Best practices in the treatment of chronic non-cancer pain

Not Just a Prescription Pad

Mon. Nov. 7 | 6:30-8:15 pm PDT

November 7, 2022

WorkSafeBC

Agenda

Nov. 7
Part 1

- Introduction: enacted scenario: James
- Persistent pain overview
- WorkSafeBC programs and community resources
- Case 1: Sue: demonstrating a bio-psycho-social approach
- Non-pharmacological modalities
- Q&A

Nov. 14
Part 2

- Case 2: Phillip: complex chronic pain requiring integration of pharmacological and non-pharmacological pain management strategies including opioid tapering; variations
- Putting it all together: James follow-up
- Q&A

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Disclosures

- Dr. Peter Rothfels
  - Salary paid entirely by WorkSafeBC
  - No financial interest or affiliations with any pharmaceutical, medical device, or communications company
- Dr. Launette Rieb
  - No financial interest or affiliations with any pharmaceutical, medical device, or communications company
  - Consultant for ActumHealth, and St. Paul's Hospital Rapid Access Addictions Clinic
  - Presents at accredited CME event; including those for WorkSafeBC
  - No perceived bias to mitigate

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Learning objectives

1. Develop confidence to have **difficult conversations** related to broadening pain education and treatment options beyond the prescription pad
2. Apply key pharmacological principles including **tapering** of opioids, initiating **substitution therapy** and medication **exit** strategies
3. Identify community and regional **resources and supports**, including WorkSafeBC programs

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Introduction: enacted scenario - James

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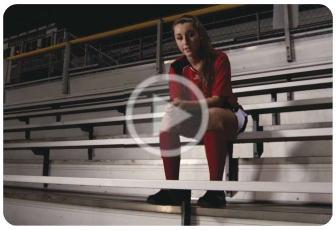
Pathways to Safer Opioid Use online training



Created by the Office of Disease Prevention and Health Promotion (health.gov)

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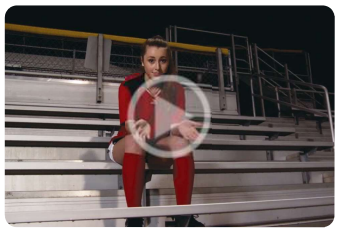
Pathways to Safer Opioid Use online training



Created by the Office of Disease Prevention and Health Promotion (health.gov)

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Persistent pain overview

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Poll question

Pain education can alter perception and function as much as medication and exercise

A. True

B. False

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Pain

is an **unpleasant sensory** and **emotional experience** associated with **actual or potential tissue damage**

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Challenge - Pain is primal

- Pain is a primitive and essential warning system
- It serves to alter behaviour – keep still, fight, avoid
- Feeling pain maximizes your chance at survival
- Numerous pathways keep pain systems alert
- Pain, mood, and addiction pathways overlap
- Highly adaptive for acute pain – not chronic pain

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Persistent pain

Chronic non-cancer pain

- **A different disease from acute pain**
- Associated with alterations in brain centers involved with emotions, reward, and executive function, as well as central sensitization of nociceptive pathways across several CNS areas
- Influenced by environmental and psychological factors
- Persists over a long period of time and can be resistant to stand-alone pharmacological treatments – pain changes the brain

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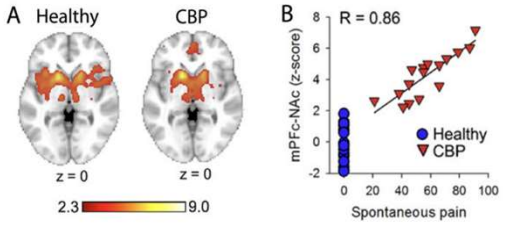
Apkarian. Pain and the Brain. PAIN 2011



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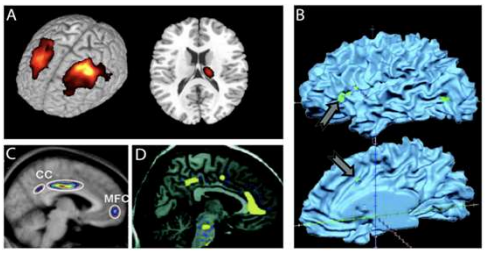
Apkarian. Pain and the Brain. PAIN 2011



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Challenge and opportunity for education

- Memory
- Meaning
- Magnification

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Challenge and opportunity for education

Alarm!

