A Retrospective Study of Radiofrequency Thermal Lesioning for the Treatment of Neuritis of the Medial Calcaneal Nerve and its Terminal Branches in Chronic Heel Pain

Joseph A. Cione, DPM, DABPS, FACFAS; John Cozzarelli, DPM, DABPS, FACFAS and Christopher Jay Mullin, DPM, DABPS, FACFAS

We undertook a retrospective analysis of 75 consecutive patients with recalcitrant plantar heel pain caused by calcaneal neuritis, all who were treated with radiofrequency thermal lesioning (RTL). The median age of the cohort was 55 (range 24 to 83) years, 25 (33.3%) of the patients were male, 50 (66.7%) of the patients were female, and 15 (20%) of the patients were treated for bilateral heel pain caused by medial calcaneal neuritis. The median preoperative VAS score was 9 (range 2 to 10), whereas the median long-term postoperative VAS score was 1 (range 0 to 8), and this difference was highly statistically significant (P < .0001). Five (6.7%) of the patients experienced recurrent heel pain, over a median follow-up duration of 18 (range 12 to 36) months. Overall, 93.3% of the patients experienced satisfactory pain relief with radiofrequency lesioning for the treatment of recalcitrant plantar heel pain caused by medial calcaneal neuritis. Level of Clinical Evidence: 2 (The Journal of Foot & Ankle Surgery 48(2): 142–147, 2009)

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Plantar heel pain is generally understood to be one of the most common presenting complaints encountered by the foot and ankle specialist, and a variety of etiological factors comprise the differential diagnosis for plantar heel pain. Although a wide range of conservative treatments are used in the management of plantar heel pain, the pain may persist and become recalcitrant despite seemingly appropriate therapy. An overlooked, and sometimes undiagnosed clinical entity that may be responsible for plantar heel pain is entrapment of the medial calcaneal nerve (1–4). Tanz (5) concluded that inferior heel pain is caused by irritation of a branch of the medial calcaneal nerve. Henricson and Westlin (2) analyzed 10 adults with chronic heel pain who were unresponsive to conservative treatment, and concluded that the patients’ symptoms were a result of compression of the anterior calcaneal nerve branch by the deep fascia of the abductor hallucis and, therefore, they recommended treatment by means of open external neurolysis. It is common to have a neurogenic component to be the cause of plantar heel pain (6). It has been documented in the literature that a neuroma of the medial calcaneal nerve branch as a cause of heel pain (1, 7). Heel neuromas are caused by the micro or macro trauma of bipedal ambulation on unyielding weight-bearing surfaces such as concrete and asphalt (1). Repeated ambulation in the form of walking, running, or the work environment can cause micro trauma leading to inflammation of the nerve sheath. Chronic irritation of a nerve in an elbow, face, or hip results in inflammation of the nerve sheath, causing proliferation of the perineural connective tissues (8). Recurrent irritation can lead to chronic neuritis and ultimately hypertrophy of the nerve sheath fibers (9).
Davidson and Copoloff (1) described a neuroma of the medial calcaneal nerve branch as a cause of heel pain syndrome. Shandles et al’s (7) study reviewed 317 cases of plantar heel pain, where 60 required surgical excision of a heel neuroma that were subsequently verified histologically with changes virtually identical with the classic Morton’s neuroma. Rose et al (10) showed that entrapment of the medial calcaneal nerve plays an important role in the development of plantar heel pain; they were able to quantify abnormal sensibility in the cutaneous distribution of both the medial calcaneal nerve and/or the plantar nerve in a significant number of patients in plantar heel pain. Eighty-two patients with a chief complaint of plantar heel pain were evaluated for sensory abnormalities within the cutaneous distribution of both the medial calcaneal nerve and the medial plantar nerve using quantitative neurosensory testing with a pressure-specified sensory device. The results showed that 72.17% of the patients displayed abnormal sensory function within the distribution of the medial calcaneal nerve (10). In a recent study, a series of 25 patients with heel pain, Oztuna et al (11) found that 22 heels (88%) with heel pain had lateral plantar nerve entrapment signs with or without medial plantar nerve findings on electromyography (EMG).

When ordinary heel pain attributed to plantar fasciitis does not respond to conservative care or there are changes in the symptoms during the conservative or surgical treatment phase, clinicians should start to think about nerve entrapment as being the culprit (12). The diagnosis of medial calcaneal nerve entrapment is usually one of exclusion and is often only considered after failure of standard measures used for the treatment of mechanical heel pain.

