

Clinical and Functional Outcomes of Common Peroneal Nerve Injury Associated with Proximal Tibial and Fibular Fractures

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ABSTRACT

Objective: To evaluate the clinical and functional outcomes of common peroneal nerve injury associated with proximal tibial and fibular fractures and to assess factors influencing neurological recovery.

Methods: A clinical observational approach was applied to patients presenting with proximal tibial and fibular fractures associated with common peroneal nerve injury. Patients were assessed through detailed neurological examination and functional evaluation. Fracture patterns were classified using radiological imaging. Nerve injury severity was determined by clinical findings and electrophysiological studies. Treatment modalities included conservative management, surgical fixation, and nerve exploration when indicated. Functional outcomes were evaluated through motor recovery, sensory improvement, and gait restoration during follow up.

Results: Improvement in neurological function was observed in patients with incomplete nerve injury and early intervention. Better outcomes were associated with minimally displaced fractures and timely fracture stabilization. Patients with severe traction injury and complete nerve disruption demonstrated limited recovery. Functional independence improved in cases receiving structured rehabilitation and orthotic support. Delayed presentation and severe fracture displacement were associated with poor motor recovery and persistent foot drop.

Conclusion: Common peroneal nerve injury associated with proximal tibial and fibular fractures results in variable functional outcomes depending on severity of injury and timing of intervention. Early diagnosis and appropriate management improve neurological recovery and functional independence.

Keywords: Common peroneal nerve injury, proximal tibial fracture, fibular fracture, neurological recovery, functional outcome, foot drop.

INTRODUCTION

Common peroneal nerve injury is recognized as a significant complication in association with fractures involving proximal tibia and fibula. The nerve is frequently affected due to its superficial course around the fibular neck and its limited soft tissue protection. The occurrence of neurological deficit in this region has been documented in orthopedic and neurosurgical literature as a cause of functional disability in lower limb function¹. The anatomical vulnerability is related to tethering points and minimal mobility of the nerve in the fibular tunnel. Trauma energy transmission in high velocity and low velocity mechanisms has been reported to contribute to nerve disruption². Clinical manifestations are often characterized by foot drop and sensory loss over dorsum of foot and lateral aspect of leg. The pathophysiology of nerve injury is considered to involve traction compression ischemia and contusion mechanisms³.

The proximal tibial and fibular fractures are commonly associated with high energy trauma and sports injuries as well as road traffic incidents. The alignment of fracture fragments may contribute to direct nerve insult or indirect compression through swelling and hematoma formation⁴. The peroneal nerve fibers are particularly susceptible to stretch injury due to limited elasticity. Progressive neurological impairment may occur in delayed fashion following initial orthopedic stabilization. The severity of fracture displacement has been correlated with increased risk of nerve involvement⁵. The anatomical course of nerve around fibular neck creates a fixed point that amplifies mechanical stress during trauma. Surgical interventions for fracture fixation may also contribute to iatrogenic injury in selected cases⁶.

Diagnosis of common peroneal nerve injury is based on clinical examination and electrophysiological studies. Clinical assessment includes motor testing of dorsiflexion and eversion weakness along with sensory evaluation. Electromyography and nerve conduction studies are utilized to determine severity and localization of lesion⁷. Imaging modalities including magnetic

resonance imaging and ultrasound have been used for evaluation of nerve continuity and surrounding soft tissue status. Early detection of nerve compromise is considered essential for optimizing functional recovery. Delayed diagnosis may result in irreversible muscle atrophy and long term disability⁸.

Functional outcomes in patients with peroneal nerve injury depend on severity of trauma and timing of intervention. Conservative management strategies include physiotherapy and orthotic support for foot drop. Surgical exploration and decompression have been indicated in selected cases with persistent deficit or evidence of nerve entrapment. Nerve grafting and repair procedures have been utilized in cases of transection or severe damage⁹. Rehabilitation programs focusing on muscle strengthening and gait training have been shown to improve functional independence. Prognosis varies widely depending on extent of axonal loss and patient related factors. Early mobilization and structured follow up are associated with improved recovery potential¹⁰.

Despite extensive clinical documentation of peroneal nerve injury in association with proximal tibial and fibular fractures there remains a lack of unified data regarding long term functional outcomes in different management approaches. Variability exists in reported recovery rates and prognostic indicators across different populations and treatment protocols. The influence of fracture pattern severity and timing of surgical intervention on neurological recovery has not been sufficiently standardized in literature. In addition limited regional data from developing healthcare systems restricts evidence based decision making in clinical practice. Differences in rehabilitation protocols and access to specialized neurophysiological testing further contribute to inconsistency in outcome reporting.

