Chronic Pain Management

North Glasgow Chronic Pain Management Team

Feb 2020

Remit

- Background – pain reduction v pain management
- Evidence base in chronic pain management
- Prescribing for chronic pain - opioids and gabapentinoids
- What are the realistic alternatives to medications?
- Patient education, supported self management
- Multidisciplinary working
- Prescription reduction
- Useful resources

Chronic Pain Definition

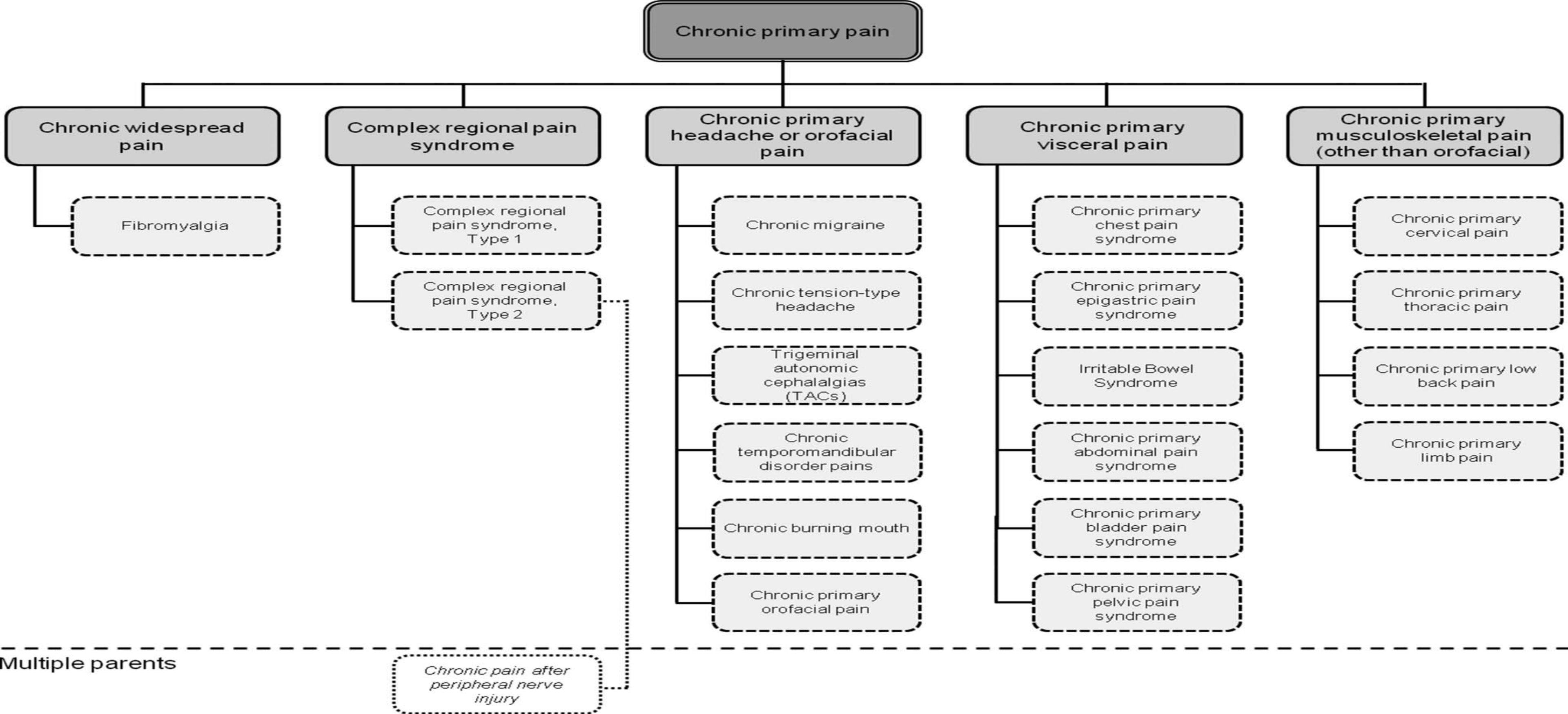
WHO ICD-11

- Chronic pain is defined as pain that lasts or recurs for more than three months
- Fundamental distinction between chronic primary pain (CPP) and chronic secondary pain(CSP)

Chronic Primary Pain

Pain in one or more anatomical regions that:-

- persists or recurs for longer than 3 months
- is associated with significant emotional distress (e.g., anxiety, anger, frustration, or depressed mood) and/or significant functional disability (interference in activities of daily life and participation in social roles)
- the symptoms are not better accounted for by another diagnosis


