EXERCISE PROGRAMME

Achilles tendinopathy and your exercise programme

Achilles tendinopathy is pain and stiffness in the tendon at the back of the ankle. It is common in runners and active people, but it also affects people who are not especially sporty. A gradual strengthening programme is the main treatment, and most people can do it at home. This guide explains the two types of Achilles tendinopathy and gives a home exercise programme for each.

At a glance

How often	Exercises most days, as set out in your programme below
Is some pain OK?	Yes. Up to 5 out of 10 during exercise is acceptable if it settles by the next morning
How long until it helps	Usually at least 12 weeks of regular exercise; some people need 6 months or more
Activity	Reduce, but do not stop, the activities that aggravate it
Rest alone	Complete rest rarely helps a tendon recover and can weaken it further

The two types

Non-insertional (mid-portion) tendinopathy causes pain and sometimes a thickened, tender area 2 to 6 cm above the heel bone. It is more common in runners.

Insertional tendinopathy causes pain where the tendon attaches to the back of the heel bone. There may be a bony bump (sometimes called a Haglund's deformity), a calcified spur, or an inflamed fluid sac (bursa) next to the tendon. Shoes with a stiff heel counter often rub and make it worse.

Both types typically feel stiff first thing in the morning and at the start of exercise, ease as you warm up, and ache afterwards. The type matters because the exercises are done differently: insertional tendinopathy is aggravated when the heel drops below the level of the toes, which squeezes the tendon against the heel bone.

Why it happens

Tendinopathy develops when the tendon is loaded more than it can adapt to. Common triggers and risk factors include:

- a sudden increase in running, walking or sport, or a change to hills or harder surfaces
- weakness or tightness in the calf muscles
- age over about 30, and being overweight
- diabetes, high cholesterol and some inflammatory conditions
- certain antibiotics (fluoroquinolones such as ciprofloxacin); tell your doctor if you develop heel pain while taking one

How it is diagnosed

The diagnosis is usually made from your symptoms and an examination. An ultrasound or MRI scan is sometimes used to confirm it, to check the tendon is intact, or to look for other causes. X-rays can show a bony bump or spur in insertional tendinopathy.

Treatment

- **Exercise** is the most effective treatment and is the first step for both types.
- **Load management:** cut back running and jumping to a level the tendon tolerates, rather than stopping completely. Cycling and swimming are good ways to keep fit.
- **Footwear:** a supportive trainer with a slightly raised heel can ease symptoms. For insertional pain, avoid shoes that press on the back of the heel; a small heel raise inside both shoes for a few weeks can help.
- **Painkillers and ice** can help in the short term but do not treat the tendon itself.
- **If symptoms persist after 3 to 6 months** of a well-followed programme, other options may be discussed, such as shockwave therapy or, less commonly, surgery. Steroid injections into or around the Achilles tendon are generally avoided because of the risk of tendon rupture.

Using pain as a guide

Some discomfort during these exercises is normal and is not a sign of harm. Use this rule:

- Pain during exercise should stay at **5 out of 10 or below**.
- Pain and stiffness should **settle by the next morning**.
- Morning stiffness should **not get worse from week to week**.

If pain goes above 5, or you are worse the next morning, drop back to the previous stage or do fewer repetitions. If all three are fine, carry on and build up.

Home exercise programme A: non-insertional (mid-portion) Achilles tendinopathy

Warm up first with 5 minutes of walking or cycling. Move to the next stage when you can do the current one comfortably within the pain rules above, usually after 2 to 4 weeks.

Stage 1: settling the tendon (if it is very painful)

- **Isometric heel raise hold:** stand holding a support. Rise up onto your toes on both feet, then hold just off the floor. Hold for 30 to 45 seconds, rest 1 to 2 minutes, and repeat 5 times. Do this once or twice a day. *Easier:* sit with a weight on your knees and press the balls of your feet down. *Harder:* hold on the affected leg only.

