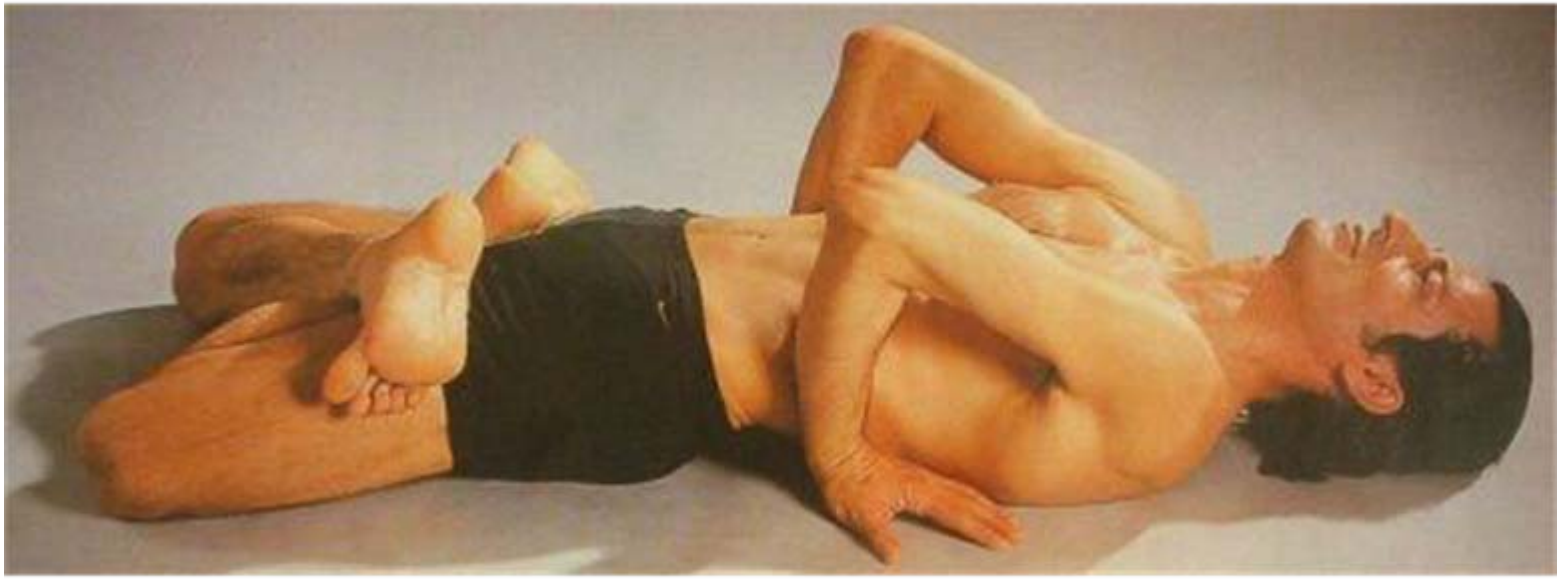
Non-drug therapies as first-line treatment for pain: analgesia and beyond



