

Original Research Article

From fracture to function: a Baird and Jackson score-based evaluation of bimalleolar ankle injuries

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ABSTRACT

Background: Bimalleolar ankle fractures are common injuries that significantly impact mobility and quality of life. Open Reduction and Internal Fixation (ORIF) remains the standard for displaced fractures, though limited evidence exists regarding outcomes of combined fibular plating with screw or tension band fixation for the medial malleolus in Indian populations.

Methods: This prospective observational study was conducted at a secondary care teaching hospital in India. Thirty patients aged 18–65 years with displaced closed bimalleolar fractures underwent ORIF. The lateral malleolus was fixed with a one-third semi tubular or anatomical plate, while the medial malleolus was fixed with either cannulated cancellous (CC) screws (n=18) or tension band wiring (TBW) (n=12). Patients were followed up for three months and functional outcomes were assessed using the Baird and Jackson scoring system.

Results: The mean age was 37.9 years; males comprised 63.3% of cases. Road traffic accidents were the predominant cause (60%), with Supination-External Rotation being the most frequent injury mechanism. Weber type B fractures were most common (53.3%). At three months, functional outcomes were excellent in 43.3%, good in 36.7%, fair in 16.7% and poor in 3.3% of patients. The mean Baird and Jackson score was 93.4 ± 4.57 . Postoperative complications occurred in 26.7% (stiffness in 4, superficial infection in 4), all managed conservatively.

Conclusions: ORIF with fibular plating and medial malleolus fixation using CC screws or TBW provides favourable short-term functional outcomes and minimal complications. Larger studies with longer follow-up are needed to further validate these findings.

Keywords: Ankle fractures, Baird and Jackson score, Indian population, Open reduction and internal fixation, Tension band wiring

INTRODUCTION

The ankle joint is inherently unstable due to its anatomical configuration and is therefore prone to injury during routine daily activities. Ankle fractures are the second most common lower limb fractures after hip fractures, accounting for approximately 10% of all fractures, with a global incidence of about 137 per 100,000 persons annually.¹ Although only around 2% of ankle fractures are open, their management presents unique challenges.² These injuries typically display a bimodal distribution

predominantly affecting younger males and older females.³ Younger men often sustain ankle injuries through high-impact sports or road traffic accidents, while elderly women tend to incur them from low-energy falls, usually due to osteoporosis.

The significance of ankle injuries lies in their impact on weight transmission and joint stability. These fractures often involve both bony and ligamentous structures due to rotational and axial forces. Even a minimal disruption in ankle mortise anatomy can compromise joint function,

reinforcing the importance of precise anatomical reduction and stable fixation in treatment.⁴ Bimalleolar fractures, involving both the medial and lateral malleoli, have shown increased incidence over the past two decades across all age groups.⁵ They often result from low-energy mechanisms, such as twisting injuries and falls, but significantly impact locomotion and quality of life. Mismanagement of these injuries may result in long-term complications like malunion, non-union, persistent pain, stiffness and post-traumatic arthritis.^{6,7}

Treatment modalities for bimalleolar fractures include non-operative management, such as closed reduction and casting and surgical management via ORIF. While conservative treatment avoids surgical risks, it is often associated with suboptimal outcomes in displaced or unstable fractures, especially in elderly patients.^{8,9}

Studies have consistently demonstrated higher rates of malunion and restricted range of motion in patients treated conservatively. ORIF, on the other hand, allows for restoration of anatomical alignment and articular congruity, facilitating better functional outcomes and early mobilization.¹⁰ Burwell and Charnley's seminal work established that rigid internal fixation with early joint movement leads to superior recovery in displaced ankle fractures.¹⁰ Moreover, lateral displacement of the talus by just 1 mm has been shown to reduce tibiotalar contact area by over 40%, emphasizing the need for accurate reduction and fixation.¹¹

Surgical approaches generally include fibular plating for lateral malleolus fractures and either tension band wiring or screw fixation for medial malleolus fractures. The superiority of operative management over non-operative methods has been well established, especially for unstable, displaced and open fractures.¹²

Despite these advancements, there remains limited literature particularly in the Indian context assessing the combined approach of fibular plating and tension band or screw fixation in bimalleolar fractures. To address this gap, the present study was conducted in a tertiary care center in India to evaluate the functional outcomes of displaced bimalleolar fractures treated with this dual fixation approach. By contributing region-specific evidence, this study aims to guide clinical decision-making and improve the standard of care in bimalleolar ankle fracture management.

