THE RIGHT (AND WRONG) WAY TO TREAT PAIN

BY CLAUDIA WALLIS

PLUS: What's behind the new FDA advice on Vioxx and Celebrex
THE RIGHT (AND WRONG) WAY TO TREAT PAIN

HINT: IT TAKES MORE THAN A PRESCRIPTION PAD TO REALLY BRING RELIEF By Claudia Wallis

CHRONIC PAIN IS A THIEF. IT BREAKS INTO your body and robs you blind. With lightning fingers, it can take away your livelihood, your marriage, your friends, your favorite pastimes and big chunks of your personality. Left unapprehended, it will steal your days and your nights until the world has collapsed into a cramped cell of suffering.

Penny Rickhoff’s world began to shrink suddenly in 1990, after a very tall and very heavy file cabinet toppled over onto her back. The freak accident damaged her spinal cord, leaving her with a constant, gnawing pressure in her lower back. “If I sit for very long, I’m in excruciating pain,” she says. Once an avid tennis player, world traveler and amateur pilot, Rickhoff, who is in her

Illustration for TIME by Anita Kunz
50s, was not only grounded, but she also became almost a prisoner in her home, unable to drive more than a short distance, unable to go anywhere without toting special "tush cushion" pillows.

After seeing a dozen doctors, Rickhoff finally realized she wasn't going to be cured and started looking for ways to live with the pain. She took up T'ai Chi and learned how to breathe deeply using her abdominal muscles. These pain-management skills enabled her to lower her dosage of morphine. But Rickhoff is the first to admit she can't make it through the day without her meds, and her powerhouse weapon was Vioxx. It helped destroy any pain, any time. Last September, when she learned that Vioxx was being pulled from the market by its manufacturer because of side effects, Rickhoff began to fret. "I knew from past experience that when I'd run out of a prescription, I would start to ache all over. I was so very distressed." She got a letter from her pharmacist urging her to return her supply of the drug, but she felt tempted—"very, very tempted"—to hang on to her hoard. "I'd taken it for five years with no problems at all," she says. In the end she figured it wasn't worth the risk. "So I returned it to the pharmacy and started suffering."

She has plenty of company in her misery. Approximately 1 in 6 Americans suffers from chronic or recurrent pain. For many, especially the millions who suffer from inflammatory diseases like arthritis or from chronic back pain, the withdrawal of Vioxx from the market last September and the serious questions raised about the safety of the entire class of COX-2 inhibitor drugs—at last week's Food and Drug Administration (FDA) hearings and in the latest issue of the New England Journal of Medicine—represent yet another setback in the long, frustrating search for relief. "I just loved Vioxx. It was magic," laments rheumatoid arthritis sufferer Lisa Dobbs, 50, of Bethesda, Md. "When they took it off the market, I was just destroyed."

After three days of contentious discussion, an FDA advisory panel last week recommended that the COX-2 drugs Bextra and Celebrex remain on the market but with certain restrictions. Most panel members favored "black box" warnings on the packages indicating that the drugs raise the risk of heart attack and stroke and are therefore inappropriate for many patients. If the FDA adopts this strategy, it would mean the end of ads like the once ubiquitous "Celebrate!" spots for Celebrex, as black-box drugs may not be advertised directly to consumers. But there was tantalizing news for Rickhoff, Dobbs and other Vioxx devotees. By a narrow vote, the panel okayed the idea of bringing the discontinued drug back to market, and Merck, its manufacturer, said this was under consideration.

Is that good news? Rickhoff isn't so sure. "I definitely feel at the mercy of the pharmaceutical companies and the FDA," she says. "It's terrible that they've scared people so much. All drugs have side effects, and..."
some probably have much worse risks than Vioxx.” Studies suggest that roughly half of Americans with chronic or recurrent pain simply do not find a good solution, and the news out of the hearings is not going to make their choices any easier. In fact, chronic pain is a leading cause of lost workdays. It costs the nation an estimated $100 billion in lost productivity and increased health care, not to mention immeasurable suffering.

