The Connections Between Chronic Pain And Dementia ? Transcript

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Introduction and Summit Welcome

Welcome back to the Reverse Alzheimer's Summit. I'm your host, doctor, Heather Sanderson. I'm so pleased to have doctor Josh Levitt here today. Doctor lab.

Its unique approach was informed by an education that includes a degree in physiology from UCLA, a doctorate in naturopathic medicine from Bastia University, formal residency training in integrative medicine in Seattle, and over 20 years of direct clinical experience with thousands of patients.

In addition to his clinical work, Doctor Leavitt is also the co-founder and medical director of UQ wellness. He's an author and creator of several popular books and many articles and videos, all of which demonstrate his passion and commitment to bringing information and products to you that can help you achieve your health and wellness goals.

Doctor Leavitt has a clinical focus on pain. And he's also the host of another summit on Alzheimer's. And so I'm so excited to have him here today to help us connect the dots between pain and dementia.

Doctor Leavitt, thank you. Thank you. It's so great to be here. This is a this is a real treat. And that intro was, was Gosh, I could have written that myself, you know, flashing throughout it.

Yeah. So I'm excited. I'm excited to be in the hot seat here. I have indeed been in the position that you are in. And it's a pleasure to be on the other side of the, of the room here, so to speak.

Yeah. So I was just asking you what you learned from doing all of those interviews. And if there was kind of a takeaway that you got from it. Yeah, that's a great question.

I mean, what a treat it is. First of all, to to get to interface with experts, right? I mean, I found that such a great way to learn it felt like, yes, it was work for me, but it was also like a joy to get to meet, and engage with smart and interesting people who have this world of experience, who then get to convey that to to me.

I'm sure you probably feel the same way. I think there's no better way to learn than from people who have been, doing it in the trenches, for for decades themselves.

Gosh, it's a big question because I interviewed a lot of people and there was a lot of takeaways, some rather technical and some of the more broad ones.

I think the broad ones are maybe most appropriate here to talk about in this context, and that is that there is reason to be hopeful. I mean, Alzheimer's disease is is really scary, right?

Like everybody lives in fear of it. We have these kind of very compelling, almost poetic, but tragically poetic terms to describe it. One in particular is the the disease that kills you twice.

You know, we've heard that, right. It takes away your memory, who you are, and then, takes away the the biology, you know, your, your physical systems and and that is frightening indeed.

And so, yes, we have, medical literature that's fraught with failures in the magic bullet looking for drugs department.

Hope for Alzheimer's Through Lifestyle

But what I'm learning from all of these experts, and I suspect you're learning it, too, is that there is reason to be hopeful. Especially if we can intervene, earlier.

Right. If we can intervene at younger ages before the disease becomes really advanced, there is an opportunity to change the course, to turn the tide, so to speak.

And a lot of the things that I'm sure your other guests are talking about, that we'll talk about here today. Diet, lifestyle, nutrition, sleep, stress management, toxic exposures, all of that sort of stuff are very real risk factors.

And there is a very real opportunity to reverse the course of this illness to change course, as long as we act early. So I think hopefulness and optimism was probably the biggest takeaway for me, which is which is a pretty good takeaway.

Yeah. That's wonderful. And part of that, what you were describing is like this lifestyle intervention. So, you know, today's talking with you. It's a little bit different, like you mentioned from other talks that I've done where we're both naturopathy doctors.

And so that certainly influences. So there's this human perspective around pain and its connection to dementia. So can you just go ahead and sort of launch into your thoughts on that?

Yeah, absolutely. And feel free to cut me off at any point. Or interrupt. I am here running a clinical practice right in the shadows of Yale University, which is just right down the road.

And Yale is a is a wonderful high level medical care center. And they have an extreme focus on specialties and subspecialties, which sort of define, I think, modern medical practice, mainstream medical practice, as we think about it.

You know, I can send people I actually have sent people to some doctors, okay. Not hand doctors, some doctors. There's a thumb specialist at Yale, and so on.

Right. Like so every disease, every body part has a specialist. Now that's remarkable. And I think quite a wonderful thing. If you have a thumb problem or, you know, a right eye or a left eye problem, that's not there's not actually right eye, left eye specialist.

But you get the idea that sub specialization super specialization is this, is this big trend. And there's some there's some beauty to that, right? People who have Alzheimer's disease see specialist in Alzheimer's, people who have Parkinson's disease see Parkinson's or movement disorder specialist.

So my perspective, and I think that you share this as a naturopathic doctor, is to treat people, rather than to treat illnesses. Right. So so far, at least in my 20 plus years of practice, every person that's come through my door is a person.

They might have cancer, they might have Alzheimer's, they might have heart disease. But I have to think about them as the person that they are, not the disease that they have.

And and that perspective really is, is a game changer. And I think it's related to what we're going to talk about here today. Right. That it's there's a, there's an easy, it's very easy to go down the road of, oh, a person has Alzheimer's disease.

So that becomes the definition of sort of who they are and all of their care, all of their medicines, all of their attention goes to that narrow thing.

But as I'm sure many of your viewers can attest, these people with Alzheimer's disease also have other problems. Low back pain, their knees or they have heart disease.

