



THIS ISSUE

Update on knee arthritis
Managing patients post TKA
New HHS recommendation
on opioid tapering

DID YOU KNOW?

GLUCOSAMINE VS TURMERIC

TRUTH ABOUT GLUCOSAMINE

A study of 1,625 people published in the journal of Arthritis & Rheumatology in 2015, found that using glucosamine and chondroitin over a 4 year period did not relieve knee pain or prevent cartilage loss in people with osteoarthritis any better than a placebo.

TRUTH ABOUT TURMERIC

The beneficial effects of turmeric are traditionally achieved through dietary consumption, even at low levels, over long periods of time. The activities of turmeric include antibacterial, antiviral, anti-inflammatory, antitumor, antioxidant, antiseptic, cardioprotective, hepatoprotective, nephroprotective, radioprotective, and digestive activities. Phytochemical analysis of turmeric has revealed a large number of compounds, including curcumin, volatile oil, and curcuminoids, which have been found to have potent pharmacological properties.



LETTER FROM THE EDITOR

Hope you enjoyed the first issue of Pain Now. The inaugural issue focused on continuing a collaborative effort with primary care and pain physicians to prevent the over prescribing of opioids and offer alternative treatments for chronic pain. The goal is to present treatment solutions to improve pain and function, and minimize medications being prescribed to excess.

This issue focuses on knee arthritis and new treatment options for our patients.

Many patients are holding off on total knee surgery due to the risk and recovery often associated post surgery. In addition patients post total knee arthroplasty continue to have pain from scar tissue and sympathetic mediated pain. DOC Pain Management provides innovative treatment options, and we are on the forefront of new medications in the pipeline.

This monthly newsletter provides our community of providers with information on prevalent chronic pain related topics, including alternative treatment options, diagnostic and treatment guidelines, Ohio policy updates, and key information for healthy and pain-free living. You can view a digital copy of this newsletter by scanning the QR code below.

Sincerely,



Dr. Priyesh Mehta, D.O.

Interventional Pain Physician
ABPMR/ABPM
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SCAN ME

ABOUT DR. MEHTA

- **Medical School:** University of New England College of Osteopathic Medicine
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UPDATE ON KNEE ARTHRITIS

How Is Osteoarthritis of the Knee Treated?

- Weight loss
- Exercise
- Pain relievers and anti-inflammatory drugs
- Injections of corticosteroids or hyaluronic acid into the knee.
- Alternative therapies
- Using devices such as braces
- Physical and occupational therapy
- Surgery

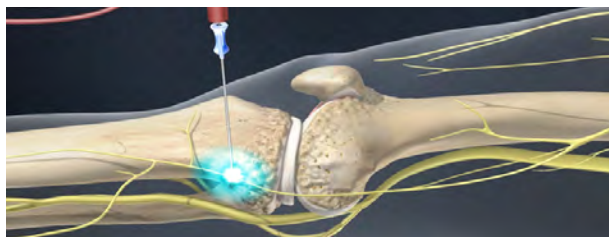
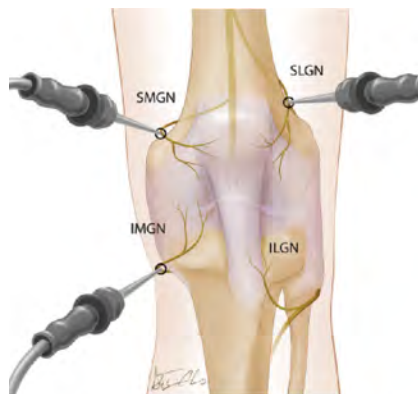
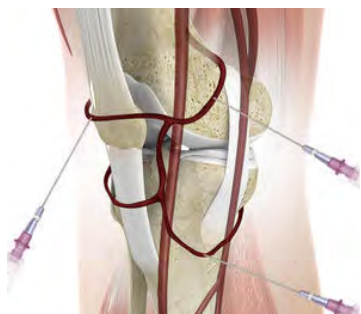


HOW WE MANAGE PATIENTS THAT HAVE FAILED CONSERVATIVE THERAPY BUT ARE NOT CANDIDATES FOR TKA:

NERVE BLOCKER / RADIOFREQUENCY ABLATION / NO CORTICOSTEROID

For people who can't have surgery or who choose to delay it, another option for pain relief is to block the nerves in the knee that transmit pain. Several branches of nerves around the knee, called genicular nerves, provide sensation. Nerve blocks target at least three nerves—one on the inside and top of the knee, one on the outside and top and one on the inside and bottom.

Radiofrequency (RF) ablation doesn't just anesthetize the nerves. It delivers heat that disrupts the outside of the nerves, which prevents them from sending a pain signal. Like with a genicular nerve block, the procedure is done on an outpatient basis. Relief comes five to seven days later after the soreness and swelling subside. RF ablation often provides pain relief for six months to one year.



HOW WE MANAGE PATIENTS THAT HAVE FAILED TKA AND STILL HAVE CHRONIC PAIN: DORSAL ROOT GANGLION (DRG) STIMULATION

Traditionally, doctors have prescribed medications to treat chronic pain, including opioids, which can lead to addiction and overdose. Treatment plans for chronic pain may also include physical therapy, psychological interventions, nerve blocks, and surgery. When these treatments fail, people with chronic pain can turn to a different therapy. Spinal cord stimulation is an option that blocks pain signals from reaching the brain in the first place. For this treatment, a surgeon places a small device in your body that sends electrical signals to your spinal cord. Research has found that 40% to 50% of people who have CRPS achieve pain relief from spinal cord stimulation. Although the development of traditional spinal cord stimulation was a big step forward, it still left many people without a solution to their chronic pain.

