Occasional Review

Pain as an old friend

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Chronic or recurring pain can be an old friend because it calls attention to a chronic disorder that demands correct diagnosis and appropriate treatment. It may be better to have mild angina pectoris than to be smitten down without warning with an acute prostrating ischaemic episode, though this is, perhaps, debatable. Better to have pleuritic pain as an expression of pulmonary embolism from peripheral thrombophlebitis than a subtle, silent infiltration of the lungs with multiple infarcts. Better, again, to have a warning epigastric discomfort rather than a sudden perforation of a peptic ulcer out of the blue, and an early pain may save many patients with a malignant process from the late discovery of inoperable disseminated neoplasia. But, at the other extreme, a complete absence of pain, as in the Charcot's joint of tabes dorsalis, is probably preferable to the dragging discomfort of most chronic arthropathies, in which pain is definitely not an old friend but an old, well-known, and well-hated enemy.

Learning to live with pain

However you define pain, the essence of it is that it is unpleasant. It hurts! To become an old friend a pain has to acquire a different symbolism from the straight message of a disturbed natural process. But pain is a word that covers a wide variety of meanings, ranging from the acute agony of a dislocation or an acute attack of gout to the black misery of a suicidal depression. To the patient whose life has become a disorderly misery an honest-to-God-pain may be very welcome and become in time truly an old friend.

She was the sort of friend, they used to say of Tulullah Bankhead, Zsa Zsa Gabor, or Bette Davis, that makes enemies redundant. Friends and foes, light and dark, heaven and hell, yin and yang, and pleasure and pain can become peculiarly intertwined and complementary, occasionally giving added richness, overtones, and complexities that render simple pains and pleasures merely mildly unpleasant or insipid. In *Cowardy Custard*, which was running in the West End at the time of the author and composer's death, an elderly couple, Darby and Joan, sing sentimental verses followed by a chorus which goes as a duet: "We've loathed each other for fifty years." Nevertheless, Darby and Joan remained together in their hate-love fixed state, as they were too old and settled for separation or divorce. Similarly, the patient with a chronic pain that cannot be shaken off has to learn to live with it and to evolve spiritual complexities to make it tolerable. To the religious the pain is sent for a divine reason and must be endured as a spiritual duty. To the dying the realisation of the approaching end is often blinkered and softened

by a kind of psychological evasion or double-think process that diverts attention to other things.

To the patient with arthritis pain is an everyday ration of unpleasantness that can be softened and controlled up to a point, but still must be endured, since life still has to be lived, however unpleasant. To those who suffer from incurable malignant disease the same applies, though usually for a shorter period. Relatively few patients with chronic pains ask their physician for death and deliverance, and very few commit suicide; they wrestle on doing their best with their lives, balancing their pleasure credits against their pain debits as best they can. These are the little martyrs, who survive not the relatively quick agony of being burnt at the stake, but the longer unpleasantness of being slowly rotted by an unpleasant chronic, progressive disease, often partially or fully realising the eventual outcome. Their pain is an enemy with which they have to live. They may not love him dearly, and while not exactly a friend, he is at least a close acquaintance. In one Marx Brothers' film Chico is asked if he loves his brother, Harpo. "No," he says, "but I'm used to him." Better an old enemy to whom you have adapted and whom you know well than a fresh, unknown newcomer who may turn out better or far worse than the old acquaintance. This, in passing, is what confronts a patient who is offered a surgical operation to improve but probably not cure his existing painful condition. Is the change worth the gamble? Will the new friend be truly a new friend or just replace the old enemy. This is a difficult decision for any sufferer and one on which he needs to have all relevant information available, if indeed this exists in his particular case.

Pain as a career

In a second group of patients pain is quite different. This Pain is spelt with a capital letter and is truly an old friend. It is not the product of organic or psychiatric disease, but an essential component of the sufferer's life. It is, as Professor Szasz¹ has it, a way of life, a career, and the sufferer is a professional in pain [sufferance]. The Pain may have started as an ordinary pain based on injury or disease, but due to social or other factors and the patient's particular personality it becomes a pain that takes the sufferer to many physicians, surgeons, radiologists, biochemists, physiotherapists, acupuncturists, manipulators, haematologists, etc, but to relatively few psychiatrists for more than one or two visits. This Pain will remain undiagnosed and will never respond to any drug, but is temporarily eased by gentle physiotherapy and the laying on of hands or the insertion of needles in one form or another. As Szasz emphasises, these people have no organic or psychiatric disease. This is not a medical or psychiatric problem, but a social one that concerns the personality. Here the Pain is not just an old friend, but an essential part of the sufferer's existence: it is not so much a part of, as a partner in, the sufferer's life.