They have other issues, skin problems, whatever the case may be. And it's very easy for all of those other problems to get lost in the shadow of their big ticket illness, which Alzheimer's disease is, for what it's worth, a big ticket illness.

So it's cancer and some other big ones. But when you have that, you get narrowed. And I think that's problematic. It's really good to have the specialist, but it's also really important to keep that pulled back 30,000ft view.

And that's the approach that I try to take. Wow. And then when it when there's interfaces with pain, there can be some other things that are actually quite cruel.

In terms of the dementia verse. Right. Like when, when someone with dementia is complaining of pain, there's a risk that they might forget it.

Pain, Dementia, and Cruel Assumptions

And so that the clinician or the caregiver might not be as apt to treat right away. So as I've read, I sort of discuss this, this landscape. You're I love the term dementia verse.

And it is indeed a, a kind of rapidly expanding universe itself. Right. As it relates to pain, you use the word cruel, which is a powerful word, but I think it's appropriate in this situation.

Cruel assumptions about pain in, the Alzheimer's community is absolutely a real thing. There's a there's a trope that goes back many, many years that that people, with Alzheimer's disease experience less pain.

This has been something that many doctors, actually still believe to this day, that that the neurocognitive decline associated with Alzheimer's also changes the perception of pain.

And it's long been thought inappropriately and inaccurately, that people with Alzheimer's disease experience less pain. Somehow that turns out not to be true.

But of course, it is very difficult to assess pain in a person who can't really articulate what they are experiencing. It's it's hard enough to assess pain in a cognitively intact person.

I can I can tell you that myself. In a person who's not cognitively intact or non-verbal, it's extremely difficult to assess pain. And so that leaves room for all these, cultural interpretations.

And some of them have turned out to be rather cruel assumptions. So one of them, yes, people who have Alzheimer's experience less pain. Not true. That's that that's a problem.

And that can lead to poor pain management practices. The other and I think you alluded to this as well, is, is that when a person has an injury or has some kind of, let's say they slip and fall down the stairs or have a low lumbar disc herniation or something like that, that because they have dementia, they'll forget the injury, which is often true.

They may have forgotten falling down the stairs or forgotten having a car accident, but the pain from that injury, that trauma, that surgery, whatever the case may be, whatever the initial stimulus was, may have been forgotten.

But the pain no doubt persists. And I would challenge anybody, you or any of your viewers, to imagine what it's like to have severe pain and not know why you have it.

Pain provokes a lot of fear by itself, even when you do know why you have it. And if you don't know why you have it, I can. I can only imagine how much more frightening and anxiety provoking that must be.

And that it is the plight of many an Alzheimer's patient who has a serious, acute or chronic pain syndrome where they can imagine, waking up in the morning or being woken up at night with this pain, not knowing why I had it.

And if am I dying, right? If you jump to what is this trying to tell me? And when you don't have the answers to that question, then the mind would go down some crazy loop, I would imagine.

Absolutely. And, you know, even even something as simple as it could be rather painful as a, as a fracture, you

know, someone falls and breaks their wrist.

Will you wake up in the morning after having broken your wrist? It hurts. It's going to hurt. I've done it. I've broken a few bones in my time and they hurt.

But every time I wake up with that pain or it hurts when I roll over, I remember why I broke that body part. And, you know, that gives me at least some comfort.

Yeah, my my foot hurts. My hand hurts because I rolled my ankle over playing basketball so I can deal with that. But if I didn't remember that, that could be really problematic.

And that, again, is another cruel assumption. Oh, they'll they'll just forget about it. So it's not really that big of a deal. I would argue that it's actually a bigger deal, in the patient who has pain and doesn't, actively or consciously understand why.

And so we really need to be really need to be careful. And compassionate in our assessment, of these folks with pain, despite the difficulties in assessing it.

Right. So there's, there's no less than like 30 different assessment tools, you know, pain rating scales and whatnot that that have attempted to qualify and quantify pain in people with dementia.

Like I said, it's extremely difficult. You can't ask a person, especially who has advanced disease, you know, how much does it hurt? Where does it hurt?

Is it sharp or dull? Can you rate it? On a scale of 1 to 10, you're more looking for subtle kind of cues. And, and it's a it's a big challenge indeed.

We've already seen at Marama, the residential care facility, how people who are in pain from one thing or another, that they also need to be reminded, okay, don't you know, you've got to use your walker because your left knee is still swollen.

And from the I'm remembering a woman who had a procedure. And so she'd had a procedure on her left knee. And we had to remind her over and over, you've got to use your walker if you step on your knee, if you put weight on that knee, it's going to hurt.

And so even, you know, this is a little bit more obvious, I think, than the nuances you were describing it. But even that it's like like you said, it's a bigger deal when there's pain.

It's a bigger deal, that someone needs to be reminded, you know, to gingerly walk on a on a limb that's ailing, when we wouldn't have to be reminded over and over afraid.

And so we would be less likely to re injure. They're almost at risk a bit more because of that. Because of the lack of memory of, an injury indeed, or.

Yeah. Or a surgical procedure as it was in your patient there. Yeah. It is, it's remarkably challenging. Right. It's highly, highly complex. Kind of clinical management in that situation.

