Appropriate and Effective Pain Treatment

Gregg VandeKieft, MD, MA

Medical Director for Hospice and Palliative Care
Providence St. Peter Hospital, Olympia, WA
Clinical Associate Professor of Family Medicine
University of Washington School of Medicine

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Learning Objectives:

- Debate reasons for and implications of undertreatment of pain.
- Differentiate elements that influence the selection of pharmacologic therapy, including the provision of opioid medications.
- Formulate strategies to provide culturally competent care for patients with pain.
- Utilize tools to assess noncommunicative patients and provide appropriate pain treatment.

Blueprint for Pain In America
Institute of Medicine, June 2011

Comprehensive review of pain management in the U.S. – three major conclusions:

1. Pain management is a significant public health problem nationwide
2. Cultural transformation is required to better prevent, assess, treat, and understand pain of all types
3. A comprehensive strategy integrating research, education, public policy, and practice is needed

Reasons to Treat Pain

Professionalism

- Common sense
- Ethics
- Humanitarianism
- Professional integrity

Reasons to Treat Pain

Patient Outcomes

- Improve ADLs, mobility, QOL
- Improve mood, appetite, weight, chronic illness mgt
- Restore social and family relationships
- Lessen dependency, financial duress
- Neurogenesis claimed by some authors

Models of Pain Management

- Acute Pain
- End-of-life Pain
- Chronic Pain

Failure to distinguish between treatment models is a major contributor to problems with pain management and opioid utilization

Pain Physiology

Nociceptive Pain

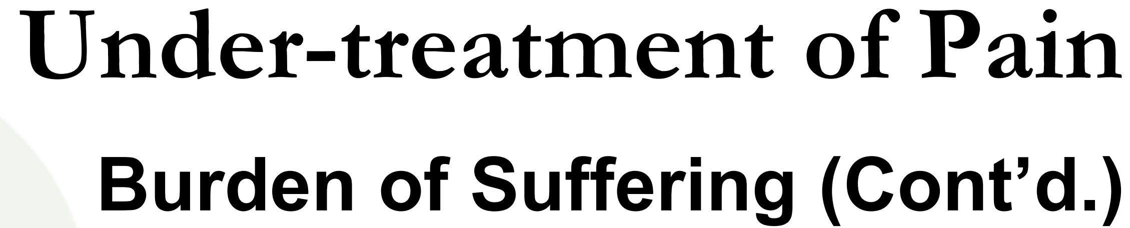
- Stimulation and transmission via normal receptors and nerves
- Somatic vs. visceral pain

Neuropathic Pain

- Abnormal peripheral or central nerve function
- Different character to pain, standard treatments often ineffective

Under-treatment of Pain
Burden of Suffering

- Hospitals, emergency departments
  - ER: 74% report moderate to severe pain at discharge
- Nursing facilities, elderly
  - Daily Pain: 62% NH residents, 40-50% frail elderly
- Cancer patients
  - SUPPORT study: 75% severe pain in last 2 wks of life



Under-treatment of Pain

Burden of Suffering (Cont'd.)

- Children
- Gender/sexual orientation
- Racial/cultural minorities
- Poverty

Loss of Function

- Limited mobility
- Diminished work/exercise capacity
- Unable to perform ADLs
- Negative mood/self-image
- Impaired social relationships/sexuality
- Financial duress

Under-treatment of Pain

Psychiatric Comorbidities

- Loss of self-esteem and social roles
- Helplessness, hopelessness, loss of control, "catastrophizing"
- Depression: comorbidity ≥ 40%-50%, some features ≥ 86%
    - Increased suicide risk

Under-treatment of Pain

Patient factors

- Culture = learned values, beliefs, behaviors
  - Largely unconscious, unexamined
  - Provides context for meaning, suffering, loss
- Stoicism and reluctance to seek treatment
- Fear/distrust of medications
- Discouragement

Under-treatment of Pain

Communication Challenges

- Time pressures
- Lack of active listening
- Patients' lack of vocabulary
- Incongruent expectations: patient vs. provider
- Health illiteracy and overt illiteracy

Under-treatment of Pain
Limited Guidance

Research on pain management is limited, studies are often poor quality

Resources:

