Chronic Pain Assessment: Ruth Dubin + Christine Sugrue

The pain-focused history and sensory exam

CONFLICT OF INTEREST DISCLOSURE

• Faculty/Speaker’s name: Dr. Ruth Dubin
• No conflicts of interest to declare
• Other: Co-Chair ECHO Ontario Founder and Past-Chair CFPC Chronic Pain Committee

Objectives

At the end of this session participants will be able to:

• Use key questions to assess important aspects of the pain history
• Efficiently delineate the biopsychosocial dimensions of your patient’s pain experience
• Perform a bedside sensory exam to detect neuropathic and myofascial pain

PAIN HISTORY ELEMENTS:


• Medical etiology of pain
• Medical co-morbidities
• Psychiatric co-morbidities
• Psychological co-morbidities (catastrophizing, passive coping, external locus of control)
• Socioeconomic assessment (finances/social support)
• Addiction risk (Opioid Risk Tool score, history of addiction)
• Impact of Pain on Function

I added 2 other components:

• What are the patient’s goals?
• Recommendations for treatment:
  • Mind-based
  • Movement-based
  • Medical/Interventional
  • Self-Management

First, get the story (if you don’t already know it)

• “When were you last well?”
• “And then what happened?”

• THIS TAKES TIME, CAN BE SPREAD OVER MANY APPOINTMENTS!
• MANY PATIENTS WILL HAVE CHRONIC WIDESPREAD PAIN (FIBROMYALGIA) FOR WHICH THE K037A CODE IS AVAILABLE
GET a patient-drawn pain diagram

Medical etiology of pain (examples)
- Low back pain with L4/5 sciatica
- Chronic daily headache
- Diabetic peripheral neuropathy
- Neuropathic pain due to herpes Zoster
- Myofascial Pain
- Chronic wide-spread pain / Fibromyalgia

Medical co-morbidities
- Type 2 diabetes,
- Hypertension,
- Chronic renal disease
- Etc....often relevant to diagnosis and treatment choices

Psychiatric Co-Morbidities
- Depression, General Anxiety Disorder, Bipolar Disorder etc.
- Look at grief, loss of role(s) in life, perceived injustice, anger

Psychological Co-Morbidities
- Passive versus Active Coping:
  - "What do you do when you have a pain flare?"
  - Passive coping = poorer outcomes
    (something is done to the patient such as outcomes e.g. rest, hot/cold packs)
  - Active coping = better outcomes
    (something that the patient does: exercise, prayer, meditation)

Catastrophizing
- Catastrophizing: "This pain is the worst thing that has ever happened to me, I can't stop thinking about it"
- Magnification, rumination, helplessness (Can use Pain Catastrophizing Scale)
  - Sullivan et al. 1995. Psychological Assessment 8B: 524-532
**Socioeconomic Assessment (finances, social support)**

- What is your income source (ODSP/LTD/Working?)
- Who do you live with?
- What is your social life like since you’ve developed chronic pain?
- Do you have a drug plan?
- How stressed are you about your finances?
- Also important: conflict with insurers, WSIB, employers, family

**Addiction Risk: gentle questions, put down your pen, make it ok to talk about**

- Do you enjoy caffeine, cigarettes, alcohol?
- How many cases of beer do you go through each week?
- Have you ever tried marijuana for your pain?
- When you were a younger were you a bit on the wild side / experiment with recreational drugs?
- Did anyone in your family have problems with drugs or alcohol?

**The Best Question to Ask:** (thanks to Dr. Pam Squire again)

- **WOULD YOU WANT YOUR CHILDREN TO HAVE HAD THE SAME UPBRINGING YOU DID?**

**Impact of Pain on Current Function:**

- What hobbies have you given up because of your pain?
- Take me through your day. When do you get up, then what…?
- Ask about sleep? Restless legs, snoring, sleep apnea

**Brief Pain Inventory: Interference Score**

- **BPI Interference Score is 63/70**
Patient’s Goals

• What makes you laugh? (usually pets/grandkids)
• Motivational interviewing when you get a series of “yes buts”
• Use SMART Goals: “when will you walk the dog, for how long, how many times this week?”
• Follow up at next visit: “so how did it go?”

