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Myofascial pain, new understanding from fascia anatomy

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Myofascial pain and myofascial pain syndrome are often discussed with regard to chronic pain. Indeed they are also commonly recognized and treated with trigger point injections, prolotherapy, and myofascial release techniques. Treatment can be done by experts in physical therapy, acupuncture, massage therapy, rolfing, prolotherapy, trigger point injections, chiropractic, and more. Myofascial pain patterns from trigger points in muscle and fascia are well documented in medical texts (Travell/Simons). It is often thought that myofascial pain has to be due to an underlying problem that may be undiagnosed or not understood. With the advent of “fascia sparing dissection” techniques, the anatomy of fascia in the body has helped to provide for a new understanding of myofascial pain and its underlying injuries and pathology. Indeed the predominant injury most of the time is to muscle and fascia rather than disc and joint. The interaction of muscle, fascia, and free small fiber nerve endings notifies the brain of these injuries as myofascial pain. Video recording of fascia-sparing cadaver dissection illustrates the body-wide continuity of fascia, and also helps to elucidate the referral patterns and enigmatic nature of myofascial pain. This new understanding of anatomy helps us to realize how radiating pain and other sensations can be caused by injury to fascia and muscle. It also provides clues as to how to help the body heal from such injuries in order to relieve chronic pain.

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Perioperative use of ketamine for pain management

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Pain management with opioids is often limited by adverse effects and sometimes by ineffectiveness in an opioid-tolerant patient. Adjuvant treatment with an inexpensive opioid-sparing drug such as ketamine may help to provide better analgesia with fewer adverse effects. Ketamine, an N-methyl-D-aspartate (NMDA) receptor antagonist, is shown to be useful in a variety of surgical patients. Perioperative ketamine in sub anesthetic doses reduces postoperative opioid requirements, postoperative nausea or vomiting (PONV), rescue analgesic requirements, and pain intensity. Ketamine has multiple mechanisms of action, including but not limited to decreasing central excitability, decreasing acute postoperative opiate tolerance, and a possible modulation of opiate receptors. Adverse effects for perioperative ketamine are mild or absent. Postop pain management can be especially challenging in patients with preexisting chronic pain because of underlying factors such as psychiatric disorders (depression/anxiety), opioid tolerance, and opioid-induced hyperalgesia. Ketamine may be most efficacious in patients who consume higher amounts of preoperative opiate medications. Studies have also shown that ketamine may reduce pain intensity and analgesic consumption up to 6 weeks in the postoperative period. Postsurgical pain typically resolves by 4 weeks and a reduction in pain intensity at 6 weeks would represent a potential reduction in chronic postsurgical pain, an outcome of interest to primary care physicians, surgeons, and anesthesiologists. Evidence suggests that postoperative pain continues to be undermanaged and poorly controlled acute postoperative pain is associated with an increased risk of developing chronic postsurgical pain and cardiopulmonary complications. Multimodal therapy, including opioids, non-opioid adjunctive medications (ketamine, NSAIDs, acetaminophen, and anticonvulsants), along with regional anesthetic techniques may often be required to minimize potential complications related to suboptimal pain management. The presentation will discuss the usefulness of low dose ketamine in the perioperative setting, highlighting its use in the opioid-tolerant patient.

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