

## Medical Pain - A Forgotten Cousin, or Lost Cause?

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### Abstract

Poorly recognised over the years, medical pain - as opposed to its surgical cousin - continues to be associated with ineffective management and distasteful patient reports. Definitions and practice guidelines are conspicuous by their relative absence, with the disproportionate involvement of specialist pain physicians with non-medical cases and the consequent dependence on less experienced junior medical staff precipitating a rampantly inadequate medical pain experience for patients.

Several barriers to effective practices in the field of medical pain are proposed herein, with seedlings of potential solutions proffered in the interest of stimulating awareness and propagating interest in this neglected area of practice.

Keywords: medical; pain; anaesthesia; education; chronicity; fear

### Introduction

What is medical pain? One answer would be a poorly defined concept which suffers the ignominy of poor management.

A quick internet search for the term brings up several hits to clinics offering the services of medical practitioners with pain specialty training. Definitions of 'medical pain' however, as opposed to those of its more easily construed post-surgical cousin, are both sparse and elusive in the learned literature. One potential candidate is provided by the International Association for the Study of Pain (IASP), whose professional presence on the web offers both a respectable description of pain syndromes of medical aetiologies as well as a taxonomical guide thereto<sup>1</sup>.

With a struggle to even define the concept, is it any wonder that medical patients with pain complaints continue to score reprehensible figures on studies into pain incidence and effective relief? This is far from a new phenomenon, with the British Journal of Anaesthesia (BJA) reporting a staggering 52% of medical inpatients in one study (N=1594) of a UK district general hospital to be in pain on the medical ward, with 20% and 12% of those in pain rating this complaint as severe and unbearable respectively<sup>2</sup>. What is particularly distressing about these statistics is the fact that data collection in the same study occurred over five days; more than ample time for complaints to be reported or recognised and appropriate relief strategies implemented. Barriers clearly exist to the provision of adequate medical pain relief, with practice shown to fall below standards recommended by the Royal College of Anaesthetists.<sup>3</sup> A sketchy definition is perhaps one such barrier, but what other challenges exist to management of medical pain?

### Predictability & On-Call Skills

In contrast to the anticipated pain following an elective surgical procedure, medical pain is less predictable in onset and consequently more the realm of an on-call physician than a specialist pain management team. One unambiguous fact when equating specialist pain rounds and the on-call services of a more junior recruit is that the former clearly benefit from greater levels of experience, even allowing for acquisition of specialist training. The latter inevitably rely more heavily on the knowledge base afforded them by theoretical education, which sadly tends to be rather scant in undergraduate medical programmes.

The lack of early teaching of junior staff on the subject represents one barrier to pain management in general, with formal teaching on the subject of medical pain management a particular shortcoming in several international medical curricula. This fact is supported by the findings of a cross-sectional study in one Sydney hospital utilising a multinational population of medical interns and residents<sup>4</sup>, indicating some 56.2% of responders felt education on pain management to be inadequate. Up to 68.8% of responders were willing to receive additional lectures on opiate use to increase their knowledge base in this regard, suggesting a definite dearth of dedicated teaching.

In recognition of similar sentiments, a dedicated junior doctor-targeted postgraduate pain curriculum was suggested in 2011 by the Faculty of Pain Medicine (FPM) of the Australia & New Zealand College of Anaesthetists (ANZCA)<sup>5</sup>. This not only recognises the need for effective pain management skills at an early career stage, but also proposes a core set of competencies

and assessments thereof for application to early postgraduate physicians' skill sets.

### A Surgical Predilection?

Skills of junior on-call medics aside, the provision of committed specialist pain services undoubtedly represents one of the major advancements in acute pain patient care. And yet, the needs of medical patients have often been overlooked in favour of acute surgical pain relief, and presumably continue to be so in the face of a lack of convincing evidence to the contrary. One study published in 2008 reporting data from over 220 United Kingdom National Health Service (NHS) hospitals revealed a paltry 16% incidence of routine acute pain service in medical wards<sup>6</sup>. The same study revealed that 82.2% of clinical leads in acute pain services actually recognise this problem of inadequate pain control on medical wards. With this stark admission from front line algologists in mind, why do elderly and general medical patients consistently appear to produce disconcertingly poor results in pain studies?

