ΛVΛNOS

WHAT TO DO WHEN PATIENT OUTCOMES DON'T MEET EXPECTATIONS

By David R. Walega, MD, Northwestern Medical Group

Chronic pain affects approximately 100 million Americans, more than diabetes, heart disease and cancer combined. It's a disease that not only impacts the individual patient—causing pain symptoms, as well as anxiety,[1] depression, lack of sleep and changes in mood, personality, and social relationships[2]—but also exacts a significant emotional and financial burden on family, friends and the broader community.

Today, pain costs the U.S. between $560 and $635 billion in direct healthcare spending, absenteeism, lost wages and decreased productivity.[3]

Regardless of the type of pain, early intervention is critical. Emerging data shows that chronic pain can develop in patients who have poorly controlled pain following a surgical procedure, and those who have inadequate pain relief during an acute or subacute pain crisis are more likely to suffer from chronic pain weeks, months or even years later.[4]

Further, pain is a highly personal experience, and as patient-to-patient variability is vast the number of available treatment options for chronic pain (including new and emerging technologies) continues to expand. Determining the best care plan for pain can be complex and challenging for patients and physicians alike.

This article provides a high-level roadmap for healthcare professionals navigating the treatment landscape for chronic pain patients and explores next steps for patients whose outcome measures from standard interventional procedures fail to meet expectations.

BEFORE MAKING TREATMENT DECISIONS, ASK THE RIGHT QUESTIONS

When deciding on the optimal treatment plan for a chronic pain patient, it's imperative that clinicians start by getting to know the patient and his or her unique experience and circumstances. Here are several important questions to consider:

1. **What is the type of pain?**
   Is it mechanical joint, neuropathic, discogenic or something else?
2. **What are the patient's treatment goals and expectations?**
   Is it to return to normal function, to regain the ability to partake in certain physical activity or improvement in overall quality of life?
3. **What is the patient's age?**
   Some treatments aren't ideal for young children or the elderly.
4. **What is the patient's weight?**
   Some treatments cannot be performed on morbidly obese patients and some conditions are aggravated by or a direct result of obesity; in these cases, nutrition counseling and planned weight loss should be considered as a first step.
5. **Does the patient have any comorbidities?**
   Some conditions unrelated to the chronic pain may limit certain options. For example, additional precautions and planning are necessary when considering any intervention involving a needle or scalpel for patients with bleeding disorders,[5] severe hepatic disease[6] or those on anticoagulation.[7]
6. **What is the patient's insurance status?**
   Are the interventions under consideration covered?

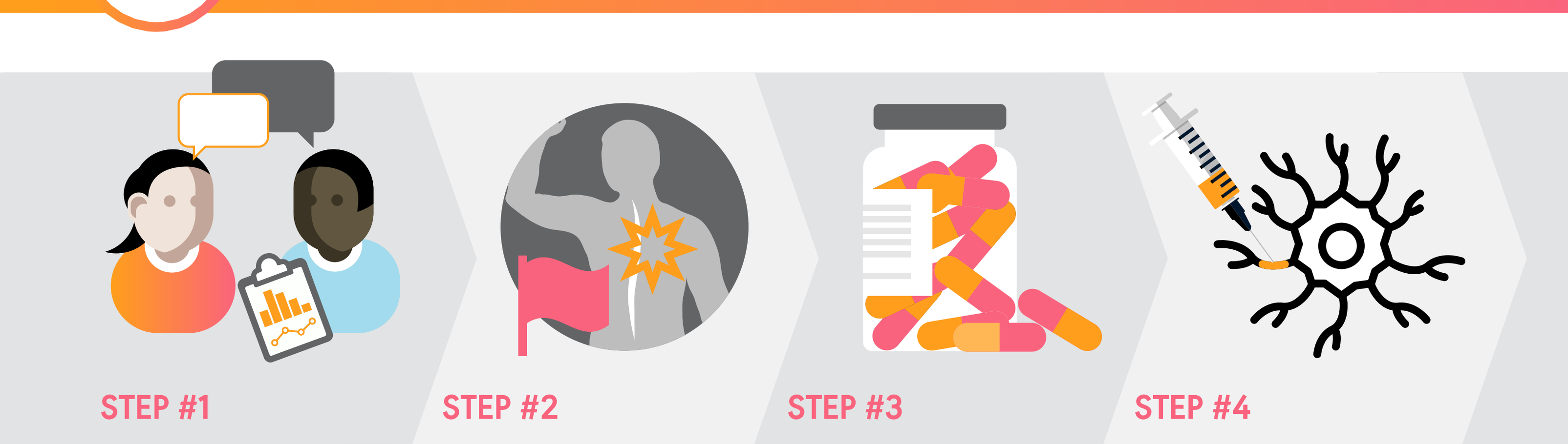
In addition to providing valuable information, the process of **engaging patients with the spectrum of treatment options at the outset** gives them a greater sense of control and empowerment, making them active participants in their care. This active engagement typically results in better outcomes.

