März 2019

Jahrestagung 2019 des
Thüringer Weiterbildungskreises

Der chronische Schmerzpatient in den Mühlen des Systems

Prof. Dr. med. R. Nickel

Helios

Inhalt

Verbreitung & (wirtschaftliche) Bedeutung chronischer Schmerzen

die Mühlsteine

Kopf- und Rückenschmerz

Medikamente (NSAR, Opiate, Cannabinoide)

Placebo-Effekte

Mögliche Auswege

2 - 3%	„Fibromyalgie“ (Punktprävalenz in der Allgemeinbevölkerung)
2 – 5 (11%)	Chronic Widespread Pain (u.a. Andrews et al. 2018)
12%	Somatoforme Schmerzen, Lebenszeitprävalenz in der deutschen Allgemeinbevölkerung (TACOS-Studie, Meyer et al 2000)
28%	Somatoforme Schmerzstörung in einer universitären Schmerzambulanz (Nickel, Egle & Schwab 2002, PPmP)

CHRONISCHE SCHMERZEN

je nach Untersuchung und zugrunde liegenden Kriterien sind ca. 17% d. Bevölkerung betroffen

in Deutschland sind von den somit etwa 15 Mio. Betroffenen 20 bis 30 Prozent „schwer behandelbar“

Andrews et al., EJP, 2018
Breivik et al. 2006
Schmidt und Kohlmann 2005
Pain in Europe Survey 2004

pro Jahr werden weit über 1Mrd. € für Werbung für **rezeptfreie** Medikamente ausgegeben

Quelle u.a.: Jahrbuch Sucht 2017, Statistica 2019

Schmerzmittelumsatz in Deutschland/Jahr: ca. 560 Mio.
Quelle: Statistica, Januar 2019

das sind ca. 140 Mio. Packungen (ohne BTM)
Quelle: Jahrbuch Sucht 2018

ca. 80% sind frei verkäuflich
ca. 20% sind Kombinationspräparate mit Coffein-Zusatz
Quelle: Jahrbuch Sucht 2018

Prävalenz der Medikamenteneinnahme *

Schmerzmittel	19,4%	(m 16,1%, w 22,9%)
Antidepressiva	4,7%	(m 3,7%, w 5,7%)
Schlaf- /Beruhigungsmittel	3,3%	(m 2,3%, w 4,3%)
Neuroleptika	1,7%	(m 1,4%, w 1,2%)