Chronic primary pain
Chronic widespread pain
Complex regional pain syndrome
Chronic primary headache or orofacial pain
Chronic primary visceral pain
Chronic primary musculoskeletal pain (other than orofacial)
Fibromyalgia
Complex regional pain syndrome, Type 1
Complex regional pain syndrome, Type 2
Chronic migraine
Chronic tension-type headache
Trigeminal autonomic cephalalgias (TACs)
Chronic temporomandibular disorder pains
Chronic burning mouth
Chronic primary orofacial pain
Chronic primary chest pain syndrome
Chronic primary epigastric pain syndrome
Irritable Bowel Syndrome
Chronic primary abdominal pain syndrome
Chronic primary bladder pain syndrome
Chronic primary pelvic pain syndrome
Chronic primary cervical pain
Chronic primary thoracic pain
Chronic primary low back pain
Chronic primary limb pain
Multiple parents
Chronic pain after peripheral nerve injury
Legend
Top (1st) level diagnosis
2nd level diagnosis
3rd level diagnosis
Additional parent of the diagnosis
Directly subordinate
Additional parent

Pain behaviour

Social reinforcers

Psychological distress

Thoughts and emotions

PAIN
SENSATION

Biopsychosocial model of pain related disability

Chronic Pain

- Chronic primary pain - chronic pain as a disease in itself
- Chronic secondary pain is chronic pain where the pain is a symptom of an underlying condition

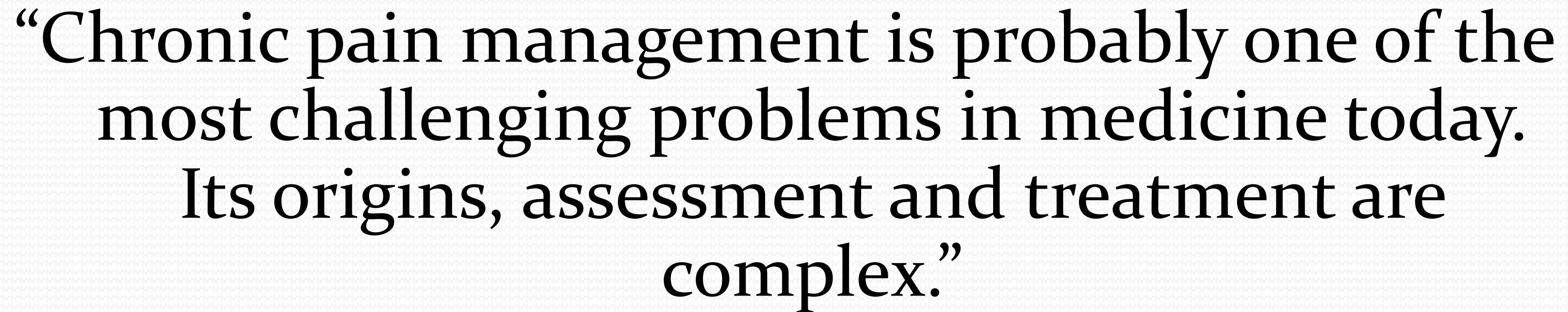
Chronic Pain – some facts

- 5.6% of adults suffer from severe, disabling chronic pain - which is 57,062 people in GG&C
- Patients with chronic pain are high users of health care
- 3 times more likely to be admitted to hospital
- 10-year mortality increased (x1.4 for any pain; x1.8 for "severe" chronic pain) – particularly heart and respiratory disease
- 60% of working-aged with "severe" chronic pain are unable to work

Getting to GRIPS with Chronic Pain in Scotland

Getting Relevant Information on Pain Services

Benchmarking Chronic Pain Services in Partnership with NHS Boards, Patients and Service Providers



"Chronic pain management is probably one of the most challenging problems in medicine today. Its origins, assessment and treatment are complex."

The issues with chronic pain management fit well with Realistic Medicine

- Ensuring high quality care
- **Reducing the burden of overtreatment**
- Reducing unwarranted variation
- Ensuring value for money
- Combining the expertise of patients and professionals
- **Identifying and managing clinical risk**

Chronic Pain Scotland Service Model

Most people get back to normal after pain that might come on after an injury or operation or for no apparent reason. Sometimes the pain carries on for longer than 12 weeks despite medication or treatment — this is called chronic or persistent pain.

