

CHAPTER ONE

How Did You Know What to Do?

Ann's pain bothered her only at night. She would go to bed and sleep well for a couple of hours and then awaken with pain in the neck, and as time went by, in the back of the head also. She would move to a reclining chair, place a heating pad behind her neck, and after a while the pain would diminish sufficiently to allow her to sleep—at least until she would again awaken with pain.

X-rays showed changes of degenerative arthritis in the cervical spine, a finding not unexpected in an elderly woman. Her physician prescribed Naproxen, an anti-inflammatory drug commonly used for the treatment of arthritis. It was without effect. He then prescribed Ultram, an analgesic. He instructed her to take it every four hours as needed for pain or, if she chose, to take it at bedtime in order to prevent painful awakenings. Neither exercise worked. Suspecting his patient's pain derived from pressure on the nerve roots by bone spurs or a ruptured disc, he referred her to a neurosurgeon. An MRI showed some narrowing of the neural foramina, the gaps in the vertebral column through which the cervical nerves pass. None of the several constrictions were severe enough, however, to warrant surgery, and even if they had been, I doubt the surgeon would have elected to operate on an eighty-four-year-old whose pain went away with an hour on a heating pad.

She was referred to an anesthesiologist for a procedure known as epidural steroid injection. A hypodermic needle was inserted through the muscles of the back of the neck and cortisone was injected adjacent to the spine to bathe the inflamed nerve roots. Pain abated for a week or so, but then returned full force each night. Nevertheless, she submitted to a second injection a month later, but that was of even less benefit. The

thoughtful anesthesiologist told Ann there was no need for any more steroid injections. He suggested another procedure, the occipital nerve block. Anesthetic was injected into the area of the occipital nerves, those

*Such is the
unfortunate lot of
the painful. They
typically see many
doctors, and they are
subject to many
treatment forms that
sometimes don't work
very well at all.*

which carry sensation from the back of the skull and the upper neck. Following the procedure, Ann slept well for one night only. Her pain then returned, again full force.

The persistent anesthesiologist, unable to relieve pain by the application of cortisone or anesthetic to inflamed nerves, opted for another form of therapy, known as Botox injection. Botox is a trademarked, proprietary drug, its name a contraction of botulinum toxin. Botulism is the most virulent form of bacterial food poisoning. The organism releases a paralyzing toxin which in severe cases can lead to death. However, the localized placement of small quantities of the toxin can be helpful in preventing unwanted muscular spasm. The anesthesiologist hoped the injections would diminish the force of muscle contractions, which, he surmised, were causing the strange nocturnal pain. They helped not at all. The anesthesiologist, thrice burned, referred her to me.

Ann, over the course of several months, had seen three different doctors. She had undergone x-rays and an MRI. She had received anti-inflammatory drugs and analgesics. She had been subjected to injections, first cortisone, then an anesthetic, and then Botox. Such is the unfortunate lot of the painful. They typically see many doctors, and they are subject to many treatment forms that sometimes don't work very well at all.

She was a handsome and vivacious woman with gold-rimmed glasses and bright, blue eyes. She was accompanied by a friend who was equally charming. They obviously enjoyed each other's company, and their conversation was quick and clever. Ann was certainly exhibiting no angst.

Her past medical history was, for an eighty-four-year-old, quite unremarkable. She had required a few operations, but her recovery from each was prompt and complete. Her emotional health had also been quite good. She denied any history of depression and, until the onset of her pain, she slept well. I inquired about her personal history because chronic pain often appears according to the dictates of destructive personal events. She had her share. What eighty-four-year-old has not? She was twice a widow. Her first marriage lasted happily for fifty years. Her second, to her husband's cousin, lasted for seven. Following his death, she returned to her ancestral home in Kentucky where she enjoyed the companionship of good friends and her church and garden club.

