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Editor-in-Chief:
Nancy E. Epstein, MD
Winthrop University Hospital, Mineola, NY, USA

"When the pain won't wane it's mainly in the brain"

Ron Pawl

Department of Neurosurgery, University of Illinois, Chicago (Retired), and Medical Director, Center for Pain Treatment and Rehabilitation, Lake Forest Hospital, Lake Forest, Illinois (Retired)

E-mail: *Ron Pawl - ron@pawl.com
*Corresponding author

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Abstract

Chronic pain syndromes either have no underlying organic explanation, or include patients whose chronic pain complaints (without focal deficits or significant radiographic findings) were not alleviated by surgery (in 80% of cases). Patients with chronic pain typically "turn off" members of the medical community; they are often "written off" as malingerers or psychiatric cases. The Minnesota Multiphasic Personality Inventory often shows elevations on the hysteria and hypochondriasis scales; together these constitute somatization defined as patients converting emotional distress into bodily complaints. Depression, anxiety, and borderline personality disorders are also often encountered. Secondary gain also plays a critical role in patients with chronic pain syndromes (e.g., includes avoiding onerous tasks/work, or rewards opioid-seeking behaviors). Tertiary gain pertains to the physicians' financial rewards for administering ineffective and repeated treatment of these patients, while validating for the patient that there is truly something organically wrong with them. Self-mutilation (part of Munchausen Syndrome/Fictitious Disorders) also brings these chronic pain patients to the attention of the medical community. They are also often involved in the legal system (e.g., workmen's compensation or tort action) that in the United States, unfortunately financially rewards "pain and suffering." The main purpose of this commentary is to reeducate spinal surgeons about the pitfalls of operating on patients with chronic pain syndromes in the absence of significant neurological deficits or radiographic findings, as such "last ditch surgery" invariably fails.

Key Words: Chronic pain, litigious, personality disorders, secondary/tertiary gain

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INTRODUCTION

Slowly, over the last two or three decades, greater attention has been paid to the complex psychological and social issues that contribute to chronic pain syndromes. In this brief review, the many issues that contribute to chronic pain are highlighted, while particular attention is also focused on warning surgeons against utilizing surgical intervention to resolve psycho-social rather than real physiological complaints.

DEFINITION AND EXAMPLES OF CHRONIC PAIN

Chronic pain syndrome is basically defined as pain without a definable underlying organic substrate or

pain (80% low back pain) that has not been alleviated by surgery; patients who underwent typically inappropriate surgery for their chronic pain complaints.[7,18]

CHRONIC PAIN (MALINGERERS, PSYCHIATRICALLY BASED) MAY "TURN OFF PHYSICIANS"

Behaviors and issues for patients with chronic pain complaints may "turn off" members of the medical community. This may lead to them being "written off" as malingerers or simply psychiatric cases. For example, when a physician enters the examining room and finds the patient curled up on the examining table, refusing to get up and sit down to give a history, or is standing next to the table, refusing to sit down because that would be too painful, the physician should anticipate that the patient has a chronic pain syndrome.

HISTORY OF PATIENTS WITH CHRONIC PAIN COMPLAINTS

When chronic pain patients give histories they are typically embedded in emotional terms. The pain is described as "harmful" or "demoralizing."[2,15] There are many "red flags," that should warn physicians that the patient has a chronic pain syndrome. One red flag is the patient's experiencing excessive pain when a bodily part is touched, a second includes a broad-based gait without a neurological explanation, while a third termed "camptocormic posturing" is characterized by the patient bending forward at the waist, with one hand holding onto the low back.[17]

CHRONIC PAIN WITH DISTINCT PSYCHOLOGICAL PROFILES

Almost all patients with chronic benign pain syndromes have distinct psychological profiles as demonstrated on the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI often shows elevations on the hysteria and hypochondriasis scales, which, together are referred to as "somatization."[3,6] These patients usually convert emotional distress into bodily complaints (e.g., they are intensely focused on their body that often normal physiologic bodily processes are interpreted as painful). Depression and anxiety are also regularly found along with borderline personality disorders. The past history of these patients regularly discloses evidence of physical or psychological, and in many female patients, sexual abuse in their early years.[19] They are particularly difficult to treat, and make up a considerable portion of patients failing to gain relief from even comprehensive rehabilitation treatment.

SECONDARY GAIN WITH CHRONIC PAIN

Secondary gain plays a critical role in patients with chronic pain syndromes.[9] It includes such things as avoiding onerous tasks; e.g., a blue-collar worker injured on the job.[14] Very often the patient perceives himself as strong and able to carry on a hard, demanding physical job throughout his working life. However, as he reaches his early 50s, his body begins to show evidence of age and he is no longer able to perform the tasks. Next, he develops either a real or perceived injury and disability that prevents him from returning to his job; he may not want to return to work, does not want to return to that job in particular, or does not have the skills to find a different job. The regular payments, received from the insurance industry or the disability system, provide a way to avoid going back to work, while providing a living.

SECONDARY GAIN TO OBTAIN OPIOIDS

Secondary gain utilized to obtain opioids has reached epidemic proportions in the United States.[4,5,13] When a patient has a history of substance addiction or evidence of addictive behaviors on the MMPI it must be addressed as part of therapy. This means arranging a drug contract/program with the patient, having frequent face-to-face assessments, performing urine drug tests, monitoring pill counts, and reviewing prescription drug monitoring program data when available. Such intense programs should reduce healthcare costs, and rehabilitate patients.

