WHO NEEDS PAIN?

Dr Rick Acland

PAIN MANAGEMENT CENTRE

BURWOOD HOSPITAL


DOCTOR

"Pain is a part of life"

Prof Bob Large

The Auckland Regional Pain Service

PAIN

"As one ruminates on pain,
one realises how deep in the
strata of life it lies.

Pain underlies the distinctions we
make among biology, thought,
action, meaning and self."

The Pain Industry

'PAIN DOCTORS'

I'VE BEEN IN PAIN FOR 25 YEARS!

Acute vs Chronic Pain

Red Flags

- Confirm diagnosis
- Most clues for ‘red flag’ conditions are found in the patient history

Yellow Flags

- Identify psychosocial variables associated with poor prognosis in terms of pain and related disability

SALLY WENLEY

Queen of Quirk

- " I've come close to killing myself, several times.
- I've clutched a fistful of lollies behind my white knuckles- the orange nortriptyline, green temazepam, imovane, neurontin, voltaren and a few others for good measure- then flushed them down the toilet. I can't sleep, I can't concentrate, and I'm not a very nice person to be around.
- That's when my pain is at its worse.
- I'm a T11 complete paraplegic after a road accident 15 years ago.
- I believe my life would be pretty good - except for the pain"

PAIN CLOSE TO HOME


HELLY HANSEN

PAIN

By virtue of its adversiveness, pain serves to promote an organism's health and integrity.

Recognition of pain by observers may lead to actions that promote recovery and survival.

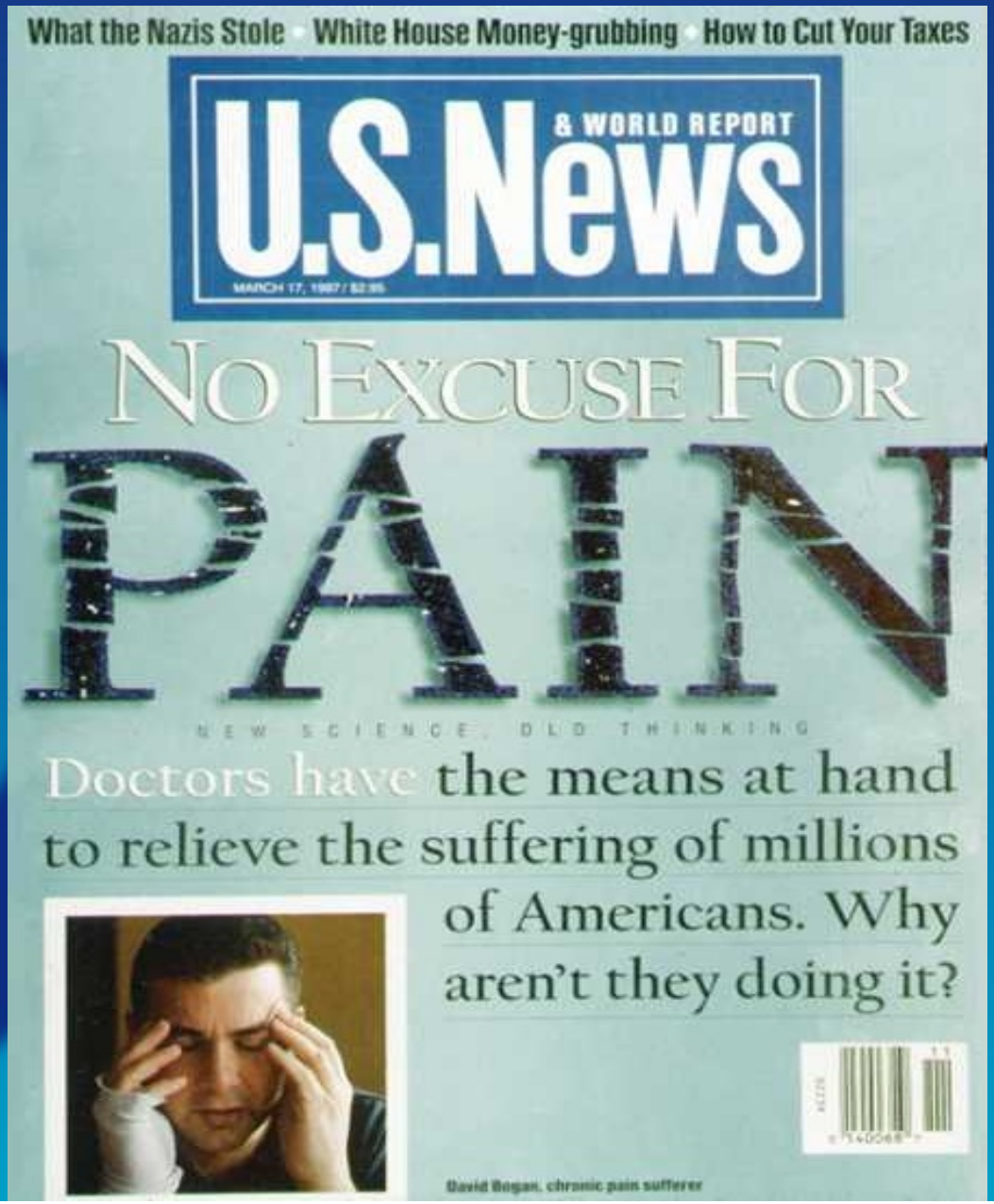
Pain can also be a potential threat in the environment and can urge observers to escape its source!

