Practical Management of Chronic Pain
In Primary Care

Release Date: September 30, 2010
Expiration Date: September 29, 2011

Estimated Time To Complete Activity: 1 hour

Target Audience
This activity is intended for internal medicine physicians and other health care professionals interested in the management of chronic pain disorders.

Prerequisites
There are no prerequisites for participants.

Overview
This enduring activity features 2 didactic presentations focused on important issues surrounding the management of chronic pain in the primary care setting. Emphasis is placed on reviewing the components of a comprehensive pain assessment, mastering key pain assessment skills, and implementing practical strategies to facilitate improved pain assessment and management in the time-limited environment of primary care. Evidence-based treatment options and the individualization of patient care are discussed, stressing both pharmacologic and nonpharmacologic therapies.

Learning Objectives
At the conclusion of this activity, participants should be able to:
- Describe and integrate into practice the critical components of comprehensive pain assessment.
- List examples of physical, psychological, and social functioning that should be assessed for impairment in the patient with chronic pain.
- Formulate an evidence-based treatment plan utilizing both pharmacologic and nonpharmacologic therapies for the management of chronic pain.

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Dr. Cole’s presentation does not include discussion of off-label, experimental, and/or investigational uses of drugs or devices.

Dr. Stanos’ presentation includes off-label discussion of benzodiazepines, gabapentin, and tricyclic antidepressants for the treatment of low back pain; and amitriptyline, cyclobenzaprine, gabapentin, 7-hydroxybutyrate, selective serotonin reuptake inhibitors, tramadol, venlafaxine, and dopamine agonists for the treatment of fibromyalgia.

All presentations have been peer-reviewed for independence, evidence base, and fair balance.

This monograph was based on a live symposium held on Friday, April 23, 2010, in Toronto, Ontario, at the Metro Toronto Convention Centre.

The presenting faculty reported the following:

B. Eliot Cole, MD, MPA, is a consultant for Eli Lilly and Company; on the speakers bureau for Eli Lilly and Company; and on the advisory boards for Eli Lilly and Company and Purdue Pharma; received a salary from Aventine Health Sciences; and has ownership interest in Johnson & Johnson.

Steven P. Stanos, DO, is on the speakers bureaus for Eli Lilly and Company, Endo Pharmaceuticals, Forest Pharmaceuticals, Ortho-McNeil, Pfizer Inc, and Xanodyne; on the advisory board for Cephalon, Eli Lilly and Company, Endo Pharmaceuticals, King Pharmaceuticals, and Ortho-McNeil; and receives research support from Abbott Laboratories and Endo Pharmaceuticals.

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PAINMEDICINE NEWS
Introduction

Pain is entirely subjective. Do 2 individuals who have the same pain intensity, at least in terms of their own reporting, have the same amount of pain, the same nociceptive generation, or neuropathic generation? Is pain extraordinarily difficult to determine? Is pain intensity at a certain moment what matters, or is it pain intensity over time? How much functional interference occurs as a result of the pain? What is it going to take in terms of pain intensity for the patient to be able to perform certain activities? Are there objective markers that we can use, such as body fluid markers or imaging studies, that associate directly with pain? Is there any linear correlation between pain-related imaging and electrical diagnostic studies that would help us do a better job with the patients we treat? No. The gold standard of pain management is to ask the patient, “How much do you hurt?” The patient’s response is noted, some treatment is given, and the patient is asked again, “How much do you hurt?” until we see a trend difference.

Pain is multidimensional. The basic definition of pain from the International Association for the Study of Pain links sensation and emotion together with potential or actual tissue damage. So, when thinking about pain, we are also addressing emotion. Spiritually, there can be the notion of an “undeserved hit.” Patients may wonder, “Why did this happen to me? I didn’t do anything wrong; I was just doing my job.” This is not uncommon and may trigger a spiral of “why me” thoughts in the minds of patients in pain. Our medical training often does not prepare us to resolve the “why me” issues, so we may consider bringing in someone from chaplaincy to address these concerns of our patients.

Therein lies the problem with pain assessment: It requires getting past the subjectivity of pain to something that can be measured or tracked through time. We know of no satisfactory objective measure thus far.

