Chronic Pain

Written By: Thomsen D'hont and Caleb Dusdal

As we all know, this is far too prevalent of an issue and can be very frustrating to manage. Chronic pain fairly recently gained recognition by the World Health Organization as a discrete condition, followed by formalization of this in the form of an ICD11 code to be launched Jan 1, 2022.

Pain, of course, is a normal and beneficial stimulus to recognize injury to tissue and to help us to avoid further injury. But its persistence following resolution of the causative factor, or being excessive for otherwise non-noxious stimuli is where it crosses over into pathology.

There is simply no way we're going to cover all of the chronic pain syndromes here or the nitty gritty details, but we're going to focus on chronic non-cancer pain, and provide a number of resources in the show notes that you can scan through to get a pretty good idea of what you need to manage these sometimes difficult to help patients.

Objective One:
In a patient with chronic pain: Establish the etiology, Reassess and periodically review the etiology and Periodically look for potential comorbidities or complications, particularly mental illness and addictions.

First, a couple definitions:

- Allodynia:
  Is pain experienced as a result of usually non-noxious stimuli
- Hyperalgaesia:
  Pain experienced out of proportion to the given noxious stimuli.
- Chronic pain:
  A painful condition that persists for longer than 3 months,
  or pain that persists beyond the reasonable time for an injury to heal
  or pain lasting 1 month beyond the usual course of an acute disease. [Tintinalli's]

Chronic pain can be classified as either Primary(aka Idiopathic) or Secondary, that is, linked to an underlying condition.

Primary Chronic Pain

Characterised by:

- significant emotional distress, or
- functional disability - reduced participation in social roles and ADLs
- not better accounted for by another diagnosis

It is also almost always multifactorial: including biological, psychological and social factors contributing to the pain experience.

Also keep in mind that a Primary Chronic Pain can co-exist with a secondary chronic pain syndrome.

Chronic Secondary Pain

diagnosed when pain emerges as a symptom of another health condition, and can persist after the triggering condition has been treated.

a) Establish the etiology

Tintinalli's offers some signs and symptoms to help guide you towards the aetiology of some chronic pain syndromes. They have divided these into Neuropathic, and Non-Neuropathic. The two tables will be in the show notes:

Some selected chronic pain syndromes are:

- **Transformed Migraine**
  A common migraine headache develops over time into a chronic pain syndrome.
  - A precursor to this syndrome is chronic migraine of 15 or more days in a month
    - most commonly results from medication overuse:
      - 5 or more days per month of barbituates, or
      - 8 or more days per month of opioids, or
      - 10 or more days per month of triptans or NSAIDs
    - In this syndrome look for:
      - migraine symptoms that transition to more tension headache symptoms
      - tenderness and tension of scalp musculature
      - increased frequency and duration
      - failure of their usual antimigraine medications

- **Fibromyalgia**
  This is widespread muscular pain affecting more than 6 body areas out of 19, and symptoms severity score of >=5 in associated areas:
    - fatigue, sleep disturbance and cognitive dysfunction

- **Postherpetic Neuralgia**
  can follow an acute episode of herpes zoster in up to 30% of cases. Pain can last more than a year in up to 30% of cases. Pain character is:
    - allodynia, shooting, lancinating.
    - They often also have hyperaesthesia in the affected dermatome
    - occasionally may see pigmentation changes in the affected distribution

- **Trigeminal Neuralgia**
  Paroxysmal, short bursts of sharp electric shock like pain in distribution of the trigeminal nerve. Pain events can be triggered by:
    - chewing, speaking, washing, brushing teeth or something touching the face
    - may see lacrimation and red eye on affected side

- **Phantom Limb Pain**
  Variable presentation. But more common in amputation patients who had pain in the extremity prior to the amputation.
  Pain can be described as:
    - aching, cramping, burning, tearing or squeezing
    - occurs in up to 81% of amputations and changes often from ‘knife-like’ to more ‘burning’ in character.

- **Complex Regional Pain Syndrome**
  Type I is from prolonged immobilization or disuse, such as after a stroke
  Type II is from an actual peripheral nerve injury and can be more severe and difficult to manage than type I
    - look for allodynia, persistent burning or shooting pain on the affected limb
    - early signs: oedema, warmth, localized abnormal sweating
    - later signs: early signs alternating with: cold, pale cyanotic skin and eventual atrophic changes
    - To make the CRPS diagnosis, use the Budapest critiera, which is included in the shownotes. In short, the criteria includes showing signs and symptoms of sensory, vasomotor, sudomotor/edema, and motor/trophic changes.

