

Pain Hurts both the person and the public pocket

Pain is a complex and subjective blend of sensation, emotion, experience and culture and clearly has a negative impact on an individual's quality of life¹. It can diminish the ability to concentrate, remain in employment, exercise, socialise, perform normal daily tasks and sleep and can result in an unrelenting downward spiral of depression, isolation and low self-esteem. Clinical studies have shown that anxiety is the most frequent psychological reaction associated with acute pain while depression is most often correlated with the chronic presentation². Epidemiological studies have revealed widespread unrelieved pain throughout society as a whole³.

Medically, pain can be defined as an unpleasant feeling that is conveyed by sensory neurons to the brain. This discomfort is a danger signal for the body and can arise from any number of situations, injury being the most common. However, pain may also be symptomatic of certain illnesses, may present as part of a psychological condition and in some cases may not even have a physiological trigger making this benign form more difficult to assess⁴.

When one tries to fully analyse the meaning of the word *pain*, one realises that it is more than just a sensation – it also includes perception, which is the subjective interpretation of the discomfort experienced⁵. This gives a person information on the pain's nature, location and intensity and the various conscious and unconscious responses to both the sensation and the perception of pain add further definition to its concept. Pain is therefore a very complex and universal human experience. The International Association for the Study of Pain (IASP) grappled with defining pain as “ an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”⁶. Its use of the words “actual and potential” further excludes the possibility of a decisive, objective test as a gold standard for pain measurement⁷. Since pain is a subjective experience, sufferers find it very difficult to communicate its exact quality and intensity to other people. Anatomical changes on an MRI scan do not equate with pain ⁸ and there are currently no accurate diagnostic tests that are accepted as being full-proof in determining the quality or intensity of an individual's pain experience. Medicine must therefore rely on adopting a subjective line of questioning and creation of a pain scale in an attempt to comprehend a person's level of discomfort^{9,10}. Pain may be symptomatic of an actual disease or a disorder in its own right, occurs only in the conscious individual and is essential for

survival¹¹. A minority of people are born without the capacity to feel pain and in consequence they tend to have short lives, robbed of the warning signs afforded by pain. However, most usually pain is experienced by all age groups, both sexes and all races and ethnic groups. The ways in which we humans express and treat such pain are shaped by our respective cultures and societies. Consideration of socio-economic factors shows that learning about pain takes place within a definite social context and the way an individual behaves when in pain reflects this fact¹². A glib generalisation, with some basis in fact, sees people from Northern Europe view complaints about pain as showing weakness of character whereas their Southern counterparts believe that complaining about pain as being beneficial to the sufferer. Diverse correlations between people and the way they view pain can be pulled from every culture in the world. In the last twenty five years, research into the neurobiology of pain has been accompanied by studies reflecting the psychological and socio-cultural factors that influence a person's experience of pain, their utilisation of health care systems and their compliance with the various treatment options for pain. Since 2003, The World Health Organisation (WHO) has emphasised the importance of an interdisciplinary approach to pain treatment that takes this complexity into account¹³.

In general, pain is recognised in two forms – acute and chronic. Acute pain is considered to have a protective function with a key role in survival and is generally of limited duration¹⁴. Treating the cause of acute pain is often found to resolve the problem – an observation which perhaps over-simplifies a common condition which is found to occur most frequently in the post-operative period. Non-surgical acute pain is frequently associated with low back pain, burns and trauma and many medical conditions such as acute pancreatitis and sickle cell disease. The deleterious effects of unrelieved acute pain are psychological, physiological and socio-economic. Unrelieved acute pain may predispose to the development of the chronic form¹⁵ but the provision of effective acute pain relief contributes to reduced hospital stays, promotes recovery and reduces the development of such chronic pain syndromes¹⁶.

However, treatment is not always totally successful and sometimes the trigger not entirely clear. Pain then persists and becomes labelled as *chronic*. Statistics show that almost one in seven people suffer from chronic pain and that 20% of those have suffered for more than twenty years¹⁷. It is therefore not surprising that people who suffer chronic pain consult their GP up to five times more frequently than others which results in approximately 5 million GP appointments a year¹⁸. A survey of chronic pain in the UK reported that two thirds felt they were given inadequate pain control with only 16% having seen a pain

specialist regarding their condition¹⁹. This survey also showed that 70% want more effective management and a better understanding of their condition¹⁷. Of chronic pain presenting to GPs about 20% is due to malignancy. 88% of cancer patients in the last year of their life are in pain and of those, 47% felt that their treatment only partially controlled their pain²⁰.

The McEwen Report²¹ (2005) was commissioned by the Scottish Executive into chronic pain services in Scotland and is considered a helpful framework within which pain services can be enhanced. It identified, that in 2004, too much variation existed in both the structure and functioning of services in Scotland and makes recommendations on how to improve this. Some of the figures quoted in the McEwen Report include : chronic pain affects between 1 in 5 and 1 in 6 Scottish adults, two thirds of which suffer moderate pain and one third suffers severe pain which means 6% (250,000) of Scottish adults suffer severe pain. In addition, one third of those patients suffer chronic pain with an average duration of 7 years. 1 in 5 sufferers have the pain for more than 20 years. This is a significant disease process which cannot be ignored but patients can still wait from 2-6 months for a first appointment at a chronic pain clinic and for some it can take up to a year. This is partly due to increased referral and partly due to a lack of trained staff to deal with and assess such complicated cases. After that, a patient might wait up to 2 years to take part in a pain management programme so it is not surprising that 48% of patients developed moderate to severe depression in the interim. However, the temptation to be ultra negative must be resisted as Scotland, and the UK in general, is actively innovative in terms of developing new treatment strategies – the weakness lying in the provision of an accessible network for pain so that such advances might become the norm instead of the exception.

