OBG MANAGEMENT

ANSWERS FROM
A NEW GUIDELINE

What's the best approach to managing chronic pain?

Take an interdisciplinary approach and avoid making medication the sole focus of treatment, according to updated recommendations

Gilbert D. Veasey, Sr, MD, MS

Dr. Veasey is a third-year family medicine resident at Clinton Memorial Hospital/University of Cincinnati, Wilmington, Ohio.

Keith B. Holten, MD

Dr. Holten is Residency Director and Physician Leader: Operation Integration, Clinton Memorial Hospital/University of Cincinnati Family Medicine Residency, Wilmington, Ohio.

The authors report no financial relationships relevant to this article.

This article is adapted from the December 2008 installment of The Journal of Family Practice's "Guideline Update" series. The Journal of Family Practice is an NLM-indexed publication of Dowden Health Media, publisher of OBG Management.

>> SHARE YOUR COMMENTS
Do you refer to a pain specialist?
E-MAIL obg@dowdenhealth.com
FAX 201-391-2778

- What are the critical steps in the assessment of a patient who suffers chronic pain?
- What are the four biologic mechanisms of pain?
- When is referral to a pain specialist recommended?

Answers to these questions are summarized on page 34, and in the 2008 edition of *Assessment and Management of Chronic Pain*, a practice guideline developed and first published in 2005 by the Institute for Clinical Systems Improvement (ICSI), which also funded the work. ICSI is a collaboration of 57 medical groups sponsored by six Minnesota health plans. A third edition of the guideline, released in August 2008, summarizes current evidence about the assessment and treatment of chronic pain in mature adolescents (16 to 18 years old) and adults.

A distinct challenge to clinicians

Chronic pain—a persistent, life-altering condition—is one of the most challenging disorders for primary care physicians to treat. Unlike the case with acute pain, for which we seek to cure the underlying biologic condition, the goal of chronic pain management is to improve function in the face of pain that may never completely resolve.

Achieving that goal, according to the new guideline, requires a patient-centered, multifaceted approach—often involving a health-care team that includes specialists in behavioral health and physical rehabilitation—that is coordinated by a primary care physician. An effective treatment plan must address biopsychosocial factors as well as spiritual and cultural issues. Patients must be taught self-

IN THIS ARTICLE

Practice recommendations for managing chronic pain

Grade A recommendations

- Develop a physician–patient partnership. This should include a plan of care and realistic goal-setting.
- Begin physical rehabilitation and psychosocial management. This includes an exercise fitness program, cognitive-behavioral therapy, and self-management.

Grade B recommendations

- Obtain a general history, including psychological assessment and spirituality evaluation, and identify barriers to treatment.
- Obtain a thorough pain history.
- Perform a physical examination, including a focused musculoskeletal and neurologic evaluation.
- Perform diagnostic testing as indicated. X-rays, computed tomography, magnetic resonance imaging, electromyography, and nerve conduction studies can help differentiate the biological mechanisms of pain.
- Teach patients to use pain scales for self-reporting.

Grade C recommendations

- Categorize the 4 biological mechanisms of pain (inflammatory, mechanical, musculoskeletal, or neuropathic).
- Consider the following pharmacologic options for Level-I care:
  - Nonopioid analgesics
  - Nonsteroidal anti-inflammatory drugs
  - Antidepressants, including tricyclics
  - Anticonvulsants
  - Topical agents
  - Muscle relaxants
  - Anxiolytics
  - Drugs for insomnia
  - Opioids (last line)
- Consider the following Level-I therapeutic procedures:
  - Facet joint injection
  - Percutaneous radiofrequency neurotomy
  - Intradiscal electrothermal therapy
  - Epidural corticosteroid injections
  - Vertebroplasty and kyphoplasty
  - Acupuncture

Consider the following Level-II interventions:

- Referral to an interdisciplinary team and pain specialist
- Surgery
- Palliative interventions (nucleoplasty, spinal cord stimulation, intrathecal medication delivery systems)
- Multidisciplinary pain rehabilitation.

management skills focused on fitness, stress reduction, and maintaining a healthy lifestyle.

Medications may be part of the treatment plan but should not be the sole focus, according to the guideline. Opioids are an option when other therapies fail.

The updated ICSI guideline also addresses the effects of various therapies, the role of psychosocial factors, and the identification of barriers to treatment. The comprehensive guideline, which has 172 references and nine appendices, also features two easy-to-use algorithms. One addresses the assessment of chronic pain (**FIGURE 1**) and the other deals with chronic pain management (**FIGURE 2**, page 36).

