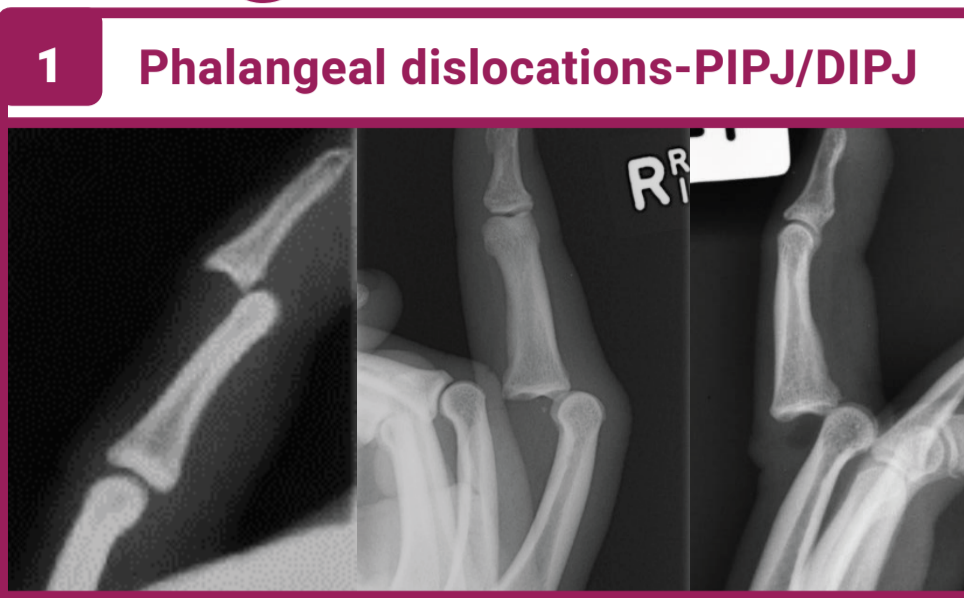


All open injuries and/or injuries with neurovascular compromise need discussion with appropriate team (orthopaedics or plastics)

Finger / Hand



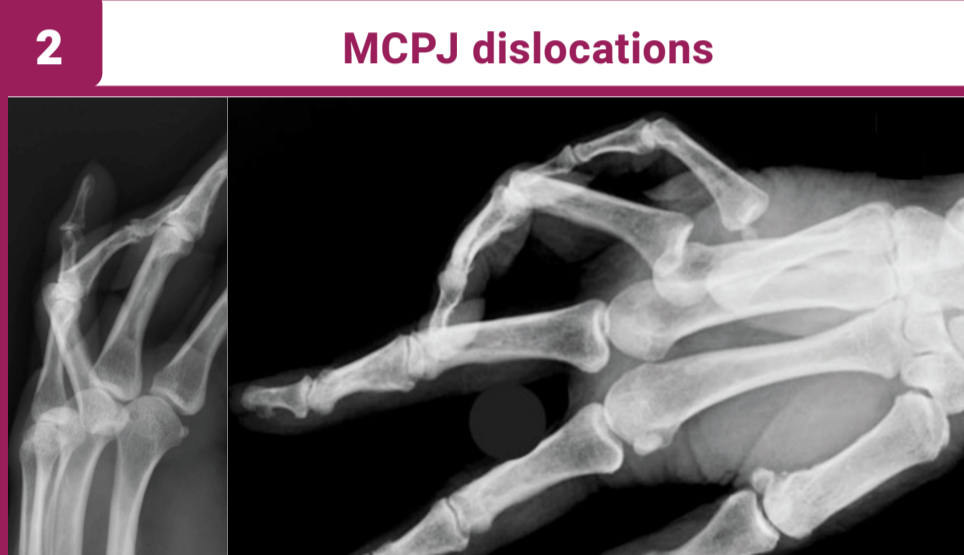
1 Phalangeal dislocations-PIPJ/DIPJ

Dorsal dislocations more common, usually sports ball injuries. If no fractures post reduction treat as volar plate injuries. Volar dislocations less common, post reduction treat as central slip injury-check with modified elson's test. Note DIPJ has no central slip but has a volar plate.

Immobilisation: Volar plate injuries 30° flexion thermoplastic splint. Central slip injuries extension thermoplastic splint. DIPJ dislocations (volar-rare) mallet/protective thermoplastic splint in slight flexion.

Follow up: Plastics OPD & hand therapy.

Red flags: if not sure if there is a volar plate versus central slip, central slip takes priority in splinting-apply extension thermoplastic splint and refer to plastics OPD for further follow up.



2 MCPJ dislocations

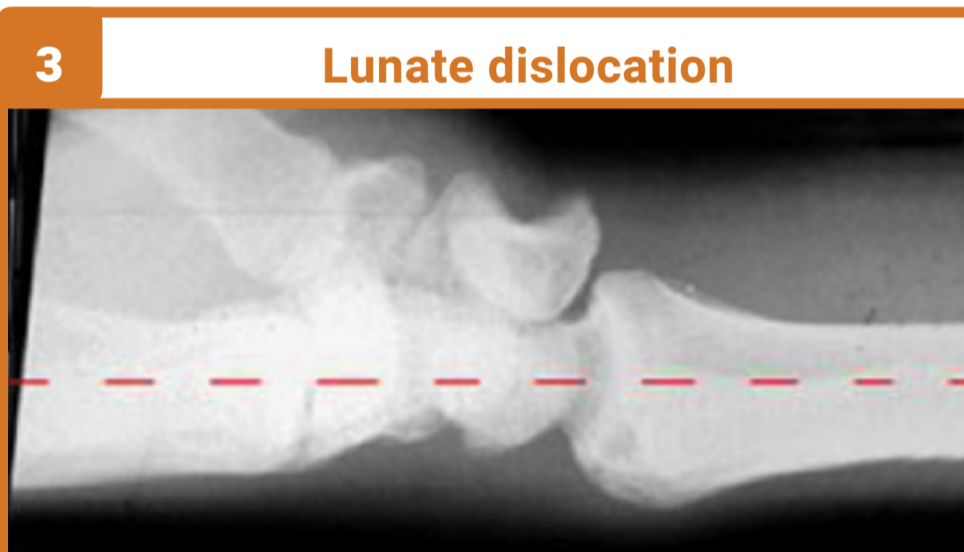
Dorsal dislocations more common. Volar dislocations rare. If dorsal dislocation has no fractures post reduction treat as volar plate injuries. To reduce dorsal dislocation, flex the wrist to take tension off the intrinsic+extrinsic flexors before applying direct pressure over dorsal aspect of proximal phalanx

