

Abdominal wall myofascial pain: still an unrecognized clinical entity

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LETTERS TO EDITOR

A 37-year-old female with right upper quadrant abdominal pain was referred to our pain clinic from the urology department. The patient had been under evaluation in the urology department for the past 3 years for recurrent episodes of abdominal pain along with small sized right kidney. At the time of referral, the patient was being worked up for right side nephrectomy presuming right small kidney as the source of abdominal pain.

The patient gave a history of intermittent right upper quadrant pain for the previous 3 years. Her currently pain had a visual analogue scale (VAS) score of 50 mm (a VAS score of 0 mm means no pain and a VAS score of 100 mm means the worst possible pain), with a constant, dull aching for the previous year with intermittent severe pain episodes with a VAS score of 90 mm, 2–3 times per month. These episodes were also associated with nausea and vomiting. In addition, the patient was complaining of a dull, aching, diffuse low back pain in the right para-spinal area adjacent to the L1 to L4 vertebra. This pain had a VAS score of 50–70 mm.

Aggravating factors for pain were prolonged sitting, standing, a right-side lateral position, forward bending, and upon getting up from a supine position. The patient

also had pain in the right flank and back. There were no signs or symptoms of neuropathic pain and no history of trauma. Previously, this patient had undergone multiple evaluations and treatment under multiple specialties like urology, gastroenterology, and orthopedics, which failed to provide pain relief. There was no history of hematuria, lithuria, turbiduria, fever, or lower urinary tract symptoms. A Contrast Enhanced Computed Tomography (CECT) scan and Ultrasonography (USG) of the abdomen revealed the small scarred right kidney (size 6.6 cm) with a normal left kidney (size 10.7 cm); there was no evidence of any kidney calculus or hydronephrosis.

Abdominal examination revealed a trigger point in the upper lateral part of right rectus abdominis muscle with pain increasing in severity on getting up from supine position (positive Carnett's sign). Low back examination revealed trigger points in right side iliopsoas and quadrates lumborum muscles.

A provisional diagnosis of myofascial pain was made and trigger point injections in the right rectus abdominis, iliopsoas and quadrates lumborum muscles was done under USG guidance with 1% lignocaine. The patient achieved 70–80% pain relief 30 min after the procedure. The patient was given mild stretching exercises with analgesics for 3 days and was asked to follow up. After 3 days, the

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patient had 70% relief in pain and also mentioned that she underwent GFR measurement which revealed a global GFR of 64 ml/min.

During a discussion with the urology team looking after this patient, it was decided that in view of the normally functioning small right kidney along with no calculus, hydronephrosis, or obstruction, it was unlikely that the small right kidney was the cause of the pain, and the pain was unlikely to be relieved after removal of the kidney. So the decision to perform a right side nephrectomy was cancelled and the patient was advised to have monthly follow ups for the next 6 months from the urology department and pain clinic. At present, the patient has been in follow up for 3 months after the first trigger point injection. The trigger point injection was repeated 2 times at monthly intervals and presently the patient is having 80–90% pain relief.

This incidence suggested the possibility that myofascial pain may sometimes remain undiagnosed [1,2]. A proper diagnosis and treatment of myofascial pain could save a lot of unnecessary interventions and patient morbidity. In this case we were able to save the precious kidney of the patient with a proper diagnosis and simple management.

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