•> CASE 32

A 42-year-old woman presents to a primary care physician with a chief complaint of back pain for the past 6 months that began after she was knocked down by a man attempting to elude the police. She states that she has extreme pain on the right side of her lower back, near L4 and L5. The pain does not radiate, and nothing makes it better or worse. She says that since the injury she has been unable to function and spends most of her days lying in bed or sitting up. immobile, in a chair. Immediately after the accident, she was taken to an emergency department where a workup revealed back strain but no fractures. Since then, the patient has repeatedly sought help from a variety of specialists, but the ongoing pain has been neither adequately explained nor relieved. She denies other medical problems, although she mentions a past history of domestic violence that resulted in several visits to the emergency department for treatment of bruises and lacerations.

On mental status examination, the patient is alert and oriented to person, place, and time. She is cooperative and maintains good eye contact. She holds herself absolutely still, sitting rigidly in her chair and grimacing when she has to move even the smallest amount. Her mood is depressed, and her affect is congruent. Her thought processes are logical, and her thought content is negative for suicidal or homicidal ideation, delusions, or hallucinations.

- **What is the most likely diagnosis for this patient?**
- **What is the best approach for this patient?**

ANSWERS TO CASE 32: Pain Disorder

Summary: A 42-year-old woman has unremitting back pain for 6 months since she was knocked down. The pain is right-sided, located near L4 and L5. There are no exacerbating or alleviating factors, and the pain does not radiate. The patient is nonfunctional since the event. No fractures were found at the time of the accident—a diagnosis of back strain was made. Further workups over the past 6 months show no anatomic or physiologic reason for continued pain. The patient has a history of domestic violence and on multiple occasions was treated in the emergency department for bruises and lacerations. The results of her mental status examination are noncontributory to the diagnosis.

- **Most likely diagnosis:** Pain disorder.
- **Best approach:** Validate the patient's experience of pain. Explain the role of psychological factors as a cause and consequence of pain. Consider antidepressants and referral to a pain clinic.

Analysis

Objectives

1. Recognize pain disorder in a patient.
2. Understand the chronicity. approach, and treatment options for patients with pain disorder.

Considerations

This patient has **chronic back pain (for 6 months or longer)** that is unaccounted for by a general medical condition. As a result, she is distressed and unable to function. There are no data suggesting that the condition was produced intentionally or is being feigned. It is possible (based on her history of domestic violence) that the accident **triggered memories of the psychological trauma** she previously experienced and thus has a role in the severity of her current pain. The patient does not exhibit signs or symptoms of any other disease that might better account for the pain. Table 32-1 lists the diagnostic criteria for pain disorder.

APPROACH TO PAIN DISORDER

Definitions

Biofeedback: A relaxation technique by which patients are trained to induce physiologic changes (most frequently the induction of alpha waves on an electroencephalogram [EEG] or vasodilatation of peripheral capillaries) that result in a relaxation response.

Dyspareunia: Painful sexual intercourse.

Table 32-1
DIAGNOSTIC CRITERIA FOR PAIN DISORDER*

1. Pain at one or more sites that is severe enough for a clinical evaluation; it is the patient's primary complaint.
2. The pain is very distressing to the patient and/or causes significant functional impairment.
3. The clinician judges that psychological factors play an important part in the initiation. worsening, or severity of the pain.
4. The pain cannot be explained by another axis I condition such as major depression or a psychotic disorder, nor can it be solely the pain of dyspareunia.

The disorder is considered acute if il lasts for less than 6 months, chronic if longer.

Pain disorder: One of several somatoform disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders, text revision (DSM-IV-TRj* that is distinguished by a primary complaint of pain that is not explained by physical factors; psychological factors are significant in the clinical picture. Pain is a very common complaint in medicine and occurs more often in older patients (fourth and fifth decade of life) and in those who are likely to have job-related physical injuries. A number of psychodynamic factors can be involved, including inability to express emotions verbally, an unconscious need to obtain attention by suffering physical pain, or an unconscious need for punishment. Individuals also learn this form of help-seeking in a family that models and reinforces the behavior.

