Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

President's Message

It is with extreme joy that I thank all of you in the Pain Management SIG for my election. I would like to first thank Tom Watson (past president) for all the hard work that he did to get us where we are now. His vision to the future has always been a powerful force to the formation and growth of the SIG. Also thanks go to John Garzione for his role as Secretary.

We had a wonderful day-long course this year with our highlight speaker David Butler, giving us his fresh ideas in the field of neurobiology. It was a tremendous success!

I hope to see all of you in Boston at CSM in February 2002 to hear Kathleen Sluka, PT, PhD share her insights and research in the areas of musculoskeletal pain and fibromyalgia. We will try to have our meeting immediately following her presentation so that as many can attend as possible. This must be YOUR SIG and new and fresh ideas will be welcomed.

I would like to congratulate John Garzione as our new Vice President and Elaine Pomerantz as our new Secretary.

With the aging of the baby boomers and some of the recent legislation concerning Medicare we are creating a series of upcoming decades that will be laced with chronicity. Chronic pain will become a much larger factor that therapists will be faced with on a daily basis. We must sharpen our skills at breakneck speed to stay current with recent advances both clinically and in research. We also have a handicap in this country with the development of new modalities with which other places in the world have greater freedom. With the increase exponentially of the information age we are finding it harder and harder to stay attuned to current thinking even in a narrow field such as Chronic Pain Management. It is important in this field to take a global view and not a myopic approach.

I would hope that all individuals interested in the Pain Management SIG actively contribute to make this truly helpful and service-oriented to the rest of the members so that we may all benefit. I would like to actively seek each of you to send papers for input to this newsletter on the topic of pain management. We are allowed a maximum of four pages per quarter and hopefully we can fill it with useful information from all of us to all of us. Please send your articles to my email at indusrehab@aol.com. If there are any topics you wish to discuss, feel free to call me at 972-887-0029 ext 211.

I look forward to an open forum where we all can share, learn, and grow as we become all that we can be.

Joe Kleinkort, PT, MA, PhD, CIE

Is a Heel Pain or Plantar Fasciitis?

Tom Watson, PT, MEd, FAAPM

Pain of the sole of the foot can be very difficult to address appropriately. X-rays are often negative and there are no significant objective signs such as muscle weakness or loss of motion. Tenderness is subjective at best but can help you to develop a working assessment and treatment program.

In the book, *Foot and Ankle Pain*, Rene Cailiet, MD (FA. Davis Company, 1980, chapter 7) describes painful conditions of a heel. It goes on to describe tenderness at the anterior medial portion of the calcaneus as plantar fasciitis. This is the attachment site of the plantar fascia. This condition occurs more frequently in males than females. A painful heel is more general across the calcaneus and not as well localized. Many of my patients will describe the pain moving medial to lateral to middle of the heel. There is usually no loss of sensation or strength associated with either condition.

Treatment approaches include:

1. A 1/4 inch heel pad—a piece of felt cut to fit the inside of a shoe is inexpensive and very effective. A hole may be cut into the felt corresponding to the localized site of pain.
2. Ischemic compression along the arch of the foot into the attachment of the plantar fascia or across the calcaneus. Hold the compression until there is no discomfort.
3. Iontophoresis, with dexamethasone, 2 or 3 times depending upon the response.
4. Interferential current at "0" hertz in a crossed "X" pattern with moist heat.
5. Microcurrent stimulation at .5 hertz through the area of pain.
6. Ultrasound continuous to the area of pain.
7. Taping from mid arch across the calcaneus up the Achilles tendon maintaining a maximum of 5° to 10° of dorsiflexion.

Combinations are frequently more effective than individual modalities or procedures. Using 1, 2, and 3 along with taping have been very effective for the patients I've treated.

Differential diagnosis that may cause heel and sole of foot pain include trigger points in adductor hallicus, peroneus tertius, medial head of the gastronemius, medial distal soleus, tibialis posterior, flexor digitorum longus, and retro-Achilles bursitis, hair-line fracture of the calcaneus, and common calcaneal tendonitis.

Proper evaluation and palpation are extremely important to derive an appropriate site of treatment. Look and listen, as the patient will usually lead you to the source of pain, and palpate. Then you can arrive at appropriate assessment and treatment intervention.

REFERENCES

Cailliet R. *Foot and Ankle Pain.* FA Davis; 1980.
Travell J. *Myofascial Pain and Dysfunction.* Williams & Wilkins; 1992.