Back Pain: The Pitfalls and the Practicalities
Dr Arun Aggarwal
RPAH Pain Management Centre
Private Rooms – Rozelle and Hornsby
PAIN
IASP Definition (1979)

‘an unpleasant sensory and emotional experience, associated with actual or potential damage or described in terms of such damage’
PAIN ASSESSMENT

• Complex process
  – Pain involves thoughts and feelings
  – Whatever the experiencing person says it is
  – Exists whenever the experiencing person says it does

  – All pain is real
    • Whether or not the biological cause is known
Low Back Pain (LBP): A National Health Priority

- Back complaints are the 7th most common reason for seeing a GP

- Affects ~ 10% of Australians in any 6 months

- Common cause of disability

- Annual cost $10 billion per annum

- Early and effective management may lessen the burden

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Acute LBP

- Acute episodes (lasting < 3 months) usually benign\(^1\)
  - ~ 85% will have non-specific LBP\(^1\)

- Complete recovery is expected\(^2\)
  - 70 - 80% will fully recover within 3 months and remain that way at 1 year\(^2\)

- Recurrence rates <25% with good management\(^2\)

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Acute Pain

- Has a purpose
  - Warn of damage
  - Underlying condition
  - Encourage rest
  - Prevent further damage
  - Increase healing
  - Progressive if not treated
Managing Acute LBP

1. Initial presentation

2. Patient assessment

3. Red flags?

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1. Adapted from ACC and NZ Guidelines Group. New Zealand Acute Low Back Pain Guide. October 2004
Red Flags

- ‘Red flag’ conditions are rare (< 1% of acute LBP)\(^1\)

<table>
<thead>
<tr>
<th>Feature or Risk Factor(^2,3)</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms or signs of infection (e.g. fever)</td>
<td>Infection</td>
</tr>
<tr>
<td>Risk of infection (e.g. penetrating wound)</td>
<td></td>
</tr>
<tr>
<td>History of significant or minor trauma</td>
<td>Fracture</td>
</tr>
<tr>
<td>History of cancer, unexplained weight loss, age &gt; 50 years, severe worsening pain especially at rest, pain at multiple sites</td>
<td>Tumour</td>
</tr>
<tr>
<td>Urinary retention, faecal incontinence, widespread neurological symptoms and signs in lower limbs, saddle area numbness, lax anal sphincter</td>
<td>Cauda Equina Syndrome</td>
</tr>
</tbody>
</table>

---

1. van den Bosch MA. Clin Radiol 2004;59:69-76  
2. ACC & NZ Guidelines Group. NZ Acute Low Back Pain Guide. 2004  
Managing Acute LBP

Initial presentation

Patient assessment

Red flags?

Yes → Investigate & refer

No

GIVE THE PATIENT THE GREEN LIGHT

• Stay active & working
• Explain & reassure
• Agree on a plan

• Control symptoms, simple analgesics
• Note yellow flags
• Review

1st month

4-6 week follow-up

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1. Adapted from ACC and NZ Guidelines Group. New Zealand Acute Low Back Pain Guide. October 2004
Neutral terms, avoid diagnostic labels and jargon that can add to patient anxiety

Poor wording can lead to patient misinterpretation

<table>
<thead>
<tr>
<th>Examples of statements</th>
<th>Potential interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have moderate facet degeneration</td>
<td>My back will continue to worsen (degenerate)</td>
</tr>
<tr>
<td>You have the back of an 80 year old</td>
<td>My back is frail, I shouldn’t do any physical activity</td>
</tr>
<tr>
<td>You don’t need surgery yet</td>
<td>Back surgery is inevitable</td>
</tr>
</tbody>
</table>

1. NHMRC Australian Acute Musculoskeletal Pain Guidelines Group. 2004
2. ACC & NZ Guidelines Group. NZ Acute Low Back Pain Guide. 2004
Patients Need to Hear\(^1\)

- The pain will settle
- Most people make an excellent recovery
  - Muscle spasm
  - Joint stiffness
- There is no sign of anything serious
- X-rays and scans are not needed
- Hurt $\neq$ harm
  - It is important to stay active
  - It is important to return to work

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1. ACC & NZ Guidelines Group. NZ Acute Low Back Pain Guide. 2004
Staying Active

Advise the patient to stay active!

