

CORRESPONDENCE

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There Is No Golden Yardstick

To the Editor:—Having the honor of being the designated “needle jockey” at the University of Washington’s Multidisciplinary Pain Center, one might ask, after reading Dr. Jacobson’s article,¹ whether I should run for cover. The answer is a categoric no. Being one of the members of a very large multidisciplinary team, most of my referrals for procedures come from other pain physicians and are highly appropriate. Is one physician on a very large team, performing procedures 2 days a week, performing too many or too few procedures? There is no golden yardstick.

One must remember that Dr. Jacobson¹ is referring to patients with chronic nonmalignant pain, whose diagnoses remain elusive or refractory to treatment by the biomedical model. I have seen patients’ pain alleviated by a procedure after they had been told that they would have to learn to live with pain, but that is the exception.

Are good technical skills all that are needed to be a competent proceduralist? Absolutely not. A thorough psychosocial history on each patient by the proceduralist places one more “check” in the system before a procedure is performed. There is a saying in pain medicine: “The best way to turn a turkey into an albatross is to stick a needle into it.” Not uncommon is the patient who states that they “were fine until that doctor stuck a needle in me, now I’m ruined” have been faced with that albatross. Proper screening before a procedure can only be performed by a person with strong behavioral management skills.

Assessment of the response to a procedure is the most challenging aspect of a proceduralist’s practice. Negative and positive responses both necessitate deep consideration of the biopsychosocial factors that influence pain. Would a positive response to a procedure place a

patient’s disability status in jeopardy? Did a positive response occur because the patient did not want to disappoint a caring and personable physician, or was it a placebo effect? These questions always challenge the best of my biopsychosocial training.

The needle jockey must first and foremost be a communicator and a behavioralist and well rehearsed in the biopsychosocial skills of pain management before being given the privilege of performing procedures. There are two ends to every needle.

After reading the review article by Hogan and Abram² about pain procedures, one can ask whether blocks should be performed at all? Yes, but only by a compassionate, well-trained behavioralist who understands his roles and limitations.

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Management of Chronic Nonmalignant Pain

To the Editor:—Regarding the medical intelligence article, “Beyond the Needle,” by Jacobson *et al.*,¹ I would like to make the following comments. First, the psychologic treatment of pain, also called cognitive restructuring, is unnatural, which is why it is neither successful nor economic, and unprudent. It is unnatural because we are attempting to teach patients to react in ways that are opposite to what nature intended.² Many of these patients with chronic nonmalignant pain, including and especially those who show “minimal pathology with maximum dysfunction” are, in fact, patients with sympathetically maintained pain. The expectation of a successful outcome in these patients with sympathetic blocks is as likely as walking on water, because the key to the successful outcome in sympathetically maintained pain is treatment of both the sympathetic dystrophy and the underlying cause. Let me illustrate this with a familiar case scenario.

Sympathetic dystrophy of the right upper extremity develops in a patient after routine carpal tunnel release. The patient is given stellate ganglion blocks, with good response. The patient returns to work. No sooner has the patient started working than the pain, stiffness, and swelling recur. In this patient, the underlying cause is the residual carpal tunnel syndrome. Unless that is corrected, the effect of stellate ganglion blocks will not last.

By residual carpal tunnel syndrome, I mean a carpal tunnel syndrome on which operation was performed, but nothing was performed for median neurodesis secondary to nonspecific flexor tenosynovitis, which is the reason for a poor surgical outcome of carpal tunnel.³ This neurodesis is at the interface of the radial synovial bursa and the median nerve at the level of the proximal edge of the transverse carpal ligament, which is also the site of

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maximum tenderness in failed carpal tunnel surgery. Incidentally, superficial to this lesion is the dreadful palmar cutaneous branch of the median nerve, which has not only turned hand surgeons into "scaredy cats," but also has led Mackinnon and Dellon⁴ to the erroneous conclusion that the cause of this tenderness is scarring of the palmar cutaneous branch; which explains why we have yet to see a successful outcome of surgery for "scarring of the palmar cutaneous branch."

According to our protocol, this patient will require repeat stellate blocks, and when the pain, stiffness, and swelling are resolved, then and there we will surgically repair the residual carpal tunnel syndrome with complete and methodic flexor tenosynovectomy and neurolysis of the median nerve.

The inextricable link between reflex sympathetic dystrophy and patient dissatisfaction—the long searched-for cause of the so-called "individual predisposition"—calls for competent and compassionate management of these patients to regain their trust.

I conclude with the prediction that, at the end of the day, we will all be convinced that pain is a simple sensory messenger from the damaged tissue crying out loud, "Please fix me."

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In Reply:—We appreciate the opportunity to respond to Drs. Khan and Erjavec. Their comments show several of the issues and concerns we discussed in our article.

It is difficult to understand the rationale of Dr. Khan's position with regard to the usefulness of psychologic treatments for pain. His confusing references to the empirical basis for psychologic treatments and his global dismissal of such interventions as "neither successful nor economic and, therefore unprudent [sic]" reveals a fundamental misunderstanding of the contemporary pain literature that defies further comment. His perspective should not be dismissed lightly as the ill-informed opinion of one isolated practitioner. Unfortunately, it represents an attitude that pervades the world of biomedicine.

Dr. Khan's concluding remarks eloquently portray the biomedical myth that lies at the root of the problem of intractable chronic pain. His prediction that, "at the end of the day, we will all be convinced that pain is a simple sensory messenger from the damaged tissue crying out loud 'Please fix me'" is quaint, but very disturbing. Although, unlike Dr. Khan, numerous practitioners do not grossly oversimplify this complex clinical problem, many well-meaning physicians practice as if this is the case. Contemporary medical education emphasizes nociception while ignoring the psychologic and social aspects of chronic pain. One of the major points of our article is that as long as the practitioner remains limited to a biomedical model those patients who are the most overwhelmed by pain will remain enigmatic.¹ It is our belief that to help those patients who show "minimal pathology with maximum dysfunction"² the anesthesiologist needs to learn a whole new set of conceptual and clinical skills.

In his letter, Dr. Erjavec shows an awareness of the importance of psychologic and social factors of chronic pain. He acknowledges that the proceduralist must "first and foremost be a communicator and a behavioralist and well-rehearsed in the biopsychosocial skills of pain medicine before being given the privilege of performing procedures." It appears that, as we suggest in our article, he restricts nerve blocks to those patients who have high levels of psychosocial functioning and clear

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organic etiologies indisputably amenable to nerve block therapy.¹ Therefore, according to Dr. Erjavec's stated position, we disagree mainly about practical matters rather than about conceptual issues. We applaud his efforts to screen patients for psychosocial problems that mitigate the decision to perform a procedure. We suspect, however, that most anesthesiologists lack the skills to perform such evaluations. Our article outlines the changes in training that we believe are necessary.¹

Unfortunately, in the real world, many "needle-jockeys" function more as technicians than as physicians. The incentives and pressures of modern medicine leave little time to practice the "art" of medicine. The major purpose of our article was to describe new opportunities for anesthesiologists to learn old medical skills that are devalued by biomedicine. It is important to understand that overwhelming chronic pain is not a biologic event, but rather an all-consuming personal experience.³ We advocate a biopsychosocial approach that is tolerant of incomplete medical knowledge and that accommodates medicine's limitations. When complete understanding is abandoned as a goal, the traditional tasks of the physician—listening, witnessing, and relieving suffering—are not relegated to a small corner of medicine, the so-called art of medicine, but are returned to the core of medical practice and medical education.⁴

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