MANAGING PERSISTENT PAIN IN PRIMARY CARE:
A Brief Guide

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Sources:
2. Washington State Pain Management Law- EHSB 2876
3. Collaborative Opioid Prescription Education (COPE), MD Sullivan, University of Washington
Managing Persistent Pain in Primary Care: I. Overview

1. Understanding the Different Types of Pain

**Acute Pain vs. Persistent pain**

*Acute pain* typically follows bodily injury and generally disappears when the injury heals. Acute pain serves as a warning signal for potential bodily harm.

*Persistent pain* is defined as pain that **persists** beyond the usual course of an acute condition or expected time for an injury to heal. Persistent pain may be associated with chronic and progressive illnesses such as cancer or AIDS, but may also occur in the absence of identifiable organic pathology. *Persistent pain is not a reliable signal for bodily harm.*

**Nociceptive Pain vs. Neuropathic Pain**

*Nociceptive pain* is related to *ongoing activation of nerves that respond to noxious stimuli*, and includes somatic pain caused by lesions in skin, subcutaneous tissues, bone, muscle and blood vessels, and visceral pain that originates in internal organs or body cavity linings.

*Neuropathic pain* is related to *disease or dysfunction of the nervous system itself*, and includes periphery syndromes such as diabetic neuropathy, radiculopathy and trigeminal neuralgia, and central pain syndromes such as fibromyalgia, complex regional pain syndrome and phantom limb.

2. Assess Pain Systematically

**Characterize Pain.** Assess location, severity, onset and duration, fluctuation, quality, and factors that worsen or improve the pain.

**Evaluate impact of pain.** Identify impact on generally activity level, sleep, mood, relationships and vocational activity.

**Conduct a physical exam.** Conduct a focused exam based on the pain complaint.

**Review prior records and diagnostic studies.** Avoid repeating or ordering unnecessary studies.

3. Identify Comorbid Conditions

*Psychological disorders, such as depression, panic disorder and post-traumatic stress disorder, are highly comorbid with persistent pain.* Persistent pain is also associated with increased prevalence of substance use disorder. Asking about symptoms of depression and anxiety, using screening questionnaires such as PHQ-9 and GAD-7, and getting a detailed substance use history should be part of every assessment.

4. Track Pain Intensity and Function over Time

*Regular measurement of pain level and daily functioning allows the clinician to assess the effectiveness of treatment and adjust the treatment plan as necessary.* In the MHIP Pain Pilot project, a brief 4-item questionnaire consisting of the 3-item PEG scale and an Activity Limitation question is recommended for this purpose.

5. When to Refer to Pain Clinic

Consider referral to a pain clinic when any of the following is present: *severe pain unresponsive to escalating doses of medication; lack of diagnostic clarity; complex psychiatric comorbidities; the need for treatment modalities that the PCP cannot directly provide.*
Managing Persistent Pain in Primary Care: II. Opioid Therapy

1. When to Prescribe

Opioids are increasingly used to treat persistent non-cancer pain, but the practice is controversial. Long-term opioid effectiveness for persistent pain has not been clearly demonstrated. The principal reason for prescribing opioids is to improve the patient's quality of life by providing pain relief. However, even if opioids provide pain relief, their use can decrease overall quality of life through other effects, such as sedation or opioid misuse. If a decision is made to prescribe opioids, the clinical focus should be on improving the patient's life and functional status, and not just decreasing pain.

2. Specific Concerns Regarding Long-term Opioid Therapy

Hyperalgesia. Instead of reducing pain intensity, long-term opioid use may lead to increased sensitivity to pain through opioid hyperalgesia.

Iatrogenic Addiction. The risk of inducing addiction in patients without previous problems with substance abuse is low. However, there appears to be a risk of worsening or reactivating addiction in patients with a current or previous history of substance abuse. Family history of substance abuse may also increase risk for opioid abuse. Nicotine dependence has been associated with increased risk for opioid abuse in a number of studies. (See Appendix A for the Opioid Risk Tool.)

Hormonal and Immune Effect. Chronic opioid treatment has been associated with suppression of testosterone, estrogen, cortisol, LH and FSH levels. This treatment may also suppress immune function.

