Navigating the Path for Chronic Pediatric Pain-Pediatric Grand Rounds-3-6-2026-Meeting Recording

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45m 9s

Calderon, Delia started transcription

Calderon, Delia 0:03

I'm gonna go ahead and start recording.

Ranch, Daniel 0:05

Sounds good.

All right. Well, it is 7:30, so we will get started. Good morning, everybody, and thank you for joining UT Health, San Antonio Pediatric Grand Rounds. As a reminder, as you log on, please don't forget to mute your devices also with today's.

CME attendance process. You're going to have to enter the text twice. We apologize. The first time you enter the code, it'll give you a link to the CME website. We have to update a couple things in your profile and once you save that, you have to enter the code again through text and then you'll you'll get confirmation that you got credit. So those instructions will be placed in the chat as well, so please don't freak out. You'll get your credits. Otherwise, it was my pleasure to introduce Dr. Magadmina, who's board certified in anesthesiology and pain management and has been practicing in San Antonio. He's originally from Egypt, where he received his medical jury with honors from Ain Shams University.

School of Medicine in 1991. He completed his residency training at UT Health Houston, where he served as chief resident for the Department of Anesthesiology in 2000 and received the award for best resident for regional anesthesia. He also completed a pain management fellowship at UT Health San Antonio in 2001 and has been practicing San Antonio for the last 20 years.

Years, 20 plus years. In addition to pain management and anesthesiology, he has significant experience in teaching as he currently serves as clinical associate professor at Utah. Dr. Mina's medical memberships include associate faculty of the American Society of Regional Anesthesiologists and Pain Management.

The American Society of Anesthesiologists, Texas Pain Society, and he is Vice President of the Texas Pain Society Chapter in San Antonio, where he also teaches

ultrasound courses. Also, Doctor Mune is the Chair of Pain Medicine Department at the South Texas Spine and Surgical Hospital and has written multiple chapters concerning pediatric pain medication in decision-making pain.
Management. So you can see Doctor Mina wears many hats. Otherwise, in his personal time, he enjoys being around his two children who are currently in medical school. He's also heavily involved in his church community and has organized and participated in multiple medical mission trips in Africa. So everyone, please welcome Doctor Mina.

Maged Mina 2:56
Thank you Doctor Ranch for this kind introduction. That's too many words and too many hats. Maybe I don't deserve them, but thanks for all the department and having me Doctor Kamat I just spoke to earlier. Thanks for Miss Delia for coordinated coordinating this.
And Doctor Fakhri who maybe initiated the conversation, but I love coming to the department. This may be years back. I was just talking. Maybe Doctor Tomlinson also invited me a few years back in person. Looking forward to join you.
In person at some point, but pediatric pain has been my passion for many years. Actually, before another had Dr. Ranch before becoming an anesthesiologist, I was doing an internship in internal medicine Pediatrics and then the pediatric chair that's in Houston.
Called me right in the middle of residence and said, hey, we want you to stay with us. We love working with you. She tried to convince me to stay in the pediatric department and I kind of wiggled my way out of it into anesthesia. But love always work with the pediatric world.
As we start this talk about chronic pediatric pain, so you see my passion comes again and goes to the pediatric world. I'm trying to advance this slide.
Go here my this is my disclosures. I work for a consultant for a legal firm called Juris Medicus and I I am part of the board of directors at the surgical hospital spine that I work at. Objectives for today's talk include discussion of.
Recognition of chronic pediatric pain. How do we kind of finalize that diagnosis? The multimodal approaches, most importantly, incorporating physical therapy modalities, the pharmacological tools. We'll touch on interventions, but as we go throughout the talk, you'll find that non.
Inventional modalities serves best for the pediatric world. These are a couple of my

