



Bruno “Bytes” – March, 2016

(Bits and Tidbits from the Post-Polio Coffee House)

Available through a “link” from www.postpolioinfo.com (or) directly through <http://www.papolionetwork.org/bruno-bytes.html>

On the topic of Hip Replacement after Steroid Injections (3/3/2016)

Dr. Bruno’s Post: A warning - Too much medicine isn't always good medicine. . .

Study: Hip Replacement Too Soon After a Steroid Injection Increases Infection Risk

Released: 2-Mar-2016 12:05 AM EST

Source Newsroom: [Hospital for Special Surgery](#)

Newswise — Patients considering hip replacement surgery would do well to wait three months if they've had a steroid injection to relieve hip pain, according to a study by Hospital for Special Surgery (HSS) researchers. "The risk of developing an infection after surgery increased significantly in patients who had a hip replacement within three months of receiving a steroid injection," said William Schairer, MD, lead study author. "However, in patients who had a steroid injection and then waited three months or longer to have the surgery, there was no increased risk at all."

Researchers reviewed thousands of patient records in California and Florida databases for their study, which was presented at the annual meeting of the American Academy of Orthopaedic Surgeons (AAOS) on March 2, in Orlando, Florida.

An injection of a steroid into the hip joint is a common treatment to relieve pain and inflammation in patients with arthritis. This the first large population study to provide strong evidence of an increased risk of surgical site infection in patients who have hip replacement 12 weeks or sooner after the injection, according to the researchers. They note that the immune system is weakened by corticosteroids, and this may contribute to the higher infection risk.

"Hip replacement is a common and safe procedure that relieves pain and improves quality of life, and overall, the risk of developing a joint infection is low," said Seth Jerabek, MD, an orthopedic surgeon at Hospital for Special Surgery and senior study author. "Although the risk is low, an infection is one of the most dreaded complications of joint replacement. Patients often need to undergo additional surgery, receive intravenous antibiotic treatment, and are off their feet during a lengthy recovery. "

For their study, investigators looked at the Statewide Ambulatory Surgery and Inpatient Databases for Florida and California from 2005-2012, which included more than 177,000 patients who had hip replacement surgery for osteoarthritis. Researchers narrowed down the list to those who had received steroid injections prior to surgery and reviewed follow-up records to determine which of those patients developed a surgical-site infection within one year of hip replacement.

Patients were grouped into those who received NO injection; those who had hip replacement within 6-12 months of an injection; those who had the surgery within 3-6 months; and those who had hip replacement within 0-3 months of receiving an injection.

The infection rate was 2.06% in non-injection patients and jumped to 2.81% in those who had the surgery from 0-3 months after an injection, representing an increased risk of 40 percent. There was no statistically significant increase in infection risk in patients who had hip replacement from 3 - 12 months after the injection.

"Based on study findings, we recommend that elective hip replacement surgery be deferred for at least three months from an injection to avoid the elevated risk of infection," said Dr. Jerabek. "However, in some cases, such as patients who are still in a great deal of pain after the injection, it may not be feasible to wait. This is something the patient and doctor should discuss to determine what will provide the most benefit and least risk to the patient."

<http://www.newswise.com/articles/view/648996/?sc=mwhn>

[On the topic of Incontinence in Women with Osteoporosis](#) (3/8/2016)

Dr. Bruno's Post: Most interesting in this article is the importance of POSTURE (with or without fractures) in "controlling dripping." (See THE POLIO SURVIVORS HANDBOOK for painless (and maybe peeless) posture).

<http://well.blogs.nytimes.com/2016/02/24/treating-incontinence-in-women-with-osteoporosis/?emc=eta1&r=1>

[On the topic of Drug Side Effects](#) (3/10/2016)

Dr. Bruno's Post: So many Coffee House members ask about drug side effects and drug interactions. Here's a good site to bookmark in your web browser



that I use to look for both, plus an interesting TED talk about finding drug interactions using "big data".

<http://www.drugs.com/sfx/>

[On the topic of "Parkinson's Like" Symptoms](#) (3/11/2016)

Original Post: Do any of you have and I use a word carefully, Parkinson type movements of your arms, where they move randomly in a twitching like movement and do not listen to you?

Dr. Bruno's Response: Involuntary limb movements, twitching and muscles jumping, is not uncommon in polio survivors and is a sign of overuse. The poliovirus did indeed damage the dopamine producing parts of the brain; you know a dopamine deficit is the cause of Parkinson's and is also what our research has shown to cause post-polio fatigue.

