Changing clinical directions for people with chronic pain

A multidisciplinary approach

Speakers

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Overview:
The role of the pain medicine specialist

A/Prof Charles Brooker
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Northern Pain Centre
Who Are We?

- Independent multidisciplinary interventional pain centre established 2012

- Team of Interventional Pain Medicine Specialists, Specialist Psychiatrist, Clinical Psychologists, Physiotherapists

Northern Pain Centre
What Do We Do?

Comprehensive multidisciplinary assessment and management of patients with persistent pain

Formulate individualised treatment program

Goal of improving pain control, improving function and restoring quality of life

Roles of the pain specialist

- Assess underlying pathology vs more generalized pain disorder
- Assess substance use and other psychosocial contributors
- Assess likely response to treatments and motivational aspects
- Assist with prescribing decisions
- Refer for further investigations if underlying pathology suspected
- Interventional techniques as appropriate
    - e.g. radiofrequency facet denervation or spinal cord stimulation
- Empower multidisciplinary approach and challenge unhelpful beliefs
- Encourage reduced reliance on medications

Overview:
The role of the pain psychiatrist

Dr Andrew Singer

Consultant Psychiatrist, Pain Medicine Specialist, Psychoanalyst

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Psychiatry & Pain Management

The Role of the Psychiatrist

- Psychiatrists tolerate ambiguity
- We screen for mental illness
- We prescribe medication and are comfortable with nonpharmacological treatments
- We work with systems and families
- We negotiate treatment compliance

Multimorbidity/Comorbidity in pain:

- Adjustment Disorder
- Anxiety and Anxiety Disorders
- Depression
- Toxicity, withdrawal, drug interactions
- Delirium
- Substance Use Disorder
- Personality Disorder
- Psychological distress
- Suicide

OPEN DOOR

CAREFULLY

THERE MAY BE PEOPLE ON THE OTHER SIDE OF DOOR

Overview:
The role of the pain physiotherapist

Adrian Brezniak
Physiotherapist

Role of physiotherapy in persistent pain

ASSESSMENT

- Pain
- Biological, psychological and social factors
- Physiotherapy -> movement

Role of physiotherapy in persistent pain

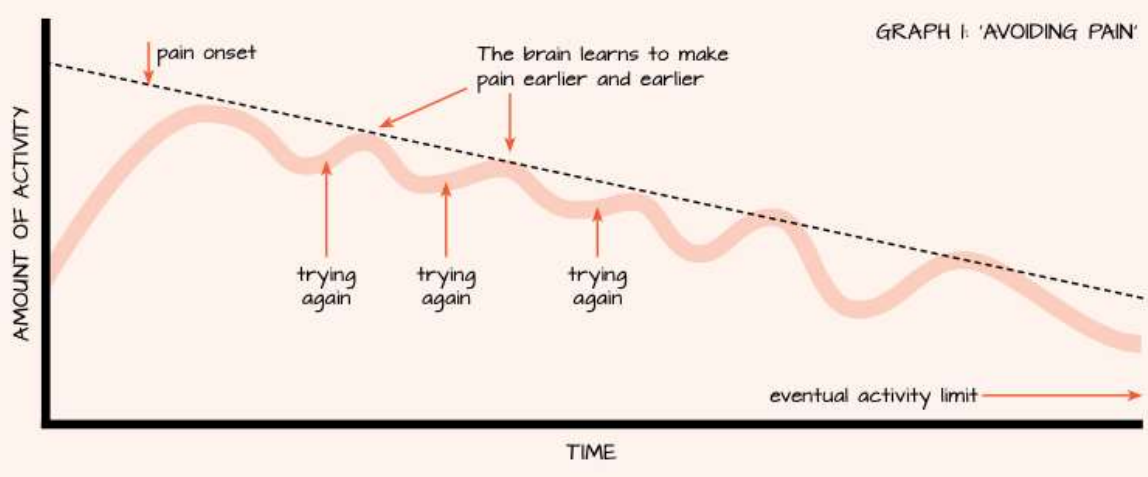
TREATMENT		
BIO- Underlying diagnosis and evidence-based treatments • Address: • Contributing factors • Specific impairments • Activity levels	**PSYCHO-** Address: • Unhelpful thinking about injury and patho-anatomical cause of injury • Concerns about declining future capacity	**SOCIAL** Address: • Identify goals and steps to work towards these • Unhelpful pain behaviours • Reinforce positive behaviours and steps • Unhelpful and passive management strategies • Unhelpful social dynamics if possible (e.g. Solicitous partners) • Unhelpful relationship with insurer and employer

