Surgical Management of Recurrent Musculotendinous Hamstring Injury in Professional Athletes

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**Background:** Hamstring injury is the most common muscular lesion in athletes. The conservative treatment is well described, and surgical management is often indicated for proximal tendinous avulsions. To our knowledge, no surgical treatment has been proposed for failure of conservative treatment in musculotendinous hamstring lesions.

**Purpose:** To describe the surgical management of proximal and distal hamstring musculotendinous junction lesions in professional athletes after failure of conservative treatment.

**Study Design:** Case series; Level of evidence, 4.

**Methods:** A consecutive series of 10 professional athletes, including 4 soccer players, 4 rugby players, and 2 handball players, underwent surgical intervention between October 2010 and June 2014 for the treatment of recurrent musculotendinous hamstring injuries. All athletes had failed at least 3 months of conservative treatment for a recurrent musculotendinous hamstring injury. Surgical resection of the musculotendinous scar tissue was performed using a longitudinal muscular suture. Lower Extremity Functional Scale (LEFS) and Marx scores were obtained at the 3-month follow-up, and a final phone interview was completed to determine recurrence of hamstring injury and return to previous level of play.

**Results:** The mean age at surgery was 25.2 years (range, 19-35 years). The musculotendinous hamstring lesions involved 8 semitendinosus and 2 biceps femoris, with 6 injuries located proximally and 4 distally. Conservative treatment lasted a mean 5.1 months (range, 3-9 months) after last recurrence, and the patients had an average of 2.7 (range, 2-5) separate incidents of injury recurrence before surgical intervention was decided upon. At the 3-month follow-up, all patients had Marx activity scores of 16 and LEFS scores of 80. All 10 patients returned to the same level of play at a mean 3.4 months (range, 2-5 months). At a mean follow-up of 28.7 months, none of the athletes had suffered a recurrence. No surgical complication was encountered.

**Conclusion:** In cases of failed conservative treatment of musculotendinous hamstring lesions, surgical intervention may be a viable treatment option in professional athletes and allows the patient to return to the same level of play.

**Keywords:** hamstring; musculotendinous lesion; sports injuries; professional athlete

Historically, the term *hamstring* is derived from the trade of butchering. Pig carcasses were hung up by these tendinous muscles in the thigh of the ham for slaughtering. Additionally, the verb *to hamstring* means “to disable or to render useless.” This is testament to the importance of the hamstrings in both daily life and recreational activities.

The hamstrings are made up of 3 separate muscles: the semimembranosus, semitendinosus, and biceps femoris, the latter with a long and short head. The tendon of origin of the semimembranosus muscle arises from the triangular lateral facet of the ischial tuberosity; yet just below the tuberosity it has the form of a flat band, which lies in the coronal plane, on the deep aspect of the biceps and semitendinosus. The biceps femoris and semitendinosus share

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the hamstrings to injury. The most commonly injured muscle in the ham-
sstrings is the biceps femoris, and the injuries are usu-
ally found at the muscle-tendon junction. The conserva-
tive treatment is well described with good results, mainly in non-
professional athletes. The hamstring spans both the hip and knee joints. Dur-
ing certain activities, these 2 joints may be moving in oppo-
site directions, which contributes to a predisposition to an
eccentric injury. In addition, the hamstrings have more
abundant type II muscle fibers, which give explosive force
compared with the quadriceps but may further predispose
the hamstrings to injury.

Hamstring injury is the most common muscular lesion in
athletes. The most commonly injured muscle in the ham-
string group is the biceps femoris, and the injuries are usu-
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tive treatment is well described with good results, mainly in non-
professional populations, and consists of rest, nonsteroidal
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an exercise program. Steroid injection has also been pro-
posed for hamstring injuries as a treatment to decrease the
symptoms but not the rate of recurrence.

Rarely is surgical intervention performed, except in
large, displaced proximal tendinous avulsions, but with
good results. To our knowledge, no surgical treatment
has been proposed for failure of conservative treatment for proximal and distal musculotendinous hamstring lesions. The purpose of this article was to describe the surgical management of recurrent musculotendinous hamstring lesions after failure of conservative treatment in professional athletes.

**METHODS**

Between October 2010 and June 2014, 10 professional ath-
letes with a mean age 25.2 years (range, 19-35 years)
underwent surgical intervention for the treatment of recur-
rent musculotendinous hamstring injuries. The diagnosis of recurrence was made on subsequent magnetic resonance (MRI) examinations confirming the location of the
new tear at the previous injury site. Among the professional
athletes, there were 4 soccer players, 4 rugby players, and 2
handball players (Table 1).

