

# Treating Pain Based on the Underlying Mechanisms

**Daniel J. Clauw M.D.**

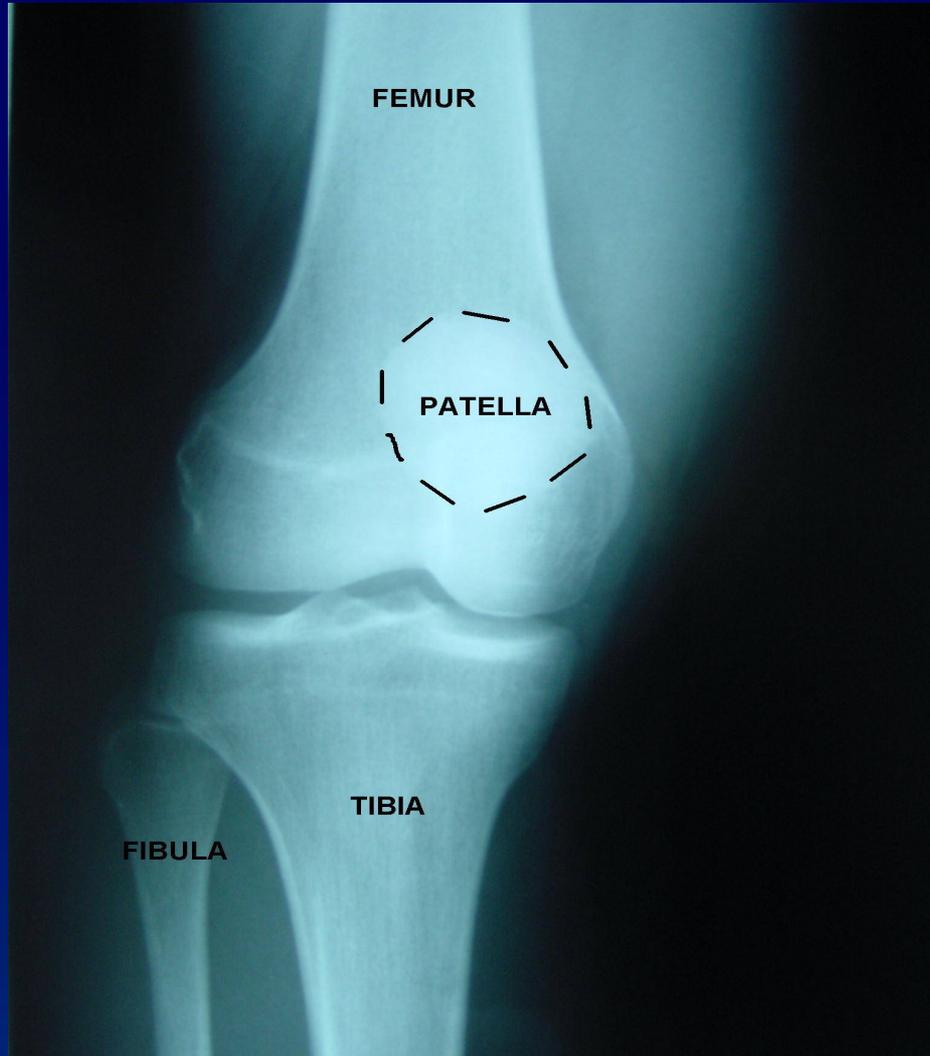
**dclauw@umich.edu**

Professor of Anesthesiology, Medicine  
(Rheumatology), and Psychiatry  
Director, Chronic Pain and Fatigue  
Research Center  
The University of Michigan

# Disclosures

- Consulting
  - Pfizer, Tonix, Theravance, Zynerba, Samumed, Aptinyx, Daiichi Sankyo, Intec, Regeneron, Teva, Lundbeck
- Research support
  - Pfizer, Cerephex, Aptinyx
- Litigation – testified against opioid manufacturers in State of Oklahoma

# Which person has pain?



# Osteoarthritis

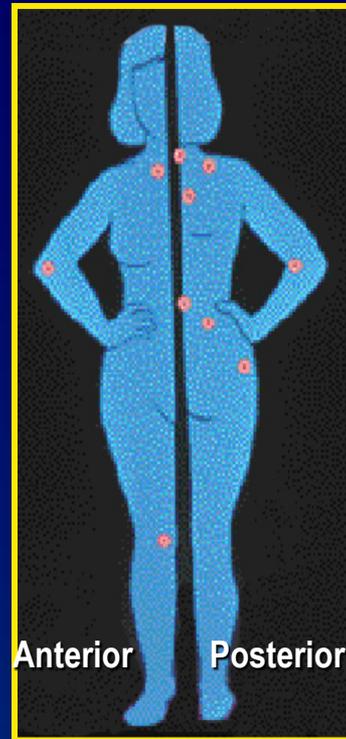
- Classic “peripheral” pain syndrome
- Poor relationship between structural abnormalities and symptoms<sup>1</sup>. In population-based studies:
  - 30 – 40% of individuals who have grade 3/4 K/L radiographic OA have no symptoms
  - 10% of individuals with severe pain have normal radiographs
- Psychological factors explain very little of the variance between symptoms and structure<sup>2</sup>
- We sometimes delude ourselves into thinking that our current therapies are adequate
  - NSAIDs, acetaminophen, and even opioids have small effect sizes<sup>3,4</sup>
  - Arthroplasty does not predictably relieve pain

(1) Creamer P, et. al. Br J Rheumatol 1997; 36(7):726-8. (2) Creamer P, et. al. Arthritis Care Res 1998; 11(1):60-5. (3) Bjordal JM, et. al. Eur J Pain 2007; 11(2):125-38. (4) Zhang W, et. al. Ann Rheum Dis 2004; 63(8):901-7.

# Evolution of Thinking Regarding Fibromyalgia

## American College of Rheumatology (ACR) Criteria

- Discrete illness
- Focal areas of tenderness
- Pathophysiology poorly understood and thought to be psychological in nature



- Chronic widespread pain
- Tenderness in  $\geq 11$  of 18 tender points

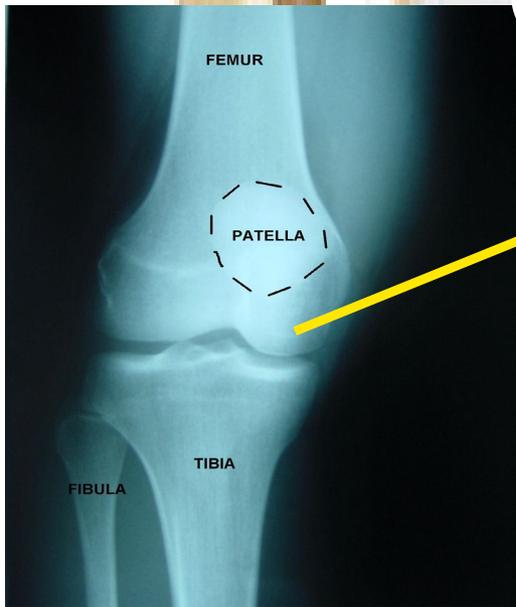
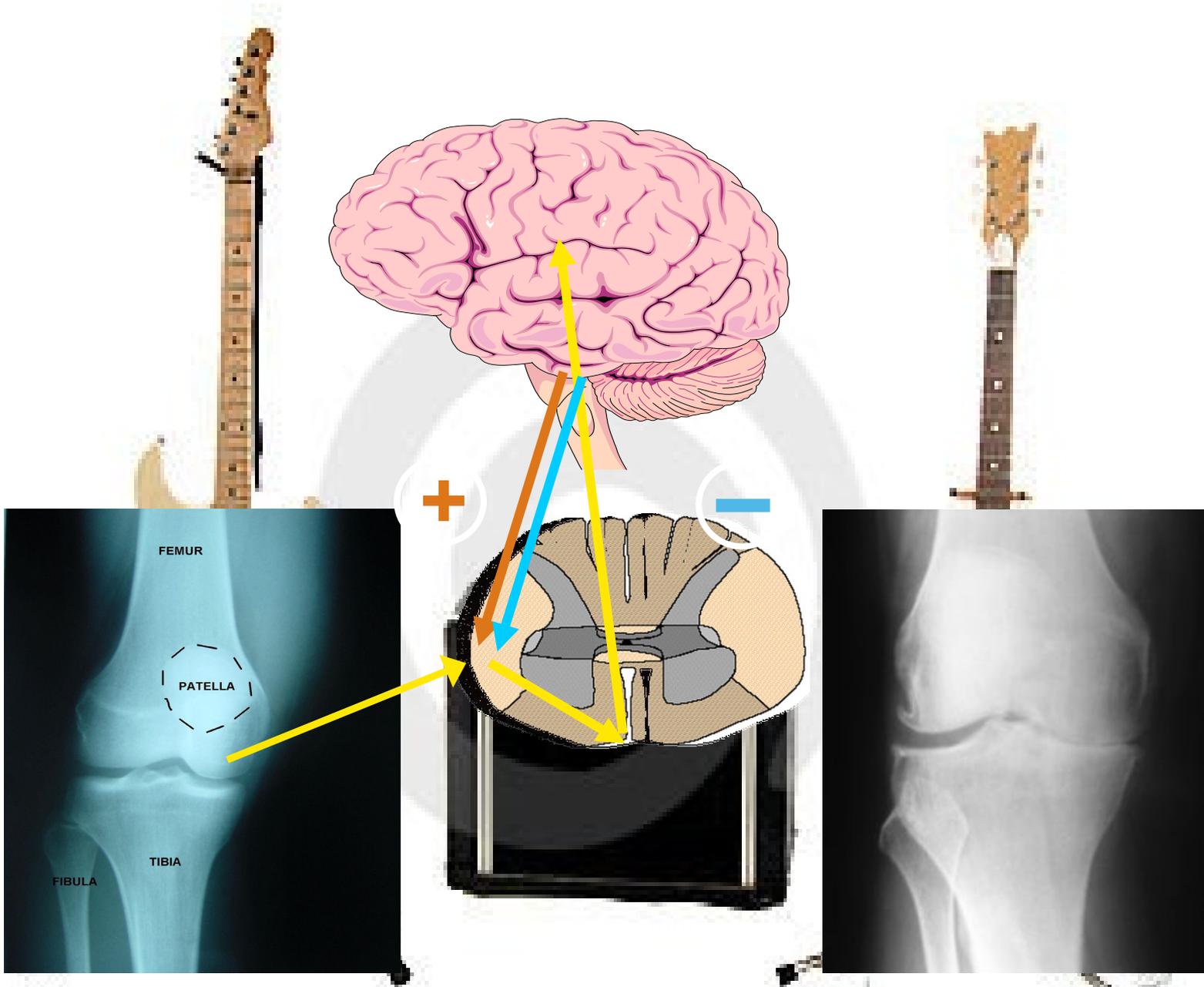


- Final common pathway (i.e. pain centralization)
- Poster child for nociplastic pain
- Not just pain
- Pathophysiology fairly well understood and is a CNS process that is independent from classic psychological factors