patients here as a father and son and collaborative work always between the family's key role to get everybody on board and the support of the family.
As we engage into the pediatric dive into pediatric pain.
All right, So what are the?
Contributing factors or how to define chronic pain. This was described by Doctor Perquin in 2000. The Europeans and the Canadians are far more advanced in the diagnosis and work up for of pediatric pain in general. So the definition was more than three months of pain, usually.
About 15 to 20% of the pediatric world. And when we say chronic benign pediatric pain, this is the pain that is not associated with significant pathology, different from cancer-related pain and etc. So like you see here, it's headaches.
The recurrent headache population, the recurrent abdominal pain that keeps repeatedly admitted to the hospital with negative work up musculoskeletal pain like fibromyalgia or this widespread autonomic dysfunction, widespread pain. All this will fall under the chronic benign pain.
Definitely there's a significant socioeconomic burden. This was described by Frederick Shoff in 2016. And definitely you could feel it. I could feel it. Everybody could feel that these patients and their families go from one hospital to the other. Here in San Antonio, because I'm affiliated with most of the hospitals, I'll see them at the Children's Hospital.
San Antonio downtown and then at university and then they will go to Methodist across the street and then the Baptist and they keep cycling and cycling. And then I meet them in each hospital and say, oh, I just saw you last week. So a lot of work, but sometimes it's repeated predisposing factors. Yeah, there's a lot of the child and parents play a role.
Psychology of the parents definitely are contributing factors. The school, the teacher, peer interactions, all these are contributing factors. You see here there's one of the children also I saw from the probably from your department or chose a patient with epidermolysis.
All across her skin. This is just her hands. I have few of these patients. The youngest is probably a few months old. He was diagnosed even as a neonate. He had to put a tracheostomy because this the lesions are across his mouth. He couldn't breathe and so even as a neonate.
The custom is required.
Other etiologies we see here, recurrent pain syndromes. We talked about the

headaches and abdominal pain, medical illnesses. So there are specific entities like juvenile rheumatoid arthritis, sickle cell disease, neuropathic pain. This child here has been diagnosed with CRPS.
Complex regional pain syndrome. She has club feet and with multiple reconstructive surgeries she developed what we call complex regional pain syndrome or the old nomenclature RSD sympathetic dystrophy. Cancer of course is a contributing factor or chemo related.
Therapies and we did share definitely few patients from the HIM onc team, Doctor Tomlinson, Doctor Shah and the oncology team. We share some sickle cell disease together patients and we try to navigate through their pain management.
Here's, you know, a overall of the the teams. It's so when it comes to just like in adult pain, pediatric pain needs a multidisciplinary team. And when I trained here at university here in San Antonio, our pain department had everybody on board. The psychologist was.
There on the on the on campus, on in the clinic, the physical therapist was there. We all worked as a team together and the and the and the patient would go from one provider to the other health professionals. So definitely a team of this is the picture here of the chairman of department, Dr. Ekman, the Department of Anesthesia.
The head of the pain program and couple of my fellow faculty. Non physicians are always included like psychologists, physical therapists, occupational nutritionists. I'm trying to negotiate now a bit for a nutritionist to come and join our practice because. The the the dietitian or nutritional help is of great support, particularly our pediatric world. And I see Doctor Ranch and nephrologist definitely would try to navigate through their blood pressure and obesity. And I say, hey, let's try just lifestyle changes, diet.
Modification, sleep adjustments before actually embark onto medications and so forth. When we look at other their comorbidities because they do have other comorbidities. Multidisciplinary psychosocial rehabilitation is essential for functional restoration. So one of the big parts here in PDF.
Pediatric pain is functional restoration. When these kids develop or start getting labeled chronic pain, they become shy. They step away from their peers, from their parents. They try to be isolated. So one of the key factors getting them back to school, to their physical functioning and so forth.
In summary, physical therapy modalities are he see here it's the key. I labeled it #1. Then you get have to have incorporate behavioral approaches. These are in

