

Foot Drop After a Car Accident and Signs of Peroneal Nerve Damage

Dragging Toes, a Slapping Step, and New Weakness Can Mean the Nerve Near Your Knee Was Injured in the Crash

You get up after the crash and realize your foot isn't moving the way it should. Your toes catch the ground. The front of your foot slaps down when you take a step. You start lifting your knee higher than normal just to keep from tripping. Maybe the outside of your lower leg or the top of your foot feels numb too. Those aren't ordinary signs of a bruised knee or sore ankle. They can point to foot drop and possible damage to the peroneal nerve.

Foot drop isn't a diagnosis by itself. It's a sign that the muscles responsible for lifting the front of the foot aren't getting a normal signal. [Mayo Clinic](#) identifies peroneal nerve compression as the most common nerve-related cause, but foot drop can also come from an L5 nerve-root injury in the lower back, a sciatic nerve injury, a more extensive plexus injury, or a problem involving the brain or spinal cord.

Our [Georgia car accident lawyers](#) at Gary Martin Hays & Associates look at where the weakness started, whether the knee or fibular head took a direct hit, what sensation changed, which ankle movements are weak, and whether EMG, nerve-conduction studies, imaging, and the rest of the neurologic exam point to the same location.

What Does Foot Drop Actually Look Like?

The clearest sign is weakness when you try to pull the front of the foot and toes upward toward the shin. That movement is called dorsiflexion. If the muscles can't generate enough force, the toes may drag during the swing phase of walking.

To compensate, many people develop a high-stepping gait. They lift the hip and knee more than usual so the toes clear the floor, then the foot may slap down when it lands. The change can be obvious to family members before the injured person realizes how differently they're walking.

Other signs can include:

- **Toe Dragging:** The front of the shoe catches on carpet, thresholds, curbs, or uneven pavement because the toes aren't clearing the ground normally.
- **Foot Slap:** Instead of lowering the foot in a controlled way after the heel strikes, the front of the foot drops quickly and audibly.
- **Weak Great-Toe Extension:** The big toe may be difficult to lift because the deep peroneal branch supplies muscles involved in toe extension.

- **Weak Foot Eversion:** Turning the sole outward may be weak when the superficial peroneal branch is involved.
- **Numbness Or Tingling:** Sensation can change over the outer lower leg and top of the foot. Numbness specifically between the first and second toes can point toward the deep peroneal branch.
- **Falls Or Near-Falls:** A toe that doesn't clear the floor can turn ordinary walking into a repeated tripping hazard.

Those symptoms can show up immediately after trauma, but they can also develop over days or weeks if swelling, a hematoma, immobilization, or another source of compression begins affecting the nerve after the initial collision.

Why Is the Peroneal Nerve So Vulnerable Near the Knee?

The common peroneal nerve, also called the common fibular nerve, branches from the sciatic nerve near the back of the knee and then wraps around the outside of the fibular neck. That location puts it close to the skin with relatively little soft tissue protecting it.

[NCBI's review of peroneal nerve injury](#) identifies direct trauma near the fibular neck, proximal fibula fractures, knee dislocations, and external compression among recognized causes of peroneal neuropathy. Once the nerve divides, its deep branch helps lift the foot and toes while its superficial branch contributes to foot eversion and sensation over much of the top of the foot.

That anatomy explains why a hard [dashboard impact to the knee](#) can create more than an orthopedic injury. The same crash that tears ligaments, dislocates the knee, or fractures the proximal fibula can also stretch, bruise, compress, or lacerate the nerve passing around the outside of the joint.

How Can a Car Accident Damage the Peroneal Nerve?

There isn't one crash mechanism that causes every case. The injury can happen at impact, during the body's movement through the cabin, or even later as swelling or immobilization places pressure on an already vulnerable nerve.

- **Direct Blow Near The Fibular Head:** The outside of the knee can strike the dashboard, door, console, or another part of the vehicle and injure the nerve where it curves around the fibular neck.
- **Knee Dislocation Or Severe Ligament Injury:** A high-energy knee injury can stretch the peroneal nerve as the joint moves beyond its normal position.
- **Proximal Fibula Fracture:** A fracture near the fibular head can injure the nerve directly or create swelling and scarring around it.

- **Crush Injury:** Intrusion into the passenger compartment can trap the leg and damage bone, muscle, blood vessels, and peripheral nerves at the same time.
- **Traction Injury:** A violent movement of the leg can stretch the nerve even when there isn't an open wound or obvious fracture.
- **Post-Crash Compression:** Swelling, braces, casts, prolonged positioning, or pressure over the fibular head can aggravate a nerve that was already injured or vulnerable after the wreck.

Some of those mechanisms overlap with serious [ankle and foot injuries](#). That can complicate the early medical picture because pain, swelling, and difficulty walking may initially be blamed on the orthopedic injury before anyone notices that the foot itself isn't dorsiflexing normally.

Peroneal Nerve Damage Doesn't Always Mean the Nerve Was Severed

Peripheral nerve trauma exists on a spectrum. Two people can both have foot drop after a collision and still have very different injuries and very different chances of recovery.