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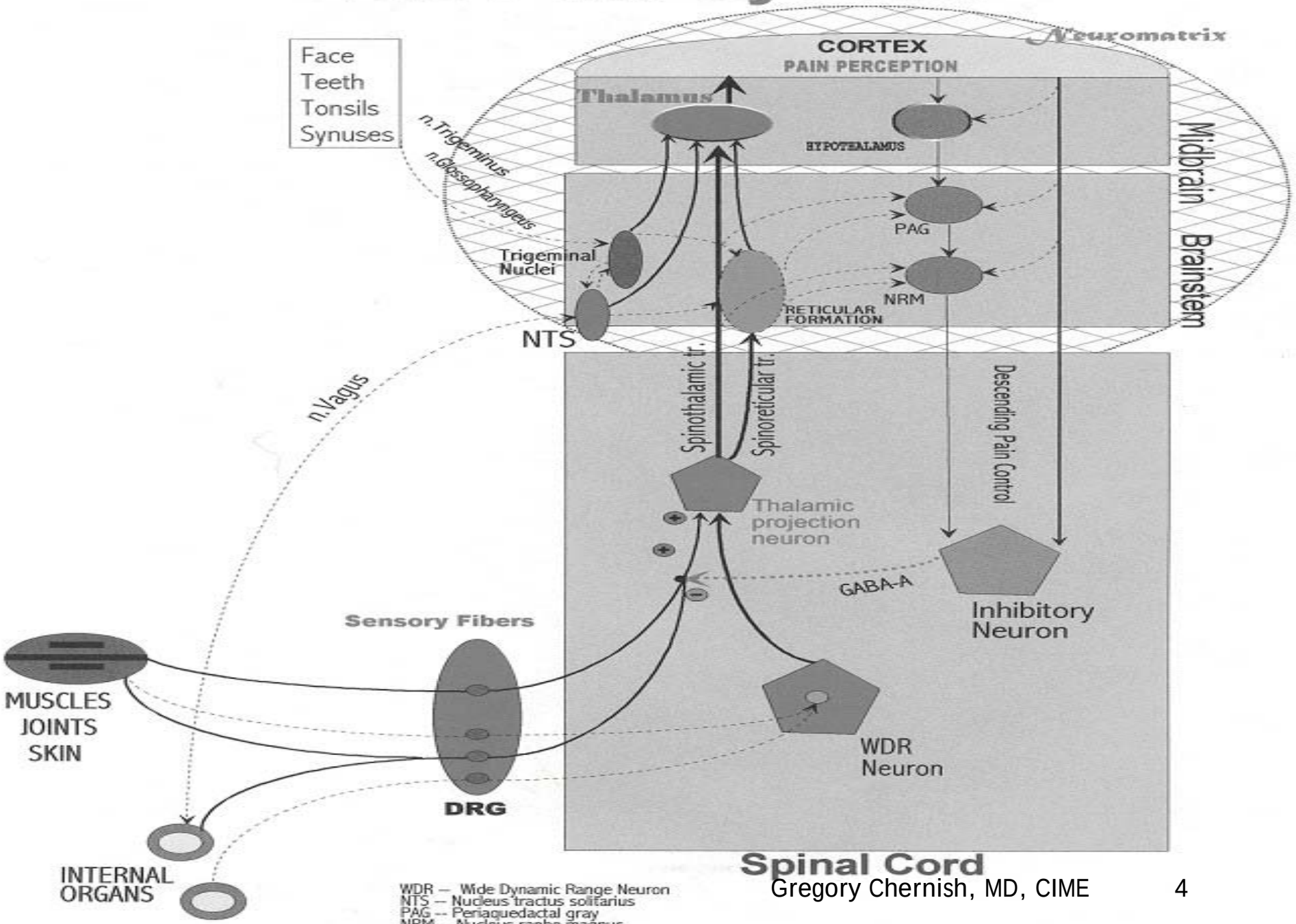
- University of Manitoba Medical School 1984
- Chengdu College of Traditional Chinese Medicine 1990
- Certified Independent Medical Examiner
- Private practice @ Healthpoint Clinic
- University of Manitoba Medical School Integrative Medicine Developer and Course Representative
- University of Manitoba Liason, National Working Group on CAM in UME
- Prairie Representative, Chronic Non-Cancer Pain Program Committee, Section of Family Physicians with Special Interests and Focused Practices, College of Family Physicians of Canada

Objective:

- Envision an evidence-based framework for integrating non-drug treatments for pain in a patient-centered model

The Pain System



2 Complementary Mechanisms of Treatment

- BOTTOM UP: Anti-nociceptive (drugs, anesthetic blocks)

- TOP DOWN: Activation of descending pain inhibitory pathways (non-drug treatments, TCA's, SNRI's)

Bottom up culture:

- Pharmacological treatment is always 1st line and pain intensity dictates pain treatment
- "Non-pharmacological treatments should not substitute for adequate pharmacological treatment."
- Multimodal treatment=multimodal drug treatment

But patients often prefer non-drug options

- Why? Risk aversion and *willingness to accept some discomfort*
- Patients informed about the risks and benefits of drug and non-drug therapies will prefer the latter *if that option is offered*. (Povar et al Am J PublicHealth 1984;74:1395-1397.)

