Appendix 33 – Patient scenario - Chronic pain consultation

Opioid Patient Scenario: Chronic Pain

Louise is a 48-year-old female with a long history of back pain that started in her 20's. It was initially intermittent but progressively became persistent. She describes persistent low back pain with acute flareups that can make her bed bound. Flareups come on every 3 weeks or so and can last for 3-4 days. Some radiation of pain into her thighs, but this does not extend below the knee. No bladder or bowel dysfunction. She can perform activities of daily living, but her function is poor. She needs a walking stick to mobilise. She used to work as a cleaner but stopped working 10 years ago. She is currently on Zomorph 40 mg BD and Oromorph 5-10 mg prn, which she takes about 3-4 times per day. Despite this, her pain is not controlled, and she is becoming increasingly restricted at home. The pain is affecting her mood, and she was started on Fluoxetine for depression, without much effect. She has had MRI scans in the past that have shown degenerative changes at multiple levels, and disc bulges but no nerve root compression.

Standard History to include:

- ❑ When and how the pain started
- ❑ Whether the condition is improving or deteriorating
- ❑ What impact it is having on function – hobbies and work.
- ❑ Is the patient concerned that they may be causing harm by being physically active
- ❑ What impact it is having on sleep, mood, and relationships
- ❑ The patients understanding of why they are in pain, and what they have been told by other healthcare professionals
- ❑ What does the patient want out of the consultation

Examination

- ❑ Rule out red flags
- ❑ Ascertain how well the patient can move
- ❑ Don't underestimate the power of physical examination

Timing

It may not be possible to cover every aspect in a short consultation and information may need to be obtained over multiple consultations.

Patient Consultation

The next section describes some of the key messages that you need to deliver in the first consultation and is an example of one possible way that the consultation could proceed.

STEP 1	Rule out / screen for red flags. Ensure that it is safe to move
STEP 2	Communicate that it is safe to move
STEP 3	Assess the efficacy of medications and communicate the lack of efficacy in chronic pain
STEP 4	Communicate the benefits of reducing opioids
STEP 5	Take steps to ensure that the patient stays mobile
STEP 6	Encourage other pain self-management strategies
STEP 7	Consider a referral to a specialist pain service

Click on the steps above to read about each

STEP 1 Ensure that it is safe to move

Are there any red flags for serious pathology? Is this pain a safe pain? Is the patient safe to move? What does the patient think the pain is due to? Are they worried about what it means? What are their specific concerns?

Most patients with musculoskeletal pain such as chronic low back pain do not have any ongoing sinister pathology. However, patients often worry that their pain means there is something dangerous going on and that the more they move, the more harm they are causing. This is a vicious cycle which leads to disability.

We know that most chronic musculoskeletal pain, such as lower back pain, is not due to a dangerous pathology. It is common for investigations such as MRI scans to show disc degeneration and bulging. Often clinicians and patients attribute their pain to these changes, but the evidence shows that there is often little correlation between imaging and pain. Even if there are changes such as spinal stenosis causing neurogenic pain, movement is still recommended.

The patient has made false assumptions about her condition which have been reinforced by negative and incorrect messages by clinicians. This means that she is less likely to be active. Being less active fits in with her understanding that the pain means harm. It is important to address these concerns.

You have been suffering from pain for more than 20 years now. What do you think is causing the pain?

I don't know. It must be the job that I did as a cleaner. All that bending does you no good. I think my discs have worn out. That's what the surgeon said - my back is like an 80-year-olds.

STEP 2 (1 of 2) Communicate that it is safe to move

Well, having examined you and having looked at your scan, I think we can be fairly sure that although you have pain, there isn't anything harmful going on. It's just that your nervous system has become oversensitive. When you move and it hurts, it does not mean you are damaging your spine. In fact, movement is good for you.

No, your pain is real. You are not making it up. The MRI is very good at telling you if there is anything dangerous causing your pain. In your case, there isn't anything dangerous. But your nervous system has become sensitive and is generating pain messages even though there is nothing concerning going on in your spine.

Does this mean the pain is all in my head?

Communicate that the MRI scan changes are a normal finding, but use non-threatening terminology, such as 'age related changes' instead of wear and tear or arthritis. Avoid the term degeneration and discuss the benefit of movement. Targeted reassurance to individuals concerns about activity or the condition of their spine will be the most effective.

Patients are often not believed by family and clinicians as they often look fine externally and are able to do more on good days. It is essential to acknowledge this and reassure the patient that you do not think they are making it up. Pain is what the patient experiences, regardless of what investigations show.

STEP 2 (2 of 2) Communicate that it is safe to move

Moving may not take the pain away but will help patients to do more despite pain. If patients don't move, their muscles will weaken, and joints will stiffen up and they will end up doing less and less. They will also lose confidence with movement and inactivity can lead to low mood. Any activity, whether it is housework or exercise has to be paced, which means doing little and often rather than pushing themselves when they feel good, and then paying for it with more pain afterwards. Over time, doing small amounts consistently should lead to an overall increase in activity. Patients should be advised that when they first start increasing activity, they may notice stiffness and pain, but by gradually increasing their activities, muscles will start to get more flexible, and they will ultimately be able to do more.

But I have tried doing this, it hurts even more! Sometimes I cannot even get out of bed. I tried physiotherapy a few times; it made the pain worse!

Moving will not take the pain away but will help you do more despite your pain. If you don't move, your muscles will stiffen up and you will end up doing less and less. You will still get days when the pain is really bad. It does not mean there is anything changing in your body. It just means the nerves are more sensitive. It's ok to rest for a bit, but you should still try and keep moving.

