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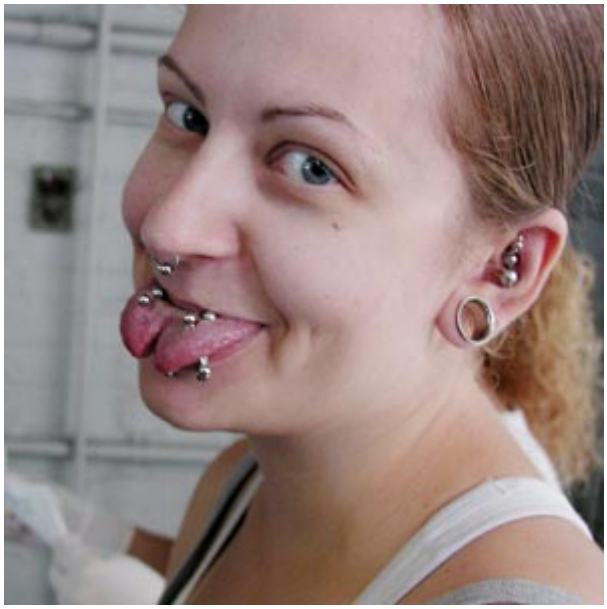
FROM THE EDITOR'S DESK

PAIN AND THE GENDER DIFFERENCE
For centuries the difference in perception of pain has been recognized, exaggerated, dismissed and disregarded; nevertheless, observational studies have gradually found some truth in the concept that some individuals perceived more pain out of the same painful stimuli than others do.

We know for a fact that some individuals (fakirs) can lay on a bed of nails,

others can walk on hot burning coals without apparently perceiving great discomfort, while others, scream when a small needle pierces there skin to receive an injection. The factors involved in the difference between being highly sensitive to pain and being tolerant or even insensitive to pain are many and varied. For what it is worth, there seems to be some differences among young and old patients, male and female individuals, and even among ethnic varieties. Our genetic matrix is most likely involved in some of these differences, although we do not yet know, how and to what extent (Anesthesiology 2003:98:1312-14).



Much has been studied about the possibility of a threshold being higher in some persons than in others. As a matter of fact pain sensitivity was attempted to be defined as the difference between threshold and tolerance.
Thresholds are not influenced by analgesics, whereas tolerance may be dependent on the motivation of the subject (the macho men image).

Pain assessment in cognitively impaired older adults has been found to be less sensitive than in unimpaired older adults (Pain 2001:92:173-86). It has also been noted that husbands of patients with osteoarthritis tended to over estimate patients pain sensitivity than their physicians, mostly because when pain was felt, pain was associated with less efficacy in the women's chores and responsibilities (Pain 2003:106:27-34).

It is obvious from these observations that pain perception is a subjective function influenced by a variety of factors. The influence of gender has been recognized by the impression that women suffer more painful conditions in their life time than men; studies observed in patients undergoing the same operation it has been found that women have lower thresholds to pain, also a greater ability to discriminate pain, higher pain ratings and less tolerance for painful stimuli (Arch Intern Med 2000:160:3424-28). Although in the past a socio-cultural difference was argued, studies conducted in non-human mammalian species showed the same difference among the genders, support the theory of a pain genotype (Neurosci Biobehav Rev 2000:24:375-89).

In another study (J Pain 2004:5:377-84), in which a large population submerged their hand in cold water for 3 min, there was a considerable difference between men (30.5%) that were able to keep their hands for the entire period, versus only 14.5% of the women were able to do it to the limit. This difference might be due to genetic polymorphisms in pain related genes, as well as prior experience with severe pain (childbirth), as well as, gender role expectations (men).

Obviously the explanation for this differences is more complex; including lower thresholds, greater ability to discriminate pain, inherited differences in the neural circuitry that detects and modulates pain, possibly regulated by sex hormones (Pain Reviews 2000:7:181-93). Differences among various ethnic groups have also been noted (Phychosomatic Med 2001:63:316-23).

In carefully controlled studies, the response to a relatively similar painful stimuli (Cesarean section) has been predicted in how much pain they are going to experience and how much narcotic analgesics will be required to alleviate such pain (Anesthesiology 2003:99:142-6).

There is also the extreme, absence of pain in certain individuals born without being able to feel any painful experience. Considered a rarity, some individuals are born with congenital insensibility to pain. See the enclosed picture of a 5 year old girl that feels no pain.

ASHLYN BLOCKER espera su turno para participar en la clase de danza de la escuela.

