

THE PAIN MANAGEMENT

5 ESSENTIAL TIPS FOR PRIMARY CARE PROVIDERS

PLAYBOOK

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MANAGEMENT

I DO NOT HAVE ANY RELEVANT RELATIONSHIPS TO DISCLOSE.

A soccer goal with an orange net stands on a lush green field at night. A bright light source, possibly the moon or a powerful spotlight, is visible in the upper left corner, casting a strong glow and creating a lens flare effect. The background is dark, with some trees visible in the distance.

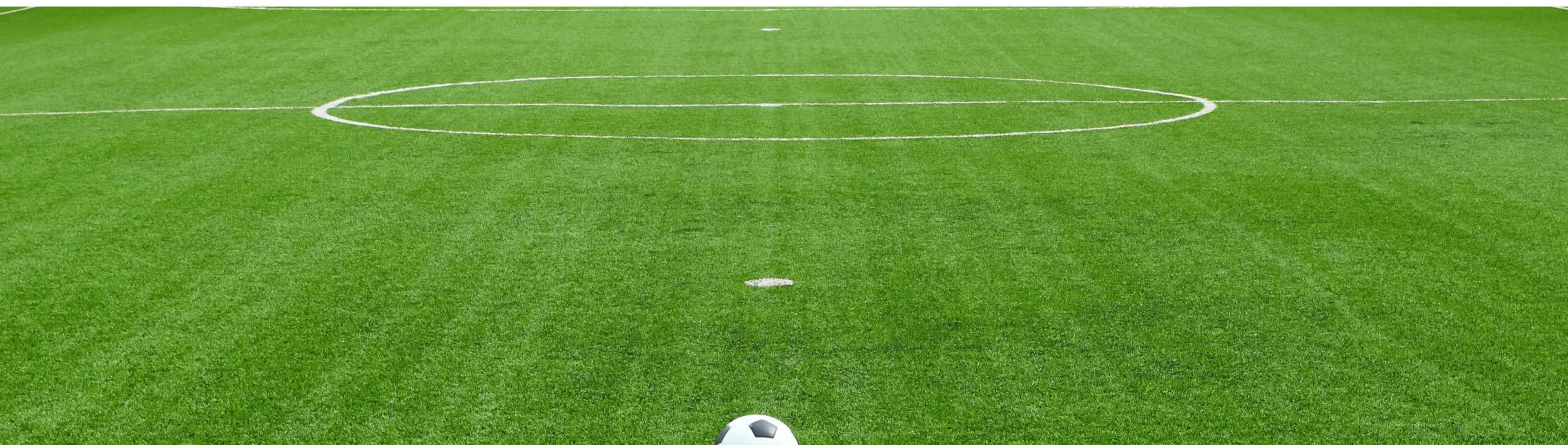
Presentation Objectives

- Understand the multidimensional nature of pain and its assessment.
- Utilize validated tools for pain assessment and management.
- Apply evidence-based pharmacological and non-pharm strategies for pain management.
- Prescribe safely using current guidelines & set realistic functional goals.
- Know when to monitor, adjust, and refer.

Why Pain Management matters

- 20-30% of primary care visits are driven by pain complaints, including musculoskeletal pain, headaches, and abdominal pain.
- Chronic pain affects > 20% of adults and is challenging to treat safely.
- Primary care providers are often the first point of contact for patients experiencing acute or chronic pain.

**TIP #1: KNOW WHAT
YOU'RE WORKING WITH**



Identify Pain Type

Pain is a complex process mediated by multiple pathways and mechanisms in both the peripheral and central nervous systems

- **Nociceptive:** Activation of pain-sensitive afferent neural pathways in response to injury
- **Neuropathic:** Abnormal pain processing due to lesions in the peripheral and/or central nervous systems
- **Nociplastic:** Pain arising from altered central pain processing, *without clear evidence* of actual tissue damage (nociceptive) or nerve injury (neuropathic).

