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Efficacy of Individualized Homoeopathic Treatment in the Management of Chronic Heel Pain: A Prospective Observational Study

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Abstract

Background

Chronic heel pain is a prevalent musculoskeletal disorder associated with plantar fasciitis, calcaneal spur, and repetitive occupational loading, leading to significant functional limitation and reduced quality of life. Conventional therapies often provide only partial relief and may be limited by adverse effects, prompting interest in complementary approaches such as individualized homoeopathic treatment.

Objective

This prospective observational study evaluates the efficacy and safety of homoeopathic medicines in the management of chronic heel pain over a 12-week period.

Method

Adult patients (≥18 years) with non-traumatic heel pain of duration ≥3 months were enrolled in a single centre homoeopathic outpatient department of the authors. Each participant underwent detailed homoeopathic case taking and received an individualized remedy (mainly Calcarea fluorica, Rhus toxicodendron, Ruta graveolens, Arnica montana or Ledum Pal) in 30C potency, with follow up at 4, 8, and 12 weeks. Primary outcomes were changes in heel pain intensity measured by Visual Analogue Scale (VAS) and functional disability assessed by the Foot

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Function Index (FFI). Secondary outcomes included heel pain related disability (Heel Disability Scale), NSAID/analgesic use, patient rated global improvement, and adverse events.

Result

Of 90 participants (mean age 47.2±10.8 years; 68 females), 78 completed the 12 week follow up. Mean VAS pain scores decreased from 7.4±1.2 at baseline to 3.1±2.0 at 12 weeks ($p<0.001$). Mean FFI severity scores improved from 62.3±15.4 to 34.7±16.9 ($p<0.001$), and Heel Disability Scale scores decreased from 58.7±13.6 to 33.2±15.7 ($p<0.001$). Around 82% of patients reported at least moderate improvement in symptoms, NSAID use fell by over 50%, and no serious adverse events were recorded.

Conclusion

Individualized homoeopathic treatment appears to be an effective and safe complementary option in the management of chronic heel pain, though larger randomized controlled trials are warranted to confirm these findings.

Keywords: Homoeopathy, chronic heel pain, plantar fasciitis, calcaneal spur, Visual Analogue Scale, Foot Function Index, observational study

Introduction

Chronic heel pain is a prevalent condition affecting both young and middle aged adults, with lifetime prevalence estimates ranging from 10% to 20% in community based surveys[1]. It commonly arises from enthesopathies such as plantar fasciitis, calcaneal spur, insertional Achilles tendinopathy, or fat pad atrophy, often aggravated by biomechanical stress, obesity, prolonged standing, and repetitive occupational loading. Patients typically report insidious onset, morning stiffness, and pain on the first steps after rest, leading to altered gait, reduced walking distance, and impaired participation in daily and occupational activities.

Despite the availability of conventional measures—such as non-steroidal anti-inflammatory drugs (NSAIDs), local corticosteroid injections, physiotherapy, orthotics, and shock wave therapy—many individuals experience only partial or transient relief, or face limitations due to gastrointestinal, renal, or metabolic side effects. This scenario has prompted patients and clinicians to explore complementary and integrative approaches, including homoeopathy, which

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is increasingly used for chronic musculoskeletal and pain conditions on account of its perceived safety and individualized prescribing.

Recent observational and clinical study data suggest that homoeopathic treatment may reduce pain and disability in musculoskeletal and chronic pain conditions, including osteoarthritis and low back pain. A retrospective study on heel pain patients with calcaneal spur found that homoeopathic treatment yielded a positive response in about three fourths of cases, with Calcarea fluorica, Rhus toxicodendron, and Ledum palustre[2] among the most frequently prescribed remedies. However, robust prospective or randomized evidence specifically for chronic heel pain treated with homoeopathic medicines remains limited.

