

Dr. Mel Richardson Interview – Pain Management

By Dr. Lynn Morrison Williams

Dr. Mel Richardson III is no stranger to the practice of pain management. He has spent most of his career sympathetic to those who live with chronic pain.

Dr. Richardson graduated from the Louisiana State University Medical School in New Orleans, LA in 1980. He is a Diplomate in the American Board of Anesthesiology and the American Academy of Pain Management. He is currently licensed to practice medicine in Florida, Louisiana, and Mississippi.

Dr. Richardson first came to Vero Beach in 1987 to practice as an anesthesiologist and as the Medical Director and Chief of Staff for the Indian River Medical Center's Ambulatory Surgery Center until its closing in 2003. Since 2003, he has been the Medical Director and co-owner with Dr. Donald Proctor of the Grove Place Surgery Center here in Vero Beach. His current practice at Grove Place Surgery Center consists of 50-60% of his time spent with pain management patients and 40-50% spent providing anesthesia in the operating room - a variety in his professional practice that he enjoys.

Dr. Richardson recently sat down with VeroBeach32963 to discuss the management of pain.

Q. How did you first become interested in pain management?

During my residency in the Air Force at Wilford Hall (located at the Lackland Air Force base in Texas), I had the opportunity to be exposed to pain management in 1981. We had a pain management clinic, which was unique at the time of my residency program. I also had the unique opportunity to spend a rotation with one of the fathers of pain management in the United States, Dr. Joseph Danmiller, who was in private practice in San Antonio, Texas.

After residency, I spent four years stationed at Eglin Air Force Base in Fort Walton Beach, Florida, where I was Chief of Anesthesia and Director of the Intensive Care Unit. In addition, I continued treating and seeing patients with chronic pain syndromes. I was able to build upon the experience I gained during my residency, and then continued my pain practice when I arrived in Vero Beach in 1987.

Q. You have been working with patients who suffer from chronic pain for a long time. Are you board certified?

Richardson: I received my Board Certification from the American Academy of Pain Management in 1991. I then received certification in pain management from the American Board of Anesthesiology in 1998. These were obtained through certification testing, as there were no pain management fellowships available at the time of my residency in anesthesiology.

Q. Would you please explain to our readers what pain management is?

Richardson: It is the management of pain which can consist of the full gamut of treatment ranging from biofeedback, medical hypnosis, acupuncture, massage therapy, psychotherapy, chiropractic manipulation, as well as medication management and other treatments. What I mean by medication management is the utilization of various types of medications to help alleviate pain that affects the patient's activity and emotional well being.

Q. How do you assess a patient for their pain management needs?

I rely on a face-to-face meeting with the patient, doing a thorough history and physical examination, interviewing and a thorough review of prior treatments, medications, and tests that the patient has undergone prior to seeing me. A patient's pain history can be very complex and may require a great deal of investigation and trial and error of various medications in order to find the best medication with the least side effects in order to provide the patient with the most pain relief. Following a thorough history and physical exam, the patient may be sent for more testing. Medication may be adjusted and dosages may be changed or omitted.

Q. How do you address the issue of pain medications and addiction?

Richardson: Obviously, that is a difficult situation. Even with the experience that I have, you can be duped and manipulated by patients. I try to look for signs of addiction and for red flags. I am not opposed to the use of narcotics in my practice, but I try to use things that are milder or non-narcotic. There has to be a certain amount of trust in the patient and in what they are communicating to me about their level of pain, especially since everyone has a different level of pain threshold. I usually try to lay out a certain number of ground rules with my patients. For instance, I have them sign a 'pain contract' with me, and I give them a copy to keep at home - plus I keep one in their file. It is a serious problem at all socioeconomic levels - not just in this community, but nationwide. In addition to medical management of chronic pain, I work with the patient, the family, and their physician to manage the patient's chronic pain issues. We are blessed in Vero Beach to have many pain management doctors as well as addictionologists, and facilities such as Hanley Hall, which is open to in-patient as well as out-patient treatment of addiction.

It is important to know that I distinguish between pain medication dependency and pain medication addiction. Many of my patients are dependent on pain medication for their pain management, but do not abuse or overuse their pain medication, whereas, a person addicted to pain medication will abuse and overuse the amount of prescribed medication. I often use some anti-seizure medications and the NSAIDS (non-steroidal anti-inflammatory drugs) whenever possible. Also, Ultram, Darvocet and some of the older medications will keep the patient comfortable but functional. My patients know that I am not going to be there to police them, but if I suspect there is a problem, I will be in their face about it. It is a fine line sometimes, but I try to always be sensitive to my patients needs. At times, it can be quite scary.

Q. For patients who need to be on stronger therapy with opiates, do you offer any other suggestions for them to manage their pain in addition to their medications?

Richardson: Yes; I find that many of my patient's who choose to utilize some of the alternative therapies such as massage, acupuncture, biofeedback, medical hypnosis, and psychotherapy, often need less medication and have less severe pain symptoms. It is always a process of exploration and on-going change for chronic pain patients.

Undeniably, treating and helping patients with narcotic abuse problems is probably the most challenging and difficult aspect of my pain practice.

My goal in treating chronic pain patients is keeping the patient comfortable and functional while as pain free as possible. I often tell patients that there are physicians who give their patients enough medication to cause them to be almost comatose, but that is not my goal, and I don't want my patients in that condition either.

Q. I understand that you administer the epidural steroid injections for pain management? Can you explain some of the types of pain where you utilize that treatment?

