

# Back Pain: The Pitfalls and the Practicalities

Dr Arun Aggarwal

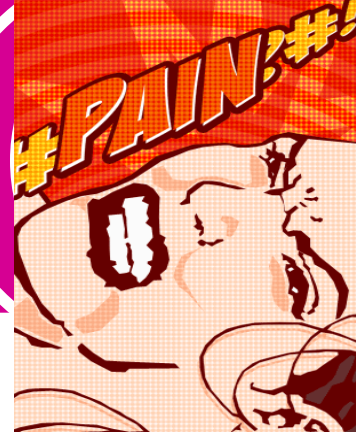
RPAH Pain Management Centre

Private Rooms – Rozelle and Hornsby



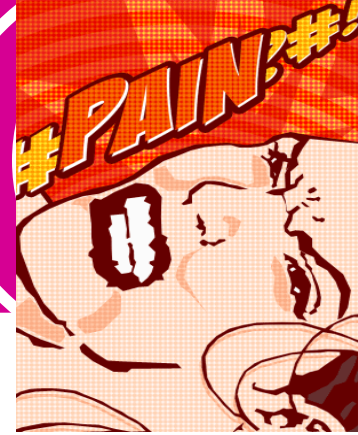
# PAIN

## 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<sup>1</sup>



- Back complaints are the 7<sup>th</sup> most common reason for seeing a GP<sup>2</sup>
- Affects ~ **10% of Australians** in any 6 months<sup>3</sup>
- Common cause of disability<sup>1</sup>
- Annual cost **\$10 billion** per annum<sup>3</sup>
- Early and effective management may lessen the burden<sup>3</sup>

# Acute LBP

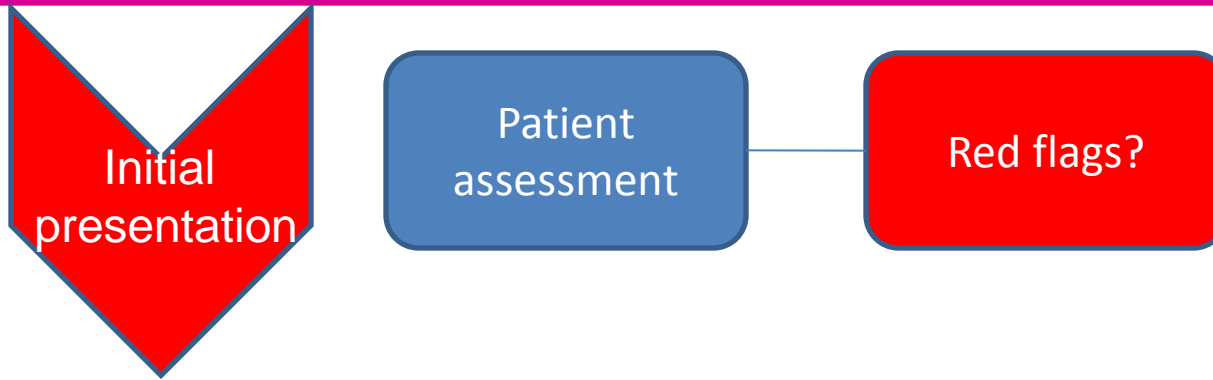
- Acute episodes (lasting < 3 months) usually benign<sup>1</sup>
  - ~ 85% will have non-specific LBP<sup>1</sup>
- Complete recovery is expected<sup>2</sup>
  - 70 - 80% will fully recover within 3 months and remain that way at 1 year<sup>2</sup>
- Recurrence rates <25% with good management<sup>2</sup>

# Acute Pain



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

# Managing Acute LBP<sup>1</sup>



# Red Flags

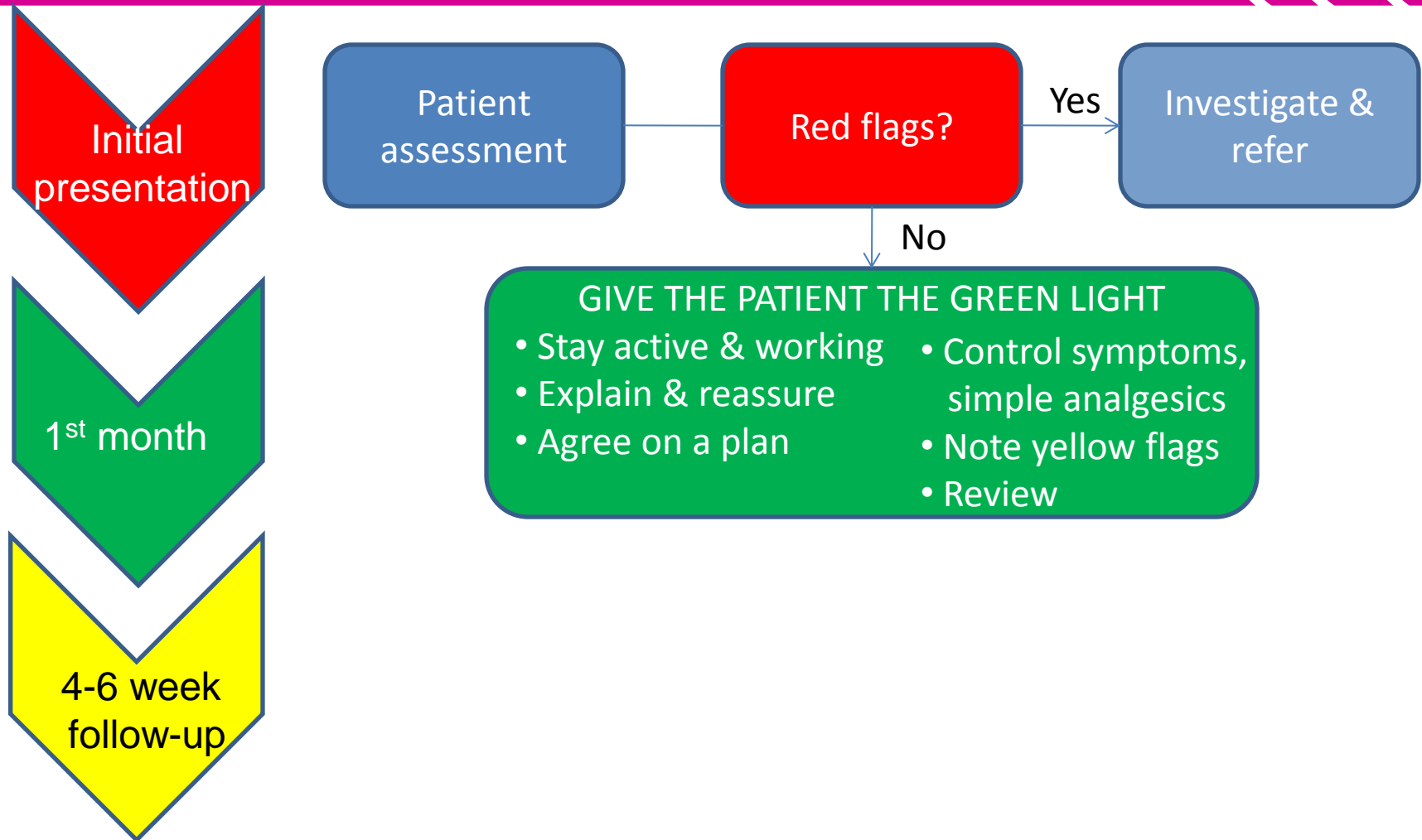
- 'Red flag' conditions are rare (< 1% of acute LBP)<sup>1</sup>

