Chronic Pain
Series Editor’s Introduction

“They are and suffer, that is all they do”
W.H. Auden ¹

“Although the world is full of suffering, it is also full of overcoming it.”
Helen Keller ²

When patients come to us with their pain, they present us with a marvelous opportunity – the chance to understand them, to understand how their pain is affecting their lives, the challenge of discovering what is causing their pain, and finally the opportunity to prescribe medications and lifestyle changes to help them gain relief from their pain. This second edition of *Chronic Pain: A Primary Care Guide to Practical Management* is, once again, an important resource in furthering those clinical objectives.

Like the first title in 2005, this updated edition is not only clearly written and practical, offering concrete evidence-based approaches to diagnosing and treating chronic pain, but it also includes three critical new topics: risk management; pain in the shoulder, upper extremity, and lower extremity; and cancer and end-of-life pain. The book is again replete with excellent easy-to-understand figures, tables, and algorithms. In addition, and very importantly, the screening tools and patient education materials that made the first edition so popular have been expanded.

*Chronic Pain: A Primary Care Guide to Practical Management (Second Edition)* approaches the discussion of pain management as primary care clinicians approach their patients, first trying to determine – with as much clarity as possible – the etiology of a patient’s pain, and then discussing the specific treatments and general treatments of the condition that has been diagnosed as well as the pain it causes. All this occurs

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against a backdrop of general issues relevant to all pain management. Most of the common conditions that lead patients to come into our offices with a pain as their chief complaint are covered. The book presents clear recommendations for treatment and supports those recommendations with useful references.

The *Current Clinical Practice Series*, conceived by a number of editors at Humana Press, has as its mission to create high-quality, evidence-based books for primary care clinicians, with an emphasis on relevance, and provide practical approaches to common problems. The books in the *Current Clinical Practice Series* can be used to gain an updated understanding of common problems and/or can be placed on office shelves to serve as important references when questions come up during the course of patient care. A cornerstone book of this series *Chronic Pain: A Primary Care Guide to Practical Management (Second Edition)* again fulfills the mission of this series – it is practical, useful, and highly relevant. There is no higher compliment for any book of medicine.

Neil Skolnik, MD
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Preface

Patients with chronic pain present a unique set of challenges to the primary care physician, who must first recognize and accept the difficult and complex constellation of problems often encountered in these patients. When confronted with patients suffering from pain, it is important to recognize three common but false myths about chronic pain:

1. Patients with chronic pain are easy to manage.
2. Chronic pain is easily relieved with just a pill.
3. As pain improves, associated problems (e.g., depression, disability, relationship issues) will spontaneously resolve.

The clinical management of chronic pain is frequently requested by patients seeing primary care physicians, although most medical schools provide little background for dealing with these often complex patients. Patients with chronic pain typically report a diversity of complaints, including pain, sleep abnormalities, mood disturbance, and interference with personal, social, and work relationships. Lack of easily identified pathology in patients who report disabling symptoms may result in conflicts between patients and their treating clinicians. In addition, managing chronic pain generally requires assessment and treatment of pain, associated symptoms, and disability.

This book is designed to provide a practical approach to assessing and treating the complex issues characteristic of patients with chronic pain. This second edition has substantially updated the information provided in the first edition *Chronic Pain: A Primary Care Guide to Practical Management*. It expands the evidence-based recommendations previously provided, and new additions to this edition include the following:

- Risk management of patients with chronic pain
- Pain syndromes in the shoulder, upper extremity, and lower extremity
- Cancer and end-of-life pain
- Expanded patient educational materials

The patient educational resources provided in the supplement have been tested and refined through use in clinical patients. The popular patient materials included
in the first edition have been expanded to include additional resources, such as the following:

- Screening tools for depression and anxiety
- Neuropathic pain tools
- Fibromyalgia assessment tools

Incorporating these practical techniques into a busy clinic practice is designed to improve the confidence with which the primary care physician can approach patients with complex pain complaints, reduce staff stress, and improve patient success.

Dawn A. Marcus, MD
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Part I
Introduction
Chapter 1
Chronic Pain and Headache Overview

Key Chapter Points:
- Pain is reported in four out of every ten primary care visits.
- The most common chronic pain locations are the back, head, and joints.
- Nearly half of all patients with chronic pain will report persistent pain complaints when re-evaluated after 1 year.
- Patients typically believe that their healthcare providers are not interested in addressing chronic pain complaints.
- A pain drawing can provide a concise picture of a patient’s pain complaints.

