- Pain / Nonprescription drugs

PREVENTION

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PAIN

While you definitely know it when you feel it, pain isn't any one thing. It has myriad causes, and the sensation—be it aching, throbbing, stabbing, an electric zap, or something else—hits your perception after making its way through different channels in your body. Pain can be short-lived or seemingly endless, intermittent or constant, and an injury or illness that puts one person flat on the sofa for weeks might barely slow someone else down. In other words, pain is complicated, and finding relief can sometimes be so as well. That's why *Prevention* is taking a look at some common complaints our readers have and what research shows can help, so you can put the pieces back together for yourself.

Here's what you need to know.

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Why WOMEN'S PAIN is pooh-poohed

BY GINNY GRAVES



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WHEN SOMETHING HURTS AND YOU VISIT YOUR DOCTOR, you expect that if a medicine or procedure exists that could alleviate your pain, the doctor will offer it up. But for a whole host of reasons, that may not happen. Research suggests that health care providers are more likely to underestimate pain in women than in men, says Tina Doshi, M.D., an assistant professor of pain medicine at Johns Hopkins University School of Medicine. "Doctors may be less likely to perceive a given [pain] score as the true reflection of a woman's experience,

MICHAEL BAUMGARTEN/TRUNK ARCHIVE.

so an 8 out of 10 from a woman may prompt a different treatment than an 8 out of 10 from a man."

This can be the case regardless of the physician's gender and despite studies showing that women are beset by more painful conditions—more headaches, lower-back and neck pain, and painful autoimmune diseases—and report higher pain scores than men with similar ailments. In one study, when participants saw videos of patients in chronic pain, they estimated women's pain, on average, as lower than men's—and judged women as more likely to benefit from psychological treatment and men as more likely to benefit from analgesics. Men and women of color face additional hurdles. Black ER patients were 40% less likely and Hispanic ER patients were 25% less likely than white ones to receive any analgesics for acute pain, found a 2019 review of 14 studies. Those groups were also less likely to receive more powerful opiates.

As you might imagine, being both Black and a woman compounds the problem. "There's this false belief that Black people in general feel less pain than white people," says Elinor Cleghorn, author of *Unwell Women: Misdiagnosis and Myth in a Man-Made World*. "It comes from a rationalization of slavery and mistreatment of slaves in the 19th century, when Black people were considered less than human. As a result, while white women in pain risk being seen as overwrought, Black women often have to fight to have their pain acknowledged at all."

Stereotypes and subjectivity

Some of the gap in pain treatment has to do with the kinds of conditions women deal with. If an X-ray shows that your arm is broken, a doctor has some objective sense of your suffering and a clear path of treatment. But what if you have abdominal pain, or an ambiguous disease like fibromyalgia, which causes widespread muscle pain and tenderness that can't be detected by diagnostic tests? The doctor will ask you about your pain—and that's when things can go wrong.

"Most pain estimation is based on a subjective report," says Janice Sabin, Ph.D., a research associate professor at the University of Washington who studies implicit bias in health care. "Only the person experiencing it knows how it really feels, so health care professionals have a high degree of discretion in interpreting it."

When there's such increased discretion, unconscious biases are more likely to creep in, says Sabin. Most doctors, of course, are there to help, but a 2018 review of 77 pain studies from around the world found that health care professionals were more likely to view men in pain as stoic and to perceive women in pain as hysterical, emotional, complaining, and even

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fabricating their pain. Also factor in racial bias: A 2016 study found that 40% of first-year medical students and a quarter of medical residents—all of whom were white—believed Black people literally had thicker skin than white people. Students who believed in this and other imaginary biological differences rated a hypothetical Black patient's pain as lower and made less accurate treatment recommendations.

It's not hard to see how such biases may lead to disaster. Take heart attacks: "When women present with chest pain—and the latest research is clear that women are as likely as men to have chest pain during a heart attack—they have longer delays in care and treatment than men," says Martha Gulati, M.D., president of the American Society for Preventive Cardiology. "And the longer it takes to treat a heart attack, the more damage the heart will incur."

"Mystery" pain

Women with chronic pain from difficult-to-diagnose conditions face the steepest challenges in getting the treatment they need. About 80% of people with autoimmune diseases such as lupus and rheumatoid arthritis are women, and research shows that on average sufferers see five different doctors over five years before they get a correct diagnosis. Along the way, many are told that their pain and other symptoms are all in their heads or labeled as chronic complainers, according to a survey by the Autoimmune Association.

