SUGGESTED GUIDELINES FOR INSERVICES DURING CLINICAL PRACTICUMS

The content of the inservice education program should either focus on the physical therapy profession in general or a specific topic of interest to the student and the audience. Discuss potential topics with the CCCE/CI early in your practicum. The CCCE/CI has final approval of the topic. The date and time of the inservice should be scheduled prior to the last day of the practicum. The inservice program should be between 20-30 minutes in length or as requested by the facility. The student will be evaluated for both the written outline and the oral presentation.

I. Objectives for the Inservice

At the completion of this activity, the student physical therapist will:
A. Demonstrate a comprehensive understanding of a topic relevant to physical therapy practice.
B. Demonstrate skills in library research and organization pertinent to the presentation.
C. Utilize skills in team communication by using other members of the health care team as resources for the presentation.
D. Employ skills in independent thinking by choosing the topic, developing it, and delivering the presentation.
E. Deliver the material in an organized, professional manner using good communication skills. A written handout is expected (word outline, patient handout, etc). An example of a patient handout for an inservice is attached.
F. If evaluation/treatment techniques are presented, please allow adequate time for demonstration and/or practice.
G. Encourage discussion by responding to the questions and comments of the audience.
H. Reflect on the work by accepting feedback related to the effort.

II. The written outline should include:
A. Title of Inservice
B. Description of Target Audience
C. Objectives (written in behavioral terms)
D. Teaching Methods Used
E. Brief Synopsis of Program Content
F. Evaluation Method(s) to be used to:
G. Assess your performance
H. Assess the level of knowledge of the audience after your presentation
Lateral Ankle Sprains

Related Anatomy and Mechanism of Injury

The most common type of ankle sprain injury is caused by an inversion stress. The anterior talofibular (ATF) ligament is most often affected with this type of injury as well as the calcaneofibular (CF) ligament. The strongest ligament of the lateral ankle is the posterior talofibular (PTF) ligament, which typically is only torn with a severe inversion stress to the ankle.

There are 3 grades of ligament sprains:
1. Grade 1: pain 2nd to tissue stress
2. Grade 2: Some ligament fibers are torn, resulting in some increased joint mobility, pain with stress and palpation of the tissue
3. Grade 3: complete, near-complete or avulsion of the ligament resulting in severe pain and joint instability

Types of Ankle Sprains

Sprains:
- Inversion stress to the ankle.
- Typically is only torn with a severe talofibular (PTF) ligament, which
- The strongest ligament of the lateral ankle is also affected with this type of injury
- The talofibular (ATF) ligament is most
- Often affected with this type of injury

Mechanism of Injury

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Sprains
- Most common type of ankle injury
- Ankle ligament resulting in severe pain and joint instability

Conservative Treatment Example

**PROTECTION PHASE (Acute):**
- Use compression, elevation, ice
- Immobilize the ankle in neutral (or slight DF and Evers)
- Use gentle joint mobilizations to maintain mobility and reduce pain
- Teach partial WB with crutches for decreased stress with ambulation

**CONTROLLED MOTION PHASE:**
- Continue wearing splint during WB to provide M/L stability and allow DF/PF
- Apply cross-fiber massage to the ligaments (as tolerated)
- Grade II joint mobilizations to maintain joint mobility (if ankle ROM is limited)
- Talocural distraction, talocural posterior glides (for DF), talocural anterior glides (for PF)
- Subtalar M/L glides (for Evers/Inv, respectively)
- Exercise examples: ankle pumps, ankle circles, writing the alphabet in the air, towel scrunches, seated gastrocnemius stretch, AROM into PF/Inv, isometric resistance to peroneal mm, partial/full WB balance board ex.

**RETURN TO FUNCTION PHASE:**
- Pt education to keep ankle splinted, taped, or wrapped with proper shoes to protect from re-injury during sport activities
- Exercise examples: 4-way ankle with TheraBand, forward/backward walking and cross-over sidestepping with TheraBand resistance to unaffected LE, BOSU or BAPS board

Indications for surgical repair/reconstruction of lateral ankle soft tissue structures:
1. Chronic mechanical or functional instability of the ankle during activity that can’t be resolved with conservative management
2. Acute, grade 3 lateral ankle sprain with a complete tear of the ATF and/or CF ligaments

The Brostrom-Gould Procedure: a direct repair of torn ATF and/or CF ligaments

What is involved in this procedure?
- The Brostrom-Gould procedure is an open procedure that involves direct suturing of the torn ATF and/or CF ligament ends. This is done by imbrication (an overlapping of lax ligaments) to tighten the ligament and provide reinforcement or reinsertion of the torn ligament to the bone. To reinforce the lateral ankle, the extensor retinaculum is stretched over the repaired structures and anchored to the anterior aspect of the distal fibula.

What are some advantages of the procedure?
- The Brostrom-Gould procedure provides stability without the need to harvest a soft tissue graft.
- Full ROM of the tibiotalar and subtalar joints can be retained.
- Due to increased retention of ROM, outcomes are better for people that want to return to activities that require full ankle mobility (i.e. gymnastics or ballet)

What does this mean for patients?
- Conservative treatment is the first step for lateral ankle sprains that are grade 1 or grade 2 in nature. Some patients may choose conservative treatment even with a grade 3 lateral ankle sprain, however, surgery is indicated when functional stability of the ankle cannot be achieved. Patients with lateral ankle sprains are more likely to suffer another sprain, which may eventually lead to chronic lateral ankle instability if proper ligament stability is not achieved.
- However, it is debatable whether the Brostrom-Gould procedure is the best available surgical repair for patients with chronic lateral ankle instability and options should be explored based on the patient’s joint stability and the activity level the patient desires to achieve following surgery.

**CURRENT RESEARCH**

For people with ‘generalized joint laxity’ and patients with generalized joint laxity (as categorized according to the Beighton criteria) are more prone to inferior outcomes and a higher failure rate after undergoing the modified Brostrom-Gould procedure when compared to people without generalized joint laxity.

Ligament augmentation reconstruction system (LARS) vs. modified Brostrom-Gould (MBG) procedure
Porter et al found that physically active patients with chronic lateral ankle ligament instability have superior outcomes following a LARS procedure compared to an MBG procedure up to 2 years post surgery.
REFERENCES

