INTRODUCTION
Achilles tendinopathy is characterised by pain, swelling, and stiffness of the Achilles tendon. The midportion of the tendon is usually affected (75%) and less commonly, the insertion in the calcaneus (25%). It is most frequently seen in athletes, with a lifetime prevalence of 52% noted in elite runners. Conversely, a sedentary lifestyle is reported in one-third of patients with Achilles tendinopathy. The mean age has been reported as between 30–60 years.1

ASSESSING THE PATIENT’S PROBLEM
Patients describe stiffness after inactivity and a gradual onset of pain during activity. If not adequately managed this can progress to pain on very minor exertion. Red-flag differentials to exclude include tendon rupture (partial/complete) and features of inflammatory arthritis in patients with insertional Achilles tendinopathy. The risk of tendon rupture is very low (4%).2 Clinical severity is assessed using the Victorian Institute of Sports Assessment — Achilles (VISA-A) questionnaire.

MANAGEMENT AND REFERRAL
Achilles tendinopathy is a clinical diagnosis and therefore investigation in primary care is seldom required (Box 1). Management should focus on medical risk-factor reduction (diabetes, obesity, hyperlipidaemia, fluoroquinolones)1 education, and exercise-based rehabilitation. Patients should adjust their usual activity to ensure pain levels are ≤5/10 using a visual analogue scale.3 Exercise-based programmes focused on eccentric calf training have the best evidence, with 82% recovering at 3 months (Box 2).4 Figure 1 shows the straight knee heel drop, starting position (A) and finishing position (B), and the bent knee heel drop, starting position (C) and finishing position (D).

Non-steroidal anti-inflammatory drugs are frequently used, although they lack good evidence. They may provide a short-term benefit; however, the potential harms

Figure 1. Eccentric heel drop exercises performed on a step.
need to be weighed up for each patient. Steroid injections are not recommended by the National Institute for Health and Care Excellence.

Patients with high clinical severity, or are recalcitrant to rehabilitation at 3 months, should be referred to musculoskeletal experts such as a sport and exercise medicine physician, enabling further investigation (ultrasound/MRI) and adjunct therapies.

Evidence suggests improved short-term outcomes with the combination of eccentric exercises and extracorporeal shockwave therapy, platelet-rich plasma, or high-volume injections.5

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

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Box 2. Example of an Achilles tendinopathy eccentric exercise prescription

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Once daily</th>
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<tbody>
<tr>
<td>Intensity</td>
<td>Within pain tolerance (≤5/10 VAS)</td>
</tr>
<tr>
<td>Time</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Type</td>
<td>1. Straight knee heel drop 2. Bent knee heel drop</td>
</tr>
<tr>
<td>Volume</td>
<td>Three sets × 15 repetitions</td>
</tr>
<tr>
<td>Progression</td>
<td>From bodyweight only initially, progression is achieved through addition of weights via a backpack</td>
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</tbody>
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VAS = visual analogue scale.

REFERENCES