

Letter to the Editor

Re-rupture is not the only failure: tendon elongation and the 6-week nonoperative protocol for Achilles tendon rupture

(Re: Happonen et al. Acta Orthop 2026; 97: 722-6. doi: 10.2340/17453674.2026.46872)



Sir,—We read with interest the article by Happonen et al. [1] comparing 8- and 6-week nonoperative protocols for acute Achilles tendon rupture in 479 patients. They concluded that the shorter strategy “may represent a safe and effective alternative.” We congratulate the authors for such an in-depth study. We believe however that the data supports a narrower conclusion.

The only endpoints were re-rupture requiring surgery and failed nonoperative management requiring surgery. Re-rupture is the most visible failure of a healing Achilles tendon, but not the only one. The healing tendon continues to elongate for 6 months, even after surgical repair, and full function takes at least 12 months to recover [2]. Elongation is accompanied by calf muscle atrophy and persisting plantarflexion strength deficit [3]. Without a measure of tendon length, such as the Achilles tendon resting angle [4], and without measurements of strength, patient-reported outcomes, or return to activity, the effectiveness of a shorter protocol cannot be fully evaluated. At 6 weeks, protection is withdrawn while the tendon is still elongating.

Overall failure did not actually decrease. Re-ruptures requiring surgery and failed nonoperative management together occurred in 8/251 (3.2%) patients in the 8-week group and 8/228 (3.5%) in the 6-week group, and failed nonoperative management rose from 0.4% to 1.8% (95% confidence interval −0.5 to 3.2 percentage points). With so few events and no prespecified non-inferiority margin, the investigation could not demonstrate equivalence: “comparable” means only that no difference was detected.

The 2 groups belong to consecutive periods, the later spanning the COVID-19 pandemic, when exposure to sport may have been reduced. Patients treated at other centers were not included, re-ruptures managed nonoperatively were not reported, and the duration of follow-up is not stated. Athletes were preferentially operated on, and operative management fell from 13% to 7.9%, leaving a nonoperative population with a mean age of about 50 years. The findings cannot be extrapolated to active, high-demand patients.

After percutaneous repair, slowing the progression of rehabilitation, with the same immediate weightbearing, produced

less tendon elongation, a better Achilles Tendon Total Rupture Score, and greater symmetry of isometric strength and calf circumference at 12 months than a faster traditional protocol [5]. Following percutaneous suture, our patients now keep the boot until 10–12 weeks and introduce eccentric loading at about 12 weeks and plyometrics at 5 months [6]. A tendon healing without sutures has no mechanical safeguard against elongation and arguably needs at least as much protection. Structural indices do not always translate into patient-reported function [7]: this is exactly why both should be measured before a shorter protocol is endorsed.

Finally, the 14% complication rate after operative management, with 8% infections, is reported without the surgical technique. Minimally invasive repair offers function comparable to open repair with fewer complications [8]. This matters when operative and nonoperative options are weighed.

We would welcome the authors’ comments on whether tendon length or functional outcomes are available for a subset of their patients.

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