Chronic Pain is a Chronic Condition, Not Just a Symptom

By Christine E Whitten, MD
Kristene Cristobal, MS


Conservative estimates indicate that 60 million Americans suffer from some type of persistent or recurrent pain sufficient to significantly affect their lives.1

The Kaiser Permanente (KP) member population includes many patients with chronic pain, and this cohort is generally characterized by a high level of utilizing medical services. Compared with other conditions addressed by the Care Management Institute (CMI), chronic pain more adversely affects quality of life, functional status, and productivity.1

Recent measurement of the KP chronic pain cohort2 by CMI showed chronic pain in 5.1% of adult KP members. This incidence can be compared with the incidence of other conditions diagnosed in the KP population: diabetes, in 7.7% of the population; depression, in 6.5%; coronary artery disease, in 3.2%; persistent asthma, in 2.0%; and heart failure, in 1.6%.

According to the recent CMI Annual Population Care Management Report,3 about a third of patients with moderate to severe impairment from a chronic condition would benefit from care management, and another third would benefit from case management (Figure 1). About 50% of these impaired patients require only support for self-care. As Figure 1 shows, patients who are moderately to severely impaired by chronic pain often demonstrate poor pain control, clinically significant deconditioning and physical impairment, and often a lack of coping skills. A state of learned helplessness may develop and substantially alter a person’s lifestyle.

The population with chronic pain has a high incidence of comorbid conditions. For example, 27.7% of members with chronic pain also had documented depression during 2000, whereas 6.5% of all adult members had depression. Compared with utilization by nonafflicted KP members, utilization of resources by KP members with chronic pain is much higher.

For example, this utilization2
• is 3.7 times higher than the HEDIS inpatient admission benchmark
• is 2.7 times higher than the HEDIS emergency visit benchmark
• includes four times more outpatient visits
• produces pharmacy costs that are 3.5 times higher.

Chronic pain is a chronic condition with its own pathological changes, its own set of clinical and behavioral characteristics, and its own subset of effective approaches to treatment regardless of etiology.

To promote healing, we teach acutely injured patients to rest passively and to focus on their pain as a gauge of when to become more active. However, treating chronic pain in the same way you treat acute pain is a prescription for failure. Ironically, the patient

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with chronic pain should not focus on pain but instead should focus on adequate pain control to allow improved functioning and independence. Care plans should aim to simplify medication regimens, decrease pain-related behavior, increase patient and family coping skills, improve sleep, restore daily activities (such as household chores and social engagements), and resume vocational activity. Use of a multimodal approach has proven highly effective in both the KP Northern California Regional programs and the KP Northwest Region’s Vohs Award-winning program.

Help your patients with chronic pain to return to improved function and independence by following four basic principles of pain management. These principles include:

- good communication between patient and clinician
- support for the active role of the patient in treatment
- optimal medication management
- use of a multimodal approach (Figure 2).

However, the degree of appropriate intervention in each category varies with acuity. The KP CMI Chronic Pain Workgroup developed evidence-based guidelines, models of care, and tools for use by clinicians and members to help primary care practitioners to effectively manage chronic pain in their patients. These tools can be found online at http://cl.kp.org/pkc/national/cmi/programs/chronicpain.

### Higher-Acuity Patients Need More Aggressive Medical Management

As with any medical condition, pain can be graded across a continuum as presenting low, moderate, or high risk of poor clinical outcome on the basis of the patient’s affective, behavioral, and physical functioning; use of medications; comorbid conditions; and ability in self-management. The earlier you identify and treat a higher-risk patient, the more likely you will be to prevent development of pathologic changes, and the better the clinical outcome will be. You must therefore recognize which type of patient you have in your office, because how you treat these patients can—and should—vary so that their care is optimized.

#### Example 1: Patient at Low Risk for Poor Clinical Outcome (level 1)

Chris trips over a box left in the hallway at home. The fall results in a twisted ankle and a scraped knee. Chris is angry with the person who left the box in the hall. Chris is also somewhat anxious about whether the ankle will interfere with driving to work the next day. Some mild spasm may be evident in the ankle and lower leg.

