UCSF School of Medicine

Case Presentation

Pilon Fracture

Ashraf El Naga

- 34 F transferred from after identification of a distal tibia fracture status post fall off BART tracks. Splinted at OSH

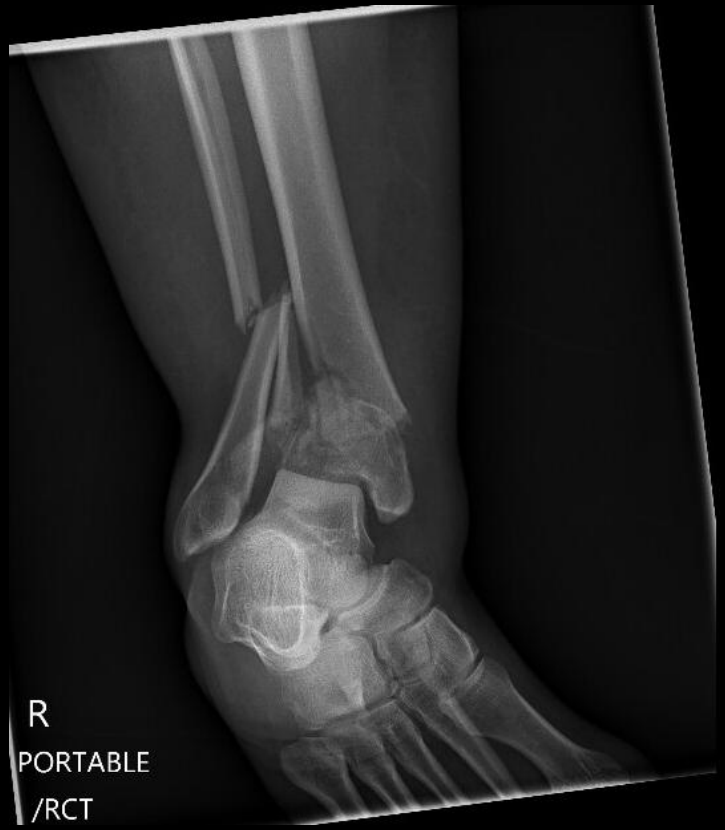
- Pain isolated to RLE
- Denies numbness or paresthesias

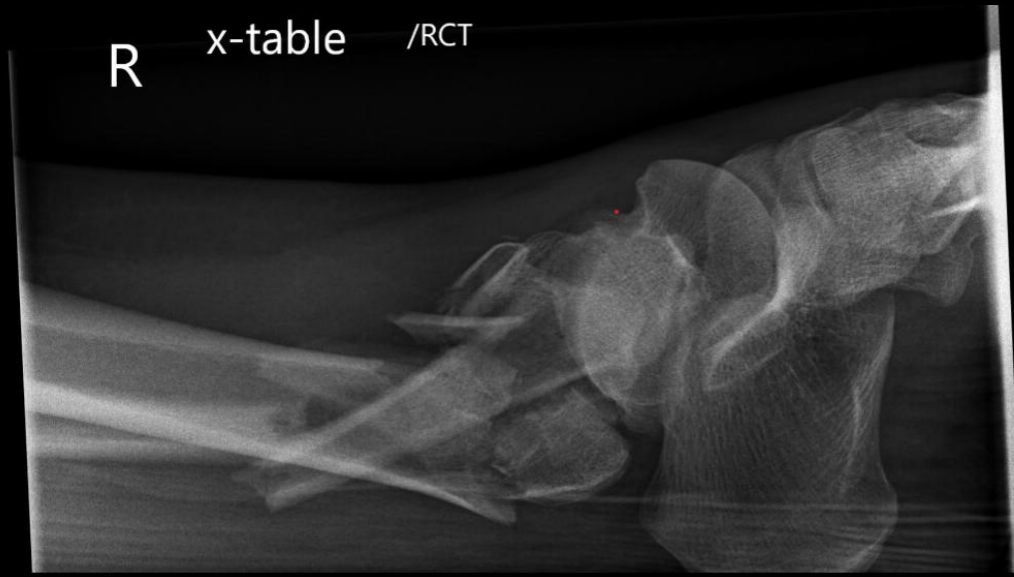
- Social history: active fentanyl and methamphetamine use.
  Homeless but with some family support several hours away

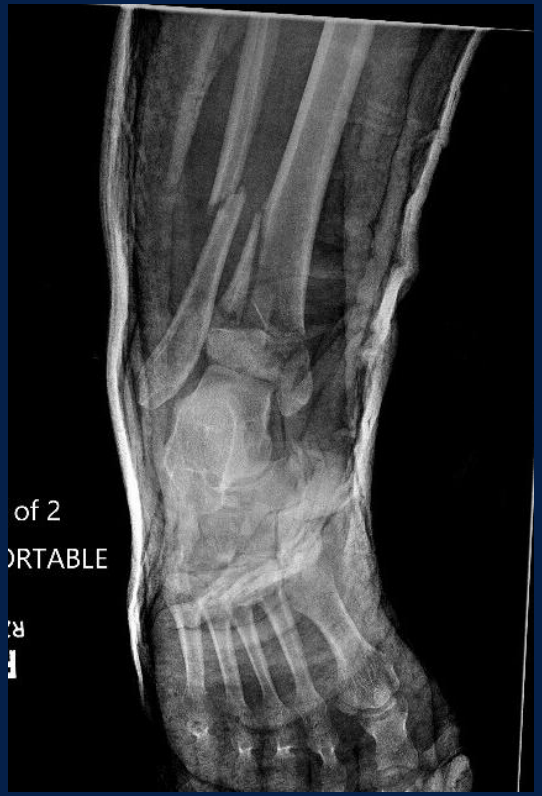
SC

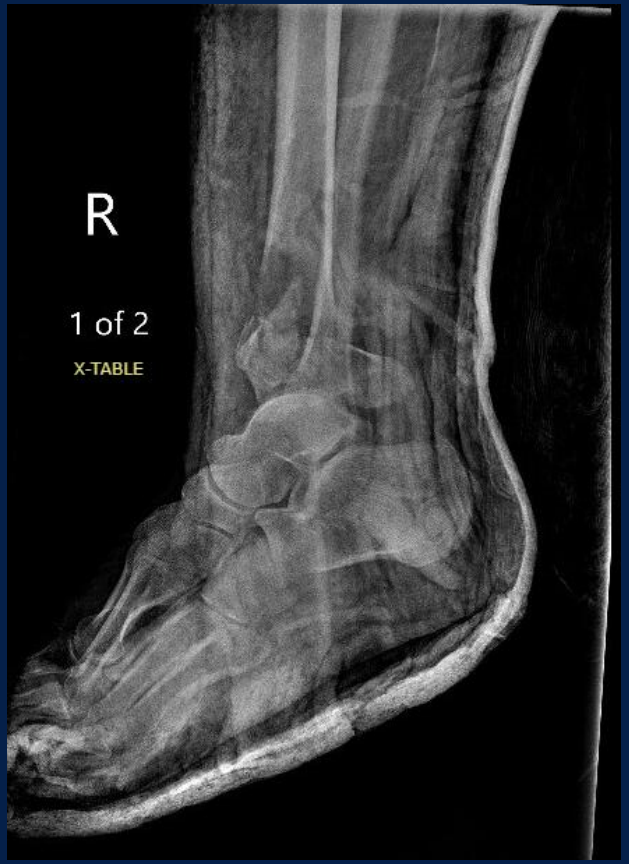
- Exam
  - 144/90 73 36.7 12

Right Lower Extremity
Notable deformity to ankle, swelling throughout ankle region, no open wounds visible
Motor: firing EHL/TA/G/S
SILT SA/SU/SP/DP/T
Palpable DP pulse, foot wwp


