

(Picture of Grim Reaper as Title Image)

My next patient grimaces with pain as he stands up from the chair. His first few steps are hobbled as I watch him walk towards me. By the time he reaches my office he is walking better. I ask him to take a seat.

We discuss symptoms: pain underneath the heel, worse first thing in the morning or after periods of rest. He can't recall injuring the foot. Just woke up and it started hurting. It's been 6 weeks and he expected the pain should have gone by now. He tells me some of his golfing buddies had a similar problem and that it lasted for over a year. He's researched on the internet and thinks it's a heel spur... says he may need to see a surgeon.



Question 1: What is the probable diagnosis?

Plantar Fasciopathy may include plantar fasciitis (inflammation), plantar fasciosis (degeneration) or plantar fascial rupture. It is cited as being the most common of all foot ailments seen in general practice and characterised by tenderness over the medial plantar aspect of the calcaneus. The mechanical cause for plantar fasciopathy is multifactorial and poorly understood, although reduced ankle dorsiflexion, increased body weight and age are considered to be significant predisposing influences.

Question 2: What are potential differential diagnoses?

Inflammation is typically associated with sharp plantar heel pain on standing after periods of rest. Degeneration and plantar fascial tears tend to be more persistent on weight bearing and less responsive to acute management strategies. Other causes of plantar heel pain include medial calcaneal nerve irritation, heel fat pad oedema (Figure 1) and calcaneal stress fracture (Figure 2). Heel spurs are not considered to be a cause of long term heel pain, though their formation is believed to be associated with related adverse mechanical aetiology. Bilateral plantar fasciopathy can be associated with seronegative arthropathy.

Question 3: What management strategies are supported by scientific evidence?

Plantar fasciopathy is usually self limiting with most cases subsiding over 12 months. However, presenting patients are typically in distress and may be seeking more than reassurance. Evidenced based recommendations¹² for the

acute management of plantar fasciitis (<6 weeks) includes rest, Achilles tendon and plantar fascia stretching, orthotics, heel taping, padding and oral anti-inflammatories. Subacute management (<6 months) recommendations included night splints, orthotics, boot immobilisation and physical therapy. Extracorporeal Shockwave therapy could be considered for chronic conditions (>6 months). Surgery is rarely required. Corticosteroid injection can be contraindicated for plantar fasciosis and plantar fascial tears as they are not considered to be true inflammatory conditions may increase risk of plantar fascia rupture and fat pad atrophy.

¹ Verona du Toit and Andrea Bialocerkowski, Clinical Guidelines for localised Musculoskeletal Foot Pain - A Podiatry Perspective© 2013, Page 38 (page38.com.au)

² McoilT et al, Heel Pain—Plantar Fasciitis: Clinical Practice Guidelines Linked to the International Classification of Function, Disability, and Health, J Orthop Sports Phys Ther. 2008;38(4):A1-A18. doi:10.2519/jospt.2008.0302

Figure 1: X-Ray of patient with prominent but asymptomatic plantar and posterior heel spurs (nb arrow indicates dorsal talar avulsion fracture).

Figure 2: MRI revealing fractured calcaneus of patient previously believed to be suffering from plantar fasciitis.