

Primary Care Assessment and Treatment Guidelines for Chronic Pain Patients

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Community Health, UMMS

ASSESS PATIENT

(see UMMHC/DFMCH
Patient Baseline Packet &
Clinician Intake forms)

History

- Treatment history
- Psychosocial history
- Family history
- Current legal or worker compensation issues

Physical Exam

- Pain level
- Impact on functioning
- Type of pain-neuropathic, myofascial, nociceptive

Testing

- Appropriate imaging, nerve conduction and lab tests
- Assess for risk of abuse, misuse, addiction or diversion of opioids (see UMMHC/DFMCH Patient Baseline Chronic Pain Evaluation Questionnaire & Pain Management Intake Forms)
- Screening tools for drug abuse are useful although not definitive

PATIENTS DO BETTER WHEN:

- Comprehensive approach used
- Consider functional impairment
- Psychosocial factors considered

CONSIDER OPIOIDS IF:

- Pain is moderate to severe
- Pain is well defined
- Pain has adverse effect on functioning and/or quality of life
- Not responded to other therapies
- Potential benefits are likely to outweigh risks based on thorough assessment

BE CAUTIOUS IF:

- High risk is identified by risk assessment screens or history
- Presence of constipation, nausea, pulmonary disease, cognitive impairment
- Family or personal history of alcohol or drug abuse
- Younger age (<45)
- Current psychiatric condition

INFORMED CONSENT:

- Set goals and expectations (see UMMHC/DFMCH Patient Baseline Chronic Pain Evaluation Questionnaire & Opioid Pain Medication Agreement)
- (one prescriber, one pharmacy, random drug screens, expected intervals between visits, use of pill counts, limits on number of pills dispensed, storage of medication)
- Review potential risks
 - Common side effects (constipation, nausea, sedation)
 - Risk of abuse, addiction, overdose
 - Risk of long term use (hyperalgesia, endocrinologic/sexual dysfunction)
- Review alternative therapies
- Specify in writing both patient and clinician responsibilities (see UMMHC/DFMCH Opioid Pain Medication Agreement)

MANAGEMENT PLAN SHOULD INCLUDE:

- Pain and functional status goals
- Schedule for medication
- Expectations for monitoring and follow up
- Expectations for concomitant therapies
- Indications for tapering or discontinuing (failure to benefit, difficult side effects, serious aberrant drug-related behavior)
- Expectations for modest improvements in pain
- Documentation (see UMMHC/DFMCH Opioid Pain Medication Agreement)
- Guidance to patients to keep medication safe (locking medication safe)
- Guidance to patients on how to dispose of unused opioids
- Periodically update and re-evaluate

INITIATING OPIOIDS:

- Consider it a trial to see if use of opioids is appropriate
- Select medication, dose, titration based on patient medical condition and history
- May want to start with short-acting for opioid naïve patients
- Transition to long-acting opioid with around the clock dosing can provide
 - More consistent pain control
 - More adherence
 - Lower risk of abuse/addiction



ROUTINELY CONSIDER ADDITIONAL INTERVENTIONS

•(see Chronic Pain Resource Sheets for your site)

- Cognitive behavioral therapy, relaxation, biofeedback-refer to UMMHC Dept. Psychiatry pain groups, therapy or patient's insurance for Behavioral Medicine
- Functional restoration (PT/OT) &/or simulated physical tasks in supervised setting
- Pain education
- Cardiovascular fitness
- Pain clinics or UMMHC Spine Clinic
- Chiropractors, acupuncture
- Osteopathic manipulation therapy



MONITORING

Risk stratify patients for regular appointments and re-evaluation

- Low risk, 1-2x per year
- Minimal risk, 4x per year (every 3 months)
- Higher risk, daily, weekly, monthly as called for

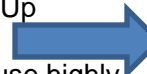
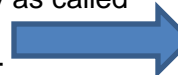
Closer monitoring required WHEN:

- History of addiction
- Occupation requiring mental acuity
- Older adult
- Unstable or dysfunctional social environment
- Comorbid psychiatric or medical conditions



MONITORING REQUIRES:

- Regular, repeat evaluation of pain severity, functioning, review of adverse effects, progress toward therapeutic goals, and review of comorbidity conditions, psychological status etc. (see UMMHC /DFMCH Patient Follow Up Questionnaire & Pain Progress Note)
- Specific monitoring for aberrant drug use highly recommended: urine screens, pill counts, family interviews, prescription monitoring (see UMMHC/DFMCH Pain Progress Note)
- Patient self-report plus careful provider review of issues important
- Abnormal urine screen should take into account range of possible explanations including abuse as well as self-medication for poorly controlled pain, psychological issues, diversion [absence of medication]
- Consider rotating medications to address adverse side effects or inadequate response
- Carefully and independently evaluate breakthrough pain for those on 24-hour medication; consider options other than adding short acting or rapid-release opioids



HIGH RISK PATIENTS:

- Usually have history of drug abuse, psychiatric disorder, or serious aberrant drug-related behaviors
- Can be safely treated only with intensive supervision
- If patient is not high risk, don't consider all aberrant medication issues as serious, but any presence should institute re-evaluation and closer monitoring
- Continually re-evaluate risk/benefit of treatment refractory patient on high doses of opioids (200 mg daily morphine or equivalent)
- Taper or wean off patients with repeated serious aberrant behaviors.

ANTICIPATE, IDENTIFY, TREAT SIDE EFFECTS:

(see UMMHC/DFMCH Pain Progress Note)

- Constipation*: fluid & fiber intake, stool softeners, laxatives
- Nausea or vomiting*: antiemetic therapy oral or rectal
- Sedation*: counsel patients to avoid driving, working with equipment, and identify interactions with other medications
- Slower reflexes/cognitive impairment*: legal proscription for public transportation employees
- Hypogonadism/dehydroepiandrosterone sulfate decreases*: fatigue, decreases libido, sexual dysfunction
- Pruritus/ myoclonus*
- Respiratory depression*: with rapid increases in dosage