1, 2, 3, 4

Level 1 – Advice and information about pain and what to do about it. Anyone can access these services from home or community settings

Level 2 – When help from a GP or therapist is needed

Level 3 – For those needing more specialist help from a chronic pain management service

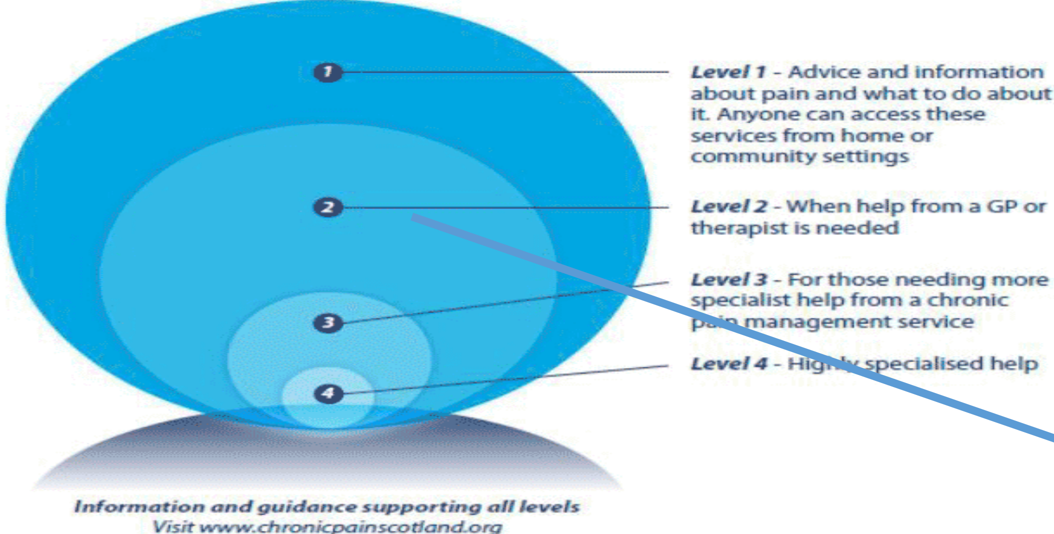
Level 4 – Highly specialised help

Information and guidance supporting all levels
Visit www.chronicpainscotland.org

NHS
SCOTLAND

Chronic Pain Scotland Service Model

Most people get back to normal after pain that might come on after an injury or operation or for no apparent reason. Sometimes the pain carries on for longer than 12 weeks despite medication or treatment – this is called chronic or persistent pain.



Level 2.5

Pain Management Interface

Those needing more pain management input or early implementation

SIGN Guidelines (2013)

