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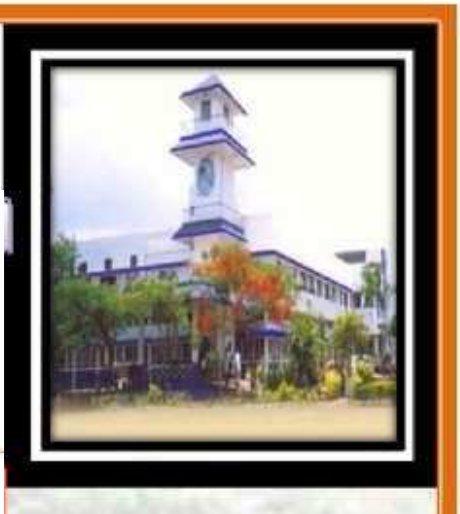

INSPIRATION

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Individualized Homeopathic Treatment in Plantar Fasciitis: A Case Report

Abstract

Background:

Plantar fasciitis is one of the most common causes of heel pain which causes difficulty in walking in adults of age between 40 to 60 years with a lifetime incidence of about 10%. It is more common in women than in men. The pain is felt at the bottom of heel, most severe with first steps of the day and prolonged standing. It is commonly seen in athletes, teachers, factory workers and obese adults. Homeopathy aims to treat the disease by considering the totality of symptoms and selecting individualized remedies based on mental, physical and characteristic symptoms of the patient

Case Presentation:

A 56 years old female presented with complaints of intense pain, specifically described as 'cannot step on the ground' in the left heel since 6 months. The pain aggravated at night, when standing, hanging the feet down and on cold floor.The symptoms were ameliorated by warm application.

Intervention:

A detailed homoeopathic case-taking was carried out, considering thepatient's mental, physical, and particular symptoms. Repertorization was performed using Complete and Kent's repertory, which indicated Pulsatilla nigricansas the most appropriate remedy corresponding to the totality of symptoms.

Outcome:

Following the administration of Pulsatilla nigricans30C, the patient showed gradual improvement in the symptoms and a notable decrease in her FFI (Foot Function Index) score during subsequent follow ups.

Conclusion:

This case report demonstrates that individualized homeopathic medicines can play a beneficial role in management of plantar fasciitis.

Keywords: Plantar fasciitis, Homoeopathy, Pulsatilla Nigerians.

Introduction

Plantar fasciitis is a painful condition of the heel caused by inflammation of the plantar fascia which originates at the medial calcaneal tuberosity. The pain is felt at the bottom of the heel which is severe with first step of the day. The plantar fascia is a thick, fibrous band of connective tissue on the bottom of the foot, spanning from the heel bone to the toes. It supports the arch, acts as shock absorber during walking and is critical for foot mechanics. This tissue can be strained from overuse, unsupportive footwear, obesity etc which can cause inflammation of the plantar fascia leading to plantar fasciitis. It is the most common reason for heel pain responsible for 80%of cases.

Case Report

Preliminary Data

- Name: xyz
- Age: 56 years
- Gender: Female
- Marital status: Married
- Occupation: Housewife
- Address: Bharat nagar, Shahpur, Belgaum.
- Date of visit: 29/01/2026

Presenting Complaints

The patient presented with complaints of intense pain, specifically described as ‘cannot step on the ground’ in the left heel since 6 months. The symptoms were aggravated at night, when standing, hanging the feet down and on cold floor. The symptoms were ameliorated by warm application.

Past History

Hypertensive since 10 years. History of left-sided ovarian cyst and fibroid uterus followed by hysterectomy five years ago. She had taken allopathic treatment for the same complaints which provided temporary relief.

Family History

All are keeping good health.

Personal History

The patient follows a mixed diet and reports a good appetite. She has a strong desire for sweets. Her sleep is disturbed due to complaints and thermally she is hot, as she likes cold weather and has intolerance to summer weather.

Life Space Investigation

The patient reported a shift in family dynamics 15 years ago following her father-in-law's death, leading to mistreatment by her joint family. Five years ago, she moved to a nuclear living arrangement after her husband was denied his inheritance. She remains highly sensitive and deeply affected by these past grievances.

Mental Generals

The patient describes herself as highly sensitive and emotional. She weeps easily and dwells on past disagreeable events. Her blood pressure increases upon hearing news of death.

General physical examination

On general examination, the patient appeared well built and nourished. There were no signs of Pallor, clubbing, jaundice, cyanosis, edema, or lymphadenopathy.

Vitals

BP: 150/90 mmHg; PR- 78 bpm; RR- 19cpm; Temperature- afebrile; Weight: 75 kg; Height- 5.3ft.

Systemic Examination

• Inspection: Swelling in the left heel.

• Palpation: Tenderness in the left heel.

