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Current Concepts in Physiatric Pain Management

Chronic Pain: Cure It First, Treat It Second

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With back pain burning into his big toe, which was worse when standing and walking, the elderly patient had failed to respond to numerous spinal injections and 2 operations for lumbar stenosis. Despite taking high-dose opioids, the pain woke him up from his sleep, and now he stumbled a lot, curtailed his work, and was seen by his family as being increasingly moody and forgetful. His pain specialist suggested an implant. Except....

Except that his family insisted on a second opinion. By a physiatrist. Who actually examined him. The patient had a tender sacroiliac joint and a purple toe. The new suspicions were confirmed with a diagnostic injection and a positive toe-brachial index. With appropriate treatment for true arterial claudication, the pain disappeared, the opioids were tapered, and the patient became perfectly functional and happy.

It's wrong to treat chronic pain when a cure is possible, yet this happens all the time. Why? And what should be done?

Decades of global efforts to improve the treatment of pain have had unintended consequences in which treatment of pain precedes treatment of the disease that caused the pain. For example:

- In response to a campaign to recognize pain as a "fifth vital sign," the Joint Commission requires that nurses document pain and create plans for pain remediation. The plan that is most easily is executed before the end of shift is not "call the doctor to make a diagnosis" but rather "pass a pill," and thus we often find miserable, sedated patients with treatable musculoskeletal conditions on medical wards.
- Oncologists who recognize that it is cruel to undertreat pain in terminal patients have become quite sophisticated in opioid prescription. They have little training in diagnosing the treatable musculoskeletal disorders that might be causing the pain, and they have difficulty shifting paradigms away from palliative management even when a long-term survivor's work or lifestyle requires that their mind be clear of opioids. As a result, we frequently see escalating opioid doses instead of a cure on the cancer service.
- The rising number of pain clinics in our specialty and in anesthesiology adds to the confusion. Both patients and referral sources reasonably assume that these clinics make a diagnosis before providing treatment. However, too many are staffed by physiatrists whose practice model is based on fluoroscopy suite throughput or by anesthesiologists who have inadequate musculoskeletal training. Patients with obvious missed musculoskeletal diagnoses get repeated injections that fail to alleviate the pain, which are usually documented in a stereotyped electronic medical record that shows little introspection or insight into the failed treatment.

Finally, physicians who are trying to do everything right can fall into the trap of assuming that nothing has changed with a patient they have been managing for some time. For example, a patient with clearly documented disk herniation whose "radiating" pain never goes away may actually have recovered from the herniation and now may be experiencing a secondary hip trochanter pain syndrome; a person subjected to multiple steroid doses might experience avascular necrosis; and a patient with chronic pain who underwent yet another surgical procedure might actually have a new hardware problem.

We recognize that a cure is not generally at hand for chronically disabled patients with pain. We also know that the most effective treatments for chronic pain usually have little to do with the anatomic diagnosis. However, it is wrong not to competently seek out those odd and meaningful diagnoses before proceeding under the assumption that pain, not disease, is the target.

What is to be done?

First, guidelines for pain management should be amended to require an initial step: the duty to seek a cure. Pain management strategies should only be applied when pain cure strategies are not appropriate.

Second, a physician who limits his or her practice to the management of pain without taking responsibility

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for seeking a cure is not the appropriate entry point for patients seeking management of chronic pain. Only patients whose pain cannot be cured by an expert competent in diagnosing the underlying disease should be seen in these types of pain clinics. Although physiatrists are often the best answer for musculoskeletal diagnosis, we need to recognize the special competencies of some neurologists for headache, gynecologists for pelvic pain, rheumatologists for generalized pain, dentists for orofacial pain, oncologists for cancer-related pain, and others.

Third, experts who diagnose and treat chronic pain syndromes need to increase their diligence and competency in seeking different or obscure diagnoses. For example, the examination of all patients with chronic back pain should include the mantra of "poke the troch, smack the sacroiliac, whip the hip, and upset the facet," no matter what the spine magnetic resonance imaging scan or electromyography shows. Radiating pain may be fibular neuropathy, polyneuropathy, a bunion, sclerotomal, or more central than the spine until proven otherwise. When presented with a "chronic crazy" patient with pain, the clinician needs to consider a long list of obscure diseases ranging from porphyria to lupus to polymyositis to somatization disorders that can affect both the body and brain. Not all diagnostic possibilities need to be exhausted, but they need to be considered.

Chronic pain is devastating. We must recognize that almost all the proven treatments for the pain itself are only partially effective, and thus the benefit-to-cost ratio for seeking a cure first is high. Treatment of chronic pain must be preceded by expert diagnostic assessment of treatable pathophysiology.

Disclosure

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