Scandinavian Journal of Pain 4 (2013) 188–189

Contents lists available at ScienceDirect

Scandinavian Journal of Pain

journal homepage: www.ScandinavianJournalPain.com

Editorial comment

Pain rehabilitation in general practice in rural areas? It works!

Torsten Gordh*

Multidisciplinary Pain Center, Uppsala University Hospital, Uppsala, Sweden

In this issue of the *Scandinavian Journal of Pain*, Stein and Miclescu [1] describe the structure and evaluate the results of a multidisciplinary pain rehabilitation programme carried out at a primary care unit, in a small town with rural surroundings in Sweden. The pain rehabilitation took place close to where the patients are living their everyday life. This is probably a strength of the programme, since this group of pain patients rarely can take part in pain rehabilitation projects offered by specialized rehab units, usually situated in urban areas, often many hours away. However, chronic pain is a major, very common health problem in primary care settings [2], thus people living in non-urban areas also need specific pain rehabilitation treatment, carried out in the countryside [3].

Multidisciplinary rehabilitation is a well-established treatment option for chronic non-cancer pain [4]. Systematic studies on the outcome of treatment programmes for chronic pain show that multidisciplinary rehabilitation programmes can improve physical functioning, quality of life, and help patients back to work [5–8].

Such programmes usually contain a combination of psychological interventions and physical training, supervised by pain rehabilitation physicians. Multidisciplinary pain rehabilitation is based upon the concept that chronic pain is best understood by using the bio-psycho-social context, where a successful treatment must take all these aspects into account [6].

Stein and Miclescu present a pragmatic, observational study, assessing outcome of multidisciplinary pain therapy at the primary care level in a small Swedish town. There are few studies of multidisciplinary pain rehabilitation outcome in primary health care, especially from those units situated in rural areas, and with a different population than that encountered in specialized hospitals. This is so in spite of the fact that the prevalence of pain in the patients treated in primary care practice is about 30% [2].

The multidisciplinary team in the present study consisted of a general practitioner, two physiotherapists, two psychologists, and one occupational therapist. The 6-week treatment programme took place in group-sessions with 6–8 patients each, three times per week. The programme included cognitive-behavioural treatment, education in pain physiology, ergonomics, physical exercises, and relaxation techniques. The 51 patients included in the study suffered from various chronic pain states, e.g. fibromyalgia, neck and shoulder pain, low back pain. Follow up after one year showed significant improvements in social activity and depression score, they used significantly less health care and showed a lower degree of sick-leave [1]. Anxiety, physical activity, pain intensity, pain severity, and opioid consumption all showed a trend to improvement, though not statistically significant.

The authors conclude that the 6 weeks treatment programme in a primary care pain clinic was of benefit for the patients, and that this treatment is provided in the local environment of the patients is likely to be a key factor for the successful outcome [1]. Most of these patients would probably not had made their way to come for treatment in the major multidisciplinary pain centres, usually located in a university-hospital far away.

Their pain rehabilitation programme at a local primary health care unit was developed according to the Swedish recommendations for rehabilitation of non-cancer pain patients [6]. The study was conducted as a prospective pragmatic observational trial .The concept “pragmatic trial” as described by Rowbotham et al. [9] is of great interest for the study of effects in “real life situation”, as was done in this study [1].

The patients acted as their own controls, before and one year after participation in the pain rehab programme. This is not optimal; a separate control group receiving no treatment (waiting list) or “sham treatment” would have been scientifically more appropriate. This is, however, difficult or impossible to arrange in this type of “real life studies”. Therefore, the design using the patients as their own controls, before and after treatment, and comparing the treatment results with data from a national quality register for pain rehabilitation is sufficient to provide new scientific data about pain rehabilitation in rural areas in a primary care setting.

We really need good follow up studies, describing the outcomes of different kinds of pain treatments. This is the only way to document and understand if our treatment efforts are of any long-term benefit for the patients, who are investing much time to take part in different kinds of treatment programmes. This is the only way to get information on whether the resources of health care are optimally and correctly allocated. This article by Stein and Miclescu, reporting outcome from a multidisciplinary pain rehabilitation programme in “rural primary care”, shows that the patients taking part had sustainable improvement in several aspects of their chronic pain syndrome [1].

DOI of refers to article: http://dx.doi.org/10.1016/j.sjpain.2013.06.003.
* Corresponding author. Tel.: +46 18 6110000; fax: +46 18 5035 39.
E-mail addresses: torsten.gordh@akademiska.se, torsten.gordh@surgsci.uu.se

http://dx.doi.org/10.1016/j.sjpain.2013.07.021

The study has contributed new knowledge on the outcome of multimodal pain rehabilitation in rural areas, suggesting that this approach has beneficial effects, thus being a good investment both from the patients' point of view, as well as from the health care system.

Conflict of interest

No conflict of interest declared.

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