INTRODUCTION
Oss trigonum are reported in 3-24% of the general population and are found bilaterally in 50% (3,4). Aided by [5,6], Symptomatic trigonum are frequently triggered by acute or chronic/repetitive compression of the posterior ankle. If conservative treatment fails, surgical removal of the os trigonum can be performed. Classically, this involves open excision of the os via a posterior, posteromedial, or posterolateral approach [7]. More recently, arthroscopic and endoscopic removal has been described as a less invasive technique [5,6]. Standard anteromedial and anterolateral ankle portals are used in most ankle arthroscopic procedures and allow for adequate access to the front of the joint. However, posterior ankle joint visualization is limited with the anterior portals. In response, Marumoto and Ferkel developed the technique of an augmented posterolateral portal in combination with the standard anterior approach. [7] This enabled proper access to posterior ankle. Later, Van Dijk et al demonstrated a posterior, two portal endoscopic technique that enabled not only access of the posterior ankle joint and also allowed access to the fleer hallucis longus tendon (FHL), os trigonum, and posterior osteochondral lesions [8]. Since the advent of the posterior approach, several studies have been published describing several posterior ankle scope technique and results [9,12]. The purpose of this study is to retrospectively analyze the post-operative outcomes following a posterior approach endoscopic os trigonum removal with specific emphasis towards return to activity and complication rate.

RESULTS
Fourteen patients underwent posterior arthroscopic excision of a symptomatic os trigonum and 12 patients met inclusion criteria. There were 7 males and 5 females. Average age was 34.0 years and median follow up was 10.2 (7.4) months. There were no major complications and 1 minor complication. The minor complication consisted of a small wound dehiscence of the lateral portal at the first post-operative visit related to excess moisture around the incision. The area healed within 1 week with local care. There were no incidences of post-operative infection or neurovascular damage. 10/12 patients reported minimal to no pain (0-2 out of 10 on VAS scale) at the first post-operative visit with the other two patients’ pain resolving by the following visit. All patients were pain free at their second postoperative visit. Average advancement to protected weightbearing was 7.1 days. Average return to full weightbearing activities without restriction was 24.4 days.

CONCLUSIONS
The current study describes the technique and results to minimally invasive os trigonum removal with favorable postoperative outcomes. Results demonstrated minimal complications and postoperative pain, also quick return to weightbearing and full activity.

BIBLIOGRAPHY