"All types of pain in all parts of the world are inadequately treated.." C. S. Hill MD ([i]), stated in 1995.

It seems scarcely believable that as we enter the new Millennium, and with all the vast array of medical technology at our finger-tips, we have yet to conquer one of mankind's worst enemies, that fights a war of attrition: PAIN.

Albert Schweitzer said

"Pain is a more terrible lord of mankind than even death."

We seek relief from diverse sources from poppies to sea-snails: we even use poisons in our endeavour to unshackle sufferers from their pain chains.

So how is it that a survey in 1999 ([ii]) found that more than four out of every ten people in America with moderate to severe chronic pain have yet to find adequate relief?

"Many Americans with chronic pain are suffering too much for too long and need more aggressive treatment"([iii])

is the opinion of Dr. Russell Portenoy, president of the American Pain Society and the American Academy of Pain Medicine.

He maintains that

"Pain that persists and impairs a person's ability to be productive and enjoy life often requires evaluation and treatment by a team of health professional who specialise in pain."

However, he has also said that

"The vast majority of patients with chronic pain never see pain specialists."([iv])

Dr. Phillip Bridenbaugh, a Professor of anaesthesia, commented at an American Medical Association (AMA) media briefing in 1997 that there are problems relating to the patient, the health professionals and to the health system.

He went on to state that the commonest problems for patients are:

- **Reluctance to take medication for fear of addiction and/or uncontrollable side-effects**
- **Reluctance to report pain due to concern about not being a "good" patient or due to not wanting to confront the issue that pain might mean a worsening condition.**

This tallies with the Roper study findings in which over a quarter of the sufferers waited for at least six months before consulting a doctor for relief of their pain.

This was construed as being due to under-estimating the seriousness of it and thinking that they could "tough it out."

Dr. Bridenbaugh suggested that there are three major concerns as regards health professionals:

- **Poor assessment of pain**
- **Fear of patient addiction**
- **Inadequate knowledge of pain management.**

Again, this was confirmed in the Roper study which reported that chronic pain sufferers are having difficulty in finding doctors who can treat their pain effectively. This has resulted in patients changing doctors, usually for one or more of the following reasons:

- **Doctor not taking their pain seriously enough**
- **Doctor's unwillingness to treat pain aggressively**
- **Doctor's lack of knowledge about pain management**
- **Persistent pain**

In the group who had severe pain the majority had changed doctors at least once and some had done so three or more times: usually because of unrelieved pain as the primary reason.

The health care system was the third area of concern mentioned by Dr. Bridenbaugh: he cited financial concerns and a lack of priority given to research on pain relief.

Pain is, of course, an invisible problem and thus very difficult to assess.

Dr. Rose Dobson of the Mayo Clinic, a specialist in pain management, says that

"there are challenges in measuring pain reduction because pain is subjective."

"...The face of the patient with chronic pain, shows very few signs of distress.

Autonomic signs (sweating, pallor, tachycardia, hypertension) are absent.

Often the suffering is hidden beneath a brave, stoic face.

After long periods of unrelieved pain, the face no longer reveals anxiety but exhaustion and depression.

The lack of objective signs and the depressed sleepy face are often misinterpreted and the patients complaints of severe pain discounted.

Facial grimacing (which is present during acute pain) cannot be used as an indicator of pain intensity."([v])

This can lead to doctors under-estimating the amount of pain the patient is experiencing.

Dr. Portenoy suggests that

"Doctors aren't trained to assess subjective complaints like pain. We like to look at X-rays and lab values and see numbers and view them as objective evidence. We're uncomfortable with the subjective." (iv)

The Roper study found that the quality of life improved significantly among those who had their pain under control. There was also a positive improvement in their emotional well-being.

They concluded, unsurprisingly, that very severe pain has a major negative impact on the quality of life.

Sufferers of severe pain in the Roper study were found to have had "a significant number of past year occurrence that required emergency room visits, hospitalisation or counseling for relief of their pain."

One of the main areas of concern in pain management has always been the risk of addiction to narcotic drugs. Some of the points already mentioned are a factor in raising suspicion that a patient has developed an addiction:

- **Changing doctors**
- **Repeated emergency room attendance**
- **Lack of visible signs of pain-related distress**
- **Doctors' lack of knowledge about pain management**

The last point in particular bears further discussion:

Oscar London MD, wrote recently in his article "Here's to a Painless New Year"([vi]):

"Like so many doctors, I've been reluctant to prescribe high-dose narcotics for severe, chronic pain. This reluctance is out of fear of my being relieved of my medical license, at the expense of my patients being relieved of their pain."