And, yeah, you're the musculoskeletal story, and there's so much musculoskeletal pain. Right? The knee procedure. And I'd love to get into the details of, of, of, of kind of some of the pitfalls, of musculoskeletal pain management and, you know, more broadly.

But yeah, you are absolutely right. It's a challenging thing to assess.

How Pain and Dementia Interact

And in people, especially with more advanced disease, you have this challenge of, being able to articulate even, even the experience of the pain. So you're looking for other cues, right?

You know, you might touch something and see if there's a grimace, this sort of thing, you know, more softer signs rather than the hard, obvious signs that where a person can articulate.

And then there's this added complexity also that I think is important. And so relatable is that that pain is, at once a signal that something is wrong, right?

And that woman's knee or, and wherever the body part may be. But it also incites, fear. And an anxiety that's really pain does serve a biological purpose.

And so for many people who experience pain, you might see a grimace or people moaning or groaning at night in their sleep, this sort of thing that looks like pain.

But a lot of times those outward expressions of, of of pain or suffering can be relieved by human contact. Right? This has been seen time and time again.

A caregiver comes in, a granddaughter comes in and holds grandma's hand, you know, and then all of a sudden the moaning and groaning and the grimacing decreases.

So it's an added challenge to wonder whether or not this outward expression that looks like suffering is actually pain, or like physical pain in my knee and my back, wherever, or is crying out for relief in some other department, like loneliness, you know, whatever else it might, it might be and, and yeah, there again, another layer of complexity in the sort of assessment and management of pain, in people with Alzheimer's disease.

Yeah. And I what I'm inspired to do. Right. Just having this conversation with you is to manage pain aggressively in our seniors, in our dementia patients, because we lack that ability to really fully communicate about it.

And so you have you have a different sort of paradigm for thinking about pain. But before we go there, I want to understand a little bit more about this sort of poorly understood but well known toxic brew, as you called it, of pain and dementia, sort of this inner phase of things that cause pain, typically lead people to live less healthy lives or less the life that would reverse or prevent dementia from happening.

And then also, as they'd potentially add things to treat pain, there's an effect on the brain. So let's dig in to what we do know at least about that.

Yeah, it's a great question. And and I support the idea of aggressively managing pain. Right. It's it's become, you know, there's some pitfalls there as well.

We'll get into those. Right. We've seen that with with opiates and you know, kind of the aggressive management of pain using opiates has led to a whole new societal crisis.

Thinking of pain as a vital sign, which it probably deserves to be. But then we have to think more elegantly and, about the way we actually approach it.

Yeah. So to unpack that a little bit, pain and dementia. Right. So, yes, it's difficult to assess, but to the extent that this has been studied and it has rather extensively, it's there's a few things that are pretty clear, people who have chronic pain, which is often musculoskeletal, but not always, but, you know, orthopedic arthritis, that type of thing.

Can be expected to have a, a more rapid course, a more rapid progression of their Alzheimer's disease. And the reasons for this are not totally well understood.

There's probably some that are related to the actual, in medical speak pathophysiology. Right. The biochemistry, the pain causes some biochemical changes in the brain and the central nervous system that may enhance the the

progression of a neurocognitive degeneration.

So pain can make the condition worse. Directly, you also alluded to that pain can influence your life. It can mess you up in all kinds of ways, right?

It becomes a preoccupation. It becomes, a big source of anxiety. It can become a big limitation on your lifestyle and ability to exercise, your ability to sleep.

The choices that you make when you're preoccupied. I think we can all relate to this. Something hurts. Donuts sound better. You know, comfort foods and these sorts of things.

So pain can have this, like this, this effect of draping over a person and impacting adversely their diet, their lifestyle, their stress management, their sleep and all of those things.

And I'm sure you have many experts that are talking about this are also associated with, advanced, you know, more severe disease, more rapid progression, etc..

So, yeah, that's that's kind of what we know. I mean, and it speaks, I think, to your, to your point. Right, which is that we should do what we can to keep the pain under control to understand it, because doing so will help people in all kinds of different ways.

Right. And when we just sort of neglect or ignore pain in a person with dementia, we are doing them a great disservice. To both in terms of their dementia and in terms of their humanity, right.

Their life itself. So then the other piece of this, I think, I think we can all agree that an increase in stress leads to more dementia and a reduction in sleep quality leads to more dementia, not sleeping or, excuse me, not eating as well.

So more inflammation, potentially from an unhealthy diet leads to more dementia. Now on the flip side of this, when we go to intervene, right. So when we think about using Tylenol or instead or opiates, like you mentioned, what are the effects of those interventions on cognitive function?

Well, it's pretty it's those drugs. I mean, you mentioned a bunch of them and they're all sort of in different categories. The, broadly speaking, there's this big class of medications that include so many different drugs called anticholinergics, which are known, sort of, triggers, for increasing risk of Alzheimer's disease and increasing the rate of progression.

Anticholinergics include common over-the-counter medications, most notably probably Benadryl, but also a whole bunch of other, other drugs that end in am I and Benadryl is diphenhydramine.

But there's all these other drugs, many of them, not all, but that end in a am I and e are anticholinergics and associated with increased risk of dementia.

