Complete Summary

GUIDELINE TITLE

Pain (chronic).

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Pain (chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 372 p. [458 references]

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

**** REGULATORY ALERT ****

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- June 15, 2005, COX-2 Selective (includes Bextra, Celebrex, and Vioxx) and Non-Selective Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): Labeling revised to include a boxed warning and a Medication Guide, highlighting the potential for increased risk of cardiovascular (CV) events and life-threatening gastrointestinal (GI) bleeding.
- April 7, 2005, Bextra (valdecoxib), Cox-2 inhibitors, Celebrex (celecoxib), Non-steroidal anti-inflammatory drugs (NSAIDS) (prescription and OTC, including ibuprofen and naproxen: Bextra (valdecoxib) withdrawn from the market and labels for other Cox-2 inhibitors and NSAIDS revised to include a boxed warning and a Medication Guide, highlighting the potential for increased risk of cardiovascular (CV) events and life-threatening gastrointestinal (GI) bleeding.

Additional Notices

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- October 17, 2005, Cymbalta (duloxetine hydrochloride): Healthcare professionals notified of revision to the PRECAUTIONS/Hepatotoxicity section of the prescribing information to include precaution against using in patients with chronic liver disease.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Work-related chronic pain

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Neurology
Physical Medicine and Rehabilitation

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To offer evidence-based step-by-step decision protocols for the assessment and treatment of workers' compensation conditions

TARGET POPULATION

Workers with work-related chronic pain

INTERVENTIONS AND PRACTICES CONSIDERED

The following interventions/procedures were considered and recommended as indicated in the original guideline document:

1. Acupuncture
2. Anticonvulsants/antiepileptic drugs for chronic neuropathic pain
3. Antidepressants as first line option for neuropathic pain
4. Antidepressants for non-neuropathic pain
5. Anti-inflammatory medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], Celebrex)
6. Behavioral interventions
7. Boswellia Serrata Resin (Frankincense)
8. Capsaicin (topical) in patients who have not responded or are intolerant to other treatments
9. Cod liver oil
10. Complex regional pain syndrome (CRPS) (medications, prevention, spinal cord stimulators, sympathetic and epidural blocks, treatment [see original guideline document for hierarchy of options])
11. Curcumin (turmeric)
12. Cyclobenzaprine (Flexeril®)
13. Detoxification
14. Duloxetine (Cymbalta®)
15. Education of patient and family
16. Electrodiagnostic testing (electromyography [EMG] and nerve conduction studies [NCS])
17. Epidural steroid injections (ESIs)
18. Evoked potential studies
19. Exercise
20. Functional restoration programs (FRP)
21. Gabapentin for neuropathic pain
22. Glucosamine (and chondroitin sulfate)
23. Green tea
24. Herbal medicines
25. Home health services
26. Implantable drug-delivery systems (IDDSs) (see original guideline document for specific indications)
27. Intrathecal drug delivery systems
28. Lumbar sympathetic block
29. Medications for acute pain (analgesics)
30. Methadone for moderate to severe pain
31. Multi-disciplinary pain programs/chronic pain programs
32. Muscle relaxants
33. Nonprescription medications (acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs])
34. Number needed to treat as a measure of absolute risk in evaluating drug therapies
35. Obtaining pain treatment agreement prior to initiating opioid therapy
36. Opioids for severe cases including cancer pain

37. Opioids: dealing with misuse & addiction, screening for misuse, screening for risk of addiction (tests) and dependence vs. addiction, psychological intervention
38. Phentolamine infusion test
39. Physical therapy/occupational therapy
40. Psychological evaluations
41. Psychological treatment
42. Pycnogenol (maritime pine bark)
43. Return to work
44. Salicylate topicals
45. Screening for comorbid psychiatric disorders and diabetic neuropathy
46. Spinal cord stimulators (SCS)
47. Stellate ganglion block
48. Topical analgesics
49. Transcutaneous electrical nerve stimulation (TENS) for acute postoperative pain
50. Trigger point injections for myofascial pain syndrome only
51. Uncaria Tomentosa (Cat's Claw)
52. Venlafaxine
53. Weaning of medications
54. White willow bark
55. Yoga

The following interventions/procedures are under study and are not specifically recommended:

1. Autonomic test battery
2. Chronic pain programs (early intervention, intensity, opioids)
3. Clonidine, intrathecal
4. Complex regional pain syndrome (CRPS), diagnostic criteria
5. Facet blocks
6. Functional imaging of brain responses to pain
7. H-wave stimulation (devices)
8. Injection with anesthetics and/or steroids
9. Intravenous regional sympathetic blocks (for reflex sympathetic dystrophy [RSD], nerve blocks)
10. Ketamine
11. Massage therapy
12. Milnacipran
13. Neuromuscular electrical stimulation (NMES devices)
14. Neuroreflexotherapy
15. Percutaneous electrical nerve stimulation (PENS)
16. Testosterone replacement

The following interventions were considered, but are not recommended:

1. Actiq® (oral transmucosal fentanyl citrate) for musculoskeletal pain.
2. Barbiturate-containing analgesic agents
3. Benzodiazepines for long-term use
4. Biofeedback
5. Botulinum toxin (Botox) for mechanical neck and back disorders
6. Cannabinoids

7. Complex regional pain syndrome, sympathectomy
8. Current perception threshold (CPT) testing/sensory nerve conduction threshold (sNCT) device
9. Electroceutical therapy (bioelectric nerve block)
10. Galvanic stimulation
11. Interferential current stimulation (ICS)
12. Low level laser therapy (LLLT)
13. Magnet therapy
14. Manual therapy and manipulation
15. Microcurrent electrical stimulation (MENS devices)
16. Nonsteroidal anti-inflammatory drugs (NSAIDs) in patients with previous ulcer disease and cyclooxygenase-2 inhibitors in patients with cardiovascular risk
17. Nucleoplasty
18. Opioids for chronic pain or as first-line therapy for neuropathic pain
19. Opioids for first-line therapy for osteoarthritis
20. Oral morphine as primary treatment
21. Percutaneous neuromodulation therapy (PNT)
22. Power mobility devices
23. Prolotherapy/sclerotherapy
24. Pulsed radiofrequency treatment (PRF)
25. Rapid detox
26. Sclerotherapy (prolotherapy)
27. Sympathetic therapy
28. TENS as primary therapy for chronic pain
29. Therapeutic ultrasound
30. Thermography (not recommended except possibly for CRPS)
31. Vioxx (withdrawn from the U.S. and worldwide market)
32. Ziconotide (Prialt)

MAJOR OUTCOMES CONSIDERED

Adverse effects of medications

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Work Loss Data Institute (WLDI) conducted a comprehensive medical literature review (now ongoing) with preference given to high quality systematic reviews, meta-analyses, and clinical trials published since 1993, plus existing nationally recognized treatment guidelines from the leading specialty societies. WLDI primarily searched MEDLINE and the Cochrane Library. In addition, WLDI also reviewed other relevant treatment guidelines, including those in the National Guideline Clearinghouse, as well as state guidelines and proprietary guidelines maintained in the WLDI guideline library. These guidelines were also used to suggest references or search terms that may otherwise have been missed. In

addition, WLDI also searched other databases, including MD Consult, eMedicine, CINAHL, and conference proceedings in occupational health (i.e. American College of Occupational and Environmental medicine [ACOEM]) and disability evaluation (i.e. American Academy of Disability Evaluating Physicians [AADEP], American Board of Independent Medical Examiners [ABIME]). Search terms and questions were diagnosis, treatment, symptom, sign, and/or body-part driven, generated based on new or previously indexed existing evidence, treatment parameters and experience.

In searching the medical literature, answers to the following questions were sought: (1) If the diagnostic criteria for a given condition have changed since 1993, what are the new diagnostic criteria? (2) What occupational exposures or activities are associated causally with the condition? (3) What are the most effective methods and approaches for the early identification and diagnosis of the condition? (4) What historical information, clinical examination findings or ancillary test results (such as laboratory or x-ray studies) are of value in determining whether a condition was caused by the patient's employment? (5) What are the most effective methods and approaches for treating the condition? (6) What are the specific indications, if any, for surgery as a means of treating the condition? (7) What are the relative benefits and harms of the various surgical and non-surgical interventions that may be used to treat the condition? (8) What is the relationship, if any, between a patient's age, gender, socioeconomic status and/or racial or ethnic grouping and specific treatment outcomes for the condition? (9) What instruments or techniques, if any, accurately assess functional limitations in an individual with the condition? (10) What is the natural history of the disorder? (11) Prior to treatment, what are the typical functional limitations for an individual with the condition? (12) Following treatment, what are the typical functional limitations for an individual with the condition? (13) Following treatment, what are the most cost-effective methods for preventing the recurrence of signs or symptoms of the condition, and how does this vary depending upon patient-specific matters such as underlying health problems?