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

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<sup>1</sup>



# Importance of Communication<sup>1,2</sup>

- Neutral terms, avoid diagnostic labels and jargon that can add to patient anxiety
- Poor wording can lead to patient misinterpretation

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

# Patients Need to Hear<sup>1</sup>

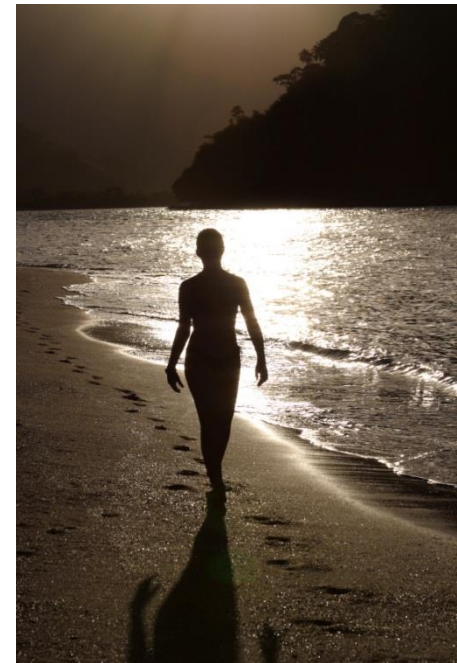


- The pain will settle
- Most people make an excellent recovery
  - Muscle spasm
  - Joint stiffness
- There is no sign of anything serious
- X-rays and scans are not needed
- Hurt ≠ harm
  - It is important to stay active
  - It is important to return to work

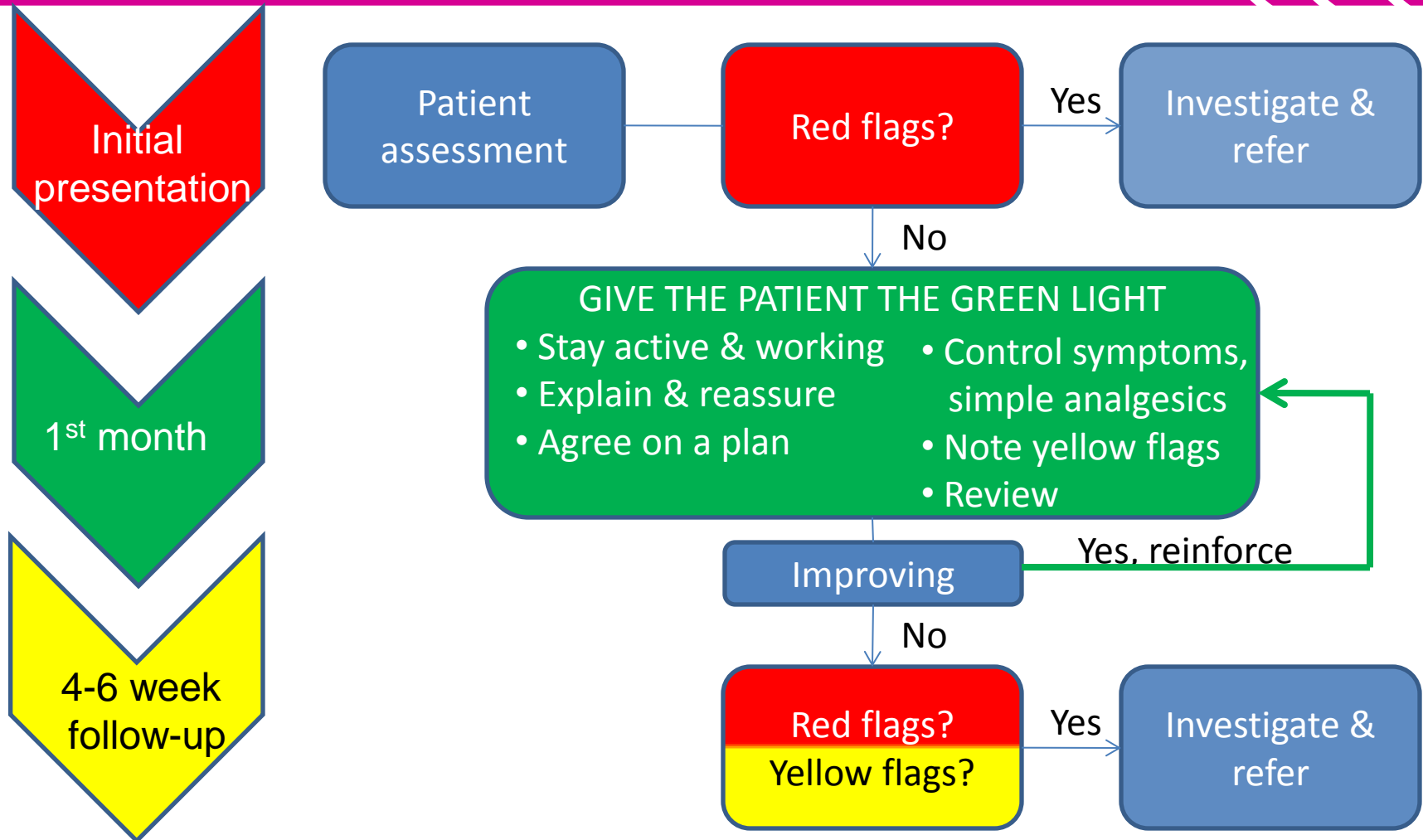
# Staying Active<sup>1,2</sup>

Advise the patient to stay active!

