A Practical Approach to the Management of Chronic Pain

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Disclosure

• Speaker: Purdue
Incidence of Pain as Compared to Major Conditions

- Pain affects more Americans than diabetes, heart disease and cancer combined

- Chronic Pain: 100 million
- Diabetes: 25.8 million
- Coronary Heart Disease: 16.3 million
- Stroke: 7.0 million
- Cancer: 11.9 million

The American Academy of Pain Medicine
Prevalence of chronic pain in Canada

• Prevalence of chronic pain in Canada: 25 to 29%
• Prevalence higher in the elderly population (up to 38%)
• Low back pain among most common site of chronic pain

2010 National Opioid Use Guideline Group (NOUGG)
Prevalence of chronic pain

• Average duration: 10.7 years
• 49% - significant difficulty participating in social or family functions
• 61% - unable to participate in hobbies
• 58% - unable to accomplish daily activities

Pain is invisible

I don't look sick? Thank you!

It only took 5 layers of make-up and some heavy pain killers

www.ThePainReliefFoundation.com
Pain is invisible
As a result of attending this workshop, participants will be able to:

- Develop a practical approach to the assessment of chronic pain
- Feel confident in establishing treatment goals focused on functional improvement
- Incorporate strategies for the management of chronic pain, including pharmacological and non-pharmacological options
Definition of pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage”

*International Association for the Study of Pain (IASP), 1986*
Classifying pain by time

ACUTE: 0-7 days

SUBACUTE: 8 days to 3 - 6 months

CHRONIC: beyond 3 - 6 months
Chronic pain

• Pain without apparent biological value that has persisted beyond normal tissue healing time (often noted as > 3 months) (IASP)

• No longer providing useful information

• The persisting pain becomes its own pathology, independent of its initial cause
Classification of pain

This diagnosis is controversial. Most pain specialists would agree that this is a diagnosis of exclusion. Its prevalence is likely very rare. Not to be confused with the psychological impact that can result from chronic pain.
Assessment tool - OPQRST

- **Onset** – How did it start, gradually or suddenly? What where you doing at the time? Accident? Illness?
- **Provokes / Palliates** – What makes it better / worse?
- **Quality** – Can you describe your pain?
- **Radiates** – Where does the pain go?
- **Severity** – Rate from 0 to 10?
- **Time** – Since when?
Biopsychosocial model

Biopsychosocial model of pain
Championed by Butler and Moseley and others. 2000

https://painisreallystrange.wordpress.com/pain-definitions/
Chronic pain’s vicious cycle

Adapted from Cooper R G et al. Rheumatology 2003;42
Chronic pain can be overwhelming
Strategies to improve pain management
Chronic pain management

- Chronic pain is a chronic disease
- Treating chronic pain ≠ treating acute pain
- Reframe success – Not cure
- Treatment goals need to be defined
- Reduce pain intensity (at least 30%)
- Improve function
Chronic pain management

- Requires complete assessment/reassessment
- Visits dedicated to chronic pain
- Appropriate history and physical examination
- Diagnostic tests dictated by clinical assessment
- Reminder – pain cannot be seen on imaging studies
Chronic pain management

• Complete biopsychosocial assessment
• High prevalence of depression concomitant in chronic pain patients
• Mood disorder symptoms need to be addressed
• Reestablishing sleep needs to be a priority
• Encourage activity
• Involve family
Chronic pain management

• Focus on function

• Set specific goals (SMART)
  • **Specific**
  • **Measurable**
  • **Achievable / Action Oriented**
  • **Realistic / Relevant**
  • **Time-bound**
Chronic pain management

- Highlight progress
- Lots of education (kinesiophobia, catastrophisation)
- Hurt ≠ Harm
- Self management strategies
  - Self management programs (mytoolbox.mcgill.ca)
About My Tool Box

My Tool Box is the MUHC's award-winning Chronic Disease Self-Management Program (CDSMP) and the only Stanford-licensed CDSMP program on the island of Montreal.