Groundbreaking New Treatment: DRG Stimulation Researchers turned their attention to the dorsal root ganglion (DRG), a bundle of nerves located on the outside of the spinal cord. The DRG was once thought to have no connection to pain, but researchers now know that this nerve bundle plays a key role in nerve pain for CRPS I and II patients. The 2017 Pain study published, stimulating the DRG helps relieve pain more effectively than spinal cord stimulation. This DRG stimulation therapy involves surgically placing a stimulator that targets the dorsal root ganglion to relieve pain of the lower limbs due to CRPS. Individuals have a hand-held iPod controller that changes the stimulation settings within prescribed limits. This new technology has made a significant difference in the treatment of chronic pain.

DID YOU KNOW?

Use of corticosteroid injections to treat knee OA is based on the medicine's capacity to reduce inflammation, but corticosteroids have also been reported to have destructive effects on cartilage.

"We now know that these injections bring no long-term benefit, and may, in fact, do more harm than good by accelerating damage to the cartilage."

— Dr. McAlindon

8 EXERCISES TO HELP YOUR KNEES

Please visit the online version of this newsletter for details in reference to these exercises listed.

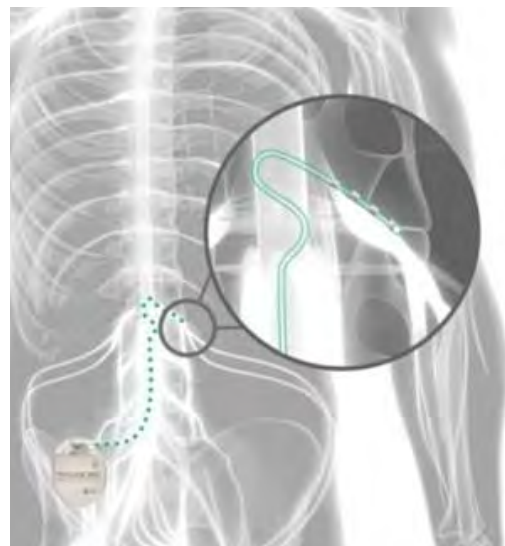
- STRAIGHT LEG RAISES
- HAMSTRING CURLS
- PRONE STRAIGHT LEG RAISES
- WALL SQUATS
- CALF RAISES
- STEP-UPS
- SIDE LG RAISES
- LEG RAISES

ON THE HORIZON FOR KNEE OSTEOARTHRITIS

In a recent randomized controlled trial, subcutaneous tanezumab resulted in moderate improvements in joint pain and physical function for patients with osteoarthritis compared to placebo.

— JAMA, June 2019

Priyesh Mehta, PI with Meta Medical Research Institute, is looking at cutting edge treatments using Fasinumab—a human monoclonal antibody designed for the treatment of knee and hip osteoarthritis pain. This drug was developed in collaboration by Teva Pharmaceutical Industries and Regeneron Pharmaceuticals. It is currently in Phase III trials.



HHS UPDATE ON OPIOID TAPERING



HHS ANNOUNCES GUIDE FOR APPROPRIATE TAPERING OR DISCONTINUATION OF LONG-TERM OPIOID USE

The U.S. Department of Health and Human Services published a new Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (a link to the PDF of this report is available at the online version of this newsletter). Individual patients, as well as the health of the public, benefit when opioids are prescribed only when the benefit of using opioids outweighs the risks. But once a patient is on opioids for a prolonged duration, any abrupt change in the patient's regimen may put the patient at risk of harm. The HHS Guide provides advice to clinicians who are contemplating or initiating a change in opioid dosage.

Clinicians have a responsibility to coordinate patients' pain treatment and opioid-related problems. In certain situations, a reduced opioid dosage may be indicated, in joint consultation with the care team and the patient.

- Before beginning a taper, patients with serious mental illness, high suicide risk, or suicidal ideation should be referred to a behavioral health provider.
- If patients show signs of opioid misuse, they should be assessed for opioid use disorder. Those meeting the disorder's criteria should be offered medication-assisted treatment.
- Clinicians should advise patients that they're at risk for overdose if they abruptly return to their higher dose. Patients can lose tolerance in as little as a week.
- Tapers commonly involve dose reductions of 5% to 20% every 4 weeks, with longer opioid use requiring longer tapers.
- Clinicians can consider transitioning patients to buprenorphine if they are on high doses and unable to taper, even if they don't meet the criteria for opioid use disorder.

For more information, go to: www.hhs.gov/opioids.

ALSO HAPPENING THIS MONTH



NOVEMBER OBSERVANCES & FUN FACTS:

- National Diabetes Month
- Lung Cancer Awareness Month
- National Adoption Month
- National Native American Heritage Month
- Thanksgiving Day Celebration on the 4th Thursday

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ISSUE 02

*Update on knee arthritis
Managing patients post TKA
HHS recommendation*

DOC: Dayton Outpatient Center is a leader in pain management and has been serving the Dayton community for over 25 years. We utilize medication, injections, physical therapy, spinal cord stimulators, intrathecal pumps, and more to treat patients.

PAIN NOW

NOVEMBER 2019

According to a 2017 study published in Pain, people with chronic pain in a lower limb from CRPS experienced superior pain relief after 12 months with DRG stimulation.

The numbers speak for themselves: 74.2% of people experienced meaningful pain relief with DRG stimulation, compared to 53% who received traditional spinal cord stimulation.

One-third had more than 80% pain relief and no tingling sensation, which is a common side effect with traditional spinal cord stimulation.

DRG stimulation led to an improved quality of life compared to traditional spinal cord stimulation.

READ MORE INSIDE ...

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