

Physician Guideline: Chronic Pain Management in Pregnancy- Management Issues

Disease Condition: Pregnant woman with chronic pain predating pregnancy

Objectives:

- 1) Guide optimal management of women with chronic pain during pregnancy
- 2) Provide guidelines for medication management for women with chronic pain
- 3) Identify resources and strategies for multidisciplinary management.
- 4) Encourage preconception planning for patients with chronic pain.

Target Population: 13-50 years

Applies to Gender: Female

Guideline Category: Evaluation, Management, Risk Assessment/Prognosis

Intended Users: Physicians, Certified Nurse Midwives, Nurses

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Aims/Measures:

- 1) AIM: To maximize clinic management of patients during their pregnancy.
MEASURE: # of women receiving Urgent Care or TEC care for pain management/# of women with antenatal diagnosis of chronic pain
- 2) AIM: To monitor the use of non-opiate pain management strategies utilized.
MEASURE: # of patients with non-opiate prescribed medications/ # of patients with diagnosis of chronic pain in pregnancy
- 3) AIM: To maximize pain management during labor and postpartum.
MEASURE: # of patients with chronic pain referred for postpartum follow-up with other members of the multidisciplinary team/# of women with diagnosis of pregnancy, delivered, with a history of chronic pain.

Title:	Chronic Pain in Pregnancy, Management Issues	Number:	XXX-X
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Major Recommendations

General concepts of chronic pain management during pregnancy

1. The most common types of chronic pain effecting pregnant women:
 - a. Chronic back pain
 - b. Pelvic girdle pain
 - c. Pubic symphysis pain
 - d. Headaches

See specific guidelines for each of these conditions.
2. Take pain seriously. Maintain an empathic, nonjudgmental approach.
3. Evaluate potential sources of pain. Rule out serious causes. See attached document.
4. Set realistic goals.
 - a. Don't expect to be pain-free
 - b. The goal should not be that the patient is capable of full function. She should not expect to continue to work full-time, or participate in a marathon
 - c. Bedrest is seldom useful and is potentially dangerous. Yoga and stretching for flexibility and mild exercise may be helpful
5. Treat with non-medication modalities as much as possible.
 - a. Physical Therapy- dry needling (a technique done by PT's for muscle/ligament pain, no medications injected), orthotics (eg. SI belt), pool therapy, massage
 - b. Occupational Therapy
 - c. Acupuncture
 - d. Chiropractic care
 - e. Good sleep hygiene and healthy eating habits (avoid excessive weight gain, constipation) are both important
6. Use non-narcotic pain medications as much as possible
7. Use support medications as warranted (tricyclic antidepressants, SNRIs, steroids) with the support of pain specialists
8. Multidisciplinary team approach may prove most useful
 - a. Care Coordination is important due to frequent visits to multiple providers and need for enhanced communication
 - b. PT, OT
 - c. Physical Medicine, chiropractic care
 - d. Pain Clinic
 1. Trigger point injections for myofascial pain, , SI joint injection, epidurals
 2. Pain psychology referral
 - e. Neurology
 - f. Behavioral Health
9. Medications for pain management
 - a. Pain Contract should be signed and enforced. Review the provider and patient requirements associated with pain contracts.
 - b. Acetaminophen- scheduled and in high enough doses (1000mg TID or QID) can have a significant effect on chronic pain, especially synergistic with opioids
 - c. NSAIDs
 1. Generally safe. Teratogenicity risk is low
 2. Use "a basal rate" to prevent pain as much as possible
 3. Terminate use at 32 weeks due to concerns about vasoconstriction of various fetal arteries (ductus arteriosus, renal vessels, mesenteric arteries)
 - d. Opiates
 1. As much as possible, use them "to rescue from pain" when the NSAIDs have proven inadequate. Discuss with the patient concerns about the high abuse potential, risks of drug dependency, and Neonatal Abstinence Syndrome

2. Prescribe only what is needed until the next appointment. Consider pill counts
3. Consider long-acting, transdermal preparations, such as buprenorphine transdermal (Butrans), or fentanyl patch
- e. Tricyclic antidepressants- nortriptyline, amitriptyline
- f. SNRIs (Effexor, Cymbalta)- effective in pain management and depression/anxiety that accompanies chronic pain. If the patient is already on an SSRI, consider switching.
- g. Gabapentin
- h. Steroid injections (local, epidural)
10. Just because something didn't help at the beginning of the pregnancy doesn't mean that it won't be helpful in late pregnancy. Retry some of the previous approaches if necessary
11. Referral to Pediatric Hospitalists should be performed at approximately 32 weeks for patients on opiates for pain management. Educate regarding NAS, scoring, and follow-up care. Referral to this service for other reasons is at the discretion of the provider
12. For patients on chronic opioid therapy, the risk of IUGR and premature labor should be considered. Ultrasound assessment of fetal growth should be done appropriately to ensure adequate growth. Education about the symptoms of premature labor should occur. Fetal surveillance with BPP and NST should be considered according to risk level
13. Postpartum management must be considered during pregnancy. Prepare for the transition to a chronic pain clinic, their PCP, or help them find one
14. Encourage pre-pregnancy counseling for patients with chronic pain prior to pregnancy. A large number of women begin their pregnancies already on pain medications, esp. opiates
 - a. Chronic back pain
 - b. Fibromyalgia, rheumatoid arthritis, Ehler-Danlos Syndrome
 - c. Chronic headache, including migraine
 - d. Patients with neuropathic pain
 - e. Patients with vulvodynia, vestibulitis, chronic pelvic pain

Level of Evidence: C

Recommendations are primarily based on expert opinion. Little research has been done on approaches to chronic pain management in pregnant women.

Level A evidence is found for back pain management by physical therapy and chiropractic care.

Algorithms

None Listed

Links to References

Gundersen Health System Guideline on chronic pain disease management

Source / Adaptation

1. Rathmell JP, Viscomi CM, Ashburn MA. Management of nonobstetric pain during pregnancy and lactation. *Anesth Analg* 1997;85:1074-87
2. Kellogg A, Rose CH, Harms RJ, Watson WJ. Current trends in narcotic use in pregnancy and neonatal outcomes. *Am J Obstet Gynecol* 2011;204:259.e1-4.
3. Babb M, Koren G, Einarson A. Treating pain during pregnancy. *Can Fam Phys* 2010;56:25-27.
4. Coluzzi F, Valensise H, Sacco M, Allegri M. Chronic pain management in pregnancy and lactation. *Minerva Anestesiol* 2013 July 15 (e-pub ahead of print)