

# Chronic Pain Conundrums in Primary-Care Practice



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Release Date: **July 14, 2007**

## Challenges & Frustrations

Pain is one of the most challenging and frustrating issues for most primary-care providers to deal with in their patients. Partly, this is because pain is a subjective symptom, not an objective sign. A physical examination or diagnostic test cannot measure its intensity, its exact duration, or, in many cases, its precise location. The patient often is unable to express the quantity or even the quality of his or her pain in words or on a rating chart.

Nevertheless, pain is the most common complaint that brings patients to private practice offices, outpatient clinics, or emergency rooms. When pain is *acute*, it is usually relatively easy to determine a cause – a car crash or other accident, a fall, a “hot” appendix, a kidney stone, a viral syndrome, or the like. Once a diagnosis is made, a plan of treatment can be developed and carried out. In a fairly short period of time, the patient either recovers and the pain is resolved or does not recover.

But when pain is *chronic* – having been present for months to years, and a variety of efforts have failed to relieve it – the picture is very different. In such cases the healthcare provider might ask, “Why are you here today?” And the patient answers, “My back hurts. My leg hurts. I’ve been hurting for 2 years. You probably can’t help me either.”

The healthcare provider charts: “Chief complaint... pain in lower back with radiating pain down back of right leg x 2 yrs.” However, he or she may think, “Oh, brother, another chronic low back pain patient/victim!”

There are several challenging reasons for such thoughts:

- Since we do not have a good understanding of the pain symptom, the diagnosis is often unclear and difficult to pin down. Presumably, the previous healthcare professionals have already tried the usual remedies without success
- Practitioners have been taught to be suspicious of pain complaints, and reluctant to prescribe opioid pain medication due to concerns about drug seeking patients or addiction, and fears about surveillance by the DEA and state drug enforcement authorities that could endanger the healthcare provider’s ability to continue practicing. This widespread reluctance to consider the use of opioid analgesics in the treatment of pain has been referred to as “opiophobia” [Tennant 2007].
- Patients who have been in pain for extended periods without sustained relief and who have put their hopes in each new practitioner, only to be disappointed again, develop the demeanor of helpless victims or help-rejecting complainers.



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- Many healthcare providers have unconscious or conscious beliefs about pain that affect their reactions to patients' complaints (discussed below).

## Difficult Diagnoses

Talking with a patient about pain involves skills that many healthcare providers have not been taught, and which most do not, indeed cannot, take the time to use in this era of the 15-minute appointment. To elicit a clear appreciation of a patient's symptoms, one must encourage the patient to talk about his or her experiences and carefully listen to what is being said.

A thorough history-taking of what the patient has tried already to relieve the pain or what he or she has discovered makes the pain better or worse is essential. A complete physical examination including extensive range of motion assessments with attempts to elicit and ameliorate the symptoms is also necessary. Additionally, it is very important for the healthcare provider to know as much as possible about the patient's life situation, such as stressors or losses (eg, employment, relationships, daily activity) both due to the pain and coinciding with the pain. Are there signs of depression, anxiety, and/or suppressed anger? Was the patient's pain initially the result of an injury, and did this involve both physical and emotional trauma that may have led to symptoms of a post traumatic stress disorder?

Another critical aspect of the history is the patient's prior experience with pain medication, including opioids, as well as with other substances that stimulate the dopaminergic reward pathways and might have addictive potential. An estimate of the patient's risk of developing problems with prescribed pain medication needs to be made and discussed openly with the patient prior to implementing any plan of pain treatment. Assessing such risk is complicated by several factors, including patients' reluctance to be open about past and present substance use, clinicians' lack of familiarity with appropriate tools for screening for substance use disorders, and conflicting data in the literature about the risks involved in prescribing daily opioids.

A recent large study of patients receiving opioid therapy for chronic noncancer pain in primary care settings that used standardized assessment tools and DSM-IV criteria found that these patients had a greater frequency of opioid-use disorders as compared with the general population [Fleming et al. 2007]. This is a strong endorsement of careful patient screening before initiating opioid therapy, and for taking special precautions for those patients found to be at high risk.

An additional area requiring a thorough examination by healthcare providers is their own attitudes and beliefs about the nature and meaning of pain. How has one been taught to think about pain? Is it simply an indicator of disease or injury? A warning sign that all is not well with the body? Or, is it also a signal that one has somehow violated the rules of society, angered the gods, accrued bad karma, done something for which punishment is warranted? Is pain an opportunity to learn important lessons about life's meaning? Do people who ardently seek relief from pain lack courage, moral stamina, or will power? Do some people (such as addicts) actually deserve to hurt? [See, Goldberg 2000; Meier et al. 2001.]

## Overcoming "Heart-Sink Reactions"

Most practitioners would deny that they make value judgments about patients, and many are not conscious of doing so. After all, they chose a career in medicine to help people, right?

But observations of practitioners' responses to patients in pain tell a different story. And many primary-care professionals will recognize in themselves the so-called "Heart-Sink Reac-

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tion” when noticing that a particular patient is on the appointment schedule that day or is waiting in the exam room [Isaacson et al. 2005]. This is a sinking feeling in the chest or gut, a powerful wish that one had not come to work that day, a silent prayer for patience, and a strong conviction of one’s own powerlessness. For most healthcare providers, the “Heart-Sink Reaction” is frequently elicited by patients with chronic pain.