Pain as a career is seen also in patients with a chronic painful or crippling condition which confines them to bed, chair, or room for many years. Such patients are almost always women,

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and like President Mossadecq of Iran, who ran his country in pyjamas from his sickbed many years ago (until deposed by the (now deposed) Shah), they run their families' lives ruthlessly from their sickbeds. Unable to leave their rooms, they exert considerable control over their husbands and children, and any departure from mother's party line precipitates fresh symptoms, fresh crises, and new consultant opinions, so that the family soon comes to heel again. Pain here is an old friend in as much as it gives power to the sufferer to organise not only her own life but almost everybody else's. A good example is that of Florence Nightingale, who, after an active and effective life, retired sick to the privacy of her bedroom and ran things from there, being visited periodically by various important personages.

Professor Szasz of Syracuse, New York, makes the excellent point in many of his writings that in this medical and pharmaceutical brave new world all pains are considered to be due to something that a doctor can treat by pharmacological, surgical, physical, or psychiatric measures. He considers this to be quite untrue. Many chronic pains are not due to organic or psychiatric disease and should not rightly go to a physician or psychiatrist. Some surgeries and consulting rooms are full of complainers who have no intention of losing their old friend. They demand attention, love, and treatment, but never get cured. These are the professionals, for whom pain is a career. Their faces fall and they look hurt and insulted when you tell them they have not got an inoperable malignant process. Mr E P Brockman, lately orthopaedic surgeon to Westminster Hospital, used to say that the one thing that brought a happy, contented smile to their faces was the remark, "I fear, Mrs Clutterbuck, I can suggest nothing to help you. Your case is far too difficult for me."

Recollected pain

Another old friend is the past pain which died, but which nevertheless lives on for ever, and achieves an immortality as painful to the audience as it is pleasurable to the recounter. I refer, of course, to the old "disc," the painful operation in 1953 which should have proved fatal and nearly did, the terrible accident, and the multiple postoperative complications. These are recollected pains that live on in the memory (and the conversation) of many patients, for whom this was perhaps their finest and certainly their most exciting hour. This dramatic and interesting event becomes in recollection and repetitive recitation everybody else's most boring one. The only escape is for the listener to retell the story of his own "disc," coronary, or other pain and enter into open competition for the best and biggest pain.

Pains are horrible at the time but may become exciting in recollection to the sufferer if not to the audience. Just as events in the last world war were more exciting and memorable for many individuals than the peace before and after it, even though at the time many were extremely unpleasant, so the severe illness, the horrible operation, the big pain, in fact, becomes the big exciting memory and lives on in the sufferer's conversation. This old friend, the past pain, can be summoned like a genie from the lamp at a few seconds' notice, merely by asking the magic question: "Was it in 1953 you had your disc, Mrs Stalemate?" There is a sentimental song, "My Old Dutch," but not, so far as I know, one entitled "My Old Disc." This should be looked into.

Pain, then, can become an old friend or a tolerable acquaintance, but whether it is caused by serious disease or not, it can fill the sufferer's life and condition and distort it, becoming an essential ingredient of it and affecting major decisions, such as where to live, whether to emigrate, whether to have babies, whether to continue to work or to retire, whether to separate from one's partner, and so on. Pains based on active underlying disease can be relieved by drugs for a while, but entrenched pain, which has become as essential a component of the person as his vertebral column, is unlikely to be effectively diverted for long.

But conversion can occur, as in religious conversion, often apparently suddenly, if the sufferer adopts a new approach to life. This apparently sudden occurrence is probably the result of many factors that have been operating for some time, but come to a head, as it were, in the conversion. The cessation of a long-standing deep sorrow or unhappiness can do it, or it may be, in current jargon, multifactorial, but the old friend *can* depart, though he often fails to do so. His importance lies in his recognition. Exorcism by pharmacology or surgery may occur in some cases, but never in others, and drug addiction or habituation may result.

Postoperative pain

Surgery may perpetuate, complicate, and magnify the pain rather than cure it; it has always seemed to me that the old failed laminectomy and the old failed gastrectomy are even more incurable than their unoperated equivalents. Pain is rarely an old friend to the physician in charge of the case and probably never to the surgeon. The pensions boards groan with the burden of patients with chronic pain that has persisted despite surgical operations and sometimes apparently because of them. In such cases the old friend has become an old paying guest or lodger who provides extra monies to compensate for his presence. The same applies in certain medicolegal cases where the old friend departs only when he has paid his full rental or been declared bankrupt.

