The duties of the team physician are to “coordinate rehabilitation and return to participation, and to provide for proper preparation for safe return to participation after an illness or injury.” There can often be immense pressure on a physician to clear an athlete to play, posing great challenges. A decision-based model was developed by Creighton et al., and it aims to build on the basic elements of the return-to-play (RTP) process and includes many factors that can influence each stage. The first step is evaluation of the athlete’s health status, which is evaluated by functional testing. The second step is determining participation risk, which is dictated by the type of sport. The third step involves decision modification and is affected by factors such as pressure from the athlete. In general, if an athlete has sustained a previous injury, the reinjury risk is increased fourfold. Despite this, athletes are likely to RTP as quickly as possible. Most existing research involving RTP decisions has been based on serious conditions, such as concussion, spinal cord injury, or cardiac anomalies. There is a lack of evidence-based medicine, especially related to the foot and ankle, to assist in the decision to allow an athlete to RTP. This can lead to disagreement, confusion, and a poor decision. Unfortunately, the priorities of the team can conflict with that of the athlete. The athlete may wish to continue to play despite an injury.

ANKLE INJURIES AND RTP

The ankle is the most common site of injury in 24 of 70 sports. Ankle sprain accounted for 76.7% of injuries, followed by fractures at 16.3%. Basketball and soccer have a higher proportion of ankle injuries. In soccer, the risk of injury during match play is 4 to 6 times greater than during training.

Once an ankle sprain occurs, up to 80% will suffer recurrent sprains, and up to 72% develop recurrent symptoms or chronic instability. Basketball athletes are 5 times more likely to injure an ankle after a prior ankle injury, with a recurrence rate of...
Recurrence most strongly correlates with premature return to sport and a prior ankle injury.\textsuperscript{23} In determining an athlete's ability to RTP, subjective and objective data are required in a quantitative and qualitative way. The lack of evidence-based guidelines for clearing an athlete to RTP with ankle injuries makes this determination very challenging. Although various foot and ankle scoring systems exist, none have been validated for RTP decisions. None can confidently determine the critical point at which RTP would be acceptable.

The World Health Organization promotes assessment of health and disability in terms of function.\textsuperscript{18} Each test should relate to the activities involved in competitive play. These assess pain, instability, kinematics, and symmetry.\textsuperscript{2} These tests can determine balance, coordination, and multiplanar muscular stabilization with loads across the ankle joint and inversion.\textsuperscript{12}

**FUNCTIONAL TESTING**

**Range of Motion: The Dorsiflexion Lunge Test**

Dorsiflexion is necessary for a normal gait, climbing stairs, and rising from a squatting position. Patients lacking adequate dorsiflexion are at increased risk for reinjury and have limitations in normal functional activities.\textsuperscript{39}

The dorsiflexion lunge test is a weightbearing test performed by placing the foot perpendicular to a wall and lunging the knee toward the wall. The foot is sequentially moved farther away from the wall until the maximum range of dorsiflexion is achieved. The heel should not be lifted off from the floor, and the subtalar joint should be locked (Figure 1). The distance from the foot to the wall is measured; less than 9 to 10 cm is considered restricted.\textsuperscript{4,30} Also, the angle of the tibial shaft in reference to the wall is measured; less than 35° to 38° is restricted.\textsuperscript{1,30} The intra- and interrater reliability of this test has been confirmed.\textsuperscript{1} This test is predictive of future injury in cricket and soccer.\textsuperscript{5,7,30}

To compensate for dorsiflexion stiffness, athletes may demonstrate exaggerated hip flexion and inhibited knee flexion, and the foot may rise from the floor. In assessing treatment, weightbearing measures are more likely than nonweightbearing measures to detect treatment effects.\textsuperscript{40}

**Balance and Proprioception: The Star Excursion Balance Test**

There is conflicting evidence of proprioceptive defects in chronic ankle instability.\textsuperscript{16,31} Balance is a crucial element of most sports; loss of proprioception is a risk factor for reinjury.\textsuperscript{26,28,37} It can be assessed with noninstrumented and instrumented techniques of varying duration, with and without vision/shoes, and with or without the use of hands.\textsuperscript{31}

The star excursion balance test (SEBT) determines unilateral balance and dynamic neuromuscular control; it requires strength, flexibility, and proprioception.\textsuperscript{29} It also requires a base of support on 1 leg while reaching maximally in defined directions with the contralateral leg, forming an 8-point star shape.\textsuperscript{13} The Y Balance Test (Functional Movement Systems, Danville, Virginia) is an instrumented version of the SEBT. It tests only the anterior, posteromedial, and posterolateral components of the SEBT. The posteromedial component is the most representative of overall performance on the original 8 components (Figure 2).\textsuperscript{14} The SEBT has excellent intraobserver reliability\textsuperscript{19} and is sensitive for ankle instability.\textsuperscript{27} The SEBT is a predictive measure of lower extremity injury in high school basketball players.\textsuperscript{29}

**Agility: Agility T-Test**

Agility is the ability to change direction rapidly; a more comprehensive description includes physical demand, cognitive processes, and technical skills.\textsuperscript{34} It is an essential component of team and field sports for a variety of reasons: neuromuscular control, injury reduction, and overall performance capabilities.\textsuperscript{38} Ankle injury often impairs agility in comparison to uninjured ankles.\textsuperscript{21} In selecting an agility test, the movement skills required will vary between sports and position played.\textsuperscript{38}

The agility T-test measures movement in multiple directions. The athlete must navigate a T-shaped course; the horizontal and longitudinal arms are 10 yd each. The athlete sprints from the base of the longitudinal arm to the center of the horizontal arm. Then, facing forward, he or she sidesteps to one end of the horizontal arm without crossing feet and continues to the other end. To finish, they sidestep back to the center of the horizontal arm and run backward down the longitudinal limb to the starting
Typical times for athletic adults are between 8.9 to 13.5 seconds; high reliability has been demonstrated.

**Strength: Sargent/Vertical Jump Test**

Athletes that demonstrate deficits in strength and flexibility are more prone to lower extremity injuries; neuromuscular training programs can prevent injuries. Athletes with muscle strength imbalance are at an increased risk of ankle injuries.

The sargent jump test evaluates strength, speed, energy, and dexterity and estimates power jumps. The athlete squats and jumps upward into full extension, reaching for a cardboard disk above. The distance jumped is measured:

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efficiency\, index = \text{weight (lb)} \times \text{jump (in)} / \text{height (in)}.
\]

The sargent jump test is a reliable test for the estimation of explosive power of the lower limb.

**Psychological Factors**

Between 5% and 19% of athletes experience psychological distress following an injury to levels comparable with patients receiving treatment for mental health illness. Stress increases the risk of an athletic injury. Rehabilitation following injury can be adversely affected by loss of confidence, fear, and anxiety. Most of these reactions are transient and improve during the rehabilitation process. An athlete should demonstrate psychosocial readiness prior to RTP. Athletes who demonstrate apprehension, fear, or anxiety are at a much greater risk of reinjury, and there is often a deleterious effect on athletic performance. Scoring systems can formally assess this component: Trait Sport Confidence Inventory.
State Sport Confidence Inventory, and the Injury-Psychological Readiness to Return to Sport Scale.

CONCLUSION

The decision to RTP following an ankle injury is a multifactorial process. Functional testing provides objective measures to gauge an athlete’s progression through the rehabilitation process. Testing balance, proprioception, strength, range of motion, and agility assess physical readiness. Coupled with psychological assessment, RTP decisions can be safely made.

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