NOTES From the Medical Director by Doug Smith, MD, ACA Medical Director

Life Without Pain Can Really Hurt You

Pain. Most of us are familiar with it and would be more than happy to do without it. We think of pain as a curse, and occasionally it can be. But in reality, it is a blessing - a mixed blessing.

Chronic pain can have devastating effects, changing a person's focus, concentration, enthusiasm and ability to relax or sleep. Persistent chronic pain can alter one's personality and adversely color the nature and tone of the individual's interactions with others. Unfortunately, there are times when a solution for chronic pain eludes us, and we must seek ways to try to cope with it when it cannot be conquered.

In other circumstances, pain can be assistive. Noted physician and philosopher Paul Brand calls pain a "friend" because it is our body's alarm system to alert us that something is wrong. Without pain, a bad situation can become much worse, and we might not even be aware it is happening.

In these situations, it can be worse for us not to feel pain, strange as that may sound. Some conditions, such as diabetes, nerve or spinal injuries, deprive a person of sensation or feeling. If loss of sensation should occur in a foot or leg, those who don't feel pain may risk serious injury if their "alarm" can't alert them that they're doing something hazardous, such as walking on an open sore, and severe destruction of tissue may occur.

Those with an ulcer on the bottom of their foot know they shouldn't walk on the sore. But without pain to alert them, they may walk on it anyway and cause additional harm. Unfortunately, some of these sores never heal, and limb loss results. As Paul Brand says, "Life without pain can really hurt you." But when pain forces a person to protect the open sore, healing can occur. Pain compels us to behave. Pain motivates us to protect injured areas.

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The issue of severe pain often enters the decision to amputate. People with chronic pain may want an amputation because they believe that once the part is gone, the pain will disappear as well. This is not necessarily true. Part of my job is to inform the person of the possible sensations, feelings and pain patterns he or she might have afterward, even though we don't have a crystal ball and can't predict them. Sometimes, an amputation can help improve one's life; sometimes, unfortunately, it cannot. For some amputees, the phantom feeling, or phantom pain, has been more bothersome than the original problem.

When people visit a doctor about pain, they have an underlying hope that the physician can wave a magic wand and, "voila," their problems with pain disappear. I also wish there were some magic but, alas, there is not. What we're left with, then, is to try to understand the different aspects of pain and the wide array of treatments available for it.

Can pain from the same injury be worse for one person than another? Do people actually feel pain differently, or do they cope differently? Is how we cope the determining factor that leads to recovery? One person may suffer a catastrophic injury and survive a major hip- or shoulder-level amputation, yet be able to recover with strength of will and resume living a successful life. Another person may incur a minor amputation and become emotionally devastated, finding it difficult to get through each passing day. The extent of the amputation does not necessarily determine who will have a more difficult recovery. Emotion, the energy of the moment, desire, behavior, cultural aspects and many unknown factors all influence how we perceive pain and are motivated to react to it.

Although it's easy to recognize when we experience pain – "I hurt!" – it's sometimes difficult to convey to others the kind of pain we're suffering and how badly we're affected. There is a wide array of feelings and types of pain following amputation: phantom sensation, phantom pain, residual limb pain and back pain. It's important to distinguish them from one another and to make sure that we are talking about the same thing and using the terms consistently. Also, pain can have many characteristics. It can be constant or episodic, frequent or infrequent, intense or mild, bothersome or not bothersome, sharp or dull, itchy or burning. A whole spectrum of words can be used, and these descriptions help the health caregiver in determining what may be causing the pain and a possible course of treatment.

Often patients will ask me, "Doc, can't you just open it up and look?" Unfortunately, we cannot see pain. Instead, to find a cause of pain we look for indirect evidence, such as abnormal-looking tissues or structures that might be the basis for the discomfort. But none of the tissues have a little sign or distinctive coloration that shout out, "I'm the pain!" Our intuition helps, but we never know for sure that surgery is actually going to get rid of the pain. The nature of surgery is that you almost always know what you're going to do before you begin. And operating for pain is no different. The surgeon must have a plan. Personally, I would be skeptical of a surgeon who embarks upon the surgical pathway by simply saying, "I'll just take a look and figure it out."

Because each person experiences pain differently, measuring it is very difficult. A scoring system can be useful in helping the person with limb loss and the physician come to an understanding about the severity of the pain. I may ask, "On a scale of zero to 10, with zero being no pain and 10 being the worst pain you can imagine, how would you rank the pain you're feeling?"

This scoring system is a beneficial tool and helps simplify matters for a person starting a medication and treatment program. If the person rates the pain as a 7 or an 8, and after a period of medication and treatment says the pain level has dropped to a 4 or 5, we know there has been improvement. This simple scale helps us score an entity that is impossible to measure.

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However, we don't necessarily know whether the intensity of the pain is less, or if the nature of the pain has changed. And a scoring system doesn't help us to figure out which parts are involved. Pain can be very complex. A scoring system is useful, but it should not be the sole method of measuring pain.

Patients hate it when their physician tells them, "You're just going to have to live with the pain," or, "It's all in your head." It sounds like an insult. He or she may think, "The doctor doesn't believe me," or, "The doctor doesn't know what I'm talking about." The person often looks as if he or she is on the *Titanic*, realizes there aren't enough lifeboats, hears the band playing and wants to scream, "How am I going to deal with this?"

People often seem to prefer being dealt with directly: "I'm sorry, but I don't know exactly why you hurt. I can't figure out the exact cause of the pain. But I believe your pain is very real." When we can't figure out what is causing the pain, it's important to focus on strategies that will improve the person's life while the pain is present. Techniques involving biofeedback, breathing, motivation, distraction, touching or medication are designed to help people cope with chronic pain; however, medication doesn't necessarily remove or cure the pain. Often, medicines just make the mind not care as much about the pain.

We shall examine the following issues related to pain in upcoming issues of *inMotion*: phantom sensation, phantom pain, neurons, neuropathy, mechanical pain and various treatments.

We all can relate to discussions of pain and its treatments, whether our culture is one that encourages us not to talk about our pain but to bear it stoically, or one in which words and emotions are used in abundance to describe what we're going through.

The French philosopher Marcel Proust said, "To kindness and to knowledge we make promises only. Pain we obey." Pain demands our attention. Living with chronic pain can change our outlook, our personality and our relationships. But, just as devastating, life without pain can really hurt you. ■