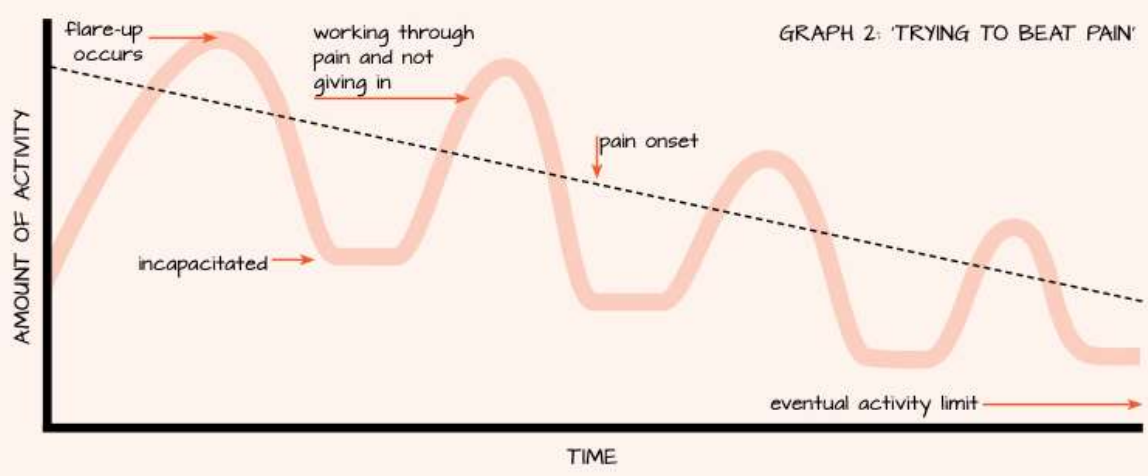
Pain physiotherapy

- Long sessions, less frequently:
  - patient working on management plan between sessions
- Active treatments which involve movement and changing behaviour
- Addressing psychological and social aspects of problem along with movement
- Sports/private practise physiotherapy:
  - session length
  - session frequency manual techniques
  - electrotherapy modalities

Key strategies

- Graded exposure
- Pacing
- Goal setting
- Active flare management
- Encourage problem solving
- Exercise therapy





Images courtesy of Explain Pain. David Butler & Lorimer Moseley.

Case study 1

Case study #1

- Male
- Late 30's
- Back & leg pain
- Recommended for surgery
- Degenerative disc disease
- **MRI**: disc bulge, no neural compression
- **Medications**: Valium and OxyContin
- Workcover
- Social issues, ETOH

Answers

1. Degenerative spinal changes and back pain without neurological compression on imaging do not require routine surgical review unless?

- a) There is progressive neurological loss
- b) There is failure to progress
- c) There is there has been failure to respond to targeted injection

2. What medications might be used to replace opioids and benzodiazepines in the management of chronic back pain?

- a) Antidepressants - TCA, SSRI, SNRI, Atypical antidepressants
- b) Anticonvulsants - Gabapentin, Lyrica, Lamotrigine
- c) Antipsychotics - quetiapine
- d) Novel hypnotics - suvorexant
- e) Cannabis
- f) All of the above
- g) All of the above, except e

3. At what stage are multidisciplinary pain programs suitable in the management of chronic pain conditions?

- a) After all other surgical and non-surgical options tried
- b) Early in treatment pathway (<3 months)
- c) Whilst exploring other treatments options
- d) After all other surgical options tried
- e) After all other non-surgical options tried
- f) At any stage provided diagnosis/ medical management is settled and the prospective participant has no other imminent surgery planned.

