Chronic Pain Assessment

Michael R. Clark, MD, MPH, MBA

- Michael R. Clark, MD, MPH, MBA
- Vice Chair, Clinical Affairs
- Director, Pain Treatment Program
- Department of Psychiatry & Behavioral Sciences
- Johns Hopkins Medicine
- Baltimore, Maryland, USA
Disclosure

- Nothing to disclose

Learning Objectives

- Describe a comprehensive stepwise approach to the assessment and formulation of patients with chronic pain
- Review the role and importance of the complete assessment of common comorbidities in the treatment of chronic pain
- Explain the multiple complex issues needing to be addressed to be more successful in the treatment of the patient with chronic pain
- Emphasize the importance of reassessment and treatment plan modification in ongoing follow-up to optimize function
- Identify support tools available to the primary care clinician managing a patient with chronic pain

American Pain Foundation, 2007; http://www.painfoundation.org
The Problem of Chronic Pain

- U.S. Center for Health Statistics conducted an 8-year follow-up survey and found that 32.8% of the general population experienced chronic pain symptoms
- Chronic pain affects about 100 million American adults (more than the total affected by heart disease, cancer, and diabetes combined)
  - 56% suffered with pain for more than 5 years
  - Only 22% ever referred to a pain specialist (DeLuca, 2001)
  - 28% of these did not have pain controlled (APS, 1999)
- In a community sample of individuals older than 70, chronic pain was present in 52% with one-third of persons over 75 rating pain as severe
- Pain also costs the nation up to $635 billion each year in medical treatment and lost productivity

Magni et al., 1993; IOM, 2011; McCarthy et al. 2009; Brattberg et al. 1996

The Need for “Good” Treatment

- Patients with chronic pain suffer dramatic reductions in physical, psychological, and social well being with Health Related Quality of Life rated lower than those with almost all other medical conditions
- Considerable variability in the type of practitioners and scope of practice of “multidisciplinary” pain clinics
- Evidence based practice guidelines emphasize interdisciplinary rehabilitation, integrated treatment, and patient selection criteria
- Interdisciplinary pain rehabilitation programs provide a full range of treatments for the most difficult pain syndromes within a framework of collaborative ongoing communication

O’Connor, 2009; Sander et al., 2005; Stanas and Hveis, 2006; Peng et al., 2008
Inadequate Preparation and Training

- Healthcare professionals receive nominal training
  - “...Available evidence indicates that pain management training is widely inadequate across all disciplines.” (Fishman, 2013)
  - Few PCPs feel comfortable treating pain; fewer feel comfortable using opioids (Upshur, 2006; O'Rouke, 2007)
    - Becoming worse as draconian legislation is enacted

What is Chronic Pain?

- “Chronic pain has a distinct pathologic basis, causing changes throughout the nervous system that often worsen over time. It has significant psychological and cognitive correlates and can constitute a serious, separate disease entity.” (IOM, 2011)
  - A complete assessment and formulation is essential for the successful treatment and rehabilitation of this complex patient
# The Complexity of Chronic Pain

- Current pain intensity
- Other concomitant symptoms
- Medical comorbidities
- Psychiatric and psychological comorbidities
- Risk for medication abuse and diversion
- Number of chronic pain problems
- Number of past surgeries
- Medication side effects
- Extensive healthcare utilization
- Body mass index
- Sleep disorders
- Head trauma history
- Tobacco usage
- Goal setting
- Educational level and employment status
- Current pharmacotherapy regimen
- Coping skills and social support
- Physical conditioning

Peppin, et. al., 2015

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## Assessment: General

- **Detailed history**
  - Pain characteristics
  - Review of medical records
    - Prior diagnoses, therapies
    - Physical, psychological comorbidities
- **Physical examination**
  - Musculoskeletal
  - Neurologic
- **Diagnostic studies**

- **Clinical considerations**
  - Pain etiologies, characteristics
  - Effect on biopsychosocial domains including risk for addiction

- **Challenges**
  - Lack of a specific measurement tool that can prove presence or intensity of pain
  - Inaccurate patient descriptions
    - Degree of pain OR relief

Treatment based on initial assessment and regular reassessments that are comprehensive, individualized, documented

## Assessment: Specific

- **Functional assessment**
  - Does the pain interfere with activities: sleeping, eating, walking, rising/sitting, hygiene, sex, relationships?