Types of Pain

When patients go to healthcare practitioners complaining of pain, they do not know or care whether it is nociceptive, neuropathic, mixed mechanism, or “other.” But the type of pain is the first clue as to its cause and appropriate treatment; therefore, we can spend a great deal of time trying to differentiate the types of pain.

Nociceptive pain (somatic and visceral) is coming in through intact “wiring” of the nervous system, so the good news is that it can be effectively relieved via nerve blocks.

Neuropathic pain is initiated or caused by a primary lesion or an abnormal process in the nervous system. Because there is already damage to a peripheral nerve, the spinal cord, or the brain, nerve blocks are an unlikely treatment. Creating more lesions to undo the damage caused by primary lesions does not work.

Mixed mechanisms often exist in back pain, due to the presence of both nociceptive and neuropathic elements. The mixed pain model requires a more comprehensive or broad approach.

Pain that is not easily classified, termed non-nociceptive, non-neuropathic, is often seen in patients with conditions involving failure of descending inhibitory control, such as fibromyalgia, irritable bowel syndrome, noncardiac chest pain, or tension-type headache.

The characteristics of the pain often indicate its type. Traditionally, pain described as throbbing or aching was thought to be nociceptive, whereas tingling, stinging, numbing, freezing, or zap-like sensations were supposedly neuropathic. However, patients with diabetes can get aching feet as well as numb feet that are tingling and have electrical sensations. So, the type of pain is not always clear.

If possible, we want to at least differentiate nociceptive normal wiring from neuropathic abnormal wiring, and then regularly assess the severity of pain. I always ask patients to rate their worst pain in the last 24 hours; their least pain in those 24 hours; their usual pain over the same 24 hours (not the average of their high and low, but their usual); and their current pain level as they sit in my office. I track all 4 numbers from appointment to appointment. With good pain management, the spread between high and low will actually narrow and even trend downward, eventually leveling off. That’s when we know we have reached the maximum treatment benefit.

Pain Processing

Patients also neither know nor care about how pain gets there; they just want it to go away. But physicians need to know. Ultimately, how the pain is produced will factor in to the treatment plan we create for each patient—a plan that takes into account the type of pain, how it came to be, and how likely it is to progress, so that pharmacologic and nonpharmacologic strategies that directly address its trouble spots can be applied successfully.

Pain travels through a process of transduction, converting chemical, mechanical, and thermal threats into electrochemical signals. Pain-related receptors for temperature change, for release of intracellular contents, for crushing, and so on exist on thinly myelinated (A-delta) and unmyelinated (C) fibers. After being transduced, the pain messages are conducted to the dorsal horn of the spinal cord via peripheral nerves (within a single first-order neuron). In the dorsal horn, facilitating and inhibiting mechanisms enhance or reduce the transmission of pain messages to the thalamus via...
second-order neurons, and then via third-order neurons to various brain structures involved with emotion, localization, interpretation, memory, and decision making. In response to incoming pain information, the nervous system modulates the pain by sending various inhibitory signals downward. This higher order processing is influenced by a myriad of internal and external stimuli and can make the experience of pain vastly different from patient to patient.

Assessing Pain

In conducting a thorough pain assessment, we evaluate pain-related disability and impairment in the physical, psychological, and social categories. Simple pain rating scales provide a good place to start, giving us a baseline from which to track treatment efficacy and patient well-being. They also offer patients a vocabulary with which to manage their pain profiles.

Pain assessment helps set goals for the future—2, 4, or 6 weeks out—defining a trajectory that helps patients improve. This requires as precise a diagnosis as possible about the mechanisms that generate the pain and those that maintain it. We also need to review the mechanisms of action of our therapeutic agents or techniques, and find an alignment that provides the least toxic treatments to achieve the best possible outcomes—while understanding that the best possible outcome is not always the absence of pain. A decrease of just a couple of points on a pain scale can allow for an increase in functionality of 30% to 50%, which can change a patient’s world.

Pain scales are either unidimensional or multidimensional. Unidimensional scales give a single characteristic about pain, whereas multidimensional scales give context and details. Examples of unidimensional pain scales are numeric, verbal, visual analog, and FACES. Using a series of numbers, words, positions on a line, or pictorial images, patients select the one best describing their pain.

