Wholistic Care for Patients with Chronic Pain

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Introduction

- Specialist Pain Medicine Physician
- Specialist Psychiatrist
- Fellow in Training:
  - Addictions Advanced Certificate
- Proudly Townsville trained.
- Full time Private Practice.

Introduction - GPs

- By far most people in pain are seen by you.
- By far most people in pain are managed by you.
- There are too many people in pain.
- There are not enough pain specialists.
- There will not likely be enough pain specialists in short and medium term.
- Enhancing your ability to manage Pain Patients is the way forward.

Psychiatrists & Pain

- Most of my work revolves around *education*.
- Developing a *therapeutic relationship* with patients is essential.
- Treatment should always be *sociopsychobiological*.
- Patients should always be understood *longitudinally* from the perinatal stage till assessment & beyond.
- Making a *diagnosis* is less important than identifying *problems*.

- "an unpleasant *sensory* **and** *emotional* experience associated with actual or potential tissue damage, or described in terms of such damage."

- Chronic non-cancer pain (> 3 months)

Pain Disorder

- DSM IV-TR:
  - A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
  - B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
  - D. The symptom or deficit is not intentionally produced or feigned.
  - E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

  - Psychological, Mixed or Secondary to a General Medical Condition.

DSM 5

- Pain disorder is omitted in DSM 5.
- Essentially taking from the IASP definition that all pains have some form of influence from Psychological Factors.
- Therefore some individuals with significant psychological factors have an additional diagnosis of *Psychological Factors Affecting Other Medical Conditions*.

Goals of treatment

- Analgesia (Pain Relief)
- Activity (Function)
- Adverse Effects
- Aberrant Drug Behaviours
- Affect

- PAIN
- DIAGNOSIS
- COMORID MENTAL ILLNESS/SUD
- PERSONALITY
- SOCIAL STRESSORS

Depression

- Chronic pain & depression is very common together.
- The combination makes it harder to treat & lengthier in duration.
- The relationship is bidirectional.
- Even in the general population, a large proportion of patients that are depressed have pain.
- The more the symptoms of depression, the more likelihood there is pain.
- Either can precede the other.

Issues with co-morbidity

- Higher absenteeism
- Reduced general functioning
- Increased clinical burden
- Increased financial cost
- Less help seeking
- Much higher odds of suicide attempts & completed suicide

Depression

- Labeled: depression-pain syndrome or depression-pain dyad
- Often co-exist, respond to similar treatments, exacerbate one another and share biological pathways and neurotransmitters.
- Some depressed patients may have medically unexplained pain.
- Depressed patients in pain are also more likely to receive an inaccurate diagnosis.
- Pain patients with depression are less likely to be recognised due to the somatic nature of the complaints.
- Patients with both conditions have worse outcomes in both pain & depression.

Assessing Depression

- Stick to the criteria.
- Keep in mind other diagnoses that include depressive symptoms including: adjustment disorder, PTSD, dysthymic disorder and bipolar disorder.
- Outrule a medical co-morbidity: thyroid function, Parkinson's, B12, folate, Iron studies.
- Outrule a co-morbid substance use disorder.

Comorbid Substance Use

- Start benign - caffeine & tobacco.
- Move on to alcohol & cannabis.
- Ask a general question: “What about drugs?”
- Rattle off a list - speed, heroin, paint, glue, ecstasy, cocaine.
- End with benzos & opioids.
- Always ask about route of administration.

Get the details.

