PLATELET RICH PLASMA FOR HAMSTRING TEARS

A retrospective, clinical case report of a single percutaneous application of platelet rich plasma to a severe traumatic partial-thickness proximal hamstring tear demonstrates sustained subjective and functional improvements with near-complete repair on MRI.

By David C. Karli, MD and Brent R. Robinson, BS

Platelet Rich Plasma (PRP) Injection Therapy is gaining popularity in musculoskeletal medicine, not only for its ease of use, but also for its consistently good results. In this excellent analysis and case study, Karli and Robinson of the Stedman Clinic in Colorado demonstrate sustained objective and subjective improvement with just one PRP treatment in a near-complete hamstring tendon tear. The authors demonstrate that—while certainly useful—ultrasound guidance is not mandatory when the anatomical location is easily palpable. They also use a very creative method of extracting autologous thrombin from the platelet-poor portion of the centrifuged blood, presenting a promising new possibility for emerging PRP protocols.

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Proximal hamstring injuries are common in athletes and frequently result in prolonged rehabilitation, time missed from play, and a significant risk of reinjury.1,2 Reports of acute hamstring strains without avulsion in dancers have suggested recovery times for return-to-play ranging from 30 to 76 weeks.1 The healing process associated with hamstring injuries and with injured skeletal muscle is inefficient as compared to that associated with injuries of other tissue such as bone. This inefficiency is driven by structural adaptations that maximize load-carrying capacity under prolonged ischemic conditions.3 Vascular supply from associated muscle and surrounding tissues typically does not extend beyond the proximal third of the tendon.3,4 Because oxygen consumption is low and energy generation is anaerobic, the resulting metabolic rate is slow and healing capacity is limited.3
Tendons are damaged when subjected to loads that exceed their tensile or physiologic threshold. This can occur in response to massive trauma or to repetitive overload if insufficient time is allowed for tissue recovery. The risk for tendon rupture is highest when tension is applied rapidly and obliquely. The highest forces have been recorded during eccentric contraction. Tendons respond to this non-physiologic overload with tendon sheath inflammation, intratendinous degeneration, or a combination of both.

Muscle and tendon recover from injury through tissue remodeling that can lead to inefficient regeneration and infiltration by scar tissue. The first phase involves an increase in vascular permeability, initiation of angiogenesis, chemotactic migration of inflammatory cells (notably neutrophils initially then followed by macrophages) to the region of injury, and induction of local tenocytes to synthesize collagen and extracellular matrix (ECM). After several days, type III collagen synthesis peaks as tenocyte proliferation continues. At roughly six weeks, the healing tissue begins to remodel. Regional cellularity decreases as up-regulation of synthesis of collagen and other proteins takes place. Tissue gradually transitions from cellular to fibrous in nature as tenocytes align in the direction of stress forces. Production of collagen type I increases as production of type III drops off. At approximately 10 weeks, fibrous tissue begins to remodel and mature. These processes continue through the course of a full year, resulting in tendon tissue with scar-like properties. As tissue matures, tenocyte metabolism decreases—either through intrinsic mechanisms contained within an intact peritenon or through extrinsic mechanisms involving invasion by cells from the surrounding tissue. Extrinsic pathways related to peritenon disruption and more severe injuries lead to greater scarring and adhesion and resultant disruption of the normal gliding of the tendon within the sheath.

Traditional hypotheses have attributed pain in tendinopathy to an inflammatory process. Studies of chronically painful Achilles and patellar tendons have shown no evidence of inflammation. Histologically, healing appears to be disordered and haphazard, with an absence of inflammatory cells but presence of hypercellularity, scattered vascular in-growth, and collagen degeneration. The etiology of pain within tendons has not been conclusively elucidated, but evidence suggests that mechanical collagen breakdown, abnormal lactate levels, neurotransmitter imbalance, the presence of pro-inflammatory prostaglandins, and neural centralization may be involved.

