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## **Lasers and Pain Treatment**

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### **Summary**

The clinical application of low incident power density laser radiation for the treatment of acute and chronic pain is now a well established procedure. This paper reviews the currently available English speaking literature and summarises a selection of serious scientific papers which report a beneficial effect following the treatment of a wide variety of acute and chronic syndromes whose main presenting symptom is pain.

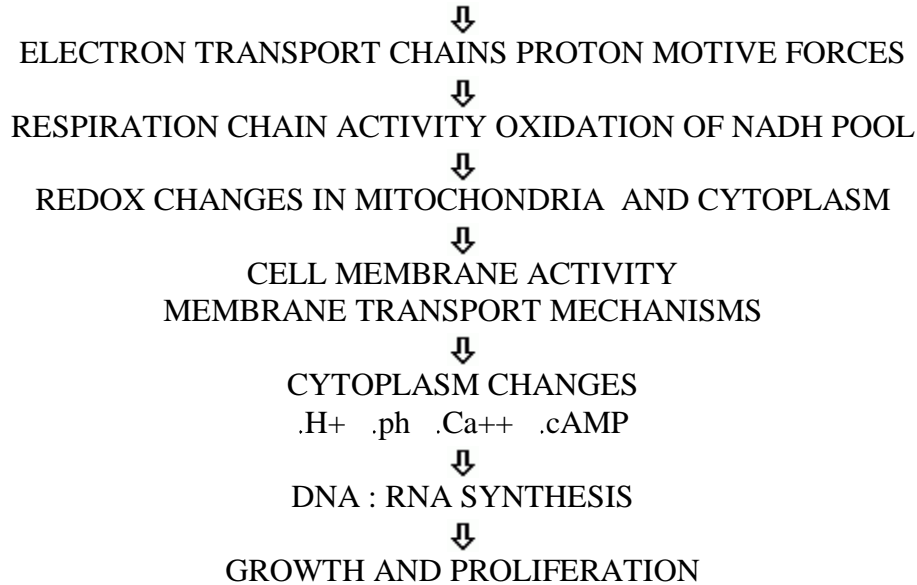
### **Introduction**

The Helium-Neon (He-Ne) laser at a wavelength of 632.8 nm has proved very successful in promoting wound healing particularly in indolent ulcers resistant to conventional methods of therapy. However, its limited depth of penetration and low power output have rendered it less effective when treating more deep seated causes of pain. The laser more frequently used for pain therapy is the Gallium Aluminium Arsenide (GaAlAs) diode emitting coherent light in the near infra-red waveband, usually 820 - 830 nm, and with a continuous wave power output of some 60 mW. The optoelectronic rationale for choosing these parameters has been discussed by Moore and Calderhead (1).

During the past 15 years experimental research has greatly added to our knowledge of the response of tissue radiation. Figure 1 summarises some 10 years work by Karu (2) into the cellular response to photon energy. Additional research at the Tissue Repair Research Unit at Guy's Hospital, London, has detailed the local tissue changes following exposure to laser light. The current concept is one of a dual response to laser bioactivation. The immediate or primary effect is a local tissue response to direct irradiation and comprises vasodilatation with increased circulatory flow: enhanced lymphatic drainage; increased neutrophil, macrophage and fibroblast activity; and an improved metabolic function in depressed or damaged cells. The delayed or secondary response consists of a systemic effect caused by circulating photoproducts of irradiation in the blood and lymphatic systems. Increased plasma concentrations of certain types of prostaglandins, enkephalins and endorphins have all been identified and most probably play a major role in the mechanism of pain attenuation.

### **Figure 1: Cellular response to laser irradiation**





### **Acute pain therapy**

Acute trauma is invariably associated with a degree of soft tissue injury comprising swelling, haematoma, pain, reduced mobility and in the lower limbs impaired weight bearing. Sporting injuries and domestic accidents usually involve damage to muscles, joint ligaments and tendons. Examples include a sprained ankle or wristed or a twisted knee. Most extensive soft tissue damage tends to result from industrial crush injuries or road traffic accidents. In the absence of bone fracture or other injury demanding priority treatment laser therapy should be instituted at the earliest opportunity. Kumar (3) reported a comparative study in 50 patients with inversion injuries of the ankle. He found that compared to conventional physiotherapy the laser treated patients showed a more rapid resolution of symptoms and an earlier return to full weight bearing. Patients were treated with a GaAlAs diode laser (830 nm: 60 mW) at 48 hour intervals on a maximum of 3 occasions. A similar therapeutic regime has been described for whiplash injuries of the cervical spine (4). Ben Hatit and Lammens (5) used a defocused CO<sub>2</sub> laser to treat a variety of acute musculoskeletal problems. The energy density varied between 40 - 70 J/cm<sup>2</sup>. Patients were treated twice a week for up to 10 sessions.