Both algorithms identify Level-I and Level-II strategies that can be readily adapted to primary care practice. They are extremely helpful to physicians who are evaluating and developing a care plan for a patient who has chronic pain.

4 objectives

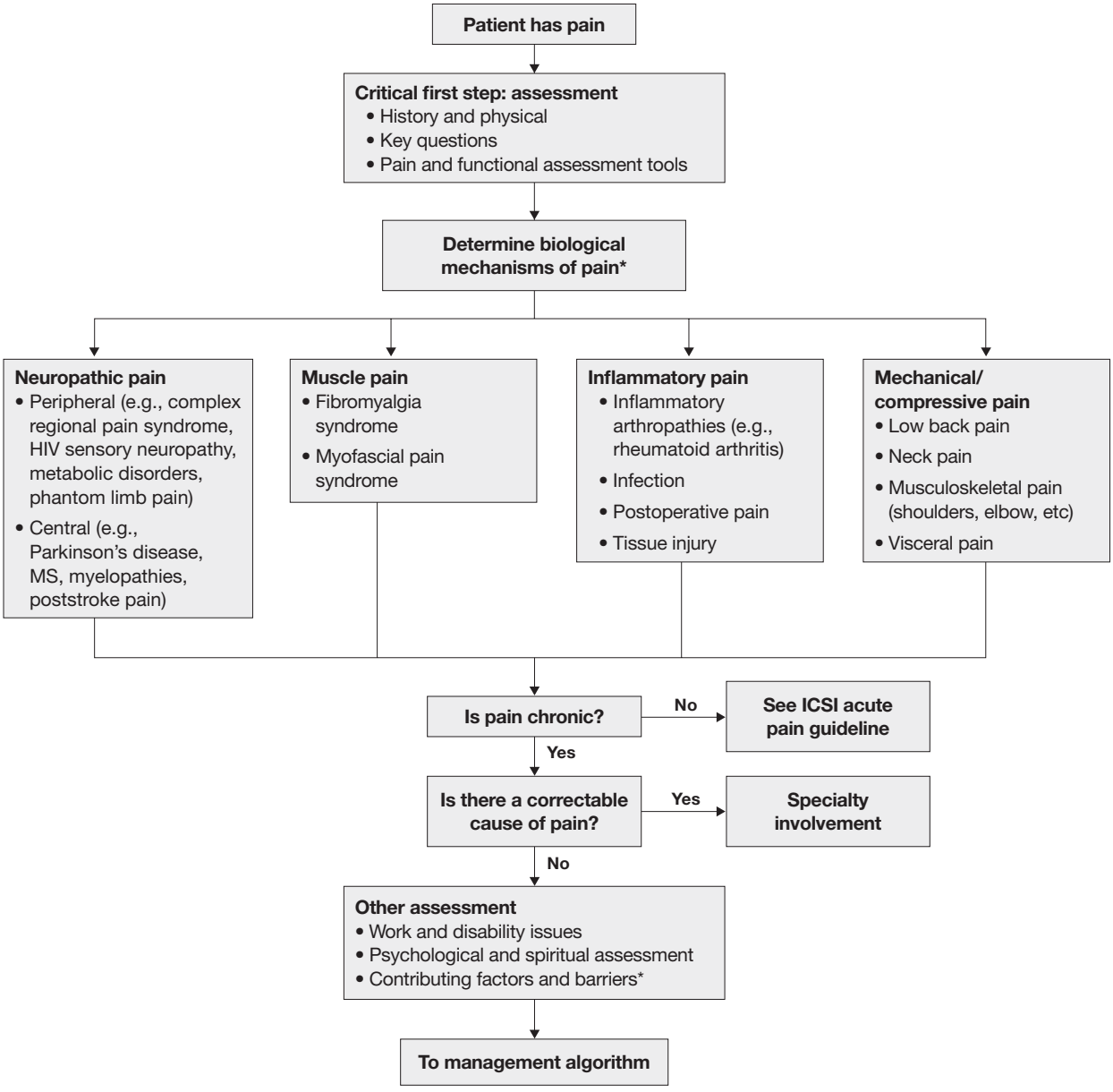
This latest guideline was developed to:

- improve the treatment of adult chronic-pain patients by encouraging physicians to complete an appropriate biopsychosocial assessment (and reassessment)
- improve patients' function by recommending development and use of a comprehensive treatment plan that includes a multispecialty team
- improve the use of Level-I and Level-II treatment approaches to chronic pain
- provide guidance on the most effective use of nonopioid and opioid medications in the treatment of chronic pain.

With these objectives in mind, the ICSI work group conducted a comprehensive literature review, giving priority to randomized controlled trials (RCTs), meta-analyses, and systematic reviews. The work group used a seven-tier grading system to rate the evidence and a three-category system for the worksheets in the guideline appendices.