- Pain & Policies Studies Group (Univ. of Wisconsin)
  - *http://www.painpolicy.wisc.edu/*
- Federation of State Medical Boards' Model Policy
  - Link on Pain & Policies Study Group web page

- Governmental regulations
  - Federal – FDA, DEA, REMS
  - State – Multiple states have legislated restrictions on opioid prescribing
- Third-party payor oversight
  - “Safety/necessity” investigations
  - CMS “fraud and abuse” audits

Under-treatment of Pain

Liability Concerns

Risks of adverse effects significantly decline with knowledgeable prescribing:

- Chronic impairment: from pain or medication?
- Adverse events from opioids include accidental overdose, death
- Addiction/abuse
- Diversion of medications

Chronic pain is not simply a long-term extension of acute pain

- Behaves differently from acute pain

Neuroplasticity: programs pain into the spinal cord

- Central sensitization syndrome

Effective Treatment of Pain

Topical Measures: Transdermal Medications

- Anesthetics/compounded formulations
- Topical NSAIDs
- Topical opioids
  - Patch, compounded gels
- Phono/iontophoresis

Effective Treatment of Pain

Pharmacotherapy: Non-Opioids

NSAIDs/acetaminophen

- Advantages
- Hazards

Corticosteroids

- Especially for bone mets, tumor impingment
- Oral, parental, or topical (eg, in gel)

Effective Treatment of Pain
Pharmacotherapy: Opioid Analgesics

- In appropriately selected patients, opioid pain control benefits outweigh the disadvantages for chronic pain
- Opiates vs. opioids
  - “Narcotics” – an over-used term based more in law enforcement than pharmacology

Advanced details about agents on lecture website

- Agent: choose in context
- Dosage: judge by situation
- Long-acting: by indications

Effective Treatment of Pain

Forestalling Tolerance

- Complementary/supportive modalities
- Maximize adjunctive Rxs from different classes
- Opioid rotation
- Multiple long-acting agents: alternative strategy

Effective Treatment of Pain

Adjunctive Medications

Nearly all of these are "off label;" try to avoid agents that cause weight gain

- Anticonvulsants
  - Especially for neuropathic pain
- Antidepressants:
  - TCAs, SNRIs, and bupropion
  - SSRIs don't directly treat pain, but mood improvement decreased burden of "total suffering"
- Muscle relaxants

Instituting Change
Tools – From the Web

- Pain history/interview forms
- Children: age-appropriate tools from AAP
- Communication barrier assessment tools
- Functional Assessment tools
- Evaluating Rx risk
- Monitoring: urine drug screens, medication audits
- Patient education

Pain Assessment in Cognitively Impaired

- Use self-report to degree possible
- Speak with someone familiar with patient's baseline – e.g. family, LTC staff
- Review medical history, health status
- Evaluate pain behaviors – see next slide
- Physical exam
    - Look for skin breakdown, contusions, focal tenderness, tenderness while moving compared to rest

Pain Behaviors in Cognitively Impaired Elderly

Facial expressions

- Grimace, frown, furrowed brow, teeth clenching, tears

Vocalizations

- Moaning, calling out, crying

Mental status changes

- Confusion, disorientation, agitation – changed from baseline

Pain Behaviors in Cognitively Impaired Elderly (cont.)

Changes in social interaction

- Aggression (physical or verbal), withdrawn, irritability

Change in usual activity or behavior

- Sleep, appetite, self-care

Physical cues

- Pacing, fidgeting, fetal position

Effective Treatment of Pain

Manage Underlying/Exacerbating Conditions

- Chronic illness
- Sleep disorders: very high incidence in chronic pain
- Psychiatric disorders: treat to remission
- Environmental factors

Effective Treatment of Pain

Load Reduction: Supportive Measures

- Firm mattress
- Supportive chair
- Lumbar/cervical supports
- Support pillows
- Elastic supports
- Braces/splints/corsets
- Orthotics

Effective Treatment of Pain

Thermal Modulation

- Ice/cold
- Dry heat
- Moist heat: penetrates better
- Electric paraffin bath
- Ultrasound/infrared
- Polypropylene undergarments

- Chiropractic, osteopathic manipulation, massage therapy
- Physical/occupational therapy
- Traction, inversion table
- Trigger point therapy
- Joint/tendon/bursa injection

