SYDNEY ORTHOPAEDIC SPECIALISTS

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Adult and Paediatric Orthopaedic Surgeon
Specialising in the Foot and Ankle

Achilles Tendon Rupture and Repair

INTRODUCTION

The Achilles tendon is the strongest tendon in the body. It is vitally important for walking and for any sporting activities. Achilles tendon ruptures most commonly occur during sports where one needs to push-off quickly, such as a racquet sports or basketball. Patients feel a pop and often feel like someone has kicked them in the back of the leg. In older, more sedentary patients, these injuries can be treated using a non-operative protocol; however, Dr. Ling prefers surgical reconstruction of Achilles tendon ruptures in the younger, more physically active patient. This is because patients are more likely to return to their pre-rupture level of function, if they have a surgical repair as they are more likely to return to function earlier, maintain more power, strength, and endurance, and are exposed to a lower re-rupture rate.

THE PROCEDURE

There are a number of steps to this procedure:
1. General Anaesthetic
2. Administration of intravenous antibiotics
3. Incision made directly over rupture
4 Tendon ends re-approximated with core and peripheral sutures
5. Wound Closure with sutures
6. Plaster Backslab

RISKS & COMPLICATIONS

Every surgical procedure carries some risk. These risks are largely uncommon and many are rare.
They include:
Anaesthetic complications
Drug reactions
Wound infection
Deep infection
Deep Vein Thrombosis (DVT)/Pulmonary embolism (PE)
Sensory nerve injury
Ongoing weakness
Re-rupture

POST OPERATIVE PROTOCOL

1 night in hospital for observation, training with hospital physiotherapist to use crutches/knee scooter
Backslab plaster and its dressings kept dry and intact until first post-op appointment
Keep foot elevated as much as possible, for the first 2 weeks
Bloodthinner (Xarelto) taken for first 2 weeks whilst non-weightbearing
Pain killers required for up to 2 weeks
First post-op appointment roughly 2 weeks post surgery for wound check and conversion to full
Protocol is as follows using Vacoped hinged boot:
Weeks 0 to 2 plaster, non-weight-bearing
weeks 2 to 4 boot, hinge on 2, wedge sole, partial weight-bearing
weeks 4 to 6 boot, hinge on 1 wedge sole, partial to full weight-bearing
sleep in boot first six weeks
range of motion exercises 10 minutes a day, do not dorsiflex beyond neutral
weeks 6 to 7 boot, hinge on 0, wedge sole, full weight-bearing, physiotherapy commences
week 7 onwards boot, hinge on 0, flat sole
week 10 out of boot, physiotherapy continues
Swimming resumed at 12 weeks in pool
Jogging resumed at 5 – 6 months
Pivoting sports at 7 – 8 months

PROBLEMS AND CONCERNS

If you have any queries or concerns, contact Dr. Ling's rooms on 9650 4782 between business hours. After hours or on weekends, if your matter is urgent, please present to the Emergency Department at Prince of Wales Hospital if you are an adult, or Sydney Children's Hospital if the patient is your child, and you will be seen by the Orthopaedic Registrar on call, who will contact Dr Ling directly