Beneficial effects of laser therapy in acute small joint inflammation in rheumatoid arthritis has been described by Asada et al (6). Multiple point irradiation using a GaAlAs diode (830 nm:60 mW) was applied for 15 seconds to each point. Pain was reduced by up to 66 % together with an improvement in the measured range of movement (ROM). In a similar report involving 938 patients with osteoarticular pain Soriano (7) found pain attenuation of 88 % when treating a variety of acute conditions such as tendosynovitis, lumbago and cervical pain. He used a GaAs diode (940 nm: pulsed 10,000 Hz: average power 40 mW) to treat patients twice weekly for a maximum of 10 sessions. The energy density delivered was 6 - 10 J/cm<sup>2</sup> per irradiated point.

Laser therapy also proved helpful in reducing the severity and duration of postoperative pain. In a comparative study involving 20 patients undergoing elective cholecystectomy

Moore et al (8) reported a 50 % reduction in the postoperative pain experienced by the laser treated patients together with a concomitant reduction in analgesic requirements.

### **Chronic pain syndromes**

Chronic pain, as the name implies, may last for months or years. Pain may arise as a result of damage caused by trauma or surgery or be manifested as a symptom of a systemic disease process. In later life pain due to musculoskeletal "wear and tear" is very common. Finally neuralgic pain such as postherpetic or trigeminal neuralgia can cause prolonged problems to sufferers. A high percentage of patients referred for laser therapy will have already shown little or no response to conventional methods of treatment.

In rheumatoid arthritis (RA) laser therapy can benefit not only the pain of acute small joint inflammation but also the more established chronic pain of the disease. Gartner (9) in an excellent review article on rheumatology considered some 18 papers published over a 10 year period. All involved double blind trials of therapy with 5 having a cross-over element. In considering the effect of laser therapy in chronic rheumatoid and associated musculoskeletal conditions all but one of the reports noted a significant improvement in pain. In his own work Gartner used a 904 nm infra-red laser to treat a variety of tendinopathies with a better than 80 % success rate in relieving pain. He compared this to a similar rate of pain attenuation using anti-inflammatory drugs

(NSAIDs) but noted that whilst laser therapy was free of side effects some 20 % of patients treated with NSAIDs suffered unacceptable side effects of medication. Asada and his colleagues (10) in a further study of some 170 patients with rheumatoid arthritis used similar laser parameters and treatment protocols to their earlier reported work. The group achieved pain attenuation of up to 90 % and improvement in ROM of up to 56 %.

In a report of some 1000 treatments using a GaAlAs diode laser (830 nm: 60 mW) for a wide variety of chronic pain syndromes Moore (11) noted an overall reduction in pain levels of some 70 %. Trelles et al (12) used a similar diode laser to treat 40 patients with degenerative joint disease to the knee. They delivered 18 J/cm<sup>2</sup> to each of 4 points around the knee twice a week for 8 weeks and reported a significant pain reduction in 82 % with improved joint mobility. Li (13) used a 25 mW combined CO<sub>2</sub>/HeNe laser to treat 90 patients with cervical spondylosis. Laser therapy was administered to a variety of acupuncture points for 10 minutes daily for 2 periods each of 10 days with an intervening rest period of 10 days. 90 % of patients showed symptoms improvement with an excellent result in 43 %.

Fender and Diffie (14) reported an interesting trial involving patients suffering from chronic generalized musculoskeletal pain. They irradiated the stellate ganglion using a HeNe laser with an initial exposure of 6 minutes (36 J/cm<sup>2</sup>) gradually increasing over 4 - 6 weeks to a maximum of 15 minutes (90 J/cm<sup>2</sup>). They postulated a mechanism of reduced sympathetic irritability causing a stabilisation of the response loop and a breaking of the pain cycle. In resistant cases they also treated segmental dermatomes and site specific trigger points.

