PAINWEEK®

Awkward Conversations: Managing Patients With Chronic Pain

Paul G. Mathew, MD, DNBPAS, FAAN, FAHS

Title & Affiliation

Paul G. Mathew, MD, DNBPAS, FAAN, FAHS

Assistant Professor of Neurology
Harvard Medical School
Headache/Sports Neurology/Concussion Specialist
Mass General Brigham Health Care

Harvard Vanguard Medical Associates

Disclosures

- Consulting Fee (e.g., Advisory Board): Allergan, Amgen, Biohaven, Impel,
- Lilly, Revance, Satsuma, Stealth BioTherapeutics, Supernus, Takeda, Theranica

Learning Objectives

- Identify the components of a comprehensive chronic pain assessment
- Choose an effective treatment plan including both pharmacological and non-pharmacologic interventions
- Identify signs of abuse and addiction

PART I

THE PRELUDE BEFORE THE PAIN

Chronic Pain Epidemiology

- 1.5 billion people worldwide suffer from chronic pain1
- 100 million Americans suffer with Chronic Pain2
- Annual cost of pain is about $635 billion in the US
  - Sum of medical costs, disability days, and lost wages/productivity 2
- 20% of the European population3
  - More common in women and the elderly

1. Global Industry Analysts, Inc. Report, January 10, 2011.
2. Institute of Medicine Report from the Committee on Advancing Pain Research, Care, and Education: Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research. The National Academies Press, 2011.
3. Van Hecke O Torrance N, Smith BH. Chronic pain epidemiology and its clinical relevance. Br J Anaesth. 2013 Jul;111(1):13-8.

Types of Pain

- Nociceptive Pain: Due to activated nerve endings from nerve or tissue injury
- Neuropathic Pain: Pain associated with intrinsic nervous system dysfunction
- Chronic Pain: Pain for 1 month after healing or 3 months total
- Acute Pain: Pain after an event that resolves as healing occurs.

TYPES OF PAIN

- Nociceptive Pain:

- Neuropathic Pain:

Chronic Pain

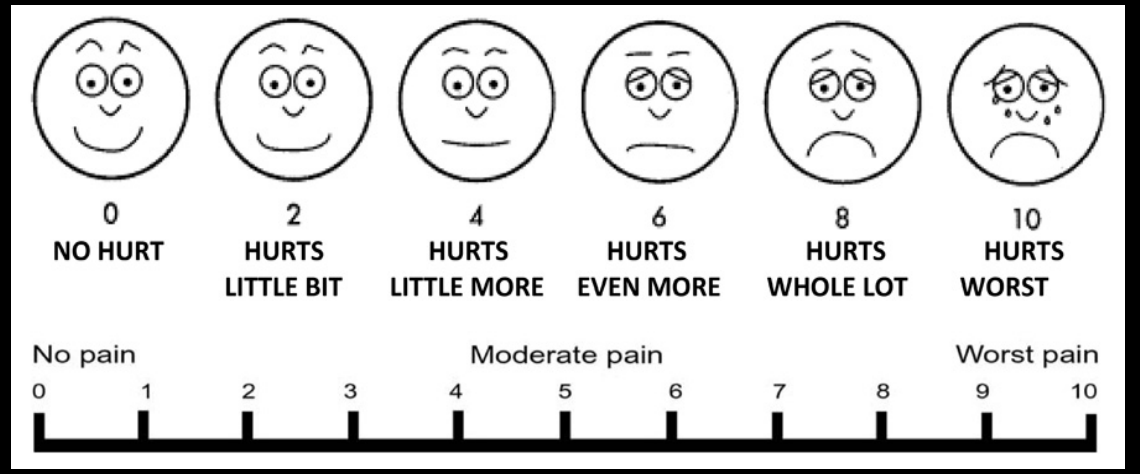
- Difficult to treat
  - At times no clear diagnosis
  - At times no objective signs
  - At times only based on patient's own subjective self assessment
  - It takes time to take a complete history
    - A provider actually listening can be very therapeutic
    - Healthcare cuts with lower reimbursement can limit face time with patients
  - Access to care in jeopardy
    - Prior authorizations for generics
    - Prior authorization denials

Pain Evaluation

- Pain History Elements
  - Location
  - Intensity
  - Duration
  - Origin
  - Exacerbating Factors
  - Alleviating Factors
  - Associated Symptoms
  - Warning signs
    - Both neurologic and non-neurologic
  - Family History
  - Toxic Habits
- Start with open ended questions and open mic time
  - Be heard can be therapeutic
  - Focus on one problem and address others as time permits

Pain Evaluation

- Pain Scales can be useful tools for evaluation1
  - 1-3/10 indicates mild pain with no significant impairment of function
  - 4-6/10 indicates moderate pain with some impairment
  - 7-10/10 indicates severe pain with complete impairment of function
- Diaries can be very helpful for treatment modification and patient reassurance
- Patients are being compared to THEMSELVES



Mathew PG, Mathew T. Taking care of the challenging tension headache patient. Curr Pain Headache Rep. 2011 Dec;15(6):444-50.