R
PORTABLE
/RCT


R
x-table
/RCT

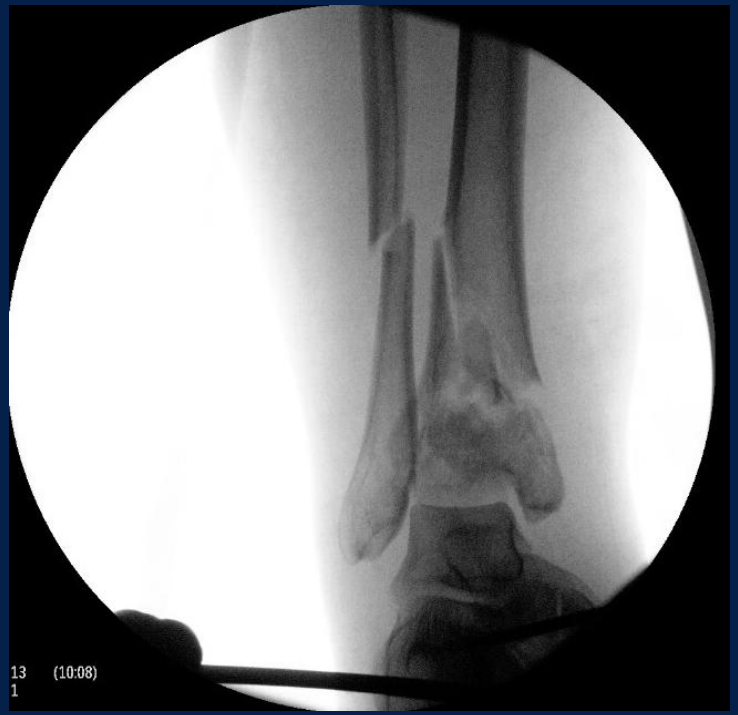

of 2
ORTABLE

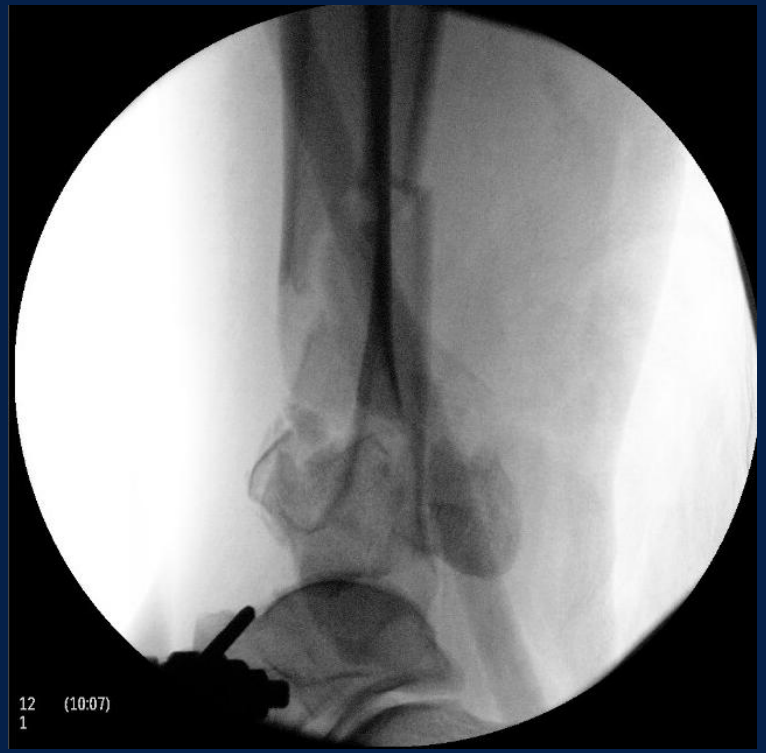

R
1 of 2
X-TABLE

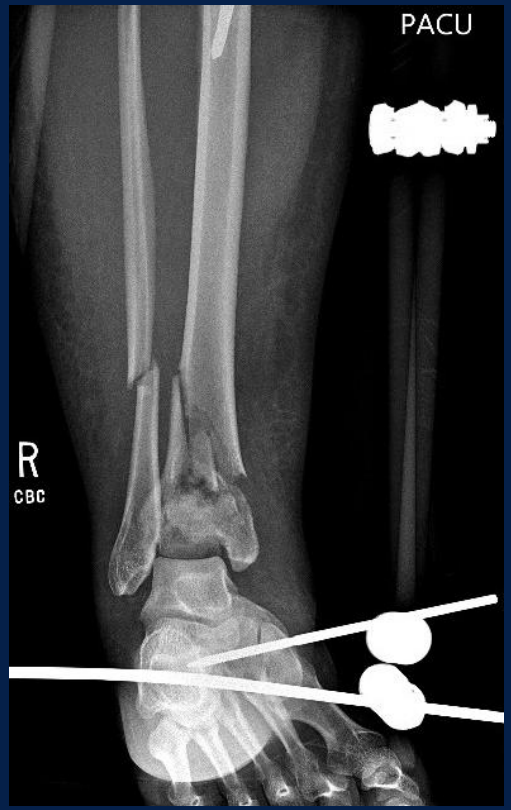
Next steps?

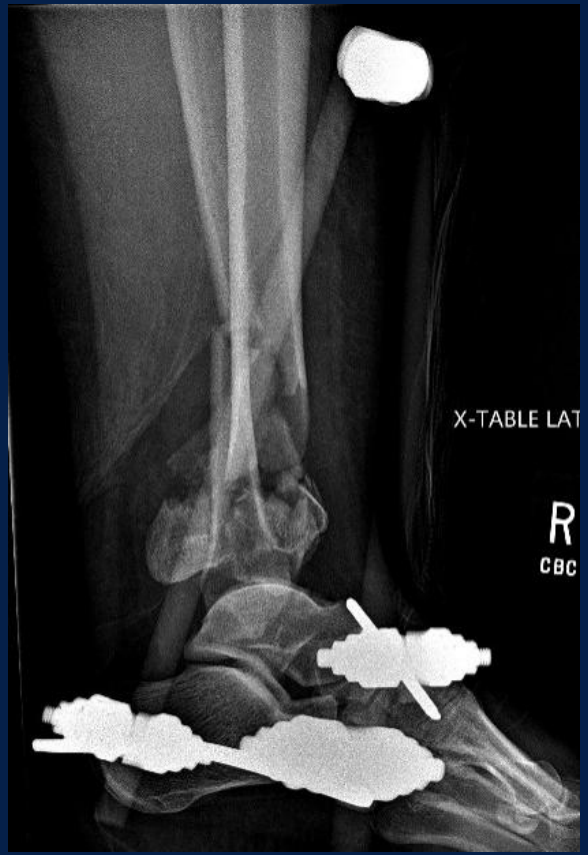
Further imaging?