Key Words Drawing, Impact, Persistence, Prevalence

Case History

During her annual examination, Ms. Malone, a 53-year-old nurse, reports increased interference from her chronic back pain. She developed low back pain while lifting equipment at work 2 years earlier. Ms. Malone was initially work disabled for 6 months, but successfully returned to modified nursing duties after completing physical therapy. “I’m still having problems with my back. I’m limited at work. I have trouble keeping my house in order, I’m missing my grandkids’ performances in school, and don’t even ask about my sleep. Is there anything else we can do?” After glancing at his watch, and realizing that the appointment has already extended 15 minutes beyond schedule, her doctor suggests they schedule a follow-up appointment to address her ongoing pain complaints. Ms. Malone begins to sob, “You don’t believe I have pain! My family doesn’t believe I’m in pain! And my boss is positive that I’m making it all up just to get out of work! I’ve been trying to just pretend everything’s fine, but it’s not and I need help! Why can’t I find a doctor who is willing to help me?”

D. Marcus, Chronic Pain: A Primary Care Guide to Practical Management, © Humana Press, a part of Springer Science+Business Media, LLC 2009
Chronic Pain: Epidemiology

Chronic pain is a frequent patient complaint, with 70% of patients with persistent pain being managed by their primary care physician and only 2% seeing a pain management specialist. Pain is a primary or secondary complaint in 40% of primary care office visits (Fig. 1.1). A World Health Organization survey of patients in primary care in 14 countries revealed that the back, head, and joints are the three most commonly affected areas (Fig. 1.2). Interestingly, two-thirds of patients reported pain affecting more than one body region. As expressed by Ms. Malone, nearly half of these patients similarly reported persistent pain complaints when

Fig. 1.1 Percentage of primary care visits for pain (based on Mäntyselkä).

Fig. 1.2 Pain location reported in international survey of primary care patients (based on Gureje).
re-evaluated after 12 months (49.2%). The probability of persistent pain varied
with the location, with the greatest persistence being seen in the three most com-
monly reported pain areas: back, head, and joint (Fig. 1.3).

As seen in Ms. Malone’s case, chronic pain negatively affects sleep, mood, and
productivity (Table 1.1). The economic impact of chronic pain is also substantial. An
estimation of annual costs (2002) on account of chronic low back pain revealed
that the majority of pain-related costs were indirect, with work absence being the
most important one (Fig. 1.4). About 60% of employed patients with low back pain
missed at least one work day during the preceding 3 months, with an average loss
of 33 out of 60 possible work days. These data suggest that healthcare providers
should minimize concerns about treatment costs to actively address pain complaints
with a view to reducing disability and avoiding the substantially greater costs of
pain-related disability.

Table 1.1 Impact of chronic pain (based on Breivik)

<table>
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<th>Impact</th>
<th>Percentage</th>
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<td>Sleep disturbance</td>
<td>65</td>
</tr>
<tr>
<td>Mood affected</td>
<td>21</td>
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<tr>
<td>Restricted household chores</td>
<td>54</td>
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<td>Restricted social activities</td>
<td>47</td>
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<tr>
<td>Job changed due to pain</td>
<td>29</td>
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<tr>
<td>Job lost due to pain</td>
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Healthcare providers are often perceived by their patients as having a negative
attitude about treating chronic pain. One in three people with chronic pain is not
currently receiving treatment. This is often due to patient perceptions that their
healthcare providers cannot help, that they should just live with their pain, or treat-
ments will not be effective (Box 1.1). Physicians likewise, report a negative out-
look on chronic pain, with only 15% of primary care physicians endorsing feeling
comfortable treating patients with chronic pain. Primary care physicians are also
uncomfortable with the expanded need to prescribe opioids to patients with chronic pain; 41% of doctors waited for patients to initiate a request for pain medication.

**Chronic Pain Assessment Tools**

The evaluation of pain begins with identifying pain location. This is most conveniently done by asking patients to complete a simple pain drawing (Fig. 1.5). This drawing effectively identifies all potentially important pain areas, rather than focusing only on a particular area of immediate concern to the patient.

