**Template for a management question regarding Chronic Pain**

1. **Assessment:** A comprehensive management plan best follows the development of a CASE FORMULATION (Shaw *et al.*, 2006; Linton *et al.*, 2008). My approach to developing a case formulation involves a thorough BIOPSYCHOSOCIAL-EXISTENTIAL assessment (FPM = sociopsychobiomedical). I use an interdisciplinary team approach based on the setting within which I practice. Initial assessment involves history taking, examination, investigations/referrals and coordination with healthcare team as appropriate (Wrigley *et al.*, 2010).
2. **Management targets** are chosen in consultation with the patient. Agreed targets apply to the contributors identified: e.g. activity (e.g. work), treatment side-effects, mood, sleep, pain ...
3. **Management** approaches are then negotiated to reach these targets.
4. **Review of management outcomes** is scheduled and outcome measures determined at different timeframes to review effectiveness of approach (Linton *et al.*, 2008).

**Potential management options for identified contributing factors**

**1. Biological** – those treatments aimed at Biological contributors

**1.1. Disease specific treatments (suggest place first)**
- cancer pain e.g. surgery, chemotherapy, radiotherapy, brachytherapy
- non-cancer e.g. modification of underlying disease process e.g. diabetes, inflammatory arthropathy

**1.2. Pharmacological** (symptom related)
- enteral/parenteral
- special e.g. neuraxial delivery

**1.3. Physical**
- exercises, stretching, pacing* …
- graded upgrading, normalisation of movement

**1.4. Pain interventional procedures**
- Spinal cord stimulation
- Neurodestructive: chemical, thermal, surgical (rarely indicated in non-cancer except e.g. facet nerve denervation)

**2. Psychological** – those interventions/strategies aimed at modifying **A**ffect/Mood, **B**ehaviours (excesses/deficits) and **C**ognitions (helpful/unhelpful)

**2.1. Education:** chronic pain ≠ harm, sensitisation of nervous system
**2.2. Psychotherapy**: Cognitive Behavioural (goal setting, *pacing, thought monitoring, flare-up plans)
other (e.g. psychodynamic - long-term)

**3. Social/environmental**

**3.1. Family**
**3.2. Work**
**3.3. Physical environment** (e.g. wheelchair access to home or work)
**3.4. Compensation** (legal, relational/social justice)

**4. Existential (Hope meaning and purpose) –** This area encompasses a person's core beliefs (whether framed in religious terms or not) that bring meaning and purpose to their actions, relationships and view of self (Chapparo *et al.*, 1997). A person's belief structure may profoundly affect behaviours and cognitions in the presence of the challenge of persisting pain (Rippentrop *et al.*, 2005).

**References:**

Chapparo C, Ranka J (1997). Occupational Performance Model (Australia): Retrieved 27 February 2007 from http://www.occupationalperformance.com/oldsite/index.html.

Linton SJ, Nicholas MK (2008). After assessment, then what? Integrating findings for successful case formulation and treatment tailoring. In: Breivik H, Campbell WI, Nicholas MK (eds). *Practice and Procedures*, edn. London: Hodder Arnold. p^pp 95-106.

Rippentrop AE, Altmaier EM, Chen JJ, Found EM, Keffala VJ (2005). The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. *Pain* 116**:** 311-321.

Shaw WS, Linton SJ, Pransky G (2006). Reducing sickness absence from work due to low back pain: how well do intervention strategies match modifiable risk factors? *Journal of Occupational Rehabilitation* 16**:** 591-605.

Wrigley PJ, Siddall PJ (2010). The clinical evaluation of pain. In: Tsui SL, Chen PP, Ng KFJ (eds). *Pain Medicine. A Multidisciplinary Approach*, edn. Hong Kong: Hong Kong University Press. p 31-49.