



Vitality

An EFAP Newsletter for Human Resource and Occupational Health Professionals, Program Administrators, Supervisors, and Key Personnel



Pain Management

Pain management has evolved to include more types of therapy, non-invasive and non-pharmaceutical forms of treatment and relief, and plenty of research on the topic. Unfortunately, this doesn't mean that cases of acute pain or chronic pain are decreasing, just that our awareness about our options and how we thrive, despite the pain, has changed.

The North American pain management profile

From the time we are born, people become aware of and sometimes accustomed to the various sensations we call pain. From the searing hot pain of an asphalt scrape to the throbbing ache of a broken bone, the feeling takes on different qualities depending on where the injury occurs, what kind of material - bone, nerves, or skin, for example - is affected, and how long it lasts. Acute pain is what is felt directly after an incident, and chronic pain is the

kind that lingers for six months or more. Sometimes chronic pain clings to an individual for the rest of their life, though it isn't necessary to suffer from such pain for so long. Therapies of all kinds exist to help pain patients improve mobility, decrease pain symptoms, and reframe how pain affects their daily lives, including where it intersects with work and career.

Workers who deal with pain daily are not alone. The typical Canadian workplace with more than 50 employees will more than likely have more than one pain patient among them; that is, a person who has a diagnosable chronic pain condition and who follows a medical protocol. Chronic pain is a daily reality for many Canadian adults. It has significant social and economic implications, including dividing the family, social isolation, poor self-image, low confidence, potential loss of income and absenteeism.



Its prevalence in Canada is as high as 29 percent. Work-related injuries are among the most common causes of chronic pain.

Over to the United States, a 2018 report from the Centers for Disease Control and Prevention estimated that 50 million adults in the country - 20.4 percent of the adult population at the time - were living with chronic pain, or pain most days or every day for at least the past six months.¹

What is chronic pain and how does acute pain turn chronic?

Not all pain is created equal.

While acute pain is a normal sensation triggered in the nervous system to indicate injury, chronic pain is different because it persists for weeks, months, and even years and can seem like it comes from no one cause in particular. There may have been an initial mishap - sprained back, infection, or there may be an ongoing cause of pain - arthritis, cancer, ear infection.

Still, some people suffer chronic pain in the absence of any past injury or evidence of body damage. Chronic pain can manifest as headaches, back pain, arthritis pain, neurogenic pain, or psychogenic pain. Several chronic pain conditions may coexist, like chronic fatigue syndrome, endometriosis, fibromyalgia, inflammatory bowel disease, bladder pain syndrome (BPS), temporomandibular joint dysfunction, and vulvodynia. In Western medicine, where it is typical to treat each symptom with one prescription, the medications for a chronic pain patient can start to add up.

Painful conditions are often associated with profound psychological symptoms for affected individuals and their families. People with chronic pain can develop depression, anxiety, or post-traumatic stress disorder as well. A poor state of mental wellbeing, in turn, can heighten the perception of pain and make rehabilitation efforts more difficult. Treating these secondary mental health conditions is essential for helping people cope and recover from a chronic pain condition and may require the aid of antidepressant drugs.

As mentioned in this New York Times - Well column from 2011, a study by the Institute of Medicine observed that pain could be endured long after the illness or injury that caused the onset is healed, until it becomes another diagnosis altogether; that is chronic pain.² When it comes to chronic pain, the pain is no longer indicative of another

prognosis - it is the prognosis, and it can be enormously disabling.

For instance, arthritis causes long term inflammation and damage to the joints, and it may hurt as long as the swelling lasts.

Long-term, or untreated, chronic pain can eventually cause damage to the nerves that transmit and communicate pain. This type of pain is neuropathic, and it can be lifelong. When any pain lasts a long time, changes in the spinal cord and the brain can end up changing how we perceive painful sensations. These changes may result in severe pain with little or no painful stimulus. Some chronic pain can be tough to treat and can become so frustrating for patients that it manifests depression or other emotional problems in the patient. It is this type of pain that represents some of the most challenging issues a pain management specialist can face.

Invisible disabilities: Two common types of chronic pain in the workplace

One of the things that frustrate patients with chronic pain is that their symptoms, though significant, are hidden from sight.

Two conditions, in particular, complex regional pain syndrome (CRPS) and fibromyalgia (FM), are common in the North American workplace. Though they are both chronic pain and may have similar symptoms, the two are treated quite differently in the medical system and matters of work and social assistance benefits.

