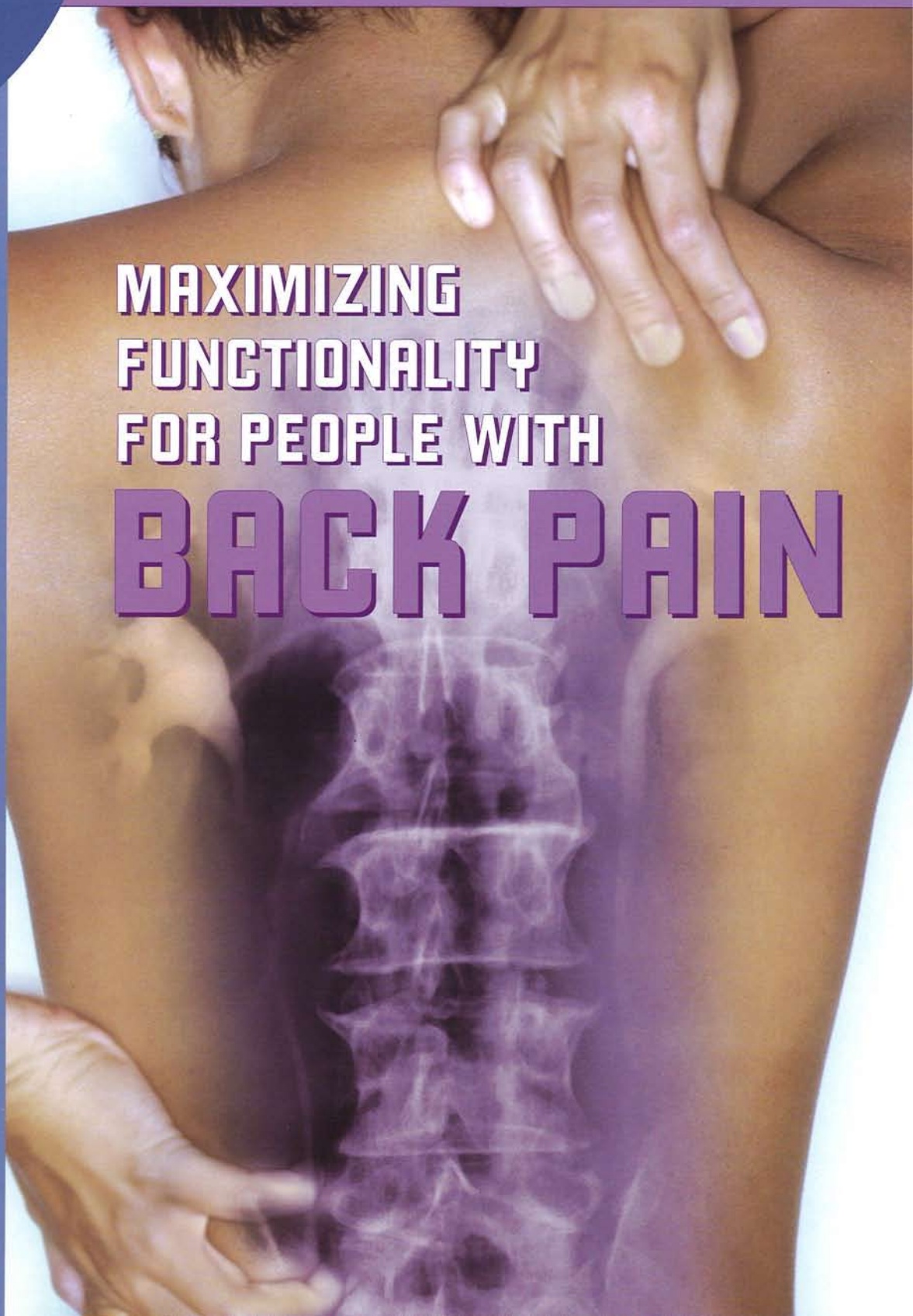
ISSUE 4

pain matters™

Partners Against Pain® Magazine



MAXIMIZING FUNCTIONALITY FOR PEOPLE WITH BACK PAIN

Dr. Winifred Bragg Shares Her Insight On Back Pain Management

State Medical Boards: Encourage Pain Management, Prevent Diversion

One Click Away... Web Sites to Enhance Your Knowledge

Inside: Barriers To Pain Relief

SPOTLIGHT

In this issue we focus attention on back pain, one of the most frequently cited causes of pain. In fact, back pain afflicts an estimated 80% of adults in industrialized countries at some point in their lives. While the type of treatment program recommended will depend on factors unique to each individual, a multidisciplinary approach involving non-pharmacologic as well as pharmacologic treatments, is generally recommended for optimal pain management. Dr. Winifred Diane Bragg, an expert in managing back pain, shares her thoughts and experience concerning how to manage the pain associated with this potentially debilitating condition.

Winifred D. Bragg, M.D.

