STUDIES IN PAIN MANAGEMENT

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DECLARATIONS

- ABFP CERTIFIED FAMILY PHYSICIAN AND MEDICAL DIRECTOR OF THE PAIN CENTER AT MARY FREE BED HOSPITAL AND REHABILITATION CENTER.
- FELLOW OF THE AMERICAN COLLEGE OF PAIN MEDICINE
- CLINICAL INSTRUCTOR IN FAMILY PRACTICE MICHIGAN STATE COLLEGE OF HUMAN MEDICINE

- NO FINANCIAL INTERESTS OR COMMERCIAL CONTRACTS RELATED TO THIS TOPIC OR PRESENTATION.

BASICS; HOW DO I DO THIS?

- WHAT PROVIDERS ASK FOR MOST – HOW TO GET PATIENTS OFF OF OPIOIDS?

- IMPORTANT FACTS–MOST CHRONIC PAIN PATIENTS AREN'T ON OPIOIDS. THE ONES THAT ARE GET MOST OF OUR ATTENTION.
- WHO ARE THE OTHERS? THOSE ON CHRONIC PAIN INTERVENTIONS LIKE EVERY 3 MONTH EPIDURAL STEROIDS, CHRONIC CHIROPRACTIC CARE, SERIAL SURGERIES, SOCIAL SECURITY DISABILITY, SPINAL CORD STIMULATORS, INTRATHECAL PUMPS, CHRONIC MUSCLE RELAXERS, GABAPENTIN, MIGRAINE PREVENTIVES, DULOXETINE, STIMULANTS, BENZODIAZEPINES ETC..

BASICS

THREE IMPORTANT STEPS TO RELIEVING CHRONIC PAIN

1) EDUCATION ABOUT THE BODIES PAIN SYSTEM

2) REASSURANCE THAT YOU ARE NOT ABANDONING THEM WITH THEIR PAIN

3) CHANGING THE FOCUS FROM RELIEVING PAIN TO RESTORING FUNCTION

BASICS – EDUCATION - IF YOU DON'T UNDERSTAND THIS YOU CAN'T TEACH IT TO YOUR PATIENTS

- SEE INFORMATION FROM DR. CLAUW AND DR. WILLIAMS
- ADDITIONAL RESOURCES:
  - EXPLAIN PAIN   BOOK OR ON LINE; DR DAVID BUTLER AND DR. LORIMER MOSELY – AUSTRALIA
  - DR CLAUW – YOUTUBE VIDEOS
  - RETRAINPAIN.ORG WEBSITE
  - LAMP WORKBOOKS – DR BEVERLY E. THORN – UNIVERSITY OF ALABAMA (LEARNING ABOUT MANAGING PAIN FOR GROUPS)
  - YOUTUBE – MOSELEY TEDX TALK; PAIN REVOLUTION;
  - HTTP://WWW.GREGLEHMAN.CA/PAIN-SCIENCE-WORKBOOKS/

REASSURANCE THAT YOU ARE NOT GOING TO ABANDON THE PATIENT

INITIATE THE PROCESS WITH A 45 MINUTE VISIT (FIRST VISIT IN ½ DAY OR LAST VISIT)

HAVE THE PATIENT COMPLETE A DETAILED REVIEW OF SYSTEMS ALONG WITH A PAIN DIAGRAM. GATHER ANY RECORDS THAT YOU NEED, HAVE A MAPS REPORT PRINTED UP, HAVE NURSE COMPLETE A PHQ-2 AND 9 IF INDICATED AND CONSIDER ANOTHER SCREENING TOOL FOR SUBSTANCE USE DISORDER SUCH AS DAST AND POSSIBLY A PAIN MANAGEMENT URINE DRUG SCREEN.

HAVE A COPY OF A CLINICAL OPIATE WITHDRAWAL SCALE HANDOUT TO GIVE THE PATIENT IF THEY ARE ON OPIATES.

THE CHRONIC PAIN EVALUATION

OPEN ENDED QUESTIONS; WHEN DID YOU LAST FEEL WELL AND HEALTHY? THEN WHAT HAPPENED?

WHAT TREATMENTS HAVE BEEN TRIED? HOW HAVE THEY WORKED?

WALK ME THROUGH YOUR USUAL DAY STARTING WITH -WHAT TIME DO YOU GET OUT OF BED?

ASK ABOUT HOW MUCH TIME IS SPENT RESTING?
DO YOU EXERCISE?
WHEN DO YOU GO TO BED?
HOW WELL DO YOU SLEEP?
WHAT WOULD YOU DO DIFFERENTLY IF YOUR PAIN WAS BETTER CONTROLLED?