importance. I would say not just in the way I'm going to discuss, but in importance. From more important to least important. So you'll see interventionals modalities are the least important and you see it here #5. So there are interventions, but I I think they play the least role. Behavioral approaches, mind modalities, integrative medicine.
Hypnosis, acupuncture play a good role. Pharmacological is here and I labeled #4, so they do have a role. But kind of towards the end, this is here with my fellows a few years ago that we were training. We had a good program and use. We used to have six fellows at a time and maybe a couple came from the military.
This is in one of our workshops with the fellows a few years ago.
All right, we'll start with physical therapy. Modalities, like we said, are key to restore functionality and get the kiddo back to where they need to be with their peers and activity, working with the physical therapists always back to school attendance.
There's a high role I've we found over the years of aquatic therapy. Children love to be in the water and this is one of the great tools we we incorporate into the one of the, you know, tools you could.
Add some so in the hospitals cannot be done and and that might be one of the tickets we use to help children get out of the hospital when they're being admitted for and the workup is negative. We come and say to the family, hey, maybe part of the role is aquatic therapy, but you need to be this will be done outside the hospital. And in a certain location and we actually over the years were able to collaborate with multiple locations here in town like the YMCA, several locations that we can engage the kids. There's a facility called auditorium here in town. They're very cheap. Now remember most of these kids are.
Come from not well funded families. They are either Medicaid and they're poor socioeconomic, so they don't have a lot of funds to travel and the aquatic program or physical therapy might not be available. So you have to work with them to encourage them to find a place within and we see patients.
From a place from Lavernia or from the Valley or Seguin or whatnot, and they don't have all the medalas, but you have to work with them. It takes time, takes a lot of collaboration to find the perfect team. You see here a couple of the pediatric patient. The one on the right you see here with the white gown is a child we saw from. Hemonc department or the Pediortho. I think Pediortho, he had an amputation. So you see his left foot and ankle. He has a prosthetic. He had I think a sarcoma or some sort of a tumor on his left lower extremity. He had a baloney amputation. He's a 14.

Year old kid and developed Phantom pain and complex regional pain syndrome of the of the the at the amputation side. So here is working with physical therapy and getting into the hospital but and he has an epidural catheter to mitigate the post amputation.
St.
By the way, this is like a year from the amputation, so it did not develop right away. Remember we're talking about chronic, so this is not an acute post amputation pain. This is like a year or two years later after and that child either cannot use the prosthetic or even use it. He's on a wheelchair and we're trying to get him up and. Talking using the prosthetic you see here. Same thing with this other image, another child walking with physical therapy. Now these kids, when they're engaged in physical therapy, I usually have them sending me pictures. So this is probably a picture from the moms or the parents or whatnot. I want the kiddo. I want to see them.
Up and down the hall every day working with physical therapy when they're during their admission. So and I watch them every day when we make rounds. I like to participate and see them up and walking. I know some hospital offer pets.
That come and maybe help the kid who got out of the bed and walk around with the pets and take them some hospital, have even an outdoor seating area where they can go and enjoy the sun. These are all very beneficial.
Skip here. We go to pharmacological approaches. Yes, they do have a role. It was second on my list of preference. And this is a kid again with, uh, complex reasonal pain syndrome. You see the foot, uh, very scaly change of colors. They become very sensitive.
It was after a very trivial trauma and over the years we collaborated both pediatric departments and even a lot of pediatricians here. I even approached the San Antonio Pediatric Society and introduced them about early diagnosis about of coronary treatment pain syndrome.
Which helps in the early interventions and modifications. So what do we what, what medications do we use? You see here how we included. You can start with basic analgesics, Tylenol and Motrin adjuvant medications. We use quite a bit including the gabapentoids, ditracyclics.
Those amitriptyline, lidocaine patches, melatonin for sleep adjustments, benzos and muscle relaxants do play some role, particularly in chronic headaches. A lot of these kids get some muscle tightness in their neck and are contributing factors. Now again,