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



# Managing Acute LBP<sup>1</sup>



# Case Study 1



## Acute LBP



# Background

- 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



# TRAMADOL

- 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)<sup>1,2</sup>

# 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

Dr Arun Aggarwal

RPAH Pain Management Centre

Private Rooms – Rozelle and Hornsby

# 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

Nerve root	Weakness	Altered sensation	Altered reflexes
L2	Iliopsoas – Hip Flexion with Hip Flexed	Groin	None
L3	Quadriceps – Hip flexion	Anterior & lateral thigh	Knee
L4	Ankle dorsiflexion (heel-walking)	Medial leg and ankle	Knee
L5	Great-toe dorsiflexion	Dorsum of foot	None
S1	Ankle plantar flexion (toe-walking)	Lateral sole of foot	Ankle

# Observing Back Pain





# Discussion Point



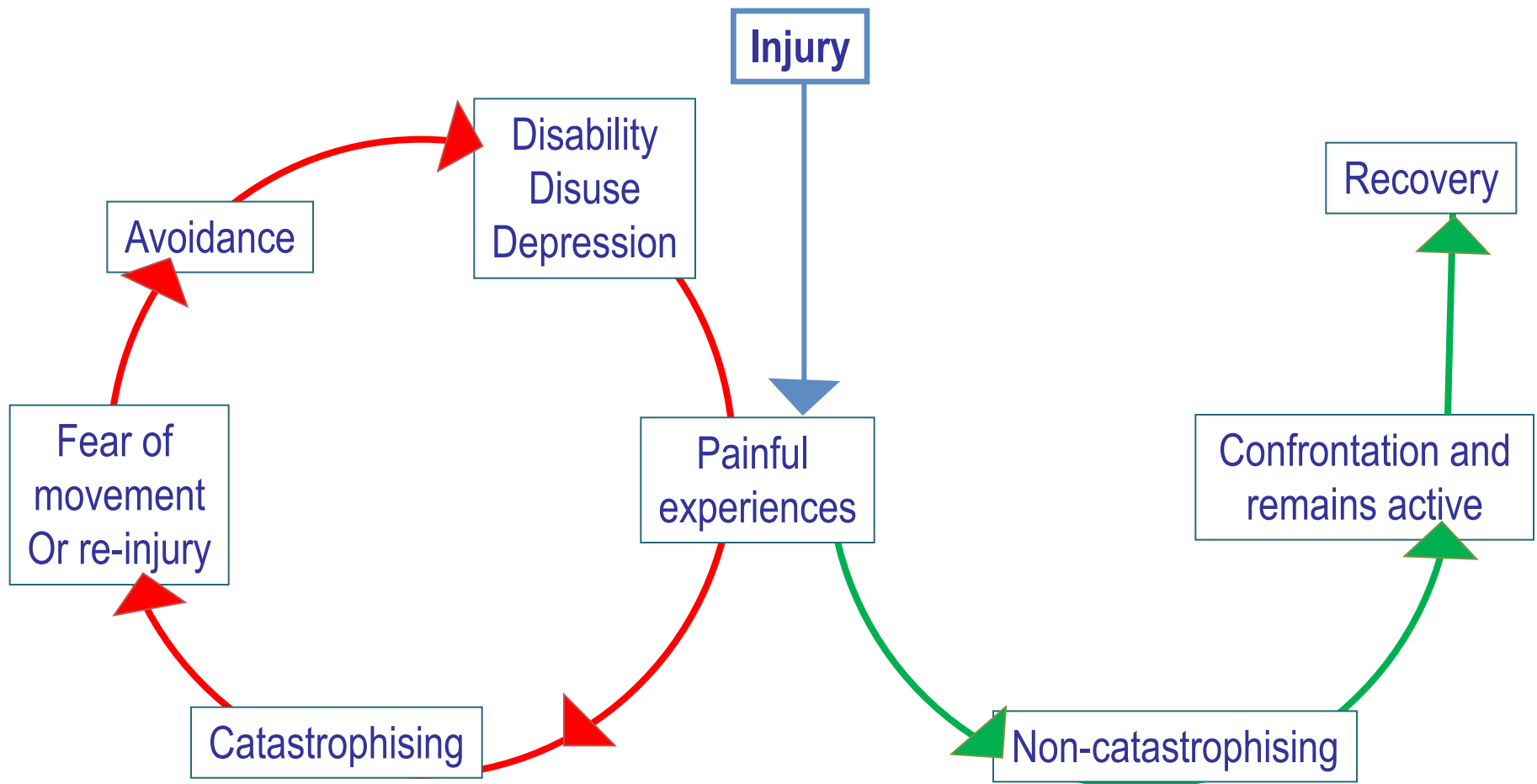
*What is the role of imaging in patients with persistent back pain?*

# INVESTIGATIONS



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

# Cognitive-Behavioural Model of Fear of Movement or (Re)Injury<sup>1</sup>



# Psychosocial Yellow Flags<sup>1</sup>



## Work

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

## Beliefs

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

## Behaviours

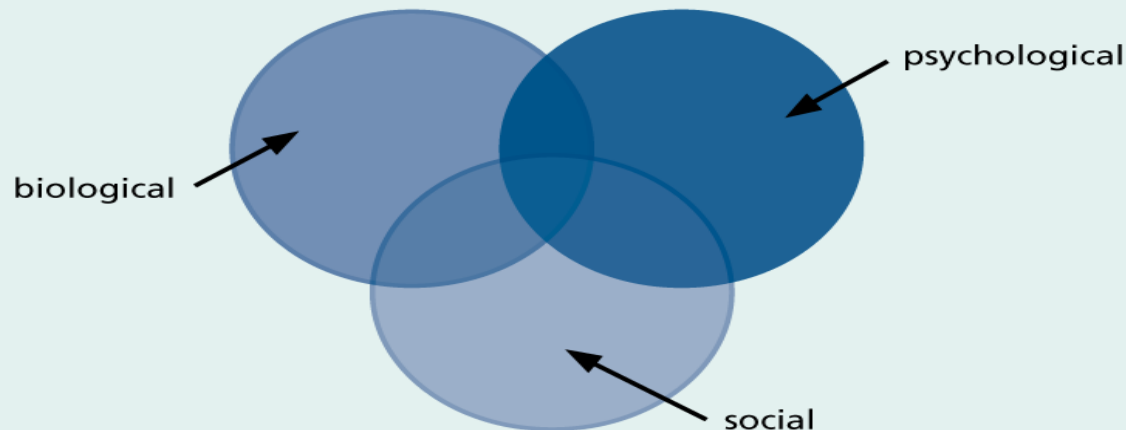
- Passive attitude to rehabilitation
- Use of extended rest
- ↓ activity
- Avoidance of normal activities
- ↑ alcohol consumption

## Affective

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

# 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<sup>1</sup>



- Low impairment & disability
  - Exercise
  - Medications
  - Brief interventions
- More severe disability
  - Multidisciplinary approach
  - Biopsychosocial
  - Realistic goals<sup>2</sup>