FOTO: AP

Es inmune al dolor

Georgia / **AP**

intenso calor. Aparte de eso, sus

Although able to feel the texture of objects like coins, cloth, files. It appears that due to a genetic mutation, the development of the small fibers that transmit pain from the periphery to the brain is affected, so they are unable to feel burning, lancinating or any other kind of pain sensations. As ideal that this condition may appear at first sight, it is quite dangerous as the body will not be informed, and conditions such as appendicitis, tonsillitis would not be felt.

Eventually it is hoped that selectively certain fibers that transmit pain may be coagulated, suppressed, or somehow interrupted so the many patients that experience unrelenting pain would suffer no more.
(pictures from http://www.fakir.org/)

ARE THE DRUGS WE PRESCRIBE SAFE?

Once held as the guardian of the USA Pharmacopea, the Food and Drug Administration the many fiascos, with the medications approved as safe, finding later on that are harmful to a substantial numbers of patients have brought doubt and concern over this federal agency. Recently the editor of the Journal of the American Medical Association, Dr, Catherine De Angelis compared this agency with a dangerous building stating "we are on very shaky ground" listing the flu vaccine fiasco of last winter, the Vioxx and Celebrex withdrawal. She concluded "I would not condemn it yet, but all of us (patients and physicians) need to know that we go into it at our own risk. Although no drug is fully safe, the apparent fast track record that the FDA was proud of proved to be plagued with assumptions, poorly designed protocols and not enough critical review of the individual patient documents. Regulators and inspectors have been found functioning within restrains favoring the manufacturer and preventing them from conducting a careful objective and unbiased review. It has been found that the protocols had been designed to accept too many deaths and side effects as the natural process of evaluation of a drug.

This created, within the FDA ranks, a "culture of denial" that favors the rapid process and the acceptance of these complications as unavoidable. The direct advertisement of Drug Companies on television also has brought among patients a feeling of "I must have it", regardless of whether it is indicated for them, or whether they have a condition that would contraindicate that medication for this patient. So they go to their doctors' office demanding to have it prescribed for them. They accept what the advertisers state in television as the facts and the truth, without realizing that the former are incomplete and the latter has been misconstrued.

Once more, the famous pharmacologist and pharmacist, Paracelsus was correct when in the XVI Century he warned "There are no safe drugs, only safe dosages".

ACCEPTANCE OF OPIOID THERAPY FOR CHRONIC, NON-CANCER PAIN, WITH CAUTION

It has repeatedly been documented that one out of three individuals in the U.S.A. experience some kind of chronic pain in their lifetime. Such pain limits normal function, recreation,

employment, sexual activities, affecting interpersonal relations as it brings about physiological changes, alters psychological behavior and disrupts sociological issues. Taking these factors into consideration, it is obvious that the prevalence of chronic pain results in a huge toll in productivity, increases largely the health care costs and brings about an insurmountable amount of suffering and despair (JAMA 2003:290:2443-54).

The use of opioid medications for the treatment of not curable, but not malignant pain has been surrounded by controversies because of the unquestionable occurrence of dependency and tolerance requiring the gradual increase of the dosages, sometimes reaching disproportionate limits that bring the attention of regulatory agencies (DEA, Medical Boards).

The gradual step-like table recommended by the World Health Organization in 1987, has been found to be outdated and non-practical nearly two decades later; specifically, it is not only unnecessary but unfair to a patient with obvious neuropathic pain to start him /her only on NSAIDs, appropriate drug therapy must include anticonvulsants, antidepressants and opioid medications.

- The subject of this section is precisely the latter, as it is a serious and most important issue that should not be taken lightly by the physician
- The patient should receive a complete informed consent
- The patient should receive comprehensive and detailed information on the potential dangers of this form of therapy.
- The potential for developing tolerance and dependency
- The governmental agency regulations that control the prescription of these medications and their high costs.

In any patient, the following "Considerations" have been recommended by the FDA when Prescribing Potentially Abusable Drugs.

1. Take a detailed history and perform an appropriate physical exam and a complete neurological exam.
2. Establish a definite diagnosis for the pain problem and relevant co-morbidities.
3. Consider the various approaches to the treatment of pain.
4. One practitioner should have primary responsibility for the management of the chronic pain condition, specially if there is a suspected history of abuse, addiction or diversion
5. In these cases, it is particularly important that the clinician explains to the patient, from the beginning the treatment plan.

To these considerations, I would add ample discussion of the expectations from the patient. In my practice any deviation is grounds for extensive discussion of the circumstances and a warning that if it recurs, the patient will receive written notice of termination from my practice. Regardless of the aggravating circumstances, no extra prescription is given until the completion of the previous prescription. Exception is made when medications are stolen from the patient, in which case a police report would be necessary. On the other hand, it is fair to say that since many of their complaints are subjective (pain, muscle spasm, tingling sensation, etc.) we should

believe what the patients tell us as the truth; if we do not trust and believe what they say to us, we are doing them a disservice by being their physician.

