Chronic Pain

Biopsychosocial assessment & stepwise multimodal care

CLINICAL PATHWAY

Function is the goal — not a pain score of zero. Chronic pain (>3 months) is common, present in 20–40% of GP consultations. Multimodal, biopsychosocial care outperforms any single treatment — escalate through the steps below, and never skip the foundation.

BIOPSYCHOSOCIAL ASSESSMENT

- **Bio:** pain location, character & duration; exam findings; imaging only if red flags; comorbid conditions
- **Psycho:** mood (PHQ-9, GAD-7), catastrophising, fear-avoidance, pain beliefs, prior trauma
- **Social:** work/income, relationships, sleep, substance use, social support, legal or compensation issues
- **Function:** ADLs, work capacity, exercise tolerance, and what matters to the patient
- **Red flags:** cancer history, weight loss, fever, neurological signs, bladder/bowel disturbance, night pain

STEPWISE MANAGEMENT LADDER

- 1. Foundation: pain neuroscience education, activity pacing, graded exercise
- 2. Psychosocial: CBT, ACT, mindfulness, sleep hygiene, mood/stress care
- 3. Physical therapies: physiotherapy, hydrotherapy, targeted strength and mobility work
- 4. Simple analgesics: topical NSAID, paracetamol, short-course oral NSAID
- 5. Adjuvants & specialist input: neuropathic agents, multidisciplinary pain clinic

DRUG CHOICE BY PAIN MECHANISM

- **Nociceptive (MSK):** topical NSAID or paracetamol first-line; short oral NSAID + PPI second-line — avoid long-term NSAIDs (CV, renal, GI harm)
- **Neuropathic:** amitriptyline 10–25mg nocte or duloxetine 30–60mg commonly first-line; pregabalin second-line (PBS authority required)
- **Mixed/nociplastic** (e.g. fibromyalgia): duloxetine plus exercise and CBT; pregabalin or a pain clinic if not settling
- **Cancer pain:** WHO analgesic ladder — opioids appropriate at any step if severe; a different paradigm from non-cancer pain
- **Acute-on-chronic flare:** optimise baseline treatment plus a short NSAID course; opioids only if severe, 5–7 days max, with a documented weaning plan

AVOID / DE-PRESCRIBE

- Long-term NSAIDs: CV, renal and GI harm rises with duration — review every 3 months if continued
- Codeine: marginal efficacy and CYP2D6 variability — favour better alternatives
- Opioid + benzodiazepine or Z-drug: overdose risk rises sharply — deprescribe one or both
- Tramadol in older adults: seizure and serotonin-syndrome risk, falls — avoid where possible

PRACTICAL RESOURCES & MBS PLANNING

Pain Australia (painaustralia.org.au), Tame the Beast (tamethebeast.org) and retrainpain.org offer free patient education. The former GP Management Plan/Team Care Arrangement items are transitioning to new GP Chronic Condition Management items through 2026 — confirm current item numbers at mbsonline.gov.au.

■ SAFETY

- Screen for red flags before treating pain as a primary chronic condition — cancer history, weight loss, fever, neurological or bladder/bowel signs, night pain
- Multimodal, biopsychosocial care drives outcomes — don't escalate to a stronger drug class before working through the step below it
- Trial any new pharmacological agent for a defined 4–6 week period then review — stop if it isn't working rather than escalating blindly

■ RED FLAGS / REFER

- Persistent disability despite 6–12 months of biopsychosocial management, or high/escalating opioid use → multidisciplinary pain clinic
- Complex psychosocial issues, iatrogenic opioid dependence, fibromyalgia or complex regional pain syndrome
- A procedural intervention or neuromodulation is being considered → refer early, pain-clinic waits often exceed 6 months

For health-professional use. Framework: RACGP Prescribing Drugs of Dependence Part C2, ANZCA Faculty of Pain Medicine.
Companion sheet: PA-01B Opioid Stewardship & Deprescribing. MBS item numbers change — verify at mbsonline.gov.au.