Medical Observer, National
01 Jun 2018, by Emily Dunn

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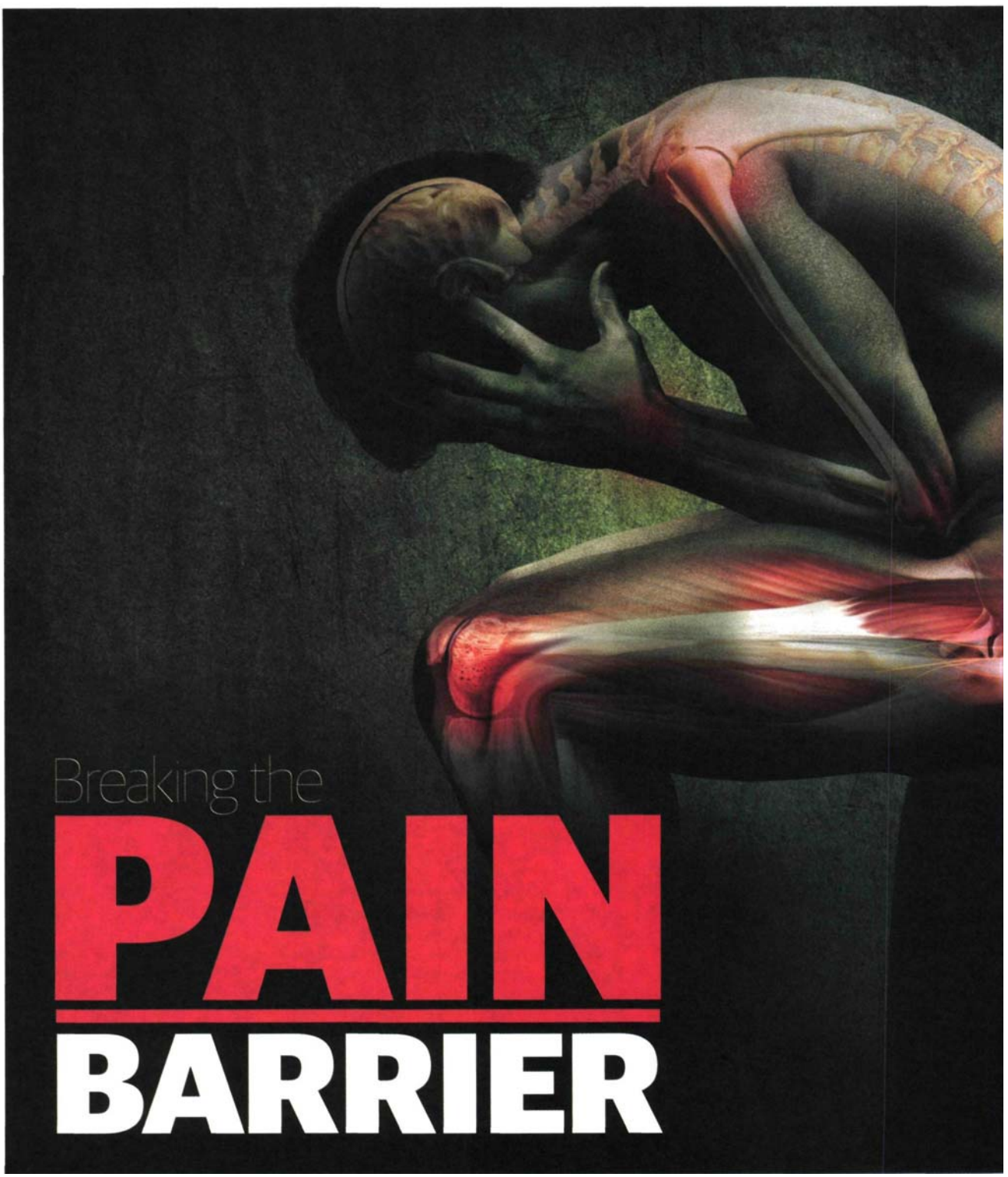
INSIDE STORY