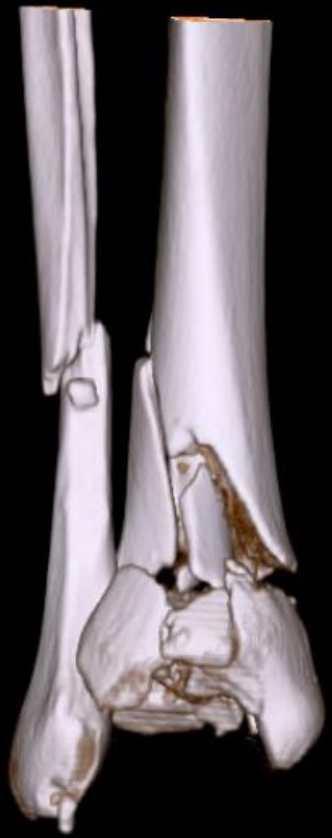
Patient with significant skin swelling

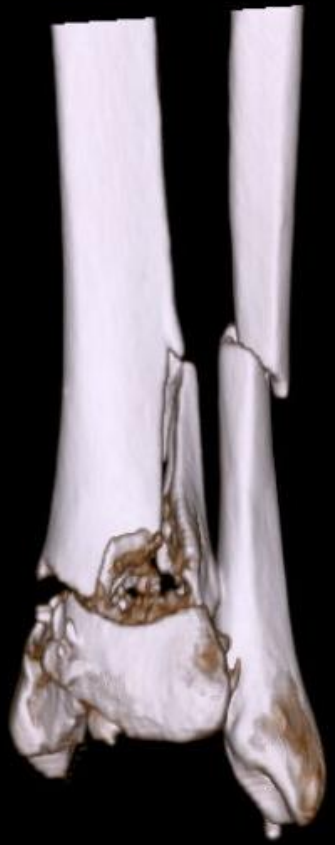

13 (10:08)
1

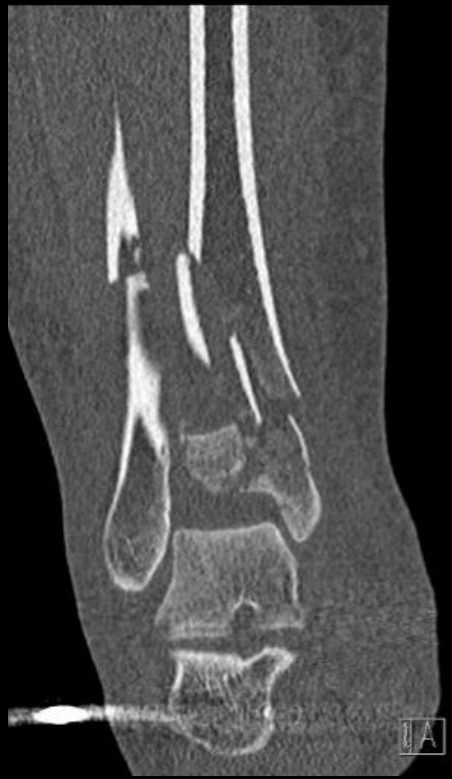

12 (10:07)
1

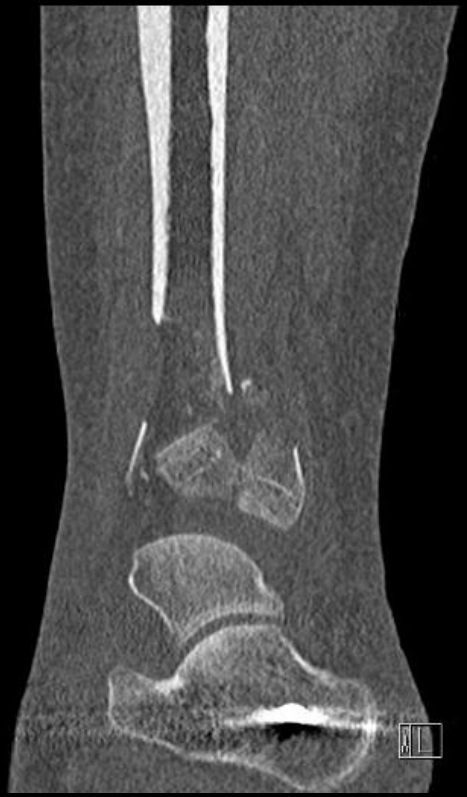

PACU
R
CBC


X-TABLE LAT
R
CBC









Anterior

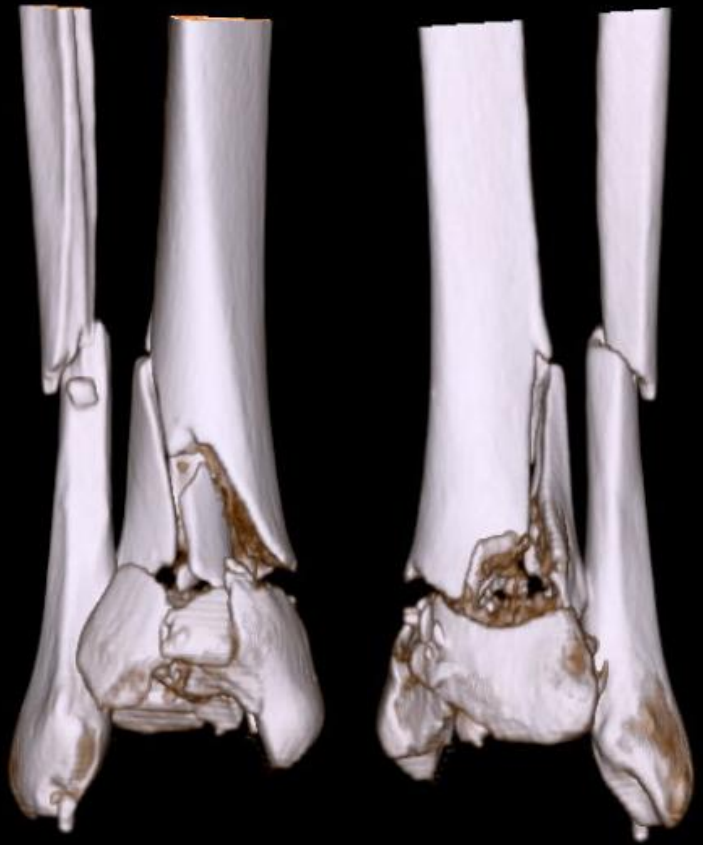
Posterior

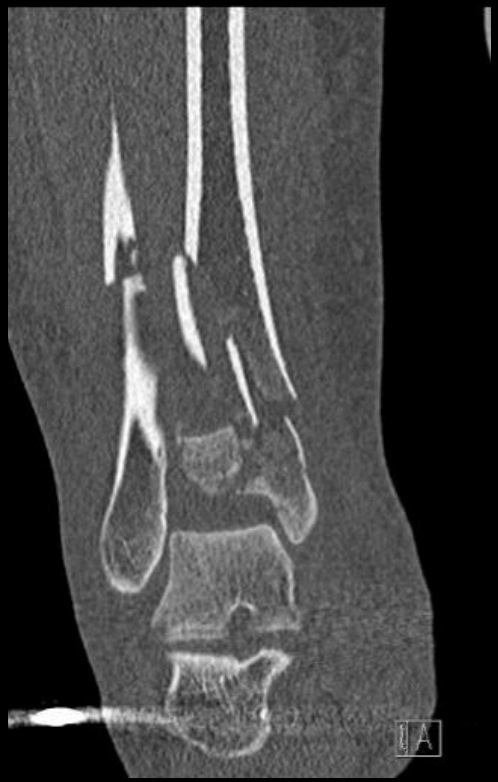
UCSF

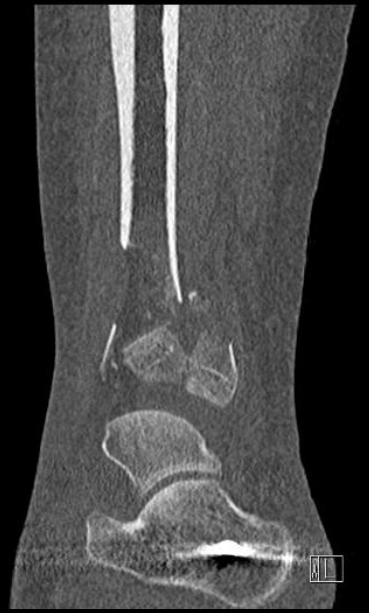
POD 3

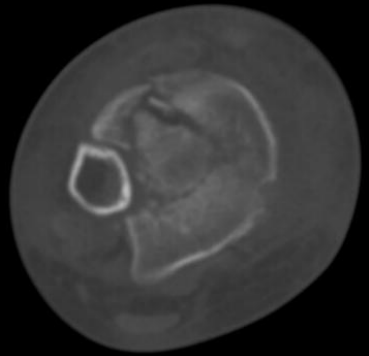
On interview:
- Feels she is going through withdrawal right now, with diffuse body aches and anxiety. Feels that oxycodone dose has been insufficient. Shares that she is 'thinking of leaving right now' due to uncontrolled withdrawal
- Open to starting methadone today and speaking with ACT tomorrow. Does not recall what her prior methadone dose was or which clinic she used to visit. Open to continuation of methadone long-term after discharge.
- On reviewing notes, patient has been fairly drowsy during day yesterday (limited ability to work with OT), and she had Foley placed for retention.

Amenable to seeing addiction care team and methadone initiated





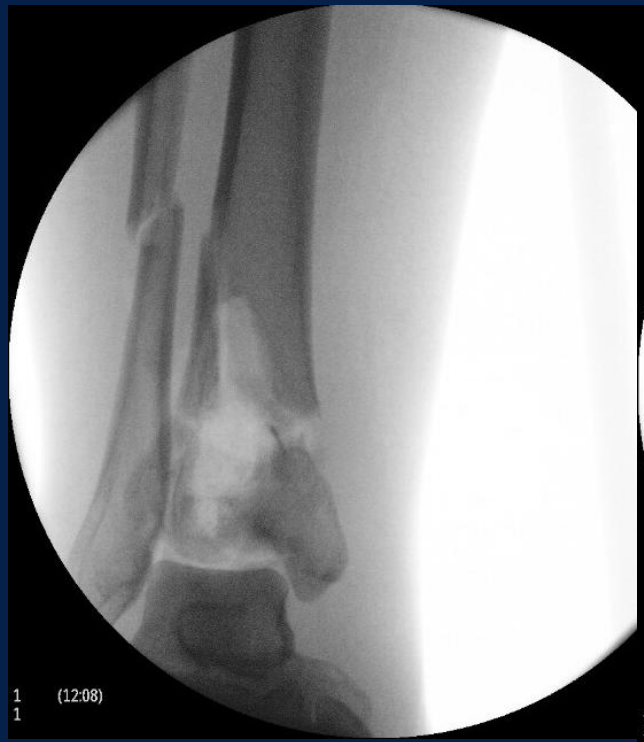


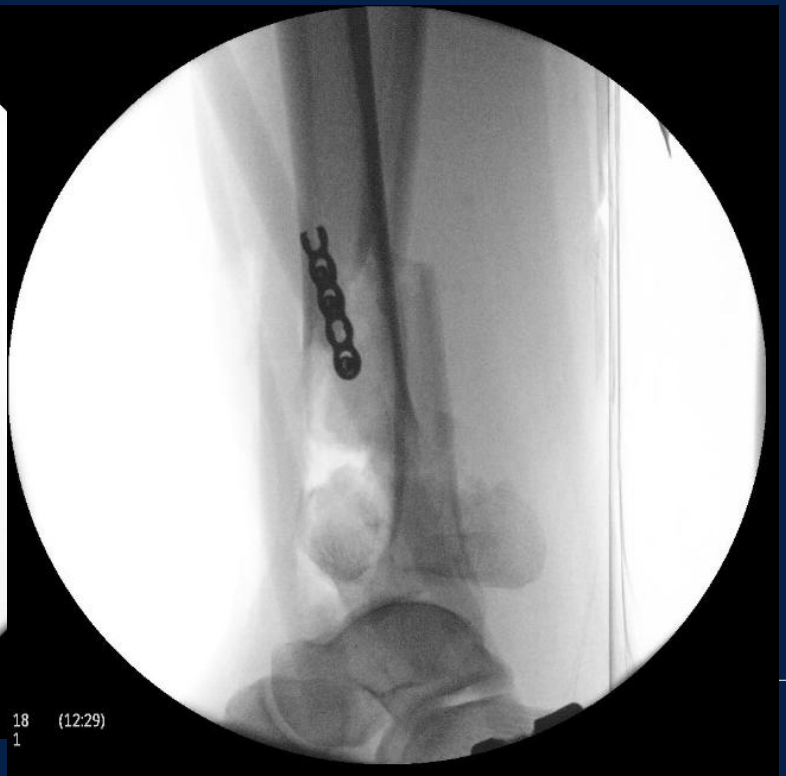


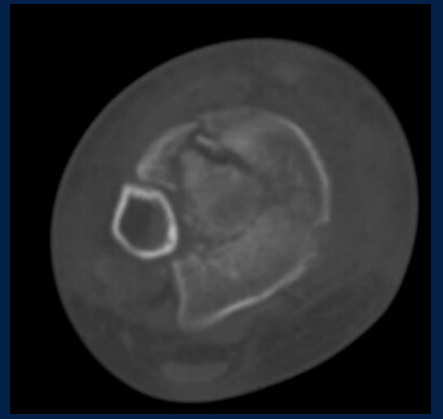
Swelling improves by POD 12 … plan?

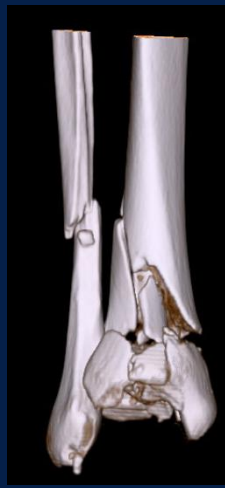
Plan: ORIF: Start with anterolateral approach

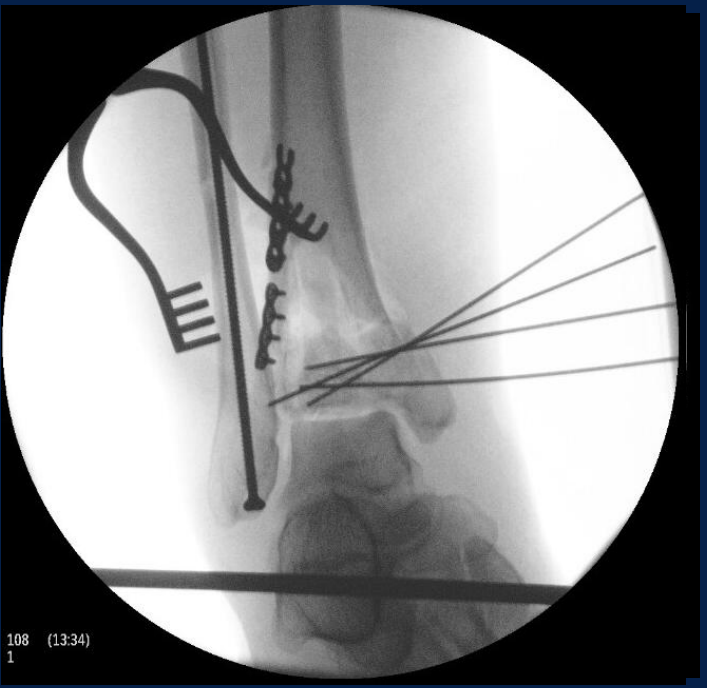
Operative course:

