

CHRONIC PAIN MANAGEMENT GUIDE

A Tool For Managing Chronic
Non-Cancer Pain

A decorative graphic consisting of numerous thin, white, wavy lines that flow across the bottom half of the page, creating a sense of movement and depth.

BASELINE HISTORY ESSENTIALS

Patients with chronic non-cancer pain should be asked about pain severity and pain interference at baseline and follow up. Pain Interference is the key outcome that should be targeted.

Severity: During the past week, what number best describes your pain, on average?¹

(0 = no pain, 10 = pain as bad as you can imagine)

Interference: During the past week, what number best describes:¹

- How pain has interfered with your enjoyment of life?
- How pain has interfered with your general activity?

(0 = does not interfere, 10 = completely interferes)

These questions should be asked at baseline to identify key treatment targets that can contribute significantly to pain interference.

Treatment Expectations: What are your pain management goals?

~ 30% pain reduction (or 2 points less) and significantly improved function is realistic.

Mood Symptoms:²

(0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day. Screen is + if D or A total score ≥ 3 .)

Depression (D): Over the past 2 weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?

Anxiety (A): Over the past two weeks, how often have you been bothered by:

1. Feeling nervous, anxious or on edge?
2. Not being able to stop or control worrying?

Social Support:

1. How often do you talk/text/visit with friends and family?
Daily / Weekly / Monthly / Not at All
2. Do you see and talk to friends and family as much as you would like? Yes / No
3. How easy is it to get help from friends and family if you need it? Very Easy / Somewhat Easy / Not Easy at All

Pain Coping:³ Ask if patient agrees or disagrees: “I feel that my pain is terrible and it’s never going to get any better.”

Fear Avoidance:³ Agree or disagree: “It’s not really safe for a person with my pain problem to be physically active.”

Pain Self-Efficacy:⁴ How confident are you that:

1. You can do some form of work (e.g., housework, paid/unpaid work) despite the pain?
2. You can live a normal lifestyle despite the pain?

(0 = not confident at all and 6 = completely confident; total score of 8 or higher is desirable. Total score of 5 or less implies that patient needs help with self-efficacy.)

Sleep: Do you feel that you get good quality sleep?

Widespread Pain:⁵ Do you often feel that you have pain all over?

If “yes” and patient has fatigue, morning stiffness and/or non-restorative sleep, consider fibromyalgia (FM). Numerous drug allergies also may support possible FM.

FIBROMYALGIA CRITERIA – 2016

Criteria⁶

A patient satisfies modified 2016 fibromyalgia criteria if the following three conditions are met:

1. Widespread pain index (WPI) ≥ 7 and symptom severity scale (SSS) score ≥ 5 OR WPI of 4–6 and SSS score ≥ 9 .
2. Generalized pain, defined as pain in at least 4 of 5 regions, must be present. Jaw, chest, and abdominal pain are not included in generalized pain definition.
3. Symptoms have been generally present for at least 3 months.

Fibromyalgia Criteria continued

A diagnosis of fibromyalgia is valid irrespective of other diagnoses. A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses.

Ascertainment

WPI: note the number of areas in which the patient has had pain over the last week. In how many areas has the patient had pain? Score will be between 0 and 19.

Left upper region (1)	Right upper region (2)	Left lower region (3)	Right lower region (4)	Axial region (5)
Jaw	Jaw	Hip	Hip	Neck
Shoulder	Shoulder	(buttock,	(buttock,	Upper back
girdle	girdle	trochanter)	trochanter)	Lower back
Upper arm	Upper arm	Upper leg	Upper leg	Chest
Lower arm	Lower arm	Lower leg	Lower leg	Abdomen

Symptom severity scale (SSS) score

For each of the 3 symptoms:

Fatigue | Waking unrefreshed | Cognitive symptoms

Indicate the level of severity over one week using the following scale:

0 = No problem

2 = Moderate: considerable problems, often present and/or at a moderate level

1 = Slight or mild

problems: generally mild or intermittent

3 = Severe: pervasive continuous, life-disturbing problems

The symptom severity scale (SSS) score: is the sum of the severity scores of the 3 symptoms (fatigue, waking unrefreshed, and cognitive symptoms) (0–9) plus the sum (0–3) of the number of the following symptoms the patient has been bothered by that occurred during the previous 6 months:

Headaches
(0–1)

Pain or cramps in
lower abdomen (0–1)

Depression
(0–1)

The final symptom severity score is between 0 and 12.

