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Case Report

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Haglund Syndrome in a Professional Basketball Player: Mini Open Excision. A Case Study

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Abstract

Haglund syndrome is a common but challenging condition for athletes, especially those involved in high-impact sports like basketball. It involves a bony enlargement of the posterosuperior calcaneus that irritates the retrocalcaneal bursa and Achilles tendon. This case study details the diagnosis, treatment, and recovery of a professional basketball player treated with a mini open excision technique.

Keywords: Achilles tendon; Haglund; Deformity; Sportsmedicine.

Introduction

Haglund syndrome is a common but challenging condition for athletes, especially those involved in high-impact sports like basketball [1]. It involves a bony enlargement of the posterosuperior calcaneus that irritates the retrocalcaneal bursa and Achilles tendon. This case study details the diagnosis, treatment, and recovery of a professional basketball player treated with a mini open excision technique.

The results show that both open and endoscopic surgical modalities are efficacious in the treatment of Haglund's deformity, significantly improving functional outcome scores such as American Orthopaedic Foot & Ankle Society (AOFAS) scores and patient satisfaction post-operatively. Endoscopic surgery appears to have the advantage of shorter operative times, lower complication rates, and better cosmesis [2-4]. We are familiar with a mini open technique laterally or medically and a purely atraumatic resection with no Achilles tendon injury. More studies are required to further validate and optimize these surgical techniques.

Case Presentation

A 27-year-old professional basketball player presented with chronic pain and swelling at the back of his left ankle worsening with training and games. He reported stiffness during dorsiflexion and difficulty wearing shoes. Conservative treatments—including rest, physical therapy, NSAIDs, PRP injections and heel lifts—had failed over 4 months. Clinical examination revealed tenderness over the Achilles insertion and a prominent bony bump at the posterior heel (Figure 1). Ultrasound and MRI showed thickening of the retrocalcaneal bursa with no evidence of a tear of the Achilles tendon. Lateral ankle radiographs confirmed a prominent Haglund deformity and retrocalcaneal spur (Figure 2).

Given the persistent symptoms and impact on performance, surgical intervention was recommended.

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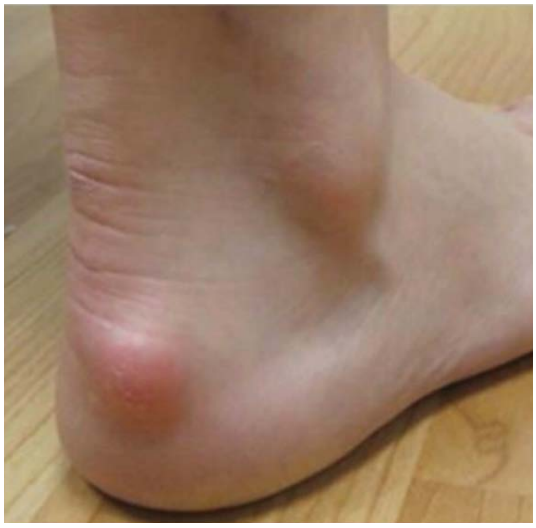
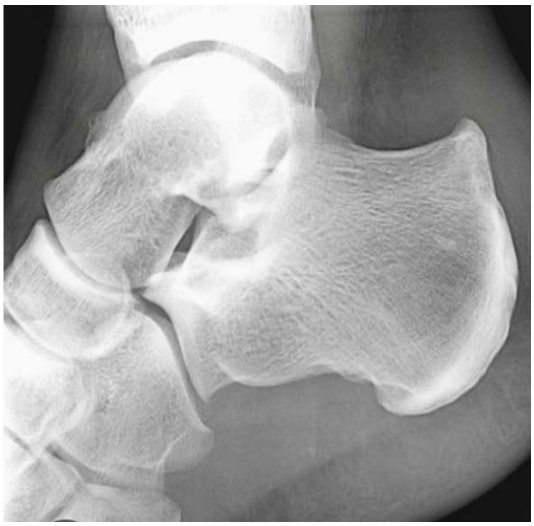


Figure 1:



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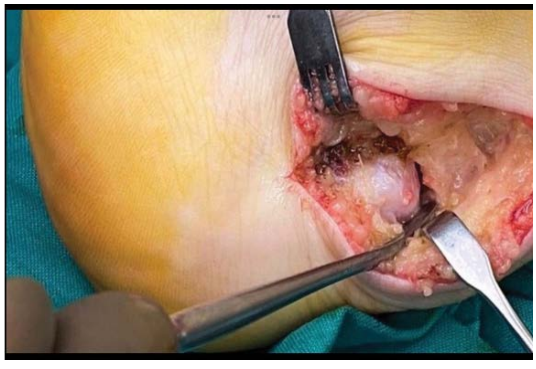

Figure 3:

Surgical Technique

A mini open excision was performed under regional anesthesia. For open surgeries, three main approaches were used. They were the lateral approach [5] medial approach and midline Achilles tendon central split approach [6]. We use lateral or medial incisions depending on where the biggest part of the bump is located. Usually we use a lateral 3–4 cm longitudinal incision (Figure 3) [7]. The retrocalcaneal bursa was excised, a motorized burr and an osteotome were used to resect the posterosuperior calcaneal prominence under direct visualization (Figure 4). Care was taken to preserve the Achilles tendon insertion and reduce disruption to surrounding soft tissue (Figure 5). The wound was irrigated and closed in layers. A sterile dressing and posterior bandage, no cast, were applied.

