

Letters to the Editor

To the Editor:

I have reviewed your article ‘Clinical Practice Guidelines for Chronic Non-malignant Pain Syndrome Patients’* in the *Journal of Back and Musculoskeletal Rehabilitation* (1995;5(2): 115–120).

In general, it appears to be a well-constructed document but I am concerned about section 2.5 on ‘Adjunctive treatment modalities’. In this section, it was indicated that chronic pain patients might benefit from ‘1 to 3 to 30 IM injections given at one time’. This has a potential total of 90 injections. Below this it stated ‘patients might also benefit from 10 sets of injections if improvement can be demonstrated’. This would be a total of potentially 300 trigger point injections.

Even though the literature supports the use of selected trigger point injections in myofascial pain and fibromyalgia, it is my opinion that anything approaching 90–300 injections is not medically indicated. I feel that in this precarious population it could lead to significant pain behavior augmentation and pathologizing of muscular discomfort.

In my clinical practice, I usually limit trigger point injections to a select population and only to a few injections if needed.

Vincent P. Herzog, D.O.
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Response:

You are quite right about using the standard dosing for selected trigger point injections. The number indicated in the guidelines would produce pharmacological toxicity. The range was intended to incorporate those interventions that use less than typical medication amounts per trigger point and dry needling or saline injection interventions. Obviously, regardless of the number of trigger point injections, the absolute amount of local anesthetic used needs to conform to standard medical dosing with regard to upper limits.

You are also quite right that excessive intervention with these procedural methods can lead to providing the wrong message for patients in isolation. This is the very reason these techniques are noted as adjunctive treatment. Likewise, the guidelines clearly note that they should not be used in isolation and only if the patient is showing proper improvement in function and coping. Thus, the methods should be applied in a secondary fashion as an ‘aid’ for the patient. This is very similar to the mind set used for medication intervention.

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Response:

The guidelines are important additions to our practice. Dr. Vincent Herzog makes the significant observation that several points were misin-

*Also see ‘Guidelines for Program Evaluation in Chronic Non-malignant Pain Management’ (1996;7(1):19–26.)

terpreted — the patient would receive excessive local injections. I agree completely with the notion that a single trial of trigger point injections could be helpful, but repeated multiple assaults on tender points are just as harmful to the patient as starting them on a morphine pump or a spinal cord stimulator.

The reinforcement of pain behavior is classically present when invasive procedures accompany visits to the physician, as well as dramatic surgical events.

Chronic pain is inevitably complex and thus must be managed with interdisciplinary efforts. The patient's psyche must be involved in the many complaints or the treatment is doomed to failure.

A 'pain specialist' who tries to manage chronic pain with an invasive procedure or a basket of narcotics is likely concerned more with his own protocol than the best plan for the patient.

The concept of an interdisciplinary program to

care for non-malignant chronic pain has suffered a setback with a recent issue of *US News and World Report* which confuses and confounds the treatment of chronic pain associated with malignancy. The pain which is much more difficult to manage, non-malignant chronic pain, is often the consequence of multiple surgical procedures on the back and neck. These are at best symptomatic treatments, and at worst, ineffective, inappropriate, and sisyphian.

Pain is a useful and natural sensation which should be appreciated as a universal experience. When it persists as continuous and intolerable, the physician must employ other specialists, e.g. psychologists, therapists, nutritionists, and others to evaluate and develop a comprehensive management strategy. Caution! Avoid reinforcement!

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