

# Chronic Non-Cancer Pain Management Clinical Guideline

**Definition:** Chronic pain has been defined as pain which lasts beyond the ordinary duration of time that an insult or injury to the body needs to heal. Duration is usually six weeks or longer.

**Types of Pain:** Pain mechanisms can be broadly categorized as nociceptive or neuropathic.

**Nociceptive Pain:** Pain that is caused by the activation of nociceptors, which are sensory neurons found throughout the body. A nociceptor is a receptor preferentially sensitive to a noxious stimulus or to a stimulus which would become noxious if prolonged.

**Neuropathic Pain:** Pain that is initiated or caused by a primary lesion or dysfunction of the nervous system. Normal nociception would not be considered dysfunction of the nervous system.

Ohio requires an OARRS review of repeated narcotic prescribing or of narcotic prescriptions for more than 7 days. Refer to [page 5](#) for additional information.

Patient presents with chronic pain; usual duration is more than six weeks

Obtain history and perform a physical examination including pain assessment; determine cause of pain, if possible.

Address specific cause; consider referral to specialist for involvement where indicated

□ Evaluation  
■ Treatment

Determine mechanism of pain.

**Neuropathic**  
(burning, stabbing, shooting) e.g., peripheral or central nervous system conditions; regional pain syndrome, Parkinson's disease, multiple sclerosis, myelopathies, stroke

**Musculoskeletal**  
(aching, soreness, stiffness) e.g., fibromyalgia, myofascial pain, trauma, low back pain; muscle, tendon, and ligament pain

**Inflammatory**  
(aching, swelling, erythema, heat)

**Visceral/ Pelvic/Urologic**  
e.g., endometriosis, irritable bowel syndrome, chronic visceral pain, interstitial cystitis, chronic pancreatitis, chronic cholecystitis, cancer-related pain, and gastroparesis

**Mixed**  
(combination of pain patterns)

Educate patient regarding treatment options; obtain shared goals about outcome of therapy

Consider non-pharmacologic treatments

- physical therapy: reconditioning, stretching exercises, massage manipulation; trigger point injection, acupuncture
- occupational therapy: body mechanics, work simplification, pacing skills
- psychology: cognitive restructuring, relaxation therapy, stress management
- if pain is controlled, monitor every 1-3 months or as needed

Ineffective or partial response: consider next line of therapy

Initiate first line drug monotherapy; consider referral to a specialist; **if pain is controlled, monitor every 1-3 months or as needed.** (See Box 1 for first line drug recommendations.)

Ineffective or partial response: consider next line of therapy

Initiate second line drug therapy; consider referral to a specialist; **if pain is controlled, monitor every 1-3 months or as needed.** (See Box 1 for second line drug recommendations.)

Ineffective or partial response: consider next line of therapy

Initiate third line drug therapy; consider referral to a specialist; **if pain is controlled, monitor every 1-3 months or as needed.** (See Box 1 for third line drug recommendations.) (See Table C for red-flag behaviors.)

# Clinical Guideline: Chronic Non-Cancer Pain Management

## Four Categories of Chronic Pain

- Neuropathic
- Musculoskeletal
- Inflammatory
- Visceral/Pelvic/Urologic

## History

Pain assessment should be a routine part of any medical encounter and has been referred to as the 5th vital sign.

### Symptom Factors:

- Pain location
- Radiation
- Intensity
- Characteristics/quality
- Temporal aspects: duration, onset, and changes since onset
- Constancy or intermittency
- Characteristics of any breakthrough pain
- Exacerbating/triggering factors
- Palliative/relieving factors

### Associated Symptoms:

- Restriction of range of motion, stiffness, or swelling
- Muscle aches, cramps, or spasms
- Color or temperature changes
- Changes in sweating
- Changes in skin, hair, or nail growth
- Changes in muscle strength
- Changes in sensation

### Pain Impact:

Question the patient regarding the impact of pain on function and quality of life.

- Social and recreational functioning
- Mood, affect, and anxiety
- Relationships
- Occupation
- Sleep
- Exercise

### Activities of Daily Living:

Address whether patient is able to bathe, dress, feed, and live independently.

