

Phantom Pain – Imaginary, Psychosomatic Pain?

Mariana-Alis Neagoe

Assistant PhD, Titu Maiorescu University, Faculty of Medicine, Bucharest, Romania.

***Corresponding Author:** Mariana-Alis Neagoe, Assistant PhD, Titu Maiorescu University, Faculty of Medicine, Bucharest, Romania.

Received Date: September 14, 2026 | **Accepted Date:** September 28, 2026 | **Published Date:** October 01, 2026

Citation: Mariana-Alis Neagoe, (2026), Phantom Pain – Imaginary, Psychosomatic Pain?, *International Journal of Clinical Case Reports and Reviews*, 37(3); DOI:10.31579/2690-4861/1170

Copyright: © 2026, Mariana-Alis Neagoe. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract:

Phantom pain can be extremely intense and debilitating; it is a complex neurological phenomenon experienced in a part of the body that no longer physically exists.

Phantom pain is the result of a complex interaction between neuroanatomical, psychological, physiological changes, it is not a psychosomatic or “imaginary” pain.

The diagnosis of phantom pain is clinical and is based on anamnesis and detailed medical history.

Key words: phantom pain; diagnosis; treatment

Introduction

Pain is the most common symptom of disease. Its treatment depends on determining the cause that produces it and removing the triggering and potentiating factors. [1] Pain is, therefore, what the patient says it hurts, it is what they describe and not what others think it is. [2]

Pain is objectified (and aggravated) by the concomitant existence of other symptoms (cough, vomiting, hiccups, dyspnoea, diarrhoea, haemorrhages, insomnia, asthenia, incontinence), psychological problems (fear, anxiety, despair, sadness, apathy, denial, avoidance), social problems (isolation, lack of social or family support, unresolved financial, interpersonal, emotional problems), cultural factors (the patient's specific value system that is not thoroughly explored and not respected by caregivers, language barriers), spiritual concerns (questions about suffering and death, regrets, blame for past events, denial of faith or, on the contrary, reaffirmation of it, exaggeration of its power in terms of resolving one's suffering). [2]

Resolving these problems leads to the success of the drug treatment of physical pain or, on the contrary, failure to resolve them makes it difficult to treat this symptom. [2]

Pain can be classified according to duration, aetiology, and physiological process. Depending on the duration, pain can be acute and chronic. In trauma, acute pain predominates as a symptom that often dominates the clinical picture, but also chronic pain, the most frequent result of late or suboptimal treatment of acute pain. [3]

Phantom pain, initially described in patients with polytrauma, is a form of chronic neuropathic pain generated by aberrant afferent nociceptive signals from the amputation stumps. [3]

The diagnosis of phantom pain is based on a comprehensive medical assessment involving an evaluation of symptoms and a detailed medical

history. It is a clinical diagnosis, as there are no specific laboratory or imaging tests to confirm it.

Differential diagnosis of tactile, somatic, and phantom limb hallucinations – Phantom limb is the sensation of persistent presence of an amputated extremity and is found in almost all amputees; patients usually describe the phantom limb as being numb or tingling, of normal size, correctly aligned, with peripheral areas more prominent; the sensation may recede gradually and may be painful. Hallucinations can be defined as a “sensory precept without external stimulation of the relevant sensory organ.” Hallucinations may occur in any sensory modality. [6]

Pain can be of somatic (cutaneous, tissue, joint, muscle) or neuropathic origin (lesions of nerves, spinal or thalamic pathways). [1]

Sensory signs and symptoms in neuropathic pain are described by the following definitions: neuralgia: pain in the innervation territory of a single nerve, such as in trigeminal neuralgia; dysesthesia: spontaneous pain, in the form of stabbing or burning; hyperalgesia and hyperesthesia: exaggerated response to nociceptive or tactile stimuli, respectively; allodynia: painful perception of non-painful stimuli, for example triggering painful sensations from vibrations. The diminished perception of pain is called hypoalgesia or, when it is completely absent, analgesia. Causalgia is a continuous sensation of intense pain in the form of burning, without precise demarcation, accompanied by dysfunctions of the sympathetic nervous system (sweating, vascular, skin and hair changes – sympathetic dystrophy), which occurs following damage to a peripheral nerve. [1]

Phantom Limb Pain

Definitions

- Phantom sensation: Any nonpainful sensation referred to the missing limb caused by cortical sensory perception of the

amputated body part. Loss of any limb or organ such as the tongue, eye, breast, and tooth can trigger this phenomenon.

