PainWeek®

Chronic Pain Assessment

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Disclosure

- Nothing to disclose

Learning Objectives

- Compare different pain rating scales
- Describe a comprehensive stepwise approach to the assessment and follow-up of patients with chronic pain
- Identify support tools available to the primary care clinician managing a patient with chronic pain

American Pain Foundation, 2007; http://www.painfoundation.org

The Problem of Chronic Pain

- U.S. Center for Health Statistics conducted an 8-year follow-up survey and found that 32.8% of the general population experienced chronic pain symptoms
- Chronic pain affects about 100 million American adults (more than the total affected by heart disease, cancer, and diabetes combined)
    - 56% suffered with pain for more than 5 years
    - Only 22% ever referred to a pain specialist (DeLuca, 2001)
    - 28% of these did not have pain controlled (APS, 1999)
- In a community sample of individuals older than 70, chronic pain was present in 52% with one-third of persons over 75 rating pain as severe
- Pain also costs the nation up to $635 billion each year in medical treatment and lost productivity

Magni et al., 1993; IOM, 2011; McCarthy et al. 2009; Brattberg et al. 1996

The Need for "Good" Treatment

- Patients with chronic pain suffer dramatic reductions in physical, psychological, and social well being with Health Related Quality of Life rated lower than those with almost all other medical conditions
- Considerable variability in the type of practitioners and scope of practice of "multidisciplinary" pain clinics
- Evidence-based practice guidelines emphasize interdisciplinary rehabilitation, integrated treatment, and patient selection criteria
- Interdisciplinary pain rehabilitation programs provide a full range of treatments for the most difficult pain syndromes within a framework of collaborative ongoing communication

O'Connor, 2009; Sander et al., 2005; Stanos and Houle, 2006; Peng et al., 2008

Inadequate Preparation and Training

- Healthcare professionals receive nominal training
  - "…Available evidence indicates that pain management training is widely inadequate across all disciplines." (Fishman, 2013)
  - Few PCPs feel comfortable treating pain; fewer feel comfortable using opioids (Upshur, 2006; O'Rouke, 2007)
    - Becoming worse as draconian legislation is enacted

What is Chronic Pain?

- “Chronic pain has a distinct pathologic basis, causing changes throughout the nervous system that often worsen over time. It has significant psychological and cognitive correlates and can constitute a serious, separate disease entity.” (IOM, 2011)
- A complete assessment and formulation is essential for the successful treatment and rehabilitation of this complex patient

The Complexity of Chronic Pain

- Current pain intensity
- Other concomitant symptoms
- Medical co-morbidities
- Psychiatric and psychological comorbidities
- Risk for medication abuse and diversion
- Number of chronic pain problems
- Number of past surgeries
- Medication side effects
- Extensive healthcare utilization
- Body mass index
- Sleep disorders
- Head trauma history
- Tobacco usage
- Goal setting
- Educational level and employment status
- Current pharmacotherapy regimen
- Coping skills and social support
- Physical conditioning

Peppin, et., al., 2015

Assessment: General

- Detailed history
  - Pain characteristics
  - Review of medical records
    - Prior diagnoses, therapies
    - Physical, psychological comorbidities
- Physical examination
  - Musculoskeletal
  - Neurologic
- Diagnostic studies
- Clinical considerations
  - Pain etiologies, characteristics
  - Effect on biopsychosocial domains including risk for addiction
- Challenges
  - Lack of a specific measurement tool that can prove presence or intensity of pain
  - Inaccurate patient descriptions
    - Degree of pain OR relief

Treatment based on initial assessment and regular reassessments

that are comprehensive, individualized, documented

AMA. http://www.ama-cmeonline.com/pain_mgmt/printversion/ama_painmgmt_m1.pdf; Argoff CE. J Am Osteopath Assoc 2002;102(9 suppl 3):S21-S27; Sinatra R. J Am Board Fam Med. 2006;19:165-177

Assessment: Specific

- Functional Assessment
  - Does the pain interfere with activities: sleeping, eating, walking, rising/sitting, hygiene, sex, relationships?
- Psychological Assessment
  - Does the patient have concomitant depression, anxiety, or mental status changes?
- Medication History
  - What medications have been tried in the past? Which medications have helped? Which medications have not helped?
    Have they gotten into trouble with medications?

The Initial Hurdle

- Patient's self-report
  - Gold standard except when the patient cannot describe pain
- Nonverbal behaviors
  - Under both direct and indirect observation
- Collateral information from family, friends, practitioners
  - Especially important for patients who cannot verbalize pain
- Physiologic measures (least sensitive)
  - Acute pain may elicit a change in vital signs;
    over time physiologic response to pain may not be seen

McCaffery M, Pasero C. Pain: Clinical Manual. p 95. 1999 Mosby, Inc.

