CAPM NEWSLETTER

ISSUE 3 VOLUME 2, FALL 2009

The literature on the management of the patient with chronic pain symptoms continues to demonstrate that there is no one reliable and evidence-based treatment program for everyone.

The type of pain (arthritis, cancer, soft tissue, post surgical) as well as the past history and the 'personality profile' of the patient usually affect treatment outcomes.

Modality (laser, TENS) and interventional studies as well as pain 'education' programs and different combinations of analgesia have proven 'helpful' but not conclusive for all patient populations.

However, throughout the literature, it is increasingly evident that appropriate analgesia (and hopefully education) is of paramount importance in the acute stage of the condition- whether medical, surgical or traumatic.
(See information on the new Acute Pain SIG of the Canadian Pain Society)

The only therapeutic approach that has shown efficacy and cost-effectiveness for sub-acute pain is a pain management program with functional restoration as a primary goal. Although more intensive in- patient programs have been shown to be more effective over the long term than less intensive out -patient programs, intensive in-patient programs remain costly These programs are often more difficult to access then out-patient programs.
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Based on the growing number of randomized controlled trials from different clinical research centres throughout the US and other countries, there is unequivocal evidence for the effectiveness of inter-disciplinary treatment. Main effects include a reduction in pain, more frequent exercise, increased activity, less time resting and greater life control. Some studies have also shown more effective work re-entry.

Although we acknowledge the benefits of inter-disciplinary pain management programs, the reality is that the majority of our patients continue to be treated by different health providers who are NOT working on the same site.

There is often little communication between the various health providers. It is 'probable' that the family physician is the health provider with the broadest knowledge base about the patient. The primary care physician is also usually the person who has referred the patient to the various health providers.

However, whether the patient is being medically managed or involved in a non-physician clinic-based treatment program, it is difficult if not impossible for the family physician to 'co-ordinate' all aspects of treatment . It is often non-physicians working in community rehabilitation clinics who become the primary health clinicians responsible for co-ordinating this kind of care.

This newsletter will present a typical 'patient scenario'. In this case, and because the patient has been injured in a motor vehicle accident (MVA), a physiotherapist working under a 'no-fault pre-approved treatment program' might be the health provider who tries to 'integrate and provide relevant information 'for the treatment plan.

A short list of references as well as a 'Call for Members' contributions to develop this subject is noted at the end of the Lead Article.

Respectfully submitted,

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(credentialing exam written in June 2009!)
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Inside this issue:

Update from the Executive

In June 2009, the CAPM president presented a lecture on 'Credentialing in Canada and Internationally to the Department of Anesthesiology, Hamilton General Hospital, Hamilton Health Sciences. This topic will be presented as well to committee members of CPSO in October. This dialogue is important to promote the Vision of the CAPM which is to encourage excellence in care. This can partly be accomplished by CAPM members choosing credentialing. In the future CAPM will endeavor to develop a Clinic accreditation process, as has been done with the AAPM.

Your Executive continues to dialogue as well with Ontario physicians about the development of an advanced certificate in interventional pain management. In discussion is also advanced certificates in behavioral management. Other areas of dialogue include advanced certification for pharmacological management as well as chiropractic rehabilitation. Advanced certificates in multi-disciplinary pain management are also being considered. Some in-roads have been made in many areas- and we are looking at more successes in the future.

Yours sincerely,

Eldon Tunks MD, FRCPC
President CAPM
Diplomate of CAPM
Member and Diplomate of AAPM

Update from the Professions

ACUTE PAIN SPECIAL INTEREST GROUP (SIG) - CANADIAN PAIN SOCIETY

Dr. Saifee Rashiq, Associate Professor and Director, Division of Pain Medicine at the University of Alberta was recently elected chair of this new SIG.

The aim of the SIG is to improve the evaluation and treatment of acute pain.

Your editor wrote to Dr. Rashiq congratulating him on this new endeavour.but also reminding him on behalf of the CAPM membership that acute pain management occurs in the community as well as in the hospital. Dr. Rashiq was encouraged to expand the scope of the SIG to include physicians, physiotherapists and chiropractors who are the primary health practitioners of acute traumatic pain.

Contact Saifee at the University of Alberta to download a copy of the minutes and other information on becoming a member of this new SIG.

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Meeting Notices

1. The American Academy of Pain Management (AAPM) 20th annual clinical meeting will be held in Phoenix from October 8-11, 2009. The program will discuss- 'Integrative Pain Management for Optimal Patient Care'. For further information and to register for the meeting, go to the AAPM website www.aapainmanage.org

2. The Ontario Psychological Association will hold its 63rd Annual Convention in Toronto on February 5-6, 2010. www.psych.on.ca

Lead Article: Case Study

It was requested by Mr. A.M.'s lawyer that he be assessed by a community-based physiotherapist.

Mr. A.M. had been involved in a MVA on December 15, 2007. He met with this physiotherapist (his second) in February 2008.