Multidimensional scales, including the Brief Pain Inventory, McGill Pain Questionnaire, and Neuropathic Pain Scale, transcend simple reporting of pain intensity to examine interferences, comorbid mood states, and other aspects of pain.4,5

Methods for performing a pain assessment start with the “who, what, when, where, why, and how” of journalism and advance to the “PQRST” approach6 or the “LDOCSARAA” technique. While the order differs from strategy to strategy, the information is similar. For the PQRST approach, P = provoking factors, Q = quality, R = radiation, S = severity and other symptoms, and T = timing and triggers. For the LDOCSARAA technique, L = location, D = duration, O = onset, C = characteristics, S = severity, A = aggravating factors, R = relieving factors, A = associated symptoms, and the last A = adverse effects.

These methods are important in determining whether the pain is from a dermatomal versus myotomal process. Or maybe it crosses multiple dermatomes, possibly indicating musculoskeletal underpinnings rather than a nerve root compression. Also look for radicular spread; pain patterns, if episodic; nociceptive or neuropathic generation; and any complicating features (e.g., changes in activities, altered relationships, mood changes, sexual disturbances, or sleep impairment).

Determining the temporal sequence of acute to chronic transition has important implications for treatment. Is the patient transitioning from acute (less than 30 days) to subacute (31 to 90 days) to chronic (more than 90 days)? The first 30 days are usually the most effective time to do any type of treatment. We start to lose ground in the subacute phase, and by the time the pain has become chronic, remission is much more unlikely.

Assessing Risk for Opioid Abuse

Many of our patients also come to us with past and present substance use, both licit and illicit. Some may already be on opioid therapy. Because opioid-related overdose and death are increasing problems, we need to consider whether these patients have underlying substance use disorders. This necessitates asking questions about personal and family use of alcohol and other substances, adopting a practice of “universal precautions,” and diligently analyzing urine for the presence of what has been prescribed, as well as any illicit substances.

Several opioid risk screening tools are available, including CAGE-AID (Cut down, Annoyed, Guilty, Eye-opener—Adjusted to Include Drugs), COMM (Current Opioid Misuse Measure), DAST (Drug Abuse Screening Test), DIRE (Diagnosis, Intractability, Risk, Efficacy), ORT (Opioid Risk Tool), PDUQ (Prescription Drug Use Questionnaire), and SOAPP (Screener and Opioid Assessment for Patients with Pain).

To make the most of these measures, consider using DIRE, ORT, and SOAPP before starting opioid therapy. COMM, PDUQ, and PMQ (Prescription Medication Questionnaire) are best for assessing medication misuse or abuse once opioids have been started. To assess current abuse rather than the potential for abuse, use CAGE, DAST, PMQ-PDUQ, RAFFT (Relax, Alone, Friends, Family, Trouble), or SASSI (Substance Abuse Subtle Screening Inventory).7

Although not a screening instrument, using the 4 A’s may help structure all interactions associated with pain where opioid or other controlled substance prescribing is planned: Analgesia (pain relief), Activity (function), Adverse events (side effects), and Aberrant behavior (drug seeking). We should be looking at these A’s in every visit with every patient in pain. And, I would add 2 more A’s: Affect and Actions. The Affect of the patient should be congruent to the situation, and the Actions you take and their effects should be documented as you get more information.8 Consider time-limited trials with specific evaluation criteria to assess treatment efficacy. Failure to relieve pain or improve function, while producing side effects, intoxication, or aberrant behavior, is often the metric we use to determine opioid discontinuation.

Assessing Pain in Special Populations

Because pain is subjective, it goes without saying that every patient is different. But some patient populations require special consideration before we begin our assessment. You may be seeing some 18- and 19-year-old adolescents. Begin by treating them as adults. Establishing rapport by talking with them and demonstrating a genuine interest is particularly important. Interviewing an adolescent is best done with the patient alone, or at least without a parent or guardian present, if you want a frank discussion. Asking about friends and personal interests may be helpful,9,10 both in establishing rapport and eliciting the more subtle signs and symptoms.

