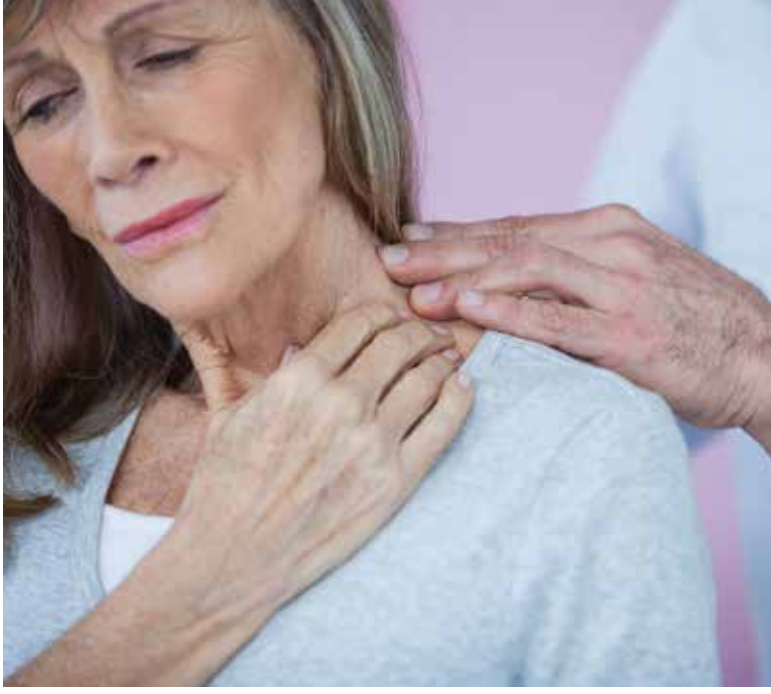
Safely managing chronic noncancer pain in general practice



IAN THONG FFPMANZCA, FRACGP, MB BS, PhD

With the change to the availability of codeine in Australia on 1 February 2018, many patients with chronic pain who have been using over-the-counter codeine are likely to present to their GPs. How should patients with chronic noncancer pain, including those dependent on codeine, be managed?

Pain is ubiquitous, experienced by every person at some time. Acute pain is a symptom, and treatment is usually short term and medically focused. Acute pain may progress in some cases to chronic persistent pain. Chronic pain has many possible causes, including cancer, congenital and degenerative diseases, trauma and surgery. Cancer pain differs clinically from chronic noncancer pain and is not further discussed here.

Chronic noncancer pain is defined as pain that persists beyond the expected time of healing (commonly regarded as three months). It is often classified as nociceptive, neuropathic or a mix of both. Neuroplasticity is a consistent feature. Chronic noncancer pain is commonly associated with psychosocial and environmental factors, emotional distress, physical impairment and sleep disturbances.

Analgesics are routinely used for short-term treatment of acute pain, but their use in patients with chronic noncancer pain is controversial. Nevertheless, many patients take analgesics for chronic pain; they may be prescribed, bought over the counter, borrowed from other patients or purchased illegally. Some patients self-medicate with illicit drugs.

The change to the status of codeine in Australia, requiring a prescription from 1 February 2018, will likely increase use of NSAIDs and paracetamol and also visits to GPs by people with chronic pain. This article outlines a strategy to manage patients with chronic noncancer pain. Use of a chronic disease approach can help us manage chronic noncancer pain effectively and safely. A case study illustrating the use of this strategy in a patient with chronic pain who is dependent on codeine appears in Box 1.

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Dr Thong is a General Practitioner and Pain Medicine Physician in Bathurst, NSW; Medical Director of Central West Pain Specialists; and Chair of the Primary Care Pain Network, Agency for Clinical Innovation, NSW Health, Sydney, NSW.

