Pain Assessment and Pain Management Podcast – Episode 2

Introduction: Welcome to the Pain Assessment and Pain Management Podcast. This series is part of a larger pain, hypertension, and cardiovascular disease initiative to educate providers on patient pain and medication management with considerations for over-the-counter pain relief for patients with high blood pressure and cardiovascular disease.

This series portrays the patient and clinician's experience with assessing and managing pain. This podcast is intended to be a guide to educate providers on the pain assessment tools available and provide practical applications for assessing and managing pain at different stages in the patient's journey. The patient used in this series is an actor who is a 65-year-old Black man with a history of hypertension, hyperlipidemia and obesity who had a knee replacement surgery. Any recommendations or information provided are not to be construed as a directive, endorsement or medical advice.

Disclaimer: The opinions expressed in this podcast are solely those of the presenter and not necessarily of the American Heart Association/American Stroke Association (AHA/ASA). The AHA/ASA does not endorse any specific products or devices.

[Begin reenactment]

PAUL ARNSTEIN: Hello Mr. Williams. I'm Paul Arnstein. I saw you in the hospital after your knee surgery. How are you doing now?

FRANK WILLIAMS (patient): I remember. Call me Frank. I'm having a tough time, and this knee pain just keeps getting worse.

PAUL ARNSTEIN: Last time we saw each other, I remember you said it was a soreness. How would you describe it now?

FRANK WILLIAMS: It was sore until the numbing medicine wore off, then it got really bad. I can't walk without a walker. I can't drive, and I can't even do what the physical therapist says I'm supposed to do.

PAUL ARNSTEIN: Sorry to hear you are struggling, Frank. Right now, what does the pain feel like?

FRANK WILLIAMS: It's a stabbing pain in the knee that sometimes shoots down to the foot. I just can't take it!

PAUL ARNSTEIN: On a scale of 0-10, where "zero" is "no pain" and "10" is the "worst possible pain," how strong would you say your pain is?

FRANK WILLIAMS: I'd say it's a "20"—twice as bad as I ever thought it could be. It is as bad as it could be.

PAUL ARNSTEIN: So, that's your new "10"— it's "worst possible pain." Has your pain been constant or intermittent since you left the hospital?

FRANK WILLIAMS: I constantly have the pain since I left the hospital, and sometimes it's worse than others.

PAUL ARNSTEIN: Frank, what if anything, have you noticed makes the pain worse?

FRANK WILLIAMS: It wakes me up at night sometimes, but it's always bad when I try to walk. And stairs, forget about it!

PAUL ARNSTEIN: It sounds very upsetting. Do you feel mad, sad or frustrated?

FRANK WILLIAMS: Yeah, all of those feelings. Nothing is helping, and I should be better by now.

PAUL ARNSTEIN: Have you noticed anything that makes it better?

FRANK WILLIAMS: Nothing makes it go away. I tried that ice cuff you suggested, but it hurts to even put that on. I ran out of the medicine prescribed the first week after I left the hospital. So, I've been maxing out on the pain medicines they sell at the drug store. The clerk gave me the strongest one I could get without a prescription.

PAUL ARNSTEIN: Hmm ... it hurt to put the cuff on? If you close your eyes, can you tell me if I'm touching your knee with something sharp or dull?

FRANK WILLIAMS: Wow! It's so tender, but it's numb there. It hurts, but I can't tell what you touched me with.

PAUL ARNSTEIN: Are you taking any other things for pain that were not prescribed by your doctor?

FRANK WILLIAMS: I tried glucosamine, chondroitin, and some menthol cream, but nothing has helped.

PAUL ARNSTEIN: Frank, I'm really concerned with how strong your pain is, and how it's interfering with your ability to do things. I know you'd like to get back to your normal routine eventually, but even walking is a struggle at this point. I'm also concerned that the over-the-counter medicines you're using, which are in a class of medicines known as NSAIDs, is not safe for your heart, given your personal and family history that puts you at risk for heart attack or stroke. Your stomach and kidneys can also be damaged by these medicines.

PATIENT: I didn't know they were bad for my heart or kidneys, but my stomach has been so upset since I started taking these medications. I'm chewing antacids like candy.