- **Psychological assessment**
  - Does the patient have concomitant depression, anxiety, or mental status changes?

- **Medication history**
  - What medications have been tried in the past?
  - Which medications have helped?
  - Which medications have not helped?
  - Have they gotten into trouble with medications?

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## The Initial Hurdle

- **Patient’s self-report**
  - Gold standard except when the patient cannot describe pain

- **Nonverbal behaviors**
  - Under both direct and indirect observation

- **Collateral information from family, friends, practitioners**
  - Especially important for patients who cannot verbalize pain

- **Physiologic measures (least sensitive)**
  - Acute pain may elicit a change in vital signs; over time physiologic response to pain may not be seen
Helpful Mnemonics: Overall Format

- HAMSTER
  - HISTORY
  - ASSESSMENT
  - MECHANISM of pain
  - SOCIAL and psychological factors
  - TREATMENT
  - EDUCATION
  - REASSESSMENT

Helpful Mnemonics: HPI

- L-DOC-SARA
  - Location
  - Duration
  - Onset
  - Characteristic
  - Severity and pain goal
  - Aggravating factors
  - Relieving factors
  - Associate symptoms
### Unidimensional Pain Assessment Tools

- **Visual Analog Scale**
- **Wong-Baker Faces Scale**
- **Verbal Pain Intensity Scale**
- **0–10 Numeric Pain Intensity Scale**

### Psychological Assessment: General

- Evaluate for depression, anxiety, suicidal ideation, sexual abuse, addiction, cognitive impairment
- Screens find cases but do not make diagnoses
  - Help place patients in risk category
  - Patient Health Questionnaire (PHQ-9)
    - Thase, 2016; Moriarty, 2015; Siu, 2016
    - USPSTF recommended (AHRQ)
  - Skeptical psychometrics
  - Multiple scales
    - Beck Depression Inventory
    - Hamilton Rating Scale
    - Zung Self-Rating Scale
Catastrophizing

▪ “Pain catastrophizing is characterized by the tendency to magnify the threat value of pain stimulus and to feel helpless in the context of pain.” (Quartana, 2009)
▪ Screening tool (Sullivan, 1995)
▪ Correlated with:
  – Adverse pain related outcomes
  – Poor treatment responses
  – Shapes emotional, functional, and physiological responses
▪ Responses to treatment

Kinesiophobia

▪ “The fear of movement was the single strongest contributor to ankle disability” (Lentz, 2010)
▪ Common in SLE, > 65% (Baglan, 2015)
▪ Impact on life
  – Job
  – Disability
  – Social support
  – Pain treatment and treatment efficacy
Chemical Coping

- “Middle ground between compliant medication use and addiction.” (Kirsh, 2007)
  - “The use of opioids to cope with emotional distress, characterized by inappropriate and/or excessive opioid use.” (Kwong, 2015)
  - Important distinction from seeking primary drug-effect
  - Screening tool (Kirsh, 2007)
  - Poor prognosticator for efficacy of treatment and reduction in pain (Delgado-Guay, 2015)

Substance Use Disorder

- Screen to indicate need for evaluation (O’Brien, 2008)
- CAGE (Ewing, 1984)
  - Have you ever felt you should Cut down on your drinking?
  - Have people Annoyed you by criticizing your drinking?
  - Have you ever felt bad or Guilty about your drinking?
  - Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)
- CAGE-AID (Brown, 1995)
  - Adapted for drug abuse
Generalized Broader Assessments

- Brief Pain Inventory
  - [https://www.painedu.org/Downloads/NIPC/Brief_Pain_Inventory.pdf](https://www.painedu.org/Downloads/NIPC/Brief_Pain_Inventory.pdf)
- McGill Pain Questionnaire
- PHQ-9
- Just Ask!
  - “Are you at risk to yourself or others?”
  - “Any history of physical or sexual abuse?”