- Perception of threat
- Hurt vs Harm
- DIMS and SIMS
(Danger in me and safety in me)

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Non-pharmacological and non-opioid pain management strategies are as important as "real pain killers"



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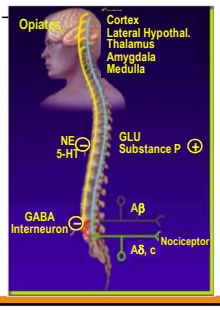
Depression and chronic pain

- Serotonin (5-HT) and norepinephrine (NE)…
- Key mediators of mood
- Part of the body's endogenous analgesic system



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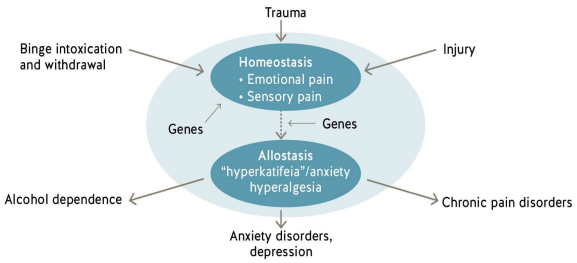
Alcohol, trauma, and injury



Egli, et al. 2012

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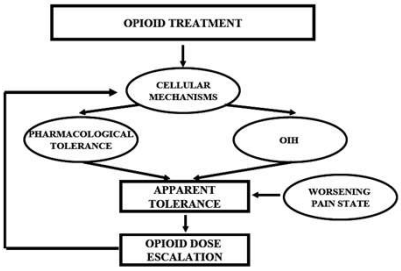

(Mao, 2008) Opioid induced hyperalgesia (OIH)

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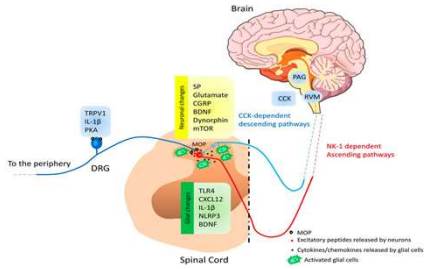
Opioid-induced pain sensitization



Ravat and Ballantyne, 2016

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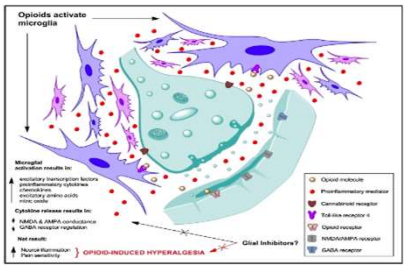
OIH mechanisms - microglia



Arout, 2015

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Clinical Note

PAIN

OPEN

Withdrawal-associated injury site pain (WISP): a descriptive case series of an opioid cessation phenomenon

Launette Marie Rieb[a,b,*], Wendy V. Norman[a], Ruth Elwood Martin[c], Jonathan Berkowitz[d], Evan Wood[b,e], Ryan McNeil[b,e], M.-J. Milloy[b,e]

December 2016, 157(12) 2865–2874.

Open access:
http://journals.lww.com/pain/pages/articleviewer.aspx?year=2016&issue=12000&article=00028&type=Fulltext

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WISP descriptions

"I was pounding my legs…old injury sites are horrendous."

"God, it felt just like it did when it was healing when it was broken."

"…the sensitivity to touch was increased."

"There's also not just physical pain,… but also there's anxiety from it too… it's like PTSD."

