

# Studies in Pain Management

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# Basics: How do I do this?

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What providers ask most:

“How do I get patients off opioids?”

# Two Groups

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1. Most chronic pain patients aren't on opioids. The ones that are get most of our attention.
2. Who are the others? Those who receive or have received:
  - Regular epidural steroids, spinal cord stimulators, intrathecal pumps
  - Chronic chiropractic care
  - Multiple surgeries
  - Multiple non-opioid medications

# Basics

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Three Important steps to relieving chronic pain:

- 1. Educate** patients about the pain system
- 2. Reassure** your patient that you are not abandoning them
- 3. Change** the focus from relieving pain to restoring function

# Basics – Educate

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## Resources for patients:

- Lorimer Mosely – “The Pain Revolution”
- Michigan Body Map
- Clinical Opiate Withdrawal Scale (COWS)
- Dan Clauw – YouTube videos “Pain Is It All In Their Head?”
- “Pain is weird” Website/blog; “Retrainpain.org
- Lamp workbooks – Beverly E. Thorn, MD – University of Alabama

# Basics—Reassure

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- Initiate process with a 45 minute visit, if possible, or in multiple visits
- The following are good practices for chronic pain patients:
  - Detailed review of systems and pain diagram
  - Patient history
  - MAPS report
  - PHQ-2 or 9
  - consider screening tool for substance use disorder (DAST)
  - Urine drug screen

# Basics—Change focus: Patient evaluation

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- Open ended questions:
  - When did you last feel healthy? Then what happened?
  - What treatments have been tried? How have they worked?
  - Walk me through a usual day starting with:
    - ***What time do you get out of bed?***
    - ***How much time is spent resting? Exercising?***
    - ***When do you go to bed? How well do you sleep?***
    - ***What would you do differently if your pain was better controlled?***
- Review systems looking for red flags (e.g. bowel and bladder control, weight loss, history of cancer, fever, mental health and mood disturbances and major psychosocial stressors)

# Chronic Pain Evaluation

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- Look for limited joint or spine mobility (active and passive) and loss of strength or reflexes
- Review findings with patient
- Determine if findings warrant further work up
- Avoid ordering studies based solely on complaints of pain, especially if they have been done before



# Case Example –Headache

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*54-year-old male with chronic headache 10 months; onset after work-related head injury*

## **Symptoms**

- Constant pain around eyes, temples bilaterally (4/10), intermittent pain in right temple (8/10), tinnitus

## **Treatment history**

- Completed post-concussion program 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, company's response
- Continued cognitive symptoms (e.g. word-finding problems, forgetful)
- Extreme fatigue after work
- Interrupted sleep, but negative evaluation for sleep apnea

# Case Example – Headache

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## **Medical History**

- Hypertension, diabetes, Crohn's disease
- Chronic pain in leg due to prior injury; no distress or impairment at present

## **Mental Health History**

- No prior mental health problems or treatment
- Currently high degree of catastrophic thinking about pain and adjustment-related depressed mood and anxiety

## **Social History**

- Married – reports guilt that wife has to help with tasks
- Childhood neglect and abuse – reports suppressing anger as an adult
- Wants to continue working

# Case Example – Headache

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## Treatment Progress

- Returned to previously valued activities (camping, hunting, exercise)
- Learned effective coping strategies for anger
- 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 ability

## 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 Example Chronic Back Pain

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## ***59-year-old man with a 15-year history of chronic back pain***

- Reported “constant aching” in spine, hands, shoulders; numbness and tingling in upper and lower extremities

## **Daily oral morphine equivalence: 185-250 mg**

- Medications include morphine sulfate ER 15 mg 3 tabs TID, hydromorphone 4 mg 2 tabs QD, diazepam 5mg Q am, temazepam 30mg HS PRN, lisdexamfetamine 70mg Q am, bupropion XL 450 mg daily, melatonin 5mg Hs, Lisinopril-hctz 10/12.5 QD, testosterone topical 10mg Qam.

## **Treatment history**

- Multiple back surgeries, physical therapy, chiropractic, nerve blocks, mental health counseling, massage, ice/heat

## **Current functioning**

- Works part time
- Prolonged periods of rest/inactivity
- Significant sleep disturbance
- Worsening depression
- Would like to return to full-time work and recreational activities (fishing, golfing, swimming)

# Case Example

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## **Medical History**

- Hypertension, obstructive sleep apnea, viral hepatitis C

## **Mental Health History**

- Depression, anxiety, ADHD
- Prior suicide attempt
- Multiple psychiatric hospitalizations

## **Substance Use History**

- “Various substances” since age 9
- Past alcohol use and heroin use disorder

## **Social History**

- History of childhood trauma
- U.S. Army veteran
- Married

# Case Example

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## Treatment Progress

- Opioid taper continued after discharge– no daily narcotics present.
- Returned to previously valued activities (golfing, home activities, exercise)

**Patient Reported:** more positive affect and energy, decreased pain, using behavioral strategies to manage pain

- Disability (ODI): Intake: 52%; Discharge: 38%
- Average pain over past month (0-10 scale): Intake = 6; Discharge = 3
- Depressed mood (CES-D): Intake = 22 (mild); Discharge = 11 (normal range)
- Anxiety (Burns): Intake = 50 (severe); Discharge = 16 (mild)
- Pain Catastrophizing (PCS): Intake = 42 (severe); Discharge = 8 (normal range)