

# PAIN

## *It's time for a new paradigm*

A look at an updated treatment guideline from the Institute for Clinical Systems Improvement (ICSI)

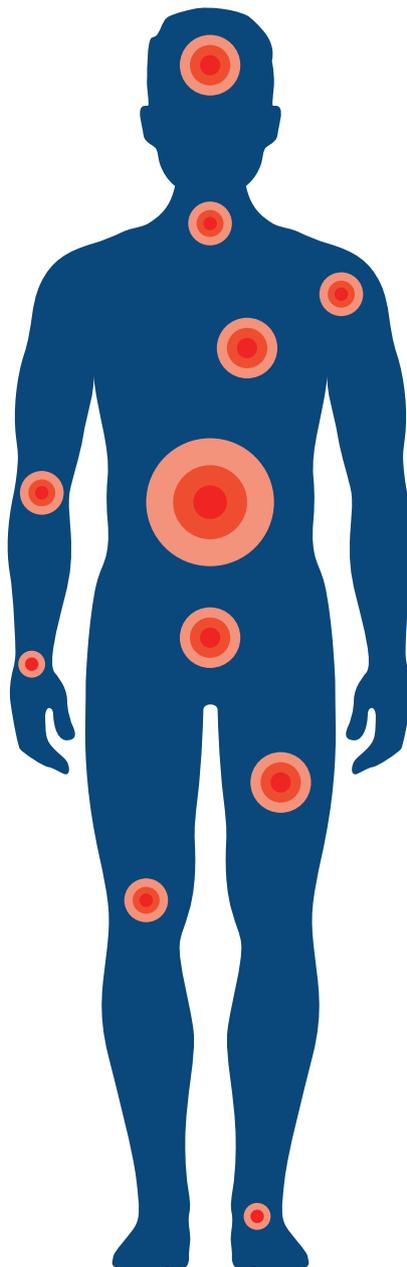
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*The 2016 ICSI guideline addresses the entire continuum of acute, subacute and chronic noncancer pain in adults. Detailed guidance for a comprehensive assessment and treatment of pain is included. Updated evidence-based and best-practice recommendations focus less on pain score and more on active management of pain based on function and helping patients reach their goals. The goals of the guideline are to increase use of nonopioid pain options and to promote safe practices around the prescription and management of opioids.*

**a** *ll pain is legitimate. All pain is real. But not all pain can be treated the same way.*

Certainly, if the present opioid crisis has taught us anything, it's that our previous thinking about pain—both assessing and treating it—has been misguided. It is time for a paradigm shift.

In 2016, the Institute for Clinical Systems Improvement (ICSI) Pain Work Group created a new comprehensive pain guideline: Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. This new guideline addresses the entire continuum of acute, subacute and chronic noncancer pain in adults. It's designed to help primary care providers



develop systems that support assessment, treatment and ongoing management of patients with pain.

Updated evidence-based and best-practice recommendations in the guideline focus less on pain score and pain elimination and more on active management of pain based on function and helping patients reach their goals. Another critical theme within the guideline is safety, with an emphasis on mitigating the harms of opioids by understanding contraindications, drug interactions and adverse effects.

The following is a high-level look at the guideline. The full version is freely available at [bit.ly/PainGuideline](http://bit.ly/PainGuideline).

### **Assessment**

As advised in the ICSI pain guideline, the following questions are key components of an assessment that helps determine a treatment plan.

*What is the severity of the pain, and how does it affect quality of life and functional status?*

To help tailor the treatment plan, explore important components of the patient's history, including pain intensity, quality of life, and function. Pain scores alone are not sufficient. Use validated tools to make these assessments.

### *What is the diagnosis and mechanism of the pain?*

Consider the following types of pain generators when evaluating a pain patient: neuropathic, musculoskeletal, inflammatory and visceral. In addition, for patients presenting with an indeterminate pain generator, assess for past exposure to opioids and current opioid use. Opioid-induced pain from opioid withdrawal, opioid-induced hyperalgesia or opioid tolerance should be considered in the differential diagnosis.

### *Are there physical and/or behavioral health comorbidities?*

A multitude of physical comorbidities (e.g., diabetes, COPD and dementia) are associated with pain. These must be diagnosed and appropriately managed. For patients with cognitive impairments, it's imperative that the treatment team has expertise in deciphering nonverbal indicators of pain symptoms. In addition, it is necessary to assess for behavioral health problems, including depression, anxiety, PTSD and substance abuse disorders.

### *What barriers might interfere with successful treatment?*

It's important to consider resources when working with the patient to determine a treatment plan. Access to resources such as housing, employment, transportation and social support affects a patient's ability to carry out the plan. The health care team must address potential socioeconomic barriers that may hinder patient engagement.

## **Treatment plan**

In counseling patients about their treatment, consider taking the following steps:

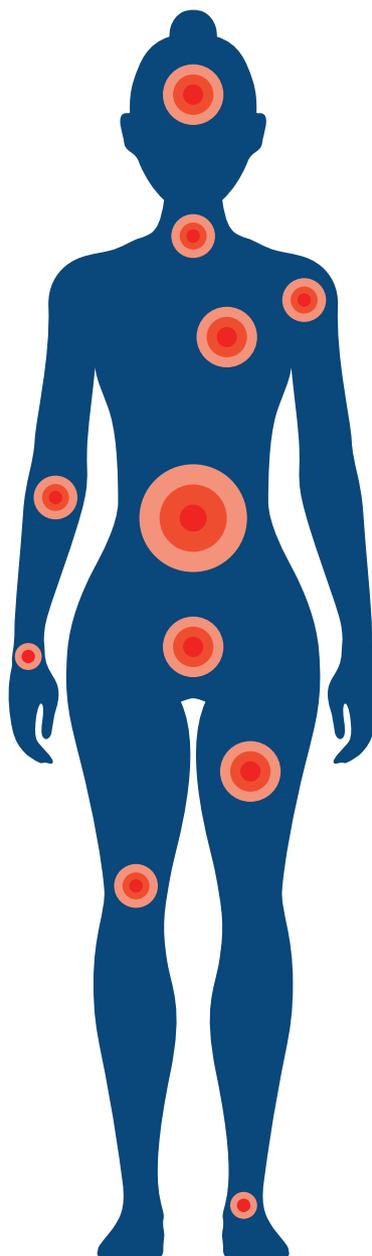
- Let the patient know you believe that the pain is real.
- Ask the patient to take an active role in the treatment plan.
- Avoid telling patients to let pain be their guide regarding activity and taking medications.
- Schedule regular return visits.
- Reinforce wellness behaviors, such as increased activity.

