EDITORIAL

Pain Management and the Role of Pain Clinics in Malaysia - Is There a Place for Alternative Medicine in Pain Clinics?

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Pain is the oldest and commonest complaint of a person who seeks medical help and care. Everyone has experienced pain sometime but it is often very subjective such that others might not be able to appreciate and understand the pain; objective assessment of pain is difficult, especially if it is long standing (chronic pain). Pain can have an organic, physical, pathological basis or a mental, emotional, functional basis. In the management or relief of pain one must consider influencing factors and attitudes such as the age, sex, social, cultural, ethnic, religious background; these factors can influence pain threshold. These factors are significant and pertinent to our multiracial, multi-religious society.

The Anaesthesiologist is intimately associated with pain control and relief stemming from his involvement, historically with pain control arising from the surgical knife.

Pain relief management is today viewed from 2 aspects:-

a. Acute pain (operative/trauma pain relief, post-operative analgesia and obstetric analgesia) - Acute Pain Service.

b. Chronic Intractable Pain (non-malignancy or malignancy related) - Pain Clinics.

Chronic pain management is a special entity because of the multifactorial aspects requiring a multidiscipline approach. The pain of a patient with a chronic long-standing complaint can be influenced by his work, environmental interaction (family and non-family, attitudes, pain threshold) beliefs, depression, anger, frustrations. Taking the various facets into account constitutes what is referred to as "Total Pain" management.

The management of chronic pain brings in many clinical disciplines; the Neurologist, Neurosurgeon, Anaesthesiologist, Psychiatrist/Psychologist, Trauma Surgeon, Rehabilitation Physician, Physiotherapist, Radiotherapist, Nurse - all have roles to play. The realisation that chronic pain requires a multidiscipline approach led to the concept of the Pain Clinic. The late John Bonica was the pioneer in the setting up of Pain Clinics (1946 Multidisciplinary Pain Clinic, Taucoma General Hospital, Taucoma, Washington, USA). The solo-blocker Anaesthesiologist grew into a multidisciplinary team.

The Pain Clinic is today accepted as a therapeutic rather than a diagnostic clinic and the modalities made available are basically pharmacological or non-pharmacological (including invasive procedures).

1. Pharmacological management
   - simple analgesics
   - non-steroidal anti-inflammatory drugs (NSAIDs)
   - opioids
   - antidepressives, tranquillizers
   - anticonvulsants
   - local analgesics, neurolytic agents

2. Non-pharmacological
   - surgical procedures
   - radiotherapy
   - acupuncture

- transcutaneous electrical nerve stimulation (TENS)
- hypnotism?
- alternative or complementary methods of pain relief

The ideal Chronic Pain Clinic should be run by a Panel of Consultants from the various multidisciplines. The patient should be interviewed by this Panel and the relevant modality of management planned. In many centres as in Malaysia it is not possible to have all the consultants present at the same time and one clinical discipline (e.g. Anaesthesiology) runs the clinic bringing in any of the other disciplines relevantly.

Is there a place for Pain Clinics in the developing countries? I would say yes, with certain provisos because of the different scenario compared to the so called "developed" countries.

Pain Clinics should be set up in the "Teaching Hospitals" (all major referrals hospitals involved in medical education, undergraduate and/or postgraduate). The value of setting up Pain Clinics in the major referral centres (University Teaching Hospitals are ideal sites) would be as follows:-

1. Improved, up-to-date multidisciplinary pain management.

2. Better understanding and rationalised management of pain.

3. Increased involvement in medical curricula (undergraduate/postgraduate) of pain as an entity.

4. Research.

5. Bringing in the contribution of alternative medicine as supplementary methods into Chronic Pain Relief Clinics - something the "underdeveloped" countries are years ahead of the "developed" countries.

One of the problems in chronic pain management is that everybody thinks he or she knows all about pain and most (medical and non-medical personnel) are convinced that they know how to manage chronic pain. "What is so fantastic about Pain Management?" Is a common statement by those who think they know all about pain!

The developing countries are steeped with many centuries of traditional or alternative therapies. The patient with chronic intractable pain (particularly non-malignancy origin) is someone who has been doctor-shopping, he is chasing after a "cure" and alternative medicine methods will appeal to him. Traditional methods can be brought into the chronic pain relief clinics where medical specialists can supervise and vet the alternative medicine contribution so that any deleterious effects are excluded, utilising the beneficial effects (see Table I for alternative or complementary methods of pain and symptom control).

Table I
Alternative or complementary methods of pain and symptom control

- Reflexology
- Acupuncture
- Shiatsu (Japanese finger pressure)
- Massage
- Aromatherapy (massaging concentrated oils or plant extracts into skin - DIY, camphor, cajputol, ginger, lavender, etc.)
- Homeopathy
- Spa therapy (hydrotherapy)
- The Alexander (Technique (good posture)
- "Homepathy" (Aloe vera!)

Chronic-Pain Clinics have a place in the "developing countries" of Asia.

In Malaysia the first Chronic Pain Relief Clinic was set up in the University Teaching Hospital, Kuala Lumpur by the Department of Anaesthesiology in February 1988. It took almost 20 years to convince everybody concerned that a Pain Clinic is necessary for the Management of Chronic Pain; it is run by the

Anaesthesiologist with a multidisciplinary referral panel contactable by phone for consultation input or for cross-referral. The Pain Specialist or Algologist is a faceless person with no accepted identity - some hospitals have disapproved of a clinical specialist putting up a name board advertising himself/herself as a Pain Specialist. Currently in Malaysia there must be some control otherwise you will see any and everyone claiming to be a Pain Specialist including the housewife, grandmother and mother-in-law (the male counterpart is not excluded) who "knows everything about Pain" and practices "Home-pathy"! This is not to say that there is no therapeutic value in some of these home-brewed concoctions - there is a need to investigate and check for unwanted side-effects in these traditional remedies. This is where the Pain Clinic can be of additional value.

Pain has to be identified as an entity in medical education (should be included in undergraduate and postgraduate medical and dental education curricula) and then will emerge the fact that it is a Multidisciplinary Team that should manage Pain as in a Chronic Pain Clinic. Accepting alternative (traditional) medicine as another modality for Chronic Pain Management might be considered by some as opening a Pandora's Box. Bringing alternative medicine into the Pain Clinic will ensure medical supervision - some good might emerge while the bad will be eliminated.