# Mechanistic Characterization of Pain

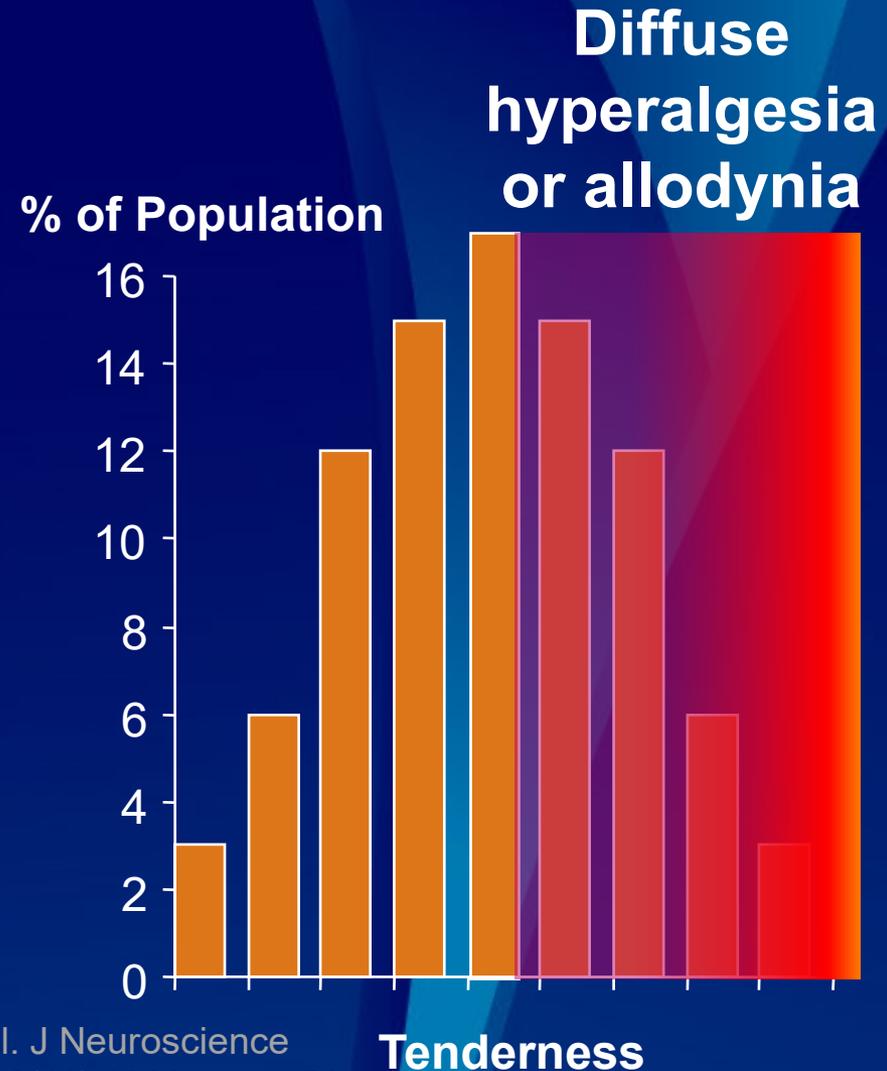
## Variable degrees of any mechanism can contribute in any disease

	<b>Nociceptive</b>	<b>Neuropathic</b>	<b>Centralized/Nociplastic</b>
<b>Cause</b>	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
<b>Clinical features</b>	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
<b>Screening tools</b>		PainDETECT	Body map or FM Survey
<b>Treatment</b>	NSAIDs, injections, surgery, ? opioids	Local treatments aimed at nerve (surgery, injections, topical) or CNS-acting drugs	CNS-acting drugs, non-pharmacological therapies
<b>Classic examples</b>	Osteoarthritis Autoimmune disorders Cancer pain	Diabetic painful neuropathy Post-herpetic neuralgia Sciatica, carpal tunnel syndrome	Fibromyalgia Functional GI disorders Temporomandibular disorder Tension headache Interstitial cystitis, bladder pain



# Pain and sensory sensitivity in the population

- Like most other physiological processes, we have a “volume control” setting for how our brain and spinal cord processes pain<sup>1</sup>
- This is likely *set* by the genes that we are born with<sup>2-4</sup>, and *modified* by neurohormonal factors and neural plasticity
- The higher the volume control setting, the more pain we will experience, irrespective of peripheral nociceptive input



1. Mogil JS. PNAS, 1999;96(14):7744-51. 2. Amaya et. al. J Neuroscience 2006;26(50):12852-60. 3. Tegeder et.al., NatMed. 2006;12(11):1269-77. 4. Diatchenko et. al. HumMolGenet. 2005;14(1):135-43.



# Overlapping Chronic Pain Conditions: Implications for Diagnosis and Classification



William Maixner,<sup>\*,†</sup> Roger B. Fillingim,<sup>‡</sup> David A. Williams,<sup>§</sup> Shad B. Smith,<sup>\*,†</sup>  
and Gary D. Slade<sup>\*,¶,||</sup>

*\*Center for Pain Research and Innovation, <sup>¶</sup>Department of Dental Ecology, <sup>||</sup>Department of Epidemiology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.*

*<sup>†</sup>Center for Translational Pain Medicine, Department of Anesthesiology, Duke University, Durham, North Carolina.*

*<sup>‡</sup>Pain Research and Intervention Center of Excellence, University of Florida, Gainesville, Florida.*

*<sup>§</sup>Chronic Pain and Fatigue Research Center, Department of Anesthesiology, University of Michigan, Ann Arbor, Michigan.*

**Abstract:** There is increasing recognition that many if not most common chronic pain conditions are heterogeneous with a high degree of overlap or coprevalence of other common pain conditions along with influences from biopsychosocial factors. At present, very little attention is given to the high degree of overlap of many common pain conditions when recruiting for clinical trials. As such, many if not most patients enrolled into clinical studies are not representative of most chronic pain patients. The failure to account for the heterogeneous and overlapping nature of most common pain conditions

# Chronic Overlapping Pain Conditions

- Most highly prevalent pain conditions in individuals under age 50
  - Headache
  - Fibromyalgia
  - Irritable bowel
  - TMJ Disorder
  - Interstitial cystitis
  - Low back pain
  - Endometriosis
  - Vulvodynia
  - Chronic fatigue syndrome
- Same central mechanisms play significant roles in all pain conditions, even those with known peripheral contributions

# Fibromyalgia-ness

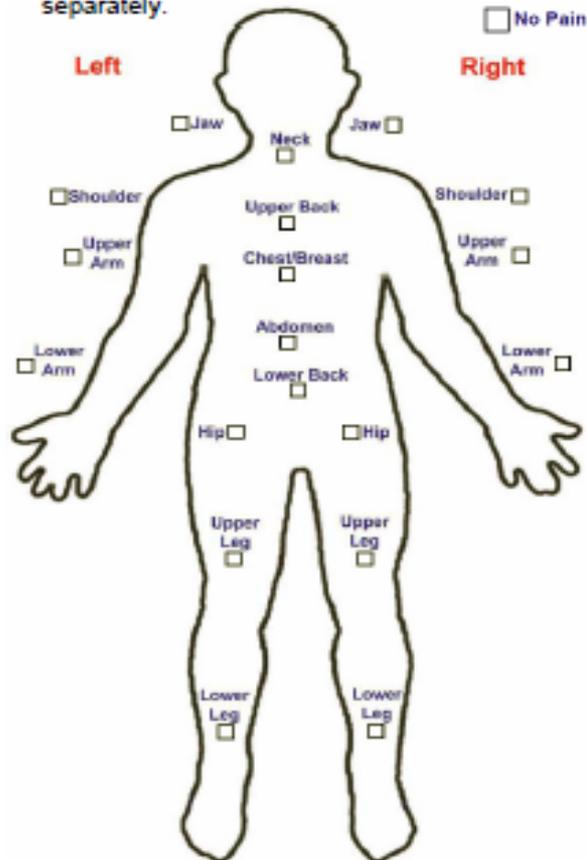
- Term coined by Wolfe to indicate that the symptoms of FM occur as a continuum in the population rather than being present or absent <sup>1</sup>
- In rheumatic disorders such as osteoarthritis, rheumatoid arthritis, lupus, low back pain, etc. this score is more predictive of pain levels and disability than more objective measures of disease <sup>2,3</sup>
- Domain overlaps with somatization in many regards, and there are many questionnaires that collect somatic symptom counts as a surrogate for this construct

1. Wolfe et. al. *Arthritis Rheum.* Jun 15 2009;61(6):715-716. 2. Wolfe et. al. *J Rheumatol.* Feb 1 2011. 3. Clauw DJ. *JAMA*, 2014.

# Concept of “Fibromyalgia-ness”

## Fibromyalgia Symptoms (Modified ACR 2010 Fibromyalgia Diagnostic Criteria)

1. Please indicate below if you have had pain or tenderness over the past 7 days in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.



2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

**No problem**

**Slight or mild problems:** generally mild or intermittent

**Moderate:** considerable problems; often present and/or at a moderate level

**Severe:** continuous, life-disturbing problems

	No problem	Slight or mild	Moderate	Severe
a. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Trouble thinking or remembering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Waking up tired (unrefreshed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the past 6 months have you had any of the following symptoms?

	No	Yes
a. Pain or cramps in lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>
b. Depression	<input type="checkbox"/>	<input type="checkbox"/>
c. Headache	<input type="checkbox"/>	<input type="checkbox"/>

4. Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months?      No       Yes

5. Do you have a disorder that would otherwise explain the pain?      No       Yes

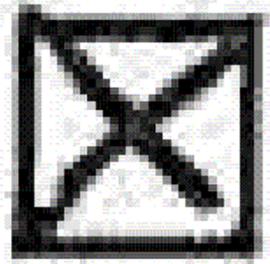
Knee



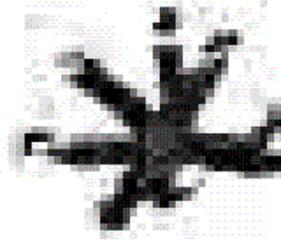
Lower



Knee



Lower



### Michigan Body Map

On the image below identify all the areas of your body where you have felt persistent or recurrent pain present for the last 3 months or longer.

**Left**      **Right**

**Head:**  Head (orgasmic headaches, need to see neurologist),  Face (tics - sometimes painful),  Jaw,  Neck

**Upper Body:**  Shoulder,  Upper Back (triggers),  Chest/Breast,  Upper Arm,  Elbow,  Lower Arm

**Lower Body:**  Abdomen,  Lower Back,  Coccyx/Pelvis,  Hip,  Groin,  Buttocks,  Upper Leg,  Knee,  Lower Leg,  Ankle,  Foot

**Hand/Wrist:**  Wrist/Hand (left),  Wrist/Hand (right)

**Handwritten Notes:**

- Im turning into a recliner chair since Dec 4th
- Limited Rheumatology in GA - 3 in Atlanta area - Primary help/pain
- Arthritis - 2 in other places now
- LT carpal tunnel release went bad in GA on 4-26-11. worse since.
- Nerve damage continues with Drs that mimic MS, carpal tunnel, spasms, twitching etc. very painful.
- Severe Polyneuropathy after chemo for AML in 1990. Took some time, months - 1yr - 2yrs to recover to feel the ground. Mid thigh to feet. Mid upper forearm to fingers. See pt, list please for more info.
- GA plan of tx changed per Dr. Dobson informed @ 1st visit to be done. No PE performed.
- due to using cane from GA in plan of tx from GA.
- surgery for carpal tunnel postponed due to move back home to MI
- arthritis or just sore filing ad dozens of forms for 3 people.
- due to wt loss no butt left, use special cushion to sit on.
- \* Sciatica - bilaterally.
- \* pain in back the priority. need an epidural. Last one was difficult to get in, allergic to Sodiaw, eat seafood + no problems. Severe problems many hrs later after last epidural. Pain Specialist concern.

**Legend:**  No Pain

# Fibromyalgia

An iceberg floating in a dark blue ocean under a lighter blue sky. The tip of the iceberg is visible above the water, while the much larger, submerged part is visible below the surface. The text is overlaid on the image.

**Centralized pain in individuals  
with any chronic pain condition**

# Sub-threshold FM is Highly Predictive of Surgery and Opioid Non-responsiveness in Patients Undergoing Arthroplasty and Hysterectomy

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- Primary hypothesis of studies is the measures of centralized pain in OA (FMness) will predict failure to respond to arthroplasty and hysterectomy
- Extensive preoperative phenotype using validated self-report measures of pain, mood, and function
- Two outcomes of interest:
  - Postoperative opioid consumption
  - Pain relief from procedure at 6 months

1. Brummett, C.M., et al., *Anesthesiology*, 2013. **119**(6): p. 1434-43.
2. Brummett, C.M., et al., *Arthritis Rheumatol*, 2015. **67**(5):1386-94.
3. Janda, A.M., et al., *Anesthesiology*, 2015. **122**(5): p. 1103-11.