Doctors who specialize in managing pain say this need not be so. Perhaps the biggest reason so many patients suffer more than they should is the tendency among doctors and patients alike to see pain as a mere sideshow—a vexing side effect of arthritis, a herniated disc, cancer or trauma—rather than what it is: a serious and consequential health issue in its own right. A long-suffering Michigan physician and mother of three, who asks that her name not be used, knows this both as a doctor and as a patient whose life has been compromised by severe neck pain stemming from a 1999 car accident. “I know all too well how most doctors really feel about people with chronic pain who don’t get better: disdainful and contemptuous,” she says. “There is a real sense of the patient as a failure and a weak person who can’t pull him- or herself together and cope.”

The second big reason for the widespread failure to find adequate pain relief is that most of us seek it entirely in a pill bottle—or two or three. The quest for pharmaceutical salvation is misguided to begin with, say doctors at the nation’s most sophisticated pain-management centers. The

BILL HIGHLAND

AGE 83

CAUSE OF PAIN An attack of shingles two years ago left him with terrible pain around his chest, right arm and shoulder blade. The discomfort is constant and can turn searingly intense from time to time.

WHAT HE DOES FOR IT A series of drugs provided only partial relief. Finally, counselors at the pain-management center at U.C. Davis taught him about breathing, guided imagery and distraction techniques. He now uses breathing exercises to quickly bring even bad episodes under control.

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lesson they have to teach us all is that chronic pain must be attacked on many fronts. Drugs are important, but they are just one weapon in the arsenal.

"Studies have shown that patients who use a multidisciplinary program do better than patients who take medications only," says Dr. Pamela Palmer, medical director of the pain-management center at the University of California, San Francisco (UCSF). "The anxiety, the depression, the hopelessness that come with chronic pain really all have to be addressed"—as do the loss of mobility, hypersensitivity to touch and other effects that can destroy the quality of life. "It's not as if you can just take an anti-inflammatory drug and all those problems go away." To pain specialists like Palmer, the hand wringing and finger pointing over the Cox-2 inhibitors are the result of expecting too much from these drugs and using them with unwise abandon. "No one's expecting a chemotherapeutic agent or a liver drug to be perfect for everyone, but because pain is so prevalent, we're all in search of that magic drug that works for everyone all the time. It's such an unrealistic burden to place on a drug."

WHAT CAUSES CHRONIC PAIN?
Before you can give pain the treatment it deserves, you have to understand what it is and why we have it. Nasty though it is, pain plays a valuable role in our overall health. Doctors liken it to an alarm system for the body. When skin, cartilage, muscle or other tissue is injured, peripheral nerves in the area send a shrieking signal to the spinal cord and brain. The immediate result, usually processed in the spinal cord: you pull your hand away from the stove, you shift your weight off the broken bone, you sit down. All pain signals ultimately land in the brain, where they trigger thought ("That was dumb!") emotions (tears, sobs), memories and a complex array of biochemical events aimed at protecting your body from further harm.

With chronic pain, however, the alarm continues to shriek uselessly long after the physical danger has passed. Somewhere along the line—maybe near the initial injury, maybe in the spinal cord or brain—the alarm system has broken down. What researchers have only recently come to understand is that prolonged exposure to this screaming siren actually does its own damage. "Pain causes a fundamental rewiring of the nervous system," says Dr. Sean Mackey, director of research at Stanford University's Pain Management Center. "Each time we..."
Muscle or Joint Injury

**LIFESTYLE CHANGES**
Doctors have an acronym—**RICE**—for rest, ice, compression and elevation. Do this for one or two days. Apply continuous low-level heat afterward. Resume gentle activity as soon as you can.

**MEDICAL THERAPY**
Try an over-the-counter analgesic, such as Tylenol, Advil or Aleve. Patients with severe pain may need an **opioid**, such as codeine.

**PHYSICAL THERAPY**
Sprains and strains usually heal on their own. **Conditioning exercises** can strengthen injured muscles or joints.