About My Tool Box's Chronic Pain Self-Management Program

My Tool Box is proud to deliver the official Stanford-certified Chronic Pain Self-Management Program in the MUHC's territory. We are also a proud partner with the AQDC, which is licensed to deliver this program elsewhere across the province.

Chronic pain can cause severe stress and upset to individuals and their families, changing the way they live on a day to day basis. This evidence-based workshop provides information and coping strategies to help people take control, better manage their pain, work more effectively with health care providers, and improve their quality of life.

The workshops are led by two trained and certified lay leaders. The workshop is delivered in groups of 10-12 participants, once a week for 2 ½ hours, for six consecutive weeks. Participants receive the “Chronic Pain Self-Management Program Workbook” and the “Moving Easy Program” CD which provides a set of easy to follow exercises which can be done in the comfort of your own home.

There is no cost to attend, and excellent reference materials are available. The program is intended for adults experiencing a wide range of chronic pain conditions. Conditions appropriate for this workshop might include musculoskeletal pain, fibromyalgia, whiplash injury, chronic regional pain syndromes, repetitive strain injury, chronic pelvic pain, post-surgical pain lasting longer than 6 months, neuropathic pain, neuralgias, post-stroke or central pain, persistent headache, Crohn’s disease, irritable bowel, and severe muscular pain due to conditions such as multiple sclerosis.
5 Minute video for patients

- [https://www.youtube.com/watch?v=qEWc2XtaNwg](https://www.youtube.com/watch?v=qEWc2XtaNwg) (eng)
- [https://www.youtube.com/watch?v=UWY_WONbd9c](https://www.youtube.com/watch?v=UWY_WONbd9c) (fren)
- Understanding Pain in less than 5 minutes, and what to do about it (available in multiple languages)

- Current research on chronic pain - it's not a joint or muscle problem, rather a 're-wiring' of the brain perception of itself
- Brain has become more sensitive
Tools for initial assessment and follow-up

Few objective signs for evaluating pain

- **Pain level (pain scales)**
- **Type of pain (DN4, LANSS)**
- **Functional impact of pain (BPI, Roland and Morris Disability Scale, Oswestry Disability Questionnaire)**
- **Psychosocial assessment (BDI, PCS, SOPA, TSK)**
PAIN ASSESSMENT TOOL

0: No Pain
1-3: Mild
4-6: Moderate
7-9: Severe
10: Very Severe
10: Worst Pain Possible
Tools for initial assessment and follow-up

• Pain level (pain scales)
• **Type of pain (DN4, LANSS)**
• Functional impact of pain (BPI, Roland and Morris Disability Scale, Oswestry Disability Questionnaire)
• Psychosocial assessment (BDI, PCS, SOPA, TSK)
The total score is calculated as the sum of the 10 items and the cut-off value for the diagnosis of neuropathic pain is a total score of 4/10.
Tools for initial assessment and follow-up

- Pain level (pain scales)
- Type of pain (DN4, LANSS)
- Functional impact of pain (BPI, Roland and Morris Disability Scale, Oswestry Disability Questionnaire)
- Psychosocial assessment (BDI, PCS, SOPA, TSK)
Brief Pain Inventory

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  
   1. Yes  2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.

3) Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.
   0 1 2 3 4 5 6 7 8 9 10
   No pain
   Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.
   0 1 2 3 4 5 6 7 8 9 10
   No pain
   Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the average
   0 1 2 3 4 5 6 7 8 9 10
   No pain
   Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have right now.
   0 1 2 3 4 5 6 7 8 9 10
   No pain
   Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the Past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.
   0% 10 20 30 40 50 60 70 80 90 100%
   Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:
   A. General activity
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
   B. Mood
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
   C. Walking ability
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
   D. Normal work (includes both work outside the home and housework)
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
   E. Relations with other people
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
   F. Sleep
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
   G. Enjoyment of life
      0 1 2 3 4 5 6 7 8 9 10
      Does not interfere
      Completely interferes
Tools for initial assessment and follow-up

