Peroneal Tendonitis

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

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

Diagnostics
1. History
   o Recent incr in activity
     ▪ Often after period of inactivity
   o May be seen during recovery period after inversion ankle sprain
2. Physical examination
   o Tenderness along peroneal tendons
     ▪ Particularly posterior or distal to lateral malleolus
   o Assess for warmth or swelling along peroneal tendons
   o Pain exacerbated by
     ▪ Passive hind foot inversion and ankle plantar flexion
     ▪ Resisted active hind foot eversion and ankle dorsiflexion
   o Note position of forefoot and hindfoot as cavovarus foot assoc w/incr peroneal injury
3. Diagnostic imaging
   o 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
1.1.10

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

2. Refer to specialist
   1. 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

**References**


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