Medical Treatment Guidelines

Ankle and Foot Injuries

DRAFT – For Public Comment JULY 2019

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A. **General Guideline Principles**

The principles summarized in this section are key to the intended application of the New York State Medical Treatment Guidelines (MTG) and are applicable to all Workers’ Compensation Medical Treatment Guidelines.

A.1 **Medical Care**

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

A.2 **Rendering Of Medical Services**

Any medical provider rendering services to a workers’ compensation patient must utilize the Treatment Guidelines as provided for with respect to all work-related injuries and/or illnesses.

A.3 **Positive Patient Response**

Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living (ADL), cognition, psychological behavior, and efficiency/velocity measures which can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.

A.4 **Re-Evaluate Treatment**

If a given treatment or modality is not producing positive results, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter. Recognizing that treatment failure is at times attributable to an incorrect diagnosis should prompt the clinician to reconsider the diagnosis in the event of an unexpected poor response to an otherwise rational intervention.

A.5 **Education**

Education of the patient and family, as well as the employer, insurer, policy makers and the community should be a primary emphasis in the treatment of work-related injury or illness. Practitioners should develop and implement effective educational strategies and skills. An education-based paradigm should always start with communication providing reassuring information to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention of future injury.

### Time Frames

A.6 **Acuity**

Acute, Subacute and Chronic are generally defined as timeframes for disease stages:

- Acute – Less than one month
- Subacute - One to three month, and
- Chronic - greater than three months.
A.7 Diagnostic Time Frames
Diagnostic time frames for conducting diagnostic testing commence on the date of injury. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.

A.8 Treatment Time Frames
Treatment time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration may be impacted by disease process and severity, patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.

A.9 Delayed Recovery
For those patients who fail to make expected progress 6-12 weeks after an injury, reexamination in order to confirm the accuracy of the diagnosis and re-evaluation of the treatment program should be performed. Assessment for potential barriers to recovery (yellow flags/psychological issues) should be ongoing throughout the care of the patient. However, at 6-12 weeks, alternate treatment programs, including formal psychological or psychosocial evaluation, should be considered. Referrals to mental health providers (i.e.: psychology/psychiatry) for the evaluation and management of delayed recovery do not indicate or require the establishment of a psychiatric or psychological condition. The evaluation and management of delayed recovery does not require the establishment of a psychiatric or psychological claim.

Treatment Approaches

A.10 Active Interventions
Active interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.11 Active Therapeutic Exercise Program
Active therapeutic exercise program goals should incorporate patient strength, endurance, flexibility, range of motion, sensory integration, coordination, and education as clinically indicated. This includes functional application in vocational or community settings.

A.12 Diagnostic Imaging And Testing Procedures
Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results. All diagnostic procedures have variable specificity and sensitivity for various diagnoses.

When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, a second diagnostic procedure will be redundant if it is performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure (that may be a repeat of the same procedure, when the rehabilitation physician, radiologist or surgeon documents the study was of inadequate quality to make
a diagnosis) can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis, and is permissible under the MTG.

It is recognized that repeat imaging studies and other tests may be warranted by the clinical course and to follow the progress of treatment in some cases. It may be of value to repeat diagnostic procedures (e.g., imaging studies) during the course of care to reassess or stage the pathology when there is progression of symptoms or findings, prior to surgical interventions and therapeutic injections when warranted, and post-operatively to follow the healing process. Regarding CT examinations, it must be recognized that repeat procedures result in an increase in cumulative radiation dose and associated risks.

A.13 Surgical Interventions
Contemplation of surgery should be within the context of expected functional outcome. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat pain, there must be clear correlation between the pain symptoms and objective evidence of its cause. In all cases, shared decision making with the patient is advised. The patient should be given the opportunity to understand the pros and cons of surgery, potential for rehabilitation as an alternative where applicable, evidence-based outcomes, and specific surgical experience.

A.14 Pre-Authorization
All diagnostic imaging, testing procedures, non-surgical and surgical therapeutic procedures within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines are considered authorized, with the exception of the following procedures: Lumbar Fusion, Artificial Disc Replacements, Vertebroplasty, Kyphoplasty, Electrical Bone Growth Stimulators, Intrathecal Drug Delivery (Pain Pumps), Osteochondral Autograft, Autologous Chondrocyte Implantation, Meniscal Allograft Transplantation and Knee Arthroplasty (Total or Partial Knee Joint Replacement). These are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Second or subsequent procedures (the repeat performance of a surgical procedure due to failure of, or incomplete success from the same surgical procedure performed earlier, if the Medical Treatment Guidelines do not specifically address multiple procedures) also require pre-authorization.

A.15 Personality/Psychological/Psychosocial Evaluations
In select patients, diagnostic testing procedures may be useful when there is a discrepancy between diagnosis, signs, symptoms, clinical concerns or functional recovery. Psychological testing should provide differentiation between pre-existing depression versus injury-caused depression, as well as post-traumatic stress disorder, and other psychosocial issues that may include work or non-work-related issues when such conditions are identified in the patient.

For those patients who fail to make expected progress 6-12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests, reexamination
in order to confirm the accuracy of the diagnosis should be made. Formal psychological or psychosocial evaluation may be considered.

A professional fluent in the primary language of the patient is strongly preferred. When such a provider is not available, services of a professional language interpreter must be provided.

Frequency: One time visit for evaluation. If psychometric testing is indicated by findings in the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

A.16 Personality/Psychological/Psychosocial Intervention

Following psychosocial evaluation, when intervention is recommended, such intervention should be implemented as soon as possible. This can be used alone or in conjunction with other treatment modalities.

- Time to produce effect: 2 to 8 weeks.
- Optimum duration: 6 weeks to 3 months.
- Maximum duration: 3 to 6 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervision may be required, and if further counseling is indicated, documentation of the nature of the psychological factors, as well as projecting a realistic functional prognosis, should be provided by the authorized treating practitioner every 4 to 6 weeks during treatment.

A.17 Functional Capacity Evaluation (FCE)

Functional capacity evaluation is a comprehensive or more restricted evaluation of the various aspects of function as they relate to the patient's ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range-of-motion, coordination and strength, worker habits, employability, as well as psychosocial, cognitive, and sensory perceptual aspects of competitive employment may be evaluated. Components of this evaluation may include: (a) musculoskeletal screen; (b) cardiovascular profile/aerobic capacity; (c) coordination; (d) lift/carrying analysis; (e) job-specific activity tolerance; (f) maximum voluntary effort; (g) pain assessment/psychological screening; (h) non-material and material handling activities; (i) cognitive; (j) visual; and (k) sensory perceptual factors.

In most cases, the question of whether a patient can return to work can be answered without an FCE.

When an FCE is being used to determine return to a specific job site, the treating physician is responsible for understanding and considering the job duties. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.

An FCE may be considered at time of MMI, following reasonable prior attempts to return to full duty throughout course of treatment, when the treating physician is unable to make a clear determination on work status on case closure.
A.18 Return To Work
For purposes of these guidelines, return to work is defined as any work or duty that the patient is able to perform safely. It may not be the patient’s regular work. Ascertainment of a return to work status is part of medical care, and should be included in the treatment and rehabilitation plan. It is normally addressed at every outpatient visit. A description of the patient’s status and task limitations is part of any treatment plan and should provide the basis for restriction of work activities when warranted. Early return to work should be a prime goal in treating occupational injuries. The emphasis within these guidelines is to move patients along a continuum of care and return to work, since the prognosis of returning an injured worker to work drops progressively the longer the worker has been out of work.

A.19 Job Site Evaluation
The treating physician may communicate with the employer or the employer’s designee, either in person or by telephone, to obtain information regarding the demands of the patient’s pre-injury job, including a description of the exertional demands of the job, the need for repetitive activities, load lifting, static or awkward postures, or any other factors that would pose a risk of re-injury or impedance of convalescence. When returning to work at the patient’s previous job task/setting is not feasible, given the clinically determined restrictions on the patient’s activities, inquiry should also be made about modified duty work settings, and a similar set of questions should be posed by the physician about work activities/demands in modified duty jobs.

Ideally, the physician would gain the most information from an on-site inspection of the job settings and activities; but it is recognized that this may not be feasible in most cases. If job videos/CDs/DVDs are available from the employer, these can contribute valuable information.

Frequency: 1 or 2 calls
- 1st call: Patient is in a functional state where the patient can perform some work.
- 2nd call: Patient has advanced to state where the patient is capable of enhanced functional demands in a work environment.

The physician shall document the conversation.

Other

A.20 Guideline Recommendations And Medical Evidence
The Workers’ Compensation Board and its Medical Advisory Committee have not independently evaluated or vetted the scientific medical literature used in support of the guidelines, but have relied on the methodology used by the developers of various guidelines utilized and referenced in these Guidelines.

A.21 Experimental/Investigational Treatment
Medical treatment that is experimental/investigational and not approved for any purpose, application or indication by the FDA is not permitted under these Guidelines.

A.22 Injured Workers As Patients
In these Guidelines, injured workers are referred to as patients recognizing that in certain circumstances there is no doctor-patient relationship.
A.23 Scope Of Practice

These Guidelines do not address scope of practice or change the scope of practice.
B. Introduction
This guideline addresses common and potentially work-related ankle and foot injuries. It encompasses assessment; including identification of “red flags” or indicators of potentially-serious injury or disease; diagnosis; diagnostic studies for identification of clinical pathology; work-relatedness; and management, including modified duty and activity, return to work, and an approach to delayed recovery. Red flags include fracture, dislocation, malignancy, metabolic disorders, infection, and other conditions.

B.1 History Taking and Physical Examination

B.1.a History Taking and Physical Examination
History taking and physical examination establish the foundation/basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not consistent with each other, the objective clinical findings should have preference. The medical records should reasonably document the following:

B.1.b History of Present Injury
- Mechanism of injury: This includes details of symptom onset and progression, and symptoms that may arise from postural or functional accommodation to the Ankle-Foot injury;
- Relationship to work: This includes a statement of the probability that the illness or injury is work-related;
- Prior occupational and non-occupational injuries: To the same area including specific prior treatment;
- Ability to perform job duties and activities of daily living; and
- Exacerbating and alleviating factors for symptoms; not limited to the Ankle-Foot.

B.1.c Past History
- Past medical history includes, but is not limited to, neoplasm, gout, arthritis, and diabetes;
- Review of systems includes, but is not limited to, symptoms of rheumatologic, neurologic, endocrine, neoplastic, and other systemic diseases;
- Smoking history;
- Vocational and recreational pursuits;
- Prior imaging studies; and
- Past surgical history.

B.1.d Physical Examination
Examination of a joint should include the joint above and below the affected area, including the opposite side for comparison. Physical examination should include accepted tests and exam techniques applicable to the joint or area being examined, including:
• Visual inspection - Examine both feet and look for and note asymmetries and for deformities suggestive of degeneration, malformation, fracture, or dislocations. Observe for signs of serious injuries, e.g., degloving injuries, lacerations, puncture wounds, open wounds and crush injuries;
• Palpation;
• Range of motion/quality of motion (active and passive); The range of motion (ROM) of the foot and ankle should be determined both actively and passively. Compare mobility of the affected and unaffected side;
• Strength (weakness / atrophy);
• Joint integrity / stability - Stress the ligaments to assess the stability and compare to contralateral unaffected side;
• Examination for deformity/displacement; and
• Assess neurologic (motor, sensory and reflexes) and vascular status (integrity of distal circulation, peripheral pulses, skin temperature) of the foot and ankle, as clinically indicated. Observe for signs of serious injuries, e.g., degloving injuries, lacerations, puncture wounds open wounds and crush injuries.

B.2 Assessing Red Flags
Certain findings, “red flags”, raise suspicion of potentially serious medical conditions. Assessment (history and physical examination) should include evaluation for red flags. In the foot and ankle these findings or indicators may include: fracture, dislocations, infection or inflammation, tumor, tendon rupture and neurological or vascular compromise including compartment syndrome. Further evaluation/consultation or urgent/emergency intervention may be indicated, and the New York Ankle and Foot Injury Medical Treatment Guidelines incorporate changes in clinical management triggered by the presence of “red flags.”

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<tr>
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<td>Dislocation</td>
<td>Significant ankle or foot trauma&lt;br&gt; Ankle or foot deformity with or without spontaneous reduction or self-reduction</td>
<td>Edema&lt;br&gt; Deformity</td>
</tr>
<tr>
<td>Fracture</td>
<td>Significant trauma&lt;br&gt; Abnormal mobility&lt;br&gt; Deformity with or without spontaneous or self-reduction&lt;br&gt; Painful swelling of ankle or foot</td>
<td>Edema&lt;br&gt; Ecchymosis or hematoma&lt;br&gt; Deformity&lt;br&gt; Abnormal mobility&lt;br&gt; Bony crepitus</td>
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<td>Infection</td>
<td>Swelling, redness, localized warmth of ankle or foot&lt;br&gt; Fever or chills&lt;br&gt; Diabetes or immunosuppression (e.g., transplant, chemotherapy, HIV)</td>
<td>Visible and/or palpable mass&lt;br&gt; Local tenderness, heat, swelling, erythema&lt;br&gt; Systemic signs of infection (fever, tachycardia)</td>
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<tr>
<td>Inflammation</td>
<td>Inflammatory arthritis or autoimmune disease</td>
<td>Swelling, effusion, erythema, warmth, or edema</td>
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<tr>
<td>Metabolic disorder</td>
<td>Poor nutrition&lt;br&gt; Changes in weight, appetite, energy level, skin, or bowel or bladder function&lt;br&gt; Hair loss</td>
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| **Acute gout** | Sudden attack(s) of joint pain, redness, and swelling, usually monarticular, especially of the great toes  
Predisposing factors of being a man or post-menopausal woman, renal impairment, hyperuricemia, and use of diuretics or cytotoxic drugs | Swelling  
Red, tender, warm first metatarsal joint |
|---|---|---|
| **Neoplasm** | Neoplastic disorder  
Unexplained weight loss, fatigue, masses | Palpable mass  
Deformity of ankle or foot |
| **Rapidly progressive neurological compromise** | Neuropathy, decreased or absent sensation  
Neurologic disease  
Diabetes  
Dislocation or fracture  
May have sustained laceration, or direct trauma | Decreased sensation in feet and ankles  
Loss of vibratory or positional sense  
Altered sensation in a dermatomal distribution  
Absent ankle jerk  
Motor loss in specific distribution  
Painless swelling (Charcot’s joint) |
| **Rapidly progressive vascular compromise** | Diabetes  
Peripheral vascular disease or bypass grafts  
Dislocation or fracture  
May have sustained laceration, or direct trauma | Decreased or absent foot and ankle pulses  
Decreased capillary filling  
Cold, pale extremity |
| **Tendon ruptures and evulsions** | Sharp pain to the posterior distal calf or ankle, may be accompanied by loud pop  
Forceful plantarflexion of the foot, or unaccustomed and vigorous running, hiking, or climbing  
May have sustained laceration, open wounds, crush injuries, or direct trauma  
May have degloving injury  
Administration of fluoroquinolones or local injections | Swelling and bruising  
Inability to point foot downward and stand or walk comfortably  
Positive Thompson test  
May have overlying signs of trauma including laceration, open wounds, puncture wounds, crush injuries |
| **Achilles** | Pain and swelling of the lateral heel  
May have sustained laceration, open wounds, crush injuries, or direct trauma  
May have degloving injury | Impaired eversion strength  
May have overlying signs of trauma including laceration, open wounds, puncture wounds or crush |
| **Peroneal** | Swelling and pain in the anterior ankle  
May have sustained laceration, open wounds, crush injuries, or direct trauma  
May have degloving injury | Anterior ankle tenderness, probable impaired dorsiflexion strength, tenderness at the first metatarsotarsal joint  
May have overlying signs of trauma including laceration, open wounds, puncture wounds, crush injuries |
| **Tibialis, Anterior** | Medial ankle pain and swelling, particularly if behind the medial malleolus, new or progressive flatfoot deformity (with or without pain) | Flatfoot deformity, particularly when unilateral; tenderness of the posterior medial malleolus, asymmetrical flat foot, difficulty with ipsilateral heel raise |
May have sustained laceration, open wounds, crush injuries, or direct trauma  
May have degloving injury  
May have overlying signs of trauma including laceration, open wounds, puncture wounds, or crush injuries

B.3  Diagnostic Criteria and Differential Diagnosis

For most cases presenting with true foot and ankle disorders, diagnostic studies are usually not needed until after a period of conservative care and observation. Most ankle and foot problems improve quickly once any red flags are ruled out. Routine testing, i.e., laboratory tests, plain-film radiographs of the foot or ankle, or special imaging studies are not recommended during the first month of activity limitation except when a red flag that is noted on history or examination raises suspicion of a dangerous foot or ankle condition or of referred pain.

B.3.a  Diagnostic Testing and Procedures

One diagnostic imaging procedure may provide the same or distinctive information as obtained by other procedures. Therefore, prudent choice of procedure(s) for a single diagnostic procedure, a complementary procedure in combination with other procedures(s), or a proper sequential order in multiple procedures will ensure maximum diagnostic accuracy, minimize adverse effect to patients and promote cost effectiveness by avoiding duplication or redundancy.

All diagnostic imaging procedures have a significant percentage of specificity and sensitivity for various diagnoses. None is specifically characteristic of a certain diagnosis. Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results.

When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, the second diagnostic procedure will be redundant if it is performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure (that may be a repeat of the same procedure, when the rehabilitation physician, radiologist or surgeon documents that the study was of inadequate quality to make a diagnosis) can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis. Usually, preference of a procedure over others depends upon availability, a patient’s tolerance, and/or the treating practitioner’s familiarity with the procedure.

It is recognized that repeat imaging studies and other tests may be warranted by the clinical course and to follow the progress of treatment in some cases. It may be of value to repeat diagnostic procedures (e.g. imaging studies) during the course of care to reassess or stage the pathology when there is progression of symptoms or findings, prior to surgical interventions and therapeutic injections when warranted, and post-operatively to follow the healing process. Regarding CT examinations, it must be recognized that repeat procedures result in an increase in cumulative radiation dose and associated risks.

When indicated, the following can be utilized for further evaluation of foot and ankle injuries, based upon the mechanism of injury, symptoms, and patient history.

Table 2. Diagnostic Criteria for Non-Red-Flag Conditions
<table>
<thead>
<tr>
<th>Probable Diagnosis or Injury</th>
<th>Mechanism</th>
<th>Unique Symptoms</th>
<th>Unique Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankle sprain</td>
<td>Inversion of ankle Eversion of ankle</td>
<td>Pain at or below lateral or medial malleolus Swelling over or near malleolus</td>
<td>Swelling at or below malleolus Tenderness over medial or lateral ankle ligament With severe sprain, positive drawer sign for instability</td>
</tr>
<tr>
<td>Forefoot sprain</td>
<td>Plantar flexion, dorsiflexion, or inversion beyond range</td>
<td>Dorsal foot pain Swelling of dorsal foot</td>
<td>Swelling in dorsum of foot Tenderness over dorsum of foot</td>
</tr>
<tr>
<td>Ankle or foot tendonitis</td>
<td>May be idiopathic, due to inflammatory conditions, and speculatively due to overuse</td>
<td>Heel cord pain Pain over specific tendon unit with plantarflexion or dorsiflexion</td>
<td>Pain over muscle/tendon unit on motion or resisted motion of tendon unit Tenderness of involved tendon</td>
</tr>
<tr>
<td>Neuroma</td>
<td>Idiopathic</td>
<td>Gradual onset of pain and paresthesias on both sides of web space</td>
<td>Reproduction of symptoms by pressing metatarsals together or pressing web space</td>
</tr>
<tr>
<td>Metatarsalgia</td>
<td>Idiopathic Degenerative changes Prolonged weight bearing</td>
<td>Gradual onset of pain under metatarsal heads with weight bearing</td>
<td>Reproduction of metatarsal pain on compression Decreased tissue padding under metatarsal heads</td>
</tr>
<tr>
<td>Bunion, hallux valgus</td>
<td>Degenerative change</td>
<td>Lateral deviation of first toe Pain in first toe from overlap with tight footwear</td>
<td>Lateral angulation of great toe Metatarsal angle of &gt; 10°</td>
</tr>
<tr>
<td>Plantar fasciitis</td>
<td>Idiopathic</td>
<td>Pain across sole of foot Pain with 1st step upon rising in the morning</td>
<td>Tenderness on compression of plantar fascia</td>
</tr>
<tr>
<td>Heel spur</td>
<td>Degenerative change Idiopathic</td>
<td>Pain at heel with weight bearing First steps upon rising in the morning very painful in heel</td>
<td>Point tenderness over plantar calcaneus</td>
</tr>
<tr>
<td>Metatarsal stress fracture</td>
<td>Repetitive load</td>
<td>Pain in the dorsal forefoot on weight bearing</td>
<td>Point tenderness over metatarsal shaft</td>
</tr>
<tr>
<td>Toe fracture</td>
<td>Direct trauma</td>
<td>Pain at fracture site (possibly)</td>
<td>Point tenderness Deformity Hematoma</td>
</tr>
<tr>
<td>Crush Injury</td>
<td>Direct trauma</td>
<td>Ranges from nonspecific pain to pain at fracture site</td>
<td>Point tenderness Deformity Hematoma Swelling</td>
</tr>
<tr>
<td>Nonspecific foot or ankle pain</td>
<td>Unknown</td>
<td>Nonspecific pain in foot or ankle</td>
<td>None</td>
</tr>
</tbody>
</table>
C. Conditions: This guideline addresses the following Foot and Ankle Disorders

C.1 Achillies Tendinopathy
C.2 Achillies Tendon Rupture
C.3 Ankle Tendinopathies
C.4 Tenosynovitis
C.5 Plantar Heel Pain (Plantar Fasciitis)
C.6 Foot Ulceration
C.7 Wound Care, Subungual Hematoma, Contusions
C.8 Charcot Joint (Neurogenic Arthropathy)
C.9 Paronychia
C.10 Foot Drop
C.11 Tarsal Tunnel Syndrome (TTS)
C.12 Ankle Sprain
C.13 Mid-Tarsus Pain and Sprains
C.14 Foot Neuroma (Morton’s Neuroma)
C.15 Bunions / Halus Valgus
C.16 Hammer Toe
C.17 Ankle and Foot Fractures
C.18 Hindfoot Fractures / calcaneus, Talus
C.19 Forefoot and Midfoot Fractures (Tarsal, Metatarsal, Phalangeal)
C.1 Achilles Tendinopathy
Achilles tendon disorders, including Achilles tendinitis, tendinosis, or tendinopathy, are painful conditions affecting the Achilles tendon, which is the largest and strongest tendon in the body, connecting the soleus, and gastrocnemius muscles in the leg to the heel at the calcaneus bone. The Achilles tendon plantar flexes the ankle and facilitates walking. Achilles tendon disorders can make walking difficult.

For each of the Achilles tendon disorders causing pain, the initial management is non-operative. It is believed that early intervention is critical, as management becomes more complicated and less predictable when the conditions become chronic.

C.1.a Diagnostic Studies
Although diagnosing non-rupture Achilles disorders is largely based on a careful history and examination, diagnostic imaging may be required to verify a clinical suspicion or to exclude other musculoskeletal disorders.

C.1.a.i X-ray for Diagnosis of Achilles Tendon Disorders, Retrocalcaneal Bursitis, or Blunt Trauma or Suspected Fracture

**Recommended** – for diagnosing insertional Achilles tendon disorders or retrocalcaneal bursitis or evaluating blunt trauma or suspected fracture.

*Rationale for Recommendation:* Radiography is poor at diagnosing soft-tissue disorders, and in the absence of trauma or suspected fracture, is not indicated as a first-line diagnostic tool for mid-portion tendon disorders. X-ray may reveal calcaneal spur, prominent posterior calcaneal tuberosity, or ossification of the Achilles tendon. For other Achilles disorders, ultrasound or MRI are more effective. Therefore, plain radiographic film studies are recommended only for insertional Achilles tendinopathy or traumatic injury.

C.1.a.ii Ultrasound for Diagnosis of Achilles Tendinopathy

**Recommended** - for diagnosing Achilles tendinopathy and may be particularly useful for differentiation of paratenonitis and tendinosis and for identifying fluid in the retrocalcaneal bursa.

*Rationale for Recommendation:* Ultrasound is frequently used to diagnose midportion tendinopathy.

C.1.a.iii Magnetic Resonance Imaging (MRI) for Diagnosis of Achilles Tendinopathy

**Recommended** - for evaluating Achilles tendinopathies including paratenonitis, tendinosis, and retrocalcaneal bursitis.

*Rationale for Recommendation:* MRI can demonstrate thickened paratenon with adhesions and offers extensive information on the internal structure of the tendon and surrounding tissues. MRI may be
helpful in differentiating inflammatory from degenerative changes in soft tissue.

**C.1.a.iv CT for Diagnosis of Achilles Tendinopathy**

**Not Recommended** - for diagnosing Achilles tendinopathy.

*Rationale for Recommendation*: CT is not helpful in differentiating inflammatory from degenerative changes in soft tissue. As CT has limitations when compared to MRI, it is not recommended.

**C.1.b Medications**

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetylsalicylic acid is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

**C.1.b.i Non-steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy Pain**

**Recommended** - for treatment of acute, subacute, chronic, or post-operative Achilles Tendinopathy pain.

*Indications* – For acute, subacute, chronic, or post-operative Achilles Tendinopathy, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration*: As needed use may be reasonable for many patients.

*Indications for Discontinuation*: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

**C.1.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding**

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications*: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration*: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per
manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

_Indications for Discontinuation:_ Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.1.b.iii**  
**NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**  
Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

_Evidence for the Use of NSAIDs and Acetaminophen_

**C.1.b.iv**  
**Acetaminophen for Treatment of Acute, Subacute, or Chronic Achilles Tendinopathy Pain**

**Recommended** - for treatment of acute, subacute, or chronic Achilles Tendinopathy Pain, particularly in patients with contraindications for NSAIDs.

_Indications:_ All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

_Dose/Frequency:_ Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

_Indications for Discontinuation:_ Resolution of pain, adverse effects or intolerance.

**C.1.b.v**  
**Systemic Corticosteroids (oral or intermuscular preparations) for Treatment of Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy**

**Not Recommended** - for the treatment of acute, subacute, chronic, or post-operative Achilles tendinopathy.

**C.1.b.vi**  
**Opioids for Treatment of Acute, Subacute, or Chronic Achilles Tendinopathy Pain**

**Not Recommended** - for treatment of acute, subacute, or chronic Achilles tendinopathy pain.
C.1.b.vii Opioids for Treatment of Pain for Post-operative Achilles Tendinopathy

**Recommended** - for short-term (not to exceed seven days) use to treat pain after Achilles tendon surgery or for patients who have encountered surgical complications.

*Indications:* Post-operative pain management.

*Frequency/Dose/Duration:* Frequency and dose per manufacturer’s recommendations; total treatment length usually ranges from a few days to a maximum of seven days.

*Indications for Discontinuation:* Sufficient pain management with other methods such as NSAIDs, resolution of pain, intolerance, adverse effects, lack of benefits, or failure to progress over a couple weeks.

*Rationale for Recommendations:* The vast majority of patients with Achilles tendinopathy do not have pain sufficient to require opioids. Patients with such degrees of pain should generally have investigations performed for alternative diagnoses. Opioids are not recommended for routine use.

C.1.b.viii Vitamin Therapy for Treatment of Achilles Tendinopathy

**Not Recommended** - as a therapeutic intervention or for prevention of Achilles tendinopathy.

C.1.b.ix High-dose Vitamin Therapy for Treatment of Achilles Tendinopathy

**Not Recommended** - for prevention of Achilles tendinopathy.

C.1.b.x Topical NSAIDs for Acute, Subacute, or Chronic Achilles Tendinopathy

**Recommended** - for treatment of acute, subacute, or chronic Achilles tendinosis.

*Indications:* Mild, moderate, or severe Achilles tendinopathy.

*Frequency/Duration:* Frequency per manufacturer’s recommendation.

*Indications for Discontinuation:* Resolution, intolerance, adverse effects, or lack of benefits.

C.1.b.xi Topical NSAIDs for Post-operative Achilles Tendinopathy

**Not Recommended** - for treatment of post-operative Achilles tendinosis.

*Evidence for the Use of Topical NSAIDs*
C.1.b.xii  Lidocaine Patches for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

Not Recommended - for the treatment of acute, subacute, chronic, or post-operative Achilles tendinopathy.

C.1.c  Treatments

C.1.c.i  Cryotherapy / Heat

C.1.c.i.a  Cryotherapy for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

Recommended - for acute, subacute, chronic, or post-operative Achilles tendinopathy.

Indications: All patients with Achilles tendinopathy.

Frequency/Duration: Approximately three to five self-applications per day as needed.

Indications for Discontinuation: Resolution, adverse effects, non-compliance.

C.1.c.i.b  Heat Therapy for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

Recommended - for acute, subacute, chronic, or post-operative Achilles tendinopathy.

Indications: All patients with Achilles tendinopathy.

Frequency/Duration: Approximately 3 to 5 self-applications per day as needed.

Indications for Discontinuation: Resolution, adverse effects, non-compliance.

Evidence for the Use of Cryotherapy and Heat for Achilles Tendinopathy

C.1.c.ii  Mobilization / Immobilization

C.1.c.ii.a  Night Splints for Acute, Subacute, or Chronic Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, or chronic Achilles tendinopathy.

C.1.c.ii.b  Night Splints and Walking Boots for Post-operative Achilles Tendinopathy
**Recommended** - for post-operative Achilles tendinopathy patients.

**Evidence for the Use of Night Splinting for Achilles Tendinopathy**

C.1.c.iii **Rehabilitation**

Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.1.c.iii.a **Therapeutic Exercise – Physical / Occupational Therapy**

**Recommended** – to improve function, including range of motion and strength.

*Frequency/Dose/Duration:* Frequency of visits is usually individualized based on severity of the limitation. Two to three visits per week for two weeks are often used to initiate an exercise program. Total numbers of visits may be as few as two to three for mild deficits or for more severe deficits up to 12 to 15 with documentation of objective functional improvement.

As part of the rehabilitation plan, patients should be instructed to continue both active and passive therapy at home as an extension of the treatment process in order to maintain improvement.
**Indications for Discontinuation:** Resolution of achilles tendinopathy pain, intolerance, lack of efficacy or non-compliance.

**Evidence for the Use of Exercise for Achilles Tendinopathy**

C.1.c.iii.b Extracorporeal Shockwave Therapy for Chronic Mid-portion Achilles Tendinopathy

*Recommended* - as an adjunct to an eccentric exercise for chronic, recalcitrant Achilles tendinopathy.

*Indications:* Moderate to severe, recalcitrant Achilles tendinopathy. Patients should have failed NSAIDs, eccentric exercises, therapy, and local injection(s).

*Frequency/Duration:* Three to 4 weekly sessions over 3 to 4 consecutive weeks.

*Indications for Discontinuation:* Completion of course, resolution of symptoms, adverse effects, intolerance, non-compliance.

C.1.c.iii.c Extracorporeal Shockwave Therapy for Acute, Subacute, or Post-operative Achilles Tendinopathy

*Not Recommended* - for treatment of acute, subacute, or post-operative Achilles tendinopathy.

**Evidence for the Use of Extracorporeal Shockwave Therapy for Achilles Tendinopathy**

C.1.c.iii.d Acupuncture for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

*Not Recommended* - for the treatment of acute, subacute, chronic, or post-operative Achilles tendinopathy.

C.1.c.iii.e Dry Needling for Acute, Subacute, or Chronic Achilles Tendinopathy

*Not Recommended* - for treatment of acute, subacute, or chronic Achilles tendinopathy.

*Rationale for Recommendation:* As there are other effective treatments, dry needling is not recommended for treatment of Achilles tendinopathy.

C.1.c.iii.f Massage and Tendon Mobilization for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy
Not Recommended - for treatment of acute, subacute, chronic or post-operative Achilles tendinopathy.

C.1.c.iii.g Therapeutic Ultrasound for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, chronic, or post-operative Achilles tendinopathy.

C.1.c.iii.h Iontophoresis with Glucocorticosteroid for Acute, Subacute, or Chronic Achilles Tendinopathy

Recommended - for treatment of acute, subacute, or chronic Achilles tendinopathy.

Indications: Acute, subacute, or chronic Achilles tendinopathy.

Frequency/Duration: Four treatments over 2 weeks with dexamethasone or other glucocorticoid. Therapy should include a concurrent eccentric exercise program.

Indications for Discontinuation: Resolution, adverse effects, intolerance, non-compliance.

C.1.c.iii.i Iontophoresis with Glucocorticosteroid for Post-operative Achilles Tendinopathy

Not Recommended - for treatment of post-operative Achilles tendinopathy.

C.1.c.iii.j Iontophoresis with NSAIDs for Acute, Subacute, Chronic, or Post-Operative Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, chronic, or post-operative Achilles tendinopathy.

Rationale for Recommendations: Although evidence is minimal for efficacy in acute and subacute Achilles tendinopathy, iontophoresis with glucocorticosteroids is recommended for acute, subacute, or chronic Achilles tendinopathy, although the treatment has not been specifically tested among those patients.

Evidence for the Use of Iontophoresis for Achilles Tendinopathy

C.1.c.iii.k Phonophoresis for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, chronic, or post-operative Achilles tendinopathy.
C.1.c.iii.i  Low-level Laser Therapy for Select Chronic Achilles Tendinopathy

**Recommended** - for treatment of select patients with chronic Achilles tendinopathy.

*Indications*: Chronic Achilles tendinopathy; patients should generally have failed NSAIDs, eccentric exercises, iontophoresis, and injection(s).

*Frequency/Duration*: Twelve sessions over 8 weeks. Therapy should include a concurrent active therapeutic exercise program.

*Indications for Discontinuation*: Resolution, adverse effects, intolerance, non-compliance.

C.1.c.iii.m  Low-level Laser Therapy for Acute, Subacute, or Post-operative Achilles Tendinopathy

**Not Recommended** - for treatment of acute, subacute, or post-operative Achilles tendinopathy.

*Evidence for the Use of Low-level Laser Therapy for Achilles Tendinopathy*

**C.1.c.iv  Injection Therapy**

C.1.c.iv.a  Glucocorticosteroid Injections (Low-Dose) for Paratendon Bursitis

**Recommended** - as therapy for treatment paratendon bursitis.

*Indications*: Treatment with other interventions such as NSAIDs and exercises should have been attempted previously and either failed or results were unsatisfactory.

*Frequency/Duration*: Up to three injections of glucocorticosteroid over three weeks, with second and third injections performed if the first provides decrease in pain and increased function.

*Indications for Discontinuation*: Resolution, intolerance, adverse effects, or lack of benefits.

C.1.c.iv.b  Glucocorticosteroid Injections (Low Dose) for Acute, Subacute, Chronic or Post-Operative
Not Recommended - for treatment of acute, subacute, chronic or post-operative Achilles tendinopathy.

Evidence for the Use of Glucocorticosteroid Injections

C.1.c.iv.c Platelet Rich Plasma Injections for Achilles Tendinopathy

Not Recommended - for treatment of Achilles tendinopathy.

Evidence for the Use of Platelet Rich Plasma

C.1.c.iv.d Glycosaminoglycan Polysulfate Local Injection (GAGPS) for Chronic Achilles Tendinopathy

Recommended - as an alternative therapy for treatment of chronic Achilles tendinopathy.

Indications: Moderate or severe chronic Achilles tendinopathy; treatment with other interventions such as NSAIDs and exercises should have been attempted previously and either failed or results were unsatisfactory.

Frequency/Duration: Up to six local injections into the paratendon area over a 2-week period; assess after two or three injections and if results are satisfactory, withhold and evaluate value of further injections while observing the clinical course.

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

C.1.c.iv.e Glycosaminoglycan Polysulfate Local Injection (GAGPS) for Acute, Subacute, or Post-operative Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, or post-operative Achilles tendinopathy.

Rationale for Recommendations: There is limited evidence that GAGPS may be beneficial for patients with chronic symptoms of Achilles tendon conditions.

Evidence for the Use of Glycosaminoglycan Injections

C.1.c.iv.f Subcutaneous Heparin Injection for Acute, Subacute, or Chronic Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, or chronic Achilles tendinopathy.

Evidence for the Use of Heparin Injections
Actovegin Injections
Actovegin injection (deproteinized hemodialysate from calf-blood) into the paratendon for acute and chronic mid-portion Achilles tendinopathy.

C.1.c.iv.g Actovegin Injection for Acute, Subacute, or Chronic Achilles Tendinopathy

Not Recommended - for the treatment of acute, subacute or chronic Achilles tendinopathy.

Evidence for the Use of Actovegin Injections

C.1.c.iv.h Prolotherapy, including Polidocanol and Hypertonic Glucose Injections for Acute, Subacute, Chronic or Post-Operative Achilles Tendinopathy

Not Recommended - for the treatment of most acute, subacute or chronic and post-operative Achilles Tendinopathy.

Evidence for the Use of Polidocanol Injections

C.1.c.iv.i Aprotinin Injection for Acute, Subacute, or Chronic Achilles Tendinopathy

Not Recommended - for treatment of acute, subacute, or chronic Achilles tendinopathy.

Evidence for the Use of Aprotinin Injections

C.1.c.iv.j High-volume Image-guided Injection for Chronic Achilles Tendinopathy

Not Recommended - for treatment of chronic Achilles Tendinopathy.

C.1.c.v Surgery

C.1.c.v.a Surgery for the Treatment of Chronic Achilles Tendinopathy without Rupture

Recommended - for select cases of chronic Achilles Tendinopathy without rupture.

Indications: Patients with moderate to severe chronic Achilles tendinopathies who have failed multiple non-surgical treatments and whose condition has lasted at least six months. Patients should generally have failed NSAID(s), eccentric exercises, iontophoresis, injection(s) and low level laser therapy.
C.1.c.v.b Surgery for the Treatment of Acute or Subacute Achilles Tendinopathy without Rupture

**Not Recommended** - for acute or subacute Achilles tendinopathy without rupture.

*Rationale for Recommendations:* Surgery is not recommended until a course of at least 6 months of other non-operative treatments without demonstrated efficacy has been attempted and the patient’s symptoms are sufficient to warrant the risks of surgical intervention.

C.1.c.vi Other

C.1.c.vi.a Orthotic Devices (Such as Heel Lifts, Heel Pads or Heel Braces) for Acute, Subacute, Chronic, or Post-operative Achilles Tendinopathy

**Not Recommended** - for treatment of acute, subacute, or chronic Achilles tendinopathy.

*Evidence for the Use of Orthotic Devices for Achilles Tendinopathy*

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C.2 Achilles Tendon Rupture

The cardinal symptom of an Achilles tendon rupture is a sudden pain in the posterior heel that is often accompanied by a “pop” heard emanating from the heel. There is generally no history of prior symptoms (pain, stiffness) prior to rupture.

Diagnosis of an Achilles tendon rupture is most often based on loss of plantar flexion strength, palpation of a gap in the mid-portion of the tendon (proximal to the calcaneal insertion), and a positive squeeze test of the calf muscle that fails to elicit plantar flexion. Specific imaging is not required for most acute rupture cases.

There are no other specific diagnostic criteria for Achilles tendon rupture. Acute rupture refers to rupture that presents for evaluation within 4 weeks, whereas chronic rupture refers to ruptures that present for evaluation 4 to 6 weeks or more after an acute injury.

Upon establishment of the diagnosis, initial treatment is symptomatic until the definitive care plan is established. This may include immobilization, relative rest, NSAIDs, acetaminophen and cryotherapy.

C.2.a Diagnostic Studies

Diagnosis of an Achilles tendon rupture is generally made through clinical history and physical examination findings.

X-ray is generally not used for the diagnosis of acute Achilles rupture, although it may be helpful in identifying tendon calcification.

C.2.a.i **Routine X-ray for Diagnosis of Acute Achilles Rupture**
Not Recommended - to diagnose acute Achilles tendon rupture.

Indications: Achilles tendon ruptures resulting from direct trauma or if suspected rupture involves the calcaneal insertion, or among patients with reasonable suspicion of tendon calcification. Ruptures of the tendon at the calcaneal insertion are reported to be rare, although if suspected radiography may detect avulsion of the bony insertion.

C.2.a.ii Ultrasound for Diagnosis of Acute Achilles Tendon Rupture

Recommended - for the diagnosis of acute Achilles tendon rupture.

Indications: Clinical suspicion of rupture is high but uncertain.

Rationale for Recommendation: It is recommended as the main confirmatory diagnostic test for Achilles ruptures, particularly when there is diagnostic uncertainty.

C.2.a.iii MRI for Diagnosis of Acute Achilles Tendon Rupture

Recommended - for the evaluation of acute Achilles tendon rupture.

Indications: Clinical suspicion of rupture is high but uncertain.

Rationale for Recommendation: MRI is recommended for select use as an alternative when clinical suspicion for rupture is high. It is sometimes used to evaluate the Achilles tendon particularly where there is diagnostic uncertainty, although ultrasound has been generally preferred.

C.2.b Medications

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.2.b.i NSAIDs for Treatment of Acute, Subacute, Chronic, or Post-operative Achilles Tendon Rupture pain

Recommended - for treatment of acute, subacute, chronic, or post-operative Achilles Tendon Rupture pain.

Indications: For acute, subacute, chronic, or post-operative Achilles Tendon Rupture, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration – As needed use may be reasonable for many patients.
Indications for Discontinuation – Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.2.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

C.2.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.2.b.iv Acetaminophen for Treatment of Acute, Subacute, or Chronic Achilles Rupture Pain

**Recommended** - for treatment of acute, subacute, or chronic Achilles Rupture Pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.
Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.2.b.v Opioids for Pain from Acute or Post-operative Achilles Tendon Repair

Recommended - Limited use of opioids (not to exceed seven days) for the treatment of acute Achilles tendon rupture is a treatment option for select patients presenting with acute or moderate to severe pain related to Achilles rupture. Limited use of opioids for a few days (not to exceed seven days) is also recommended for select patients who have undergone recent Achilles tendon repair or those who encountered surgical complications.

Indications: Acute rupture or post-operative pain management for patients with moderate to severe pain.

Frequency/Dose/Duration: Frequency and dose per manufacturer’s recommendations; may be taken scheduled or as needed; generally taken for short courses of a few days, with subsequent weaning to nocturnal use if needed, then discontinuation. Total length of treatment usually ranges from a few days to one week. Generally should be utilized to supplement pain relief in addition to an NSAID or acetaminophen to reduce total need for opioid and the consequent adverse effects.

Indications for Discontinuation: Sufficient pain management with other methods such as NSAIDs, resolution of pain, intolerance, adverse effects, lack of benefits, or failure to progress over a couple weeks.

Rationale for Recommendations: Opioids are recommended for brief select use in post-operative patients with primary use at night to facilitate adequate post-operative sleep.

C.2.b.vi Opioids for Pain from Subacute or Chronic Achilles Tendon Repair

Not Recommended - for treatment of pain from subacute or chronic Achilles tendon repair.

Rationale for Recommendation: Opioids are not recommended for routine use.

C.2.b.vii Prophylaxis for Prevention of Deep Venous Thrombosis

Recommended - for the prevention of deep venous thrombosis.

Indications – Patients with predisposing risks for developing venous thrombosis events. High-risk populations are not well defined currently,
and therefore require a high degree of physician and patient judgment. A low threshold for prophylaxis may be appropriate for patients with prior history of thrombolic and thromboembolic events, delayed rehabilitation or ambulation, obesity, diabetes, or other coagulation disorders.

C.2.b.viii Thrombosis Prophylaxis for Prevention of Deep Venous Thrombosis

Not Recommended - to prevent deep venous thrombosis.

Evidence for the Use of DVT Prophylaxis for Achilles Tendon Rupture Repair

C.2.c Treatments

C.2.c.i Cryotherapy / Heat

C.2.c.i.a Self-application of Cryotherapy or Heat Therapy for Acute, Subacute, Chronic, or Post-operative Achilles Tendon Rupture

Recommended - for treatment of acute, subacute, chronic, or post-operative Achilles tendon rupture.

Indications: Acute, subacute, chronic, or post-operative patients with Achilles tendon rupture.

Frequency/Duration: Approximately three to five self-applications per day as needed.

Indications for Discontinuation: Resolution, adverse effects, non-compliance.

Rationale for Recommendation: Ice may be of short-term benefit in reducing swelling and pain for acute rupture. Heat may be helpful for healing for a few days after the rupture or surgery.

C.2.c.ii Rehabilitation

Therapy
Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active
therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.2.c.ii.a Therapeutic Exercise - Physical / Occupational Therapy

**Recommended** – to improve function, including range of motion and strength.

*Frequency/Dose/Duration:* Frequency of visits is usually individualized based on severity of the limitation. Two to three visits per week for two weeks are often used to initiate an exercise program. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement.

As part of the rehabilitation plan, patients should be instructed to continue both active and passive therapy, at home as an extension of the treatment process in order to maintain improvement.

*Indications:* All post-operative and conservatively managed Achilles rupture patients.

*Indications for Discontinuation:* Resolution of pain, intolerance, lack of efficacy or non-compliance.

C.2.c.ii.b Post-Operative TENS for Achilles Tendon Repair

**Not Recommended** - as a post-operative treatment for Achilles tendon rupture.

*Rationale for Recommendation:* There is no defined benefit of TENS for promoting the healing process.

C.2.c.iii Surgery

C.2.c.iii.a Surgery for Treatment of Achilles Tendon Rupture

**Recommended** - for treatment of ruptured Achilles tendon. The mixed results of the data supporting operative and non-operative care should be discussed with patients when covering treatment options. Discussion should include the
equivocal superiority of surgical compared to non-operative treatment.

C.2.c.iii.b Non-Operative Management of Achilles Tendon Rupture with Functional Splinting and Casting

**Recommended** - for Achilles tendon rupture. Non-operative management may be indicated in many cases, particularly for select patients with low physical demands where risk factors may outweigh benefits.

*Evidence for the Use of Non-operative and Surgical Repair for Achilles Tendon Rupture*

**Surgical Repair - Open and Percutaneous Methods**
Surgical repairs have included two basic approaches – open and percutaneous methods.

C.2.c.iii.c Open and Percutaneous Operative Approaches

**Recommended** - for patients undergoing operative repair. There is no recommendation of one approach over the other.

C.2.c.iii.d Augmented Surgical Repair for Acute Ruptures

**Not Recommended** - for acute ruptures unless primary repair is not possible.

C.2.c.iii.e Augmented Surgical Repair for Chronic or Neglected Ruptures

**Not Recommended** - for chronic or neglected ruptures.

*Evidence for the Use of Surgical Technique for Achilles Tendon Rupture*

C.2.c.iii.f Early Weight Bearing for Post-Operative Rehabilitation of Achilles Tendon Repair

**Recommended** - as a primary treatment method for post-operative rehabilitation of Achilles tendon ruptures for functional bracing or rigid immobilization.

*Indications*: All post-operative non-augmented Achilles tendon repairs concomitant with functional bracing or rigid casting.

*Frequency/Duration*: Initiate post-operative to two weeks.

*Indications for Discontinuation*: Rerupture, surgical complications, physical ability.
Rationale for Recommendation: There is strong evidence that early immobilization is beneficial for short-term functional recovery, may result in increased mobility of the patient with improved quality of life, and has no demonstrated increase in complication rates.

C.2.c.iii.g Functional Bracing for Post-Operative Rehabilitation of Achilles Tendon Repair

Recommended - as a primary treatment method for post-operative care of Achilles tendon ruptures.

Indications: All post-operative Achilles tendon repairs.

Frequency/Duration: Apply 0 to 2 weeks post-operative.

Indications for Discontinuation: Discomfort, non-compliance, device intolerance.

Evidence for the Use of Post-operative Management for Achilles Tendon Rupture

C.3 Ankle Tendinopathies (Other than Achilles Tendinopathy)
The ankle’s tendinous compartments are susceptible to stenosing tenosynovitis, similar to those of the wrist. They may be affected by disease (e.g., rheumatic disorders, diabetes mellitus, and infection) and undergo age-related degenerative changes. Tendon subluxations, dislocations, and tears occur. There are no quality trials addressing ankle tendinopathies other than Achilles tendinopathy. Guidance for these ankle-foot tendon disorders is based on analogies to other tendinopathies, particularly of the wrist.

C.4 Tenosynovitis (Including Stenosing Tenosynovitis)
Patients with tendinopathy present with localized ankle pain that is augmented by movement. Occasionally, pain may extend along the affected tendon sheath.

Initial care usually involves limitation of the physical factors thought to be contributing. Walking casts or boots, splints, or braces for tendinoses may be helpful especially in moderate to severe cases. NSAIDs are often prescribed for initial treatment.

C.4.a Diagnostic Studies
There are no tests that are typically performed for tenosynovitis. X-rays are usually not helpful. Bone deformities may contribute to the tenosynovitis and occult fractures may occur.

C.4.b Medications
For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should
include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.4.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Acute, Subacute or Chronic Ankle Tenosynovitis

**Recommended** - for treatment of acute, subacute, or chronic ankle tenosynovitis.

**Indications:** For acute, subacute, chronic, or post-operative ankle compartment tenosynovitis, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration:** As needed use may be reasonable for many patients.

**Indications for Discontinuation:** Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.4.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

C.4.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.
**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

*Evidence for the Use of NSAIDs for Compartment Tenosynovitis*

**C.4.b.iv Acetaminophen for Tenosynovitis Pain**

**Recommended** - for treatment of acute, subacute, or chronic Achilles Tenosynovitis Pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.

**C.4.c Treatments**

**C.4.c.i Mobilization / Immobilization**

**C.4.c.i.a Walking Boots, Casts, Splints, and Braces for Acute and Subacute Ankle Tenosynovitis**

**Recommended** - for treatment of acute and subacute ankle tendinoses.

*Indications:* Patients with tendinosis.

*Frequency/Duration:* Worn while ambulating.

*Indications for Discontinuation:* Failure to respond or resolution.

**C.4.c.ii Rehabilitation**

Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement.
pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.4.c.ii.a Therapy to Address Residual Deficits, Particularly Post-Operatively

**Recommended** - for the treatment of residual deficits associated with acute, subacute, chronic, or post-operative tenosynovitis.

*Frequency/Dose/Duration:* Exercises are generally individualized and increased over time. Many therapists combine exercises with other treatment modalities. Frequency of visits is usually individualized based on severity of the deficits. Two to three visits per week for two weeks are often used to initiate an exercise program. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement.

As part of the rehabilitation plan, patients should be instructed to continue both active and passive therapy, at home as an extension of the treatment process in order to maintain improvement.

*Indications for Discontinuation:* Resolution of pain, intolerance, lack of efficacy or non-compliance.

C.4.c.ii.b Other Non-Operative Interventions Including Manipulation and Mobilization, Massage, Deep Friction Massage, or Acupuncture for Acute, Subacute, or Chronic Ankle Tenosynovitis

**Not Recommended** - for the treatment of acute, subacute, or chronic ankle tenosynovitis.

C.4.c.ii.c Iontophoresis for Acute and Subacute Ankle Tenosynovitis
**Recommended** - for ankle tenosynovitis using glucocorticosteroids and sometimes NSAIDs.

**Indications**: Patients with ankle tendinosis. Generally those who either fail to respond adequately to NSAIDs, splints, and activity modifications or decline injection.

**Dose**: Glucocorticosteroid is generally used.

**Frequency/Duration**: Generally 2-3 treatments to ascertain efficacy; an additional 4-6 treatments may be scheduled if efficacious. If improvements continue at 6 appointments, an additional 4-6 treatments are reasonable.

**Indications for Discontinuation**: Failure to respond, development of adverse effects, resolution.

**Rationale for Recommendation**: Iontophoresis with either a glucocorticoid or NSAID is recommended for select patients who fail to respond to other treatments or who decline injection.

**C.4.c.iii Injection Therapy**

**C.4.c.iii.a Glucocorticosteroid Injections for Acute, Subacute, or Chronic Ankle Tendinosis**

**Recommended** - for treatment of acute, subacute, or chronic ankle tendinosis.

**Indications**: Ankle symptoms of pain over a compartment. Generally, at least one week of non-invasive treatment to determine if condition will resolve without invasive treatment. It is reasonable to treat cases with an initial injection. An adjuvant injectable anesthetic is typically used.

**Frequency/Duration**: It is recommended that a single injection be scheduled, and the results evaluated to document improvement. Failure of a response within one to two weeks should result in reanalysis of the diagnosis and consideration of repeat injection. Recurrence of symptoms months later should result in consideration of re-injection. Repeat injections can be considered when there is decreased pain and increased function from the previous injection. More than three injections in a year should be avoided due to tendon weakening and risk of rupture. Recurring injections on a year after year basis should also be similarly avoided.

**Indications for Discontinuation**: If a partial response, consideration should be given to repeating the injection, typically at a modestly higher dose.
Evidence for the Use of Glucocorticosteroid Injections for Ankle Tendinoses

C.4.c.iv Surgery

C.4.c.iv.a Surgical Release for Subacute or Chronic Ankle Tenosynovitis

Not Recommended - for patients with subacute or chronic ankle tenosynovitis who fail to respond to non-operative interventions including injections.

C.5 Plantar Heel Pain (“Plantar Fasciitis”)

Heel pain is the most common area of pain in the foot. Plantar heel pain, known as “plantar fasciitis,” is common. Other names for plantar heel pain include painful heel syndrome, heel spur syndrome, runner’s heel, subcalcaneal pain, calcaneodynia, plantar fasciopathy, and calcaneal periostitis. Plantar fasciitis is usually marked pain in the inferior or plantar aspect of either the center or medial heel. Pain may be reported distal towards the arch of the foot. As noted, it is most noticeable during weight-bearing activities, especially the first weight-bearing step of the day or after periods of sitting or recumbency.

Plantar fasciitis generally responds well to conservative management, with more than 90% of patients resolving over a 6 to 12 month period with non-surgical intervention.

Initial management of plantar heel pain is non-invasive. More than 90% of plantar heel pain will resolve with non-invasive measures over a six to 12 month period. Possibly, the most important non-operative treatment is reassuring the patient that 95% of those with plantar fasciitis will have resolution of symptoms in 12 to 18 months.

Plantar Fasciitis Diagnostic Criteria (Appendix D.2 – Table 3)

C.5.a Diagnostic Studies

Imaging plays a limited role in routine clinical practice and is generally reserved for select cases to rule out other causes of heel pain or to establish the diagnosis of plantar fasciitis when it is in doubt.

Plain radiographs are utilized for diagnosing plantar fasciitis.

C.5.a.i Use of X-Ray for Diagnosis of Plantar Heel Pain

Recommended – for diagnosing suspected fracture in patients with plantar heel pain.

Indication: Evaluation of plantar heel pain when calcaneal fracture or osseous tumor is suspected, or to rule out other causes of heel pain. Plain films should not be obtained solely to identify the presence of heel spurs.
C.5.a.ii  MRI for Diagnosis of Select Patients with Plantar Fasciitis

**Recommended** - for the evaluation of select patients with plantar fasciitis.

*Indications:* Suspected plantar fascial rupture, avascular necrosis of talar dome, and stress fracture of the talar neck particularly if heel pain is not improving.

*Rationale for Recommendation:* MRI may be useful in the diagnosis of causes of heel pain other than plantar fasciitis, including calcaneal stress fracture, plantar fascia rupture, perifascial fluid, calcaneal spurs, avascular necrosis of talar dome, joint fluid, ganglion cyst, stress fracture of the talar neck, and osseous tumors.

**Evidence for the Use of MRI for Plantar Fasciitis**

C.5.a.iii  SPECT-CT for Diagnosis of Plantar Fasciitis

**Not Recommended** - for the diagnosis of plantar heel pain.

C.5.a.iv  Ultrasound for Diagnosis of Plantar Fasciitis

**Recommended** - for the evaluation of select patients with plantar fasciitis.

*Indications:* Evaluation of plantar heel pain when clinical diagnosis is uncertain or after no improvement from a course of conservative treatment of four to six weeks.

*Rationale for Recommendation:* is recommended for cases of suspected plantar fascial rupture or plantar calcaneal bursitis if symptoms are not resolved after a trial of non-invasive therapy.

C.5.b  Medications

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.5.b.i  Non-steroidal Anti-inflammatory Drugs (NSAIDs)

**NSAIDs for Treatment of Acute, Subacute, Chronic, or Post-operative Plantar Fasciitis Pain.**

**Recommended** - for treatment of acute, subacute, chronic, or post-operative plantar fascitis pain.
Indications: For acute, subacute, chronic, or post-operative plantar fasciitis pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.5.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.5.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.5.b.iv Acetaminophen for Treatment of Plantar Fasciitis Pain

Recommended - for treatment of acute, subacute, or chronic Plantar Fasciitis Pain, particularly in patients with contraindications for NSAIDs.
Indications: All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

Evidence for the Use of NSAIDs and Acetaminophen for Plantar Fasciitis

C.5.b.v Infliximab for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - for the treatment of acute, subacute, or chronic plantar fasciitis.

Evidence for the Use of Infliximab for Plantar Fasciitis

C.5.b.vi Opioids for Acute, Subacute, or Chronic Plantar Fasciitis Pain

Not Recommended - for the treatment of acute, subacute, or chronic plantar fasciitis.

C.5.b.vii Opioids for Post-operative Plantar Fasciitis

Recommended – for limited use for a few post-operative days (not to exceed seven) for select patients with plantar fasciitis.

Indications: Post-operative pain management.

Frequency/Dose/Duration: Frequency and dose per manufacturer’s recommendations; may be taken as scheduled or as needed. Generally suggested to be taken for short courses (a few days), with subsequent weaning to nocturnal use if needed, then discontinued.

Indications for Discontinuation: Sufficient pain management with other methods such as NSAIDs and acetaminophen, resolution of pain, intolerance, adverse effects, lack of benefits, or failure to progress.

Rationale for Recommendations: There is no quality evidence for the use of opioids for the treatment of acute, subacute, or chronic plantar heel pain. The vast majority of patients with plantar fasciitis generally do not have pain sufficient to merit trialing with the risks of opioids. They are not recommended for routine use.

Some patients may have insufficient pain relief with NSAIDs, thus judicious use of opioids in the immediate post-operative period may be helpful, particularly for nocturnal use. Opioids are recommended for brief select use in post-operative patients with primary use at night to achieve post-operative sleep while not impairing early rehabilitation.
Evidence for the Use of Opioids for Plantar Fasciitis

C.5.b.viii Oral or Intramuscular Glucocorticosteroids for Acute, Subacute, or Chronic Plantar Heel Pain

**Not Recommended** - for the treatment of acute, subacute, or chronic plantar heel pain.

*Rationale for Recommendation:* As evidence is lacking and evidence of efficacy is present for several other treatments, the use of glucocorticosteroids by oral or intramuscular routes is not recommended.

Evidence for the Use of Systemic Glucocorticosteroids for Plantar Heel Pain

C.5.b.ix Vitamins for Treatment or Prevention of Plantar Fasciitis

**Not Recommended** - for the treatment or prevention of plantar fasciitis.

Evidence for the Use of Vitamins for Plantar Fasciitis

C.5.b.x Lidocaine Patches for Acute, Subacute, Chronic, or Post-operative Plantar Fasciitis

**Not Recommended** - for the treatment of acute, subacute, chronic, or post-operative plantar fasciitis.

Evidence for the Use of Lidocaine Patch for Plantar Fasciitis

C.5.b.xi Topical NSAIDs for Acute, Subacute, or Chronic Plantar Fasciitis Pain

**Recommended** - for treatment of acute, subacute, or chronic plantar fascial pain syndromes.

*Indications:* Mild, moderate, or severe plantar fasciitis or in patients with contraindications for oral treatment. There is no evidence of comparative superiority of one topical NSAID versus another.

*Frequency/Duration:* Frequency according to manufacturer’s recommendation. Topical NSAIDs have been used for one to three weeks.

*Indications for Discontinuation:* Resolution, intolerance, adverse effects, or lack of benefits.

*Rationale for Recommendations:* They are recommended for treatment of acute, subacute, and chronic plantar fascial or plantar heel pain,
particularly in patients who do not tolerate or are poor candidates for oral treatment.

C.5.b.xii  **Topical NSAIDs for Post-Operative Plantar Fasciitis**

*Not Recommended* - for post-operative plantar fasciitis.

*Evidence for the Use of Topical NSAIDs for Plantar Fasciitis*

**C.5.c Treatments**

C.5.c.i  **Cryotherapy / Heat**

C.5.c.i.a  **Cryotherapy for Acute, Subacute, Chronic, or Post-operative Plantar Heel Pain**

*Recommended* - for treatment of acute, subacute, chronic, or post-operative plantar heel pain.

*Indications:* All patients with plantar heel pain.

*Frequency/Duration:* Approximately three to five self-applications per day as needed.

*Indications for Discontinuation:* Resolution, adverse effects, non-compliance.

C.5.c.i.b  **Heat Therapy for Acute, Subacute, Chronic, or Post-operative Plantar Heel Pain**

*Recommended* - for treatment of acute, subacute, chronic, or post-operative plantar heel pain.

*Indications:* All patients with plantar heel pain.

*Frequency/Duration:* Approximately three to five self-applications per day as needed.

*Indications for Discontinuation:* Resolution, adverse effects, non-compliance.

*Rationale for Recommendations:* Ice and heat may help particularly with more acute symptoms.

*Evidence for the Use of Cryotherapy and Heat for Plantar Heel Pain*

C.5.c.ii  **Mobilization / Immobilization**

C.5.c.ii.a  **Casting for Chronic Plantar Fasciitis**
Not Recommended - as a treatment for chronic plantar fasciitis.

Evidence for the Use of Casting for Plantar Fasciitis

C.5.c.ii.b Night Splints for Plantar Heel Pain

Recommended - for subacute or chronic plantar heel pain.

Indications: Subacute or chronic plantar fasciitis requiring temporary pain and stiffness improvement.

Frequency/Duration: Nightly for duration of effectiveness (as determined by improvement in symptoms and function while under the care of a health care provider).

Indications for Discontinuation: Resolution, adverse effects, intolerance, non-compliance.

Evidence for the Use of Night Splints for Plantar Heel Pain

C.5.c.iii Rehabilitation

Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient's daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.5.c.iii.a Magnets for Acute, Subacute or Chronic Plantar Heel Pain
**Not Recommended** - for the treatment of acute, subacute, or chronic plantar heel pain.

*Evidence for the Use of Magnets for Plantar Heel Pain*

C.5.c.iii.b **Stretching Exercises for Plantar Fasciitis**

**Recommended** - for treatment of plantar fasciitis.

*Indications*: Acute, subacute, or chronic plantar fasciitis.

*Frequency/Duration*: Ten-minute stretches three times a day; no limit identified for duration.

*Indications for Discontinuation*: Resolution, adverse effects, intolerance, non-compliance.

*Evidence for the Use of Stretching Exercises for Plantar Fasciitis*

C.5.c.iii.c **Heel Taping for Acute or Subacute Plantar Fasciitis or Heel Pain**

**Recommended** - as a short-term treatment for acute or subacute plantar fasciitis or heel pain.

*Indications*: Patients with acute or subacute plantar fasciitis without adhesive allergies as a short-term intervention for pain relief.

*Frequency/Duration*: Daily application of tape for one to four weeks.

*Indications for Discontinuation*: Resolution, adverse effects, non-compliance, completion of four week course of treatment.

C.5.c.iii.d **Heel Taping for Chronic Plantar Fasciitis or Heel Pain**

**Recommended** - for the treatment of chronic plantar fasciitis or heel pain.

*Rationale for Recommendations*: The efficacy of taping is limited to modest short-term pain relief. Taping is generally limited to short-term use because of its potential for skin sensitization and breakdown. The use of taping is recommended as a short-term strategy as an adjunct with other non-operative treatments.

*Evidence for the Use of Taping for Plantar Fasciitis*
C.5.c.iii.e Acupuncture for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - treatment of acute, subacute, or chronic plantar fasciitis.

Evidence for the Use of Acupuncture for Plantar Fasciitis

C.5.c.iii.f Low Frequency Electrical Stimulation for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - for acute, subacute, or chronic plantar fasciitis.

Evidence for the Use of Electrical Stimulation for Plantar Fasciitis

C.5.c.iii.g Extracorporeal Shockwave Therapy for Chronic Plantar Fasciitis

Recommended - for chronic plantar fasciitis in select patients with chronic recalcitrant conditions.

Indications: Chronic plantar heel pain consistent with plantar fasciitis. In most studies of ESWT used for treatment of plantar fasciitis, patients often have at least 6 months of symptoms and fail therapy with active and passive exercises, NSAIDs, and glucocorticoid injection(s). The presence or absence of heel spur does not impact decision for use of ESWT.

Frequency/Duration: Treatment protocols vary; one to three treatment sessions with reported efficacy may be appropriate.

Indications for Discontinuation: Resolution, intolerance, non-compliance.

C.5.c.iii.h Extracorporeal Shockwave Therapy for Acute or Subacute Plantar Fasciitis

Not Recommended - for treatment of acute or subacute plantar fasciitis.

C.5.c.iii.i Ultrasound or Fluoroscopy Guidance for Shockwave Therapy for Plantar Fasciitis

Not Recommended - for treatment of plantar fasciitis.
C.5.c.iii.j Local Anesthesia with High Shockwave Therapy for Plantar Fasciitis

Recommended - in conjunction with high-energy ESWT for the treatment of plantar fasciitis.

C.5.c.iii.k Local Anesthesia with Low or Medium Shockwave Therapy for Plantar Fasciitis

Not Recommended - for the treatment of plantar fasciitis.

C.5.c.iii.l Radial Extracorporeal Shockwave Therapy for Chronic Plantar Fasciitis

Not Recommended - for the treatment of chronic plantar fasciitis.

C.5.c.iii.m Radial Extracorporeal Shockwave Therapy for Acute or Subacute Plantar Fasciitis

Not Recommended - for the treatment of acute or subacute plantar fasciitis.

Evidence for the Use of ESWT for Plantar Fasciitis

C.5.c.iii.n Iontophoresis with Glucocorticosteroid or Acetic Acid for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - for treatment of patients with acute, subacute, or chronic plantar fasciitis.

Evidence for the Use of Iontophoresis for Plantar Fasciitis

C.5.c.iii.o Low-level Laser Therapy for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - for treatment of acute, subacute, or chronic plantar fasciitis.

Evidence for the Use of Low-level Laser Therapy for Plantar Fasciitis

C.5.c.iii.p Manipulation for Acute, Subacute, Chronic, or Post-operative Plantar Heel Pain

Not Recommended - for treatment of acute, subacute, chronic, or post-operative plantar heel pain.

Evidence for the Use of Manipulation for Plantar Heel Pain

C.5.c.iii.q Massage and Soft Tissue Mobilization for Acute, Subacute, Chronic, or Post-operative Plantar Fasciitis
Not Recommended - for treatment of acute, subacute, chronic, or post-operative plantar fasciitis.

Evidence for the Use of Massage and Soft Tissue Mobilization for Plantar Fasciitis

C.5.c.iii.r Phonophoresis for Acute, Subacute, Chronic, or Post-Op Plantar Heel Pain

Not Recommended - for treatment of acute, subacute, chronic, or postoperative plantar heel pain.

Evidence for the Use of Phonophoresis for Plantar Heel Pain

C.5.c.iii.s Therapeutic Ultrasound for Acute, Subacute, Chronic, or Post-operative Plantar Fasciitis

Not Recommended - for treatment of acute, subacute, chronic, or post-operative plantar fasciitis.

Evidence for the Use of Therapeutic Ultrasound for Plantar Fasciitis

C.5.c.iii.t Low-dose Radiation (Radiotherapy) for Chronic Plantar Heel Pain

Not Recommended - for treatment of chronic plantar heel pain.

Evidence for the Use of Radiation Therapy for Plantar Heel Pain

C.5.c.iv Injection Therapy

C.5.c.iv.a Autologous Blood Injection for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - for treatment of acute, subacute, or chronic plantar fasciitis.

Evidence for the Use of Autologous Blood Injections for Plantar Fasciitis

C.5.c.iv.b Botulinum Toxin A Injection for Acute, Subacute or Chronic Plantar Fasciitis

Not Recommended - as a treatment for chronic plantar fasciitis.
Evidence for the Use of Botulinum Toxin A Injections for Plantar Fasciitis

C.5.c.iv.c  Glucocorticosteroid Injections for Chronic Plantar Fasciitis

**Recommended** - for short-term relief of chronic or recalcitrant plantar fasciitis.

*Indications*: Moderate or severe plantar fasciitis, failed stretching, exercise and other non-operative options.

*Frequency/Duration*: A second injection may be performed if the problem is incapacitating, other options have been exhausted, and the patient understands and accepts that rupture is a possible complication and will likely necessitate surgery.

*Indications for Discontinuation*: Resolution, intolerance, adverse effects, or lack of benefits.

C.5.c.iv.d  Glucocorticosteroid Injections for Acute or Subacute Plantar Fasciitis

**Not Recommended** - for treatment of acute or subacute plantar fasciitis.

C.5.c.iv.e  Guidance of Steroid Injection with Ultrasound or Scintigraphy

**Not Recommended** - compared with palpation.

Evidence for the Use of Injected Glucocorticosteroids for Plantar Fasciitis

C.5.c.iv.f  Hyperosmolar Dextrose Injections for Plantar Fasciitis

**Not Recommended** - for treatment of plantar fasciitis.

Evidence for the Use of Hyperosmolar Dextrose for Plantar Fasciitis

C.5.c.iv.g  Platelet Rich Plasma Injections for Plantar Fasciitis

**Not Recommended** - for treatment of plantar fasciitis.

Evidence for the Use of Platelet Rich Plasma for Plantar Fasciitis

C.5.c.v  Surgery

C.5.c.v.a  Surgery for Select Chronic Recalcitrant Plantar Fasciitis
Recommended - for select chronic recalcitrant plantar fasciitis. There is no recommendation for any particular procedure or method over another.

Indications: Moderate to severe chronic plantar fasciitis patients who have failed multiple non-surgical treatments and whose condition has lasted at least six to 12 months. Patients should generally have failed NSAID(s), plantar fascia stretching, injection(s) and failed other conservative treatment

Rationale for Recommendations: Surgery is recommended as an intervention after at least six months of other non-operative treatments have been attempted and the patient's symptoms are sufficient to warrant the risks of surgical intervention. Patient education regarding suboptimal expected outcomes is recommended.

C.5.c.v.b Surgery for Acute or Subacute Plantar Fasciitis

Not Recommended - for treatment of acute or subacute plantar fasciitis.

Evidence for the Use of Surgery for Plantar Fasciitis

C.5.c.vi Other

C.5.c.vi.a Orthotic Devices for Acute, Subacute, or Chronic Plantar Heel Pain

Recommended - for treatment of acute, subacute, or chronic plantar heel pain.

Indications: Patients with plantar fasciitis.

Duration/Frequency: Daily use for two to three months.

Indications for Discontinuation: Resolution, adverse effects, non-compliance.

C.5.c.vi.b Custom Orthoses for Acute, Subacute, or Chronic Plantar Fasciitis

Not Recommended - for acute, subacute, or chronic plantar fasciitis.

C.5.c.vi.c Orthoses for Prevention of Plantar Fasciitis or Lower Extremity Disorders

Not Recommended - for the prevention of plantar fasciitis or lower extremity disorders.
Evidence for the Use of Orthoses for Plantar Fasciitis

C.5.c.vi.d Cryosurgery for Subacute, Acute or Chronic Plantar Heel Pain

Not Recommended - for treatment of chronic plantar heel pain.

Evidence for the Use of Cryosurgery for Plantar Fasciitis

C.5.c.vi.e Intracorporeal Pneumatic Shockwave Therapy (IPST) for Select Chronic Plantar Fasciitis

Recommended - for treatment of select chronic plantar fasciitis.

Indications: The use of IPST is recommended as an alternative to surgical intervention for recalcitrant plantar fasciitis among those patients who fail other non-operative treatments (i.e. NSAIDs, injection(s), stretching, other exercises and night splinting) and have a demonstrable heel spur.

Evidence for the Use of Intracorporeal Pneumatic Shock Therapy for Plantar Fasciitis

C.5.c.vi.f Percutaneous Calcaneus Fenestration for Chronic Plantar Heel Pain

Not Recommended - for treatment of chronic plantar heel pain.

Evidence for the Use of Percutaneous Bone Fenestration for Plantar Heel Pain

C.5.c.vi.g Radiofrequency Microtenotomy for Chronic Plantar Fasciitis

Not Recommended - for treatment of chronic plantar fasciitis.

Evidence for the Use of Radiofrequency Microtenotomy for Plantar Fasciitis

C.6 Foot Ulceration

C.6.a Physical Examination

The size, depth, and location of and condition of the area surrounding an ulcer should be recorded. Check for exudate, odor, tunneling, undermining, sinus tracts, necrosis or eschar formation, infection, and signs of healing (granulation and...
epithelialization). Assess the wound margins and areas around the wound, including for induration, and tracking of infection or inflammation. Determine the stage of each ulcer.

Sensation of the foot and bone and joint deformities should be carefully assessed. Evaluation of perfusion of the foot and ankle, including dorsalis pedis and posterior tibial pulses, and of capillary refill is helpful. Footwear should be assessed for good repair, provision of comfort and support, and freedom from protruding, abrasive, or sharp features.

Wagner Grading System:
- Grade 0 – No ulcer in a high-risk patient
- Grade 1 – Superficial ulcer involving the full skin thickness but not underlying tissues
- Grade 2 – Deep ulcer, penetrating down to ligaments and muscle, but no bone involvement or abscess formation
- Grade 3 – Deep ulcer with cellulitis or abscess formation, often with osteomyelitis
- Grade 4 – Localized gangrene
- Grade 5 – Extensive gangrene involving the whole foot

C.6.b Diagnostic Studies

C.6.b.i X-Rays

**Recommended** - for those with questions of bone involvement, particularly concerns about osteomyelitis.

C.6.b.ii Bone Scans

**Recommended** – for those with question of bone involvement with indeterminate x-rays.

C.6.c Medications

Acetaminophen and/or non-steroidal anti-inflammatory drugs (NSAIDs) for pain control are often not needed due to the propensity for the join to be denervated, but if needed are recommended.

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.6.c.i Non-Steroidal Anti-Inflammatory Drugs

**Recommended** - for treatment of acute, subacute, chronic, or post-operative non-healing and/or infected ulcers
Indications: For acute, subacute, chronic, or post-operative pain. NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.6.c.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.6.c.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

C.6.c.iv Acetaminophen for Treatment of Acute, Subacute, or Chronic Non-Healing and/or Infected Ulcers

Recommended - for treatment of acute, subacute, or chronic pain, particularly in patients with contraindications for NSAIDs.
Indications: All patients with pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.6.c.v Opioids for Pain from Acute, Subacute, Chronic or Post-Operative Foot Ulcer

Recommended - Limited use of opioids (not to exceed seven days) for the treatment of select patients presenting with severe pain related to foot ulcer. Limited use of opioids for a few days (not to exceed seven days) is also recommended for select patients who have undergone recent surgical intervention.

Frequency/Dose/Duration: Frequency and dose per manufacturer’s recommendations; may be taken scheduled or as needed; generally taken for short courses of a few days, with subsequent weaning to nocturnal use if needed, then discontinuation. Total length of treatment usually ranges from a few days to one week. Generally should be utilized to supplement pain relief in addition to an NSAID or acetaminophen to reduce total need for opioid and the consequent adverse effects.

Indications for Discontinuation: Sufficient pain management with other methods such as NSAIDs, resolution of pain, intolerance, adverse effects, lack of benefits, or failure to progress over a couple weeks.

C.6.c.vi Antibiotics

Recommended – for most non-healing and/or infected ulcers. Antibiotic selection should be tailored to the cultured or anticipated organism.

C.6.d Treatments

C.6.d.i Mobilization / Immobilization

C.6.d.i.a Total Contact Casting for Foot Ulcers

Recommended - for foot ulcers.

Indications – All patients with non-healing foot ulcerations are potential candidates.

Evidence for the Use of Total Contact Casting

C.6.d.i.b Foot Waffle Support Brace

Not Recommended - for patients with foot ulcers.
Evidence for the Use of the Foot Waffle Support Brace

C.6.d.ii  Surgery

C.6.d.ii.a  Surgical Debridement to Treat Lower Extremity Ulcers

**Recommended** – for the treatment of lower extremity ulcers; particularly for devascularized, callus, wound edge tissue and foreign debris.

C.6.d.iii  Other

C.6.d.iii.a  Negative Pressure (Vacuum) Wound Care Systems

**Recommended** - for the treatment of chronic lower extremity ulcers.

*Indication:* Chronic, non-healing lower extremity ulcers.

C.6.d.iii.b  Hyperbaric Oxygen for Foot Ulcers

**Recommended** - for treatment of select foot ulcers.

*Indications:* Wagner’s 2, 3, 4 foot ulcer(s) of more than three months duration.

*Frequency:* Treatments five days per week for eight weeks. May extend to ten weeks; maximum 40 treatments.

**Evidence for the Use of Hyperbaric Oxygen**

**Evidence for the Use of Negative Pressure Therapy (Vacuum Devices)**

C.7  Wound Care, Subungual Hematoma, Contusions

See Hand, Wrist, and Forearm guideline.

C.8  Charcot Joint (Neurogenic Arthropathy)

Refers to progressive degeneration of a weight bearing joint, a process marked by bony destruction, bone resorption, and eventual deformity due to loss of sensation secondary to neuropathy. Treatment includes addressing the underlying neuropathy.

C.8.a  Diagnostic Studies

C.8.a.i  X-Rays

**Recommended** – for diagnosing Charcot Joints.
C.8.a.ii MRIs

**Recommended** – to improve staging of Charcot joints.

C.8.b Medications

Acetaminophen and/or non-steroidal anti-inflammatory drugs (NSAIDs) for pain control are often not needed due to the propensity for the joint to be denervated, but if needed are recommended.

