letters to the editor

Welcome for the Journal

To the Editor:

□ Congratulations on the new *Journal of Family Practice.* Your editorial introduction to the first issue pinpoints precisely what I have felt is one of the most important problems for the family medicine movement. It was refreshing to read; I have no doubt that the journal will be successful in accomplishing what you have set forth for it.

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Associate Professor
of Medical Care Organization
Department of Family Medicine
The University of North Carolina
at Chapel Hill

To the Editor:

□ Just finished reviewing the baptismal issue of *The Journal of Family Practice.* I thought the total effect came across very well, and I hope you are pleased with the results. In addition to the selection of articles, I found your innovative sections on self-instruction and research-in-progress to be excellent ideas.

Congratulations on a good start. Hope all continues to go well.

Robert Graham, M.D.
Assistant Director,
Division of Education
American Academy
of Family Physicians
Kansas City, Missouri

To the Editor:

□ I have received and read with great interest *The Journal of Family Practice.*

I must say that it is done extremely well, and I can anticipate that it has a definite place in the media of family medicine. My faculty and I have discussed the journal, and they concur with me in the evaluation. We will encourage our group to subscribe and to submit material for publication.

M. L. Ross, M.D., Chairman
Department of Family Medicine
University of Texas
Galveston

To the Editor:

□ Just a note to tell you that I enjoyed very much the new *Journal of Family Practice* and have just written for a subscription. This is a much-needed development and I do hope the journal will have every success.

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Psychogenic backache

To the Editor:

□ The recent article by Dr. John E. Sarno ("Psychogenic Backache: The Missing Dimension," *J Fam Prac 1(2):*8-12, 1974) is both valid and important. Physicians have for many years felt that backache represented "body language expression of emotions" (i.e., was psychogenic). Pain of psychic origin is nonetheless "real" and studies of mechanisms in psychogenic pain are in order.

I am concerned, however, that some concepts in this article may be interpreted in such a way as to produce a negative effect on physician attitudes toward back pain. My concerns are as follows:

1. The article tends to foster an "either/or" concept, i.e., real pain of discogenic disease vs psychogenic pain. Back problems are multifactorial. The most valid surgical procedure may fail when applied to the most clearly defined lesion if there is a defensive need for pain.

2. The author states categorically that "The present state of the diagnostic art in backache is such that no etiology, aside from degenerative disc disease, enjoys the support of scientific data." It is this fallacy which promotes the abuse of surgery. Is the author unaware that the back has two sets of true joints, the facets? Does anyone doubt the ability of a true synovial joint to be painful? We have repeatedly demonstrated pain, "locking" of the back, pain with sciatic radiation and pain with abnormal EMG findings reproduced by injection of hypertonic saline into the facet and relieved by local anesthesia or local and corticoid injection.

3. The important field of muscle trigger point pain is ignored. There are certainly more trigger point syndromes in the back than demonstrable disc herniations. Trigger points cannot be lumped with muscle spasm. They are precise hyperirritable areas of muscle tissue with a distinct pathology. Muscle spasm is a result, not a cause of back pain. We, too, like to give a patient a physiologic explanation of our treatment (exercise) program. We say, "It is a good back, but you need to relearn body mechanics and use the back more appropriately." Our fear about using "muscle spasm" as a pseudo-scientific explanation of back pain is that it promotes the use of "muscle relaxant drugs." We find them counter-productive, depressing and addictive.

4. Described psychometrics are not very precise. Asking the patient to draw his pain on a human figure will give a diagnosis of organic vs functional quite accurately. We find the Minnesota Multiphasic Personality Inventory to have valid predictive capability. Conversion-hysteria is clearly separated from depression in this type of psychometric test. Depressed patients respond extremely well to antidepressant drugs plus operant conditioning. A high level of conversion and a high level of hypochondriasis *without* depression gives the poorest prognosis of any pattern we see. The implication here is that the pain is working well to solve the patient's life situation.

Obviously Sarno's article was sufficiently interesting and challenging that I could not resist a critical analysis. A similar analysis of my own article ("Psychophysiology of Pain: Diagnostic and Therapeutic Implications," *J Fam Prac 1(1):*9-13, 1974) would be welcomed whether from Dr. Sarno or from readers.

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