Collateral Information

- There is no single diagnostic test for pain
  - Imaging, neurophysiologic testing, laboratory studies
- Confirm or exclude underlying causes such as rheumatoid arthritis, diabetic neuropathy, spinal disorders, HIV/Hep C, herpes viruses, vitamin deficiencies, autoimmune disorders, malignancies
- Multiple tests may not be helpful and produce false positive results
- The best source of data is old records from previous practitioners
Developing a Care Plan

- Working diagnosis
  - Pain etiology
  - Pain syndrome
  - Inferred pathophysiology
- Initial treatment
  - Individualized based on pain intensity, duration, disease, tolerance of AEs, risk for aberrant behavior
  - May be stepwise in nature
  - May involve multidisciplinary team
  - May include behavioral + nonpharmacologic + pharmacologic modalities
  - May include analgesics with different, complementary MOAs and agents to reduce other symptoms (depression, anxiety, sleep disturbance, fatigue)

Risk of Abuse, Misuse, Diversion, and Overdose Death

- Universal precautions (Gourlay, 2005)
- Risk screening tools (Passik, 2008)
  - ORT—Opioid Risk Tool
  - SOAAP—Screener and Opioid Assessment Measure for Patients with Chronic Pain
  - SOAAP-R—Revised
  - DIRE—The Diagnosis, Intractability, Risk, Efficacy Tool
  - SISAP—Screening Instrument for Substance Abuse Potential

http://diginole.lib.fsu.edu/islandora/object/fsu%3A207738/datastream/PDF/view
## Aberrant Drug-Taking Behaviors

### Probably More Predictive of Addiction

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selling prescription drugs</td>
<td>Prescription forgery</td>
</tr>
<tr>
<td>Stealing or “borrowing” drugs</td>
<td>Injecting oral formulations</td>
</tr>
<tr>
<td>Obtaining prescription drugs from nonmedical sources</td>
<td>Concurrent abuse of alcohol or illicit drugs</td>
</tr>
<tr>
<td>Multiple dose escalation or other noncompliance with therapy despite warnings</td>
<td>Multiple episodes of prescription “loss”</td>
</tr>
<tr>
<td>Repeatedly seeking prescriptions from other clinicians or from emergency departments without informing prescriber or after warnings to desist</td>
<td>Evidence of deterioration in the ability to function at work, in the family, or socially that appears to be related to drug use</td>
</tr>
<tr>
<td>Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug</td>
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### Aberrant Drug-Taking Behaviors (cont’d)

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<tr>
<td>Aggressive complaining about the need for more drugs</td>
<td>Drug hoarding during periods of reduced symptoms</td>
</tr>
<tr>
<td>Requesting specific drugs</td>
<td>Openly acquiring similar drugs from other medical sources</td>
</tr>
<tr>
<td>Unsanctioned dose escalation or other noncompliance with therapy on 1 or 2 occasions</td>
<td>Unapproved use of the drug to treat another symptom</td>
</tr>
<tr>
<td>Reporting psychic effects not intended by the clinician</td>
<td>Resistance to a change in therapy associated with “tolerable” adverse effects with expressions of anxiety related to the return of severe symptoms</td>
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Reassessment: Key to Treatment Efficacy

- Consistent reassessment is critical
  - Upfront time investment worth the effort
    - Shortens subsequent visits
  - But still reassessment should include:
    - Treatment efficacy, goals, medication side effects, QOL, etc
      - Address appropriate medication usage
      - Re-review medications, OTC, prescription, supplements
      - Other medical problems that may have surfaced since last visit
      - Readdress psychological health
      - Readdress functionality
      - Other
    - Physical examination

Helpful Mnemonics: Follow-Up

- Four As
  - Analgesia
  - Adverse side effects
  - Activities of daily living
  - Aberrant behavior
**Principles of Pain Management**

- Individualize pain management
- Assess and treat disability and physical, psychosocial, and psychological comorbidities\(^1,2\)
- Select simplest approach using multimodal therapy (pharmacologic and nonpharmacologic)\(^1,2\)

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**Principles of Pain Management (cont’d)**

- Consider expert consultation if:
  - Uncertainty about diagnosis
  - Specialized treatment (eg, nerve block) is indicated
  - Unable to achieve pain and functional goals
  - Discomfort with opioid therapy in person with a history of substance abuse
  - Evidence suggests opioid misuse/abuse
  - Several treatments/combinations tried without success
Conclusion

- Evaluate/adopt personalized “step approach” to pain assessment/management (eg, HAMSTER)
- Identify pain tools that work for your practice
- Set realistic, achievable goals in pain reduction
- Comprehensive management should include combination of nonpharmacologic/pharmacologic therapy
- Seek to minimize specialist referrals, only for times when absolutely necessary

References

References (cont’d)


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- Upshur CC, Luckmann RS, Savageau JA. Primary care provider concerns about management of chronic pain in community clinic populations. J Gen Intern Med. 2006;21(6):652-655