Pain Evaluation (cont'd)

- Physical Examination
  - Comprehensive with a focus on area in question
  - Physical examination guides diagnosis and informs management
  - Therapeutic value of physical contact with the patient
    - Gives the patient a sense of a more comprehensive evaluation
    - Touch expresses healing, caring, and connection.
    - Should NOT be replaced by technology, but rather guide when to order diagnostic studies.
    - The element of touch is lost with virtual care

Kelly MA, Gormley GJ. In, But Out of Touch: Connecting With Patients During the Virtual Visit. Ann Fam Med. 2020 Sep;18(5):461-462.

Pain Evaluation (cont'd)

- Imaging, laboratory, and other testing should be performed based on clinical suspicion, cost of testing, and patient preferences
  - Refused tests should be clearly documented
  - Unnecessary/repeat testing should be avoided when possible given the potential for risks, cost, time, and incidentalomas

The Testing Line

- Your symptoms sound very consistent with _____.
- Your examination and family history (if applicable) further suggests this diagnosis.
- Let's proceed with x, y, z treatments.
- If your symptoms worsen or do not respond to treatment, we can proceed with an MRI or other tests for further evaluation.
- If pain suddenly worsens, contact me, another physician, or proceed to the ED for further evaluation

Pitfalls For The Line

- High Anxiety
- Already Failed Multiple Treatment Plans
- High Frequency/Intensity Pain

Untreated Pain Consequences

- Sleep dysfunction
  - Classically thought that chronic pain can affect sleep continuity and sleep architecture
  - Conversely sleep deprivation can increase pain sensitivity in acute and chronic pain states
    - Hyperalgesia to heat, cold, blunt pressure, and pinprick stimuli demonstrated
  - Sleep deprivation can interfere with analgesic treatments involving opioid and serotoninergic mechanisms of action

1.Lautenbacher S, Kundermann B, Krieg JC. Sleep **deprivation and pain perception.** Sleep Med Rev. 2006 Oct;10(5):357-69. Epub 2006 Jan 4.

2. Schuh-Hofer S, Wodarski R, Pfau DB, Caspani O, Magerl W, Kennedy JD, Treede RD. One night of total sleep **deprivation promotes a state of generalized hyperalgesia: a surrogate pain model to study the relationship of insomnia and pain.** Pain. **2013 Sep;154(9):1613-21.**

Untreated Pain Consequences

- Sleep dysfunction red flags
  - Sleep interruptions during the night
    - Bathroom
    - Pets
    - Partner
  - Snoring
    - Witnessed pauses or choking
  - Excessive daytime drowsiness and daytime naps
  - Memory and cognitive issues
- "No doctor, I sleep just fine"
  - Increased risk of stroke, heart attack, and cognitive dysfunction

Untreated Pain Consequences

- Reduced activity
  - Weight gain
  - Potential exacerbation of pain
- Financial Concerns
  - Full time → Part Time → Disability
  - Treatment and transportation costs

Untreated Pain Consequences

- Depression/Anxiety
  - Secondary or Primary?
  - Some patients will use pain medication to treat these symptoms
- Progressive Social Isolation
  - Social Events: Early Departure → Cancellation → No Scheduling
  - Support: Friendectomy → Familyectomy → Physicianectomy

Red Flags

- Symptoms do not match examination
- Misses appointments and looses prescriptions
- Calling for early refills
- Refusing tox screens
- Allergic to multiple medications in the same class
- “This is the only medication that works for me.”
- Frequently switching providers or seeing multiple providers in the same specialty
- Requesting different prescriptions be sent to different pharmacies
- Lifestyle and pain mismatch
  - Vacations, extravagant social life, etc.
- Work related or ensuing litigation

Pit Fall Avoidance

- Set expectations early
  - Contracts with consequences
- Reassurance and alliance for a team approach
  - Body language and tone are important
  - Avoid patient invitations to antagonize other physicians
- Avoid Poly-Sourcing
    - Communicate with other providers, Use PMP
- Periodic drug testing
- Pharmacy audits
- Opioid diversion should be treated seriously including selling of opioids or prescription tampering

Pit Fall Avoidance

- Salutary Neglect
- Use your staff effectively
- Routine visits
  - Provide refills with pill counts
  - Monitor pain and side effects
- Refer rather than abandon
  - Behavioral health including cognitive behavioral therapy
  - Suggest contribution rather than causality, which can make a big difference to the patient.