# Variables Analyzed

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- Age
- Sex
- Surgery (Knee vs Hip)
- Primary anesthetic (GA vs neuraxial)
- Home opioids (IVME)
- Pain severity (BPI)
  - Overall
  - Surgical site
- Neuropathic pain score (PainDETECT)
- Depression (HADS)
- Anxiety (HADS)
- Catastrophizing
- Physical function-WOMAC

# “Fibromyalgia-ness” can be scored 0-31

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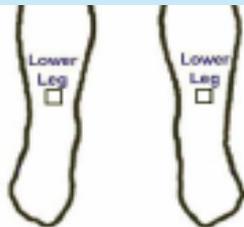
Left



Right

No Pain

19/31 potential  
FM score  
derived from  
how  
widespread  
pain is



2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

No problem

Slight or mild problems: generally mild or intermittent

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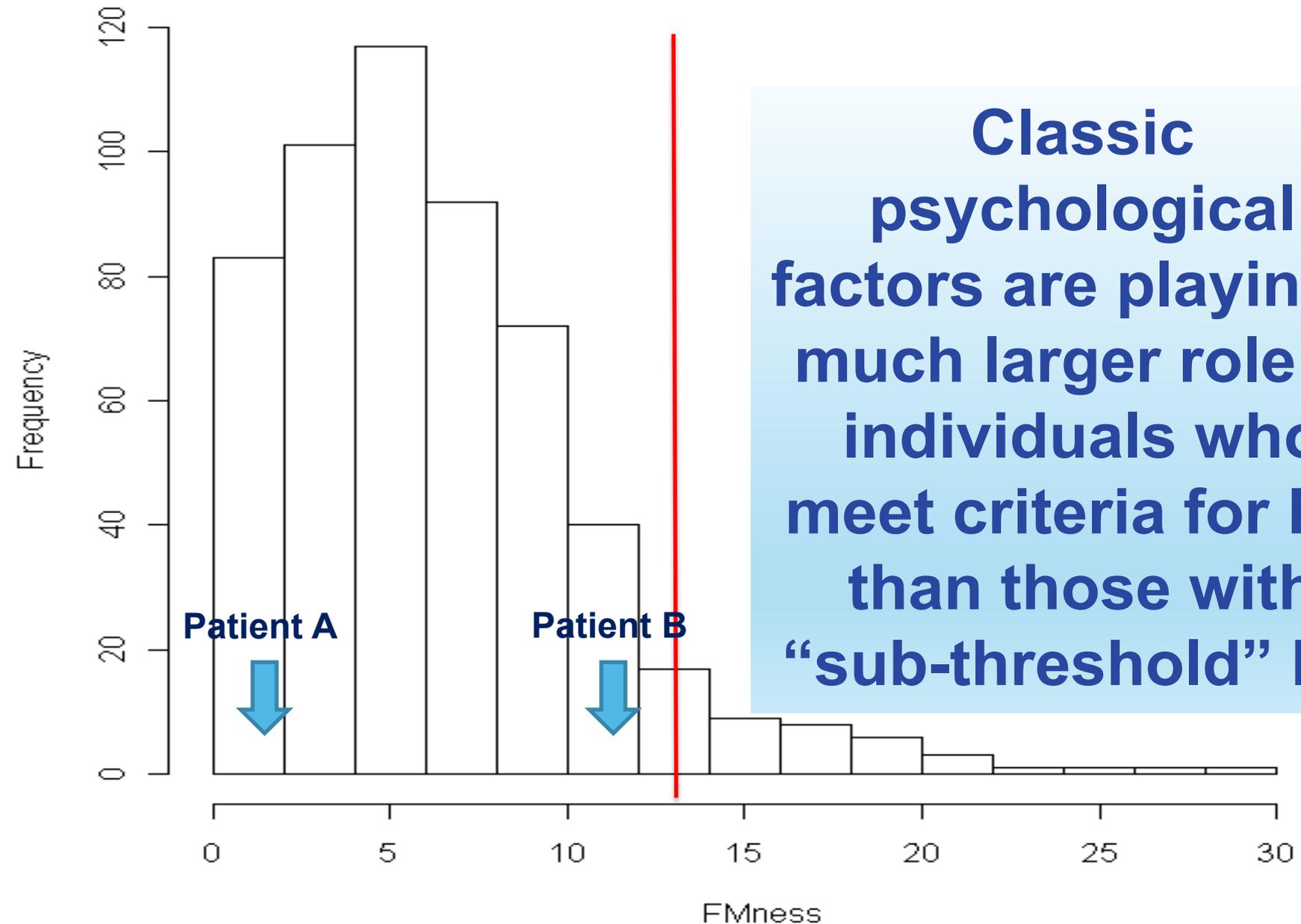
Severe: continuous, life-disturbing problems

- 12/31 potential  
FM score  
derived from  
co-morbid  
CNS-derived  
symptoms that  
accompany  
CNS pain
- a. Fatigue  Severe
- b. Trouble remembering
- c. Waking (unrefreshed)
3. During the past week, have you had any of the following symptoms?  
a. Pain on moving
- b. Depressed mood
- c. Headaches
4. Have the following symptoms been present at a similar level for at least 3 months?  
a. Irritable bowel syndrome
5. Do you have any of the following symptoms?  
a. Irritable bladder
- No  Yes

# Each one point increase in fibromyalgiansess led to:

- 9 mg greater oral morphine requirements during acute hospitalization (8mg greater when all individuals taking opioids as outpatients excluded)
- 20 – 25% greater likelihood of failing to respond to knee or hip arthroplasty (judged by either 50% improvement in pain or much better or very much better on patient global)
- These phenomenon were linear across entire scale up to a score of approximately 18 - and equally strong after individuals who met criteria for FM were excluded
- This phenomenon was much stronger than and largely independent of classic psychological factors

## Distribution of FMness



**Classic  
psychological  
factors are playing a  
much larger role in  
individuals who  
meet criteria for FM  
than those with  
“sub-threshold” FM**

# Mechanistic Characterization of Pain

## Variable degrees of any mechanism can contribute in any disease

	Nociceptive	Neuropathic	Centralized
<b>Cause</b>	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
<b>Clinical features</b>	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
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Mixed Pain States

# Centralization Continuum

*Proportion of individuals in chronic pain states that have centralized their pain*

Peripheral

Centralized



Acute pain

Osteoarthritis  
RA

SC disease  
Ehler's Danlos  
Low back pain

Fibromyalgia  
Tension HA  
TMJD IBS

# The widespreadness of pain (half of the 2011 FM criteria) predicts increased responsiveness to duloxetine in Low Back Pain

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- In LBP, responsiveness to duloxetine was strongly related to number of sites on the Michigan Body Map.
  - Average number of sites of pain in this LBP study was 3 – 4
  - At 14 weeks, using any measure of pain improvement, individuals with more body sites of pain were significantly more likely to respond
  - Relative response rate for responders (30% improvement in pain)

■ MBM pain sites = 1	RR = 1.07
■ MBM sites = 2	1.30
■ MBM sites = 3	1.34
■ MBM sites = 4	1.47
■ MBM sites > 5	1.60

# In RA, the residual pain and fatigue seen despite treatment with biologics can be treated as such

- In a large cohort of RA patients being treated at a US academic medical center, 47.3% continued to report having moderate to high levels of pain and fatigue. Most of these patients had minimal signs of inflammation but high levels of FM or Fmness.<sup>1</sup>
- Using quantitative sensory testing, active inflammation was associated with heightened pain sensitivity at joints (peripheral sensitization), whereas poor sleep was associated with diffuse pain sensitivity as noted in FM (central sensitization or centralized pain).<sup>2</sup>
- In a cross-over trial of six weeks of milnacipran in RA patients, in the overall group there was no statistical improvement, but in the subgroup with the least inflammation (swollen joint count  $\leq 1$ ) milnacipran decrease average pain intensity more than placebo (95% CI -2.26 to -0.01,  $p = 0.04$ ).<sup>3</sup>

# Samumed WNT inhibitor shows differential responsiveness in OA based on pain centralization

- A small molecule, intra-articular, Wnt pathway inhibitor in development for the treatment of knee OA<sup>1,2</sup>
- In preclinical studies, inhibited inflammation, decreased cartilage degradation, and regenerated cartilage<sup>1</sup>
- In preclinical studies, demonstrated sustained local exposure and no observable systemic toxicity<sup>1,2</sup>
- Previous phase 1 study suggested a single intra-articular SM04690 injection appeared well-tolerated and showed potential for improving symptoms and maintaining joint space width in knee OA subjects<sup>2</sup>

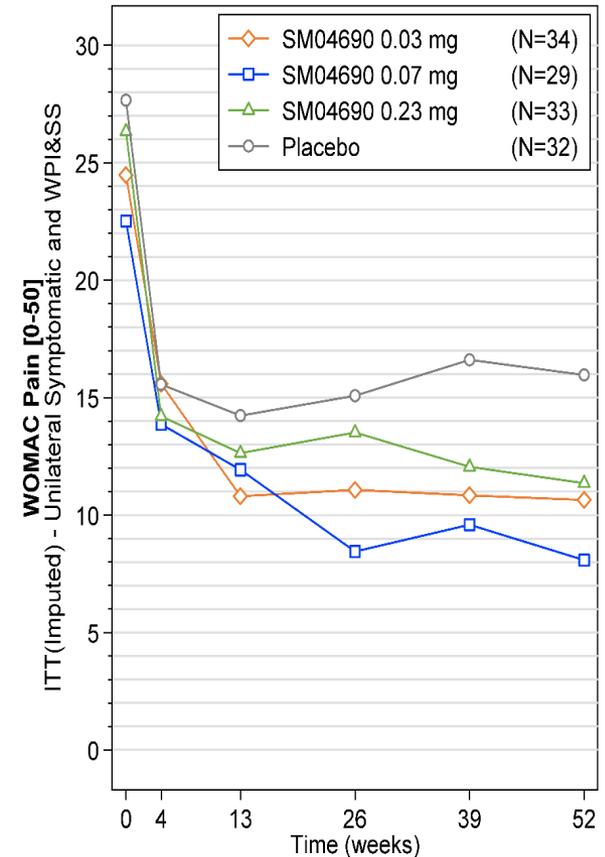
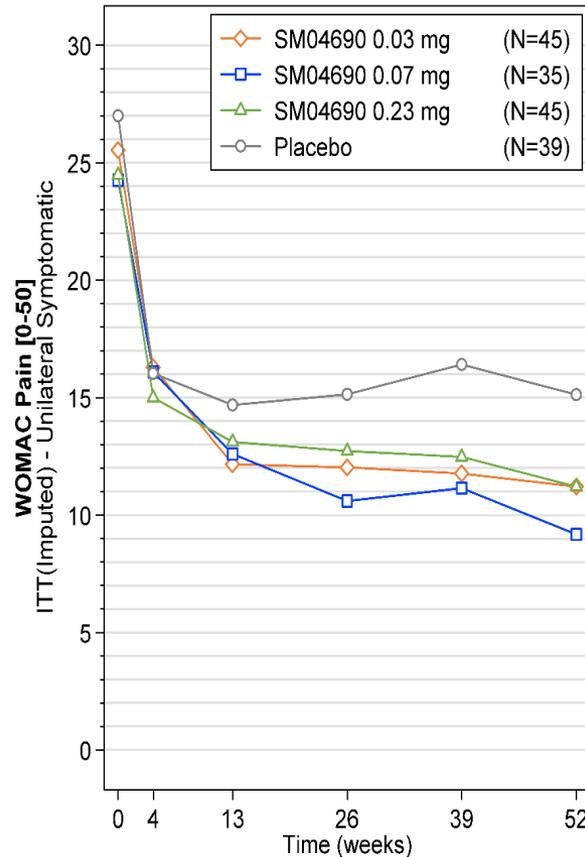
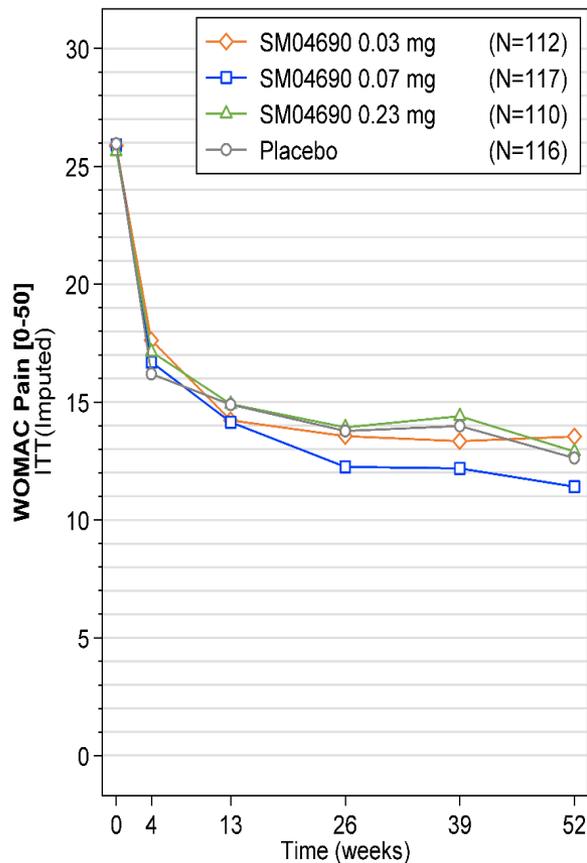
# WOMAC Pain [0-50]

