

Diagnosis and Treatment of Common Pain Syndromes and Disorders



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KEYWORDS

• Pain syndromes • Chronic pain • Diagnosis • Treatment • Primary care

KEY POINTS

- As more patients access the health care system for the management of pain-related disorders, providers will be challenged with seeking appropriate methods of treatment.
- It is essential for all care givers to have a general understanding of common pain syndromes, and how to appropriately manage the care of patients with chronic pain.
- A pain specialist will continue to provide care and expertise for complex patients; however, limitations in access to comprehensive pain care will necessitate the use of primary care for a large portion of pain-related health care.

INTRODUCTION

The management of patients with chronic pain has become a significant challenge for primary care providers. It is projected that as many as 1 out of every 10 Americans will develop chronic pain at some point over their life course, and the cost is staggering. Recent estimates suggest that the treatment of pain-related syndrome in the United States costs as much as \$635 billion a year.¹

Although some patients receive treatment for pain in specialty pain clinics, the majority will access care in a primary setting. Because chronic pain is widespread and increasing, most health care providers will see patients with chronic or severe pain resulting from any number of disease states. Treatment protocols for patients in pain requires specialized knowledge of the pain's etiology and evidence-based approaches to manage the pain. The goal of this review is to provide an overview of common pain syndromes seen in the primary care setting and to highlight current treatment options for those syndromes.

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MYOFASCIAL PAIN SYNDROME

Myofascial pain syndrome (MFP) is a noninflammatory disorder of the musculoskeletal system associated with pain and stiffness. It is thought to be caused by repetitive injury to the muscles, but can occur with a single injury. Contributing factors include autoimmune dysfunction, connective tissue disorders such as lupus and rheumatoid arthritis, stress, and depression. Patients present with musculoskeletal pain, limited mobility, weakness, and referred pain. MFP can begin at any age, but is most commonly seen in women ages 15 to 40. Estrogen seems to play a significant role in the development of MFP.²

The most significant physical finding in MFP is the presence of hyperirritable palpable nodules in the skeletal muscle fibers referred to as myofascial trigger points.³ Fibromyalgia (FM) and MFP are often confused with each other because symptomatology often overlaps. Individuals with either of these disorders may exhibit headaches, abdominal and pelvic pain, dysmenorrhea, prostatitis, and irritable bowel. The distinct, but difficult to ascertain difference, is that FM is centrally mediated and MFP is a peripheral disorder in which pain originates within the muscle at myofascial trigger points.⁴

Diagnosis

The most significant finding in a patient with MFP is a tight band within a muscle group that has a reproducible localized point of tenderness. The pain duration should be greater than 3 months, and the patient should not have another disorder that would account for the pain. The initial evaluation of a patient suspected with MFP is very important. Positive findings should include areas of pain that can be reproduced by provocative maneuvers. They should be consistent and not wandering. In addition, the identified point of most intense pain should produce referred pain along the muscle when stimulated for a few seconds.⁵ The primary clinical finding in MFP is referred pain. The patterns of referral often do not make neurologic sense. For example, pain from a trigger point in the trapezius, innervated by cranial nerve XI, may refer to the forehead, innervated by cranial nerve V. However, the clinical presentation, characteristic referral, and the response to local anesthetic or other peripheral treatments are accepted by most providers to meet diagnostic criteria.⁶

Treatment

Pharmacologic treatment, typically used to combat most pain syndromes, includes nonsteroidal antiinflammatory drugs (NSAIDs). However, beyond the analgesic properties of NSAIDs, it is likely that they are not helpful because the syndrome is noninflammatory. Muscle relaxants, such as tizanidine, have been shown to support significant improvement in pain intensity. Benzodiazepines also decrease pain symptoms in MFP through inhibition of neurotransmission. Anticonvulsants such as gabapentin and pregabalin have been used to treat MFP, but there is little evidence of their effectiveness. The use of Duloxetine, a serotonin-norepinephrine reuptake inhibitor, has been shown to be a useful adjunct to improve mood and treatment compliance, although little evidence exists to suggest the use of other classes of antidepressants for the treatment of MFP.⁷

Some interventional therapies have shown promise in the treatment of MFP. Deactivating the myofascial trigger point is essential in treatment. Cryotherapy, muscles stretching, ultrasound therapy, dry needling, and local anesthetic injections have been used with varying degrees of success. Cryotherapy, or cold compression therapy, is controversial among providers. Some feel that cold therapy inhibits hyperactive

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