3. Informed Consent and Opioid Agreement

Long-term opioid therapy should be a conscientious decision made jointly by the prescriber and the patient based on informed consent about the potential risks and benefits of chronic opioid use. Ideally, continued opioid prescription is contingent on the patient showing functional improvement with opioid use. Signing an opioid management agreement at treatment outset can increase adherence and reduce aberrant opioid use behavior. (See Appendix B for a sample opioid agreement.)

4. What Is ESHB 2876?

The Washington State legislature has mandated new rules regarding the management of persistent pain. (Note that the law specifically excludes from its jurisdiction the treatment of acute pain, surgical pain, palliative care, and cancer pain.) The new law states that all providers in the State of Washington should comply with the following guidelines for opioid prescriptions.

1. All clinicians prescribing long-acting opioids, including methadone, are expected to complete 4 hours of CME on the topic of long-acting pain medications.
2. All clinicians are required to document for all their patients on chronic opioids:
   - A risk assessment for prescription drug abuse.
   - A running assessment of the effects of treatment on pain and function.
   - Documentation of results of periodic urine toxicology screens
3. Clinicians are also required to refer all of their patients taking more than 120 mg morphine-equivalents daily (MED) for a pain specialist consultation unless one of the following exemptions for a mandatory consult are met (See www.agencymeddirectors.wa.gov/Files/DosingCalc.xls for an MED calculator):

- You have documented that the patient's function is improved and patient is on a stable dose and I without high-risk factors for abuse.
- You have documented that the patient is on a scheduled dose tapering down.
- You have documented that the dosing above 120 mg MED is a temporary, time-limited, acute increase.
- The clinician has ≥ 12 hours (every 2 years) of CME on pain management.

5. Additional Training Tool
COPE (Collaborative Opioid Prescribing Education) is an online training tool for physicians who treat patients with persistent non-cancer pain. The University of Washington School of Medicine offers COPE as a Category 1 accredited activity through the Office of Continuing Medical Education. See www.cope-pain.org.
## Opioid Risk Tool

**Date**

**Patient Name**

### Opioid Risk Tool

<table>
<thead>
<tr>
<th>1. Family History of Substance Abuse</th>
<th>Mark each box that applies</th>
<th>Item Score If Female</th>
<th>Item Score If Male</th>
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<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
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<td>3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
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<td>4</td>
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</table>

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<th>2. Personal History of Substance Abuse</th>
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<th>Item Score If Male</th>
</tr>
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<tbody>
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<td>Alcohol</td>
<td>[ ]</td>
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<td>3</td>
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<tr>
<td>Illegal Drugs</td>
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<th>4. History of Preadolescent Sexual Abuse</th>
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<th>Item Score If Male</th>
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<tr>
<td>Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia</td>
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<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ]</td>
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</table>

**Total Score Risk Category**

- Low Risk 0 – 3
- Moderate Risk 4 – 7
- High Risk ≥8

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Managing Persistent Pain in Primary Care: II. Opioid Therapy

Appendix B. Sample Opioid Agreement

Effective pain management requires that the patient and clinician work together. This agreement is designed to make sure that you understand your obligations and the conditions of your care.

If you do not understand any part of this agreement, please talk with your clinician. If you do not fulfill your obligations in your care, we will be less effective in helping you. We might even have to stop treating you.

1. I will take my pain medications as prescribed. I will not increase or decrease the dose on my own. I will not take more than is prescribed, so I will not run out early.

2. The _______ clinic provider will prescribe enough medication to last until my next visit or next scheduled medication refill date.

3. I will not request, and will not be provided with early refills. I understand that it is my responsibility to keep track of my pain medications. I must allow at least ___ business days for them to be refilled. I understand that if I allow less time than this, I may have to go without.

4. Refills will not be provided on an emergency basis, after hours, on weekends, or on holidays. On-call providers will not provide refills of my pain medication.

5. Prescriptions are like money. If I lose my medication or the written prescription slip, neither will be replaced. I will have to wait until my next visit or scheduled refill date.