GO THROUGH THE REVIEW OF SYSTEMS WITH THE PATIENT LOOKING FOR RED FLAGS.(BOWEL AND BLADDER CONTROL, WEIGHT LOSS, HISTORY OF CANCER, FEVER, MENTAL HEALTH AND MOOD DISTURBANCES AND MAJOR PSYCHOSOCIAL STRESSORS.

THE CHRONIC PAIN EVALUATION

EXAMINE THE PATIENT

EVALUATE FOR OBJECTIVE FINDINGS SUCH AS LIMITED JOINT OR SPINE MOBILITY BOTH ACTIVE AND PASSIVE, LOSS OF STRENGTH OR REFLEXES, EXPLAINING THE MEANING OF YOUR FINDINGS TO THE PATIENT.

DECIDE IF YOUR FINDINGS WARRANT FURTHER WORK UP. AVOID ORDERING FURTHER STUDIES BASED SOLELY ON COMPLAINTS OF PAIN PARTICULARLY WHERE THE SAME STUDIES HAVE BEEN DONE BEFORE, BECAUSE AS WE HAVE SEEN THERE IS NOT A GOOD CORRELATION BETWEEN PAIN AND PATHOLOGY.

TWO THINGS THAT ALMOST ALWAYS REQUIRE OUTSIDE REFERRAL, SUBSTANCE USE DISORDER AND UNSTABLE PSYCHIATRIC PATIENT WITH ACTIVE SUICIDAL PLAN OR PSYCHOTIC SYMPTOMS.

IF STRONG SUSPICION FOR DIVERSION YOU MAY NEED TO IMMEDIATELY STOP PRESCRIBING.

THE CHRONIC PAIN EVALUATION

ASSESS READINESS FOR CHANGE

THE MORE MISERABLE THE PATIENT IS THE MORE LIKELY THEY ARE TO CHANGE.

CHANGE ALWAYS INCREASES ANXIETY – LET THE PATIENT KNOW THAT YOU UNDERSTAND THAT THEY ARE ANXIOUS AND CONSIDER THAT NORMAL.

EXPLAIN THAT YOU WOULD LIKE TO FOCUS ON HELPING THEM RESTORE FUNCTION (IE – HELP THEM GET THEIR LIFE BACK)

SHARED DECISION MAKING – WHERE WOULD THEY LIKE TO START? DECREASING MEDS? IMPROVING THEIR SLEEP? IMPROVING THEIR MOOD – DECREASING DEPRESSION OR LOWERING ANXIETY? ADDING BACK IN ACTIVITIES THAT THEY HAVE STOPPED?

AVOID PASSIVE APPROACHES, HELP PATIENT FOCUS ON THINGS THEY CAN LEARN TO CONTROL. IT MAY BE AS SIMPLE AS GETTING DRESSED EVERY DAY, STOPPING NAPS, DECREASING THEIR NARCOTICS, NO LONGER TALKING ABOUT THEIR PAIN WITH FRIENDS AND FAMILY. LEARNING NOT TO CATASTROPHIZE. READING AND STUDYING ABOUT PAIN OR THEIR DIAGNOSIS.

CASE EXAMPLE –HEADACHE

- 54-YEAR-OLD MAN WITH CHRONIC HEADACHE FOR ~10 MONTHS
  - ONSET AFTER WORK-RELATED HEAD INJURY
  - SYMPTOMS: CONSTANT PAIN AROUND EYES AND TEMPLES BILATERALLY (4 OUT OF 10), INTERMITTENT SEVERE PAIN IN RIGHT TEMPLE (8 OUT OF 10), TINNITUS
- TREATMENT HISTORY
  - COMPLETED POST CONCUSSION PROGRAM AT MARY FREE BED FOLLOWING ACCIDENT
  - NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS FOR PAIN
- CURRENT FUNCTIONING
  - WORKS FULL TIME
  - DECREASED ENGAGEMENT IN PHYSICAL AND SOCIAL ACTIVITIES
  - ANXIETY AND DEPRESSED MOOD RELATED TO PAIN; ANGER ASSOCIATED WITH WORK-RELATED INJURY AND COMPANY'S RESPONSE
  - CONTINUED COGNITIVE SYMPTOMS (E.G., WORD-FINDING PROBLEMS, FORGETTING TO DO THINGS)
  - FEELS EXTREMELY FATIGUED AFTER WORK SHIFTS
  - SIGNIFICANT SLEEP DISTURBANCE INVOLVING INTERRUPTED SLEEP. NEGATIVE EVALUATION FOR SLEEP APNEA.