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Opioids: A double-edged sword

Pain relief, but also pain from…

- Opioid induced hyperalgesia (OIH)
- Withdrawal-induced hyperalgesia (WIH)
- Withdrawal-associated injury site pain (WISP)
- General myalgias and arthralgias of withdrawal

Primary mechanisms

- Neuroinflammatory/neuroimmune changes
- Microglia activation
- NMDAr – glutamate pathway activation

Possible mitigators of OIH

- NSAIDS, gabapentinoids, alpha blockers, NMDAr blockers, TLR-4 antagonists, naltrexone, neurosteroids, opioid rotation, opioid lowering, detoxification

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Guidelines for opioid prescribing for chronic non-cancer pain

- CPSBC practice standard, 2022 cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf
- Canadian guideline for opioid therapy and chronic noncancer pain, 2017 cmaj.ca/content/189/18/E659
- US CDC guideline for prescribing opioids for chronic pain, United States, 2016 cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- Draft US CDC guideline for prescribing opioids for chronic pain, United States, 2022 cdc.gov/media/releases/2022/s0210-prescribing-opioids.html

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Addiction to pain medications

- Those at highest risk:
  - Active SUD
  - Past Hx of SUD
  - Family Hx of SUD
  - Active psychiatric illness
  - Early childhood trauma history
  - Youth
  - Past minor injuries requiring prolonged opioid Rx
- Tight contracts, follow-up, and collateral

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Analgesic Efficacy of Opioids

- Average **20–30% analgesia** (Ballantyne, 2006)
- **Only 1 in 7-11 get relief** for CNCP (Busse, 2018)
  - The non-responders should be taken off right away, not left on with other medications added
  - Fantasy that endless dose escalations will provide further reductions in pain

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Factors associated with unintended persistent opioid use for CNCP

- Depression
- Anxiety
- Previous SUD
- **# pills given at first prescription or after surgery**
- **# days of opioid prescription given at 1st prescription or after surgery**
- N.B. Degree of pain and the type of surgery are not predictive

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Dose dependent risk of opioid addiction

- One study of a large claim database found long-term prescribed opioid use (>90 days' supply) associated with increased risk of an opioid abuse or dependence diagnosis vs. no opioid treatment
  - Low dose (1–36 mg MED/day): OR 15
  - Moderate dose (36–120 mg MED/day): OR 29
  - **High dose (≥120 mg MEDD): OR 122**

Edlund MJ. Clin J Pain 2014;30:557

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Prescription opioid treatment for non-cancer pain and initiation of injection drug use

- Large retrospective cohort study
- **Chronic opioid prescription users: 4% became injection users**
- Episodic opioid users: 1.3%
- Acute opioid users: 0.7%
- No hx prescription opioid use: 0.4%
- Higher opioid dose and younger age increased risk
- **The risk of initiation of IDU was 8.4 X higher** in those with chronic prescription opioid use than those who were opioid naïve (95% CI, 6.4-10.7)

Wilton J, et. Al. BMJ 2021; 375:e066965 doi: https://doi.org/10.1136/bmj-2021-066965

Factors Associated with OD

- Aberrant behaviors
- Recent initiation of opioids
- Methadone
- Concomitant use of benzodiazepines
- Obtaining opioid prescriptions from multiple providers
- Substance abuse and other psychological comorbidities
- **Higher dose**

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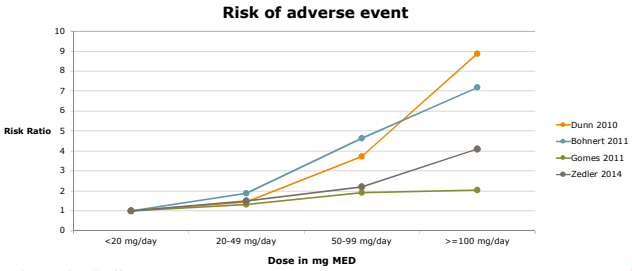
Dose-related risk of opioid overdose



Courtesy Gary Franklin

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Emotional pain of substance withdrawal

- ↓ dopamine → depression, grief, loss, lethargy, motivation

- ↑ noradrenalin → anxiety, insomnia, worry, perseveration, agitation, aggression, activation of traumatic memories, flight

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Common Tx goals for pain and SUD

- Correct sleep disturbance
- Stabilize mood
- Eliminate unnecessary medications
- Restore function

