

Diagnosing and Treating Chronic Pain: Are We Doing This Right?

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Abstract

The diagnosis, treatment, and management of chronic pain is complex, nuanced, and challenging in primary care settings. These challenges often give rise to internal provider conflicts around appropriate management strategies, perhaps avoiding diagnosis all together. Factors that contribute to internal provider conflict include knowledge, responsibility, and uncertainties surrounding chronic pain management. This piece acknowledges the complexity and competing priorities of chronic pain management from a provider perspective. We advocate for coordinated and committed care of patients with chronic pain and a sense of shared responsibility among providers to adequately address patient needs.

Keywords

opioids, chronic pain, provider decision making, patient-centered care

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Narrative

Health care providers are often drawn to medicine out of an interest in improving and supporting the health of others. In the case of chronic pain, there is often unclear or conflicting guidance on how to provide care. When faced with a decision where there is no obvious right answer, the value of clinical judgement, experience, and humility become critical. For even the most seasoned provider, internal conflicts arise: “Am I doing the right thing?” or “Did I do enough or know enough?”

Pain is multi-faceted, complicated, and can stretch the health care provider's time, patience, and boundaries. Chronic pain, pain lasting 3 months or longer,¹ may affect 11% to 25% of United States citizens.^{2,3} Chronic pain is one of the most common complaints in ambulatory outpatient and Emergency Department visits. According to a systemic review by Finley et al⁴ in developed countries such as the United States, depression, anxiety, and back pain were the most common reasons for a visit to a primary care provider, making chronic pain a likely recurring theme within many primary care visits. A separate study found that chronic pain represented 37.5% of primary care visits in a typical week.⁵ Complicating diagnosis, there are 7 groups of clinically relevant chronic pain disorders with many more specific diagnoses or classifications in the new ICD-11.⁶ Merskey and Bogduk¹ cite as many as 36 diagnoses as part of generalized pain syndromes (eg, Fibromyalgia,

Centralized Pain, Rheumatoid Arthritis, and Pain of Psychological Origin). Understanding the nuanced differences between these conditions, and their presentation, can be challenging for providers.

Some chronic pain diagnoses, such as Fibromyalgia, are difficult to classify given a lack of a specific source of pain as well as associated symptoms including “emotional distress” and “significant functional impact” without other explanation.⁶ However, work is underway to clarify classification of chronic pain. When ICD-11 codes start being utilized, potentially in January 2022,⁷ a new disorder category will be introduced, “Chronic Primary Pain” which encompasses Fibromyalgia, Widespread Pain, and Irritable Bowel Syndrome.⁶ Despite increasing awareness and classification of chronic pain syndromes, some providers

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question the existence of chronic pain,⁸ which can leave the patient feeling unheard and their ongoing pain untreated. As providers, we can find ourselves in a proverbial “no man’s land,” a place where Fibromyalgia is subconsciously thought of as the “F bomb.” Internal conflicts can arise, even for seasoned providers, given uncertainty in diagnosis and treatment surrounding chronic pain management. A lack of diagnosis or clear treatment plan can be disheartening for patients looking for answers. The “right thing” is not always clear and making clinical decisions can feel daunting. Providers could benefit from a generalized framework or approach around diagnosis and treatment, clarification of responsibility, and education and confidence surrounding multimodal approaches for treatment and management of chronic pain.

First, **diagnosis**. How should chronic pain syndromes (CPS) such as Fibromyalgia, Myofascial Pain, and Chronic Fatigue be diagnosed? In practice, it may be difficult to tease the different chronic pain syndromes apart given similarities in diagnostic criteria, considerable time required for adequate assessment, and diagnoses that rely heavily on exclusion and nuance to determine which features are more prominent.⁹ Symptoms like fatigue, musculoskeletal pain and general malaise could indicate any of the previously mentioned chronic pain syndromes. Guidelines for diagnosis come from varying sources (eg, CDC, American College of Rheumatology, etc.) and have similar symptoms that can equate to multiple diagnoses. With a high prevalence of Chronic Overlapping Pain Conditions (COPC)⁹ providers should consider the potential for additional pain related diagnoses and continue to evaluate for untreated or undertreated pain sources. This can easily overwhelm a provider, who may have low knowledge or confidence in chronic pain management, and discourage patients who are searching for a clear path forward.

Providers, especially in primary care, rarely have enough time during routine appointments to adequately treat pain or fatigue without a clear source. Tackling pain is especially challenging while also juggling general health screening and chronic disease management. According to a survey of primary care clinicians,⁵ 83% of those surveyed responded that it was difficult to add on chronic pain management to their regular visit. Providers cited this as a limiting factor for optimal pain control.⁵ It is likely that time constraints, difficulty identifying the cause of pain,¹⁰ lack of evidence based guidelines,⁵ and the overlapping nature of chronic pain may keep many chronic pain syndromes undiagnosed and unmanaged. Even if the PCP strongly suspects that together, the patient’s pain, comorbid psychiatric diagnosis, and fatigue suggest a chronic pain syndrome, the provider may not want to diagnose the pain. With minimal guidance or algorithms on how to treat chronic pain, no cure, modest improvements expected no matter what treatment is selected, and significant provider time investment required

for diagnosis, treatment and management, what good is the diagnosis? For specialty providers who are often consulted on these complicated cases, their specialty excludes them from having to manage the pain: for example, “I am a neurologist. I treat epilepsy. Pain patients are referred to the pain clinic,” or, “I am an orthopedic surgeon. I operate. Chronic pain is not my job.”

