PAIN MANAGEMENT FROM A PHYSIATRIST'S PERSPECTIVE

An Interview with Dr. Jerrold L. Kaplan, the attending physiatrist and medical director at Gaylord Hospital, as well as an assistant clinical professor of orthopaedics at Yale University School of Medicine.

Interviewed by: Michael R. Kerin, Esq.

CQ: What is a physiatrist?

Dr. Kaplan: A physiatrist is a physician who specializes in physical medicine and rehabilitation. Our perspective is to look at a person's functional status and to get the patient to his or her highest possible functional ability.

CQ: How does your perspective differ from that of a surgeon?

Dr. Kaplan: I look at the person as a whole person, not just at the back or just at the disc or a ligament or a muscle. I try to put many different pieces together. The literature supports that in the vast majority of pain management cases, especially when we get into the realm of chronic pain management which is defined as more than six months of pain, we need to look at the whole person to be as successful as we can. As a physiatrist dealing with pain management, my first objective is to try to diagnose the source of the pain. Where is it coming from? In order for me to have an appropriate treatment plan, I am going to treat this specific type of pain with the intervention or interventions that I think are going to be most successful.

CQ: Are there other less comprehensive approaches to pain management?

Dr. Kaplan: The narcotic-based pain management approach is to minimize the individual symptoms so that it's more of a "shotgun" approach. If you give enough narcotic pain medications hopefully you will be able to decrease the pain, but you are really not treating the underlying source of the pain. You are really just being completely symptom-based, and if you require higher and higher dosages of narcotics, the narcotics themselves can cause secondary problems, whether there are dependency issues or whether there are physiological problems. A classic example is something as simple as constipation. If you have a patient with a disc herniation that you start giving narcotic medication to and the patient starts getting more constipated from the narcotics and you don't effectively deal with their regimen, that's all you're dealing with: the symptom of pain. You are going to have increased constipation; the patient will be straining more which will increase the pressure on the discs, which causes them to have more pain, to potentially be on higher dosages of narcotics and all of sudden you are getting into this vicious cycle with narcotics: more constipation; more straining; more pain; and more narcotics.

CQ: When a patient comes into your office, what do you do?

Dr. Kaplan: I have to get the right diagnosis and then once I have the diagnosis, I determine what treatment combination is going to be most effective for the individual. I would do a pain management assessment which would involve reviewing medical records, interviewing the patient and performing a comprehensive physical examination. If he or she has a family member with them, I also talk to the family member. Finally, I review any diagnostic studies, MRI, x-rays, EMG nerve connection studies or other test reports if available.

If you're seeing a patient soon after the injury and it is a relatively simple muscular sprain/strain, then the patient may not need to lose any time from work. Educational training is provided to help him or her get over this acute phase so that they can stay at work and get back to functioning. On the other hand, you may have a chronic pain patient that you are seeing six months down the line who has a lot of these chronic pain behaviors that have now kicked in. You may now need to deal with other issues such as nutrition, psychological problems, and medication dependency. By having the rehabilitation physician as the first step in your pain assessment, you may be able to avoid having the acute pain patient turn into a chronic pain patient.

CQ: If you determine a person may not be a surgical candidate, what treatment do you offer?

Dr. Kaplan: As a physiatrist, before I would consider surgery or anything else, I would do what I call a functional spinal stabilization. I would see if I could work with the individual and get his or her back as strong as possible using his or her own body and his or her own muscles to do what a surgeon would do with bone grafts and rods. The nice thing about that approach is you have not destroyed any anatomy; you have not put any foreign hardware in there and if you are successful for that individual, you are going to not only get them over this particular pain episode, but hopefully you are going to prevent a future injury.