The research gap is therefore identified in the absence of comprehensive prospective evaluation of clinical and functional outcomes in patients with common peroneal nerve injury associated with proximal tibial and fibular fractures. There is insufficient correlation between radiological severity neurological deficit and long term functional recovery. Standardized outcome measures are not uniformly applied across clinical studies which limits comparability of results.

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The objective of this study is to evaluate the clinical and functional outcomes of common peroneal nerve injury associated with proximal tibial and fibular fractures and to analyze the relationship between injury characteristics treatment modalities and recovery patterns in order to improve evidence based management strategies in affected patients.

MATERIALS AND METHODS

Study Design and Setting: This study was conducted as a hospital based observational study at Lady Reading Hospital Peshawar which is a major tertiary care center providing neurosurgical and orthopedic services to a large population of the Khyber Pakhtunkhwa region. The study period extended from 23 July 2022 to 23 July 2023. A total sample size of 125 patients was included in the final analysis after applying inclusion and exclusion criteria. Patients presenting with proximal tibial and fibular fractures associated with clinical features of common peroneal nerve injury were enrolled and followed for clinical and functional outcomes. The study was carried out through coordinated effort between neurosurgery and orthopedic departments to ensure standardized evaluation and management of all cases.

Study Population and Enrollment: All patients presenting to the emergency and outpatient departments with traumatic fractures of proximal tibia and fibula during the study period were screened for eligibility. Patients with suspected or confirmed involvement of the common peroneal nerve were further evaluated for inclusion. Both male and female patients across a wide age range were included. Patients were enrolled after initial stabilization and confirmation of diagnosis. Each patient was followed from admission through hospital course and subsequent outpatient visits to evaluate neurological recovery and functional improvement over time.

Inclusion Criteria: Patients with radiologically confirmed proximal tibial fractures with or without associated fibular fractures were included in the study. Patients demonstrating clinical signs of common peroneal nerve injury such as dorsiflexion weakness, foot drop, reduced ankle eversion strength, or sensory impairment over the lateral aspect of the leg and dorsum of the foot were considered eligible for inclusion. Patients presenting within the defined study period who consented for participation and follow up were included. Both closed and open fractures were considered eligible provided that neurological deficit consistent with common peroneal nerve involvement was documented at initial assessment. Patients who underwent either conservative or surgical management of fractures were included to allow comparison of outcomes across treatment modalities.

Exclusion Criteria: Patients with pre existing peripheral neuropathy affecting lower limbs were excluded from the study to avoid confounding neurological assessment. Individuals with spinal cord injuries or central nervous system disorders causing lower limb weakness were also excluded. Patients with pathological fractures due to malignancy metabolic bone disease or systemic skeletal disorders were not included in the study. Cases with incomplete clinical records or insufficient radiological documentation were excluded from final analysis. Patients who were lost to follow up before completion of outcome assessment were also excluded. Patients refusing consent for participation were not enrolled in the study.

Clinical Evaluation: Detailed clinical evaluation was performed for all included patients at the time of admission. A structured history was obtained focusing on mechanism of injury timing of trauma and associated symptoms. Clinical examination included assessment of motor power of ankle dorsiflexion and foot eversion as well as sensory examination of lateral leg and dorsum of foot. The severity of nerve injury was categorized based on clinical findings into partial injury and complete injury patterns. Serial neurological examinations were performed during hospital stay and follow up visits to document progression or recovery of nerve function.

Radiological Assessment: Radiological evaluation was performed using standard anteroposterior and lateral radiographs of the tibia and fibula in all patients. Fracture characteristics including location

displacement and comminution were recorded in detail. Computed tomography scans were utilized in complex fracture patterns for better anatomical delineation. Magnetic resonance imaging was performed in selected cases where nerve entrapment soft tissue injury or hematoma compression was suspected. Radiological findings were correlated with clinical severity of neurological deficit to assess relationship between fracture pattern and nerve injury.

Electrophysiological Studies: Nerve conduction studies and electromyography were performed in patients who demonstrated persistent neurological deficits beyond initial stabilization phase. These studies were used to differentiate between neuropraxia axonotmesis and neurotmesis. Baseline electrophysiological assessment was conducted after initial fracture management and repeated during follow up when clinically indicated. Results of these studies were used to guide prognosis and further management strategies in selected cases.

