

Rehabilitation Guidelines Following Proximal Hamstring Primary Repair

The hamstring muscle group consists of three muscles: the biceps femoris, semitendinosus and semimembranosus. All three of these muscles originate from the ischial tuberosity of the pelvis and then insert below the knee with the biceps femoris attaching on the fibula and the semimembranosus and semitendinosus attaching on the tibia (Figure 1). These muscles

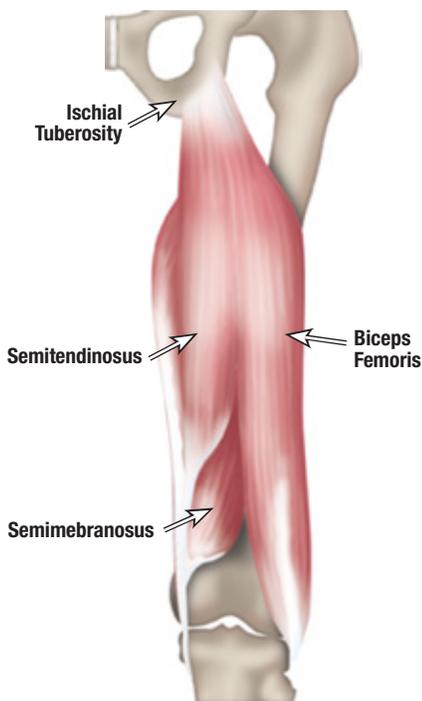


Figure 1 Normal hamstring anatomy. Three muscles (semimebranosus, semitendinosus and biceps femoris) originate from the pelvis (ischial tuberosity).

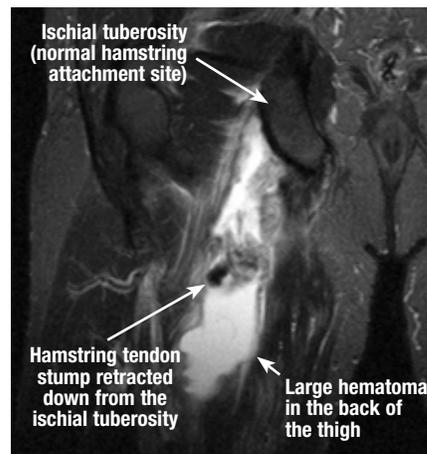
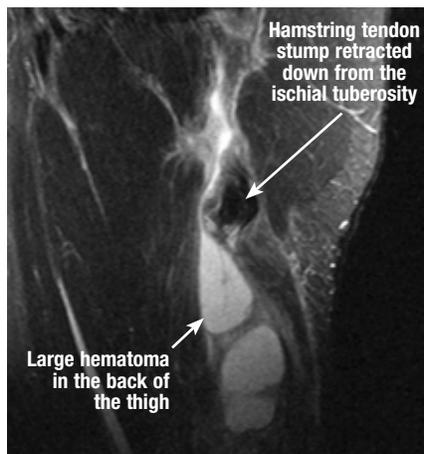
Image Copyright 2010 UW Health Sports Medicine Center.

cross the hip and the knee, and therefore can affect both hip and knee motion.

Acute hamstring strains are common in sports that involve sprinting, kicking and high-speed skilled movements. A National Football League team published injury data for their team during pre-season training camp from 1998-2007.¹ Hamstring strains were the second most common injury, only surpassed by “knee sprains”.¹ Numerous studies have shown that hamstring strains are one of the most common injuries in sprinting sports, soccer, rugby and Australian rules football.¹⁻¹² Hamstring strains primarily occur at the proximal musculotendon junction.¹³ Proximal musculotendon strain injuries

have been shown to be treated effectively with rehabilitation.^{1, 8}

Much less common, but most often much more severe, are the hamstring injuries involving complete avulsion of the hamstring complex off the ischial tuberosity. When this occurs a large amount of bleeding (hematoma) will form in the back of the thigh and the tendon will move down the thigh, retracting away from the ischial tuberosity (Figures 2 and 3). Almost all injuries occur from a slip or a fall that creates forceful hip flexion with simultaneous knee extension, many of these during sporting activities. In addition to falls this injury can occur with waterskiing starts and bull riding.¹⁴⁻¹⁵ These complete avulsions result in



Figures 2 and 3 MRI demonstrating a complete avulsion of the hamstring tendon from the ischial tuberosity.

