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# “Real-life” treatment of chronic pain: Targets and goals



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### A B S T R A C T

Treating chronic pain is a complex challenge. While textbooks and medical education classically categorize pain as originating from peripheral (nociceptive), neuropathic, or centralized origins, in real life each and every patient may present a combination of various pain sources, types, and mechanisms. Moreover, individual patients may evolve and develop differing types of pain throughout their clinical follow-up, further emphasizing the necessity to maintain clinical diligence during the evaluation and follow-up of these patients. Rational treatment of patients suffering from chronic pain must attempt at deconstructing complex pain cases, identifying variegated pain generators, and targeting them with appropriate interventions, while incorporating both pharmacological and non-pharmacological strategies, rather than focusing on the total pain level, which represents an integral of all pain types.

Failing to recognize the coexistence of different types of pain in an individual patient and escalating medications only on the basis of total pain intensity are liable to lead to both ineffective control of pain and increased untoward effects.

In the current review, we outline strategies for deconstructing complex pain and therapeutic suggestions.

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## Introduction

Rheumatism is classically defined as a disease that causes stiffness and pain in muscles and joints. Thus, the medical specialty of rheumatology is primarily focused on treating the various causes of such pain. Treating chronic pain, however, remains an unmet challenge [1]. While rheumatology has made impressive progress over recent decades in all that regards treating the inflammatory component of joint disease, chronic pain in joints and elsewhere remains unsolved. Evidently, when dealing with this challenge, the rheumatologist must accept the fact that more of the same is not good enough, and successfully treating chronic pain calls for a more flexible, even eclectic strategy.

As of the present day, with the plethora of biological agents available, it has become relatively unusual for a rheumatologist to encounter a patient suffering from inflammatory joint disease who is totally unresponsive to treatment, though side effects may still be a major issue [2]. Similarly, treating acute pain is also usually attainable – with opiates continuing to play a major role – although again side effects are a limiting factor. On the other hand, treating chronic pain, and particularly pain that has been centralized (i.e., amplified within the central nervous system), remains extremely difficult and only partially successful. This difficulty is partially related to the clinical difficulty in distinguishing different types of pain among different patients, as well as recognizing the coexistence (and mutual interaction) of different types of pain in the same patient. This diagnostic lack of clarity often limits the proper application of therapeutic measures, and it renders treatment insufficiently effective. Still, even when pain is properly labeled and accordingly treated, success rates are not very high. While intriguing research strategies are emerging, which may in the future more rationally differentiate between various subgroups of patients who may respond favorably to specific therapeutic strategies [3], at the present, treatment is to a large extent a matter of trial and error. As patients with chronic pain are notoriously sensitive to external stimuli including a heightened sensitivity to the side effects of drugs, it is not surprising that this trial-and-error strategy comes at the cost of significant suffering, as well as low compliance, on behalf of the patients.

In the current review, we aim at elucidating the ways in which clinicians can attempt at directing treatment, both pharmacological and non-pharmacological, to patients with chronic pain, with emphasis on the topic of tailoring the treatment according to the type/types of pain.

## Deconstructing the pain experience

Pain remains a subjective experience. Although we currently have at hand remarkable tools that can show us how various areas of the central and peripheral nervous systems act and interact among pain patients [4], and have diligently sought after biomarkers of chronic pain [5], it is only the individual at pain and no one else who is experiencing pain at any given moment, and all others, be it health-care professional, family, or bystanders, can only indirectly try and quantify or document the experience of pain. As Susan Sontag put it in her essay, “Regarding the pain of others,” those looking on “Can’t understand, can’t imagine” [6] (Sontag was in fact referring to pain in a broader sense and particularly to the horrors of war; nonetheless, the statement holds for individual physical pain as well). Thus, in each patient encountered in the clinic, pain is personal experience. The severity of pain is notoriously poorly correlated with objective measures of joint destruction, inflammation, or peripheral nerve damage [7]. In addition, psychological factors such as levels of stress and anxiety, personality characteristics, cognitive patterns such as level of catastrophizing as well as psychosocial factors such as the presence or absence of supporting networks may all have an impact on the total experience of pain [8–11].

It is important to understand in this context that pain patients do not “respect” our taxonomic frameworks of thinking. When a patient is referred to a rheumatologist because he or she has pain in joints, bones, or muscles, the patient does not necessarily fit neatly into traditional categories such as “osteoarthritis,” and “fibromyalgia.” Even when a patient has clear-cut evidence of the existence of an inflammatory joint disease, such as positive serological test and erosions on X-rays, this still does not mean that all pain is attributable to this diagnosis. In clinical practice, a high proportion of patients previously diagnosed as suffering from rheumatoid arthritis, ankylosing spondylitis, or systemic lupus

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