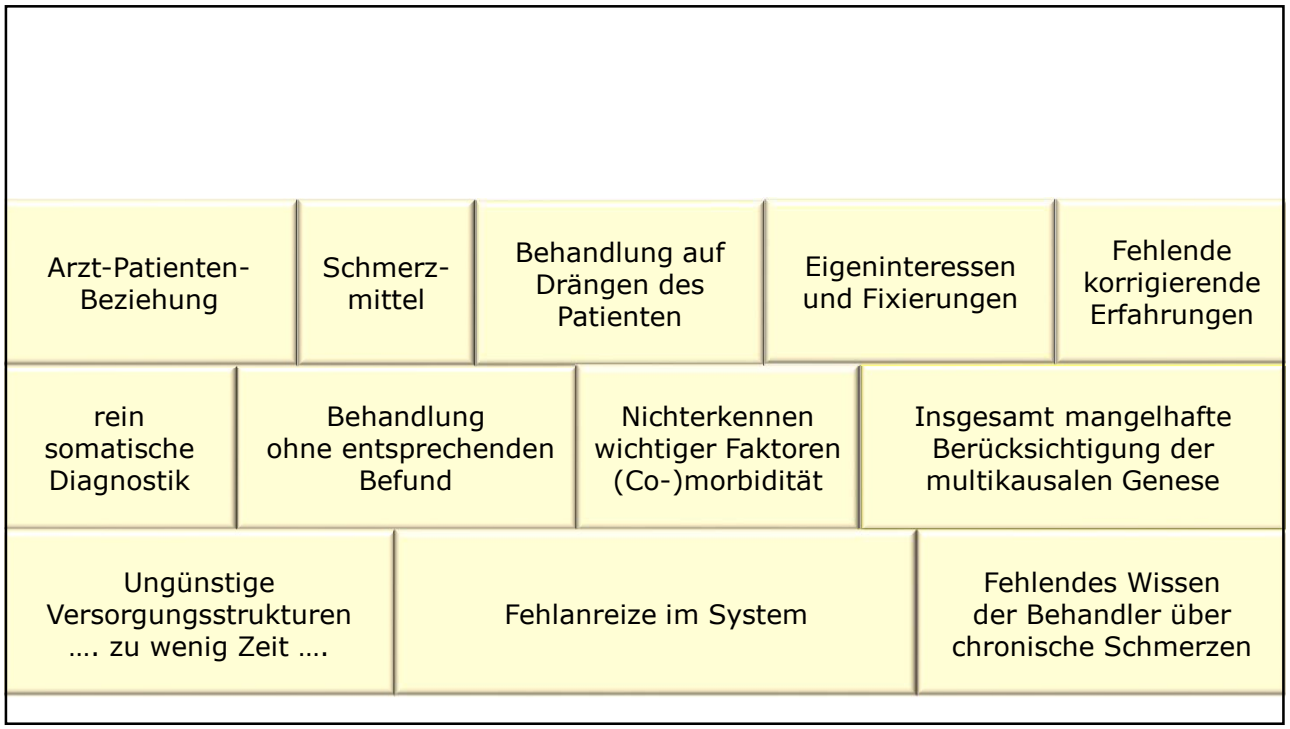
Quelle: Epidemiologischer Suchtsurvey 2015 / Jahrbuch Sucht 2018
* mindestens einmal wöchentlich in den letzten 30 Tagen

Top Ten der meistverkauften Arzneimittel*

1. Nasenspray-ratiopham (Xylometazolin)	(24,2 Mio)
2. Ibuflam (Ibuprofen)	(23,1 Mio)
3. Novaminsulfon	(18,1 Mio)
4. Voltaren (Diclofenac)	(17,5 Mio)
5. Paracetamol ratiopharm (Paracetamol)	(15,5 Mio)

Unter den Top Ten der meistverkauften Arzneimittel sind in den letzten Jahren immer mindestens **3 bis 5** Analgetika-Präparate

Quelle: Jahrbuch Sucht 2018
* Industrieabsätze in Packungsmengen



Kosten pro Jahr

Rückenschmerzen: ca. 25 Mrd. €

(direkte ca. 10 Mrd. und indirekte Kosten ca. 15 Mrd.;
je nach Schätzung ca. **49 Mrd.**, davon 46% direkte,
54% indirekte Kosten,
Wenig et al. EurJPain 2009; 13(3): 280-286)

Spiegel Nr. 40 2011: 50 Mrd. Kosten insgesamt

Migräne: ca. 3,7 Mrd. €

(Schätzungen KS insgesamt bis zu 7 Mrd. €; direkte Kosten hier unter 10%)

Rückenoperationen

Der Wohnort bestimmt, ob Patienten ins Krankenhaus kommen, konservativ behandelt oder operiert werden

Diagnosen und operative Eingriffe bei Rückenerkrankungen

Für diesen „Faktencheck Rücken" wurden Daten von rund fünf Millionen stationären Behandlungen aus den Jahren 2007 bis 2015 ausgewertet. Es handelt sich um alle Patienten, die mit einer der folgenden ICD-10-Hauptdiagnosen vollstationär aufgenommen wurden (unberücksichtigt blieben traumatologische und entzündliche Erkrankungen sowie Erkrankungen der Halswirbelsäule):