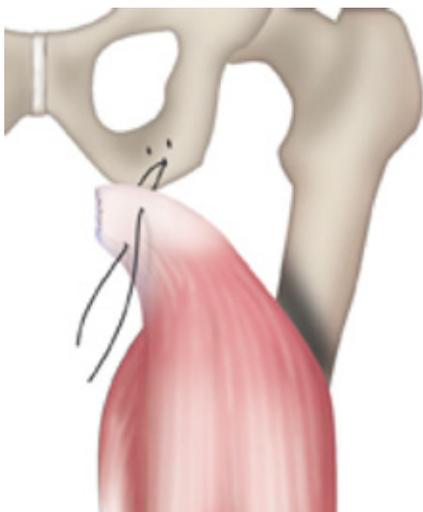


Figure 4: Sutures extending out to the torn tendon stump from anchors placed in the ischial tuberosity (pelvic bone).

significant or complete loss of hamstring function depending on how many of the tendons are avulsed. This can lead to poor leg control and difficulty even walking. Because of the significant structural damage and resultant disability, these injuries are often treated with open surgical repair.

The clinical indications for surgical repair are complete hamstring avulsion of all 3 tendons or significant retraction with less than 3 tendons avulsed. Outcome studies indicate that if surgery is performed shortly after injury, the outcome is superior to those whose surgery was delayed several months. Acute surgical repair is performed by suturing the torn tendons to suture anchors placed in the bone at the anatomical origin. This usually requires 2-4 suture anchors and Panacryl or Ethibond sutures (Figures 4 and 5).¹⁶⁻¹⁷

Post-operatively crutches are used to assist in walking for the first

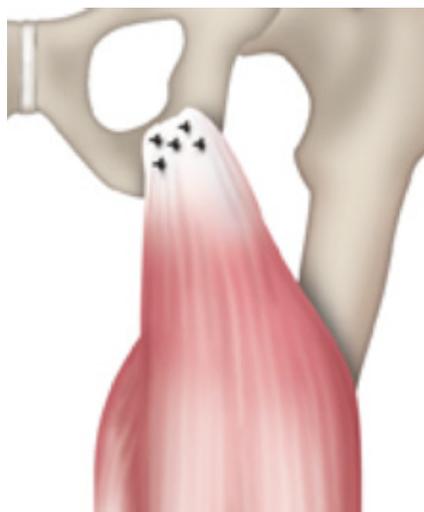


Figure 5: Sutures tied off to approximate the torn tendon to the ischial tuberosity (pelvic bone).

few weeks. A brace or protective device also may be used to protect the hamstring. One factor in this decision is the time of year (snow / ice), as most reported episodes of early failure are related to slipping and falling. Another factor, which is assessed during surgery, is the ease with which the torn tendon can reach its original insertion on the pelvis. If the tendon was significantly retracted there is a greater likelihood of longer post-operative protection.

The University of Wisconsin Sports Medicine and Rehabilitation post-operative rehabilitation guidelines consist of 4 phases. Phase I consists of range of motion and gait training exercises. This phase focuses on protecting the repair to allow adequate healing and usually lasts 6 weeks. This is followed by a progressive, supervised strengthening program. Phases II and III include progressions with the speed and amplitude of movement, as well as force distribution. Early

in the strengthening phase most exercises are done with both legs simultaneously in a short arc of motion either at the hip or the knee. Late in Phase III, most exercises are done in a single leg fashion with movement and force occurring at both the hip and knee simultaneously. In the final phase of rehabilitation, the focus shifts to the control of high speed movement and the development of power. This is the return to sport phase.

Not all athletes will return to sport after this injury due to how significant these injuries can be. Return to sport depends on the nature of the sport, severity of initial injury, timeliness of surgical intervention and compliance with the post-operative rehabilitation program. Most studies state approximately 75% of athletes may return to their sport in some capacity.^{14, 18} Sports requiring longer bouts of sprinting seem to be the most difficult sports to which an athlete may return.

The rehabilitation guidelines below are presented in a criterion based progression. Specific time frames, restrictions and precautions are given to protect healing tissues and the surgical repair/reconstruction. General time frames are also given for reference to the average, but individual patients will progress at different rates depending on their age, associated injuries, pre-injury health status, rehab compliance and injury severity. The number of tendons repaired, the time from injury and the retraction prior to repair may also affect the rate of post-operative progression.

PHASE I (surgery to 6 weeks after surgery)

The timeframes for each phase may be extended if the repair is delayed or the injury included other associated injuries (such as a hip adductor tear).

