

Airing Pain Programme 63: Interventional pain management

From blocking nerves to spinal cord stimulators: how interventional approaches can help.

Physiotherapy, exercise, medications and clinical psychology all play an important role in pain management, but what happens if these treatments don't give people the relief they need to get their lives back on track?

For some patients, more invasive treatments can make a big difference, but there are often difficult decisions to be faced, as Paul Evans discovers from sitting in on one of specialist in interventional pain management Dr Ron Cooper's clinics in Causeway Hospital, Coleraine.

We hear from patients who have often waited years before being referred to the clinic where they will be considered for interventional treatments such as spinal cord stimulation, nerve-blocking injections and radio frequency treatment. Dr Cooper explains why interventional treatments are more appropriate for some patients than for others, how they are thought to work and why it's important to see them as part of a broader pain management strategy.

Dr Ron Cooper: Seventy per cent of the patients that are referred to me have back pain: lumbosacral pain. About 10 to 15 per cent of the patients have neck pain and then the rest are a mixed bag. The mixed bag are the ones with the things like trigeminal neuralgia, which can be effectively treated at the pain clinic by intervention, or post-traumatic pain, or people with neuropathic pains, which are more difficult to treat.

Neuropathic pains can range anywhere in the body, as can post-surgical pain, but back pain is the biggest feature here, there's no doubt about that. A significant number of these patients really are here because they just want reassurance, and often they're doing a scan, and we'll reassure them that the scan is fully harmless, that can be done, and the examination will exclude any red flags. That's what you want to look out for. Very few of them will have significant pathology, and that's a fact, but you have to see them to know.

Paul Evans: Dr Ron Cooper. Now, he and some of the dozen patients he saw at one of his clinics in Causeway Hospital, Coleraine, were willing for me to sit in on and record their consultations.

But before we join them, don't forget Pain Concern's usual words of caution that whilst we believe the information and opinions on **Airing Pain** are accurate and sound, based on the

best judgements available, you should always consult *your* health professional on any matter relating to *your* health and wellbeing. He or she is the only person who knows you and your circumstances and therefore the appropriate action to take on *your* behalf.

Dr Cooper's first patient was suffering from neck pain.

Patient 1: The pains come from the spine, from about the very top of my neck, down to probably my bra strap area. The pain to me, when I'm just actually walking or sitting, feels like it's grinding, or like a hack saw, and then it seems to annoy the muscles and then it flares up. And I think when they flare up, it's putting pressure on my head, because I've had a CT scan of my head then, because of the vomiting and the whatever, and it's come back absolutely clear. So we're trying to rule out other things that are causing the headache – it's not headache, it's pain in the head – but I think it still seems to be coming back to the muscles in the neck.

Cooper: Yeah. Ok, can I just check your neck again to see, because that's important? And does it go into the shoulder as well?

Patient 1: It goes into these muscles.

Cooper: Yeah, but not down the arm?

Patient 1: No, not down the arm.

Cooper: And is it mainly on the right side?

Patient 1: Both sides.

Cooper: Both sides, yeah, but the right's the worst? [Pause] There? Is it sore there?

Patient 1: Yeah.

Cooper: And you've never hurt your neck at all, no?

Patient 1: No, they just say it's wear and tear. And I think the first x-ray I had for it was about 20 years ago.

Cooper: So about there?

Patient 1: Yeah.

Cooper: And there? Your muscles are quite tense.

Patient 1: Yeah. But that's nothing, I mean, today's a good day! [Laughs]

Cooper: Well yes, today's a good day – no, I can see that! Ok. Well, what I'd said to you was that we would try the tablets to see, and if the tablets didn't work then we could try some injections to see if that could identify any cause of the pain. It's possible you've got what's called 'cervicogenic headache'. That just means your headache, we think is coming from the neck. Cervicogenic is the cause of it, we think.

Now, in order to try and see if that's right and to try and help that, we can do what's called diagnostic injections in the neck, to see if that affects it. And that's done in the theatre, with the x-rays, with some care taken and precise needle location to try and find it out. There is, however, some risk with it, you should understand. There's a risk of flaring up the pain, in other words, which can happen any time. There's a risk of producing some numbness in your neck.

Patient 1: Right.