And chronic pain is complicated (see page 24). An unidentifiable cause plus gender and racial biases often equals needless suffering. "What too many doctors fail to realize is that you can have a completely clear CT scan and still be in unbearable pain," says Robert Sorge, Ph.D., director of the Interactions of Nociception, Social, Psychological, and Immune Relationships via Experimentation (INSPIRE) Lab at the University of Alabama at Birmingham. And untreated pain is a larger problem, Sorge says: "It has serious negative effects on mental health, social interactions, cognitive function, and ability to sleep and exercise, all of which take a terrible toll."

Be heard!

There has been progress toward closing the gender pain gap, including research into sex-specific pain pathways and programs to help medical students and doctors become more aware of unconscious biases. In the meantime, making yourself clear

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is one way you can get the relief you deserve. Here's how:

COME WITH AN ADVOCATE. "This can ensure that you ask the right questions and remember the answers," says Penney Cowan, cofounder of the World Patients Alliance. Another person can support you *and* be a witness to your experience.

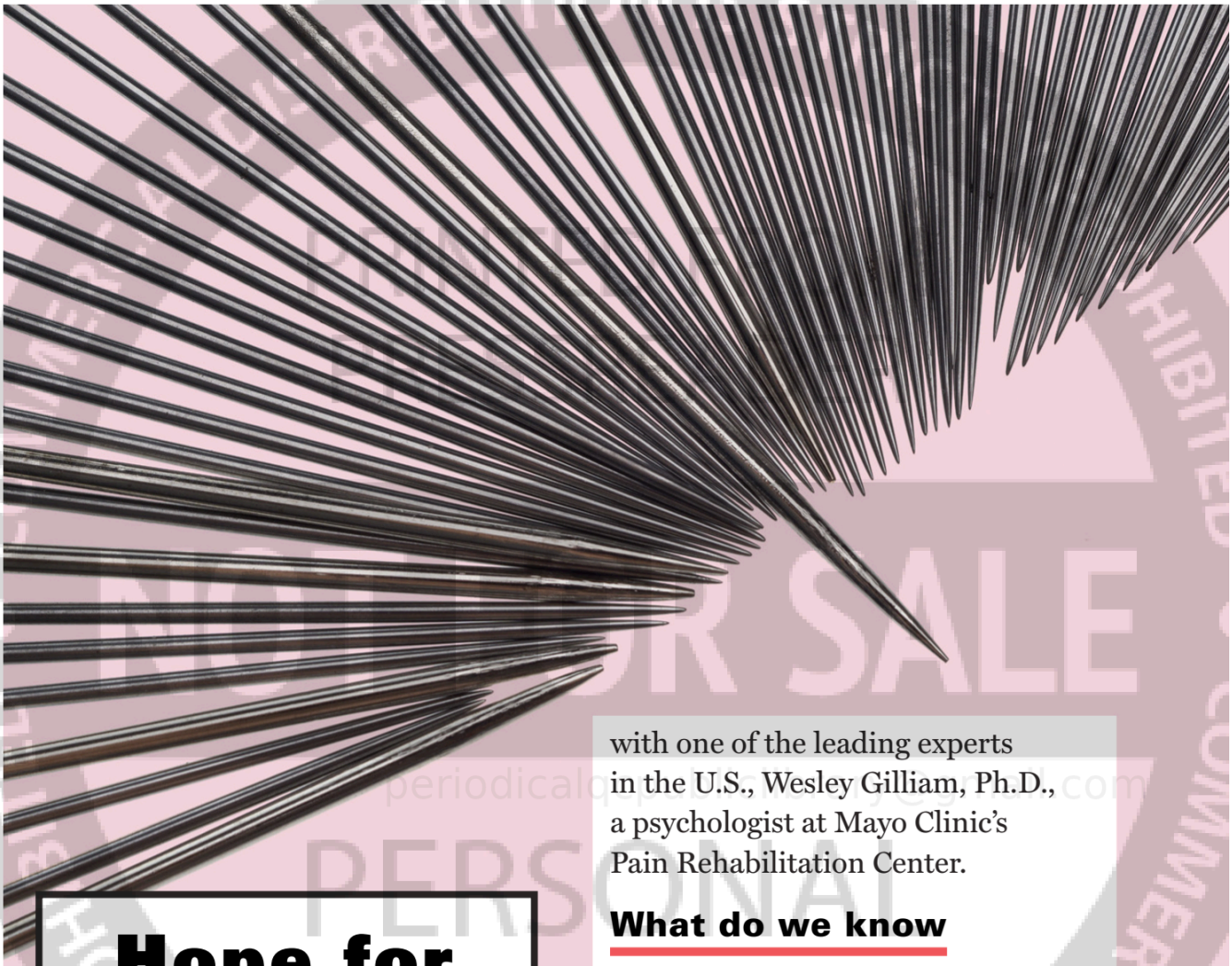
GET RIGHT TO THE POINT. Women tend to explain their pain through an emotional narrative, whereas men are more likely to say, "My arm hurts here," says Cleghorn. Studies show that the former approach is seen as less trustworthy.

