

# The new normal—pain control in COVID era

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## Abstract

Pain is a universal phenomenon; every human being has experienced some type of and some degree of pain during his or her life span. Roughly one third to one half of the whole population has suffered from chronic pain. During the recent past the approach towards management of chronic pain has dramatically changed. The opioid epidemic created alarm in the developed countries, and forced the clinicians to seek new pharmaceutical agents with less side effects and less potential for abuse. The interventional pain management developed itself as an advanced branch of the pain management, thanks to the development of new and better technologies, e.g., radiological imaging including ultrasound use as well as fluoroscopic and even CT and MRI use for guided neural interventions. COVID-19 forced us initially to cease all interventions, only after a few months to modify patient selection and our routine management protocols. This editorial offers a glimpse of this transformation to 'the new normal'.

**Key words:** Pain; Pain management; Opioids; COVID-19

**Citation:** A.B. Akhtar AB, Durrani RS, Ghafoor AR. The new normal – pain control in COVID era (Editorial). *Anaesth. pain intensive care* 2020;24(4):373-376.

Received: 26 July 2020, Reviewed: 5 August 2020, Accepted: 9 August 2020

## 1. Introduction

Pain is defined as “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage”.<sup>1</sup> Chronic Pain is persisting or recurrent pain for more than three months.<sup>2</sup> It is not merely a symptom associated with other diseases but rather a separate multifaceted ailment with its own medical definition and taxonomy.<sup>3-5</sup> Pain is one of the most common causes for patients to seek medical care.<sup>6</sup>

Chronic pain affects one-third to half of the whole population.<sup>7</sup> *The Global Burden of Disease Study 2016* confirmed that pain and pain-related illnesses are the second leading cause of disability and disease, affecting 1.6 billion people till 2013.<sup>8</sup> Globally, the single most cause of “years lived with disability (YLD)” was chronic low back pain. In the year 2013, chronic pain caused an estimated number of 146 million YLD's.<sup>9</sup> The chronic pain patients need

repeated follow ups and interventions by pain physicians in clinics or in operating rooms.

The COVID-19 outbreak has led to rapid changes throughout the healthcare system. The main aim of the changes is to protect patients and staff from infection as well as to mobilize resources towards the critical needs. There was an abrupt cessation of nearly all the services in most of the hospitals across the globe including Pakistan. This was followed by the introduction of strict isolation and distancing protocols to resume near normal medical services. The treatment has to continue as the disease also continues. Treating or refilling medications of patients on regular follow up at a distance from healthcare provider has become imperative, besides emergency cover.

## 2. Telemedicine and eHealth

Telemedicine is perhaps one of the most rapidly changing facets of medical practice in the face of this crisis. Electronic health (eHealth) and Telemedicine

clinic approaches have been tested and developed gradually over the past many years.<sup>10-12</sup> Telemedicine is “the use of technologies and telecommunication systems to administer health care to patients who are geographically far from physicians”.<sup>13</sup> eHealth is the “cost-effective and secure use of information and communications technologies in support of health and health-related fields, including healthcare services, health surveillance, health literature, and health education, knowledge and research”.<sup>14</sup> Many hospitals and clinics have started video consultations.<sup>15</sup> The role of social media is being discussed positively in directing people and containing misinformation as much as possible.<sup>16</sup>

One of the telemedicine services have been introduced by the Epic Systems (IT company), with three components:

- eVisit is a structured template of 10 questions which is answered by the patient.
- E-consult, where primary care provider obtains specialists' input into a patient's care / treatment.
- VideoVisit® (VV), video appointments between a provider and patient.<sup>17</sup>

### 3. ESRA and ASRA Recommendations for Pain Medicine

Following are the recommendations of American Society of Regional Anesthesia and Pain Medicine (ASRA) and European Society of Regional Anesthesia and Pain Therapy (ESRA):

- Any elective, in-person patient visits or meetings have to be suspended.
- Only provide chronic pain interventions that fall in urgent category, e.g. intrathecal pump refills, malfunction, neurotransmitter infection and malfunction. Intractable cancer pain, trigeminal neuralgia, excruciating cluster headaches, acute herpes zoster or herniated disc and early complex regional pain syndrome are examples of semi-urgent pain management scenarios.