- Avoid bed rest
  - >2 days impairs recovery
- Resume normal activities
- Gradually \( \uparrow \) aerobic activity
  - 30 minutes per day
- Advice on lifting
  - Twisting and bending

Managing Acute LBP

Initial presentation

1st month

4-6 week follow-up

Patient assessment

Red flags?

GIVE THE PATIENT THE GREEN LIGHT

- Stay active & working
- Explain & reassure
- Agree on a plan

- Control symptoms, simple analgesics
- Note yellow flags
- Review

Improving

Yes, reinforce

Red flags?

Yellow flags?

Yes

Investigate & refer

No

Yes

No
Case Study 1

Acute LBP
35 year old editor

1 week history of sharp low back pain

“It usually comes on when I’m sitting at the computer”

Pain is getting worse

Fears it may indicate something more serious
Patient Assessment

• Pain is moderate, 5/10
  – Not interfering with her quality of life but it is difficult to concentrate
  – Paracetamol 2 x 500mg ineffective
  – Paracetamol/codeine 2 x 500mg/15mg provides short term relief
  – Has begun yoga, but doesn’t believe it is helping

• Localised low back pain without radiation
  – Normal lower limb neurological assessment

• No red flags suspected from history & examination
What are your next steps for Belle?

**Activity**
- Remain ACTIVE
- Continue working
- Continue yoga, consider physiotherapy (core strengthening)
- AVOID bed rest

**Explain, Reassure**
- No serious underlying condition
- Pain will progressively settle
- Safe to continue activity

**Control symptoms**
- Prescribe short course paracetamol/codeine (500mg/30mg) 2 qid
- **Consider Tramadol SR 100 mg mane or Duro-Tram XR**
- Laxatives

Adapted from ACC and NZ Guidelines Group. New Zealand Acute Low Back Pain Guide. October 2004
• CNS-active analgesic, synergistic action via:
  – Non-opioid - inhibition of noradrenaline reuptake and stimulation of serotonin release at the spinal level
  – Opioid - weak binding to mu-opioid receptors.

• Quick acting, slow release, extended release, IV or IM

• Side effects:
  – CNS (somnolence, confusion, dizziness) & GIT (nausea)
    • More frequent with quick acting capsule
  – Small risk of seizures (use contraindicated if seizure history)
Would you set up a review appointment for Belle or only check if the pain persists?

- Follow up is critical
  - Care
  - Partnership
  - Reassurance
- Reinforce the green light to be active
- Adherence to medications & activity
- Address/assess fears
- Check for red & yellow flags (if not improving)\textsuperscript{1,2}

Follow-up: 1 month

- Back pain lasted 10 days but has now gone away

- On paracetamol/codeine (500mg/30mg, 2 qid)
  - Average pain was a 3/10
  - Coped better with the pain than with OTC medications

- Doing both yoga and Pilates classes at her local gym
- Pain free for the last 10 days
Persistent Back Pain

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CHRONIC (Persistent) PAIN

• Pain persists beyond expected recovery time
  – Pain continuous or recurrent beyond 3-6 months
  – Up to 33% persistent back pain at 1 year
  – 20% substantial limitations in activity

• Pain interferes with life
  – Pain affects self-esteem, well-being and relationships
  – Pain can lead to avoidance, depression and irritability
  – Physical disabilities, psychological distress
  – Unable to work
# Physical (Back) Examination