# 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".



# NOCICEPTIVE PAIN



- 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

# NEUROPATHIC PAIN

- “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.**

# Stepped Approach to Analgesia<sup>1</sup>

## 1. Start with simple analgesics

- Paracetamol
- NSAIDs or COX-2's

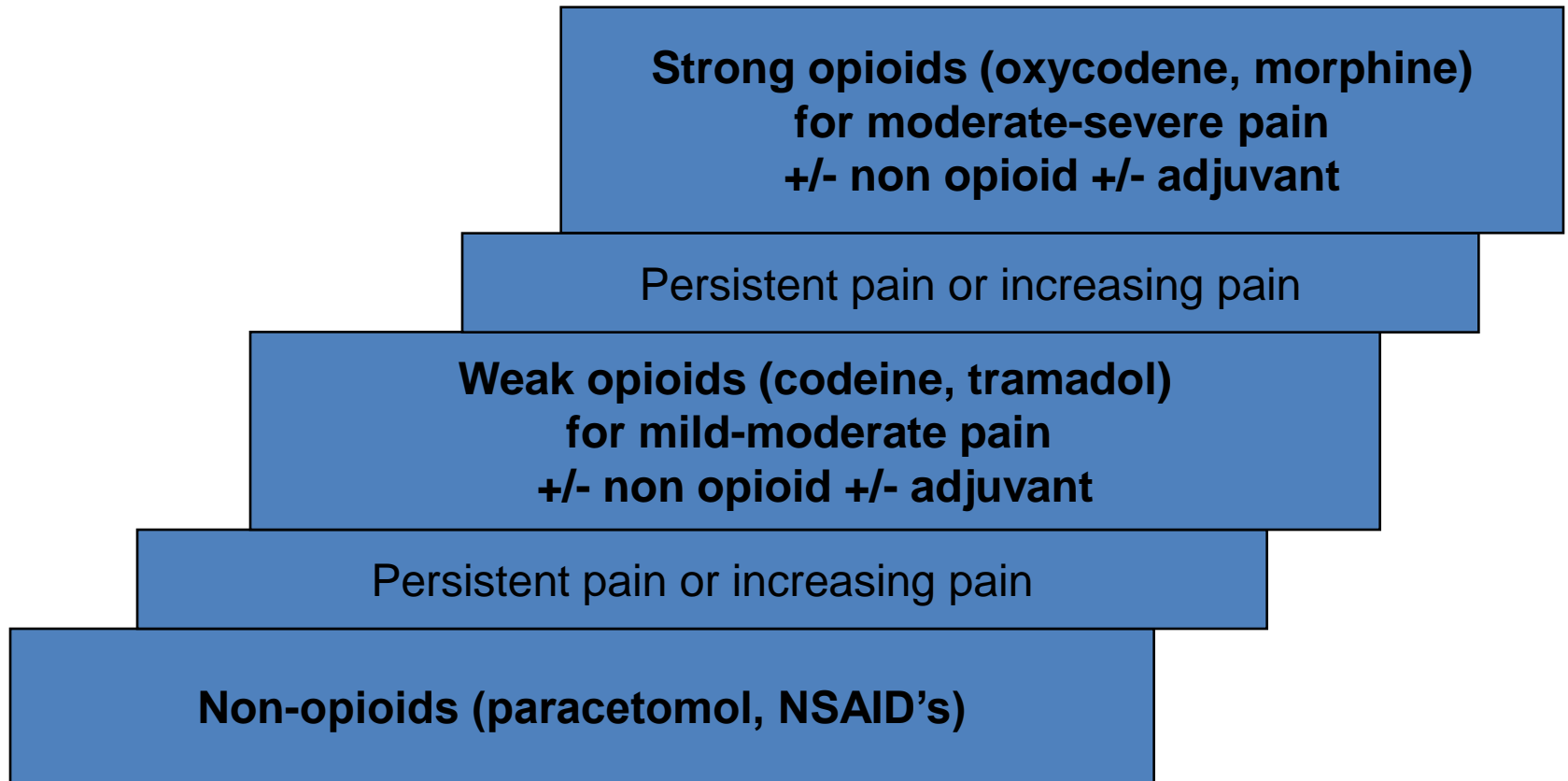
## 2. Add adjuvants

- TCA and AED's

## 3. Trial opioids

- Selected patients

# WHO Analgesic Ladder (generally for nociceptive pain)



# Pharmacological Treatments



Initial Analgesic options	<ul style="list-style-type: none"> <li>• Paracetamol (1000mg qid)</li> <li>• Paracetamol + codeine (2 x 500mg/30mg qid)</li> <li>• Tramadol Quick Acting Capsules (50mg qid)</li> </ul>
Pain lasting > 5 days	<ul style="list-style-type: none"> <li>• Tramadol SR (100-200 mg bd)</li> <li>• Duro-Tram XR (100-200mg nocte)</li> <li>• Buprenorphine patch (5-20 ug/hr weekly)</li> <li>• Oxycontin 10-20 mg bd</li> <li>• Fentanyl patch 12-25 mcg every 3 days</li> </ul>
Nocturnal Pain (TCA antidepressant)	<ul style="list-style-type: none"> <li>• Amitriptyline (10-25mg nocte)</li> <li>• Nortriptyline (10-25mg nocte)</li> <li>• Doxepin (25-50mg nocte)</li> <li>• Clonazepam (0.25-0.5mg nocte)</li> </ul>
Daytime Pain (Adjuvant AED)	<ul style="list-style-type: none"> <li>• Epilim (200-400 mg bd)</li> <li>• Gabapentin (100 – 600 mg tds)</li> <li>• Pregabalin (25-300 mg bd)</li> <li>• Duloxetine (30-60 mg mane)</li> </ul>



