

Open enucleation of the talus in a case report

Abstract

We report a case of open enucleation of the talus, surgically treated conservatively. Enucleation or triple dislocation of the talus is a rare and serious traumatic injury. The study reports case of a 55 years old, was the victim of an attack by a stone with a direct point of impact on the right ankle while the foot was fixed, resulting in total functional impotence and severe pain. Enucleation of the talus is a rare lesion, rarely described in the literature. The functional prognosis of the ankle is compromised by the risk of osteonecrosis.

Keywords: enucleation of the talus, severe pain, osteonecrosis, traumatic injury

Introduction

Talus Enucleation or triple dislocation of the talus is a rare traumatic injury [1,2] accounting for 2-10% of talar traumas [3,4]. A review of the literature revealed fewer than 80 cases of pure enucleation of the talus [5], and the majority were a consequence of an open injury [3].

The main risk factor for this type of injury is infection, which can even lead to osteonecrosis.

We report a case in which the patient underwent open enucleation of the talus and was surgically treated conservatively.

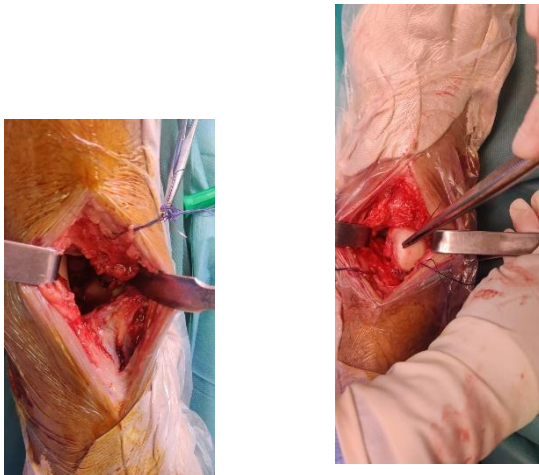
OBSERVATION

H. At 55 years of age, the victim of an attack by a stone, had a direct point of impact on the right ankle while the foot was fixed, resulting in total functional impotence and severe pain. Clinical examination revealed a varus deformity of the foot, with the talus protruding anteriorly and medially, associated with a 4 cm anteromedial wound classified as type II according to Cauchoix and Duparc, with no downstream vascular-nervous disorders. X-rays of the right ankle showed complete anterolateral enucleation of the talus without fracture of the malleolar pincer (fig. 1).

Surgery was performed as needed. After the wound was trimmed, exploration revealed soft tissue incarceration, preventing reduction of the talus (Figure 2). The soft tissue was therefore released, followed by reduction of the talus maintained by a trans-calcaneo-talo-tibial pin and two scapho-talar pins. The reduction was stable and maintained by a cast boot for two months (Figure 3), followed by rehabilitation. The functional result was satisfactory at the last follow-up, with no signs of radiological necrosis.



*Figure 1*X-ray of the right ankle showing pure anterolateral talus dislocation



*Figure 2*Intraoperative aspect of talus enucleation



*Figure 3*Postoperativeradiographic control

Discussion:

The talus is exposed to significant traumatic risk due to the intermediate position between the leg and the foot and the absence of muscular or tendinous insertion. It is subjected to considerable stress during walking and other activities and is at the center of a highly mobile joint complex.

Talus enucleation isn't an unusual lesion that has rarely been described in the literature. The functional prognosis of the ankle is compromised by the risk of osteonecrosis. The direction of enucleation can vary. Most often it is dislocated anterolaterally but the displacement may also be anteromedial or, and less in posteromedial.

However, the pathophysiological mechanism is still debated. For Pennal [8], anterolateral enucleation is performed through a dual process of forced plantar flexion and inversion. Plantar flexion results in rupture of the collateral ligament, while inversion leads to a tear of the talocalcaneal ligaments. The most precise study of enucleation mechanisms is that of Leitner (in 2), who described enucleation as the ultimate stage of supination trauma—in other words, the ultimate stage of medial subtalar dislocation. The treatment advocated by the various authors is far from unequivocal. Currently, the trend goes for a conservative treatment for acute enucleations [2], reserving arthrodesis for secondary septic complications and late arthrosis evolution. The reduction of talus dislocation should be an emergency in order to prevent skin and vascular complications [10]. Tibiocalcaneal arthrodesis was adopted by Detenbeck and Kelly [3] but is a source of significant stiffness. Butel and Witvoet [9] noted the poor functional results of talectomy in enucleations of the talus and recommended triple arthrodesis as the first-line procedure, using the talus as a graft. Some authors recommend closed reduction with the aid of transcalcaneal traction [10].

Tibiocalcaneal arthrodesis was adopted by Detenbeck and Kelly [3] but is a source of significant stiffness. Butel and Witvoet [9] noted the poor functional results of talectomy in enucleations of the talus and recommended triple arthrodesis as a first-line treatment, using the talus as a graft. Some authors recommend closed reduction with the aid of transcalcaneal traction [10]. In the event of failure, the bloody approach is recommended [11,12]. Once the talus has been reduced, open focus allows the capsuloligamentous structures to be repaired [10,13]. Immobilization is achieved with a cast for four to eight weeks [10] or with a pin [13]. The evolution of talus enucleation is fraught with complications—the main one being osteonecrosis after conservative treatment. Some authors consider this necrosis inevitable [2,11]. This is thought to be due to destruction of the capsuloligamentous attachments and complete rupture of the entire vascular supply [2]. As a few cases of enucleation of the talus have escaped this type of complication, several hypotheses can be put forward. Shahparee [14] suggested that the persistence of some ligamentous attachments, particularly the deltoid ligament, explains the inconsistency of necrosis. The tarsal canal artery is a branch of the posterior tibial artery and constitutes the main vascularization site of the body of the talus [6]. Its integrity at the time of the accident could explain the absence of talus necrosis in some anterolateral enucleations. Biga and Defives [1] reported a case of pure anterolateral enucleation of the talus treated by simple reduction.

At the two-year follow-up, we found no radiological signs of talar necrosis in any of our patients.

Conclusion:

Conservative treatment with reduction by external manoeuvring of an enucleation of the talus, whatever its variety', constitutes a major prognostic element to avoid damage by bloody reduction, which remains the vascular attachments and favors evolution toward osteonecrosis of the talus, which remains the main complication in this rare pathology.

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