



Returning to work safely after chronic pain experiences

Does medication help or hinder?



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Workplace Injury Factors

NCETA

- > 15% workplace injuries attributable to alcohol or drugs
- > 60% people who consume alcohol / drugs at harmful levels are in f/time employment
- > Over-represented: tradespeople, unskilled workers; hospitality, mining and agricultural sectors



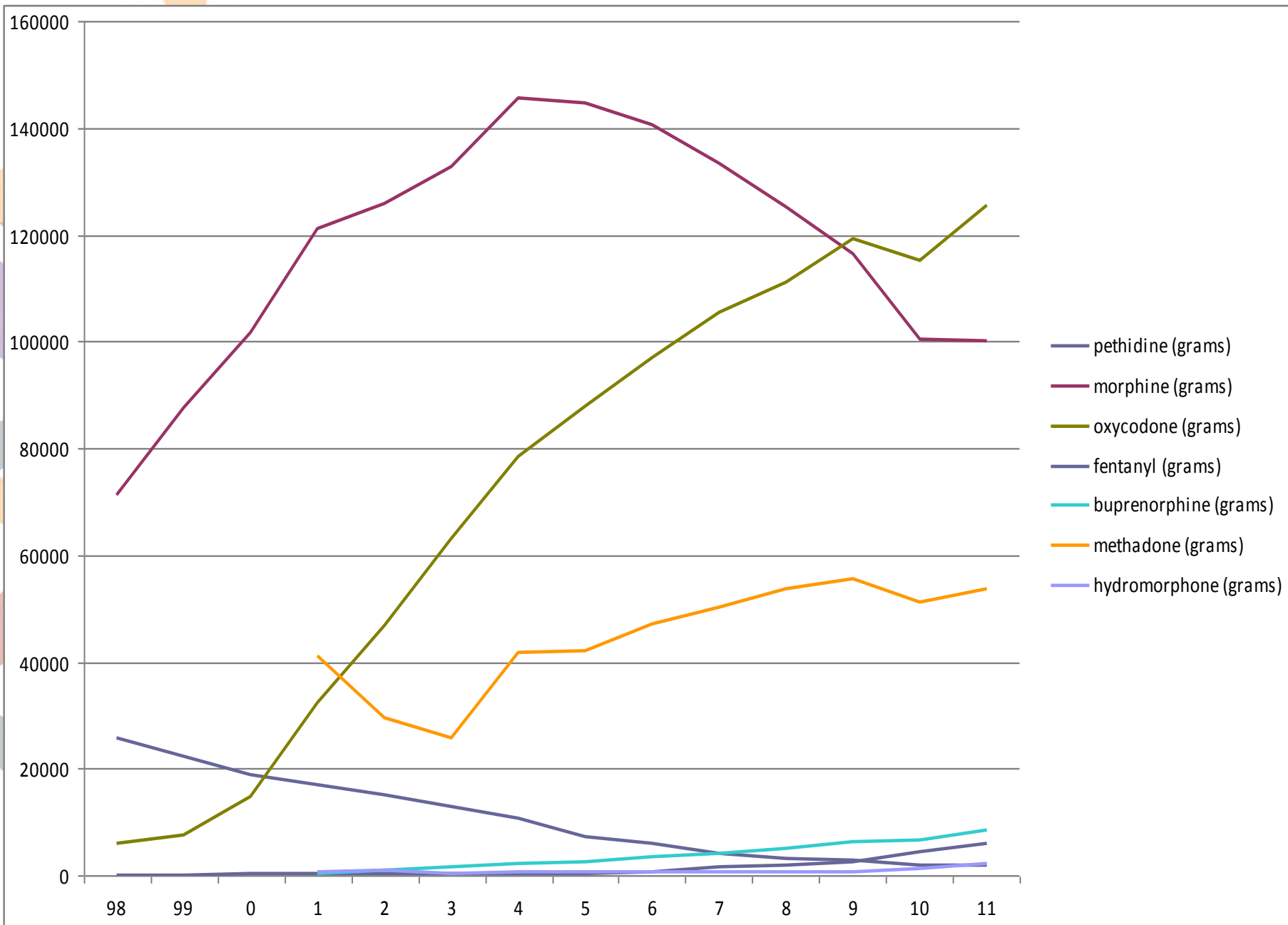
Features of Chronic Pain

- > Pain that has lasted for more than six months.
- > Feelings of depression, anger, worry, discouragement, and irritability.
- > Sleep difficulties.
- > Financial problems.
- > Problems relating to others, causing significant disturbance in relationships.
- > Withdrawal from social activities.



Features of Chronic Pain

- > Poor memory / concentration
- > Decreased sexual activity or performance.
- > Decreased in self-esteem.
- > Secondary physical problems.
- > Misuse of [pain medications and/or alcohol.](#)
- > Avoiding work and leisure activities.
- > Negative attitudes concerning everyday life.





