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Cannabinoids and pain management

Theresa Mallick-Searle
Stanford Health Care, USA

The use of cannabis (marijuana) or of its psychoactive ingredient delta-9-tetrahydrocannabinol (THC) as a medicine has been highly contested in many settings. Preclinical and clinical studies have suggested that cannabinoids may be useful in treating diverse diseases, including those related to acute or chronic pain. The endo cannabinoid system (ECS) is now recognized as an important modulator of various central nervous system processes. More recently, an increasing body of evidence has accumulated to suggest antioxidant, anti-inflammatory, antineuropathic and neuroprotective roles of ECS. Cannabinoid receptor agonists have more capacity for suppressing pathophysiologic mechanisms like the windup phenomenon linked to chronic neuropathic pain (Strangman et al., 1999). Behavioral studies have shown that cannabinoids reduce thermal and mechanical allodynia in rat models of neuropathic pain. Recent clinical studies provided evidence that cannabinoid based medicine with controlled doses of plant derived cannabinoids can provide symptomatic relief in a subset of patients suffering from pain, and there is hope based on preclinical studies that these medications would also positively modulate disease progression. Cannabis was a part of the American pharmacopoeia until 1942 and is currently available by prescription in Canada and many countries in Europe. In 1997, The Office of National Drug Control Policy commissioned the Institute of Medicine to conduct a comprehensive study of the medical efficacy of cannabis therapeutics. The IOM concluded that cannabis is a safe and effective medicine, patients should have access, and the government should expand avenues for research and drug development.

tmallick@stanfordhealthcare.org

New trends in treating cervical and upper extremity pain

Gabor B Racz
Texas Tech University Health Sciences Center, USA

Epidural injections with multiple substances seriously started in the 1970's. Site-specific catheter placement in the cervical epidural space was started by Racz in the early 80's. The frequency of fluoroscopic guidance increased with the arrival of a soft-tipped, X-ray visible, unkinkable catheter that could be steered to the desired target site. The recognition of degenerative changes such as leaky discs, trauma, and surgical procedures can lead to scar formation and compression not only of the nerves exiting the spinal canal, but also venous runoff causing venous distention, edema from the venous side, cervical pain from the dural adhesions to the posterior longitudinal ligament, and radiculopathy from restriction and compression of nerve roots from scar formation. Any injection in the spinal canal with limited space can lead to loculation and compression of blood supply to the spinal cord which can lead to ischemic changes in myelopathy and in some instances cord injury as well as syrinx formation. The recognition of ischemia can be treated with flexion rotation to enlarge the neural foramina and allow runoff. Unusual contrast spreads from the injection side can be a danger sign and is becoming a standard of practice to treat it by the flexion rotation. The danger sign is the contrast spreading in the absence of runoff to the outside, to the upper inside of the spinal canal because of the dye spread follows the large ventral veins in the perivenous space. This is referred to as perivenous counterspread (PVCS). The benefits of lysis of adhesions followed by neural flossing exercises and long-term favorable outcome from cervical lysis of adhesions will be presented.

gbracz@yahoo.com