Criteria for Selecting the Evidence

Preference was given to evidence that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reports a cohort study, whether prospective or retrospective, or (5) The article reports a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

More information about the selection of evidence is available in "Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument" (see "Availability of Companion Documents" field).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Ranking by Type of Evidence

1. Systematic Review/Meta-Analysis
2. Controlled Trial-Randomized (RCT) or Controlled
3. Cohort Study-Prospective or Retrospective
4. Case Control Series
5. Unstructured Review
6. Nationally Recognized Treatment Guideline (from www.guideline.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides

Ranking by Quality within Type of Evidence

a. High Quality
b. Medium Quality
c. Low Quality

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Work Loss Data Institute (WLDI) reviewed each article that was relevant to answering the question at issue, with priority given to those that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reported a cohort study, whether prospective or retrospective, or (5) The article reported a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

Especially when articles on a specific topic that met the above criteria were limited in number and quality, WLDI also reviewed other articles that did not meet the above criteria, but all evidence was ranked alphanumerically (see the Rating Scheme of the Strength of Evidence field) so that the quality of evidence could be clearly determined when making decisions about what to recommend in the Guidelines.. Articles with a Ranking by Type of Evidence of Case Reports and Case Series were not used in the evidence base for the Guidelines. These articles were

not included because of their low quality (i.e., they tend to be anecdotal descriptions of what happened with no attempt to control for variables that might effect outcome). Not all the evidence provided by WLDI was eventually listed in the bibliography of the published Guidelines. Only the higher quality references were listed. The criteria for inclusion was a final ranking of 1a to 4b (the original inclusion criteria suggested the methodology subgroup), or if the Ranking by Type of Evidence was 5 to 10, the quality ranking should be an "a."

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Prior to publication, select organizations and individuals making up a cross-section of medical specialties and typical end-users externally reviewed the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Note from the National Guideline Clearinghouse (NGC): For the Work Loss Data Institute's "Disclaimer: limitations of scope" statement, refer to the "Qualifying Statements" field in this summary or see the original guideline document.

Introduction

Pain has been classified in multiple ways. One common methodology is to temporally classify the condition according to duration, with the most common categories given as acute and chronic. Acute pain is a sign of real or impending tissue damage and usually disappears with healing. It is the normal predicted physiologic response and is usually of short duration. Chronic pain, a common and expensive problem in occupational and disability medicine, has been defined by

multiple different time durations (generally from 6 weeks to 3 months after the onset of symptoms). It has also been defined as pain that persists for at least 30 days beyond the usual course of an illness. Chronic pain is a condition that ultimately adversely affects the patient's well being, level of function and quality of life. This chapter of Official Disability Guidelines (ODG) *Treatment* focuses on chronic pain.

Pain has also been classified according to presumed neurophysiologic mechanisms. There is no real consistency to this type of classification, but texts on pain suggest that pain is either of somatic/nociceptive origin, or a non-nociceptive origin; the latter commonly classified as neuropathic and/or idiopathic/psychogenic. (Definition: somatic pain is a pain arising in the body tissues typically associated with injury or trauma, and nociceptive pain is a normal and expected pain response to injury.) Nociceptive pain is not necessarily synonymous with acute pain. Examples of chronic pain conditions that have been classified as nociceptive include arthritis and other degenerative conditions such as rotator cuff disease.

