

**Table 1: The diagnosis and treatment of acute Achilles tendon rupture
clinical practice guideline summary of recommendations**

Recommendation	Strength of recommendation
1. In the absence of reliable evidence, it is the opinion of this work group that a detailed history and physical exam be performed. The physical examination should include two or more of the following tests to establish the diagnosis of acute Achilles tendon rupture: <ul style="list-style-type: none"> • Clinical Thompson test (Simmonds [calf] squeeze test) • Decreased ankle plantar flexion strength • Presence of a palpable gap (defect, loss of contour) • Increased passive ankle dorsiflexion with gentle manipulation 	Consensus*
2. We are unable to recommend for or against the routine use of magnetic resonance imaging (MRI), ultrasound (ultrasonography), and radiograph (roentgenograms, X-rays) to confirm the diagnosis of acute Achilles tendon rupture.	Inconclusive
3. Nonoperative treatment is an option for all patients with acute Achilles tendon rupture.	Weak
4. For patients treated nonoperatively, we are unable to recommend for or against the use of immediate functional bracing for patients with acute Achilles tendon rupture.	Inconclusive
5. Operative treatment is an option in patients with acute Achilles tendon rupture.	Weak
6. In the absence of reliable evidence, it is the opinion of the work group that although operative treatment is an option, it should be approached more cautiously in patients with diabetes, neuropathy, immunocompromised states, age above 65, tobacco use, sedentary lifestyle, obesity (BMI >30), peripheral vascular disease, or local/systemic dermatologic disorders.	Consensus
7. For patients who will be treated operatively for an acute Achilles tendon rupture, we are unable to recommend for or against preoperative immobilization or restricted weight bearing.	Inconclusive
8. Open, limited open, and percutaneous techniques are options for treating patients with acute Achilles tendon rupture.	Weak
9. We cannot recommend for or against the use of allograft, autograft, xenograft, synthetic tissue, or biologic adjuncts in all acute Achilles tendon ruptures that are treated operatively.	Inconclusive
10. We cannot recommend for or against the use of antithrombotic treatment for patients with acute Achilles tendon ruptures.	Inconclusive
11. We suggest early (≤ 2 weeks) postoperative protected weight bearing for patients with acute Achilles tendon rupture who have been treated operatively.	Moderate
12. We suggest the use of a protective device that allows mobilization by 2-4 weeks postoperatively.	Moderate
13. We are unable to recommend for or against postoperative physiotherapy for patients with acute Achilles tendon rupture.	Inconclusive
14. In all patients with acute Achilles tendon rupture, irrespective of treatment type, we are unable to recommend a specific time at which patients can return to activities of daily living.	Inconclusive
15. In patients who participate in sports it is an option to return them to sports within 3-6 months after operative treatment for acute Achilles tendon rupture.	Weak
16. In patients with acute Achilles tendon rupture treated nonoperatively, we are unable to recommend a specific time at which patients can return to athletic activity.	Inconclusive

Note: This summary does not contain rationales that explain how and why these recommendations were developed nor does it contain the evidence supporting these recommendations. All readers of this summary are strongly urged to consult the full guideline and evidence report for this information. We are confident that those who read the full guideline and evidence report will also see that the recommendations were developed using systematic evidence-based processes designed to combat bias, enhance transparency, and promote reproducibility. This summary of recommendations is not intended to stand alone. Treatment decisions should be made in light of all circumstances presented by the patient. Treatments and procedures applicable to the individual patient rely on mutual communication between patient, physician, and other healthcare practitioners.