painmanagement

SPECIAL INTEREST GROUP

PRESIDENT'S MESSAGE

John E. Garzione, PT, DPT, DAAPM

This year's CSM had the most attendees with many of the educational sessions filled to maximum capacity. Every year, I am amazed how the Orthopedic Section staff and Educational Chairperson can put together this logistical challenge to make the conference flow so smoothly. This year was no exception even with the increased numbers of people attending.

The PMSIG's program entitled "Fear Avoidance Behavior: State of the Art Review" presented by James Thomas, PhD; Christopher France, PhD; and Steven George, PhD was well attended and extremely interesting. I thank the presenters for their work and their informative presentation.

Please take 5 minutes of your time to complete and send back the practice analysis questionnaire so we can start compiling the data to develop content areas that should be included in the education of the pain management physical therapist. The results will be published in a future issue of OP.

Physical therapists are now being called upon, by our medical colleagues, to evaluate and treat more difficult conditions than ever before. Recently, I was sent a 50-year-old male who reported a mixture of nonlocalized pain sensations with the most common description being burning on the left side of his body. He had a difficult time describing the nature and location of his pain which brought back memories of the old axiom among neuropsychologists that human thought can take place only with words. Since newborns have no words, they were thought to have no thoughts. In my experience, many physicians thought that if a patient had no words to describe their abnormal pain sensations, it didn't exist. These are usually the patients who will go into great lengths to try to describe their symptoms with little success. Since pain is an impolite and boring topic to others, these people are impolitely pushed aside or sent to physical therapy with the idea that exercise will take their mind off their symptoms.

My patient had a past medical history of Lymphatic Cancer which was treated with various chemotherapeutic agents. One year, after his original cancer diagnosis, he developed left sided pain which started as allodynia in the left groin, burning sensations to the left arm, Thoraco-Lumbar area including the abdomen, and down the left leg. When questioned closely, which took the better part of 30 minutes, he admitted to many triggers including cold, sitting, movement, stress, and touch. He was dismissed by 2 neurologists previously as being "crazy" and instructed to seek psychiatric help. His range of motion of the spine and extremities were normal actively, and his strength was within functional range even though movement increased his pain complaints. He remained working as a bus driver which also increased his symptoms especially in the winter. Since his symptoms did not add up to the standard neurological pain pattern, I could understand the previous neurologist's conclusion. With that said, I concluded that he was suffering from Central Pain Syndrome or Thalamic pain which has been described as "the worst pain known to man."

The various components of Central Pain Syndrome (CPS) are: Muscle pain, Dyesthesia, Hyperpathia, Allodynia, Shooting pain, Circulatory pain that mimics circulatory insufficiency, and Peristaltic pain in the visceral organs. (The mnemonic for remembering this is: "MD has CP."[1] CPS is a neurological condition caused by damage to the central nervous system by either stroke, MS, reactions to medications, tumors, Parkinson's Disease, brain or spinal cord injury.[2]

Currently, the theory is that there is a template in our brains that defines normal sensory input. This template requires the various pain tracts including the posterior columns, the spinothalamic tract, etc. be balanced. When imbalance occurs there is discordance between the normal template and the incoming signals so a pain message is generated. After the brain detects indistinct or confusing pain signals, it recruits additional brain matter to try to sort out the situation. This recruitment (called the NMDA system) becomes so powerful that it can kill brain cells. To avoid cell death, a separate inhibitory system (called the GABA system) begins to shut down blood flow to various brain parts as seen on PET scan. This conflict between the 2 systems is probably central pain. The pain doesn't make sense, but it exists. This theory, provides an idea of how a person without sensation, such as a quadriplegic, can experience pain. The pain isn't in the person's head, but it is in their brain.

I consulted with the referring physician who agreed to put the patient on a tricyclic antidepressant and an anticonvulsant. I treated the patient with transcranial microcurrent and stress reduction techniques for a total of 16 treatments. His pain levels decreased from an 8/10 to 4/10 overall. He still had the same pain triggers, but his pain levels were much less.

I do love it when a plan comes together.

REFERENCES

1. Pain Online. Available at: http:// www.painonline.org/mnem.htm. Accessed February 26, 2009.
2. Pain Foundation. Available at: http:// www.painfoundation.org. Accessed February 26, 2009.

PAIN SIG MEETING MINUTES CSM 2009 LAS VEGAS, NV

Wednesday February 12, 2009

The meeting was called to order at 7:05 AM by John Garzione, President.

Last year's minutes were approved with a slight change to the Addendum which should have read "EIGs would only be involved with educational programs at CSM."

All attendees were thanked for their involvement with SIG activities over the past year. We can still use more articles for the OP newsletter. These articles can be submitted via email to: johngarzione@frontiernet.net for submission.

Terri Delaune attended the interdisciplinary conference coordinated by the Orthopedic Research Center in Fort Worth, TX last

year. Future pain meeting announcements and educational opportunities can also be emailed to johngarzione@frontiernet.net for inclusion in the quarterly email blast to our members.

The practice analysis questionnaire has been completed and will be sent to all SIG members for their response after CSM. This is the first step to develop content areas for the curriculum and guidelines for residency and/or fellowship programs.

The Orthopedic Section and Pain Management SIG Web site will be updated in March. Discussion was held about possible inclusions for our webpage. Some suggestions included having links to other pain treatment interest sites and links to previous email blasts.

People interested in presenting an educational program at next year's CSM can email their proposal to "SCHOLAR" on the APTA Web site for consideration. The deadline is April 10, 2009. The consensus of the business meeting attendees is that they strongly support a program on "barriers to healing" and pelvic pain masked as low back pain. Ideas for specific titles and speakers can be emailed to Marie Hoeger Bement at mariehoeger.bement@Marquette.edu before the April deadline.

The meeting was adjourned at 7:40 AM.

Respectfully submitted,
John E. Garzione, President