Actual scores (mean)

ITT

Unilateral  
Symptomatic

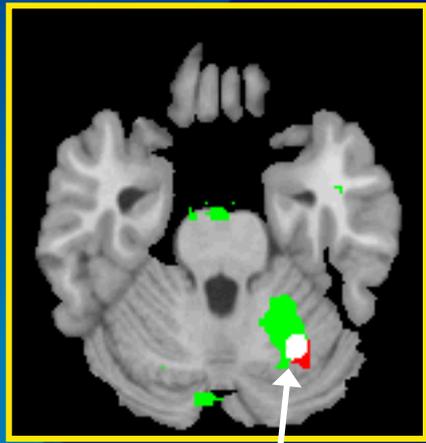
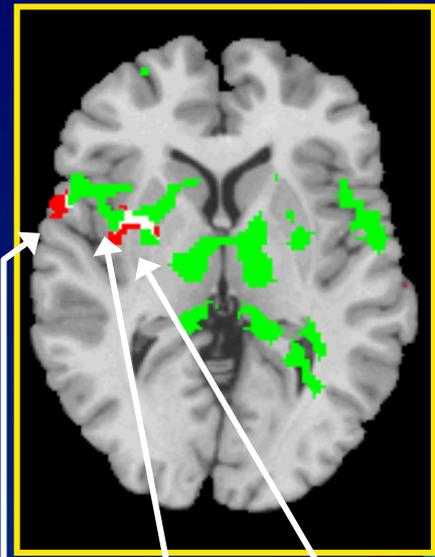
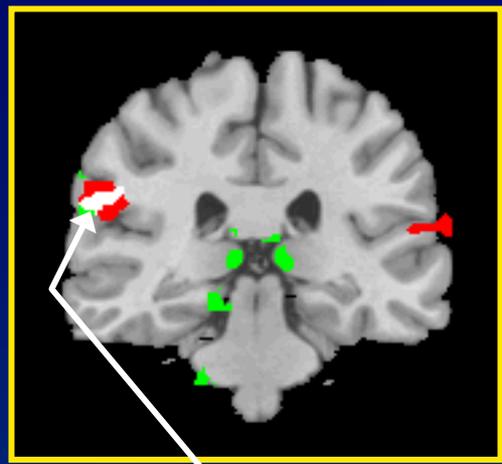
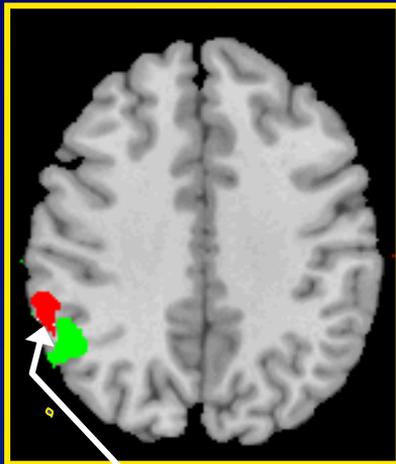
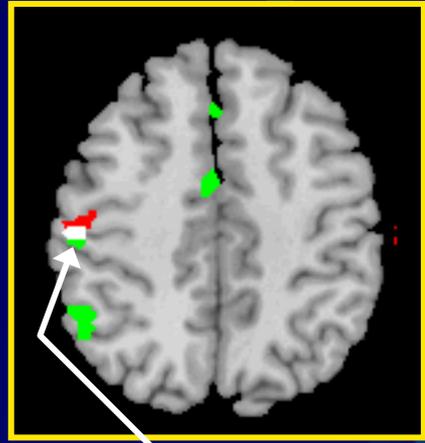
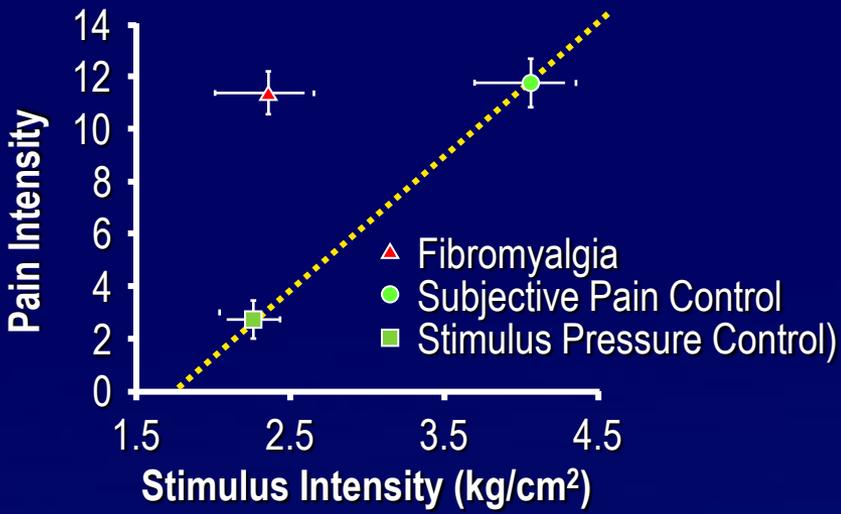
Unilateral  
Symptomatic w/o  
Widespread Pain



# Pathophysiology of centralized pain states

- Most patients display augmented pain and sensory processing on quantitative sensory testing and functional neuroimaging<sup>1,3</sup>
- Manifest by increased connectivity to pro-nociceptive brain regions and decreased connectivity to anti-nociceptive regions<sup>2,3</sup>
- These abnormalities are being driven by imbalances in concentrations of CNS neurotransmitters that control sensory processing, sleep, alertness, affect, memory<sup>3,4</sup>
- Autonomic, HPA, and peripheral abnormalities likely play a prominent role in some individuals

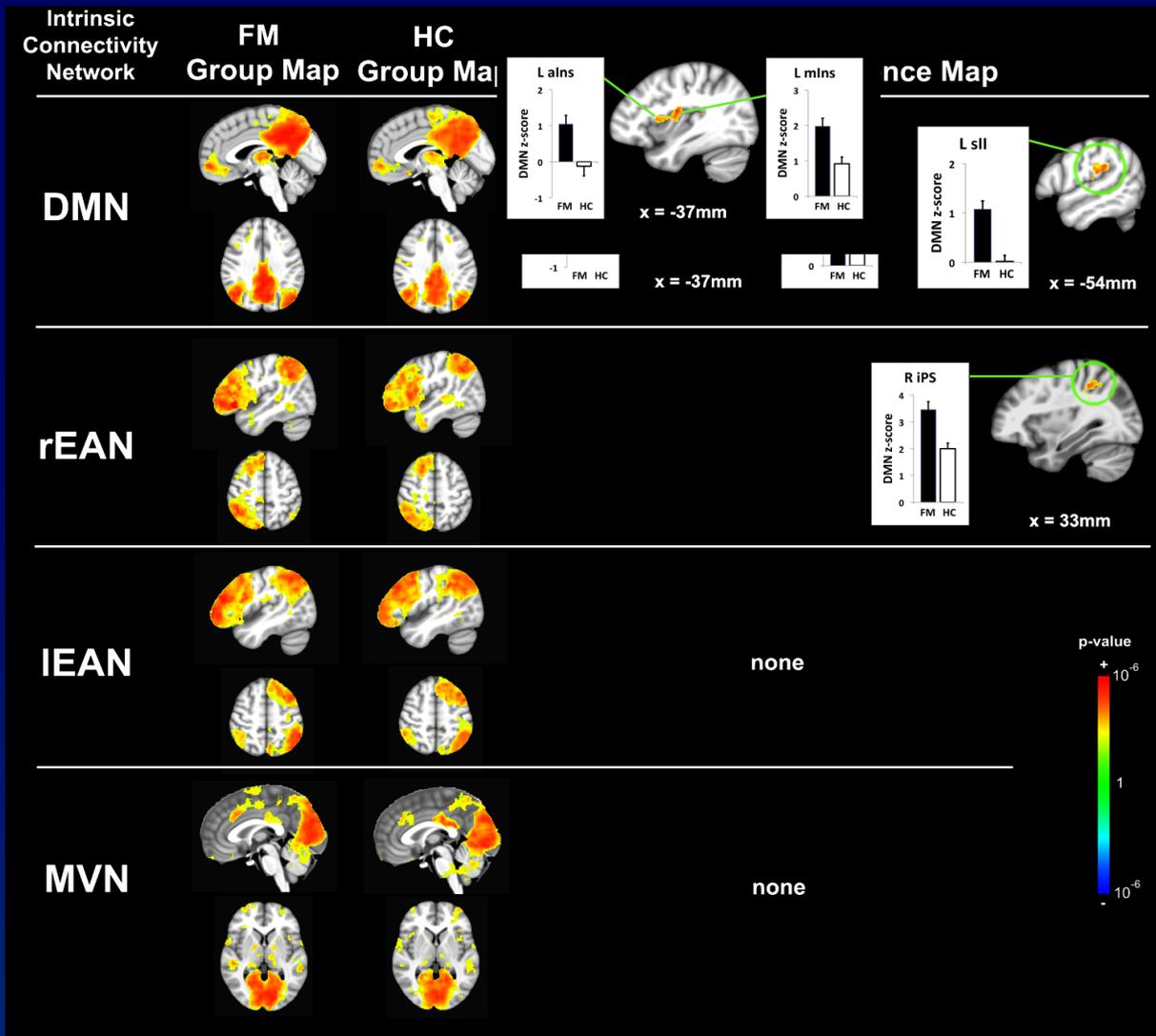
# fMRI in Fibromyalgia



STG=superior temporal gyri; SI=primary somatosensory cortex  
 SII=secondary somatosensory cortex; IPL=inferior parietal lobule.

Gracely. *Arthritis Rheum.* 2002;46:1333-1343.

# Intrinsic Brain Connectivity is Altered in FM patients



- In FM, DMN and rEAN show greater intrinsic connectivity within component DMN (PCC), and rEAN (iPS) as well as limbic (insula), and sensorimotor (SII) regions outside conventional network boundaries.

- All FM vs. HC differences driven by greater connectivity for FM patients.