He goes on to cite Dr. James Cleary of the University of Wisconsin, a cancer pain specialist, who points out that less than 0.1% of people

"treated in a proper medical setting with no history of previous abuse run into problems with addiction."

Dr. London clearly states that

"Addiction doesn't come from using narcotic for physical pain; it comes from using narcotics for psychic pain. We are shamefully depriving our patients with great physical pain of the only thing that works: opioids."

Dr. Harvey L. Rose of Carmichael, California, believes that there is "more suffering from taking too little pain medication than from taking too much."

This viewpoint is echoed by Dr. Russell Portenoy: his points are outlined in an article "Opioids in Chronic Non-malignant Pain" by Eugene A. Conrad PhD([vii])

He proposes reappraising the traditional prescribing of opioid drugs.

The five main problems perceived by clinicians are:

- **Addiction potential**
- **Frequent side-effects**
- **Tolerance with long-term use**
- **Many non-responsive pains**
- **Chronic therapy contributes to disability."**

Epidemiological studies show a low risk of addiction to opioids (if there is no history of substance abuse).

Dr. Richard Patt of the M. D. Anderson Cancer Center of Houston says([viii]),

"When addicts use drugs, they become less functional, more isolated, and they move away from the mainstream. When pain patients use drugs, they become more

functional, much less isolated, and they move toward the mainstream";

(in other words, they get their life back!)

Dr. Patt goes on to say that if they no longer need the medication they tend not to experience problems weaning off it gradually.

Side-effects occur frequently but none of these cause serious organ damage:
(Dr. London (vi) compares this with NSAIDS (anti-inflammatory drugs) which are in widespread use but can cause serious deleterious effects in the gut, liver and kidneys.)

Portenoy maintains that therapeutic resistance is not a feature of opioid treatment and that the need for escalating doses is not generally seen.

Studies such as that done by Schofferman ([ix]) show that the

"perceived risks of tolerance, systemic toxicity, addiction, and sanctions"

are not borne out by results seen in patients using long-term opiate medication.

Various studies support the use of long-term opiates for non-malignant pain.

At one time, it was thought that neuropathic pain was unresponsive to opiates, whereas nowadays, it is recognised that at higher doses, opiates may be effective.

The notion that chronic opioid therapy is disabling is not of major concern provided that

the physician keeps a careful check on pain levels, side-effects and signs of any drug-related aberrant behaviour.

MISDIAGNOSIS

One of the problem areas for chronic pain patients is that they may not be correctly diagnosed. In fact, a significant number may be misdiagnosed with a psychological disorder.

The Mensana study ([x]) found, however, that chronic pain patients do tend to have underlying organic pathology.

However sophisticated tests have become, they do not show up all conditions (nor, indeed do they show how much pain the patient is suffering); in addition, the results of tests (such as MRI scans) may not correlate well with the severity of symptoms.

There is a danger that doctors will treat test results and not patients.

Narcotics still carry a stigma, which was amply demonstrated in the Roper study.

Dr. Russell Portenoy has commented:

"This survey shows the stigma associated with opioid drugs. Although these drugs can clearly benefit some patients with chronic pain, patients, caregivers and physicians overestimate the risks and fail to use them appropriately."([xi])

The Roper study found that amongst patients, concerns about addiction and side-effects, rather than stigma, were the greatest barriers to wider usage.

In the group of sufferers on narcotic medication, the survey found that the commonest concern expressed by doctors, family and friends was over the possibility of addiction.

In 1995, Joranson (Associate Director for Policy Studies, Pain Research Group, University of Wisconsin Medical School) wrote a paper entitled "Current Thoughts on Opioid Analgesics and Addiction".([xii])

In this paper, he suggested that

"The fear of addiction comes from years of misinformation about opioids and has been reinforced in some countries by national antidrug campaigns that ignore the medical benefits of opioids.

We have been so effective in warning the medical establishment and the public in general about the inappropriate use of opiates that we have endowed these drugs with a mysterious power to enslave that is overrated."