Immobilisation: Radial or ulnar gutter backslab according to affected fingers. For thumb, zimmer splint at 30° flexion.

Follow up: Plastics consults for volar dislocations. Plastics OPD & hand therapy.

Red flags: if unable to reduce volar dislocations, may need open reduction. Discuss with plastics.

Wrist

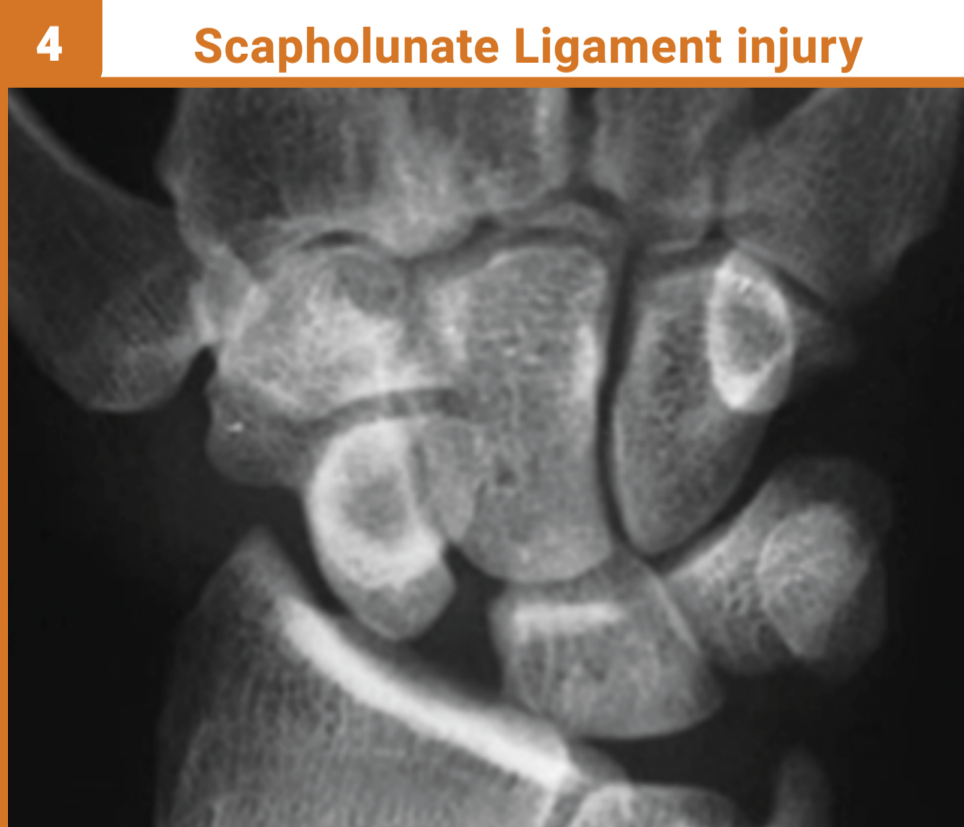


3 Lunate dislocation

- Loss of collinearity of radius, lunate and capitate on lateral view xray (usually volar)
- Scapholunate angle >70°
- Spilled teacup sign
- Closed reduction in ED Discuss with orthos about further management
- Immobilisation: Sugar tong backslab.

Follow up: Orthopaedics OPD.

Red flags: High risk of median nerve injury/acute carpal tunnel syndrome.



4 Scapholunate Ligament injury

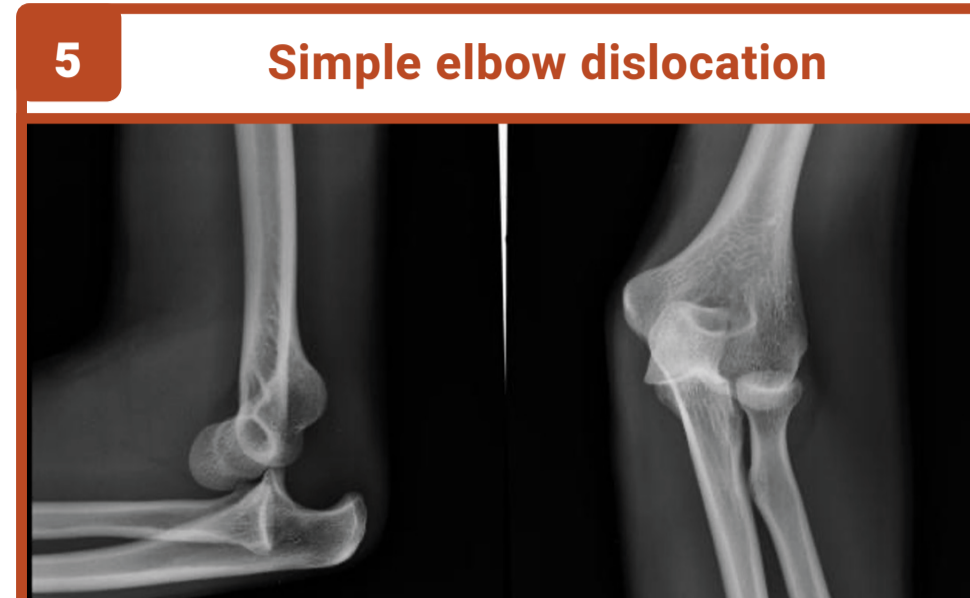
- Scapholunate gap >3mm in AP xray view (Terry Thomas sign)
- Scapholunate angle >70°
- Pain increase with extreme wrist extension and radial deviation.