The continuum of care for 4 common types of chronic pain

Once a clinician clearly understands the individual patient, it's time to develop and implement a treatment plan. While there is no "one-size-fits-all" approach to treating chronic pain, there is a standard continuum of care beginning with non-invasive treatment options and proceeding to more aggressive injections, ablation, neuromodulation or other surgical interventions.

Here, we explore the typical treatment journey – including key considerations at each step in the process – for four of the most common types of chronic pain patients:

1 Patients with chronic low back pain
with nerve pain that radiates into the leg:

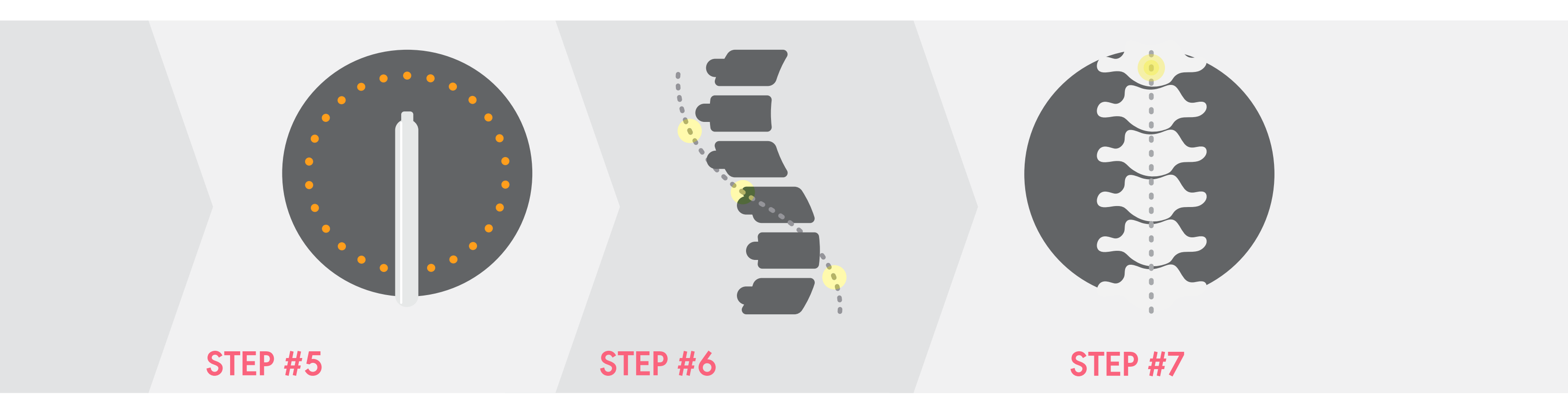


STEP #1
Conduct a thorough pain history, physical examination and evaluation of patient's psychosocial health.

STEP #2
Evaluate patient's current status, **identify "red flag" issues** requiring immediate surgical consultation/intervention. **If such issues are present, progress to Step 5. Otherwise, proceed to Step 3.**

STEP #3
If patient's pain is mild and there are no critical issues, **explore least invasive options:** PT, non-opioid analgesics and/or acupuncture. If pain is functional, address issues such as weight and stress management.

STEP #4
For patients who fail non-invasive options or have moderate to severe pain, **consider therapeutic injections** (epidural steroid, selective nerve root, sacroiliac joint, facet joint, trigger point) **or diagnostic spine injections** (medial branch nerve blocks, lateral branch nerve blocks, discography); evaluate outcomes/results.

