

## Improvement in Quality-of-Life Indicators for Patients Suffering from Chronic Pain Syndromes

***An Internal Medicine Pain Clinic was started at our facility to help primary care practitioners manage pain associated with chronic, disabling, nonmalignant conditions. This article describes results of a study done to evaluate the success of this clinic in the two years since its inception. By providing a compassionate care environment and by assuring members that their medications would be available on a designated day each month, scores in pain, anxiety, life satisfaction, and mood were improved for most patients.***

### Introduction

Practicing physicians are concerned about how our profession manages patients who have pain.<sup>1,2</sup> Patients with terminal cancer can be referred to a hospice program, which allows patients to die with minimal suffering.<sup>3,4</sup> Patients with chronic pain syndromes may be more difficult to treat and may often require narcotic analgesia to manage their pain.<sup>5-9</sup> These patients are often depressed, and their reported use of pain medication may differ from actual use.<sup>10-13</sup> In some cases, this misreporting becomes a major problem because many physicians are reluctant to refill prescriptions for pain medications without examining the patient.<sup>2</sup> Pharmacists know the patients who frequently ask for medication refills and are concerned because of the long-term toxicity associated with medication formulated to include acetaminophen.<sup>14,15</sup> Because of complaints by patients, pharmacists, and primary care practitioners, an Internal Medicine Pain Clinic was started at the Kaiser Permanente Antelope Valley Medical Offices to help primary care providers understand the characteristics of these patients

and to understand the tools needed that may help in long-term pain management for patients suffering from chronic disabling conditions.

### Methods

Health Plan members were selected for inclusion in the study on the basis of being referred by primary care providers and pharmacists to the Internal Medicine Pain Clinic. All patients answered a psychosocial questionnaire at their initial visit and answered life satisfaction surveys at every visit. A social worker met with members individually and in weekly support groups to focus on management of other conditions (eg, dependence on opioid analgesic agents, psychosocial trauma) that may affect patients' perception of pain. Treatment plans included referral for further studies or consultative services (eg, neurology, physical medicine, anesthesiology) when necessary. Patients with nonmalignant medical conditions who were receiving opioid analgesic therapy for chronic pain were promised that they would receive a predetermined quantity of medications at regular (28-day) intervals and were informed of the risks and benefits of this therapy as well as alternatives to it. Antidepressant agents with or without referral to psychiatry or drug addiction medicine specialists were given to patients as indicated.

Before and after their course of treatment at the clinic, patients answered a questionnaire that asked them to rate their subjective experience with the treatment on a scale of one to ten, a score of ten indicating severe pain, anxiety, dissatisfaction with life, and negative mood (Figure 1).

### Results

Questionnaires about pain were received from 180 patients who were evaluated in the clinic during the two years since its inception in May 1999. Of those patients who returned for follow-up management, (n = 113), most (69%) were female, and the mean age was 49 years.

Of the patients who filled out questionnaires (n = 180), tobacco use (n = 80) and depression (n = 92) were common characteristics, as were a history of family problems (n = 58) and of divorce (n = 59). Most of these patients had tried physical therapy and pain medication without improvement. Fewer than 20% of the patients had tried acupuncture or other forms of alternative therapy.

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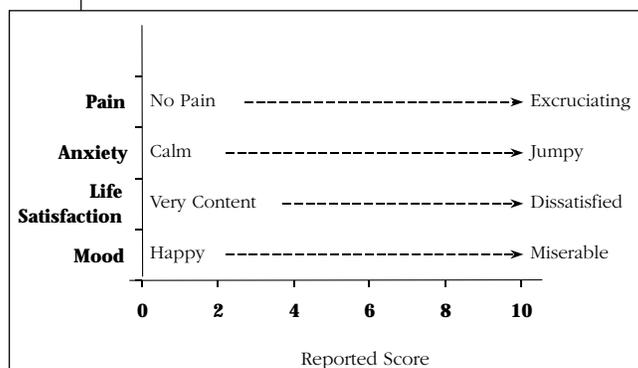


Figure 1. Scale used by Pain Clinic patients for rating their subjective experience living with chronic, disabling, nonmalignant medical conditions.



