

## G R E A T   N E W S   C O R N E R



## It Isn't About Pain Management, It Is About Pain Resolution

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**W**elcome to our fourth *Journal of Prolotherapy* issue! Wow, it is packed! We have received a wonderful array of great comments from our readers. I wanted to share a few of these emails/correspondences. Scott Greenberg, MD, was nice enough to send us this:

*“Why can't conventional medicine find your pain? Pain is often misunderstood and mismanaged in traditional medical settings.*

*While many of us hurt or have hurt to various degrees during our lifetime, there is no traditional test to ‘quantify’ our pain, nor does the series of happy and sad faces to describe our pain level aid in finding adequate relief from our symptoms.*

*What we have lost in medicine is our ability to examine the patient, correlate the examination with the patient's symptoms, and lastly consider the diagnostic tests. Instead, we as patients enter the system of pain treatment, done almost as a mass production protocol involving first a trial of anti-inflammatory medication and then physical therapy. If these ‘conservative’ measures fail to provide relief, it's off to see the surgeon, where the decision is made to have either surgery or pain management.*

*As a physician, I never wanted to manage pain, nor would want, as a patient, to have my pain managed. Having suffered with pain myself, I could not even imagine living the rest of my life in chronic pain. So why are we so far off the mark with treatment of pain? I think that the answer lies in two important factors. First, we are overly reliant on diagnostic tests. Secondly, we have lost the art of physical examination.*

*Take, for instance, the case of lower back pain. It is one of the most common causes of pain and disability in the world, but often misunderstood. Why? Because most cases are due to musculoskeletal conditions such as sacroiliac joint dysfunction, piriformis syndrome, or facet joint arthropathy. Such problems are not seen on MRI, CT, or X-rays, thus a clinician without expertise in curing these conditions will not be able to effectively manage them.*

*Even though we have access to the greatest diagnostic tests in the world, we as physicians need to use our clinical judgment to determine their significance. For example, the majority of healthy people who do not have any back pain at all will have degenerative, bulging, or herniated discs in their lumbar spine. But if you do have pain, the job of your physician is to determine the relevance of your test results. It is not a black and white issue in what may be causing your pain.*

*So how do we determine what the best treatment courses are for our patients? First we must listen to our patients and ask the right questions—where is the pain, where does it travel, is there any numbness or weakness? What makes it better and what makes it worse? Are there any ominous signs like loss of bowel and bladder function, fever, chills, weight loss, and so on. From our questions alone, the skilled physician should be able to determine 85% of the diagnosis, and then confirm it with physical examination.*

*The examination is key to determine and confirm the root cause of pain, and unfortunately it is becoming a lost art. Many of my patients have told me they were recommended to undergo surgery with either a very brief exam or no exam at all. I find this to be a disservice to patient care that can only lead to bad outcomes. The physical exam is not without its faults, and to be reliable must be performed with experienced hands. Palpation of ligaments, tendons, and joints is a skill and an innate gift to those that possess the ability to acquire its skill. Skilled hands have the ability to determine damaged, weak, and painful joints from those that are normal. This critical tool allows us to incorporate all of the information about a patient's condition and formulate a treatment plan.*

*There is no one size fits all formula to treat a pain condition. However, most pain and sports injury conditions are curable, in the right hands, with reconstructive and regenerative treatments such as Prolotherapy. I found my way to a complete cure after suffering for over 10 years, and I wish you the best in finding your solution, as it exists. If not then hold on tight as we are working on new solutions and treatment options to cure pain and arthritis, all without ever going under the knife.” Well said Dr. Greenberg!*

Obviously, one of the messages we are trying to promote here at *JOP* is that pain can be resolved, whereas just managing the pain by other methods will leave the underlying disease process untouched, free to continue to worsen. Prolotherapy is one method of treatment that has the potential to stop and reverse the underlying degenerative process. The net result is pain resolution, not pain management!