Yet non-drug therapies often only seriously considered when:

- Patient requests or we assume they want: BSE
- Last Resort: Medication/surgery not effective, safe or available
- Unrecognized depression

When to consider non-drug treatments as first line therapy?

Hierarchy of patient-centered goals and values:

- Analgesia
- Maintenance of function; rehabilitation
- Preservation of higher consciousness
- Prevention of suicide, accidental death
- Risk aversion, QOL
- Other specific patient preferences

Resources

- NCCAM: http://nccam.nih.gov/
- SIO: http://www.integrativeonc.org/
- Cochrane collaboration: http://www.cochrane.org/cochrane-reviews
- AAFP : http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=60

Types of pain we will review

- Acute pain
- Chronic cancer pain
- Chronic non-cancer pain
- Pain and comorbid depression *

Thich Quang Duc
June 11, 1963


Omm!
Breathe!

Pain mgmt in labour

- http://summaries.cochrane.org/CD009234/pain-management-for-women-in-labour---an-overview
- **Published Online: March 14, 2012**

- "the findings are not definitive, but we found that immersion in water, relaxation, acupuncture and massage all gave pain relief and better satisfaction with pain relief… *some important outcomes were rarely or never included (for example sense of control, breastfeeding, mother and baby interaction, costs and infant outcomes)".*

- Diagnosis and treatment of low back pain: Joint clinical practice guidelines from the American College of Physicians and American Pain Society. *Annals of Internal Medicine 2007; 147(7) Chow et al.* *http://www.annals.org/content/147/7/478.full*

- Primary goal of treatment of low back pain is *restoration of function*, with modifications if necessary

Recommendation # 7
For pts who do not improve with self-care consider the addition of non-pharmacologic therapy with proven benefits:

- For acute LBP: spinal manipulation

What about Chronic Pain?

- NOT a linear extension of acute pain
- NOT a biomedical problem that will respond to a bottom up approach
- NOT a psychological problem
- A biospsychosocial condition that requires bottom up AND top-down approaches

Chronic Cancer Pain: More than Meds

- Dana Farber Cancer Institute, Memorial Sloan-Kettering Cancer Center, MD Anderson Cancer Center, and the American Cancer Society established the International Society for Integrative Oncology 2003

SIO Guidelines 2009

- *Recommendation 2: All patients with cancer should receive guidance about the advantages and limitations of complementary therapies in an open, evidence-based, and patient centered manner by a qualified professional.*

SIO multimodal treatment recommendations for pain, mood, quality of life

- Mind-body modalities 1B
- Support groups, CBT 1A
- Massage 1C
- Exercise specialist 1B
- Acupuncture (inc. nausea) 1A; xerostomia 1B

Preservation of higher consciousness at end of life

Chronic Non-cancer Pain

CPS/APS LBP Guideline Recommendation # 7
For pts who do not improve with self-care consider the addition of non-pharmacologic therapy with *proven* benefits:

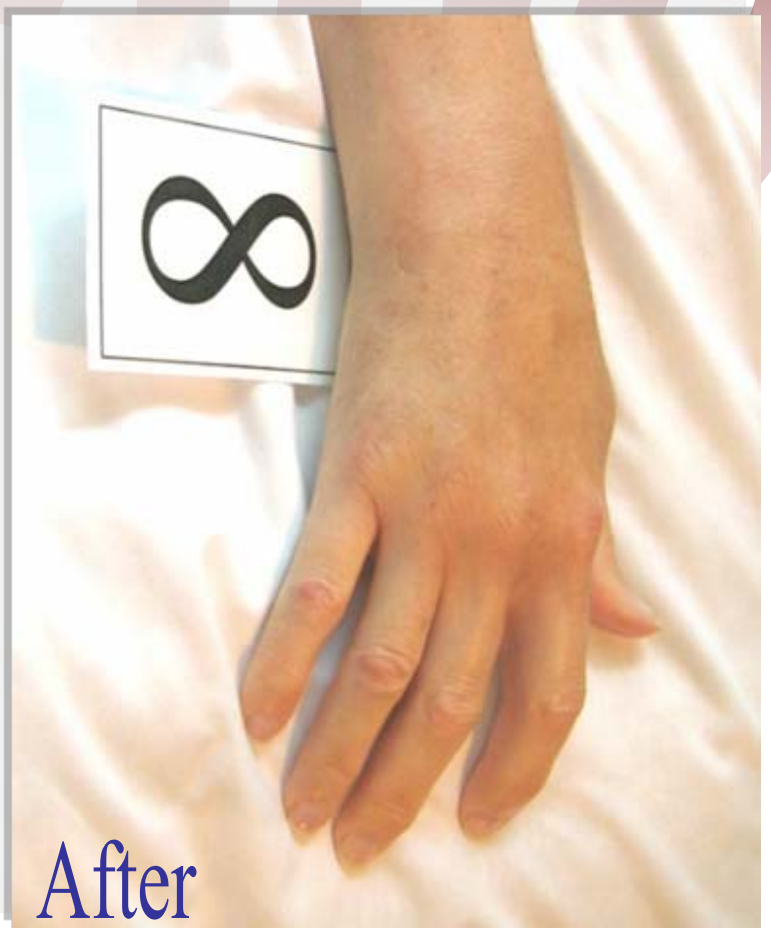
- For subacute or chronic LBP:
  - Interdisciplinary rehab
  - Supervised exercise therapy
  - Acupuncture
  - Massage
  - Spinal manipulation
  - CBT
  - Progressive relaxation

Other pain conditions for which non-drug treatments may be considered 1st line

- Neck pain
- Headaches
- Osteoarthritis of the knee
- Others where conventional treatment not effective, unsafe, not in line with patient's values, difficult to treat:

Acupuncture

RSD



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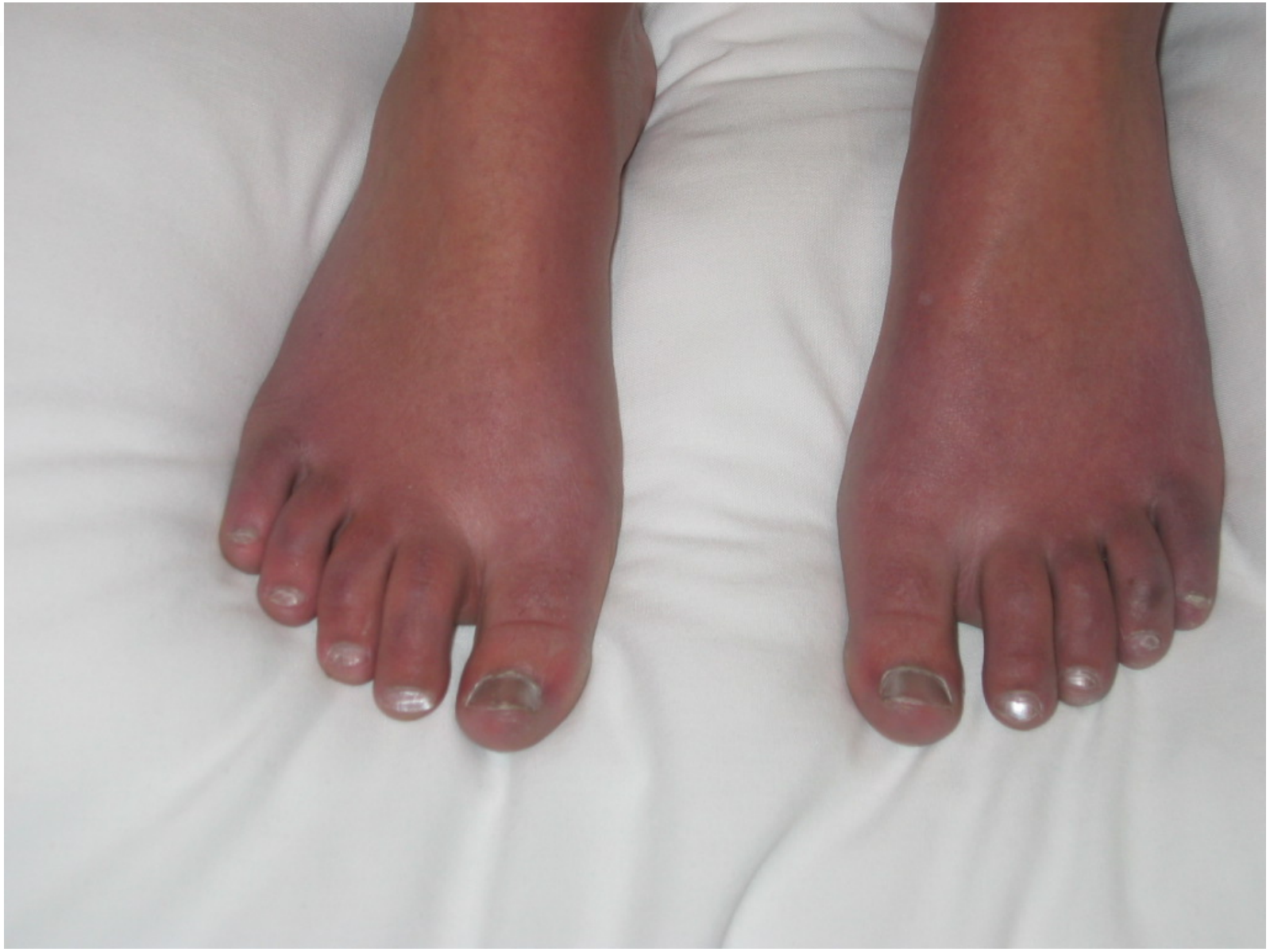
