VALI KANDAM: A LINEAR CHRONOLOGY

Transcript

Slide 1 – வணக்கம் (VANAKKAM).

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If your mode is linearity, here is a timeline of significant events in the progression of chronic pain management, with attention paid to often overlooked non-Western histories; the blossoming of fibromyalgia in me and my search for care over cure; and moments of overlap with Sri Lanka's ethnic conflict and Tamil genocide. This timeline is an artificial construct. My pain, and my cultural heritage, disrupted the fabric of time for me; thus, my temporal experience of what you see here is non-linear, recursive, cyclical, simultaneous, all at the surface, awaiting notice.

Slide 2 - 2450 BCE: CRYO-ANALGESIA.

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Figure 1 An ancient Egyptian relief of a man being circumcised and then relieved of his pain with the "Stone of Memphis," calcium carbonate, acetic acid, and CO2 (El Ansary et al., 2003, p. 85). *Credit: El Ansary et al. (2003).*

Ancient Egyptian physicians believed that disease was due to a loss of continuity and strove for internal balance, much like marmapuncture and Ayurvedic traditions later recorded in Sri Lanka. Egypt was the capital of medical science in the Greek empire, and dating back to 2450 BCE, common analgesics in Egyptian medical practice included the "king" of painkillers, opium, and the more commonly used salicyl bark from the willow tree for rheumatic disease and joint pain. It wasn't until the 18th century that this substance was recognized as a pain reliever in the West. Surgical anesthesia involved cryo-analgesia, by combining calcium carbonate with acetic acid, producing fresh

carbon dioxide for local cooling or freezing (El Ansary et al., 2003, pp. 84-85).

Slide 3: 1900 BCE - 1600 BCE: Enuma Elish

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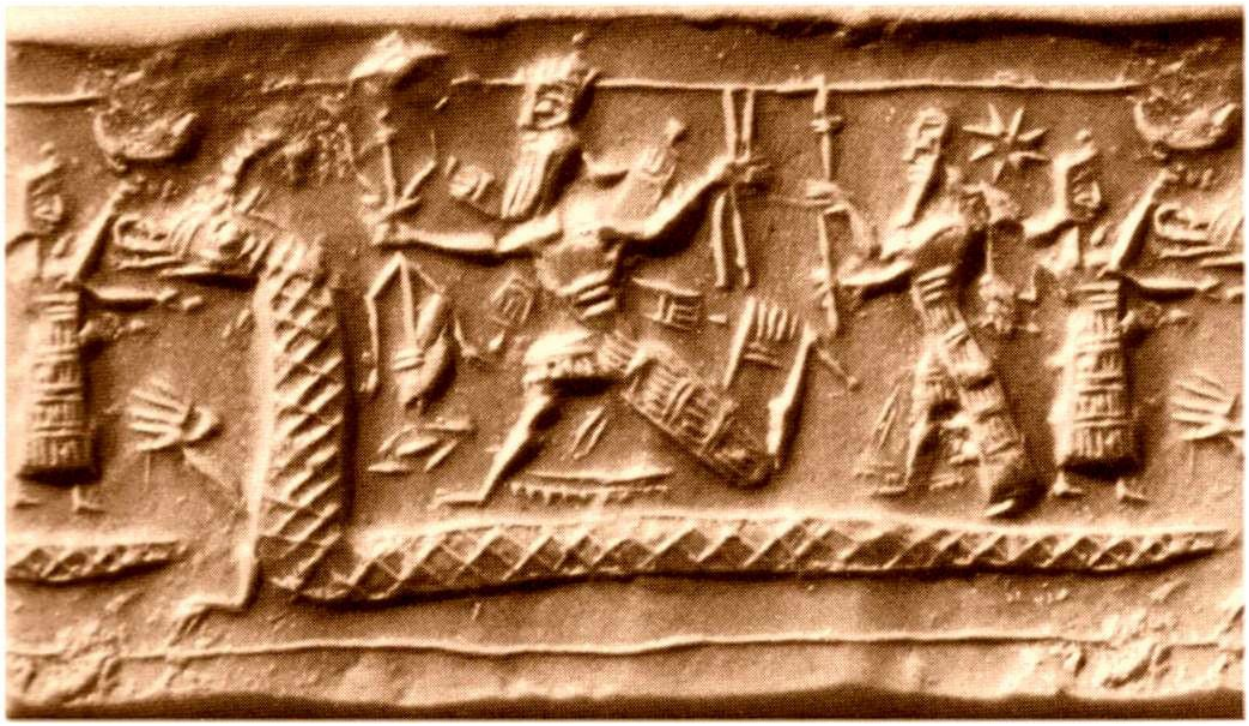

Figure 2: A Neo-Assyrian cylinder seal impression potentially depicting the slaying of Tiamat. *Credit: Wikimedia Commons*

In the Enuma Elish, Tiamat endeavors to endure the pain of the gods in her/its belly, and is enraged by Apsu's belief that infanticide will solve the problem, but scholarly interpretations of the text erase both her/its anger at the suggestion and her/its pain. This is a patriarchal mythology, after all, to which Tiamat's monstrification is integral, but it's also telling that scholarly representations essentialize her as feminine chaos, ignoring her maternal willingness to indulge her children and endure the pain. What's important to Western reductive, phallogocentric dichotomization—of old/young, feminine/masculine, evil/good—is that Tiamat's matriarchal body resists order, and only the masculine energies of Marduk can "surgically," necessarily, reconstruct her into the floors and roofs of a rational, livable world (Xiang, 2018, pp. 39-50). The female pain of this violence is not worthy of representation.

Figure 3: A fragment of the Ebers Papyrus, weathered paper and stark hieroglyphics, some red, most black. *Credit: Wikimedia Commons*

Slide 4: 1200 BCE - PAIN/DISEASE.

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Pain/disease in the head, and other body parts, is described in the Ebers Papyrus, the oldest known medical manuscript, dated to 1200 BCE and said to be based on medical documents from 2500 BCE. The papyrus was discovered in the Theban necropolis, and pain is characterized as a force, an opponent to be exorcised. In other papyri, recipes for cures include incantations to specific deities recited over a clay amulet that is then bound to the patient's ailing body part with a strip of linen, on which is written the names of the invoked deities (Popko, 2018). This is localized, acute pain, and therefore not analogous to chronic pain conditions like fibromyalgia or rheumatoid arthritis, but what strikes me is that the wax figure, with divine encouragement, was thought to absorb the pain, and that when this is described in scholarly writing it is, for the most part, with a tongue-in-cheek superiority. I include this because it sounds a lot like a theory of affect transmission to me, an understanding that the body is leaky and anyone is a potential destination, and the lived body is irreducible to the skin-wrapped entity we call human (Brennan, 2004; Gibbs, 2008; Shildrick, 2015). The ancients knew what so many doctors forget: that pain, not purely biological, travels indiscriminately, a missive that still signifies even if the language is cryptic, the sender mysterious, and the destination a wax mimicry of flesh. In asking the gods to touch you, you have already accepted a permanent, unknowable change.

Slide 5 - 410 BCE - 287 BCE: RHEUMA THEORY.

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Greek physician Hippocrates describes a mechanism of pain caused by an increase of liquid in the joints, sent there by the brain. This is close to a modern theory of central sensitization. In Western medical literature, Hippocrates is among the first to record that pain is not a punishment, but a natural phenomenon. After

him, Theophrastes describes the “characters” of widespread pain conditions in muscles and tendons, calling it *lassitude* (Perrot et al., 2012).

Slide 6 - 180: RHEUMA.

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Greek physician Galen, who studies in the Alexandria school of medicine, observes that widespread pain is linked to the *rheuma*, from the word for flow. He discovers the nerves that carry sensations and describes the senses of hearing, taste, and vision. He learns to use opium. He creates the first classification system of pain, using words equivalent to *stabbing*, *burning*, and *shooting* (El Ansary, 2003, p. 86).

Slide 7 – 500: AYURVEDIC ANALGESIA.

