TuftsMedicine
Lowell General Hospital

Department of Family Medicine September Meeting Minutes

Date: September 11, 2026
Time: 7:00am
Facilitator: Dr. Sangita Pillai
Attendees: Dr. Cindy Cheng; Dr. Shaun Farraher; Dr. Christen Fragala; Dr. Malina Holmes; Dr. Roberto Larios; Dr. Raymond Lewis; Dr. Cara Marshall; Dr. Margaret Mills; Dr. Emelyn Molato; Dr. Patrick O'Neil; Dr. John Ragucci; Dr. Catherine Trinh; Dr. Audra Williams; Dr. Jennifer Wolf; Dr. Pratiksha Yalakkishettar; Dr. Marian Younge
Guests: Dr. Alexandra Adler; Dr. Benjamin Henkle, Spine and Pain Associates

I. Call to Order

- Dr. Pillai called the meeting to order at 7:00am.

II. Approval of Minutes

- The department approved the previous minutes of the hybrid meeting in June.

III. New Business

- Dr. Pillai discussed the Chief Election results and said that she has been voted as Chief for another two year term.
- Lassa Clinic – a free clinic that happens in the Lowell community twice a year in the Fall and Spring.
- The clinic takes place on Old Ferry Road, and they do basic screenings for patients or for anyone in the community regardless of their insurance status.
- They offer vaccinations like flu and COVID.
- Specialties are at the clinic which includes a list of endocrinology, cardiology, gastroenterology, nephrology, psychiatry, internal medicine, pediatrics, oncology, amongst other specialties present there.
- Dr. Pillai thought it would be nice to join them as there has not been much presence from the family medicine specialty.
- The next clinic is on Saturday October 17th from 8:30am-2:30pm – anyone interested in being involved can reach out to Dr. Pillai and she can let the LGH contacts know, Dr. Gunturi and Dr. Koganti.

IV. Old Business

a. Medical Executive Committee

- Gastro Health is no longer admitting patients to Lowell General Hospital or doing procedures at Lowell General Hospital.
- They are in the process of recruiting more physicians to make it more feasible to practice in the hospital.
- They are still accepting referrals, but it is something to let your patients know that if they do require any procedures, they will be done outside of our system.
- If your patient is admitted the possible, they will be treated by Integrated Gastroenterologists.
- Tufts Medical Center will be having some Gastroenterologists credentialed at Lowell to have some procedures done more locally.
- A change in Epic now distinguishes between the "attending physician of record" and the "first contact provider."
- Staff should contact the first contact provider, often an NP or resident, for immediate questions regarding admitted patients.
- The marketing team is seeking physician point people to handle media requests and provide expert perspectives on health topics so if anyone is interested in representing the Family Medicine department, please reach out.
- Dr. Gunturi has been on multiple media platforms and news stations recently.
- A mandatory Chaperone Policy is now in effect for all sensitive exams conducted within the hospital or hospital-employed locations.
- Providers are required to offer a trained chaperone for exams such as Pap smears, breast exams, and prostate exams.
- Although most patients decline these offers, staff must follow training protocols via Workday to ensure compliance.

b. Labor and Delivery Committee

- Dr. Holmes discussed a few policies being reviewed around the deliveries at Saints Campus and emphasized prenatal education and the importance of vitamin K at birth.

c. Credentials Committee

- Dr. Marshall had no new updates from the Credentials Committee meeting.

d. Morbidity and Mortality Council

- Dr. O'Neil brought up a relevant case for the outpatient setting regarding pre-surgical evaluations.
- Some discussion was had regarding EKG exams before a surgical procedure, and it was stated that any man over the age of 40 and any woman over the age of 50 should be having a pre-op EKG.

- Dr. O'Neil hopes this can be investigated further and believes if this is the case that from a family medicine standpoint, that this protocol could be reevaluated and revisited from a hospital policy standpoint.
- Dr. Pillai will bring this up at the next Medical Executive Committee meeting to see if a new policy is being made.

e. Perinatal Committee

- There were no updates for the Perinatal Committee as they meet next week.

f. MCH Updates

- No updates were given.

g. Belonging and Engagement Council

- Celebration of Hispanic Heritage Month is from September 15 to October 15 and the system-wide celebration that is being held on September 18th from noon to 1:00pm via zoom.
- Dr. Lewis encourages all to participate if your schedule allows.
- Diwali, the Festival of Lights will be happening on Friday, November 13th from 6:00-10:00pm in the Clark Auditorium.
- Registration link should have been sent to your email.

h. Family Medicine Residency Program

- Six residents have started and are rotating in outpatient rotations and inpatient rotations so far with OB.