As we shall see in the case studies which follow, only occasionally does chronic pain strike out of the blue. It usually appears under the persuasion of forces such as depression, drug abuse, or emotional trauma. Ann, it seemed, was an exception. Until the onset of pain, her life had been of one of social, emotional, and physical comfort.

The examination was unremarkable. She described no pain as she rotated her neck to the left and to the right, and even the extremes of extension (looking up at the ceiling) and flexion (looking to the floor) produced no discomfort at all. Her arthritic neck was certainly not bothering her at the time of my examination.

"Ann, I am very taken with the fact that your pain seems to appear only at night. Does it ever occur during the day? Are there certain activities that seem to bring it on?"

"No, I never have pain during the day. My activities are not limited at all. I am able to garden, and just a couple of weeks ago I painted my kitchen."

"Did you have more pain that night?"

"No, no more than usual."

One does not comfortably paint a kitchen with a badly arthritic neck nor does such a neck flare up exactly at midnight. I will suggest to the reader that I was not treating a person who suffered from cervical arthritis, pinched nerves, or spastic muscles. I was treating a person who suffered chronic pain. There is a difference.

“Ann, I am going to give you a couple of medicines that I believe may be helpful. One of them is known as Nortriptyline and the other Clonazepam. I want you to take a single pill every night. I’m not sure they will work, but it is certainly worth a try. I would like to see you again in two weeks.”

On her return, she took my hand and said, “This really has been remarkable. From the first night I had no more pain, and I have slept quite well.”

“That’s wonderful. I thought I might be able to help you, but as you say, this is truly remarkable.”

“I feel like I have been cured.”

“Well, perhaps you are. I will write you a long-term supply of medicines, enough to last six months. I will have you come back at the end of that time to see how you are doing. In the meantime, if there are problems, I want you to call me.”

“That’s fine with me. I promise you, I will keep taking the medicine. I look forward to seeing you again. I am very grateful for what you have done.” Then she squeezed my hand, looked me in the eye, and said, “Young man, how did you know what to do? I’ve seen several doctors, and I have had all kind of injections in my head and neck, and none of them worked. And then you gave me some pills and immediately my pain went away. I want you to tell me how you knew what to do.”

Pat was tall and blond and attired in a loose-fitting, beltless cotton dress. She was not unhandsome, but her face suggested desperation. I would have put her age at sixty-five had I not known that she was forty-eight. She began the conversation by saying, “You are my last resort. If you can’t help me, my life is over.”

I hear this kind of declaration a lot. It is a testament to the destructiveness of chronic pain, and it holds enormous implications for treatment. The physician must always be guided by the dictum *primum non nocere*, that is—first, do no harm. Thus, whether administering pharmaceuticals, performing an operation, or engaging in psychotherapy, the doctor must, at the very least, avoid making the patient worse. Unfortunately—or

perhaps fortunately—this is hard to do in those who truly suffer chronic pain. Many of them are at the absolute end of their tether, and that offers an opportunity for imagination and creativity that would not be employed in those who suffer less destructive illnesses. This is what makes the treatment of the painful patient so exciting—and challenging. If the doctor is not excited and challenged by hearing his patient say, “You are my last resort,” that doctor has no fire in the belly at all.

I reviewed the notes of the referring physicians, an internist and a gastroenterologist. Both recorded her lifelong history of abdominal pain and increasingly frequent

Only within the past few years has come the recognition that chronic pain may be a unique disorder, a thing unto itself.

attacks of explosive diarrhea. They listed the various medications she had taken and noted that none had been particularly helpful except for the opiate Hydrocodone, which she was using in suspiciously large quantity. They reviewed the diagnostic studies which had been performed, and reported that all had been quite normal. Both described the physical examination as unremarkable, save for some abdominal distention and tenderness. They concluded that Pat suffered from irritable bowel syndrome.

The internist, in his summation, observed that she was sleepless and chronically depressed and also that she was having difficulty with some of her personal relationships. He suggested consultation with a psychiatrist. The gastroenterologist offered the terse judgment that *this patient suffers more of a pain problem than an intestinal problem*. Had he seen her ten years before, I doubt he would have written that. Only within the past few years has come the recognition that chronic pain may be a unique disorder, a thing unto itself.