- Prefer telemedicine but where it deems necessary patients can be called for physical assessment.<sup>18</sup>
- Some basic precautions are to be followed during interventions:
- The procedure is to be done by an experienced person with minimal staff around.
- Patient's face should be covered with surgical mask throughout the procedure.
- All the required equipment should be present in the room.
- Instruments coming in contact with the patient are to be covered.
- Minimum trolleys with drugs and instruments should be inside the room.
- Surgical mask, eye protection, surgical gown, and double gloves for personnel involved in performing the procedure are enough.
- N95 is not necessary.<sup>18</sup>
- In case of a COVID positive or high-risk patient:
- Only urgent procedures may be performed.
- Intervention should be done in a COVID designated area.
- Standard donning and doffing.
- Patient to be kept away from crowded places, like holding area or post anesthesia recovery unit.
- Local guidelines should be considered when making decisions.<sup>18</sup>

### 4. Telemedicine pain clinic

Shaukat Khanum Memorial Cancer and Research Center (SKMCH & RC) is one of the leading hospitals in cancer care in Pakistan. It started telemedicine clinics in April 2020. The hospital provided smart phones in clinics. Due to lack of nurse practitioners and general practitioners (GP) in the treatment cadres, the only type of telemedicine possible is VV. Patients were informed about their online appointments earlier. A method of online payment was also devised for private patients. The idea was to have a video call on

WhatsApp to see the physical condition of the patient, enquire about their current state and also to see the drugs they are using. However, poor internet services, language barriers, phone with a family member outside home, privacy /confidentiality of the patient and casual attitude etc. were various hurdles faced during the use of this mode of communication.

The next thing tried was to call the patients and have a communication. This preserved the confidentiality somewhat but the problems of phone being carried by someone else or poor cellular signals remained. Medication names and scheduling were difficult to understand by the patient. Some of the patients wanted physicians to text them the medication list which not only bears medicolegal issue but an extra cost and time. Beside the good effects of telemedicine, it also turns out to be more tiring for the physicians.

Patients were told to send only one family member to hospital pharmacy for collecting the medication. The reason for collection of drugs solely from hospital pharmacy is non- availability of opioids in local markets. Opioid availability is a perpetual issue in the developing world. It had serious repercussions during pandemic. Even in the hospitals where these were available, patient access was not possible. Patients from far-flung areas could not reach due to travel restrictions and precautionary measures of lock down. There was no arrangement for them to collect their regular opioids. This indeed made it clearer that these medicines should be available at local level. Or a system could be devised for delivery of such medication at doorstep.

In the early days of COVID pandemic, interventional pain services were ceased. Only pharmacotherapy was possible through telemedicine. But telemedicine cannot replace invasive therapies. Initially pain procedures were performed only for intractable cancer pain as inpatient. In a couple of weeks, services were expanded for cancer pain out-patients only (as per hospital policy). As the COVID guidelines continued to change globally on daily basis, so did the hospital policies, following Center for Disease Control (CDC) updates. It further gradually allowed pain physicians to include non-cancer pain procedures as well. COVID screening of all patients was done prior to these procedures with minimal number of staff inside procedure room. All the safety measures were taken including surgical mask for patient, proper donning

and doffing. With the passage of time as the situation is evolving, pain interventions are now done on a near regular basis.

## 5. Conclusion

The current pandemic has opened new venues for medical practice. Technology is taking over the old practices.

The lesson to learn is to live with and adopt the technology with open arms; accepting and merging it in the new practices. New systems may need to be devised to make the life easier, for both the patient as well as the practitioner. New ideas are needed to improve the service without compromising the safety. This is the only way to ease the burden of this pandemic on all of us and to embrace the '*new normal*'.

## 6. Conflict of interest

None declared by the authors

## 7. Authors' contribution

ABA, RSD: Writing and editing the manuscript

ARG: Concept, writing and final approval

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