This leads to a second challenge of managing chronic pain, **responsibility**. Is the provider who diagnoses the CPS also responsible for managing the CPS? For instance, in rheumatology, chronic pain can be associated with underlying autoimmune conditions such as Rheumatoid Arthritis,¹ Lupus, or Sjogren’s which can affect many organ systems. However, the CPS may be idiopathic, as not all chronic pain stems from a rheumatic condition. The specialty could just as easily be neurology where chronic pain is associated with various neuropathies, or orthopedics where pain may be associated with a surgical complication or osteoarthritis. These are all diagnoses that often include a component of chronic pain. However, rheumatology often gets referrals asking to make the official diagnosis and manage the condition. To handle the demand, the practice is forced to set expectations around how to approach pain referrals without a known autoimmune cause. Rheumatology will typically evaluate the patient, make a diagnosis if appropriate and possible, provide treatment recommendations, and send the patient back to the referring provider for ongoing management. Patients with an underlying identified autoimmune component will be retained in rheumatology but the CPS may or may not be treated in rheumatology, potentially necessitating additional referrals, not to mention the ambiguity surrounding what to do with patients who have been taking or may need opioids for optimal pain management. Patients can feel rejected by the lack of ownership and frustrated by the “wait and see” during this time of referral and evaluation. These experiences can lead to patient’s lowered self-esteem and decreased desire to seek care.¹¹ In many cases, the referring providers often feel they do not have the time,⁵ knowledge,³ or responsibility to manage “these types of patients.” So who is truly the right person to manage chronic pain? Pain management? Primary care? Psychiatry? A combination? Does the ideal setting exist and is it accessible?

What is the best approach to **diagnose and manage** chronic pain? The answer is rather complex and different for each provider. Each provider has a different specialty, role, knowledge level, education background, and time constraints. The list of competing priorities and limitations are endless. As responsible and concerned providers, we may consider learning more about chronic pain so that we can diagnose it when we see it and advocating for increased education for trainees at all levels surrounding pain diagnosis and management. All providers can start

by discussing and addressing their patient's pain with empathy and a desire to help. If you identify a comorbid psychiatric disease, refer the patient to psychiatry. There is considerable overlap with psychiatric symptoms and psychosocial aspects of chronic pain.⁸ As many as 67% of patients with chronic pain have an Axis I psychiatric disorder.¹² Be persistent in getting the patient seen in psychiatry, as untreated psychiatric conditions can exacerbate chronic pain conditions.¹³ Encourage your patients to focus on increasing activity, stretching, yoga, tai chi, walking, etc. The physical activity should be as tolerated but start with an attainable goal with slow upward titrations.^{14,15} You may consider pharmacological interventions such as: Duloxetine, Gabapentin, Pregabalin, Tramadol, the list goes on. A stepwise approach to chronic pain management has been recommended and typically includes non-pharmacological, pharmacologic, and opioid interventions,¹⁶⁻¹⁸ with the likely need for treatment modalities to be ongoing and simultaneous.

There are many reasons why providers don't treat pain; but, when we get to the bottom of it, chronic pain care matters. These patients must be helped. While there is not one clear approach to managing chronic pain, in many cases, there is also not one specialty pain clinic to refer patients to, even at some major medical centers. When choosing not to treat chronic pain or when hoping another provider will pick up the case, patients are left behind.

Consider chronic pain management from the patient's perspective, as pain is such a personal experience. Imagine waking up each day with diffuse widespread pain all over your body with no expectation it will improve and no resources to turn to. As health care providers, we all have our part to play.

1. If you suspect a chronic pain syndrome, or components of one, try to diagnose it or exclude other diagnoses.
2. If a patient has a diagnosed chronic pain syndrome that overlaps with a diagnosis you have provided; yet, you cannot tease apart the pain from the diagnosis you are managing, do your best to treat the pain, especially if the patient is planning to follow up with you.
3. If managing a chronic pain syndrome, keep in mind that stepwise therapy is recommended and will likely include combination therapy with pharmacologic, non-pharmacologic and consideration for opioids at times.^{3,16}
4. If you have exhausted your knowledge base, consider making a referral. Do not refer just to get it off your plate. Refer because you believe additional evaluation and/or care is what is best for the patient. Bottom line: Be the change that the patient needs, not another referral or failure to act.

So, are we doing what is best? There truly is no right way to treat chronic pain and no perfect diagnostic algorithm. The only wrong way to treat chronic pain is to not treat it at all or to pretend chronic pain does not exist. To claim chronic pain is not within one's scope of practice is to limit one's expertise and potential to help patients. As healthcare providers, we are all capable of initiating treatment of this complex diagnosis. We can work together to empathize with the patient, learn about chronic pain resources, and identify opportunities to improve chronic pain diagnosis and treatment within our practices.

To diagnose and treat chronic pain requires persistence from both the provider and the patient. There are significant time and knowledge components associated with diagnosis, particularly given the need for ruling out other diagnoses. However, naming and diagnosing chronic pain is a critical first step towards validating patients' ongoing struggles and frustration. A diagnosis can potentially lead to treatment of the chronic pain as well as the opportunity to connect with support groups and identify self-care strategies. In summary, as providers, we can and should collectively provide quality chronic pain management to our patients in whatever setting we currently practice. This can be accomplished through increased provider knowledge in combination with conversations around roles, responsibility, and ownership of this complex diagnosis. However, the ongoing internal provider conflicts and system-level issues highlighted would suggest the need for increased awareness and education surrounding comprehensive pain management strategies plus coordination and collaboration of care between specialty practice and primary care to improve the care of patients with chronic pain.

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