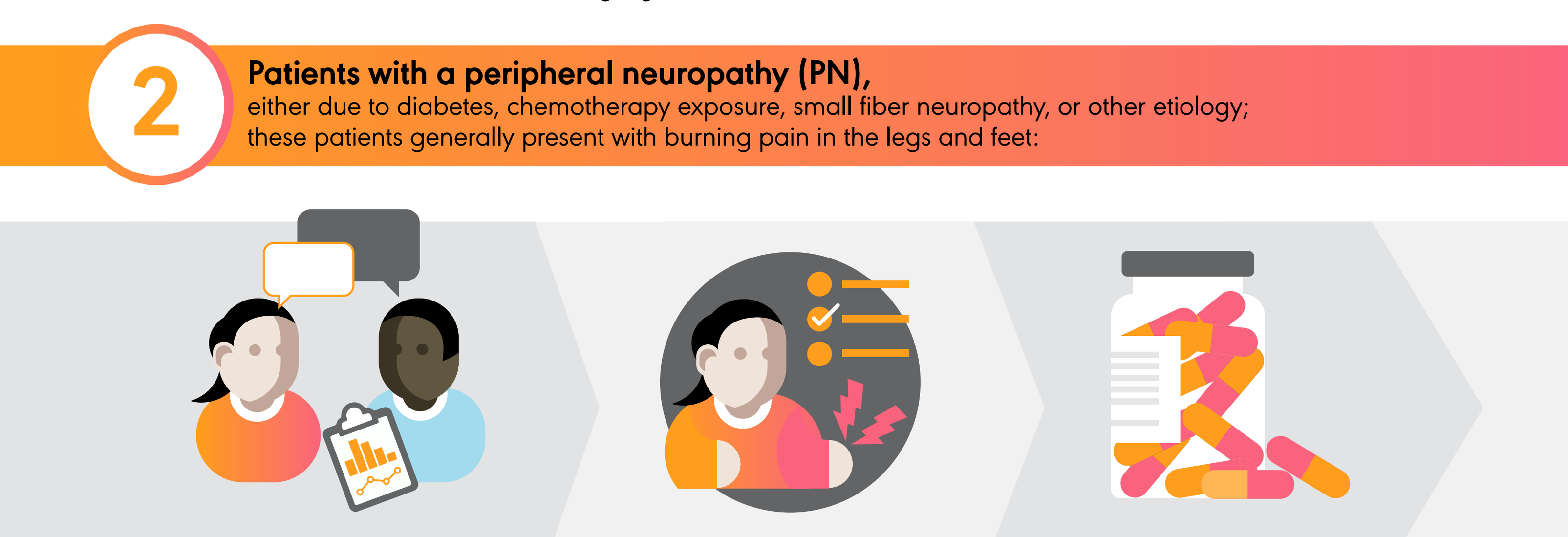


STEP #5
Response to diagnostic blocks may be an indication for **neurolysis/ablation procedures.**

STEP #6
If neurolysis/ablation is not indicated or results unsatisfactory, consider **spinal cord stimulation or dorsal root ganglion (DRG) stimulation**.

STEP #7
In rare cases, **intrathecal drug delivery** may be a salvage option.