Chris should be evaluated and treated as indicated in the following grid:

<table>
<thead>
<tr>
<th>Pain issues</th>
<th>Interventions</th>
<th>Multimodal approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>Massage</td>
<td>Complementary and Alternative Medicine (CAM)</td>
</tr>
<tr>
<td>Anger</td>
<td>Ice</td>
<td>Physical modalities</td>
</tr>
<tr>
<td>Some anxiety</td>
<td>Gentle stretching</td>
<td>Medical prescription</td>
</tr>
<tr>
<td>Slight spasm</td>
<td>NSAIDs</td>
<td></td>
</tr>
</tbody>
</table>

#### Example 2: Patient at Moderate Risk for Poor Clinical Outcome (level 2)

Joe has a long history of low back pain and has had two back surgeries in the past five years. Joe trips over a box in the hallway. The fall results in a twisted ankle and pain radiating from the lower back down the outside of the injured leg. Joe is very angry with the person who left the box in the hall. The last time something like this happened, a two-week period of bed rest was followed by the second back surgery.

Joe should be evaluated and treated as indicated in the following grid:
Chronic Pain is a Chronic Condition, Not Just a Symptom

What worked for Chris was not sufficient for Joe, and what worked for Joe was not sufficient for Pat. Unless the patient is treated as a whole entity, the chances of a successful outcome become diminished despite receipt of good medical care. For up-to-date recommendations for delivering multimodal care, see the Evidence-Based Guidelines and Technical Review for Chronic Pain Management in Primary Care.7

**Why is Good Pain Management Critically Important?**

The past decade provides extensive information—not only about how the pain system works but also on how plastic the nervous system is in response to painful stimuli and injury. From the moment of injury, repeated pain signals produce a cascade of physical and chemical changes in the nervous system—especially activation of the N-methyl-D-aspartate (NMDA) receptor. These neuropathologic changes create new synaptic contacts, changes in neurotransmitter types and balance, receptor type and sensitivity, and can even lead to cell death. All these changes can cause pain that is prolonged, severe, or both. This sensitization of the nervous system—called “wind-up”—can become permanent if pain continues.8,9

During wind-up, pain is felt as more severe than previously. Stimuli that were not previously painful (eg, light touch or temperature change) can become painful. An example of wind-up is the phenomenon of undamaged skin near a laceration becoming painful to touch. In most patients, wind-up resolves as the injury heals; however, these changes persist in some patients. The more severe the pain and the longer it persists, the more likely the change will become permanent.10 The exact combination of pain severity, duration, etiology, and genetic predisposition leading to chronic pain are not yet known, but the need to ensure adequate pain management for all pain is clear. Research shows that possible risk factors for development of chronic pain include unrelieved moderate or severe acute pain, previous episodes of acute pain, poor coping skills, and psychologic distress. Good pain control may prevent development of chronic pain and will certainly help prevent progression of problems related to fear, stress, guarding, loss of elasticity, and muscle atrophy due to pain.

**Assessing Pain: Room for Improvement**

As is true for managing any condition, good assessment is key. The goals of assessment are to

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**Example 3: Patient at High Risk for Poor Clinical Outcome (level 3)**

Pat has a long history of low back pain and fibromyalgia. She had multiple back surgeries during a 20-year period; relief from the last surgery lasted less than one month. Because of pain, Pat has trouble sleeping. She trips over a box in the hallway. The fall results in intense burning pain in the entire leg, extending from the lower back through the buttocks and down the leg to the foot. She is very angry with the person who left the box in the hall and is almost in a state of panic: The last time something like this occurred, the pain and spasms led to five days in the hospital, and since that time—nearly a year ago—the pain has never been fully controlled. She has lost so much time at work that she worries that she might lose her job.

