Traditional ankle arthroscopy has primarily utilized anterior approaches to the ankle joint with the main working portals anteromedial and anterolateral. The posterolateral portal has been advocated as a routine portal for both irrigation inflow and for instrumentation and viewing, especially in cases of osteochondral lesions located on the far posteromedial talar dome. The use of a posteromedial portal has been discouraged because of fears of neurovascular injury when operating on that side of the ankle. However, van Dijk has shown that posterior ankle arthroscopy can be performed safely in the prone position using a posterolateral and a posteromedial portal to
gain access to the posterior compartment.

The objectives of this presentation include:
1. To familiarize the surgeon with the posterior technique emphasizing the pertinent anatomy and safe techniques for visualization.
2. To review indications and contra indications for posterior ankle arthroscopy
3. To present case examples and discuss the pros and cons of arthroscopic vs open techniques for treatment.

POSTERIOR ANKLE ARTHROSCOPY: INDICATIONS

I. INTRA ARTICULAR PATHOLOGY
   a. Chondral and osteochondral lesions of the ankle joint
   b. Chondral and osteochondral lesions of the subtalar joint
   c. Loose bodies ankle and subtalar joints
   d. Posterior soft tissue impingement lesions
   e. Ankle/subtalar fusion

II. EXTRA ARTICULAR PATHOLOGY
    a. Retrocalcaneal bursitis
    b. Haglund’s deformity
    c. FHL tenosynovitis

III. PERI ARTICULAR PATHOLOGY
    a. Os trigonum
    b. Prominent posterior talar process

REVIEW OF PHYSICAL EXAMINATION FINDINGS OF POSTERIOR IMPINGEMENT
REVIEW OF RADIOGRAPHIC WORK UP FOR POSTERIOR IMPINGEMENT
REVIEW OF TECHNIQUE FOR POSTERIOR ANKLE ARTHROSCOPY

I. PRONE POSITION

II. POSTEROMEDIAL AND POSTEROLATERAL PORTALS AT LEVEL OF TIP OF FIBULA

III. SCOPE POSTEROLATERAL, ADVANCED TOWARD FIRST WEB SPACE

IV. SHAVER POSTEROMEDIAL INSERTED PERPENDICULAR TO SCOPE UNTIL CONTACT MADE, THEN SHAVER “WALKED” DOWN SCOPE SHEATH TO TIP

V. CREATE SPACE WITH SHAVER: SHAVER BLADE DIRECTED LATERAL, IE AWAY FROM FHL AND NEUROVASCULAR BUNDLE

VI. IDENTIFY FHL AT LEVEL OF SUBTALAR JOINT
VII. DO NOT WANDER MEDIAL TO FHL
VIII. LIMITED CAPSULECTOMY FOR EXPOSURE INTRA ARTICULAR

IX. SURGERY

CASE PRESENTATIONS

REFERENCES


