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CHRONIC PAIN: AN INCREASING PREVALENCE AND BURDEN OF DISEASE

Preventing the onset of chronic pain plays a pivotal role in its overall management. Chronic pain affects more than 3.24 million Australians. Chronic pain (also called persistent pain) is pain that continues for more than three months and often has its inception in surgery, an injury, or as a result of disease or chronic condition like arthritis or lower back pain. It is estimated that 2.39 million Australian men and 2.85 million Australian women will be living with chronic pain by 2050. In 2018, chronic pain cost Australia $73.2 billion in direct health, productivity and related costs and $66.1 billion in quality of life costs totaling $139 billion.

PREVENTING THE ONSET OF CHRONIC PAIN

Post-surgical intervention

Acute pain associated with surgery, trauma and other conditions can result in adverse outcomes, including the risk of progression from acute to chronic pain. Strategies for improved management of acute pain and early recognition of patients at risk of developing chronic pain offer important preventative options in decreasing the prevalence of chronic pain.[1]

Chronic postsurgical pain is also a possible complication of various surgical procedures, which can impair patients' quality of life while also contributing to chronic opioid use. Research indicates that currently in Australia, many patients are discharged with high doses of opioids post-surgery, an identified risk factor for long-term use [2]. This is concerning given research finding the provision of a prescription or supply of opioids places the patient at a higher risk of opioid harm, which may be unnecessary in these cases.

Post-surgical support and rehabilitation can play a very important role in the prevention of chronic pain post-surgery. This is a challenging time for most consumer to navigate and there is a tremendous lack of awareness around what people should do in these situations, and a lot of people end up seeking more pain medication, unaware that they will likely be unhelpful in the long-term management of pain, and may make the pain worse.

Research also highlights [3,4] the need to pre-emptively identify risk factors for development of chronic pain after surgery and manage them, a role that is well suited to general practice. Painaustralia recommends that GPs flag higher-risk patients to the anesthetists or perioperative clinic when making a referral.

Nexus of Chronic Pain and Comorbidities: Recognising chronic pain as a condition in its own right

Recent Australian Institute of Health and Welfare (AIHW) data highlights [5] that chronic pain goes hand in hand with other chronic conditions. As detailed in the Cost of Pain Report,[6] 44% per cent of people with chronic pain are also living with depression and anxiety, 29.3% with arthritis and 25% with high blood pressure. These comorbidities often contribute to worse health, societal and financial outcomes – for example; major depression in patients with chronic pain is associated with reduced functioning, poorer treatment response, and increased health care costs.

For those who experience chronic pain understandably the pain can be debilitating and have an adverse effect on work, sleep, and relationships. The consequences of these gaps are immense. The price paid by people with chronic pain results in physical and psychological ill health, social exclusion and financial disadvantage.

The electronic persistent pain outcomes collaboration (ePPOC) also reviews the most common comorbidities with chronic pain among patients presenting to a pain specialist, and their findings are as summarised in the table below. The reported comorbidity for chronic pain and depression or anxiety is estimated at 44.6% of patients, which is within the range of estimated values from the international literature.[7]

There is strong evidence that supports the importance of recognising symptoms, getting diagnosed and modifying lifestyle as soon as possible before the onset of symptoms like neuropathic pain set in for several chronic pain conditions.[8]

An important recognition of need for early intervention is the fact that chronic pain is increasingly recognised as a disease entity by the relevant international bodies, including the World Health Organisation (WHO). The WHO officially adopted the 11th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) in May 2019. This includes a systematic classification of clinical conditions associated with chronic pain. The new classification system is important because it treats chronic pain as a distinct health condition and as a symptom to an underlying disease. It also takes into account the intensity of pain, pain-related disability, and psychosocial factors that contribute to pain.

The ICD-11 is scheduled to come into effect in the year 2022. With the implementation of this systematic classification, ICD-11 takes a decisive step to better reflect the significance of chronic pain as a health problem of enormous epidemiological, economic, and sociological impact. This significant change in classification will also play a role in the way general practice screen and treat chronic pain into the future.