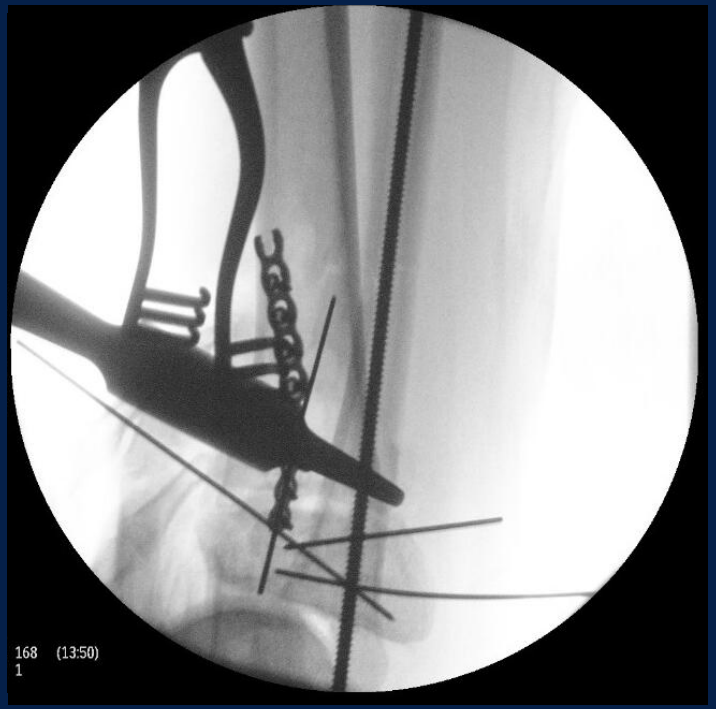


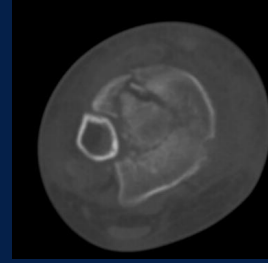


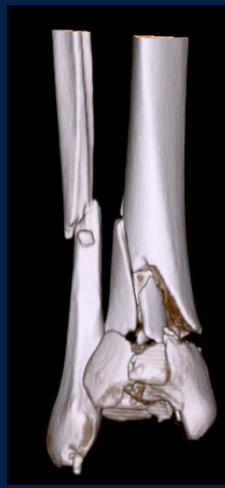




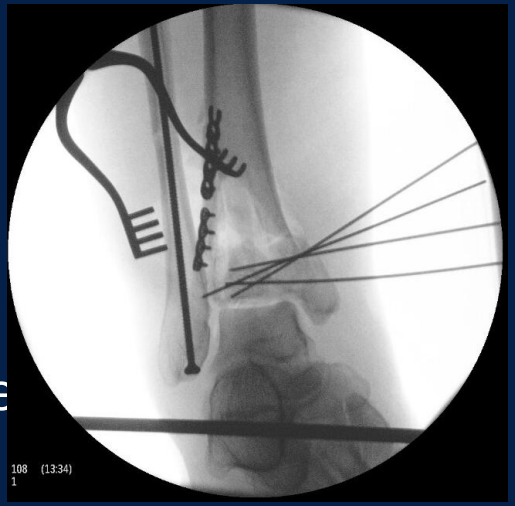

108 (13:34)
1

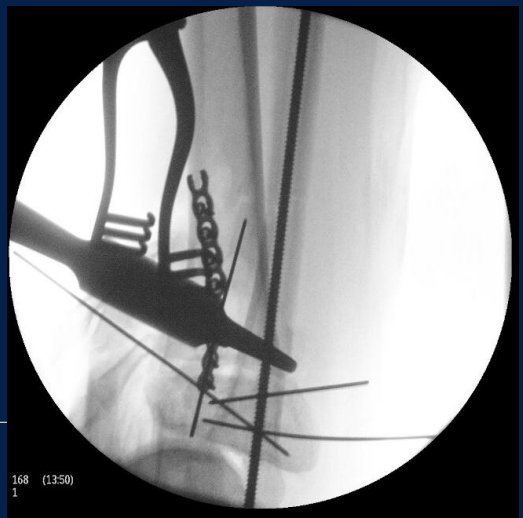

168 (13:50)
1

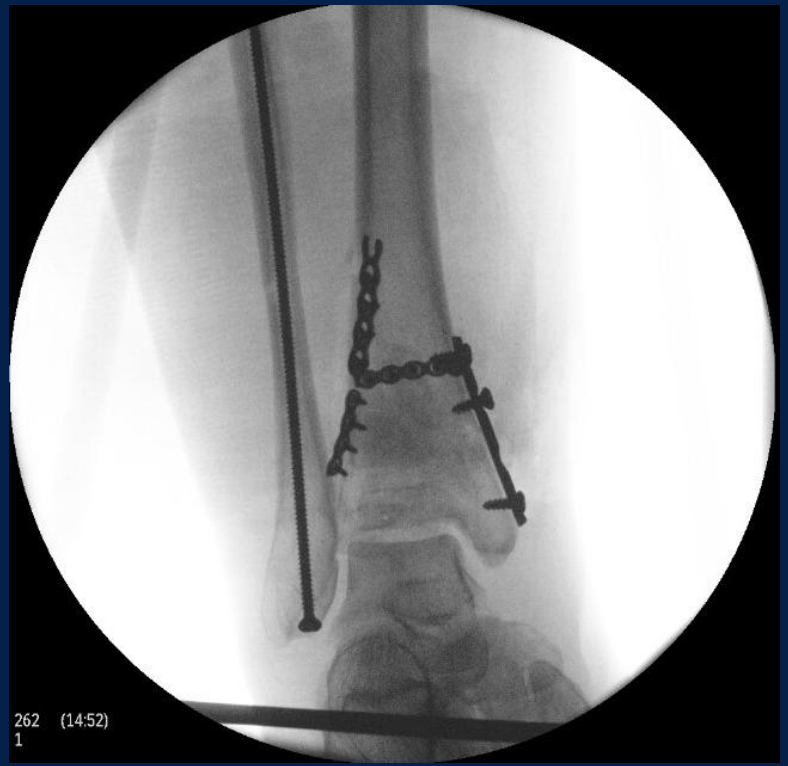


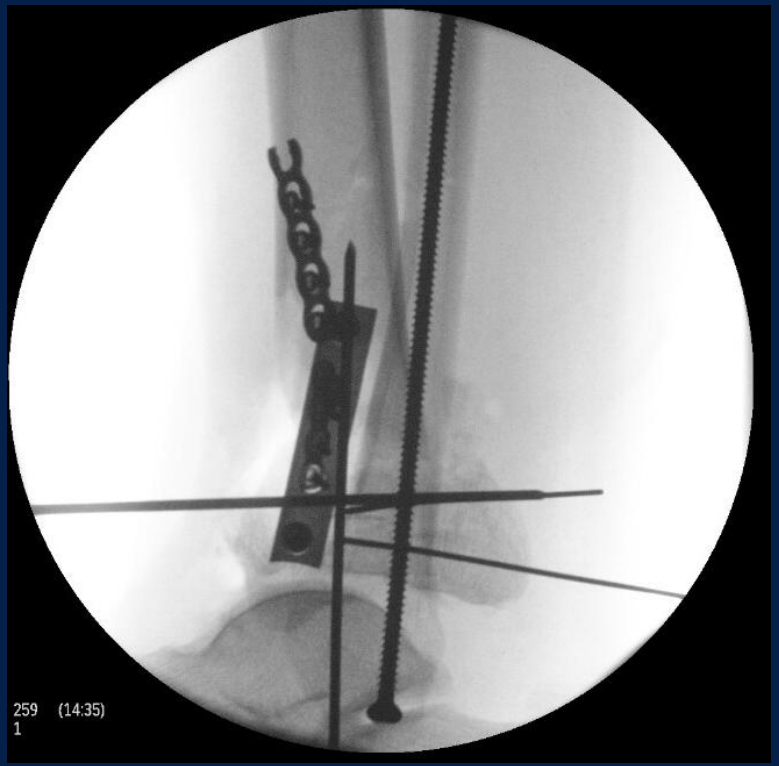


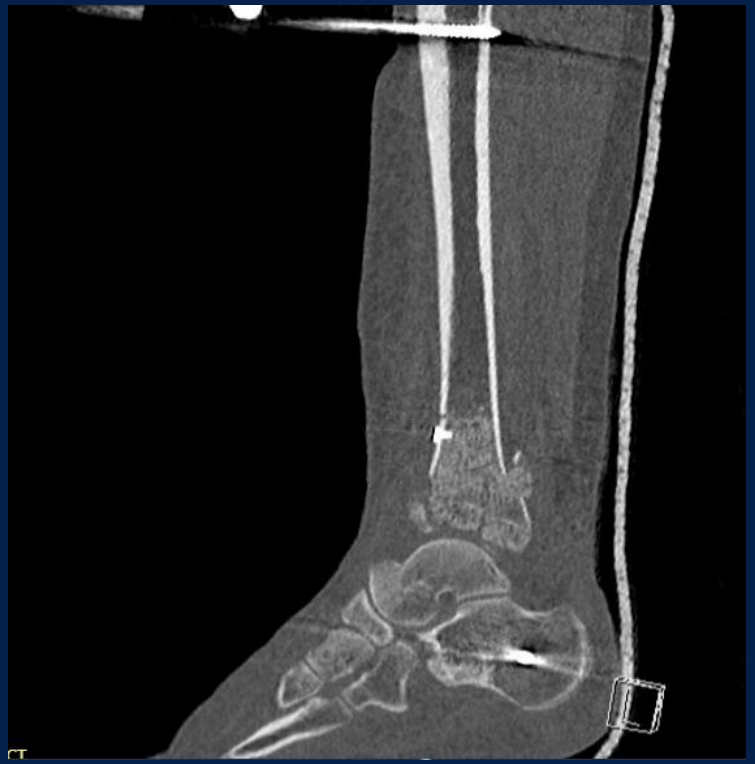
- Fair amount of denuded cartilage
- Did not feel as though I could achieve an acceptable reduction without a separate posterior approach
- Hesitancy against doing so given risk factors
- Decision made to restore the metaphysis acutely bone graft and return later for a TTC nail after patient discussion

