Nye anbefalinger fra EULAR om håndtering av smerte

I mai 2018 publiserte The European League Against Rheumatism, EULAR, anbefalinger for helsepersonells tilnærming til smertehåndtering ved inflammatorisk artritt og artrose.

Her er selve artikkelen og abstractet til anbefalingene: http://ard.bmj.com/content/77/6/797

Anbefalingene er utviklet for å hjelpe helsepersonell i sin tilnærming til håndtering av smerter hos pasienter med inflammatorisk artritt og artrose. Målet er å redusere smertene og øke funksjon og velvære hos pasientene. Samtidig er det et mål at anbefalingene skal bidra til å redusere de negative konsekvensene smerte kan ha for både individet og samfunnet.

En kort presentasjon av anbefalingene finner du også på EULARs nettsider (bla ned til «completed projects»): https://www.eular.org/health_professionals_projects.cfm

Under ledelse av professor Rinie Geenen har en tverrfaglig arbeidsgruppe gjennomført et systematisk litteratursøk for å evaluere effekten av ulike tiltak for å håndtere smerte. Den tverrfaglige gruppen bestod av 18 medlemmer fra 12 ulike land derav pasientrepresentanter, revmatolog, fysioterapeuter, sykepleiere, psykologer, en ergoterapeut, en allmennlege, en metodeekspert og en forskningsmedarbeider.

Her finner du de 10 anbefalingene fra EULAR (vi legger ved dette i et eget vedlegg)

1. Assessment by the health professional should include the following aspects (the assessment is brief or extensive depending on factors such as available time, whether it is a first or regular consultation, and the needs of the patient):

- Patient's needs, preferences and priorities regarding pain management and important activities, values and goals in daily life.
- Patient's pain characteristics including severity, type, spread and quality.
- Previous and ongoing pain treatments and the perceived efficacy.
- Current inflammation and joint damage as sources of pain, and whether these are adequately treated.
- Pain-related factors that might need attention: (a) the nature and extent of pain-related disability, (b) beliefs and emotions about pain and pain-related disability, (c) social influences related to pain and its consequences, (d) sleep problems and (e) obesity.

2. The patient should receive a personalised management plan with the aim of reducing pain and pain-related distress and improving pain-related function and participation in daily life. This plan is guided by shared decision-making, the expressed needs of the patient, the health professional's assessment and evidence-based treatment options. A stepped-care approach may include, in step 1, education and self-management support (recommendation 3); in step 2, one or more treatment options by a specialist if indicated (recommendations 4 to 9); or, in step 3, multidisciplinary treatment (recommendation 10).

3. The patient should receive education.

* All patients have easy access to (1) educational materials (such as brochures or links to online resources with encouragement to stay active, sleep hygiene guidelines and so on), (2)

psychoeducation by the health professional and (3) online or face-to-face self-management interventions.

4. If indicated, the patient should receive physical activity and exercise.

* The health professional and patient appraise whether advice to stay active, supervised physical exercise or multidisciplinary treatment is needed.

* If the patient is not able to initiate physical activity and exercises without help, then consider the possibility for referral to a physiotherapist for individually tailored graded physical exercise or strength training.

* If psychosocial factors such as fear of movement or catastrophising cognitions underlie a disabled, sedentary lifestyle, then consider a multidisciplinary intervention including cognitive – behavioural therapy.

5. If indicated, the patient should receive orthotics.

* If a patient has pain during activities of daily living which impedes functioning, orthotics (such as splints, braces, gloves, sleeves, insoles and shoes), daily living aids (such as a tin opener), an assistive device (such as a cane or rollator) or ergonomic adaptation (at home, workplace) can be offered. If the patients wants to use this assistive support, then consider referral to the occupational therapist, who can proceed with several actions: offer education about appropriate ways to use joints and ergonomic principles, appraise the need for the use of an orthotic or assistive device, give advice about how to acquire it, fit the customised aid to the patient , offer training in the use of it, refer to the appropriate specialist who will do this, eg, orthopaedic shoemaker.

6. If indicated, the patient should receive psychological or social interventions.

* If there are indications that social variables or psychological factors interfere with effective pain management and functional status, then consider (depending on the severity) providing basic social and psychological management support or referral to a psychologist, social worker, self-management support programme, CBT or multidisciplinary treatment.

* If psychopathology (eg, depression and anxiety) is present, discuss treatment options with the patient and the patient ’s primary care physician.

7. If indicated, the patient should receive sleep interventions.

* If sleep disturbance is reported, inquire about causes (eg, pain, persistent worrying, poor sleep habits) and offer basic education about good sleep hygiene practices.

* If sleep remains (severely) disturbed, refer to a therapist or programme aimed at restoring sleep, or to a specialised sleep clinic.

8. If indicated, the patient should receive weight management.

* If the patient is obese, explain to the patient that obesity can contribute to pain and disability. Discuss accessible weight management options with the patient or signpost appropriate specialised

weight management support; for example, dietitian, psychologist, community lifestyle services or bariatric clinic/surgery.

9. If indicated, the patient should receive pharmacological and joint-specific pain treatment according to recent recommendations.

* Ask about the patient ’s existing use of prescribed and over - the - counter pain relief including homeopathic remedies and consider if the frequency of use is safe (not over dosing) and appropriately regular. Ask or refer for further specialist or medical advice if there are concerns or if additional pharmacological treatment may be indicated.

10. If indicated, the patient should receive multidisciplinary treatment.

* If more than one treatment options are indicated, for example, to treat psychological distress in combination with a sedentary lifestyle, and if monotherapy failed, consider a multidisciplinary intervention.