Postoperative Care and Rehabilitation

The patient had partially weight bearing for two weeks immediately after the operation. No cast was used at all. Physical therapy focused on range of motion, followed by progressive strengthening of the calf and Achilles complex. By week six, the athlete had returned to low-impact training. At ten weeks, he resumed sport-specific drills. He returned to full basketball activity at 12 weeks post-op.

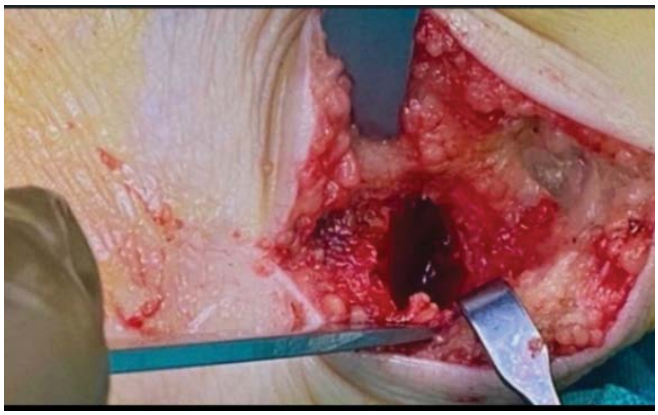

Figure 4:

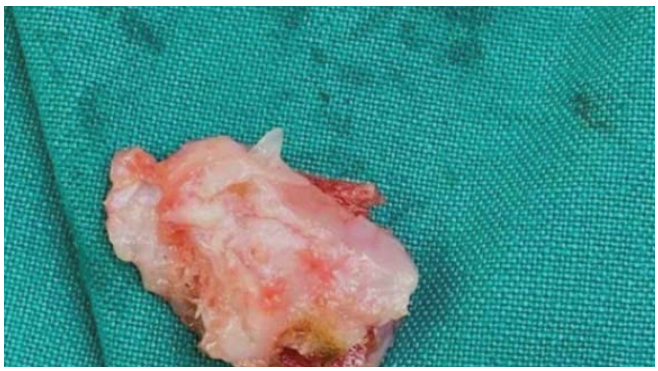

Figure 5:

Outcome

At five to six months, the player reported full pain relief and had returned to pre-injury performance levels. Follow-up imaging showed no recurrence of the bony prominence or tendon damage [8]. The minimally invasive approach allowed for fast recovery and reduced soft tissue complications [9].

Discussion

Haglund syndrome can be debilitating for athletes, and timely intervention is critical to prevent long-term damage. While conservative care remains first-line treatment, surgical excision is effective for resistant cases [10]. The mini open approach offers a balance between direct visualization and limited soft tissue disruption. It reduces the risk of wound healing complications and speeds up recovery—key considerations for high-performance athletes.

Conclusion

Mini open excision is a reliable surgical option for Haglund syndrome in elite athletes when conservative treatment fails [11]. This case highlights the importance of early diagnosis, targeted surgical intervention, and structured rehabilitation to achieve a successful return to sport [12].

References

1. Vaishya R, Agarwal AK, Azizi AT, et al. Haglund's syndrome: a commonly seen mysterious condition. Cureus 8 (2016): 820.
2. Scholten PE, van Dijk CN. Endoscopic calcaneoplasty. Foot Ankle Clin 11 (2006): 439-446.
3. Wu Z, Hua Y, Li Y, et al. Endoscopic treatment of Haglund's syndrome with a three portal technique. Intthree-portal 36 (2012): 1623-1627.
4. Leitze Z, Sella EJ, Aversa JM. Endoscopic decompression of the retrocalcaneal space. J Bone Joint Surg Am 85 (2003): 1488-1496.
5. Anderson JA, Suero E, O'Loughlin PF, et al. Surgery for retrocalcaneal bursitis: a tendon-splitting versus a lateral approach. Clin Orthop Relat Res 466 (2008): 1678-1682.
6. Xia Z, Yew AK, Zhang TK, et al. Surgical correction of Haglund's triad using a central tendon-splitting approach: a retrospective outcomes study. J Foot Ankle Surg 56 (2017): 1132-1138.
7. Natarajan S, Narayanan V. Haglund deformity - surgical resection by the lateral approach. Malays Orthop J 9 (2015): 1-3.
8. Tourne Y, Baray AL, Barthelemy R, et al. The Zadek calcaneal osteotomy in Haglund's syndrome of the heel: clinical results and a radiographic analysis to explain its efficacy. Foot Ankle Surg 28 (2022): 79-87.
9. Pi Y, Hu Y, Guo Q, et al. Open versus endoscopic osteotomy of posterosuperior calcaneal tuberosity for Haglund Syndrome: a retrospective cohort study. Orthop J Sports Med 9 (2021).
10. Slobogean G, Bhandari M. Introducing levels of evidence to the Journal of Orthopaedic Trauma: implementation and future directions. J Orthop Trauma 26 (2012): 127-128.
11. Wright JG, Einhorn TA, Heckman JD. Grades of recommendation. J Bone Joint Surg Am 87 (2005): 1909-1910.
12. Schneider W, Niehus W, Knahr K. Haglund's syndrome: disappointing results following surgery -- a clinical and radiographic analysis. Foot Ankle Int 21 (2000): 26-30.

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