Perhaps the lack of adequate medical pain services in the light of a frank admission to a predilection for surgical patients reflects inadequate training, staffing or application of resources as a barrier to effective management of medical pain.

### Community Confounders

Limitations of secondary care pain services aside, the primary care setting also exhibits a confounding factor for professional provision of medical pain management – the propensity for patients to easily self-medicate their complaints with non-prescription remedies. The immemorial complaint of headache in the community provides a convenient example of the potential for patients to self-manage their pain symptom. In doing so however, they simultaneously skirt the legion of adverse drug reactions, drug interactions and other implications including paradoxical rebound pain which may complicate management later on in the professional setting. Data published following a recent review of literature sources<sup>7</sup> indicate codeine-based compound analgesics to be the most popular over-the-counter medications dispensed across several international populations. This telling fact may be suggestive of a trend in non-professional pain management which impedes effective management according to professional standards. Assuming a relative deficit of surgical to medical pain patients in the community, this may represent a unique challenge to providers of medical pain services.

### Chronicity

One further important consideration to be made in medical pain is its potential for chronicity, with prevalence of leading pain disorders including lower back pain and chronic migraine indicated at 10.2%<sup>8</sup> and 1-3%<sup>9</sup> respectively in recent studies. The former in particular has exhibited an explosive trend in prevalence over recent years, with a more than 2.5-fold increase

since 1992 in relative prevalence observed in one 2006 American study of households state-wide (N=5357)<sup>8</sup>.

Implicit in the chronicity of pain complaints exist a number of secondary disorders which can prove troublesome for effective engagement of pain management services. The European Journal of Pain quotes a large transnational study of chronic pain patients (N=46,394)<sup>10</sup> as finding 21% of patients to have been diagnosed with depression because of their pain. Interestingly while almost half of subjects were self-administering over-the-counter analgesics and only 2% were being seen by a pain specialist, an astonishing 40% reported inadequate pain relief – an almost anticipated outcome of the 'do it yourself' approach to pain management in chronic, refractory cases? This may be less relevant in surgical pain experiences which intuitively represent a more acute event in a more controlled environment, and therefore may be more amenable to effective management than a drawn out pain experience over several years!

### Fear of Pain

Chronicity of pain in turn evokes a largely self-explanatory phenomenon known as fear of pain, which can present a potentially sizeable obstacle to management of patients. High levels of fear of pain and also movement as a provocative agent thereof have been described in 38.6% of fibromyalgia syndrome patients (N=233)<sup>11</sup>, with this heightened fear of a painful experience linked to increased disability, depressed mood and most importantly pain severity. This latter component alludes to one of the more insurmountable barriers to management of chronic medical pain – the impasse resulting from a vicious circle of pain, fear and infinite vice versas.

The fear of pain may in turn be compounded by a fear of narcotic analgesic therapy on both the part of the patient and the prescribing physician, with this being an issue in non-cancer pain as well as malignant disease. The fear of commencing and continuing long term opiates is traditionally said to be particularly prevalent in the primary care setting<sup>12</sup>. Fear can arise in view of a number of reasons, including the potential for addiction and major side effects as well as the notion that opiate drugs represent a terminal stage in a disease process. Mention of opiates has been linked to accusations of 'hidden diagnoses' on the part of the physician, where patients suspect malignant pathology has been concealed from them by their care provider out of a deep-rooted belief that opiate analgesia is merited solely by cancerous conditions<sup>13</sup>. Whether this signifies an already fragile patient-doctor relationship or a contribution to the deterioration thereof, the connotation for effective management of medical pain remains a significant one. Repeated careful review of patients on long term opiate therapy for chronic non-cancer pain must be emphasised however, with up to 19% of chronic pain patients found to have some form of addictive disorder in a 2001 paper on the subject<sup>14</sup> courtesy of the BJA.

## Conclusion

In summary, patients requiring relief of medical pain issues are clearly disadvantaged by the presence of numerous hurdles to effective management of their complaints. The literature base in this regard is conspicuous by its absence, with practices in medical pain management being poorly evidence-based as a result. This represents a major potential target for investigative studies and research into potential trends and best practices. Exploration of effective methods for implementation of improved education for newer staff and also resource allocation for more experienced practitioners would also be of benefit to the standard of care in medical pain.

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None

### Competing Interests

None declared

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