CAPM NEWSLETTER

ISSUE 2 VOLUME 2, SPRING 2009

The Winter 2009 edition of the CAPM newsletter reminded us that in order to truly develop inter-disciplinary pain management programs (whether on one site or several), it is essential that we learn more about each other- the different health care professionals involved in the 'Team'

Another goal discussed in the newsletter was the need to improve our ability to dialogue with our patients- and with each other about PAIN.

The Spring newsletter will continue with the format previously developed.

Update from the CAPM Executive- Dr. Eldon Tunks
Pain Initiatives from other Health Disciplines: The Chiropractic Association of Canada, Dr. Howie Vernon
Communicating with your patient: Developing a Pain Vocabulary- Gloria Gilbert
Lead Article: Pain Questionnaires: Dr. Kevin Rod, Toronto Polyclinic

Members should be aware of the IMMPACT Recommendations- published in the Journal of Pain, Vol. (No.2. pp 105-121 (www.sciencedirect.com). The Consensus Statement was on 'Interpreting the Clinical Importance of Treatment Outcomes in Chronic Pain Clinical Trials'. The authors reminded us the 'systematically collecting and reporting the recommended information that is needed to evaluate the clinical importance of treatment outcomes of chronic pain clinical trials will allow additional validation of proposed benchmarks and provide more meaningful comparisons of chronic pain treatments'.

And an 'interesting website' that your patients may tell you about is WEB MD- a Chronic Pain Newsletter. You can become a subscriber by emailing them at pain_news@health.webmd.com

As your Editor, I would encourage members of all health disciplines to share with CAPM their own useful assessment procedures- and intake questionnaires.

Members are also encouraged to continue to provide other ideas for future newsletter topics, articles and meeting notices. Please forward all submissions to the Editor at gloria@downtownclinic.ca.

Should you wish an electronic copy of the first newsletter, contact Ellen at the CAPM office office@eventsinsync.com.

Yours sincerely,

Gloria Gilbert B.Sc. (PT), M.Sc.
Secretary CAPM
Member of AAPM

Inside this issue:

Update from the Executive

A meeting was held with the Assistant Deputy Minister of Health in Ontario to discuss barriers to care for chronic pain patients. The Executive noted the high prevalence and social cost of pain as a health care problem; and emphasized that pain management cannot be addressed by specialists from any one discipline alone. It was emphasized that there is a need to identify those clinicians with particular specialized skills- setting the bar for standards of excellence and identifying practitioners who have important skills to offer in pain management.

CAPM has formalized an agreement with the American Academy of Pain Management (AAPM) regarding the credentialing process. Members, ready for credentialing are encouraged to contact Ellen Maracle-Benton at CAPM (ellen@eventsinsync.com) and add your name to the enrollment list.

The Executive is also working on a credentialing process related to specific pain management skills - '*Advanced Certificates in Pain Management*' . Two committees have been struck within the last month- and one initiative is moving towards working in concert with another Pain Organization also interested in the advanced credentialing status.

As CAPM reaches the end of the first year with an elected Board of Directors, the need to continue to maintain the multidisciplinary focus remains imperative. The proposal now under consideration is the formation of an additional body within CAPM- a multidisciplinary advisory board, to better represent the various clinical disciplines involved with pain management.

Yours sincerely,

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

Update from the Professions

Neck Pain Task Force, Cervical Outcome Measures- Canadian Chiropractic Association

The Bone and Joint 2000-2010 Task Force on Neck Pain and its associated disorders published its finding in a supplement to Spine (Haldeman S, Carroll L, Cassidy JD, et al. Spine, 2008;33 (Supplement): S5-7. A new classification system for neck pain of all causes (insidious, whiplash, work-related) was devised.
Additional information on functional ability was added to the degree of structural pathology. The Grades from I to IV also emphasized the need for further investigation and treatment based on the assessment.

Cassidy et al conducted a supplementary study on the risk of vertebrobasilar stroke and chiropractic care within one week (of presentation). They did find a positive association but a similar level of association was also observed among patients receiving care from a general family physician during this one week time period. They proposed that this finding could be attributed to the fact that 'patients with vertebrobasilar artery dissection-related neck pain or headache seek care (from chiropractors and physicians equally) before having their stoke' (Cassidy JD, Boyle E, et al in Risk of vertebrobasilar stroke and chiropractic care: results of a population –based case-control and case-cross-over study. Spine 2008; 33 (Supplement): S176-S183)

A special issue of the Journal of Manipulative and Physiologic and Therapeutics (Pub Med) in September 2008 was edited by Dr. Howard Vernon on 'Outcome Measures for the Cervical Spine'. Of particular note are articles on the neck disability index, testing for central sensitization in the neck, balance testing and deep cervical flexor testing and anterior head postures.