Helpful Mnemonics: Overall Format

- HAMSTER
  - HISTORY
  - ASSESSMENT
  - MECHANISM of pain
  - SOCIAL and psychological factors
  - TREATMENT
  - EDUCATION
  - REASSESSMENT

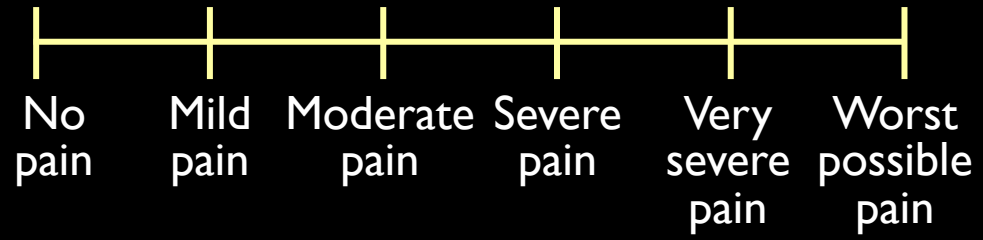
Helpful Mnemonics: HPI

- L-DOC-SARA
  - Location
  - Duration
  - Onset
  - Characteristic
  - Severity and pain goal
  - Aggravating factors
  - Relieving factors
  - Associate symptoms

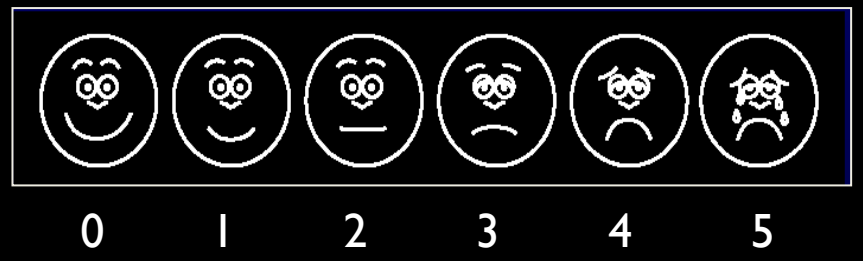
Unidimensional Pain Assessment Tools

Visual Analog Scale[1]

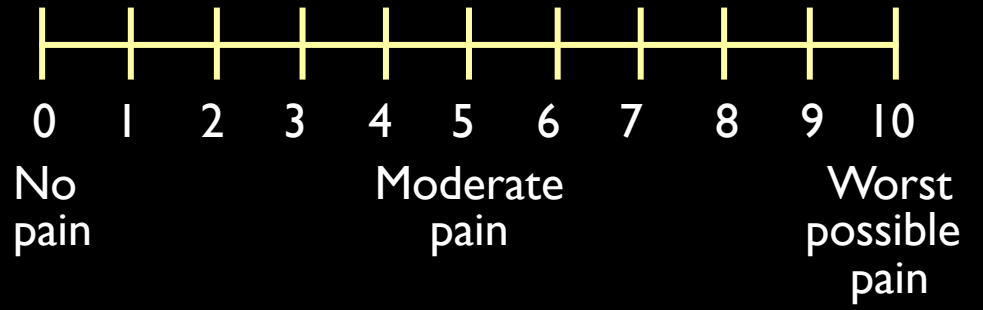
Verbal Pain Intensity Scale[1]



Wong-Baker Faces Scale[2]



0–10 Numeric Pain Intensity Scale[3]



1. Kremer E, et al. Pain. 1981;10:241-248
2. Bieri D, et al. Pain. 1990;41:139-150
3. Farrar JT, et al. Pain. 2001;94:149-158

Psychological Assessment: General

- Evaluate for depression, anxiety, suicidal ideation, sexual abuse, addiction, cognitive impairment
- Screens find cases but do not make diagnoses
  - Help place patients in risk category
  - Patient Health Questionnaire (PHQ-9)
    - Thase, 2016; Moriarty, 2015; Siu, 2016
    - USPSTF recommended (AHRQ)
  - Skeptical psychometrics
  - Multiple scales
    - Beck Depression Inventory
    - Hamilton Rating Scale
    - Zung Self-Rating Scale

Catastrophizing

- "Pain catastrophizing is characterized by the tendency to magnify the threat value of pain stimulus and to feel helpless in the context of pain." (Quartana, 2009)
- Screening tool (Sullivan, 1995)
- Correlated with:
  - Adverse pain related outcomes
  - Poor treatment responses
  - Shapes emotional, functional, and physiological responses
- Responses to treatment

Kinesiophobia

- "The fear of movement was the single strongest contributor to ankle disability" (Lentz, 2010)
- Common in SLE, > 65% (Baglan, 2015)
- Impact on life
  - Job
  - Disability
  - Social support
  - Pain treatment and treatment efficacy

Chemical Coping

- "Middle ground between compliant medication use and addiction." (Kirsh, 2007)
  - "The use of opioids to cope with emotional distress, characterized by inappropriate and/or excessive opioid use." (Kwong, 2015)
  - Important distinction from seeking primary drug-effect
  - Screening tool (Kirsh, 2007)
  - Poor prognosticator for efficacy of treatment and reduction in pain (Delgado-Guay, 2015)

Substance Use Disorder

- Screen to indicate need for evaluation (O'Brien, 2008)
- CAGE (Ewing, 1984)
  - Have you ever felt you should **C**ut down on your drinking?
  - Have people **A**nnoyed you by criticizing your drinking?
  - Have you ever felt bad or **G**uilty about your drinking?
  - Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye opener)
- CAGE-AID (Brown, 1995)
  - Adapted for drug abuse

Generalized Broader Assessments

- Brief Pain Inventory
  - https://www.painedu.org/Downloads/NIPC/Brief_Pain_Inventory.pdf
- McGill Pain Questionnaire
- PHQ-9
- Just Ask!
  - "Are you at risk to yourself or others?"
  - "Any history of physical or sexual abuse."

