CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

ISSUE 2 VOLUME 3, SPRING 2010

In the last two editions of the CAPM newsletters (Winter 2010 and Fall 2009), the lead articles have highlighted challenges health providers have in clinical practice when treating the patient with chronic pain symptoms (see Issue 3, Volume 2, Fall 2009).

We have learned (or are in the process of learning) that too often health providers initiate a treatment plan-assuming that because the patient has attended the appointment/consultation, that they are in fact ready to begin 'treatment or some rehabilitation intervention'. We need to better delineate and understand the reasons that are impeding a patient's recovery… so that we can develop comprehensive, integrative treatment goals. (See article on Readiness to Change written by Dr. Eldon Tunks in Winter 2010 newsletter).

Your Editor, a physiotherapist (PT), presented a challenging (but typical) Case Study to the CAPM membership. A patient, who sustained injuries in a motor vehicle accident (MVA) 3 years previously attends with this PT (or a chiropractor) who works in a solo private practice.
How do we start the process?

The CAPM membership (and guests) were asked to comment on this 'process'. Dr. Brian Kirsh, psychiatrist and Medical Director of the Chronic Pain Management Unit at Hamilton Health Sciences reminded us of the important role of the family physician. Brian presented a comprehensive plan ensuring that the family physician remain the primary co-ordinating health professional for all pain management programs.

Brian is correct of course… but how do we initiate that process when the patient is seen by an O.P. health provider?

One must also add that there is a shortage of primary care physicians in some regions of this large country. In some Canadian jurisdictions, a chiropractor (DC), nurse practitioner or PT fulfils much of the role of the primary care physician in managing pain. Whomever the primary health care provider is (physician or otherwise), it is incumbent on that health provider to both communicate and provide a co-ordinated team approach so that everyone is kept "in the loop".

Thank you in advance to Dr. Eleni Hapidou, psychologist at Chedoke McMaster Hamilton and to Dr. Howie Vernon, chiropractor and educator for assisting with this case study development.

Members are reminded to notify your Editor about 'updates in your professions' concerning pain management initiatives and courses.

You may also want to consider reviewing a book or article or presenting your own article for publication in this newsletter.

HOPE TO SEE YOU ALL AT THE ANNUAL GENERAL MEETING OF CAPM which will be held in Calgary in conjunction with the CANADIAN PAIN SOCIETY ANNUAL CONFERENCE May 12-15, 2010.

CAPM Annual Meeting - Thursday May 13 from 7:30 am - 8:30 a. in Room Neilson 3 (breakfast will be served outside the room).

Respectfully submitted,

Gloria Gilbert, PT, M.Sc.
Secretary, CAPM
Fellow, CAPM
Member and Fellow, AAPM

INSIDE THIS ISSUE:

Update from the Executive

Dear Members:

Election results for officers from May 2010-2011 are as follows:

CAPM Executive Board Members : Eldon Tunks, President, Howard Jacobs, Vice-President, Gloria Gilbert, Secretary and Editor of the newsletter, Eleni Hapidou, Treasurer, and Members-at-large Lisa Goldstein, Eddie Wasser, Pam Squire, and Kevin Rod.

Members appointed to the ***Multidisciplinary Advisory Board*** are Brenda Poulton, Ruth Ringland, Janice Muir, Howie Vernon, and Ken Craig.

The CAPM office is managed by Ellen Maracle-Benton, Georgina Smith, and Laura Williams.

In 2010 ***Dr. Eddie Wasser*** resigned from the executive because of his busy schedule with the OMA and CPSO. We thank Eddie for his enthusiasm and work with the executive. Kevin Rod has agreed to take over the role of Chair of Credentialing.

We are grateful for the support and encouragement of two Corporate members – Purdue Pharma & Sanofi-Aventis as Bronze level members.

Howie Vernon and Eldon Tunks have been in discussion with Dr. Francoise Hains, President of the ***Chiropractic College of Clinic Sciences*** about the possibility of developing a pain credentialing program. This program would be suitable for chiropractors in postgraduate studies who also complete Fellowship training. Will keep you advised of deliberations.

A CAPM two-day course on 'Chronic Pain Assessment and Management' is planned for the late autumn in Toronto. Emphasis will be placed on developing skills working in a multi-disciplinary environment.