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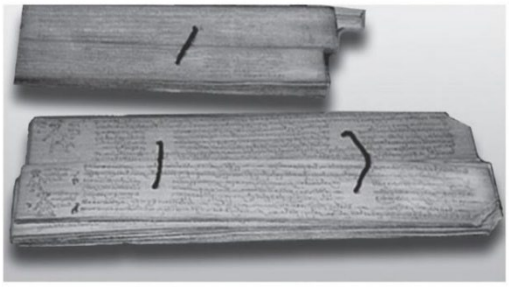

Figure 4: Ancient ola manuscript depicting marmapuncture and Ayurvedic pulse diagnosis. *Credit: Ros (2014)*

Marmapuncture, a form of acupuncture based on Vedic principles that is indigenous to India and Sri Lanka, is a documented part of therapeutic and analgesic procedures like வர்மக்கலை (varmakkalai), the art of vital points. It is a means of controlling Asiatic elephants, using fine needles of gold, silver, iron, copper, and bronze (Zarrilli, 1992; Jayasuriya, 2005; Ros, 2014). Marma points —locations on the body where the body-and-mind most manifest as one—should not be punctured. According to Sri Lankan ethnomedical researchers like Devasena (1981), who studied ancient Sinhalese-Buddhist medical texts, and Jayasuriya (2005), an acupuncturist who “discovered” native acupuncture practice in Sri Lanka (a fact already well-known to Sri Lankans), this belief may date to ancient wars, when kshatriyas required surgical treatment after their marmas had been brutally punctured by spears and astras on the battlefield (Ros, 2003). Varmakkalai, siravedhana, and other

traditional treatment modalities are still practiced by Siddhas in Sri Lanka; these techniques are native, sacred, and not for the uninitiated. Price's (2015) bodymind was a lifechanging English word for me, but I guess I always knew, from Ayurvedic practice and colloquial Tamil, that *Udambum manasum thani thaniyaaha illai*—the body is not separate from the mind.

Slide 8 - 980 - 1037: THE LOCATION MATTERS.

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Figure 5: Illustration of a medieval Arab doctor cauterizing a patient's wounds. *Credit: Wikimedia Commons*

Ibn-Sina, the chief physician of Islamic society, introduces the practice of diagnosing and treating the causes of pain. His treatments differentiate between analgesics and hypnotics and also involve cauterization with an oiled and heated nail, applied at the location of pain (El Ansary et al., 2003, p. 86), well before "Where does it hurt?" becomes a pivotal question in modern biomedical practice (Foucault, 1963/1994).

Slide 9 - 1592: MUSCULAR RHEUMATISM.

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In one of the earliest recorded European references to musculoskeletal aches and pains, French physician Guillaume de Baillou coins the term rheumatism, later defined in 1690 as "a great fluxion which races to various parts of the body and goes from one to another" (Lagier, 2001, pp. 467-468). de Baillou uses it to describe the clinical presentation of muscular pain and rheumatic fever, inflammation being a conjoining feature (Inanici & Yunus, 2004, p. 369).

Slide 10 - 1815 - 1827: FOCAL TENDERNESS AND FATIGUE.

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Sir William Balfour, an Edinburgh surgeon, furthers the idea of inflammation in connective tissue by suggesting it creates and sustains painful nodules. In 1824, he refers to this as *focal tenderness*, the precursor to the modern trigger points used to diagnose fibromyalgia (Inanici & Yunus, 2004, p. 370). He calls it *fibrosisitis*, "a special pain, usually driven by an inflammatory action, involving fibrous and white tissues, belonging to muscles and joints, like tendons, aponevroses" (qtd. in Perrot, 2012, p. 187).

Slide 11 - 1841 - 1903: TENDER POINTS.

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In France, Valleix (1841) offers the first Western description of tender points, characterizing them as painful places on the body that hurt when palpated. In Germany, Froriep (1843) discovers nodules in the muscles that respond to pressure with pain. In 1858, Inman describes pain localized to the muscles, independent of innervation, and conditions of *referred pain*. Cornelius (1903) in Great Britain describes "nervous points" located in the muscle, susceptible to emotions and to the weather (Perrot, 2012, p. 187).

Slide 12 - OCTOBER 16, 1846: WESTERN ANALGESIA.

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In the first public demonstration of anesthesia in the U.S., a painless dental surgery was carried out at the Massachusetts General Hospital, dubbed Ether Day. Anesthesia heralded the death of pain, forever changing cultural assumptions about pain and the human condition—*in the West* (Morris, 1991, pp. 63-65).

Figure 6: "Ether Day 1846," the official commemorative oil painting by Warren and Lucia Prosperi, displayed inside the Ether Dome at Massachusetts General Hospital, capturing the moment after the first painless incision performed in the West. *Credit: Warren and Lucia Prosperi (1999-2001)*

Slide 13 - OCTOBER 6, 1847 - 1955: KILLING PAIN IN SRI LANKA.

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The exact date that painkilling was medicalized and enacted in Sri Lanka is unknown, but chloroform appears to have been the most popular form of analgesia during and after surgery. The first reference to chloroform anesthetic is in the *Ceylon Medical Journal* in 1887, but historical evidence indicates a Boston physician working in Jaffna, Dr. Samuel Fisk Green, may have been the first person to use ether in Sri Lanka. Dr. R.L. Spittel, a Burgher physician and expert on the indigenous Vedda community, wrote about surgical practice in the early 1900s, recommending the following substances for operative or post-operative pain relief: chloroform, morphine, heroin, veronal, scopolamine, potassium bromide, cocaine, ether, hot strong coffee with brandy (ingested orally or administered as an enema), hyoscine, dry cupping, oxygen (whose prescription usually signaled impending death). Pain relief during childbirth is recorded in 1917, with chloroform being the most popular agent. In the 1930s, Sri Lankan

physicians develop a form of anesthetic inhaler that more safely and efficiently channeled chloroform to patients, inciting wonder in visiting British physicians after World War II. All this anesthesiology training is in the Western tradition, but no Sri Lankan anesthesiologist is published in an international journal until 1955 (Jayasuriya, 2010, pp. 5-13).

Slide 14 - NOVEMBER 1847: CHLOROFORM.

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James Young Simpson successfully administers chloroform to patients as a stronger, better alternative to ether. It was rapidly adopted in obstetric practice (Kyle & Shampo, 1997). This is in stark contrast to the medicalization of childbirth in Tamil Nadu, where women often insist on oxytocin to induce labor contractions with more pain, thus gathering more shakti (van Hollen, 2004).

Figure 7: Antique bottle of chloroform labeled Duncan, Flockhart & Co. Ltd, the company James Young Simpson commissioned to manufacture chloroform from 1847 onwards. *Credit: Wikimedia Commons/Wellcome Collection.*

Slide 15 - 1869: NEURASTHENIA.

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Neurasthenia, popularized by American neurologist Charles Beard, is a common diagnosis in the West, strongly resembling modern descriptions of chronic fatigue syndrome. He remarks on the following features: cephalalgia, insomnia, nightmares, rachialgia, coccygodynia, fatigue (usually in the morning) with muscular atrophia, dyspepsia, sexual disorders and dysfunction, psychological

asthenia, and memory loss. This closely parallels the ACR 2010 criteria for fibromyalgia (Evengard et al., 1999, p. 455; Perrot, 2012, p. 188).

Slide 16 - 1893: STUCKNESS.

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Graham, a Boston physician, says, "muscular rheumatism is probably coagulation of the semi-fluid contractile muscular substance and adhesion of muscular fibrils" (qtd. in Inanici & Yunus, 2004, p. 370). This reads like the precursor to adhesions in fascia, which in contemporary bodywork is a prime suspect in fibromyalgia's trigger points (Myers, 2009). It also reads like the ancient Ayurvedic principle of Vata, which governs flow and motion in the body and is considered the leader of the body since the other energies can't circulate without it. When imbalanced, Vata types, like me, become stiff, cold, dry, fatigued, arthritic, stuck in the musculoskeletal system and bowels. Among other things, Ayurveda prescribes frequent massage and regular physical contact with loved ones, implying this quality of stuckness is a bodymind problem, not solely muscular in origin.

1904

Slide 17 – 1904: THE FIRST FAMILIAR BIOMEDICAL NAME.

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British neurologist Sir William Gowers introduces the term *fibrositis*, describing spontaneous pain, sensitivity to pressure, muscular strain, and extreme temperatures, particularly cold, as well as sleep disturbances and fatigue. It becomes entrenched as a biomedical term because, that same year, pathologist Ralph Stockman biopsies myalgic nodules and provides a pathologic basis for fibrositis in his findings. The findings are later deemed inconclusive, but for the next 72 years, fibrositis becomes the official diagnosis (Inanici & Yunus, 2004, p. 370; Perrot, 2012).

Slide 18 - 1909: NERVOUS SYSTEM INVOLVEMENT.