Table 1

Budapest diagnostic criteria for CRPS.

A) Clinical diagnostic criteria for CRPS
- Continuing pain, which is disproportionate to any inciting event
- Must report at least 1 symptom in 3 of the 4 following categories:
  - Sensory: Reports of hyperalgesia and/or allodynia
  - Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry
  - Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry
  - Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, and dystonia) and/or trophic changes (hair, nails, and skin)
- Must display at least 1 sign at the time of evaluation in 2 or more of the following categories:
  - Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement)
  - Vasomotor: Evidence of temperature asymmetry and/or skin color changes and/or asymmetry
  - Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry
  - Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, and dystonia) and/or trophic changes (hair, nails, and skin)
- There is no other diagnosis that better explains the signs and symptoms

B) Research Diagnostic Criteria for CRPS
- Differs from the above in that "Must report at least 1 symptom in each of the 4 categories"

The diagnostic criteria are not perfect; sensitivity and specificity for differentiation against easy to distinguish neuropathic pain disorders are 0.99 resp. 0.68 (specificity) for the clinical criteria and 0.78 resp. 0.79 (specificity) for the research criteria.
CRPS, complex regional pain syndrome.

- **HIV Associated Pain Syndrome**
  pts can develop distal sensory polyneuropathy. Features to look for include: distal sensory polyneuropathy with:
  - shooting pain, numbness, burning usually to soles and dorsum of feet and toes.
  - associated with antiretroviral therapy, but not with low CD4 counts

This is not the episode to cover acute pain, but it is important to recognize that you need to appropriately treat nociceptive, inflammatory or neuropathic pain appropriately. Failure to do so can contribute to central sensitization or 'nociplastic' pain.

b) **Reassess and periodically review the etiology (e.g., previously undisclosed abuse, evolution of the underlying cause)**

- review symptoms, meds, other social factors, mental health. Review whether there are reversible causes or underlying diseases causing the pain.
- Often there is overlap with chronic pain and abuse, either in the past or current. The Canadian Task Force on Preventive Health Care recommends screening, among others, elderly or vulnerable adults. They essentially cite the US preventive services task force review and suggest using screening tools such as:
    - HARK - 'Humiliation, Afraid, Rape, Kick' - includes 4 questions that assess emotional and physical intimate partner violence in the past year.

c) **Periodically look for potential comorbidities or complications, particularly mental illness and addictions**

This is important, as there is an very common overlap of mental illness and addictions in patients suffering with chronic pain. A 2014 paper found this overlap to be up to 67% of patients with chronic pain also had a diagnosable mental illness, the most common were:

- mood disorder at 50% of patients
- anxiety disorder, at 33%
- somatoform disorders at 20.4%, and
- a substance use disorder at 17%

This is made particularly important because the mental illness and/or addiction could be a direct contributor or maintainer of their chronic pain. It will also completely change your approach to their treatment.

The basic idea is to ensure you do a PHQ-9, GAD-7 and PTSD screen, as well as screen for opioid and other substance use disorders, but if you'd like a list, we will link to a table of them in the show notes.
https://www.uptodate.com/contents/image?imageKey=ANEST%2F126443&topicKey=ANEST%2F116196&search=chronic%20pain%20mental%20illness&source=see_link

Pain-relevant behavioral risk screening assessment tools

Mood
1. Anxiety: GAD-7
2. Depression: PHQ-9 or, anxiety ***and*** depression: PHQ-4 (includes two items from both GAD-7 and PHQ-9)
3. Posttraumatic Stress Disorder Checklist-Civilian Version (PCL-C), 17 items or, PC-PTSD: four question primary care PTSD screening (comparable to PCL-C)
4. Catastrophizing: four item Patient Catastrophizing (PCS) short-form
Opioid misuse and opioid use disorder risk
1. Opioid Risk Tool (ORT)
2. Clinical Opioid Misuse Measure (COMM)
3. Screener and Opioid Assessment for Patients with Pain (SOAPP)
4. CAGE-AID (Control, Anger, Guilt, Eye-Opener, And Including Drugs)
5. Diagnosis, Intractability, Risk, Efficacy (DIRE)
6. Screening to Brief Intervention (S2BI)
7. Drug Abuse Screen Test (DAST)
8. Tobacco, Alcohol, Prescription medication, and other Substance Use (TAPS)

Objective Two:
In a patient with chronic pain who complains of significantly increased pain, search for an alternative etiology (e.g., malignancy, addiction, diversion) as you cannot assume that the original cause of the pain is the reason for the exacerbation.

