

The physician must have sympathy and empathy. You have to be understanding and supportive. You cannot watch the clock.

—Subhash Jain, MD



Talking With Subhash Jain, MD, about Pelvic Pain

Pain Medicine with Compassion

BY DEBRA NELSON-HOGAN

SUBHASH JAIN, MD, is a clinician, researcher, and teacher in pain management. One of the pioneers in his field, he has lectured internationally and trained more than 100 pain management physicians throughout his career. For 22 years, Dr. Jain was an attending physician at Memorial Sloan-Kettering Cancer Center, where he was the founding chief of the Department of Anesthesiology's Pain Service and director of the hospital's respected fellowship program. He was also the chairman of Hackensack University Medical Center's Department of Pain and Palliative Care. Today he heads the Centers for Pain Management, which he established in New York and Dumont, New Jersey. While he treats all pain, his research expertise has been in pelvic pain, back pain, reflex-sympathetic dystrophy pain, and cancer pain.

Dr. Jain is the founder and medical advisory board president of the World Foundation for Pain Relief and Research and he is involved in efforts to improve access to quality healthcare in India through the International Human Benefit Services Trust. He remains a consultant in pain management at Memorial Sloan-Kettering.

Q. How did you become interested in studying pain?

DR. JAIN. I came to the United States after graduating from medical school in India. At that time, I wanted to be a cardiac surgeon, because my father had died of a heart attack.

When I was a surgical resident, a young man who was suffering incredible amounts of pain changed my direction. He had been in an accident and his leg was in a cast. He was suffering way too much pain. I pleaded with the attending surgeon to let us open the cast and see what was going on.

No two patients are identical, regardless of what insurance companies may think. A pain syndrome occurs in different bodies that live in different environments and have different physical and emotional issues. Pain is a combination of everything.



He refused, saying the patient just wanted drugs. The young man's high levels of pain didn't make sense to me, so I started doing some research. It looked like classic reflex sympathetic dystrophy syndrome.

The leading authority on pain management at that time was Dr. John Bonica. So I called him in Seattle, Washington, and described the patient. Remember, I was a resident and didn't have a lot of money, so it was quite an investment to call all the way across the country! Dr. Bonica agreed that it sounded like reflex sympathetic dystrophy (RSD). I asked to be present when the patient's cast was removed and sure enough, the leg was grossly discolored and had other classic symptoms of RSD. The attending surgeon turned pale as a ghost—he couldn't believe it. This patient should have been treated better.

Q. One area you specialize in is pelvic pain. Why did you become interested in this pain condition?

DR. JAIN. At Memorial Sloan-Kettering, I used to see a fair number of people, both male and female, who primarily had cancer-related pelvic pain. After surgery and radiation, they were essentially cancer-free, but they still had enormous amounts of pain. The drugs didn't suppress their pain, and their doctors didn't know what to do because they treated cancer, not pain. They would send these patients to me. I was knowledgeable about nerve pain, so I started blocking some of the nerves.

For both men and women, there are a lot of issues that impact pelvic pain—physiological, pathological, and psychological. You have to be patient and listen. Often, people with pelvic pain, both men and women, have been sexually abused.

And it made a difference. I didn't cure these people, but I comforted them.

Q. What is chronic pelvic pain and what are the causes?

DR. JAIN. Basically, it is any pain in the lower abdomen, groin, upper thighs, genital areas, or even lower back that lasts more than six months. The causes are wide and varied. For example, pain associated with the female reproductive organs can be caused by endometriosis, fibroids, cysts, sexually transmitted diseases, uterine or cervical cancer, oophoritis, and others. Non-gynecological pelvic pain can be caused by appendicitis, bladder disorders, interstitial cystitis, nerve conditions, or hernia.

Q. How common is pelvic pain?

DR. JAIN. An estimated one in seven women go to their gynecologist complaining of chronic pelvic pain, but because it is generally so poorly understood, there are no hard data on the incidence, particularly of non-gynecological pelvic pain.

Q. Do you treat both men and women for pelvic pain?

DR. JAIN. Yes, although it is more common in women and presents as endometriosis and vulvodynia. Men commonly present with chronic prostatitis, prostatodynia, and chronic orchalgia.

Q. What are the symptoms?

DR. JAIN. Again, the symptoms depend on the patient's condition, but they can include severe to mild pain, severe menstrual cramps, pain during intercourse, pain during urination or bowel movements, and rectal pain. Low backache can also signal pelvic pain.

