Chronic Pain & Functional Illness

Bolton GPST2 Teaching

Dr Seb Pillon

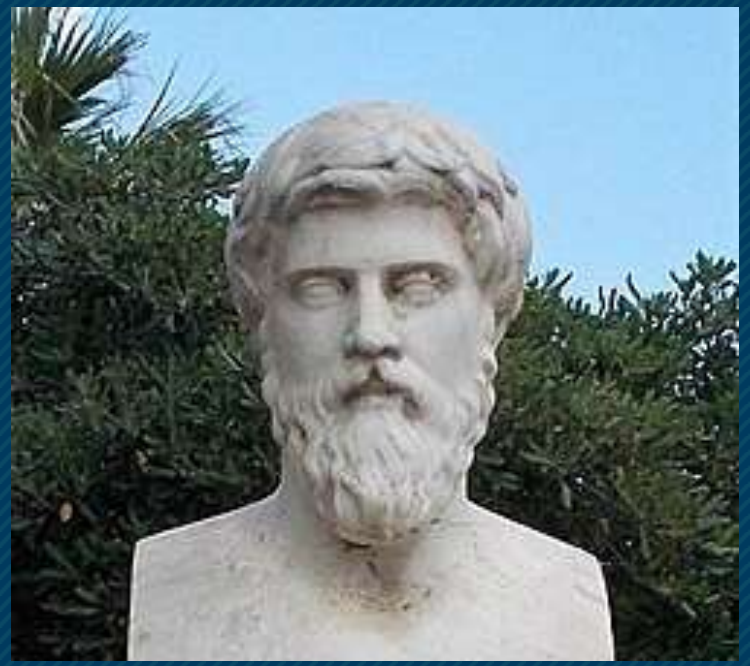
Baggage Check

- **Most GPs feel unprepared to manage medically unexplained symptoms and chronic pain**
- https://academic.oup.com/fampra/article/18/5/519/664885
- **Medically unexplained symptoms—GPs' attitudes towards their cause and management**
  - Steven Reid, David Whooley, Tim Crayford, Matthew Hotopf
  - *Family Practice*, Volume 18, Issue 5, October 2001, Pages 519–523
- **Conclusion.** GPs consider the management of patients with MUS to be an important part of their workload, but there is a perception that effective management strategies are lacking.

What do you want to know?

- What would you like to leave this session with?

Plutarch



- Erasistratus notices that Antiochus, whilst apparently sick in bed, develops symptoms when Stratonice appears:

- *“stammering speech, fiery flashes, darkening visions, sudden sweats, palpitations of the heart and finally helplessness, stupor and pallor”*

- What’s the diagnosis?

Psychosomatic Symptoms are Normal

- Tears
- Blushing
- Headache when busy
- Butterflies in Stomach
- Twitching/restless legs

- How does this differ from patients who present with “medically unexplained symptoms”?

Common Functional Problems

- Irritable bowel syndrome
- Fibromyalgia
- Chronic fatigue syndrome
- Chronic pelvic pain
- Cyclic vomiting syndrome
- Interstitial cystitis
- Temporomandibular joint pain
- Functional neurological symptoms

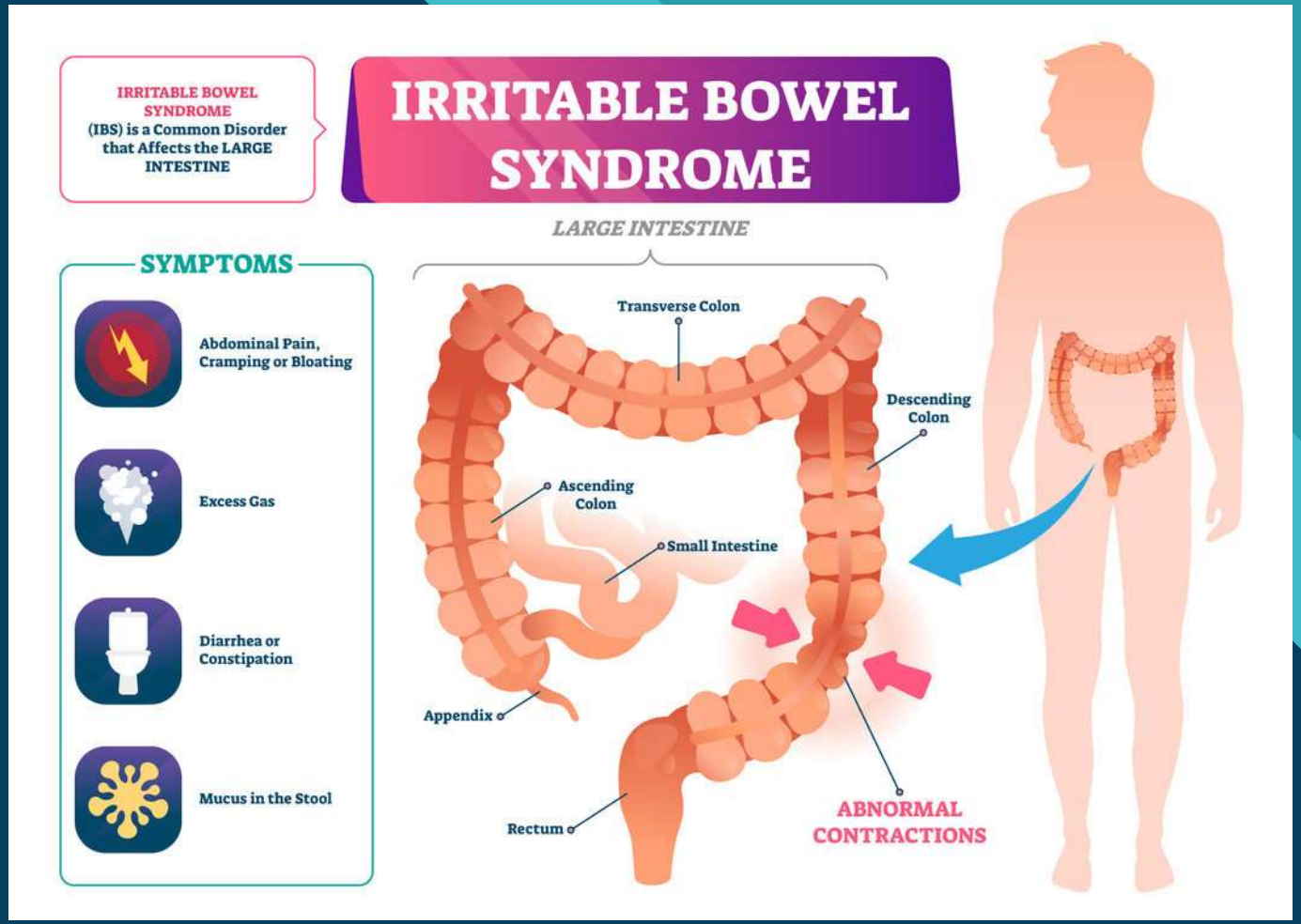
Irritable Bowel Syndrome

IBS

- How do we “diagnose” IBS?

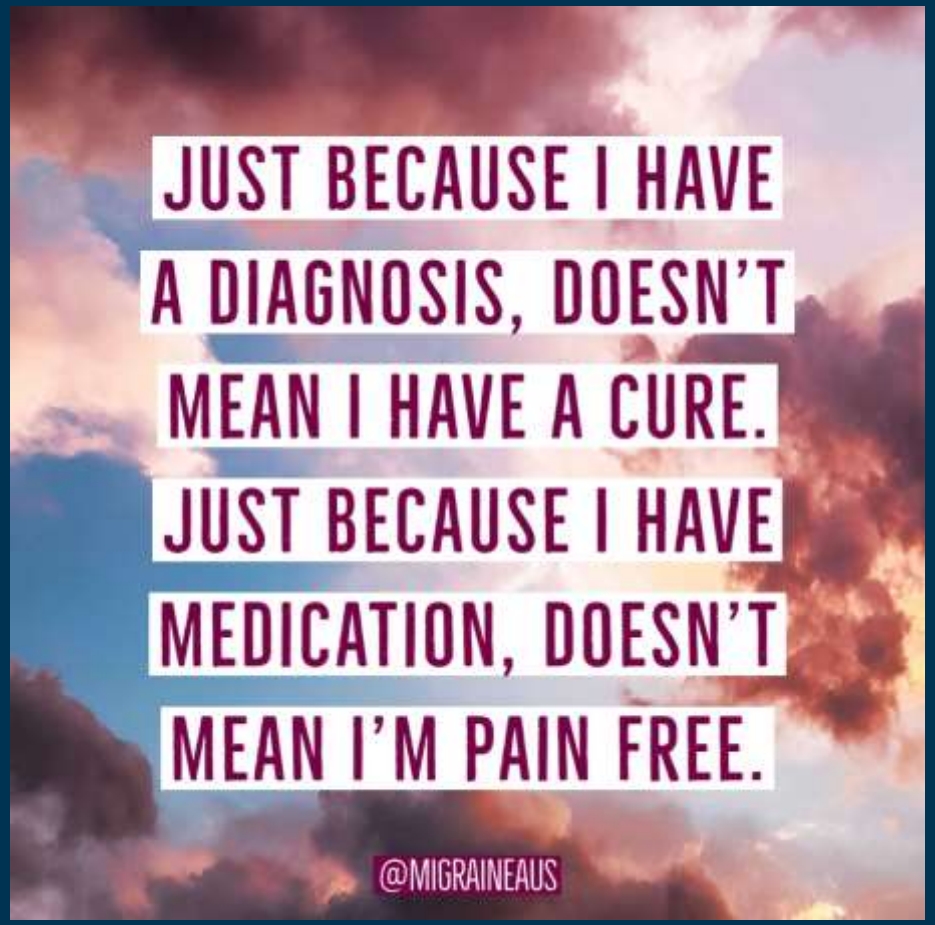
- FBC, CRP, TTG, U&E, LFT
- Faecal calprotectin, FIT test
- Diet restriction
- Ultrasound
- Colonoscopy
- CT imaging
- MRI imaging

What do these tests actually do?