METHODS

This prospective observational study was conducted in the Department of Orthopaedic Surgery at a secondary care teaching hospital in Khurshitji Beharamji Bhabha Municipal General Hospital, Mumbai, India, following approval from the Institutional Ethics Committee. The study included adult patients between 18 to 65 years of age presenting with displaced closed bimalleolar ankle fractures, treated surgically. Patients were recruited from

both casualty and outpatient departments, a total of 30 patients were enrolled using a non-random, convenient sampling technique. Inclusion criteria were: patients aged 18–65 years, with closed displaced bimalleolar fractures, deemed medically fit and who provided informed consent. Exclusion criteria included patients younger than 18 or older than 65 years, those with pathological or open fractures, distal neurovascular deficits, unfit for surgery or unwilling to undergo surgical treatment.

All patients underwent a thorough clinical and radiological assessment including AP and lateral views of the ankle joint. Surgery was timed prior to peak swelling or after resolution of oedema. Prophylactic antibiotics were administered and surgeries were performed under tourniquet control with the patient in supine position. For lateral malleolus fractures, a postero-lateral incision was used, exposing the fracture site after standard dissection.

After hematoma evacuation and cleaning, anatomical reduction was achieved and fixed using either a 1/3rd semi tubular or anatomical plate secured with cortical screws (Figure 1). For medial malleolus fractures, a medial longitudinal incision was made, preserving the long saphenous vein. Fracture reduction was followed by fixation using either 4 mm cannulated cancellous screws or tension band wiring. All wounds were closed in layers with sterile dressing applied. Postoperative radiographs were taken on the day of surgery. Patients were discharged between postoperative days 2 and 3 with a 5 days course of antibiotics and analgesics.

The first follow-up was scheduled between postoperative days 10–14 for suture removal and slab reapplication. Subsequent follow-ups occurred monthly for 3 months, during which patients were educated on active and passive ankle and knee mobilization exercises along with strengthening routines. Clinical and radiological assessments were performed during each visit (Figure 2).

The parameters assessed included patient demographics, comorbidities, mode and mechanism of injury, laterality, radiological diagnosis, type of surgical fixation and complications. Functional outcomes were evaluated using the Baird and Jackson scoring system, which includes objective clinical parameters (pain, walking ability, range of motion), subjective symptoms and radiographic evaluation. Outcomes were graded as Excellent, Good, Fair or Poor depending on the total score. This methodology aimed to standardize surgical techniques and objectively assess short-term functional recovery following operative fixation of bimalleolar fractures.

Statistical analysis

Following data collection, all entries were compiled and organized using Microsoft Excel. Statistical analysis was conducted using GraphPad InStat version 3.0. Quantitative variables were summarized using descriptive statistics such as mean and standard deviation (SD), wherever

applicable. Categorical data, including distribution by age, gender and mechanism of injury, were expressed as frequencies and percentages. Descriptive statistics were used to evaluate the demographic and clinical profiles of the patients. Statistical significance testing was applied where necessary, with a p value of <0.05 considered statistically significant.

RESULTS

A total of 30 patients meeting the inclusion criteria were enrolled in the study. The mean age of the study population was 37.9±11.81 years, with a range of 19 to 62 years and a median age of 35.5 years. The majority of the patients were male (n=19, 63.33%), while 11 (36.67%) were female (Table 1). This gender distribution is in line with the general epidemiological trend indicating a higher incidence of ankle fractures among males in the younger population and females in the older age group. Occupational analysis revealed that the most affected group were manual laborers (n=11), followed by housewives (n=7), indicating a likely correlation between physical activity levels and injury risk. Other reported occupations included students, agriculturists and individuals involved in business. Comorbidity analysis showed that most patients (n=20, 66.67%) had no

underlying health issues. Among the comorbid patients, diabetes mellitus was the most common (n=5, 16.67%), followed by hypertension (n=4, 13.33%) and hypothyroidism (n=1, 3.33%). These findings are clinically relevant as comorbidities like diabetes may affect wound healing and post-operative recovery.

