Dear Editor,

We appreciate and agree with what seems to be the crux of Dr. Richeimer’s editorial: “…we want pain medicine to be viewed as a legitimate medical specialty, with a broad knowledge base & a wide arsenal of treatments…” However, we strongly disagree with his statement: “Hopefully, it is clear that the trend toward the use of the label ‘interventional pain medicine’ is very problematic for our specialty.”

The valid points that the author makes are diminished by the derisive tone of this letter. The two anecdotes that he provides upon which he builds his arguments (there are no data or statistics presented) seem to be attestations to the superiority of his skills over those of the referring physicians:

1. The 23-year-old woman with complex regional pain syndrome (CRPS) who was “…referred to a community pain specialist who immediately started procedural treatment.” Following this, the patient was referred to the author’s pain clinic and received two years of medications and psychological therapy without much relief before finally receiving a spinal cord stimulation (SCS) with 60% reduction in pain.

The ASIPP guidelines indicate that this patient should have been offered not only psychological INTERVENTION but also SCS INTERVENTION much earlier in the treatment with reduced costs and, based on available literature support, higher likelihood of functional improvement and return to work.

2. “I saw a 42-year-old male with right buttock pain that radiated down the thigh.” The balance of the history is that the patient received three epidural injections and three facet injections elsewhere without relief and prior to referral. The author examined the patient, made the diagnosis of piriformis syndrome, INTERVENED with trigger point injections and physical therapy with a good outcome. The author’s conclusion is that only he performed an appropriate examination and this led to the correct INTERVENTIONAL treatment and that the previous doctors performed multiple unnecessary spinal injections.

Assuming that the provided history is correct, ASIPP guidelines were not followed by the physicians who performed the spinal injections [1,2]. The comment about being the only physician to perform a correct physical examination requires no response except to note that self-reporting definitionally presents issues of potential bias. Additionally, it should be noted that, according to the Office of the Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS), fraud and abuse associated with spinal injections such as facet injections are largely a problem among physicians who do not consider themselves to be interventional pain specialist [3–5].

Furthermore, Dr. Richeimer opines: “Another reason that drives the trend toward ‘interventional pain medicine’ is the perception that prescribing pain medications involves adding a large component of medical-legal risk to the practice.” As evidence, the author relates the case of a physician who did not consult an interventional pain physician (or any other pain specialist) regarding an elderly man dying of cancer pain. Although the patient was discharged from the hospital to the care of a hospice, where he subsequently died, the physician was found to be inadequately trained in opioid management guidelines (such as those published by ASIPP) [6] and, therefore, reckless with a jury award of $1.5 million. This was later reduced to $250,000 by the judge.

Is it Dr. Richeimer’s contention that prescribing opioids results in a higher medical legal risk than providing complicated interventional pain procedures? To our knowledge, this argument is not supported by any closed claims analysis—or for that matter, assessment of malpractice insurance costs. In fact, most interventionally capable practices routinely prescribe opioids when indicated. Interestingly, the vast majority of pain pills are prescribed by physicians without any formal pain training. Indeed, in many of these practices, nonphysicians prescribe controlled medications with little or, in some areas, no oversight by any physician [7].

Is the author trying to link this unfortunate anecdotal case of a poorly trained noninterventional pain specialist treating end-of-life cancer pain as a cause célèbre for eliminating interventional pain management in such cases? In the interventional pain literature—and as taught in the ASIPP comprehensive controlled substance training seminars—highly effective techniques including systemic polymodal pharmacological approaches, intrathecal pumps, tunneled epidural catheters, and...
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neuroablative procedures are just a few of the tools available to a well-trained interventional pain physician to achieve pain control while preserving quality and dignity of life.

Is the argument being made that the US medical system does not write enough opioids for pain? In the context of lacking rigorous scientific data to support long-term management of chronic pain solely with opioids, why does the author not mention the issues of epidemic abuse, morbidity, mortality, and fraud associated with prescription pill diversion \[7,8\]. The National All Schedules Prescription Electronic Reporting Act is the product of ASIPP’s efforts to forward the goal of preserving access to opioid analgesia therapy for suffering patients while at the same time addressing this enormous public health problem \[7\].

ASIPP has and will continue to provide support, training, and research of clinically meritorious, evidence-based approaches for treating chronic pain while leading the effort to rein in abuse and overuse of procedures. We acknowledge the need to do even more, but we believe that editorial comments that are foundationless, divisive, and accusatory are counterproductive to these goals.

The author decries the word “intervention” while actually only describing interventions that he performed to achieve success. Perhaps because of his background as a psychiatrist, Dr. Richeimer wrongly feels that medical societies such as ours do not understand, value, or advocate for the use of appropriate “noninterventional” approaches.

His conclusion: “If there are pain doctors that do not have the knowledge and expertise to assess the complex pain patient, and to prescribe a wide variety of pain-related therapies, medications, and adjuvants, then they either need to get the knowledge and training, or they should stop calling themselves pain specialists.”

We agree. However, the editorial comment does nothing to help in this regard.

References