PAUL ARNSTEIN: You have to be careful which antacid you take because many are high in sodium, which should be limited given your hypertension. Also, there is no perfect medicine that will eliminate pain or be free of potential harm. We consider individual risk and balance concerns for reducing pain, improving functioning, while avoiding treatment-related harm.

FRANK WILLIAMS: Can you just make the pain go away?

PAUL ARNSTEIN: Well, you know, (chuckles) I once had this magic dust that I could sprinkle over patients and the pain would miraculously go away, but it's on back-order. I'll get it to you as soon as it comes in. But no, seriously, there is no fully effective, risk-free medicine for the type of pain you're experiencing, but there are things we can do to better manage your pain and get you on your feet again. Let's talk more about opioids and other options.

FRANK WILLIAMS: I understand. So, can you prescribe me some opioids to help with the pain?

PAUL ARNSTEIN: Well, when we think about potentially habit-forming medicines like opioids, we do take some safety precautions including screening people who might already have unhealthy habits related to alcohol, tobacco or other problems. And because we want to help you with your current problems and not create new ones, we can discuss opioids as one of the medication options to help with your current pain problem.

FRANK WILLIAMS: Okay, just none of that stuff that people can overdose on.

PAUL ARNSTEIN: Understood. You know, and as an older adult, we'll have to consider limiting the number and types of medicines that can make you sleepy or affect your mental clarity and avoid the daily use of non-prescription medicines that increase cardiovascular risk. Additionally, there are lower risk nondrug options we can explore. Let's go over each of the options and discuss your risks, the benefits and trade-offs of each one.

FRANK WILLIAMS: Okay. Thank you.

[Begin Interview]

KRISTIN COLSON: Welcome to episode two of the Pain Assessment and Pain Management three-part podcast series. My name is Kristin Colson, and I am a Quality Programs Manager with the American Heart Association. Once again, we have Paul Arnstein with us today. Paul is a certified family nurse practitioner, clinical nurse specialist, and a pain management nurse. He is also an Adjunct Professor of Nursing at the Mass General Hospital Institute of Health Professions and an independent pain educator and consultant. Dr. Arnstein, welcome back to our podcast.

PAUL ARNSTEIN: Thank you for having me back.

KRISTIN COLSON: So, it seems this is a complicated case. Do you often see patients a month after surgery that still have pain like this?

PAUL ARNSTEIN: Yes, unfortunately persistent, postsurgical pain is not uncommon after total knee arthroplasty surgery. Between 30-50% of patients continue to have significant pain months after surgery, but this patient's pain is different.

KRISTIN COLSON: What makes his pain different?

PAUL ARNSTEIN: One month after surgery, the pain trajectory should be getting better, but it seems to be getting worse.

KRISTIN COLSON: Okay, so Frank rated his pain intensity at a "20," what do you make of that?

PAUL ARNSTEIN: Well, as Frank describes, it's twice as bad as he thought pain could be. We established at an earlier encounter that the Numeric Rating Scale isn't easy and meaningful for Frank, but he said it was "as bad as could be." On the Numeric and Simple Descriptive Scale that's equivalent to a "10/10." Hearing these unexpected severity ratings made me wonder if it's some physical or psychosocial amplifiers that need to be addressed. Some examples of amplifiers are infection, neuroinflammatory processes, strong emotions or opioid-induced hyperalgesia. He admitted to feeling angry, sad and frustrated; but behaviorally and given the circumstances these seemed appropriate and wouldn't have this strong of an effect. That left me to think of neuroinflammatory or other neuropathic processes, as accounting for his unexpectedly high levels of pain.

KRISTIN COLSON: Can you tell us more about opioid-induced hyperalgesia?

PAUL ARNSTEIN: Opioid-induced hyperalgesia is different than tolerance in that with sustained exposure to high-dose opioids, the nervous system becomes more sensitive to pain. Neuroimmune inflammation driven primarily by glial cells and a build-up of excitatory amino acids in the CNS are believed to underlie this phenomenon. Medication-specific and genetic factors appear to play a role but are not yet fully understood. Mr. Williams only had a few days of opioid therapy weeks ago, so this is not a case of opioid-induced hyperalgesia.

KRISTIN COLSON: Hmm, I see. How would you assess for these pain amplifiers?

