Peroneal Tendonitis

Background

1. Definition
    - Inflammation of peroneal longus and/or brevis tendon or tendon sheath
        - Acute tendonitis: < 2 wk
        - Subacute: 2-4 wk
        - Chronic: > 6 wk[1]
2. General information
    - Can be difficult to distinguish from lat ankle sprains
    - Underdiagnosed, frequently missed
    - Frequently seen in runners and ballet dancers[9]

Pathophysiology

1. Results from prolonged or repetitive activity
    - Commonly seen following inactivity or sig incr in activity
2. Risk factors[2-5]
    - Cavovarus foot position
    - Severe inversion sprains
    - Hypertrophy of peroneal tubercle
    - Trauma
    - Chronic ankle instability
3. Incidence unknown
    - Est 25-77% of pts w/chronic lat ankle instability had some type of injury to peroneal tendons[4]
4. Morbidity/mortality
    - If chronic, can be more prone to tendon ruptures/tears
    - Can lead to ankle instability, which may incr falls

Diagnostics

1. History
    - Recent incr in activity
        - Often after period of inactivity
    - May be seen during recovery period after inversion ankle sprain
2. Physical examination
    - Tenderness along peroneal tendons
        - Particularly posterior or distal to lateral malleolus
    - Assess for warmth or swelling along peroneal tendons
    - Pain exacerbated by
        - Passive hind foot inversion and ankle plantar flexion
        - Resisted active hind foot eversion and ankle dorsiflexion
    - Note position of forefoot and hindfoot as cavovarus foot assoc w/incr peroneal injury
3. Diagnostic imaging
    - X-rays
        - Wt-bearing AP and lat films of ankle to rule out
            - Fractures
            - Hypertrophy of peroneal tubercule

        - Loose bodies
    - MRI
        - Standard for evaluating tendon disorders[6-8]
    - Ultrasound
        - Useful but user dependent

Differential Diagnosis

1. Key DDx
    - Lateral ankle sprain
    - Lateral ankle instability
    - Peroneal tendon subluxation
    - Peroneal tendon tears
    - Fracture
        - Fibula
        - Fifth metatarsal
        - Cuboid
2. Expanded DDx
    - Sinus tarsi syndrome
    - Talar osteochondral lesions
    - Ankle loose bodies
    - Degenerative joint dz
    - Os perineum
    - Gout
    - Spondyloarthropathy
    - Rheumatoid arthritis

Therapeutics

1. Acute Tx
    - Relative rest
        - Avoid activities that cause pain
    - Ice
    - NSAIDs
    - Activity modification
    - If pain is severe or for refractory cases[9]
        - Immobilization in CAM boot
        - Rigid ankle orthosis
        - Short leg walking cast for up to 6 wks
    - Corticosteroid injections not recommended due to risk of tendon rupture[9]
2. Long-term care
    - Physical therapy, including
        - Stretching
        - Strengthening
        - Proprioceptive training
    - If foot misaligned, consider orthotics
    - Surg consult if pain persists despite prolonged conservative Tx

Follow-up

1. Return to the office

- Within 2-4 wk
- Earlier if worsening pain despite compliance w/conservative mgmt

2. Refer to specialist
   - Refer for surgical consultation for refractory cases

Prognosis

1. Nonoperative Tx usually successful
2. Resolution of Sx may take 2-3 mos
3. Consider surg consult if pt fails comprehensive nonsurgical Tx for 3-6 mos

Prevention

1. Gradual inc in activity/training
2. Good pre-exercise and post-exercise warm-up/stretching of ankles

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