Members of the CAPM executive in association with the Collaboration with Chiropractic College of Clinical Sciences will be presenting an academic symposium at the ***Canadian Chiropractic Association Annual Meeting in Toronto in November 2010***. Using case-based studies, the treatment of pain based on a multi-disciplinary assessment will be presented.

Newsletters: Consistent with the Mission and the multi-disciplinary focus and educational mandate of CAPM, Gloria Gilbert has put considerable effort into the development of our newsletters. Four newsletters have been published since our last AGM.

Awards of excellence will be presented to the four original founders of the CAPM during the CAPM Annual General Meeting on May 13, 2010; Dr. Howard Jacobs, Dr. Alan Russell, Dr. James Clark, and Dr. Peter Rothbart.

Eldon Tunks, President of CAPM, is participating in a new ***McMaster Guidelines Center initiative*** to do a systematic search and evaluation of published guidelines pertaining to interventional pain clinic procedures. In time, results will be available on the McMaster Guidelines Center website.

Sincerely,

Eldon Tunks MD FRCPC
President of CAPM

Meeting Notices

1. **Canadian Pain Society Annual Conference, May 12-15, 2010 Calgary** (www.canadianpainsociety.ca).

2. The 13th World Congress on Pain to be held in Montreal from August 29 - September 2, 2010. www.iasp-pain.org/Montreal **for registration details.** A two-day symposia on 'Moving the Pain Education Agenda Forward: Innovative Models' will be chaired by Judy Watt-Watson in Toronto on August 26-27, 2010. For information contact Judy at paineducationsymposium@utoronto.ca.

3. 21st Annual Clinical American Academy of Pain Management September 21-24, 2010 in Las Vegas. Exploring the Science, Practicing the Art: Integrative Pain Management for Optimal Patient Care (www.aapainmanage.org).

Educational Initiatives and Information Sites

A few excellent educational resources for you and your patients:

(*i*) www.nepknowmore.ca Neuropathic Pain. Developed by Pfizer

(*ii*) www.painexplained.ca A joint venture of the Canadian Pain Coalition, the Canadian Pain Society, Chronic Pain Association of Canada and the Quebec Pain Society

(*iii*) www.WebMD.com Site for many different topics, peer-reviewed, enter chronic pain as key words

(*iv*) www.PainEdu.org Education 'modules'

(*v*) Two excellent educational posters (PDF format) are available:

- Pain Explained - Pain Pathways & Medication supported by Valeant
- Neuropathic Pain - supported by Pfizer (can be laminated and/or applied to a poster board)

(vi) The Pain & Movement SIG of the IASP is putting together a short 3 minute YouTube video on Pain and Exercise for the Global Year Against Musculoskeletal Pain.

For additional information on the Global Year Against Musculoskeletal Pain, go to:
www.iasp-pain.org/GlobalYear/MSP

Lead Article: Assessment and Treatment of the Patient with Chronic Pain in the Community

Gloria Gilbert, MSc, Physiotherapist, Eleni Hapidou PhD, Psychologist and Howie Vernon, DC, PhD, Chiropractor

Members and guests are asked to review previously published newsletters. These newsletters are posted on the website (www.canadianapm.com).

In the Fall 2009 (Issue 3, Volume 2) edition, a case study was presented of Mr. A.M. who had been referred to a PT/DC by a lawyer.

Discussion by the membership previously, showed us how complicated problems can become when 'we are not listening to the patient and/or when our own professional biases get in the way of appropriate treatment/management'.

This Lead Article is now presented somewhat differently.

We want YOU to assume that YOU are the primary health practitioner. After you have reviewed this Case Study and the treatment orientation that this inter-disciplinary team is taking, please send us your comments! Don't be concerned if you have other concerns or a 'different opinion'.

