

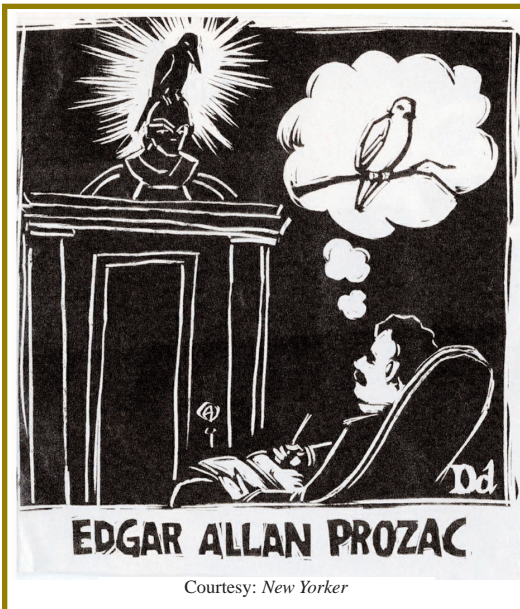
the painless messenger



The practitioner's
resource for chronic
pain management

The newsletter for Pain and Wellness Center Winter 2007 Issue #8

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Courtesy: *New Yorker*

Dear Colleague:

As we meet people outside the work environment, one of the questions asked sooner or later is: "So what do you do for a living?" Well, I have no choice but the truth: "I am a pain doctor," and inevitably, there is silence on the other side. A little brow frowning and then the second question: "What do you mean by that?" At that point, I wish I had a profession defined by one word only: internist, surgeon (no discrimination please), etc, and then the conversation would stop right there. But, then I start explaining that, well, I do a little of everything: internal medicine and neurology, because most of the time I need to start with a diagnosis. Then, I prescribe medications, and if they don't work I become an anesthesiologist and perform nerve blocks. (Alas, not just "3 epidural injections"; God empowered us with many more nerves and branches.) If the nerve blocks don't work, I became an improvised surgeon and make incisions to implant pumps and nerve stimulators. If the nerves are really deep, well then I become a real impostor and become a neurosurgeon. Last but not least, if all fails then I borrow the psychiatrist's mantra and prescribe Prozac, or as this cartoon is suggesting, I become a poet...

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Thank you for your ongoing trust and support,

Julien Vaisman, MD

Our current location, including the ambulatory surgical center, is at 10 Centennial Drive in Peabody. If you have comments or any topics of interest, please do not hesitate to contact us. Our website provides various methods of contacting us: www.painandwellnesscenter.com.

PELVIC PAIN



By James Spinelli, DO

Pelvic pain is quite prevalent in the United States, as it is estimated that nearly 10 million women in this country have it. Accordingly, 10 percent of all gynecologic office visits, 45 percent of all female laparoscopies, and 15 percent of hysterectomies are performed for pelvic pain. It is also a fairly common symptom in the male population, comprising 8 percent of all urological office visits in the U.S.

Unfortunately, treating pelvic pain often proves to be challenging. This is due, in part, to the numerous potential etiologies, which include the genitourinary, gastrointestinal, musculoskeletal, and neurological systems. Further complicating the clinical picture is pelvic pain of psychogenic origin. Sometimes, an exhaustive workup fails to uncover the etiology.

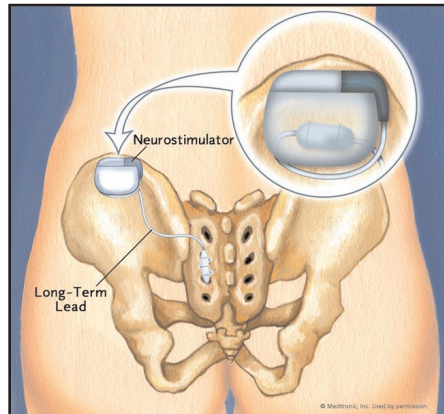
Medication Management

After all potentially reversible causes have been ruled out, conservative medical treatment is a logical first step. A trial of acetaminophen or NSAIDs is a good starting point. If this fails, and the pain is thought to be of neurogenic origin, tricyclic antidepressants (TCAs), selective serotonin and norepinephrine receptor inhibitors (SSNRIs), and antiseizure drugs can be used. The analgesic tramadol is another option for moderate to moderately severe pain. (Of note, tramadol should be used cautiously

with most antidepressants because of the increased risk of serotonin syndrome and seizure.)

