INJECTION RULES FOR PRIMARY CARE PROVIDERS

ALWAYS:

Do the 4 E's: engage/empathy/enlist/educate

Have a clear definitive diagnoses; with an injection as only part of a holistic/comprehensive management program

Have patient point with one finger to "THE" pain

Have a clear understanding of the anatomy and anatomical landmarks

Aspirate if red/hot/ swollen: bursa/joint r/o infection/sepsis
(Liquid biopsy of the joint)

Informed consent should always be obtained for any invasive procedure. Discussion with the patient should include indications, potential risks, complications and side effects, alternatives, and potential outcomes from the injection procedure. Patients should sign documentation that informed consent for the procedure was given and understood.

NEVER:

Inject if patient less than 30yrs age/ rarely less than 40

History of acute condition less than 6-8wks (try pt)

If contraindications: absolute: infection/allergy; Achilles/patellar tendon
Relative; dm/warfarin/prosthesis

SUGGESTIONS:

avoid injecting several large joints simultaneously because of the increased risk
of hypothalamic-pituitary-adrenal suppression and other adverse effects.

It can take as long as 20 to 30 minutes following the injection forallergic/sensitive
symptoms to present. For this reason, and to monitor for allergic reactions, patients
should be observed in the office
for at least 30 minutes following the injection.

To avoid direct needle injury to articular cartilage or local nerves, attention should
be
paid to anatomic landmarks and depth of injection.

When possible, the patient should be placed in the supine position, or comfortable
position for patient and provider allowing easy access to the involved tissue. This
will help prevent or mitigate the effects of a vasovagal or syncopal episode.

To prevent complications, adhere to sterile technique for all joint injections; know
the
location of the needle and underlying anatomy; avoid neuromuscular bundles; avoid
injecting corticosteroids into the skin and subcutaneous fat; and always aspirate
before
injecting to prevent intravascular injection. The injection should flow easily and
should
not be uncomfortable to the patient. Most pain is the result of tissue stretching and
can be mitigated
by injecting slowly. If there is strong resistance while injecting, the needle may be
intramuscular, intratendinous, or up against bone or cartilage, and it should be
repositioned.

To minimize pain and inflammation after leaving the office, the
patient should be advised to apply ice to the injection site (for no longer than 15
minutes at
a time, once or twice per hour), and nonsteroidal anti-inflammatory agents may be
used, especially for the first 24 to 48 hours. The affected area should be rested from
strenuous
activity for several days after the injection

TIMING:

Allow adequate time between injections, generally a minimum of four to six weeks

NO REPEAT INJ ECTIONS IF:

if no clear improvement (relief/improvement 4-6wks) no continued inj

N0T more often than 3-4/yr