House of Cards

Exploring the Limitations of Interventional Pain Management

By Debra L. Doby

Should patients live with pain? Current cultural expectations have led to failed attempts to meet the expectation of being pain-free. Workers' compensation adjusters should be wary of the "easy fix" when it comes to back pain.

Back pain was ranked as the third most burdensome condition in the United States according to National Institute of Neurological Disorders and Stroke (NINDS), affecting 80 percent of adults. Back pain is the most common cause of job-related disability and the leading contributor to work absences. Physicians classify back pain into two categories: *subacute* pain, defined as lasting four to twelve weeks, and *chronic* pain, defined as persisting longer than twelve weeks. As reported by NINDS, about 20 percent of people affected by subacute low back pain develop chronic back pain, which persists despite medical and surgical treatment. Persistent chronic pain constructs a house of cards for chronic pain sufferers, a circular chase for cures, assisted by the internet or chatrooms, and sought-after tests, pills, injections, TENS units, spinal cord stimulators, and even surgeries, in the hope that the next procedure will work. Such patients are on a well-worn march to laminectomies, fusion, and repeat fusions, which only work 40 percent of the time, leaving the majority of people still in pain. Peter Waldman and David Armstrong, *Doctors Getting Rich with Fusion Surgery Debunked by Studies*, Bloomberg, December 30, 2010.

Evolving Perception of chronic pain

In 2003, Marcia Meldrum, Ph.D., wrote an article, *A Capsule History of Pain Management,* recognizing that physicians have long grappled with patients reporting chronic pain without evident pathology and chronicling physicians' various approaches to dealing with chronic pain. Marcia Meldrum, *A Capsule History of Pain Management*, 290(18) JAMA 2470–

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75 (Nov. 12, 2003). In the seventeenth and eighteenth centuries, Meldrum noted, physicians valued a patient's report of pain as a sign of the "patient's vitality." In addition, "[t]hat men, women, and children endured physical suffering was inevitable; the meaning, rather than the fact of pain was what mattered…." However, in the early nineteenth century, this philosophy shifted to aid in the removal or relief of an individual's pain. During this period, opiates were the primary prescription for any type of pain, from headaches to surgery. Opium, alcohol-based compounds, and a myriad of liquids, pills, and powders remained unregulated and available over the counter. By the mid-nineteenth century, physicians began lengthy discourses on pain by questioning the pain's meaning and exploring treatment methods. Physicians heavily debated whether morphine and other narcotics should be used to treat chronic pain in light of the "hideous spectacle" of drug addiction, and ultimately, they reserved morphine as an extreme last resort and for the dying. In late nineteenth century, a new theory emerged about chronic pain. Known as the "specificity theory," it posited that "true pain is a direct, proportional response to specific stimulus." In other words, for pain to be valid, pain must be result of a specific and identifiable pathological condition. This theory, adopted widely by U.S. medical schools, affected physicians' perceptions of pain for half a century. By the 1920s, individuals suffering from chronic pain were stigmatized as malingers, drug abusers, or just deluded.

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In 1930s and 1940s, a few clinicians found the specificity theory too limiting and sought to provide their patients relief from chronic pain. In the 1930s, patients were treated by a series of procaine injections (referred to as "blocks") into the spine in an attempt to avoid surgery. In contrast, another pain theory emerged, proposed by Dr. Henry K. Beecher of the University of Oregon, that chronic pain resulted from a combination of patient's physical, cognitive, and emotional issues. But it was not until the 1950s that Dr. Jon Bonica proposed the idea of a multidisciplinary approach to chronic pain. Dr. Bonica called for the treatment of the entire patient, including psychosocial and behavioral factors, as well as underlying physical pathology. His idea was promptly ignored, possibly scorned, by the rest of the medical community, and Dr. Bonica spent the next twenty years attempting, and failing, to build an "interdisciplinary pain world." Meldrum, *supra*.

In 1965, Ronald Melzach and Patrick Wall elaborated on their "gate theory of pain," which was that the spinal cord contained a neurological "gate" that either blocked or allowed pain signals to the brain and theorized about why counter stimulation methods (touch, skin blistering, and electricity) worked to reduce pain perception commonly known as "gate control theory." Ronald Melzach & Patrick Wall, *Pain Mechanisms: A New Theory*, 150(3669) Science 971–79 (Nov. 19, 1965). Lorne M. Mendell explains that this model was not entirely accurate, but, for the first time, provided a clear and concise model on the function of pain mechanisms. L.M. Mendell, *Constructing and Deconstructing the Gate Theory of Pain*, 155(2) Pain 210–16 (2014). The Melzach and Wall article generated sufficient interest to allow Dr. Bonica to convene a conference that ultimately led to the founding of the International Association of the Study of Pain (IASP). The IASP would later collaborate with the World Health Organization Cancer Unit, in 1982, to produce a three-step guideline for physicians to follow when prescribing medications. This three-step "ladder," readily recognizable today, recommended starting with a prescription for an NSAID and progressing to a weak opiate and then a strong opiate.

As reported by Dr. Meldrum, the next twenty years, aided by pharmaceutical companies' aggressive marketing campaigns, witnessed the rise of a "prescription culture." *The Ongoing Opioid Prescription Epidemic: Historical Context*, 106(8) Am. J. Pub. Health 1365–66 (2016). During this period, we observe the rise of interventional pain management practices dedicated to chronic pain, which rapidly became one of the most profitable aspects of spinal care. Physicians' concept and treatment of pain radically shifted. The American Academy of Pain Management recently revised the definition of chronic pain to define it as pain that "extends beyond the period of healing with levels of identified pathology that are often low and insufficient to explain the presence and/or extent of the pain." Physicians, encouraged by the introduction of pain as "the Fifth Vital Sign," ignored the management of pain and focused on the futile attempt to eliminate pain completely.