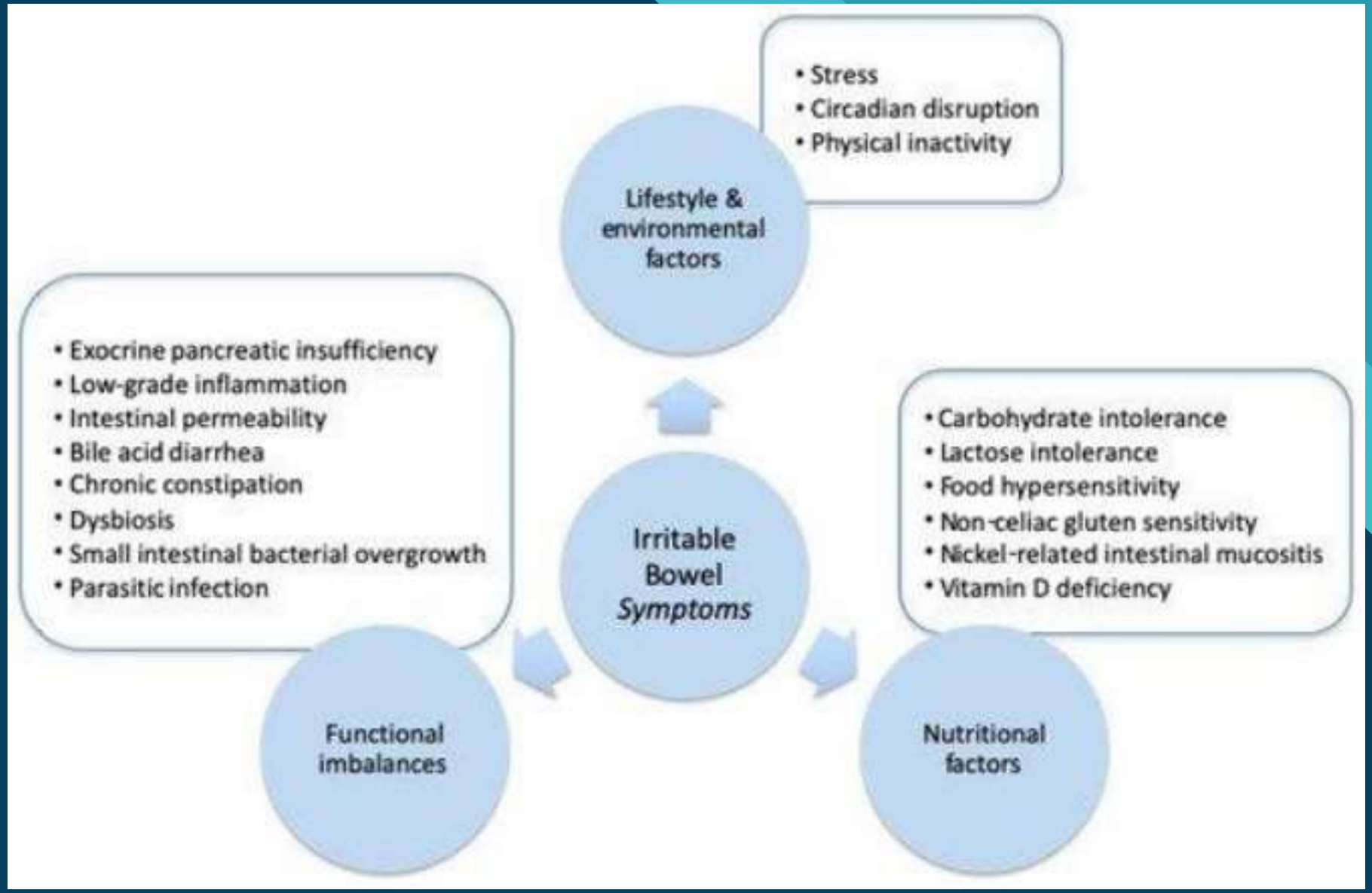
What Colour is Seb thinking about?

- You have 10 questions to guess
- I'll only answer "Yes" or "No"


JUST BECAUSE I HAVE
A DIAGNOSIS, DOESN'T
MEAN I HAVE A CURE.
JUST BECAUSE I HAVE
MEDICATION, DOESN'T
MEAN I'M PAIN FREE.
@MIGRAINEAUS

IBS is not one condition

- Syndrome is probably an amalgam of a range of problems
- https://bit.ly/2Gn0QGg
- Does Irritable Bowel Syndrome Exist? Identifiable and Treatable Causes of Associated Symptoms Suggest It May Not



Chronic Disease Model

History & Examination

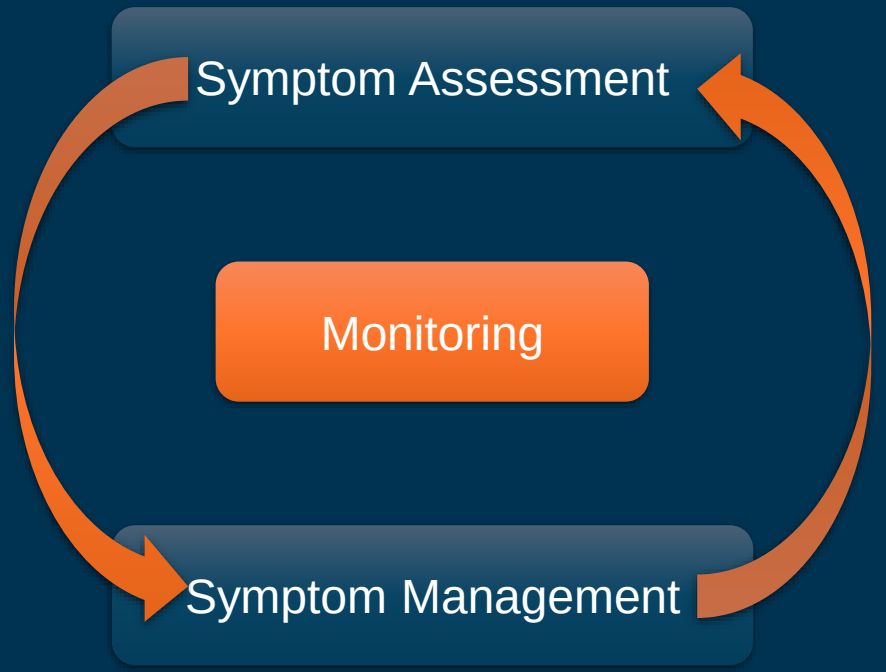
Differential Diagnosis

Investigation

Diagnosis

~~Treatment~~

~~Cure~~



How do we treat IBS?

- FODMAP Diet
- Lactose-Free diet
- Antispasmodics (Buscopan/Mebeverine/Peppermint)
- Fibre (dietary/Fybogel/Psyllium Husk)
- SSRI
- TCA
- Laxatives
- CBT*
- Loperamide
- Linaclotide*

“Medicine” isn’t just about medicines

- How does this affect the patient?
- What do they want?
  - Be careful of a superficial “ICE”
- What are the available options?
- How will you and the patient determine if a treatment works?
  - Is this different?

Sarah 32 with Functional Gut Disorder

- Abdominal pain, cramping, can cause constipation and diarrhoea
- Normal bloods
- Normal USS, endoscopy and MRI bowel
- Struggled to eat, now has PEJ feeds for nutrition
- PEJ – needs frequent re-siting. Frequent site infections and blockages.
- Chronic pain – uses about 50ml oxycodone/day
- Will she need to go on TPN?