The fibromyalgia severity (FS) scale is the sum of the WPI and SSS.

OPIOID RISK TOOL

(Assign points for each applicable factor)⁷

Family History of Substance Abuse	♀	♂
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age 16-45	1	1
History of Preadolescent Sexual Abuse	3	0
Psychological Disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Total Score (risk) 0-3: low 4-7: moderate ≥8: high		



The **Stratified Tool for Opioid Risk Mitigation (STORM)** is recommended for all VA patients taking opioids.

PHYSICAL EXAMINATION ESSENTIALS

Common Pain Sites/How to Focus the Exam

Always perform a routine physical examination of the region in question; in addition, evaluate for regional myofascial pain and perform the other maneuvers listed:

- **Abdominal Pain:** Evaluate for abdominal wall (myofascial) pain using Carnett's test.
- **Arm (upper):** Neck, shoulder (see shoulder exam, page 7), rotator cuff
- **Buttocks/Groin:** Hip internal rotation, SI joint (FABER's test, palpate SIJ, thigh thrust, pelvic compression in side-lying)
- **Knee:** 1. Observe alignment and for effusion, 2. AROM vs. PROM (hip and knee), 3. Palpation (joint line, tendons, Pes anserine bursa), 4. Provocative testing:
 - » McMurray (meniscus)
 - » Apley's compression/Lachman (instability)
 - » Patellar compression (Patellofemoral Syndrome)
 - » Noble (IT band)

MYOFASCIAL PAIN (MP)⁸

Taut bands, trigger points – look for in everyone, for all pain locations/types:

- » Palpate firmly, with intent, perpendicular to fibers.
- » Dx when palpation mimics spontaneous pain.
- » Distal pain radiation mimics radiculopathy; can have paresthesias, sweating, other autonomic sx.
- » Activity may improve or worsen.

- **Low Back:** Lumbar range of motion, hip internal rotation, knee exam, SI joint (FABER's test, palpate SIJ, thigh thrust, pelvic compression in side-lying), leg length discrepancy, spinal alignment (scoliosis [palpation, Adam's Forward Bend], kyphosis); quadratus lumborum/erector spinae (iliocostalis lumborum)/gluteus medius myofascial pain
- **Neck/Upper Back:** Range of motion of neck, shoulder (see

shoulder exam, page 7); if concerns for multiple sclerosis, check Lhermitte's sign.

- **Sciatica:** Straight leg raise, piriformis exam (piriformis syndrome)
- **Shoulder:** Active ROM (Apley's scratch test) vs. Passive ROM
 1. Rotator cuff muscle strength testing with resistance:
 - » Supraspinatus – empty can
 - » Infraspinatus – external rotation
 - » Subscapularis – lift off
 - » Teres minor – Hornblower's
 2. Impingement – Neer sign and Hawkins-Kennedy test
 3. Biceps – Speed's and Yergason's
 4. Acromioclavicular – cross arm test
- **Thigh:** Hip internal rotation, IT band (lateral pain) – Ober's test, direct palpation, SI joint (FABER's test, palpate SIJ, thigh thrust, pelvic compression in side-lying), lumbar spine (dermatomes); if pain, paresthesias and diminished sensation of anterolateral thigh, consider meralgia paresthetica (lateral femoral cutaneous nerve entrapment)

Neuropathic Pain Symptoms: Focusing the Evaluation

- **Bilateral symptoms (e.g., paresthesias, dysesthesias) with distal +/- proximal extremity involvement:** R/O toxic/metabolic causes (e.g., DM, heavy metal poisoning), hereditary (e.g., Charcot-Marie-Tooth), malignancy
- **Unilateral or bilateral symptoms:** Compression mononeuropathy (check Tinel's at carpal tunnel, and/or Phalen's for median nerve symptoms; check Tinel's at cubital tunnel if ulnar neuropathy symptoms; check Tinel's at tarsal tunnel if tibial neuropathy symptoms)
- **Radiculopathy symptoms:** Check Spurling's and/or upper extremity neural tension test for upper extremity symptoms, seated slump test for lower extremity symptoms, femoral nerve tension test if anterior thigh symptoms.