i. Bridge Clinic

- The Trinity Pride Star EMS crew is going to be offering buprenorphine on the ambulance as a novel project
- This will be post overdose, post Narcan, and they would have the opportunity to be offered buprenorphine to start their transition onto outpatient treatment.
- This is being worked on with the Lowell General Hospital Emergency Department.
- Dr. Wiliams reminded the department that they are always available for referrals and that they have the resources to connect people for medication management.
- For substance use disorders, the clinic is seeing a lot more kratom use disorders including its derivatives, 70H and MGF15 which are derived from the kratom plant.
- Kratom is officially banned in Massachusetts, but they are still available and lot of people are struggling with them.
- It acts similar to opiates and requires the same treatment.
- If people are looking to get onto same-day access to buprenorphine, there is a low dose kit to help avoid risk for precipitated withdrawal.

- These kits are available to patients through the emergency room at either campus to get started on that.
- They are actively working on a procedure to be able to offer these kits at the Bridge Clinic instead of having to go to the emergency department.

j. Mass Medical Society

- Dr. Dulac was not at the meeting to give an update.

k. Inpatient Care Update

- There were no updates from an inpatient standpoint.

V. Lowell Pain Clinic – Pain Management Services

- Dr. Adler discussed the services offered at the Lowell Pain Clinic and what they do, which is interventional spine and non-surgical spine with an overall mission to be a full service chronic pain clinic that treats all types of pain.
- Another part of their mission is to offer truly multimodal pain treatment including medication, injection and cognitive therapies.
- To offer truly multimodal pain treatment including medication, injection and cognitive therapies.
- They currently work collaboratively with many specialties including neurology, neurosurgery, orthopedics, rheumatology, etc.
- Conditions that are treated at the clinic include: spine, facial pain, pelvic pain, chronic post-surgical pain, nerve pain, like diabetic neuropathy or CRPS, and pelvic pain.
- Dr. Henkle's background is in Physical Rehab Medicine, and he sees a lot of dystonia, spasticity.
- The clinic takes Epic referrals, and you just have to click off LSC Pain Management or referrals can be faxed.
- A pre-referral checklist was presented and states:
    1. Has the pain been present for greater than 6 weeks?
    2. Does the patient already have a pain doctor?
    3. Has the patient tried 1-2 conservative modalities?
    4. Is there a specific referral goal?
- The slides from Dr. Adler's presentation are attached at the bottom of the minutes to review more in depth scenarios.

VI. Adjournment

- The meeting adjourned at 8:05am.

Next Meeting:
Friday, October 9, 2026, at 7:00AM via Zoom

Respectfully submitted,

Maxine Miller
Medical Staff Coordinator

Approved by:

_____ _____

Sangita Pillai, MD — Date
Chief, Department of Family Medicine

TuftsMedicine

Pain Management at Lowell General Hospital

Alexandra Adler MD
Lowell Spine and Pain Associates
Assistant Professor of Anesthesiology, Tufts University School of Medicine

Benjamin Henkle MD
Lowell Spine and Pain Associates
Assistant Professor of Anesthesiology, Tufts University School of Medicine

April 2026

Mission

- To be a full-service chronic pain clinic that provides comprehensive and collaborative care for all types of pain, not just spine pain.
- To offer truly multimodal pain treatment including medication, injection and cognitive therapies.
- To support primary care physicians by managing painful conditions from the pre-diagnosis stage through treatment and recovery.
- To work collaboratively with many other specialists including neurology, neurosurgery, orthopedics, and rheumatology to help reduce patient appointment burden and costs and expedite surgical care when needed.

