

Re: Epididymitis but don't want Cipro or Bactrim...options?

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- *From:* bbgator <frankenferley@xxxxxxxxx>
 - *Date:* 7 May 2007 15:34:25 -0700
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On May 6, 11:01 pm, NoFun <PDStayA...@xxxxxxxxx> wrote:

History:

Male, Mid 20's

Acute prostatitis 7 years ago (can't remember how it was treated)

Epididymitis 2 times in last year – resolved spontaneously after 1 week – no treatment (I was traveling).

Small epididymal cyst and small varicocele on same side.

Now:

Minor case of epididymitis began 2 weeks ago and some urinary symptoms (slightly increased frequency, minor occasional burning). I went to my uro and he gave me a choice of either Cipro or Bactrim DS and no tests were done (except chlamydia which was negative). I am nervous about taking either med because:

Cipro: I have severe tendonitis in my knee and it seems that Cipro on its own can cause tendon problems including spontaneous rupture. Medscape is full of citations and the Illinois Attorney General has been pushing for a warning about Quinolone induced tendinopathy.

Bactrim DS: I am hesitant to take Bactrim because of the allergic reactions including regular old anaphylaxis and also the often fatal Stevens–Johnson Syndrome which results in one's skin "sloughing off". I'm sorry but even though this is rare...it scares the %\$%#\$^% out of me. I have never taken a sulfa drug.

My doc is saying that I have no options except Cipro/Bactrim and Doxy (I can't take Doxy due to an esophageal ulcer caused by NSAIDs). Can this be true? Are there no other non–quinolone antibiotics effective for prostatitis/epididymitis ?
How about Zithromax?

I feel like not treating this could be a serious mistake, but I don't exactly like options number 1 and 2,

Myofascial Pain Syndrome (MPS) is a painful musculoskeletal

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condition, a common cause of musculoskeletal pain. MPS is characterized by the development of Myofascial trigger points (TrPs) that are locally tender when active, and refer pain through specific patterns to other areas of the body. A trigger point or sensitive, painful area in the muscle or the junction of the muscle and fascia (hence, myofascial pain) develops due to any number of causes. Trigger points are usually associated with a taut band, a ropey thickening of the muscle tissue. Typically a trigger point, when pressed upon, will cause the pain to be felt elsewhere. This is what is considered "referred pain".

These factors can cause trigger points:

- Sudden trauma to musculoskeletal tissues (muscles, ligaments, tendons, bursae)
- Injury to intervertebral discs
- Generalize fatigue (fibromyalgia is a perpetuating factor of MPS, perhaps chronic fatigue syndrome may produce trigger points as well)
- Repetative motions; Excessive exercise; Muscle strain due to over activity
- Systemic conditions (eg, gall bladder inflammation, heart attack, appendicitis, stomach irritation)
- Lack of activity (eg, a broken arm in a sling)
- Nutritional deficiencies
- Hormonal changes (eg, trigger point development during PMS or menopause)
- Nervous tension or stress
- Chilling of areas of the body (eg, sitting under an air conditioning duct; sleeping in front of an air conditioner)

The fascia is a tough connective tissue which spreads throughout the body in a three dimensional web from head to foot without interruption. The fascia surrounds every muscle, bone, nerve, blood vessel and organ of the body, all the way down to the cellular level. Therefore, malfunction of the fascial system due to trauma, posture, or inflammation can create a binding down of the fascia, resulting in abnormal pressure on nerves, muscles, bones or organs.

This can create pain or malfunction throughout the body, sometimes with bizarre side effects and seemingly unrelated symptoms. It is thought that an extremely high percentage of people suffering with pain and/or lack of motion may be having myofascial problems; but most go undiagnosed, as the importance of fascia is just now being recognized.

Many of the standard tests, such as x-rays, myelograms, CAT scans, eletromyography, etc., do not show the fascia. (John Barnes, P.T., 1992)

Occassionally, trigger points produce autonomic nervous system changes such as flushing of the skin, hypersensitivity of areas of the skin,

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sweating in areas, or even "goose bumps." The trigger points cause localized pain, although TrPs can involve the whole body.

In three studies, the prevalence of myofascial TrPs among patients complaining of pain anywhere in the body ranged from 30% to 93%; (among patients with chronic craniofacial pain, 55%; and for lumbogluteal pain, 21%.)