Working with older patients may be challenging due to auditory and visual changes, cognitive impairment, and coincident pathology. However, most older patients can self-report pain and work with a rating scale.11 Allow extra time for history taking and physical examination, including a thorough medication history and a list of all clinicians involved in the patient’s care.12

Much of what we do in medicine—whether applying mechanical restraints, doing line placements, or moving patients from chair to examining table—may be quite painful for our patients, even if their
underlying condition is not. So we need to think more strategi- 
gically and become more preemptive in our analgesic approaches, 
so our patient’s pain does not flare up and then we have to double 
back to relieve it. Recommending that the patient take a rescue 
medicine before a visit can improve the assessment as well as 
patient interaction.

For patients incapable of communicating verbally, behavioral 
assessments for grimacing, moaning, wincing, and self-protective 
movements can give us a reasonable pain assessment. Importantly, 
we frequently underappreciate pain as an independent source of 
agitation in patients with dementia. The assumption that non- 
communicative patients do not have pain is a significant error, lead-
ing to the sad fact that pain is generally less well treated in those 
with coincident dementia.

Assessing Pain in the Intensive Care Unit

Patients in the intensive care unit (ICU) are commonly unable 
to work with typical pain scales. The Behavioral Pain Scale is an 
alternative for assessing pain in critically ill, sedated, or mecha-
nically ventilated patients, using facial expression, upper limb move-
ments, and compliance with mechanical ventilation. Another 
instrument useful in the ICU is the Critical Care Pain Observation 
Tool, which measures the presence and intensity of pain through 
changes in facial expression, body movements, muscle tension, and 
compliance with mechanical ventilation.

Consider using family members or guardians (surrogates) to 
report a patient’s pain. Analysis of more than 2,000 patients in the 
SUPPORT (Study to Understand Prognoses and Preferences for 
Outcomes and Risks of Treatments) trial found that surrogates cor-
rectly identified that patients had pain 73% of the time, but were 
less accurate (53%) in identifying its severity, scoring high enough 
to be valuable assets when patients cannot give self-reports.

Conclusion

Treatment follows assessment and diagnostic formulation. 
Along with this section, the following section by Dr. Steven Sta-
nos will enable readers to integrate pain assessment with treat-
ment for common pain conditions. Regardless of the underlying 
cause of pain, having a schema for assessing pain is essential. 
Although there are many opinions and options for treating pain, 
there is little debate that pain must be thoroughly assessed to be 
well treated.

Applying Evidence-Based Guidelines to Common Pain Conditions

Steven P. Stanos, DO

Objective

• Formulate an evidence-based treatment plan utilizing both pharmacologic and nonpharmacologic therapies for the management of chronic pain.

Introduction

Pain has only recently been the target of evidence-based medi-
cine (EBM). Pain used to be considered just a subjective symptom 
that would improve as the disease state improved. The evidence 
now shows that pain can be its own disease state, influencing the 
course of an illness or the life of a patient in ways we are only now 
beginning to understand.

The quest for EBM is a noble cause. But, as clinicians, we must 
ask, what is EBM? Is it literature-based medicine? Is it consensus-
based medicine? In reality, EBM is a combination of both. Thou-
sands of peer-reviewed articles are published yearly. One can break 
them down by looking at quality (ie, randomized controlled trials, 
double-blinded, withdrawals, etc), credibility (ie, sufficient number 
of patients, exclusion criteria, methods of analysis, etc), and utility 
(ie, can we extract useful outcome data, what is the number needed 
to treat, and how do the findings compare with clinical practice). 
From this large body of work, findings are synthesized into sys-
tematic reviews, meta-analyses, and evidence-based clinical practice 
guidelines. Although by no means perfect, these guidelines can 
assist us with diagnostic uncertainties, inform our treatment deci-
sions, and provide a useful synthesis of current evidence for a par-
ticular disorder or disease state. As pain research has developed an 
evidence base, and pain has been declared the fifth vital sign by the 
Joint Commission, guidelines for treatment of disease states with 
pain as their hallmark are getting a fresh look.