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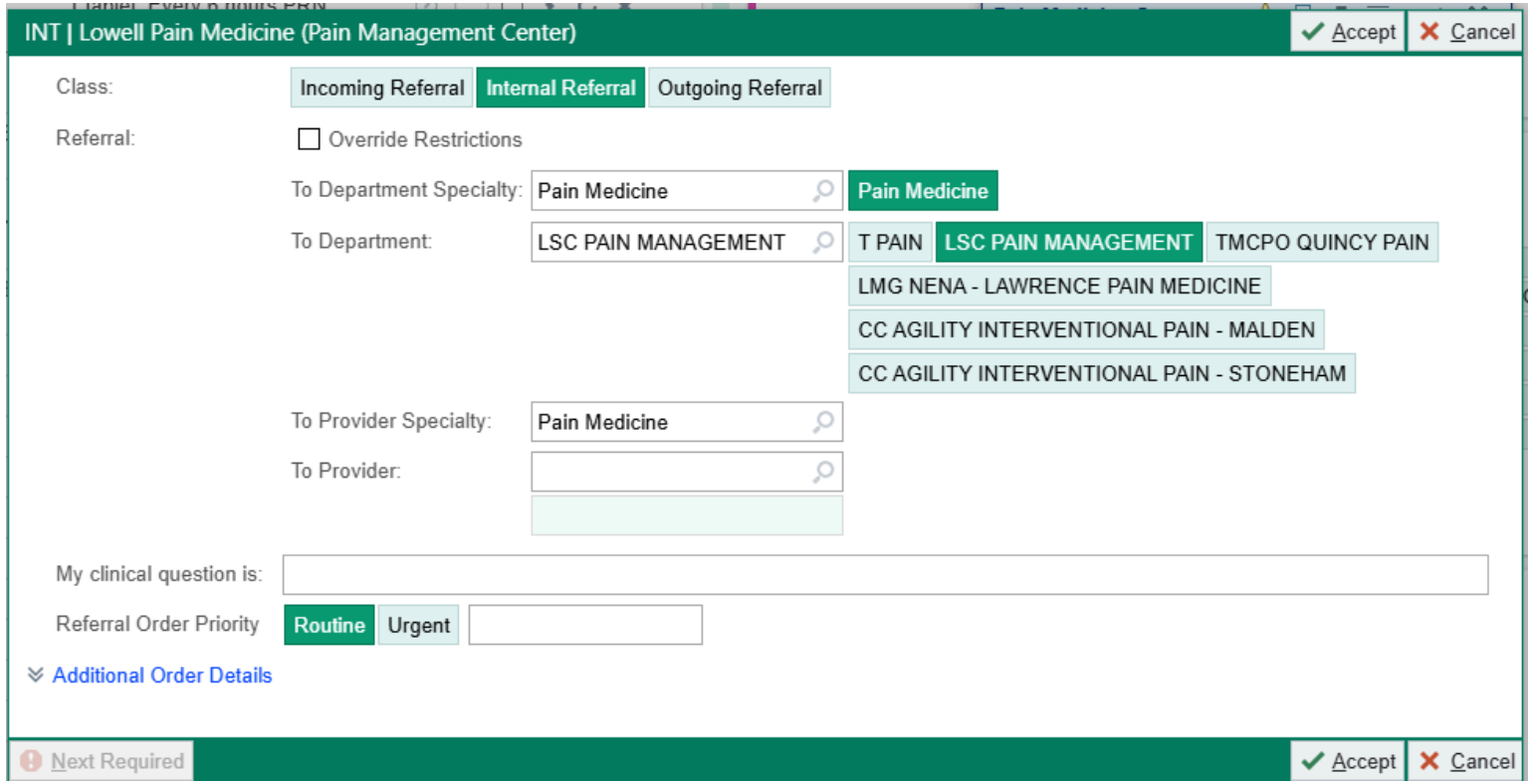
Common conditions treated

- Spine
  - Lumbar radiculopathy
  - Low back pain or lumbosacral spondylosis
  - Cervical radiculopathy, cervicalgia
  - Compression fractures
  - Post-laminectomy lumbar syndrome (“failed back”)
- Fibromyalgia
- Facial and jaw pain including TMJ
- Peripheral neuropathy and nerve pain, chronic regional pain syndrome (CRPS)
- Pelvic and abdominal pain
- Cancer pain
- Headaches, occipital neuralgia, and migraine
- Spasticity
- Dystonia
- Chronic post-surgical pain
- Central pain syndromes

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Referrals

- EPIC
- By fax 978-937-6842
- Issues or urgent situations? Tiger text me or Ben!



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Pre-referral checklist

1. **Has the pain been present > 6 weeks?**
   (unless it's sciatica or compression fracture)
2. **Does the patient already have a pain doctor?**
3. **Has the patient tried 1–2 conservative modalities?**
   (e.g., PT, NSAIDs, ice, heat, Tylenol)
4. **Is there a specific referral goal?**
   (e.g., injections, medications)

ADDITIONAL THINGS THAT HELP

Remind patient to bring imaging
if not in our system (e.g., X-ray, CT, MRI) or previous reports.

Include list of prior injections / surgeries
(as specific as possible)

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Today we'll talk about

- Back pain
  - Background
  - Common treatments
- Central pain

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Low back pain is a symptom, not a disease

Table 2: Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients[a]

Imaging Finding	Age (yr)						
	20	30	40	50	60	70	80
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height loss	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

[a] Prevalence rates estimated with a generalized linear mixed-effects model for the age-specific prevalence estimate (binomial outcome) clustering on study and adjusting for the midpoint of each reported age interval of the study.

Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations

W. Brinjikji, P.H. Luetmer, B. Comstock, B.W. Bresnahan, L.E. Chen, R.A. Deyo, S. Halabi, J.A. Turner, A.L. Avins, K. James, J.T. Wald, D.F. Kallmes and J.G. Jarvik
American Journal of Neuroradiology April 2015, 36 (4) 811-816; DOI: https://doi.org/10.3174/ajnr.A4173

"Many imaging-based degenerative features are likely part of normal aging and unassociated with pain. These imaging findings must be interpreted in the context of the patient's clinical condition."

If you take 100 70-year-olds with no back pain, 69% will have facet joint degeneration.

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“I’m here because I have arthritis of my spine”

- There is some correlation between arthritis of large joints (hip, knee, shoulder) and pain
- We should not assume that it’s the same for the spine
- The type of arthritis does matter
- When researchers looked at middle-aged patients without back pain and got MRI’s, about 50% of patients had arthritis on the MRI

Osteoarthritis	Segmental level								
	L3-4			L4-5			L5-S1		OR (95% CI)
	Pain	No pain	OR (95% CI)	Pain	No pain	OR (95% CI)	Pain	No pain	
Grade 1-3	110	88	1.7	155	148	1.5	160	157	0.5

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How do we diagnose “low back pain”

- Take a good history (20+ minutes)
  - Is it acute (<1 mo), subacute (1-6 mo) or chronic (>6 mo)?
  - Back pain is a symptom not a disease
  - Not all back pain comes from the spine
  - Patients know their bodies, but often we do not listen
- Perform a physical exam
- Consider how imaging fits into the overall picture and whether the imaging obtained makes sense for the symptoms
- Educate patients about imaging findings
- Only once you understand the whole picture can you start treatment
- The holy grail would be to have imaging findings to identify low back pain

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Are epidural steroid injections for low back pain?

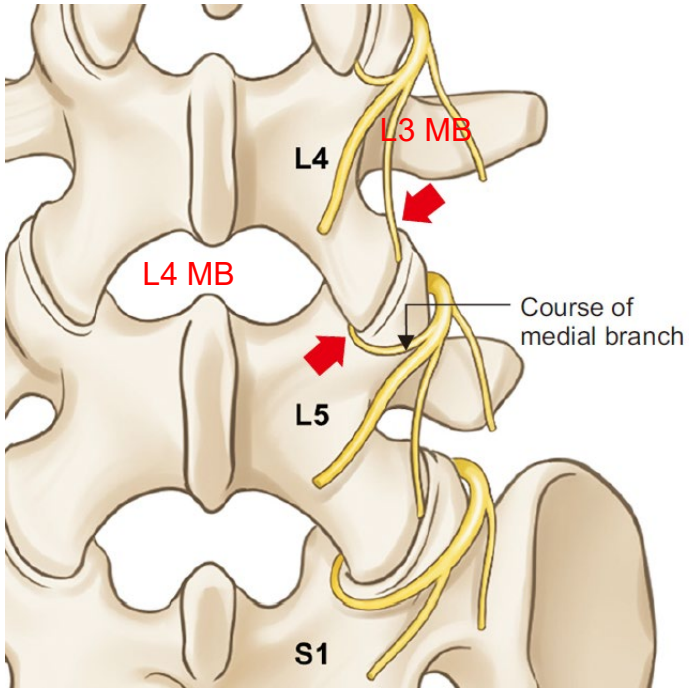
- No (about 95% of the time)
- And before we think about injections, we need to utilize conservative therapies emphasizing MOVEMENT.

Does the patient need an MRI before being referred?

- NO!
- Acute back pain will often get better with conservative care however we are happy to see sciatica more acutely to facilitate a patient's ability to return to work or daily activities.

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Interventional treatment for low back pain: lumbar facet joint-mediated pain