Treatment Protocol: Fracture management was individualized based on stability and displacement. Conservative treatment included immobilization with plaster cast or splint in stable fracture patterns. Surgical fixation was performed in unstable displaced or comminuted fractures using standard orthopedic fixation techniques. In cases with suspected nerve entrapment or severe neurological deficit surgical exploration of the common peroneal nerve was considered. Intraoperative findings were documented when nerve decompression or repair was performed. Postoperative care included analgesia infection control and limb elevation.

Rehabilitation and Follow Up: All patients were enrolled in structured rehabilitation programs following initial stabilization. Physiotherapy focused on strengthening of lower limb musculature prevention of contractures and maintenance of joint mobility. Ankle foot orthoses were provided to patients with persistent foot drop to improve gait stability. Gait training and functional mobility exercises were incorporated into rehabilitation protocols. Patients were followed at regular intervals in outpatient clinics for assessment of motor recovery sensory improvement and functional independence.

Outcome Measures: Primary outcome measures included recovery of dorsiflexion strength improvement in sensory function and restoration of normal gait patterns. Secondary outcomes included duration of recovery and degree of functional independence achieved during follow up. Outcomes were categorized as complete recovery partial recovery or no recovery based on clinical evaluation at final follow up.

Statistical Analysis: Data were compiled and analyzed using standard statistical software. Continuous variables were expressed as mean and standard deviation while categorical variables were presented as frequencies and percentages. Comparative analysis was performed to evaluate association between fracture characteristics nerve injury severity and functional outcomes. Statistical significance was assessed using appropriate tests with predefined probability thresholds. Correlation analysis was applied to determine relationship between clinical variables and recovery patterns.

Ethical Considerations: Ethical approval was obtained from the institutional ethical review committee of Lady Reading Hospital Peshawar prior to initiation of the study. All procedures performed in the study involving human participants were in accordance with institutional and national ethical standards. Written informed consent was obtained from all patients or their legal guardians prior to inclusion in the study. Confidentiality of patient data was strictly maintained and all records were anonymized during analysis. Patients were informed about the purpose of the study and assured that participation would not affect their standard medical care. The study adhered to principles of patient safety and ethical research conduct throughout the entire duration.

RESULTS

Demographic Profile and Baseline Characteristics of Patients: A total of 125 patients with proximal tibial and fibular fractures associated with common peroneal nerve injury were included in the final analysis. The majority of patients were young to middle aged

males. Road traffic accidents were the most common mechanism of injury followed by fall related trauma. Right sided limb involvement was slightly more frequent compared to left sided injury. Most patients presented with foot drop and sensory deficit over the dorsum of foot at initial assessment. The baseline clinical profile indicated a higher prevalence of closed fractures compared to open fractures.

Table 1: Demographic and Clinical Characteristics of Patients

Variable	Value
Total patients	125
Mean age (years)	36.8 ± 11.4
Male	89 (71.2%)
Female	36 (28.8%)
Road traffic accident	78 (62.4%)
Fall from height	34 (27.2%)
Other causes	13 (10.4%)
Right limb involvement	68 (54.4%)
Left limb involvement	57 (45.6%)
Foot drop at presentation	118 (94.4%)

Fracture Pattern Distribution Among Study Patients: Fracture classification revealed that transverse and comminuted fractures were most frequently observed in proximal tibial region. Associated fibular fracture was present in a significant proportion of cases. Open fractures were less frequent but were associated with higher severity of neurological deficit. Patients with comminuted fractures demonstrated more severe clinical presentation compared to simple fracture patterns.

Table 2: Distribution of Fracture Patterns

Fracture Type	Number of Patients	Percentage
Transverse fracture	42	33.6%
Comminuted fracture	51	40.8%
Oblique fracture	22	17.6%
Spiral fracture	10	8.0%
Associated fibular fracture	93	74.4%
Open fractures	18	14.4%

Severity of Common Peroneal Nerve Injury at Presentation:

Clinical assessment revealed that neuropraxia was the most common type of nerve injury followed by axonotmesis. A smaller proportion of patients presented with complete nerve disruption suggestive of neurotmesis. Severe nerve injury was more commonly associated with high energy trauma and comminuted fracture patterns.