BE SPECIFIC. "You could say, 'I have shoulder pain that feels like someone is taking a knife and putting it under my shoulder blade,'" says Kathryn Schubert, president and CEO of the Society for Women's Health Research. Vivid images let you describe your pain more precisely than by giving it a 0-to-10 rating.

EXPLAIN WHAT YOU'VE DONE TO MANAGE YOUR PAIN. "This can give doctors an objective sense of how bad it is," says Schubert.

DESCRIBE THE FALLOUT. "If pain disrupts your sleep or has caused you to take days off work, or you're gaining weight [because you're not moving], be prepared to discuss this with your doctor," says Marjorie Jenkins, M.D., an expert on sex and gender differences in medicine and dean of the University of South Carolina School of Medicine in Greenville. It can also help determine your best treatment approach.

STOCKSY UNITED.



Hope for CHRONIC PAIN sufferers

AN ACHY BACK AFTER A NIGHT ON A SOFA BED is one thing, but some pain persists long after you're technically healed. Chronic pain might be musculoskeletal pain, nerve pain, or both—and it's a challenge to live with and treat. For insight into what's going on, we spoke with one of the leading experts in the U.S., Wesley Gilliam, Ph.D., a psychologist at Mayo Clinic's Pain Rehabilitation Center.

What do we know about pain that doesn't come from an identifiable source?

This is called nociplastic pain, which is believed to be generated exclusively by the central nervous system—the brain. Even if you were to MRI someone with an issue like migraines or fibromyalgia up and down, you would not necessarily see anything that could account for what they were feeling. The brain is the primary driver of pain states, but for folks with pain not clearly attributable to anything physical, this can be a tough

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thing to comprehend. Depending on how the idea is articulated to them, people might think they're being told that it's all in their head, an exclusively psychological phenomenon.

But chronic pain *isn't* just in someone's head?

The pain is real. What's happening is that specific areas of the brain that appear to contribute to the pain experience work together to make up the pain circuitry. One is the emotional center in the brain, or the limbic system; another is the frontal lobes, where we make sense of what's happening around and within us. The areas of the brain responsible for memory are also involved. Past experiences of pain are consolidated in your memory—for instance, if you previously felt pain flare up while you were getting in or out of a car, your brain will activate those memories when you find yourself in a similar context. There might not be a physical reason for you to feel the pain, but you still will.

How do you help people with this kind of pain?

A comprehensive, multidisciplinary approach tends to work best. Purely medical approaches to pain intervention tend to break down over time. If you've gotten five or six injections or taken multiple medications and the pain persists, continuing to go down that pathway can be counterproductive. With pain management, behavioral intervention, and physical therapy, we see patients learn to cope better with their pain. To watch people who are in wheelchairs or using walkers come in and then be able to walk out without medications—it's why we all do this work.

What can people who can't get to your clinic do on their own?

We always advocate the importance of daily exercise. When people are in pain, they start to shift away from even basic movement, which furthers the disability process. For people who have been very sedentary, walking on a treadmill or riding a recumbent bike can be very fear-inducing—but getting them to start to challenge those fears is a core component of pain management. It can also be really helpful to create your own team, including a physical therapist and a mental health professional who specializes in pain. Think about it as learning to cope with symptoms: It's a fundamental principle of any pain management plan, and it can change what is happening in the brain.

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"Oh, my ACHING..."