Among the various points to discuss, the following are a must:

Clinically used and effective, controlled drugs have been classified by the Drug Enforcement Administration (DEA) within the following schedule:

I. Non-prescribable drugs such as heroin and cocaine.
II. Narcotics with higher possibilities to develop dependency such as morphine, codeine, fentanyl, oxycodone, alfentanyl, sufentanyl, methadone, etc.
III. Opiates that produce dependency of lesser degree and on a reduced scale such as hydrocodone and propoxyphene.
IV. Other medications such as benzodiazepines, barbiturates, hypnotics, tranquilizers, etc.

There are other drugs that are also controlled but that have a dual effect of being agonists like those already listed and antagonists, in other words, if given alone, they can produce some analgesia but all of them have a ceiling effect (after a certain dose there is no greater analgesia obtained). But, when given after an opioid with pure agonist action, then they will revert the analgesia, also inducing a withdrawal reaction. These include butorphanol, buprenorphine, pentazocine and nallorphine. Naloxone is a pure agonist used to revert overdosages from the agonists.

There are basic and important differences, as far as the prescription format of Schedule II and III groups:

- Schedule II medications can not be called over the phone
- In Schedule II medications, refills can not be written on the prescriptions
- Schedule II medications can only be prescribed on the date that the patient is evaluated by the physician

Discussing the consequences of these differences among patients and their physicians is an essential understanding at the time the first prescription is written. It is also essential that they are included in the “Controlled Substances Contract” signed between the patient and the prescribing physician (A joint statement from 21 Health Organizations and the DEA. Available at http://www.ampainsoc.org/pdf/advocacy/concensus_.1pdf

Some of these drugs are available in combination with acetaminophen, aspirin or ibuprofen, that potentiate their analgesia, while providing some anti-inflammatory action; however they have their own side effects that have to be watched for.
It is also relevant to explain some of the pharmacological differences among the opiates; for example

- ❖ Fentanyl and sufentanyl have a short duration of action.
- ❖ Longer lasting are meperidine, hydromorphone, and oxycodone.
- ❖ Morphine and codeine have a slightly longer duration but methadone lasts the longest.

- Different special forms of encapsulation have been designed over oxycodone (Oxycontin) and morphine (depodur) that prolong their effect by slowing their release from the specially prepared tablets, however a higher dose is usually contained in them. Fentanyl patches include dosages for three days duration. (http.deadiversion.usdoj.gov/faq/pain_meds_faq.pdf)

The lowest dosage is usually prescribed when patients have not received opiates recently; if a change of medication is indicated, then an equipotent dose is necessary in order to have an equivalent effect. The simultaneous prescription of adjuvant medications is usually recommended to potentiate the opiates effect and to treat other accompanying symptoms such as anxiety, muscle spasms, headaches tingling, electric shock like pain. After a reasonable period of time (weeks or months), the dose may be up-scaled to the next fraction of the dose or whatever presentation is available.
If side effects such as somnolence, mental clouding, lack of coordination or slurred speech appear, the dose has to be reduced. Constipation may be treated with laxatives or magnesium oxide.

Everyone concerned needs to be aware that patients may have certain preoccupation about addiction that may lead to non-compliance, concerns about side effects, acceptance that pain is an inevitable sign of disease and thus unavoidable. In fact opiate medications carry a risk beyond side effects or toxicity; dependency is a serious effect that happens in every patient that takes this type of medication.

The consensus is that the patients, their physicians, pharmacists, regulatory agencies, law enforcement agencies, all have a responsibility that this process is carried out as designed by the law in order to afford the benefits of this type of medications to patients in pain (Semin Neurol 1997:17:203-11).

Although the use of opioid analgesics in non-cancer pain patients remains controversial, most enforcement agencies and regulatory organizations, physicians and pharmacists endorse their appropriate use. Similarly, all of us need to be vigilant to prevent drug abuse without hindering the patients ability to receive the care they need and deserve.

The above noted discussion on the regulations that act on the prescription of opiate medications is included as a point of information for patients and physicians alike. For patients, it is intended to inform them of the seriousness of this issue and as an explanation of why we, physicians, act cautiously to the point of being suspicious and we must be since our medical license depends on it, our medical practice will most likely cease if sanctioned and there are financial fines usually applied, as well.

To our patients – it is imperative that you are open and truthful with us so we continue to trust you and provide you with the medications that although they do not cure your pain, they usually reduce it to a more comfortable levels and you can be somewhat active and have a slightly better quality of life.