- Again, think about whether there is a flare in an underlying condition or whether the etiology of the pain has changed. What else could be causing it to worsen. Identify alleviating and aggravating factors.

- This is super important because often these patients will have had multiple visits to the ED or urgent care and it can become too easy to dismiss their concerns as being a flare

of their chronic pain. You still need to do an assessment as with anyone else to ensure there is not a new secondary cause for their pain.

Objective Three:
In a patient in whom you did not make the initial diagnosis of chronic pain: Establish an effective relationship, verify the diagnosis and clarify the goals of treatment and the management plan.

Establish an effective relationship

This is such a seemingly small objective, yet there are obviously many factors involved with this and a lot of personal style that will come into establishing an effective relationship with a patient.

Ridd et al. (2009) wrote a review article on the qualitative research on patients' perspectives of what constitutes a strong patient-doctor relationship. The paper highlights four main attributes that determine the depth of the relationship: knowledge, trust, loyalty and regard.

Knowledge goes both ways: the doctor's knowledge of the patient, and the patient's knowledge of the doctor.

Trust is just what it sounds like, but is a very challenging and widespread issue in Canadian healthcare, with various populations, such as Indigenous people, that have distrust of Canadian healthcare institutions with good reason stemming from the colonial roots of these institutions. In terms of chronic pain, the notion of trust can also mean the patient feels the doctor believes them.

Loyalty refers to the patient being loyal to the provider and the provider being loyal to the patient when certain parts about their relationship might not be ideal. ie. the doctor remaining committed to a patient despite the patient exhibiting deceitful behaviour.

Regard: refers to comfort, respect and liking. The patient feels the doctor is on their side. This refers to a bond that was likened to friendship in some of the studies reviewed in the Ridd et al. (2009) paper.

These are all pillars that one can keep in mind when trying to establish an effective relationship with a patient.

Szasz and Hollender in 1956 wrote about the three basic models of the physician-patient relationship:

1. Activity-passivity: doctor does something to the patient who is unable to respond or is inert.

2. Guidance-cooperation: doctor tells patient what to do and the patient cooperates.
3. Mutual participation: doctor helps patient help themself.

I think it goes without saying that for the purposes of this episode and in most clinical interactions we aim for the mutual participation model, but also recognizing that others may be the preferred model in some situations, eg the activity-passivity model in acute trauma when the patient may be unable to respond.

a) Verify the diagnosis

- As many things in medicine, try to lay fresh eyes on a patient and do your own assessment. Think critically about what your assessment shows. Try to avoid diagnostic momentum, but also respecting and taking into account others' assessments before you.
- Again, go through a similar process to what is outlined above in terms of establishing the etiology.

b) Clarify goals of treatment and plans for management

We are going to cover this thoroughly with an excellent resource in the next objective.

Objective Four:
In managing a patient with chronic pain: Use shared decision-making, and engage other professionals in this care when appropriate

The Centre for Effective Practice (in Ottawa I think?) collaborated with the Ontario College of Family Physicians to create a pretty cool tool to help organize and formalize the management of chronic non-cancer pain and to ensure logical documentation of the plan. Management of Chronic Non-Cancer Pain

It organizes the process into four main steps:

Step One - Assessment
Get a thorough baseline assessment, which may occur over multiple visits, and begin to develop rapport with the patient.