like I said.
We incorporate the medications after starting other metals of treatments on the top portion. Here you see ketamine has been advocated and published by Ferguson 2020 ketamine nasal spray. Also there's currently a ketamine product for intractable headaches that.
Actually been FDA approved. So it's very expensive and it's very hard to get approved. We do use however ketamine nasal spray through compounding pharmacies, so use a very cheap format for these kids, whether with the chronic headaches, migraines or abdominal pain or chronic whites.
Spread pain. We use it for breakthrough pain, like if they're at the stage of missing school and they have an acute flare up, maybe to break that flare up instead of going to the emergency room where nothing will be happening, wasted admission and nothing will be done.
And we tell the family, OK, I mean you've been there already 2-3 times, so try and you know navigate and stay home. So sometimes this works that ketamine nasal spray to break that cycle. Antidepressants we use heavily. I pretty prefer or have been working years on the.
SNRI guloxetine. Not a whole lot of studies. Unfortunately we don't. We do not have lot of studies on medications for pediatric pain and we use them anecdotally or outside the of the approval other SSRIs.
Been also used like sertraline, isitalopram, citalopram, some evidence, but I used between us, the psychiatrist, the rheumatologists and et cetera. I rely mostly heavily on duloxetine because of its neuropathic component with the kids. I can't remember the.
Cut off age for the FDA approval. I think it might be 12 years old, but I have kids as young as maybe 9 or 10 and this has to come in Full disclosure with the family. When we discuss these medications, whether it's the ketamine or the gabapentin, I'll we'll tell them, you know, we don't have enough studies.
But this is probably our best bet and we will you know start at a low dose like for example the gabapentin. These kids with the with the epidermolysis bullosis, we start them even at three months or two months on gabapentin. Are there studies? I I I don't see much.
But we just talk with the family, say, hey, this is our best bet. If it was my child, it's what I would do. These are the side effects and we get an agreement from the family on all of these medications, particularly if they're used outside the the realm or the

approvals. And the families understand opioids have very little.
Role in the chronic benign pain and has there is clear CDS guidelines about use of opioids. You should all be aware of it, but do have a role and maybe a sickle cell. Of course we see those sickle cell patients and.
We work together with the oncology department here. They're on doses of methadone for example. We navigate through this cancer related patients and I have few kids with juvenile rheumatoid arthritis that ended up on on some sort of an opioid.
Here is collaborative work over the years. This is a kid. You see the one wearing purple in the screen. She I inherited her with cerebral palsy, maybe in she was 10 or 12 years old. We worked with her through the years. She'll still come to see us. By the way, I got permission from the family.
To share these photos with you all and when I do these presentations elsewhere, this is a kid here I was telling you a few months old with epidermolysis bullosis. I'm carrying him in my on my hands and his hands are all covered because of course he'll rip off his hands and his feet are covered.
Because of the rash and the significance. And he has a feeding tube. That tube is a feeding tube and he probably, I remember he has a tracheostomy as well because of the disease affecting his face. But this kid here you see with the cerebral palsy, we got her through graduation.
And she currently works at one of the local water burgers. I think she's in 24 years now. I've seen her. I've taken care of her for at least 10 plus years. She comes through our practice. All right, interventions.
Little we there do have a role fluoroscopic guided procedures we typically use or ultrasound guided procedures. This is one of our two of our fellows here. We're teaching them placing doing their procedures. The kid with the foot up in the air. That's one of the kids with complex reason.
Pin syndromes and they don't like anything touching their feet. It's up in the air. We're here. She's in the procedure room. We're about to do fluoroscopic guided epidural catheter to give her a sensory and some sort of you need a sympathetic and a sensory block.
Botox insects have been published. There's a great colleague of mine, Dr. Shah and UCLA, who published a lot of data about using Botox for pediatric headaches and it is currently used. I use some of it. It's hard to get approved. It's very expensive.
But we it can be utilized for chronic headaches in children. Peripheral nerve

