Sir,

I read the three excellent articles under the heading ‘Does a diagnosis in pain medicine promote disability’ with a mixture of pleasure and sadness. What the authors have to say is clearly eminently worth saying but the question is: why does it still need saying after all these years? When I came into pain medicine more than three decades ago, it was already apparent that I had to change my dualistic mindset, and I spent much time and energy working on my colleagues and with my patients to help them do likewise. The damage caused by careless use of language in presenting depressing diagnosis and prognosis was already only too obvious. I fear my medicolegal reports caused some exasperation in the legal profession with my efforts to explain that long-standing chronic pain was usually complex and multifactorial in nature, but even then this was nothing new.

I am sure I am far from alone in this and that the theme is only too familiar to many of your readers. But the question remains: why have we apparently still failed to put over these concepts so many in the health and legal professions, or for that matter the public? Surely it cannot be for want of trying. The difficulty is perhaps understandable: relatively simple concepts like mind-body dualism hold a natural appeal for professionals and patients alike. (We are perhaps inclined to forget that not all of the latter have enjoyed the same benefits of education as ourselves – or sometimes, conversely, to assume this and not bother to try to explain such difficult issues.)

It isn’t easy for any of us to avoid thinking simplistically about complex issues or to hold apparent contradictions in mind at the same time. The culture of scientific medicine has sometimes seemed to encourage dualist thinking. (The reductionist method may recognise the complexity but often fails in the more complicated task of putting the pieces together in a complete picture relevant to human suffering.) The law asks for simple certainties (such as could this patient’s continuing pain be attributed to a single incident many years ago) where they are difficult to prove.

What is to be done about it? Here I fear I find myself somewhat bereft of new solutions to a problem that appears to have defeated us for so long. Much of the onus would appear to lie with those responsible for medical, or indeed general education. And pain professionals will have to continue to bang on about it to colleagues and patients, however discouraging the response may sometimes seem. But may I invite your readers to contribute some fresh ideas? It would certainly seem to be necessary!

Yours sincerely,
Peter Wemyss-Gorman

Response from the author:
Expectation and the experience of pain and disability

I would like to thank Dr Peter Wemyss-Gorman on his interest and his contribution to the three linked articles ‘Does a diagnosis in pain medicine promote disability?’, published in Pain News 2012 vol. 10 no. 1. He states that what was said was eminently worth saying but questions why it needs to be said still after all these years?

I entirely agree, but what fascinates me is that there is no direct relationship between injury, physical impairment, the perception of pain and disability. Medico-legally, we talk about conscious and unconscious exaggeration; what fascinates me is the increasing neurobiological evidence that expectation of pain or disability will produce it in a very real way.

In a fascinating paper entitled ‘Descending analgesia – when the spine echoes what the brain expects’, published in Pain 2007 vol. 137 p. 143 by Goffaux et al., it is stated that changes in pain produced by psychological factors (e.g. placebo analgesia) result from activity in specific cortical regions. Goffaux et al. state that some cortical nuclei including the periaqueductal grey and the rostral ventral medulla also show selective activation when subjects expect pain relief. These brainstem regions send inhibitory projections to the spine and produce diffuse analgesic responses. It is stated by the authors that the precise contribution of spinal mechanisms in predicting the strength of placebo analgesia is unknown.

In this study, subjects in the ‘analgesia expectancy group’ were told that immersing the right arm in cold water would help lessen the painful sensations of the stimulus applied elsewhere in the body, and a painful electrical stimulus was applied to their sural nerve (near their left ankle). In the ‘hyperalgesia expectancy group’, participants were told that the immersion procedure would have pain-enhancing effects. Immediately prior to the testing session, participants rated the extent to which they expected the immersion procedure to change the pain produced by the electrical stimulation.

What was the remarkable was that the change in pain intensity perceived after painful electrical stimulation of their sural nerve by the immersion of their right arm in cold water matched their expectations and importantly those subjects that expected to feel a decrease in pain because of the immersion did so and, in those who expected to feel more pain, also did so. Moreover and even more remarkably, the sural reflex electrophysiological response also actually changed depending on the expectation and
Sir,

The article by Ian Yellowlees is a bold and thought-provoking take on the current uncertainty surrounding the pain service. Many of us, I am sure, are concerned about the uncertainty surrounding the long-term viability of the pain service. As members of the Pain Society, we passionately believe in the need for specialisation and the importance of our expertise to patients we serve.

In reality however, the schism within specialists supporting procedural treatments and those supporting comprehensive psychosocial interventions creates confusion in the marketplace. Which part of the package will the commissioners fund? In the face of the drive to minimise secondary care referrals and reduce outpatient clinic episodes, how will the service be funded? Can the localisation of multidisciplinary team (MDT) services, including Improving Access to Psychological Therapies (IAPT) services in the community work? Is it the suitable framework for chronic pain care in the 21st century?

I do not have the answers but agree with Yellowlees that a number of packages of treatment that we provide do not result in overall improvement and service appears to be faltering. To speak about the goal of treatment, an improvement for chronic pain patients is clearly an improvement in their perception of functioning ability, both physical and emotional.2

How can one evaluate it? In the 21st century, we have access to valid, sensitive, generic, health-related quality of life questionnaires for measuring function. For example, the SF36 questionnaire has been used extensively and was found to be a suitable in chronic diseases evaluation.3 To an external observer, the logical method of resolving conflict would be a comparison of outcomes of the varied interventions. If we are to convince others that we are the experts for resolving the problem and enabling patients to function better, it is in our interest to incorporate the objective outcome evaluation of our practice. Although international consensus recommendations for the measurement were published a decade ago (http://www.immpact.org), routine use is not established in practice.

Unless we take up the challenge to objectively measure outcomes and publish guidelines incorporating them, will we be listened to? By avoiding routine objective assessment of chronic pain measurement, we will not only end up kidding others but kidding ourselves too. We have a window of opportunity to make a difference.

References

Dr Gnanie Panch
Consultant Pain Specialist/Anaesthetist, Whittington Hospital, London

The magnitude of pain relief. This is a profoundly illuminating study and I would urge others to read it.

Like Dr Wemyss-Gorman, I believe that the only way to practise pain medicine is to throw the mind-body duality and Cartesian logic out of the window as an unhelpful model in being able to understand and treat patients. There is no doubt that severe chronic pain will profoundly affect the mind of an individual but in addition the power of the mind to influence the experience of pain is just as profound.

As attributed to Job in the oldest book of the Bible: ‘For the thing which I greatly feared is come upon me, and that which I was afraid of is come unto me.’

The strength of the membership of British Pain Society is to recognise the multidisciplinary nature of generation, maintenance and treatment of pain. The days when interventionists no longer talk to non-interventionists, I hope, is gone. We recognise that not all pain is in the brain, but neither is the power of the mind to be ignored.

Dr Rajesh Munglani, Cambridge.