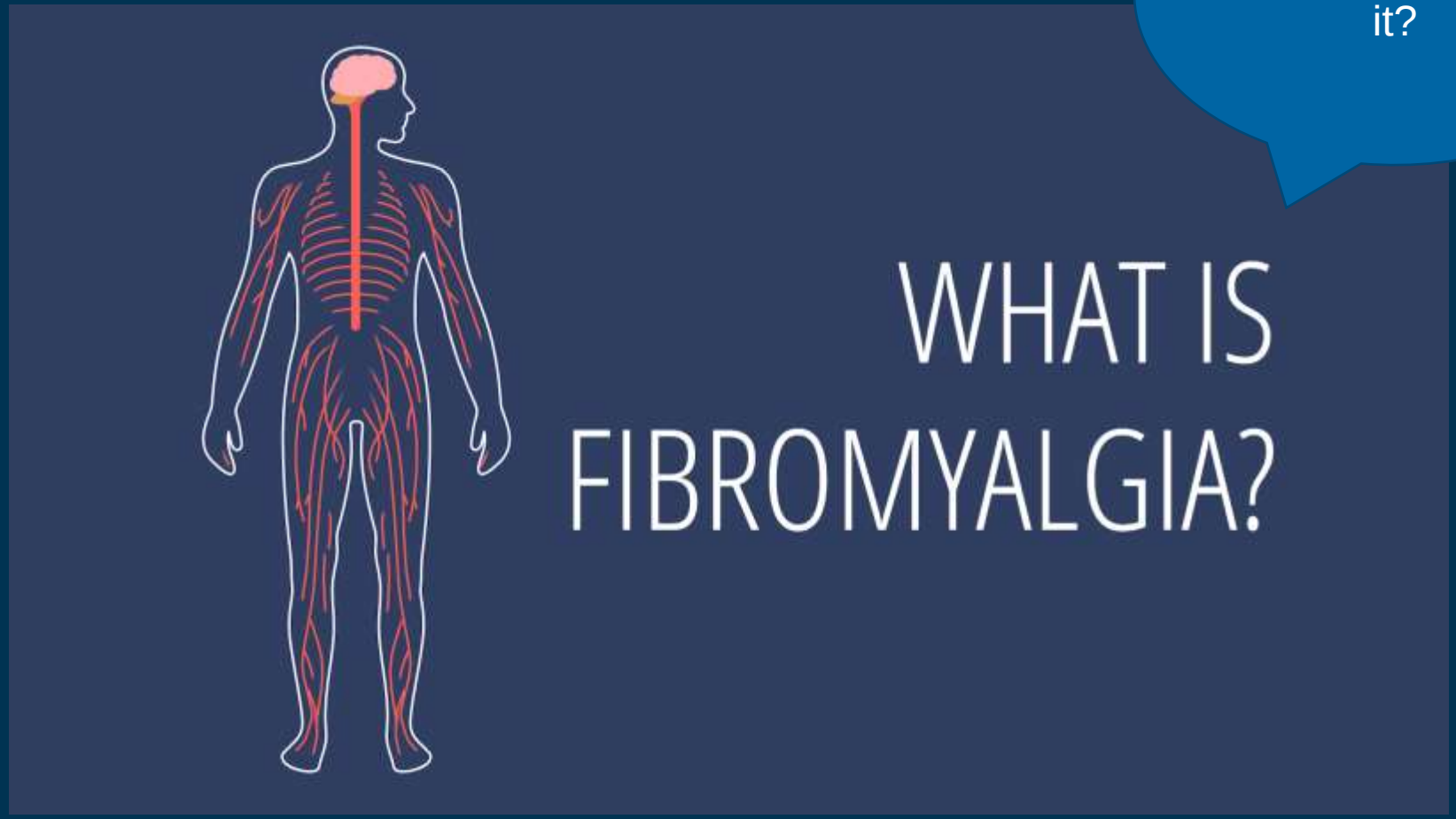
- Not in work, struggles to manage feeding and meds as well as frequent sick time
- No partner since diagnosis, doesn't feel could commit to someone as ill too often and feels would let them down
- Aunt to several children, loves looking after them

NEAD

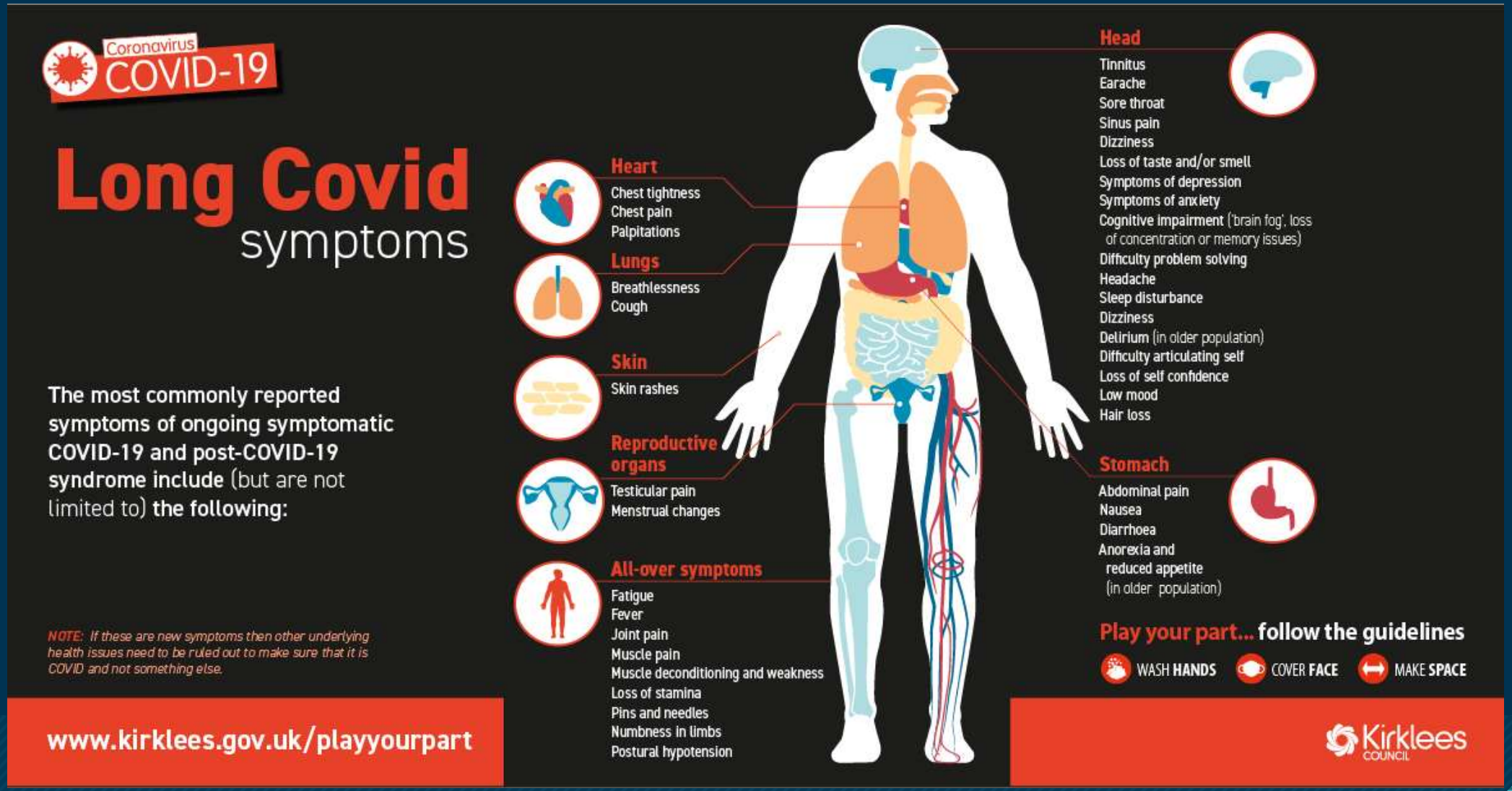
- Kelly, 33 presents with “another seizure” to ED Resus from NWAS
- What happens next?
- Kelly has a history of being victim of domestic violence. Her NEAD started soon after. She hasn’t had an episode for 4 years since she left him.
- Her ex (who abused her) has recently moved back to the same town.

What's in a name?

No, really, what is it?



Does Long Covid signify diagnostic and therapeutic hope?



FAQs

- **Medically unexplained symptoms are really frustrating because:**
  - The tests for your symptoms are all normal - but you still have your symptoms.
  - An important part of getting better is understanding what the problem is – and neither you nor your doctor know.
  - It can feel as though other people think that your problems are imaginary, or that you are making them up.
- **What causes medical unexplained symptoms?**
  - Medically unexplained symptoms aren't “all in the mind”, but neither are they all in the body.
  - To understand them we have to think about how the mind and the body work together.
- **What tests should I have for my symptoms?**
  - It is often unhelpful to have investigations that are unlikely to show anything because
    - Tests may be painful and carry a risk of harm.
    - Unnecessary investigations that don’t show anything are often not reassuring. They can make someone worry even more that there is something still to be found and that more tests are needed.

