



Observational study

Identifying characteristics of the most severely impaired chronic pain patients treated at a specialized inpatient pain clinic



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HIGHLIGHTS

- The most complex chronic persistent pain (CPP) patients are offered in-hospital treatment.
- These patients documented a multitude of psychosocial signs and symptoms.
- They suffered from psychiatric comorbidity, poor physical-functioning and symptom-preoccupation.
- These obstacles to treatment must be focused on during pain rehabilitation.
- A specialist in psychiatry and sleeping disorder should amplify the team.

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ABSTRACT

Background and aims: Patients suffering from chronic nonmalignant pain constitute a heterogeneous population in terms of clinical presentation and treatment results. Few data are available about what distinguishes different groups in this huge population of patients with chronic persistent pain (CPP). A subgroup that is poorly studied, consists of the most severely impaired chronic pain patients. At the Uppsala University Hospital Pain Clinic, there is a specialized department accepting the most complex patients for rehabilitation. In the endeavour to improve and evaluate treatment for this subgroup, a better understanding of the complex nature of the illness is essential. This prospective study aimed to describe the characteristics of this subgroup of patients with CPP.

Methods: Seventy-two consecutive patients enrolled in the Uppsala programme were evaluated. We collected data on demographics, type of pain and experienced symptoms other than pain using a checklist of 41 possible symptoms. Psychiatric comorbidity was assessed by a psychiatrist using a structured clinical interview. Quality of life (QoL), pain rating and medication/drug/alcohol usage were measured by validated questionnaires: SF-36, NRS, DUDIT and AUDIT. Concerning physical functioning and sick leave, a comparison was made with data from the Swedish Quality Register Registry for pain rehabilitation (SQRP).

Results: The cohort consisted of 61% women and the average age was 45 (range 20–70) years. For this cohort, 74% reported being on sick leave or disability-pension. In the SQRP 59% were on sick leave at the time they entered the rehabilitation programmes [1]. On average, the study-population reported 22 symptoms other than pain, to be at a high rate of severity. Patients treated in conventional pain-rehabilitation programmes reported a mean of 10 symptoms in average. Symptoms reported with the highest frequency (>80%), were lethargy, tiredness, headache and difficulties concentrating. Seventy-six percent were diagnosed with a psychiatric disorder. Sixty-nine fulfilled the criteria for depression or depression/anxiety disorder despite that most (65%) were treated with psychotropic medication. Alcohol/drug abuse was minimal. Seventy-one percent were on opioids but the doses were moderate (<100 mg) MEq. The pain rating was ≥ 7 (out of a maximum of 10) for 60% of the patients.

Conclusion: This study describes what makes the subgroup of pain patients most affected by their pain special according to associated factors and comorbidity. We found that they were distinguished by a high degree of psychiatric comorbidity, low physical functioning and extreme levels of symptom preoccupation/hypervigilance. Many severe symptoms

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additional to pain (e.g. depression/anxiety, tiredness, disturbed sleep, lack of concentration, constipation) were reported. The group seems hypervigilant, overwhelmed with a multitude of different symptoms on a high severity level.

Implications: When treating this complex group, the expressions of the illness can act as obstacles to achieve successful treatment outcomes. The study provides evidence based information, for a better understanding of the needs concerning these pain patients. Our result indicates that parallel assessment and treatment of psychiatric comorbidities and sleep disorders combined with traditional rehabilitation, i.e. physical activation and cognitive reorganization are imperative for improved outcomes.

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1. Introduction

Chronic pain is one of the most common health problems worldwide [2], and a common cause for patients consulting a doctor [1–3]. Impairment due to chronic pain leads to high levels of work absence and dramatically increases the consumption of health care. Pain imposes a huge financial and psychosocial burden on patients, their families and society [4,5]. Patients suffering from nonmalignant chronic pain are at risk for developing somatic and psychiatric co-morbidities [6–9]. Changes in lifestyle, associated with chronic pain (e.g. less physical activity, weight gain and sleep disturbance) leads to risk factors for fatal diseases and increased mortality [7,10].

