

Definitions

anesthesiologist - a doctor who specializes in giving drugs that block, prevent, or relieve pain, especially during surgery

central nervous system - the brain and spinal cord

central pain - pain associated with an injury to the central nervous system

dermatology - medical specialty focused on problems with the skin

ER - emergency room

MRI - Magnetic Resonance Imaging; diagnostic device which uses a strong magnetic field to create images of the body's internal parts

modality - a method of treatment

nanotechnology - the science of making devices that are extremely small, about the size of a molecule

narcotic - class of drugs derived from the opium plant - or created synthetically for the same effect; used as pain-killers

Nash syndrome - disorder of the liver

neuropathic - abnormal pain caused by damage to the nervous system

nociceptive - normal response to pain

opioid - narcotic

orthopedics - branch of medicine that deals with the muscular and skeletal systems

pulmonary sarcoidosis - a rare disease involving inflammation, stiffening, and sometimes scarring of the lungs

syringomyelia - neurological condition where a fluid filled cyst forms in the spinal cord

Pain Expert, Pain Patient, Pain Advocate

Pain. Everyone feels it - especially people with Chiari and syringomyelia - and everyone has their own views on it. One person with a very unique view is Dr. Mark Gorchesky. Dr. Gorchesky spent years as an anesthesiologist and pain medicine specialist, treating over 100,000 patients before his career was cut short by a chronic, debilitating, and painful condition. After treating pain patients for so many years, Dr. Gorchesky got a first-hand look at what it's like to navigate today's healthcare system.

Although his health problems may have knocked him around a little bit, he did not let them knock him down. A man of tremendous passion and spirit, he decided to use his experiences to help people in a different way, by starting the PAIN Foundation of Western Pennsylvania.

As a pain specialist, pain patient, and pain advocate, he offers unique insights into the world of pain. Dr. Gorchesky agreed to share his thoughts, feelings, and knowledge with us, In The Spotlight...

Let's start by talking about your experience as a pain practitioner. How do you define pain?

G: Pain is defined by the International Association for the Study of Pain, of which I am a member. It's the unpleasant sensory and emotional experience associated with actual or potential tissue damage. The key phrase here is the unpleasant sensory *and* emotional experience, one doesn't happen without the other. Being a chronic pain sufferer myself, I define it in simple terms, you know it when you feel it.

How and why did you become interested in treating pain?

G: At a very young age in the early 1960's, a number of my family members were quite ill in hospitals and suffered from pain and cancer. I always remember their struggles and how there were very few things available for them. As I went through college and medical school both pharmacology and the use of medications was very interesting to me and I loved to read and understand how these things work both in the spinal cord and in the brain and in the peripheral mechanisms. As an anesthesiologist, it is a natural process for us to treat pain in the preoperative period, postoperative period and even in the long term chronic setting with both acute pain and chronic pain in cancer patients. It became a natural transition for me, with my love of interventional procedures, and love for the knowledge of pharmacology and mechanisms to graduate into the wonderful field of pain medicine.

Should anyone with chronic pain seek treatment from experts?

G: Resoundingly YES! In medicine today we've graduated into very significant and highly technical and specialized areas and fields. We all see and are treated by primary medical doctors, but if things don't tend to go well, we're often referred to other doctors. For example, if you have a rash, you are seen by a specialist in dermatology. If you have bone disorders you are seen by doctors of orthopedics and bone specialists. So, if someone were suffering with pain for longer than six weeks to six months, it would be a natural progression to be seen by experts in the field, and those are pain medicine physicians.

What is a pain clinic?

G: There are a number of different types of centers the word pain clinic has been used to describe. Sometimes it refers to a single modality-like place where either it's a doctor practicing and using shots or blocks or injections; or a chiropractor just using manipulation. A pain center may have one or two different modalities but the ideal setting is a multidisciplinary pain management center or institute where the individuals are board certified in pain medicine, they use multiple modalities including physical medicine, physical therapy, psychology, biofeedback, pharmacology, regional anesthetics and a whole combination of alternative and complementary means. Treating the mind, body and spirit appears to be the best approach in the long-term with the best long-term plausible results.

