Management of Lower Limb Injuries

Remember to perform VTE risk assessment on **all** ambulatory patients with lower limb immobilisation (including non-weight bearing crutches)

Pelvis

Condition	Management	Disposal
Pelvic Iliac Wing	ATLS if significant mechanism Analgesia	Refer acutely to Orthopaedics Consider CT Imaging
Isolated Pubic rami fracture	Analgesia	If FWB - consider discharge with analgesia If elderly with social/ medical concerns, or NWB - refer RMO. No specific follow up from Orthopaedics
Dislocated prosthetic hip	Analgesia	Refer acutely to Orthopaedics
Fracture neck of femur	Analgesia IV fluids Oxygen Fast track system	Refer acutely to Orthopaedics
Traumatic Hip pain NWB or concerning features	Analgesia	See NOF protocol Refer acutely to Orthopaedics
Femoral shaft fractures	ATLS approach 2 large bore cannulae IV fluids Analgesia Femoral nerve block	Refer acutely to Orthopaedics
Supracondylar fracture	ATLS approach 2 large bore cannulae IV fluids Analgesia Femoral nerve block	Refer acutely to Orthopaedics

Knee

Condition	Management	Disposal
Dislocated patella	Entonox / Analgesia Straighten leg into full extension Reduce patella Ensure SLR X-ray if first occurrence Wool & crepe or cricket pad splint	Fracture clinic followup
Fractured patella	Analgesia	If undisplaced - Cylinder POP or Cricket pad splint If displaced or transverse - refer Orthopaedics
Intercondylar tibial avulsion	Cricket pad splint	Refer acutely to Orthopaedics
Significant ligamentous knee injury	X-ray Wool & crepe or cricket pad splint Crutches PWB	Refer acutely to Orthopaedics
Isolated ?Single ligamentous injury	X-ray Wool & crepe or cricket pad splint Crutches PWB	Fracture clinic follow up
Significant knee STI without clear ligament problems	Analgesia Crutches Wool and crepe if appropriate	A&E Physiotherapy referral as follow up
Tense haemarthrosis or lipo-haemarthrosis(post- trauma)	Analgesia	Refer acutely to Orthopaedics
Tibial plateau fracture	Analgesia Full leg backslab	Refer acutely to Orthopaedics

Condition	Management	Disposal
Fibula head fracture	Analgesia Consider ankle x-ray Check common peroneal nerve damage Full leg backslab Crutches PWB	Fracture clinic followup
Quadriceps or Patella tendon rupture	Cricket pad splint	Refer acutely to Orthopaedics

Lower Leg

Condition	Management	Disposal
Fibula shaft fracture	Analgesia, Full leg backslab Crutches PWB	Fracture clinic followup
Tibial shaft fracture	IV analgesia Full leg backslab MUA if angulated/displaced	Refer acutely to Orthopaedics
Fracture dislocation of ankle	IV morphine/Entonox +/- sedation Immediate reduction Back slab with stirrup Then x-ray	Refer acutely to Orthopaedics
Ankle fracture Weber A	Analgesia Consider splint / aircast boot Crutches Weight bear as comfortable	Advice leaflet

Condition	Management	Disposal
Ankle fracture Weber B	Analgesia Below knee backslab Crutches NWB	Fracture clinic followup but if talar shift or tender medially refer Orthopaedics acutely
Ankle fracture Weber C	Analgesia Backslab below knee	Refer acutely to Orthopaedics
Isolated medial malleolus fracture	Assess for proximal fibula fracture Backslab or airboat	Fracture clinic follow up
Ankle STI	If weight bearing Analgesia If non weight bearing Analgesia Crutches Ankle splint or Aircast boot if severe	No follow up A&E Physiotherapy referral as follow up
Talus fracture	Below knee backstab	Refer acutely to Orthopaedics
Intra-articular distal tibia fracture (pilon#)	Above knee backstab Analgesia	Refer acutely to Orthopaedics
Calcaneal fracture	Analgesia Wool and crepe	Refer acutely to Orthopaedics
Achilles tendon rupture	Consider urgent MSK ultrasound Below knee Backslab 30º plantarflexion (equinus) - NWB or Aircast Boot with 5 wedges - WB as tolerated	Refer acutely to Orthopaedics for trauma meeting
Avulsion injuries to foot/ ankle	Treat as for sprains	A&E Physiotherapy referral as follow up
Lisfranc fracture	Analgesia Wool and crepe	Refer acutely to Orthopaedics

Condition	Management	Disposal
Base of 5th Metatarsal Fractures	Wool and crepe Analgesia Consider velcro airboot if severe	Advice leaflet
5th Metatarsal Neck or shaft Fractures	Wool and crepe Analgesia Consider velcro airboot if severe	Fracture clinic followup
Other Isolated undisplaced Metatarsal fractures	Wool and crepe Analgesia Consider velcro airboot if severe	Fracture clinic followup
Multiple metatarsal fractures / crushed foot / High energy injury	Padded will and crepe Analgesia Crutches	Refer acutely to Orthopaedics
Toes fractures/ dislocation: hallux	Reduce if dislocated Wool and crepe Analgesia Consider backslab if severe	Fracture clinic followup
Toes fractures/ dislocations: other toes	No x-ray unless deformed MUA if required Neighbour strap,	No follow up