



Guidelines for the Medical Management of Chronic Pain

According to the International Association for the Study of Pain, pain is defined as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.” Chronic pain persists beyond the usual period of healing after injury frequently causing significant physical, psychological, and social disability. It is estimated that more than 60 million people in the United States suffer from persistent or recurrent pain sufficiently intense to adversely impact their lives. Chronic pain causes untold physical and emotional suffering and costs billions of dollars each year in lost productivity, lost income, and increased health care and disability costs.

These guidelines have been created by an interdisciplinary group convened by the Medical Society of Delaware, and are intended to assist primary care physicians and other clinicians in their assessment and treatment of patients with chronic pain. These guidelines consider chronic pain to be multi-dimensional and so advocate an interdisciplinary approach to pain management. Also, these guidelines are not all inclusive but meant to be flexible and practical in application. Other states have completed similar consensus documents, and we recognize their work as being a key contributor to this effort in Delaware.

Key elements of this consensus statement include the importance of an open approach to the patient with chronic pain, with consideration of the multiple causes of and reasons for maintenance of pain; careful documentation and communication among treating professionals; and development of a clear treatment plan that emphasizes patient responsibility and self-management skills. Consultation with specialists in pain medicine, addiction medicine, anesthesiology, psychology, psychiatry, physical medicine and rehabilitation, surgery or other disciplines may be used and should be incorporated into the patient’s treatment plan.

The diagnosis summarizes assessment findings into a coherent statement that identifies the type and scope of the problem. As chronic pain affects multiple dimensions of life, the diagnostic impression should comment on all of these. Diagnosis is important but treatment during the course of establishing a diagnosis is equally important.

The components of a multidimensional pain diagnosis include:

- Primary ICD-9 diagnoses (ICD-9)
- Medical comorbidities when present
- Psychiatric comorbidities when present; multiaxial (DSM-IV) diagnosis where pertinent
- Impact of pain on function

Pain can be described and classified by a variety of different characteristics. Analysis of these characteristics can then guide the differential diagnosis, most appropriate diagnostic testing, and rational choices for treatment. The International Association for the Study of Pain has described several of these diagnostic classifications and the clinician should refer to these for more detail¹:

- Chronicity
- Temporal Characteristics: e.g. continuous, fluctuating, paroxysmal, associations with activity or specific positions or actions (sleep, walking, meals, urinating etc.)
- Anatomical Location: Region or Anatomical System
- Characterologic:

Somatic Nociceptive: Localized, sharp, aching and/or throbbing with pressure.

Neuropathic: Burning, shock-like, tingling.

Visceral nociceptive: Commonly diffuse, often difficult for the patient to describe. Squeezing, gnawing, cramping, dull, sharp, aching.

Etiology

- Trauma
- Infective
- Inflammatory, immune
- Psychological Origin (no physical/pathophysiological mechanism is evident, an etiology of exclusion)
- Dysfunctional (e.g. migraine, irritable bowel, tension headache)
- Toxic, Metabolic
- Degenerative Mechanical
- Congenital
- Neoplasm (*increasing or persistent spine pain in a patient with a cancer diagnosis should be considered to be likely metastatic in origin, and potentially at risk of creating cord compression, until MRI/CT demonstrates otherwise)

The differential diagnoses for a painful condition may be extensive. Treatable and reversible etiologies should be ruled out. Rational management of severe pain should proceed while the diagnostic workup is underway.

¹ Mersky H., Bogduk N. (1994) Classification of Chronic Pain Descriptions of Chronic Pain Syndromes and Definition of Pain Terms (2nd ed.). IASP Press, ISBN#0-931092-05-1.