TIP #1: KNOW WHAT YOU'RE WORKING WITH

Nociceptive Pain - Somatic

Descriptors: constant, achy

Location: well-localized in skin and subcutaneous tissues; less well-localized in bone, muscle, blood vessels, connective tissues

Examples:

- incisional pain
- bone fractures
- bony metastases
- burns
- rheumatoid arthritis
- osteoarthritis
- degenerative joint/spinal disease

TIP #1: KNOW WHAT YOU'RE WORKING WITH

Nociceptive Pain - Visceral

Descriptors: cramping, splitting

Location: originates in internal organs or body cavity linings;
poorly localized, diffuse, deep

Examples:

- appendicitis
- intestinal distention
- myocardial ischemia
- organ metastases
- bowel obstruction
- cholecystitis

Neuropathic pain

Descriptors: electric, sharp, shooting, numb, non-volitional

Location: well-localized or diffuse/centralized; may follow dermatomal distribution

Examples:

- sciatica
- diabetic neuropathy
- shingles
- MS-related pain
- phantom limb pain
- trigeminal neuralgia
- chemo-therapy induced neuropathy
- complex regional pain syndrome

Nociplastic pain

Descriptors: Diffuse, allodynia (pain from non-painful stimuli), hyperalgesia (heightened pain response), often associated with fatigue, cognitive difficulties, and sleep disturbances

Examples:

- Fibromyalgia
- IBS
- Tension headache
- Interstitial cystitis
- Chronic pelvic pain
- Tension headache

Acute vs. Chronic

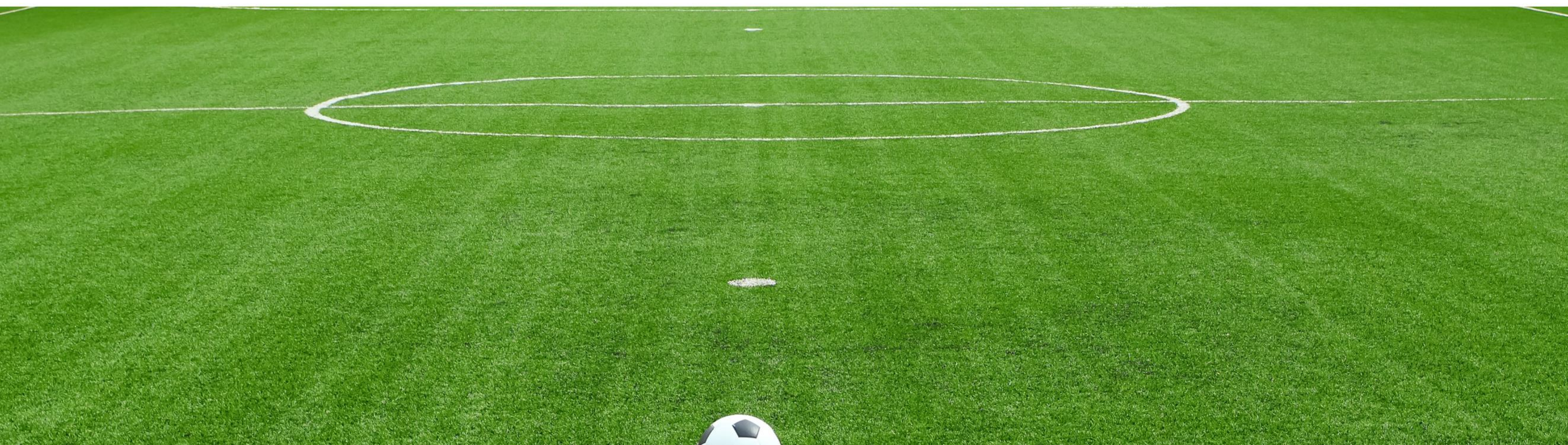
Acute pain: Sudden onset, typically related to a specific injury, surgery, or illness.

- Duration: Usually less than 3 months (some sources say <6 weeks).
- Purpose: Serves a protective function—a biological warning of injury or disease.

Chronic pain: Pain that persists or recurs > 3 months, beyond normal healing time.

- Duration: ≥3 months (per CDC, IASP, and most guidelines)
- Purpose: Often serves no protective function; may become its own disease state.

