RACGP | *PM16 Pain management contextual unit*

# Rationale

The burden of pain in Australia is significant and thus this is an area of healthcare that all general practitioners (GPs) need to understand and maintain current knowledge in. It is estimated that almost one in five adult Australians report current chronic pain. Pain management is said to be frequently inadequate for individuals with acute, chronic and palliative pain, with consequent detrimental impacts on quality of life.[1]

With current available therapies and techniques, it is estimated that more than 90% of patients should have access to effective management for acute and chronic pain.[2–5] GPs are typically on the front line of providing or facilitating access to this care. According to Bettering the Evaluation and Care of Health (BEACH) data, individuals with acute and chronic pain present commonly to GPs.[6] The National Health Survey 2007–2008 of adults over 18 years of age reported that 9.7% of participants said that they had severe or very severe pain; 19.3% said that they had moderate pain, and 39.1% reported mild or very mild pain.[3]

Distinguishing the type of pain experienced (ie nociceptive, neuropathic or visceral pain) by an individual, and thus understanding the pathophysiology as part of a holistic assessment that also incorporates assessment of risk factors for chronic pain management options, is an essential part of the diagnostic process.

Acute pain may be described as 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage, of recent onset and probable limited duration'.[7] This pain usually has an identifiable temporal and causal relationship to an injury or disease process. Chronic pain is increasingly recognised as being in continuum with acute pain rather than a separate entity and 'commonly persists beyond the time of healing of an injury and frequently there may not be any clearly identifiable cause'.[8,9] Chronic pain may, by definition, indeed be incurable and last forever[10] and tends to be related to complex psychosocial elements, which require broader treatment approaches than the pharmacotherapy approach of acute pain. Another important distinguishing feature between acute and chronic pain is that the response to opioids is vastly different.

In clinical practice, the time of transition between acute and chronic pain is usually unclear. The underlying pathophysiology needs to be understood, as does the individual's subjective 'pain experience'. The core skills of general practice focus on the importance of establishing the therapeutic relationship. This relationship is an ideal place to understand an individual's pain experience, which can be influenced by interactions between various psychological and sociocultural factors, particularly:

- previous experiences of pain, and personal and family history of mental health and substance use disorders
- beliefs and expectations (eg fear of movement after surgery or with low back pain)[11]

- mood – tendency to negative affect and coping abilities (eg propensity to catastrophise, neuroticism and anxiety, rumination, hypervigilance)[12]
- social determinants of health and cultural factors (eg socioeconomic status, ethnicity, language, geography, age, gender, health literacy, social and community supports, relevant cultural health beliefs)
- presence of aberrant drug-related behaviours,[13] which raises concerns about possibility of drug seeking and/or dependence.

Consideration of these factors can assist in assessing an individual's risk of developing chronic pain. If risk factors are recognised early and addressed, risks of progression and development of complications such as opioid misuse can be minimised. The costs of chronic pain are significant and include negative mental health with increased rates of depression and anxiety, financial difficulties due to impacts on employment, relationship breakdowns and social isolation.[14]

Assessment of pain can be more complicated in individuals who are young, elderly, have particular disabilities, or are from culturally and linguistically diverse (CALD) backgrounds. Use of effective communication, having an awareness of how pain can present in different individuals, and consideration of use of visual analogue scales can be helpful in these groups and, indeed, in dealing with all individuals experiencing pain. Use of scales such as the Pain Enjoyment General (PEG) activity scale,[15] which focuses on impacts on activity rather than pain intensity, can also be useful. Refer to the 'Useful pain management resources and tools' section for examples of these scales.

There is often a need for an effective multi-modal approach for at-risk individuals with acute pain or individuals who have chronic pain to address biological and psycho-sociocultural factors that may be contributing. The type of approach required depends largely on the type of pain and the factors contributing to the individual experience of pain, but may include collaborating with pain specialists, physiotherapists, occupational therapists, mental health professionals, social workers, acupuncturists and massage therapists. Effective chronic pain management involves a long-term multidisciplinary management plan. Focusing on just one aspect of management (medications, physical therapy or psychological approaches) is unlikely to lead to positive outcomes (such as improved daily function). Understanding the influences of potential for secondary gain and consequent risks of individual disempowerment, and addressing these through the avenues required (such as communication with the employer if consent is provided), is another important aspect of care.