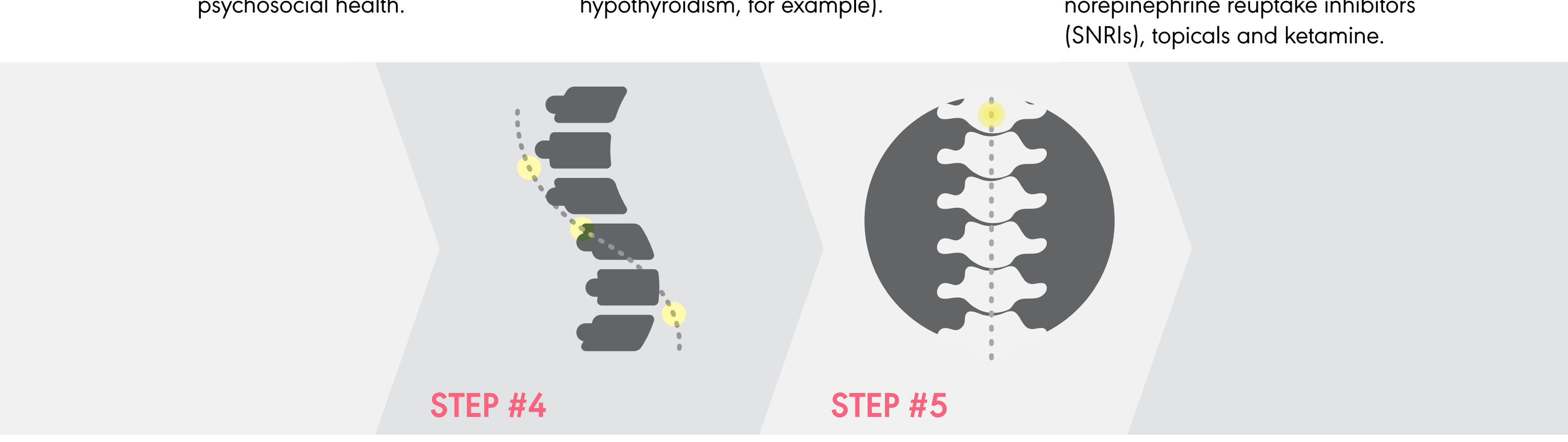
2 Patients with a peripheral neuropathy (PN),
either due to diabetes, chemotherapy exposure, small fiber neuropathy, or other etiology; these patients generally present with burning pain in the legs and feet:



STEP #1
Conduct a thorough pain history, physical examination and evaluation of patient's psychosocial health.

STEP #2
Conduct a full neurologic work up to identify and treat reversible causes of PN (such as B12 deficiency, uncontrolled diabetes, or hypothyroidism, for example).

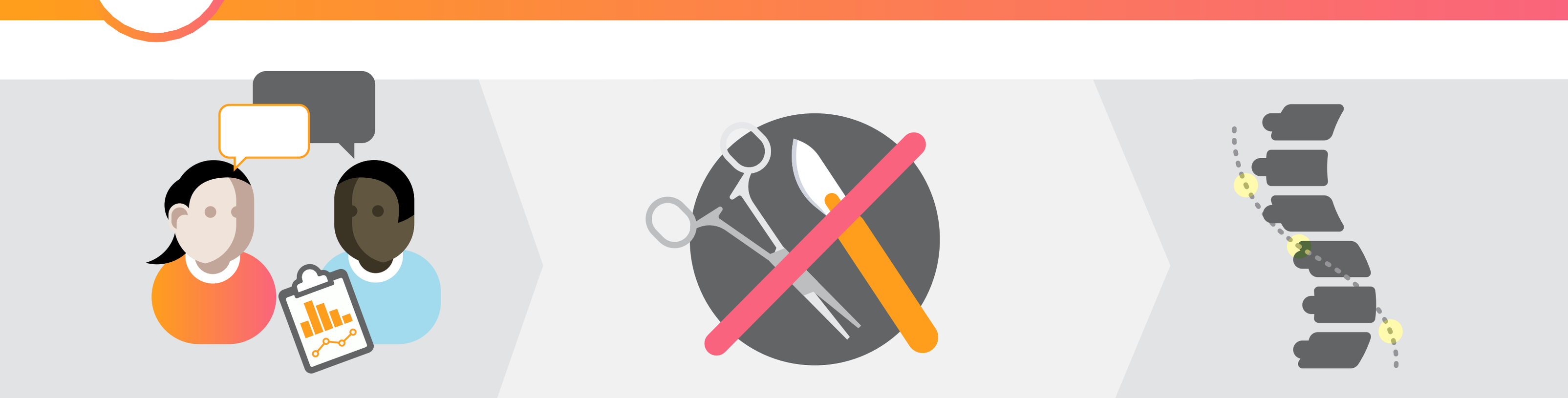
STEP #3
Medication management options include membrane stabilizers (such as gabapentin or pregabalin), tricyclic antidepressants (TCAs), serotonin and norepinephrine reuptake inhibitors (SNRIs), topicals and ketamine.