Although the majority of patients will report more than one active pain area, many patients may only express verbal complaints about the area that is most troublesome on the day of evaluation or for which the patient believes treatment is available. For example, patients with fibromyalgia may complain most of headache or low back pain to the doctor, despite having other widespread pain areas. Failure
to recognize additional pain complaints may result in an incomplete diagnosis and failure to adequately identify all of the patient’s disabling complaints. Samples of completed pain drawings are shown in Fig. 1.6.

Some patients find it easier to describe pain complaints using a drawing rather than describing them verbally. A study evaluating headache complaints in 226 children showed the diagnostic sensitivity of a pain drawing for evaluating pain in patients with migraine was 93%, with a specificity of 83%, and a positive predictive value of 87%.7 Findings in a second study were perhaps most significant, because up to half of children eventually diagnosed with symptoms of migraine failed to endorse features of migraine during the initial interview.8 For example, aura was not identified in 46% who were later discovered to have an aura; vomiting was not confirmed by 50%, nausea by 31%, unilateral location by 38%, throbbing quality by 29%, photophobia by 11%, or phonophobia by 11%.

Patients should also be asked to rate the severity of their pain. Verbal rating scales (using selected descriptive adjectives), visual analog scales (marking a severity score on a line scaled from 0 to 100), and numerical rating scales (e.g., 0 = *no pain* and 10 = *excruciating pain*) may all be used. Numerical rating scales (“select a pain severity rating between 0 and 10”) are valid, easy for patients, and sensitive to treatment impact.9 Furthermore, recorded numerical pain scores are easy to use to assess and document the effectiveness of treatment interventions.

**Fig. 1.5** Pain drawing. Instructions to pain drawing: please shade all painful areas, using the following key: /////, pain; ::::::::, numbness; ***, burning or hypersensitivity to touch.**
Fig. 1.6 Chief complaints with sample pain drawings: (A) episodic, left-sided, incapacitating headache; (B) episodic, left-sided, incapacitating headache. Diagnoses: (A) migraine; (B) migraine plus fibromyalgia.
Fig. 1.6 (continued) Chief complaints with sample pain drawings: (C) persistent low back pain; (D) persistent low back pain. Diagnoses: (C) myofascial low back pain; (D) low back pain with radiculopathy.
Summary

Clinicians can gain confidence in managing chronic pain by getting to know more about the causes, diagnosis, and treatment options for patients with chronic pain. This can be achieved through easy-to-use pain assessment strategies and tools. This book is designed to provide practical information about the pathogenesis, diagnosis, and treatment of the most common chronic pain conditions seen in typical patients, as presented in case histories. In addition, patient assessment and educational materials are provided in formats that are easy to use in most busy primary care practices. The practical information provided in this text should improve both the understanding of these conditions and the efficacy of chronic pain management options in primary care. The CD that accompanies this book can facilitate patient education and charting documentation by providing easily reproduced materials to be used in the clinic. The information and tools provided in this book should help the busy clinician simplify broad patient complaints into manageable problems, so that commonly encountered problems can be addressed.

References

Chapter 2
Summary of Pain Management Issues: Frequent Concerns in Treating Chronic Pain Patients

Patients with chronic pain often come to their doctors with a myriad of complaints and expectations. When confronted with such a patient, doctors often have their own concerns about the legitimacy of reported pain severity and associated disability, the amount of time and resources required by patients to address these concerns, and the inadequate amount of information healthcare providers had received during their medical education and training for the management of chronic pain.

This book is designed to fill this knowledge gap for the most common chronic pain conditions and to provide useful clinical tools to facilitate an effective approach to patient complaints in a busy office practice. Several concerns about pain legitimacy, significance, and the ability to effectively treat patients with pain are addressed here. Each of these issues is addressed in greater detail in the following chapters.

Do People Really Have Chronic Pain Long After They Have Recovered From an Injury?

- Chronic pain is one of the most common reasons for seeing a primary care physician. For example, about one-third of primary care visits are for musculo-skeletal pain.
- Studies in laboratory animals consistently show changes in the nervous system in response to old injuries. Increased nerve sensitivity and the rewiring of nerves to activate pain pathways occur after injuries and correspond to demonstrated pain behaviors.
- Complete fabrication of pain symptoms, or malingering, is rare and usually easy to identify.
- Premorbid mood disturbance, poor social support, and smoking increase the risk of developing a chronic pain complaint.