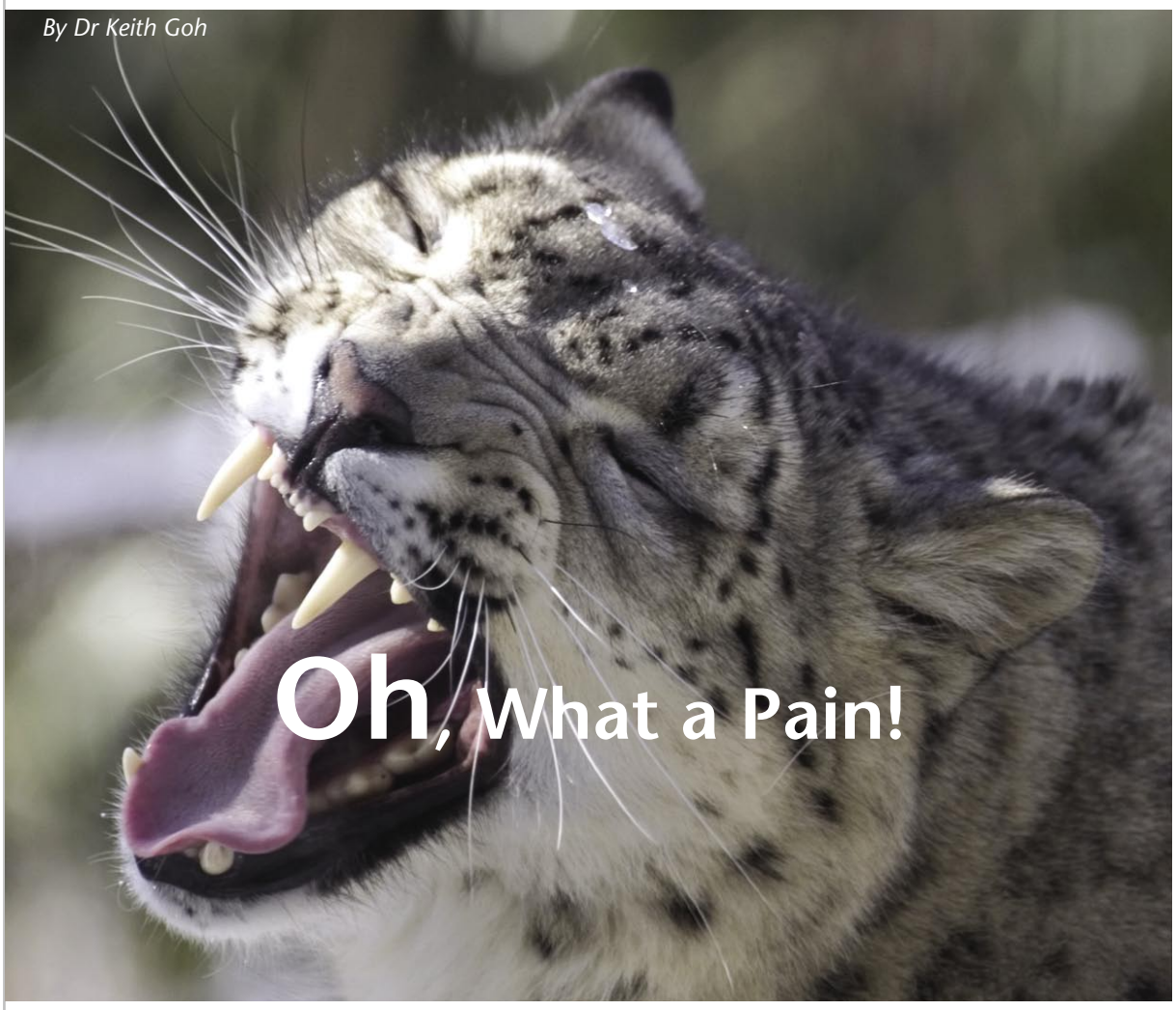
*By Dr Keith Goh*



# Oh, What a Pain!

Dr Keith Goh is now busy setting up a neurosurgery centre in the private sector, while continuing to maintain his academic links with Hong Kong and earnestly pursuing his golfing links in the region.

