Clinical Education Initiative
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ECHO: MANAGEMENT OF CHRONIC PAIN IN PATIENTS LIVING WITH HIV

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ECHO: Wound Care for People who Use Drugs
[video transcript]

00:07
Talk a little bit about pain in patients who are HIV positive, and is certainly in management of pain or chronic pain specifically is one of the hardest things that we find in primary care and other fields. So I'm going to provide an overview of that. So what are the learning objectives for this session is to understand the presentation of chronic pain in people living with HIV. Review the current guidelines, as presented by HIVMA IDSA and review a little bit of what the current evidence is for the management of chronic pain. So in kind of following the format or having a case, and I'm going to just kind of highlight the most important things. This is a patient who I took care of a 67 year old male with HIV that having overall well control undetectable viral load with a CD four count of 244 with multiple comorbidities as you see here, hypertension, asthma, you know, dysplasia lipo dystrophy, depression, insomnia and chronic pain syndrome. He had a number of medications when I met him as listed here. Medications for pain, medications for depression, for insomnia, and his HIV regimen being seem to set which we're going to review in a second. He was followed by pain medicine. But his pain was still not a not well controlled with significant neck pain, lower back pain, knee pain, and not really able to identify worsening factors have received epidural injections, have not recently participate in physical therapy, because he was just tired of it and have done in the past without minimum relief, and he deny any other symptoms of numbness or paresthesia. A little bit of his HIV histories with diagnosing 1992, the lowest CD four that I could find through their records was 136 history of anal dysplasia, and it was actually enroll in the ANCHOR study. He received some of the earlier area Ts and had associated lipid dystrophy and a very extensive resistance pattern, which we're not reviewing for the purpose of this of this talk. But I wanted to make note of it. And that led to the most recent regimen. So for the participants with Symtuza and Tivicay, so Symtuza being a having a boosted PI with an NRTI backbone and Tivicay being the integrase. So for in his exam, appropriate strength, some limited flexibility due to pain and walks the patient walks with a cane. He has some basic X rays done at the time, we show multiple levels of spondylosis. And he also had MRI that show pretty significant degenerative disc disease on the cervical spine. So that brings us to sort of the main questions. What kind of pain does the patient have? What are the optimal management modalities for for this type of pain? And then the other question is, how does HIV play a role in the etiology, but also how we manage pain? want to take a pause here for the audience. If anyone wants to put it on the chat? What have been some of your experiences in managing chronic pain for patients who are HIV positive? You can put it on the chat or you can unmute yourself to share some of your current experiences.

04:21
Think today's a quiet audience. Okay, so will you feel free to put comments on the chat? I'll keep going. And so the purpose of the second part of this presentation is to review the

guidelines that were created in 2017. So about five years now, but this has been one of the most comprehensive clinical practice guidelines for the management of pain of patients living with HIV. And so just to give an overview there were about a panel of 10 experts from different fields, psychiatry, palliative care, addiction, medicine, pharmacology, and the you is a grading system to determine the level of the recommendation and the quality of the evidence. This is probably one of the most comprehensive PRAK practice guidelines. But it's also important to recognize that it has its own limitations. There is limited evidence, few studies actually included people living with HIV, and how pain is defined, was very heterogeneous. And we know a defining pain is very hard. And it's very hard to have a specific criteria for is very subjective. This is just a graph or how they look at the evidence. And some important definitions, especially for there is a chronic pain is longer than three to six months before the initial injury. But I want to remind all of ourselves, especially when working for patients, that pain can be experienced in different ways. And even though one person might have the same type of injury and signal, how they experience pain is very dependent of what their overall context of bike, bio psychosocial factors. And so those are going to influence how a patient experiences pain, the tolerance for pain. And so it's very important that we keep that in mind, because we might say, Oh, but that was nothing, you know, why are you experiencing so much pain? And so it has, we had to remind ourselves that it's very specific to the individual. And so, you know, chronic pain is whether it's an ongoing injury, but also it can just be AB regulation of the sensory system. And then affected by this bio psychosocial factors is the range of pain and people who live with HIV is from 40%, to almost 85%. And I want to remind all of ourselves that pain management is really an essential component of the overall disease management and the quality of life of people who live with HIV. So how do the panelists describe pain I classify them, so the big categories neuropathic and neuropathic, and when we think of neuropathic pain, we have to think about impact from the virus. We also have to think about infection from secondary pathogens, or from side effects from the medications and this usually are with earlier medications that we have with HIV. We didn't see as much of HIV associated neuropathy. But it was still it was more common in the earlier part of the epidemic, with more distal sensory poly neuropathies. And it was also associated with certain medications like Sepi Dean and data seen. neuropathic pain is also affected by comorbidities, and orthopedic. Neurology. Yep. So that's a neuropathic pain. And then we have the non neuropathic pain with musculoskeletal pain, and then Tissue Injury secondary to inflammation, infection, and neoplasia. Now, this is sort of like, you know, the important part, right, like what can we offer our patients, and then they, the quality of the recommendations, and the level of evidence was review. And they certainly started with cognitive behavioral therapy. And this is really pointed to this bio, psychosocial elements and training to support the patient and help them develop adaptive behaviors to the management of pain. Yoga is actually very strongly recommended. And so no surprise, but then we had to think, you know, how can we make that accessible to to all of our patients, physical and occupational therapy, strong level of recommendation. One that was really important

