



Model's Involved in Primary Care Patients with Chronic Non-cancer Pain

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Abstract

Patients reporting moderate to severe CNCP for at least 6 months with an active analgesic prescription from a primary care physician were recruited in community pharmacies. Recruited patients completed questionnaires documenting bio psychosocial characteristics. Using administrative data-bases, direct costs were estimated for health care services used by each patient in the year preceding and following the recruitment. Heavy health care users were defined as patients in the highest annual direct health care costs quartile. Logistic multivariate regression models using the information criterion were developed to identify predictors of heavy health care use.

Introduction

CNCP is associated with significant costs for patients, their family, and society in a large Danish study. Found that patients with moderate or severe chronic pain visited their physicians more often (six and nine times/year, respectively) than did those without pain (four times/year). They were also more likely to be hospitalized (0.8 and 1.6 days/ year, versus 0.43 days/year, respectively). Annual number of pain-related medical visits for CNCP patients were estimated to be eight in Europe and in the United States and average length of hospital stay was 0.3 days in Europe. In Canada, CNCP patients have been reported to be four times more likely to visit their physician (12.9 versus 3.8 visits) and to stay in hospital six times longer (3.9 versus 0.7 days) than patients without CNCP [1].

Given the heavy societal and economic burden of CNCP, a thorough understanding of the bio psychosocial factors driving health care costs is of prime interest. Indeed, being able to longitudinally identify CNCP patients most likely to be heavy health care users could be beneficial in order to possibly modify their continuum of care, improve their health outcomes, and thereby reduce their health care costs [2].

Studies have shown that CNCP patients with depression, anxiety, sleep problems, higher pain intensity, more pain-related disability and comorbidities and those reporting low treatment satisfactions were more likely to use health care resources and generate higher economic costs. However, nearly all of these studies used a cross sectional design or included only patients with specific CNCP syndromes followed in specialized pain clinics. To our knowledge, no longitudinal studies have been conducted among CNCP patients followed in primary care settings [3-5]. The aim of the present longitudinal study was to identify the socio demographic, psychosocial, and clinical predictors of heavy public health care use among primary care CNCP patients.

Another aspect to consider in assessing CNCP costs is the presence and severity of comorbidity. Many patients with CNCP suffer from other chronic but non painful diseases such as cardiovascular diseases and diabetes, multiple sclerosis, insomnia and mental disorders, including anxiety and depression disorders. In our study, patient's comorbidity level was found to be a predictor of health care use. Our results are consistent with those reported in a Swiss study that included patients suffering from osteoarthritis, back pain, and fibromyalgia, whose comorbidity level was measured with the Self-administered Comorbidity Questionnaire. That study found that patients' comorbidity levels increased direct health care costs. Likewise, in a sample of patients suffering from osteoarthritis followed in primary care, a higher comorbidity score, measured by the Comorbidity Index, was found to increase the risk of incurring higher direct health care

costs. Thus, comorbidity appears to be an important driver of health care costs. The non-significance of its associated OR in our final predictive model is likely due to the fact that pre recruitment health care use would represent a good proxy of patient's comorbidities [6].

The present study suggests that patients who expect a medical cure for their CNCP tend to incur higher health care costs. In another study and also found in a sample of patients suffering from chronic low back pain that those whose expectations regarding an outpatient rehabilitation program were low used more health care resources. These results are interesting in that patient attitude toward chronic pain and its treatment is a factor that can be modified by simple education programs or cognitive Behavioral therapy [7].

Chronic pain is a pervasive problem that affects the patient, their significant others, and society in many ways. The past decade has seen advances in our understanding of the mechanisms underlying pain and in the availability of technically advanced diagnostic procedures; however, the most notable therapeutic changes have not been the development of novel evidenced-based methods, but rather changing trends in applications and practices within the available clinical armamentarium. We provide a general overview of empirical evidence for the most commonly used interventions in the management of chronic non-cancer pain, including pharmacological, interventional, physical, psychological, rehabilitative, and alternative modalities. Overall, currently available treatments provide modest improvements in pain and minimum improvements in physical and emotional functioning. The quality of evidence is mediocre and has not improved substantially during the past decade [8]. There is a crucial need for assessment of combination treatments, identification of indicators of treatment response, and assessment of the benefit of matching of treatments to patient characteristics.

All groups of participants described opioids as non-first-line drugs for pain management. Opioids should be prescribed only for severe

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pain, when non-opioid pharmacotherapy and non-pharmacological therapies are not effective. Patients reported that the benefits of opioids were for pain relief; while physicians and most family members highlighted that opioid use should improve functional outcomes [9,10].

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