Pain drawing in lumbar disc hernia

Sir–In an interesting paper in *Acta Orthop Scand* 1996; 67 (5): 470-2, Brismar et al. discuss the capacity of pain drawings to predict operative findings in patients with lumbar disc hernia. Since disc herniation is related to nociception and pain drawing to pain, I think that an analysis in terms of nociception, pain, suffering and pain behavior may increase our understanding (Loeser 1980).

It is well known that disc hernia is seen in the lumbar spine in 20–30% of persons without back problems (Riihimäke 1991)—possibly because some herniae do not compress neural structures. However, it is also known that disc herniation and enlargement of facet joints causing histological alteration in the nerve roots occur in asymptomatic individuals (Lindblom and Rexed 1948). In patients with unilateral symptoms because of spinal stenosis, there is neurophysiological evidence of nerve damage also on the asymptomatic side in most cases (Johnsson et al. 1987). Thus, it is obvious that tissue damage can occur in these cases without pain.

Even if pain drawing can be used to predict the occurrence of disc hernia in patients with sciatic pain (Udén and Landin 1987), MRI and CT are probably superior. Pain drawing reflects pain and perhaps suffering and pain behavior. We have earlier used the terms "organic and non-organic pain" (Udén et al. 1988). I agree with Brismar et al. (1996) that this is not adequate and could be misunderstood. I believe it is better to think in terms of localized pain and widespread pain. Widespread pain does not exclude local nociception or disc hernia, but it indicates that systemic factors are important. These are not necessarily psychogenic. In this context central sensitization is probably present (Woolf 1996) and there is a risk that pain persists, in spite of removal of the disc herniation. In a study of patients with herniated discs, imaging techniques were the best predictors of operative findings and psychological factors were of no value. However, as regards the outcome of surgery, psychological factors were much the best predictors (Spengler et al. 1990).

In our study on pain drawings in chronic back pain, widespread pain dominated in a group of patients evaluated for a disability pension (Udén et al. 1988), indicating a poor prognosis. Thus there is much evidence that pain drawings are more related to the outcome of surgery than to the operative findings. I also think that the expression "non-organic pain" may be replaced and that we should instead use "centralized pain, systemic pain or widespread pain", depending on the situation when the pain drawing is being used.

Alf Udén

Department of Orthopaedics, Malmö University Hospital, S-205 02 Malmö, Sweden

Sir—The main symptom in orthopedic disorders—pain—is still an enigma and deserves much more emphasis in clinical trials than is common today. In a comment on our article "Pain patterns in lumbar disc hernia", Dr. Alf Udén suggests a new terminology which seems to be relevant from a clinical point of view. Dr. Udén believes that pain drawings are more related to outcome than to diagnosis. In our opinion, pain drawings are not a one-way tool. Pain drawings could also be of value for analyzing the patient's symptoms (Vucetic et al. 1995) and, of course, if the diagnosis therefore becomes more accurate, the outcome will also improve. However, we shall soon present a short paper on outcome correlated to pain drawings.

Harald Brismar

Department of Orthopedics, Huddinge University Hospital, S-141 86 Huddinge, Sweden

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