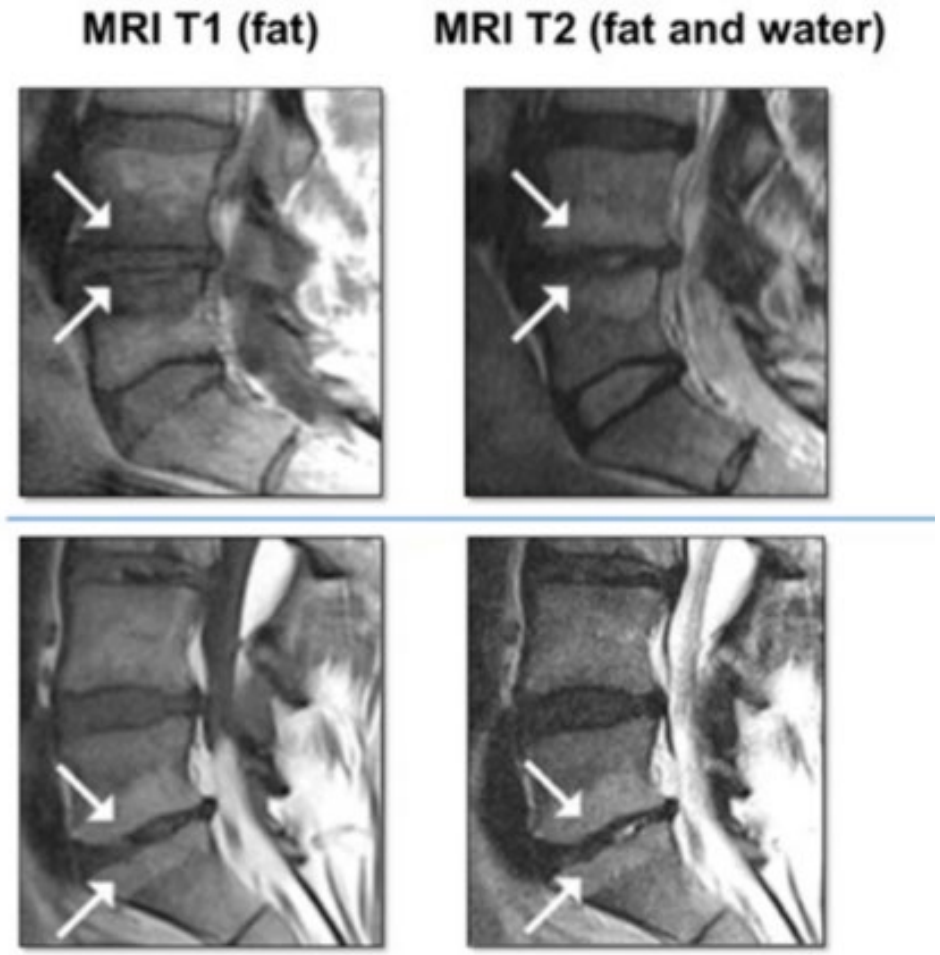
- Each facet joint is innervated by two medial branch nerves
- For the L4-5 joint, for example, you block the L3 and L4 nerves
- We do “dual diagnostic” blocks, we hope to predict whether radiofrequency ablation (RF, a low-risk procedure) using a heated needle will treat pain

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Image: https://anesth-pain-med.org/journal/view.php?number=974&viewtype=pubreader#!po=5.00000

Interventional treatment for low back pain: basivertebral nerve ablation (BVN) - Intracept

- Chronic low back pain last >6 months
- Tends to be midline, deep/aching/burning worse with bending forward and varying in intensity, reproduced by flexion. It is partially ”defined” by the presence of modic changes.
- Pain localized to the midline back causing significant functional impairment
- Need to exclude other pain generators like spinal stenosis or prior fusion surgery