Facts about chronic pain in the UK :

- 1 in 7 (13%) of the population suffer from chronic pain²²
- studies show that chronic pain can be persistent and seldom totally resolves, even with treatment¹⁷
- at least 7 million adults in the UK suffer from painful musculoskeletal conditions¹⁸
- more than half a million people in the UK suffer neuropathic pain²⁰
- untreated pain affects the quality of life for sufferers and carers resulting in isolation, depression and often family breakdown²³

- musculoskeletal conditions have more negative impact on quality of life than cardiovascular, chronic respiratory, gastrointestinal disease and visual impairment and found to be more prevalent in socially deprived areas²⁴
- more females than males are affected and prevalence increases with age²⁵
- economic impact of days lost from work through pain, invalidity benefit and health service utilisation due to chronic back pain has risen rapidly since the mid 1970s and this is in line with findings from other countries²⁶
- economic burden of pain is substantial and consists of three cost components – direct, indirect and psychosocial²⁷
- health and social costs per annum are estimated at £12.3 billion which is 22% of the UK healthcare expenditure and 1.5% of the UK GDP. Despite this, 64% of Primary Care Organisations taking part in this survey²⁸ failed to allocate any specific funding to chronic pain management services and reflects findings in the McEwen Report that suggests vast variation in the provision of pain management. A glaring example of this can be found in the North of Scotland where the Acute Pain Management Clinic at the Royal Infirmary in Aberdeen, serves the whole of Grampian and most of Highland regions, covering thousands of square miles and catering for thousands of sufferers.

In the USA a survey of 3982 Americans concluded that a pain epidemic exists there too²⁹.

- **% Americans in pain at any one time** 28
- **% of those in pain**
 - who earn less than \$30,000 34.2
 - who earn more than \$100,000 22.9
 - who didn't finish high school 33
 - who got a degree 20.2
 - who are not satisfied with life 53.9
(average pain rating 2.26)
 - who are very satisfied with life 22.4
(average pain rating 0.66)
- **amount spent annually on non-prescription painkillers** \$2.6 b

prescription painkillers	\$13.8b
productivity lost annually due to pain	\$60b

Source : Kreuger and Stone; Lancet: 3 May 2008.

To help complete a worldwide picture, MBF, who is Australia's second largest private health insurer, commissioned research in conjunction with the University of Sydney's Pain Medicine Research Institute (PMRI) to determine the cost of chronic pain in Australia in 2007. This Access Economics (AE) Survey³⁰ shows that 1 in 5 Australian adults suffers from chronic pain which translates into 36.5 million days/year of lost working days making it one of the most costly healthcare problems here too. The AE survey revealed that the annual cost of pain is a massive \$34.3b which is approximately \$11,000 for each of the estimated 3.2 million people who live in Australia with chronic pain. The study also found that the Australian Healthcare System (AHS) structure meant that sufferers have to bear more than half the financial burden themselves and that a large proportion of the \$7b spent directly on pain by the AHS could be saved if pain was better managed within that continent.

The statistics clearly show that persistent pain is a very common cause of personal suffering and economic adversity. In addition to a severe erosion in quality of life, constant pain can impose severe financial burdens on many levels from cost of healthcare services and medication, loss of income, non-productivity in the economy, financial burden on family and employers to worker compensation costs and welfare payments²⁶. Strong evidence exists that a multidisciplinary pain management approach is of benefit in improving the quality of life of sufferers and in lessening the socio-economic burden of unrelieved chronic pain³¹. As part of this multidisciplinary approach, the use of Complementary healthcare for problems associated with pain is shown to have increased over the past twenty years³². In the UK, a study by Greenfell *et al* was undertaken to determine the use of Complementary Therapies (CTs) by patients attending three hospital outpatient departments for reasons including pain³³. A high level of CT use (68%) was reported of which over half freely admitted to using this first before consulting their GP and almost all patients felt that CT should be available on the NHS. In conclusion, this study showed a need for doctors to be more aware of the value of CTs to ensure appropriate communication and referral. Another study, based in Aberdeen³⁴,

explored a similar theme and had similar outcomes. These two studies, although drawn from relatively small samples, are representative of many more and point to the fact that medical practitioners should be aware of an increasing popularity in Complementary Therapies within the UK population as a whole and as a result should be prepared to counsel patients appropriately, a skill currently falling short of patient expectation.

So, pain continues to hurt.....and will do for the foreseeable future. Pain is a massive medical and economic problem in a modern world which has an increasingly aging population. Efficiency and improvement in pain management services for sufferers is paramount, not least as they have a domino effect on benefits to the economic burden caused by such a complex and multi-faceted health conundrum.

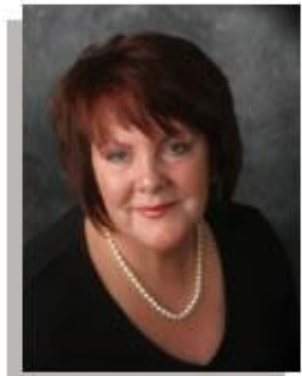
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