Q. How do you assess and diagnose pelvic pain?

DR. JAIN. The assessment is very important and must be done thoroughly. I make the diagnosis based on a detailed patient history and a physical examination. This history includes asking about the duration of the pain; what factors make the pain worse or better; the quality of the pain; and, how it is distributed. I look at the reproductive, urologic, gastrointestinal, musculoskeletal, neurologic, and psychologic systems as possible sources of the pain.

For both men and women, there are a lot of issues that impact pelvic pain—physiological, pathological, and psychological. You have to be patient and listen. Often, people with pelvic pain, both men and women, have been sexually abused, so it may take them a long time to open up to their physicians.

Some diseases are so complicated that they require many types of specialists—gynecologists, urologists, etc. For example, look at the kinds of diseases that can cause pelvic pain in women. You have dysmenorrhea, endometriosis, adenomyosis, leiomyomata, uterine retroversion or prolapse, pelvic adhesions, and inflammation. The urinary system can cause interstitial cystitis, or nephrolithiasis, urinary tract infections, and so on.

The physical examination must also be done very thoroughly. Because the pelvis is the main support structure for the upper body, and it also connects to the lower body, I observe posture, gait, back, abdomen, thighs, and upper legs. I check out the musculoskeletal system for problems that could increase general pelvic floor muscle tension. I look for changes in skin sensation, numbness, or tenderness to determine any specific nerves that may be involved. Then, depending on the source of pain, I check the abdomen and pelvis for trigger points.

For women with gynecologic pain, an examination would include the vulva and the areas surrounding the vagina and the rectum. The area of the glands on the inside of the minor lips of the vulva is often a source of pain, and a physician might lightly touch different sections with a Q-tip to elicit a response. Areas of vaginal tenderness may relate to problems with specific muscles, nerves, or urinary tract structures, or to cervical and paracervical problems. A bimanual exam is used to delineate conditions involving the uterus, cervix, tubes and ovaries, and the abdominal wall.

A rectovaginal exam will show areas of nodularity and tenderness in the area below the uterus and uterosacral ligaments. I ask the patient to tense and relax pelvic and abdominal muscles during the exam to clarify findings, and to reveal certain disorders of pelvic support. Finally, the physician will examine the vagina with a speculum for possible lesions of the vagina or cervix, infection, or other visible abnormalities.

