Why things hurt? Shifting the paradigm on chronic pain

Shefali Kadambande

Dr Shefali Kadambande began a career in Medicine in 1987 in Mumbai, India. She was one of the first in Wales to be awarded the FFPMRCA by the Faculty of Pain Medicine and is currently practising as a Consultant at the Teaching University Hospital of Wales, Cardiff. She is also a member of the British Pain Society, Royal College of Anaesthetists and features on the specialist register of the GMC.

Dr Kadambande has a special interest in neuropathic pain, headaches, facial pain, post-surgical persistent pain, pelvic pain and complex regional pain syndrome amongst other chronic pain conditions. She has been the local pain medicine educational supervisor for the advanced pain management trainees for almost 10 years. Throughout her career she has focussed on service development and started Qutenza and External neuromodulation clinics in Cardiff which are innovative for Wales.

As Mahatma Gandhi once said "You must be the change you wish to see in the World". It defines my journey in pain management over the last two decades. Pain unlike some health conditions is not visible and often doesn't get the attention it deserves. It may come as a surprise to some readers that the definition of pain itself includes the emotional dimension. Pain medicine is a relatively young speciality and despite awareness campaigns by the British Pain Society it still has a long way to go for public recognition. Often, patients and their referrers are completely unaware of the remit of their local pain management services. The British Pain Society and Faculty of Pain Medicine have produced useful resources for patients and healthcare providers on medications such as Gabapentin, Pregabalin, Amitriptyline and other aspects such as 'Managing pain after your surgery', and 'Understanding and managing your long-term pain'.

Pain is one of the commonest reasons to visit the GP and affects 1 in 4 people. Between a third and one half of the UK population is affected by chronic pain and 10% - 14% have moderate to severely disabling pain and struggle to participate in daily activities. The prevalence increases with age: 30% in 18-39 year olds and 62% in the over 75s. The most common types of pain are back pain, headache and joint pain due to an ageing population and increasing arthritis. It is well known that chronic pain affects an individual's ability to function, their sleep pattern, mood and emotions thereby resulting in a much bigger impact upon society.

I hope that by reading the articles in this section, I can enthuse you to explore this topic further and encourage you to talk to your local pain management team earlier with your complex cases. Reviewing the anatomy and physiology of pain pathways is important to understand the principles of 'Why things hurt'. So, the next time you might think 'It is all in the head', I hope you will recall the thalamocortical affective influence. It may not be surprising for those of you who deal with chronic postsurgical pain (CPSP) that many factors contribute to its pathogenesis including the patient's emotional and psychological status, pre-existing painful conditions and central sensitisation, pre-operative opioid intake and the severity of their post-operative pain. Therefore a careful patient selection and being vigilant in recognising the risk factors is important to minimise the burden upon health resources later.

The classification of pain into nociceptive, neuropathic and nociplastic categories reflects the evolving understanding of the pathophysiology of pain. Complex regional pain syndrome (CRPS) remains the highest concern for most orthopaedic surgeons, and is an example of nociplastic pain. I hope the article on CRPS can give you some reassurance. A team effort is essential in managing all aspects of care including physical therapy, psychological support, patient education and pain modulation.

I envisage a future of collaborative patient centred care in the form of prehabilitation including opioid management prior to surgery, transitional pain clinics, and an emphasis on prevention rather than management of chronic pain. I am grateful to my colleagues for their contribution and expertise within the articles which will hopefully help the readers understand and manage their patients more effectively.

In conclusion, in the words of Henry Ford: "Coming together is a beginning, staying together is progress and working together is success". ■