- M47: Spondylose (Gelenkverschleiß der Wirbelsäule)
- M48: Sonstige Spondylopathien (Veränderungen der Wirbel, oft mit Verengung des Rückenmarkkanals)
- M51: Sonstige Bandscheibenschäden
- M54: Rückenschmerzen

Krankenhausaufenthalte mit einer Hauptdiagnose M47, M48, M51 oder M54

Fälle in Tausend, Jahre 2007 bis 2015, Bevölkerung im Alter ab 15 Jahren

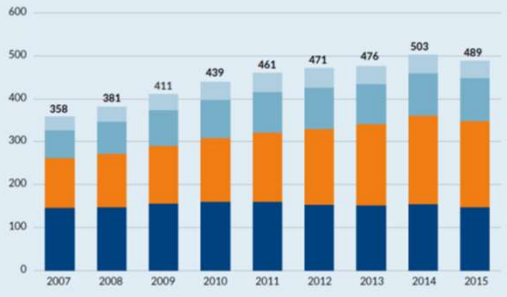


Abbildung 1 | Quelle: Statistisches Bundesamt, Berechnungen IGES 2017, Faktencheck Gesundheit 2017

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Krankenhausaufenthalte aufgrund einer Hauptdiagnose M47, M48, M51 oder M54 und deren relative Veränderung zwischen 2007/2008 und 2014/2015

Fälle je 100.000 Einwohner, direkt standardisiert an der Bevölkerung des Jahres 2014 nach Altersgruppen und Geschlecht, Bevölkerung im Alter ab 15 Jahren

Abbildung 3 | Quelle: Statistisches Bundesamt, Berechnung IGES 2017, Faktencheck Gesundheit 2017

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Häufigkeit des operative

Je 100.000 Einwohner, 201

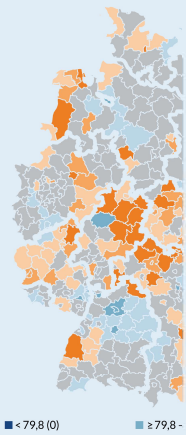
... „Entfernung von Band
(OPS 5-8

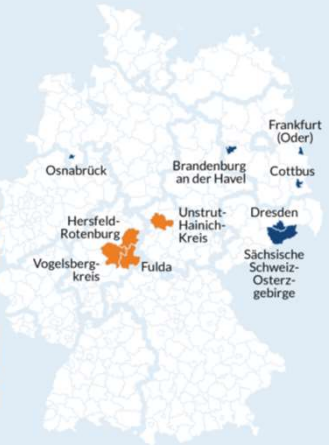
Eingriffe am Rücken: Wo wird am häufigsten operiert?

Operative Eingriffe je 100.000 Einwohner, 2014/2015, direkt standardisiert an der Bevölkerung des Jahres 2014 nach Altersgruppen, Bevölkerung im Alter ab 15 Jahren

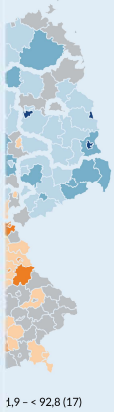
15 Jahren

pression"





Am häufigsten:	Am seltensten:
Bandscheiben-Operation (OPS 5-831)	
199 Bundesdurchschnitt	
567 Hersfeld-Rotenburg	85 Sächsische Schweiz-Osterzgebirge
514 Fulda	87 Cottbus
461 Unstrut-Hainich-Kreis	91 Dresden
Verblockung/Versteifung von Wirbelkörpern (OPS 5-836)	
102 Bundesdurchschnitt	
355 Fulda	27 Frankfurt (Oder)
284 Hersfeld-Rotenburg	50 Cottbus
266 Vogelsbergkreis	51 Osnabrück
Knöcherne Dekompression (OPS 5-839.6)	
155 Bundesdurchschnitt	
549 Fulda	40 Frankfurt (Oder)
404 Hersfeld-Rotenburg	43 Brandenburg an der Havel
390 Vogelsbergkreis	52 Cottbus