Effective Treatment of Pain

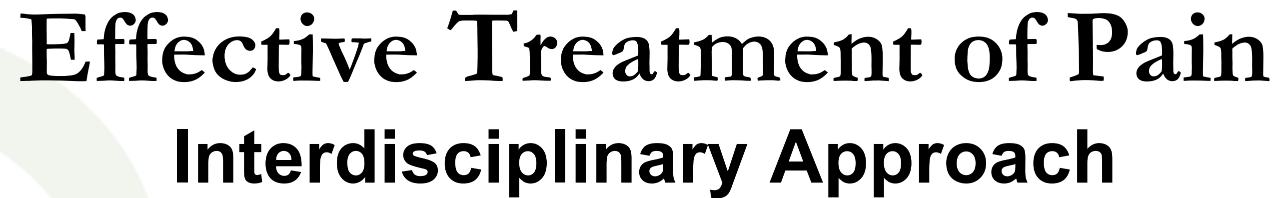
Exercise/Stretches

- Fibromyalgia: gentle AROM stretches
- Low-impact yoga
- Contracture: e.g., hamstrings, iliotibial band
- Swimming: often the ideal exercise
- Aerobic exercise

Effective Treatment of Pain

Anesthesiology Procedures

- Epidural, caudal blocks: et. al.
- Ganglion blocks
- Intradiscal electrothermal therapy (IDET)
- Neuroablation
- Intrathecal pump



- Psychological assessment, counseling
- Support groups, websites
- Family conference: better sooner than late
- Consider “total suffering,” including spiritual

Effective Treatment of Pain

Non-Allopathic Modalities

Never discourage a modality that does no harm and could help some patients

- Acupuncture/pressure
- Nutritional management
- Herbal/homeopathic supplements
- Distraction techniques
- Meditation

End Harmful Hospital Traditions

- Avoid judgmental terminology, especially in documenting
- Participate in updating institutional policies to pain management, speak out against disregard for pain
- Be wary of staff ignoring or “editing” pain scores

Instituting Change

End Harmful Hospital Traditions

- Avoid (or countermand) reducing/stopping baseline chronic pain medications
- Avoid painful intramuscular injections
- Avoid open-ended instructions to nurses when writing pain treatment orders
  - “Morphine drip, titrate to comfort” is not acceptable to the Joint Commission

Instituting Change
Networking

Fosters both skills and commitment to effective treatment

Find a pain mentor

- e.g. pain specialist or palliative care clinician

Connect with websites offering pain topics

Attend live pain CME

Telemedicine Pain Consults

Prescription Drug Monitoring Programs

JCAHO Core Principles of Pain Assessment and Management

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Core Principles of Pain Assessment and Management 89

- Patients have the right to appropriate assessment and management of pain
- Pain is always subjective. Therefore, the patient's self-report of pain is the single most reliable indicator of pain. A clinician needs to accept and respect this self-report, absent clear reasons for doubt
- Physiological and behavioral (objective) signs of pain (e.g., tachycardia, grimacing) are neither sensitive nor specific for pain. Such observation should not replace patient self-report unless the patient is unable to communicate
- Assessment approaches, including tools, must be appropriate for the patient population. Special considerations are needed for patients with difficulty communicating. Family members should be included in the assessment process, when possible

- Released 2001

JCAHO Core Principles of Pain Assessment and Management Cont.

- Pain can exist even when no physical cause can be found. Thus, pain without an identifiable cause should not be routinely attributed to psychological causes
- Different patients experience different levels of pain in response to comparable stimuli; a uniform pain threshold does not exist
- Pain tolerance varies among and within individuals depending on factors including heredity, energy level, coping skills, and prior experiences with pain
- Patients with chronic pain may be more sensitive to pain and other stimuli
- Unrelieved pain has adverse physical and psychological consequences. Therefore, clinicians should encourage reporting of pain by patients who are reluctant to discuss pain, deny pain when it is likely present, or fail to follow through on prescribed treatments
- Pain is an unpleasant sensory and emotional experience, so assessment should address physical and psychological aspects of pain

- Released 2001

www.aafp.org/cls/pain