As exemplified by the 2016 Centers for Disease Control and Prevention guidelines on the management of chronic nonmalignant pain (CNMP), much of the conversation about CNMP revolves around the appropriate use of opioids and overlooks a golden opportunity for family physicians to partner with patients to prevent this chronic disease. Prevention is a focal point of the care that I, as an osteopathic family physician, provide to my patients, and it is fundamental to the treatment of other chronic diseases such as diabetes. Whereas 29.1 million people in the United States have diabetes, an Institute of Medicine report noted that every year, 100 million people have CNMP. In light of the number of patients with CNMP, family physicians need to do a better job in addressing how to prevent this chronic disease in their local communities.

A valuable model for addressing diabetes is the concept of chronic disease management, defined as “an organized, proactive, multicomponent, patient-centered approach to health care delivery that involves all members of a defined population who have a specific disease.” Managing chronic diseases may include prevention, screening, multimodal treatment modalities, patient and physician engagement in care, self-management, goal initiation, referral for lifestyle modification, and information technology with database and electronic medical record use. This model of care is equally beneficial for treating patients with CNMP.

As osteopathic physicians caring for patients with diabetes, we should never consider using an oral medication alone to manage hyperglycemia. Rather, we approach the patient’s treatment from many different angles. However, in the treatment of CNMP, physicians have used traditional analgesic ladders for the titration of pain medications without other modalities. This use of a single-treatment modality focused only on lowering the patient’s pain score has contributed to our present opioid abuse crisis. Every day in the United States more than 650,000 opioid prescriptions are given. In 2014, almost 2 million Americans abused or were dependent on prescription opioids, and more than 14,000 people died from overdoses involving prescription opioids. Furthermore, in the management of diabetes, the examination room discussion has shifted to a focus on prevention. In 2002, the US Department of Health and Human Services and the American Diabetic Association defined prediabetes, which creates a clear link between diabetes and the terms impaired fasting glucose and impaired glucose tolerance, enabling patients to understand the importance of diet and exercise to prevent disease. Likewise, I advocate replacing the term acute pain with prechronic pain. This concept would remind patients and physicians of the potential for CNMP, which could develop from the acute pain episode.

Physicians often forget to address prevention when managing acute pain. Unfortunately, we start to address the possibility of CNMP only after the patient has had acute pain lasting more than 3 months or longer than the accepted length of healing. Using the concept of prechronic pain to create a stronger link between acute and chronic pain would change the discussion between patients and physicians from the beginning of the painful episode. Medical literature has shown that the cellular and neurobiologic changes leading from the peripheral sensitization of acute pain to the central sensitization of chronic pain often begin within a few minutes to days of the inciting injury. Thus, for a patient with an acute injury, osteopathic primary care physicians should address CNMP prevention at the onset of acute pain. Such methods of prevention include...
cultivating a caring patient-physician relationship, encouraging the long-term goal of restoring function over the short-term goal of pain relief, providing osteopathic manipulative treatment for a variety of painful conditions including low back pain and migraine headaches, keeping the patient active, and identifying and managing opioid use disorder or psychiatric disease as appropriate. As in the management of diabetes, we need to immediately develop a multimodal treatment plan aimed at secondary prevention of CNMP from the onset of an acute illness or injury.

Apart from the secondary prevention strategies noted above, osteopathic primary care physicians should also focus on primary prevention of CNMP, where our goal is to prevent pain before the acute or prechronic episode occurs. Common examples of primary prevention in primary care medicine include providing the shingles vaccine to prevent shingles and postherpetic neuralgia and encouraging seatbelt use to prevent whiplash and injuries related to motor-vehicle accidents that can cause CNMP. In addition, addressing posttraumatic stress disorder and pain in patients in medical and surgical intensive care units is important because these patients are at higher risk of these conditions after discharge. Other primary preventive measures address tobacco use, which can inhibit tissue healing, and the need for a structured exercise program, which can be a protective mechanism for the prevention of pain. As osteopathic physicians, we can provide osteopathic manipulative treatment as a primary prevention strategy to maximize tissue functioning and prevent injury. Thus, through a focus on prevention and linking acute pain to CNMP with the concept of prechronic pain, osteopathic primary care physicians have an opportunity to make a lasting impact on the CNMP and opioid abuse crises. (doi:10.7556/jaoa.2016.126)

References


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