

CONFERENCE REPORTS

Spring Symposium - Continuing Medical Education May 23, 1998 Back Pain

Laurence V. Zrinzo*
(Chairman of the Conference)

The Continuing Medical Education Committee, under the aegis of the University of Malta Medical School, assigned its 1998 Spring Symposium to Back Pain

The topics presented and the respective speakers were:

Not just the pain: The art & science of the problem

Not just the back-pain: The lumbar radiculopathies

Not just the back: Retro-peritoneal pain

Not so much the back: Rheumatological conditions

What about the female back?

Not just the patient: Psycho-social aspects

Not just the "Doctor"

- The Physiotherapist

- The Acupuncturist

- The Chiropractor

Keeping an Eye on the Back

Posters presented were:

- Anatomy of the Lumbar Spine

- Radiology of the Lumbar Spine

Mr Laurence V. Zrinzo

Mr Antoine Zrinzo

Mr Alex Attard

Dr Carmel Mallia

Mr Ray Galea

Dr David Cassar

Ms Margaret Muscat

Dr Nazzareno Azzopardi

Dr Elaine MçDougall

Mr Frederick Zammit Maempel

Dr Ludvic U. Zrinzo

Drs Kenneth Saliba & Michele Calleja

* Mr. L. Zrinzo, Consultant Surgeon, Villa Mourisca, G. Despott Street, Kappara, Malta

Pain as the symptom

In 1979, the International Association for the Study of Pain issued the taxonomic definition that pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.

However, besides being related to tissue damage, pain can also occur solely as an emotional experience or as an intentionally fabricated sensation.

Consequently, there are various components and mechanisms of pain. It is only when these are understood scientifically that there can be instituted rational treatments which have predictably effective outcomes.

Medicine as a science

Medicine, in all its branches - including the so-called para-medical ones - is the most humane of all the sciences.

The humaneness in medicine is, par excellence, in the art of communication, whether an adequate description of the symptoms is being obtained from the patient or a course of action proposed by the practitioner.

As for the rest, medicine is a science.

By definition, a science quantifies observable phenomena that can be integrated in the formulation of a working hypothesis which, in turn, would suggest a

relevant experiment to confirm or refute the hypothesis.

By quantifying observable phenomena, that is by finding objective correlates to the patient's subjective pain, the signs, (hence the title of the first presentation : Not just the Pain), the practitioner would be able to formulate a working diagnosis.

This, in turn suggests the investigation(s) necessary to confirm the diagnosis prior to commencing treatment.

After all, it is well-known that the keys to maximizing the success of any medical or surgical procedure, be this investigative or therapeutic, are appropriate patient selection and meticulous techniques. And maximising success makes for cost-effectiveness.

Now, even as medical students, we have heard all this before. "If you take a good history and do a careful examination, the rest might not be too difficult or too expensive."

Cost-effectiveness

But are we actualizing this concept in our clinical practice? Are we actualizing it in the management of our patients suffering from back-pain?

All of us would have realized that, not only are more and more people claiming to have back pain and ascribe their disabilities to it but that more and more health care finances are being devoted to its treatment.

Indeed, the biggest problem in the health care of back

pain seems to be the inability - or the unwillingness - of health institutions to ascertain as to how much this spiralling increase in the cost that this symptom currently incurs is a response to the growing number of the genuinely disabled and how much due to the abuse of the system by both care users and care providers.

Is there an art or a science to deal with this administrative problem?

Modern technology

For example, should we, in this technological age, arrive at a diagnosis simply by taking a brief history, performing a cursory examination and then filling-in a request form for an investigation?

Is that enough to establish a humane rapport with our patient?

Not so long ago, one should have had a good clinical indication for subjecting a patient to a myelogram. Would a lesser clinical indication today suffice for ordering an MRI, simply because MRI's are available and less invasive?

Indeed, if a good clinical examination is not needed, do we need clinicians or should the nation invest in bare-foot doctors?

Record keeping

In this setting, which is really investigation-based rather than clinical, patients' records can only be, to say the least, poor and paltry. Without an adequate clinical pre-investigation base-line, how can the clinical progress or deterioration of the patient be assessed? Indeed, how can the efficacy of treatment be assessed?

Another use for clinical records is, of course, clinical research; poor case-notes are not conducive to such endeavours.

An outstanding example of clinical research occurred in the city of Glasgow. In the early 1970's, the neurosurgeons Jennett and Teasdale analyzed the clinical findings in head injury patients and correlated them with outcome. They arrived at the now well-established dictum that prognosis depends on what the head-injured patient does with his eyes, with his mouth and with his limbs. The Glasgow Coma Scale, a paradigm of clinical research, has, over the last three decades, proved to be a cheap and most effective clinical tool. Countless lives have been saved by Jennett and Teasdale's critical appraisal of well-kept patients' records.

Certainly, the Glasgow Coma Scale saved lives in Malta when the Neurosurgical Unit still lacked scanning facilities; several patients were operated successfully on the basis of clinical data.

Clinical audit

Finally, poor case-notes, most certainly, hamper auditing and the assessment of future financial needs in health care. Indeed, poor case-notes utterly preclude the exercise of containing superfluous expense.

As members of the profession that proclaims so loudly its interest in the welfare of our patients, should we not consider how we are upholding these various facets of our activities?

Obviously, the technological-non-clinical approach is

not cheap and, that, at a time when governments are requested to construct multi-million pound hospitals and senior citizens are sometimes charged for their prescription.