surprising to me is that hypnosis is actually recommended for neuropathic pain. Maybe towards the end, I will ask one of my one of our colleagues that I can stay in and see what he has heard about hypnosis, in the management of theme, so I could come back to you in a little bit, but also acupuncture for the manager of chronic pain. So these are non pharmacological treatments that were provided by the by the panel. And then we have the pharmacologic treatments. So first step is always at starting on your T if the patient is that on it, so we want to really delay we want to sort of pause the damage that the virus is causing, but also address the chronic inflammation that is happening. Then in terms of other in terms of medications, Gabapentin actually has strong is provide a strong recommendation from the panel and had a moderate level of evidence. So that should be so one of our first lines for the management of pain, especially when it's a age of chronic HIV associated with neuropathic pain. And then they provide our word standard second line and 10. Second lines for medication, they actually provided start to talk about medical cannabis. And this was published in 2017. But I so we have been learning that over the past few years, there's a lot more evidence for the use of medical cannabis on the management of chronic pain. So I really would be excited to see more data and more recommendations regarding that. And then we have a la for the management of also chronic HIV associated peripheral neuropathy pain. And then what also what are the other four Mala ecological treatments. So capsaicin, capsaicin has become one of my go to medication, especially the topical one. But I have to warn patients that you know, it can be really warm, it can be hard to tolerate. And usually the ones that we use over the counter is a very low is a low percentage. And as you can see, here, the studies looked at 8%, which I think is going to be almost impossible for patients who tolerate that level of that concentration of capsaicin, but it actually works for the management of pain. They also talk about opioids. And as we know, it should not be prescribed the first line agent for long term. And it could only be consider as a limited trial. So want to take a pause here and actually wanted to bother that you're like in Stein, and just as he ask you a little bit of what your thoughts are about some of these recommendations that they gave, and if you have any spirits or anything else to add about this recommendation for the management of chronic pain.

11:57
Yeah, thanks. So I think you know, all these recommendations are very good. And usually when they're talking about hypnosis, for chronic pain, they're talking usually a specific type of hypnosis, which is associated with cognitive behavioral therapy. And it's really about developing a very deep state of mental and physical relaxation. So it can be extremely helpful, you know, hypnosis is, you know, it gets a bad rap, it's not really quite the same thing as like stage hypnosis, it's a little bit of a different beast, though it does kind of use some of the same tenants. And it can actually be extremely effective. And really, any kind of deep mental relaxation can kind of be put in place there. So like, certainly types of yoga or Eastern meditation, fill in that as well, as well as acupuncture in certain ways can kind of help with this,

like deep relaxation feeling that is, can be very helpful for all kinds of painful conditions. Additionally, did they mention things like TCAS and duloxetine?

13:04
They did, and they put it more as sort of kind of the second line for the management of pain and people living with HIV with Gabapentin being the first line.

