Regional Pain Control Program as a Good Practice

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We are in nine Portuguese islands in the Atlantic Ocean, at the western point of Europe. It was a great achievement to put the pain on the political agenda of the Portuguese Government since 2001. At this date was issued the first National Plan to Combat the Pain, created a National Commission, a post graduate Course at the University of Porto in 2003 and a second Pain Management Program in 2008. The General Health Directorate has published guidelines as good practice standards. The Regional Autonomous Government of the Azores has the capacity to adapt national legislation or create new laws. In 2009 we organized a Regional Pain Control Program to apply in three years with the first goal the education in pain for all professionals, doctors, nurses and other technicians, with more than 27 courses; second, to organize Pain Units in 3 Hospitals. This Program was based on the pain as Priority, Right, Duty, Quality Indicator, Quality of Life Suffering Decrease, Cost Reduction. Since 2014 there were defined new strategies, repeated courses, practical training for family doctors and are scheduled prevalence studies. In 2013 the Regional Pain Control Program was introduced at national level, as a standard of good practice and classified in the first 11 in a total of 75 projects. In 2014 it was presented at a meeting of Good Practices promoted by the European Parliament and we suggested the following conclusions: to get a well motivated team, to come from national level to regional and to local levels with interested leaders, to find carefully our partners, to get the support of the politicians and Institutions, to be obstinate and persevering.

Multidisciplinary multimodal pain therapy (MMPT)

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Background: Chronic pain is the result of the interaction of multiple etiological factors. They have a sensory, affective, cognitive and functional dimension and evolve in the context of relationships and behavior in the social field of the patient. An effective treatment should address all the dimensions and is therefore multimodal (Pfingsten 2011). Chronic pain is often accompanied by a retreat of physical and social activities like pain avoiding posture, isolation and other dysfunctional patterns of coping with pain like helplessness, catastrophizing etc. These factors increase the pain and promote chronicity (Arnold 2009). The prevalence of chronic pain in Europe is between 10 and 20% (Breivik 2006). The indirect costs of chronic pain in Germany are estimated to a total of more than 29 billion euros (Dietl 2011).

There is a blatant inappropriate treatment of pain patients (for example, by an oversupply of surgery), a problem-adequate treatment has been requested (German Advisory Council 2000).

Materials and methods: MMPT is defined as the simultaneous, content, time and the procedure coordinated comprehensive treatment of patients with chronified pain syndromes. Various somatic, physically and psychologically practicing and psychotherapeutic methods according to the specified treatment plan with the same therapeutic objective are involved (Arnold 2009).

The aim of the MMPT is in addition to the relieve of pain and promoting a biopsychosocial disease understanding the improvement of objective and subjective functional capability (functional restoration).

Results: Longer-lasting effects in terms of improving the quality of life and the restoration of the ability to work are only proven for multimodal interdisciplinary treatments (Van Tulder 2006, Williams 1996).

Clinically significant evidence of efficacy can be demonstrated only for intensive multimodal programs (> 100 h treatment), but not for programs with low intensity therapy (Bendix 1997, Arnold 2009).Multimodal methods are superior to unimodal methods also with an end point of the return to work (Hazard 1989 Cutler 1994).

In a meta-analysis (Flor 1992) was demonstrated, that multimodal were superior to unimodal methods not only with respect to the decline of pain, improvement of mood, but also less utilization of the health system and an increased return to work.

Their effectiveness depends on the intensity of treatment, which is the number of treatment units (Bendix 1997 Härkäppäa 1990) and which is determined by the quality of treatment. Both depend on the length of stay.

Conclusions: MMPT is the gold standard for the therapy highly chronified pain patients (Guzmán 2002).