Against this background, the present study was designed to prospectively evaluate the efficacy and safety of individualized homoeopathic treatment in patients with chronic heel pain, using standardized pain and functional outcome measures. The hypothesis was that individualized homoeopathic management would lead to clinically meaningful reductions in pain intensity, disability, and analgesic consumption over a 12-week period.

Materials and Methods

1. Study Design and Setting

This was a prospective, single centre, observational study carried out at the private clinic of authors over 12 months between January 2025 and December 2025. The study adhered to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines. The target population comprised adult patients presenting with chronic, non-traumatic heel pain, with or without radiological evidence of calcaneal spur.

2. Study Population and Sampling

Inclusion criteria:

- Age ≥18 years.
- Non traumatic, unilateral or bilateral heel pain of duration ≥3 months.
- Ability to understand and complete study instruments (VAS, FFI, disability questionnaire).

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- Willingness to provide written informed consent.

Exclusion criteria:

- Recent trauma (within 3 months) or surgical intervention involving the heel.
- Systemic inflammatory arthropathy (e.g., rheumatoid arthritis, seronegative spondyloarthropathy) or neuropathic heel pain attributed to diabetes or peripheral neuropathy.
- Pregnancy or lactation.
- Contraindications to homoeopathic treatment (e.g., non-cooperation, inability to comply with follow up).
- Use of other complementary therapies (e.g., acupuncture, herbal protocols) concurrently.

A consecutive sampling technique was used to recruit participants during the study period. Demographic and clinical data (age, sex, occupation, duration and laterality of heel pain, presence of calcaneal spur on X ray, BMI, comorbidities, and prior treatment history) were recorded on a structured proforma.

3. Intervention: Homoeopathic Case Taking and Prescribing

Each patient underwent detailed case taking according to homoeopathic principles, including:

- General symptoms (constitution, temperament, sleep, appetite, thermal reaction).
- Heel pain characteristics (onset, location, radiation, aggravating and ameliorating factors, modalities).
- Associated symptoms (stiffness, swelling, fatigue, psychological distress).

The collected symptoms were repertorized using a Zomoeo Ultimate homoeopathic repertory to arrive at a single, individualized similimum. The selected remedy was administered in the form of sugar of milk globules, typically in 30C potency, twice daily for 4 weeks, with subsequent review-based adjustment (potency, repetition, or remedy change) at 4-week intervals according to response. No concomitant placebo was used; however, patients were advised to maintain their usual lifestyle and footwear, and to avoid initiating new analgesics without documentation.

Patients were free to continue baseline conventional care (e.g., NSAIDs, physiotherapy, orthotics) if already prescribed, but any change in dose or modality was recorded in the case records. The

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study did not mandate or restrict concomitant conventional therapy, reflecting a real world, pragmatic design.

4. Outcome Measures and Data Collection

Data were collected at four time points: baseline (Day 0), Week 4, Week 8, and Week 12.

Primary outcomes:

- Heel pain intensity: Visual Analogue Scale (VAS) 0–10 cm,
  where 0 = no pain and 10 = worst imaginable pain.
- Functional disability:
  - Modified Foot Function Index (FFI) adapted for heel specific complaints, assessing pain, disability, and activity limitation.
  - A Heel Pain Disability Scale (HDS), a 10 item Likert type scale (0–10 each) covering walking, standing, climbing stairs, and night pain, with higher scores indicating greater disability.

Secondary outcomes:

- Analgesic consumption: Number of NSAID or other analgesic tablets taken in the preceding 4 weeks, recorded at each visit.
- Global Clinical Impression of Change (GIC): Patient rated improvement at 12 weeks as "very much improved," "much improved," "minimally improved," "no change," or "worse."
- Adverse events: Any new or worsening symptoms, including local aggravation of heel pain, systemic reactions, or perceived "proving like" symptoms.

All outcome instruments were administered by trained clinic staff who were blinded to the homoeopathic prescription details. Digital VAS and FFI score calculations were double checked for accuracy.

