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Globalization of Myofascial Pain Syndromes

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The bare essentials of a myofascial pain syndrome are: 1) a myofascial trigger point, 2) referred pain, and 3) hypertonicity and weakness of the muscle that houses the trigger point. Many patients with pain suffer solely from this basic form of myofascial syndrome. Therapy that desensitizes the trigger point and normalizes the muscle tone provides lasting relief. It can be as simple as that.

Unfortunately, simple myofascial syndromes can become complex. The lesioned muscle can draft other muscles into the syndrome. These other muscles can form and activate their own trigger points.[1] From this spreading myofascial brushfire, the patient's whole body emblazons with pain and dysfunction, and his fight for relief becomes an all-consuming obsession. With his total inner-resources poured into this physical and mental conflagration, his work and home life can come to ruin. When he's eventually depleted and dispirited, he may end his life by his own hand.

This complex global version of myofascial syndrome begins with the original lesioned muscle blasting noxious sensory signals into the CNS. These signals heat up the brainstem's reticular activating system. When the reticular system is stimulated to a high enough pitch, it sizzles the patient with noxious physical and mental arousal.[2] The arousal doesn't stop just because he's tired and decides it's time to sleep. He lies there awake, his mind reeling with uncontrollable thoughts, his body glowing with myofascial pain.

Naturally, he's still tired the next day.[3] He slumps and irritates joints and their soft tissue supports. Noxious sensory signals from these joints then join the assault on his spinal cord and brain.[4] The signals stimulate his sympathetic nervous system, and this escalates his generalized arousal. By now he not only hurts -- he's stiff, exhausted, restless, and irritable.[5]

His sympathetic arousal reduces his GI secretions and absorption. This can lead to multiple nutritional inadequacies that intensify his tired-but-wired affliction. The sympathetic arousal also slows his intestinal motility.[6] When briefly inhibited, his GI tract bloats with gas; and when it's inhibited repeatedly for

extended periods of time, he’s said to have spastic colon or irritable bowel syndrome.

His ever-present fatigue, insomnia, and sympathetic arousal combine to intensify his sensitivity to pain. He perceives his agony worsening and becomes desperate for relief. The numbing effects of drugs or alcohol are irresistible, but the relief they offer is partial and brief. What’s worse, he may submit to drugging by his medic -- a step into chemical quicksand. His only escape rope may be inpatient drug rehabilitation.

For all practical purposes, drugs don’t work. Only Elavil or Flexeril may give a modicum of relief through sedation. But when the pain and desperation remain, relations with his medics turn sour. Arrogant medics are quick-tempered with such an "incorrigible" patient. They’ll pass him around like a bad girl at a frat house until they’ve had enough of him, then they’ll banish him to a psychiatrist.

The psychiatrist will try to drug him further and preach that he hurts because he’s depressed.[7] The strong-willed patient, insisting that reason rule, will set the doctor straight on the sequence of events. His depression (like the fatigue and GI problems) came late, and is partly a result of a fruitless pursuit of relief.

If the patient has been detained by medics too long, some of his constricted myofascia may become scarred and incapable of total recovery.[8] Hopefully his tissue will only be functionally impaired, and a DC adept at myofascial therapy will be able to restore them to normal.

Myofascial pain syndromes can be simple and quickly relieved; or they can be complex and relieved only with great diligence. Complex myofascial pain syndromes involve numerous somatic, visceral, and mental symptoms -- all pimples on the same pathophysiological face. Doctoring them one at a time won’t cure the syndrome. The patient must be made to realize that his whole body is out of control. He must fully cooperate in calming it down in some ways, and stoking it up in others. His deliverance depends on broad-scope myofascial therapy -- partly DC-administered, partly self-administered and maintained. It takes determination and persistence to return these patients to a normal life. But considering the alternatives, this is a clinical rescue that’s well worth the effort.

References

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