Key Elements of the Initial Chronic Pain Assessment

History:

- History of present pain complaint including: location, chronology, intensity (via verbal, visual or other scale), duration, radiation, aggravating, relieving factors, additional symptoms (motor, sensory and autonomic).
- Past treatments with noted successes/failures including surgery, injections, modalities and physical therapy. (Visual Analog Scales before and after.)
- Current medications including benefits and side effects. (Visual Analog Scales before and after.)
- Previous medications including benefits, side effects and reasons for discontinuation.
- Functional Assessment
- Past medical and surgical history. Co-morbidities- Medical and psychological
- Family history of chronic pain states and related disorders; e.g. Celiac Sprue
- Psychosocial Assessment
 - Ability to use pain scale, pain log appropriately
 - Ability to manage breakthrough medications appropriately
 - Social support system
 - Psychological: Assess for pre existing or pain related depression and/or anxiety
- Vocational and Legal Issues

Physical Exam: general, spinal, musculoskeletal, neurological, joint, muscular, palpation and provocative testing (key to correlation of subjective complaints with objective physical examination).

Diagnostic Studies:

- Radiological, laboratory and electro diagnostic testing as indicated by history and physical examination
- Psychological assessment tools

Assessment and Diagnosis:

- Establish a specific presumptive and differential diagnosis based on History, Physical Exam, and studies

Treatment Plan:

- Initiate Treatment plan based on History, Physical Exam, and presumptive diagnosis
- Discussion with patient about patient's goals and expectations is essential to compliance

The differential diagnoses for a painful condition may be extensive. Treatable and reversible etiologies should be ruled out. Rational management of severe pain should proceed while the diagnostic workup is underway.

Key Principles in Implementing a Treatment Plan

- 1) Whenever possible, intervene early.
- 2) Identify specific and realistic goals for therapy.
- 3) Define what will be done and the time required to reach each goal.
- 4) Identify the rationale for each treatment and who will be involved.
- 5) Physician and non-physician clinician should agree upon the treatment plan and work toward the same goals.
- 6) Use a combination of therapeutic interventions to obtain the best outcome.
- 7) Document treatments and measure progress against the treatment plan.
- 8) A simple ABCDE mnemonic from the Agency for Health Care Policy and Research illustrates key elements for assessment and management (Table 1).

Table 1 ABCDE for Pain Assessment and Management

Ask about pain regularly. Assess pain systematically.

Believe the patient and family in their reports of pain and what relieves it.