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.8.b.i NSAIDs for Treatment of Acute, Subacute, Chronic, or Post-operative Charcot Joint Pain

**Recommended** - for treatment of acute, subacute, chronic, or post-operative Charcot Joint pain.

**Indications:** For acute, subacute, chronic, or post-operative Charcot Joint pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration:** As needed use may be reasonable for many patients.

**Indications for Discontinuation:** Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.8.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.
Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.8.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

C.8.b.iv Acetaminophen for Treatment of Acute, Subacute, or Chronic Charcot Joint Pain

**Recommended** - for treatment of acute, subacute, or chronic Charcot Joint Pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with joint pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

C.8.c Treatments

C.8.c.i Rehabilitation

**Therapy**

Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active
therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.8.c.i.a  Gait Training
   Recommended – for treatment of Charcot Joints.

C.8.c.i.b  Splints, walking braces, orthoses and casts in select patients
   Recommended – for treatment of Charcot Joints.

C.8.c.ii  Surgery

C.8.c.ii.a  Surgical Procedures Including Ostectomy May Be Performed to Address Deformities That Place the Foot at Risk of Ulceration
   Recommended – to address deformities that place foot at risk of ulceration.

C.8.c.ii.b  Open Reduction Internal Fixation of Fractures
   Recommended – open reduction internal fixation of fractures.

C.8.c.ii.c  Fusion of Charcot Joints in Select Patients
   Recommended – fusion of Charcot Joints.

C.8.c.ii.d  Arthroplasty (Total Joint Replacement) for Charcot Joints
   Not Recommended – for Charcot Joints.

C.9  Paronychia
Paronychia is an inflammatory disorder of the nail folds. It is generally classified as acute and chronic. Acute cases are caused by trauma to the nail folds or cuticle.

C.9.a  Medications
For most patients, generic ibuprofen, naproxen, or other older generation non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.9.a.i  **NSAIDs for Treatment of Paronychia Pain**

**Recommended** - for treatment of paronychia pain.

*Indications*: For paronychia pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration*: As needed use may be reasonable for many patients.

*Indications for Discontinuation*: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.9.a.ii  **NSAIDs for Patients at High Risk of Gastrointestinal Bleeding**

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications*: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration*: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation*: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.9.a.iii  **NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.
**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

C.9.a.iv Acetaminophen for Treatment of Paronychia Pain

**Recommended** - for treatment of paronychia pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.

C.9.a.v Topical anitbiotics for the Treatment of Acute Paronychia

**Recommended** – for treatment of acute paronychia.

C.9.a.vi Systemic Antibiotics for the Treatment of Complications of Paronychia

**Recommended** – for the treatment of complications of paronychia such as signs of systemic infection or surrounding cellulitis.

C.9.a.vii Topical and Systemic Antifungals for the Treatment of Select Patients with Chronic Paronychia Due to Fungal Infections

**Recommended** – for the treatment of chronic paronychia.

C.9.a.viii Topical Glucocorticosteroid Cream for Treatment of Select Patients with Chronic Paronychia Not Due to Bacterial or Fungal Infections

**Recommended** – for treatment of select patients with chronic paronychia with chronic paronychia not due to bacterial or fungal infections.

C.9.a.ix Topical and Systemic Antibiotics for Treatment of Secondary Chronic Paronychia Due to Bacterial Infections

**Recommended** – for treatment of secondary chronic paronychia infections.

C.9.b Treatment
C.9.b.i  Chryotherapy / Heat

Warm compresses to Treat Acute Phase of Paronychia.

**Recommended** – for treatment of acute paronychia.

C.9.b.ii  Surgery

C.9.b.ii.a  En Bloc Excision of the Proximal Nail Fold and Eponychial Marsupialization, With or Without Nail Plate Removal

**Recommended** – for treatment of recurrent paronychias.

C.9.b.ii.b  Surgical management for treatment of chronic paronychia for those who fail non-operative measures.

**Recommended** – surgical intervention, including en bloc excision of the proximal nail fold and eponychial marsupialization, with or without nail plate removal for treatment of chronic paronychia.

C.9.b.iii  Other

C.9.b.iii.a  Incision and drainage of abscess formed in response to acute paronychia.

**Recommended** – in response to acute paronychia.

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C.10  Foot Drop

Foot drop is a weakness in the dorsiflexion strength of the affected lower extremity resulting in an abnormal gait pattern. Foot drop is most commonly caused by a variety of central and peripheral nervous system disorders, although any disorder affecting muscle strength may cause foot drop. Foot drop results in an abnormal gait pattern most often because the ankle of the weak side cannot undergo voluntary dorsiflexion.

The acute onset of foot drop after ipsilateral leg trauma may be a manifestation of compartment syndrome. Acute cases of foot drop are urgencies if not emergencies due to the potential for significant enduring impairments.

Acute trauma followed by foot drop and lower leg pain may mark compartment syndrome, which is one of the surgical emergent causes of foot drop.

C.10.a  Diagnostic Studies

Diagnostic studies to determine the cause of foot drop most often include MRI of the brain, spinal cord and/or MRI of the periphery and electrodiagnostic studies of the peripheral nerves as clinically indicated.

C.10.a.i  Diagnostic Studies for Diagnosis of Foot Drop
Recommended – to determine cause of foot drop (see General Principles A.12 – Diagnostic Imaging and Testing Procedures).

C.10.b Treatments

C.10.b.i Rehabilitation

Therapy
Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.10.b.i.a Taping for Treatment of Foot Drop

Not Recommended – for the treatment of foot drop.

Rationale for Recommendation: Generally, braces are used for foot drop.

Evidence for the Use of Taping

C.10.b.ii Other

C.10.b.ii.a Ankle-foot Orthotics for Treatment of Foot Drop

Recommended – for the treatment of foot drop.

Evidence for use of Orthotics
C.11 Tarsal Tunnel Syndrome (TTS)

Tarsal tunnel syndrome (TTS) is a relatively infrequent condition defined as an entrapment neuropathy of the tibial nerve or one of its branches from its entry point under the flexor retinaculum below the medial malleolus to the end of its lateral and medial plantar and posterior calcaneal branches, which innervate the base of the foot. TTS is described by the constellation of symptoms of intermittent tingling, numbness or burning paresthesias in the toes and the plantar surface of the foot.

In the absence of neuropathic findings (sensory or motor involvement) four to six weeks of conservative care before using invasive measures may be reasonable. The commonly prescribed conservative measures are intended to relieve pressure and pain. These include cold, taping, exercises (especially posterior tibial nerve stretching), anti-inflammatory medications, splints, orthotic devices and supportive footwear.

There are no well-established standard diagnostic criteria for TTS. Clinicians should maintain a high level of suspicion for TTS in patients presenting with pain and paresthesias of the plantar foot that worsen with prolonged standing and walking, or cause interruption of sleep.

C.11.a Diagnostic Studies

C.11.a.i Nerve Conduction Studies (NCS) for Diagnosis and Pre-operative Assessment of TTS Patients

Recommended - for confirming the diagnosis of entrapment of the tibial nerve at the ankle for cases that do not improve with conservative treatment or if considering surgical release after excluding the possibility of other causes such as polyneuropathy and radiculopathy.

C.11.a.ii NCS for Initial Evaluation of TTS Patients

Not Recommended - for the initial evaluation and most TTS patients as NCS does not change the management of the condition during the first four to six weeks while conservative therapy is being tried.

C.11.a.iii Electromyography (EMG) for Initial Evaluation, Diagnosis or Pre-operative Assessment of TTS Patients

Not Recommended - for initial evaluation, diagnosis or pre-operative assessment of TTS patients. Electromyography (as distinguished from a nerve conduction study) is not generally recommended as there is no quality evidence demonstrating the utility of EMG in the diagnosis of TTS.

Rationale for Recommendations: NCS is recommended for diagnosis of entrapment of the tibial nerve at the ankle and for pre-operative assessment, but is not recommended for initial evaluation and most TTS patients.

C.11.a.iv MRI for Diagnosis of TTS
**Recommended** - for the diagnosis of select cases of clinically suspected TTS that has failed conservative management or if a mass lesion is suspected.

### C.11.a.v MRI to Diagnose TTS

**Not Recommended** - for the initial evaluation of TTS.

### C.11.a.vi Use of Ultrasound as an Aid to NCS

**Recommended** - as an aid to NCS as it may be beneficial to identify suspected space occupying lesions in the tarsal tunnel after failed conservative management, or as an adjunct to guide interventional therapies.

### C.11.a.vii Routine Use of Diagnostic Ultrasound

**Not Recommended** - as a routine diagnostic test for TTS.

*Rational for Recommendations*: The routine use of ultrasound for initial evaluation is not recommended. Ultrasound studies should be reserved for patients that have failed conservative therapy. Use as an adjunct to guide interventional therapies may be useful.

### C.11.b Medications

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

#### C.11.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) and Acetaminophen for TTS Pain

**Recommended** - for treatment of TTS

*Indications*: For TTS Pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration*: As needed use may be reasonable for many patients.

*Indications for Discontinuation*: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

#### C.11.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding
**Recommended** – concomincent use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications**: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration**: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation**: Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.11.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**
Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended**: Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended**: If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.11.b.iv Acetaminophen for Treatment of TTS Pain**

**Recommended** - for treatment of TTS Pain, particularly in patients with contraindications for NSAIDs.

**Indications**: All patients TTS pain. Acetaminophen may provide enough mild analgesic relief to allow the patient to exercise or function at a higher level

**Dose/Frequency**: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation**: Resolution of pain, adverse effects or intolerance.

**C.11.b.v Oral Systemic Glucocorticosteroids for Treatment of TTS**
Recommended - for treatment of TTS patients who decline tarsal tunnel injection.

Indications – Tarsal tunnel syndrome unresponsive to splinting. Most patients should be injected rather than given oral steroids. However, among those declining injection, oral glucocorticosteroids may be warranted.

Frequency/Dose: It is recommended that one course (10 to 14 days) of oral glucocorticosteroid be prescribed, rather than repeated courses. Prescriptions of low rather than high doses are recommended to minimize potential for adverse effects.

Opioids

Opioids have occasionally been used to treat patients with TTS. These medications have primarily been used for a few nights in the post-surgical period (see Non Acute Pain Guideline).

C.11.b.vi Routine Use of Opioids for Treatment of Pain from TTS

Not Recommended - for treatment of patients with pain from TTS.

Rationale for Recommendations: The vast majority of patients with TTS do not have pain of sufficient intensity to require opioids. Patients having such degrees of pain should generally have investigations performed for alternative diagnoses. They are not recommended for routine use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.11.b.vii Opioids for Pain Treatment of TTS in Select Patients Post Op

Recommended - limited use (not more than seven days) for select patients

Indications: Patients who have undergone recent tarsal tunnel release and have large incisions or encountered significant complications and whose pain cannot be managed with other means.

Evidence for the Use of Opioids for TTS

C.11.b.viii Diuretics for Routine Treatment of TTS

Not Recommended - for routine treatment of TTS.

Rationale for Recommendation: Most of the medical conditions described as risk factors for TTS do not involve edema or swelling of the lower extremities.

C.11.b.ix Vitamins, Including Pyridoxine

Not Recommended - for the treatment of TTS in patients without vitamin deficiencies.
C.11.b.x Lidocaine Patches for Treatment of TTS

**Recommended** - for treatment of select cases of TTS.

*Indications:* Patients with moderate to severe TTS with pain as a central complaint and in whom other treatable causes of the pain have been eliminated. Generally should have previously been treated with likely more efficacious treatment strategies.

*Frequency/Duration:* Per manufacturer’s recommendation.

*Indications for Discontinuation:* Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least a couple weeks.

C.11.c Treatments

C.11.c.i Cyrotherapy / Heat

C.11.c.i.a Self-application of Ice or Heat for Treatment of TTS

**Recommended** - for the treatment of TTS.

*Rationale for Recommendations:* Ice and heat may help particularly with more acute symptoms.

C.11.c.ii Mobilization / Immobilization

C.11.c.ii.a Nocturnal Splints for Treatment of TTS

**Not Recommended** - nocturnal splinting for treatment of TTS.

C.11.c.iii Rehabilitation

**Therapy**

Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.
Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.11.c.iii.a Rest for Treatment of More Symptomatic Cases of TTS

**Recommended** - for the treatment of TTS.

*Rationale for Recommendations:* Ankle rest may be beneficial for the more symptomatic cases where aggravating factors include constant standing or walking.

C.11.c.iii.b Exercise

**Recommended** - for the treatment of TTS.

*Rationale for Recommendation:* Exercise regimens for tendon gliding or nerve gliding may be appropriate with documentation of improved function and decreased pain.

C.11.c.iii.c Taping

**Not Recommended** - for the treatment of TTS.

C.11.c.iii.d Magnets

**Not Recommended** - recommended for the treatment of TTS.

C.11.c.iii.e Acupuncture

**Not Recommended** - for the treatment of TTS.

*Rationale for Recommendation:* There are other interventions with documented efficacy. Therefore, the use of acupuncture for treatment of TTS is not recommended.

C.11.c.iii.f Manipulation and Mobilization of the Distal Lower Extremity

**Not Recommended** - for the treatment of TTS.

C.11.c.iii.g Ultrasound

**Not Recommended** - for the treatment of TTS
C.11.c.iii.h Iontophoresis

**Not Recommended** - for the treatment of TTS.

*Rationale for Recommendation*: Other treatments have documented efficacy and should be used preferentially.

C.11.c.iii.i Phonophoresis

**Not Recommended** - for the treatment of TTS.

*Rationale for Recommendation*: Other treatments have documented efficacy and should be used preferentially.

**Evidence for the Use of Phonophoresis**

C.11.c.iv Injection Therapy

C.11.c.iv.a Glucocorticosteroid Injections

**Recommended** - as part of a conservative management strategy for treatment of TTS.

*Rationale for Recommendation*: Injections are commonly reported as part of conservative therapy and as an additional mode for confirmation of suspected diagnosis of TSS. Thus, if a more conservative treatment strategy fails to improve the condition, glucocorticosteroid injections may be useful.

C.11.c.iv.b Insulin Injections

**Not Recommended** - for the treatment of TTS.

C.11.c.iv.c Botulinum Injections

**Not Recommended** - for the treatment of TTS

C.11.c.v Surgery

C.11.c.v.a Surgical Release for Space Occupying Lesion

**Recommended** - Surgical release of posterior tibial nerve impingement at the tarsal tunnel upon failure of conservative treatment and in the presence of space occupying lesion. Surgical release for cases with nonspecific causes are otherwise expected to have mixed results and patients should be counseled regarding potential lack of benefit before consideration of surgery.

C.11.c.vi Other
C.11.c.vi.a Orthotics for treatment of select patients with TTS

**Recommended** - selectively for those with TTS thought to be of biomechanical origin.

C.12 Ankle Sprain

Injuries to the ankle are common and are a frequent reason for seeking acute care.

Ankle sprain injuries involve tear of one or more ligaments in any of the three ligament groups. The majority of ankle sprains involve only the lateral ligaments, with approximately 15% involving the medial ankle. The natural course of the lateral ankle sprain is rapid improvement. Ten to 20% of patients with acute ankle sprain may develop chronic ankle instability.

Classification systems for lateral ankle sprain severity are based on physical examination findings and are used to define the extent of ligament injury.

Sprain: Injury, not necessarily permanent, of a ligament.
- S, Grade I: overstretching or slight tearing without instability.
- S, Grade II: incomplete tearing.
- S, Grade III: complete tear or rupture.

Red flags, including fracture, should be considered.

C.12.a Diagnostic Studies

C.12.a.i Routine Use of Arthrography in Diagnosis of Acute, Subacute or Chronic Ankle Sprain

**Not Recommended** - for evaluation of acute ankle sprain.

*Rationale for Recommendations*: Arthrography is invasive, is associated with adverse effects including risks from dye and post-procedure pain. MRI, CT, and ultrasound have essentially replaced plain arthrography in current practice.

C.12.a.ii X-Ray in Assessment of Acute Ankle Sprain when Fracture is Not Suspected

**Not Recommended** - for evaluation of acute ankle sprain when fracture is not suspected.

C.12.a.iii X-Ray in Assessment of Acute Ankle Sprain when Fracture is Suspected

**Recommended** - if fracture is likely and the differential diagnosis reflects suspicion of fracture.

*Rationale for Recommendations*: The primary purpose of obtaining radiologic imaging for the acute ankle injury is to evaluate for the
presence of ankle or foot fractures. Ankle fracture occurs in approximately 15% of patients with ankle sprain.

**Indications:** Suspicion of fracture or if the history or physical is clinically suspicious for an injury other than an ankle sprain.

**Views:** Anteroposterior, lateral, and mortise radiographs should be obtained.

C.12.a.iv Routine Stress X-Ray for Evaluation of Ligament Rupture in Acute Ankle Sprain

**Not Recommended** - for evaluation of acute ankle ligament rupture.

C.12.a.v Routine Stress X-Ray for Evaluation of Ligament Rupture in Subacute or Chronic Ankle Sprain

**Not Recommended** - for evaluation of subacute or chronic ankle pain.

**Rationale for Recommendations:** Plain films are not required for the diagnosis of acute ankle sprain as x-ray is poor at diagnosing soft-tissue disorders. The use of plain film x-ray rather is utilized for evaluation of accompanying ankle or foot fracture, orientation of fracture plane(s), and magnitude of the involvement of the articular surfaces, which if present may alter management in favor of surgery. X-ray is indicated based on high clinical suspicion. Therefore, x-ray is recommended for assessment of suspected ankle or foot fracture.

**Evidence for the Use of X-ray for Evaluation of Ankle Fractures**

C.12.a.vi CT for Assessment of Subacute or Chronic Ankle Sprain

**Recommended** - for the assessment of select patients with subacute or chronic ankle sprain.

**Indications** – Patients who have no improvement with non-operative therapy after four to six weeks, persistent pain with weight bearing, or chronic feeling of instability; ankle injuries that involve crepitus, catching or locking, as these symptoms may be associated with a displaced osteochondral fragment.

C.12.a.vii CT for Assessment of Acute Ankle Sprain

**Not Recommended** - for assessment of patients with acute ankle sprain.

C.12.a.viii Magnetic Resonance Arthrography (MRA) for Assessment of Subacute or Chronic Ankle Sprain

**Not Recommended** - for the assessment of subacute or chronic ankle sprain.
C.12.a.ix  MRA for Assessment of Acute Ankle Sprain

*Not Recommended* - for the assessment of acute ankle sprain.

C.12.a.x  Magnetic Resonance Imaging (MRI) for Assessment of Subacute or Chronic Ankle Sprain

*Recommended* - for the assessment of select patients with subacute or chronic ankle sprain.

*Indications:* Patients who have no improvement with non-operative therapy after 4 to 6 weeks, persistent pain with weight bearing, or chronic feeling of instability; ankle injuries that involve crepitus, catching or locking, as these symptoms may be associated with a displaced osteochondral fragment.

*Rationale For Recommendation:* MRI is used to evaluate ligament, osteochondral injury such as talar dome lesions, fractures, ankle impingement, and other soft-tissue injuries.

C.12.a.xi  MRI for Assessment of Acute Ankle Sprain

*Not Recommended* - for the assessment of acute ankle sprain.

C.12.a.xii Bone Scans for Assessment of Acute Ankle Sprain

*Recommended* - for select patients with acute ankle sprain.

*Indications:* Suspected stress fracture, infection, or tumor.

C.12.a.xiii Bone Scans for Assessment of Subacute or Chronic Ankle Sprain

*Not Recommended* - for patients with subacute or chronic ankle sprain.

C.12.a.xiv Ultrasound for Diagnosis of Subacute or Chronic Ankle Sprain

*Not Recommended* - for evaluation of patients with subacute or chronic ankle sprain.

C.12.a.xv Electrodiagnsotic Studies of the Peroneal Nerve

*Recommended* – for select patients with recurrent / recalcentrant lateral sprains.

*Indications* – To rule out peroneal neuropath in Patients with Lateral sprains as a result of marked inversion injury.

C.12.b  Medications

The use of non-steroidal anti-inflammatory Drugs (NSAIDs) and acetaminophen are well-described interventions for numerous soft-tissue and musculoskeletal injuries, including ankle sprains.
For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.12.b.i Acetaminophen for Treatment of Acute, Subacute, or Chronic Sprain Injury Pain

**Recommended** - for treatment of acute, subacute or chronic ankle sprain injury pain, particularly in patients with contraindications for non-steroidal anti-inflammatory (NSAIDs).

**Indications:** All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

C.12.b.ii Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

NSAIDs for Treatment of Acute, Subacute, Chronic or Post-operative Ankle Sprain

**Recommended** - for treatment of acute, subacute, chronic, or post-operative Ankle Sprain.

**Indications:** For ankle sprain pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration:** As needed use may be reasonable for many patients.

**Indications for Discontinuation:** Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.12.b.iii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be
considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

### C.12.b.iv NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

- **Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

- **Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

**Evidence for the Use of Acetaminophen for Ankle Sprain**

**Evidence for the Use of NSAIDs for Ankle Sprain**

### C.12.b.v Opioids for Select Acute or Post-Operative Ankle Sprain

- **Recommended** - for no more than one week for select patients with severe pain related to acute ankle sprain. Limited use of opioids for no more than one week may be indicated for those that have undergone ankle ligament repair surgery or those who encountered surgical complications.

**Indication:** Highly selective use. Severe pain with acute ankle sprain and post-operative pain management. Generally to be used only with either demonstrated insufficient control of pain with NSAID or severe sprain/post-operative pain.

**Frequency/Dose/Duration:** Frequency and dose per manufacturer’s recommendations; may be taken scheduled or as needed; generally suggested to be taken for short courses of a few days.

**Indications for Discontinuation:** Sufficient pain management with other methods such as NSAIDs, resolution of pain, intolerance, adverse effects, lack of benefits, or failure to progress over a couple weeks.
Rationale for Recommendation: The vast majority of patients with ankle sprain generally do not have pain sufficient to require opioids.

Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief select use in post-operative patients primarily at night to achieve post-operative sleep.

Evidence for the Use of Opioids for Ankle Sprain

C.12.b.vi Lidocaine Patches for Acute, Subacute, or Chronic Ankle Sprain

Not Recommended - for the treatment of acute, subacute, or chronic ankle sprain.

Evidence for the Use of Lidocaine Patches for Ankle Sprain

C.12.b.vii Topical NSAIDs for Acute Ankle Sprain

Recommended - for the treatment of acute ankle sprain.

Indications: Acute ankle sprain or patients with contraindications for oral treatment or who prefer not to take oral medications. No evidence of comparative superiority of one topical NSAID over another.

Frequency/Duration: Frequency per manufacturer’s recommendation. Topical NSAID use has been reported for one to three weeks.

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale for Recommendation: Topical NSAIDs are used to deliver medication locally and superficially in musculoskeletal disorders, including ankle sprain disorders.

C.12.b.viii Topical NSAIDs for Subacute or Chronic Ankle Sprain

Not Recommended - for the treatment of subacute, or chronic ankle sprain.

Evidence for the Use of Topical NSAIDs for Ankle Sprain

C.12.c Treatments

C.12.c.i Rest, Ice, Compression, Elevation (RICE)

C.12.c.i.a Immediate Non-weight Bearing (Rest) for Acute Ankle Sprain

Recommended - as an initial intervention for acute ankle sprain for patients unable to tolerate weight.
Indications: Acute mild, moderate, and severe ankle sprain patients who are unable to tolerate weight bearing. A short period of up to 48-hours may be prescribed based on tolerance and ability to bear weight. Early mobilization is recommended.

Frequency/Duration: Up to 48 hours of non-weight bearing; early mobilization, progressive weight bearing as tolerated, addition of home therapeutic exercises.

Indications for Discontinuation: Resolution, ability to tolerate weight.

Evidence for the Use of RICE for Ankle Sprain

C.12.c.i.b Cryotherapy for Acute Ankle Sprain

Recommended - for treatment of acute ankle sprains.

Indications: Acute ankle sprain.

Frequency/Duration: Self-application for 10 to 20 minutes every two hours for up to three days as needed.

Indications for Discontinuation: Resolution, adverse effects, non-compliance.

Evidence for the Use of Ice/Cryotherapy for Ankle Sprain

C.12.c.ii Cryotherapy / Heat

C.12.c.ii.a Heat for Acute Ankle Sprain

Not Recommended - for the treatment of acute ankle sprain.

Evidence for the Use of Heat for Ankle Sprain

C.12.c.iii Mobilization / Immobilization

C.12.c.iii.a Ankle Brace (Orthosis) for Acute Ankle Sprain

Recommended - for treatment for acute ankle sprain with optional use as needed by the patient for mild and moderate sprains.

Evidence for the Use of Ankle Brace Support (Pneumatic/Gel) for Ankle Sprain
Evidence for the Use of Ankle Support or Brace for Ankle Sprain

C.12.c.iii.b Walking Boot for Acute Ankle Sprain
Not Recommended - of acute ankle sprains.

C.12.c.iii.c Walking Boot for select cases of severe Ankle Sprain

Recommended - of select cases of severe ankle sprains.

Evidence for the Use of Walking Boots for Ankle Sprain

C.12.c.iii.d Early Mobilization for Acute Ankle Sprain

Recommended - for acute ankle sprains without fracture.

Indications: Acute ankle sprains (severe sprains should undergo no more than three weeks of immobilization, splints should be sufficient for immobilization; ankle sprains that are mild or moderate should not undergo immobilization.

Rationale for Recommendations: Early mobilization is recommended over immobilization for most patients

C.12.c.iii.e Immobilization for Acute Mild to Moderate Ankle Sprain

Not Recommended - for patients with acute mild to moderate ankle sprain as splints should be sufficient.

Rationale for Recommendation - Mild acute sprains are generally self-limited and respond well to early mobilization and other therapies; therefore, casting is not recommended.

C.12.c.iii.f Immobilization for Severe Ankle Sprain

Recommended – splinting for immobilization for severe ankle sprain.

Indications: Severe ankle sprain.

Frequency/Duration: Application of a splint for ten days to three weeks after a 48-hour period of elevation and non-weight bearing.

Rationale for Recommendation: Casting is restrictive of activity, including return to work, impairs driving performance more than bracing, and is associated with risk for deep venous thrombosis. Cast immobilization is therefore not recommended. Splinting is recommended for immobilization of severe ankle sprain.

Evidence for the Use of Early Mobilization for Ankle Sprain

C.12.c.iv Rehabilitation
Therapy
Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.12.c.iv.a Compression Therapy for Acute Ankle Sprain

Not Recommended - for acute ankle sprains.

C.12.c.iv.b Tubigrip for Acute Ankle Sprain

Not Recommended - for acute ankle sprains.

C.12.c.iv.c Tape, Elastic Wrap or Tubular Elastic for Acute Ankle Sprain

Not Recommended - for acute ankle sprains.

Evidence for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain

C.12.c.iv.d Intermittent Elevation for Acute Ankle Sprain

Recommended - for controlling edema of acute ankle sprains.

Indications: Acute ankle sprain that manifest significant edema.

Indications for Discontinuation: Resolution, adverse effects, non-compliance.
Evidence for the Use of Elevation for Ankle Sprain

C.12.c.iv.e Contrast Bath Therapy for Acute Ankle Sprain

Not Recommended - for the treatment of acute ankle sprain.

Evidence for the Use of Contrast Bath for Ankle Sprain

C.12.c.iv.f High-Voltage Pulsed Current for Acute Ankle Sprain

Not Recommended - for acute ankle sprains.

C.12.c.iv.g Magnets for Acute, Subacute, or Chronic Ankle Sprain

Not Recommended - for treatment of acute, subacute, or chronic ankle sprain.

Evidence for the Use of Magnets for Ankle Sprain

C.12.c.iv.h Diathermy for Acute, Subacute, or Chronic Ankle Sprain

Not Recommended - for the treatment of acute, subacute, or chronic ankle sprain.

Evidence for the Use of Diathermy for Ankle Sprain

C.12.c.iv.i Low Frequency Electrical Stimulation for Acute, Subacute, or Chronic Ankle Sprain

Not Recommended - for acute, subacute, or chronic ankle sprain.

C.12.c.iv.j High-voltage Pulsed Electrical Stimulation for Acute, Subacute, or Chronic Ankle Sprain

Not Recommended - as a treatment for acute, subacute, or chronic ankle sprain.

Evidence for the Use of Electrical Stimulation for Ankle Sprain

C.12.c.iv.k Iontophoresis for Acute, Subacute, or Chronic Ankle Sprain

Not Recommended - for treatment of acute, subacute, or chronic ankle sprain.

Evidence for the Use of Iontophoresis for Ankle Sprain

C.12.c.iv.l Low-Level Laser Therapy for Acute, Subacute, or Chronic Ankle Sprain
**Not Recommended** - for treatment of acute, subacute, or chronic ankle sprain.

*Evidence for the Use of Low-level Laser Therapy for Ankle Sprain*

**C.12.c.iv.m** Phonophoresis for Acute, Subacute, or Chronic Ankle Sprain

**Not Recommended** - for treatment of acute, subacute, or chronic ankle sprain.

*Evidence for the Use of Phonophoresis for Ankle Sprain*

**C.12.c.iv.n** Therapeutic Ultrasound for Acute, Subacute, or Chronic Ankle Sprain

**Not Recommended** - for the treatment of acute, subacute, or chronic ankle sprain.

*Evidence for the Use of Therapeutic Ultrasound for Ankle Sprain*

**C.12.c.iv.o** Acupuncture for Acute, Subacute, or Chronic Ankle Sprain

**Not Recommended** - for treatment of acute, subacute, or chronic ankle sprain.

*Evidence for the Use of Acupuncture for Ankle Sprain*

**C.12.c.iv.p** Hyperbaric Oxygen Therapy for Acute, Subacute, or Chronic Ankle Sprain

**Not Recommended** - for treatment of acute, subacute, or chronic ankle sprain.

*Evidence for the Use of Hyperbaric Oxygen for Ankle Sprain*

**C.12.c.iv.q** Manipulation or Mobilization for Acute or Subacute Ankle Sprain

**Not Recommended** - for the treatment of acute or subacute ankle sprain.

**C.12.c.iv.r** Manipulation or Mobilization for Chronic Recurrent Ankle

**Not Recommended** - for the treatment of chronic recurrent ankle sprain.
Evidence for the Use of Manipulation and Mobilization for Ankle Sprain

C.12.c.v Injection Therapy

C.12.c.v.a Autologous Blood Injection for Acute, Subacute, or Chronic Ankle Sprain

*Not Recommended* - as a treatment for acute, subacute, or chronic ankle sprain.

Evidence for the Use of Autologous Blood Injections for Ankle Sprain

C.12.c.v.b Glucocorticosteroid Injections for Acute, Subacute, or Chronic Ankle Sprain

*Not Recommended* - for treatment of acute, subacute, or chronic ankle sprain.

Evidence for the Use of Injected Glucocorticosteroids for Ankle Sprain

C.12.c.v.c Hyaluronic Acid Injections for Acute, Subacute, or Chronic Ankle Sprain

*Not Recommended* - for the treatment of acute, subacute, or chronic ankle sprains.

Evidence for the Use of Hyaluronic Acid for Ankle Sprain

C.12.c.v.d Prolotherapy Injections for Acute, Subacute, Chronic or Ankle Sprains

*Not Recommended* - for the treatment of most acute, subacute or chronic and post-operative ankle sprains.

Evidence for the Use of Polidocanol Injections

C.12.c.v.e Platelet Rich Plasma Injections for Acute, Subacute, or Chronic Ankle Sprain

*Not Recommended* - for the treatment of acute, subacute, or chronic ankle sprains.

Evidence for the Use of Platelet Rich Plasma for Ankle Sprain

C.12.c.vi Surgery

C.12.c.vi.a Surgery for Treatment of Acute or Subacute Ankle Ligament Tear
C.12.c.vi.b Surgery for Treatment of Chronic Ankle Instability (CAI)

**Recommended** - for select cases of chronic ankle instability.

*Indications:* Chronic ankle instability of at least 6-months duration, lateral ankle ligament laxity, and failure of non-operative therapies including therapy and use of ankle orthosis.

*Rationale for Recommendations:* Persistent functional instability of a chronic nature may be considered for ligament reconstruction.

**Evidence for the use of Surgical Intervention for Chronic Ankle Instability**

**Evidence for the Use of Acute Surgical Repair for Ankle Ligament Tear**

C.12.c.vi.c Post-Operative Management of Ankle Instability

**Recommended** - Short-term cast immobilization with early mobilization and therapy for ankle instability.

*Rationale for Recommendation:* Immobilization or early motion and therapy are described as frequent post-operative management techniques.

**Evidence for the Use of Post-operative Management for Ankle Instability**

C.13 Mid-Tarsus Pain and Sprains

Mid-tarsus or mid-foot pain and sprains frequently involve the ligaments of the mid-foot. A primary diagnostic focus is to eliminate the diagnosis of midfoot fracture. Metatarsalgia is included in this category as is metatarsophalangeal joint sprain. However, metatarsalgia is a broad categorization of forefoot pain that also includes numerous other conditions (e.g., Morton’s neuroma).

C.13.a Diagnostic Studies

C.13.a.i Weight Bearing X-Rays
Recommended – AP and lateral views without obliques; often bilateral for comparative purposes:
- Often normal in mild injuries (Grade 1 Sprains).
- Generally abnormal in moderate (Grade 2 Sprains).
- Always abnormal in severe injuries (Grade 3 Sprains).

C.13.a.ii CT Scans

Recommended – in uncertain cases and in select pre-operative cases.

C.13.b Treatments

C.13.b.i Mobilization / Immobilization

C.13.b.i.a In immobilization in a Short-Leg Walking Boot or Cast

Recommended – for mild to moderate cases without diastasis.

Duration of Therapy – four to six weeks with repeat x-rays and evaluation for stability at two weeks.

C.13.b.ii Surgery

C.13.b.ii.a Surgery

Recommended – for all severe cases, unstable injuries, and those with significant diastasis [e.g. >2mm].

C.14 Foot Neuroma (Morton’s Neuroma)

Morton’s neuroma is a common neuralgia affecting the web spaces of the toes, typically the third toe. The pain of Morton’s Neuroma may be debilitating in cases where patients have difficulty walking or applying pressure on their foot out of fear of pain. The neuroma is associated with a pathology of the plantar digital nerve as it divides at the base of the toes to supply the sides of the toes. There are many different treatments that have been used for Morton’s neuroma such as NSAIDs, corticosteroid injections, ablative procedures, and surgery.

A careful history and physical examination is considered the most important diagnostic approach and in most cases needs no further diagnostic testing.

C.14.a Treatment

C.14.a.i Rehabilitation

C.14.a.i.a Extracorporeal Shockwave Therapy

Not Recommended - for Morton’s Neuroma.
Evidence for the Use of Extracorporeal Shockwave Therapy for Morton’s Neuroma

C.14.a.i.b Manipulation or Mobilization of the Distal Lower Extremity for Treatment of Morton’s Neuroma

**Not Recommended** - for treatment of Morton’s Neuroma.

Evidence for the use of Manipulation and Mobilization

C.14.a.ii Injection Therapy

C.14.a.ii.a Glucocorticosteroid Injections for Select Morton’s Neuroma

**Recommended** - for Morton’s Neuroma.

*Indications:* select cases where pain and/or debility are significant and changing shoe wear, and/or orthotics fail to sufficiently control symptoms.

*Rationale for Recommendation:* Up to three injections to attempt to reduce symptoms is a reasonable intervention to try before surgery. Ongoing injections are not recommended.

Evidence for the use of Glucocorticosteroid Injections

C.14.a.ii.b Sclerosant Injections for Morton’s Neuroma

**Not Recommended** - for Morton’s Neuroma.

C.14.a.iii Surgery

C.14.a.iii.a Ablation for Morton’s Neuroma

**Recommended** - for Morton’s Neuroma.

*Indications:* Select cases where pain and/or debility are significant and changing shoe wear, orthotics and glucocorticoid injection(s) fail to sufficiently control symptoms.

C.14.a.iii.b Surgical Excision and/or decompression for Morton’s Neuroma

**Recommended** - where pain and/or debility are significant and changing shoe wear, orthotics and glucocorticoid injection(s) fail to sufficiently control symptoms.

*Rationale for Recommendations:* Ablative procedures or surgery are recommended in select cases where pain
and/or debility are significant and changing shoe wear, orthotics and glucocorticoid injection(s) fail to sufficiently control symptoms.

**Evidence of the Use of Surgery**

C.14.a.iv Other

C.14.a.iv.a Changes in Shoewear for Treatment of Morton’s Neuroma

**Recommended** - for treatment of Morton’s Neuroma.

**Indications** – Essentially all patients should be advised to wear stiff-soled, wide toe box shoes with a low heel and soft insert.

C.14.a.iv.b Orthotics for Treatment of Morton’s Neuroma

**Recommended** - for treatment of Morton’s Neuroma.

C.14.a.iv.c Metatarsal Pads for Treatment of Morton’s Neuroma

**Recommended** - for treatment of Morton’s Neuroma.

**Rationale for Recommendation:** An attempt at an orthosis or a metatarsal pad is recommended.

**Evidence for use of Orthotics**

**C.15 Bunions / Hallux Valgus**

Hallux valgus (“bunion”) is a lateral deviation of the great toe at the metatarsophalangeal joint with respect to the midline of the body, generally defined as over 14.5 degrees; and occurring in most cases with medial deviation of the first metatarsal.

The feet should show valgus deviation of the great toe beyond the first metatarsophalangeal joint.

**C.15.a Diagnostic Studies**

A careful history and physical examination is considered the most important diagnostic approach and in most cases needs no further diagnostic testing for preliminary treatment.

C.15.a.i X-Rays

**Recommended** – to evaluate alternate conditions such as osteoarthrosis, gout and degenerative joint disease. Also, x-rays are useful for measuring angles and surgical planning.

**C.15.b Treatments**
C.15.b.i Rehabilitation

C.15.b.i.a Low Intensity Ultrasound

**Not Recommended** - for postoperative osteotomy hallux valgus treatment.

*Evidence for the Use of Ultrasound*

C.15.b.i.b Manipulation or Mobilization for Treatment of Hallux Valgus

**Not Recommended** - for treatment of hallux valgus.

*Evidence for the use of Manipulation and Mobilization*

C.15.c.ii Surgery

C.15.b.ii.a Surgery for Hallux Valgus

**Recommended** - for Hallux Valgus.

*Indications*: Select cases of mostly moderate hallux valgus where pain and/or debility are significant and changing shoe wear and orthotics fail to sufficiently control symptoms.

*Evidence of the Use of Surgery*

C.15.b.iii Other

C.15.b.iii.a Orthotics for Treatment of Hallux Valgus

**Recommended** - for treatment of Hallux Valgus.

*Indications*: Use of orthoses for hallux valgus should generally be limited to 1 of 2 conditions: 1) There should be demonstrable hyperpronation or radiographic evidence of hyperpronation with a talar flexion angle of 30 degrees or more on a standing study; or 2) there should be pain localized to the plantar aspect of the hallux metatarsal head with or without bunion pathology.

*Rationale for Recommendation*: Orthotics are recommended for those with symptoms insufficiently controlled by changing shoewear when possible.

*Evidence for use of Orthotics*
C.16 Hammer Toe
Hammer toe syndromes normally occur in the sagittal plane. The metatarsophalangeal joint is dorsiflexed, while the proximal interphalangeal joint is plantarflexed. Hammer toe mostly affects the second toe.

C.16.a Treatment

C.16.a.i Non-Operative Treatments Include Footwear Modifications to Improve Toe Box/Room, Padding, Corticosteroid Injections, and Orthoses.

Recommended – for treatment of hammer toe.

C.16.a.ii Operative Treatment (Arthroplasty, Flexor Tendon Transfer, Flexor Tenotomy, Extensor Tendon Lengthening and Metatarsophalangeal Joint Capsulotomy, Fusion, and Diaphysectomy)

Recommended – for hammer toes with insufficient results from non-operative procedures.

C.17 Ankle and Foot Fractures
The initial evaluation of a patient with ankle injury should seek to identify conditions that require immediate treatment. These conditions include open fracture, vascular compromise, compartment syndrome, and joint dislocation.

In general, undisplaced or minimally displaced injuries are treated non-operatively, whereas displaced or unstable injuries are treated operatively. Complications of ankle and foot fractures include decreased range of motion, post-traumatic osteoarthritis, pain, persistent pain despite hardware removal, progressive talar instability, and malunions with concomitant syndesmotic widening.

The initial treatment of foot and ankle fractures is dictated by injury type (displaced or stable, open or closed) and by concomitant soft tissue injury. Closed, stable injuries are generally treated non-operatively. Open fractures require emergent debridement and antibiotic prophylaxis. Closed unstable fractures generally require operative management. Management should be initiated for severe swelling, compartment syndrome, and skin integrity breakdown from fracture blisters.

C.17.a Diagnostic Studies

C.17.a.i X-Ray for Suspected Acute Ankle Fractures

Recommended – as a first-line study.

Indications: Suspicion of fracture.

Rationale for Recommendation: X-ray is the recommended initial imaging study for suspected fracture.

Evidence for the Use of Ottawa Ankle and Foot Rules for Ankle Sprain
C.17.a.ii MRI for Distal Lower Extremity and Ankle Fractures

**Recommended** – for investigation of distal lower extremity and ankle fractures.

*Indications:* For acute or subacute fracture to evaluate soft tissue/ligament trauma in complex displaced or comminuted fracture, or if stability of fracture is uncertain and MRI will guide management decision.

*Rationale for Recommendation:* MRI should not be used as a first-line imaging technique. Upon confirmation of displaced, comminuted, or unstable fracture, MRI may be an important diagnostic technique for the evaluation of suspected injuries of soft tissues related to distal fibular, tibial, and malleolar fractures, such as to the syndesmotic ankle ligament complex, extensor tendons, deltoid ligament, or tibial nerve. MRI is recommended for these select circumstances.

*Evidence for the Use of MRI for Evaluation of Ankle Fractures*

C.17.a.iii CT for Diagnosis and Classification of Ankle Fractures

**Recommended** – for investigation of distal lower extremity and ankle fractures.

*Indications:* Suspected occult and complex ankle fractures; to gain greater clarity of fracture displacement. If intraarticular displacement is considered, then axial views are recommended in addition to any coronal views.

*Rationale for Recommendation:* CT should be considered when x-ray images are negative, but on the basis of physical findings, an occult fracture is strongly suspected. CT may also be useful for evaluation of complex comminuted fractures, providing superior depiction of distal tibial articular surface involvement, fragment positioning, and diagnosis of subluxations.

*Evidence for the Use of CT for Evaluation of Ankle Fractures*

C.17.a.iv Ultrasound Imaging for Diagnosing Ankle Fracture

**Recommended** – for evaluation of soft-tissue injury associated with select displaced fractures or suspected malleolar stress fractures.

*Indications:* Evaluation of soft-tissue injury associated with select displaced fractures to assess stability of fracture, particularly of the deltoid ligaments with medial and bimalleolar fractures, and in detection of suspected occult or stress fractures. Also used for suspected stress fracture of the distal tibia.
Rationale for Recommendation: Ultrasound imaging may be a useful adjuvant to clinical assessment of patients with regards to selection for further radiological examination, and is therefore recommended in select patients.

Evidence for the Use of Ultrasound for Evaluation of Ankle Fractures

C.17.b Medications

C.17.b.i Pre-Operative Antibiotic Prophylaxis for Ankle Fractures

Recommended – for closed or open ankle fracture surgery.

Evidence for the Use of Antibiotic Prophylaxis for Ankle Fractures

C.17.b.ii Use of Nasal Spray Calcitonin for Post-fracture Osteopenia

Not Recommended – for prophylaxis of post-fracture osteopenia.

Evidence for the Use of Calcitonin Prophylaxis for Post-fracture Osteopenia

C.17.b.iii DVT Prophylaxis

See discussion of DVT prophylaxis in the Achilles tendon rupture section.

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and Acetaminophen

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.17.b.iv Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Acute Ankle Fracture Analgesia

Recommended - for treatment of pain associated with ankle fracture.

Indications: For acute, subacute, chronic, or post-operative ankle fracture, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.
C.17.b.v NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** - concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

C.17.b.vi NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

C.17.b.vii Acetaminophen for Treatment of Acute, Subacute, or Chronic Acute Ankle Fracture Pain

**Recommended** - for treatment of acute, subacute, or chronic acute ankle fracture pain, particularly in patients with contraindications for NSAIDs.

**Indications** – All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency** – Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation** – Resolution of pain, adverse effects or intolerance.
Evidence for the Use of NSAIDs and Acetaminophen for Foot and Ankle Fractures

C.17.b.viii Limited Use of Opioids for Acute and Post-operative Pain Management

**Recommended** – for limited use (less than seven days) for acute and post-operative pain management as adjunctive therapy to more effective treatments.

**Indications:** For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation, splinting) is often required, especially nocturnally.

**Frequency/Duration:** Prescribed as needed throughout the day, then later only at night, before weaning off completely.

**Rationale for Recommendation:** Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

Evidence for the Use of Opioids for Foot and Ankle Fractures

C.17.b.ix Tetanus Immunization Status for Open Fractures

**Recommended** – updating of tetanus immunization status as necessary.

**Indications:** Wounds that are not clean if more than five years have elapsed since last tetanus immunization.

**Rationale for Recommendation:** As the adverse effects of not immunizing may be fatal, tetanus immunization updating for open wounds is recommended. Wounds that are not clean or burns should require immunization if more than five years since last immunization, rather than ten years. Patients without a completed immunization series of three injections should receive tetanus immune globulin along with immunization.

Evidence for the Use of Tetanus Immunization for Open Foot and Ankle Fractures

C.17.b.x Analgesia for Non-Operative Reduction Ankle Fractures

**Recommended** – for performing non-operative closed reduction of ankle fractures.

**Rationale for Recommendation:** Appropriate technique should be based on factors of physician experience and preference, patient history of
intolerance to medications or level of anxiety, and availability of equipment and supplies.

Evidence for the Use of Non-operative Reduction Analgesia for Ankle Fractures

C.17.c Treatments

C.17.c.i Mobilization / Immobilization

C.17.c.i.a Cast Immobilization for Ankle Fractures

**Recommended** - for the management of ankle fractures.

**Indications**: All ankle fractures.

**Frequency/Duration**: Immobilization generally for six to eight weeks.

**Rationale for Recommendation**: Cast immobilization is recommended for all patients and the use is dependent on physician and patient preference.

C.17.c.i.b Early Mobilization for Ankle Fractures

**Recommended** - in the management of post-operative and stable non-operative ankle fractures.

**Indications**: Stabilized malleolar fractures with or without surgery and closed ankle fractures with adequate fixation and stabilization.

**Frequency/Duration**: Early mobilization can be started within one to three days post-operatively.

**Rationale for Recommendation**: Early mobilization is recommended for most patients with stable or repaired malleolar ankle fracture.

C.17.c.i.c Early Post-Operative Weight-bearing for Ankle Fractures

**Recommended** - Early weight-bearing of operatively fixated ankle fractures postoperatively.

**Indications**: Stabilized malleolar fractures with or without surgery and closed ankle fractures with adequate fixation and stabilization.

**Rationale for Recommendation**: Early weight-bearing may provide improvement in functional recovery short-term, does not appear to result in increased adverse events.
Evidence for the Use of Immobilization, Early Mobilization, Early Weight-bearing for Ankle Fractures

C.17.c.ii Rehabilitation

C.17.c.ii.a Electrical Stimulation for Prevention of Muscle Atrophy

Not Recommended - for prevention of muscle atrophy in ankle and foot fracture management.

Evidence for the Use of Electrical Stimulation for Ankle and Foot Fractures

C.17.c.ii.b Therapy for Patients with Functional Deficits after Cast Removal

Recommended - after cast removal for ankle fractures.

C.17.c.ii.c Manual Therapy as Part of a Post-ankle Fracture Rehabilitation Program

Recommended - as part of an active post-ankle fracture rehabilitation program.

C.17.c.ii.d Passive Stretching for Contractures After Immobilization of Ankle Fractures

Not Recommended - for contractures after immobilization of ankle fractures.

Frequency/Dose/Duration: Frequency of visits is usually individualized based on severity of the limitation. Two to three visits per week for two weeks are often used to initiate an exercise program. Total numbers of visits may be as few as two to three for mild deficits or for more severe deficits, up to 12 to 15 with documentation of objective functional improvement.

Evidence for the Use of Therapy for Ankle Fractures

C.17.c.ii.e Ultrasound to Stimulate Bone Healing for Ankle and Foot Fractures

Not Recommended - for ankle and foot fracture management.

Evidence for the Use of Ultrasound Stimulation for Ankle and Foot Fractures

C.17.c.ii.f Hyperbaric Oxygen for the Management of Ankle or Foot Fractures
Not Recommended - for management of ankle or foot fractures.

Evidence for the Use of Hyperbaric Oxygen for Ankle and Foot Fractures

C.17.c.iii Fracture Care

Malleolar Ankle Fractures
Management of non-displaced and stable fractures has traditionally been non-operative with good results. There is continued debate regarding treatment for particular fractures types that are not clearly stable or unstable. Non-union of the distal fibula fracture is rare lending support to a trial of conservative management for non-displaced and stable displaced fractures. Reduction failure or delayed union may require surgical intervention. Posterior malleolar fractures are often missed and are highly variable.

C.17.c.iii.a Immobilization for Non-displaced Ankle Fractures

Recommended - for the treatment of non-displaced and reduced stable ankle fractures.

C.17.c.iii.b Immobilization and Reduction for Closed Displaced Ankle Fractures

Recommended – for select non-comminuted closed displaced ankle fractures.

Indications: Non-comminuted closed displaced ankle fractures with post-reduction displacement less than two to three mm and less than 25% posterior malleolus articular surface involvement.

C.17.c.iii.c Operative Fixation for Closed Displaced Ankle Fractures

Recommended – for unstable closed displaced ankle fractures.

Indications: Generally severe lateral fracture with medial malleolar involvement. Comminuted closed displaced ankle fractures with post-reduction displacement more than 2 to 3mm and more than 25% posterior malleolus articular surface involvement; patients 55 years of age or older.

Rationale for Recommendations: Non-operative management is recommended in select patients with non-severe fractures with minimal displacement after closed reduction. Operative fixation is recommended for patients with severe fractures, non-satisfactory closed reduction, unstable fracture, or aged 55 or greater.
Evidence for the Management of Malleolar Ankle Fractures

Tibial Shaft Fractures (Diaphyseal)

C.17.c.iii.d Operative Fixation for Tibial Shaft Fracture (Closed, Diaphyseal)

**Recommended** – for definitive management of displaced tibial shaft fracture.

*Indications*: Displaced, comminuted distal tibial shaft fracture.

C.17.c.iii.e Cast Immobilization for Tibial Shaft Fractures (Closed, Diaphyseal)

**Not Recommended** – as non-operative management of tibial shaft fractures.

Evidence for the Management of Tibial Shaft Fractures

Distal Tibial Extra-articular Fractures

C.17.c.iii.f Operative Fixation (i.e., Fracture Plating, Intramedullary Nail) for Distal Tibial Extra-Articular Fractures

**Recommended** – in select patients.

*Indications*: Open fractures, initial shortening >15mm, angular deformity after initial manipulation >5° in any plane.

C.17.c.iii.g Cast Immobilization for Distal Tibial Extra-Articular Fractures

**Recommended** – in select circumstances for distal extra-articular tibial fractures.

*Indications*: Closed simple fractures with initial shortening <15mm, angular deformity after initial manipulation <5° in any plane.

Evidence for the Management of Tibial Extra-articular Fractures

Tibial Plafond (Pilon) Fractures

C.17.c.iii.h Non-operative Management of Tibial Plafond and Pilon Fractures

**Recommended** – in select patients.
**Indications:** Non-displaced, non-comminuted, stable fracture; ability to obtain acceptable fracture alignment with closed reduction.

C.17.c.iii.i **Operative Management of Tibial Plafond and Pilon Fractures**

**Recommended** – for tibial plafond fractures in select patients.

**Indications:** Displaced, comminuted, or inability to obtain acceptable fracture alignment with closed reduction.

**Rationale for Recommendations:** Distal lower leg fractures that impinge on the articular surface with the talus are known as plafond fractures. These fractures are noted to have high complication rates from surgical reduction and fixation.

**Evidence for the Management of Tibial Plafond and Pilon Fractures**

C.17.c.iii.j **Operative Fixation for Syndesmotic Ruptures**

**Recommended** - for unstable syndesmotic rupture.

**Indications** – Closed ankle fractures with unstable syndesmosis, AO fracture type C and/or pathologic widening of more than 2mm of the syndesmosis at intra-operative testing.

C.17.c.iii.k **Non-operative Management of Syndesmotic Injuries**

**Recommended** - for stable syndesmotic injury.

**Indications:** Absence of other destabilizing injury including ankle fracture or deltoid ligament injury.

**Rationale for Recommendations:** There is opinion that not all ankle syndesmotic injuries lead to ankle instability, and may not need repair in the absence of other destabilizing injury. Fixation is required in the presence of fracture. Thus, non-operative management is recommended for select patients. Operative repair is recommended for non-stable injuries, which include most syndesmotic rupture with concurrent fractures or deltoid ligament injury.

**Evidence for the Treatment of Syndesmotic Injury**
Fibular Fractures

C.17.c.iii.l Operative Fixation for Displaced Distal Fibula Fractures

**Recommended** - for displaced distal fibula fracture.

*Indications*: Distal fibula shaft fracture, unsatisfactory closed reduction.

*Rationale for Recommendation*: Operative fixation is recommended for displaced, unstable distal fibular fractures.

*Evidence for the Operative Management of Fibular Shaft Fractures*

Arthroscopy with ORIF of Distal Fibular Fractures

C.17.c.iii.m Use of Arthroscopy Assisted ORIF for Distal Fibular Fractures

**Not Recommended** - for distal fibular fractures.

*Evidence for the Use of Arthroscopy Evaluation during Distal Tibia Fracture Fixation ORIF*

Deltoid Ligament Repair with ORIF of Lateral Ankle Fracture

C.17.c.iii.n Deltoid Ligament Repair Concurrent with ORIF for Unstable Ankle Fractures

**Not Recommended** - for ankle fracture.

*Rationale for Recommendation*: Surgical repair of a ruptured deltoid ligament is not currently recommended as it can add to surgical time without evidence of clinical benefit. The use of weight-bearing radiographs is reported to be an effective, pain-free, and reliable method to exclude the need for operative repair of isolated lateral malleolar fractures with possible deltoid injury.

*Evidence for the Repair of Deltoid Ligament with Lateral Ankle Fracture Fixation*

C.17.c.iv Other

C.17.c.iv.a Pneumatic Compression for Treatment of Ankle and Foot Edema

**Recommended** - for patients with significant post-operative edema.
Indications: Excessive swelling after ankle fracture surgery.

Evidence for the Use of Pneumatic Compression for Edema Management

C.17.c.iv.b Interferential Therapy for Treatment of Ankle Edema

**Not Recommended** - for the treatment of post-operative swelling following ORIF for displaced malleolar fracture.

Evidence for the Use of Interferential Current Therapy for Post-operative Edema Management

C.18 Hindfoot Fractures (Calcaneaus, Talus)

C.18.a Diagnostic Studies

C.18.a.i X-ray

**Recommended** - as a first-line study for suspected acute hindfoot fractures.

*Indications:* Suspicion of fracture.

*Views:* Calcaneus: AP, lateral, and calcaneal view; Talus: AP, lateral, mortise, Broden views (45° internal oblique) and Canale views (talar neck).

Evidence for the Use of X-ray for Hindfoot Fractures

C.18.a.ii MRI

**Recommended** - for suspected acute occult fracture of the talus and calcaneus.

*Indications* – Generally reserved for suspicion of occult fracture of the talus neck or lateral process. Patients whose plain images indicate osteochondral lesion and those who remain symptomatic after six weeks should undergo evaluation with MRI.

C.18.a.iii MRI for Follow-up Evaluation of Non-acute Calcaneus Fracture

**Recommended** - for calcaneus fractures for identification of complications in the non-acute fracture patient.

*Indications:* Non-acute fracture patient with persistent pain more than 4 months after injury.
Rationale for Recommendations: MRI is used for suspected occult fracture, as some talus fractures are not apparent on radiographs. MRI is also indicated for evaluation of avascular necrosis. In general, MRI is suboptimal compared with CT scan for calcaneus injury.

Evidence for the Use of MRI for Hindfoot Fractures

C.18.a.iv Bone Scanning for Calcaneus Fracture

**Recommended** - for diagnosis of occult and stress fractures in select patients.

Rationale for Recommendation: A bone scan may be reasonable for those with high clinical suspicion but with negative x-ray and CT scan. Bone scans are utilized to diagnose occult calcaneus fractures and stress fractures of the calcaneus.

Evidence for the Use of Bone Scanning for Hindfoot Fractures

C.18.a.v CT for Diagnosis and Classification of Hindfoot Fractures

**Recommended** - for investigation of hindfoot fractures.

Indications: CT is recommended for occult and complex distal extremity, ankle, and foot fractures to gain greater clarity of fracture displacement, articular involvement, and subluxation of affected joints. If intraarticular displacement is considered, then axial views are recommended in addition to any coronal views. CT is indicated for evaluation of suspected subtalar joint fractures.

Views: Coronal and axial.

Rationale for Recommendation: CT scans are considered the gold standard for diagnosing and characterizing calcaneus fractures. For other hindfoot fractures, CT should be considered when x-ray images are negative, but on the basis of physical findings an occult fracture is strongly suspected. CT may also be useful for evaluation of complex comminuted fractures, providing superior depiction of distal tibial articular surface involvement, fragment positioning, and diagnosis of subluxations. The value of CT has been demonstrated – its use for evaluation of articular step off and gaping, comminution, and treatment has influenced observers to change treatment plans developed from radiographs.

Evidence for the Use of CT for Hindfoot Fractures

C.18.a.vi Follow-up Visits – Imaging

For talus fracture, if clinically suspected in the setting of negative radiographs, follow-up radiographs may be helpful; after approximately seven days there will be resorption at the fracture line, which will then be visible more easily. Follow-up radiography at six to eight weeks for confirmed talus fracture, looking for the Hawkins sign, a radiographic
subchondral radiolucent band in the talar dome. This sign, visible in the anterior-posterior view, is indicative of viability at six to eight weeks post-fracture indicating that avascular necrosis is unlikely to develop.

C.18.b Medications

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and Acetaminophen

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.

C.18.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) and Acetaminophen for Hindfoot Fractures Analgesia

**Recommended** - for hindfoot fracture analgesia.

*Indications*: For hindfoot fracture analgesia, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration*: As needed use may be reasonable for many patients.

*Indications for Discontinuation*: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.18.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding.

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications* – For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration* – Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation* – Intolerance, development of adverse effects, or discontinuation of NSAID.

C.18.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects
Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.18.b.iv Acetaminophen for Treatment of Hindfoot Fracture Pain

**Recommended** - for treatment of Hindfoot Fracture Pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

**Evidence for the Use of NSAIDs and Acetaminophen for Foot and Ankle Fractures**

C.18.b.v Limited Use of Opioids for Acute and Post-operative Pain Management

**Recommended** – for limited use (less than seven days) in select patients for acute and post-operative pain management as adjunctive therapy to more effective treatments.

**Indications:** For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation, splinting) is often required, especially nocturnally.

**Frequency/Duration:** Prescribed as needed throughout the day, then later only at night, before weaning off completely.

**Rationale for Recommendation:** Select patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select
use in post-operative patients with primary use at night to achieve sleep post-operatively.

Evidence for the Use of Opioids for Foot and Ankle Fractures

C.18.b.vi Tetanus Immunization Status for Open Fractures

**Recommended** – updating of tetanus immunization status as necessary.

**Indications:** Wounds that are not clean if more than 5 years have elapsed since last tetanus immunization.

**Rationale for Recommendation:** As the adverse effects of not immunizing may be fatal, tetanus immunization updating for open wounds is recommended. Wounds that are not clean or burns should require immunization if more than 5 years since last immunization, rather than 10 years. Patients without a completed immunization series of 3 injections should receive tetanus immune globulin along with immunization.

Evidence for the Use of Tetanus Immunization for Open Foot and Ankle Fractures

C.18.b.vii Pre-Operative Antibiotic Prophylaxis for Ankle Fractures

**Recommended** – for closed or open ankle fracture surgery.

Evidence for the Use of Antibiotic Prophylaxis for Ankle Fractures

C.18.b.viii Use of Nasal Spray Calcitonin for Post-fracture Osteopenia

**Not Recommended** – for prophylaxis of post-fracture osteopenia.

**Rationale for Recommendation:** Nasal calcitonin obtained from salmon compared with placebo did not result in significant differences in bone mineralization 3 months after surgery.

Evidence for the Use of Calcitonin Prophylaxis for Post-fracture Osteopenia

C.18.b.ix DVT Prophylaxis

See discussion of DVT prophylaxis in the Achilles tendon rupture section.

C.18.c Treatments

C.18.c.i Rehabilitation

**Therapy**

Rehabilitation required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily
and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist such as verbal, visual and/or tactile instruction(s). At times, the therapist may help stabilize the patient or guide the movement pattern, but the energy required to complete the task is predominately executed by the patient. Patient should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.

Active interventions should be emphasized over passive interventions. Passive interventions are those not requiring the exertion of effort on the part of the patient, but rather dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains.

Assistive devices maybe included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.18.c.i.a Diathermy for Management of Edema Associated with Calcaneus Fracture

Not Recommended - for management of edema associated with calcaneus fractures.

Evidence for the Use of Diathermy for Edema Control

C.18.c.i.b Therapeutic Exercise - Physical / Occupational Therapy

Recommended – to improve function, including range of motion and strength.

Frequency/Dose/Duration: Frequency of visits is usually individualized based on severity of the limitation. Two to three visits per week for two weeks are often used to initiate an exercise program. Total numbers of visits may be as few as two to three for mild deficits or for more severe deficits, up to 12 to 15 with documentation of objective functional improvement.

As part of the rehabilitation plan, patients should be instructed to continue both active and passive therapy at home as an extension of the treatment process in order to maintain improvement.

C.18.c.ii Fracture Care

Talus Fractures
Because of its key position, diagnosis and treatment of talus fractures is critical for foot and ankle function.

C.18.c.ii.a Non-operative Management of Non-displaced Talar Fractures

**Not Recommended** - for non-displaced talar fractures (head, neck, body).

C.18.c.ii.b Operative Management of Displaced Talar Fractures

**Recommended** - for all displaced talar fractures (head, neck, body, lateral process).

*Indications*: All non-displaced, non-reducible fractures. Referral to specialist is indicated for all injuries due to the high potential for poor outcomes of these injuries. Emergent referral for talar neck fractures.

*Rationale for Recommendations*: Because of the key role the talus plays in locomotion, and the risk for significant disability and complication with these fractures referral to specialists for most, if not all, talus fractures is recommended.

Evidence for the Management of Talar Fractures

Osteochondral Lesions of the Talus

C.18.c.ii.c Non-Operative Management of Osteochondral Lesions of the Talus

**Recommended** - for select patients.

*Indications*: A non-operative approach is indicated for initial management of lateral lesions that radiographically appear to be a compression lesion with no visible fragment or there is a fragment but it is still attached.

*Management*: Cast or brace immobilization and protected weight-bearing for 6 to 12 weeks, followed by increasing pain-free range-of-motion exercises and strengthening.

C.18.c.ii.d Operative Intervention for Osteochondral Lesions of the Talus

**Recommended** - after an initial course of conservative management. Microfracture and osteochondral autograft are recommended.
Rationale for Recommendations: A trial of conservative management is recommended initially. A trial of protected weight bearing for 6 to 12 weeks is reasonable.

Evidence for the Use of Operative Management for Osteochondral Lesions

Calcaneus Fractures

C.18.c.ii.e Cast Immobilization for Select Calcaneus Fractures

Recommended - for select calcaneus fractures.

Indications: Non-displaced fracture, displaced extra-articular, displaced intra-articular.

C.18.c.ii.f Operative Management for Select Calcaneus Fractures

Recommended - for select calcaneus fractures.

Indications: Displaced, non-reducible extra-articular fractures, displaced intra-articular fractures.

Rationale for Recommendations: Both operative and non-operative management have considerable potential for adverse effects, including secondary late fusion, compartment syndrome and fasciotomy, DVT and pulmonary embolism, and late-term arthrodesis.

Evidence for the Management of Calcaneal Fractures

C.18.c.iii Other

C.18.c.iii.a Use of Pneumatic Compression Device for Treatment of Calcaneus Fractures

Recommended - for patients with significant edema after closed calcaneus fractures.

Indications: Patients with excessive swelling after closed displaced calcaneus fractures who are surgical candidates. Use in non-operative patients to reduce risk of other complications.

Frequency/Duration: Pedal compression device used continuously until swelling subsides sufficiently to allow for surgery or to manage non-operatively.

Rationale for Recommendation: Pneumatic compression for edema management is recommended for management of acute calcaneus fracture management in select patients with significant edema.
Evidence for the Management of Edema Associated with Calcaneal Fractures

C.18.c.iii.b Treatment of Cancellous Bone Defect with Displaced Intra-Articular Calcaneus Fractures

Not Recommended - for treatment of displaced intra-articular fracture defects.

Evidence for the Use of Bone Graft and Fillers for Calcaneal Fracture Defect

C.19 Forefoot and Midfoot Fractures (Tarsal, Metatarsal, Phalangeal)

C.19.a Diagnostic Studies

C.19.a.i X-ray for Suspected Acute Forefoot or Midfoot Fractures

Recommended - as a first-line study for suspected forefoot or midfoot fractures.

Indications: Suspcion of all forefoot and midfoot fractures.

Views: AP, lateral, and oblique.

Rationale for Recommendation: X-ray assists in identifying fractures, orientation of fracture plane(s), magnitude of the involvement of the interphalangeal and metatarsal phalangeal joints, which if large enough may alter management in favor of surgery (see below). If fracture is clinically suspected in the setting of negative radiographs, follow-up radiographs may be helpful; after approximately 7 days there will be resorption at the fracture line, which will then be visible.

Evidence for the Use of X-ray for Suspected Tarsal, Metatarsal, or Phalangeal Fractures

C.19.a.ii MRI for Suspected Acute Forefoot and Midfoot Fractures

Recommended - for suspected occult and stress fracture in select patients.

Indications: Generally reserved for suspicion of occult or stress fracture of the fore or midfoot, however, CT is viewed as superior by some.

Rationale for Recommendation: MRI should not be used as a first-line test. MRI may be an important diagnostic technique for the evaluation of suspected injuries of the navicular, tarsometatarsal joint (Lisfranc injury) and for early diagnosis of suspected stress fracture. MRI is also used for suspected occult fracture and for evaluation of avascular necrosis.
Evidence for the Use of MRI for Suspected Tarsal Metatarsal and Phalangeal Fractures

C.19.a.iii Bone Scanning for Forefoot and Midfoot Fractures

**Recommended** - for diagnosis of occult and stress fractures in select patients.

**Indications:** Generally reserved for suspicion of occult fracture of the tarsal and metatarsal bones.

**Rationale for Recommendation:** Bone scans are not required for evaluation of the majority of patients with forefoot and midfoot fractures. A bone scan may be reasonable for patients with high clinical suspicion but negative x-ray or CT scan.

Evidence for the Use of Bone Scan for Suspected Tarsal, Metatarsal, or Phalangeal Fractures

CT Imaging

C.19.a.iv CT for Diagnosis and Classification of Forefoot and Midfoot Fractures

**Recommended** – in select patients for investigation of forefoot and midfoot fractures.

**Indications:** Evaluation of displaced or comminuted fracture of the tarsal and metatarsal bones to gain greater clarity of fracture displacement, articular involvement, and subluxation of affected joints. Generally, this is a second-line diagnostic tool after x-rays.

**Rationale for Recommendation:** CT should not be used as a first-line test. CT may be an important diagnostic technique to gain greater clarity of fracture displacement, articular involvement, and subluxation of affected joints, and is recommended for select patients.

Evidence for the Use of CT for Suspected Tarsal Metatarsal and Phalangeal Fractures

C.19.b Medications

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and Acetaminophen

For most patients, generic ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative for these patients, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (and tramadol) and less impairing.
C.19.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) and Acetaminophen for Phalangeal or Metatarsal Fracture Pain Control

**Recommended** - for phalangeal or metatarsal fracture pain control.

**Indications**: For acute, subacute, chronic, or post-operative phalangeal or metatarsal fracture pain control, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration**: As needed use may be reasonable for many patients.

**Indications for Discontinuation**: Resolution of foot/ankle pain, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.19.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding.

**Recommended** – concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications**: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration**: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation**: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.19.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.
C.19.b.iv Acetaminophen for Treatment of Acute, Subacute, or Chronic phalangeal or metatarsal fracture Pain

**Recommended** - for treatment of acute, subacute, or chronic phalangeal or metatarsal fracture pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with foot/ankle pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.

C.19.c Treatments

C.19.c.i Fracture Care

C.19.c.i.a Non-operative Management for Non-Displaced Tarsal-Metatarsal Injury (Lisfranc)

**Recommended** - for select patients.

*Indications:* Fracture/joint dislocation displacement <2mm.

*Management:* Non-weight bearing cast for six weeks.

C.19.c.i.b Operative Management for Displaced Tarsal-Metatarsal Injury (Lisfranc)

**Recommended** - for an unstable tarsal-metatarsal injury.

*Indications:* Fracture joint displacement with joint dislocation >2 mm.

*Management:* May take four to five months to heal; therapy may be started. Removal of hardware prior to full activities.

*Rationale for Recommendations:* Immobilization or fixation technique is dictated by the physical and radiographic findings.

*Evidence for the Management of Lisfranc Injuries*

C.19.c.i.c Non-Operative Management for Non-Displaced Metatarsal Fractures

**Recommended** - for non-displaced metatarsal fractures.
Indications: Non-displaced shaft fractures or with up to 3 to 4mm displacement in dorsal or plantar direction, angulation less than 10° dorsally.

C.19.c.i.d Operative Management for Displaced Metatarsal Shaft Fractures

Recommended - for displaced metatarsal shaft fractures.

Indications: Multiple metatarsals fractured if displaced; shaft fracture near metatarsal head.

Management: Percutaneous pinning or internal fixation with screws, plates; non-weight bearing four to six weeks. Progressive weight-bearing over next four to six weeks in fracture shoe/boot or walking cast. Full weight-bearing in shoes/stiff soled shoe after radiographic evidence of union.

Rationale for Recommendations: Immobilization or fixation technique is dictated by the physical and radiographic findings.

Evidence for the Management of Metatarsal Fractures

C.19.c.i.e Non-operative Management for Proximal Fifth Metatarsal Fractures (Including Joints and Avulsion).

Recommended - for select patients.

Indications: Avulsion of tuberosity: non-displaced, <1 to 2mm step-off on articular surface or less than 30% of articular surface with cuboid; Jones Fracture: patient/provider preference.

Management: Repeat films at one and six weeks. Jones Fracture: non-weight-bearing short-leg cast immobilization for one and six weeks, followed by hard-sole shoe or walking cast until union.

C.19.c.i.f Operative Management for Fifth Displaced Metatarsal Shaft Fractures (Jones, Avulsion)

Recommended - for select patients.

Indications: Avulsion of tuberosity: displaced >1 to 2mm step-off on the articular surface or more than 30% of articular surface with cuboid; Jones Fracture: patient/provider preference.

Management: Avulsion of tuberosity: similar to other metatarsal shaft fractures treated operatively. Jones
Fracture: non-weight bearing Jones splint for 2 weeks, followed by weight bearing in hard-sole shoe as tolerated.

*Rationale for Recommendations:* Immobilization or fixation technique is dictated by the physical and radiographic findings.

*Evidence for the Management of Proximal Fifth Metatarsal Injuries*

**C.19.c.i.g** Immobilization for Distal, Middle, or Proximal Phalanx

*Recommended* - for treatment of select patients.

*Indications:* Closed, non-displaced or stable after reduction, involves less than 25% of articular surface.

*Management:* Closed reduction after digital or hematoma block; obtain post-reduction film, repeat at one and six weeks; splint toe with buddy taping to adjacent toe until non-tender (three to four weeks) excluding hallux. Additional immobilization with a post-operative shoe or cast-boot should be considered.

**C.19.c.i.h** Operative Management for Distal, Middle, or Proximal Phalanx Fractures

*Recommended* - for treatment of select patients.

*Indications:* Displaced fractures of great toe with poor reduction, unable to hold reduction with tape splinting.

*Rationale for Recommendations:* Immobilization or fixation technique is therefore dictated by the physical and radiographic findings. It is generally limited to displaced fractures of the great toe or multiple toe fractures.

*Evidence for the Management of Phalangeal Fractures*

**C.19.c.i.i** Non-operative Management for Lower Extremity Stress Fractures

*Recommended* - for low risk lower extremity stress fractures.

*Indications:* Non-displaced stress fractures.

*Management:* All non-displaced stress fractures can be treated conservatively initially.

**C.19.c.i.j** Operative Management for Lower Extremity Stress Fractures
Not Recommended – for lower extremity stress fractures

Rationale for Recommendations: Stress fractures respond well to activity restriction in most instances. Activity restriction is therefore recommended. Stress fractures that do not respond or that are displaced are treated operatively.

Evidence for the Management of Stress Fractures
Appendix D.1 – Definitions

Bunion: See hallux valgus.

Fasciitis: Inflammation of supportive band or covering.

Hallux Valgus: Lateral deviation of the great toe at the metatarsophalangeal joint with respect to the midline of the body, generally defined as over 15° and occurring in most cases with medial deviation of the first metatarsal.

Inflammation: A tissue reaction marked by redness, warmth, swelling, and pain, usually in response to injury or infection.

Ligament: A band or sheet of strong fibrous connective tissue connecting the articular ends of bones serving to bind them together and facilitate or limit motion.

Metatarsalgia: Pain in the forefoot at one or more of the metatarsal heads.

Morton’s Neuroma (Interdigital Neuroma): A benign tumor of the neurovascular bundle of the intertarsal spaces that can be between any two distal metatarsal bones, although classically, “Morton’s neuroma” describes the specific location only between the 3rd and 4th metatarsals.

Neuroma: A benign tumor composed of nerve cells.

Paratenon: tissue filling the space between a tendon and its sheath.

Plantar Fasciitis: Pain in the plantar aspect of the heel that may also be present along the fascia of the arch of the foot determined by clinical criteria, and not clearly originating in the fascia of the plantar foot or caused by inflammation.

Retinaculum: A band or bandlike structure that holds an organ or a part in place. (Stedman Medical Dictionary 15)

Sprain: Injury, not necessarily permanent, of a ligament.
S, Grade I: overstretching or slight tearing without instability.
S, Grade II: incomplete tearing.
S, Grade III: complete tear or rupture.

Strain: Injury, not necessarily permanent, of a muscle or musculotendinous unit.
S, Grade I: overstretching or slight tearing.
S, Grade II: incomplete tearing.
S, Grade III: complete tear or rupture.

Synovitis: Inflammation of synovium.

Tendinitis or Tendonitis: Inflammation of a tendon.
Tendinosis: A chronic degenerative tendon injury, unaccompanied by redness or heat. It is associated with pain and limited movement.

Tendinopathy: Any pathology of a tendon.
### Table 3. Diagnosis of Plantar Fasciitis

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Number of Subjects with Heel Pain (# of Painful Heels)</th>
<th>Plantar Fascial Thickness of Painful Heels (mm±SD)</th>
<th>Number of Controls (# of Heels)</th>
<th>Plantar Fascial Thickness of Controls</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Abdel-Wahab 2008</td>
<td>17 (23)</td>
<td>4.9 ± 1.3</td>
<td>11 (22)</td>
<td>1.7 ± 0.06</td>
<td>Ultrasound, controls not matched</td>
</tr>
<tr>
<td>Berkowitz 1991</td>
<td>8 (9)</td>
<td>7.40 ± 1.17 sagittal 7.56 ± 1.01 coronal</td>
<td>5 age- and sex-matched; 5 unmatched</td>
<td>3.22 ± 0.44 sagittal 3.44 ± 0.53 coronal</td>
<td>MRI</td>
</tr>
<tr>
<td>Akfirat 2003</td>
<td>25</td>
<td>4.75</td>
<td>15</td>
<td>3.37 mm</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>Cardinal 1996</td>
<td>15 (19)</td>
<td>5.2 ± 1.13</td>
<td>15 (11) asymptomatic heels of patients, and 15 asymptomatic persons</td>
<td>2.9 mm ± 0.70 2.6 mm ± 0.48</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>Gibbon 1999</td>
<td>190 (297)</td>
<td>5.9 in unilaterally and 6.0 in bilaterally effected subjects</td>
<td>58</td>
<td>3.3mm in completely asymptomatic and 3.6 mm in unaffected side of unilateral subjects</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>Kane 2001</td>
<td>28 (23)</td>
<td>5.7 ± 0.3</td>
<td>28 (5)</td>
<td>3.8±0.2</td>
<td>Ultrasound, longitudinal view, asymptomatic heels of patients served as control</td>
</tr>
<tr>
<td>Tsai 2000</td>
<td>102 (123)</td>
<td>5.47±1.09 in persons with bilateral heel pain; 5.61±1.19 in those with bilateral heel pain</td>
<td>33</td>
<td>3.83±0.7 in asymptomatic heels of heel-pain patients; 3.19±0.43 in asymptomatic subjects</td>
<td>Ultrasound, demographic characteristics documented included age, BMI, and sex, which were not different between heel pain patients and controls</td>
</tr>
<tr>
<td>Vohra 2002</td>
<td>109 (211)</td>
<td>5.35 in symptomatic bands</td>
<td>2.70 in asymptomatic bands</td>
<td></td>
<td>Ultrasound, thickness of lateral and medial bands</td>
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<tr>
<td>measured and reported</td>
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DRAFT – For Public Comment
### Appendix D.3 - Evidence Tables

#### Evidence for the Use of NSAIDs and Acetaminophen

There are 4 moderate-quality RCTs incorporated in this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jakobsen 1988</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 212 Army personnel with acute soft tissue injuries &lt;48 hours duration</td>
<td>Tenoxicam 20mg vs. piroxicam 20mg vs. placebo once daily for 10 days.</td>
<td>Significantly better improvement comparing tenoxicam with placebo: global judgment Day 2 (p = 0.025); median difference, -0.2; 95% CI, -0.4 to +0.0); tenderness Day 7 (p = 0.019; median difference, -0.5; 95% CI, -0.9; -0.1); functional limitation Day 10 (p = 0.0048; median difference, -0.3; 95% CI, -0.8 to -0.0).</td>
<td>“The use of tenoxicam 20 mg daily is superior to placebo and at least equal to piroxicam 20 mg daily in the treatment of some specific soft-tissue injuries.”</td>
<td>Randomization, allocation, blinding details unclear. Data suggest NSAID superior for treatment of 6 acute injuries. Insufficient data for specific recommendation for Achilles tendinopathy.</td>
</tr>
<tr>
<td>Jakobsen 1989 (An analysis Achilles tendinopathy subgroup of Jakobsen 1988)</td>
<td></td>
<td>5.0</td>
<td>N = 115 Army personnel with tendinitis, periostitis or sprains &lt;48 hours duration</td>
<td>Tenoxicam 20mg vs. placebo once daily for 10 days.</td>
<td>Clinical outcomes measured on 4-point scale (excellent, good, moderate, bad) based on spontaneous pain, tenderness, pain on movement, functional limitations, and adverse reactions. In tendonitis group,</td>
<td>In this 10-day trial for acute Achilles tendinopathy “[The authors] find the effect of tenoxicam 20 mg/ day in the treatment of tendinitis of the Achilles tendon to be convincingly superior to placebo.” They found no</td>
<td>Randomization, allocation, baseline, blinding details unclear. Military population (mostly male) and included other soft tissue disorders. For acute Achilles tendinitis, 40 of 46 completed study. Data support NSAID</td>
</tr>
</tbody>
</table>
excellent or good results reached 71% vs. 31% in placebo (p = 0.008). Significant difference between piroxicam and placebo. Superior to placebo.