Some practical suggestions can improve overall management of these patients in the primary-care setting and help to identify who needs referral for specialty consultation and treatment. [For additional suggestions, see: Webster and Dove 2007; Ziegler 2007.]

- When it is known that a new patient is presenting with a complaint of chronic pain, schedule a longer initial appointment or an extended visit with intake staff – eg, nurse, physician assistant, nurse practitioner – to carefully review the patient’s history, get releases for medical records from previous providers, document all medications, and conduct a thorough physical examination. Using standardized risk assessment tools, some of which the patient can self-administer by paper and pencil or on a computer in the office, to determine the patient’s history of substance abuse and risks of misuse or addiction with opioid pain medication can save time and improve accuracy of prediction.
- Develop a written Treatment Plan (sometimes called an “Agreement” or “Contract”) for pain management, which should include medications to be prescribed, appointments to be scheduled with the physician or other practitioners, participation in support groups, and other requirements.
- Emphasize that successful control of chronic pain requires a team effort [Ziegler 2005]. When the Treatment Plan is approached in this manner, it is less threatening and derogatory to the patient than asking her or him to sign a Contract or Agreement for medication monitoring, even though the intent is similar.
- Use non-opioid medications, referrals for physical therapy, complementary treatments (acupuncture, massage, meditation, therapeutic touch, etc.), and focused group therapy along with opioids to improve the likelihood of treatment adherence and symptom improvement. Include all of these approaches in the Treatment Plan.
- The Treatment Plan also should include a statement of goals, including both reduction of pain and improvement of function. Copies of the Plan should be given to the patient, placed in the medical record, and, when indicated, given to family members designated by the patient.
- Review with the patient all healthcare-provider expectations (rules) for pain treatment, which should include:
  - ◆ no replacements for lost or stolen prescriptions or pills,
  - ◆ no early medication refills,
  - ◆ all prescriptions are to be written only by professionals at one medical practice,
  - ◆ all prescriptions are to be filled at only one pharmacy as designated by the patient but which has extended hours,
  - ◆ no visits to the emergency room without prior authorization,
  - ◆ a professional from the practice will be on call at all times – there should be no reason to contact other prescribers for pain treatment or medication,

*Schedule added time and plan extensive assessments of new patients with chronic pain.*

*The successful treatment of chronic pain requires a team effort.*

- ◆ periodic urine drug screens for the medications being prescribed and for other substances not being prescribed which could complicate the patient's treatment.
- If the patient does not improve, cannot adhere to the Plan, or is continuing to report severe pain despite apparently improved function or high doses of opioids, a meeting of all treatment providers is indicated to determine appropriate changes that need to be made and/or the necessary referral(s) for the patient. These referrals could include...
  - A. Referral to a pain specialist or pain treatment center for assessment of further therapies that might be attempted [also see side note]. Such a referral may result in the patient returning to the primary-care setting with recommendations for modifications of the Treatment Plan, or the patient may continue treatment with the pain specialist or center. This decision depends on the nature of the treatment recommendations, the patient's preferences, and/or the primary-care practitioner's preference.
  - B. Consultation with an addiction psychiatrist or other addiction/ mental health professional to assess possible development of a substance use disorder (SUD), relapse of a prior SUD in remission, and/or presence of a previously unrecognized psychiatric disorder. Based on the results and recommendations of this consultation, the Treatment Plan might be modified in several ways:
    - referral for treatment of the SUD while continuing with the pain management treatment within the primary-care setting,
    - referral to the addiction psychiatrist for management of both the SUD and the chronic pain, with or without additional psychiatric complications,
    - referral to a specialized residential program for persons with addiction and chronic pain, with continuing-care planning to be determined by the treatment team at the specialized center.

**Editor's Note:** According to a recently reported survey [Breuer et al. 2007], there are only an estimated 6 board-certified pain specialists per 100,000 adults in the US with chronic pain. Such practitioners are under-represented in rural areas and only 96% of all pain specialists treat chronic pain conditions.

*This implies that, realistically, fewer than half of patients with chronic pain could get an appointment to see a specialist in any year. Thus, there may be a burden on primary care practitioners to manage chronic pain on their own, especially in less populated regions of the country. –SBL*

When approached in this systematic manner, with written, structured Treatment Plans and clearly stated expectations, most patients with chronic pain disorders can be treated effectively in the primary-care setting, and the primary-care professional will find much satisfaction in working with them. In addition, exit strategies are in place for those patients who need joint management by their primary-care provider and a consultant in either addiction medicine or pain medicine, or who will do better when referred outside for specialty treatment.

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**PAIN TREATMENT  
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Published by...

*Pain Treatment Topics*  
202 Shermer Road  
Glenview, IL 60025

<http://www.Pain-Topics.org>

Supported by an unrestricted educational grant from Mallinckrodt Pharmaceuticals, St. Louis, MO, USA.

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