Being a pain doctor is arduous work, but there is one advantage that comes with it. He or she does not have to reinvent the wheel. My patient’s medical history and physical and laboratory examinations had been recorded in elegant detail by physicians of competence at least equal and

probably exceeding my own. I was able—indeed I was invited—to spend my time on other matters. These, as we shall see time and time again, include the exploration of the patient’s personal, social, and emotional history as well as their medical, for only by doing so can we understand the true meaning of chronic pain.

“Your doctors have told me that you have irritable bowel syndrome and a lot of pain in your abdomen. Tell me about it.”

“I hurt all the time. I have a lot of constipation, and sometimes I have diarrhea. It swings from one to the other. I have a lot of gas, and that is embarrassing.”

“You have taken lots of different medicines. I see you are taking Hydrocodone now. That is a pretty strong pain killer.”

“Yes, I have taken all the medicines, and I have taken so much Metamucil that I get sick when I even think about it. The drugs have never helped me very much. The Hydrocodone does help a bit, but I don’t like the way it makes me feel. Sometimes, though, I have to take it—lots of it.”

“Your doctors have some concerns that you are using too much of it. What is your take on that?”

“Yes, I do take more than I should. They will only give me a little bit at a time. I use it up in just a few days, then I suffer for weeks.”

“How long has your stomach trouble been going on?”

“As long as I can remember. I used to be able to put up with it, but now it is really interfering. I am not sure I can keep working.”

“Why is that?”

“The pain is getting worse and worse, and I am getting to where I soil myself. I can’t control my bowels.” She then placed her hands on her abdomen, pulled the dress tightly about it, and said, “Look at my stomach. It’s huge. People think I am pregnant. I have to wear clothes like this to hide it. You may not believe this, but I can’t even wear panties. The elastic hurts my stomach.”

“I assure you, I have heard that kind of complaint before.”

“You have?”

“Yes, many times, but let’s move on to another subject. I understand that you are having trouble sleeping.”

“Yes, I have a terrible problem with sleep. Sometimes I lose control of my bowels during the night, and I have to change the bed.”

“How long have you had insomnia?”

“Most of my life. I have never been a very good sleeper.”

“How do you feel when you wake up in the morning?”

“Terrible. I wake up exhausted.”

“Your internist made reference to some difficulties you are having in your personal life. I would like to explore that a little bit, if you don’t mind.”

“Go ahead. I will tell you when I want you to stop.”

“Are you married? Do you have children?”

“No to both.”

“Have you ever been married?”

“No, never. I would like to be married, and I have certainly had plenty of opportunities. I have been engaged nine times.”

“Nine times! Why so many?”

“I don’t know, really. I guess it has just been my bad luck to not find the right man.”

I will suggest to the reader that *nine* unsuccessful engagements do not happen just by bad luck. Nor does irritable bowel syndrome happen just by bad luck.

“Pat, do you ever suffer periods of depression?”

“Oh, yes. I have been depressed many times in my life. I have taken Wellbutrin and Prozac, but they never worked very well. Most of the time the depression goes away on its own.”

“Have you ever thought of suicide?”

“Yes, I have thought about it a lot, but I don’t believe I could ever do it. Let’s just say it is against my religion.”

“I want to ask you a strange question. Are you a spender? Do you sometimes go out and buy things that you don’t need? Are you irresponsible with money?”

“Actually, I am rather good with money. I have worked hard and made a very good living. It’s been easy for me. I’ve always had a lot of energy, at least until a few years ago when my stomach pain got so bad. I will admit that I do have a vice. I get a big kick out of gambling. I travel a lot, and

whenever I am in a river town, I will go to a casino. I lose a lot of money that way, sometimes \$1,000 a pop.”

“Does that bother you?”

“Not really. Sometimes it makes me feel good.”

