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Review Article

Why Not Relief?

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The field of pain management is currently a battleground on several fronts, with controversies virtually at every aspect of the subject and lack of education and misconception at the center of the fight. It has been shown that the number of patients suffering with psychosomatic chronic pain are 2% or less. Similarly, it was also shown that the risk of true addiction in chronic pain patients was approximately 0.3%. Accurate anatomical diagnosis can be provided in only 15% of the patients utilizing traditional medical technology. The question of, "Why not relief?" should be raised in our society on a daily basis. It is imperative to understand the true nature of pain by separating the myth of psychological pain from the reality of organic pain and manage it appropriately utilizing all available means, not only narcotics and interventional technology, but also behavioral therapy.
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The field of pain management is currently a battleground on several fronts. At virtually every aspect of the subject, there is controversy, controversy rooted in misconception, misinformation and the unknown. In order to place the issues in perspective, it is necessary to review the recent history of pain management and present knowledge available, and contrast it with prevailing myth.

Until recently and only in certain institutions, medical education historically has not accorded much instructional time or emphasis to the subject of pain or the related topics of pain management. Indeed, a bias often exists in academic medicine toward aggressive disease treatment to the exclusion of palliative or symptom management (1). Therefor, the profession generally has proceeded from assumptions only marginally better informed than those of the general public.

Furthermore, it has been shown that peer pressure within the profession from the less informed is capable of adversely influencing the prescribing of the better informed. This phenomenon has prompted the question: "When will pain treatment be the norm?" (2).

Exacerbating the fundamental misinformation and peer pressure is the effect of the regulation by various state and federal agencies (3, 4), which have been--historically and, in some cases, still are--unable to distinguish between the self-destructive drug-seeking lifestyle of the addict and the productive and responsible life of the legitimate pain patient consuming the same or greater doses of narcotics. The list of physicians professionally martyrized for rational narcotic prescribing is long and, unfortunately, still growing (5).

The depth of misconception in this connection is reflected in the fact that the pioneers in seeking to reverse such destructive policy were those attempting to relieve the pain of terminal cancer. In contrast, experience has shown that when very large doses of narcotics were given to patients with bona fide pain, they became more functional and productive, and did not become dysfunctional drug-seekers (6). In fact, Portenoy and Payne (7) reviewed 25,000 pain patients treated with narcotics and found only seven true instances of addictive lifestyle with the risk of true addiction in 0.3% of the population suffering with chronic pain of non-malignant origin. Nonetheless, the perception remains that cancer pain--not chronic pain resulting from other disorders-- is the only pain to be treated with narcot-

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ics because the patient is dying and addiction is therefore acceptable. With the available information, it is quite apparent that pain management continues to be very much out of step with the powers-that-be who are guided by the controversial but conventional wisdom of the past. Accordingly, many publications appeared in the medical literature in the early 1990's on this topic. A few states enacted legislation encouraging adequate narcotic use, but it remains risky to one's professional well-being to prescribe according to one's conscience (8).

Another front in the battle for adequate recognition of pain is the perception that chronic non-malignant pain, especially myofascial and neuropathic pain resulting from injury, is either extensively affected by psychological considerations or somehow not worthy of the full attention of the medical profession of pain management (9). It is this attitude that probably underlies the lingering objections to adequate pain management of these problems. It is interesting to note that these types of perceptions are not limited to narcotic usage only. In fact, some investigators have attempted to identify and correlate the outcomes of facet joint injections in the lumbar spine and concluded that the outcome depended on the patients biopsychosocial ability of self-facilitated improvement, suggesting that somatic treatment does not work in the presence of persistent high levels of inappropriate behavior (10, 11). However, Wallis et al (12) questioned the extraordinary attention focused on psychological status. They (12) studied the role of cervical facet denervation and reported that the pain relief achieved following radiofrequency facet denervation not only returned these patients to work but also resolved all of their psychological problems.

There is no objective "pain meter" to demonstrate and measure pain reliably. Because pain cannot be proven to others, sometimes the chronic pain patient typically lives in a private, portable hell of false accusation from virtually every corner. Even well-meaning family members occasionally suspect that, "It's all in his/her head," or "He/she has a low pain threshold," or "They're just trying to get out of the housework/yard-work/work/etc." However, those with less well-meaning vested interests, including insurers and managed care organizations, assume that the pain, patient's life and, at times, the physician who's treating these patients, is filled with attorneys and paperwork. Not surprisingly, these patients embark upon a merry-go-round of referrals--extensive, and expensive and, at times, redundant evaluations, rarely with any relief. A British study has showed that many back pain patients simply give up doctor visits despite suffering (13). It has been observed that, "Managed care views pain as a big black hole into which they keep dumping money" (14).

This factor is especially tragic in that pain management, both by behavioral and interventional means, is emerging from the dark ages into a Renaissance. It is emerging with specialists from various walks, including anesthesiologists, physiatrists, and neurologists and others devoting their specialization to pain management and utilizing cutting-edge technology, armed with the most up-to-date knowledge. Sadly, but certainly, the need for such services always existed. However, the "utilization review," based upon arbitrary and uninformed so-called "guidelines" has been used by many insurers--including the Health Care Financing Administration, at times--to discourage the use of safe, available, non-narcotic means of pain relief. It is a well-known fact that most interventional pain management procedures involve the insertion of one of more needles, which, in the general population is one of the more feared forms of pain in itself. It would thus appear that it is rather far-fetched to suggest that patients would repeatedly submit to such procedures unless they were both absolutely necessary and substantially effective, thereby, once again, proving that the concept of biopsychosocial facilitation is not only invalid but also irrelevant.