However, I want to be very clear that as of now, with the opiate medications that we have at hand, it is my firm conviction that we must continue to explore for non-narcotic medications to reach this target. This may be surprising to many of you and deceiving to my colleagues. The reasons for this conclusion are several.

Throughout my medical carrier that expands over half of century, I have seen it too many times, in patients as well as in laboratory animals, that opiates produce dependency, change the personality and the mind of patients, their habits, their purpose in life and their outcome.

Our purpose is to prevent the conditions that cause the pain that affects our patients and sometimes forced them to do the unthinkable to obtain their pain relief even if only partial and for a few hours.

At the risk of sounding idealistic and insane, I am convinced that there are other ways, other medications, that without cutting, burning, freezing, injecting, chemically degrading or electrically stimulating, pain can be relieved without the risk of making it worse, or having to turn patients into dependency. Disappointingly, I am unable to give you the answer, but I hope that in a short while some one will. In the meantime it is important not to settle completely for opiates, but to continue the search.

COMMENTARY BY THE EDITOR:

BE AWARE OF WADDELL SIGNS

About 25 years ago an orthopedist who used to treat patients with low back pain for Workers Compensation agencies wrote a series of clinical signs and maneuvers that depending on how they were executed and interpreted supposed to define whether the patient was representing factual information or was "malingering" (Waddell G et al: Non-organic physical signs in low back pain. Spine 1980:5:117-25). These maneuvers and their questionable interpretation caused many injured workers to loose the just compensation and medical care that were due to them.

This article was published before MRI was available and CAT scan exams were rarely done, so their application on WC cases, victims of MVA's and other accidents were evaluated for compensation, medical care or disability with doctors claiming the proper application of Waddell signs declared too many of these patients unsuitable for medical care, or denial for certain treatment or medication requested for the relief of their pain, that would have been required for their re-incorporation to the work force.

Twelve years later Waddell and Richardson published a revision of their initial paper, tangentially accepting that, in part, the originally proposed set of maneuvers and signs and their interpretation were incorrect, adjudicating some of the disparity to psychological disturbances acquired by the patient as a result from the injury (Waddell G, Richardson J:

Observations of overt pain behavior by physicians during routine clinical examination of patients with low back pain. Spine 1993:18:2412-8).

Later, Polatin and others in a polite criticism of Waddell's signs, found that they were only partially applicable in patients with short-term low back pain, but unacceptable in patients with chronic low back pain. Specifically they found that the signs were not prognostical. Moreover since comprehensive functional restoration is common these days, it has been found that the typical patients' complaints do not present a barrier to recovery.

Moreover since the "non-organic signs were unrelated to "organic pathology". They also found that in many cases, the Waddell's signs were initially low at the preprogram assessment, as compared to what Waddell described in his original article were non-applicable as there was little room to demonstrate improvement (Polatin PB, Cox B, Gatchel RB, Mayer TG: A prospective study of Waddell signs in patients with chronic low back pain. Spine 1997:22:1618-21). In these days when more sophisticated and effective imaging studies are available to find and verify the precise diagnosis and having shown that the functional restoration program was by far more reliable than the application of Waddell signs in any evaluation of physical capacity, the current use of this latter predictive test is valueless

Patients that are contemplating a Functional Capacity Examination or evaluation by a physician, as determined from an unfriendly party, have to make sure that Waddell signs are not used against them.

The Editor

INQUIRIES

I need to state that to protect patient's confidentiality under HIPAA, I do not offer medical opinions over the Internet.
However, not uncommonly our web site receives inquiries about certain issues and if they are related to arachnoiditis.

Patient questions:
Q : Does Neurontin produce bloated stomach
A : This sensation may be due to other medications producing gastritis, such as anti-inflammatories.

CALL FOR WRITTEN CONTRIBUTIONS

As in the past, we invite contributions by physicians, patients, relatives of patients, therapists on subject related to ARACHNOIDITIS, specially their impressions, experiences and sacrifices as they help or care for this patients.

CALL FOR LETTERS, ARTICLES, CONFESSIONS POEMS, DEBATES, etc.

Readers are invited to write short, but meaningful, articles on any subject related to Arachnoiditis. They may be submitted with the author's name or anonymously, however, with the understanding that:

a. The Editorial Board reserves the right to modify them or alter them to conform with the style and the "Objectives" of the ARC Newsletter.
b. The copyrights will be waived with the assurances that the Editorial Board will not derive any profit from any of these publications.
c. They are simple, constructive and civil.

Thank you.
The Editorial Board

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Arachnoiditis Foundation, Inc.
P.O. Box 4627, Seaside, FL 32459-4627
E-mail: taldrete@arachnoiditis.com

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