PAUL ARNSTEIN: It's probably too early for quantitative sensory testing to be helpful, but I interviewed him using the WILDA acronym which stands for words, intensity, location, duration, aggravating and alleviating factors and affect for assessing pain and that's supported a neuropathic origin.

"W" stands for **W**ords used to describe pain. He described it as a stabbing and shooting pain.

"I" stands for Intensity, which he described as "bad as it could be."

"L" for Location was described as right knee pain radiating to the foot.

"D" for **D**uration, which started after the local anesthetic wore off, remaining constant since then.

"A" ... Aggravating factors including walking, using stairs, and just sleeping.

"A" also stands for Affect, so I asked about his mood.

Additionally, he displayed allodynia, which is a pain response to non-painful stimuli. Placing the ice pack cuff on his knee was intolerable. Plus, despite heightened pain sensitivity in the area, he had diminished awareness of normal sensations (like sharp versus dull discrimination).

KRISTIN COLSON: So how serious is this, and what should clinicians do about it?

PAUL ARNSTEIN: Neuropathic pain is often experienced transiently after surgery as nerves may be cut or inflamed. Empirical treatment with gabapentinoids, or an SNRI antidepressant for a few weeks is common, with a re-evaluation in a month if there are no other complications or contraindications.

KRISTIN COLSON: You spoke about NSAIDs not being safe given Frank's cardiovascular risk profile. Can you expand on that?

PAUL ARNSTEIN: NSAIDs or nonsteroidal anti-inflammatory drugs are considered safe for younger persons and short duration of exposure. But they are deemed potentially inappropriate by the American Geriatrics Society for older adults (AGS, 2019); especially for those with preexisting cardiovascular risks. NSAIDs may be used briefly for many with acute pain but sustained daily use for one to two years has been linked to a 5% morbidity and 1% mortality rate from gastrointestinal ulceration or bleeding, renal failure and cardiovascular events.

KRISTIN COLSON: Are there any concerns of misusing opioids?

PAUL ARNSTEIN: Yes. You can never tell who will misuse opioids. Therefore, we use standard "universal precautions" before prescribing an opioid including checking the State Prescription Drug Monitoring Program database and asking about personal or family history of drug misuse, addiction or mental illness with periodic reassessments, especially the first one to three months. Although Frank didn't want a medication with overdose potential, opioids, gabapentinoids or sedatives do have an abuse and overdose potential that are concerning and would need to be discussed before they are prescribed. I would pick the top two options to discuss which <u>one</u> he preferred to start with.

KRISTIN COLSON: Thanks, Paul. That's a great approach. What *other* risks did you assess for when talking with Frank?

PAUL ARNSTEIN: I asked Frank about all prescribed and non-prescribed treatments he was using. It's important because medication-interactions occur between prescribed, non-prescribed medications and other substances, like nutritional supplements. Whereas glucosamine, chondroitin preparations can interact with certain blood thinners, Frank was not on any of those. He was on NSAIDs, as we discussed, and as a person with hypertension, we would want to check his prescribed and nonprescribed medications for sodium content. Also, as an older adult, when developing a treatment plan, I would avoid combinations of more than two CNS-active drugs (like opioids plus, anticonvulsants plus, anxiolytics plus an antidepressant).

KRISTIN COLSON: Wow. These assessments and treatment decisions seem very time-consuming. How do you manage that in clinical practice?

PAUL ARNSTEIN: Often the risk assessment, current medications, over-the-counter and nutritional supplements used are obtained in pre-visit questionnaires. Since I only like to make one change at a time, if I didn't have time to discuss the risk, benefits and trade-offs of several pain treatment options, I would pick the top two options and discuss which <u>one</u> he preferred to start with. I would then schedule a follow-up appointment within a week or two to assess side effects and go over other options. I also developed a checklist I give to patients about the breadth of low-risk, non-drug methods people use to control pain, along with a web-based resource directory they can review ahead of that visit. At a subsequent visit, we would use a shared decision-making model acknowledging that pain control is not about one treatment to achieve one desired outcome; rather it identifies shared values and achievable goals.

KRISTIN COLSON: Thanks for your insights, Paul. I think that's all we have time for today. Again, thank you for joining us. In the final episode of this three-part series, we will be discussing observational tools to assess chronic pain, the differences between chronic and acute pain, as well as the role of pain stigma in pain assessment. See you next time!

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