What should a patient expect at a Pain Center?

G: When one enters a multidisciplinary pain evaluation center, one should expect a very thorough evaluation towards finding an accurate and correct diagnosis. If you don't have an accurate diagnosis, treatment plans will fail. In the beginning, the most important thing is supplying your medical records. They would also want to see if there are legal issues, scenes of accidents and anything written about that. They will also look at the objective data that you have had taken before, such as x-rays, CT scans, MRIs, previous procedures and surgeries, and medicines you have used. A very thorough history will be taken on all of your general medical issues, then a particular pain history will be taken about when your particular pain started, how did it get started, what makes it worse, what makes it better, does the timing of it appear to be in relation to anything, do meds make it better or worse, and your own particular opinion of why you think this is going on. Looking and reading about all of the things that have been done in the past and creating an opinion is very important. Ninety-nine percent of the decision-making in a diagnosis is often made with a very specific and thorough history. After that's completed, a very thorough physical examination will be used, a broad physical examination of all of the systems and then a focused exam on your particular problems. They should look very carefully at how you walk, how you sit, the

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of the PAIN Foundation of
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Qualifications:

- Volunteer Clinical Assistant Professor of Anesthesiology, University of Pittsburgh Medical Center
- Former Director, Center for Pain Management Shands Jacksonville, University of Florida
- Former Director, Center for Pain Management, Altoona Hospital (Pennsylvania)
- Former Medical Director of Pain Management Services, Georgetown University Medical Center
- Board Certified in Pain Management
- Diplomate of the American Board of Pain Medicine
- Diplomate of the American Board of Anesthesiology

Education:

- **Indiana University of Pennsylvania**, BS Biology
- **Ross University School of Medicine**, MD
- **Western Pennsylvania Hospital**, Internship, Anesthesiology Residency

PAIN Foundation of Western Pennsylvania

- **Mission:** Dedicated to improving the quality of life of severe chronic and cancer/oncology pain patients through research, education, and advocacy programs
- www.pain-inc.org

duration of your ability to sit or stand or move if there are limb disorders. If there are problems with moving or musculature, they may look at different lengths of your legs and pelvis, the length of your legs to the length of your arms, your spine and if there are any curvatures, muscle spasms, nervous disorders, movement disorders, even reflex changes or neurosensory changes. Once there is an accurate diagnosis, the doctor should impart a plan and a program for you in a multidisciplinary way. He should use additional disciplines to his own to help improve your situation. Goals should be to improve your function, aid in your coping through this disorder, decreasing your need and dependence on the health care system, reducing your need and dependence on habitual medications, and lastly to reduce your pain and pain perceptions. He should reassess with each visit, whether or not these goals are being reached.

Some pain experts point out that treatment - and even research - is complicated by the fact that many patients are experiencing several discrete types of pain at the same time. Do you agree with this, are there fundamentally different kinds of pain?

G: Several different types of pain can overlap or appear separately. Nociceptive pain is specifically focused in the area where you feel pain. If you stub your toe, that's where you feel the pain. Visceral pain is a vague, diffuse type of pain and is harder to diagnose and treat. Neuropathic pain is also difficult to treat due to the overlap of nerves and their functions. Central pain - due to stroke or abnormality in the brain - is also difficult to diagnose. Combinations of these types of pain exist as well.

Do you think the current pain scales and measurement techniques are adequate for both clinical use and research?

G: No particular scale is perfect, especially for humans given the male-female and cross-cultural differences. However we are getting better. Pain centers should be using particular scales to assess pain on a 0-10 number scale or pointing to faces to measure pain. Also using other assessments such as mood, functioning, and daily activity in combination to make judgments is important.