Analgesic Treatment Objectives

- Increase ability to function
- Reduce pain and suffering
- Improve quality of life
- Minimise risk of adverse effects



Evidence for efficacy

Eriksen J et al. Critical issues on opioids in chronic non-cancer pain. An epidemiological study. Pain. 2006

Opioid users reported:

- More moderate to very severe pain
- Poorer self-rated health and quality of life
- Low levels of physical activity and employment
- Higher health care utilisation

(compared with non-opioid using people with pain)



Efficacy of opioids for chronic pain

4 systematic reviews and meta-analyses 2004-2008

Only 2 out of 5 patients will benefit

Patient distress, rather than pain, is often the reason for chronic opioid prescription



Opioid side effects

- Usual constipation, sedation, sweating, dry mouth
- Weight gain (hormonal/sedentary causes)
- Lower testosterone (effects on libido, energy, drive, motivation)
- Osteoporosis
- Drug interactions, overdose and death
- Dependence



Opioid side effects

Opioid deaths

- Over-represented in people prescribed 80mg oxycodone and 100mg morphine preparations
- These people are mainly 35-49 years of age
- Only one third are primary opioid addicts



Opioid side effects

Hyperalgesia

- Chronic opioid users have lower pain tolerance and are more sensitive to pain
- Process starts after initial dose; High dose intra-operative analgesia leads to greater post-op pain
- Chronically: leads to tolerance / dose increase
- People with chronic pain may have less pain after opioid withdrawal



Other drugs of concern

Benzodiazepines

- Rationale for use lacking
- Tolerance and dose escalation especially with alprazolam
- Dependence after medium term use



Other drugs of concern

Benzodiazepines

- Actually worsen sleep
- Prevent acquisition of memory
- Increase risk of driving accidents
- Interact with opioids and alcohol



Other drugs of concern

Alcohol / cannabis

- Not much literature about use after injury
- Likely to be problem due to boredom, access, high use in working population



Opioid strategy

Appropriate information prior to opioid trial and an exit strategy

- not “painkillers”
- expect analgesic benefit of ~ 30% in less than half trialled
- only if component of multimodal approach
- encourage weaning after 3 – 6 months

- 120mg morphine/day (80mg oxycontin, fentanyl patch 25mg)
 - = “*high dose*”
 - = *2nd opinion*



Reasonable patient expectation of chronic pain management

- **Bio-psycho-social assessment, diagnostic formulation and explanation**
- **Non-opioid analgesic trial**
- **Access to self-management approaches**
- **Physical therapies, exercise regimens, psychological treatments**
- **If opioids used, only as functional outcome-based, low-dose, time-limited trial**

Pain education tools direct from
the consumer via the net

Pete Moore EPP



The Pain Toolkit

....is for people who live with
persistent pain

A persistent pain problem can be difficult to understand and manage on an everyday basis.

The Pain Toolkit is a simple information booklet that could provide you with some handy tips and skills to support you along the way to manage your pain.

It is not meant to be the last word in pain self-management but a handy guide to help you get started - all you need to be is willing to read it and take on board some of the suggestions.

Good luck!

Pete Moore

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Pete Moore who has persistent pain, asthma and osteoarthritis, has put these tools together with the help of friends, family and health care professionals.

Special acknowledgement to the Bradford Pain Rehabilitation Programme team and NHS Kirklees.

These tools have helped many people and could also help you!

- Tool 1** - Accept that you have persistent pain...and then begin to move on
- Tool 2** - Get involved - building a support team
- Tool 3** - Pacing
- Tool 4** - Learn to prioritise and plan out your days
- Tool 5** - Setting Goals/Action Plans
- Tool 6** - Being patient with yourself
- Tool 7** - Learn relaxation skills
- Tool 8** - Stretching & Exercise
- Tool 9** - Keep a diary and track your progress
- Tool 10** - Have a set-back plan
- Tool 11** - Team Work
- Tool 12** - is keeping it up... putting into daily practice the tools from 1-11.



Evidence for psychological treatments in persisting pain states

- Degree of disability and distress in persisting pain relate primarily to psychological and social factors
- Cognitive behavioural therapies are effective at improving function, pain and quality of life - Level 1 evidence

Guzman et al. BMJ 2001;322:1511-17



Active rehabilitation approaches

- Ensure worker has good advice and support
- Work with treating doctor to reduce non-useful treatments
- Refer early to pain specialist / psychologist if problems anticipated



Returned to work

- Benzodiazepines / opioids can affect memory, concentration and alertness
- Benzodiazepines are likely to affect driving and working with machinery
- Workers need to maintain physical and psychological rehab routines after return



The case of the divine Ms M

2001: 33 yo married woman, 2 children, home duties since 1990, 130kg. Previous aged care work.

1998: Hysterectomy with complications

1999-2001: Abdo pain, frequent diarrhoea, doctor shopping (16 in 6/12, no firm diagnosis)

Oxycodone 80mg daily



The case of the divine Ms M

1/3/01 Saw pain specialist,
fixated on pain, medication,
seemed depressed

2005: Oxycodone 200mg,
morphine tabs 720mg,
diazepam 20mg daily, morphine
injections 4/week

Sabotaged all attempts for
colonoscopy



The case of the divine Ms M

2005: referred to DASSA,
claimed diagnosis of Crohn's
Disease and nephrotic
syndrome, never confirmed.
Claimed GP wished her dose
to remain as is – false.

Converted to MS Mono 900mg
daily, gradual reduction
planned



The case of the divine Ms M

Complained of great pain, poor sexual relationship with husband, dizzy spells

5/12/05 Feeling much better, planning holiday, down to 840mg morphine

6/3/6 No mention of pain, doing Cert 3 in Aged Care, wants to become enrolled nurse – Husband had left her.



The case of the divine Ms M

Full time study, intermittent bowel looseness, minor emphasis on pain, dose reduction continued.

11/06 lost weight, working as pizza deliverer – dose 600mg

5/07 Sleep apnoea confirmed

9/07 daughter gave birth, son had affair, she was held up, friend's suicide, relationship with married man



The case of the divine Ms M

8/09 psychology support re hold up anxiety, completed security guard training, started work as guard. Dose 210mg morphine

3/11 past rapist released from prison, fears re stalking

2012 90mg morphine, working full time, new teeth, very little pain



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