**NSAID plus Exercises vs. Placebo plus Exercise**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparis on Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astrom</td>
<td>1992</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 70 non- rheumatic patients with painful Achilles tendinopathy</td>
<td>Piroxicam vs. placebo for 30 days, both groups with stretching and strengthening.</td>
<td>No differences at any time between groups in pain, swelling, muscle strength or ankle joint movement. Pain and tenderness improved in both groups.</td>
<td>&quot;We conclude that a non-steroid anti-inflammatory agent (piroxicam) does not afford symptomatic relief in Achilles pain; a limited rate of success was noted, presumably due to the combined effect of rest, exercises and the placebo response.&quot;</td>
<td>Details of randomization, allocation, baseline comparability are sparse. Both groups underwent stretching and strengthening exercises, providing potentially major co-interventions. Data suggest no effect of NSAID.</td>
</tr>
</tbody>
</table>

**Glucosaminoglycan Injection vs. NSAID**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study Type</th>
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<th>Sample Size</th>
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<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sundqvist</td>
<td>1987</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 60 recreational athletes suffering from Achilles peritendinitis</td>
<td>Local injection glycosaminoglycan polysulfate (GAGPS) vs. indomethacin.</td>
<td>No difference in percentage with good response ratings in acute patients. Significant differences in chronic patients with GAGPS vs. indomethacin (59% vs. 12%, p &lt;0.05).</td>
<td>&quot;Local injections of GAGPS were shown to be more effective than high-dose indomethacin especially in chronic cases.&quot;</td>
<td>Allocation, blinding details unclear. Possible co-interventions (orthotics, physical therapy). Data suggest injection superior to NSAID.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Topical NSAIDs**

There are 2 moderate-quality RCTs incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparis on Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russell</td>
<td>1991</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 214 with 1 unilateral acute soft tissue injury</td>
<td>Piroxicam 0.5% topical gel</td>
<td>Piroxicam vs. placebo VAS Means Day 8. Spontaneous</td>
<td>&quot;This study demonstrates that piroxicam gel,&quot;</td>
<td>Allocation, blinding details unclear. Study included mixed</td>
</tr>
</tbody>
</table>
### Evidence for the Use of Glyceryl Trinitrate Patches

There is 1 moderate-quality RCT with a second report of an extended evaluation period incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paoloni 2004 RCT</td>
<td>5.5</td>
<td>N = 65</td>
<td>Topical glyceryl trinitrate (GTN) patch (1/4)</td>
<td>GTN group had significantly less activity pain at 12, “[C]ontinuous topical glyceryl trinitrate therapy can result in significantly decreased Achilles”</td>
<td>Study included 84 tendons in 65 patients. Co-interventions: rest, heel</td>
<td></td>
</tr>
</tbody>
</table>
### Evidence for the Use of Exercise for Achilles Tendinopathy

There are 2 high- and 3 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exercise vs. Other Intervention</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rompe 2007 RCT</td>
<td>9.0</td>
<td>N = 75 with a chronic recalcitrant (&gt;6 months) noninsertional Achilles tendinopathy; (25 in each group)</td>
<td>ESWT vs. eccentric exercises vs. no treatment in persons with chronic Achilles tendinopathy.</td>
<td>No differences between SWT and EE in any outcome measure. Both significantly better than wait and see for outcomes of VISA-A score, Likert score, load induced pain, and pain threshold.</td>
<td>“Both eccentric loading and repetitive low-energy SWT led to a successful outcome in 50% to 60% of patients. This is absolutely within the range of results of surgery.”</td>
<td>Data suggest ESWT and eccentric exercises effective compared to no treatment.</td>
</tr>
<tr>
<td>Rompe J Bone Joint Surg Am 2008</td>
<td>8.5</td>
<td>N = 50 with chronic (≥6 months) recalcitrant insertional</td>
<td>ESWT (3 sessions over 3 weeks, 0.12mJ/mm² total energy)</td>
<td>Eccentric loading vs. ESWT: VISA-A score: 63.4±12.0 vs.</td>
<td>In this subset of “patients with recalcitrant insertional Achilles</td>
<td>No placebo control. All enrolled had failed local anesthetic</td>
</tr>
</tbody>
</table>
### Comparisons of Different Exercises and of Exercise versus Rest

<table>
<thead>
<tr>
<th>Study</th>
<th>Tendinopathy Type</th>
<th>Comparison Details</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sibernagel 2007 RCT</td>
<td>Achilles tendinopathy (N = 42)</td>
<td>Tendon loading exercises with jumping, running during treatment vs. active rest (no physical activity that caused symptoms). Active group allowed to exercise to pain VAS of 5 as upper limit.</td>
<td>No negative effects could be demonstrated from continuing Achilles tendon loading activity, such as running and jumping, with the use of a pain-monitoring model during treatment.</td>
</tr>
<tr>
<td>Sibernagel 2001 RCT</td>
<td>Proximal achillodynia (N = 49)</td>
<td>12 weeks of less-intense vs. more-intense exercise program for eccentric/concentric in both arms in persons with chronic Achilles tendinopathy.</td>
<td>Measurement techniques and the treatment protocol with eccentric overload can be recommended for patients with chronic pain from the Achilles tendon. More patients achieved full recovery, had less pain during and after activity, and improved ankle range of motion in the following 6 months. Study had 49 patients (69 tendons). Randomization, details sparse. Controls received part of experiment exercise interventions. Results focused on changes from baseline, but data favored intense exercise group.</td>
</tr>
</tbody>
</table>
Mafi 2001 RCT 5.0 N = 44 painful chronic Achilles tendinosis Daily eccentric vs. concentric training regimens for 12 weeks. Patient satisfaction at 12 weeks favored eccentric group: 82% vs. 36%, p <0.002. “Treatment with eccentric calf muscle training in patients with painful chronic Achilles tendinosis yielded good short term clinical results and significantly better results than concentric calf muscle training.” Small sample size; details sparse on compliance, avoiding co-interventions. No blinding.

**Evidence for the Use of Cryotherapy and Heat for Achilles Tendinopathy**

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knobloch Am J Sports Med 2008 RCT</td>
<td>6.5</td>
<td>N = 60 healthy participants with no prior tendon problems</td>
<td>Cryotherapy with compression vs. cryotherapy alone</td>
<td>No adverse effects from cryotherapy. Cryotherapy plus compression vs. compression: no differences in superficial or deep blood flow with treatment, higher capillary flow in recovery with cryo/compression group.</td>
<td>“Intermittent administration of 3 x 10-minute cryotherapy and compression is superior to cryotherapy alone as far as Achilles tendon micro-circulation is concerned.”</td>
<td>Baseline comparability unclear. Results of study are of uncertain clinical significance.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Night Splinting for Achilles Tendinopathy**

There are 2 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roos 2004 RCT</td>
<td>7.0</td>
<td>N = 44 with Achilles tendinopathy</td>
<td>Eccentric exercises (EE) vs. night splint vs. EE plus anterior night splint (90° dorsiflexion)</td>
<td>All groups improved significantly across all times. No differences in pain between groups at “[E]ccentric exercises seem to improve function and reduce pain in primary care patients. The effects were apparent after</td>
<td></td>
<td>Small sample size with low power for 3 interventions. All intervention groups improved over time and similar at 1</td>
</tr>
</tbody>
</table>
Evidence for the Use of Orthotic Devices for Achilles Tendinopathy

There are 3 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petersen 2007</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 100 with chronic Achilles tendinopathy</td>
<td>AirHeel brace vs. eccentric training vs. both combined.</td>
<td>AOFAS scores improved in all groups. No between-group differences. At 1-year follow-up, AOFAS scores improved 10-12% in all groups vs.</td>
<td>“This study could not demonstrate any significant differences between treatment with the AirHeel brace and an eccentric training program…”</td>
<td>Allocation, compliance details unclear. Data suggest orthotic provided no benefit.</td>
</tr>
<tr>
<td>deVos 2007</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 58 chronic midportion Achilles tendinopathy</td>
<td>Night splints plus eccentric exercises vs. eccentric exercises only for 12 weeks.</td>
<td>VISA-A score change: NS and EE only 50.1 to 68.8 and 49.4 to 67 (p &lt;0.001)</td>
<td>“Splinting in addition to eccentric exercises did not lead to a significantly better outcome for patient satisfaction and VISA-A score. Both reduced pain and improved functional outcome.”</td>
<td>Seventy (70) tendons in 58 patients. Patient mix included subacute and chronic conditions. Lack of details on co-intervention. Data suggest no difference.</td>
</tr>
</tbody>
</table>

DRAFT – For Public Comment

NYS WCB MTG – Ankle and Foot Disorders
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Comparison</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knobloch 2008 RCT</td>
<td>4.5</td>
<td>N = 116 with unilateral tendinopathy of main body of Achilles tendon</td>
<td>Eccentric exercise with and without use of AirHeel brace.</td>
<td>Excentric exercise plus AirHeel vs. excentric exercise alone – no difference in superficial blood flow, paratenon blood flow. Blood flow at 2mm at insertion significantly reduced in excentric exercise alone (p &lt;0.05). Oxygen saturation higher in excentric exercise plus AirHeel group (p &lt;0.012). “Patient with tendinopathy of the main body of the AT experienced improved clinical outcome with both management options. Tendon microcirculation was optimized in the combined group.” Drop-out rate &gt;20%. Effect on microcirculation is of unknown clinical effect as demonstrated by equivalency of clinical outcomes. Data suggest no difference.</td>
</tr>
<tr>
<td>Knobloch 2008 RCT – 2nd report of above study</td>
<td>4.5</td>
<td>N = 116 with tendinopathy of Achilles tendon</td>
<td>Capillary blood flow in tendon and paratenon not significantly different at 2 or 8mm tissue depths at 12 positions. Pain reduced p &lt;0.05 in combined treatment groups vs. those that dropped out (labeled non-compliant).</td>
<td>“No microcirculatory changes are evident in non-compliant and compliant patients with Achilles tendinopathy undergoing 12 weeks of eccentric training.” Second report of same study group. Initial report indicated compliance not known, but here reports 92/116 compliant, which appears to refer to those who completed study rather than compliance to exercise regimen or wearing...</td>
</tr>
</tbody>
</table>
### Evidence for the Use of Extracorporeal Shockwave Therapy for Achilles Tendinopathy

There are 5 high-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rasmussen 2008</td>
<td>9.0</td>
<td>N = 48 assigned to non-operative treatment of chronic Achilles tendinopathy</td>
<td>ESWT vs. sham ESWT (ESWT: 1 session each week for 4 weeks, 2000 shots 0.21-0.51 ml/mm², 50 Hz); all patients assigned eccentric exercises.</td>
<td>AOFAS score increased more in intervention, 70 to 88 (p &lt;0.05), than controls, 74 to 81. No difference in pain between groups.</td>
<td>“EWST appears to be a clinically relevant supplement to conservative treatment of tendinopathy. Currently, however, there is no convincing evidence for recommendation of ESWT.”</td>
<td>Conservative treatment included stretching and eccentric exercise training as co-interventions. AOFAS score measures pain (40 points), function (50 points), alignment (10 points). Clinical significance set at 10 point difference. Baseline lower AOFAS scores in ESWT group than controls. Data suggest no superiority of ESWT compared to sham.</td>
</tr>
<tr>
<td>Costa 2005</td>
<td>8.0</td>
<td>N = 49 with chronic Achilles tendon pain</td>
<td>ESWT vs. sham ESWT (ESWT: 1500 shocks at 0.2J/mm², 1 a month for 3 months).</td>
<td>No differences between groups on pain at rest, during sports, ankle ROM, tendon or calf diameter, or functional scoring.</td>
<td>“Results of our study do not provide any evidence for use of shock wave therapy for treatment of chronic Achilles tendon pain. Complications in the treatment group included two tendon ruptures, suggesting</td>
<td>Difference in median age 58 vs. 48 (control). Treatment was guided by ultrasound data. Data suggest no differences.</td>
</tr>
<tr>
<td>Study</td>
<td>ESWT vs. Exercise</td>
<td>Results</td>
<td>Notes</td>
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</tr>
<tr>
<td>Rompe 2009 RCT</td>
<td>N = 68 with chronic recalcitrant (&gt;6 months) non-insertional Achilles tendinopathy</td>
<td>EE vs. EE + SWT at 4 months. Visa-A: 73 vs. 86.5 (p = 0.016); Likert Scale (1-6): 2.9 vs. 2.1 (p = 0.035); Load-induced pain, (0-10) 3.9 vs. 2.4 (p = 0.045); 56% vs. 82% reported complete or good recovery (p = 0.001). All groups significantly better than baseline.</td>
<td>The likelihood of recovery after 4 months was higher after a combined approach of both eccentric loading and SWT compared to eccentric loading alone. Eccentric training plus SWT should be offered to patients with chronic recalcitrant midportion tendinopathy of the Achilles tendon. No blinding of patients. Study shows both groups improved over baseline. Still had 30% failure at 4 months. Of EE failures, 12/15 success with SWT at 12 months. Of EE+SWT failures, 3/6 success with surgery. Data suggest ESWT of additive benefit to eccentric exercises.</td>
<td></td>
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</tr>
<tr>
<td>Rompe J Bone Joint Surg Am 2008 RCT</td>
<td>N = 50 chronic (≥6 months) recalcitrant insertional Achilles tendinopathy</td>
<td>ESWT (3 sessions over 3 weeks, 0.12 mJ/mm² total energy) vs. daily regimen eccentric loading exercises for 12 weeks. (ESWT: 2000 shocks at 0.12 J/mm², 1 a week for 3 weeks.)</td>
<td>In this subset of &quot;patients with recalcitrant insertional Achilles tendinopathy&quot; the results &quot;demonstrate that the probability for recovery is significantly lower after eccentric loading as applied in the present study compared with repetitive low-energy shock. All enrolled had failed local anesthetic injection, steroid injections, NSAIDs, physiotherapy and heel lifts. Data suggest ESWT superior to eccentric exercise, however patients likely had prior exercise providing some potential bias.</td>
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</tbody>
</table>
0.004 (favors ESWT); Tenderness at 3 kg: 4.4±3.2 vs. 2.4±4.2, p = 0.031.

wave therapy as applied."

against exercise group.

### ESWT vs. No Treatment

<table>
<thead>
<tr>
<th>Author/Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Rompe 2007</td>
<td>9.0</td>
<td>N = 75 chronic recalcitrant (&gt;6 months) non-insertional Achilles tendinopathy (25 in each group)</td>
<td>ESWT vs. Eccentric Exercises vs. No treatment (ESWT: 2000 shocks at 0.1 J/mm², 1 a week for 3 weeks).</td>
<td>No differences between SWT and EE in any outcome measure. Both active treatments superior to wait and see. For VISA-A score, Likert score, load induced pain, and pain threshold.</td>
<td>“Both eccentric loading and repetitive low-energy SWT led to a successful outcome in 50% to 60% of patients. This is absolutely within the range of results of surgery.”</td>
<td>Data suggest ESWT and eccentric exercises effective compared to no treatment.</td>
</tr>
</tbody>
</table>

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**Evidence for the Use of Iontophoresis for Achilles Tendinopathy**

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Neeter 2003 RCT</td>
<td>6.0</td>
<td>N = 25 with acute (&lt;3 months) pain from Achilles tendon</td>
<td>Iontophoresis with dexamethasone 3ml suspension vs. iontophoresis with saline (4 treatments over 2 weeks); 1-year follow-up (volume specified, but</td>
<td>Performance and pain outcomes measured at 2 and 6 weeks, and 3 and 6 months. No differences between groups on toe-raising test, ROM, morning stiffness at any point. Of 16</td>
<td>“[T]he experiment group (iontophoresis with dexamethasone) displayed better overall results compared with the control group in terms of less pain during and after</td>
<td>Small sample size. Some details sparse. All placed in program including stretching, strengthening making co-intervention a significant consideration. Lack of randomization, allocation, blinding</td>
</tr>
</tbody>
</table>
Evidence for the Use of Low-level Laser Therapy for Achilles Tendinopathy
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stergioulas 2008</td>
<td>7.0</td>
<td>N = 52 recreational athletes with chronic Achilles tendinopathy symptoms</td>
<td>Low level laser therapy (LLLT) with eccentric exercises (EE) vs. placebo LLLT with EE; 12 sessions, 8 weeks (60mW/cm², total 5.4 J per session.)</td>
<td>Mean pain intensity scores LLLT plus EE vs. placebo plus EE (0, 4, 8, 12 weeks): 79.8 vs. 81.8, 53.6 vs. 71.5, 37.3 vs. 62.8, 33.0 vs. 53.0, p &lt;0.001 at all intervals after baseline.</td>
<td>“Low-level laser therapy with the parameters used in this trial seems to be a safe and effective method for more rapid recovery when combined with an EE regimen…using power densities below 100mW/cm² seems to be important for obtaining good results.”</td>
<td>Withdrawal rate 23% (12/52) although included in ITT. Randomization, allocation unclear. Not clear what amount of effect due to eccentric exercises. Data suggest LLLT may be of modest additive benefit to eccentric exercises.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Glucocorticosteroid Injections
There are 2 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
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<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fredberg 2004</td>
<td>7.5</td>
<td>N = 48 (24 with Achilles tendinopathy; 24 with patellar tendinopathy)</td>
<td>Up to 3 injections of triamcinolone (20mg) injection vs.</td>
<td>No significant changes in placebo group over 6 months. All received steroids at 6 months. Subjects treated with steroid</td>
<td>“Ultrasonographically guided injection of long acting steroid can normalize the ultrasonographic pathological”</td>
<td>Study excluded 2/3 of patients referred to study (those without ultrasound findings). High treatment failure rate in all</td>
</tr>
</tbody>
</table>
DRAFT – For Public Comment

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DaCruz 1988</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 28 with Achilles paratendinitis</td>
<td>One peri-tendinous methyl-prednisolone 40mg injection vs. placebo.</td>
<td>Some evidence of short-term efficacy. Crossover of non-improving placebo group to treatment after 12 weeks. No significant differences between groups in pain scores, tenderness, activity level; 23 appeared to fail to respond to therapy, despite cross over.</td>
<td>“It appears that locally-acting steroids have no role to play. Patients who did respond to treatment had only minimal signs and symptoms when they presented and recovered within six weeks.”</td>
<td>Study of 36 tendons in 28 patients. Lack of details for randomization, blinding. Coinventions with physiotherapy, heel lifts. Twenty-three percent dropout. Study states it is a crossover but details unclear. Data suggest lack of efficacy.</td>
</tr>
<tr>
<td>de Vos 2010</td>
<td>RCT</td>
<td>9.0</td>
<td>N = 54 patients, aged 18 to 70 years with chronic tendinopathy 2 to 7 cm above the Achilles</td>
<td>Eccentric exercises (usual care) with either a PRP injection (PRP group) vs. saline injection (placebo group).</td>
<td>Mean VISA-A score improved after 24 weeks in the PRP group by 21.7 points (95% confidence interval [CI], 13.0-30.5) and in the placebo group by 20.5</td>
<td>“Among patients with chronic Achilles tendinopathy who were treated with eccentric exercises, a PRP injection compared with a saline injection did not result in</td>
<td>Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Platelet Rich Plasma
There is 1 high-quality RCT incorporated into this analysis.
Evidence for the Use of Glycosaminoglycan Injections
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sundqvist 1987 RCT</td>
<td>6.0</td>
<td>N = 60 recreation al athletes suffering from Achilles peritendinitis</td>
<td>Local injection glycosaminoglycan polysulfate (GAGPS) vs. indomethacin 50mg 3 times a week for 2 weeks.</td>
<td>No difference in percentage with good response ratings in acute patients. Significant differences in chronic patients with GAGPS vs. indomethacin (59% vs. 12%, p &lt;0.05).</td>
<td>“Local injections of GAGPS were shown to be more effective than high-dose indomethacin especially in chronic cases.”</td>
<td>Allocation, blinding details unclear. Sixty-six percent of participants had co-intervention of orthotic. Data suggest benefit in chronic conditions over indomethacin. No placebo.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Heparin Injections
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larsen 1987 RCT</td>
<td>6.5</td>
<td>N = 20 young males with acute calcaneal peritendinitis crepitans</td>
<td>Physical work plus heparin (5,000 IU) injection once daily for 5 days vs. physical work plus saline injections for acute Achilles calcaneal (insertional) pain.</td>
<td>During 1st week, total symptom score dropped 32% in heparin group and 34% in placebo from baseline. No difference between groups on outcomes measures over 2 week follow-up.</td>
<td>“The present study showed no certain effect of subcutaneous injections of heparin on the course of calcaneal peritendinitis.”</td>
<td>Small sample size, blinding details unclear. Data suggest not effective.</td>
</tr>
</tbody>
</table>
### Evidence for the Use of Actovegin Injections

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pförringer 1994</td>
<td>6.5</td>
<td>N = 60 with Achilles paratendinitis</td>
<td>Actovegin (5ml solution of deproteinized hemodialysate from calf-blood) vs. placebo injections into paratendon (3 injection series at days 1, 3-4, 9-10).</td>
<td>Competitive and recreational “athletes” who had achillodynia no more than 3 months. Mean Achilles diameter reduction from 13.5mm to 9.8mm (active treatment), 27.2±10.4% reduction. Mean diameter decrease with placebo from 14.2 to 12.9mm, a decrease of 9.3±7.5%, p &lt;0.0001. Severe and moderate pain provoked by stress while standing on tiptoes in 43.3% at baseline decreased to 0% in active drug group vs. 26.7% in placebo group.</td>
<td>“Injection therapy with Actovegin ensures a high therapeutic success, both for acute and chronic Achilles paratendinitis. Due to the excellent low rate of side effects, a very favorable benefit/risk ratio is confirmed.”</td>
<td>Conclusions state treatment effective for chronic pain, but cases over 3 months were excluded. Treatment is not FDA approved.</td>
</tr>
</tbody>
</table>

### Evidence for the Use of Polidocanol Injections

There is 1 high- and 2 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yelland 2010</td>
<td>6.5</td>
<td>N = 43 with painful mid-portion Achilles tendinosis</td>
<td>Eccentric loading exercises (ELE) 12-week program (n = 15) vs. prolotherapy injections of hypertonic glucose with lignocaine alongside affected</td>
<td>Mean (95% CI) increases in VISA-A scores at 12 months were 23.7 (15.6 to 31.9) for ELE, 27.5 (12.8 to 42.2) for prolotherapy and 41.1 (29.3 to 52.9) for combined</td>
<td>“For Achilles tendinosis, prolotherapy and particularly ELE combined with prolotherapy give more rapid improvements in symptoms than ELE”</td>
<td>Small sample sizes. No placebo. Baseline differences in pain duration (21 vs. 24 vs. 6 months). Some data suggest earlier improvement with prolotherapy or combined.</td>
</tr>
<tr>
<td>Alfredson 2005 RCT</td>
<td>6.0</td>
<td>N = 20 with chronic painful midportion Achilles tendinopathy</td>
<td>Sclerosing injection (polidocanol) vs. lidocaine w/epi injection into neovascularization in chronic AT.</td>
<td>Mean VAS scores during activity decreased 77±10 to 41±10 (p &lt;0.005) vs. placebo 66±6 to 64±6, (p = 0.878) after 1 injection; 5 of 10 intervention group not satisfied after 1 injection; administered 2nd, all satisfied. All of placebo group crossed over after treatment failure; 90% satisfied after 1 injection (VAS 64±6 to 16±4, p &lt;0.005). Outcome-observation period 3 months (range 6-20 weeks).</td>
<td>“Sclerosing injections with the substance Polidocanol, but not non-sclerosing injections with Lidocaine plus adrenaline, targeting the area with neovascularization of the Achilles tendon, led to significantly reduced pain during tendon-loading activity. Clinical improvement corresponded with elimination of the colour Doppler appearance of neovascularization.”</td>
<td>Baseline comparison data sparse and higher pain scores in active treatment group at baseline. Small sample size. Data suggest efficacy.</td>
</tr>
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<tr>
<td>Willberg 2008 RCT</td>
<td>9.5</td>
<td>N = 52 Achilles tendons (48 patients with chronic painful midportion)</td>
<td>Sclerosing injections with polidocanol: 5mg vs. 10mg (6-8 weeks between injections, up to 3 injections before initial)</td>
<td>Mean VAS score improvement: 5mg vs. 10mg: 66±14 to 25±28, p &lt;0.05, 66±21 to 24±31, p &lt;0/05. No differences in the clinical results, number of treatments or volume injected when treating</td>
<td>“We found no differences in the clinical results, number of treatments or volume injected when treating”</td>
<td>No placebo-control. Data suggest no differences, suggesting equal (in)efficacy.</td>
</tr>
</tbody>
</table>
Achilles tendinopathy evaluation) All had pain during loading of Achilles tendon and "long duration of symptoms": 26-month mean (range 6-72 months) in low-concentration group; 28-month mean (range 2-120 months) in high-concentration. difference between groups in VAS improvement, number of treatments, adverse effects. chronic painful midportion Achilles tendinopathy with sclerosing Polidocanol injections."

**Evidence for the Use of Apoprotinin Injections**

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown 2006</td>
<td>RCT</td>
<td>6.5</td>
<td>N = 26 with Achilles tendinopathy</td>
<td>Apoprotinin (weekly injection x 3 weeks) plus eccentric exercises vs. placebo plus eccentric exercises.</td>
<td>No differences between treatment groups at any follow-up (2, 4, 12, or 52 weeks).</td>
<td>“Apoprotinin did not show any statistically significant benefit over placebo.”</td>
<td>Thirty-three tendons in 26 patients. Allowed other conservative treatments to ensure enrollment (NSAIDs, heel pads, etc). Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Non-operative and Surgical Repair for Achilles Tendon Rupture**

There are 7 moderate-quality RCTs (one with two reports) incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
</table>

Non-operative Functional Brace vs. Rigid Immobilization
<table>
<thead>
<tr>
<th>Study</th>
<th>Quality</th>
<th>N</th>
<th>Condition</th>
<th>Treatment</th>
<th>Comparison</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saleh 1992 RCT</td>
<td>4.0</td>
<td>40</td>
<td>N = 40 with acute complete rupture of calcaneal tendon</td>
<td>Rigid cast (8 weeks) vs. functional splint (cast x 3 weeks, then splint x 6-8 weeks Sheffield splint)</td>
<td>Splint vs. cast (3, 6, 12 months): no differences in plantar strength or range of flexion at any period. Dorsiflexion ROM: 7.9 vs. 1.4, 13.2 vs. 3.8, 13.6 vs. 8.6 (all periods p &lt;0.001) favor splint. Time to walk comfortably outdoors (cast vs. splint): 11 weeks vs. 6 weeks (p &lt;0.001); time to walk comfortably indoors 15 weeks vs. 9 weeks (p &lt;0.001); 1 re-rupture in each group.</td>
<td>“Recovery of ankle dorsiflexion is quicker, without overstretched, and return to normal activities is more rapid. It was more popular with patients than a plaster cast. The risk of re-rupture did not appear to be increased.”</td>
</tr>
<tr>
<td>Metz 2007, 2008 RCT</td>
<td>7.5</td>
<td>83</td>
<td>N = 83 acute Achilles tendon ruptures</td>
<td>Percutaneous surgery vs. non-operative treatment with immediate full weight bearing</td>
<td>Mean days for return to work: nonoperative: 108, surgery: 58. Difference of 49 days, 95% CI, 4-94, p &lt;0.05.</td>
<td>“Minimally invasive surgical treatment of acute AT rupture appears to have a lower risk of complications than does nonoperative treatment using functional bracing, although this difference is not statistically significant.”</td>
</tr>
</tbody>
</table>

### Achilles Rupture Surgery vs. Non-operative Care

- **Study:** Metz 2007, 2008 RCT
- **Quality:** 7.5
- **N:** 83
- **Condition:** N = 83 acute Achilles tendon ruptures
- **Treatment:** Percutaneous surgery vs. non-operative treatment with immediate full weight bearing
- **Comparison:** Mean days for return to work: nonoperative: 108, surgery: 58. Difference of 49 days, 95% CI, 4-94, p <0.05.
- **Findings:** “Minimally invasive surgical treatment of acute AT rupture appears to have a lower risk of complications than does nonoperative treatment using functional bracing, although this difference is not statistically significant.”

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| NYS WCB MTG – Ankle and Foot Disorders | 138 |
| Möller 2001 | 7.5 | N = 112 with acute, complete rupture of Achilles tendon | Plaster immobilization (equinus position neutral for 4 weeks) vs. end-to-end surgical repair with functional orthosis (ROM-Walker brace, 2 weeks equinus cast, 2 weeks 30° equinus brace, 2 weeks 10° equinus, 2 weeks 10° dorsiflexion). | Re-rupture after non-surgical treatment in 11 patients (20.8%), only 1 patient in surgical group (1.7%) (p = 0.0013). VAS quality of life scores favored surgical group for all follow up. VAS treatment results: 8 weeks – surgical: 89.2 (SD 10.3); non surgical: 74.9 (SD 19.1) (p <0.0001); 2 years surgical group: 88.7 (SD 9.0); non surgical group: 70.3 (SD 20.1) (p = 0.0001). “...surgical treatment followed by early functional rehabilitation is a safe and reliable method of treatment. Conservative management resulted in failure in every fifth patient, and cannot be regarded as acceptable in healthy, active patients under the age of 65.” | First report of study population (see Möller 2002). Data suggest surgery particularly helpful for return to work in light jobs (35.7 days vs. 67.2 days), with no differences between heavy work (102.2 vs. 108.1 days) or sedentary jobs (30.8 vs. 33.2 days). |
| Möller Scand J Med Sci Sports 2002 | 7.5 | N = 112 with Achilles tendon rupture | Plaster immobilization (equinus position 4 weeks, neutral 4 weeks) vs. end-to-end surgical repair with functional orthosis (ROM-Walker brace, 2 weeks equinus cast, 2 weeks 30° equinus brace, 2 weeks 10° equinus, 2 weeks 10° dorsiflexion). | Re-rupture rates: non-surgical 11/53 (20.8%) vs. 1/59 surgical group (1.7%) p = 0.0013). Plantar flexion: no differences between groups in concentric muscle strength at 6 months, 1 and 5 years; dorsiflexion: no differences; endurance: no difference. “If re-ruptures are avoided, surgical treatment followed by early functional rehabilitation and non-surgical treatment with a plaster for ATR appear to produce equally good results.” | Study represents 2nd report on same population. No baseline comparison data provided. No blinding. Both groups had significant functional deficits compared to non-injured leg after 2 years. |
Möller
Knee Surg,
Sports
Traumatol
2002
RCT

N = 58 closed injury of tendon substance with injury no older than 7 days
Surgery (end-to-end suture) vs. progressive casting: healing evaluated by MRI and ultrasound.
No statistically significant differences between treatment groups in terms of positive healing findings on ultrasound or MRI at 6 or 12 months.
“Ultrasound (evaluation) performed during the healing after ATR detected no significant difference in the number of positive findings between the treatment groups. MRI findings after 1 year were well correlated with [ultrasound] findings, but no significant correlation was found between clinical parameters and the number of positive radiological findings.”
Intent of study was to describe healing process in terms of ultrasound and MRI studies. Baseline comparability unclear. Findings suggest no advantage to either protocol based on MRI or ultrasound (tendon thickness, tendon glide function, tendon defects).

Twaddle
2007
RCT

N = 50 acute ruptures of Achilles tendon
Surgery vs. non surgical intervention, both with controlled early motion (10 days cast than orthosis for both groups).
No significant differences in any outcome measures (musculoskeletal functional assessment instrument, dorsiflexion, plantar flexion, calf circumference, reruptures, complications) at measured follow-up at 8 weeks, 12 weeks, 24 weeks or 52 weeks.
“…there was no difference in any of the measured parameters for operatively and nonoperatively treated patients as long as both groups received early, controlled motion as part of their rehabilitation.”
Randomization by coin toss. No blinding. Early motion orthosis did not include weight bearing until 6 weeks.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cetti 1993</td>
<td>5.5</td>
<td>N = 111 acute ruptures of Achilles tendon</td>
<td>Surgery (end to end suture) + vs. progressive casting (casting 20° equinus for 6 weeks vs. 20° equinus, no weight bearing 4 weeks, neutral cast with 1-cm heel raise 4 weeks, heel raise alone 2 weeks).</td>
<td>Mean sick time (off work) for surgery group 6.2 weeks vs. 8.0 weeks (conservative) (p = NS). Complication rates not different. Rupture rates not significant (5% vs. 15%). Differences in ankle movement/calf atrophy favored surgical group at 12 months; 57.1% surgical group vs. 29.1% returned to level of sports at same level (p &lt;0.05).</td>
<td>“Operative treatment using end to end suture of acute Achilles tendon rupture results in a higher resumption of sports activities at the same level as before the rupture. Major complications were equal in both groups. Operative treatment using end-to-end suture is preferable, while non-operative treatment is an acceptable alternative.”</td>
<td>Study appears to have excluded dropouts and noncompliant subjects as 156 were enrolled. Surgical technique varied. Data suggest benefit from surgery limited to faster return to sport.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Surgical Technique for Achilles Tendon Rupture**

There are 5 moderate-quality RCTs or quasi-randomized controlled trials incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pajala 2009</td>
<td>6.5</td>
<td>N = 60 acute Achilles tendon ruptures</td>
<td>End-to-end suture with and without augmentation (gastrocnemius fascia flap).</td>
<td>Twelve month follow-up: No differences in pain, stiffness, calf muscle weakness, ROM, or subjective satisfaction. Both groups 3 re-ruptures.</td>
<td>“…the augmented repair in cases of fresh complete Achilles tendon rupture does not have any advantage over simple end-to-end repair.”</td>
<td>No assessor blinding noted. Data suggest no benefit to augmentation for acute rupture repair.</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Type</td>
<td>Description</td>
<td>Results</td>
<td>Notes</td>
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<tr>
<td>Gigante 2008 RCT</td>
<td>5.0</td>
<td></td>
<td>Open vs. percutaneous repair of Achilles rupture.</td>
<td>Operating room time: 47 vs. 24 minutes for percutaneous repair (p &lt;0.01). No differences in calf circumference or ankle ROM. Ankle circumference at 12 months open repair: 24.5 cm (SD 1.5) vs. percutaneous repair: 25.8 (SD 1.1) (p &lt;0.01).</td>
<td>“…both the open and percutaneous technique are safe and effective in repairing the ruptured Achilles tendon, and that both afford nearly total restoration of clinical, US (ultrasound) and isokinetic patterns with the same rehabilitation protocol, despite slight differences in the duration of immobilization.”</td>
<td></td>
</tr>
<tr>
<td>Mortensen 1992 RCT</td>
<td>5.0</td>
<td></td>
<td>Mason suture technique vs. continuous 6 strand suture technique.</td>
<td>No cases of infection or re-rupture in either group. No difference in metal marker separations of plantar repaired ends or planter flexion strength measured in 3 ankle positions between both groups found.</td>
<td>“[W]e did not find any clinical advantage in using a stronger and more extensive suture technique. Consequently, we recommend a simple suture technique.”</td>
<td></td>
</tr>
<tr>
<td>Lim 2001 Quasi-RCT</td>
<td>4.5</td>
<td></td>
<td>Percutaneous vs. open repair (both groups receiving post-operative casting for mean of 12.6 weeks).</td>
<td>No differences in recovery duration to return activities of daily living, functional activity, sports at 8, 13, 26 weeks follow-up; 21% of open repairs had infection vs. 0% with percutaneous repair (p &lt;0.05), No difference in re-ruptures (6% vs. 3%).</td>
<td>“…no difference in the numbers of re-ruptures between open and percutaneous groups, and the rate of injury to the sural nerve occurring during the repair is low, but nevertheless present.”</td>
<td></td>
</tr>
</tbody>
</table>

**Allocation unclear. No baseline characteristics provided. Differences in immobilization duration. Casting 30 days open surgical group vs. 15 days for percutaneous. Data suggest comparable results.**
Evidence for the Use of Post-operative Management for Achilles Tendon Rupture
There are 2 high- and 7 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costa 2006</td>
<td>RCT</td>
<td>8.0</td>
<td>N = 96 Achilles tendon ruptures</td>
<td>Trial 1: early weight bearing vs. non-weight bearing in 48 operative patients. Trial 2: early weight bearing vs. non-weight bearing in 48 non-operative patients.</td>
<td>Trial 1: return to normal walking; treatment group: 22 weeks, control group: 25 weeks (p = 0.027). Return to normal stair climbing; treatment group: 22 weeks, control: 24 weeks (p = 0.023). Trial 2: return to normal walking (p = 0.765), climbing stairs (p = 0.484), return to sport (p = 0.631), quality of life (p = NS).</td>
<td>The study “[A]dvocates immediate weight-bearing mobilisation for the rehabilitation of all patients with rupture of the tendon Achilles.”</td>
<td>Randomization, allocation, baseline comparability data not reported. Small sample with high dropout although intention to treat analysis reported. 2 trials in article. Two cases of rerupture in the 2 operative weight-bearing groups. Data suggest better results with earlier walking.</td>
</tr>
<tr>
<td>Suchak 2008</td>
<td>RCT</td>
<td>8.0</td>
<td>N = 110 Achilles tendon</td>
<td>Weight bearing vs. non weight bearing 2 weeks after surgery</td>
<td>Quality of life RAND-36 scores: physical functioning weight bearing: 61.4 SD 29.4). Non weight bearing 47.6 (SD</td>
<td>“The postoperative early weight-bearing protocol provided enhanced quality</td>
<td>Surgical repair techniques not uniform. Compliance quantified with sensors in</td>
</tr>
</tbody>
</table>
ruptures (both groups using same functional brace).

34.4) \((p = 0.03)\). Social functioning weight bearing: 72.7 (28.5). Non weight bearing: 60.7 (26.8) \((p = 0.03)\). Vitality weight bearing 69.4 (23.7). Non weight bearing 60.6 (21.1) \((p = 0.04)\). Role-emotional weight bearing 84.6 (32.0); on weight bearing 67.3 (43.1) \((p = 0.02)\).

"of life and activity level without an increase in complications in the early postoperative period."

<table>
<thead>
<tr>
<th>Kangas 2007 RCT</th>
<th>7.0</th>
<th>N = 50 acute Achilles tendon ruptures</th>
<th>Functional brace (braced neutral and plantar flexion) vs. cast immobilization post-surgical repair.</th>
<th>Elongation of AT occurred to lesser extent in early motion group rather than cast group ((p = 0.054)) at mean 60 weeks. AT elongation correlated significantly with clinical outcome ((p = -0.42, P = 0.17)); patients with less AT elongation achieving a better clinical outcome.</th>
<th>&quot;Achilles tendon elongation was somewhat less in the early motion group and correlated with the clinical outcome scores. We recommend early functional postoperative treatment after Achilles rupture repair.&quot; Data suggest less elongation of Achilles tendon after suture repair correlates with better clinical outcome. But does not show early mobilization significantly reduces elongation over cast group; likely underpowered to detect a difference.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kangas 2003 RCT</td>
<td>6.5</td>
<td>N = 50 acute Achilles tendon ruptures</td>
<td>Cast immobilization vs. functional brace and full weight bearing (after 3 weeks) after open repair.</td>
<td>At 3 months, difference in isometric strength deficit 25.2% weight bearing group vs. 24.1% cast group ((p = NS)). Pain relief, stiffness, subjective calf muscle weakness, footwear restrictions, and ROM not statistically significant over follow-up period.</td>
<td>&quot;The isokinetic calf muscle strength results were somewhat better in the early motion group, whereas the other outcome results obtained in the two groups of patients were very similar. We recommend early functional postoperative treatment after Achilles rupture repair for athletes and well-motivated patients and for less-motivated Author conclusions related to differences within same group over time rather than between group deficit comparisons, which were not significant. Three reruptures; no difference between groups (6%).&quot;</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Sample Size</td>
<td>Treatment</td>
<td>Outcome Measures</td>
<td>Results</td>
</tr>
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</tr>
<tr>
<td>Kauranen 2002</td>
<td>RCT</td>
<td>N = 30 acute Achilles tendon ruptures</td>
<td>Post-op functional treatment vs. early immobilization</td>
<td>No differences found between groups in reaction time, speed of movement, tapping speed. Lateral coordination value of operated leg higher in plaster cast group than in active brace group 12 weeks after operation; p &lt;0.05.</td>
<td>&quot;It seems that the recovery of the above mentioned motor performance functions of the leg does not depend on whether the leg is in a plaster cast with the AT in tension or in an active brace during the early postoperative period after AT rupture repair.&quot;</td>
</tr>
<tr>
<td>Cetti 1993</td>
<td>RCT</td>
<td>N = 111 acute Achilles tendon ruptures</td>
<td>Surgery (end to end suture) plus vs. progressive casting (casting 20° equinus for 6 weeks vs. 20° equinus, no weight bearing 4 weeks, neutral cast with 1-cm heel raise 4 weeks, heel raise alone 2 weeks)</td>
<td>Mean sick time (off work) for surgery group was 6.2 weeks vs. 8 weeks (conservative) (p = NS). Complication rates not different. Rupture rates were not significant (5% vs. 15%). Differences in ankle movement and calf atrophy favored surgical group at 12 months. 57.1% of surgical group vs. 29.1% returned to level of sports at same level (p &lt;0.05).</td>
<td>&quot;Operative treatment using end to end suture of acute Achilles tendon rupture results in a higher resumption of sports activities at the same level as before the rupture. Major complications were equal in both groups. Operative treatment using end-to-end suture is preferable, while non-operative treatment is an acceptable alternative.&quot;</td>
</tr>
<tr>
<td>Cetti 1994</td>
<td>RCT</td>
<td>N = 60 acute Achilles tendon ruptures</td>
<td>Mobile cast (n = 30) vs. below knee rigid cast (n = 30) after operative repair (4-string suture)</td>
<td>60% of rigid cast patients reported discomfort from cast vs. 30% from mobile cast (p = 0.0037); 77% mobile cast found it “excellent,” 20% rigid cast thought same (p &lt;0.00005). Mean</td>
<td>&quot;Operative treatment with a 4-string suture and use of a postoperative mobile cast proved safe and convenient and preferable to treatment with the mobile cast.&quot;</td>
</tr>
</tbody>
</table>

Data limited to motor testing and motor performance, which may not correlate with functional outcomes of recovery studied by other researchers.
<table>
<thead>
<tr>
<th>Source Year</th>
<th>Study Design</th>
<th>Study Population</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortensen 1999</td>
<td>RCT</td>
<td>N = 71 acute Achilles tendon ruptures</td>
<td>Cast x 2 weeks plus 6 weeks modifiable brace vs. equinus position cast x 6 weeks plus 2 weeks neutral cast (both groups after open repair)</td>
<td>Early motion vs. cast 16 months after operative treatment: sick leave in Days 43 (1-103)/68 (2-285); p &lt;0.05, number of patients who returned to sports 22 (73%)/ 22 (76%); p = 1.00, months until sports resumed 4 (2-13)/7.5 (3-22); p &lt;0.001, number who reached pre-injury level 17 (57%)/16 (55%); p = 1, months until preinjury level reached 6 (2.5-13)/9 (6-14); p &lt;0.001.</td>
<td>“Early restricted motion appears to shorten the time needed for rehabilitation. There were no complications related to early motion in these patients. However, early unloaded exercises did not prevent muscle atrophy.”</td>
</tr>
<tr>
<td>Costa 2003</td>
<td>RCT</td>
<td>N = 28 unilateral ruptures of Achilles tendon</td>
<td>Functional brace (immediate weight bearing) vs. progressive casting for 8 weeks following open end-to-end operative repair.</td>
<td>Time to return to sports (months): early loading: 6.0 (2.0 IQR) Cast: 8.0 (8.0 IQR). (-5.0, 3.5 95% CI for median difference). Flexion deficit degrees: Early loading plantar: 5.0 (3.5 IQR) Dorsal: -5.0 (4.25 IQR). Cast plantar: 5.0 (5.0 IQR) Dorsal 0.0 (0.0 IQR). (95% CI for median difference plantar: -10,0 dorsal: 0, 14) Peak torque deficit (%)</td>
<td>“(I)mmediate controlled weight-bearing mobilisation after Achilles repair is safe and may produce functional benefits for the patient.”</td>
</tr>
</tbody>
</table>
at 12 months); Early loading concentric: 13.5 (50.8 IQR) Eccentric: -1.5 (27.8 IQR). Cast concentric: 29.0 (23.5 IQR) Eccentric: 41.0 (26.0). (95% CI for median difference concentric: -56, 53 Eccentric -30, 45).

### Evidence for the Use of DVT Prophylaxis for Achilles Tendon Rupture Repair

There are 2 high-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparator Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lapidus 2007</td>
<td>RCT</td>
<td>10.0</td>
<td>N = 105 with Achilles tendon rupture</td>
<td>Low molecular weight heparin (5,000 u) vs. saline placebo for post-op DVT prophylaxis</td>
<td>Patients underwent modified Kessler end-to-end suture repair with casting. Incidence of DVT 34% LMWH group, 36% in placebo (p = 0.8). No difference in proximal DVT between groups.</td>
<td>&quot;Our study showed that DVT is common during immobilization after Achilles tendon rupture surgery, and therefore effective thromboprophylaxis is desirable. [T]he daily administration of 5000 U of (low molecular weight heparin) did not affect the incidence of DVT.&quot;</td>
<td>Allocation method unclear. Diagnosis made with ultrasound with majority being asymptomatic. Thus, clinical significance of these findings unclear.</td>
</tr>
<tr>
<td>Lassen 2002</td>
<td>RCT</td>
<td>9.0</td>
<td>N = 440 ≥18 years or older undergoing elective hip replacement surgery</td>
<td>Low molecular weight heparin (5000 u) vs. saline placebo for post-surgical DVT prophylaxis.</td>
<td>Reviparin vs. placebo; Thrombosis-17/189 (9%) vs. 35/188 (19%), OR 0.45 (0.24-0.82). Achilles tendon specific - 3/48 (6%) vs. 6/28 (21%), OR 0.24 (0.27-1.03). Bleeding events (14 vs. 12), major bleeding (2 vs. 1).</td>
<td>&quot;[R]outine use of reviparin for prophylaxis against thrombosis during the period of leg immobilization after fracture of the leg or rupture of the Achilles tendon is beneficial. However, further evaluation is warranted before such treatment can be recommended for routine use.&quot;</td>
<td>Study included lower limb fractures and Achilles rupture patients with bracing and casting mean 7-8 weeks. Intent to treat based on 371 patients. Baseline between group differences in smoking rate. DVT diagnosis made on findings of venography. Data suggest</td>
</tr>
</tbody>
</table>
Evidence for the Use of NSAIDs for Compartment Tenosynovitis
There are no quality studies evaluating the use of NSAIDs for compartment tenosynovitis.

Evidence for the Use of Education for Plantar Fasciitis
There are no quality trials incorporated into this analysis.

Evidence for the Use of Infliximab for Plantar Fasciitis
There are no quality trials incorporated into this analysis.

Evidence for the Use of Opioids for Plantar Fasciitis
There are no quality trials incorporated into this analysis.

Evidence for the Use of Systemic Glucocorticosteroids for Plantar Heel Pain
There are no quality trials incorporated into this analysis.

Evidence for the Use of Vitamins for Plantar Fasciitis
There are no quality trials incorporated into this analysis.

Evidence for the Use of Lidocaine Patch for Plantar Fasciitis
There are no quality trials incorporated into this analysis.

Evidence for the Use of Topical NSAIDs for Plantar Fasciitis
There are no quality trials incorporated into this analysis.

Evidence for the Use of Wheat Grass Cream for Plantar Fasciitis
There is 1 high-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
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</tbody>
</table>
Wheatgrass Cream vs. Placebo

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young 2006</td>
<td>RCT</td>
<td>8.5</td>
<td>N = 80 with chronic plantar fasciitis</td>
<td>Wheatgrass cream vs. placebo cream</td>
<td>VAS 1st-step pain improved from baseline to 6 weeks (wheatgrass p = 0.013; placebo p = 0.017), but NS between groups. Improvements continued to 12 weeks (wheatgrass p = 0.003; placebo p = 0.017). No changes in calf muscle strength and ankle dorsiflexion ROM.</td>
<td>“The topical application of wheatgrass cream is no more effective than a placebo cream for the treatment of chronic plantar fasciitis.”</td>
<td>Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Magnets for Plantar Heel Pain

There are 2 high-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winemiller 2005</td>
<td>RCT</td>
<td>9.5</td>
<td>N = 89 health care employees with non-specific feet pain for at least 30 days</td>
<td>Magnetic vs. sham-magnetic cushioned insoles for 8 weeks.</td>
<td>“All better” or “mostly better” at 4 8 weeks sham-magnetic vs. magnetic group: 33% vs. 32%; p = 0.98/33% vs. 32%; p = 0.86.</td>
<td>“This study provides convincing evidence that use of static magnets for a total of 8 weeks was not effective in relieving symptoms of nonspecific foot pain in the workplace.”</td>
<td>Heterogeneous inclusion criteria. Non-specific diagnoses. No control for co-interventions. Data suggest lack of efficacy.</td>
</tr>
<tr>
<td>Winemiller 2003</td>
<td>RCT</td>
<td>9.0</td>
<td>N = 101 adults with diagnoses of plantar heel pain for at least 30 days</td>
<td>Magnetic vs. sham-magnetic cushioned insoles for non-specific foot pain for 8 weeks.</td>
<td>“All better” or “mostly better” at 8 weeks sham-magnetic vs. magnetic group: 33% vs. 35%; p = 0.78; VAS 4, 8 weeks (placebo vs. magnets) 4.2 vs. 4.4 p = 0.63, 3.9 vs. 3.9 p = 0.94.</td>
<td>“Static bipolar magnets embedded in cushioned shoe insoles do not provide additional benefit for subjective plantar heel pain reduction when compared to nonmagnetic insoles.”</td>
<td>Randomization by drawing insoles from box. Acute pain included in study. Baseline differences in pain characteristics biased positively toward magnetic group. Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Casting for Plantar Fasciitis
There are no quality trials evaluating the use of casting for plantar fasciitis.

Evidence for the Use of Night Splints for Plantar Heel Pain
There are 4 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 1.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batt 1996</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 40 with plantar fasciitis</td>
<td>Standard treatment of anti-inflammatory medication, Viscoheel sofspot heel cushion, and stretching program for gastrocnemius and soleus muscles vs. Tension Night Splint.</td>
<td>Healed: Control 6/17 (35.3%) vs. TNS 16/16 (100%). After crossover, 8 of 11 (72.7%) controls asymptomatic after average 13 weeks.</td>
<td>“When used in combination with a visco-elastic heel pad, stretching program and nonsteroidal anti-inflammatory drugs, the TNS is an effective treatment of plantar fasciitis.”</td>
<td>No blinding. Symptom chronicity not provided. Cure rates reported may indicate acute condition as no other studies have reported such efficacy of intervention.</td>
</tr>
<tr>
<td>Probe 1999</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 116 with plantar fasciitis</td>
<td>Night splints vs. no splints in groups that received 1 month NSAIDs, Achilles stretching exercises, and shoe recommendations for 3 months.</td>
<td>At 19 months follow-up, 84% experienced improvement of symptoms. No statistical differences between treatment groups (p = 0.95). Improvement rate, defined as decrease of 1 pain grade on 4-point scale in Group 1 was 66% and in Group 2 71% (p = 0.69).</td>
<td>“No statistically significant improvement was seen to a standard nonoperative protocol with the addition of night splinting in this group of patients with symptoms of less than 12 months duration.”</td>
<td>Lack of study details. No additional benefit of using commercial splints in study over other conservative measures (NSAID, Achilles stretching). Study suggests lack of efficacy of night splints.</td>
</tr>
<tr>
<td>Powell 1998</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 37 with chronic plantar fasciitis</td>
<td>Group A: splints for 1st month; Group B: for 2nd month. No splints used in either group for final 4 months of study.</td>
<td>Mayo Clinical Scoring System – significant differences found between Groups A and B.</td>
<td>“We demonstrated that dorsiflexion night splints can be an effective treatment in…”</td>
<td>Classified as cross-over but appears not true cross-over design, rather treatment delayed for 1-month in...</td>
</tr>
</tbody>
</table>
Evidence for the Use of Orthoses for Plantar Fasciitis

There is 1 high- and 7 moderate-quality RCTs incorporated into this analysis. There are 6 low-quality RCTs or crossover trials in Appendix 2. (208, 215, 217, 223, 225, 226) (Martin 01; Caselli 97; Kavros 05, Mejjad 04; Fauno 93; Lynch 98)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthotics vs. Sham/No Treatment</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Landorf 2006</td>
<td>RCT</td>
<td>8.5</td>
<td>N = 136 with plantar fasciitis</td>
<td>Prefabricated orthoses vs. customized orthoses vs. sham orthoses. All had plaster molds of their feet. Sham orthosis fabricated &quot;by molding a 6-mm, soft (120 kg/m3) ethyl vinyl acetate foam over an unmolded cast of the foot…. [in such a way as] to provide minimal structural support for foot. Prefabricated orthosis was 3/4 length, retail mold</td>
<td>ANCOVA adjusted differences between mean of Foot Health Status Questionnaire (95% CI); PF vs. sham, custom vs. sham, PF vs. custom. Pain 3-months: 8.7 (-0.1 to 17.6), 7.4 (-1.4 to 16.2), 1.3 (-7.6 to 10.2); Pain 12 months: 2.2 (-5.6 to 10.0), -0.1 (-7.8 to 7.7), 2.3 (-5.6 to 10.1); Function 3 months: 8.4 (1.0)</td>
<td>“Foot orthoses produce small short-term benefits in function and may also produce small reductions in pain for people with plantar fasciitis, but they do not have long-term beneficial effects compared with a sham device. The customized and prefabricated orthoses... have</td>
<td>Inclusion criteria for pain duration was at least 4 weeks, with mean of 12 months. Data suggest modest function at 3 months over placebo but no differences in pain.</td>
</tr>
</tbody>
</table>
made from firm-density polyethylene foam sufficiently thick to fill the arch area and prevent the orthosis from flattening."

Custom orthotic made in commercial lab of semirigid polypropylene, had firm foam heel post “designed to provide significant support for the foot and influence the position of the foot relative to the leg.”

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<table>
<thead>
<tr>
<th>Orthoses: Custom vs. Fabricated</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Pfeffer</strong></td>
<td>6.5</td>
<td>N = 236 with proximal plantar fasciitis</td>
</tr>
<tr>
<td>RCT</td>
<td></td>
<td>Silicone heel pad vs. felt insert vs. rubber heel cap vs. custom-made “neutral” orthoses vs. no orthoses. All received AF and PF stretching exercises. Trial at 15 orthopedic foot/ankle centers; personnel at each center underwent instructional video on obtaining molds; orthoses made at single production facility of 1/4 or 3/16 inch [6 to 9 mm] polypropylene.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentages improved in each group: 1) silicone insert, 95%; 2) rubber insert, 88%; 3) felt insert, 81%; 4) stretching only, 72%; 5) custom orthosis, 68%. Multivariate analysis of mean pain score changes showed all groups with significant improvement, no significant differences between groups.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“We conclude that, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms as part of the initial treatment of proximal plantar fasciitis than a custom polypropylene orthotic device.”</td>
</tr>
<tr>
<td><strong>Baldassi</strong></td>
<td>7.0</td>
<td>N = 142 adults (75% female) with plantar fasciitis,</td>
</tr>
<tr>
<td>n 2009</td>
<td></td>
<td>Prefabricated vs. custom foot orthoses for 8 weeks. Both prefabricated and custom orthoses</td>
</tr>
<tr>
<td>RCT</td>
<td></td>
<td>Significant improvement both groups for modified FFI, no difference between them, p &lt;0.05.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“The low-cost prefabricated and customized foot orthoses, as used in this trial, had similar effectiveness in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High dropout (~40%). No compliance data provided. Data suggest no differences in pain relief</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>Kelly 1998</td>
<td>RCT</td>
<td>5.0</td>
</tr>
<tr>
<td>Chalmers 2000</td>
<td>RCT</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Orthotics vs. Other Therapies

without anatomic alterations in feet made of ethylene vinyl acetate. Cointerventions used 67% of the time, 40% performed stretching for Achilles tendon and 28% used other cointerventions. the treatment of noncomplicated plantar fasciitis after 8 weeks of use." between prefabricated and custom EVA inserts.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Intervention</th>
<th>Results</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pfeffer 1999</td>
<td>6.5</td>
<td>236</td>
<td>Silicone heel pad vs. felt insert vs. rubber heel cap vs. custom orthoses vs. no orthoses.</td>
<td>The percentages improved in each group were: 1) silicone insert, 95%; 2) rubber insert, 88%; 3) felt insert, 81%; 4) stretching only, 72%; and 5) custom orthosis, 68%. Multivariate analysis of mean pain score changes showed all groups with significant improvement, no significant differences between groups.</td>
<td>Lack of blinding. Data suggest added benefit from orthosis plus stretching program. Percentages of improvement are of uncertain clinical significance as benefit response included broad category of “all, much, or slightly better.” No differences in mean pain scores.</td>
</tr>
<tr>
<td>Roos 2006</td>
<td>4.5</td>
<td>43</td>
<td>Foot orthoses vs. orthoses plus night splints vs. night splints only.</td>
<td>All groups improved significantly in all 5 FAOS subscales across all times (p &lt;0.04). No significant differences found in pain among 3 groups at any time.</td>
<td>No baseline data. No blinding. Lack of details on co-interventions, compliance. Study likely underpowered. No statistical differences in interventions.</td>
</tr>
<tr>
<td>Stratton 2009</td>
<td>4.5</td>
<td>26</td>
<td>Low frequency electrical stimulation with orthoses and stretching vs.</td>
<td>No intergroup differences in VAS, Activities of Daily Living Subscale of FAAM 4 weeks</td>
<td>Study included those with symptoms ranging 1 week to 6 months. Inclusion</td>
</tr>
</tbody>
</table>
### Orthotics for Prevention

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esterman 2005</td>
<td>4.0</td>
<td>N = 47 Royal Australian Air Force recruits with flexible flat feet embark ing on 10-week basic training course</td>
<td>Orthotics vs. no orthotics for prevention in asymptomatic group.</td>
<td>Results not significant different but those with the orthotics had the least limb pain, the lowest rate of injuries, the best general foot health, and the best quality of life.</td>
<td>“The results of this pilot randomized controlled trial provide some tentative evidence that orthotics may improve lower limb pain and general foot health and decrease injury rates among military recruits with flexible flat feet.”</td>
<td>Pilot study. Study performed on military recruits in basic training who were deemed to have “flat” feet. No blinding. Data suggest orthotics may have preventive benefit.</td>
</tr>
</tbody>
</table>

### Evidence for the Use of Shock Absorbing Shoes for Plantar Fasciitis
There are 2 moderate-quality RCTs incorporated in this analysis. There is 1 low-quality RCT in Appendix 2.(229) (Fransen 97)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torkki 2002</td>
<td>6.5</td>
<td>N = 176 lower-limb overuse injuries</td>
<td>Individually adjusted footwear with good shock absorbing properties vs. subjects’ own used footwear (control).</td>
<td>No differences between groups at 3 or 12 months follow-up for lower-limb pain intensity, number of painful days, or ability to work.</td>
<td>“[I]ndividually fitted shock-absorbing shoes seem to offer only rather small health benefits to subjects exposed to daily walking and having”</td>
<td>Study of newspaper carriers in Finland. Study of lower limb “overuse injury.” No control for other treatments. No analysis by disorder. Those in intervention expected improvement from...</td>
</tr>
</tbody>
</table>
Evidence for the Use of Stretching Exercises for Plantar Fasciitis
There are 4 moderate-quality RCTs (one with two reports) incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pfeffer 1999 RCT</td>
<td>6.5</td>
<td>N = 236 with proximal plantar fasciitis</td>
<td>Silicone insert vs. rubber insert vs. felt insert vs. vs. custom orthosis vs. stretching only. Each group performed Achilles and plantar fascia stretching for approximately 10 minutes, twice a day. Follow-up at 8 weeks.</td>
<td>Percentages improved in each group: 1) silicone insert, 95%; 2) rubber insert, 88%; 3) felt insert, 81%; 4) stretching only, 72%; and 5) custom orthosis, 68%. Multivariate analysis of mean pain score changes showed all groups with significant improvement, no significant</td>
<td>“We conclude that, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms as part of the initial treatment of proximal plantar fasciitis than a custom polypropylene</td>
<td>Lack of blinding. Study suggests added benefit from orthosis plus stretching program. However, percentages of improvement are of unknown clinical significance as benefit response included broad category of “all, much, or slightly better.” No differences</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Description</td>
<td>Inclusion Criteria</td>
<td>Outcomes</td>
<td>Summary</td>
</tr>
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</tr>
<tr>
<td>DiGiovanni</td>
<td>2003, 2006</td>
<td>101</td>
<td>Plantar fascia-tissue-stretching program vs. Achilles tendon-stretching (concentric) program</td>
<td>Failure of non-operative treatments. Subject-relevant outcome measures all statistically better in positive responses for PF stretching vs. Achilles stretching. Overall better 82.6% vs. 55.6% (p = 0.01), &gt;50% improvement in pain 82.6% vs. 58.3% (p = 0.03). Totally satisfied 91.3% vs. 60% (p = 0.006). At 8 weeks, Achilles group switched to PF stretching. At 2-year follow-up (attrition 40%) PF stretching resulted in improvement of Achilles group; both groups improved with no differences.</td>
<td>In mean pain scores.</td>
<td>“After eight weeks of treatment, the group managed with plantar fascial stretching exercises exhibited enhanced outcomes with regard to pain, function, and overall satisfaction compared with those of the group managed with standard Achilles tendon-stretching exercises. This study supports the use of the tissue-specific plantar fascia-stretching protocol as the key component of treatment for chronic plantar fasciitis.”</td>
</tr>
<tr>
<td>Hyland</td>
<td>2006</td>
<td>41</td>
<td>Stretching (plantar fascia, gastrocnemius) vs. calcaneal taping vs.</td>
<td>Stretch vs. taping vs. control vs. sham taping. VAS, PSFS</td>
<td>All groups received orthoses and NSAIDs. Baseline differences in duration of symptoms reported, (duration &gt;in PF group, p&lt;0.01) although the mean (years) not provided. Baseline pain scores not provided limiting comparison of change in scores (main outcome). High attrition (28%, 14/50) in Achilles stretching group. Lack of control group for Achilles limits conclusion for group treated with PF stretching at the 2 year follow-up as natural history is not ruled out.</td>
<td>“Calcaneal taping was shown to be a more effective tool for the Randomization and allocation unclear. No blinding. Small sample size.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Taping for Plantar Fasciitis

There is 1 high- and 1 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.(226) (Lynch 98)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radford 2007 RCT</td>
<td>5.5</td>
<td>N = 92 with plantar heel pain &gt;3 months duration</td>
<td>Calf muscle stretching and sham ultrasound vs. sham ultrasound only. Required stretching 5 minutes per day.</td>
<td>No statistically significant differences between groups in first-step pain, foot pain, foot function, general foot health, or functional measures in ROM.</td>
<td>“[A] two-week stretching program provides no statistically significant benefit in ‘first-step’ pain, foot pain, foot function or general foot health compared to not stretching.”</td>
<td>Improvement in both groups occurred, but no between group differences. Short trial duration – only 5 minutes of intervention per day. Results suggest no benefit of calf stretches using wedge technique.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Acupuncture for Plantar Fasciitis

There is 1 high-quality RCT incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radford 2006</td>
<td>8.0</td>
<td>N = 92 with plantar heel pain</td>
<td>Low-Dye taping with sham ultrasound vs. sham ultrasound. Symptoms &gt;4 weeks. Treatment effect measured over 1 week.</td>
<td>Taping vs. control: (adjusted mean difference 95% CI), First step pain; -12.3 (-22.4 to -2.2) p = 0.017. Foot pain, foot function, general foot health scores all non-significant between groups.</td>
<td>“Low-Dye is effective for the short-term treatment of the common symptoms of &quot;first-step&quot; pain in patients with plantar heel pain.”</td>
<td>Short trial of 1 week. High level of adverse events in taping (28%) due to discomfort, allergic reactions. Data suggest no differences in outcomes measures except first step pain.</td>
</tr>
<tr>
<td>Hyland 2006</td>
<td>4.5</td>
<td>N = 41 with plantar fasciitis</td>
<td>Stretching (plantar fascia, gastrocnemius) vs. calcaneal taping vs. sham taping vs. no treatment. Durations of symptoms unknown. Treatment effect measured after 1 week.</td>
<td>Stretch vs. taping vs. control vs. sham taping: VAS, PSFS stretching: 6.3±0.8 to 4.6±0.7, 5.6±1.1 to 4.9±1.2; taping: 7.0±0.8 to 2.7±1.8, 4.5±6.2±1.8; control: 6.3±1.3 to 6.2±1.0. Sham taping: 6.4±1.2 to 6.0±0.9, 5.3±0.5 to 5.4±0.6 pre/post intra-group difference p &lt;0.05; intra-group: taping vs. stretching p &lt;0.06, tape vs. sham and control p &lt;0.001, stretch vs. sham and control p = NS.</td>
<td>“Calcaneal taping was shown to be a more effective tool for the relief of plantar heel pain than stretching, sham taping, or no treatment.”</td>
<td>Randomization and allocation unclear. No blinding. Small sample size. Duration of symptoms at study entry unknown but suspect acute and subacute as previous treatment was a study exclusion criteria. Very short term trial and follow-up of only one week limits utility of study for guidance.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Electrical Stimulation for Plantar Fasciitis
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stratton 2009</td>
<td>4.5</td>
<td>N = 26 with plantar fasciitis</td>
<td>Low frequency electrical stimulation with orthoses and stretching vs. orthoses and stretching.</td>
<td>No intergroup differences in VAS, Activities of Daily Living Subscale of FAAM 4 weeks and 3 months after treatments. Both treatment arms statistically significant improvements compared to baseline.</td>
<td>“The efficacy of using low-frequency electrical stimulation in the management of patients with plantar fasciitis is questionable.”</td>
<td>Study included patients with symptoms of 1 week to 6 months. Inclusion criteria: athletic activity 5 times per week for &gt;90 minutes limiting generalizability. Randomization and allocation details sparse. Data suggest no added benefit from low frequency electrical stimulation.</td>
</tr>
</tbody>
</table>

Evidence for the Use of ESWT for Plantar Fasciitis
There are 9 high- and 14 moderate-quality RCTs (one with two reports) or quasi-RCTs incorporated into this analysis. There are 2 low-quality studies in the Appendix.(265, 266) (Furia 05, Alvarez 03)
### Study Type (0-11)

<table>
<thead>
<tr>
<th>Study Type</th>
<th>(0-11)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haake 2003</td>
<td>10.0</td>
<td>N = 272 chronic plantar fasciitis with symptoms &gt;6 months and failure of conservative treatment (non-specified)</td>
</tr>
<tr>
<td>Buchbinder 2002</td>
<td>9.5</td>
<td>N = 166 plantar fasciitis with symptoms range 8-900 weeks, mean 36-43 weeks; 12-week follow-up period; Dx of thickened insertion of plantar fascia (&gt;4 mm) by ultrasound required</td>
</tr>
<tr>
<td>Speed 2003</td>
<td>9.5</td>
<td>N = 88 adults with plantar fasciitis with symptoms &gt;3 months (most failed analgesics)</td>
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</table>

### ESWT vs. Sham

<table>
<thead>
<tr>
<th>Study Type</th>
<th>(0-11)</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Haake 2003</td>
<td>10.0</td>
<td>ESWT vs. sham. Active treatment: 4,000 shocks 0.08 mJ/mm² x 3 treatments 2 week intervals; mepivacaine local used. Energy focused on insertion of fascia guided by ultrasound; 12 week at 12-month follow-up period; 320 mJ/mm²; low energy flux. Primary outcome: success on Roles and Maudsley Scale (score 1-2): 12 weeks – difference in success rates 3.6% (-8.0% to 15.1); p = 0.5927, OR 1.18 (0.675 to 2.07). 12 months: 91 of 113 (81%) ESWT vs. 87 of 115 (76%) placebo p &gt;0.05. No significant effect of ESWT. “We cannot recommend specific applications of extracorporeal shock wave therapy to be tested in further clinical studies because all major trials, using different shockwave variable and types of lithotripters, showed negative results.”</td>
</tr>
<tr>
<td>Buchbinder 2002</td>
<td>9.5</td>
<td>ESWT vs. sham. Active treatment: 2,000-2,500 shocks of variable energy (0.02-0.33mJ/mm2) dictated by pain tolerance) x 3 weekly treatments. No local used. Energy focused on insertion of fascia guided by ultrasound; ≤825 mJ/mm²; low to medium energy flux. At 6 and 12 weeks, significant improvements in overall pain in both active group placebo group although no differences between groups (mean±SD): 17.9±30.5 and 19.8±33.7 at 6 weeks (p = .74). 26.3±34.8 and 25.7±34.9 at 12 weeks (p = .99). No significant effect of ESWT. “We found no evidence to support a beneficial effect on pain, function, and quality of life of ultrasound-guided ESWT over placebo in patients with ultrasound proven plantar fasciitis 6 and 12 weeks following treatment.”</td>
</tr>
<tr>
<td>Speed 2003</td>
<td>9.5</td>
<td>ESWT vs. sham pain VAS (mean): 0/1/2/3/6 months: 73.6/62.5/51.6/41.4/34.7 vs. 70/63.7/48.1/47.1/29. No significant difference between groups “There appears to be no treatment effect of moderate dose ESWT in subjects with plantar fasciitis. The improvement shown with</td>
</tr>
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</table>
### Gollwitze 2007 RCT

| N | 40 | with chronic painful heel syndrome (symptoms >6 months); failed 4 conservative treatments; 12 week follow-up | ESWT vs. sham. Active treatment - 2000 shocks of 0.25 mJ/mm² x 3 treatments at weekly intervals. No local used. Energy focused on at point of maximal tenderness; 500 mJ/mm²; low energy flux. | Final percent change from baseline in composite heel pain VAS score: 73.2% in the ESWT group vs. 40.5% in placebo group. Between-group difference not statistically significant. No differences in overall success rate. No significant effect of ESWT. | In conclusion, ESWT with 3 repetitive applications of 2000 impulses of an electromagnetic shockwave device without local anesthesia appeared to be an effective, non-invasive treatment modality for proximal plantar fasciitis. This intervention was associated with negligible side effects. | Use of anesthesia was not indicated. Mann Whitney effect test to determine clinical significance of observed differences to justify conclusion. None of the clinical outcomes measures reached statistical significance. |

### Malay 2006 RCT

<p>| N | 172 volunteers with symptoms &gt;6 months, failed 2 pharmaceutical and 2 non-pharmaceutical treatments. VAS &gt; 5 (0-10 scale); 3-month follow-up period | ESWT (115) vs. sham. Control (57) - Active treatment of 3500 impulses in single session (energy variable, total dose not reported). Energy Flux not specified. | Mean VAS change ESWT vs. placebo (1, 2, 3 months): -1.61 vs. 11.27 p = 0.34, -2.30 vs. -1.31 p = 0.26, -2.51 vs. -1.57 p = 0.45. Mean VAS change ESWT vs. placebo at 3 months: Spur absent; -3.67 vs. -2.19 p = 0.12, Spur present; -2.06 vs. -1.99, p = 0.96; Assessment of heel pain (responder vs. non-responder) at Months 1, 2, 3: 35.5% vs. 31.5% p = 0.61, 43.2% | “All assessments of the reduction of heel pain were found to be statistically significant when compared with placebo in participants who had already failed standard conservative treatments…with a single treatment session without the use of local anesthetics or systemic analgesics or sedatives.” | Study performed by manufacturer for FDA approval of Orthospec device (portable ESWT). Anesthesia not used. Study suggests delayed reduction in pain on assessor and patient report, but no improvement in function or activity after single treatment session. Effect seems greatest |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Intervention</th>
<th>Comparisons</th>
<th>Results</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kudo 2006 RCT</td>
<td>8.5</td>
<td>N = 114</td>
<td>ESWT vs. sham. Active treatment 3800 impulses at variable energy (0.36 - 0.64 mJ/mm²) in single treatment for total of 1,300 mJ/mm² ED, or 2330 mJ/mm² ED; high energy flux.</td>
<td>Clinical success [No. of subjects (%)] active treatment group vs. placebo: 25/53 (47%) vs. 12/52 (23%); p = 0.0099. Adverse events through 3 months: pain during treatment (% incidence): 79.3 vs. 8.9; p = 0.000. Mixed, mostly non-statistically significant effects and questionable clinically-significant effects of ESWT.</td>
<td>“The results of this study confirm that high-energy ESWT, administered with the Dornier Epos Ultra is a safe and effective treatment for patients who have failed previous conservative nonsurgical treatments for chronic plantar fasciitis.” Local anesthesia with 5 ml lidocaine. Study suggests ESWT provided benefit over placebo.</td>
</tr>
<tr>
<td>Marks 2008 RCT</td>
<td>8.5</td>
<td>N = 25</td>
<td>ESWT (16) vs. Sham (9). Active treatment of 500 impulses day 1, 2000 impulses on day 4 and 7 at 0.16 mJ/mm². No report on use of local or guidance method; 320 mJ/mm²; low energy flux.</td>
<td>VAS change &gt;50%: ESWT 4/9 vs. sham 9/16 p = 0.44. VAS change overall: p = 0.75 between group mean Roles and Maudsley Scores: p = 0.22 between group mean. No “There appears to be a significant placebo effect with low-energy ESWT in patients with heel pain, and there is also a lack of evidence for its efficacy compared to sham therapy.” Randomization by drawing lots. Use of anesthesia not noted. Small sample size. Data suggest no clinically significant effect at 1 or 6 months.</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Patients</td>
<td>Patient Description</td>
<td>Treatment Details</td>
<td>Outcome Measures</td>
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<td>Rompe 2003</td>
<td>7.5</td>
<td>N = 45</td>
<td>Recreational runners with symptoms &gt;12 months, failure of 3 non-operative treatments including NSAIDs, physiotherapy, orthotics; 12-month follow-up</td>
<td>ESWT vs. sham. Active treatment – 2,000 shocks of 0.16 mJ/mm² x 3 treatments at weekly intervals. No local used. Energy focused on at point of maximal tenderness; 320 mJ/mm²; low energy flux.</td>
<td>Mean reduction in self-assessment of pain on 1st walking in morning. Initial rating/6 months/1 year treatment vs. sham: 6.9±1.3/2.1±2.0/1.5±1.7 vs. 7.0±1.3/4.7±1.9, 4.4±1.7; p &lt;0.0005 at 6, 12 months. Mean scores on AOFAS Ankle-Hindfoot Scale: 52.7±10.0/89.9±8.6/9.4±8.3 vs. 49.7±10.1/69.1±20.1, 75.4±17.3; p = 0.0211. Subjective scale results: 4.0±0.0/2.1±0.8/1.9±0.6 vs. 4.0±0.0/3.0±1.0/2.7±1.1; p = 0.0445. Statistically significant positive effect of ESWT.</td>
</tr>
<tr>
<td>Theodore 2004</td>
<td>7.5</td>
<td>N = 150</td>
<td>With plantar fasciitis with symptoms &gt;6 months, failed stretching, failed NSAIDs and 2 other</td>
<td>ESWT vs. sham. Active treatment 3800 impulses at variable energy (0.36-0.64 mJ/mm²) in single treatment for total of 1,300 mJ/mm². Local anesthetic was used in conjunction with ultrasound guidance and VAS: ESWT vs. sham (0, 5 days, 6 weeks, 3 months): 7.7 vs. 7.7, 7.8 vs. 7.5, 5.0 vs. 5.7, 7.8 vs. 5.0, 3.4 vs. 4.1. Mean change from baseline -4.4 vs. -3.6, p = 0.435. Roles &amp; Maudsley (number reporting improvement from fair/poor to good/excellent): 7.5 vs. 7.5, 7.5 vs. 7.5, 5.0 vs. 5.0, 3.4 vs. 3.4.</td>
<td>“In conclusion, extracorporeal shock wave therapy has emerged as a safe treatment option for chronic plantar fasciitis. This study demonstrates that electromagnetically generated, Anesthesia through medial calcaneal nerve block with 5 ml of 1% lidocaine. Data suggest single treatment provides some pain relief but minimal functional improvement at 3 months post single</td>
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</table>
therapies; 12-month follow-up

modification with pain feedback. Study patients unblended at 3 months and placebo group was allowed to crossover; 1300 mJ/mm²; medium to high energy flux.

excellent/good at 3 months: 45/73 (63%) vs. 29/73 (40%), p = 0.0327. AOFAS Ankle-Hindfoot, SF-12: no differences. Statistically significant differences between groups noted in 3 months of blinded comparison. Some findings not statistical different and differences in VAS scores between groups less than 1.0. Mixed statistically significant, but positive short-term effect of ESWT, some statistically significant effects of questionable clinical significance.

high-energy shock waves administered with ultrasound guidance during a single therapeutic session can safely produce clinical improvement by 3 months post treatment.

