REPORT

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PAINFUL CONDITIONS NEED A CAUSATIVE DIAGNOSIS

By

Forest Tennant DrPH, MPH, MD

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Arachnoiditis Hope
Tennant Foundation
336 ½ S. Glendora Ave.
West Covina, CA 91790
Email: tennantfoundation92@gmail.com
Website: www.arachnoiditishope.com

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Recently I was given a report written by a prestigious professional pain organization proposing that "back pain" should be the only diagnosis assigned to this condition. They wanted to do away with any diagnosis like herniated disc, arachnoiditis, sprain, strain, or rheumatoid spondylitis. Their rationale was that pain treatment should be the same for every case, therefore there is no need to make a causative, underlying diagnosis for each patient. To me, the motivation was clear. It takes training, time, expertise, and money to make a correct medical diagnosis, and this group only wanted to treat the symptom of pain. Or, shall we, conclude that they really wanted robots to simply take a pain complaint and exercise a preconceived, no-human touch medical protocol as treatment?

The above non-diagnostic proposal goes along with the large number of papers that wish to declare pain a disease rather than a symptom. Let us be abundantly clear. Pain, as a symptom, can be part of a disease, syndrome, disorder, or condition, but pain itself is not a disease. Some diseases definitely cause pain. Good common sense medical practice has always included, and should continue to include a search for the basic cause of an individual's pain. What's more, the focus should be on treating the cause of pain rather than just treating the symptom, pain. Diagnosis is the process of identifying the cause of illness whether it be a disease, condition, or injury.

My recent experience in studying adhesive arachnoiditis (AA) has revealed some pathetic information about the failure to make a diagnosis. In an effort to develop prevention measures and treatment protocols we have surveyed several dozen people who developed AA after an epidural corticosteroid injection or a spinal tap. In these cases, the individual singularly blamed the development of AA on one of these procedures. The amazing statistic, however, is that barely a third of these individuals could give us the diagnosis that prompted a physician to do an epidural injection or spinal tap in the first place. Spinal taps were usually done in an emergency room, and only about half of these patients could even remember the symptoms that caused the emergency visit.

A great disconnect has developed between the primary care physician, pain clinic, and patient. In most cases today, a person with neck, back, or extremity pain will initially consult their primary care physician. In many cases the primary doctor will refer the patient to the local pain clinic expecting the pain clinic to determine a specific causative diagnosis and develop a patient-specific treatment plan. After all, this is what usually happens when a primary care doctor refers a patient to an allergist, rheumatologist, or cardiologist. The medical specialist makes a diagnosis and develops a patient specific plan that either the specialist or the referring doctor will follow while treating the patient. This rarely happens when a primary care physician refers a patient to a pain clinic. Almost never is a specific diagnosis made, and a "one size fits all" symptomatic pain treatment regimen is initiated. Or worse, the pain patient is given the diagnosis of "opioid use disorder" and placed on the addiction treatment drug, Suboxone® even

if they have been successfully maintained for years on opioids with no abuse issues. The referring physician may never see the patient again. The upshot of this practice is that some pain clinics are treating dozens of bonafide patients without a specific medical diagnosis other than neck, back, or leg pain, or "opioid use disorder."

There are some other unacceptable non-diagnostic scenarios these days. Severe chronic pain is often caused by a rare obscure disease such as adhesive arachnoiditis or Ehlers-Danlos Syndrome. Patients will often obtain their unusual disease diagnosis and present it to a physician for care who declares he/she doesn't accept the diagnosis. If the patient then dares to ask, "Then what do I have and what is the treatment?" It's hard to believe but the patient may then be told, "I don't accept that diagnosis, but since I don't have another one, I can't treat you." Another story commonly told these days is the patient who complains about "pain all over" and takes a long list of medications but doesn't have a causative diagnosis. Some patients have gone to a dozen or more doctors but not one has rendered a causative diagnosis.

The opioid and COVID epidemics have obscured a lot of positive diagnostic developments that have gone on behind the scenes and which greatly assist in making a causative diagnosis. Improved blood tests for inflammatory and autoimmune markers are now available. Genetic and hormone testing can not only pin down a diagnosis but also provide a roadmap for treatment. Contrast magnetic resonance imaging (MRI) which distinguishes spinal fluid from solid tissue has made the specific diagnosis of spinal canal pathologies most accessible. In summary, every chronic pain patient not only deserves but needs a specific medical diagnosis so the basic cause of pain can be treated as well as relieving the symptom of pain. Without treating the underlying cause(s) of chronic pain, the patient is often doomed to a pained life of diminishing quality until death. Modern medicine now has the knowledge and technology to do better. Why aren't we?