It’s All In Your Head

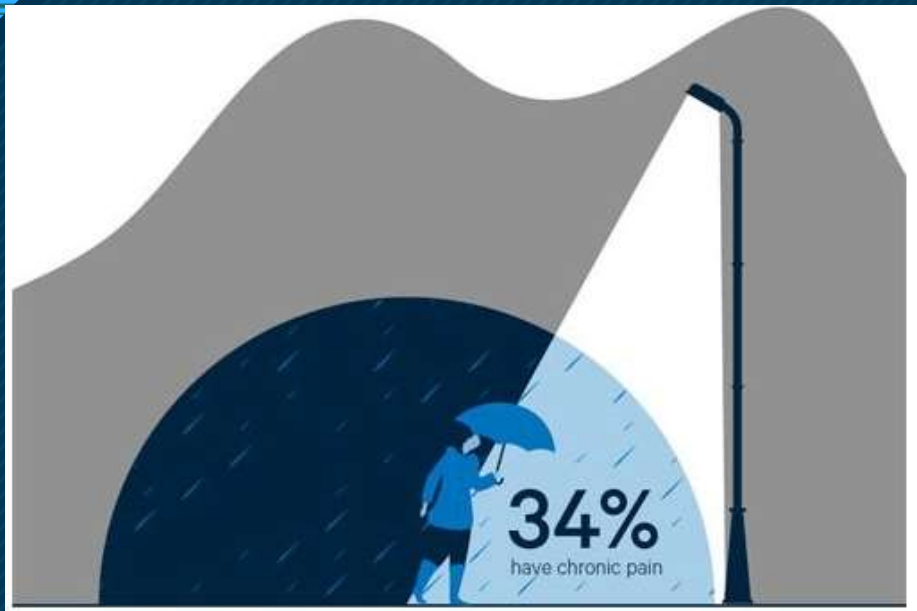
"Everybody’s experience of illness is their own, and that is where illness become distinct from disease. I recall a non-medical friend of mine wondering why it was not possible to define all the characteristics of single disease…. Tap your symptoms into a computer screen and then a diagnosis pops up on a screen. That friend had failed to understand the human condition.”

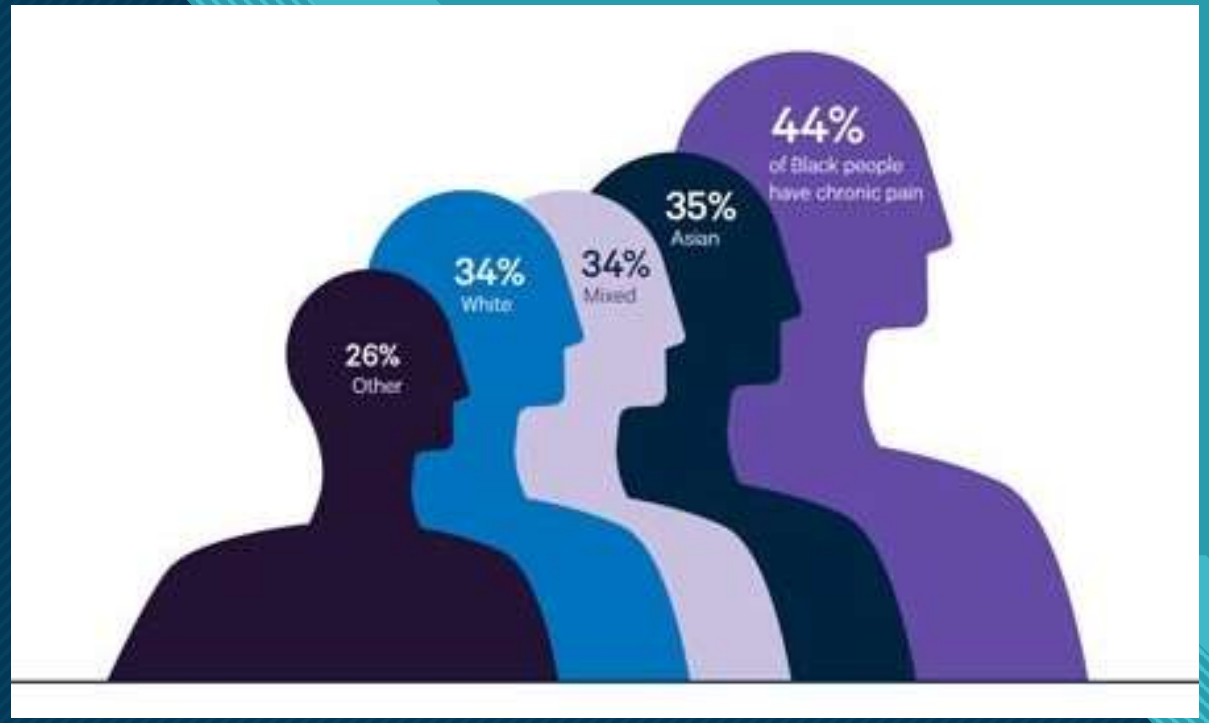
However…

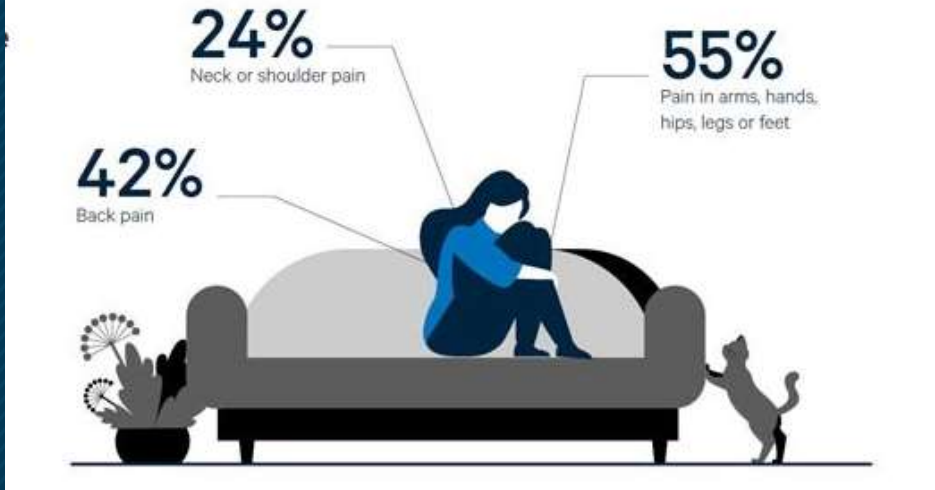
- We see large numbers of patients with non-specific symptoms and *some* of them have cancer
- Two thirds of patients with multiple myeloma present with back pain, and nearly half of patients with pancreatic cancer with abdominal pain.
- Calibrate index of suspicion
- Consider minimum routine data gathering for patients presenting with abdominal or msk pain

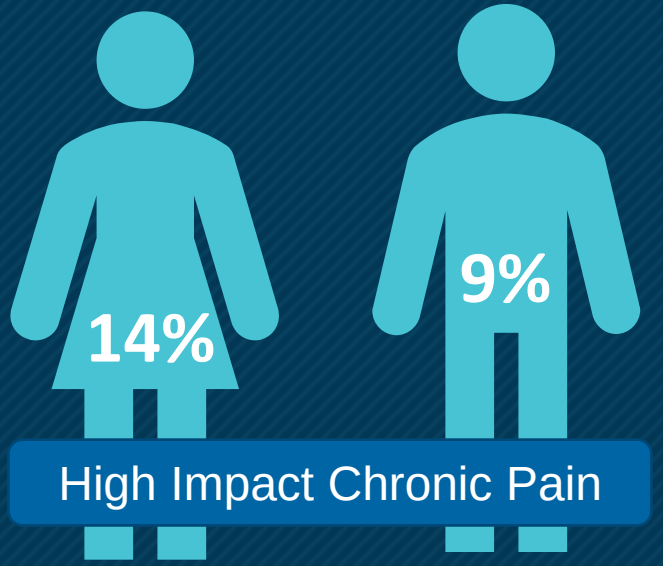
Chronic Pain

What is it?