1,9 – < 92,8 (17)
23,8 – < 185,7 (165)
16,6 – < 247,6 (28)

Abbildung 4 | Quelle: Statistisches Bundesamt, Berechnung IGES 2017, Faktencheck Gesundheit 2017

BertelsmannStiftung

Die Werte einzelner Kreise können in

Abbildung 6 | Quelle: Statistisches Bundesamt, Berechnung IGES 2017, Faktencheck Gesundheit 2017

BertelsmannStiftung

Systematic Review

Fusion or Not for Degenerative Lumbar Spinal Stenosis: A Meta-Analysis and Systematic Review

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Free full manuscript: www.painphysicianjournal.com

Background: Degenerative lumbar spinal stenosis (DLSS) is the main cause for chronic low back pain in the elderly. When refractory to conservative treatment, symptomatic patients commonly undergo surgery. However, whether or not fusion is a relatively better surgical option still remains unclear.

Objective: The purpose of the present study was to systematically review the clinical outcomes of spinal decompression with or without spinal fusion for DLSS.

Study Design: A systematic review of the therapeutic effect for DLSS with or without fusion.

Methods: A literature search of 5 electronic databases was performed including PubMed, EMBASE, MEDLINE, Cochrane Library, and CENTRAL from inception to August 2016. Only randomized controlled trials (RCTs) assessing the comparison between decompression and fusion surgery for DLSS were included.

Results: A total of 5 RCTs involving 438 patients met the inclusion criteria. Low-quality evidence of the meta-analysis was performed for the heterogeneity of the included studies. Pooled analysis showed no significant differences between decompression alone and fusion groups for the Oswestry Disability Index (ODI) scores at the baseline ($P = 0.50$) and 2 years follow-up ($P = 0.71$), and the satisfaction rate of operations was also similar for the groups ($P = 0.53$). However, operation time ($P = 0.002$), blood loss ($P < 0.00001$), and length of hospital stay ($P = 0.007$) were remarkably higher in the fusion group. Furthermore, there was no difference in the reoperation rate between these 2 groups at the latest follow-up ($P = 0.49$).

Limitation: The methodological criteria and sample sizes were highly variable. The studies were heterogeneous.

Conclusion: The present meta-analysis is the first to compare the efficacy of decompression alone and spinal fusion for the treatment of DLSS, including 5 RCTs. Our results demonstrate that additional fusion surgery seems unlikely to result in better outcomes for patients with DLSS, but it may increase additional risks and costs. High-quality homogeneous research is required to provide further evidence about surgical procedures for patients with DLSS.

Key words: Decompression, fusion, lumbar spinal stenosis, meta-analysis

Pain Physician 2018; 21:1-7

Cochrane Library

Cochrane Database of Systematic Reviews

Topical NSAIDs for chronic musculoskeletal pain in adults (Review)

Derry S, Conaghan P, Da Silva JAP, Wiffen PJ, Moore RA

Derry S, Conaghan P, Da Silva JAP, Wiffen PJ, Moore RA.
Topical NSAIDs for chronic musculoskeletal pain in adults.
Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD007400.
DOI: 10.1002/14651858.CD007400.pub3.

www.cochranelibrary.com

Bild

AUCH BEI UNS SIND SIE BELIEBT

Schweden warnen vor Schmerzsalben

Schmerzsalben sollen uns helfen, doch sie schaden häufig der Umwelt
Foto: Adam Gregor - Fotolia

Artikel von: **INGRID RAAGAARD**
veröffentlicht am
09.01.2019 - 17:00 Uhr

Stockholm – Man kennt das: Ein Knie tut weh oder irgendwo ein Muskel, der etwas verzerrt ist. Gern greifen wir dann zu seiner Schmerzsalbe. Doch das sollten wir besser lassen!