[PM&R KnowledgeNow](#) describes the classic categories as neurapraxia, axonotmesis, and neurotmesis.

- **Neurapraxia:** The nerve stays structurally intact, but conduction is blocked because the myelin has been injured. This is generally the least severe category and can recover as the nerve remyelinate.
- **Axonotmesis:** The axons are damaged and undergo degeneration beyond the injury site, but some of the nerve's supporting structure remains. Recovery can occur through axonal regrowth, but it takes time and may be incomplete.
- **Neurotmesis:** The nerve and its supporting structures are severely disrupted or completely divided. Spontaneous recovery is much less likely, and surgical repair or reconstruction may be necessary.

That distinction usually can't be made from the fact that someone has foot drop alone. Serial examinations, EMG and nerve-conduction studies, imaging, and the pattern of recovery help doctors determine how severe the injury is.

A Normal X-Ray Doesn't Rule Out Peroneal Nerve Damage

X-rays are useful for finding fractures and joint alignment problems, but a nerve can be injured even when no bone is broken. Someone can leave the emergency department with a diagnosis of knee contusion or ankle sprain and later realize that the toes keep catching the ground.

A doctor evaluating foot drop may use several kinds of testing. [Mayo Clinic's diagnostic guidance](#) notes that MRI can help identify soft-tissue causes of nerve compression, while

ultrasound can show swelling, masses, or other abnormalities along a superficial nerve. Imaging may also be directed at the lumbar spine if the symptoms suggest an L5 nerve-root problem.

The key is matching the test to the suspected location. A lumbar MRI can't show whether the common peroneal nerve is swollen at the fibular head, and a knee MRI doesn't answer every question about a lumbar nerve root.

EMG and Nerve-Conduction Studies Can Help Locate the Injury

Electrodiagnostic testing is especially important when foot drop could be coming from more than one level. Nerve-conduction studies measure how electrical signals travel through peripheral nerves. Needle EMG looks at electrical activity in selected muscles.

A 2021 clinical review of [peroneal neuropathy](#) notes that nerve-conduction testing can help localize a lesion around the fibular head and that EMG can assess severity and help distinguish a common peroneal mononeuropathy from sciatic neuropathy, lumbosacral plexopathy, or lumbar radiculopathy.

Timing matters because nerve injury evolves biologically. [A 2024 review of traumatic peripheral nerve injuries](#) explains that electrodiagnostic findings are time-dependent and that many traumatic peripheral nerve injuries are evaluated with NCS and EMG around three weeks after injury. More recent reviews similarly note that testing is often most informative around three to four weeks, after denervation changes have had time to develop.

That doesn't mean testing performed earlier is worthless. Early studies can sometimes identify conduction block or establish a baseline. It means a normal study very soon after the crash shouldn't automatically be treated as proof that the nerve was never injured.

Peroneal Neuropathy and L5 Radiculopathy Can Look Almost Identical

One of the most important diagnostic problems in a foot-drop case is figuring out whether the weakness comes from the peroneal nerve near the knee or from the L5 nerve root in the lower back. Both can cause weak ankle dorsiflexion and weak toe extension.

There are clues. A review of the [differential diagnosis of peroneal neuropathy](#) notes that weakness of ankle inversion suggests the problem extends beyond the common peroneal nerve because the tibialis posterior muscle is supplied by the tibial nerve but receives strong L5 innervation. In practical terms, weak dorsiflexion plus weak eversion with preserved inversion points more toward a peroneal lesion, while weakness that also affects inversion raises more concern for an L5 root or a more proximal injury.

The history can help too. Low-back pain or pain traveling through the buttock and posterolateral thigh may support an L5 radicular source, while tenderness or trauma around

the fibular neck and sensory change over the outer leg and top of the foot may fit a peroneal lesion.

A [herniated disc](#) can therefore be relevant even when the most obvious symptom is in the foot. If a crash damages a lumbar disc and compresses the L5 nerve root, the resulting weakness can look like peroneal nerve palsy until the exam and testing localize it.

Foot Drop Can Also Come From the Sciatic Nerve or a More Central Injury

The common peroneal nerve is only one part of a longer neurologic pathway. The signal starts in the brain, travels through the spinal cord and lumbar nerve roots, enters the lumbosacral plexus and sciatic nerve, and eventually reaches the peroneal branches that activate the muscles lifting the foot.

A sciatic nerve injury can therefore cause foot drop along with broader weakness or sensory changes. A lumbosacral plexus injury can affect several nerve territories. Brain and spinal-cord disorders can cause foot drop too, though the examination often shows additional findings beyond one peripheral nerve.

New foot drop accompanied by severe low-back pain, saddle numbness, new bowel or bladder dysfunction, or rapidly worsening leg weakness needs urgent medical evaluation because those symptoms can overlap with [cauda equina syndrome](#) or another serious neurologic emergency.

What Treatment Is Used for Traumatic Foot Drop?