Table 3: Severity of Nerve Injury

Type of Nerve Injury	Number of Patients	Percentage
Neuropraxia	58	46.4%
Axonotmesis	47	37.6%
Neurotmesis	20	16.0%

Treatment Modalities and Management Distribution:

Management strategies varied depending on fracture stability and neurological status. Conservative management was applied in stable fracture patterns while surgical fixation was performed in unstable and displaced fractures. Nerve exploration was required in selected patients with persistent severe neurological deficit or suspected entrapment. Majority of patients were managed with surgical fixation followed by structured rehabilitation.

Table 4: Treatment Modalities Applied

Treatment Type	Number of Patients	Percentage
Conservative management	38	30.4%
Surgical fixation	72	57.6%
Surgical fixation with nerve exploration	15	12.0%

Functional Outcomes and Recovery Patterns: Functional outcome assessment demonstrated variable recovery depending on severity of nerve injury and type of fracture. Patients with

neuropraxia showed highest rate of complete recovery. Axonotmesis cases showed partial recovery in majority of patients. Neurotmesis was associated with poor functional outcome and persistent foot drop in most cases. Early intervention and rehabilitation were associated with better outcomes.

Table 5: Functional Outcomes at Final Follow Up

Outcome Category	Neuropraxia	Axonotmesis	Neurotmesis	Total
Complete recovery	52	18	2	72
Partial recovery	6	24	5	35
No recovery	0	5	13	18

Statistical Analysis of Factors Affecting Functional Recovery:

Statistical analysis demonstrated significant association between type of nerve injury and functional outcome. Early surgical intervention and less severe fracture patterns were significantly associated with better recovery rates. Patients with comminuted fractures and delayed presentation had poorer outcomes. P value analysis indicated strong statistical significance in correlation between nerve injury severity and recovery status.

Table 6: Statistical Association Between Clinical Variables and Recovery Outcome

Variable	Good Outcome (%)	Poor Outcome (%)	p-value
Neuropraxia	89.6%	10.4%	<0.001
Axonotmesis	42.5%	57.5%	<0.001
Neurotmesis	10.0%	90.0%	<0.001
Early surgery (<2 weeks)	76.3%	23.7%	0.002
Delayed surgery (>2 weeks)	38.1%	61.9%	0.002
Comminuted fracture	41.2%	58.8%	0.004
Simple fracture	78.5%	21.5%	0.004

Summary of Overall Functional Outcome Distribution:

Overall analysis indicated that a significant proportion of patients achieved complete or partial recovery following treatment and rehabilitation. However, a subset of patients with severe nerve injury and complex fractures demonstrated persistent neurological deficits. Functional independence was significantly improved in patients receiving early multidisciplinary management.

Table 7: Overall Functional Outcome Distribution

Outcome	Number of Patients	Percentage
Complete recovery	72	57.6%
Partial recovery	35	28.0%
No recovery	18	14.4%

DISCUSSION

The discussion of common peroneal nerve injury associated with proximal tibial and fibular fractures remains clinically important because functional impairment after trauma is often underestimated in early phases of care. The present study demonstrated that a considerable proportion of patients developed neurological deficit following high energy lower limb injury and this finding aligns with previously observed clinical patterns reported in large trauma populations¹¹. The vulnerability of the nerve at fibular neck region has been repeatedly emphasized in anatomical and clinical studies and this structural susceptibility explains the high frequency of injury seen in fracture related trauma. In the current cohort motor deficit presenting as foot drop was the most dominant clinical feature and this reflects disruption of dorsiflexor control due to nerve compromise. Similar observations have been described in earlier clinical evaluations where motor impairment was found to be more frequent than isolated sensory loss¹².

The demographic pattern in this study showed predominance of young male patients which is consistent with trauma epidemiology in developing regions where road traffic accidents contribute significantly to orthopedic injuries. Comparable studies from similar clinical settings have reported male dominance and high incidence

of lower limb fractures in economically active age groups¹³. This pattern reflects increased exposure to high risk environments and occupational hazards. The mechanism of injury in most cases was high energy trauma which produced significant fracture displacement and associated soft tissue damage. This relationship between trauma intensity and nerve injury severity has been documented in previous clinical analyses where comminuted fractures were strongly associated with neurological compromise¹⁴.

Fracture morphology played an important role in determining nerve injury severity in the present study. Comminuted and displaced fractures were associated with more severe neurological deficit compared to simple fracture patterns. This observation is consistent with earlier findings where mechanical distortion and fragment displacement were identified as major contributors to nerve compression and traction injury¹⁵. The peroneal nerve is particularly sensitive to stretch forces due to its fixed anatomical position around fibular neck and this anatomical feature increases susceptibility during fracture displacement. Similar biomechanical explanations have been supported by cadaveric and imaging based studies demonstrating increased strain on nerve during tibial and fibular disruption¹⁶.

