ENTHESES/ENTHESALGIA (REF 1): ARE CHRONIC LOW BACK PAIN (CLBP)/FAILED BACK SURGERY (FBSS) DUE TO NEUROPATHIC MICRONEUROMAS ON DAMAGED 'A-DELTA' AND 'C' FIBRE RECEPTORS, ASSOCIATED WITH TRPV1 ACTIVATION?

BACKGROUND:
Chronic Low Back Pain (CLBP)/Failed Back Surgery Syndrome (FBSS) is difficult and poorly managed in Primary Care due to lack of any simple logical explanation as to cause. The underlying patho-physiological mechanisms have been unclear.

In 2004 McKay (REF 4) found that multiple stabbing injections to damaged entheses resulted in immediate loss of CLBP/FBSS of most signs and symptoms. In 2008 Blomberg (REF 10) produced a complex algorithm for CLBP management and McKay in 2002 (REF 1) identified the single most effective compound identified by Blomberg—dextrose or mannitol, reducing the neuropathic burning sensation considerably. This use of dextrose or mannitol for entheses and caudal epidurals, is still in use.

RESULTS:
Since 2012, the addition of isotonic 5% dextrose Neuroprolotherapy pioneered by J Lyftgoft NZ (REF 5) Similarly, 5% mannitol has also been used for entheses and caudal epidurals. All 33 patients from 2004 were followed up for two years and some gradually lost to follow-up. One died in the fourth year, but his Parkinson’s disease was not related to the injections. There were no problems with the injection set per year. 1.8% required 4+ injection per year and only 14, (0.47%) patients required re-injection between 4–8 weeks apart for most years.

The logical assumption and hypothesis has been that the needle is physically damaging these small, central synapses and altering the central excitatory and inhibitory controls underlying chronic pain.