The side of injury was more commonly the right ankle (n=18, 60%), while the left side was involved in 12 patients (40%). In terms of the mechanism of injury, road traffic accidents (RTAs) were the most prevalent cause, accounting for 60% (n=18) of all cases. Domestic falls were responsible for 33.33% (n=10) and 6.67% (n=2) were due to sports-related injuries. These patterns suggest that both high-energy trauma (such as RTAs) and low-energy mechanisms (like falls) contribute substantially to bimalleolar fractures.

When classified according to Lauge-Hansen's mechanism of injury, the most common was supination-external rotation (SER) seen in 14 patients, followed by pronation-external rotation (PER) in 8 cases. Supination-Adduction (SA) accounted for 6 cases and Pronation-Abduction (PA) was observed in 2 patients. This distribution confirms the predominance of SER injuries in bimalleolar fracture patterns, consistent with existing literature.

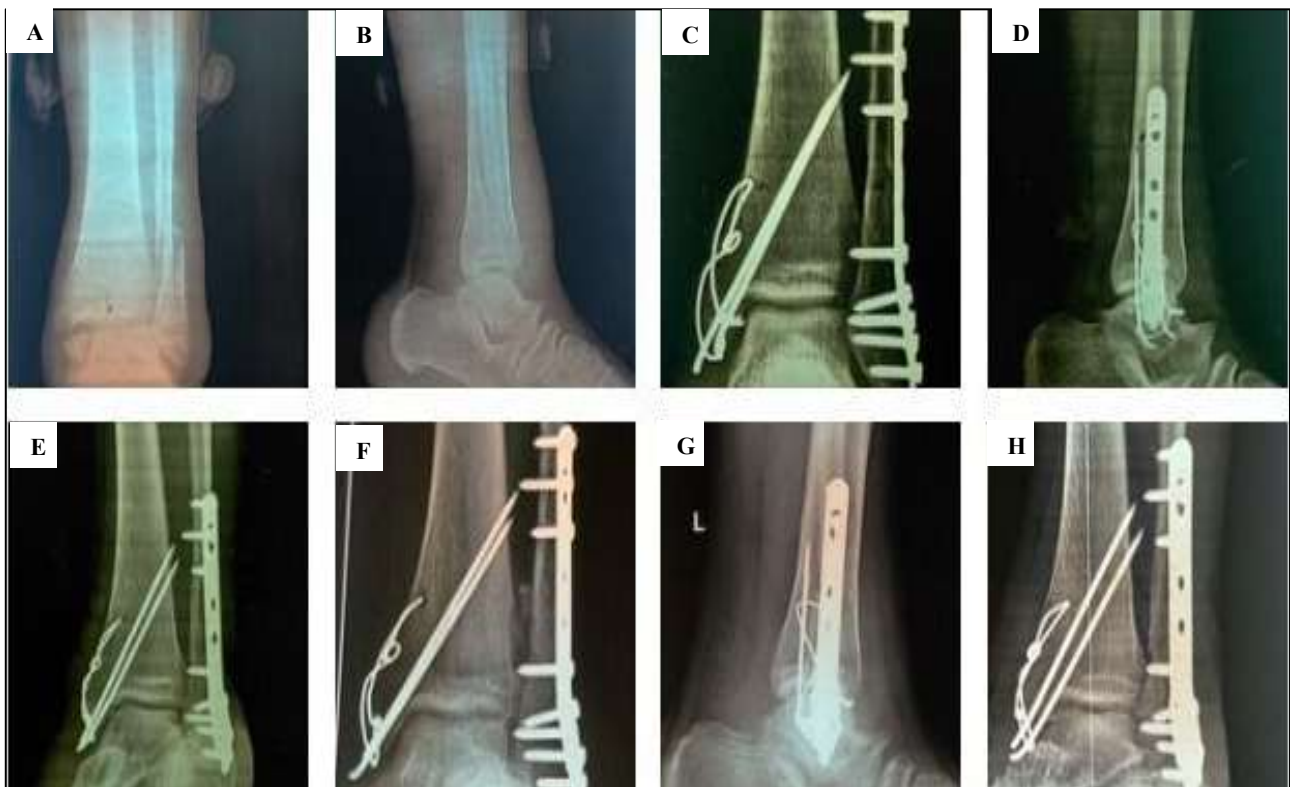


Figure 1: Case illustration of displaced bimalleolar ankle fracture managed with anatomical fibula plate fixation for the lateral malleolus and K-wire with tension band wiring for the medial malleolus. (A) Pre-operative anteroposterior (AP) view; (B) Pre-operative lateral view; (C) Immediate post-operative AP view; (D) Immediate post-operative lateral view; (E) Immediate post-operative mortise view; (F) Three-month follow-up AP view; (G) Three-month follow-up lateral view; (H) Three-month follow-up mortise view.



Table 2: Case illustration of displaced bimalleolar ankle fracture managed with one-third tubular plate fixation for the lateral malleolus and cannulated cancellous screw fixation for the medial malleolus. (A) Pre-operative anteroposterior (AP) view; (B) Pre-operative lateral view; (C) Immediate post-operative AP view; (D) Immediate post-operative lateral view; (E) Immediate post-operative mortise view; (F) Three-month follow-up AP view; (G) Three-month follow-up lateral view; (H) Three-month follow-up mortise view.