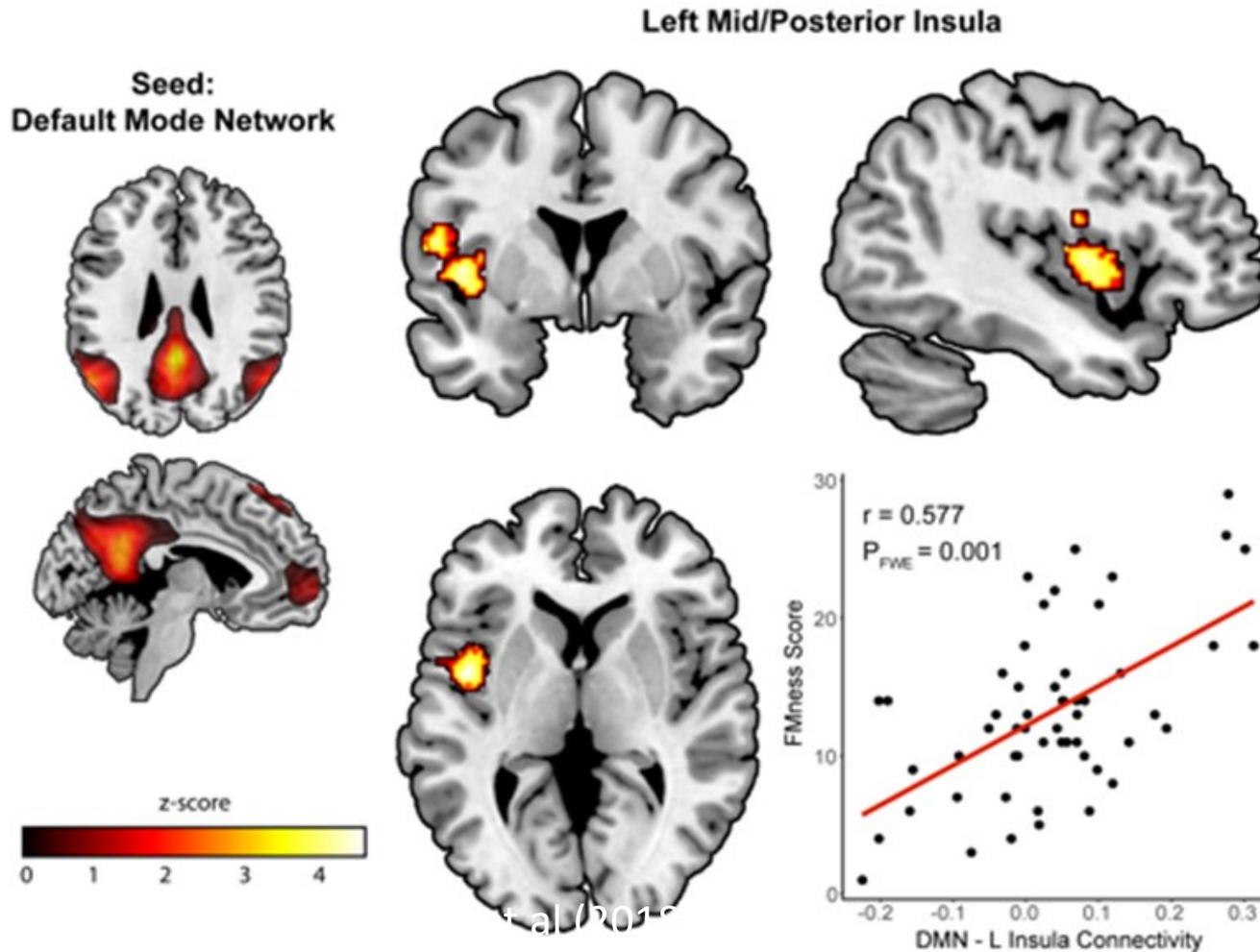
# Changes in size and shape of brain regions indicate CNS neuroplasticity in chronic pain

- Apkarian<sup>1</sup> was first to show that chronic pain may be associated with decrease of size of brain areas involved in pain processing
- More recently seen in virtually all other chronic pain states including headache,<sup>2</sup> IBS,<sup>3</sup> FM<sup>4</sup>
- May be partially due to co-morbid mood disturbances<sup>6</sup>
- Data from NIH MAPP network presented at 2016 IASP (Kutch et. al.) suggests *increase* in size of and connectivity to S1 may represent neural signature for widespreadness of pain

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## Neurobiologic Features of Fibromyalgia Are Also Present Among Rheumatoid Arthritis Patients

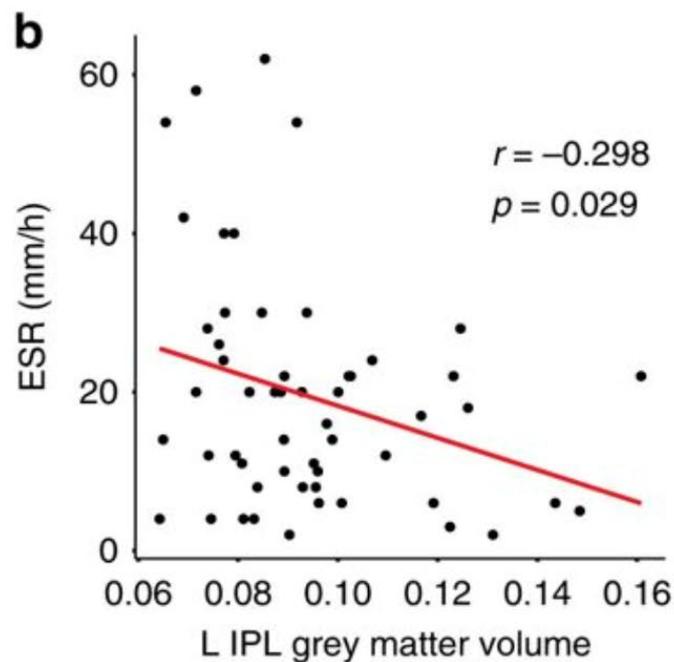
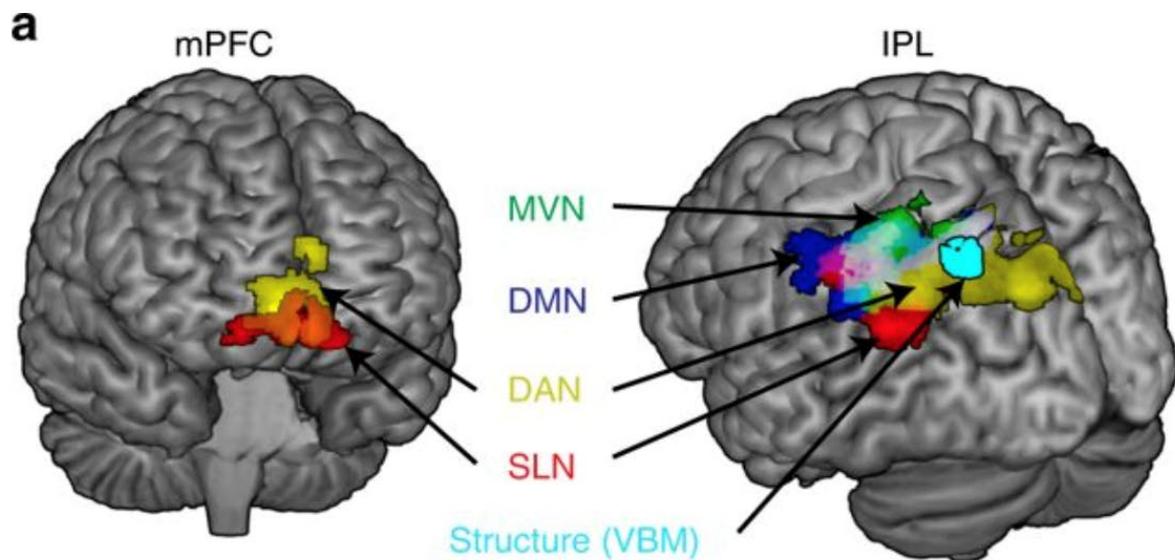
Neil Basu MD, PhD , Chelsea M. Kaplan PhD, Eric Ichesco BS, Tony Larkin BS, Richard E. Harris PhD, Alison Murray MD, PhD, Gordon Waiter PhD, Daniel J. Clauw MD



## A multi-modal MRI study of the central response to inflammation in rheumatoid arthritis

Andrew Schrepf , Chelsea M. Kaplan, Eric Ichesco, Tony Larkin, Steven E. Harte, Richard E. Harris, Alison D. Murray, Gordon D. Waiter, Daniel J. Clauw & Neil Basu

Nature Communications 9, Article number: 2243 (2018) | [Download Citation](#)



## Towards a neurophysiological signature for fibromyalgia

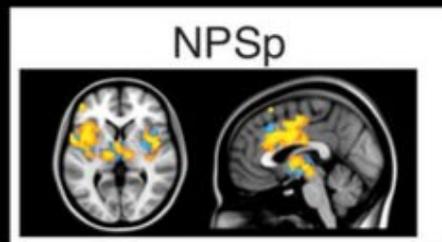
Marina López-Solà<sup>a,b,\*</sup>, Choong-Wan Woo<sup>a,b</sup>, Jesus Pujol<sup>c</sup>, Joan Deus<sup>c,d,e</sup>, Ben J. Harrison<sup>f</sup>, Jordi Monfort<sup>g</sup>, Tor D. Wager<sup>a,b</sup>

### Abstract

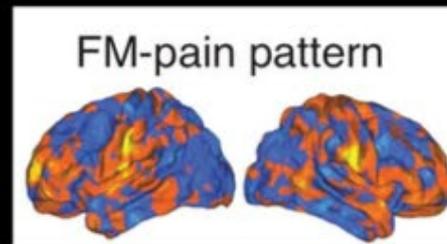
Patients with fibromyalgia (FM) show characteristically enhanced unpleasantness to painful and nonpainful sensations accompanied by altered neural responses. The diagnostic potential of such neural alterations, including their sensitivity and specificity to FM (vs healthy controls) is unknown. We identify a brain signature that characterizes FM central pathophysiology at the neural systems level. We included 37 patients with FM and 35 matched healthy controls, and analyzed functional magnetic resonance imaging responses to (1) painful pressure and (2) nonpainful multisensory (visual–auditory–tactile) stimulation. We used machine-learning techniques to identify a brain-based FM signature. When exposed to the same painful stimuli, patients with FM showed greater neurologic pain signature (NPS; Wager et al., 2013. An fMRI-based neurologic signature of physical pain. *N Engl J Med* 2013;368:1388–97) responses. In addition, a new pain-related classifier (“FM-pain”) revealed augmented responses in sensory integration (insula/operculum) and self-referential (eg, medial prefrontal) regions in FM and reduced responses in the lateral frontal cortex. A “multisensory” classifier trained on nonpainful sensory stimulation revealed augmented responses in the insula/operculum, posterior cingulate, and medial prefrontal regions and reduced responses in the primary/secondary sensory cortices, basal ganglia, and cerebellum. Combined activity in the NPS, FM pain, and multisensory patterns classified patients vs controls with 92% sensitivity and 94% specificity in out-of-sample individuals. Enhanced NPS responses partly mediated mechanical hypersensitivity and correlated with depression and disability ( $P_{\text{uncorrected}} < 0.05$ ); FM-pain and multisensory responses correlated with clinical pain ( $P_{\text{uncorrected}} < 0.05$ ). The study provides initial characterization of individual patients with FM based on pathophysiological, symptom-related brain features. If replicated, these brain features may constitute objective neural targets for therapeutic interventions. The results establish a framework for assessing therapeutic mechanisms and predicting treatment response at the individual level.