• Range of Motion: Plantar flexion is greater than dorsiflexion.

Diagnosis

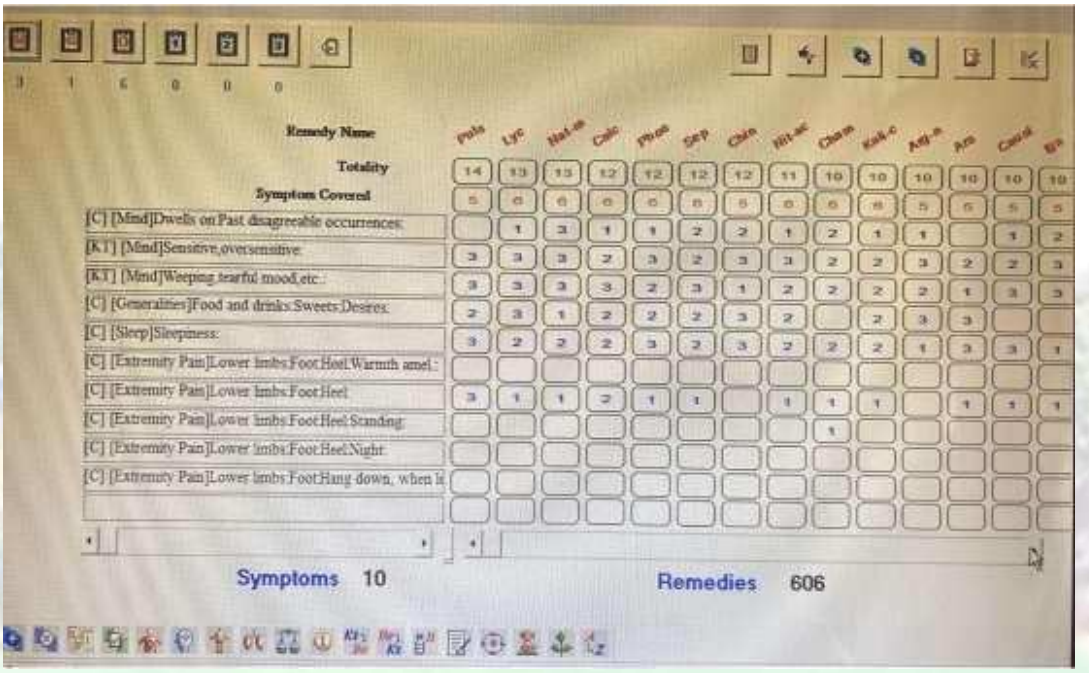
Plantar Fasciitis ICD-11 Code FB40.1)

Totality of Symptoms

1. Pain in the left heel, worse at night, standing, and on cold floors, hanging the feet down.
2. Amelioration from warmth and wearing shoes.
3. Strong desire for sweets.
4. Sleep disturbed due to complaints.

5. Sensitive, emotional, and weeps easily.

6. Dwells on past disagreeable events.



Therapeutic Intervention

The patient was prescribed Pulsatilla 30 (3 doses) and placebo. Pulsatilla was selected due to its coverage of the patient's emotional state (sensitive/weeping) and the modality of pain being worse when hanging the limb.

Case Analysis and Repertorisation

After detailed case-taking, the totality of symptoms was formed, and Repertorisation was performed using the complete repertory and Kent's repertory. The rubrics selected included mental symptoms, general symptoms, and particular symptoms related to the heel. The Repertorisation results suggested several remedies, including Pulsatilla, Lycopodium, Natrummur and Calcarea carb. Among these remedies, pulsatilla corresponded most closely with the patient's mental state, general characteristics, and particular symptoms.

Follow-up and Outcomes

- 26/02/2026: Heel pain and swelling reduced; sleep improved. Treatment continued with Pulsatilla 30.
- 26/03/2026: Patient felt significantly better; pain persisted only occasionally. The Foot Function Index score improved from an initial 71.8% to 41.2%.

Discussion

A 56 years old female presented with intense pain in the left heel for 6 months. The complaints were aggravated at night, standing, hanging the feet down, cold floor and ameliorated by warm application. A detailed case taking was carried out, and the totality of symptoms was formed by considering the patient's mental, physical, and particular symptoms. Repertorisation of the case was performed using the Complete Repertory and Kent's Repertory which suggested remedies such as Pulsatilla, Lycopodium, Natrummur, Calcarea carb. Among these remedies, pulsatilla most closely with the patient's mental state, general characteristics, and particular symptoms .In the present case, gradual improvement in the patient's complaints was observed following individualized homoeopathic treatment. A reduction in symptoms was noted during successive follow-up visits. The improvement observed on clinical examination along reduction in Foot Function Index which indicates a positive response to the prescribed individualized homoeopathic remedy.

