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EDITORIAL

Comprehensive Pain Care

"Physical pain however great ends in itself and falls away like dry husks from the mind, whilst moral discords and nervous horrors sear the soul." —Alice James

As long as humans have experienced pain, they have given reasons for its existence and sought after soothing agents to terminate the painful sensation. Archeologists have found "clay tablets," dating back as far as 5,000 BC, which were of proof of the use of opium poppy to cease pain. In 800 BC, the Greek writer Homer wrote in his epic, The Odyssey, of Telemachus, a man who consumed opium to soothe his pain. While some cultures allowed their use, in others perceived pain was thought to be a necessary, integral sensation.[1,2]

Pathophysiologically, we know there are different types of pains like nociceptive, neuropathic, and psychological depending on their inception. If no timely treatment is offered, most of the nociceptive pains do become secondarily neuropathic due to some reparable and largely irreparable changes taking place in the nervous system: The SENSITIZATION.

It is also important to note that many chronic pains may have an underlying inflammatory link with other noncommunicable diseases, in the form of **metaflamation**.[3,4] This hypothesis has brought up a new insight into the field of pain management today. For example, obesity and chronic pains are supposed to be interlinked, and therefore, both of these issues should be addressed in the management of such patients.

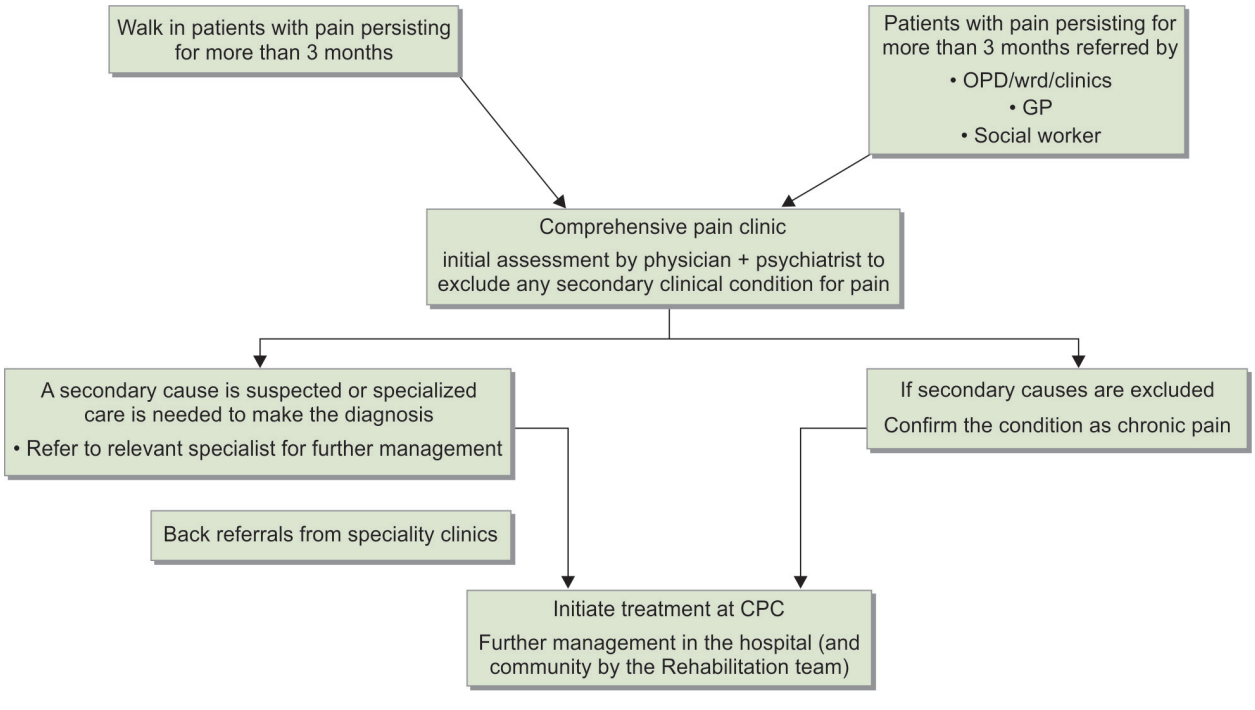
However, in the real world, unlike acute pain sufferers, majority of the chronic pain sufferers are likely to be under treated for many practical reasons. Therefore, it is vitally important that an organized comprehensive pain care (CPC) service is available for large numbers of such sufferers, specifically suffering from chronic nonmalignant pains (CNMP). The cost-effectiveness of CPCs is published with evidence by Okifuji et al, in the Journal of American Pain Society in 2006.[5]

Since the situation in our country (Sri Lanka) was largely unknown, we conducted a preliminary survey to assess the prevalence of chronic pains, among the medical clinic patients, in General Hospital – Badulla, Sri Lanka, in 2011. Unpredictably, it was revealed that about 66% of medical clinic attendees had chronic pain issues (defined as pain lasting for more than 3 months), mainly involving neurological and musculoskeletal systems.[6]

Therefore, it was decided to initiate a CPC facility in our hospital to bring about a new change in the system and to initiate an audit cycle thereof.[6]

The pathways, the patients to be taken, on a predetermined floor plan were as shown in Flow Chart 1.