**MINDFULNESS THERAPY**
If you’re having chronic pain, get adequate rest. If you have trouble sleeping, practice **good sleep hygiene**: avoid caffeine, tobacco and alcohol, don’t exercise or watch TV right before bed and try relaxation techniques.

Back Pain

**LIFESTYLE CHANGES**
Use a cold pack for the first day or so, then switch to continuous heat. Get back on your feet as soon as possible. Bed rest won’t help, so resume normal activity, then moderate exercise.

**MEDICAL THERAPY**
Nonprescription pain relievers may be enough. For severe episodes of pain, you may need a long-acting **opioid** such as OxyContin or morphine. Disk pain or spinal problems could require epidural **cortisone injections** or, as a last resort, **surgery**.

**PHYSICAL THERAPY**
Strengthen stomach and back muscles. **Chiropractic**, massage or **Pilates** may help.

**MINDFULNESS THERAPY**
Relaxation techniques can lessen discomfort. They can also help reduce stress, which may be contributing to your pain.

Neuropathy

**LIFESTYLE CHANGES**
Neuropathy is pain from nerve damage, often caused by diseases such as AIDS, diabetes, cancer or shingles. Start by treating the underlying cause.

**MEDICAL THERAPY**
Doctors recommend **anticonvulsant drugs** like Neurontin, **tricyclic antidepressants** such as Elavil, the antidepressant **duloxetine** (Cymbalta), **lidocaine patches** to numb pain or **opioids**.

**MINDFULNESS THERAPY**
Relaxation is key. **Psychotherapy** can also help manage pain and depression.

**ALTERNATIVE THERAPY**
Supplements containing **primrose oil**, **B vitamins** or **E vitamins** may help.

Fibromyalgia

**LIFESTYLE CHANGES**
To help ease the overall pain and tenderness caused by fibromyalgia, a musculoskeletal disorder, you must get enough **restful sleep**, stay active and keep your weight down.

**MEDICAL THERAPY**
**Tricyclic and SSRI** (Prozac-type) antidepressants can help.

**PHYSICAL THERAPY**
Begin weight-bearing and aerobic activities as well as **flexibility exercises** such as yoga.

**ALTERNATIVE THERAPY**
Some doctors recommend the Feldenkrais Method, which teaches you how to move and posture your body more efficiently.

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Sources: Consumer Reports; Dr. Seymour Diamond, National Headache Foundation; Dr. Scott Fishman, American Academy of Pain Medicine; Dr. Julie Wippel, Arthritis Foundation; Dr. Bill McCarron, Kaiser Permanente; National Pain Foundation
feel pain, there are changes that occur that tend to amplify our experience of pain.” That is why it is a mistake, despite our grin-and-bear-it tradition, to ignore or undertreat severe pain.

GETTING THE TREATMENT RIGHT
AT TOP PAIN-MANAGEMENT CLINICS SUCH AS those at Stanford and UCSF or the Wasser Pain Management Center in Toronto, doctors dive in with a broad array of therapies, devising a program that is tailored to the individual patient. The four main elements of such programs are drugs; injection therapies (nerve blocks like epidurals); physical therapy and exercise; and behavioral techniques that include relaxation training, biofeedback and psychotherapy.

“If you ask most physicians how they would treat a patient, they would say, ‘I use this drug’ or ‘I use that drug.’ But there are many ways of treating chronic conditions that don’t involve drugs,” says Dr. Allan Gordon, director of the Wasser Center. “You have to look at the whole individual. A multidisciplinary approach is the only answer.” A patient who learns to reduce pain with breathing exercises or biofeedback, Gordon notes, can often manage his misery with lower or only intermittent doses of drugs, reducing the risks of side effects that come with every pain-killer.

