Original article

Risk of sural nerve injury during lateral distal Achilles tendinoscopy: A Cadaver Study

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ARTICLE INFO

Article history:
Accepted 22 October 2014

Keywords:
Ankle
Sural nerve
Lateral calcaneal nerve
Calcaneal tendon
Arthroscopic surgical procedures

ABSTRACT

Background: The risk of damage to cutaneous sensory nerves located near portals has been evaluated for both conventional arthroscopy and extra-articular posterior ankle endoscopy. The objective of the anatomic study reported here was to assess the risk of injury to the sural nerve or lateral calcaneal nerve while using the distal lateral portal for the Achilles tendinoscopy procedure described by Vega et al. in 2008.

Materials and methods: We dissected the sural nerve and its branch, the lateral calcaneal nerve, of 13 human cadaver ankles in the prone position. We defined P as the point where the Achilles peritendon was opened during the distal lateral approach used for the study technique. P was adjacent to the lateral edge of the Achilles tendon, 2 cm proximal to the pos tero-superior edge of the calcaneal tuberosity. T was defined as the attachment site of the most lateral fibres of the Achilles tendon to the postero-superior edge of the calcaneal tuberosity. We evaluated the origin of the lateral calcaneal nerve relative to T and we measured the shortest distances separating P from the sural nerve and lateral calcaneal nerve.

Results: A lateral calcaneal nerve was identified in 10 (77%) ankles and originated a mean of 39.1 mm (range, 25.0–65.0 mm) proximal to T. P was at a mean distance from the sural nerve of 12.3 mm (range, 5.0–18.0 mm) and from the lateral calcaneal nerve of 6.8 mm (range, 4.0–9.0 mm). The median difference between these two distances was statistically significant (P = 0.002).

Discussion: While using the distal lateral portal for Achilles tendinoscopy, the lateral calcaneal nerve is at greater risk for injury than is the sural nerve.

Level of evidence: Level IV. Anatomic Study.

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1. Introduction


In addition to Achilles tendinoscopy, the array of endoscopic techniques for treating posterior ankle compartment disorders includes conventional (intra-articular) arthroscopy procedures and extra-articular endoscopy procedures (for posterior ankle impingement syndrome and Haglund’s deformity) [3]. Riley et al. reported a lower overall complication rate after extra-articular endoscopy procedures than after open surgery [4]. Nerve injury is among the most common complications (Table 1) and is chiefly related to the creation and use of the portals [5,12]. The sural nerve or its branch, the lateral calcaneal nerve, can be injured while creating a postero-lateral portal [13].

In a 2009 article, Bohu et al. [3] pointed out the lack of studies specifically designed to assess the risk of sural nerve injury during Achilles tendinoscopy. A comment written by Golanó and Vega [14] in 2013 underlines the importance of anatomy to avoid complications during endoscopic procedures.

Here, we used cadaver ankles to assess the distal lateral portal used in the Achilles tendinoscopy technique described by Vega et al. in 2008 [2]. Our objective was to evaluate the risk of injury to the sural and lateral calcaneal nerves.

2. Material and methods

2.1. Material

The cadavers were dissected at the anatomy laboratory of the school of medicine in Amiens, France. We dissected 13 well-preserved, embalmed, lower limbs harvested under the knee and
free of posterior scars. The specimens were from 7 males and 6 females, all Caucasians. The right limb was harvested in 8 cases and the left limb in 5 cases.

2.2. Dissection protocol

The lower limbs were maintained in the prone position by a clamp with the ankle hanging free over the edge of the table. A transverse incision was made two fingerbreadths under the tip of the lateral malleolus, to the middle of the postero-superior edge of the calcaneal tuberosity. A 90° extension to this incision was then made along the midline toward the proximal end of the limb (Fig. 1). The cutaneous plane of the posterior ankle was detached along the upper surface of the fascia superficialis covering the Achilles tendon. We identified the small saphenous vein, sural nerve, and lateral calcaneal nerve [13]. Our objective was to make no changes to the positions of the sural and lateral calcaneal nerves relative to the lateral edge of the Achilles tendon (Fig. 2).