Conjunctive Therapies

Pelvic physical therapy including manual intravaginal treatment can also be very useful. This type of therapy is very specialized, so finding a qualified practitioner may be difficult.* Referral to an acupuncturist for pain management and a psychologist or social worker for treatment of the psychological aspects of pelvic pain may also be of use. If these conservative medical treatments fail, referral to a pain management specialist can be beneficial because there are various interventional procedures targeting the nervous system that can offer significant pain relief. Three of these procedures include a hypogastric plexus block, a ganglion impar block, and neuromodulation with sacral nerve stimulation.



Hypogastric Plexus Block

A hypogastric plexus block is indicated for pelvic pain originating from a sympathetic nervous system mechanism in the pelvic viscera, including the cervix, uterus, bladder, prostate, or rectum. The hypogastric plexus is mainly sympathetic and is formed by the confluence of lumbar sympathetic chains and branches of the aortic plexus. With the patient in the prone position, fluoroscopic guidance is used to maneuver a needle just

anteromedial to the L5-S1 intervertebral disc. After radiocontrast dye confirms correct needle placement, injection of local anesthetic can inhibit this pain pathway and break the pain cycle.

Ganglion Impar Block

A ganglion impar block is indicated for pain originating from a sympathetic nervous system mechanism in the perineum, rectum, or genitalia. The ganglion impar is a solitary structure located at the level of the sacrococcygeal junction that marks the termination of the paired paravertebral chains. It contains both sympathetic and parasympathetic fibers. With the patient in the prone position, fluoroscopic guidance is used to maneuver a needle anterior to the first coccygeal vertebra and after radiocontrast dye confirms correct needle placement, local anesthetic is injected. Recently, an ablation technique for this ganglion has been described.

Neuromodulation

Neuromodulation with a sacral nerve stimulator is indicated for chronic intractable pelvic pain of neuropathic origin. Initially, effectiveness is evaluated with a three to five day trial whereby temporary electrodes are placed adjacent to the exiting sacral nerves and are connected to an external generator. If the trial is successful, the sensation of pain is partially replaced (at least a 50 percent reduction in pain) by a tingling sensation in a given distribution. If the response achieved is favorable to the patient, a fully implantable system is placed.

James Spinelli, DO, is a fourth-year psychiatry resident at Spaulding Rehabilitation Hospital and Harvard Medical School in Boston.

** Editor's note: Pain and Wellness Center offers pelvic physical therapy.*

VITAMIN D AND MUSCULOSKELETAL HEALTH



By Leonid Shinchuk, MD

Vitamin D deficiency is pandemic among patients in musculoskeletal clinics. Male and female patients of all ages and ethnic backgrounds are affected. In recent studies, 57 percent of medical inpatients, 83 percent of rehabilitation patients, and 93 percent of patients attending a musculoskeletal pain clinic were vitamin D deficient.

Vitamin D deficiency causes secondary hyperparathyroidism, which can lead to osteopenia and osteoporosis. Vitamin D also binds to receptors on skeletal muscles. Treatment of vitamin D deficiency has been shown to improve proximal muscle strength and postural sway, and to reduce the number of falls in elderly patients. Thus, identification and treatment of vitamin D deficiency reduces the risk of vertebral and non-vertebral fractures by improving bone health and musculoskeletal function.

Vitamin D deficiency can also lead to osteomalacia. This condition can cause aching and throbbing pain that can be elicited on physical examination by applying minimal pressure over the sternum or anterior tibia. It is caused by hydration and swelling of demineralized collagen rich

osteoid that exerts upward pressure on the richly innervated periosteum. Osteomalacia should be considered in the differential diagnosis of patients with musculoskeletal pain, fibromyalgia, chronic fatigue syndrome, or myositis.

Diagnosis

Vitamin D status is determined by measurement of serum 25-hydroxyvitamin D, or 25(OH)D. The ideal level is between 30 to 60 ng/mL. Levels of 25(OH)D greater than 30 ng/mL are sufficient to suppress parathyroid gland response, and to maximize the efficiency of dietary calcium absorption from the small intestine.

Treatment

Vitamin D deficiency can be prevented through sensible sun exposure, adequate dietary intake, and vitamin D supplementation. Children and adults should consider exposing arms and legs to sunlight two to three times a week for five to ten minutes before applying a sunscreen.

Recommendations for vitamin D and calcium intake were developed by the Institute of Medicine (IOM) with the most recent set of guidelines published in 1997. These daily intake recommendations are as follows:

- 200 IU for adults up to 50 years old
- 400 IU for adults 51 to 70 years old
- 600 IU for adults over 71 years old.

However, more recent data show that approximately 1000 IU of vitamin D3 daily is needed to maintain serum 25(OH)D concentration above 30 ng/mL. Care must be taken to ensure adequate vitamin D supplementation as recent studies demonstrate high prevalence of vitamin D deficiency even in patients on pharmacologic therapy to treat osteoporosis while taking a multivitamin that contained vitamin D.