The avoidance/approach paradox when we see others in pain:

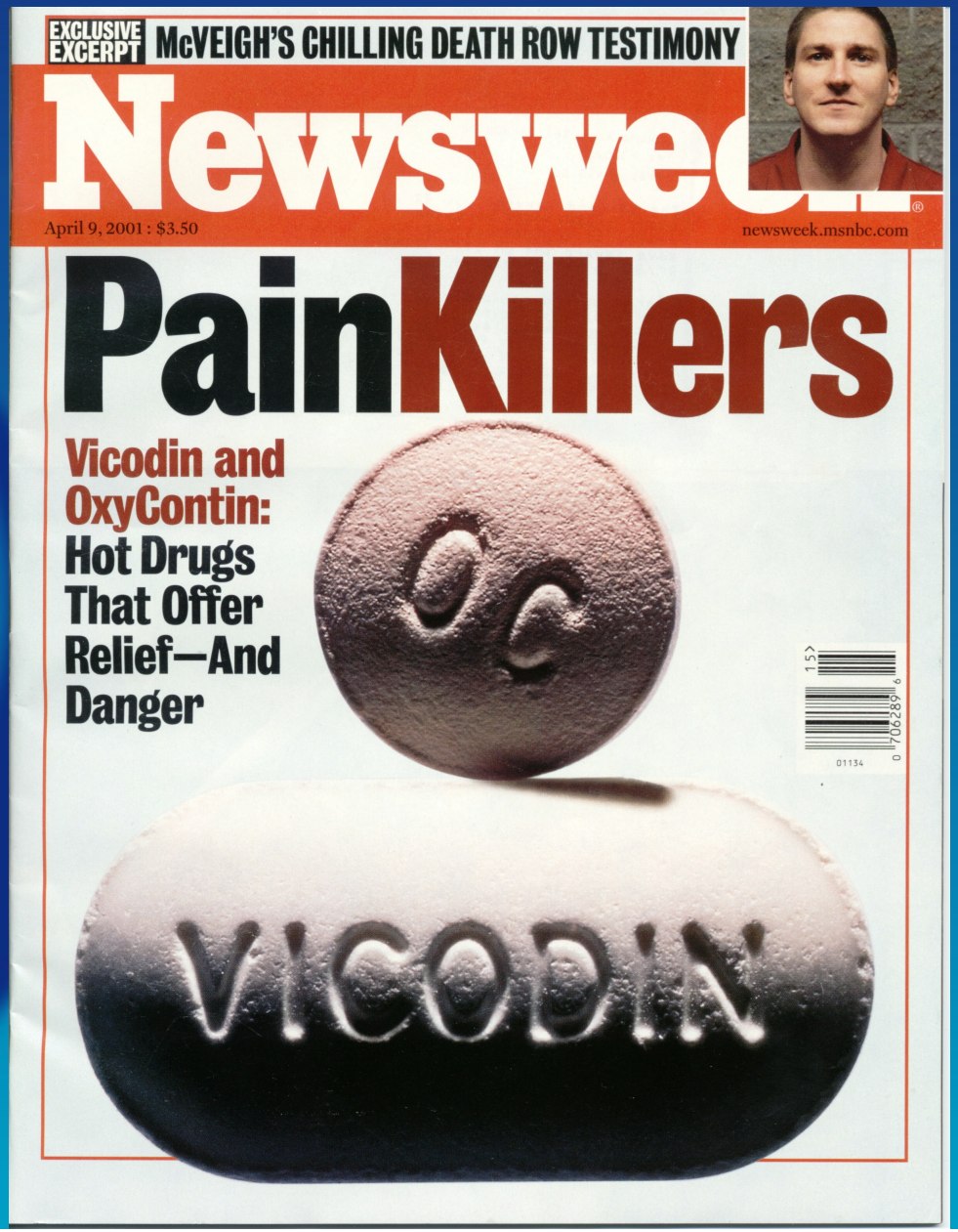
Self-orientated (egoistic) emotions-feelings of personal anxiety and discomfort