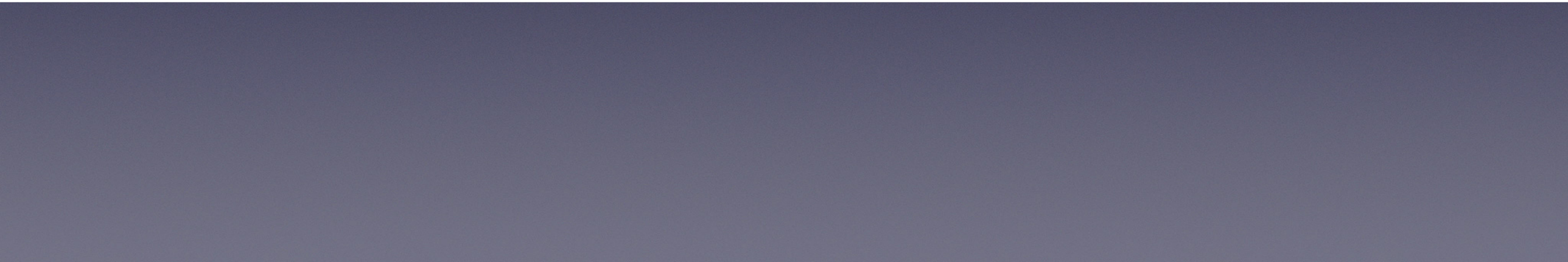
- Ask “have you ever…?”
- Out-rule aberrant drug behaviours as much as possible.

FPM
FACULTY OF PAIN MEDICINE
ANZCA

PM10
2015

Faculty of Pain Medicine
Australian and New Zealand College of Anaesthetists

Statement on “Medicinal Cannabis” with particular reference to its use in the management of patients with chronic non-cancer pain



Mark each box that applies	Female	Male
1. Family hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 1 ☐ 2 ☐ 4	☐ 1 ☐ 2 ☐ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 3 ☐ 4 ☐ 5	☐ 3 ☐ 4 ☐ 5
3. Age (mark box if 16-45)	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 3
5. Psychologic disease ADD, OCD, bipolar, schizophrenia Depression	☐ 2 ☐ 1	☐ 2 ☐ 1
Scoring totals:		

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

CURRENT OPIOID		CONVERSION FACTOR	PROPRIETARY NAMES
ORAL (SWALLOWED) PREPARATIONS ***Note:*** *Modified release formulations are marked MR*			
Morphine	mg/day	1	Anamorph, Kapanol (MR), MS Contin (MR), MS Mono (MR), Ordine, Sevredol
Oxycodone	mg/day	1.5	Endone, OxyContin (MR), OxyNorm, Targin (MR)
Hydromorphone	mg/day	5	Dilaudid, Jurnista (MR)
Codeine	mg/day	0.13	Aspalgin, Codalgin, Panadeine, Panadeine Forte, Mersyndol, Nurofen Plus, others
Dextropropoxyphene	mg/day	0.1	Di-Gesic, Doloxene
Tramadol	mg/day	0.2	Durotram-XR (MR) , Tramal, Tramadol SR (MR), Zydol, Zydol SR (MR), others
Tapentadol	mg/day	0.4	Palexia-SR (MR)
SUBLINGUAL PREPARATIONS			
Buprenorphine	mg/day	40	Suboxone, Subutex, Temgesic
RECTAL PREPARATION ***Note:*** *Absorption from rectal administration is highly variable*			
Oxycodone	mg/day	1.5	Proladone
TRANSDERMAL PREPARATIONS			
Buprenorphine	mcg/hr	2	Norspan
Fentanyl	mcg/hr	3	Denpax, Durogesic, Dutran, Fenpatch, Fentanyl Sandoz

OPIOID CONTRACT

- See attached.