All athletes were treated conservatively after the first
injury with rest, NSAIDs, and physical therapy. Once gait
was normalized and hamstring strength was 50% of the
contralateral leg, concentric and eccentric loading of the
hamstrings with exercises such as straight-leg deadlifts
and Nordic hamstring exercises commenced. Increased
stretching was also initiated. This phase was completed
when the hamstrings obtained a 5 out of 5 in manual mus-
cle testing and forward/backward jogging was pain free.
The final phase focused on increasing functional exercises
and strengthening in a lengthened state. Plyometrics,
high-level balance activities, and sport-specific drills were
performed. After completion of this stage, the athlete
should have obtained full mobility, strength, and coordi-
ation to return to full sport participation without restric-
tions. All athletes had failed at least 3 months of this
conservative protocol initiated for a recurrent musculoten-
dinous hamstring injury, with 6 injuries located proxi-
ma lly and 4 distally.

Failure was defined as recurrence of the same musculo-
tendinous hamstring injury despite at least 3 months of conser-
vative treatment. In the 3 months of this conservative
protocol, all athletes had no less than a failed and
return hamstring.

All surgeries were then performed by 2 senior orthopae-
dic surgeons (B.S.C., M.T.). Institutional review board
approval was obtained for this study.

**Surgical Technique**

**Proximal Lesions.** The patient was placed in the prone
position with a pillow under the hip to obtain slight hip flex-
ion. Just prior to surgery, the scar tissue at the musculoten-
dinous injury site was identified via sonography by a senior
radiologist (J.C.), and a metallic anchor with metal suture
(X-Reidy Breast Lesion Localization Needle; Cook Medical)
was placed through the skin into the lesion (Figure 1). This
served as a navigation beacon for our surgical dissection. A
vertical 8-cm incision was made just under the gluteal fold.
Dissection was carried down to the gluteal fascia, with care
to avoid the posterior femoral cutaneous nerve, which
crosses the hamstring from lateral-proximal to medial-
distal and can cause hypoesthesia to the posterior thigh
when damaged. Next, a transverse incision was made in the

| Patient | Sex | Age, y | Side | Location | Tendon Involved | Sport   | Number of Prior Injuries | Months From First Injury to Surgery | Months From Surgery to Return to Play | Follow-up, mo |
|---------|-----|--------|------|----------|----------------|--------|------------------------|--------------------------------------|---------------------------------------|--------------|
| 1       | M   | 35     | L    | Proximal | BF           | Handball | 5                      | 8                                    | 2                                      | 17           |
| 2       | M   | 25     | R    | Proximal | ST           | Handball | 2                      | 3                                    | 3                                      | 7            |
| 3       | M   | 25     | L    | Proximal | ST           | Rugby    | 3                      | 7                                    | 4                                      | 60           |
| 4       | M   | 21     | L    | Proximal | BF           | Rugby    | 2                      | 3                                    | 5                                      | 45           |
| 5       | M   | 22     | R    | Proximal | ST           | Rugby    | 2                      | 3                                    | 3                                      | 32           |
| 6       | M   | 26     | L    | Distal  | ST           | Soccer   | 5                      | 9                                    | 3                                      | 46           |
| 7       | M   | 25     | R    | Distal  | ST           | Soccer   | 2                      | 3                                    | 4                                      | 32           |
| 8       | M   | 26     | R    | Proximal | ST           | Soccer   | 2                      | 3                                    | 3                                      | 35           |
| 9       | M   | 28     | R    | Distal  | ST           | Soccer   | 2                      | 4                                    | 4                                      | 7            |
| 10      | M   | 19     | R    | Distal  | ST           | Soccer   | 2                      | 8                                    | 3                                      | 6            |

BF, biceps femoris; L, left; M, male; R, right; ST, semitendinosus.
The gluteal fascia at the inferior border of the gluteus maximus. The gluteus maximus was then elevated and retracted superiorly to expose the hamstring fascia. Care was taken not to place a retractor too deep on the ischium to minimize risk to the inferior gluteal nerve.

A longitudinal incision of the hamstring fascia was then made. This is the point at which the fibrous scar tissue and, occasionally, hematoma are encountered. The metallic anchor allows for precise localization of the scar tissue. The sciatic nerve is palpated in this plane and protected by lateral retraction of the tendons, keeping in mind that it passes in close proximity deep and lateral to the proximal hamstring origin.

