Management of Chronic Non-Malignant Pain


Rating (out of 4): 🍊🍊🍊🍊

**Scope**
This guideline is intended for all physicians with responsibility for managing patients with chronic non-malignant pain.

Clinical Question
What are the best strategies to manage patients with chronic pain not related to cancer?

**CHRONIC HEADACHE:**

Excellent / Good Evidence

- Uncontrolled trials support the use of either repetitive injections of dihydroergotamine, a course of dexamethasone, or a short course of nerve blocks; if the patient is overusing abortive medication, they must cease doing so if they are to be improved by treatments.

- Effective drug treatments include tricyclic antidepressants and anticonvulsants.

Fair

- Non-drug methods of relaxation, biofeedback, and cognitive therapy are useful for many patients.
MUSCULOSKELETAL PAIN

Excellent / Good Evidence

- Short term efficacy of cortisone injection for lateral epicondylitis has been demonstrated, but not for chronic shoulder disorders.

Fair

- The evidence for TENS or acupuncture is contradictory; may be useful in individual cases.
- There is some evidence for the efficacy of manual therapy or manipulation, particularly for chronic low back pain; may be worthwhile in individual cases with no contraindications.
- Passive physical therapy modalities are not recommended in chronic pain; active exercise is recommended as part of a comprehensive program.
- There is evidence for efficacy of tricyclic antidepressants in depression, chronic headache or neuralgia, but the evidence is contradictory for chronic soft tissue pain, and there is equivocal evidence for efficacy in chronic low back or neck pain.

OPIOID USE

Excellent / Good Evidence

- Chronic musculokeletal pain and neuropathic pain may be responsive to opioids.

Consensus

- If trial of non-opioids is ineffective, try fixed opioid-non opioid analgesic combinations such as acetaminophen, caffeine, codeine; if above is ineffective, try stronger opioid.
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- Initial analgesic effect should begin at relatively low doses (if not, anticipate opioid unresponsiveness); increasing doses should be accompanied by increasing analgesic effect.
Megadoses of morphine (hundreds or thousands of mgs) may indicate: non absorption leading to lack of efficacy, non opioid responsive pain mechanisms, and drug diversion.

If short-acting morphine proves useful and there are no features suggesting abuse, switch to sustained release opioid preparations.

Doses of oral morphine or equivalent above 300mg daily are unusual, though not necessarily contraindicated.

Parenteral dosing of opioids to treat chronic non-malignant pain should be strongly discouraged unless there are extenuating medical circumstances and oral or transdermal routes of administration are not available for medical reasons.

Verbal or written contract should stipulate NO unsanctioned dose escalation, selling of opioids, injecting of opioids, double-doctoring, obtaining opioids off the street or hoarding of opioids, and clearly define consequences of violation.

Assess patient every 9 weeks or more frequently if there are specific reasons, and document at each visit analgesic efficacy, adverse pharmacological effects, physical and psychological function and occurrence of drug abuse related behaviour.

Include a few extra doses of oral opioids for flare ups of pain; use breakthrough doses sparingly.

Goal of opioid therapy is NOT pain elimination, but achievement of tolerable pain and/or improvement of function.

Focusing on opioids without incorporating psychosocial and behavioural approaches may reinforce pain-related behaviours and undermine a rehabilitative program targeting functional restoration.

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