No long-term results available for control group.

<p>| Cosentino 2001 RCT | 6.0 N = 60 talalgia associated with heel spur with symptoms &gt;6 months, failure of other non-surgical treatments in past 6 months (non-specific); 3-month follow-up period | ESWT vs. sham. Active treatment 1200 impulses x 6 weekly treatments of 0.03-0.4 mJ/mm². Energy directed to enthesophytosis with ultrasound. No local used. Energy flux not clearly specified, may have been between 36 and 480 mJ/mm². Low to medium energy flux. No numerical statistics provided. ESWT significant decrease of VAS at rest, walking, after awakening and normal activity (p &lt;0.0001) at treatment end, at 1, 3 months. Control (Group 2) no significant decrease of VAS (p = 0.47) at these points. Enthesitis statistically significantly reduced in grade in intervention and compared to &quot;Our results confirm the presence and size of bony spurs do not correlate with clinical symptoms and that ESWT can, in our opinion, be considered the best treatment for painful heel with heel spurs, owing to its lack of side effects and because it is repeatable and non-invasive treatment. Randomization, allocation, baseline characteristics not well described. Blinding uncertain. No anesthesia used. Intervention group received variable levels of energy (0.03-0.4 mJ/mm²). Suggests ESWT more effective than placebo in pain scores after treatment, |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Participants</th>
<th>Control</th>
<th>Treatment</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mehra 2003</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 47 (23 plantar fasciitis, 24 tennis elbow); mean duration of symptoms 11 months; failure treatments: topical NSAIDs, steroid injection and/or surgery; 3 and 6 month follow-up</td>
<td>ESWT vs. sham. Active treatment – 2000 shocks of 2.5 bars of air pressure x 3 treatments at 2 week intervals. Local injection used. No guidance method reported.</td>
<td>Plantar fasciitis: mean pain score (13 patients ESWT) reduced from 5.9 to 1.9 at 6 months vs. 7.0 to 6.6 in control (no p-value provided); 12 patients (93%) showed significant improvement, 1 patient remained unchanged in treatment group. No improvement noted in control group.</td>
<td>“The mobile lithotripter is an effective form of treatment for tennis elbow and plantar fasciitis but warrants further larger studies.”</td>
</tr>
<tr>
<td>Ogden 2004</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 384 plantar fasciitis (symptom duration not described); failure of 2 physical methods or pharmacologic treatments; 12-month follow-up</td>
<td>ESWT vs. sham. Active treatment of 1500 shocks of variable energy (1400 at 0.22 mJ/mm²) in single session (total 324.25 J). Local block used. Guidance by point of maximal tenderness; 324 mJ/mm²; low energy flux.</td>
<td>ESWT vs. sham: completely successful treatment 3 months; 3 months after treatment, 67/144 (47%) vs. 42/141 (30%) (p = 0.008). 1 year; 65/67 ESWT maintained successful result. 36/51 (71%) of non-randomized patients had a successful result.</td>
<td>“The application of electrohydraulic high-energy shock waves to the heel is a safe and effective noninvasive method to treat chronic plantar fasciitis, lasting up to and beyond one year.”</td>
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</table>

FDA clinical trial. Multiple arms (randomized and non-randomized patients) combined in multiple analyses. Study similar to and may be same population as Ogden 2001. “Ankle-block” anesthesia used. Data suggest benefit of ESWT.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Criteria</th>
<th>Randomization</th>
<th>Allocation</th>
<th>Baseline Comparisons</th>
<th>Compliance</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rompe 1996</td>
<td>1996</td>
<td>RCT</td>
<td>N = 36 with persistent symptoms of painful heel. Calcaneal spur, symptoms &gt; 12 months, unsuccessful conservative therapy (not specified)</td>
<td>ESWT vs. sham. Active treatment – 1000 shocks of 0.06 mJ/mm² x 3 treatments at weekly intervals. No local used. Treatment guided by fluoroscopy; 60 mJ/mm²; low energy flux.</td>
<td>ESWT vs. sham (3, 6 weeks): Night pain % reduction from baseline; 58.2% vs. 13.6%, 57.4% vs. 8.1% (p &lt; 0.05). Resting pain % reduction from baseline: 75% vs. 36.6% (p &lt; 0.05), 79.6% vs. 33.8% (p &lt; 0.01). Walking ability rated 1 to 5. Increase of 171.4% in Group I after 6 weeks of 178.6%; after 12 weeks 200%; after 24 weeks 185.7%. Sham: 0% (p &lt; 0.0001) and 4.8% (p &lt; 0.0005) at 3, 6 weeks.</td>
<td>“We found a significant decrease of pain and an increase of walking ability compared with a control group. After cross-over had been finished, all but 9 patients had improved - 6 had become pain free - after ESWT, but, just as after surgery, the average time to maximum improvement was 6 months.”</td>
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<tr>
<td>Ogden 2001</td>
<td>2001</td>
<td>RCT</td>
<td>N = 302 with MSDs (260 random, 42 non-random) symptoms 6 months to 18 years; failed at least 3 conservative treatments; 1-year follow up</td>
<td>ESWT vs. sham. Active treatment of 1500 shocks of 18kV power in single session (repeat allowed in some cases). Local block used. Guidance by point of maximal tenderness.</td>
<td>ESWT vs. placebo (0, 12 weeks) VAS: 7.68 vs. 7.87, 3.13 vs. 4.37; Pain Self-assessment: 8.02 vs. 8.14, 3.48 vs. 4.20; Activity Self-assessment: 3.49 vs. 3.53, 1.72 vs. 1.88. No p-values provided between groups. Author states number of patients improved in all categories was significantly higher than placebo.</td>
<td>“The results suggest that this therapeutic modality should be considered before any surgical options, and even may be preferable to cortisone injection, which has a recognized risk of rupture of the plantar fascia and recurrence of symptoms.”</td>
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**rESWT vs. Sham**

**Study** is similar (may be same population as Ogden 2004). Randomization, allocation unclear. Lack of details for compliance, co-interventions; 42 non-randomized patients included for training. Unclear if results are clinically significant but suggest modest clinical global improvement after ESWT.
| Gerdesmeyer 2008 | 8.5 | N = 254 chronic plantar fasciitis with symptoms >6 months, failed 2 pharmacistial and 2 non-pharmacistial treatments; VAS >5 (0-10 scale); follow-up at 3 and 12 months | Radial ESWT (rESWT) vs. sham. Active treatment of 2000 impulses x 3 sessions 2 weeks apart of 0.16 mJ/mm². Energy applied without anesthesia to the spot of greatest tenderness; 320 mJ/mm²; low energy flux. | rEWST vs. placebo (VAS) % change from baseline: 12 weeks; -72.1 vs. -44.7, p = 0.0220, 12 months: -84.8 vs. -43.2, p = 0.0086; overall success heal pain (VAS), (n): 12 weeks ESWT (75) vs. placebo (49), p = 0.0020, 12 months ESWT (78) vs. placebo (51), p = 0.0014. Changes baseline to 12 weeks: SF-36 (%) -44.1 (-37.2±48.42) vs. -23.9 (-19.5±52.13), p = 0.0013; Roles & Maudsley Score excellent or good % -58.40 vs. 41.5, p = 0.0031; patient global judgment (very satisfied or moderately satisfied) % -63.16 vs. 46.36, p = 0.0045. “Radial ESWT demonstrated safety and effectiveness. Radial ESWT can be strongly recommended for patients with therapy-resistant plantar painful heel syndrome.” | No anesthesia used. Study performed by manufacturer for FDA approval of radial ESWT device. Randomization, allocation methods details sparse. Radial ESWT is alternative method of application with expanded energy field as compared to focused energy field of ESWT. |
| Rompe 2002 | 7.0 | N = 112 intractable plantar heel pain with symptoms for 6 to 20 months; failure for at least 6 months of conservati ve therapy; follow-up 3 and 6 | Three applications of 1000 impulses of low-energy shock waves of 0.08 mJ/mm² vs. those of three applications of ten impulses of low-energy shock waves; 80 mJ/mm²; low energy flux. | Scores for subjective variable for Group I vs. Group II: Modified Roles and Maudsley: (Excellent/Good at 6 months) 28/49 vs. 5/48, p < 0.0001. Night pain at baseline (N): 31±8 vs. 30±10; p = 0.8681. 6 months: 6±10 vs. 6±10. In conclusion, the current pilot study revealed dose-related effects of low-energy extracorporeal shock-wave therapy in patients with chronic plantar fasciitis. The therapy with three applications of 1000 impulses Pilot study. No anesthesia was used. Authors opine the modified Roles and Maudsley scale is not valid for the foot. Data suggest efficacy at 6 month follow-up. Efficacy at 5 years uncertain at 58% of low shock group. | "ESWT (Dose, Location, Frequency Studies)"
<table>
<thead>
<tr>
<th>Dorotka 2006 RCT</th>
<th>6.5 months, 5 years</th>
<th>Pain at rest (VAS) before ESWT / 6/ 12 weeks for Group 1 vs. Group 2: 67.0/ 83.8/ 74.6 vs. 67.7/ 104.5/ 119.0. No significant differences noted between Group 1 and 2.</th>
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<tbody>
<tr>
<td>N = 41 with chronic plantar fasciitis (radiologic evidence of heel spur), symptoms &gt;6 months; failed conservative treatment with at least 3 different therapeutic modalities; follow-up at 6 and 12 weeks</td>
<td>32±9; p &lt;0.0001. After 5 years: 4±8 vs. 11±15; p = 0.0015. Resting Pain at baseline: 27±14 vs. 26±14; p = 0.0890. 6 months: 7±10 vs. 25±13; p &lt;0.0001. After 5 years: 4±9 vs. 11±12; p = 0.0033.</td>
<td>appeared to be a useful, noninvasive treatment method with negligible side effects that reduced the necessity for a surgical procedure. Nevertheless, low-energy shock-wave application cannot be recommended as a first-line procedure for chronic heel pain.”</td>
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<tr>
<td>Location of heel spur for ESWT by fluoroscopy vs. patient location for ESWT by maximal point of tenderness; 80 mJ/mm².</td>
<td>had undergone surgery.</td>
<td>“We found no noticeable differences in the clinical outcome between the groups. However, due to the longer lasting therapy sessions and the burden of additional radiation with fluoroscopy, we recommend patient location as a safe and effective technique for positioning the focus of ESWT in the treatment of plantar fasciitis with a calcaneal spur.”</td>
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<tr>
<td>Both groups showed statistically significant improvement from baseline, although no difference between groups. Treatment protocol 1,000 impulses, lower than many other low energy ESWT studies. Lack of significant difference in localization suggests non-fluoroscopic technique is acceptable, if not preferred.</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
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<tr>
<td>Tornese 2008</td>
<td>5.5</td>
<td>RCT</td>
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<tr>
<td>Rompe 2005</td>
<td>10</td>
<td>RCT</td>
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steroid injections; follow-up 3 weeks, 3 and 12 months; (1.9-3.3), 2.4 (1.4-3.3); p < .001. Subjective rating scale [1-4]: 1.9 (1.6-2.2) vs. 1.2 (0.9-1.5), 0.7 (0.3-1.1); p < .001.

<table>
<thead>
<tr>
<th>ESWT vs. Other Therapies</th>
<th>Hammer 2002, 2003 RCT</th>
<th>N = 47 chronic proximal plantar fasciitis with symptoms 6 to &gt;12 months unsuccessful treatment of at least 6 months consisting of NSAIDs, heel cup, orthoses and/or shoe modifications, local steroid injections and electrotherapy (iontophoresis with diclofenac); follow-up 6, 12, 24 weeks</th>
<th>Three sessions of ESWT (3000 shockwaves/session of 0.2 mJ/mm²) at weekly intervals vs. in the patients of Group 2 treatment was continued for 12 weeks. Group 2 then were crossed-over to ESWT and followed for 2 years; 600 mJ/mm²; low energy flux.</th>
<th>VAS (Mean±SD) score decreased t = 0 to t = 24 weeks (p &lt;.01) in both groups without significant difference between groups. VAS score at rest baseline/6/12/24 weeks for Group 1: 34.0±27.1/13.8±26.0/11.8±19.8/2.0 ±25.9. Group 2: 43.1 ±26.9/18.8±29.8/10.2±24.4/5.0±20.4. Everyday life Group 1: 78.2±17.5/28.2±31.4/29.0±31.6/22.6 ±33.6. Group 2: 70.4 ±22.2/37.1±32.8/26.0 ±30.1/11.9±23.5</th>
<th>“ESWT was able to decrease pain and increase the comfortable walking time significantly in patients with previous unsuccessful nonsurgical treatment for proximal plantar fasciitis. Up to 80% of the patients experienced a complete or nearly complete pain relief after a follow-up of six months.”</th>
<th>ESWT group showed significant improvement over 24 month study. Control group showed no improvement over 12 weeks prior to crossover, where results became similar to ESWT group (no differences at last follow-up.)</th>
</tr>
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<tbody>
<tr>
<td>Porter 2005 RCT</td>
<td>N = 132 proximal plantar fasciopathy with symptoms present for at least 6 weeks; follow-up</td>
<td>ESWT 1000 impulses at 0.08mJ/mm² x 3 weekly sessions vs. Intraleisional corticosteroid injection. Inclusion criteria included symptoms of 6 months.</td>
<td>VAS pain scores, values for CSI (1.48; 0-7) significantly lower than ESWT (3.69; 0-8), and controls (3.58; 2-5) at 3 months. At 12 months, VAS scores for CSI</td>
<td></td>
<td>“Corticosteroid injection is more efficacious and multiple times more cost-effective than ESWT in the treatment of plantar fasciopathy that In this study both ESWT and CSI were used as first line therapy for acute symptoms. Results are therefore limited as no control for</td>
<td></td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>N</td>
<td>Inclusion Criteria</td>
<td>Methodology</td>
<td>Results</td>
<td>Comments</td>
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<tr>
<td>Greve 2009 <em>RCT</em></td>
<td>4.0</td>
<td>32</td>
<td>Plantar fascia &gt;4mm thickness on ultrasound; symptoms ≥3 months; follow-up immediately after treatment and 3 months</td>
<td>ESWT (3,000 impulses at unspecified energy density for 3 weekly sessions vs. physiotherapy (ultrasound 1.2 W/cm² twice weekly for 5 weeks plus stretching posterior leg; no energy flux specified.)</td>
<td>No differences in two groups in parameters of pain duration after treatment, morning pain, pain with gait, use of analgesics.</td>
<td>“The two evaluated treatments were effective for reducing pain and incapacitation among patients with plantar fasciitis for at least three months after treatment.”</td>
</tr>
<tr>
<td>Wang 2006 <em>Quasi-RCT</em></td>
<td>4.0</td>
<td>149 (168 heels) with chronic plantar fasciitis with symptoms for 6-38 months; follow-up 60-72 months</td>
<td>ESWT (1500 impulses at 0.32 mJ/mm² x single treatment) vs. conservative modalities. Outcomes measures reported at 3 to 6 years; 480 mJ/mm²; medium energy flux.</td>
<td>Nearly 25% of ESWT group required second treatment. ESWT vs. Control: Final VAS 0.2 vs. 4.2, p &lt;0.001. Mean function score (out of 30) - 29.6 (18-30) vs. 14.0 (10-17) p &lt;0.001.</td>
<td>“ESWT is a new therapeutic modality that can safely and effectively treat patients with plantar fasciitis, with good long term results.”</td>
<td></td>
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</table>

ESWT = extracorporeal shock wave therapy; CSI = cavitational shock wave therapy; NSAIDs = nonsteroidal anti-inflammatory drugs; PT = physical therapy; VAS = visual analog scale.

At 3 and 12 months duration; 80 mJ/mm²; low energy density. (0.84; 0-7) and ESWT (0.84; 0-4) both significantly lower than controls (2.42; 1-4). Tenderness values at 3 months significantly higher for CSI (9.42; 7-11) than both ESWT (6.72; 4-11) and controls (7.63; 6-9); p <0.05 used throughout. Of 64 heels that received CSI, no infections or cases of rupture of plantar fascia.

Natural history of improvement in this disorder. Effects of CSI are short term.
## Evidence for the Use of Iontophoresis for Plantar Fasciitis

There are 2 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osborne 2006</td>
<td>RCT</td>
<td>7.5</td>
<td>N = 31 medial calcaneal origin plantar fasciitis</td>
<td>0.4% dexamethasone vs. placebo (0.9% NaCl) vs. or 5% acetic acid. All groups with LowDye taping. 6 treatments over 2-week period. Final outcome at 2-weeks post treatment.</td>
<td>Numerical statistics not provided. Placebo/taping and acetic acid/taping groups significantly better than dexamethasone/taping for morning pain relief and reduction of worst pain in past 2 days at end of treatment. At 2 weeks post-treatment, no difference between groups in pain ratings, although placebo/taping lost all gains from baseline. No difference in functional improvement between dexamethasone/taping and acetic acid/taping at 4 weeks, but significant difference between AA/Taping and placebo/taping (p = 0.031).</td>
<td>“Six treatments of acetic acid iontophoresis combined with taping gave greater relief from stiffness symptoms than, and equivalent relief from pain symptoms to, treatment with dexamethasone/taping. For the best clinical results at four weeks, taping combined with acetic acid is the preferred treatment option compared with taping combined with dexamethasone or saline iontophoresis.”</td>
<td>Co-intervention of stretching (gastrocnemius/soleus). Small sample size with questionable baseline differences in duration of disease. Data results are of unknown clinical significance.</td>
</tr>
<tr>
<td>Gudeman 1997</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 40 feet with plantar fasciitis</td>
<td>Group I: feet treated with traditional modalities and placebo iontophoresis. Group II: feet</td>
<td>Group II had significantly greater improvement between pre-treatment and immediate post treatment than Group I; increase of 6.8±5.6 for Group II and 3.0±4.1 for Group I. At 1-month follow-up, no significant difference between</td>
<td>“Based on these results, iontophoresis of dexamethasone for plantar fasciitis should be considered when more immediate results are needed.”</td>
<td>Randomization and allocation unclear. Possible baseline difference in outcome measure. Baseline pain</td>
</tr>
</tbody>
</table>
received traditional modalities plus iontophoresis with dexamethasone.

groups. Difference in increase (control vs. treatment groups) between pre- and post testing statistically significant (p = 0.022), but difference in increase between pre- and follow-up testing not significant (p = 0.434).

scores were mostly of mild severity.

Evidence for the Use of Low-level Laser Therapy for Plantar Fasciitis
There are 2 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kiritsi 2010 RCT</td>
<td>7.0</td>
<td>N = 30 unilateral plantar fasciitis</td>
<td>904 nm gallium-arsenide (GaAs) laser vs. sham laser, 18 sessions (3 x a week for 6 weeks).</td>
<td>LLLT vs. sham: VAS night rest 48±9.4 to 21±24.3 vs. 49±9.4 to 38±10.3 p = 0.000 favoring LLLT change; VAS Daily Activities - 67±8.3 to 28±24.4 vs. 67±9.3 to 50±15.9, p = 0.001 favoring LLLT.</td>
<td>“We believe that 904 GaAs infrared (IR) laser therapy may contribute to plantar fasciitis healing and pain reduction. At this point, we should state that LLLT warrants further study as a treatment for plantar fasciitis.”</td>
<td>Small sample size with 1/3 of control group withdrawing related to non-treatment reasons. Duration of baseline symptoms unknown, although inclusion criteria were 6 weeks or longer. No comparison of symptom duration between groups provided. Conclusions therefore limited.</td>
</tr>
<tr>
<td>Basford 1998 RCT</td>
<td>6.5</td>
<td>N = 32 plantar fasciitis &gt;1 month duration</td>
<td>30mW .83µm gallium aluminum arsenide (GaAlAs) laser vs. placebo.</td>
<td>No significant differences over study period between groups in terms of pain severity in morning, duration of painful walking on rising, exam, or medication, orthotic use.</td>
<td>“Low-intensity IR laser therapy appears safe but, at least within the parameters of this study, is not beneficial in the treatment of plantar fasciitis.”</td>
<td>Randomization, allocation not described. Possible co-interventions of NSAIDs, orthoses. Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Manipulation for Plantar Heel Pain
There are 2 moderate-quality RCTs incorporated into this analysis.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Cleland 2009</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 60 (age 18 to 60) with chronic plantar heel pain</td>
<td>Manual physical therapy soft tissue mobilization, joint mobilization, manipulation) and ankle eversion exercises (MTEX) (n = 30) vs. electrophysical agents (iontophoresis with dexamethasone, ultrasound, and stretching/strengthening (EPAX) (n = 30); therapies 2 times week for 2 weeks, then once a week for 2 weeks.</td>
<td>EPAX vs. MTEX: 4, 26 weeks; Improvement in Lower Extremity Function Scale (LEFS- 0-80, higher is better): 7.5 vs. 21.0; p = 0.001; 12.9 vs. 22.8, p = 0.027. Improvement on Pain Scale from baseline (0-10) -1.4 vs. -2.9, p = 0.08; -2.8 vs. -3.4, p = 0.39.</td>
<td>“The results of this study provide evidence that MTEX is a superior management approach over an EPAX approach in the management of individuals with plantar heel pain at both the short- and long-term follow-ups. Future studies should examine the contribution of the different components of the exercise and manual physical therapy programs.”</td>
<td>Multiple co-interventions used and lack of details for compliance to exercise/stretching regimens. Significance levels set by minimal clinically important difference for disability scores (9 points on scale). Study suggests both groups improved, but mobilization group demonstrated better disability scores. Actual clinical significance uncertain. Baseline pain scores moderate, and although change in score (improvement) significant at 6 weeks; clinical significance of VAS score of 3 vs. 2 is small.</td>
</tr>
<tr>
<td>Dimou 2004</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 20 chronic plantar fasciitis</td>
<td>Manipulation (chiropractic adjustments twice weekly x 4 weeks) plus Achilles stretching (3 sessions daily) vs. orthotics.</td>
<td>Intergroup comparisons: Pain: no differences at Day 1, 1 or 2 months. Heel pain (leisure, work, sports); no differences at any interval.</td>
<td>“With the small sample size and methodological limitations of this trial, no firm conclusions can be drawn...[B]oth treatments appeared useful when used individually.”</td>
<td>Lack of study details. Range of symptom duration was wide (8 weeks to 5 years). Small sample size with low power. Results inconclusive.</td>
</tr>
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</table>

**Evidence for the Use of Massage and Soft Tissue Mobilization for Plantar Fasciitis**

There is 1 moderate-quality RCT incorporated into this analysis.
### Evidence for the Use of Therapeutic Ultrasound for Plantar Fasciitis

There are 2 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Crawford 1996</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 19 with plantar heel pain (26 heels)</td>
<td>Ultrasound vs. placebo (0.5 W/cm2, 3 MHz, pulsed for 8 minutes); 8 treatments.</td>
<td>VAS ESWT vs. placebo: 6.7 vs. 7.5, 4.5 vs. 5.6 p &gt;0.05</td>
<td>&quot;Therapeutic ultrasound (at dosage described) is no more effective than placebo in the treatment of plantar heel pain.&quot;</td>
<td>Randomization, allocation methods unclear. Study details sparse. Treatment for 4 weeks. Data suggest no benefit from ultrasound at stated dosage.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Radiation Therapy for Plantar Heel Pain

There is 1 moderate-quality RCT incorporated into this analysis.

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<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heyd 2007</td>
<td>5.0</td>
<td>N = 130 with painful heel spurs</td>
<td>Total dose of 3.0 Gy given in 2 weekly fractions of 0.5 Gy (low dose [LD] group) vs. total dose of 6.0 Gy using 2 weekly fractions of 1.0 Gy (high dose [HD] group).</td>
<td>No statistically significant difference between both study groups</td>
<td>“Our prospective study demonstrated an equivalent efficacy of both fractionation schedules. More clinical and experimental trials are needed for evaluation of the minimum effective dose and optimization of the dose-fractionation schedules in anti-inflammatory RT.”</td>
<td>Allocation method unclear. No control for co-interventions noted. No placebo group.</td>
</tr>
</tbody>
</table>
**Evidence for the Use of Autologous Blood Injections for Plantar Fasciitis**

There are 3 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Injection Therapies – Autologous Blood vs. Glucocorticosteroid</strong></td>
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<tr>
<td><strong>Lee 2007</strong></td>
<td>5.5</td>
<td>N = 64 with chronic plantar fasciitis</td>
<td>Autologous blood 1.5mL vs. 20mg triaminolone acetonide.</td>
<td>Mean VAS score at 0, 6 weeks, 3 months, 6 months for blood vs. steroid: 7.3±1.8 vs. 6.9±1.7 p = .3; 4.6±2.3 vs. 2.9±2.8 p = 0.011; 4.3±2.7 vs. 2.3±2.6 p = 0.005, 3.6±2.6 vs. 2.4±3.0 p = 0.094. Mean tenderness threshold scores at 0, 6 weeks, 3 months, 6 months for blood vs. steroid: 3.1±1.2 vs. 3.7±2.9 p = 0.167; 4.1±1.8 vs. 6.4±3.5 p = 0.003; 5.5±2.7 vs. 7.9±3.2 p = 0.003; 6.5±2.9 vs. 8.6±3.1 p = 0.008. Over 6-month follow-up, significant reduction in pain levels noted in both groups (p &lt; 0.0001).</td>
<td>“Intralesional autologous blood injection is efficacious in lowering pain and tenderness in chronic plantar fasciitis, but corticosteroid is more superior in terms of speed and probably extent of improvement.”</td>
<td>No placebo. Lack of blinding. Many co-interventions (rest, NSAIDs, stretching, repeat injections). Data suggest steroids more effective in short term for pain relief.</td>
</tr>
<tr>
<td><strong>Kalaci 2009</strong></td>
<td>5.5</td>
<td>N = 100 with plantar fasciitis</td>
<td>Group A: 2mL autologous blood only vs. Group B: anesthetic (2mL lidocaine) combined with peppering vs. Group C: corticosteroid (2mL triaminolone) only vs. Group D: corticosteroid (2mL triaminolone) combined with peppering.</td>
<td>Pain in affected heel on a 10-cm VAS at 6 months (mean ± SD): Group A (3.5±3.06) vs. Group B (3.40±2.88) vs. Group C (1.52±2.14) vs. Group D (0.96±1.24). All improved from baseline (p = 0.000). C+D more effective than A+B (p &lt;0.05). No difference between C+D. Modified roles/Maudsley score at 6 months: Group C, excellent and good 20/25; Group D, excellent and good 22/25, p = 0.24.</td>
<td>“[C]orticosteroid injection with peppering can be used as a first alternative in plantar fasciitis in cases in which other conservative methods failed.”</td>
<td>Data suggest steroids equally effective with and without peppering from presented data. No placebo arm.</td>
</tr>
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</table>
Kiter 2006 RCT 5.5 N = 45 with plantar heel pain

Peppering (10-15 injections with local) vs. autologous blood (2mL) vs. methylprednisolone acetate 40mg injection (all allowed up to 3 injections at monthly interval) followed for 6 months.

Peppering vs. autologous blood vs. steroid VAS (0-10): baseline 6.4±1.1 vs. 7.6±1.3 vs. 7.28±1.2. VAS: 6 months 2.2±2.2, 2.4±1.8, 2.57±2.9. All intragroup changes p <0.001, intergroup not significant.

“[P]eppering technique and autologous blood injection seem to be good alternatives to corticosteroid injection for the treatment of plantar heel pain, although the mechanism of cure is not completely understood.”

Small sample size for each arm. Randomization by drawing lots. Author states demonstrated improvement in all groups, and therefore equal efficacy of treatment, but no placebo, limiting conclusions.

Evidence for the Use of Botulinum Toxin A Injections for Plantar Fasciitis

There are 4 moderate-quality RCTs incorporated into this analysis. (Babcock 05; Peterlein 12; Huang 10; Elizondo-Rodriguez 13)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Injection Therapies – Botulinum Toxin A vs. Placebo</td>
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<tr>
<td>Babcock 2005 RCT</td>
<td>6.5</td>
<td>N = 27 (43 feet) with plantar fasciitis</td>
<td>Botulinum toxin A 70 units vs. saline placebo.</td>
<td>Mean P-VAS pain scale score at 0, 3, 8 weeks for BTX-A vs. placebo: 5.1/2.7/1.6 vs. 4.9/4.7/4.4. Mean MFS score: 44/72/81 vs. 46/49/54. Compared with placebo injections, Botulinum toxin A group improved in all measures: Pain VAS (p &lt;0.005), Maryland Foot Score (p = 0.001), Pain relief VAS (p &lt;0.0005), pressure algometry response (p = 0.003).</td>
<td>“Botulinum toxin A injection for plantar fasciitis yields significant improvements in pain relief and overall foot function at both 3 and 8 weeks after treatment.”</td>
<td>Data suggest Botulinum toxin A is effective for plantar fasciitis, although sample size is low, due to significant difference found at mid-study evaluation and subsequent termination of recruitment.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Study Design</td>
<td>Patient Selection</td>
<td>Treatment</td>
<td>Duration</td>
<td>Outcome Measures</td>
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<tr>
<td>Peterlein</td>
<td>2012</td>
<td>RCT</td>
<td>N = 40 with refractory plantar fasciitis for 4+ months and at least 2 previous conservative treatment fails. Median age 51.5 years.</td>
<td>BoNT-A 200 units in 2 mL 0.9% saline solution (n = 20) vs. saline placebo 2 mL (n = 20). Study duration: 18 weeks. Concomitant treatment prescribed for study was continued. Follow-up at baseline week 2, 6, 10, 14, and 18.</td>
<td>There were no significant differences between groups.</td>
<td>“In our study, we showed that fan-shaped local injections with 200 units of BoNT-A (Dysport) on the origin of the plantar fascia may decrease the 6-week pain score (VAS) and 18-week pain intensity, but this was not statistically significant when compared with the placebo group in patients with refractory plantar fasciitis.”</td>
</tr>
<tr>
<td>Huang</td>
<td>2010</td>
<td>RCT</td>
<td>N = 50 chronic unilateral plantar fasciitis</td>
<td>Botulinum toxin A 50 units vs. saline placebo under ultrasound guidance.</td>
<td>BTX-A vs. placebo 0, 3 weeks, 3 months. VAS (0-10): 5.9/3.4/2.0 for BTX-A group vs. 5.4/5.1/5.2 for placebo, p &lt;0.001. Plantar fascia thickness (mm): 5.5/4.2/3.6mm for BTX-A vs. 5.5/5.6/5.6mm for placebo, p &lt;0.001.</td>
<td>“Treatment of unilateral plantar fasciitis with [BTX-A] led to significant pain relief and a reduction in the plantar fascia thickness 3 weeks and 3 months post-injection.”</td>
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</table>

Multicenter study with relatively small N and meaningful dropout. Data do not support treatment.
**Evidence for the Use of Injected Glucocorticosteroids for Plantar Fasciitis**

There are 6 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in the appendix.(226) (Lynch 98)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Crawford 1999 RCT</td>
<td>7.5</td>
<td>N = 106 with heel pain</td>
<td>Prednisolone acetate (25mg) plus 1ml of 2% lignocaine vs. 25mg</td>
<td>Mean heel pain scores at baseline/1/3/6 months for local anesthetic alone: 46.0±14.83 vs. 46.8±11.2 (NS)/93.2±9.31 vs. 74.8±10.29 (p = 0.0000006).</td>
<td>A steroid injection can provide relief from heel pain in the short term.</td>
<td>Large drop-out rate, 48% at 6 months. Patients allowed to continue co-</td>
</tr>
<tr>
<td>Study (Year)</td>
<td>N</td>
<td>Interventions</td>
<td>Outcomes</td>
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<tr>
<td>Blockey 1956</td>
<td>6.0</td>
<td>Hydrocortisone acetate 25mg injection vs. saline.</td>
<td>Steroid vs. saline group: relief at 1 week: 4/13 vs. 1/9. Relief at 2 months: 6/13 vs. 4/9. No statistical analysis provided but author states not significant.</td>
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</tr>
<tr>
<td>Kalaci 2009</td>
<td>5.5</td>
<td>Group A: 2mL autologous blood only vs. Group B: anesthetic (2mL of lidocaine) combined with peppering vs. Group C: corticosteroid</td>
<td>Pain in affected heel on a 10cm VAS at 6 months (mean ± SD): Group A (3.53±3.06) vs. Group B (3.40±2.88) vs. Group C (1.52±2.14) vs. Group D (0.96±1.24). All outcomes favor steroid at 1 month (p = 0.02).</td>
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</table>

5.5±2.1/4.0±2.9/3.7±3.3/3.3±2.7. Corticosteroid plus LA plus tibial nerve block: 5.5±2.1/4.5±2.6/3.4±2.7/2.5±3.2. Corticosteroid and LA: 5.6±2.3/2.9±2.5/3.6±2.8/2.4±2.6. Local anesthetic plus tibial nerve block: 5.8±2.8/5.3±2.9/3.1±2.7/0.6±1.1. Outcomes favor steroid at 1 month (p = 0.02).

Interventions although analysis controlled for covariates. Statistical methods and analytical approach not specified. Data suggest glucocorticosteroid injection modestly superior to placebo.

Randmization, allocation methods unclear. Baseline comparisons not provided. All subjects given heel cups. One-hundred percent follow-up although at variable number of months for final visit (6-18 months). Small sample size. Data suggest no benefit from 25mg hydrocortisone, which may have been a suboptimal dosage.

Data suggest steroids appear equally effective with and without peppering from presented data. No placebo arm.

“Hydrocortisone acetate may be the best substance to inject, but its advantage over saline has not been proved in this series.”
<table>
<thead>
<tr>
<th>Glucocorticosteroid Injection vs. Other Treatments</th>
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<tbody>
<tr>
<td><strong>Porter 2005</strong> RCT</td>
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</table>

| **Kriss 2003** RCT | **4.5** | **N = 76** | Unilateral heel pain | Soft anti-pronatory pad vs. steroid injection (20 mg triamcinolone hexacetonide) vs. both; 6-month follow-up period. | Mean difference in VAS Week 0, 1, 4, 8, 12, 24 (injection vs. injection plus pad vs. pad): Baseline: 76.1 vs. 66.3 vs. 71.7 p = 0.1; Week 1: -51.5 vs. -36.5 vs. -18.4 p = 0.001; Week 4: -65.3 vs. -49.3 vs. -20.3 p = 0.001; Week 8: -65.0 vs. -52.1 vs. -30.9 p = 0.05; Week 24: -63.7 vs. -61.3 vs. -50.6 p = 0.1. Difference in pain relief between 2 | “Patients had significant and immediate pain relief following injection. This was maintained for the 6-month trial period. Orthoses also alleviate symptoms but within this trial group the benefit is delayed.” |

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(2mL of triamcinolone only vs. Group D: corticosteroid (2 mL of triamcinolone) combined with peppering. Triamcinolone salt and dose not specified. 6-month follow-up. improved from baseline (p = 0.000), C+D more effective than A+B (p <0.05). No difference between C+D. Modified roles and Maudsley score at 6 months: Group C, excellent and good 20/25; Group D, excellent and good 22/25, p = 0.24. which other conservative methods failed.”

**Glucocorticosteroid Injection vs. Other Treatments**

Porter 2005

- **RCT**
- **6.5**
- **N = 132**
- Plantar fasciopathy present for at least 6 weeks; follow-up at 3 and 12 months
- Low-energy ESWT vs. intralesional corticosteroid injection. ESWT - 3 applications of 1000 pulses 0.08/mm² flux density; Injection of 5.7 mg betamethasone (salt not specified) into maximal tender point.
- VAS Scores at 0, 3, 12 months post treatment CSI: 5.47 (2-8), 1.48 (0-7), 0.84 (0-7); ESWT: 5.52 (3-8), 3.69 (0-8), 0.84 (0-4) p<0.05 at 3 months only favoring CSI TT (tenderness threshold, 0.3-12 months); CSI: 5.3 (1-11), 9.42 (7-11), 9.6 (7-11); ESWT: 5.2 (3-7), 3.69 (0-8), 9.54 (5-11); p>0.05 for all measurements
- “Once plantar fasciopathy has persisted for more than 6 weeks, intralesional corticosteroid injection is more effective than ESWT within the first 3 months with regard to pain and tenderness, but at 12 month follow-up, there is no difference between the 2 treatments.”

Kriss 2003

- **RCT**
- **4.5**
- **N = 76**
- Unilateral heel pain
- Soft anti-pronatory pad vs. steroid injection (20 mg triamcinolone hexacetonide) vs. both; 6-month follow-up period.
- Mean difference in VAS Week 0, 1, 4, 8, 12, 24 (injection vs. injection plus pad vs. pad): Baseline: 76.1 vs. 66.3 vs. 71.7 p = 0.1; Week 1: -51.5 vs. -36.5 vs. -18.4 p = 0.001; Week 4: -65.3 vs. -49.3 vs. -20.3 p = 0.001; Week 8: -65.0 vs. -52.1 vs. -30.9 p = 0.05; Week 24: -63.7 vs. -61.3 vs. -50.6 p = 0.1. Difference in pain relief between 2
- “Patients had significant and immediate pain relief following injection. This was maintained for the 6-month trial period. Orthoses also alleviate symptoms but within this trial group the benefit is delayed.”

**Randomization methods unclear. All had stretching as co-intervention. No true placebo included (compared with non-enrolled subjects). Effects of CSI appear short term. Inclusion criteria for most ESWT studies include failure of conservative treatment. In this case it was 1st line therapy.**
steroid groups and pad-only group stayed statistically significant for 4 months.

<table>
<thead>
<tr>
<th>Glucocorticosteroid Injection by Palpation vs. Imaging</th>
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<tbody>
<tr>
<td><strong>Author/Year</strong></td>
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<tr>
<td>Yucel 2009 RCT</td>
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</table>

*Evidence for the Use of Platelet Rich Plasma for Plantar Fasciitis*
There are no quality trials evaluating the use of platelet rich plasma injections for plantar fasciitis.

*Evidence for the Use of Cryosurgery for Plantar Fasciitis*
There are no quality trials incorporated into this analysis.

*Evidence for the Use of Intracorporeal Pneumatic Shock Therapy for Plantar Fasciitis*
There is 1 high-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<tbody>
<tr>
<td>Dogramaci 2010 RCT</td>
<td>8.5</td>
<td>N = 50 clinically and radiologically confirmed plantar fasciitis</td>
<td>Intracorporeal pneumatic shock wave (IPST) vs. sham.</td>
<td>VAS ESWT vs. sham (0, 3 weeks, 6 months) 8.92 vs. 9.12, 2.60 vs. 5.04 p = 0.000, 2.04 vs. 7.16 p = 0.000; *Pneumatic lithotripter may be used safely and effectively in the treatment of chronic PF.</td>
<td>Chronic patients assessed at 3, 6 months. No mention of control for co-interventions. Data suggest...</td>
<td></td>
</tr>
</tbody>
</table>
### Evidence for the Use of Percutaneous Bone Fenestration for Plantar Heel Pain

There are no quality trials incorporated into this analysis.

### Evidence for the Use of Surgery for Plantar Fasciitis

There are no quality trials incorporated into this analysis.

### Evidence for the Use of Patient Education and Temperature Monitoring

There are 4 moderate-quality RCTs incorporated into this analysis. (Lavery 07; Lincoln 08; Corbett 03; Borges 08) There is 1 low-quality RCT in the Appendix. (Donohoe 00)

<table>
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<tr>
<th>Author/Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Lavery 2007</td>
<td>RCT, multicenter trial</td>
<td>6.0</td>
<td>N = 173 with diabetic foot ulceration. Age range 40 – 80 years.</td>
<td>Standard therapy group: lower extremity evaluation by physician every 8 weeks, an education program about foot complications and self-care practices, and therapeutic insoles and footwear (n = 58) vs Structured foot exam group: standard therapy in addition to training to</td>
<td>Significant difference in times to develop ulcers (p = 0.011). Enhanced therapy significantly different from both standard therapy (p = 0.0059) and structured foot exam (p = 0.0055). Trend of survival better in enhanced therapy than standard therapy or structured foot exam (p = 0.0107). Decrease in risk</td>
<td>“Infrared temperature home monitoring, in serving as an “early warning sign,” appears to be a simple and useful adjunct in the prevention of diabetic foot ulcerations.”</td>
<td>Enhanced therapy group had fewer ulcers than other 2 groups and the other groups were 4 and 5 times more likely to develop ulcers.</td>
</tr>
</tbody>
</table>
conducted a structured foot inspection twice a day using a mirror to see the bottom of foot (n = 56) vs Enhanced therapy group: digital infrared thermometer to measure and record temperatures on each foot (n = 59). Follow-up for 15 months.

<p>| Lincoln 2008 RCT | 6.0 | N = 172 with diabetes and recently healed foot ulcers. Mean age 63.5 [12.1] years in the intervention group and 64.9 [10.9] years in control group. | Intervention group: education program (n = 87) vs Control group: usual care (n = 85). Follow-up 6 and 12 months. | At 12 months, intervention group followed more foot care behaviours vs control group (median score: 42.0 vs. 38.7, p = 0.03). No significant difference in ulcer incidence at 6 (intervention 30%, control 21%) and 12 months (intervention 41%, control 41%). | “Even though the intervention was associated with improved foot care behaviour, there was no evidence that this programme of targeted education was associated with clinical benefit in this population when compared with usual care. The usefulness and optimal delivery of education to such a high-risk group requires further study.” | No apparent benefit in one on one education in prevention of diabetic foot ulcers. |</p>
<table>
<thead>
<tr>
<th>Study</th>
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</tr>
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<tbody>
<tr>
<td>Corbett 2003</td>
<td>RCT, prospective</td>
<td>4.5</td>
<td>N = 40 with type 2 diabetes. Age range 26 – 91 years.</td>
<td>Educational intervention: foot care education (n = 20) vs Control group (n = 20). Follow-up for 6 and 12 weeks.</td>
<td>At baseline, risk for lower-extremity ulceration was high. Foot risk score 1.88 at baseline, 1.97 at 6 weeks, 1.87 at 12 weeks. At 12 weeks, intervention group had greater foot care knowledge (p = 0.029) and improved self-care practices (p = 0.007) vs. control group. At 12 weeks, intervention group improved significantly in self-efficacy (p = 0.014), reported foot self-care practices (p = 0.003), and foot care knowledge (p = 0.007).</td>
</tr>
<tr>
<td>Borges 2008</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 167 with type 2 diabetes who lived in a predominantly Mexican American community. Mean age 61.5 (11.4).</td>
<td>Intervention Group: 15-min intervention designed to improve diabetes self-efficacy and foot self-care behaviors (n = 55) vs Risk Assessment Group: 5-min foot risk assessment using a monofilament (the LEAP Abbreviated Diabetes Foot</td>
<td>Significant increase of the foot self-care knowledge score after follow-up within control group (p &lt; 0.05). Diabetes self-efficacy scores high at baseline and remained high after follow-up in all groups. There was a significant increase of diabetes self-efficacy score within control.</td>
</tr>
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</table>

“Recommendations for foot care education to prevent foot pathology indicate that the intervention should be simple, relevant, consistent, and repeated. Brief interventions delivered as patients interact with...”

Significant difference regarding foot self care behaviors between groups at 1 month follow-up suggested that a brief education intervention may lead to increased preventive diabetic behaviors.
Evidence for the Use of Wound Dressings

There is 1 high (Sibbald 12) and 4 moderate-quality RCTs (Jeffcoate 09; Jude 07; Trial 10; Piaggesi 10) incorporated into this analysis. There are 3 low-quality RCTs in the Appendix. (Veves 02; Jacobs 08; Shukrimi 08)

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</thead>
<tbody>
<tr>
<td>Sibbald 2012</td>
<td>8.5</td>
<td>N = 45 with leg and foot ulcers.</td>
<td>Polyhexamethylene biguanide (PHMB) foam</td>
<td>Bacteriology at week 4 (polymicrobial)</td>
<td>“PHMB foam dressing successfully”</td>
<td>Pilot RCT suggesting PHMB</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Participants</td>
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<tr>
<td>RCT</td>
<td>No mention of CO or Sponsorship</td>
<td>Mean±SD age was 55.8±13.13 years. dressing (n=22) (vs. non-antimicrobial foam (n = 23). Follow-up 5 weeks. organisms): detected in 5.3% of wounds treated with PHMB foam dressing vs. 33% control foam, p = 0.04). reduced chronic wound pain and bacterial burden.</td>
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<tr>
<td>Jeffcoate 2009</td>
<td>RCT</td>
<td>N = 317 with type 1 or type 2 diabetes with a chronic full-thickness foot ulcer, for at least 6 weeks and over age 18 or mean age was 60 years. N-A or a non-adherent, knitted, viscose filament gauze (n = 106) vs. Inadine or an iodine-impregnated dressing both traditional dressings (n = 108) vs. Aquacel a newer product or hydrocolloid preparation (n = 103). Follow-up for 24 weeks.</td>
<td>At 12 weeks, incidences of healing for 3 dressings were; N-A/Inadine/Aquacel; 25.5%/29.6%/ and 28.2%. At week 24, number of ulcers managed in each group; N-A/Inadine/Aquacel; 30%/50%/55%. Overall healing rates for 3 dressings were: N-A/Inadine/Aquacel; 39%/44% and 45%. “As there was no difference in effectiveness, there is no reason why the least costly of the three dressings could not be used more widely across the UK National Health Service, thus generating potentially substantial savings.”</td>
<td>Large sample size. High dropouts. Data suggest no difference in healing rates.</td>
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</tr>
<tr>
<td>Jude 2007</td>
<td>RCT</td>
<td>N = 134 with non-ischaemic diabetic foot ulcer resulting from Type 1 or 2 diabetes mellitus or DM, all wounds ≥1cm². Mean age in AQAg and CA group; 58.9 ± 1.6 / and 61.1 ± 11.4. AQAg, AQUACEL® Hydrofiber® dressing group, with 1.2% ionic silver left in place for up to 7 days (n = 67) vs. CA or Algosteril® calcium alginate dressing group, instructed to moisten it before use on dry wounds and to change daily (n = 67). Heaping efficacy; primary endpoint, healing speed, similar in AQAg-dressed and CA-dressed wounds; AQAg, (p = 0.993). 21 in AQAg group healed vs 15 in CA during 8 weeks. Wound infection; median time for clinical infection to resolve without recurring for AQAg and CA: 9 days for eight (88.9%) AQAg-</td>
<td>“When added to standard care with appropriate off-loading, AQAg silver dressings were associated with favourable clinical outcomes compared with CA dressings, specifically in ulcer depth reduction and in infected ulcers requiring antibiotic treatment.”</td>
<td>Ulcer depth was significantly decreased in Hydrofiber group compared to CA group (p = 0.04) but other outcome measures did not show statistical significance.</td>
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<tr>
<td>Study</td>
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<tr>
<td>Trial 2010</td>
<td>2010</td>
<td>RCT</td>
<td>N = 42 with locally infected chronic wounds, one of which is diabetic foot ulcers. The mean age was 68.9 for women and 66.5 for men.</td>
<td>Askina Calgitrol Ag or test dressing consists of a proprietary ionic silver alginate matrix and an absorbent polyurethane foam layer (n = 20) vs. Algosteril standard silver-free alginate dressing controlled and sustained over 72 hours (n = 22).</td>
<td>Diabetic foot ulcers in 29% of participants. Chronic wounds: pressure ulcers (57%) or venous or mixed aetiology leg ulcer (29%); few acute wounds (14%). Clinical scores of infection decreased significantly in both groups at day 15, 3.8± 2.9 in Askina Calgitrol Ag, (p = 0.001) vs 3.8±3.4 in Algosteril group, (p = 0.007). No adverse events recorded during study.</td>
<td>“The regression of local signs of infection, local tolerance, acceptability and usefulness were similar for the two dressings.”</td>
</tr>
<tr>
<td>Piaggesi 2010</td>
<td>2010</td>
<td>RCT</td>
<td>N = 40 patients with diabetic ulcers greater than 5 cm2 area; Mean age was 62.05 years.</td>
<td>Group A treated with daily instillation of Dermacyn Wound Care (DWC) solution in amounts varying from 5-20mL (n = 20)</td>
<td>Healing rate (complete closure) at 6 months: 90% in Group A vs. 55% in group B (p = 0.002). Average healing time 10.5 weeks in</td>
<td>“The data from this study permit the observation that DWC should be considered as part of the integrated therapeutic approach.”</td>
</tr>
</tbody>
</table>

Follow-up for 8 weeks.

resolved infections and 15 days, (p = 0.35) for 10 (76.9%; p = 0.48) CA resolved infections. Safety: Of AQAg patients, 25 (37%) experienced 1 or more adverse events, vs 26 (39%) of CA patients.

Follow-up for 1 and 15 days.

N = 40 with diabetic foot ulcers. The mean age was 62.05 years. | Healing rate (complete closure) at 6 months: 90% in Group A vs. 55% in group B (p = 0.002). Average healing time 10.5 weeks in | “The data from this study permit the observation that DWC should be considered as part of the integrated therapeutic approach.” | Data suggest faster healing. |
Evidence for the Use of Negative Pressure Therapy (Vacuum Devices)
There are 6 moderate-quality RCTs incorporated into this analysis. (Blume 08; Armstrong 12; Vuerstaek 06; Lavery 14; Armstrong 05; Moues 04) There is 1 low-quality RCT in the Appendix. (Mars 08)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Blume 2008</td>
<td>RCT</td>
<td>7.0</td>
<td>N = 341 with diabetes a stage 2 or 3 calcaneal, dorsal, or plantar foot ulcer ≥ 2 cm². Mean age of 58 years.</td>
<td>Negative pressure wound NPWT therapy or vacuum-assisted closure (n = 172) vs. Advanced moist wound therapy or AMWT, predominately hydrogels and alginates (n = 169). Follow-up at 3 and 9 months.</td>
<td>NPWT group significantly greater for complete ulcer closure vs AMWT group; 73/169 [43.2%] vs. 48/166 [28.9%], (p = 0.007). Fewer amputations observed in NPWT group or 4.1% vs AMWT group or 10.2%, (p = 0.035). Home care therapy days to total therapy days for NPWT was 9,471 of 10,579 (89.5%) vs 12,210 of 12,810 (95.3%) for AMWT.</td>
<td>“NPWT appears to be as safe as and more efficacious than AMWT for the treatment of diabetic foot ulcers.”</td>
<td>Total wound closure in NPWT group 43.2% vs. AMWT 28.8% at 112 days.</td>
</tr>
<tr>
<td>Armstrong 2012</td>
<td>RCT, multicenter, prospective</td>
<td>6.5</td>
<td>N = 132 with noninfected, nonischemic, nonplantar lower extremity diabetic and</td>
<td>The ultraportable mechanically powered Smart Negative Pressure (SNaP) Wound Care System vs Electrically</td>
<td>SNaP group demonstrated non-inferiority vs. VAC group at 4, 8, 12, and 16 weeks: -33.08±68.46 vs. -</td>
<td>“[T]his study provides prospective, randomized controlled trial evidence that treatment of</td>
<td>Similar efficacy between groups at all time points up to 16 weeks.</td>
</tr>
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</table>
Sponsored by Spiracur, Inc. COI, two authors (DGA and WAM) have received research funding from both Spiracur, Inc. and KCI.

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Vuerstaek 2006 RCT</td>
<td>5.5</td>
<td>N = 60 with chronic leg ulcers of &gt;6 months duration. Age for SWC/VAC groups: 23 (77)/ 23 (77).</td>
<td>Vacuum-assisted closure (VAC) group applied to wound during preparation stage, permanent negative pressure of 125 mmHg exerted (n = 30) vs. Therapy or SWC group, conventional wound care techniques (n = 30).</td>
<td>Treatment by VAC associated with significant faster time to complete healing, HR = 3.2; 95% CI, 1.7 – 6.2, (p &lt; 0.000) and preparation time HR = 2.4; 95% CI, 1.2 – 4.7, (p &lt; 0.01). Secondary outcome: median recurrence rate at month 4 (95% CI, 0.7 – 7.4) after VAC therapy vs. month 2 (95% CI, 0.5 – 3.6) in control group, (p = 0.47).</td>
</tr>
<tr>
<td>Lavery 2014 RCT</td>
<td>5.0</td>
<td>N = 40 with diabetic foot wounds, age 21-90 years, surgical lower extremity wounds, and ankle-brachial</td>
<td>Negative-pressure wound therapy with 75-mmHg continuous pressure with a silicone-covered dressing (75 mmHg) vs. 125mmHg with a polyurethane foam</td>
<td>Mean±SD wound area and volume: 20.10±14.33cm² (125mmHg) vs. 34.61±32.92cm² (75mmHg), p = 0.08. No differences were found in outcomes in wounds treated with low pressure (75 mmHg) with a silicone-coated interface and Pilot study. No non-negative pressure group. Small sample size (n = 40). Similar efficacy</td>
</tr>
</tbody>
</table>

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| COI, Dr. Lavery has research grants from KCI, Osirus, Health Point, ThermoTek, Integra, GlaxoSmith Kline, ConvaTec, and Innovative Therapies, Inc. He is on speaker's bureau for Shire, KCI, and Innovative Technologies and a consultant/advisor for Innovative Therapies and Pamlab, L.L.C. He has stock ownership in Diabetica Solutions and Prizm Medical and holds patents with Diabetica Solutions. |
| N = 162 patients with diabetic partial foot amputation wounds up to transmetatarsal level and evidence of adequate perfusion. Also corresponding indices > 0.70. Mean±SD age 70.5±7.4 years (75mmHg) and 51.3±12.7 years (125mmHg). dressing. Both devices changed 3x/week. Follow up to 4 weeks or until surgical closure. found between treatments. high pressure (125 mmHg) with a polyurethane foam interface." |
| Negative pressure wound therapy (NPWT) group (n = 77) received Vacuum-Assisted Closure (VAC) and dressing changes every 48 hours vs. Control group (n = 85) received dressing changes only everyday. Patients within the NPWT group (56%) showed faster healing results than control group (39%). In wound closure 0.1702 (95% asymptotic CI (0.0184-0.322) when comparing NPWT to control. "In conclusion, our results indicate that NPWT as delivered through the VAC Therapy System seems to be a safe and effective treatment for complex diabetic foot. |
| Armstrong 2005 RCT Sponsored by KCI USA. COI, two authors (DGA and LAL) have received research |
| 5.0 132/162 patients male. Proportional healing at 12 and 16 weeks similar. More frequent dressing changes in... |
Evidence for the Use of Total Contact Casting
There is 1 moderate-quality RCT incorporated into this analysis. (Lavery 14)
Evidence for the Use of Growth Factors

There are 17 moderate-quality RCTs incorporated into this analysis. (Blume 11; Wieman 98; Niezgoda 05; Steed 06; d’Hemecourt 98; Hardikar 05; Bhansali 09; Fernandez-Montequín 09; Uchi 09; Viswanathan 06; Kusumanto 06; Lyons 07b; Fife 07; Brigo 06; Reyzelman 09; Purandare 07; Kakagia 07) There are 7 low-quality RCTs (Steed 95; Landi 03; Huang 14; Akbari 07; Eginton 03; Landsman 10; Richard 95) and 1 other study (Lyons 07) in the Appendix.

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<tr>
<td>Blume 2011 RCT</td>
<td>7.0</td>
<td>N = 129 patients with Wagner Classification Grade 1 cutaneous lower extremity ulcer between 1.5</td>
<td>GAM501 Group-Ad5PDGF-B (Becaplermin) combined with Formulated Collagen Gel-Sub group, one treated at week 1, group</td>
<td>No significant difference for ulcer closure incidences between groups 31% in SOC, 45% in FCG and 41% in GAM501 (p &gt;0.05). All groups showed significant increase in</td>
<td>“We conclude from this exploratory trial that a single application of GAM501 or FCG increases the healing rate of neuropathic DFUs for the</td>
<td>At 1 week GAM501 and Formulated Collagen Gel improved healing rates vs.</td>
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**Evidence for the Use of Growth Factors**

There are 17 moderate-quality RCTs incorporated into this analysis. (Blume 11; Wieman 98; Niezgoda 05; Steed 06; d’Hemecourt 98; Hardikar 05; Bhansali 09; Fernandez-Montequín 09; Uchi 09; Viswanathan 06; Kusumanto 06; Lyons 07b; Fife 07; Brigo 06; Reyzelman 09; Purandare 07; Kakagia 07) There are 7 low-quality RCTs (Steed 95; Landi 03; Huang 14; Akbari 07; Eginton 03; Landsman 10; Richard 95) and 1 other study (Lyons 07) in the Appendix.

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</table>
are products in development by Cardium Therapeutics Inc., Lois A. Chandler is an employee of and owns stock options in Cardium Therapeutics, Inc. Robert L. Engler is a Consultant to and owns stock options in Cardium Therapeutics. Barbara K. Sosnowski is a named inventor of an applicable patent and currently an employee of Pfizer. Other authors were principal investigators and have no financial relationship with Cardium Therapeutics.

<p>| Wieman 1998 | 6.5 | N = 382 patients with type 1 or 2 diabetes and chronic low-extremity | Becaplermin Gel 30 group: 30µg/g of 0.01% Regranex gel (n = 132) vs. Becaplermin | The 100 group showed a 50% incidence of complete healing at week 20 vs. 35% in placebo (p = 0.007) and 36% |
| RCT | | | | “Becakernub gel 100 µg/g, in conjunction with good wound care, significantly increased the first two weeks after treatment; whereas SOC with weekly visits seems to have a much smaller and delayed effect on wound healing rate.” |
| No mention of | | | | Phase 3 trial suggesting becaplermin 100µg/g associated with better wound healing |</p>
<table>
<thead>
<tr>
<th>Sponsorship</th>
<th>Gel 100 group: 100µg/g of 0.01% Regranex gel (n = 123) vs. Placebo Group - Identical to vehicle component of gel with active drug, however it was saline. (n = 127). Follow-up for 20 weeks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcers; mean age 58 years.</td>
<td>in the 30 group (p &lt;0.05). The 100 group also showed a significantly decreased time to achieve complete healing vs. placebo; 86 days vs. 127 days (p = 0.013).</td>
</tr>
<tr>
<td>Incidence of complete wound closure and significantly reduced the time to complete closure of chronic diabetic neuropathic ulcers.”</td>
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<tr>
<td>Niezgoda 2005 RCT</td>
<td>N = 90 patients with at least 1 diabetic foot ulcer; mean age 57.6 years.</td>
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<td></td>
<td>At 12 week follow-up 18 (49%) in OASIS group were considered healed vs. 10 (28%) patients in Regranex group (p = 0.055). In subgroup analysis, OASIS showed a significantly higher number of healed ulcers vs. Regranex for Plantar Ulcers; 14 (52%) vs. 3 (14%) (p = 0.14) and for Type 2 Diabetes; 12 (63%) vs. 8 (29%) (p = 0.034). There were 17 Complications/Adverse Events in OASIS group vs. 10 in Regranex group (p &gt;0.05).</td>
</tr>
<tr>
<td></td>
<td>“In this study, OASIS was as effective as Regranex Gel in treating full-thickness diabetic foot ulcers and appears to be a viable treatment option for these patients.”</td>
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</table>

NYS WCB MTG – Ankle and Foot Disorders
<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Methodology</th>
<th>Participants</th>
<th>Intervention</th>
<th>Healing Rates</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steed 2006 RCT</td>
<td>5.5</td>
<td>N = 118</td>
<td>N = 118 with chronic, full-thickness, lower-extremity diabetic neurotrophic ulcers of at least 8 weeks. Pooled from 10 centers. Mean age not provided.</td>
<td>PDGF group-rhPDGF-BB (Becaplermin) gel applied at dose equivalent to 2.2 micrograms until completely healed, or 20 weeks (n = 61) vs. Placebo Gel Group-Saline Gel (n = 57).</td>
<td>Healing rates in gel group vs. placebo group at 6 weeks: 29 (48%) vs. 14 (25%); p = 0.01. Median reduction in wound area gel vs. placebo group: 98.8% vs 82.1%; p = 0.09.</td>
<td>PDGF applied once daily was effective in healing chronic diabetic neurotrophic foot ulcers when used in conjunction with good wound care.</td>
</tr>
<tr>
<td>d’Hemecourt 1998 RCT</td>
<td>5.0</td>
<td>N = 172</td>
<td>N = 172 patients with type 1 or 2 diabetes and chronic lower extremity diabetic ulcers. All received sharp debridement of ulcer; mean age 58.3 years.</td>
<td>Wound Care Group-good wound care alone – Sharp debridement of ulcers to remove calluses, fibrin and necrotic tissue (n = 68) vs. NaCMC Group-good wound care plus NaCMC gel (n = 70) vs. Becaplermin Group-100µg/g of 0.01% Regranex gel plus good wound care (n = 34). Follow-up for 20 weeks.</td>
<td>22% of Patients in the wound care alone group achieved complete wound closure at 20 weeks compared to 36% of NaCMC group and 44% of the Becaplermin group. Mean time to achieve complete closure was 85 days in the Becaplermin group, 98 days in the NaCMC group and &gt;141 days in the wound care group. P-values not given.</td>
<td>In conclusion, the results presented here demonstrate that treatment with NaCMC gel does not impact wound healing negatively; NaCMC gel may have a beneficial effect on wound healing when compared with good wound care practice alone in patients with chronic diabetic ulcers of the lower extremity.</td>
</tr>
</tbody>
</table>
| Hardikar 2005                 | 5.0 | N = 111     | N = 111 with type 1 or 2 diabetes | Placebo gel (n = 58) vs. rhPDGF-based gel (n = 53). | Complete healing (achieving a functional score of 1) reported at end | “The efficacy assessed at 10 weeks in the present study | Pragmatic RCT. Treatment administrat
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Bhansali 2009</td>
<td>4.5</td>
<td>20</td>
<td>Platelet-derived growth factor group (PDGF): A rh-PDGF-BB (Becaplermin) 0.01% Regranex gel (n = 10) vs. Standard Wound Care group (SWC) moist saline used (n = 10). Follow-up at 30, 60, 90, 120 and 150 days. Mean duration of healing target ulcers 50.10 days in PDGF group and 86.10 days in SWC group; a 41.8% reduction in favor of PDGF group (p &lt;0.02). Ulcers completely healed by 90 days in PDGF group vs. 120 days in SWC group (p &lt;0.05). Reduction of size of ulcer did not show significant difference between groups.</td>
<td>20 weeks</td>
<td>“In conclusion, the results of this study suggest that within the setting of TCCoff-loaded patients with diabetic neuropathic large plantar ulcers, short-term use of rh-PDGF-BB gel reduced the time to complete healing considerably compared to SWC.”</td>
</tr>
<tr>
<td>Uchi 2009</td>
<td>6.5</td>
<td>150</td>
<td>Placebo group (n = 51) vs. 0.001% bFGF group (n = 49) vs. 0.01% Area of ulcer decreased by ≥75%: 57.5% (27/47) vs. 72.3% (34/47) vs. 82.2% “The findings obtained in this trial showed wound healing accelerating Data suggest a dose-response relationship.</td>
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**Autologous-derived growth factors**

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<tr>
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<tr>
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</tr>
<tr>
<td>Study Type</td>
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<td>Age</td>
<td>Group Details</td>
<td>Follow-up</td>
<td>Results</td>
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<tr>
<td>Fernandez-Montequin 2009 RCT</td>
<td>6.5</td>
<td>≥18 years old</td>
<td>N = 149 with Wagner’s grade 3 or 4 diabetic foot ulcers (DFUs).</td>
<td>Follow-up for 3, 6 and 12 months.</td>
<td>Ulcer closure occurred in 41 (77.4%), 25 (52.1%) and 27 (56.2%) from I, II and group III, respectively, (p = 0.018). The granulation tissue covering ≥50% of ulcer at 2 weeks; achieved by 19/48 controls vs 44/53 in 75μg group, OR = 7.5; 95% (CI) 2.9-18.9 vs. 34/48 in 25μg group, OR = 3.7, 1.6-8.7.</td>
</tr>
<tr>
<td>Viswanathan 2006 RCT</td>
<td>5.0</td>
<td>Age of 18 and 65 years</td>
<td>N = 60 with target ulcers no less than 2 cm and no more than 50 cm² in area.</td>
<td>Follow-up for 15 weeks.</td>
<td>90% of ulcers healed in 15 weeks vs. 22 weeks in the control group. Chances of non-healing within 15 weeks 14% in test group and 50% in control. Those with an ulcer area &gt;6 cm in test group exhibited better</td>
</tr>
</tbody>
</table>
Kusumanto  
2006  
RCT  
Sponsored by Fornix BioSciences. No mention of COI.  

| 5.0 | N = 54 with diabetic foot ulcers and/or rest pain >2 weeks, failure of conventional treatment, serious limb ischemia, type 1 or 2 diabetes; Mean age 68.4 for control group and 68.7 for phVEGF group. | Control group (n = 27) vs. Vascular endothelial growth factor (2000 µg; phVEGF<sub>165</sub>) treatment group (n = 27). Both groups received their allocated treatment at baseline and 28 days. Assessments at baseline, 7, 14, 35, 42, 72 and 100 days. | At final assessment, phVEGF group had significantly higher percentage of hemodynamic improvement and improvement in skin ulcer vs. control group; hemodynamic – 33% vs. 6%, (p = 0.05). Ulcer improvement – 33% vs. 0%, (p = 0.01). | “[W]e did not meet the primary end point of a reduced amputation rate. We did, however, demonstrate that intramuscular injections of the naked plasmid DNA encoding VEGF165 (phVEGF165) significantly improved wound healing and reduced hemodynamic insufficiency compared with placebo. Importantly, in the responders these clinical improvements resulted in improved physical functioning (mobility, and daily activities such as washing, dressing, and cleaning) and improved social functioning as detected by the RAND-36 questionnaire for QOL. Therefore “response” as defined in this study seems to be a meaningful notion.” | Longer ulcer duration in controls (5 vs. 3 months). No difference in amputations. Some data favor growth factor.

29). Follow-up for 15 weeks. healing vs. control (p <0.002).
<table>
<thead>
<tr>
<th>Study</th>
<th>Outcome</th>
<th>Participants</th>
<th>Methods</th>
<th>Results</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lyons 2007 RCT</td>
<td>N = 46 with diabetes mellitus HbA1C 6-13%, full thickness diabetic foot ulcer below that ankle that has not reduced in size ≥30% in past 4 weeks with typical treatments, post debridement size between 0.5 to 10 cm², transcutaneous oxygen tension ≥30mm Hg or ankle-brachial index ≥0.7; Mean (±SD) age 58 (±10) for 2.5% gel group, 53 (±15) for 8.5% gel group and 56 (±14) for placebo gel group.</td>
<td>2.5% Talactoferrin gel group (n = 15) vs. 8.5% Talactoferrin gel group (n = 15) vs. Placebo gel group (n = 16). Groups instructed to apply gel twice daily to ulcer for 12 weeks alongside typical wound care. Assessments at baseline, 30 days, 90 days and 180 days. 50% of participants in treatment groups reduced ulcer size ≥75% compared to 25% of participants in placebo group, approaching significance (p = 0.091). No statistically significant differences reported between varying percentages of talactoferrin gel.</td>
<td>&quot;[T]alactoferrin was a safe and well-tolerated treatment of diabetic neuropathic foot ulcers without associated adverse events or laboratory abnormalities. In addition, talactoferrin enhanced the rate of healing in these ulcers. A phase 3 will be required to confirm these results.&quot;</td>
<td>Study Phase 2 - same article as above. Small samples. High dropouts. Data suggest no differences in healing during treatments – modest differences appeared later.</td>
<td></td>
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<tr>
<td>Fife 2007 RCT</td>
<td>N = 60 with diabetic foot ulcers. Median age for the saline placebo, 1, and 10mg groups were 54.7, 59.6, and 53.7.</td>
<td>1 mg Chrysalin® twice weekly for up to 20 weeks or until ulcer reached complete closure, Bandages removed during twice-weekly visits for evaluation. ITT population, 61% (11/18) of ulcers treated at 10mg dose achieved complete closure vs 52% (11/21) in 1mg dose and 48% (10/21) in saline-treated group. In PP population, incidence of</td>
<td>&quot;These results indicate the potential safety and efficacy of Chrysalin® for treatment of diabetic foot ulcers.&quot;</td>
<td>Phase 1/2 study report. High dropouts. Data suggest efficacy.</td>
<td></td>
</tr>
<tr>
<td>Study Type</td>
<td>N</td>
<td>Patients Description</td>
<td>Treatment</td>
<td>Follow-Up</td>
<td>Results</td>
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<tr>
<td>Reyzelman 2009 RCT</td>
<td>4.5</td>
<td>N = 86 patients with diabetes and University of Texas (UT) grade 1 or 2 ulcer. Mean Age was 56.3 years.</td>
<td>Study Group-received single application of human acellular dermal regenerative tissue matrix graft (n = 47) vs. Control Group: standard wound care management (n = 39).</td>
<td>Follow-up for 12 weeks.</td>
<td>There was a significantly higher rate of complete ulcer closure in study group compared to control group; 32/46 69.6% vs. 18/39 46.2% (p = 0.0289). No significant difference between groups for time it took to completely heal; 5.7 weeks vs. 6.8 weeks (p &gt;0.05). “The results of this prospective, randomised, multicentre study indicate that diabetic foot ulcers treated with AM therapy have a two to three times higher probability of healing compared with those with standard of care management.”</td>
</tr>
<tr>
<td>Brigido 2006 RCT</td>
<td>4.5</td>
<td>N = 28 diabetic patients with full-</td>
<td>A single application of Graftjacket tissue matrix,</td>
<td>12/14 patients treated with Graftjacket were healed by 16</td>
<td>“Patients with chronic ulcers of various aetiologies who Pilot study. Data suggest efficacy.”</td>
</tr>
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</table>
**Kakagia 2007 RCT**

No mention of sponsorship or COI.

<table>
<thead>
<tr>
<th>Thickness wounds for at least 6 weeks. Mean age for Graftjacket / and Debridement group: 61.43 (7.18) / 66.21 (4.37).</th>
<th>Plus mineral oil-soaked fluff compression dressing (n = 14) vs. Control treatment of wound gel with gauze dressings (n = 14). Follow-up for 16 weeks.</th>
<th>Weeks and only 4/14 patients in the control group. Average time to heal 11.92 weeks and 13.50 weeks for control group. Final ulcer area / depth / volume and number of ulcers healed in favor of Graftjacket, (p ≤0.001).</th>
<th>Were treated with Graftjacket, a human acellular regenerative tissue matrix, showed a statistically significant higher percentage of wound closure by week 16 than the patients treated with sharp debridement only.”</th>
</tr>
</thead>
</table>

| N = 54 diabetics with foot ulcers, or soft tissue defects, present >3 months; Mean (±SD) age 58 (±10) for group A, 57 (±12) for group B and 61 (±9) for group C | Promogran only group (n = 18) vs. Autologous growth factors group (n = 18) vs. both Promogran and autologous growth factors group (n = 18). All groups received treatment for 8 weeks. Assessments at baseline and 8 weeks. | Both promogran and autologous growth factors treatment group demonstrated significantly greater reduction in all dimensions of wound compared to other two groups, (p <0.001). | “[W]e have shown that dressing nonhealing diabetic foot ulcers with modulators of the wound environment in combination with the administration of autologous growth factors significantly accelerates the healing rate. It is suggested that rebalancing of the wound microenvironment by using dressings that inhibit proteases should initiate the repair process and increases the healing potential of autologous growth factors.” |

Data suggest combination therapy superior and no differences between individual treatments.
### Evidence for the Use of Granulocyte Colony-stimulating Factor

There are 4 moderate-quality RCTs incorporated into this analysis. (Kastenbauer 03; Gough 97; DeLalla 01; Yonem 01)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kästenbauer 2003 RCT</td>
<td>6.5</td>
<td>N = 37 diabetic patients with moderate sized (diameter 0.5 – 3 cm) infected neuropathic (abnormal 10g- monofilament test) foot ulcer of Wagner’s grade 2 or 3. Mean age G-CSF 60.8±11.1</td>
<td>G-CSF 5µg/kg injected subcutaneously, stopped if neutrophil count &gt;50,000/l and leukocyte count &gt;75,000/l (n = 20) vs. placebo, 0.9% sterile saline injected subcutaneously (n = 17) for a 10 day in-hospital stay. All patients put on bed rest and treated with i.v. antibiotics</td>
<td>Mean±SD leukocyte count (10^9L^-1) at day 10: G-CSF 40.8±16.3 vs. placebo 9.3±8.3 (p = 0.00005).</td>
<td>“[A]ntibiotic and non-weight-bearing therapy (bed rest) accelerated the resolution of cellulitis in infected foot ulcers. Additional treatment with G-CSF had no further beneficial effect.”</td>
<td>Small sample size. G-CSF associated with pathogen reduction faster than placebo leading to earlier resolution of cellulites.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Methodology</td>
<td>Patients Description</td>
<td>Intervention</td>
<td>Outcomes</td>
<td>Notes</td>
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<tr>
<td>Gough</td>
<td>1997</td>
<td>RCT</td>
<td>N=40 diabetic patients with extensive cellulitis (acute spreading skin infection with involvement of subcutaneous tissues, characterized by erythema in association with purulent discharge with or without lymphangitis). Mean age G-CSF 65 years, placebo 66 years.</td>
<td>G-CSF: initial dose of 5µg/kg daily and then lowered to 2.5µg/kg daily after 2 doses if neutrophil count higher than 25x10⁹/L and stopped if neutrophil &gt;50x10⁹/L (n = 20) vs. placebo, saline (n = 20) daily as an injection for 7 days. All patients received 4 antibiotics (ceftriaxone, amoxicillin, flucloxacillin, and metronidazole) intravenously until cellulitis and ulcer discharge resolved. Patients followed until resolution of infection and discharge from hospital.</td>
<td>Median time to hospital discharge (days): G-CSF 10 vs. placebo 17.5 (p = 0.02). Median time to resolution of cellulitis (days): G-CSF 7 vs. placebo 12 (p = 0.03). Median time to withdrawal of intravenous antibiotics (days): G-CSF 8.5 vs. placebo 14.5 (p = 0.02). Median time to negative swab culture (days): G-CSF 4 vs. placebo 8 (p = 0.02).</td>
<td>“This study showed that in diabetic patients with foot infection G-CSF treatment significantly accelerated resolution of cellulitis, shortened hospital stay, and decreased antibiotic requirements.” Small sample size. G-CSF shortened hospital stay, accelerated wound healing (cellulitis), and decreased antibiotics. The mechanism may be related to increases in neutrophil superoxide production.</td>
</tr>
<tr>
<td>De Lalla</td>
<td>2001</td>
<td>RCT</td>
<td>N = 40 adult diabetic patients with limb-threatening infection (full-thickness ulcer, &gt;2cm of cellulitis with or without lymphangitis)</td>
<td>Conventional treatment: local treatment (debridement, daily inspection, cleaning with sterile water, disinfection with povidone iodine, surgical removal</td>
<td>NS between groups for bacterial species or number of isolates per species. Mean±SD neutrophil counts: G-CSF 25,200±3,500 vs. saline 24,800±3,800.</td>
<td>“[T]he administration of G-CSF for 3 weeks as an adjunctive therapy for limb-threatening diabetic foot infection was relatively small sample size. Comparable results in, both conventional therapy and G-CSF group. At 6 months</td>
</tr>
</tbody>
</table>
without lymphangitis, bone or joint involvement, and systemic toxicity). Mean age G-CSF 56.6±8.6 years, control group 59.8±9.6 years.

| Yönem | 4.5 | N = 30 diabetic patients with pedal cellulitis or Wagner's grade 2 or less lesion on their feet. Mean age G-CSF group 60.3±1.3 years, standard group 61.0±1.4 years. | Standard treatment: local wound care and parenteral antibiotherapy, ciprofloxacin and metronidazole intravenously (n = 15) vs. G-CSF 5µg/kg subcutaneously daily and stopped if neutrophil count >45x10⁹/l in addition to | Mean±SD neutrophil count post-treatment: G-CSF group 48700±1000 vs. standard group 4800±300 (p <0.001). | “Although G-CSF improves neutrophil function as well as increasing the absolute numbers, this improvement is not associated with shortening of duration of antibiotic administration, duration of Small sample size (n = 30), appears to lack efficacy GCSF increased neutrophil counts but was not associated with decreased antibiotic administration or shortened hospital stays. |
standard treatment (n = 15). Patients were followed until hospital discharge.

hospital stay or need for amputation in diabetic foot infection”

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**Evidence for the Use of Prostacyclin Analogues (Iloprost)**

There is 1 low-quality in the Appendix. (Sert 08)

**Evidence for Low-Molecular Weight Heparins**

There is 1 exploratory RCT incorporated into this analysis. (Rullan 08)

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<th>Author/Year Study Type</th>
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</thead>
<tbody>
<tr>
<td>Rullan 2008 RCT</td>
<td>8.0</td>
<td>N = 70 patients with diabetes and with a foot ulcer persisting for &gt;3 months. Mean age 64.5 years.</td>
<td>Bemiparin Group- Administered at 3500 IU/day for first 10 days followed by 2500 IU/day for 3 months (n = 37) vs. Placebo Group: 0.2mL of isotonic saline administered for 3 months (n = 33). Follow-up for 3 months.</td>
<td>Ulcer improvement rates at 3 months were significantly higher in the Bemiparin group compared to the Placebo group; 26/37 70.3% vs. 15/33 45.5 %, (p = 0.035). There was not a significant difference between the two group for complete healing rates Bemiparin vs. Placebo; 35.1% vs. 33.3% (p=0.874). In the subgroup of Wagner grade II ulcers Bemiparin showed a significantly higher rate of complete healing compared to placebo; 50% vs. 0% (p=0.047).</td>
<td>“[T]his exploratory trial provides a ‘proof of concept’ of the potential usefulness of bemiparin in the treatment of diabetic foot ulcers.”</td>
<td>&quot;Exploratory trial.&quot; Data suggest efficacy.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Complementary and Alternative Medications
There are 3 low-quality RCTs in the Appendix. (Leung 08; Larijani 08; Bahrami 08)

Evidence for the Use of Hyperbaric Oxygen
There is 1 moderate-quality RCT incorporated into this analysis. (Löndahl 10) There are 2 low-quality RCTs in the Appendix. (Wang 09; Duzgun 08)

<table>
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<tbody>
<tr>
<td>Löndahl 2010</td>
<td>RCT</td>
<td>7.5</td>
<td>N = 94 with grade 2, 3, or 4 Wagner rated ulcers below foot lasting &gt;3 months, diabetes, previous treatment at diabetes foot clinic &lt;2 months; Mean age 69 for HBOT group; 68 for placebo group.</td>
<td>HBOT (100% O², 5 min compression, 2.5 atmospheres 85 min., 5 min decompression) vs. hyperbaric air treatments 5 days/week for 8 weeks. Treatment adjunctive to infection treatment, revascularization, off-loading, metabolic control.</td>
<td>Ulcer healing in 25/48 (52%) HBOT vs. 12/42 (29%) in sham group. p = 0.03. Sub analysis of those completing &gt;35 sessions showed HBOT vs. placebo group healing at 1 year: 61% vs. 27%, (p = 0.009).</td>
<td>“…Adjunctive treatment with HBOT facilitates healing of chronic foot ulcers in selected patients with diabetes.”</td>
<td>Sham hyperbaric air. Data suggest NNT 3-4 to prevent non-healing ulcer with HBO.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Extracorporeal Shock Wave Therapy
There are 3 low-quality RCTs in the Appendix. (Moretti 09; Wang 09; Petrofsky 10)

Evidence for the Use of Skin Grants
There are 11 moderate-quality RCTs incorporated into this analysis. (Edmonds 09; Hanft 02; Sams 02; You 12; Caravaggi 03; Uccioli 11; Gentzkow 96; Pollak 97; Veves 01; Han 10; Caputo 08) There are 2 low-quality RCTs in the Appendix. (Martson 03; Moustafa 07)
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<tr>
<td><strong>Tissue Engineered Skin Grafts</strong></td>
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<tr>
<td>Edmonds 2009 RCT</td>
<td>6.0</td>
<td>N = 82 patients with ulcer of neuropathic origin; mean age 58.7 years.</td>
<td>Apligraf group: Apligraf placed directly on base of target ulcer (n = 40) vs. Control Group-standard therapy, treated with same primary and secondary dressings as apligraf group (n = 42). Follow-up for 12 weeks.</td>
<td>There were more Apligraf patients who did not have debridement at week 1; (p = 0.001), and after week 4; (p = 0.0273). Shorter wound healing time in Apligraf group compared to control group; (p = 0.059). At 12 week follow-up 51.5% of Apligraf group had complete closure compared to 26.3% in control group (p = 0.049).</td>
<td>“The overall results suggest that Apligraf, in combination with debridement, standard wound care, and offloading, should be considered in treating patients with nonhealing neuropathic diabetic foot ulcers.”</td>
<td>Open label 1:1 prospective study.</td>
</tr>
<tr>
<td>Hanft 2002 RCT</td>
<td>5.0</td>
<td>N = 46 patients with type 1 or 2 diabetes and a plantar foot</td>
<td>HFDD group-application of Dermagraft at baseline and up to 7 additional</td>
<td>28 patients (14 each group) with ulcers of &gt;6 weeks duration. HFDD group</td>
<td>“The results of this study suggest that the Dermagraft”</td>
<td>Wound closure significantly better in HFDD</td>
</tr>
</tbody>
</table>
Sponsored by Advanced Tissue Science, Inc. No mention of COI.

| Study | N= 22 patients diabetes and foot ulcer longer than 2-weeks in duration; mean age 53.6 years. | Graftskin group: graft contoured to ulcer base during surgery (n = 9) vs. Control: aggressive debridement, dressing change 2x/day, custom-made tridensity pressure-relieving footwear (based on ADA recommended treatment for diabetic ulcers (n = 8). Follow-up for 6 months (weekly first 12 weeks). | No statistically significant differences between groups. Graft skin group showed complete healing in 56% of patients at 12 weeks compared to 38% in the control group. There were no significant differences between groups in baseline ulcer history. No significant adverse events were attributable to either treatment group. | “Graftskin application appears to reduce healing time in difficult to heal diabetes-related neuropathic foot ulcers. The ease of application is exceptional. In our study, no serious side effects were associated with Graftskin.” | 17 treated due to 5 failing screening process after randomization. Small sample size (n = 17). |

| Graft skin group | significantly greater number of complete wound closure vs. control group; 10 (71.4%) vs. 2 (14.3%) (p = 0.003). Time to complete wound closure was significantly faster in HFDD group vs. control (p = 0.004). |

Allogeneic keratinocytes vs. vaseline gauze
### You 2012

**RCT**

- No mention of COI.
- Sponsorship, supported by grants from Tego Science (Seoul, Korea).

