



Is the Pain Real or Not?

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Chronic pain (constant pain lasting 6 months or longer) is a subjective experience, which is influenced by many pre-morbid (before the onset of pain) psychological problems. However, chronic pain often can produce depression, anxiety, and marital difficulties [1]. Although physical examination and other studies, including x-ray studies, 3D-CT, electromyograms (EMG), nerve conduction velocity studies and MRI [2-4] in many cases may document an organic basis of chronic back pain, some organic syndromes defy definition by objective tests [5]. This may be a greater problem for women, where physician prejudice can result in a significantly less extensive evaluation of their complaints of back pain [6]. Also, any litigation may influence symptoms [7] and the type of litigation may influence outcomes [8]. Therefore, there is a need to differentiate between “organic” and “functional” (negative physical and laboratory examination) back pain [9,10].

Many of the articles in the medical literature devote their efforts to measuring pain, rather than addressing the presence or absence of organic pathology. This research tries to correlate the subjective severity of pain with work capacity or failure to improve [11,12]. More importantly, 40%-71% of chronic pain patients are misdiagnosed [13-15]. However few articles appear in the medical literature that actually correlate perceived pain with the presence or absence of documented organic pathology, as measured by objective testing. Everyone just assumes that a broken leg is painful, and the X-ray is positive to confirm that. Likewise, many articles try to correlate psychological disturbance with the absence of organic pathology [16-20], while failing to recognize that severe organic pathology produces psychiatric problems in a previously well-adjusted individual [1,10,21-23]. Consistently, clinicians keep asking the wrong question.

Since pain is a subjective experience, there is actually no objective way to measure pain. [24]. This produces a real issue for medical care, since patients use the complaint of pain to obtain narcotics. In recent years, there has been an increasingly stringent effort by the Drug Enforcement Agency (DEA), and local police departments to “crack down” on physicians, who they perceive as “drug pushers.” [25]. While there are instances where physicians may establish “prescription mills” that indiscriminately hand out narcotic prescriptions to anyone who claims to have a pain, often without an examination, or where narcotics were prescribed to someone who was not a patient, or prescribe narcotics in quantities deemed unacceptable by the DEA, these instances are rare [25]. However, the arrest and subsequent jail terms for physicians in highly publicized cases has sent a chilling message to all physicians who prescribe narcotics [25]. Compounding this issue is

the finding that most physicians are not able to detect deception very well [26]. Finally, the various techniques used for deceiving the physician, in order to obtain narcotic medication, are legion [25,26].

Increasingly, physicians and nurses need to protect themselves from deceptive patients. These clinicians need to document that they are participating in some effort to avoid being deceived. Recent recommendations have been requiring a narcotics contract, obtaining random urine testing to determine the quantity of narcotics in the system, and not prescribing narcotics until there is clear-cut evidence of organic pathology. Unfortunately, the last criteria is fallacious, since between 40%-71% of chronic pain patients are misdiagnosed [13-15]. As an example, the false negative rate of MRIs for detecting painful disc pathology is 75%-78% [27]. This is due to the fact there are painful fibers in the rear portion of the annulus which can produce pain when the nucleus pulposus herniates into this area, without producing any distortion to the anatomy of the disc [28]. This has been termed Internal Disc Disruption (IDD) by Bogduk and his colleagues [28]. Therefore, this painful pathology fails to produce abnormal MRI or CT since there is no external disc distortion, and can be detected only by using a physiological test, such as the provocative discogram, rather than an anatomical test [28].

On the other hand, since the advent of the requirement to document the severity of pain in patients, the so-called 5th vital sign, physicians are obliged to provide pain relief [29]. Failure to do so have resulted in law suits against physicians [30], with awards as high as \$1,500,000. So now physicians are caught between the DEA and the trial lawyers - the proverbial rock and hard place.

In an effort to provide a consistent method of assessing patients with chronic pain, a group of physicians from Johns Hopkins Hospital developed the Pain Validity Test [31-35]. This test is available, in English or Spanish, over the Internet at www.MarylandClinicalDiagnostics.com. It takes only 5 minutes of secretarial time to set up a computer to administer the test, and turn the computer over to the patient. It takes an unattended patient only 15 minutes to complete the 32 question Pain Validity Test, and results are available 5 minutes after the patient completes the test. The Pain Validity Test can predict the presence of abnormal medical testing with 95% accuracy, and the absence of abnormal medical testing with 85%-100% accuracy [31-35]. The Pain Validity Test can be used to determine if a patient should have additional medical testing, or is faking or malingering. The Pain Validity Test can detect “drug seeking



behavior” with 95% accuracy, and has been admitted as evidence in over 30 legal cases in 8 states [36]. Finally, the Pain Validity Test can predict that a surgeon will find intra-operative pathology with 93% accuracy [37].

For any clinician in a busy office or Emergency Department, facing with the determination of prescribing narcotics, or ordering additional medical testing, or dismissing a patient, the Pain Validity Test lends a degree of objectivity to the decision making process.

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