Mental Health Impact

Nowhere do psychiatric and medical pathologies intertwine more prominently than in pain conditions.[9] Painaustralia's new report on the Cost of Pain in Australia, prepared by Deloitte Access Economics, finds that the reported comorbidity for chronic pain and depression or anxiety is estimated at 44.6% of patients, which is within the range of estimated values from the international literature.[10]

Chronic pain is also a significant risk factor for suicidal behavior and people living with chronic pain are two to three times more likely to experience suicidal behaviour compared with the general population[11]. There are several ways that pain and major depression may be associated:[12]

- the psychological and physical distress of persistent pain may precipitate an episode of major depression for an individual;
- depression may be a precursor to, and contribute to, an individual's experience of pain by lowering their level of pain tolerance; and/or
- chronic pain and major depression may both be associated with a common underlying process, such as a neurological illness or fibromyalgia.

Of the 1,123 registered opioid-induced deaths in 2018, 88.9% of these occurred in the setting of other substances. Benzodiazepines were the most common drug to appear alongside opioids with 708 deaths (63.1%) having both drugs present. Approximately one-quarter of opioid-induced deaths also recorded an anti-depressant or anti-psychotic drug.[13] While the data is unclear around exactly how many opioid overdose deaths are actually suicides, some experts estimate that up to 30% of opioid overdoses may fit this description.[14]

Highlighting and identifying the comorbidity and linkages between chronic pain and mental health in general practice will aid in the provision of appropriate management plans and timely intervention.

BIOPYSCHOSOCIAL APPROACH TO CHRONIC PAIN MANAGEMENT

As chronic pain is largely invisible, people can feel misunderstood and stigmatised by co-workers, friends, family, and even the medical profession.[15] If their condition cannot be explained in the typical framework of biomedicine, people with chronic pain can find their personal legitimacy is compromised, and they can experience barriers to accessing income support, health care and other support services.

The National Pain Strategy and the National Strategic Action Plan for Pain Management documents the growing epidemiological and 'risk factor' research base that has provided very strong support for the 'bio-psycho-social' (or more recently 'sociopsychobiomedical') model of pain assessment and management. This model recognises three components: physical, psychological and social/environmental, which can overlap, and that to assess a person living with pain, it is important to assess the contribution of factors in these three areas to the pain experience of each patient.[16] This understanding has led to enhanced knowledge, effectiveness and innovation in pain management. The emerging consensus rightly promotes more holistic evaluation of a patient where neither psychology nor biology is rendered redundant in addressing the complexity of chronic pain.[17]

Modifiable risk factors

Like most chronic conditions, while chronic pain in an individual may have a single primary cause (e.g. injury), there are other factors which influence the duration, intensity and spectrum (physical, psychological, social and emotional) of the effects of chronic pain, and the perception of these.[18]

Physical Activity

Physical activity is important in the prevention and treatment of many chronic conditions including chronic pain. Pain is a commonly cited barrier to participation in physical activity. Understanding that pain in this context is not a sign of further tissue damage is crucial to feeling safe to undertake continued activity despite pain.

In the section covering physical activity (7.5), reference should be made to activity pacing for people living with chronic pain. Pacing is considered to be a multifaceted coping strategy, including broad themes of not only adjusting activities, but also planning activities, having consistent activity levels, acceptance of current abilities and gradually increasing activities, and one that includes goal setting as a key facet.[19]

Nutrition

Inflammation is common to chronic diseases including chronic pain. Diet plays a large role in modulating the immune system which causes release of cytokines, which can be either pro-inflammatory or anti-inflammatory.[20]

A recent systematic review evaluated the impact of nutrition interventions on pain severity and intensity in patient populations with chronic pain.[21] The study noted that nutritional interventions could be of particular use in a clinical setting as their implementation in practice could improve the quality of life for people experiencing chronic pain.