**Keywords:** Fibromyalgia, fMRI, Brain, Chronic pain, Multisensory, Pressure, Machine learning, Predict

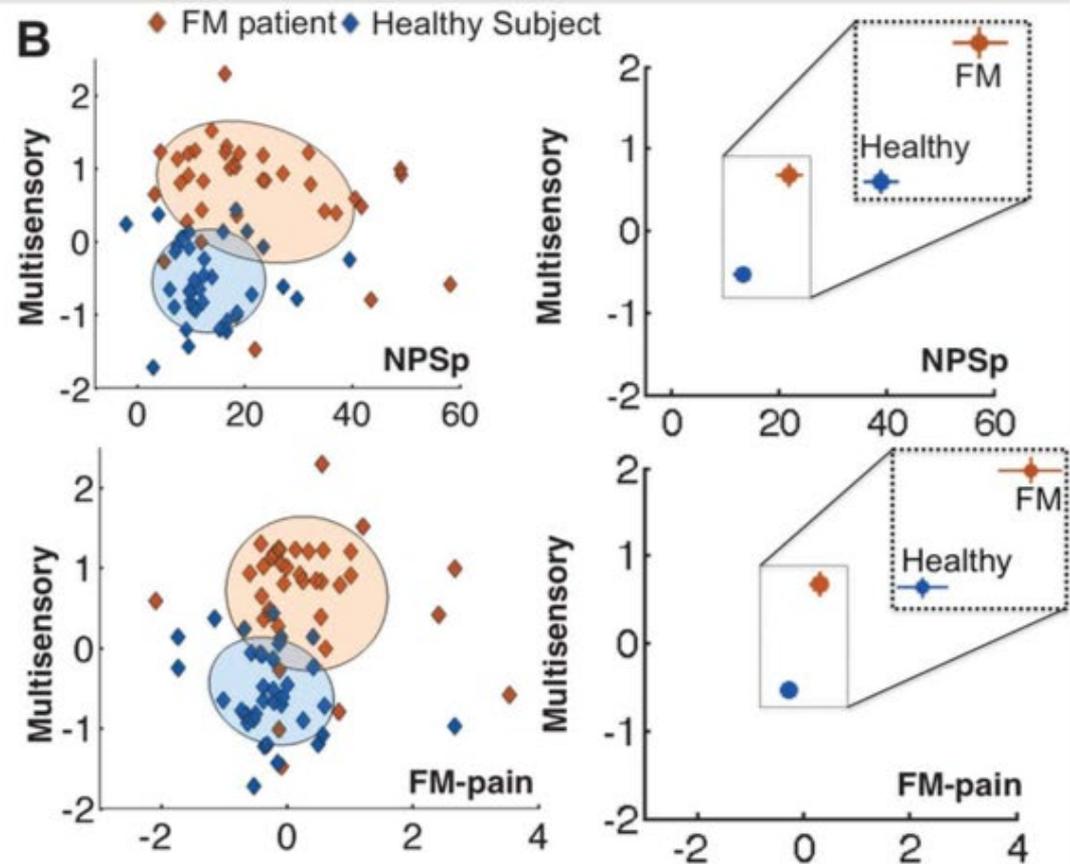
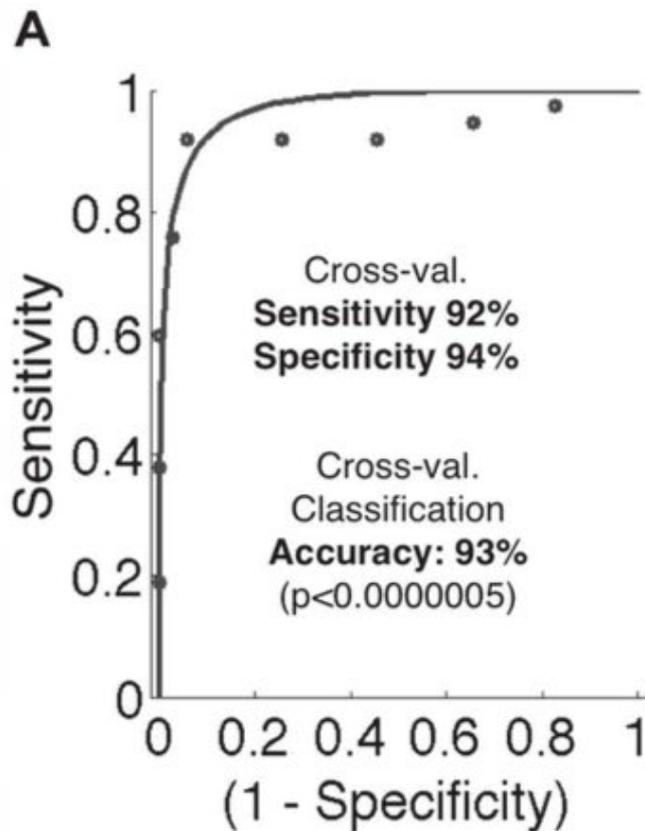
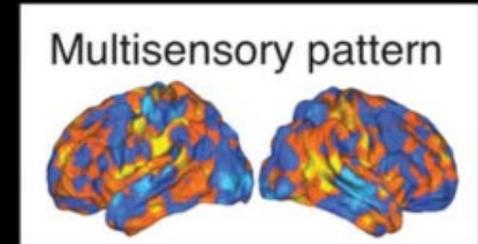
# COMBINED NEURAL CLASSIFIER



&



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# Pharmacological Therapies for Fibromyalgia (i.e. Centralized Pain)

<b>Strong Evidence</b>	<ul style="list-style-type: none"><li>■ Dual reuptake inhibitors such as<ul style="list-style-type: none"><li>■ Tricyclic compounds (amitriptyline, cyclobenzaprine)</li><li>■ SNRIs and NSRIs (milnacipran, duloxetine, venlafaxine?)</li></ul></li><li>■ Gabapentinoids (e.g., pregabalin, gabapentin)</li></ul>
<b>Modest Evidence</b>	<ul style="list-style-type: none"><li>■ Tramadol</li><li>■ Older less selective SSRIs</li><li>■ Gamma hydroxybutyrate</li><li>■ Low dose naltrexone</li><li>■ Cannabinoids</li></ul>
<b>Weak Evidence</b>	<ul style="list-style-type: none"><li>■ Growth hormone, 5-hydroxytryptamine, tropisetron, S-adenosyl-L-methionine (SAME)</li></ul>
<b>No Evidence</b>	<ul style="list-style-type: none"><li>■ Opioids, corticosteroids, nonsteroidal anti-inflammatory drugs, benzodiazepine and nonbenzodiazepine hypnotics, guanifenesin</li></ul>

# CNS Neurotransmitters Influencing Pain

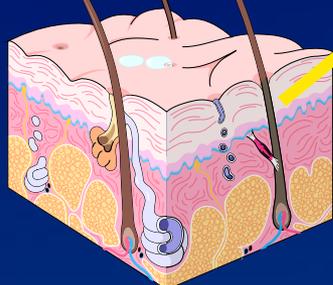
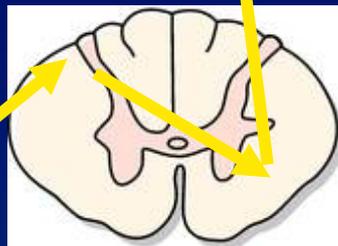
Arrows indicate direction in Fibromyalgia

Generally facilitate pain transmission

- Glutamate
- Substance P
- Nerve growth factor
- Serotonin (5HT<sub>2a, 3a</sub>)

Gabapentinoids, ketamine, memantine

Anti-migraine drugs (-triptans), cyclobenzaprine



Generally inhibit pain transmission

- Descending anti-nociceptive pathways
- Norepinephrine-serotonin (5HT<sub>1a,b</sub>), dopamine
- Opioids
- Cannabinoids
- GABA

Tricyclics, SNRIs, tramadol

Low dose naltrexone

No knowledge of endocannabinoid activity but this class of drugs is effective

Gammahydroxybutyrate moderate alcohol consumption

1. Schmidt-Wilcke T, Clauw DJ. *Nat Rev Rheumatol*. Jul 19 2011.
2. Clauw DJ. *JAMA*. 2014.

## Hijacking the endogenous opioid system to treat pain: who thought it would be so complicated?

Daniel Clauw

In this issue, there is an especially interesting and important special review by Ballantyne and Sullivan entitled, “The discovery of endogenous opioid systems: what it has meant for the clinician’s understanding of pain and its treatment”.<sup>1</sup> This review adds to these authors’ significant prior contributions to the pain field, as they are now proposing that many of the problems associated with opioid therapy can be understood mechanistically as being off-target effects on the endogenous opioid system. They describe how our emerging understanding of the endogenous opioid system might allow us to better understand how exogenous opioids can “hijack” this system to produce unexpected and undesired consequences, both when they are used for pain relief, and when they are misused or abused. They especially focus on how acute or chronic opioid therapy (COT) may impair some of the nonanalgesic functions of the endoge-

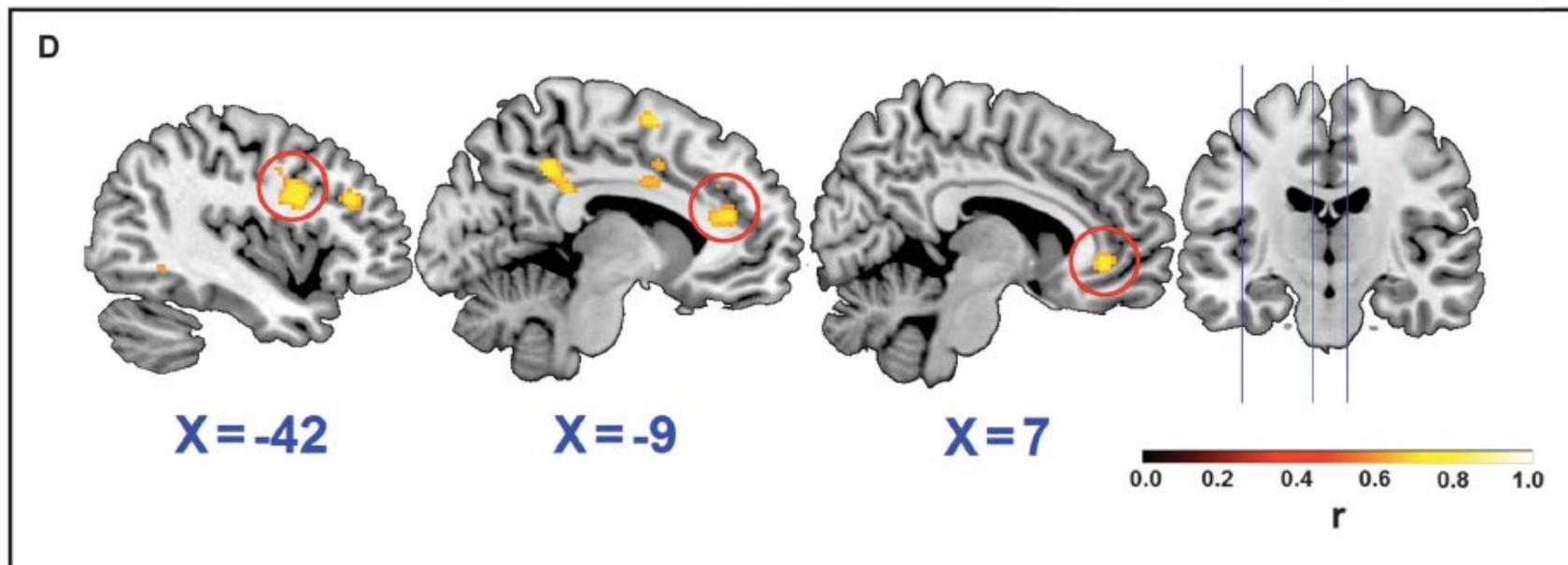
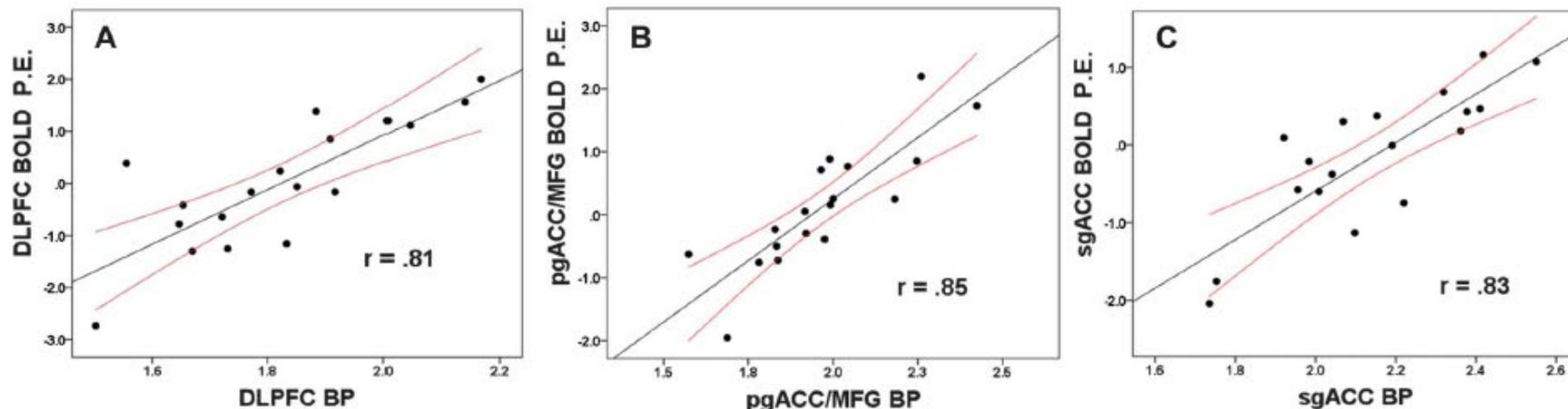
These issues of excess death and addiction, combined with a lack of any evidence of long-term efficacy,<sup>3</sup> have led many of us in the pain field to question whether opioid should ever be used to treat chronic nonmalignant pain. We know of some patients with chronic pain who are on long-term high-dose opioid therapy who are doing well (ie, have good pain control and good functional status), but these patients are exceedingly rare. Instead, we see large numbers of individuals who want to keep taking opioids, although after we assess them, we conclude that the long-term side effects of these drugs far exceed any benefit they are receiving.

This review highlights why we may see some of the more insidious problems that occur with COT, which are summarized below.

