Safety of Achilles Detachment and Reattachment Using a Standard Midline Approach to Insertional Enthesophyte

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Summary:
Detachment with reattachment of the Achilles tendon is a common surgical exposure for debridement of retrocalcaneal exostosis, bursitis and other insertional pathologies. This midline approach of the Achilles provides excellent exposure and allows for rapid and efficient surgical debridement. The purpose of this study is to report on the safety and low complication rate for the midline approach with reattachment of the Achilles tendon for insertional Achilles tendinitis.

Introduction:
Detachment with reattachment of the Achilles tendon is a common surgical exposure for debridement of retrocalcaneal exostosis, bursitis and other insertional pathologies. This midline approach of the Achilles provides excellent exposure and allows for rapid and efficient surgical debridement. The tendon is re-approximated and repaired with a suture anchor to facilitate fixation back to the posterior calcaneus. Some surgeons are concerned there may be an increased rupture risk in the post-operative period with this technique.

Methods:
This IRB approved study is a retrospective chart review of 98 patients (100 feet) who underwent midline approach with Achilles reattachment following insertional Achilles debridement over a three-year period. Cases were identified through our CPT billing system and then cross-referenced to clinical charts. All patient identifiers were removed and demographic and co-morbidity data was collected and analyzed. Outcome measures were post-operative rupture and need for revisional surgery or re-repair. All chart review was performed by an author who was not the primary surgeon (JM) in effort to reduce potential bias.

Results:
The average age in the study was 52 years old (range, 30 – 73) and included 59 females and 39 males. Mean follow-up was 6.2 months. There were 4 revisions (4%) for ruptures or avulsions and 2 revisions (2%) for recurrent pain and tendinitis. The most common re-repair procedure included hardware removal and a flexor hallucis longus (FHL) transfer or augmentation. Eight patients (8.1%) had wound complications post-operatively. Seven of these 8 necessitated incision and drainages.

Conclusion:
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