That’s been true for Bill Highland, a retired electrician from Yuba City, Calif., who for the past two years has been battling searing pain in his shoulder blade and armpit from shingles. Highland tried a variety of drugs, but they brought only temporary relief. Finally he was referred to pain psychologist Ingela Symreng at the Pain Management Center at the University of California, Davis, to learn techniques that would help him control his pain. Symreng teaches patients relaxation exercises, breathing skills, guided imagery (focusing on pleasant mental images) and distraction techniques. Highland, 83, quickly became a master of deep abdominal breathing. “It’s pretty amazing, because

HOW COX-2 INHIBITORS WORK
PAIN RELIEF: 1. COX-2 is an enzyme that is activated at sites of injury. It manufactures hormone-like substances called prostaglandins, which trigger painful inflammation. COX-2 inhibitors are designed to block the activity of the COX-2 enzyme and relieve pain.

HEART RISK: 3. Prostacyclin, a prostaglandin produced by COX-2 in blood-vessel walls, opens blood vessels and prevents platelets from clumping.

4. Researchers believe that when COX-2 is blocked, prostacyclin may also be suppressed, allowing platelets to stick together and blood vessels to constrict, which can lead to heart attacks and strokes.

PAIN DRUGS
Was Vioxx Really That Dangerous?

The first sign of trouble came last fall when a large trial involving the popular pain-killer Vioxx was halted two months early because some patients had developed serious heart problems. The results were so disturbing that Merck, which manufactures Vioxx, pulled its billion-dollar blockbuster off the market.

That left two drugs in the same family, Pfizer’s Celebrex and Bextra, on pharmacy shelves, along with lingering questions about whether they too could cause heart attacks and strokes.

Those concerns were answered last week by a series of studies that showed an increased risk of heart problems in users of not just Vioxx but Celebrex and Bextra as well, and by FDA advisory panels that recommended stronger warnings for the whole class of pain relievers known as COX-2 inhibitors. “The cardiovascular problems appear to be a class effect,” says Dr. Eric Topol, director of cardiovascular medicine at the Cleveland Clinic. “But the magnitude of risk does seem to differ from drug to drug.” It’s now up to the FDA to decide whether the dangers, which in some drugs start to appear only at high doses, warrant its strongest, black-box warning, which would halt direct-to-consumer advertising and restrict use of the drugs to patients with the greatest medical need.

The findings—which confirmed what many scientists have long suspected but that drug companies desperately tried to deny—make sense, given the way that the drugs work. COX-2 inhibitors were designed to bypass the side effects of aspirin and other nonsteroidal anti-inflammatory agents, which can rip through the stomach lining. In the 1990s, researchers discovered that COX appears in the body in two different forms. COX-2 inhibitors, as their name implies, were designed to block just the inflammatory functions of the COX-2 enzyme, leaving the stomach-protecting functions of the COX-1 form intact.

Or so scientists thought. Animal studies suggest that COX-2 also promotes chemical reactions that churn out prostacyclin, a protein that keeps blood vessels dilated and keeps platelets from clumping together to form blood clots. Doctors believe a drop in prostacyclin may also be behind the increased incidence of heart attacks and strokes in COX-2 users. In separate studies published in the New England Journal of Medicine last week, researchers found that high-dose Celebrex users were three times as likely as nonusers to die from a heart or stroke event, while those taking Vioxx had twice the chance of suffering a heart attack or stroke. It’s too early to say whether these studies mean one drug is more dangerous than another.

The FDA will be looking closely for similar risks when the next three COX-2 inhibitors in the pipeline—Merck’s Arcoxia, Pfizer’s Dynastat and Novartis’ Prexige—come up for review in a few years. This time they hope to discover potential problems before the drugs are approved, not after.—By Alice Park
older folks tend to not be as open to this type of therapy," says Symrenz. Highland put his new skills to the test when he was struck by a horrific shooting pain while driving on a Sacramento freeway. "As soon as I felt it," he recalls, "I just breathed through my nose and let it go out my open mouth without moving my chest—two or three times. I felt relief almost instantaneously."