<table>
<thead>
<tr>
<th>N = 59 type 1 or 2 diabetes, foot ulcer &gt;1.0cm² that did not exhibit healing for 6 weeks, Wagner grade 1 or 2, and transcutaneous oxygen pressure ≥40mmHg. Mean±SD age 63.5±9.0 years (treatment) and 62.4±9.4 years (control).</th>
</tr>
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<tbody>
<tr>
<td>Keratinocyte group (n = 27) vs. vaseline gauze (n = 32). Follow-up weekly until wound closure or week 12.</td>
</tr>
<tr>
<td>Mean percentages of wound area reduction: 100±0% vs. 85±65% in treatment and control groups, Respectively, p &lt;0.05. Complete wound healing: 85% of keratinocyte-treated group vs. 59% of control group, p&lt;0.05. “These results indicate that cultured allogeneic keratinocytes may offer a safe and effective treatment for diabetic foot ulcers.”</td>
</tr>
</tbody>
</table>

### Other Skin Graft

**Caravaggi 2003**

- RCT
- Supported by a grant from Fidia Advanced Biopolymers. No mention of COI.

<table>
<thead>
<tr>
<th>N = 79 patients with diabetic foot ulcer either plantar or dorsal; Mean Age not reported.</th>
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<tbody>
<tr>
<td>Autologous graft treatment: patients received autologous fibroblasts on Gyalograft3D which was grafted onto ulcer (n = 43) vs. Control Group treated with nonadherent paraffin gauze.</td>
</tr>
<tr>
<td>At final follow-up 65.3% in treatment group showed complete healing vs. 49.6% in control group (p = 0.191). In dorsal subgroup, treatment group showed significantly higher odds ratio (95% CI) for complete healing vs. control; 4.44</td>
</tr>
<tr>
<td>“The results of this clinical study clearly show that the use of total offloading is so important to the tissue repair process in plantar ulcers that the efficacy of fibroblasts on Hyalograft3D and Open label. Data suggest improved healing in dorsal ulcers compared to standard care.”</td>
</tr>
<tr>
<td>Study</td>
</tr>
<tr>
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<tr>
<td>Uccioli 2011 RCT</td>
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<tr>
<td>Gentzkow 1996</td>
</tr>
</tbody>
</table>
### RCT
No mention of sponsorship. COI: GDG and SDI are employed by and hold stock in Advanced Tissue Sciences, Inc. DPS, SJL, JJP, JJR and KSH receive funds from Advanced Tissue Sciences, Inc. for their participation as clinical investigators using Dermagraft to treat diabetic foot ulcers.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic foot ulcers; Mean Age was 61.4 years.</td>
<td></td>
<td></td>
<td>Dermagraft applied weekly for a total of 8 pieces (n = 12) vs. Group B-two pieces of Dermagraft applied every 2 weeks for a total of 8 pieces and 4 applications (n = 14) vs. Group C: One piece of Dermagraft applied every 2 weeks for a total of 4 pieces (n = 11) vs. Group D: Control group, conventional therapy and wound-dressing (n=13).</td>
<td>Follow-up for 12 weeks.</td>
</tr>
<tr>
<td>Higher in group A compared to the control group; a, b, c, d respectively, 50% vs. 21.4% vs. 18.2% vs. 7.7% (p = 0.03 for A vs. D). Median time for complete wound closure was 12 weeks in Group A and &gt;12 weeks in the remaining groups. Median closure time in Group A vs. Group B (p = 0.056). Median time to 50% closure was 2.5 weeks in group A compared with &gt;12 weeks in group D (p = 0.0047).</td>
<td></td>
<td>Pilot evidence of effectiveness and has defined which treatment regimen should be used for pivotal studies of dermagraft as an active wound-healing agent for diabetic foot ulcers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pollak 1997 RCT
No mention of sponsorship or COI.

<table>
<thead>
<tr>
<th>Design</th>
<th>Patients</th>
<th>Intervention</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 281 patients with full-thickness diabetic ulcers of the plantar surface. Mean age was 55.4 years.</td>
<td></td>
<td>Control Group-Standard care with debridement, moist dressings and pressure relief (n = 142) vs. DG Group-Dermagraft added to ulcer</td>
<td>50.8% of patients in DG group showed complete wound healing at 12 weeks compared to 31.7% (p = 0.006). At week 32, DG group had 41.7% healed ulcers compared to 29.9%.</td>
</tr>
<tr>
<td>4.5</td>
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<td>“Thus, Dermagraft within the therapeutic range of metabolic activity, used in addition to a well-defined regimen of wound care, significantly improves wound healing in diabetic foot ulcers.”</td>
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</tr>
</tbody>
</table>

### Potential randomization failure due to differences in baseline comparability. Control groups depicts duration of ulcers 37 weeks longer than in Dermagraft group A and 46 weeks longer than group B and 44 weeks longer than group C.
<table>
<thead>
<tr>
<th>Apligraft</th>
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<tr>
<td></td>
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</tbody>
</table>
| with standard treatment (n = 139).

Primary follow-up for 12 weeks, secondary follow-up at 32 weeks.

| a significantly higher healing. |
| standard care, has been demonstrated to provide significantly improved healing of diabetic foot ulcers compared to standard care alone. |

<p>| healing for DG-TR group 13 weeks vs. 28 weeks for control group. At week 32, DG-TR group sustained healing when compared to control group (58% vs. 42%), p = 0.04. |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Veves 2001 RCT</td>
<td>N = 208 with type 1 or 2 diabetes and full-thickness neuropathic ulcers; mean age 57.1 years.</td>
<td>Graftskin Group: Graftskin applied after debridement directly over ulcer site and trimmed to fit ulcer. Graftskin could be reapplied from weeks 1-4 (n = 112) vs. Control Group-Standard care of American Diabetes Association, with complete dressing changes every week, and 2 secondary dressing changes 2x per day (n = 96). Follow-up at 1, 4 and 12 weeks. Complete wound healing achieved in 63 (56%) of graftskin-treated patients compared with 36 (38%) control patients (p = 0.0042). Odds ratio (95% CI) of Graftskin compared to control was 2.14 (1.23-3.784). Median time to complete closure 65 days for graftskin which was significantly lower than 90 days in control group (p = 0.0026).</td>
<td>“In summary, in the present study we have shown, in a randomized prospective controlled fashion that weekly application of Graftskin for a maximum of 4 weeks results in a higher healing rate when compared with state-of-the-art currently available standard treatment and is not associated with any significant side effects.”</td>
</tr>
<tr>
<td>Han 2010</td>
<td>4.5</td>
<td>N = 54 with diabetic foot ulcers &gt;1.0cm² that did not display signs of healing for 6 weeks. Mean age for treatment/control group: 6.5 ±7.5/68.4 ± 8.7.</td>
<td>PLA cell treatment wound management and pressure off-loading, were set up to be identical for all (n = 28) vs. Control treatment only fibrinogen 0.3–1.0 mL + thrombin 0.3–1.0mL, without cells, applied topically over debrided wounds (n = 26). Follow-up for 8 weeks.</td>
</tr>
<tr>
<td>Caputo 2008 RCT</td>
<td>4.0</td>
<td>N = 41 with clinical signs of infection in the study ulcer. Mean age (range) 68.0 (33.0 – 95.0).</td>
<td>VERSAJET® Hydrosurgery System (n = 22) vs. Conventional debridement with scalpel plus pulsed lavage (n = 19). Follow-up for 12 weeks.</td>
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<tr>
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<tr>
<td>Sponsored by Smith &amp; Nephew Inc, Florida. No COI.</td>
<td></td>
<td>At baseline median ulcer duration 1.2 months in both groups median surface area of 5.9cm² and median area of devitalized tissue of 5.3cm² in treatment group/surface area of 3.9cm² and devitalized tissue of 3.7cm². Wound closure between patients treated with Versajet vs conventional debridement (p = 0.733). At 12 weeks, wounds closed in 52.6% of Versajet group and 47.4% in controls.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“[T]he Versajet Hydrosurgery system is a quick and effective means of debriding lower extremity ulcers.”</td>
<td>Ulcer size differed at baseline (5.9 v 3.9 cm²) but favoring conventional. No difference in wound closure rate. Versajet faster.</td>
</tr>
</tbody>
</table>

**Evidence for use of Orthotics**
There is 1 low-quality RCT in Appendix 2. (Hausdorff 08)

**Evidence for the Use of Opioids for TTS**
There are no quality studies evaluating the use of opioids for the treatment of pain from TTS.

**Evidence for the Use of Phonophoresis**

There are no quality studies evaluating phonophoresis for treating TTS patients.

**Evidence for the Use of Return-to-work Programs for TTS**

There are no quality studies incorporated into this analysis (see Chronic Pain guideline for additional studies).

**Evidence for the Use of Ottawa Ankle and Foot Rules for Ankle Sprain**

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derksen 2005 RCT</td>
<td>7.0</td>
<td>N = 106 ankle sprains</td>
<td>Application of Ottawa ankle and foot rules: specialized emergency nurse assessment (SEN) vs. house officer assessment (HO)</td>
<td>SEN group found indication of radiography in 60 (57%) of 106 patients vs. HO 69 (65%), ( p = 0.10 ). SEN vs. HO sensitivity of detecting fractures by means of OAR and OFR: 0.93 (CI 0.64-1.00)/0.93 (CI 0.64-1.00), ( p = 1.00 ). Specificity: 0.49 (CI 0.38-0.60)/0.39 (CI 0.29-0.50), ( p = 0.20 ). OAR and OFR overall results for lateral malleolus ( k = 0.30 ), medial malleolus ( k = 0.50 ), navicular ( k = 0.45 ), metatarsal vs. base ( k = 0.43 ).</td>
<td>“Specialized emergency nurses are able to assess ankle and foot injuries in an accurate manner with regard to the detection of acute fractures after a short, inexpensive course.”</td>
<td>Randomized variable order of assessment. All patients assessed by both (quasi-cross over trial). Data suggest trained nurses are able to apply Ottawa rules.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Education for Ankle Sprain**

There are no quality studies incorporated into this analysis.

**Evidence for the Use of Acetaminophen for Ankle Sprain**

There is 1 high- and 1 moderate-quality RCTs incorporated into this analysis.
### Evidence for the Use of NSAIDs for Ankle Sprain

There are 4 high- and 14 moderate-quality RCTs incorporated into this analysis. (Lyrtzis 11) There are 4 low-quality RCTs in Appendix 2.(459-462) (Dupont 87; Fredberg 89; Aghababian 86; Andersson 83)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
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<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dalton 2006</strong> RCT</td>
<td>8.5</td>
<td>N = 260 Grade I or II lateral ankle sprains</td>
<td>Acetaminphen Extended Release (1,300mg TID vs. ibuprofen 400mg TID) for mild and moderate acute ankle sprain.</td>
<td>No significant differences at 4 or 9 days on outcomes of pain on walking, ability to walk, swelling, bruising, ROM, satisfaction with treatment, negative anterior drawer, time to resume normal activity.</td>
<td>“Acetaminophen extended release 3,900 mg daily was comparable to ibuprofen 1,200 mg daily for treatment of grade I or II lateral ankle sprains. Both treatments were well tolerated.”</td>
<td>Comparison is to OTC strength ibuprofen. Data suggest no difference in benefit for acute mild to moderate ankle sprain.</td>
<td></td>
</tr>
<tr>
<td><strong>Kayali 2007</strong> RCT</td>
<td>4.0</td>
<td>N = 100 1st or 2nd degree lateral ankle sprains within 48 hours of admission</td>
<td>Diclofenac sodium 75mg twice a day vs. paracetamol 500mg 3 times a day for 5 days for Grade I and II ankle sprains; follow-up 6 weeks.</td>
<td>Physician global mean assessment diclofenac sodium vs. paracetamol at Day 1, 10, and Week 6: 1.46±0.5 vs. 1.42±0.49, 3.18±0.5 vs. 3.14 ±0.53, 3.76±0.43 vs. 3.72±0.45. ROM initial/last exam: 28.8°±9.3 vs. 30.2°±8.5 p = 0.43, 68.4°±3.1 vs. 67.6°±3.6 p = 0.03. No differences in swelling at any period.</td>
<td>“[D]iclofenac sodium and paracetamol are effective and well tolerated as a short term treatment alternatives for acute ankle injuries.”</td>
<td>No placebo. Lack of randomization, allocation, baseline comparison and blinding details. Data suggest paracetamol is at least equivalent to NSAIDs for analgesia. No placebo arm.</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Intervention</td>
<td>Procedure</td>
<td>Outcomes</td>
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<tr>
<td>Slatyer 1997 RCT</td>
<td>N = 364</td>
<td>Piroxicam 40mg x 2 days, then 20mg x 5 days vs. placebo. 7-day trial with 6 month follow-up. All grades included.</td>
<td>Piroxicam vs. placebo “positive anterior drawer tests” Day 0, 3, 7, and 14 (%): 36/38 ($\chi^2 = 1.12, p = 0.57$), 26/10 ($\chi^2 = 16.14, p = 0.001$), 15/2 ($\chi^2 = 18.00, p = 0.001$), 8/1 ($\chi^2 = 9.08, p = 0.001$). VAS scores better Day 3, 7 (p &lt;0.001). Subjects experiencing difficulty with activities at Day 14, 1 month, 3, and 6: p = 0.0001/ $\chi^2 = 50.58$, p = 0.0001/ $\chi^2 = 88.02$, p = 0.0001/ $\chi^2 = 64.96$. p = 0.0001/ $\chi^2 = 16.90$ favoring piroxicam.</td>
<td></td>
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<tr>
<td>Ekman 2002 RCT</td>
<td>N = 445</td>
<td>Celecoxib 200mg BID vs. ibuprofen 800mg TID vs. placebo, 10-day trial,</td>
<td>Patient global assessment 0-100 scale: celecoxib vs. placebo Day 4, 8, 11: 67 vs. 55 p &lt;0.05, 82 vs. 72 p &lt;0.05, 90 vs. 88 p = NS. Celecoxib</td>
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</table>

“[N]onsteroidal anti-inflammatory agents should form an integral part of the treatment of acute ankle sprains.”

Military training camp population. Clinical significance of improving positive anterior drawer sign unspecified. Study suggests benefits in pain scores at 2 weeks from NSAID but not in swelling. Suggests long-term benefit in reduction of difficulty with activities (difficulty in walking, running, jogging, forced march)
<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Design</th>
<th>Pain</th>
<th>Treatment</th>
<th>Outcome Measures</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sloan Injury 1989 RCT</td>
<td>122</td>
<td>RCT</td>
<td>N = 122 acute ankle injuries within 6 hours of injury</td>
<td>Immediate ibuprofen (1,200mg loading, 2,400mg total per day) vs. placebo 1st 48 hours, then same ibuprofen schedule. Uniform background therapy of 20 minutes cooling, compression and elevation given to all patients using cooled anklet.</td>
<td>Immediate vs. delayed soft tissue swelling index: % improvement 49% vs. 37% p &lt;0.01. Severity of injury: no data presented, favored immediate group p = 0.05; range of movement no differences; ability to bear weight no differences.</td>
<td>Immediate medication with high-dose ibuprofen at 2400 mg/day should be considered in the routine treatment of moderate to severe ankle sprains, whether patients.</td>
</tr>
<tr>
<td>NYS WCB MTG – Ankle and Foot Disorders</td>
<td>222</td>
<td></td>
<td>to severe ankle pain</td>
<td>Grade I, II sprains, treated within 48 hours. Follow-up on Day 11. vs. ibuprofen no differences between groups. VAS weight bearing 0-100 scale: celecoxib vs. placebo Day 0, 4, 8, 11: 68.5 (14.1) vs. 71.3 (12.1), 35.3 (1.6) vs. 42.4 (1.6) p &lt;0.05, 23.3 (1.8) vs.31.2 (1.8) p &lt;0.05, 15.6 (1.8) vs. 19.9 (1.8) p = NS. Celecoxib vs. ibuprofen no differences between groups. Median return to normal function: celecoxib 5 days vs. ibuprofen 6 days vs. placebo 8 days, p = 0.001 for celecoxib vs. placebo, no difference between celecoxib and ibuprofen.</td>
<td>celecoxib 400 mg/day was more effective as the maximum recommended dose of ibuprofen (2400 mg/day).”</td>
<td>benefit in weight-bearing pain, patient global assessment, and return to function over placebo acutely. Differences not significant after 1 week. Differences in clinical VAS scores of questionable significance.</td>
</tr>
<tr>
<td>Name</td>
<td>Year</td>
<td>Study Type</td>
<td>N</td>
<td>Description</td>
<td>Methodology</td>
<td>Findings</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Bahamonde</td>
<td>1990</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 93 mild to severe sprained ankles</td>
<td>Diclofenac potassium 50mg TID vs. piroxicam 20mg vs. placebo (7-day trial) for acute ankle sprain (severity not specified, no torn ligaments).</td>
<td>Minimal statistical details provided. Volume of foot: no differences between 3 groups at 7 days. Pain at 2 days: lower VAS for diclofenac vs. placebo (p &lt;0.0001) and piroxicam (p &lt;0.0002). Differences continued to Day 3 vs. placebo, disappeared with piroxicam. Investigators assessment (excellent) higher for diclofenac p = 0.001.</td>
</tr>
<tr>
<td>Dreiser</td>
<td>1993</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 60 with symptoms and signs of traumatic distortion of the ankle</td>
<td>Nimesulide 100mg BID vs. placebo for acute ankle sprain.</td>
<td>Nimesulide vs. placebo (0-10) VAS at 0, 4, 8 days. Functional impairment: 2.7 vs. 2.8, 1.7 vs. 2.4 (p &lt;0.01), 0.8 vs. 1.8 (p &lt;0.001); Pain on passive movement: 2.6 vs. 2.7, 1.6 vs. 2.2 (p &lt;0.01), 0.9 vs. 1.7 (p &lt;0.001); Joint swelling: (units not specified) 19.3 vs. 21.8, 12.1 vs. 16.1 p &gt;0.05, 5.7 vs. 5.7 p &gt;0.05.</td>
</tr>
<tr>
<td>Goldie</td>
<td>1974</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 30 ankle sprains</td>
<td>Metopyramizol vs. phenylbutazone vs. placebo (dosages and schedule not stated), 7-day trial.</td>
<td>Mean improvement of foot volume: 60% metopyramizol vs. 51% phenylbutazone, vs. 56% placebo.</td>
</tr>
</tbody>
</table>

Diclofenac potassium 50mg TID vs. piroxicam 20mg vs. placebo (7-day trial) for acute ankle sprain (severity not specified, no torn ligaments).

Minimal statistical details provided. Volume of foot: no differences between 3 groups at 7 days. Pain at 2 days: lower VAS for diclofenac vs. placebo (p <0.0001) and piroxicam (p <0.0002). Differences continued to Day 3 vs. placebo, disappeared with piroxicam. Investigators assessment (excellent) higher for diclofenac p = 0.001.

“Diclofenac potassium was a good alternative to piroxicam for the treatment of stable (non-surgical) ligamentary injuries of the ankle, with a rapid onset of action and good overall tolerability by the patients.”

Lack of randomization, allocation, compliance details. Suggests NSAIDs provide short-term benefit for acute sprains. Possible superiority of diclofenac vs. piroxicam at this dosage although conclusions limited by lack of presented data.

Nimesulide 100mg BID vs. placebo for acute ankle sprain.

Nimesulide vs. placebo (0-10) VAS at 0, 4, 8 days. Functional impairment: 2.7 vs. 2.8, 1.7 vs. 2.4 (p <0.01), 0.8 vs. 1.8 (p <0.001); Pain on passive movement: 2.6 vs. 2.7, 1.6 vs. 2.2 (p <0.01), 0.9 vs. 1.7 (p <0.001); Joint swelling: (units not specified) 19.3 vs. 21.8, 12.1 vs. 16.1 p >0.05, 5.7 vs. 5.7 p >0.05.

“Nimesulide 100 mg administered twice daily is an effective and safe short term treatment in the management of post-traumatic joint injuries.”

Lack of randomization, allocation, baseline comparison, blinding details. Only included subjects with slight to moderate pain (>5 on 10 point VAS). Study suggests NSAIDs beneficial for pain relief over 8-day course for mild to moderately painful sprains. Clinical significance likely small.

Metopyramizol vs. phenylbutazone vs. placebo (dosages and schedule not stated), 7-day trial.

Mean improvement of foot volume: 60% metopyramizol vs. 51% phenylbutazone, vs. 56% placebo.

“The comparison between phenylbutazone and metopyramizol did not therefore yield any information as Not clear if study was randomized. Sparse methodology details. Study suggests no benefit on ankle swelling. Conclusions
The reduction of swelling was the largest in the placebo group, might be an indication that Nature’s own way in repair of tissue injury may be preferable to interference with drugs whose exact effect in the organism still remains unknown."

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Severity</th>
<th>N</th>
<th>Medication Details</th>
<th>Outcome</th>
<th>Method Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moran 1991</td>
<td>RCT</td>
<td>Moderate to severe</td>
<td>60</td>
<td>Diclofenac Potassium 50 mg. t.i.d. vs. Ibuprofen 400 mg. t.i.d. vs. placebo for acute ankle sprain</td>
<td></td>
<td>Lack of randomization, allocation, baseline comparison, blinding details. Ibuprofen group appears to have had significant difference in baseline swelling. Data suggest NSAIDs may be superior to placebo for analgesia.</td>
</tr>
<tr>
<td>Petrella 2004</td>
<td>RCT</td>
<td>Grade I, II</td>
<td>397</td>
<td>Celecoxib 200mg BID vs. naproxen 500mg BID, 7-day trial for acute Grade I, II sprains.</td>
<td>Celecoxib is as effective as naproxen in treating acute first-degree or second-degree ankle sprains but causes</td>
<td>No placebo. Study suggests no difference in NSAID efficacy between Cox-2 inhibitor and naproxen.</td>
</tr>
</tbody>
</table>

Reference:
Moran 1991 RCT:
- N = 60 ankle sprains suffering from moderate to severe inflammation and tenderness
- Diclofenac Potassium 50 mg. t.i.d. vs. Ibuprofen 400 mg. t.i.d. vs. placebo for acute ankle sprain
- Severity rating of 0 on Day 7 using 4-point scale: 0-none to 3 wincing and withdrawal

Petrella 2004 RCT:
- N = 397 acute 1st-degree or 2nd-degree ankle sprain
- Celecoxib 200mg BID vs. naproxen 500mg BID, 7-day trial for acute Grade I, II sprains.
- Mean VAS scores Day 4 and 8: celecoxib = 31.9±1.96/15.0±1.70, naproxen = 29.0±1.91/15.3±1.65. Non-inferiority treatment differences (upper 95% CI) Day 4 (p = .001, p = .004 respectively vs. placebo. Pain on passive movement rating of 0: 17/20 vs. 14/21 vs. 7/19 p <.05 vs. placebo for both.

- Celecoxib vs. ibuprofen vs. placebo: 12/20 vs. 8/21 vs. 1/19. p = .001, p = .004 respectively vs. placebo.

"[D]iclofenac potassium has been demonstrated to be effective in the treatment of acute ankle sprains."
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Treatment</th>
<th>Patient global assessment Day 4 and 8 (%): celecoxib = 71%/89%, naproxen = 72%/90%. Celecoxib vs. naproxen AE of dyspepsia p = 0.032.</th>
<th>significantly less dyspepsia.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ekman 2006 RCT</td>
<td>9.5</td>
<td>N = 829 acute 1st- or 2nd-degree ankle sprain</td>
<td>Valdecoxib 20mg bid vs. valdecoxib 20mg qd vs. tramadol 50mg 4 times vs. placebo.</td>
<td>Patient global assessment good/very good: Day 4 no differences, Day 7 (76.4 vs. 67.3 vs. 59.6 vs. 55.5) p &lt;0.001 for BID vs. placebo. APS questionnaire: 33.9 vs. 26.6 vs. 20.6 vs. 24.4 (p = 0.009 Day 4). Patient assessment of return to walking with/without pain Day 4 47.5/44.6/38.4/35.0) p = 0.002; Day 7 (79.4/72.5/ 67.3/63.9) p = 0.001. Tramadol treatment withdrawals due to adverse events vs. valdecoxib treatment (12.2% vs. 3.4%, p = 0.0005). Withdrawal rates due to adverse events similar in valdecoxib and placebo groups (3.4% vs. 2.4%, p = 0.75).</td>
<td>“…valdecoxib 20 mg bid was at least as effective as Tramadol 50 mg 4 times daily and significantly better than placebo.” Data suggest valdecoxib 20mg BID superior to placebo and trended towards better than tramadol for acute pain relief at Days 4 and 7. Data suggest no difference in tramadol and placebo at Day 4, with higher withdrawal rates in tramadol group.</td>
</tr>
<tr>
<td>Nadarajah 2006 RCT</td>
<td>9.5</td>
<td>N = 370 1st- or 2nd-degree ankle sprain ≤48 hours</td>
<td>Celecoxib 200mg BID vs. diclofenac SR 75mg BID x 3 days for</td>
<td>VAS score on full weight bearing (celecoxib/diclofenac): Day 4 (182/164) LS mean -0.8; final visit (188/177) LS mean -0.2.</td>
<td>“Celecoxib (400 mg loading, 200 mg bid) was as effective as diclofenac Study did not include a placebo group and allowed co-interventions of RICE, PT. Efficacy trial.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
<td>Description</td>
<td>Intervention</td>
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<tr>
<td>Lyrtzis 2011 RCT</td>
<td>7.0</td>
<td>N = 86 with acute Grade II sprains of the lateral collateral ligaments, age range 18 to 60</td>
<td>Group A, diclofenac, 75mg orally, twice a day, first 10 days (n = 42) Group B, paracetamol , 500mg, orally, 3 times a day (n = 44). All: RICE protocol, ankle bandage, for 10 days, elevation for first 3 days, start walking after 10 days. Follow-up: baseline, days 3 and 10.</td>
<td>Mean score for VAS pain scale: diclofenac vs. paracetamol: baseline/3rd day: 70.2/22.1 vs. 72.5/22.3, p &lt; 0.001; baseline vs. baseline/10th day: 70.2/6.9 vs. 72.5/5.1,p &lt; 0.001.</td>
<td>“[D]iclofenac and paracetamol had the same effect on pain reduction of ankle sprains but more acute ankle edema was present in patients who were treated with diclofenac than in patients who were treated with paracetamol.”</td>
</tr>
<tr>
<td>Finch 1989 RCT</td>
<td>5.5</td>
<td>N = 50 acute ankle sprains or strains</td>
<td>Flurbiprofen 100mg vs. diflunisal 500mg BID x 18 days for acute ankle sprain &lt;36 hours. All subjects had 7-day plaster cast immobilization.</td>
<td>Flurbiprofen vs. diflunisal physician assessment mean score changes: (only significant differences reported) measured Day 0, 7, 14, 21. Functional capability: Day 7 -1.96/-1.59 gait: Day 7 -1.22/-1.00, Day 14 -1.96/-1.77; Joint swelling: no differences; Ankle discoloration: no differences; Pain on passive motion: Day 7, -2.17/-1.81; Patient assessment mean scores. Pain while walking: no differences; Pain</td>
<td>“Flurbiprofen and diflunisal appear to be effective and well-tolerated medications for the treatment of acute ankle sprains and strains.”</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Diagnosis</td>
<td>Comparator</td>
<td>Measure</td>
<td>Findings</td>
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<tr>
<td>Duncan 1988</td>
<td>5.0</td>
<td>N = 139 acute sprains and/or strains of knee or ankle</td>
<td>Diclofenac 75mg BID vs. aspirin 1.2g TID for acute ankle, knee injuries (&lt;72 hours) for 3-10 days.</td>
<td>Diclofenac vs. aspirin mean (±SEM) for swelling, limitation of active ROM, pain on active motion: -1.17 (0.12)/-1.45 (0.11), -1.79 (0.11)/-1.88 (0.11), -1.96 (0.10)/-1.82 (0.10). Intragroup improvement from baseline p &lt;0.001. Intergroup differences not significantly different; % returned to sport in 10 days: 83% vs. 82%, p &gt;0.05).</td>
<td>&quot;Diclofenac is useful in treating sports-related injuries and may allow an earlier return to playing fitness.&quot;</td>
</tr>
<tr>
<td>Adams 1978</td>
<td>4.5</td>
<td>N = 37 acute, minor ligamentous injuries</td>
<td>Diflunisal 500mg twice daily vs. 200mg oxyphenbutazone 3 times daily (3-day trial, double-dummy, acute sprains classified as minor).</td>
<td>Spontaneous pain (rest) completely resolved in all patients by Day 3. Improvement (better/cured) in pain on movement: 16/17 diflunisal vs. 9/14 oxyphenbutazone p &lt;0.01. Overall assessment (patient and physician): no differences at Day 1 or 3.</td>
<td>&quot;On the third day of treatment showed considerable improvement in the presenting symptoms and at this point diflunisal was statistically significantly better than oxyphenbutazone in regard to relief of pain on movement of the joint.&quot;</td>
</tr>
<tr>
<td>Hayes 1984</td>
<td>4.5</td>
<td>N = 191 males &gt;18 years old diagnosis of acute unilateral sprains or strains of ankle, hips, shoulders, or knees</td>
<td>Sulindac 200mg BID vs. ibuprofen 400mg TID, 4-day treatment.</td>
<td>Outcomes at 4 days: sulindac vs. ibuprofen mean rank for day pain, night, active motion, tenderness, ROM, and swelling: 86.3/91.0, 72.6/77.6, 88.5/87.4, 91.7/ 84.9, 83.2/93.3, 88.7/86.2. No differences reported.</td>
<td>&quot;Sulindac has a place in the treatment of acute sprains and strains.&quot;</td>
</tr>
</tbody>
</table>

No placebo. Thirty-percent loss to follow-up/excluded from study. Data suggest no difference between ASA and diclofenac x.

Time elapsed from injury to entry into study significantly longer in oxybutazone group (median 13 vs. 4 hours). Sparse study details. Results suggest little clinical differences for acute pain relief. Medication off market.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Quality</th>
<th>N</th>
<th>Diagnosis</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>McLatchie</td>
<td>1985</td>
<td>4.5</td>
<td>N = 144</td>
<td>Grade 1 and 2 inversion injuries to ankle sustained in sport</td>
<td>Ibuprofen 600mg QID vs. 1200mg BID vs. placebo for Grade I, II injuries; 7-day trial.</td>
<td>Ibuprofen QID vs. BID vs. placebo: Joint tenderness (0-8 scale): Day 3 no differences between any group. Day 7 VAS 2.44 vs. 2.647 vs. 3.182 (p &lt;0.001). Mean level of training (0-3 scale): Day 3; 1.34 vs. 1.34 vs. 1.23, p &lt;0.01 for ibuprofen vs. placebo. No difference between ibuprofen groups.</td>
<td>“In soft tissue injuries to the lateral ligament complex caused by sporting activity a short course of high dose ibuprofen should be considered.”</td>
</tr>
<tr>
<td>Kayali</td>
<td>2007</td>
<td>4.0</td>
<td>N = 100</td>
<td>1st or 2nd degree lateral ankle sprains within 48 hours of admission</td>
<td>Diclofenac sodium 75mg twice daily vs. paracetamol 500mg 3 times daily for 5 days for Grade I and II ankle sprains; follow-up for 6 weeks.</td>
<td>Physician global mean assessment for diclofenac sodium vs. paracetamol Day 1, 10, and Week 6: 1.46±0.5 vs. 1.42±0.49, 3.18±0.5 vs. 3.14±0.53, 3.76±0.43 vs. 3.72±0.45. ROM initial and last examination: 28.8°±9.3 vs. 30.2°±8.5 p = 0.43, 68.4°±3.1 vs. 67.6°±3.6 p = 0.03. No differences in swelling at any period.</td>
<td>“Diclofenac sodium and paracetamol are effective and well tolerated as a short term treatment alternatives for acute ankle injuries.”</td>
</tr>
<tr>
<td>Viljakka</td>
<td>1983</td>
<td>4.0</td>
<td>N = 119</td>
<td>ankle sprains</td>
<td>Layer bandage vs. elastic adhesive tape. Oxyphenbutazone 100mg tid vs. clonixin 300mg TID vs. placebo.</td>
<td>No significant differences between layer bandage vs. elastic tape bandage in pain, tenderness, swelling, ROM. Elastic caused more rash, irritation or compression of skin. Examiners estimate of “Good” result: layer bandage (64%) vs. elastic (62%) vs. placebo.</td>
<td>“The layer bandage proved more stable in the lateral direction than the elastic adhesive tape bandage (p less than 0.001). Clonixin proved useful</td>
</tr>
</tbody>
</table>

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Evidence for the Use of Opioids for Ankle Sprain

There are 2 high-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hewitt 2007</td>
<td>9.5</td>
<td>N = 603 adults with ankle sprain and a diagnosis of partial ligament tear</td>
<td>Tramadol plus acetaminophen (37.5/375) QID vs. hydrocodone plus acetaminophen (7.5/650) qd vs. placebo for acute mild and moderate ankle sprain short term analgesia (5-day follow-up).</td>
<td>Tramadol/APAP vs. hydrocodone/APAP vs. placebo (pain relief score 0-4 scale) Immediate Mean Pain Relief: Tramadol better than placebo at 2, 3, 4 hours. Hydrocodone better than placebo at 1, 2, 3, 4 hours. Differences continued through Day 3. No differences between Tramadol and hydrocodone. Pain scores were at rest, not with movement (scores on 4 point scale). Total adverse events (95% CI): tramadol/acetaminophen 43.2% (36.2-50.2); hydrocodone/acetaminophen 36.5% (29.8-43.1); placebo 19.3% (13.9-24.7). Discontinuation caused by adverse events: tramadol/acetaminophen 5.2%;</td>
<td>“One or 2 capsules of 37.5 mg tramadol/325 mg acetaminophen and 1 capsule of 7.5 mg hydrocodone/65 mg acetaminophen were well tolerated, had comparable clinical utility, and were more effective than placebo in the management of acute musculoskeletal pain caused by ankle sprain.”</td>
<td>Study limited to short-term analgesia. Pain scores were at rest and not with activity, limiting overall conclusions.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Study Design</td>
<td>Description</td>
<td>Comparison</td>
<td>Treatment Differences</td>
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<tr>
<td>Ekman 2006</td>
<td>9.5</td>
<td>RCT</td>
<td>N = 829 acute 1st- or 2nd-degree ankle sprain</td>
<td>Valdecoxib 20mg BID vs. valdecoxib 20mg qd vs. Tramadol 50mg 4 times vs. placebo.</td>
<td>Patient global assessment good/very good: Day 4 no differences, Day 7 (76.4 vs. 67.3 vs. 59.6 vs. 55.5) p &lt;0.001 for BID vs. placebo. APS questionnaire: 33.9 vs. 26.6 vs. 20.6 vs. 24.4 (p = 0.009 Day 4). Patient assessment of return to walking with/without pain Day 4 (47.5/44.6/38.4/35.0) p = 0.002; Day 7 (79.4/72.5/67.3/63.9) p = 0.001. Adverse events, any, (%): valdecoxib 20mg BID 33.0% vs. vadlecoxib 20mg qd 27.2% vs. tramadol 50mg QID 58.0% vs. placebo 43.1%. Adverse events, severe, (%): valdecoxib 20mg BID 2.1% vs. valdecoxib 20mg qd 1.7% vs. tramadol 50mg QID 7.5% vs. placebo 3.3%. Withdrawals due to adverse events: tramadol 12.2% vs. valdecoxib 3.4% (p = 0.0005); valdecoxib 3.4% vs. placebo 2.4% (p = 0.75). Adverse events included upper GI discomfort, GI-related adverse events, CNS-related adverse...</td>
<td>Data suggest valdecoxib 20mg BID superior to placebo and trended towards better than tramadol for acute pain relief at Days 4 and 7. Data suggest no difference in tramadol and placebo at Day 4, with higher withdrawal rates in tramadol group.</td>
</tr>
</tbody>
</table>

Valdecoxib 20mg BID was at least as effective as Tramadol 50mg 4 times daily and significantly better than placebo.
**Evidence for the Use of Proteolytic Enzymes for Ankle Sprain**

There is 1 high- and 1 moderate-quality RCT incorporated into this analysis. There is 1 low-quality RCT in Appendix 2. (Brakenbury 83)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerkhoffs 2004 RCT</td>
<td>8.0</td>
<td>N = 692 aged 16-53 years with acute unilateral sprain of the lateral ankle joint</td>
<td>Oral hydrolytic enzymes (various combinations of phlogenzym, trypsin, bromelain, rutoside) vs. placebo.</td>
<td>Pain reduction at 7 days: Bromelain-trypsin 73.7%, Phlogenzym 60.3%, placebo 73.3%. Ankle swelling reduction: no significant differences found.</td>
<td>“Administration of proteolytic enzymes is no more effective than placebo in patients with an acute lateral ankle sprain treated functionally with a brace.”</td>
<td>All patients treated with functional brace in addition to interventions. Data suggest lack of efficacy.</td>
</tr>
<tr>
<td>Craig 1975 RCT</td>
<td>4.5</td>
<td>N = 61 soft-tissue ankle injuries</td>
<td>Proteolytic enzymes (chymoral) vs. placebo taken for 5 days after acute ankle sprain.</td>
<td>Chymoral vs. placebo measurements for volume, horizontal circumference, diagonal circumference, and diameter: 60±1.608/75.42±57.274 (p = 0.2), 1.10±0.8807/1.229±0.9019 (p = 0.4), 0.469±0.3631/0.466±0.2842 (p = 0.9). Percent improved (%): 4.958±3.378/6.374±4.616 (p = 0.2).</td>
<td>“[N]o significant improvement in the treated series, there would appear to be no economic grounds for the continued use of these enzymes.”</td>
<td>Allocation, blinding, baseline comparability, compliance details sparse or missing. Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Streptokinase/Streptodornase for Ankle Sprain**
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calandrello 1991</td>
<td>RCT</td>
<td>6.5</td>
<td>N = 200 ankle sprains</td>
<td>Streptokinase 10,000 units plus Streptodornase 2500 units, 2 tabs po TID for 8 days vs. placebo (acute sprain, Grade II, III)</td>
<td>SS vs. placebo, Days 4, 8 mean (SE) (0 none, 1 mild, 2 moderate, 3 severe VAS score) Spontaneous pain: 0.41± 0.05 vs. 0.56±0.06 p = NS, 0.04±0.020 vs. 0.19±0.040, p &lt;0.05; Mobilization pain: 1.26±0.06 vs. 1.70± 0.06, p &lt;0.0001, 0.69±0.062 vs. 1.14±0.060, p &lt;0.0001; edema: 1.38±0.072 vs. 1.96 ±0.060, p &lt;0.0001, 0.60±0.062 vs. 1.41±0.070, p &lt;0.0001.</td>
<td>&quot;Oral (streptokinase +streptodornase) appears as a suitable alternative to NSAIDs because of its efficacy and low incidence of side effects.&quot;</td>
<td>Data suggest SK, SD may modestly reduce edema, pain over placebo. Clinical results however are of uncertain significance.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Systemic Glucocorticosteroids for Ankle Sprain
There are no quality trials incorporated into this analysis.

Evidence for the Use of Vitamins for Ankle Sprain
There are no quality trials incorporated in this analysis.

Evidence for the Use of Cold Gel for Ankle Sprain
There is 1 high- and 1 moderate-quality RCT incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Gonzalez de Vega 2013</td>
<td>RCT</td>
<td>9.0</td>
<td>N = 449 with unilateral ankle sprain of the lateral ligaments; age range 17- 48</td>
<td>Traumeel ointment (T-O), 2 g (n = 152) vs. Traumeel gel (T-G) (n =150) vs. Diclofenac gel (D-G) (n = 147). Administered to ankle 3x/day for 14 days, paracetamol used as rescue medication for</td>
<td>No significant differences between groups for primary outcomes.</td>
<td>&quot;T-O and T-G decreased pain and improved joint function to the same extent as D-G in acute ankle sprain, and were well tolerated.&quot;</td>
<td>No placebo, non-inferiority. Multicenter study. Large N. Data suggest comparable efficacy. However, less paracetamol use in diclofenac group (14.6% vs. 19.7%, 20.7%), suggesting potential confounding.</td>
</tr>
</tbody>
</table>
pain. Follow-up: baseline, days 4, 7, 14 and 42.

Airaksinen 2003
RCT

6.5

N = 74 sports-related soft tissue injuries

Cold Gel (Ice Power) vs. placebo gel (4 times a day for 14 days) for acute minor injuries (mixed, including ankle).

Cold gel vs. placebo: pain at rest (0-100 VAS): Day 1; 59±15 vs. 59±15, Day 7; 30 ±16 vs. 45±15, Day 14; 14± 13 vs. 26±18, Day 28; 7±12 vs. 13±14, p <0.001 at 1, 2, 4 weeks.

Functional disability (0-100 VAS): Day 1; 63 vs. 62 Day 7; 31 vs. 48 p <0.001.

"[C]old gel caused significantly faster pain relief and significantly faster rehabilitation results after minor soft tissue injuries." Heterogeneous injuries included, 23/74 of ankle. Severity of ankle sprain not specified other than minor. Clinical significance of pain and disability differences likely small. Skin temperature not measured (cold) objectively and thus not considered as part of cryotherapy. Data suggest modest efficacy.

### Evidence for the Use of Comfrey Extract for Ankle Sprain

There are 3 moderate-quality RCTs incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koll 2004 RCT</td>
<td>7.5</td>
<td>N = 143 unilateral acute ankle sprains</td>
<td>Comfrey extract gel vs. placebo (4 times daily application of 2g).</td>
<td>Comfrey vs. placebo, VAS: mean between injured/healthy foot at Day 4, 7; Pain: 2.37 vs. 3.35, p = 0.001, 1.44 vs. 2.85, p = 0.0001; swelling: 1.69 vs. 2.36, p = 0.0011, 1.09 vs. 1.90, p = 0.0001. Patient global efficacy (good/excellent) 61.3% vs. 50%, p = not reported.</td>
<td>&quot;Compared to placebo, comfrey proved clinically and statistically superior concerning reduction of pain, swelling, movement limitation and global efficacy.&quot;</td>
<td>Lack of randomization, allocation, compliance details. Data suggest comfrey root extract superior to placebo gel for treatment of acute ankle sprains.</td>
</tr>
<tr>
<td>D’Anchise 2007 RCT</td>
<td>5.5</td>
<td>N = 164 acute unilateral ankle</td>
<td>Comfrey extract ointment (Kitta-Salbe®) vs.</td>
<td>Mean difference in tenderness values measured by tonometry of injured vs.</td>
<td>&quot;The re-evaluation of the data showed superiority of Second report of Predel 2005 (consider one study). Data suggest&quot;</td>
<td></td>
</tr>
</tbody>
</table>
### Evidence for the Use of Lidocaine Patches for Ankle Sprain

There are no quality trials incorporated into this analysis.

### Evidence for the Use of Movelat for Ankle Sprain

There are 2 moderate-quality trials incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Predel 2005 RCT</td>
<td>5.5</td>
<td>N = 164</td>
<td>Comfrey extract ointment (Kitta-Salbe®) vs. diclofenac gel (6-cm QID × 7 days for acute ankle sprain.)</td>
<td>Comfrey vs. diclofenac VAS reduction (%) from baseline: Day 7; At rest: 92.01% vs. 84.96% (p &gt;0.05); At motion: 83.2% vs. 72.37% (p &gt;0.05); Good/Excellent patient assessment: 84.2% vs. 70.8% p = 0.0111.</td>
<td>“It was confirmatorily shown that Comfrey extract is non-inferior to diclofenac. Moreover, the results of the primary and secondary variables indicate that Comfrey extract may be superior to Diclofenac gel.”</td>
<td>No placebo. Randomization, allocation, compliance details sparse. Suggests comfrey root extract of equal efficacy.</td>
</tr>
<tr>
<td>Author/Year</td>
<td>Score</td>
<td>Sample Size</td>
<td>Comparison Group</td>
<td>Results</td>
<td>Conclusion</td>
<td>Comments</td>
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<tr>
<td>Frahm 1993</td>
<td>6.0</td>
<td>N = 163 acute sprains of the knee or ankle joint</td>
<td>Movelat vs. placebo. 10cm cream BID for acute mild, moderate ankle sprain.</td>
<td>Movelat vs. placebo: mean pain with movement (100mm VAS) Day 2, 4, 9, 11: 57.46 vs. 64.33, ( p = \text{NS} ); 41.53 vs. 48.13, ( p = \text{NS} ); 24.87 vs. 38.73, ( p = 0.0065, 21.11 \text{ vs. 32.10, } p &gt; 0.05 ). No differences in pain at rest, swelling, or physician assessment of efficacy or tolerability.</td>
<td>“Treatment with the active cream lessened the pain on movement by 28% compared with the placebo, a statistically significant difference.”</td>
<td>Double-blinding details sparse. Data suggest topical Movelat cream has limited, if any, analgesic efficacy as only significant Day 9. No differences for pain at rest, edema, or subjective efficacy. Data suggests benefit clinically non-significant.</td>
</tr>
<tr>
<td>Lester 1981</td>
<td>5.5</td>
<td>N = 50 sprained ankles</td>
<td>Movelat vs. placebo.</td>
<td>Scoring system 1-4 (not defined) for movement limitation, swelling, pain, side effects created. Mean cumulative score (higher = better): Movelat gel group 12.1 (±3.8) vs. placebo gel group 9.7(±3.7), ( p &lt; 0.05 ).</td>
<td>“Movelat Gel as an adjunct to physiotherapy was shown to be superior to placebo gel and physiotherapy in alleviating the signs and symptoms of sprained ankle.”</td>
<td>Randomization, allocation, compliance details sparse. Minimal statistical analyses presented. Data suggest cream may be effective, however, findings not clearly supported by details of analysis.</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Topical NSAIDs for Ankle Sprain**

There are 4 high-quality RCTs (Predel 12) and 4 moderate-quality RCTs incorporated in this analysis. There is 1 low-quality study in Appendix 2.(485) (Campbell 94)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mazière 2005</td>
<td>9.0</td>
<td>N = 163 suffering painful (spontaneous pain ( &gt; \text{or } = 50\text{mm on a 0- to 100-mm VAS}, ) benign ( \text{Grade I or II}, ) recent (&lt; 2 \text{ days} ) ankle sprains as a model of general</td>
<td>Ketoprofen 100mg patch daily vs. placebo patch; 2-week trial for acute Grade I, II.</td>
<td>Ketoprofen vs. placebo Day 3, 7, 14. Spontaneous pain VAS (100mm): 33±19 vs. 40±22 ( p = 0.0053, 18±17 \text{ vs. 28±24 } p = 0.007, 9±13 \text{ vs. 20±26 } p = 0.006 ). Pain on active motion, VAS (100mm): 37±18 vs. 45±22, 22±17 \text{ vs. 33±24 } p = 0.192, 10±14 \text{ vs. 22±25 } p = 0.0178 ). Ankle swelling (%): 3.9±3.7 \text{ vs. 4.0±3.4, } p = 0.0476,</td>
<td>“This trial suggests that a 3- to 14-day treatment course by once-a-day 100-mg ketoprofen TDS patch is useful in post-traumatic painful soft tissue injuries, the duration depending on the results</td>
<td>Data suggest modest short-term benefit of ketoprofen patch over placebo for acute injury.</td>
</tr>
<tr>
<td>Study</td>
<td>Level</td>
<td>n</td>
<td>Sample Description</td>
<td>Outcome Measures</td>
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<tr>
<td>Diebschlag 1990 RCT</td>
<td>8.5</td>
<td>N = 37 ankle sprains</td>
<td>Topical Ketorolac tromethamine 2% gel vs. etofenamate gel 5% vs. placebo x 15 days for acute ankle sprain.</td>
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<td>Ketorolac vs. placebo: (% mean difference, 95% CI, p-value). Max volume change: -0.72 (-1.16 to -0.28, p = 0.002; AUC: -0.84 (-1.17 to -0.51) p = 0.0001; Day 15 volume: -0.82 (-1.02 to -0.61) p = 0.0001. Ketorolac vs. etofenamate (% mean difference, 95% CI, p-value). Max Vol Change -0.02 (-.46 to 0.42) p = 0.92. AUC: 0.13 (-0.20 to 0.46) p = 0.44. Day 15 Volume: 0.13 (-0.08 to 0.33), p = 0.22. VAS pain on movement: no differences between groups Day 2. Lower scores Days 4, 8. Ketorolac lower than placebo at Day 4, 8.</td>
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<td>“Overall, this small study shows topical application of ketorolac would seem to show excellent efficacy with few side-effects.”</td>
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<td>Small sample size. Data suggest modest short-term benefits of ketorolac gel vs. placebo for ankle swelling. No superiority over etofenamate gel. No other functional outcomes measured.</td>
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<tr>
<td>Dreiser 1994 RCT</td>
<td>6.0</td>
<td>N = 131 outpatients, 18-70 years old, with acute pain in ankle joint caused by post-traumatic sprain</td>
<td>Flurbiprofen patch (40mg) vs. placebo patch twice daily.</td>
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<td>Flurbiprofen vs. placebo at Day 0, 3, 7; spontaneous pain VAS: 64.0 vs. 63.3, 30.2 vs. 31.2, p &gt;0.05, 14.0 vs. 17.6, p &lt;0.05. Periarticular edema (cm): 1.93 vs. 1.79, p &gt;0.05, 0.94 vs. 0.87, p &gt;0.05, 0.42 vs. 0.54, p &lt;0.05; overall efficacy (patient rating good/very good Day 7): 75% vs. 62% p = 0.14.</td>
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<td>“After 7 days treatment, the 40 mg flurbiprofen patch proved superior to the control in the treatment of acute, uncomplicated ankle sprains with respect to both the subjective symptoms (pain) and the</td>
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<td>Sparse details for randomization, allocation, baseline comparability and blinding. Data suggest benefit at 7 days over placebo but no benefit at 3 days. No difference in patient satisfaction.</td>
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<tr>
<td>Study</td>
<td>N</td>
<td>Patients Description</td>
<td>Treatment</td>
<td>Treatment Description</td>
<td>Results/Conclusion</td>
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<tr>
<td>Russell 1991</td>
<td>5.5</td>
<td>N = 200 acute soft tissue injuries (ankle or acromioclavicular sprains, supraspinatus, or Achilles tendinitis)</td>
<td>Piroxicam 0.5% gel 1gm applied QID vs. placebo gel.</td>
<td>Piroxicam vs. placebo: failure to complete study due to lack of efficacy: 6/100 vs. 42/100, p &lt;0.001. Spontaneous pain: improvement from baseline in VAS Days 2-8 in both groups p &lt;0.001, piroxicam significantly better than placebo p = 0.047. In sprain group, differences between placebo not significant.</td>
<td>“Piroxicam gel, administered on a q.i.d. basis for a total daily dose of 20 mg, is effective treatment for patients suffering from musculoskeletal injuries (sprains and tendinitis) and is significantly more effective than placebo.” Mixed MSDs limit conclusions for specific disorders. Study suggests topical NSAID is effective for tendinitis (shoulder) but did not demonstrate VAS difference in sprains.</td>
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<tr>
<td>Dreiser 1990</td>
<td>5.0</td>
<td>N = 60 recent uncomplicated ankle sprains</td>
<td>Niflumic acid gel 2.5% applied TID vs. placebo gel for 7 days; uncomplicated sprains with moderate-severe pain &lt;3 days from injury.</td>
<td>Niflumic acid vs. placebo: Differences from baseline in VAS, Day 4: 31.9±3.31 vs. 22.35±3.761, p = 0.056. Day 8: 54.1±4.31 vs. 38.95±5.26, p = 0.03. Investigator rating of patient response Day 4: pain on palpation very much improved, much improved 9 vs. 3, p = 0.026. Pain on contraction much improved, improved 21 vs. 9, p = 0.017; functional disability much improved, improved 24 vs. 11, p = 0.002.</td>
<td>“A new 2.5% topical gel formulation of niflumic acid administered 3-times daily in the treatment of simple ankle sprains has been shown to be effective and well tolerated, with a significantly higher proportion of patients in the group treated with niflumic acid gel being healed at the end of the study.” Randomization, allocation, blinding methods unclear. Compliance uncertain. Results suggest topical niflumic acid superior to placebo.</td>
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</table>

**Topical NSAIDs vs. Other**
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Primary Outcome</th>
<th>Secondary Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mahler 2003</td>
<td>RCT</td>
<td>8.5</td>
<td>N = 100 mild to moderate post-traumatic injuries (Grade 1 ankle, knee and muscle injuries)</td>
<td>Diclofenac (DHEP with lecithin) vs. DHEP plain gel for acute ankle sprain.</td>
<td>Pain on movement (VAS) for both groups decreased p &lt;0.01. Lecithin decrease in absolute value Day 3, end of treatment: lecithin = -27.4mm/gel = -16.8 mm/p = 0.025, lecithin = -48.3 mm/gel = -41.3mm/p = 0.036. Spontaneous pain (VAS) significant after 3 days: lecithin = -18.4mm/gel = -9.9mm/p &lt;0.01. Pain on movement, spontaneous pain on movement significant Day 2 on, p &lt;0.01.</td>
<td>“Due to the presence of lecithin in the new gel formulation, DHEP lecithin showed a faster and significantly more marked therapeutic effect compared with that of DHEP gel.”</td>
</tr>
<tr>
<td>Predel 2012</td>
<td>RCT</td>
<td>8.0</td>
<td>N = 242 with acute ankle sprains (Grade I and II); age range 18 to 81</td>
<td>DDEA 2.32% TID, (n = 80) vs. DDEA 2.32% BID, 2 tubes (n = 80) vs. placebo (n = 82). All given 3 tubes labeled morning, noon, evening; 1st dose at center, 2g of gel with fingertips on both sides of ankle ~1 min.; rescue med 500mg paracetamol. Follow-up: baseline, and days 2 to 8.</td>
<td>Mean mm ± SD for POM (VAS): DDEA 2.32% tid vs. placebo: day 5: 49.7±21.5 vs. 25.4±14.8, p &lt;0.0001; DDEA 2.32% bid vs. placebo: 49.1±19.3, p &lt;0.0001.</td>
<td>“DDEA 2.32% gel twice daily (applied in the morning and evening) was well tolerated and provided lasting relief from pain, improved function, and reduced symptomatic healing time in un-complicated ankle sprain.”</td>
</tr>
</tbody>
</table>

No placebo. Data suggest formulation with lecithin is more effective for pain relief in treatment of acute ankle sprains.
Evidence for the Use of Contrast Bath for Ankle Sprain

There is 1 moderate-quality trial incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cote 1988</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 30</td>
<td>post-acute sprained ankles</td>
<td>Cold bath (50-60°F) vs. heat bath (102-106°F) vs. contrast bath for acute ankle sprain (Grade I, II) swelling applied once daily (20 minutes) on post-injury Days 3, 4, 5. Outcomes measured 1-3 days post-treatment.</td>
<td>Ankle volume change pre- to post-treatment (mL): cold vs. heat vs. contrast mean (SD); Day 1: -1.3 (27.1) vs. 27.4 (25.2) vs. 27.4 (13.6); Day 3: 1.7 (14.2) vs. 28.7 (15.8) vs. 35.3 (31.2). Total 3 day change: 3.3 (11.3) vs. 25.3 (19.5) vs. 26.5 (8.2), p &lt;0.05 cold vs. heat, contrast. No difference between heat and contrast.</td>
<td>“[C]old therapy is clearly the most favorable of the three treatments if the therapeutic objective is to minimize edema before rehabilitative exercise during the third, fourth and fifth days post injury for first- and second-degree ankle sprains.”</td>
</tr>
</tbody>
</table>

Evidence for the Use of Early Mobilization for Ankle Sprain

There are 6 moderate-quality RCTs (two with multiple reports) incorporated into this analysis. (Bendahou 14) There are 3 low-quality RCTs in Appendix 2.(147, 499, 500) (Zwipp 92; Cetti 94; Korkala 87)
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Cooke 2009</td>
<td>RCT</td>
<td>7.5</td>
<td>N = 584</td>
<td>Tubular bandage vs. below-knee cast (10 days) vs. Aircast vs. Bledsoe boot. Inclusion criteria of inability to bear weight for 3 days as surrogate for Grade II, III sprains. Study is also known as CAST trial.</td>
<td>Tubular bandage results used as control; 4 weeks: below-knee cast better than tubular bandage for FAOS scores on pain, symptoms, activities of daily living scales. No differences between other interventions except Aircast superior for FAOS ADL scores; 12 weeks: casting better than control FAOS pain, ADL, sports, QoL scores; 9 months: no differences between groups in any measure.</td>
<td>“[I]nitially treated [non weight bearing ankle sprains] treated with 2-3 days of elevation, ice and non-weight bearing exercise, had a more rapid resolution of symptoms and return to normal activities in the first 3 months when treated with a below knee cast for 10 days than when treated with tubular bandage.”</td>
<td>Three reports of same study. All evaluations by postal questionnaire. Compliance to protocols unclear. Co-interventions allowed (ice, NSAIDs, walking aids). Loss to follow-up between 23-27% across groups. Although some statistical differences, clinical differences in outcomes between 4 treatment arms small and of uncertain significance.</td>
</tr>
<tr>
<td>Lamb 2005, 2009</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 140</td>
<td>Cast immobilization (3 weeks) vs. functional treatment (strapping with controlled mobilization) for severe ankle sprains.</td>
<td>Functional treatment showed significant benefit over immobilization at 3, 6 months for pain, swelling, and at 3 months only for stiffness and subjective instability. Mean time to return to sport at same activity 70% vs.36% favoring functional treatment (p &lt;0.01). No differences at 12 months except for relative reduction in talar tilt, also favored functional group.</td>
<td>“[F]unctional treatment is safe, associated with a more rapid recovery, and particularly suitable in athletic populations.”</td>
<td>Both groups received multiple co-interventions with cryotherapy, physical therapy, proprioception training, and NSAIDs. Data suggest functional treatment is beneficial at 3 and 6 months but is equivocal at 12 months.</td>
</tr>
<tr>
<td>Ardevol 2002</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 140</td>
<td>Grade III rupture of lateral ankle ligaments</td>
<td>Cast immobilization (3 weeks) vs. functional treatment (strapping with controlled mobilization) for severe ankle sprains.</td>
<td>Functional treatment showed significant benefit over immobilization at 3, 6 months for pain, swelling, and at 3 months only for stiffness and subjective instability. Mean time to return to sport at same activity 70% vs.36% favoring functional treatment (p &lt;0.01). No differences at 12 months except for relative reduction in talar tilt, also favored functional group.</td>
<td>“[F]unctional treatment is safe, associated with a more rapid recovery, and particularly suitable in athletic populations.”</td>
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<tr>
<td>Beynnon 2006 RCT</td>
<td>5.5</td>
<td>N = 212 suffering 1st acute ankle ligament sprain injury (Grades I, II, or III)</td>
<td>Elastic wrap vs. bracing plus elastic wrap vs. casting for 1st time ankle sprains of Grades I, II, and III and excluded fractures.</td>
<td>Outcomes by severity grade and treatment. Grade I sprain: no casting group included. Elastic vs. brace vs. brace plus elastic: Days to return to normal walking 11.16 vs. 10.33 vs. 4.62, p = 0.008; Days to normal stair climbing: 12.05 vs. 11.43 vs. 5.46, p = 0.003. No difference between elastic wrap and Air-Stirrup for return to normal walking (p = 0.84) and stair climbing (p = 0.98). No differences in secondary outcomes (return to full weight bearing, full capability in normal activities, work or athletics. Grade II sprain: no differences between 3 non-casting treatments. Casting had significantly more days to normal walking (24.12 vs. 10.10, p = 0.001) and stair climbing (27.94 vs. 11.72, p = 0.001) than brace plus wrap, and return to full capability in work and athletics vs. elastic wrap. Grade III sprain: no differences any measure between brace and cast.</td>
<td>“…Air-Stirrup brace combined with an elastic wrap provided earlier return to preinjury function compared with treatment with the Air-stirrup brace alone, elastic wrap alone, or walking cast for 10 days followed by elastic wrap. At 6 months, all treatments produced comparable outcomes in terms of clinical testing, activity level, functional status, and patient satisfaction.”</td>
<td>Several co-interventions (PT, RICE). High drop-out rate although ITT analyses. Data suggest brace with wrap superior to other treatments for mild sprains. Casting in Grade II sprains resulted in more days for recovery in multiple outcomes measures, whereas no difference in non-casting methods. Grade III sprains demonstrated equivalency of casting and bracing.</td>
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<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Participants</td>
<td>Intervention</td>
<td>Comparison</td>
<td>Outcome</td>
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<td>Bendahou 2014 RCT</td>
<td>5.0</td>
<td>N=126 with recent ankle sprain without fracture or traumatic injury seen in ER. Mean age compression stockings 31±9 years, placebo 30±8 years.</td>
<td>Compression stockings (Venoflex) applied from tibia tuberosity to base of toes: class II with pressure between 15-20.3mm Hg (n = 61) vs. placebo: noncompressive stockings (n = 65). All patients received standard care consisting of RICE protocol, immobilization with same orthosis for 4-6 weeks, and acetaminophen or tramadol depending on pain severity, and rehabilitation (2-3 sessions per week of strengthening exercises, proprioception exercises, and weight-bearing postures). Follow-up 6-9 days after trauma, 15-30 days after trauma, and 90 days after trauma.</td>
<td>No significant differences between groups.</td>
<td>“Compression stockings failed to significantly modify the time to return to normal painless walking in ankle sprain.”</td>
<td>Baseline of more physical activity in compression group may have biased in favor of that group. Data suggest lack of efficacy of compression stockings.</td>
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<tr>
<td>Dettori 1994 a, b</td>
<td>5.0</td>
<td>N = 64 moderate or severe Plaster cast immobilization vs. AirCast vs. elastic</td>
<td>Cast vs. air-stirrup vs. elastic: Median days return to work (full military duty)</td>
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</table>

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Evidence for the Use of Tubular Elastic, Elastic Wrap, or Tape for Ankle Support

There are 10 moderate-quality RCTs (two with multiple reports) incorporated into this analysis. (Sultan 12) There are 7 low-quality RCTs in Appendix 2. (411, 416, 500-504) (Muwanga 86; Scotece 92; Cetti 84; Korkala 87; Nilsson 83; Brooks 81; Airaksinen 90)
<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Cooke 2009</td>
<td>7.5</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Lamb 2005, 2009</td>
<td>6.0</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Ardevol 2002</td>
<td>5.5</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Sultan 2012 RCT</td>
<td>6.5</td>
<td>N = 36 with ankle sprains sustained within 72 hours of attending a fracture clinic; 18 years or older</td>
<td>Standard treatment, written and verbal information on ankle sprains, advice on RICE (rest, ice, compression, elevation), Tubigrip, worn for 7 weeks (n = 18) vs. Class II elastic stockings, same advice and information, fitted stockings to patient, wear continuously, day/night, for 7 days, wear during day remove at night for 6 weeks until pain free (n =</td>
<td>Mean (95% CI) for VAS: baseline vs. 4 weeks: Stocking: 65 (56-73) vs. 9 (5-13), p = 0.004; baseline vs. 8 weeks: 65 (56-73) vs. 5 (0-11), p = 0.002; Tubigrip: baseline vs. 4 weeks: 66 (59-73) vs. 21 (11-31), p = 0.004; baseline vs. 8 weeks: 66 (59-73) vs. 18 (10-26), p = 0.002. Mean (95% CI) for AOFAS: stocking vs. Tubigrip: 4 weeks: 94 (84-102) vs. 83 (70-90), p = 0.004; 8 weeks: 99 (92-105) vs. 88 (78-95), p = 0.002. Mean (95% CI) for SF 12 scores improved with stocking group from 4 to 8 weeks: 112 (109-115) vs. 119 (118-121), p &lt; 0.01.</td>
<td>“ES applied early following ankle sprain significantly improved recovery compared with Tubigrip. By 4 weeks, the ES patients experienced less pain, swelling and restriction in ankle movement. The functional outcome and SF12 at 4 and 8 weeks were also better.”</td>
<td>Few baseline characteristics. ES significantly reduced ankle circumference following ankle sprain vs. Tubigrip. Recovery time decreased and ankle ROM and movements at both 4 and 8 weeks.</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Design</td>
<td>Methods</td>
<td>Results</td>
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<tr>
<td>O'Hara 1992 RCT</td>
<td>1992</td>
<td>220</td>
<td>RCT</td>
<td>Follow-up: baseline, 4 and 8 weeks.</td>
<td>Support vs. standard: outcomes at 12-14 days; VAS: rest pain 178.5 vs. 235.8 p &lt;0.05; speed of response rest pain: 9.13 vs. 11.38 days, p &lt;0.05. Overall assessment: normal 88% vs. 67%, p &lt;0.001.</td>
<td>“In patients with acute ankle injuries, a Malleotrain ankle support results in more rapid alleviation of symptoms than does Tubigrip and is acceptable to patients.”</td>
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<tr>
<td>Boyce 2005 RCT</td>
<td>2005</td>
<td>50</td>
<td>RCT</td>
<td>Elastic support bandage vs. Aircast ankle brace for acute Grade II, III sprains</td>
<td>Function measured by Karlsson scores: 10 days (35 for elastic vs. 50 for Aircast, p = 0.028) at 1 month (55 for elastic vs. 68 for Aircast, p = 0.029). No significant differences between groups for secondary outcome measures of swelling, pain at 10 days.</td>
<td>“The use of an Aircast ankle brace in the treatment of moderate and severe lateral ligament ankle sprains, presenting within 24 hours of injury, produces a significant improvement in ankle joint function, at both 10 days and one month, compared with standard management with an elastic support bandage.”</td>
</tr>
<tr>
<td>Leanders on 1999 RCT</td>
<td>1999</td>
<td>73</td>
<td>RCT</td>
<td>Air cushioned ankle brace (AirCast) vs. compression bandage for acute ROM discrepancy injured vs. uninjured foot decreased at follow-up; still decreased at 10 weeks (p &lt;0.01). ROM in uninjured foot increased at follow-up (p &lt;0.05).</td>
<td>“[T]he methods used in the present study are well suited for further studies of objective modalities of ankle joint function with the sparse details for randomization methods, baseline comparability, control of cointerventions. Results are of uncertain clinical significance.”</td>
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</table>

Data suggest benefit of using ankle support compared to tubigrip. Despite statistical significance of some factors, clinical significance is uncertain.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Patients Description</th>
<th>Treatment</th>
<th>Results</th>
<th>Study Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viljakka 1983</td>
<td>4.0</td>
<td>N = 119</td>
<td>with ankle sprains</td>
<td>Layer bandage vs. elastic adhesive tape. Oxyphenbutazone 100mg TID vs. clonixin 300mg. TID vs. placebo. Severity of acute injury not specified.</td>
<td>No significant differences between layer vs. elastic tape bandage in pain, tenderness, swelling, ROM. Elastic caused more rash, irritation, skin compression. Examiner estimate of “good” result: layer bandage (64%) vs. elastic (62%) vs. placebo 50%) vs. oxyphenbutazone (53%) vs. clonixin (84%). No differences between bandage groups. Placebo vs. oxyphenbutazone, p &gt;0.05; oxyphenbutazone vs. clonixin, p &lt;0.01, placebo vs. clonixin, p &lt;0.01.</td>
<td>“The layer bandage proved more stable in the lateral direction than the elastic adhesive tape bandage (p less than 0.001). Clonixin proved useful in controlling swelling and in the authors opinion gave the best clinical results.”</td>
</tr>
<tr>
<td>Watts 2001</td>
<td>4.0</td>
<td>N = 400</td>
<td>with acute Grade I or II (mild to moderate) lateral ankle sprains</td>
<td>Double Tubigrip (elastic wrap) vs. no compressi on wrap for acute Grade I and II sprain.</td>
<td>In DTG group, 81 took pain killers vs. 50 in no-DTG group, p = 0.001; 54 DTG and 48 no-DTG group had to take days off work, p = 0.072. DTG average 3.37 days off work vs. 3.21 days for no-DTG, p = 0.94.</td>
<td>“This study suggests that the use of double tubigrip compression bandage in grade 1 and 2 ankle sprains does not shorten recovery time or number of days off work….(and) 50% loss to follow-up. No details on co-interventions other than “therapy and analgesia.” No details on compliance to intervention.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Ankle Support or Brace for Ankle Sprain
There are 7 moderate-quality RCTs (two with multiple reports) incorporated into this analysis. There are 5 low-quality RCTs in Appendix 2.(499, 501-503, 505) (Zwipp 92; Cetti 84; Wilkerson 93; Scotece 92; Muwanga 86)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<tbody>
<tr>
<td>Cooke 2009</td>
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<td>Lamb 2005, 2009</td>
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<td>Beynnon 2006</td>
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<td>Eiff 1994</td>
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<td>Leanderson 1999</td>
<td>4.0</td>
<td>See Evidence Table for the Use of Tubular Elastic, Elastic Wrap, or Tape for Ankle Support above.</td>
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</table>

Evidence for the Use of Walking Boots for Ankle Sprain
There are 2 moderate-quality RCT (with multiple reports) incorporated into this analysis. (Prado 14)

<table>
<thead>
<tr>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
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<tr>
<td>Cooke 2009</td>
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<td>Lamb 2005, 2009</td>
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<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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</tbody>
</table>
| Prado 2014, RCT        | 4.0          | N = 104 with severe lateral ankle ligament | Group A, walking boot first 3 weeks, functional brace for an | Mean ± SD for AOFAS score: Group A vs. Group B: first week after injury: 61±11.2 vs. 67±10.8, p = 0.00003, in favor of Group B. | "Conservative treatment of patients with acute, severe, first episode lateral ankle injuries using a... Minimal baseline comparability. Functional brace showed a slight improvement over use of walking boot and...
Evidence for the Use of Heat for Ankle Sprain
There is 1 moderate-quality trial incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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<th>Results</th>
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<tbody>
<tr>
<td>Cote 1988 RCT</td>
<td>4.0</td>
<td>N = 30 post-acute sprained ankles</td>
<td>Cold bath (50-60°F) vs. heat bath (102-106°F) vs. contrast bath for acute ankle sprain (Grade I, II) swelling applied once daily (20 mins) on post-injury days 3, 4, 5. Outcomes measured 1-3 days post treatment.</td>
<td>Ankle volume change pre-to post-treatment (mL): Cold vs. Heat vs. Contrast mean (SD), Day 1: -1.3 (27.1) vs. 27.4 (25.2) vs. 27.4 (13.6), Day 3: 1.7 (14.2) vs. 28.7 (15.8) vs. 35.3 (31.2). Total 3 day change: 3.3 (11.3) vs. 25.3 (19.5) vs. 26.5 (8.2), p &lt;0.05 cold vs. heat, contrast. No</td>
<td>“[C]old therapy is clearly the most favorable of the three treatments if the therapeutic objective is to minimize edema before rehabilitative exercise during the third, fourth and fifth days post injury for first- and second-degree ankle sprains.”</td>
<td>Small sample size. Details of allocation, baseline comparability missing. Age of injury not specified. Effect of treatment is limited to edema as functional improvement and pain measures were not included.</td>
</tr>
</tbody>
</table>
### Evidence for the Use of Casting for Ankle Sprain

There are 6 moderate-quality RCTs or crossover trials (two with multiple reports) incorporated into this analysis. There are 5 low-quality RCTs in Appendix 2. (499-501, 510, 511) (Zwipp 92; Cetti 84; Korkala 87; van den Hoogenband 84; Gronmark 80).