Complex regional pain syndrome (CRPS) is a chronic pain condition that most often affects one limb - arm, leg, hand, or foot - usually after an injury.³

The painful part of this condition comes from what is happening within the affected area. Blood vessels in the affected limb may open up or leak fluid into the surrounding tissue; the tissues can also become starved of oxygen and nutrients, which causes muscle and joint pain as well as damage.⁴

Fibromyalgia (FM) is characterized by chronic, full-body, musculoskeletal pain that can occur throughout their body, sometimes due to stimuli that wouldn't typically cause pain, such as light pressure, touch, odours, sounds, and changes in temperature. The pain of FM can be accompanied by issues with memory, mood, sleep, and fatigue, which causes difficulties in all aspects of life, including work and career.⁵

People with FM regularly report activity limitations and impaired workability. Problems arise, however, when there is confusion as to how to accommodate FM in the workplace.

In a systematic search of FM literature, which included 34 articles published from the year 2000 through 2017 on the subject, several observations were made, prompting the researchers to conclude that more research is necessary.

The researchers found that workers with FM find “physically demanding jobs and work tasks were especially troublesome and were reported to constitute higher risks of work disability.” They also noted that working people with FM “seemed to hold a careful balancing act to manage the risk of overload where well-functioning strategies such as making a career change, working part-time, and developing personal skills were necessary for managing work, in the short- and long term.”

The studies that were considered did not have data about the effects of FM on sick leave and work disability as compared to workers without a chronic pain condition. When it comes to FM, the worker may not be entitled to compensation for this condition as it is pre-existing and not work-related.

When it comes to occupational injury compensation, the Worker Safety Insurance Board, one of the largest insurance organizations in North America, covering over five million people in more than 300,000 workplaces across Ontario, Canada, the policy “will accept entitlement for chronic pain disability (CPD) when it results from a work-related injury, and there is sufficient credible subjective and objective evidence establishing the disability.” The reality is that compensation is much more accessible for someone with CRPS and less likely for someone with fibromyalgia.⁶

In the United States, fibromyalgia isn’t listed in the Social Security Administration (SSA) Blue Book. What that means for claimants is that there are no cut and dried standards for who can and cannot gain approval for disability benefits based on a fibromyalgia diagnosis.⁷ Part of why social assistance for fibromyalgia patients remains out of reach for some is that the condition is not fully understood, starting with its root causes. For instance, the image of fibromyalgia that comes from National Health Interview Survey data depicts patients that self-report painful and non-pain symptoms, comorbidity and psychological distress. Fibromyalgia is associated with substantial medical costs and high rates of Social Security disability

and work disability. It is also associated with gender - more female patients than male patients - the level of education attained, ethnicity, citizenship and unhealthy behaviours like smoking and living a sedentary life.

The bottom line for most fibromyalgia patients is that unless they are financially stable without working, they will be expected to work despite their condition.

Pain treatments, pain management and patient support

Treatment for pain runs the gamut of medications, acupuncture, local electrical stimulation, surgery, talk therapy and more. Which treatment is right for an individual, primarily if they work, can be tricky to figure out and may take some trial and error before a pain management system is adequate.

Alternative avenues for pain management are psychotherapy, relaxation and medication therapies, biofeedback, and behaviour modification as part of chronic pain is its emotional and psychological impact.⁸

As mentioned earlier, there are many medications that a pain patient may take to alleviate various symptoms. In the case of a bone break or surgery, this could entail a short course of opioid-based drugs prescribed by the doctor, followed by an over-the-counter NSAID (non-steroidal anti-inflammatories, like Advil) until the pain subsides.

If the patient already had a chronic pain condition or develops one, they could require medications for those symptoms as well as for mood, sleep, and fatigue. If a patient would like to lessen the number or amount of prescription drugs they take altogether, they can devise with their treating medical team a program that includes occupational therapy, rehabilitation, massage, and psychotherapy.

Exercise alone can help bring mobility and circulation back to the affected area while preventing or reversing the structural and functional brain changes that are associated with chronic pain.⁹ Remember, even gentle forms of exercise will help release several types of “happy” chemicals in the brain. Exercise can help improve mobility, flexibility, strength, and function. And continuing to move, stretch and lift can even help prevent future injuries to the area. As we age, our bodies lose muscle and bone density, putting us at higher risk of painful injuries, like bone breaks, muscle tears, and sprains.

Many people with chronic pain can improve their quality of life. The individual must first understand the root of the pain and the many pain management tools that are useful for undoing what chronic pain has done physically and mentally. They may require medical guidance, plus support from family and peers, and finally, they may need prolonged therapies.

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