2.3. Measurement of the study variables

We defined two points, P and T. P was the site at which the Achilles peritenon was opened via the distal lateral portal as described by Vega et al. [2] in 2008. P was 2 cm proximal to the postero-superior edge of the calcaneal tuberosity and adjacent to the lateral edge of the Achilles tendon. T was the site of attachment of the most lateral Achilles tendon fibres on the postero-superior edge of the Achilles tendon.

We used callipers graduated in millimetres to measure three distances: from T to the point of intersection between the edge of the Achilles tendon and a line perpendicular to that edge and starting at the origin of the lateral calcaneal nerve (Fig. 3) and the shortest distances separating P from the sural nerve and from the lateral calcaneal nerve (Fig. 4).

2.4. Statistical analysis

Each of the three distances measured was described as the mean value and the qualitative variable, i.e., presence of absence of a lateral calcaneal nerve, as n (%). To determine whether median differences between two series of distances differed significantly, we chose the Wilcoxon signed rank test performed using Stat View 5.2 software (SAS Institute Inc., Cary, NC).

3. Results

A lateral calcaneal nerve was identified in 10 (77%) of the 13 ankles. It arose from the posterior aspect of the sural nerve then coursed more posteriorly and closer to the midline than the main sural nerve branch, which was directed towards the lateral edge of the foot. The mean distance from the origin of the lateral calcaneal nerve and T proximally was 39.1 mm (range, 25–65 mm).
The mean shortest distance from P to the sural nerve was 12.3 mm (range, 5–18 mm). The mean shortest distance from P to the lateral calcaneal nerve was 6.8 mm (range, 4–9 mm). The median difference between these two differences for the 10 ankles with lateral calcaneal nerves was 7 mm (range, 2–11 mm). This difference was statistically significant (P < 0.002).

Table 2 reports the values of all the study measurements.

### Table 2

<table>
<thead>
<tr>
<th>Case #</th>
<th>Presence of lateral calcaneal nerve</th>
<th>Distance A (mm)</th>
<th>Distance B (mm)</th>
<th>Distance C (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>40</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>35</td>
<td>17</td>
<td>9</td>
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<tr>
<td>3</td>
<td>Yes</td>
<td>40</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>25</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>No</td>
<td>–</td>
<td>10</td>
<td>–</td>
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<td>40</td>
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<td>7</td>
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<td>65</td>
<td>15</td>
<td>8</td>
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<td>8</td>
<td>No</td>
<td>–</td>
<td>5</td>
<td>–</td>
</tr>
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<td>9</td>
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<td>–</td>
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<td>10</td>
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<tr>
<td>12</td>
<td>Yes</td>
<td>30</td>
<td>10</td>
<td>8</td>
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<tr>
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<td>Yes</td>
<td>38</td>
<td>18</td>
<td>7</td>
</tr>
</tbody>
</table>

Distance A (mm): from T to the origin of the lateral calcaneal nerve; Distance B (mm): from P to the sural nerve; Distance C (mm): from P to the lateral calcaneal nerve.

4. Discussion

The sural nerve is at moderate risk for injury while creating the distal lateral portal for the Achilles tendinoscopy technique as described by Vega et al. [2]. The risk is greater for the lateral calcaneal nerve.

Measurement bias can occur during anatomic studies. We used well-preserved embalmed cadavers as opposed to fresh cadavers. Although we took care to avoid bias related to ankle position during the measurements, some of the ankles were in the equinus position. In a study involving magnetic resonance imaging in adult volunteers, Ürgüden et al. showed that ankle position affected the relationships between the portals and nerves [15]. In a cadaver study, Sitler et al. [16] found that the mean distance from the sural nerve and the postero-lateral arthroscopy portal described by Ferkel et al. [5] was shorter than that reported by Feiwell et al. [17] and suggested ankle position as the explanation to this difference. Moreover, bias occurred in the evaluation of the risk, as the dissections were started before the tendinoscopy procedure was complete. The creation of the three-tendinoscopy portals (lateral distal, proximal, and medial distal) followed by the introduction and manipulation of instruments requires ankle motion [2]. Injuries may result both from this motion and from the passage of the instruments, given their diameter and direction [18].