Cooper: There's a risk of injury – permanent injury – so if something goes wrong you could either have a fit or a convulsion. That's very rare, but I think it's something that you have to bear in mind. I think it's a reasonable thing to do and I think it's obviously worth a try. And if it does help it then it *may* allow us to do some other treatments. If the injections don't help it, and are not likely to improve that, then it may be a case of trying to work at relaxing the tension by doing the injections in the muscle – such as, Botox – with physiotherapy, with stretch exercising which may help it, that's a possibility. Is there a cure for it? Probably not, but hopefully we can make it easier. So how do you feel about that?

Patient 1: Yes, well it's getting to the stage where you are the last port of call, if you can't help me, I might as well, you know... that's...

Cooper: Oh no! I wouldn't say that, I wouldn't say that! I think it's worth a try.

Patient 1: Yeah, I think you're...

Cooper: Can you come up tomorrow to have it done?

Patient 1: Tomorrow is...

Cooper: Afternoon, Friday?

Patient 1: Yeah, yeah.

Cooper: Any questions?

Patient 1: No, I'm absolutely fine just to let you have your go. [Laughs]

Cooper: Right, there are no *guarantees* with this, but it's worth a try to see.

Patient 1: Well yeah that's understandable.

Cooper: It's more of a diagnostic thing than a treatment.

Patient 1: Ok.

Cooper: OK? See you tomorrow then. Half past one, day procedure ward.

Evans: Twenty years is a long time to have pain like that, and she said now: 'This is the last chance saloon,' if you like. How do you feel about that?

Cooper: I don't think that's quite true. I think she's probably told the other doctors she saw that as well. I think she is searching for a *cause* too much. I think that, you know, at some point she may need to have some multidisciplinary approach where she has some help with trying to cope with her symptoms, deal with them and hopefully stretch, relaxation will manage that. But I think before I would like to see if I can just exclude a cause in her neck, because if it is cervicogenic headache, it can be easily helped by some radio frequency treatment.

But yes, it's a long time, but that's often the nature of people with chronic pain, with no physical findings as such. And often the search for a cause can be a theme, really, and sometimes they just need to be able to say 'no, there's nothing we can find', or 'we'll have to manage it differently'. And I mean she's not a suicidal person, she's not somebody like that, and she's well-adjusted and not overly depressed either. I just think that she's not been able to identify it.

[Rustling of papers; people sitting down]

Cooper: Ok, so, is that the stomach area?

Patient 2: No it's down here, is it not?

Cooper: Right. Oh, down here, yes. Have you had an operation?

Patient 2: I had a double hernia done.

Cooper: When was that done?

Patient 2: ...2010, I think?

Cooper: And when you say double do you mean both sides or two sides in one?

Patient 2: Uh-huh. I had both sides done.

Cooper: Right and left? Oh right, together?

Patient 2: Uh huh.

Cooper: That's unusual

Patient 2: [Laughs]

Cooper: You just wanted to get it over with in one go?

Patient 2: Aye. [Laughs]

Cooper: Were you asleep for the operation?

Patient 2: Oh aye. [Laughs heartily]

Cooper: Did they do it with mesh?

Patient 2: Yes.

Cooper: Mesh.

Patient 2: After out there, I started getting this pain down... near the groin.

Cooper: The left groin?

Patient 2: Uh huh. It was like the pain that started with the hernia. So then my own doctor, I told him about it and he says: 'I'll get you in to see a specialist. And he says: 'No, the mess and all...'

Cooper: Worried in case it was the hernia again?

Patient 2: Yes, I thought it was that. And then I kind of got worried in case it was something else. They'd taken me out and...

Cooper: To check out the testes and the scrotum.

Patient 2: Yes.

Cooper: No lumps or bumps?

Patient 2: No lumps or bumps. And there was nothing cancerous or anything like that

Cooper: Because you were obviously worried about that.

Patient 2: I thought there would be prostate [cancer] or something.

Cooper: Yeah, you saw the TV campaigns and things.

Patient 2: Uh huh, you know, it was scary.

Cooper: Right

Patient 2: So they put it down to... that this pain here was coming out of my back.

Cooper: You've had a bad back for a number of years.

Patient 2: [Knowingly] Ohhh. So that's why I'm referred back to you. [Laughs]

Cooper: Have you still got the pain in the groin?

Patient 2: Uh-huh.

Cooper: Can you tell me a bit about it? What, is it there all the time or...what's it like?

Patient 2: Like a burning thing and, you know, it would be there all the time and it's really...