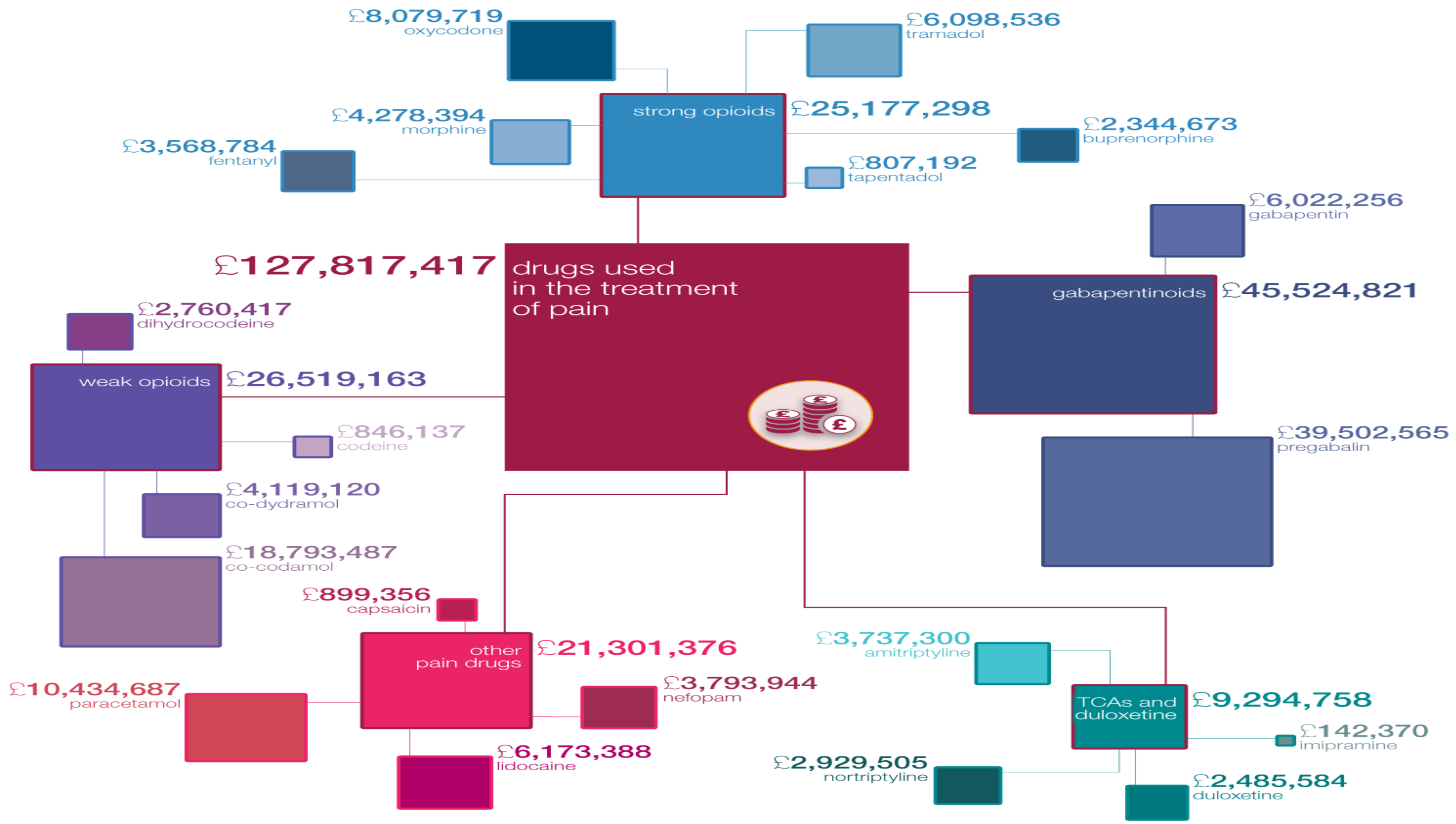
"*Management of Chronic Pain*"

- The only comprehensive, evidence-based guideline internationally

- Key evidenced recommendations include:
  - Supported self management
  - Rational prescribing
  - Exercise and Physical activity
  - Appropriate specialist referral

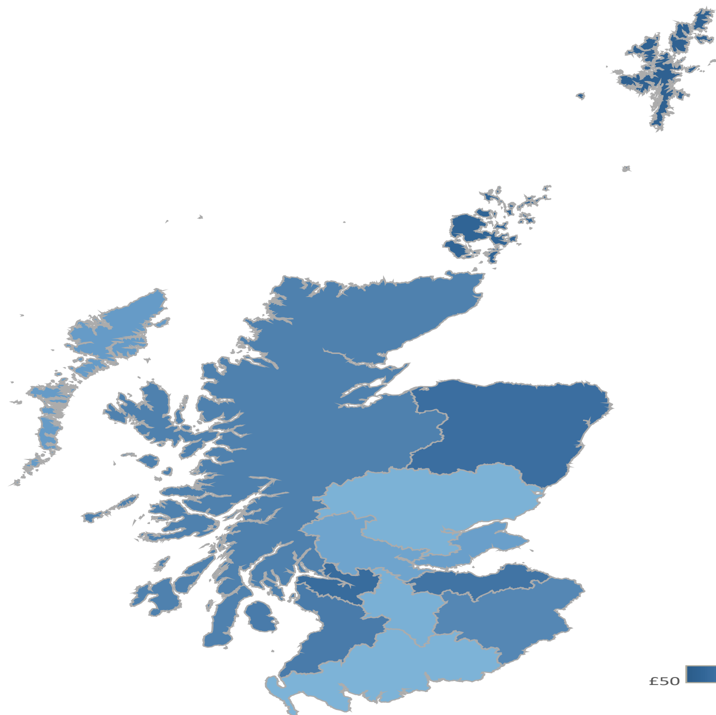
Scottish Intercollegiate Guideline Network

