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Introduction

Dance is an enchanting activity that requires tremendous and optimized physical and technical skills. It forces dancers in major loads which lead to musculoskeletal injuries, with ankle injuries being undoubtedly amongst the most common dance injuries [1-3].

In a series of studies the incidence of dance related ankle injuries vary between 4,7% an 54% with so tissue lesions representing a great proportion of these ailments [1].

Although Flexor Hallucis Longus Tendonitis (FHL) is a well recognized pathology a ecting the female classical ballet dancers, Posterior Tibial Tendinopathy (PPT) is frequently an underestimated and misdiagnosed dance injury [4].

PPT in dancers, which is originally the result of overuse infestations that lead to PTT tenosynovitis, may restrict their artistic performance with a harmful in uence on their career.

In this review an analysis of basic aspects of pathogenesis, diagnosis and treatment of this clinical entity is conducted with special focus on dancers.

Anatomy-Biomechanics

e Posterior Tibialis (PT) is the deepest muscle in the posterior compartment of the leg. It takes origin on the interosseous membrane and the posterior surfaces of the tibia and bula. PT attaches primary on the tuberosity of the navicular while other attachments of this muscle are located to cuneiform, and cuboid bones as well as the bases of the second, third, and fourth metatarsals [4,5].

Normally, this muscle participates in inversion and secondary in "winged"(f)9(o)-9(o)15(t t)-6(h)3(a)190t presupposes an ex-6ssive planar exion,sabductions,shiland(e)-8(v)8(er)6(sio)12(n o)12(f t)-6(h)4(7(

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