Tendon recovery is frequently incomplete in severe or full-thickness tears, due to the proliferation and up-regulation of fibroblasts, which induce formation of excessive scar tissue that leads to suboptimal tissue integrity and functionality. Research suggests that throughout tendon repair, trophic substances, such as growth factors released from damaged tissue, may regulate the healing response. It has been hypothesized that autologous growth factors found in platelets may augment the healing of musculoskeletal soft-tissue abnormalities.

An understanding of the role of platelets in tissue healing has led to the use of autologous platelet concentrates for therapeutic purposes. Degranulation and subsequent release of growth factors from platelets can be induced and the isolated growth factors can be delivered directly into injured tissue to stimulate a physiologic response. Platelet-rich plasma (PRP) is easy to produce through centrifugation of peripheral blood and separation of the resulting component. As an autologous substrate, PRP has limited potential to harm. The therapeutic response of the percutaneous implantation of PRP into tendon, muscle, ligament, cartilage, intervertebral disc, and fascia has generally been positive.

Numerous growth-factor peptides have been identified in both the dense granules and the alpha granules of platelets, which bind to membrane-bound receptors, thereby activating intracellular second-messenger pathways. Bioactive functions associated with platelet-derived growth factors (PDGFs) include angiogenesis, chemotaxis, cell recruitment, cellular proliferation, cellular differentiation, and ECM synthesis. Some researchers have suggested that, due to the complexity of healing pathways and tissue regeneration, the synergistic interaction of multiple growth factors at physiologic concentrations may be superior to the action of a single exogenous growth factor.

Case Report
A 48-year-old female sustained a severe left proximal hamstring tear while water skiing. Her left leg became hyperextended when she attempted to drop her right ski and the ski caught the water, aggressively forcing her left hip into eccentric hyperflexion. Subsequently, she felt a tearing sensation localized to the left ischial tuberosity region at the origin of the left common hamstring tendon. She immediately experienced pain and transient numbness in the left lower extremity. Ini-
surgical options, the patient opted for PRP

tially, she did not seek care, instead relying
on rest and oral nonsteroidal anti-inflammatory drugs (NSAIDs) for two and
one-half weeks. During this time, al-
though symptom intensity decreased,
pain and dysfunction persisted with am-
bulation, prolonged sitting, and exertion-
al activity. Nocturnal pain interrupted the
patient’s sleep patterns. In addition, the
patient experienced subjective weakness
and instability of the affected leg as well
as localized swelling at the site of injury.

Sixteen days after the injury, the patient
consulted an orthopaedic surgeon be-
cause of the persistence of pain and func-
tional limitation. The consulting physi-
cian identified pain on palpation, which
was localized to the left buttock and ag-
gravated by resisted knee flexion. Left
hamstring strength was rated 4/5 and left
lower extremity sensory and vascular
exams were normal.

Radiographs of the pelvis revealed no
bony defects at the hamstring insertion
into the ischial tuberosity or evidence of
any other hip-joint abnormality. MRI con-
ﬁrmed a full-thickness tear of the prox-
imal semimembranosus tendon near the
myotendinous junction. Tendon-fiber re-
traction was measured to be 3 cm. A par-
tial-thickness tear of the conjoined biceps
demoris and semitendinosus tendon at the
ischial tuberosity insertion was also re-
ported. No bone marrow edema was
noted. A diffuse hematoma within the re-
ported. No bone marrow edema was

Figure 2A. Autologous thrombin. Removal of
the clot following the addition of 10% Calcium Chloride.

Figure 2B. Autologous thrombin. Harvesting of autologous thrombin prior to injection.

PROCEDURE Production of Platelet Rich Plasma

With sterile technique, 60mL of whole
blood was collected by peripheral phle-
botomy into a syringe containing 6 cc of
the anticoagulant citrate dextrose solu-
tion A (ACD-A, Cytosol Laboratories,
Brantree, MA). The specimen was
processed with a Harvest® SmartPreP®
centrifugation system and 60mL dispos-
able kit (Harvest Technologies, Plymouth,
MA). The blood sample was loaded, cen-
trifuged, and harvested following the
manufacturer’s protocol. The initial
60mL of whole blood yielded 7mL of PRP,
which was drawn into a sterile syringe.
The red blood cell fraction was discarded,
and the platelet-poor plasma (PPP) was
saved for the production of autologous
thrombin (AT).