This also means that those patients, who repeatedly return to their doctors claiming inadequate pain relief with non-opioid drugs, may be misconstrued as at least potentially, if not actively seeking opiates to feed a drug addiction.

The chances are that they will then be denied the very drugs which might enable them to function far better and have a much higher quality of life.

This of course will also impact on their families.

In other words, as Joranson says (xii)

"The fear of addiction can be so strong that legitimate patient requests for opioid analgesics are mistaken for addictive behavior."

A new term has been suggested to describe the condition which results from inadequately treated pain: pseudoaddiction.

As early as 1939, Weissman and Haddock ([xiii]) described this iatrogenic syndrome:

"Inadequate treatment of the [cancer] patient's pain led to behavioral changes similar to those seen with idiopathic opioid psychologic dependence (addiction)."

Dr. Neil Irick ([xiv]) wrote in 60 years later in 1999 about the problems faced by patients with chronic non-malignant pain who have been labeled as addicts.

"These patients have been seen by numerous physicians and other care providers, none of whom have adequately treated their pain, and may be unaware that the patient is getting medications from other sources.

Pseudoaddicts are drug seekers not because they are addicted to narcotics, but because their pain is inadequately controlled.

They often present as hostile and belligerent drug seekers who commonly are inaccurately labeled as drug abusers."

Irick stated that

"Because there are no guidelines for the care of such people, most primary care physicians are reluctant to incur the scrutiny of not only local colleagues, but also

regulators and law enforcement officials."

The National Foundation for the Treatment of Pain suggests that continued under-treatment of pain is due to a cyclical phenomenon known as

"customary prescribing behaviour.".....

"This is behaviour perpetuated by community thought as opposed to individual outcomes."([xv])

A further problem seems to be the use of "PRN" prescriptions: i.e. "as needed".

This pattern of use is no longer considered effective.

They may, in fact, produce a roller-coaster effect and this may enhance the possibility of tolerance and addiction rather than reducing it.

The National Foundation for the Treatment of Pain quotes the following figures: 7,000,000 people suffer intractable pain.

Only 4000 physicians in the United States are willing to prescribe opiates to them.

This leads us back to Dr. London's letter (vi):

"For years my chronic pain patients drifted from one pain clinic to the

other.....finally, an enlightened use of narcotics has brought many of my pain patients solace.....Doctors should know that their license will remain secure if they can document in the charts of patients on long-term narcotics that their pain and function have been notably improved."

A New Jersey report by the Commission for the Study of Pain Management Policy found that patients often cannot obtain appropriate pain relief: and recommended that pain medication should be made more readily available.

Assemblywoman Charlotte Vandevallk (chair of the Commission) wrote in an editorial of the Bergen Record (April 1999):

"We heard a lot about fear. Physicians feared trouble with law enforcement for prescribing large doses of controlled substances, especially if they have a practice with a heavy caseload of patients with intractable pain.

Pharmacists were also afraid of losing their licenses for filling prescriptions for high doses of painkillers. Patients feared that their supply of medicine would run out, so they cut back and did not take the optimal dosage.

Some patients feared that they would be considered weak or troublesome if they complained about their pain."

She concluded

"Government must do all it can to eliminate obstacles, so that the best medical care becomes easier to give and receive. Science has shown us how to eliminate pain. The need for action is clear. We would be barbaric if we did not go forward with these recommendations."

The Oregon Board of Medical Examiners undertook disciplinary action in March last year against a physician for undertreating pain.

However, experts such as Dr. William Hurwitz and Dr. Harvey Rose, who have both been very active in campaigning for improved pain relief for patients, both feel that this step is not necessarily a helpful one.

Dr. Hurwitz commented that an educational rather than punitive discipline would be the most appropriate: to tackle the issue of fear of prescribing narcotics.

Indeed, this seems to be the core of the problem and one which needs to be addressed not just in the States, but all over the world: as the opening quote said "All types of pain in all parts of the world are inadequately treated."

Whilst opiates are not the answer in a number of cases, the principle remains the same: chronic pain sufferers must be taken seriously and their pain attacked rigorously if we are to call ourselves a caring and progressive society.

Dr. Sarah Andreae-Jones MB BSPatron of the Arachnoiditis Support Groups
February 2000.

SUGGESTED READINGS

Released from the Web Janet Kraal Minerva Press ISBN 1 86106 3

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