Even more subtle, and an even greater headache for the serious-minded casualty surgeon on duty, is the surgical Munchausen who arrives in an untried casualty department with an acute abdominal crisis and undergoes yet another laparotomy for a pain which nobody can adequately explain and which appears to have no organic basis. Before dismissing these cases as unrelated to organic disease, it is wise to remember that in the past, patients with acute porphyria occasionally underwent operation as surgical emergencies and nothing was found at laparotomy. There may be several other as yet undiagnosable conditions awaiting accurate identification. Meantime, the poor surgical Munchausen continues to have enough abdominal distress to wish surgical operative attention to be repeated, whatever odd mental state produces it. In our context this Munchausen is a difficult fellow to identify and pin down, but he probably comes into the class of temporary or palindromic old friend who comes and goes and turns up intermittently in response to signals not fully understood by patient or medical profession. Certain cases of the stiff-man syndrome and other rare conditions may come into the same category.

Losing the old friend

If one suffers the long chronic pain what can one do to stop it from invading and taking over one's life, narrowing it down to a mean, nagging, unpleasant existence? Anti-inflammatory agents, analgesics, narcotics, surgical operations, and psychotropic agents all play their part, as do general measures such as correction of anaemia and improvement in nutrition, but more important is mental diversion. In a study of pain in rheumatoid arthritis, Huskisson and I² found that patients living at home with no particular outside interests had lower pain thresholds and took more analgesic tablets than patients with much the same amount of active painful arthritis who stayed at work. De Haas *et al*³ drew in Holland attention to a subgroup of patients who, despite severe, crippling rheumatoid disease, kept at work and lost little or no time off from sickness, and who seemed none the worse for it. People of this "typus robustus" were all men and usually self-employed. Tough extraverts, they ran their lives in their own way and generally showed more initiative and interest in what they were doing than the average person.

Absorption in interests outside themselves helps sufferers with any chronic painful process. For the male patient extension

of his ego, proving himself successful and effective in career or job, and rising in the esteem of his fellow men (usually making more money in the process) helps greatly; for most female patients faith and affection play more important parts. In either sex faith in the Almighty, the physician, the surgeon, the physiotherapist, and the future generally is essential, or the need for more treatment and more analgesics escalates. The occupied mind suffers less than the unoccupied, which provides little to distract the patient from his own suffering, and the mind with faith and without fear for the future is more contented and relaxed and suffers less pain than the one in doubt, which is anxious for the future and mentally insecure. It is at night in the small hours that these factors are particularly apparent, for without distractions the patient is alone with his pain, his doubts, and his fears. Chronic pain can only stop being an old enemy when all these factors are controlled. He can then become an old acquaintance, reasonably well tolerated but still a rather unpleasant fellow. For him to become truly an old friend is much more rare and calls for a much more complex and subtle metamorphosis.

Pains which become old friends are born of necessity. In psychiatric disorders such as depressive psychosis pain is an enemy difficult to dislodge but often rapidly routed by electric

convulsion therapy. In hysteria pain may act as a friend in getting the patient through difficulties when no other escape is possible. But in many cases pain is not based on physical or psychiatric disease alone, but also on unhappiness, maladjustment to life, the local environment, and personal factors. Here pain can come to the rescue and be an old friend, almost a partner or spiritual support. And, regrettably, in certain circumstances, such as prolonged disability, compensation and insurance claims, separation allowances, and pensions the old friend may help to take over financial responsibility. It is he who often helps to make the big decision for the future—where to live, whether to retire, to emigrate, to separate, to have no more babies, and many other things. Here the old friend is an old friend indeed. Almost a father figure.

References

- ¹ Szasz, T S, in *The Treatment of Chronic Pain*, ed F Dudley Hart, p 43. Lancaster, Medical and Technical Publishing Co, 1974.
- ² Huskisson, E C, and Hart, F D, *British Medical Journal*, 1972, **4**, 193.
- ³ de Haas, W H D, et al, *Annals of the Rheumatic Diseases*, 1973, **32**, 91.

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MATERIA NON MEDICA

Coarse fishing down under

The atlas shows that Australia consists of a large amount of land, mostly desert, surrounded by a long coastline spread over 30° of latitude, and these geographical features provide a great variety of fishing. Though trout have been fished here for a century and hatcheries guarantee a continuing supply, most Australian fishing is of the coarse variety.

