NORTH SYDNEY SPORTS MEDICINE

60 Pacific Highway
St Leonards NSW 2065
ph: 02 9966 4700
fax: 02 9966 4733
E: reception@nssmc.com.au

July 11, 2022

Dr Chumki Majumder
Macquarie Medical Centre
Shop 45
197 Herring Rd
NORTH RYDE NSW 2113

Dear Dr Majumder

RE: Ms Belinda Bean - DOB: 25/05/73
201/1A Orinoco St, PYMBLE NSW 2073

Presenting Problems

1) **Persisting right midfoot symptoms;**
2) **On the background of resolving midportion Achilles tendinopathy and plantar fasciitis**

Plan

1) **Discussion and reassurance today regarding clinical and imaging findings;**
2) **Trial graded walk/jog program over the next 2-3 weeks;**
3) **Reduce Meloxicam use and supplement with paracetamol;**
4) **Further investigate use of HRT.**

Many thanks for your referral of Belinda whom I saw today regarding her ongoing right foot symptoms. I also received a detailed letter from Janet, Belinda's treating physiotherapist. Belinda is 49 years old and works in marketing, both from home and back at the office. She has no significant medical history but is menopausal and has been suffering with some associated symptoms. Sometimes that can have an impact on musculoskeletal symptoms also. She is currently just using some supplements and not on HRT.

Belinda has historically been a runner with typical running volumes of 40km-50km per week. She has completed ultramarathons in the past. She has not been running over the last 2-3 months due to this foot problem. She also currently does a couple of hiit classes per week which she modifies to avoid any running or impact load.

Belinda describes initially developing some patellofemoral symptoms on the right side last year. She went into some new orthotics in December to try and help with that and seemingly her right Achilles started to stir up soon thereafter. She had fairly typical signs and symptoms of midportion

Achilles tendinopathy at that stage, and these were managed appropriately and she was able to continue some running volume. She completed a 22km race in March and the Achilles seemed to pull up well after that initially. Subsequently, however, she had some increasing Achilles symptoms which started to include plantar heel pain and symptoms consistent with plantar fasciitis. From there she started to develop aching through the midfoot which is now her main ongoing symptom. This is quite poorly localised and she feels it throughout the midfoot region. It is particularly bad if she sits down in the evening to watch TV and then into the night when she describes it as an aching sensation.

She went on to have an MRI scan at the end of April through the midfoot region and we reviewed those films and reports today. There is some radiological evidence of plantar fasciitis which looks fairly typical. In the midfoot itself she has a small amount of increased fluid through the lateral intercuneiform and 2/3 intermetatarsal joint region, but no obvious arthritis otherwise. There is an associated small area of mild bone oedema in the base of the middle cuneiform of uncertain significance. Aside from that the midfoot looks normal.

Since then she has given up all of her running, modified her hiit classes and generally reduced her activity level. Her symptoms, if anything, are feeling worse as a result. She has had to use Mobic on a daily basis to help manage the pain and she is also using Panadol or Panadeine Forte at times. At night she has had to use Temazepam intermittently to help get to sleep as a result of the foot. She has had no focal neurological symptoms or lower back pain. There are no other red flags.

Footwear and orthotics can sometimes make a difference, as can manipulating the midfoot or taping it, there does seem to be a mechanical component to things. Ultimately her new orthotics have not helped settle things completely.

On examination today Belinda has quite neutral lower leg mechanics. She slightly overpronates on the right and, as Janet commented, has an early bunion formation there which looks mild. She has normal subtalar and ankle joint mobility. Today she can do single leg calf raises without pain on the right. She does get some Achilles symptoms with hopping. Lumbar spine movements are full and pain free. She does have a slightly tighter slump stretch on the right than the left but it is equivocal otherwise. She has supple movement through the right midfoot which is pain free. There is some tenderness over the dorsal midfoot joints, particularly the lateral intercuneiform and 2/3 intermetatarsal region. She does have some mild tenderness over the plantar fascia insertion and also tender to palpation through the mid portion of the Achilles which is slightly thickened to examination and under ultrasound in rooms measures 7.5mm. The deep part of the Achilles has some focal hypoechogenicity, but otherwise the tendon looks relatively normal, other than being thickened.

In summary, Belinda presents with a slightly atypical persisting midfoot pain. This does not bother her too much when active but is most noticeable when she is sat down resting later in the day or at night. There is no morning stiffness. I note she has had some normal blood tests including normal inflammatory markers. The only relevant finding on her MRI scan is of some increased fluid in a couple of the midfoot joints but this may just be incidental. I have reassured Belinda that form a structural perspective there is nothing significant going on.

I have suggested we try and return her to some light walk/jog sessions over the next 2-3 weeks just to see if she can tolerate that and it may be a matter of trying to gradually progress her activities rather than restricting her, particularly in the context of no clear structural pathology. We do need to be a bit cautious about increasing her loads too quickly with the residual plantar fasciitis and Achilles tendinosis, but I do not feel they are her main problems at present. Her

menopausal symptoms may be relevant and she will look into her options there a little further. We could consider a localised corticosteroid injection to those midfoot joints where there is a small effusion as much from a diagnostic as a therapeutic perspective. Depending on progress over the next few weeks that is something we might try as it is a low risk thing to do.

We have pencilled in a time to review things in a few weeks to see how she has tolerated some initial walk/jog sessions and go from there.

Kind Regards,

dictated and edited but not signed by Dr James Lawrence

Dr James Lawrence
Sport & Exercise Physician
BMedSci BMBS FACSP
Provider No. 418615CF

Please note North Sydney Sports Medicine uses
Healthlink - EDI nthsydsp

North Sydney Sports Medicine acknowledges the Cameraygal people of the Eora Nation as the traditional custodians of the land on which we are fortunate to work and live, and recognise their continuing connection to land, water, and community.

cc: Ms Belinda Bean, 201/1A Orinoco St, PYMBLE NSW 2073
cc: Janet Brandt-Sarif, Janet Brandt-Serif Physiotherapy & Sports Injury Clinic, 79 Longueville Road, LANE COVE NSW 2066