ADULT GUIDE: ASSESSMENT and MANAGEMENT of PAIN

Assessment and Diagnosis

While all patients should be screened for pain, identifying a specific etiology for pain is challenging. A complete assessment, including physical, mental, emotional, and spiritual components is helpful in determining the appropriate course of management. All patients should be actively engaged in self-management of their pain (an 'active' approach.) If necessary, therapies that represent a 'passive' approach may be utilized to encourage self-management strategies to help achieve patient centered goals.

History: Assess

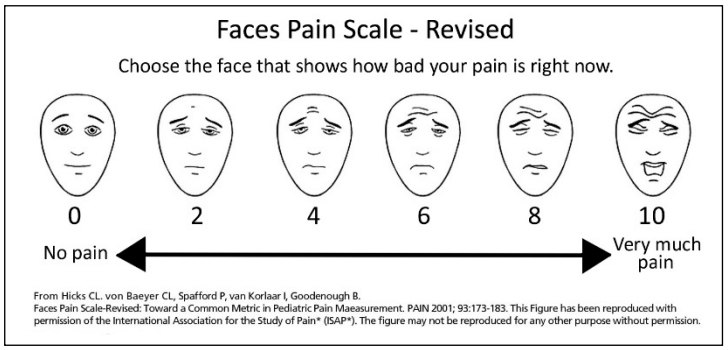
- Onset, location, quality, intensity, temporal pattern, aggravating and alleviating factors, associated symptoms
- Characteristics of pain
- Red flags: indicative of underlying pathology
- Yellow flags: Psychosocial factors shown to be indicative of long term chronicity and disability: A negative attitude that pain is harmful or potentially severely disabling; fear avoidance behavior and reduced activity levels; an expectation that passive, rather than active, treatment will be beneficial; a tendency to depression, low morale, and social withdrawal; social or financial problems
- Previous methods of treatment
- Other medical and surgical conditions
- Substance use

Psychosocial History: Assess

- Depression, anxiety, PTSD, sleep pattern, suicide risk
- Impact on quality of life, ADLs & functional status
- Pain coping skills
- Patient, family, and caregiver's cultural and spiritual beliefs
- Secondary gain: psychosocial/financial

Assessment

- Order and evaluate appropriate diagnostic testing
- Evaluate pain on all patients using the 0-10 scale:
  - A. mild pain: 1-3
  - B. moderate: 4-7 (interferes with work or sleep)
  - C. severe: 8-10 (interferes with all activities)



Treatment

Goals

- Treat acute pain actively to avoid transition to chronicity.
- Treat chronic pain thoughtfully and systematically.
- If possible, identify and address the etiology of pain, including potential confounders (such as psychosocial issues.)
- Maintain an active approach that enables the ability to function safely and productively
- Allow emergence of emotions associated with pain
- Establish patient specific SMART (Specific, Measurable, Agreed Upon, Realistic, Time-based) goals that result in improved function and quality of life & reduction in suffering.

Nonpharmacologic Therapy: Active Approach

- Patient and Family Education
- Community and Web-based Support Groups
- Cognitive Behavioral Therapy; Supportive Psychotherapy
- Physical Therapy; Chiropractic/Osteopathic Care
- Exercise: Yoga, Tai Chi, Qi Gong, Walking, Water Therapy
- Cutaneous Stimulation: Ice, Heat; Counterstimulation: TENS
- Acupressure (trigger point therapy)
- Relaxation Techniques: Biofeedback,
- Meditation, Mindful Practice; Visualization/Interactive Guided Imagery; Prayer, Spiritual & Pastoral Support

Nonpharmacologic Therapy: Passive Approach

- Massage, Music, Hydrobath
- Cutaneous Stimulation: Ice, Heat; Counterstimulation: TENS
- Acupuncture (trigger point therapy)
- Therapeutic Touch, Reiki, Healing Touch

Pharmacologic Therapy

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for treatment of pain.
- For neuropathic pain, use anti-epilepsy drugs (AEDs) first
- Use adjuvant therapies or analgesics as needed
- Opioids are not first line for chronic pain, which should be managed with an active approach and non-opioid pain relievers, if possible.
- Consider opioid therapy based on a careful risk assessment that determines the expected benefits for both pain & function are anticipated to outweigh risks. If opioids are used, establish treatment goals, combine w/active approach & nonopioid analgesics as indicated.
- When opioids are indicated (e.g. patients with cancer, palliative and end-of-life care), combine with an active approach & adjuvant medications as indicated. See Opioid Guidelines on Equianalgesic Table for Adults.
- Avoid inappropriate use of opioids; prevents potential misuse

Management and Monitoring

General

- Reassess pain, quality of life and function regularly, focusing on patient-centered goals
- Follow amount and duration of response
- Partner with patient/family in setting goals of care
- Balance function vs. acceptable control of pain

Referrals

Acute pain

- Refer early to appropriate specialist or Pain Center, if diagnosis unclear or pain refractory to treatment

Chronic pain

- Set realistic chronic care goals
- Transition from passive recipient to patient-directed management.
- Refer "difficult to treat" cases (H/O substance abuse, neuropathic pain, rapidly escalating opioid doses) to MD with pain management expertise

