

SURGICAL INTERVENTION

An incision was made along the lateral ankle and foot (figure 6). The peroneal longus tendon was followed down to the cuboid tunnel where thickening, tendinosis and a fragmented os peroneum were found (Figure 7). A 0.5x8cm FlexBand device was measured and cut to bridge the tendon defect. (Figure 8) Suture was used to secure the FlexBand device to the distal aspect of the remaining peroneal longus (Figure 9,10). The unattached end of the Artelon FlexBand was pulled into 10-20% tension and secured directly to the proximal tendon. (Figure 11) The reconstructed peroneal longus tendon was relocated and closed in layers (Figure 12). The incision was closed and the foot was splinted in plantarflexion and eversion.



Figure 6: Incision along the peroneal longus.



Figure 7: Thickened peroneal longus, excised os peroneum, and resulting gap.



Figure 8: Measuring and cutting the FlexBand matrix.



Figure 9: Suture passer used to attach non-absorbable suture to the distal peroneal longus remnants.



Figure 10: Securing the FlexBand to the distal peroneal longus tendon.



Figure 11: Proximally securing the Flexband and reinforcing the proximal peroneal longus tendon.



Figure 12: Final repaired peroneal longus tendon

FOLLOW UP

Immediately post-op, the patient had a short leg splint placed. At his 1-week follow-up, he was placed in a short leg cast, allowed weight bearing and started physical therapy at 6 weeks. He continued to rehab well, and at 12 weeks returned to light exercise.

CONCLUSION

This 47 year-old active man with os peroneum syndrome and peroneal longus tendinosis underwent a successful reconstruction utilizing Artelon's FlexBand matrix augmentation. Through the procedure, we achieved a strong and reliable repair, which allowed him an early return to pain-free exercises. Tendon reconstruction including Artelon's matrix technology is safe and effective, with the capability of supporting an early return to activities.