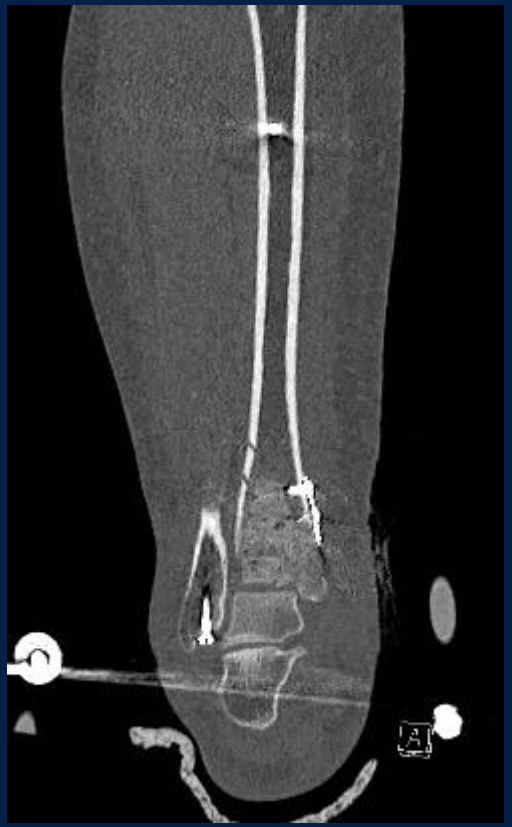


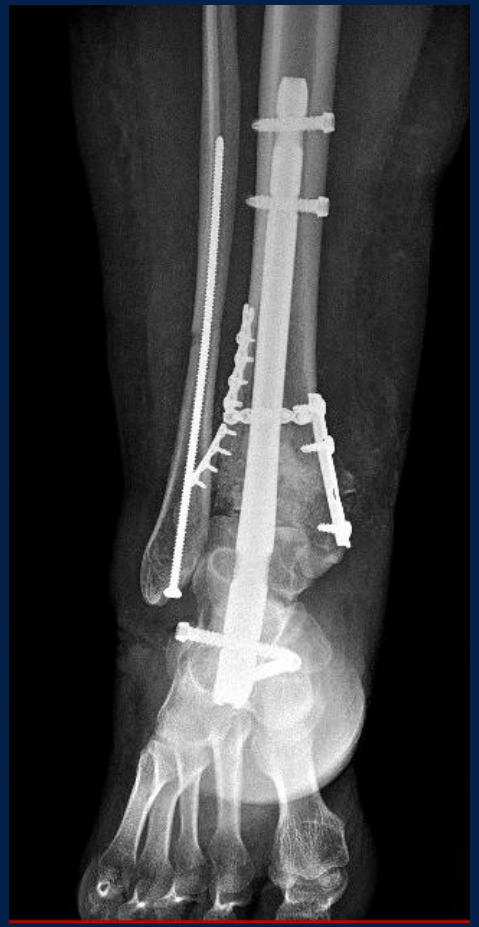


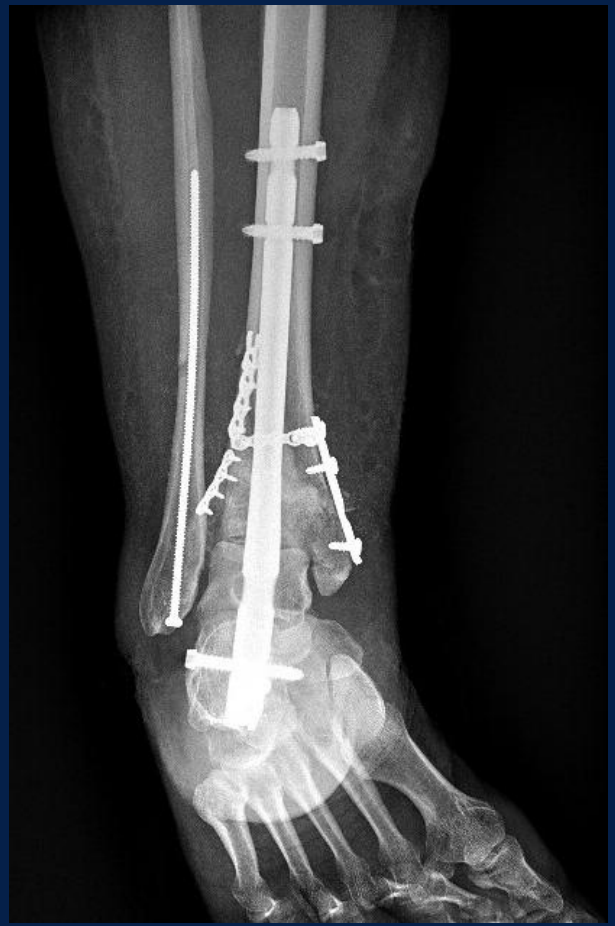

262 (14:52)
1

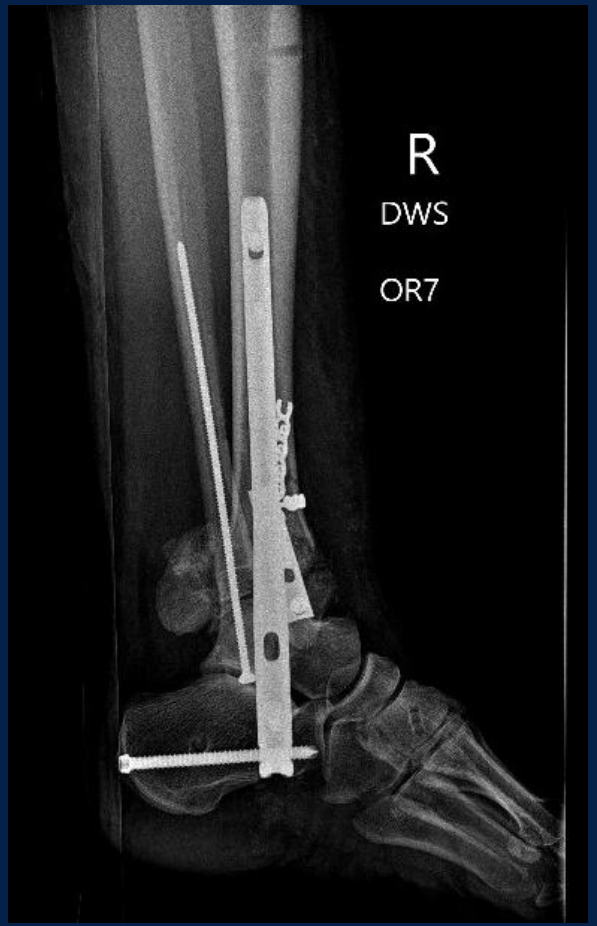

259 (14:35)
1





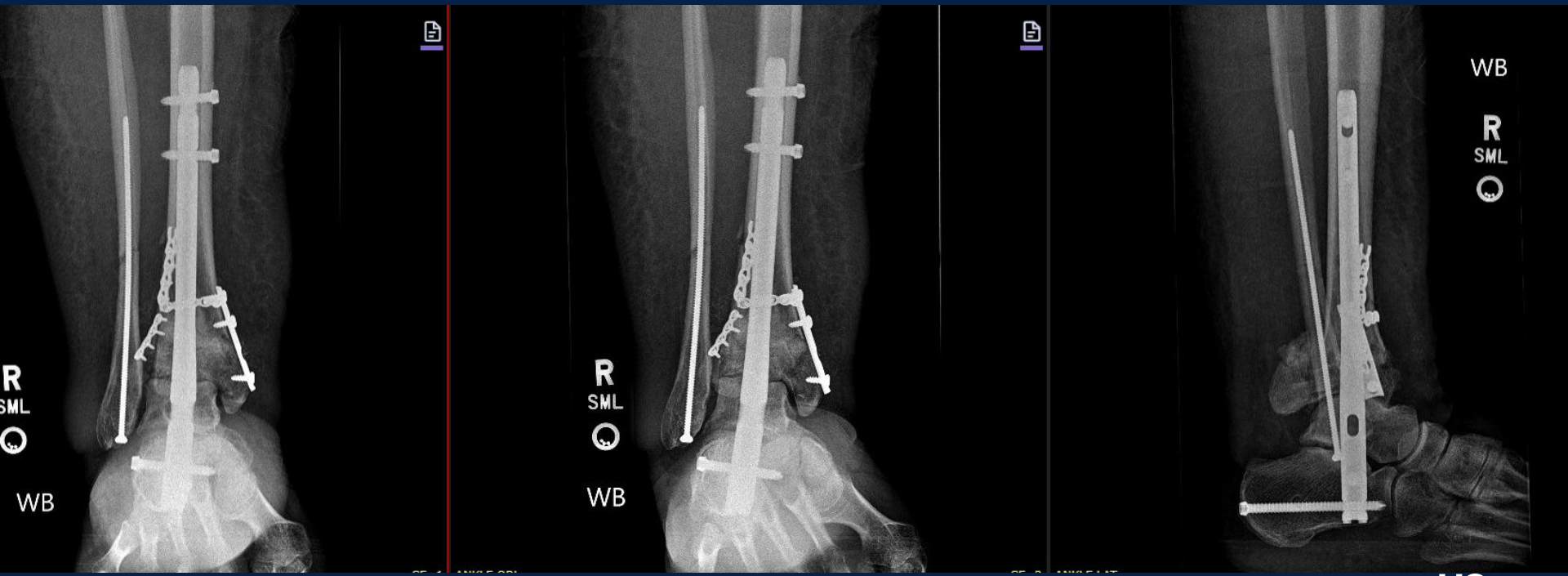





R
DWS
OR7

Discharged home with family POD 2

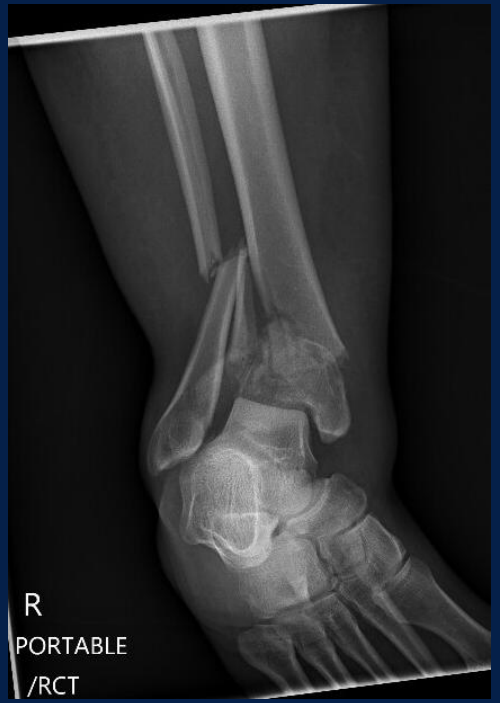
Care established with a methadone clinic

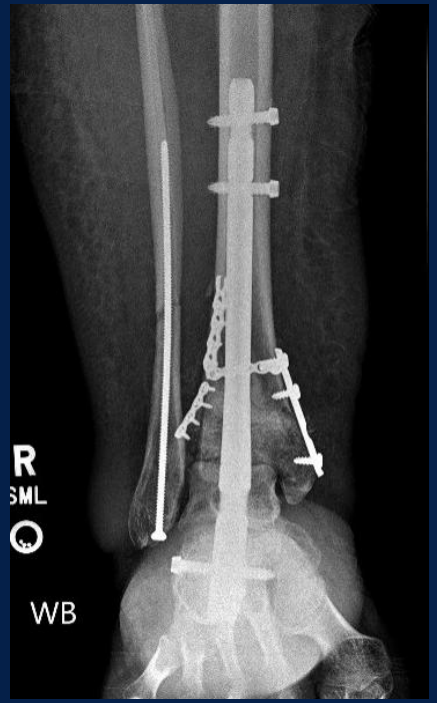


Discussion points:

1. Patient risk stratification

2. Role of acute TTC nail for pilon fractures in select populations?





Case 2: Distal Tibia