Collateral Information

- There is no single diagnostic test for pain
  - Imaging, neurophysiologic testing, laboratory studies
- Confirm or exclude underlying causes such as rheumatoid arthritis, diabetic neuropathy, spinal disorders, HIV/Hep C, herpes viruses, vitamin deficiencies, autoimmune disorders, malignancies
- Multiple tests may not be helpful and produce false positive results
- The best source of data is old records from previous practitioners

Developing a Care Plan

- Working diagnosis
  - Pain etiology
  - Pain syndrome
  - Inferred pathophysiology
- Initial treatment
  - Individualized based on pain intensity, duration, disease, tolerance of AEs, risk for aberrant behavior
  - May be stepwise in nature
  - May involve multidisciplinary team
  - May include behavioral + nonpharmacologic + pharmacologic modalities
  - May include analgesics with different, complementary MOAs and agents to reduce other symptoms (depression, anxiety, sleep disturbance, fatigue)

Zorba-Paster R. Expert Opin Pharmacother. 2010;11:1823-1833

Risk of Abuse, Misuse, Diversion, and Overdose Death

- Universal Precautions (Gourlay, 2005)
- Risk Screening Tools (Passik, 2008)
  - ORT—Opioid Risk Tool
  - SOAAP—Screener and Opioid Assessment Measure for Patients with Chronic Pain
  - SOAAP-R—Revised
  - DIRE—The Diagnosis, Intractability, Risk, Efficacy Tool
  - SISAP—Screening Instrument for Substance Abuse Potential

http://diginole.lib.fsu.edu/islandora/object/fsu%3A207738/datastream/PDF/view

Aberrant Drug-Taking Behaviors

Probably More Predictive of Addiction	
Selling prescription drugs	Prescription forgery
Stealing or "borrowing" drugs	Injecting oral formulations
Obtaining prescription drugs from nonmedical sources	Concurrent abuse of alcohol or illicit drugs
Multiple dose escalation or other noncompliance with therapy despite warnings	Multiple episodes of prescription "loss"
Repeatedly seeking prescriptions from other clinicians or from emergency departments without informing prescriber or after warnings to desist	Evidence of deterioration in the ability to function at work, in the family, or socially that appears to be related to drug use
Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug	

Portenoy RK. J Pain Symptom Manage. 1996;11:203-217

Aberrant Drug-Taking Behaviors

Probably Less Predictive of Addiction	
Aggressive complaining about the need for more drugs	Drug hoarding during periods of reduced symptoms
Requesting specific drugs	Openly acquiring similar drugs from other medical sources
Unsanctioned dose escalation or other noncompliance with therapy on 1 or 2 occasions	Unapproved use of the drug to treat another symptom
Reporting psychic effects not intended by the clinician	Resistance to a change in therapy associated with "tolerable" adverse effects with expressions of anxiety related to the return of severe symptoms

Portenoy RK. J Pain Symptom Manage. 1996;11:203-217

Reassessment: Key to Treatment Efficacy

- Consistent reassessment is critical
  - Upfront time investment worth the effort
    - Shortens subsequent visits
  - But still reassessment should include:
    - Treatment efficacy, goals, medication side effects, QOL, etc
      - Address appropriate medication usage
      - Re-review medications, OTC, prescription, supplements
      - Other medical problems that may have surfaced since last visit
      - Readdress psychological health
      - Readdress functionality
      - Other
    - Physical examination

Helpful Mnemonics: Follow-Up

- Four **A**s
  - Analgesia
  - Adverse side effects
  - Activities of daily living
  - Aberrant behavior

Principles of Pain Management

- Individualize pain management
- Assess and treat disability and physical, psychosocial, and psychological comorbidities[1,2]
- Select simplest approach using multimodal therapy (pharmacologic and nonpharmacologic)[1,2]

1: American Medical Association. Pain management. http://www.ama-cmeonline.com/pain_mgmt/
2: American Pain Society, 2007. http://www.ampainsoc.org

Principles of Pain Management

- Consider expert consultation if:
  - Uncertainty about diagnosis
  - Specialized treatment (eg, nerve block) is indicated
  - Unable to achieve pain and functional goals
  - Discomfort with opioid therapy in person with a history of substance abuse
  - Evidence suggests opioid misuse/abuse
  - Several treatments/combinations tried without success

Conclusion

- Evaluate/adopt personalized “step approach” to pain assessment/management (eg, HAMSTER)
- Identify pain tools that work for your practice
- Set realistic, achievable goals in pain reduction
- Comprehensive management should include combination of nonpharmacologic/pharmacologic therapy
- Seek to minimize specialist referrals, only for times when absolutely necessary

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