Pain Condition

- Identify the diagnosis: eg: OA, fibromyalgia, complex regional pain, etc
- assess for Biomedical yellow flags (these identify patients at risk of poor outcomes)
- Brief pain inventory:
    - intensity, character, duration, exacerbating and alleviating factors, systemic symptoms
- prior investigations or consults

- PMHx
- current medications, both Rx and OTC

Functional and Social History

- functional status
- psychosocial history
- Social yellow flags

Mental Health

- screening for depression, anxiety and PTSD
- psychological yellow flags

Substance Use Hx and Opioid Risk Assessment

- what did they use?
- prior treatments for addiction
- there is a link on the document to an opioid risk tool, but note this has insufficient accuracy to actually risk stratiy

Step Two & Three - Management Options & Adapt and Evaluate

Always consider non-pharmacologic options:

This might also be an area where your motivational interviewing prowess (refer back to 'Counselling' episode) will come into play.

1. Physical Activity. Indicated for:
    a. Fibromyalgia
    b. Low back pain
    c. Headaches
    d. Osteoarthritis
2. Self-Management Programs
    a. Fibromyalgia
    b. Low back pain
    c. headache
    d. Osteoarthritis
    e. Neck Pain
    f. Rheumatoid arthritis
    g. Neuropathic pain
3. Psychological therapies
    a. Fibromyalgia
    b. Low back pain
    c. Headache

   d. Osteoarthritis
   e. Neck Pain
   f. Rheumatoid arthritis
   g. Neuropathic pain
   h. Particularly effective for those with co-morbid depression or anxiety
4. Physical therapies
   a. Low back pain
   b. Neck pain
   c. Neuropathic pain

Non-Opioid Pharmacotherapy

Initiate through shared decision-making with the patient while agreeing on goals and length of trial. Then titrate up as indicated and avoid polypharmacy as possible. Switching to a sequential medication rather than in parallel.

Your approach will depend on whether you identify it as nociceptive, inflammatory, neuropathic. Again, we will discuss this in the pain episode, but here are some example first line non-opioid pharmacologic approaches.

1. Acetaminophen/NSAIDs
   a. may be helpful for Osteoarthritis or low back pain
2. Anticonvulsants:
   a. Carbamazepine
      i. first line for trigeminal neuralgia
      ii. can also be used for general neuropathic pain
   b. Gabapantin
      i. for neuropathic pain. Gabapentin and Amitriptyline usually first line for these.
   c. Pregabalin
      i. could try for neuropathic pain if Gabapentin or Amitriptyline not cutting it
3. Antidepressants
   a. Amitriptyline (or nortriptyline or imipramine)
      i. general neuropathic pain
   b. Duloxetine
      i. for neuropathic pain due to: diabetes, fibromyalgia or osteoarthritis
   c. Fluoxetine
      i. for fibromyalgia
4. Topicals
   a. NSAIDs
      i. for MSK pain, such as osteoarthritis
   b. Topical rubifacients
      i. also for MSK pain if others are not effective

5. Cannabinoids are not equivalent to antidepressants or anticonvulsants, but could be considered for neuropathic pain.

Opioids

Opioids are NOT preferred treatment for chronic non-cancer pain. But if used, should be combined with non-pharmacologic options as well as non-opioid pharmacotherapy.

- Select patients carefully. Can use the Opioid Risk Tool https://www.mdcalc.com/opioid-risk-tool-ort-narcotic-abuse#use-cases along with high risk factors such as:
    - current anxiety, depression or PTSD
    - current or past history of problematic substance use: EtOH, opioids, cannabis

- Initiation
    - set specific goals for this medication
    - ensure you discuss modest benefits as well as risks and potential for loss of effectiveness over time
    - of course ensure no concomitant ingestions like EtOH, sedatives or hypnotics
    - discuss discrete trial, eg 2 weeks
    - encourage take home naloxone, particularly if > 90meq/day

    - ensure you discuss the exit strategy for how you will discontinue the opioids if they do not produce the benefits desired
- Titrate
    - until efficacious. Most response in range of 0-50MME
    - opioids have moderate effect on pain of 10-20% reduction, and a small effect on function (usually < 10%)
    - use lowest effective dose, aiming to keep under 90MME
- Evaluate
    - evaluate benefits and risks at least every 3 months
    - if not producing pre-agreed benefit, initiate taper
    - Always check on double-doctoring, or running out of pills prior to scheduled refill

Step Four - Refer

There are three likely referrals to consider at this point: Psychology/Psychiatry, Pain Specialist Service or a Multidisciplinary Pain Management Program.