Respectfully submitted,

Howie Vernon, D.C.

Talking To Your Patient About Pain: Developing a Pain Vocabulary

By: Gloria Gilbert

Only the person who is experiencing the pain knows what it feels like. And as bad as they feel, it is their ability to participate in their usual activities that often affects them the most.
I have found it helpful with my physiotherapy patients to separate *how they are feeling* **(emotional words**) from *what they are feeling* (**physical words).**
Trying NOT to use the pain, but to describe the physical sensation of aching, burning, stabling, shooting, cramping etc- makes the patient realize that not all the 'pain is the same' (and may have to be managed differently).
Appreciating that these 'noxious' sensations can also make you feel depressed, sad, angry, frustrated, worried, stressed out- assists the patient to better delineate their 'emotional feelings'.
Patients are encouraged to work on physically feeling better (use of thermal and electrotherapeutic devices, mobilizations, hydrotherapy, exercise, medication etc so that they can gradually increase their activity tolerance.
Patients can then better understand that the 'emotional pain' must be treated/managed simultaneously – but often differently. And that feeling better physically assists in making them feel better emotionally.

Check out additional helpful clinical tips, including 'Speaking to Your Doctor About Pain' at www.downtownclinic, the website of The Downtown Clinic, Physiotherapy & Health Counselling

Lead Article: Using Scales in the Assessment & Treatment of Chronic Pain

Submitted by Dr. Kevin Rod, executive member of CAPM and physician and Director of the Multidisciplinary Chronic Pain Management Program at the Toronto Poly Clinic (www.tpclinic.com). The Poly Clinic is also involved in physician training for pain management pain research and pain patient education.
This newsletter is written by associate Dr. David Mula and is from a publication sent every 6 weeks to physicians involved in chronic pain management.

Using Scales in the Assessment and Treatment of Chronic Pain

Pain is the most common reason patients seek out medical attention. Whether acute or chronic, pain is a subjective experience. It is not only influenced by the disease, but by its dynamic interactions with the patient's psychological and social factors [1]. This biopsychosocial aspect of pain, along with each individual's differing perception in both quality and quantity makes it challenging to understand and treat the patient's illness experience [1]. An accurate assessment of pain is essential for the diagnosis and treatment of the patient. There is a need for standardizing pain assessment tools, so we can have a common understanding about a patient's pain complaint.

Chronic pain has many measurement tools that have been developed to assist us as healthcare providers. Such measures can be unidimensional or multidimensional, allowing for better understanding of the patient's pain experience (pain severity, description, location, fluctuations, functioning, impact, coping, etc.) [2].

The most basic and easiest tool to employ is simply asking the patient to qualify and quantify the pain they are in. Asking the patient what kind of pain they are experiencing (sometimes giving descriptors such as sharp, cramping, squeezing, etc.) yields a great deal of information. Adding a quantitative component such as a scale, the patient is asked to rate their pain from 0 (no pain) to 10 (worst possible), gives us a second dimension. This system is extremely useful, has multiple variations, and may be enhanced with visual aids (Fig. 1).