## Inspect
- Wasting
- Scars

## Palpate
- Tender

## Move
- Flex - to ankle
- Ext 20
- Lat Flex – to knee
- Lat Rot 90

## Assess
- Power
- Nerve root compression

<table>
<thead>
<tr>
<th>Nerve root</th>
<th>Weakness</th>
<th>Altered sensation</th>
<th>Altered reflexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2</td>
<td>Iliopsoas – Hip Flexion with Hip Flexed</td>
<td>Groin</td>
<td>None</td>
</tr>
<tr>
<td>L3</td>
<td>Quadriceps – Hip flexion</td>
<td>Anterior &amp; lateral thigh</td>
<td>Knee</td>
</tr>
<tr>
<td>L4</td>
<td>Ankle dorsiflexion (heel-walking)</td>
<td>Medial leg and ankle</td>
<td>Knee</td>
</tr>
<tr>
<td>L5</td>
<td>Great-toe dorsiflexion</td>
<td>Dorsum of foot</td>
<td>None</td>
</tr>
<tr>
<td>S1</td>
<td>Ankle plantar flexion (toe-walking)</td>
<td>Lateral sole of foot</td>
<td>Ankle</td>
</tr>
</tbody>
</table>
Observing Back Pain
What is the role of imaging in patients with persistent back pain?
# INVESTIGATIONS

<table>
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<tr>
<th>Test</th>
<th>When</th>
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</thead>
<tbody>
<tr>
<td>Plain X-ray (AP and Lat)</td>
<td>Initially, if risk factors for fractures</td>
</tr>
<tr>
<td></td>
<td>If the patient fails to improve (within 4-6 weeks)</td>
</tr>
<tr>
<td>CT</td>
<td>To evaluate bony details (fractures, facet joints)</td>
</tr>
<tr>
<td></td>
<td>MRI contraindicated (e.g. metal implants)</td>
</tr>
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<td>Tumour</td>
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<tr>
<td></td>
<td>Infection</td>
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<tr>
<td></td>
<td>Disk pathology</td>
</tr>
<tr>
<td></td>
<td>Spinal stenosis</td>
</tr>
<tr>
<td>Bone scans</td>
<td>Infections or fractures not noted on X-rays</td>
</tr>
<tr>
<td></td>
<td>Facet joint inflammation</td>
</tr>
<tr>
<td>Electrodiagnostic studies (NCS/EMG)</td>
<td>Radiculopathy, suspect multilevel root lesions</td>
</tr>
<tr>
<td></td>
<td>Symptoms don’t match imaging studies</td>
</tr>
<tr>
<td></td>
<td>Fluctuating levels of strength in 1+ muscle groups</td>
</tr>
</tbody>
</table>
Cognitive-Behavioural Model of Fear of Movement or (Re)Injury

## Psychosocial Yellow Flags

### Work
- Belief pain is harmful ➔ fear avoidance behaviour
- Belief pain must be abolished before returning to work
- Compensation issues

### Behaviours
- Passive attitude to rehabilitation
- Use of extended rest
- ↓ activity
- Avoidance of normal activities
- ↑ alcohol consumption

### Beliefs
- Catastrophising, thinking of the worst
- Misinterpreting bodily symptoms
- Belief pain is uncontrollable
- Poor compliance with exercise

### Affective
- Depression
- Feeling useless, not needed
- Irritability
- Anxiety
- Lack of support
- Overprotective partner

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Managing Persistent Pain

- Effective pain management requires comprehensive assessment which incorporates:
  - Biological – nociceptive or neuropathic
  - Psychological – anxiety, depression, negative thoughts
  - Social factors - litigation, cultural, financial, isolation
Managing Persistent LBP

• Low impairment & disability
  – Exercise
  – Medications
  – Brief interventions

• More severe disability
  – Multidisciplinary approach
  – Biopsychosocial
  – Realistic goals

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MANAGEMENT

Self-Care
- Remain active
- Self help books (Manage Your Pain)

Non-pharmacological
- Spinal manipulation, Exercise and Core
- Acupuncture and TENS
- Yoga, Meditation, CBT

Medications
- Paracetamol, NSAID’s and COX-2s
- TCA’s and AED’s
- Tramadol and Strong Opioids
Types of pain

• **Nociceptive**
  – Stimulation of somatic or visceral nociceptors by tissue damaging (noxious) stimuli.