Discuss with orthos about management.

Immobilisation: Dorsal backslab.

Follow up: Orthopaedics OPD.

Elbow



5 Simple elbow dislocation

Posterolateral dislocation is the most common.

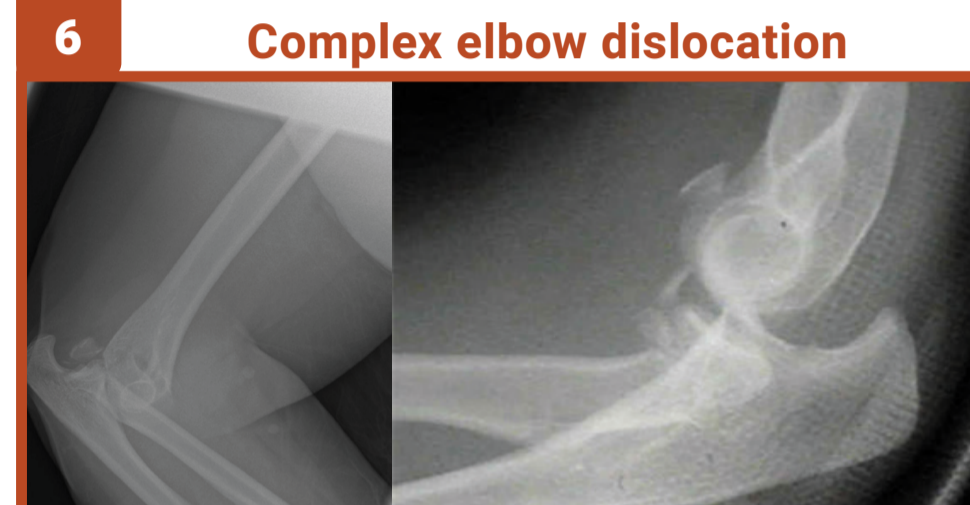
- No associated fractures
- No instability.
- Reduce in ED.

Discuss with orthopaedics about management.

Immobilisation: Broad arm sling.

Follow up: Orthopaedics OPD.

Red flags: Risk of brachial artery and ulnar nerve injuries.



6 Complex elbow dislocation

Terrible Triad Injury:

- Posterolateral dislocation most common
- Associated radial head/neck fracture and coronoid fracture
- Elbow instability
- LCL and possible MCL disruption.

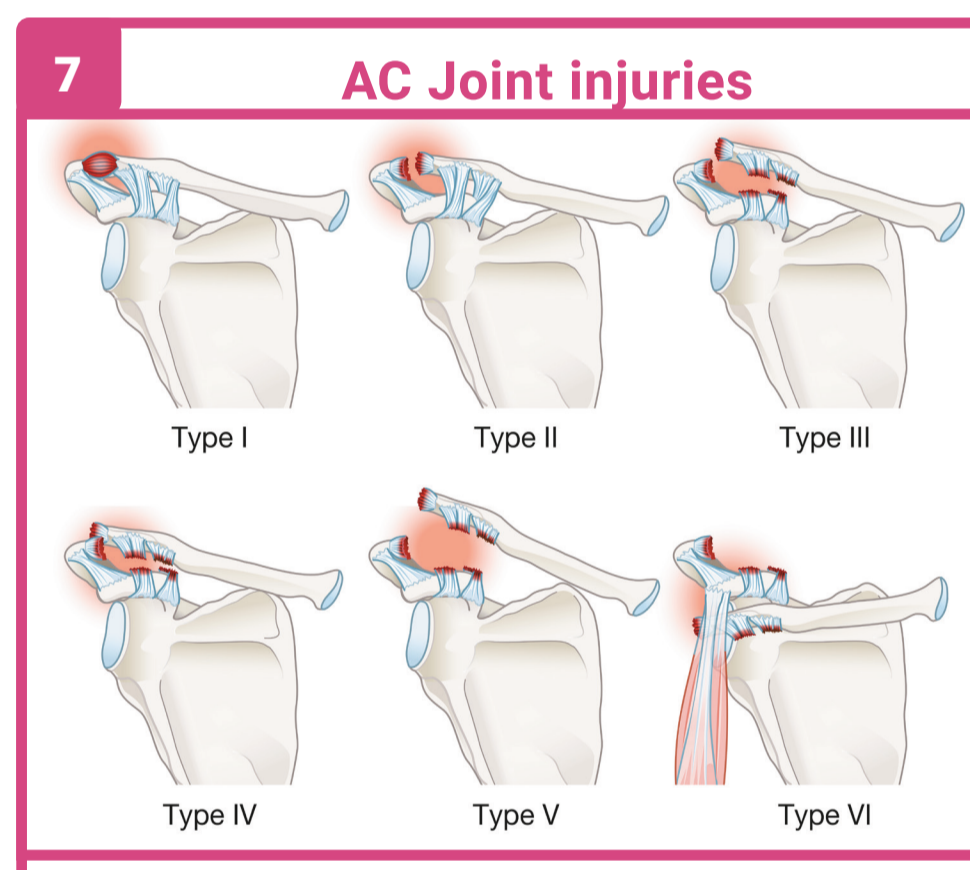
Reduce in ED and discuss with orthos for further management +- ORIF, risk of brachial artery and ulnar nerve injury.

Immobilisation: Above elbow backslab at 90° Flexion and forearm pronation.

Follow up: Orthopaedics OPD.

