Jean is a 43-year old female† who was in our original intervention group. When she first came to us she was on 180 MME. As trust developed in our primary care relationship, she began to tell us about how her uncle would "spank" her. He instructed her to pull her pants and underwear down to her knees, bend over and grab her ankles, while he hit her repeatedly on her exposed bottom and perineum. This happened until she left home at age 17 years.

At a recent appointment, Jean shared with us her joy about spending a beautiful fall day shopping and going out for dinner with 3 girlfriends. Other than receiving 5 Tylenol # 3 after foot surgery, Jean has been completely off opioids for more than a year.

If we as a medical community really want to address the opioid crisis, we need to move beyond passing out self-report forms of pain and function and start passing out the Adverse Childhood Experiences form.[1] We need to recognize that "the body keeps the score[2]" and that many of our patients with chronic noncancer pain are using opioids to anesthetize real psychophysiological pain that has resulted from childhood neglect and trauma.[3,4]

Family medicine physicians are in the position to take the lead in promoting evidence-based, trauma-informed therapies[5] in our communities. We also must advocate for infant-parent mental health services in our communities if we hope to exorcise the "ghosts in the nursery[6]" that perpetuate the cycles of neglect and abuse.

Much like the game, "whack-a-mole," our society has tried for decades to suppress the addiction crisis *du jour*, only to have another pop up in its place. Family medicine doctors need to take the lead in addressing the all-too-frequent common denominator of our patients' chronic pain and chemical dependence. . .. the reality that we live in a society that neglects and abuses its children.

*At 1-year followup, we continue to provide primary care for 75% of the patients who were in our original control group. The current MME for our original intervention group is significantly lower now (11.7 MME) than it was at the end of the intervention period (29.7 MME) ($P = .01$; CI, 6.1-17).

†Name and demographics changed for patient confidentiality.

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Dry Needling Treatment of the Myofascial Trigger Point in Nocturnal Calf Cramp

To the Editor: We read with interest the article, "The Effects of Myofascial Trigger Point Injections on Nocturnal Calf Cramps."[1] In this study, the investigators have raised awareness of myofascial trigger point (MTrP) in calf muscles resulting in nocturnal calf cramp (NCC), which we commonly see in our daily practice, and they discussed diagnosis of NCC. Alternatively, they offered treatment with local anesthetic injection to the trigger points in NCC. However, dry needling (DN) was not mentioned among the treatment modalities for NCC in the article. We wish to put forward that DN may be considered for calf muscle trigger point treatment in NCC.

A 32-year-old male patient was admitted to corresponding author's outpatient clinic with cramp and pain in left calf for 2 years. His pain was relieved with rest and he did not experience typical neuropathic pain components (such as numbness, tingling, etc.). He did not have a history of trauma, surgery, chronic diseases, or regular medication. Cramp duration was 60 seconds, intensity was 8 cm according to visual analog scale (VAS), and frequency was once a day. Previously suggested magnesium oral intake (365 mg/day) and home exercises for stretching the calf muscles did not solve his problem. His physical examination did not show swelling or redness of joints; however, MTrP was revealed with palpation of the left calf muscles. Pressure pain threshold via Baseline dolorimeter (Fabrication Enterprises, Inc., Elmsford, NY) of MTrP was 7.2 kg/cm^2. DN treatment with stretching exercises was performed once a week for 3 weeks for a total of 3 sessions by a physiatrist (Figure 1). One month later, cramp duration was reduced to 10 seconds and intensity reduced to 1 cm according to VAS. Frequency improved to once a week and his sleep pattern ameliorated. Pressure pain threshold increased to 11.2 kg/cm^2. The patient is still followed in the corresponding author's outpatient clinic and 3- and 6-month follow-up visits are planned.

Even though the relationship between MTrP and NCC has been demonstrated in the literature, there are limited studies concerning DN as a treatment option. In a previous study, Kim et al[1] performed 1 session of

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Figure 1. Dry needling of gastrocnemius muscle.

lidocaine injection to MTrPs of gastrocnemius muscles of 12 patients with NCC and demonstrated improvement in pain intensity, cramp frequency, and sleep pattern. In another study, Prateepavanich et al[2] evaluated the effects of oral quinine sulfate and local anesthetic injection in 2 groups, each consisting of 12 patients with active gastrocnemius MTrP and NCC, and reported significant reduction in pain intensity, cramp frequency, and cramp duration in both groups. Besides, pain threshold of the gastrocnemius MTrP has increased in local anesthetic injection group, on the fourth week of treatment. They concluded local anesthetic injection had as much effect as oral kinin sulfate treatment, and a longer improvement on pain threshold had been observed. In addition, Ge et al[3] injected glutamate to latent MTrP of the gastrocnemius of 14 healthy individuals, and demonstrated that pain is promoted in latent MTrP injection sites more than in non-MTrP sites. In addition, muscle cramps were generated 92.8% in latent MTrP sites.

MTrP is a painful focal lesion in muscle or fascia.[4] In active MTrP, pain perseveres during movement or rest, but in latent MTrP a pressure to relevant site promotes the pain.[4] Both in active and latent MTrPs, an enhanced sensitivity of nociceptors occurs. Nociceptive sensitivity, which is expected to reduce with effective treatment, may be objectively evaluated by algometer. In literature, treatment of latent or active MTrPs, which are accompanying NCC, is shown to be treated by medications, invasive procedures, and exercises. Among these invasive procedures, both DN and local anesthetic injections are proven to be similarly effective in treatment.[5] In conclusion, DN is a practical, medication free, inexpensive method for treating NSS. Further randomized, controlled trials are needed on this topic.

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