Excision of the scar tissue, including the torn portion of the tendon, was then performed using a diathermy electrosurgical cautery pencil. The entire tendon stump was removed, leaving only the muscle belly. The belly of the remnant muscle was fixed with resorbable sutures (Vicryl USP 2; Ethicon) of approximately 4 cm without tension to the surrounding muscles in a side-to-side fashion (Figure 2). A suction drain was placed, and the wound then closed.

**Distal Lesions.** A different technique was performed for distal musculotendinous lesions of the semitendinosus. In these lesions, presurgical sonography was still performed, but no metallic anchor was placed. In all cases, the tendon was retracted proximally in the popliteus fold. The distal semitendinosus was located on sonography in the prone position and the skin marked. The tendon is superficial at this lesion location, so the use of a metallic anchor is not required. An incision was performed centered on the mark, and the tendon was easily exteriorized from its superficial location and removed using an open stripper (Figure 3).

**Figure 1.** Injury site identification. (A) Skin marking of the different structures. (B) Ultrasound transducer placed at the muscle-tendon junction to locate the injury site. (C) Metallic anchor loaded with a metallic wire placed in the identified lesion site to serve as an Ariadne’s thread for accurate surgical approach.

The incision was then closed after a suction device was placed. The drain was removed after 24 hours.

**Postoperative Rehabilitation Protocol**

Patients were mobilized 3 to 5 days after surgery and were on crutches for 2 weeks, with weightbearing as tolerated. Hip flexion in conjunction with knee extension was strictly...
forbidden; otherwise, range of motion was allowed as symptoms resolved, and no brace was used. Crutches were used for comfort until symptoms subsided. NSAIDs were used for postoperative pain management.

From weeks 2 to 6, a rehabilitation program was implemented based on progressive stretching of the hamstring group, with active and passive range of motion. From weeks 6 to 10, muscular strengthening was implemented and progressed as tolerated. At 2 months, sport-specific training was implemented, and return to play was allowed when the patient was pain free and completed sport-specific training. No isokinetic testing was performed.

Follow-up

All 10 patients were followed clinically until physician release for return to play. MRI scans were performed between 2 and 3 months postsurgery. At 3 months postoperatively, Lower Extremity Functional Scale (LEFS) and Marx activity scale scores were obtained.1,5,28 The patients were then subsequently contacted for a phone interview by an independent investigator, with a mean follow-up of 28.5 months (range, 6-60 months). As part of the questionnaire, 2 specific questions were asked: (1) Have you had any recurrence of hamstring injury? (2) Can you confirm how many months were required for you to return to your previous level of play after surgery?

RESULTS

The mean player age at surgery was 25.2 years (range, 19-35 years). The musculotendinous hamstring lesions involved 8 semitendinosus and 2 biceps femoris, with 6 injuries located proximally and 4 distally. Conservative treatment lasted a mean 5.1 months (range, 3-9 months) after last recurrence, and patients had a mean 2.7 (range, 2-5) separate incidents of injury recurrence before surgical intervention was decided upon.

Of the 10 professional athletes undergoing surgical intervention, all returned to their preinjury level of play (Table 1). Neither significant abnormality nor remodeling of the muscle structure was observed on postoperative MRIs (Figure 4).

Figure 3. Distal lesion. (A) Coronal and (B) sagittal magnetic resonance images demonstrating distal avulsion of the semitendinosus. (C) Incision and identification of the tendon. (D) Stripping of the tendon.
The mean amount of time from surgery to return to play was 3.4 months (range, 2-5 months). At 3 months post-operatively, 9 athletes had a Marx activity rating of 16 of a maximum of 16, and 1 had a 14. Additionally, 9 patients had an LEFS score of 80 of a maximum of 80, and 1 patient had a score of 78. There was no recurrence of injury reported by any of the athletes. In addition, no surgical complications were encountered (see Table 1).

**DISCUSSION**

Hamstring injuries can occur at either the proximal or distal “free” ends, the musculotendinous junctions, or at the central intramuscular tendon. To our knowledge, this is the first study investigating the surgical treatment of recurrent musculotendinous injuries to the hamstring muscle group in professional athletes. Athletes in our study had excellent clinical outcome scores as defined by both the Marx activity rating score and LEFS score. Return to preinjury activity level is a commonly used outcome for treatment success, and our results demonstrate 100% return to previous level of play after surgical intervention, with no recurrences or complications.