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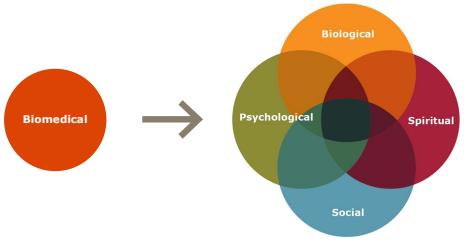
Moving beyond a biomedical model



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WorkSafeBC programs and community resources

WorkSafeBC outpatient programs

- Occupational Rehabilitation 1 (OR1)
  - Kin and PT, 4 hours/day, 5 days/week (6 weeks)
- Occupational Rehabilitation 2 (OR2)
  - Counsellor, Kin, OT, PT 6 hours/day, Physician available, 5 days/week (10 weeks)
- Pain and Medication Management program (PMMP)
  - Physician, Psychologist, Kinesiologist, OT, PT, 6 hours/day, 5 days/week (8-12 weeks)
- Concurrent Care Program (CCP)
  - Addiction Psychiatrist, Addiction Medicine Specialist, Psychologist, Clinical counselor, PT, OT, Kin 4-6 hours per day (8-12 weeks), access to residential treatment
- Community Pain and Addiction Services (CPAS)
  - Addiction Medicine assessments referral to treatment and some outpatient services

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WorkSafeBC Physician's line

- Information line for health care providers treating an injured worker with chronic pain
- We can help with information on the following:
  - Opioid and sedative/hypnotic prescribing practices
  - Tapering strategies and alternative (pharmacological and non-pharmacological) treatment strategies for injured workers with chronic pain
  - Treatment resources, such as pain or medication management programs and addiction treatment programs

WorkSafeBC Physician's line
1.855.476.3049

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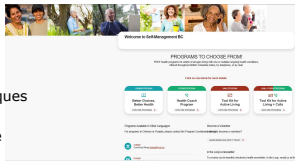
Community resources
Self-Management BC

- selfmanagementbc.ca
- Call toll free: **1.866.902.3767**
- Patient self-referral
- Self-management support consists of techniques and strategies that can be used by health professionals in clinical practice to encourage healthy behaviours
- Visit the website to find local self-management programs (Tool Kit for Active Living)



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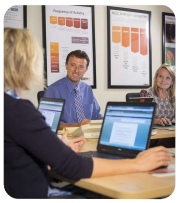
Local multidisciplinary groups

- If a formal program is not available, consider forming an informal group
- Groups can include:
  - Physicians
  - Nurse practitioners
  - Kinesiologists
  - Pharmacists
  - Physiotherapists
  - Occupational therapists
  - Therapists (e.g., psychologists, clinical counsellors)
- Other support
  - Online CBT, mindfulness, sleep programs



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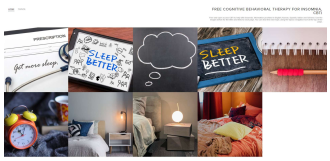
Community resources
Self-Management tools and resources

- Free Cognitive Behavioral Therapy For Insomnia, CBTI freecbti.com
  - Free sleep apps include sleep hygiene, mindfulness, and meditation
- Pain BC: Live Plan Be liveplanbe.ca
  - 6 – 12 weeks coaching



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Community resources
Bounce Back

- Canadian Mental Health, BC Division cmha.bc.ca/programs-services/bounce-back/
- Guided self-help with telephone interview overcoming depression low mood and anxiety
- Cognitive behavioral interpersonal skills manual
- GP who consults Bounce Back can bill community patient conferencing fee

Bounce Back

1.866.639.0522

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Other community resources

- PainBC painbc.ca
- American Pain Society painmed.org/american-pain-society/
- Dr. Lorimer Moseley's
  - Tame the Beast – It's time to rethink persistent pain (video) tamethebeast.org
  - Pain, the brain and your amazing protectometer (YouTube video)
- Addiction medicine resource access numbers
  - Bc211 - Phone: 211 bc211.ca
  - Rapid Access Addiction Clinic (RAAC) - Phone:604.806.8867 providencehealthcare.org/rapid-access-addiction-clinic-raac
  - Rapid Access to Consultative Expertise (RACE) - Phone: 604.696.2131 / toll-free: 1.877.696.2131