Using best practice guidelines enables institution of the most effective pharmacological and/or non-pharmacological modalities that optimise the individual's possibility for recovery. Recent evidence suggests that GP compliance with guidelines in regards to use of opioid analgesics for chronic, non-malignant pain is unfortunately low, suggesting the need for improved access to resources and training for GPs.[16] Health education is typically an important part of pain management, providing information on potential side effects and the limitations of medications prescribed, risks of addiction, addressing fears and unreasonable expectations, considering risk of misuse of analgesics, avoiding (or de-prescribing) opiate-based therapy (apart from brief exceptional cases), enhancing self-efficacy (eg through exercise, weight loss, nutrition, strengthening core stabilisers) and establishing a clear person-centred management and review plan are all important aspects of quality care.

Providing care to patients in pain can be complex and at times challenging. Individuals in pain are often vulnerable and can have their sense of self challenged, particularly if the pain impairs their ability to function and to carry out their normal roles in society and/or within their family. It is common for individuals to describe feelings of hopelessness, helplessness, desertion and anger, and GPs may experience frustration when pain fails to respond to treatment.

Maintaining currency with understanding of pain and how it is managed is important, as new areas such as the role of pharmacogenomics in pain management become apparent. Genetic factors need to be considered within the context of the multiple factors outlined above that influence an individual's response to pain and to analgesia. An example of this is the CYP2D6 polymorphism, which can impact the rate of metabolism of medications like codeine and tramadol.[17,18]

A strict legislative framework is in place to minimise risks of prescription drug dependence. All GPs need to be aware of the regulatory responsibilities current in each state and territory and should follow guidelines when prescribing analgesic and other potentially addictive medications.[19] The landscape of prescribing analgesics and other drugs of dependence is currently changing with the pending implementation of the Electronic Recording and Reporting of Controlled Drugs, or real-time prescribing program. This may assist the identification of a number of those seeking opioids from multiple sources. GPs need to be aware of these changes and to implement appropriate processes into their clinical work to ensure that they remain up to date to improve quality and safety. Every GP should have strategies

at hand to manage individuals who present with signs consistent with prescription drug dependence. Individuals presenting with these flags require the same holistic care to manage the often complex contributing factors to their experience of pain and their perception of requirements for analgesic medication.

# Related contextual units

AM16 Addiction medicine

PS16 Psychological health

MS16 Musculoskeletal and sports medicine

CY16 Children and young people's health

CO16 Care of older people

DB16 Individuals with disabilities

RC16 Residential care

OP16 Oncology and palliative care

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# Useful pain management resources and tools

National Pain Strategy: Pain management for all Australians – National pain summit initiative, www.chronicpainaustralia.org.au/files/PainStrategy2010Final.pdf

Australian and New College of Anaesthetists (ANZCA) and Faculty of Pain Medicine, *Acute pain management: Scientific evidence*, 2nd edn, www.anzca.edu.au/resources/college-publications/pdfs/Acute%20Pain%20Management/books-and-publications/acutepain_update.pdf/view?searchterm=Acute pain management

Visual analogue pain scales can be useful for children, people of CALD background, people with disabilities, elderly people, http://health.vic.gov.au/qualitycouncil/downloads/acute/wimmera_obschartguide.pdf

NSW Therapeutic Advisory Group, Guidelines on rational use of opioids, www.ciap.health.nsw.gov.au/nswtag/reviews/guidelines.html

The Royal Australian College of General Practitioners (RACGP), *gplearning*, activities include:

Effective pain management in general practice; Making an effective pain diagnosis: A whole person approach; Management of moderate acute pain and the role of combination analgesia, http://gplearning.racgp.org.au/Course/Search?topicID=62

# Glossary

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