In diesen Salben steckt der Wirkstoff Diclofenac – und der schadet der Umwelt mehr, als er uns hilft. Weil ein großer Teil der Salbe beim Duschen im Abwasser landet.

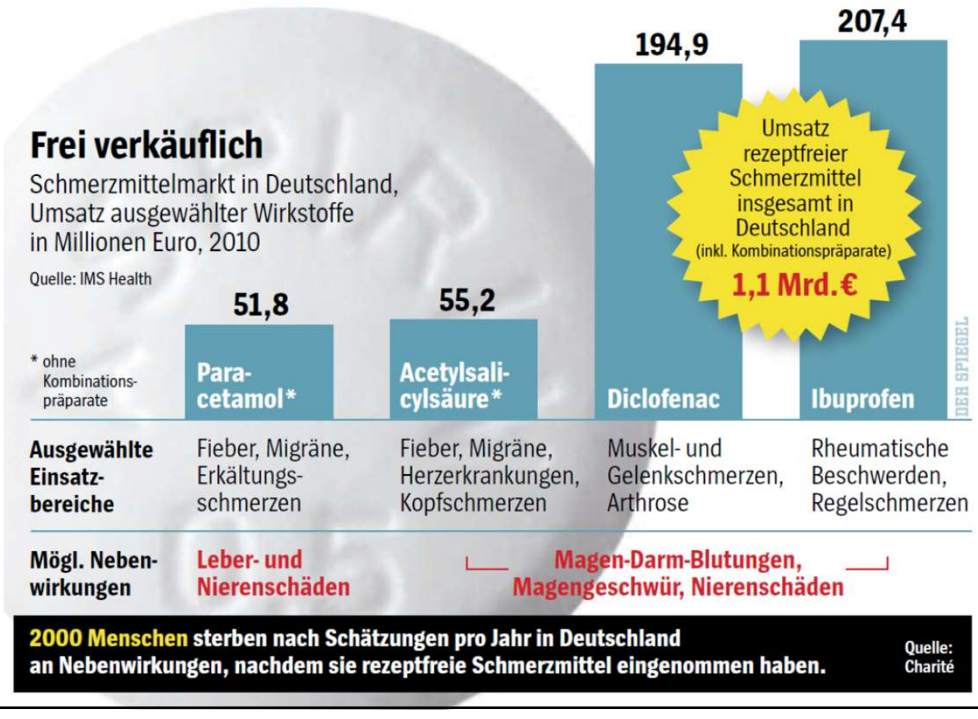
Das teilte ein Sprecher des Arzneimittel-Komitees der schwedischen Region Gävleborg mit. Björn Ericsson, Sprecher des Komitees, warnte in der Zeitung „Hälsingland" vor dem Gebrauch dieser Salben.

► **Denn Diclofenac wird in der Umwelt nicht abgebaut. Das ist besonders bei Salben gefährlich, da nur vier Prozent des Wirkstoffes wirklich durch die Haut eindringen. Der Rest verschwindet beim Duschen mit dem Duschwasser im Abfluss.**

„Verglichen mit der Wirkung ist der Schaden einfach zu groß. Ich bin mir sicher, dass Patienten diese Salben vermeiden würden, wenn sie wüssten, was sie anrichten." Eine Tube Diclofenac-Salbe reiche aus, um ein 25 Meter langes Bassin mit Trinkwasser zu verunreinigen.

Auch in Deutschland ist das Diclofenac-Problem bekannt. Untersuchungen haben gezeigt, dass es das Arzneimittel ist, das am häufigsten in Gewässern nachgewiesen werden kann. Bereits 2012 teilte das Bundesumweltamt mit, dass Diclofenac deutsche Gewässer belastet.

Medikamentenreste gelangen allerdings auch über den Urin in die Abwässer. Pille statt Salbe ist also auch keine umweltfreundliche Lösung. Das Problem der Salben wurde allerdings bei bisherigen Diskussionen kaum angesprochen.