Opioid Calculator

A new horizon in safety

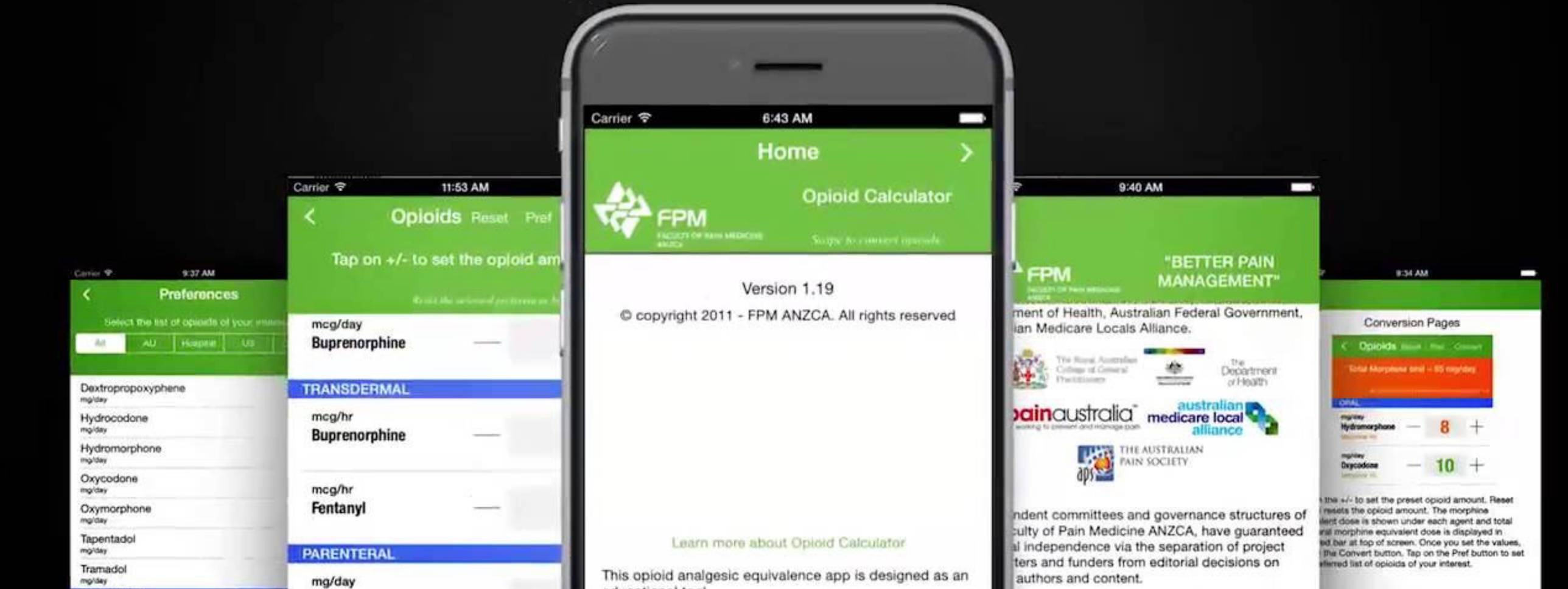


Table 3. Spectrum of aberrant drug taking behaviours among cancer pain patients[29]

Aberrant drug-related behaviours more suggestive of addiction	Aberrant drug-related behaviours somewhat suggestive of addiction	Differential diagnosis of aberrant drug-related behaviours

• Selling prescription drugs
• Prescription forgery
• Stealing or borrowing drugs from others
• Obtaining prescription drugs from non-medical sources
• Injecting oral formulations
• Concurrent abuse of alcohol or illicit drugs
• Multiple dose escalations or other non-compliance with therapy despite warnings
• Repeatedly seeking scripts from other clinicians without informing the initial/ongoing prescriber
• Evidence of deterioration in function related to drug use
• Repeated resistance to a change in therapy, despite clear evidence of drug related diverse physical or psychological effects
	• Aggressive complaining about the need for more drugs
	• Drug hoarding during periods of reduced symptoms
	• Requesting specific drugs
	• Openly acquiring similar drugs from other medical sources
	• Unsanctioned dose escalations or other non-compliance with therapy on one or two occasions
	• Unapproved use of the drug to treat another symptom
	• Reporting psychic effects not intended by the clinician
	• Resistance to a change in therapy associated with tolerable adverse effects accompanied by expressions of anxiety related to the return of severe symptoms
		• Addiction/substance use disorder
		• Unrelieved cancer pain
		• Psychiatric disorder:
		  • depression
		  • anxiety
		  • borderline personality disorder
		• Organic brain syndrome
		• Criminal intent

Outcome Tools

- Brief Pain Inventory (Severity & Interference)
- Pain Self Efficacy Questionnaire
- Pain Catastrophizing Scale
- Depression Anxiety Stress Scales

Diagnosis or Formulation

- Depression in the context of chronic pain - does it mean anything?
- It is important to identify the disorder but to formulate a treatment plan, you will need to understand the PERSON.
- Formulating a Pain case is no different than any case - the 5 P's are still relevant: predisposing, precipitating, perpetuating, protective and prognostic factors.