The Patient:

Mr. A.M.
53 years old
Native of El Salvador, has been in Canada for 15 years
Worked as soccer coach and dance instructor before MVA

- No previous accident, injuries necessitating time off work
- No prescription medication
- Was political activist in El Salvador, was injured in protest rally, made his way to Canada
- Father of 13 children, 4 different women but never married, was now living with the woman who is the mother of 2 youngest children, maintains father-daughter relationship with 2 older children who live in same city
- Patient's lawyer initiated referral to PT or DC

MVA: December 15, 2007

- Started physiotherapy treatment at another facility 6 months after the MVA; attended for 4 months and then 'stopped' because was not feeling any better
- Attends with family physician every 2-3 weeks for medication, developing constipation problems because of Tylenol #3, complete GI work-up ordered (normal); no investigative scans ordered (beyond neck x-rays which were taken in Emergency Department in December 2007 (which noted that there were 'no fractures')

Physiotherapy / Chiropractic Assessment : February 6, 2008

Because the patient had legal counsel, the PT/DC requested the index of the Medico-legal and/or Insurer Examination file. Of interest was whether there was any other relevant information available that would be helpful in designing a treatment program. The medical brief contained the usual accident benefits forms completed by the family physician and the initial PT. There were no assessments or new investigative reports.

The current PT/DC requested the initial accident report and ER summary- in order to determine if there was any documentation to determine the type of trauma Mr. A.M. sustained at the time of impact (Was he unconscious? Did air bags deploy? Was the car driveable post collision?).

Lead Article continued...

Patient Concerns & Complaints:

1. Constant headaches
2. Constant neck pain
3. Pins and needles into right arm; more evident when tries to do any activity
4. Sleeps on futon, cannot stay asleep for longer than 1 hour because of neck pain
5. Financial concerns because has been unable to return to work
6. Fear/anxiety about why he has not been able to get better, fear of what will happen to him in the future

The Actual Assessment:

The PT/DC chose to do a brief but relevant physical assessment initially.

It was evident to the health provider that:

- This patient was generally an active person and that if he could not resume his pre-morbid activity (with or without treatment), there were additional physical and/or psychological issues compromising his recovery
- Given the longevity of his physical symptoms and the acuteness of its presentation, it was likely that a PT/DC assessment would in fact cause the patient additional pain/discomfort, which could impact on Mr. A.M.'s involvement with this health provider

The PT/DC chose to ask additional questions regarding any other noxious symptoms patient might be experiencing- in order to distinguish musculoskeletal from possible other causes of pain, i.e. dizziness, tinnitus, blurred vision, changes to his balance.

Mr. A.M. was asked what he does to control his pain (noxious) symptoms, i.e. what is his daily 'routine' besides taking medication? Does he also implement any conservative methods for better control (hot or cold packs, showers, specific exercises, etc.).

Physiotherapist/Chiropractor's Recommendations & Rationale for Rehabilitation Management:

1. The PT/DC acknowledged that Mr. A.M. had great difficulty explaining the various symptoms he was experiencing and had no understanding about how to control them.

   Mr. A.M needed assistance to provide some routine/structure in his day so that he could better delineate the different 'physical sensations' he was experiencing.

   Mr. A.M. also needed to appreciate that although this PAIN was significant, it had been present for a long time, and that it was not 'dangerous' pain.

   The patient additionally needed to appreciate that in the MVA, he may have injured several parts of his body and sustained different types of injuries. This would make pain control more difficult.

   The patient was also made aware that the different type of pain he was experiencing needed to be assessed in more detail; and that the PT/DC would be asking his family physician to refer him to one or more medical specialists.

2. The PT/DC was concerned that Mr. A.M. had significant physical injuries sustained at the time of the MVA that had not been investigated fully. Symptoms suggested a Grade III Whiplash-Associated Disorder (as per FSCO definition). Associated neurological symptoms needed to be further investigated.

   The health practitioner felt that tinnitus, issues with balance and blurred vision were suggestive of vestibular and visual involvement. It was evident as well that the cervical and thoracic spine needed to be investigated more fully to determine whether there was any nerve impingement/herniation, etc.

Lead Article continued...

3. The PT/DC required information from a rehabilitation psychologist who would be better able to expand on the patient's coping abilities, his psycho-social situation and other issues that might be impeding his recovery. These factors had to be considered when considering both the 'type and orientation needed for any treatment plan.

4. The PT/DC also recommended that an In-Home Occupational Therapy (OT) Assessment be done to assess whether Mr. A.M. had appropriate equipment/furniture to involve himself in this treatment plan. The OT would also assess the patient's ability to care for himself personally and his ability to involve himself in his usual daily household tasks.