Individuals on COT may continue to “need” opioids to replicate the functions of endogenous opioids that are no longer being

## Endogenous opioidergic dysregulation of pain in fibromyalgia: a PET and fMRI study

Andrew Schrepf<sup>a,\*</sup>, Daniel E. Harper<sup>a</sup>, Steven E. Harte<sup>a</sup>, Heng Wang<sup>a</sup>, Eric Ichesco<sup>a</sup>, Johnson P. Hampson<sup>a</sup>, Jon-Kar Zubieta<sup>b</sup>, Daniel J. Clauw<sup>a</sup>, Richard E. Harris<sup>a</sup>



# And what about those patients already on opioids?

- Don't try to take them away – try to convince the patient that the risk outweighs the benefit
  - US consumes over 80% of world's opioids annually
  - 30% increase in annual all-cause mortality<sup>1</sup>
- A slow gradual taper of opioids rarely leads to worsening of chronic pain
  - Use the patients own history to point out that opioids have not improved pain and function, or are leading to side effects
- Discern what symptom(s) opioids are treating
- Consider opioid-sparing drugs
  - Mixed opioids (tapentadol, buprenorphine)
  - Gabapentinoids
  - Cannabinoids<sup>2</sup>

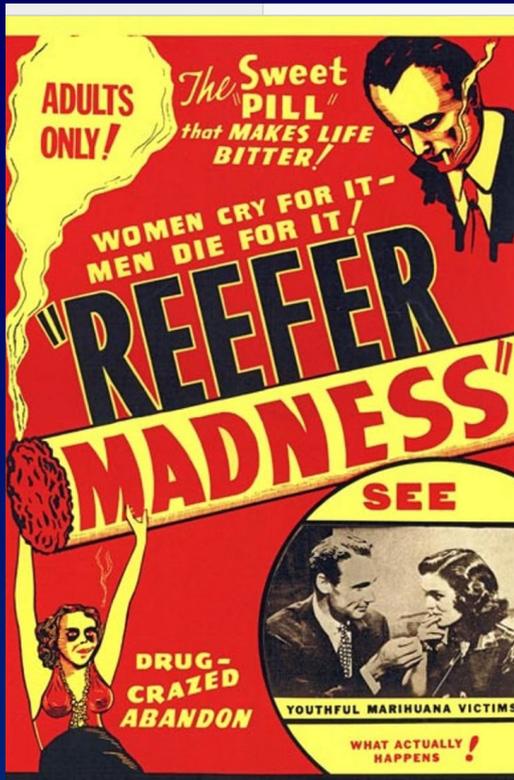
# How useful do you feel cannabinoids are for treating pain?

0

10

Worthless

Wonderful



# Pragmatic Advice for Using Cannabinoids in 2021

- Where possible use a cannabinoid or cannabinoid extract of consistent and known potency
- Start with 5 – 10 mg of CBD twice daily and go up to as high as 50 – 100mg per day
- If CBD alone ineffective then go to low dose of low THC:high CBD strain and go up slowly
- Emerging evidence of U-shaped curve
- Oral dosing better once stable dose and strain identified
- The strongest recommendation based on current benefit: risk data is for the use of cannabinoids instead of opioids for neuropathic or centralized pain states
  - Data from US suggest that legalizing cannabis in a state leads to fairly dramatic reductions in opioid overdoses<sup>1</sup>

CBD, cannabidiol; THC, tetrahydrocannabinol

1. Bachhuber MA, et. al. JAMA Int Med 2014;174:1668-73.

# Proposed marketing program for medical cannabis

Cannabis plant talking to opium producing poppy plant



We don't  
suck as  
bad as you  
do



# Treating Based on Mechanisms

*Any combination may be present*

	Peripheral (nociceptive)	Neuropathic	Centralized Pain
NSAIDs	+	-	-
Opioids	+	+	-
Surgery/ Injections	+	+	-
Tricyclics	+	+	+
SNRIs	+	+	+
Gabapentinoid	-	+	+
CBD	+	-	-
THC	-	+	+

## Symptoms of Pain, Fatigue, etc.

- Nociceptive processes (damage or inflammation of tissues)
- Disordered sensory processing

## Functional Consequences of Symptoms

- Increased stress
- Decreased activity
- Poor sleep
- Obesity
- Maladaptive illness behaviors

## Dually Focused Treatment

- Pharmacological therapies to improve **symptoms**
- Nonpharmacological therapies to address **dysfunction**

## Topical Review

**PAIN**<sup>®</sup>**AQ:1** **Considering the potential for an increase in chronic pain after the COVID-19 pandemic**

Daniel J. Clauw<sup>b</sup>, Winfried Häuser<sup>b,c</sup>, Steven P. Cohen<sup>d,e</sup>, Mary-Ann Fitzcharles<sup>f,g,\*</sup>

**1. Introduction**

The COVID-19 pandemic has impacted the lives and health of persons worldwide, with potential for further effects in the future. The experience of living within this pandemic has disrupted daily life across all sectors, including those living with chronic pain (CP), those infected with the coronavirus Severe Acute Respiratory Syndrome (SARS)-CoV2, healthcare providers and essential workers, as well as those who remained physically healthy. The toll of this pandemic extends beyond physical illness, with important psychosocial stressors that include prolonged periods of limited interpersonal contact, isolation, fear of illness, future uncertainty, and financial strain. Uncertainty is fuelled by the

organ-specific biological factors, which may preferentially occur in individuals with a fragile stress response system.<sup>8,10,24,40,47</sup>

The COVID-19 pandemic has many characteristics that could potentially increase the prevalence of CP, especially with stressors extending over many months.

The worldwide pain community is invited to consider the possible downstream consequences of COVID-19, not only for patients surviving infection, but also for the wider community that has experienced psychological, social, and economic effects. Although we address these issues from the perspective of physicians practicing in developed countries, many of the consequences discussed will be particularly relevant for people in other countries, with a call for colleagues in Asia, Africa, and

# Nonpharmacological Therapies are similar to those for any Chronic Pain State

## Strong Evidence

- Education
- Aerobic exercise
- Cognitive behavior therapy

## Modest Evidence

- Strength training
- Hypnotherapy, biofeedback, balneotherapy, yoga, Tai Chi
- Neuromodulation
- Acupuncture, chiropractic, manual and massage therapy

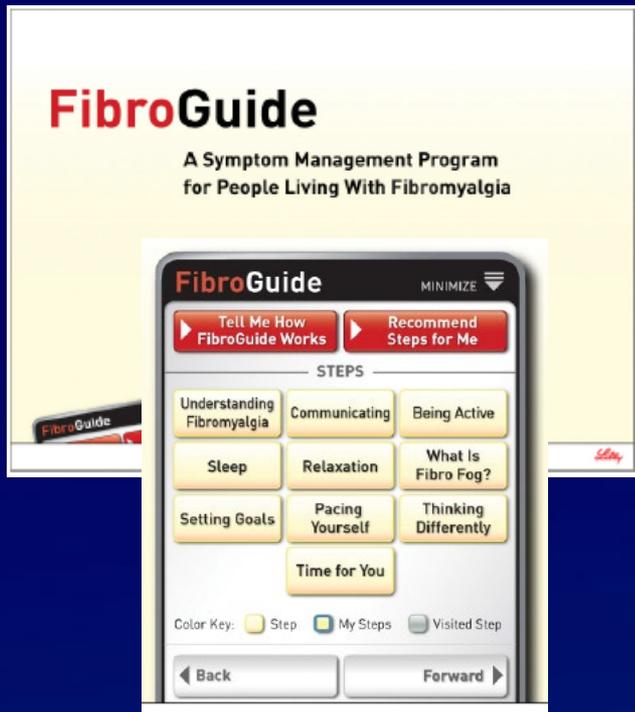
## Weak Evidence

- Trigger point injections

## No Evidence

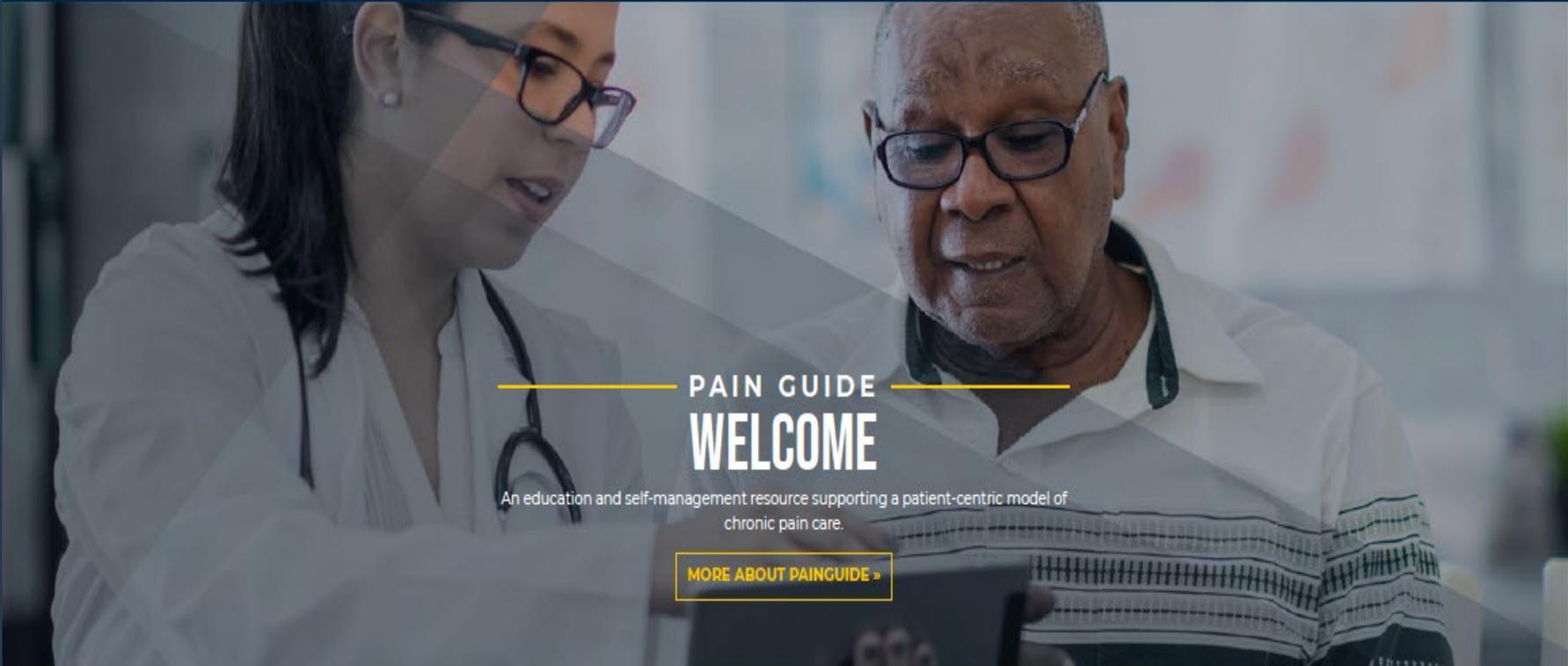
- Doing nothing

# www.fibroguide.com



- Program features 10 CBT modules:
  - Understanding Fibromyalgia
  - Being Active
  - Sleep
  - Relaxation
  - Time for You
  - Setting Goals
  - Pacing Yourself
  - Thinking Differently
  - Communicating
  - Fibro Fog

- In a RCT of 118 FM patients comparing the earlier version of this website plus usual care, to usual care alone, Williams demonstrated statistically significant improvements in pain (29% in the WEB group had 30% improvement in pain vs 8% in usual care,  $p=.009$ ) and function (i.e., 31% in WEB-SM had .5 SD improvement in SF-36 PF vs. 6% in standard care,  $p<.002$ ) Williams et. al. Pain. 2010;151(3):694-702



## PAIN GUIDE WELCOME

An education and self-management resource supporting a patient-centric model of chronic pain care.

[MORE ABOUT PAINGUIDE »](#)

## Self Care



### Exercise

Exercise, when done safely, can benefit you physically and mentally. It helps prevent deconditioning of muscles which is often associated with more pain. Studies find that exercise is one of the most beneficial approaches to managing pain.

[Learn more >](#)



### Pacing

People with pain often "over do" resulting in pain flare ups. Pacing can allow activities to get accomplished safely, without flare-ups, and in a manner that conserves energy (i.e., with less fatigue).

[Learn more >](#)



### Nutrition & supplements

Eating a healthy diet has many benefits for everyone, however there may be some specific benefits for pain sufferers. The examination of pain and diet is an emerging literature.