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Sir William Osler, the most famous English physician at the time, compares muscular rheumatism to "neuralgia of the sensory nerves of the muscles" (qtd. in Inanici & Yunus, 2004, p. 370).

Slide 19 - 1918: WHOLE-BODY SYNDROMES AND SHOCK.

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World War I ends in 1918, and with it comes *wound shock*, a little understood disorder that is both highly individualized and affects the whole body. It can't be anticipated, has unpredictable effects, and doesn't have a single, clear cause. The body's responses to injury paradoxically prove more devastating than the injury itself. This is when medicine has to take a holistic approach, reconceiving the body as a united organism to save it. Patient treatment has to be personalized, swift, and creative, for without such intervention, the body irreversibly collapses. Shock is cast as a vicious cycle in which the body catastrophizes its reactions unto death (Geroulanos & Meyers, 2018, pp. 34-36). This might be the English name for the war trauma syndromes that marmapuncture treated in kshatriyas. It might also be the whole-body syndrome of diasporas whose existence is a history of violence, the ontology of bodies raised to expect war.

Slide 20 - 1940: DOLORIMETRY.

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In the effort to quantify pain, researchers at Cornell University create a unit of measure for pain, the *dol*—from the Latin word for pain, *dolor*—by burning the foreheads of their research subjects repeatedly and using their responses to craft a 0-10.5 scale for pain. Second-degree burns are often reported as 8, and pain ranked at 11 is described as *indiscernible*, too intense to quantify. The dolorimeter, the instrument used to measure pain, is a type of algometer, which doesn't measure pain itself. It was first designed and used in the late 19th century "to stimulate subjects in precise and potentially painful ways, and then to quantify the minimal intensity of stimulation that results in a response to pain"

(Tousignant, 2010, p. 146). However, it became popular in the early 20th century for measuring pain and sensory thresholds in Othered populations: women, "deviants," and non-Europeans. The difference between the old algometer and the new dolorimeter is explained thus: algometers measure affective responses to pain, but dolorimeters isolate pure sensation without affective content, as seen in the heat intensity experiments. As an "elegant" solution to quantifying and standardizing pain, the dolorimeter was celebrated as a breakthrough in biomedical analgesic research, further entrenching clinical practice and scholarship that pretend affect and culture are inconsequential (Tousignant, 2010).

Slide 21 - 1942: WAR-RELATED TRAUMA.

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The end of World War II sees a high incidence of chronic pain in returning soldiers. Savage (1942) reports fibrositis in soldiers in his clinic, and Boland (1947) describes *psychogenic rheumatism* in the army. Interestingly, clinical imaging finds abnormalities, offering objective evidence for what might be considered a psychosomatic or stress-based disorder (Geroulanos & Myers, 2018, p. 35).

Slide 22 - 1952: THE FIRST RECOGNIZABLE BIOMEDICAL DESCRIPTION.

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Much of the research in the 1950s follows the theory of stress and endocrine abnormality (Perrot, 2012, p. 189), but Travell and Rinzler (1952) publish a paper describing myofascial pain and myofascial trigger points and their referral patterns. These terms are later popularized (Inanici & Yunus, 2004, p. 372). I've encountered both *trigger* and *tender* in my research and in my own patient-doctor interactions, and I've heard the cases for each, but I prefer *trigger*. *Tender* makes more victims of members of a diaspora onto whom victimhood is imposed, while *trigger* contains the possibility of agency. When I am *tender*, I am womanly, capacious, a soft and ready storehouse for all the world's pain. When I am attired

in *triggers*, contagion means I can wear them like a Black Tiger's C4 vest, aiming inward and out. Virulent transmission reconfigured as an expression of will.

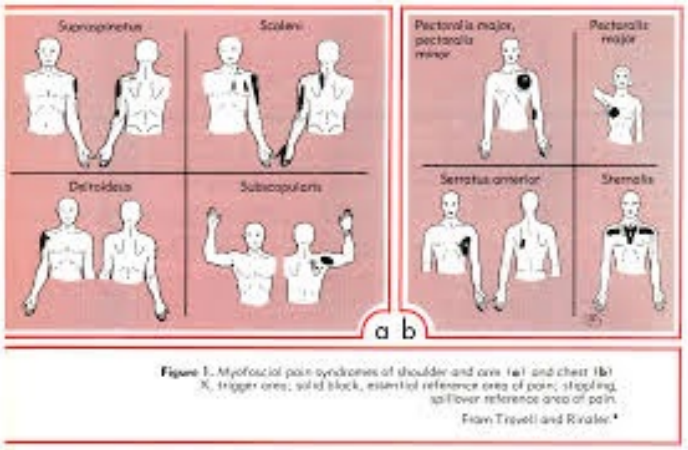

Figure 8: Diagrams depicting myofascial pain syndromes of the shoulder and arm, with trigger points and referred patterns of pain. The male body, as always, is emphasized, despite higher morbidity in women. *Credit: Travell & Rinzler (1952), pp. 425-434*

Slide 23 – 1972 - 1976: THE FINAL RENAMING.

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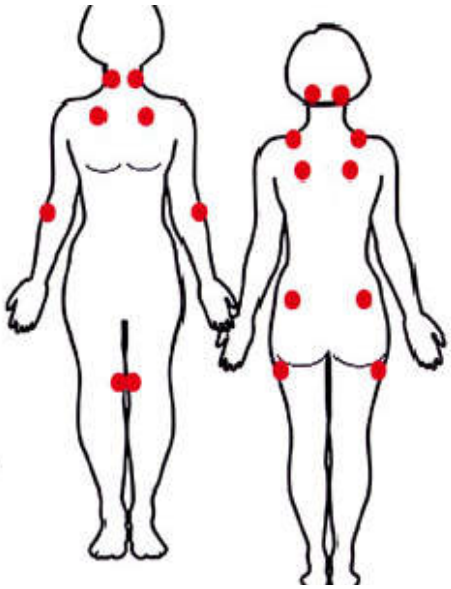

Figure 9: An anatomic drawing, front and back, with red dots identifying pairs of trigger points at the throat, clavicles, inner elbows, inner knees, lower back, cervical spine, glutes, shoulders. Although future questionnaires feature male bodies, this drawing is of a woman, and she is, as always, white.

In 1972, Smythe proposes a set of criteria for diagnosing fibromyalgia, which he revises in 1977, just after Philip Hench uses *fibromyalgia* for the first time in 1976, describing it as a non-articular rheumatism. Smythe's work is highly influential. He is the one who describes fibromyalgia as a generalized pain syndrome, including factors and symptoms like fatigue, poor sleep, morning stiffness, emotional distress.

He locates the trigger points that are used in 1990 ACR criteria and provides a working, albeit anecdotal, set of diagnostic criteria for FMS (Inanici & Yunus, 2004, p. 373).

Slide 24 - 1975: QUALITATIVE ASSESSMENT.

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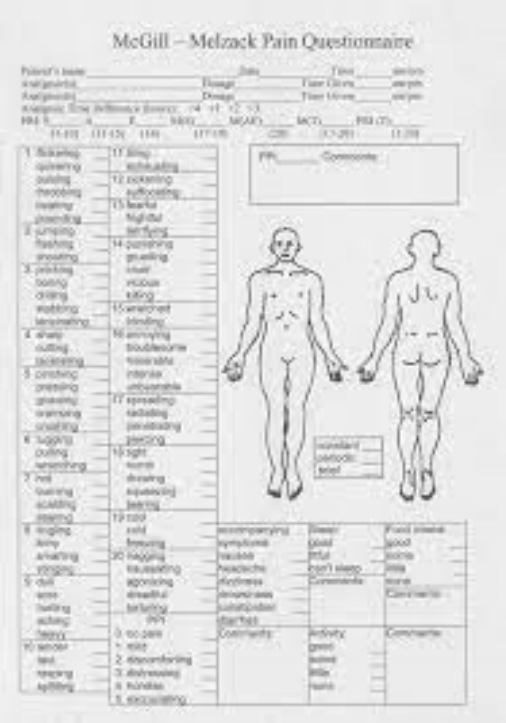

Figure 10: A portion of the long-form McGill Pain Questionnaire, including prefabricated descriptions of pain. An anatomic drawing, front and back, is included. The body is, of course, male.