<u>Psychology/Psychiatry</u>

Consider if patient:

- had moderate to high levels of distress
- difficulty adjusting to pain
- struggling to change behaviours
- referred to specialist pain service

<u>Pain Specialist Service</u>

Consider if:

- failure of 4 drugs for neuropathic pain
- opioid dose is greater than 90 MME
- inadequate response to non-specialist management

<u>Multidisciplinary Pain Management Program</u>

Usually includes: rehab and exercise therapy, patient education, vocational therapy and/or medical management.

Consider for patient who:

- has poor functional capacity
- has moderate to high level of distress
- has significant social and occupational problems related to their pain
- prefers self-management to a medical approach

Objective Five:
In a patient with chronic pain: Comprehensively document the assessment, plan, goals, and prescription details and Make the treatment plan appropriately accessible

Of course upload any documentation to a widely available database, such as NetCare in Alberta and aim to have it distributed to other prescribers involved with the patient, the pharmacy, etc.

The CEP document referenced in Objective four also has an awesome fillable PDF on the final page which gives a consolidated record of the treatment plan, prior sequential assessments, and current/previous treatments trialled. This can be distributed to everyone involved, and presumably the patient can have this on hand as well anytime they go to a new venue.

Objective Six:
When prescribing medications with abuse potential in a patient with chronic pain where you have no established relationship or insufficient records, be prudent in your prescribing. Do not simply provide or refuse to prescribe.

https://www.cpsbc.ca/files/pdf/WS-Prescribers-2018-09-28-Mead.pdf

The College of Physicians and Surgeons of BC recommends a few key considerations for this patient:

- Review the goals of the treatment, eg:
    - objective improved function
    - reduction in pain
- Outline a schedule of appointments as well as frequency of monitoring. This will depend on your impression of their risk of addiction, compliance or rerouting of medications. and might include measures such as
    - weekly appointments
    - point of care urine drug screening frequency
    - random pill counts or pharmacist witnessed ingestions
- Outline prescribing elements and contingency consequences if they were to breach elements of the contract
- Check PharmaNet, Netcare of whatever provincial solution you have to ensure they are not double-doctoring
    - ensure the patient knows you will check this prior to each refill

Give patient a signed copy of their opioid treatment agreement contract, (sample in the show notes) and have this agreement readily available in the chart

- Have the patient choose one pharmacy and advise that the pharmacist is part of the treatment team and will have regular contact
- Notify other prescribers the patient sees

*A couple of pearls they mention in this presentation as well are:

1. Prescribe in weeks, and document specific start and end dates, with the end landing on a Monday or Tuesday, this helps avoid running out on a Friday and the clinic being closed.
2. Have the patient make their renewal appointment before they leave the clinic, to avoid the crisis of not being able to get an appointment on the day the pills are finished

RxFiles has an open access pdf with tons of tips for prescribing opioids safely https://www.rxfiles.ca/RxFiles/uploads/documents/members/Prescribing%20Opioids%20Safely.pdf

Objective Seven:
Use a written treatment contract with realistic consequences when prescribing medications with abuse potential to a patient with chronic pain.

Some examples to consider of medications with abuse potential include: Opioids (including T3s and Tramadol), Benzodiazepines, Z-Drugs, Stimulants,

- if high risk of substance abuse, should also include meds such as:
    - Gabapentin, Cyclobenzaprine, Bupropion.

The college of physicians and surgeons of BC has a good presentation covering the process https://www.cpsbc.ca/files/pdf/WS-Prescribers-2018-09-28-Mead.pdf which we will link to in the show notes.

A sample treatment contract will also be in the show notes.

The CPSBC relates a few 'levers' available to you for managing consequences of breach of contract:

- initiating prescription in the first place
- increased appointment frequency, and related shortening of prescription length
- pharmacy dispensing frequency
- prescription dose
- frequency of monitoring:
    - random pill call back counts
    - random urine drug screening

Pain Treatment Agreement

I, _____ agree that Dr. _____ will be the only physician prescribing opioid pain medication for me. I will not seek opioid medications from other doctors.

I will give written consent for ongoing access to my PharmaNet profile by my doctor as a condition of prescribing. PharmaNet is an important tool in ensuring opioids are used safely.

I will not take opioid medication in larger amounts or more frequently than as prescribed.