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<tr>
<td>Immobilization vs. Early Mobilization</td>
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<tr>
<td>Tremblay 2009</td>
<td>7.5</td>
<td>N = 48 healthy volunteers</td>
<td>Braking performance in walking cast vs. Aircast Walker vs. running shoe (control).</td>
<td>Adjusted mean total braking time (seconds): running shoe vs. walking cast vs. Aircast Walker undistracted; 0.604±0.051 vs. 0.636±0.60 vs. 0.639±0.05, p &lt;0.05 vs. control. Distracted, 0.680±0.059 vs. 0.700±0.067 vs. 0.712±0.063, p &lt;0.05 vs. control, p &lt;0.05 vs. walking cast.</td>
<td>“[W]earing a walking cast or a removable Aircast Walker on the right lower limb increases the emergency braking time during simulated driving.”</td>
<td>Data suggest reduced reaction times in emergency braking with and without distractions although findings were linked to lab situation in health subjects. Applicability to injured patients uncertain.</td>
</tr>
<tr>
<td>Cooke 2009</td>
<td>7.5</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Lamb 2005, 2009</td>
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<tr>
<td>Ardevol 2002</td>
<td>6.0</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Beynnon 2006</td>
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<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Dettori 1994 a, b</td>
<td>5.0</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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<tr>
<td>Eiff 1994</td>
<td>4.5</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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</table>
Evidence for the Use of RICE for Ankle Sprain

There are 2 moderate-quality RCTs (one with two reports) incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Combined RICE Therapies</td>
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<tr>
<td>Bleakley 2007, 2010 RCT</td>
<td>7.0</td>
<td>N = 101 acute Grade 1 or 2 ankle sprain</td>
<td>PRICE vs. PRICE plus early therapeutic exercises. Intermittent cryotherapy protocol: 10 minute ice, 10 minute rest (control) or 10 minute exercises (intervention) then 10 minutes cryotherapy, 3 times a day, 1 week). Both groups received exercise protocol after Week 1: 30-minute session once a week, 4 weeks) for Grade I and II sprains; 16 week follow-up.</td>
<td>Treatment effect: control vs. exercise. Difference in lower extremity function score: Week 1: 5.28 (0.31-10.26) p = 0.008. Week 2: 4.92 (0.27-9.57) p = 0.0083. No difference after Week 2. Pain at rest, pain with activity, and swelling: no differences any interval. Re-injury rate 16 weeks 2/50 vs. 2/51. Physical activity: Time (hours/day) 1st week, control vs. exercise; walking-1.2 (0.9-1.4) vs. 1.6(1.3-1.9) p = 0.029. Step sitting, standing, p &gt;0.05.</td>
<td>“Incorporating therapeutic exercises during the first week after ankle sprain resulted in significant improvements in short term ankle function compared with a standard functional intervention.”</td>
<td>Compliance &lt;80%, &gt;20% dropout in exercise group. Data suggest addition of therapeutic exercises to protection, RICE protocols provides short term functional benefit as measured on subjective lower extremity functional scale and in time spent walking. No difference in other outcomes measures.</td>
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</tbody>
</table>
| Green 2001 RCT | 6.5          | N = 41 acute ankle inversion sprains <72 hours and no other injury to the lower limb | RICE vs. passive accessory joint mobilization + RICE for acute sprain. | At 4th treatment session, 68% of treatment group and 3 subjects from control released as attained full ROM in dorsiflexion, p <0.01. For dorsiflexion ROM, experimental group improved 10.9° (SEM = | “Addition of talocrural mobilization to the RICE protocol in the management of ankle inversion injuries necessitated fewer treatments to achieve pain-free dorsiflexion | Baseline differences in number of recurrent sprains (higher in experimental group). Despite outcome improvements in dorsiflexion, does not appear to be a statistically significant difference in
1.9°) and control 5.8° (SEM = 1.1°). Stride speed increased more within 1st and 3rd treatment sessions for experimental group, p <0.05. Experiment group returned to work 6 days after injury, and the control group patients returned to work 5.3 days after injury.

and to improve stride speed more than RICE alone.”

lost work days or return to work, sports, or normal walking. Thus, improved dorsiflexion ROM as an outcome measure is of unknown clinical importance.

**Evidence for the Use of Immediate Post-injury Rest for Ankle Sprain**

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Eiff 1994</td>
<td>4.5</td>
<td>N = 89 mild/moderate acute ankle sprain</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
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</table>

**Evidence for the Use of Ice/Cryotherapy for Ankle Sprain**

There are 6 moderate-quality RCTs incorporated into this analysis. (Sandoval 10) There are 4 low-quality RCTs in Appendix 2.(505, 518, 521, 522) (Stockle 97; Michlovitz 88; Wilkerson 93; Laba 89)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleakley 2006 RCT</td>
<td>7.5</td>
<td>N = 89 mild/moderate acute ankle sprains</td>
<td>Cryotherapy (20 minutes continuous application every 2 hours repeated vs. 10 minutes continuous application, 10 minute break, 10 minutes application, repeated q 2 hours) up to 72 hours; 6 week follow-up.</td>
<td>Subjective measures of function, swelling, and pain at rest improved significantly for both groups. No intergroup differences with exception of more pain relief with activity during Week 1 in intermittent group, although there were baseline</td>
<td>“The application of an intermittent cryotherapy protocol after mild or moderate ankle sprain significantly reduced the level of subjective pain on activity, one week after the injury, compared with a standard protocol. There was no</td>
<td>No placebo or sham. Baseline differences in pain at rest favoring intermittent (less pain) group was nearly significant p = 0.08 which weakens conclusion.</td>
</tr>
<tr>
<td>Study</td>
<td>Score</td>
<td>N</td>
<td>Description</td>
<td>Differences Between Groups</td>
<td>Significant Difference in Terms of Function, Swelling, or Pain at Rest</td>
<td>Randomization Variable</td>
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<tr>
<td>Okcu 2006 RCT</td>
<td>7.0</td>
<td>44</td>
<td>Skin temperature measurement after cryotherapy: Robert Jones bandage vs. elastic bandage vs. plaster cast vs. synthetic cast.</td>
<td>All groups had significant temperature reduction after use of ice packs regardless of material. Average time to reach minimum temperature was 48 minutes (RJB), 42 minutes (elastic), 30 minutes (Plaster) and 38 minutes (synthetic cast). Time to cooling significantly faster in casting groups compared with RJB.</td>
<td>“A bandage or cast does not prevent measurable skin temperature lowering by frozen ice packs both in normal and swollen ankles.”</td>
<td>Treatment but immobilization technique. All subjects received ice packs and skin temperature was measured by thermistor. No differences found. Data suggest that cryotherapy results in skin temperature cooling regardless of material over injury.</td>
</tr>
<tr>
<td>Sloan Injury 1989 RCT</td>
<td>5.5</td>
<td>122</td>
<td>Immediate ibuprofen (1200mg loading, 2400mg total per day) vs. placebo 1st 48 hours, then same ibuprofen schedule. A uniform background therapy of 20 minutes cooling, compression and elevation was given to all patients using cooled ankle.</td>
<td>Immediate vs. delayed soft tissue swelling index: % improvement 49% vs. 37% p &lt;0.01. Severity of injury: no data presented, favored immediate group p = 0.05; range of movement no differences; ability to bear weight no differences</td>
<td>Immediate medication with high-dose ibuprofen at 2400 mg/day should be considered in the routine treatment of moderate to severe ankle sprains, whether patients.”</td>
<td>Patients treated within 6-hours. Data suggest immediate NSAIDs may be beneficial for immediate pain relief and swelling relief judged at 7 days vs. placebo.</td>
</tr>
<tr>
<td>Sloan Arch Emerg Med 1989</td>
<td>5.0</td>
<td>143</td>
<td>Cryotherapy vs. sham cryotherapy (both with cold therapy group and 40% of dummy)</td>
<td>At Day 7, improvement in swelling by 46% of cold therapy group and 40% of dummy</td>
<td>“[A] single 30-minute period of treatment in the accident and emergency”</td>
<td>Lack of randomization, allocation, baseline comparability</td>
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<tr>
<td>RCT</td>
<td>within 24 hours of injury</td>
<td>NSAIDs, elastic wrap</td>
<td>therapy, p = 0.07; also, 88% of cold therapy group had improved by 2-4 scale points compared to 79% of dummy therapy, p = 0.15. Weight bearing, 36% of cold therapy group and 29% of dummy therapy showed improvements by 3-4 scale units, p = 0.64.</td>
<td>department cannot be justified, though advice to paramedics, sports trainers and patients themselves to give and continue cold and compression is probably important.</td>
<td>details. All patients had NSAIDs, elastic wrap. Data suggest no benefit of single 30 minute cold treatment vs. placebo at 1 week.</td>
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<td>Cote 1988 RCT</td>
<td>N = 30 post-acute sprained ankles</td>
<td>Cold (50-60°F) vs. heat bath (102-106°F) vs. contrast bath for acute ankle sprain (Grade I, II) swelling applied once daily (20 minutes) post-injury Days 3, 4, 5. Outcomes measured 1-3 days post-treatment.</td>
<td>Ankle volume change pre- to post-treatment (mL): cold vs. heat vs. contrast mean (SD); Day 1: -1.3 (27.1) vs. 27.4(25.2) vs. 27.4 (13.6); Day 3: 1.7 (14.2) vs. 28.7 (15.8) vs. 35.3 (31.2). Total 3 day change: 3.3 (11.3) vs. 25.3 (19.5) vs. 26.5(8.2) p &lt;0.05 cold vs. heat, contrast. No difference between heat and contrast.</td>
<td>“[C]old therapy is clearly the most favorable of the three treatments if the therapeutic objective is to minimize edema before rehabilitative exercise during the third, fourth and fifth days post injury for first- and second-degree ankle sprains.”</td>
<td>Small sample size. Details of allocation, baseline comparability missing. Age of injury not specified. Effect of treatment limited to edema as functional improvement; pain measures not included.</td>
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<tr>
<td>Sandoval 2010 RCT</td>
<td>N = 28 participants with lateral ankle sprain; age range 18 to 26 (21±2.5 years)</td>
<td>Control group (CG), convention treatment (cryotherapy) only (n = 10) vs. HVPC(+) (high-voltage pulsed current), conventional treatment and HVPC, using active electrodes with positive polarity (n = 8) vs. HVPC(-), conventional</td>
<td>Mean ± SD for ROM: CG vs. HVPC(+): first -13±8.2 vs. -2±9.5 vs. -6±5.5, p = 0.03.</td>
<td>“The results showed no significant differences between groups. However, they suggest a possible contribution of HVPC(-) to the acceleration of recovery during the initial healing phase of ankle sprain in humans.”</td>
<td>Small groups. No significant differences in 3 groups but HVPC- trended towards improved recovery time. Possible underpowering.</td>
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</table>
treatment and HVPC, using active electrodes with negative polarity (n = 10). Follow-up: baseline, final assessment at completion.

Evidence for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain

There are 11 moderate-quality RCTs (one with three reports) incorporated into this analysis. (Lardenoye 12; Sultan 12) There are 7 low-quality RCTs in Appendix 2.(411, 416, 500-504) (Muwanga 86; Scotece 92; Cetti 84; Korkala 87; Nilsson 83; Brooks 81; Airaksinen 90)

<table>
<thead>
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<tr>
<td>Lardenoye 2012 RCT</td>
<td>5.0</td>
<td>N = 70 with grade II or III ankle sprain; mean age for tape 30 years, mean age for brace 29.8 years</td>
<td>Tape group; first layer of latex free, adhesive, bandage to protect skin; 2nd layer of 2.5cm non-elastic strapping tape used for support; 3rd layer of elastoplasts 6cm broad, elastic used for fixation (n = 35) vs. semi-rigid brace with air cushions to inflate and</td>
<td>No statistically significant differences were seen between both groups for the primary outcome.</td>
<td>“In summary this study shows that treatment of acute lateral ankle sprain with a semi-rigid brace leads to less complications and a higher patient satisfaction than treatment with tape. In line with previous studies there is no difference regarding functional</td>
<td>Semi-rigid brace is better than taping for patient comfort in ankle sprain but no significant differences between 2 groups and a high dropout rate.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Rating</td>
<td>N</td>
<td>Condition</td>
<td>Intervention</td>
<td>Follow-up</td>
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<tr>
<td>Rucinski</td>
<td>1991</td>
<td>4.5</td>
<td>30</td>
<td>Post-acute (&gt;24 hours post-injury) 1st- and 2nd-degree sprained ankles</td>
<td>Elastic (Ace) wrap plus elevation vs. pneumatic compression device plus elevation vs. elevation (all 30 minute treatment sessions)</td>
<td>In volume measurements post treatment, the control (elevation) is only group with reduced measurement from baseline p &lt;0.01.</td>
</tr>
<tr>
<td>Boyce</td>
<td>2005</td>
<td>4.0</td>
<td>50</td>
<td>Presented consecutively within 24 hours moderate or severe lateral ligament sprain after an ankle inversion injury</td>
<td>Elastic support bandage vs. Aircast ankle brace for acute Grade II, III sprains.</td>
<td>Function measured by Karlsson scores: 10 days (35 for elastic vs. 50 for Aircast, p = 0.028) at 1 month (55 for elastic vs. 68 for Aircast, p = 0.029). No significant differences between groups for secondary outcome measures of swelling, pain at 10 days.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Diagnosis</td>
<td>Interventions</td>
<td>Outcome</td>
<td>Comments</td>
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<tr>
<td>Leanders 1999</td>
<td>1999</td>
<td>73</td>
<td>Age 15-55 with acute Grade II or III ankle sprain, who sought medical care</td>
<td>Air cushioned ankle brace (Aircast) vs. compression bandage for acute Grade II and III ankle sprains.</td>
<td>ROM discrepancy in injured vs. uninjured foot decreased at follow-up; still decreased at 10 weeks (p &lt;0.01). ROM uninjured foot increased at follow-up. Figure-of-eight running times for both groups between 2-10 week follow-up improved significantly from baseline, but no differences between groups.</td>
<td>“[T]he methods used in the present study are well suited for further studies of objective modalities of ankle joint function with the possible exception of the joint position sense test.”</td>
</tr>
<tr>
<td>Viljakka 1983</td>
<td>1983</td>
<td>119</td>
<td>Ankle sprain</td>
<td>Layer bandage vs. elastic adhesive tape. Oxyphenbutazone 100mg TID vs. clonixin 300mg TID vs. placebo. Severity of acute injury not specified.</td>
<td>No significant differences between layer vs. elastic tape bandage in pain, tenderness, swelling, ROM. Elastic: more rash, irritation or skin compression. Examiner estimate of “good” result: Layer bandage (64%) vs. elastic (62%) vs. placebo 50% vs. oxyphenbutazone (53%) vs. clonixin (84%). No differences between bandage groups. Placebo vs. oxyphenbutazone, p &gt;0.05. Oxyphenbutazone vs. clonixin, p &lt;0.01, placebo vs. clonixin, p &lt;0.01.</td>
<td>“The layer bandage proved more stable in the lateral direction than the elastic adhesive tape bandage (p less than 0.001). Clonixin proved useful in controlling swelling and in the authors opinion gave the best clinical results.”</td>
</tr>
<tr>
<td>Watts 2001</td>
<td>2001</td>
<td>400</td>
<td>Acute Grade 1 or 2</td>
<td>Double Tubigrip (elastic wrap) vs. No compression</td>
<td>81 patients in DTG group and 50 in no-DTG group took pain killers, p = 0.001. 54 of DTG</td>
<td>“This study suggests that the use of double tubigrip compression Loss of 50% to follow-up. No details on co-interventions other than</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Population</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sultan 2012</td>
<td>RCT</td>
<td>6.5</td>
<td>N= 36 aged 18 years or over with ankle sprains sustained within 72 hours. Mean age (range): stocking group 34 (20-59). Tubigrip group 30 (21-57).</td>
<td>Tubigrip (n = 18) vs. class II below knee elastic stockings (ESs, Medi UK Ltd.) (n = 18) worn until patient pain-free and fully mobile. Follow-up at 4 weeks.</td>
<td>At 4 weeks: ES reduced mean ankle circumference to 22 (22-23) cm and calf circumference to 38 (37-39) cm compared with no change in either ankle or calf circumference using Tubigrip, p&lt;0.05.</td>
<td>&quot;Elastic compression improves recovery following ankle sprain.&quot;</td>
</tr>
</tbody>
</table>

"therapy and analgesia." No details on compliance to intervention.

Few baseline data. Data suggest elastic stockings superior to tubigrip for ROM and edema.

Evidence for the Use of Elevation for Ankle Sprain
There is 1 moderate-quality RCT incorporated into this analysis.
### Evidence for the Use of Ankle Brace Support (Pneumatic/Gel) for Ankle Sprain

There are 9 moderate-quality RCTs (one with multiple reports) incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooke 2009</td>
<td>7.5</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamb 2005, 2009</td>
<td>7.5</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ardevol 2002</td>
<td>6.0</td>
<td>3</td>
<td>See Evidence Table for the Use of Early Mobilization for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beynnon 2006</td>
<td>5.5</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O'Hara 1992</td>
<td>5.5</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dettori 1994 a, b</td>
<td>5.0</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eiff 1994</td>
<td>4.5</td>
<td>3</td>
<td>See Evidence Table for Immediate Post-injury Rest for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rucinski 1991</td>
<td>4.5</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boyce 2005</td>
<td>4.0</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leandersson 1999</td>
<td>4.0</td>
<td>3</td>
<td>See Evidence Table for the Use of Compression Bandage, Wrap, or Tape for Ankle Sprain above.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evidence for the Use of Magnets for Ankle Sprain

There are no quality RCTs incorporated in this analysis.

### Evidence for the Use of Diathermy for Ankle Sprain

There are 2 high- and 3 moderate-quality RCTs or quasi-RCTs incorporated into this analysis.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Score</th>
<th>N</th>
<th>Ankle sprain classification</th>
<th>Intervention</th>
<th>Outcome Time Points</th>
<th>Outcome Measurement</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barker</td>
<td>1985</td>
<td>8.5</td>
<td>82</td>
<td>Mild ankle sprains</td>
<td>Diathermy vs. sham diathermy</td>
<td>1, 2, 3, 8, 15 days</td>
<td>ROM, volume, pain scores, gait scores</td>
<td>No differences at any time</td>
<td>“All the quantitative measurements carried out in this trial have failed to show a statistically significant difference between the active and control groups.”</td>
</tr>
<tr>
<td>McGill</td>
<td>1988</td>
<td>8.0</td>
<td>31</td>
<td>Lateral ligament sprain of ankle within 48 hours</td>
<td>Pulsed diathermy vs. placebo</td>
<td>0.44 ± 0.51 vs. 0.29 ± 0.55</td>
<td>Pain score, number analgesics/day, time to weight bearing</td>
<td>No significant differences in terms of pain, swelling, or time to full weight-bearing have been shown.</td>
<td>Small sample size. Placebo group had proportionately more females. Data suggest no benefit over placebo.</td>
</tr>
<tr>
<td>Pennington</td>
<td>1993</td>
<td>6.5</td>
<td>50</td>
<td>Grade I and II sprained ankles</td>
<td>Diathermy vs. sham diathermy</td>
<td>1, 1.5, ± 216 to 1,141 ± 213</td>
<td>Ankle edema (cc of water displacement)</td>
<td>Placebo vs. Diapulse 11, 44, p &lt;0.01. Subjective improvement: 8/25 vs. 16/25 favoring diathermy.</td>
<td>Study purpose for short-term effect of diathermy in a military population. Minimal baseline comparability with heterogeneity in mean outcome measure of swelling. Data suggest benefit immediately after treatment with diathermy but duration and long-term effect uncertain.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Description</td>
<td>Outcome</td>
<td>Randomization</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pasila 1978</td>
<td>5.0</td>
<td>321</td>
<td>Recent ligamentous injuries of ankle and foot</td>
<td>No differences in abduction, adduction, strength of forefoot.</td>
<td>Randomization by drawing lots. No blinding noted although it is possible patients blinded. Data suggest no short term clinical benefit from diathermy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilson 1972</td>
<td>4.5</td>
<td>40</td>
<td>With inversion injury of ankle during preceding 36 hours</td>
<td>Improvement of swelling – sum of scores for all subjects (0-4 VAS) 38 to 14 (63.2%) vs. 38 to 26 (31.6%); Improvement of Pain: sum of scores for all subjects (0-3 VAS) 38 to 14 (63.2%) vs. 38 to 26 (31.6%).</td>
<td>Quasi-randomization (treatment machine randomized not subject). Allocation unclear. Author states statistical significance but results not reported and are of uncertain clinical significance as</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Evidence for the Use of Electrical Stimulation for Ankle Sprain
There is 1 moderate-quality RCT incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man 2007 RCT</td>
<td>4.5</td>
<td>N = 34 subjects recovering from ankle sprain</td>
<td>Neuromuscular electrical stimulation (NMES) vs. sub-motor NMES sham NMES</td>
<td>No significant differences among groups for adapted Hughston Clinic Subjective Rating Scale for Ankle Disorders scores between 1st and 3rd sessions, ankle volume or girth differences.</td>
<td>“…no differences were found between the NMES and submotor or sham ES groups in ankle-foot volumes in the early period after ankle sprain.”</td>
<td>Baseline differences existed in outcomes measure of ankle girth. Lack of randomization, allocation details. Small sample size, low power. Data suggest lack of efficacy.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Iontophoresis for Ankle Sprain
There are no quality trials incorporated into this analysis.

Evidence for the Use of Low-level Laser Therapy for Ankle Sprain
There is 1 high- and 1 moderate-quality RCT incorporated into this analysis.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>N</th>
<th>Description</th>
<th>Perceived pain Day 5 (mean±SD) (low dose/high dose/sham):</th>
<th>Co-interventions of elastic wrap, bracing, home exercises. No added benefit from laser therapy at low or high energy compared with sham. Treatment groups had significantly more absence days away from work and lower functional outcomes in first 4 weeks. Data suggest lack of efficacy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>de Bie</td>
<td>1998</td>
<td>217</td>
<td>acute lateral ankle sprains</td>
<td>(2.8±2.2/2.9±2.1/3.3±2.4) p = 0.6; Day 10 (2.0±2.0/2.1±1.9/1.7±1.9) p = 0.48; Day 14 (1.6±1.9/1.7±1.7/1.4±1.7) p = 0.42; Day 28 (0.6±1/0.8±1/0.4±1) p = 0.14</td>
<td>Laser treatment is not effective in the treatment of ankle sprains. On the basis of this trial, therapists should reconsider the use of laser therapy in the treatment of ankle sprains.</td>
</tr>
<tr>
<td>Stergioulas</td>
<td>2004</td>
<td>47</td>
<td>soccer players with 2nd degree ankle sprains</td>
<td>(25.1±15/24.7±15.1/25.7±14.8) p = 0.92; Day 10 (42.2±16.1/44.1±14.9/49.9±15.9) p = 0.01; Day 14 (56.3±16.1/56.0±15.7/60.0±17.1) p = 0.03. Sick leave; 12.5±11.1/11.2±10.0/7.8±9.2, p = 0.02. Outcome measures 1 year follow-up (mean ±SD/low/high/placebo): (13.1±12.3/11.5±10.7/7.8±9.3) p = 0.013</td>
<td>Although significant difference from baseline in volumetric measurement of edema reduction in LLT group, no intergroup statistical analysis provided. Thus, unknown if LLTT provided benefit over placebo or RICE related to edema. Results limited to 72-hours post-treatment. Significance of edema reduction is of unknown clinical significance.</td>
</tr>
<tr>
<td>Explained by</td>
<td>1998</td>
<td></td>
<td>Low-level laser therapy (5J/cm2 and 0.5J/cm2) vs. sham laser therapy, 12 treatments over 4 weeks for acute mild, moderate, and severe ankle sprain. Each of 3 groups received bracing and therapeutic exercises.</td>
<td>Largest volume change in laser group: 40.3±2.4ml decreased after 24 hours (p &lt;0.01), 56.4±3.1ml after 48 hours (p &lt;0.002), 65.1±4.4ml after 72 hours (p &lt;0.001).</td>
<td>“LLLT combined with RICE can reduce edema in second-degree ankle sprains.”</td>
</tr>
</tbody>
</table>
Evidence for the Use of Phonophoresis for Ankle Sprain
There are no quality studies incorporated into this analysis.

Evidence for the Use of Therapeutic Ultrasound for Ankle Sprain
There are 4 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality study in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nyanzi 1999</td>
<td>RCT</td>
<td>6.5</td>
<td>N = 58 ankle injuries</td>
<td>Ultrasound vs. sham ultrasound; 3 10-minute sessions on consecutive days. Energy 0.25 W cm(^2), 1:4 mark ratio at 3MHz. Follow-up 2 weeks post last session. Acute sprains, severity not described.</td>
<td>Placebo vs. ultrasound: VAS (0-10cm): No differences any day (1-14). Intragroup placebo improved 4.8 to 0.7cm p &lt;0.0001, ultrasound 4.9 to 0.9cm p &lt;0.0001. Ankle swelling: No intergroup differences at any interval. Both groups improved significantly from baseline. No differences between dorsiflexion, plantar flexion, and weight bearing ability.</td>
<td>“[This study has shown that at the dose and duration used, ultrasound therapy offers no benefits over sham ultrasound (placebo) in the management of lateral ligament sprains of the ankle joint.]”</td>
<td>Study blinded to patient and researcher applying treatment. Allocation not described. Few baseline variables presented for comparison. Suggests ultrasound treatment does not provide therapeutic effect for acute ankle sprain. Grade of sprain uncertain, although all subjects eligible after fracture ruled out by radiograph.</td>
</tr>
<tr>
<td>Oakland 1993</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 220 acute injuries of lateral ankle ligaments</td>
<td>Felbinac gel plus sham ultrasound placebo vs. placebo gel plus ultrasound vs. felbinac plus ultrasound for acute ankle sprains (severity not described).</td>
<td>Changes from baseline in VAS Pain: 21.5mm vs. 19.4mm vs. 16.5mm, p &gt;0.05. Investigator Assessment (% moderate or better response) 84.5% vs. 83.5% vs. 86.5%; Full Weight bearing: 73% vs. 77% vs. 80%, p &gt;0.05</td>
<td>“[F]elbinac gel has a similar clinical efficacy to ultrasound in the treatment of acute injuries of the lateral ankle ligaments.”</td>
<td>Allocation, blinding of investigator not described; 52 of 220 dropped out although results carried forward in analysis. Study suggests ultrasound and topical NSAID of similar efficacy. No evidence of combined effect. No control arm.</td>
</tr>
</tbody>
</table>
### Evidence for the Use of Acupuncture for Ankle Sprain
There are no quality RCTs incorporated into this analysis.

### Evidence for the Use of Hyperbaric Oxygen for Ankle Sprain
There is 1 moderate-quality RCT incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zammit 2005 RCT</td>
<td>5.0</td>
<td>N = 34 acute lateral ligament sprains of ankle joint</td>
<td>Ultrasound vs. sham ultrasound vs. control. All groups received elastic wrap (tubigrip), exercise, and ice; 6 sessions of ultrasound over 2 weeks, energy 0.25Wcm² for 10 minutes, sessions 4-6 increased to 0.5Wcm². Acute Grade I and II sprains.</td>
<td>Ultrasound vs. sham vs. control: Mean changes at 22 days. Pain (VAS cm): 3.9/4.0/4.2, p &gt;0.05; Swelling reduction (cm): 1.0/1.3/1.2, p &gt;0.05; Plantar flexion: 10°/5.2°/5°/5°, p &gt;0.05; Dorsiflexion: 4.7°/4.6°/8.8°, p &gt;0.05.</td>
<td>“At the does and duration used in this study, ultrasound is not effective in the management of acute lateral ligament sprains of the ankle joint, with respect to the following outcomes: pain, swelling, range of motion during dorsiflexion and plantar flexion, and postural stability.”</td>
<td>Randomization, allocation, baseline comparability details sparse. Data suggest no added benefit of ultrasound therapy to mild and moderate acute ankle sprains over placebo combined plus conservative measures of exercise, elastic wrap. Use of these modalities limits ability to differentiate effect of natural history.</td>
</tr>
<tr>
<td>Williamson 1986 RCT</td>
<td>4.0</td>
<td>N = 154 age 12-65 with history of inversion injury to lateral ligament of ankle</td>
<td>Ultrasound vs. sham ultrasound for acute mild and moderate ankle sprains. Treatment every other day until reaching end point of 0-1 on a 15 point scale for pain and degree of limitation.</td>
<td>No significant difference between groups for time spent on crutches or time taken off work. Both groups reached the end points at the same rate.</td>
<td>“Ultrasound treatment by the method used... does not hasten recovery after a lateral ligament sprain of the ankle.”</td>
<td>Lack of randomization, allocation, baseline comparability, compliance details. High withdrawal rate. No additive effect of ultrasound to other methods demonstrated.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Manipulation and Mobilization for Ankle Sprain

There is 1 high- and 5 moderate-quality RCTs or crossover trials incorporated into this analysis. (Truyols-Dominguez 13; Yeo 11; Cosby 11) There are 5 low-quality RCTs in Appendix 2.(544, 546-549) (Eisenhart 03; Pellow 01; Coetzer 01; Kohne 07; Lopez-Rodriguez 07)

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicenzino 2006</td>
<td>8.0</td>
<td>N = 16 recurrent lateral ankle sprains</td>
<td>Mobilization with movement (MWM)t: weight bearing vs. non-weight bearing</td>
<td>Weight bearing vs. non-weight bearing</td>
<td>“[T]he application of the MWM treatment techniques improved posterior talar glide and talocrural dorsiflexion immediately after application in subjects with chronic recurrent lateral ankle sprain. [T]here appears to be little difference in treatment effect between the 2 MWM techniques.”</td>
<td>Crossover trial. Reported double-blinding, but not feasible subject or intervention could be blinded. Results of uncertain clinical significance as no report of long-term outcomes regarding recurrence of sprain.</td>
</tr>
<tr>
<td>Truyols-Dominguez 2013</td>
<td>7.0</td>
<td>N = 50 with unilateral inversion</td>
<td>Combined treatment group had greater improvement on each functional score domain. No p-values to report.</td>
<td></td>
<td></td>
<td>Addition of myofascial techniques to thrust and non-thrust manipulations</td>
</tr>
</tbody>
</table>
### Experimentation Group

The experimental group received myofascial manual therapy and manipulation (n = 25). Both groups received ankle and foot non-thrust mobilization and thrust manipulation, general exercises, and instruction to elevate and ice the ankle. Follow-up included baseline, post intervention, and 1-month follow-up.

### Mean±SD for Dorsiflexion (mm)

<table>
<thead>
<tr>
<th>N</th>
<th>Technique</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Mobilization with movement vs. placebo mobilization vs. no-treatment (single sessions)</td>
<td>57.27±41.00</td>
<td>68.93±45.44</td>
</tr>
<tr>
<td>41</td>
<td>RICE vs. passive accessory joint mobilization plus RICE</td>
<td>60.17±38.49</td>
<td>56.42±33.48</td>
</tr>
</tbody>
</table>

### Findings

- **Mulligan’s dorsiflexion mobilization** significantly increases talocrural dorsiflexion initially after application in subacute ankle sprains.

### Baseline Differences

- **Addition of talocrural mobilization to the RICE protocol** in the management of ankle inversion injuries necessitated baseline differences in number of recurrent sprains (higher in experimental group). Despite

### Differences in Treatments

- **At 4 Weeks** and at **1 Month Follow-up**. However, differences modest.

### Collisions

- **2004 Crossover Trial**
- **Sample Size**: N = 16
- **Grade II Lateral Ankle Sprains**
- **Technique**: Mobilization with movement vs. placebo mobilization vs. no-treatment (single sessions).
- **Mean±SD for Dorsiflexion (mm)**
  - **Pre**: 57.27±41.00 vs. 60.17±38.49 vs. 58.29±32.67
  - **Post**: 68.93±45.44 (p < 0.017) vs. 62.07±38.97 vs. 56.42±33.48

### Green 2001 RCT

- **Sample Size**: N = 41
- **Technique**: RICE vs. passive accessory joint mobilization plus RICE for manipulation vs. control: attained full ROM after 4 sessions: 68% vs. 16%, p < 0.01.
- **Dorsiflexion ROM improvement**: 10.9°
<p>| Yeo 2011 Experimental Trial | 5.5 | N = 13 with unilateral acute and subacute ankle supination injury (2-10 weeks). Mean age 29.5 years. Acute and subacute ankle sprains &lt;72 hours and no other injury to lower limb | Maitland’s passive accessory mobilization of the talus on distal tibia and fibular (manual application of repetitive gentle oscillation of talus for 1 min, repeated 3 times) vs. manual contact control (hand contact on ankle) vs. no contact control. 3 study sessions scheduled at least 48 hours apart where all patients | Ankle dorsiflexion index: increase of 9.6mm following treatment condition (p = 0.000), significant between treatment and manual contact control (p = 0.000) and no contact control (p = 0.000). Pressure pain threshold: increased 17.76% after treatment (p = 0.000), significant between treatment and manual contact control (p = 0.000) and no contact control (p = 0.002). Pain VAS scores: NS (p = 0.369). Ankle functional scores: NS (p = 0.475). | Fewer treatments to achieve pain-free dorsiflexion and to improve stride speed more than RICE alone. “[A]ccessory mobilisation of the ankle joint using the anteriopeposterior glide technique produced an immediate and rapid onset hypoalgesic effect and an improvement in ankle dorsiflexion range of motion in subjects with an ankle supination injury.” | Outcome improvements in dorsiflexion, does not appear statistically significant in lost work days or return to work, sports, normal walking. Thus, improved dorsiflexion ROM as an outcome measure of unknown clinical importance. |</p>
<table>
<thead>
<tr>
<th>Cosby 2011 RCT</th>
<th>4.5</th>
<th>N = 17 with acute lateral ankle sprain (Grade I and II); mean age 19.76 ± 1.35</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Treatment group, physical therapist guided 30 second grade III AP talocrural joint mobilizations, one mobilization/second vs. Control group, no treatment, no physical contact with physician. All participants: dorsiflexion ROM, posterior talar translation using a portable ankle arthrometer, and self-reported function. Follow-ups: baseline, immediate post-treatment, and 24-hour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small N with few baseline characteristics. No significant decrease in pain perception between 2 groups at 24 hours. No significant followup to afford assessment of utility.</td>
</tr>
</tbody>
</table>
### Evidence for the Use of Ankle Support (Brace, Tape) for Prevention of Ankle Sprain

There are 3 moderate-quality RCTs incorporated in this analysis. There are 3 low-quality RCTs in Appendix 2. (Stasinopoulos 04; McGuine 11; McGuine 12)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoroso 1998 RCT</td>
<td>6.0</td>
<td>N = 777 U.S. Army Airborne School volunteers</td>
<td>Outside boot ankle brace (Aircast) vs. no additional support in parachute jump training in military population.</td>
<td>Brace vs. control: Ankle inversion injuries 7/376 (3.79% vs. 1/369 (0.55%) p &lt; 0.04. No differences in ankle fractures, syndesmosis sprains, knee or leg sprains/strains.</td>
<td>“Inversion ankle sprains during parachute training can be significantly reduced by using an outside-the-boot ankle brace, with no increase in risk for other injuries.”</td>
<td>Randomization based on odd/even military numbers. No baseline comparisons. Compliance not stated but inferred in this military population.</td>
</tr>
<tr>
<td>Mickel 2006 RCT</td>
<td>5.0</td>
<td>N = 93 ankle sprains in high school football players during a single season</td>
<td>Bracing (semi-rigid airsport brace) vs. taping for prevention of sprain in high school football league.</td>
<td>There was 0.83 ankle sprains per 1,000 exposures for brace group and 0.77 sprains per 1,000 exposures in tape group, p &gt; 0.05.</td>
<td>“Both of these prophylactic measures were well tolerated by the players, and the incidence of lateral ankle injuries was equal in both groups, whereas the cost to implement these measures was higher in the taping group.”</td>
<td>Allocation, baseline details sparse. Study may not have been powered to detect differences. Cost discussion compares retail taping costs to wholesale device costs.</td>
</tr>
<tr>
<td>Sitler 1994 RCT</td>
<td>5.0</td>
<td>N = 1,601 U.S. Military Academy cadets with no pre-participation, clinical, functional, or radiograph</td>
<td>Ankle stabilizer (Aircast) vs. no ankle stabilizer in healthy military recruits intramural basketball program.</td>
<td>Total number of ankle injuries for 2 years: ankle stabilizer 11, control 35, p &lt; 0.05. For contact injuries, those who wore ankle stabilizers had fewer ankle injuries compared to controls, p &lt; 0.01. The</td>
<td>“The total number of ankle injuries as well as the number of single and combined anterior talofibular and calcaneofibular ligament injuries were significantly reduced with ankle stabilizer use. No significant difference existed.”</td>
<td>Randomization, allocation methods not described. Overall incidence lower with brace group. Study completed in young military population</td>
</tr>
</tbody>
</table>
Evidence for the Use of Balance Training/Proprioception for Prevention of Ankle Sprain

There are 4 moderate-quality RCTs (one with two reports) incorporated into this analysis. There are 8 low-quality RCTs (one with 2 reports) in Appendix 2.(554, 560-567) (Coughlan 07; Engebretsen 08; Mohammadi 07; Verhagen 04; Verhagen Br J Sports Med 05; Verhagen Clin Biomech 05; Wedderkopp 99; Melnyk 09; Stasinopoulos 04)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tr>
<td>Emery 2007</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 920 high school basketball players</td>
<td>Wobble board training plus warm-up exercises vs. warm-up exercises in high school basketball league.</td>
<td>Control vs. training player exposure hours, number of injuries, injury rate/100 hour, relative risk, 95% CI, statistically significant. All injury: 34955/39369, 141/130, 4.03 (3.4-4.76)/3.3 (2.76-3.92), 1/0.8, 0.57-1.11, p = 0.18. All acute injury: 34955/3969, 134/109, 3.83 (3.21-4.54)/2.77 (2.27-3.34), 1/0.71, 0.5-0.99, p = 0.047. Lower extremity injury: 34955/39369, 111/106, 3.18 (2.61-3.82)/2.69 (2.2-3.26), 1/0.83, 0.57-1.19, p = 0.3. Ankle injury: 34955/39369, 76/62, 2.46 (1.97-3.04)/1.57 (1.21-2.02), 1/0.71, 0.45-1.13, p = 0.15.</td>
<td>“A basketball-specific balance training program was effective in reducing acute-onset injuries in high school basketball. There was also a clinically relevant trend found with respect to the reduction of all, lower-extremity, and ankle sprain injury.”</td>
<td>Randomization conducted by team rather than individual. Compliance less than 60%. No significant effect on ankle sprains but data suggest reduced acute injuries.</td>
</tr>
<tr>
<td>McGuine 2006</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 765 high school soccer and basketball players</td>
<td>Balance training (wobble board) vs. control for high school basketball and soccer players.</td>
<td>“Taking part in the intervention program significantly reduced the risk of an ankle sprain (risk ratio, 0.56; 95% CI, 0.33-0.95; p = 0.033).”</td>
<td>“[B]alance training program, implemented throughout a sports season, will reduce the rate of ankle sprains by 39% in high school basketball and soccer players.”</td>
<td>Subjects randomized as whole team. Method not described. No blinding of assessors. Suggests balance training program beneficial in</td>
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</table>
Evidence for the Use of Foot Orthotics for Prevention of Ankle Injury
There is 1 moderate-quality RCT incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Hupperts 2008, 2009</td>
<td>5.0</td>
<td>N = 522 active participants in sports with a lateral ankle sprain up to 2 months prior to inclusion</td>
<td>Home-based 8-week proprioceptive training program regression analysis showed lower recurrences of ankle sprain in intervention vs. control (0.63/95%CI = 0.45-0.88). Effect of non-medically treated athletes' regression showed lower recurrence of ankle sprains in intervention vs. control. Self reported recurrences of ankle sprain (0.45, 0.28-0.72). Recurrences leading to loss of sports time (0.47, 0.23-0.96).</td>
<td>&quot;The use of a proprioceptive training programme after usual care of an ankle sprain is effective for the prevention of self reported recurrences. This proprioceptive training was specifically beneficial in athletes whose original sprain was not medically treated.&quot;</td>
<td>No blinding, Low compliance rates (23% fully compliant, 29% partially). Data suggest home based training for proprioception may be beneficial in preventing recurrent ankle sprain.</td>
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<tr>
<td>Rotem-Lehrer 2007 RCT</td>
<td>5.0</td>
<td>N = 36 male volunteers with Grade 1 or 2 ankle sprains</td>
<td>Internal focus of attention (IFA) during postural control training vs. external focus (EFA) during postural control training. Stability scores: overall/anterior posterior stability/medial lateral stability; pretraining, post-training, change score: IFA mean±SD for (95%): 13.5±4.1/11.9±5.5/-1.59 (-3.13 to -0.05), 8.3±3.2/6.8±3.2/-1.43 (-3.13 to 0.28), 10.3±4.2/9.6±5.1/-0.69 (-1.99 to 0.61). EFA: 15.7±3.3/10.2±3.5/-5.45 (-6.62 to -3.97), 10.1±3.4/6.0±2.0/-4.14 (-5.75 to -2.54), 11.5±2.6/8.2±3.4/-3.36 (-4.88 to -1.84).</td>
<td>&quot;[E]xternal focus of attention is advantageous for the transfer of learning of a postural control task following an ankle injury.&quot;</td>
<td>Randomization, allocation details sparse. Blinding described but not of intervention or assessment. Results do not include injury recurrence or improvement and are thus of limited significance.</td>
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</table>
**Evidence for the Use of Foot Wear for Ankle Sprain**

There are 3 moderate-quality RCTs incorporated into this analysis.

<table>
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<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knapik 2010 RCT</td>
<td>5.5</td>
<td>N = 1,411 Marine Corps recruits</td>
<td>Motion control shoes for low arch-motion vs. cushion shoe for high arch vs. stability (control) running shoes; 12-week basic training (Marines).</td>
<td>Hazard ratio (men) intervention/control; Low arch: 0.91 (0.40-2.07) p = .82; High arch: 1.05 (0.53-2.10) p = .89; hazard ratio (women) intervention/control: Low arch: 0.74 (0.31-1.76) p = .49; High arch: 1.11 (0.62-2.00) p = .72</td>
<td>“This prospective study demonstrated that assigning shoes based on the shape of the plantar foot surface had little influence on injuries even after considering other injury risk factors.”</td>
<td>Lack of compliance, co-intervention details. Compliance assumed high (military training/shoe assignment tracked). Results suggest fitting shoe type to perceived plantar shape provides no additional benefit in preventing injuries, including sprains.</td>
</tr>
<tr>
<td>Knapik 2010 RCT</td>
<td>4.5</td>
<td>N = 2,702 U.S. Air Force Basic Military Training (BMT) recruits</td>
<td>Motion control shoes for low arch-motion vs. cushion shoe for high arch vs. stability (control)</td>
<td>Training-related Injury Index: hazard ratio (men) intervention/control 1.17 (0.95-1.45) p = .14; Training-related Injury Index: hazard ratio</td>
<td>“This prospective study demonstrated that assigning running shoes based on the shape of the plantar surface had little influence on the injury risk in BMT even after”</td>
<td>Lack of compliance, co-intervention details. Compliance assumed high (military training/shoe assignment tracked). Results suggest fitting shoe type to perceived plantar</td>
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</tbody>
</table>
Evidence for the Use of Stretching/Strengthening Exercises for Prevention of Ankle Injury
There are no quality RCTs incorporated into this analysis. There are 4 low-quality RCTs in Appendix 2.(562, 583-585) (Pope 00; Puls 07; Ekstrand 83; Mohammadi 07)

<table>
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<th>Author/Year</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>Barrett 1993</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 622 college intramural basketball players</td>
<td>High-top shoes vs. low-top vs. high top with inflatable air chambers for prevention of ankle sprain.</td>
<td>Injury rates per 10,000 player minutes, 95% CI (high-top air chamber vs. low-top vs. high-top): 2.69 (0.6-6.8) vs. 4.06 (1.2-10.3) vs. 4.8 (2.0-9.8).</td>
<td>“The major finding of this study was that there was no difference between high- and low-top basketball shoes in the prevention of ankle sprains.”</td>
<td>Allocation method, compliance unclear. Results suggest no difference after 2 months in college intramural population with shoe types.</td>
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</table>

Evidence for the Use of Therapy for Ankle Sprain/Instability
There are 6 moderate-quality RCTs (two with two reports) incorporated into this analysis. (Cleland 13; Ismail 10) There are 9 low-quality RCTs in Appendix 2.(416, 588-591, 601) (Christakou 07; Laufer 07; Youdas 09; Chaiwanchsiri 05; Wester 96; Brooks 81; Kim 14; Collado 10; Asimenia 13)

<table>
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<tr>
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<th>Conclusion</th>
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<tr>
<td>Van Rijn 2009, 2007</td>
<td>RCT</td>
<td>7.5</td>
<td>N = 107 adults with acute lateral ankle sprain</td>
<td>Physical therapy (PT) plus conventional care vs. conventional care only (education, home exercises, early weight bearing, tape, brace). Intervention group: 9 sessions of supervised PT</td>
<td>Outcomes after 3, 12 months follow-up (conventional/PT) AR%: re-sprain 3 months (14/10) - 4.2(-21.5 to 13.1%); re-sprain 12 months (16/13) 2.5 (-16.8 to 22.0%); reported instability 3 months (34/32) 1.2 (-17.4 to 19.7); instability 12 months (30/26) 3.5 (-22.9 to 15.8%); tested instability 3 months (26/18) - 11.5 (-32.6 to 9.5);</td>
<td>“Usual care combined with supervised exercises compared with usual care alone at 3 months and 1-year follow-up after an acute lateral ankle sprain did not indicate clinically meaningful differences in the occurrence of re-sprains or in subjective</td>
<td>Of those in home exercise group, 82% reported rarely or never doing home exercises, essentially making this a study of supervised PT vs. “usual care,” with no clinical benefit demonstrated by supervised PT. The 2009 study presented</td>
</tr>
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</table>
consisting of individualized program of balance exercises, walking, running, and jumping. Home exercise program not defined.

full treatment appreciation 3 months (32/40) 22.8 (7.0 to 38.7%). Mild/moderate vs. severe sprain subgroups: pain (walking on flat) 2.2 vs. 1.3%, OR 1.1 (0.1-2.0); pain (walking on rough) 2.5 vs. 2.3%, OR 1.7 (0.6-2.9); stability (walking on rough) 2.6 vs. 2.1%, OR 1.8 (0.6-2.9). No differences sprain recurrence between groups.

recovery in patients consulting a GP or the emergency department. The results of (2009) study only partially support the recommendation regarding the use of the ankle function score in the Acute Ankle Injury guideline of the Royal Dutch Society of Physiotherapists."

| Cleland 2013 RCT | 7.5 | N = 74 with inversion ankle sprain; mean age for home exercise program: 33.2, mean age for manual therapy and exercise: 37.1 | Manual Therapy & Exercise (MTEX), mobilizing and strengthening, standing and functional exercises; seen by physical therapist (PT) twice weekly for 8 sessions (n = 37) vs. Home Exercise Program (HEP), manipulations of joints, home exercises, strengthening and balancing exercises; seen by PT for 4 sessions 1 per week (n = 37). Both treatments lasted 30 minutes, advice to stay active, and Mean percent score for FAAM activities of daily living (ADL): MTEX vs. HEP: 4 weeks: 85% vs. 70%, p <0.05; 6 months: 95% vs. 85%, p <0.05. Mean percent score for FAAM sports: MTEX vs. HEP: 4 weeks: 75% vs. 65%, p <0.05; 6 months: 90% vs. 85%, p <0.05. Mean (95 CI) for FAAM ADL: Between group differences: baseline to 4 weeks: 11.7 (7.4 to 16.1), p <0.001 (in favor of MTEX); baseline to 6 months: 6.2 (0.98 to 11.5), p = 0.02 (in favor of MTEX). FAAM sports: baseline to 4 weeks: 13.3 (8.0 to 18.6), p <0.001 (in favor of MTEX), “The results suggest that an MTEX approach is superior to an HEP in the treatment of inversion ankle sprains.”

“Good baseline comparability. Both groups had pain improvement from treatment with Manual therapy and exercise group having slightly better results for pain relief and function at 4 weeks and also 6 months vs. HEP group. However, as the intervention group had both active supervision of exercise as well as manual therapy, what was responsible for the modest differences is unclear.
<table>
<thead>
<tr>
<th>Study</th>
<th>RCT</th>
<th>Participants</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
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<tbody>
<tr>
<td>Bleakley 2007, 2010</td>
<td>7.0</td>
<td>N = 101 acute Grade I or II ankle sprains</td>
<td>PRICE vs. PRICE plus early therapeutic exercises. Intermittent cryotherapy protocol: 10 minutes ice, 10 minutes rest (control) or 10 minutes exercises (intervention) then 10 minutes cryotherapy 3 times a day for 1 week. Both received exercise protocol after Week 1 for 30 minutes once a week, 4 weeks for Grade I and II sprains; 16 week follow-up.</td>
<td>Treatment effect: control vs. exercise; Difference in lower extremity function score: Week 1; 5.28 (0.31-10.26) p = 0.008. Week 2; 4.92 (0.27-9.57) p = 0.0083. No difference after Week 2. Pain at rest, pain with activity, swelling: all no differences at any interval. Reinjury rate at 16 weeks 2/50 vs. 2/51. Physical activity: Time (hours/day) spent first week, control vs. exercise; Walking 1.2(0.9-1.4) vs. 1.6(1.3-1.9) p = 0.029. Step sitting, standing p &gt;0.05.</td>
<td>&quot;[I]ncorporating therapeutic exercises during the first week after ankle sprain resulted in significant improvements in short term ankle function compared with a standard functional intervention.&quot;</td>
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<tr>
<td>Bassett 2007</td>
<td>6.0</td>
<td>N = 47 acute ankle sprains</td>
<td>Home PT vs. clinic based management.</td>
<td>Post-PT scores (mean±SD/ clinic/home): LLTQ recreational activity subscale (12.00±10.10/ 8.18±7.24) p &gt;0.05; LLTQ ADL subscale (2.32±3.60/1.82±3.58) p &gt;0.05; motor activity scale (5.14±1.28/5.73±1.08) p &gt;0.05. Appointments (mean±SD/</td>
<td>&quot;Home based physical therapy intervention plus adherence enhancing adjuncts is a safe and viable option for patients with ankle sprains, and physical therapists should contemplate using it with patients who have problems attending regular</td>
<td>No control group of PT vs. no PT. Wide inclusion criteria (all but non-English speakers eligible). Data suggest home PT for acute ankle sprain as effective as structured/super vised PT with higher compliance to regimen.</td>
</tr>
<tr>
<td>Holme 1999 RCT</td>
<td>4.0</td>
<td>N = 92 ankle sprain injuries obtained during sports activity</td>
<td>Supervised PT vs. education and home exercises.</td>
<td>Side-by-side percent differences similar in both groups for all variables, p &gt; 0.05. Re-injury data 12 months after injury: yes = 2 in training group, 11 in control group (p &lt; 0.05). “Six weeks after an ankle injury a side-to-side difference in isometric ankle strength and postural control was demonstrated, which appeared to normalize after 4 months, with or without supervised physical therapy. Supervised rehabilitation may reduce the number of re-injuries, and therefore play a role in injury prevention.”</td>
<td>Baseline difference possibly suggesting randomization failure; 30% lost to follow-up. Measured values of uninjured side not constant over study. Appeared to improve in both groups. No between-group comparisons provided as discussion limited to comparison of injured to uninjured ankle.</td>
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<tr>
<td>Ismail 2010 RCT</td>
<td>4.0</td>
<td>N = 36 athletes with lateral ankle sprain referred to physical therapy clinic; mean age for plyometric group, exercise program of jumping and hopping different directions with or without barrier, with single of double leg; 2 days/week (n = 19) vs. Resistive group, manual exercise for dorsiflexion,</td>
<td>Mean±SD for functional tests: plyometric vs. resistive: post-test: climbing downstairs (sec): 13.7±2.6 vs. 16.6±2.3, p = 0.01; raising on heel (times): 47.7±3.5 vs. 38.5±4.4, p = 0.00; raising on toes (times): 46.1±4.4 vs. 41.5±6.6, p = 0.01; single-limb stance (sec): 65.9±6.4 vs. 56.7±3.9, p = 0.00. “Plyometrics were more effective than resistive exercises in improving functional performance of athletes after lateral ankle sprain.”</td>
<td>Small N, large dropout rate. Plyometrics better than resistive exercises for increased function of lateral ankle sprains in athletes.</td>
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Evidence for the Use of Rehabilitation for Chronic Ankle Instability

There are 2 moderate-quality RCTs incorporated into this analysis. There are 5 low-quality studies in Appendix 2. (Han 09; Ross 07; Bernier 98; Kidgell 07; Powers 04)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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<th>Results</th>
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<tbody>
<tr>
<td>Hoiness 2003 RCT</td>
<td>6.5</td>
<td>N = 20 recurrent ankle sprains and positive stress x-ray films</td>
<td>Bi-directional bicycle pedal vs. regular (unicycle) pedal in 6 week high intensity training program.</td>
<td>Test group improved performance to 80% maximum level after training, 72.5% before. The control group improved from 56.1% or 67.8%. Figure 8 running (seconds before/after): test group (12.41/12.17) p = 0.003 vs. control group (12.22/12.11) p = 0.078. Eversion torque (before/after): all ankles 60°s⁻¹ (22.75/2.35) p = 0.037; unstable ankles 60°s⁻¹ (22.50/25.50) p = 0.154; stable ankles 60°s⁻¹ (23.00/25.20) p = 0.182.</td>
<td>“Short-term high-intensity training with a bi-directional pedal improves ankle performance and may be an option in the treatment of recurrent ankle sprains.”</td>
<td>Bi-directional pedal tilts 20° sideways during loaded cycles. Small sample size. Results of uncertain clinical significance in general population (test group 0.2 seconds faster running on 40 meter figure 8 track). No significant difference in Karlsson functional scores, figure of 8 running times, or eversion torque angles despite intragroup improvements in intervention group.</td>
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<tr>
<td>Author/Year Study Type</td>
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<tr>
<td>Hale 2007 RCT</td>
<td>4.5</td>
<td>N = 48 with unilateral chronic ankle instability (CAI)</td>
<td>Chronic ankle instability (CAI) rehab vs. CAI control vs. healthy group.</td>
<td>CAI groups showed increase in COPV when evaluating eyes closed (p = 0.034) and eyes open (p = 0.029) when standing on involved limb vs. uninvolved limb. CAI rehab and control could reach further standing on uninvolved limb: posteromedial reach p = 0.047, posterolateral reach p = 0.007, lateral reach p = 0.025. The CAI rehab group showed improvement for the FADI-Sport change scores vs. CAI control (p = 0.009), and healthy (p &lt;0.0005).</td>
<td>“[P]ostural control and functional limitations exist in individuals with CAI. In addition, rehabilitation appears to improve these functional limitations. Finally, there is evidence to suggest the SEBT may be a good functional measure to monitor change after rehabilitation for CAI.”</td>
<td>Sparse study details for randomization, allocation, baseline comparability. Data suggest rehab regimen may improve postural deficits although it is not clear from this study if findings correlate to improved function and reduced recurrence of ankle injury.</td>
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</table>

**Evidence for the Use of Autologous Blood Injections for Ankle Sprain**
There are no quality trials incorporated into this analysis.

**Evidence for the Use of Injected Glucocorticosteroids for Ankle Sprain**
There are no quality trials incorporated into this analysis. There is 1 low-quality study in Appendix 2.(411) (Nilsson 83)

**Evidence for the Use of Hyaluronic Acid for Ankle Sprain**
There is 1 moderate-quality RCT (with two reports) incorporated into this analysis.
delivering medication in AP, medial, lateral directions. Acute Grade I, II sprains treated <48 hours.  

patient satisfaction Day 4, 8. Baseline scores not presented so total change significantly different but uncertain if actual data different.  

associated with reduced pain and more rapid return to sport, with few associated adverse events.  

in clinical improvement in total pain reduction over placebo with long-lasting effect. Reported results may be of small clinical significance.

### Evidence for the Use of Platelet Rich Plasma for Ankle Sprain

There are no quality trials incorporated into this analysis.

### Evidence for the use of Surgical Intervention for Chronic Ankle Instability

There are no quality RCTs incorporated into this analysis.

### Evidence for the Use of Acute Surgical Repair for Ankle Ligament Tear

There are 6 moderate-quality RCTs (one with two reports) incorporated into this analysis. (Pihlajamaki 10) There are 9 low-quality RCTs in Appendix 2,(412, 499, 500, 510, 511, 605, 618, 619, 621) (Moeller-Larsen 88; Specchiulli 01; Sommer 89; Zwipp 92; Korkala 87; Niedermann 81; van den Hoogenband 84; Gronmark 80; Clark 65)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<tbody>
<tr>
<td>Surgery vs. Non-operative Care</td>
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<p>| Pijnenburg 2003 Quasi-RCT | 6.0 | N = 370 adults 18 to 45 years with painful ankle caused by an indirect supinat ion injury | Surgical repair vs. functional treatment of lateral ligament rupture. Functional treatment either non-weight bearing cast for 5 days followed by elastic wrap or taping. | Operative vs. functional (%), Residual pain: 16 vs. 25, p &lt;0.05. Giving way: 20% vs. 32%, p &lt;0.016, Recurrent sprains: 22 vs. 34, p &lt;0.022. Score of excellent and good: 86% vs. 74% (no P provided). | “We found operative treatment led to better results at the short and long term follow-up. We believe that operative treatment for lateral ligament ruptures can be adopted in selected cases when higher functional demands are required. If operative treatment is rejected or not available, taping is | Quasi-randomization (odd-even week of enrollment to study). Allocation not concealed. Study demonstrates mixed results as patient report of residual pain, recurrent sprains higher in conservative group, but no difference in subjective satisfaction with treatment. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Study Details</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Povacz 1998</td>
<td>RCT</td>
<td>Surgery plus cast for 6 weeks vs. ankle orthosis (6 weeks) using Aircast.</td>
<td>Pain at 2-year follow-up: Surgery vs. Aircast mild (29% vs. 21%), severe (3% vs. 3%), none (68% vs. 77%). Overall results were not significantly different. Time to resume normal work activities (7.0 weeks vs. 1.6 weeks, p &lt;0.0001).</td>
</tr>
<tr>
<td>Pihlajamaki 2010</td>
<td>RCT</td>
<td>Surgical; ligament repair, talofibular ligament, anterior talofibular and calcaneofibular ligaments (n = 25) vs. Functional; functional light-weight orthotic device for 3 weeks; allowed dorsiflexion and plantar flexion, but resisted inversion and eversion of ankle (n = 26). After care: anti-inflammatory medication and crutches, mobilization and muscle</td>
<td>No significant differences to report between two groups in any outcome measure. All patients in both groups recovered preinjury activity level and reported they could walk and run normally.</td>
</tr>
</tbody>
</table>

Povacz 1998 RCT

1998 RCT

N = 167 adults with isolated injury of ankle fibular collateral ligaments

Pihlajamaki 2010 RCT

2010 RCT

N = 51 with an acute Grade-III lateral ligament rupture of ankle, age range 18-26 (mean, 20.4)

Surgical vs. functional treatment of acute ankle ruptures have similar outcomes although surgical patients showed more degenerative cartilage changes post-surgery via MRI.
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>N</th>
<th>Description</th>
<th>Comparison</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evans 1984</td>
<td>RCT</td>
<td></td>
<td>Strengthening exercises supervised by physiotherapist.</td>
<td>Comparisons at 3 months and 2 years after injury. Operative repair vs. plaster cast only: Giving way only; 13 vs. 4. Recurrent sprains only; 13 vs. 11. Giving way and recurrent sprains 3 vs. 4.</td>
<td>“Early mobilisation with the protection of a cast brace may achieve equal functional results with the advantage of earlier recovery.” Randomization, allocation details missing. Study demonstrated similar outcomes in both groups with higher symptomatic instability at 2 years in surgical group.</td>
</tr>
<tr>
<td>Jeong 2010</td>
<td>RCT</td>
<td></td>
<td>Treatment group receiving blood bank platelet concentrate (ABO-and Rh-compatible) (n = 52) vs. Control group (n = 48). Both groups received 25ml or 12.5ml for 1st application and 25ml or 12.5ml 3-4 days post-op alongside standard wound care. Assessments at baseline and 12 weeks.</td>
<td>Mean (±SD) time for complete ulcer healing significantly lower in the treatment group versus the control group; 7.0(±1.9) weeks vs. 9.1 (±2.2) weeks, (p&lt;0.05). Degrees of wound shrinkage significantly lower in treatment group versus the control; 96.3 (±7.8) vs. 81.6 (±19.7), (p&lt;0.05).</td>
<td>“Although further investigations are needed to determine the ultimate value of the blood bank platelet concentrate allograft, the present study demonstrates that this method may be used to treat diabetic foot ulcers. The use of a blood bank platelet concentrate may provide a simple, safe, and effective means of treating diabetic foot ulcers.” Data suggest efficacy.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Post-operative Management for Ankle Instability

There are 2 moderate-quality RCTs incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karlsson 1999 RCT</td>
<td>5.0</td>
<td>N = 30 chronic lateral ligament instability of the ankle</td>
<td>Post-ligament reconstruction: plaster cast x 6 weeks vs. cast x 7-10 days followed by Aircast (early mobilization) with early motion training. Subjects failed 3 months physiotherapy prior to study.</td>
<td>Cast vs. early motion: Functional results excellent or good (%) - 12/15 vs. 14/15, p &gt;0.05; Sick leave 7 vs. 6 weeks (p &gt;0.05).</td>
<td>“Early mobilization after ankle ligament surgery for chronic ligamentous instability should be preferred to postoperative immobilization.”</td>
<td>Randomization, allocation, baseline comparability details sparse. Study demonstrates early mobilization may have better functional outcomes at 3 months and faster return to sport but no differences in long-term outcomes.</td>
</tr>
<tr>
<td>Karlsson 1995 RCT</td>
<td>4.0</td>
<td>N = 40 chronic lateral instability of the ankle</td>
<td>Post-ligament reconstruction: plaster cast vs. walking boot (6 weeks) with early motion training. Subjects failed 3-months physiotherapy prior to study.</td>
<td>Cast vs. early motion: functional results excellent or good (%) - 80% vs. 95%, p &gt;0.05; dorsiflexion at 6 weeks: 5.4 vs. 15.2</td>
<td>“Early range of motion training in an ankle joint brace is a safe method after anatomical reconstruction of the ankle ligaments in patients with chronic instability. The lack of study details including randomization method, allocation, baseline comparability, compliance, and timing of assessments. No significant differences on</td>
<td></td>
</tr>
</tbody>
</table>
(p <0.001), plantar flexion 16.2 vs. 38.5 (p <0.001). Both ROM measures at 2 years not different.

method allows the patients to return earlier to work and sports activities with preserved mechanical stability.”

long term follow-up but early ROM may result in quicker return to work and sports.

_Evidence for use of Orthotics_
There is 1 moderate-quality RCT incorporated into this analysis. (Kilmartin 94)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Kilmartin 1994 RCT</td>
<td>4.5</td>
<td>N = 23 with unilateral pain in 3rd/4th metatarsal space which was irritated by exercise and relieved by rest. Mean age of participants was 43.</td>
<td>Supination Orthoses group (n = 10) vs. Pronation Orthoses group (n = 11). Patients followed up at 4, 8, 12 and 52 weeks.</td>
<td>At final follow-up, 5 patients in each group reported their symptoms were better than at baseline. Results not significant between groups for any measurement. Alternative treatment necessary for a number of patients (52% of participants) who were not helped at all by orthoses upon discharge from study.</td>
<td>“While this study has not demonstrated that compressed felt orthoses have any significant effect on Morton’s neuroma, it does show that preventing subtalar joint pronation produces no significant benefit.”</td>
<td>High dropout rate and small N with subjective measurements of patient responses. Pronation did not appear to be superior to supination.</td>
</tr>
</tbody>
</table>

Evidence for the use of Lidocaine
There is 1 low-quality RCT in Appendix 2. (Quiding 13)

Evidence for the use of Manipulation and Mobilization
There is 1 moderate-quality RCT incorporated into this analysis. (Govender 07)
Evidence for the Use of Extracorporeal Shockwave Therapy for Morton’s Neuroma

There is 1 moderate-quality RCT incorporated into this analysis. (Fridman 09)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fridman 2009</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 25 with Morton’s neuroma confirmed clinically and by ultrasound</td>
<td>Active group treated with OSSATron device using 2,000 pulses at 21 kV directed inferior to neuroma (n = 13) vs. Sham Group: 5mL of bupivacaine hydrochloride but no shockwave therapy (n = 12). Follow-up at 1, 6, and 12 weeks post-treatment.</td>
<td>Active group had significant difference from baseline VAS pain after 12 weeks. (p&lt;0.0001). Sham group had no differences from baseline (p=0.1218). 69% (9) of ESWT vs 40% (4) of sham achieved VAS 3 or less. No difference between groups.</td>
<td>“Owing to the success with this procedure (no complications and no post-treatment disability), we continue to offer extracorporeal shockwave therapy as an alternative to surgical excision for Morton’s neuroma.”</td>
<td>Pilot study, small numbers. Data suggest EST may be better than sham for Morton’s Neuroma, but data suggest underpowered. Reproduction in full trial needed.</td>
</tr>
</tbody>
</table>

Evidence for the use of Glucocorticosteroid Injections

There is 1 moderate-quality RCT incorporated into this analysis. (Thomson 13)
### Evidence of the Use of Surgery

There are 3 moderate-quality RCTs incorporated into this analysis. (Akermark 13; Colgrove 00; Nashi 97)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomson 2013 RCT</td>
<td>4.5</td>
<td>N = 131 patients who had a clinical diagnosis of Morton’s neuroma.</td>
<td>Corticosteroid and anesthetic group (1mL methylprednisolone [40mg] and 1mL 2% lignocaine) (n = 64) vs. Anesthetic alone group (2 mL 1% lignocaine) (n = 67). Patients assessed at 1, 3 and 12 months via questionnaire.</td>
<td>Steroid group reported significantly higher FHT scores compared to control group (mean (SD)) at 1 month 61.1 (22.6) vs. 49.8 (25.4) (p = 0.002), and at 3 months, 64.7 (22.0) vs. 50.9 (27.2) (p = 0.002). Results significantly lower for MFPDS pain score (walking pain) for steroid group compared to control at 1 month 31.4 (20.3) vs. 42.0 (20.9) (p = 0.002) and at 3 months 30.5 (21.5) vs. 41.9 (26.3) (p=0.004).</td>
<td>“The groups also differed significantly in this measure at one month after injection, and improvements with corticosteroid injection (significant and nonsignificant) were observed for measures of pain, function, and patient global assessment of general health at one and three months after injection.”</td>
<td>Methylprednisolone better than control at 3 months.</td>
</tr>
<tr>
<td>Colgrove 2000 RCT</td>
<td>5.5</td>
<td>N = 44 patients with foot neuromas. Average age of participants was 49 in resection group and 46 in</td>
<td>Resection procedure (R Group) (n = 22) vs. Transposition procedure (T Group) (n = 22). Follow-up via phone call 1, 3, 6, 12, 36-48 months to measure pain,</td>
<td>Preoperative pain levels were 78 (T Group) vs. 77 (R Group). At 1 month is was 22 vs. 19, at 6 months 11 vs. 8, at 12 months 4 vs. 6 respectively. These results were not found to be significant. At</td>
<td>“Excellent results can be obtained by performing either a resection or a transposition of the ION, but this review indicates that a long term asymptomatic”</td>
<td>Transposition compared with resection showed better long-term results. Question baseline comparability</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Sample Size</td>
<td>Inclusion Criteria</td>
<td>Treatment Group 1</td>
<td>Treatment Group 2</td>
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<tr>
<td>Akermark 2013</td>
<td>2013</td>
<td>Prospective RCT</td>
<td>N = 76</td>
<td>patients with a typical history and clinical diagnosis of primary Morton’s Neuroma for at least 4 months.</td>
<td>Plantar Incisions (n = 35) vs. Dorsal Incisions (n = 41). Patients’ follow-up at 3 months, 12 months and 33-34 months.</td>
<td>There was a significant reduction of VAS pain score compared with baseline in both groups at all follow-up periods. (p&lt;0.001). There was no significant difference between groups at any follow-up for VAS scores. Restrictions in daily activities were reduced 77% in the plantar group and 67% in the dorsal group. These results were significant compared to baseline for both groups (p&lt;0.001), with no significant difference between groups. There were 5 complications in the plantar group 6 in the dorsal group.</td>
</tr>
<tr>
<td>Nashi 1997</td>
<td>1997</td>
<td>RCT</td>
<td>N = 52</td>
<td>patients with Morton’s neuroma. Mean age among participants (44 female and 8 male)</td>
<td>Dorsal approach group (n = 26) vs. Plantar approach group (n = 26). Average follow-up was 3.1</td>
<td>In first 2 weeks after operation, 8 patients in dorsal group able to fully bear weight compared to 0 patients in plantar group. Average return to</td>
</tr>
</tbody>
</table>
was 53 years. years and minimum follow-up time was one year. work time after surgery was 22 days in dorsal group with 37 days in plantar group. In dorsal group. 80% of patients reported good or satisfied compared to 65% in plantar group. earlier weight-bearing, a shorter time taken to return to work, a less painful scar and greater patient satisfaction.” Far more females in study questioning baseline comparability.

### Evidence for use of Orthotics
There are 2 moderate-quality RCTs incorporated into this analysis. (Torkki 01; DuPlessis 11)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
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<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torkki 2001 RCT</td>
<td>7.5</td>
<td>N = 211 patients with mild or moderate hallux valgus deformation (painful bunion with hallux valgus angle ( \leq 35^\circ ) intermetatarsal angle ( \leq 15^\circ ). Mean age surgery 48±10 years, orthosis 49±10 years, control 47±9 years.</td>
<td>Surgery, chevron procedure followed by abduction splint for 6 weeks (n = 71) vs. functional foot orthosis, negative cast technique (n = 69) vs. control, no surgery or foot orthotics (n = 69). Follow-up at 6 months and 1 year after randomization.</td>
<td>Differences in adjusted group means (95% CI) at 6 months: pain in last 6 months (NS between groups); intensity of foot pain, surgery vs. control -20 (-28 to -12), orthosis vs. control -14 (-22 to -6), surgery vs. orthosis (NS); ability to work, significant in surgery vs. orthosis -1 (-9 to -7). Differences in adjusted group means (95% CI) at 12 months: pain in last 6 months surgery vs. control -22 (-42 to -1), orthosis vs. control (NS), surgery vs. orthosis -34 (-55 to -14); intensity of foot pain, surgery vs. control -19 (-28 to</td>
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</table>

“[T]he chevron operation is an effective treatment for patients who have a mild to moderate hallux valgus deformity and bunion pain while walking as their main symptom.” Mild or moderate cases studied and studied worst foot. Data suggest surgery superior to orthosis. Orthosis minimally superior to no treatment at 6 months but not at 12 months.
DRAFT – For Public Comment

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</tr>
</thead>
<tbody>
<tr>
<td>Zacherl 2009</td>
<td>6.5</td>
<td>N = 44 participants (52 feet) with mild to moderate hallux valgus deformity; Mean age 53 years.</td>
<td>Verum Group-Daily transcutaneous low intensity pulsed ultrasound (LIPUS) (n = 26 feet) vs. Placebo Group-sham</td>
<td>No significant difference between groups for the metatarsophalangeal-interphalangeal scale (p = 0.57). Also, no significant</td>
<td>“Despite potential impact of LIPUS on bone formation, we found no evidence of an influence on outcome 6”</td>
<td>LIPUS not associated with improvement in outcomes at 6 weeks or 1 year after chevron osteotomy.</td>
</tr>
</tbody>
</table>
Evidence for the use of Manipulation and Mobilization
There is 1 moderate-quality RCT incorporated into this analysis. (DuPlessis 11)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Du Plessis 2011 RCT</td>
<td>6.0</td>
<td>N = 30 participants with symptomatic hallux (ces) with pain and disability being ≥ 30% on the VAS pain scale and disability scale respectively; Mean Age was 42 years.</td>
<td>Experimental group: Brantingham protocol: Mobilization, Mobilization with HVLA, Post-treatment cold therapy and Mobilization of other foot and ankle joints as indicated (n = 15) vs. Control Group: Night split which holds the big toe in a corrected position (n = 15), Follow-up at 1 week and 1 month</td>
<td>There were no significant differences between the two groups at 1-week follow-up. At the 1 month follow-up there was a significant difference between the experimental group vs. control group for Pain scores; 1.2 vs. 17.7 (p &lt;0.01) and for Foot function scores (FFI); 2.3 vs. 33.4 (p &lt;0.01). Both groups showed statistically significant improvements in both outcome measures at final follow up.</td>
<td>“This exploratory trial has demonstrated that a structured protocol of MMT (the Brantingham protocol) is possibly as effective as standard care (night splint) in the short-term (3 weeks) for symptomatic mild to moderate HAV. At the 1-month follow-up the MMT maintains its treatment effect without further treatment, but the night splint does not.”</td>
<td>Pragmatic trial. Small sample size. Baseline comparability unclear. Suggests MMT is comparable to night splint at 1 seek but after that MMT sustained outcomes up to 1 month for mild to moderate HAV.</td>
</tr>
</tbody>
</table>
### Evidence of the Use of Surgery

There is 1 moderate-quality RCT incorporated into this analysis. (Torkki 01)

<table>
<thead>
<tr>
<th>Author/Yeal</th>
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<tr>
<td>Torkki 2001 RCT</td>
<td>7.5</td>
<td>N = 211 patients with mild or moderate hallux valgus deformation (painful bunion with hallux valgus angle ≤ 35° intermetatarsal angle ≤15°. Mean age surgery 48±10 years, orthosis 49±10 years, control 47±9 years.</td>
<td>Surgery, chevron procedure followed by abduction splint for 6 weeks (n = 71) vs. functional foot orthosis, negative cast technique (n = 69) vs. control, no surgery or foot orthotics (n = 69). Follow-up at 6 months and 1 year after randomization.</td>
<td>Differences in adjusted group means (95% CI) at 6 months: pain in last 6 months (NS between groups); intensity of foot pain, surgery vs. control -20 (-28 to -12), orthosis vs. control -14 (-22 to -6), surgery vs. orthosis (NS); ability to work, significant in surgery vs. orthosis -1 (-9 to -7). Differences in adjusted group means (95% CI) at 12 months: pain in last 6 months surgery vs. control -22 (-42 to -1), orthosis vs. control (NS), surgery vs. orthosis -34 (-55 to -14); intensity of foot pain, surgery vs. control -19 (-28 to -10), orthosis vs. control (NS), surgery vs. orthosis -14 (-22 to -5); ability to work (NS between groups).</td>
<td>&quot;[T]he chevron operation is an effective treatment for patients who have a mild to moderate hallux valgus deformity and bunion pain while walking as their main symptom.&quot;</td>
<td>Mild or moderate cases studied and studied worst foot. Data suggest surgery superior to orthosis. Orthosis minimally superior to no treatment at 6 months but not at 12 months.</td>
</tr>
</tbody>
</table>

### Evidence for the Use of X-ray for Evaluation of Ankle Fractures

There are no quality studies incorporated into this analysis.