Other-orientated (altruistic) emotions-feelings of sympathy and compassion

Late 1990's: The Right to Relief

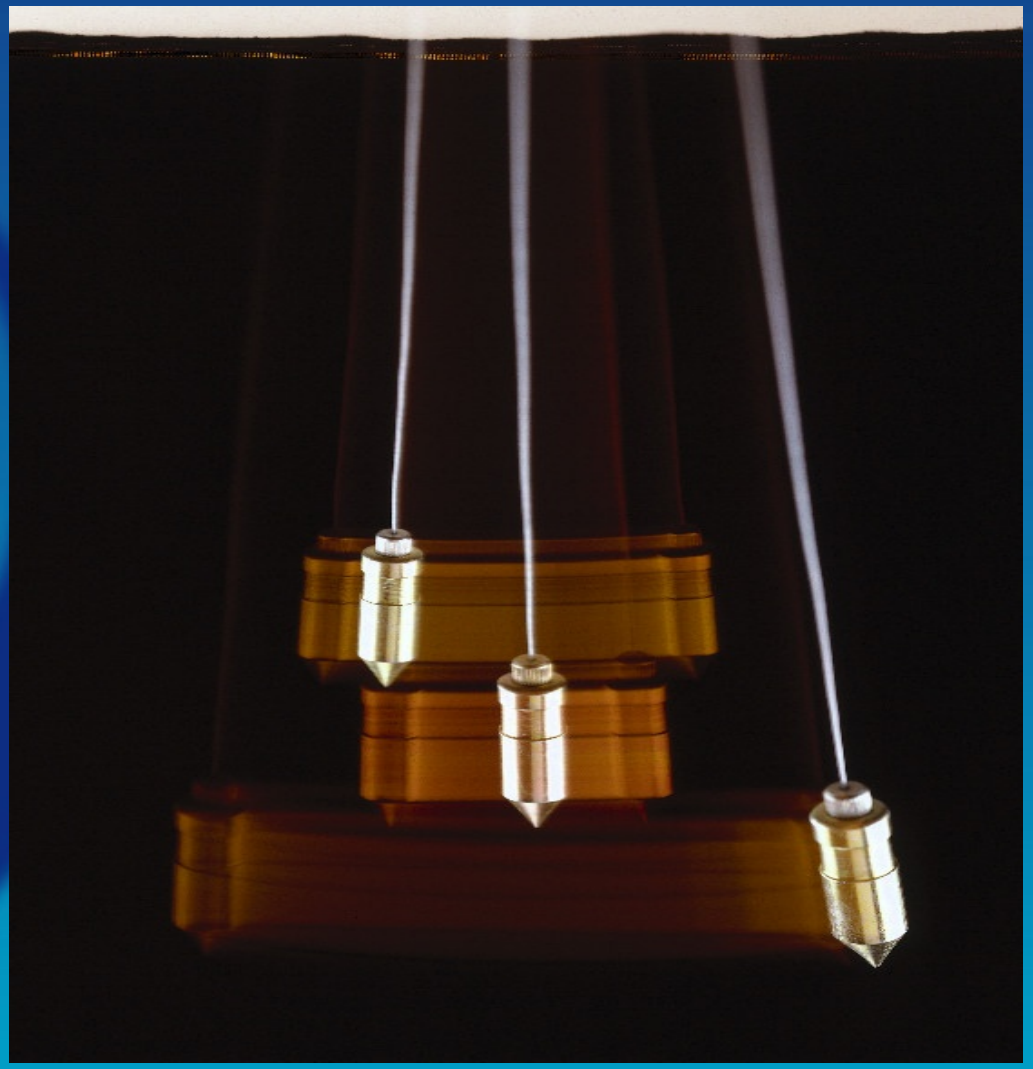


New Millennium: Risks Recognized



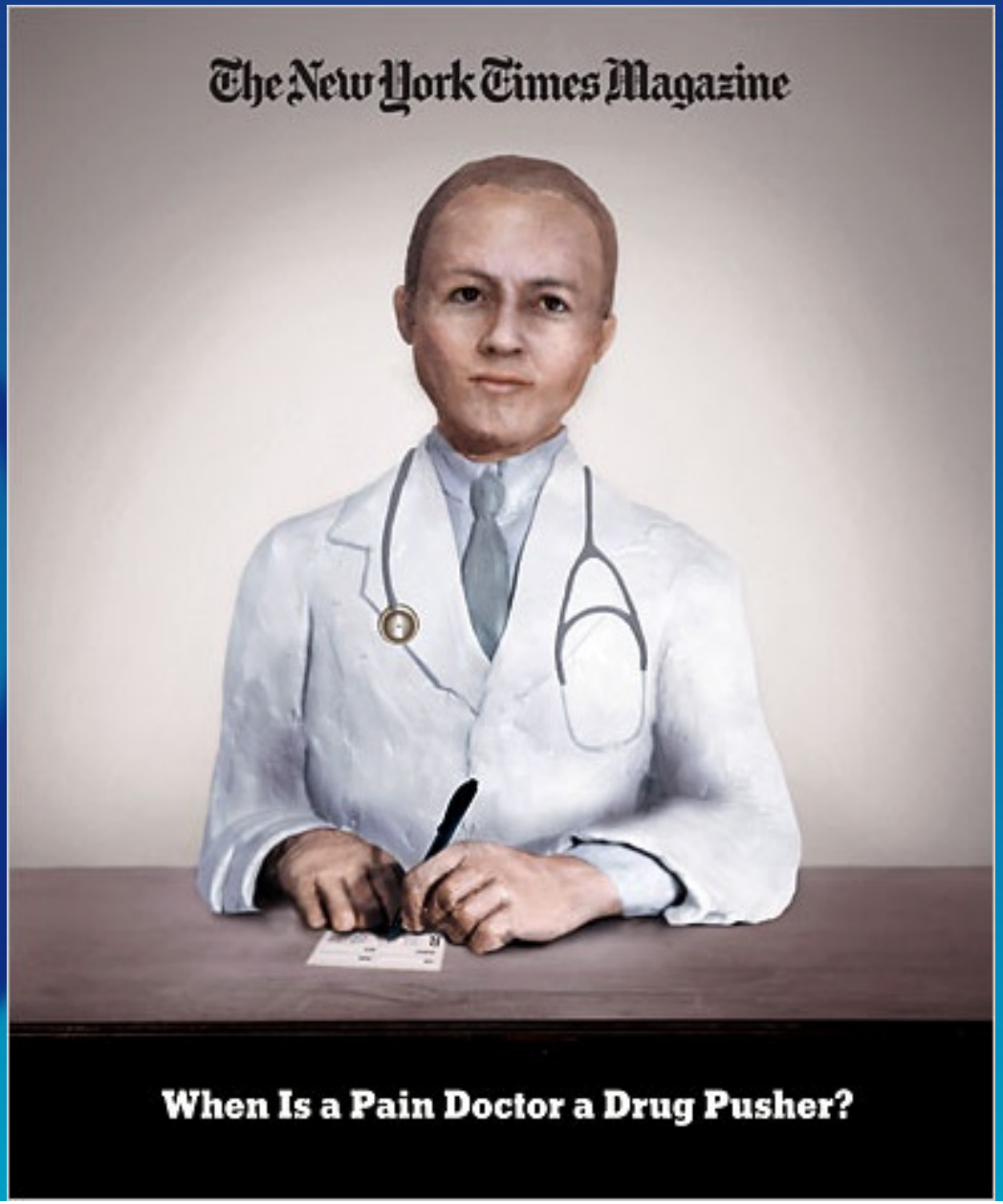
From One Extreme to Another?