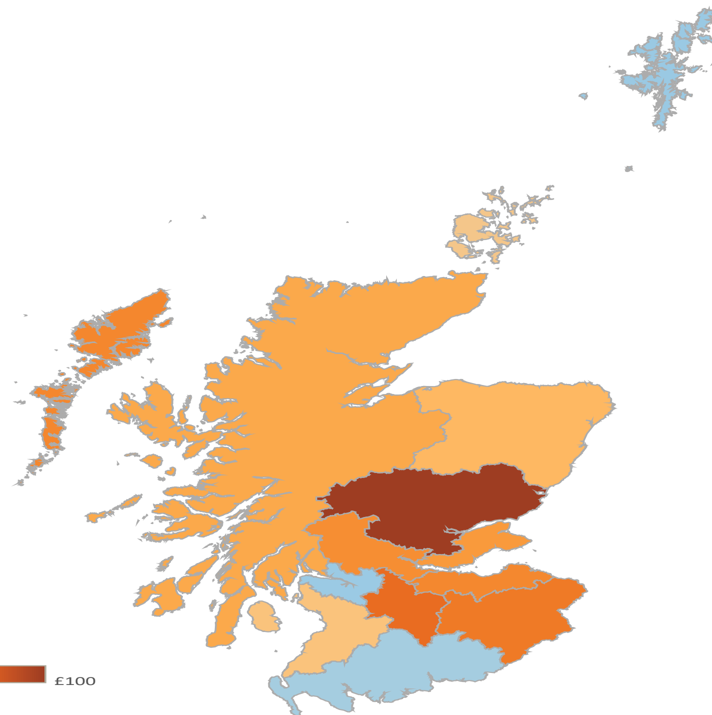
Painkillers - what's the problem?


£127,817,417
drugs used
in the treatment
of pain
strong opioids
£25,177,298
£8,079,719
oxycodone
£6,098,536
tramadol
£4,278,394
morphine
£3,568,784
fentanyl
£2,344,673
buprenorphine
£807,192
tapentadol
gabapentinoids
£45,524,821
£6,022,256
gabapentin
£39,502,565
pregabalin
weak opioids
£26,519,163
£2,760,417
dihydrocodeine
£846,137
codeine
£4,119,120
co-dydramol
£18,793,487
co-codamol
other
pain drugs
£21,301,376
£899,356
capsaicin
£10,434,687
paracetamol
£3,793,944
nefopam
£6,173,388
lidocaine
TCAs and
duloxetine
£9,294,758
£3,737,300
amitriptyline
£142,370
imipramine
£2,929,505
nortriptyline
£2,485,584
duloxetine

The maps demonstrate change in cost per treated patient since 2012.

Analgesic cost per treated patient

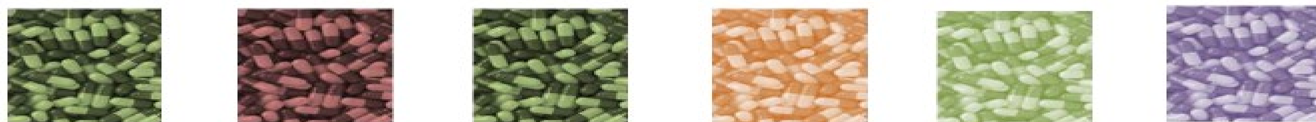




Quality Prescribing For Chronic Pain

A Guide for Improvement

2018 - 2021



National Direction

Scottish Access Collaborative Workshops and Report

Themes identified:

1) Supported self-management – need to increase awareness, access and confidence

2) Pathways / Service Models – must strengthen professional relationships between primary-secondary care, as well as acute and chronic care

3) Workforce - educate, train, supply and retain to ensure right skillsets in right places

4) Measurement / Data – broaden availability of data to inform improvement activity

5) Effective Prescribing – build capacity for shared decision making between professional and patient to discuss risks and benefits of medical and non-medical options

6) Sustainable funding – re-designing models of care and valuing third sector role

Progress and Next Steps

- Programme leadership – new appointments
  - Emma Mair, Primary Care Chronic Pain Clinical Lead
  - Dr. Kieran Dinwoodie, National GP Advisor for Chronic Pain
- Engagement with stakeholders (service providers and people with lived experience) starting with survey https://www.surveymonkey.co.uk/r/7MNQKT6
- Building on professional networks nationally to map and share learning - models, good practice and improved outcomes
- Get in touch:

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Kieran.Dinwoodie@lanarkshire.scot.nhs.uk
Carolyn.Chalmers@gov.scot

