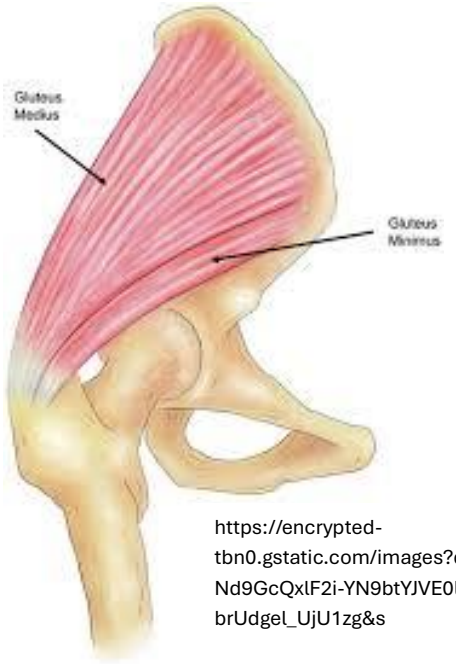
ORTHOPEDICS & SPORTS MEDICINE
BAYCARE CLINIC

Abductor Tendon Tear

Hip Anatomy

The hip is considered a “ball and socket” joint. With proper anatomy, the joint moves freely with good stability in all directions. The hip joint is made up of the femoral head (ball), the acetabulum (socket) and supporting structures.



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Some of the supporting structures include a group of muscles called the gluteal muscles. This group includes the gluteus maximus (not pictured, are rarely involved in any symptom causing problem), gluteus medius and gluteus minimus. These two muscle/tendon structures are commonly called the hip abductors (or the “rotator cuff of the hip”).

The abductors facilitate hip abduction (hip movement to the outside) and extension (hip movement to the back) and also help to keep the pelvis level/stable with walking.

Abductor Tendon Tears

The hip abductors, similar to the rotator cuff of the shoulder, are very strong but prone to degeneration (wear and tear) with aging. The tendon portion is the “weak link”. With excessive tendon degenerative tearing, one will typically experience pain on the outside of the hip (often burning pain), difficulty walking, weakness, and trouble laying (sleeping) on the side of the hip.

A degenerative tendon tear typically progresses from tendinopathy (wear) to partial thickness (usually undersurface) tearing and ultimately to a full thickness (complete) tear. A high grade, partial thickness tear compromises most of the tendon with some of the tendon remaining intact while a full thickness tear is completely detached from the bone. These two types of tears do not have healing potential and by natural history tend to worsen with time. Some people can compensate for a tear and function relatively well. More often, surgery is necessary to repair the torn tendon.

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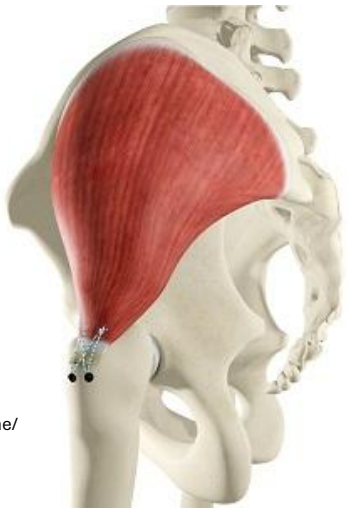
Surgical Repair – endoscopic vs open

Surgery can be done open, with a large incision on the skin, or endoscopic, through small incisions on the skin with the use of a camera. Large full thickness tears are more likely to need open surgery whereas smaller full thickness tears and partial thickness tears are more likely to be fixed using the scope. In either case the surgical goal is the same: to achieve stable and anatomic tendon-to-bone fixation. Following surgery, a careful and faithful rehabilitation process is necessary for a good treatment outcome.



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Recovery

This is an outpatient procedure meaning that one will be discharged home on the same day as the procedure. The recovery from this surgery is not quick or easy. The initial post-surgery goal is to protect the repair in order to facilitate the healing process. This requires avoidance of gluteal muscle activation. Toe touch weight bearing may be used, via crutches or walker, with no more than 25 lbs. weight on the surgical leg for the first 6-8 weeks post operatively. Before moving forward with surgery, it is recommended to attend a prehab visit (with physical therapy) to educate and reinforce these postoperative restrictions and ensure you are optimally prepared. Physical therapy will be initiated within 2-3 weeks after surgery and continue in a graduated process through 4-6+ months post operative. A full recovery from this surgery can take upwards of one full year, not uncommon for any type of tendon repair.

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