Red flags: If reduction cannot be performed closed is often due to entrapped soft tissue or osteochondral fragments, resting slab and discuss with orthos.

Shoulder

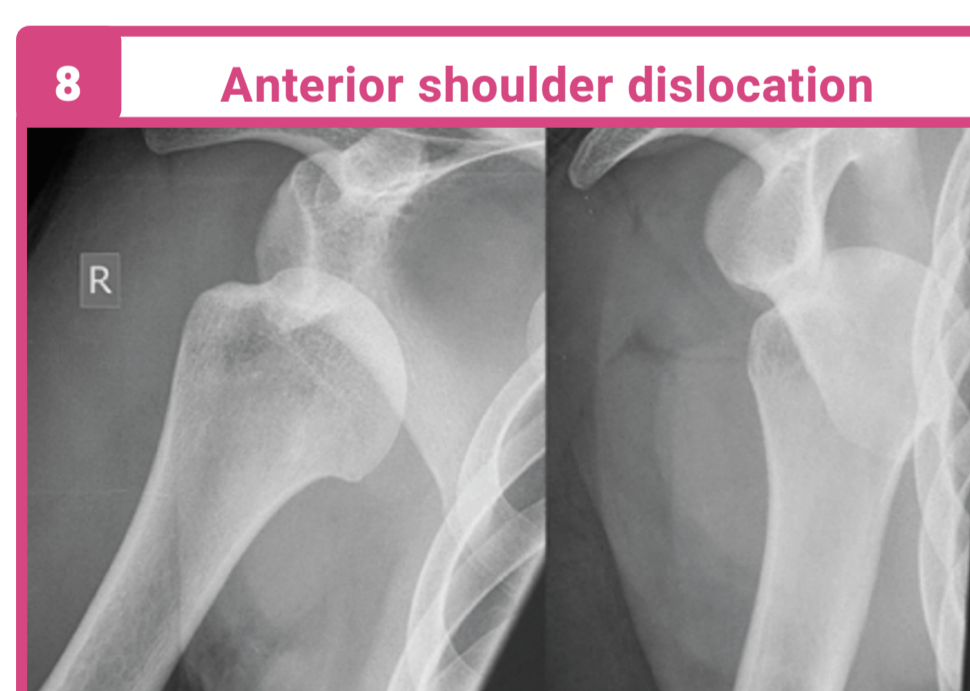


7 AC Joint injuries

- Uncomplicated: Type I-III <2cm displacement
- Complicated: Type III > 2cm displacement, IV-VI discuss with Orthos about potential ORIF.

Immobilisation: Broad arm sling.

Follow up: Uncomplicated-physio rehab. Complicated Orthopaedics OPD.



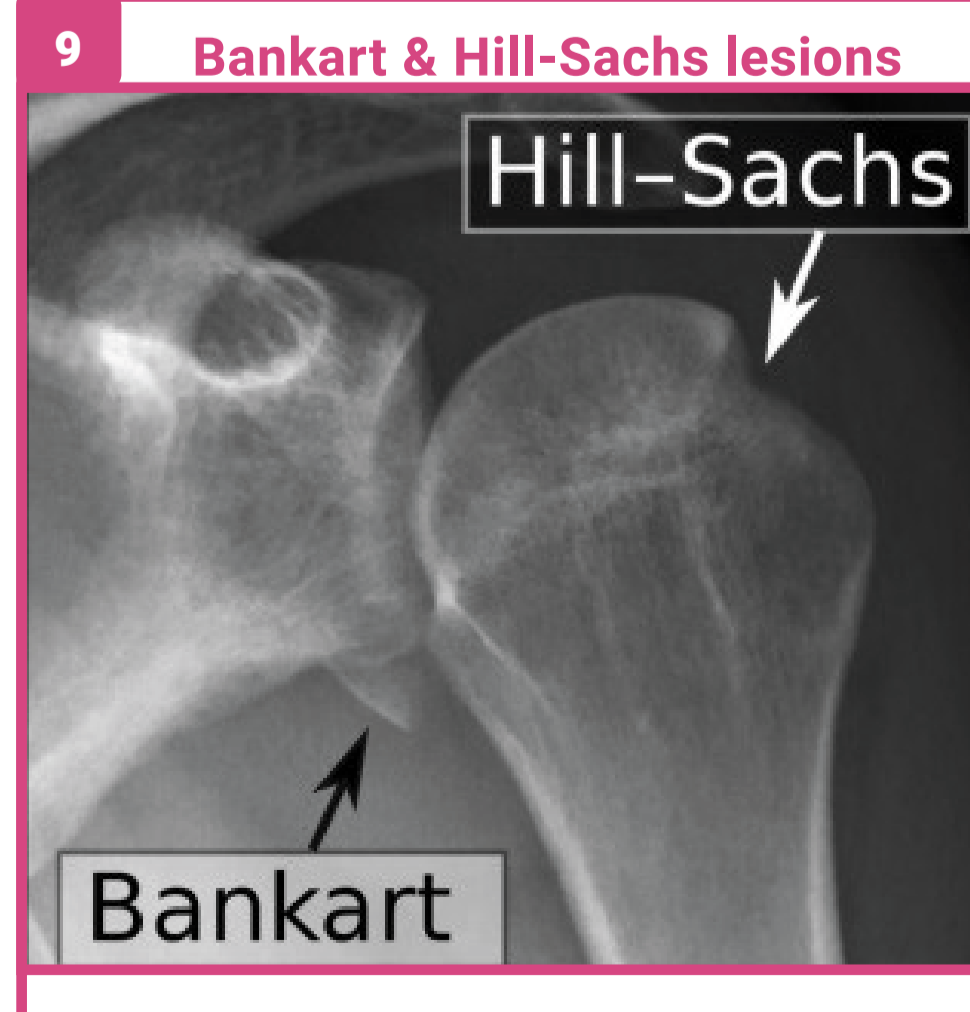
8 Anterior shoulder dislocation

- Uncomplicated: 1st dislocation without lesions/fractures
- Complicated: Multiple dislocations, fractures or associated lesions (Bankart/Hill-Sachs).