Radiofrequency thermal lesioning (RTL) works by means of lateral heat dissipation from the active electrode. In essence, an insulated electrode is placed into the tissues that are to be treated. When the electrical generator source is connected to this electrode, the impedance of the surrounding tissue conducts the electromagnetic energy (radio wave) from the generator source into the tissues, thereby generating heat in the involved tissues. The current spreads into the surrounding tissues as it leaves the tip of the electrode, raising the temperature of the tissues to the point where proteins denature and physiological function is disrupted. Precise placement of the tip of the electrode at the site of maximum pain is critical, because the tissues directly adjacent to the active electrode are heated (hence, damaged) the most (13). This causes destruction of the peripheral nerve endings, as well as the myelin sheath, at the site of maximal heel tenderness.

RTL has been used in the treatment of a number of clinical entities including trigeminal neuralgia, lumbar disc herniation, coronary vascular disease, cardiac arrhythmia, cervical pain syndrome, and essential tremor. The use of RTL in the foot has been reported in regard to the treatment of Morton’s neuroma, verrucae, and ingrown toenails (13). Percutaneous radiofrequency ablation of an osteoid osteoma involving the calcaneus was performed by Migues et al (14), and resulted in relief of pain without evidence of recurrence of symptoms or the lesion at a 3-year follow up. Solitto et al (13) performed RTL for resistant plantar fasciitis that was unresponsive to conservative treatments in 39 patients, and reported that 92% of the patients experienced complete resolution of symptoms following the procedure. Based on our understanding of the literature related to the use of RTL for conditions involving nerve pain, and because we believe that recalcitrant plantar heel pain, while initially presenting as plantar fasciosis, often involves neuritis of the medial calcaneal nerves near the attachment of the plantar fascia to the calcaneus, we undertook a retrospective cohort investigation to evaluate the effectiveness of RTL in the treatment of plantar heel pain unresponsive to traditional therapeutic measures.

**Patients and Methods**

We reviewed the records of all of the patients who had undergone RTL for the treatment of recalcitrant plantar calcaneal heel pain, initially diagnosed as proximal plantar...
fasciosis, and ultimately identified as medial calcaneal neuritis, during the time period extending from January 2000 to January 2003. The initial diagnosis of proximal plantar fasciosis was made based on clinical and radiographic, as well as ultrasonography, findings. In 2004, each of the patients who had undergone RTL was sent a survey (Figure 1) in an effort to evaluate their long-term results following the procedure. At that time, moreover, each patient was also asked to rate their current level of pain, and to recall their preoperative level of pain, using a 10-cm visual analog scale (VAS) rating system.

Before undergoing RTL, for each of the patients, conservative treatment was attempted for at least 6 months, and included the use of oral anti-inflammatory medications, local corticosteroid injections, foot orthotics, physical therapy, padding and strapping, a home stretching program, and the use of a plantar fascia night splint. When conservative treatment failed and the plantar heel pain persisted, further diagnostic testing was performed on each of the patients. An electrodiagnostic sensory nerve conduction threshold (sNCT) test was performed on each patient using the Neurometer CPT Device (Neurotron Inc., Baltimore, MD), which measures the current perception threshold (CPT) of the sensory nerve. The neuroselective sNCT test is capable of documenting abnormalities in both large and small fibers (15), and it is capable of measuring sensory dysfunction ranging from the hyperesthesia associated with early nerve irritation to hypoesthesia associated with profound loss of sensory function (16, 17). Every patient who had an abnormal sNCT result was considered a candidate for the RTL procedure. RTL was attempted on consecutive patients who failed 6 months or more of conservative treatment for their plantar heel pain, if they also had an abnormal sNCT result.

