

Insertional Achilles Tendinitis

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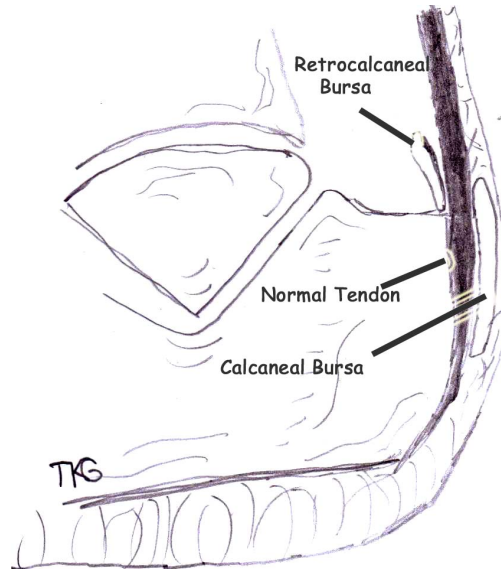
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You have been diagnosed with Insertional Achilles Tendinitis. The achilles tendon inserts onto the calcaneus bone at the back of the heel. Surrounding this insertion are fluid-filled bags called bursae. These bursae allow for the tendon to glide against the skin and surrounding tissues.



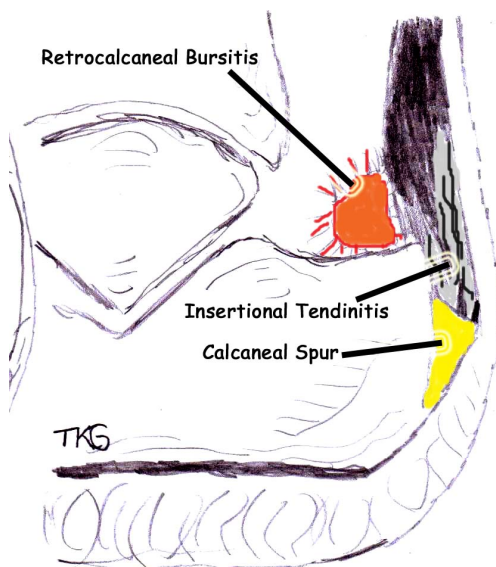
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Inflammation can occur at the insertion of the tendon, either in the bursa, or in and around the tendon. This is known as an **insertional tendinitis**. The inflammatory process is commonly seen in runners, especially hill climbers, and is associated with a bump in the bone of the heel, known as a **Haglund deformity**. Often the cause is unknown, progressing from heel pain to degeneration of the tendon.



Patients with this condition will have pain **at the insertion of the tendon to bone**. In chronic conditions, the tendon may be thickened and calcifications or bony spurs may be present.

X-rays are important as they can reveal a prominence of bone at the heel and calcifications (heel spurs) within the tendon. An **MRI** is useful to demonstrate **bursitis** and the amount of **tendon degeneration**. This information is useful when considering surgery.

Initial treatment of this condition is always non-operative, as 85 to 90% of cases improve with non-surgical methods. These treatments include achilles tendon stretches, heel-lifts, ice, and anti-inflammatory medication. A walking boot can also be used to rest the tendon and reduce inflammation. Physiotherapy is vital to initiate these treatments, and I will prescribe therapy to someone who has experience in the treatment of this condition.

If physiotherapy and rest fails to help after three to six months, then surgery can be considered. Treatment may vary depending upon the extent of tendon involvement. Generally speaking, the tendon is debrided (cleaned) of diseased tissue and bony prominences are removed. The tendon is then reattached with metal anchors and sutures. With extensive tendon involvement, a healthy tendon from the foot (Flexor digitorum longus) is transferred to the achilles attachment. Usually this tendon can be sacrificed without significant loss to the normal functioning of the foot. The foot is then protected in a plaster slab for two weeks. The success of the surgery is 75%.

Surgery requires one night stay in hospital. A physiotherapist will assist with crutch walking while not allowing weight to be put on the leg. When walking is comfortable, discharge from the hospital is allowed. Prescriptions for pain medications and **anti-coagulation** medication will be given. The anti-coagulation medication is important to prevent **blood clots**, and will be given until weight is allowed to be placed on the leg, usually in four to six weeks. I will check the wound at two weeks after surgery in my rooms. If the wound looks good a boot will be placed on the leg to keep the tendon protected. The boot must be worn **at all times**, except for showering, unless other instructions are given.

Driving is okay if the left foot is the operated leg and the automobile is an automatic. The RTA states that one cannot drive with an injured foot or with plaster until the foot is better. With this procedure, I will not allow use of the right leg for driving until **eight weeks** after surgery. At that stage the foot may be used for driving when the patient is comfortable doing so.

All surgery is accompanied by possible risks and **people can be made worse by surgery**. The complications of surgery include, but are not limited to, anaesthetic problems, infection, bleeding, blood clots, damage to nerve, vessel or tendon, incomplete relief of symptoms and recurrence of deformity or condition. Any of these complications may require further surgery.