So how does one become convinced of the reality of another's pain? One way is by experience with large numbers of pain patients. The collective experience of many pain practitioners makes clear that the patient's own report of pain is to be believed yet another declaration of conflict with the existing medical mentality. Hendler et al (15), to whom a number of suspected "psychosomatic" cases have been referred, found an organic origin of the pain in 98% of these cases. Hendler and Kolodny (16) also estimated that the true incidence of psychogenic pain occurs in 1 of every 3,000 pain patients.

Why is pain management so at odds with general perception? To be blunt, a deficiency exists in the usual state of the art of physical diagnosis, as do specific gaps in the technology of diagnostic devices. In physical diagnosis, a "trigger point" is a palpable tender soft tissue nodule in musculotendinous structures and a marker for muscle spasm, which in turn is evidence of muscle, tendon and/or nerve abnormality (17). It has been emphasized that in order to find a trigger point, one must know how and where to find it and then actually look for it (18). However, the present system of medical education is too busy to teach symptom technology in the management of chronic pain (19, 20). Furthermore, the injection of trigger points with

local anesthetic is capable at times of "miraculous" relief of "psychosomatic" complaints. Even if this relief is only temporary, it is an eye-opening experience for patient and physician. But "temporary" can mean several days or weeks, and there is a chance that the pain will stay away indefinitely.

Despite the prevalence of chronic pain and its afflictions on the human race, its pathophysiology remains poorly understood, both in the presence and absence of structural pathology (21-25). It is a well-known but little utilized fact that clinical features, neurophysiologic studies and advanced imaging do not permit the accurate diagnosis of the causation of spinal pain in approximately 85% of the patients in the absence of disc herniation and neurological deficit (21-25). However, by utilizing neural blockade for diagnosis with precision diagnostic blocks in cases where there is a lack of definitive diagnostic, radiologic or electrophysiologic criteria, an examiner can identify the source of pain in the majority of patients, thus reducing the proportion of patients who cannot be given a definite diagnosis from 85% to 15%-35%. In addition, problems with traditional evaluation of pain patients with imaging and neurophysiological evaluation is met with a multitude of deficiencies. The electromyogram (EMG) and nerve conduction velocity study (NCV), which are commonly obtained in chronic pain patients, yield equivocal results. These procedures are capable of identifying nerve abnormalities in the larger motor fibers, which are the most resistant to the adverse effect of compression by other structures, or irritation by biochemical exudates. These conventional investigations and resultant findings often label chronic pain patients as malingerers or somatizers. However, it is well known that sensory fibers, which carry pain, are much more susceptible to compression-irritation than motor fibers and are not adequately measured by these devices (26, 27). Unfortunately, the same is true for imaging procedures. X-ray, computerized tomography (CT), and magnetic resonance imaging (MRI) search for visible encroachment of disc, joint or other spinal structure upon nerve. The problem here is twofold. First, the degree of encroachment often does not correlate with the degree of pain – visible abnormalities exist without pain, and vice versa (28). Second, Rowlingson and others have studied the effect of enzyme exudation (phospholipase A2) from the injured but visually intact intervertebral disc, which can irritate the nerve without compression, the so-called "Sick Disc Syndrome" (29).

This is not to discount the value of behavioral therapy. The need for psychiatric and psychological consultation is often quite valid, but not for the reason usually assumed. Chronic pain is a destructive force in the central nervous system. Through sleep deprivation, it can cause biochemical disorder in brain function, leading to depression and maladaptive or even self-destructive activity (30). Counseling may well be in order. Training sessions in coping with and working around the limitations imposed by pain in activities of daily living can surely be helpful. Biofeedback, hypnosis and self-hypnosis are not to be scoffed at.

Why is it so difficult to get across the simple notion that, despite all the coping and managing, pain must also be relieved?

Goldstein (31) has answered this question by presenting three quotations:

1. Pierre Pochet said: "Louis Pasteur's theory of germs is a ridiculous fiction. How do you think that these germs in the air can be numerous enough to develop into all these organic infusions? If that were true, they would be numerous enough to form a thick fog, as dense as iron."

2. Lord Kelvin said: "X-rays are a hoax."

3. E. Shorter, in 1995, said: "In every large community there will be found at least one physician willing to play up to his patients' psychological need for organicity. Thus, do the caregivers themselves contribute to their patients' somatic fixations, plunging youthful and productive individuals into careers of disability."

Three ideas whose times have come...and gone, though one of them is apparently still making policy.

The ongoing national debate on the subject of assisted suicide amply underscores the gravity of this issue. The U.S. Supreme Court, in its decision on assisted suicide, specifically addressed the problem of untreated pain and, in effect, declared that it is public policy to take pain seriously (32).

CONCLUSION

In spite of the devastating and widespread nature of chronic pain, its management is currently a battleground

on several fronts. However, many of the controversies are the result of misconception and the lack of adequate education in the phenomenon of pain and its management. The deleterious results of inadequate pain management are well known. While biopsychosocial approach has a role in pain management, it has been overstated. Proper pain relief with interventional pain management technology or appropriate management with narcotics is essential for the future of appropriate pain management.

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