CORRESPONDENCE

An Internet-Based Intervention for Chronic Pain

A Three-Arm Randomized Controlled Study of the Effectiveness of Guided and Unguided Acceptance and Commitment Therapy

by Dr. phil. Jiaxi Lin, M. Sc. Psych., Dipl.-Psych. Sarah Paganini, Dipl.-Psych. Lasse Sander, Dipl.-Psych. Marianne Lüking,
Dr. rer. nat. David Daniel Ebert, Monica Buhrman, PhD, Prof. Gerhard Andersson, PhD, and Prof. Dr. phil. Harald Baumeister in issue 41/2017

No Panacea in Sight

Considering the frequency and importance of chronic pain conditions, the suffering associated with it, and the somatic, mental, and social (especially occupational) impairments, all new preventive and therapeutic approaches that have a chance of success, as well as Internet methods for documentation and treatment, are welcome.

A point of criticism of the work by Lin et al. (1) is that a pain therapy with a rational and serious foundation requires an adequate diagnostics. Further, and especially for ongoing cases, pain therapy should not be used as a stand-alone treatment, as described for ACTonPain in the article summary, but always only as a component within the patient-therapist relationship.

Patients with chronic pain often have very complex problems requiring instrumentally and ethically differentiated measures and recurring examinations, and—last but not least—pain management and ethical competence (2).

It should also be emphasized that distinct types of chronic pain have to be treated very differently. For example, cluster headaches with a chronic course are treated in a completely different way than trigeminal neuralgia or myoarthropathies of the masticatory system with facial pain. A panacea is not in sight.

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Conflict of interest statement

The author declares that no conflict of interest exists.

In Reply:

We thank Dr. Wörz for pointing out, as already mentioned in our article (1), that a multimodal and interdisciplinary approach is the gold standard in the treatment of chronic pain. At the same time, this type of care is inaccessible to the majority of those affected, and pharmacological monotherapy is in line with our

reality of care (2). Against this background, it also appears ethically imperative to exhaust all treatment options and to promote the development, evaluation, and, if proven effective, integration of online interventions into our health care system (3).

A „stand-alone“ treatment, such as ACTonPain, offers many possibilities to move towards the multimodal treatment, for example through:

- the option of a general practitioner or specialist being able to prescribe an online pain intervention;
- the involvement of such interventions in disease management programs;
- the integration of online and offline offers (3).

A prerequisite for this is the proof-of-efficacy, which has now been shown for ACTonPain, for the first time in Germany (1).

To implement ACTonPain in routine care, which is the next logical step, the multitude of integration options should be exhausted and the respective variants to be implemented should be scientifically evaluated.

With regard to a wide range of applications and high scalability, an advantage of ACTonPain is that it presents a generic pain intervention with a wide range of application areas.

Psychological interventions focus on altering cognitive, emotional, and behavioral mechanisms for dealing with chronic pain and therefore often adopt a wide-range of area, generic approach (4). We thus agree with Dr. Wörz that treatment of chronic pain should be based on a biopsychosocial assessment at initial diagnosis as well during further diagnostic work-up (3).

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Dr. Lin, M.Sc. Psych, and Prof. Baumeister are (co-)authors and co-developers of ACTonPain.

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CLINICAL SNAPSHOT

A 21-Year-Old Man With Coronary Artery Dissection After Blunt Trauma to the Chest

Initial ECG, intravascular ultrasonography, and coronary angiography showing the acute proximal LAD dissection before PCI

A 21-year-old man was taken to the trauma room after a motorcycle accident. He was awake and oriented and complained of chest pain. He had no prior illnesses and no cardiovascular risk factors. The physical examination, FAST sonography, and polytrauma computed tomography revealed rib fractures and pulmonary contusions. The ECG aroused suspicion of cardiac ischemia, and a cardiologist was urgently called to the emergency room. Coronary angiography was performed at once and demonstrated a traumatic proximal LAD dissection. The lesion was then directly stented under IVUS (intravascular ultrasonographic) guidance. Six days after the accident, the patient was discharged home with only mild impairment of left-ventricular pump function revealed by echocardiography. Acute coronary artery injuries after blunt trauma to the chest are rare and life-threatening. This case underscores the need for 12-channel electrocardiography, rapid clinical response, and interdisciplinary management in the trauma emergency room.

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