Activation of Platelet-Poor Plasma and
Production of Autologous Thrombin Supernatant

Once the whole blood was separated, 7mL
of the PPP was added to each of two 10-
mL glass BD Vacutainer tubes (BD,
Franklin Lakes, NJ), both of which had been
pre-dosed with 0.15mL of 10% cal-
cium chloride (American Regent, Inc.,
Shirley, NY) to reverse the effects of the
anticoagulant. The tubes were vigorously
shaken for 60 seconds to adequately mix
the contents and then left to stand for 15
minutes. After the rest period, a thick, soft
clot formation was noted within each tube.
Under sterile conditions, the clot was
manually broken apart to produce a clear
supernatant, which was harvested (see
Figure 2a) and drawn into a sterile syringe
(Figure 2b). Consistent with reports de-
scribed by Everts and other authors, the
resulting supernatant following PPP acti-
vation has been demonstrated to contain
autologous thrombin protein.

PRP Implantation

The patient was placed in a prone posi-
tion. The left gluteal and proximal ham-
string region was prepared and draped
under sterile conditions. With the tendon
at rest and with concentric contraction,
the areas of maximal tenderness and the
site of proximal insertion of the hamstring
into the ischial tuberosity were identified
by palpation.

Contact with and isolation of the target
region was maintained through applica-
tion of isometric contraction with manu-

al soft tissue depression by the second
and third digits of the examiner’s nondom-
nant hand. Local anesthesia was achieved
by placing 1% preservative-free Xylocaine
(2-3mL) into the soft tissue of the proxi-
mal hamstring.

While constant pressure was maintai-
ned with the nondominant hand, a 22-
gauge, 1.5-inch needle was inserted into-
toward the ischial tuberculosis. Once peri-
ratrocal contact was made, the PRP was
placed at the insertion site in a fanlike dis-
tribution with a radius of several centime-
ters and also along the proximal 3-5 cm
of the common tendon tissues utilizing 4-
5 needle fenestrations of the tendon and
myotendinous junction. After negative as-
pirations, all 7mL of PRP was infiltrated.
The PRP syringe was disconnected, the ac-
tivated PPP/AT-filled syringe was attached,
and then 7mL of PPP/AT was infiltrated
into the tissue in a similar fashion. A ster-
ile dressing was applied to the region, and
the patient was discharged home.

Post-Procedure Protocol

A two-week period of relative rest and ac-
tivity restriction was recommended.
Weight-bearing and ambulation as toler-
ated were allowed but any aggressive
stretching or concentric or eccentric
loading of the tendon was not. The pa-
tient was advised to avoid NSAIDs or any
other anti-inflammatory medication for
at least two weeks. At week three, the pa-
tient was permitted to increase her activ-
ities slowly and progressively as pain allowed her to tolerate.

Post-Procedure Clinical Course

The patient reported no significant increase in pain after the intervention. Subjective improvement in pain was noticeable at one week, and functionality began to improve gradually about the same time. By week four, the patient was able to ambulate without pain or antalgia and to sit pain-free for reasonable periods. In addition, the quality of her sleep had also improved due to resolution of nocturnal pain and she no longer required NSAIDs or other analgesics. She was able to resume light exercise, including treadmill-walking, at week six and was able to tolerate stationary bicycling at moderate exertion by week eight. When followed up by phone at 20 weeks, the patient reported exertion by week eight. When followed up by phone at 20 weeks, the patient reported exertion by week eight. When followed up by phone at 20 weeks, the patient reported exertion by week eight. When followed up by phone at 20 weeks, the patient reported exertion by week eight. When followed up by phone at 20 weeks, the patient reported exertion by week eight.