Breaking the PAIN BARRIER

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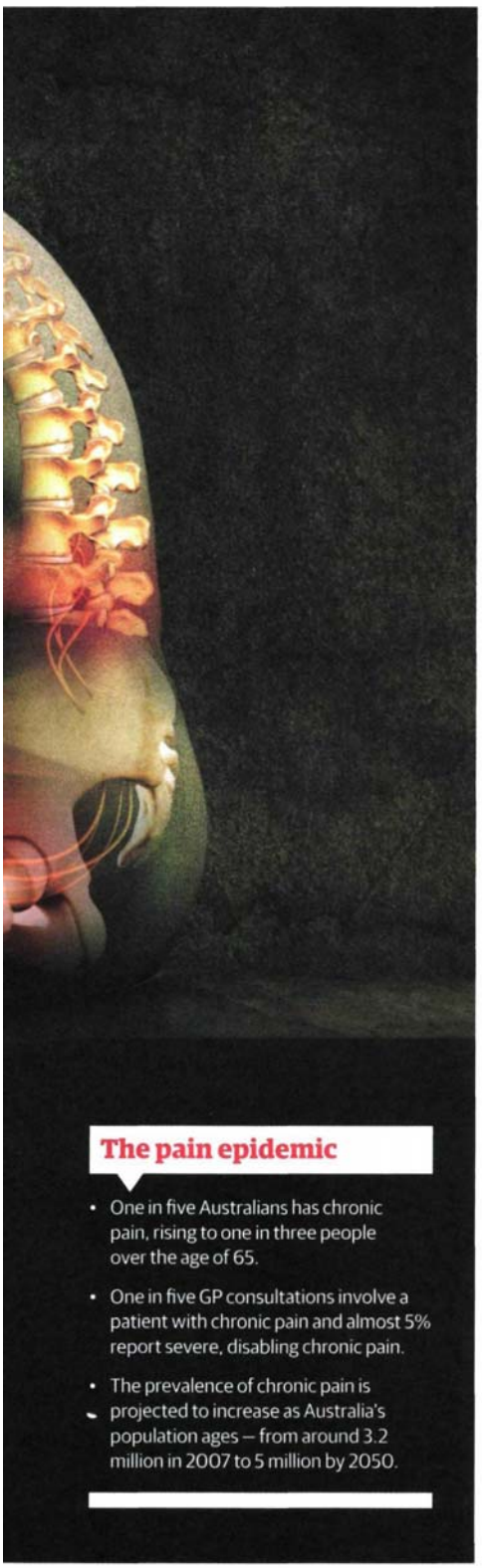

The pain epidemic

- One in five Australians has chronic pain, rising to one in three people over the age of 65.
- One in five GP consultations involve a patient with chronic pain and almost 5% report severe, disabling chronic pain.
- The prevalence of chronic pain is projected to increase as Australia's population ages – from around 3.2 million in 2007 to 5 million by 2050.

Pain medicine specialists are working to find better ways to help those with chronic pain, writes **Emily Dunn**

THE patient arrives at the surgery with a clutch of test results, imaging reports and specialist referrals. Their history could be a motor vehicle accident, rheumatoid arthritis, trigeminal neuralgia or unexplained dyspareunia but the theme is similar – living with pain.

Of the estimated one in five Australians who do so, 95% are managed in general practice.

In May, there was a promise of action. At the Painaustralia board meeting in Canberra, Minster for Health Greg Hunt announced support for a national action plan to address chronic pain management.

The move comes on the back of long-running campaigns by patient advocate groups calling for better access to optimum treatment, greater public awareness of pain and improved referral pathways.

For many patients, a multidisciplinary pain clinic is the best option as they follow a standard, evidence-supported pathway with group-based sessions.

Following an initial session about chronic pain, patients are triaged according to factors such as their daily function, their level of opioid use – measured as a daily morphine equivalent – and their mental health status. They then enter a multidisciplinary assessment phase to formulate a treatment plan and set goals.

This leads to either a low- or high-intensity multidisciplinary group treatment program, involving psychologists, physiotherapists and pain medicine nursing and medical specialists.

However, Dr Chris Hayes, a board member of the Australian and New Zealand College of Anaesthetists' Faculty of Pain Medicine, says the current system for accessing pain care is failing patients.

"We don't have good systems that say 'this is a complex patient and we send them to a multidisciplinary pain service' and 'this is the patient that we send to local allied health service' and 'this is the one that we give lifestyle advice to as a GP or practice nurse'," he explains.

"We need a national system that recognises the strengths but also the limited responses of the multidisciplinary pain clinics."

Dr Hayes, a pain medicine specialist and director of the John Hunter Hospital pain service in Newcastle, says the system's failings are more serious for patients in rural and regional areas.

Not all regions, for example, have HealthPathways – a directory of allied health services for GPs and other practitioners – and in those regions that do, Dr Hayes says, GPs may not utilise the service.