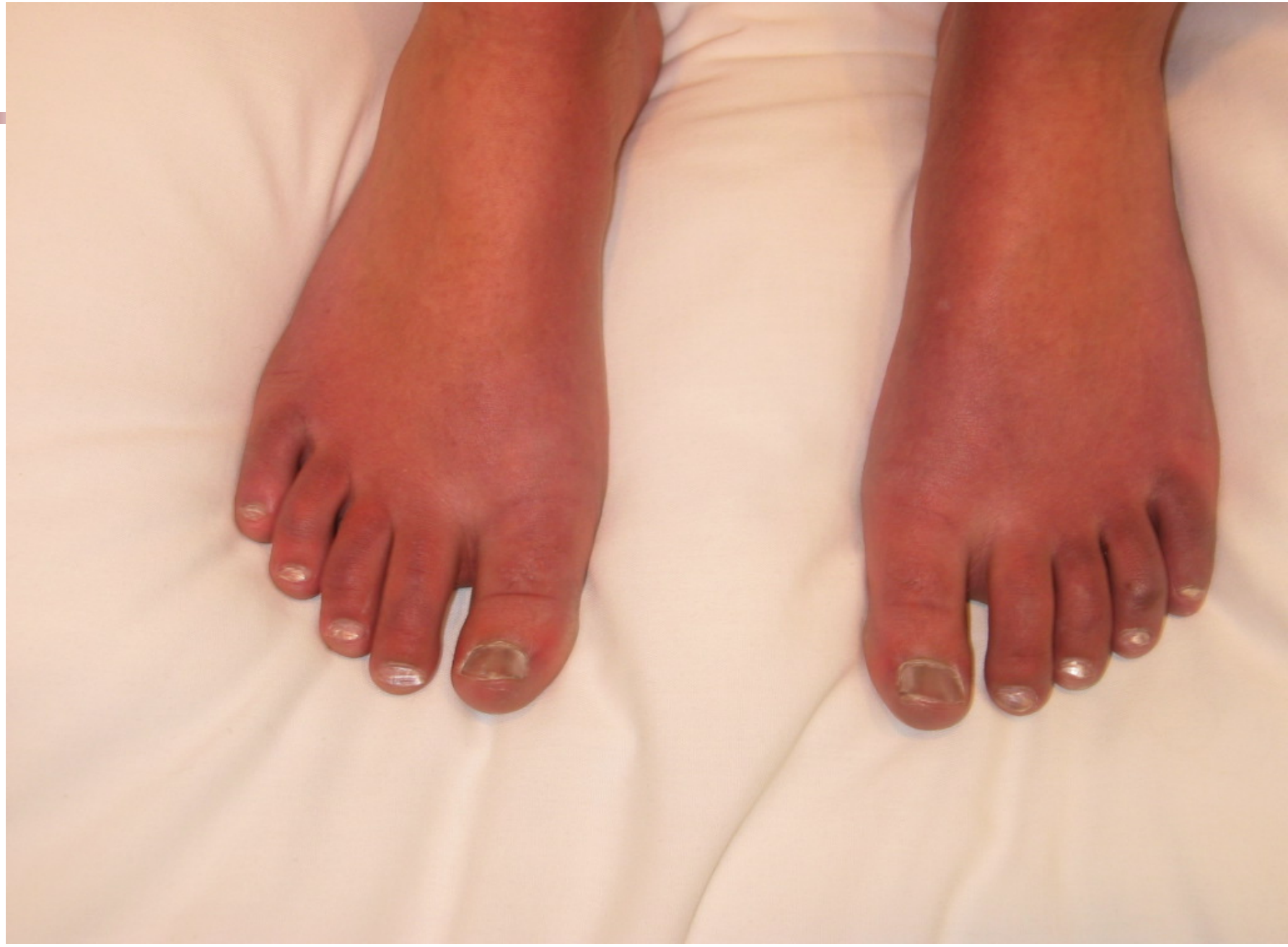
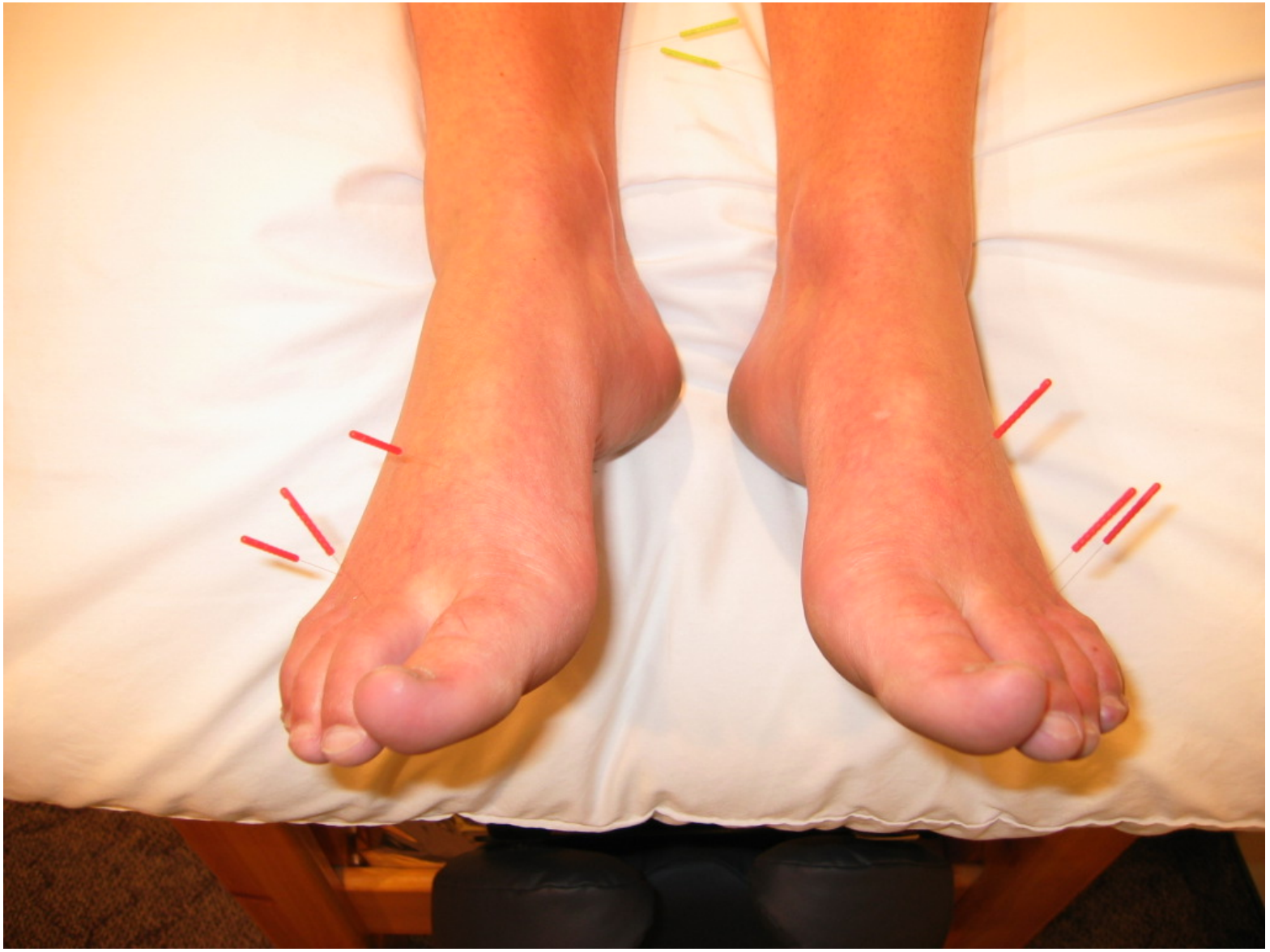




