Plantar Fascitis

Pain in the heel may be the result of arthritic, neurologic, traumatic or other systemic conditions – although the overwhelming cause is mechanical. Plantar fasciitis commonly causes inferior heel pain and occurs in up to 10% of the population. It accounts for more than 600,000 outpatient visits annually in the United States. It affects active and sedentary adults of all ages. Plantar fasciitis is more likely to occur in persons who are obese, who spend most of the day on their feet, or who have limited ankle dorsiflexion. It is believed the pain is caused by acute or chronic injury to the origin of the plantar fascia from cumulative overload stress. Plantar fasciitis is often referred to as heel spurs or heel pain. The pain may be in the arch of the foot or on the heel pad and typically occurs without identifiable injury.

History:
- Non-isolated plantar heel pain
- Pain with initial weight bearing after periods of rest
- Morning pain upon arising
- Barefoot walking or poor footwear

Findings:
- Weeks to months of persistent or recurrent heel pain
- Pain on palpation of the inferior heel or plantar fascia
- Obesity (high BMI)
- Pronated or flat foot type (although normal and high arched feet are common)
- Localized swelling or atrophy of the infra-calcaneal fat pad

Diagnostic studies are generally not indicated.

Treatment Recommendations:
- Reassurance as generally self-limited – 80% complete recovery in 2 years
- Wear shoes with good support
- Alter activities to rest foot
- Avoid walking barefoot (including when indoors)
- Weight loss (make patient aware that weight may be a factor)
- Stretching (calf and Achilles stretching exercises on AVS)
- Ice to plantar heel 3 times daily
- Prefabricated orthotics (outcomes equivalent to custom orthotics)
- Analgesics – Tylenol/NSAIDS (no RCT evidence of benefit)

When to Refer:
- Diagnosis in question
- Radiating pain (although commonly due to altered gait from heel pain)
- Hyperesthesias (consider tarsal tunnel)
- History of inflammatory arthridities
- Failure to improve after 3 months of conservative treatment (patient actively treating the condition with proper footwear, stretching, daily ice application, alteration or modification of activities, etc.)

What is done by the specialist:
- Confirm diagnosis by history and exam (rarely need x-rays)
- Continue conservative care if not yet attempted or half-hearted self-treatment
- Prefabricated orthotics (custom if OTC / prefab failure or abnormal structure)
- Steroid injection for significant heel pain despite months of treatment
- Night splint (could be ordered in primary care but not first line treatment)
- Surgery is rarely needed

References:

Questions: Please reply to this e-mail, and your questions(s) will be directed to the author of this Pearl, Bryan Warren, MD

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All Pearl recommendations are consistent with professional society guidelines, and reviewed by HealthPartners Physician Leadership.