

Achilles tendon insertional tendinopathy surgery

Patient Information by Mr Stefan Weitzel, Consultant Foot & Ankle Surgeon

General Info

This leaflet provides general information to a patient undergoing **debridement surgery of the heel for insertional Achilles tendinopathy** for reference both pre- and postoperatively. There may be individual differences of the exact procedure carried out and/or the recommended postoperative rehabilitation protocol, and therefore this may be used only as **a general guide**.

For specific questions or concerns please do not hesitate to get in touch through the practice manager on 020-32914143 or via laura@weitzelorthold.co.uk

What happens before surgery?

Patients who have been booked for foot fusion surgery will receive admission information directly by the hospital. They may be contacted by the pre-admission team and may have to attend preoperatively for some basic tests (e.g. bloods, heart tracing (ECG), MRSA swab) to confirm anaesthetic fitness and ensure perioperative safety.

Day of surgery

On the day of the surgery there will be a further opportunity to discuss the exact nature of the proposed surgical procedure with the surgeon as well as details of the postoperative recovery & follow-up arrangement. In addition, benefits and potential complications & alternative treatment options will be re-explained and the topics covered will be documented on a consent form that is signed by both the patient and the surgeon.

Detail of surgical procedure

This typically involves an incision at the back of the heel that allows exposure of the back part of the heel bone after detaching the Achilles tendon partly. Then any abnormal tendon tissue and protruding bone spurs are removed, and the tendon reattached using a special suture anchor (Speedbridge). The skin wounds are sutured and dressed. Routinely a local anaesthetic injection is administered by the surgeon or anaesthetist before the end of surgery to reduce postoperative pain for 12 to 24 hours. Tingling or other abnormal sensation in the ankle or foot may be experienced temporarily and usually but not always resolves. A cast is normally applied that may allow some protected weight-bearing with crutches.

Anaesthetic

Surgery is normally carried out under general, spinal or regional anaesthetic and the anaesthetist will discuss with the patient the most suitable technique.

Before discharge

Postoperatively, the patient will be supported with a cast and will be asked to elevate the foot at least 2 hours to reduce bleeding risk. Thereafter, crutches and a plaster shoe will be provided to offload and aid mobilisation. Normally some weight-bearing is allowed and depending on the individual case there may be modifications, and this will be communicated to the patient by the surgeon, nursing staff or physiotherapist prior to leaving the hospital. Further suitable pain relief in the form of tablets is provided. Almost always thrombo-prophylaxis (prevention of blood clots) is recommended by compression stockings and daily heparin injections (Clexane). For most patients, this is an overnight stay procedure, but some may choose to leave the same day (day case) if fully recovered and mobilising safely with pain adequately controlled.

Clinic follow-up & return to activities including work

Follow-up usually takes place in clinic around 10-14 days, for wound check & removal of any non-absorbable sutures or clips and change of plaster. Non-weight-bearing continues along with heparin injections until about 4 weeks postoperatively. At this stage and depending on the progress of tendon-to-bone healing the plaster is removed, and the limb is placed into a walker boot to facilitate the start of increasing weight-bearing & ankle exercises. Heparin injections are now discontinued.

Many patients in sedentary jobs (e.g. office work) may now be able to return to work fully or in a modified capacity. Patients in physically more demanding professions may have to delay return to work until a further 4-6 weeks (approximately 10-12 weeks postoperatively). Physiotherapy usually commences from around 4-6 weeks postoperatively.

Swelling can occasionally persist for 4-6 months postoperatively (and rarely longer) delaying the return to normal or tight-fitting shoes. Recovery is occasionally slow and continues over 4-6 months.

Complications & Outcome

Early postoperative risks include *bleeding* (which may rarely require an early change of plaster) and *wound healing problems & infection*. The latter is rarely serious and responds quickly to regular wound care and a short course of oral antibiotics. *Nerve problems* may be noted when the plaster is removed and are either experienced as a reduced sensation or tingling in the foot or around the surgical scars. This is usually temporary but uncommonly can be permanent (but even then, is rarely troublesome). A more generalised but very rare form of nerve dysfunction is caused by *complex regional pain syndrome (CRPS)* that gives rise to swelling, aching, stiffness & abnormal sensation in the ankle and foot. This almost always resolves with physiotherapy and mobilisation over a period of several months.

Thrombo-embolism (blood clot) in calves and/or lungs is relatively uncommon in ankle and foot surgery in patients without significant risk factors (e.g. previous history). However, after more complex procedures such as Achilles surgery when the leg is protected in a cast for several weeks and weight-bearing and mobility are restricted the blood clot risk is increased and, therefore, chemical thrombo-prophylaxis is routinely recommended by self-administered injection (low-molecular-weight heparin = Clexane) and, in addition, a compression stocking is usually offered by the nursing staff.

Longer term risks include significant and persisting *residual or recurrent pain and/or tendon rupture or weakness*). A general outcome review shows that a large majority of patients gets good improvement of symptoms with surgery (>80%).