“Did you have a happy childhood?”

“Yes, my father was very well-to-do. I went to private schools. My parents, both of them, treated me very well.”

“There were no destructive events when you were young?”

“Why in the world do you ask that?”

“Because it may be important. It may help me understand your illness.”

She hesitated and then said, “Well, yes, something did happen to me when I was twenty years old, but I don’t want to talk about it.”

“Was it a bad thing that happened to you?”

“Yes, it was really bad.”

“So bad that you sometimes dream about it or flashback to it? Do you sometimes relive it?”

“Yes, I do, but I am not going to tell you what it was. I’ll just say it was something that was against my religion.”

“Did you see a psychologist or psychiatrist about it?”

“Yes, I’ve seen many of them, at least a half dozen.”

“Why so many?”

“Well to tell you the truth, I didn’t like most of them. One was really nice, though. I spent a couple of months with her.”

“What did you talk about?”

“Mostly about my feelings about what happened. She said I had a disease called traumatic stress or something like that. I can’t remember exactly.”

“Post-traumatic stress disorder?”

“Yes, that is what she said it was.”

“Did she give you medicine?”

“Yes, she was the one who gave me Prozac. It didn’t do me any good, so I decided to quit seeing her.”

“Do you think that was a pretty hasty decision?”

“Yes, I suppose so.”

“I imagine you have seen lots of different doctors for your bowel problem.”

“Indeed I have. I have seen three or four internists and a lot of gastroenterologists. I have been scoped four or five times altogether, some from above and some from below, and I am scheduled for another one pretty soon.”

“Pat, I am going to make an observation here, and I hope I don’t offend you. It seems like your relationships with your lovers, your therapists, and your physicians are about as irregular as the workings of your bowels. Do you suppose there could be some kind of connection?”

She hesitated and then said, “I never thought about it quite that way, but you may be right. You know, you are pretty good. I like talking to you.”

Pat suffered chronic pain in the form of irritable bowel syndrome. She also suffered post-traumatic stress disorder, a common legacy of severe emotional trauma. She also, quite possibly, had

*An aggressive,
energized lifestyle with
periodic depression
and periodic
disinhibition
(gambling) certainly
suggests bipolar
disease.*

bipolar (manic-depressive) disease. An aggressive, energized lifestyle with periodic depression and periodic disinhibition (gambling) certainly suggests bipolar disease. Nine unsuccessful engagements are virtually diagnostic of it. This is the way it usually plays out in chronic pain. Co-existent psychiatric diseases are the rule, not the exception. Unfortunate though this may seem to be, it offers an incredible variety of treatment options. As I began my therapy, I chose, unlike the physicians who had seen her before, to treat her mind rather than her bowels.

“I am giving you two prescriptions. One is for Nortriptyline and the other for Clonazepam. I want you to start on a low dosage and, if you tolerate them, to gradually increase the amount according to my instructions. I expect the first good thing that will happen to you is that you will begin to sleep. I will see you back in two weeks.”

“I like you. I want to talk to you some more.”

“I will talk with you as much as time allows, but you must understand I am not a psychologist or psychiatrist. I am not trained to address the

issues that I suspect you may want to talk about. What I will be doing mostly is to administer medication that I think has a real prospect of helping you.”

My enthusiasm for the use of pharmacy in the treatment of chronic pain is so great that in *Understanding Chronic Pain* I wrote that it is the drugs that cure pain, not the doctor. In that judgment, I believe now I was at least partially wrong. The drugs can be enormously helpful—of that there is absolutely no doubt—but they must be administered by a physician who connects with the patient. And that connection begins with understanding their illness. This invites trust and confidence, and it is in this environment that the drugs really work best.

Pat returned at the appointed time and began the conversation in a manner that surprised me—to show me her new engagement ring. She said, “This time I am really in love. He’s a wonderful man. He’s a machinist, and he doesn’t have a lot of money, but that doesn’t matter. He insists on a prenuptial agreement before we get married. He doesn’t want to inherit any of my father’s money. Isn’t that wonderful? Do you think I ought to marry him?”

