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Evaluating the Chronic Pain Patient in an Office Setting

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Introduction

Diagnoses provide physicians and nurses with a short-hand, which encompasses all the elements needed to evaluate and treat a patient. A diagnosis helps medical personnel understand seven essential elements about a disease:

A. The cause of a disease, whether it be infective, or vascular, or orthopedic, or other causes, based on the description of the pain (burning, sharp, shooting, numbness, pressure, pins and needles, throbbing, pounding, cold or hot).

B. A careful history which describes the onset of the symptoms and what makes things worse or better

C. The clinical manifestations of a problem, called symptoms,

D. The medical signs that a physicians should find on physical examination,

E. The proper type of test to order to help confirm the disease, compared to other diseases,

F. The expected test results a physician should see in the test and

G. Ultimately, the type of treatment to follow, and

H. The expected result of this treatment (outcome studies)

All this information is contained in a single acute diagnosis. However, there have been three major abuses of the diagnostic process.

A. Physicians and nurses are allowed to "diagnose" a patient with nothing more than a "description." As an example, patients who complain of low back pain are often given the "diagnosis" of "low back pain."

B. There are diagnostic "errors of omission," when medical personnel miss the correct diagnosis in chronic pain patients 40%-80% of the time [1-5]. Examples of this are "diagnoses" of cervical or lumbar sprain in patients with neck and back pain for more than 6 weeks, while the medical literature documents that sprains and strains are self-limited diseases which resolve by themselves in 4-6 weeks [6,7].

C. There are "errors of commission" where a patient is given the wrong diagnosis 71%-97% of the time [4,5,8]. An example of this is the over-diagnosis of fibromyalgia. In a study of 38 patients, Hendler & Romero [1] found only one patient met the diagnostic criteria of fibromyalgia. In the remaining 37 of the 38 patients (97%), not only did they not meet the diagnostic criteria of fibromyalgia, but in these 37 patients, 133 other medical diagnoses were documented by objective medical testing, which had been overlooked by the referring physician [8].

The Wall Street Journal reports that the most common cause of misdiagnosis is the failure of a physician to spend enough time with a patient, and ordering the wrong tests [9]. The most important component of establishing a diagnosis is a careful history, which reveals more information than medical tests or the physical examination [10]. However, modern medicine is not predisposed to this most important element of medical care. A physician spends an average of only 11 minutes with a patient, [11,12] during which time the physician speaks 7 of the 11 minutes [11]. In fact, physicians interrupt the patient an average of only 12 seconds after starting the medical visit.

To compound this oversight, typically the wrong medical tests are ordered. One glaring example of this is the over reliance on the MRI for neck and back pain, which has a false positive rate of 28% [13] and a false negative rate of 78% [14,15]. This means that 78% of the time, the MRI will miss a damaged disc, which is detected by a provocative discogram.

To help assist medical personal, a team of physicians from Johns Hopkins Hospital developed an Internet questionnaire, or "expert system," for chronic pain patients, which asks all the questions medical personnel should ask, if they spent 50 minutes with a patient. This questionnaire is called the Diagnostic Paradigm and Treatment Algorithm for chronic pain, which is available in English or Spanish, and has 72 questions, with 2008 possible answers. It takes medical support staff only 5 minutes to prepare a patient to take the test on an Internet linked computer, and it takes a patient between 30-60 minutes to complete the questionnaire. The answers to the questionnaire are analyzed

using a proprietary scoring program, which uses Bayesian analysis. It was developed by reviewing 10,000 patient charts over a 17 year period of time. The interpretation of the answers produce diagnoses which have a 96% correlation with diagnoses of Johns Hopkins Hospital physicians [16]. The results are available within 5 minutes after the completion of the test questions by the patient. Then, based on the accurate diagnoses, the Treatment Algorithm portion of the test recommends the correct medical test to use to confirm the diagnosis. The use of this test produces documented improvement in patients who otherwise might not receive proper care [17]. The use of this Internet test provides a history taking technique, which normally would take a clinician 30 to 60 minutes to obtain, with no expenditure of their time, and without compromising care.

In summary, the use of the Internet based Diagnostic Paradigm and Treatment Algorithm could speed the evaluation of chronic pain patients, increase the accuracy of diagnosis, and improve outcome results. The use of an "expert system" could prove beneficial to medical personnel and patient alike. A more comprehensive review of this material can be found in a recently released book, "Why 40%-80% of Chronic Pain Patients Are Misdiagnosed, and What To do About That," by Nelson Hendler [1] (Nova Science Publishers, 2017).

Disclosure

The author is the CEO of Mensana Clinic Diagnostics, which offers the Diagnostic Paradigm and Treatment Algorithm for chronic pain to the medical community over the website www.MarylandClinicalDiagnostics.com

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