Conclusion

Plantar fasciitis is a chronic orthopedic disorder that can affect the patient's Physical and psychological well-being. This case report shows the positive role of individualized homoeopathic treatment in the management of plantar fasciitis. After administration of the constitutional remedy Pulsatilla Nigerians, the patient showed marked improvement in the complaints during follow-up. The improvement was also supported by clinical observation and the reduction in FFI (Foot Function Index) score from 71.8% to 41.2%. The findings of this case that individualized homoeopathic medicine may be beneficial in managing plantar fasciitis. However, further well-designed clinical studies and systematic research is needed to support these findings and to better understand the role of homoeopathy in plantar fasciitis.

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GUILLAIN-BARRE SYNDROME AND HOMOEOPATHIC MANAGEMENT

ABSTRACT:

Guillain-Barre syndrome (GBS) is an acute, frequently severe, and fulminant polyradiculoneuropathy that is autoimmune in nature. It occurs year-round at a rate of between 10 to 20 cases per million annually; in the United States, ~5000–6000 cases occur per year. Males are at slightly higher risk for GBS than females, and in Western countries, adults are more frequently affected than children.[1]Guillain-Barre syndrome (GBS) classified into Acute Inflammatory Demyelinising Polyneuropathy (AIDP); Acute Motor Axonal Neuropathy (AMAN); Acute Motor-Sensory Axonal Neuropathy (AMSAN); Miller Fisher Syndrome (MFS).[2] This review aims to summarize the definition, epidemiology, types, pathophysiology, clinical features, the recent outbreaks, the latest updates and Management of Guillain-Barre Syndrome, investigation, complication, homoeopathic management related to GBS.

DEFINITION:

Guillain-Barre syndrome is an acute immune-mediated polyradiculoneuropathy characterized by rapidly progressive, symmetrical weakness of the limbs, are flexia, and variable sensory and autonomic dysfunction, usually occurring after a preceding infection.[1]

EPIDEMIOLOGY:

- In Western countries, the annual incidence of Guillain-Barre Syndrome (GBS) is estimated to range between 0.89 and 1.89 cases per 100,000 individuals.
- The condition is more prevalent among older adults, with the risk increasing by approximately 20% per decade of life.
- Men are also more likely to develop GBS compared to women, with a higher relative risk.[3]

TYPES OF GUILLAIN-BARRE SYNDROME:

- Acute Inflammatory Demyelinating Polyneuropathy (AIDP): Most frequently found in Western nations.
- Demyelination of the nerves causes muscle weakness that begins in the legs.
- Acute Motor Axonal Neuropathy (AMAN): More frequently found in Asia and Latin America.
- Causes more widespread and faster muscle weakness without loss of sensation.
- Acute Motor-Sensory Axonal Neuropathy (AMSAN): A more severe form that also affects the sensory nerves. Tends to lead to long recovery periods.
- Miller Fisher Syndrome (MFS): Its rare form, characterized by weakness of muscles around the eyes, loss of coordination, and loss of reflexes.[2]

CLINICAL FEATURES:

- The cardinal features of GBS are progressive, symmetric LMN type muscle weakness (flaccid paralysis) and are flexia (absent deep tendon reflexes).
- Weakness usually starts in the lower limbs, and then ascends up to involve trunk and upper limbs (ascending paralysis). Weakness can vary from mild weakness of legs to complete paralysis of all extremity, facial, respiratory, and bulbar muscles.
- However, in some patients weakness can begin in the arms or facial muscles and then descend down to involve trunk and lower limbs (descending paralysis).
- Severe respiratory muscle weakness may lead to respiratory failure and requires ventilator support.
- Facial (LMN type) and coulometer nerve involvement occur in some patients. Bilateral facial palsy also can occur.
- Sensory symptoms such as paresthesias occur in the hands and feet in most of the patients, but usually there are no objective sensory deficits.
- There is often prominent severe pain in the lower back.
- Autonomic neuropathy occurs in majority of patients and manifests as tachycardia, urinary retention, fluctuating BP, orthostatic hypotension, bradycardia, arrhythmias, ileus, and loss of sweating.
- GBS usually progresses over a period of about two weeks and recovery starts after about a month.[4]

The recent Outbreaks (2025-2026):

The Pune Outbreak (Maharashtra, 2025):

- Reported between Jan–March 2025 with over 230 cases and 12 confirmed fatalities.
- This was a "human-made" epidemic linked to contaminated drinking water (PMC report).
- Pathogens isolated included Campylobacter jejuni and the less common Norovirus.[5,6]
- The Neemuch Paediatric Cluster (Madhya Pradesh, 2026):
- A localized outbreak in Manasa town (Neemuch) reported in January 2026.
- Unique for its high paediatric impact: 11 out of 18 cases were children under 18.
- Claimed two young lives (ages 7 and 15), prompting an immediate WHO-led investigation.
- Symptoms were rapidly progressive, requiring emergency airlifting of IVIg supplies.[7]