TIP #2: USE VALIDATED PAIN ASSESSMENT TOOLS



Pain is Multidimensional

Assess physical, psychological, and social factors:

- How does the pain affect daily activities, work, and quality of life?
- Does the pain impact sleep, mood, or relationships?

Use validated tools to assess pain:

- Pain Scales: Visual Analog Scale (VAS), Numeric Rating Scale (NRS).
- Functional Assessments: Brief Pain Inventory (BPI), Oswestry Disability Index (ODI).

Pain is Multidimensional

Use validated tools to assess pain, continued:

- Psychosocial Measures: Pain Catastrophizing Scale (PCS), PHQ-9 for depression.
- If considering or using opioids, use an opioid risk assessment tool:
 - Opioid Risk Tool (ORT), Screener and Opioid Risk Assessment for Patients with Pain – Revised (SOAPP-R), Current Opioid Misuse Measure (COMM)

Detailed Pain History

OPQRST framework to systematically evaluate the pain:

- **Onset:** When did the pain start? Was it sudden or gradual?
- **Provoking/Palliating Factors:** What makes the pain worse or better?
- **Quality:** How does the pain feel (sharp, dull, throbbing, burning)?
- **Radiation:** Does the pain move to other areas?
- **Severity:** Rate the pain on a scale (e.g., 0–10 or visual analog scale).
- **Timing:** Is the pain constant or intermittent? Any patterns or triggers?

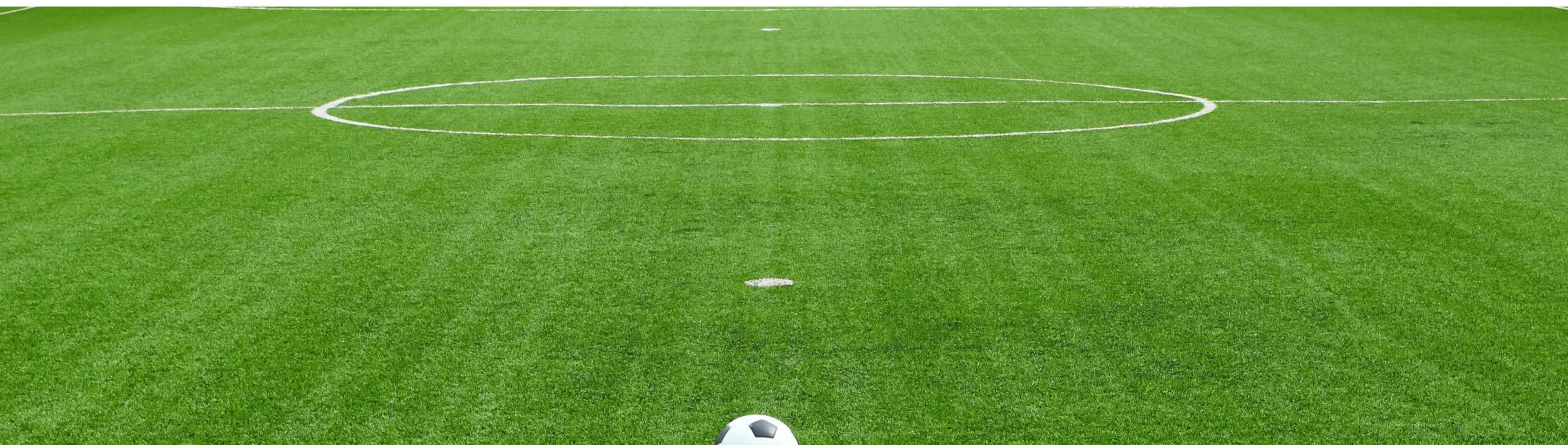
Physical Exam

- Focus on the area of pain but include a broader assessment to rule out referred or systemic causes.
- Look for signs of inflammation, deformity, tenderness, or neurological deficits.
- Perform functional tests to assess mobility and limitations.
- **Red Flags:** Trauma, fracture, fever or infection, unexplained weight loss, neuro symptoms.