I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication may not be replaced.

I will not use over-the-counter codeine containing medications such as 222's and Tylenol #1's (codeine compounded with caffeine, ASA or acetaminophen).

I will attend all reasonable appointments, treatments and consultations as requested by my physician.

I understand that the long-term use of opioids to treat chronic pain will often result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of opioid withdrawal. I understand that opioid withdrawal is uncomfortable but not life threatening.

I understand that there is a risk that I may become addicted to the opioids I am being prescribed. My physician may require that I have additional blood or urine testing and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment. I will comply with all requests for laboratory tests including random urine drug screens ordered by my physician.

I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.

I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, and emergency departments. This includes reviewing information available from PharmaNet.

I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

I will comply with requests by my physician to attend at the office for a pill count between scheduled visits.

Patient's signature: _____

Physician's signature: _____

ıs and Surgeons of British Columbia Date: _____

Objective Eight:
When a patient with chronic pain has breached a contract: Manage your own emotions, Address the possible impact on your staff and team, and Apply or judiciously amend the contract

a) **Manage your own emotions**
   - Spaced repetition: remember loyalty. Remaining loyal to a patient despite deceitful behaviour.
b) **Address the possible impact on your staff and team**

c) **Apply or judiciously amend the contract (e.g., not putting a patient into immediate withdrawal)**

   Some of the options or 'levers' available to you were mentioned in objective seven. Some of these are:
   - more frequent appointments
   - more frequent urine tests or pill counts
   - shorter prescription durations
   - inclusion of witnessed ingestions
   - ensure prescriptions end on Monday or Tuesdays, not Fridays or weekends
   - have them make their next appointment before they leave the clinic to ensure follow-up is confirmed

Your other option in this case is the exit strategy. See the full document linked in the show notes from RxFiles. This means discontinuation or taper of an opioid. aOf course you don't want to throw them into withdrawal. The rule-of-thumb for taper is 5-10% taper q2-4weeks, but of course this is going to be very situation dependent.

- ensure the patient does NOT feel abandoned! https://www.rxfiles.ca/RxFiles/uploads/documents/members/Prescribing%20Opioids%20Safely.pdf

Sources

Canadian Pain Task Force Report: June 2019

https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2019.html

Albert Dahan, Monique van Velzen, Marieke Niesters; Comorbidities and the Complexities of Chronic Pain. *Anesthesiology* 2014; 121:675–677 doi: https://doi.org/10.1097/ALN.0000000000000402

https://www.cpsbc.ca/files/pdf/WS-Prescribers-2018-09-28-Mead.pdf

https://tools.cep.health/wp-content/uploads/2019/10/CEP_CNCP_Updated2018.pdf

https://www.painnewsnetwork.org/stories/2019/6/6/who-recognizes-chronic-pain-as-disease-with-new-coding-system

Tintinalli's Ch 38 pp.256-261

https://www.dynamed.com/condition/chronic-pain-in-older-adults

https://www.uptodate.com/contents/approach-to-the-management-of-chronic-non-cancer-pain-in-adults?search=chronic%20pain&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Ridd, M., Shaw, A., Lewis, G., & Salisbury, C. (2009). The patient–doctor relationship: A synthesis of the qualitative literature on patients' perspectives. British journal of general practice : the journal of the Royal College of General Practitioners, 59(561), e116–33. doi: 10.3399/bjgp09X420248

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

YELLOW FLAGS[1]

Assess the following to identify patients with CNCP who are at risk for poor outcomes:	
Biomedical	• Severe pain or increased disability at presentation • Previous significant pain episodes • Multi-site pain • Non-organic signs • Iatrogenic factors
Psychological	• Belief that pain indicates harm • Expectation that passive rather than active treatments are most helpful • Fear-avoidance behaviour • Catastrophic thinking • Poor problem-solving ability • Passive coping strategies • Atypical health beliefs • Psychosomatic perceptions • High levels of distress
Social	• Low expectations of return to work • Lack of confidence in performing work activities • Heavier workload • Low levels of control over rate of workload • Poor work relationships • Social dysfunction/isolation • Medico-legal issues
Patients at higher risk of poor outcomes may require closer follow-up and greater emphasis on a diversified non-pharmacological and pharmacological, multi-modal approach to treatment.[7]	