Pain intensity scales are reliable to compare the intensity of one patient's pain at different times allowing clinicians and patients to judge whether the pain is increasing or decreasing with treatment.

Assess for prior evaluation and treatment for pain; obtain records with patient's permission.

### Patient Perceptions and Psychological Factors:

- Assess for maladaptive behavioral patterns that may influence the course of treatment (anxiety or substance abuse)
- Determine the patient's expectations for treatment and counsel on how realistic expectations are

## Physical Examination

Complete a physical examination, including a detailed neurologic assessment, regardless of the patient's area of complaint.

## Diagnostic Testing

- Blood Tests—Routine studies are not indicated unless specific causes (infectious) are identified
- Imaging—patients with chronic pain typically have already had imaging; review past studies. Consider imaging if not performed in the past
- Neurophysiologic testing, nerve conduction studies, and electromyography are used in suspected disorders of the peripheral nervous system.

## Referral to a Pain Specialist

Reasons to refer:

- Symptoms are debilitating
- Symptoms are at multiple sites
- Symptoms do not respond to initial therapies
- Escalating need for pain medication

## Psychiatric Comorbidity

- Depression and anxiety are common in patients with chronic pain and complicate the patient's condition

## Classifications of Pain

- Pain location—low back pain
- Pain duration—acute, chronic
- Pain origin—nociceptive, neuropathic
- Diagnosis—cancer
- Body system—rheumatic
- Pain severity—mild, moderate, severe
- Pain mechanism—peripheral sensitization
- Treatment responsiveness—opioid-responsive pain

## Box 1: First, Second, and Third Line Drug Therapies

First Line	Second Line	Third Line
OTC pain medications; NSAIDs or acetaminophen if no contraindications	antidepressants: tricyclic antidepressants, e.g., nortriptyline or desipramine, SSRI; antiepileptics: gabapentin (Neurontin), lamotrigine (Lamictal) 5% lidocaine patch; consider using ad-junctive therapy: capsaicin cream (Zostrix), mexiletine (Mexitil)	tramadol, opioid analgesics; tens unit stimulation, nerve block

## Pharmacologic Treatment

**Neuropathic pain:** Initial treatment usually includes antidepressants or calcium channel alpha2-delta ligands with adjunctive topical therapy (lidocaine). Opioids are second-line treatment.

**Nociceptive pain:** Treatment includes non-narcotic and opioid analgesia, first-line therapy include acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs)

### Acetaminophen

- Recommended for management of hip or knee osteoarthritis
- Commonly combined with opioid medications to reduce amount of opioid needed
- Overdose can lead to severe hepatotoxicity

### Nonsteroidal anti-inflammatory drugs (NSAIDs)

- Indicated for mild or moderate pain of somatic origin, i.e., soft tissue injury, sprains, headaches, arthritis
- Adverse effects: inhibition of platelets, interactions with antihypertension drugs, warfarin and low-dose aspirin, dyspepsia, gastric ulceration, nephrotoxicity, fluid retention, and hepatic toxicity

### Opioids

- Reserved for patients with moderate to severe chronic pain that adversely impacts function or quality of life
- Patients should be assessed for the risk of substance abuse, misuse, and addiction
- Meperidine should not be used for chronic pain because of CNS toxicity and availability of less toxic and more effective alternatives
- Selection of opioid regimen should be individualized and dose titrated until the goal for pain is achieved or side effects limit further dose escalation
- Opioid agreements and/or contracts and informed consent regarding risks and benefits of treatment foster adherence to the treatment program, limit potential for opioid abuse, and improve efficiency of the pain treatment program
- Monitoring should take place at each visit (at least every 1 to 3 months) and include documentation of pain intensity, functional status, progress toward goals, adverse effects, and adherence to the treatment
- Periodic urine drug screens are recommended for patients who are at high risk for aberrant drug related behaviors
- To discontinue therapy, a slow taper of a 10 percent dose reduction per week will minimize withdrawal symptoms
- Side effects include: nausea, vomiting, constipation, opioid-induced hyperalgesia, narcotic bowel syndrome, and somnolence