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The most common causes of pain seen in the clinic were headache (n = 88) and disc disease (n = 135). Some unusual causes of chronic pain treated in the clinic included postherpetic neuralgia, avascular necrosis, multiple sclerosis, muscular dystrophy, and reflex sympathetic dystrophy (RSD).

Table 1 presents the mean scores reported by Health Plan members seen in the pain clinic before and after initial treatment (n = 113). Before treatment, mean pain score reported was 6.5, and most patients (68 of 113 respondents) were anxious (reported score greater than or equal to five).

By receiving care in a compassionate environment, most people improved their scores in mood, anxiety, and life satisfaction. A supportive team approach and promising the member that medication would be available at the same time each month reduced patients' overall anxiety levels by 20% (ie, from a mean pretreatment score of 5.4 to a mean posttreatment score of 4.3). For 59% of members, the total score improved after initial treatment; for 41% of members, their condition either did not improve or became worse (Figure 2).

### Discussion

Research has shown that subjective pain ratings higher than four on a ten-point scale interfere substantially with a patient's activities and mood.<sup>3,6</sup> However, management of chronic pain is a complicated process that requires the skills of many people, including the patient. Patients in our study were thus encouraged to be aware of the different components of their pain syndrome and to be constantly aware of the long-term side effects of their pain medications.

In our study, mean pretreatment and posttreatment mean pain scores were much higher than four. Despite thorough examination of patients, the team of providers working in the clinic could not substantially improve this pain score. In contrast, mood and anxiety scores improved greatly after treatment and were associated with an overall improvement in patient's life satisfaction. To achieve these improved scores, patients seen in the pain clinic were evaluated carefully in an empathetic environment to determine what part of their perceived pain was caused by physical injury (ie, the body's need for pain medication), psychosocial trauma, or both. These factors are subjective, and effective tools to monitor their role in pain perception have not been developed. Consequently,

**Table 1. Ratings reported by 113 Health Plan members responding to questionnaire before and after receiving treatment at the Internal Medicine Pain Clinic**

| Experience Measured | Mean Scores Reported |                 |                |
|---------------------|----------------------|-----------------|----------------|
|                     | Before Treatment     | After Treatment | Difference (%) |
| Pain                | 6.5                  | 5.9             | 0.6 (9.2)      |
| Anxiety             | 5.4                  | 4.3             | 1.1 (20.3)     |
| Life Satisfaction   | 4.6                  | 3.7             | 0.9 (19.5)     |
| Mood                | 5.4                  | 4.0             | 1.4 (25.9)     |
| All Combined        | 21.9                 | 17.9            | 4.0            |

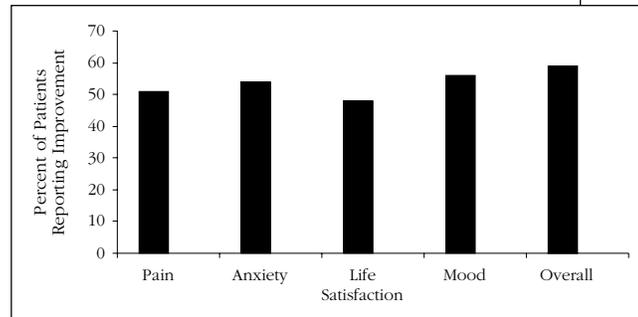


Figure 2. Bar graph shows percentage of patients reporting improvement in the experiences evaluated.

clinicians who work with patients suffering from chronic nonmalignant pain should tend to believe the scores reported to them by their patients.<sup>4</sup>

### Conclusion

From a patient's perspective, the first goal of treatment is to manage pain. After this has been accomplished, the provider-patient team can work to address psychosocial issues and any addictive behavior that may exist. Patients with a chronic pain syndrome are understandably anxious and need support and encouragement from the primary care practitioners. When this support is provided and the pain is alleviated, patients can begin the process of improving their overall quality of life. ❖

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## The Patient Always

"Nothing about me without me."

*Thomas L. Delbanco, MD,*

*from Through the Patient's Eyes:*

*Understanding and Promoting Patient-Centered Care.*