> Dr. Meldrum aptly stated,
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> We are in this culture now where too many people see drugs as the answer not only to pain, but to improving their lives. Pain can make it impossible to live your life. You lose so much qualify of life. So for many people, if the solution also means that they may become somewhat dependent on a drug, they probably think, "Well, that would be better than this."

Roger Collier, *A Short History of Pain Management*, 190(1) CMAJ E26–E27 (2018). After the tightening controls of opioids, newspapers and social media teemed with a public outcry by individuals with chronic pain who felt abandoned, ignored, and left to suffer alone.

Unnecessary Procedures

As Cathryn Jakobson Ramin explained in her book, *Crooked: Outwitting the Back Pain Industry and Getting on the Road to Recovery* (2017), modern society, including physicians, has a

> very mechanical view of the human body, one that suggests that you can find out what's broken and replace it or fix it..... [Industry players] are just making money hand over fist from back pain patients who are desperate.... And it is remarkably easy... to undergo a series of treatment that are both unnecessary and terribly destructive.

Ms. Ramin hypothesized that treatment of back pain was problematic from the first MRI ordered. The *New England Journal of Medicine* determined that excessive use of MRI within the early stages of back pain was detrimental. Spinal imaging, within the first six weeks of back pain, won first place on the prestigious list of unnecessary medical procedures at the 2011 National Physician Alliance. Having an MRI of the back invariably led to discovering spinal "abnormalities," which were actually quite normal, and promoted a referral to a back specialist. In 2013, *JAMA Internal Medicine*, a journal of the American Medical Association, advised that MRI usage increased by 4.1 percent and referrals to back specialists increased 7.1 percent from 1999 to 2010. Once someone is referred to a back specialist, the specialist's myopic recommendations involve some form of action that range from injections to surgery. On occasion, surgeons do not recommend surgical intervention, but back patients remain wholly convinced that surgery is the key to recovery and proceed to shop around until someone agrees to operate.

Injections remain a well-known and favored tool in the physicians' arsenal, including, but not limited to, epidural steroid injections, selective nerve root blocks, discography, facet job blocks, facet neurotomy (radiofrequency), and trigger point injections. Injections, or blocks, are typically ordered in a series of three for no discernable rhyme or reason and are typically delivered in one sitting or serially. Even if the first injection fails to provide relief, physicians invariably complete the series. In *Crooked,* Ms. Ramin reported that one patient in Colorado received fifty-one injections in a single year, and a New Jersey patient developed kidney failure after receiving thirteen injections in a five-month period.

Probably less well-known is that medical studies have found no evidence that epidural steroid injections are effective in treating spinal stenosis or low back pain. The U.S. Food and Drug Administration (FDA) issued a warning on April 23, 2014, that injecting glucocorticoids into the epidural space of the spine could result in rare but serious neurological problems. In 2015, *JAMA* advised physicians to avoid recommending injections to patients with chronic back pain. Despite these recommendations, epidural injections remain widely popular with pain management physicians. Such unnecessary procedures can result in iatrogenic pain.

Before recommending injections or surgery, physicians often will write a prescription for physical therapy (PT), typically a "check-the-box" requirement before an insurance carrier will authorize injections or surgery. As many legal practitioners already can attest, physicians rarely oversee or review physical therapy progress. Physical therapy, arguably, could result in significant improvement for patients if appropriately administered, but as Ms. Ramin reports, most patients do not receive high-quality physical therapy. John Childs, the director of the Army-Baylor University Doctoral Program in Physical Therapy, advised that active (and possibly painful) physical therapy is a key element to improvement and recovery. It should be intensive exercise, and the patient should participate actively. Instead, most PT treatments remain passive (*e.g.*, ultrasound, muscle stimulation, cold and hot packs, low-level laser therapy). Patients fail to recover due to suboptimal, "cookie-cutter" physical therapy and progress on to injections and surgery.

Controlling Exposure

Just as people are unique, so, too, is their chronic pain. Treatment of chronic pain remains routine, with physicians adopting a "one-size-fits-all" approach, under which patients fail to recover, and as legal practitioners, we must guard against such patterns by paying attention to the frequency and type of treatment sought by injured workers. Injured workers often seek immediate treatment with a chiropractor, which could worsen their condition. Instead, adjusters should focus on getting injured workers to a reputable physical therapy facility immediately to begin active (and possibly painful) participation. In particular, care should be taken to avoid corporate physical therapy facilities and physical therapists operating solely out of treating physicians' offices. Adjusters should also elevate any claim in which a doctor recommends spinal imaging within the first six weeks and contest such requests. Adjusters should also be advised to challenge epidural injections routinely, as they simply are not effective for treating spinal stenosis or low back pain. As for any other injections, adjusters should contest any and all injections when the claimant fails to experience lasting relief for more than four weeks from an initial injection.

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Parting Thoughts

Treatment of chronic pain is a $100 billion industry, and change will come slowly. Based on medical literature, chronic back pain sufferers would certainly benefit from an engaged, multidisciplinary approach that addresses the underlying psychosocial, behavioral, and physiological aspects of their pain. But the crucial element to improvement, similar to physical therapy, is active participation from the physicians and the patients.