The real CME

As intellectuals, we should provoke, not stifle, thought. It is only good clinicians who make good diagnosticians and it is only good diagnosticians who mete out the proper treatment, be they physicians, be they surgeons.

Should we come to rely on a perfunctory history and examination, we are not only stifling our own thoughts, thereby negating our own continued medical education, but the thoughts of those around us, including radiologist colleagues, our doctors-in-training and those who are responsible for evaluating the financial needs for our properly treating our patients.

As the saying goes, one only finds diamonds if one digs for diamonds. The sheer pleasure of finding the gem is intensified by having gone through the drudgery of sifting through all that muck : after all, that is why it is a gem. However, finding a diamond presupposes digging in the appropriate terrain; otherwise the exercise is very time- and cost- inefficient.

The same applies to reaching a working diagnosis and relevantly investigating only the deserving clinical case.

Indeed, the subject matter of the several presentations of this symposium was chosen to heighten the awareness of the different bio-psycho-social aspects of back pain that are of clinical import in arriving at a tentative diagnosis prior to requesting the warranted investigations.

The presentations

A slide presentation by Mr Laurence V Zrinzo showed various neurosurgical conditions that can present under the guise of back pain. These include the "warning leaks" of an intracranial aneurysm. Amongst the cases discussed was the first cerebral aneurysm clipped in Malta in July 1987. It was at the trifurcation of the right middle cerebral artery. Dr Joseph Zarb Adami was the anaesthetist. The patient, a female nurse, was back at work within a few weeks.

Very often, patients with localized back pain are diagnosed as suffering from a "pinched nerve". Mr Antoine Zrinzo discussed the clinical aspects that objectively reflect the pathophysiology that is present in lumbar nerve-root entrapment and that, therefore, must be elicited to establish the diagnosis of a compressive lumbar radiculopathy.

As an example of retroperitoneal pathology presenting with backpain, Mr Alex Attard discussed the mode of presentation, diagnostic work-up and surgical treatment of a patient with a dissecting abdominal aortic aneurysm. On four occasions, this particular patient had presented to an accident and emergency department complaining of severe back pain that radiated to his abdomen. His condition was diagnosed when he consulted a neurosurgeon.

With the exceptions of the atlanto-occipital and atlanto-axial joints, the motion-segment in the spine is a three-joint complex consisting of a secondary

cartilaginous (symphyseal) joint between the vertebral bodies anteriorly and two facet joints between the articular pillars, posteriorly. In the cervical region, there are also the synovial neuro-central joints of Luschka. On the other hand, although the sacro-iliac joint is a synovial joint, it exhibits very little functional mobility due to the thick ligamentous structures surrounding it.

With such a large number of joints and such a wide variety of joint-structure and joint-mobility in the vertebral column, it is not surprising that various rheumatological conditions can present with backpain. A slide demonstration of such clinical conditions was presented by Dr Carmel Mallia.

Mr Ray Galea noted that there is, really, not much anatomical difference, between male and female backs. Gynaecological conditions often blamed for back pain were reviewed and the clinical replaced the mythical.

Attempted suicide is often a call for help. The practitioner need also be alert to such a call when pain occurs solely as an emotional experience or as an intentionally fabricated sensation.

Financial, marital, work-related and imagined problems may all render a person unable to cope with subsequent somatisation of the psychological lesion.

Dr David Cassar discussed the psychological and psychiatric aspects that can lead to "pain behaviour" as well as the disturbances of the psyche that real pain can itself produce.

The psychiatrist, with expertise in eliciting a history from the patient and close relatives as well as with knowledge of psycho-therapy and pharmacology, is an invaluable colleague in the diagnosis and treatment of such cases.

On a different tack, it is about time that the medical profession also increased its awareness of how other health care providers look at the problems of back pain patients.

Diagnostic and treatment alternatives need to be critically evaluated. One needs to increase knowledge by being provocative and discussing controversies in a scientific way.

These matters were expounded during the symposium by Ms Margaret Muscat in her discussion of what physiotherapy can offer to the patient with back-pain.

Dr Nazzareno Azzopardi discussed the history and clinical indications of acupuncture therapy. In this field, the traditional is gaining credibility with developments in neuro-physiology.

Dr Elaine McDougall summarized the increasing clinical evidence of the beneficial role of chiropraxy in the treatment of backpain.

In his presentation on "Keeping an eye on the back", Mr Zammit Maempel discussed the clinical aspects of scoliosis. Although backpain is not so common a presentation of scoliosis, this condition certainly warrants early diagnosis and adequate follow-up.

The cultural

During the symposium, Mr Alex Dalli, a nurse on the Coronary Care Unit at St Luke's Hospital, exhibited a collection of his works. The serenity of the paintings, often of landscapes and inanimate objects, is the central theme of Mr Dalli's individual style.

The scope of CME

Information is a low-power way to change behaviour, but it is the intellectual's way and hope springs eternal. The CME Committee trusts that this conference made everyone present feel challenged to assess how we look at back pain and, indeed, at our clinical practice in general.

The copyright of this article belongs to the Editorial Board of the Malta Medical Journal. The Malta Medical Journal's rights in respect of this work are as defined by the Copyright Act (Chapter 415) of the Laws of Malta or as modified by any successive legislation.

Users may access this full-text article and can make use of the information contained in accordance with the Copyright Act provided that the author must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the prior permission of the copyright holder.

This article has been reproduced with the authorization of the editor of the Malta Medical Journal (Ref. No 000001)