Given the time since the MVA and A.M.'s complaints and concerns, he presented as severely compromised. He had not been able to return to work as a soccer coach and dance instructor. He was also experiencing persistent neck and upper back pain, blurred vision, tinnitus and headaches. He was unable to sleep for more than an hour at a time.

Further dialogue noted that Mr. A.M. was also experiencing pins and needles into his right arm and fingers. He stated that any activity increased his symptoms.

Family Physician: after reviewing the ER report which had noted 'no fractures', pain medication was prescribed. The physician met with the patient every 2-3 weeks, but did not refer him to either a physiotherapist or any medial specialist until 6 months following the MVA. Prior to the MVA, Mr. A.M. had attended with his family physician only 'occasionally'. Because of the use of pain medication, Mr. A.M. became severely constipated. Severe abdominal and back pain resulted in a GI work-up arranged by his family physician.

The physiotherapist was concerned that Mr. A.M. sustained significant physical trauma at the time of the MVA, and requested that the family physician refer the patient for further investigation. Additional neck and back x-rays were inconclusive. Because of ongoing concerns, the PT again approached the family physician and Mr. A.M. was referred to a physiatrist. It took 5 months to get this appointment!

Dr. D.D., physiatrist ordered MRI studies of the cervical spine and also arranged for Mr. A.M. to have 'pain' injections by an anesthesiologist. The MRI had noted mild impingement and possible compromise of the spinal cord and spinal nerve roots.

The injections into his neck were very uncomfortable and did not appear to afford Mr. A.M. any significant pain relief. Further dialogue with the physiatrist recommended discussion with a neuro-surgeon to consider a laminectomy with spinal fusion.

Lead Article continued...

The physiotherapist had also arranged for Mr. A.M. to be assessed by a rehabilitation psychologist. The psychologist seemed concerned that Mr. A.M. had been a political activist in his native El Salvador and that he had also been physically injured. She noted that Mr. A.M. had also fathered 13 children by 4 different women.

Because of a change in his hearing, dizziness and balance concerns as well as blurred vision, it was recommended by his physiotherapist that he meet with a 'behavioural optometrist'-one familiar with the constellation of symptoms related to 'Mild Traumatic Brain Injury'. The family physician made the referral. The third party insurer however, did not agree to fund any specialized rehabilitation services or pay for prism glasses designed to reduce the 'blurred vision'. Mr. A.M. also met twice with an ENT specialist who informed him that he did not have any hearing deficits.

The physiotherapist copied her reports to all the other health providers involved in Mr. A.M.s care. However, she only received copies of their reports when 'requested in writing'.

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Unfortunately, this is a typical treatment scenario when a patient with persistent pain is treated in the community.

Acute complaints and symptoms take time to be 'confirmed' and managed appropriately. Psychological issues are often treated in isolation (and sometimes inappropriately) when there is no integration of physical and psychological facts as well as goals.

Although we see the development of an increasing number of one site chronic pain clinics in Canada, the reality is that most of our patients continue to be treated/followed by different health providers located in different treatment sites.

How can we better dialogue with each other (and with our patient) to ensure that we establish realistic treatment goals? Too often, there is a great disparity between physical and psychological treatment goals –when all the facts are not shared.

In the scenario delineated the extent of the physical trauma and application of appropriate pain control measures (possibly including surgery) have to be considered. Biases can occur if the psycho-social factors are considered as the main reasons why patients cannot return to work or resume their usual daily activities.

Developing way of communicating with each other is of paramount importance. Too often, the family physician (who usually knows the patient better than any other health provider) is *not* the key person directing care in no-fault or worker's compensation injuries.

Our readers are challenged to come up with a vehicle that would assist with improved integration of outpatient services (for the patient with persistent pain).

Lead Article continued...

Our health care system is additionally burdened by third payment carriers who often have their own 'treatment agenda'.

Do you have suggestions to improve our clinical skills and work together on this very important issue?

REFERENCES

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2. Gatchel, RJ and Okifuji, A (2006). Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic non-malignant pain. J.Pain 7 (11): 779-793

3. Guzman J., Esmail R, Karjalainen K et al (2002). Multi-disciplinary bio-psycho-social rehabilitation for chronic low back pain. Cochrane database Syst-Rev. (1):CD000963.Via the Australian Pain Society.

4. Otis, JC, MacDonald, A, Dobscha, SK (2006). Integration and co-ordination of pain management in primary care. J. Clinical Psychology, 62(11): 1333-1343

(Other references available on request)

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You are asked to review the scenario and *recommend ways that we can improve our communication skills with each other. Send them to us and we will publish them in subsequent newsletters.*

Of paramount importance is the need to *establish realistic goals*- both physical and psychological.

Because each health provider *assesses, recommends or provides treatment in a unique manner,* you are also asked how we could *expand on this assessment and treatment process so that all factors influencing recovery can be addressed.*