This section provides a brief review of low back pain (LBP) and 
fibromyalgia (FM), 2 of the most common and painful conditions 
seen in our patients. Also discussed is the use of opioids in patients 
with chronic pain.

American Pain Society Low Back Pain Guidelines

Low back pain is the second most common symptomatic reason 
for clinical office visits, with the first being simple upper respira-
tory infections. Estimates of total health care expenditures sug-
gest LBP costs approximately $100 billion. The American Pain
Low Back Pain Guidelines: Surgery and Interventional Therapies

The APS also recently published guidelines focused on the evidence base for use of interventional diagnostic tests and therapies, surgery, and interdisciplinary rehabilitation for the treatment of LBP. These guidelines suggest there is sufficient evidence to consider interdisciplinary rehabilitation, surgery, epidural steroid injection, and spinal cord stimulation in certain clinical circumstances. Shared decision making is of utmost importance and should include a specific discussion with the patient regarding potential benefits, harms, costs, and burdens of these therapies compared to other therapies.

Fibromyalgia

Fibromyalgia is a common chronic pain condition that we often see in primary care. Understanding FM can help us to understand some of the changes underlying other chronic pain conditions. Several lines of evidence support FM as a central nervous system disorder of pain and sensory processing. Patients with FM experience global increases in sensitivity to pain, and their pain is distinct from peripheral nociception or neuropathic pain. But pain is rarely the only symptom of FM. Patients may present with a wide range of symptoms, including hyperalgesia, tenderness, stiffness, sleep disturbances, fatigue, and possible cognitive complaints and mood disorders, all of which should be evaluated as part of the initial diagnosis.

There are 3 evidence-based, multinational clinical practice guidelines. The APS guidelines published in 2005, the European League Against Rheumatism (EULAR) in 2008, and the Association of the Scientific Medical Societies in Germany (AWMF), also in 2008. There are some inconsistencies in the recommendations between the guidelines, but the evidence is strong that optimal treatment of patients with FM should include both nonpharmacologic and pharmacologic therapies. Nonpharmacologic therapies with strong evidence include patient education, aerobic exercise, and cognitive-behavioral therapy. Those with modest or weak evidence for benefit include strength training, hypnotherapy, balneotherapy, biofeedback, chiropractic and massage therapies, acupuncture, ultrasound, and electrotherapy. Nonpharmacologic therapies with no evidence for efficacy include trigger point injections and flexibility exercises.

Pharmacologic therapies with strong evidence for efficacy in FM patients include off-label use of tricyclic compounds (eg, amitriptyline, cyclobenzaprine), FDA-approved serotonin-norepinephrine reuptake inhibitors (ie, duloxetine and milnacipran), and FDA-approved anticonvulsants (ie, pregabalin). Modest evidence of efficacy has been established for off-label use of the following medications: tramadol, gabapentin, venlafaxine, selective serotonin reuptake inhibitors, γ-hydroxybutyrate, and dopamine agonists. There is no evidence of efficacy for the use of opioids, corticosteroids, NSAIDs, or benzodiazepines.

American Pain Society Guidelines for Opioid Use in Patients With Chronic Pain


Society (APS) and American College of Physicians (ACP) recently convened a panel of experts from a wide spectrum of medical specialties, including physicians, nurses, chiropractors, therapists, and psychologists, to develop consensus-based guidelines focused on the appropriate assessment and treatment of LBP in primary care.

Our challenge in assessing and treating LBP is that in most cases the natural history is very favorable. Most patients recover over time, even without treatment, making treatment outcomes and pain response studies often difficult to interpret. Pain assessment in LBP should incorporate a comprehensive, biopsychosocial approach, including a focused history and physical exam; evaluation of pain severity and functional deficits; and identification of psychosocial risk factors that may affect the development of chronic pain or predict aberrant or problematic medication use. The APS guidelines highlight the need for clinicians to limit the use of advanced diagnostic testing for acute LBP except in patients with signs of severe or progressive underlying disease or those who present with neurologic deficits.

