Myofascial pain syndrome associated with Epstein-Barr virus

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Pain is the most common complaint that doctors of various specialties deal with in their daily practice. In neurological practice, the most common pains in the back and neck, headaches. In addition to dorsalgia and cephalgia, abdominalgia, thoracalgia and cardialgia are also quite common, and pains of other localization are somewhat less common. In recent years, the so-called chronic pain has attracted special attention [1]. Their main characteristic is a prolonged, often monotonous manifestation of pain, which is often not strictly localized, but diffusely widespread. Myofascial syndrome is a variant of chronic pain originating from skeletal muscle and adjacent fascia. According to the localization of damage, this type of pain is a deep somatic pain. The formation of pain in the muscles is caused by irritation of pain receptors - nociceptors of non-encapsulated nerve afferent fibers located in muscle fibers and fascia. These sensory units are activated by mechanical influences, temperature or chemical stimuli, which is accompanied by the appearance of diffuse, poorly localized pain.

Diseases of the joints and internal organs are one of the most common causes of the formation of myofascial pain syndrome. Almost any somatic pathology can be accompanied by myofascial pain syndromes. In diseases of the nasopharynx, myofascial pain syndrome (MBS) may develop with the involvement of the muscles of the neck, face and shoulder girdle. Often the cause of myofascial pain syndromes affecting the muscles of the pelvic floor is gynecological pathology. With this option, chronic pain is localized in the lower abdomen, lower back, and sacral region.

MBS associated with visceral pathology can form against the background of osteochondrosis of the spine, complicating its course. However, in many cases, MBS is not directly associated with osteochondrosis of the spine or facet syndrome, and pain impulses primarily originate from the affected muscle. The diagnosis of "myofascial pain syndrome" is made on the basis of a clinical examination and requires the identification of trigger points, the determination of the range of motion in the corresponding part of the spine, as well as the identification of concomitant autonomic and somatic disorders. The factors predisposing to the development of MBS are the presence of chronic inflammation caused by a viral or bacterial infection, as well as a deficiency of some trace elements and vitamins [2].

A common cause of chronic inflammation in the body is the persistence of the Epstein-Barr virus (EBV). This virus is one of the representatives of a large group of opportunistic infections. It belongs to the family Herpesviridae, subfamily Gammaherpesviridae (or herpesvirus type 4). EBV is a typical representative of primate lymphotropic viruses (Lymphocryptovirus). It is believed that by the age of 25, 70–90% of the population are infected with EBV [3]. In most immunocompetent people, primary EBV infection ends with clinical recovery. Moreover, unlike many other infections, the virus remains in the human body for life. An effective immune response prevents future activation and clinical manifestation of EBV. However, in some cases EBV is able to get out of immunological control.

chronic active or active-latent form [3]. The resulting transient immunodeficiency affects both adaptive immunity (content and functional activity of T and B lymphocytes) and factors of natural cytotoxicity (NK cells, monocytes / macrophages, neutrophils), which can serve as an immunological basis for maintaining myofascial pain syndrome ... Cytomegalovirus (CMV) and human herpesvirus types 6 and 7 (human herpesvirus - HHV-6, HHV-7) can also cause a transient decrease in the body's immune response, but it is believed that their persistence is somewhat less common.

For laboratory diagnosis of EBV, the virus is isolated in the body's media (saliva, urine, blood, tears) by quantitative PCR, as well as serological methods. Currently, the definition of IgM to VCA (viral capsid antigen - viral capsid antigen) and IgG to EBEA (Epstein-Barr early antigen) is used. that appear after 3–6 weeks. from the onset of the disease. The interpretation of the results obtained is presented in the table.

table

Interpretation of serological diagnostics of EBV infection activity

No.	Disease period	VCA IgM	EA IgG	EBNA IgG
1	Incubation period or no infection	-	-	-
2	Very early primary infection	+	-	-
3	Early primary infection	+	+	-
4	Late primary infection	+ / -	+	+ / -
5	Atypical primary infection	-	-	+
6	Chronic infection	- / +	+	-
7	Early paste infection	-	+	+
eight	Late Paste Infection	-	-	+
nine	Reactivation	+	+	+
ten	Atypical reactivation	-	+	+

To diagnose EBV activity by the method of vegetative resonance test, a potentiated EBV nosode can be used. Testing of the nosode in the D6-D30 potency indicates the activity of the virus and is usually confirmed by the detection of the virus in the appropriate medium by PCR.

Testing of the EBV nosode in higher potencies is usually characteristic of previous and inactive infection.

Treatment of EBV infection within the framework of classical medicine is based on the use of antiviral (acyclovir and its derivatives) and immunocorrective (Viferon, Cycloferon, Likopid) therapy.

Within the framework of the concept of bioresonance therapy, the following can be used for treatment:

- Frequency exogenous bioresonance therapy aimed at suppressing EBV;
- symptomatic endogenous bioresonance therapy;
- constitutional homeopathic therapy;
- targeted autonosodes made from the medium of virus isolation in a patient;
- bioresonance copies of allopathic immune preparations.

Clinical example

Patient S. 37 years old. She complained of pain in the neck and right shoulder blade, pulling and aching in nature, aggravated by physical exertion and periodically accompanied by non-systemic dizziness due to "weather change".

These symptoms appeared 2 years ago after suffering a respiratory infection. An earlier MRI examination of the cervicothoracic spine did not reveal any significant pathology. Previously, 2 courses of standard in this situation drug therapy with non-steroidal anti-inflammatory drugs, muscle relaxants and B vitamins were carried out, as well as physiotherapy and a course of manual therapy. The treatment provided only temporary relief.

When examined in a clinical blood test: not pronounced lymphocytosis and relative neutropenia. There are no meningeal symptoms. Cranial nerves and peripheral reflexes were normal.

EBV in potency D30 was revealed by the method of vegetative resonance test.

In the control examination by the method of qualitative PCR, EBV was detected in saliva and urine.

Ongoing therapy: targeted autonosode of the patient's saliva, endogenous bioresonance therapy with the addition of a copy of the drug Likopid, Lymphomyosot, as well as Calcium Carbonicum LM 1 as a constitutional homeopathic remedy.

After 2 weeks of taking the drugs, pain in the neck and scapula gradually stopped, and during the follow-up examination carried out 2 months later, the CBC returned to normal. EBV was not isolated in the control analysis of biological media by PCR.

At the second admission, the patient was prescribed an EBV nosode D200, selected according to testing, and it was recommended to continue taking Calcium Carbonicum LM1 2 times a week for another 2 months. At the follow-up examination a year later, the pain syndrome did not bother the patient anymore, and the virus was not released in the media.

Output

The possibilities of autonomic resonance testing make it possible to re-evaluate the nature of MBS. The effectiveness of the conducted bioresonance antiviral therapy indicates a causal relationship between viral infection (in particular EBV) and MBS. Myofascial pain syndrome, which does not respond to traditional therapy, may be associated with some infectious inflammatory process and requires a different approach to treatment. Treatment should be directed at the underlying disease, in particular, a viral infection, and not at its symptom - myofascial pain.

List of used literature

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