Pat should be evaluated and treated as indicated in the following grid:

<table>
<thead>
<tr>
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</tr>
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<tbody>
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<td>• Massage</td>
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<tr>
<td>• Anger</td>
<td>• Ice</td>
<td>• Physical modalities</td>
</tr>
<tr>
<td>• High anxiety level</td>
<td>• Gentle stretching</td>
<td>• Medical prescription</td>
</tr>
<tr>
<td>• Generalized leg spasm</td>
<td>• NSAIDs</td>
<td>• Self-management</td>
</tr>
<tr>
<td>• Lowered level for activation of pain systems</td>
<td>• Relaxation/meditation</td>
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<tr>
<td>• Hypersensitivity of central and peripheral</td>
<td>• Trigger-point therapy</td>
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<tr>
<td>nervous systems induced by longstanding,</td>
<td>• McKenzie stretches</td>
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</tr>
<tr>
<td>poorly controlled pain</td>
<td>• Antidepressant drugs</td>
<td></td>
</tr>
<tr>
<td>• Depression</td>
<td>• Anticonvulsant drugs</td>
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<tr>
<td></td>
<td>• Opioid drugs</td>
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<td></td>
<td>• Prophylaxis for side effects, especially</td>
<td></td>
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<tr>
<td></td>
<td>constipation or nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Self-care education and flare-up management plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider cognitive behavioral therapy referral</td>
<td></td>
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</tbody>
</table>
clinical contributions

• obtain the physical and historical information needed to reach a diagnosis
• guide treatment
• begin planning long-term management
• allow early identification of the patient at high risk for poor outcome so that a more aggressive care plan can be pursued
• reassess the patient’s medical response to the care plan and to monitor for side effects and complications of therapy.

Assessing Patients With Pain in Your Busy Practice

The most important first step is to ask patients if they have pain. This step may seem self evident, but pain is too often not discussed or assessed in any routine manner. Many studies done during the past 25 years have consistently shown that lack of assessment can lead to inadequate pain management. In one study of resident physicians’ skills in assessing cancer pain, more than half of the resident physicians failed to perform simple assessment of pain characteristics such as intensity. Research shows that when clinicians do not obtain overall pain ratings from patients, the pain—especially moderate to severe pain—is likely to be underestimated. These studies were done in cancer patients; and if pain assessment and treatment is done inadequately for cancer patients—cases where presumably the complicating issues of regulatory oversight and fear of substance abuse are minimal—imagine how insufficient this assessment and treatment must be for patients with pain unrelated to cancer! More than 40% to 50% of patients treated in routine medical practice settings fail to achieve adequate relief from primary pain, despite the current availability of effective treatments for pain. Assessing pain and tracking trends in progress over time can be done reasonably as a two-step process (Figure 3, top). The Numeric Rating Scale (NRS) is a validated tool used to assess severity of pain. This severity is defined as whatever the patient says it is—not how you as clinicians perceive the severity on the basis of patient behavior. However, we all have seen patients who rate their pain as being a 10—a number typically associated with hospitalization—despite their continued ability to function. Often, patients fear that using a smaller number will lead to their pain being given less priority. Teaching patients how to effectively use the NRS is a first step toward making your patient your partner in their care. For more guidance on this topic, see Christine Whitten et al, Pain Management Doesn’t Have to Be a Pain: Working and Communicating Effectively with Patients Who Have Chronic Pain.

Tracking trends in functional progress is as important as evaluating the pain score. Functional information gives an objective barometer of pain’s impact on life activities, guides future management decisions, expands the conversation with the patient (beyond asking “How’s your pain?”) and is useful for setting goals jointly with the patient. Tracking progress in this way also helps fulfill documentation for regulatory requirements related to prescribing opioid therapy.

Using KP HealthConnect, clinicians will soon easily track and record pain scale and functional scale (just as is done currently for patients’ vital signs). The basis of your care plan—ie, typical characteristics of pain sought while obtaining the medical history—can be remembered by using the mnemonic PAIN BASE (Figure 3, bottom):

- Place/location of pain
- Amount/severity of pain
- Interactions: What aggravates the pain?
- Neutralizers: What alleviates the pain?
- Breakthrough pain: How often?
- Activities: Are they limited by pain?
- Side Effects: constipation, nausea, dizziness, sedation, dry mouth?

