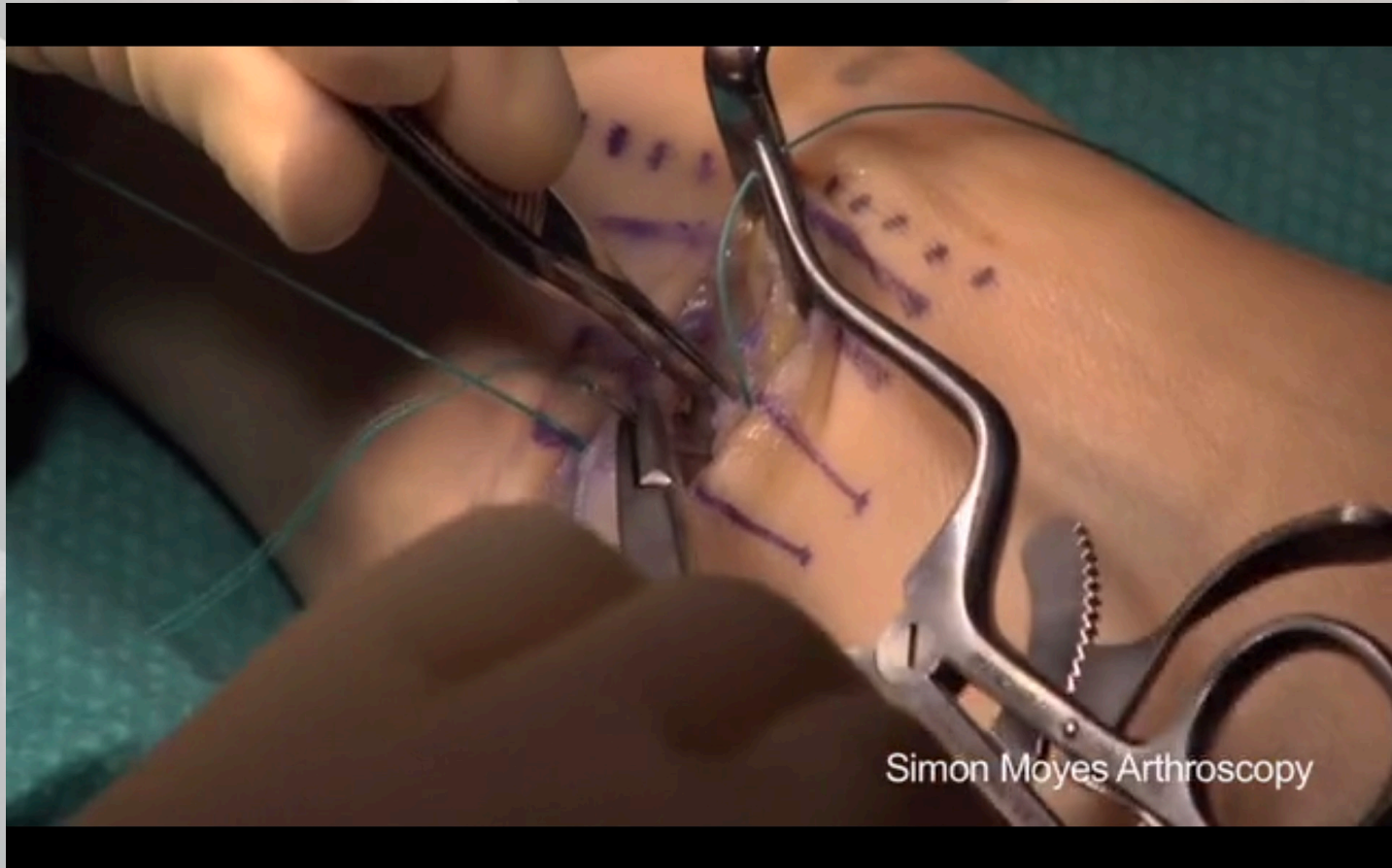
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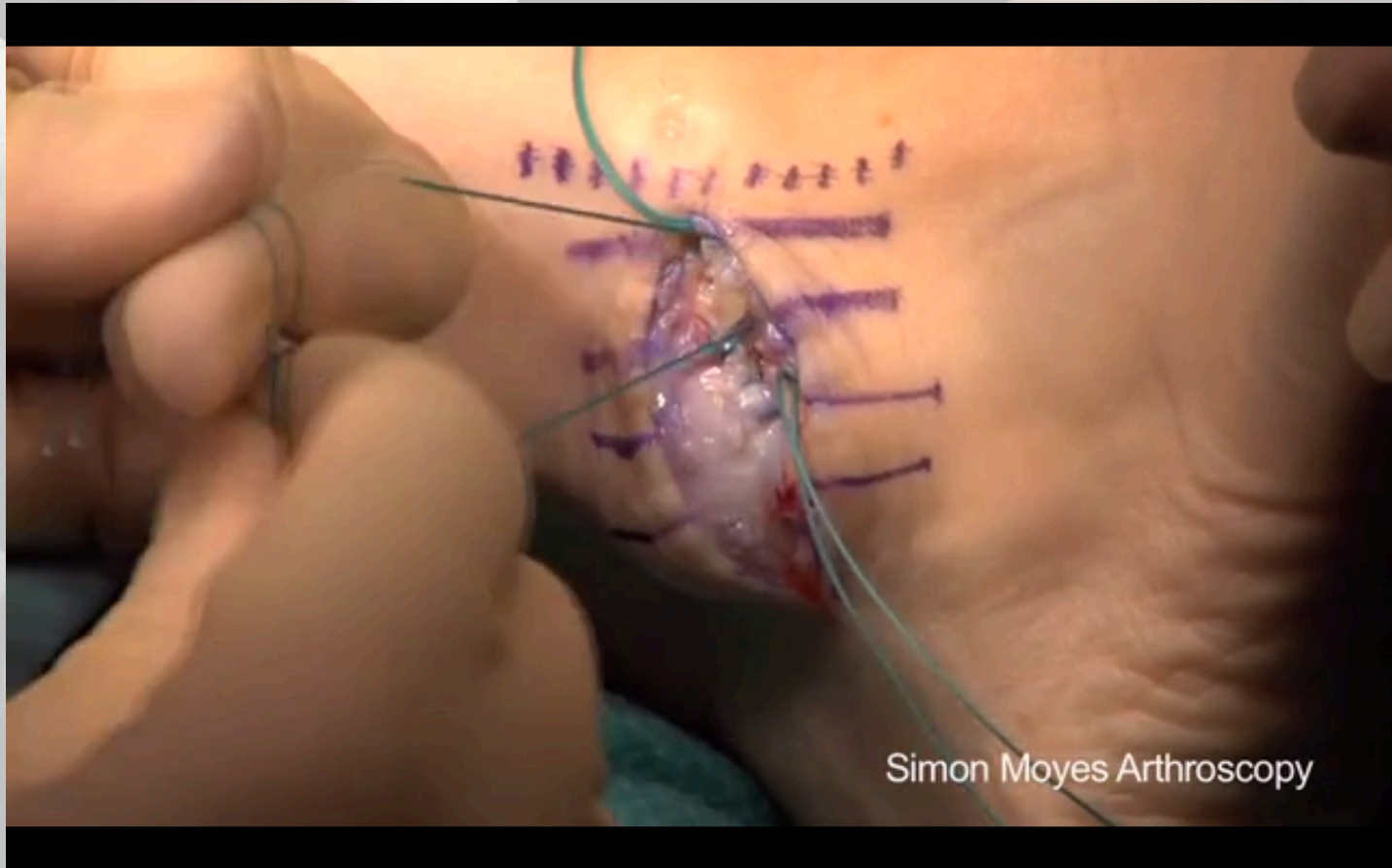
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Take Home Messages

- Not benign condition
- MRI misses a range of intra-articular pathologies
- Ankle arthroscopy required with the brostrom repair
- Brostrom repair highly successful

A close-up photograph of a hand holding a foot, likely in a medical or caregiving context. The hand is positioned on the left, with fingers gently gripping the foot. The foot is the central focus, showing the heel and the side of the foot. The background is blurred, suggesting a clinical or hospital setting. The text "Thank You" is overlaid in the center of the image in a black, serif font.

Thank You