“I wouldn’t dare offer you advice on a matter like that.”

“I thought you would probably say that.”

“How is your pain—and your sleep? Have the drugs made any difference?”

“Yes, I am sleeping a lot better. My stomach doesn’t bother me as much. I think the medicines may be doing some good, but the real reason for my improvement, I am sure, is that I am finally in love.”

Medication, the right medication, can certainly relieve chronic pain. So can falling in love. That experience is probably the best non-pharmacologic treatment there is for chronic pain. I suspected, though, that this woman’s love experience would be a short one, and in the long run it would be the drugs that would see her through. I congratulated her on her good fortune, but suggested she increase the dose of Nortriptyline.

She appeared two weeks later exactly as scheduled. She spoke excitedly and rapidly about her plans for marriage, and then getting back to work.

“I have a lot more energy now. I feel better in every way. I will let you in on a little secret. Sex is better.”

“How so?”

“I used to poop in the bed when I had sex. I don’t do that anymore.”
She was in my face.

“I am not using any protection. I am forty-eight years old. Do you think I will get pregnant?”

Pat was exhibiting two of the major features of bipolar mania, disinhibition and flight of ideas. I followed up with an important question.

“How are you sleeping now?”

“It’s strange, I don’t seem to need sleep. I have a lot of energy, and I am staying awake a lot. My mind is full of ideas. I really feel good.”

“Pat, have you ever had experiences like this before where you got wound up and energized?”

“Yes, I have had lots of them.”

“How long do they usually last?”

“A few days usually.”

“And then?”

“Then I get down.”

The employ of pharmacy entails inherent risk because unwanted side effects certainly do occur. Victims of bipolar disease seem to be particularly disposed to a very strange one. Sometimes the administration of antidepressants incites mania in the form of grandiosity, disinhibition, and mind-busy hyperactivity. Chief among the drugs which do this (and there are many) are the tricyclic antidepressants, of which Nortriptyline is an example. Unfortunately, the tricyclics are among the very best drugs for the treatment of pain. They must be used with caution, however, for many victims of chronic pain are bipolar. So the risk must be accepted, but the physician must remain vigilant.

“I am going to give you a new medicine. It’s called Seroquel. I want you to add it to the other drugs.”

“What is it supposed to do?”

“It has many uses, but I’m employing it as a mood stabilizer.”

“Do you think I’m bipolar?”

It is astonishing how often I am asked that question. Many victims of chronic pain, I have learned, suspect that they are bipolar, but they usually hesitate to address the issue with their physicians.

“Why do you ask that? I have never mentioned that word before, have I?”

“No, you never did, but I have thought for a long time that I was manic-depressive.”

“Did you ever mention that to any of your other doctors?”

“Only to the psychiatrist. She said I wasn’t. She said I had post-traumatic stress disorder.”

“Well, you probably have both and chronic pain as well. They all seem to run together.”

“I really like talking to you.”

“I like talking to you, too.”

Chronic pain is the most complex of diseases. It cohabits with many disorders of the mind, be this stress disorder, depression, bipolarity, drug addiction, and host of others. Recognition of this, which I consider an unassailable truth, offers the beginning of understanding into the true nature of the disease. I instructed Pat to continue her Nortriptyline and Clonazepam. They had been quite helpful in tempering her bowels. She needed, however, another drug, one which would temper her moods.

On her return visit, she greeted me by saying, “Thanks for giving me the Seroquel. It is a wonder drug. For the first time in my life, I feel like I am even! I’m actually in control of my emotions. I have never felt that way before.”

“How is your pain?”

“So much better. My BM’s are regular, and I don’t soil myself. My stomach still swells up some, but my clothes don’t hurt me the way they used to. Are you going to ask me about my engagement?”

“Well, I figured we would get around to that sooner or later.”