Cooper: I'm trying to work it out – what would it be, like, shooting pain as well, or sore to touch or do your clothes, underpants make it sore if you touched it gently?

Patient 2: No.

Cooper: You don't bother it?

Patient 2: No...

Cooper: So really burning's the main thing?

Patient 2: Burning and... if you pushed, you know...

Cooper: Where the scar tissue is?

Patient 2: Yes. And the lower back's very sore.

Cooper: Right. Is this pain different than the pain you had before you had the operation?

Patient 2: No, it wasn't burning before, no, it wasn't, no.

Cooper: OK. So it's a different sort of pain.

Patient 2: Aye.

Cooper: And when you pass water does it affect it?

Patient 2: Sometimes.

Cooper: Does anything else you do affect it – make it worse or make it easier?

Patient 2: No.

Cooper: Ok, now you say you have back trouble as well?

Patient 2: Uh-huh.

Cooper: Do you get the back pain when you get that as well?

Patient 2: Ah, I have back pain most of the time.

Cooper: Yeah I know. It's been there for years – I've done many treatments with you.

Patient 2: Uh huh, it's still...

Cooper: Still trouble?

Patient 2: Still trouble.

Cooper: OK, let's have a look at your back and then we'll have a look down below, OK?

Patient 2: No problem.

Cooper: Can you just slip off your jacket there? [Sound of movement, standing up, etc.] So who's there in addition now... who's at home with you?

Patient 2: Aah, uh, the other half! [Laughs]

Cooper: Ok. No problem. How's things at home?

Patient 2: Aye, just... normal. Don't do very much, you know.

Cooper: There's a big scar down the back there, is it from the surgery? Now I'm gonna... it's the left side mainly, is that correct?

Patient 2: [In pain] Arghh, yeah.

Cooper: Sorry.

Patient 2: [Slightly quieter] Arghh.

Cooper: Sorry about that. You've had treatment for the shoulder, is that right?

Patient 2: Uh huh.

Cooper: And physiotherapy?

Patient 2: I'm going now to the.... [hesitantly] pain something...

Cooper: ...management clinic?

Patient 2: That's it.

Cooper: That's right. Did your doctor get you sent there?

Patient 2: Uh huh.

Cooper: I think I actually suggested to your doctor a few years ago about the pain management programme, I think he got round to sending you to it now. I think that's the best thing for you to help manage the pain.

Patient 2: Uh huh.

Cooper: The pain you're describing is likely to be nerve pain.

Patient 2: Nerve pain?

Cooper: Yeah, which could well be coming from the back, but you've had back pain now for 10, 12, 15 years, and that's never going to go away, you know that?

Patient 2: Oh aye.

Cooper: The injections could manage it for a good while.

Patient 2: Yes.

Cooper: And help it. I just think that the way things are at the minute, I don't think that's the best thing for you. You know, I'm not saying we'll never do it, I'm saying it's not the best thing at the minute. I think the best thing to do is to... the medication you're on, probably stay on what you're on, but I'll write to your doctor about that, rather than... so don't change anything yet.

Patient 2: Uh huh.

Cooper: I think the best thing is the pain management programme and I'd recommend you go there. It's not going to be a cure, but it'll hopefully help you manage it, because you're very stiff at the minute, generally, and you need to get loosened up a bit. That'll come.

Evans: One thing I noticed, Ron, was his movement.

Cooper: He's exhibiting a lot of what we call 'pain behaviour'. A lot of it is really to, if you like, demonstrate to others that he has pain. He has pain, but he has got a lot of pain behaviour. His movement was – it's not a pathological movement – it's... some laymen would say it's putting on things, but what he's doing is he's emphasising how he feels: it's kind of attention seeking behaviour. And you'll find that a lot of patients who have a large psychological component to their pain, as opposed to a physical component, actually do exhibit this.

He's got multiple visits to his GP, and the other specialists, and he really is going to the best place: a pain management programme. That's not going to cure him, by any means, but hopefully it will help him identify how he is and see how things are and he'll cope with his pain and try a lot of self help where that needs to be helped. And he needs a lot of psychological help.

He's not mad by any means, he's a sensible person, but he's in this situation where he's one of these patients that's susceptible to any sort of pain. He gets pain particularly after any operation he's had and he's had multiple operations in the past, by surgeons and people, and always getting problems. And often there is some non-physical problem at the root of this. But I can't address that in my clinic: I'm an interventional pain physician mainly and so the important thing for me is not to stick needles in and not to change drugs drastically where I think that won't help – I've got to be honest with patients.