Patients suffering from postherpetic neuralgia (PHN) have shown a good response to laser therapy. In a double blind cross-over trial Moore et al (15) reported a mean reduction in pain levels of 74 %. Patients were treated with a GaAlAs diode (830 nm: 60 mW) with the laser applied in contact mode to the centre of each 2 cm<sup>2</sup> grid over the affected area giving 24 - 30 J/cm<sup>2</sup> to each point. Treatment was given twice a week for 4 weeks. Using an identical treatment protocol but an extended regime of some 12 weeks Kemmotsu et al (16) reported at the end of treatment pain attenuation of 89 %. Otsuka and colleagues (17) used an 8.5 mW HeNe scanner to treat the acute rash of herpes zoster. Once the skin rash has subsided treatment was continued using a GaAlAs laser (830 nm: 60 mW). Within 1 month pain had been reduced by 76 % with a final end treatment improvement of 97 %. The early introduction of laser therapy produced a rapid resolution of acute herpes zoster rash and a reduced incidence of PHN.

## **Discussion**

Laser therapy is effective for a wide variety of acute and chronic pain syndromes. During the past 7 years the Laser Therapy Journal has featured some 30 papers on the subject. The preferred laser is the GaAlAs diode emitting light in the near infra-red usually at 830 nm. The majority of reports detail a power output of 60 mW continuous wave. Recently, however, researchers have been assessing the use of higher output powers in the range of 150 - 300 mW.

In a preliminary trial Yamada and Ogawa (18) compared the results of treating PHN with 60 and 150 mW. They found that the higher output power reduced both the frequency and duration of the treatment sessions and improved pain attenuation by some 25 %. Ohshiro (19) has devised an ingenious protocol for a computer controlled double blind comparative trial which compensates for the placebo effect of treatment and for patient and therapist bias. In a paper comparing the therapeutic outcomes in 2 geographically separate but otherwise identical clinics Shiroto (20) described how a positive therapist attitude motivated by enthusiasm and commitment can improve the results of therapy by 15 - 20 %.

There remains a need for more scientific studies based on well constructed double blind comparative trials. Nevertheless the bulk of published work to date supports the use of laser therapy for the treatment of pain. In a report of the cost-effective benefits of using laser therapy to treat PHN Moore (21) noted that, compared with conventional methods of treatment, laser proved to be not only more effective but more economical as well. The added advantage of absence of side effects, non-invasive nature of therapy and the ease of application ensured good patient acceptance of the treatment modality.

## **References**

1. MOORE & CALDERHEAD: The clinical application of low incident power density 830 nm GaAlAs diode laser radiation in the therapy of chronic intractable pain: a historical and optoelectronic rationale and clinical review. *Int. Jour. Optoelectronics* 6: 503-520, 1991

