It is estimated that CNCP affects over 100 million people in the U.S. and is 1 of the most common reasons for healthcare visits. The total annual cost of health care associated with chronic pain ranges from $560 to $635 billion; this includes direct medical costs and economic costs.¹

A comprehensive patient evaluation should be completed for all patients. A patient assessment should include: physical examination, clinical history (pain, medical, psychosocial), and laboratory/diagnostic criteria. When treating CNCP it is important to first determine:

1) If possible, the underlying mechanism of pain. See CNCP classifications below
2) Characterize the pain quality, including site and severity

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CNCP Classifications²⁻⁵

**Neuropathic**
- Pain produced by damage to or dysfunction of the somatosensory system
  - Pain is described as burning, shooting, stabbing
  - Diabetic peripheral neuropathy, trigeminal or postherpetic neuralgia

**Musculoskeletal**
- Trauma or injury results in the dysfunction in 1 or several muscles in a region of the body with loss of range of motion. Commonly involves neck, shoulders, trunk, arms, low back, hips, and lower extremities.
  - Muscle sites are tender and pain is referred (trigger points)
  - Caused by injury or due to occupational repetitive activity

**Inflammatory**
- Inflammatory mediators activate primary sensory nerves that carry pain to spinal cord
  - Pain is described as hot, red, and swelling at pain site with a history of injury or known inflammation

**Mechanical/Compressive**
- Mechanical pressure or stretching directly stimulates the pain sensory neurons
  - Neck and back pain related to muscle/ligament strain sprain, degeneration of disks or facets or osteoporosis with compression fractures

**1st Line Treatment Options:**
- Anticonvulsants; TCAs; Topical Agents
- NSAIDS; TCAs; Topical Agents
- NSAIDS/APAP; TCAs; SSRIs or SNRIs
- NSAIDS/APAP; TCAs; SSRIs or SNRIs

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TCAs: tricyclic antidepressants; NSAIDS: non-steroidal anti-inflammatory drug; APAP: acetaminophen; SSRIs: selective serotonin reuptake inhibitor; SNRI’s: serotonin and noradrenergic reuptake inhibitors
The PQRSTU Mnemonic\textsuperscript{8}:

A helpful tool to evaluate your patient’s pain symptoms

<table>
<thead>
<tr>
<th>P</th>
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</thead>
<tbody>
<tr>
<td>Precipitating or Palliative</td>
<td>Quality or quantity</td>
<td>Region or radiation</td>
<td>Severity</td>
<td>Timing or temporal</td>
<td>Understanding</td>
</tr>
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**Ask the patient**

- What precipitates the symptoms?
- What does the symptom feel like, look like, or sound like?
- Are you having the symptom right now? If so, is it more or less severe than usual?
- To what degree does the symptom affect your normal activities?
- Where in the body does the symptom occur?
- Does the symptom appear in other regions? If so, where?
- How severe is the symptom? How would you rate it on a scale of 1 to 10, with 10 being the most severe?
- Does the symptom seem to be diminishing, intensifying, or staying the same?
- When did the symptom begin?
- Was the onset sudden or gradual?
- How often does the symptom occur?
- How long does the symptom last?
- What do you think caused the symptom?
- How do you feel about the symptom? Do you have fears associated with it?
- How is the symptom affecting your life?
- What are your expectations of the health care team?

Characterization of Pain Severity\textsuperscript{5-7}:

1. Pain intensity should be evaluated at \textbf{EACH} visit
   - Current pain
   - Least pain in past 7 days
   - Usual or average pain in past 7 days

2. A pain rating scale should be used

Useful pain rating scales:
- Wong-Baker FACES Pain Rating Scale
- Numeric Rating Scale
- Pain Quality Assessment Scale (PQAS)
**FIRST-LINE** treatment options for the management of CNCP include non-pharmacological and non-opioid analgesic pharmacological therapies. Most patients will benefit from a multimodal approach.²,⁵,⁷

### Multimodal Analgesic Approach

The use of multiple methods of pain management concurrently can reduce the amount of medications (e.g., dosage, quantity) necessary to relieve pain and can minimize adverse drug reactions. This approach should be considered at all times for CNCP management.

<table>
<thead>
<tr>
<th>CNCP Guidelines</th>
<th>Recommended first-line treatment options for CNCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interagency 2010³</td>
<td>Use opioid medications for acute or chronic pain ONLY AFTER determining alternative therapies DO NOT deliver adequate pain relief.</td>
</tr>
<tr>
<td>VA/DoD⁵</td>
<td>A trial of opioid therapy is indicated for a CNCP patient if moderate to severe pain has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions</td>
</tr>
<tr>
<td>APS 2009⁹</td>
<td>Clinicians should consider a trial of chronic opioid therapy (COT) when there is no alternative therapy that is likely to pose as favorable a balance of benefits to harm.</td>
</tr>
<tr>
<td>ASIPP 2008⁶</td>
<td>Documentation of failure to respond to non-controlled substances, adjuvant agents, physical therapy and/or interventional techniques</td>
</tr>
<tr>
<td>WHO¹⁰</td>
<td>Non-opioid analgesics initially recommended. Supports multimodal treatment approach</td>
</tr>
<tr>
<td>CDC¹¹</td>
<td>Non-pharmacological and non-opioid pharmacological therapies to modulate pain should be recommended first</td>
</tr>
</tbody>
</table>

**SUMMARY**

Clear consensus across all current CNCP guidelines that all patients presenting with CNCP should be started on non-pharmacological and/or non-opioid therapies before an opioid is prescribed.


### First-Line Treatment Options for CNCP³,⁵,⁶,⁹

**Non-Pharmacological Treatment Options²,⁵,⁷**

- Exercise
- Massage
- Behavioral therapy
- Physical rehabilitation

**Non-Opioid Pharmacological Treatment Options²,⁵,⁷**

- Acetaminophen
- NSAIDs
- Adjuvant analgesics (*anticonvulsants, benzodiazepines, TCAs, corticosteroids, topical analgesics, muscle relaxants, SSRIs, SNRIs)*
The World Health Organization (WHO) analgesic ladder, which is commonly used for the treatment of cancer pain, also supports a multimodal approach for CNCP in addition to recommending that opioid therapy be reserved for persisting/increasing pain. Additionally, all non-opioid and adjuvant therapeutic options should be attempted prior to opioid initiation.

Patients started on non-pharmacological and/or non-opioid analgesic therapies for CNCP should be reassessed for improvement in pain and/or functional status at 2-4 weeks.