

Management of a Case of Myofascial Pain: An aggressive way of Management

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Abstract

Backgrounds: 38 years old lady presented with generalized body-ache, lack of energy and other constitutional symptoms. She was on various forms of treatment since last 3 years but not getting any substantial improvement. She was managed by different specialist but not got any any positive improvement.

Methods: Patient came with generalized symptoms and after assessment we decided to undergo trigger point release injection and infiltration around accessory nerve. Trigger point was repeated after 6 months with almost complete relief in symptoms.

Results: Substantial relief in symptoms had been achieved in a short span of time. Relief was almost complete with improved performance and quality of life.

Keywords: myofascial pain; trigger point; posture; botox; VAS; methylprednisolone plus; vitamin D3 supplements; iron supplements; physiotherapy

Introduction

38 years old lady presented with complaints of generalized body-ache, giddiness, lack of energy, easy fatigability, recurrent episodes of gastritis and behavioral symptoms. Symptoms started 3 years back, with no apparent history, increased intensity with time and now the symptoms become intolerable. She used to work in a private company, 8-10 hours of sitting work in front of computer daily. Now she is showing off & on episodes of high Blood Pressure and Blood Sugar in slightly higher range.

History of Present Illness: Patient was apparently asymptomatic almost 3 years back, when she first started working with a private consultancy firm, her task required sitting in front of system for almost 8-10 hours/day. Initially she complained of easy fatigability and frontal headache, which gradually increased in intensity with time and other symptoms, also started building up. She started physiotherapy sessions initially regularly later on intermittently, but without any relief. Her symptoms increased gradually and after 7-8 months, she first consulted one orthopedic surgeon and later consulted various other doctors but didn't have any relief.

She first came to our clinic 3 months back; she was in severe pain along with swelling around cervical region and between both the shoulders, unable to move her neck fully in each direction because of pain. Both the trapezius and scalene are tender on palpation, her pain intensity was level

8-9 on VAS. Para-spinal muscular stiffness was present, with straightening of cervical lordosis. She often complained of lack of energy and least interest in her surroundings. Her attention span is grossly reduced with difficulty in focusing on a single task. Her behavior was aggressive and she often gets irritated on minor issues. Despite eating less her weight was increasing gradually, her digestion was poor, with regular episodes of acidity & gaseous abdominal distension.

Investigations: MRI cervical spine shows disc bulges at C4/C5, C5/C6 & C6/c7 levels, compressing thecal sac without any neural compromise. X-ray shows straightening of cervical curve with early spondylotic changes. Her all the blood investigations were within normal limits, with wildly reduced hemoglobin (11.2 gm) and slightly increased Cholesterol, Low Density Lipoprotein (LDL) & Triglyceride level.

Management

Initially she was started with analgesic-anti-inflammatory medicines plus muscle relaxants, but without any significant results. Looking at her condition, we planned pain management procedure. After taking written consent from the patient, we planned and did our procedure after 2 days. Under guidance of Nerve Stimulator we infiltrated 40 mg Methylprednisolone plus 3 ml 2% lignocaine around both the divisions of accessory nerve. 50 I.U. Injection Botox was injected, 25 I.U. in both the upper trapezius. Procedure was uneventful and she was sent home after

one hour of observation. She was advised analgesic-anti-inflammatory medicine for two days and called for follow up after 2 days. On her follow up her pain was 2 on VAS, she was much comfortable than before, her symptoms were resolved to the great extent. Stretching exercises was started immediately and advised to do stretching exercises for the next few months and called for follow up after 6 weeks.

At 6 weeks follow up she was very comfortable without any pain or discomfort, Neck ROM were full & painless, was doing stretching exercises twice daily. We put her on Vitamin D3 supplements and Iron supplements.

At 6 months follow up, her pain intensity was 4 on VAS, she stopped doing exercises 3 months back and developed few small triggers in both the upper trapezius muscles. Injection Botox 25 I.U. was again injected in both the upper trapezius and called for follow up after a week time. Her pain and other symptoms were totally settled by now and she was living a comfortable life.

