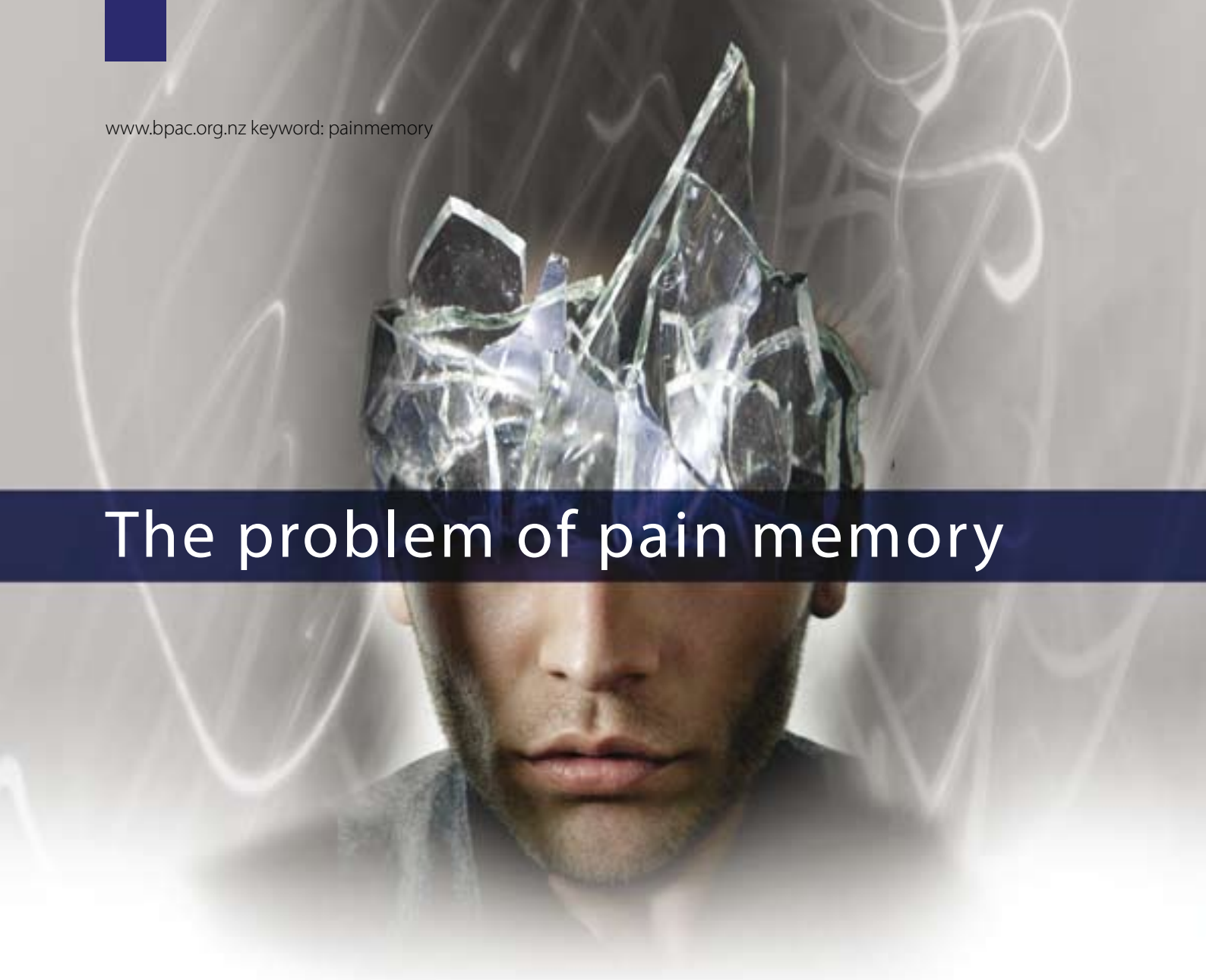

The problem of pain memory

Persistent central sensitisation pain

There is one group of patients with chronic pain that is particularly difficult to treat. Despite the best efforts of their doctor, and often the involvement of the chronic pain clinic, they continue to be disabled with pain. Often these patients do not have a discernible disease process, but seem to be suffering from the effects of what may be termed a pain memory.

Pain memory, or persistent central sensitisation pain, arises when the nervous system has become up regulated from previous trauma or severe pain. Despite the removal of the original damage, nerves continue to send pain signals. The situation may be compounded by the coping strategies adopted by the patient.

Central sensitisation pain may be a feature of several chronic pain syndromes such as fibromyalgia, tension-type headache, irritable bowel syndrome and post-traumatic pain.

Simple pain management often does not work. In this situation, it can be wiser to say “we can help you manage and cope with pain even if we can not make you complely pain free”.

Role of primary care in managing persistent central sensitisation pain

Primary care clinicians can make major contributions to improve outcomes for this type of pain. These contributions do not need to take a lot of time and can often be achieved by a simple change in management approach.

Contributions can include:

- Early recognition of the diagnosis
- Pharmacological pain management
- Management of negative mood
- Acknowledging your influence on patients' thought patterns
- Spending as much time discussing reintegration with normal life as discussing pain and disability
- Encouraging adherence to multidisciplinary pain management programmes which are offered through pain clinics or ACC

Characteristics of persistent central sensitisation pain

People experiencing persistent central sensitisation pain often exhibit some of the following features:

- Pain persists significantly longer than expected
- Pain spreads to other areas
- Pain varies for no reason
- Even small movements hurt
- History of harmful physical or emotional events
- Presence of psychosocial risk factors e.g. psychiatric illness, poor coping strategies

Management of negative mood

Depression is common in people with persistent pain. It should be treated like any other depression. This may involve a combination of cognitive and pharmacological interventions. Although TCAs may have some theoretical advantage due to their effect on both pain and mood, their adverse effect profile often means that they may not be tolerated at antidepressant levels.

Cognitive intervention

Clinicians in primary care can have a strong influence on negative thought patterns of people with persistent central sensitisation pain. Examples of harmful thought patterns include:

- Equating hurt with harm
  - It hurts therefore I must be causing damage
- Polarising
  - I am not perfect therefore I am a failure
- Over-generalisation
  - I can't do this therefore I cannot do that
- Catastrophising
  - This has gone wrong, it's a total disaster
- Emotional reasoning
  - This doesn't feel normal there must be something wrong

Recognition of these thought processes, allows clinicians to gently point out to the patient that persistent pain is distorting their thinking, and these thoughts are interfering with their return to normal activities.

Further reading

Linton SJ. Understanding pain for better clinical practice: a psychological perspective. Chapter 3 The biological-psychological Interface: pain perception. Elsevier. Edinburgh, 2005.

Gatchel R, Peng YB, Peters M, et al. The biopsychosocial approach to chronic pain: scientific advances and future directions. Psychol Bull 2007;133(4):581-624