STEP #4
If symptomatic relief is unsatisfactory, consider **spinal cord stimulation** or **dorsal root ganglion (DRG) stimulation.**

STEP #5
If all other options are exhausted, **intrathecal drug delivery** may be an option.

3 Patients with degenerative, traumatic or post-surgical joint pain,
particularly in the knee, hip and shoulder:

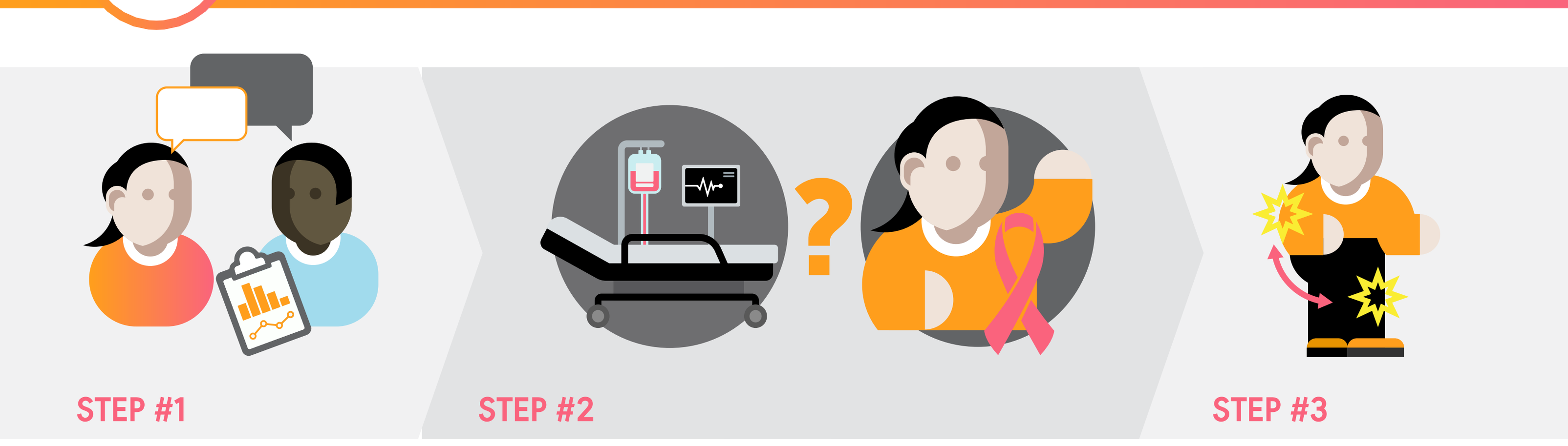


STEP #1
Conduct a thorough pain history, physical examination and evaluation of patient's psychosocial health.

STEP #2
Many patients want to avoid joint replacement, have medical contraindications to surgery (such as obesity or a bleeding disorder), want to avoid opioids due to fear of addiction, or are susceptible to side effects (including constipation, delirium, sedation or other impairment). **In addition, at least 20% of total knee replacement patients** and more total hip replacement patients **have chronic pain six months after surgery.** For these patients, neurolysis or ablation can often be considered as a first-line treatment.

STEP #3
Spinal cord stimulation, dorsal root ganglion (DRG) stimulation and **intrathecal drug delivery** can be considered.

4 Patients in need of cancer pain management:



STEP #1
Conduct a thorough pain history, physical examination and evaluation of patient's psychosocial health.

STEP #2
Determine if **short-term pain control (end of life)** or **long-term term pain control (cancer survivorship)** is the goal and then proceed to the appropriate treatment options. **Focal, localized pain** may be amenable to neurolysis/ablation. **Visceral pain** may be amenable to celiac plexus, superior hypoplexus or ganglion impar neurolysis. **Neuropathic pain** from chemotherapy, radiation therapy or tumor infiltration to nerve/plexus may respond to spinal cord stimulation (SCS) or dorsal root ganglion (DRG) stimulation. **Diffuse or multifocal pain** (due to bone or organ metastases) may respond to intrathecal drug delivery.

STEP #3
Pain patterns can change as cancer recurs, or side effects of chemo, RT, surgery may present new problems.