Pain has also been described as an experience rather than a sensation. Chronic pain may occur without obvious tissue damage, and psychological components have a substantial impact on its development and chronicity. Pain societies have recognized that psychological input to pain may include components of cognitive, behavioral, emotional, and certain predisposing factors (such as childhood trauma or abuse), as well as a potential role of traumatic stress. In addition, in workers' compensation cases and other cases involving personal injury, the "sick role" is further reinforced by the promise that compensation (indemnification) may play in the process. Additionally, there is an increasing emphasis on the role psychiatric co-morbidities such as anxiety disorder, bipolar disease and addictive disease may play in the pathogenesis of the condition.

Initial Evaluation for Chronic Pain

History

1. Determine the chief complaint.
2. Determine if there was a specific incident that caused or triggered the onset of pain or if pain was insidious in onset.
3. Determine the severity and specific anatomic location of the pain (including radiation patterns).
4. Determine if the pain has remained localized, or if it become more multifocal/generalized.
5. Determine the character of pain including the following:
    a. Quality of pain (by descriptions such as aching, dull, sharp, allodynia, burning, electric, dysesthesia, paresthesias, and or neuralgia)
    b. Continuous or intermittent
    c. Associated neurological factors (weakness, numbness, balance problems)
    d. Factors that exacerbate or relieve
    e. Effect of activity, body position
    f. Effect of stress

6. Determine previous tests and results.

7. Determine the effect of previous treatment including medications.
8. Assess the ability of the patient to perform functions such as walking, lifting, sitting, and standing including job-related limitations.
9. Assess for evidence of substance abuse in the patient in the past or currently (including alcohol, smoking, or illicit drugs). A family history should also be ascertained.
10. Examine for evidence of concordant depression, anxiety, other mood disturbance, sleep disturbance, or eating disturbance.
11. Assess the effect that pain has had on quality of life in regards to social and family interactions and sexual function.
12. Assess for involvement of litigation or evidence of secondary gain.
13. Assess the patient's goals of treatment.

Physical Examination

1. Assess vital signs, weight, and body mass index. Assess pain using an instrument such as the visual analog scale (VAS), and functionality.
2. Observe appearance, attitude and behavior (such as response on examination maneuvers), and gait.
3. Observe for musculoskeletal defects: deformity, atrophy, masses or lesions, signs of trauma, alignment of spine, range of motion. Determine muscle strength, and evaluate for evidence of myofascial dysfunction.
4. Assess neurologic status: mental status sensory examination (including hyperalgesia, hyperpathia, paresthesias, dysesthesias, allodynia, hypesthesia, hyperesthesia), muscle stretch reflexes.
5. Assess pain-exacerbating maneuvers.
6. Assess for Waddell's signs and inconsistencies in the above examination.

Begin an Assessment of the Presumed Chronic Pain Mechanism Based on the History and Physical

The Institute for Clinical Systems Improvement (ICSI) has differentiated distinct biological mechanisms that contribute to chronic pain. Each patient may have multiple and/or overlapping contributors. The criteria and suggested treatment of specific conditions listed are given in the Procedure Summary of the original guideline document.

Neuropathic Pain: Defined as "pain initiated or caused by a primary lesion or dysfunction of the nervous system." Neuropathic pain can be classified according to several methodologies. The first includes a classification into categories of peripheral, central, or a controversial category that includes "dysfunction of the nervous system." An alternative mechanism is to classify neuropathies associated with pain into the following: 1) mononeuropathies, either traumatic or from other causes; 2) polyneuropathies, with etiologies including metabolic, nutritional, drugs, toxins, hereditary, malignant, infective, or an "other" category. See the Procedure Summary in the original guideline document for recommendations concerning the use of various treatments and, in particular, medications such as antidepressants and anticonvulsants (e.g., gabapentin [Neurontin®]) for neuropathic pain.

Muscle Pain: Includes fibromyalgia and myofascial pain.

Inflammatory Pain: This type of pain mechanism is commonly associated with acute pain (postoperative pain and acute tissue injury). An example of chronic inflammatory pain includes arthritis.

Mechanical Pain: Examples of chronic conditions include etiologies that create pressure or stretching, resulting in pain including fracture, dislocation. Another chronic pain example would include compression of tissue by bony structures.