Listening, Rapport & Empathy

- Validate pain, avoid stigma
- Rapport reduces anticipatory pain signals
- Empathy can modulate pain processing
 - increases perceived safety, which activates endogenous opioids

TIP #3: Use Pharm- and non- Pharmacologic Strategies



Non-Pharm Strategies First

- **Prioritize non-pharmacologic interventions as first line:**
 - Physical therapy, CBT, mindfulness
 - Ice, heat, distraction, sleep hygiene
 - TENS, massage, acupuncture
 - Music therapy, Animal-assisted therapy

Non-Opioids Next

Class	Action	Examples
Acetaminophen, NSAIDs	Varied mechanism, action on prostaglandin synthesis	Acetaminophen, celecoxib, ketorolac, ibuprofen
Alpha-2 agonists	Inhibition of NE release	clonidine, dexmedetomidine
Anticonvulsants	Decrease excitability of neurons by modulating sodium channels	Gabapentin, pregabalin
Antidepressants	Inhibition of NE and serotonin reuptake	Amitriptyline, duloxetine
Local anesthetics	Modulate sodium channels; interrupts nerve conduction	Bupivacaine, lidocaine, liposomal bupivacaine
NMDA-receptor antagonists	Dissociative anesthesia/analgesia; reduce CNS excitability	Ketamine, dextromethorphan

Short-Acting Opioids are Third

Is patient opioid naïve or opioid tolerant?

- Opioid-Naive: A patient who has not taken opioids on a regular (daily or near-daily) basis for the past 7 days.
- Opioid-Tolerant: A patient who has been taking at least 60 mg oral morphine equivalent (MME) daily for ≥ 7 consecutive days.

Start low and go slow: Opioid-naïve patient examples:

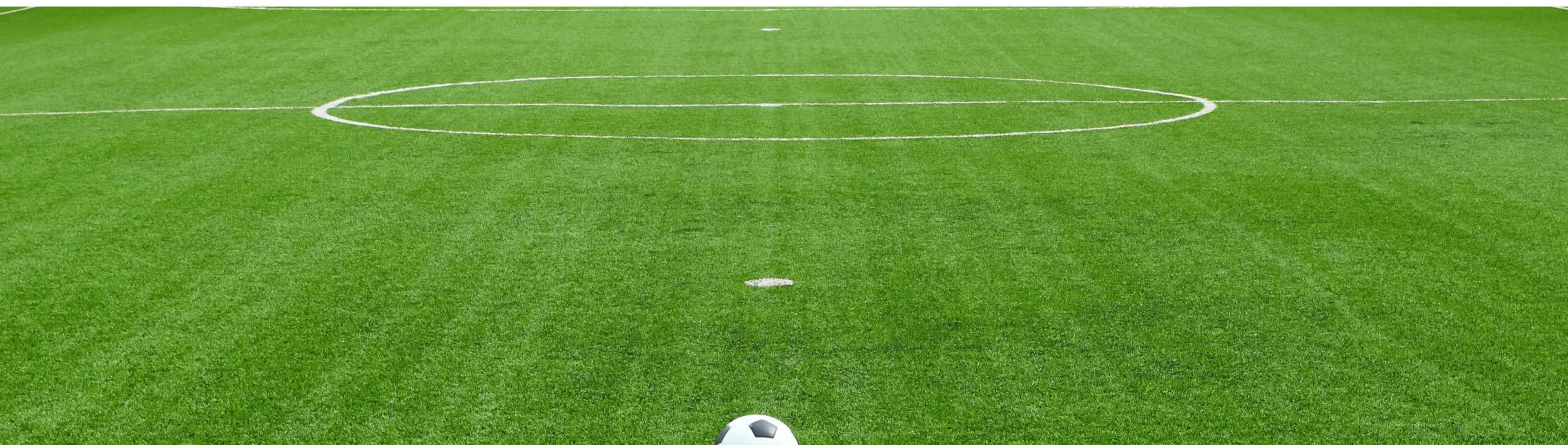
Hydrocodone/Acetaminophen 5/325 1 tab PO q4-6 hours PRN

Oxycodone 5mg PO q4-6 hours PRN

Caution with Long-Acting Opioids

- Do not prescribe long-acting opioids for acute pain or to opioid naïve patients (special circumstances for this exist but consult a pain management specialist)
- Need to be familiar with assessing tolerance, opioid equivalency calculations, and document well – come to my talk later on All About Opioids!