Older Adults: Essential Supplemental Exams

- **Mobility/Balance:** Observe gait, righting reflexes (i.e., ability to right self in response to backward tug of pelvis)
- **Cognitive Function:** Mini-cog (3-word recall with clock draw as distractor)⁹

- » 0/3 recall: Dementia very likely.
- » 1-2/3 recall + normal clock: Dementia less likely.
- » 1-2/3 recall + abnormal clock: Dementia possible.
- » 3/3 recall: Dementia very unlikely.

FOLLOW-UP ASSESSMENT

- **Severity/Interference:** See “Baseline History Essentials,” page 2.
- **Re-educate:** Address unrealistic expectations.
- **Conduct medication reconciliation:** Taper or d/c drugs that are not effective or that the patient d/c’ed because of side effects.

TREATMENT ESSENTIALS

What to do if:

- **Depression/anxiety screen +:** Take a more detailed history to confirm or refer for psychiatric evaluation.
- **Poor coping/fear avoidance/low self-efficacy:** Consult pain psychologist or PT with chronic pain expertise or interdisciplinary pain program.
- **Sleep quality poor:** Identify etiology and treat; consult sleep specialist if needed.
- **Widespread pain:** Consult rheumatology or pain clinic.
- **Moderate-high opioid risk:** Educate, co-manage with substance abuse program, interdisciplinary pain program.
- **Myofascial pain:**
 1. Identify and treat perpetuating factors (physical, emotional, environmental); consider gabapentin for neuropathic generators.
 2. Trigger point deactivation.
 3. PT for gentle stretching, strengthening.
- **Positive SI maneuvers:** 1. Identify/treat perpetuating factors (e.g., hip OA, recent LLD). 2. Consider SI injection as bridge. 3. PT (brace, walker, pelvic musculature Rx).
- **IT band pain:** Refer to Physical Therapy.
- **Scoliosis/kyphosis:** PT referral; consider walker to unload spine.
- **Leg length discrepancy (LLD):** If pain started after LLD (e.g. after TKA, THA), refer to PT for evaluation and possible shoe lift.

- **Poor balance or mobility:** PT referral; Geriatric Medicine referral; avoid opioids, if possible.
- **Mini-cog abnormal:** If 0/3 recall refer to Geriatric Med; if 1-2/3 recall refer for neuropsych testing.



CLCR CALCULATION

www.globalrph.com/multiple_crcl_2012.htm

STEPPED CARE DRUGS FOR NOCICEPTIVE PAIN (e.g., OA, not myofascial pain, fibromyalgia)

- **Intra-articular corticosteroid/topical diclofenac/capsaicin**
Diabetics should monitor glucose post-corticosteroid injection; prescribe assistive device. It is prudent to monitor Cr after topical NSAID initiated.
- **Acetaminophen** 325-1,000 mg q4-6h, max 3 gm/d (ask about all OTCs with acetaminophen).
- **Salsalate** 500-750 mg bid (max 3 gm/d) with food or milk (mild anti-inflammatory); does not interfere with platelet function; GI bleeding and nephrotoxicity rare, but Cr monitoring is prudent.
- **Celecoxib** 100-200 mg bid – Not for long-term use in elderly.
- **Ibuprofen** 400 mg po q4-6h OR **naproxen** 250-500 mg bid with food or milk – Do not use long-term in older adults¹⁰; PPI/misoprostol if long term.
- **Duloxetine** Consider for musculoskeletal pain; see dosing under Peripheral Neuropathy.
- **Tramadol** Start 25 mg qd; increase by 25-50 mg in divided doses every 3-7 days to max dose of 100mg QID. Renal dosing (CrCl < 30 ml/min) 100mg BID. Educate on s/sx of serotonin syndrome if other serotonergics.



GENERAL NSAID PRECAUTIONS

- » Avoid in older adults.
- » Avoid in renal insufficiency.
- » Use with extreme caution in HTN, CHF.