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments begin 2-5 days after surgery and are once every 6-10 days after
Rehabilitation Goals	<ul style="list-style-type: none"> • Protection of the repaired tendon(s) • Pain control
Weight Bearing	<ul style="list-style-type: none"> • Use axillary crutches for up to 6 weeks • Post-operative weeks 0-2: Touch down weight bearing • Post-operative weeks 3-4: 15% - 40% weight bearing progression • Post-operative weeks 5-6: Weight bearing as tolerated with weaning from crutches • Full weight bearing occurs at week 6
Brace (Dr. Baer, Dr. Walczak)	<ul style="list-style-type: none"> • The use of a brace is determined by the surgeon at the time of surgery, which is based on time of year, timing of surgery and associated injuries
Brace (Dr. Spiker)	<ul style="list-style-type: none"> • Bledsoe brace locked at 30 degrees of flexion while walking and have knee flexed to 90 degrees while sitting.
Precautions	<ul style="list-style-type: none"> • Avoid hip flexion coupled with knee extension • Avoid unsafe surfaces and environments
Suggested Therapeutic Exercise	<ul style="list-style-type: none"> • Quad sets • Ankle pumps • Abdominal isometrics • Passive knee range of motion (ROM) with no hip flexion during knee extension • Post-operative weeks 3-4: May begin pool walking drills (without hip flexion coupled with knee extension), hip abduction, hip extension, and balance exercises • Scar mobilizations
Cardiovascular Exercise	<ul style="list-style-type: none"> • Upper body circuit training or upper body ergometer (UBE)
Progression Criteria	<ul style="list-style-type: none"> • 6 weeks post-operative

PHASE II (begin after meeting Phase I criteria, usually 6 weeks after surgery)

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments are once every 1-2 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> • Normalize gait • Good control and no pain with functional movements, including step up/down, squat, partial lunge (do not exceed 60° of knee flexion)
Precautions	<ul style="list-style-type: none"> • Avoid dynamic stretching • Avoid loading the hip at deep flexion angles • No impact or running
Suggested Therapeutic Exercise	<ul style="list-style-type: none"> • Non-impact balance and proprioceptive drills – beginning with double leg and gradually progressing to single leg • Stationary bike • Gait training • Begin hamstring strengthening – start by avoidance of lengthened hamstring position (hip flexion combined with knee extension) by working hip extension and knee flexion moments separately; begin with isometric and concentric strengthening with hamstring sets, heel slides, double leg bridge, standing leg extensions, and physioball curls • Hip and core strengthening
Cardiovascular Exercise	<ul style="list-style-type: none"> • Upper body circuit training or UBE
Progression Criteria	<ul style="list-style-type: none"> • Normal gait on all surfaces • Ability to carry out functional movements without unloading the affected leg or pain while demonstrating good control • Single leg balance greater than 15 seconds • Normal (5/5) hamstring strength in prone with the knee in a position of at least 90° knee flexion

PHASE III (begin after meeting phase II criteria, usually three months after surgery)

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments are once every 1-2 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> • Good control and no pain with sport and work specific movements, including impact
Precautions	<ul style="list-style-type: none"> • No pain during strength training • Post-activity soreness should resolve within 24 hours

Rehabilitation Guidelines Following Proximal Hamstring Primary Repair

Suggested Therapeutic Exercise	<ul style="list-style-type: none"> • Continue hamstring strengthening – progress toward strengthening in lengthened hamstring positions; begin to incorporate eccentric strengthening with single leg forward leans, single leg bridge lowering, prone foot catches, and assisted Nordic curls • Hip and core strengthening • Impact control exercises beginning 2 feet to 2 feet, progressing from 1 foot to the other and then 1 foot to same foot • Movement control exercise beginning with low velocity, single plane activities and progressing to higher velocity, multi-plane activities • Initiate running drills, but no sprinting until Phase IV
Cardiovascular Exercise	<ul style="list-style-type: none"> • Biking, elliptical machine, Stairmaster, swimming, and deep water running
Progression Criteria	<ul style="list-style-type: none"> • Dynamic neuromuscular control with multi-plane activities at low to medium velocity without pain or swelling • Less than 25% deficit for side to side hamstring comparison on Biodex testing at 60° and 240° per second

PHASE IV (begin after meeting phase III criteria, usually 4-5 months after surgery)

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments are once every 1-2 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> • Good control and no pain with sport and work specific movements, including impact
Precautions	<ul style="list-style-type: none"> • No pain during the strength training • Post-activity soreness should resolve within 24 hours
Suggested Therapeutic Exercise	<ul style="list-style-type: none"> • Continue hamstring strengthening – progress toward higher velocity strengthening and reaction in lengthened positions, including eccentric strengthening with single leg forward leans with medicine ball, single leg dead lifts with dumbbells, single leg bridge curls on physioball, resisted running foot catches, and Nordic curls • Running and sprinting mechanics and drills • Hip and core strengthening • Impact control exercises beginning 2 feet to 2 feet, progressing from 1 foot to other and then 1 foot to same foot • Movement control exercise beginning with low velocity, single plane activities and progressing to higher velocity, multi-plane activities • Sport/work specific balance and proprioceptive drills • Stretching for patient specific muscle imbalances
Cardiovascular Exercise	<ul style="list-style-type: none"> • Replicate sport or work specific energy demands

Rehabilitation Guidelines Following Proximal Hamstring Primary Repair

<p>Return to Sport/Work Criteria</p>	<ul style="list-style-type: none"> Dynamic neuromuscular control with multi-plane activities at high velocity without pain or swelling Less than 10% deficit for side to side hamstring comparison on Biodex testing at 60° and 240° per second Less than 10% deficit on functional testing profile
---	--

These rehabilitation guidelines were developed collaboratively between Marc Sherry, PT, DPT, LAT, CSCS and the UW Health Sports Medicine physician group.