"People don't want to travel six hours to Sydney," he says.

"Telehealth could be an opening but it is not always clear what patients meet the criteria for telehealth consultations."

One thing that is in no doubt is that GPs are central to helping chronic pain patients navigate the health system, says Dr Meredith Craigie, dean of the Faculty of Pain Medicine.

"In the multidisciplinary pain clinics we see the tip of the iceberg but most of the burden of disease is in general practice."

"The specialist rheumatologists, gynaecologists [and] surgeons all revolve around the GP. They come and go out of people's lives and the GPs are the centre," she says.

Where GP care often falters is in the options for referral pathways, says Dr Craigie, from the Royal Adelaide Hospital pain clinic.

Not all patients are suitable candidates for, or have access to, a multidisciplinary pain clinic. However, for these patients GPs can play a similar role in pulling together allied health services.

However, private clinics are expensive and Dr Craigie acknowledges that even a GP-coordinated plan incorporating allied health services would be unaffordable for many patients with chronic pain.

"Many ... are struggling financially. ▸

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CNBP Director Prof Mark Hutchinson

CENTRE FOR NANOSCALE BIOPHOTONICS, UNIVERSITY OF ADELAIDE

THE COLOUR OF PAIN

A bedside test to diagnose pain by immune cell colour biomarkers could soon be available for use by GPs, according to researchers at the Faculty of Pain Medicine conference in Sydney in May.

The painHS test has been developed by an Australian neuroscience team based at the Australian Research Council Centre of Excellence for Nanoscale BioPhotonics, at the University of Adelaide. It uses light measurement tools to identify the molecular structures of what pain looks like in white blood cells.

Professor Mark Hutchinson, who led development of the test, told the conference it could be ready for broader use by pain medicine physicians and GPs within 18 months. It would be a cost-effective way to determine the severity of chronic pain in patients with migraine, low back pain, fibromyalgia, pelvic pain and cancer pain.

The test could also help diagnose pain in babies and people with dementia who were unable to communicate the source or severity of their pain. It might also help diagnose pain in animals, he said.

"What we've found is that persistent chronic pain has a different natural colour in immune cells than in a situation where there isn't persistent pain," Professor Hutchinson said, adding that it had the potential to lead to new treatment pathways.

"We now know there is a peripheral cell signal so we could start designing new types of drugs for new types of cellular therapies that target the peripheral immune system to tackle central nervous system pain."

◂ Care plans for physiotherapy are limited to five sessions a year. That is not enough for some of these people. From the mental health perspective, they can receive up to 10-12 sessions a year, which is better but not adequate."

For patients who can afford a private clinic, Dr Craigie says that interventions, such as spinal cord stimulation, can be helpful but might not be for everyone.

"There is an evolving body of evidence that there are people who benefit – but for varying amounts of time – and the problem is working out the characteristics of people who do benefit."

The GP is also central to pain education, says Dr Craigie.

"Maybe the patient has unhelpful beliefs or behaviours. Sometimes their families need that education – they [may be] promoting rest, which is not a good strategy for chronic pain."

In order to educate patients, Dr Craigie suggests GPs access specialised online resources focussing on, for example, pelvic pain or spinal cord injury.

"There is still a lot of misunderstanding in the community of what constitutes chronic pain. Often a chronic pain patient is an acute pain patient wondering what went wrong," Dr Craigie says.

"Quite often I see a new patient in the pain clinic and they don't really understand why they have been referred. These are important conversations that can happen before they come along."

Adding to the complexity of managing chronic pain is that it often overlaps with mental health disorders: up to 85% of patients attending a specialist pain clinic have an anxiety disorder and 50-60% have depression.

Although less common, substance misuse disorders are also linked to chronic pain, and there are often concerns around the misuse of prescription opioids and benzodiazepines.

GP Dr Simon Holliday, an addiction medicine specialist working on the NSW mid-north coast, says GPs have been unfairly criticised in the new paradigm of pain management and are "deemed to be just doling out the opiates".

"Last decade GPs were told to put everyone on high-dose opiates but now we know that was all wrong. Now we are saying you have to send them all to multidisciplinary pain centres."

Dr Hayes says de-prescribing plans for pain medication make up the bulk of his work within a multidisciplinary team. "Almost 50% of our consults involve something to do with someone in pain and often we can't refer those people on because the clinics are just not there."