Answers

4. An increase in pain in this case should generally be managed with?

- a) MRI to exclude further disc changes
- b) Recommendation to rest
- c) Recommendation to avoid heavy lifting and bending
- d) Breakthrough medication
- e) Exclusion of red flags, reassurance and recommendation to return to normal activities as early as possible
- f) All of the above, except e

5. What is the significance of abnormal findings on imaging?

- a) An abnormal result requires context for proper interpretation
- b) All abnormal results should be followed up with further tests
- c) All abnormal findings are clinically significant
- d) Bulging disks and other abnormalities are extremely common in people who have no back problems at all.
- e) Excessive radiology scans may contribute to raised rates of cancer while not informing treatment
- f) b and c are correct
- g) All of the above, except b and c

Case study 1

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Priorities & options

- **Priority:**
  - Prevent patient having back surgery unless absolutely required
  - Minimise medication
- **Encourage pain management approach**
  - Screen with Orebro questionnaire
- **Consider interventions:**
  - Short term steroid injections
  - Medium term RF facet denervation if contributing to pain disorder
  - Caution: over medicalising
- **Occasionally** spinal cord stimulation used successfully to defuse the situation and avoid spinal surgery but rare in this case

Case study 1

Dr Andrew Singer
Consultant Psychiatrist, Pain Medicine Specialist, Psychoanalyst
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Assessment

✓**HISTORY:**
- Developmental adversity over represented in pain population

ASSESS:
- Current stressors
- Current and past depression

MEDICATION:
- Replace diazepam
- Opioids:
  - reduce or rationalise
  - exit strategy

SLEEP:
- Treat sleep disturbance with melatonin
- Behavioural sleep improvement

WORKERS COMPENSATION:
- Address workers compensation issues

ALCOHOL:
- Assess
- Interview
- Refer

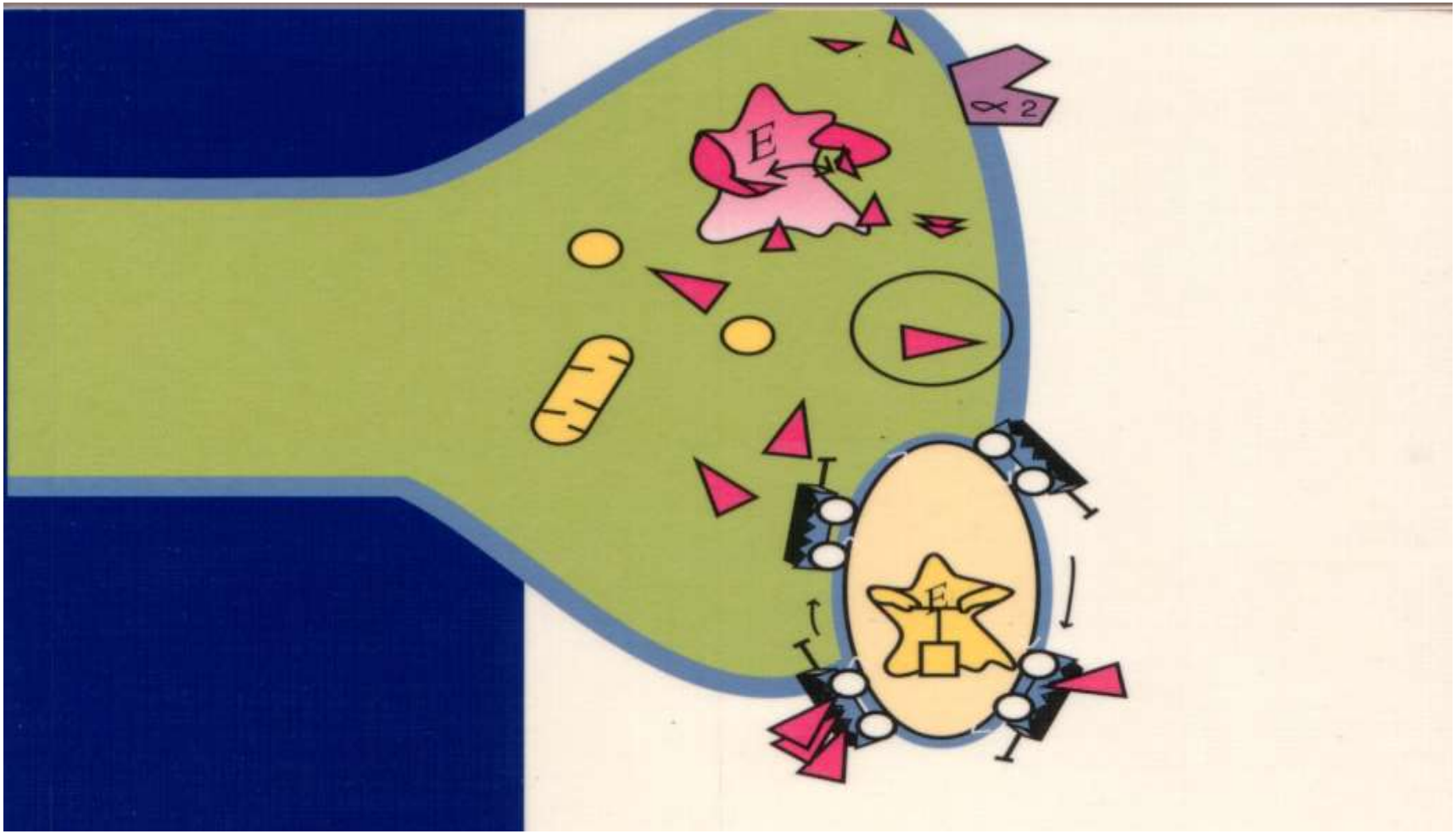
ACTIVE MANAGEMENT:
- Physical and behavioural strategies