Treatment depends on what's causing the weakness and how badly the nerve was injured. A nerve that's temporarily compressed needs a different plan from one that's lacerated, trapped in scar tissue, or damaged alongside a major knee dislocation.

- **Ankle-Foot Orthosis:** An AFO holds the ankle and foot in a safer position so the toes clear the ground during walking. It can reduce tripping while the nerve recovers or provide longer-term support if weakness remains.
- **Physical Therapy:** Therapy can work on gait, strength, balance, range of motion, and prevention of calf or Achilles tightness while clinicians monitor neurologic recovery.
- **Nerve Decompression Or Repair:** Surgery may be considered when the nerve is being mechanically compressed, when a severe traumatic lesion isn't recovering, or when the nerve has been lacerated or otherwise disrupted.
- **Nerve Or Tendon Reconstruction:** In selected severe cases, nerve transfer, grafting, or tendon-transfer procedures may be considered to restore useful dorsiflexion when spontaneous recovery isn't expected.
- **Treatment Of The Actual Source:** If the foot drop comes from lumbar nerve-root compression rather than the peroneal nerve, treatment has to address the spine rather than the fibular head.

Recovery isn't predictable from the word "foot drop." A temporary conduction block may improve substantially, while a severe axonal injury can take many months and may leave permanent weakness. That uncertainty is why serial strength testing and repeat electrodiagnostic studies can matter.

Foot Drop Changes More Than the Way You Walk

The functional impact can reach into almost every part of the day. A person may need to watch every step, slow down on stairs, avoid uneven ground, or stop carrying objects while walking because one trip could cause another injury.

Driving can become more difficult when the affected side controls the pedals. Work can change even more. Construction workers, nurses, warehouse employees, delivery drivers, machine operators, first responders, and anyone who spends a large part of the day walking, climbing, balancing, or carrying equipment may not be able to perform the same job safely.

Persistent foot drop can also create secondary problems. An abnormal gait can strain the knee, hip, or lower back. Falls can cause new injuries. An AFO may need replacement over time, and a person with permanent weakness may need ongoing therapy, assistive equipment, or surgical care.

When those limitations are expected to last, a [life care planner](#) can help organize future treatment and equipment needs, while vocational and economic evidence may be needed to prove [lost earning capacity](#) if the person can't return to the same work.

What Evidence Helps Prove Peroneal Nerve Damage Came From the Crash?

A strong claim usually depends on more than one abnormal test. The medical timeline has to show what happened to the leg, when the weakness appeared, where doctors localized the injury, and how the condition changed the person's function.

- **Crash And Injury Mechanism:** Photos, vehicle damage, emergency records, and orthopedic findings can show whether the knee, fibular head, or lower leg took the kind of force capable of injuring the nerve.
- **Early Gait And Strength Findings:** Documentation that the toes dragged, ankle dorsiflexion was weak, or a high-stepping gait developed soon after the wreck helps establish when the neurologic problem began.
- **Sensory Pattern:** Numbness over the outer lower leg, top of the foot, or first web space can help localize which peroneal branch may be involved.
- **Serial Neurologic Examinations:** Repeated strength testing can show whether dorsiflexion, toe extension, and eversion are improving, stable, or getting worse.

- **EMG And Nerve-Conduction Studies:** Electrodiagnostic testing can help distinguish a lesion near the fibular head from an L5 radiculopathy, sciatic injury, or more diffuse neuropathy.
- **Imaging And Ultrasound:** Studies of the knee, fibular head, nerve, or lumbar spine can identify fractures, scar tissue, swelling, disc pathology, or other structures that fit the clinical findings.
- **Pre-Crash Records:** Prior medical records can show whether the person had any earlier gait problem, lumbar radiculopathy, neuropathy, or other condition capable of causing foot drop.

Promptly reporting the weakness matters. [Seeing a doctor after a car accident](#) gives a provider a chance to document the gait change, test ankle strength, check sensation, and order the right referral before weeks of compensation and altered walking muddy the picture.

A [symptom journal](#) can also preserve details that are easy to forget later, such as how often the toes catch, whether the foot slaps more when you're tired, what stairs feel unsafe, whether you can drive normally, and how much time you spend in an AFO.

Talk With Our Georgia Car Accident Lawyers About Foot Drop

Foot drop is the kind of injury that can be obvious in everyday life but medically complicated on paper. The front of the foot isn't lifting, but the real question is why. Was the common peroneal nerve injured at the fibular head? Did a knee dislocation stretch it? Is the weakness actually coming from L5? Did swelling or immobilization create delayed compression? Is the nerve showing signs of axonal loss or recovery?

At [Gary Martin Hays & Associates](#), we can build that timeline from the crash forward and compare the orthopedic injuries, neurologic examinations, gait findings, EMG and nerve-conduction results, imaging, prior medical history, and the ways the weakness has changed work and daily life.

If your toes began dragging, your foot started slapping the ground, or you developed new weakness or numbness after a Georgia car accident, [contact us online](#) for a free consultation. We can review what happened and explain what medical and factual evidence may be needed to document the nerve injury and its long-term impact.