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Pain practice in Nepal thirty years ago: A practitioner's Quest

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Abstract

The article describes the initial days of the authors pain practice in Nepal.

Keywords: pain; pain clinic; pain medicine; Nepal

Article History

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Pain management, until the last five decades, was based on theories which were amazingly bizarre, anecdotal, unreliable and unpredictable. Traditionally, surgeons operating on the brain used to get involved in the management of pain. The surgical literature from 1930-1960 is filled with the report of varieties of neurosurgical (nerve and brain-related) adventures which were mostly based on biomedical model (medical and surgical methods of disease correction). Some of these destructive procedures were devastating and the patient had to accept the loss of body function for pain relief. That was a time when the other accompanying complexities of pain were ignored.[1]

Into this Milieu, the publication of gate control theory by Melzack and Wall in 1965 created a revolution in the thinking of pain philosophy and management and had a remarkable scientific impact.[2] This theory was formulated on the basis of clinical observations and experiences, incorporated into the physiological data. It was not however intended to be a perfect and complete explanation for pain but was rather a functional way of approach to the problem.

Pain management direction took a different mode after the theory. Rather than irreversibly destroying their peripheral and central nerve tissues, the new treatment goal was to achieve "interaction" of various therapeutic strategies ranging from nerve tissue

stimulation to pharmacological agents with inherent and endogenous "control systems" of brain modulation. The science of pain management was rapidly developing in the western world. However, in a developing country, I was struggling to create a pain clinic. This article describes the initial days of my pain practice in Nepal.

Pain medicine in Nepal: Scenario of the past 30 years

One important event in my life, in a small village in western Nepal named Ridikot in around 1940s, me, an 8-year-old boy had a severe toothache on the left side which kept on increasing in intensity. This region was a very difficult and treacherous region of Himalaya with absolutely no access to modern medicine. As advised, I visited a local "healer". She kept me in left lateral position with my left palm beneath my ear. After a fascinating ritual, she asked me to sit up and show my hand. What I could see was one small lively insect crawling on my hand. Strangely my pain was totally relieved. Time and again, I did wonder about the probable reason for this, but now I guess it was an act of attention diversion / a placebo effect.[3] I think she enabled me how to manipulate the connectivity between the emotional and modulating act of psychology. This event created a lot of curiosity in me for the answer of what had happened to my pain and how?

Later, in October 1970, one fine morning in the military hospital, new road, Physician Dr Shyam Pandey asked me to travel with him. He also asked me to take and oxygen cylinder and relevant anaesthesia accessories. He, however, did not reveal the purpose of this preparedness and destination. After few minutes of drive, we reached the royal residence in Maharajgunj. We waited for some time for the permission to enter the room on the first floor where the crown princess resided. Dr Pandey was a personal physician to the princess. He told me that she was suffering from chronic low back pain. Upon entering her room, we saw her lying on the bed. Dr Pandey introduced me to her as an anaesthetist from the military hospital and inquired her regarding what was wrong with her. She complained about her inability to even sit up. Dr Pandey was already informed regarding the arrival of one American pain specialist. He used to come all the way from New York to treat her recurring exacerbation of a backache. He had successfully treated her pain in the past and on that day he arrived in Kathmandu to repeat the same epidural steroid injection, and we all were standby onlookers. At the end of the day, after completing his treatment, he left Kathmandu.

These events, indeed, motivated and inspired me greatly to know more, in detail, regarding pain management. It took many more years for me to start but this was already the beginning of the pain management program in Nepal which I started in Kathmandu Nursing Home, Tripureshwor.

New generation clinicians of that time were exposed to cutting-edge medical technology and procedures. They demanded quality anaesthesia and effective pain relief for all painful conditions. Two particular people among the group of medical professionals were Dr Baskota and the now late Dr RP Lohani, very graceful personalities. Dr Kishore Pradhan taught me the art of sedation and manipulation of temporo-mandibular joint pain. Dr Baidya and some other wonderful colleagues strongly advocated pain relief as a human rights issue. This hastened the birth of the "Pain clinic" in 1985 in Kathmandu nursing home and later B & B hospital orthopaedic wing. There, we performed procedures like epidural steroids for back pain with local anaesthetics, trigger point blocks, tens application, certain psychotherapy and coping strategy lessons. Eventually, The pain clinic came into existence in B&B hospital. The patients attending the clinic were referrals where the physicians had tried everything but failed to relief pain. Interestingly, these referrals were mostly (95%) from the B&B orthopaedic department. Once, a physician, late Dr Puskar Raj Satya referred a case of Meralgia Paresthetica. The doctors used to drop into my clinic and they observed the procedures we were doing. On joining the Nepal Medical college, I saw the Pain Journal in the medical college library, published by International Association of Study of Pain (IASP). We then approached the surgeons for their possible help in establishing a pain clinic, most of the surgeons trained specially in Britain told us that it was a wonderful idea of having a pain centre.

But we were so little familiar with the pain concepts and lacked past experience in its functioning until we met one very senior retired British Pain specialist named Dr Churcher. He used to regularly come to Nepal during his annual holidays. Upon our request, he accepted to be with us in our Pain clinic for

approximately 7 days a month whenever he visited Nepal. He was the one who demonstrated certain specific techniques on how to block certain nerves (Glossopharyngeal nerve) with absolute alcohol and phenol under radiological guidance in Tribhuvan University Teaching Hospital, Maharajgunj. He helped us to understand the amount of work done and scientific progressin pain management in the international arena.