stimulation is a new horizon for peripheral neuropathic pain.
Dorsal root ganglion stimulation has a complex regional pain syndrome when other medalas of treatment have failed. This is a new horizon where you put the leads are epidural leads instead of the dorsal column. The lead go to right on the dorsal root ganglion for patients with.
Complex regional pain syndrome. I am hesitant to do this myself. I give it to the neurosurgeons when it comes to dorsal root stimulation. This is a question probably in the questionnaire coming at the end of the remember DRG for a refractory complex regional pain syndrome.
We see a lot of patients with occipital neuralgia with headaches and these pediatric neurology from the department here at shared with us and they benefit quite a bit from occipital nerve blocks. So remember greater occipital nerve blocks and even we do ablation for these occipital nerves in patients with.
With occipital headaches, virtual reality has some role. There's one of the publications we presented at the American Society of Regional Anesthesia. This was in 2018. OK, so many years ago. So over the years we inherited, I think over 200 kids with.
Complex regional pain syndrome. The youngest I've seen was a three-year old kiddo that was referred to us by the PD ortho team at Chosa after multiple reconstructive surgery for club feet.
Developed now CRPS of both feet. We put a an epidural catheter for the child at the hospital because he couldn't walk. Now his feet is corrected, but he can't walk because of the sensitivity. Usually it's a 2448 hour admission to get them to be able to work with the physical therapy.
Walk on their feet. But that was the youngest kid and it was part of this publication which included 100 kids over a 10 year period. Here's the fluoroscopic guided procedure with the catheter towards the left side and the nerve roots coming. So we try to be specific.
Targeting the nerve roots towards the extremity, whether it's the foot, knee and ankle, just to get a sensory block to be able to endure the physical therapy, facilitate the physical therapy for the desensitization and so forth.
Headaches. Here we talked together about the headaches. Don't forget about Botox. We talked about here's my colleague Dr. Shah from 2021 published utilizing Botox for headaches and also GR occipital nerve blocks for occipital headaches can be utilized. This is published.

In child neurology 2021. So my one of my patients here with chronic headaches. This picture is probably 15 years ago. I know it's my old office, but this is after working with. This is 6 months from us working together. Of course she comes first. She doesn't want to talk. She doesn't want to do anything.
With time and different modalities and this is something we have to reiterate to our the family. It's not a switch. They have got chronic pain. We got to work together. It's like going to school for it's got to take a year, maybe six months, I don't know, but we got to work together and.
Gain through this pain and finally get this child to be happy exercising. She's off medications. But six months before this picture, she was on tons of medicine. We worked with her for maybe six months to a year. Finally, she's off medicine. She's going back to school.
She's getting into a driver's license, etc, etc. So it takes time and an effort and patience, patience, patience to get them there. We talked about peripheral nerve stimulation, just one key item here to take back home.
It's still under a lot of investigation. There's only case reports, but no studies as far as pediatric pain. There's a wide, very few pediatric paperworks on that, just case reports in the literature. Remember, those are root gains.
Stimulation for refractory pain. This is the mechanism of action for peripheral nerve stimulation, usually targeting large A alpha and beta fibers, which gives them that kind of stimulation for the to mitigate the pain.
Sparing the small C, which are the pain fibers are myelinated in delta. OK, DRG, we talked about it. There are a few trials and I usually reserve this for the refractory patient that failed the typical standard spinal cord stimulation. So we do if it's a standard spinal cord stimulation.
We will do it, but when it comes to DRG, I'll defer that to our neurosurgeon colleagues. By the way, on my first appointment at UT came as an invite from Doctor Tarasovic. If you all aware of her, she's head of the Pediatric neurosurgery.
Team here at UT also one day that's probably 1520 years ago, inherited the patient from her with headaches from hydrocephalus and then we talked together on the phone and said, hey, I want you to come over at UT and have a clinic in our department. So she invited me and we had clinic for maybe 2-3 years right before the time of.
COVID. So probably from 19, 2019 through 2021 maybe. And then when COVID hit, clinics closed and it was very difficult to come back. But we still share patients. Matter