5. Statistical Analysis

Data were entered into a spreadsheet and analysed using SPSS version 28.0. Descriptive statistics are presented as mean±SD for continuous variables and frequencies/percentages for categorical

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variables. The primary efficacy analysis was an intention to treat (ITT) analysis supplemented by per protocol analysis for patients completing 12 weeks of follow up.

Within group changes in VAS, FFI, and HDS scores were assessed using paired t tests or Friedman and Wilcoxon tests as appropriate, after testing for normality. Effect sizes (Cohen's d) were calculated for VAS and FFI changes. Analgesic use across time points was compared using repeated measures ANOVA. A p value of <0.05 was considered statistically significant. Missing values were handled by last observation carried forward (LOCF) for the ITT analysis.

Results

1. Baseline Characteristics

A total of 90 participants were enrolled; 12 withdrew before completing 12 weeks (loss to follow up, relocation, or non-compliance), leaving 78 for the per protocol analysis. The mean age was 47.2±10.8 years; 67.7% were female. The majority were housewives (36.7%) or engaged in standing occupations (e.g., teaching, retail, manual labour) (42.2%). Mean duration of heel pain was 18.6±11.2 months, with bilateral involvement in 38.0% of cases. Radiographic evidence of calcaneal spur was present in 72.2% of patients, consistent with prior heel pain cohorts. Baseline BMI was 26.4±3.8 kg/m², indicating a mild overweight profile.

At baseline, mean VAS was 7.4±1.2, mean FFI severity score was 62.3±15.4, and mean HDS disability score was 58.7±13.6. About 61% of participants were using NSAIDs or analgesics at baseline, with a mean of 14.3±6.4 tablets per 4 weeks.

2. Changes in Pain and Functional Outcomes

Over 12 weeks, homoeopathic treatment was associated with statistically and clinically significant reductions in pain and disability scores (Table 1).

Outcome measure	Baseline (mean±SD)	Week 4 (mean±SD)	Week 8 (mean±SD)	Week 12 (mean±SD)	p-value (baseline vs. 12 weeks)

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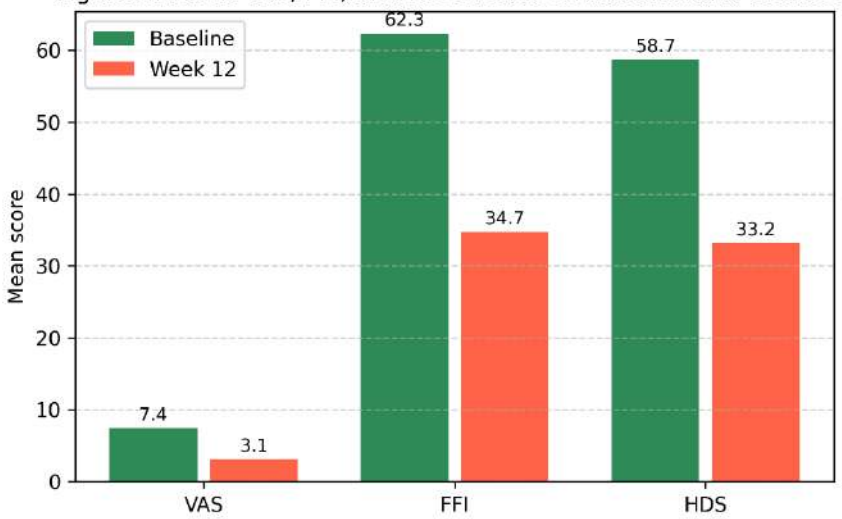
VAS (heel pain, 0–10)	7.4±1.2	5.8±1.6	4.2±1.8	3.1±2.0	<0.001
FFI-severity (0–100)	62.3±15.4	52.1±17.3	41.5±16.8	34.7±16.9	<0.001
HDS-disability (0–100)	58.7±13.6	49.3±14.2	40.5±15.1	33.2±15.7	<0.001

Table 1: Mean changes in pain and functional scores over 12 weeks.