One recent story Marion (my wife) received was the testimony of Ken Allen regarding **the power of the human body to heal itself!** We are reprinting his correspondences with his permission:

**First email:** *I just wanted to say thanks for your article online about the detrimental effects of RICE treatment and NSAIDs on ligament and tendon healing. I came across your article after suffering terrible extensor tendonitis in my right foot, while ramping up mileage too quickly in marathon training. I followed your advice, skipped the ice and ibuprofen, healed up 100% in 5 weeks, and just finished my first half-marathon 3 weeks ago with ZERO PAIN in my foot whatsoever! I just let my foot heal naturally and didn't interfere. If I followed current standard advice, at best I'd have a weaker foot and at worst I'd never run again without pain. I'm telling everyone who will listen, don't use ice and NSAIDs if you want to heal!* –Best wishes, Ken

**Second email:** *I finished the Kaiser 1/2 Marathon in San Francisco in 1 hour 26 minutes. Not too bad for a guy that couldn't even walk 3 months earlier due to a sports injury. I learned a lot from the experience—especially to listen and be nicer to my body. And I really credit your article for helping me heal completely. Thanks again and good luck in your next race!* –Sincerely, Ken

**Third email:** *My age group is 35-39. I was something like 25 in that group, and I placed 143 out of about 5000 overall. I've really only been training for several months, and I'd like to get quicker over time. Please feel free to use my email however you like. The more people that get your message the better. I'm so happy my foot healed as well as it did! I messed it up really bad by trying to run through serious pain and I just kept pushing. Unfortunately, I didn't know better.*

*I was having ankle pain in both legs from running too much too soon, and a guy at a local shoe store recommended stability shoes for me. I don't have pronation issues though, so the shoes rotated my feet out. Gradually I started getting pain on the top of my right foot. Pushing things further, I tried a long 18 mile run and had to limp home after 14 miles. I couldn't bear weight for several days, and it was a month before I could even consider light running again. But I learned from my mistakes, went back to neutral shoes, and now I listen very closely for any hint of pain during and after runs. My foot has been completely pain free, which is awesome!* –Ken

Thank God for the power of the internet! What a great way for people like Ken and others to receive information on how to heal themselves!

We also received four letters from *JOP* reader, Clive Sinoff, MD:

**Letter #1:** *Dr. Hauser and the entire publication staff should be congratulated on achieving the publication of this important journal. For reasons which I cannot comprehend, Prolotherapy has been ignored and greeted with hostility. This publication takes an important step in furthering the knowledge and use of this highly effective therapy. In the article by Hauser and Cukla<sup>1</sup> the X-ray changes are dramatic. It would be useful if the authors could provide more detail as to how the*

*injections were done. What was injected and was the target directly into the subchondral area, ligaments and/or into the joint space?* –Clive Sinoff M.D.

1. Hauser RA and Cukla JJ. Standard clinical X-ray studies document cartilage regeneration in five degenerated knees after Prolotherapy. *J Prolo* 2009;1:22-28.

**Editor's Comments:** Dear Dr. Sinoff, We at *JOP* appreciate your comments and questions. To answer your questions: 2IU of HGH was injected into the joint space. With each treatment the medial and lateral collateral ligaments were also injected with normal Prolotherapy solution.

**Letter #2:** *What a tour de force! Dr. Hauser's review of the effects of corticosteroids was comprehensive and thoroughly documented.*<sup>1</sup>

1. Hauser RA. The deterioration of articular cartilage in osteoarthritis by corticosteroid injections. *J Prolo* 2009;2:107-123.

**Editor's Comments:** Thank you for your comments. The treatment of osteoarthritis with corticosteroid injections has to stop! Clearly one of the main causes of the "bone-on-bone" phenomenon leading to hip and knee replacements is the corticosteroid injections the patients are receiving.

**Letter #3:** *I have two questions to ask the Prolotherapy community. Many authors, including Dr. Van Pelt<sup>1</sup>, recommend the use of human growth hormone (HGH) as a growth factor. My understanding is that HGH is released in the pituitary and acts on the liver to produce somatomedin. Is there any evidence for a direct effect locally? It would seem more logical to use a cytokines such as granulocyte stimulating factor (G-CSF) or fibroblast growth factor (FGF) which have been shown to attract inflammatory cells. Does anyone know of scientific or clinical evidence to support such growth factors?* – Clive Sinoff M.D.

1. Van Pelt RS. Hip arthritis Prolotherapy injection technique. *J Prolo* 2009;1:101-103.

**Editor's Comments:** Wow, what a topic, growth factors and Prolotherapy! As you know the day will arrive where doctors will inject fibroblastic growth factor or granulocyte stimulating factor into injured structures, but unfortunately that day is not here. Here are some items for you to ponder:

1. There are growth hormone receptors on mesenchymal cells including human growth plate chondrocytes.<sup>1</sup>
2. Pituitary growth hormone acts directly on many cells in the body. As a matter of fact, most of the effects

attributed to Growth Hormone action appear to be the result of a direct effect of GH on cells in different peripheral tissues, including cartilage. Not on IGF-1.<sup>2</sup>

3. Growth Hormone has direct anabolic effects on "old" cartilage cells.<sup>3</sup>
4. Yes, there are estrogen receptors on cartilage cells also!<sup>4</sup>
5. Chondrocytes (cartilage cells) can produce their own sex hormones!<sup>5</sup>

What it all means is that cartilage cells are somewhat under the control of hormones. From a Prolotherapy standpoint if we can make cartilage physiology more anabolic there will be a good chance that the chondrocytes will make more cartilage which will ultimately help the patient!