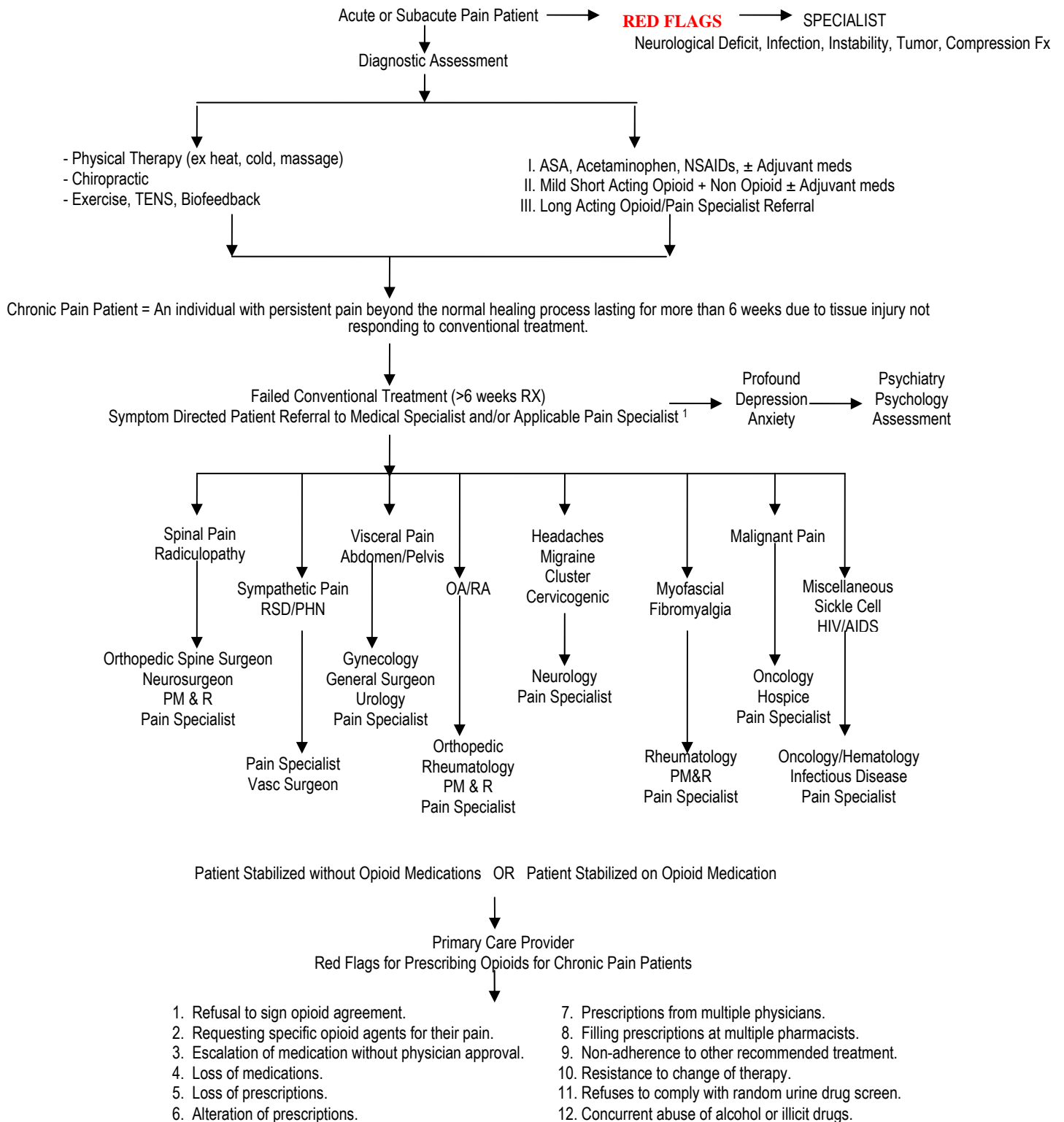
Choose pain control options appropriate for the patient, family, and setting.

Deliver interventions in a timely, logical, and coordinated fashion.

Empower patients and their families. Enable them to control their course to the greatest extent possible.

Source: Jacox AK, Carr DB, Payne R et al. Management of cancer pain. Clinical Practice Guidelines. No. 9. AHCPR Publication No. 94-0592. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services; March 1994.

Pain Treatment Protocol



See Equivalent Doses of Opioids (*Appendix B*)

¹ Subspecialties are listed in alphabetical order and do not imply a referral hierarchy, not do they reflect the comprehensive array of subspecialists that may be required to treat a patient.

Outcomes

Maintain accurate and complete records of pain treatment and its effectiveness.
Outcomes may include:

- Pain reduction (not all patients will be pain free)
- Improved physical function—ability to perform various activities and exercises
- Improved psychosocial function—resumption of family/home roles, activities of daily living, activities outside the home
- Improved sleep
- Reduced depression or anxiety
- Return to work or resumption of full duty work or with restrictions (where applicable)
- Change in medication use—decreased use, or appropriate use of effective medications to improve function
- Increased ability to self-manage residual pain and related problems
- Reduced utilization of pain-related health care services – fewer clinic or emergency visits, fewer phone calls, improved self-reliance
- Resolution of medical legal claims by providing information to assist in “case closure”

Pain outcomes can be difficult to quantify, as many of them are most easily measured in terms of qualitative statements, e.g. “I feel better.”

