

When It Comes to Severe Pain, Doctors Still Have Much to Learn

by Jane Brody; [New York Times](#); Sec F; Col 1; Health & Fitness; Personal Health; pg 6; February 15, 2005
Originally posted: 2/15/2005; [www.doctordeluca.com/Library/Pain/SeverePainDocsMuchToLearn05.htm]

My surgeon did a marvelous job replacing my arthritic knees and, at the same time, straightening my terribly bowed legs when, at 63, I decided to have knee replacement surgery.

Although a class given at the hospital before the operation repeatedly emphasized the importance of adequate pain control, the surgeon and his helpers were not experts in treating prolonged, debilitating postoperative pain.

They are hardly alone. Pain management is not generally taught as a part of medical education, not even to residents in orthopedic surgery. As a result, most doctors are clueless or unnecessarily cautious about treating pain, especially chronic pain like that caused by incurable neurological or muscular disorders.

They are especially ill-informed about opioids, which are synthetic versions of morphine, the most potent painkillers that can be taken by mouth.

As Dr. Jennifer P. Schneider writes about opioids in her book "Living With Chronic Pain" (Healthy Living Books, \$15.95), "Fear and lack of knowledge of these drugs prevent many doctors from prescribing them for people whose pain is caused by anything other than cancer."

Yet, she continues, in 1995 The Journal of the American Medical Association lamented the reluctance of physicians to prescribe needed pain medication. The journal stated: "Bringing about significant change may depend on empowering patients to demand adequate pain treatment. This empowerment will not come easily, especially if opioids must be used for pain relief and if the pain is of a nonmalignant origin."

Pay attention, current and future patients. The journal's message is really for you: Learn what you can about pain control and insist that experts in treating pain help you through it.

A Painful Lesson

I did not know that the dose of the sustained-release opioid OxyContin (oxycodone) that I was taking -- 20 milligrams twice a day -- was a "low" dose until seven weeks after surgery.

I also did not know that the other pain drug I was prescribed for breakthrough pain, Percocet, was really short-acting oxycodone plus acetaminophen. Because my pain was frequently intolerable despite the two doses of OxyContin, I was taking as many as 10

Percocets a day, incorrectly using it as a maintenance drug.

Yet, when I complained about the severity of my pain, which had me crying for several hours a day, the surgeon added an anti-inflammatory drug and told me to take half the OxyContin and Percocet. No surprise that my pain remained unrelenting and occasionally worsened.

I called the surgeon's office weekly and reported my minimal progress in pain control, but at no point was an increase in pain medication suggested, nor was I referred to a pain management specialist on the hospital staff.

When, at seven weeks after surgery, I spoke to Dr. Schneider, a Tucson-based specialist in pain management and addiction medicine, she chastised me for not being more insistent about getting adequate pain relief. The trouble is, when you're experiencing intense pain, it's hard to be proactive about anything.

I know now from speaking with several doctors who routinely treat chronic pain patients that my story is hardly unique. Millions of people suffer needlessly year after year because their doctors do not know how to treat pain properly and don't refer patients to doctors who do know.

Many doctors are afraid to prescribe narcotic drugs like oxycodone, fearing they will create addiction problems. But that in fact rarely happens to chronic pain patients who don't have a history of addiction. When a pain patient needs increasing doses of a narcotic, it's nearly always because the pain worsens, as often happens in patients with advanced cancer. Patients do become tolerant to side effects, like grogginess, but rarely to the pain-relieving properties of these drugs.

When the Nerves Respond

Furthermore, undertreatment of pain can actually cause a chronic problem when the nervous system changes in response to continuing pain signals. Nerves can become permanently hypersensitive to painful and nonpainful stimuli, like touch or vibration. With chronically undertreated pain, the painful area can also spread well beyond the original injured site, as happened to a man I know who now has to take 500 milligrams a day of OxyContin.

"The way to prevent this undesirable outcome is to avoid repeated pain signals," Dr. Schneider said. "Long-acting opioids like OxyContin, which provide many hours of consistent pain relief, are more effective than short-acting opioids, like Percocet, at preventing pain. It takes less drug to prevent recurring pain than it takes to treat it."

However, Dr. Schneider wrote, "Because breakthrough pain is common in patients with chronic pain, patients being treated with long-acting opioids often need a second prescription for an opioid with rapid onset" to treat breakthrough pain. These second medications are "meant for transiently increased pain, not as part of your regular pain regimen," she explained.

When I read this, I realized I was on the wrong track, taking too little of the long-acting drug and too much of the short-acting one. The latter had, in effect, become my maintenance drug rather than the one I used now and then when, say, I had physical therapy or spent hours riding in a car.

Surgeons may know a great deal about cutting, repairing and sewing up, but they are not experts on pain control, though I think they should be. I know of an orthopedic surgeon in New Jersey who won't see his knee replacement patients for two months after surgery because he doesn't want to see them when they're suffering.

As it turned out, my internist knew far more than my surgeon about treating pain. He has many elderly patients with chronic pain and knows very well how to treat it. I realize now I should have sought his help from the beginning. Or I should have asked to be referred to a pain management specialist at the hospital where I had my surgery.

Let's Fix What's Broken

First and foremost, patients need to be proactive and insist on the help they need. If patients are not able to do this for themselves, an advocate should do it for them.

Second, every person with prolonged or chronic pain should become educated about the huge range of medications, therapies and complementary remedies available to treat pain.

"Most chronic pain patients receive more than one type of drug and end up taking a cocktail of pills," Dr. Schneider said. The many possibilities include anti-inflammatory drugs, muscle relaxants, drugs like anticonvulsants that treat nerve pain, antidepressants (in doses much lower than that used to treat depression), topical analgesics and sleeping pills.

In addition to using combinations of drugs to control pain that does not respond to one remedy alone, Dr. Schneider writes that patients may be helped by physical therapy, exercise, acupuncture, electrical stimulation, heat, massage, yoga, hypnosis (including self-hypnosis), cognitive-behavioral therapy, biofeedback and various relaxation techniques like guided imagery, meditation and progressive muscle relaxation.

[END]