Richardson: Any type of back or neck pain – whether it is cervical neck pain, sciatica, or lower back pain. The epidural steroid injection is now done under fluoroscopy (live x-ray). After almost thirty years of doing them without fluoroscopy, we are now mandated by the government to do them with fluoroscopy. The injections provide relief from pain for one week up to one year.

An epidural can be very beneficial for a patient during an acute episode of back, neck and/or leg pain. Importantly, an injection can provide sufficient pain relief to allow a patient to progress with a rehabilitative stretching and exercise program. If the initial injection is effective for a patient, he or she may have up to three in a one-year period. Of course, I think that my training and certification as an anesthesiologist was likely a factor in my being able to do the injections without fluoroscopy. Many other doctors now also give these injections. Epidural Steroid injections can provide either temporary or long lasting relief. The epidural steroid injection can be extremely beneficial –especially in relieving neck and back pain. I usually administer a series of three injections over a 4 -6 week period. I will repeat the injection if the pain recurs within a 4 – 6 month interval, depending on the patient's symptoms.

Q. Do you find that many of your patients suffer emotional difficulties living with chronic pain?

Richardson: Most of my patients struggle with an underlying depression of some sort. I tell all of my patients that pain is something that depletes your energy and vitality physically, emotionally, and spiritually. It is sometimes hard to tell which came first - the depression or the increase in pain.

Q. What are some of the most prevalent types of pain that you treat?

Richardson: Back pain is the most prevalent type of pain that we treat in this facility and in my practice, and is the most pervasive cause for missing work. Of course, the effects of aging certainly contribute to the incidence of back pain, but sports such as golf and tennis, where there is a fair amount of twisting motion is another cause of back pain. I have also had patients who were morbidly obese and complained of back, knee, hip, and ankle pain prior to their bariatric surgery. After surgery and losing one hundred plus pounds, they would return and report that their joint and muscle pain has disappeared.

I also see patients with complex regional pain syndrome (CRPS), also called Reflex Sympathetic Dystrophy (RSD). It is a chronic, painful, and progressive neurological condition that affects the skin, muscles, joints, and bones. RSD/CRPS is characterized by various degrees of burning pain, excessive sweating, swelling, and sensitivity to touch. Pain may begin in one area or limb and then spread to other limbs. In some cases, symptoms of RSD/CRPS diminish for a period of time and then reappear with a new injury.

I see patients with post-herpetic neuralgia or shingles, and fibromyalgia. There is a big emotional component to fibromyalgia. I see patients with nerve entrapment syndrome following hernia surgery, but probably ninety-five percent of our patients have had one or multiple back surgeries.

Q. Do you find that physical therapy is particularly helpful to these patients?

Richardson: Yes; for some of patients. Like I said, I am for anything that will provide pain relief for patients. In some cases, physical therapy is of great benefit and in other cases there is little or no benefit. I have had a couple of patients who have benefitted from qigong or tai-chi. I have even had some patients who have said that magnet therapy has helped them, although I have never seen any hard and fast clinical evidence that showed that magnet therapy would work with pain management. I am open to anything and everything that helps people. We do not know all the answers.

Q. Do you utilize a treatment called 'transcutaneous electrical stimulation or TENS'?

Richardson: No; I send these patients to some local physical therapists and to some massage therapists who use it. The purpose is to use a slight electrical stimulus to bypass or circumvent the channels where pain travels. It works well with some people under some conditions. Today, there is even an implantable version. I refer those types out as well.

There are two other procedures we do not do here, which are the narcotic pump pain therapy and the epidural stimulator (which blocks the pain). However, I do refer patients to other practitioners in the area who do provide those services. The reason I do not do them here is that I feel they need to be performed by physicians who do lots of them.

Q. What alternative treatments have you found to be beneficial?

Richardson: It all depends on the patient. I have received a lot of feedback from patients on acupuncture and massage, although I have heard some positive feedback from almost all of the complementary treatments. What I like about some of the alternative practitioners I refer to is

that if they cannot help the patient then they do not keep seeing them, but rather refer them back to me. I appreciate it when they do that.

Q. Are there any cutting-edge treatments for pain management on the horizon?

Richardson: There is a new treatment out there whereby the patient's blood is taken and spun down to get the blood serum platelets which are being used in various types of pain treatments. This procedure is not covered by insurance. Also, something called 'prolotherapy', where you inject substances between the joints, is being done by some practitioners.

The newest drug that is being used for pain management is a product made from snails - which is injected into the spine to block pain. Botox is being used to help block the pain of headaches. Again, these are not covered by insurance.

Q. What do you enjoy about being a physician treating pain?

Richardson: I like helping people. It is very gratifying to help patients and provide them some measure of relief from their pain. Chronic pain is so debilitating that when you bring a smile to your patients and their families, it is deeply gratifying.

Q. Is there anything else that we have not covered that you would like the VeroBeach32963 readers to know about your practice?

Richardson: I am available and experienced to help patients suffering from various types of acute and chronic pain problems, and the ramifications that chronic pain patient's experience. Grove Place Surgery Center and its staff are here to provide this service for the community. If need be, patients will be referred to other facilities and other physicians in the state for treatment if necessary.

Dr. Richardson can be reached at the Grove Place Surgery Center located at 1325 36th Street, Vero Beach, Florida, and by phone at 772.778.3113.

Dr. Lynn Williams has a Master's of Science in nursing and a Doctorate in clinical psychology. She has a private clinical health psychology practice, Mind Health, on the barrier island.