Case Scenario 1
The Benefit of Pain Education

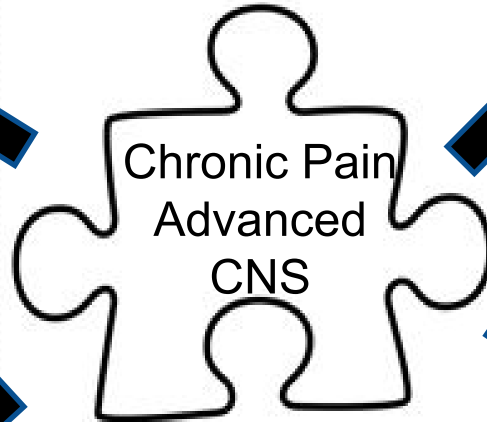
“Pain Ed Changed my LIFE”

CHRONIC PAIN PATIENT JM 45yr

ATTENDED CLYDEBANK HEALTH CENTRE SATELLITE CLINIC 2018-2019

Pillars of ADVANCED NURSING practice

Clinical Practice
- Biopsychosocial Assessment
- Medication Management
- Risk Assessment
- Low Level Psychological Strategies
- Qutenza/TENS



Facilitating Learning
- Early Information Group Sessions
- Pain Education groups/1:1

Evidence, Research and Development

Leadership

Right professional, right time

PATIENT (PAIN) EDUCATION

WEEK 1

Explain Pain

Pacing Activity / Flare up Management

Medications

“What matters to you”

WEEK 2

Mood and Emotions

Sleep Hygiene

Relaxation / Mindfulness

Friends and family

What next?

Pre PAIN ED

- 45 yr Female JM (married, x1 daughter <10yrs)
- PC – L sided Chronic Abdominal Pain
- PMH -: Pancreatic Ca
- Whipples, numerous abdominal procedures (SBO 2017 due to adhesions)
- Low Mood, sleeping a lot of the day, lacking motivation
- weight gain
- She was attending mindfulness sessions through the maggies centre.
- No longer working
- Oral Morphine 80mg daily
- Gabapentin 1800mg daily

POST PAIN ED

- Morphine weaned over a 1 year period (GP also supported) to 0mg
- Gabapentin reduced by 50%, aiming to wean and stop
- No increase to pain levels
- No longer sleeping during the day, no cognitive impairment
- Exercising regularly (walking, swimming, spin, pilates, pacing activity)
- Successful weight loss
- Volunteering at her daughters school and also with MacMillan Cancer support
- Broadened social network/circle of friends
- happy with quality of life and living well with pain.

Case Scenario 2
Multidisciplinary Input

A.L. 48 year old male

- Long history of ulcerative colitis
- Chronic abdominal pain - 4 x abdominal operations - total colectomy and ilioanal pouch
- R forearm fasciotomy 2011 – CRPS diagnosis
- Chronic back pain – disproportionate disability
- Previous attendance at Pain Clinic 2011-2013

A.L. Analgesia

- Fentanyl 50mcg/hr patches – severe withdrawal symptoms on day 3, changing patches early
- Sevredol 60g to 80mg/day
- He also takes Paracetamol, Mirtazepine and Solpadine.
- His sleep pattern is poor, increasingly depressed, hopeless and desperate for new medication

A.L. Analgesia

- Previous medication trials include Gabapentin, Pregabalin, Nortriptyline, Lidocaine patch
- Ketamine infusions, guanethidine blocks
- Mood low
- Low level of functioning, marked lethargy
- Very low quality of life

Pain Service Input

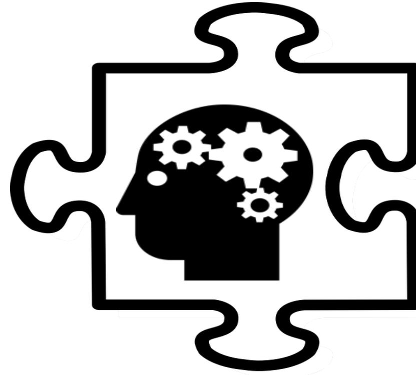
- Consultant initial assessment
- Clinical Nurse Specialist
- Specialist Pain Physiotherapist
- **Pain Clinical Psychologist**
- Pain clinic pharmacist input