Psychological: In addition to the ICSI mechanisms, it is suggested in guidelines (such as the Chronic Pain Disorder Medical Treatment Guidelines, 2003) to also evaluate for psychological contributors. Specific examples of psychological contributors/comorbidities that are either associated with or contribute to chronic pain include depression, anxiety, personality disorders somatization, and post-traumatic stress. The possibility of the contribution of underlying substance abuse problems must also be assessed. Specific guidelines for both suggested and required psychological testing for specific treatment interventions are included in the Procedure Summaries of the original guideline document. Descriptions of specific standardized psychological tests are provided in "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients."

Secondary Gain Issues: Issues such as indemnity and current litigation may have impact on resolution of pain. Some authors also suggest even more important social contributors including the primary loss of physical health and functioning, as well as secondary losses such as loss of financial stability and relationships (both on a personal and work-related level).

Determine the Need for Specific Diagnostic Studies

Specific recommendations for diagnostic tests are given in the Procedure Summaries of the original guideline document for both the Pain Chapter and specific body-part chapters.

General Treatment Management

Specific recommendations for each condition are given in the Procedure Summaries of the original guideline document for both the Pain Chapter and specific body-part chapters. General management suggestions as suggested by ICSI also include the following:

1. Develop a written plan of care that addresses the patient's personal goals, sleep, physical activity, stress management, and recommendations to improve pain control.
2. Provide adequate information to the patient, including opportunities for education on their condition.
3. Include the patient in the treatment plan.
4. Acknowledge that the treatment team recognizes that their pain is considered as "real."
5. Provide all patients with an exercise and fitness program.
6. Consider the use of a cognitive behavioral program when indicated.
7. Schedule routine appointments to avoid the incidence of visits secondary to increased pain.
8. Stress self-management by the patient.

9. Enlist family and friends to both support the patient and reinforce gains.
10. Assist in return to work.
11. Assist in appropriate attainment of entitlements.

At a certain point in the course of care, there are two general treatment options for claimants with chronic pain. One is medication, and the second is cognitive therapy/pain management programs. See the Procedure Summary in the original guideline document for more details and links to the medical evidence.

Medication Issues: (See also Medications in the Procedure Summary of the original guideline document for links to specific choices)

Non-neuropathic pain is generally treated with analgesics and anti-inflammatories. First-line treatment for neuropathic pain requires treatment with medications that influence the various transmitters involved in the underlying pain pathology, with opioids reserved for refractory pain. When considering opioids for either type of pain, discussion should include duration of treatment and when to discontinue their use (as occasionally suggested as "detoxification" by many reviewers). This area of opioid treatment remains extremely controversial, and research remains ongoing. It is generally felt that "detoxification" should not be proposed without offering another treatment solution, although alternative options also remain controversial.

Anticonvulsants are also currently suggested medications for neuropathically related chronic pain. When dealing with neuropathic pain, and in particular, neuropathic pain of possible spinal origin, treatment issues are confounded due to the presence of underlying non-work-related conditions that also can present with neuropathic pain such as impaired glucose tolerance/type 2 diabetes (i.e. diabetic peripheral neuropathy) and/or aging (possible neurogenic claudication secondary to spinal stenosis). The question often arises as to the actual indication of the use of anti-convulsant medication in these instances, and their compensability in regards to the work-related injury. These questions include how the medications should be prescribed and how outcomes should be recorded. Antidepressants have also been indicated for both neuropathic and non-neuropathic pain. Not only do compensability issues arise for this class of medications in regards to the underlying issues of etiologies of neuropathy, but also in regards to their use for pre-existing conditions of depression and anxiety. Needless to say, the issues involved with medication for chronic pain are controversial, and current literature addressing the above issues is included in the Procedure Summary in the original guideline document.

Note: In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the "pain" and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the "sickness" role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors.

