CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION

Achilles tendinopathy

What you're feeling

The pain usually builds slowly rather than coming from one injury. You might notice it at the back of your ankle, either just above your heel or right where the tendon attaches to the heel bone. The spot just above the heel is a common trouble zone, roughly 2 to 6 cm up the tendon, where blood flow is poorer and the tendon wears down more easily.

The pain often flares when you first get out of bed in the morning or after you have been sitting still for a while. It tends to ease as you warm up and move around, then can return after activity. Running and other repetitive loading, whether from sport or work tasks, commonly make it worse. Some people also find closed-back shoes uncomfortable because they press on the sore spot at the heel.

You may feel or see a thickened, lumpy area in the tendon. In some cases there is also redness and warmth over the tendon. Over time, calcium can settle inside the tendon, or a bony bump can form at the heel where the tendon attaches. That bump can make shoe wear progressively harder.

Daily tasks that load the tendon, such as climbing stairs, walking uphill, or pushing off to run, can become difficult. The problem often grumbles along for a long time rather than settling quickly.

What's actually happening

Your Achilles tendon is the thick cord you can feel at the back of your ankle. It is the largest tendon in the body. It joins your calf muscles to your heel bone, and every time you push off your foot, it pulls on that bone to move you forward.

Think of it as a rope made of many fine fibres, all running in the same direction. With repeated heavy use, tiny tears can appear in that rope. If the tendon cannot repair them fast enough, the structure slowly wears down and thickens. This is a wearing-out problem, not an infection or a bruise, which is why the older name "tendinitis" does not really fit.

The trouble spot is usually the zone you have already read about, 2 to 6 cm above the heel. That part of the tendon has a poorer blood supply than the rest, so repairs happen slowly and damage can build up. Where the tendon attaches to the heel bone, a different set of problems can occur, often alongside a bony bump that rubs

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in shoes. The small fluid sacs that cushion the tendon near the heel can also become irritated and add to the pain.

Because the tendon itself is wearing down rather than being inflamed, the pain comes from the damaged structure and from fine nerves that grow into the worn area as the body tries to cope. That is why rest alone often does not settle it, and why the morning pain and thickening you have noticed tend to persist.

The good news is that most of these problems respond to exercise-based treatment rather than surgery. The tendon can adapt and strengthen when it is loaded in the right way, gradually. Surgery is generally kept for the smaller group of people whose pain does not settle after at least 6 months of the right non-surgical care.

What we can do about it

Dr Kieran Hirpara, an orthopaedic surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At your first visit we take a history, examine your tendon, and arrange scans if they would help plan your care.

For a long-standing problem like this, we usually begin with non-operative care. You can start by easing back on the activities that flare your pain, resting more, and using a small heel lift in your shoes. Some people need a walking boot for a short period. Physiotherapy is the mainstay: your program will focus on strengthening the calf and tendon under load, often with slow, controlled exercises. This works for roughly 50% to 70% of people. Give it a fair go, because the tendon adapts slowly and improvement builds over months rather than days. Shock wave therapy, where sound waves are directed at the tendon, is another option we may add to your program. A nitroglycerin patch applied to the skin over the tendon can also reduce pain with activity and at night.

We do not use platelet-rich plasma (PRP) injections for this condition. PRP is a preparation made from your own blood, and the evidence does not show it works any better than a placebo for Achilles tendinopathy.

If your pain has not improved after at least 6 months of the right non-surgical care, we will talk with you about surgery. The operation we recommend depends on where the tendon is worn and how much of it is affected. It may involve cleaning out the damaged tissue, removing a bony bump at the heel, lengthening a tight calf muscle, or rebuilding the tendon with a nearby tendon transfer. We will go through the specific operation, what it involves, and what recovery looks like with you before any decision is made. Surgery is a shared decision between you and our team, and we only suggest it when simpler measures have reached their limit.

What to expect

For most people, this condition responds to the right treatment without surgery. Exercise-based programs work for the majority, and many people recover fully in both symptoms and function with exercises alone. The catch

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is patience: the tendon adapts slowly, so improvement builds over months rather than days, and you will need to stick with the program even when progress feels slow.

It is also honest to say that not everyone gets a full fix. Some people still have pain years after starting therapy, even when they have done the exercises properly. The outlook also depends on where the tendon is worn. Shock wave therapy tends to work better for problems in the main body of the tendon than where it attaches to the heel bone. Women with this condition sometimes get less benefit from a 12-week program of slow, controlled lengthening exercises than men do. None of this means treatment is not worth doing, but it is worth knowing before you start.

Leaving it alone does not usually work either. Simply waiting it out has not proven effective for long-standing cases that will not settle. The problem tends to grumble on, and the thickening and morning pain you have already read about tend to persist without active treatment.

If your pain has not settled after at least 6 months of proper non-surgical care, surgery becomes an option. Most people who reach that point do well, and many return to the activities they enjoy. Surgery carries real risks, though, including wound problems and, rarely, a rupture of the tendon itself. Recovery from surgery takes time and is not quick.

Whatever path you take, the realistic picture is gradual improvement measured in months, not days or weeks. Some people get back to everything they did before. Others manage their symptoms long term and adjust their activities to suit. Your surgeon will talk with you about where you sit in that range based on your tendon, your activity goals, and how your body responds to treatment.

When to see someone

See your GP if the back of your ankle has been sore for more than three months, or if the pain and thickening you have already read about are not settling with rest and easier activity. Ask for a specialist review if simple changes, such as softer shoes or a heel lift, are not helping, or if the lump in the tendon is growing. Get checked sooner if the pain is stopping you running, working, or sleeping. And go to an emergency department if you feel a sudden snap or pop in your ankle, or you suddenly cannot push off or stand on your toes, that needs same-day assessment.

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