Attention Swelling and Other Clinical Phenomena

BY K. JEFFREY MILLER, DC, DABCO

Frequently patients enter the office describing an injured area as swollen, yet to me the area looks perfectly normal. The most common site for this phenomenon is the area of the vertebral prominence (the C7-T1 region). When this area is painful, patients describe it as swollen and often worry that they may have a tumor. It is difficult to convince some of these patients that this is a naturally occurring bump. Sometimes the complaint of swelling is about a hand or knee that again looks normal or just like the one on the opposite side.

When I was first in practice I thought the problem might be me. Maybe I was missing something. After all, these patients were adamant about the swelling. Maybe it was my inexperience. I did find cases where stiff muscles produced a tight feeling, similar to the tight feeling experienced with a swollen joint. However, this did not explain the majority of cases.

Later I began to think the problem was the patients. This was after I noticed the patients reporting the swelling phenomenon usually worried excessively, had low pain thresholds, and needed a little extra attention. I'm not saying they were faking it or they were a half bubble off level. They were just a little excitable.

I think this swelling phenomenon may be like the three-dimensional pictures that were popular a few years ago. At first glance, the picture is a colorful pattern or a bunch of dots. However, if you cross your eyes, squint, and tilt your head just right, you eventually see Bugs Bunny, Elvis, or whatever. I think patients become so focused on a painful area over a period of time that it begins to feel or appear different to them. The patient has probably never paid attention to this body region prior to the onset of pain and has no idea how the area looks normally.

A similar phenomenon often occurs when a child complains of a sore throat. A parent who has never looked at the child's throat when the child feels well will insist the throat is "red" despite assurance from a doctor that everything is perfectly normal.

Another explanation may be asymmetry seen throughout the body. Ring size and shoe size are often different side to side. Musculature differences in the upper extremity are often seen with the side of handedness usually being more developed. The patient may not have noticed a preexisting difference in a body region; once pain begins, the difference is noticed and concern grows.

A good example of this occurred recently in my office during an independent chiropractic exam of a female patient from an automobile accident. She claimed that her left breast was now twice the size of the right breast after being bruised by the auto's shoulder belt at the time of the accident. There was no noticeable difference in breast size fully dressed and she denied a change in bra size. I explained to the patient that one breast being slightly larger than the other is not unusual and suggested that she may not have noticed this before. *That* was a big hit! If she wasn't already mad about having to submit to an independent exam, she was now! I then suggested she consult her gynecologist regarding this particular complaint and tried to avoid the subject. No, I didn't take measurements.

Another patient recently reported his entire right leg was swollen and turning blue. He also reported feeling a knot in the posterior aspect of his right thigh when he flexed his knee. He immediately dropped his pants to show me. Both legs were pale white, the same size, and the knot was his hamstring musculature. I told him I didn't see anything abnormal and explained that the hamstring musculature always bulges when the knee is flexed. He was very disappointed in me. After

all, he had showed all the women at church and they agreed he had a swollen blue leg with a knot on it. It was the middle of summer and this guy's legs were so white it was obvious he did not own a pair of short pants. I can only assume that he showed his leg to the good women of the church the same way he showed me. I'm not making this up. I don't have that good of an imagination. I didn't ask where he goes to church, but it sounds like an interesting place.

I have thought about these situations on and off over the years before finally deciding to write about them. Since I have never heard a lecture or read an article on this subject, I thought I might be the first to describe the phenomenon. So, I considered naming the phenomenon "Miller's sign." However, despite the fact that I have a large ego and a lot of initials after my name I settled on "attention swelling" or "pseudo swelling." The "attention" is derived from the fact that they never paid attention to the painful area before it hurt; "pseudo," of course, means "false." I like "attention swelling" best.

Speaking of pseudo, I recently coined another term, "pseudoambidexterity." This evolved from asking patients to identify their dominant hand. Handedness, as you know, is important for determining grip strength, upper extremity impairment, and other clinical information. When I first began asking patients if they were right or left handed, I was amazed at how many people claimed to be ambidextrous. Actually, many of them would sit up, pull their shoulders back, and say proudly, "I'm amphibious."