Prescribing Behaviour



Patient Expectations

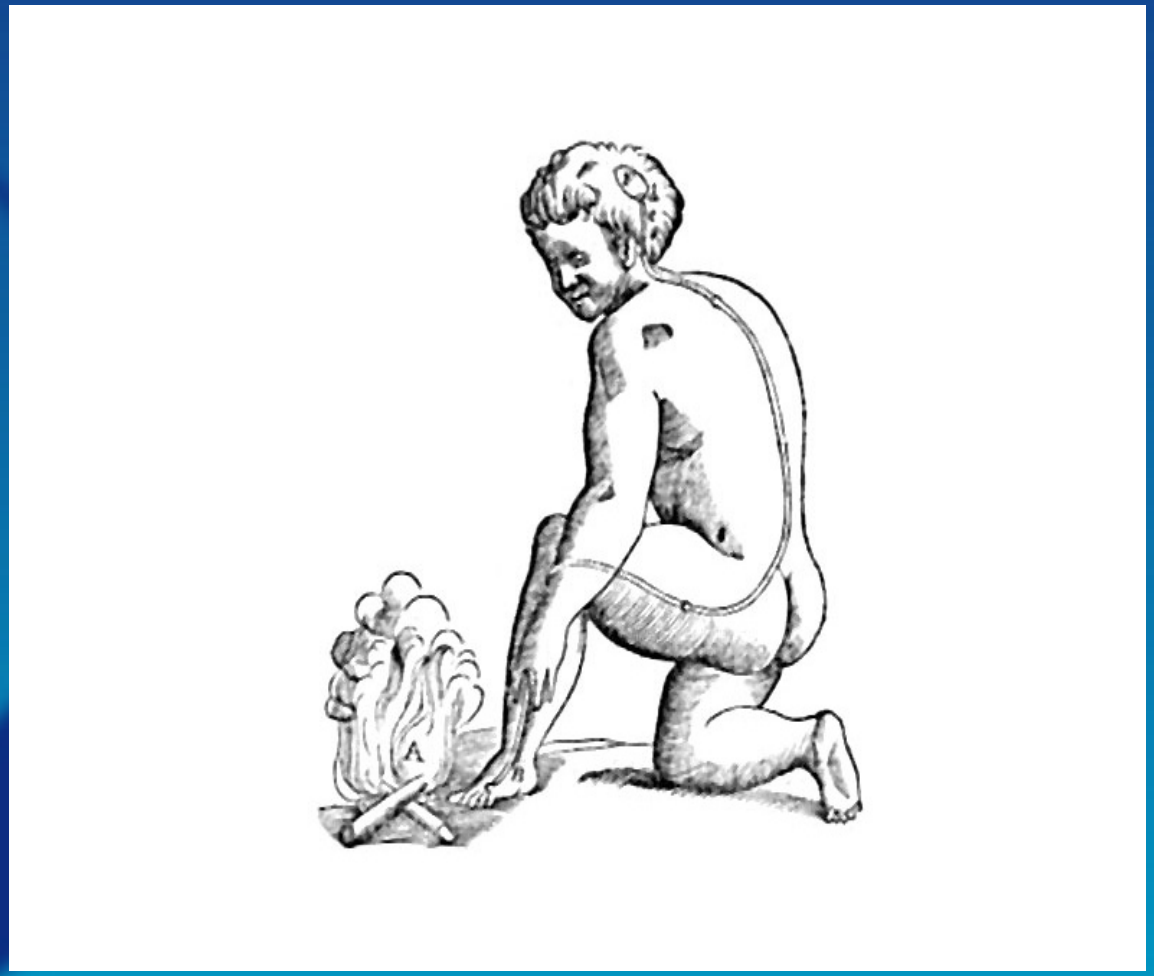
Recent times: The Backlash