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Other community resources

- Alcoholics Anonymous (AA)
  - Surrey & North Delta district42aa.com
- Narcotics Anonymous (NA) bcrna.ca
- Books:
  - *Explain Pain* by Drs. David Butler and Lorimer Mosely
  - *Nice Recovery* by Susan Juby
  - *Pain Chronicles* by Melanie Thernstrom
  - *Painful Yarns* by Dr. Lorimer Mosely

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Medical return-to-work reference guidelines

- Canadian National Opioid Use Guideline Group ncbi.nlm.nih.gov/pmc/articles/PMC3215602/
- Railways Workers Medical Guides (RAC) railcan.ca
- Law Enforcement Officer Guides (ACOEM) acoem.org
- Drivers Medical Fitness Guidelines (CMA) cma.ca
- ACOEM Practice Guidelines: *Opioids and Safety-sensitive work* acoem.org acoem.org
- ACOEM Guidelines: *Marijuana in the Workplace: Guidance for Occupational Health Professionals & Employers* acoem.org
- Aeronautics Act – *Pilots & Air Traffic Control* laws-lois.justice.gc.ca/eng/acts/a-2/page-1.html

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Clinical case 1: Sue

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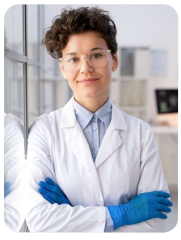
Case study: Sue

- 35 years old
- Geologist doing well inspection
- Hit head off truck mirror
- No symptoms initially
- Later that day nausea, dizzy, and neck pain, right arm non-dermatomal paresthesia
- 6 months later still c/o cervical occipital neck pain and right arm pain; has not returned to full duties however remains work attached performing modified work



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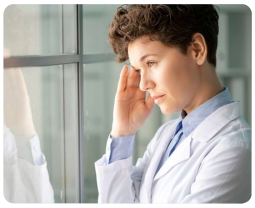
She's frustrated

↓

You're frustrated

↓

Dreaded feeling with hand on the door knob



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Taking a pain history

Pain is the key reason for 30% of presentations to primary care

- Mechanism of injury
- Pain onset, location, quality, exacerbating and relieving factors, pros/cons to 0-10 pain rating
- Pain interference on QOL and function
- Beyond the initial history and queries about medication response, it is counterproductive to ask patients to rate their pain or keep a pain diary
- Focus should be on functional gains and activity achievements despite pain

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Gathering sleep history

- Time the patient gets into bed
- Sleep onset
- Wakenings (when, how long)
- Further sleep
- Time awake finally
- Time up out of bed for the day
- Napping
- Signs of sleep apnea (snoring, apneic spells, choking, wakenings)
- Symptoms of sleep issues/disorders: Restless leg syndrome, nightmares, night terrors, sleep walking

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Screening/assessment tools – pain & psych

Pain

- Brief Pain Inventory (BPI)
- Pain Disability Index (PDI)
- Orebro Musculoskeletal Pain Screening Questionnaire
  - Predicts long term disability and failure to return to work

Psychiatric

- Adverse Childhood Experiences (ACE)
- Generalized Anxiety Disorder (GAD7)
- Patient Health Questionnaire 9 (PHQ) – screens for major depressive disorder
- Beck Depression Inventory (BDI)
- Pittsburgh Sleep Quality Assessment (PSQI)
- PTSD Checklist (PCL) or the Davidson Trauma Scale (DTS)

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Screening/assessment tools – addiction

Addiction

- CAGE (Cut, Annoyed, Guilty, Eye) - alcohol
- Alcohol Smoking and Substance Involvement Screening Test (ASSIST)
  - Screens for problem or risky substance use in adults
- Alcohol Use Disorder Identification Test (AUDIT-C) – 3 questions
- Cannabis Use Disorder Identification Test - Revised (CUDIT-R)
- Drug and Alcohol Screening Test (DAST)
- Current Opioid Misuse Measure (COMM) – current prescription opioid use for pain
- Opioid Risk Tool (ORT) – prescreen and current prescription opioid use for pain
- Screener and Opioid Assessment for Patients with Pain (SOAPP-R)
- Geriatric Screener and Opioid Assessment for Patients with Pain (GSOAPP-R)
- Diagnosis Intractability Risk and Efficacy Score (DIRE) - used before initiating prescription opioids for pain or during current use to evaluate risk

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Single question screening tool for drug use

How many times in the past year have you used an illegal drug or prescription medication for non-medical reasons?