In contrast, if you immediately jump to a surgical intervention, for example, a fusion at the L4-5 level, you are going to put an increased force and pressure on the disc level above and below. You may have fixed the problem at L 4-5, but now you have increased irritation and increased pressure at L 3-4 and L5-S1. Guess what happens? For a number of years the person is successful. They get back to work, they do things, and they put more force and more pressure on the fused joint. Now you have destroyed the underlying anatomy during the surgical procedure and you are causing more irritation and more pressure above and below the level where you have done the fusion. In contrast, if I am doing my functional spinal stabilization, I have made all the muscles stronger, not just at the L4-5 level, but above and below as well.

CQ: What other techniques are used in functional spinal stabilization?

Dr. Kaplan: The individual is taught posture, body mechanics, safe lifting techniques, and pacing techniques. We also use various other rehabilitation techniques. The most common is land-based physical therapy. We also use aquatic physical therapy, which is especially helpful for those individuals who might not be able to tolerate a land-based physical therapy program. The patient can do stretching and gentle strengthening exercises, and slowly try to improve their condition without putting a huge amount of force on their back. Then we can gradually add various weight belts and more advanced exercises to build them up. Aquatic physical therapy is an excellent tool to use for posture, body mechanics, and strengthening exercises for the pain patient.

CQ: Do you include the use of medications in the functional spinal stabilization?

Dr. Kaplan: It is not that I am opposed to medications; I just want to use as specific a medication as possible. If the pain is coming from nerve irritation, I'm going to use a medication that is geared toward neuropathic type pain. If pain is coming more from muscle spasms, I am going to use medication that is more helpful for muscle spasms. If pain is coming from acute inflammation, then I am going to use an anti-inflammatory medication. In many cases, it is a combination of several different things, so I might use a neuropathic medication as well as a muscle relaxant medication. I am going to be careful to monitor medication benefits, side effects, and drug interactions.

CQ: Do you prescribe narcotic medications?

Dr. Kaplan: A patient who has had major trauma may have a severe pain issue and may need narcotic pain medications, either for the acute episode right after the major trauma or on a long-standing basis. A spinal cord injury patient who has bone fragments that are pinching his or her nerves has a good objective reason for serious pain. That type of injury may well receive long-term narcotic use, but that is quite a bit different than back strain patients.

CQ: Do you ever prescribe sleeping medication?

Dr. Kaplan: If an individual doesn't sleep at night, he or she can never get the proper rest for his or her muscles. The muscles are always going to be fatigued which may cause the patient to either get reinjured or delay their recovery. I want to make sure the patient has appropriate sleep hygiene before I give them sleeping medications. I will also look at their nutritional status. Is this an individual who has three cups of caffeinated coffee at eight o'clock at night? The patient is going to have trouble sleeping. At Gaylord, we have a sleep medicine program, so we have expertise in a whole variety of sleep disorders. Sometimes we use sleep medicine services in conjunction with managing our chronic pain patients. Patients need to get a full night's sleep if they are going to recover effectively.

CQ: Does nutrition, and specifically weight gain, factor into treatment?

Dr. Kaplan: Nutrition is an important issue related to the patient's overall recovery especially as we are talking about chronic pain. If you have a patient who has had an injury and now has gained 50 pounds, the patient is putting more pressure on the related body part. This can cause a marked increase in pain, especially for back pain patients.

CQ: A claimant who suffers from chronic pain often suffers from resulting depression. How does depression factor into a pain management treatment plan?

Dr. Kaplan: When I deal with the issue of chronic pain, I need to deal with the associated psychological issues as well. Many individuals develop reactive depression. That is a depression related to changes in their circumstances, because they can't do what they used to be able to do. Depending upon how severe that reactive depression may be, it can interfere with their ability to participate in their rehabilitation program. If someone is depressed to the point that they don't want to participate and are not listening to instructions about exercises or weight loss, then the prognosis for recovery, unless you deal with the depression, is poor.

CQ: Are there instances when the depression may interfere with your treatment?

Dr. Kaplan: Sometimes I'll get an individual referred to me for pain management assessment and I'll need to say unless the psychiatric issues are treated, I can't help this individual. That individual needs a full psychological or psychiatric assessment to determine the other issues impacting their ability to participate in a functionally based rehabilitation program.