Assessing a patient with chronic noncancer pain

New patient consultations with a pain specialist are generally 40 to 60 minutes' duration and aim to obtain a detailed history and sufficient information to formulate a comprehensive treatment recommendation (Box 2). In contrast, the first consultation in general practice is nearly always 15 minutes because the patient has booked a routine appointment. This is not enough time for a complete assessment and formulation of a comprehensive treatment plan but is still an opportunity to evaluate the clinical situation, engage the patient and formulate and explain a general plan. The decision whether to start treatment at the first consultation or to wait until a second consultation should be made on clinical grounds.

A longer consultation should be scheduled without delay to allow thorough history-taking, physical examination and psychosocial assessment. The patient should be given a pain questionnaire such as the Brief Pain Inventory (BPI) or PEG Pain Screening Tool to complete before the next consultation (Box 3).[1-4] This questionnaire can help elucidate the history, identify concerns and barriers to a safe appropriate treatment plan that is manageable in general practice and set a baseline for assessing response to treatment.

If the patient's condition is complex then referral to a pain specialist is advisable (Box 4). However, waiting times may be long, and pain specialists may not be available in rural areas. Many pain specialists are happy to offer brief interim phone advice.

History taking

A comprehensive assessment is the foundation of good pain management. The patient should be given time to talk at the beginning of the consultation. They are likely to have been 'rehearsing' in the waiting room. Patients with pain typically want their

1. CASE STUDY: A PATIENT WITH CHRONIC PAIN AND CODEINE DEPENDENCE

Presentation

Claire, aged 48 years and a new patient to the general practice, presents with pain that she has had for years and has been managing with over-the-counter ibuprofen plus codeine tablets. She has heard that codeine will no longer be available without a prescription and would like advice on managing the pain.

Claire has two children and works full time. She does not smoke, is a social drinker, has no concerning health issues and is generally content with life. She takes four to six ibuprofen–codeine tablets most days and eight when she is busy. She started taking the analgesics after a motor vehicle accident 10 years ago that left her with chronic neck pain and daily headaches. She says she would struggle without the analgesics.

How should Claire be managed initially?

As Claire is a new patient, I spend the first few consultations building the therapeutic relationship. This is advisable before attempting to introduce the more challenging nonpharmacological pain management strategies.

At the initial consultation, I spend a few minutes clarifying the history of the pain, the injury and symptoms, and then focus on how the pain affects her life. I also consider red flags. Claire has no history of unexplained weight loss or fever and no worrying abnormal pain or behaviours suggesting drug misuse. By the end of this 20-minute consultation, I provide Claire with a prescription for codeine with ibuprofen, advise her how to take the medication and explain that this is a limited supply because I have concerns about her taking codeine and ibuprofen long term.

I also arrange for a follow-up appointment in a few days, explaining that this will be a long consultation to perform a full examination and take a further history. I give Claire a Brief Pain Inventory questionnaire to complete at home before her next visit; this is a simple way to establish a baseline to monitor pain, progress and treatment response.

What is the next step?

At the next consultation, I take a more detailed history of Claire's headaches and conduct a physical examination, including the neck, shoulders, arms, spine, cranial nerves, eyes and temporal arteries. I explain my findings to Claire before proceeding. The history and examination clarify the source and nature of the pain (nociceptive, functional, neuropathic, radicular or muscular). I also explain why I did not order any imaging at this time.

I administer the Depression, Anxiety, Stress Score (DASS) questionnaire and, to assess the risk of drug dependence and addiction, the Opioid Risk Tool (ORT) questionnaire.

I spend a few minutes explaining the role of medications and their place in treatment. I describe the disadvantages of codeine in treatment of pain and suggest a trial of a long-acting opioid (morphine, oxycodone or transdermal buprenorphine) that will provide more consistent relief than codeine. I change ibuprofen to celecoxib, which requires once daily dosing and causes less gastric irritation. I introduce Claire to the videos about pain management on the NSW Agency for Clinical Innovation (ACI) website and suggest she watch one or two at home (Box 5, https://www.aci.health.nsw.gov.au/chronic-pain/for-everyone). Each video runs for about five minutes and describes an aspect of pain management. This is an easy way to introduce a patient to pain management education.

