



Current Concepts in Physiatric Pain Management

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Management of Chronic Pain**CASE SCENARIO**

A 44-year-old woman has a history of chronic low back and buttock region pain. Five years previously, she underwent posterior decompression and discectomy for an L5-S1 disk protrusion. This provided no measurable benefit, and 5 months later she underwent anterior fusion at L5-S1. She notes persistent low back and sacral pain bilaterally since that time. Her history also includes chronic pelvic pain, headaches, and irritable bowel syndrome. She has undergone multiple radiographically guided diagnostic (and “therapeutic”) procedures to evaluate for other sources of pain, none of which were successful. She reports being referred to a counselor and a psychiatrist in the past because of a physically and emotionally abusive relationship at a young age. She is overweight and does not exercise because her pain worsens. Physical therapy flared her pain as well. Per the patient, “they told [her] there was nothing they could do for [her].” She currently works, but frequently calls in sick because of pain flares. Her primary care physician has been prescribing fluoxetine, extended-release oxycodone, and a “muscle relaxant.” She has tried nonsteroidal anti-inflammatory drugs in the past, without benefit. She is referred to a physiatrist for “chronic pain management.” Drs Scott Laker and Jason Friedrich will take the position that a physiatrist is not the appropriate medical specialist to manage this patient with chronic pain, whereas Dr Steven Stanos will advocate that physiatrists are the best-suited physicians to manage this type of patient.

Scott Laker, MD, and Jason Friedrich, MD, Respond

For purposes of full disclosure, the authors are both Accreditation Council for Graduate Medical Education (ACGME) Pain Fellowship–trained, board-certified physiatrists, working in a university-based spine center, on the faculty of an ACGME Pain Medicine Fellowship. It is our feeling that physiatrists have the ability to make a positive impact on any patient diagnosis, *provided that they have the appropriate training and clinical tools to do so*. Physiatry is not synonymous with pain management, and we must be aware of the evidence surrounding chronic nonmalignant pain when making decisions about how to treat our patients. Would we assume that the gastroenterologist managing her IBS, the gynecologist managing her pelvic pain, or the neurologist managing her headaches should be the coordinator of this patient’s overall pain program? We would make the argument that no one reading this article would think that this would be acceptable. We will explore why we believe that Physiatry has become synonymous with chronic pain management and why we disagree with this premise.

In this article, we will define “chronic pain syndrome,” discuss PM&R training for management of chronic pain syndromes, review clinical best practices for the treatment of chronic pain, and more appropriately place physiatry at the periphery of care team for this patient. We will argue that keeping physiatry out of this central management role is better not only for the patient but also for our specialty and the health care system. We need to fundamentally rethink how chronic pain management is delivered, and continue to lead in the primary and secondary prevention of chronic pain and its complications.

Definition

We will define chronic pain syndrome as chronic pain with secondary complications, including behavioral, emotional, social, and physical. The literature supports the notion that alteration of neural processing and encoding of sensory information occurs to some extent in all chronic pain [1] and is not a secondary complication. These secondary complications differentiate the

“chronic pain patient” from well-functioning individuals with chronic pain. One might argue that this case scenario is an example of failed back surgery syndrome (FBSS). Although FBSS is defined as persistent back pain despite back surgery or as a result of surgery [2], its use should be restricted to those patients who truly had symptomatic spinal pathology before surgery or developed new and definable symptoms because of the surgery. This patient has a history of chronic pain in multiple body regions despite appropriate therapy, and should not be defined as having surgery-related pain as her primary issue. This definition is important to avoid the temptation of directing further physical interventions, such as spinal injections, at a problem that is largely behaviorally based. Let us not forget that chronic pain lives in the brain.

There is a deep literature base regarding chronic pain management, including clinical practice guidelines for primary care, specialty care, and insurance companies. Virtually all guidelines support intensive interdisciplinary care [3-9] that includes case management, behavioral modification, and physical training/exercise, ideally in a fully integrated model of care. This is especially true for patients with high levels of disability and psychological distress. It is well established that psychological factors, specifically fear avoidance and catastrophizing, predict outcomes better than somatic factors and underlying spinal pathology [6,10]. The literature does not support single-provider care, chronic opioid therapy, or spinal injections for this patient or others with “chronic pain syndrome.”

Physiatrists who are not working within an interdisciplinary pain management program are not equipped to successfully manage this patient. We are professionally and ethically obligated to provide excellent psychiatric examination, evaluate for neurological or structural compromise, and provide recommendations about the role of appropriate posture, biomechanics, strengthening/conditioning programs, modalities, pharmacological strategies, interventional procedures, and surgical indications. However, this patient needs structured behavioral modification, including case management and behavioral therapy at the foundational level integrated with a physical therapist trained in the concepts of fear avoidance and other illness behaviors.

Assuming that our history and physical examination do not reveal neurological compromise or other red flags and the routine postoperative radiographs do not demonstrate significant structural abnormalities, hardware failure, or instability, then further diagnostic testing would be unlikely to change management. Follow-up magnetic resonance imaging (MRI) does not distinguish between good and bad outcomes in sciatica even 1 year after surgical or nonsurgical treatment [11]. The chronic pain literature would suggest that measures of pain-related anxiety and fear avoidance would be better assessments for this patient [10,12].

Ongoing medical management for this patient is expensive and unnecessary. It is likely that this patient was seen and evaluated multiple times on the road to her 2 prior back surgeries. Ongoing treatment without any realistic hope of improvement will reinforce dysfunctional entrenched beliefs, as well as passivity. If this inadequate treatment is unsuccessful, this patient is harmed, a useful diagnosis is delayed, her dysfunctional beliefs are reinforced, and her trust in the system is again challenged. Available literature suggests relatively low satisfaction in treating chronic pain patients, low goals for improvement, and tendency to choose poor treatment options for patients with chronic pain diagnoses [13]. This study showed enormous variability in treatment patterns for these patients, which we would argue points to a lack of successful treatment for the disorder.

Training

We maintain that PM&R residency training does not equip physiatrists to treat this type of complex pain management without additional subspecialization. According to the official ACGME program requirements for training in PM&R, our residents “must have progressive responsibility in diagnosing, assessing, and managing the conditions commonly encountered in the rehabilitative management of patients of all ages in the following areas: acute and chronic pain conditions, including use of medications, therapeutic and diagnostic injections, and psychological and vocational counseling” [14]. However, this 27-page document mentions the word “pain” only once. Clearly, some residencies may have a more robust pain curriculum, but PM&R core training is not focused on complex pain management.

The PM&R physician should not take over prescription management for this patient, and should recommend against chronic opioid therapy. This patient’s problem is not an exogenous opioid deficiency. Although the harms of chronic opioid use are well established, population-wide benefits are not [15-18]. If we are to “first, do no harm,” then chronic opioid prescribing in this case is not easily justifiable. If chronic opioids are considered, then this patient deserves a formal psychiatric evaluation, including substance abuse screening and global psychosocial assessment including physical, social, and occupational limitations before even beginning the discussion [17]. As outpatient physiatrists, we do not have the time or the training to complete such an assessment. If a patient is deemed appropriate to be considered for opioid therapy by the above assessments, then this therapy should be carried out by a practice that can effectively monitor these patients, including the negative health consequences with chronic use. Many PM&R practices do not have the infrastructure to carry this out, and should avoid the temptation to give inadequate albeit well-intentioned care.

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