Based on Weber classification, 53.33% of patients (n=16) were categorized as type B fractures, while 7 patients each were classified as types A and C (Table 2). Implant choices varied depending on the specific fracture characteristics. For medial malleolus fixation, 18 patients (60%) received cannulated cancellous (CC) screws and 12 patients (40%) underwent tension band wiring (TBW). For the lateral malleolus, a one-third semi tubular plate was used in 22 cases (73.33%) and anatomical plates were used in the remaining 8 cases (26.67%). The average duration between injury and surgery was 2.87 ± 2.2 days, with the earliest being within one day and the latest extending to ten days post-injury. This relatively prompt surgical intervention was in accordance with best practices to minimize complications related to swelling and soft tissue compromise.

Functional outcome was assessed using the Baird and Jackson scoring system (Table 3). The mean total score was 93.4 ± 4.57 out of a possible 100. Among the individual components, pain had a mean score of 13.8 ± 1.49 out of 15,

ankle stability achieved a perfect score (15/15) in all patients and walking ability scored 14.3 ± 1.29 . The ability to run averaged 8.73 ± 0.98 , while the ability to work scored 8.8 ± 1.24 . Range of motion scored 8.1 ± 2.15 and radiographic outcomes averaged 24.66 ± 1.82 out of 25 (Table 4).

According to the overall outcome, 13 patients (43.33%) had excellent functional results, 11 (36.67%) had good results, 5 (16.67%) had fair results and only one patient (3.33%) had a poor outcome. Post-operative complications were noted in 8 patients (26.67%). Among them, 4 patients experienced ankle stiffness and 4 patients developed superficial wound infections, all of which were managed successfully with conservative measures.

These findings suggest that surgical management of bimalleolar fractures with fibular plating and either CC screw or TBW fixation for the medial malleolus provides favourable functional outcomes with minimal complications in the short-term follow-up.

Table 1: Demographic profile of study participants.

Parameter	Value
Mean age (in years)	37.9±11.81
Median age (in years)	35.5
Age range (in years)	19 – 62
Males	19 (63.33%)
Females	11 (36.67%)

Table 2: Distribution of patients by mechanism of injury and weber classification in study patients (n=30).

Mechanism of injury	Number of patients	% of patients	Weber classification	Number of patients	% of patients
Supination-external rotation (SER)	14	46.67	Type A	7	23.33
Pronation-external rotation (PER)	8	26.67	Type B	16	53.33
Supination adduction (SA)	6	20.00	Type C	7	23.33
Pronation abduction (PA)	2	6.66			
Total	30	100	Total	30	100

Table 3: Baird and Jackson scoring.