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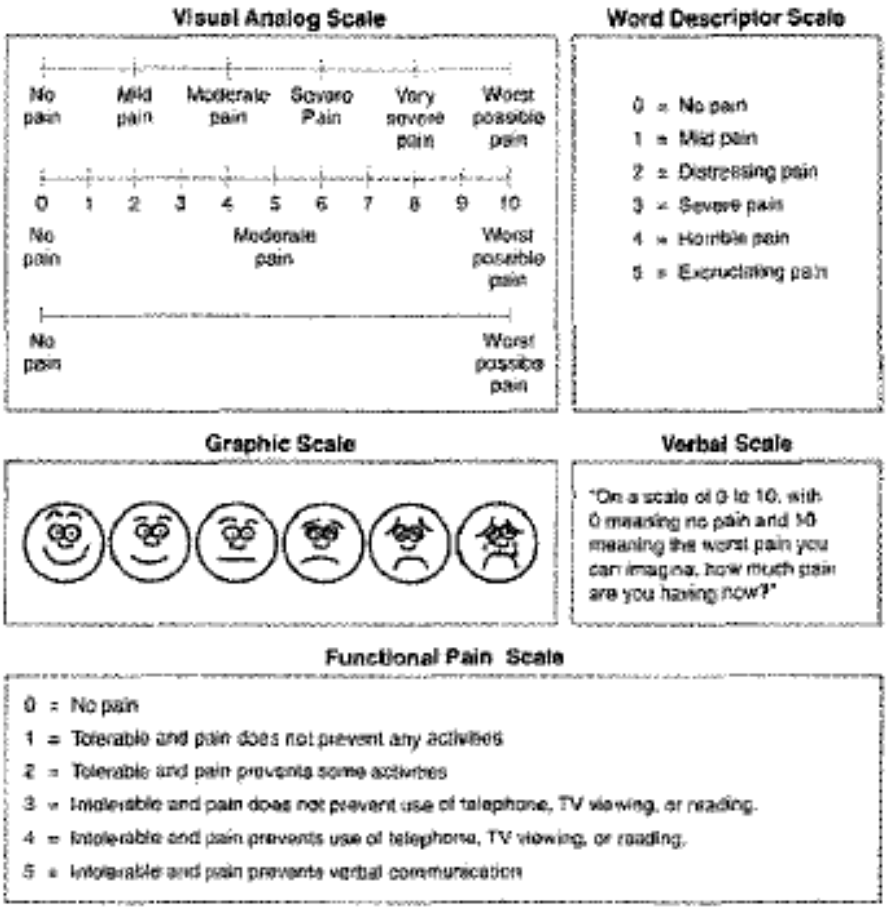


Fig. 1: Functional Pain Scales [3]

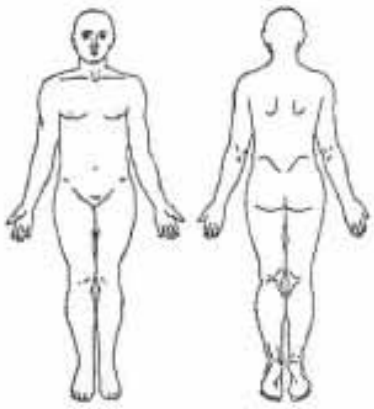
Since pain is subjective, it may be necessary to use more complex measurement scales — specifically in chronic pain, in order to:

- distinguish between nociceptive pain vs. neuropathic vs. psychological (vs. mixed)
- determine the best treatment plan and/or medication class to prescribe
- determine if the patient requires other medical services (such as psychological counselling,
- occupational therapy, social work, etc.)
- understand the impact of the pain on the patient's function
- see how specific interventions/treatments have affected the patient's pain

The McGill pain questionnaire (short form is shown in Fig. 2) is a self-report measure of pain quality. The descriptors fall into two groups (11 sensory; 4 affective) which are rated on an intensity scale from 0 (none) to 3 (severe) [2]. Three pain scores are derived from the sum of the intensity rank values of the words chosen for sensory, affective and total descriptors. The questionnaire also includes the Present Pain Intensity (PPI) index, based on a scale 0—10. This may be combined with a body diagram for the patient to mark the location where they are experiencing the pain. This allows for a more detailed understanding of the patient's illness experience on a multilevel platform (sensory, affective, quantity, and location).

Lead Article continued...

		Mild 1	Moderate 2	Severe 3
1	Throbbing			
2	Shooting			
3	Stabbing			
4	Sharp			
5	Cramping			
6	Gnawing			
7	Hot-burning			
8	Aching			
9	Heavy			
10	Tender			
11	Splitting			
12	Tiring-Exhausting			
13	Sickening			
14	Fearful			
15	Cruel-Punishing			



Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

No Pain _____ Worst Possible Pain

Score:

S-PRI (Sensory Pain Rating Index)	(questions 1-11)	max score = 33
A-PRI (Affective Pain Rating Index)	(questions 12-15)	max score = 12
T-PRI (Total Pain Rating Index)	(questions 1-15)	max score = 45
PPI-VAS (Present Pain Intensity-Visual Analog Scale)		max score = 10

Fig. 2: Short Form McGill Pain Questionnaire [4]

Determining the type of pain the patient has is essential to designing the correct treatment plan. The diagnosis of neuropathic pain requires an accurate history and physical. The DN4, seen in Fig. 3 is one such diagnostic tool designed to standardize this process, using a combination of history and physical exam.