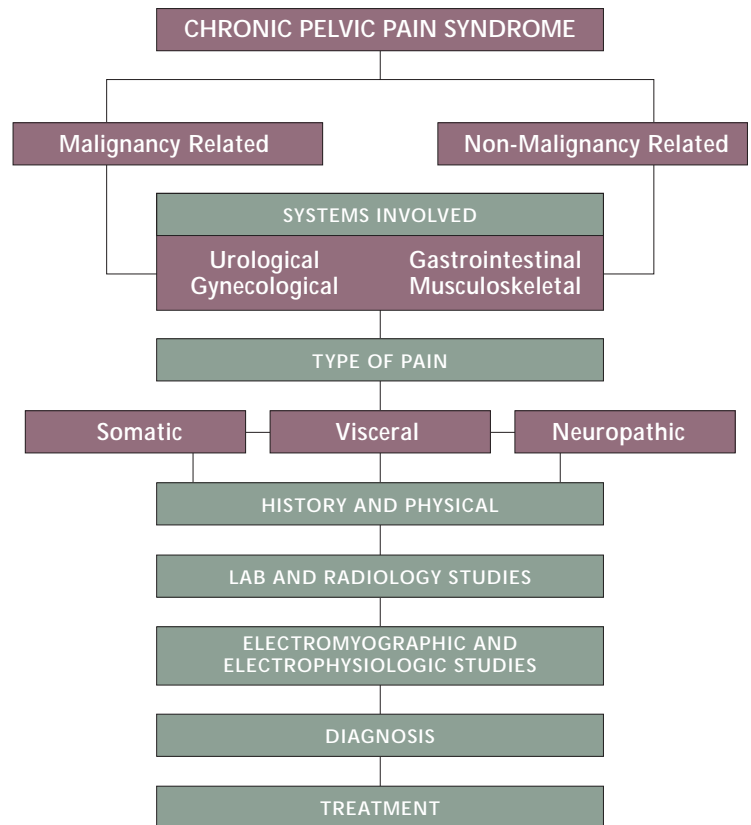


Table 1 · Sources of Chronic Pelvic Pain

REPRODUCTIVE SYSTEM	URINARY SYSTEM	MUSCULOSKELETAL SYSTEM	NEUROLOGIC DISORDERS
<ul style="list-style-type: none"> ▸ Mittelschmerz ▸ Primary dysmenorrhea ▸ Endometriosis ▸ Adenomyosis ▸ Leiomyomata ▸ Mullerian malformations ▸ Uterine retroversion ▸ Uterine prolapse ▸ Chronic pelvic inflammatory disease ▸ Adnexal tumors ▸ Pelvic congestion syndrome ▸ Cervical stenosis ▸ Pelvic adhesions 	<ul style="list-style-type: none"> ▸ Nephrolithiasis ▸ Urinary tract infection ▸ Interstitial cystitis ▸ Urethral syndrome ▸ Cystocele ▸ Pelvic kidney 	<ul style="list-style-type: none"> ▸ Obturator syndrome ▸ Disorders of the lumbo-sacral spine ▸ Disorders of the hip joint ▸ Piriform syndrome ▸ Rheumatic polymyalgia ▸ Pelvic floor tension myalgia 	<ul style="list-style-type: none"> ▸ Diabetic neuropathy ▸ Multiple sclerosis
	GASTROINTESTINAL SYSTEM		PSYCHIATRIC DISORDERS
	<ul style="list-style-type: none"> ▸ Constipation ▸ Irritable bowel syndrome ▸ Inflammatory bowel disease 	DIVERTICULOSIS	<ul style="list-style-type: none"> ▸ Affective disorders ▸ Munehausen syndrome
		<ul style="list-style-type: none"> ▸ Diverticulitis ▸ Neoplasms 	

http://www.medical-library.org/journals2a/chronic_pelvic_pain2.htm

Q. In addition to the physical examination, are there tests for pelvic pain?

DR. JAIN. Yes. They include X-rays, ultrasound, laparoscopy, colonoscopy, sigmoidoscopy, computed tomography (CT), magnetic resonance imaging (MRI), intravenous pyelography (IVP), and barium enemas. Lab tests check blood, urine, sexually transmitted diseases, hormone assays, and thyroid-stimulating hormones.

Q. What is your treatment approach to pelvic pain?

DR. JAIN. I consider pelvic pain a combination of somatic, visceral, and neuropathic pain and I usually work with the traditional pain medicine protocol. I start with pharmacotherapy in conjunction with psychological support before going on to physiological support for pelvic floor dysfunction, emotional support, and social support.

Q. Is the treatment standard for all kinds of pelvic pain?

DR. JAIN. Eventually all pelvic pain becomes centralized in the brain and the spinal cord. So, although local treatments such as topical lidocaine might have a temporary, soothing effect, we have to treat pain at various levels, including peripheral, spinal, and central levels by using appropriate analgesics and medications that have impact on the central nervous system.

“Today’s medicine has forgotten that doctors are healers. I believe this economic medicine has made things very difficult.”

Q. What drugs do you use?

DR. JAIN. I use combinations of antidepressants, antiseizure drugs, and non-narcotic analgesics. And, I still use some of the old-fashioned drugs. For example, tricyclic antidepressants (amitriptyline) are among the most effective medications available. I always start very low and slowly titrate up. Some of the antiseizure drugs that have been found to help neuropathic pain are gabapentin, topiramate, oxcarbazepine and carbamazepine.

I also use drugs that block NMDA receptors because of the role these receptors play in neuropathic pain. Drugs, such as ketamine, can reduce neuropathic pain. Opioids, including methadone, can also reduce neuropathic pain, as do sodium channel blockers, such as lidocaine-related oral drugs (tocainide, mexiletine, and intravenous lidocaine).

I have just started using serotonin and norepinephrine reuptake inhibitors (SSNRIs) and duloxetine (Cymbalta®) for neuropathic pain. It is indicated for people who have diabetic neuropathy that is small C-fiber-related-disease. It is the kind of neuropathic pain we think is involved in interstitial cystitis and other pelvic pain. Duloxetine also is indicated for depression, which affects many people who suffer chronic pain.

Q. Do you prescribe opioids?

DR. JAIN. Yes, of course. I use methadone to treat pelvic pain because we have learned that it also blocks the NMDA receptor. It is long acting and patients usually respond well. In addition, it is one of the least expensive pain drugs available.

