



## Bruno “Bytes”

March, 2018

**Bits and Tidbits from Dr. Richard L. Bruno, HD., PhD.**

from the Post-Polio Coffee House

Available through a “link” from Dr. Bruno’s website: [www.postpolioinfo.com](http://www.postpolioinfo.com)  
(or) directly through <http://www.papolionetwork.org/bruno-bytes.html>

### On the topic of Hip Replacement (3/8/2018)

Dr. Bruno’s Original Post: “Dual Mobility” hip replacement reduces risk of dislocation and may be a possibility for polio survivors with hip muscle weakness.”

More than 330,000 total hip replacements are performed in the United States each year. Overall, it is a highly successful procedure. However, as with all surgeries, a risk for complications exists.

Dislocation is one of the most common complications after hip replacement and the number one reason for revision surgery. A study by Geoffrey Westrich, MD, research director of the Adult Reconstruction and Joint Replacement Service at Hospital for Special Surgery (HSS), found that patients who received a newer implant known as a “dual mobility” hip replacement had zero dislocations. In comparison, study patients who received a traditional fixed bearing hip implant had a dislocation rate of 5 percent.

The research, which focused on patients under 55 years old, was presented today at the American Academy of Orthopaedic Surgeons Annual Meeting in New Orleans. “We were especially interested in seeing how the younger patient population fared because they are generally more active and put more demands and stress on their hip after joint replacement, and this increases the risk of dislocation,” Dr. Westrich explained.

Although the concept of dual mobility was originally developed in France in the 1970s, the technology is relatively new in the United States. “Dual mobility” refers to the bearing surface of the implant - where the joint surfaces come together to support one’s body weight.

A hip replacement implant is a ball-and-socket mechanism, designed to simulate a human hip joint. Typical components include a stem that inserts into the femur (thigh bone), a ball that replaces the head of the thigh bone, and a shell that lines the hip socket.

“Dual-mobility hip components provide an additional bearing surface,” Dr. Westrich explains. “A large polyethylene plastic head fits inside a polished metal hip socket component, and an additional smaller metal or ceramic head is SNAP-FIT within the polyethylene head. Dual mobility means that there are two areas of motion, improving the range of movement and reducing the risk of dislocation.”

Dr. Westrich and colleagues compared the dual mobility system with the traditional fixed bearing system in two age-matched groups of patients who had a primary total hip replacement over the same time period. There were 136 patients in each group with a mean age of 48.

At three-year follow-up, the researchers found that the patients who received the dual mobility implant had no dislocations. In the group receiving the standard fixed bearing implant, seven patients, or 5.1 percent, had a dislocation and needed a revision surgery.

“Total hip replacement is increasingly being performed in younger patients,” Dr. Westrich said. “The results of our study are encouraging for this active, high demand group of patients and may lessen concerns for dislocation. More research is needed to see how dual mobility implants perform over the long term.”

### On the topic of Opioid Pain Medications (3/13/2018)

Dr. Bruno’s Original Post: I recently posted the study showing how taking the recommended doses of acetaminophen and ibuprofen together were equal to 5mg of oxycodone. Here's a follow-up to that study.

Assuming your kidneys and liver are doing what they should and your stomach can tolerate the irritation from the ibuprofen, this study suggest you can take the combination daily as described on the bottles.

(The “-cet” drugs have been off the market or not prescribed because you can't control the dose of narcotic separate from the dose of acetaminophen, causing people take too much acetaminophen (making livers very unhappy) to get more narcotic. Percocet (or any -cet drug) is a narcotic plus tylenol. Percocet is oxycodone + acetaminophen. (Ultracet is tramadol + acetaminophen.)

## For Arthritis Pain, Nonopioid Drugs Work as Well as Opioids

By **NICHOLAS BAKALAR** MARCH 7, 2018 New York Times

Opioids are no better than nonopioid pain relievers for treating the chronic pain of osteoarthritis, a clinical trial has found.

Researchers randomized 240 patients with moderate to severe chronic back pain or hip or knee osteoarthritis to either an opioid (morphine, oxycodone or hydrocodone) or to nonopioid pain relievers (such as Tylenol, topical lidocaine or nonsteroidal anti-inflammatory drugs). The [study, in JAMA](#), used 11-point pain and function scales to measure the effect of treatment, with higher scores indicating poorer results. This is, the authors write, the first randomized trial of opioid therapy to report long-term pain and function outcomes.

At the end of 12 months, the opioid group scored an average 3.4 on the function scale, and the nonopioid group 3.3, an insignificant difference. On the pain scale, the nonopioid group did slightly better — 3.5, compared with 4.0 for the opioid group. Unsurprisingly, there were significantly more medication side effects in the opioid group than in those who took nonopioids.

“Should we use opioids if nonopioids don’t work?” asked the lead author, Dr. Erin E. Krebs of the Minneapolis Veterans Affairs Health Care System. She answered her own question: “No. We tried four different nonopioids — don’t give up on them too soon — and we should also be using exercise and rehab for most osteoarthritic pain.”