Figure 5. Yellow Flags

Risk factors for developing or persisting chronic pain and long-term disability are called 'yellow flags'. Yellow flags are psychosocial barriers to recovery. They include:

- The belief that pain and activity are harmful.
- Sickness behaviours, such as extended rest.
- Social withdrawal, lack of support.
- Emotional problems such as low or negative mood, depression, anxiety, or feeling under stress.
- Problems or dissatisfaction at work.
- Problems with claims for compensation or applications for social benefits.
- Prolonged time off work (e.g. more than 6 weeks). Length of time off work prognostic factor 4wks 10-20% chance will not return within yr. 3 months only small chance return to work ever.[7]
- Overprotective family.
- Inappropriate expectations of treatment, such as low expectations of active participation in treatment.

Reproduced from Back pain (low) and sciatica.[10]

Psychosocial & cultural considerations

- Loss of role & role reversal.
- Somatization as a defense mechanism.
- Beliefs about the pain.
- Consequences culturally regarding the presence of pain.
- Beliefs by family about the nature or actual presence of pain.
- Primary & secondary gain.
- Financial gain & burden in relation to pain & disability.
- Self efficacy & locus of control.

Medications

- Tricyclic antidepressants: amitriptyline, nortriptyline, dothiepin, doxepin.
- SNRIs: duloxetine, mirtazapine, milnacipran, venlafaxine & desvenlafaxine.
- SSRIs: escitalopram, citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline.
- Gabapentinoids: pregabalin & gabapentin
- Antiepileptics: carbamazepine, lamotrigine & valproate
- Opioids: codeine, tramadol, tapentadol, morphine, oxycodone, fentanyl, buprenorphine, hydromorphone.
- Benzodiazepines (not recommended long term or with opioids)
- Baclofen (not recommended without specialist consultation)
- Lithium

International Association for the Study of Pain
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PAIN
CLINICAL
UPDATES

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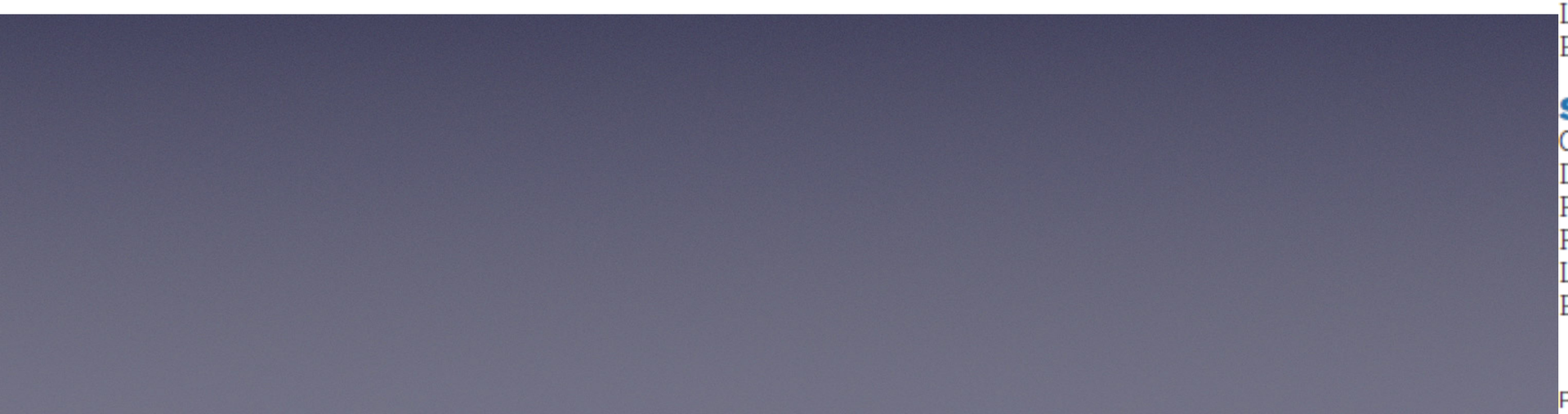
Warnings Unheeded: The Risks of Co-Prescribing Opioids and Benzodiazepines