6. I agree to take only my own medications. I will not take someone else’s medication, even if I think it is the same medicine. I will not share my medications with anyone else.

7. My _______ clinic providers will be the only clinicians prescribing my long-term pain medications and other controlled substances (opioids, tranquilizers, muscles relaxants, and/or sedatives).

8. If I require more pain medications from another provider for an acute injury or procedure, I will not use my long-term medication for this problem. I will disclose my full medication list and the existence of this Pain Management Patient Care Agreement to this other provider, and arrange to have him/her provide refills of the new medication. I must let my _______ clinic providers know about any medicines prescribed for me by other doctors or any other health care providers within 48 hours or 2 business days of the change.

9. I understand that I may fill my first prescription at the pharmacy of my choice. After that, all refills must be made with the same pharmacy. My ________ clinic provider must agree to any change of pharmacy.

10. I agree not to take or use any street or recreational drugs, other controlled substances, or unauthorized substances during the course of my treatment.

11. I agree to advise my prescribing provider of any over-the-counter drugs, vitamin supplements, and/or herbal remedies I am taking. I agree to disclose my full medication list.

12. I understand that my provider may request blood or urine drug tests to help guide my treatment.

13. I will keep all of my follow-up appointments.
14. Lowering my dose over time will help me know if I still need pain medicines. Once the right
dose for me is determined, the medication management *may* be transferred to a primary
care provider.

15. If other treatments are needed, such as physical therapy or counseling, I agree to follow
through with the entire program. I understand that I will not continue to receive pain
medications unless other therapy appointments are kept.

16. If I do not comply with the above, then I understand that my pain medications will be
stopped after tapering the dose.

**By signing below, I am saying that I:**

- Agree to these obligations and conditions.
- Have read them and understand them.
- Have received and reviewed the handout “About Your Pain Management.”
- Have had my questions answered to my satisfaction.
- Will notify my prescribing providers if I feel I will not be able to honor the commitments
  made in this agreement.

My Primary Care Provider: _____________________________________________________

My Pharmacy Name, Phone Number and Location: ________________________________

__________________________________________________________________________
Managing Persistent Pain in Primary Care: III. Non-Opioid Pharmacotherapy

Several classes of nonopioid medications are useful for various pain disorders. The choice of medications should be matched to the individual patient, considering factors such as type of pain disorder, inferred pathophysiology, comorbid conditions and prior response to specific analgesics.

1. **Acetaminophen**
   Acetaminophen is safe and effective in relieving mild to moderate pain at up to 4,000mg per day. Lower doses or complete avoidance may be necessary for patients with liver disease.

2. **NSAIDs**
   All NSAIDs inhibit the cyclooxygenase (COX) enzyme and thereby exert analgesic and anti-inflammatory effects. Drugs that selectively inhibit COX-2 have similar analgesic and anti-inflammatory effects as the nonselective NSAIDs but are associated with reduced risk of GI toxicity.

3. **Muscle Relaxants**
   Muscle relaxants are indicated to treat acute muscle spasm and are often used for acute exacerbations of chronic muscle pain. Several studies have demonstrated the efficacy of muscle relaxants in decreasing muscle spasm, reducing local pain and tenderness, and increasing range of motion in acute, painful musculoskeletal conditions. Muscle relaxants are often associated with sedation, and therefore should be used judiciously.

4. **Anticonvulsants**
   Anticonvulsants reduce neuronal hyperexcitability, and are generally as effective as opioids for neuropathic pain, with the best evidence for effectiveness in fibromyalgia, diabetic peripheral neuropathy, and headache. There is, however, no strong evidence for their use in nociceptive pain. Gabapentin and pregabalin are the most commonly used anticonvulsants for persistent pain, and their common side effects include weight gain, edema, cognitive slowing and ataxia.

