SUNDHEDSSTYRELSEN

NATIONAL CLINICAL GUIDELINE FOR THE ASSESSMENT, TREATMENT AND REHABILITATION OF PATIENTS WITH CHRONIC WIDESPREAD PAIN

Quick guide

It is good practice to consider a patient with chronic widespread pain fully diagnosed when relevant differential diagnoses have been excluded. The patient can be fully diagnosed based on the medical history, the symptoms, the duration and a physical examination. Chronic widespread pain is considered a condition with a wide variety of potential diagnosis designations.

It is good practice to assess the overall functioning of the patient based on a bio-psycho-social conceptual framework.

Good practice (consensus)

It was not considered necessary to update the recommendation in 2017.

The condition 'chronic widespread pain' is a clinical condition and can often be finally diagnosed in general practice. When the GP meets a patient with chronic widespread pain, the following guidelines can be used to make an overall assessment, including characterisation of the pain condition and making a clinical diagnosis. The diagnosis should be made without delay once relevant differential diagnoses have been ruled out.

1. Medical history:
a. Symptom history (pain, accompanying symptoms, duration).
b. Clarify any symptoms of emotional problems.
c. Ask about anxiety and depression symptoms, exhaustion, sleep disturbances, concentration and memory problems.
d. Identify any strain, stress and external factors (social, work-related and family-related).
e. Ask about functioning in relation to the body, activity and participation (physically, socially and role-related) 1.
i. The ability to maintain daily routines, family relations, housework, leisure activities and how the symptoms influence this.
ii. The balance between resources and strains, work or training/education and other social matters and how the symptoms influence this.
iii. Surroundings, e.g. family situation, including the approach and attitudes among family and friends to the pain condition, attitudes at the workplace etc.
f. Identify the patient's understanding of disease.
g. Identify the patient's expectations for treatment and assessment.
h. Physical examination, including neurological examination and assessment of pressure sensitivity (tender points).
i. Clarification of somatic and psychiatric differential diagnoses and any given comorbid conditions, including biochemical screening.

2. Paraclinical tests:
Biochemical screening (haemoglobin, leukocytes and differential count, platelets, CRP, SR, creatinine, albumin/creatinine ratio, albumin, electrolytes, ALT, serum calcium, creatinine kinase (CK), TSH and vitamin D). Further diagnostic tests, including diagnostic imaging, should only be carried out with a clear medical indication. If there is still doubt as to whether there are other diseases underlying the chronic widespread pain upon completion of this test programme in general practice, the patient should be referred to another relevant specialist. In cases where additional tests or assessments are initiated, it is important to communicate the progress and expected results to the patient, since a number of so-called negative findings do not necessarily have a calming effect on the patient. In case of new symptoms or other changes in the condition, the doctor should consider whether further assessment is necessary.

It is important to remember that chronic widespread pain can coexist with other somatic and mental diseases as well as other pain conditions. When the GP assesses that the patient's chronic widespread pain is not caused by other somatic diseases, he/she must clearly communicate this to the patient. The doctor must explain the negative findings (what is not wrong with the patient) and at the same time acknowledge that the symptoms are real. He/she must also explain why there is no indication for further somatic assessment. In addition, the patient must be informed about chronic widespread pain, treatment options and prognosis. When specialised assessment of functioning is needed, the patient can be referred to a relevant professional.

1. The term functioning is used in accordance with the WHO's International Classification of Functioning, Disability and Health, hereinafter referred to as the ICF classification. The ICF classification is based on the WHO's bio-psycho-social conceptual model and is aimed at providing a general conceptual framework and a systematic terminology for health-related functioning. The functioning comprises three components: The body structure and functioning, activities and participation. The components influence each other, and the overall functioning is influenced by environmental factors, personal factors and health.

Consider offering supervised training to selected patients with chronic widespread pain if the purpose is to increase the level of functioning.

Weak recommendation

It was not considered necessary to update the recommendation in 2017.

Whether to offer the intervention to the patient should be decided based on an individual overall assessment, including consideration of not only the physical, but also the psychological, emotional and social aspects of the pain condition. The recommendation to supervise the physical training concerns patients with a particular need for improved functioning.

Everyone, including patients with chronic widespread pain, should be physically active. The recommendation concerns whether physical training should be supervised and managed by a healthcare professional.

General recommendations for physical activity for patients with chronic widespread pain appear from the DHA's manual on physical activity as prevention and treatment (Fysisk aktivitet – håndbog om forebyggelse og behandling, in Danish only) (18).