Pertinent physical examination is a critical part of any evaluation for pain. Having these facts makes the resulting treatment plan more likely to succeed.
The Brief Pain Inventory (BPI) is another assessment tool for optional use by clinicians. This tool has the benefit of crosscultural reliability and validity and is available in multiple languages, including Spanish, Chinese, and Tagalog. Although not required, use of such tools better documents the severity of pain and its persistence.

Risk Factors for Development of Chronic Pain: Care Management Institute Chronic Pain Guideline

In patients with acute herpes zoster, acute low back and neck pain, or acute musculoskeletal pain, the likelihood of having chronic pain is increased by several risk factors:

- Unrelieved moderate-to-severe pain (an evidence-based determination)
- Age: moderate risk for patients aged >60 years; severe risk for patients aged >80 years old (an evidence-based determination)
- Self-perceived risk of a chronic problem developing (an evidence-based determination)
- Previous episodes of continuous low back pain (an evidence-based determination)
- Psychosocial factors: psychological distress, stressful life events, depression (an evidence-based determination)
- Poor functional status or high level of disability (an evidence-based determination)
- Lack of active coping skills, eg, realistic goal setting, pacing, realistic beliefs about condition (an evidence-based determination).

As these risk factors show, many of the criteria for moderate-to-severe risk relate to pain-related distress and to the patient’s ability to function (Figure 4). How can you screen for this risk and identify patients at higher risk? One way to check for signs of inability to cope in the course of long-term management is to look for these signs—sometimes called the “dysfunctional D’s”—which include the following:19

- Distress: anxiety, conflictual feelings, anger, hostility, resentment, and alienation
- Depression
- Deficits in the following: impulse control, assertiveness, attention, concentration, memory, and judgment
- Disturbed sleep resulting from pain or from other pain-related distress
- Disability
- Deconditioning.

Be on the Lookout for Neuropathic Pain!

Neuropathic pain is defined as abnormal processing of sensory input by the peripheral and central nervous system. This abnormality may be the critical process in development of chronic pain. You should suspect neuropathic pain when a patient describes the pain as burning, shooting, lancinating, “pins and needles,” or “a strange feeling” (dysesthesia). Allodynia is diagnosed when normally nonpainful sensations (eg, light touch or temperature changes) are painful. Sunburn is a good example of a condition causing allodynia. In clinical practice, neuropathic pain is common in painful diabetic neuropathy and in postherpetic neuralgia and may occur as a result of orthopedic injury. However, physical examination of the patient may show no obvious cause of the pain.

Neuropathic pain is an important symptom to recognize, because delayed or otherwise ineffective treatment can result in chronicity and in permanent change in the nervous system.

Neuropathic pain often responds more fully to adjuvant medication (eg, antidepressants or anticonvulsants) than to opioid analgesics.20 These adjuvant classes of drugs can remodulate the hypersensitivity changes of the nervous system by simultaneously limiting excitation and enhancing inhibition.20 Some patients with chronic pain achieve effective analgesia with low doses of agents that influence the refractory period of peripheral nerve fibers.
of the drugs, whereas other patients with chronic pain need antidepressant levels. Benefit may be seen within two weeks after initiation of treatment or may be delayed for several weeks. Opioid analgesics may be needed; if so, higher doses may be necessary because of changes in the nervous system that produce resistance to the effect of the drugs. Neuropathic pain is rarely relieved by nonsteroidal antiinflammatory drugs (NSAIDs).

Patients suspected of having complex regional pain syndrome (CRPS, previously known as reflex sympathetic dystrophy, RSD) who do not respond rapidly to adjuvant treatment should be referred to a pain specialist. Signs of possible CRPS in an extremity include:
- allodynia, hyperesthesia, or both
- abnormal skin color
- temperature greater than or less than 1ºC compared with the unaffected limb
- edema
- pseudomotor activity (increased sweating or dry skin).

When suspected neuropathic pain does not respond to treatment, early referral to a pain specialist is recommended.