Non-medication Interventions

- Physical/Occupational Therapy
- Behavioral Modification
- Bio Feedback
- Psychology
- Acupuncture
- Massage Therapy
- Nutrition
- Personal Trainer

Part II

THE AWKWARD CONVERSATIONS

OPENING LINE TRAP DOOR

- How would you respond?
- A good response
- A bad response

Opening Line Trap Door

- A good response
- Non-judgmental response
- Buy some time to get organized
- Demonstrate a genuine interest in understanding the patient
- Policy discussions are appropriate, but only after a rapport is established with the patient.

The Rambling Patient With The Never Ending Story

- How would you respond?
- A good response
- A bad response

The Rambling Patient With The Never Ending Story

- A good response
- Interrupt politely
- Avoid body language that suggests disinterest
- Talk about maximizing the patient's time, not your busy schedule
- Make it clear there will be adequate time to talk about other issues even if there is not.

Frustration: It's Not Me, It's You Doctors

- How would you respond?
- A good response
- A bad response

Frustration: It's Not Me, It's You Doctors

- A good response
- Express empathy
- Barraging the patient with kindness when they are most frustrated can be a turning point for cooperation and trust
- The frustrated/angry patient is often the vulnerable patient

Pain Scales:
1 Is The Loneliest Number

- How would you respond?
- A good response
- A bad response

PAIN SCALES:
1 IS THE LONELIEST NUMBER

- Most patients think they have an abnormally high tolerance for pain
- Tying function to pain is a good way assess intensity
- Establishing parameters will help to gauge progress after interventions
- Pain diaries can be priceless in assessing and modifying therapies

Mathew PG, Mathew T. Taking Care of the Challenging Tension Headache Patient. Curr Pain Headache Rep.2011 Dec;15(6):444-50.

DIARY USE IS CRITICAL?

- Establishes baseline
- Establish seasonal, weather associations
- Establish menstrual association
- Steers titrations
- Functional pain scale helps physician and patient agree on quantification of pain

BRIGHAM AND WOMEN'S Faulkner Hospital

Harvard Medical School Teaching Affiliate

JOHN R. GRAHAM HEADACHE CENTER
PGM HEADACHE CALENDAR

MONTH:

DAYS	MENSES	INTENSITY (1-3 Mild, 4-6 Mod, 7-10 Disabling)	ABORTIVE MEDICATION USED
ex	P	1 2 3 4 5 6 7 8 9 10	N + S
1		1 2 3 4 5 6 7 8 9 10	
2		1 2 3 4 5 6 7 8 9 10	
3		1 2 3 4 5 6 7 8 9 10	
4		1 2 3 4 5 6 7 8 9 10	
5		1 2 3 4 5 6 7 8 9 10	
6		1 2 3 4 5 6 7 8 9 10	
7		1 2 3 4 5 6 7 8 9 10	
8		1 2 3 4 5 6 7 8 9 10	
9		1 2 3 4 5 6 7 8 9 10	
10		1 2 3 4 5 6 7 8 9 10	
11		1 2 3 4 5 6 7 8 9 10	
12		1 2 3 4 5 6 7 8 9 10	
13		1 2 3 4 5 6 7 8 9 10	
14		1 2 3 4 5 6 7 8 9 10	
15		1 2 3 4 5 6 7 8 9 10	
16		1 2 3 4 5 6 7 8 9 10	
17		1 2 3 4 5 6 7 8 9 10	
18		1 2 3 4 5 6 7 8 9 10	
19		1 2 3 4 5 6 7 8 9 10	
20		1 2 3 4 5 6 7 8 9 10	
21		1 2 3 4 5 6 7 8 9 10	
22		1 2 3 4 5 6 7 8 9 10	
23		1 2 3 4 5 6 7 8 9 10	
24		1 2 3 4 5 6 7 8 9 10	
25		1 2 3 4 5 6 7 8 9 10	
26		1 2 3 4 5 6 7 8 9 10	
27		1 2 3 4 5 6 7 8 9 10	
28		1 2 3 4 5 6 7 8 9 10	
29		1 2 3 4 5 6 7 8 9 10	
30		1 2 3 4 5 6 7 8 9 10	
31		1 2 3 4 5 6 7 8 9 10	

Use P to indicate days of your menstrual period.
Use abortive medication abbreviations like T for Tylenol.
Combinations of medications like Naproxen and Sumatriptan can be written as N + S

Incomplete Response Or Irresponsibly Complete?

- How would you respond?
- A good response
- A bad response

Incomplete Response Or Irresponsibly Complete?

- A good response
- Combining lifestyle changes with pharmacological and intervention approaches tend to have the best results
- Empowering the patient to be proactive can lead to shared responsibility and positive outcomes
- Hinting at additional testing, therapies, referrals can give a hopeless patient hope

NARCOTICS OR NO-COTICS?

- How would you respond?
- A good response
- A bad response

NARCOTICS OR NO-COTICS?