The patient's experience with performing physical training independently should be clarified. Patients with no previous training experience may find it hard to train independently and continuously. It may be relevant to offer a supervised and individualised training course to these patients. On the other hand, patients who are used to train independently and are motivated to continue to do so will most likely not benefit further from a supervised training course.

For the sake of motivation and adherence, it is important that the patient is interested in the type of training offered. Many people find it difficult to find time for physical exercise in daily life. For patients with chronic widespread pain, physical training may cause exacerbation of pain and therefore training may actually be experienced as harmful by some patients. The patient should therefore be informed that pain/discomfort before/during/after training is okay, but that the training in itself should not worsen the patient's usual pain/discomfort. The conversation with the patient should initially be directed at avoiding inactivity and then at making suggestions concerning training forms.

Offer cognitive behavioural therapy to patients with complex issues due to chronic widespread pain.

Strong recommendation

The recommendation has been updated and amended in 2018.

Whether to offer the intervention to the patient should be decided based on an individual overall assessment, including consideration of not only the physical, but also the psychological, emotional and social aspects of the pain condition.

The focused question concerned cognitive behavioural therapy (ACT and CBT), but other therapies can probably also be used. There is no consensus on which therapy would be most helpful. The evidence indicates a moderate effect of CBT and ACT in the patient group, and the working group therefore considers it important to provide an offer to motivated patients who are capable of making an effort themselves throughout the treatment course. Not all patients with chronic widespread pain would want or benefit from psychological treatment. Therefore, the working group recommends to offer psychological treatment to patients with more complex issues in particular. The disease pattern in this subgroup is typically multi-facetted and may include, e.g., many years of pain, mental and/or physical exhaustion, impaired ability to cope with everyday tasks, difficulties as regards labour market retention and loss of leisure activities. The patient may also have experienced physical traumas, dysfunctional social relations or other stressful life events [13].

The treatment intervention should be presented to the patients in such a way that they understand the reason for offering the intervention and are informed about its beneficial effects. Cognitive behavioural therapy should be given by healthcare professionals with basic professional knowledge within the field of psychology as a whole and pain conditions in particular resulting from specific high-level supplementary training. The health care professional must have a thorough understanding of, and knowledge of, the possible mechanisms affecting the pain sufferer and must be adequately trained within the relevant therapeutic fields.

It is good practice to offer interventions involving strategies that promote activity and participation in daily life to selected patients with chronic widespread pain.

Good practice (consensus)

It was not considered necessary to update the recommendation in 2017.

This kind of interventions is characterised by being aimed directly at solving issues related to performing and being involved in everyday activities. The decision as to whether this kind of interventions should be offered to patients with chronic widespread pain should be based on an individual overall assessment of the pain condition, including assessment of the patient's functioning in relation to body function, activity as well as participation.

The assessment and clarification of the functioning should be based partly on the patient's information and partly on actual observation. During this clarification it may also be relevant to discuss the work situation and family life, including resources and challenges as regards activity and participation.

In this context, interventions may be offered, e.g., by municipal occupational therapy and/or in an outpatient hospital setting and preferably near the patient's home.

Offer patient education to patients with chronic widespread pain.

Strong recommendation

It was not considered necessary to update the recommendation in 2017.

In mild to moderate cases, patient education (also known as psychoeducation) may be handled by the GP. In other, more severe cases, dedicated programmes will be more appropriate.

Patient education should be offered as soon as the patient has been fully diagnosed or immediately thereafter in case the offer is made via referral to another professional group/sector. If the patient does not wish to accept the offer in the given situation, it should be possible to accept it later.

Patient education must include training in pain physiology, treatment options, the significance of psychosocial factors and pain management. Patient education or psychoeducation may be placed in between 'information' and 'psychotherapy'. Patient education does not need to be provided by someone trained in psychotherapy, but good communication tools and an understanding of modern pain science are required. The teaching can take place in groups or 1:1 and must always include a professional and possibly other patients. In the opinion of the working group, peer-to-peer teaching without a professional cannot be interpreted as patient education.

Patient education differs from general information in that the information is tailored to the patient's conceptual framework and addresses potentially inappropriate perceptions. New technology such as telemedicine may be used to minimise transport and interference with daily life.

It is good practice to identify the patient's level of functioning in relation to the labour market and to identify his or her working conditions, including how the job affects the patient's disease, way of life and health in the eyes of the patient. The purpose of this is to make the patient aware of the possibility of introducing interventions at the workplace aimed at labour market retention.