The postero-lateral portal used for conventional (intra-articular) arthroscopy as described by Ferkel et al. [5] is created by drawing a line perpendicular to the axis of the leg and running through the tip of the lateral malleolus (Fig. 5). The portal is adjacent to the lateral edge of the Achilles tendon, 12 mm above the line, and is directed towards the centre of the ankle joint [5,9]. For posterior ankle endoscopy, the postero-lateral portal described by Van Dijk et al. [19] is adjacent to the lateral edge of the Achilles tendon, located just proximal to the line running through the tip of the lateral malleolus, and directed towards the first inter-metatarsal space. In patients with Haglund’s deformity, an accessory portal can improve the visualisation of the Achilles tendon insertion site [6,20,21]. No published studies have assessed the risk of lateral calcaneal nerve injury related to the postero-lateral approach during ankle endoscopy (Fig. 5). The risk of sural nerve injury during Achilles tendinoscopy as described by Vega et al. [2] may be moderate compared to the risk associated with other endoscopic procedures on the postero-lateral ankle (Table 3). The distal lateral portal is safest when created in contact with the Achilles tendon.
Table 3
Anatomic studies evaluating the shortest distance between the sural nerve and postero-lateral portals used for endoscopic ankle surgery.

<table>
<thead>
<tr>
<th>Studies</th>
<th>Year</th>
<th>Number of patients</th>
<th>Portal evaluated</th>
<th>Shortest distance from the portal to the sural nerve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feiwell [17]</td>
<td>1993</td>
<td>18</td>
<td>Ferkel PLP</td>
<td>[0;12.0]</td>
</tr>
<tr>
<td>Acevedo [6]</td>
<td>2000</td>
<td>10</td>
<td>AccPLP</td>
<td>[2.3;14.3]</td>
</tr>
<tr>
<td>Webb [20]</td>
<td>2000</td>
<td>30</td>
<td>T</td>
<td>18.8</td>
</tr>
<tr>
<td>Sitter [16]</td>
<td>2002</td>
<td>13</td>
<td>Ferkel PLP</td>
<td>[0;8.9]</td>
</tr>
<tr>
<td>Wang [20]</td>
<td>2007</td>
<td>40</td>
<td>AccPLP</td>
<td>3.2</td>
</tr>
<tr>
<td>Woo [22]</td>
<td>2010</td>
<td>23</td>
<td>Van Dijk PLP</td>
<td>12.6</td>
</tr>
<tr>
<td>Ejd [23]</td>
<td>2011</td>
<td>24</td>
<td>T</td>
<td>16</td>
</tr>
<tr>
<td>Heck [24]</td>
<td>2012</td>
<td>7</td>
<td>Van Dijk PLP</td>
<td>7.1</td>
</tr>
<tr>
<td>Carmont [21]</td>
<td>2012</td>
<td>17</td>
<td>AccPLP</td>
<td>12.0</td>
</tr>
<tr>
<td>Carmont [21]</td>
<td>2012</td>
<td>17</td>
<td>Van Dijk PLP</td>
<td>14.1</td>
</tr>
<tr>
<td>Blackmon [25]</td>
<td>2013</td>
<td>107</td>
<td>P</td>
<td>11.9</td>
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<td>2013</td>
<td>107</td>
<td>T</td>
<td>19.4</td>
</tr>
<tr>
<td>Our study</td>
<td>2014</td>
<td>10</td>
<td>P</td>
<td>12.3</td>
</tr>
</tbody>
</table>

PLP: postero-lateral portal described by Ferkel et al. [5] or Van Dijk et al. [19]; AccPLP: accessory postero-lateral portal; P: point adjacent to the lateral edge of the Achilles tendon, 2 cm proximal to the postero-superior edge of the calcaneal tuberosity; T: site of attachment of the most lateral Achilles tendon fibres on the postero-superior edge of the calcaneal tuberosity.

Fig. 5. Diagram of the posterior aspect of the right ankle. Postero-lateral portals for ankle endoscopy. 1. Conventional arthroscopy as described by Ferkel et al. [5]; 2. Extra-articular endoscopy as described by Van Dijk et al. [19]; 3. Accessory postero-lateral portal as described by Acevedo et al. [6]; 4. Accessory postero-lateral portal as described by Wang et al. [20]; 5. Accessory postero-lateral portal as described by Carmont et al. [21]; P: distal lateral portal used for the Achilles tendinoscopy procedure described by Vega et al. [2].

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

References
