

Management of planter fasciitis

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Plantar fasciitis is very common and sometime disabling condition¹ orthopaedic surgeon deals with in clinical practice in Pakistan. I see commonly plantar fasciitis in people with high basal metabolic index. Other risk factors include limited ankle dorsiflexion, flatfoot deformity and prolonged work-or activity-related weight bearing. These patients complain of painful heel on first ambulation in the morning. Planter fascitiis is initiated by excessive tensile strain within the fascia during repetitive loading producing microscopic tears and an acute inflammatory response.¹

Also see pages 2 and 7

On patients first visits to me I suggest them to modify shoe ware and watch their weight and do plantar fascia, achilles tendon and hamstring stretchings at least 3 times a day. I usually refer them to my physiotherapist and also prescribe them soft heel pad and modify shoe ware, as is being reported in this issue of *Journal*.² With this treatment, 70-80 % of patients usually do quite well.

Besides surgical approaches like endoscopic plantar fasciotomy,^{1,3} several minimally invasive modalities have been used in managing patients who are not improving or getting desired result with physical therapy. These include extracorporeal shockwave therapy, radiofrequency microtenotomy, platelet-rich plasma injections and micromobile compression.¹ I usually refer them for shock wave treatment. Shock wave treatment is based on audible sound patient receives 2000 waves per session weekly and mostly 3 sessions are done. These sessions can be repeated after a month or so. Out of these patients, more than 95% get good results.⁴ Very rarely, 1-2 % get injection of 10 mg of triamcinolone with bupivacaine and physical therapy has to continue.

Autologous biological blood-derived product that

contains high concentrations of platelet-derived growth factors and soft tissue healing is thought to be stimulated via enhanced fibroblast migration and proliferation, up regulated vascularization, and increased collagen deposition.¹ In one study nearly 90% patients benefited at one year follow up.⁵ In a report in this issue of *Journal*, autologous blood injection resulted in nearly 90% improvement of some degree.⁶ However, it is quite invasive procedure and one should go for physical therapy and for shock wave treatment first. In rare occasions, patients may require anti-inflammatory dose of steroid with local anesthesia injection. I think autologous blood injection should be reserved to non-responders to physical therapy and shock wave treatment.

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