Managing Orthotic Fit Issues

Common Patient Complaints, Causes and Clinical Solutions

Patient-reported fit issues are among the most common reasons for orthotic non-compliance and abandonment. Many issues are straightforward to resolve with targeted modifications — but accurate identification of the cause is essential before any adjustment is made. This reference covers the most common fit complaints, their likely causes, and the clinical solutions available.

1 Footwear-Related Issues

Complaint	Likely Cause(s)	Clinical Solution
Orthotic does not fit in shoe	Device too thick / too long / too wide for footwear	Reassess footwear suitability; consider sulcus or ¾ length; reduce shell thickness; grind lateral borders; advise appropriate footwear
Orthotic slides or moves in shoe	Insufficient shoe depth to hold device in place; slippery insole surface; no lace closure	Add non-slip base material; advise lace-up footwear; check device length matches insole; adhesive heel pad
Original insole must be removed first	Patient unaware of standard fitting guidance	Educate patient — remove manufacturer's insole before inserting orthotic in most cases
Device feels too elevated in shoe	Shell + top cover + shoe insole height exceeds shoe depth	Remove original insole; consider thinner top cover; reduce shell height at heel

2 Heel and Rearfoot Issues

Complaint	Likely Cause(s)	Clinical Solution
Heel slippage / heel not sitting in cup	Heel cup too shallow; incorrect casting position; heel cup too wide; shoe heel counter too low	Deepen heel cup; recast if morphology significantly different; add posterior heel wedge; advise shoes with firm heel counter
Medial heel pressure / rubbing	Medial heel skive too aggressive; medial flange height excessive; bony prominence contact	Reduce skive degree by grinding; lower flange height; add Plastazote padding over pressure area; reassess posting angle
Lateral heel pressure	Lateral heel skive too aggressive; lateral bony prominence (fibula, peroneal tubercle)	Reduce lateral skive; spot relief grinding over bony prominence; add Poron spot padding
Heel pain worse with orthotic	Device increasing compression at calcaneus; deep heel cup creating rim pressure; heel raise required	Check rim height — smooth and bevel edges; add Poron heel cushion; consider heel raise; review posting angle
Posterior heel pressure (Haglund's area)	Orthotic heel counter or posterior rim pressing on Haglund's deformity	Grind posterior rim; add Plastazote relief pad; consider open heel or reduced posterior heel cup height

3 Arch and Midfoot Issues

Complaint	Likely Cause(s)	Clinical Solution
Arch too high / uncomfortable pressure	Overcorrection; STJ neutral cast on compensated foot; arch fill too aggressive	Reduce arch height by grinding; consider recasting in SWB or WB; add Poron/Plastazote over arch contact area
Arch not supportive enough	Under-correction; shell too flexible; posting insufficient	Increase rearfoot post angle; consider rigid shell upgrade; add intrinsic arch fill; reassess casting position
Medial midfoot pressure / navicular pain	Navicular prominence contacting shell; arch fill pressing on bony prominence	Spot relief grinding at navicular; add Plastazote accommodation pad; reduce medial flange if present
Cuboid or lateral midfoot pain	Lateral arch overly elevated; lateral flange too high; cuboid prominence	Reduce lateral arch height; lower/remove lateral flange; spot relief; check for cuboid syndrome

4 Forefoot Issues

Complaint	Likely Cause(s)	Clinical Solution
Met head pressure / metatarsalgia worse	Met dome incorrectly placed (under met heads, not proximal); forefoot post too aggressive	Reposition met dome proximally — must be behind met heads; reduce forefoot post angle; add Poron forefoot topping
1st MTPJ pain (Morton's extension)	Morton's extension too rigid or too thick; hallux dorsiflexion fully blocked when partial block sufficient	Reduce extension thickness; bevel or taper extension; consider semi-rigid carbon extension rather than rigid EVA
Lesser toe discomfort / clawing worsens	Full-length top cover creating friction; device pushing toes into flexion	Trim to sulcus length; add toe crest; review toe box depth in footwear
Lateral forefoot pain (5th met area)	Lateral forefoot post too aggressive; forefoot valgus post excess; shell extending too far laterally	Reduce lateral post angle; trim lateral forefoot margin; add Poron lateral relief
Forefoot feels unstable / rolls off edge	Forefoot post insufficient; top cover delaminating; device too narrow at forefoot	Increase forefoot post; replace top cover; assess forefoot width and trim/extend accordingly

5 Systemic / Whole-Device Issues

Complaint	Likely Cause(s)	Clinical Solution
General discomfort throughout wear	Break-in period not explained to patient; too much time too soon	Structured wear-in protocol: 1–2 hrs day 1, increase by 1 hr/day; review at 2–4 weeks
Device makes noise (clicking/squeaking)	Shell contact with shoe; material friction; loose components	Apply thin non-slip base layer; check for delaminating top covers; apply small amount of talc between device and shoe
Top cover wearing out quickly	Inappropriate top cover material for activity level; insufficient thickness; perspiration degradation	Upgrade to more durable top cover (PPT, leather); increase thickness; consider antimicrobial/moisture-resistant covers for high-activity patients
Symptoms improved but new area of pain	Load transfer to adjacent structure — common and expected with significant correction	Monitor — new symptoms often temporary adaptation; if persistent, modify post angle or add relief to new pain area
Device causing skin breakdown	Pressure over bony prominence; inadequate cushioning for at-risk patient; shell edge contact	Immediate removal if skin break; spot relief grinding; Plastazote accommodation; reassess for at-risk category (see M10)

6 Wear-In Protocol

Standard Orthotic Wear-In Protocol

Day 1–2: 1–2 hours. Day 3–4: 3–4 hours. Day 5–7: 5–6 hours. Week 2: Full-day wear as tolerated. Review at 4–6 weeks.

High-risk patients (neuropathy, elderly): daily skin check; review at 2 weeks. If pain, skin redness, or blistering occurs — remove device immediately and contact clinician.

Note: Rigid shell prescriptions typically require longer adaptation than semi-rigid or soft devices.

IDENTIFY THE CAUSE BEFORE MODIFYING

The same complaint (e.g. medial arch discomfort) can result from overcorrection, an incorrect casting position, a bony prominence, or a top cover issue — each requiring a different solution. Modify the correct component.

SMALL INCREMENTAL CHANGES

Orthotic modifications are cumulative. Reduce a post by 2° at a time; grind in stages; add padding incrementally. Over-modification in one step is harder to reverse and may simply create a new problem.

MOST ISSUES ARE SOLVABLE WITHOUT REMAKING

The majority of fit complaints can be resolved with in-house grinding, padding, or post modification. Remaking should be reserved for fundamental casting errors, significant morphology changes, or failed modification attempts.