- Pain intensity (pain scales)
- Type of pain (DN4, LANSS)
- Functional impact of pain (BPI, Roland and Morris Disability Scale, Oswestry Disability Questionnaire)
- Psychosocial assessment (BDI, PCS, SOPA, TSK)
Pain Catastrophizing scale (PCS)

When I’m in pain …

0 – not at all   1 – to a slight degree   2 – to a moderate degree   3 – to a great degree   4 – all the time

☐ I worry all the time about whether the pain will end.
☐ I feel I can’t go on.
☐ It’s terrible and I think it’s never going to get any better.
☐ It’s awful and I feel that it overwhelms me.
☐ I feel I can’t stand it anymore.
☐ I become afraid that the pain will get worse.
☐ I keep thinking of other painful events.
☐ I anxiously want the pain to go away.
☐ I can’t seem to keep it out of my mind.
☐ I keep thinking about how much it hurts.
☐ I keep thinking about how badly I want the pain to stop.
☐ There’s nothing I can do to reduce the intensity of the pain.
☐ I wonder whether something serious may happen.

...Total
TREATMENT OPTIONS
Multimodal approach

- Non pharmacological treatments
- Medication
- Interventional
  - Injections
  - Surgery
  - Neuromodulation
## Non pharmacological treatments

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<th>Lifestyle</th>
<th>Cessation of tobacco products, weight loss, nutritional counselling</th>
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<tbody>
<tr>
<td>Physical</td>
<td>Exercise, manipulation, physical therapy, stretching and yoga, surgical therapies (nerve blocks, trigger point injections, spinal infusion, or stimulation), TENS</td>
</tr>
<tr>
<td>Psychological</td>
<td>Biofeedback, cognitive behaviour therapy, hypnosis, relaxation</td>
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<tr>
<td>Complementary/alternative</td>
<td>Acupuncture, massage, mindfulness meditation</td>
</tr>
<tr>
<td>Occupational</td>
<td>Occupational therapy, work conditioning programs</td>
</tr>
</tbody>
</table>

Mindfulness for pain

• Patients with chronic pain are often given the message that “you will have to live with this pain”
• Traditional approaches come up short on teaching patients how to live with the pain
• Mindfulness: moment-to-moment non-judgmental awareness, being fully present with what is happening right now. (Kabat-Zinn, J., 1990)
Mindfulness for pain

• Goal is not to change the content of one’s experience, but rather altering the way in which it is experienced.

• Suffering caused by chronic pain comes from the combination of the pain sensation and what it means to the sufferer—how it is interpreted.

• Example: pain in extreme sport may be tolerated better than as a result of a MVA.
Mindfulness for pain

• Mindfulness-Based Chronic Pain Management (MBCPM™)

• Program developed by Dr. Jackie Gardner-Nix, a physician and chronic pain consultant at St Michael’s Hospital, Toronto, Canada

• Based on the Mindfulness-Based Stress Reduction Program (MBSR) originated by Jon Kabat-Zinn

• Developed into a program more customized to the needs of those dealing with chronic pain

• Patient courses (groups) are usually once a week for 12 to 13 weeks, for 2 and a half to 3 hours per session
PHARMACOLOGICAL TREATMENTS
Medications for nociceptive pain (somatic or visceral)

- Acetaminophen
- NSAIDS
- Opioids
- Cannabinoids
- Muscle relaxants
- Antispamamodics
Neuropathic pain – Canadian algorithm

Treatment Guidelines For Treatment of Neuropathic Pain

- TCA ↔ Gabapentin or Pregabalin
- SNRI ↔ Topical lidocaine
- Tramadol or CR opioid analgesic
- Fourth line agents