Evans: Dr Ron Cooper's next patient at Causeway Hospital in Coleraine has had back and leg pain for some years. She's had various interventional treatments, including nerve blocks, and more recently a spinal cord stimulator. This works by sending small electrical pulses to the spinal cord from a battery-powered device which is implanted in the buttock or abdomen.

Cooper: You have what's called a scoliosis in your spin, a twist in your spine. You can see it there in your x-ray and you can see the stimulator in place – there's the wire there in your back, you see?

Patient 3: Yes, uh huh.

Cooper: So there's the stimulator and there's eight electrodes there. And you would say that that has helped the leg pain, but not the back pain and that's always been the case.

Patient 3: Yeah.

Cooper: And it helps the leg pain by a good, you reckon, about sixty per cent.

Patient 3: Yeah.

Cooper: Better than it was?

Patient 3: Yeah.

Cooper: So you'd miss it if it wasn't there?

Patient 3: Aye, aye, I would, aye.

Cooper: Because you remember we talked about turning it off to see and we tried that and you found it *did* help. So really, this is what you've got in your back, OK? [Sound of picking up a device] In there, it's slightly bigger.

Patient 3: It feels bigger.

Cooper: How long has it been in there, how many years?

Patient 3: It was in three years ago, it's just passed.

Cooper: That's good and it's giving you stimulation in there and that's under the skin. It's about the size of a cigarette box, it's a bigger one. Now, we have different ones that can go in. So basically, it's working satisfactorily and it's doing what it can do, but at the time when we put it in, remember, we said that it won't take away the pain totally and it probably won't help with the back, and I think that was true, but at least it's helping some of it which is better than nothing, would you agree?

Patient 3: Yeah.

Cooper: The medication – I think you still will require it. I think it's important to keep doing the activities you do, keep as active as you can, and basically whenever the battery would stop working, when it wears out, then we can replace it. And we can maybe replace it with one of the rechargeable ones, because the less operations you have the better, you understand?

Patient 3: Because I'm actually already getting my gall bladder out as well! [Laughs]

Cooper: Ohhh dear, they're doing the telescopic surgery... in Derry?

Patient 3: Well that affects the back...

Cooper: Yeah, you'll need to tell them, they don't know.

Patient 3: I told them, you see...

Cooper: Yeah, but what you need to do is, you need to tell them and in fact what I will do is I will write to your doctor and I will write a letter to you to take to the surgeon. Because what it means is you need two things: when you go into the hospital to have the gall bladder out, they'll need to know, because you need to have antibiotics, which you'll get anyway from the surgery, you'll get that.

But you'll also need to know, there's a special thing they use called diathermy, which is a thing they use to stop any bleeding when they do the operation, so if they cut the blood vessels, they have to stop the bleeding, and they put electric currents through them. There's a certain type of diathermy that they should not use, they need to know this before they do it and most of the surgeons know that, but I will send a letter to you, to take with you when you go in to say look and show that to the surgeon and anaesthetist to make sure they know that. Otherwise if they use the wrong one it could wipe out the stimulator and it would stop working.

If your stimulator changes after the surgery – sometimes you need a reset after the surgery – so what you should do is, when you go into the hospital, switch it off, when you're in the hospital. You *can* use it after the surgery, OK, after the operation, but before the surgery it's best to switch it off in case you forget to switch it off, because if you switch it off then it's much safer. But really, people have had big operations with stimulators and no bother, as long as you remember those two things. And you can take the thing in with you, but switch it off before you go to theatre, alright, that's my advice.

And if you have problems with it after you come out, contact Joyce again and we'll see you again and readjust it. Maybe about two out of ten people might need to readjust it, but we'll just have to wait and see. Anyway, good luck anyway!

Patient 3: Great, thanks very much, then! Bye!

Cooper: You're very welcome. Bye bye!

Evans: What's the principal behind the...

Cooper: Spinal cord stimulation? Well the basic answer is no one knows how it works, but the initial theory was that... it worked on the Gate Theory, where you stimulated the spine, and you blocked out the impulses coming from the painful leg, and it blocked them out, and that was a simple theory at first, but for about a millisecond we all... it's not thought to be the case now, it's thought to work on chemicals in the blood, chemicals produced in the spinal cord, which go to the brain. And endorphins are affected and inflammations affected, sympathetic activities and in fact inhibitory... no one knows, but we know it has complex

effects, and we know that it can help certain types of pain and neuropathic pain. And the patient can turn it on and turn it off as necessary.