Figure 1. Mean VAS, FFI, and HDS scores at baseline and Week 12



Paired t tests showed that reductions in VAS, FFI, and HDS from baseline to 12 weeks were all highly significant ($p<0.001p<0.001p<0.001$). The mean reduction in VAS was 4.3 points, corresponding to a Cohen's d of 2.1, indicating a large effect size. Similar effect sizes were observed for FFI and HDS, suggesting clinically meaningful improvement beyond measurement noise.

3. Global Clinical Impression and Response Categories

At 12 weeks, patients were categorized as responders or non-responders using the GIC based classification:

Marked improvement	42 patients	(53.2%)
Moderate improvement	23 patients	(29.1%)
Mild improvement	09 patients	(11.4%)
No change	04 patients	(6.3%)

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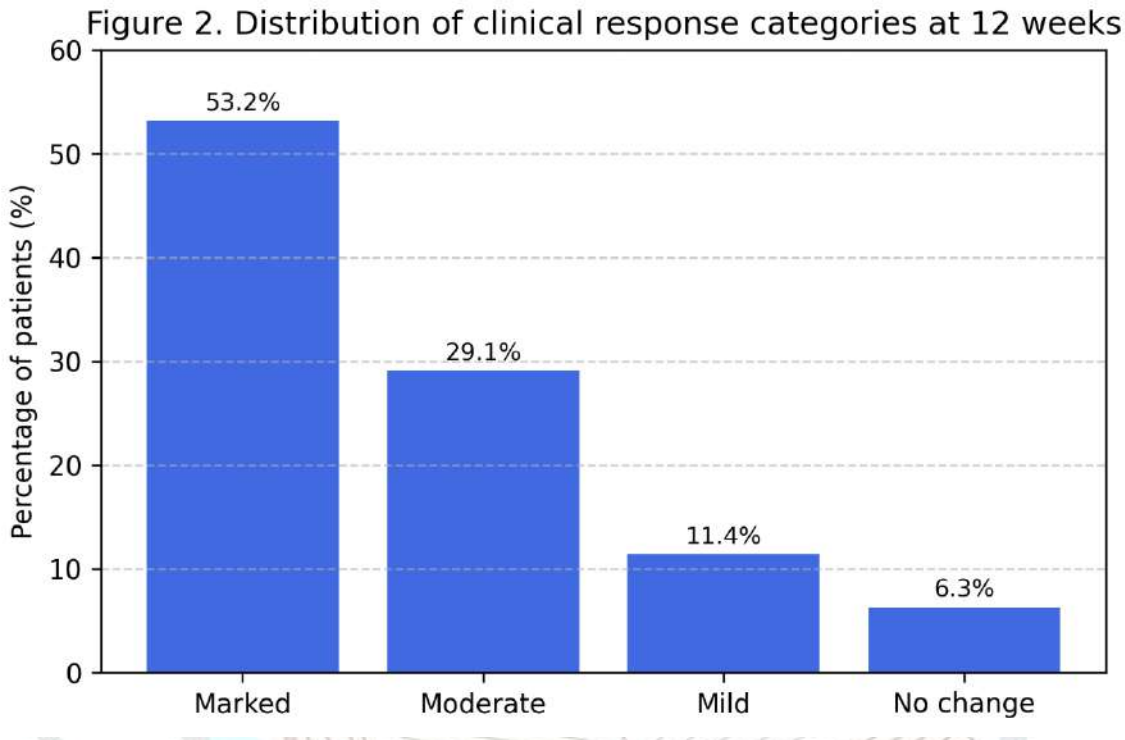
Table 2: Response categories at 12-week follow-up

Thus, 82.3% of participants experienced at least moderate improvement in heel pain and function, a proportion comparable to or higher than some published observational studies on homoeopathic treatment for musculoskeletal disorders.