Flow Chart 1: Pathways, the patients to be taken, on a predetermined floor plan. (OPD: outpatient department; GP: General practitioner; CPC: Comprehensive pain care)



All the patients were initially assessed by a self-reporting questionnaire, based on prevalidated "painDETECT" questionnaire, a morbidity assessment questionnaire and a depression assessment questionnaire, and subsequently, they were reassessed by a pain physician and a psychiatrist. The rest of the team involved, comprised a dedicated nursing officer, physiotherapist, and a social worker (with defined roles to play in patient management).

Following were the pain issues mainly encountered among the CPC clinic patients.

- Spinal pains (neck and back pains)
- Headaches and facial pains (mainly migraine, tension headaches, sinusitis)
- Shoulder pains (mainly frozen shoulders)
- Lower limb degenerative arthritis
- Painful neuropathies (mainly diabetic peripheral neuropathy)
- Enthesopathies like Golfer's/Tennis elbows and plantar fasciitis
- Nerve entrapments (mainly carpal tunnel syndrome).

All the pain issues and other comorbidities including noncommunicable diseases and psychological issues were assessed and managed parallelly. Our aim was offering a holistic care than the traditional dualistic (model of pain) care.[7] (Table 1)

Two noninvasive modalities, pharmacotherapy and physical therapy, and two invasive modalities, interventional pain procedures (IPP) and neurosurgeries, were utilized to manage pain issues (Table 2).

From 11/2012 to 12/2014, 2,124 CNMP patients were treated in our CPC clinic. Some patients were offered individualized treatment while some were offered group treatment depending on the circumstances. Most of the patients could be discharged from the clinic within three clinic visits.

Table 1: Traditional (dualistic) model/emerging (holistic) model

• Medical or psychological focus	• + Social and environmental focus
• More clinician-centered	• More patient-centered
• Limited benefits for limited time	• Significant, long-term benefits
• Individual treatment approach	• Individual + group treatment
• Patient as recipient of treatment	• Patient as partner in treatment
• Potential dependency/ complications	• Limited dependency/ complications
• Distracts recipient from active management	• Involves recipient in active self-management
• "Siloed" health system approach	• Integrated health system approach
• Neural plasticity disregarded	• Neural plasticity vital for treatment
• Ongoing/discontinued biomedical treatment	• "Tapered" biomedical treatment
• Individual health perspective only	• Population health perspective
• Little or no attention to lifestyle change	• Significant attention given to lifestyle

Table 2: Four modalities utilized to manage pain issues

Modality	*Percentage of patients*
Noninvasive	
a. Nonpharmacological	80 (e.g., Physiotherapy)
b. Pharmacological	100
Invasive	
c. Interventional pain procedure	20
d. Surgeries	~1

It is apparently clear from the above data that nearly 20% of CPC clinic patients had required interventional pain procedures (IPPs) for pain relief. Therefore, IPP is an integral and indispensable part of chronic nonmalignant pain management. However, it is also important to note that the majority of patients around 80% did not require any IPP. This is an ample proof to highlight the fact that "the need of the day" is not just interventional pain clinics but organized multidisciplinary CPC clinics when it comes to the appropriate management of CNMPs.

Two years after starting the CPC clinic, patient-outcomes were assessed in five main domains, including pain relief, mobility, psychological wellbeing, need for hospital admissions, and time to return to work, to complete the audit cycle. It was clearly evident that there is a significant improvement in outcomes in many domains, in a vast majority of CPC clinic patients (this data is being prepared for publication). Unfortunately, we could not follow-up these patients in community for some practical reasons, that time.

In conclusion, with all above evidence, CPC clinics should be the way forward to care for CNMP sufferers cost-effectively, in low- to middle-income populations like ours (where care givers too have a distinct and defined role to play in the patient management pathway). Hope this editorial will give insight to all pain caring physicians to reorganize their thoughts to fight against the common long-known evil: The PAIN without delay.

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DJMN Rohitha Jayamaha
General Consultant and Pain Physician
Base Hospital, Mawanella, Kandy, Sri Lanka