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Doctors' Challenge: How Real Is That Pain?

Even When Patients Describe Pain in Vivid Detail, Doctors Have Few Tools to Determine What's Real

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Linzie Hunter

A patient walks into the examining room and says, "Doctor, my back hurts and nothing works—except my Percocet." Now, the physician must decide: Is this pain for real?

Despite decades of research, doctors have few tools to measure pain objectively. Generally, they ask patients to rate it themselves from one to 10, or point to the cartoon face on the wall chart whose expression best matches how they feel.

"We don't have a pain-o-meter," says Joel Saper, director of the Michigan Head Pain and Neurological Institute in Ann Arbor, which draws about 10,000 patients a year, including some of the nation's toughest migraine cases.

Dr. Saper estimates that 15% to 20% of them are faking—or at least, aren't as incapacitated as they say. Some are dependent on painkillers or seeking to resell them, he says. Some want a doctor to

certify that they'll never be able to work again and deserve disability payments. Some, he thinks, don't really want to get well because they subconsciously find power in their pain.

Even when pain is real, it's highly subjective. "Two people can have the same nerve compression, but one guy will be bedridden and the other guy will be saying, 'Nah, I'm fine,' " says David Kloth, an anesthesiologist and past president of the American Society of Interventional Pain Physicians.

Evaluating patients' pain is posing a greater dilemma than ever for doctors, given two colliding health-care trends.

On the one hand, opioid painkillers—the most commonly prescribed medications in America—have become a major drug of abuse. With prescriptions up 48% since 1999, opioids are now the nation's second-leading cause of accidental death, after car crashes, according to the Office of National Drug Control Policy.

On the other hand, the Institute of Medicine, which advises the government on health issues, reported last week that pain is all too often undertreated in the U.S. For many of the 116 million Americans afflicted with chronic pain, help is delayed, inaccessible or inadequate, the IOM found.

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Experts say it's critical for primary-care physicians to take time to know a patient's history and circumstances. The lower-back pain he's experiencing may be magnified by an unhappy work situation or pressures at home.

Lasting Aches

Chronic pain affects 116 million Americans (one-third of the population) and costs $550 billion to $635 billion a year in medical bills and lost productivity. The most common types people reported in a survey:

• Low back pain – 28%

• Knee pain – 20%

• Severe headache or migraine - 16%

• Neck pain – 15%

• Shoulder pain – 9%

• Finger pain – 8%

• Hip pain – 7%

Source: Institute of Medicine; 2011 survey of U.S. adults reporting that they had pain in the past three months

Use and Abuse

Opioids are the most commonly prescribed drugs in the U.S. Hydrocodone (Vicodin) is the No. 1 drug.

• Prescriptions rose nearly 50% from 2000 to 2009; milligrams prescribed per person rose 400% from 1997 to 2007.

• 15% to 20% of doctor visits in the U.S. involve an opioid prescription.

• Four million Americans a year are prescribed a long acting opioid.

• Abuse of opioid pain relievers is the second-leading cause of accidental death in the U.S., after car crashes.

• Fatalities rose from 3,000 in 1997 to 12,000 in 2007.

• Emergency-room visits due to prescription-drug overdose rose 500% from 2005 to 2010.

Source: Archives of Internal Medicine, 2011; Office of National Drug Control Policy

Many patients feel stigmatized even asking for help. "I hear from people all the time who say they are at a loss to communicate how bad they feel to their doctors—without being eyed as potential criminals," says Karen Lee Richards, a co-founder of the National Fibromyalgia Association. Like many people with fibromyalgia, a complex disorder in which even mild sensations are interpreted as pain, Ms. Richards was told for years that she was probably just getting older.

Some doctors say they have to look at every patient as a potential drug abuser, since there are no typical ones—although there are suspicious patterns. "Sometimes it's the patients with elegant clothes and three kids who call a week after a filling and say they need pain medication. That's when my radar goes up," says George Kivowitz, a dentist in New York City and Newtown, Pa. Insisting that the patient come in to be re-examined usually ends the conversation, he says.

Some physicians make patients take periodic urine tests and sign treatment contracts, promising to take medications only as prescribed and not seek drugs from other sources, or face expulsion from the practice.

In 38 states, doctors can also check prescription registries to see whether patients are getting similar drugs from other physicians in the state. A nationwide version, passed by Congress and signed by President George W. Bush in 2005, has been stalled by lack of funding.

Several bills before Congress would require doctors to undergo additional training in opioid use and abuse as a condition of renewing their license to prescribe them.

"I always ask a patient, 'How are we going to show that this intervention has helped?' “says Scott Fishman, president of the American Pain Foundation who wrote a widely used guide to responsible opioid prescribing. "The person who is just trying to get opioids will say, 'Ah, later, dude' and go somewhere else."

Experts also say it's critical for primary-care physicians, who treat 80% of pain issues, to take time to know a patient's history and circumstances. The lower-back pain he's experiencing may be magnified by an unhappy work situation or pressures at home.

"The answer may not be a neuropathic pain drug but reassurance and counseling," says Perry Fine, a professor of anesthesiology at the University of Utah and president of the American Academy of Pain

Medicine (AAPM). But connecting all those dots is very difficult, he concedes, when the typical office visit lasts less than 12 minutes.

There's growing recognition that acute pain and chronic pain require very different approaches. Acute pain is a warning signal to stop something that's harmful, experts say. In chronic pain, that alarm keeps sounding and producing pain long after the original cause is gone, probably due to a malfunction in the central nervous system.

Chronic pain, in turn, can cause changes in the emotional and attention centers of the brain, and lower pain tolerance even further. Antidepressants are helpful in some cases. There is little evidence that opioids are effective at alleviating chronic pain, yet some doctors keep prescribing them, in ever higher doses.

Many pain-management centers now have a multidisciplinary team including anesthesiologists, neurologists, physical therapists and psychologists evaluate patients. At University of California, Davis, where he is chief of pain medicine, Dr. Fishman says, "We start from the beginning and assess where the pain is, what it's robbed the patient of, and how treatment might help," says Dr. Fishman. "It's not a quick visit."

Some centers typically stop all of a patients' pain medicine and start over. If they protest, "I say, 'If the drugs were working, you wouldn't be here,' " Dr. Saper says.

At his migraine center in Michigan, some patients with intractable pain are admitted and observed around the clock. "We can learn a lot that you don't see in an office visit such as how they party in the cafeteria and how they argue with their spouse," he says. One patient who said her chronic migraines made her unable to work was overheard planning an ambitious honeymoon in Europe. Dr. Saper refused to sign her disability form. "We make some patients angry," he says, "but about 75% of the people who come to us improve and are grateful."

Pain psychologists also play a key role, especially when physicians can't minimize patients' pain and have to help them live with it instead. Therapists often wish they were brought in sooner. "Many patients feel like the doctors are saying to them, 'There's nothing we can do from a medical standpoint, so it must be mental,' " says Robert Twillman, a veteran pain psychologist who is now director of advocacy for the AAPM. He often tells patients that whatever the initial cause, the pain must be taking an emotional toll as well, which is in their own power to change.

Many centers focus on improving function rather than eliminating pain. Sean Mackey, chief of Stanford University's division of pain management, doesn't even ask patients how much pain they are in.

Instead, he asks, " 'If I could wave a magic wand and take away all your pain, what would you be doing in a month?' We may not be able to measure a patient's pain, but we can define some goals and work toward them," he says.

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Link to Dr. Pizzo interview

http://med.stanford.edu/ism/2011/july/5q-pizzo-0711.html