Sharon Shore
3 Richview Court
Thornhill, Ont.
L3T 7S9
April 28, 1998

Dr. Angela Mailis
Toronto Western Hospital

Re: Lisa Shore

Dear Dr. Mailis,

My pediatrician has received a copy of your consult letter and discussed its contents with me, specifically that you believe that Lisa's present pain pattern is primarily non-physiological.

As it has now been four weeks since you have seen her, I would like to elaborate on her present progress.

When you saw her, she had been taking gabapentin for ten days and amitriptyline for seven. Three days after you saw her, the thirteenth day after starting gabapentin, there was a significant decrease in both the chronic pain level and the severity of the stabbing pains. For the first time, Lisa began moving her leg and attempting weight bearing. The stabbing pains, while still intolerably painful, caused her to grunt, groan and cry, but she did not scream incoherently, as had been the case previously.

I have been recording her pain cycles in the past month, using the chart that you gave me. I can state unequivocally that contrary to initial indications, they are not fixed and regular. Although the worst pain is always in the evenings, she does get periods of severe pain during other times of the day. For example, on particularly bad days, there is no sudden onset of evening pain, as the pain may never have abated from earlier in the day.

The pains that occur in the evening will begin anywhere from 7:30pm – 10:00pm. Mindful of your comments that the evening onset of these pains seemed a bit too regular, I made deliberate attempts to ensure that there were no cues around her to help her consciously or unconsciously determine the time. Clocks were removed, and only videotapes were played so time could not be told by any scheduled TV programming. The pains still occur every night, regardless of what activity she is performing. They have begun while she was outside in the park, engrossed in a book, or while sitting around a table during our Passover Seder.

The pain levels, both chronic and stabbing, increase dramatically after her foot is manipulated in any way, and/or if she does significantly more walking than usual, such as occurs during a visit to Sick Kids Orthopedics. It takes about two or three days following such activity until the increased pain levels subside down to "regular" levels.

Lisa's cast was made removable last Wednesday April 22, and it was cut away to expose her ankle. It is now clearly noticeable that whenever she walks, the exposed foot and ankle turn a dark purple-gray colour.

Lisa is an extremely shy child, and – oftentimes to our chagrin - a very compliant one. You mentioned in your letter that Lisa would abruptly stop crying on your prompt to settle. Because she is so shy and compliant, it is her nature to obey a firm command issued by an adult in authority such as you. She has become quite adept at holding her pain in, not wishing to offend. It is only in the evening, when the pain is nearly intolerable, that she cannot "hold it in", and she was not experiencing that degree of pain in your presence. It is precisely for this reason that we videotaped Lisa one night, as her presentation to the doctors at Sick Kids during the day did not compare to the pain she underwent at night and they therefore tended to discount it.

We have made every attempt to ensure Lisa does not become a chronic invalid. She has gone to school on several occasions for short periods, and continues to see her friends. We also take her out visiting. Lisa and the rest of the family had a psychiatric evaluation done by the Psychosomatic Pain Team at Sick Kids, by Drs. Geist and Jeavans. I enclose a page of Dr. Jeavans' report, wherein he states (highlighted) that "...the pain would seem to have a physiological basis, even if L's response may be variable." It is understandable that you would question the family psychodynamics given that at our visit I was under great stress - having spent the previous few weeks watching my daughter endure terrible pain - but the psychiatrists at Sick Kids did not find Lisa's family relationships to be an area for concern.

While I do not discount the effectiveness of teaching coping techniques and strategies to anyone experiencing chronic pain, Lisa included, she has always been a happy, contented child with no history of psychological complaints, or problems at school. I feel that her pain is primarily physiological rather than psychological for the following reasons:

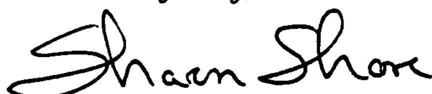
a) the decrease in the pain levels and the ability to move her leg commenced approximately two weeks after starting gabapentin and amitriptyline. This would appear to be in accordance with the usual length of time required for these medications to be efficacious, and indicative of a physiological response. (I would also point out that at no time did we tell Lisa that she could expect the medications to become effective after a particular length of time.)

b) Lisa's foot turns purple whenever she walks on it.

c) The Pyschosomatic Pain Team at the Hospital for Sick Children felt that the pain was likely physiological in origin, and did not make any comments regarding family dynamics or lack thereof, nor did they recommend any follow-up family counseling.

I would like to request that you review the additional information I have provided in this letter and consider the possibility that Lisa's pain may be more physiological than may have presented to you on her initial visit.

Yours very truly,



Sharon Shore

cc Dr. L. Gallant