COMMENTARY

Post-deployment Pain: A Need for Rapid Detection and Intervention

Pain, typically of musculoskeletal or unexplained origin, was one of the most common symptoms reported by military personnel deployed to the Persian Gulf prior, during, and following the 1991 Gulf War [1]. Despite the brief duration of armed conflict and the limited number of casualties, almost 15% of US Persian Gulf War (PGW) veterans have pursued treatment for Gulf War-related problems [2]. High rates of symptom clusters similar to those reported by US troops have been observed in UK [3] and Dutch [4] military returnees as well. Concerns over the prevalence of pain and other health complaints among PGW deployees led to several large-scale epidemiologic and interventional studies designed to identify symptom clusters, risk factors, potential etiologic agents, and intervention outcomes. Although the meaningfulness and associated etiology of the identified multisymptom illness clusters, which include pain, remain in dispute [2,5], evidence for the efficacy of cognitive behavioral and multidisciplinary treatment of this constellation of complaints (also termed Medically Unexplained Symptoms or MUS) has been reported [6]. Subsequently, clinical practice guidelines for MUS diagnosis and treatment were developed (http://www.oqp.med.va.gov/cpg/cpgn/mus/mus_base.htm) as a resource for practitioners.

In the last several years an increasing number of Afghanistan/Iraq War (AIW) military deployees have returned to the US and sought treatment at Veterans Affairs (VA) and Department of Defense medical facilities. Because the scope of the AIW is far greater than that of the PGW, when measured in terms of number of casualties, duration of hostilities, rates of traumatic and blast-related injuries, and intensity of ongoing threats, it is reasonable to expect that the prevalence of AIW-related medical illnesses will be at least equal to if not greater than the prevalence observed during the PGW.

To evaluate this supposition, and as part of the process for improving pain services to AIW returnees, we examined summary medical data for 619 post-deployment personnel enrolling for treatment at a large southeastern VA medical center from 2002 to the present. Consistent with the VA’s “Pain as the 5th Vital Sign” initiative [7], pain scores (using the 0–10 numeric rating scale) were obtained for approximately 90% of the enrollees during their initial visits. Of the 553 cases with scores recorded, 42.7% reported some level of current pain. Over 50% of those reporting some pain (23.1% of the total) had scores exceeding the VA’s national trigger for significant pain (pain ≥ 4).

The high rate of pain problems in this sample is consistent with the report that the most frequent diagnoses among all AIW veterans are diseases of the musculoskeletal system which affect approximately 30% of those enrolling in VA healthcare services [8]. Although the case summary data did not distinguish between acute or chronic pain, it is likely that the vast majority reflects the latter given that the time between active duty injury and VA enrollment and assessment routinely exceeded three to six months. While AIW pain intensity levels in this sample of post-deployment personnel cannot be compared directly to PGW levels because pain scores were not routinely collected during the latter era, pain prevalence was higher in our sample of AIW returnees when compared to the 34.8% reported for PGW returnees [9]. Indeed, if previous findings documenting delayed onset of symptoms among PGW returnees, where 40% of the PGW symptoms had a latency greater than one year [1], apply to AIW personnel, pain prevalence estimates based on initial VA enrollment examinations may underestimate actual rates.

Although more methodical and detailed examinations of the prevalence of pain-related problems among AIW veterans clearly is needed, this initial review has important implications for medical practitioners within and outside of the VA healthcare network. First, if the high rates of pain-related problems among AIW returnees enrolling for VA medical care are replicated among AIW veterans not seeking VA treatment, community practitioners will need to be aware of the importance of assessing for the presence of pain, as well as other unexplained illness symptoms, among post-
deployment military personnel. Second, given the evidence that early intervention in both acute pain [10] and chronic pain [11] is associated with improved outcomes, timely treatment of these problems may lead to enduring improvements in patients’ quality of life and corresponding reductions in the psychosocial sequelae that are closely associated with chronic pain conditions. Third, based on evidence of the effectiveness of multidisciplinary and cognitive-behavioral therapy treatment of PGW MUS conditions [6,12], greater access to these interventions should be made available to AIW returnees, particularly those who do not respond to alternative pain interventions. Last, as a relatively high proportion of National Guard and military reserve personnel are serving in the AIW, and because these individuals tend to be significantly older than other military groups, we can expect that a higher frequency of cases will present with significant medical co-morbidities that may complicate care.

With the continuation of hostilities in the Afghan/Iraq area, the potential exists for sustained increases in the number of former military personnel seeking treatment for pain-related problems both within and outside of the VA healthcare system. As we improve in our success in the early identification of pain-related problems we also must expect increased demands on pain care resources. By anticipating the needs of returning AIW military personnel and implementing corresponding changes in healthcare systems responsible for their care we may be able to minimize their suffering while maximizing their potential for improvement.

Note: The views expressed herein are solely the author’s and do not represent those of the Department of Veterans Affairs or the University of South Florida.

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References