- **Hydrocodone/acetaminophen** 5/325 – 10/500 mg q4-6h; max acetaminophen dose 3gm/day.
- **Oxycodone** 5-10 mg q4h OR **morphine** 2.5-5 mg q4h (not recommended if CLcr < 30); assess total needs after 7d on stable dose, then convert to long acting; if morphine needed, avoid long acting if renal insufficiency.
- **Fentanyl** and **methadone** safest of opioids if renal insufficiency; ALWAYS consult pain expert.

OPIOID PRECAUTIONS

- » Start stimulant laxative at first sign of constipation.
- » Always carefully calculate opioid conversions: opioidcalculator.practicalpainmanagement.com.
- » Use extreme caution when prescribing opioids if mobility dysfunction or sleep apnea.
- » All patients taking opioids should also be prescribed intranasal naloxone.

i

STEPPED CARE DRUGS FOR NEUROPATHIC PAIN

Peripheral Neuropathy/Postherpetic Neuralgia (PHN)

**2017 ADA Guidelines recommend starting with pregabalin or duloxetine for diabetic peripheral neuropathy, and avoiding opioids.*

- **Lidocaine patch** 5% 1-3 patches 12h on/12h off – PHN only.
- **Gabapentin** For younger pts. with normal CLcr: Day 1: 300mg, Day 2: 300mg BID, Day3: 300mg TID, then titrate to pain relief (max 3600 mg/d). Older adults: 100 mg qhs, titrate by 100 mg q week. Renal dosing maximum: CLcr 30-59: 600 mg bid; CLcr 15-20: 300 mg bid; CLcr < 15: 300 mg qd. Supplement post dialysis.
- **Pregabalin** 25-50 mg qhs; increase 25-50 mg q7d to 100 mg bid; max 300 mg qd. Renal dosing: CLcr 30-60: 150-300 mg/d; CLcr 15-30: 75-150 mg/d; CLcr < 15: 25-50 mg/d. Supplement dose after dialysis.

- **Venlafaxine** 37.5 mg/d; increase by 37.5 mg q week to 150 mg/d. Max 225 mg/d.
- **Duloxetine** 20-30 mg/d; increase to 60 mg/d in 7d. Not recommended in ESRD or CLcr < 30.
- **Nortriptyline** or **desipramine** 10 mg qhs; increase 10 mg q7d to max of 50 mg qhs. Watch for QT prolongation; EKG prior to starting in older adults.
- Add or substitute **opioids** (dose per nociceptive pain) add if some effect with other drugs; substitute if no effect with other drugs.

Trigeminal neuralgia

- **Carbamazepine** Start at 50 mg q week; titrate 50 mg q week to 100 mg bid. Max 1,200 mg/d. In patients who are Chinese, Thai, or Malaysian, consider testing for HLA-B* 1502 allele. If present, increased risk of toxic epidermal necrolysis and Stevens-Johnson syndrome.
- **Gabapentin** if CBZ not tolerated (see PHN dose).
- Add **baclofen** if needed (not in older adults).

DRUGS OF ABUSE URINE (DAU)¹¹⁻¹⁴

Lab menu: DAU and oxycodone screen

Screening (DAU)	Confirmation (GC/MS)
Sensitive	Most sensitive
Specificities vary	Highly specific
Rapid turn-around – < 24 hr	Up to four weeks
Higher cut-off limit	Lower cut-off limit
Detects a class – i.e., opiate, BZD	Identifies the opiate*, BZD
Presumptive positives or negatives	Definitive identification of opiate, BZD or confirms absence (false +)

+ **Opiates**: Indicates any combination of codeine, MSo4, hydrocodone, hydromorphone, oxycodone.

- When ordering DAU, add screen for oxycodone, buprenorphine, and fentanyl.
- Tramadol will not be detected by DAU opiate screen; confirmation required.

DAU tests specifically for cocaine and methadone metabolites benzoylecgonine and EDDP, respectively.

- Nucynta may produce false positive for methadone.

Detection period

- **Opiates** 1-2 days for most, 2-3 days for fentanyl
- **Methadone** 3-11 days
- **THC** 3 days single use, 4 days moderate use, 10 days heavy use, 30-36 days for chronic, heavy use
- **Alcohol** 7-12 hours

Collection 50 ml, ward collect.

Temperature 90-100 degrees within four minutes of voiding.

Tampering/Dilution Order creatinine and specific gravity.

Urine Creatinine < 20mg/dl considered dilute.