of fact, I just called her yesterday about a patient that she will be seeing from our end. So that's Isabella Teresa.
And the Pediatric neurosurgery department. So when it comes to DRG, I'll send it to her if it needs for the CRPS or complex regional pain syndrome patient. Virtual reality plays a role. So I have a child yesterday in clinic with chronic headaches and she's on one of those injectables.
And I'm not trying to market them. I don't know if any of the pediatric neurology team is here, but she's one of those injectables monthly. Over time, the child developed phobia and anxiety from the needles, so she doesn't want to do the injection, although it helps her. It mitigated her pain.
This is outside the box of utilizing. We use these in adults, but now we're trying it even in teenagers. So I told the mom, OK, let's start virtual reality. I mean, as soon as she sees the vial or the syringe coming out, then it gets screamed. This is a teenage kiddo, 15.
So we met with her a couple of times in clinic and this is kind of where virtual reality to get them maybe outside this fear of pain. Some families I know cannot afford it, but it's a certain role that can get them active and this kid, it worked for her.
So we got to engage in the virtual reality thingy and after a few times the mom has to actually has to bring her to our clinic. So I do the injection which is could be done by the mom or the child at home. But for the first few times I said OK, that's fine, just bring your virtual reality heal into clinic and get engaged.
And play tennis or do something and then we'll sneak in and without your notes, we give the sub Q injection.
So it can play a role. We have to kind of figure out which family could afford it, but it gets the child out of their fear, out of the restrictions and limitations. These are my colleagues which I worked with over the years. On the far left corner, there's Doctor Isabella Teresa.
There is a factor salvage and one of our first patient and this is actually in her clinic here in the neurosurgery department. I remember it was on the 2nd floor in the Rio tower and one of our first patients we saw here in UT he has a CRPS of the right foot. This kid was in a motor vehicle accident and gun.
Shooting. He was in the department here in UT for maybe over six months in the ICU, had a liver resection, spleen resection, yada yada, spinal cord injury. And then when he was about to start getting to walk six months into the hospital, they they figured out he has a CRPS of the foot he we could intend.

You know, he's been in bed in ICU and when he starts to talk walking, he couldn't bear weight on the right foot. You see here, that's the foot that had the CRPS. So we treated him actually at university. It was one of our first pediatric CRPS cases at university. He got an epidural catheter. These are my colleagues, the head of the. Society, American Anesthesia. On the far right corner on the bottom, this is my mentor in UT Houston. I still meet with him, Doctor Pivaliza. This is last year and my son next to him and then one of the neurosurgeons we work with. So you know you got to connect.
People that are compassionate about pediatric pain that help you over the years and guide you through it. And this is my family and I'm always gratitude to all of them because they make this happen to me, my wife, my son and my daughter. There's a picture a few years ago in.
when I took them to see where we originally came from. And I think we'll we'll stop here, Dr. Ranch, and whatever you want to take it from here. Thank you all for having me.

Ranch, Daniel 32:21
Thank you very much, Doctor Meyer, for that wonderful overview. I'm pretty sure everyone in the audience has at least one patient still with chronic pain, and so we're glad to hopefully have more avenues for treatment for these poor kids.
But I'd love to open it up to the audience for questions. You can raise your hand, unmute yourself, or place it in the chat.

Svatek, Mandie 32:47
Doctor Mina, thank you as always for educating us and taking that time to help manage the the pediatric hospitals patients that we care for. My question is, and I'm sorry if you might have gone over this, I had to take a quick phone call.
Is there some sort of, you know, protocol when we do get these high paying kids that we could work through as far as like access to when you're coming in with a considerable amount of pain, our management?
This is what we're going to, you know, go through with these patients because sometimes we do find there can be us having to turn to opioids, which we don't want to do and it makes it pretty difficult, but just trying to see if there is a way to streamline these sort of situations.

Maged Mina 33:45
Thank you. Wonderful question. I don't have the names who are speaking, so I apologize. I I could recognize you, but thank you.

Svatek, Mandie 33:53
Oh, this Mandy Spatak. Sorry, Mandy Spatak. Yeah.

Maged Mina 33:55
Oh, Dr. Svatek. Yes, thank you. Yeah, we do share quite a bit of patience. Thank you. Dr. Svatek. Yes, if it comes to the the opioid role, unless they have an acute event.

Svatek, Mandie 34:01
Yes.

Maged Mina 34:11
That really requires IV medications. Maybe we could start there, but once the acute process is down, start go back strictly to oral. Always push on the oral talk with the family.
Say this is what they're taking at home and if the child is, and we do the same thing with adults, if the child is able to tolerate oral, let's work on the oral route, maybe navigate with his current regimen, escalate it a little bit using again the oral.
Out because it'll be easier on the discharge. So we're once we I know this what's happening when they come in they want to be on IV medicine but we will if so number one is if do they really need an IV. OK yes start IV process but maybe give it 2448 hours. The acute process has been mitigated. Now we're back to.
Square one start switching ASAP to the oral. Escalate the oral as much as we can and escalate few things. You know we don't have doesn't have to be the opioids. Maybe escalate the the antiapleptic, the gabapentoids, the Lyrica, the what?
If you had the pregabalid, maybe add a mosul relaxant. Try to find some other avenues. That would be my thought process from day one. I want this kid dischargeable easy in the next two one or two days.
That's my key point.