JUST GOING ABOUT OUR LIVES can bring on pain in three areas of the body in particular: the back, the neck, and the knees. We sit in traffic, we hunch over our phones, we trip over a sidewalk crack, and...*whoa*! Something (or more than one thing!) starts to hurt. And even when an ache in one of these areas is relatively minor and transient, it can really get in the way of having a normal, active day.

If the pain is intense or lasting—or even if you're simply worried—of course you'll talk to a doctor. In the meantime, try some of these ideas to ease the ouch.

BACK PAIN

What causes it?

Most people will experience back pain at some point in their lives; in fact, it's one of the most common reasons people seek out emergency care, according to the NIH's National Center for Biotechnology Information. There are a wide range of potential causes, including inflammation, trauma, disc problems, and osteoporosis. Since there

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are so many things that can bring on the pain, if it sticks around you should talk to a doctor to pinpoint what might be causing it.

HOW TO EASE IT

"In most cases, back pain resolves in a week or two," says Justin J. Park, M.D., a board-certified orthopedic spine surgeon with the Maryland Spine Center at Mercy Medical Center in Baltimore. But it could last much longer, he says, depending on your age and your activity level. Your doctor may suggest a prescription medication or physical therapy, and stretching can also help (see page 32). Here's what you can do on your own:

TRY AN ANTI-INFLAMMATORY DRUG.

Research shows that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and naproxen can help reduce the discomfort. (See page 30 for more information on OTC pain meds.)

USE ICE, THEN HEAT.

For the first 48 hours after the pain sets in, break out an ice pack (or even a bag of frozen peas) and use it for 20 minutes at a time. This reduces blood flow to the area, which helps ease swelling; it also thwarts your nerves' ability to conduct pain signals. After those first two days, switch to 20-minute intervals with a heating pad to loosen tight muscles and increase circulation.

MOVE AROUND.

In addition to doing gentle stretches, standing up at regular intervals and walking can help stabilize your spine and prevent muscle imbalances. And studies have shown that regular exercise is one of the best approaches to easing recurrent back pain. Walking, yoga, tai chi, and Pilates have all been shown to help.

WEAR FLATS FOR NOW.

Having on high heels forces your back into an arched position. Flats, or even shoes with lower heels, will help.

CONSIDER ACUPUNCTURE.

There's some evidence, such as in a 2021 study review in the *Annals of Palliative Medicine*, that acupuncture can help with acute lower-back pain.

NECK PAIN

What causes it?

Maybe you slept in a weird position or on an unfamiliar bed, or your life is super-stressful right now. Or you're leaning forward toward your computer screen for much of the day, or you've been sitting in one position during a long car ride. Any of these things can cause muscle tightness or pressure on the nerves in your neck.

Some neck pain is brought on by degenerative changes, says Neel Anand, M.D., MCh, a board-certified orthopedic spine surgeon and

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codirector of spine trauma at Cedars-Sinai Spine Center in Los Angeles. As we get older, the alignment of our vertebrae can change, and that can create pressure on the spinal nerves. And of course any sort of injury that involves the head, whether from a fall or from a car accident, can bring on neck pain.

HOW TO EASE IT

If the pain is intense and/or radiates to other body parts, talk to a doctor. For localized, transient pain, these tips may help:

TRY AN OTC DRUG.

As with back pain, reducing inflammation in the area can reduce the pain, so try an NSAID such as ibuprofen or naproxen.

CHILL OUT.

Rest and relaxation may loosen those tight muscles. You can also try mindfulness, breathing exercises, or meditation to quell the stress that may be contributing.

GET MASSAGE THERAPY.

Research has shown that a series of sessions with a massage therapist can significantly reduce neck pain. One study found that people had the best results when they were able to do 60-minute sessions two or three times a week—but even once-a-week sessions helped ease pain.

ASK ABOUT MUSCLE RELAXERS.

Sometimes prescription meds, even a short course of them, can help, depending on your personal health history and how intense the pain is.

KNEE PAIN

What causes it?

Knees bear most of the body's weight, and there is more potential for problems in women's knees than in men's. The wider pelvis and weaker hip muscles women have mean their knees tend to tilt inward, which increases stress on the ACL (the anterior cruciate ligament, critical for the knee joint's job of stabilizing the leg). Natural ups and downs in levels of estrogen may also lead to more knee injuries because of that hormone's role in flexibility and bone and cartilage integrity. And women are up to twice as likely as men to suffer from osteoarthritis, a painful condition that often affects the knee joint.