GESUNDHEITSNOTSTAND WEGEN NATIONALER OPIOID-KRISE

Trump: „7 Tote pro Stunde“

US-Präsident Donald Trump (71) ruft in Washington den nationalen Gesundheitsnotstand aus
Foto: JIM WATSON / AFP

28. Oktober 2017

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Opioid Overdose

The United States is in the midst of an opioid overdose epidemic.

Opioids (including prescription opioids, heroin, and fentanyl) killed more than 42,000 people in 2016, more than any year on record. 40% of all opioid overdose deaths involve a prescription opioid.

(https://www.cdc.gov/rxawareness)

2016

mehr als 40.000 Tote durch Opioide in den USA

40% davon aufgrund einer Überdosis eines verschriebenen Opioides

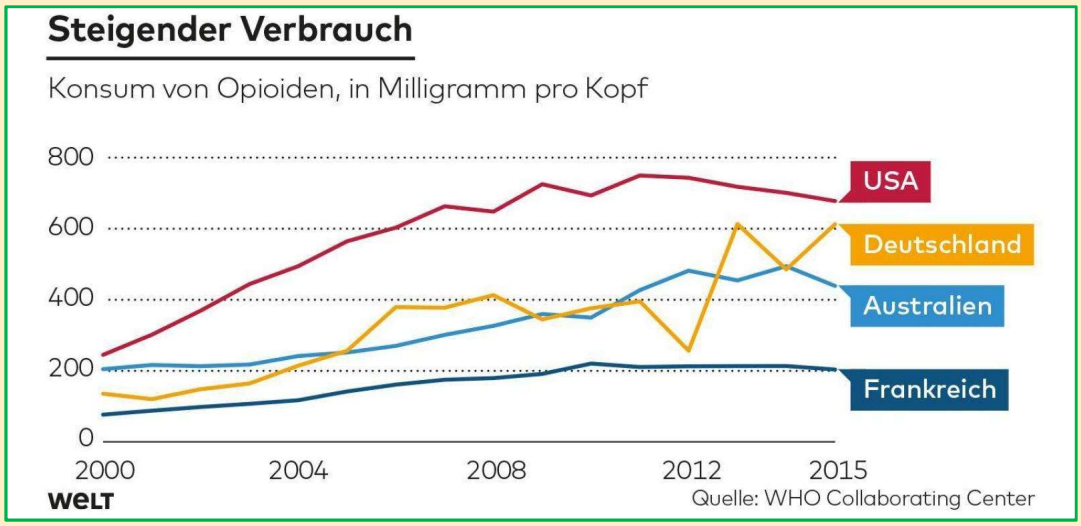
ZAHLEN UND ALTERSADAPTIERTE RATEN AN TODESFÄLLEN DURCH VERORDNETE OPIATE VS HEROIN; USA 1999-2014

Year	Opioid analgesics		Heroin	
	Number	Deaths per 100,000	Number	Deaths per 100,000
1999	4030	1.4	1960	0.7
2000	4400	1.6	1842	0.7
2001	5528	1.9	1779	0.6
2002	7456	2.6	2089	0.7
2003	8517	2.9	2080	0.7
2004	9857	3.4	1878	0.6
2005	10928	3.7	2009	0.7
2006	13723	4.6	2088	0.7
2007	14408	4.8	2399	0.8
2008	14800	4.9	3041	1.0
2009	15597	5.1	3278	1.1
2010	16651	5.4	3036	1.0
2011	16917	5.4	4397	1.4
2012	16007	5.1	5925	1.9
2013	16235	5.1	8257	2.7
2014	18893	5.9	10574	3.4