So why isn't there a higher incidence of Parkinson's in polio survivors than the general population?

Back at the 1949 conference on polio, the man who discovered the brain activating system was asked to comment on why polio survivors who had encephalitis, could be in a coma as a result of damage to dopamine brain activating neurons but that polio survivors only incredibly rarely (and by rarely I mean a handful of cases) had symptoms of Parkinson's. His disturbing conclusion was, "If the poliovirus did that much damage to dopamine producing neurons in the brain, individuals had no tremor because they did not survive."

Additional Post: I have this in my legs but not in my arms, mainly at night in bed.

Dr. Bruno's Response: That's the norm for polio survivors. But any muscle can twitch and jump any time of the day. There are many kinds of tremors. Some look like the Parkinson's "pill rolling" tremor in one or both hands where the thumb moved back-and-forth & the wrist turns when the hands are at rest. Others have the hands shaking only when they are being used. And sometimes the entire arm or both arms shake.

[On the topic of the new FDA Guidelines for Painkillers](#) (3/15/2016)

Dr. Bruno's Original Post:

Prescribing Narcotics

If your doctor refuses to prescribe narcotics after surgery or a severe injury because of the new "FDA guidelines" they are probably unaware of the facts. Polio survivors need to know that the guidelines are "nonbinding," are "meant for primary care doctors, who prescribe about half of all opioids but often have little training in how to use them," and do not apply to postoperative pain. Doctors can prescribe whatever they want as long as they follow state regulations, which are usually less strict than the "FDA guidelines."

(Rev. 4/8/2016)

<http://www.nytimes.com/2016/03/16/health/cdc-opioid-guidelines.html?ref=health&r=1&login=email>

[On the topic of Low Back Pain Always Being PPS](#) (3/16/2016)

Original Post: I was paralyzed from the waist down. Although I'm weaker all over now, my lower back is the most affected by PPS. Just a very few minutes of bending makes my lower back scream with pain, so that I have to whimper limp to couch or bed to ease it. I'm wondering just exactly what is happening to cause this

pain? I know I've lost the motor neurons that make the muscles work, but is the pain coming from the last surviving neurons? I realize that I don't really understand how pain works.

2nd Post: Don't assume the pain is all PPS.

Dr. Bruno's Response: You need to have your back evaluated and probably low back MRI.

3rd Post: I was surprised when my MRI showed severed degenerative disc disease and lumbar facet arthropathy. I just assumed it was weak back muscles from PPS.

Dr. Bruno's Response: Always have significant / long term pain evaluated. Never assume that all symptoms are PPS.

On the topic of Spinal Stenosis (3/23/2016)

Original Post: How common is spinal stenosis in the PPS population? I was diagnosed with it many years ago, but a recent fall and MRI revealed that my condition has gotten significantly worse. I slipped out of a chair onto a ceramic tile floor, injuring my back and legs. For the last month, I have been experiencing excruciating pain in my backside, thigh, lumbar spine and hip, mostly on the right side. I've been on Vicodin and have had the first of my cortisone injections. There is no position I am comfortable in except sleeping. Is this now a glimpse into my future? That I'll just have to learn to deal with this like every other pain that has come along? Is surgery helpful?

Dr. Bruno's Response: Spinal stenosis has never been studied and I don't have data from our Post-Polio Institute patients. My impression is that spinal stenosis is not more frequent in the post-polio patient population. But I would also think that spinal stenosis would be more frequent polio survivors given muscle imbalances, the absence of back muscles and abnormal gait.

Regardless of all that, you have it and need to treat it.

Having injections of Cortizone and local anesthetic is often very helpful. Stretching in physical therapy and treatment of muscle spasms is also helpful. The drug Lyrica is often effective in decreasing nerve pain related to stenosis. One thing that typically is not helpful is surgery.

Whether you use Lyrica, Neurontin, Lidocaine (or other) patches make sure it's right for you.

On the topic of Medical Marijuana (3/28/2016)

Original Post: Do you have an opinion on the use of medical marijuana for post-polio muscle pain? There has been a lot in the news lately about legalizing medical marijuana in Pennsylvania. I would be interested to know if you have an opinion on its use for post-polio pain management. I am a 69 year old male and I contracted paralytic polio at the age of 5. About 5 years ago I had a TIA and my doctor put me on Plavix, prior to that I had taken Naproxen for several years with some success managing pain. Now I can't take Naproxen, aspirin, Advil or anything in that family of pain medications.

I experience chronic shoulder and foot pain and would appreciate any advice for pain management. I am going for PT now and I occasionally go to a massage therapist.

