Practical Management of Myofascial Pain

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Myofascial pain syndrome (MPS) is a common chronic pain problem in clinical practice.[1] As the etiology and the pathophysiology are exactly not known, the inevitable controversy still persisted though more researches and clinical studies supported the real body of myofascial trigger point (MTrP).[2, 3] MPS can address as a condition that occurs as a primary source of pain (primary MPS) as well as a comorbid with other diseases or a consequence pain from other conditions (secondary MPS).[4] Awareness in certain circumstances is important issue in practicing with MPS. In this presentation will focus on key awareness that more or less benefit for practitioner.

Awareness 1. Overlook: In clinical practice MPS is a source of pain that had been overlooked.[1, 5] As other chronic pain; overlooking primary MPS leading to the over-diagnosis of psychological problem is a common situation[6, 7] and overlooking secondary MPS usually leading to the over-estimate of primary disease.[8]

Awareness 2: Look-over: Dealing with MPS we have to take a look at both the source of pain (pain generator: MTrP) and more over the cause (primary or secondary) of MTrP, always.[2, 3, 9]

Awareness 3: Short-termed therapy (MTrP inactivation) for long-termed change (find out and correct perpetuating factors) is the main principle of MPS management.[2, 3]

Awareness 4: MTrP inactivation is just symptomatic treatment, as MTrP is a source of the symptoms.[2, 3, 9] And no single standard of MTrP treatment strategy [10] for example stretch and spray[11], acupuncture[12], dry needling[12], trigger point injection[13], massage[14], ultrasound diathermy[15], laser therapy[16], extracorporeal shockwave therapy[17], repetitive peripheral magnetic stimulation.[18] In practice, when there is doubt about the clinical significance of a particular trigger point, it can be inactivated with either MTrP release strategies, an immediate (with 2–3 minutes) unequivocal decrease in pain is good evidence that the MTrP in question is clinically relevant.[4] Regarding to MTrP inactivation one of the common question is which one should be a strategy of choice? It is depended on individual profile of the patient and combination may benefit in certain cases.[10, 19, 20] Also how long does the symptom relieve last after one time of the MTrP treatment? Definitely no one can tell as depended on individual PPF so rarely study reported.[21] And the number of the local MTrP treatment in clinical study was vary from few to 10 sessions within few weeks to few months.[3] Immediate and short-term relief is common finding but long-term not.[2, 3, 5]

Awareness 5: Long-termed prognosis is to find out and correct the cause of the MTrP (comorbid or PPF).[2, 3, 9] In case of secondary MPS, comorbid may be one disease

but in case of primary MPS, PPF common to be multifactor.

Awareness 6: Do all of the multifactor need to be corrected? By theory is yes but in practice may be not. Multifactor is not sole agent to activate MTrP, corrected one or some factors may attenuate the active MTrP to latent MTrP. So mix & match, set priority and evaluate the feasibility of each and which PPF to correct is important.

Awareness 7: Does all the symptoms will gone after the comorbid was cured or all the PPF were corrected? In practice not all is found. Possible explanation might be regarding to self-sustaining positive feed-forward process of MTrP pathophysiology.[2, 3] At this moment any local MTrP treatment strategy obtained usually promise a magic result.

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