Neuropathic Pain:

• A type of chronic pain mediated through nerve injury
• ASK FOR DESCRIPTION: Burning, stabbing, tingling, like electric shocks etc.
• 3 cardinal symptoms present to variable degrees:
  • Radiation of pain
  • Paroxysmal pain
  • Allodynia

Physical findings in chronic pain: sensory loss and gain

Vasomotor: edema, temperature changes, dermatographism
Sudomotor: skin, sweat, trophic changes
Sensory gain:
  • Allodynia: Mechanical/thermal
  • Hyperalgesia: Increased sensitivity to pain
  • Dysesthesia: normal sensation is unpleasant, after-sensations.
Sensory loss:
  • Thermal, vibration, soft touch
Summation (windup): central sensitization

Seek and ye shall find: sensory testing in chronic pain and other tricks of the trade

Hi tech tools:
  • Cotton balls
  • Safety pin
  • Brush
  • Tuning fork
  • Warm and cold water

Meet Christine

• 52 year old teacher, active and healthy
• Past history of migraine, BPV
• Supportive family
• Nonsmoker
• No alcohol or drug abuse Hx
• Crush injury to back in 2002 (riding)
• Compression #T8, T11

Mid back pain, fibromyalgia,
Christine: an active self-manager:

- T7/8 facet joint injection and ablation 2005
- Physio, massage, TENS, Exercise including YPEP
- Meds (pregabalin, tramadol, duloxetine, bupropion) – low doses as sensitive to med effects
- Supplements: Vitamin D, B12, Salmon oil, Calcium, magnesium, Vit C,
- Trigger points in mid back: dry needling helps
- Mindfulness meditation for chronic pain
- Neural feedback
- Co-founder of Kingston Chronic Pain Support Group

Meet Christine: active self-manager, chronic pain patient advocate + teacher

Central Sensitization - compression # after crush injury while horseback riding

STEPWISE PHARMACOLOGIC MANAGEMENT OF NEUROPATHIC PAIN
(Moulin et al, 2014)

1. TCA → Gabapentinoids → SNRI
2. Tramadol → Opioid Analgesic
3. Cannabinoids
4. 4th line agents

Add additional agents sequentially if partial but inadequate pain relief

* Topical lidocaine (second line for postherpetic neuralgias), methadone, lorcicept, low-dose naltrexone, tapentadol, botulinum toxin

+ Limited randomized controlled evidence to support add-on combination therapy

ALWAYS LOOK FOR MYOFASCIAL TRIGGER POINTS*

Hyperirritable nodules located within a taut band of skeletal muscle. Painful MTrPs activate muscle nociceptors that cause motor and sensory changes in the peripheral and central nervous system (sensitization)*


GREAT Myofascial Pain APP
“Real Bodywork (itunes)”

Myofascial Pain does not respond to OPIATES!
You can use trigger point injections, acupuncture, TENS, stretching, Yoga, And other Manual Therapies

Myofascial Pain spreads if untreated
(Arendt-Nielsen J.Man+Manip Therapy 2011:19-186)
The ideal treatment of CNCP*

Useful framework for making management suggestions

MOVEMENT
Physical / Rehabilitative

SELF MANAGEMENT

MIND
Psychological

MEDICINE
Medications & Interventions

*R Jovey, Canadian Pain Society, 2009 - with input from R. Dubin

Also see: Action Plan for the organization and delivery of chronic pain services in Nova Scotia, 2006

Take-Home Message

• Take your time & listen with compassion

ECHO ONTARIO: VISION

• That all primary care providers in Ontario have the knowledge and support to manage chronic pain safely and effectively.

Questions