Professional athletes place especially high demand on the hamstring muscles, given the rapid acceleration and pivoting maneuvers inherent in their activities. The patients in our study were all professional athletes who had sustained multiple, recurrent hamstring injuries, some of which were potentially career ending. Hamstring injuries are common in this unique population and are a significant source of lost time. With the exception of large, proximal avulsions, treatment for these athletes is initially conservative. Rehabilitation after injury consists of warm-up stretching, flexibility training, and eccentric muscle strength training, known as “Nordic exercises.” These eccentric exercises are an instrumental component to any rehabilitation protocol but have demonstrated mixed results in the literature. With completion of rehabilitation, most athletes can return to their previous level of play with good results.

However, despite the success of conservative rehabilitation in many of these patients, reinjury is still relatively common, occurring in between 12% and 31% of patients. While there are many factors likely contributing to reinjury, including early return to play, incomplete rehabilitation, and the significant forces placed on the hamstring muscle group in this population, it can...
also be secondary to insufficient healing of the musculotendinous junction.

When the injury occurs, a hematoma forms and scar tissue eventually develops. Over time, remodeling of the injured tissue occurs, but tendons heal at a prolonged rate and are relatively weak.\(^{4,18}\) In addition, Pomeranz and Heidt\(^ {29}\) identified longer recovery times when the injury was in the musculotendinous junction. Furthermore, other studies have found that remodeling after injury predisposes to recurrence and prolonged healing times.\(^ {6,37}\) This is particularly true in musculotendinous tears, as tendon-to-muscle healing is often of poor quality and weak scar tissue is prone to recurrence.

Given the significant forces placed on the hamstring muscle group in this high-level population, the weakness and prolonged healing of the injury can place the professional athlete in jeopardy of recurrence.

Although the concept of removal of this remodeled musculotendinous structure is the same regardless of location, the surgical technique differs slightly. Proximally, the hamstring muscle group is a large musculotendinous structure; thus, removal of the degraded tissue is performed via a posterior approach, and subsequent suturing is performed connecting muscle to muscle. We believe it is important in this subset of patients to mark the lesions preoperatively using an imaging device to assist in directing the surgical dissection. For distal lesions, simply marking the lesion is adequate, as the dissection is more superficial and less complicated. Lempainen et al.\(^ {23}\) previously reported a series of distal lesions of the hamstring musculotendinous junction that were successfully treated using the same surgical protocol, including excision of the scar tissue and muscle stump suture. However, in their study, the series described did not include patients with recurrent lesions but instead included 18 patients with chronic pain and disability as a result of a single traumatic event that prevented them from resuming their sport at the same level. The elimination of fibrous scar tissue combined with intermuscular suturing allows for integral healing of muscle to muscle (see Figure 3). We believe this decreases the chances of reinjury by eliminating the remodeling tissue that is attempting to heal the musculotendinous defect. In addition, it allows the muscle to heal to the adjacent muscle in a tension-free manner, and thus, a stronger healing process will occur.

Ischiatic reinsertion of the distal stump is not feasible because the stump is located at the myotendinous junction, distant from the bony insertion. Repair using autograft or allograft has been proposed for chronic retracted proximal hamstring tears;\(^ {27}\) we did not choose this option given the delay required for return to play.

Our study has some weaknesses. We have no comparative group and few cases. Ideally, isokinetic testing would have been performed in these patients prior to the decision on return to play. In our series, this was not possible, given the vast geographic locations of these patients. Nevertheless, this is the first surgical option we are aware of for this injury in professional athletes. All patients suffered at least 2 recurrences of hamstring injury prior to surgery and then failed conservative treatment. Many of these athletes were facing career-ending circumstances due to recurrence of injury, and our treatment is the first to demonstrate successful surgical intervention without recurrence and with full return to play. In addition, all patients completed sport-specific training regimens and were asymptomatic prior to being released.

CONCLUSION

The surgical treatment of recurrent hamstring musculotendinous injury is a reliable and safe technique. Our results are encouraging, given that all of our patients returned to professional sports without surgical complication or recurrence after a mean follow-up of over 2 years. In cases of failed conservative treatment of musculotendinous hamstring lesions, surgical intervention may be a viable treatment option in professional athletes. Further investigation is needed to confirm these initial findings.

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