2. KARU: Photobiology of low power laser therapy. Chur, Switzerland, Harwood Academic Publishers, 1989
3. KUMAR et al.: A comparative study of low level laser therapy and conventional physiotherapy for the treatment of inversion injuries of the ankle. Lasers and Medical Science, Abstract issue 298, 1988
4. OHSHIRO: Low reactive level laser therapy: practical application 103-110, Chichester, UK, John Wiley & Sons, 1991
5. BEN HATIT & LAMMENS: Laser therapy with defocussed CO<sub>2</sub> laser, Laser Therapy 4: 175-178, 1992
6. ASADA et al.: Diode laser therapy for rheumatoid arthritis: a clinical evaluation of 102 joints treated with low reactive level laser therapy (LLLT), Laser Therapy 1: 147-151, 1989
7. SORIANO: The analgesic effect of 904 nm GaAs semiconductor low level laser therapy (LLLT) on osteoarticular pain: a report on 938 irradiated patients, Laser Therapy 7: 75-80, 1995
8. MOORE et al.: The effect of infra-red diode laser irradiation on the duration and severity of postoperative pain: a double blind trial, Laser Therapy 4: 145-149, 1992
9. GARTNER: Low reactive level laser therapy (LLLT) in rheumatology: A review of the clinical experience in the author's laboratory, Laser Therapy 4: 107-115, 1992
10. ASADA et al.: Clinical application of GaAlAs 830 nm diode laser in treatment of rheumatoid arthritis, Laser Therapy 3: 77-82, 1991
11. MOORE: LLLT for the treatment of chronic pain, Frontiers of Electro-optics (Conference proceedings) 283-290, 1990
12. TRELLES et al.: Infra-red diode laser in low reactive level laser therapy (LLLT) for knee osteoarthritis, Laser Therapy 3: 149-153, 1991
13. LI: Laser therapy for radicular cervical spondylosis, Laser Therapy 4: 151-153, 1992
14. FENDER & DIFFE: Physiological response in chronic pain patients to a new LLLT protocol, Laser Therapy 4: 169-173, 1992
15. MOORE et al.: A double blind cross-over trial of low level laser therapy in the treatment of postherpetic neuralgia, Laser Therapy (pilot issue) 7-9, 1998
16. KEMMOTSU et al.: Efficacy of low reactive level laser therapy for pain attenuation of postherpetic neuralgia, Laser Therapy 3: 71-75, 1991
17. OTSUKA et al.: Effects of Helium-Neon laser therapy on herpes zoster pain, Laser Therapy 7: 27-32, 1995
18. YAMADA & OGAWA: Comparative study of 60 mW diode laser therapy and 150 mW diode laser in the treatment of postherpetic neuralgia, Laser Therapy 7: 71-74, 1995
19. OHSHIRO et al.: Critical considerations in protocol design for the double blind trial on pain attenuation by laser therapy, Laser Therapy 6: 101-106, 1994
20. SHIROTO et al.: The importance of therapist education and motivation on diode LLLT efficacy in pain therapy: a comparative study, Laser Therapy 5: 175-179, 1993

21. MOORE: Cost effective benefits of the use of laser therapy in the treatment of intractable postherpetic neuralgia, Laser Applications in Medicine and Surgery, 61-63 Bologna, Italy, Monduzzi Editore, 1992

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### **Joint International Laser Conference in Edinburgh**

In September, 2003, the Edinburgh International Conference Centre in Scotland hosted the Joint International Laser Conference, organized jointly by the American Society for Laser Medicine and Surgery, European Laser Association and British Medical Laser Association. More than 500 registered participants had the opportunity of seeing not only the most advanced laser medical technology presented by 39 exhibitors, but also of attending numerous meetings and presentations, getting acquainted with top issues of laser surgery and therapy. A significant portion of scientific papers and posters dealt with laser therapy (LLLT), and theory was well supplemented with a series of educational courses called "How I do it". The organizers provided Laser Partner with full text of some of the lectures and now we bring the first one.

### **Low Level Laser-Therapy in pain treatment of the ambulatory system**

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#### **Zusammenfassung**

#### **Summary**

In spring 1995 we expanded our treatment methods with Low Level Laser Therapy. We decided to test the effectiveness of this kind of therapy through a study on 41 consecutive patients with ailments of the ambulatory system. For each case respective parameters, such as diagnosis, localisation, number of treatment points and output of the applied laser energy, were listed on a individual protocol where the patient also had to assess his pain (before and after the treatment) to a number on the so called visual-analog pain scala (rating from 1 to 10). Furthermore the doctor had to note objective parameters like mobility, inflammation and swellings before and after the laser therapy. The indications concerned exclusively pain of the ambulatory system, especially epicondylitis and other posttraumatic or stress induced pain of tendons and articulations, but also some degenerative changes of joints (arthrosis of knee and shoulder).

During this study no other therapy method or drugs were applied, in order to allow a reliable judgement of the effectiveness of laser therapy. Conventional methods were only used if the treatment by laser light was not sufficiently effective.

Generally, the results obtained with laser therapy were very good - both subjectively and objectively rated. Only 12 percents of the patients felt no pain release, one patient had to stop the laser therapy after two applications because of an increasing subjective pain. 73

percent of the patients felt a good or very good effect of the therapy. The treated patients liked laser therapy very much, because there are no side effects, the treatment is painless and the ailment decreases rapidly.