HOW TO EASE IT

Acute injuries should be tended to via urgent care or the ER, and you should consult with your doctor about knee pain that is the result of a bad fall or another injury or accompanied by swelling or signs of infection such as redness and warmth. If the pain isn't intense, you can use these tips:

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MOVE IT, MOVE IT.

"Motion is lotion for your joints," says Bert Mandelbaum, M.D., an orthopedic surgeon at Cedars-Sinai Kerlan-Jobe Institute in Los Angeles. The more your joints move, the more synovial fluid (a natural lubricant) they produce, which can lead to less pain.

NUMB THE OUCH.

Along with NSAIDs, you can try a cream that contains numbing lidocaine.

COOL IT, WARM IT.

After a minor injury, you can use the same ice-and-heat process described on page 27 for back pain.

SUPPORT YOUR ARCHES.

If the pain stems from osteoarthritis, your physician may suggest specific arch supports that will take some of the pressure off your knees.

TRY COMPRESSION.

Wearing a knee sleeve has been shown to reduce pain from osteoarthritis of the knee. With less pain, people tend to be more willing to stick to exercise programs—a win-win!

THE VOORHES.

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Your Over-the-Counter PAIN DRUG GUIDE



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IF NON-PHARMACEUTICAL TREATMENTS like ice and heat aren't helping enough, there are over-the-counter meds that can bring relief, but they're not interchangeable. Here's what to take for various types of pain (and what to know before you do).

PAIN MEDS 101

Despite coming in what seems like a dizzying array of blister packs, capsules, caplets, and liquids, OTC pain drugs fall into two general groups: acetaminophen and NSAIDs (pronounced "EN-saids"), which stands for "nonsteroidal anti-inflammatory drugs." Acetaminophen targets pain, not inflammation, whereas NSAIDs are designed to target inflammation. The most common NSAID is ibuprofen, but the category also includes naproxen, which is longer-acting than ibuprofen, and aspirin, which isn't as good for pain as are other NSAIDs. Here, discover how these can help as well as some of their downsides.

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Acetaminophen

▶**Common brand name:** **TYLENOL**

BEST FOR: Fever, general aches from the common cold or the flu

HOW IT WORKS: Acetaminophen is thought to block pain nerve impulses in the brain.

SAFE LIMIT: Up to 3,000 mg a day (six extra-strength pills; about 10 regular ones), but taking even a little too much can be hazardous.

WHAT TO KNOW:

Do not take extra.

Taken appropriately, acetaminophen is safe and has fewer side effects than NSAIDs (and it's the only drug recommended for pregnant women). But overdosing can lead to liver failure within hours, and you can easily get an excessive amount accidentally because it's in drugs including multi-symptom cough and cold meds. If you think you've taken too much (signs of liver failure include nausea, diarrhea, and abdominal pain), go to the ER.

Don't take after drinking.

Mixing alcohol and acetaminophen can result in liver damage.

It lasts a while.

As long as it hasn't been in excessive heat or moisture—yes, the bathroom cabinet is a bad idea—it's OK to take a pill a year or so past its expiration date, says Jack Fincham, Ph.D., a faculty affiliate at the University of Arizona Osher Lifelong Learning Institute.

Ibuprofen

▶**Common brand names:** **ADVIL, MOTRIN**

BEST FOR: Aches and pains such as headaches, menstrual cramps, toothaches, back pain, joint pain, and muscle strain

HOW IT WORKS: It inhibits prostaglandins, chemicals that trigger inflammation and pain.

SAFE LIMIT: No more than 3,200 mg a day (16 regular-strength pills—but you'd usually take that much only with a doc's OK).

WHAT TO KNOW:

Have it with food.

You'll create a barrier that prevents the tablet from sitting on your stomach lining, which can cause a nauseated feeling, says Fincham.

Take it pre-period.

To fend off cramps, timing is key, so take a dose when your period is due; this will block some chemicals that cause inflammation and bloating.

Space things out.

If you take aspirin, wait at least 30 minutes to pop an ibuprofen. Taking ibuprofen first? Give the painkiller eight hours to clear your system.

—reporting by Kristen Dold

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