• **Neuropathic**
  – "pain initiated or caused by a damage, disease or dysfunction in the nervous system, in the absence of an ongoing peripheral noxious stimulus".
• Stimulation of somatic or visceral nociceptors by tissue damaging (noxious) stimuli
  – Response to damaged tissue with an intact nervous system
  – Dull ache, tightness, pressure

  – Cancer Pain
  – Osteoarthritis
  – Orthopaedic surgery
• “Pain initiated or caused by a damage, disease or dysfunction of the nervous system, in the absence of an ongoing peripheral noxious stimulus”

  – 25-30% of chronic pain referrals have unrecognised neuropathic “component”
NEUROPATHIC PAIN CONDITIONS

- Post herpetic neuralgia
- Trigeminal neuralgia
- Peripheral neuropathy
- Injury to the nerve
  - Crush, avulsion, stretch or section
- Neuroma formation
- Complex regional pain syndromes
  - Type 1 - RSD, Type 2 - causalgia
- Spinal cord trauma, ischaemia or tumour
- Thalamus or brainstem trauma, ischaemia or tumour
NEUROPATHIC PAIN

• Pain delayed months or even years after original injury
  – Absence of ongoing tissue damage
  – Burning, shooting, lancinating, stabbing electric shock
  – Spontaneous or stimulus evoked pain

• Allodynia - pain to non-painful stimulus

• Hyperalgesia - increased pain to painful stimulus
PRINCIPLES of MANAGEMENT

• Aim is to relieve pain in three steps:
  – Relief of pain at night
  – Relief of pain at rest
  – Relief of pain on movement

• Constant pain should be treated by regular long acting medication, NOT by short acting drugs given PRN

• Patients believe that pain relief should only be taken when the pain becomes unbearable
  – Based on the belief in the community that addiction will follow

• PRN = pain relief never.
1. Start with simple analgesics
   – Paracetamol
   – NSAIDs or COX-2’s

2. Add adjuvants
   – TCA and AED’s

3. Trial opioids
   – Selected patients

WHO Analgesic Ladder
(generally for nociceptive pain)

Non-opioids (paracetamol, NSAID’s)

Persistent pain or increasing pain

Weak opioids (codeine, tramadol)
for mild-moderate pain
+/- non opioid +/- adjuvant

Persistent pain or increasing pain

Strong opioids (oxycodone, morphine)
for moderate-severe pain
+/- non opioid +/- adjuvant
# Pharmacological Treatments

| Initial Analgesic options | • Paracetamol (1000mg qid)  
• Paracetamol + codeine (2 x 500mg/30mg qid)  
• Tramadol Quick Acting Capsules (50mg qid) |
| --- | --- |
| Pain lasting > 5 days | • Tramadol SR (100-200 mg bd)  
• Duro-Tram XR (100-200mg nocte)  
• Buprenorphine patch (5-20 ug/hr weekly)  
• Oxycontin 10-20 mg bd  
• Fentanyl patch 12-25 mcg every 3 days |
| Nocturnal Pain  
(TCA antidepressant) | • Amitriptyline (10-25mg nocte)  
• Nortriptyline (10-25mg nocte)  
• Doxepin (25-50mg nocte)  
• Clonazepam (0.25-0.5mg nocte) |
| Daytime Pain  
(Adjuvant AED) | • Epilim (200-400 mg bd)  
• Gabapentin (100 – 600 mg tds)  
• Pregabalin (25-300 mg bd)  
• Duloxetine (30-60 mg mane) |
Somatic Pain