Patients with chronic non-malignant pain constitute a heterogeneous population as to aetiology and clinical presentation [11]. Despite that, they are often treated as though they were a homogeneous group. Few data are available about what distinguishes different groups in the large population of CPP patients. This lack of data affects the ability to design treatment options for various groups. CPP can be complex, and there is an order from those least affected to those most affected by their pain, other symptoms and comorbidities. Evidence-based treatments addressing the requirements of the most severely impaired group of CPP patients have neither been established nor evaluated in Sweden (or elsewhere to our knowledge). The conventional multimodal rehabilitation programmes that focus on regaining physical function, psychosocial ability and return to work are well supported by science [12–16]. The target group for this kind of intervention is patients motivated to overcome their physical disabilities and quickly return to work. Through clinical experience, we know that there are groups of CPP patients not succeeding in these treatments. One of these groups comprises patients most affected by the pain.

Uppsala University Hospital runs a specialized inpatient pain rehabilitation unit that accepts this group of severely disabled patients with chronic pain syndromes. The intervention consists of a six-week multimodal, acceptance based, individualized programme starting with a one-week team-based evaluation of obstacles for physical and cognitive functioning as well as pharmacological treatment. The following four-week treatment programme are based on individualized exposure to avoided activities led by a psychologist and a physiotherapist/occupational-therapist/nurse in pair with the patient. The exposure is done in activity. This is a key component in the treatment since our group of patients are extremely avoiding. Another approach focus on reducing stress, tension and worry by using mindfulness. After six weeks, there is a follow-up week with focus on evaluation of the results of the treatment intervention.

The primary aim of this prospective study was to identify deeper characteristics of an almost intractable subgroup of patients with CPP. We try to form evidence based information concerning a group of the most complex pain patients. A future goal is to use this information to assess and improve interventions tailored to special needs of this group.

A further aim was to determine whether it was possible to identify any association between medications and reported symptoms.

The information presented includes demographic data, psychiatric comorbidity, the total burden of symptoms other than pain, quality of life (QoL), pain rating, type of pain, medication and alcohol/illicit drug use and abuse.

2. Methods

The study was performed in full accordance with the Declaration of Helsinki (1965 and later revisions).

The study was approved by the Regional Ethical Review Board in Uppsala, Sweden (Dnr 2010/182).

2.1. Patients setting and demographics

Seventy-two consecutive patients referred to a specialized inpatient pain rehabilitation programme at the Pain Clinic at Uppsala University Hospital, Sweden, were enrolled and gave informed written consent. No patients refused to participate and there were no drop-outs. The inclusion criteria that had to be met before entering the programme were; primary or secondary pain care, including multidisciplinary rehabilitation had failed to overcome chronic disability and hence severe functional limitations remained. The patients have severe functional limitations, with some entirely bedridden. Exclusion criteria were active alcohol/illicit drug abuse, psychosis or suicidal behaviour. At the pain clinic, patients with various diagnoses of CPP were accepted. They had a variety of diagnoses when they were referred to the clinic. They were diagnosed with mixed pain conditions musculoskeletal pain, fibromyalgia, widespread pain, abdominal pain, pelvic pain, facial pain, complex regional pain syndrome (CRPS), neuropathic pain of various origins, etc. All the patients had an extreme degree of chronic pain syndrome with physical, social and mental function limitations. This group of patients is at the extreme end of the spectrum of CPP patients, often considered “too complex for health care”.

2.2. Procedure

A prospective descriptive design was used. Information on symptoms, QoL, alcohol/drug use/abuse and pain rating were collected by validated self-assessment tools. Psychiatric disorders were diagnosed by a psychiatrist using a structured clinical interview. The survey was conducted during the patients first week in the unit. When possible, a comparison was done with data from the Swedish Quality Registry for Pain Rehabilitation (SQRP), a registry established in 1995 to compare the results among pain rehabilitation programmes in Sweden [17].

2.3. Assessment-tools and surveys

2.3.1. Demographics

Data on age, sex and job status were obtained from patient medical records and the clinical interview.

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