Editorial

Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Pain

Pain is protective, it may be life saving. However, for many of our patients, pain no longer fulfils any useful purpose but rather becomes a burden from which there appears to be no escape. For some, pain becomes the controller of day-to-day activities. It seems to be an evil that not only inhibits their lifestyle but also eventually comes to direct all that they do and torments their days and their nights. It is associated with depression, dependency and despair.

We all live with pain; the pain of childbirth, the everyday hurts of children, for some the result of discipline, for others the consequence of violence, the pain of injury, the pain of disease and of dying and the pain of emotional trauma. Pain is the most commonly reported symptom[1] and the most common reason for consulting a doctor.[2] It is almost certainly the most common reason for people taking medication but figures on this are difficult to find. A 1999 survey of US households found that 42% reported having a member of the household who experienced pain on a daily basis and 80% of these considered that it was a normal part of their medical condition.[3]

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Every day we see patients who have acute pain. Pain that has a pattern that conveys a diagnosis. Pain that is exacerbated by a fear of the unknown or of incorrect expectations. Pain that is difficult for the patient to define and for us to interpret. We also see patients who have debilitating pain from chronic inflammatory disease or from cancer. It is sometimes difficult to avoid being drawn into their suffering.

We also all have a few of those patients who regularly and frequently visit us with their ongoing complaints of persistent unrelenting pain. Some have had an old injury, some have a current medical condition, many return for completion of ACC and WINZ certification and repeat prescriptions. Some of these patients seem content to live with their disability and to receive their ongoing benefits, others are demanding and angry. We may be tempted to slot them into one of Grove's stereotypes of 'hateful patients', dependent clingers, entitled demanders, manipulative help-rejecters or self-destructive deniers.[4] These patients often come to be thought of, but are hopefully seldom referred to, as pains in the neck. The neck of the receptionists, the nurses and the doctors. Their management may seem superficially to be simple but is, in reality, complex (a topic that we will address in more detail in the next issue of the journal). It may be useful to think of their pain as being a symptom of dysfunctional systems. A cry that homeostasis is out of control.[5] The challenge is to define the systems failure, as it is likely to be a complicated interaction of dysfunction at multiple levels of systems from cells and organs through to psychological and social interactions moving across the patient's internal and external environments.

In this issue we not only have several theme papers on pain but also the CME section is concerned with aspects of pain management. Rod MacLeod provides us with an overview of pain management in palliative care and reminds us of the *'importance of seeing pain in its totality – that is, a symptom having physical, psychological, social and spiritual components'*. He assures us that more than 90% of cancer pain can be alleviated. Keela Herr has a special interest in pain management in the elderly. She believes that pain is vastly under treated in those over the age of 65 and she addresses some of the misconceptions about the use of opioids in this age group. She also reminds us of the challenge of managing pain in those who are unable

to reliably communicate their pain. She exhorts us to do better. Bronwyn Thompson is an occupational therapist who has a special interest in pain management. She discusses the management of musculo-skeletal pain using the example of persistent low back pain. All GPs have patients who have this complaint. Her contention is that our patients need to learn how to live with their pain rather than have their fear of pain direct their lives. In the CME section we have evidence-based contributions updating the management of migraine and inflammatory joint disease. The third paper in this section focuses on the use of morphine and methadone in palliative care.

These papers merely touch on some of the issues regarding pain and pain management that we see in our practices. The field is enormous. There are organisations and journals devoted to the study of pain and its management. A search of the literature produces thousands of results, even when the search terms are quite narrowly defined. Amongst the vast number of resources that are readily available on-line there are a couple of sites that I have found particularly useful. One is the Oxford Pain Internet Site http://www.jr2.ox.ac.uk/bandolier/booth/painpag/index2.html that is a free access site committed to providing evidence-based information on various aspects of pain management. This includes gems such as the following: *'How much is spent in the USA every year on magnetic devices to treat pain? Answer is $500 million, with a total worldwide market to date above $5 billion. To put that into some sort of perspective, that $500 million is just half the annual sales that the pharmaceutical industry defines as a 'blockbuster'. And what do you think is the evidence for magnets affecting pain? You guessed it. None.'* It also includes systematic reviews of all of the analgesics that I have ever used and many that I have never thought of using. The site is easy to navigate and will provide answers to most of your questions even if the answer is – 'there is insufficient evidence'! The other is a useful review of the use of adjunctive agents in the management of chronic pain[6] that can be viewed at http://www.medscape.com/viewarticle/409782?src=search. This review points out that although antidepressants have long been viewed as first-line therapy for diabetic neuropathy and central poststroke pain and as adjunctive therapy for cancer-related pain, their adverse-event potential has led to the evaluation of antiepileptic and other agents for the mangement of chronic neuropathic pain. There are some useful tables summarising adjunctive analgesia dose guidelines, analgesic interactions and interactions between analgesics and other drugs.

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We are all inevitably involved in pain management and we hope that there will be something useful in this issue to guide your advice to patients who are distressed.

References

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'Life is pleasant. Death is peaceful. It's the transition that's troublesome.'

– Isaac Asimov