ODG Return-To-Work Pathways for Selected Generalized Pain Syndromes

(See body-part chapters for disability duration information for pain that is the result of conditions in specific body parts, such as low back, neck or extremity pain)

ODG Return-To-Work Pathways

Myalgia and Myositis, Unspecified *(Muscle Pain or Inflammation)* (see the original guideline document for International Classification of Diseases, Ninth Revision [ICD-9] codes for this and other diagnoses)

Moderate pain: 0 days

Debilitating pain, with hospitalization, modified work: 14 days

Debilitating pain, with hospitalization, regular work: 42 days

Myofascial pain syndrome, trigger point injection: 1 to 7 days

Myofascial pain syndrome, acupuncture: 7 to 21 days

Myofascial pain syndrome, physical therapy: 14 to 21 days

Fibromyalgia: Controversial and self-perpetuating diagnosis - see related conditions and return to regular activities as soon as possible

Reflex Sympathetic Dystrophy *(including complex regional pain syndrome [CRPS]-I)*

Note: this is a controversial diagnosis

Sympathetic nerve block: 3 to 7 days

Complex regional pain syndrome (CRPS-I), early stage: 28 to 84 days

Complex regional pain syndrome (CRPS-I), late stage: 210 days to indefinite

Late stage reflex sympathetic dystrophy (RSD) (CRPS-I): 365 days to indefinite

Causalgia of Upper Limb *(including CRPS-II)*

Note: this is a controversial diagnosis

Medical treatment: 0 days

Sympathetic nerve block: 2 days

Complex regional pain syndrome (CRPS-II): 28 to 84 days

Causalgia of Lower Limb *(including CRPS-II)*

Note: this is a controversial diagnosis

Medical treatment: 0 days

Sympathetic nerve block: 2 days

Complex regional pain syndrome (CRPS-II): 28 to 84 days

Mononeuritis of Unspecified Site *(including CRPS-II)*

Note: this is a controversial diagnosis

Sympathetic nerve block: 3 to 7 days

Complex regional pain syndrome (CRPS-II), early stage: 28 to 84 days

Complex regional pain syndrome (CRPS-II), late stage: 210 days to indefinite

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

During the comprehensive medical literature review, preference was given to high quality systematic reviews, meta-analyses, and clinical trials over the past ten years, plus existing nationally recognized treatment guidelines from the leading specialty societies.

The heart of each Work Loss Data Institute guideline is the Procedure Summary (see the original guideline document), which provides a concise synopsis of effectiveness, if any, of each treatment method based on existing medical evidence. Each summary and subsequent recommendation is hyper-linked into the studies on which they are based, in abstract form, which have been ranked, highlighted and indexed.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

These guidelines unite evidence-based protocols for medical treatment with normative expectations for disability duration. They also bridge the interests of the many professional groups involved in diagnosing and treating pain.

POTENTIAL HARMS

- Adverse effects of medications
- Side effects of implanted catheters for complex regional pain syndrome (CRPS) include technical failure and infection.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Tricyclic antidepressants are contraindicated in patients with cardiac conduction disturbances and/or decompensation as well as those patients with epilepsy.
- Both cyclooxygenase-2 (Cox-2s) and nonsteroidal anti-inflammatory drugs (NSAIDs) are contraindicated in patients with previous ulcer disease. Patients with cardiovascular risk should not use Cox-2s.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- **Note from the Work Loss Data Institute**: Disclaimer: limitations of scope. See body-part chapters for condition specific information, especially the Low Back Chapter. The Pain Chapter is focused on chronic pain, and also covers causalgia, complex regional pain syndrome (CRPS), myofascial pain, and generalized pain syndromes. Users interested in pain that is the result of conditions in specific body parts (e.g., low back, neck, or extremity pain), should also access those other chapters for management of pain of those body parts, although those chapters may refer to the Pain Chapter for certain generalized evidence summaries.
- The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries (in the original guideline document) for complete lists of the various options that may be available, along with links to the medical evidence.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Pain (chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 372 p. [458 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 (revised 2007 Jul 12)

GUIDELINE DEVELOPER(S)

Work Loss Data Institute - Public For Profit Organization

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Editor-in-Chief, Philip L. Denniston, Jr. and Senior Medical Editor, Charles W. Kennedy, MD, together pilot the group of approximately 80 members. See the ODG *Treatment in Workers Comp* Editorial Advisory Board.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

There are no conflicts of interest among the guideline development members.

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Background information on the development of the Official Disability Guidelines of the Work Loss Data Institute is available from the Work Loss Data Institute Web site.
- Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument. Available to subscribers from the Work Loss Data Institute Web site.

PATIENT RESOURCES

The following is available:

- Appendix B. ODG Treatment in Workers' Comp. Patient information resources. 2006.

Electronic copies: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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