

TREATMENT OF RETROMALLEOLAR TENDINITIS

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Of all tendinous lesions, those of the ankle and foot represent 17% in professional athletes and 14% in amateur athletes. The retromalleolar medial tendons include: medially the tibialis posterior and flexor digitorum longus, and laterally the peroneus brevis and longus.

From an anatomo-pathological point of view, tendinitis include peritendinitis, characterized by a prevalent inflammation of the tendon sheath, peritendinitis with tendinosis, in which the inflammatory component is combined with degeneration, tendinosis which is frequently associated to partial laceration or complete tear, and finally insertional tendinitis. In some cases, especially in the peroneus tendons, the inflammatory or degenerative process can be associated to a luxation of the tendons anterior to the external malleolus. With regards to pathogenesis, certain intrinsic factors (reduced blood flow, aging or degeneration, sovralsegmentary malalignment of the foot, reduced elasticity) or extrinsic factors (sudden increase in workload, insufficient recuperation period, frequent change in the playing surface, inadequate training techniques, unsuitable equipment) must be considered. Treatment of retromalleolar tendinopathies can be conservative or surgical. Conservative treatment includes rest from sports activity, both basic and specific, cryotherapy, stretching, raised heel with the aim to reduce traction of the tendons and NSAID. In certain cases the so called "brisement" consists in the subfascial infiltration of local anesthetic with the double aim to reduce pain and to mechanically break the tendon-sheath adhesions. With regards to instrumental therapy, aside from laser and ultrasounds, good results have also been obtained with shockwaves. Bandaging and braces have also proven to be useful. Fundamental in the conservative treatment, but above all, in the prevention of recurrence of acute episodes, is the recognition of extrinsic risk factors with their consequent correction. In the presence of malalignment of the foot or of the sovralsegmentary malalignment or malalignment of the foot, their compensation or correction with orthotics is necessary.

Surgical treatment is indicated after 6 months of failed conservative treatment, if MRI indicates partial or total tendon rupture, or in the presence of an important malalignment of the foot. Surgery of the tendon or of the predisposing factors, as in malalignment, can be distinguished. The techniques used on the tendon include tenolysis with toilette of the sheath associated with scarification, the repair of the lesioned tendon. In cases characterized by degenerative inclusions, excision and associated repair are necessary. In the event that the residual tendon does not guarantee hold or in cases of complete rupture, reinforcement with nearing tendons or tenodesis are therefore indicated. In insertional tendinopathies, more frequent at the level of the tibialis posterior, due to the presence of an accessory or prominent navicular bone, a tangential resection of the scaphoid and tendon retention are indicated. Surgical treatment of intrinsic factors as prevalent or excessive pronation or supination, is performed with the intent to prevent recurrence of acute episodes or to protect a repaired tendon and can be performed in association with surgical steps on the tendon. In athletes, correction of malalignments must always be achieved through extra-articular techniques such as calcaneus or first metatarsal osteotomies or arthroereisis of the subtalar joint. In cases in which the tendinopathy is associated to luxation of the tendon from the normal site of retromalleolar sliding, aside from tendon repair, plasty of the retromalleolar is necessary.