Urine specific gravity (SG) 1.002-1.020, SG H₂O = 1.0.

Substitution pH extremely low < 3 or high > 11.

Confirmation GC/MS-confirms DAU result and identifies the drug.

To order Consult, lab consult, DAU confirmation outpt.

False positives To rule out (or in) especially amphetamine, BZD, other unexpected results.

CUTOFF LIMITS: DAU VS GC/MS		
	DAU (NG/ML)	GC/MS(NG/ML)
BZD	200-1000	50
Barbiturate	200-800	100
Cocaine	300	125
Cannabinoids	50	10
Methadone	300	100
Morphine	300	50
Oxycodone	300	50
Codeine	200	50

Miscellaneous

Heroin 6-MAM in ~6-8hr, then morphine

Only the presence of **6-MAM confirms heroin**:

- + THC with passive exposure highly unlikely;
- Poppysed-+morphine, patient counseled to abstain; or next positive will be assumed to be illicit.
- Low dose or PRN use-may not be + on DAU or confirmation.

Consider pill counts mid-prescription for actual use:

- **High dose oxycodone** expect parent drug and metabolite i.e., oxycodone AND oxymorphone.
- Absence of oxycodone implies not taken recently, oxymorphone can last 1-2 days after oxycodone.
- **Morphine** can also confirm for hydromorphone.
- Vicodin-hydrocodone or hydrocodone and hydromorphone or hydromorphone alone.

Approach to Opioid Tapering in the Patient without Addiction: BETTa

Identify all **Biopsychosocial** treatment targets.

Educate patient about pain contributors and benefits of opioid tapering.

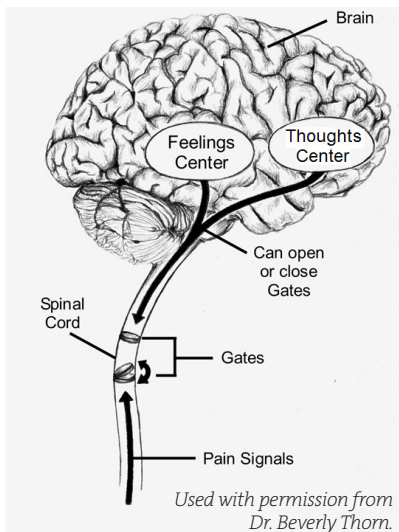
Treat all targets using an evidence-based, collaborative approach.

Taper opioids very slowly - <10% of total daily dose every 1-2 months for those on chronic treatment.

PATIENT TEACHING TOOLS

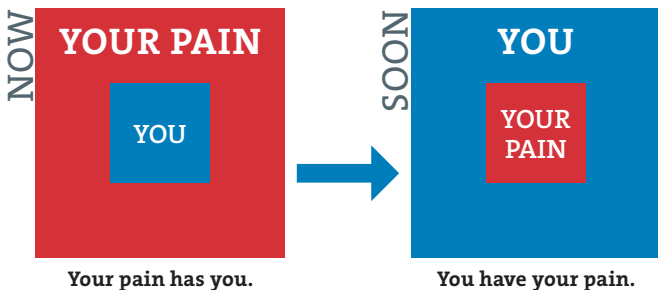
Pain and the Brain

There is a neurological gate in the spinal cord through which pain travels from the body to the brain. This gate can be opened or closed by signals from the brain. Some positive signals from the brain that close the gate (i.e., lessen the impact and/or intensity of pain) are physical activity and distraction by positive emotions. Some negative signals that open the gate (i.e., increase the impact and/or intensity of pain) are depressive, catastrophic, and/or worrying thoughts about pain.



The Goal of Pain Management

Patients with chronic pain may feel that pain controls them (i.e., “Your pain has you.”). The goal of chronic pain treatment is to change this perception (i.e., “You have your pain.”) Remember, the main goal is to REDUCE PAIN INTERFERENCE, not to eliminate pain.



There are other tools and explanations that may be helpful when teaching this to patients. For more information about training and materials for evidence-based psychotherapies like Cognitive Behavioral Therapy for Chronic Pain (CBT-CP), go to the 'Evidence Based Psychotherapy (EBP) Resources' Sharepoint.