The patient underwent follow-up MRI just under four months following the injury. The radiologist who had interpreted the pre-procedure study reported the following at follow-up:

1. “Significant interval healing response within both the semimembranosus tendon and the conjoint tendon of biceps femoris and semitendinosus. Mild granulation tissue and contour irregularity persists within the proximal tendons. There is persistent partial, but not complete, avulsion of the conjoint tendon from the ischial tuberosity. The semimembranosus tendon origin is intact.

2. Interval complete resolution of the hamstring muscle strains and posterior thigh hematoma” (see Figure 1b).

Discussion

Traditional nonsurgical therapies for acute and chronic tendon injuries have limited potential to alter the long-term course of the disease process. If acute or repetitive tendon trauma results in fibrosis of the intratendinous tissue, chronicity usually develops and results in pain, functional limitation, and risk of reinjury. In a study of transected Achilles tendon in sheep, histologic and biomechanical properties of spontaneously-healed tendons did not match those of intact noninjured tendons. At 12 months, rupture force in the transected group rated only 56.7% of that in the normal group. Peritendinous scar formation has also been observed to produce sciatic nerve irritation and lower extremity sensorimotor symptoms. Disappointing clinical results have led to a growing interest in the potential of anabolic and regenerative therapies which, in theory, may be able to augment the capability of tissues for repair.

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play would no longer be a risk.

If its safety profile continues to be favorable, PRP may represent a safer alternative to more traditional treatments, such as steroidal and nonsteroidal medications—whether injected or delivered orally. In a study evaluating the histopathologic changes in proximal hamstring tendinopathy, Lempainen et al concluded that with corticosteroid application, chronic tendinopathy was likely to develop and usually only short-term relief was provided.

PRP infiltration could also complement rehabilitation programs that are so often used to treat soft-tissue disorders. Post-procedure activity-modification and rehabilitation protocols have yet to be clearly defined. Most clinical research has suggested the need for a period of tissue rest—due to the sustained bioactivity and release of growth factors—followed by graded return to activity and training at different intervals.

The case presented here demonstrates the potential therapeutic effects of PRP. A single infiltration of PRP promoted the healing of a severe, near-complete thickness, traumatic hamstring tendon disruption that otherwise would likely have faced surgical debridement and reimplantation. As of six months post-procedure (after a single application), the outcome continues to be good in terms of both symptoms and function. MRI follow-up has suggested that limited residual scar tissue has formed. In contrast, to judge from histologic research data, the likelihood of scarred, dysfunctional tissue following spontaneous tissue repair of an injury of this magnitude would have been high.

The exact mechanism of anabolic stimulation with PRP or PDGFs has yet to be elucidated. It may, in fact, reflect a complex interaction of cellular and noncellular events. The stage of the healing process during which PRP is effective also remains unclear. Without question, further research is required not only to validate the biotherapeutic effects and clinical results of PRP therapy but also to unveil the physiologic mechanisms of action.

Summary

Percutaneous, autologous platelet rich plasma injection was selected as a conservative treatment option for a proximal hamstring injury within the setting of a private orthopedic surgical practice. Subjective improvement post-procedure was monitored through six months. Pre-injury MRI was performed at approximately two weeks after the initial injury. At four months post-treatment, a follow up MRI with the same parameters was repeated and reviewed by the same radiologist to evaluate healing and tissue integrity. The patient subjectively reported a decrease in pain at one week post-procedure. Reduction in pain and improvements in functionality continued through weeks 4, 6, 8, 20 and at final follow-up at six months. The improvements noted by the patient coincided with significant tissue healing as reported by the evaluating radiologist on follow-up MRI.

Platelet rich plasma represents a simple, low-cost, low-risk, autologous regenerative biotherapy whose utility in treating soft-tissue pathology remains under investigation. This case report demonstrates sustained subjective and functional improvements with near-complete repair on MRI with a single application of platelet-rich plasma in a severe tendon injury.

Disclosure

The authors certify that no party having a direct interest in the results of the research supporting this article has or will confer a benefit on the authors or on any organization with which the authors are associated.

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References