A Holistic Approach to Pain Management

So we want to try to minimize the use of those things. Whenever possible. Tylenol PM, Advil PM, these kinds of things. The PM is, is is diphenhydramine, and should try it, attempt to be avoided.

It also is soporific and induces sleep. People take Benadryl. That's what the PM is about. And so many over-the-counter and prescription medications contain these anticholinergic compounds.

And that's a problem. And you mentioned and then when we go up the chain, you know, in terms of, force of the intervention, if you will, you ultimately wind up at opiates.

Right? This is your OxyContin and oxycodone, Percocet, Vicodin, fentanyl is a lot and all these all these drugs,

which are, a pandemic of their own, and are widely used for pain management, including in the dementia population.

And are are fraught with all kinds of problems, including, cognitive deficits. I mean, anybody who has ever had the even the short term experience of what it feels like to be, under the influence of opiates knows that they are powerful agents on the central nervous system.

And, not exactly associated with, like, sharp cognitive function. Right. So, so, yeah, if we can, if we can find a way to help people feel better with respect to their musculoskeletal pain, that doesn't make their other problems, including their dementia, worse, well, that's a win.

When you mention just something as simple as, granddaughter's hand, on a dementia patient or touch from a caregiver, these are things that they take human time, they take some labor, but really do tend to reduce the effect of the intensity of pain.

Our experience of pain goes down. And we know this also from, from assessing people who are not do not have dementia. Right. So any sort of human touch, human interaction, again, good diet, all of these things as a healthy lifestyle can reduce not only dementia but also, can help with how intensely we might feel pain.

Yeah. Well, you're you're right. And yeah, of course we're talking about people with dementia, but but pain is a universal experience. Well nearly universal.

There's a few select people who, who, who are not fortunate to not be able to experience pain. It's a rare condition, but, but for the rest of us, you know, 99.9%, we it's a universal experience.

And and but it's a complex one, right? It's not as simple as measuring something like blood pressure. And that's largely because and I think you just alluded to this pain is both about what you are feeling and how you feel about it. Right.

So the and that's a really important thing in pain management. Right. Because and I think this is a nice segue into the next part of our discussion, is that the stimulus that caused the pain in the first place is one thing.

But then the way we feel about that pain, what it means to us, what fears it provokes, what stories we've told ourselves, what our past experiences have been, what we've seen, what our mother or our father or our grandparents went through.

Those inform the experience of the pain and have a dramatic impact, for better or for worse, on the, the, the, the amplitude of, of the experience. Right.

And so this is why some people can have, you know, a certain stimulus, maybe a fracture or whatever the case may be, a surgery and kind of come through it just fine.

And others, there may be genetic reasons and other types of reasons, but much of what our experience is of pain and how bad or impactful it is upon our lives has to do not with the trigger, but with our story, the story that we tell ourselves around it.

How often around fear, anxiety, those sorts of things. And so, yeah, so human touch, caring, compassionate care, music, these kinds of things can influence the story that can calm that, that inner fear and anxiety, which actually has a benefit on the experience of the pain.

This is this is a well known well known phenomenon in mindfulness research and, and all sorts of other non-pharmaceutical ways to manage pain. And it's a beautiful thing if we can employ those techniques in this population.

Right. And I think that's maybe the point I was trying to make was that we have a lot that we do know about pain

from people who can fully articulate their experience.

Yes. If we can aggressively apply that information to a dementia population, then we can get them sort of the best of both worlds, right? We can reduce the pain that might be driving the dementia.

Or maybe not driving, but certainly contributing to that rate of decline. And we can also get them pain management, which is just from a human perspective, so important.

And, and then not also be adding to the dementia scape, like what's going to further lead to progression. And so I want to jump into that. So if that's the goal and I think that that's a worthy one.

And certainly that's what we aim to do at Marama, the goal is to get them the best of the medicine that with a broad idea of what medicine is, because even prescriptions in the broadest sense of the word. Yes.

So if that's the goal, then what does that look like? How do you think about pain management from your natural perspective? Yeah, it's a it's such a great discussion here that we're having because and I think it's just so important. You're so right. Right.

If we can apply aggressive pain management and all these nontoxic, safe things that are going to help people in other ways, I mean, we're doing, we're doing we're relieving suffering, right?

And that's that's really I think one of the primary responsibilities of a doctor, naturopathic or otherwise, is to help relieve suffering. And pain is such a fundamental cause of it.

So, yeah, let's look at this. I suspect and correct me if I'm wrong. There's been a lot of discussion about diet and the influence of diet on inflammation, neurocognitive decline, all of that same information, applies to pain management, to inflammation being one of the really fundamental sort of pieces that, that that enhances the experience of pain in a person with a degenerative musculoskeletal condition.

So, yeah, all the dietary approaches that I'm sure have been mentioned, diets that are minimally processed, that are rich in omega three, oils that are low in industrial seed oils and bad fats, so to speak, that they're coming from whole, minimally processed, kind of plant centric type of diets.

Those are the kind of diets that I advocate for general health. And for pain management as well. And then we also touched on lifestyle. So I'm sure there's discussion here about sleep.