Add additional agents sequentially if partial but inadequate pain relief

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Figure 1) Stepwise pharmacological management of neuropathic pain.
*5% gel or cream – useful for focal neuropathy such as postherpetic neuralgia (the lidocaine patch is not available in Canada);
†Cannabinoids, methadone, lamotrigine, topiramate, valproic acid;
‡Do not add serotonin noradrenaline reuptake inhibitors (SNRIs) to tricyclic antidepressants (TCAs). CR Controlled-release

### Neuropathic pain – Quebec algorithm

#### 1ère ligne
- Prégabaline
- Gabapentine
- Antidépresseurs tricycliques (ADT) ou tétracycliques
- Anesthésique local

#### 2e ligne
- IRSN
- Cannabinoïdes

#### 3e ligne
- ISRS
- Autre antidépresseur
- Autres anticonvulsivants

#### 4e ligne
- Méthadone
- Kétamine
- Mexilétine
- Baclofène
- Clonidine
- Clonazépam
- À déconseiller
- Mépéridine
- Phénytoïne

**Pour les opioïdes et tramadol:**
Utiliser les courtes actions en 1ère ligne en association avec les autres agents de 1ère ligne en présence des situations suivantes:
- soulagement rapide pendant la titration des agents de 1ère ligne (jusqu’à la posologie efficace);
- épisodes d’exacerbation grave de la douleur / douleur neuropathique aiguë / douleur neuropathique liée au cancer.

Utiliser en 2e ligne en monothérapie ou en association (lorsqu’une utilisation à long terme est envisagée, favoriser l’administration d’agents à longue durée d’action).

Opioid prescribing: a rigorous approach

- CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016


  Review expected 2017
Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

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The Canadian Guideline is presented in two separate documents: Part A (Executive Summary and Background) and Part B (Recommendations for Practice). PDF versions posted on this website are the official Canadian Guideline documents. Web formatted content is the unofficial version of the Guideline. While best efforts have been made to ensure accuracy and consistency with the official documents, if any discrepancies exist in the web format, content of the PDF version shall apply. Please feel free to download the PDF files of the Canadian Guideline documents.

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Overview of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Summary of Recommendations

- Cluster 1: Deciding to Initiate Opioid Therapy
- Cluster 2: Conducting an Opioid Trial
- Cluster 3: Monitoring Long-Term Opioid Therapy (LTOT)
- Cluster 4:Treating Specific Populations with LTOT
- Cluster 5:Managing Opioid Misuse and Addiction in CNCP Patients

*Recommendations Roadmap*

When referencing the Canadian Opioid Guideline use the following format:

http://nationalpaincentre.mcmaster.ca/opioid/

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# Opioid risk assessment tool

**OPIOID RISK TOOL PATIENT FORM**

<table>
<thead>
<tr>
<th></th>
<th>Mark Each Box That Applies</th>
<th>Score if Female</th>
<th>Score if Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse</td>
<td>• Alcohol&lt;br&gt;• Illegal Drugs&lt;br&gt;• Prescription Drugs</td>
<td>✦</td>
<td>1&lt;br&gt;4&lt;br&gt;3</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse</td>
<td>• Alcohol&lt;br&gt;• Illegal Drugs&lt;br&gt;• Prescription Drugs</td>
<td>✦</td>
<td>3&lt;br&gt;5&lt;br&gt;3</td>
</tr>
<tr>
<td>3. Age (Mark Box if 16-45 years)</td>
<td>✦</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of Preadolescence Sexual Abuse</td>
<td>✦</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological Disease</td>
<td>• Attention-Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia&lt;br&gt;• Depression</td>
<td>✦</td>
<td>2&lt;br&gt;1</td>
</tr>
</tbody>
</table>

**Total Score ______ Risk Category______**

- Low Risk 0-3
- Moderate Risk 4-7
- High Risk >7
Multimodal balanced analgesia

- Use of multiple medications
- Different mechanisms of action
- Lower dosing
- Fewer side effects
Pain Algorithms by diagnosis

- Algorithms prepared by interdisciplinary teams of the 4 “centres d’expertise en gestion de la douleur chronique” of the 4 RUIS in 2015