Updated 11/2017

References:

1. Feeley BT, Kennelly S, Barnes RP, et al. Epidemiology of National Football League Training Camp Injuries From 1998 to 2007. *Am J Sports Med.* Apr 28 2008.
2. Gabbe BJ, Finch CF, Wajswelner H, Bennell KL. Predictors of lower extremity injuries at the community level of Australian football. *Clin J Sport Med.* Mar 2004;14(2):56-63.
3. Orchard J, Best TM, Verrall GM. Return to play following muscle strains. *Clin J Sport Med.* Nov 2005;15(6):436-441.
4. Orchard J, Marsden J, Lord S, Garlick D. Preseason hamstring muscle weakness associated with hamstring muscle injury in Australian footballers. *Am J Sports Med.* Jan-Feb 1997;25(1):81-85.
5. Orchard J, Steet E, Walker C, Ibrahim A, Rigney L, Houang M. Hamstring muscle strain injury caused by isokinetic testing. *Clin J Sport Med.* Oct 2001;11(4):274-276.
6. Orchard JW. Intrinsic and extrinsic risk factors for muscle strains in Australian football. *Am J Sports Med.* May-Jun 2001;29(3):300-303.
7. Orchard JW, Best TM. The management of muscle strain injuries: an early return versus the risk of recurrence. *Clin J Sport Med.* 2002;12(1):3-5.
8. Sherry MA, Best TM. A comparison of 2 rehabilitation programs in the treatment of acute hamstring strains. *J Orthop Sports Phys Ther.* Mar 2004;34(3):116-125.
9. Verrall GM, Kalairajah Y, Slavotinek JP, Spriggins AJ. Assessment of player performance following return to sport after hamstring muscle strain injury. *J Sci Med Sport.* May 2006;9(1-2):87-90.
10. Verrall GM, Slavotinek JP, Barnes PG. The effect of sports specific training on reducing the incidence of hamstring injuries in professional Australian Rules football players. *Br J Sports Med.* Jun 2005;39(6):363-368.
11. Verrall GM, Slavotinek JP, Barnes PG, Fon GT. Diagnostic and prognostic value of clinical findings in 83 athletes with posterior thigh injury: comparison of clinical findings with magnetic resonance imaging documentation of hamstring muscle strain. *Am J Sports Med.* Nov-Dec 2003;31(6):969-973.
12. Brooks JH, Fuller CW, Kemp SP, Reddin DB. Incidence, risk, and prevention of hamstring muscle injuries in professional rugby union. *Am J Sports Med.* Aug 2006;34(8):1297-1306.
13. Askling CM, Tengvar M, Saartok T, Thorstensson A. Acute First-Time Hamstring Strains During High-Speed Running: A Longitudinal Study Including Clinical and Magnetic Resonance Imaging Findings. *Am J Sports Med.* Dec 14 2006.
14. Chakravarthy J, Ramisetty N, Pimpalnerkar A, Mohtadi N. Surgical repair of complete proximal hamstring tendon ruptures in water skiers and bull riders: a report of four cases and review of the literature. *Br J Sports Med.* Aug 2005;39(8):569-572.
15. Sallay PI, Friedman RL, Coogan PG, Garrett WE. Hamstring muscle injuries among water skiers. Functional outcome and prevention. *Am J Sports Med.* Mar-Apr 1996;24(2):130-136.
16. Sarimo J, Lempainen L, Mattila K, Orava S. Complete proximal hamstring avulsions: a series of 41 patients with operative treatment. *Am J Sports Med.* Jun 2008;36(6):1110-1115.
17. Wood DG, Packham I, Trikha SP, Linklater J. Avulsion of the proximal hamstring origin. *J Bone Joint Surg Am.* Nov 2008;90(11):2365-2374.
18. Klingele KE, Sallay PI. Surgical repair of complete proximal hamstring tendon rupture. *Am J Sports Med.* Sep-Oct 2002;30(5):742-747.

At UW Health, patients may have advanced diagnostic and/or treatment options, or may receive educational materials that vary from this information. Please be aware that this information is not intended to replace the care or advice given by your physician or health care provider. It is neither intended nor implied to be a substitute for professional advice. Call your health provider immediately if you think you may have a medical emergency. Always seek the advice of your physician or other qualified health provider prior to starting any new treatment or with any question you may have regarding a medical condition.

Copyright 2017 UW Health Sports Medicine