Integrated management of chronic pain

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Recent understanding of chronic pain has indicated unequivocably the involvement of an important emotional component in this kind of pain.[1-3] It is this awareness which has stimulated psychiatrists and psychologists to enter this area of medicine. Anaesthetists do not seem to have responded to this new information and persist in running nerve block clinics while others willing to take a broadened approach to pain management have started to treat their patients.

Why respond to this challenge?

It is well established that nerve blocks given alone, as in a nerve block clinic, can produce a 30 per cent cure rate for chronic pain problems.[4-6] But, when approaches encompassing a wide understanding of chronic pain are added, then a 60 per cent improvement rate can be achieved.[4,2] Furthermore, these patients are not psychiatric patients; the presenting complaint is one of chronic pain, not of emotional difficulty.[1,2,7] Anaesthetists are well equipped to undertake this broader approach. They perform nerve blocks which are valuable for diagnostic and therapeutic purposes and recognize the effects of anxiety and stress on pain, from their anaesthetic experience. They are well aware of the efficacy of inter-personal interactions in reducing pain and are generally sympathetic and empathetic physicians who are experienced in cooperative and team medicine.

Anaesthetists need to have some practice outside the OR

Stress in the operating room is very high and has been recognized only recently. For the health of anaesthetists and welfare of their patients, it has been suggested that anaesthetists should diversify out of the OR.[8] One way of doing this is to become part of a pain management team.

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It has been shown that there is a mixed physical and psychological problem in at least 70 per cent of patients with chronic pain. Both of these aspects should be dealt with concurrently by the same team, i.e., integration of the overall management. In our original model at the Royal Victoria Hospital this goal was achieved by an anaesthetist and a psychiatrist working together. In this way the pain problem was treated as one "physiological" system. Several beneficial effects were clear:

- The consequences of changing to this format were that patients could not split up the physical and psychological parts of their pain.
- Brief rapid improvements induced with nerve blocks and TCNS were used as stepping stones to longer term discussion of psychological factors in the individual and spouse.
- Patients feel more confident that their problem is being treated when they receive both physical and psychological treatment at the same time.
- All problems, physical or psychological, are within the competence of this "tandem"team.
- Valuable information gathered, during a nerve block for instance, about the way a patient handles his anxiety could be elaborated and discussed more fully by the anaesthetist and psychiatrist in the 45-minute follow-up sessions.
- It is not necessary for both the anaesthetist and the psychiatrist to see patients for this kind of psychotherapy very frequently. Once every three weeks normally suffices for the first three months.
- This psychotherapy is supplemented by simple psychological strategies such as relaxation, biofeedback and simple expression of feelings in twice weekly sessions with an assistant.
- The psychiatrist uses techniques not normally applied for the general psychiatric patient but which are successful in this combination for this kind of patient.
- Gradually the anaesthetist learned the particular

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style and format of psychotherapy required for this kind of patient, but he did *not* become a psychiatrist.
- Although apparently convinced that their problems are physical, patients rarely, if ever, object to the psychological inquiry and subsequent psychological treatment.

Obtaining results

We showed that in a difficult group of patients, the Worker's Compensation Group, this integrated approach improved treatment success rate to 60 per cent, when long-term return to work was used as a measure of success.[9] Others have produced similar results with similar approaches[10,3]

Feasibility

Certain difficulties exist in establishing such a pain management centre. These include the problems of obtaining an interested psychiatrist who will agree to share but not compete over patients, and who is prepared to learn another approach. Many psychologists and psychiatrists are interested in this work and are willing to cooperate. They understand the need for a physical approach combined with a psychological approach.

Nature of the psychological problem

These patients do not present with a conventional psychiatric diagnosis. Rather, they are the kind of people who are described as "alexithymic," which means they do not possess the words to express their feelings. Also, they have trouble recognizing what they feel and, especially, have difficulty in doing anything about that feeling.[11,12] Several sophisticated tests are available for research purposes to detect the syndrome but we have found the Middlesex Hospital Questionnaire gives a typical response pattern with chronic pain patients. This simple test will help to diagnose this kind of problem and serve as an introduction to the patient, of some psychological matters.

Evolution of a treatment program

After psychological testing patients undergo an initial comprehensive medico-psychosocial evaluation by the anaesthetist/psychiatrist when physical, psychophysiological and psychiatric diagnoses are formulated.

Treatment programs usually incude diagnostic and therapeutic non-neurolytic nerve blocks every week for two to three months; TCNS with relaxation exercises and general discussion of feelings twice a week; supervision of an exercise programme by the unit physiotherapist; anti-depressant medication indicated in small doses in about 80 per cent of the patients; psychotherapy visits every three weeks of 45 minutes with the couple and the anaesthetist/psychiatrist. Videofeedback, group therapy sessions and re-integration into the work force may also be important parts of the treatment. This intensive treatment programme continues for about ten weeks when there is a re-assessment. At this time, about two-thirds of patients will report improvement but half of these will stop while the other half will continue psychotherapy. About one-third will be unchanged. This psychotherapy may become more frequent, every two weeks or every week. If further psychotherapy is required, patients will be referred to selected psychotherapists.

Chronic pain management is a challenging, stimulating area of anaesthetic practice which is very rightly the domain of anaesthetists. They should meet the challenge presented by new information and the demands for a broader approach to management. This summary demonstrates how this can be achieved to satisfy the needs of the patient and of the psychiatrist and to produce an improved outcome.

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