DEFINITIONS

Physical dependence: adaptive physiologic state; drug class-specific withdrawal if abrupt drug d/c

Tolerance: a state of adaptation in which ongoing exposure induces changes that result in lessening of one or more of the drug's effects over time

Addiction: primary, chronic, treatable, neurologic disease with impaired control over drug use, compulsive/continued use despite harm and craving

Pseudoaddiction: behaviors that look like addiction motivated by inadequate pain relief



CHRONIC PAIN COMMUNICATION PEARLS

Positive – Deliver a positive message – e.g., “I have cared for many patients with pain like yours. You can have an active, fulfilling life, even though you will continue to have some pain.”

Action-oriented – Help the patient identify action-oriented and specific goals. (e.g., walk one-half block twice a week. Do not simply ask the patient how much he/she wants their pain to be reduced.) At follow-up visits, measure response to treatment by evaluating progress toward goals.

Identify – Chronic pain is a complicated, multifactorial syndrome, not a vital sign. To prescribe effective treatment, work with your patient to identify the multiple contributors to his/her pain and difficulty functioning. As our brains control pain in our bodies, comprehensive pain management means identifying and treating both the brain (e.g., maladaptive coping, depression, anxiety) and body.

Navigate – Help the patient understand that ups and downs are common and expected. Reinforce your willingness to assist him/her in navigating the maze of chronic pain and learning self-management strategies for use on good and bad days.

REFERENCES

1. Krebs EE, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *J Gen Intern Med* 2009; 24(6): 733-8.
2. Lowe B, et al. A 4-Item Measure of depression and anxiety: validation and standardization of the patient health questionnaire-4 (PHQ-4) in the general population. *J Affect Disord* 2010; 122(1-2):86-95.
3. Deyo RA, et al. Report of the NIH task force on research standards for chronic low back pain. *J Pain* 2014; 15 (6): 569-585.
4. Nicholas MD, McGuire BE, Asghari A. A two-item short form of the Pain Self-Efficacy Questionnaire: Development and psychometric evaluation of PSEQ-2. *J Pain* 2014. DOI: 10.1016/j.jpain.2014.11.002
5. Jochum J, et al. Advancing the screening and diagnosis of fibromyalgia in late-life: Practical implications for psychiatric settings. *International Psychogeriatrics* 2015; 27(9): 1513-21.
6. Wolfe F, et al. 2016 Revisions to the 2010/11 Fibromyalgia diagnostic criteria. *Sem Arthritis Rheum* 46 (2016) 319.
7. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the opioid risk tool. *Pain Med* 2005; 6(6): 432-42.
8. Finando D & Finando S. Trigger point therapy for myofascial pain—the practice of informed touch. www.innertraditions.com.
9. Borson S, et al. The mini-cog: a cognitive ‘vital signs’ measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry* 2000; 15(11): 1021-7.
10. 2019 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2019 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatr Soc* 2019; 67(4) 674-94.
11. DAU Screen-Cutoff Levels. (2014). VA Pittsburgh Healthcare System.
12. Department of Veteran Affairs. VHA Handbook 5383/5 (2012, Nov 20). VA-Drug-Free Workplace Program. Washington, DC: Author.
13. Drug Metabolism, Cutoff limits, Detection periods for drugs in urine (Appendix A & Appendix B). (2013). Philadelphia VA Medical Center.
14. U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment. (2012). *Clinical Drug Testing in Primary Care*. Rockville, MD: Author.

VA



U.S. Department of Veterans Affairs

Veterans Health Administration
VA Pittsburgh Healthcare System

PROJECT LEAD:

Debra Weiner, MD^{1,2*}

CONTRIBUTORS:

Amelia Matteliano, BFA³

Benjamin Congedo, MS^{1*}

Jason Trojnar, BA³

Jennifer Pruskowski,
PharmD, MS^{1,2*}

José Pérez, MFA¹

K. Sean Mathers, DC, DPT¹

Kimberly Graham, MA¹

M. Melissa Moon, DO³

Mary Lou Bossio, MSN¹

Rebecca McCarthy, PharmD¹

William Tellin, DC¹

1. VA Pittsburgh Healthcare System (VAPHS)

2. University of Pittsburgh

3. PerforMax

*Geriatric Research, Education, and Clinical Center (VAPHS)