- [http://publications.mssss.gouv.qc.ca](http://publications.mssss.gouv.qc.ca)

- Neuropathic pain
- Low back pain
- Fibromyalgia
- Chronic Regional Pain Syndrome (CRPS)
Pain Algorithms by diagnosis

- Diagnostic criteria
- Diagnostic tools
- Pharmacological options – what to prescribe and how (dosing, cautions, interactions, side effects, cost)
- Non-pharmacological treatment options
- Invasive procedures
- Follow up recommended
- When and where to refer
- Patient resources
SOULèR LOMBaire
Plan de prise en charge interdisciplinaire
1er niveau de traitement

Critères diagnostiques :
A. Selon les critères du guide de pratique CUP. Lombalgie simple, lombalgie avec composante neurologique et lombalgie avec pathologie sacro-iliaque grave suspectée (disques rouges) est tabulaire. (1A)
B. Basé sur les antécédents, les symptômes, l'examen physique et l'évaluation des facteurs psychosociaux.

3. Voir particularités pour :
- Myélopathie : voir l'algorithme de Mc Gill si le patient démontre une instabilité à la marche, une faiblesse, des engourdissements ou une incoordination des doigts.
- Radioscaphie : voir l'algorithme de Mc Gill si le patient décrit de la douleur similaire à la jambe, pour le genou (avec ou sans engourdissements ou faiblesses).
- Claudication et sténose spinale : voir l'algorithme de Mc Gill si la lombalgie est associée à des douleurs intermittentes aux jambes, qui est aggraver par la station debout ou par la marche et qui est soulagée par la position assise.

Présence de signes d'alarme (disques rouges)
Diriger le patient vers le service d'urgence de votre RUIS (niveau tertiaire) pour évaluation et traitement immédiat si :
- Apparition récente d'instabilité ou de douleur lombaire, une lombalgie grave récidive, paraplégie, quadriplégie ou autres signes neurologiques évolués.
- Parésie de pieds isolée, perte de sensibilité, perte de force, absence de sensation tactile, douleur augmentée ou non soutenue par la position couchée, douleur croisée qui se fait pas, contactez le service d'urgence de la colonne de votre RUIS.

Traitement pharmacologique
Interventions non pharmacologiques
(au besoin)

CET ALgorithme de traitement ne se substitue pas au jugement clinique

1A
1B
Complex cases

- Requiring multidisciplinary / interdisciplinary approach
- Network of allied health care professionals
- Specialized programs
- Pain clinics
- Remain active while waiting
- Multidisciplinary education groups
- Rehabilitation centres – adapting to chronic pain
Where and how to refer?

- 4 centres of expertise in chronic pain (by RUIS)

- RUIS Université de Montréal:
  - [http://ruis.umontreal.ca/CEGDC](http://ruis.umontreal.ca/CEGDC)

- RUIS McGill:
  - [https://www.mcgill.ca/ruischronicpain/fr](https://www.mcgill.ca/ruischronicpain/fr)
  - [https://www.mcgill.ca/paincentre/clinicians/refer-your-patient](https://www.mcgill.ca/paincentre/clinicians/refer-your-patient)
• RUIS Université de Sherbrooke
  • http://www.chus.qc.ca/soins-services/douleur-chronique-centre-dexpertise/

• RUIS Université Laval:
  • https://www.douleurchroniquequebec.ca

• Referral form:

• AQDC website (Clinics and rehabilitation programs): http://www.douleurchronique.org/content_new.asp?node=36&lang=en
**REQUEST FOR CONSULTATION - CHRONIC PAIN MANAGEMENT**

**Patient Information**

- Address
- Phone
- Email
- Date of birth
- Gender
- Date of referral
- Referring physician

**Referring physician**

- Name:
- License No.

**Attending physician**

- Name:
- License No.