# Therapeutic Interventional Techniques<sup>1</sup>

## 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

\* Not evidence based

## 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

# 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

# A Multidisciplinary Approach<sup>1</sup>



- 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

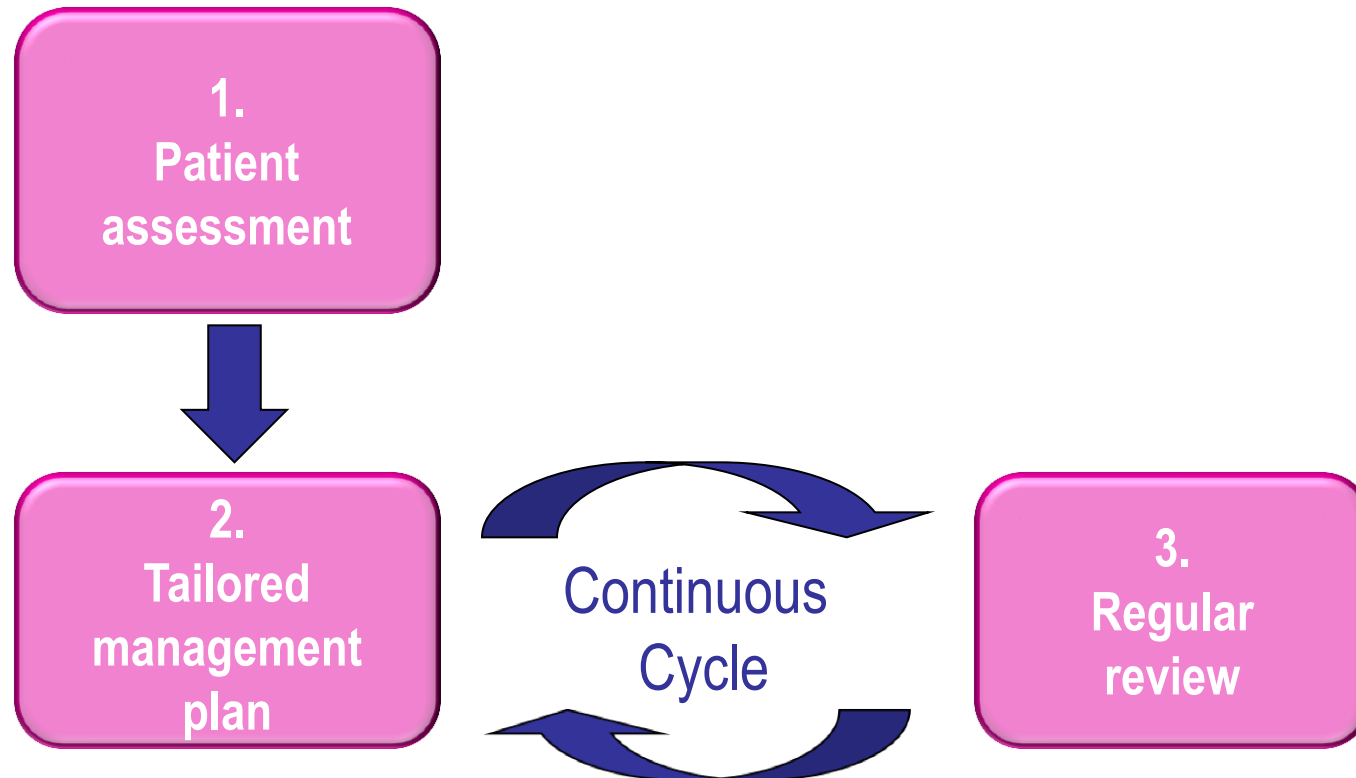
# Quality Use of Opioids

Dr Arun Aggarwal

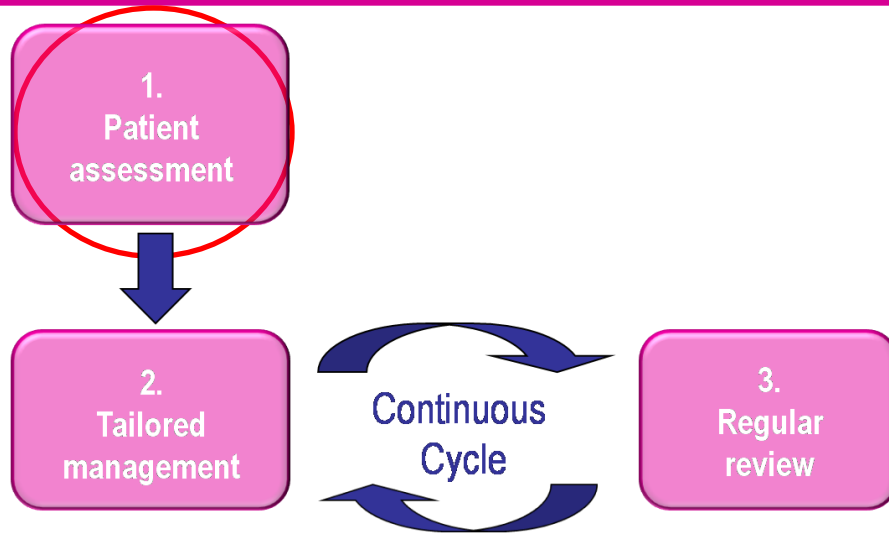
RPAH Pain Management Centre

Private Rooms – Rozelle and Hornsby

# Systematic Approach



# 1. Patient Assessment<sup>1,2</sup>



- i. Biopsychosocial pain assessment
- ii. Assess risk of problematic opioid use
- iii. Appropriate patients for opioids

- Unresponsive to trials of conservative therapies<sup>1,2</sup>
  - Non-pharmacologic and pharmacologic
- Exclude Neuropathic pain
  - TCA and AED's
- Concordance between pathology and observed pain behaviour
- Benefits > risks<sup>2</sup>
  - Psychologically stable

# Aberrant Drug Related Behaviour<sup>1</sup>



## 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<sup>1</sup>



- Opioid treatment accepted for nociceptive LBP
- True prevalence of substance abuse not known<sup>1</sup>
- Absence of Australian data<sup>2</sup>
- In LBP, the prevalence of aberrant behaviour ranges from 5% to 24%<sup>1</sup>
- No single factor can predict risk, so universal precautions required<sup>3</sup>