Developed by Melzack and Torgerson in 1971, the McGill Pain Questionnaire was published in 1975 and revolutionized Western medical approaches to pain by recasting the qualitative experience of pain as significant to diagnosis and treatment. It assesses three dimensions of pain experience—sensory, affective, and evaluative—through 78 descriptive words, and it evaluates the current intensity of pain through 6 words. Its validity as a measuring tool and convenience in a doctor-patient setting, given its cumbersome length, have been called into question, but it remains one of the primary tools for qualitative assessment of patient pain (Melzack, 2005). This is problematic because it discourages patient self-assessment that is personalized and idiosyncratic, in many ways diverging from the model of care that emerged after WWI with regards to whole body shock.

Slide 25 - 1981: CONTROLLED STUDIES.

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Yunus publishes findings from the first controlled clinical study that verifies trigger points and anecdotal reports and associates fibromyalgia with other “proven” functional syndromes, like IBS, as well as adding new symptoms, such as

paresthesia, and data-based diagnostic criteria (Inanici & Yunus, 2004, p. 371).

Slide 26 - JULY 23, 1983 — JULY 30, 1983: BLACK JULY.

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Figure 11: A naked Tamil youth cowering before his grinning Sinhalese attackers. You don't need to see it, to know what happens next. *Credit: Chandragupta Amarasinghe (1983)*

Government-sponsored anti-Tamil pogroms set Sri Lanka ablaze, like Hanuman with his burning tail setting fire to Ravana's kingdom. More than 3,000 Tamils are chopped or burned alive by Sinhala mobs. I'm nascent in the womb when my parents hear of this, in Stony Brook, New York. What affective cycle am I caught in, in utero, that I cannot refuse; what eternal route between depression and painervation is becoming my home? I'm reflexively wary of Brennan's (2004) linkage of fibromyalgia and trauma, as it facilitates victim-blaming and medical disbelief or diagnoses of hysteria, but at the same time, what an American thing for me to think. Really, Brennan is grounding this coupling in non-Western ontologies that are as familiar to me as the imperative *niminthu*. She proposes that the notion of the discrete individual driven by endogenous affects is a uniquely Western belief, that the transmission of affect may augment or warp a person's affective makeup, that chemical processes situate us in emotional places, that vision may reassure us that we are not our environments, but the other senses have always minimized this distinction (pp. 8-10). The idea of being less well-shielded from negative affects by (repeated) traumatization, the identification of musculature with ego, is noteworthy and echoes the sentiments

of other painervated writers articulating their internal disarray (Morris, 1991, 1998; Barker, 2005; Huber, 2017; Berkowitz, 2015; Lau, 2020).

Slide 27 - NOVEMBER 13, 1983: ஆவி (AAVI).

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Family folklore says that I stopped breathing when I was born, and Amma, having just endured childbirth, was the one who ran to the nurse's station, where a nurse whacked me on the back until I inhaled. Running in spite of post-childbirth exhaustion, stitches, pain: such is the shakti of motherhood, a suffering we culturally construct as specifically female power (Van Hollen, 2004). Thus, the punchline of this story, that in this moment Appa is frozen in panic and useless, signifies doubly. I am born in an American hospital shaped like the panopticon, into a heritage of genocidal ethnic conflict, into a hermeneutics of pain that finds diagnoses in deities, planetary misalignment, dreams, and indigenous folklore. In 2006, biomedicine says I have fibromyalgia, chronic fatigue, affective dysfunction, but I grow up hearing I brought something back with me when I was revived, like an aavi or peyththai. An uncle says the sins of the parents are visited on the child, blaming familial karma. All this is a testament to Morris' (1991) reminder that pain once linked us—still links many of us, from a decolonial standpoint—to ancient cultural beliefs, many of which have vanished or are no longer recognizable due to colonization. I can't say any of this in Western clinics if I want to be believed.

Slide 28 - NOVEMBER 13, 1985: BATTICALOA LAKE ROAD MASSACRE.

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Embedded Tweet: Remembering the Lake Road Massacre (@PEARL_Action)

I turn two on the date of the Batticaloa Lake Road massacre, and I grow up with this story. On this day, Sri Lanka's Special Task Force (STF) troops round up Tamil civilians as retaliation after a landmine explosion. Thirteen Tamil men are made to walk with their ID cards held high to Lake Road, where they are shot in

the head or neck. A monitoring committee puts an end to the massacre before it goes any further. Later, a landmine explosion kills the perpetrators; the victims' families are able to identify their sons' killers because the soldiers still carried those ID cards as trophies (PEARL, 2018). Brennan (2004) likens fibromyalgia to the contours of trauma, but this is a cultural and political "dumping" before I can fully apprehend its weight, a non-Western form of fear, panic, and paranoia, which "represents the greatest moment of sensory receptivity of the human body to others—for in it, sympathetic or affective contagion is at its height" (Gibbs, 2008, p. 132). I celebrate my birthday, but I never do fully divorce it from war.

Slide 29 - 1990 – 1992: OFFICIAL CONSENSUS.

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The WHO recognizes fibromyalgia in 1990, and it's integrated into the ICD with that name, in the section on non-articular rheumatic diseases, described as having no known etiology. Two years later, the Copenhagen Declaration 1992 is published in *The Lancet*, as a consensus statement on fibromyalgia that medical researchers arrived at during the Second World Congress on Myofascial Pain and Fibromyalgia held in Copenhagen (Perrot, 2012, p. 189).

Slide 30 - SEPTEMBER 5, 1990 - SEPTEMBER 9, 1990: GHOSTBODIES.

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Sri Lanka Army soldiers round up 158 Tamils who are taking refuge in the Vantharumoolai campus of Eastern University in Batticaloa. Days later, soldiers round up and kill 186 Tamil men, women, and children in Sathurukondan and surrounding villages in Batticaloa. Two weeks later, another 16 are arrested. It's

Figure 12: Tamil men and women, some holding protest posters, stand outside Eastern University in 2019, calling for truth, justice, and accountability for the 60,000 to 100,000 disappeared persons since the 1980s, most of them Tamil. I can't be sure, but I wonder if they are searching for the ghostbodies I know of. *Credit: Tamil Guardian (2019)*

the 158 and 16 that haunt me. Dolphin-Krute (2017) describes chronic illness as a ghostbody existence: a body unsettled from its vitality and forced to haunt itself to reside in its own flesh, a ghostly body that, like a horror movie, is configured as contamination and infection; and it also must accommodate the projections of mainstream society onto it, a logic of *you look too well to be ill but are somehow ill* (pp. 10-25). It's a critical frame of reference, but these are Euro-Western ghosts. Batticaloa's ghostbodies possess a literal dimension as well. Of the 158 and 16, not one has been seen again. There is no closure, only perpetual haunting. For Eelam Tamils in the diaspora, this is a frame of reference worn in the flesh.

Slide 31 - 1991: BODIES IN THE AGE OF CATASTROPHE.

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Gulf War Syndrome, delineated 50 years after the psychogenic theories of rheumatic disease in soldiers after World War II, nevertheless retains many of the characteristics of that disease, amounting to a clinical picture closely related to psychological stress and PTSD (Perrot, 2012, p. 188). There's plenty to suggest that vicarious trauma, a label I lacked until I was in my twenties, shares that clinical picture, but it's a risky phrase to utter in the Western biomedical complex. Neither of the two most likely responses, "Trauma is irrelevant as you yourself have survived nothing" or "Your condition is a psychiatric disorder, then," results in medical care.

Slide 32 - 2002: THE CENTURY OF NEUROSCIENCES.

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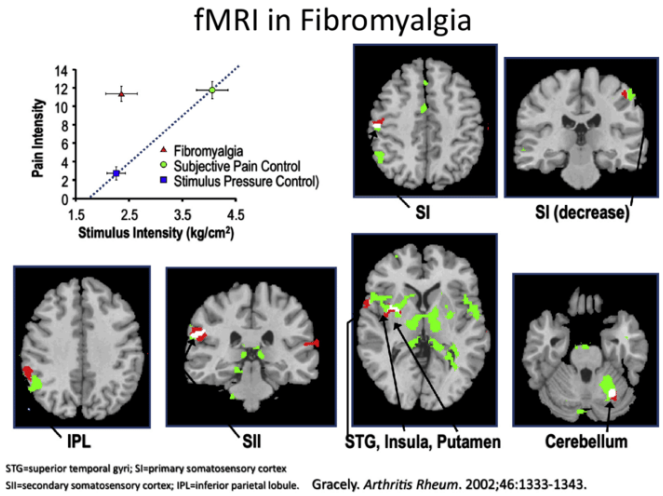

Figure 13: Cross-sections of an fMRI of a fibromyalgic patient's brain, showing decreased and increased blood flow to specific regions when pain stimuli is applied. *Credit: Gracely (2002)*

Biomedical science aims to visibilize fibromyalgia, using imaging technologies like MRI (magnetic resonance imaging) or fMRI (functional magnetic resonance imaging). Imaging is used to differentiate between patients and control groups, to identify sensitivity to particular painful stimuli, and to investigate the associations between increased pain sensitivity and patient behavior and catastrophizing. Gracely and Ambrose (2011) describe how fMRI technology is used to analyze the mechanisms involved in pain processing. The success of these imaging tests suggests that chronic widespread pain of indeterminate etiology can be located using visual technology. The implication is that, if it can't be located, the patient's pain threshold is normal.