13:15
Yeah, I think that's broadly true, though people for especially for gabapentin, it's not effective or has side effects of Gabapentin is pretty, you know, side effect minimal. I've really found that nortriptyline and amitriptyline have been, you know, very, very helpful for my folks with chronic pain. In addition, Cymbalta as well are duloxetine there's a lot more evidence for amitriptyline nortriptyline, but they're all basically SSRIs serotonin, serotonin norepinephrine reuptake inhibitors, you know, considerations about that amitriptyline nortriptyline the person, you know, psychiatric considerations, they're very toxic medications and overdose. So if a patient is suicidal, they're not certainly not a good idea to have someone with a large stash of these medications. They typically can be prescribed and pretty low doses side effects are pretty minimal, except for sedation and sort of anticholinergic side effects. So people are already struggling with that from other medications, pain or otherwise, that may not be the best choice duloxetine, I found can be helpful, it tends to have a lot fewer side effects in the TCAS. But it you often have to push the dose up to like 120 which, of course, you know, sexual side effects, things like that can be bothersome for patients, but that's that tends to be where I go. I don't typically treat people's pain primarily we are fortunate enough to have a pain management console, but it's often in the concert of depression and sort of choosing medications to help treat psychiatric disorders in addition to their pain.

14:57
Got it. Well, thank you very much. This is When I am the presenter, but I was like, let me reach out to the expert here. So I'm really happy to do the review of the evidence and then reach out to our colleagues here. So thank you for adding so much more to that. So we cover as I mentioned here, then known opioids, we make the statement about the opioids. And then now I want to switch a little bit about the non neuropathic pain of what the evidence and these guidelines recommended. So non opioids, the for non neuropathic pain, acetaminophen and says continue to be the first line and then opioids only in a very limited trial, and also they recommended Tramadol, although the recommendation is actually on the weaker side, because and the evidence is moderate, they recommended for only up to three months as this is for non neuropathic pain. But going back to our patients, so what can we offer this patient? You know, can we offer CBT physical therapy? Can we offer capsaicin, Tramadol continue to follow with pain management. So something that I found here is there was a little bit of disconnect

between pain management psychiatry, and primary care in with this patient when I started to take care of. So part of that is kind of the three teams trying to come together and sort of optimize look at his medications. He's mental health was sort of kind of the core and trying to improve the management of his depression, his isolation, and then seeing from there kind of from the behavioral part, can we start adding physical therapy again, and see what other options we have. So this patient is still has other regimens or other things that we can add best certainly thing, the first bar was sort of the better coordination of care among the three specialists and optimizing his management or his depression. So that was a little bit of just kind of given an overview of what our patient and they went. And so wanted to bring it back to the audience that we had when we're managing pain, I think we have to remind ourselves, oh, how this signal on how pain is very experienced by our patients, and really unfortunate which the most humility and that diminish or disregard patient's pain, because we really need to understand the within the context of their experience of their environment, and their psychosocial factors. So it's very important to kind of take a pause there. Then we also have to remind ourselves that neuropathic pain is very common among people who are living with HIV. And even though HIV associated neuropathy is not as common, which is still being mindful of that, and where it's more of a sort of distill sensory polyneuropathy. As we mentioned earlier, CBT is behavioral therapy is really a crucial, crucial step in the management of chronic pain. And among the different levels of evidence that they look at under medications or they look, based on this guidelines, capsaicin, Gabapentin acetaminophen, and NSAIDS actually have the strongest level of recommendation. And it also this is based in having the highest levels of the quality of the evidence. So perhaps there is all these other options that are available just when they look at the guidelines, the evidence, and the studies were not there. So it doesn't mean that we can use them and one of them also be in medical care, cabinets that will be sort of excited to look at more data comment in terms of the use of it for the pain for pain management. Here is a little bit of the reference that I wanted everyone to have there, the HIV clinical guidelines. Also HIV-Age.org is actually a great resource and thinking of sort of our aging, patient population. There are a lot of resources there and HIVma.org so that was a sort of an overview of the management certainly open to other comments, experiences from anyone else in the team or any other questions?
[End Transcript]