- 42 F with LLE pain after fall and having a twisting injury to the ankle. No pain elsewhere.
- PMH: GERD
- SHx: denies tobacco. Wine 4 days/week. THC/CBD use. Housed.

Musculoskeletal:

Comments: **The LLE is externally rotated. Skin intact w/o open wounds.**

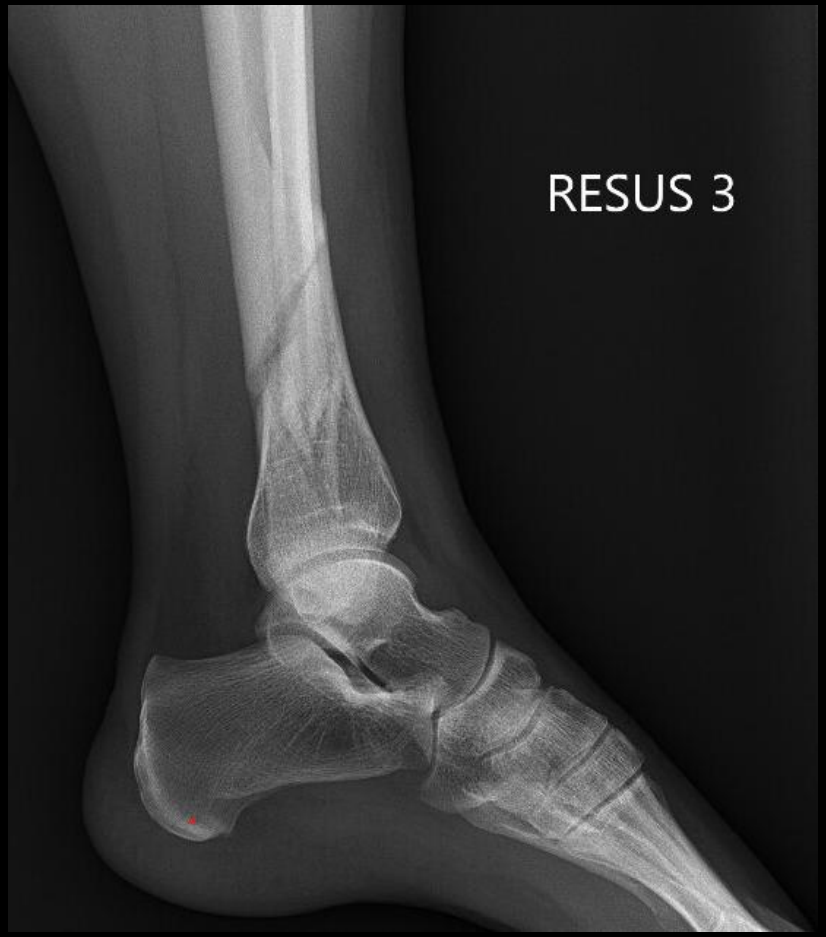
Compartments soft and compressible, no pain with passive stretch of the hallux

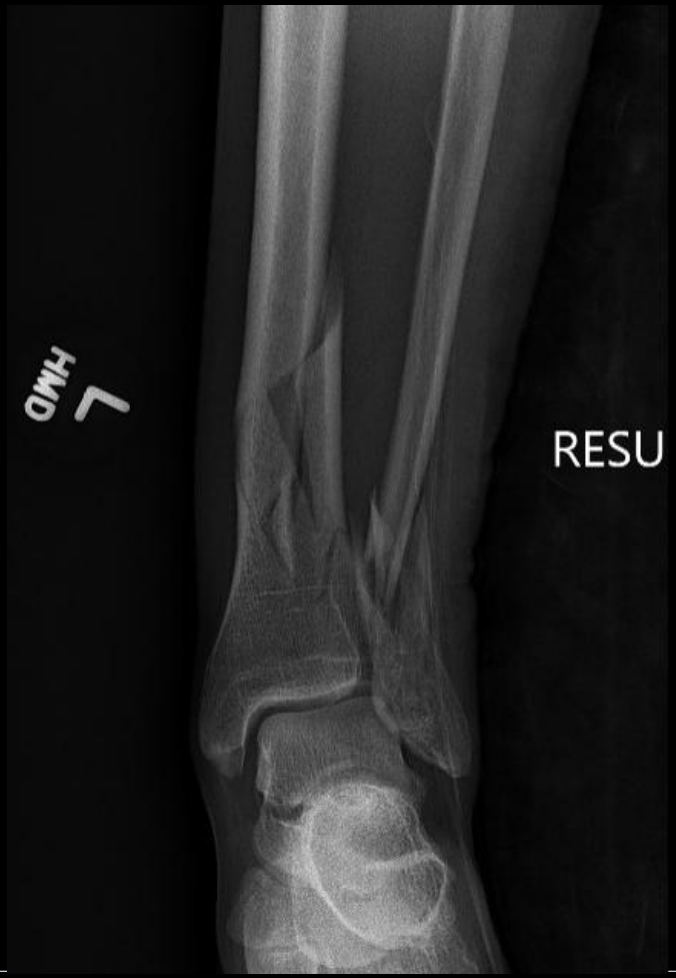
TTP over the distal tibia with mild soft-tissue swelling.

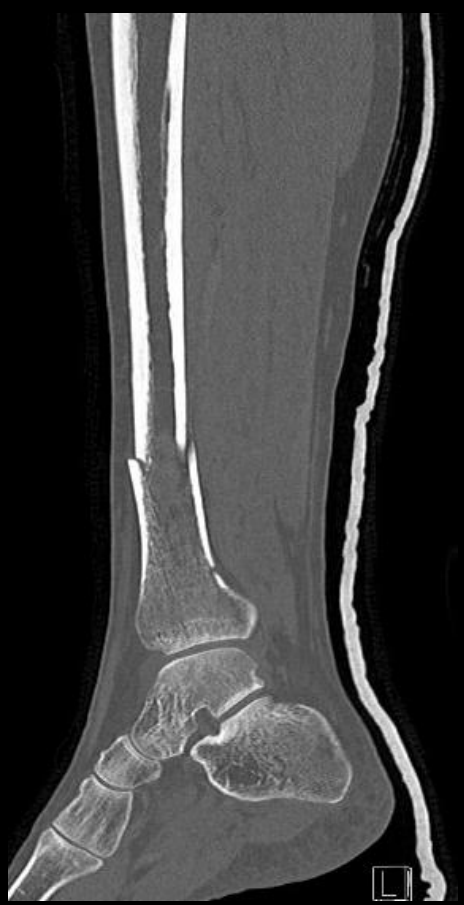
SILT S/S/Dp/SP/PTt. Able to move toes but has difficulty with ankle flexion and extension secondary to pain.