In your clinical experience, did you favor some types of therapies more than others? If so, which ones?

G: Everything is individualized per patient. The pain specialist treats each patient individually. There is always some specific nature that comes out in a case that may preclude using something, or favor one thing over another. I like the KISS method, keep it simple stupid, because the less medicines and tests and even doctors involved the better.

Do you think there are any effective treatments for people with neuropathic pain due to syringomyelia?

G: Very difficult disorder to treat. I want to underscore the importance of the correct diagnosis. There may be secondary issues in the spine, such as cysts, so it's important to have a clear and specific diagnosis. Once that is made, the neuropathic nature of the pain is difficult, because we're looking at central and peripheral mechanisms. Some medicines, such as anti-seizure drugs like Neurontin have been helpful as well as some anti-depressants. Local anesthetics and narcotic spinal infusions have been helpful in severe cases. Even some electro-stimulating procedures have been helpful. All have been used, but none have been 100% effective in this difficult disorder.

What are your views on the use of narcotics to treat pain? Should patients and/or doctors be concerned about addiction?

G: The use of narcotics is quite controversial but does have a role in pain management. Overall, narcotic analgesics are quite safe. Thousands upon thousands of patients die every year with non-steroidal anti-inflammatory complications. Those types of cases are not reported with opioids. It is unfounded to believe that addiction is quite common. As a matter of fact in the chronic pain population, the incidence of addiction is no greater than among the general population. When seen by pain experts, and managed and followed and reasonably screened, the risks of addiction are quite low and the rewards are quite high. Again, going back to the functional goals: are the patients functioning, are they coping, are they reducing their dependence on the medications and the healthcare system? Meaning they're not doctor shopping or going from ER to ER. Also is their pain and pain perception improving? Those are valuable; improving the quality of life is significant. You can't put a measure on someone's quality of life. And there is an unfounded fear among those practitioners who are not experienced with these medicines in their reluctance to use them. Often the medicines are given to the wrong patients. Patients need to be screened, especially for prior alcohol abuse, and other social factors. A pain expert does this and follows the patients closely. Choosing the proper patient is critical in opioid treatment.

As a clinician, how did you view your patients? Do you feel you were empathetic?

G: One of the deepest, most treasured things any physician can have is empathy and a deep trust in your patients. I certainly tried in every possible way to treat every person with dignity, respect and empathy. I would often tell residents and med students to put a small stone in their shoe and walk the halls that way and realize how far it is to walk from registration to your office and back. Go to the pharmacy and listen to the inappropriate treatment and costs patients face. In every angle and every aspect of patient's lives I tried to experience what they experienced. It was often a very emotional day for me on a regular basis.

Let's move on to your experience as a pain patient. Could you describe your own medical situation?

G: I've been diagnosed with pulmonary sarcoidosis with systemic manifestations including problems with my eyes, sinuses, trouble breathing, cough, and pain in the back. As a result of some of the medicines I used for treatment I have liver disease. I have Nash syndrome and spinal osteoporosis due to steroid use. Sometimes I have memory problems and depression. There's not a day that goes by that I'm not reminded of the profound effect this disease has on my life and the life of my wife, my son and my family. Not a day. Some days I wake up

and wonder why? Some days I think of patients who are suffering more and I shouldn't consider myself unlucky. I try to embrace it as something I need to focus on to improve myself rather than lie around and feel sorry for myself. I can get up and feel the same symptoms, but I can be productive and maybe make a difference in the lives of others.

What was it like going through the system as a patient after being an integral part of the system for so long?

G: It's interesting, now the doctor becomes the patient. I'd been sick before and gone to the ER for things, but never on a chronic basis where you have to keep going back to your doctors and getting blood drawn and getting constant scans - like many of the SM patients. I have to tell you, I'm not very happy with the overall system. We've made major strides in medicine, science, and tests, but we've lost the human hand and human touch. I, like many other patients, have worn the fancy gowns and had my rear end hang out as I walked the hallway, or had to turn on my side and throw up into my bed, or been so weak I needed multiple nurses to help me move. I have a profound increased sense of the special nature of what a person goes through: the loss of humanity, dignity, and particularly control, when you enter the medical system.

