

TEACHING TECHNIQUES

Prolotherapy Tips for Beginners: How I Started with Prolotherapy

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I wish to help make hospital and practice-based colleagues aware of Prolotherapy. So, I will tell you how I started with Prolotherapy. After completing my study of medicine at the University of Leipzig, in 1972, I worked at the orthopedic clinics at the Universities of Leipzig and Würzburg, Germany. Then, after finishing my clinical education, I switched to musculoskeletal medicine and manual therapy. I received specialized training in the Cyriax technique for orthopedic medicine.

I had opened a private practice in downtown Leipzig in 1994. At that time, Dr. Funck, in Lübeck, was already successfully applying Prolotherapy in treating causes of spinal and joint pains, and gave me my initial instruction. Thereafter, I took several courses with Dr. Tom Ravin in Denver, Colorado, and I bought the basic work on Prolotherapy *Ligament and Tendon Relaxation treated by Prolotherapy* by G.S. Hackett, MD.

After returning home, however, I did not immediately start applying the new procedure. One of the reasons was the fact that we did not immediately change our everyday routines with methods of treatment that had been handed down for years. But the main reason for my initial reticence was just the normal nervousness of a beginner.

This changed, however, when a 53 year-old patient turned up who complained of one-sided hip pains, especially when climbing stairs or when getting up from a seated position. To specify the area of pain, she put the fingers of her right hand on the large trochanter. She reported that she had gone through a whole series of unsuccessful specialized consultations. She vividly explained that imaging methods such as X-rays, nuclear spin tomography and bone scans did not result in any clinically relevant findings. Above all, there were no signs of wear and tear to be found in the hip region. A clinical function test did not result in any relevant negative findings either.

The patient also reported that she had rather intense pain when turning over in bed or when lying on the hip where the pain was located. She did not get better, in spite of extensive therapy, including physical applications, chiropractic and acupuncture. Therapists were at a loss with such relatively long-lasting symptoms.

What made the greatest impression on me in the case of this patient was the considerable pain that I provoked when pressing on the region with my thumb.

When examining the patient I used the following procedure:

1. I put one hand around the region of the trochanter major mandibulofacially and pressed the region with the thumb of my other hand. (See Figure 1.) Then I asked

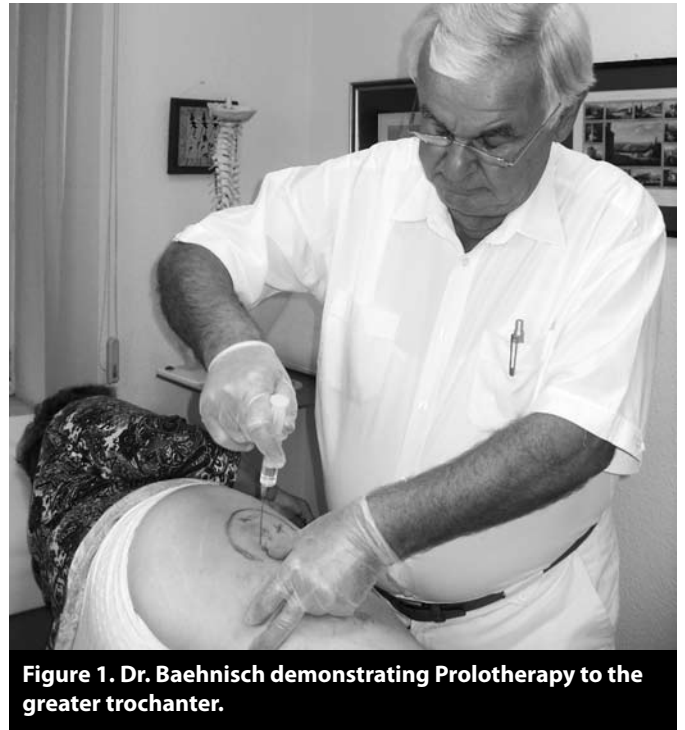


Figure 1. Dr. Baehnisch demonstrating Prolotherapy to the greater trochanter.

the patient how intense the pain was to enable myself to clearly identify the pain areas on the large trochanter. I carried out a side-comparison examination to enable the patient to compare. The pain areas identified were marked in dots with a marker.

Immediately after marking the pain areas, I explained the causes of the pain to the patient in detail as a consequence of the instability at the base of the tendon at the large trochanter. The next step was to explain the procedure of the treatment to her and propose using the pepper technique to infiltrate the pain areas that are in contact with the bone with 20% glucose solution.* I explained to the patient that the glucose solution used in Prolotherapy enhances collagen synthesis. Finally, I informed the patient that normally three sessions at intervals of two weeks are needed.

2. Explaining the gradually continuing cascade-shaped reconstruction processes in the area of the base of the tendon that reduce the symptoms was particularly important to make sure that the patient understood the situation. No less important was explaining that this was a developmental process for reducing symptoms. In other words, it was not just simply a question of getting an injection and making the pain go away. Since this patient had substantial pain over a longer period of time and had gone through a whole series of unsuccessful specialized consultations (mostly with surgeons, orthopedic surgeons and neurologists) with the corresponding apparatus diagnostics, she consented to the therapeutic procedure. She was also sufficiently patient in her expectations of a reduction in pain during the treatment.

There were three injection sessions, over a period of three to four weeks. After the third session of therapy I agreed to another appointment for a check-up after three months. As it turned out, this relatively long time between appointments proved to be beneficial because this was the period of time when there was a significant reduction in pain. I recommended the patient to live normally, subject herself to normal stress and strain, and I appealed to her to be patient in her expectations of a reduction in pain.

We quickly had our first “sensational success.” The patient reported that she had fewer symptoms, and none at all about three months after the last session. She also reported that she was able to stand, walk and climb stairs normally without any impairments, and even was able to lie on the hip that had previously caused her pain.

The initial experience I had with Prolotherapy led to localizing other areas of the locomotor system and supporting apparatus in continuing to expand our range of treatments. For instance, over the years, I have seen that Prolotherapy treatment is very efficient and promising for treating pain caused by connective tissue damage syndrome.

I recommend that anybody who intends to learn the principles of Prolotherapy, and introduce them to their own practice, follow this procedure:

1. Start off by reading the basic work on Prolotherapy: *Ligament and Tendon Relaxation treated by Prolotherapy*, by George Stewart Hackett, MD, Gustav A. Hemwall, MD, and Gerald A. Montgomery, MD.

2. Attend courses on the topic of Prolotherapy established and conducted by experts.**

3. Start with Prolotherapy in your practice immediately after completing the training courses. If you should still be reticent, I recommend overcoming your reticence by first treating your patients who complain of pains caused by instability at the large trochanter. If you, as the person treating, and the patient being treated can muster the needed patience and composure, you will inevitably be rewarded with successes in your first Prolotherapy. Indeed, you will not be able to avoid extending your range of treatments as you learned it from your initial study of the literature and attending courses. ■

EDITORS NOTES

* Additional illustrations detailing Prolotherapy to the hip can be found in the *Teaching Technique* column in *JOP* Volume 1, Issue 2.

** Please see the *Skill Enhancement* section for more information on upcoming seminars and organizations.