Anything and everything that we can do to enhance the the quantity and the quality of sleep. We should we should do. And that includes, you know, limiting exposure to light.

You know, we have all sorts of artificial, toxic light in our lives. And that's not the problem. It impairs our melatonin secretion. And on and on the list goes of different ways to naturopathic, so to speak, intervene and to help people get more, restful and restorative sleep.

We're doing them a favor for pain management, for Alzheimer's progression, and for their general health. Stress management is another piece that I'm sure is being discussed here by other experts.

And yeah, again, everything that we that we can do to help manage that stress, in a, in a, in a nontoxic in there's many ways to do this non-pharmaceutical cognitive behavior therapy, mindfulness.

And if a person is more advanced and those tools aren't accessible than just simple human compassionate care is a great way to help relieve people stress.

It's really scary to not have your memory, and especially if you're in pain. And so the comfort of another human. We are a social species, so the loneliness and as we've seen in this last year and a half or so, really has advanced disease progression in this, in this community.

And that's largely because of the, the, the dangers of loneliness, which is a risk factor, physical activity, motion, you know, getting people moving in a safe, controlled manner so important for general health, cardiovascular health, dementia prevention and pain management.

So movement and physical activity is critical. Yeah. So that's the kind of the broad overview. And then I'd like to narrow in and if this is appropriate on musculoskeletal pain in general, and kind of a different way of thinking about that, that, that cover your answer to your question.

Yeah. But I think the other thing I want to drive home here is it the list that you just gave us is the same list, whether we're talking about dementia itself or pain, whether we're talking about cardiovascular vascular disease or dementia, right.

Whether we're talking about diabetes or heart disease. And so just to drive home that there is a healthy lifestyle and and there's nuances to this, right?

Like some people would say, ketogenic is definitely the most important for cognitive function. And somebody else might say it's plant based if you really want to reduce inflammation.

So there's some nuance amongst that. But overall, the recommendations are the same. And this is I think it's it's great. And it's a little bit challenging right.

Because we have to sort of give up our attachments to these things that really are not healthy. If we want to heal. And if you want to heal, the answer is sort of the same across the board, right?

So it simplifies things. But it also it sometimes people need a little a little kick to get started. Right. And I hope that these conversations are part of that, that inspiration to go ahead and get started making these decisions the day and that it's the chop wood carry water.

Right. It's so what we do every day that really changes the trajectory of our health. So yes, thank you for sharing that list kind of in this context of pain, because it's such a reminder not only, I think to our listeners, but to me personally, that it's these, these lifestyle decisions that really make the big the biggest difference is you're so you're absolutely right.

And that was a very eloquent way to to to describe it. I think that that, you know, we see I think I see a lot these days. And you're right about the nuance to like, you can sort of split hairs, but there is this overarching kind of patterns, right?

Patterns, that people who are healthy, who live long, healthy lives without, as much suffering from the chronic diseases that plague the Western world right now, they're patterns that are that are pretty clear.

You know, we see a lot and it's very trendy and attractive to think about. Like, you know, what's now called being called biohacking, you know, running all these laboratory stat tests and assessing different parameters and all this kind of stuff, and then eating in funky, weird, interesting ways and exercising and using all kinds of different tools.

And I think, I think a lot about the people who live in the blue zones, which, which, which of these famous areas, people have long, healthy lives and don't suffer from the cardiovascular disease, cancer, the, the neurodegenerative diseases that we see here.

And there's no biohackers in the blue zones. You know, they just they just like live long, healthy lives. They chop wood and carry water, right? Like they move their bodies a lot.

They sleep well. They live in communal kind of high social interactions. There's not a lot of loneliness. They eat well, whatever that means. It usually means minimally processed.

In some places they eat meat. It's usually kind of either wild or pastured. In some places they eat a lot of fish. In some places they eat none. No animal products.

So you're right. Like, yes, there's nuance, but that's the details, right? The the overarching pattern is what really matters the most. And if we can implement that kind of pattern in people starting younger, right.

We can really make we can turn the tide. We I really am convinced that we can. And I also hope that these conversations with what you just illustrated with that society plays a big role too.

Like how healthy is society? How how many of the people around us are living this way? Do we feel like we're swimming upstream, or are we making the decisions everyone around us isn't?

Or to the people in the blue zones, you know, are we living in a place like that where everyone around you is social? Everyone around you is getting plenty of movement, everyone around you is eating these really great foods, and so you're not having to constantly make the harder decision all day long to stay healthy.

And so I think it's a little bit of both the individual decision making and the collective. You're right. And you you said you said before and I love that, that that you use the word medicine in the broadest possible sense.

And you were referring to like, yeah, medicines can be prescriptions from a pharmacy, but it can also be, you know, your food and your, your, your sleep and your movement and all these other things.

I think also, and I heard this recently, it really struck me that your diet. Right, we think of diet as the things that we eat right, which is an appropriate definition for it.

But your diet, if you think of it really broadly, is all that you consume. You can think about it that way, which is like the news media that you consume, the people that you're that are around you and all of their, you know, potential toxicity, your relationships, you know, the the chemicals that are out on your lawn, which you are consuming inadvertently.