Criteria	Score description	Score
Pain	No pain	15
	Mild pain with strenuous activity	12
	Mild pain with activities of daily living	8
	Pain with weight-bearing	4
	Pain at rest	0
Stability of ankle	No clinical instability	15
	Instability with sports activities	5
	Instability with activities of daily living	0
Ability to walk	Able to walk desired distances without limp or pain	15
	Able to walk desired distances with mild limp or pain	12
	Moderately restricted in ability to walk	8
	Able to walk short distances only	4
	Unable to walk	0
Ability to run	Able to run desired distances without pain	10
	Able to run desired distances with slight pain	8
	Moderate restriction in ability to run with mild pain	6
	Able to run short distances only	3
	Unable to run	0
Ability to work	Able to perform usual occupation without restrictions	10
	Able to perform usual occupation with restrictions in some strenuous activities	8
	Able to perform usual occupation with substantial restriction	6
	Partially disabled; selected jobs only	3
	Unable to work	0
Motion of the ankle	Within 10° of uninjured ankle	10
	Within 15° of uninjured ankle	7
	Within 20° of uninjured ankle	4
	<50% of uninjured ankle or dorsiflexion <5°	0
Radiographic result	Anatomical with intact mortice (normal medial clear space, normal superior joint space, no talar tilt)	25
	Same as above with mild reactive changes at joint margins	15
	Measurable narrowing of superior joint space (≥2 mm) or talar tilt >2 mm	10
	Moderate narrowing of joint space (1–2 mm)	5
	Severe narrowing (<1 mm), widened medial clear space, sclerotic changes, osteophytes	0

Table 4: Mean Baird-Jackson scoring for patients (n=30).

Parameter assessed	Maximum possible score	Calculated value
Mean pain score	15	13.8±1.49
Mean ankle stability	15	15 (±0)
Mean score for ability to walk	15	14.3±1.29
Mean score for ability to run	10	8.73±0.98
Mean score for ability to work	10	8.8±1.24

Continued.

Parameter assessed	Maximum possible score	Calculated value
Mean score for motion of ankle	10	8.1±2.15
Mean score for radiographic result	25	24.66±1.82
Total mean Baird Jackson score	100	93.4±4.57

Table 5: Functional outcome in similar studies based on Baird Jackson scoring.

Study	Excellent (%)	Good (%)	Fair (%)	Poor (%)
Our study	43.33	36.67	16.67	3.33
Mohapatra et al ¹⁹	20.23	55.95	17.85	5.96
Bhargava et al ¹³	60	26.67	6.67	6.67
Kakkar et al ¹⁴	57.7	26.9	7.69	7.69
Colaco et al ¹⁶	32	51	13.3	3.7
Motwani et al ¹⁵	57.5	25	12.5	5
Maruthi et al ¹⁷	20	70	10	0

DISCUSSION

Ankle fractures are among the most common injuries encountered in orthopaedic practice, ranking second only to hip fractures in terms of lower limb involvement and accounting for approximately 10% of all fractures, with an annual incidence of around 137 per 100,000 persons.¹ Given the ankle joint's crucial role in weight-bearing and locomotion, its anatomical and biomechanical vulnerability makes it prone to injury during even low-energy trauma such as falls or sports activities. The bimalleolar fracture pattern, involving both the medial and lateral malleoli, represents a significant proportion of these injuries and poses unique challenges in management due to its complex nature.⁵ The goal of treating ankle fractures is not only to promote bone healing but also to restore joint congruity and preserve function while preventing long-term complications such as post-traumatic arthritis and infection.⁴

Inadequate or conservative treatment, especially in displaced fractures, may lead to malunion, reduced ankle range of motion and long-term disability.⁹ While closed methods may be suitable for non-displaced fractures, displaced fractures often necessitate ORIF to achieve anatomical reduction and early mobilization.⁸ Burwell and Charnley emphasized the importance of anatomical restoration and rigid fixation to ensure optimal functional outcomes.¹⁰ Our study aimed to evaluate the functional outcomes and complications of displaced bimalleolar ankle fractures treated surgically by fibular plating for the lateral malleolus and either tension band wiring or cancellous screw fixation for the medial malleolus.

