

# **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<sup>1</sup>
2. General information
  - Can be difficult to distinguish from lat ankle sprains
  - Underdiagnosed, frequently missed
  - Frequently seen in runners and ballet dancers<sup>9</sup>

## **Pathophysiology**

1. Results from prolonged or repetitive activity
  - Commonly seen following inactivity or sig incr in activity
2. Risk factors<sup>2-5</sup>
  - 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<sup>4</sup>
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 tubercle

- Loose bodies
- MRI
  - Standard for evaluating tendon disorders<sup>6-8</sup>
- 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<sup>9</sup>
    - 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<sup>9</sup>
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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