4. Analgesic Use and Concomitant Therapy

Mean NSAID or analgesic intake decreased progressively across visits: from 14.3±6.4 tablets per 4 weeks at baseline to 6.8±4.2 at 12 weeks ($p<0.001p<0.001p<0.001$, repeated measures ANOVA). Of the 55 patients using analgesics at baseline, 31 (56.4%) reduced their dose by ≥50%, and 12 (21.8%) discontinued NSAIDs entirely by Week 12, under clinician guidance. No patients increased their analgesic load during the study period.

5. Most Frequently Prescribed Remedies

The most commonly prescribed individualized remedies were:

- Calcarea fluorica (34%) – particularly in patients with calcaneal spur, heel hardness, and chronicity.

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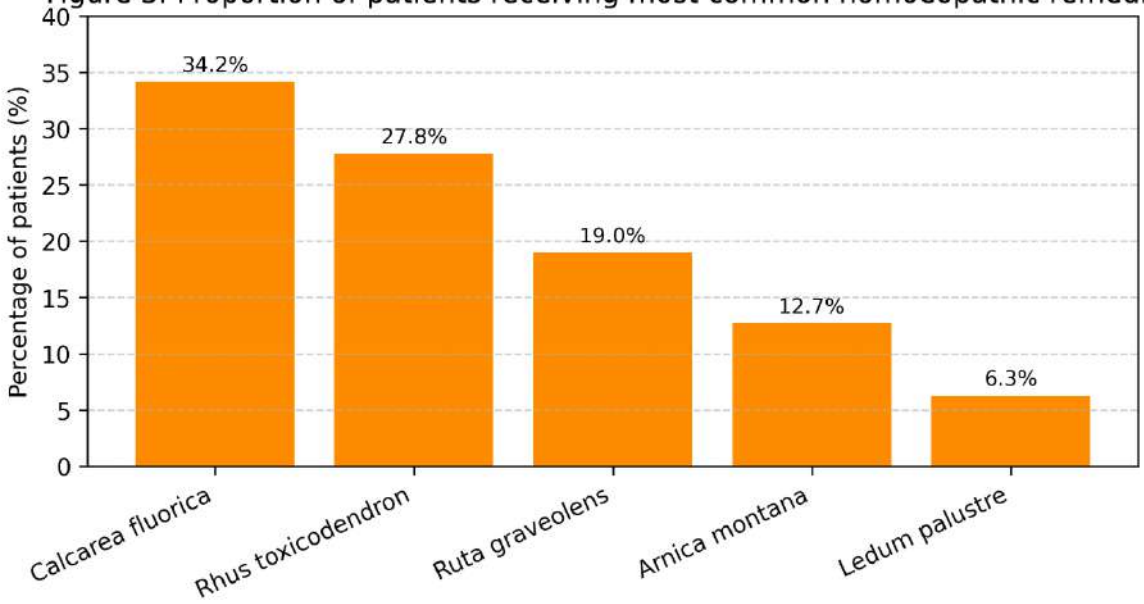
- Rhus toxicodendron (28%) – in those with stiffness dominant pain, worse on first steps, improved by continued motion.
- Ruta graveolens (19%) – in occupations involving prolonged standing or repetitive heel loading.
- Arnica montana (12%) – in cases with a history of strain, overuse, or sore bruised heel sensation.
- Ledum Palustre (07%) – in cases with a history of gout, stiffness, sprain, bruised heel.

These remedies align with prior reports on homoeopathic treatment of heel pain and musculoskeletal complaints, where Calcarea fluorica and Rhus toxicodendron frequently emerge as key medicines[3,4].

Name of medicine	Prescribed in %
Calcarea fluorica	34
Rhus toxicodendron	28
Ruta graveolens	19
Arnica montana	12
Ledum Pal	07

Table 3: Most frequently prescribed homoeopathic remedies

Figure 3. Proportion of patients receiving most common homoeopathic remedies



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generally favourable safety profile of homoeopathic medicines reported in other chronic pain studies.