Slide 33 - JANUARY 2006: CLINICAL ONSET.

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I see Nancy, a nurse practitioner at Columbia University's Health Services, for *pain everywhere*, which I've always had, which I have tolerated until it is suddenly intolerable: troweled flesh, intermittent partial blindness, and a skullcap of static charge that I semi-affectionately name *scalpies*. Nancy takes me seriously, referring to me by name or pronoun instead of *Pt* in her clinical notes and recording and investigating every symptom and context I report. Because I trust her, I'm maybe too forthcoming about the cultural dimensions of this pain. As a nurse practitioner, her reach is limited. She can't help that the specialists she

shunts me to call this *graduate student syndrome*, or tell me, “But you look so well, how can anything be wrong?”

Slide 34 - NOVEMBER 2006 - DECEMBER 2006: வாகரை (VAKARAI).

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Also in 2006, peace talks in Sri Lanka officially end, and violence by both the Sri Lanka Army and the Tamil Tigers escalates. On November 7, as I record pain like fire in my face, shoulders, and hands, Tamil civilians taking refuge at the Kathiravelli school in the Vakarai area in the east are killed in artillery shelling by the Sri Lanka Army. Many survivors are struck by shrapnel, while the dead are in pieces. The Army claims that they were returning fire after the LTTE fired at them from a military installation near the school. However, there is no evidence of such an installation in proximity to the school, and survivors interviewed by Human Rights Watch say that there were no Tigers in the area, and no noise of shelling until the Army fired (HRW, 2007). In December 2006, the government announces its plan to completely drive out the LTTE from the east, commencing the final years of the ethnic conflict that culminates in 2009 with genocide.

Slide 35 - 2007 – 2012: THE PRICE OF REHABILITATION.

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I’m diagnosed by different specialists in accordance with their specialty: trigeminal neuralgia, restless leg syndrome, irritable bowel syndrome, carpal tunnel syndrome. Every specialist tells me I’ll need physical therapy for life, but this is contingent on my healthcare coverage. I end up almost exclusively seeing Marco at Central Park Physical Therapy, because they take my insurance and he acknowledges all the dimensions of chronic illness. I’m allowed five visits per body part by Horizon Blue Cross Blue Shield. Marco treats me with full body massage therapy but bills per body part so I can afford to keep going, until I run out of body parts and Horizon denies coverage, claiming I’m too functional to need it.

Slide 36 - APRIL 2007 - OCTOBER 15, 2007: PRESCRIBERS' PREFERRED DRUGS.

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Embedded Video: The Sri Lanka Army loads rocket launchers and fires mortar rounds and rockets into the Thoppigala area. *Credit: AP Archive (July 10, 2007)*

From 2006 to around now, I am liberally treated with Ativan, Valium, and Lunesta, anti-anxiety and sleep aids. Meanwhile, displacements of Tamil and Muslim populations increase in the embattled north and east, and in June, two Tamil aid workers from Batticaloa are abducted in white vans by men pretending to be policemen; their bodies are discovered near Ratnapura. The Battle of Thoppigala rages from April to July. Also in April, I am given codeine to be taken *as needed*, which often ends up being daily. I am not told about contraindications. I take 1-2 daily, sometimes with Lunesta, and swim through teaching and my MFA coursework. Thoppigala falls in July, and the LTTE loses its presence in the east. This is presented like a victory.

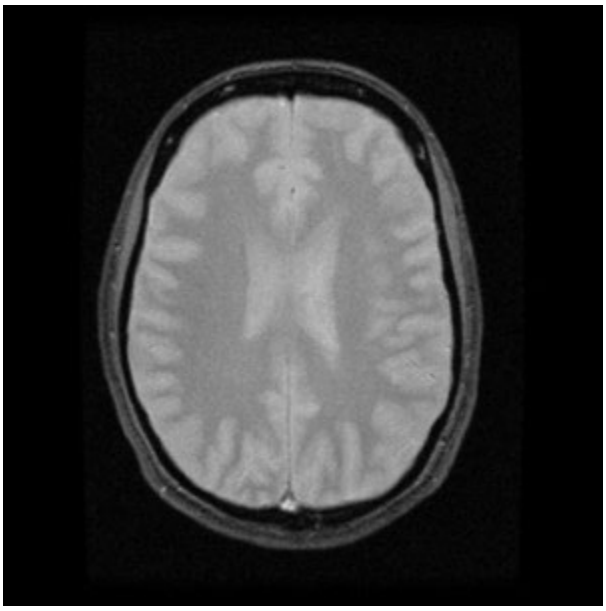

Figure 14: Top-down view of an MRI of the author's brain, intended to visually capture (and conquer) her chronic pain symptoms as neurological and curable.

Slide 37 - APRIL 11, 2007: ENDPOINTS.

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Kurt Vonnegut dies of brain injuries today, while I see an old white man neurologist Nancy refers me to, for a repeat of the basic neurological exam I received in the ER for my complaints of unilateral facial numbness and blindness. At the ER, a white woman physician ruled out Bell's palsy and prescribed codeine, in some echo of the 1990s prescription trends for patients with chronic pain. At my appointment

today, the neurologist says matter-of-factly, with astonishing confidence after a single exam, that my headache is likely a stroke or brain tumor. He doesn't appear concerned. He orders an MRI for the following week. I silently panic until the radiology report is released, finding no microbleeds, lesions, or cancers. I should be relieved, but I'm disappointed. Somewhere I was hoping for something medically comprehensible. Something with an end.

Slide 38 - NOVEMBER 9, 2007: DIAGNOSIS.

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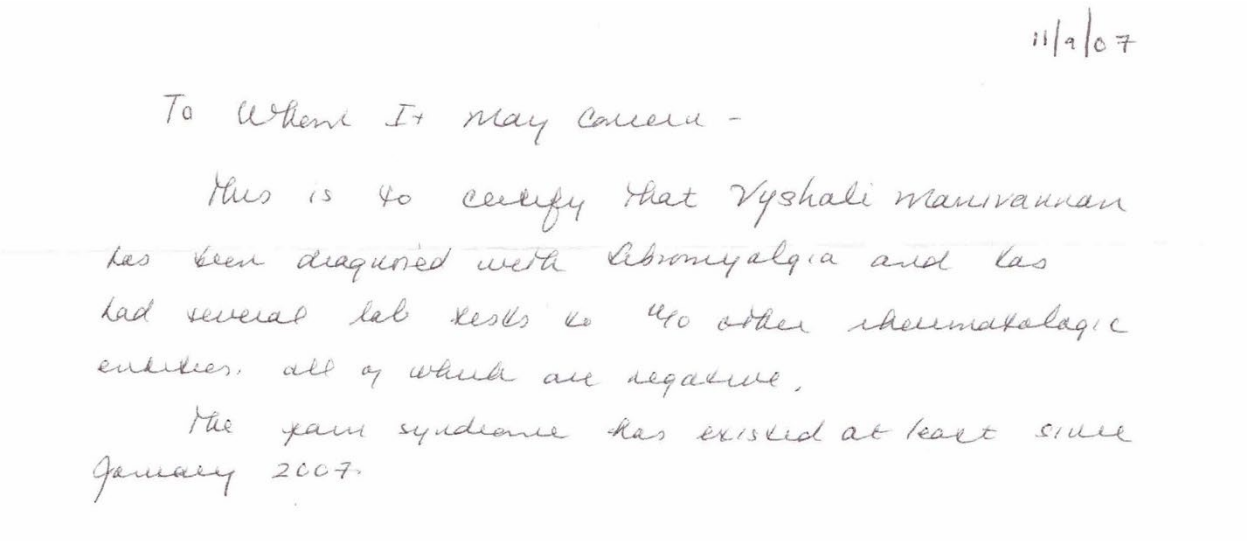

11/9/07

To Whom It May Concern -

This is to certify that Vyshali Manivannan has been diagnosed with fibromyalgia and has had several lab tests r/o other rheumatologic entities, all of which are negative.