Clinical Approach

Differential Diagnosis

Pain is a very common complaint in medicine and occurs more often in older patients (fourth and fifth decade of life) and in those who are likely to have job-related physical injuries. It is important that the patient undergo an evaluation for all medical or surgical illnesses that could cause the pain. Patients with depression can sometimes present with a primary complaint of pain; however, on evaluation, the depressive symptoms predominate. Patients with hypochondriasis can complain of pain symptoms, but the main clinical feature is a conviction that they have a serious medical illness. Patients with factitious disorder *intentionally* produce an injury or illness in order to assume the sick role. Patients who are malingering can consciously present false reports of pain in order to achieve secondary gain (such as financial compensation, evading the police by being hospitalized). Patients with pain disorders often use substances to relieve distress, which can mask the pain disorder or some other medical or surgical illness.

Treatment

In treating a patient with pain disorder, the clinician must accept that the **condition is often chronic** and that the goal of pain relief can be unrealistic; providing **gradual rehabilitation is a more reasonable approach.** Although the physician must validate the existence of the patient's pain. education about the contributing effect of psychological factors is important. The use of antidepressants can be an effective pharmacologic approach; **both tricyclics and selective serotonin reuptake inhibitors (SSRIs) have been shown to be helpful.** These agents work by decreasing comorbid depression or by exerting an independent analgesic effect. **Analgesic medications are generally not helpful,** and the patient has usually tried this approach before seeking treatment. Narcotic analgesics should be avoided given their abuse and withdrawal potential. Biofeedback is helpful in certain pain disorders, specifically headaches and muscle tension. Hypnosis and nerve stimulation are also used. Psychodynamic psychotherapy focused on the impact of the disorder on the patient's life can be helpful. For treatment-resistant individuals, comprehensive pain clinics (either inpatient or outpatient) should be considered.

Comprehension Questions

[32.1] A 63-year-old woman returns to her family physician with continuing headaches for 9 months. She describes the pain as "constant. . . always with me," around her entire scalp. She does not appreciate much variation throughout the day. and she cannot name any aggravating or alleviating factors. Although she occasionally feels lightheaded when in severe pain, she denies photophobia, visual changes, nausea, or vomiting. She is especially upset about the headaches as she retired in the past year and has been unable to visit her infant granddaughter. Complete neurologic exams, computerized tomography, magnetic resonance imaging, laboratory studies, and lumbar punctures have been unremarkable. Which of the following is her most likely diagnosis?

A. Factitious disorder
B. Hypochondriasis
C. Malingering
D. Pain disorder
E. Somatization disorder

[32.2] Which of the following would be the most useful approach for the patient in question [32.1]?

A. Confrontation regarding the psychological nature of her pain
B. Reassurance that there is no evidence of pain
C. Referral to a mental health professional
D. Validation of her experience of pain

[32.3] The patient in questions [32.1] and [32.2] feels that her headaches are now "unbearable." Which of the following treatments would be the most appropriate?

A. Acetaminophen
B. Biofeedback
C. Lorazepam
D. Nonsteroidal anti-inflammatory
E. Oxycodone

Answers

[32.1] D. This patient presents with criteria for pain disorder. She has chronic, unremitting headaches that are the focus of her complaints. They have interfered with her ability to travel, and the onset seems to coincide with her retirement and new grandchild. Her condition is not intentionally produced as in factitious disorder or malingering, nor is there any appreciable secondary gain (avoidance of work, financial compensation, etc.). The concern is not on having a serious medical illness as in hypochondriasis or multiple physical complaints as in somatization.

[32.2] D. One of the most important aspects is to validate the patient's experience of pain. An empathic response will serve to strengthen the therapeutic alliance. Conversely, implying that the symptoms are "not real" or denying that "there is anything wrong" will only cause the patient further distress and can actually worsen the pain. Although referral to a mental health professional can be indicated and helpful given the psychological factors present in pain disorder, this subject should first be gently broached with the patient in order to avoid the appearance of not taking the pain seriously.

[32.3] B. Biofeedback and relaxation techniques have demonstrated efficacy in patients with pain disorder, particularly with headaches. Analgesics are often not helpful in these patients. Potentially addicting medications such as benzodiazepines and opiates should especially be avoided in these individuals given the chronic nature of this illness.

CLINICAL PEARLS

- Patients with pain disorder actually feel pain; it does not help to tell them that "it's all in your head."
- Pain disorder tends to be a chronic condition; patience, acceptance, and regular visits can promote amelioration of the intensity and frequency of complaints. The patient's therapeutic relationship with the clinician is very important in the management of this condition.

REFERENCES

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