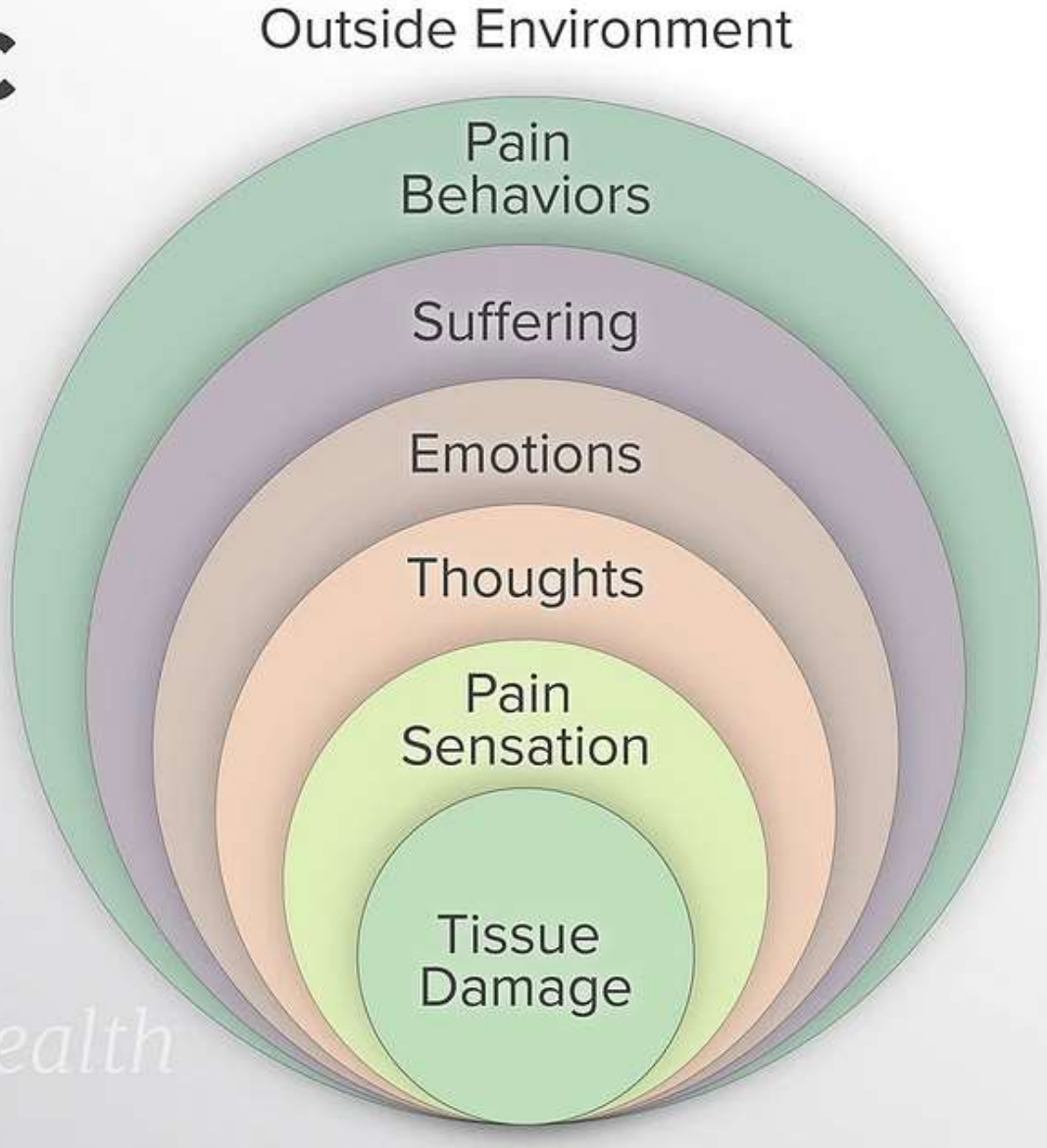

34%
have chronic pain
22%
Low-impact
chronic pain
12%
High-impact
chronic pain


44%
of Black people
have chronic pain
35%
Asian
34%
Mixed
34%
White
26%
Other


24%
Neck or shoulder pain
55%
Pain in arms, hands,
hips, legs or feet
42%
Back pain


14%
9%
High Impact Chronic Pain

Chronic Pain Model



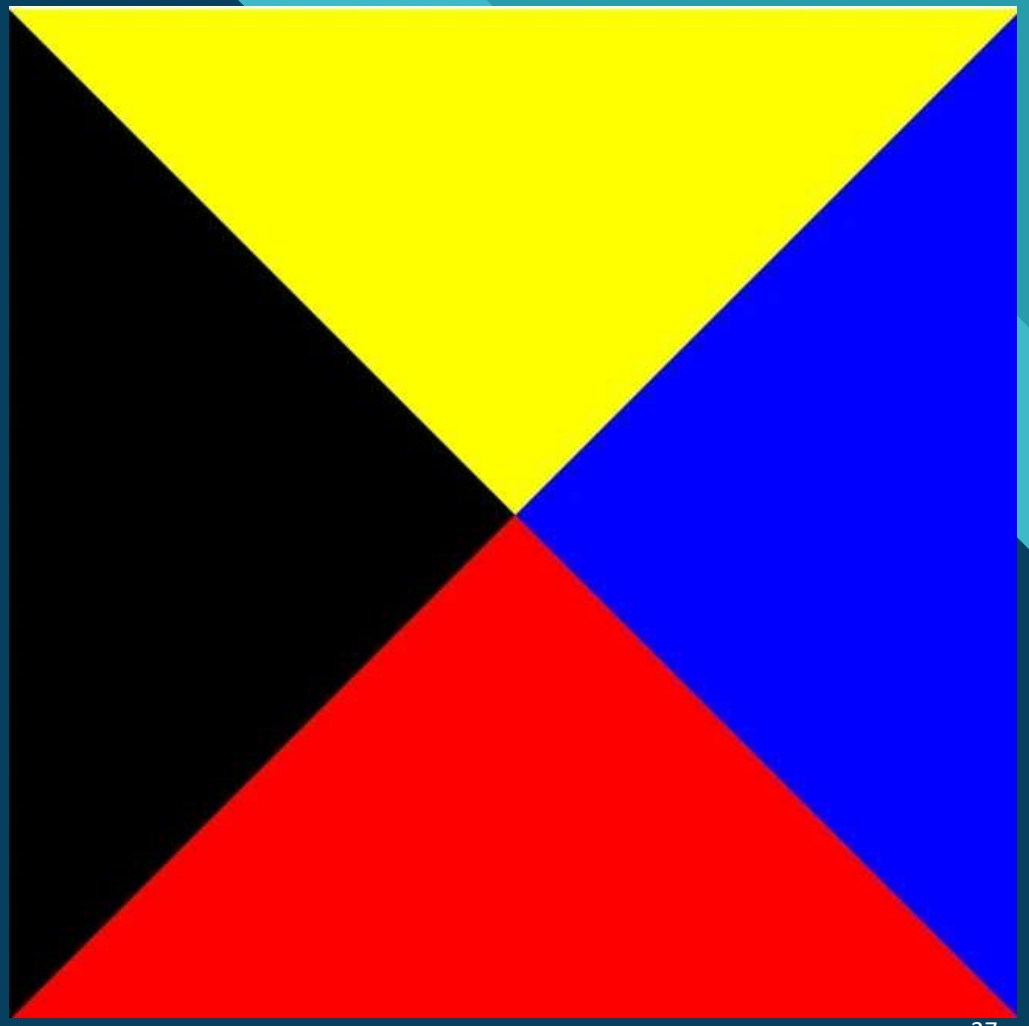
VERITAS health


Fatigue
Disease pain
Depression
The Pain Cycle
Tense muscles
Fear, anger frustration
Stress

How do we assess pain?

Flag system

- **Red Flags**
  - Signs of serious pathology
- **Yellow Flags**
  - Beliefs/appraisals/judgements
  - Emotional Responses
  - Pain behaviour
- **Blue Flags**
  - Perceptions about the relationship between work and health
- **Black Flags**
  - System or contextual obstacles



How to manage chronic pain

“Medicine” isn’t just about medicines

An “A* Approach”