Stage 2: building strength

- **Double-leg heel raises:** stand on a flat floor, holding a support for balance. Rise up onto your toes over 2 to 3 seconds and lower over 2 to 3 seconds. 3 sets of 15, once a day.
- **Single-leg heel raises:** as above, on the affected leg only. Build up to 3 sets of 15.
- **Seated heel raises:** sit with your knees bent at a right angle and a weight on your thighs (a backpack with books works well). Raise and lower your heels. 3 sets of 15. This targets the deeper

calf muscle (soleus).

Stage 3: heavier loading off a step

- **Heel drops, straight knee:** stand on the edge of a step on the balls of both feet. Rise up on both feet, shift your weight onto the affected leg, then lower the heel slowly over 3 seconds until it is just below the level of the step. Use both legs to come back up. 3 sets of 15.
- **Heel drops, bent knee:** the same, with the knee slightly bent throughout. 3 sets of 15.
- Do these once or twice a day. When they become easy, add weight by wearing a backpack and increasing it gradually.

Stage 4: returning to running and sport

- When you can do 3 sets of 15 single-leg heel drops with some extra weight, and hop 20 times on the affected leg without pain above 3 out of 10, start springing exercises: skipping, then hopping on the spot, then hopping forwards.
- Return to running with a walk-run programme on flat ground, building up over several weeks. Keep doing your strengthening exercises 2 to 3 times a week for at least 3 months after symptoms settle.

Home exercise programme B: insertional Achilles tendinopathy

The key difference is that **your heel should not drop below the level of your toes**. Do all exercises on a flat floor, not off the edge of a step, and avoid calf stretches that pull your heel down and toes up, at least in the early stages.

Stage 1: settling the tendon

- **Isometric heel raise hold:** as in programme A, stand on a flat floor and hold just off the floor for 30 to 45 seconds, 5 times, once or twice a day.

Stage 2: building strength on the flat

- **Double-leg heel raises on the flat:** rise up over 2 to 3 seconds and lower over 2 to 3 seconds until your heels touch the floor. 3 sets of 15, once a day.
- **Single-leg heel raises on the flat:** build up to 3 sets of 15.
- **Seated heel raises:** as in programme A, with a weight on your thighs. 3 sets of 15.
- **Slow lowering on the flat:** rise up on both feet, then lower slowly over 3 seconds on the affected leg only, stopping when your heel reaches the floor. 3 sets of 15.

Stage 3: heavier loading

- Add weight to the heel raises and slow lowering by wearing a backpack, increasing gradually.
- If your symptoms are well controlled, your physiotherapist may let you work into a little more range by standing on a thin board or book, so the heel lowers only to level with the toes.

Stage 4: returning to running and sport

- Follow stage 4 of programme A, using the same hop test before you start. Avoid steep hills, stairs taken two at a time and running on soft sand early on, as these drop the heel and compress the tendon.

When to seek medical advice

Get urgent help (minor injuries unit, urgent treatment centre or A&E) if:

- you feel a sudden snap or pop at the back of the ankle, as if you were kicked, followed by weakness or difficulty walking; this may be a ruptured tendon and needs prompt assessment

Stop the exercises and seek advice if:

- pain keeps getting worse despite following the pain rules
- the back of the heel becomes hot, red and swollen, or you feel unwell or feverish
- you have numbness or tingling in the foot
- pain wakes you at night or is present all the time, even at rest
- there is no improvement after about 3 months of regular exercise

Sources

This guide is based on Mr Umar's practice and follows NICE Clinical Knowledge Summaries (Achilles tendinopathy), NICE interventional procedures guidance IPG571 (shockwave therapy for Achilles tendinopathy) and published exercise programmes for Achilles tendinopathy, including the Alfredson eccentric programme, the Silbernagel pain-monitoring model and the modified floor-level programme for insertional tendinopathy.

Questions?

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This is general guidance. Always follow the specific instructions from your own clinical and physiotherapy team, as your programme may differ.

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