The pain syndrome has existed at least since January 2007.

Figure 15: Handwritten letter of diagnosis from Dr. Birnbaum that the author carries as proof of disability. The letter reads: "To whom it may concern: This is to certify that Vyshali Manivannan has been diagnosed with fibromyalgia and has had several lab tests r/o other rheumatologic conditions, all of which are negative. The pain syndrome has existed at least since January 2007."

A year and a half after I begin searching for a diagnosis, I find a rheumatologist, Dr. Birnbaum, who screens me for multiple disorders and finally diagnoses me with fibromyalgia. I'm lucky. According to the American Autoimmune Related Diseases Association, it takes an average of five years and at least five specialists to receive appropriately tailored care (O'Rourke, 2013). Still, in this year and a half, I spend thousands of dollars out-of-pocket on insurance, specialists, lab tests, drugs, imaging, and second opinions. Fibromyalgia is a contentious diagnosis. Dr. Birnbaum suggests the disorder awoke in 2006, when I first began experiencing symptoms, but she doesn't rule out the possibility that I've lived

with it for much longer. Colleagues and classmates joke that everyone in academia is tired; it's just stress; join the club. Everyone has a theory about its origin. A brain thing. A heart thing. A minor infection that compromised my immune system or confused it into hyperactivity. I become a body-as-text for all these laypeople and professionals, composed by the processes of textualization imposed by others around me (Kalin & Gruber, 2018). Whatever I say or do, I'm misbelieved, made to fit others' Procrustean belief systems and medical understandings, none of which consider that I'm an Eelam Tamil. My parents are baffled. To them, the condition of life is a series of exclamations of nohuthu, as unmedicated as amputations done out of necessity in wartime makeshift hospitals. They can't conceive of pain as a disorder separate from the disorder of living, and comparatively, no, it isn't bad at all.

Slide 39 - DECEMBER 2007 - JANUARY 2008: CYBORG TRIALS

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Under Dr. Birnbaum's direction, I wean myself off codeine and Lunesta to gain admission into a paid double-blind study treating unmedicated fibromyalgia patients with an experimental headset that transmits a pulsed electromagnetic field (PEMF) to the brain, with allegedly analgesic effects. I'm supposed to wear the headset every morning for 30 uninterrupted minutes. I end up having to wear it during my morning lecture, an unwanted, unintentional disclosure to students and faculty observers that suggests I am neurologically compromised. After the trial, the PI tells me I received a functional headset, not a placebo. I tell her I felt no difference. *That's too bad. Others felt it helped*, she says. Even in this demographic where I supposedly belong, I'm made to feel like the outlier.

Slide 40 - FEBRUARY 2008 - JULY 2008: DRUG TRIALS.

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At first, a low dose of nortriptyline is my primary medication, and it reduces the pain just enough for me to get by. The popular drugs for treating fibromyalgia, Dr. Birnbaum tells me, are oxycodone, gabapentin, and nortriptyline. She feels the last is more sustainable with fewer side-effects in the long run. Memory loss

is the worst one. Without a stable, enduring self-concept, and now with a flickering history, my general attitude is that "for about a month now i've been praying i die before i wake up the next morning" (V. Manivannan, personal communication, February 24, 2008). When nortriptyline stops working for me after a year, Dr. Birnbaum isn't surprised, suggesting the reason is either tolerance or an increase in pain. We want to try Lyrica, recently FDA-approved for fibromyalgia, but it's $600 a month and not on my insurance's formulary. So in July, we try Cymbalta, an SSNRI with an FDA-approved off-label use for chronic pain, though all the ads for it point to the exclusive treatment of depression. Initially, Cymbalta makes me magical. I deep clean my apartment, caulk all the cracks, work out for four hours every day. I drop 10 pounds I couldn't afford to lose. Dr. Birnbaum tells me that Cymbalta triggers mania in patients with bipolar disorder, and we wonder if I have it but decide not to mention the possibility in my official patient records, because a history of mental illness could interfere with treatment under other doctors. I taper off Cymbalta, and the withdrawal is like radiation settling in all my linings. At least it's summer, or the withdrawal alone would cost me my job.

Slide 41 - OCTOBER 2008: MISCONSTRUED AS ACID REFLUX.

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I've described these symptoms to doctors before, so I know what to do when I'm coming home from a restaurant with my roommate and pain makes itself known as a gymnastic bar I can easily fold over. I'm an incoherent hinge. My roommate holds my arm in the line at Rite Aid while shoppers look at me like I'm drunk and buys me a roll of Tums. I eat the whole roll. It doesn't help. Eventually, the pain passes. As I've been implicitly coached to do, I deem it a *flare-up* and forget about it.

Slide 42 - MAY 2009: முள்ளிவாய்க்கால் (MULLIVAIKKAL).

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From the 1980s onward, anesthesia may have been crucial in caring for those wounded in Sri Lanka Army or Tamil Tiger attacks, but here's the thing: in a place like Mullivaikkal in 2009, analgesia is impossible. Amputations transpire without anesthetic. There is no palliative care for the fragmented and dying. Blood is a precious commodity, siphoned from the wounds of those bleeding out and filtered back into them for transfusions. Tamil civilians are herded into a smaller and smaller zone in the north and indiscriminately killed. The war ends the day after what's now known as Tamil Genocide Remembrance Day. On that day, May 19, international policymakers don't call this genocide. Rather, President Mahinda Rajapaksa has done the impossible by stamping out the Tamil Tigers, more globally renowned for their terrorist tactics than their self-determination struggle. It's the ultimate victory, one where genocide is overshadowed by counterterrorism. Mary and Sara tell me I was a ghostbody, teaching and writing and fulfilling my obligations like a habitual haunting I couldn't break. I remember nothing of this month.

Figure 16: Debris and rubble in an area of Mullivaikkal after the Army overruns it. No Fire Zone designations don't matter. The UN suggests that 70,000 Tamil civilians were killed in the final months. Local census records indicate 146,679 are unaccounted for, presumed dead or disappeared by the Army, which is what happened to most who surrendered. *Credit: Tamil Guardian (2019)*

Slide 43 - MAY 15, 2009: PILATES.

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To make up for my decreasing physical therapy coverage, I start seeing Sara for Pilates, a combination of massage therapy and movement work. My first Pilates session is dated to today, the same day I also observe *the govt expects to take over the 2 sq mi territory in 48 hrs*. It matches my cultural referent for the experience of bodywork, which is torture enacted before extrajudicial execution. I can close my eyes and imagine all the Tiger cadres tied naked to banana trees with barbed wire

before being necklaced, or Tamil women mutilated post-mortem. What an awful thing it is to make my friend and bodyworker into a torturer, to know that she knows this care is experienced as such, and that it is her job to inflict it. But I am not quite victim. This starts and stops on my command.

Slide 44 - JUNE 9, 2011: WHAT I'VE BEEN TAUGHT TO IGNORE.

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I get brunch with a comics scholar at Dojo in Greenwich Village. We step out together, and I'm dizzy as soon as the sunlight hits me. It must be obvious, because he asks, "Are you okay? Can I get you a cab?" Conscious of my empty wallet, I decline with a "Probably just ate too much!" and a laugh. He nods; we part ways. I make it less than half a block before the pain crawls up from my crotch to my breast and everything in its wake is liquefied. I wake up 20 minutes later, sprawled against a doorway, sticky with sweat that doesn't smell like mine. On the way home, I make sure I have all my belongings, my clothes are intact, I haven't been touched. I wonder if these episodes reflect a stronger resistance to nortriptyline. I have better insurance, so I switch to Lyrica and Savella and tell myself that once I adjust, everything will improve.

Slide 45 - SEPTEMBER 2011: AND IGNORE AGAIN.

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The next time it happens, I'm adjusting to Lyrica, Anji and I go out for pizza and chocolate mousse cake with pistachio cream, she forgets her umbrella and goes back downtown, and again it surfaces, that same strange alien pregnancy that brings me to my knees outside that same Rite Aid. I'm afraid to move. Middle-class white folk pass me without comment. The homeless black man who panhandles at the corner asks, "Sista, you okay there?" and crouches by me like a guard until Anji returns to save me. The axes of race and class aren't lost on me. I lean on Anji all the way home.

Slide 46 - DECEMBER 13, 2012: LUMPS.