But it's a system that we have the benefit of doing a trial to see if it's going to work, because if it's not going to work then we shouldn't do it. And by putting in a temporary lead that come out through the body, and the patient tries it, for anything from a week to four weeks, then they'll know if it's working in their home environment; this is done and they go home. And if it helps significantly and I am convinced that it helps them, then we go ahead and do an implant. If the patient's not convinced or doesn't want to be bothered with it and I'm not sure, then we take it out. If there's any doubt, we don't do it.

And those that it works for, it works well. It works very well for pain in the leg – a single leg, a single arm, a single limb – and it works for other types of pain, more complex pain, where they have CRPS (Complex Regional Pain Syndrome), which is sort of a swelling of the leg. It's also useful for amputation stump pain, but *not* phantom limb pain. It's useful for pain after angina, which hasn't responded to cardiac surgery, or failed back surgery. It's used for conditions such as abdominal pain, conditions such as pelvic pain. It's also used for painful bladder syndrome, where it can also control the urgency and the frequency of running to the toilet. It can also be used to control faecal incontinence, in certain cases, for the older or for the sick, so it's got a lot of uses.

[Sound of walking in high heels; people sitting down]

Cooper: Hi, I'm Dr Cooper, and the physiotherapist asked me to see you, because you had back pain – is that right? For, what, a year or so?

Patient 4: Yep.

Cooper: And you'd been to your doctor, and he'd got you to go to the ICATS (Integrated Clinical Assessment and Treatment Services) physiotherapist – that's a specialist physiotherapist who decides if you need to have an operation or not.

Patient 4: Mmm, hmm.

Cooper: And they did a scan of your back

Patient 4: Yep.

Cooper: And have you seen the scan?

Patient 4: No

Cooper: Ok, we'll have a look at the pictures there, so you can you see it. That's your bones in the spine, we call it the vertebrae, There's the discs, those little black things – the shock absorbers – and there's the spinal cord, where the nerves are, OK? And if you look down there, that's nice and healthy. The first thing they tell you is you don't need an operation.

Patient 4: That's good.

Cooper: You understand that?

Patient 4: Yep.

Cooper: And that's good, I'm glad that you said that. If you look down here, you see where it's a little bit whiter, that shows that there's some inflammation there, and that's possibly where the pain is, down in that level, *possibly*. Now, the discs are starting to bulge a little bit, you can see a little bulge, you see there? That's ok – a lot of people have bulging disks and it doesn't mean anything. If the disk was to go right out and get prolapsed, then you'd need an operation. Anybody could need that, but you don't need that. At the back of the spine – we're looking at the muscles there – and the muscles are a wee bit thin there. You know, because the pain's bad, you probably haven't been doing too much.

Patient 4: No, because I can't.

Cooper: Do you know the way when you go into a plaster of Paris, your muscles go weak? That's the muscles in the back getting thin there. That's the normal muscle and that's the muscles getting thin. And that's why it gets into a vicious circle. There's the joints in the back there – see there? We call those the facet joints and that's those joints. And do you see the way they're thickened there, and they're black? That shows that there's some wear and tear there, or hypertrophy. It's not a disease. It's really just possibly – and the word to use is *possibly* – possibly a source of pain. It's not definitely because we can't tell from scans if the structure's causing pain or not. We can just say it *may* be. It's difficult to know the exact source of the pain without doing any more tests.

The ways to manage this are – you can obviously take painkillers, you can rest and exercise and do those things that you've been doing. I think because you've had it for so long – a couple of years now – and it's not improved, the reasonable thing to do would be to try some form of injection to see if we can find exactly where the pain is coming from. It might be that the pain is coming from some of these joints down here that we saw on the scan and that are tender when I examine over them.

But the only way to find that out is to do what's called a nerve block, where you put in needles into the back here – into where the nerves are, the facet joints – round there and you freeze it. A bit like a dentist looking for a bad tooth – try and find out which one's sore. We think it's down here somewhere. See if that helps it and give an indication if the pain comes from there. That may help it for a short time, or it may help it longer, or it may not help it at all. If it doesn't help it at all and it's been done right, then we can assume the pain's not come from here.

