IN RESPONSE

Psych Assessment of the Chronic Pain Patient: Cannot Afford to Live Without vs Cannot Afford

I doubt there is a physician involved in the treatment of chronic pain patients who would disagree with many of the holistic thoughts expressed in Dr. James Thompson's letter to the editor. I would like to respond to of a couple of his statements.

Certainly we have all come to accept as fact that current radiological and H&P techniques fail to correctly identify pain generators in up to 80% of patients. This is a limitation of these techniques, not a declaration of the psychologically controlled basis of pain. With regard to chronic pain, we have emerged from the primordial soup, but are only now crawling out from under the rock. We need better non-invasive tools for identifying pain generators accurately and efficiently, and then similarly effective and specific curative treatments.

Numerous studies have established the prevalence and significance of depression, anxiety, poor coping and personality disorders in the chronic pain population. The failure to recognize and deal with such components when appropriate can lead to failure to reach physical and vocational treatment goals. While all of us would prefer multidisciplinary approaches to the chronic pain patient, many such clinics have failed financially. Further, studies also demonstrate that when pain is resolved with medical treatment, psychological measures return to the norm of the population in general. Dr. Thompson correctly sighted several studies demonstrating that psychologically inclusive chronic pain programs have fairly good initial benefits. However, this is not observed in day-to-day practice, and not accepted universally.

Dr. Thompson commented on the psychological assessment of patients facing possible implantation. While the assessment tool may help the interventionalist decide who may not respond well to implantation of a neurostimulators, the real value of the evaluation may lie in identifying psycho-behavioral co-treatment or pretreatment. However, the referral of every pain patient to a clinical psychologist is not necessary. It's also not necessary for every psychological evaluation or testing to be performed by a licensed psychologist. All healthcare providers must understand that. The already financially strapped patient cannot afford or may not be willing to pay for such evaluations and treatment. If our society is telling us that it is unwilling to afford psychological evaluation and treatment even in the obviously indicated cases, we cannot expect them to willingly pay for every pain patient to be so cared for.

Interventional pain physicians have been challenged numerous times on reimbursement issue. We have had to prove with clinical evidence the efficacy and cost efficacy of our diagnostic and therapeutic procedures. I do believe in the necessity of psych assessment and cognitive-behavioral therapies for some of my patients. The burden of proof of the efficacy and cost efficacy does not lie with the interventionalist, rather with the pain psychologist. Psychologists should bring forth controlled randomized studies with favorable long-term outcomes that stand up to rigorous peer review, for the insurers to be convinced of the cost efficacy paying for such services, rather than criticizing interventions.

The family practitioner (FP) must screen respiratory illness, pregnancies and cardiovascular disease in their patients. The FP cares for the routine cases appropriately. The FP refers to the pulmonologist, obstetrician or cardiologist the severe or complicated cases. In the same fashion, the interventional pain physician evaluates the patient. If he has reasonable suspicion there is a pathophysiologic pain generator, he pursues the differential diagnosis with appropriate invasive tests. Over 80% of the time he diagnoses the pain generator. If the resultant treatment is successful in resolving the pain and the psychosocial fallout of the pain also resolve, then no further intervention is needed. Often the physician does identify that a patient has symptom magnification or serious psycho-social issues that unaddressed will retard or complicate any physical treatment plan. In such cases referral to a clinical psychologist specializing in chronic pain is appropriate. One should not belittle the efforts of solo pain physicians to holistically treat the patient because he is not a professional Psychologist any more than we should criticize the FP for providing primary care to patients with respiratory, OB-Gyn or cardiac problems.

Not all anesthesiologists or physiatrists are effective in providing interventional pain services. The same is true with clinical psychologists. Much time and money may be wasted before a psychologist concentrates on effective pain treatments, rather than ongoing general passive counseling or wasteful modalities. Psychologists who have a specialization in chronic pain are typically more effective and efficient.

Until the economics favor multidisciplinary private practices, interventional pain physicians will have to rely on their clinical impressions of psychological factors whether measured or by educated impression, not "hunch," and rely on referral to psychologists when indications exist and finances allow.

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