MBIPA Monterey Bay INDEPENDENT PHYSICIAN ASSOCIATION

MBIPA CONSENSUS STATEMENT

EVALUATION AND TREATMENT OF CHRONIC NON-CANCER PAIN

CRITICAL GOALS

- **SET REASONABLE EXPECTATIONS AND RE-EVALUATE REGULARLY**
- **TAKE MULTIDISCIPLINARY, COORDINATED APPROACH**
- **MEDICATIONS NOT SOLE TREATMENT – USE IN CONJUNCTION WITH OTHER MODALITIES**
- **REFER TO PAIN MEDICINE SPECIALISTS EARLY FOR CHRONIC PAIN**
- **AVOID INITIATING OPIOID NARCOTICS – *NOTE RECENT EPIDEMIC OF IATROGENIC ADDICTION, OVERDOSE DEATHS***

COMMON CAUSES

- Neuropathic – abnormal neural activity
  - Peripheral – e.g., post-herpetic neuralgia, neuroma formation
  - Central – e.g., phantom limb, spinal cord injury, post stroke, MS
- Musculoskeletal – e.g., back pain, myofascial pain syndrome, ankle pain
- Inflammatory – e.g., inflammatory arthropathies, infection
- Mechanical/compressive – e.g., renal calculi, visceral source such as expanding masses

EVALUATION

- HISTORY
  - Characteristics – location, radiation, intensity, timing, triggers, relieving factors, etc.
  - Associated symptoms – restricted ROM, muscle aches/weakness, color/temp changes, etc.
  - Pain's impact –
    - Social and recreational functioning
    - Mood, affect, and anxiety
    - Relationships, Occupation, Sleep, Exercise
  - Activities of daily living, ambulation, dressing, household necessities
  - Pain intensity scales – multiple options, use patient's individual longitudinal scores
  - Previous evaluation and treatment
  - Patient perceptions and psychological factors
- PHYSICAL EXAM
  - Specific comprehensive exam, tailored to specific type of chronic pain
- DIAGNOSTIC TESTING – *Limited, targeted*
  - Blood tests
    - "Routine" tests not indicated - only order as specifically suggested by Hx and PE
    - Markers of inflammation - if suspect polymyalgia rheum., RA, infection
  - Imaging – minimize before referral, target to specific suspected diagnoses

TREATMENT

- NONPHARMOCOLOGIC THERAPIES
  - BEHAVIORAL MEDICINE THERAPIES
    - Cognitive behavioral Therapy
    - Biofeedback
    - Relaxation Therapy
    - Psychotherapy and counseling
  - AEROBIC EXERCISE
  - ACUPUNCTURE
  - PHYSICAL AND OCCUPATIONAL THERAPY
  - CHIROPRACTIC AND OSTEOPATHIC MANIPULATION
  - ULTRASONIC STIMULATION
  - ELECTRICAL NEUROMODULATION (TENS, Spinal Cord Stimulation, Deep Brain Stimulation)
  - THERMAL APPLICATIONS (Heat/cold)
  - INTERVENTIONAL APPROACHES
    - Ablative techniques
    - Botox
    - Nerve blocks
    - Trigger point injections
    - Epidural Steroids
  - SURGICAL APPROACHES
  - MINIMALLY INVASIVE PROCEDURES
  - EVIDENCE SUPPORTING DESTRUCTIVE PROCEDURES IN NON-CANCER PAIN IS LIMITED
- REFERRAL TO PAIN SPECIALIST / CLINIC
  - Institute of Medicine committee report 2011 encourage referral when:
    - Symptoms are debilitating
    - Symptoms located at multiple sites
    - Patient does not respond to initial therapies
    - Escalating need for pain medication
  - Make referral earlier than later, especially with neuropathic pain (where early intervention has been shown to be superior long-term)
- MEDICATIONS
  - NON-OPIOID ANALGESICS
    - Acetaminophen, NSAID's, Cox-2 inhibitors
    - good first line alternative, especially for somatic, musc/skel., headache
  - ANTICONVULSANTS
    - Gabapentin, pregabalin, carbamazepine – esp. neuropathic pain
  - ANTIDEPRESSANTS
    - TCA's, SNRI's – esp. Neuropathic pain
    - Can be helpful with concurrent depression
  - ADJUVANTS
    - Topicals, Antispasmodics, Botox, Benzodiazepines (*note increased risk of death when combined with opioids*), Cannabinoids
  - OPIOIDS
    - use in chronic non-cancer pain *controversial*
    - AVOID in primary care setting. *EXTREME CAUTION* re: accidental addiction
    - If opioid prescribed:
      - Remember legal requirement to query CURES database
      - Execute a narcotic "contract" with patient.