TERTIARY GAIN IN CHRONIC PAIN PATIENT

There are also tertiary gains in the medical system associated with the care of chronic pain patients. Physicians, who regularly treat such patients, often use the same treatments that have failed in the past, (e.g., injections, physical therapy), but gain financial reward for their continued therapeutic efforts. Furthermore, the repeated treatments by the physician validates in the patient's mind the notion that there must be something organically wrong, or the physician would not continue to treat them. This in turn, enhances the patients' continued chronic pain "misbehaviors."[14,16]

EXAMPLE: RESOLUTION OF A LEGAL CASE SOLVING CHRONIC PAIN

A male patient returned to a Pain Center after a hiatus of several years with a new chronic pain problem related to a new accident that included new litigation. When asked about the outcome of his previous pain from a prior work-related injury, he stated that problem had completely resolved. Obviously, this occurred following resolution of the prior legal case. Likely his new

complaints would abate once this new litigation was resolved.[10]

CHRONIC PAIN AND SELF-MUTILATION

There are some patients with chronic pain syndromes who self mutilate in order to obtain attention from the medical community. They are part of a somewhat larger group of Munchausen patients (Fictitious Disorders) with personality disorders. Such patients often bruise themselves and complain of chronic pain or may place a tourniquet on a limb to produce swelling or use dye to discolor a limb, usually blue, to imitate complex regional pain syndrome (reflex sympathetic dystrophy). Pain treatment practitioners need to be aware of such disorders.[8,11,12]

LEGAL INVOLVEMENT

Patients with chronic benign pain are often regularly involved with the legal system (e.g., workmen's compensation or tort action). In the United States, the legal system is geared toward financially rewarding "pain and suffering" from injuries or activities; pain and suffering litigation, therefore, serves to remove such patients from having to deal with onerous activities (e.g., work). Laws regarding such rewards vary from state to state. For example, Illinois has a reputation for rewarding people rather well through the legal system, while Wisconsin and Indiana do not.

"SLEUTHING" AND "SURVEILLANCE"

It is critical that any evaluating and treating physician be aware of the "reward" system applicable to the situation at hand. Consideration of the motivation of the patient to "get better" and return to a normal lifestyle may play a paramount role on how that patient will respond to treatment, and, therefore must be evaluated with the same ardor as the medical and psychological conditions of the patient. Demonstration of such motivation may include review of surveillance of the patient carried out by third party groups (e.g., private detectives). This type of sleuthing is not taught as a part of the education for most medical personnel, so an alteration of attitude and behavior on the part of the physician, the psychologist, and the other medical therapists is necessary in these legal circumstances.

ROLE OF LEGAL REWARDS

In comprehensive pain centers, legal issues and financial reward play as important a role as medical or secondary gain issues, and, therefore, need to be addressed as part of the patient's therapy. Oftentimes, treatment needs to involve the patient's attorney(s), and more regularly, the defense insurance industry and the rehabilitation nurses working for them. Physicians treating chronic benign pain syndromes need to be very familiar with the legal system and need to be willing to provide "expert" testimony through depositions or court appearances regarding a particular patient's pain. This includes testifying as to the underlying psychological, social, and motivational issues that are an integral component of that patient's experience.

PSYCHOLOGICAL UNDERPINNINGS OF CHRONIC PAIN (LEGAL CONTEXT)

The treating physician or the expert hired to review the case for the legal proceeding must properly disclose the psychological underpinnings of a plaintiff's case. Any motivational issues must also be disclosed. Unfortunately some treating physicians "believe" the patient's complaints are real, even when they cannot clearly demonstrate an underlying organic process related to a specific injury that is consistent with the patient's complaints. Consequently, there is a need for a review by a qualified physician expert as to whether or not the injury in question did indeed cause the patient's persistent pain complaints.

DETERMINATION OF AWARDS

The court has the difficult decision to determine what percentage of any award is related to the actual incident. These decisions are based on several issues: How the patient's preexisting psychological profile played into their developing extended pain complaints, how much of the pain complaint is related to secondary gain or motivation for reward, and what is the specific economic significance of the legal action. The great variability of legal outcomes are based on local laws.[1]

EDUCATION OF SPINAL SURGEONS REGARDING PITFALLS OF TREATING CHRONIC PAIN PATIENTS

This brings to the forefront the education and training of spinal surgeons to avoid operating on the wrong patients with persistent chronic pain complaints, without focal neurological deficits or significant radiographic findings. Here, surgery should be avoided as a "last ditch effort" to resolve chronic pain syndromes, as it will invariably fail. Furthermore, once the patient has a surgical scar on the back, they have a "reason" (e.g., spinal surgery) for any layman to see, that their pain is both real and organic. This can clearly influence any court or jury regarding their case. Spinal surgeons need to recognize the psychological and motivational issues concerning chronic pain patients, and should refer them for appropriate psychological evaluation and treatment. Not all psychologists are familiar with the issues underlying chronic benign pain patients, so the psychologist/psychiatrist selected

by the spinal surgeon for referral should be well educated in the manifestations of this unique disorder.

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