Lead Article continued...

If answer yes to 4 or more items, neuropathic mechanisms are likely to be contributing to pain.

DN4 Questionnaire

Please complete this questionnaire by ticking one answer for each item in the 4 questions below:

INTERVIEW OF THE PATIENT

Question 1: Does the pain have one or more of the following characteristics?

		yes	no
1 -	Burning		
2 -	Painful cold		
3 -	Electric Shocks		

Question 2: Is the pain associated with one or more of the following symptoms in the same area?

		yes	no
4 -	Tingling		
5 -	Pins and Needles		
6 -	Numbness		
7 -	Itching		

EXAMINATION OF THE PATIENT

Question 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

		yes	no
8 -	Hypoesthesia to touch		
9 -	Hypoesthesia to prick		

Question 4: In the painful area, can the pain be caused or increased by:

		yes	no
10 -	Brushing		

Fig. 3: DN4 diagnostic tool for neuropathic pain [5]

As physicians, it is not only our duty to treat the disease and the symptoms — we must also look at the person as a whole. Evaluating the patient's function (as seen in Fig. 4), and how the pain interferes with their quality of life is a major part of pain management. Many times, function scores have improved dramatically from very modest improvement in pain levels. This should be considered in the evaluation and treatment of the patient.

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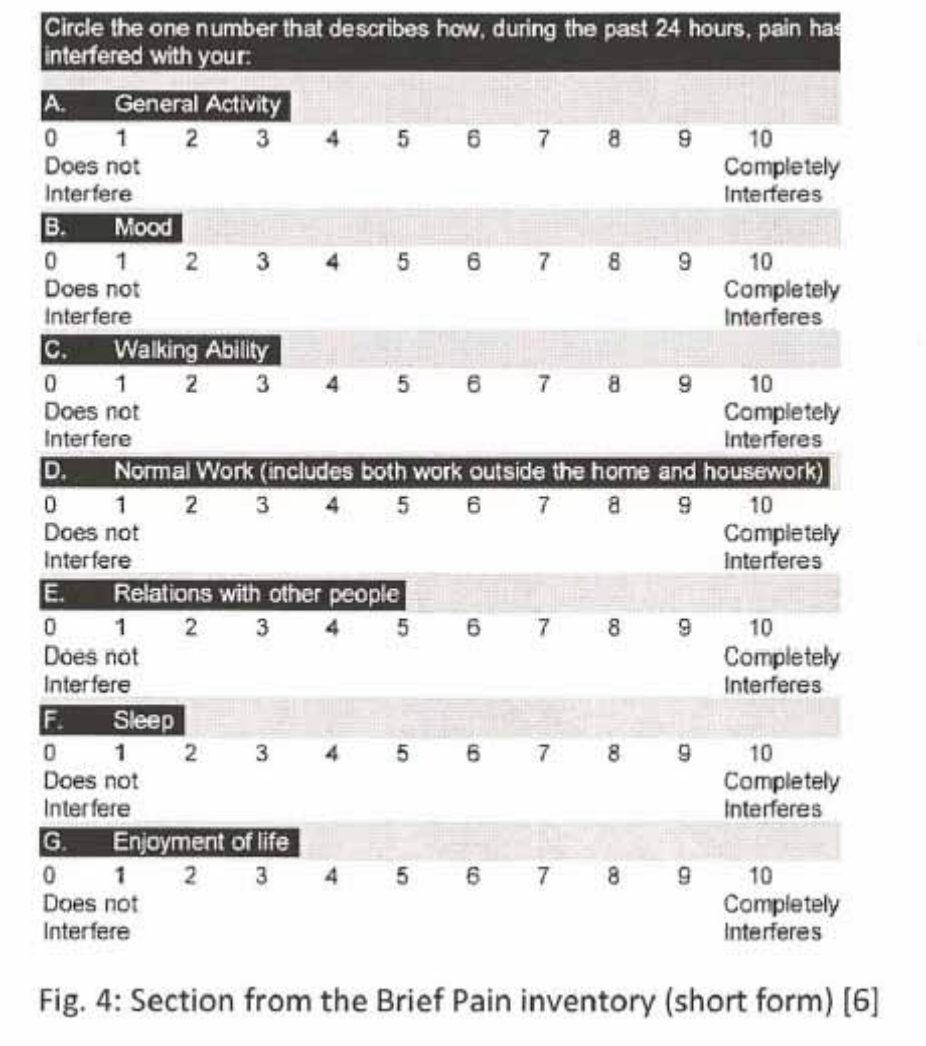