Before entering the operating room, each patient’s heel was palpated and the area or areas of maximum tenderness were indicated with a marking pen. Following identification of the specific areas of tenderness, the patient was administered general anesthesia and the involved foot was prepped and draped in a sterile fashion. An ankle tourniquet was inflated to 250 mm Hg following exsanguination of the foot and ankle (Figure 2). Under fluoroscopic guidance, a 22-gauge cannula with a solid stylet was inserted into the first marked site (Figure 3). After proper placement of the cannula and stylet at the level of the proximal attachment of the plantar fascia, the inner stylet was removed leaving the 22-gauge cannula in place. It is through this cannula that the insulated radiofrequency probe was inserted and then connected to the radio energy generator (Radionics RFG-3C Lesion Generator, Radionics, Inc., Burlington, MA) (Figure 4). After confirming placement of the electrode fluoroscopically, muscle stimulation was performed with the electrode at low energy to ensure that the tip of the electrode was not in a muscle belly. The energy required to stimulate muscle
is much lower than that required to cause radiofrequency thermal lesioning. During this process of muscle stimulation, if any gross movement of the digits or if any muscle fasciculation was evident, the cannula was redirected. It is important that the tip of the electrode not be in muscle, rather it should be placed at the level of the plantar fascia attachment to the calcaneus or, if a distally elongated shelf-like plantar calcaneal spur is present, at the tip and just plantar to the spur. After confirming proper placement of the electrode, the thermal lesion was produced using radiofrequency heat at 86°C for 105 seconds (Figures 5 and 6). The area was lesioned for a total of 90 seconds, following a 15-second lead-in time during which the Radionics RFG-3C Generator reached the optimal temperature of 86°C. The lesioning process was repeated at each of the marked areas on the heel, after which 10 milliliters of a mixture of 8 mL of 1% lidocaine plain with 1 mL of 0.5% bupivacaine plain and 1 mL of triamcinolone acetonide (40 mg/mL) was injected in each of the treated sites. Following the injections, small bandages (coverlets) were applied to the involved sites on the heel, and the patient was allowed to return to shoe gear immediately following the procedure and was able ambulate on the foot as tolerated. No other postoperative medications were provided, and the patient was instructed to ambulate as desired, and to follow up at scheduled visits. Patients were also instructed to continue with supportive shoe gear and orthoses, and to continue stretching, if they desired.

Results

A total of 75 consecutive patients, who underwent RTL for a total of 90 heels with medial calcaneal neuritis, were retrospectively evaluated. Of these patients, 25 (33.3%) were male, 50 (66.7%) were female, and the overall median age was 55 (range 24 to 83) years (mean 55.8 ± 13.9 years). Fifteen (20%) of the patients had the procedure performed on both feet. The median duration of follow-up was 18 (range 12 to 36) months. The most common areas of tenderness to palpation before administration of the RTL were noted along the medial aspect of the calcaneus, and along the central aspect of the plantar heel region. The average number of areas lesioned was 6 per foot. Each patient was asked to rate his or her heel pain using a 10-cm VAS. The median preoperative VAS score was 9 (range 2 to 10), whereas the median long-term postoperative VAS score was 1 (range 0 to 8), and this difference was highly statistically significant (P < .0001) (Table 1). Overall, an approximately 79.7% reduction in pain, as measured by the 10-cm VAS, was observed following RTL. Overall, 5 (6.7%) of the patients experienced recurrent plantar heel pain, although none of the patients related any worsening of their pain in comparison to their preoperative status. There were no observed wound complications in this cohort, and all of the patients were able to ambulate in their regular shoes immediately following the RTL procedure.
TABLE 1 Comparison of preoperative to postoperative pain* (N = 90 heels in 75 patients)

<table>
<thead>
<tr>
<th>Preoperative pain, median (range)</th>
<th>Postoperative pain, median (range)</th>
<th>P value, Wilcoxon signed ranks test</th>
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<td>9 (2, 10)</td>
<td>1 (0, 8)</td>
<td>&lt;.0001</td>
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*Patients graded their pain on a 10-cm visual analog scale, with 0 = no pain, and 10 = severe pain.

Discussion

A number of previously published reports (1–7, 10, 11), as well as the results of this cohort study, suggest that entrapment of the medial calcaneal nerve and heel neuroma are possible causes of recalcitrant plantar heel pain. In such cases, resection of the inflamed medial calcaneal nerve could be considered to be the last reasonable therapeutic intervention (1). When entrapment has led to formation of a neuroma-in-continuity, neurotomy and internal neurolysis have been considered (18, 19). RTL is a procedure that enables destruction of a peripheral nerve, hence resolution of pain associated with the nerve lesion, without the need for performing an open dissection of the heel. This type of intervention, while conveying a number of methodological shortcomings that could threaten the validity of our conclusions. Although the 10-cm VAS pain scale is known to be a valid health measurement, the method in which it was used in this investigation, wherein patients were asked to recall their preoperative level of pain, was subject to recall bias because a long period of time had passed since they had undergone the RTL procedure. Moreover, we do not know how much of the clinical response was related to the injection that was administered following the RTL procedure, to continuation of any of the supportive measures, or simply to the passage of time following the RTL procedure. However, since the heel pain in each of the cases was recalcitrant, it is very likely that the RTL procedure had a clinically significant influence on the outcome.

In conclusion, the use of RTL has shown its effectiveness in the treatment of a cohort of 75 patients who suffered with recalcitrant plantar heel pain of a neurogenic origin. The procedure requires specialized RTL equipment, as well as precise placement of the active electrode by means of fluoroscopic image intensification. Although the procedure did not relieve pain in every case, it did so in 93.3% of the patients, and was shown to be safe and associated with a rapid return to regular shoes and weight-bearing activity.

References