### Evidence for the Use of MRI for Evaluation of Ankle Fractures

There are no quality studies incorporated into this analysis.
Evidence for the Use of CT for Evaluation of Ankle Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Use of Ultrasound for Evaluation of Ankle Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Use of Antibiotic Prophylaxis for Ankle Fractures
There is 1 high-quality RCT incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Paiement 1994 RCT</td>
<td>9.0</td>
<td>N = 122 isolated closed ankle fractures undergoing ORIF</td>
<td>Cephalotin 1g (n = 60) vs. placebo (n = 62) IV every 6 hours for 24 hours.</td>
<td>Functional outcome at 1 year comparable, no pain or limp, and return to work and other activities not statistically different between groups; 1 deep tissue infection in placebo group.</td>
<td>“This series of ORIF of 122 patients with closed ankle fracture shows that the infection rate after such a clean orthopaedic procedure is relatively low, approximately 3%. Therefore, cefalotin prophylaxis does not seem justified in this patient population.”</td>
<td>Intra-operative IV antibiotics did not result in any significant different outcome in terms of infection, return to work or pain in patients undergoing ORIF with an isolated closed ankle fracture. Appears likely underpowered.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Calcitonin Prophylaxis for Post-fracture Osteopenia
There is 1 moderate-quality RCT incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peterse 1998 RCT</td>
<td>6.5</td>
<td>N = 24 ankle fractures requiring ORIF</td>
<td>Nasal salmon calcitonin 200 IU once daily for 12 weeks vs. placebo.</td>
<td>Bone mineralization at 3 months: placebo lost 14%, sCT 2.1% (NS) in injured leg. Uninjured: placebo lost 2.2%, sCT gained 8.6% at 1.5 months (p = 0.07).</td>
<td>“200 IU of nasal salmon calcitonin given daily could not inhibit the development of posttraumatic osteopenia in the injured legs, following ankle fractures, but a statistically significant effect was observed in the healthy legs.”</td>
<td>No mention of co-interventions or compliance with medication on daily basis. Small numbers; drop outs after 3 months make changes seen not able to reach statistical significant in injured leg. Data suggest no benefit for osteopenia prophylaxis.</td>
</tr>
</tbody>
</table>
Evidence for the Use of NSAIDs and Acetaminophen for Foot and Ankle Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Use of Opioids for Foot and Ankle Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Use of Tetanus Immunization for Open Foot and Ankle Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Use of Non-operative Reduction Analgesia for Ankle Fractures
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
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</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>RCT</td>
<td>7.0</td>
<td>N = 42 closed, displaced ankle fracture requiring non-operative manipulation reduction</td>
<td>Conscious sedation vs. intraarticular block (12mL lidocaine) for reduction maneuver, application of splint.</td>
<td>Conscious sedation vs. block: 2/21 vs.6/21 required repeat analgesia, p = 0.15. No differences in duration, difficulty of performing procedure; both methods effective in reducing pain from baseline (p &lt;0.001, p&lt;0.0002), no differences between groups.</td>
<td>&quot;Compared with conscious sedation, an intra-articular lidocaine block provides a similar degree of analgesia and sufficient analgesia to achieve successful closed reduction of an ankle fracture-dislocation with minimal medical risks. It is a safe and reasonable alternative to conscious sedation.&quot;</td>
<td>Small sample size. Suggests conscious sedation and hematoma block effective in providing analgesia for ankle fracture reduction.</td>
</tr>
</tbody>
</table>

Evidence for the Management of Malleolar Ankle Fractures
There are 5 moderate-quality RCTs incorporated in this analysis. There are 2 low-quality RCTs in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Bauer</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 111 intra-articular malleolar fractures</td>
<td>Closed reduction with cast immobilization vs. ORIF</td>
<td>Cast vs. ORIF: hospitalization (days): 5.0 (0-19) vs. 9.5 (2-33); Cast</td>
<td>&quot;[T]he initial results indicated a more favorable early course in the patients</td>
<td>After randomization, 10 not treated according to protocol received</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Authors</td>
<td>Design</td>
<td>Sample Size</td>
<td>Treatment 1</td>
<td>Treatment 2</td>
<td>Findings</td>
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</tr>
<tr>
<td>Brink 1996 RCT</td>
<td>5.5</td>
<td>Brink</td>
<td>N = 66</td>
<td>lateral malleolar fractures, stable syndesmosis, Weber types A, B, C</td>
<td>Aircast stirrup, full weight bearing</td>
<td>DonJoy ROM Walker Brace, full weight bearing</td>
<td>At 4 weeks, Air 11/33 (34%) vs. DonJoy 4/33 (13%) able to do unlimited activity. Average time for return to work 6 weeks in both groups. No differences remained at 12 weeks.</td>
</tr>
<tr>
<td>Stuart 1989 RCT</td>
<td>4.0</td>
<td>Stuart</td>
<td>N = 40</td>
<td>lateral malleolar fractures, type II</td>
<td>Below-knee walking plaster and crutches (Group A) vs. pneumatic air stirrup and crutches (Group B)</td>
<td>Air cast group: Comfort at 24 hours better (p &lt;0.05); swelling at 7 days better (p &lt;0.00001). No difference in time to union. Arc of motion better (p &lt;0.0001).</td>
<td>&quot;[B]oth dynamic braces provided good pain relief at 4 weeks, allowed return to work at 6 weeks, and resulted in healing at 12 weeks. The Aircast was found to be easier to use and more comfortable, but the R.O.M-Walker gave greater pain relief, increased range of motion, and earlier return of ambulation.”</td>
</tr>
</tbody>
</table>

"We advocate the use of the Aircast pneumatic air stirrup in the cost-effective management of stable ankle fractures.”
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Participants</th>
<th>Study Design</th>
<th>Data</th>
<th>Analysis</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phillips 1985</td>
<td>RCT</td>
<td>N = 138 closed severe ankle fracture (Grade-4 supination-external rotation or pronation external rotation)</td>
<td>All underwent closed reduction. If satisfactory, closed treatment vs. ORIF. Unsatisfactory closed reduction: trial of reduction under general anesthesia, randomized to ORIF vs. or ASIF technique.</td>
<td>For patients with initial satisfactorily closed reduction, ORIF had better outcomes in ROM. Gait better if a medial malleolar fracture (p &lt;0.05). For closed reduction: no difference between ORIF and ASIF. Better alignment by x-ray after surgery had better clinical outcome in both groups (p &lt;0.01).</td>
<td>Poor compliance with follow-up. No blinding. Measurement scale more weighted by subjective than objective measures. Validity of scoring system unknown. Study suggests for severe ankle fractures, ORIF may be better option, particularly with medial malleolar fractures and in persons older than 55.</td>
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<tr>
<td>Makwana 2001</td>
<td>RCT</td>
<td>N = 47 displaced ankle fractures requiring reduction in patients age 55 and older</td>
<td>Acceptable post-reduction then closed treatment (CT) (below-knee plaster cast, elevation 48 hours, Hospital stay: CT: 2.6 days, ORIF: 6.7 (p = 0.01). Immediate reduction: CT: 57%, ORIF 86% (p = 0.03). Loss of reduction: CT: 8/21 (38%), ORIF: 0/22 (p =</td>
<td>&quot;We recommend treating displaced ankle fractures in patients over the age of 55 years by open reduction and internal fixation.&quot;</td>
<td>No blinding, no mention of co-interventions, follow up ranged from 15-42 months. More smokers in the closed group. Study suggests in age group 55 and older.</td>
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</tbody>
</table>
Evidence for the Management of Tibial Shaft Fractures

There is 1 moderate-quality RCT incorporated in this analysis. There is 1 low-quality RCT in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karladani 2000 RCT</td>
<td>4.5</td>
<td>N = 53 unilateral displaced and closed or Grade 1 open tibial shaft fractures</td>
<td>Intramedullary nail (Group I, n = 27) vs. cast only (Group IIa, n = 12) vs. cast plus additional minimal internal fixation (Group IIb, n = 14).</td>
<td>Mean time to union (mean±SD): Group Ila (25 weeks ±11), Group 2b (26 weeks ±8.3) 95% CI: -4.9-17.6; Group II (a and b) (25 weeks ±9.4) Group I (19 weeks ±8.2) 95% CI: 2.5-12; 6 patients in Group I and 16 in Group II had delayed union, p = 0.005.</td>
<td>“Delayed union, malunion, and restricted range of motion at the ankle joint were common complications when these fractures were treated with a cast. We recommend intramedullary nailing for these fractures.”</td>
<td>Large portion crossed over as 14/26 (53.8%) in cast group required ORIF, making comparison groups nonhomogeneous. Data suggest cast only may not be appropriate for specific fracture types as &gt;50% required ORIF.</td>
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</table>

Evidence for the Management of Tibial Extra-articular Fractures

There are 2 moderate-quality RCTs incorporated into this analysis.
### Study Type

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Im 2005 RCT</td>
<td>6.0</td>
<td>N = 78 distal metaphyseal fractures of tibia undergoing operative treatment</td>
<td>Closed intramedullary nailing (N) vs. ORIF with plates and screws (PS).</td>
<td>Duration of operation: N = 72 minutes, PS = 89 minutes (p = 0.02). Radiological union: N = 18 weeks, PS = 20 weeks (p = 0.89). Infections: N = 1 superficial, PS = 6 superficial, 1 deep (p = 0.03). Average angulation: N = 2.8°, PS = 0.9° (p = 0.01). Ankle dorsiflexion: N = 14°, PS = 7° (p = 0.001). Olerud Molander score: N = 88.5%, PS = 88.2% (p = 0.71).</td>
<td>“[L]ocked intramedullary nails have an advantage in restoration of motion and reduce wound problems, and anatomic plate and screws can restore alignment better than intramedullary nails.”</td>
<td>Suggests benefit of intramedullary nailing in less angulation. No differences in radiological union, and Olerud Molander scores, suggesting both methods similar in functional outcomes. More infections with plates and screws.</td>
</tr>
<tr>
<td>Guo 2010 RCT</td>
<td>5.0</td>
<td>N = 111 distal closed metaphyseal fractures, non-intraarticular</td>
<td>Intramedullary nail (IMN) vs. percutaneous compression plating (LCP).</td>
<td>IMN vs. LCP: Time to union (weeks) 17.7 vs. 17.6, p = 0.05; AOFAS at 1 year, 86. vs. 83.9, p &gt;0.05; Percent wanting hardware removed 84.1% vs. 92.7%, p &gt;0.05; Operative time (minutes) 81.2 vs. 97.9, p &lt;0.001; radiation use (minutes) 21.2 vs. 3.0, p &lt;0.001.</td>
<td>“[B]oth a closed IMN and LCP with MIPO can be used safely to treat OTA type 42-A distal metaphyseal fractures of the tibia. Closed nailing has the advantage of shortened operating and radiation time and ease of removal of hardware.”</td>
<td>Randomization, allocation details sparse, 85/111 completed study. Results suggest no differences in techniques for functional outcomes.</td>
</tr>
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</table>

### Evidence for the Management of Tibial Plafond and Pilon Fractures
There are no quality studies incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

### Evidence for the Treatment of Syndesmotic Injury
There are 3 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Design</th>
<th>N</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Thordarson</td>
<td>2001</td>
<td>RCT</td>
<td>32</td>
<td>Pronation lateral rotation fractures requiring fibular fixation of syndesmosis. PLA (polylactide) syndesmosis screw vs. fibular plate fixation. Stainless steel syndesmosis screw requiring removal of screw on average at 13.4 weeks post-op. All uncomplicated healing of fibular fractures without loss of function. No evidence of displacement or osteolysis or sterile effusion. No wound complications from original surgery. All satisfied with surgery. No difference in subjective complaints, pain, walking tolerance. Average ROM: PLA $10^\circ$. “PLA syndesmotic screw is an attractive [option] to avoid the subsequent morbidity for the removal of the stainless steel screw.” No blinding, average age PLA group 34.7, in stainless steel 24.2. Study suggests both equally effective for syndesmotic stabilization with major benefit of eliminating need for hardware removal.</td>
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</table>
DRAFT – For Public Comment

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<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Groups</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaukonen 2005 RCT</td>
<td>5.0</td>
<td>N = 40 lateral malleolar fracture with disrupted syndesmosis requiring screw placement</td>
<td>Metallic screws (n = 18) vs. syndesmotic (bioabsorbable) polylevolactic acid screw (n = 20).</td>
<td>Mean operative time decreased in metallic screw group by 15 minutes (p = -0.033). No difference in active ROM, return to sport activity, subjective measures.</td>
<td>“[P]LLA screws may be reliably used in the fixation of syndesmotic ruptures without compromises in the incidence of local postoperative complications.” No blinding or co-interventions noted. PLLA screws did not have increased adverse reactions, and had similar clinical outcomes as metallic screw. Study suggests both methods as effective, with advantage of PLA screws not requiring removal.</td>
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Evidence for the Operative Management of Fibular Shaft Fractures

There is 1 moderate-quality RCT incorporated in this analysis.

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<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Groups</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Pritchett 1993 RCT</td>
<td>4.0</td>
<td>N = 50 unstable fibular fractures in elderly patients, supination-eversion Stage IV</td>
<td>Rush rods (n = 25) vs. AO plates (n = 25).</td>
<td>Rush Rod: 88% good or fair functional results. Full weight bearing was possible 6 weeks earlier. AO Plate: 76% had good or fair functional results. 2 deep infections and 2 non-unions resulting in 2 ankle fusions.</td>
<td>“The load sharing nature of the fixation allows early weight bearing, which is beneficial for many patients. Also, patients may return to their preoperative status (and hence, home) more rapidly with lack of details. Intramedullary rod has potential to decrease morbidity with earlier weight bearing on fractured ankle. Reported less morbidity with rod vs. AO plate.</td>
<td></td>
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Evidence for the Repair of Deltoid Ligament with Lateral Ankle Fracture Fixation

There is 1 moderate-quality RCT incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Stromsoe 1995</td>
<td>4.5</td>
<td>N = 50 Weber type-B or C with ruptured deltoid ligament; plaster slab 2-3 days, mobilization allowed on crutches with full weight bearing at or after 6 weeks.</td>
<td>No repair of deltoid ligament with ORIF vs. repair of deltoid ligament with ORIF.</td>
<td>Mean average operation time 75 minutes for suture group vs. 95 for ligament repair group. Mean hospital stay 6 days; absence from work 7 weeks. No difference in symptoms and clinical findings at review. All radiographs showed normal healing.</td>
<td>“[R]uptured deltoid ligament can be left unexplored without any effect either on early mobilisation or on the long-term result.”</td>
<td>Assessor blinded at 17-month follow-up visit. Many details sparse. Difference in age between 2 groups. Study suggests repair of deltoid ligament in Weber type B or C fractures may not change clinical outcome.</td>
</tr>
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</table>

Evidence for the Use of Operative Procedures and Fixators for Ankle Surgery

There are 4 moderate-quality RCTs incorporated into this analysis. There are 8 low-quality RCTs in Appendix 2 (688, 741, 744, 747, 749-752) (Dijkema 93; Kankare 96; Takao 04; Bucholz 94; Ahl 94; Moore 06; Kankare 95; Thordarson 01)

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<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Høiness 2004</td>
<td>7.0</td>
<td>N = 64 closed ankle fractures and unstable syndesmosis; AO fracture type B and/or C</td>
<td>Tricortical fixation with 2 3.5mm screws through 1 cortex of tibia after 2-3 days, 2-5kg weight bearing for 6 weeks. (TC) vs. Quadracortical fixation with 1 4.5mm screw through both tibial cortices. No weight</td>
<td>Olerud-Molander functional scores: TC- 77, QC 66 (p = 0.025) at 3 months, at 1 year (NS). Pain: TC&lt;QC (p = 0.017) at 3 months, at 1 year (NS). Dorsiflexion: No difference; no loss of fixation in any patient; 2 in TC had to have screws removed.</td>
<td>“[T]ricortical screw fixation of a ruptured syndesmosis is adequate and improves early function compared with the traditional transsyndesmotic fixation with bicortical holds in the tibia.”</td>
<td>No blinding, no mention of co-interventions. No return to work or ADLs outside of Olerud Molander score. Suggests tricortical screws for ruptured syndesmosis repair may provide early functional benefit through earlier mobilization by earlier partial weight bearing status. However, no long-term...</td>
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<tr>
<td>Study</td>
<td>Rating</td>
<td>N</td>
<td>Fracture Type and Treatment</td>
<td>Procedure Details</td>
<td>Key Outcomes</td>
<td>Notes</td>
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<tr>
<td>Joukainen 2007 RCT</td>
<td>5.5</td>
<td>N = 62</td>
<td>Displaced ankle fractures needing operative treatment. Weber B or C</td>
<td>Bioabsorbable screws for fixation: SR-PLA70 screws (retains strength for 24 weeks vs. SR-PLLA screws (retains strength for 36 weeks).</td>
<td>Only difference in sick days: SR-PLA70 60, SR-PLLA 65 (p = 0.02). Operating time, at one year: ROM, pain, x-rays, Olerud-Molander score no statistical difference. No difference in return to sports or syndesmotic ossification.</td>
<td>&quot;Both SR-PLA70 and SR-PLLA screw implants exhibited good biocompatibility.&quot;</td>
</tr>
<tr>
<td>Rokkanen 1985 RCT</td>
<td>5.0</td>
<td>N = 44</td>
<td>Displaced ankle fractures</td>
<td>Metallic implants (n = 22) vs. biodegradable implants (n = 22).</td>
<td>Mean operating time 34 minutes in metallic group and 42 minutes in biodegradable group; 1/22 (4.5%) had a non-anatomic reduction. Mean number of sick days equal between groups. No difference in &quot;outcome&quot; measures.</td>
<td>&quot;[T]he biodegradable fixation method is advantageous because the removal procedure associated with metallic implants is avoided.&quot;</td>
</tr>
</tbody>
</table>
| Kaukainen 2005 RCT | 5.0    | N = 40 | Lateral malleolar fractures with disrupted syndesmosis requiring screw placement | Metallic screws (n = 18) vs. syndesmotic (bioabsorbable) polydextran acid screw (n = 20). | Mean operative time was decreased in metallic screw group by 15 minutes (p = 0.033). No difference in active ROM, return to sport activity, subjective measures. | "[P]LLA screws may be reliably used in the fixation of syndesmotic ruptures without compromises in the incidence of local postoperative complications."

**Evidence for the Use of Post-Operative Dressings for Ankle Surgery**
There are no quality studies. There is 1 low-quality RCT in Appendix 2.(753) (Reed 98)
**Evidence for the Use of Immobilization, Early Mobilization, Early Weight-bearing for Ankle Fractures**

There are 13 moderate-quality RCTs (one with two reports) incorporated in this analysis. There are 4 low-quality RCTs (one with two reports) in Appendix 2. *(652, 768-770, 773) (Finsen 89a; Finsen 89b; Ahl 93; Fitzgerald 94; Marsh 06)*

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Dogra 1999</td>
<td>7.0</td>
<td>N = 52 bimalleolar ankle fractures requiring surgery</td>
<td>Early mobilization (EM) started 24 hours post-op: 10 minutes dorsiflexion and plantarflexion 4 times a day for 2 weeks. Then, below-knee plaster cast applied until Week 6 with partial weight-bearing vs. 6 weeks of plaster cast (IM).</td>
<td>At 3 months: average pain and Olerud score not different. ROM Plantar mean loss: EM = 12.31 degrees, IM = 12.69 (p = 0.83). Symmetrical gait: EM = 20/26 (77%); IM = 6/26 (23%) (p = 0.0001).</td>
<td>“We have demonstrated in our study that ankle remobilisation in the first 2 weeks after surgery does not make a difference to the early outcome at 12 weeks.”</td>
<td>Lack of details for co-interventions and compliance with exercises or weight-bearing status. Suggests 2 weeks of early mobilization followed by 4 weeks of immobilization post-op for bimalleolar fractures does not have a large clinical benefit at 12 weeks.</td>
</tr>
<tr>
<td>Honigmann 2007</td>
<td>6.5</td>
<td>N = 45 Weber A or B isolated malleolar fracture post-ORIF</td>
<td>Vacuum stabilized orthosis with full weight bearing after 2 weeks and walking without crutches at 3 weeks if able vs. partial weight bearing of 15kg for 6 weeks.</td>
<td>At discharge and 6 weeks, no difference between groups for ability to partially bear weight. Control group favored for mean difference of plantar flexion of 2.5° (p = 0.05) and inversion of 10° (p = 0.02) after 6 weeks.</td>
<td>“We observed that patients receiving surgical treatment for malleolar fractures of the types Weber A and B experienced no adverse events when being treated with a functional orthosis.”</td>
<td>No blinding/lack of details on compliance with weight-bearing and co-interventions. Early mobilization appears to trend for earlier return to work with a mean of 37 days in orthosis group compared to 53 days in control (p = 0.79).</td>
</tr>
<tr>
<td>Van Laarhoven 1996</td>
<td>6.0</td>
<td>N = 81 ankle fractures AO A, B, and C managed by ORIF</td>
<td>Post-op management with weight bearing in a below-knee walking plaster cast vs. non-weight bearing with crutches.</td>
<td>Walking plaster group had small difference for subjective ankle score and linear analogue score compares to non-weight bearing, p = 0.03 and p =</td>
<td>“Early application of a walking plaster did not result in an increased rate of complications such as wound dehiscence,”</td>
<td>No blinding or discussion of compliance with weight bearing vs. non-weight bearing. No clinical difference at 12 months, thus benefits of</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Fracture Type</td>
<td>Intervention</td>
<td>Outcome Measures</td>
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<tr>
<td>Franke 2008</td>
<td>2008</td>
<td>6.0</td>
<td>Weber B fractures status post ORIF</td>
<td>Dynamic vacuum orthotic applied for 6 weeks post-op to allow movement of 10-0-10° of upper ankle joint movement. Allowed 20kg weight bearing post-op Day 2, full weight bearing post-op Day 15 (O) vs. circular cast with dorsal window cut out to allow dorsal extension of talocrural joint; 6 weeks immobilization (C).</td>
<td>0.02. AO type B and type C had no difference. No difference between groups at 12 months. Superficial wound infection, arthritis, osteitis or secondary dislocation. Early ambulation should not be discounted for fear of complications in ankle fractures AO types A, B and C.</td>
<td></td>
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<tr>
<td>Hedstrom 1994</td>
<td>1994</td>
<td>5.0</td>
<td>Dislocated lateral malleolar fractures &gt;2mm requiring ORIF</td>
<td>Post-op protocol of orthosis with active ankle movement and weight bearing vs. walking cast with no ankle movement.</td>
<td>Linear analogue scale results between groups better for orthosis patients at 3-month follow-up examinations, p = 0.02. “In this prospective randomized study it is not possible to show any clinical advantages by active ankle movements.”</td>
<td></td>
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</table>

No blinding, lack of study details. Baseline difference in classification levels between groups with 5 supination eversion III in cast group and 2 in orthosis group. Suggests no difference in early ankle mobilization compared with cast.

No blinding, no mention of co-interventions or pain medication use. Orthosis does appear to provide benefit for return to work and activities. Wound complication rate similar between two groups.

“...for early return to work. Its application not only reduces the working time required by medical personnel but it is also likely to save on expenditure for treatment, aftercare and rehabilitation.”
<table>
<thead>
<tr>
<th>Study</th>
<th>Level</th>
<th>Study Design</th>
<th>Study Population</th>
<th>Intervention Details</th>
<th>Outcome Details</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vioreanu 2007, 2006</td>
<td>5.0</td>
<td>RCT</td>
<td>N = 66 closed Weber A, B, C post ORIF; posterior splint until suture removed (10-14 days) and non-weight bearing</td>
<td>Early mobilization (EM) at 2 weeks vs. immobilization. Both non-weight bearing until Week 6. Early motion group performed exercises 3 times a day for 10 minutes, active and passive ROM with PT.</td>
<td>Return to work: EM-67 days, LM-95 days. No difference in SF-36 at 6 months; 3 post-op infections in EM. EM had better ROM at 6 weeks (p &lt;0.05). No difference in swelling at 6 weeks. EM had less muscle wasting (p &lt;0.005) at 6 weeks. Early motion is consistently beneficial for all outcomes, including pain relief, range of motion, swelling, and return to work.</td>
<td>No blinding. Data suggest early mobilization is associated with earlier return to work and less muscle wasting.</td>
</tr>
<tr>
<td>Ahl 1989</td>
<td>4.5</td>
<td>RCT</td>
<td>N = 99 dislocated lateral or bimalleolar fracture (lateral and medial malleoli) with verified rupture of anterior tibiofibular ligament</td>
<td>Early weight-bearing group: starting 1st postoperative day. Below-knee cast for 7 weeks vs. late weight bearing group: 4th or 5th post-op week. Below-knee cast for 7 weeks.</td>
<td>No differences at 18-months between 2 groups for healing, arthrosis, roentgenographic stereophotogrammetric analysis. No negative consequences in 14 patients with ruptured deltoid ligament that was not repaired.</td>
<td>Early weight bearing does not result in fracture dislocation. No tendency to redislocation was revealed, supporting the opinion that a repair of the deltoid ligament is unnecessary.</td>
</tr>
<tr>
<td>DiStasio 1994</td>
<td>4.5</td>
<td>RCT</td>
<td>N = 61 active duty military patients with isolated closed ankle fractures</td>
<td>Six weeks of removable orthosis, starting PT 1 week post-op, 6 weeks non-weight bearing vs. 6 weeks short leg cast, starting PT at 6 weeks; 6 weeks non-weight bearing.</td>
<td>At 3 months post-op, short-leg cast group had lower scores compared to removable orthosis (p = 0.001). Difference remained at 6 months (p = 0.0027). No difference in strength at 3 months, no difference in swelling at 3 months, no difference in edema control, early motion, and strengthening.</td>
<td>The use of a removable orthosis for six weeks is advocated, with the patient non-weightbearing and following a formal physical therapy program emphasizing edema control, early motion, and strengthening.</td>
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</table>

Lack of blinding, No mention of co-interventions. Suggests no long-term consequences from early mobilization after surgical fixation. Also suggests no consequence of not repairing deltoid ligament although sample only included 14 with ruptured ligament.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>RCT</th>
<th>Patient Characteristics</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahl 1986</td>
<td>4.5</td>
<td>N = 46</td>
<td>dislocated fractures of fibula with pre-op verified ruptures of anterior tibiofibular ligament</td>
<td>Early weight bearing from 1st post-op day (n = 24) vs. late weight bearing from 4th post-op week (n = 22). Both groups had below-knee cast for 7 weeks. All fractures healed “properly.” No infections. No significant difference in swelling, circumference of ankle or calf, or range of motion at 3 or 6 months.</td>
<td>“[W]ith the use of this operative technique, using a minimum amount of osteosynthesis devices, an exact reconstruction of the ankle mortise can, as a rule, be achieved with sufficient stability to allow immediate postoperative weight bearing in a walking cast.”</td>
<td>Lack of details. No functional outcomes measured to see if early mobilization affected ADLs or return to work. Early weight bearing in stable lateral malleolus fractures without demonstrable adverse events.</td>
</tr>
<tr>
<td>Lehtonen 2003</td>
<td>4.5</td>
<td>N = 100</td>
<td>unstable and/or displaced Weber Type A or B with ORIF and casting for 6 weeks, non-weight bearing for 2 weeks, then partial weight bearing to 4 weeks, then full weight bearing at 6 weeks</td>
<td>Early mobilization in Aircast. Daily ROM exercises immediately post-operatively vs. immobilization group in below-knee cast for 2 weeks. Then in weight-bearing fiberglass cast until 6 weeks. All fractures healed well. No difference in ankle swelling, atrophy of calf muscles, laxity of ankle joint, active ROM (NS). Overall complications rates between the cast group (16%) and the brace group (66%) was significant (p = 0.0005) with the majority of the increased complications in the brace group being wound infections.</td>
<td>“In conclusion, the results of this study show that the postoperative treatment of ankle fractures can be accomplished equally effectively both with use of a plaster cast and with a functional brace. The risk of postoperative wound complications associated with this treatment approach is considerably increased compared with that after</td>
<td>No blinding, no mention of co-interventions or compliance with program. Mobilization began immediately post-op which may have contributed to increased wound complication rate seen in study.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Fracture Type</td>
<td>Treatment</td>
<td>Outcome</td>
<td>Conclusion</td>
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<tr>
<td>Egol 2000 RCT</td>
<td>4.0</td>
<td>60</td>
<td>Unstable fractures requiring ORIF; Weber B fractures</td>
<td>Function removable brace with early movement (active and passive exercises of ankle and subtalar joint by PT then at home 3x/day) vs. immobilization postoperatively in below the knee cast. PT after 6 weeks.</td>
<td>All fractures clinically united at 6 weeks and radiographically united at 12 weeks. Early mobilization group had higher functional scores (0-100) at all follow up visits but only significant at 6 weeks 55.5 vs. 52.4 (p = 0.03). Return to work: Early mobilization mean days 53.8, immobilization 106.5 (p = 0.007).</td>
<td>“We recommend the use of functional bracing and early exercises after operative treatment of fractures of the ankle.”</td>
</tr>
<tr>
<td>Sondenaa 1986 RCT</td>
<td>4.0</td>
<td>43</td>
<td>Ankle fractures requiring surgery</td>
<td>Primary mobilization group: plaster cast for 3 days. Full weight-bearing at 6 weeks vs. Immobilization group: plaster cast for 6 week with no weight bearing.</td>
<td>At 6 weeks, ROM greater in primary mobilization group (p &lt;0.01). Swelling decreased in mobilization at 12 weeks (p &lt;0.05). Pain less in mobilization group at 6, 12, 18 weeks follow-up; equal 1 year follow-up.</td>
<td>“Plaster immobilization after ankle fracture results in a minor increase in morbidity. If the patient is cooperative and fixation of the fracture stable, an early mobilization (1 week) is preferable.”</td>
</tr>
<tr>
<td>Tropp 1995 RCT</td>
<td>4.0</td>
<td>30</td>
<td>Weber B or C ankle fractures requiring ORIF</td>
<td>Double-hinged brace (received program for self training or mobility, muscular strength, and function immediately post-op) vs. plaster cast (post-op for 6</td>
<td>At 6 weeks 6/15 (40%) in brace group vs. 1/15 (7%) in cast group showed failure of syndesmotic staples. No correlation in displacement or fracture healing. No difference in ankle scores or ROM</td>
<td>“We conclude that the double-hinged brace is appreciated by the bearer. Higher ROM was noted in the brace group, but the obvious advantage of the brace is...”</td>
</tr>
</tbody>
</table>
weeks, full weight bearing allowed with crutches for 2-4 weeks, then same self-training program at 6 weeks.

improvement compared to uninjured ankle at 12 months. No difference Olerud function scores. ROM: dorsiflexion better in brace group at 1 year (p <.05), no correlation with functional outcomes at 12 months.

subjective to the bearer. There is a higher expense for the brace than for the plaster cast. Long-term results of brace and case treatment are comparable."

<table>
<thead>
<tr>
<th>Author/Year</th>
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</thead>
<tbody>
<tr>
<td>Thordarson 1997</td>
<td>6.0</td>
<td>N = 30 Weber B and C ankle fractures</td>
<td>Pneumatic pedal compression device pre-operatively vs. posterior splint, ice, elevation before surgery.</td>
<td>Compression group: change in volume Day 1-2: -88ml (p = 0.027), Day 1-3: -31ml (p = 0.049). Control group: change in volume Day 1-2: +33ml, Day 1-3: +32ml.</td>
<td>“Pneumatic pedal compression device resulted in a significant decrease in preoperative edema following ankle fractures compared with a control group.”</td>
<td>No baseline characteristics provided. No blinding. Suggests compression device is effective in reducing preoperative edema in ankle fracture patients.</td>
</tr>
<tr>
<td>Caschman 2004</td>
<td>5.5</td>
<td>N = 64 closed unilateral fractures unable to be operated on immediately secondary to edema but in need of surgery</td>
<td>Pneumatic compression in cast device (AVI) (n = 27) vs. elevation (control) pre-op (n = 27). Compression continuous until time of surgery and without elevation.</td>
<td>AVI vs. Elevation: mean final pre-op swelling (mm±SD): control (24.0± 16.6) vs. AVI (13.1±13.2), p = 0.030. A-V bladder: 3/27 (11%) had soft-tissue complications. 2/27 (7%) had blisters. Limb elevation: 12/27 (44%) had soft-tissue complications; 7/27 (26%) skin blisters, 2/27</td>
<td>“[T]he A-V impulse in-cast system is of value in reducing preoperative swelling following ankle fracture, and this is associated with a reduction in delay of surgery and overall morbidity.”</td>
<td>Suggests pneumatic compression superior to elevation alone for reducing edema pre-operatively and complications associated with fracture blister.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Pneumatic Compression for Edema Management

There are 3 moderate-quality RCTs incorporated into this analysis.
Evidence for the Use of Interferential Current Therapy for Post-operative Edema Management
There is 1 high-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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</thead>
<tbody>
<tr>
<td>Christie 1990 RCT</td>
<td>8.0</td>
<td>N = 24</td>
<td>Interferential therapy (electrotherapy) 20 minutes a day before casting and after surgery (2-4 days) vs. placebo.</td>
<td>Foot/ankle volumetric changes: no difference (p &gt;0.05), no trend seen.</td>
<td>“The results of this double-blind study do not support the use of interferential therapy in the treatment of oedema.”</td>
<td>Interferential therapy does not appear effective.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Electrical Stimulation for Ankle and Foot Fractures
There are no quality studies incorporated into this analysis. There is 1 low quality RCT in Appendix 2.

Evidence for the Use of Therapy for Ankle Fractures
There are 2 high-quality and 1 moderate-quality RCTs incorporated with this analysis. There is 1 low-quality RCT in Appendix 2.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Moseley 2005</td>
<td>RCT</td>
<td>8.5</td>
<td>N = 150 plantarflexion contracture patients after ankle cast immobilization for fracture</td>
<td>Exercises plus short-duration passive stretch: 6 minutes a day broken into 12, 30-second stretches vs. exercises plus long-duration stretch: 30 minutes a day vs. exercises; 4 week home-based program. Up to 5 PT visits after cast removal. Included exercises for mobility, strengthening, stepping, weight bearing, balancing.</td>
<td>No difference in main outcomes measures of passive dorsiflexion with knee bent and straight or Lower extremity functional scale. At 4 weeks, long-duration group felt more ready to return to sports and leisure activities (p = 0.03) but not at 3 months.</td>
<td>“The addition of a program of passive stretches confers no benefit over exercise alone for the treatment of plantarflexion contracture after cast immobilization for ankle fracture.”</td>
<td>Exercise program details sparse. No benefit found from passive stretching of either duration in addition to a 4 week exercise program for plantarflexion contractures after casting. Suggests treatment emphasis should be on exercise compliance not stretching.</td>
</tr>
<tr>
<td>Lin 2008</td>
<td>RCT</td>
<td>8.0</td>
<td>N = 94 isolated ankle fractures: able to weight bear or partial-weight bear and referred to PT with some residual pain</td>
<td>PT and manual therapy with anterior-posterior joint mobilization over talus. Seen twice a week for 4 weeks for MT, maybe longer for PT vs. PT; twice a week for 1st week, then once a week for at least 4 more weeks.</td>
<td>No significant difference in primary outcomes of activity modifications or quality of life between groups. Control group had increase return to sports and activities over MT at 12 weeks. Fracture severity did not influence outcomes. Experimental group incurred an increase cost on average of $200.00AU more.</td>
<td>“When provided in addition to a physiotherapy programme, manual therapy did not enhance outcome in adults after ankle fracture.”</td>
<td>No blinding of participant or therapist, but assessor was blinded. No mention of co-interventions. Manual therapy added costs but not any other benefits over PT in patients after ankle fractures with or without surgical fixation.</td>
</tr>
<tr>
<td>Nilsson 2009</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 110 post-op ankle</td>
<td>Supervised PT 12-week program vs. usual care</td>
<td>Training vs. control; average PT visits: 17 vs. 7 (p &lt;0.001).</td>
<td>“The training model used in this study showed Co-interventions allowed (usual care). Compliance with</td>
<td></td>
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</table>
Evidence for the Use of Ultrasound Stimulation for Ankle and Foot Fractures

There is 1 high-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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<th>Comparison Group</th>
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<th>Conclusion</th>
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<tbody>
<tr>
<td>Handolin 2005 RCT</td>
<td>9.0</td>
<td>N = 16 dislocated lateral malleolar fractures fixed with 1 bioabsorbable poly-L-lactide screw</td>
<td>Ultrasound machine daily for 20 minutes applied by patient at home vs. sham ultrasound daily for 20 minutes applied by patient at home.</td>
<td>All fractures fully healed. No foreign body reactions documented. No difference in Olerud-Molander scores.</td>
<td>“In conclusion, the six-week low-intensity ultrasound therapy had no effect on radiological bone morphology, bone mineral density or clinical outcome in bioabsorbable screw-fixed lateral malleolar fractures 10 months after the injury.”</td>
<td>Small numbers. No mention of specific co-interventions. Sparse baseline characteristics presented. Suggests ultrasound of no benefit for fracture healing.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Hyperbaric Oxygen for Ankle and Foot Fractures

There are no quality studies incorporated into this analysis.

Evidence for the Use of Hypnosis for Ankle and Foot Fractures

There is 1 moderate-quality RCT incorporated into this analysis.
Evidence for the Use of X-ray for Hindfoot Fractures
There is 1 high- and 1 moderate-quality study incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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</table>
| Knight 2006 Diagnostic Comparison Study | 8.0 | N = 133 calcaneal fractures (CT diagnosis, x-ray comparisons) vs. case controls | CT-verified calcaneal fractures, then standard mediolateral foot and ankle projections used on the lateral foot or ankle radiographs vs. Negative lateral x-rays for evidence of Emergency physicians 97.9% accurate in diagnosing calcaneus fractures based on reviewing plain films without assistance from angles (97%-99%). K value when measured against gold standard was 0.96 (0.94-0.98). Radiologist had sensitivity of 98.5% and specificity of 100%. Bohler’s BA is somewhat helpful and the CAG is not useful in diagnosing calcareous fractures in the ED. | Trial randomized order of x-ray reading (case vs. control) by MD. Lateral x-rays appear to have acceptable specificity and sensitivity for diagnosing calcaneal fractures in acute trauma patients compared with CT. Use of angles did not add significant
calcaneal fractures. angle had intraclass correlation of 0.84 (0.79-0.87). CAG intraclass correlation 0.52 (0.43-0.60).

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<tbody>
<tr>
<td>Ebraheim 1996 Diagnostic Comparison Study</td>
<td>7.0</td>
<td>N = 35 lateral x-rays, coronal CT scans and intra-operative findings in calcaneal fractures</td>
<td>All patients had lateral x-rays, coronal CT, and surgery.</td>
<td>Good correlation between lateral x-rays and coronal CT images in 26/35 patients. In the other 9 there was evidence of articular depression and incongruity in lateral x-ray but not CT.</td>
<td>“The present study emphasizes that coronal CT images often fail to accurately reveal the articular depression and severity of rotational displacement of calcaneal fracture fragments.”</td>
<td>Imaging findings verified intra-operatively on all 35 patients. Study suggests coronal CT may underestimate severity of posterior talocalcaneal fractures.</td>
</tr>
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</table>

**Evidence for the Use of MRI for Hindfoot Fractures**

There is 1 moderate-quality study incorporated in this analysis.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
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</thead>
<tbody>
<tr>
<td>Zeiss 1991 Diagnostic Comparison Study</td>
<td>5.5</td>
<td>N = 29 cadavers, calcaneal fracture patients, and healthy volunteers</td>
<td>Use of MRI for indentifying both bone and soft tissue injury in calcaneal fracture.</td>
<td>Difficult to interpret MRI scans in fracture patients up to 4 months after injury. After 2 years with continued symptoms MRI useful in identifying possible problems in both bone and soft tissue.</td>
<td>“The usefulness of MRI evaluation of calcaneal fractures in acute and subacute evaluation will most likely be very limited to occasions where CT does not clearly define tendon displacement or when avascular necrosis or osteomyelitis is a concern. It could be more helpful in evaluation of persistent pain complicating healed fractures.”</td>
<td>Data suggest MRI not helpful in acute or subacute calcaneal fracture or soft tissue injury evaluation. Can be helpful in chronic pain patient in identifying possible pain generating issues.</td>
</tr>
</tbody>
</table>
**Evidence for the Use of Bone Scanning for Hindfoot Fractures**
There are no quality studies incorporated into this analysis.

**Evidence for the Use of CT for Hindfoot Fractures**
There is 1 moderate-quality study incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ebraheim 1996</td>
<td>Diagnostic Comparison Study</td>
<td>7.0</td>
<td>N = 35 calcaneal fractures (lateral x-rays, coronal CT scans and intraoperative findings)</td>
<td>All had lateral x-rays, coronal CT, and surgery.</td>
<td>Good correlation between lateral x-rays and coronal CT images in 26/35 patients. In other 9, evidence of articular depression and incongruity in lateral x-ray, but not CT.</td>
<td>“The present study emphasizes that coronal CT images often fail to accurately reveal the articular depression and severity of rotational displacement of calcaneal fracture fragments.”</td>
<td>Imaging findings verified intra-operatively on all 35 patients. Study suggests coronal CT may underestimate severity of posterior talocalcaneal fractures.</td>
</tr>
</tbody>
</table>

**Evidence for the Management of Talar Fractures**
There are no quality studies incorporated into this analysis.

**Evidence for the Use of Operative Management for Osteochondral Lesions**
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
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</thead>
<tbody>
<tr>
<td>Gobbi 2006</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 32 osteochondral lesions of talus: Ferkel class 2b, 3 or 4</td>
<td>Chondroplasty (CP) vs. microfracture (MF) vs. osteochondral autograft transplantation (OAT).</td>
<td>No difference in Ankle-Hindfoot scale at 6 or 12 months. No difference in SANE scores at final follow-up. Pain less for CP group compared to MF and OAT at 24 hours post-op (p &lt;0.001).</td>
<td>“On the basis of AHS and SANE ratings, no differences can be seen between chondroplasty, micro fracture, or OAT for patients with osteochondral lesions of the talus.”</td>
<td>No blinding or mention of co-interventions or compliance with aftercare. No significant differences at 6 or 12 month follow-up between 3 groups. All 3 methods appear effective therapeutic options with similar outcomes. However, chondroplasty shown ineffective in knee.</td>
</tr>
</tbody>
</table>

**Evidence for the Management of Calcaneal Fractures**
There are 4 moderate-quality RCTs incorporated in this analysis. There are 2 low-quality RCTs in Appendix 2 (668, 805) (Parmar 93; Ibrahim 07)

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<tbody>
<tr>
<td>Buckley 2002 RCT</td>
<td>5.5</td>
<td>N = 424 displaced intra-articular calcaneal fractures</td>
<td>Non-operative treatment involved no attempt at closed reduction, treated with ice, elevation, and rest vs. ORIF.</td>
<td>Outcomes after non-operative treatment not different for those after operative treatment. SF-36 score was non-op: 64.7 vs. ORIF: 68.7 (p = 0.13). VAS score: non-op:64.3, ORIF 68.6 (p = 0.12). Patients not in workers’ comp and managed operatively had significantly higher satisfaction scores (p = 0.001).</td>
<td>“Without stratification of groups, the functional results after nonoperative care of displaced intra-articular calcaneal fractures were equivalent to those after operative care. However, careful stratification of the patient population and clinical outcome information distinguishes certain features that support surgical care for displaced intra-articular calcaneal fractures. Statistical analysis demonstrated that women, patients who were not receiving workers’ compensation, younger males, patients with a higher Böhler angle, patients with a lighter workload, and those with a single, simple displaced intra-articular calcaneal fracture were more likely to have better outcomes. Data suggest no difference in general population between treatments, but ORIF may be superior to non-operative management in specific populations.</td>
<td>No blinding noted. Operative management trended towards better outcomes in subsets of study. Post-hoc analyses suggests good anatomic reduction provides a positive effect on outcomes. Data suggest no difference in general population between treatments, but ORIF may be superior to non-operative management in specific populations.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
<td>Description</td>
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<tr>
<td>Howard 2003</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 424</td>
<td>Displaced intra-articular calcaneal fractures with disruption of posterior facet &gt;2mm. Non-operative treatment (NOP). Pain management, RICE, non-weight bearing. PT and full weight bearing at 6 weeks vs. ORIF, lateral approach. Full weight bearing and PT at 6 weeks. ORIF had more clinical complications than NOP. NOP 42.218 (19%) had complications that led to surgery; 2/218 (0.01%) had late compartment syndrome. 37/218 (16%) had secondary late fusion. 1/218 developed CRPS. ORIF: 11/206 (0.5%) deep wound infections. 2/206 developed PE. 4/206 had compartment syndrome. “Outcome scores in this study tend to support ORIF for calcaneal fractures. ORIF patients are more likely to develop complications, however. Certain patient populations have a high incidence of complications regardless of the management strategy chosen (WCB patients, Sanders type IV patients).”</td>
<td></td>
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<tr>
<td>O’Brien 2004</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 319</td>
<td>Patients with 351 displaced intra-articular calcaneal fractures. Non-operative management vs. ORIF measuring gait satisfaction scores at 2-8 years. No difference in SF-36 scores between groups at 2 to 8 years follow-up (p = 0.22). Age &lt;30 with ORIF = improvement in gait scores compared to non-op (p = 0.02). Quality of fracture reduction no different between groups. Bohler angle in non-op group of &gt;15° compared to &lt;0° had better “[P]ersonal gait satisfaction scores were not significantly affected by treatment method in patients with DIACF at 2-8 years follow up. However, gait scores were better in patients treated with ORIF if they were younger than 30 years of age, had no worker’s comp claims, had jobs requiring a</td>
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Second report of Buckley 2002. No blinding, large drop out rate, no mention of co-interventions. Suggests non-operative management of displaced intra-articular calcaneal fractures with disruption of posterior facet >2mm has fewer complications than ORIF. Third report of same population (see Buckley 2002). Post-hoc analyses suggests restoration of Bohler angle is predictive of function. Data also suggests those with workers’ comp claims have worse outcomes regardless of treatment.
Evidence for the Management of Edema Associated with Calcaneal Fractures

There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Thordarson 1999 RCT</td>
<td>6.0</td>
<td>N = 28 closed displaced intra-articular calcaneal fractures</td>
<td>Intermittent pedal compression device, posterior splint, and leg elevation. Started 24 hours after injury. Compression 3 x cycles/minutes full time until surgery vs. compression dressing, posterior splint, and elevation.</td>
<td>All patients tolerated foot pump without need of ankle nerve block. Volumetric measurements: Day 1-2: Pump = -40mm, control = +76mm (p = 0.02); Day 1-3: pump = -96mm, control = +37mm (p = 0.02).</td>
<td>“In summary, we found that using a foot pump prior to surgery resulted in a significant decrease in preoperative edema in patients after an intraarticular calcaneal fracture in comparison with those in the control group.”</td>
<td>No blinding or mention of baseline characteristics. Pedal pump appears beneficial in reducing post injury pre-op swelling in displaced intra-articular calcaneal fractures.</td>
</tr>
</tbody>
</table>
**Evidence for the Use of Diathermy for Edema Control**
There are no quality studies incorporated into this analysis.

**Evidence for the Use of Bone Graft and Fillers for Calcaneal Fracture Defect**
There are no quality studies incorporated into this analysis. There are 2 low-quality trials in Appendix 2. (803, 822) (Johal 09; Dickson 02)

**Evidence for the Use of X-ray for Suspected Tarsal, Metatarsal, or Phalangeal Fractures**
There are no quality trials incorporated in this analysis.

**Evidence for the Use of MRI for Suspected Tarsal Metatarsal and Phalangeal Fractures**
There are no quality studies incorporated into this analysis.

**Evidence for the Use of Bone Scan for Suspected Tarsal, Metatarsal, or Phalangeal Fractures**
There are no quality studies incorporated into this analysis.

**Evidence for the Use of CT for Suspected Tarsal Metatarsal and Phalangeal Fractures**
There are no quality studies incorporated into this analysis.

**Evidence for the Management of Lisfranc Injuries**
There is 1 moderate-quality RCT incorporated into this analysis.

<table>
<thead>
<tr>
<th>Author/Year</th>
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<tbody>
<tr>
<td>Henning 2009</td>
<td>5.0</td>
<td>N = 40</td>
<td>Primary arthrodesis (PA) vs. ORIF</td>
<td>Study discontinued after 40 patients (planned for 60) secondary to hardware removal rates and secondary surgery (79 vs. 17%) favoring arthrodesis. No differences in functional outcomes, clinical assessments or patient satisfaction.</td>
<td>“PA resulted in a statistically significant decrease in the number of follow up surgeries compared to [primary] ORIF if hardware removal is routinely performed. If performed properly, patients are satisfied with either technique.”</td>
<td>Small sample size. Baseline differences suggest potential randomization failure. Loss to follow-up 20%.</td>
</tr>
</tbody>
</table>

**Evidence for the Management of Metatarsal Fractures**
There are no quality studies incorporated into this analysis.
Evidence for the Management of Proximal Fifth Metatarsal Injuries
There is 1 moderate-quality RCT incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.(826) (Wiener 97)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Mologne 2005 RCT</td>
<td>6.0</td>
<td>N = 37 acute Jones fractures</td>
<td>Cast immobilization vs. intramedullary screw fixation. Non-weight bearing cast 8 weeks, followed by walking cast or hard shoe until union. Post-op non-weight bearing with bulky Jones splint for 2 weeks.</td>
<td>8 of 18 (44%) in cast group had treatment failures vs. 1/19 (5.3%). Mean time to clinical union 7.5 weeks (surgery) vs. 14.5 weeks (cast), p &lt;0.001. Mean time to running and jumping sports (weeks) 8.0 vs. 15.0 (cast), p &lt;0.001</td>
<td>“Early surgical treatment results in a shorter time to clinical union and allows patients to return to sports and activities of daily living faster than with cast treatment.”</td>
<td>Lack of details for allocation, blinding. No loss to follow-up. Suggests surgical fixation of acute Jones fracture provides fewer treatment failures and quicker time to healing and functional recovery.</td>
</tr>
</tbody>
</table>

Evidence for the Management of Phalangeal Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Management of Stress Fractures
There are no quality studies incorporated into this analysis.

Evidence for the Use of Glucocorticosteroid Injections for Ankle Tendinoses
There are no quality studies evaluating the use of glucocorticosteroid injections for ankle tendinosis.

Evidence for Surgical Release
There are no quality studies incorporated into this analysis.

Evidence for the Use of MRI for Plantar Fasciitis
There are no quality studies incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.(191) (Maier 00)

Evidence for the Use of NSAIDs and Acetaminophen for Plantar Fasciitis
There are no quality trials incorporated into this analysis. There are 2 low-quality RCTs in Appendix 2.(36, 201) (Donley 07; Bourne 80)

Evidence for the Use of Benzydamine for Ankle Sprain
There are no quality trials incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.(469) (Elswood 85)

Evidence for the Use of Arthroscopy Evaluation during Distal Tibia Fracture Fixation ORIF
There are no quality RCTs incorporated into this analysis. There are 2 low-quality RCTs in Appendix 2. (737, 744) (Takao 04; Thordarson 01)

*Evidence for the Use of Phonophoresis for Plantar Heel Pain*
There are no quality trials incorporated into this analysis.

*Evidence for the Use of Hyperosmolar Dextrose for Plantar Fasciitis*
There are no quality trials evaluating the use of hyperosmolar dextrose injections for plantar fasciitis.

*Evidence for the Use of Radiofrequency Microtenotomy for Plantar Fasciitis*
There are no quality trials incorporated into this analysis.

*Evidence for the Use of the Foot Waffle Support Brace*
There is 1 low-quality RCT in Appendix 2. (Tymec 97)

*Evidence for the Use of Taping*
There is 1 low-quality RCT in Appendix 2. (Vicenzino 00)

*Evidence for the Use of Cryotherapy and Heat for Plantar Heel Pain*
There are no quality trials incorporated in this analysis.

*Evidence for the use of Topical Nerve Growth Factors*
There is 1 low-quality RCT in Appendix 2. (Landi 03)
Appendix D.4 - Low-Quality Randomized Controlled Trials and Non-randomized Studies

The following low-quality randomized controlled studies (RCTs) and other non-randomized studies were reviewed by the Evidence-based Practice Ankle and Foot Panel to be all inclusive, but were not relied upon for purpose of developing this document's guidance on treatments because they were not of high quality due to one or more errors (e.g., lack of defined methodology, incomplete database searches, selective use of the studies and inadequate or incorrect interpretation of the studies’ results, etc.), which may render the conclusions invalid. ACOEM’s Methodology requires that only moderate- to high-quality literature be used in making recommendations.(835) (Harris JOEM 08)

**FOOT ULCERATIONS**

<table>
<thead>
<tr>
<th>Author/Year/Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donohoe 2000 RCT</td>
<td>3.5</td>
<td>N = 1939 with diabetes. Age range 18.7 -95.8 years in intervention group and 18.0 -93.6 years in the control group.</td>
<td>Intervention group: explanatory practice visits and foot care education (n = 981) vs. Control group (n = 958). Follow-up for 6 months.</td>
<td>There was a significantly greater change of attitude about foot care in intervention group (p = 0.01). Intervention group had better attitudes towards personal foot care by 2.5% vs. 0.2% decrease in control group (p = 0.027). Small improvement in knowledge score within intervention group with mean percentage change of 1.1 (p = 0.015) and 1.3 in</td>
<td>“Provision of integrated care arrangements for the diabetic foot has a positive impact on primary care staffs’ knowledge and patients' attitudes resulting in an increased number of appropriate referrals to acute specialist services.”</td>
<td>Pragmatic RCT. Health care professionals. Knowledge of diabetic footcare improved in intervention group (p &lt;0.001).</td>
</tr>
</tbody>
</table>
### Wound Dressings

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Participants</th>
<th>Outcome</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veves 2002 RCT Sponsored by Johnson &amp; Johnson Wound Management</td>
<td>3.5</td>
<td>N = 276 diabetics with a foot ulcer &gt;30 days, rating grade 1 to 2 on Wagner scale and area ≥1cm; Mean age 58.3 years for both groups.</td>
<td>Promogran Group (n = 138) vs. Moistened gauze control Group (n = 138). Assessments at baseline and 12 weeks.</td>
<td>No significant results of improvement reported for Promogran group versus moistened gauze control group. “We have shown that Promogran, a wound dressing consisting of collagen and oxidized regenerated cellulose, was as effective as moistened gauze in promoting wound healing in diabetic foot ulcers,…”</td>
</tr>
<tr>
<td>Jacobs 2008 RCT</td>
<td>3.0</td>
<td>N = 40 diabetic patients with Wagner grade 1 or 2 ulcers. Mean age was not provided.</td>
<td>Bensal HP group- Benzoic Acid 6%, Salicylic acid 3% and extract from Q rubra, 3%. Application daily every 12 hours (n=20) vs. SSC Group- Silver Sulfadiazine cream. Application every 12 hours daily (n=20). Follow-up for 6 weeks.</td>
<td>At 6 week follow-up wound diameter decreased in both groups; difference approached significance for Bensal HP vs. SSC group; 72.5% reduction vs. 54.7% (p = 0.059). Reductions significant in both groups compared to baseline (p = 0.016). Effect size of Bensal HP was 2.06 vs. 1.03 in SSC group. “In this tightly controlled and random study, Bensal HP not only served as an adequate adjunct to generally accepted wound care, but also convincingly outperformed SSC used in the control.”</td>
</tr>
<tr>
<td>Shukrimi 2008 RCT</td>
<td>1.5</td>
<td>N = 30 with Wagner’s grade-II diabetic foot ulcers.</td>
<td>Honey dressing group (pH of 6.5, glucose 321mmol/l and specific gravity Mean healing time in standard dressing group vs. Honey group:</td>
<td>“Honey dressing is a safe alternative dressing for Wagner Sparse methodological and sample size. Data suggest mostly comparable results. Sparse methodology. Blinding only mentioned without details. Sparse baseline comparability details.”</td>
</tr>
<tr>
<td>Study Details</td>
<td>N or Age Range</td>
<td>Treatment Details</td>
<td>Healing Details</td>
<td>Key Findings</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td>Mars 2008 RCT</td>
<td>3.0</td>
<td>N = 60 with non-ischemic diabetic foot ulcers, type 1 or 2 diabetes mellitus; Mean (±SD) age 51.5 (±7.6) for treatment group and 55.3 (±9.0) for control group</td>
<td>Compressed air massage group receiving 15-20 minutes of treatment (1 bar; 100kPa pressure) daily 5x a week until healed or administered skin graft (n = 30) vs. Control group (n = 30). Both groups received standard wound care for their ulcers.</td>
<td>Mean (±SD) time of ulcer healing in days significantly greater in air massage group versus control group: Air massage – 58.1 (±22.3) vs. control – 82.7 (±30.7), (p = 0.001). No significant results reported between groups for Wagner grade and ulcer size, Wagner size and time to healing and ulcer size and time to healing. “Compressed air therapy can be viewed as a variant of pneumatic compression. It appears to be a safe and simple treatment modality, which, when added to standard medical and surgical management of infected diabetic ulcers, enhances ulcer healing. Further studies with this treatment modality are warranted.”</td>
</tr>
<tr>
<td>Tymec 1997 RCT</td>
<td>1.5</td>
<td>N=52 patients within age range 27 to 90 years (M=66.6, SD=16.5) Pillow positioned under both legs from below knee to Achilles tendon region, leaving heels suspended above (Pillow group) vs. Foot waffle placed on each leg (Foot waffle group)</td>
<td>Both groups Odds Ratio of 4.38 with interface pressure &gt;0mm Hg 4 times often with foot waffle than pillow. Significant difference between groups in skin changes (p = 0.036).</td>
<td>“The results of this study did not support the use of the previously designed foot waffle for continuous heel elevation.”</td>
</tr>
</tbody>
</table>

**Negative Pressure Therapy (Vacuum) Wound Care Systems**

**Foot Waffle Support Brace**
<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Design</th>
<th>N</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steed 1995</td>
<td>RCT</td>
<td>3.0</td>
<td>Patient’s position order: supine then right lateral tilt or right lateral tilt then supine. Difference between groups in mean length of survival; pillow group vs. foot waffle (13 vs. 10 days).</td>
</tr>
<tr>
<td>Landi 2003</td>
<td>RCT</td>
<td>3.0</td>
<td>Topical nerve growth factor (NGF) may be an effective therapy for patients with severe pressure ulcers.</td>
</tr>
</tbody>
</table>

**Growth Factors**

**Becaplermin**

<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Design</th>
<th>N</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steed 1995</td>
<td>RCT</td>
<td>3.0</td>
<td>N = 118 with chronic, full-thickness, lower-extremity diabetic neurotrophic ulcers of at least 8 weeks; Mean Age was 60.8 years. PDGF group-rhPDGF-BB (Becaplermin) gel applied at dose equivalent to 2.2 micrograms until completely healed, or 20 weeks (n = 61) vs. Placebo Gel Group-Saline Gel (n = 57). Follow-up for 20 weeks. At 20 weeks, 29 (48%) of patients treated with PDGF showed complete wound healing (functional assessment score of 1) compared with 14 (25%) of placebo group (p = 0.01). From day 68 to end of trial a difference of 30-40 days in time to complete wound healing observed in favor of PDGF group (p = 0.01). “…demonstrated that repeated, once-daily, topical application of rhPDGF-BB is safe and stimulates rapid healing of chronic, full-thickness neurotrophic ulcers of the lower extremity in patients with diabetes mellitus. Sparse study design details. Wound healing in experimental group was 2x vs. placebo.</td>
</tr>
</tbody>
</table>

**Topical nerve growth factor (TNGF)**

<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Design</th>
<th>N</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landi 2003</td>
<td>RCT</td>
<td>3.0</td>
<td>N = 38 patients with pressure ulcers on foot. Mean age of participants was 80.3 years. 2.5 S murine nerve growth factor used (topical nerve growth factor treatment, n=18) vs. (topical conventional treatment, n = Mean area (±SD) of ulcers between groups after 6 weeks treatment; treatment group vs. controls. “Topical application of nerve growth factor may be an effective therapy for patients with severe pressure ulcers.” 1 patient from treatment group died and another from control group lost to follow-up. Topical treatment with NGF appears effective for...</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Sample Size</td>
<td>Description</td>
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<tr>
<td>Huang 2014 RCT</td>
<td>2.5</td>
<td>N = 60 with refractory chronic skin ulcers, which persisted for &gt;1 month. Aged between 20 and 75 years with an average age of 50.6.</td>
<td>Group A or rhGM-CSF paste covered by alginate dressing (n = 20) vs Group B or rhGM-CSF only, applied to wounds (n = 20) vs Group C or Conventional vaseline dressing gauze applied (n = 20). Follow-up for 6 weeks.</td>
</tr>
<tr>
<td>Akbari 2007 RCT</td>
<td>3.0</td>
<td>N = 18 patients with diabetic foot ulcers corresponding to grade 2 of University of Texas Diabetic Foot Wound Classification system.</td>
<td>Experimental group (n = 9) received Vacuum-Compression Therapy (VCT) and conventional therapy vs. Control group (n = 9) received After 10 VCT sessions or conventional therapy sessions, surface area of foot ulcer diminished. Experimental showed a larger improvements.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
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<tr>
<td>Eginton</td>
<td>2003</td>
<td>RCT, prospective</td>
<td>10</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Study Design</td>
<td>Study Details</td>
</tr>
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</tr>
<tr>
<td>Landsman</td>
<td>2010</td>
<td>RCT</td>
<td>N= 32 wounds (number of patients not specified) with forefoot or midfoot ulcer of Wagner Grade 1 or 2. Mean Age; 57.2 years. N = 32 wounds (number of patients not specified) with forefoot or midfoot ulcer of Wagner Grade 1 or 2. Mean Age; 57.2 years. TheraGauze (TG) group- treated with standard wound debridement as needed and dressing changes every other day with TheraGauze applied to wound surface (n = 16 wounds) vs. TheraGauze + Becaplermin (TG + B) Group- Same treatment as TG group, with the extra treatment of becaplermin (Regranex 0.01%) daily (n = 16 wounds).</td>
</tr>
<tr>
<td>Richard</td>
<td>1995</td>
<td>RCT</td>
<td>N = 17 suffering from chronic neuropathic ulcer of the plantar surface of foot. Typical neuropathic ulcer (n = 17) with Wagner Grade 1 or 2. Mean Age; 57.2 years.</td>
</tr>
</tbody>
</table>

**Landsman 2010 RCT**
Sponsored by Soluble Systems LLC. COI: Dr. Landsman is a paid consultant for Soluble Systems LLC.

**Richard 1995 RCT**
Sponsorship, supported

**NYS WCB MTG – Ankle and Foot Disorders** 325
by Farmitalia Caro Erba Laboratory, Milano, Italy.

No mention of COI.

| Lyons 2007 Dose-escalation study | N/A | N = 9 with diabetes mellitus with an HbA1c from 6% to 13%, full thickness diabetic foot ulcer below that ankle that has not reduced in size ≥30% in past 4 weeks with typical treatments, post debridement size between .5-10 cm², transcutaneous oxygen tension ≥30 mm Hg or ankle-brachial index ≥0.7; Mean (±SD) age 57 (±6) for 1% gel group, 54 (±7) for 2.5% gel group and 52 (±11) | 1% Talactoferrin gel group (n=3) vs. 2.5% Talactoferrin gel group (n=3) vs. 8.5% Talactoferrin gel group (n=3). Groups instructed to apply gel twice daily to ulcer for 30 days alongside typical wound care. Assessments at baseline, weekly during treatment, weekly for 1 month after final treatment, and semimonthly for 3 months after final treatment. No p-value statistics reported for this phase of the study. 2.5% and 8.5% talactoferrin selected for use in phase 2. “[T]alactoferrin was a safe and well-tolerated treatment of diabetic neuropathic foot ulcers without associated adverse events or laboratory abnormalities. In addition, talactoferrin enhanced the rate of healing in these ulcers. A phase 3 will be required to confirm these results.” | Study Phase 1 - same article as below. | ulcer of Wagner grade I-III, more than 0.5 cm in the largest diameter. Mean age 61.9±10.0 years in treatment group. linear advance from entry to 6th week of treatment (bFGF: 0.053±0.048 mm vs. placebo: 0.116±1.129 mm): same result obtained at 11th week. diabetic ulcer of the foot. Because diabetes causes significant wound-healing defects, we hypothesized that using a single growth factor might be insufficient to accelerate wound closure of diabetic ulcers.” }
## Prostacyclin Analogue (Iloprost)

<table>
<thead>
<tr>
<th>Study</th>
<th>RCT</th>
<th>Group Characteristics</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sert 2008</td>
<td>RCT</td>
<td>N = 60 with type 2 diabetic patients (61.8 ± 9.7 years, mean ±SD) with diabetic foot ulcer and peripheral arterial occlusive disease, stage III or more by Wagner classification. Plus 15 healthy controls.</td>
<td>Group I: iloprost infusion (0.5-2 ng/kg/min for 6 h) for 10 consecutive days. (n = 30) vs. Group II: (n=30) treated same except iloprost treatment constituting a patient control group. 30 day follow-up.</td>
<td>Improvement in endothelial functions at 10th and 30th day (p = 0.002) in respect to group II.</td>
</tr>
</tbody>
</table>

## Complementary and Alternative Medications

<table>
<thead>
<tr>
<th>Study</th>
<th>RCT</th>
<th>Group Characteristics</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leung 2008</td>
<td>RCT</td>
<td>N = 80 with chronic foot ulcers, type 2 diabetes; Mean (±SD) age 66.3 (±12.6) for herbal group and 68.5 (±11.1) for placebo group</td>
<td>Herbal treatment group receiving a mixture of 12 herbs given 2x daily in a drink (n = 40) vs. Placebo control group (n=40). Both groups received typical antidiabetic treatment. Assessments at baseline, 1 week, 2, 3, and 4 weeks.</td>
<td>No statistically significant p-value results reported for limb salvage or healing of ulcers.</td>
</tr>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Participants</td>
<td>Intervention</td>
<td>Outcome</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>Larijani 2008 RCT</td>
<td>2.0</td>
<td>N= 25 patients with diabetic foot ulcers; Mean Age was 53.6 years.</td>
<td>Semelil Group-Intravenous administration of ANGIPARS 4 mL daily for 28 days (n = 16) vs. Conventional Therapy included betadine bath, antibiotic therapy, wound debridement. (n = 9). Follow-up for 4 weeks.</td>
<td>Significant decrease in ulcer surface area for Semelil vs. Conventional Therapy; 64% reductions vs. 25% reduction (p = 0.015). Treatment group showed decrease in wound size compared to baseline (479.93 mm² to 198.93 mm², (p&lt;0.001)). No significant decrease in area in control group (p = 0.076). “This herbal extract by intravenous route in combination with conventional therapy is more effective than conventional therapy by itself probably without side effect. However, further studies are required in the future to confirm these results in larger population.”</td>
</tr>
<tr>
<td>Bahrami 2008 RCT</td>
<td>1.0</td>
<td>N = 21 with diabetic foot ulcers. Age range from 18 to 75 years.</td>
<td>Group 1 received 100mg of oral ANGIPARS™ twice a day for 6 weeks, plus conservative treatment (n = 6) vs. Group 2 received ANGIPARS™ gel 3% added to oral form of same product and not conventional therapies (n = 6) vs. Group 3 or control, only conventional therapies.</td>
<td>Foot ulcer surface areas decreased from 375.00±118.14 mm² to 41.67±32.70 mm² in group 1, (p = 0.040); and from 916.67±228.64 mm² to 137.50±41.71mm² in group 2 (p = 0.010). In group 3, ulcer surface areas reduced from 766.22±320.17 to 854.20±280.14. “In diabetic foot ulcers, either treatment with oral ANGIPARS™ capsules (100mg) twice a day or combination therapy with oral and topical forms, in conjunction with good wound care significantly increased the incidence of complete Phase 3 trial. Small sample size (21), and unequal group sizes. Baseline differences (ulcer surface area 375 vs. 917 vs. 766), concerning for randomization failure.</td>
</tr>
</tbody>
</table>
### Hyperbaric Oxygen

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Description</th>
<th>Treatment</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang 2009 RCT</td>
<td>72</td>
<td>N =72 with chronic diabetic foot ulcers. Mean±SD age was 58.6±12.6 years (ESWT); 63.4±10.3 years.</td>
<td>ESWT group received 300 100/cm² impulses of shockwave at 0.11 mJ/cm² energy flux density every 2 weeks for 6 weeks vs. hyperbaric oxygen therapy (HBO) group received HBO daily for 20 treatments via mask.</td>
<td>Completely healed in 31%, improved in 58%, and unchanged in 11% for the ESWT group vs. 22% completely healed, 50% improved, and 28% unchanged for HBO group.</td>
</tr>
<tr>
<td>Duzgun 2008 RCT</td>
<td>100</td>
<td>N = 100 with foot wound that had been present for at least 4 weeks despite appropriate local and systemic wound care.</td>
<td>Standard therapy (ST) administrated 2 sessions per day, followed by 1 session on following day (n = 50) vs ST combined with HBOT standard therapy supplemented by hyperbaric oxygen treatments (n = 50). Follow-up for 4 to 5 months.</td>
<td>No patients in ST group who healed without surgery vs 33 (66%) of patients in group receiving HBOT healed without surgery. Healing ST vs HBOT; (Ulcer grade 2)/(Ulcer grade 3)and (Ulcer grade 4): (0 vs 6) / (0 vs 13) / and (0 vs 14).</td>
</tr>
</tbody>
</table>

**In conclusion, this study showed that the use of HBOT in the treatment of diabetic foot ulcers statistically significantly improved the prevalence of healing in foot ulcers of diabetic patients.”**

**Multiple baseline differences concerning for randomization failure. Data suggest better results with HBO.**
### Extracorporeal Shockwave Therapy

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moretti 2009</td>
<td>N = 30 with neuropathic diabetic foot ulcers. Mean±SD age: 56.8±7.5 years.</td>
<td>Standard care and shock wave therapy. Other group treated with standard care. Follow-up over 20 weeks.</td>
<td>Complete wound closure ESWT-treated vs. control: 53.33% vs. 33.33%. Healing times: 60.8 vs. 82.2; p &lt;0.001.</td>
<td>“ESWT may be a useful adjunct in the management of diabetic foot ulceration.”</td>
<td>Details sparse.</td>
</tr>
<tr>
<td>Wang 2009</td>
<td>N = 72 with chronic diabetic foot ulcers. Mean±SD age: 58.6±12.6 years (ESWT); 63.4±10.3 years.</td>
<td>ESWT group received 300 100/cm² impulses of shockwave at 0.11 mJ/cm² energy flux density every 2 wk for 6 wk vs. hyperbaric oxygen therapy (HBO) group received HBO daily for 20 treatments via mask.</td>
<td>Completely healed in 31%, improved in 58%, and unchanged in 11% for the ESWT group vs.22% completely healed, 50% improved, and 28% unchanged for the HBO group.</td>
<td>“ESWT appears to be more effective than HBO in chronic diabetic foot ulcers”</td>
<td>Quasi-randomized (date of treatment). HBO administered by a “mask” in a chamber.</td>
</tr>
</tbody>
</table>

### Electrical Stimulation

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petrofsky 2010</td>
<td>N = 20 non-healing diabetic foot ulcers (mean duration 38.9±23.7 months. Mean±SD age: 48.4±14.6 years</td>
<td>Local dry heat (37°C; n = 10) vs. local dry heat + ES (n = 10) three times a week for 4 weeks.</td>
<td>Average wound area and volume decreased in ES + heat group: 68.4±28.6% and 69.3 ± 27.1%, respectively (both p&lt;0.05), over the 1-month period.</td>
<td>“Local dry heat and ES work well together to heal chronic diabetic foot wounds; however, local heat would appear to be a relevant part of this therapy</td>
<td>Sparse details. Attempted to study additive benefit of Electrical stimulation over dry heat alone.</td>
</tr>
</tbody>
</table>
because ES alone has produced little healing in previous studies.”

<table>
<thead>
<tr>
<th>Skin Grafts</th>
<th>Dermagraft</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martson 2003 RCT</td>
<td>3.5</td>
</tr>
<tr>
<td>Supported by a research grant from Advanced Tissue Sciences, Inc. and Smith and Nephew, Inc. COI- W.A.M. is on speaker's bureau for Smith and Nephew, Inc., and has received honoraria and travel support for lectures and travel programs from Smith and Nephew, Inc. J.H. has received consulting fees for lectures and program sponsorshi p from</td>
<td>N= 314 patients with diabetes with a foot ulcer of at least 2 weeks duration. Mean Age was 55.7 years</td>
</tr>
<tr>
<td>Dermagraft Group: Dermagraft application with standard wound dressings (n = 163) vs. Control Group: Standard wound dressings (n = 151). Follow-up for 12 weeks.</td>
<td>There were 245 patients with chronic ulcers (&gt;6 weeks duration). 39 (30%) of patients in dermagraft group had completely healed at 12 weeks compared to 21 (18%) in control group (p = 0.023). The dermagraft group had a significantly faster time to complete wound closure than the control group (p=0.04). No significant differences in the number of adverse events between groups.</td>
</tr>
<tr>
<td>“In conclusion, Dermagraft has been shown in this multicenter, prospective randomized study to be safe and effective for the treatment of chronic diabetic foot ulcers.”</td>
<td>Some dissimilar baseline comparability data. Adverse events similar between groups. Dermagraft group had more complete ulcer healing at 12% compared to control group (30% vs. 18%, p = 0.023).</td>
</tr>
<tr>
<td>NYS WCB MTG – Ankle and Foot Disorders</td>
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<td>----------------------------------------</td>
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</table>

### Apligraft

| Moustafa 2007 RCT | 3.5 N= 16 patients (21 Ulcers) with diabetic ulcers. Mean age was 52.4 years. | Active Group- received up to 12 active dressings (n = 8) vs. Placebo Group: initially received 6 placebo dressings followed up by up to 12 active dressings (n = 8). Follow-up for 12 weeks. | Ultimately, 12 patients each with 1 ulcer index were analyzed (7 active, 5 placebo). In the placebo group 1/5 ulcers completely healed and 4/7 in the active group. During follow-up, 3 of 4 completely healed ulcers in the active group recurred. Ulcer size reduction after treatment was greater in active group compared to the placebo group, however, these differences were not significant (p >0.05). | Repeated regular applications of the patient’s keratinocytes, delivered on the carrier dressing, initiated wound healing in ulcers resistant to conventional therapy, with 19 out of 21 ulcers responding. | Partial crossover. High dropouts. |

Advanced Tissue Sciences, holds stock in ATIS, and has been a paid speaker for Smith and Nephew, Inc.
### FOOT DROP

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthotics</strong></td>
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</tr>
<tr>
<td>Hausdorff 2008</td>
<td>RCT</td>
<td>1.0</td>
<td>N = 24 with chronic hemiparesis whose walking was impaired by foot drop, with mean age 54.0 ± 5.2.</td>
<td>Subjects walked for 6 minutes while wearing force-sensitive insoles, once with and once without the neuroprosthesis. Neuroprosthesi s were conducted after using the device for 4 and 8 weeks. Follow-up for a total of 8 weeks.</td>
<td>Gait asymmetry index instantly improved by 28% or from 0.58±0.30 to 0.42±0.22 and by 45% (to 0.32±0.20; p ± 0.001, after 8 weeks. Stride time variability decreased by 23% immediately (from 5.7±2.9% to 4.4± 1.3%) and by 33% (to 3.8 ± 1.4%; p &lt; 0.002) after 8 weeks.</td>
<td>“The studied neuroprosthesi s enhances gait and improves dynamic stability in chronic hemiparetic patients, supporting the idea that this is a viable treatment option in the rehabilitation of patients with foot drop.”</td>
<td>Neuroprosthesi s appeared to improve gait and stability in patients with foot drop but study elements were sparse and omitted many details.</td>
</tr>
<tr>
<td><strong>Taping</strong></td>
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<tr>
<td>Vicenzino 2000</td>
<td>RCT Cross-over</td>
<td>1.0</td>
<td>N = 14 with an increase in vertical navicular height of at least 10mm when foot was moved from relaxed calcaneal stance to subtalar neutral, mean age 23.8 ± 3.5.</td>
<td>LowDye taping, temporary felt orthotics, consisting of a spur and mini-stirrup, and adding calcaneal slings and reverse sixes which are anchored one third up leg and all subjects have</td>
<td>Exercise challenge effect on each treatment technique: with tape, there was a significant reduction in mean percentage change in mean vertical navicular height from 19.0%-5.9%</td>
<td>“Antipronation tape and temporary orthotics help to control excessive foot pronation initially after application and following exercise.”</td>
<td>Crossover study with small N and few details on methodology.</td>
</tr>
</tbody>
</table>
participants in fitness activities (10 and 20 minutes). In control condition, subjects did not have tape or orthotics applied.

Follow-up of exercise challenge (0, 10, and 20 minutes of controlled jogging).

over first 10-minute period, but not over second 10-minute period (5.9%-3.5%). Tape and orthotic treatments produced approximately a 19% and 14% increase in vertical navicular height.

<table>
<thead>
<tr>
<th>Author/Year Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quiding 2013 RCT</td>
<td>3.0</td>
<td>N=27 patients with Morton neuroma for at least 3 months confirmed by MRI.</td>
<td>2mL Placebo vs. 1mg/mL lidocaine vs. 10mg/mL lidocaine. Patients had 3 visits each. At each visit, a patient randomly assigned to one of three treatments and then immediately tested with QST assessments and a step-up test.</td>
<td>Mean QST assessment value calculated for affected and non-affected foot. Difference between feet not significant for any group (p &gt;0.10). Lidocaine (10mg/mL) showed significant effects compared to placebo for QST for 3 measurements, CDT measurement (p = 0.039), MDT measurement (p = 0.009) and wind up (p = 0.016). Mean pain intensity following injection was 4.1 after placebo, 2.0</td>
<td>“The present results may therefore suggest that lidocaine is relatively more effective on heat pain in damaged tissue and, although results were seen in only 3 patients, could be effective in patients with heat hyperalgesia, ie, in patients with pain resulting from sensitized heat nociceptors.”</td>
<td>Crossover study with small N and minimal baseline characteristics. Some data suggest possible efficacy.</td>
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</table>
after 1 mg/mL lidocaine and 1.2 after 10 mg/mL lidocaine. Difference between placebo and lidocaine (1 mg/mL) and lidocaine (10 mg/mL) significant. (p < 0.001).

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<tr>
<th>Study Type</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>ACHILLES TENDINOPATHY</strong></td>
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<tr>
<td>Niesen-Vertommen 1992</td>
<td>2.5</td>
<td>N = 17 athletic patients, chronic Achilles tendinitis</td>
<td>Eccentric vs. concentric exercise regimens daily for 12 weeks.</td>
<td>No differences in return-to-activity ratings. Differences favoring eccentric in pain ratings 3.0 vs. 4.7 at 12 weeks.</td>
<td>&quot;The subjective symptoms of pain with Achilles tendinitis were better controlled in the eccentric exercise group than in the concentric group.&quot;</td>
<td>Small sample size. Lack of study details.</td>
</tr>
<tr>
<td>Bourne 1980</td>
<td>3.5</td>
<td>N = 60 acute sports injuries</td>
<td>Ibuprofen (1,600 mg) vs. paracetamol (3,600 mg) daily.</td>
<td>Days to return to sport in 1-5 days: Ibuprofen 14/28, paracetamol 5/27, (p &lt; 0.05).</td>
<td>&quot;If ibuprofen is given within two days of injury return to sporting activity is hastened, and our results support those of Muckle (1974).&quot;</td>
<td>Sparse study details.</td>
</tr>
<tr>
<td>Lowdon 1984</td>
<td>2.5</td>
<td>N = 33 age 11-51 years with unilateral Achilles tendinitis</td>
<td>Sorbothane heel pads for 2 months (n = 11) vs. soft sponge rubber pads of &quot;Molefoam&quot; (n = 10) vs. no pads (n = 12). All received 5 consecutive daily 5</td>
<td>All groups with improvement at 10 days and 2 months.</td>
<td>&quot;Patients treated with ultrasound and exercises alone (group III) revealed the most significant improvement in the clinical findings, as characterized by a reduction in both swelling and tenderness.&quot;</td>
<td>All groups with ultrasound and exercise therapy. Data suggest possible randomization failure. Small sample size for 3 comparison groups. &quot;No heel pad group&quot; significantly shorter duration of symptoms.</td>
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</table>
minute ultrasound treatments.

Outcomes measures were gain parameters that may have little clinical significance.