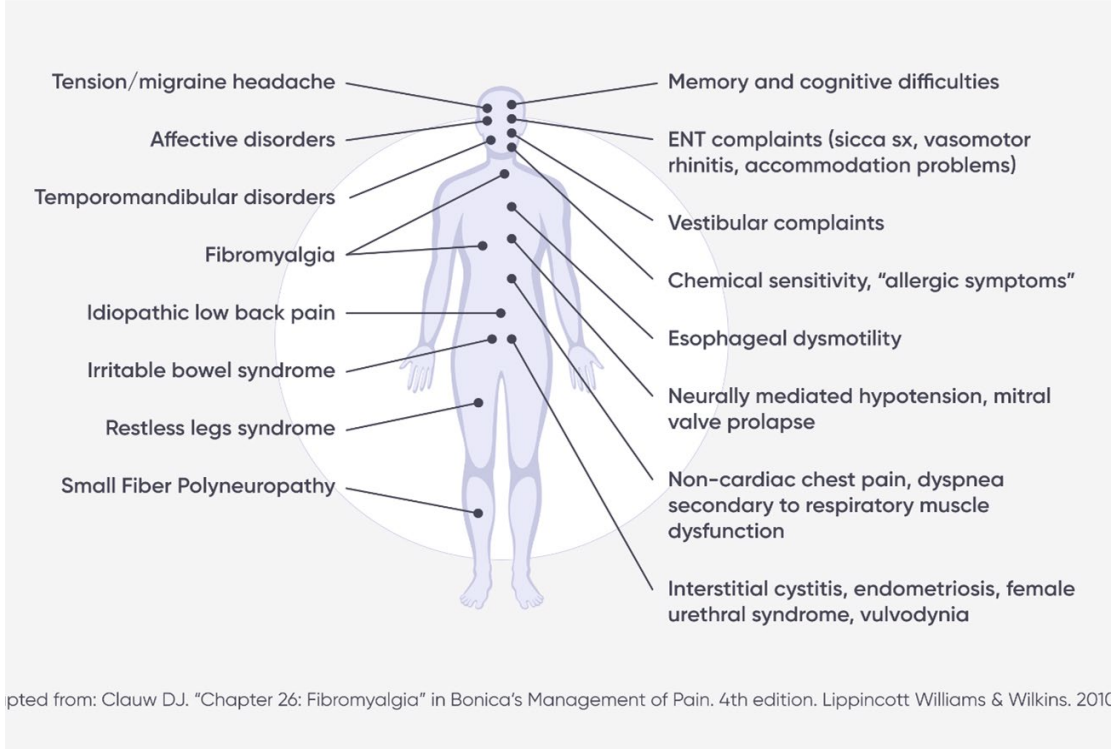


Sayed D 2022
Mok 2016

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Low back pain is a symptom, not a disease … maybe we should treat it that way

- Pain reprocessing therapy (PRT) is a behavioral treatment that relies on neuroplasticity to help patients reconceptualize their chronic back pain as a signal from the central nervous system that is not dangerous
- Virtual work with a pain coach and the pain center to learn techniques to quiet the pain response and build new habits to support pain recovery
- Covered by most insurances
- Program started 2023, most referred patients happily participate

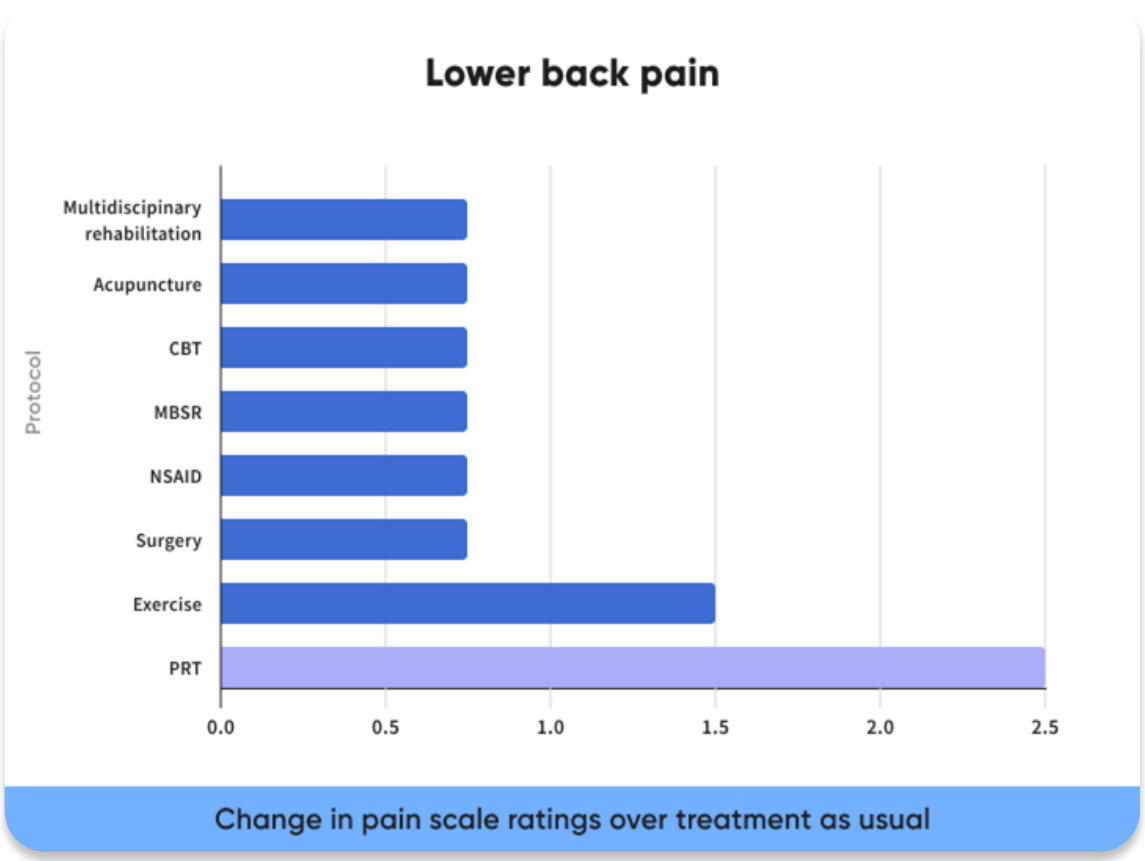


ıpted from: Clauw DJ. "Chapter 26: Fibromyalgia" in Bonica's Management of Pain. 4th edition. Lippincott Williams & Wilkins. 201