For each type, every effort should be made to exhaust all reasonable treatment options before turning to short- or long-acting opioids. The opioid crisis, as well as the Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing, updated in 2016, necessitate that ongoing use of opioids be considered a last resort for many types of chronic pain.[8]

FINALLY, THROUGHOUT THE TREATMENT ARC, CLINICIANS SHOULD ASSESS PATIENTS FOR:

- Signs and symptoms of depression, anxiety and sleep disorders. These often improve with cognitive or behavioral therapy or other treatments;
- The need for physical therapy/functional restoration or general reconditioning;
- The need for lifestyle changes, such as smoking cessation, weight loss/exercise programs, stress reduction, substance abuse evaluation and support; and
- The need for complementary therapy, such as acupuncture, chiropractic treatments or massage therapy.

As chronic pain symptoms and patient needs often change over time, these assessments should be done continually to ensure that the right treatment modalities are incorporated at the right time.

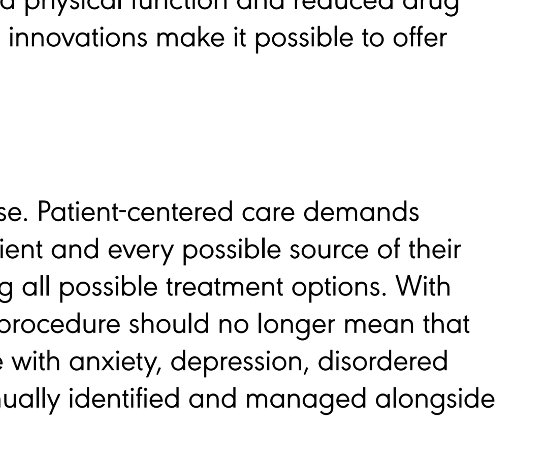
WHEN OUTCOMES AREN'T AS ANTICIPATED (OR HOPED FOR), WHAT'S NEXT?

In the treatment of chronic pain, it's not uncommon that even when patients undergo the most advanced pain management intervention, patient-reported outcome measures don't always meet expectations. This might be because the patient has ongoing chronic pain, is experiencing new pain or simply isn't satisfied with the results. In any case, unsatisfactory outcomes can be disappointing for everyone. However, the lack of a positive outcome from one procedure or course of treatment should not signal a "dead end" in the patient's journey to find patient relief. Instead, clinicians should leverage every patient outcome to inform and guide next steps.

In these situations, it's often best to start fresh and approach the chronic pain complaints using the same decision-making process previously discussed. Once again, start by asking questions aimed at understanding of the type of pain, as well as treatment goals and expectations:

- What activity are you still not able to do because of your residual pain symptoms?
- What is keeping you from meeting your functional goals?
- What are you willing to do to reach these goals?

Then, collaboratively, come up with a plan, one that may include starting over and revisiting traditional therapies or exploring newer technologies. As previously discussed, surgery can be beneficial in properly selected patients.



However, due to factors such as body mass index, age, other comorbidities and invasiveness, it is not for everyone, making the availability of less invasive options increasingly important. As one example, cooled radiofrequency (RF) is a minimally invasive treatment targeting nerves that cause pain. Cooled RF has been clinically documented to provide chronic back pain patients up to 24 months of pain relief, improved physical function and reduced drug utilization. By expanding the arsenal of tools accessible by clinicians, these innovations make it possible to offer more options and renewed hope to a greater number of patients.

CONCLUSION

Chronic pain isn't simply a symptom, it's a common and debilitating disease. Patient-centered care demands that clinicians be diligent and systematic in evaluating each individual patient and every possible source of their pain, charting a course of care tailored to their unique needs and exploring all possible treatment options. With so many choices now available, an unsatisfactory outcome following one procedure should no longer mean that a patient is out of options. In addition, many chronic pain patients struggle with anxiety, depression, disordered sleep or side effects from medications and these conditions must be continually identified and managed alongside pain symptoms.

Ultimately, outcomes are best when clinicians use an individualized approach to patient care. With the right combination of treatments, lifestyle considerations, open patient communication and a high level of patient engagement in their health journey, relief from chronic pain is possible.

There are inherent risks in all medical devices. For more detail on indications, cautions, warnings and contraindications, click here.

David R. Walega, MD, has a consulting/speaking/financial relationship with Avanos Medical, Inc.

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