- Pain intensity can be assessed with a numeric scale (0-10) or other validated, reliable rating scale(s).
- Functional improvement is more difficult to quantify, but can be measured. Whenever possible, pain treatment outcomes should be assessed on the basis of objective measures of function, e.g., physical capacity ratings (lifting, bending, carrying, walking speed). The American Medical Association (AMA) released the first edition of its *AMA Guides to the Evaluation of Permanent Impairment* in 1971. The fifth edition is currently available.

SMART Goals

Specific

- ~ Well defined
- ~ Clear to anyone that has a basic knowledge of the project

Measurable

- ~ Know if the goal is obtainable and how far away completion is
- ~ Know when it has been achieved

Agreed Upon

- ~ Agreement with all the stakeholders what the goals should be

Realistic

- ~ Within the availability of resources, knowledge and time

Time Based

- ~ Enough time to achieve the goal
- ~ Not too much time, which can affect project performance

Follow-up and Monitoring

Interim Medical History to include:

- Review of presenting and current painful areas and levels
- Response to initial interventions
- Functional and social improvements or lack thereof

Physical Examination:

- Focused exam including correlation of subjective reporting with objective
- Physical examination including palpation and/or provocative testing of affected areas
- Observation of functional limitations

Diagnostic Tests:

- Review of results of preliminary testing
- Follow up testing ordered as indicated

Reassess:

- Revise presumptive and differential diagnosis as appropriate

Treatment:

- Revise treatments based on physical findings and presumptive and differential diagnosis
- If patient is taking chronic opioids, the recommended visit frequency is approx every 1 – 3 months

When to Refer:

- The physician is unable to help the patient in the current situation, in which case appropriate alternate or specialty treatment is recommended.

Regulatory Issues

- Prescriptions for controlled substances in Schedules II and III:
 - will become void unless dispensed within seven (7) days of the original date of the prescription **or if the original prescriber authorizes the prescription past the seven (7) days period.**
 - cannot be written **nor dispensed** for more than 100 dosage units **or a 31 day supply whatever is the greater** at one time.
- Partial Filling
 - As an exception to dosage limitations set forth in this subparagraph, and in accordance with 21 C.F.R. Section 1306.1(b), prescriptions for controlled substances in Schedule II for patients either having a medically documented terminal illness or patients in Long Term Facilities (LTCF), may be filled in partial quantities, to include individual dosage units.
 - For each partial filling, the dispensing pharmacist shall record on the back of the prescription (or another appropriate record, uniformly maintained, and readily retrievable) the date of the partial filling, quantity dispensed, remaining quantity authorized to be dispensed and the identification of the dispensing pharmacist.
 - The total quantity of Schedule II controlled substances dispensed in all partial fillings must not exceed the total quantity prescribed.
 - Schedule II prescriptions for terminally ill or LTCF patients, shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the medication.
- Only the prescriber may communicate a verbal order to the pharmacist for a controlled substance. Electronic prescribing of controlled substances is not permitted in Delaware. Prescriptions communicated by an employee or agent of the prescriber are not valid.
- Regulation 4 (b)(2) of the Uniform Controlled Substance Regulations requires that only the prescriber may communicate a verbal controlled substance prescription to the pharmacist. Prescriptions for controlled substances communicated by an employee or agent of the prescriber are not valid. Pharmacists who are in violation of this requirement are subject to discipline by either the Board of Pharmacy and/or the controlled substance administrator.
- Patients should sign and follow medication agreements. Agreements should discuss risks and benefits of chosen medication, outline treatment goals, and overall therapeutic plan. Conditions of continued treatment should include periodic drug screenings, serum levels for dose titration, the use of one pharmacy to obtain dispensed medications, restrictions to practitioners seen, and/or the frequency of prescription refills. The agreement should also state the reasons for which therapy may be discontinued including violations of the agreement, evidence of illicit drug use and/or diversion. It is important to follow through with discontinuance since failure to do so could proceed with further diversion from this as well as other clients and possible liability.