Feature	IVIg (Standard)	Efgartigimod (2026 Update)	Complement Inhibitors (ANX005)
Primary Goal	Neutralize current antibodies.	Rapidly clear antibodies from the body.	Prevent physical damage to the nerve.
Speed of Action	Moderate (days to weeks).	Fast (significant reduction in recovery time).	Immediate (prevents dam age before it happens).
Mechanism	Decoy/Immune modulation.	FcRn Antagonist (stops antibody recycling).	C1q / C5 Inhibition (stops the MAC attack).
Best Used For	General GBS cases	Patients needing fast mobilization (walking).	Axonal variants (AMAN) to prevent permanent paralysis.
Primary Benefit	High safety profile widely available	Reduces time spent on a ventilator.	Saves the core of the ner ve (axon) from dying.

INVESTIGATIONS:

1. Nerve conduction studies (NCS) and electromyography (EMG): These are used to confirm the diagnosis and also to know the type of GBS.

- Abnormalities in NCS that are consistent with demyelination are delayed distal latencies, slowed nerve conduction velocities, conduction block, etc.
- In case of axonal damage, needle EMG will show decreased recruitment and rapid firing motor units in weak muscles.

2. CSF analysis: Protein is elevated with a normal WBC count:

- This is known as albuminocytologic dissociation, and is present in most patients one week after the onset of symptoms.
- However, cell count may be increased in patients with HIV infection.

3. Antibodies: Against nerve components can be detected in the blood of GBS patients. However, antibody testing is not routinely used. [4]

4. Haematological and Biochemical Investigations:

- Findings are generally within normal limits
- Performed mainly to rule out metabolic, systemic, or infectious causes of peripheral neuropathy
- Tests Included:
- Complete blood count (CBC)
- Inflammatory markers: ESR and C-reactive protein (CRP)

- Serum electrolyte levels
- Liver and kidney function tests
- Blood glucose estimation
- Serum vitamin B12 level[1,12]

5. Pulmonary Function Testing:

- To evaluate the strength of respiratory muscles and detect impending respiratory failure
- Tests Performed:
- Measurement of vital capacity
- Assessment of negative inspiratory force
- Evaluation of tidal volume[1]

COMPLICATIONS:

1. Respiratory Failure

2. Autonomic Nervous System Dysfunction

3. Cardiovascular Complications

4. Thromboembolic Complications

5. Infectious Complications

6. Musculoskeletal Complications

7. Residual Neurological Sequelae [1]

HOMOEOPATHIC MANAGEMENT:

- Rhus toxicodendron: Lameness in the limbs with stiff, tight joints; worsening of symptoms when rising from a chair; total paralysis, hemiplegia, or paraplegia with a slow, dragging, and difficult gait.
- Gelsemium sempervirens: Paralysis affects motor nerves only; sensory nerves stay normal; limbs feel heavy, muscles weak, cold, and bruised; tingling, crawling sensations; difficulty speaking (aphonia) and swallowing (dysphagia) due to muscle weakness; used for post-diphtheritic palsies, paraplegia, unsteady gait, and trembling hands when raised.
- Conium maculatum: Paralysis of involuntary muscles and weakness in the legs; tottering gait and painless lameness without spasms; good fixed vision but slow accommodation, Skin conditions like humid tetters; paralysis spreads from peripheral nerves up to spinal cord and medulla.

- Lathyrus sativus: Motor weakness in lower limbs with a trembling, unstable gait; abductor muscles affected more than adductors; sensitivity is normal or heightened; muscle wasting (emaciation) in legs worsens with standing or walking.
- Plumbum metallicum: Paralysis of tongue and speech muscles; wrist drop; weakness mostly affects right limbs; hands and feet feel cold; no sweating and persistent constipation; progressive muscle wasting with pain alternating with colic; extensor muscles are more affected than flexors.
- Belladonna: Loss of coordination in both upper and lower limbs; trembling and general tremors accompanied by anxiety; paralysis affecting one side of the body, with spasms on the opposite side; overall muscle weakness, especially in the feet; paralysis of the right side of the face; difficulty speaking (aphasia), double vision (diplopia), and partial blindness (amaurosis); early signs of locomotor ataxia include the above symptoms.
- Silicea terra: Poor nerve nutrition leading to paralysis and social withdrawal; brain and spinal cord sensitive to normal vibrations or shocks; paralysis after convulsions and difficulty swallowing; left hand paralysis with finger atrophy and numbness; limb paralysis accompanied by increased morning heaviness and head pressure; tinnitus (ringing in the ears).[13]

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