Results

Till date she is not on any medication and living her life comfortably. All the symptoms are well under control without any medication.

Discussion

MPS is defined as a pain syndrome characterized by local tenderness, trigger points and typical referred pain pattern, and is known to be a common clinical syndrome. Commonest are neck and shoulder pain [1] with an estimated point prevalence of almost 13% and a lifetime prevalence of more than 50%. The most characteristic symptom of MPS is local and radicular pain. There is a lack of any specific diagnostic criteria for MPS.

The health impact of myofascial pain can be quite severe as patients with the disorder not only suffer from decreased functional status associated with musculoskeletal pain and loss of function, but also suffer from impaired mood as well as decreased quality of life [2].

Symptoms of a Myofascial trigger points include: focal point tenderness, reproduction of pain upon trigger point palpation, hardening of the muscle upon trigger point palpation, pseudo-weakness of the involved muscle, referred pain, and limited range of motion following approximately 5 seconds of sustained trigger point pressure [3].

The causes of MPS are not fully documented or understood. Common etiologies of myofascial pain and dysfunction may be from direct or indirect trauma, spine pathology, exposure to cumulative and repetitive strain, postural dysfunction, and physical deconditioning [4,5]. Some systemic diseases, such as connective tissue disease, can cause

MPS [6]. Poor posture and emotional disturbance might also instigate or contribute to MPS [7].

There are several therapies currently used to treat myofascial trigger points including massage, stretching, dry needling/injections, electrical stimulation, cold laser treatment, and ultrasound. There are several massage treatments that relax myofascial trigger points such as passive rhythmic release, active rhythmic release, and trigger point pressure release [8].

Conclusion

Myofascial Pain is an ever increasing problem associated with generalized symptoms. Most of the time this problem is either not diagnosed or not treated properly till date. There are so many available treatment options but none of these proved effective till date. We have adopted a new treatment protocol to treat our patient and got the excellent results. Early diagnosis & management is always very important to prevent & effectively manage any ailment.

References

1. Horal J. The clinical appearance of low back disorders in the city of Gothenburg, Sweden. *Acta Ortho Scand. Suppl* 1969; **118**:42-45.
2. Gerber L. H., Sikdar S., Armstrong K., et al. A systematic comparison between subjects with no pain and pain associated with active myofascial trigger points. *PM & R: The Journal of Injury, Function, and Rehabilitation*. 2013; 5(11):931-938. doi: 10.1016/j.pmrj.2013.06.006.
3. Bennett, Robert (2007). "Myofascial pain syndromes and their evaluation". *Best Practice & Research Clinical Rheumatology*. 21 (3): 427-445. Doi:10.1016/j.berh.2007.02.014.
4. Simons D, Travell J, Simons L, editors. *Travell and Simons' myofascial pain and dysfunction: the trigger point manual*. 2nd ed. Baltimore: Williams & Wilkins; 1999.
5. Wheeler A, Aaron G. Muscle pain due to injury. *Curr Pain Headache Rep*. 2001; 5:441-446. doi: 10.1007/s11916-001-0055-5.
6. Gerwin, Robert (2005). "Differential Diagnosis of Trigger Points". *Journal of Musculoskeletal Pain*. 12 (3): 23-28. doi:10.1300/J094v12n03_04. S2CID 71224028.
7. Fricton, James R.; Kroening, Richard; Haley, Dennis; Siegert, Ralf (1985). "Myofascial pain syndrome of the head and neck: A review of clinical characteristics of 164 patients". *Oral Surgery, Oral Medicine, Oral Pathology*. 60 (6): 615-623. doi:10.1016/0030-4220(85)90364-0. PMID 3865133
8. Simons D. G. Review of enigmatic MTrPs as a common cause of enigmatic musculoskeletal pain and dysfunction. *Journal of Electromyography and Kinesiology*. 2004; 14(1):95-107. doi: 10.1016/j.jelekin.2003.09.018.