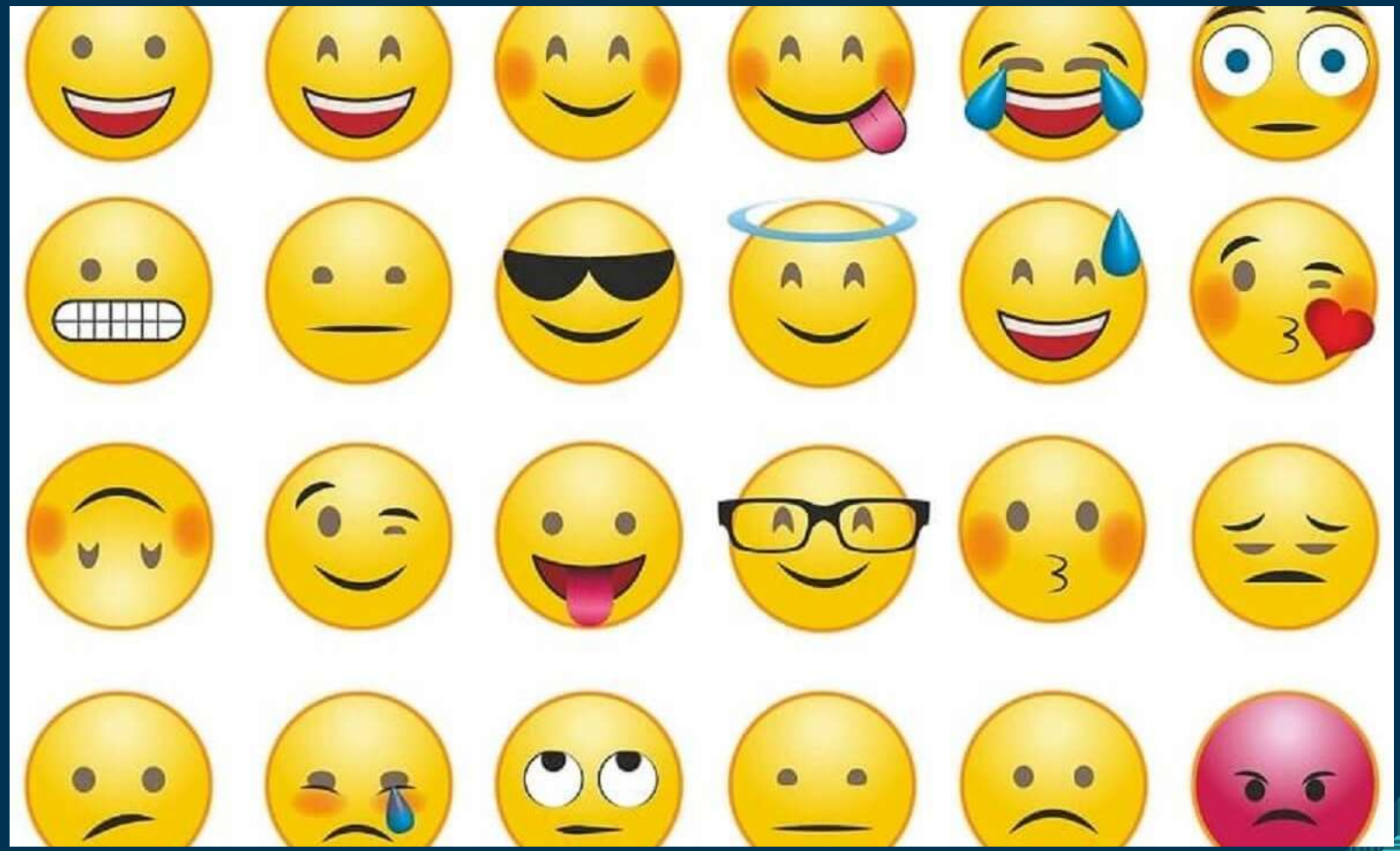
- Assess the pain
- Assume nothing
- Acknowledge the symptoms
  - Vocally make clear that you believe what the patient is telling you
- Appreciate the person in front of you
  - What does the pain stop them doing?
- Account for why they have their symptoms
  - Use your knowledge to provide an explanation
- Accept that reduction of the pain’s effect on life is the goal
- *(symptoms can go up and down)

Red Flags

- Review the notes and patient
- Ensure you both understand the story and what has been ruled out
- Ensure you have ruled out what the patient is worried about.
  - Challenge false assertions, with further investigations if that's appropriate

Yellow Flags

- Understand the patient's pain behaviour
- Help them understand the role of emotion in pain
- Use their response to formulate plan to challenge maladaptive strategies or falsehoods, i.e.
  - movement will make the pain worse
  - cracking joints are the sound of bones grinding together
  - daily headaches are a sign of a missed brain tumour – same as my dad



Blue Flags

- What are the patient's barriers to work?
- What are the benefits to work?
- Help employer understand condition
  - MED3
  - Empower patient to explain

Black Flags

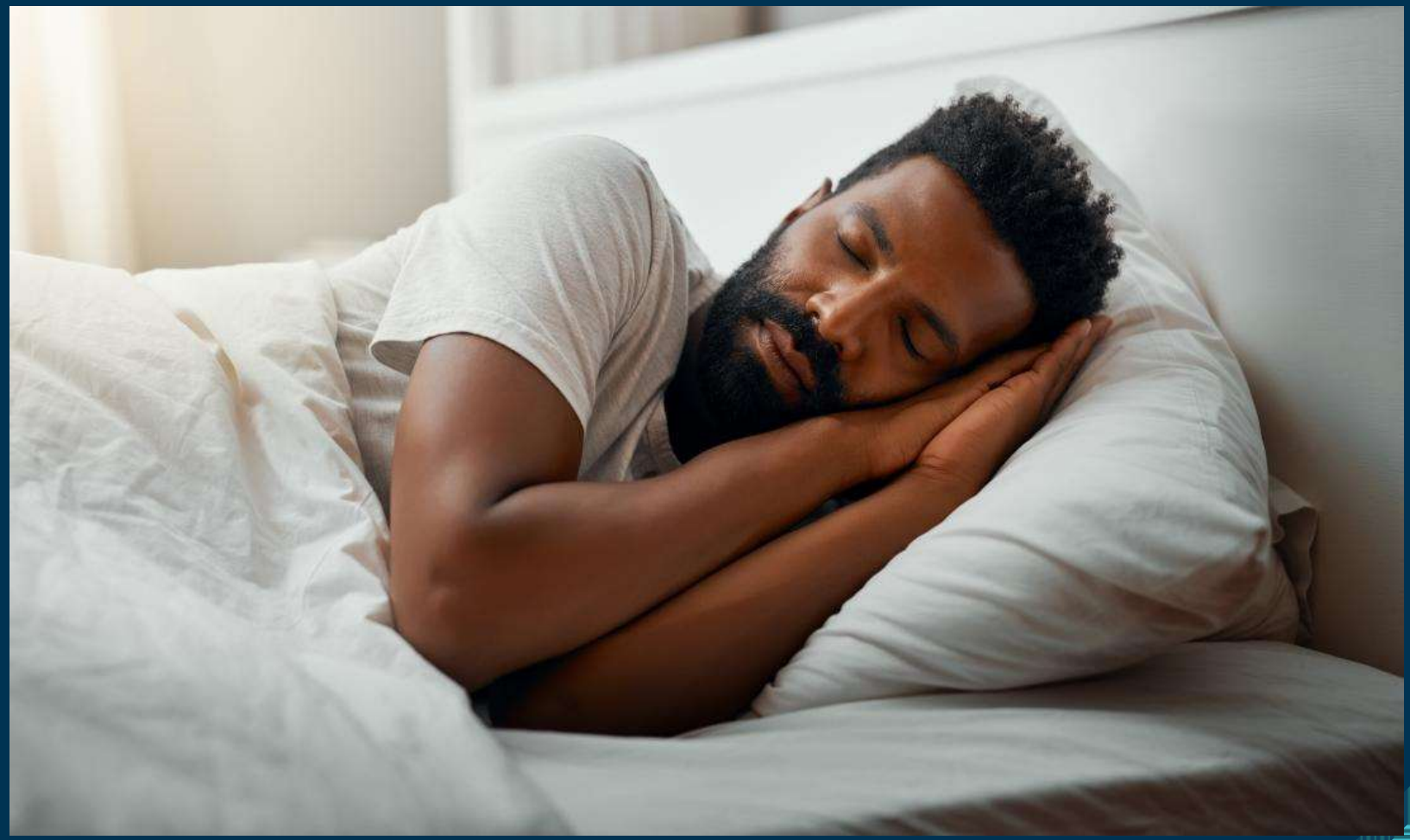
- **Consider:**
- System or contextual obstacles
- Legislation restricting options for return to work.
- Conflict with insurance staff over injury claim.
- Overly solicitous family and health care providers.
- Heavy work, with little opportunity to modify duties.