I visited a few pain centres in the South Asian countries. In the Sir Gangaram hospital pain centre in New Delhi, I met the doctor in charge, Dr Jain who took us around and familiarized us with different kinds of prevailing pain conditions. It was particularly interesting seeing leukaemia pain being managed. I really got re-educated in pain management procedures again. I also visited a few other pain centres in the European countries like Germany and Austria where I attended some pain congresses as well. On one such visit, I was amazed to see a pain specialist in the Heidelberg University pain centre pouring a highly lethal dose of morphine into one implanted container releasing the required amount slowly and in a regulated method. However, we eventually found was that the regional and especially the South Asian pain management centres were more realistic and practical for us in Nepal.

I shall never forget Brigadier Salim from Pakistan, a renowned pain specialist, writer of books on pain and the one who established pain management programme in Pakistan. We were introduced by Dr Gautam Bajracharya in a conference of Anesthesiologists. He presented a plaque of appreciation from Pakistan Pain Society as I was the only physician practising pain management in Nepal. The Bangladesh pain society also presented a plaque for attempting to establish the pain centre in Nepal during those times. After exploring the regional and foreign pain centres, I realized that we all South Asians share the similar bio-psychosocial background and contextual cues. Our approach to pain management model in Nepal should be more similar to them rather than that of the Western countries.

With all the exploration of different international hospitals, our clinic gradually got better. We were hoping that one day the pain clinic would be a multidisciplinary centre providing all kinds of pain-relieving facilities for different kinds of acute and refractory pain conditions. We started thinking that the chronic pain conditions will be managed collectively by a team of different medical specialists and talents.

Broadly, we encountered two types of patients in Nepal; one living in city areas like Kathmandu having better access to modern medical facilities and another living in the mountainous region, deprived of similar privileges as city dwellers, but sharing a similar type of diseases and pain conditions. Our pain centre was placed in a facilitated area like Kathmandu, we were treating more city dwellers rather than mountain dwellers. We were seeing a few patients in the clinic suffering from intense cancer pain, AIDS pain, Failed Back Surgery Syndrome and a few cases of Persisting Post-Operative Pain. We also encountered very refractory type headaches such as Cluster headaches, Trigeminal Neuralgia (Very rarely seen), Musculoskeletal Pain, Post Herpetic Neuralgia and Migraine Headaches. Among the very common pain problems were Trigger point pain, Rheumatic pain diseases and so on. Regarding the pharmaceutical agents, only a few pain-relieving drugs were available at the time. The restricted availability was primarily owing it to the unrestricted and uncontrolled use of those drugs by addicts.

The people living in the most difficult mountainous regions with no proper means of transportation as well as unavailability of the communication system are comparatively less educated and poor. They have poor access to our healthcare system.[4] Most of the times, doctors visit these areas in the form of medical camps and outreach clinics.[5] They did not have the privilege of seeing a doctor during illnesses. Their treatment of choice, whether for pain treatment or other diseases was locally available medical systems like traditional medicine and spiritual rituals and herbal plants. These rural people strongly believed and expected miracles from "Dhami-jhakri". Dhami-jhakri is the Nepali word for shaman, so-called Witch Doctors. The "Dhami-jhakri" create a highly charged emotional milieu during the treatment ritual as to defuse emotional tension. In the high hills, this method is still considered as a therapeutic agent to please the angry spirits.

A Dhami makes the people and patients believe whatever he says. This seems to be similar to the Henry

Beacher's experience of "Power of Expectation" during the management of pain of wounded American soldiers when allied forces landed in Anzio beachhead in Italy.[6] I also believe that conscious awareness of the healing encounter plays an important role in triggering a placebo response and enhancing therapeutic effectiveness.[7] Another way of treating and satisfying the angry spirits was by sacrificing animals like "Kukhura" (chicken) and "Hass" (duck). The alternative way of treating illnesses including pain was to advise the patients to wear what was believed to contain a powerful medicine around the wrist, ankle or neck a "Junter" or keeping some religious book under the pillow as an effective antidote to protect against potential bad dreams and nightmares. Blessings by sages like "Khaptad babas" was also considered very effective. All of which are cases of diffusion of emotional tension considered as a therapeutic goal for piled up and hidden emotional stress. All of which I believe today occur as "Placebo Analgesia" which is a scientific topic of tremendous research these days. In my opinion, this is a way of shaping the expectation in altering the neurobiological response to pain and the process has nothing to do with quackery.

After I left the B&B Hospital, the circumstances and contexts I encountered were mostly very pungent and discouraging. It was difficult for me to get a chance to talk about pain management, especially on placebo analgesia and its effects in the local conferences. I even had to spend a lot of money to make a presentation. Despite all the odds, I established pain clinics in two medical colleges. Once I tried my luck to establish a palliative pain clinic in my own residence in Nepalgunj. I did not get even a single referral and no patient turned up. Gradually, age started taking a turn for me and I stopped all the adventures in the pain management program.

Lastly, I kept on persuading junior doctors to join me in my efforts for establishing IASP chapter in Nepal. Perhaps failed to evoke the interest in them. All this time, I was an IASP member from Nepal. I helped few anesthesiologists and pain practitioners visit pain conferences. However, in an IASP conference taking place in Sydney, my paper about problems in pain was accepted for presentation, but I couldn't afford that trip.

In conclusion, I feel, the government of Nepal and the government health organizations and upcoming anesthesiologists and pain practitioners have a lot to develop the field of pain management. There is a scarcity of research and publications in this field in our country. There is still no data on simple pain facts like the incidence of acute postoperative pain and prevalence of chronic pain in Nepalese population. The placebo effect of the "healers" still remains the main treatment procedure in rural Nepal. The pain specialists now have to focus on developing a pain ward to treat patients with chronic pain and refractory pain conditions. As a pain specialist, you should have the knowledge of identifying the emotional and cognitive states of the patients and the non-pharmacological modulation. We already know these patients need patience, time including cognitive and behavioral communication. This all might not be possible without a team approach.

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