Erythromelalgia



Accidents waiting to happen…

Pain and comorbid depression: a distinct entity

Depression, chronic pain and suicide by overdose

- Risk of successful suicide in CPP 2x controls
- When treating this patient population, the *standard of care should* include the routine screening of depression and risk assessment of suicide potential with validated tools. -Cheatle, Pain Med 2011; 12: S43-8

Validated screening tools; more than a feeling

- BDI, POMS recommended by Initiative on Methods, Measurements and Pain Assessment in Clinical Trials (IMMPACT) consensus group on measuring emotional states in chronic pain clinical trials
- REMEMBER: Pain affects provider recognition of depression

Fishbain et al Clinical Journal of Pain 1999

- Risk of suicide in middle-aged white men with chronic pain on worker's comp 3x that of general population

Kroenke et al SCAMP trial JAMA 2009; 301(20):2099-2110

- Optimized antidepressant therapy followed by a pain self-management program resulted in substantial improvement in depression as well as moderate reductions in pain severity and disability on top of that achieved with usual medical care.

Safety: non-drug treatments as first line

- Increased use of OPR has contributed to overall increases in rates of overdose death in US (14,800 due to OPR in 2008) -CDC Morbidity and Mortality Weekly 14/11/11
- 16000 deaths/yr attributed to NSAID's in US

Summary; Non drug, TOP DOWN treatments are:

- Proven and accepted as first line therapy for acute and chronic pain
- Recommended as multimodal options for all patients with cancer pain
- Effective when combined with NE active antidepressants in treatment of pain and comorbid depression
- Safe

Barriers to treatment

- Awareness
- Assumptions
- Availability
- Affordability
- Adjudication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