Fears of Addiction and Monitoring for Abuse

Addiction is defined as a psychic compulsion to continue taking a drug on an ongoing basis—and despite harm—to obtain effects other than pain relief. Addiction is a major problem in the general population, but most patients are not at risk for substance abuse. Patients at low risk include middle-aged or older patients with no prior drug or alcohol abuse and a stable family and social history. Concerned about potential addiction, many clinicians fear prescribing opioid analgesics; however, the actual risk of opioid abuse is comparable to the incidence of alcohol abuse in the general population.

When considering long-term opioid use for chronic, noncancer pain, you must assess your patient’s potential for and risk for abusing these drugs. Cancer experts also are beginning to recognize that addictive disease can be a problem in some cancer patients because these patients are living longer (and therefore, receiving long-term analgesic drug therapy) even if not cured. You should be cautious about prescribing long-term opioid analgesics for young patients, patients with severe psychological pathology (eg, personality disorders or schizophrenia), and patients with a history of chemical dependency. Before initiating long-term opioid therapy, clinicians can use the CAGE-AID tool to assess for risk of addiction or whether a patient may already be addicted to alcohol or drugs. The CAGE-AID questionnaire is an assessment tool which helps to identify patients who may be at risk of substance abuse of alcohol or drugs. The CAGE-AID questionnaire asks whether a patient has ever:
C: Wanted or needed to cut down on drinking or drug use?
A: Been annoyed or angered by others complaining about the patient’s drinking or drug use?
G: Felt guilty about the consequences of the patient’s drinking or drug use?
E: Taken a drink in the morning as an “eye opener” to decrease hangover or withdrawal?

AID: The questionnaire can be adapted to include drugs.

A single positive response suggests that the physician should exercise caution in prescribing opioids to the patient; two or more positive responses suggest the need for increased vigilance by the physician prescribing opioid analgesics to the patient.

If long-term use of opioid analgesics is considered appropriate, do discuss the pros and cons of this therapy with patients and document their informed consent. Some physicians find useful a written agreement of the opioid therapy plan with specification of the conditions under which opioid analgesics will be prescribed. An easy-to-use template of an opioid therapy plan will be readily accessible for your use in KP HealthConnect.

Monitoring your patients receiving opioid therapy is of paramount importance. More common than addiction is the phenomenon of “pseudoaddiction.” Patients who are receiving an inadequate dose of opioid medication often “seek” more pain medications to obtain pain relief. This is called pseudoaddiction because it is often mistaken for the true drug-seeking behavior of addiction. Other common signs of pseudoaddiction and inadequate analgesia include:
- requesting analgesics by name
- demanding, manipulative behavior
- clock watching
- taking opioid drugs for an extended period
- obtaining opiate drugs from more than one physician.

Whereas pseudoaddiction resolves when the patient obtains adequate analgesia, true addictive behavior does not. Consultation with an addiction medicine specialist is recommended if you observe any of the following “red flags” for addiction or substance abuse:
- multiple dose escalations or noncompliance despite warnings
- multiple episodes of prescription loss
• repeatedly seeking prescriptions from other clinicians without informing the prescriber or after receiving warnings to desist
• evidence of deteriorated ability to function at work, in the family, or socially that appear related to drug use
• selling prescription drugs
• stealing or borrowing drugs
• injecting oral formulations of drugs
• obtaining prescription drugs from nonmedical sources.

Some patients with a history of substance abuse (or the potential for it) also have chronic pain and may need opioid therapy. An estimated 30% to 40% of patients participating in methadone maintenance programs do so because pain is one reason why they cannot stop taking opioid drugs. This type of complex case often requires expert consultation. Do not hesitate to seek the advice of an addiction medicine specialist whenever you are concerned about the risk of addiction.

**Recalcitrant Pain: When to Issue a Referral to a Pain Program**

Reassess your patients periodically for adequate pain control and side effects. If pain is continuing, check to see if they are taking their medications correctly and following the prescribed care plan before you try a new approach or increase medication dosage. Patients might not volunteer the information that they have stopped taking a medication because of a side effect, fear, cost, or the disapproval of a family member or friend.

Treatment of pain is an expected part of good medical management, and all physicians should therefore address the problem to the best of their ability. Sometimes, however, despite your best efforts—and just as for any medical condition—consultation will be needed. This need will vary, depending on the physician’s knowledge and skills and on availability of support systems for monitoring pain.