5. The PT/DC requested that the family physician refer Mr. A.M. to meet with a physiatrist. (*Unfortunately it took an additional 5 months to get this appointment scheduled).*

Besides the physical examination, what information was gleaned from questionnaires (Q) completed by the patient?

McGill Pain Q: 12 areas of the body noted as uncomfortable, primarily back of head, into face and jaw, down right arm and into right scapular region. Able to discriminate between aching, pins and needles and burning sensations.
Visual Analogue scale (for Pain): currently 6/10
Neck Disability Index: 78%
Oswestry Low Back Q: 54%
DASH (Disorders of the arm, shoulder and hand): 82% for ADL, 100% for work, 100% for leisure activities (soccer, dancing).

The health provider chose not to ask Mr. A.M. to complete a Coping Questionnaire since the patient had not yet been involved in any realistic treatment program. Results would (most probably) demonstrate a compromised ability to deal with pain symptoms appropriately throughout the day.

Mr. A.M. was a referred to a rehabilitation psychologist and met with her 10 days after the PT/DC assessment. What information was obtained from history/questionnaires completed by the patient?

Patient Questionnaire:
On this 25-item instrument, the patient indicates which symptoms they were bothered by 'A LOT' during the past month.

Mr. A.M. endorsed 12 symptoms (average) and rated his health as 'poor'.

Pain Intensity Scale:
(Where 0 is no pain and 10 is unbearable pain)

Mr. A.M was asked to evaluate his pain intensity over the 2 previous weeks. He rated his least level of pain as 5 and usual level of pain at 8 respectively.

Pain Disability Index:
(Where 0 is no disability and 10 is total disability)
On this 7-item scale, the patient is asked to rate the extent to which pain interferes with their life in family/home responsibilities, social activities, recreation, occupation, social behaviour, self-care and life support activities.

Out of a maximum score of 70, Mr. A.M rated his pain-related disability as 58.

Lead Article continued...

Chronic Pain Coping Inventory:

This is a 70-item instrument assessing frequency (0-7 days over the past week) of use of some pain coping strategies: guarding, resting, asking for assistance, relaxation, task persistence, exercise/stretch, pacing, seeking support and coping self-statements. Adaptive strategies include: exercise/stretch, task persistence, pacing, relaxation, coping self statements and seeking social support while guarding, resting and asking for assistance are considered maladaptive coping strategies and are generally discouraged. Results are expressed as T-scores.

Mr. A.M initially scored 58 on stretch/exercise, relaxation 34, and pacing 47, guarding 72, resting 77 and asking for assistance 56.

Results of both assessments noted that Mr. A.M. tended to under-report the severity of his symptoms. However physically he was significantly disabled because of the pain (NDI and DASH results). He also had little ability to control/cope with these symptoms (psychologist results).

Both the PT, psychologist and family physician discussed the short term treatment goals (at a Team meeting in the MD office or by conference call). The group recommendations were presented to the patient by his PT/DC. The patient agreed to involve himself in the Treatment Program.

Short term Goals:

1. Attend with PT/DC for pain management, i.e. implementing a 24/7 schedule to better control and delineate the different types of pains sensations he was experiencing (PT /DC would use manual, thermal, electrotherapeutic and assistive devices as needed).
2. Education goals emphasized understanding the different type of noxious symptoms he was experiencing and learning how to better explain how any change in his activity resulted in a change in Mr. A.M.'s experience of the noxious symptom.
3. To follow-through on medical/orthopaedic assessments that would be arranged by his family physician (physiatrist, additional radiological scans, discussion and/or referral to a physician knowledgeable about pharmaceutical management).
4. To attend with the psychologist regularly to learn how to better control anxiety and pain symptoms, apply relaxation techniques which could also be used as a complement to a 24/7 pain management schedule, to discuss possible reasons why patient was always angry and upset.

PLEASE GIVE US YOUR OPINION ABOUT THIS CASE STUDY

Do you want to pursue the second stage of treatment/management? Long-term goals? Vocational Issues?

Do you want to review other than musculoskeletal/orthopaedic case studies, i.e. neuropathic pain, associated psychiatric and/or medical conditions?

Do you want to know which questionnaires can easily be scored in your 'waiting room' and how to score them? (No need for investigating in soft-ware).