### Anticonvulsants

- Gabapentin: effective treatment for postherpetic neuralgia and painful diabetic neuropathy
- Pregabalin: effective treatment for postherpetic neuralgia, painful diabetic neuropathy, central neuropathic pain and fibromyalgia; can cause euphoria and is a Schedule V controlled substance

### Antidepressants

- Tricyclic antidepressants: believed to have independent analgesic effects as well as ability to relieve depressive symptoms; adverse effects include anticholinergic and antihistamine effects; side effects include: sedation, constipation, mental clouding, orthostatic hypotension, urinary retention and dry mouth.
- Serotonin norepinephrine reuptake inhibitors:
  - Venlafaxine: effective in painful diabetic peripheral neuropathy and polyneuropathies of different origins; use with caution in patients with cardiac disease due to possibility of cardiac conduction abnormalities and increase blood pressure; taper when discontinuing due to withdrawal symptoms.
  - Duloxetine: effective treatment of painful diabetic neuropathy, fibromyalgia, chronic low back pain, and osteoarthritis; side effects include nausea, dry mouth, insomnia, drowsiness, constipation, fatigue, and dizziness.
  - Milnacipran: FDA-approved for treatment of fibromyalgia but not depression

### Adjuvant Medications

Used to treat side effects of pain medication and/or potentiate analgesia.

- Benzodiazepines: may be utilized in patients with anxiety disorder; disadvantages: addictive potential, sedative effects, and respiratory depression in patients who currently use opioids
- Antispasmodics: may cause CNS depression
- Topical agents: 1) Lidocaine for neuropathic pain 2) Capsaicin cream for post herpetic neuralgia, HIV neuropathy, and diabetic neuropathy 3) Topical nonsteroidal anti-inflammatory drug chronic low back pain, widespread musculoskeletal pain and peripheral neuropathic pain

### Ziconotide

- Intrathecal analgesic therapy should be reserved for intractable severe pain with significant impact on quality of life that is refractory to all other treatments
- Patients with preexisting history of psychosis should not be treated with ziconotide
- Should only be used in patients with no other reasonable options for pain control

## Non-Pharmacologic Treatment

- Behavioral medicine: biofeedback, relaxation therapy, psychotherapy
- Aerobic exercise
- Acupuncture
- Chiropractic
- Interventional approaches: nerve blocks, trigger point injections, epidural steroid injections
- Ultrasonic stimulation
- Electrical neuromodulation: TENS
- Heat/cold application
- Physical and occupational therapy
- Surgical interventions

## Prescription Drug Misuse

Opioid analgesics, benzodiazepines, other sedatives and tranquilizers, and stimulants have important medical uses, but they also stimulate the reward center of the brain. In susceptible individuals, this can lead to misuse, substance use disorders/addiction, and other serious consequences. It has led to the development of an illicit market for these medications. Because of their potential for misuse, addiction, and illicit diversion and sale, opioid analgesics, stimulants, and benzodiazepines and other sedatives/hypnotics are regulated, restricting whether and how they can be prescribed. In the U.S., these drugs are referred to as "controlled substances" and subject to Federal regulations.

Misuse is any use of a prescription medication that is outside of the manner and intent for which it was prescribed. This includes overuse, use to get high, diversion (sharing or selling to others), having multiple prescribers or non-prescribed sources of the medication, and concurrent use of alcohol, illicit substances, or non-prescribed controlled medications. Misuse is a necessary but insufficient criterion for a substance use disorder.

## Risk Factors

Patient factors associated with increased risk for opioid analgesic misuse when prescribed the medication for chronic pain include:

- Substance use disorder (most consistently identified), including tobacco use disorder
- Family history of a substance use disorder
- Mental health disorder, including depression or posttraumatic stress disorder
- History of legal problems or incarceration
- White race (compared with black race) despite studies that have identified greater clinician concern and closer monitoring for black patients
- Age less than 40 to 45 years old, in most studies