Ranch, Daniel 35:52

Thank you for that. There is a question in the chat. Dr. Jeremy Pelman asks, are you aware of an intensive inpatient pain treatment center in Texas where we could hospitalize our most refractory patients?

Maged Mina 36:05

Not that I'm aware of. Even Texas children in Houston that I collaborate a lot of patients, there are a couple of my colleagues there, but they do not have and where it is they can be admitted. They will treat them as an outpatient so.

Outside, within even the whole state of Texas. I don't know about Dallas, but even in Houston they have a robust pediatric program with Texas children. And I, by the way, I trained there as a resident when I was in my residency. I am not aware of. So they will usually these kids will end up in Mayo Clinic up in Minnesota.

Jacksonville or somewhere where they have that. Yes, the full multimodal admission. They spend there a week, the whole 9 yards. Now to scale it a little down, I do admit these kids under my.

Admission privileges in couple of hospitals we work in town, but they don't have the full typical multidisciplinary where they get that whole 4-5 days of pain management, the specialist. So yes, so I I do it on a miniature scale on my end.

We admit them for a brief 2-3 days workup. Usually it's associated with an intervention. Like you see these kids, we admit them for a specific intervention for an epidural catheter or a nerve ablation, and then we get them with physical therapists. Mostly and maybe a dietitian. We don't have a therapist, psychotherapist or psychiatrist that could come and see them while in the hospital. I think this is 1 area we're missing, but the the robust admission, I don't see anything in Texas. It's outside. We have a miniature scale. I do some of it.

I'm not sure about the Children's Hospital. I can reach out to the head there and ask him, it's Dr. Wong. But I remember I sent him a couple of patients, but they treated him as an outpatient.

Ranch, Daniel 38:11

Thank you. Couple more questions in the chat. First, Doctor Janet Williams asks if you could please comment on the role of hypnosis or acupuncture in treatment of these kids.

Maged Mina 38:23

Oh, wonderful. Thanks. That's a wonderful question. Thank you. Yes, this is a great Ave. And like I said in the beginning of our talk, physical therapy modalities, acupuncture, hypnosis play a great role. There's a lot of publications.
I can't remember the names top of my head, but it mitigates acute pain as well as chronic pain. There are several publications for patients in the ICU and post operative tonsillectomy or post appendectomy, yes.
Not all specialists. I'm back in the day when I trained, I used to do hypnosis. My chairman, it was Doctor Rama Murthy, whose wife was actually a pediatrician and she was probably part of the department.
I can't remember his wife's name, but Rama Murphy was the name and his wife was chief of the NICU. Matter of fact, she was in the NICU department. I remember her from those days. Yes, we do rely on that. I do a lot of acupuncture. So yes, I will talk. I will talk with the family. Now remember.
They do play a role. It depends on their family's acceptance and willing to participate it. Some kids are very, very needle freaks, so acupuncture to them is a little bit of an issue. Some some kids like when we do the Botox injections.
Adults cry, but I get a kid because of her headaches. She was like, do whatever. And when you do the Botox injections, she does well, even without sedation, without anything. So if the kid really is interested and focused into the deal, yes, they will participate with acupuncture. If it's for hypnosis, I'll refer.
Them out. I don't do it myself, but I Rama Murphy taught me how to do it back in the day in 2001, but I don't do it now. Yeah, refer them out.

Ranch, Daniel 40:20
Thank you. I'm going to combine the next two questions from Doctor Andrew Meyer and Dr. Rob Sanders. They ask, have you heard about new drugs that target sodium channels for peripheral pain such as I'm going to mess this up, Susetrigine, a selective NAV 1.8 blocker and also Doctor Sanders asks.

Maged Mina 40:35
Yes.