Are survivors in other states experiencing similar symptoms that have been helped by trying it?

Dr. Bruno's Response: The Post-Polio Institute protocol is that you treat the cause of the pain, not cover the pain up with medications.

This is especially true for muscle pain. Marijuana may cause a decrease in blood clotting so the combination of Plavix, anything that irritates your stomach like naproxen or ibuprofen plus

marijuana could be dangerous. What is more, marijuana has been associated increased risk of side effects



linked to musculoskeletal or connective tissue disorders, falls, muscle problems (pain, twitching, or weakness), numbness, reduced coordination, restlessness, and speech disorders. If you need medication for pain there are many other drugs that you can take that don't affect clotting, like Tylenol and tramadol. Motrin is ibuprofen and can burn your stomach. Tylenol is acetaminophen; dose must be limited because it can kill your liver.

2nd Post: An officer of the British Polio fellowship has just written a personal letter to members saying that possibly as the result of taking strong painkillers for PPS, the early signs of the advanced terminal cancer he is currently suffering may have been hidden. And, he feels that perhaps had he not been taking the painkillers the cancer might have been discovered earlier, and may have been treatable.

Dr. Bruno's Response: This post is just one of the many reasons The Post-Polio Institute doesn't treat pain with drugs in polio survivors but tries to treat the CAUSE of the pain. This was a sad example. I use the example of giving someone reporting chest pain at the ER, getting a dose of morphine and relieving her pain, then sending her home to die of a heart attack.

Pain is a MESSAGE, not a disease. Listen to your body, don't drug it into submission.

On the topic of having been Diagnosed with ALS (3/28/2016)

Original Post: The medical team I have been seeing has decided I have ALS. This is Not good news.....

Dr. Bruno's Response: On what basis that they make this diagnosis?

2nd Post: Rapid deterioration and EMG.

Dr. Bruno's Response: Where did they put the EMG needles? Did they did they do your tongue?

Are you having difficulty swallowing that is increasing rapidly?

3rd Post: Only in my legs and arms. I'm not having any tongue problems.

Dr. Bruno's Response: Trouble speaking and swallowing are common symptoms of ALS and an EMG of the tongue muscle typically helps with confirming the diagnosis.

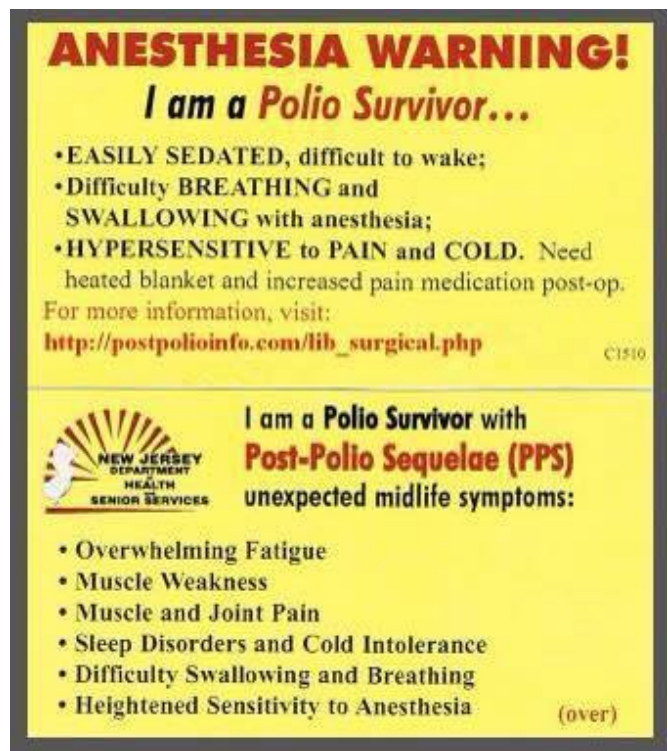
But regardless, another opinion is in order.

On the topic of Giving an Anesthesia Warning Card to Your Doctor (3/29/2016)

Original Post: I had my second cataract surgery last week. Both my doctor and the anesthesiologist were given a copy I had made for them. They had read the card and asked me quite a few questions about previous surgeries and drug affects. They asked me about any concerns. I was so glad to have their attention to something very important.

There is a clear image available for printing here:

http://www.postpolioinfo.com/lib_surgical.php



Additional Bruno "Bytes" are available for you to share by going to:

<http://www.papolionetwork.org/bruno-bytes.html>

Scroll down the page (through the Current Month posts).

Previous months are located there, and are available by "clicking" on them, in easily printable PDF format.