This prospective observational study was conducted at a secondary care teaching hospital. Ethical approval was obtained prior to initiation and only patients medically fit for surgery and willing to provide informed consent were included. The study population consisted of 30 patients with a mean age of 37.9±11.81 years, ranging from 19 to 62 years, aligning with previous findings that ankle fractures have a bimodal age distribution and are commonly seen in young adults and older females.^{3,6} A

male predominance (63.33%) was observed, similar to studies by Bhargava et al, and Kakkar et al, which reported a higher incidence in males possibly due to increased outdoor activities and occupational hazards.^{13,14} The most affected age group was 31–40 years, supporting the theory that these injuries are more prevalent in the active working population. Road traffic accidents (RTAs) were the predominant cause of injury (60%), followed by domestic falls (33.33%). Similar trends were reported by Motwani et al (45% RTA), Bhargava et al (83.3% RTA) and Colaco et al (64.2% RTA).¹⁵⁻¹⁷ The mechanism of injury most commonly observed was Supination-External Rotation (SER) in 46.67% of cases, followed by Pronation-External Rotation (26.67%). This aligns with the Lauge-Hansen classification, where SER injuries are known to be the most frequent pattern in ankle fractures.¹¹ According to Weber classification, more than half (53.33%) of the patients had Type B fractures. This is consistent with literature indicating that Weber Type B fractures, occurring at the level of the syndesmosis, are the most common fracture types.¹²

In terms of surgical management, fibular plating was done using a one-third semi tubular plate or anatomical plate, while the medial malleolus was fixed using either tension band wiring (40%) or cancellous screw fixation (60%). The choice of implant was based on the size, comminution and configuration of the medial malleolar fragment, in accordance with AO principles of fracture fixation.¹⁸ Postoperative assessment using the Baird and Jackson scoring system demonstrated excellent or good outcomes in 80% of patients.

The mean total score was 93.4±4.57 out of a maximum of 100. These findings are similar to those of Bhargava et al, who reported excellent outcomes in 60% and good outcomes in 26.67% of patients.¹³ In the study by Mohapatra et al, 76.19% of patients achieved excellent or good outcomes.¹⁹ Other studies, including those by Kakkar et al, Motwani et al and Colaco et al also reported comparable results with more than 75% of patients achieving satisfactory functional outcomes.¹⁴⁻¹⁷

In the study, eight patients (26.67%) developed postoperative complications four developed ankle stiffness and four had superficial skin infections. These complications were minor and manageable with physiotherapy and antibiotics. Ankle stiffness may be attributed to non-compliance with physiotherapy protocols, which we did not track after discharge. Importantly, no cases of malunion, non-union or deep infection were observed. The complication rates observed are comparable to those reported by Mohapatra et al, (25%), Kakkar et al (11.5%) and Motwani et al (17.5%) (Table 5).^{14,15,19} The favourable functional outcomes in the study emphasize the effectiveness of timely ORIF with appropriate implant selection in managing displaced bimalleolar fractures. Furthermore, early rehabilitation and structured physiotherapy play a vital role in maximizing recovery, although adherence remains a concern in real-world settings. The standardized use of the Baird and Jackson score allowed a comprehensive evaluation of pain, stability, motion and radiographic outcomes, providing a robust assessment tool validated by multiple studies.²⁰

This study adds to the limited body of evidence from Indian populations regarding the surgical outcomes of bimalleolar fractures. Our results highlight the efficacy and safety of fibular plating combined with appropriate medial malleolar fixation. However, the study is limited by its small sample size and relatively short follow-up period. Long-term studies with larger cohorts and stratification based on fracture severity, comorbidities and physiotherapy adherence may further elucidate the outcomes.

The study was limited by a small sample size and being conducted at a single centre. Additionally, it was a single-arm design without comparison to other surgical modalities, which may limit the generalizability of the findings. Larger multicentre studies are needed to validate these results.

CONCLUSION

The majority of patients with displaced bimalleolar ankle fractures treated with fibular plating for the lateral malleolus and either tension band wiring or cannulated cancellous screw fixation for the medial malleolus achieved excellent to good short-term functional outcomes. Post-operative complications were infrequent and effectively managed with conservative measures. These findings highlight the effectiveness and safety of ORIF in restoring ankle stability and function. Larger studies with longer follow-up are recommended to validate and strengthen these results.

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