I schedule a follow-up consultation to review Claire's progress.

How should Claire be followed up?

At Claire's next visit, I talk about some of the concepts presented in the ACI videos and ask her thoughts. Claire, like many other patients, has not started watching the videos as she says she has been too busy. However, she is happy to watch the first video and discuss it during the consultation. It describes how the pain 'message' is augmented with time.

I then introduce the concept of nonpharmacological pain management. I show her how the brain and other central neurophysiological systems process pain messages and explain how through the same nerves, we can reduce pain with our thoughts, mood, relaxation, cognitive therapy and exercise. Regular exercise is as important as cognitive techniques, and improving mind and body 'fitness' reduces pain, lessens medication use and improves overall wellbeing. Chronic pain is recognised as a chronic disease in NSW, so I offer Claire a GP Management Plan and Team Care Arrangement to consult a physiotherapist or exercise physiologist. If required, she could see a psychologist with a Mental Health Treatment Plan (availability varies between jurisdictions).

What reviews are needed?

I schedule regular follow-up reviews for Claire at fortnightly to monthly intervals. At each review, I assess the five As (activity, analgesia, adverse effects, aberrant behaviours and affect [mood]); this is an effective and structured way to monitor progress, medication use, mood and function (Box 3). Over several consultations, I build on Claire's knowledge of the nonpharmacological strategies and introduce a plan to wean the medications. Claire is willing to reduce and finally stop the pain medications and achieves this over several months. This is not always the case, and success stopping analgesics depends on the patient's pain condition, personality and expectations.

Discussion

Claire's situation is common. Many patients self-medicate with over-the-counter medications such as codeine, paracetamol and NSAIDs. The codeine restrictions starting on 1 February 2018 raise two concerns: more patients presenting for codeine scripts, and more use of over-the-counter paracetamol or NSAIDs, increasing the risk of kidney, liver and heart morbidity.

Pain management is challenging medicine. Clinicians are always pushing the 'cart up the hill', contradicting established thoughts, beliefs and therapeutic expectations. Many patients with pain expect medications, scans, surgery or injections. Some want a cure, and others expect lifelong medications. However, long-term analgesic medications are not recommended to treat patients with simple mild or moderate chronic pain and should be used cautiously in those with severe persistent pain. Imaging scans do not diagnose pain, and results can sometimes be misleading. Surgery generally does not stop pain and can worsen it. Pain intervention treatments such as injections usually provide only temporary relief. An emphasis on education of patients, self-management and changing the way they manage with chronic pain is essential to care. Our role as health professionals is to help the patient learn and adopt more effective ways to live with persistent pain.

2. ASSESSING A NEW PATIENT WITH CHRONIC NONCANCER PAIN

General medical history
- Pain: site and radiation, onset, character, type (nociceptive, neuropathic or mixed), effect on function and sleep
- Medical and surgical history: concurrent and past diseases, surgery and trauma (physical or emotional)
- Medications: current and past analgesics and adverse reactions, other medications including over-the-counter and complementary medications

Physical examination
- Sites of pain, movement and restrictions, functional limitations
- For nociceptive pain: nature, radiation, physical limitations
- For neuropathic pain: nature, radiation, sensitisation (hypersensitivity or reduced sensation, altered proprioception)
- Red flags (e.g. history or clinical features of cancer, trauma, systemic disease, fever, intravenous drug use)
- General neurological and musculoskeletal examination

Psychosocial assessment

Psychological history
- Anxiety, depression, personality type
- Psychiatric disorders
- Impact of pain on person and function
- Psychoactive medications

Social history
- Relationships, children, living arrangements
- Employment (past and present) with a focus on nature of work
- Responsibilities (e.g. carer for parent or child with disability)
- Finances
- History of trauma or abuse