TIP #4: Prescribe Safely & Set Realistic Goals



Follow Evidence-Based Guidelines

- Use CDC 2022 Guidelines: Shared decision-making, flexible dosing, documented risk-benefit (CDC, 2022)
- Always check your state's Controlled Substance Prescription Monitoring Database; document that you checked and what you found.
- Document patient consent to use opioids and educate on risks; opioid agreements.
- Do not co-prescribe opioids and benzodiazepines.
- Consider co-prescribing naloxone (if risk factors or daily dose $>$ or $=$ to 50 MME)
- Close follow-up & urine drug screens when indicated

Set Functional Goals

Help patients reframe from pain number to something more tangible

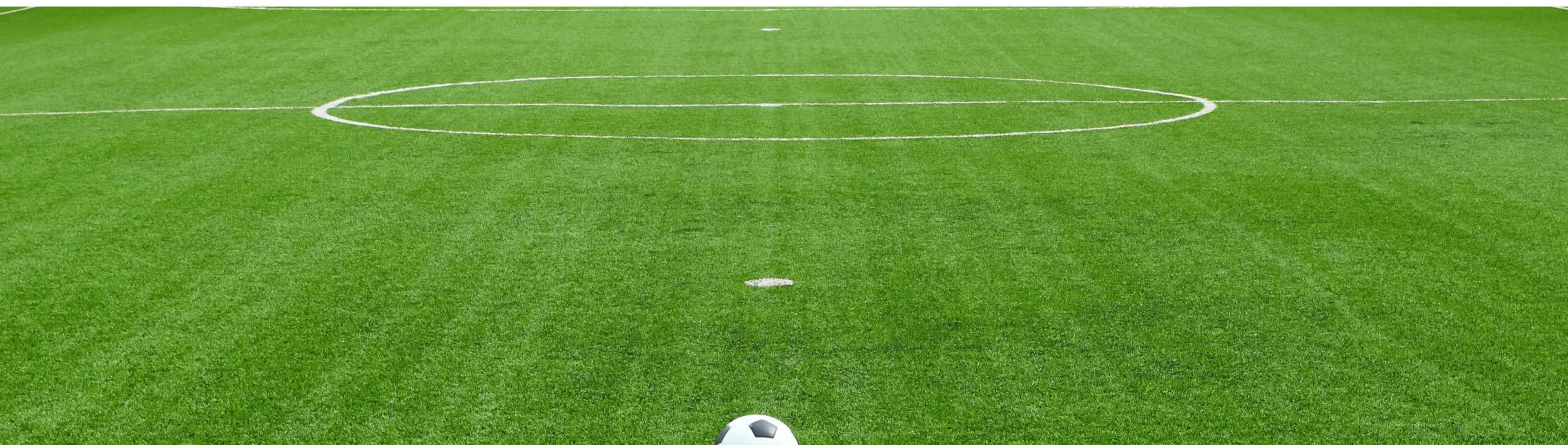
- Discuss what success looks like to your patient
- Set goals around function rather than complete pain elimination

Measure and document progress with a validated tool, and anecdotal comments from patient at every follow up visit

Functional Assessment Tools

- **Brief Pain Inventory (BPI):** Assesses pain severity and interference with function.
- **Pain, Enjoyment of Life, and General Activity (PEG) Scale:** Brief version of the BPI, ideal for primary care
- **Oswestry Disability Index (ODI):** Measures functional disability due to low back pain

TIP #5: Know when to Monitor, Adjust & Refer



When to Monitor

Close follow up (1-2 weeks) for:

- anyone starting opioid therapy, significant comorbidities, older age, history of aberrant behavior
- anyone starting on therapy for chronic pain expected to be taking medications for an extended period of time.

Longer follow up (3-4 weeks) okay for:

- acute pain flares that are expected to resolve with resolution of injury and pain that is responsive to non-opioid therapies.

When to Adjust

When patient is taking analgesics as directed and...