Treatment

MANAGEMENT PLAN

- Psychotropic medication
- Behavioural pain management
- Drug and alcohol issues

Psychotropic medication



Psychotropic medication for pain

ANTIDEPRESSANTS

- **TCA**: amitriptyline, nortriptyline, dothiepin
- **SRI**: fluoxetine, escitalopram others
- **SNRI**: venlafaxine, desvenlafaxine, duloxetine, milnacipran
- **Atypical antidepressant** e.g. mirtazapine, agomelatine

ANTICONVULSANTS

- Gabapentin, pregabalin, sodium valproate, carbamazepine
- Lamotrigine

ANTIPSYCHOTICS

- Role of atypical for agitation and sleep
  - e.g. quetiapine

NOVEL HYPNOTIC

- Suvorexant

OTHER

- Cannabis
  - not yet, watch this space

Cognitive distortions

•Catastrophising
•Negative affectivity

Personalisation

Amplification of significance

Learned helplessness

Overgeneralisation

Labelling
Misattribution

Distorted beliefs

Non pharmacological treatments

Non pharmacological treatments

PSYCHOTHERAPEUTIC APPROACHES

Cognitive-behavioral

- Behavioural activation:
  - goal setting
  - pacing
- Sleep hygiene
- Target unhelpful beliefs and attributions
- Reduce catastrophizing
- Attentional techniques:
  - distraction
  - meditation
  - desensitization