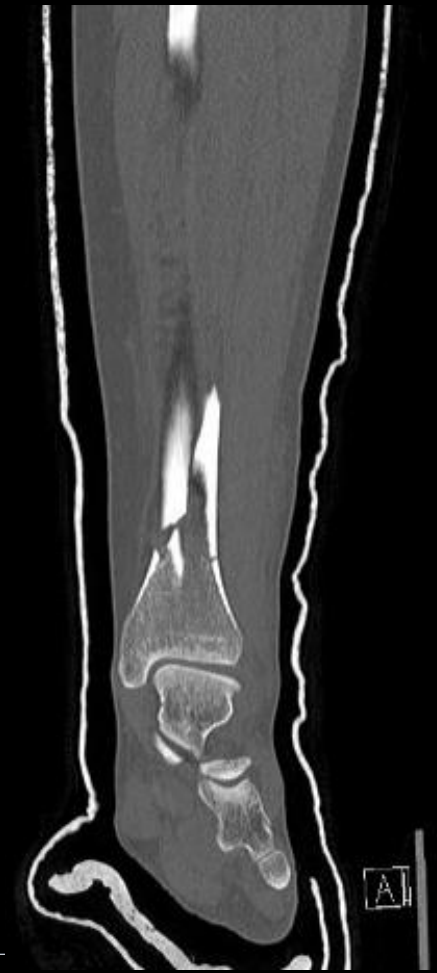
Skin is warm and well-perfused. 2+ DP pulses bilaterally.

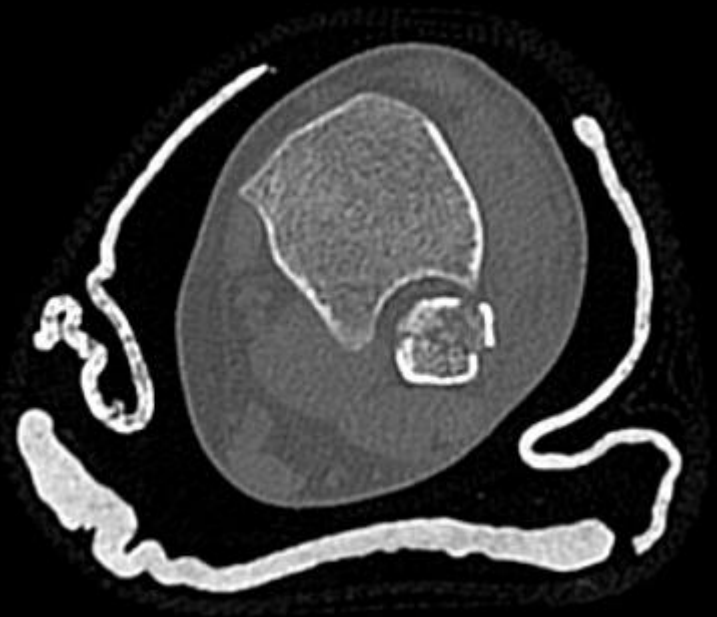
- 42 F with LLE pain after fall and having a twisting injury to the ankle. No pain elsewhere.
- PMH: GERD
- SHx: denies tobacco. Wine 4 days/week. THC/CBD use. Housed.


RESUS 3

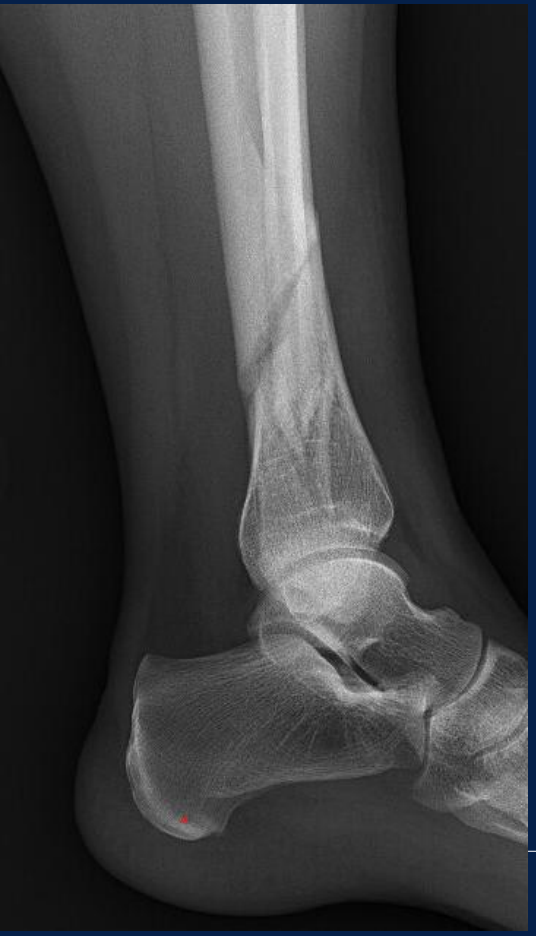

L
HMD
RESU

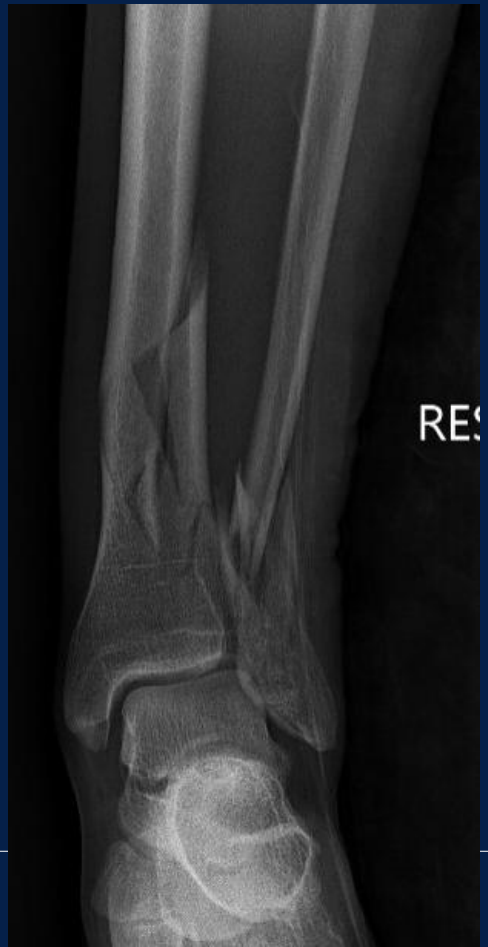

L

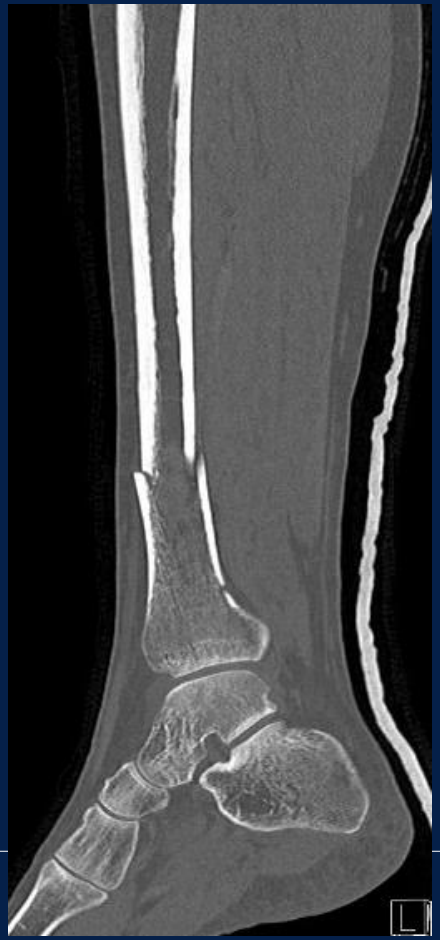

A

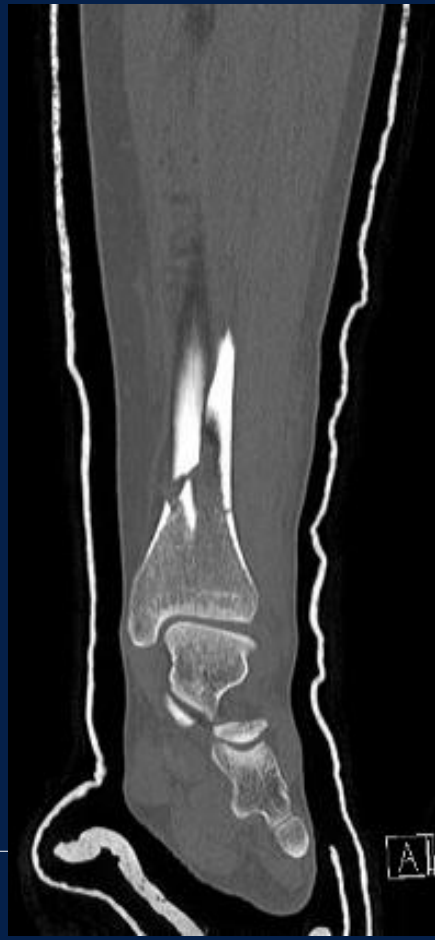


Nail versus plate???

