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Editors:
Ade O Adebajo FRCP(Glasgow)
D John Dickson MBChB FRCP(Glasgow) FRCP(London) MRCGP

These reports are produced under the direction of the arc Education Sub-Committee.
They were first published individually between 2000 and 2003 and were subsequently reviewed for this volume.
• Chronic pain is a distinct diagnosis, encompassing all sites and causes of long-term pain
• Chronic pain is common and important in primary care
• The effects of chronic pain are far-reaching, and are at least as important as its cause
• General practitioners (GPs) have a crucial role in assessing and managing people with chronic pain, treating its effects to limit disability and maximise patients’ potential
• Assessment and management must be multidimensional and rehabilitative, and agreed, realistic treatment goals are important
• Acknowledging the diagnosis of chronic pain is a simple, yet important, step in its management

INTRODUCTION
Chronic pain presents a major challenge to primary care. It is a symptom associated with many of the common primary care conditions, but it may also be regarded as a distinct entity. It stimulates a huge number of prescriptions, investigations and referrals, causes frustration in its resistance to treatment, and leaves patients and doctors with low expectations of successful outcomes. It is often seen as the side-effect of a ‘more interesting’ condition (such as a connective tissue disease), or an inevitable part of the ageing process. Its lack of outward sign may even lead to assumptions about the veracity or severity of reported symptoms or a search for other gain (such as social security benefits). Yet research shows that chronic pain is common and important, may be preventable, and that general practitioners (GPs) and their colleagues in primary care have an important role in its management. Individuals with chronic pain use the primary care services up to five times more frequently than the rest of the population.

DEFINITIONS
Pain of any kind is difficult to define, in view of its subjective nature. The most commonly accepted definition is that of the International Association for the Study of Pain (IASP) which acknowledges the multifactorial nature and the importance of individual interpretation and experience:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described by the patient in terms of such damage.¹

The IASP goes on to define chronic pain as:

Pain which has persisted beyond normal tissue healing time.²

‘Normal tissue healing time’ is taken (arbitrarily) to be 3 months. This apparently simple definition introduces the notion of the maladaptive nature of chronic pain. The difference between acute and chronic pain is more than one of semantics or of an arbitrary transition point; chronic pain is not just acute pain that has lasted a long
time. From the GP’s viewpoint it is important that, while treatment of acute pain tends to focus on its cause, with a view to a cure, treatment of chronic pain must also focus on its effects, with a view to limiting disability and maximising potential.

Classification of chronic pain is difficult, and is often based on the site or cause of pain. While there are clearly important diagnostic and treatment distinctions between many causes of chronic pain, there are also many similarities, and the severity of chronic pain may be more important than the cause. This article addresses chronic pain as a distinct diagnostic concept, which includes pain arising from all sites and causes. This approach allows important consideration of the experience and needs common to all sufferers, encourages practical consideration of the effects of chronic pain, and proposes the adoption of common management strategies. It also circumvents difficulties with vague or impossible diagnoses, and with pain arising from multiple causes or sites.

**EPIDEMIOLOGY OF CHRONIC PAIN**

Chronic pain is commoner than many might think. A World Health Organization (WHO) study across fifteen countries estimated a prevalence of 22% among primary care attenders, and a literature review of community-based studies found a prevalence of 15%. More recent work in the UK estimated the population prevalence as high as 46%. Although these high figures undoubtedly include many in whom the condition is relatively mild, a reasonable consensus is that the prevalence of severe disabling chronic pain is between 5% and 10%. There is consistent evidence that older individuals and those in lower socio-economic groups are more likely to be affected, and an inconsistent suggestion that women are at greater risk. The presence of other psychosocial characteristics, such as depression or deficient social support, has also been shown to be associated with chronic pain, and may provide clues to treatment or prevention. A relative lack of longitudinal research renders it difficult to distinguish between cause and effect with many of these associations. Newer evidence is emerging to support the intuitive impression that recovery from chronic pain is rare: once an individual has developed chronic pain, he or she is likely to keep it. This fact requires us to be realistic in our management objectives, and emphasises the importance of prevention.

**THE IMPACT OF CHRONIC PAIN**

Although the experience of chronic pain is subjective, it has a wide-ranging impact that must be appreciated by primary care professionals. Chronic pain detrimentally affects all aspects of physical health, not only those directly related to the underlying cause. It is associated with significant disability, unemployment and loss of other physical roles. These produce social and financial problems, which include reduced earning capacity, family disharmony and isolation. The interaction between chronic pain and depression has been well-demonstrated, and it is likely that ‘bi-directional’ causal mechanisms are at play. Other psychological consequences include reduced self-esteem, anxiety and sleep disturbance. Recent research has suggested a higher mortality, particularly from cancer, among people with widespread benign pain.

**DIAGNOSIS AND ASSESSMENT**

A diagnosis of chronic pain (despite the arbitrary component – see above) is often crucial. There is evidence to suggest that patients who accept their pain’s chronicity, rather than continue exclusively to seek relief or cure, fare better with therapeutic intervention. Retrospectively, many patients report that the moment when their doctor diagnosed chronic pain (or used an equivalent term) was the moment when acceptance and a degree of resolution began. It is, of course, important also to diagnose and assess any other treatable condition, such as rheumatoid arthritis or endometriosis; this diagnosis and consequent treatment will be undertaken using the usual channels of assessment, investigation and (where appropriate) referral. It is equally important, however, to consider chronic pain as a distinct diagnosis, to allow for both otherwise undiagnosed conditions and the fact that many ‘treatable’ conditions produce persistent pain symptoms, which may ultimately become the most significant and disabling aspect.