CQ: Are there some claimants who are depressed before they are injured, but for whom a new injury exacerbates their depression?

Dr. Kaplan: Sometimes I see the individual who was just barely making it at their job. Then a relatively minor injury occurs and the individual is now out of work and has symptom magnification. They are expressing themselves out of proportion to the objective physiology that I see. I need to determine if there are other factors interfering with their ability to participate and their desire to return to work. Maybe they've had some type of stressful situation at work that they don't want to confront. There are factors other than the work injury that are interfering with their ability to return to the workplace.

CQ: Are epidural injections generally effective as a tool in pain management?

Dr. Kaplan: At times, an epidural is the best treatment, if done in conjunction with the rehabilitation program. You can do an epidural and give the individual significant pain relief. Epidural injections should be done with fluoroscopic guidance that allows the physician to visualize where the needle is in relation to the rest of the anatomy. This is critical to ensure the medicine is injected into the correct location.

Spinal injections can often be diagnostic as well as therapeutic. If someone has significant pain and you inject medication into that area, if they have a great result, there is a good likelihood that this is at least one of the causes of their pain.

CQ: What does the ideal pain management candidate look like for you and when can you best help the patient?

Dr. Kaplan: The ideal candidate is the patient who is referred shortly after their injury and can tolerate a conservative functionally based program. The individual should not have any acute neurological changes that would require an urgent surgical intervention.

CQ: Does pain management necessarily mean pain elimination?

Dr. Kaplan: A successful pain management outcome has to have improvement in function, as well as a lowering of the pain. It may not be the complete elimination of the pain. The pain should be brought to a more manageable level so the person can have the best possible function. If all the pain management program is doing is slightly decreasing pain and not changing the person's functional ability at all, it is not really a successful outcome.

CQ: What training exists for physicians in the realm of pain management?

Dr. Kaplan: Many disciplines have pain management training as components of the training. In physical medicine and rehabilitation, there is training that includes aspects of pain management. Various other specialties have different degrees of pain management training during residency.

CQ: Are there any professional conversations between the surgeons and the physiatrists, in terms of what might be the most effective therapy prior to and after surgery?

Dr. Kaplan: Absolutely. The way the system works best is for the conversation to take place. I do an initial pain management assessment and if I have a patient who I feel needs a surgical intervention or at least an evaluation to determine that aspect of care, I am going to refer them to the surgical specialists. In other cases, if the patient is not a surgical candidate and needs a conservative

approach, the surgeon refers the patient to me. I also see patients who do a pre-operative conditioning program in an effort to have a more successful outcome after surgery.

CQ: Is there any nationally accepted consensus for the treatment of chronic pain?

Dr. Kaplan: There are various protocols in place. The problem is most of the protocols are for acute injury management. For chronic pain, which is defined as greater than six months of pain, there are many differences of opinion and no clear protocols.

CQ: What is the ideal window of time for you to treat a patient?

Dr. Kaplan: I would ideally like to see the patient within a few days of their acute injury. Certainly within the first few weeks to have the best chance for that positive outcome. Can you be successful if it takes you months to see the individual? You can but your chances are best before they become a chronic pain patient.

CQ: Within your practice have you observed shortfalls in the workers' compensation system in Connecticut?

Dr. Kaplan: I think you hit on one already - the timing. The longer it takes to get a patient in for services the harder it is to get a positive functional outcome. Anything that can be done to speed up the referral approval process so that the treatment can be started sooner would be most beneficial.

The other aspect is that once the treatment has started, as long as there are good objective outcomes that are being achieved, it's very difficult to stop the program in the middle. We should be able to complete the therapy program. If a patient is successfully treated for three weeks and needs one to two weeks more to complete their treatment and I do not have authorization to continue the program then there is a gap in treatment. I sometimes have to wait weeks to months for approval of continued services. The patient may have to start over again in many cases. We need clear guidelines for objective improvements. Improvement in these two areas would greatly enhance the workers' compensation system.