I. Facet joint pain
   Medial branch blocks or
   Radiofrequency thermoneurolysis
   Intraarticular injections*

II. SI joint pain
   SI joint intervention*

III. Discogenic pain
    Intradiscal therapy

Radicular Pain

I. No surgery/post-surgery/spinal stenosis
   Step 1: Caudal/interlaminar or transforaminal epidural
   Step 2: Percutaneous adhesiolysis

II. No surgery
   Step 3: Percutaneous disc decompression

III. Post-surgery
    Step 4: Spinal endoscopic adhesiolysis

* Not evidence based

Local Blocks

- **L2 paravertebral blocks**
  - Innervation of disc with nerve root distribution of pain.
  - Pain on flexion. Pain on sitting

- **Peri-radicular block**
  - Nerve root compression with radicular symptoms

- **Epidural block**
  - Disc pain with radicular pattern

- **Facet joint block**
  - Pain on extension.
  - Pain usually not below knee
Multi-modal approach is recommended

- ↑ complexity, early referral:
  - Psychologist and/or
  - Physiotherapist (skilled in teaching patients to move without fear of harming/damaging the body) and/or
  - Multidisciplinary management program

Quality Use of Opioids

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Systematic Approach

1. Patient assessment
2. Tailored management plan
3. Regular review

Continuous Cycle
1. Patient Assessment$^{1,2}$

- Unresponsive to trials of conservative therapies$^{1,2}$
  - Non-pharmacologic and pharmacologic
- Exclude Neuropathic pain
  - TCA and AED’s
- Concordance between pathology and observed pain behaviour
- Benefits > risks$^2$
  - Psychologically stable

1. Biopsychosocial pain assessment
2. Assess risk of problematic opioid use
3. Appropriate patients for opioids

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2. RACP Prescription Opioid Policy 2009.
Aberrant Drug Related Behaviour

Probably MORE predictive of problematic use

• Selling prescription drugs
• Prescription forgery
• Stealing or “borrowing” drugs
• Injecting oral formulations
• Obtaining prescription drugs from non-medical sources
• Concurrent abuse of alcohol or illicit substances
• Multiple non sanctioned dose escalations
• Repeated episodes of prescription “loss”
• Repeatedly seeking prescriptions from other clinicians or A&E without informing prescriber or after warning to desist
• Evidence of deterioration in ability to function (work, family, socially) that appear to be drug related
• Repeated resistance to therapy change despite clear evidence of adverse physical or psychological drug effects

Risk of Aberrant Behaviour

- Opioid treatment accepted for nociceptive LBP
- True prevalence of substance abuse not known
- Absence of Australian data
- In LBP, the prevalence of aberrant behaviour ranges from 5% to 24%
- No single factor can predict risk, so universal precautions required

## Opioid Risk Tool (Appendix 2)\(^1\)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Alcohol</td>
<td>3 points</td>
<td>1 point</td>
</tr>
<tr>
<td>- Illicit drugs</td>
<td>3 points</td>
<td>2 points</td>
</tr>
<tr>
<td>- Prescription drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td>Personal history of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Alcohol</td>
<td>3 points</td>
<td>3 points</td>
</tr>
<tr>
<td>- Illicit drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td>- Prescription drugs</td>
<td>5 points</td>
<td>5 points</td>
</tr>
<tr>
<td>Aged between 16 and 45</td>
<td>1 point</td>
<td>1 point</td>
</tr>
<tr>
<td>History of preadolescent sexual abuse</td>
<td>0 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Psychiatric disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia</td>
<td>2 points</td>
<td>2 points</td>
</tr>
<tr>
<td>Depression</td>
<td>1 point</td>
<td>1 point</td>
</tr>
</tbody>
</table>

\(^1\) Kahan M et al. Can Fam Physician 2006;52(9):1081-7
2. Appropriate Management

