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Primary Care Assessment and Treatment Guidelines for Chronic Pain Patients

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, nocioceptive

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

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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