Initially, I didn't question the high number of "amphibious" claims. Later I began to wonder if my patients were truly that coordinated. So I began to ask the amphibious patients what they could do with either hand. One patient could write to a degree with either hand. I say "to a degree," because one hand was very legible and the other left me with the impression she could have been a doctor. Most patients, however, were under the impression that turning a doorknob, using a fork, or petting the dog with either hand qualified as ambidexterity. This is pseudoambidexterity. The only truly ambidextrous person I have encountered was a childhood friend. He could hit or throw a baseball equally well right or left handed. And he could kick a football with either foot. He might qualify for amphibious, too, but I can't remember if he could swim. Feel free to use these terms, so long as you quote me.

This brings me to the next phenomenon: pain rating. There are dozens of instruments available these days for rating pain — scales using the numbers 1 through 10, visual analogue scales, and pain drawing, just to name a few. I like these instruments, and the insurance industry (which rarely has good taste) also seems to like them. My favorite is the scale from 1 to 10, with 10 being the most severe pain. The scale is generally easy to use. However, there can be a few glitches in this system.

First of all, everybody's a 10; at least, it seems that way. The patient who has missed work all week and was carried in by two family members said his back pain was a 10. The patient before him who stopped by after work and was scheduled to play golf after his appointment also reported his back pain to be a 10. One of these makes sense and the other doesn't. Yet, both claimed that no person in all of humanity had ever hurt as bad as they were hurting.

I think the problem lies in points of reference. Doctors have points of reference based on experience with thousands of patients in pain. Patients' points of reference are based only on their own previous experiences. If the current episode is the worst a patient has experienced, then the pain is a 10.

Have you ever noticed that the people who always rate their pain as a 10 also tell you they have a high pain tolerance? They are also more likely to grimace or cry out as soon as you lay a finger on

Number	AMA Scale	Miller Pain Scale
1	Minimal	"Oh, it ain't nothin'."
2	Minimal	"It hurts a tad bit/smidgen."
3	Minimal	"It bothers me some."
4	Slight	"Somethin' ain't right."
5	Slight	"It hurts right smart."
6	Slight	"I'm sufferin' terrible."
7	Moderate	"It hurts like far (fire)!"
8	Moderate	"It's killin' me!"
9	Moderate	"I'm 'bout ta die!"
10	Marked	"Just shoot me!"

Table 1. Comparison of Pain Scales (Number/AMA/Miller)

them. This is in sharp contrast to the patients who, according to examination findings, should have been dead a week ago, yet report their pain as minimal. To me the second group has the high pain tolerance. You can hit these people with a hammer and they don't blink. Patients with true tolerance to pain do not realize they have a high pain threshold, because they seldom hurt. Think about that...

In order to obtain a more accurate rating I give the patient points of reference when I ask for a number from 1 to 10. I do this by saying: "I need you to rate your pain on a scale from 1 to 10. 'One' means you noticed the problem but you are not going to take an aspirin or call a doctor. 'Ten' means you cannot work, go to school, drive, or do things around the house. Now, what number is your pain?" This usually works very well. It even brings the hypochondriacs down to a 9.75. Another good method is to obtain a range of numbers by asking the patients to rate their pain at its best and at its worst. The patient may relate, "most of the time it is a 4, but it can get up to a 7." These are of course suggestions. Some doctors may prefer an initial overrating since the only place to go is down the scale.

Another difficulty in using the 1 to 10 pain scale is getting a number out of some patients. If there is a phobia of numbers several of my patients are stricken with it. When I ask these patients, "What number is your pain?" I get, "It hurts right smart," or "I'm sufferin' terrible." They describe the pain ten different ways and never give a number. Maybe it is because I practice in a rural area — I don't know. This led to the development of the Miller pain scale (I just had to

name something after myself). Since I grew up in the country I felt it my duty to translate some of the more common rural descriptions of pain into numbers for my urban colleagues. Thus, the Miller pain scale. This scale — with comparison to the number scale and terminology from the *Guides to the Evaluation of Permanent Impairment, Fourth Edition* by the AMA — appears in Table 1. The scale is fairly self-explanatory.

In *Curing a Cold* (1863) Mark Twain wrote, "It is a good thing, perhaps, to write for the amusement of the public, but it is a far higher and nobler thing to write for their instruction, their profit, their actual and tangible benefit." This statement sums up my purpose for writing this article. Remember, if you document attention swelling or pseudoambidexterity you can quote me. And, you may use the Miller pain scale liberally. By the way, what is the technical name for a phobia of numbers?

About the Author

Dr. K. Jeffrey Miller recently began his fifteenth year of practice in Shelbyville, KY. He has published over 80 articles and is the author of the new chiropractic text, *Practical Assessment of the Chiropractic Patient*, which is published by MPA Media.