The severity of chronic pain is again difficult to assess, given its subjective nature. Nonetheless, several useful tools have been devised, and some may be useful in the context of primary care. The Chronic Pain Grade, for example, provides four hierarchical grades of severity based on pain intensity and pain-related disability, from Grade I (low intensity–low disability) to Grade IV (high disability–severely limiting). This simple, seven-item questionnaire is responsive to change over time, and could be used to judge the relative need for treatment as well as its success. Perhaps 16% of sufferers have the most severe grade of chronic pain.

A full assessment of chronic pain must be multidimensional (physical, psychological, social), and may, at its worst, require admission to a specialist centre in view of the breadth and depth of potential impact. Local hospital pain management clinics will also provide multidimensional assessment with a view to management. However,
the high prevalence of chronic pain means that the majority of sufferers must be assessed in primary care. With his/her knowledge of and access to patients’ medical and social histories, the GP is uniquely placed to assess chronic pain patients appropriately. This is part of the specialist discipline of general practice. This assessment will often be informal, will be conducted over several visits, and will deploy years of accumulated knowledge of the patient and his/her background. The main message is, not that this assessment be undertaken (because it probably will be anyway), but that it is crucial for the management of the patient with chronic pain.

**MANAGEMENT**

The management of chronic pain has to balance both treatment and rehabilitation. An evaluation of the therapies available in primary care is beyond the scope of this article. It is a familiar concept to GPs that 'cure' need not be the objective of medicine. Perhaps the key is for patients and professionals to agree realistic goals of treatment, and, equally importantly, to agree that which cannot be cured. For example, the goal may be to return to work (see Figure 1), acknowledging that certain activities will be limited because of pain.

Drug treatment is important, though should not be the only treatment modality employed. The WHO Analgesic Ladder (Table 1) is a useful guide, part of whose function is to remind us that there is rarely benefit in trying alternative therapies on the same rung. Adjuvant therapy includes corticosteroids and radiotherapy in cancer pain. The role of ‘unconventional’ analgesics, such as tricyclic antidepressants and anticonvulsants, is now well-established in neuropathic pain, and these should be considered at an early stage. Drug treatment for specific conditions, such as osteoarthritis and rheumatoid arthritis, has been well-researched and presented elsewhere. Drug treatment for chronic pain is often monitored imperfectly, and it is essential to ensure continued safety as well as effectiveness of treatment, remembering particularly that many patients purchase analgesics over the counter in addition to receiving prescriptions.

Other treatment approaches available in primary care include physical and occupational therapy, psychological treatments such as counselling, and treatment of comorbidity such as depression. These may involve referral to other members of the primary care team. We must also address the impact of chronic pain by considering the effect on employment, providing support with aids and benefits, and considering the need for home care management.

Some treatments (such as disease-modifying anti-rheumatic drugs) need to be initiated in secondary care, and other specialist treatments (such as nerve blocks or surgical interventions) can only be provided by specialists. Judicious referral to colleagues in secondary and tertiary care is therefore an important part of the strategy. Referral to pain management programmes, where these are available, is also an option. Ultimately, though, the ongoing care of the patient with chronic pain is likely to return to the GP and these referrals will represent temporary episodes. The GP’s responsibility is to optimise their long-lasting benefit through the encouragement of realistic expectation and the provision of continuing medical support. A rehabilitation model of management should therefore complement specific treatments (Table 2).

### TABLE 1. The World Health Organization (WHO) Analgesic Ladder

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<th>Step 1</th>
<th>Non-opioid</th>
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<td>+/- adjuvant therapy</td>
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<th>Step 2</th>
<th>Weak opioid + non-opioid</th>
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<td>+/- adjuvant therapy</td>
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<tr>
<th>Step 3</th>
<th>Strong opioid + non-opioid</th>
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<td>+/- adjuvant therapy</td>
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**FIGURE 1. Chronic pain severity* and reported inability to work due to sickness or disability (people of employment age).** Chronic pain reduces the ability to work, and this makes the chronic pain itself more severe. This graph shows how the percentage of people unable to work for health reasons is greater in people with severe chronic pain, reaching 60% at the most severe.

*Chronic Pain Grade (see text)
The role of patient organisations, such as Arthritis Care (www.arthritiscare.org.uk), Pain Association Scotland (www.painassociation.com), Pain Concern (www.painconcern.org.uk) and The Pain Relief Foundation (www.painrelieffoundation.org.uk), is also increasing. These can provide individual and group support, with increasing use of internet-based material.

NEW RESEARCH AND POTENTIAL

The role of complementary medicine is not yet fully evaluated. There is no doubt that many (and an increasing number of) patients attend therapists such as homeopaths, acupuncturists and other healers, many with apparent benefit despite the lack of objective scientific evidence to support this, and osteopathy is now almost a part of mainstream medicine. Further research in this field is required.

New or alternative methods of assessing and delivering care for patients with chronic pain are being explored in primary care. These include nurse- and pharmacist-led clinics, brief cognitive behavioural therapy, and educational packages for patients and professionals. These may be set in individual practices, groups of practices (such as Primary Care Trusts or Local Healthcare Cooperatives), or community hospitals.

SUMMARY

In summary, chronic pain is a frequent and important problem in primary care, with far-reaching implications. The GP is well-placed to assess and coordinate the management of chronic pain, and this is an important, even a specialist role. Many approaches to management are possible, and a multidimensional approach, in discussion with the patient, is the most helpful. New methods of delivery of care are under research, but perhaps the most important step in management is a mutual acknowledgement of the diagnosis of chronic pain.

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FURTHER READING


REFERENCES