STEP 3 Assess the efficacy of medications and communicate the lack of efficacy in chronic pain

We know opioid medicines do not work very well for chronic pain. They may provide initial relief but this impact fades as patients develop tolerance to the medication. These medications also have side effects that can cause harm over time. Patients should essentially use opioids as a tool to help them do more despite the ongoing pain.

You are on a fairly high dose of morphine. Is it working for you?

The morphine worked at first but is not working any more.

Unfortunately, we know medicines do not work very well for chronic pain. As you've described, the morphine worked well to start with, but doesn't anymore; this is called tolerance.

So, can you increase the dose?

You are already taking a lot of morphine, and we know that this sort of dose can cause harm. Even when they work, there are often side effects to this kind of medication. Some of these side effects can't be felt immediately, but over time can cause harm. These include making you more susceptible to infection, altering your hormones, causing confusion, making you constipated.

STEP 4 (1 of 2) Communicate the benefits of reducing opioids

A reduction in opioid medicines is the best way to address tolerance and improve efficacy. There is little point in just saying we need to reduce opioids as they are bad for you, or they are addictive. Humans are poor at appreciating risks that they cannot see. It is important to convey how the reduction might improve pain relief.

Now, this might seem a bit odd to you. But the best way to deal with this is to reduce the morphine. Cutting down will allow your body to recover and become sensitive to morphine again. It will also reduce the side effects that you are experiencing.

But I am in pain all the time. I need the pain killers! I once missed a dose and the pain was so bad. Surely the morphine must be doing something?

It just feels that way because your body is so used to morphine, it does not like being off it and the way it reacts is by hurting more. The only way we can deal with this is to reduce the morphine. We can do it slowly, at your own pace. You might notice the pain is worse initially, but it will settle down.

STEP 4 (2 of 2) Communicate the benefits of reducing opioids

Patients should be advised that pain medication is essentially a tool to help them do more despite ongoing pain. See step 6 for additional pain management advice.

What should I do then when I have a flareup?

You can take an extra dose if needed which might take the edge off, but no pain killer will completely take away the pain. The best way of using morphine is occasionally, but not every day, to help you be more active. If you know you are going to do something that will hurt, such as walking for longer or exercise, it is ok to take a pain killer to help you do that. What you should not do is take the morphine regularly as your body will just get used to it and it won't work very well.

There is no absolute rule for opioid reduction. You could tackle the long-acting medication first or the immediate release. As long as the trajectory is downwards, any approach is appropriate.

STEP 5 Take steps to ensure that the patient stays mobile

Where investigations have shown that there is no dangerous cause of chronic pain, patients should be encouraged to move, as over time this can increase function and reduce pain. There are options to refer to physiotherapy and social prescribers.

We have discussed a lot today. The one thing I would like you to take away is that although you are hurting, there is nothing dangerous going on. The best thing that you can do is to move those muscles, help them get less stiff so that you can do more. This is the only thing that will help in the long run.

What happens next?

I am going to refer you to my physiotherapy colleagues. But you do not have to wait for the referral, you can start the process yourself. I will contact you again in a few weeks' time to review your progress.

Patients often think that the purpose of physiotherapy is to get rid of the pain. This is probably true for acute pain but not for chronic. The purpose is to keep patients moving despite their pain. Physiotherapy does not primarily affect the pain intensity, although some patients might gain relief from reduced muscle spasm.

STEP 6 Encourage other pain self-management strategies

Direct patients to additional resourses and websites on chronic pain, so that they get a deeper understanding of chronic pain physiology and can develop their pain self-management skills. Based on individual needs, this may include stress management and relaxation skills, strategies to improve mood, better sleep hygiene and advice around staying in or returning to work.

This is all well and good , but I'm worried about how I'm going to cope. I'm hardly coping as it is, I'm really tearful these days, and I can't be bothered to go out.

It sounds like pain is making you feel very low, and perhaps a bit anxious. This won't be causing your pain but will make it more overwhelming to deal with. Have you had any support with your mood before? ...

What about my sleep, is there anything I can have for that? If I could sleep, I think I could cope better with the pain.

Tell me more about your sleep. What are you doing currently to help? Medications to aid sleep come with lots of issues but there are a whole host of behavioural changes that could be helpful to you.

Patients might want to look for another quick fix, a medicine to help them sleep perhaps. This is an opportunity to speak about their role in pain management and direct them to self-management resources.

STEP 7 Consider a referral to a specialist pain service

When patients have considerable difficulty in reducing their opioids or when pain is having a significant impact on both pain and mood, it is possible that a pain service can be of assistance. For chronic pain such as this, medicines do not always help, and interventional procedures help in very specific conditions. A pain service that has an MDT (including pain specialist physiotherapy/occupational therapy/nursing/ psychology) and a Pain Management Programme could help with managing the impact of pain on mood and function.

I'm hearing that this pain has had an enormous impact on your life. It's affecting your activity, your mood, your ability to work. And you've tried to help yourself with what we've discussed before. Maybe it's time we refer you for some professional support from a chronic pain service.

Yes, I don't know what else I can do, maybe the pain clinic will have something to reduce my pain.

It is important for me to say that the pain service won't have access to any specific drugs that I can't prescribe, and procedures only work in few patients. What they will have is a team who can help you with coping better with the pain you have. Developing your other coping skills might mean that you will need to rely less on the medication.

Patients often think that the pain service will approve repeat opioid prescriptions or have something else that might cure their pain. It is important to manage patient expectations.

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