"We tend to use our doctors early and then we keep out of it," he says. "We try and give the patient a new explanation of why their pain is there."

They might be told, for example, that their MRI does show age-related changes but it also shows they have a strong and stable spine.

He believes that any national strategy should be about more than just "throwing resources" at pain clinics.

"Ninety per cent of our patients are not ready to engage with more active lifestyle management, they are focused

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on 'isn't there a medication or surgery that will sort out my life?'," he says.

"We need a public health approach to change community expectations of treatment for chronic pain. If patients engaged with treatments, then perhaps the multidisciplinary pain clinics we have around the country would be enough."

Patient expectations of what a pain clinic can offer are important in determining whether they will engage with the program.

Of the patients referred to Dr Hayes' clinic in Newcastle, only 10% engage with the program. Of those who do commit, however, 80% make substantial improvements in at least one key area.

"Many do not like the treatments outlined, even the suggestion that they will just reduce their opioids," Dr Hayes says.

Specialists and GPs need to support each other through this process, he says.

"We will write to a GP with management suggestions based on evidence. Yes, we have a duty of care to the patient referred but we need to support the GP who is often struggling with the patient who is coming in and asking for opioid prescriptions.

"We say to the GP we are not trying to mandate – we are just expressing our view of best practice and interpretation of the evidence."

It is also expected that GPs will play a role in de-prescribing opioids.

A landmark randomised controlled trial this year comparing long-term opioids to non-opioid medicines for chronic musculoskeletal pain showed that opioids failed to improve function, resulted in greater adverse outcomes such as hyperalgesia, and marginally worsened pain intensity.[1]

Non-opioid analgesics fare little better. A systematic review of analgesic medicines – opioids or otherwise – failed to achieve a targeted 50% reduction in pain intensity for chronic pain sufferers.[2]

Despite the rescheduling of codeine-containing analgesics in February, Dr Craigie says she is yet to see an increase in the number of patients attending multidisciplinary clinics with an opioid dependency.

Often a chronic pain patient is an acute pain patient wondering what went wrong

DR MEREDITH CRAIGIE

"A lot of people actually have taken on board some of the messages that low doses of codeine are no more effective than taking simple analgesics."

"Certainly there will be people who have stockpiled because they are worried they will not be able to get a prescription, but not everyone who has been using a codeine-containing analgesic has been misusing it."

For patients on opiates, Dr Holliday says, the GP can work towards minimising the opiate load, where appropriate.

"We shouldn't be starting people on opiates, we need to start by initiating everyone on excellent pain care," he says.

"Pain management has been about reaching for a script but all the evidence is showing that we don't need opiates for chronic non-cancer pain."

In July the patient advocacy group, Chronic Pain Australia, will release the results of a survey of people living with chronic pain as part of National Pain Week.

Dr Mark Whitty, a GP in Newcastle and a clinical adviser to the Chronic Pain Australia board, says many patients feel their doctor does not validate their experience of pain.

"Non-cancer pain is difficult because there is nothing to see, no infection to treat or wound to stitch," he says.

One issue revealed by the survey is that patients avoid their doctor or pharmacist out of fear their medications will be taken away.

"They feel there is this push to de-prescribe opioids and that this is something they can't discuss with their GP or specialist," Dr Whitty says. "Patients feel as if they are being treated as drug addicts."

Dr Craigie says for some patients who have been taking opioids for a long time, maintaining medications might be important to help them engage in rehabilitation.

"We thought 25 years ago that it made sense to give them opioids. We now know ... they cause a huge amount of damage."

Dr Whitty says that while he is fortunate to work in an area with referral options, wait times can take months.

"You still need to manage the patient in the meantime," he says. "It is the classic bio-social-psychological model of healthcare; asking what the patient wants from the consultation, where they want to be in their daily life and it takes more than 10 or 15 minutes."

Dr Holliday says that in any national strategy, GPs should be "reclaiming the space" of chronic pain management. And this means being comfortable in coordinating treatment.

"GPs can coordinate multidisciplinary care. They can give advice on exercise or refer to a psychologist.

"If someone has chronic pain there will be something more than chronic pain – but we don't need to have every aspect of that person's suffering dealt with by a different healthcare provider.

"That is why we are generalists."

References on request

Resources

- Pain Management Network
  See: bit.ly/NPQwFe
- painHEALTH
  See: bit.ly/2tgVuQl
- Hunter Integrated Pain Service
  See: bit.ly/2JvYmVv