**Reason for request**

- Date
- Month
- Year
- Reason:
- Referral to pain clinic
- Referral to specialist rehabilitation services
- Medication adjustment
- Other, specify:
- Communications for physical activity? Specify:

**Pain history**

- Cessation of work
- Cessation date
- Year
- Month
- Day
- Type of work:
- Partner:
- Quebec:
- CSST:
- Insurance
- Date of onset

**Circumstances**

- Accident, specify:
- Surgery, specify:
- Illness, specify:
- Other, specify:

**Location and quality of pain (shade affected area)**

- Neuropathic:
- Mixed:
- Vicdine:
- Nociceptive:
- Generalized pain:
- Average intensity over last 7 days:

**Reason for consultation and diagnostic impression(s)**

- Patient's record
- Physician's copy
### Overall physical health

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<th>Disorder</th>
<th>Active</th>
<th>Remission</th>
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<td>Diabetes</td>
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<td>Cardiovascular disease</td>
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<td>Autoimmune disease</td>
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### Overall psychological health

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### Previous Interventions and Investigations

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<th>Medical investigations</th>
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<td>Physical therapy</td>
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<td>Exercise program</td>
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<td>Interdisciplinary rehabilitation</td>
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<td>Psychological treatment</td>
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<td>Other</td>
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### Medication

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<th>Medication</th>
<th>Current</th>
<th>Stopped</th>
<th>Name(s) and prescribed changes of medications tried (please indicate maximum tolerated)</th>
<th>Reason for stopping</th>
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</thead>
<tbody>
<tr>
<td>NSAIDs/Acetaminophen</td>
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<tr>
<td>Antidepressants</td>
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<tr>
<td>Anticonvulsants</td>
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<td>Muscle relaxant</td>
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<td>Other 1</td>
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<tr>
<td>Other 2</td>
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### Anticoagulants

<table>
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<tr>
<th>Anticoagulants</th>
<th>ANT/PLATELETS (except ASA)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Request for Consultation

**Chronic Pain Management**

Date: Year, Month, Day

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*All relevant reports are attached to this request.*

I understand that incomplete requests will be returned. In referring the patient, I undertake to monitor the patient's chronic pain condition during further treatment and follow-up the discharge from the pain clinic. If I am a consulting specialist, I undertake to inform the referring/family physician of this request for transfer to ensure an accurate follow-up with the patient.*

**Referring physician phone**

**Signature**

**Data**

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*REQUEST FOR CONSULTATION*
Some of the resources in rehabilitation centres:

- **Centre de réadaptation Lucie-Bruneau**
  - Clinique d'adaptation à la douleur chronique
  - [http://www.luciebruneau.qc.ca/fr/main_nav/focus_group_programmes/douleur-chronique/](http://www.luciebruneau.qc.ca/fr/main_nav/focus_group_programmes/douleur-chronique/)

- **Constance-Lethbridge rehabilitation centre**
  - Chronic pain self-management program

- **CSSS Cavendish**
  - Low back pain management program
  - [https://www.cssscavendish.qc.ca/en/care-and-services/for-all-ages/lower-back-chronic-pain/b054b9415c7c4ce1b5909e54a1481fe6/](https://www.cssscavendish.qc.ca/en/care-and-services/for-all-ages/lower-back-chronic-pain/b054b9415c7c4ce1b5909e54a1481fe6/)

- **Jewish rehabilitation hospital (Laval)**
  - Programme d’adaptation à la douleur chronique (PADOc)
Multifaceted treatment model
CHUM pain clinic example

Traditional treatment includes: pharmacological, physiotherapy, psychotherapy, trigger points injections, nerve blocks, epidurals, radio frequency, intrathecal pumps, neuromodulation: central and peripheral
Conclusion – Key points

• Chronic pain is a chronic illness
• Reduction in pain intensity (not a cure)
• Improving function (specific objectives)
• Use clinical tools to follow progress
• Multimodal approach
• Biopsychosocial and multidisciplinary approach
• Lots of patient education
• Lots of listening and empathy