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I finally make an appointment to assess a slow-growing lump in my right armpit. I hope it's cancer, even though I'm sobbing in Mee's Noodles as I email Jack to let him know I'll be missing class for an axillary lymph node dissection. Cancer is a destination everyone recognizes, which makes it more desirable than fibromyalgia. After the operation, tissue analysis shows that the lump is benign, but the nodes are blue with tattoo ink, which the surgeon has heard of, but never seen, and treats like a medical marvel. Blue, as in the skin of Vishnu or Krishna, is infinite, formless, and without measure. Like the sky, like painervation, it has no end and no fixity to the naked eye.

Slide 47 - 2013: The FM/a Test

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I hear about a blood test by EpicGenetics, allegedly definitive, that can objectively diagnose fibromyalgia. It analyzes chemokine and cytokine protein patterns in white blood cells and scores abnormality on a scale from 1 to 100. Higher than 50, and you're positive for fibromyalgia. Dr. Birnbaum does not offer me this test, and I think I know why. It feels like a trap. So many patients, including myself, might be seronegative. A positive result on the EpicGenetics test might bolster my hard-won fibromyalgia diagnosis with scientific evidence, but a negative result would strip me of treatments and insurance coverage, just like that.

Slide 48 - OCTOBER 25, 2013: "I'M SICK AND TIRED OF ALL THIS."

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My protein markers are elevated and Dr. Birnbaum informs me she's leaving her practice. Selfishly, this feels like a betrayal. She refers me to a doctor at NYU Langone, Dr. Jiang, whom she praises, but I'm already grieving the loss of the first and maybe only clinician-advocate I had, and I'm dreading the process of retesting everything with a stranger-physician whose disposition and mannerisms I don't yet know, don't know how to exploit if I need to. In one of my

last appointments with Dr. Birnbaum, I agree to a cortisone shot in the piriformis because my current flare-up is intolerable. I usually endure torture in silence, but this one has me cursing. Dr. Birnbaum wonders aloud about the possibility of misdiagnosis or emergent underlying conditions. She tells me about Enbrel, a biopharmaceutical drug approved for rheumatoid arthritis. I've seen the commercial, highly gendered, where getting better is essential to correcting an imbalance in household (re)productive labor and care work. I'm out of spoons, battery life, balut. I undergo the screening tests but ultimately refuse to alter my medication regimen, deciding "to pass on everything from here on out unless it's a matter of life or death" (V. Manivannan, personal communication, October 25, 2013).

Slide 49 - MAY 20, 2014: FACIALITY.

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I see a GI doctor at St. Luke's about the recurring abdominal pain, which knocks on the peritoneum so frequently I've normalized it as inherent to being a body in flux. He doesn't contest that I have fibromyalgia, but when he conducts the rebound tenderness test, he looks at my face, as though evaluating my expressions more than my self-assessment of the sensations his tapping creates. That's a mistake on his part, but I make mistakes too; I ask about Rovsing's sign and McBurney's point and my climbing AST and ALT values, like an expert in medicine or imposture. I have no fever, usually a classic sign of internal infection. He suggests liver damage or pancreatic issues. He orders a scan of everything above the intestine, presumably because I didn't instinctively flinch or cry during the rebound exam, so I walk away without a picture of the appendix, which is where it ultimately is.

Slide 50 - JULY 2, 2014: "CRESTS TO A 9 OR 10, DROPS TO A 6 OR 7."

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My gut is bothering me, I tell Sara online. I average it at a 9 or 10, and she worries that it's been really high for so long. She asks if I've gone back to the GI doctor. I

have. He'd said, "It's too bad you couldn't come in during an episode," and prescribed me an anti-spasmodic and narcotic to get me through future episodes. I tell Sara, *whatever, i'm just going to be told more of the same*. When I go back, he says he can't identify what's wrong after the fact, but if the anti-spasmodic works, then I have an excited, nervous gut, something muscular and neuropathic; otherwise, he'll order an endoscopy, which doesn't make much sense to me since my complaints are about the lower abdomen. "i just feel like the end is coming and i want [my projects] to be done before that" (V. Manivannan, personal communication, July 4, 2014), I tell Mary. I make Anji promise to hire ghostwriters to finish my books. I know something is wrong, and I'm tired of having to know it when knowing is a kind of expertise I'm given only to be denied.

Slide 51 - SEPTEMBER 1, 2014 - SEPTEMBER 2, 2014: "DEATH IS PREFERABLE."

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Anji leaves for Ghana for a postgraduate fellowship on August 25, and I backdate my appendix rupture to this day, when the diarrhea starts, and the waves of pain, dizziness, sweat as cold as winter. I wrap myself around a body pillow; between blackouts, I stumble to and from the bathroom, I draft a will on my phone, I tell Amma *I wish I was dead*. "Call the doctor," she says. "They'll say it's a flare-up," I say. "I'm tired. I'll call when I wake up. I hope I never wake up." But I do wake up, so I call Dr. Jiang's office to make an appointment. The man who answers asks how I'm feeling, and I tell him, "This pain is so bad, death is preferable," but probably I sound too articulate, because he tells me her earliest availability is in two weeks. I should have cried, but it's too late now. I take the appointment. I later find out he never told her that I said I was praying for death.

Slide 52 - SEPTEMBER 16, 2014: THIS PISASU PEY-N.

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Even though my appointment is in two days, this pisasu pey-n has gotten so intolerable I can't wait. I call a nurse right before I teach one of my classes. She

kindly tells me it sounds like an internal rupture and to go to the ER if it's intolerable. Off the phone, I sob into my hands as a crowd of my students file past me to get to class, and as if that weren't shameful enough, Jack follows shortly after, slows down to talk to me, suggests I cancel class and go home. *I'm failing on all fronts*, I say, which is how I feel even on a good day when I'm better able to hide it. *No*, he says, genuinely surprised, *Do the minimum until you're back on your feet. I'd actually been thinking about meeting with you, but I sensed you would treat it like a task and didn't want to overwhelm you.* What a still-surprising gift, to have an advisor who doesn't become Parasurama when my secrets are exposed.

Slide 53 - SEPTEMBER 18, 2014 - SEPTEMBER 19, 2014: "IF THIS HAS REALLY BEEN GOING ON FOR 3 WEEKS, I'D EXPECT SOMETHING REALLY BAD TO HAVE HAPPENED."

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This is what Dr. Jiang says when I finally get to see her, with my handwritten list of symptoms she dismisses in favor of feeling it for herself. After I tell her about the receptionist who ignored the severity of my symptoms, she stops reproaching me, steps out briefly, and comes back saying, "That's really not okay." She examines my abdomen with her hands, telling me that the body *builds walls to protect itself* and those walls might be keeping me alive. She's feeling for my ovaries in case of cyst rupture, but pain makes me hyperventilate so badly I can't speak. She sends me to radiology for a CT scan, which sends me to the ER, where I'm eventually admitted as an inpatient with no diagnosis, no course of treatment, no options. In emergency care, I doze fitfully, wake up to an old white doctor telling the students gathered by my bed about an atypical presentation of severe constipation, and I say, "*That's* what you're telling them? I want to talk to a surgeon, now," over and over until he dismisses the students and asks me quietly what I want. "I want to talk to a surgeon," I say. "Or I'm leaving." Minutes later, a GI surgeon does come by, a South Asian man in my age bracket, Dr. Sattva, who asks me for the whole story. When I finish, he palpates my abdomen and says, "If you have fibromyalgia and you're in the ER for pain, it must be really bad. I don't know what it is from your imaging, but I can do an exploratory laparoscopy, and with your consent, we can deal with whatever we find." "Just cut me open today,"

I say, and we both laugh. While waiting for my turn in the OR, I field student emails and film a lecture for the Monday classes I expect I'll have to miss. Whose expertise is at fault, mine or the doctors who steadily trained me to do my due diligence, dismiss everything as a flare-up, and live until I run out of life?

Slide 54 - SEPTEMBER 19, 2014: நோகுது (NOHUTHU).

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I wake up in a gurney, sans glasses, groggy and disoriented, and my first thought is *am I late to class*. Two women are standing nearby, the nearest in a black motorcycle jacket, oozing cool. I recognize her as Sara when she asks me something. Anji can't make it back in time, but she has apprised Mary and Sara of my situation and location. I somehow choke out *hurts*, though my diaphragm balks at compressing air into words. Vayiru nohuthu. Nenju nohuthu. Sara tells a nurse. I remember nothing, and then I wake up in a bed in the recovery room. I'm told I have to stay until I pee and walk, and out of sheer determination, I do both, gritting my teeth against the deep pulling sensation that ultimately never goes away. I'm told to practice coughing and breathing, to avoid lifting anything, to rest for a minimum of two weeks. I leave with Mary and Sara, who flag a cab, asking the West African cabbie to drive as smoothly as possible because I just got out of surgery. I lay across the backseat with Mary. He keeps asking in concern during the drive, "Is this okay? Is she okay?" and it strikes me again that the most care I receive is rarely from those credentialed to give it.