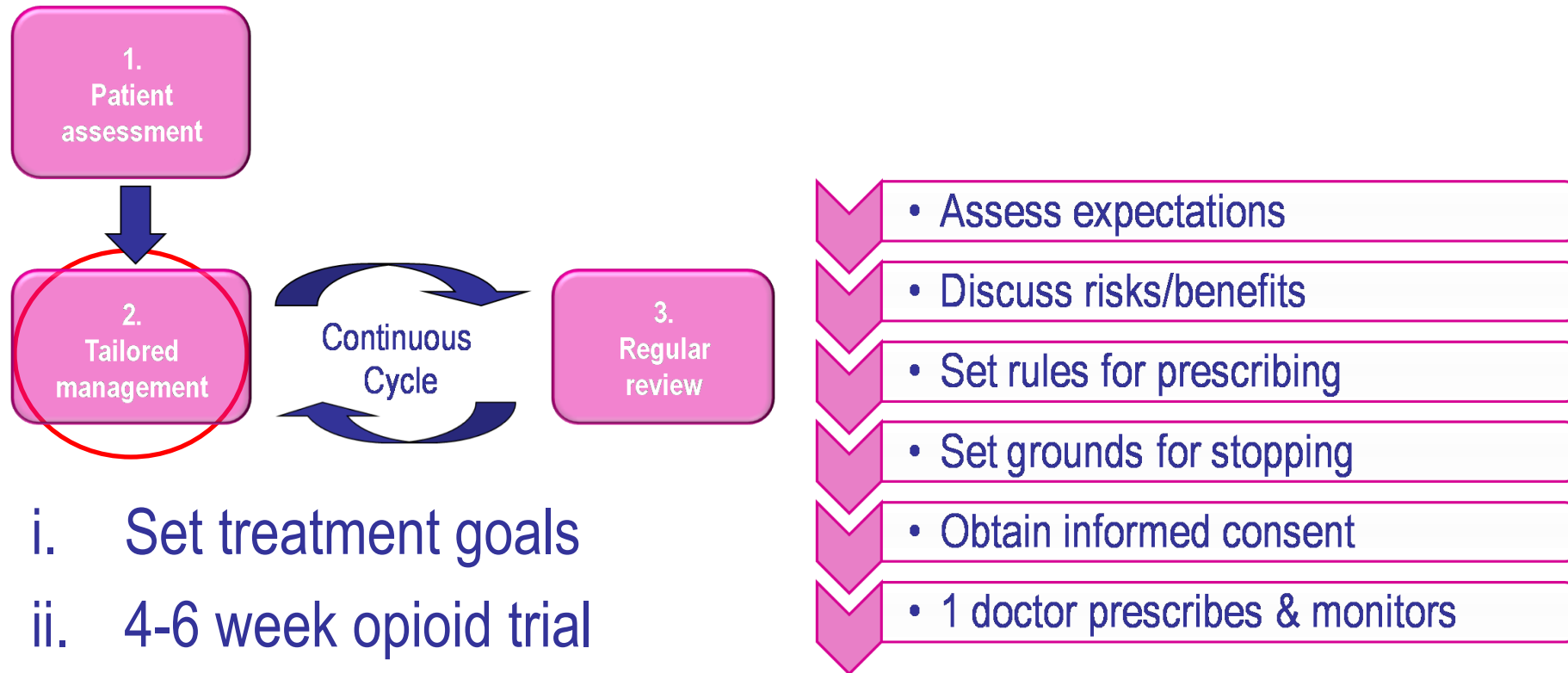


# Opioid Risk Tool (Appendix 2)<sup>1</sup>

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

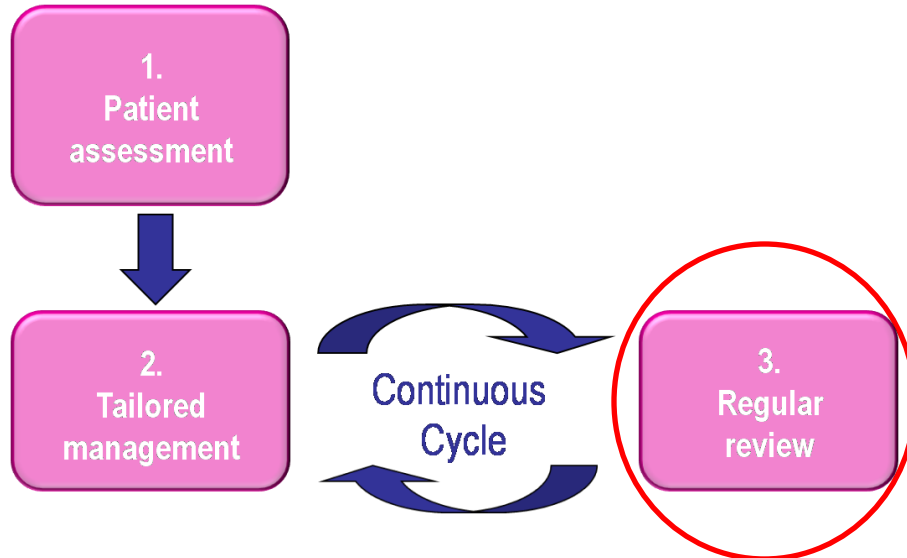


## 2. Appropriate Management<sup>1,2</sup>



- i. Set treatment goals
- ii. 4-6 week opioid trial
  - Opioid one part of multimodal treatment
- iii. Assess versus goals

# 3. Patient Review<sup>1</sup>



- i. Regularly assess 4 + 2As<sup>1,2</sup>
- ii. Periodically review pain diagnosis

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

# Opioid Trial Outcomes



## Successful Trial

- Positive progress vs. treatment goals improved function
- Medication used responsibly



- Discuss risk/benefits of continuing therapy<sup>1,2</sup>

## Unsuccessful Trial

- Pain unresponsive
- Evidence of aberrant drug behaviours



- Taper & cease opioid
- Continue other physical & psychological therapies
- Consult pain specialist

# Opioid Titration<sup>1</sup>



- 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

# Morphine Equivalent Dosages

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<sup>1-3</sup>

**Approximate opioid conversions:**<sup>4-9</sup>

## Oral Dose

morphine : oxycodone	<b>1.5-2 : 1</b>
morphine : methadone*	<b>3 : 1</b>
morphine : hydromorphone	<b>5-7.5 : 1</b>
morphine : tramadol	<b>1 : 5</b>
morphine : codeine	<b>1 : 6</b>

\* For morphine doses < 100mg/day

## Transdermal dose

TD buprenorphine 5mcg/hr	<20mg
TD buprenorphine 10mcg/hr	20-45mg
TD buprenorphine 20mcg/hr	46-90mg
TD fentanyl 12	<60mg
TD fentanyl 25	60-134
TD fentanyl 50	135-224
TD fentanyl 75	225-314
TD fentanyl 100	315-404

1. Goucke CR and Visser EJ. 2008. 2. Opioid Use in Persistent Pain (HIPS) 3. Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: Washington State Agency Medical Directors' Group 2007. 4. NORSPAN® patch Product Information (2009).

5. The RACP. Prescription Opioid Policy (2009). 6. Durogesic Product Information (2008).

7. OxyContin® tablets Product Information (2009). 8. Dilaudid Product Information (2009). 9. Jurnista Product Information (2009).

