NICHOLAS L. STRASSER, MD
FOOT & ANKLE SURGERY
(615) 936-7846
nickstrassermd.com

REHABILITATION PROTOCOL

Open Insertional Achilles Repair

Traditional Open Haglund's Excision / Achilles Debridement and Repair or Reconstruction — Rehabilitation Protocol

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> This protocol is a general guideline and does not replace individualized medical advice. Timelines vary with the procedure performed, healing, and individual factors. Always follow the specific instructions from your surgeon and physical therapist, which take precedence over this document.

About the Surgery

Haglund's deformity or "pump bump" is an increased prominence of the posterosuperior portion of the calcaneus. It can cause increased pain in the posterior heel area by irritating the bursa and Achilles tendon insertion. When nonoperative measures fail to provide relief, surgical intervention may be used. It is important to communicate with the surgeon in order to determine the procedure performed as this will determine the post op course.

This surgery briefly involves the careful removal of the Haglund's spur in the back of the heel and debridement (removal of inflammatory tissue) of the Achilles tendon, followed by the repair of the tendon down to the bone with strong plastic screws and thick suture. Sometimes, the Achilles is too damaged and a tendon transfer (with the FHL tendon in the back of the ankle) is indicated.

This protocol is for the **traditional open** repair. If you had the minimally invasive (SpeedBridge) repair, follow the MIS Insertional Achilles Repair protocol instead. This is a general guideline and may be tailored to specific patient needs and conditions.

Phase 1: Protection and Healing

0–8 Weeks

GOALS

- Protect the repair
- Decrease swelling
- Provide optimal conditions for wound healing and healing of the repair
- Initiate gentle range of motion (ROM) activities

WEEK 1

Discuss procedure and quality of tissue with MD to determine how quickly to progress.

- Splint to protect incision
- **NO WEIGHT BEARING** in splint
- Elevate leg above heart 23 hours/day
- Ice behind knee to control pain and swelling
- Avoid direct pressure right behind the heel

WEEKS 2–4: SUTURES OUT AT 2 WEEKS

- **Remain strictly non-weight bearing** through the end of week 4
- Continue strict elevation and ice
- Active motion protocol — begin ankle dorsiflexion/plantar flexion (move ankle up and down) out of boot/splint, 5 minutes, 5 times per day

WEEKS 5–8: BEGIN PROTECTED WEIGHT BEARING IN BOOT WITH 3 WEDGES

- Start with 25% weight, progress 25% per week until 100%
- Take one wedge out per week
- Monitor for swelling, use modalities for swelling and pain control

- Patient may begin A/AROM exercises
- **No dorsiflexion beyond neutral**
- May initiate exercises for proximal joints in NWB (i.e., SLR, sidelying hip abduction)
- Compression stocking to be worn to control swelling along with ice/elevation (16 hours per day)
- Keep incision completely dry for first 2 weeks; may then shower but do NOT immerse in water (no pools, tubs, lakes, oceans, etc.) for 6 weeks
- Continue active motion protocol
- Wear CAM boot or splint while sleeping until 8 weeks post op
- Use assistive device (walker, crutches, rollabout) at all times for safety until full weight bearing
- Begin physical therapy. Note that the therapist should not at this time start passive dorsiflexion (movement of the ankle and toes towards the head); this will overstretch the tendon
- Continue to work on AAROM and AROM with goal of obtaining neutral DF by 6 weeks after surgery
- Limit active dorsiflexion to neutral and no passive stretching into dorsiflexion until 8 weeks post op
- Initiate static balance activities in boot at 6 weeks post op
- Patient may ride stationary cycle with light resistance with boot/brace on for 10 to 20 minutes
- Progress with PREs for proximal muscles and joints, avoiding any closed chain activities with dorsiflexion past neutral until 8 weeks post op
- Initiate desensitization and scar mobility when wound is healed

Phase 2: Recovery

8–12 Weeks

GOALS

- Return to normal gait pattern
- Pain and edema control
- Progress functional ROM

WEEKS 8–10

- Wean from boot to shoes with gel heel lift
- SLOWLY transition to regular shoe wear initially around the house, then increase to outside activities
- Patient may be progressed to HEP/gym program if gait is normal and pain and edema are minimal
- Initiate WB activities outside of boot and gradually progress. May use heel lifts or towels to maintain foot and ankle in slight plantarflexion
- Initiate static balance activities as tolerated
- Initiate gentle passive dorsiflexion at 8 weeks
- Initiate light resistance bands (level 1)
- Continue modalities and manual therapy for pain, desensitization, scar mobility

WEEKS 10–12

- Progress balance with dynamic activities
- Initiate retro walking if patient has appropriate dorsiflexion ROM (5–10 degrees active)

Phase 3: Retrain

12–24 Weeks

GOALS

- Improve functional mobility with stairs
- Improve tolerance for ambulation
- Strength to WNL
- ROM to WNL

MONTHS 3–6

- Progress progressive resistance exercises (PRE) as tolerated with focus on eccentric control with plantar flexion
- Progress closed chain activities

- Progress to return to prior level of activity/sport

- Progress walking program; may progress to walk/jog when able to perform minimum 15–20 single leg toe raises with good control
- Non-athletic patients may be discharged to HEP/gym program

DRIVING

- **Left foot:** may drive an automatic transmission vehicle when off narcotic pain medication
- **Right foot:** may drive once out of the boot, walking normally, off narcotic pain medication, and able to perform an emergency stop