Chronic Pain and Neuroplasticity (NP):

This is the 4th in a multi-part series that will explain the science of NP, how it relates to various aspects of claims, and how it puts scientific holes in the denial of many claims. In the first 2 NP articles, I gave a basic overview of the science of NP and chronic pain and in the 3rd I began discussion of treatment concepts.

Again, chronic pain is the result of neuroplasticity gone bad! NP is the new science that will win cases for you by explaining why the patient's multiple complaints, including new complaints, are real and claim-related.

Patients with bad NP are generally the most difficult patients to treat. First, the pain sensitivity levels have to be brought down to a more normal level. Once peripheral pain is centralized, aggressive therapy is required.

It is important that clinicians recognize that the adequate management of persistent pain is necessary to avoid the potential downstream multiple consequences of central and peripheral sensitization. What does this mean? Physicians need to aggressively treat pain issues, particularly when they are not responding in a reasonable time frame to the treatments that the physician is utilizing. This failure to respond to treatment frequently requires referral to multiple providers to get multiple treatments, and eventually may require referral to a multidisciplinary pain program, where all modalities will be used.

Multidisciplinary or interdisciplinary chronic pain programs. These are recommended by all guidelines and are considered the “gold-standard” for treatment by many experts. These pain rehabilitation programs combine multiple treatments, including psychological care.

It is well known that the likelihood of return to work diminishes significantly after approximately 3 months of sick leave. It is even being suggested that there is a place for interdisciplinary programs at a stage in treatment prior to the development of permanent disability, and this may be at a period of no later than 3 to 6 months after a disabling injury.

ODG (a national treatment guideline used by many Drs. and insurance companies): about Multidisciplinary pain programs or Interdisciplinary rehabilitation programs. These may be the most effective way to treat chronic pain. These treatment modalities are based on the biopsychosocial

model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. The types of treatment for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical therapy (and possibly chiropractic); (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

From the CO DOWC medical treatment guides online:

INTERDISCIPLINARY REHABILITATION PROGRAMS are the gold standard of treatment for individuals with chronic pain who have not responded to less intensive modes of treatment. There are current studies to support the use of pain programs, with good evidence that interdisciplinary programs which include screening for psychological issues, identification of fear-avoidance beliefs and treatment barriers, and establishment of individual functional and work goals, will improve function and decrease disability. In general, interdisciplinary programs evaluate and treat multiple and sometimes irreversible conditions, including but not limited to painful musculoskeletal, neurological, and other chronic painful disorders and psychological issues, drug dependence, abuse or addiction high levels of stress and anxiety, failed surgery; and pre-existing or latent psychopathology. The DOWC recommends consideration of referral to an interdisciplinary program within 6 months post-injury in patients with delayed recovery unless successful surgical interventions or other medical and/or psychological treatments complications intervene.

Outpatient chronic pain programs are available with services provided by a coordinated interdisciplinary team within the same facility (formal) or as coordinated among practices by the authorized treating physician (informal). Inpatient pain rehabilitation programs are rarely needed but may be necessary for patients with specific needs, such as patients with addiction problems.

Informal interdisciplinary pain programs may be considered for patients who are currently employed, those who cannot attend all day programs, those with language barriers, or those living in areas not offering formal programs. Before treatment has been initiated, the patient, physician, and insurer should agree on treatment approach,

methods, and goals. Generally the type of outpatient program needed will depend on the degree of impact the pain has had on the patient's medical, physical, psychological, social and/or vocational functioning.

An example from the literature:

BMJ. 2010 Nov 30;341:c6414. doi: 10.1136/bmj.c6414.

Effect of integrated care for sick listed patients with chronic low back pain: economic evaluation alongside a randomized controlled trial.

Department of Public and Occupational Health, VU University Medical Center, Amsterdam, Netherlands.

Abstract

RESULTS: Total costs in the integrated care group were significantly lower than in the usual care group. The cost-benefit analyses showed that every £1 invested in integrated care would return an estimated £26.
CONCLUSIONS: Implementation of an integrated care program for patients sick listed with chronic low back pain has a large potential to significantly reduce societal costs, increase effectiveness of care, improve quality of life, and improve function on a broad scale. Integrated care therefore has large gains for patients and society as well as for employers.

Next in this series on NP:
Recognizing and explaining how bad neuroplastic changes can scientifically refute and destroy the reports and testimonies of biased defense IME doctors.