GPs at the Deep End

Pioneer Scheme Half-day Learning programme

Wednesday 17th April 2019

KNOWLEDGE EXCHANGE

Chronic pain management

With Dr Colin Rae (Anaesthetist), Pamela Gavin (Physio), Lauren McAllister (Clinical Psychologist), Diane Watson (Pharmacist), Stobhill Pain team.

1) What were the key learning points from this session?

Chronic pain is a "long-term condition" and is considered as such by the health board

- Often associated with other long-term conditions and mental health problems, psychological trauma
- Commoner with higher levels of deprivation

Severe chronic pain associated with increased 10-yr mortality from circulatory and respiratory causes

Pain is a subjective experience and influenced by a range of complex factors including emotion / mood (e.g. anxiety), social / cultural / environmental factors / genetics

Chronic pain causes mental distress and may significantly affect patients mood and thinking

Assessment

1. Should always take account of mental health / emotional factors
2. Needs to exclude / diagnose treatable conditions
3. Rating scales e.g. VAS can be used but are more suited to acute pain

70-80% of chronic pain is managed in primary care

Management should be primarily *non-medical,* aiming for:

1. Supported self-management
2. Rational prescribing – note: *the WHO analgesic ladder is not appropriate to chronic pain*
3. Exercise / activity-based approaches
4. Referral to specialist pain service for complex cases

Chronic pain service structure / team members (in Greater Glasgow & Clyde):

1. Referrals are vetted by MDT
2. Initial assessment by consultant, or sometimes physio/nurse
3. Management will almost always include patient education classes:
   - 12-week pain management programme – half-day once weekly, OR
   - 3-week residential pain "boot camp" for suitable patients
4. Physiotherapy – usually slower-paced with gradual build-up
5. Psychology – limited to more complex cases, may involve referral to other services (e.g. psychological trauma)
6. Pharmacist – for patients on complex/high-dose opioids, may take over prescribing, works across pain and addiction service

2) What changes to practice might you consider?

Ask everyone with chronic pain about adverse childhood experiences, home/family life and mental health

Discuss/explain to patients:

1. why they have pain and the need for holistic/broad management
2. that medications for chronic pain are generally ineffective
3. ALL medications have side effects, long-term harms from opioids include effects on endocrine & immune systems, hyperalgesia, falls

If prescribing painkillers:

1. Only start as a trial - then review and stop if ineffective
2. Emphasise for PRN use

Try and help patients to have realistic expectations – may need to be acceptance of *living with* pain

Signpost to patient information resources (below) or one of the NHS GGC Pain Education Sessions – paineducation@ggc.scot.nhs.uk for info, patients book by phoning 0141 277 7625

If patients reluctant to engage with holistic pain management - need to explore *fears*: e.g. worsening pain (physio *may* increase pain initially but will be paced accordingly), reduction of medications, effect on benefits such as PIP

3) **Any useful resources to share?**

https://paindata.org/ - West of Scotland chronic pain education group – info for professionals and patients, includes opioid tapering calculator

https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
https://www.rcoa.ac.uk/node/21103 - long term harms of opioids

http://painconcern.org.uk/resources/about-pain/ - videos and podcasts amongst other things
https://sheffieldpersistentpain.com – lots of useful patient info

https://www.sign.ac.uk/sign-136-management-of-chronic-pain.html - 2013