Substance use
- Smoking, alcohol
- Illicit substance use (present and past)
- Addiction assessment (Opioid Risk Assessment Tool)

Legal matters and forensics
- Compensation claims
- Involvement in crime, time in gaol, criminal charges

Formulation of diagnosis and treatment plan
- Type of pain
- Cause and diagnosis (if possible to determine)
- Treatments: physical, psychological, education
- Medications and interventions
- Investigations (if there are red flags or a diagnosis that relies on test results or referral to a physician or surgeon is being considered)
- Plan and follow-up arrangements

3. SELECTED TOOLS FOR ASSESSING PATIENTS WITH CHRONIC PAIN*[1-4]

- Brief Pain Inventory (BPI): assesses pain severity and interference; used for initial assessment, reviews and monitoring
- PEG Pain Screening Tool: assesses and monitors pain over time[1]
- Depression, Anxiety and Stress Scale (DASS 21): measures anxiety, depression and stress
- DN4 Questionnaire: estimates the probability of neuropathic pain
- Pain Self-Efficacy Questionnaire (PSEQ): predicts pain-related disability and loss of confidence[2,3]
- Opioid Risk Assessment Tool: indicates risk of aberrant behaviours[4]
- 5 As – Opioid Therapy Monitoring Tool: reviews opioid therapy outcomes

* These tools are available on the website of the NSW Agency for Clinical Innovation (https://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/assessment).

story to be heard and are often afraid of being pre-judged. Listen to the story, reflect and clarify the issues. Try to develop a therapeutic alliance that can promote self-management and steer the patient away from relying on medications, surgery, interventions and a 'quick fix'.

Essential elements of the history for patients with chronic noncancer pain are listed in Box 2. The history should include medication and other substance use and an addiction assessment with the Opioid Risk Assessment Tool, which is a brief, self-reported screening tool that can assess risk of aberrant use of medications and other substances (Box 3). In addition, gently ask if they have ever been on an opioid treatment program. Other useful standard questionnaires to assess depression, anxiety and stress, the probability of neuropathic pain and pain-related disability are also shown in Box 3. Further useful resources for GPs managing patients with chronic noncancer pain are listed in Box 5.

Physical examination

A physical examination is always important, and imaging rarely provides the whole story. The examination should explore the nature of the pain, the areas affected and the patient's perception of the pain. This helps the clinician understand the nature of the pain and its impact on function. Clinical documentation is important to assess progress and response to treatment. Ask the patient to keep a pain diary, another useful monitoring tool.

Imaging and other investigations

Imaging and other investigations are second to clinical history-taking and physical examination in diagnosis and management of chronic noncancer pain. Studies consistently show that imaging confirms clinical suspicion and is less reliable as a diagnostic tool for pain.[5] However, imaging may be warranted early in the assessment if a red flag is suspected.

Treatment of a patient with chronic noncancer pain

Formulation of a treatment plan

A holistic approach to management of patients with chronic pain includes education, identifying psychological and social issues, providing support, encouraging physical conditioning and self-management, and minimising reliance on medication use, with weaning whenever possible. These elements should be formulated into a comprehensive treatment plan (Box 2).

The treatment plan should be explained to the patient. It is also useful to give the patient a brief letter summarising the plan and instructions about any medications.

4. WHEN TO REFER A PATIENT TO A PAIN SPECIALIST

- Pain fails to respond to usual recommended treatment
- Patient is taking a regular opioid dose equivalent to 100 mg oral morphine per day or more
- Patient is a long-term regular user of opioids for pain
- Patient has complex pain syndrome or pain due to a combination of conditions
- Patient has a complex medical history or comorbidities with potential drug interactions or adverse effects
- Patient has coexistent psychological or psychiatric conditions, especially if these conditions potentially cause misuse of analgesic medications
- There are concerns that the patient is misusing prescription or illicit drugs for pain or is noncompliant with a treatment agreement
- Patient has a current or past history of drug dependence or addiction

Patients often forget aspects of the consultation and some are confused by the medications. Clear written instructions resolve these problems. Note that this letter can in rare instances be used by patients for 'doctor shopping'. Including your contact details in the letter can help prevent this.

