South County
Orthopedics Specialist

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Peroneal Tendinopathy

There are two peroneal tendons the peroneus longus and brevis, they originate from the lateral fibula, with the peroneus brevis muscle belly continuing further distally than the peroneus longus. The peroneus brevis tendon lies deep to the peroneus longus tendon where it runs through the retromalleolar sulcus. Anatomically, any decreases of space through the retromalleolar region will also be a risk factor as this increases recurrent dislocation or subluxation of the tendon out of that sulcus. The patient may also have a history of recurrent inversion ankle sprains or pes cavus.

Patients with peroneal tendinopathy have pain posterior or distal to the lateral malleolus, along the course of the peroneal tendons, which is exacerbated by passive hindfoot inversion and ankle plantarflexion or by active-resisted hindfoot eversion and ankle dorsiflexion. On examination tenderness and possible palpable tendon thickening may be present along the course of the peroneal tendons.

A diagnosis of a peroneal tendon tear can be difficult as the symptoms are non-specific, so an MRI can assist with making the diagnosis and is often performed preoperatively to determine if and where the location of the tear. Peroneus brevis tears are usually found within the retromalleolar sulcus, conversely, peroneus longus tears frequently occur within the cuboid tunnel, at the os peroneum, at the peroneal tubercle, or at the tip of the lateral malleolus.

Treatment

Nonoperative treatment

Conservative treatment includes using a walking boot to help off load the tendon, ice, NSAID's, and a home exercise program that emphasizes eversion ankle strength training. If a patient has pes cavus a medial-lateral heel lift can also be used vs orthotics.

Operative treatment

If conservative therapies fail an operative treatment is necessary which includes, debridement and tubularization of the tendon or a tenodesis in severe tears. An incision will be made along the posterior lateral ankle and visualization of the tear is made, most often the tear only involves a small portion of the peroneus brevis in which a tubularization can be performed. If the event the quality of the tendon is undesirable with large tears and degradation a tenodesis will be performed where the peroneus brevis and peroneus longus are woven together to provide strength and stability through the lateral ankle. If the tendons are not constructible a graft or tendon transfer will be used.

Post-operative care

Immediately after surgery you will be placed in a non-weightbearing soft splint.

At 2 weeks post-op: sutures will come out, splint will come off and will transition into a walking boot or cast you may weight bear as tolerated. If a significant repair was made a short leg cast may be applied.

At 6 weeks post-op: transition out of cam boot or short leg cast into supportive athletic shoes with a light ankle brace support. Light aerobic exercises, stationary bike, walking, water aerobics. No running or jumping. Physical therapy vs home exercise program with calf stretching, scar massage ankle ROM

At 12 weeks post-op: can begin transitioning to all activities with continued strengthening ankle muscles.

Additional Links

https://www.orthobullets.com/foot-and-ankle/7023/peroneal-tendon-subluxation-and-dislocation

https://www.footcaremd.org/conditions-treatments/ankle/peroneal-tendinosis

https://www.jfas.org/article/S1067-2516(11)00575-8/fulltext