

Patient history

Six failed attempts over five years to treat endometriosis with pelvic surgery and, ultimately, an abdominal hysterectomy produced for this 36-year-old female office manager and mother of two progressively worsening chronic pain.

Each surgery left the patient in ever greater chronic pain and disability. During the hysterectomy, her bladder was nicked, causing the onset of septic and additional pain symptoms.

Her primary-care physician attempted to manage the pain by prescribing various medications, including low-grade narcotics. All were ineffective.

Case description

The patient was first seen by us on referral in May 2008. She presented with severe bilateral pelvic pain that featured minor peroneal involvement. The pain was moderately disabling: lifting all but the lightest objects was problematic for the patient and she reported being unable to enjoy normal marital relations with her spouse. Further, owing to her pain, she had drifted into depression (she was being treated for it by a psychiatrist).

Our workup included taking a comprehensive history and conducting a careful review of the surgeons' notes. Additionally, we took an MRI of the lumbar spine; no radicular symptoms were observed. We determined that scar tissue formation with

each surgery was responsible for the chronic pain symptoms and their progressive intensification.

Treatment plan

The relatively young age of the patient, coupled with the fact that she was caring for young children at home, militated against treating her pain with stronger, more appropriate narcotics. Therefore, with the referring physician's concurrence, we prescribed fluoroscopically guided superior hypergastric blockade injections consisting of long-acting local anesthetic (to achieve sympathetic interruption) and a small amount of corticosteroid (to decrease inflammation). Frequency of administration was to be patient-dependent but, ideally, no more than once every 16 weeks.

Outcome

The injections delivered the desired results – the patient experienced almost total pain relief. Unfortunately, for this particular individual, the relief lasted only about eight weeks after each injection. But based on how well she responded initially to those blocks, we believe she is a very good candidate for implantation of a spinal cord stimulator, a trial of which is slated to begin presently.

Discussion

One other way besides superior hypergastric injections that pain relief can be

obtained in patients such as this is by ablating the involved nerves with alcohol or phenol injections. We rejected this option because the patient's multiple prior surgeries would have made denervation risky and, therefore, inadvisable.

As to spinal cord stimulation, studies dating back to the 1990s have demonstrated the efficacy of this device in relieving select chronic pain disorders such as failed back syndrome, complex regional pain syndrome (Types I and II) and peripheral neuropathy. Newer indications for this treatment modality include cancer pain, abdominal pain, interstitial cystitis, phantom limb pain, diabetic neuropathy and postherpetic neuralgia. The January 2008 issue of *The Review of Cardiovascular Medicine* confirms that spinal cord stimulation is effective in the treatment of intractable angina pectoris (in Europe, intractable angina pectoris is the leading indication for use of spinal cord stimulation). According to a study published in the journal *Pain Practice* (March 2006), many physicians view spinal cord stimulator implantation as an intervention of last resort, when in fact they should esteem it in the exact opposite regard because evidence suggests that early intervention with spinal cord stimulation results in greater efficacy.

Call 225-368-2300 today to schedule your preferred appointment time. We encourage, honor and welcome your referrals.