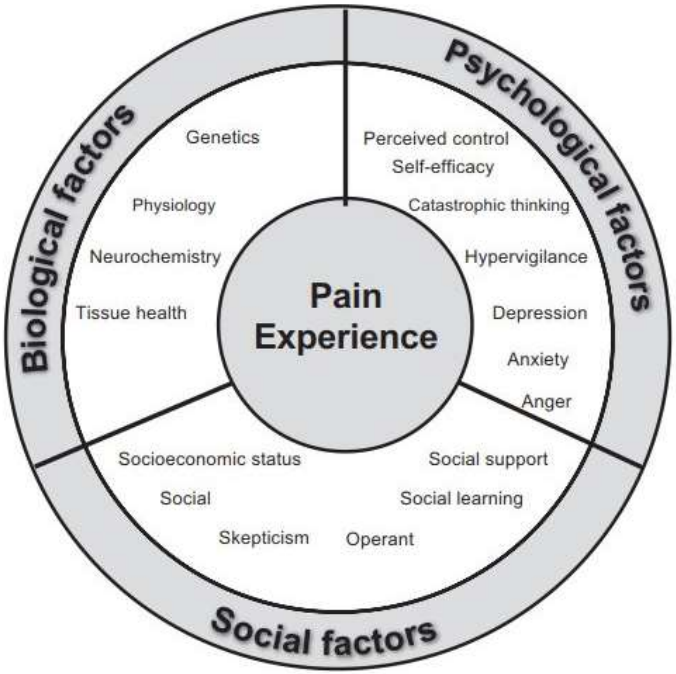


FIGURE 2 Biopsychosocial model of pain

Image courtesy of Physio meets science.

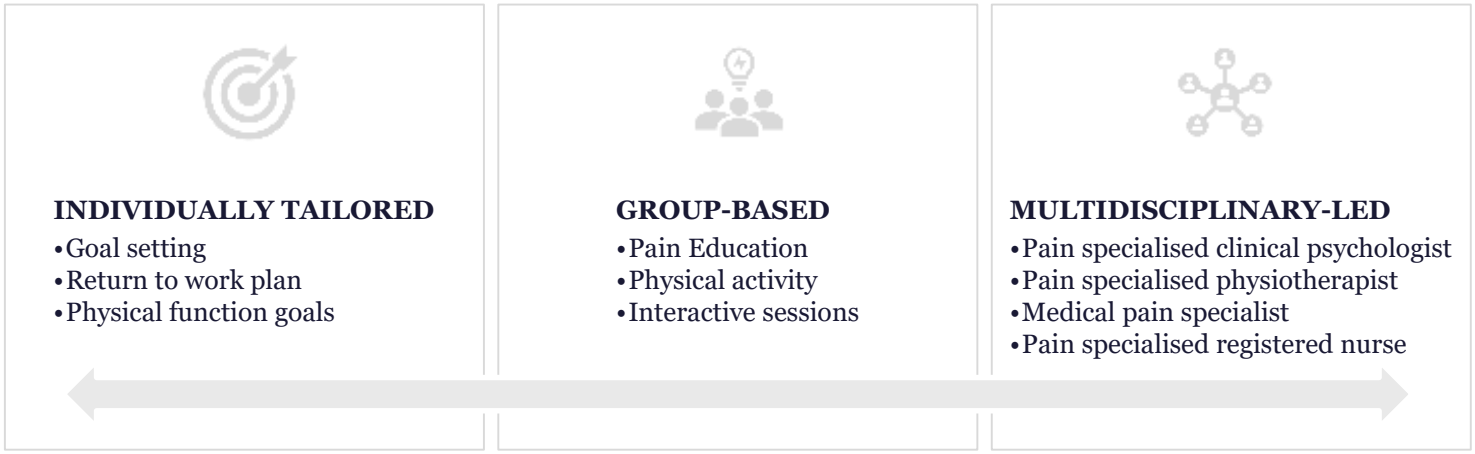
Other therapies

- **Psycho dynamically oriented**: brief or long term
- **Acceptance and Commitment Therapy** (ACT)
- **Supportive therapies**
- **Couples/marital and family therapies**
- **Other**
  - Narrative therapy
- **Psycho education** (ACI web site, Northern Pain Centre Website**)**
  - Hypnosis
  - Biofeedback
  - Relaxation training

Multi disciplinary treatment

Multi-disciplinary pain management program:

- **ADAPT**
- **EMPOWER**



Drug and alcohol

- **Self Referral Resources**
- **RNSH Drug and Alcohol services** https://www.nslhd.health.nsw.gov.au/Services/Directory/Pages/DrugAlcoholLNS.aspx
- **Alcoholics Anonymous Group Program**
- **Hello Sunday Morning and Daybreak App** https://www.hellosundaymorning.org/
- **Family Drug Support Australia** https://www.fds.org.au/
- **Tobacco** https://www.health.gov.au/health-topics/smoking-and-tobacco/how-to-quit-smoking
- **Inpatient Services**
- **Detoxification admission**
- **Inpatient Drug and Alcohol Program**

