

What is pain management for persistent pain?

»» *A distillation of best practice reflecting ACC's current position*

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- Chronic or persistent pain is pain that persists beyond the expected time of healing.
- With persistent pain it is important to establish a diagnosis and treat any underlying causes. However, some persistent pain cannot be completely relieved or cured.
- Unimodal treatments are not always successful or appropriate for persistent pain.
- Pain management aims to minimise the interference of pain in a person's lifestyle. It helps individuals to understand their persistent pain, and provides strategies and skills that allow them to cope and function more effectively.
- Pain management incorporates a biopsychosocial model of care that deals with the biological, psychological, and social aspects that can aggravate an individual's pain symptoms e.g. sleeplessness, depression, reduced function, or job loss.

Introduction

'Pain management' is a term that describes the co-ordinated use of combined interdisciplinary therapeutic options for persons with persistent pain. It is a patient-centred medical paradigm incorporating the biopsychosocial model of care.

What is pain?

The nuances of pain may range from a simple sensation to complex emotional experiences, including grief and suffering. The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage".¹ Acute pain is defined as "pain of recent onset and probable limited duration. It usually has an identifiable temporal and causal relationship to injury or disease". Chronic or persistent pain "commonly persists beyond the time of healing of an injury and frequently there may not be any clearly identifiable cause".² It is increasingly recognised that acute and persistent pain may represent a continuum rather than distinct entities.

Signals generated within the nervous system, in response to actual or potential tissue damage, are termed 'nociceptive'. There is stimulation of a variety of receptors (e.g. pressure, thermal, chemical) that then activate the nociceptive cascade from peripheral nerve to spinal cord through to brain. Pain consciousness is the outcome of the complex excitatory and inhibitory modulation that occurs both in the spinal cord and brain.

The central sensitisation concept is useful to explain the persistent 'sensitised' state or exaggerated 'pain signalling' experienced by some with persistent pain. Central nervous system sensory dysregulation is often characterised by increased sensitivity to touch and the spread of the pain map or tenderness away from the site of peripheral injury i.e. 'new' areas become painful. Central sensitisation results from an intricate interplay between sensory and cognitive mechanisms in which experience, emotion, and meaning have important roles.

Treatment of pain

While short-term/acute pain is generally well understood and managed, persistent or chronic pain is far more complex. It is important to establish a diagnosis and, where possible, treat any underlying causes. However, some persistent pain cannot be completely relieved or cured.

Unimodal approaches to pain

Unimodal medical/physical approaches to the treatment of chronic/persistent pain-states generally attempt to reduce or eliminate the afferent (incoming) excitatory signalling through specific treatment of tissue pathology. For example, rest or surgery may relieve acute pain but not be appropriate for persistent pain. The focus is on the mind/body dichotomy i.e. the concept that all signalling is unidirectional and the mind is only a receiver of nociceptive information.

A single explanation for persistent pain symptoms is often sought, particularly through sophisticated radiological imaging, but not all pain conditions have simple stimuli or solutions. A purely biomechanical/inflammatory approach limits the understanding of pain. Since the 1970s, the organic/functional distinction of pain has become seen as simplistic and relatively meaningless.

Multimodal approaches to pain

Multimodal approaches incorporate the complexity of the mind and body interaction i.e. the wider aspects of central/autonomic nervous system, and/or endocrine and immune function. Psychological approaches are pivotal in assisting and maintaining change, and reducing grief and suffering.

A biopsychosocial approach incorporates a patient's physical health (bio) and also psychological factors (psycho), all within a social and cultural context (social).³ Thus, it is now recognised that many factors may aggravate persistent pain, including:

- Disease progression
- Repeated treatment failures, complex medication use

- Psychological distress, sleep disturbance
- Reduced activity
- Social/vocational loss
- Social interactions, ethnic and cultural context
- The desire to constantly pursue a 'cure' for pain
- Unhelpful thoughts and beliefs, illness behaviour.

Persistent pain should be considered in similar ways to other chronic conditions, such as diabetes. A condition like chronic low back pain does not have good long-term outcomes from medical/physical therapies but can respond well to pain management strategies.

Principles of pain management

Pain management is not aimed at total pain relief or cure, but at minimising its interference in a person's lifestyle. The focus is to help people understand their persistent pain symptoms, and to provide strategies and skills that will allow them to cope and function more effectively. Allaying fears, restoring function, providing realistic goals and reducing dependency on medication, healthcare, and passive treatments are key to the patient gaining control of their pain. Pain management programmes can help address many of the contributing factors through structured interdisciplinary processes.

Pain management programme strategies

Pain management can be delivered to an individual or in groups. The strategies used, and amount of intervention, vary according to the patient's assessed needs.

Comprehensive assessment of the patient using a team approach that evaluates physical, psychological, and environmental factors is important. Personally-relevant goals and barriers to progress are identified and incorporated into an individualised treatment plan that is negotiated with the patient, allowing that each patient may require variable amounts of different facets of a pain programme.

Depending on the needs of the patient, other commonly-used pain management strategies include:

- Exercises (stretching, muscle strengthening, and fitness)
- Activity-pacing strategies (to deal with a pattern of excessive activity followed by excessive rest after pain recurs)
- Goal setting. Identifying and planning to achieve activities the patient would like to do despite their pain (e.g. work, household chores, social activities).
- Cognitive strategies. Identifying unhelpful beliefs and responses to pain, and providing strategies to deal with them, including problem-solving, ways of accepting the presence of pain, and stress and sleep management.
- Rationalising medication use e.g. reducing or stopping unhelpful medications, titrating those that are most appropriate and, in some people, using analgesics regularly, rather than according to pain.
- Dealing with flare-ups without resorting to medication alone.

The patient must do most of the work (and keep doing it). Without creating dependency, health professionals should provide support and encouragement, and regularly reassess to see if the expected goals are being met.

If you have a patient with persistent pain (resulting from an injury) that may benefit from a pain management programme, please contact an ACC case manager to discuss a Comprehensive Pain Assessment.

References

1. International Association for the Study of Pain. See resources, pain definition under www.iasp-pain.org. Cited 12.02.2007.
2. Ready LB, Edwards WT. Management of Acute Pain: A Practical Guide. Seattle, WA: IASP Publications, 1992.
3. Waddell G, Burton AK. Concepts of rehabilitation for the management of low back pain. *Best Practice and Research Clinical Rheumatology*. 2005;19(4): 655-6702.

Further Reading

1. Nicholas MK, Molly AR, et al. *Manage Your Pain*. Sydney: ABC Books, 2006.
2. Linton, SJ. *Understanding Pain for Better Clinical Practice: A psychological perspective*. London: Elsevier, 2005.