For patients with chronic pain lasting more than three months and unresponsive to conventional treatment, consider referral to a Pain Management Program. Moderate- to high-risk patients with either acute or chronic pain unresponsive to an optimized multimodal treatment should be given this referral early to try to minimize development of nervous system hypersensitivity.

Treatment may include medical evaluation and consultation, highly technical interventional and implantable techniques, and cognitive-behavioral intervention as indicated. However, because internal services vary from region to region, you should educate yourself about your local resources for pain management within and outside KP. Intranet resources include our National Clinical Library. Click the “National” tab and search for “chronic pain” in the Google field. Internet resources

| Table 1. Risk stratification characteristics for patients with acute and chronic pain⁴ |
|---------------------------------|---------------------------------|---------------------------------|
| **Goals of treatment**          | **Moderate risk (level 2)**     | **Severe risk (level 3)**       |
| • Provide routine care, self-management education, support for coping | • Enhance self-care skills and abilities; provide clinical management using care paths and protocols for patients who have begun to show deterioration in functioning, increased medication usage, or onset of moderate deconditioning | • Restore the most severely impaired patients to their highest level of functioning. Using professional expertise and supervision, reinforce learning by providing appropriate, supportive environment and structured experiences |
| **Characteristics**             |                                 |                                 |
| • Absent to mild depression, anxiety symptoms | • Mild to moderate depression, anxiety symptoms | • Moderate to severe depression, anxiety symptoms |
| • Adequate functioning in most areas | • Deteriorating functioning in most areas | • Severely deteriorated functioning |
| • Absent or minimal physical impairment | • Moderate physical impairment and deconditioning | • Severe physical impairment and deconditioning |
| • Minimal or no current use of pain and/or sedative hypnotic medications | • Inadequate medication management due to incorrect dosing/selection or because pain generator is increasing | • Habituation to analgesics and/or sedative medications |
|                                 |                                  | • Indications of domestic violence or sexual abuse |
|                                 |                                  | • Inadequate medication management due to incorrect dosing/selection, or because pain generator is increasing |
|                                 |                                  | • Coexisting addictive disease |

When to Consider Cognitive Behavioral Therapy

Consider using cognitive behavioral therapy (CBT) for any patient who presents a challenging pain management situation or who has poor social, occupational, physical, or psychological function. CBT is a psychotherapeutic approach delivered in a series of group and individual sessions focusing on the interrelation of cognition, mood, behavior, and symptoms. Contrary to popular misconception, CBT is not a health education class. Based on complex theory of personality and psychopathology, CBT includes an integrated program of well-defined therapeutic strategies and techniques (interventions) for use by trained psychotherapists.

Of great importance is that you assure your patient upfront that using CBT does not mean that the pain is not real or that the patient has a psychological problem. Educate the patient that every illness has psychological as well as physical components and that a comprehensive approach is intended to help the patient to regain function. Referring to a common experience—such as asking if the patient has ever “worried themselves sick” or gotten a headache when stressed—can often point out the “mind-body” connection.

Remember that CBT represents only one modality for treating chronic pain. Unless their pain is already optimally controlled, patients with this diagnosis are likely to benefit from full consultation at your Pain Management Program.

Summary

Pain exists on a continuum, and acute pain sometimes leads to chronic pain as it molds the nervous system and your patient’s life. To treat these patients effectively, clinicians should not expect success from simply prescribing medication; early, effective pain management is the best preventive therapy for chronic pain. For patients who already have chronic pain, multimodal treatment is key and must address not only pain relief but also the negative impacts of chronic pain and analgesic medications on the patient’s life, sleep patterns, psychosocial distress, conditioning, retraining, and pacing. Under your care, with optimal pain management, your patients can get their lives back.

Disclosure Statement

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**The Wheel of Life**

Please subdue the anguish of your soul.
Nobody is destined only to happiness or to pain.
The wheel of life takes one up and down by turn.

— *Kalidasa, circa 5th century, Indian dramatist and poet*