# Maximum Dosage Recommendations in General Practice (HIPS) <sup>1</sup>

- 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 (3<sup>rd</sup> 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<sup>1</sup>

- 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

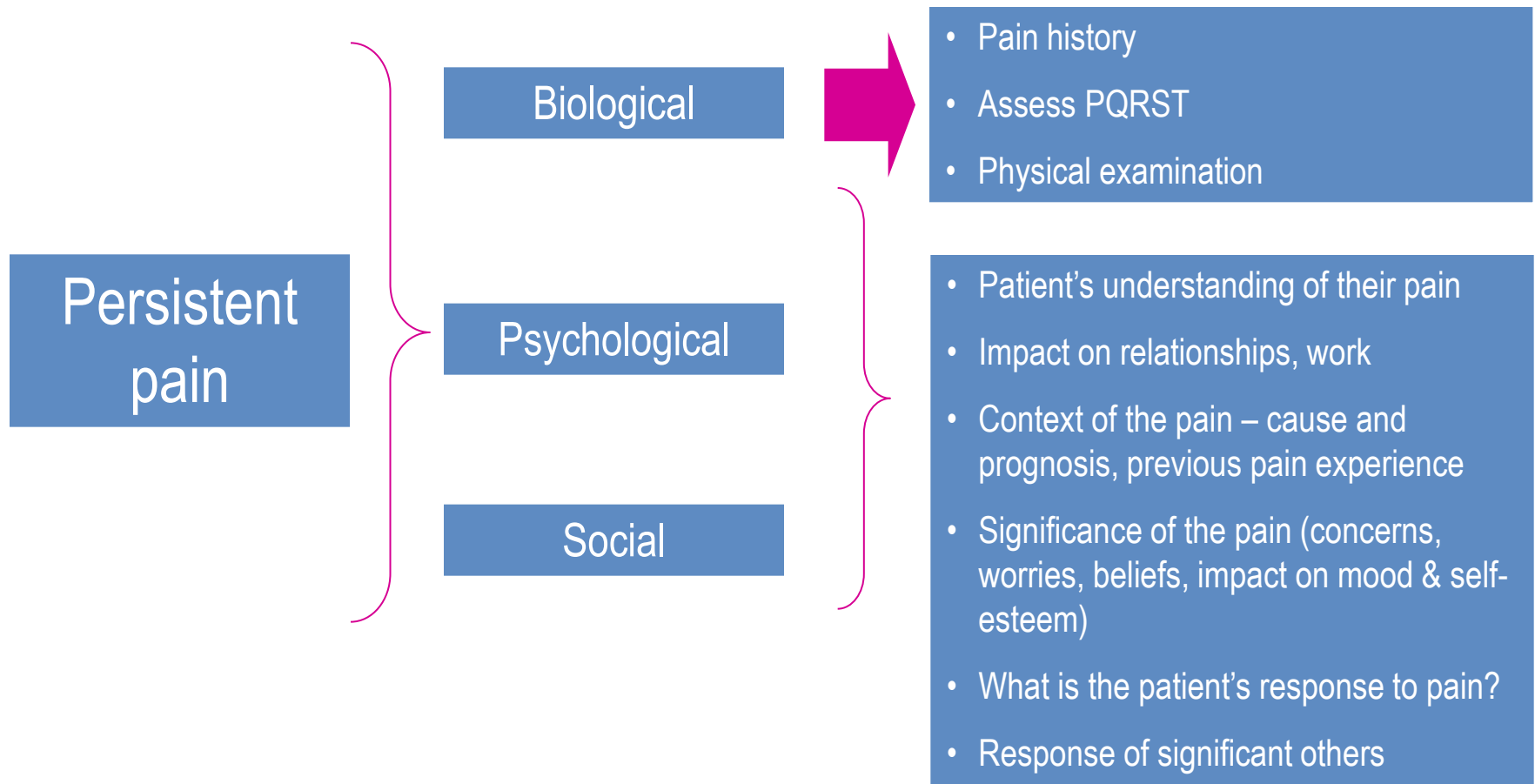
Ms LS, a 50 year old  
primary school teacher  
Divorced for 7 years



# Background

- 2-year history of persistent non-specific LBP
  - Non work-related lifting injury
- No red flags
- Mod degenerative changes, L<sub>5</sub>S<sub>1</sub> 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<sup>1</sup>



# Assessing Ms LS's Pain



<b>P</b> rovoking factors	Prolonged sitting/standing Tolerance 15-20/5-10 minutes
<b>Q</b> uality of the pain	Severe dull aching pain
<b>R</b> egion, <b>R</b> adiation	Pain localised to lower lumbar spine
<b>S</b> everity	Current pain 7-8/10
<b>T</b> iming	Pain is present 24 hours a day Marked sleep disturbance

# 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?

Factor	Males	Females
Family history of substance abuse		
- Alcohol	<input type="checkbox"/> 3 points	<input checked="" type="checkbox"/> 1 point
- Illicit drugs	<input type="checkbox"/> 3 points	<input type="checkbox"/> 2 points
- Prescription drugs	<input type="checkbox"/> 4 points	<input type="checkbox"/> 4 points
Personal history of substance abuse		
- Alcohol	<input type="checkbox"/> 3 points	<input type="checkbox"/> 3 points
- Illicit drugs	<input type="checkbox"/> 4 points	<input type="checkbox"/> 4 points
- Prescription drugs	<input type="checkbox"/> 5 points	<input type="checkbox"/> 5 points
Aged between 16 and 45	<input type="checkbox"/> 1 point	<input type="checkbox"/> 1 point
History of preadolescent sexual abuse	<input type="checkbox"/> 0 points	<input type="checkbox"/> 3 points
Psychiatric disease		
- Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	<input type="checkbox"/> 2 points	<input type="checkbox"/> 1 point
Depression	<input type="checkbox"/> 1 point	<input type="checkbox"/> 1 point