www.cdc.gov › Opioid Overdose › Data

..... IN DEN MÜHLEN DES SYSTEMS

Cannabinoide



..... IN DEN MÜHLEN DES SYSTEMS

Chronischer Schmerz und Opiate

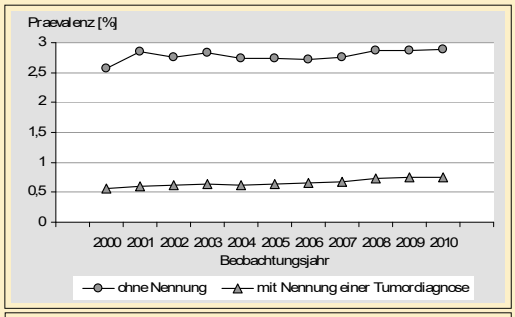
Nicht-Tumor-Erkrankungen versus

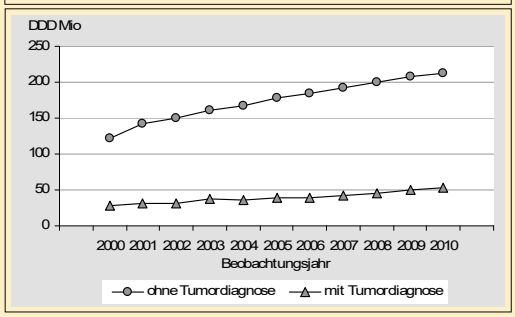
Tumor-Erkrankungen

Angaben standardisiert auf die Bevölkerung Deutschlands zum 31.12. des Vorjahres

Für die Langzeitanwendung gibt es KEINE gesicherte Evidenz

Schubert, Ihle, Sabatowski. Dtsch Ärztebl Intl 2013; 110: 45-51





PSYCHOSOMATISCHE SCHMERZTHERAPIE

Chronischer Schmerz und Sucht

- Die Langzeitanwendung (≥ 3 Monate) von opioidhaltigen Analgetika beim chronischen Nichttumorschmerz wird national und international aufgrund der Diskrepanz zwischen klinischer Anwendung und vorhandener Evidenz kritisch diskutiert.
- Opioidhaltige Analgetika sind eine medikamentöse Therapieoption in der kurzfristigen Therapie (4–12 Wochen) von chronischen Schmerzen bei Arthrose, diabetischer Polyneuropathie, Postzosterneuralgie und chronischen Rückenschmerzen.
- Von einer Langzeittherapie (≥ 26 Wochen) bei diesen Erkrankungen profitieren circa 25 % der Patienten.
- Bei anderen Krankheitsbildern ist eine kurz- und langfristige Therapie mit opioidhaltigen Analgetika als individueller Therapieversuch zu bewerten.
- Kontraindikationen einer Therapie mit opioidhaltigen Analgetika sind primäre Kopfschmerzen sowie funktionelle und psychische Störungen mit dem Leitsymptom Schmerz.
- Um die möglichen Risiken einer Therapie mit opioidhaltigen Analgetika zu minimieren (missbräuchliche Verwendung, sexuelle Störungen, erhöhte Mortalität), müssen die Wirksamkeit und Nebenwirkungen regelmäßig überprüft werden.

http://www.awmf.org/leitlinien/detail/ll/145-003.html

Baseline and Postfusion Opioid Burden for Patients With Low Back Pain

Kevin L. Ong, PhD; Kirsten E. Stoner, PhD; B. Min Yun, PhD; Edmund Lau, MS; and Avram A. Edidin, PhD

Low back pain (LBP) is among the most prevalent and costly musculoskeletal conditions and is the second most common reason for physician visits in the United States.[1] The economic burden of LBP in the United States is between $84 billion and $625 billion, with significantly higher medical costs for patients with LBP than those without.[1] Despite the prevalence of LBP, there are inconsistent recommendations for treating this ailment.[2,3] Treatment options include nonsurgical and surgical approaches.[2] Nonsurgical treatments commonly include physical therapy, exercise-based multidisciplinary rehabilitation programs, and analgesics, such as nonsteroidal anti-inflammatory drugs, antidepressants, anticonvulsants, and opioids.