Importantly, we should attempt to classify patients presenting with LBP conditions into 1 of 3 categories and then approach treatment in a systematic fashion. The 3 important categories are nonspecific LBP; back pain associated with neurologic signs, radiculopathy, or spinal stenosis; and back pain associated with an alternative cause (eg, referred organ pain). As with any medical assessment, LBP assessment should include ruling out potential “red flags,” which are signs or symptoms that warrant emergent and aggressive care, including cauda equina syndrome, cancer, infection, or fracture. Confirmation of red flag conditions may require appropriate laboratory testing, medical imaging (ie, x-ray, computed tomography, or magnetic resonance imaging), and emergent surgical or specialist referral.

Evidence-based treatment of LBP should be guided by the assessment and categorization of the patient. The first guideline recommendation on treatment addresses self-care options. At a minimum, we should provide all patients with evidence-based information about their expected course; we should advise them to remain active; and we should inform them about effective self-care options. Additionally, provider reassurance and discussion of our expectations with the patient are likely to have a great impact on outcomes, and we should provide those at the initial diagnosis.

For patients who do not improve with self-care options, we should consider adding nonpharmacologic therapy that has proven benefits. For chronic or subacute LBP, options associated with moderate benefit include intensive interdisciplinary rehabilitation, exercise, behavioral therapy, massage, manipulation, yoga, acupuncture, and progressive relaxation.

In terms of guideline-concordant pharmacologic options for LBP, for most patients, our first-line choices are going to be acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs), which are associated with small to moderate benefit. Skeletal muscle relaxants are associated with moderate benefit for acute LBP, but are not recommended as first-line agents because of their sedative side effects. Tricyclic antidepressants (off-label) are associated with a small to moderate benefit for chronic LBP only. It is important to point out here that many patients with chronic LBP also have depression, and they are undertreated for it. Fair evidence was found for the use of opioids, tramadol, benzodiazepines (off-label), and gabapentin (for radiculopathy; off-label), and good evidence that systemic corticosteroids are ineffective and should be avoided.
guidelines if you ever prescribe opioids. Opioids certainly have a place in the management of pain, even chronic pain, but we need to be aware of best practices for evaluating risk in the individual patient and patient monitoring. These guidelines provide a good reference section and give a concise and practical review of patient selection and informed consent.

A brief overview of key guideline components includes:

1. Careful patient selection and risk stratification: Before initiating chronic opioid therapy (COT), conduct a history, physical examination, and appropriate testing, including an assessment of risk for abuse, misuse, or addiction. COT may be considered an option if pain is moderate or severe and is adversely impacting function or quality of life. Benefit and risk evaluations should be performed and reassessed on an ongoing basis.

2. Informed consent and management plans: Written or verbal informed consent that includes a discussion of goals, expectations, potential risks, and alternatives should be completed and documented. A written management plan may be helpful in documenting patient and clinician responsibilities, outlining expectations, and developing a tool for patient education.

3. Initiation and titration of COT: Clinician and patient should regard initial treatment with COT as a “trial,” and opioid selection, initial dosing, and titration should be individualized according to patient characteristics, including previous history of response, attainment of therapeutic goals, and potential harms of therapy.

4. Monitoring recommendations: Monitoring includes periodic assessment for aberrant drug-related behaviors, documentation of pain intensity and level of functioning, assessment of progress toward achieving goals, therapeutic adherence, and the presence of adverse events.

5. Opioid-related adverse effects: Anticipate, identify, and treat common adverse effects. Adverse effects may include constipation, nausea or vomiting, sedation, cognitive dysfunction, hypogonadism, pruritus, myoclonus, and respiratory depression.

Additionally, these guidelines provide recommendations regarding driving and work safety, identifying a medical home and when to obtain consultation with a specialist, high-risk patients, use of psychotherapeutic co-interventions, dose escalations, opioid rotation, indications for discontinuing therapy, appropriate treatment of breakthrough pain, and the use of opioids during pregnancy.

**Summary**

An estimated 50 million Americans suffer from chronic pain, and we now know that pain itself, although subjectively measured, is both a disease state and a complicating factor. Numerous studies report that pain management is suboptimal in the majority of these patients, leading to increased levels of disability and health care utilization. Evidence-based guidelines now are available to help guide us in our assessment and treatment of common pain conditions. Utilizing these guidelines to avoid ineffective treatments and maximize the use of treatments with demonstrated benefits can undoubtedly produce better patient outcomes and more effective and constructive patient encounters.