Electrophysiological evaluation in the present study helped in classification of nerve injury into neuropraxia axonotmesis and neurotmesis. The majority of patients demonstrated neuropraxia which showed favorable recovery patterns. This finding corresponds with previously reported clinical series where transient conduction block was the most frequent type of injury in fracture associated nerve dysfunction¹⁷. Axonotmesis cases demonstrated slower recovery and required prolonged rehabilitation which is consistent with regenerative limitations described in neurophysiological literature. Neurotmesis was associated with poor outcome and minimal recovery which aligns with established understanding of complete nerve discontinuity leading to irreversible functional loss without surgical intervention¹⁸.

Treatment strategies in this study included conservative management surgical fixation and combined nerve exploration in selected cases. Patients who underwent early surgical stabilization demonstrated better functional outcomes compared to those managed conservatively in unstable fracture patterns. Similar trends have been observed in previous comparative studies where early stabilization reduced secondary nerve compression and improved recovery rates¹⁹. Surgical exploration of nerve was reserved for cases with persistent severe deficit or suspicion of entrapment and outcomes in these patients were variable depending on intraoperative findings and degree of nerve damage.

Rehabilitation played a critical role in functional recovery and patients who adhered to structured physiotherapy programs demonstrated improved gait and motor strength. The use of orthotic support particularly ankle foot orthosis contributed significantly to ambulation in patients with persistent dorsiflexion weakness. Comparable rehabilitation based studies have shown that early mobilization and structured physiotherapy improve neuroplastic adaptation and functional independence²⁰. The importance of multidisciplinary approach involving neurosurgery orthopedics and physiotherapy was evident in overall recovery outcomes observed in this study population.

The timing of intervention emerged as an important prognostic factor. Patients who received early diagnosis and prompt management demonstrated better recovery compared to delayed presentation cases. This finding is consistent with previous clinical observations where early decompression and stabilization were associated with improved neurological outcomes²¹. Delayed treatment often leads to prolonged compression ischemia and irreversible axonal degeneration which significantly reduces functional recovery potential.

Statistical analysis in this study demonstrated strong association between severity of nerve injury and final functional outcome. Neuropraxia had highest recovery rate while neurotmesis showed poorest outcomes. Similar statistical correlations have been reported in earlier clinical investigations where injury grading was

directly proportional to recovery probability²². The presence of comminuted fracture pattern also showed significant negative impact on recovery which suggests that fracture complexity contributes to both mechanical and vascular compromise of nerve.

The overall functional outcome in this study indicated that majority of patients achieved either complete or partial recovery. However a notable proportion of patients continued to experience persistent neurological deficit which highlights the clinical burden of this condition. Comparable studies have reported similar outcome distribution emphasizing that while recovery is possible in many cases a subset of patients remain functionally impaired despite optimal treatment²³.

The findings of this study highlight the importance of early recognition of peroneal nerve injury in proximal tibial and fibular fractures. Anatomical vulnerability combined with high energy trauma creates a clinical scenario where timely intervention is crucial. The correlation between fracture severity nerve injury grade and functional outcome provides valuable insight for clinical decision making. Early imaging and electrophysiological evaluation can improve diagnostic accuracy and guide treatment planning.

Multidisciplinary management remains essential in optimizing outcomes for these patients. Coordination between orthopedic fixation and neurological assessment ensures comprehensive care. Rehabilitation must be initiated early to prevent long term disability and improve gait restoration. Patient education regarding prognosis and recovery timeline is also important to ensure compliance with therapy protocols.

In summary the present study reinforces that common peroneal nerve injury in proximal tibial and fibular fractures is a significant contributor to long term disability if not managed appropriately. Early diagnosis structured management and rehabilitation are key determinants of favorable outcome. Further research is needed to develop standardized treatment protocols and improve prognostic accuracy in different injury patterns.

CONCLUSION

Common peroneal nerve injury was found to be frequently associated with proximal tibial and fibular fractures.

Functional recovery was improved when early diagnosis and timely intervention were applied.

Better neurological outcomes were achieved through structured management and rehabilitation.

Limitations: Small sample size was analyzed in a single center setting. Advanced imaging and long term follow up were not uniformly available. Selection bias may have been introduced due to hospital based enrollment.

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