Pharmacological treatment

Pharmacological treatments for pain include simple analgesics such as NSAIDs and paracetamol. Renal and cardiac risks should be considered before NSAIDs are prescribed. Paracetamol is more effective for chronic pain when taken regularly rather than as required, as stable therapeutic levels are achieved.

There is no evidence supporting the use of opioids to treat chronic noncancer pain, and the decision to prescribe an opioid for pain must be carefully considered, with an assessment of the medical and psychosocial risks versus benefit. A plan to wean or cease the opioid should be part of the treatment plan. Short-acting opioids such as codeine are generally not recommended for chronic pain because of the fluctuation in serum levels between doses, which precipitates opioid withdrawal symptoms. These unpleasant feelings are relieved by taking more medication, which can lead to overuse and dependency. Codeine analgesia also varies between individuals because of genetic variability. Low-potency opioids include tramadol and tapentadol, which are available in sustained release formulations. Stronger full mu opioid agonists include morphine, oxycodone, buprenorphine, fentanyl and hydromorphone.

If a clinician decides to prescribe an opioid to treat chronic pain then a treatment agreement with the patient should be prepared that includes dosing, prescriber, dispensing pharmacy, planned regular reviews and a plan to wean and cease the opioid if it is ineffective or early signs of dependence or worrying adverse effects emerge (see below). Starting 'low and slow' with dosing may help avoid adverse effects and makes it easier to stop if any occur. Before prescribing an opioid, also consider potential drug interactions (e.g. with antidepressants and benzodiazepines). An oral opioid should not be prescribed for a person with known addiction (e.g. they are or have been in an opioid treatment program). If uncertain, the clinician should contact the state or territory pharmaceutical regulatory authority.

Other pharmacological treatments to consider as adjuvants for neuropathic pain include tricyclic antidepressants (first line) and gabapentinoids (second line). Antidepressants, antiepileptics, muscle relaxants, antihypertensives, antiarrhythmics, corticosteroids and bisphosphonates can also be considered as adjuvants for specific indications. GPs should seek advice from a pain specialist if uncertain.

Antidepressants such as amitriptyline, duloxetine and venlafaxine prescribed for depression sometimes help with neuropathic pain. Other antidepressants have not been shown to alter neuropathic pain. Amitriptyline is sometimes prescribed with a selective serotonin reuptake inhibitor or serotonin–noradrenaline reuptake inhibitor when anxiety and depression coexist with neuropathic pain. Serotonergic symptoms are a concern with this combination, but the risk is low at the amitriptyline doses prescribed for pain (10 to 50 mg). The risk increases if either medication is prescribed at a high dose.

Benzodiazepines are not recommended in combination with opioids because of drug interactions and the risks of sedation and dependence.

Patients should be warned about the adverse effects of the different medications. Driving is a common concern, and the best advice is not to drive if the medication causes sedation or cognitive impairment.

5. USEFUL RESOURCES FOR GPS MANAGING PATIENTS WITH CHRONIC PAIN

- NSW Agency for Clinical Innovation (ACI) Pain Management Network: provides resources on pain for patients, family and health professionals, including youth-specific resources (https://www.aci.health.nsw.gov.au/chronic-pain)
  Resources include:
  - Chronic Pain Toolkit for Clinicians: includes the patient assessment tools listed in Box 3 (https://www.aci.health.nsw.gov.au/chronic-pain/health-professionals)
  - pain education videos (https://www.aci.health.nsw.gov.au/chronic-pain/for-everyone)
  - consumer books about pain (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0017/212930/Pain_Book_List.pdf)
- Faculty of Pain Medicine: free opioid calculator app to calculate dose equivalence of opioid analgesic medications (http://fpm.anzca.edu.au/front-page-news/free-opioid-calculator-app)
- NSW Health application forms for authority to prescribe (http://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/Application-Forms.aspx)

Other adverse effects of pain medications include QTc prolongation caused by tricyclic antidepressants and methadone. When drug interactions or adverse effects are of concern, a useful resource is the hospital or local pharmacist.