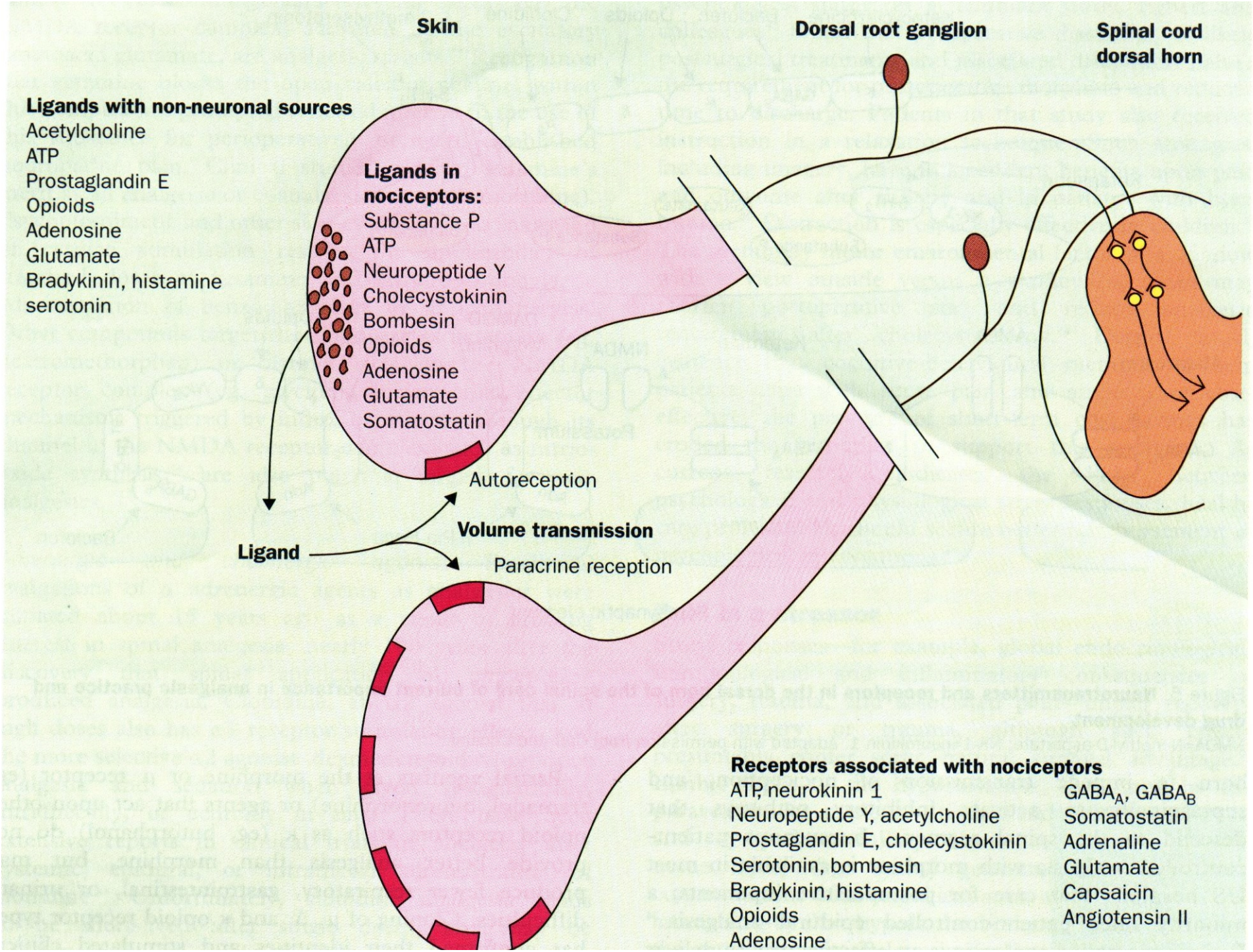


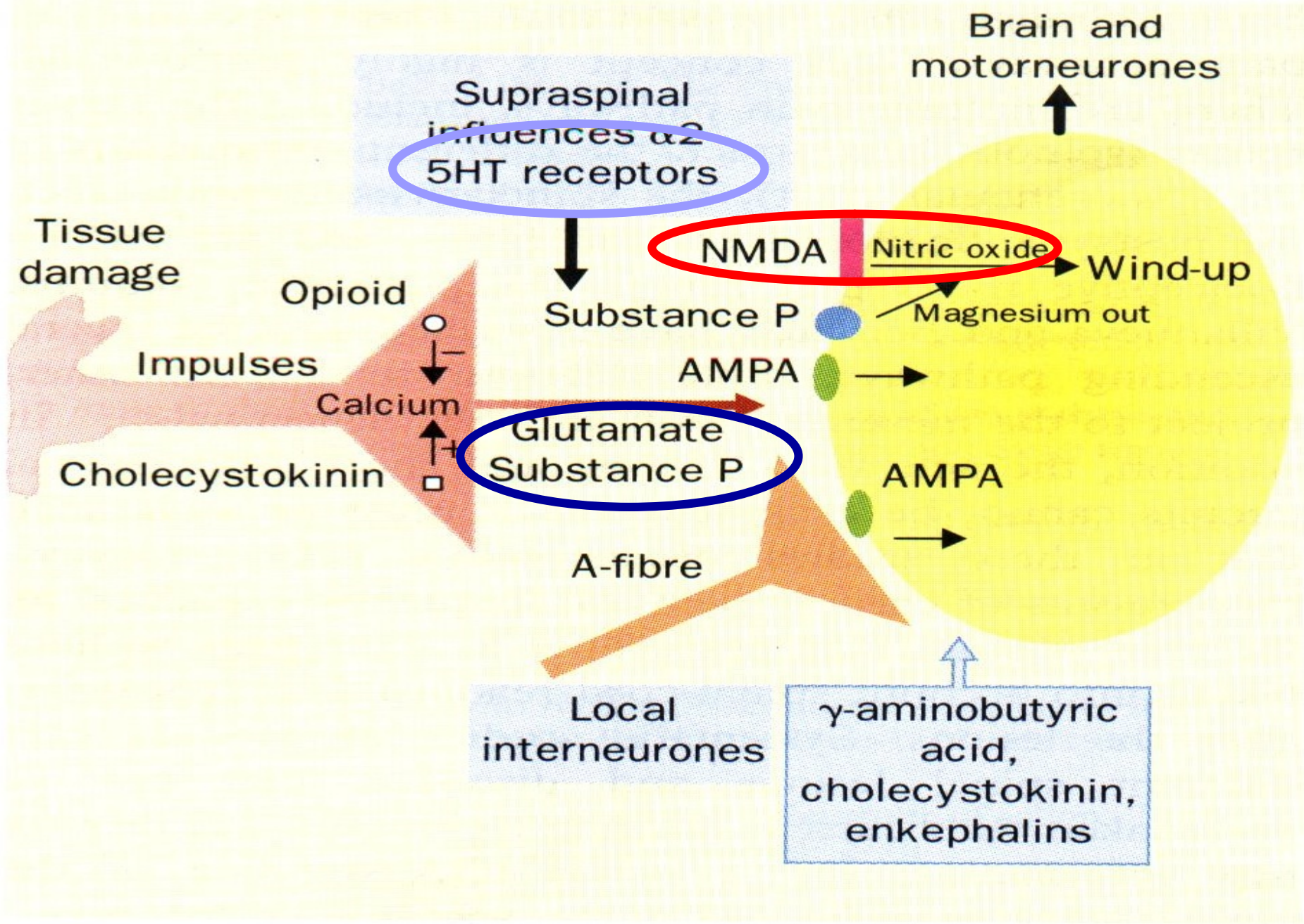
WHAT IS PAIN?