Pain psychologists like Symrenz play a vital role at most pain-management centers, though patients are often reluctant to consult them. "Patients hate to hear you offer them mind therapy, because they feel what you're doing is telling them they have a mental illness and you don't really believe they have a physical problem," says Dr. Scott Fishman, an anesthesiologist, internist and psychiatrist who is chief of pain medicine at U.C. Davis. But the mind is always actively involved in pain, especially in chronic cases. "We know that when you imagine the brain, the areas that light up when you experience pain include parts of the brain involved in emotions," says Fishman. That is why learning to relieve fear, anxiety and depression related to pain actually helps bring relief, probably by activating the body's own pain-killing chemicals.

This is true even for patients in extreme agony. After knee-replacement surgery, Donna Jaeger, 56, of Auburn, Calif., developed a neurological condition that caused excruciating pain that she rated a "17 on a 1-to-10 scale." Pain-management experts at U.C. Davis prescribed a multifaceted treatment that included powerful opioid drugs and a spinal implant—all of which helped. But Jaeger regards psychologist Symrenz as "my saving angel." Breathing techniques and soothing relaxation tapes help Jaeger reduce her pain level from 17 to 4 or 5 on a good day. "But really," she says, "it is just the talking to her that helps, because the more you hurt the more anxious you get, and the more anxious you get the more you hurt."

Imaging techniques, which build on biofeedback principles, are another psychological option used at pain centers. At Stanford, Mackey has taught patients to literally watch "their brain on pain," using functional magnetic resonance imaging. By relaxing, they can watch lighted

**PAIN IN KIDS**

*When It's A Child Who Is Hurting*

Doctors have long believed that children experience pain differently than adults. Unfortunately, most doctors thought kids felt pain less than grownups do, and didn't retain any memory of it. As late as the 1970s, infants underwent major surgery without anesthetics while older kids were often denied powerful pain-killers, on the theory that narcotics were too addictive and dangerous to be administered to children. This barbaric notion was finally put to rest in the 1980s, as research proved that kids, with their still developing nervous systems, actually experience pain more intensely than adults do. But only recently have doctors begun to get serious about the problem of chronic pain in kids—even though millions of children suffer from juvenile arthritis, cancer, fibromyalgia and other extremely painful disorders. Moreover, as many as 20% of kids who undergo surgery each year develop chronic pain that lasts long after the body has healed. According to Dr. Lonnie Zeltzer, founder and director of the Pediatric Pain Program at UCLA's Mattel Children's Hospital, an operation can jump-start a child's immature nervous system, stimulating pain-sensing neurons that will keep firing indefinitely.

The UCLA program uses an innovative mind-body approach that has typically not been used before to treat chronic pediatric pain. Team members begin by taking a detailed pain history and asking kids—even as young as 4 or 5—where it hurts and exactly how bad it feels. Says Zeltzer: "You have to be a detective and put all the pieces together." The resulting treatment plan may include pain-killers, but these often have side effects—and because they're usually only tested in adults, they sometimes act unpredictably in kids. Whenever possible,

TURNAROUND: Three months ago, Dunitz was confined to a wheelchair.

Kate Dunitz, 16, was plagued by chronic pain following surgery in 2004, and was prescribed a mix of healing lyengar yoga, craniosacral massage, art therapy and hypnotherapy. The clinic also uses acupuncture, meditation and relaxation exercises. "I thought they were hocus-pocus," says Dunitz, "but I did a complete turnaround." She will return to high school full time next fall as a senior.

According to Zeltzer, some 80% of kids under 17 treated in her pain clinic also suffer from anxiety and depression, and the clinic addresses those feelings as well (so do the handful of other programs around the country that focus on pediatric pain). "It's really sad that children were so undertreated in the past," says Dr. Catherine Skae, director of Pain Service at the Children's Hospital at Montefiore in New York. "I think we've come a long way, but we still have a long way to go." —By Michael D. Lermanick. Reported by David Bjerklie/New York and Jeanne McDowell/Los Angeles

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areas change color as pain fades. "It's tremendously empowering," he says, "all without medication."

