What's New in Chronic Pain Management?

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Objective

1. Interdisciplinary team
2. Education
3. Intervention in Pain Medicine
4. Pharmacotherapy
5. Preoperative opioid withdrawal
6. Postoperative analgesia and management
7. THC

Interdisciplinary team, is it essential?

1. Physiotherapist
2. Clinical psychology
3. Psychiatrist
4. Drug & alcohol
5. OT
6. GP
7. Pain specialist

Education

1. Informal
   Advice
   Guidance

2. Formal
   Pain Management Programme
      LEAP
      PACE
      ADAPT

Education

1. Changing negative cognition
   Catastrophisation
   Unhelpful belief

2. Changing negative behaviour
   Passive coping
   Chemical coping
   Boom bust behaviour

Intervention in Pain Medicine

1. Facet joint, (lumbar, thoracic, cervical)
2. Medial branch nerve bock/rhizotomy
3. Sacroiliac joint
4. Epidural
5. Nerve root sleeve injection
6. Trigger point injection
7. Nerve denervation procedures
8. Occipital nerve block
9. Spinal cord stimulator

Pharmacotherapy

Multimodal analgesia

NSAID, gabanoids, TCA, SNRI

How about opioids?

Long term effect of opioids use

Dependency
Tolerance
Immune suppression
Osteoporosis
Endocrine effect
GIS, respiratory system
Opioid induced hyperalgesia

Opioid Induced Hyperlagesia

Complex changes in the neuro-hormonal system

Reduced pain threshold

Diffuse pain

Increased opioid use

Preoperative opioid withdrawal

1. Why is on opioid?

2. For how long?

3. Stable dose or escalating?

4. What is functional status?

Case 1

58 female, married, unemployed

Fibromyalgia--- amitriptyline, codeine, pregabalin, Targin 5/2.5
Migraine--------- paracetamol, celecoxib
IBS---------- diet
Depression------ duloxetine
Hip pain

Case 1

Added PRN oxycodone

X-ray: nothing exciting

After multiple clinic visit

Referred to Ortho

Case 1

9 months after referral

Surgeon: we can do THR, on waiting list

Targin is 20/10 mg bd

Case 1

24 months after referral

Admitted for elective THR

Targin is 30/15 mg bd
Oxycodone 5mg (30mg/day)

Case 1

What could have been done differently

Early referral to the pain centre
Addressing depression
Education about medications
Avoiding opioids!
If opioid is needed, short term opioid with support from physiotherapy, psychology
Perhaps Tapentadol or buprenorphine patch

Case 1

What if you inherit the patient late

All of the above plus

- opioid dose reduction
- opioid rotation

Opioid rotation

No right or wrong approach

1- Gradual dose reduction over few months +/- opioid rotation. Example tapentadol

2- Consider clonidine to smooth the transition

3- Consider gabanoids as opioid sparing role

4- Multimodal analgesia

Case 2

58 Female, married, unemployed

Fibromyalgia--- amitriptyline, codeine, pregabalin, Targin 5/2.5
Migraine--------- paracetamol, celecoxib
IBS---------- diet
Depression------ duloxetine
Hip pain

Case 1

Added PRN oxycodone

X-ray: ? malignancy

Rapid escalation of pain level

Rapid increase in opioid use

Urgent Ortho referral

Case 1

2 weeks after referral

Targin 40/20 BD
Oxycodone 5mg (30mg/day)

Ortho: for urgent surgery

Case 1

What could have been done differently

Red flag

Acute escalation of analgesic requirement

Maybe tapentadol instead of oxycodone considering the risk factors

Spinal Cord Stimulation

CRPS

Severe ischaemic limb pain

Intractable angina

Neuropathic limb pain

Failed back surgery syndrome with leg pain

THC

Evidence for:

1- Epilepsy
2- Spasticity/neuropathic pain in MS?
3- Chemotherapy induced N/V

No evidence that THC is beneficial in chronic painful conditions

Post-operative analgesia management

Depends on the surgery and underlying pathology

Overall aim is to minimise risk of being on opioid for long time

Gradual reduction of the SR opioids

Having a plan to cease opioids and other medications

Any Questions?