1. Patient assessment

2. Tailored management

Continuous Cycle

3. Regular review

i. Set treatment goals

ii. 4-6 week opioid trial
   – Opioid one part of multimodal treatment

iii. Assess versus goals

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2. RACP Prescription Opioid Policy 2009.
3. Patient Review

1. Patient assessment

2. Tailored management

Continuous Cycle

3. Regular review

- Activity
- Analgesia
- Adverse effects
- Aberrant behaviours (unsanctioned use)
- Affect
- Adequate prescription records

i. Regularly assess 4 + 2As

ii. Periodically review pain diagnosis

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2. Jovey R. Personal communication 2009
# Opioid Trial Outcomes

<table>
<thead>
<tr>
<th>Successful Trial</th>
<th>Unsuccessful Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positive progress vs. treatment goals improved function</td>
<td>• Pain unresponsive</td>
</tr>
<tr>
<td>• Medication used responsibly</td>
<td>• Evidence of aberrant drug behaviours</td>
</tr>
<tr>
<td>• Discuss risk/benefits of continuing therapy(^1,2)</td>
<td>• Taper &amp; cease opioid</td>
</tr>
<tr>
<td></td>
<td>• Continue other physical &amp; psychological therapies</td>
</tr>
<tr>
<td></td>
<td>• Consult pain specialist</td>
</tr>
</tbody>
</table>

Opioid Titration

- Start with lowest possible dose and titrate over 4-6 weeks
- Greatest incremental benefit at lower doses
- With each dose increase patient should experience
  - Decline in pain intensity
  - Improvements in function
- If minimal analgesic benefit is obtained from several dose increases further escalations are unjustified

Developing consensus amongst Australian pain specialists suggest that a dosage range below 100 – 120 mg of oral morphine/day (or equivalent) is clinically appropriate for the GP management of PNCP\textsuperscript{1-3}

**Approximate opioid conversions:**\textsuperscript{4-9}

<table>
<thead>
<tr>
<th>Oral Dose</th>
<th>Transdermal dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine : oxycodone</td>
<td>TD buprenorphine 5mcg/hr &lt;20mg</td>
</tr>
<tr>
<td>morphine : methadone*</td>
<td>TD buprenorphine 10mcg/hr 20-45mg</td>
</tr>
<tr>
<td>morphine : hydromorphone</td>
<td>TD buprenorphine 20mcg/hr 46-90mg</td>
</tr>
<tr>
<td>morphine : tramadol</td>
<td>TD fentanyl 12 &lt;60mg</td>
</tr>
<tr>
<td>morphine : codeine</td>
<td>TD fentanyl 25 60-134</td>
</tr>
<tr>
<td></td>
<td>TD fentanyl 50 135-224</td>
</tr>
<tr>
<td></td>
<td>TD fentanyl 75 225-314</td>
</tr>
<tr>
<td></td>
<td>TD fentanyl 100 315-404</td>
</tr>
</tbody>
</table>

* For morphine doses < 100mg/day

Maximum Dosage Recommendations in General Practice (HIPS) ¹

- Tramadol (sustained release) 200mg bd
- Tramadol (extended release) 300mg daily
- Buprenorphine (Norspan) patch 40 mcg/hr (weekly)
- Oxycodone (sustained-release) 40mg 12-hourly
- Fentanyl patch 25mcg/hr (3rd daily)
- Morphine (sustained-release) 60mg 12-hourly
- Methadone 20mg bd
- Elderly patients: lower doses and slower titration

Note: The doses listed above are not equianalgesic doses

Exit Strategies

• Opioids should be stopped *gradually* due to physical dependence

• Slow dose reduction, over several weeks to months, may minimise/prevent withdrawal symptoms

• Reduce the opioid dose by 10% per week
  – Depends on duration of use

Case Study 2

Persistent LBP
Ms LS, a 50 year old primary school teacher
Divorced for 7 years

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Background

- 2-year history of persistent non-specific LBP
  - Non work-related lifting injury
- No red flags
- Mod degenerative changes, L₅S₁ disc narrowing on X-rays
- Previous therapies, minimal relief
  - Paracetamol, NSAIDs, tramadol and TCA
- Exercise stopped, exacerbated pain
- Has no time to attend multidisciplinary pain management program
Biopsychosocial Pain Assessment

