Changing Our Relationship with Pain

Most of us in our busy Clinics are dealing with patients with chronic pain (by the time they reach us!) predominantly back pain (CLBP). But is the bark worse that the bite? Our spine has not changed in the past 500 years or more. Instead our behaviour has led on to the evolution of a large number of differentials for CLBP. The explanation of each being obscured by myths and jargons of modern medicine. Most of the time it’s some kind of dysfunction causing pain where it’s difficult to put a finger at a single structure or source.

Let’s do MRI! Is the patients and the physicians next and probably the final stop, but many a times it is not needed as much as it is used. Premature MRI is often worse than useless, leading the detective physician to follow a red herring! By itself the MRI behaves like a Nocebo, an inert substance that causes harm. (Opposite of placebo).

For a few lessons from running, help us run an OPD. When running long distances. One may choose to go with adaptive strategies, like ignoring pain, or overriding it with the urge to keep going. Or choose a maladaptive strategy like fear of worsening and despondence (“Oh it’s terrible!”). The more you think of a negative thought the higher the odds of one slowing down and see the finish line receding. The last 2 of 42nd KM literally feels like a 10K! So, is it all in the mind for the back pain too? It is now well established that CLBP is not limited to spinal impairments, but can also be characterised by changes. In regions in the brain called “pain matrix and these changes are reversible by various strategies and interventions. It is not our intention to practice unsafe medicine and ignore the red flags. Let’s learn differentiate between threats and risk, understand the tip of the Ice berg well before using that mountain of so-called evidence in treating our patients.

Let’s lend our ears to these patients, talk to them nicely and try and convince them that we can get over it.

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