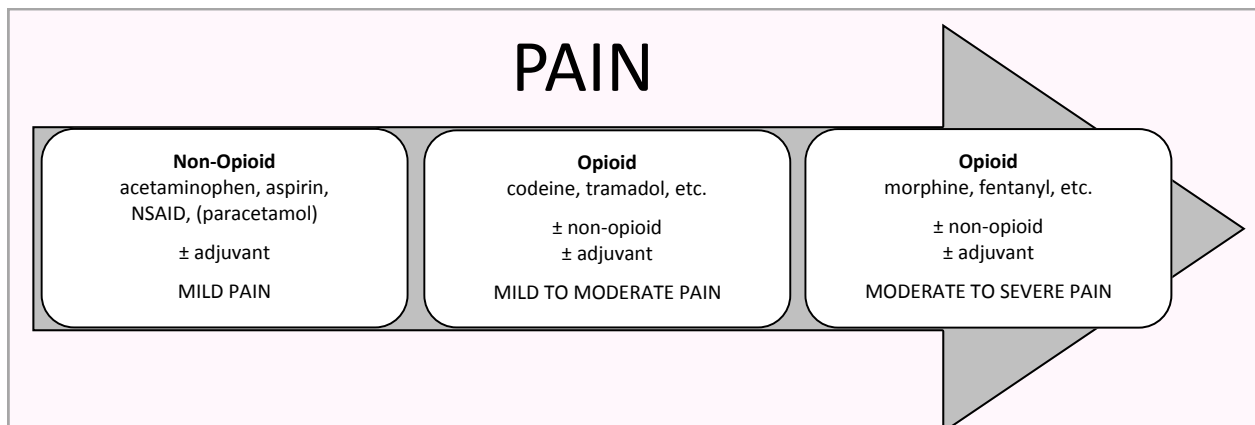
Studies are most robust for misuse, but these are also generally considered to be risk factors for developing opioid use disorder and for overdose.

## Prevention

**Optimize alternative treatments.** The first principle in prevention is to reduce a patient's and the clinician's reliance on controlled substances. Clinical indications for prescribing controlled substances, such as pain, anxiety, and attention deficit hyperactivity disorder, each have evidenced-based treatment modalities that can complement or even replace use of controlled substances. These include non-pharmacologic treatment with self-management strategies, behavioral treatments, physical therapy, as well as non-controlled pharmacotherapy.

Monitoring patients who are prescribed a controlled substance should include regular follow-up, drug testing, pill counts, and use of prescription monitoring programs or other information sources about patients who receive these medications from multiple prescribers. Monitoring should include documentation of benefits and harms of treatment, including assessment of functional status to assure that function is stable or improving on the current regimen, and evaluation for concerning behaviors that may indicate misuse or a substance use disorder.

## World Health Organization (WHO) Analgesic Ladder



**Table A: Schedules of Controlled Substances in the United States\***

Schedule	Examples	Medical Use?	Potential for Abuse/Dependence	Prescription
I	• Marijuana • Heroin	No	High	Not applicable
II	Narcotics: • Codeine • Fentanyl • Hydrocodone and hydrocodone combinations (e.g., with acetaminophen) • Hydromorphone • Morphine • Methadone • Oxycodone and oxycodone combinations (e.g., with acetaminophen) Stimulants: • Amphetamine • Methamphetamine • Methylphenidate Other: • Cocaine • Pentobarbital, secobarbital	Yes	High	Requires a written prescription by a licensed practitioner. Refilling of individual prescriptions is prohibited.
III	Narcotics: • Buprenorphine • Combination products with <90 mg codeine/unit (e.g., acetaminophen with codeine) Non-narcotics: • Dronabinol • Ketamine	Yes	Less than with Schedule I and II drugs	A prescription for a drug in Schedules III through V must be issued by a practitioner and may be communicated orally, in writing, or by facsimile to the pharmacist; may be refilled up to five times
IV	Narcotics: • Tramadol and combinations (e.g., with acetaminophen) Others: • Alprazolam • Diazepam • Carisoprodol • Clonazepam • Lorazepam • Midazolam	Yes	Less than with Schedule III drugs	
v	Preparations containing limited quantities of certain narcotic and stimulant drugs used for antitussive, antidiarrheal, and analgesic purposes (e.g., cough preparation with <200 mg codeine/100 mL [e.g., Robitussin AC])	Yes	Lower than with Schedule IV drugs	

\*Drugs and other substances that are considered controlled substances under the Controlled Substances Act are divided into five schedules based upon whether they have a currently accepted medical use in the United States and their relative abuse potential and likelihood of causing dependence when abused.