If a medication is required to treat pain and proves useful then the clinician should record the benefit (e.g. function, mood and sleep) and concerns (adverse effects, mood and misuse) and conduct regular routine reviews. Although analgesia efficacy is routinely recorded with a numeric rating scale, this is still a subjective measure.

Treatment agreements

A treatment agreement is a collaborative arrangement between a clinician and a patient to safely prescribe a drug that carries a risk of dependence, tolerance or addiction. It is not a legal document or 'contract', and this term should be avoided as it can undermine the therapeutic relationship. A treatment agreement should not be a barrier to appropriate care. Agreements should be individualised (e.g. it would be unacceptable to expect an older patient of good reputation to undergo regular urine drug screening).

A treatment agreement includes:

- an undertaking to take the medication as prescribed, using one prescriber or practice and one dispensing pharmacy (I also insist that all used fentanyl patches are returned to the dispensing pharmacy for safe disposal)
- an undertaking to attend regular appointments for scripts; this allows:
  - regular review of the medication's benefits, adverse effects, safe use and drug interactions
  - opportunities for pain management education, counselling and progression to nonpharmacological pain management strategies
  - assessment and management of psychological health concerns and social worries
- a plan to wean the medications if they are ineffective or causing side effects
- clear medical documentation and instructions for other doctors in the practice (for when you are away).

Other possible elements include:

- regular checks with the Prescription Shopping Program and the state or territory pharmaceutical regulatory authority (e.g. Pharmaceutical Service Branch)
- regular review of the use of other drugs, such as over-the-counter analgesics, borrowed medications and illicit substances
- a urine drug screen.

Injections and other interventions

Interventions for pain such as injection of a corticosteroid or botulinum toxin and nerve stimulation have specific indications and are provided by specialists.

Facet and epidural corticosteroid injections may provide relief in certain circumstances, but the benefit is always temporary. Pain specialists may consider spinal cord stimulation.[6] Spinal cord stimulation and peripheral nerve stimulators have been shown to have a limited role in the treatment of neuropathic pain and migraine. Botulinum toxin injections have been shown to help some people with migraine.[7] The benefit of platelet-rich plasma and prolotherapy injections is unclear.[8,9] The evidence supporting complementary therapies to treat chronic noncancer pain is inconclusive. Evidence supporting medicinal cannabis is also limited.[10,11]

Psychological care

Psychological and social issues affect pain perception, thoughts, behaviours, expectations, beliefs and function and should be explored. Psychological care starts with the GP. The psychologist's role is to support the GP, providing expertise in cognitive therapy and other cognitive self-management techniques.

Patients with chronic pain can access Medicare-rebatable sessions with a psychologist through a Mental Health Treatment Plan that includes 'pain with malaptive thoughts and behaviours' in the diagnostic list. Recommended psychological treatments for patients with chronic noncancer pain include cognitive therapy, thought and behaviour management despite persistent pain. If available, mindfulness, meditation, relaxation and sleep techniques can be helpful. Some patients benefit from relationship or family counselling.

Cognitive and physical therapies

The safest treatments for chronic noncancer pain are nonpharmacological strategies, including cognitive and physical therapies (Box 1). These focus on education, understanding of the condition, self-management, improving fitness, pacing, management of thoughts, mood and sleep, and desensitisation to activity despite pain. Unlike medication, these strategies require an investment of time, usually with gratifying results.

Follow-up pain consultations

Follow-up pain consultations should be routine practice for patients with chronic noncancer pain. Prioritising a pain consultation prevents pain becoming a last-minute addition to another consultation. Pain management is a psychosocial, biomedical, pharmacological and educational task that requires time.