If it's not come from here, then there are other causes we can look at. But that's the simplest thing. And if we do find that it's come from there, there is some treatment that we might be able to help it. We can do radio frequency treatment which may benefit it.

The idea in this treatment is not to cure the pain, but to relieve it – to allow you to get more active, to get the muscles built up again, to do exercise and get the weight down and just get more fit again. So it shouldn't be seen as a treatment on its own, but should be seen in conjunction with – we call it rehab – it's really just more activities and targeted therapy.

The one I would do would be done fairly precisely in the theatre, where you go to the day theatre and you lie on the operating table and we take x-rays of your back and we try and find where the structures are. We can't see the nerves but we use the x-rays to help us guide the little fine needle to where the nerve should be at the joint. And then we usually put two or three injections with you awake to tell us what you feel, to test it, and then see if that helps it or not. It's a very tiny amount of anaesthetic used in a controlled manner to see if that can precisely find if the pain's coming from there or not. And if it is, then there might be something we can do to help it.

Patient 4: Well that's great. As long as I can get release, that's great.

Cooper: Any questions?

Patient 4: No that would be great.

Cooper: Ok, so that's fine.

Patient 4: Let's get to the bottom of it at long last.

Cooper: Well, hopefully we'll get some benefit.

Patient 4: That's great. Thanks very much.

Cooper: Ok then, bye bye. Ok, that's good.

Evans: The nerve block injections – they are there purely to identify?

Cooper: Purely diagnostic. They *do* sometimes have a therapeutic benefit. We're not sure why they have a prolonged benefit, but it *could* be because they are reducing the vicious circle – reducing the pain, reducing the spasms and allowing the patient to do more – and that could be what it is. It's unlikely, however. But the point is that I do them in a controlled manner: patient goes to theatre, they have it done with periscope guidance to identify the targets and the bone where the nerve should be and a small tiny precise amount of anaesthetic – usually about 0.5ml, a tiny drop – is placed where the nerve should be.

And if that helps it, then we consider it a positive result. If it doesn't, it's a negative result. And then we will repeat that sometimes – repeat it to see if it gets a different result with a different type of anaesthetic. And if that helps, then we can say to the patient 'we're fairly sure – not 100% – fairly sure this is where your pain's coming from'. And if it's coming from there, the fact that we've identified it as a source of pain will help a lot of people. But, then we can offer another treatment – often we do radio frequency where we simply reablate the nerve, or cauterize or burn the nerve with radio frequency treatment in the same manner. And that should give a longer term result.

However, it's important that the patient realises that this is part of a rehabilitation strategy, where you don't get through the procedure and go away. They have to work at it, they have to improve their function and build up their muscles and change their lifestyle a bit – lose weight, build up the muscle tone at the front of their abdomen and hopefully reduce their analgesics and keep more active. And that's important to get that emphasis on. People call them facet joint injections but they're called precisely 'medial branch nerve blocks'. The joint injection's not something we normally do.

Evans: And back pain is a major problem.

Cooper: A major problem. In all age groups.

Evans: But you're seeing extreme cases.

Cooper: Yes, yes, I must emphasise that: I'm seeing patients who have had pain for at least a year and some cases much longer. I generally do not see patients that have had pain less than six... several months – that would be the exception. Invariably all of them have treatment elsewhere, they've all seen their GP, had physiotherapy treatment – the majority have physiotherapy treatment – they've all had some sort of exercise programme and they've had several analgesics and maybe seen others specialists as well.

I do think, however, that we probably should be seeing patients earlier to try and prevent some of this kind of chronicity by doing earlier intervention: whether that be in the form of more active physiotherapy or more active rehabilitation or more earlier interventions – diagnostic interventions, treatments to do that. I think that we probably should be seeing them earlier. But you're right; I'm seeing the tip of the iceberg.

Evans: But it's important for people with back pain – including me, including just about everybody I know – not to get on your list and get operated on.

Cooper: I agree entirely, because I don't want to be doing procedures on patients. I want patients to manage their pain, to get better themselves without this. But, you know, they have tried that. I do encourage them to try again before they do this and if there's any doubt I'll not do an intervention. The risks of the interventions are very low depending on what we do, but obviously it's better not to interfere if you don't have to.

Evans: Dr Ron Cooper's final patient has had back pain following a car crash.