And so, you know, if we think of improving our diet, again, sort of like your medicine in the broadest possible terms. Yeah, I think that's that's what the people are doing in the blue zones and other places where people live these long, healthy lives.

And that's what I hope that these kinds of conversations can inspire people to do. So leaving aside the societal piece for a moment, as much as I love to have those conversations, I really want people.

Yeah, we might not fix those problems. We might not fix those problems here today. Right? We might not. We try. Oh, it'll be a start. So for someone who's listening to this conversation in particular, because maybe they have pain or someone they're asking for has some musculoskeletal pain, I want to understand more specifically, like what is the approach that you would that you would take to help a patient like that?

Yeah, it's a great question. And like you said in the intro, this has been a big chunk of my career is is helping people or at least trying to help them.

Who have musculoskeletal pain. And I think there's a lot of pitfalls in the mainstream management of this. And this might be a little controversial for people, to hear the next part of what I'm about to say.

But so so it goes, I'm going to propose that for so many people who have pain, whether it's in their knee or their hip or their back or their neck or whatever, who have had x rays or MRI's that have told them things and said words in there like degeneration or disc herniation or bone on bone or whatever the case may be, this, these, these kind of very colorful, scary sounding, degenerative terms that describe the, the, the syndrome on x ray or on MRI.

Then a lot of times those descriptions, are certainly fear mongering and are wrong. They're inaccurate. And we know this this is not this is actually not as controversial as it may sound.

We know that many lumbar spine surgeries are unnecessary. We know that many knee arthroscopy surgeries. And that includes, total knee replacements are not necessary.

And this has been studied. We've seen sham surgery studies where they do a group, who actually gets the knee, the arthroscopic knee surgery versus a group who just gets a pretend surgery?

And seeing that outcomes are the same after one year. So what I'm proposing here is this very simple idea, which is that the reason why you've been told you have pain is not the reason why you actually have pain.

You're being told that it's the disc that's herniated, or that it's the cartilage that's lost, or that it's the osteo. It's the little bone spurs they're sticking down here and there.

And that you can see it on the X-ray. So it's like, oh, you know, I saw it on the MRI. It looked like this little white part or this little black part.

And it was super scary. And, you know, and, and in many, many cases those diagnoses. And when I say diagnosis, I mean the description that's given on the x ray or the MRI that is associated with the pain is inaccurate.

There's other reasons why the people are hurting. And in order to explore this a little bit further, I'd like to share a quick story. Do you mind as a quick story about a, 85 year old lady who was who was a patient of mine that I think, you know, explains this very well.

So this woman came in to see me. I was actually in a teaching capacity at the time, so I was in an institutional setting. She was in a wheelchair. Her daughter was was pushing her in the wheelchair.

And she was in a wheelchair because her neck hurt. She couldn't walk. Her neck was in excruciating pain. She had a soft collar on. And I was worried because she was in her 80s.

And she seemed a bit hunched over that she had osteoporosis. And I was worried that she probably had a fracture in her cervical spine. So I was in an institutional setting.

I had students that were following me around. We got an x ray. That was the first thing we did. The exam was very difficult to conduct because she was in agony.

We did an x ray, an x ray, we had this was in the days where you had a light box, you know, now it's all on the computer. It was like, snap the x ray up on the light box there with the radiologist.

And he was telling me and the students behind me, what he saw and what he saw was advanced, cervical spine disease, you know, stenosis, you know, all kinds of degeneration.

This was an x ray, so you couldn't see the disks. But for stenosis and all kinds of problems, degenerative spine, you call it arthritis. And, and his implication was that this was the reason why her neck was hurting.

And I at that point challenged him and said, I'm going to with all due respect, you, you haven't met the woman, and I'm going to respectfully disagree with your diagnosis here.

And this is why. So I just talked to this woman. It was hard conversation because she was in so much agony. But she told me that her neck had been hurting for three days.

Right. So she was something like 85 years old and she had three days of neck pain. Thankfully, it wasn't fractured. That was the good news. So we're looking at this x ray and her neck is a mess.

It looks terrible. This is advanced cervical disc disease. And this doctor is telling me that her neck. What we see on the x ray is the reason why she's in pain.

And I ask my students, let's do a thought experiment here. Let's just say for a moment that we had the good fortune to be able to travel back in time to four days ago when her neck felt fine because she told us it only hurt three days.

So we go back 4 or 5 days. We take an x ray then. Well, what do you think the x ray would look like? Well, you and I both know. We all know it would look the same as it does today.

It would look terrible, right? All the disks collapsed and all kinds of bone spurs. And it's a mess. But four days ago, her neck didn't hurt. So how could it possibly be that what we're seeing on the x ray is explaining this woman's pain? It can't be.

She had that same x ray four days ago or four years ago. Right. So there must be something else. And so that's my story. And that story I think illustrates this perspective.

So forgive me if I if I rant here for a while. What was it. What was causing her neck pain. Right. Well that's a good that's a good question. Right. So the cause of her neck pain and the cause of many people's musculoskeletal pain is three things.

Number one, inflammation. And we just talked about that. Right. And the influence that it has on diet not just regular inflammation but excessive inflammation.

Inflammation in excess of what the appropriate amount of inflammation is when we have trauma or infection, inflammation is an appropriate healthy response.