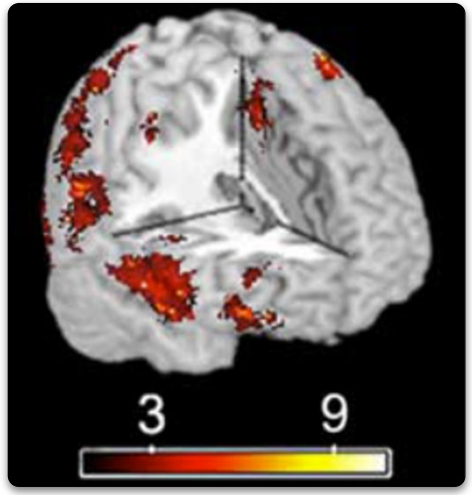
Ashar Y 2022

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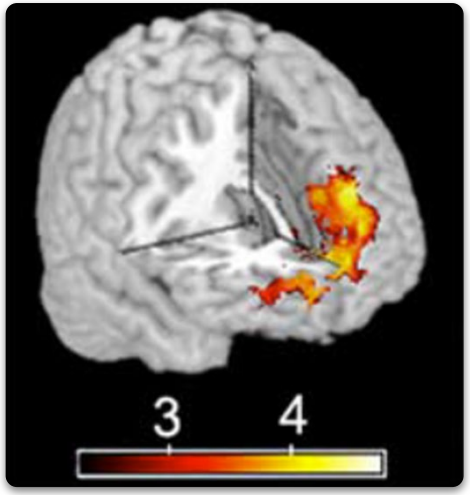
Treatment of central pain/primary pain syndromes