Discuss with orthos about management.

Immobilisation: Shoulder immobiliser sling for a week post-reduction in ED.

Follow up: Uncomplicated-physio rehab. Complicated Orthopaedics OPD.



9 Bankart & Hill-Sachs lesions

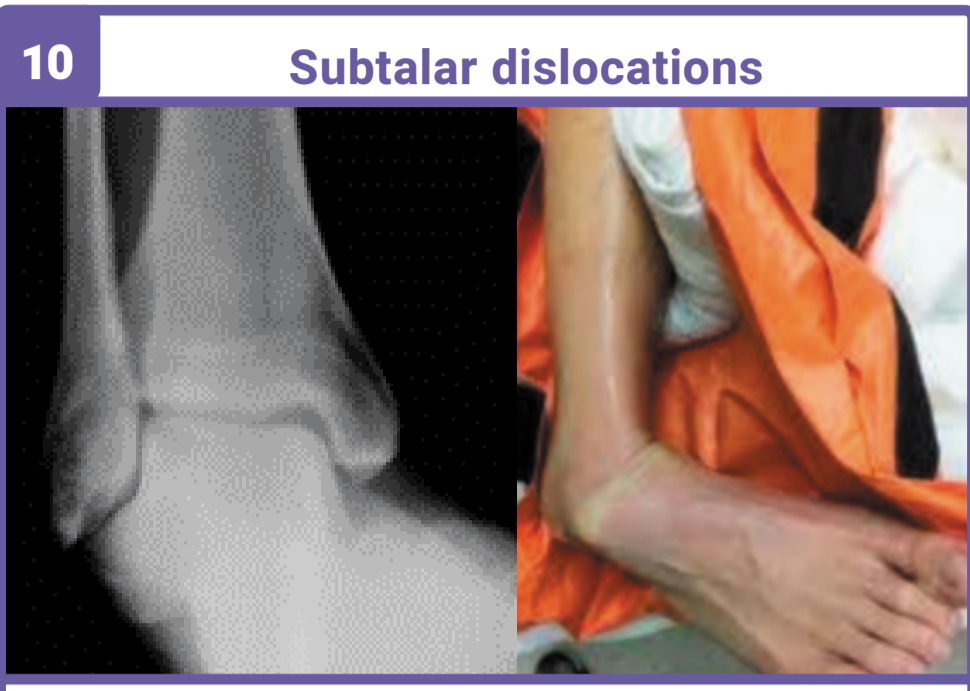
- Dislocated shoulder associated lesions
- Bankart: fracture/fragment of the anterior inferior glenoid labrum
- Hill-Sachs: Dent in the back of the humeral head.

Discuss with orthos about management.

Immobilisation: Shoulder immobiliser sling for a week post-reduction in ED.

Follow up: Ortho OPD.

Foot



10 Subtalar dislocations

- Hindfoot dislocation that result from high energy trauma
- Medial dislocation more common (acquired clubfoot), talar head will be superior to navicular on lateral view
- Lateral dislocation more likely to be open (acquired flatfoot), talar head will be collinear or inferior to navicular on lateral view
- Reduce in ED.

Discuss always with orthos about management.

Immobilisation: Below knee backslab, non-weight bearing.

Follow up: Orthopaedics OPD.



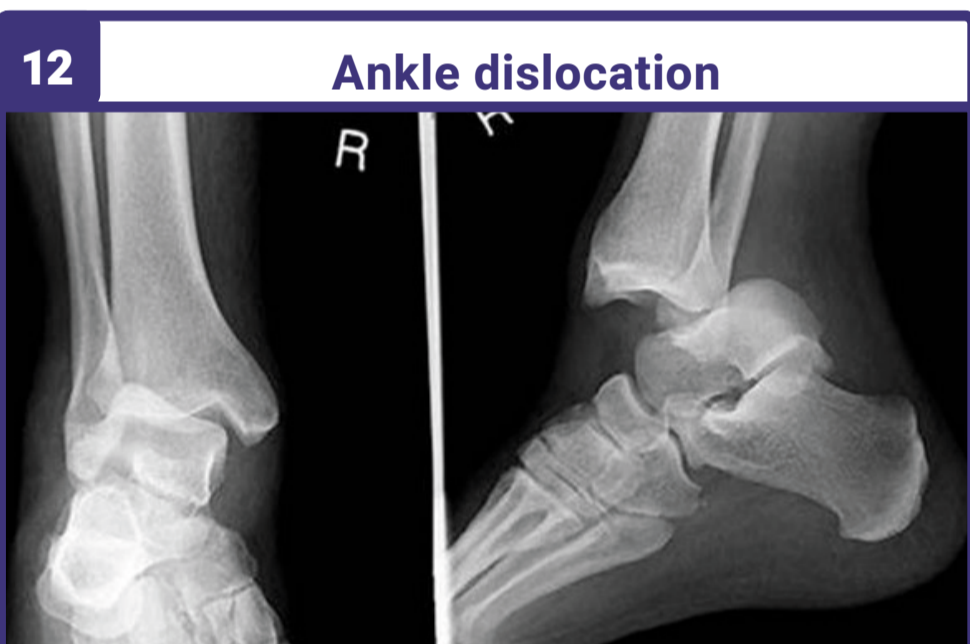
11 Toe dislocations-Interphalangeal/MTPJ

- Reduce in ED.

Immobilisation: Buddy splinting for a week.

Follow up: GP follow up.

