Results of the CHANGE PAIN® survey on physician’s perception about the management of severe chronic non-cancer pain

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Introduction
Recent studies and publications suggest that there is no general consensus as to what constitutes best practice in the management of chronic pain, and that the treatment prescribed is highly dependent on geographical location. The primary aim of the CHANGE PAIN® initiative is to increase healthcare professionals’ understanding of chronic pain, and thereby improve its management. In September 2009, a worldwide survey was started, to explore physicians’ perceptions of severe, chronic non-cancer pain and their opinions regarding current treatment modalities. This analysis focuses on the results from three groups of healthcare professionals: pain specialists, primary care physicians and other specialists (e.g. neurologists and rheumatologists).

Objectives
The objective of this ongoing survey is to compare the understanding of severe, chronic non-cancer pain, opinions of current treatment options, and experience with classical strong opioids, in physicians from the three groups.

Methods
This computer-based survey was started at the EFIC congress in 2003 and has since been conducted at numerous European pain congresses. Physicians themselves answered questions about the management of severe, chronic non-cancer pain via touch-screen computers. The survey is also available online (www.change-pain.com). Data from September 2009 to December 2010 have been analyzed descriptively.

RESULTS

Specialization of respondents
2,919 participants had completed the survey by December 2010. 48% of the respondents were pain specialists (pain medicine, anaesthesiology), 22% were primary care physicians (primary care, internal medicine, general practice) and 31% worked in other disciplines (neurology, palliative care etc.).

The NRS - where does severe pain start and what is the objective in pain reduction?
Participants had no common understanding of the point at which severe pain starts on an 11-point numeric rating scale (NRS). Overall, a large majority (86.1%) considered the threshold to be 5 to 8 range, and no major differences existed between the three groups of healthcare professionals.

Choice of analgesic treatment
Many different factors weigh into the choice of analgesic treatment, the results from the survey shows. Pain specialists ranked efficacy and tolerability as most important. In contrast, primary care physicians ranked efficacy and side effects (balance) as most important.

Factors limiting the treatment of severe, chronic non-cancer pain with opioids
A large majority of respondents agreed that lack of knowledge of the physiological difference between nociceptive and neuropathic pain, and of the pharmacology of different analgesics, currently limits the successful treatment of chronic pain. It was also agreed that diagnosing the presence of a neuropathic component in a patient with chronic pain is often difficult, and that a neuropathic component is frequently associated with pain that is more severe and difficult to treat.

Prescription of opioids
Differences were also recorded in the use of classical strong opioids by the different groups. More than half the pain specialists (55.4%) use classical strong opioids for severe, chronic non-cancer pain often or very often, and only 9% never use them. This compares with 30.4% and 33.8% of primary care physicians and other specialists who use these drugs often or very often, and 14.5% and 20.2%, respectively, who never use classical strong opioids. The average duration of treatment for severe, chronic non-cancer pain with a specific opioid also varied between the different physician groups. Whereas 57.0% of the pain specialists considered the average duration to be 3 months, this was reported by only 36.1% and 40.3% of primary care physicians and other specialists, respectively.

Conclusion
The results of the CHANGE PAIN® physician survey show that pain reduction and improvement in quality of life are the most important treatment goals for all healthcare professionals, while pharmaceutical treatment approaches differ. The lack of consistency in treatment indicates that apparently no single drug is particularly good for managing any chronic pain condition and, furthermore, implies that current treatment choices which physicians make may not be evidence-based.

Table 2 shows the 10 most frequently mentioned approaches reported by the different physician groups. Classical strong opioids feature more prominently in the columns relating to pain specialists and other specialists, indicating that they may be used more often by these two groups. This reflects the results for monotherapy, in which the proportions of pain specialists, primary care physicians and other specialists prescribing classical strong opioids are 34.1%, 15.8% and 25.5%, respectively.

Table 1: Top 10 reported drug combinations for severe chronic low back pain

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Figure 1: Rating of severity of chronic non-cancer pain on a numeric rating scale (NRS)

When treating patients with severe, chronic non-cancer pain, two-thirds of respondents aimed to reduce pain intensity to a NRS score of 2 to 4, with primary care physicians tending to aim for lower scores.

Ranking of treatment goals in order of importance
Survey participants were given a list of six treatment goals for patients with severe, chronic non-cancer pain, and asked to rank their top three in order of importance. All three groups considered reduction of pain to be the most important. The results for pain specialists and other specialists differed only slightly (86.1% and 83.2%, respectively), but the proportion of primary care physicians was higher at 87.4%. These differences between the physician groups were statistically significant (p < 0.0001). All three groups had equal priority of life in second place; this option was chosen by approximately one-third of both specialist groups, but by almost half the primary care group.

Figure 2: Factors determining the choice of analgesic treatment

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Main pharmacological approach for treating severe chronic low back pain
The overwhelming majority (93.2%) of respondents use combination treatment rather than monotherapy in this indication, and the proportion varies little in the different physician groups (89.0% to 90.6%). No fewer than 136 different combinations were listed by the survey participants, confirming a wide diversity in the treatment of chronic pain. Primary care physicians use a smaller range of combinations (109) than either pain specialists (148) or other specialists (143).

Figure 3: Pharmacological treatment approach for severe chronic low back pain

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