ACUTE PAIN
Sensory processing regions



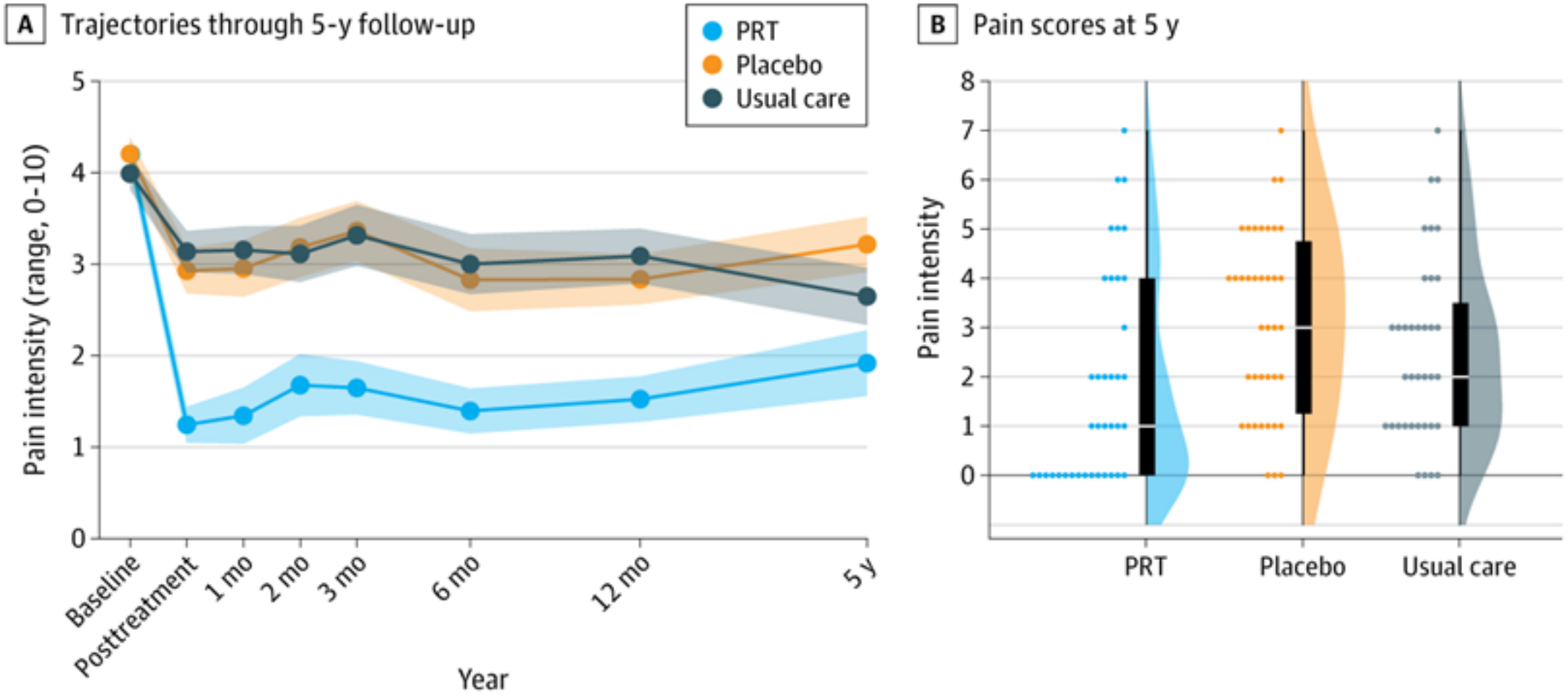
CHRONIC PAIN
Learning-memory regions



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Low back pain is a symptom, not a disease

- 113/151 patients provided 5-year follow up



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Ashar Y 2025

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Thank you!

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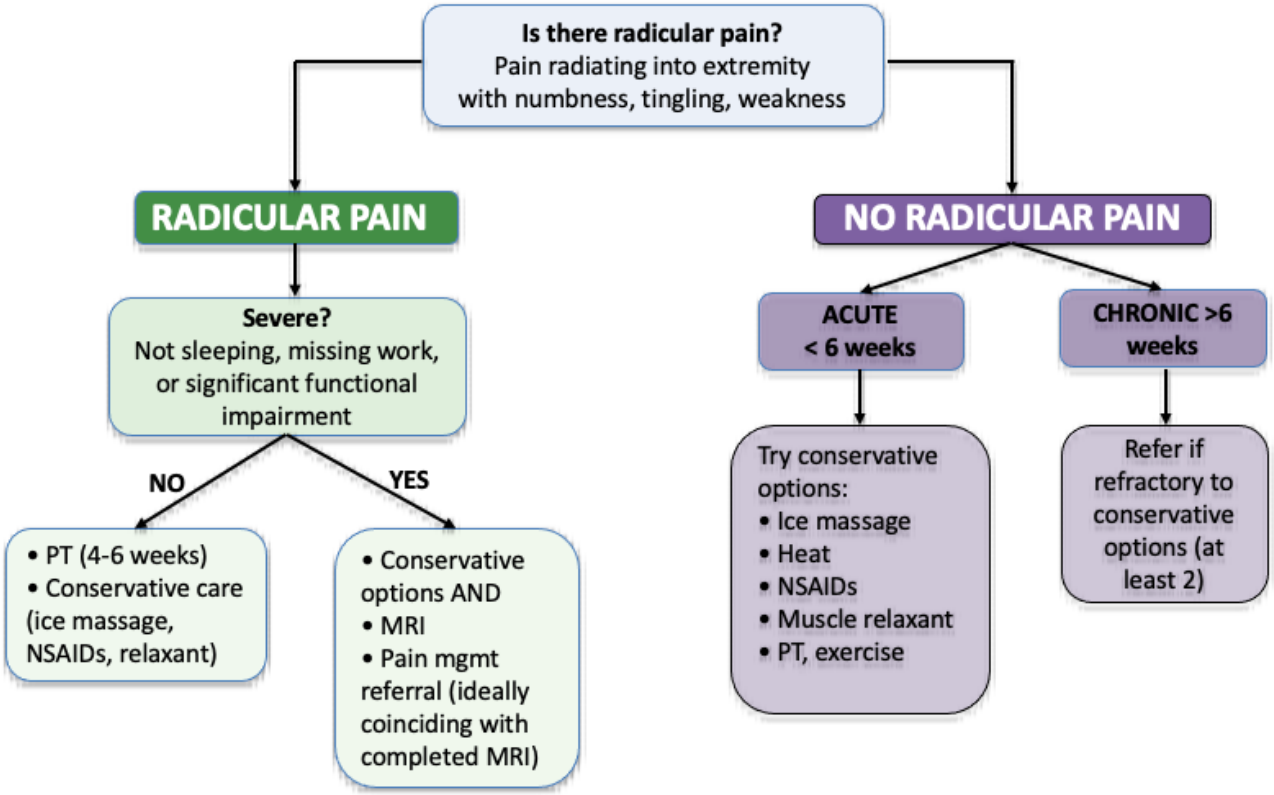
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BACK + NECK PAIN REFERRAL PATHWAY FOR PCPs



PLEASE NOTE BEFORE REFERRING

Check if patient has a current pain doctor
If so, refer only if for second opinion.

Is there a specific referral goal?
(e.g., injections, medications)

Remind patient to bring outside imaging
Discs are preferred (e.g., X-ray, CT, MRI)

Include list of prior injections / surgeries
(as specific as possible)