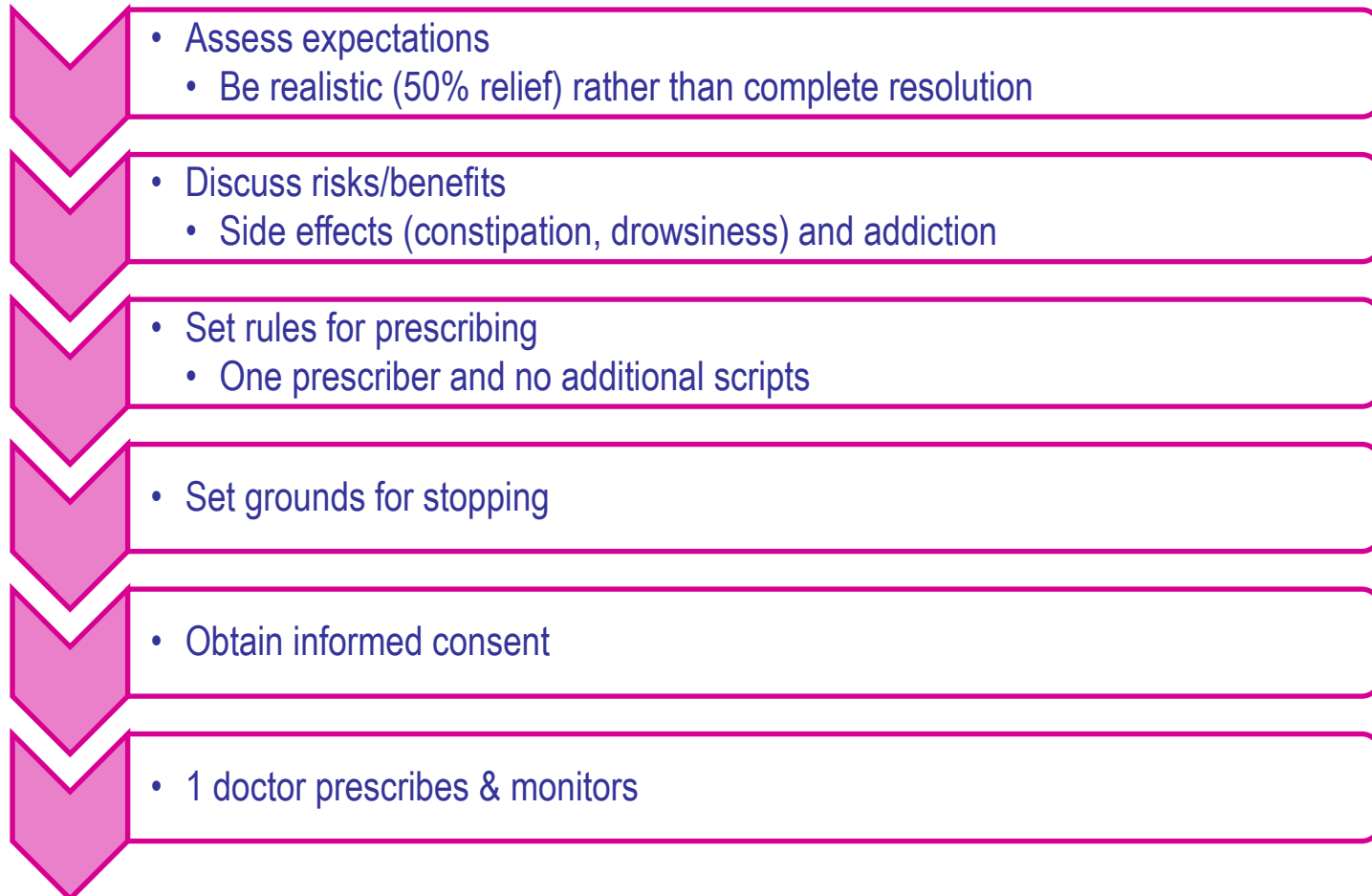
8+  
HIGH  
RISK

4-7  
MODERATE  
RISK

0-3  
LOW  
RISK

1 low  
risk

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





# Setting Treatment Goals

- Informed consent<sup>1</sup>
- Criteria for ongoing use<sup>1</sup>
- 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

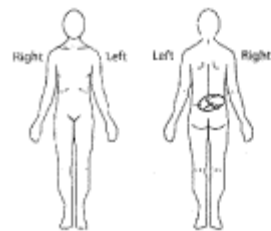
## THE BRIEF PAIN INVENTORY

Date: 1/1/12 Patient: M L S First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Time: 10:00 Last: \_\_\_\_\_

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday aches of pain today? 1. yes 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?  
Buprenorphine 5 pg/hr patch

8) In the past 24 hours, how much RELIEF have pain treatments or medications provided? Please circle the one percentage that most shows how much.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%  
No relief Completely relief

9) Circle the one number that describes how, during the past 24 hours, PAIN HAS INTERFERED with you:

A. General Activity

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere Completely interferes

Pain Research Group, Department of Neurology, University of Wisconsin-Madison.  
May be duplicated and used in clinical practice.

# 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

## THE BRIEF PAIN INVENTORY

Date: 7/7 Patient: Ms. L.S.  
Time: WEEK Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  
☒ 1. yes ☐ 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?  
Buprenorphine (5+10) µg/hr patches

8) In the past 24 hours, how much RELIEF have pain treatments or medications provided? Please circle the one percentage that most shows how much.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%  
No Complete relief

9) Circle the one number that describes how, during the past 24 hours, PAIN HAS INTERFERED with your:

A. General Activity

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

B. Mood

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

F. Sleep

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10  
Does not Completely interfere  
interfere

Pain Research Group, Department of Neurology, University of Wisconsin-Madison.  
May be duplicated and used in clinical practice.

# 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?*

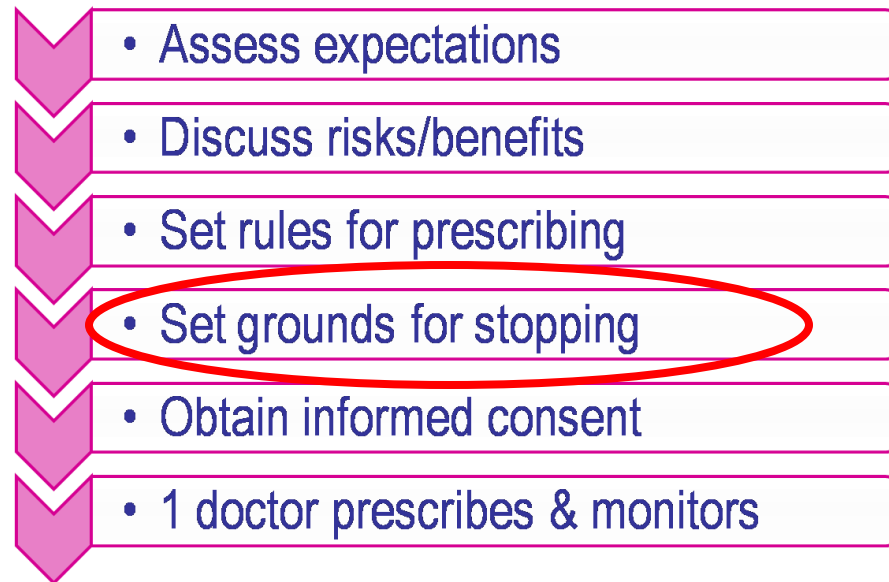


- Potential to trial ceasing the opioid

- 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



# 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



# PAIN CLINICS

- **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**
  - 1<sup>st</sup> 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<sup>1</sup>

- 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.*

© 2010

*According to the Professor, it is a DISEASE.”*



# Thank You

*Please complete your  
evaluation forms*



# Sponsored by Mundipharma Pty Limited

ABN 87 081 322 509,  
50 Bridge Street, Sydney NSW 2000

Before prescribing any product referred to in this education programme please refer to the approved Product Information and State and Federal regulations

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

Sponsored by:  
Mundipharma Australia

Committed to General  
Practitioner Education