Case study 1

Adrian Brezniak
Physiotherapist

Case study 1

- **Role of surgery**
- **Elements of presentation**:
  - Fear
  - movement and activity patterns
  - appraisal of pain
  - communication from HCP
- **Questionnaires**:
  - Orebro Short
  - Pain-Self Efficacy Questionnaire
  - Brief Pain Inventory
  - PEG
- **Workcover**- need for early intervention
- **Coping strategies**
- **Physiotherapy assessment and treatment**

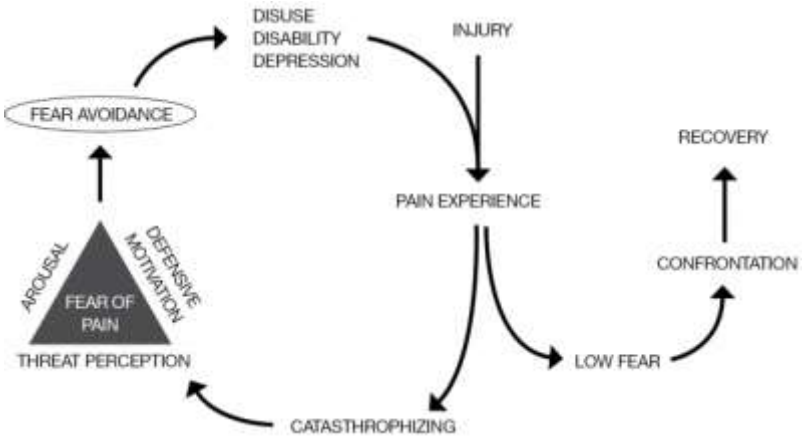


Image courtesy of Practical Pain Management.

Case study 2

Case study #2

- Woman
- Mid 70's
- Retired, carer for son.
- Shoulder pain -> Panadeine forte
- #Ankle -> Oxycontin -> Sx -> rehab
- Facet joint pain, rotator cuff tear, knee arthritis.
- Comorbidities: Obesity, 30yrs hx of alcohol use, depression
- Sleeping tablets for last 1mth whilst in hospital

Answers

1. Are there any special considerations in the elderly in terms of using opioids and benzodiazepines?

- a) They are less addictive in the elderly
- b) They can lead to cognitive impairment but don't increase the risk of falls
- c) They can cause a depressed mood
- d) All of the above

2. What are some strategies- pharmacological and non-pharmacological - to improve sleep?

- a) Sleeping tablets
- b) Sleep hygiene, stimulus control, cognitive behavioural therapy
- c) Melatonin
- d) All of the above, except a
- e) All of the above

3. What are some treatment approaches to manage a substance use disorder (alcohol)?

- a) Controlled drinking
- b) Abstinence and motivational interviewing
- c) Detox admission and referral to specialised services
- d) Medications for cravings
- e) All of the above
- f) All of the above, except a

Case study 2

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Priorities & options

- **Priority:**
  - Provide hope for this patient who is likely to be poorly motivated to improve her own pain management
- **Consider some interventions**
  - Lumbar facet denervation
  - Knee PRP injections
  - +/- Genicular blocks and RF for the knee.
- **Shoulder issues:**
  - Often will respond to less steroid and more emphasis on physiotherapy
  - Can use pulsed RF of suprascapular nerve to assist with rotator cuff pain for a few months without causing weakness or sensory loss
- **Focus:**
  - Increasing activity
  - Reducing alcohol excess
  - Reducing stigmatization
  - Encouraging longer term focus on active self management

Case study 2

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OMEGA
SWISS
27074690

Case study 2

This case is more complex …

- Multiple site pain = multi modal response
- Target treatable comorbidities

Treatment

- Deconditioning and inactivity
- Obesity
- Depression
- Substance use alcohol
- Sleep disturbance and dependency on sleeping medication

Obesity & deconditioning

- **Pain Management**
  - ✓ Education
  - ✓ Goal setting
  - ✓ Behavioural activation
- **Dietary advice**
- **Physical rehabilitation/ Pain program**
- **Consider for referral** to metabolic clinic

