

## PAIN MEDICINE-NEED TO FORMULATE GUIDELINES & PREVENT QUACKERY

Pain medicine has evolved as a specialty in its own right during the last few decades. It was made possible by growing awareness about the prevalence of persistent pain with all its implications for distress, disability and socioeconomic impact. The Nuprin Pain Report<sup>1</sup> found that most people experienced pain, and reported on average three to four different kinds of pain experiences per year. Back pain was experienced by 16% of all adults, headache by 15% and joint pain by 11%. In the Christchurch psychiatric epidemiology study 81.7% of the population reported pain in one or more sites<sup>2</sup>. The epidemiology of pain in children and adolescents is relatively undocumented. In a survey in 18 countries of Europe, it was found that chronic pain of moderate to severe intensity occurred in 19% of adult Europeans, seriously affecting the quality of their social and working lives. Very few were managed by pain specialists and nearly half received inadequate pain management<sup>3</sup>. Although differences were observed between the 16 countries, we have documented that chronic pain is a major health care problem in Europe that needs to be taken more seriously. Education has brought about great advances in the management of predictable pain such as those associated with trauma or surgery. Expertise in the management of such pains is now widespread among all healthcare professionals managing these patients. In contrast, the management of patient with persistent pain is still too often based on inappropriate reductionist models that ignore the complexity of, and myriad influences on, the human pain experience. Here lies the greatest educational need. Although in the recent past great inroads have been achieved in the pathogenesis of some types of persistent pains, our scientific

knowledge remains incomplete in many a types of other chronic pains. The emphasis on evidence-based practice in other branches of medicine has led to various guidelines for diagnosing and treating diseases, but very little data is available for us to practise pain management on strictly evidence-based grounds.

It is generally accepted that pain management is best achieved in a multi-dimensional and multidisciplinary approach. Managing patients with persistent pain requires a range of skills that cannot be held to the highest degree by one individual as each requires specialist training and a wealth of experience. Bonica<sup>4</sup> advocated establishment of multidisciplinary pain clinics in the 1950's, but it was only in 1961 that the first pain treatment center was set up at the University of Washington. In the era of 1970's and 80's the pain clinics spread in the developed world at an alarming pace. This spread was parallel to the establishment of palliative care centers. It also paralleled with the progress in the anaesthesiology as a specialty and the interest amongst the groups of anaesthesiologists in clinical areas outside the operating theatres. This interest was largely due to professional dissatisfaction among many anaesthesiologists due to presumed long and hard working hours and poor recognition of their services by their colleagues in sister specialties as well as by the patients and the community. This trend persists even in most of the developed countries up till now. That's why anaesthesiologists are seen in increasing numbers, indulged in the newer specialty of pain management. To most of them, pain management is merely an offshoot of their experience in post-operative pain management and regional anaesthesia. But pain medicine is not confined to the

anaesthesiologists alone. Many orthopaedic surgeons, neurosurgeons, psychiatrists and even internal medicine specialists are now turning to this specialty.

Some pain clinics and centers focus primarily on one mode of pain treatment, such as injections of steroids, which reduce inflammation. Others specialize in treating one particular type of pain, such as headaches or back pain. Those affiliated with universities or medical schools typically provide more comprehensive services with a broader variety of specialists and treatment methods. Each pain clinic model has its own advantages and disadvantages. For example, a comprehensive program offers more variety, so you have a greater chance of finding a treatment that works for a particular patient. However, there is probably only one odd example of these types of centers in our country. Clinics that focus on one method of treatment are generally easier to find, less expensive and less time-consuming. But if a clinic's particular mode of treatment doesn't work for you, it may be difficult to have access to a different treatment. "When your only tool is a hammer, everything you see becomes a nail," says David Martin, M.D., an anesthesiologist who specializes in pain medicine at Mayo Clinic, Rochester, Minn. This is more applicable to available pain clinics in our country. Most clinics here, are being run by anaesthesiologist who have little formal training, if any, in broader principles of pain management. These usually offer steroid injections and/or ill-advised acupuncture. The pain clinics fall miles short of desired criteria as recommended by International Association for Study of Pain. Most of the physicians involved in pain management ultimately earn a reputation as 'teekon wala doctor'. Few patients are referred for investigations, and fewer are sent for advice from other specialists. The broad approach, which is required in great many a patients, is very conveniently overlooked. The great risk of this approach is that the pain medicine is likely to earn bad reputation in its very infancy, barring the establishment of quality pain service in the private as well as public sector. It will also be a discouraging factor for the young professionals eager to adopt pain medicine as

their full time career. Of course there is only a thin line in-between practice and malpractice.

Society for Treatment & Study of Pain is a promising organisation in the emerging field of pain medicine in Pakistan. It has shown its capability to create awareness about pain management in the medical circles as well as among the masses by hosting a variety of activities, including free pain camps and pain workshops. But it can prove to be a useful echelon to formulate policies and guidelines regarding assessment, diagnosis and treatment of pain syndromes. It will probably require a broader and consistent approach through the media as well as government agencies, including Ministry of Health, National and Provincial Assemblies and others. It must work towards a system of training/certification of pain medicine through PMDC, College of Physicians & Surgeons of Pakistan. She has to go a long way and put in strenuous efforts to draw clear lines and a road map towards better and scientific practice. The foundations of pain medicine must be laid on firm grounds, and mockery and quackery must be discredited.

## REFERENCES:

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