Sleep

- Poor sleep often precedes onset of chronic pain…
- …and then serves to maintain the cycle

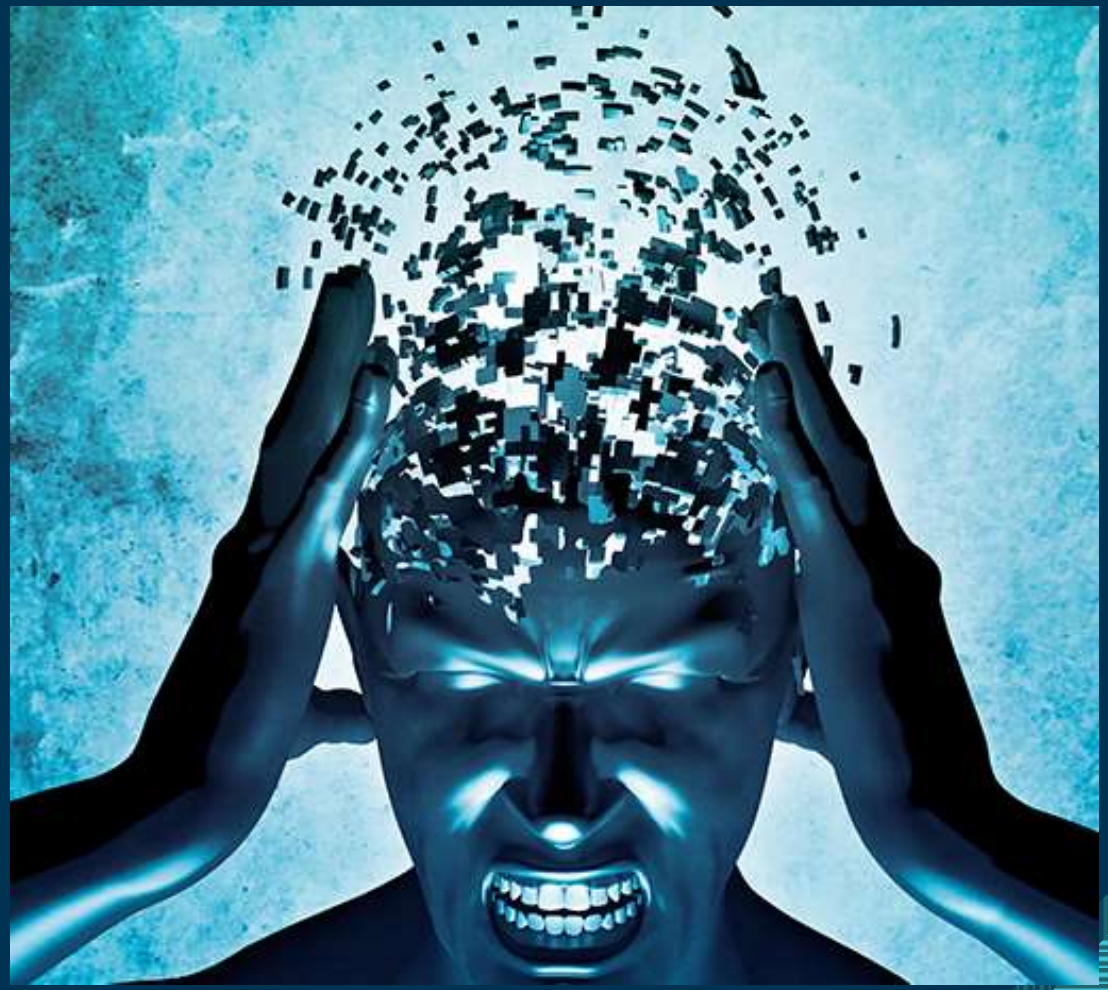
- Caffeine is important
- 0.25-0.5 of a cup of coffee is still in bloodstream 12 hours later
- “Energy” drinks

- Ask how people relax
  - Allows personalisation of help



Chronic Pain Medication

- Draft NICE guidance for primary chronic pain recommends:
  - supervised group exercise programmes,
  - some types of psychological therapy,
  - or acupuncture.
- Some antidepressants may help
- Paracetamol, NSAIDS, benzodiazepines, gabapentoids and opioids not recommended
- Collaborative, supportive relationship



Example drugs

Name	Dose range	Pain type	Side effects/Cautions
Paracetamol	500-2000mg/day	All	Toxic overdose
Codeine	30-240mg/day	All	Sedation, constipation, nausea, addiction
Ibuprofen/Naproxen	400mg QDS/250mg QDS	Inflammatory	GI side effects
COX-2	Celecoxib 100-400mg/day	Inflammatory, esp spinal	Cardiac risk
Oramorph	As tolerated	All	Tolerance, addiction, sedation, constipation, alcohol
Oxycodone	As tolerated	All	Tolerance, addiction, sedation,
GABApentinoids	Gabapentin 100-1200mg TDS	Neuropathic	Sedation, tolerance, addiction, neurological
TCAs	Amitriptyline 10-75mg	Neuropathic	Sedation, anticholinergic
Capsaicin	TDS	Neuropathic	Skin reaction

If more information is required please seek help from specialist palliative care

Opioid dose conversion chart, syringe driver doses, rescue / prn doses and opioid patches

Use the conversion chart to work out the equivalent doses of different opioid drugs by different routes.
The formula to work out the dose is under each drug name. Examples are given as a guide

Oral opioid mg /24 hour (Divide 24 hour dose by six for 4 hourly prn oral dose)		Subcutaneous infusion of opioid Syringe driver (SD) dose in mg per 24 hours (or micrograms for alfentanil where stated)				Subcutaneous prn opioid Dose in mg every 4 hours injected as required prn NB Alfentanil in lower doses in micrograms				Opioid by patch Dose microgram/hour	
Morphine 24 hour	**Oxycodone 24 hour**	**Diamorphine sc 24 hour**	**Morphine sc 24 hour**	**Oxycodone sc 24 hour**	**Alfentanil sc 24 hour** (500microgram/mL)	**Diamorphine 4 hour**	**Morphine 4 hour**	**Oxycodone 4 hour**	**Alfentanil 2 to 4 hour** (500microgram/mL)	**Fentanyl** normally change every 72 hours	**Buprenorphine** B=Butrans change 7 days T = Transtec change 96 hrs (4 days)
	Calculated by dividing 24 hour oral morphine dose by 2	Calculated by dividing oral morphine dose by 3	Calculated by dividing oral morphine dose by 2	Calculated by dividing oral oxycodone dose by 2	Calculated by dividing 24 hour oral morphine dose by 30	Prn dose is one sixth (1/6th) of 24 hour subcutaneous (sc) syringe driver dose plus opioid patches if in situ. *NB **Alfentanil injection is short acting**. Maximum 6 prn doses in 24 hours. If require more seek help*				Conversions use UK SPC	
20	10	5	10	5	500mcg	1	2	1	100mcg	(6)	B 10
45	20	15	20	10	1500mcg	2	3	2	250mcg	12	B 20
90	45	30	45	20	3mg	5	7	3	500mcg	25	T 35
140	70	45	70	35	4500mcg	8	10	5	750mcg	37	T 52.5
180	90	60	90	45	6mg	10	15	8	1mg	50	T 70
230	115	75	115	60	7500mcg	12	20	10	1.25mg	62	T 70 + 35
270	140	90	140	70	9mg	15	25	10	1.5mg	75	T70 + 52.5
360	180	120	180	90	12mg	20	30	15	2mg	100	T 140
450	225	150	225	110	15mg	25	35	20	2.5mg	125	-
540	270	180	270	135	18mg	30	45	20	3mg	150	-
630	315	210	315	160	21mg	35	50	25	3.5mg	175	-
720	360	240	360	180	24mg	40	60	30	4mg	200	-

Equivalent doses if converting from oral to sc opioid

Calculation of breakthrough/ rescue / prn doses

Oral prn doses:

- Morphine or Oxycodone: 1/6th of 24 hour oral dose

Subcutaneous:

- Morphine & Oxycodone: 1/6th of 24 hour sc syringe driver (SD) dose
- Alfentanil: 1/6th of 24 hour sc SD dose
  - Short action of up to 2 hours
  - Seek help If reach maximum of 6 prn doses in 24 hours

(For ease of administration, opioid doses over 10mg, prescribe to nearest 5mg)

Renal failure/impairment GFR<30mL/min: Morphine/Diamorphine metabolites accumulate and should be avoided.

- **Fentanyl patch** if pain is stable.
- **Oxycodone** orally or by infusion if mild renal impairment
- If patient is dying & on a fentanyl or buprenorphine patch top up with appropriate sc **oxycodone** or **alfentanil** dose & if necessary, add into syringe driver as per renal guidance
- **If GFR<15mL/min and unable to tolerate oxycodone** use **alfentanil** sc

If unsure please seek help from palliative care

Fentanyl and buprenorphine patches in the dying/moribund patient

- **Continue fentanyl and buprenorphine patches in these patients.**
  - Remember to change the patch(es) as occasionally this is forgotten!
  - Fentanyl patches are more potent than you may think

If pain occurs whilst patch in situ

- Prescribe 4 hourly prn doses of subcutaneous (sc) morphine unless contraindicated.
- Use an alternative sc opioid e.g. **alfentanil** or **oxycodone** in patients with
  - poor renal function,
  - morphine intolerance
  - where morphine is contraindicated
- **Consult pink table when prescribing 4 hourly prn subcutaneous opioids**

Adding a syringe driver (SD) to a fentanyl or buprenorphine patch

If 2 or more rescue/ prn doses are needed in 24 hours, start a syringe driver with appropriate opioid and continue patch(es). The opioid dose in the SD should equal the total prn doses given in the previous 24 hours up to a maximum of 50% of the existing regular opioid dose. Providing the pain is opioid sensitive continue to give prn sc opioid dose and review SD dose daily.