- Enlist the family or other supports.
- Assist the patient in returning to work.
- Acknowledge that chronic pain is a complicated problem, but emphasize that management strategies aimed at improving function and enhancing quality of life are available.

## **Nonpharmacologic strategies**

### *Psychotherapy*

Psychotherapy techniques, such as cognitive behavioral therapy or mindfulness-based stress reduction, can help many patients who have chronic pain improve their emotional and physical function.



Therapy should be focused on guiding the patient to cope with the functional limitations the pain causes and to manage their expectations of the treatment plan.

Patients with chronic pain benefit from psychotherapy even if they don't have a diagnosed mental health disorder. However, mental health diagnoses are more prevalent in chronic pain patients.

### *Physical rehabilitation*

When appropriate, exercise should be a component of the treatment plan for a patient with chronic pain. Passive modalities should be performed only as an adjunct to a concomitant active physical therapy or exercise program. Extending physical therapy beyond eight to 12 weeks for chronic pain patients should be based on objective clinical improvement.

### *Interventional treatment*

Interventional treatment refers to various percutaneous or minor surgical procedures targeting potential anatomic pain sources. Such treatments are generally considered for patients who have failed conservative treatment.

### *Complementary and integrative medicine*

There is some evidence suggesting that acupuncture may be helpful with musculoskeletal pain and that tai chi and yoga may help with chronic back pain. These may be potential adjuncts to other modalities.

## **Pharmacologic strategies**

Don't rely upon pharmacologic treatment alone for treatment of chronic pain; rather, use it as an adjunct to other modalities. A thorough medication history is critical to the development of an effective treatment plan. The history should include use of prescription medications, over-the-counter medications, herbals and supplements. Always first ask if a nonopioid approach has been tried. If one hasn't, pursue such an approach before proceeding with an opioid.

### Nonopioid pain management

The nonopioid medications listed below may have select use for specific pain syndromes:

- Acetaminophen.
- Anticonvulsants.
- Antidepressants (tricyclic antidepressants or serotonin norepinephrine reuptake inhibitors).
- Glucocorticoids.
- Muscle relaxants and antispasmodics.
- Nonsteroidal anti-inflammatory drugs.

Sedative hypnotics, including benzodiazepines and carisoprodol, should rarely be used, and if they are, it should be for short-term (lasting less than one week) treatment of muscle spasms. Use of non-sedative hypnotic muscle relaxants is of low benefit. If they are used, limit the length of use to less than four weeks. Do not prescribe carisoprodol for pain.

### Opioid pain management

The following are general principles related to opioid management:

- Avoid using opioids for chronic pain.
- Avoid using opioids for patients with substance abuse disorder or concomitant benzodiazepine use.
- Use opioid risk-assessment tools in combination with the clinical picture to guide care.
- For the first opioid prescription for patients with acute pain, prescribe the lowest possible effective dose of a short-acting opioid, not to exceed 100 MME total. Instruct patients that three days or less will often be sufficient.
- For patients presenting in acute pain who are already on chronic opioids, are opioid-tolerant or are on methadone, consider prescribing an additional 100 MME maximum for this acute episode, with a plan to return to their baseline dose as soon as possible.
- Discuss storage and opioid disposal options with patients at the first opioid prescription and in follow-up visits, as needed.
- Consider offering the patient and close contacts (such as family members, friends and/or caretakers) a naloxone kit.

- For high-risk patients, query the prescription monitoring program (PMP). Consider also querying for all other patients receiving opioids.

Assess geriatric patients for risks of falls, cognitive decline, respiratory malfunction and renal malfunction before prescribing opioids. If impairment or risk is detected

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- When initiating an opioid prescription, monitor patients within a month to evaluate harms and benefits and to assess treatment goals. Patients on stable opioid doses should be seen every three months.
- Have referral sources for psychiatric treatment, substance use disorder treatment, physical therapy and pain medicine available, to provide as needed.
- Recognize the symptoms of opioid use disorder, understand the treatment options for it, and have available a referral source who can address it.
- Discuss and offer opioid tapering at intervals of six months for all patients on chronic opioids.

### Special populations

Before prescribing opioids to women of childbearing age, counsel them about the risks that opioids and other, nonopioid analgesics (e.g., anticonvulsants) pose to pregnancy and contraception. Also offer pregnancy testing.

Regularly counsel women of childbearing age who are already using opioids about the risks of opioids during pregnancy, and offer reproductive health advice.

in a geriatric patient, consider reducing the initial opioid dose by at least 50 percent.

It is also noteworthy that the guideline emphasizes the importance of patient engagement and shared decision-making in the development of a treatment plan. It received the seal of approval from ICSI's Patient Advisory Council.

The full guideline includes appendices with detailed information on nonopioid and opioid pharmacology. When the continued use of opioids is unavoidable for patients with chronic pain, the guideline provides recommendations for management and discusses indications for discontinuation and/or tapering. **MM**

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