Ankle



12 Ankle dislocation

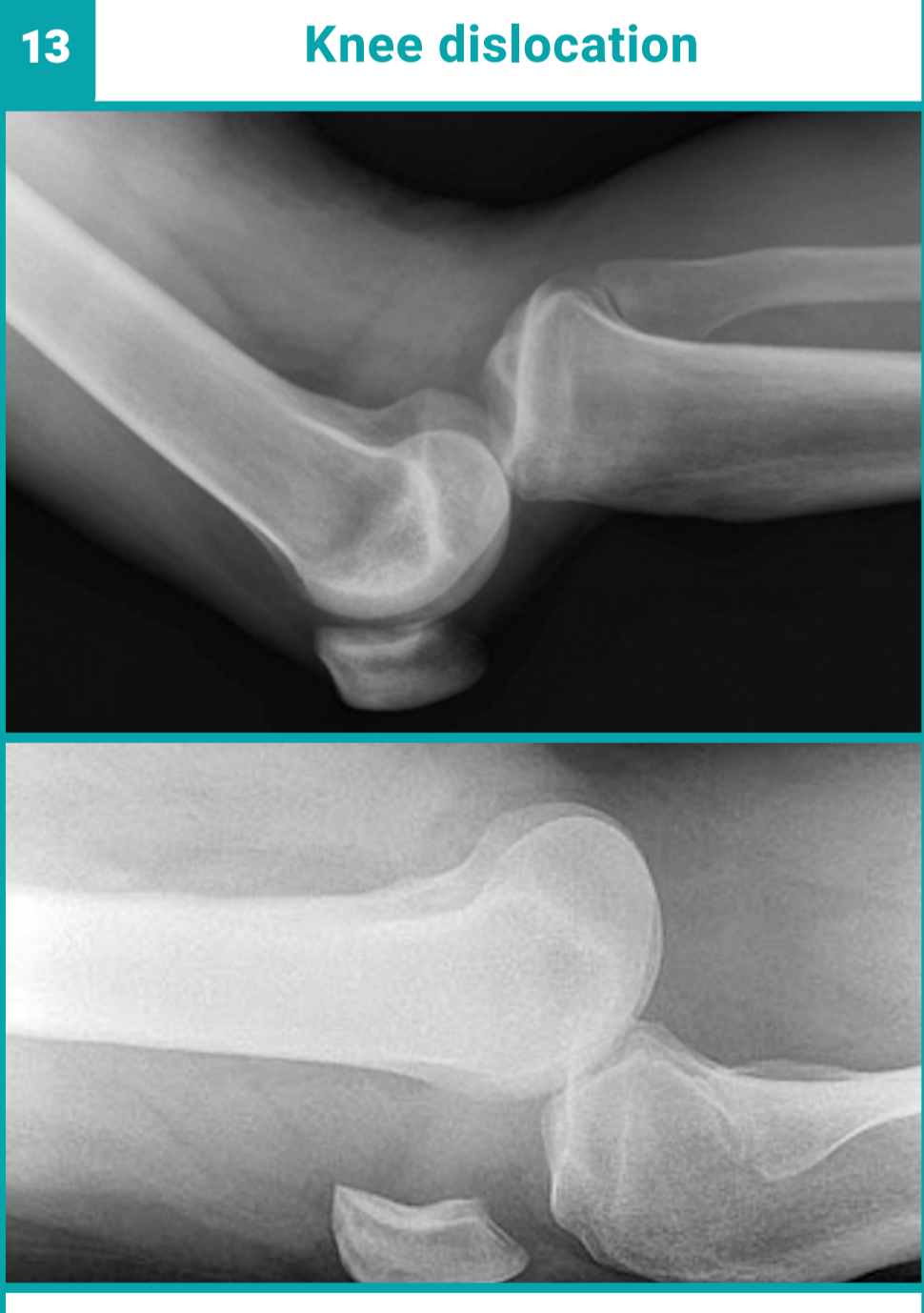
- Reduce in ED.

Discuss with orthos about management.

Immobilisation: Below knee backslab, non-weight bearing.

Follow up: Orthopaedics OPD.

Knee



13 Knee dislocation

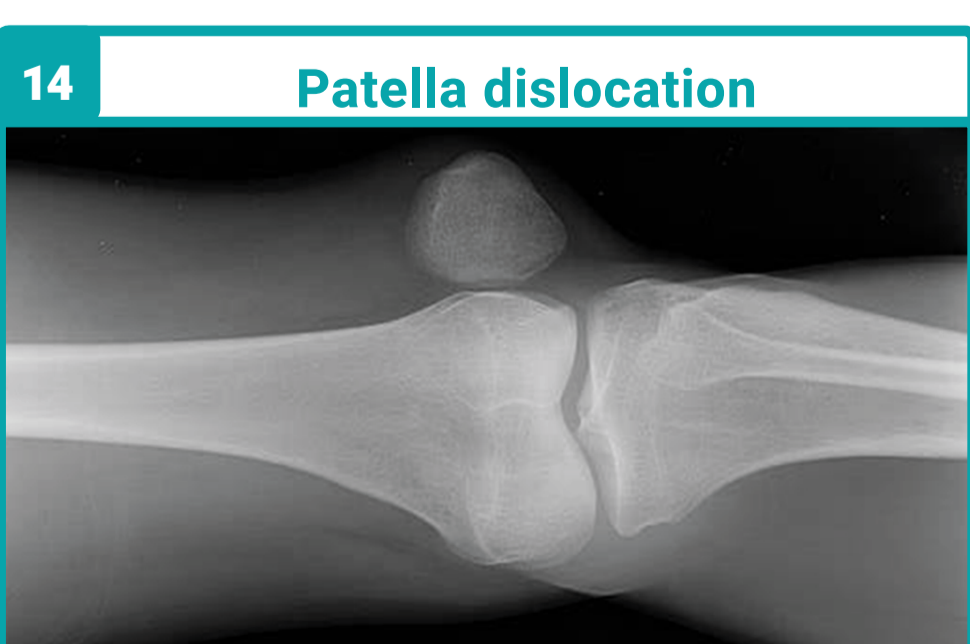
- High energy traumatic injuries
- Rule out vascular injury before and after reduction in ED.