" An unpleasant sensory and emotional experience associated with actual or perceived tissue damage"

Rene Descartes 1664




Skin
Dorsal root ganglion
Spinal cord dorsal horn
Ligands with non-neuronal sources
Acetylcholine
ATP
Prostaglandin E
Opioids
Adenosine
Glutamate
Bradykinin, histamine
serotonin
Ligands in nociceptors:
Substance P
ATP
Neuropeptide Y
Cholecystokinin
Bombesin
Opioids
Adenosine
Glutamate
Somatostatin
Autoreception
Volume transmission
Ligand
Paracrine reception
Receptors associated with nociceptors
ATP, neurokinin 1
Neuropeptide Y, acetylcholine
Prostaglandin E, cholecystokinin
Serotonin, bombesin
Bradykinin, histamine
Opioids
Adenosine
GABA$_A$, GABA$_B$
Somatostatin
Adrenaline
Glutamate
Capsaicin
Angiotensin II



Interactions between different excitatory and inhibitory systems in the spinal cord

MEASURING AND DISTILLING THE IMPACT OF PAIN

Pain Challenges:
"C's the reality of pain"

- Confirm diagnosis
- Cure not always possible
- Complex
- Consider Central mechanisms
- Coordinated Care

CHRONIC PAIN

is associated with:

Reduced cognitive/functional activity

Suffering

Depression

Anxiety

The GP Conundrum

What to do with the 'chronic pain sufferer' who presents yet again for another consultation when all avenues have been exhausted?

MEASUREMENT?

BIOPSYCHOSOCIAL APPROACH TO PAIN?

"As regards any associated psychological factors, I am a Neurosurgeon and it is not within my province to explore the patient's psyche or reaction to his predicament, although you could contact the Pain Clinic and I am sure that the Psychologists there could give you voluminous and almost unreadable amplification on the psychosocial factors that have coloured his current problem."

The use of the Visual Analogue Scale (VAS) 0-10

What does it mean in chronic pain?

The Dignity of the Diagnosis

HOPE:

'My hopes are not always realised, but I always hope.'

Ovid

WHAT ABOUT REASSURANCE?

BEWARE of BIAS!

PAIN TREATMENT OPTIONS

Surgical- excision/replacement/decompress

Pharmacological –prescriptions

Physical –'hands on' therapy

Psychological –'hands off' therapy

SURGERY

So how good are:

Joint replacements?