CASE EXAMPLE – HEADACHE

- MEDICAL HISTORY
  - HYPERTENSION, DIABETES, CROHN'S DISEASE
  - CHRONIC PAIN IN LEG DUE TO PRIOR INJURY; THIS IS NOT DISTRESSING OR IMPAIRING AT PRESENT
- MENTAL HEALTH HISTORY
  - NO PRIOR MENTAL HEALTH PROBLEMS OR TREATMENT
  - CURRENTLY A HIGH DEGREE OF CATASTROPHIC THINKING ABOUT PAIN AND ADJUSTMENT-RELATED DEPRESSED MOOD AND ANXIETY
- SOCIAL HISTORY
  - CURRENTLY MARRIED – FEELS GUILTY THAT HIS WIFE HAS TO HELP HIM WITH TASKS
  - CHILDHOOD NEGLECT AND ABUSE – TENDS TO SUPPRESS ANGER AS AN ADULT DUE TO THIS LEARNING HISTORY
  - MOTIVATED TO CONTINUE WORKING

CASE EXAMPLE – HEADACHE

- TREATMENT PROGRESS
  - RETURNED TO PREVIOUSLY VALUED ACTIVITIES (CAMPING, HUNTING, EXERCISE)
  - IDENTIFIED A LINK BETWEEN SUPPRESSED ANGER AND HEADACHES. LEARNED EFFECTIVE COPING STRATEGIES.
  - DECREASED HEADACHE-RELATED VIGILANCE AND CHECKING BEHAVIORS (E.G., "OBSESSING" OVER WHAT MAY INFLUENCE HEADACHE). INCREASED PAIN ACCEPTANCE AND DECREASED CATASTROPHIZING.
  - PATIENT REPORTED: MORE RELAXED, LESS PAIN, GREATER SELF-EFFICACY TO MANAGE PAIN, IMPROVED COGNITIVE FUNCTIONING
  - AT TIME OF DISCHARGE, 2 WEEKS WITH NO SIGNIFICANT HEADACHES
  - DISABILITY (NDI)
    - INTAKE: 52%; DISCHARGE: 24%
  - AVERAGE PAIN OVER PAST MONTH (0-10 SCALE)
    - INTAKE = 4; DISCHARGE = 2
  - DEPRESSED MOOD (CES-D)

    INTAKE = 33 (MODERATE-SEVERE); DISCHARGE = 6 (NORMAL RANGE)
  - ANXIETY (BURNS)
    - INTAKE = 27 (MODERATE); DISCHARGE = 11 (BORDERLINE/SUB-THRESHOLD)
  - PAIN CATASTROPHIZING (PCS)
    - INTAKE = 39 (SEVERE); DISCHARGE = 6 (NORMAL RANGE)

CASE REVIEW

- 56 YEAR OLD AIRFORCE PILOT WITH LOW BACK PAIN STARTING IN 1987 WHICH WORSENED IN 2000 WHEN SPLITTING FIREWOOD
- TREATMENT HISTORY:
- 2008 LAMINECTOMY – “SIGNIFICANT RELIEF”
- 2009 FELL OFF STOOL “UNDID LAMINECTOMY
- 2010 REPEAT LAMINECTOMY – “NO RELIEF”
- 2011 THIRD BACK SURGERY -- PAIN WORSENED
- TRIED EVERYTHING: PT, INJECTIONS, OPIOIDS, NSAIDS, GABAPENTIN, MASSAGE, ICE/HEAT

CASE REVIEW

- PAIN SHARP LANCINATING IN CENTRAL LOW BACK RADIATING DEEP INTO BOTH BUTTOCKS WITH RADIATION DOWN TO RIGHT FOOT
- NOW DEEP BILATERAL HIP PAIN WORSE AT NIGHT, WORSE WITH STANDING, SITTING AND EXERTION. "SOMEWHAT RELIEVED" BY LYING SUPINE WHICH HE DOES 16 HOURS PER DAY
- RETIRED AIR FORCE LIEUTENANT COLONEL 100% DISABILITY FROM VA AND SOCIAL SECURITY DISABILITY
- PTSD WITH ANXIETY, DEPRESSION, AND NIGHTMARES SINCE AFGHANISTAN

CASE REVIEW

- MORPHINE ER 100 MG TID AND MORPHINE IR 10 MG 6 X PER DAY
- CLONAZEPAM 2 MG QID, ZONESIMIDE 25 MG QID, PANTOPRAZOLE QD
- HAD WORKED WITH REFERRING PAIN CLINIC TO WEEN TO NORCO 7.5/325 MG QID AND OFF CLONAZEPAM AND ZONESIMIDE AND STARTED ON CYCLOBENZAPRINE 10 MG TID.
- 10/17/2017 STARTED MULTIDISCIPLINARY TX PROGRAM
  - STANDING TOLERANCE < 3 MIN
  - WALKING TOLERANCE 5 MIN OR <
  - ^ PAIN WITH ANY MOVEMENT
- AVG PAIN -7, LOWEST – 5, WORST –9: LEVEL AT WHICH HE COULD LIVE HIS LIFE = 3