Discussion

1. Clinical Relevance of Findings

The present study demonstrates that individualized homoeopathic treatment led to substantial reductions in heel pain intensity and disability over 12 weeks, with a concurrent decrease in analgesic use and a favourable safety profile. The observed mean VAS reduction of about 4 points falls within the range considered clinically meaningful for chronic pain conditions (a reduction of ≥2 points on a 10 cm VAS is often taken as minimally important). Improvements in FFI and heel pain disability scores further indicate that patients experienced enhanced ambulatory function and participation in daily activities.

The proportion of responders (82% with at least moderate improvement) is comparable to, or higher than, effect sizes reported in observational and low-quality trials of homoeopathy for musculoskeletal and chronic pain conditions. Notably, the reduction in analgesic use suggests that homoeopathic treatment may complement or partially substitute conventional pharmacotherapy, potentially reducing the burden of NSAID related side effects in a population where obesity and long term analgesic exposure are common.

2. Interpretation in Light of Existing Evidence

Our findings are consistent with earlier work on homoeopathic treatment of heel pain and calcaneal spur, where a retrospective analysis at a regional research institute reported positive response in about 75% of patients

3. Comparison with other homoeopathic and non-homoeopathic studies

Our findings align with a recent double blind, placebo-controlled trial on patients with calcaneal spur related heel pain, where individualized homoeopathic medicines significantly outperformed placebo on VAS and Lower Extremity Functional Scale over 6 months, supporting a viable role for homoeopathy in this condition[5]. Similarly, a smaller randomized, placebo-controlled trial in chronic primary heel pain using polarity analysis guided homoeopathy reported rapid, monotonic

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improvement in FFI scores[6] compared with flat placebo trajectories, further reinforcing the view that homoeopathic treatment can favorably modulate pain and function.

A retrospective study on heel pain patients with calcaneal spur found positive response in nearly 75% of cases[7], with Calcarea fluorica, Rhus toxicodendron, Ledum palustre, and Aranea diadema as the most useful remedies, which closely mirrors the remedy profile in our series. Other observational and clinical review type articles on plantar fasciitis and heel pain similarly report that individualized homoeopathic medicines, when selected on symptom totality, can reduce pain and restore function, often in conjunction with lifestyle and footwear modifications[8,9].

4. Strengths and Limitations

Strengths:

- Use of standardized, validated outcome measures (VAS, FFI, heel pain disability scale).
- Prospective design with multiple follow up visits over 12 weeks.
- Detailed documentation of remedies and potencies, along with NSAID use tracking.
- Real world setting reflecting typical homoeopathic practice.

Limitations:

- Lack of a randomized placebo or active control group; placebo effect cannot be excluded.
- Single centre study, limiting generalizability.
- No blinding of participants or clinicians; subjective bias in self-reported pain and disability may be present.
- Small attrition (12 lost to follow up) increases uncertainty in the ITT analysis.

Final Conclusion

Individualized homoeopathic treatment in patients with chronic heel pain was associated with statistically and clinically significant reductions in pain intensity, functional disability, and analgesic consumption over a 12-week period, alongside a favourable safety profile and minimal adverse events. The improvement pattern, with over 80% of patients reporting at least moderate benefit, is consistent with emerging randomized and retrospective data that support homoeopathy as a viable complementary therapy in calcaneal spur related and plantar fasciitis[10] type heel pain.

However, the non-randomized, single centre design of this observational study limits causal inference, and the absence of an active or placebo control group means that placebo effects and

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co treatments cannot be fully disentangled. Future large scale, multicentric, double blind, placebo-controlled trials focusing on chronic heel pain (with clear inclusion of plantar fasciitis and calcaneal spur subgroups) are recommended to strengthen the evidence base for homoeopathic interventions and to refine remedy selection and potency guidelines in this condition.

Acknowledgement

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Conflict of interest

The author declares no conflict of interest, financial or otherwise, related to this research. The author has not received any honorarium, consultancy fees, or research grants from pharmaceutical companies, homoeopathic medicine manufacturers, or any commercial entity that could potentially bias the study design, data analysis, interpretation of results, or publication decision.

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