Vitamin D deficiency is treated by administration of vitamin D2 (ergocalciferol) 50,000 IU once a week for eight weeks, followed by supplementation with 50,000 IU twice a month. Vitamin D toxicity usually develops when 25(OH)D is above 150 ng/ml. A person must ingest more than 10,000 IU of vitamin D daily for six months to achieve this level.

Leonid Shinchuk, MD, is a physiatrist and pain fellow at Spaulding Rehabilitation Hospital and Harvard Medical School in Boston.

ACUPUNCTURE IN THE SERVICE OF PAIN MEDICINE



*By Ra'Ufa Clark,
licensed acupuncturist,
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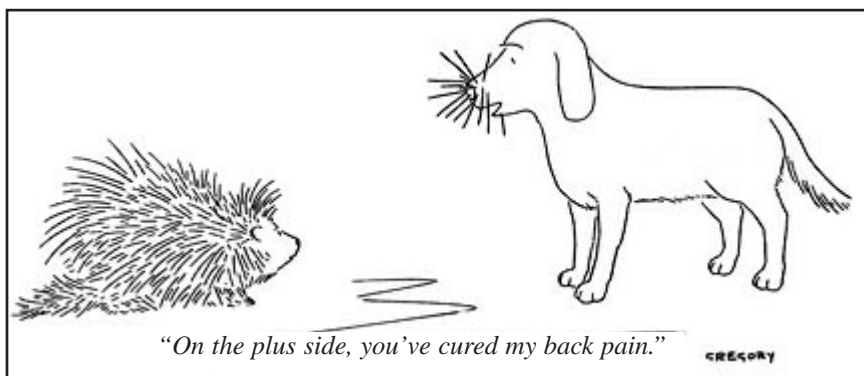
Many healthcare providers are unaware of the broad range of painful conditions, both acute and chronic, seen by the licensed acupuncturist. Last week, for example, I treated patients with chronic cluster headaches, fibromyalgia, lingering sciatic pain after back surgery, fibrocystic breast pain, costochondritis, severe endometriosis, rheumatoid arthritis, post-herpetic neuralgia, upper gastrointestinal pain from gastroesophageal reflux disease, trigeminal neuralgia, prostatitis and urinary

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pain, severe ankle sprain, anterior cruciate ligament (ACL) damage in the knees, chronic angina, anxiety, and Crohn's disease...to name a few. In too many cases, patients turn to an acupuncturist as the last opportunity for help, after having exhausted conventional therapies, and are thus often quite compromised.

Truth be told, most of these patients do find success with Oriental Medicine (OM) and its multiple modalities. Pain relief usually happens gradually as normal function is restored. How is it possible, you might wonder, for one medical approach to address so many different types of painful complaints successfully?

Traditional theories of Oriental Medicine hold that most painful conditions are the result of interruption in the flow of blood, body fluids, or Qi (subtle, bioelectric currents that stream through body tissues in pathways called "meridians" or "channels"). Thus, restoring flow, wherever it is blocked, is key to making progress with pain. Acupuncturists seek to restore flow by utilizing acupuncture needles, manual therapy on soft tissue, low-level lasers, the application of herbal poultices or



linaments, and heat therapy on acupoints. Heat therapy utilizes a substance known as moxa (the traditional herb *Artemisia vulgaris*), whose piezoelectric properties gently stimulate the meridians to respond by moving the Qi, blood, and fluids. Skillful practitioners may also "conduct" Qi, either while needling or by moving the palms of their hands several centimeters above a patient's body to stimulate an energetic response in the bioelectric field around a painful area. Areas of pain will feel heavy, or dense, or may exhibit a prickly quality to the sensing hand. In a single treatment session, several of these strategies may be used.

Before choosing to apply any OM methods, a Traditional Diagnosis (TD) is made to establish the patient's constitutional type and to elucidate how patterns of dysfunction have arisen over time. Acupuncturists are

highly trained in pattern recognition and will often see relationships between signs and symptoms that have no great significance to the allopathic provider. This skill allows for novel interpretations and fresh approaches to treating pain.

Ra'ufa Clark served as Clinical Faculty in Acupuncture & Oriental Medicine in Dr. Andrew Weil's Program in Integrative Medicine at the University of Arizona School of Medicine in Tucson, Arizona from 1997-2001. In that role, she mentored some of the leading voices in academic medicine and innovative integrative medicine centers around the country. From 2002-2006, she served as Board President of the Acupuncture & Oriental Medicine Society of Massachusetts. She can be reached at Heart of the Rose Family Medicine in Beverly, MA (978-922-3030; raufa@heartoftherose.com).

Pain and Wellness Center

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