On a sleepy and slow weekday afternoon last week, a middle-aged lady in her fifties came to the clinic to consult me about recurring headaches which had been bothering her for many years. Being a neurosurgeon, most of these cases are not usually seen by me. Instead, they are often "triaged" to the neurologist who screens through such cases, and sends on only those cases with pathologic causes requiring surgery. The neurosurgeon is thus spared the "headache" and often, "heartache" of sorting out these difficult patients.

In many large hospitals, especially teaching hospitals or public-sector hospitals, something called a "headache" clinic is specially set up for all the difficult-to-treat cases. These clinics unfortunately, are usually delegated to the most junior registrars or consultants who have not been quick enough to claim other subspecialty interests, such as epilepsy, stroke or movement disorders. This dreaded duty often results in a painful encounter for both parties.

Since the volume of cases can sometimes be quite high, and since it takes a long time to really find out about the characteristics of the headache, a specially designed questionnaire is often given to the patients for completion before they see the doctor. After answering all kinds of questions about every imaginable aspect of headache, (and this may take up to 30 minutes to complete), the tired patient by now has a major recurrence of headache. He then meets a doctor who spends most of the time looking at the questionnaire instead of at him! Needless to say, the most common diagnosis are "common migraine", "classical migraine" or "tension headache", all of which I knew even before I entered medical school, much less neurology class.

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Well, I hope that my neurology colleagues do not take offence to what I have said – much of it is tongue-in-cheek and an over-exaggeration. Nevertheless, this particular patient who came to see me, expressed some of these sentiments, especially that she was not taken seriously enough by the "headache" specialists.

Being in private practice, I usually do not turn cases away, unless the case is something really out of my field. And as I had a free afternoon, I gave her my ear and listened to her story.

Needless to say, the most common diagnosis are "common migraine", "classical migraine" or "tension headache", all of which I knew even before I entered medical school, much less neurology class.

Her headaches were mainly bilateral, in both temples, and often worse at the end of the day. Sometimes she woke up in the morning with the pain. For the past five to six years, she was treated with drugs ranging from Panadeine, Norgesic, all kinds of NSAIDS to even Tramal. These were supplemented with Dormicum, Xanax, Amitriptyline and Lexotan. She was even referred to a number of psychiatrists and psychologists, one of whom wanted to try hypnosis, and another insisted that she had undisclosed childhood trauma which she needed to confront. CT and MRI scans were done – all normal, and even acupuncture and TCM were tried.

Could I offer or suggest anything more? It is quite hard in such a situation. Surgeons are trained to be quick and decisive, and it goes against our grain when we have to ponder such ambiguities more deeply. Furthermore, surgeons always tend to think of how to "fix" things, such as what to remove, or what to connect up, or what to implant. In fact, with all the new pain control devices such as spinal cord stimulators, drug-infusion pumps and deep brain stimulators, my thoughts almost ran riot.

Anyway, I decided that it would be best to revert to what my old boss taught me before, and that was to change the subject, talk about something else, and just try to buy time to come up with something sensible to say. So I changed the subject and asked her about her work, social activities, and so on. I found out that she worked in a bank, loved to chew gum (yes, in Singapore too) and enjoyed travelling tremendously. Unfortunately, her husband was always fed-up with her because he would be kept awake at night by her teeth-grinding!

At that point, it seemed like a light bulb was turned on (!). I palpated her TM joints, and found that they were subluxing, with a lot of crepitus. I looked in her mouth and her molars were ground down and very short. The diagnosis was obvious: chronic TM joint pain, radiating to her head, aggravated by the stress of her bank job, and the wretched chewing gum. No wonder the Singapore government banned gum.

Well, this story has a happy ending. My patient was referred to a dental surgeon who knew how to treat TM joint problems, and she eventually became much better. But I understand that it was tough for her to give up the gum!

I learnt a lot from this encounter; the problem of pain is often overlooked and swept under the carpet. Doctors in public hospitals are too busy and have too many patients to spend the time needed for these more complex cases. Doctors in private hospitals often want easily compartmentalised patients and a readily available solution. Sometimes all it needs is time, and a listening ear. ■