Ranch, Daniel 40:39
On your thoughts on methoxyflurane for acute pain.

Maged Mina 40:44

Well, thanks, Doctor Sanders. Dr. Myers. Yes, the sodium channel blockers can play a role, but it's mostly acute pain. I'm not aware of data in the pediatric world, but yeah, like I said.

If you have interest in a medicine and use it and feel it might, uh, alleviate some of the pain, I will discuss with the families and we try this, that and the other. Uh, there's this new Uh solium channel blocker. We can give it a try. Uh.

I'm not very robust on the dosage for pediatrics, but we can always, you know, based on their weight and so forth, try a small dose, discuss with the family, say, hey, there's little, there's not a lot on literature, but we can give it a try and so forth. Yeah, it could be worth a trial. That's on the sodium channel blockers.

Um, the other questions was I I I forgot what it was. Mythofloric.

Ranch, Daniel 41:40

Methoxyflurane for acute pain.

Maged Mina 41:44

I'm. I'm not aware for that. I'm not aware. I could look into it, but I'm sorry. Is it whether Doctor Sanders or Mars? I'm not aware of it.

Sanders, Robert Scott 41:52

No, it's all right. It's a it's a it's an it's like an it's a self administered, inhaled pain medicine that they a lot of times they use in Europe.

Maged Mina 42:01

Mhm.

Sanders, Robert Scott 42:02

It's it's an inhale. It's an inhale anesthesia medicine, but it's been proved. It's been shown to be very effective for like in acute pain.

Maged Mina 42:10

In Europe.

Sanders, Robert Scott 42:13
Yeah.

Maged Mina 42:13
What is it called again?

Sanders, Robert Scott 42:15
Methoxyflurane or Panthrox?

Maged Mina 42:18
Methoxifluorine. OK, I'll look into it. Now a lot of these medications, yes, if you know something that Europe's or the Canadians are using, like I said, the Europeans are much more advanced than the Canadians. So when I go to all these meetings like the ASA meeting, which is the national meeting, there's like 10,000 anesthesiologists. They come from Europe and Canada, everywhere.
Yeah, the Canadians and the Europeans are far and advanced. They have a lot of tools. So if you find a drug that works, you can work with a local pharmacy here, like I said, and if they can do it, a compounding pharmacy and there's literature from Europe, I'll share with the patients. Hey, this is used in Europe. Can we use it here? And if I find a pharmacy that will work with like Oakdale Pharmacy here, I'm not marketing for any specific pharmacy. Yes, find the medicine, work with it, pull the literature, share with the patient and say, hey, we can try this and I will. But again, the question mark, who's paying for all of this? Will the family pay for it?
For it. How much it's going to cost? Insurance will not pay for it. Again, that answers my question on the acupuncture and the hypnosis. Insurance doesn't pay for any of that. And these kids are Medicaid or very poorly funded. So I have to kind of be careful when I'm discussing things because I don't want to give them hope.
And then they come and say, well, I can't afford it. It's cost me 50 bucks a week or whatnot like the ketamine for example, the ketamine nasal spray. We we navigate with the compounding pharmacy. It's all off insurance. This is not covered. The the families will pay between 50 to 100 a month or something.
Families can afford, some don't, and I'm assuming these other medications will cost somewhere in that range. Uh, it's worth a trial, yes.

Ranch, Daniel 44:08

Great. Thank you for that. Additional questions from the audience.

Um.

OK. Well, if there's no additional questions, Doctor Mina, thank you again for that wonderful overview. I'm sure I'll be sending more kids to you knowing that, you know, we have you available to help these kids out.

As a reminder, when you're entering your CME code for your attendance, you're going to have to do it twice because it's asking you to update your profile. So don't don't barrage Delia with calls and chats. Otherwise, thank you again for attending UT Health Pediatrics Grand Rounds. Thank you.

Dr. Mina for that wonderful presentation. Everyone have a great rest of your day.

Maged Mina 45:03

Thank you all. Have a blessed day, Doctor Ranch and all. Thank you.

Ranch, Daniel 45:05

Uh.

Kellogg, Nancy D stopped transcription