Good practice (consensus)

It was not considered necessary to update the recommendation in 2017.

In order to identify how the patient's work affects the total life situation, the doctor may, e.g., ask the patient to describe his/her perception of the impact of the work on the disease and symptoms. It can be discussed with the patient that the prognosis for labour market retention seems to be improved, when work requirements are adapted to the patient's level of functioning (63). The doctor may not disclose health information to the employer, but he/she is allowed to disclose information about the patient's level of functioning. The so-called 'fit for work' certificate can be issued for that purpose. Alternatively, the doctor may disclose information on level of functioning in a medical certificate with the patient's written consent, see section 43(1) and section 44 of the Danish Health Act.

From clinical experience the working group finds that workplace interventions such as changed working hours, breaks, reduced working hours, aids and a specially designed workstation can increase the possibility for patients to maintain their work ability and therefore their labour market retention.

For a patient with a significantly reduced level of functioning assessed to be unable to work in any normal job, the treating doctor should assist in identifying the level of functioning in relation to the labour market quickly. The treating doctor may contribute to this end by providing a good description of the functioning and its prognosis in the socio-medical certificates to the job centre.

Consider offering multidisciplinary intervention consisting of at least two treatment modalities provided by at least two professional groups to selected patients with chronic widespread pain.

Weak recommendation

It was not considered necessary to update the recommendation in 2017.

Multidisciplinary intervention is mainly recommended for patients with pain of a duration of more than 6 months and with complex issues due to the pain condition, cf. the DHA's speciality guidelines [93]. The intervention should be based on an individual overall assessment, including assessment of the patient's functioning in relation to body function, activity as well as participation. Most often the functioning of these patients is severely reduced, and therefore they are also frequently threatened in their work ability.

Patients with chronic widespread pain constitute a heterogeneous group, which is why the intervention must be individualised and tailored to the patient's current needs. From clinical experience the working group finds that single physical, psychological or medical treatment interventions will often not be sufficient in patients with very complex pain conditions, i.e. patients with severely reduced functioning and/or complicating psychosocial issues. Such patients often need a broader coordinated rehabilitating intervention with participation of an interdisciplinary, specialised treatment team (e.g. a doctor, a psychologist, a nurse, occupational therapists, physiotherapists and a social worker). Frequently, there will be significant social aspects in the overall complex of issues, and it has been shown that lack of social clarification (e.g. pending social processing of the case, economic uncertainty etc.) and/or lack of support in the close social network can have a negative impact on the course of the disease.

Tramadol should only be used in patients with chronic widespread pain upon due consideration.

Weak recommendation AGAINST

The recommendation has been updated without amendments in 2018.

The literature search only identified studies concerning tramadol. Therefore, the working group cannot comment on treatment with tapentadol. Non-pharmacological treatment in the form of cognitive behavioural therapy, psychoeducation and training is not always sufficiently effective. Therefore, the clinician can get into a situation where pharmacological treatment in order to provide pain relief, improved quality of life and functioning may be necessary.

Clinical experience has shown that patients with chronic widespread pain are often very sensitive to pharmacological treatment. Therefore, the treatment should be initiated with a low dosage followed by a slow uptitration.

In case of initiating opioid, it should be done under strict control, consideration of adverse reactions and with a plan for discontinuation. In order to avoid dependence, the doctor should draw up a treatment plan together with the patient prior to initiating addictive drugs. Among other things, this plan should specify the expected efficacy and adverse reactions and when to reassess the treatment efficacy. See also the DHA's guidance on the prescription of addictive drugs (Ordination af afhængighedsskabende lægemidler, in Danish only) [100].

It is not good practice to offer opioids without dual action to patients with chronic widespread pain.

Good practice (consensus)

The recommendation has been updated without amendments in 2018.

In the opinion of the working group, these drugs do not belong in the treatment of chronic widespread pain. If opioids without dual action are offered to this patient group anyway, the treatment should be of the shortest possible duration or, alternatively, be given only as needed due to a high risk of adverse reactions and dependence.

Please also refer to the DHA's guidance on the prescription of addictive drugs (Ordination af afhængighedsskabende lægemidler, in Danish only) [100].

Consider offering amitriptyline for pain relief and sleep regulation in patients with chronic widespread pain.

Weak recommendation

The recommendation has been updated without amendments in 2018.