The characteristic electrical activity of myofascial TrPs most likely originates at dysfunctional endplates of extrafusal muscle fibers. This dysfunction appears to play a key role in the pathophysiology of TrPs. (Simons 1996)

Subjective shortness of breath can be part of the myofascial pain syndrome of the levator scapulae muscle. In one study, 75 patients who reported neck pain & shortness of breath were examined. Trigger points were located and inactivated with acupuncture needles (dry needling). 68 of the 75 patients in the study reported that their shortness of breath and soreness were abolished immediately after inactivation of the TrPs. The other 7 patients needed a second trial of inactivation. Eliminating the trigger points eliminated the symptoms. (Journal of Musculoskeletal Pain, 1996)

Like fibromyalgia, Myofascial Pain syndrome is an often misunderstood condition. Even today, some doctors either don't believe that MPS exists or they don't understand its symptoms and treatment.

Treatment of MPS can only begin after an accurate diagnosis is accomplished. Methods for managing this painful condition:

- Trigger Point Therapy {Myofascial release therapy, myotherapy, massotherapy (medical massage therapy)}
- Spray and Stretch technique (stretching of the muscles involved with a vapocoolant spray – a coolant is sprayed on the trigger point to lessen the pain and then the muscle is stretched. this is often done by a physical therapist.)
- Trigger Point Injections (local anesthetic, such as lidocaine, injected directly into the trigger points)
- Dry Needling (the use of a needle without injecting anything) [TrP injections and dry needling mechanically disrupt the trigger point. The use of lidocaine is no more effective, but it reduces the soreness after injection. For MPS there is no role for injected steroids]
- Chiropractic or Osteopathic manipulation treatment
- Craniosacral Therapy
- Physical Therapy (hands-on)
- Exercise
- Improvement of nutrition
- Changing sleeping habits
- The use of tricyclic antidepressants in low doses

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· Elimination of stress; Biofeedback; Counseling for depression that may result from this painful condition

An active trigger point when treated well or with rest will become latent (quiet, or not causing active symptoms). It can often resurface after trauma after acute overload or fatigue, or even sudden exposure to cold. Conversely, new trigger points may arise elsewhere, or at least become more significant as others become latent.

For MPS, you should see a doctor knowledgeable in chronic pain such as a physical medicine doctor (a physiatrist), or a neurologist. The diagnosis is made by the history and physical exam. There is no lab test nor imaging studies to confirm the diagnosis. A history of acute trauma or chronic overuse should be looked for. On exam, there is typically restricted motion with pain of the affected muscle. Other medical problems need to be ruled out with imaging or other studies. For instance, if a patient presents with back pain, disc and other problems need to be ruled out.

Altered Pain Perception Accompanies MPS: A Danish study indicates that people with chronic myofascial pain perceive and transmit pain differently than people without the syndrome. As many as 72 percent of people with fibromyalgia may have trigger points associated with myofascial pain.

Source: "Qualitatively altered nociception in chronic myofascial pain," by L. Bendtsen, R. Jensen, and J. Olesen, *Pain*, 65 (1996), pages 259–264

Fibromyalgia or Myofascial Pain Syndrome or both?

Differential features of Fibromyalgia & Myofascial Pain Syndrome

Feature

FMS MPS

Pain Diffuse

Local

Fatigue Common

Uncommon

AM Stiffness Common

Uncommon

Tender Points X

Trigger Points X

Prognosis Chronic

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Resolves with treatment

A little humor for those who are tired of IAIYH doctors:

HOW TO TEACH DOCTOR ABOUT MPS

(This was posted to the newsgroup in April 1996)

NOT SERIOUSLY RECOMMENDED. Hanna Jones went to see Doc Smith, her internist. The receptionist asked the nature of the visit and she stated it was Myofascial Pain Syndrome. The receptionist took her blood pressure and got her ready for the doc.

Ten minutes later Dr. Smith entered the room. "Hello Hanna, what are we seeing you for today?" Hanna replied, "Myofascial Pain Syndrome." Dr. Smith looked up from his chart and said, "That's a waste-basket diagnosis. I don't believe it exists."

Hanna motioned for him to come toward her. She said, "Put your right thumb and first finger on this wad of muscle at the outside of my left forearm (a brachioradialis muscle), and gently squeeze it." He was facing her, and as he did so, she drew back her right fist and socked him across the mouth as hard as she could.

Dr. Smith went reeling out of the exam room door into the nurses arms. The nurse said, "So what does she have?" Dr. Smith said, "Myofascial Pain Syndrome." The nurse replied, " I thought you don't believe in that diagnosis." Dr. Smith said, holding his lip, "I've never had it explained to me that way before."