How has it effected your views on treating pain and pain patients?

G: I no longer clinically treat patients. Running the foundation give me a reason to get up in the morning and allows me to interact with patients and their needs and questions, and to teach and educate them through our pain support group lecture series here in Johnstown [Pennsylvania]. It has made me a better person; it allows me to see the inside of what patients are going through, because I'm the same person who has to wait in waiting rooms or gets an appointment miss-scheduled. Many of those things happen. The most important thing for patients is to not give up, not to feel hopeless and helpless, to feel that there is someone to talk to, and to use their own God given mind to get out of situations and better themselves.

Can you talk about the organization you founded? What is its mission?

G: The PAIN Foundation of Western Pennsylvania. PAIN is an acronym for Pain Awareness and Investigation Network. The acronym speaks to the mission. The mission is to help improve the quality of life of severe chronic pain patients and cancer pain patients through efforts in research, education, and advocacy. We were founded in Western PA in 2002 out of my need and my significant disorder; suffering and seeing the significant loss of my energy, health, and my life. I felt there was very little out there to find in ways of help, people with ideas similar to mine or problems similar to mine. I wanted to create a place where people could view literature in the area as well as find help for some of their questions, concerns, and problems.

What has the response been so far?

G: The response has been growing. Our website is viewed by over 25,000 people a month from 25 different countries. It's very difficult to for me to imagine the success so far and we are slowly accomplishing our goals.

What do you hope to accomplish over the next 1-2 years?

G: I hope to accomplish further alliances and partnerships with groups, hospitals and non-profits to bring in and assimilate information and to streamline the information and deliver it on a regular basis to patients, families, and even medical professionals. We would like to improve our website and include a regional resources network where people can click and add on and find different doctors in the area for their needs. I want people to be able to find what they need quickly.

Where would you like to see the organization be in 10 years?

G: In ten years I would hope to have a significant endowment of money that will perpetuate the organization and its employees and can generously give to those in need of education and training, and to develop a network wide support group system.

What motivates you?

G: Several things: my faith, my family, and the patients that call daily. The faces of pain and the faces of help. Seeing people cry when they are finally helped and realize they are not alone. It's a very powerful motivator. Realizing that I don't need to feel sorry for myself, I need to do this and this is probably what was meant for me all along. And I've had to travel all these years through school and education and disease to get here. It's a wonderful journey and it continues to be a journey for me. It will not be a destination.

As both a clinician and a patient, what research really excites you?

G: Novel compounds like carbohydrates being considered as analgesics. Sucrose and glucose and fructose have been known to be analgesics; that's why chronic pain patients enjoy sweets or binge on sweets from time to time. But engineering new forms of carbohydrates are going to be potentially on the forefront as analgesics with minimal side effects. Also genetic engineering is exciting. Using common viruses or viral splicing to cause viruses to be released in your body to actually secrete or produce different chemicals or molecules to fight pain. Also nanotechnology is a very impressive process on the forefront of research which may improve the wellbeing of all of us.

What advice do you have for someone facing a lifetime of chronic pain?

G: This is simply what I say to myself everyday; you must be your own best advocate. You must believe in the doctors that are treating you and have a strong diagnosis you believe in from leaders in the field. Once this occurs you should come up with an easy, but specific multi-disciplinary plan. Reduce the overwhelming amount of medicines and procedures and improve your life through hope, happiness, health, and exercise. Try water aerobics, or alternative measures such as Tai Chi and Yoga. Healthy dieting including whole grains, vegetables,

and low fat is important. Three simple things I live for are find someone to love, find something to do, and find something to hope for.

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