For this article, we converted evidence ratings in the guideline into so-called strength-of-recommendation taxonomy, or SORT.[1]

FIGURE 1 Chronic pain assessment



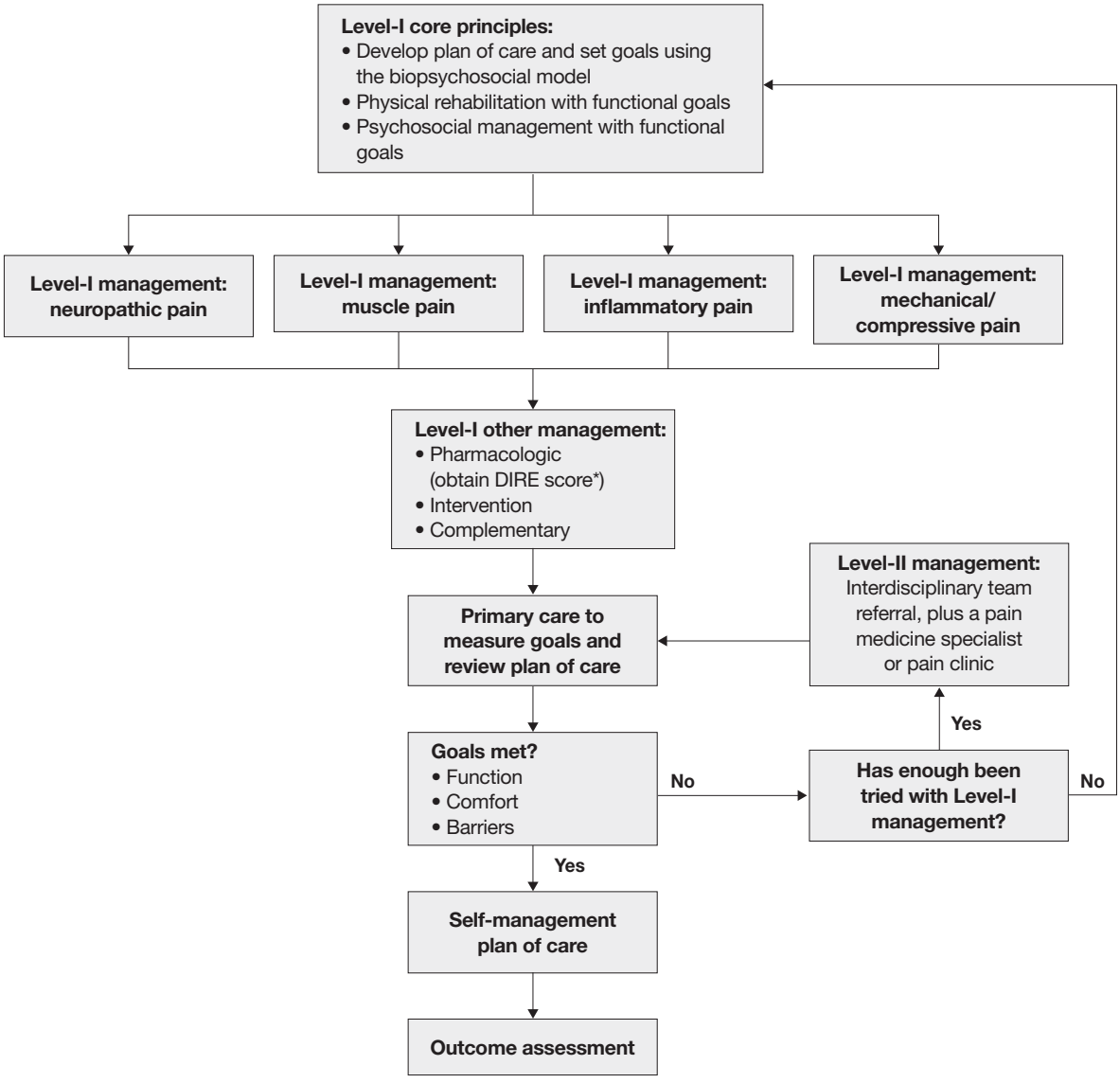
HIV, human immunodeficiency virus; ICSI, Institute for Clinical Systems Improvement; MS, multiple sclerosis.
*Pain types and contributing factors are not mutually exclusive. Patients frequently have more than one type of pain, as well as overlapping contributing factors.
Source: Institute for Clinical Systems Improvement. Reprinted with permission.

What aspects of practice have changed?