5. **Antidepressants**
   Antidepressants, particularly those that inhibit the reuptake of norepinephrine, such as tricyclic antidepressants (TCAs) and seroton-norepinephrine reuptake inhibitors (SNRIs), are used to treat pain. Additionally, TCAs block sodium channels that cause ectopic discharges at sites of peripheral nerve injury, which may partially explain their efficacy in neuropathic pain. Among TCAs, secondary amines, such as nortriptyline and desipramine, are preferred over the others due to their favorable side effect profile. SNRIs, such as venlafaxine and duloxetine, and other antidepressants with noradrenergic action, such as bupropion, may be preferable to TCAs in patients with cardiac comorbidities.
Managing Persistent Pain in Primary Care: IV. Rehabilitative and Behavioral Approaches

1. Physical Therapy and Exercise Programs
Physical therapy, in particular exercise therapy, is an essential part of treating musculoskeletal pain, and is also valuable in managing secondary musculoskeletal problems that develop as a consequence of inactivity and poor posture caused by a persistent pain disorder. Exercise has been shown to reduce disability and provide a range of physical and psychological benefits for the patients. Physical therapy differs from self-guided exercise programs in that the therapist provides expertise in exercise therapy, motivation and structure for the patient, and ongoing monitoring of the patient’s progress. However, the end goal of a course of physical therapy is that patients learn a set of beneficial exercise routines that they continue practicing on their own on a regular basis indefinitely.

2. Biofeedback
Biofeedback trains patients to reduce physiological arousal through audio or visual feedback of one or more physiological measures, such muscle tension, heart rate or skin temperature. Biofeedback can reduce pain by helping patients physically and emotionally relax, and has been shown be to effective for conditions such as headaches, chronic neck pain and chronic abdominal pain.

3. Cognitive Behavioral Therapy
Pain patients may require psychological interventions to manage the life changes, anxiety, depression or relationship problems that may have preceded, been caused or worsened by persistent pain and accompanying disability. Cognitive behavioral therapy (CBT) aims to reduce suffering and disability by helping patients to change their thinking and behavior, and to learn and apply effective coping skills.

4. Mindfulness-Based Exercises
A variety of mindfulness-based exercises such as breathing exercises, meditation and hypnosis are effective in reducing the anxiety and stress associated with persistent pain. A number of self-help books for persistent pain provide good instructions on how to do these exercises. Here are two excellent books that can be recommended to pain patients: The Pain Survival Guide by Denis Turk and Fritz Winter, and Manage Pain Before It Manages You by Margaret Caudill.
Managing Persistent Pain in Primary Care: V. Key Elements of a Treatment Plan

1. Treatment Goals
Treatment goals should be behaviorally defined and personally meaningful for the patient. Pain reduction itself usually does not make a good goal, because pain reduction without functional improvement does not lead to improvement in quality of life. The patient can be educated about the fact that many people who have successfully managed their chronic pain do not experience a reduction in their pain level, but that they do find their pain becoming less interfering with their daily lives.

A useful way of eliciting goals from the patient involves asking what activities the patient would like to be able to do if pain was under better control. Some examples of behaviorally-defined goals include “being able to walk four times around the block”, “being able to sit through a 90-minute concert.”

2. Non-Opioid Pharmacotherapy
Non-opioid and adjuvant analgesics should be considered before opioids. The type of medication is selected according to the pathophysiology of the pain condition, and the dosage should be titrated to a therapeutic level tolerable by the patient.

3. Opioid Therapy
As noted in Section II, the decision to start a patient on opioid therapy for chronic pain needs to be an explicit and conscientious one, which is made after having taken into account the patient’s age, comorbidities, opioid risk factor and functional goals. The patient should be informed that the use of opioids is a trial, the success of which is judged by the presence and degree of functional improvement. Opioid therapy will be tapered and discontinued if the trial fails, i.e., if there is no demonstrable functional improvement on opioids.

4. Physical (Exercise) Therapy
Learning and maintaining a set of exercise routines that the patient practices on a regular basis is an important part of the treatment for most chronic pain conditions. Physical exercise prevents deconditioning, improves fitness, and is beneficial for common mental health disorders, such as depression and anxiety.

5. Psychological and Behavioral Treatment
Mental health evaluation and treatment are essential for patients with signs and symptoms of emotional distress, either as a result of having chronic pain, or as part of the premorbid condition.

6. CAM Methods
These include (but are not limited to) chiropractic and osteopathic manipulations, TENS units, acupuncture, and biofeedback.