### ACHILLES TENDON RUPTURE

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<tr>
<th>Author/Year Study Type</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Nistor 1981</td>
<td>3.5</td>
<td>N = 105 closed acute ruptures of Achilles tendon</td>
<td>Surgery (end to end suture) vs. progressive casting.</td>
<td>“Absence from work varied depending on work. It averaged thirteen weeks (0-30) in surgically treated groups and nine weeks (0-44) in non-surgically treated groups (P &lt;0.05).” No differences in plantar flexion strength or increases in tendon size.</td>
<td>“Results of both surgical and non-surgical treatment of acute ruptures of the tendo Achilles were good, and they confirmed the results reported previously. There were only minor differences in the groups, but the period of morbidity was shorter, the complaints were fewer, and no hospital stay was needed in the conservatively treated patients. ...The treatment of choice should be non-surgical.”</td>
<td>Quasi randomized (odd-even day). No blinding of assessment. Casting group was quicker to return to work, although also had higher re-rupture rate (8% vs. 4%).</td>
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</table>

### PLANTAR FASCIITIS

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<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
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<th>Conclusion</th>
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<tr>
<td></td>
<td>MRI</td>
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</table>
### Ankle and Foot Disorders

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study Design</th>
<th>N</th>
<th>Characteristics</th>
<th>MRI Comparison</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maier 2000</td>
<td>RCT</td>
<td>2.5</td>
<td>N = 43 patients (48 heels) with chronic courses of plantar fasciitis</td>
<td>MRI with a high field system vs. MRI with a low field system</td>
<td>While thickness of plantar aponeurosis, soft tissue signal intensity changes, and soft tissue contrast medium uptake did not correlate with clinical outcome, presence of a calcaneal bone marrow edema highly predictive for satisfactory outcome (positive predictive value 0.94, sensitivity 0.89, specificity 0.8).</td>
<td>“This study indicates that in patients with chronic plantar fasciitis, the presence of calcaneal bone marrow edema on pretherapeutic MRI is a good predictive variable for a satisfactory clinical outcome of ESWA.”</td>
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</table>

**NSAIDs**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study Design</th>
<th>N</th>
<th>Characteristics</th>
<th>Comparison</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bourne 1980</td>
<td>3.5</td>
<td>See NSAIDs in Evidence Table for Achilles Tendinopathy above.</td>
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</table>

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<tr>
<th>Study</th>
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<th>N</th>
<th>Characteristics</th>
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<th>Findings</th>
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</thead>
<tbody>
<tr>
<td>Donley 2007</td>
<td>2.5</td>
<td></td>
<td>N = 29 with plantar fasciitis</td>
<td>NSAID (celecoxib 200mg q day) vs. placebo</td>
<td>NSAID vs. Placebo (1, 2, 6 months); Pain (VAS improvement): 2.55 vs. 1.47, 3.73 vs. 2.97, 6.06 vs. 4.85, all p &gt;0.05; Disability (VAS improvement): 1.92 vs. 0.88, 2.71 vs. 2.42, 4.96 vs. 3.81, all p &gt;0.05.</td>
<td>“…the use of an NSAID may increase pain relief and decrease disability in patients with plantar fasciitis when used with a conservative treatment regimen.”</td>
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</table>

**Glucocorticosteroid Injections**

<table>
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<tr>
<th>Study</th>
<th>Year</th>
<th>Study Design</th>
<th>N</th>
<th>Characteristics</th>
<th>Comparison</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Lynch 1998</td>
<td>RCT</td>
<td>3.0</td>
<td>N = 103 with plantar fasciitis</td>
<td>Group 1 (n = 35) steroid injection 0.5ml dexamethasone plus 2 300mg capsules of etodolac a day vs. Group 2 (n = 33) viscoelastic</td>
<td>High treatment failures in injection group (23%) and heel cup (42%). Final outcome of “excellent” or “fair” vs. “poor.” Injection group 33% (9 of 27) Heel cup group 30% (7 of 23) vs. 70% (19 of 27) of orthoses group (p = 0.005).</td>
<td>“The results of this study show that mechanical control of the foot with taping and orthoses is more effective than either anti-inflammatory therapy with NSAIDs in combination with injections or accommodative.”</td>
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<table>
<thead>
<tr>
<th>Magnets</th>
<th>Orthoses</th>
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<tbody>
<tr>
<td>Caselli 1997 RCT</td>
<td>Martin 2001 RCT</td>
</tr>
<tr>
<td>2.5</td>
<td>3.5</td>
</tr>
<tr>
<td>N = 40 with medial plantar calcaneal heel pain</td>
<td>N = 255 plantar heel tenderness, history of pain on rising in morning or after rest, no history of trauma to heel within previous</td>
</tr>
<tr>
<td>PPT/Rx Firm Molded Insole with magnetic foil vs. PPT/Rx Firm Molded Insole with no magnetic foil.</td>
<td>Custom-made orthoses vs. OTC arch supports vs. tension night splints.</td>
</tr>
<tr>
<td>No significant difference between number of patients reporting improvement in each group (chi-squared = 1.22; p = NS). No significant difference in improvement made by magnetic foil group vs. PPT/Rx Firm Molded Insole group as measured by percentage difference in mean scores on foot function index.</td>
<td>No statistically significant differences among treatment groups in overall effectiveness during 12 weeks of treatment for plantar fasciitis. Overall success rate of treatment in present study lower than rates in studies in which multiple modalities used.</td>
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<tr>
<td>“Approximately 58% of patients using the PPT/Rx Firm Molded Insole with magnetic foil for 4 weeks and 60% of patients using the PPT/Rx Firm Molded Insole alone for the same period reported improvement in foot function as measured by the foot function index. The magnetic foil offered no advantage over the insole.”</td>
<td>“Mechanical control of the foot is a successful method of treating plantar fasciitis. Custom-made orthoses, over-the-counter arch supports, and tension night splints are all effective as initial treatments for plantar fasciitis. Patients in the present study demonstrated the best compliance with the use of</td>
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<tr>
<td>Lack of method details. Unclear if this was an RCT.</td>
<td>No blinding. High drop-out rate; 12 week study.</td>
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<tr>
<td>Study</td>
<td>N or Sample Size</td>
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<tr>
<td>Kavros 2005 RCT</td>
<td>N = 50</td>
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<td>Lynch 1998</td>
<td>N = 50</td>
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<tr>
<td>Caselli 1997</td>
<td>N = 16</td>
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<tr>
<td>Mejjad 2004 Crossover Trial</td>
<td>N = 16</td>
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<tr>
<td>Study</td>
<td>Design</td>
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<tr>
<td>Fauno 1993</td>
<td>Quasi-</td>
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<td>Fransen 1997</td>
<td>RCT</td>
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<tr>
<td>Lynch 1998</td>
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<td>Furia 2005</td>
<td>RCT</td>
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## ANKLE SPRAINS

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<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
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<th>Results</th>
<th>Conclusion</th>
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<tbody>
<tr>
<td>Alvarez</td>
<td>RCT-Mixed</td>
<td>Excluded</td>
<td>ESWT vs. sham</td>
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### NSAIDs

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<tr>
<th>Author/Y Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Dupont 1987</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 67 acute ankle sprains, varying degree of severity</td>
<td>Ibuprofen 600mg, 4 times daily vs. placebo</td>
<td>Ibuprofen vs. placebo VAS 0-4 (day 4, 8); Rest: 0.3 vs. 0.2, 0.2 vs. 0.2; Jumping: 0.7 vs. 1.0, 0.5 vs. 0.5; Walking: 1.8 vs. 1.9, 1.2 vs. 1.3.</td>
<td>“Although there were trends indicating a superiority of effectiveness in the treatment group, the differences between groups were not statistically significant.”</td>
<td>Study not clear if it is a randomized trial. Allocation unclear. Reported no differences between placebo and ibuprofen group.</td>
</tr>
<tr>
<td>Fredberg 1989</td>
<td>RCT</td>
<td>3.0</td>
<td>N = 68 acute ankle joint injuries presented to casualty ward</td>
<td>Ibuprofen 600mg, 4 times daily vs. placebo for 4-6 days.</td>
<td>No difference in swelling reduction, number of patients taking additional analgesics (5/47 vs. 9/53).</td>
<td>“No difference between relief of pain and reduction of swelling was demonstrated. We cannot recommend routine treatment with ibuprofen for acute ankle joint injuries.”</td>
<td>Drop outs (14) replaced by new patients. No data on compliance. Multiple co-interventions. Study suggests no difference between placebo and ibuprofen.</td>
</tr>
<tr>
<td>Aghababian 1986</td>
<td>RCT</td>
<td>2.5</td>
<td>N = 40 mild to moderate pain</td>
<td>Diflunisal (1000mg loading, 500mg BID/TID) vs. acetaminophen at base line (%)</td>
<td>Severity of pain for diflunisal vs. acetaminophen with codeine are equally effective in</td>
<td>“[D]iflunisal and the combination of acetaminophen with codeine are equally effective in”</td>
<td>Lack of study details regarding randomization, allocation, blinding,</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Study Population</td>
<td>Intervention</td>
<td>Comparison</td>
<td>Results</td>
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<tr>
<td>Andersson 1983</td>
<td>1983</td>
<td>RCT</td>
<td>N = 100 sprained ankles</td>
<td>Ibuprofen 800mg TID (compression vs. ace bandage) x 10 days vs. placebo (compression vs. ace) 2-week trial for acute sprain (injury extent non-defined).</td>
<td>No differences in swelling improvement between 4 groups found. No differences in pain at rest, walking, or tenderness. Minimal statistical analysis presented.</td>
<td>“Neither Ibuprofen nor high quality bandaging had a significant effect on the swelling, pain or tenderness.”</td>
<td>Lack of randomization, allocation, baseline comparison, cointerventions and blinding details. Suggests no benefit from ibuprofen or elastic/compression bandages.</td>
</tr>
<tr>
<td>Aghabanian 1986</td>
<td>1986</td>
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<td>See NSAIDs above.</td>
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<tr>
<td>Brakenbury 1983</td>
<td>1983</td>
<td>RCT</td>
<td>N = 400 males who attended ER within 24 hours</td>
<td>Proteolytic enzymes plus plaster cast vs. placebo plus plaster vs. enzymes plus Tubigrip vs. placebo</td>
<td>Day 7, bruising significant difference favor placebo/Tubigrip vs. enzymes/Tubigrip (p &lt;0.01). Day 14, improvement in placebo/Tubigrip (89%) and Tubigrip vs. placebo</td>
<td>“[T]hose who received a plaster cast and enzymes recovered faster than those in a cast alone. In addition, the power of dorsiflexion recovered faster in the Tubigrip group</td>
<td>Lack of study details regarding randomization, allocation, blinding, compliance. High drop-out rate (148/400). Results suggest little clinical</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
<td>Intervention</td>
<td>Control</td>
<td>Outcome</td>
<td>Significance</td>
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<tr>
<td>Elswood</td>
<td>1985</td>
<td>Quasi-RCT</td>
<td>86</td>
<td>Tubigrip vs. placebo</td>
<td>Tubigrip vs. placebo</td>
<td>Mean scores for time from presentation Tubigrip vs. placebo vs. benzydamine at 0, 2, 9 days: 7.9/8.8/8.4, 5.2/5.9/5.7, 2.6/2.4/2.45. Mean scores for improvement days 0-2, SEM: 2.71/2.93/2.7, 0.53/0.51/0.33. All made similar progress.</td>
<td>Quasi-randomization (odd/even birth year), then randomized tubes of topical treatment. High loss to follow-up (34/86). Suggests no treatment effect from benzydamine for acute ankle sprains.</td>
</tr>
<tr>
<td>Campbell</td>
<td>1994</td>
<td>RCT</td>
<td>100</td>
<td>Ibuprofen cream 5% applied QID vs. placebo cream</td>
<td>Placebo cream</td>
<td>Significant difference in mean VAS score and walking ability Days 2 and 3 only.</td>
<td>Results are of uncertain significance as 49% of randomized patients did not complete study and were not included in the analysis.</td>
</tr>
<tr>
<td>Nilsson</td>
<td>1983</td>
<td>RCT</td>
<td>178</td>
<td>Elastic wrap I vs. elastic wrap plus cold pack, rubber pad II vs. elastic wrap, cold, rubber pad plus</td>
<td>Placebo</td>
<td>Injury severity determined by arthrography. Temperature: no ligament rupture, mean temperature less in Group III than I and II (p &lt;0.005).</td>
<td>Randomization, allocation, baseline comparability, blinding details not described. Timing of assessments variable for long</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Treatments</td>
<td>Results</td>
<td>Notes</td>
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<tr>
<td>Zwipp 1992 RCT</td>
<td>3.5</td>
<td>N = 200 ruptured ankle ligaments</td>
<td>Surgery plus cast immobilization vs. surgery plus functional orthosis vs. cast immobilization vs. functional orthosis.</td>
<td>At 3 months, better ROM in primary functional group. No differences in subjective outcomes. At 12 months, no differences regarding joint stability, ROM, recurrence of injury, limitations, instability.</td>
<td>&quot;As a result of the trial, the only remaining surgical indications would seem to be dislocations of the foot and ankle, ankle ligament rupture with additional intra-articular pathology, and second-stage injuries or re-ruptures.&quot;</td>
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</table>

- Hydrocortisone local injection 4mg (III).
- Severity of the injury.
- Term follow-up (3-6 months).
- Multiple cointerventions (PT in groups II and III) make comparisons difficult for individual treatment recommendations.

**Early Mobilization**
| Korkala 1987 | 2.5 | N = 150 recent tears of lateral ligament of ankle | Bandaging (1-4 weeks) vs. plaster cast of 4 weeks (weight bearing at 1 week) vs. operative repair of ligament plus plaster cast of 4 weeks for severe acute first time ankle sprain. | No significant differences at 2-years in sprain recurrences, number of subjects reporting decrease in sporting activities, tenderness, or talar tilt on radiographs. “Fear of giving way” more common in non-operative treatments (52.8% bandage, 32% cast vs. 9% operative). total chi square = 15.36>13.816 = $\chi^2$.001 (df = 2). Good/ excellent results based on age (15-40 and 41-50): total chi square = 8.75<6.635 = $\chi^2$.01 (df = 1). Significant difference in favor of younger group. No differences in interventions between age groups. | “Patients over 40 should be treated conservatively, since the capacity for ligamentous regeneration appears significantly less good that that of young people. Severe ankle sprains in patients under 40 should be preferably be treated by operation.” |
| Muwanga 1986 | 3.5 | N = 156 with acute ankle injuries | Tubigrip vs. strapping vs. Velcro strap (Nottingham Ankle support). | Tubigrip vs. strapping vs. Nottingham; support able to bear weight (%): 40 vs. 62 vs. 67. P value and ROM data not reported. Nottingham > both Tubigrip and "The Nottingham Ankle Support was a convenient, economical and effective method of treatment of a common condition. It allowed a greater range of movement at early follow-up |

**Tubular Elastic, Elastic Wrap, and Tape**

Lack of study details. Only follow-up reported is at 2-years. Thus, unknown whether any short-term benefits. Suggests no significant differences at 2 years. Results limited to non-athletic populations.
strapping \( p = 0.001174 \). Feeling of confidence: data not reported, Nottingham > both Tubigrip and strapping \( p = 0.02 \). Stability at 10 days.

<table>
<thead>
<tr>
<th>Study</th>
<th>Grade</th>
<th>N</th>
<th>Group Details</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotece 1992</td>
<td>3.5</td>
<td>184</td>
<td>Taping (unchanged 3 days) vs. gel cast x 3 days vs. taping (changed each day x 3 days).</td>
<td>3-day strap vs. 3-day gel cast vs. daily strap return to duty Day 3 (military) 24/54 vs. 20/59 vs. 36/54. No grade II sprains returned by Day 3.</td>
<td>&quot;[A] treatment protocol of daily ankle strapping plus standard physical therapy modalities/exercise was more effective than a single ankle strapping and a gel-O-cast wrap...for Grade I and II ankle sprains.&quot; Sparse study details. No baseline comparisons. Multiple cointerventions with PT and modalities. Some subjects had treatment repeated at end of 3-days for initial failure.</td>
</tr>
<tr>
<td>Korkala 1987</td>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
<td>See Evidence Table for Early Mobilization above.</td>
</tr>
<tr>
<td>Nilsson 1983</td>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
<td>See Evidence Table for Glucocorticosteroid Injections above.</td>
</tr>
<tr>
<td>Brooks 1981</td>
<td>1.5</td>
<td>104</td>
<td>No support vs. physiotherapy vs. double Tubigrip support vs. immobilized.</td>
<td>Days off work: days at clinic (no support/physiotherapy/double Tubigrip support/immobilized), 5.1: 23.6/6.0:21.4/7.5:21.5/41.0:25.0.</td>
<td>&quot;[M]obilisation, with early physiotherapy or even without, offers the most rapid return to functional activity.&quot; Lack of study details; 241 entered trial with high drop-out or exclusion. Not clear how many randomized.</td>
</tr>
<tr>
<td>Airaksinen 1990</td>
<td>1.0</td>
<td>44</td>
<td>Elastic bandage vs. elastic bandage plus intermittent pneumatic compression.</td>
<td>Results section did not include measurement data. After 5 IPC sessions, edema volume 33 mL (IPC) vs. 80 mL (control), ( p &lt;0.001 ). Pain, &quot;Elastic bandage with IPC treatment is effective in decreasing edema, relieving pain, and increasing ankle joint motion after ankle sprains. All these factors Lack of study details (randomization, allocation, baseline comparability, no blinding, compliance, co-interventions,</td>
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</tbody>
</table>
Ankle Support/Brace

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Score</th>
<th>Study Design</th>
<th>Participants</th>
<th>Methodology</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muwanga</td>
<td>1986</td>
<td>3.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See Tubular Elastic, Elastic Wrap, and Tape above.</td>
</tr>
<tr>
<td>Scotece</td>
<td>1992</td>
<td>3.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See Tubular Elastic, Elastic Wrap, and Tape above.</td>
</tr>
<tr>
<td>Zwipp</td>
<td>1992</td>
<td>3.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See Early Mobilization above.</td>
</tr>
<tr>
<td>Cetti</td>
<td>1984</td>
<td>3.0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See Early Mobilization above.</td>
</tr>
<tr>
<td>McGuine</td>
<td>2012</td>
<td>3.0</td>
<td>RCT, cluster</td>
<td>N = 2081 high school football players</td>
<td>Laced-up Ankle brace, Don-Joy Ankle Stabilizing Brace; team-organized conditioning session, practice, competition until season is completed (n = 993) vs. Control, no intervention (n = 1088).</td>
<td>“The incidence of the acute ankle injury per 1000 exposures was significantly lower for the braced group compared to the control group: 0.48 vs. 1.12, p = 0.003.” Injury rate (95% CI) for acute ankle injury without a previous history of ankle injury: control vs. braced; 0.91 (0.64, 1.28) vs. 0.40 (0.20, 0.81), p = 0.010; with a history of ankle injury: 2.91 (1.92, 4.41) vs. 1.05 (0.53, 2.09), p = 0.004. “Players who used lace-up ankle braces had a lower incidence of acute ankle injuries but no difference in the incidence of acute knee or other lower extremity injuries. Braces did not reduce the severity of ankle, knee or other lower extremity injuries.” Cluster randomization. Laceup braces associated with lower number of ankle injuries vs. placebo but ankle injury severity same between 2 groups.</td>
</tr>
<tr>
<td>McGuine</td>
<td>2011</td>
<td>2.0</td>
<td>RCT</td>
<td>N = 1460 male and female basketball players</td>
<td>Lace-up ankle brace, McDavid Ultraviolet 195; team-organized conditioning session, practice,</td>
<td>“The overall incidence of acute ankle injury was lower in the braced group (0.47; 95% CI: 0.30, 0.74) than in the control group</td>
</tr>
</tbody>
</table>

ROM scores not presented but reported to be significantly improved in IPC group. Improve limb function and lead to good results in the rehabilitation of ankle sprains.”

Follow-up. Suggests intermittent compression results in greater reduction of edema/improved ROM.
competition until season is completed (n = 740) vs. Control, no intervention (n = 720).

(1.41: 95% CI: 1.05, 1.89). The incidence of first-event acute ankle injury was lower in the braced group (0.83; 95% CI: 0.37, 1.84) than in the control group (1.79; 95% CI: 0.98, 3.27), p < 0.001, in favor of the braced group.”

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Level</th>
<th>Study Design</th>
<th>N</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilkerston</td>
<td>1993</td>
<td>1.5</td>
<td>RCT</td>
<td>N = 34</td>
<td>Elastic tape plus Air-stirrup vs. Air-stirrup plus room temp cooling device vs. Air-stirrup plus ice.</td>
<td>F-ratio calculated (ANOVA) for evaluation of significant difference among treatment methods not significant p = 0.055.</td>
<td>“Subjects who receive focal compression to the soft tissues around the periphery of the fibular malleolus… recover higher function than…uniform external compression. Application of cold with greater frequency and longer duration than typical…does not appear to increase the rate of recovery.”</td>
</tr>
<tr>
<td>Cetti</td>
<td>1984</td>
<td>3.0</td>
<td></td>
<td></td>
<td>See Evidence Table for Early Mobilization above.</td>
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<tr>
<td>Korkala</td>
<td>1987</td>
<td>2.5</td>
<td></td>
<td></td>
<td>See Evidence Table for Early Mobilization above.</td>
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<td></td>
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<tr>
<td>van den Hoogenb</td>
<td>1984</td>
<td>2.5</td>
<td>RCT</td>
<td>N = 150</td>
<td>Surgical repair vs. cast immobilization (5 weeks) vs. tape bandage (elastic) x 4 weeks for proven lateral</td>
<td>Surgical vs. cast vs. tape: Resumption of work activities (weeks): 9.7 vs. 6.8 vs. 2.5 (no p values given); Return to sports at 12 weeks: 35.7% vs. 47.4% vs. 81.4%</td>
<td>“The results…clearly showed the collective advantages of early mobilization with a Coumans-bandage. The long term results, as indicated by the one year follow-up, showed no significant differences and were completely</td>
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</table>

**Casting**

Zwipp 1992

3.5

See Evidence Table for Early Mobilization above.

Cetti 1984

3.0

See Evidence Table for Early Mobilization above.

Korkala 1987

2.5

See Evidence Table for Early Mobilization above.

van den Hoogenb 1984

2.5

N = 150 acute ankle sprain injury

Surgical repair vs. cast immobilization (5 weeks) vs. tape bandage (elastic) x 4 weeks for proven lateral

Surgical vs. cast vs. tape: Resumption of work activities (weeks): 9.7 vs. 6.8 vs. 2.5 (no p values given); Return to sports at 12 weeks: 35.7% vs. 47.4% vs. 81.4%

“The results…clearly showed the collective advantages of early mobilization with a Coumans-bandage. The long term results, as indicated by the one year follow-up, showed no significant differences and were completely

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>RCT</th>
<th>N</th>
<th>Subjects</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gronmark 1980</td>
<td>2.0</td>
<td>RCT</td>
<td>95</td>
<td># rupture of lateral ligaments of ankle</td>
<td>Ligament repair and immobilization vs. cast immobilization 6 weeks vs. strapping (tape) and mobilization.</td>
<td>Results at follow-up (4-34 months range): Operation vs. strapping vs. cast: % free of symptoms 97% vs. 77% vs. 67%. (No p values given.)</td>
<td>“Young, physically active people, particularly active sportsmen and women, are recommended for primary suture combined with splinting in a plaster cast for at least 6 weeks. Strapping is preferred if conservative treatment is indicated.”</td>
<td>Lack of methodological details. Follow-up times not same for each subject. Follow-up by postal questionnaire in proportion of subjects vs. clinical exam. No statistical analyses limits conclusions.</td>
</tr>
<tr>
<td>Stöckle 1997</td>
<td>3.0</td>
<td>RCT</td>
<td>60</td>
<td>Foot or ankle trauma</td>
<td>Continuous cryotherapy vs. intermittent compression vs. cold packs 4 times daily for pre and post-operative edema.</td>
<td>Percent of swelling compared with admission-lower percent is better (Int. Compression/continuous cooling/ice packs): Preoperative ankle at 24 hours - 42% vs. 64% vs. 82%; Post-operative ankle at 24 hours - 64% vs. 73% vs. 80%; Post-operative ankle at 4 days - 37% vs. 36% vs. 62%</td>
<td>“It could be shown that both continuous cryotherapy and intermittent impulse compression therapy lead to faster reduction of swelling compared with standard cool pack therapy.”</td>
<td>Lack of details. Pre-, post-op cooling provided, but not all subjects received both (&lt;50%) despite randomization. No statistical analyses. Included heterogeneous disorders limiting conclusions. Suggests advantage of both treatments compared with standard ice pack application. Equipment costs moderate to high for rental or purchase.</td>
</tr>
<tr>
<td>Michlovitz 1988</td>
<td>2.0</td>
<td>RCT</td>
<td>30</td>
<td>Young adults with Grade</td>
<td>Ice pack (30 minutes) vs. high voltage pulsed stimulation</td>
<td>Ice and high voltage pulsed stimulation at 28 and 80pps tend to produce</td>
<td>&quot;HPVS did not further enhance the effects of ice, compression, and elevation.”</td>
<td>Lack of study details for allocation, baseline comparability.</td>
</tr>
</tbody>
</table>

Cryotherapy

NYS WCB MTG – Ankle and Foot Disorders 349
<table>
<thead>
<tr>
<th>Study</th>
<th>Voltage</th>
<th>Study Type</th>
<th>N =</th>
<th>Condition</th>
<th>Treatment</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilkerson 1993</td>
<td>1.5</td>
<td>See Evidence Table for Ankle Support/Brace above.</td>
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</tr>
<tr>
<td>Laban 1989</td>
<td>1.0</td>
<td>RCT</td>
<td>30</td>
<td>acute ankle sprain (no other associated condition) referred to physiotherapy</td>
<td>Ice vs. no ice (all subjects received ultrasound, exercises, ankle support) for moderate acute ankle sprain.</td>
<td>Rate of recovery (days) ice vs. no ice: Group 3 (able to stand without pain, pain with stairs or walking 10 steps): 4.6 vs. 3.0 days; Group 4 (unable to bear weight): 7.3 vs. 10.2 days</td>
<td>“This clinical trial reveals no significant differences between subjects with ankle sprain injuries who received ice therapy as part of a standard treatment programme and those that did not.” Randomization via coin toss. Duration of study, time of outcomes measurement, and frequency of interventions not described. Lack of overall details.</td>
</tr>
<tr>
<td>Michlovitz 1988</td>
<td>2.0</td>
<td>See Evidence Table for Cryotherapy above.</td>
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<tr>
<td>Makuloluw 1977</td>
<td>2.0</td>
<td>RCT</td>
<td>80</td>
<td>mild or moderate ankle sprains</td>
<td>Immobilization with elastoplast vs. ultrasound and ice</td>
<td>Ultrasound vs. elastoplast recovery at Week 1, 2: 46.2%/26.6%, 86.4%/58.6%. P-values not provided.</td>
<td>“[T]he use of ice packs and ultrasound relieved the pain, swelling and loss of function more than in patients immobilized with elastoplast.” Lack of study details. No statistical analyses. Ultrasound group also had ice pack treatment. No definition of “recovery” as an outcome measure.</td>
</tr>
<tr>
<td>Coetz 2001</td>
<td>3.5</td>
<td>RCT</td>
<td>30</td>
<td>acute Grade I, II sprains</td>
<td>Chiropractic manipulation of subtalar, talocrural joints (6 sessions for No differences at 2 weeks or 6 weeks in NRS-101 questionnaire, McGill Pain</td>
<td>“As there was no statistically significant difference found between the two treatment</td>
<td>Lack of study details. Partial blinding of observer (not on all outcomes). Co-interventions of</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
<td>Condition</td>
<td>Intervention</td>
<td>Outcome</td>
<td>Conclusion</td>
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<tr>
<td>Pellow 2001</td>
<td>2001</td>
<td>RCT</td>
<td>30</td>
<td>Subacute and chronic Grade I and Grade II ankle inversion sprains</td>
<td>Ankle mortise separation adjustment vs. placebo group for 8 treatment sessions over 4 weeks.</td>
<td>Although both groups showed improvement, statistically significant differences in favor of the adjustment group were noted with respect to reduction in pain, increased ankle range of motion, and ankle function.</td>
<td>“This study appears to indicate that the mortise separation adjustment may be superior to detuned ultrasound therapy in the management of subacute and chronic grade I and grade II inversion ankle sprains.”</td>
</tr>
<tr>
<td>Eisenhart 2003</td>
<td>2003</td>
<td>RCT</td>
<td>55</td>
<td>Unilateral ankle sprain</td>
<td>Osteopathic manipulative treatment (single treatment) vs. control. Both groups received RICE, NSAIDs.</td>
<td>Mean±SD VAS score for treatment group vs. control group: 3.15±1.4 vs. 3.5±2.8; p = 0.61. ROM (degrees): 42.5±14.4 vs. 39.0±15.4.</td>
<td>“Data clearly demonstrate that a single session of OMT in the ED can have a significant effect in the management of acute ankle injuries.”</td>
</tr>
<tr>
<td>Köhne 2007</td>
<td>2007</td>
<td>RCT</td>
<td>30</td>
<td>Recent sprain in chronic recurrent ankle sprain patients</td>
<td>Manipulation (6 sessions over 4-week period) vs. single manipulation (talocrural manipulation).</td>
<td>“Subjects in multiple manipulation treatment arm demonstrated statistically significant improvement in 2 measures of proprioception as well as ROM in dorsiflexion.”</td>
<td>“[M]anual manipulation of the ankle is an effective treatment for chronic ankle sprains...It is suggested that careful manipulative therapy in conjunction with exercise may offer effective therapy for recurrent ankle sprain.”</td>
</tr>
</tbody>
</table>

Methods: Sparsely detailed, 6 subjects excluded after inclusion of convenience sample. States placebo single-blinded study, but blinding or placebo use unclear. Comparison: Manipulation to detuned ultrasound. No placebo of “manipulation.”

Lack of study details. Single blinding claimed of control group although blinding not of treatment. Results are of unknown clinical significance.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>N</th>
<th>Setting</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
<th>Methodological Issues</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lopez-Rodriguez</td>
<td>2007</td>
<td>RCT</td>
<td>52</td>
<td>Field hockey players with Grade II ankle sprain</td>
<td>Manipulation (2 techniques) vs. placebo technique; single treatment, immediate follow-up results.</td>
<td>“Intergroup comparison revealed statistically significant differences in the increase in percentage of posterior load on the manipulated foot, percentage of bilateral posterior load, percentage of anterior load on the manipulated foot, and percentage of bilateral anterior load.”</td>
<td>Lack of study details. Patients received both intervention and placebo, although order and washout not clear. Placebo questionable as subjects presumably could discriminate between manipulation and simply holding foot with same manipulation grip. Results of no clinical significance.</td>
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<tr>
<td>Stasinopoulos</td>
<td>2004</td>
<td>RCT</td>
<td>52</td>
<td>Female volleyball players with ankle sprains</td>
<td>Technical training (land, takeoff technique) vs. proprioception vs. orthosis (ankle stirrup).</td>
<td>Ankle sprain recurrence during season (training vs. proprioception vs. orthosis): 2/18 (12%) vs. 3/17 (18%) vs. 6/17 (35%). No statistical analysis presented.</td>
<td>“All three preventive strategies were effective in athletes who had suffered ankle sprain once or twice only during their career.”</td>
<td>Lack of study details. No compliance data for each intervention limits results. No statistical analyses presented.</td>
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</tr>
<tr>
<td>Coughlan</td>
<td>2007</td>
<td>RCT</td>
<td>20</td>
<td>From active athletic population</td>
<td>Four week neuromuscular training program (proprioception, conditioning, strength) vs. no exercise group.</td>
<td>No significant differences in ankle joint position or velocity of postural control (p &gt;0.05).</td>
<td>“The mechanisms by which neuromuscular training improves function in normal subjects and those with functional ankle instability do not appear to result in measurable changes in gait kinematics.”</td>
<td>Randomization performed on matched pairs of healthy subjects (no previous injury). Results are of unknown clinical significance.</td>
<td></td>
</tr>
<tr>
<td>Engeberson</td>
<td>2008</td>
<td>RCT</td>
<td>508</td>
<td>Male soccer players with history</td>
<td>Identified athletes at high risk for injury (previous injury). Intervention</td>
<td>Injury incidence (intervention vs. control) ankle: 10/102 (10%) vs. 14/107 (13%), RR 0.9 (0.5-1.3) p = 0.21. Knee,</td>
<td>“Although we were able to identify players with an increased injury risk through a comprehensive questionnaire, Randomization, allocation methods not described. No blinding. Cointerventions not controlled</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>N</td>
<td>Group</td>
<td>Interventions</td>
<td>Outcomes</td>
<td>Comments</td>
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<tr>
<td>Mohammadi 2007 RCT</td>
<td>3.0</td>
<td>N = 80 male soccer players with previous ankle inversion sprain</td>
<td>Proprioception training (ankle disk) vs. evertor muscle strength training vs. orthosis (Aircast stirrup) vs. no treatment control for prevention of recurrent ankle sprain.</td>
<td>Number of incidence (injuries/1000 players), relative risk of injury (95% CI), and percent sprained. Proprioception: 0.13/0.003-0.93/5%. Strength: 0.5/0.11-1.87/20%. Orthosis: 0.25/0.03-1.25/10%. Control: 3.33/0.12-1.91/40%.</td>
<td>“Proprioceptive training, compared with no intervention, was an effective strategy to reduce the rate of ankle sprains among male soccer players who suffered ankle sprain.”</td>
<td>Lack of details on randomization, allocation, baseline comparability, blinding, compliance, co-interventions. Small sample, power may have been insufficient as incidence lower in orthosis group although p = 0.06. Duration of regimens not indicated.</td>
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</tr>
<tr>
<td>Verhagen 2004, Verhagen Br J Sports Med 2005 Cluster-RCT</td>
<td>3.0</td>
<td>N = 1,127 volleyball players (4 regions, 116 teams)</td>
<td>Normal training routines vs. addition of balance board training. Randomize by 4 geographic regions, all regional</td>
<td>Control group, 0.9 incidences of ankle injuries per 1000 hours, 95% CI of 0.6-1.2. In intervention group, 0.5 incidences of ankle injuries per 1000 hours, 95% CI 0.3-0.6. No differences</td>
<td>“Proprioceptive balance board program was effective in preventing recurrence of ankle sprains. However, there seemed to be an increase in recurrence of overuse knee injuries. Positive”</td>
<td>Single study with two reports. Cluster randomization. Lack of study details. Studies suggest balance board training may reduce recurrent ankle sprains, but increases risk of</td>
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</table>
teams assigned to control or intervention). between groups for total, training, match injury incidence. Costs per player: $93.87 vs. $47.09 (control) effects of the balance board programme could only be achieved at certain costs.”

**Verhagen Clin Biomech 2005**

| RCT  | N = 30 volleyball players | Balance program (14 exercises with balance board) vs. no balance program for 5.5 weeks. | Outcome measure is center of pressure (CoP) excursions measured by sway platform. No differences in any sway measures with and without eyes closed at end of training. | “The 5 1/2 week balance training programme applied in this study did not reduce CoP excursion in a general population of non-injured and previously injured subjects.” | Lack of randomization, allocation, compliance details. Small sample size. Non-randomized comparison group included. Results are of unknown clinical significance as outcome measure is surrogate for ankle instability but did not measure injury. |

**Wedderkopp 1999**

| Cluster-RCT | N = 237 young female players in European handball (22 teams) | Ankle disk 10-15 minutes all practice sessions with 2 or more functional activities for all major muscle groups vs. usual practice in healthy subjects. | More ankle and finger sprains in control group compared to intervention, p <0.05. | “[T]he intervention programme used in this study had a significant effect on the number of injuries and the injury incidence in young female European Handball players.” | Cluster randomization by team vs. individual player; included multiple injury outcomes. For ankle: 23 injuries in control vs. 6 in intervention, p <0.01. Effect cannot be made attributable to intervention in this study design. |

**Melnyk 2009**

<p>| RCT | N = 26 healthy subjects | Whole body vibration training x 4 weeks vs. no training. | No differences in latencies and reflex activity in both long peroneal and tibialis muscles in response to ankle sprain simulation or ankle inversion motion. | “…it is unlikely that 4-weeks of whole body vibration training has beneficial effects on ankle joint stability in the case of an ankle inversion motion.” | Lack of study details. Results are of unknown clinical significance as the subject population had no orthopedic injuries and outcomes measures did not include incidence |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Evidence Level</th>
<th>Methodology</th>
<th>Outcome</th>
<th>Intervention Details</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stasinopoulos 2004</td>
<td>2.0</td>
<td></td>
<td>See Ankle Support for Prevention above.</td>
<td>of injury post training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fauno 1993</td>
<td>3.0</td>
<td>See Evidence Table for Plantar Fascitis (Orthoses) above.</td>
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<tr>
<td><strong>Foot Orthotics for Prevention</strong></td>
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<tr>
<td><strong>Stretching/Strengthening Exercises</strong></td>
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<tr>
<td>Pope 2000</td>
<td>Cluster-RCT</td>
<td>3.5</td>
<td>N = 1,589 male army recruits (39 platoon s)</td>
<td>Stretching vs. no stretching for prevention of ankle sprain.</td>
<td>1538 recruits, 170 (11%) transferred to officer training before end of training. Incidence of lower-limb injury: 3.5 per 1,000 training days. Hazard ratio .95 (95% CI .77-1.18). Ligament sprain, ankle joint: control vs. stretch; 27 vs. 19 out of 175 and 158.</td>
<td>“[P]reexercise muscle stretching does not produce a clinically worthwhile reduction in the risk of lower-limb injury. Injury risk is strongly associated with age and 20mSRT scores. This suggests that fitness may be a modifiable risk factor for injury.”</td>
</tr>
<tr>
<td>Puls 2007</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 30 healthy subjects</td>
<td>No training vs. Thera-band training 3 times a week vs. Thera-band 5 times a week for 6 weeks.</td>
<td>Primary outcome of postural control measured on force plate. There were no differences related to intervention.</td>
<td>“[F]ound no significant improvements in static postural control among healthy individuals related to a specific Thera-band training regiment after six weeks of training regardless if the exercises were performed three or five times per week.”</td>
</tr>
<tr>
<td>Ekstrand 1983</td>
<td>RCT</td>
<td>1.5</td>
<td>N = 180 male soccer</td>
<td>Warm-up exercise program (passing soccer ball, prophylactic program vs. nonobservance prophylactic program vs. “The proposed prophylactic program, including close supervision and correction by sparse study details. No compliance to training data presented. Study suggests Thera-band training provides no benefit to healthy population. Results are of uncertain clinical significance.”</td>
<td></td>
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</tr>
<tr>
<td>Player flexibility stretches, cool down vs. control.</td>
<td>Control number of injuries: Strains 5/1/23, lower leg injuries (traumatic) 0/0/3, lower leg injuries (overuse) 1/0/7, ankle sprain in players with history of previous strain 0/2/9 (p &lt;0.05), reinjuries 0/0/13, knee sprains with ALRI 0/0/3, injuries due to fouls 1/0/6, injuries at training camp 1/0/8, injuries connected with prophylactic program 8/3/72, other injuries 12/0/21, total 20/3/93.</td>
<td>Doctors and physiotherapists, significantly reduces soccer injuries.</td>
<td>And ankle sprains.</td>
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<tr>
<td>Mohammadi 2007</td>
<td>3.0</td>
<td>See Balance/Proprioception Training above.</td>
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</tr>
</tbody>
</table>

**Physical or Occupational Therapy**

**Acute and Subacute**

<p>| Christakou 2007 RCT | 3.5 | N = 20 athletes who sustained Grade II acute ankle sprains | Imagery rehearsal and physical therapy vs. physical therapy. Total (heel and toe) risings between imagery rehearsal vs. control: 19.00±2.11 vs. 14.50±4.38, p &lt;0.0167. No differences heel or toe raising individually or in single-leg hop, stairs or balance measures. | “Results revealed significant differences only in the variable of muscular endurance. This study partly supports the contribution of imagery to the functional rehabilitation of grade II ankle sprain.” | Sparse study details for compliance, baseline comparability. Both groups with extensive PT (12 sessions over 4 week period). Study results suggest mental imagery techniques is of little benefit. |</p>
<table>
<thead>
<tr>
<th>Study Author</th>
<th>Year</th>
<th>N</th>
<th>Description</th>
<th>Design</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laufer 2007 RCT</td>
<td>3.5</td>
<td>40</td>
<td>volunteers referred to treatment within 4 months after Grade 1 or 2 ankle sprain; no concurrent impairment</td>
<td>Balance training: external attention focus vs. internal attention focus: 4 sessions</td>
<td>Outcomes after 4 sessions of training measured on stability index: EFA group experienced significant decrease in Overall Stability Index (OSI) p = 0.030. “External focus of attention is advantageous for the learning of a postural control task following an ankle injury.”</td>
</tr>
<tr>
<td>Youdas 2009 RCT</td>
<td>3.5</td>
<td>27</td>
<td>acute inversion sprains</td>
<td>Ankle-heel stretch to improve dorsiflexion in mild and moderate ankle sprains: Group 1: 30 second stretch vs. Group 2: 1 minute stretch vs. Group 3: 2 minute stretch</td>
<td>Active ankle dorsiflexion ROM: Mean improvement at 6 weeks (Group 1 vs. 2 vs. 3)-16°±5°, 19°±6°, 18°±9°, p &gt;0.05 for intergroup differences. “We were unable to demonstrate a significant group effect. Therefore, we are unable to recommend with confidence that after an inversion ankle sprain subjects perform a minimum of 3 daily static heel-cord stretches each of 30 seconds duration.”</td>
</tr>
<tr>
<td>Chaiwanichsiri 2005 RCT</td>
<td>3.0</td>
<td>40</td>
<td>male athletes with Grade 2 ankle sprain</td>
<td>Star-excursion balance training plus PT vs. PT for moderate acute sprains. PT included heat, ultrasound, ROM exercises, strengthenin g and balance training vs. control. Single leg stance time (SLST): eyes closed: 11.76+6.25 to 18.10+8.99 p &gt;0.05, vs. 14.65+18.43 to 39.91+22.51, p = 0.002. Eyes closed SLST: 58.68+38.99 to 72.39 +31.47 p &gt;0.05 vs. 74.82+73.49 to</td>
<td>“The 4 weeks program of Star Excursion Balance training is more effective in improving functional stability of the sprained ankle than the conventional therapy program.”</td>
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<td></td>
<td>Lack of study details. Clinical significance of single leg stance test is uncertain. Appears to include baseline differences in outcomes measures (SLST, recurrence of injury). No differences in sprain recurrence.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
<td>Treatment Description</td>
<td>Outcome Measures</td>
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<td>---------------</td>
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<td>-------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Wester 1996</td>
<td>Quasi-RCT</td>
<td>2.5</td>
<td>N = 61 primary ankle sprains</td>
<td>Wobble board + RICE vs. RICE</td>
<td>6/24 vs. 13/24 patients had recurrent sprains, p &lt;0.05. After 1, 6, and 12 weeks, no significant difference between groups for edema.</td>
</tr>
<tr>
<td>Asimenia 2013</td>
<td>RCT</td>
<td>2.0</td>
<td>N= 30 with unstabile ankles; ages ranged 20 to 22 (20.58± 0.64)</td>
<td>Land group, rehab program on land (n = 15) vs. Aquatic group, rehab program in swimming pool (n = 15). Both groups: static (total stability, anterior-posterior, and medial and lateral indices computed) and dynamic balance test</td>
<td>Mean ± SD for Balance Assessments: land vs. aquatic: injured: post-training: total stability index: 4.41±1.7 vs. 4.36±1.4, p &lt; 0.01; anterior-posterior index: 3.76±1.4 vs. 3.23±1.3, p &lt; 0.01; medial-lateral index: 3.41±0.9 vs. 3.12±1.1, p &lt; 0.01.</td>
</tr>
</tbody>
</table>
with Biodex Stability System (6 wks, 3x/wk); 20 min training program (45 secs/exercise, 15 secs rest). Follow up: pre- and post-training.

| Kim 2014 RCT | 1.5 N = 30 with ankle sprains | Mean ± SD for muscle strengthening: Group A vs. Group B vs. Group C: plantar flexion: 45.8±21.6 vs. 75.2±26.4 vs. 71.6±26.3, p < 0.05; dorsiflexion: 18.4±7.3 vs. 27.5±9.5 vs. 30.7±5.4, p < 0.05; inversion: 17.8±5.5 vs. 28.7±6.6 vs. 26.2±8.9, p < 0.05; eversion: 10.2±2.2 vs. 14.3±1.9 vs. 14.7±3.0, p < 0.05. | "Applying combined muscle strengthening and proprioceptive exercises to those who have functional ankle instability is more effective than applying only muscle strengthening exercises."

Three arms but poorly described and small N. Combination muscle strengthening and proprioceptive exercises to patients with ankle instability more effective than muscle strengthening exercises alone.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Minutes (n = 10)</th>
<th>Days off work: days at clinic (no support/physiotherapy/ double Tubigrip support/immobilized), 5.1:23.6/6.0:21.4/7.5:21.5/41.0:25.0.</th>
<th>“[M]obilisation, with early physiotherapy or even without, offers the most rapid return to functional activity.”</th>
<th>Lack of study details; 241 entered trial. High drop-out or exclusion rate(s). Not clear how many randomized.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brooks 1981 RCT</td>
<td>1.5</td>
<td>N = 104 inversion injuries during a 10-week period at regional accident unit</td>
<td>No support vs. physiotherapy vs. double Tubigrip support vs. immobilized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collado 2010 RCT</td>
<td>1.0</td>
<td>N = 28 with ankle sprains; mean age in eccentric group: 25.1, mean age for concentric group: 23.3, mean age for control group: 24.4</td>
<td>Concentric reinforcement (CG), foot inverted and everted, 10 reps, 2 min. rest period, proprioceptive rehabilitation on Freeman plate (n = 9) vs. Eccentric reinforcement (EG), foot blocked in eversion position, physiotherapy grasped lateral part of patient’s forefoot, push inwards, patient resisting inversion movement, returning to</td>
<td>Mean ± SD for peak torques: CG vs. EG: concentric mode: 29.11±11.8 vs. 38.6±16, p = 0.01, eccentric mode: 35.7±17.5 vs. 45.8±20.3, p = 0.01. Strength deficits for injured side vs. healthy side: concentric: CG vs. EG: -28% vs. 19%, p = 0.01; eccentric: -41% vs. 1.6%, p = 0.03.</td>
<td>“After the eccentric reinforcement in the EG group, the muscle strength was significantly greater during concentric movements. Eccentric rehabilitation therefore restored the strength of the injured evertor muscles. These results show the value of this method, especially as the weakness of these muscles after sprains is one of the main risk factors contributing to instability and the recurrence of sprains.”</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Score</td>
<td>N</td>
<td>Description</td>
<td></td>
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</tr>
<tr>
<td>Han 2009</td>
<td>RCT</td>
<td>3.5</td>
<td>40</td>
<td>Exercise CAI vs. exercise healthy normal vs. control CAI vs. control healthy normal. Post training (change over the first 4 weeks): Treatment t = -5.51/ p = 0.001, ankle sprain history CAI vs. healthy normal t = -2.76/ p = 0.010. “Balance was improved after 4 weeks of elastic resistance exercise in subjects with and without a history of lateral ankle sprains. Balance improvements persisted 4 weeks following the treatment cessation.”</td>
<td></td>
</tr>
<tr>
<td>Ross 2007</td>
<td>RCT</td>
<td>3.0</td>
<td>30</td>
<td>Conventional coordination training (CCT) vs. stochastic resonance coordination training (SCT) vs. control (no training). Programs 6 weeks. Center of pressure as outcomes measure: control vs. CCT - no pre or post-test differences. SCT group had less post-test COP than post-test pooled mean of control and CCT groups. “[C]oordination training alone did not result in significantly better postural stability than subjects who did not participate in coordination training at posttest. Coordination training with SR stimulation enhanced postural stability.”</td>
<td></td>
</tr>
<tr>
<td>Bernier 1998</td>
<td>RCT</td>
<td>2.5</td>
<td>48</td>
<td>Control (no treatment) vs. electrical stimulation sham treatment (peroneus). Maximum inversion test showed passive position sense better than active position sense, p. “[P]ostural sway can be improved in subjects with functional instability of the ankle following 6 weeks”</td>
<td></td>
</tr>
</tbody>
</table>

**Chronic Ankle Instability**

N = 40 (20 with chronic ankle instability, 20 healthy subjects)
longus and brevis) vs. 6 weeks of balance and coordination training. No differences between groups for sway index. Modified equilibrium score anterior/posterior: condition F (1, 42) = 56.64, p <0.001; eyes, F (1, 42) = 1118.18, p <0.001; F (2, 42) = 5.19, p <0.01. Modified equilibrium score medial/lateral: condition F (1, 42) = 89.2, p <0.001; eyes F (1, 42) = 1212.81, p <0.001; F (2, 42) = 6.90, p <0.003.

| Kidgell 2007 RCT | 2.5 | N = 20 athletes with functional ankle instability | Dura disc training vs. mini-trampoline training vs. control (routine daily activities) in subjects with hx of ankle inversion injury and ankle instability with injury in past 2 years. Balance training program 6 weeks. Postural Sway (pretest vs. post-test) in mm. Control: 36.9±9.9 vs. 36.7±8.2; Mini-tramp: 56.8±20.5 vs. 33.3±8.5, p = 0.003. Dura Disc: 41.3±2.6 vs. 27.2±4.8 p = 0.003. | “[R]esults indicate that not only is the mini-trampoline an effective tool for improving balance after LAS, but it is equally as effective as the dura disc.” Lack of randomization, allocation, co-intervention, compliance details. Small sample size with non-randomized comparison group included. Results are of unknown clinical significance as outcome measure is surrogate for ankle instability but did not measure injury. |
### Surgical Repair

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Intervention</th>
<th>vs.</th>
<th>Primary Outcome Measures</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powers 2004</td>
<td>1.5</td>
<td>N = 38</td>
<td>Strength vs. proprioception</td>
<td>vs.</td>
<td>No differences in muscle fatigue measures or static balance measures.</td>
<td>“Strength training, proprioception training, and the combination of the 2 failed to improve postural-stability characteristics in a group of subjects with functional ankle instability.”</td>
</tr>
<tr>
<td>Møeller-Larsen 1988</td>
<td>3.5</td>
<td>N = 200</td>
<td>Surgery vs. cast immobilization</td>
<td>vs.</td>
<td>Tendency of patients treated with tape to start to work earlier than other 2 groups, difference not significant; no differences in talar tilt. Report ankles asymptomatic: 21/34 vs. 20/29 vs. 34/40, p &lt;0.005 favoring tape.</td>
<td>“Patients treated with tape had fewer symptoms, fewer complaints when running, and more ankles recovered to the preinjury state. Therefore, in lateral ankle ligament rupture, tape bandages seem preferable.”</td>
</tr>
<tr>
<td>Specchiulli 2001</td>
<td>3.5</td>
<td>N = 100</td>
<td>Surgical repair vs. conservative care</td>
<td></td>
<td>Surgical vs. taping: Ankle Hind-foot Scale (100 point scale): 79+16 vs. 82+11 p &gt;0.05. Return to sports: 10 vs. 7 weeks, p &lt;0.05. Ankle swelling: no differences at any time.</td>
<td>“[I]n the short term, surgical treatment does not show any advantage over functional treatment. Therefore, nonsurgical treatment is recommended for grade III ankle ligament tears.”</td>
</tr>
<tr>
<td>Sommer 1989</td>
<td>3.5</td>
<td>N = 80</td>
<td>Surgery plus cast for 3 weeks vs. functional (strapping for 2 weeks)</td>
<td></td>
<td>Surgery vs. functional: Restriction in ROM at 6 weeks: 22/36 vs. 0/27. Restriction in ROM at 1-year: both groups full movement and normal stability.</td>
<td>“The comparably good results of functional and operative treatments reported by others are confirmed by our study.”</td>
</tr>
</tbody>
</table>

### Notes

- **Lack of study details** (randomization, allocation, baseline comparability, no blinding, compliance, co-interventions, follow-up).
- **Møeller-Larsen 1988**
  - RCT
  - 3.5
  - N = 200
  - Arthrographically verified rupture of 1 or both lateral ankle ligaments
  - Surgery vs. cast immobilization vs. tape (non-elastic) for 5 weeks, Grade II, III acute sprains.
  - Tendency of patients treated with tape to start to work earlier than other 2 groups, difference not significant; no differences in talar tilt. Report ankles asymptomatic: 21/34 vs. 20/29 vs. 34/40, p <0.005 favoring tape.
  - Patients treated with tape had fewer symptoms, fewer complaints when running, and more ankles recovered to the preinjury state. Therefore, in lateral ankle ligament rupture, tape bandages seem preferable.
  - Lack of details for randomization, allocation, baseline comparability, compliance. All sprains were confirmed by arthrography.
  - Suggests benefit of non-elastic tape for faster recovery than surgery.
- **Specchiulli 2001**
  - Quasi-RCT
  - 3.5
  - N = 100
  - Grade III injuries of lateral ankle ligament
  - Surgical repair vs. conservative care (taping x 40 days)
  - Surgical vs. taping: Ankle Hind-foot Scale (100 point scale): 79+16 vs. 82+11 p >0.05. Return to sports: 10 vs. 7 weeks, p <0.05. Ankle swelling: no differences at any time.
  - “[I]n the short term, surgical treatment does not show any advantage over functional treatment. Therefore, nonsurgical treatment is recommended for grade III ankle ligament tears.”
  - Quasi-randomization (odd/even birth year), Many details sparse. Compliance, dropout rate unknown. Results suggest no difference in functional outcomes although taping resulted in faster return to sports.
- **Sommer 1989**
  - RCT
  - 3.5
  - N = 80
  - Recent rupture of fibular ligament
  - Surgery plus cast for 3 weeks vs. functional (strapping for 2 weeks)
  - Surgery vs. functional: Restriction in ROM at 6 weeks: 22/36 vs. 0/27. Restriction in ROM at 1-year: both groups full movement and normal stability.
  - “The comparably good results of functional and operative treatments reported by others are confirmed by our study.”
  - Sparse study details. Grade of sprains likely moderate and severe, but not specified. No statistical analysis.
### Ankle and Foot Disorders

<table>
<thead>
<tr>
<th>Author/Year</th>
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</thead>
<tbody>
<tr>
<td>Zwipp 1992</td>
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<tr>
<td>Korkala 1987</td>
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<tr>
<td>Niedermann 1981</td>
</tr>
<tr>
<td>van den Hoogenband 1984</td>
</tr>
<tr>
<td>Gronmark 1980</td>
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<tr>
<td>Clark 1965</td>
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</tbody>
</table>

#### TIBIA SHAFT FRACTURES – OPERATIVE MANAGEMENT

<table>
<thead>
<tr>
<th>Author/Years</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Niedermann 1981</td>
<td>2.5</td>
<td>N = 444 acute ankle sprains</td>
<td>Surgery plus cast for 5 weeks vs. cast for 5 weeks; randomized portion likely moderate and severe sprains.</td>
<td>Outcomes measures: strapping (non-randomized Grade I) vs. plaster vs. operation. No differences in return to sport, functional recovery, pain when walking. Good Results: 76% plaster vs. 81% operative (p = NS).</td>
<td>“[T]here was no statistically significant difference between the results of conservative and operative treatment of rupture of the lateral ligaments of the ankle.”</td>
<td>Sparse study details. Only 209/444 randomized. Results did not clearly indicate if randomized portion considered separately. High drop-out rate at 1-year follow-up (37%). No differences in treatment in any major indicator.</td>
</tr>
<tr>
<td>van den Hoogenband 1984</td>
<td>2.5</td>
<td>See Casting above.</td>
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</tr>
<tr>
<td>Gronmark 1980</td>
<td>2.0</td>
<td>See Casting above.</td>
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</tr>
<tr>
<td>Clark 1965</td>
<td>1.5</td>
<td>N = 24 with injuries of the lateral ligaments of ankle</td>
<td>Surgical repair vs. cast immobilization.</td>
<td>Surgical vs. cast: Average return to full duty (weeks): 12 vs. 8, p not specified. Excellent results (time measured not indicated) 9/12 vs. 9/12</td>
<td>“In terms of function...there was no difference between the two groups. Surgical treatment, however, is associated with a greater morbidity.”</td>
<td>Timing of outcome measures unclear. Duration of conservative group immobilization not defined. Operative group received PT. Suggests outcomes similar in functional measures. Earlier return to work in cast group.</td>
</tr>
<tr>
<td>Authors</td>
<td>Year</td>
<td>Study Design</td>
<td>n</td>
<td>Study Population</td>
<td>Intervention</td>
<td>Results</td>
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<tr>
<td>Fernandes</td>
<td>2006</td>
<td>RCT</td>
<td>45</td>
<td>with closed multi-fragmented tibial diaphyseal fractures AO classification type B or C</td>
<td>Nonreamed interlocking intramedullary nails (n = 23) vs. bridging plates (n = 22).</td>
<td>No infections. Healing time for nails group was 20.3 weeks, for plates 16.0 weeks (p = 0.019). No differences in mobility.</td>
</tr>
<tr>
<td>Wyrsch</td>
<td>1996</td>
<td>RCT</td>
<td>39</td>
<td>with intra-articular fracture of the tibial plafond</td>
<td>Open reduction and internal fixation (n = 18) vs. external fixation and limited internal fixation (n = 20).</td>
<td>No statistical differences in radiographic or functional results measured by clinical scores between groups; 15 operative complications in 7/19 ORIF group; 4 in 4/20 external fixation with or without limited internal fixation. Follow-up on average 39 months after injury.</td>
</tr>
<tr>
<td>Moore</td>
<td>2006</td>
<td>RCT</td>
<td>127</td>
<td>unstable malleolar fractures with fluoro-scopically confirmed tibiofibular instability</td>
<td>Fixation of syndesmosis, with 3.5mm screws through 3 cortices. Non-weight bearing 6-10 weeks (n = 59) vs. fixation of syndesmosis, with Hardware failure: 3 = 5/59 (8%); 4 = 4/61 (7%). Loss of reduction: 3 = 3/59 (5%); 4 = 0/61 (0%). Screw removal: 3 = 4/59 (7%); 4 = 4/61 (7%). All 3 patients in 3 cortical fixation group who needed screw removals because of pain</td>
<td>Either three or four cortices of fixation are sufficient to stabilize the syndesmosis during healing.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Screws</td>
<td>Reduction and Fixation</td>
<td>Fixation</td>
<td>Fixator Details</td>
<td>Fixator Details</td>
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<tr>
<td>Rowley 1986</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 42 with displaced ankle fractures requiring reduction (Presumably AO B and C level of fracture)</td>
<td>Closed reduction and long leg plaster cast 6 weeks with early weight bearing encourage vs. ORIF using AO technique. Below-knee plaster cast 6 weeks with early weight bearing.</td>
<td>At 20 weeks from injury more of the closed reduction group regained normal movements and foot position.</td>
<td>“[I]f a good reduction can be achieved and maintained then closed treatment is as good as operative treatment in the short term and, indeed, seemed to result in a quicker return to normal gait.”</td>
</tr>
<tr>
<td>Salai 2000</td>
<td>RCT</td>
<td>1.5</td>
<td>N = 84 elderly patients with displaced closed trimalleolar ankle fractures with manipulation under anesthesia for reduction</td>
<td>Conservative therapy including short leg cast and mobilization vs. open reduction surgery.</td>
<td>Total ankle scores: 91.37±8.96 for non-operative group vs. 75.22±14.38 for operative group, p = 0.001.</td>
<td>“[C]onsideration of a non-operative approach to the treatment of well-reduced ankle fractures in the elderly.”</td>
</tr>
<tr>
<td>Dijkema 1993</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 43 closed non-</td>
<td>ORIF with biofix implants</td>
<td>Patients with biodegradable rods scored an</td>
<td>“Patients treated with the biodegradable”</td>
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</tbody>
</table>

**Malleolar Ankle Fracture Management**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Screws</th>
<th>Reduction and Fixation</th>
<th>Fixation</th>
<th>Fixator Details</th>
<th>Fixator Details</th>
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</tbody>
</table>

**Ankle Fracture Operative Management: Procedures and Fixators**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Screws</th>
<th>Reduction and Fixation</th>
<th>Fixation</th>
<th>Fixator Details</th>
<th>Fixator Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rowley 1986</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 42 with displaced ankle fractures requiring reduction (Presumably AO B and C level of fracture)</td>
<td>Closed reduction and long leg plaster cast 6 weeks with early weight bearing encourage vs. ORIF using AO technique. Below-knee plaster cast 6 weeks with early weight bearing.</td>
<td>At 20 weeks from injury more of the closed reduction group regained normal movements and foot position.</td>
<td>“[I]f a good reduction can be achieved and maintained then closed treatment is as good as operative treatment in the short term and, indeed, seemed to result in a quicker return to normal gait.”</td>
</tr>
<tr>
<td>Salai 2000</td>
<td>RCT</td>
<td>1.5</td>
<td>N = 84 elderly patients with displaced closed trimalleolar ankle fractures with manipulation under anesthesia for reduction</td>
<td>Conservative therapy including short leg cast and mobilization vs. open reduction surgery.</td>
<td>Total ankle scores: 91.37±8.96 for non-operative group vs. 75.22±14.38 for operative group, p = 0.001.</td>
<td>“[C]onsideration of a non-operative approach to the treatment of well-reduced ankle fractures in the elderly.”</td>
</tr>
<tr>
<td>Dijkema 1993</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 43 closed non-</td>
<td>ORIF with biofix implants</td>
<td>Patients with biodegradable rods scored an</td>
<td>“Patients treated with the biodegradable”</td>
</tr>
</tbody>
</table>

**Ankle Fracture Operative Management: Procedures and Fixators**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Screws</th>
<th>Reduction and Fixation</th>
<th>Fixation</th>
<th>Fixator Details</th>
<th>Fixator Details</th>
</tr>
</thead>
<tbody>
<tr>
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<td>ORIF with biofix implants</td>
<td>Patients with biodegradable rods scored an</td>
<td>“Patients treated with the biodegradable”</td>
</tr>
<tr>
<td>RCT</td>
<td>N = 37 displaced malleolar fractures aged 65 and older</td>
<td>Self-reinforced polyglycolide rods and screws (n = 16) vs. metallic screws and plates (n = 19)</td>
<td>Re-displacement occurred in 1/16 (6%) in biodegradable group. Exact reduction obtained in 15/16 (94%) biodegradable group and 16/19 (84%) metallic group.</td>
<td>“It seems that displaced malleolar fractures can be treated successfully also in elderly people using totally biodegradable self-reinforced polyglycolide rods and screws when comminution does not require plate fixation.”</td>
<td>Lack of study details. Suggests biodegradable implants achieved similar outcomes to metallic screws and plates in elderly patients with displaced malleolar fractures.</td>
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<tr>
<td>Kankare 1996</td>
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<tr>
<td>RCT</td>
<td>N = 72 Weber type B distal fibular fractures surgically repaired</td>
<td>Arthroscopically assisted open reduction and internal fixations (AORIF) (n = 41) vs. open reduction and internal fixation (ORIF) (n = 31).</td>
<td>AORIF: 30/41 (73.2%) had osteochondral lesions, 33/41(80.5%) had tibiofibular ligament disruption, 6/41 (14.6%) had no combined disorder found. Ankle Hind-Foot score: AORIF 91.0, ORIF 87.5 (p = 0.0106).</td>
<td>“In the treatment of distal fibular fractures, precisely diagnosing and treating the combined intra-articular disorders is important for gaining satisfactory clinical results.”</td>
<td>No blinding, minimal baseline characteristics included. No mention of co-interventions. At 1 year follow-up, AORIF patients appear to have better scores on Ankle Hind-Foot score. No increase in adverse events reported with AORIF over just ORIF.</td>
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<tr>
<td>Takao 2004</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>N</td>
<td>Condition</td>
<td>Intervention</td>
<td>Outcome</td>
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<tr>
<td>Bucholz 1994</td>
<td>3.5</td>
<td>RCT</td>
<td>155</td>
<td>Closed displaced malleolar fractures</td>
<td>Polylactide (bioabsorbable) screws vs. stainless-steel screws (control group)</td>
<td>No significant difference between groups for ability to walk, p = 0.95, run, p = 0.14, jump, p = 0.27, or climb stairs, p = 0.13. At 1 year, average ankle score: 83 points for study group, 79 for control, p = 0.13.</td>
</tr>
<tr>
<td>Ahl 1994</td>
<td>3.0</td>
<td>RCT</td>
<td>32</td>
<td>Supination-eversion fractures</td>
<td>Fixation with biodegradable polyglycolic acid rods or screws vs. metal wires, staples, and pins.</td>
<td>Residual displacement after operative treatment lateral malleolus rod: 0/15 poor; screw 0/17 poor; nondegenerative 0/13 poor. Medial mall: rod 0/3 poor; screw 0/7 poor; nondegenerative 0/13 poor. Tibialis posterior: rod 1/7 (14%) poor; screw 1/7 (14%) poor; nondegenerative 3/18 (17%) poor.</td>
</tr>
<tr>
<td>Kankare 1995</td>
<td>3.0</td>
<td>RCT</td>
<td>29</td>
<td>Closed displaced malleolar fx in alcoholics</td>
<td>Self-reinforced dyless polyglycolide (PGA) screws (Biofix) vs. metallic AO implants.</td>
<td>Difference in redisplacements significant between groups, 8/16 for PGA and 1/13 for metallic AO, p = 0.04. Wound infections: 4 superficial, 1 deep all in PGA group 5/16 (31%).</td>
</tr>
<tr>
<td>Moore 2006</td>
<td>3.0</td>
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<td>See Syndesmosis Injury Operative Technique above.</td>
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</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Patients</td>
<td>Study Design</td>
<td>Methodology</td>
<td>Results</td>
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<tr>
<td>Thordarson 2001</td>
<td>2001</td>
<td>N = 19 with SER or PER fractures with intact medial malleolus; no evidence of intra-articular pathology</td>
<td>Open plate fixation with arthroscopic visualization of joint vs. open plate fixation.</td>
<td>8/9 patients who had arthroscopy had evidence of articular damage to the dome of the talus. No difference in SF-36 scores or objective clinical findings between groups.</td>
<td>&quot;Most patients who underwent arthroscopic examination of the ankle joint were found to have a variable degree of articular cartilage damage at the dome of the talus…with no significant difference noted between groups in subjective or objective outcomes.&quot;</td>
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<td></td>
<td>Lack of study details. Does not appear to be clinically beneficial results from arthroscopic investigation of ankle joint in addition to open reduction and plate fixation in SER or PER fractures with an intact medial malleolus.</td>
<td></td>
</tr>
<tr>
<td>Reed 1998</td>
<td>1998</td>
<td>N = 54 undergoing open reduction and internal fixation</td>
<td>Immobilization with backslab (n = 28) vs. wool and crepe bandage (n = 26) for 1 day for post-op pain management.</td>
<td>Significant difference between groups for closet angle to plantigrade patient could achieve 1st day of physiotherapy, 25.0° for backslab group, 48.3° for wool and crepe group, p = 0.04.</td>
<td>&quot;Either a backslab or wool and crepe bandages may be applied after internal fixation of ankle fractures, depending upon the surgeon’s preference.&quot;</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td>Abstract with lack of details results in low-quality study. Study suggests no difference in post-op management of ORIF ankle fracture between back slab or crepe bandage.</td>
<td></td>
</tr>
<tr>
<td>Johal 2009</td>
<td>2009</td>
<td>N = 47 displaced intra-articular calcaneal fractures closed</td>
<td>ORIF with a bioabsorbable calcium phosphate paste to fill voids vs. ORIF.</td>
<td>No difference between groups Bohler angles at 6 weeks and 3 months. At 6 months Bohler angle collapse was: BSM: 5.6 degrees, ORIF: 9.1 degrees (p = 0.03). At one year BSM: 6.2 degrees, ORIF: 10.4 degrees (p = 0.05). No difference in SF-36, general health, limb specific function, pain.</td>
<td>&quot;The results of this study show that use of bioabsorbable calcium phosphate paste leads to less calcaneal collapse after operative management once weight bearing is begun. We suggest the use of a bioresorbable calcium phosphate paste to fill the cancellous bone defect and augment ORIF.&quot;</td>
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<tr>
<td></td>
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<td></td>
<td>No blinding or mention of co-interventions. Drop-out rate &gt;20%. Bioabsorbable group and less collapse of Bohler angle at 6 months and greater than 1 year. No clinical outcome differences noted at any times. Clinical correlation of findings warrant further study to see if any clinical benefits occur with</td>
<td></td>
</tr>
</tbody>
</table>

### Post Operative Care – Dressings

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Patients</th>
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<th>Methodology</th>
<th>Results</th>
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### Calcaneal Fractures: Operative Care – Cancellous Bone Defect Filling

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
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<tr>
<td></td>
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<td></td>
<td>Lack of study details. Does not appear to be clinically beneficial results from arthroscopic investigation of ankle joint in addition to open reduction and plate fixation in SER or PER fractures with an intact medial malleolus.</td>
</tr>
</tbody>
</table>

NYS WCB MTG – Ankle and Foot Disorders 369
### Dickson 2002

**RCT**

| Grafting material: BoneSource (BS) mineral product vs. Autograft (AG) from iliac crest or other location. | All fractures healed by 12 months follow-up. Maintenance of reduction observed in BS: 10/12 (83%), AG 10/15 (67%). Pain over fracture site resolved at 6 months: BS: 10/13 (77%), AG 9/16 (56%). (NS). | “Data from this demonstrate that BoneSource was both safe and effective as a bone void filler. The BoneSource showed equal or better maintenance of reduction than the autograft group.” |

Dickson 2002 RCT 3.0 N = 38 acute closed Type I fractures of radius, humerus, ulna, femur, tibia, or calcaneal, traumatic void requiring grafting.

### Post-Operative Rehabilitation: Immobilization, Early Mobilization, Early Weight Bearing

**Finsen 1989a; 1989b**

**RCT**

| Cast for 3 days, then no cast. Non-weight bearing. (A) Early motion with daily flexion, extension, inversion, eversion exercises vs. (B) Non-weight bearing plaster cast for 6 weeks vs. (C) plaster walking cast first 6 weeks. | Report 1: No significant difference in bone mineral content between 3 different treatment groups. Report 2: No complications with fracture healing in any of the groups. No difference in mean ROM of ankle. Weeks lost from work: A) 9.5, B) 13.8, C) 12.9 (NS). Participants encouraged to bear as much weight as possible). | “It appears that the amount of early weight bearing and active exercises after ankle fracture obtainable in clinical practice does not modify the degree of post-traumatic osteopenia. [T]he three postoperative regimens did not discernibly influence the clinical outcome, the risk of complications, or the delay in returning to work.” |

Finsen 1989a; 1989b RCT 3.5 N = 57 displaced ankle fractures including the lateral malleolus. Weber A, B, C. Treated operatively. All casts removed after 6 weeks.

Small numbers, no blinding, no co-interventions, no mention of compliance with surgical after care. Study did not include control of no grafting. Suggests no difference in bone graft materials.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Value</th>
<th>Number &amp; Description</th>
<th>Intervention</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahl</td>
<td>1993</td>
<td>3.0</td>
<td>N = 40 dislocated bi- or trimalleolar fractures</td>
<td>Early weight bearing after 1 week of non-weight bearing in an orthosis vs. late weight bearing using dorsal splint.</td>
<td>Orthosis group had better dorsal flexion at 3 and 6 months, p &lt;0.05 and better plantar flexion at 3 months, p &lt;0.05 compared with dorsal splint group.</td>
</tr>
<tr>
<td>Fitzgerald</td>
<td>1994</td>
<td>1.5</td>
<td>N = 27 ankle fractures, type not described but all treated non-operatively</td>
<td>Immobilization in plaster for 6 weeks (n = 10) vs. plaster immobilization along with compression stocking for 6 weeks (n = 10) vs. immediate mobilization (n = 7).</td>
<td>Difference in limb circumference between control limb and fractured one less for stocking group vs. immobilization alone at 12 weeks (1.03±0.72 cms vs. 0.37±0.46 cms), p &lt;0.004, and 18 weeks (1.15±0.72cms vs. 0.45±0.30cms), p &lt;0.03. Reduction in limb swelling not seen in early mobilization group. Circumference at 5cm and 10cm from lateral malleolus decreased in compression stocking group only at 12 and 18 weeks.</td>
</tr>
</tbody>
</table>

When comparing the 4 postoperative regimes, only small differences between the groups were found. As early postoperative weight bearing considerably facilitates rehabilitation it is to be recommended.

Two different results included. Compliance with motion exercises or weight bearing status not noted. No increases in complications for early weight bearing at 18 months follow-up. Suggests no long-term differences from each protocol.

Lack of details. Compression stocking while in a plaster cast may decrease overall calf swelling.
<table>
<thead>
<tr>
<th>Study</th>
<th>Method</th>
<th>N</th>
<th>Description</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marsh 2006</td>
<td>RCT</td>
<td>55</td>
<td>Tibial plafond fractures with external and minimal internal fixation</td>
<td>In 31 patients who had follow-up after 2 years, no difference detected. NMG averaged 11.7 weeks in a fixator MG 15.5 weeks (p = 0.008).</td>
</tr>
<tr>
<td>Wilson 1991</td>
<td>RCT</td>
<td>10</td>
<td>Ankle fracture treated operatively or conservatively with immobilization in cast for 6 weeks</td>
<td>MT group: 5/5 at Week 5 had full dorsiflexion. 4/5 had full plantarflexion. Control group: 1/5 at Week 5 had full dorsiflexion. 2/5 had full plantarflexion.</td>
</tr>
<tr>
<td>Hernandez 2006</td>
<td>RCT</td>
<td>24</td>
<td>Closed ankle fractures requiring surgery</td>
<td>Cast plus percutaneous electrical stimulation (Myospares) for 6 weeks</td>
</tr>
</tbody>
</table>

**Post-Operative Care – Physical Therapy**

- **Wilson 1991**
  - Method: RCT
  - N: 10
  - Description: Exercise plus manual therapy 3 times a week for 5 weeks vs. exercise only 3 times a week for 5 weeks
  - Outcome: MT group: 5/5 at Week 5 had full dorsiflexion. 4/5 had full plantarflexion. Control group: 1/5 at Week 5 had full dorsiflexion. 2/5 had full plantarflexion.

  “The results of this small pilot study suggest that the use of manual therapy techniques and exercise used in the mobilisation of fractured ankles post-cast immobilisation is more effective than the traditional physiotherapy approach of mobilising exercises alone.”

- **Hernandez 2006**
  - Method: RCT
  - N: 24
  - Description: Cast plus percutaneous electrical stimulation (Myospares) for 6 weeks
  - Outcome: No adverse effects from Myospares reported. Reported trend (p >0.05) toward improvement in calf diameter as abstract description only. Sparse details.

  “The use of the Myospares device under a cast in patients after surgical fixation of ankle fractures has been demonstrated as...”
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sample Size</th>
<th>Treatment arms</th>
<th>Outcome measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parmar 1993</td>
<td>1993</td>
<td>Quasi-RCT</td>
<td>N = 80</td>
<td>Non-operative (elevation for 5-7 day with mobilization, then non-weight bearing cast for 6-8 weeks vs. ORIF with post-op cast and non-weight bearing for 6-8 weeks)</td>
<td>Displaced fractures: increased pain scores on VAS correlated with significant delays in return to employment (p &lt; 0.002), return to full recreational activities (p &lt; 0.01), and reduced patient satisfaction (p &lt; 0.000002)</td>
<td>Quasi-randomization (birth-year odd/even). Lack of detail on how many included in each group. No blinding or post-op compliance noted. Suggests non-displaced fractures superior to displaced fractures, regardless of treatment. In patients with displaced fractures, no significant differences in outcomes between surgery and cast.</td>
</tr>
<tr>
<td>Ibrahim 2007</td>
<td>2007</td>
<td>RCT</td>
<td>N = 46</td>
<td>Conservative treatment (C) of elevation for 5-7 days, movement as able, cast with non-weight bearing for 6-8 weeks vs. ORIF lateral approach. (Op) Plaster</td>
<td>AOFAS hindfoot score: C = 78.5, Op = 70.0 (p = 0.11). AOFAS foot function index: C = 24.4, Op = 26.9 (p = 0.66). Calcaneal fracture score: C = 70.1, Op = 63.5 (p = 0.41). Bohler's angle: C = 10.4° Op = 16.9° (p = 0.07). Height of calcaneus: C = 37.2 mm, Op = 38.2 mm (p = 0.57). Grade of Plaster</td>
<td>At a mean follow-up of 15 years, we have shown no difference between conservative or operative patients using both functional and radiological outcomes.</td>
</tr>
</tbody>
</table>

Calcaneal Fractures – Non-operative vs. Operative Care
<table>
<thead>
<tr>
<th>Metatarsal Fracture (Avulsion) – Operative Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wiener 1997</strong></td>
</tr>
<tr>
<td><strong>Quasi-RCT</strong></td>
</tr>
<tr>
<td><strong>3.0</strong></td>
</tr>
<tr>
<td><strong>N = 89 with avulsion fracture of 5th metatarsal (exclude d Jones fractures)</strong></td>
</tr>
<tr>
<td><strong>Short leg cast vs. Jones Fracture soft dressing.</strong></td>
</tr>
<tr>
<td><strong>Cast vs. dressing:</strong> Average time to union (days) 43 vs. 45, p = ns. Average time return to pre-injury level activity (days): 46 vs. 33, p&lt;0.05. Modified Foot score 86 vs. 92, p = NS.</td>
</tr>
<tr>
<td><strong>&quot;The Jones dressing proves to be an effective, non-debilitating treatment modality for avulsion fractures of the base of the fifth metatarsal. It allows patients an earlier return to full activity than when treated in a short leg cast, without the risk of compromising clinical or radiographic healing.&quot;</strong></td>
</tr>
<tr>
<td><strong>Quasi-randomization by even/odd day of injury presented. Baseline comparability details sparse. Loss to follow-up 35%. Study suggests no dressing for avulsion fracture may lead to quicker return to activity.</strong></td>
</tr>
</tbody>
</table>
Appendix D.5 - References


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240. Tóth-Kischkat A. Shockwave overview: principles - basic physics and definition of physical parameters. International Society for Medical Shockwave Treatment.


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