Ref: Arch. Intern Med 2010 Jul 12 170(13) 1155-1160

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Poll question

When taking a history from a chronic pain patient, which of the following would you consider to be a "Yellow flag" (warning sign) statement or condition?

A. Belief that activity will cause more pain and therefore more harm

B. Patient frustration that his/her chronic pain has not been cured

C. Persistent low or negative mood

D. Social and/or work withdrawal

E. All of the above

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Yellow flags to watch for

- Work problems or poor job satisfaction
- Frustrated with current treatment
- Belief that pain and activity will cause physical harm
- Excessive reliance on rest, time off work or dependency on others
- Persistent low or negative moods, social withdrawal
- Belief that passive treatments are key to recovery
- Non-supportive, dysfunctional or dependent family relationships
- Exaggerated pain symptoms
- Personal/family Hx of SUD and/or chronic pain

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Sue's biopsychosocial interview

- Sue had a prior concussion 8 months earlier
- Red flags ruled out
- Headaches low level constant, with episodic flare – incapacitating
- Non-dermatomal pattern of arm pain
- Still managing to work but is very fatigued afterwards
- Has stopped going out of the house outside of work and groceries
- She lives alone with her cat

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Sue's initial yellow flags

- Lives alone
- Past history of MDD – currently ruminating thoughts
- Poor sleep initiation and maintenance, non-restorative, snoring
- No longer engaging in social activities, isolated
- Family hx: Father AUD, mother fibromyalgia

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Sue's testing for psychiatric conditions

- Rating disability due to pain: PDI score - moderate
- Anxiety: a GAD score - moderate
- Depressive symptoms with rumination: PHQ9 score - high
- Addiction screening CUDIT score - at risk for cannabis use disorder
- Catastrophizing: Orebro Musculoskeletal Pain Questionnaire score - high

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Gathering medication history

- Bring in all medications used currently and left over
- Show PharmaNet profile as you talk
- Mention both the generic and trade names
- Ask current dose and highest dose ever tried
- Ask about benefits and adverse side effects
- Sort out the reason for discontinuations
- Detail usage (starting dose, how it was titrated, maximum dose reached, duration of trial)
- Explore patient's belief around a medication

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Sue's medications and substances

- Acetaminophen (Tylenol arthritic): 650 mg 2 TID – "Little bit" of pain relief
- Melatonin: 5 mg HS – helps her fall asleep but not stay asleep
- St. John's Wort: 2-3 days a week when feeling "stressed"
- Alcohol: 5 standard drinks twice weekly – "to get to sleep", no craving, consequences, or loss of control
- Cannabis: 2 joints a day – weekdays after work, 3-4 joints per day on weekends, can't recall a day without, temporarily decreases anxiety, pain, and nausea, yet decreases motivation to do other things

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Non-pharmacological treatment modalities

Poll question - Non-pharmacological interventions

List all the non-pharmacological interventions that you recommend to your patient. Select all that apply.

- ☐ Exercise and activity
- ☐ CBT
- ☐ Mindfulness
- ☐ Hypnosis
- ☐ Acupuncture
- ☐ Yoga
- ☐ TENS
- ☐ Massage

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Evidence-Based Non-Pharmacological Therapy for LBP	# trials
Exercise	122
Chiropractic/manipulation	61
Acupuncture	49
Multidisciplinary rehabilitation	44
Psychological therapy	32
Massage	26
Yoga	14
Mindfulness-based stress reduction	3
Tai chi	2

Chou, Ann Intern Med 2016; slide courtesy of K. Kroenke

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Non-pharmacological treatments

