Phantom thresholds
Michael Sultan discusses pain control

The International Association for the Study of Pain (IASP) selects a different, pain-related issue to study each year. 2011 has been designated as the ‘Global Year Against Acute Pain’ with the focus on raising the levels of understanding and the quality of treatment for acute pain in all its forms.

A natural consequence of medical advances in the control or subjugation of previously life-ending diseases and trauma repair is greater longevity for the victims. With average life expectancy for all of us rising, the importance of research into pain management and its effects on the individual’s quality of life is axiomatic. While few people actually die of pain, many lives are blighted by a failure to reduce or understand its debilitating effects and how destructive it can be for the individual, particularly over an extended period.

Acute pain should not be confused with chronic pain. Acute pain, by definition, is spasmodic in nature and relatively short lived, while chronic pain, however intense, is continuous. Acute pain develops when the brain receives sudden notice of tissue damage, and the nerve signals are amplified by sensitisation in the central and peripheral nervous systems. Although the incidence may be brief, repeated occurrences quickly disrupt the quality of daily life and without treatment can develop into a condition of chronic pain.

Pain by its very nature is subjective; pain ‘thresholds’ vary hugely between genders, ages and cultures, and the intensity of physical pain can also be affected by psychological and emotional factors. Comparisons between individuals suffering from very similar conditions are therefore rarely of any value and can be offensive to the sufferers.

The priority for every clinician should be the immediate reduction of acute pain, both to relieve the sufferer and to prevent the onset of chronic pain. However, the situation is often not as simple as it seems. An IASP report has found that many healthcare professionals have a tendency to downplay the importance of acute pain management for a variety of reasons. Reasons include a belief that pain relief medication may mask symptoms or impede curative medication, or that the patient should in any event expect, and therefore tolerate, a certain amount of discomfort. This lack of education in the practitioner may be mirrored in the patient, who fears becoming addicted to palliatives, or that taking pain killers may have side-effects, or perhaps delay recovery. With parties experiencing uncertainty, acute pain is all too often under assessed and under treated.

It is my own contention that as healthcare professionals compassion is integral to our responsibilities and we have a duty to be fully aware of the nature, treatment methodology and potential consequences of acute pain. Within dentistry, endodontics is an area where practitioners should pay particular attention to this aspect of patient care by keeping up to date with the latest information and techniques for pain management. The need is therefore to be addressed on three fronts – by individual practitioners, their colleagues and by the patients.

Traditionally, dental and endodontic practices’ professional promises of intent have been altruistic, vague, and expressions of the obvious in bland, Quixotic language. Announcing a goal of delivering the best possible care in the best possible environment is neither binding nor reassuring on the clinician nor reassuring for the patient. I suggest that our mission statements should be rewritten to imply a greater sense of imperative, obligation and urgency – for example:

‘It is the absolute right of every patient to be free from pain, and we as endodontists will take every possible measure to protect and promote a higher quality of life for all our patients. Once we have made our own commitment to expand our knowledge, we can progress to spreading the word amongst our colleagues about the optimum application of anaesthesia and analgesics in the resolution of the pain associated with extreme dental disease or tooth restoration. Increased awareness among practitioners will in turn enable more patients to be properly advised on the appropriate control of post-treatment pain, and so overall standards of care will rise.

A key issue in endodontics today is the cost of treatment, which was recently highlighted by the Steele report. The relief of pain by tooth preservation or root canal treatment is be yond the means of many, with a huge, less well-off demographic obliged under the NHS to accept extractions or removable prosthetics as the only alterna-

About the author
Dr Michael Sultan BDS MSc DFO FDS is a specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1990. He worked as a general dental practitioner for 14 years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in Endodontics in 1995 and as an in-house endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has attained extensively to postgraduate qualifications as well as attending the Endodontic courses at Eastern CFP, of London. In 2009 he became clinical director of EndoCare, a group of specialist practices. For further information please call EndoCare on 020 8949 4520 or visit www.endocare.org.uk.