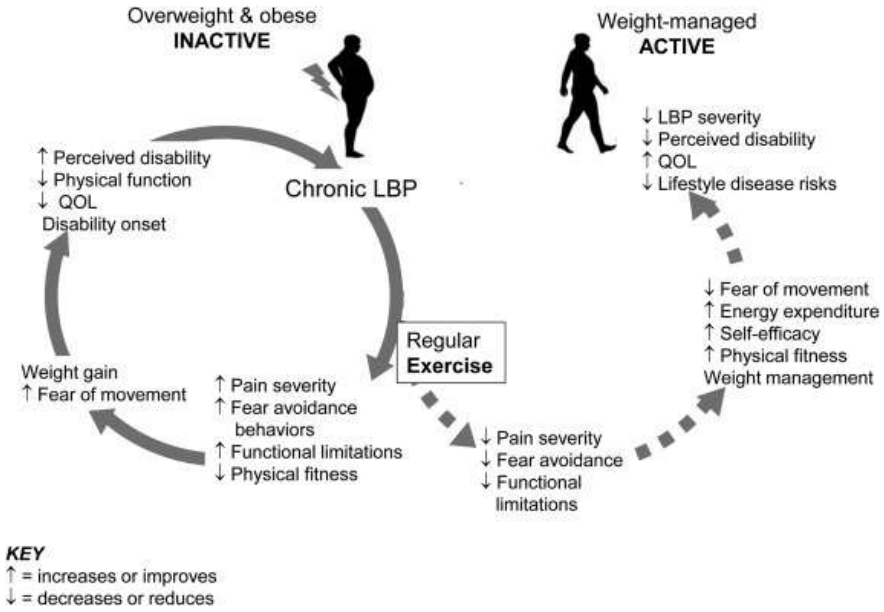

Image courtesy of
"Exercise Benefits for Chronic Low Back Pain in Overweight and Obese Individuals"

Depression

DEPRESSION & CHRONIC PAIN

Pharmacotherapy

- Rationalise opioids
- Review history and AD medication history, dosages
- Trial of analgesic AD in therapeutic dosage