Follow-up reviews assess the five As: activity, analgesia, adverse effects, aberrant behaviours and affect. GPs should enquire about the pain and its impact on daily life. The history will often include a discussion of mood, self-esteem, the stigma of pain, financial burden and relationships. Each review is an opportunity to explore the person's understanding of their pain. Help them understand that getting better involves activities such as exercise, good diet and thought management.

Management tips

Telephone and corridor consultations

Patients sometimes telephone for advice and prescriptions. I discourage this, especially telephone requests for a prescription. The need for the medication is difficult to assess in a telephone call, and it is a lost opportunity to provide pain education and an inadequate way to monitor use of

6. PRACTICE POINTS ON MANAGEMENT OF PATIENTS WITH CHRONIC NONCANCER PAIN

- Assess and treat patients with chronic noncancer pain using a psychosocial and biomedical approach.
- A holistic approach to chronic pain includes education, identifying psychological and social issues, providing support, encouraging physical conditioning and self-management, and minimising reliance on medication use, with weaning whenever possible.
- Base the decision whether to use an analgesic on the disease, the patient's wellbeing and risks.
- Patients with chronic noncancer pain generally do better with regular assessment, continued education and regular review of treatments.
- Take every opportunity to engage the patient in education and self-management strategies.
- For a treatment agreement to be most helpful, deliver it in a therapeutically engaging way.
- Refer the patient to a pain specialist if their condition is complex, difficult or refractory to treatment or they are opioid-dependent.
- Keep good records of all encounters (including phone and corridor consultations), treatments and specialist involvement to optimise treatment and minimise risks.

medications, especially opioids. If patients have regular scheduled reviews then telephone requests are rare. Corridor consultations between doctors and colleagues and between doctors and patients are common. If advice is provided then it is important to document it. I am often impressed how often a patient remembers a passing comment or advice.

Record keeping

To help your colleagues when you are away, keep a clear clinical record of the patient's medical history, medications and treatment plan in the medical record system. If you plan to be away then arrange for a specific doctor to take your place and provide a concise summary of the medical history, current medications and prescribing instructions either on the computerised medical record system or as a printed outline. This will significantly reduce distress for the relieving doctor and the patient. Your clinical record should accurately reflect what you are treating, when you prescribe, what you prescribe and the name of any pain specialist or drug and alcohol specialist involved in the patient's care and the dispensing pharmacy. The clinician's clinical records should also include the latest blood test results, latest Prescription Shopping Programme check and any urine drug screen results.

Family involvement

Sometimes it is useful to involve a carer or family member in the patient's care. Invite them to pain education sessions, as they usually benefit from these. Family members who accompany the patient to consultations can be educated as well as updated on the patient's progress.

When to refer

Consider referring patients with chronic pain to a pain management program. These are always useful, especially if patients have complex issues or you feel they would benefit from the expertise of a multidisciplinary team.

Referral to a pain specialist is advisable when the patient's clinical situation is refractory to usual general practice care. Other circumstances when a referral may be required are listed in Box 4. It is always appropriate to refer a patient with chronic pain if, for any reason, you feel uncomfortable treating the patient.

A person with chronic pain and proven addiction has two referral pathways: to an addiction specialist or a pain specialist. Pain specialists usually offer to share care with the GP and also refer patients to addiction specialists for advice when required.

Conclusion

The recommendations described above are becoming standard practice in pain management. Some practice points for GPs managing patients with chronic noncancer pain are summarised in Box 6. It is important to document all consultations, including telephone and corridor consultations. Keep an accurate record of prescriptions (easy with today's software), referrals and other letters. Contact or refer the patient to a pain or addiction specialist if further advice is needed. Most pain specialists are happy to offer simple advice on the telephone. A shared care model between a GP and a pain specialist is an effective way to deliver good chronic pain care. MT

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