Discuss with orthos immediately, may require vascular consult too.

Immobilisation: Above knee resting backslab at 20-30° flexion.

Follow up: Orthopaedics OPD.

Red flags: Orthopaedic emergency.



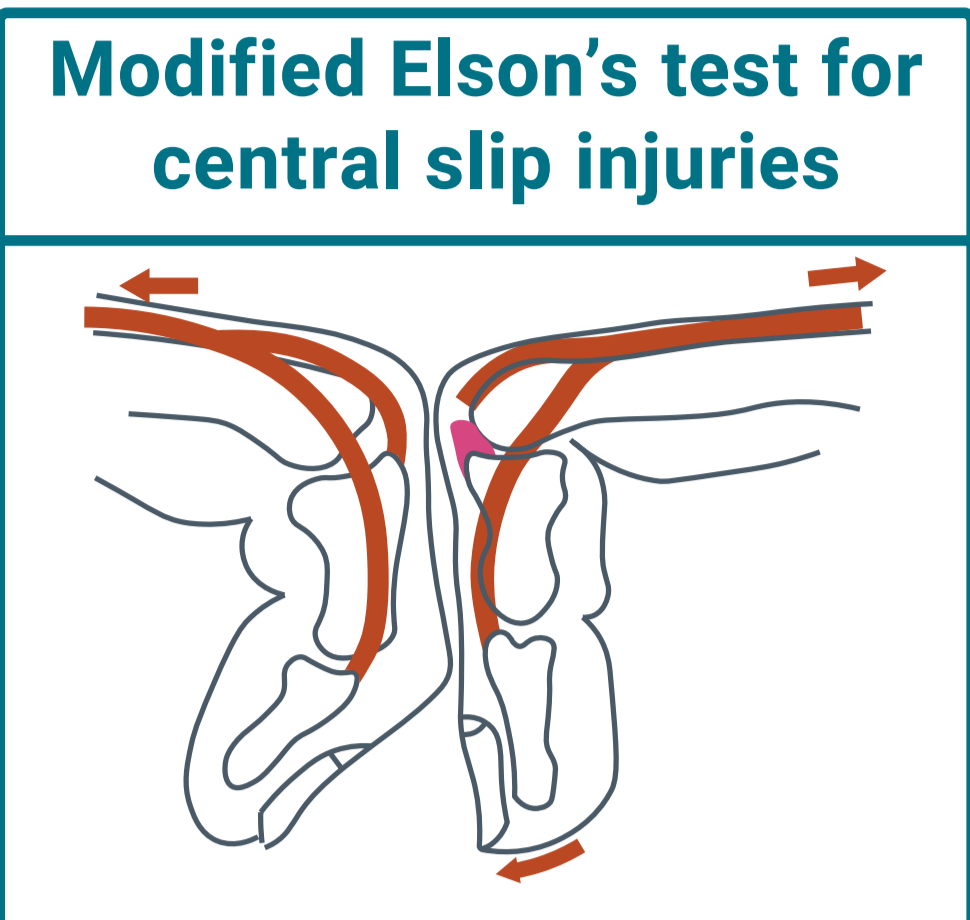
14 Patella dislocation

- Reduce in ED.

Immobilisation: Richards splint, weight bear as tolerated for 3-5 days.

