

## Foreword



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*Consulting Editor*

I am certain that the readers are all familiar with the eponymic origin of Achilles to describe the tendon we are so accustomed to treating. There are certainly eponymic uses of injuries, procedures, techniques, and tests, but there are no other anatomic parts of the lower limb that have such significance. Perhaps this is wrapped up in the mythology of the same, or the significance that we attach to this tendon (no pun intended). There are certain treatments of Achilles tendon pathology that I have not changed much in 25 years.

Removal of a postero-superior lateral bone prominence (a Haglund deformity) is one that comes to mind. Management of acute or acute on chronic paratendinitis has not changed much either. There are fortunately or unfortunately so many diverse treatments for Achilles tendon pathology that work reasonably well. We have seen some of these come and go, but the basic issues, with respect to acute or chronic rupture have not changed much.

In my own practice, I have emphasized early range of motion and early weight bearing following treatment of acute ruptures for more than two decades. What I have noted, however, is that there is always some stretching out of the repair during healing and rehabilitation. I used to match the operated and the contralateral limb during surgery so that I could obtain a perfect static resting tension on the operated side. I do not think that this is ideal, and now place the operated foot in far more equinus than I did a decade ago. I have yet to see a limb where the foot is placed in equinus, and return to function, including strength, endurance, and power are compromised. Be careful how you use a boot or cast during the recovery of either acute or chronic ruptures. If your goal is to protect the repair and keep the foot in slight equinus, this must be achieved by placing the foot and not the boot or cast in equinus. If the boot is in equinus, there is a forced leverage on the foot during push off aggravated by the back kneeing that accompanies equinus. This is not the situation if the boot is in neutral and the foot maintained in equinus with pads or wedges.

Have you noticed that regardless of what type of surgical treatment you pursue to manage chronic noninsertional tendinopathy the tendon is generally thicker than before surgery? This seems to be part of the pathologic process of healing. I would

like to think that there are some procedures that work better than others, but I have yet to find one type of reconstruction for chronic noninsertional tendinopathy that is very predictable. All procedures seem to work in the 85% to 90% range, depending on how one defines success. I note that some authors are very optimistic with the use of a transfer of the flexor hallucis longus (FHL) to augment chronic tendinopathy. This is not an unreasonable procedure, but I am always concerned that we are unnecessarily sacrificing the strength of hallucal push off. We all have our “favorite” procedure or technique for management of either insertional or noninsertional tendinopathy, and I do not think that we can be adamant about one or the other. I suspect that in the next decade we will look back at this editorial and recognize that we have come a long way in our understanding of the pathogenesis and treatment of the pathophysiology of Achilles tendinopathy.

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