Helpful Hints in Deterring Diversion:

Provide Consistent Thorough Care - The deterrence of diversion begins with consistent and thorough care for every patient complaining of pain. This includes verifying past provider profiles, taking a complete medical history, performing a thorough physical examination and documenting each visit and prescriptions authorized.

Obtain Proper Identification - An official form of identification which includes a picture should be requested, copied and placed in the chart.

Utilize Patient Medication Agreements - Patients should sign and follow medication agreements. Agreements should discuss risks and benefits of chosen medication, outline treatment goals, and overall therapeutic plan. Conditions of continued treatment should include periodic drug screenings, serum levels for dose titration, the use of one pharmacy to obtain dispensed medications, restrictions to practitioners seen, and/or the frequency of prescription refills. The agreement should also state the reasons for which therapy may be discontinued including violations of the agreement, evidence of illicit drug use and/or diversion. It is important to follow through with discontinuance since failure to do so could proceed with further diversion from this as well as other clients and possible liability. *(See Appendix C)*

Protect Your Prescriptions - It is important to remember that the practitioner is responsible for their prescription blanks. The following are hints to protecting your prescriptions:

- The number of available prescription pads should be limited to one. Only the practitioner should have the prescription pad available. Extra pads should be in a locked area only accessible to the practitioner/s.
- Unlocked pads should be kept on the person of the practitioner.
- Never sign prescription blanks in advance.
- Write the quantity out in addition to the numerical value.
- Do not leave the refill area of the prescription blank.
- Use prescription pads only for prescribing, not for notes, etc.
- Use tamper-resistant prescription pads that expose the word "void" when the prescription has been photocopied.

- Make copies of the prescription or consider using duplicate available pads, keeping the prescription copy in the chart.
- Consider using prescription pads that are numbered, have different colors and have more than one color of ink.

Keep Good Pharmacist Relationships - You should have a strong relationship with local pharmacists who are often the first to detect an attempted diversion. Consider using only one pharmacy per patient.

Alert Staff - Your staff members should pay close attention to patients and the possibility of diversion.

The following simple steps or procedures should be followed if diversion has occurred:

- Contact local law enforcement authorities immediately via "911";
- Contact the Office of Opioids and Dangerous Drugs (ONDD);
- Establish a clear description of the suspect, any other persons with the suspect and persons to whom the dispensed prescription would be delivered. If possible secure, record or make a copy of any personal identification material available such as a drivers license or a similar document containing a photograph and the name and address of the person;
- Document the facts of the transaction noting the "who, what, when, where and how" of the diversion.

For a complete copy of Controlled Substance Rules and Regulations see www.dpr.Delaware.gov/Boards/Pharmacy.

Resources

Other Resources: *(These websites are randomly listed and are considered by the panel to demonstrate factual validity. Not all websites do; use caution.)*

American Pain Society - www.amPainSoc.org - The American Pain Society is a multidisciplinary organization of basic and clinical scientists, practicing clinicians, policy analysts, and others. The mission of the American Pain Society is to advance pain-related research, education, treatment and professional practice.

American Academy of Pain Management - www.PainMed.org - The American Academy of Pain Management is an inclusive, interdisciplinary organization serving clinicians who treat people with pain through education, setting standards of care and advocacy.

International Association for the Study of Pain - www.iasp-pain.org - Non-profit organization dedicated to furthering research on the diagnosis and treatment of pain.

Pain.com - Dannemiller Memorial Educational Foundation funded website that seeks to foster an environment where health care professionals can grow in their knowledge and management of pain and its management.

Delaware Pain Initiative, Inc. - www.EndPain.org 1-800-866-PAIN - Statewide non-profit organization whose mission is to provide education and information to healthcare professionals and the lay public regarding barriers that prevent optimum pain management.