Cairns is well known as a base for big game fishing, now patronised by film stars and golf millionaires. Two thousand five hundred kilometres of reef teem with fish—so much so that it is at times possible to pick one up with an unbaited hook dragged through the water. Moving south, the angler has the choice of estuary, rock, and surf fishing. The rock fisherman must be aware of the dangers of his sport: many a rock-hopper has been plucked from his eyrie by the rare unexpected giant wave and swept away never to be seen again. With his 4.5-m rod and 15-cm side-casting reel the surf fisherman hurls his line far into the sea, wading out to do so and back again to take up his position on the hard wet sand. When tailor abound his creel soon fills, but the non-expert is likely to illustrate the truth of the well-known saying: wet arse and no fish.

Country folk are not denied this sport. Though many rivers shown on the atlas run only in times of heavy rain, a few deep holes provide permanent water. Much debate has taken place on the origin of the fish in these west-flowing streams, one theory being that a powerful willy willy lifted fish bodily from eastern rivers, carried them over the mountains and deposited them in the western side, where they have flourished ever since. Be that as it may, enthusiasts think nothing of driving 500 kilometres to pursue the Murray cod and the yellow belly in holes on the Barcoo and Cooper's Creek.

The angler has his favourite bait. Not for the coarse fisherman are the niceties of fly tying. His concern is with Cribb Island worms, mullet gut, eugarie, cunjevoi, yabbies, raw prawns, and the humble pilchard, with flashing spinners for the big reef fish and bread for the fastidious luderick. But in enclosed waters, as any realist knows, for the angler who wishes to be sure of his dinner there is no substitute for a clandestine stick of gelly.—DEREK MEYERS (physician, Brisbane).

Piltdown man

It seems that Piltdown man just will not lie down. After the suggestions last year that Professor Sollas was responsible for the hoax, a book by Malcolm Bowden (*Ape Men—Fact or Fallacy*, Sovereign Publications, Bromley) points the finger at none other than Teilhard de Chardin. Not only was he responsible for the Piltdown deception, says Mr Bowden, but also for Peking and Java man, both of which, he contends,

are fraudulent. Certainly the evidence that he marshals in this painstakingly researched book seems convincing. Teilhard was one of the three excavators of the Piltdown site and only he of the three had the anthropological and chemical expertise to perpetrate the hoax. Most damning is the evidence that one of the planted fossils was radioactive, indicating that it had come from northern Tunisia, a site that Teilhard but not Smith Woodward or Dawson had visited.

Teilhard later turned up at both Choukoutien and Trinil, the sites of discovery of Peking and Java man respectively. Both discoveries are shrouded with mystery and the concealment of vital evidence relating to the finds. In addition, Peking man managed to get lost during the second world war and Java man was disowned by his discoverer before he died. The way Mr Bowden tells it the discovery of ancient hominids owes more to speculative fiction than to science.

But what motive could Teilhard have for faking it all? He was committed to a strange sort of evolutionary philosophy whereby man is evolving from the apes to "point omega," when he will be like God—a philosophy described by scientist Peter Medewar as "pious bunk" and by theologian C S Lewis as "something uncomfortably like pantheism."—T J HAMBLIN (consultant haematologist, Bournemouth).

Brain failure

In his description of the symptoms and signs of brain failure (3 March, p 591) Dr Gooddy has provided us with a perfect description of that modern phenomenon, the disothèque. I read his paper after attending our senior registrar's leaving party, which had elapsed (I think that is the right word—at least in retrospect) at a local hostelry on the previous night. The vague feelings of uncertainty and instability were certainly there, as were transient losses of concentration induced by gynaecological memorabilia beneath the flashing lights. While doubting that the odd behaviour of our party was "occasional," I can testify to dimness of vision, especially when the food was served. The limb weakness and numbness were more apparent 24 hours later—after rather nebulous pains in the lumbar region and feet; and a degree of depression did follow the news of Blondie's relegation to No 2 in the Charts.

We didn't stay long enough for the incontinence to set in, although I am told it is fairly common in disothèques on the Costa Brava, where it is associated with lack of both insight and of memory ("He was called José, and he distinctly said Lugano, Daddy").

The following day the entire staff demonstrated loss of temporal and spatial recall, failing concentration, diminished language fluency, poverty of abstract thinking, and failing powers of judgement, insight, and behaviour. They were also deaf.—PETER JONES (paediatrician, Newcastle).