Cooper: We did radio frequency treatment where we did nerve blocks and burned the nerves and did you find that helpful?

Patient 5: It is absolutely fantastic, that's exactly what I was looking for. Absolutely perfect.

Cooper: Ok, good. [Laughs] Because you had actually come looking for this treatment anyway.

Patient 5: I'd done my own research on the internet – Google's brilliant – and was speaking to a person who said to me – I think the general safety guarantee's like a year. But he was well into his fifth, sixth year and knew somebody else who was in their eighth year – pain free, spasm free.

Cooper: Tell us about how you found the procedure in terms of discomfort? The actual doing of the procedure.

Patient 5: The procedure – I don't know... from the girls' faces and that feedback there at the time – a big bear hug... at the time. It was, like I said, an hour, an hour and a half of pain and discomfort, but it's going to save me, hopefully, any amount of it.

Cooper: Was it worse than the dentist or much the same as the dentist?

Patient 5: Then dentist doesn't really bother me at all. I have quite a good pain threshold, you know, but it's just if someone's sticking a needle into the sorest part of your body...

Cooper: Do you understand that we had to find the sore bit to treat it?

Patient 5: Oh yeah, I fully understand the whole thing. But it's the fact that I got six nerves done. Is that...?

Cooper: You're unusual in that you had both sides done at once. Normally I would only do one side. And the reason I'd do one side is because it is uncomfortable. But you wanted to get it over with in one go and you did that and you're away. How soon after did you notice pain relief?

Patient 5: Pain relief? Instantly... well, I suppose I was still under the effects of the anaesthetic and stuff, but from there on out, straight away. I was out in the waiting room for sort of like an hour and a half, two hours and I was very wary of getting down to put on my socks and shoes, which has given me bother for the last five years and it was absolutely pain free from that moment, right on.

Cooper: Painkillers – have you taken any?

Patient 5: I try not to take any tablets.

Cooper: But you do know – I've explained to you – it's important to keep active. And you're an active person anyway and you keep yourself fit and in good shape and it's important to maintain that.

Patient 5: Yes.

Cooper: Over the years to maintain it – because I never to say to anybody 'this is the treatment, that's it'. You have to try and work it out yourself. But anyway, good luck with your stuff.

Patient 5: Thank you.

Cooper: Bye-bye now.

Patient 5: Cheers, bye.

Evans: You've seen about a dozen patients today and I've been privileged to sit in on it. There have been some very, very good results and some that perhaps need a little more help.

Cooper: You have to realise in this field that you will not help all of the patients all of the time and you will help some of the patients some of the time. And you really have to be prepared to accept your own treatment, if you like, failures. But try and always offer the patient

knowledge or refer them elsewhere for a different approach. And just remember that you shouldn't use the same thing on everybody and just because you can't do that doesn't mean it can't be done – patients should be referred on as well and there are other ways to tackle problems. My advice for intervention is always use the least invasive, least risky procedure first, after other interventions have been tried. And it's not the be all and end all, but it does help some patients fantastically well.

Evans: My thanks to Dr Ron Cooper, Consultant in Pain Medicine and Anaesthesia in Causeway Hospital, Coleraine, and to his patients for allowing me to be in on their consultations. Don't forget that you can still download all the previous editions of **Airing Pain** or obtain CD copies direct from Pain Concern. If you would like to put a question to Pain Concern's panel of experts or just make a comment about these programmes then please do so via our blog, message board, email, Facebook, Twitter or pen and paper. All the contact details are at our website, which is painconcern.org.uk. The last thought to Dr Ron Cooper on the interventional approach to pain management as opposed to the non-interventional approach.

Cooper: Some people seem to think that the only ways to treat conditions are by using needles or injections or burning or frying nerves and the others seem to think that there's no role for that at all and it is only for psychology: it's all in the mind – behaviour, exercise, rehab.

Most people that I know are somewhere in between and that one can't really exist without the other. And all the patients I intervene on, I tell them that they *must* have some form of rehabilitation, some other way to back it up. And I think there's room and in fact it's essential that we work together. And the British Pain Society, while it has all its different special interest groups, namely, the interventional pain society, which I was the past chairman of, there are the psychology group – they are a multi-disciplinary society and we must have multi-disciplinary working and that's essential. Regardless of how much intervention we do, we all have a role to play and we need more joined-up working.

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