Non Pharmacological

Education

- Book e.g. Manage Your Pain
- Web resources e.g. Northern Pain Centre web site

- **Psychological treatment**
  - Individual
  - group

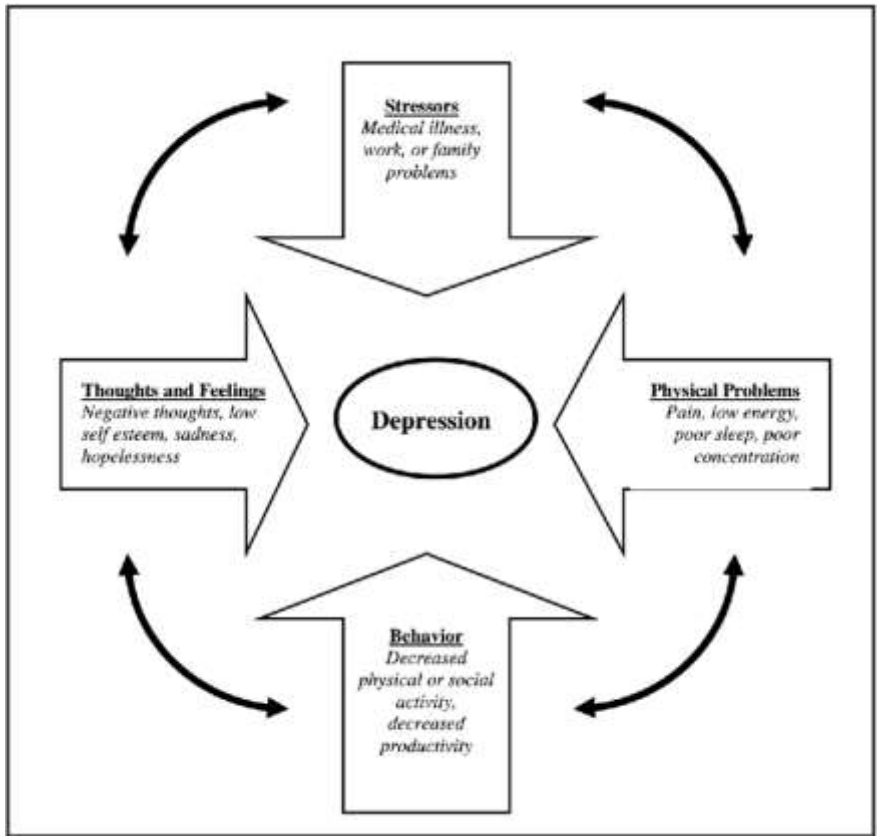

Image courtesy of Research Gate.

Substance use disorder

- **Alcohol history**
  - how much, how often and for how long
- **Physical comorbidity**
  - assess LFT's etc
- **Motivational interviewing**
- **Controlled drinking vs abstinence**
- **Referral to specialised services**
- **?Detox admission**
- **Anti craving drugs**
  - e.g. acamprosate depending on clinical situation
- **Wean sleeping medications**

Suicide prevention

- Lifeline on 13 11 14
- Kids Helpline on 1800 551 800
- MensLine Australia on 1300 789 978
- Suicide Call Back Service on 1300 659 467
- Beyond Blue on 1300 22 46 36
- Headspace on 1800 650 890
- QLife on 1800 184 527

Sleep disturbance

- **Sleep history**
  - Initial/middle/early insomnia
  - **Sleep study**: sleep apnoea, restless legs
- **Pharmacotherapy** - often limited
  - Sleep enhancing AD e.g TCA, mirtazapine or agomelatine but may have side effects
  - Melatonin SR 2mg to 4mg or 5mg compounded
  - Quetiapine 25mg for severe sleep disturbance
  - Prazosin for nightmares
- **Non- Pharmacological therapy**
  - Education
  - **Sleep hygiene**: scheduling, physical environment, caffeine, alcohol
  - Meditation apps: Headspace, Calm etc
  - **Sleep resources**: Northern Pain Centre Website Sleep Series

JUST ADD MAGIC!

Case study 2

Adrian Brezniak
Physiotherapist

Case study 2

- Widespread pain
- “Yellow flags”
- Role of activity
- Goal setting
- Physiotherapy assessment and treatment

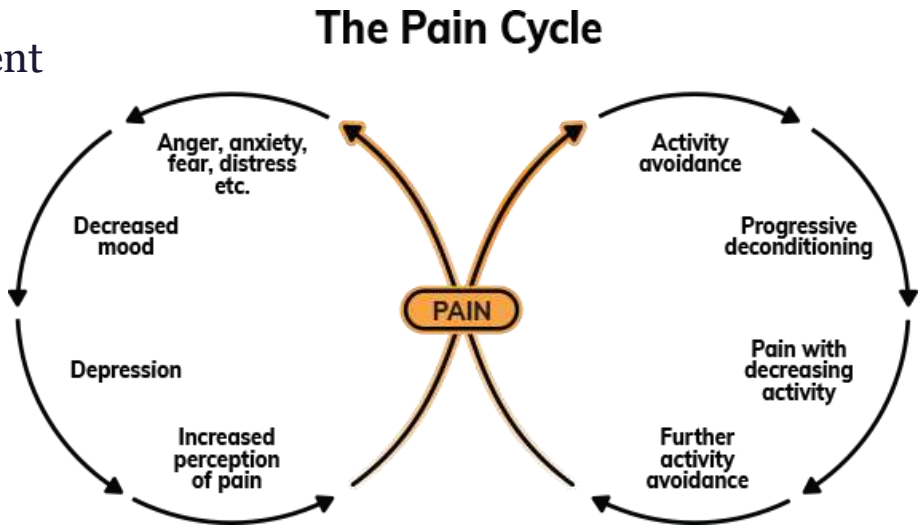

Image courtesy of Reach for the Facts.

Any questions?

Email your further questions to acarter@northernpaincentre.com.au

Thank you