### On the topic of Multiple Symptoms and PPS (3/15/2018)

Original Post: I have racing heartbeat all the time, loss of strength and muscle in my legs, weakness on left side of my body, unexplainable fatigue, insomnia, trouble swallowing, no appetite and extreme anemia. At times my legs are very heavy and I have a hard time going up stairs. Could this be PPS?

Dr. Bruno’s Response: Racing heartbeat all the time, insomnia, no appetite and extreme anemia are not PPS symptoms. You need to have them diagnosed since PPS is ALWAYS a Diagnosis of Exclusion.

### On the topic of Sleep Studies and Sleep Apnea (3/15/2018)

Dr. Bruno’s Original Post: Here’s another reason to get a sleep study and treat sleep apnea...

## Sleep Apnea Study Finds Male-Female Differences in Cerebral Cortex Thickness, Symptoms.

Article ID: 690985

Released: 12-Mar-2018 6:05 PM EDT

Source Newsroom: UCLA School of Nursing

### **FINDINGS**

Researchers from the UCLA School of Nursing examined clinical records and magnetic resonance imaging brain scans of patients who were recently diagnosed with sleep apnea, and discovered several apparent connections between thinning of the brain’s cerebral cortex and apnea symptoms. The researchers also could discern distinct changes in brain structures and concurrent symptoms that differed between men and women. For example, more regions of the superior frontal lobe were thinner in women with apnea than men or control groups, which might explain enhanced cognitive deficits among women with the disorder. No sleep apnea patients showed any thickening of the cerebral cortex. In addition, overall

cortical thinning could possibly lead to impaired regulation of the autonomic nervous system and associated impaired breathing function through the upper airway in these patients.

#### **BACKGROUND**

Obstructive sleep apnea, which involves disruption of the upper airway, affects about 10 percent of adults. Its cause is unknown. Men are twice as likely to have sleep apnea as women, and symptoms and brain function appear to vary between men and women. However, while previous studies have made connections between brain structure changes and general clinical signs, none have definitively linked sex differences in brain structure with symptoms in sleep apnea. Left untreated, the impact of sleep apnea on brain damage progresses overtime.

#### **METHOD**

Using high-resolution magnetic resonance imaging scans, the researchers looked at cortex thickness of 12 women and 36 men who had diagnoses of mild to severe obstructive sleep apnea (who were not being treated for their condition), and compared those findings to 40 male and 22 female controls (who did not have sleep apnea). The researchers then compared clinical findings of each patient with evidence of cortex thinning.

#### **IMPACT**

The study is one of the first to underscore significant clinical differences between men and women with sleep apnea, and points to the need for different treatment approaches to address these varied symptoms. The greater cortex injury in cognitive centers of women's brains may underlie their more common cognitive problems compared with men, while thinning associated with both men and women who have sleep apnea may be behind the disordered breathing seen between both. It is not clear whether these physical brain changes precede the sleep apnea disorder, or worsen sleep apnea's symptoms as the disorder progresses.

#### **AUTHORS**

UCLA's Dr. Paul Macey is lead author, associate professor at the School of Nursing, and member of the Brain Research Institute at the David Geffen School of Medicine at UCLA. Other authors are Natasha Haris, Rajesh Kumar, Albert Thomas, Mary Woo and Ronald Harper, all at UCLA.

<http://www.newswise.com/articles/view/690985/?sc=mwhn>

#### **On the topic of Cleaning CPAP/BIPAP (3/15/2018)**

Dr. Bruno's Original Post: This is the best thing since sliced bread for cleaning CPAP/BIPAP. You just put the mask in the box and, viola, it's Clean!

[https://www.cpapdirect.com/cleaning/soclean-2-cpap-cleaner-and-sanitizer?gclid=EA1aIQobChMIy66G79Du2QIViwOGCh1USgMgEAAAYAiAAEgL4rPD\\_BwE](https://www.cpapdirect.com/cleaning/soclean-2-cpap-cleaner-and-sanitizer?gclid=EA1aIQobChMIy66G79Du2QIViwOGCh1USgMgEAAAYAiAAEgL4rPD_BwE)

#### **On the topic of a "Super Light" Power Wheelchair (3/17/2018)**

Dr. Bruno's Original Post: This is the NEW "Portashopper" super-light power wheelchair many polio survivors love:

<https://www.wheelchair88.com/product/pw-999ul/>



Open/Fold in 1 second only

#### **On the topic of Anger (3/20/2018)**

Dr. Bruno's Original Post: This comment bears repeating:

The DANGER of ANGER!

by Tom Stein

Anger unexpressed accumulates and morphs into resentment.

Resentment becomes like radar and is always in a scanning mode in search for targets of opportunity.

Accumulated anger also invariably fuels disproportionate emotional responses.

Soon after disproportionate responses get exhibited, guilt feelings and self-blame are manufactured.