“It’s off.” She held up her left hand and said, “Look, no ring.”

“Are you happy with that decision?”

“Very happy. Let me ask you something. I have been thinking about this bipolar thing, and I have been reading about it a lot. Do you think it

is possible that my engagements took place when I was manic and my separations when I was depressed? It seems bizarre, but I am beginning to think that is what was going on.”

“You may be correct, but it could be the other way around.”

“And the thing I was involved in so many years ago—could that have happened when I was manic?”

“It certainly could have.”

“Then I am not a bad person, after all.”

“No, you are a good person with a very bad disease.”

“There is a lot more to it than irritable bowels, isn’t there?”

“Yes, a whole lot more.”

She looked at me with her brown eyes full of tears and said, “I’ve seen lots of doctors, some of the best. None of them helped me like you have, and I want to know why. This is important to me. Why has it taken me twenty-five years to understand what was wrong with me? Tell me, how did you know what to do?”

*Medication, the
right medication, can
certainly relieve
chronic pain.*

The answer to that question is, I believe, at the very core of understanding chronic

pain. It is certainly not because I am more intelligent than other physicians or that I am better trained (I am forty-five years removed from my formal academic studies, and the field of pain medicine did not even exist at that time). My success rate certainly does not derive, as some have suggested, from my great compassion for those who suffer chronic pain. The notion that I am more compassionate than other physicians is patently absurd. And besides, we will not cure chronic pain with compassion, we will cure it, and understand it, by clinical observation.

I suggest that I know what to do because I recognize, as do few other physicians, *that chronic pain is a mental illness.*

It is not that others are not trying. Pat’s gastroenterologist, competent and knowledgeable, recorded that she suffered more of a pain problem than an intestinal problem. He was getting close, and so was the internist who tried to explore her relationships and the pattern of her life in an effort to understand her pain. Their efforts were noble.

Ann and Pat were very different people. Ann's life was one of well being and comfort. Only late into it did she experience pain, this in the head and neck. Pat's life was chaotic and disturbed, and her abdominal pain began when she was quite young. The two women hurt at different times in their lives and at different places in their bodies, and the patterns of their fundamental existence were remarkably unlike. And yet, their pains responded

*I suggest that
I know what to do
because I recognize,
as do few other
physicians, that
chronic pain is a
mental illness.*

to the very same drugs (admittedly, in Pat, whose disease was much more complex, an add-on drug was necessary).

Readers may be surprised to learn that I find Ann's illness much harder to understand than Pat's. She had none of the common antecedents or risk factors for the development of chronic pain and very few of the symptoms of the disease. I chose to treat her as I did only because her pain occurred exclusively at night and regularly at the same hour of the night. These features are quite common in those who suffer chronic pain. They were enough to invite me to make a least a tentative diagnosis of that disease and to initiate therapy that, fortunately, worked quite well and continues to work well three years later.

Pat practically wrote the book on chronic pain. She suffered a common antecedent in the form of trauma in her youth. We don't know what it was, but it was enough to make her flashback to the experience and enough for her psychiatrist to make a diagnosis of post-traumatic stress disorder. She almost certainly suffered another psychiatric disorder—bipolar disease. She had many of the symptoms of chronic pain, sleeplessness among them. Another was the experience of *allodynia*, which means perception of pain in response to a trivial sensory stimulus. The elastic waistband of her panties hurt her.

Pat, four years later, has done less well than Ann. She is the victim of a cruel disease characterized by erratic mood swings with pain along for the ride. She is better than when we started, but by no means has her recovery been complete.



In this book I will describe many people who suffer chronic pain. I will illustrate the commonalties among them and will suggest that chronic pain, like all diseases, has discernible origins. It has a complex, but nonetheless predictable, pattern of clinical behavior, and it has a somewhat predictable response to drug therapy. I will suggest chronic pain can best be understood as a disease of the mind, and I will emphasize that we have many drugs, hundreds of them, which can alter the conduct of that organ and diminish pain.