Sleep

Chronic impairments in the systems regulating pain and sleep can have a broad negative impact on health and well-being. Sleep complaints are present in 67-88% of chronic pain disorders[22] and at least 50% of individuals with insomnia—the most commonly diagnosed disorder of sleep impairment—suffer from chronic pain[23]. Across most medical interventions, the development of pain as a side effect coincides with the development of sleep disturbance, and vice-versa[24]. Further, both chronic pain and sleep disturbances share an array of physical and mental health comorbidities, such as obesity[25], type 2 diabetes[26], and depression.[27]

Patient Education and Health Literacy

As the current version of the Redbook emphasises, patient education and counselling contribute to behavior change for the primary prevention of disease. In this light, it is also important to recognise that the words used in speech and writing can influence others' mood, self-esteem, and feelings of happiness or depression, in fact, the words that a health professional uses can influence patients experience of pain itself.[28]

People living with chronic pain still face stigma and isolation every single day. From the workplace that refuses to accommodate the standing desk that a person with low back pain may need, to the family member who remarks "surely it can't be that bad if you can still walk", to the doctor who says, "nothing on your scan warrants the amount of pain you are feeling so I'd like you to see a psychologist".

A casual misuse of words or the use of words with negative connotations when talking about chronic pain in everyday conversations can have a profound impact on the person with chronic pain, as well as on their family and friends. It can also influence how others think about chronic pain and increase the likelihood of a person with chronic pain experiencing stigma or discrimination.

Painaustralia has developed Language Guidelines[29] that emphasise appropriate language that is accurate, respectful, inclusive and empowering. As cited in the Red Book, the patient plays a large role in enabling primary care, and it is useful to facilitate more active inclusion of patients in their care. This process is an essential component of self-management support strategies, and the use of language that reduces the stigma of chronic pain can play a pivotal role in enabling both prevention and ongoing management.

OPIOIDS AND CHRONIC PAIN MANAGEMENT

There is mounting evidence around the increasing harm and side effects of commonly prescribed pain management medications. Opioid misuse has been labelled a major health crisis in Australia and internationally, and there are increasing calls to address opioid misuse within treatment for chronic pain.[30]

Painaustralia's Cost of Pain report highlights that GPs manage arthritis or chronic back pain in about one fifth of all consultations. Within GP presentations, common forms of pain management included prescribing a medication. Nationwide, medications were used to manage chronic pain in an average 68.4% of GP consultations involving someone attending for pain management.

As noted in the RACGP's Prescribing drugs of dependence in general practice resource, prescription of opioids[31] should be based on a comprehensive biopsychosocial-based assessment; a diagnosis; thoughtful consideration of the likely benefits and risks of any medication, as well as of non-drug alternative interventions; and a management plan derived through shared decision making (SDM) and continual clinical monitoring.

Health practitioners and care givers must also recognise that chronic pain and opioid use disorder are complex conditions, and each can cause significant disability, social exclusion and a diminished financial situation. The issues of opioid misuse and overprescribing will not be addressed by pharmacological alternatives, regulatory reforms or dispensing practices alone. While each of these are important to minimise harms, systemic change across the health system and its response to pain is essential.

Greater awareness of pain management is essential to moving away from a reliance on medications. The third goal of the National Action Plan is that 'skilled professionals will support people with pain to have timely access to best-practice, evidence-based assessment and care' and includes:

- understanding the biopsychosocial processes underpinning acute and chronic pain;
- consumer expertise included in the development of professional education materials; and
- palliative care to include well managed preventable pain, in the place of choice for patients and their families.

Ideally, any patient presenting to their GP with chronic pain being considered for treatment with opioids should be given a comprehensive pain assessment and a plan that includes a multidisciplinary approach, sound communication and early liaison with a pain management service.

Opioid dependency treatment

Provision of opioid dependency treatments should be essential in any evidence based preventative overview. Pharmacotherapy for opioid misuse is well established in Australia, as in many parts of the world, as an effective treatment for opioid dependence. For those experiencing problematic use of prescription opioids, detoxification and abstinence based treatments may be effective. Maintenance therapies may also be utilised to assist clients to successfully manage physical dependence.

CONCLUSION

To meet the health challenges of opioid misuse and the rising pain burden, Australia needs a strong preventive focus towards chronic pain that has the support and engagement of General Practice. We hope that the suggestions and recommendations made in our submission provide useful input to your deliberations.

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