But many people who don't eat well, who have poor diets, lifestyles, nutrition, etc. have more inflammation than they should. Whether they have advanced cervical, this disease or a mosquito bite.

Right. More inflammation because of underlying nutritional biochemical problems. So inflammation is number one. And that she had that number two muscular tension.

So muscular tension is a major trigger for joint pain. You can't see it on X-ray. You can't see it on an MRI. But when you have a bad cervical disc or a bad knee or a bad shoulder, it's very, very common.

We've all experienced this for the muscles around and adjacent to that joint to get tight, and they do that for a purpose, to protect you, to protect you from further motion.

So that you don't further injure the already problematic area, that muscle tension in the setting of nutritional problems, especially magnesium deficiency, can be excessive, just like inflammation and be excessive.

So now you have a person with an arthritic shoulder, but all the muscles in the shoulder girdle are just tight and spasmodic, putting further pressure on the already painful shoulder and making it hurt even worse.

Right? So inflammation was number one. Excessive muscle tension is number two. And then number three is something that's called fibrosis. Fibrosis is scar tissue. Right.

The deposition of fibrin, which is this, fibrous gristly like substance. It's there when you get a piece of gristle, if you eat meat, that's, that's that's what you're chewing.

There is that fibrous stuff that's very chewy and tough. And if inflammation and muscle tension and all the consequences of that persist for extended periods, we start to see the transition of normal soft, supple, healthy soft tissue into something that's more fibrotic, just like a more gristly piece of a piece of meat or something.

Right.

Natural Treatments for Joint and Muscle Pain

And so this combination of inflammation, muscle tension and fibrosis is a pattern that I've observed in people with musculoskeletal pain over and over and over again in my practice, regardless of whether they have advanced disease.

X ray, regardless of whether they have bone on bone pain, you know, bone on bone, evidence of bone on bone disease in their knee or their hip. Very often, not always, but very often the effective management of inflammation, muscular tension and fibrosis can help alleviate pain, even in people with the most advanced imaging findings and severe looking disease on, on on imaging.

So that's my matrix, if you will. And I found it. You know, there's a lot of tools when we can talk about those in the naturopathic doctors toolkit that can be useful in that, in that department.

So that's the story. And so yeah, what do you do next? Great. I mean, great question. So, you know, obviously, you know, I am a doctor, but I'm not your doctor.

Right. So each case, you know, needs to be managed individually. Right. Because there's all kinds of factors. What other medicines you're on, what the nature of your problem is, what your diet is.

But broadly speaking. Right. Not treating anyone in particular the kind of primary tools that I, that I use. Yes. Dietary manipulation, to try to enhance all the anti-inflammatory stuff and decrease the pro-inflammatory stuff.

I'm sure you've heard speakers address that. We do that, but that's not going to get somebody out of pain today. What I've employed in my practice is a number of different things.

Herbal and nutritional medicine tools. I'll give you a list of my favorites. Turmeric. The herbal medicine. Kirk humor lager. I usually use, the high potency extracts of, of turmeric in some form or another where we can concentrate the cure.

Humanoids. And I find it a very, very useful anti-inflammatory agent to address. Point number one. Another of my favorite herbal medicines in this department is Boswell. Yes.

Or otherwise known as frankincense. And there's a number of novel extracts of Boswell that have very potent anti-inflammatory activity and are much safer than their sort of prescription and over-the-counter alternatives.

And there's a little evidence that some Boswell extracts also can enhance the integrity of the cartilage surfaces and joints as well. So curcumin and Boswell are very useful.

I also love to use bromelain, which is the extract from from pineapple, the center core of of pineapple because it's anti fibrotic. Here's a little fun fact for you by the way.

You may know this, but I bet a lot of your viewers don't. Meat tenderizer I don't use meat tenderizer too much because I don't eat very much meat. But meat tenderizer is this powder that you sprinkle on a tough piece of meat, and you can pound it with one of those meat tenderizing hammers. Right.

And it'll make the meat less tough. So do you know what the active ingredient in meat tenderizer is? No. Bromelain. Probably. Yeah. That's what better meat tenderizer is made out of.

And so that's why it works because it breaks up fibrin. So bromelain is another tool that I love. Quercetin, which is this amazing bio flavonoid which comes from, widely distributed in the plant world, concentrated in onions and apples and other plants.

Also have some anti fibrotic and anti-inflammatory activity. I mentioned magnesium as well. Magnesium really important, very common micronutrient deficiency.

And when people are deficient in magnesium, they are much more likely to have muscle spasms at the site of joint

injury or trauma. So optimizing magnesium status is really important.

Yeah. So those are that's a handful of the kind of tools. And then I also and this is very difficult to convey in a telemedicine kind of setting, but I mentioned briefly the meat Tenderizing hammer.

Right. Which is I don't have, you know, it's like a, it's like a mallet with the pokey bits on there, and you whack it into the meat to soften it up. So for 20 years of my practice, these were my meat Tenderizing hammer.

And I use my hands. Right. And sometimes some tools to to work on people. So going back to that, that woman, the 85 year old lady with the neck in agony, I gave her those those tools right.