In addition to reflecting the latest research, the new guideline contains a number of clarifications. For example: The update states that medications are not the "sole" focus of treatment and should be used, when necessary, as part of an overall approach to pain management. (The previous version noted that medications were not the "primary" focus.)

The management algorithm (**FIGURE 2**, page 36) now leads with "core principles"—a

FIGURE 2 Chronic pain management



* DIRE, diagnosis, intractability, risk, efficacy.
Source: Institute for Clinical System Improvement. Reprinted with permission.

term suggesting greater importance than the former term, "general management," implied. Clinical highlights, a synthesis of key recommendations, have been revised to better align with the guideline's main components—assessment, functional goals, patient-centered/biopsychosocial care planning, Level-I versus Level-II approaches, and medication and patient selection.

Other changes in the guideline may contribute to clinicians' understanding of chronic pain and its complex presentation. The guideline now includes a statement about allodynia and hyperalgesia to indicate that both may play an important role in any pain syndrome—not just in complex regional pain syndrome. Information about fibromyalgia symptoms and myofascial pain has been added. The definitions page now has an entry for "biopsychosocial model," as well as language

designed to stress the differences between untreated acute pain and ongoing chronic pain.

A limitation, an improvement

A limitation of the guideline is the lack of studies addressing the effectiveness of a comprehensive, multidisciplinary treatment approach to chronic pain management; most studies consider single-therapy management. An improvement, on the other hand, is that the evidence levels for each strategy are now listed within the section describing it—a notable change that makes it easier to identify the quality of individual recommendations.

As has been the case in the past, this latest edition of the guideline offers a number of tools for physicians. The assessment and management algorithms walk clinicians through decision-making. In addition, the following nine appendices provide practical guidance to physicians in various aspects of patient evaluation and care:

- Brief Pain Inventory (Short Form)
- Patient Health Questionnaire (PHQ-9)
- Functional Ability Questionnaire
- Personal Care Plan for Chronic Pain
- DIRE (diagnosis, intractability, risk, efficacy) Score: Patient Selection for Chronic Opioid Analgesia
- Opioid Agreement Form
- Opioid Analgesics
- Pharmaceutical Interventions for Neuropathic Pain
- Neuropathic Pain Treatment Diagram.

Source

As noted, the source document for this guideline is: *Assessment and Management of Chronic Pain*. 3rd ed. Bloomington (Minn): Institute for Clinical Systems Improvement (ICSI); 2008 July.

The complete guideline is available at: www.icsi.org/pain__chronic__assessment_and_management_of_14399/pain_ _chronic_ _assessment_and_management_of_ _guideline_.html. (Accessed August 18, 2009.)

CONTINUED ON PAGE 38

FOR PATIENTS

Managing chronic pain: Your personal care plan

The goal of managing chronic pain is to help you to return to the activities (work, family, social, and recreational pursuits) that are most important to you. This form can help us work together toward that goal.

Use the space under **"Personal goals"** to identify the activities you want to be able to do again, and the dates by which you hope to be able to do them. The remainder of the care plan lists treatment goals for all chronic pain patients, with check marks next to the actions and interventions that the doctor recommends for you.

We will review your progress in reaching these goals at every visit, based on your pain level and score on the Functional Ability Questionnaire, and make any necessary changes in your care plan. If you have any questions or problems between visits, be sure to call the office and let us know.

1. PERSONAL GOALS

❑ **Return to the following activities/tasks/etc:**

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____

❑ **Return to work**

Limited schedule Date_____

Normal schedule Date_____

2. IMPROVE SLEEP: SLEEP _____ HOURS PER NIGHT

❑ **Follow basic sleep plan**

1. Eliminate caffeine and naps
2. Relax before bedtime
3. Go to bed at _____ every night

3. INCREASE PHYSICAL ACTIVITY

❑ Daily stretching (_____ minutes _____ per day)

❑ Aerobic exercise (_____ minutes _____ days per week)

❑ Strengthening (_____ minutes _____ days per week)

❑ Attend physical therapy, as directed

4. MANAGE STRESS

❑ Practice relaxation techniques (meditation, yoga, imagery, etc) daily

❑ Participate in formal interventions (counseling, classes, support group/group therapy) as directed

❑ Take medication, as directed

5. DECREASE PAIN

❑ Nonmedication treatments (ice/heat, massage, etc)

❑ Take medication, as directed

❑ Other treatments: _____

Adapted from: Institute for Clinical Systems Improvement (ICSI). *Assessment and Management of Chronic Pain Guideline Summary*. 3rd ed. Personal care plan for chronic pain. July 2008. Available at: http://www.icsi.org/pain_ _chronic_ _assessment_and_ management_of_14399/pain_ _chronic_ _assessment_and_management_of_ _guideline_.html.