Persistent pain

- Biological
  - Pain history
  - Assess PQRST
  - Physical examination

- Psychological
  - Patient’s understanding of their pain
  - Impact on relationships, work
  - Context of the pain – cause and prognosis, previous pain experience
  - Significance of the pain (concerns, worries, beliefs, impact on mood & self-esteem)

- Social
  - What is the patient’s response to pain?
  - Response of significant others

### Assessing Ms LS’s Pain

<table>
<thead>
<tr>
<th>Provoking factors</th>
<th>Prolonged sitting/standing Tolerance 15-20/5-10 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of the pain</td>
<td>Severe dull aching pain</td>
</tr>
<tr>
<td>Region, Radiation</td>
<td>Pain localised to lower lumbar spine</td>
</tr>
<tr>
<td>Severity</td>
<td>Current pain 7-8/10</td>
</tr>
<tr>
<td>Timing</td>
<td>Pain is present 24 hours a day Marked sleep disturbance</td>
</tr>
</tbody>
</table>
Social Assessment

• Avoiding activities requiring sitting for extended periods of time
  – Avoids movies or theatre

• Modifying work activities
  – Frequent postural changes needed
  – Impeding teaching role

• Lies down every afternoon after work
Psychological Assessment

- ↑ frustration
- Minor mood lowering, no major depression or suicidal ideation
- Not fearful pain/reinjury
- Positive outlook about the future, despite her pain
What else do we need to consider before commencing an opioid trial?

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<tr>
<td>- Prescription drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td>Personal history of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Alcohol</td>
<td>3 points</td>
<td>3 points</td>
</tr>
<tr>
<td>- Illicit drugs</td>
<td>4 points</td>
<td>4 points</td>
</tr>
<tr>
<td>- Prescription drugs</td>
<td>5 points</td>
<td>5 points</td>
</tr>
<tr>
<td>Aged between 16 and 45</td>
<td>1 point</td>
<td>1 point</td>
</tr>
<tr>
<td>History of preadolescent sexual abuse</td>
<td>0 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Psychiatric disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia</td>
<td>2 points</td>
<td>1 point</td>
</tr>
<tr>
<td>Depression</td>
<td>1 point</td>
<td>1 point</td>
</tr>
</tbody>
</table>

What do we want to discuss before commencing an opioid trial?

- Assess expectations
  - Be realistic (50% relief) rather than complete resolution
- Discuss risks/benefits
  - Side effects (constipation, drowsiness) and addiction
- Set rules for prescribing
  - One prescriber and no additional scripts
- Set grounds for stopping
- Obtain informed consent
- 1 doctor prescribes & monitors

Adapted from RACP Prescription Opioid Policy 2009.
Setting Treatment Goals

- Informed consent
- Criteria for ongoing use
- Collaborative

Ms LS’s goals:
- Improve her ability to do normal activities e.g.
  - Sit to watch a movie
  - Conduct normal classroom teaching activities
- pain to tolerable level (4-5/10)
- sleep

Initiate Buprenorphine 7-day Patch

• Commence buprenorphine 5 µg/hour patch, prophylactic laxatives
  – Instruct Ms LS on correct usage of the patch

• Discuss recommencing exercise program

• Provide her with a **Brief Pain Inventory** to complete the day before her next visit in 2 weeks
Buprenorphine - NORSPAN

- Transdermal patch - weekly
  - Partial opioid agonist

- SE’s
  - Application site skin irritation (rotate sites)
  - Headaches
  - Dizziness, drowsiness, nausea, constipation

