Dynamic Chiropractic

BACK PAIN

Pain: The Enemy of Function

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We have all noticed that many patients come to us for pain-related complaints. I know we talk about wellness care and preventive care, but in my practice, a vast majority of my patients come to me for some pain-related complaint. A significant portion of the typical chiropractic case load is urgent care for musculoskeletal pain. Fortunately, we are often able to get our patients out of pain quickly and without drugs.

I am proud to be a pain doc. I am proud to help patients with their symptoms. However, I am a bit skeptical of structural corrective care. My interpretation of the evidence is that we cannot yet say that correcting spinal curves is worth doing or whether it is really effective.

I know this is heresy to many of you. I spent several years of my career taking full-spine X-rays, making corrections and then retaking the X-rays. Looking back, I am not sure this was worth the radiation exposure or expense to the patient. On the other hand, when I get patients out of pain and teach them exercises that allow them to modify their function and pain, I know I have done something.

Chronic Pain: The Consequences and the Challenges

One of the huge downsides of chronic pain is how it affects the body, whether we know it or not. The atrophy around the knee after a knee injury is the most obvious example of this, but other structures are similarly affected. In the lower back, both the multifidus and the psoas show inhibition and true atrophy, as measured by CSA of the muscle after disc injury.

Chronic pain also affects the brain. Patients with chronic pain show impairment of their cognitive function, reporting difficulty in memory, mental flexibility and rate of response to stimuli.1 Some of the effects may be related to long-term use of narcotics. We are all aware of the downsides of narcotic medications, but the pain itself may affect the brain in a significant way.

When the patient has ongoing chronic pain, stabilizing the spine is a little like Sisyphus rolling his rock up the hill, only to watch it roll back down again. Sometimes, we can effectively rehab patients, get their pain reduced and reverse the vicious cycle. Yet sometimes we don't succeed, even with cooperative, willing patients.

One of the key issues to treating pain is finding some kind of exercise the patient can do when they are in pain that both brings relief and moves them toward better functioning. Sometimes, we don't have as much success, particularly when the patient does not commit to the rehab process. Other times, patients have some underlying pain generator that cannot be effectively and easily solved. These

patients tend to get thrown on the garbage heap, especially if their pain generator cannot be seen on imaging.

When we don't help someone, it's only human nature to either blame them or give them the message that nothing is really wrong. A better statement to the patients with whom we do not succeed is, "I am sorry that I was unable to help you. I am not really sure what is the cause of your pain or what the eventual solution will be." It is important to remain humble in the face of failure and to continue to learn.

I know the research has shown that the Oswestry and visual analogue are accurate ways of measuring pain, but many times, I think a more important factor may be a more subjective quality of pain. Some of your patients come in wearing the "mask of pain." This is a quality of those who are struggling with chronic, unrelenting pain.

Another question I ask goes like this: "Is your pain at the center of your life or is it out on the periphery?" Pain that is at the center of your life, that consumes you and takes way too much of your attention, is obviously more significant. When we can help get the patient's pain out to the periphery where it is just an irritant, rather than the focus, we have really accomplished something. I don't know that our standardized tests necessarily tell us about these other factors, even though they have great value. The factors are all evident in a good history if you take the time to talk to your patients.

Searching for Answers: My Story of Pain

Personally, I am well-aware of myself as a wounded healer. I suspect that I am a better chiropractor, both in my empathy and in my search for answers, due to my own lumbar pain. I wrote briefly about my own experience seven years ago in the context of diagnosis of discogenic back pain. [See "Discogenic Pain: Diagnosis and Treatment" in the Sept. 1, 2003 issue.] Most of what I said then still rings true to me.

Several weeks ago, I had a lumbar disc injection of methylene blue solution. (If you don't yet know about this newer procedure for lumbar discogenic pain, see my article on this procedure in the July 1, 2010 issue .) Typically, someone undergoing this procedure would likely have a full discogram, pressurizing the disc and if positive, reproducing the pain. If the diagnostic injection were concordant, the doctor would inject the methylene blue solution, hoping to denervate the painful nerves.

This procedure is obviously not for all back pain and not even for all chronic back pain. For one, it is still quite experimental, with only one good research paper. It does involve an invasive discogram, which has the risk of further damaging the disc. Nevertheless, I felt that since I already had a discogram showing pain coming from L4-5, it was worth the risk.

One of the primary qualities of my ongoing discomfort is my inability to be still. I have not been comfortable sitting for any length of time. I could not previously stand for more than five or 10 minutes without needing to move. Long sits and long stands would not only create a gradually increasing pain, but would also lead to pain for several hours afterward. After a long plane flight or car ride, I could count on several days of pain. This made me not much fun on vacations, as I would spend the first few days in an irritable state. The other aspect of long sits/long stands is that I am more vulnerable to a disc tear event from some trivial motion, creating a sudden, sharp pain that can leave me in bad pain for anywhere from three to 10 days.

Within 24 hours after the methylene blue injection, I found myself able to sit and stand, almost like a normal human. This has given me an increased sense of calm. Is my back fine? Am I pain free? The answer to both of these questions is *no*. I am still a 60-year-old stiff guy who has had back pain off and on for more than half of my life, but I'll take the improvement with gratitude. At this point, my back pain is much less at the center of my life. I enjoyed a long movie without a problem, sat at a concert, was able to stand around and talk with others; all with mild pain and minimal after-effects.

I am still in a bit of shock from this change, not sure what to expect or how my life will change. I have previously done both an IDET and a proliferant-like disc injection, neither of which had these particular positive effects on my sitting or on my standing tolerance.

Ideally, my diminished pain levels will allow me to effectively strengthen my core and to further stabilize my damaged discs. Yet even with all these improvements, I know that my lower lumbar discs are not normal and that I need to be careful first thing in the morning. I also know I must avoid excessive lifting and twisting.

I hope that my personal story has been useful to you and that my attempts to describe the qualities of pain provide you with a new perspective on treating pain.

References

Kreitler S, Niv D. "Cognitive Impairment in Chronic Pain." *Pain*: *Clinical Updates*, July 2007;15(4):1-4.

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