Q. How do you handle patient fears of addiction?

DR. JAIN. I remind them that addicts may have all sorts of problems—emotional, psychological, whatever—but they don’t have dysfunctional pelvises. I say to them, ‘You, however, have

a well-documented pathological and physiologic problem in your pelvic area that needs pain relief. That separates you from the addict population. Also, I will be closely monitoring your opioid intake.'

Q. What non-pharmacological therapies do you use?

DR. JAIN. I use some of the anesthetic techniques to relax the bladder or other pelvic floor structures and also some of the interventional techniques—epidurals, pudendal nerve blocks, superior hypogastric blocks (to treat painful gynecologic disorders), and blocks of the ganglion of impar (a cluster of nerve cells in front of the sacrum/coccyx joint) to treat coccydynia.

Q. What kinds of alternative therapies do you use?

DR. JAIN. I refer patients to an acupuncturist if they want to try it. If a patient wants to try a therapy, I will support it unless I feel it will make things worse.

Q. In treating pain, would you say that the time constraint established by insurance companies is a problem?

DR. JAIN. People with pain, and particularly pelvic pain, have such complicated histories that a physician needs time to listen and unravel their stories. Unfortunately, most of my patients have experienced apathy from other physicians. The physician must have sympathy and empathy. You have to be understanding and supportive. You cannot watch the clock. Patients come to me full of steam—they need to share. The patients are my masters—patients teach me something every day. I learn from them. No two patients are identical, regardless of what insurance companies may think. A pain syndrome occurs in different bodies that live in different environments and have different physical and emotional issues. Pain is a combination of everything.

Q. Does your Indian culture and background affect you as a healer?

DR. JAIN. Yes, significantly. My Indian background makes me compassionate. My parents were wonderful and taught me to value the elderly. My religious background made helping a natural inclination, because I have to do "right karma" in my life. I must do right. I come from a philosophy where we do not kill anything, not even mosquitos. We respect the environment, animals, and all humans. This philosophy helps me as a healer. Also, when I finished medical school, my father told me, 'Remember, you didn't become a doctor to earn money. You are a healer' I may not be a wealthy man, but I am very rich. The blessings I get from my patients are my reward.

I am a very patient man—you have to be in treating pain. That is one reason why I am in private practice again. I can't practice good medicine in the 'rat race.' Today's medicine has forgotten that doctors are healers. I believe this economic medicine has made things very difficult. Physicians today are beaten

from every angle: from the public, insurance companies, and regulators. Physicians are losing their identity as healers. The insurance companies give you ten minutes to see a patient—they are promoting garbage medicine. By the time patients open their mouths, their time is up. I am very close to my patients. I give them my personal phone number so they can always find me. I believe in being accessible to my patients.

Q. What is the World Foundation for Pain Relief and Research?

DR. JAIN. It is a foundation that my family and I started several years ago to help train physicians from Third World countries. My older sister was also a physician and she died of cancer. We wanted to establish something that would honor her work. For many physicians in the developing world, the dues and fees of the larger pain organizations are prohibitively expensive. So we established this organization to focus on clinicians and their educational needs. We have held meetings in the Philippines, in Bangladesh, and we will be doing one in September, 2007, in Jaipur, India. We devote one day to cancer pain, another to nonmalignant pain, and a third day to controversies surrounding pain management. It has been an excellent way to 'give back.'

Q. You were on the "ground floor" of pain medicine. How are we doing today?

DR. JAIN. In pain management we have chosen a difficult and dangerous path. The reason is simple: the original concept—to make pain management comprehensive—is not there. It has become specialty-oriented. For example, if a patient goes to a psychologist for treatment, the psychologist only looks at the patient from that point of view. If a person goes to an anesthesiologist, that physician does procedure after procedure. Go to a neurologist and you get drugs. Treatment has become so financially oriented for all parties. This is one of the barriers we have now for good pain management. There are physicians for whom I think financial incentives dictate treatments. This is pathetic. However, this is a two-edged sword, because with today's economic model of medicine, physicians can't make a decent living. That's why a lot of pain centers are closing and university-based centers can't make it financially.

Q. So what would you tell a new pain physician?

DR. JAIN. If you really want to be a pain doctor, if you have sympathy and compassion and if you are ready to eat pizza all your life, come on in. You're not going to be a rich man, but if you want to heal and want to make a difference, it is an excellent field. In fact, in my next life, I would like to come back as a doctor.