[Read nutrition & supplements tips >](#)



### Relaxation

Teaching the body to relax can both diminish muscle tension and decrease stress. To work properly, regular practice is needed so that the body learns a rhythm of relaxation and can relax on your command. Less tension and less stress can lead to decreased pain intensity.

[Learn more >](#)



### Reframing

What we think influences how we feel and how much pain we experience. Sometimes negative thoughts become automatic and make us feel worse. Learning to reframe our thinking in realistic terms that challenge negative automatic thinking can help diminish pain intensity.

[Learn more >](#)



### Managing Emotions

Emotions are integral to the production of pain. You cannot have pain without emotions. Thus anything we can do to alter the emotional content of one's brain will influence pain. Better management of stress can influence pain as well as engaging in pleasant activities. The pleasant activities will help diminish pain intensity.

[Learn more >](#)



### Communication skills

Conflictual social relationships with family, friends, doctors, and employers can make pain worse. Alternatively, these same relationships can be used constructively to make pain better. Communication skills can help make social relationship work in your favor.

[Learn more >](#)



### Sleep

Pain and Sleep are closely related such that poor sleep can make pain worse. These are a number of behavioral sleep strategies that can be used to get a more refreshing night's sleep.

[Learn more >](#)



### Acupressure

Like acupuncture, which uses needles, acupressure is an ancient treatment that uses the pressure of one's own finger on the skin so as to help rebalance the flow of energy through the body as a means of reducing symptoms such as pain.

[Learn more >](#)



### Spirituality

The belief in something "bigger," "more powerful," or "more knowledgeable" than oneself has been key to many individuals being able to successfully deal with pain. Spirituality may refer to a specific religious belief or it can be any belief that provides a source of strength and comfort to the individual with pain.

[Learn more >](#)



### Ergonomics/Posture

How you sit, stand, transition and lift can either make pain worse or allow you to function even with pain. This section offers help in optimizing how you interact with your environment in ways that don't exacerbate pain.

[Learn more >](#)



### Resilience

We often focus on fixing what is broken but we can't lose sight of our personal strengths that help us get through challenging times. Finding our sources of resilience can be a valuable tool for reducing pain and living a quality-filled life.

[Learn more >](#)



## PAIN CARE

### Self Care

### Professional Care

- Medications
- Therapies
- Devices
- Procedures



# Emerging Issues in Chronic Pain

- Vitamin D
- Small fiber neuropathy
- Neuroinflammation/Glial activation
- Diet/nutrition

# Can we use diet/nutrition to treat chronic pain?

Andrew Schrepf,<sup>\*</sup> Steven E. Harte,<sup>\*</sup> Nicole Miller,<sup>†</sup> Christine Fowler,<sup>†</sup> Catherine Nay,<sup>†</sup> David A. Williams,<sup>\*</sup> Daniel J. Clauw,<sup>\*</sup> and Amy Rothberg<sup>†,‡</sup>

*<sup>\*</sup>Chronic Pain and Fatigue Research Center, Department of Anesthesiology, <sup>†</sup>Department of Internal Medicine, <sup>‡</sup>School of Public Health, University of Michigan, Ann Arbor, Michigan.*

**Abstract:** Weight loss is known to improve pain localized to weight-bearing joints but it is not known how weight loss affects the spatial distribution of pain and associated somatic symptoms like fatigue. We sought to determine if weight loss using a low-calorie diet improves pain, affect, and somatic symptoms commonly associated with chronic pain conditions in an observational study. We also documented changes in inflammatory markers in serum before and after weight loss. Participants were 123 obese individuals undergoing a 12- to 16-week calorie restriction weight loss intervention. The spatial distribution of pain, symptom severity (eg, fatigue, sleep difficulties), depression, and total fibromyalgia scale scores were measured before and after weight loss. Pain ( $P = .022$ ), symptom severity ( $P = .004$ ), depression ( $P < .001$ ), and fibromyalgia scores ( $P = .004$ ) improved after weight loss; men showed greater improvement than women on somatic symptoms and fibromyalgia scores (both  $P < .01$ ). Those who lost at least 10% of body weight showed greater improvement than those who lost <10%. Levels of the regulatory cytokine interleukin-10 increased after the intervention ( $P = .002$ ). Weight loss may improve diffuse pain and comorbid symptoms commonly seen in chronic pain participants.

**Perspective:** *This article presents the effect of a weight loss intervention on characteristics of chronic pain, including the spatial distribution of pain and comorbid somatic symptoms. Weight loss appeared to produce larger improvements in somatic symptoms for men.*

# VA/DoD Stepped Care Model for Pain Management

## Stepped Care Model for Pain Management (SCM-PM)

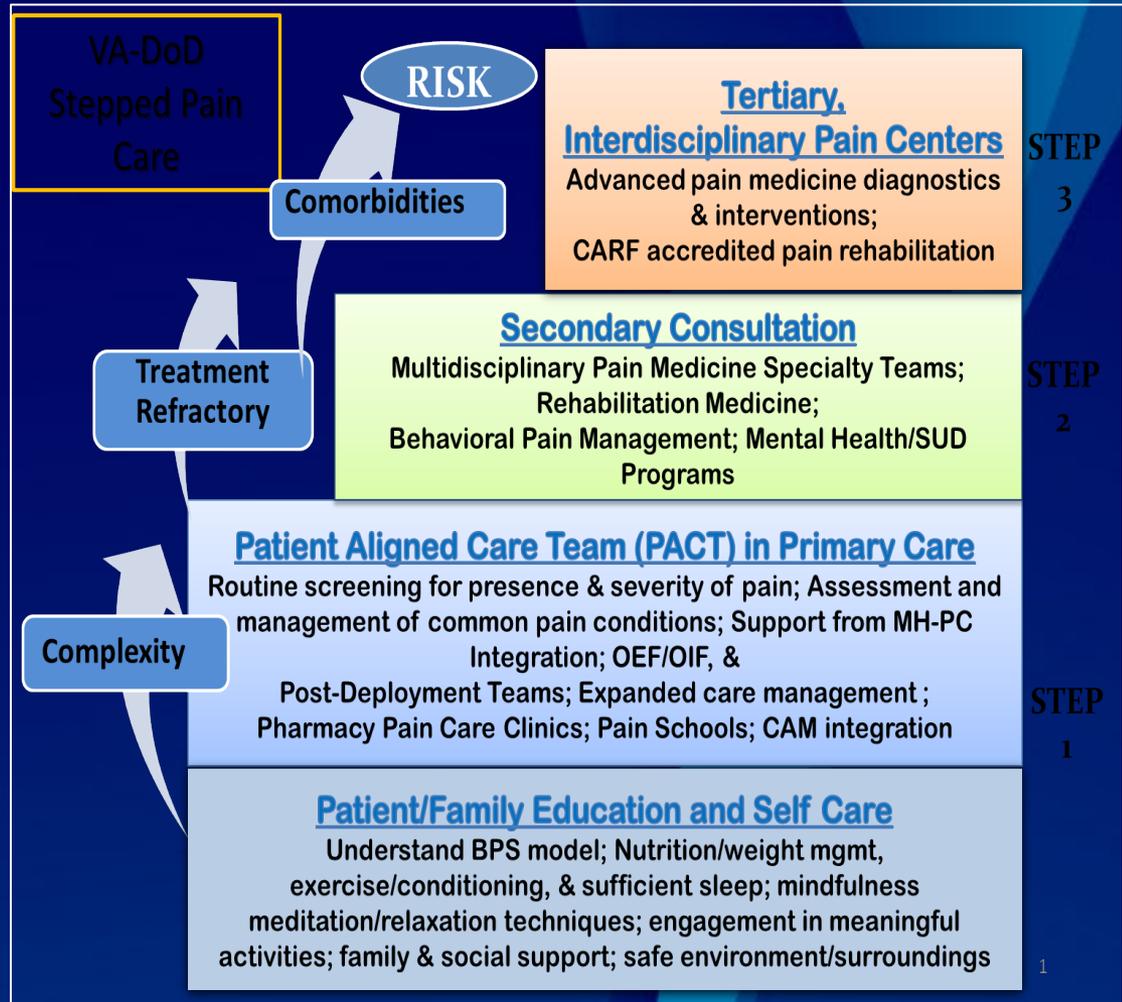
Foundational Step: Self-Care/Self-Management

Primary Care (PACT) = Medical Home

- Coordinated care and a long-term healing relationship, instead of episodic care based on illness
- Primary Care Mental Health Integration (PCMHI) at all facilities

CARA Legislation:

- Full implementation of the SCM-PM at all VHA facilities
- Pain Management Teams at all facilities



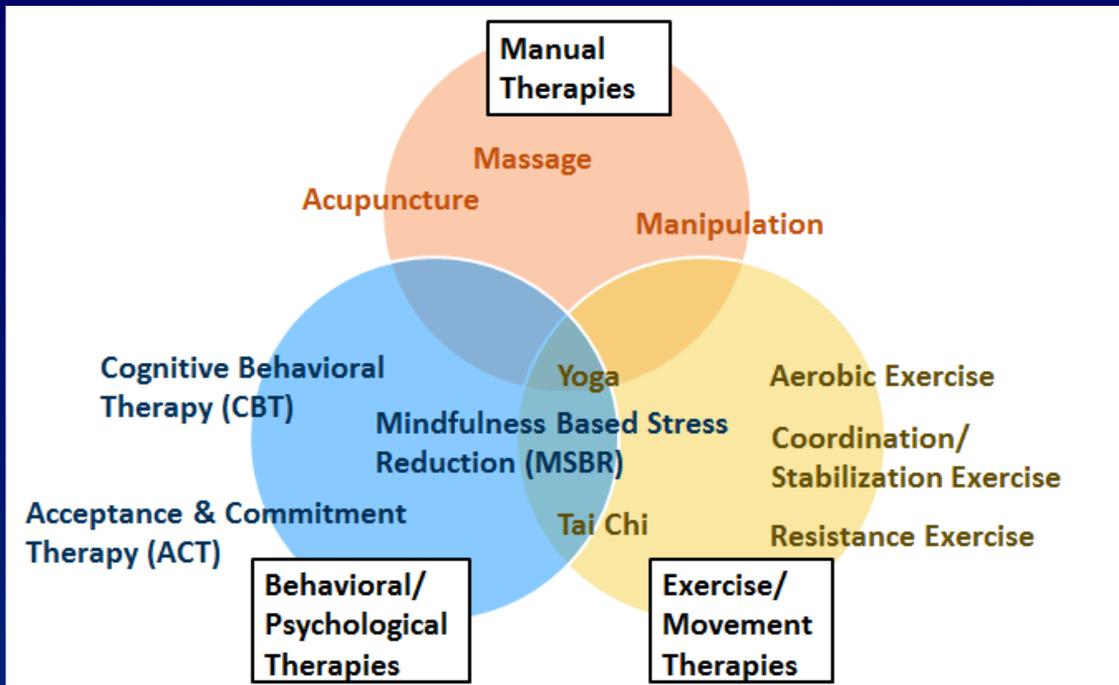
# Non-Pharmacological Pain Treatments in VHA

## VA State of the Art Conference Nov. 2016: Evidence-based non-pharmacological approaches for MSK pain management

- Evidence to support CIH and conventional therapies.
- Provision of multi-modal therapies accessible from Primary Care.

## VHA Directive 1137: Advancing Complementary and Integrative Health (May 2017)

- List 1: Approaches with published evidence of promising potential benefit.
  - Acupuncture
  - Massage Therapy
  - Tai Chi
  - Meditation
  - Yoga
  - Clinical Hypnosis
  - Biofeedback
  - Guided Imagery



Chiropractic Care was approved as a covered benefit in VHA in 2004 and is part of VA whole health care.

To be made available across the system, if recommended by the Veteran's health care team.

# Take Home Messages for Managing Chronic Pain

- Have patient complete the FM measure (or a body map) intermittently to help determine whether pain is nociceptive, neuropathic, nociplastic – or some combination – and treat based on that assessment
- Look for and treat common co-morbidities
  - Sleep
  - Mood
  - Fatigue
- Embrace the effectiveness of non-pharm therapies
  - Your patients can tell if you don't think these therapies are as effective as drugs
- Encourage patients try new therapies rather than allowing them to get into rut