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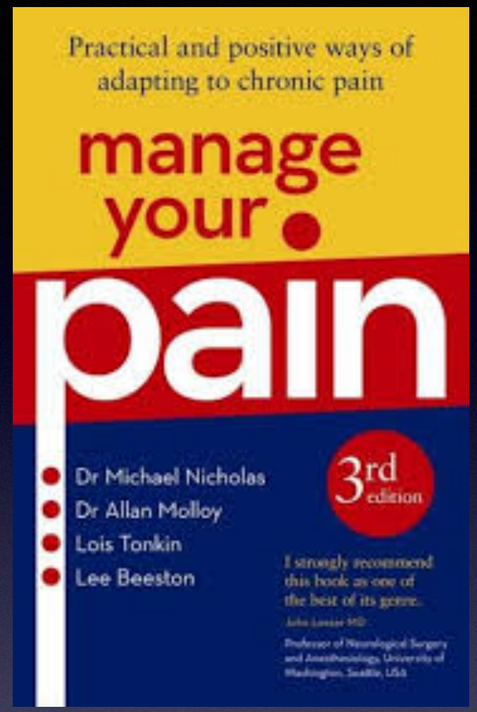
Psychological Therapies

- Cognitive & Behavioural Therapy
- Acceptance & Commitment Therapy
- Mindfulness
- Motivational Interviewing

Other

- Flexibility training like yoga, pilates or tai chi.
- Education:
  - Explain to the patient what's going on.
  - bibliotherapy
  - group programs
  - online modules
  - family



Take Home Messages

- Assess all chronic pain patients for a Mental Health Condition.
- Outrule suicidal ideation & reduce risk of self harm & suicide
- Outrule medical & substance use co-morbidities and treat accordingly if present.
- Remember to address things from a hierarchal perspective.
- Always remember the 5A’s.
- Limit opioids to less than 100mg of morphine per day (or 60mg)
- Don’t combine opioids with benzodiazepines.
- Know why you’re referring for psychological therapy.
- Education Education Education (involve family).
- Say no to medicinal cannabis (for now).

Formulating a Pain Case

- Formulate the diagnosis of Pain then look at the “P” Factors.
- 5 P’s:
  - Predisposing
  - Precipitating
  - Perpetuating
  - Protective
  - Prognostic
  - Formulate Opioid Risk

Management Plans

- USE A TEMPLATE

- Risks:
  - Driving
  - Self
  - Others (don’t forget children)
  - Red Flags

- Further information:
  - Collateral Information (family, other professionals)
  - Other Pain Clinic/Medical services.
  - MRQ
  - Investigations (pathology, imaging, nerve conduction studies)
  - Questionnaires: baseline & interval

- Education:
  - Education Day
  - Pain Programs
  - Bibliotherapy
  - 1:1 Education
  - Family Education
  - Support Groups
  - Online Modules & Forums

- Biological:
  - Medications (analgesia, biological modifiers and psychiatric medications) - don’t forget drug/drug interactions.
  - Diet/weight loss
  - Interventions
  - Surgery
  - Infusions

- Ask a colleague
- External referrals
  - Specialists
  - Allied Health
- Second opinions

- Psychological:
  - Pain Beliefs
  - Motivational Interviewing
  - CBT
  - ACT
  - Sleep hygiene
  - Relaxation training

- Physical & Occupational:
  - Physiotherapy
  - Occupational Therapy
  - Vocational Rehabilitation
  - Differentiate Passive vs. Active therapies.
  - Graded Motor Imagery & Mirror Box Therapy

- Social:
  - Legal status
  - Finances
  - Supports
  - Accomodation

- Barriers:
  - Language
  - Culture
  - Distance
  - Finances
  - Pre-contemplative
  - Splitting
  - Addiction issues
  - Pain Beliefs
  - WorkCover/Compensation

CASES