Special Considerations for Patients on Opioids

- Use risk assessment tools (e.g. Opioid Risk Tool), treatment agreements, and medically necessary urine drug testing for compliance/diversion
- Check Prescription Drug Monitoring Program for opioids or benzodiazepines from other sources
- Follow state and federal regulations
- Evaluate benefits & harms w/patients in 1-4 wks. of starting opioid for chronic pain or dose escalation.
- Be wary of dose escalation over time due to tolerance.
- Evaluate benefits & harms of continued therapy with patients every 3 months or more frequently.
- If benefits do not outweigh harms of continued opioid therapy, optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
- Avoid abrupt cessation of opioids
- Address opioid-seeking behavior and addiction behaviors without moving patients to illegal means of obtaining opioids. Refer to addiction or pain specialist and community services as needed

Special Situations

Anxiety and depression

- Refer to Depression Guidelines

Verbally non-communicative patients

- See Nurse's Guide

Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines & principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs. Approved in April 2017; Next Scheduled Update in 2019

ADULT GUIDE: NONOPIOID PHARMACOLOGIC THERAPY

Drug/Class	Common Uses in Pain Management	Clinical Considerations
Analgesics		
Acetaminophen	Mild-moderate pain	NOT anti-inflammatory; maximum 3 grams/24 hours from ALL sources for ALL purposes and 2-3 grams/day for frail elders, alcohol use (3 or more drinks per day), renal impairment; limit to 325mg or less per dose; leading cause of acute liver failure (including accidental overdose); monitor for severe liver injury & acute renal failure
Nonselective nonsteroidal anti-inflammatory drugs (NSAIDs)	Mild-moderate pain	Assess risk of nephrotoxicity, drug interactions, CV disease and GI toxicity prior to prescribing; administer with PPI or H2 blocker if GI intolerance or high risk; risk of cardiac adverse events (ibuprofen > naproxen); COX 2 agents mabe preferred agents for cardiac & renal safety; consider topical agents for individuals unable to use oral therapy
Cyclooxygenase (COX)-2 selective NSAIDs (coxibs)	Mild-moderate pain	Caution in patients with cardiovascular disease or at high risk for CV disease. Improved upper GI safety compared to NSAIDs ; use celecoxib if contraindication or severe intolerance to NSAID
Botulinum Toxin	Neuropathic pain	Randomized, double-blind, placebo-controlled study; further investigation needed
Anesthetics		
Lidocaine (systemic)	Local and regional anesthesia, nerve block, epidural	Do not use in patients with severe degrees of SA, AV or interventricular heart block
Anticonvulsants		
Carbamazepine	Pain associated with trigeminal or glossopharyngeal neuralgia	Watch for BMD, many DDI's Boxed Warning: Blood dyscrasias, Dermatologic toxicity, Asian ancestry (HLAB*1502 allele)
Gabapentin	Post-herpetic neuralgia, diabetic neuropathy, peripheral neuropathy, fibromyalgia, post-op pain adjunct	CNS depression when combined with other sedatives. May cause peripheral edema
Pregabalin	Fibromyalgia, neuropathic pain, post-herpetic neuralgia	May cause weight gain, watch for CNS depression when combined with other sedatives. May cause hallucinations and peripheral edema.
Valproic Acid	Diabetic neuropathy, post-herpetic neuralgia	Many drug-drug interactions. Boxed warning: hepatotoxicity, use in mitochondrial disease, pancreatitis
Topiramate	Neuropathic pain, cluster headache prophylaxis	May cause weight loss, drug-drug interactions Trokendi ER: do not use if ETOH use within 6 hours, may cause metabolic acidosis in patients taking metformin
Anti-Depressants		
TCA's: Amitriptyline, desipramine, imipramine, nortriptyline	Neuropathic and chronic pain	Anticholinergic effects, older adults more sensitive to adverse effects including orthostatic hypotension, use cautiously with comorbid CV disease. Boxed Warning: Suicidal thinking/behavior
Other antidepressants: Duloxetine, venlafaxine, ,milnacipran	Neuropathic pain, fibromyalgia, depression	May increase bleeding risk especially if combined with ASA or NSAIDs; taper dose prior to discontinuing; adjust dose with renal impairment Boxed Warning: Suicidal thinking/behavior
Muscle Relaxants		
Cyclobenzaprine, baclofen, methocarbamol, tizanidine, metaxolone	muscle spasm associated with acute, painful musculoskeletal conditions	Recommend short term use for relief of acute pain; avoid in the older adults due to limited efficacy and adverse effects. May cause hypotension.
Topical Medications		
Lidocaine	Localized neuropathic pain	Avoid use on traumatized mucosa, skin irritations
Diclofenac (gel, patch)	Osteoarthritis pain, minor strains, sprains and contusions	Avoid use on non-intact/damaged skin including dermatitis, eczema, burns or wounds.
Capsaicin (OTC)	Only use: dermal neuropathic pain	Avoid use on wounds, damaged/broken/irritated skin. Do not cover with bandage or use with external heat source
Herbal/Homeopathic		
Alpha Lipoic Acid	Diabetic nerve pain	Low evidence
Butterbur	Migraine prophylaxis	Low evidence
Feverfew	Migraine prophylaxis, anti-inflammatory	Low evidence