Audit and research

Assessment

Formulation

Teaching and training



Intervention … where appropriate

Interface with mental health services

Stepped / matched care

MDT working

A.L. 48 year old male

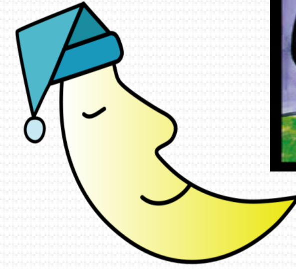
- Pain Clinical Psychologist input
  - Assessment and formulation identified mood low in relation to pain
  - Vicious cycle of limited valued activity, increasing isolation, anxiety, and low mood
  - Approach tailored to patient, drawing from CBT and ACT
  - Helping A.L to come to a different understanding of his difficulties
  - Identifying what really matters (values) and setting goals in line with these
  - Recognising and unhooking from unhelpful stories
  - Ultimately *"feeling sore for doing something worthwhile is better than feeling sore with nothing to show for it"*
  - Where next? Pain Management Programme …

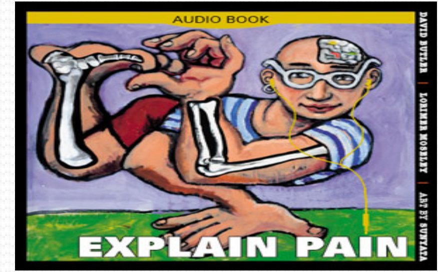
Pain Service Input

- Consultant initial assessment
- Clinical Nurse Specialist
- **Specialist Pain Physiotherapist**
- Pain Clinical Psychologist
- Pain clinic pharmacist input

Pain Management Physiotherapy

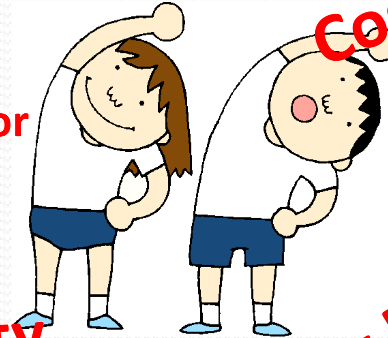
Expectations





Exposure

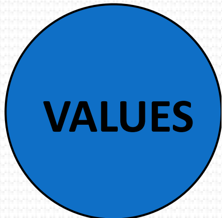
Graded Motor Imagery

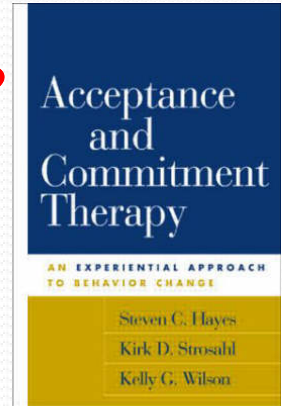


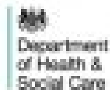
Cognitions

Graded Activity

Activity Planning







Scottish Government
Riaghaltas na h-Alba
gov.scot

UK Chief Medical Officers' Physical Activity Guidelines

Published 7 September 2019

Moderate or strong evidence for health benefit

Children	Adults	Older Adults
Bone Health	All-cause mortality	Falls
Cognitive function	Stroke and heart disease	Frailty
CV fitness	Hypertension	Physical function
Muscle fitness	Type 2 diabetes	
Weight status	8 cancers	
Depression	Depression	
	Cognitive function	
	Dementia	
	Quality of life	
	Sleep	
	Anxiety/depression	
	Weight status	

Some is good, more is better

Case study

Goals

- Walking Outside
- Dressing
- Standing up from sofa
- Lying Flat

Physiotherapy Treatment

- Pacing
- Exercises for strength and stretching lower limbs
- Gym work
- Graded exposure supine lying

Daily Walks outside
Increased walking speed
Out for coffee with wife
Dressing independently 3-4 times week
Independent from sofa

Pain Service Input

- Consultant initial assessment
- Clinical Nurse Specialist
- Specialist Pain Physiotherapist
- Pain Clinical Psychologist
- **Pain clinic pharmacist input**

Pharmacist Role in Pain team

Medication Advice to MDT

Polypharmacy review

Medication rationalisation

Opioid reduction

Prescribing clinic

comorbidity

Case Study

- High dose opioids (Fentanyl 50mcg/h + Sevredol 10mg QID) **MED 190mg**
- Withdrawal every 3rd day & numerous SEs with Sevredol
- Motivated Pt - prev failed attempts to reduce due to withdrawal
- SEs of medication worse than pain symptoms

Goals

- Reduce & stop opioids
  - Minimise long term risks
  - Reduce SE burden
  - Improve QoL

Challenges

- Smallest Fentanyl patch = 12.5mcg (20% of MED)
- ? Minimise withdrawal symptoms with replacement opioid
- Limited oral absorption - ileostomy