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
B. Mood										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
C. Walking Ability										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
D. Normal Work (includes both work outside the home and housework)										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
E. Relations with other people										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
F. Sleep										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
G. Enjoyment of life										
0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes

Fig. 4: Section from the Brief Pain inventory (short form) [6]

One of the barriers to effective opioid treatment of chronic pain is the fear of causing a substance abuse [7]. While opioid addiction is a possibility, it must be weighed against the patient's potential distress and impairment by not treating their pain. One of the ways of predicting the possibility of addiction is to screen with tools such as the Opioid Risk Tool (Fig. 5). By determining which patients are in the medium or high risk groups, the physician will be better suited to adjust the treatment plan. Such adjustments may include an assessment by a pain management specialist, an addiction specialist, a psychiatrist, more frequent assessments, and/or using other methods of pain control (adjuvant medications, physical therapy, etc.) [7].

Lead Article continued...

Opioid Risk Tool
Clinician Form

(includes point values to determine scoring total)

	Mark each box that applies: Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
2. Personal History of Substance Abuse:		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription Drugs	☐ 5	☐ 5
3. Age (mark box if between 16-45)	☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse	☐ 3	☐ 0
5. Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals	_____	_____

The patient can be placed into one of three opioid risk categories based on their total score.

Low Risk = 0 - 3 points
Medium Risk = 4 - 7 points
High Risk = 8 points and above

Fig. 5: The Opioid Risk Tool, Clinician Form [8]

Specific tools for diagnosis criteria are also available. Figure 6 is a graphical representation of the fibromyalgia tender points, as set by the American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia:

1. History of widespread pain.
   Definition. Pain is considered widespread when all of the following are present: pain in the left side of the body, pain in the right side of the body, pain above the waist, and pain below the waist. In addition, axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. “Low back” pain is considered lower segment pain.

Lead Article continued...

2. Pain in 11 of 18 tender point sites on digital palpation.
   Definition. Pain, on digiEal palpation, must be present in at least 11 of the following 18 sites:
   Occiput: Bilateral, at the suboccipital muscle insertions.
   Low cervical: bilateral, at the anterior aspects of the intertransverse spaces at cs-C7.
   Trapezius: bilateral, at the midpoint of the upper border.
   Supraspinatus: bilateral, at origins, above the scapula spine near the medial border.
   Second rib: bilateral, at he second costochondral junctions, just lateral to the junctions on upper surfaces.
   Lateral epicondyle: bilateral, 2 cm distal to the epicondyles.
   Gluteal: bilateral, in upper outer quadrants of buttocks in anterior fold of muscle.
   Greater trochanter: bilateral, posterior to the trochanteric prominence.
   Knee: bilateral, at the medial fat pad proximal to the joint line.

   Digital palpation should be performed with an approximate force of 4 kg.
   For a tender point to be considered "positive" the subject must state that the palpation was painful. "Tender is not to be considered "painful."

Fig. 6: Tender points in Fibromyalgia [9]

Lead Article continued...

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3. Adapted from the American Geriatrics Society (AGS) Panel on Chronic Pain in Older Persons: The management of chronic pain in older persons. Journal of the American Geriatrics Society 46:635-651, 1998; from Gloth FM Ill, Scheve AA, Stober CV, et al: The functional pain scale (FPS): Reliability, validity, and responsiveness in a senior population. Journal of the American Medical Directors Association 2 (3):110-114, 2001; and from Gloth FM Ill: Assessment. In Handbook of Pain Relief in Older Adults: An Evidence-Based Approach, edited by FM Gloth Ill. Totowa (NJ), Humana Press, 2003, p. 17

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7. www.paincare.ca, 2008

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9. Lippincott Williams & Wilkins, Arthritis Rheum, 1990;33: 169.