- improving -> continue to monitor and taper by extending dosing interval or decrease dose
- not improving -> titrate dose or rotate to different approach/medication

When patient is having side effects...

- reduce dose
- treat side effects
- rotate to different medication

When aberrant behavior is suspected...

- dose reduce to d/c and refer

When to Refer

- Pain is chronic or complex
- Initial treatments are ineffective
- Pain involves high risk of complications
- Interventional or advanced techniques may be needed
- Significant psychological and emotional components of pain
- Red flags suggest specialized care
- When multidisciplinary support is needed

Know your Allies: Refer when needed!



A soccer ball with black and white panels sits on a lush green grass field. A large, faint, light-gray circle is centered on the image, with a horizontal line passing through its middle. The text "Game Time!" is written in a large, white, sans-serif font across the upper portion of the circle.

Game Time!

Case Study Examples

Case #1: Frieda with Fibro

A 43-year-old woman with fibromyalgia presents for follow-up due to persistent, diffuse musculoskeletal pain. Symptoms include widespread aching, burning, fatigue, morning stiffness, allodynia, and non-restorative sleep. She has been practicing daily yoga and meditation for the past three months with minimal relief.

The pain is now interfering with her ability to care for her young children and manage her nonprofit organization. She has no depression, anxiety, or substance use history. Physical exam reveals soft tissue tenderness at multiple sites without inflammation. She asks about medications to improve function and quality of life.

What's Your Play?



- A. Duloxetine 30mg once daily**
- B. Oxycodone 5 mg orally every 4–6 hours as needed**
- C. Ibuprofen 600 mg orally every 8 hours as needed**
- D. Colchicine 0.6 mg orally once or twice daily**

***TIP #1: KNOW WHAT YOU'RE WORKING WITH –
Nocioplastic, Chronic Pain***

***TIP #2: ASSESS WITH VALIDATED TOOLS –
Screened and assessed for psych, SUD***

***TIP #3: USE PHARM & NON-PHARM STRATEGIES –
Tried meditation and yoga; next step is non-opioid***

***TIP #4: PRESCRIBE SAFELY & SET GOALS –
Share goal of improved interaction with kids and career***

***TIP #5: MONITOR, ADJUST, REFER –
No red flags; follow up in 3-4 weeks***



Case #2: Larry with LBP

A 57-year-old man with chronic low back pain presents for follow-up. He has trialed 3 nonopioid analgesics and physical therapy, but pain limits his participation in PT. He reports significant functional impairment and missed workdays. He requests a stronger analgesic to improve his ability to engage in therapy. He has no psychiatric history, takes no other medications, and does not use tobacco or alcohol. After discussing risks and benefits, he agrees to a short-term opioid trial. A patient-provider agreement is signed. Nonopioid medications and physical therapy will continue.

What's Your Play?

A diagram of a soccer field on a green background. The field is marked with white lines for the center circle, center point, and two goal areas. Each goal area has a goalpost and a net. The title 'What's Your Play?' is centered at the top of the field.

- A. Morphine sulfate immediate-release 15 mg 3 times a day PRN**
- B. Morphine sulfate extended-release 15 mg twice daily**
- C. Oxycodone immediate-release 5 mg twice daily PRN**
- D. Oxycodone extended-release 10 mg twice daily**

***TIP #1: KNOW WHAT YOU'RE WORKING WITH –
Nociceptive, Somatic, Chronic Pain***

***TIP #2: ASSESS WITH VALIDATED TOOLS –
Screened and assessed for psych, SUD***

***TIP #3: USE PHARM & NON-PHARM STRATEGIES –
Tried PT and non-opioids; next step is short-acting opioid***

***TIP #4: PRESCRIBE SAFELY & SET GOALS –
Pt is opioid-naïve; low dose is appropriate;
shared goal of improved participation with PT***

***TIP #5: MONITOR, ADJUST, REFER –
No red flags; follow up in 1-4 weeks***







Remember:

- **Pain is multidimensional – assess the whole human and individualize plans.**
- **Use evidence-based pharmacological and non-pharm strategies.**
- **Always follow guidelines when prescribing opioids.**
- **Refer when a case feels out of your league.**



THANK YOU!

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