Chronic Pain – Overview

Chronic pain is not benign.
It causes depression, anxiety, insomnia, muscle tightness, withdrawal from life, fatigue, impaired relationships, loss of self-esteem, problems concentrating.
Health professionals often lack knowledge about pain control.
The person with pain is the only authority to indicate the existence and nature of that pain.
Having an emotional reaction to pain does not mean that pain is caused by an emotional problem.
Although the patient may report sever pain, the patient is not always acting like he/she is in pain since they have been in pain for so long.
The health team's reactions to a patient with chronic nonmalignant pain may present an impossible dilemma. If depression is expressed, it may be believed to be psychogenic; if depression is hidden, they may not believe it to be significant.
Pain tolerance is the individual's unique response.
Respect for the patient's pain tolerance is crucial for adequate pain control.
Patients who exaggerate their pain may just be trying to get their physician to believe them.
Physical dependency is the body's natural adaptation to some types of medication.
A withdrawal effect from stopping a medication is not an addiction.
Addiction is the taking of a substance for pleasure, leading to increasing amounts.
No evidence supports fears of addiction as a reason for withdrawing narcotics when they are indicated.
All studies show that regardless of doses or length of time narcotics true incidence of addiction is less than 5%
Several studies have shown that prolonged narcotic therapy for selected patients with chronic non-malignant pain may be a safe and humane alternative to surgery or no treatment.
If all other alternatives have been tried with no success, and if the patient is doing everything possible otherwise, mild narcotics may be the answer for proper pain management.

Guidelines for Patients

Each person uniquely different
Trial and error
No cook book recipe
What works well for one, may not work for another
Keep a careful medication history
Medications should be tried in very small doses
Take as little medication as possible
Use nonmedical regimens to improve symptoms
Know physical and cognitive/emotional side effects
Know food or drug interactions
Have all prescriptions filled at one pharmacy
Know whether periodic blood tests are required
Know your specific target symptom
Work until an acceptable level of symptom relief is obtained
Take responsibility
Involve family and friends
Be flexible and fine-tune adjustments
Be honest with your physician.
Always start slowly and taper slowly
Continue to use meds only if it is working

Guidelines for Physicians

Trust and believe in your patients
Treat each patient as your parent; if you like your parents
Teach your patients. Doctor comes from "docere" in Latin and means teacher
Take a detailed history and especially focus on the onset of clinical symptoms.
Go slow on therapeutics- it's a chronic disorder; it's not going to be cured at all, and it may take 6-12 months for optimal management
Focus on functionality
Emphasize reasonable pain control i.e. VAS 4-5
Control the big 3 symptoms, as simply and safely as possible – pain, insomnia, and fatigue
Exercise to capability
Find a good rheumatologist to evaluate/treat co-existing rheumalogical disorders that may respond to specific therapy and secondarily improve the FM
Successful treatment depends greatly on management of comorbid disorders especially psychiatric
Analgesic misuse is common, forgivable, and can respond to education.
True addiction i.e. 4 C's is fairly rare (Craving, Compulsive, loss of Control over use, Continued use despite knowledge of harmful Consequences)
Understand the differences between misuse, physiological dependency, withdrawal syndrome, pseudoaddiction and addiction
Educate and involve the extended family; don't forget Vitamin D and statins
Document everything.

Take a short walk in the woods with enduring friends every Wednesday and finish at the 19th hole.