*E.g. Patient on 50 micrograms/hour fentanyl patch, unable to take prn oral opioid and in last days of life. Keep patch on. **Use appropriate opioid for situation or care setting.** If 2 extra doses of 15 mg sc morphine are required over the previous 24 hours, the initial syringe driver prescription will be morphine 30mg/24 hour. **Remember** to look at the **dose of the patch and the dose in the syringe driver** to work out the **new** opioid breakthrough dose **each time a change is made**.*

Always use the chart above to help calculate the correct doses.

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

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ABOUT | PEOPLE WITH PAIN | EVENTS | BECOME A MEMBER | FOR MEMBERS | COUNCIL

PEOPLE LIVING WITH PAIN

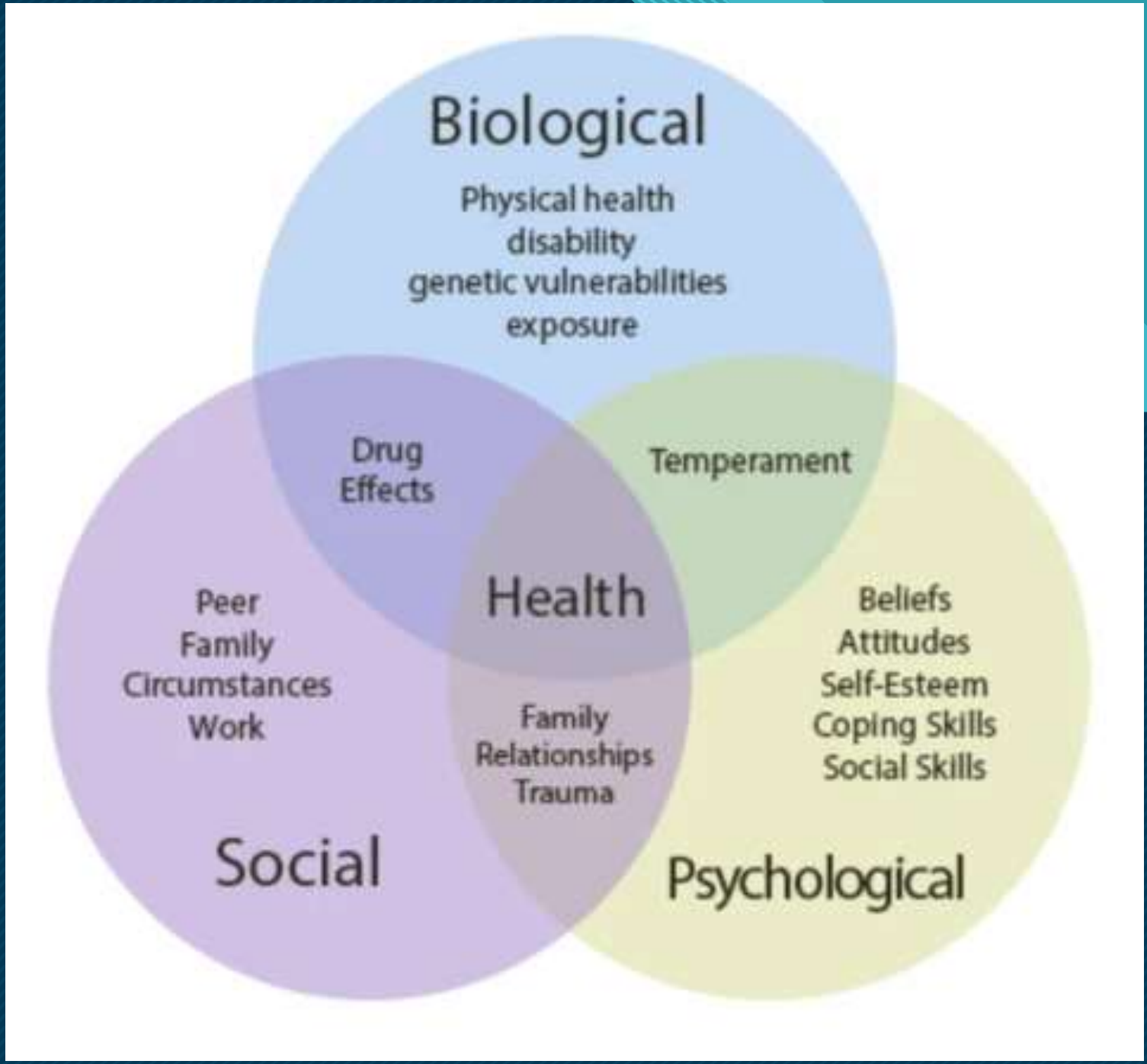
- THE PATIENT VOICE COMMITTEE (TPVC)
- FREQUENTLY ASKED QUESTIONS
- USEFUL DEFINITIONS AND GLOSSARY
- BPS PATIENT PUBLICATIONS
- USEFUL ORGANISATIONS AND LINKS FOR FURTHER INFORMATION
- PATIENT VOICES VIDEO RESOURCES
- SUGGESTED READING LIST
- NATIONAL AWARENESS CAMPAIGN

Home / People living with Pain

PEOPLE LIVING WITH PAIN

This page provides links and information for People with Pain

The following pages provide information that may be of use to people living with pain, including a list of UK-based patient organisations, a frequently asked questions section and a suggested reading section.


Biological
Physical health
disability
genetic vulnerabilities
exposure
Drug
Effects
Temperament
Health
Peer
Family
Circumstances
Work
Family
Relationships
Trauma
Beliefs
Attitudes
Self-Esteem
Coping Skills
Social Skills
Social
Psychological

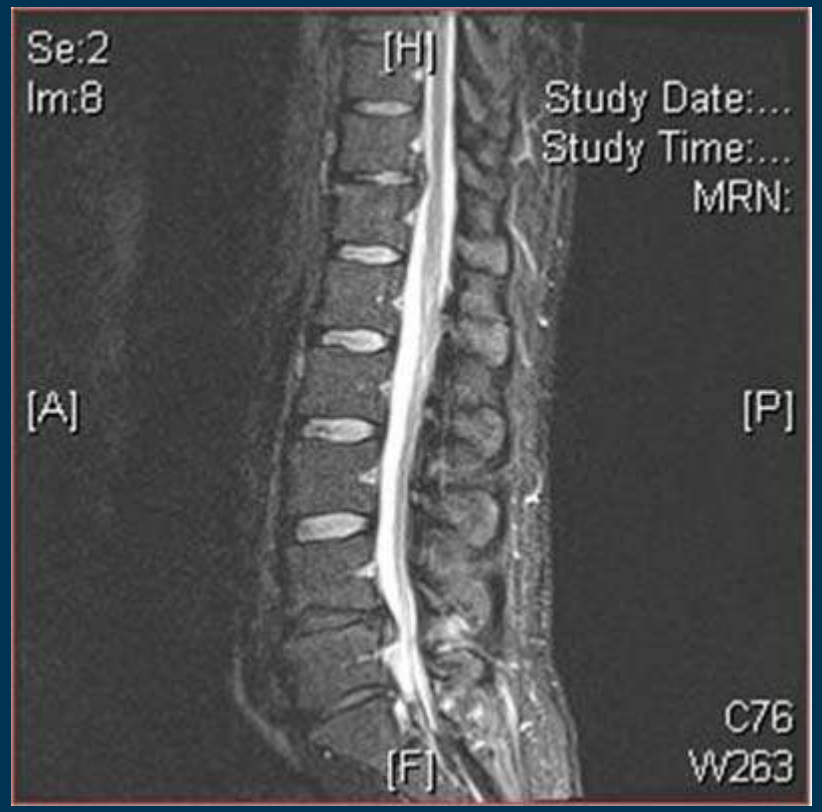
Kevin 36

- Father of 2, ex warehouseman
- CVA aged 32
- Chronic daily headache and all body pain since
- On 200mg morphine per day

- Research then explanation – Central Post Stroke Pain
- Opioid reduction, initial pain but then felt more alert, did more with kids
- Celecoxib – reduced back pain
- Settled on 20mg BD plus oramorph on waking
- GABA drugs, mild improvement
- Fluvoxamine – mild improvement
- Referred to Walton Neurosciences Centre

Lynda, 56

- Chronic disc disease
- On 100mcg fentanyl per day
- Foster carer of grandchildren
- Under Beaumont for spinal injections – they worked for 4-5 months
- Incredibly angry about “opioid reduction” letter
- Amitriptyline, helped sleep and reduced pain
- Reduced fentanyl to 25mcg/day
- Over 6 months, gradual acceptance of pain reduction, instead of elimination



Your questions