All of those herbal medicines in a, in a, in a in a formulation. And then I worked on her very gently, with my, my meat tenderizer in the neck and the upper back to try to soften up those muscles.

And it didn't take long, you know, we had we had a few visits and she was back to back to feeling good again, you know, neck range of motion back. The agony was gone.

Her neck still looked terrible on X-rays and we taken another picture. It still would have looked awful, but her, her pain went away and that's really what it was all about.

So that's. That's my story, I love it. Yeah. It's such a great illustration of how to think more holistically about pain, not be jumping right away to, you know, do I need surgery?

Do you know that how that cycle can sort of perpetuate pain? I can't tell you how many patients I've seen. I'm sure you've seen them as well. I wish I never got in that surgery because that led to the next thing that led to the next thing that led to the next thing.

And I can't find the subspecialists that is going to unwind the whatever is causing the pain secondary to that procedure. So I, I just love having these conversations where we can expand our, our worldview around something.

And instead of being so stuck on because I have the stones for because I have this herniated disc, I must be in pain, I, I just want to sort of second your claim that, that imaging is the end all, be all.

And just because you have abnormal imaging means that's why you're in pain. There are many, many, many of us walking around. I think the statistics are about 30% of us walk around with completely asymptomatic herniated discs.

So there's a reason why your particular herniated disc is causing pain, if that is actually what's doing it. And I think very often people start to feel something, then go get the x ray and or the MRI and want to connect those dots because it makes it feel simpler.

And then the surgeon wants to connect those dots because that's their tool and it makes them feel helpful. But seeing someone like you, there may be a whole world of interventions that are going to be less aggressive and just as effective, if not more so.

You're absolutely right. It was eloquently stated. And, and, just to piggyback on your on your comments about the 30% number. So that number increases with advancing age.

Right? So what you described is accurate. There are loads and loads of people walking around with disc herniations and arthritis, cartilage degeneration in their knees or hips who do not have any pain.

Right. There's loads of people and if you and if you talk about the neck, the lumbar spine, the hip and the knee, these kinds of diagnoses, radiological or imaging based diagnoses are very, very common in asymptomatic people.

And it almost follows the the decade of life. So that 30% figure applies to people who are in their 30s. Right?

People who are in their 30s. There's 30% of them with lumbar disc herniations who don't have any pain in their 40s, 40% in their 50s, 50%, and so on.

Right. So that means when you get up to 80, 80% of people and this is asymptomatic people, they don't have any pain, have have herniations in their neck or in their back, or degenerative changes that are visible in their knees.

And this, this is people who do not have pain. Right? So it's it's well known. I started my rant by suggesting that I was saying something controversial.

It's actually not controversial. We know this. We know that the imaging lies right? I mean, you're seeing what you're seeing, but to connect the dots between the discrimination and the pain is unfair and inappropriate.

And there's many, many people who can have perfectly healthy, pain free lives with a disc herniation, with degeneration in their knee. And it's a real shame when we intervene operatively on a person who could, who could have otherwise benefited from some of the tools that I just mentioned now.

And I'd like to conclude that by saying surgery is amazing when it's necessary, right? I'm not opposed to someone getting their knee scoped or knee replaced, or their lumbar lumbar spine operated on.

It's stabilized if they need it, but not until they've exhausted those other options that are lower force, less expensive, safer, and and often more effective.

So yeah, that's, we're on the same page, which I'm not surprised to find out that I love it. Thank you so much for being here. I want to make sure our listeners know where to find out more about you.

Thank you for that. So, like you said in the beginning, I, I have a clinical practice here in Hamden, Connecticut. I am, my practice is rather exclusive these days.

I'm kind of, focusing my energies more on my writing and consulting and other, other sorts of things, and having the, the younger doctors. I can't believe I'm saying that now.

Kind of, do the clinical work at my practice, here in Connecticut. And I'm putting a lot of my energy these days into product formulation, into consulting, for a company that I co-founded and own that is called Up Wellness.

So if people want to scope out that wellness and see the sorts of products that I've put together, to address the kinds of issues here, musculoskeletal pain and otherwise, feel free, to jump over to up wellness.com up and start up wellness.com.

I have my, my mug here that shows the I wave logo. I'm an old surfer from Southern California, so the wave logo speaks to me, and, yeah, a wave of hopefully, tidal wave of good of good health, that we can that we can bring to people, over at Up wellness.

So thank you for that. Fantastic. And I'm so happy to hear that you are training doctors, because I know that I certainly have patients in mind. Where in San Diego, where you're from, and I know you're in Connecticut and I'm thinking, gosh, I wish that my 85 year old female patient who was complaining of pain could come see you.

And I'm sure there are going to be lots and lots of people who might not be able to get in to see you, but just knowing that you are passing on this wisdom to future doctors, or newer doctors is reassuring.

I'm doing my best. Yeah, yeah, I'm. I'm trying. I think it's it's such, important. It's such important medicine. It's at a really, at a really critical time, so.

Yeah. Let's, thank you for that. It's. Well, thank you. Thank you again for sharing your time today. It's been an absolute pleasure. Very insightful, very helpful.

And I know so many of our listeners are going to get a ton out of this. Thank you. Well that's great I hope so. That's what we're here for.