The literature search for the original NCG as well as for the update only identified studies investigating the use of amitriptyline, and therefore the recommendation only concerns amitriptyline. It is considered good practice not to give amitriptyline in the daytime due to its sedating effect. Based on experience, use of nortriptyline, Noritren or imipramine is advantageous when patients require daytime TCA treatment, since these drugs are less sedative. TCAs must be used at lower doses for pain relief than for the treatment of depression.

The patient should be made aware that the treatment with antidepressants is aimed at reducing pain and providing better sleep quality – and not at treating depression. The treating doctor should be aware that the product is only indicated for the treatment of neuropathic pain in accordance with the current summary of product characteristics and therefore is off-label. Use of TCAs may be considered if other recommended treatments have shown lack of efficacy.

Consider offering duloxetine for pain relief in patients with chronic widespread pain.

Weak recommendation

The recommendation has been updated without amendments in 2018.

For that focused question, the search for evidence concentrated on the use of the drugs duloxetine and venlafaxine. While several studies investigating the use of duloxetine were identified, the search only identified one review investigating the efficacy of venlafaxine [128]. This review included four cohort studies and an RCT in the form of an abstract. Thus, there is not sufficient evidence to conclude on the usefulness of venlafaxine in patients with widespread pain, which is why the recommendation only concerns duloxetine. Non-pharmacological treatment in the form of cognitive behavioural therapy, psychoeducation and training is not always sufficiently effective.

Therefore, the clinician can get into a situation where pharmacological treatment in order to provide pain relief, improved quality of life and functioning may be necessary. The treating doctor should be aware that SNRIs are not indicated for the treatment of pain and that duloxetine is approved for the treatment of neuropathic pain, but not for fibromyalgia. Therefore, the use of the product in patients with chronic widespread pain is off-label. Use of SNRIs may be considered if other recommended treatments have shown lack of efficacy.

The patient should be made aware that the treatment with antidepressants is aimed at reducing pain – and not at treating depression.

SSRIs should only be offered for pain relief in patients with chronic widespread pain upon due consideration, since the pain relieving effect is limited.

Weak recommendation AGAINST

It was not considered necessary to update the recommendation in 2017.

Non-pharmacological treatment in the form of cognitive behavioural therapy, psychoeducation and training is not always sufficiently effective. Therefore, the clinician can get into a situation where pharmacological treatment in order to provide pain relief, improved quality of life and functioning may be necessary. The patient should be made aware that the treatment with antidepressants is aimed at reducing pain – and not at treating depression. Based on the price and adverse reaction profile, it is suggested to first try out tricyclic antidepressants (TCAs) and then duloxetine. The treating doctor should be aware that SSRIs are not indicated for the treatment of pain. Therefore, the use of the product in patients with chronic widespread pain is off-label. Use of SSRIs may be considered if other recommended treatments have shown lack of efficacy.

Consider offering gabapentin or pregabalin for pain relief in patients with chronic widespread pain.

Weak recommendation

It was not considered necessary to update the recommendation in 2017.

Non-pharmacological treatment in the form of cognitive behavioural therapy, psychoeducation and training is not always sufficiently effective. Therefore, the clinician can get into a situation where pharmacological treatment in order to provide pain relief, improved quality of life and functioning may be necessary.

Anticonvulsants with analgesic effect are not efficacious in all patients, and many patients are very bothered by adverse reactions.

Patients with chronic widespread pain are often very sensitive to pharmacological treatment. Therefore, the treatment should be initiated with a low dosage followed by a slow uptitration.

The pharmacological treatment and potential discontinuation should be reassessed regularly in comparison to continued indication and balance between efficacy and adverse reactions.

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About the quick guide

This quick guide contains the key recommendations from the national clinical guideline for the assessment, treatment and rehabilitation of patients with chronic widespread pain. The guideline was prepared by the DHA.

The national clinical guideline for the assessment, treatment and rehabilitation of patients with chronic widespread pain focuses on issues where clarification of the evidence basis was needed. The focused questions concern diagnostics and assessment as well as non-pharmacological and pharmacological treatment.

Thus, the guideline contains recommendations for selected parts of the field only and therefore must be seen alongside the other guidelines, process descriptions etc. in this field.

Further information at sundhedsstyrelsen.dk
At sundhedsstyrelsen.dk, a full-length version of the national clinical guideline is available, including a detailed review of the underlying evidence for the recommendations.

About the national clinical guidelines
The national clinical guideline is one of the DHA's 47 national clinical guidelines for which a review with the purpose of updating them will be performed during the period 2017-2020.

Further information about the choice of subjects, method and process is available at sundhedsstyrelsen.dk.