Exercise and activity (including physiotherapy)

- Activity that enhances and/or maintains muscle strength, physical fitness, and overall health
- High quality **evidence** that exercise improves pain and functional outcomes immediately after exercise. Moderate support of some sustained pain and function for over 6 months
- Aerobic exercise in FM — ↑Quality of life and function, ↓ pain

Cochrane Review Bidonde, 2017

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Non-pharmacological treatments

Psychological (CBT, Mindfulness, Hypnosis)

- Therapy whose aim is to re-frame and/or restructure the way someone has been thinking about a problem
- Focuses on adopting positive ways of coping with pain
- Cochrane Reviews
  - CBT — ↓depression, disability, pain (Williams, 2020)
  - Mindfulness Meditation — as good as CBT (*Cherkin, JAMA2016)*
- Internet-based psychotherapies may have some improvement in pain and disability
  - moodgym.com.au/
  - https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/depression-in-adults
- Clinical management has effect

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Non-pharmacological treatments

Complementary therapies

- **Acupuncture** — low quality studies demonstrating short-term and mid-term benefit
- **Yoga** – some evidence to support improved socialization, decreased absenteeism, and psychological benefit in the short term
- **TENS** – Inadequate evidence
- **Massage** – Some evidence of short-term benefit for low back pain
- Cochrane Reviews:
  - TENS — conflicting (Khadilkar, 2008); AP — ↓tension H/A (Linde, 2016)
  - Massage — ↓ pain , esp combined with stretching/ed (Furlan 2008)
  - Spinal manipulation for CLBP — no better/worse than tx like PT/exercise, unclear compared to sham (Rubinstein 2011)

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Review

- Herbal Medicine for Pain Management: Efficacy and Drug Interactions
- Behdad Jahromi 1, Iulia Pirvulescu 1 , Kenneth D. Candido 1,2,3 and Nebojsa Nick Knezevic 1,2,3,*

Pharmaceutics **2021**, *13*, 251. https://doi.org/10.3390/ pharmaceutics13020251

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Herbal treatments

- If your patient is interested in herbal treatments, your pharmacist can run herbal databases to look for drug-herb interactions + evidence for benefits/ side effects
- The first 8 are covered in the previous study:

1	**St. John's Wort**	10	**Arnica**
2	**Ginger**	11	**Bromelain**
3	**Turmeric**	12	**Valerian root, Hops, Chamomile (for sleep)**
4	**Omega 3 fatty acids**	13	Gamma linolenic for RA
5	**Capsaicin**	14	Gum resin – avocado-soybean for OA
6	**Butterbur**	15	Cayenne
7	**Feverfew**	16	Devil's claw
8	**Willow bark**	17	Comfrey root
9	**Menthol**	18	Lavender and essential oils

Review

- Herbal Medicine for Pain Management: Efficacy and Drug Interactions
- Behdad Jahromi 1, Iulia Pirvulescu 1 , Kenneth D. Candido 1,2,3 and Nebojsa Nick Knezevic 1,2,3,*

Pharmaceutics **2021**, *13*, 251. https://doi.org/10.3390/ pharmaceutics13020251

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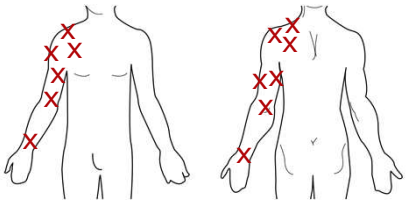
Physical examination

- No neurological findings
- Myofascial trigger and tender points in his neck including radiation into arm and head

Sue's pain diagram

Triggered with myofascial trigger points in neck and shoulder girdle



Physical examination and reexamination

- Emotional overlay and perception of threat can create pain behaviours that are counterproductive to functional progress and can distract the clinician
- Observe the patient's emotional state, reactivity, mental flexibility, movements and posture throughout the encounter
- Include non-threatening exam techniques (e.g., seated straight leg raise)
- Do a thorough neurological and MSK exam – walking the patient through what you are doing, what you find, and the implication of the findings

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Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients

Imaging finding	Age (yrs.)						
	20	30	40	50	60	70	80
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height loss	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

Brinjikl W. et al. Systematic literature review of spinal degeneration in asymptomatic populations American Journal of Neuroradiology Nov 27, 2014

Sue's summary to date

- Chronic non-cancer pain – myofascial
- Unresolved mild concussive symptoms
- Symptomatology consistent with moderate MDD with anxious features
- Poor sleep efficiency, rule out sleep apnea
- Ineffective medication regime that may be contributing to symptoms
- Drinking above low risk guidelines
- Significant likelihood of a cannabis use disorder that may be contributing to symptoms
- Social isolation, high perception of disability, catastrophizing and functionally limited
- **In her favour - Positive** that she remains at work, and has a cat

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> To write prescriptions is easy, but to communicate with people is difficult
>
> — Franz Kafka, A Country Doctor, 1916

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Communication is critical

- Talk less, interfere less
- Listen more. Discovery and curiosity
- Summarize or acknowledge
- Reconcile conflicting views of the seriousness of the diagnosis or seriousness of the condition

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Help patient gain insight into his or her behavior rather than over medicalizing the problem

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Goal

- Improvement in quality of life
- Sustained improvements in function including a return to work within a specified time period
- Meaningful reduction in pain may not happen but pain experience will improve

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Shifting focus from pain to function

COACH patients in the following cognitive shifts:

- At a certain point, pain becomes MALADAPTIVE
- As pain persists it is less and less useful – it is an abnormal and pathological signal unto itself – like static on the line – that you can learn to turn down or tune out with practice
- Explain you are going to help them retrain their brain to decrease attending to the pain signal, and increase other aspects of wellness, including a focus on function and activities
- Returning to work decreases depression, poverty, relationship breakup, and suicide rates

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Sue's treatment

- Over the next 6 months step-wise engagement in a bio-psycho-social treatment plan including pain education on hurt vs harm
- Topical diclofenac 10% with menthol 4% TID for pain
- Nortriptyline 10 mg hs – for sleep along with CBTi
- Bounce Back CBT manual and refer to local mental health
- Massage X 3 with an RMT who taught myofascial self-release techniques, back hook, rollers, breathing techniques
- Decrease alcohol to 2 drinks 2 nights a week
- Refer to SMART for cannabis education and reduction
- Neil Pearson - *Life is Now* online modules

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Sue's follow-up

- Neck pain 5/10 (30% improvement), arm pain 3/10 (40% improvement)
- Headaches now only 3 days per week, rarely severe
- GAD 7 – normal
- PHQ 9 – mild. Finished Bounce Back manual, on wait list for counsellor
- Sleeping at least 6.5 hours per night
- Marijuana Saturday evenings and considering quitting, alcohol 4 drinks per week
- Walking 3km 5 times per week
- Started meditation/mindfulness, notes decreased workplace tension

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Summary

- Chronic pain is not acute pain
- Remember biopsychosocial approach to management
- Communication includes active listening
- Brief Action Planning
- Acceptance and commitment therapy- create a rich and meaningful life and accept the pain that goes with it
- Exercise/Activity is crucial
- Staying at work or returning to work is therapeutic
- Use a ladder approach to treatment
- Attempt first to do no harm

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Questions ?

Join us again on November 14

Part 2 webinar

Date: Monday, November 14, 2022

Time: 6:30 – 8:00 pm (PST)

- Case 2: Phillip: complex chronic pain requiring integration of pharmacological and non-pharmacological pain management strategies including opioid tapering; variations
- Putting it all together: James follow up
- Q&A

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Phillip

54 years old right hand dominant ironworker with chronic pain: thumb, hand, shoulder

- Sustained a work-related hyperextension injury of right thumb in 2008, seen in 2017
- Volar plate for MCP joint, and arthrodesis
- Carpel tunnel release
- Residual symptoms of neuropathic pain
- Surgeon said "avoid narcotics at all costs" yet on opioids
- Severe depression, nightmares, with PTSD from war experience in Iran as journalist
- Walking his dogs helps – not working

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Thank you
for attending