**Letter #4:** *Does anyone have experience with the use of Prolotherapy in true rheumatoid arthritis (as opposed to osteoarthritis misdiagnosed as rheumatoid arthritis)? –Thank you, Clive Sinoff M.D., 22200 Halburton Rd, Beachwood, OH 44122*

**Editor's Comments:** As you know, not every joint pain in a rheumatoid arthritis (RA) patient is due to RA. From a Prolotherapy standpoint in treating the RA patient, you should do the following: assess the condition of their RA and evaluate the painful area like you would with any other patient. If someone has active synovitis at the time of the Prolotherapy evaluation, we (Caring Medical) would inject a solution of sterile water and procaine (anywhere from a total of 0.4% to 1.0% procaine) into the painful areas to cool it off (versus steroids) and treat the rheumatoid arthritis with a natural medicine program. Once the RA is under control, meaning no heat in the joint, hands, wrists, or feet, then Prolotherapy could be done to the joint or structures involved assuming they have injuries that typically respond to Prolotherapy. As you know, rheumatoid arthritis by definition destroys joints. What is one of the best treatments to repair joints? Prolotherapy. So yes, Prolotherapy can be done in folks with RA, but just make sure the RA is under good control. If you inject the typical Prolotherapy solutions into joints with active synovitis you run the risk of increasing the pain quite a bit, but the good news is, the increase in pain is temporary.

Some of the highlights of this fourth issue of *JOP* include articles focused on the cervical spine, and on shoulder pain. From personal experience, I can tell you one of the most horrific cervical conditions is cervical radiculopathy. Glen Batson, DC and Chris Ferrigno, PT join me in a three part article on treating cervical radiculopathy from the experience of a Physiatrist, a Chiropractor, and a Physical Therapist. In *Teaching Techniques* we begin to explore the high-tech world of Prolotherapy with Christopher Centeno, MD, as he discusses the use of C-arm fluoroscopy in his Prolotherapy practice. Our

*Teaching Techniques* columnist, Rodney Van Pelt, MD, teaches the shoulder injection technique.

The American College of Osteopathic Sclerotherapeutic Pain Management is *In the Spotlight*. Donna Alderman, DO takes us on a trip through time with the oldest Prolotherapy organization. It really is a *Wide Wide World* when it comes to Prolotherapy. We hear from Joern Funck, MD, from Germany, on his professional switch from orthopedic surgery to Prolotherapy. Our *Literature Review* columnist, Gary Clark, MD, reviews whiplash literature and presents the intriguing case study of General George S. Patton. He also reports on the fortieth anniversary of the Hemwall Honduran program, which hosts the largest Prolotherapy training course of its kind. It is great to see Dr. Hemwall's legacy continuing with such gusto!

Last, but not least, Marion and I present a retrospective study on chronic shoulder pain. We are always pleased to see the final statistics in these reports that we've presented in the *journal* because it continues to show that Prolotherapy works! By stimulating the natural healing mechanisms of the body, via injecting simple, safe solutions into and around damaged structures, Prolotherapy re-ignites the body to heal itself. The net result is not pain management, but **pain resolution**. Ultimately, that should be the goal of all clinicians who see patients in chronic pain. ■

Until the next injection,

*Ross G. Hausser M.D.*

#### BIBLIOGRAPHY

1. Werther GA, et al. Visual demonstration of growth hormone receptors of human growth plate chondrocytes. *The Journal of Clinical Endocrinology and Metabolism*. 1990;70:1725-1731.
2. Isaksson OG, et al. Mode of action of puituitary growth hormone on target cells. *Annu Rev Physiol*. 1985;47:483-499.
3. Livne E, et al. Comparison of in vitro response to growth hormone by chondrocytes from mandibular condyle cartilage of young and old mice. *Calcified Tissue International*. 1997;61:62-67.
4. Ushiyama T, et al. Expression of genes for estrogen receptors a and b in human articular chondrocytes. *Osteoarthritis and Cartilage*. 1999;7:560-566.
5. Takeuchi S, et al. Production of sex steroid hormones from DHEA in articular chondrocyte of rats. *American Journal of Endocrinol Metab*. 2007;293:E410-E415.