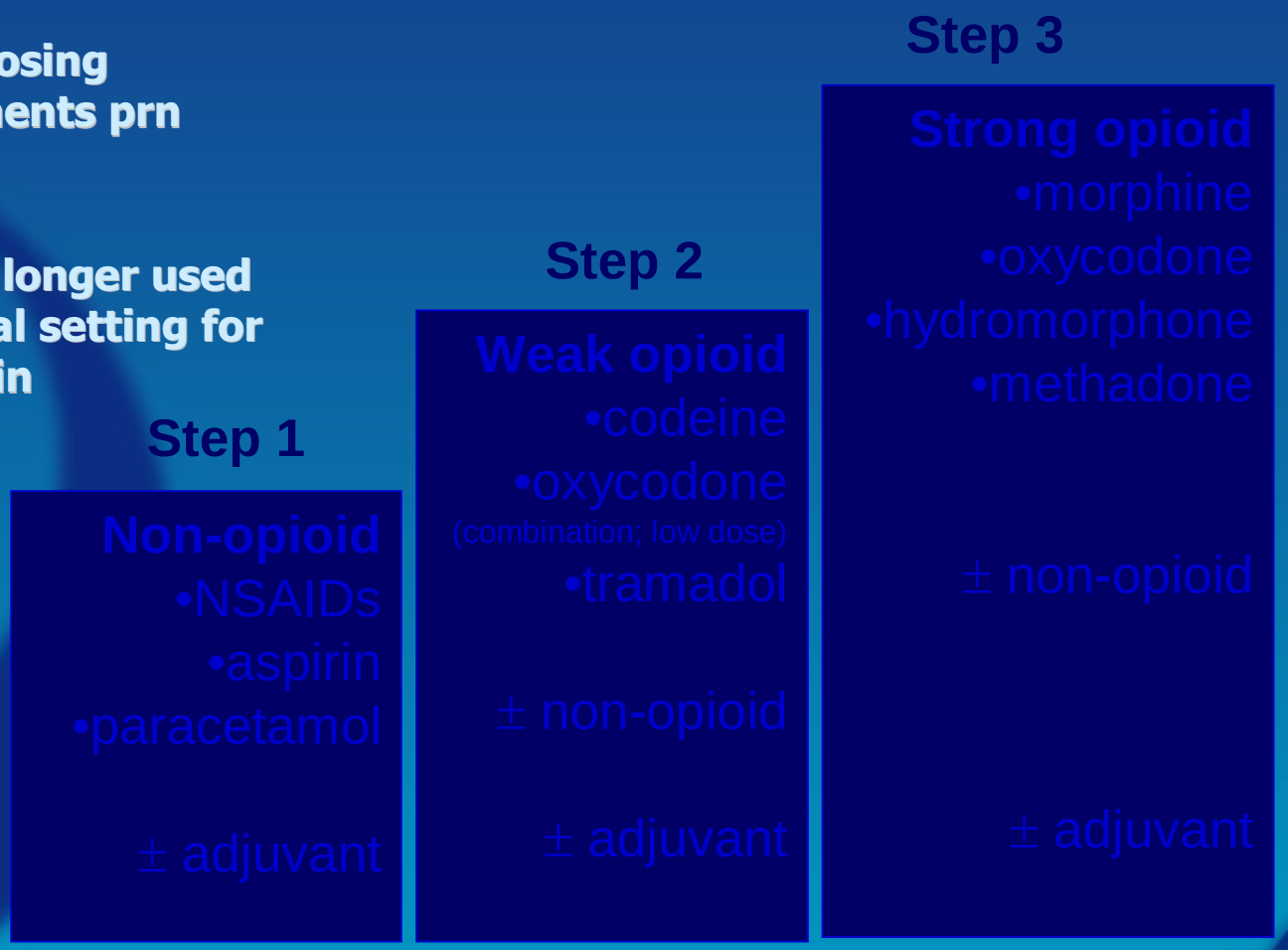
Back surgery?

ANALGESIC PRESCRIBING

- The use of ‘the ladder’ ??

Choice of Analgesic: Follow the WHO Analgesic Ladder

- **Regular dosing**
  ± supplements prn
- **Note:**
  Step 2 no longer used in a clinical setting for cancer pain



Adapted from *WHO,1986*

The Opioid/Opiate/Narcotic Choice/Decision/Controversy!

McQuay, BMJ 2001:

- "Opioids are our most powerful analgesics, but politics, prejudice and our continuing ignorance still impede optimum prescribing. What happens when opioids are given to someone in pain is different to what happens when they are given to someone not in pain. The medical use of opioids does not create drug addicts, restriction on its use hurts patients".

Chronic Opioid Analgesia: J Ballantyne. BMJ 2007

- "Now it is becoming clear that the outcome of chronic opioid treatment is often poor. Studies are urgently needed to investigate who benefits and under what conditions."

J. Ballantyne
Pain: 2007

- "One of the great difficulties of quantifying, recognising and treating iatrogenic opioid addiction is the subjective nature of the judgement on whether behaviours have crossed an ill-defined boundary between problematic opioid use and addiction. This judgement then becomes dependent on the reporting person's experience, prejudices, and knowledge."

PROBLEMATIC PRESCRIPTION OPIOID USE

Overwhelming focus on opiate issues
Early refills
Multiple queries
Pattern of prescription problems
Supplemental source of opiates

Does this represent:

- Recreational use?
- Addiction?
- Intentional criminal diversion?
- Or expected behaviour from anxious depressed patients with untreated pain

So, should we prescribe opioids for chronic nonmalignant pain?

Are some of the nonmalignant pain conditions no different to longer term "cancer pain" conditions?

So what do I make of pain?

THANK YOU