**Ohio Automated Rx Reporting System (OARRS)**

The Ohio Automated Rx Reporting System (OARRS) was established in 2006 as a tool to assist health care professionals in providing better treatment for patients with medical needs while quickly identifying drug seeking behaviors. An OARRS Prescription History Report can assist in assuring that a patient is getting the appropriate drug therapy and is taking his or her medication as prescribed. Prescribers are required to request, assess, and document receipt of a patient’s OARRS prescription history report. Ohio law has established several requirements for Ohio prescribers related OARRS:

- Before initially prescribing or personally furnishing an opioid analgesic or a benzodiazepine to a patient, the prescriber must request patient information from OARRS that covers at least the previous 12 months.
- The prescriber must also make periodic requests for patient information from OARRS if the course of treatment continues for more than 90 days. The requests must be made at intervals not exceeding ninety days, determined according to the date the initial request was made.
- Under the circumstances described above, the prescriber is required to assess the OARRS information and document in the patient record that a patient prescription history report was received and assessed.

An exception to mandatory checks prior to prescribing an opioid analgesic or benzodiazepine occurs when the drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days (all prescribers except optometrists). A prescriber who is required to review OARRS information must document in the patient's medical record that the report was received and the information was assessed.

Ohio Automated Rx Reporting System  
 Ohio State Board of Pharmacy  
 77 South High Street, Room 1702  
 Columbus, OH 43215  
 Phone: 614-466-4143

Live Support Available: 8:00 a.m.—5:00 p.m., Monday—Friday  
<https://www.ohiopmp.gov/>

**Table B: Common Fraudulent Techniques Used by Drug Seekers and Recommended Management**

Technique	Characteristics	Management
Lost prescription	Calls or returns stating that opioid prescription was lost before being filled	Establish a policy: no opioid prescriptions refilled. Notify patients of policy at discharge as they receive prescriptions.
Impending surgery	Wants temporizing opioids; doctor “unavailable”; previous surgery; patient from out of town	Call physician. Check medical records. Offer substitute for opioid.
Carries own records and x-rays	Suspicious or forged records; doctor’s written permission to receive opioids; patient from out of town	Make phone calls. Check records. Offer substitute for opioid.
Factitious hematuria with complaint of kidney stones	Appears comfortable or overacting; pricked finger dipped in urine; lip/cheek bitten and blood spit into urine	Examine fingers and mouth. Obtain witnessed urine sample. Offer non-narcotic pain medicine. Obtain confirmatory test before giving opioid.
Self-mutilation	Done with dominant hand; requests opioids for pain	Use bupivacaine for local block. Do not prescribe opioids without indications. Offer substitute for opioids.
Dental pain	Dental caries only	Give local nerve block with bupivacaine. Refer to dentist.
Factitious injury	Old injury; old deformity; self-massaged to produce erythema; patient from out of town	X-ray before treatment. Check records. Check for erythema that dissipates over time.
Partner waiting near telephone at home	“Call my doctor” and handwritten number offered: partner answers, “Doctor so-and-so”	Question respondent for medical knowledge. Verify number with telephone company or Internet search.
Partner in ED	Confirms history; urges opioids	Check records. Send to waiting room if verbally abusive.

**Table C: Characteristics of Drug-Seeking Behavior**

More Predictive of Drug-Seeking Behavior*	Less Predictive of Drug-Seeking Behavior
Sells prescription drugs	Admits to multiple doctors prescribing opioids
Forges/alters prescriptions	Admits to multiple prescriptions for opioids
Factitious illness, requests opioids	Abusive when refused
Uses aliases to receive opioids	Multiple drug allergies
Current illicit drug addiction	Uses excessive flattery
Conceals multiple physicians prescribing opioids	From out of town
Conceals multiple ED visits for opioids	Asks for drugs by name

\*Behaviors in this category are unlawful in many states.

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*This clinical guideline outlines the recommendations of Mount Carmel Health Partners for this medical condition and is based upon the referenced best practices. It is not intended to serve as a substitute for professional medical judgment in the diagnosis and treatment of a particular patient. Decisions regarding care are subject to individual consideration and should be made by the patient and treating physician in concert.*