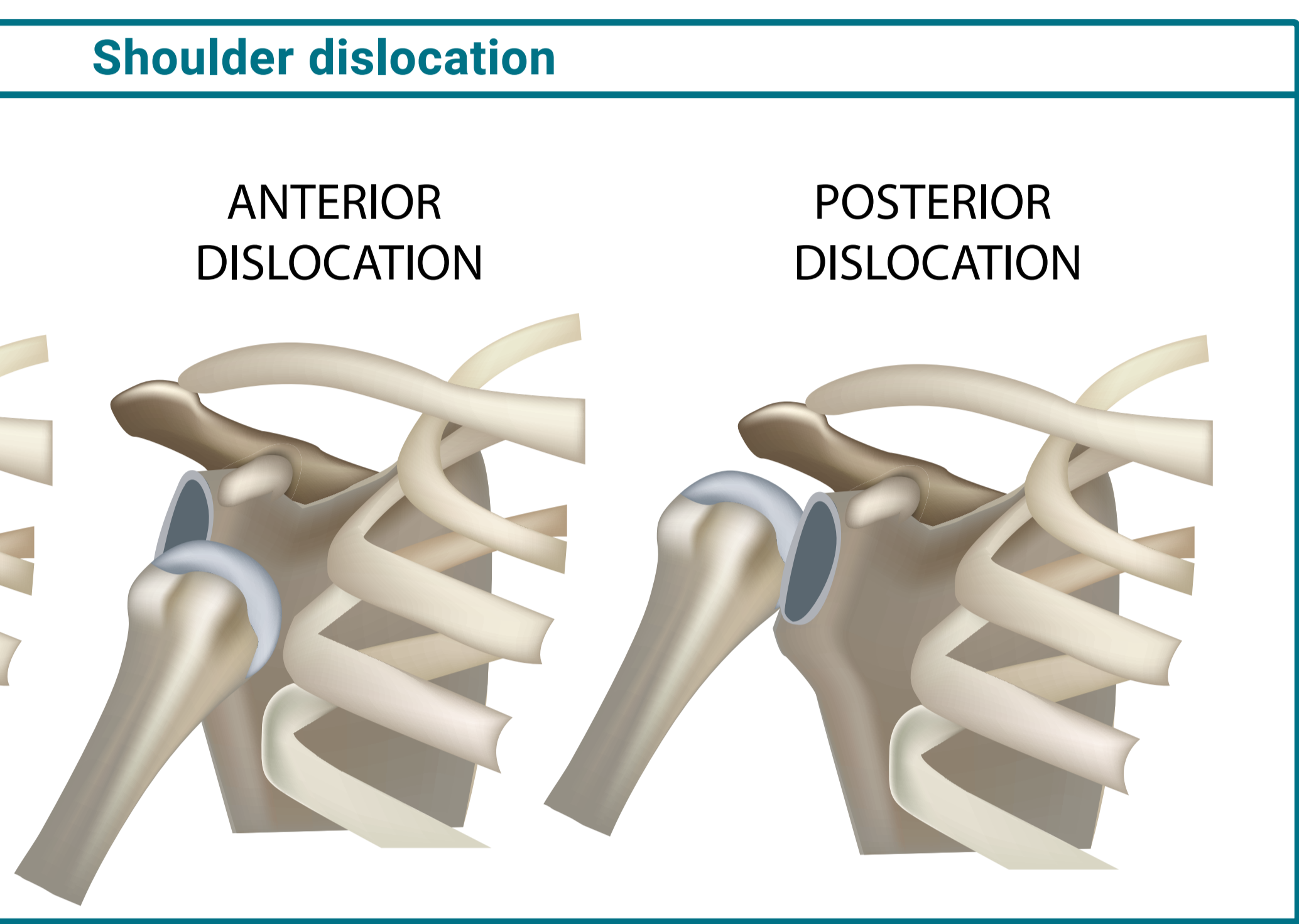
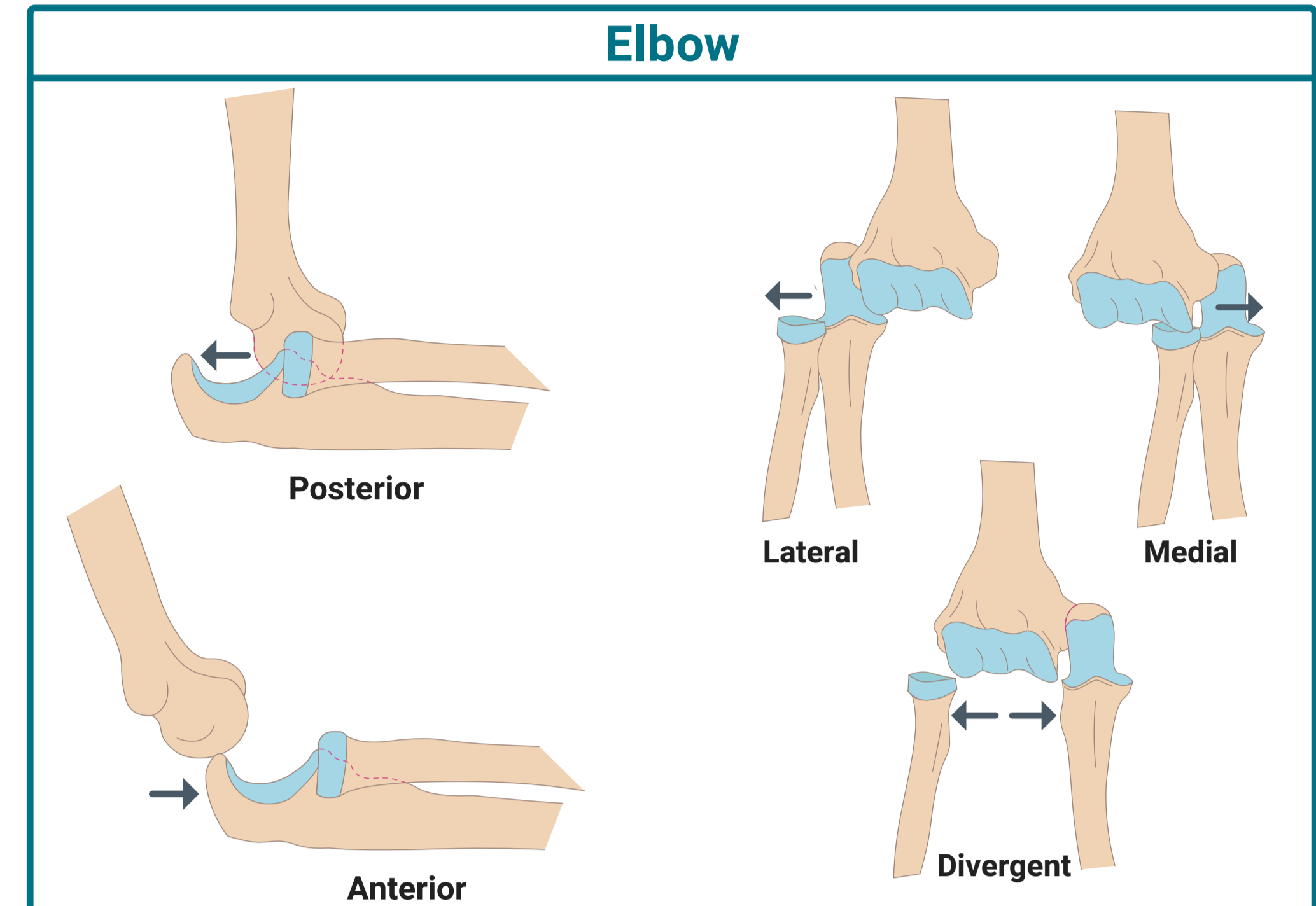
Follow up: Physiotherapist. If multiple dislocations have occurred or ongoing instability refer to ortho OPD.

Education



Modified Elson's test for central slip injuries

- Injured & contralateral fingers knuckle to knuckle in 90° PIP flexion, pr extends DIPs
- Normal: DIPs symmetrically flexed
- Central slip injury: Injured DIP extends more



Treatment and intervention