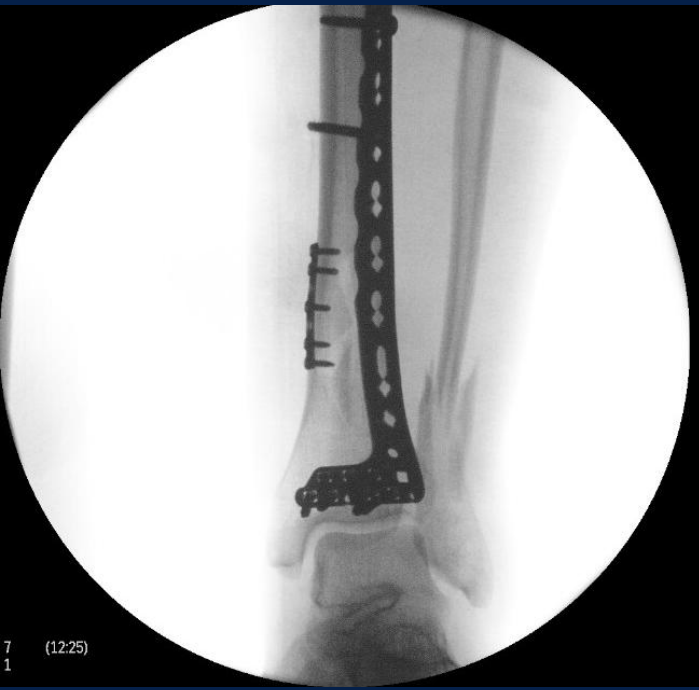


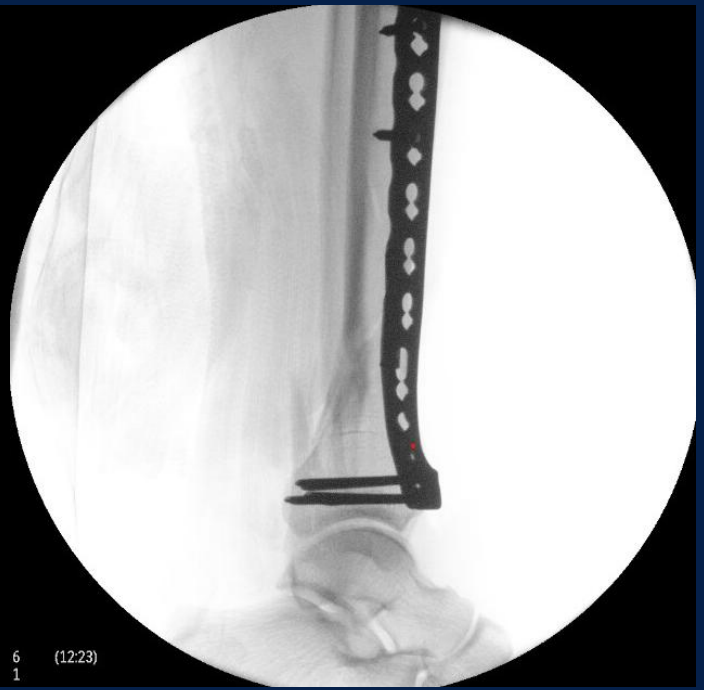


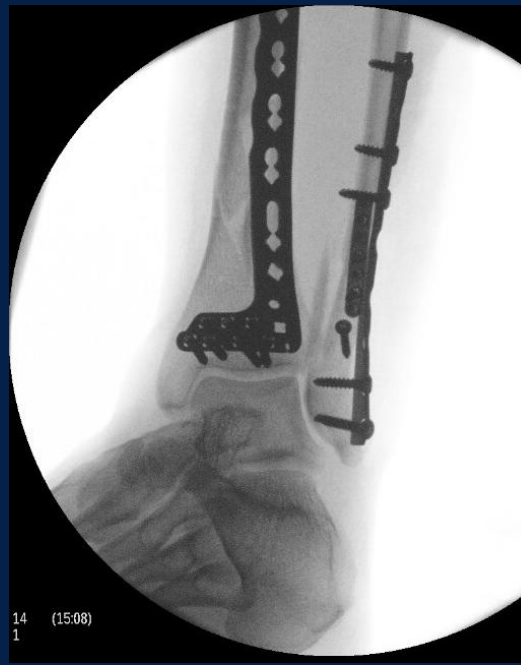


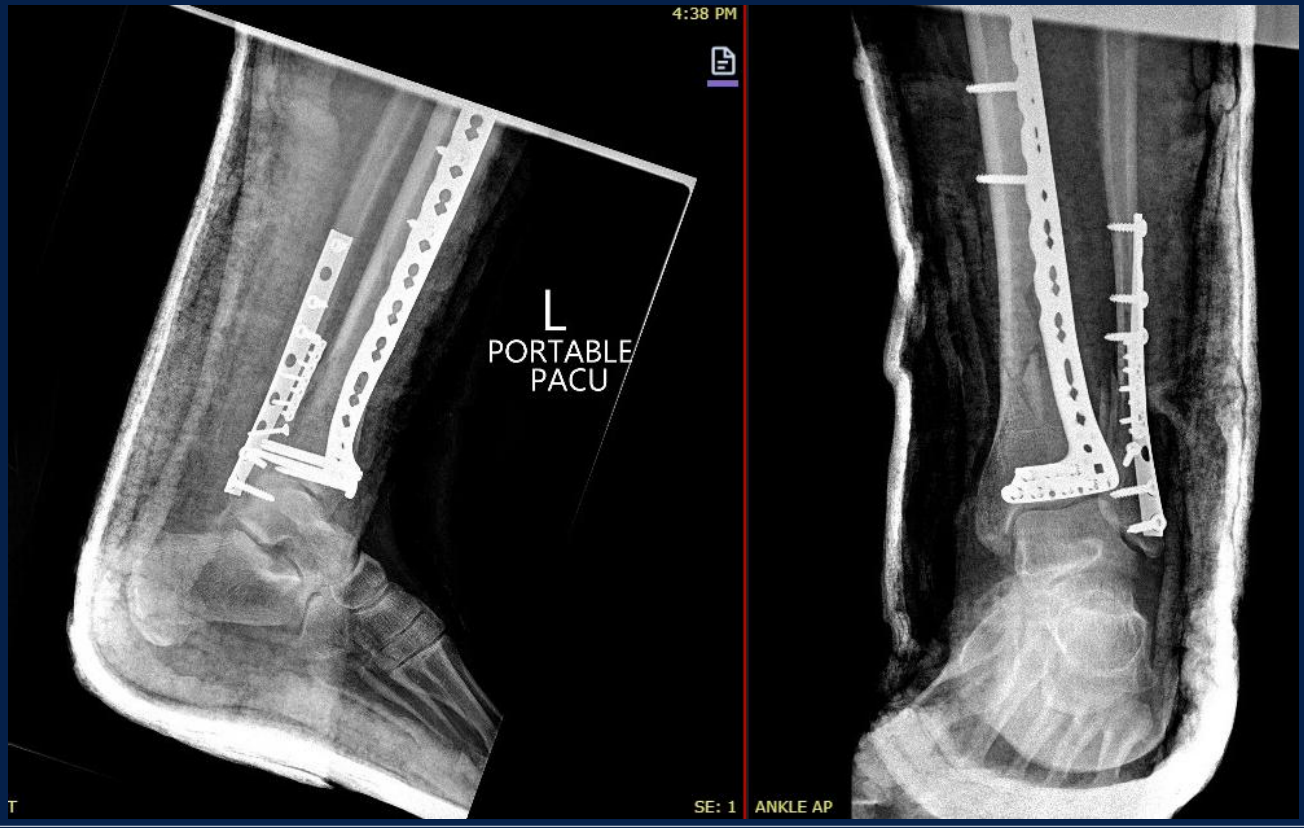


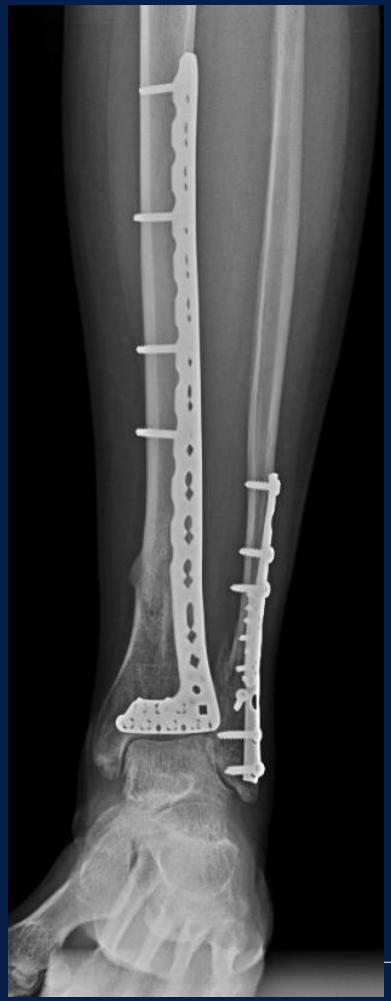
Plan: Distal tibia plate (anteromedial approach) and distal fibula plate (posterolateral approach)

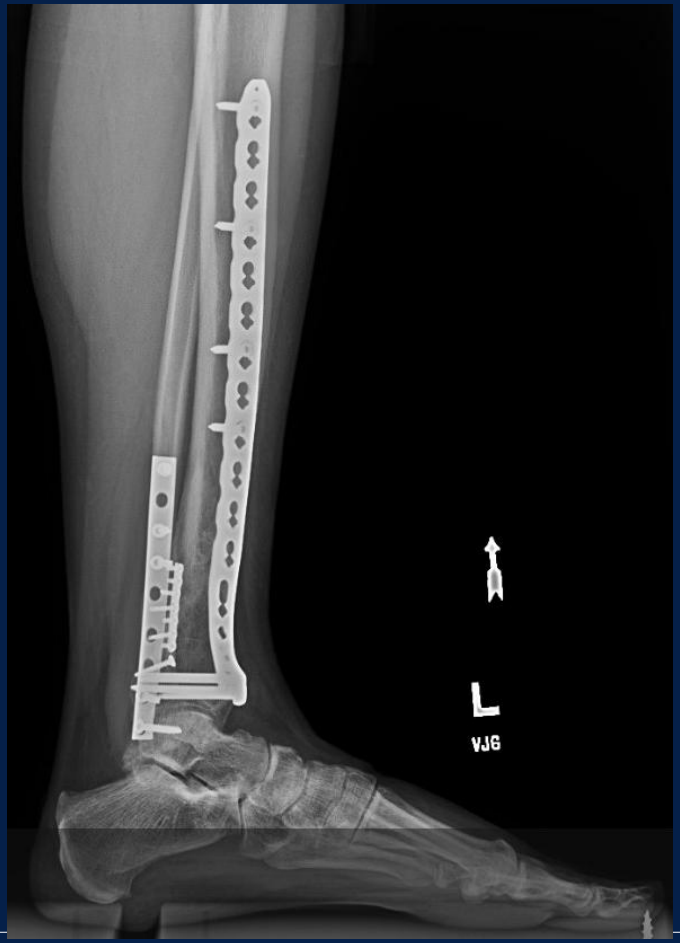







4:38 PM
L
PORTABLE
PACU
T
SE: 1
ANKLE AP





- 12 month follow up:
- Residual CRpS symptoms

UCSF