**References**


CME Post-Test

Choose the best answer.

1. Which of the following is a characteristic of pain?
   a. Subjective
   b. Objective
   c. Cannot be assessed
   d. Self-evident

2. Which of the following is a comorbidity typically associated with pain?
   a. Anxiety and depression
   b. Weight loss
   c. Marital satisfaction
   d. Improved sleep

3. Pain processing in a damaged nervous system occurs in which condition?
   a. Nociceptive pain
   b. Somatic pain
   c. Visceral pain
   d. Neuropathic pain

4. Which of the following is an example of a multidimensional pain scale?
   a. Numeric Rating Scale
   b. Verbal Rating Scale
   c. Brief Pain Inventory
   d. FACES scale

5. Patients treated in an intensive care unit may be assessed using which of the following assessment instruments?
   a. McGill Pain Questionnaire
   b. Behavioral Pain Scale
   c. Behavioral Pain Inventory
   d. Neuropathic Pain Scale

6. Three common side effects associated with opioid medications are:
   a. Diarrhea, anxiety, and nausea
   b. Edema, diarrhea, and dry mouth
   c. Constipation, sedation, and nausea
   d. Diarrhea, sedation, and nausea

7. Which of the following nonpharmacologic therapies has not been proven to be effective in fibromyalgia?
   a. Acupuncture
   b. Cognitive-behavioral therapy
   c. Cardiovascular fitness exercise
   d. Education

8. There is strong evidence that each of the following medications is effective in fibromyalgia except:
   a. Pregabalin
   b. Amitriptyline
   c. Ibuprofen
   d. Duloxetine

9. At a minimum, every patient seeking medical care for low back pain should receive:
   a. Patient education, advised bed rest, and information regarding self-care options
   b. Patient education, advice to remain active, and information regarding self-care options
   c. Patient education, confirmation of symptoms via medical imaging, and medication
   d. Patient education, modified work schedule, medication, and information regarding self-care options

10. There is no evidence of efficacy for corticosteroids in the treatment of:
    a. Low back pain
    b. Fibromyalgia
    c. Low back pain and fibromyalgia
    d. Corticosteroids are efficacious for low back pain
Activity Evaluation

Practical Management of Chronic Pain in Primary Care

Participant Information (please print)

First Name: ___________________________ Last Name: ___________________________

Degree/Title: __________________________

Address: ___________________________

City: __________________ State: ______ Country: ______ ZIP: __________

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Evaluation Questions

Please respond to the following by circling the appropriate rating.

5 = Strongly Agree    4 = Agree    3 = Neutral    2 = Disagree    1 = Strongly Disagree

As a result of attending this activity, I should be able to

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<th>Description</th>
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<td>Describe and integrate into practice the critical components of comprehensive pain assessment.</td>
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<td>List examples of physical, psychological, and social functioning that should be assessed for impairment in the patient with chronic pain.</td>
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How well did this activity

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<tr>
<td>Address competencies identified by your specialty?</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Provide clear evidence to support content?</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Translate evidence to practice?</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Address barriers to optimal performance?</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Provide evidence that will lead to changes in your practice?</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Present material applicable to your clinical practice?</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

Was the monograph fair-balanced and free of commercial bias?

阚 Yes       ❏ No (please explain): __________________________

Please describe the scientific level of this monograph.

阚 Too basic       ❏ Appropriate       ❏ Too advanced

Based on the information presented in this activity, please indicate one of the following:

阚 I plan to make changes within my practice.

阚 I do not plan to make changes because the information affirmed my current practice.

阚 I do not plan to make changes because the information is not relevant to my current practice.

阚 I do not plan to make changes for other reasons. (Please explain)

As a result of this activity, what will you do differently in your practice?

__________________________________________________________________________

What might impede you from making the above change(s)?

__________________________________________________________________________

Please suggest other topics that should be covered in future activities.

__________________________________________________________________________

What is your specialty?

阚 Internal medicine       ❏ Other (specify) __________________________

Additional comments:

__________________________________________________________________________