What is all this stuff about pain?

John Connor: *Does it hurt when you get shot?*

The Terminator: *I sense injuries. The data could be called "pain."*

(Terminator 2: Judgment Day, 1991)

The word *'pain'* was used for the first time in the Middle Ages and is a derivation of the old French *'peine'* and the Latin *'poena'* (as in 'subpoena') meaning 'punishment' or 'penalty'. The concept of *pain* as an 'evil punishment' is expressed in many languages, cultures and epochs, suggests that it's more than just an unpleasant sensation ,or 'hurting'; it is a negative emotional experience linked to 'suffering' with social, spiritual and philosophical dimensions.

Over millions of years, many of earth's life forms (from crustaceans-*'so be kind to lobsters'*-to humans) have evolved a pain *alarm system* to protect their tissues from injury and damage. The pain alarm's had millions of years head start on us doctors, and has developed effective failsafe systems (such as *central sensitization* or 'wind-up', which amplifies the pain signal in the spinal cord so we don't ignore it)—so it's pretty robust and hard for us to 'switch it off' with drugs, pain blocks or operations-this leads to chronic pain in many instances.

Pain is an output of the conscious brain whenever a person is under *threat,* anything from a sabre-toothed tiger on the Africa savannah in Neolithic times, to a whiplash injury in a car crash, or domestic violence.

Pain is much more than a simple *sensation* (it's not even one of the 'five senses'), just like an emotional piece of music is more than just 'sound'.

Pain is *'an unpleasant sensory and emotional* experience' (emphasis on the word *experience*). It's a multi-dimensional, whole-person experience (that word again) that may impact on family, friends, work, lifestyle and even society.

'Pain is what the person-in-pain says it is', that is, pain is a unique personal experience. Our default position as health care professionals should always be to *believe a person's pain reports.*

We can *o*nly know someone's 'in pain' if they tell us; this makes it difficult for neonates, dementia or stroke patients, refugees who don't speak our language, or indeed animals. *Pain behaviours* (grimacing, limping, taking a Panadol or calling an ambulance) can sometimes help us identify persons-in-pain, but they are subject to misinterpretation—ultimately in the form of 'pain-acting' or 'malingering' (quite uncommon really).

Importantly, *it IS possible for a person to experience pain without any evidence of tissue damage*. *Ph*an*tom limb pain* is the best example-there's pain where there's

not even any tissue-in the ‘phantom’! Therefore it’s entirely plausible and acceptable for people to report low back pain with a ‘perfect looking MRI scan’-lawyers and workers' compensation providers often find this a difficult idea to accept!

Remember, you can’t 'see' pain on an x ray or scan.

Pain and anxiety are inextricably linked. In evolution, anxiety (fear) probably developed from primitive pain systems to better protect our tissues: It's better to see a sabre-toothed tiger in the distance, become scared of it and run away, rather than waiting for it to maul your leg, generate a pain signal and then run away!

In other words, anxiety is a highly-evolved pain alarm system.

High levels of anxiety (such as panic or PTSD) around the time of an injury (a back strain at work, whiplash, surgery, sporting injury) is the best predictor of developing chronic pain months or years down the track.

Persons-in-pain are often disadvantaged and stigmatised, usually through no fault of their own. Even the most caring health care professional can lose their sense of empathy as pain management can be extremely challenging…but also very rewarding too.

Whatever you do in medicine, you will be helping persons-in-pain, who will be frightened, distressed and even suffering.

Relieving pain is one of the Hippocratic arts we should all excel in.

With this in mind, your *alma mater* Notre Dame, along with St John of God Health Care and the generosity of Mr and Mrs Geoff and Moira Churack, have this year established the Churack Chair for Chronic Pain Education and Research.

We are happy to help you in your future careers to become 'pain management champions'.

Five key tips

1. Always ask pain patients to point to the worst site of their pain with *their index finger only*-it allows you to home-in on the site of pain (often a missed entrapped nerve, such as in the abdominal wall).

2. Always pin-down exactly what happened around the time the person developed their pain-there’s often some piece of forgotten history such as an injury or illness which helps you with the diagnosis. Always look at a patient’s old medical notes and drug charts, not just for pain, but for EVERYTHING.

3. If a patient's pain isn't making sense or is worse than expected (I know, I just said pain is a person's own unique experience) consider;

4. **Red flags** 'TINT' = **T**umour, **I**nfection or **I**nflammation, **N**europathic pain, **T**rauma.

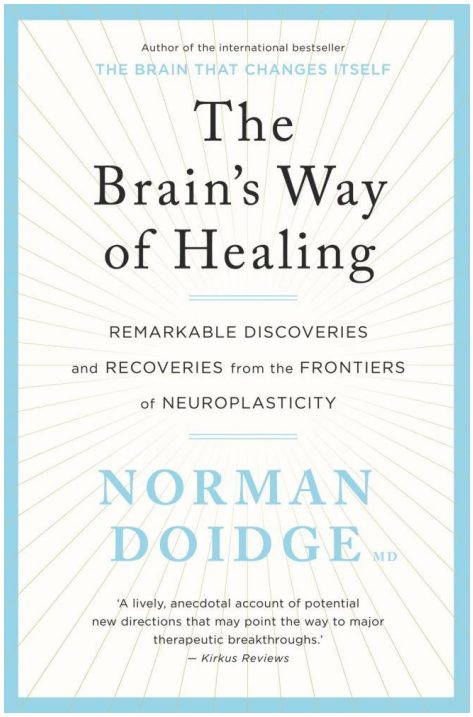
5. **Yellow flags** (psychosocial factors that magnify the pain experience) 'CHAMPS'= **C**atastrophic thinking (doomsday state of mind), **H**ypervigilance (just think of Meerkats), **A**nxiety (the big one), '**M**edicalised' (lots of tests, doctors x-rays, and jargon), **P**assive-coping ('you need to fix me doctor'), **S**tress (lots of things happening in their lives) and **S**ubstance overuse (not addiction *per se*, but what we call *chemical coping*).

6. When we talk to patients about these issues (psychological or behavioural) we don't mean they don't have 'real pain', 'it's all in their heads', or they are 'weak in some way', it just emphasises that pain is an emotion experience and we cant ignore this dimension!

7. Finally, visit two websites and read a book:

- Neuro Orthopaedic Institute (neuroplasticity) http://www.noigroup.com/en/Home

- The PainHEALTH website (practical pain information)
- http://painhealth.csse.uwa.edu.au/



Wishing you all the very best for the future.

Eric Visser