Slide 55 - SEPTEMBER 25, 2014: PATHOLOGY RELEASED.

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Pathology confirms appendicitis as a result of chronic perforation. The appendix was full of dead white blood cells. It had wrapped up the right fallopian tube and descended into the groin, where increased proximity to lymphatic flow helped fight the infection. Part of the mesentery and peritoneum were also taken for testing. None of the tissues appear malignant, but follow-ups with reproductive specialists are recommended.

Slide 56 - OCTOBER 2, 2014: FOLLOW-UPS.

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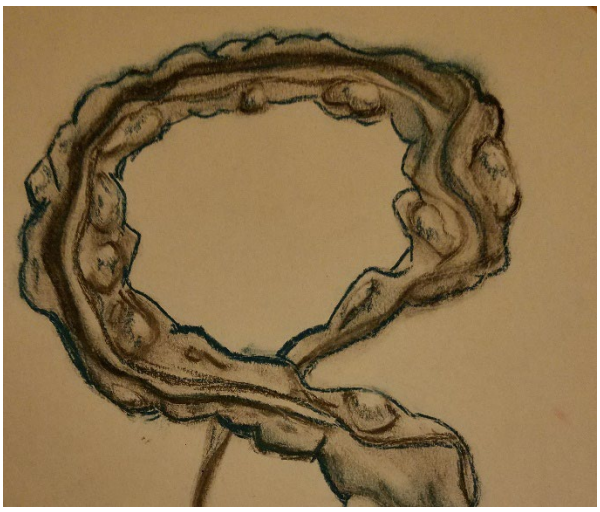

Figure 17: Author's drawing from imagination of her hardened intestine, blue-gray, with hard pearl blisters rendered in peacock blue. *Credit: Manivannan (2014)*

I'm referred to an OB/GYN to make sure that the thickened tissues excluded from pathology testing aren't indicative of ovarian or uterine cancer. This doctor is an older white man who looks at my chart and asks, "Why are you here? The average age of reproductive cancers is fifty. You're too young. You look fine." There is no exam besides this eyeballing through my clothes. By contrast, in my surgical follow-up, Dr. Sattva feels my abdomen from the last rib down, checks my glue-stitched navel visually and by touch, and then draws me a picture of (1) a normal appendix and (2) mine when I was opened up, descended and swollen, organs stuck on and around it like *wet paper, separating them was like shredding papier-mache and so hardened when I opened you up, I was worried it might be stage 4 cancer*. He removes the remnants of the surgical glue from my navel and pronounces me well. He does not, however, flag for me that my uterus and colon have irreparably fused together, which I learn only when I read all the physician's notes from that weekend.

Slide 57 - NOVEMBER 13, 2014: FULL RECOVERY.

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How many times now have I cheated death? I celebrate my official full recovery and my 31st birthday by tattooing my right ribs with a snail crawling on a razor, on the edge but unable to die. A heavily tattooed man watches me with concern, one asking, "You're real quiet. You okay there?" and when I say, "Yeah, I have

chronic pain, so I'm pretty good with ink," he replies, "Respect. I cried like a baby when I had mine done." I know I've just problematically framed my disability as a superpower, so I shouldn't feel flattered, but I am (Dolmage, 2014). It's so rare that the advantages to chronic pain are noted without surprise, revulsion, or critique.

Slide 58 - NOVEMBER 25, 2015: NO ROOM LEFT.

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Embedded Audio: The aurality of digestion: the author grunting, groaning, audibly on the brink. Small wonder I was afraid of eating. *Credit: Manivannan (2014)*

Once a month, during my period, I feel too full and there's no room for food, which I've so far had to deal with by fasting. Every doctor I talk to about this kindly, condescendingly, asks if it's bloating, if I'm anorexic, if it's just cramps putting me off food. Finally, I see Dr. Sattva who orders a follow-up CT scan to see if adhesions have formed. He doesn't mention the uterine-colon adhesion discovered during the laparoscopy; anyway, abdominal adhesions are usually invisible to the biomedical-technological eye. The scan comes back normal. Always, but especially on my period, my interoception is grossly attuned to peristalsis, anticipating the sensation of stilts wobbling through scar tissue. It's only much later that I see an OB/GYN who explains that the uterine-colon adhesion can create that sense of stuckness. Until then, without that evidence and authority to make such a claim, I sound like factitious disorder, unwilling to share the biomedical limelight with those really in need, i.e., those who can be cured.

Slide 59 - AUGUST 16, 2017: COVERAGE DENIED.

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Savella is dropped from my insurance company's formulary. I receive no notification, not like it makes a difference since I'm stuck with the insurance I have, and I'm lucky to have any insurance at all. When I go to refill it and pay my

$50 copay, I'm told it now costs me $425 for a one-month supply. I hyperventilate at the counter, retreat, make a few phone calls, and when I'm sure it isn't a clerical oversight, I stop the drug cold turkey. I've been on it daily for six years. The withdrawal is like a red giant's collapse.

Slide 60 - OCTOBER 2019: நடைப்பிணம் (NADAIPPINAM).

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Embedded Tweet: Sinhalization series focusing on Kokkilai (@PEARL_Action)

If the human body absorbs and reflects the postmodern condition of the body politic (Morris, 2001), what does it mean that, for all these years, a contiguous Tamil homeland in Sri Lanka has been threatened in all its joints? Like Sinhalization efforts in Kokkilai, a pivotal piece of land that connects the northern and eastern parts of the island? Or Buddhisization through the razing of Hindu temples and memorials for Tamil dead? (PEARL, 2019). I might as well name this month's symptoms after these sites of invasion. Costochondritis cages Batticaloa in my chest. Each creak of my wrists and knees, a mine detonating around Elephant Pass, the strategic military base that controls access to the Jaffna peninsula. My stuck diaphragm, the execution of five ethnic Tamil students in Trincomalee. The stiff vertebrae in my cervical spine, the ruined infrastructure of the Vanni. Trigger points in the shoulders, knees, elbows, hips, ankles, another of Gota's or Karuna's lingering white vans. Misbelieved appendix rupture, the Mullivaikkal Massacre. *Rheuma*, the flow or great fluxion throughout the body, renamed as *refugee*. Brennan's (2004) transmission of affect. Everywhere and nowhere at once. *Nadaippinam*, a *walking corpse*, is the shambling thing I am left with, but internal displacement and dispossession are not terrible metaphors for chronic pain and fatigue. Fibromyalgia has been described by patients and researchers as internal disorder, bodily chaos, contingency. I just have a cultural explanation to anchor it.

Slide 61 - NOVEMBER 3, 2019: DEMALA SANNIYA.

Font: Dark Gray, Background: White

Figure 18: A stamp featuring a demonic caricature of a Tamil man: mustached, dark-skinned, red-mawed, with Vibhuti and red pottu on his forehead, clutching betel leaves, wearing traditional Tamil clothes. The bottom of the stamp reads, "traditional Sinhalese exorcism ritual." *Credit: Arulthas (2018)*

Daha Ata Sanniya is Sinhala for dance of demons or diseases, since these demons are responsible for particular ailments like madness and emesis. This month, the Sri Lankan government releases a series of stamps with this theme, including Demala Sanniya, or demon of Tamil in Sinhala, the demon that causes *disease of Tamil*. We as a people are framed as sickness, a malady that must be cast out of the political body for the body to be well (Arulthas, 2019). "The concepts we invent to account for disease come to shape not only the observations we make and the remedies we prescribe, but the very manifestations of the disease itself" (Eisenberg, 1988, p. 1). Pain might make sense in Sri Lanka's North and East, where it is normal to be primed for horror, to cultivate a body so ready to react to violence that it is as though violence is being done to it (Geroulanos & Myers, 2018), tortured into both hypersensitivity and high tolerance; thus, complaining about pain is the abnormality. Pain is the condition of persecution. Of having illness writ large in my skin. Of embodying *disease of Tamil* before my fibromyalgia officially began. Degrees may be conferred, jobs attained, but this, this never ends.