Psychologists often play a critical role in persuading pain-hobbled patients to get moving again despite the blaring siren that tells them to keep still. "By educating them, by saying 'You've healed as much as you're going to heal,'" says Symr, "we can deal with the No. 1 issue from a psychological perspective: the fear of reinjuring something."

Getting the patient to move—or, better yet, exercise—not only restores function and raises spirits, it also prevents the cascade of health problems that stem from paralyzing pain. "If you're lying in bed all day," explains UCSF's Palmer, "you're going to have more problems from a cardiac standpoint, a pulmonary standpoint and a mental-health standpoint."

THE ROLE OF MEDS

EVEN WITH THE BEST ALTERNATIVE TECHNIQUES, most patients with chronic pain will need some medication. Many general practitioners tend to use common analgesics as a one-size-fits-all remedy—a practice that contributed to the COX-2 fiasco—but pain experts try to carefully match the drug to the type of pain, the patient's risk profile and even his or her personality. "A patient's psychological preference for treating pain can be more important than the amount of medication," Palmer says. She cites the case of an elderly woman with arthritis in her back who preferred taking the oral narcotic Vicodin to using a more potent opioid drug delivered through a patch. "The Vicodin wasn't nearly as powerful as the opioid patch," says Palmer, "yet it gave her more pain relief. That tells you this is a patient who wants control. In some patients the psychological impact of being able to open a pill bottle, pull out a pill and take it gives them some sense of control in their life. If you have a pump sending medication into your spine, or a patch on your skin, you in fact may feel out of control."

Although high-profile cases of addiction to OxyContin and other opioid pain-killers have scared off many doctors and patients, such drugs have an important role to play in chronic pain. They are particularly useful, says Palmer, for elderly patients, many of whom can't tolerate the side effects of anti-inflammatories. Younger people develop tolerances to opiates more quickly than the elderly, says Palmer, which means the young wind up needing ever higher doses. That is not a big problem in older patients. "I like to use low-dose opioids in the elderly because there aren't any liver effects, there aren't any cardiac effects, and the biggest problem you have is some constipation," which you can treat. On the other hand, Palmer believes that the COX-2 drugs are much safer in the

why aren't more doctors following their lead? The sad fact is that virtually every trend in medicine—from the training doctors get to the treat-em-fast pressures of managed care to the way insurance companies cover or fail to cover alternative therapies—works against this. "We don't teach medical students enough about pain, even though it's the most common reason people go to doctors," complains Fishman of U.C. Davis. "We've really wandered from a basic philosophy in medicine, where you cure what you can but always treat suffering, to being focused only on curing."

Fishman, who is the incoming president of the American Academy of Pain Management, laments the way insurance plans favor quick pharmaceutical fixes over the kinds of physical and psychological therapies that chronic-pain patients need. The bias toward drug treatment is not only bad medicine but is also expensive. "When somebody comes in with 25 years of chronic pain," says Fishman, "I might sit with them for 90 minutes to get the beginning of the story, to really understand what's happening. The insurers would rather pay me $1,000 to do a 20-minute injection than pay me a fraction of that to spend an hour or two talking with a patient."

Inevitably, many patients who find their way to pain-management centers wind up paying out of pocket for some of the nontraditional parts of their treatment. Still, demand for these services is soaring. Six years ago, the center at U.C. Davis received 50 to 60 patient referrals a month; now it receives 500. With fewer than 200 multidisciplinary centers across the U.S., the need simply cannot be met. "The bottom line is that there will never be enough specialists to deal with the problem," says Fishman. "So we have to train primary-care physicians at the front lines to be able to do this as part of the basic care that we give patients."

For that to happen, more doctors and patients will have to heed the lessons of Vioxx and Celebrex and refuse to settle for prescription-pad medicine. —With reporting by Dan Cray/Los Angeles, Chris Daniels/Toronto, Alice Park/New York and Maggie Sieger/Chicago