- A good response
- Avoid labeling patients drug seeking
- True pain patients are not looking for a high
- Highlighting side effects can be powerful motivation
- Stress that patients will not be abandoned or forced into sudden withdrawal
- Formal contracts and keeping the PCP in the loop are always good ideas

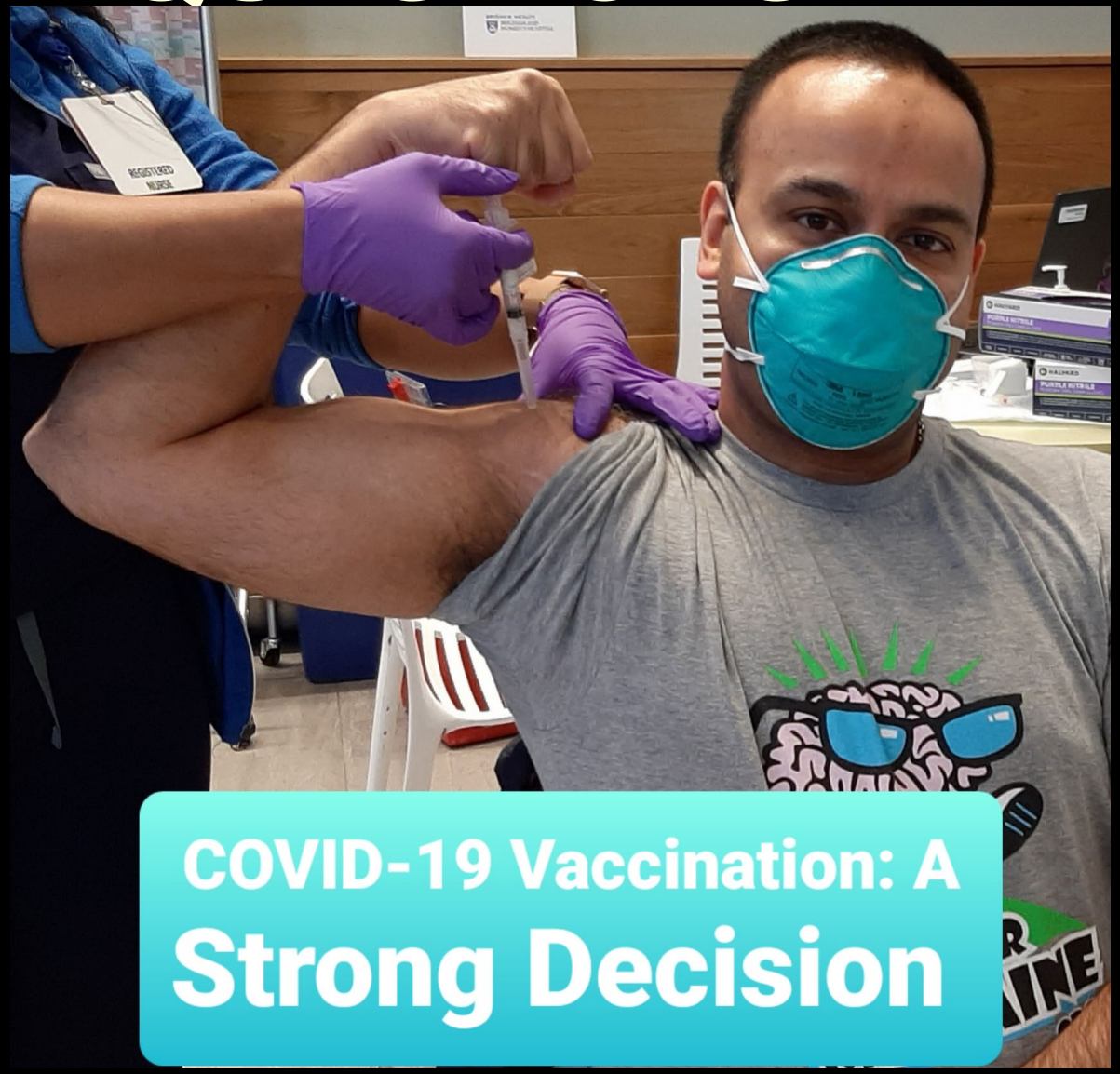
COMPLAINTS ABOUT COLLEAGUES?

- How would you respond?
- A good response
- A bad response

COMPLAINTS ABOUT COLLEAGUES?

- A good response
- It is best not to comment on the treatment choices of a specific patient, especially in front of a mutual patient.
- Decline to comment and change the subject back to the patient's present condition.
- Peer to peer feedback can be useful, but this is typically better done face to face as tone can be lost over e-mail/text
- If the patient brings up safety or inappropriate behavior, it is likely worth mentioning to the chair/chief of the department

QUESTIONS???



PAINWEEK