Anatomy: Pes anserinus is the anatomic term used to identify the insertion of the conjoined tendons into the anteromedial proximal tibia. The pes anserinus is made up of the tendons of the sartorius, gracilis, and semitendinosus muscles, which are the primary flexors of the knee. The tendon's name, which literally means "goose's foot," was inspired by the pes anserinus's webbed, footlike structure.

Causes/Mechanism of Injury:
Overuse of the hamstrings, especially in athletes with tight hamstrings is a common cause. Runners are affected most often, improper training, sudden increases in distance run, and running up hills can contribute to this condition.

It can also be caused by trauma such as a direct blow to this part of the knee. A contusion to this area results in an increased release of synovial fluid in the lining of the bursa. The bursa then becomes inflamed and tender or painful. Anyone with osteoarthritis of the knee is also at increased risk for this condition. And alignment of the lower extremity can be a risk factor for some individuals. A turned out position of the knee or tibia, genu valgum (knock knees), or a flatfoot position can lead to pes anserine bursitis.

Symptoms:
The patient often points to the pes anserine as the area of pain or tenderness. The pes anserine is located about two to three inches below the joint on the inside of the knee. This is referred to as the anterior knee or proximal-medial tibia. The pain is made worse by exercise, climbing stairs, or activities that cause resistance to any of these tendons. Local swelling may be noted.

Treatment/Management: Bedrest is not required but it may be necessary to modify some of your activities. This will give time for the bursa to quiet down and for the pain to subside. Patients are advised to avoid stairs, climbing, or other irritating activities. This type of approach is called relative rest.

Ice- is applied three or four times each day for 15 to 20 minutes at a time.
Nonsteroidal antiinflammatory drugs (NSAIDs)- such as Ibuprofen may be advised. In some cases, the physician will prescribe stronger NSAIDs.

Iontophoresis- Can be performed by your physical therapist. Using an electric charge, an antiinflammatory drug can be pushed through the skin to the inflamed area. Iontophoresis puts a higher concentration of the drug directly in the area compared to taking medications by mouth.

Improving flexibility- is a key part of the prevention and treatment of this condition.

Rehabilitative exercise including stretching and strengthening.

Post op protocol:
If resective surgery is performed, the knee remains in extension or slight flexion within an immobilizer for 1-2 weeks after surgery. Pursue active range of motion (AROM) until 3 weeks postsurgery, and then begin progressive resistive exercises (PREs).