

Doctor Bernard Filner describes in this article his recent experiences regarding the use of the Low Power Laser in the treatment of patients with neuropathic pain, particularly after oncologic radiation therapy.

The first group includes breast cancer patients, where therapy has included lumpectomy and/or chemotherapy/radiation therapy. Their primary complaints have been pain in the anterior/posterior chest, neck, or arm (on the surgical side); shoulder pain and/or dysfunction, including “frozen shoulder”, on the operated side; edema of the arm and anterior chest on the operated side; and soft tissue muscular dysfunction on one or both sides attributed to post-radiation scarring and fibrosis. These patients have suffered for as long as ten-plus years, and usually assume that the problem is an “unavoidable” part of having cancer and surgery. I have discovered that this is rarely true, and the symptoms can be significantly ameliorated or resolved if treated properly. The use of the low power laser has dramatically improved the results, given that the lack of pain and risk of the LLLT makes the best and most effective treatments possible. In these cases, the pain of Myofascial Trigger Points and their referred pains can easily be treated with the low power laser. Additionally, these tight muscles can create a “noose” around particular nerves, causing entrapment neuropathies, which usually go unrecognized by clinicians untrained in this area. Inactivation of the appropriate trigger point relieves the “nerve” pain (e.g. greater occipital nerves, Brachial Plexus – TOS, long thoracic nerve, median nerve, ulnar nerve, sciatic nerve, ilioinguinal nerve, common peroneal nerve, and pudendal nerve). Additionally, tight muscles from active trigger points can prevent normal lymphatic drainage of almost any area of the body. And finally, positioning pre-, intra-, and post operative and radiation therapy can create new trigger points and cause significant soft tissue pain and dysfunction.

Lastly, a patient was seen recently who clearly illustrates the benefits and limitations of this analysis and approach to therapy. He is a 52 year old man complaining of bilateral knee pain. His history began in 1975 when he discovered a testicular lump, was diagnosed with testicular cancer, had a single orchiectomy, and underwent significant pelvic, lower back, and groin radiation therapy. He does not recall how much of his body was shielded during the treatment. For the next fifteen years, he was active, played tennis, jogged, etc. In the early 1990’s he began to complain of subpatellar knee pain bilaterally, was seen at Johns Hopkins Neurology Dept., and diagnosed with bilateral foot drop and “Radiation Neuropathy”. He was also noted to have “patchy” abnormalities of the EMG related to the common peroneal nerve on the left. He had dysesthetic sensations on both feet (L>R), that the patient felt was “numb” but were not objectively so. To make a long story short, Using the low power laser (ML830), trigger points were inactivated in both piriformis, Left semimembranosus, both vastus medialis and both vastus lateralis, both medial gastrocnemius, both soleus, both peroneus longus, and both tibialis posterior muscles. The result was elimination of 95% of the patient’s pain, but a significant decrease (pt’s estimate was 50%) in his foot drop bilaterally. His feet felt completely normal when walking in the exam room. The overall impression was that most of his residual “foot drop” was from significant disuse atrophy of the involved musculature, and could be improved significantly.

In summary, using the ML830® laser, could result in significant benefits, in terms of decreased morbidity, to patient receiving various treatments for cancerous tumors. If there are any specific questions, please don’t hesitate to call me at the number below.

Bernard E. Filner, M.D.
Suite 260
14955 Shady Grove Rd.
Rockville, MD 20850
301-251-1266

www.thepaincenter.us

www.fallsgrovemedispa.com