Pain Management in the LTC Setting – www.amda.org 1-800-876-2632 - 1999 Revised 2003, American Medical Directors Association, 10480 Little Pawtuxet Pkwy, Suite 760, Columbia, MD 21044

The Management of Persistent Pain in Older Persons - www.AmericanGeriatrics.org - American Geriatrics Society 2002

Practice Guidelines for Chronic Pain Management - www.asahq.org - Anesthesiology 1997;86:995-1004; (c)1997 American Society of Anesthesiologists, Inc.; Lippincott-Raven Publishers

Guidelines for the Assessment and Management of Chronic Pain; Wisconsin Medical Society – www.WisconsinMedicalSociety.org/uploads/wmj/ACFC7.pdf - 2004; Volume 103, No. 3

Pediatric Pain Management Resources:

Tobias, J. (Eds.) (2005) Pediatric Pain Management for Primary Care. 2nd Edition: American Academy of Pediatrics.

Finley, G. A. & McGrath, P. J. (Eds.). (2001). Acute and Procedure Pain in Infants and Children. *Progress in Pain Research and Management*. Vol. 20. Seattle: IASP Press.

McGrath, P. J. & Finley, G. A. (Eds.). (1999). Chronic and Recurrent Pain in Children and Adolescents. *Progress in Pain Research and Management*. Vol 13. Seattle: IASP Press.

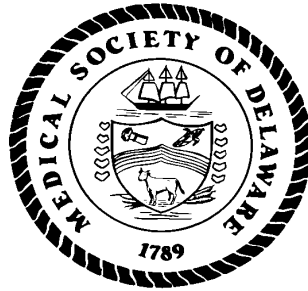
Local Resources:

Delaware Pain Initiative: www.EndPain.org Delaware Technology Park, Suite 303, One Innovation Way, Newark DE 19711, 302-292-1616, 1-866-337-PAIN

Delaware HelpLine: www.DelawareHelpLine.org 1-800-464-HELP

For further information on chronic pain management, please see the "Guidelines for Chronic Pain Management" located on the Medical Society of Delaware's website (www.MedSocDel.org).

Guidelines for the Medical Management of Chronic Pain



Introduction	Page 1
Etiology	Page 1
Key Elements of the Initial Chronic Pain Assessment	Page 2
Key Principles in Implementing a Treatment Plan	Page 2
Pain Treatment Protocol	Page 3
Outcomes	Page 4
Follow-up and Monitoring	Page 4
Regulatory Issues	Page 5
Helpful Hints in Detering Diversion	Page 5
Resources	Page 6
Pain Management Assessment Scale	Appendix A
Equivalent Doses of Opioids	Appendix B
Opioid Maintenance Agreement	Appendix C
Ten Tips for Prescribing Opioid Analgesics	Appendix D
Checklist for Long-Term Opioid Therapy	Appendix E
Guidelines for the Assessment and Management of Chronic Pain	Appendix F
Local Detoxification Sites	Appendix G

This guideline was developed by the Medical Society of Delaware's Committee for Lesser Known Illnesses. It is part of an overall strategy to improve the diagnosis and management of conditions and diseases in Delaware. Although there are no randomized clinical trial studies available, this guideline is based on best available evidence and expert opinion. All recommendations are based on clinical opinion and are **NOT** intended to replace clinical judgment and should be modified for patient-specific clinical indications. These parameters of practice should be considered guidelines only.

Created May 2006

This guideline was developed by the Medical Society of Delaware's Chronic Pain Management Committee:

Kirk Beebe, MD - Family Medicine
Shirley Brogley, Advanced Practice Nurse
Emmanuel DeVotta, MD – Pain Management
Margaretta Dorey, Pain Educator

David Dryden, RPh, JD – Department of State
Frank Falco, MD – Pain Management
Theresa Gillis, MD – Pain Management
John Goodill, MD – Internal Medicine

Phil Kim, MD – Pain Management
Irene Mavrakakis, MD – Pain Management
Susan Trone, Advanced Practice Nurse
Betsy Wheeler, MBA, Project Manager

Project Sponsorship was secured through the Delaware Division of Public Health through a grant sponsored by the Delaware Health Fund.