- Doses
  - 5 mcg/hr / 10 / 20
Follow-up: Week 2

- Activity: No change
- Analgesia
  - Some pain relief, average pain 7/10
  - A slight improvement in sleep
- Adverse effects: None
- Aberrant behaviours: None
- Continue titration and fortnightly review
Ongoing Assessment

- **Week 4, 10μg/hr patch:**
  - Improvement in activity, sleep & analgesia
  - No adverse effects or aberrant behaviours
  - 🟠 to 10μg/hr + 5μg/hr patches

- **Week 6, 10μg/hr + 5μg/hr patches**
  - Further improvement but drowsy & sluggish

- **Down-titrate to 10μg/hr patch**
Follow-up: 6 Months

- Activity:
  - Sitting tolerance ~ 1 hour, enjoys the occasional movie
  - Hydrotherapy 3 days/week & recommenced exercising
  - More confidence in teaching
- Analgesia: Average pain 4/10
- Adverse effects: Occasional constipation
- Aberrant behaviours: None
- Affect: Mood improved
- Accurate prescription records: Completed
Would you stop the opioid and how would you approach this?

- Potential to trial ceasing the opioid
- Maintained exercise program for some months
- Raise the original discussion at the time of opioid trial
- Trial opioid ↓, reduce dose to 5μg/hr patch for 1-2 weeks and review

- Assess expectations
- Discuss risks/benefits
- Set rules for prescribing
- Set grounds for stopping
- Obtain informed consent
- 1 doctor prescribes & monitors
Opioids Place in Persistent Pain

- Beneficial in some patients
  - Demonstrated good efficacy outcomes
  - Dose dependent response
  - Only moderate side effects
  - Low risk of abuse or addiction when used for pain

- Longer acting opioids are better than short-acting
- Patient selection and close follow-up important

- Most common side effects
  - Nausea and constipation - NNH was 4.2 (CI 3.2-5.6)
  - Followed by drowsiness, dizziness and vomiting
• **Does not imply “Pain is not Real”**

  – When pain persists beyond healing or with no cause, it is often assumed patient is willingly aggravating the pain

  **This is rarely the case**

  – Pain is a perception, which is filtered through the brain

• **Multidisciplinary treatment**

  – 1st pain clinic to include psychological component – 1976

  – Cognitive components are crucial to the treatment

    • Reduce pain but also improve mood and decrease disability

  – Medical, physical, behavioural, emotional, vocational, social
PAIN CLINIC RECOMMENDATIONS

• Investigations and referrals
• Medications
  – Nociceptive
  – Anti-neuropathic
• Anaesthetic blocks or TENS
• Physical therapy and exercise program
• Occupational therapy
• Psychiatric or D & A review
• Psychological management
  – Meditation / relaxation
  – Pain Education Program
• Implantable drug pump and spinal cord stimulation
Summary

• Acute low back pain
  – Most benign
  – Avoid over medicalising
  – Rule out non-spinal origin & red flags
  – No routine imaging
  – Green light to activity
  – Simple analgesia
  – Note yellow flags

• Chronic low back pain
  – Reassess
  – Rule out red flags
  – Focus on function
  – Address yellow flags

• Low impairment/disability
  – Exercise, medications, brief interventions

• High impairment/disability
  – Multidisciplinary approach

“Every day is the same for me:
I am almost crying!
I am so scared of living but more scared of dying.
Don’t say it’s self pity, that just makes it worse.

Chronic pain is like a never-ending curse.
Take some tablets, put on another patch, hope to goodness it’s not a bad batch.
Relief for a while, then it’s back to the old grind.

Hopefully my specialist will find something of a magic kind.
A remedy for Chronic pain is like whistling in the breeze.
According to the Professor, it is a DISEASE.”
remove pain

be more specific
Thank You

Please complete your evaluation forms
PBS Information: Restricted benefit. Chronic severe disabling pain not responding to non-narcotic analgesics. Authority required for increased maximum quantities and/or repeats. Refer to PBS Schedule for full Authority Required information