

Pain Management: Are We Upside Down?

Denise Millstine, MD

Dr. Millstine is a member of the Forum editorial board and can be reached at Millstine.Denise@mayo.edu.

Pain management can be one of the most challenging aspects of primary care. Concern for medication adverse events, lack of objective diagnostic tests, and fear of litigation contribute to the unease felt commonly by providers.

Pain is common and comes in many forms. Acute pain from acute injury can be easily identified and often corrected with short-term care. Sub-acute pain can also be improved with proper attention and treatment strategies. Chronic pain can be difficult to specifically diagnose and to treat with efficacy.

Still, we are asked to discuss pain with patients on a regular basis and to show documented effort to improve symptoms and suffering. In our toolbox, we have exercise, physical therapy, over-the-counter analgesics, and potent pharmaceutical-grade pain medications. We rely on our patients' subjective reporting on their treatment response, and we remain fully cognizant of the abuse potential of our therapies. If we are lucky, we have a pain specialist in our local community with adequate access to provide a subspecialized opinion and set of recommendations.

It's possible, however, that we have been approaching pain in a sub-optimal way. Pain results from a heightened stimulus of discomfort from the body, of course, but also from the mind, patient beliefs, and/or past experiences. Most often, we focus our history and differential on the physical site of the pain. We forget—or better yet have never been trained—to be open to the other contributing factors.

Integrative medicine, in which health and healing are the focus of care and all effective modalities are considered, has been shown to be effective in the management of pain. For chronic low-back and neck pain, yoga, acupuncture, biofeedback, and qi gong have shown efficacy. For fibromyalgia, tai chi, mindfulness meditation, and yoga are significantly beneficial. Other pain conditions have other effective strategies.¹

Additional strategies have been recommended for pain evaluation as well. At a recent talk, a doctor who focuses on hypnosis as part of his therapeutic strategy recommended exploring the onset of pain and the surrounding situation. He offered the need for forgiveness, of

self or others, as a common barrier to resolution or improvement of the symptoms. Others describe the gate theory of pain, which is a learned and established response that must be relearned and retrained with intention. In neither of these approaches does numbing the pain or distracting away from it lead to prolonged healing and symptom relief.

In general internal medicine, our training and experience in managing pain is generally poor. We, the providers, feel helpless, and our patients are dissatisfied. Perhaps we have it wrong. Perhaps we need to take pain head on and explore it more, which would be easier with more tools, more openness, and a broader framework for its assessment.

Reference

1. Lee C, Crawford C, Teo L, Spevak C. An analysis of the various chronic pain conditions captured in a systematic review of active self-care complementary and integrative medicine therapies for the management of chronic pain symptoms. *Pain Med* 2014; 15 Suppl 1:S96-S103. *SGIM*