The Five Pillars of Chronic Pain: A Rational Approach to Pain Recovery

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Faculty/Presenter Disclosure

► Faculty: Andrew J Smith, MDCM
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The Five Pillars of Chronic Pain: Learning Objectives
By the end of this session, participants will be able to:

1. To learn a comprehensive approach to managing chronic pain and risk
2. To understand the burden of chronic pain in our society
3. To differentiate between neuropathic and nociceptive pain

What Is Pain?

- IASP (1986): an unpleasant sensory and emotional experience associated with actual or potential tissue damage
- Acute pain is a vital, protective mechanism that permits us to live in an environment fraught with potential dangers
- In contrast, chronic pain serves no such physiologic role and is itself not a symptom, but a disease state
- Chronic = pain which lasts beyond the ordinary duration of time that an insult or injury to the body needs to heal
  - Beyond 3-6 months in duration

Chronic Pain is Common

- Prevalence of chronic pain in the adult population may be 30% (Moulin et al 2001)
- 18% of Canadian adults suffer from moderate to severe chronic pain daily or most days of the week (Nanos Survey 2007-2008)
- Most common reason for visit to family physician (~ 20-25%)
- Chronic pain is unlikely to completely resolve (30% reduction is a GOOD outcome)
- Opioids have long been used to manage pain, especially in acute and palliative contexts
- Cannabinoids

35 yo woman with chronic migrane and facial pain taking opioids and running out early.

- Kicked in head by horse 5 years ago — brief loss of consciousness; left lancinating facial pain and headache
- Assaulted by ex-partner 2 years ago; bilateral jaw pain; bilateral lancinating facial pain; vomiting; nausea; "drop attacks"; "space out spells"; other "migraine" headaches; 9 photophobic, eye pain
- DX with Trigeminal neuralgia; Rx gabapentin (effective); Morphine 10mg BID prn started 2 years ago to facilitate participation in therapy
- Currently taking 25mg tabs: 4 tabs po qfhr (5-10 tabs per day). Runs out early. Then uses T1s.
- Naproxen 500mg BID daily
- Cannabis 8 g/day ... Alcohol – 10-12 SD on bad headache days (1 year ago: 1 day q2 weeks; now 3 days per week)

NOTE: Unless otherwise indicated, all sources are cited in the Prescription Opioid Policy Framework
...& Complicated

- Associated with the worst quality of life when compared with other chronic diseases such as chronic cardiovascular or respiratory diseases (Jovey et al. 2010)
- Mood and anxiety disorders are 2–7x more prevalent in populations of chronic pain and migraine patients in primary, specialty and tertiary care samples (Tunks et al 2008)
- Co-morbidities multiply functional compromise and QOL restrictions with pain (NB: OUTCOMES)
- Suicide risk 2x higher in CP population vs the non-pain population (Tang, 2006)
- Substance use disorder among patients with chronic pain: 2–14%

ADDOP: The Five Pillars of Pain Management

- Assess: Symptoms and Risk
- Define the problem: where and what is it?
- Diagnose the kind of pain and treat it
- Other issues: mood, anxiety, sleep, addiction, sex
- Personal management, self management

Pillar 1: Assessment

- Lancinating pain V2, V3. Triggered by brushing chin
- Cervical headaches exacerbated by movements; cold, stress; radiate up over vertex and behind both eyes R>L. Assoc photophobia, osmophobia.
- Childhood adversity
- Trauma
- Aberrant drug-related behaviours

Pillar 2: Define the Underlying Problem

- General, MSK and neurological exam
- Investigation
  - Neurophysiological testing: EMG/NCT and possibly evoked response
  - Pain scales including BPI and DN4, S-LANNS
- Neuroimaging

- Where is the lesion and what is the lesion?
- Applies to neurological conditions and non-neurological conditions
- Treating underlying disease sometimes helps reduce pain

Homo sum, humani nihil a me alienum puto - Terrance

I am human, and I consider nothing that is human alien to me
Pillar 3: Diagnose Pain and Treat Accordingly

- Nociceptive vs. Neuropathic
- Cancer vs. Non-Cancer
- Acute vs. Chronic
- Mild, Moderate and Severe

Pillar 3: Diagnosis: Nociceptive vs. Neuropathic


Pain

Nociceptive
- Normal stimulation of nociceptors
- Thermal, chemical, mechanical

Neuropathic
- Abnormal nervous system activation
- Somatic, Visceral, Central, Peripheral

Existential
- Pain that occurs in response to questioning and doubting the value of one's ongoing existence as a living, sentient being

Pillar 4: Other Symptoms and Conditions

- Sleep
- Mood and Anxiety Disorders
- Substance Use Disorders
- Trauma
- Fatigue
- Sexual Function

Pillar 4: Other Symptoms and Conditions

- Depression
- Suicidal ideation associated with pain
- Dissociative episodes
- Fragmented sleep \(\rightarrow\) wakes up sweaty and restless
- Flashbacks and trauma-related nightmares

Pillar 5: Personal Responsibility and Self-Management

- Who's working harder?
- Lack of buy-in and self management \(\rightarrow\) ‘refractory’ patient
- Proactive management of realistic expectations
- Need to educate patient and family about pain management techniques
- Therapeutic alliance is key
- Clinicians need to practice (not just talk about) interprofessional model
  - Lack of prompt recovery \(\rightarrow\) we tend to repeatedly apply medical model – more consults, tests, drugs
  - Other modalities – psychological and otherwise – are left out

Pain as a Motivational Disorder

- A daily reminder of derailment
- Traumatic
- Robs assertiveness
- A neurological signal to STOP
- Multifactorial – multiple concurrent disorders
- Overwhelming
- Isolating
Stages of Change – Where's the Patient?

Meet them where they are

Continuum of ambivalence

Explore readiness to change, importance and confidence

Treating Chronic Pain: The 3 Ps

• Physical

• Psychological

• Pharmaceutical

Pharmacologic Steps in Neuropathic Pain

TCA Gabapentin / Pregabalin SNRI

Tramadol opioid Analgesics

Cannabinoids

Fourth Line Agents **

Add additional agents sequentially if partial but inadequate pain relief**

** eg SSRIs, methadone, benzodiazepine, valproic acid

*** Do not add SNRI to TCA

Non-pharmacologic therapy

• Self-Management

• Cognitive and Behavioural Therapy (CBT)

• Meditation

• Mindfulness techniques

• Exercise

• Physical therapy

• Interventional approaches: nerve stimulation or block

• Acupuncture

• Botox

• ETC...
Pillar 5: Pain Recovery
- Reimagining pain from uncontrollable to manageable
- Fostering optimism and combating despair
- Promotion of patient feelings of success, self-control and efficacy
- Patients attribute success to their own role
- Education in specific skills: pacing, relaxation, problem-solving
- Emphasis on active patient participation and responsibility

ECHO: Introducing a 6th Pillar...
- Assess: Symptoms and Risk
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ECHO Chronic Pain / Opioid Stewardship
- Launched June 2014
- Affiliations: University Health Network (Toronto) and Queen’s University (Kingston)
- 12-member interprofessional hub
- ECHO Weekly Sessions: Thursdays 12:30 to 2:00 pm
- Special Evening Sessions: Opioid Tapering and Safe Prescribing
- ECHO ON Opioids  → 1 hr Suboxone Modules

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