Winifred D. Bragg, M.D. is a specialist in physical medicine and rehabilitation at Orthopaedic Associates of Virginia, Ltd., where she focuses on non-operative treatment of spine disorders, and industrial and general musculoskeletal medicine. Dr. Bragg graduated from Meharry Medical College in Nashville, Tennessee, in 1991, and completed an internship at The Baptist Medical Centers in Birmingham, Alabama, in 1992. In 1995, Dr. Bragg completed her residency training in the Department of Physical Medicine and Rehabilitation at the University of Michigan in Ann Arbor, Michigan. She is board certified by the American Board of Physical Medicine and Rehabilitation, and is licensed by the states of North Carolina and Virginia. She lectures frequently, and has presented talks at numerous national medical meetings.

Dr. Bragg has published articles in several journals including Southern Medical Journal, Contemporary Surgery, American Family Physician, and the Archives of Physical Medicine and Rehabilitation.

Please provide a profile of your typical back pain patient.
I see a varied population of patients, ranging from 25- to 75-years old; approximately 60 percent of these patients are female.

What are the most common causes of back pain you see in your office?
Most of the patients I see each week have low back pain resulting from sports or work-related injuries, or from motor vehicle accidents. Primarily, their pain is caused by soft tissue injuries, commonly referred to as lumbar strains/sprains; herniated disks, resulting in lumbar radiculopathies; or degenerative diseases of the spine, specifically lumbar stenosis, which is primarily seen in patients 60 years of age and older.

Since back pain is often thought of as "something you live with," what motivates your back pain patients to finally seek treatment for their pain?
As pain and function are intimately related, many of my patients finally seek "medical care" when they are no longer able to perform their daily activities.

What is your definition of appropriate pain management?
My primary goal in treating people with pain is to have a positive impact on improving their quality of life. While my goal is to totally alleviate a person's pain, this is not always realistic. Therefore, I strive to provide adequate pain relief, which will allow the patient to participate in his or her activities of daily living.

What type of treatment programs do you feel are most effective in managing back pain and at what point do you recommend surgery?
I believe that the vast majority of patients with back pain respond to conservative management, consisting of a program involving non-pharmacologic and pharmacologic treatments. Physical therapy can be very effective in treating patients with back pain. However, it is important that physicians understand that a specific physical therapy/rehabilitation program should be designed to fit the patient's diagnosis.

For patients with mild to moderate back pain, I often utilize non-opioid analgesics, including medications such as acetaminophen, nonsteroidal anti-inflammatory drugs, and tramadol. If a patient experiences moderate to severe back pain, opioid analgesics can be used. Additionally, I also use adjuvant medications, such as antidepressants and anticonvulsants, to treat patients with back pain.

I recommend surgery when patients with back pain have bowel or bladder incontinence, infection, tumor or progressive neurologic loss. Additionally, when a patient has well-documented structural spinal disease, and continues to have incapacitating pain despite appropriate conservative treatment, I will recommend surgery.

SPOTLIGHT

Are there any tips you would like to offer a practicing physician, who does not specialize in musculoskeletal medicine, to successfully manage their patient's back pain?

I suggest that physicians utilize the ABCs of pain management when treating people with back pain.

A = Ask the patient about their pain frequently, and understand that assessment is the key to diagnosing a patient's back pain. I recommend that a routine x-ray of the spine be obtained on initial evaluation for any patient greater than 50 years of age.

B = Believe the patient's report. In order to successfully treat a patient with pain, I stress to physicians that it is important that during the time of their evaluation that they believe the patient's report. This helps to ensure that an objective evaluation can be done, and appropriate treatment plan devised. If A and B are done appropriately, then one can:

C = Choose the appropriate non-pharmacologic therapies and medications to manage back pain. If the patient has not responded to conservative management after six weeks, a referral to a specialist such as a physiatrist or orthopedic surgeon is recommended.

How do you gauge if a patient is being adequately treated for their pain?

Upon their initial visit, patients are given a pain questionnaire, which includes a visual analog scale. This questionnaire is essential in initially assessing the patient's pain, and the information is used as a baseline for future visits. At each follow-up visit patients are asked to again quantify their pain, and to identify those activities that aggravate their pain and those that relieve their pain.

If a patient reports that he/she has had a significant reduction in pain as noted on the visual analog scale, this suggests that the pain is being adequately treated. More importantly, if the patient has become more involved in functional activities, such as returning to work or engaging in social interactions, this indicates that he/she is getting appropriate pain management.

Is there anything a patient can do to prevent back pain?

By practicing good biomechanics, many patients can prevent back pain. I stress to my patients every day that they need to incorporate these simple tips to prevent back pain:

a. When lifting an object, bend at the knees, straighten your back and tighten your abdominal muscles;
b. When lifting objects, bring them close to the chest and do not lift any object with outstretched arms;
c. Perform back stretches and strengthening exercises daily, recognizing that strong abdominal muscles are the key to preventing back pain;
d. Maintain your ideal body weight.