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PRIMARY CARE

In Chronic LBP, Outcomes Unchanged By Provider Specialty

BOSTON—Outcomes are equivalent in patients with low back pain whether they saw pain management specialists or transitioned from specialists to their primary care doctors, according to researchers.

A recent prospective, randomized clinical trial enrolled 60 subjects with nonstructural, nonspecific chronic low back pain (LBP) and randomly assigned them to one of two treatment groups of 30. One group was treated by pain management physicians and the other was treated by each individual patient's own primary care physician (PCP). Both groups were treated at three-month intervals over a six-month period.

The study, presented at the 2017 annual meeting of the American Society of Anesthesiologists (abstract A4021), considered whether back pain patients who transition from pain

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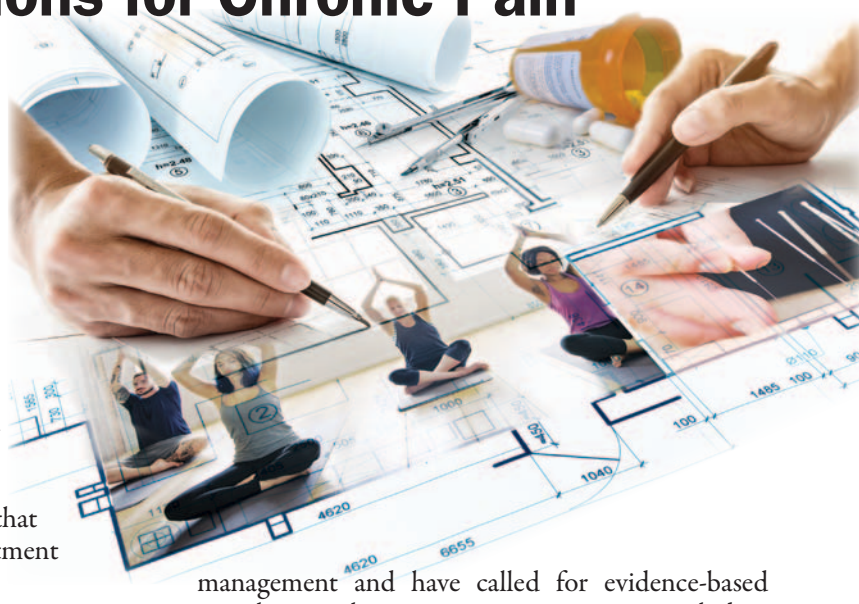
White Paper Assesses Nonpharmacologic Treatment Options for Chronic Pain



A newly issued white paper by the Pain Task Force of the Academic Consortium for Integrated Medicine and Health responds to calls for evidence-based nonpharmacologic pain treatment options by weighing the available evidence and recommending proven interventions.

The document, "Evidence-Based Nonpharmacologic Strategies for Comprehensive Pain Care" (www.nonpharmpaincare.org) was released in December, days before the Jan. 1 implementation of the Joint Commission's revised pain standard that requires nonpharmacologic pain treatment options as a scored element.

The consortium is a North American institutional member organization comprising 72 academic medical centers and health systems.

In addition to the Joint Commission, the task force points to the breadth of agencies and associations that have identified a crisis in current pain care management and have called for evidence-based nonpharmacologic treatment options, including the National Institutes of Health, National Academy of Medicine, FDA, American College of Physicians and CDC. It also notes that 37 state attorneys general have now appealed to America's Health

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OnabotulinumtoxinA Injections Greatly Minimize Chronic Migraine in Children

BOSTON—OnabotulinumtoxinA injections substantially reduced intensity, frequency and duration of migraines in children. The study was the first to evaluate the drug solely for chronic migraine in children, rather than for generalized headache pain.

A major advantage of onabotulinumtoxinA (Botox, Allergan) is that it doesn't sedate, unlike alternative medications for migraine treatment, said principal investigator Shalini Shah, MD, chief of the Division of Pain Medicine and director of pain services at UC Irvine Health, in Orange, Calif.

"They are more able to concentrate in school and less likely to feel tired, as well as less likely to become addicted or dependent on opioid medications," Dr. Shah said.

OnabotulinumtoxinA is approved by the FDA for migraines in adults, but is not approved for prevention of migraines in children. "Despite being safe in children, the vast majority who present to a physician with migraine don't get prophylactic therapy," said co-author Michael-David Calderon Jr., BS, a research specialist in the Department of Anesthesiology and Perioperative Care at UC Irvine Health, who presented

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POLICY & MANAGEMENT

WHITE PAPER

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Insurance Plans, a national political advocacy and trade association, to recognize and provide incentives for evidence-based nonopioid treatments for pain.

"Transforming the system of pain care to a responsive comprehensive model necessitates that options for treatment and collaborative care must be evidence based and include effective nonpharmacologic strategies that have the advantage of reduced risks of adverse events and addiction liability," the task force stated in announcing the release of the white paper.