Method & Result

- Fentanyl reduced in 12mcg increments – replaced by reducing regime of Morphine (Sevredol then Oramorph)
- Reviewed after each patch reduction to ensure rate tolerable – process repeated
- Difficult process - many breaks needed
- Pt now off Fentanyl - remains on small daily dose oramorph (30mg) – in process of changing to Buprenorphine patch
- QoL much improved – **Pain unchanged but better able to cope!**

Chronic pain management General principles

- Pain management will usually involve more than one approach
- Exclude/diagnose treatable underlying conditions
- Important to find out what the patient believes about his/her pain
- Explain why the patient has pain
- **Think – biopsychosocial model**

Chronic Pain Management: Self-management

- Any treatment given to help chronic pain should encourage self-management
- Self management helpful for improving quality of life with pain
- Can be a difficult concept to promote!

Chronic pain management
‘Home truths’

- Chronic pain is difficult to ‘medically’ treat
- Individual treatments are rarely appropriate
- Complete pain relief is unrealistic
- Helping patients do things more easily is more important than reducing pain intensity
- Patients should be helped to have realistic expectations – role of patient/public education

Chronic pain management
Drug treatment

- All pain medicines have side effects
- Different medicines may help different people so may need to try more than one medication
- Polypharmacy develops easily
- Medicines should always be part of a broader pain management plan - reinforce

  Medicines should only be given if there is a clear benefit and require regular review

British Journal of General Practice April 2017

Editorials

Opioid analgesic dependence:

where do we go from here?

The British Medical Association has recently produced recommendations for the support of people with prescribed drug dependence.[1] Their focus is appropriately broad, addressing benzodiazepines, antidepressants and opioids, with three main themes for development:

- the creation of a national helpline for prescribed drug dependence;

"A significant proportion of these patients with chronic pain will have been prescribed opioids: drugs that, when used long term, we now know to be generally ineffective, harmful, addictive, and difficult to stop."

pain, it is understandable that clinicians and

of Pain Medicine and the British Pain

Summary

- Chronic pain is common
- Chronic pain is commoner in areas of high social deprivation
- Chronic pain is associated with reduced life expectancy
- Purely 'medical' approach is unhelpful for patient (and health care provider!)
- Self management promotion is key aim of pain service
- Dependence issues with prescribed pain medications is a common problem
- Chronic pain services unable to address the needs of this patient group

Useful Resources and organisations

The Pain toolkit

THE BRITISH PAIN SOCIETY

paths for all

BackCare
The National Organisation for Healthy Backs

NHS inform
Health information you can trust

BREATHING SPACE

PAIN ASSOCIATION SCOTLAND
Self Management for Chronic Pain

Better Together
Scotland's Patient Experience Programme

affasair
self help for chronic pain sufferers

Fibromyalgia Association UK
raising awareness of FM in the UK

Palouse Mindfulness

PAIN CONCERN

MOODJUICE

moodjuice

healthtalkonline.org
youthhealthtalk.org

- www.painconcern.org.uk

  Helpline

  Videos and podcasts

  Information leaflets

- www.painassociation.com

  Local groups and community based pain management courses

- www.aliss.org

  Provides local information across Scotland for people with long term conditions and their carers

- www.paindata.org/

  Website with information leaflets, multi-lingual visual and audio resources.

- http://breathingspace.scot/living-life/

  NHS Scotland organisations providing telephone based support for people suffering from anxiety a MOODJUICE or depression

- http://www.moodjuice.scot.nhs.uk

  A site designed to help you think about emotional problems and providing resources to help work towards solving them

- www.nhsinform.scot/healthy-living/keeping-active

  Provides information about a range of physical and recreational activities.

- https://www.nhs.uk/live-well/

  Advice, tips and tools to help you make the best choices about your health and wellbeing.

- http://palousemindfulness.com

Offers a free 8 week on-line mindfulness course and has audio files of diff
practices for you to try

- https://www.headspace.com

Has an app and a website with lots of different practices. Offers a free 10 day trial of 10 minute practices (which you can repeat!)

- http://www.volunteerscotland.net/

Consider volunteering in your community – Volunteer Scotland can put you in touch with lots of different organisations which can use your skills

Resources

- https://www.sign.ac.uk/sign-136-management-of-chronic-pain.html
- https://www.therapeutics.scot.nhs.uk/pain/
- www.paindata.org
- https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671
- http://fpm.anzca.edu.au/documents/apmse4_2015_final
- https://www.smmgp-fdap.org.uk/Handlers/Download.ashx?IDMF=a17bcd1f-c7a6-4635-a6ca-73c4a81b50b0