- b. Phantom limb pain (PLP): Painful sensation referred to the missing limb.
- c. Stump sensation: Pain referred to the amputation stump. [5]
1. Epidemiology: Phantom limb sensations occur in almost all amputees; however, PLP occurs in up to 85% of amputees and can be severe in 10% to 15%. Risks include acute postoperative pain, pre-amputation pain, female sex, and upper limb involvement and is lower in young patients and congenital amputees. [5]
2. Symptoms: Onset usually within a few days after amputation. The pain is neuropathic (burning, shocklike, paresthesias, etc.) and localizes to the distal part of a limb (arm: fingers, palm; leg: toes, foot, ankle). It occurs mostly episodic on a daily basis and decreases in frequency and intensity over time. [5]
3. Prevention: There is weak evidence that pre-amputation anesthesia with epidural morphine and bupivacaine as well as perineural anesthesia can prevent PLP in the short term. Perioperative memantine in addition to brachial plexus anesthesia might also decrease PLP in the short term. [5]
4. Medical treatment: Medications used for other neuropathic conditions are generally used for PLP, including tricyclic antidepressants (TCAs), gabapentinoids, serotonin norepinephrine reuptake inhibitors (SNRIs), anticonvulsants, and opioids. For chronic PLP, best evidence exists for oral morphine and oral gabapentin; weak evidence exists for N-methyl-D-aspartate (NMDA) receptor antagonists such as intravenous (IV) ketamine and dextromethorphan (60 or 90 mg p.o. twice daily) as well as topiramate (800 mg daily). Minimal evidence exists for the treatment of PLP with mirtazapine, pregabalin, midazolam, milnacipran, fluoxetine, and duloxetine. [5]
5. Interventions: Spinal cord stimulation or peripheral nerve stimulation can be tried; however, data is conflicting, and the benefit is often only temporary. Botulinum toxin injections appear not to be effective. [5]
6. Other therapies: Mind-body therapy including biofeedback, mirror therapy, mental imagery, hypnosis, and meditation are all valuable options, are generally easy to implement, and do not have side effects. [5]

Recovery in case of amputated leg: recovery in this situation promotes the ability to move, including exercises to improve general condition and

balance, to stretch the knee and hip, to strengthen all extremities and to tolerate the prosthesis. As soon as the patient is medically stable, recovery should begin to avoid the appearance of sequelae. [4]

The physiotherapist will instruct the amputee on how to care for the affected limb and how to recognize the earliest signs of skin damage. [4]

Medications (e.g. gabapentin) may also be helpful. [4]

The most common cause of pain in the amputated limb is a poorly attached prosthesis.- Other common causes are neuroma and the formation of a spur at the amputated end of the bone. An amputation neuroma is usually palpable. Daily ultrasound treatments, 5-10 sessions, can be extremely effective. Other treatments include injection of corticosteroids or analgesics into the neuroma or the surrounding area, cryotherapy, and tight bandaging of the stump. Surgical resection often has disappointing results. Spur formation can be diagnosed by palpation or radiologically. The only effective treatment for a formed spur is surgical resection. [4]

Pain therapy is the result of teamwork, frequently with family physicians, neurologists, neurosurgeons, orthopaedists, psychologists and, last but not least, rehabilitation physicians and physiotherapists. Systemic approach to possible causes and their elimination through diagnosis procedures can lead to the discovery of often unsuspected causes. [3]

Conclusion

Each patient requires a personalized approach and treatment plan, and the chances of controlling symptoms increase the earlier treatment is initiated.

References

1. Kurt JI, Eugene B, Jean D.W, Joseph B.M, Anthony S.F, Dennis L.K (1997). Harrison's Principles of Internal Medicine, 13th Edition. Orizonturi Publishing House; Bucharest.p. 13-14
2. Marilena O (2015). Home Palliative Care Treatise. Etna Publishing House; Bucharest. p. 103-104
3. Ostin C.M, Dorel S (2018). Pain Therapy 3rd Edition. Etna Publishing House; Bucharest. p 11, 88-89
4. Mark HB, Robert SP. (2016). Merck's Manual 18th Edition. ALL Publishing House; Bucharest. p 2755-2756
5. Martin A.S, Allan H.R (2017). Samuels's Manual of Neurologic Therapeutics. Wolters Kluwer Publishing House; Philadelphia. p 387-388
6. Osama O.Z, J. Douglas M, Alan J.L (2020) .The Little Black Book of Neurology. Elsevier Publishing House; Philadelphia. P 257-258



This work is licensed under Creative Commons Attribution 4.0 License

To Submit Your Article Click Here:

Submit Manuscript

DOI:[10.31579/2690-4861/1170](https://doi.org/10.31579/2690-4861/1170)

Ready to submit your research? Choose Auctores and benefit from:

- fast, convenient online submission
- rigorous peer review by experienced research in your field
- rapid publication on acceptance
- authors retain copyrights
- unique DOI for all articles
- immediate, unrestricted online access

At Auctores, research is always in progress.

Learn more <https://auctoresonline.org/journals/international-journal-of-clinical-case-reports-and-reviews>