Changing Pain Care Practice

The lead author of the paper, Heather Tick, MD, MA, clinical associate professor and Gunn-Loke Endowed Professor for Integrative Pain Medicine in the Departments of Family Medicine and Anesthesiology & Pain Medicine, University of Washington, in Seattle, discussed the challenges in transforming the current system of pain care with *Pain Medicine News*.

"The goal of this white paper is to present the case for changing the way pain care is practiced," Dr. Tick said. "There are two parts to this. First is to level the playing field so all potential practices are judged by their evidence and not by the use of arbitrary labels, such as 'complementary,' 'alternative' or 'conventional' in a way that is prejudicial. We need to be open to different forms of treatment based on the evidence of effectiveness—both short- and long-term, the safety, costs and acceptability to patients.

"Second, the change is more than substituting one set of practices for another. The change also requires a patient-centered approach that is a different way to practice medicine. The pursuit of health becomes the focus instead of merely the relief of symptoms; and team-based collaborative care with the patient and their significant supporters are central figures in the plan."

In the "Call to Action" section, specific steps are proposed to implement the two-pronged approach described by Dr. Tick. The stated goals are to:

- increase awareness of effective nonpharmacologic treatments for pain;
- train health care practitioners and administrators in the evidence base of effective nonpharmacologic practice;
- advocate for policy initiatives that remedy system and reimbursement barriers to evidence-informed comprehensive pain care; and
- promote ongoing research and dissemination of the role of effective nonpharmacologic treatments in pain, focused on the short- and long-term therapeutic and economic impact of comprehensive care practices.

Recommending Proven Interventions

The task force drew on systematic reviews and meta-analyses to assess nonpharmacologic interventions. The evidence-based therapies found to be safe, effective and opioid-sparing are recommended as integral components of comprehensive pain care.

"We chose to cover areas with high levels of evidence from systematic reviews, so consensus [within the task force] was not difficult," Dr. Tick said. "The urgent need was to provide information for stakeholders who are making decisions in order to stay compliant with the Joint Commission mandate of Jan. 1, 2018. We wanted to ensure that decision makers know that there are good options out there for [nonpharmacologic] practices to include that are safe, effective and have been used extensively."

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—Heather Tick, MD, MA

The task force noted that the nonpharmacologic interventions have the advantage of involving patient participation and commitment to self-care, which is less likely to occur with medication-based pain management. "Increased self-efficacy in managing pain often accompanies nonpharmacologic pain care, and correlates with improved mood and predicts improved outcomes in many chronic conditions, including pain," the white paper stated.

Although most of the evidence on nonpharmacologic interventions has accrued in the management of chronic pain, these approaches also have been found to be effective in reducing acute pain. The somatic interventions of acupuncture and massage therapy were found to reduce postoperative pain, and have had application in some cases of acute, nonsurgical pain. In addition to efficacy, the task force found both therapies to have high levels of safety when performed by appropriately trained practitioners.

Among mind-body–directed therapies, music therapy has been related to reduced postoperative pain, with examples including burn patients and post–cesarean delivery pain. Suggestive techniques and guided imagery have also been useful in alleviating postoperative pain, especially in minor surgeries, according to the task force. Virtual reality–assisted distraction that immerses the patient in a computer-simulated, 3-D environment, can distract from pain, and—coupled with standard analgesia—has effectively reduced burn pain and burn wound care pain.

Pain related to cancer is often considered too severe and unremitting to manage using nonopioid treatments, but the task force found evidence that these interventions can be helpful to these patients, too. It cites the American Society of Clinical Oncology clinical practice guidelines, which indicate that acupuncture has effectively reduced pain as well as alleviates side effects of radiation therapy, including dysphagia.

Massage therapy has been found to be useful in reducing metastatic bone pain, pain in children with cancer, and those undergoing stem cell transplantation. Mind-body–directed therapies have been used to benefit a range of patients, including those with breast cancer. In a large systematic review with meta-analysis, music therapy demonstrated improvement in cancer pain, emotional distress from pain, and a small but statistically significant reduction in anesthetic and analgesic use.

Movement therapies that have been found to be increasingly useful in managing chronic pain include therapeutic yoga, tai chi, and a range of practices including Pilates, Alexander technique (AT) and Feldenkrais. The task force pointed out that these therapies share features of touch, directed exercise, strengthening, and awareness of posture and muscle utilization.

Self-efficacy, a psychological construct based on social cognitive theory, may not only be enhanced with application of nonpharmacologic interventions but is the objective of lifestyle behavior programs that target healthier choices in nutrition, activities, emotional disposition and outlook. "Though pain-specific studies are scarce," the task force acknowledged, "there are many studies that document the relationship of healthy behaviors to improved overall health and a reduction of disease, such as diabetes, atherosclerosis and obesity."

Dr. Tick told *Pain Medicine News* that even though the white paper provides good options to stakeholders, much work remains to be done to change how pain care is delivered. "Well intentioned though they may have been, the strategies of pain treatment have caused considerable harm. There is the will to overturn decades of unquestioning adherence to standard care that lacked evidence."

—Kenneth Bender