Get the anger out; a myriad of ways exists to accomplish that.

Even when anger is a legitimate emotional response we are entitled to have, it is not our friend.

### On the topic of “Brain Fog” and Mental Status Exams (3/18/2018 - 3/21/2018)

Original Post: I did a book review for my book club. It was a challenging book and I was well prepared. This used to be easy for me but I talked cautiously and felt brain “foggy” at times. I just couldn’t think very fast. I generally feel my mind is good but I guess the stress of doing the presentation was too much.

Dr. Bruno’s Response: A polio survivor with “Brain Fog?” You’re not alone! Here in the U.S., Medicare pays for a MMSE (Mini-Mental State Examination) at primary care checkups for everyone over 65. These tests ask questions like day & month, counting backwards and repeating simple words/phrases. Those results could in fact be skewed by PPS fatigue.

Here are two articles you can share with your primary care physician:

CAUTION: False Positives in Polio Survivors with Post-Polio Sequelae Given Mental Status Examinations:

[https://www.papolionetwork.org/uploads/9/9/7/0/99704804/mental\\_status\\_exam\\_caution.pdf](https://www.papolionetwork.org/uploads/9/9/7/0/99704804/mental_status_exam_caution.pdf)

Post-Polio Brain Fatigue – Little Spots Mean A Lot.

[https://www.papolionetwork.org/uploads/9/9/7/0/99704804/brain\\_fatigue.pdf](https://www.papolionetwork.org/uploads/9/9/7/0/99704804/brain_fatigue.pdf)

### On the topic of Pain and Depression (3/24/2018)

Original Post: I am going through a rough time right now, the pain and fatigue, weakness and depression are destroying my life. I spend at least 20 hours a day in bed with the pain. I don't know how much longer I can live like this. I take Oxycodone 10mg 4 times a day, Fentanyl patch every 3 days 75 mg, gababentin 600 mg 3 times a day plus Ativan for depression.

Dr. Bruno’s Response: Ativan isn't for depression; it's for anxiety and can make you depressed. So can Oxycodone, Fentanyl and gababentin. You may be trying to treat pain but the meds are giving you fatigue, weakness and depression instead. Please see your physician.

### On the topic of Exercise and Polio Damage (3/26/2018)

Original Post: Can I do intense exercises for my “good” upper limbs, back and belly because I am overweight?

Dr. Bruno’s Response: No! I addressed this issue in my article “Exercise: Use it or lose it.”

[https://www.papolionetwork.org/uploads/9/9/7/0/99704804/exercise.\\_\\_use\\_it\\_and\\_lose\\_it.\\_\\_by\\_dr.\\_richard\\_bruno.pdf\\_\\_rev\\_2017\\_.pdf](https://www.papolionetwork.org/uploads/9/9/7/0/99704804/exercise.__use_it_and_lose_it.__by_dr._richard_bruno.pdf__rev_2017_.pdf) and please see the Post-Polio "Diet"

[https://www.papolionetwork.org/uploads/9/9/7/0/99704804/eat\\_well\\_be\\_well\\_protein\\_diet\\_\\_final\\_2-2018\\_.pdf](https://www.papolionetwork.org/uploads/9/9/7/0/99704804/eat_well_be_well_protein_diet__final_2-2018_.pdf)

### On the topic of purchasing The Polio Paradox (3/21/2018)

Original Post: I'm having a problem finding how to purchase your book, The Polio Paradox. Post-Polio Library at [postpolioinfo.com](http://postpolioinfo.com). I see the cover there but it’s not the book.

Dr. Bruno’s Response: You’re right. Our website has the *POLIO PARADOX* “Book Tour” Video for [download](#). The *Polio Paradox* is available through both Amazon and Barnes & Noble. Your local book store can order it for you as well.

### On the topic of Physical Therapy and PPS (3/26/2018)

Original Post: I want to stop physical therapy until after I visit with my neurosurgeon. I know that I should not overuse my affected leg. But I also can’t do intense exercises for my upper limbs, my back and belly to lose weight. I am severely fatigued all of the time and feel that the physical therapy is counterproductive. I am completely worn out.

Dr. Bruno's Response: I would recommend that you listen to your body and STOP physical therapy until the doctor visit. Once there tell the doc you are exhausted and ask exactly WHAT physical therapy is being recommended and WHY it's necessary.

Here are some outstanding guidelines for physical therapy. They were written by the physical therapist who cared for Polio Survivors at The Post-Polio Institute for almost 10 years.

[https://www.papolionetwork.org/uploads/2/7/7/2/27726699/physical\\_therapy\\_and\\_pps\\_by\\_shanti\\_chacko\\_molayal.pdf](https://www.papolionetwork.org/uploads/2/7/7/2/27726699/physical_therapy_and_pps_by_shanti_chacko_molayal.pdf)

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

Would you like to see Dr. Bruno in "action"? The video from his 2015 Conference is now available.

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