Opioids are the most common class of analgesic medication prescribed for chronic LBP,[4] and patients with chronic LBP have significantly greater opioid use than those without.[1,5] Opioids have shown short-term analgesic efficacy for LBP, but their long-term efficacy is unclear.[6-8] Some loss of long-term efficacy could stem from drug tolerance and emergence of hyperalgesia.[7] Opioid use for LBP has also been associated with greater disability after 6 months.[9]

Opioid use is not only ubiquitous among hospitalized patients undergoing surgical procedures,[10] but it is also common in many nonsurgical encounters.[11] The elevated use of opioids appears to contribute to increased misuse.[12] Moreover, opioid use has been linked to adverse events,[10,11,13] which can lead to longer hospital stays, higher costs, readmissions, and mortality.[10,13] Complications of opioid use for LBP include addiction and overdose-related mortality, which have risen along with prescription rates.[7]

Am J Manag Care. 2018;24(8):e234-e240

Systematic Review

Efficacy of Cannabis-Based Medicines for Pain Management: A Systematic Review and Meta-Analysis of Randomized Controlled Trials

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Disclaimer: There was no external funding in the preparation of this manuscript. Conflict of interest: Each author certifies that he or she, or a member of his or her immediate family, has no commercial association (i.e., consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted manuscript.

Manuscript received: 09-12-2015 Revised manuscript received:01-18-2016, 02-22-2017 Accepted for publication: 04-12-2017

Free full manuscript: www.painphysicianjournal.com

Background: The management of chronic pain is a complex challenge worldwide. Cannabis-based medicines (CBMs) have proven to be efficient in reducing chronic pain, although the topic remains highly controversial in this field.

Objectives: This study's aim is to conduct a conclusive review and meta-analysis, which incorporates all randomized controlled trials (RCTs) in order to update clinicians' and researchers' knowledge regarding the efficacy and adverse events (AEs) of CBMs for chronic and postoperative pain treatment.

Study Design: A systematic review and meta-analysis.

Methods: An electronic search was conducted using Medline/Pubmed and Google Scholar with the use of Medical Subject Heading (MeSH) terms on all literature published up to July 2015. A follow-up manual search was conducted and included a complete cross-check of the relevant studies. The included studies were RCTs which compared the analgesic effects of CBMs to placebo. Hedges's g scores were calculated for each of the studies. A study quality assessment was performed utilizing the Jadad scale. A meta-analysis was performed utilizing random-effects models and heterogeneity between studies was statistically computed using I^2 statistic and tau^2 test.

Results: The results of 43 RCTs (a total of 2,437 patients) were included in this review, of which 24 RCTs (a total of 1,334 patients) were eligible for meta-analysis. This analysis showed limited evidence showing more pain reduction in chronic pain -0.61 (-0.78 to -0.43, $P < 0.0001$), especially by inhalation -0.93 (-1.51 to -0.35, $P = 0.001$) compared to placebo. Moreover, even though this review consisted of some RCTs that showed a clinically significant improvement with a decrease of pain scores of 2 points or more, 30% or 50% or more, the majority of the studies did not show an effect. Consequently, although the primary analysis showed that the results were favorable to CBMs over placebo, the clinical significance of these findings is uncertain. The most prominent AEs were related to the central nervous and the gastrointestinal (GI) systems.

Limitations: Publication limitation could have been present due to the inclusion of English-only published studies. Additionally, the included studies were extremely heterogeneous. Only 7 studies reported on the patients' history of prior consumption of CBMs. Furthermore, since cannabinoids are surrounded by considerable controversy in the media and society, cannabinoids have marked effects, so that inadequate blinding of the placebo could constitute an important source of limitation in these types of studies.

Conclusions: The current systematic review suggests that CBMs might be effective for chronic pain treatment, based on limited evidence, primarily for neuropathic pain (NP) patients. Additionally, GI AEs occurred more frequently when CBMs were administered via oral/oromucosal routes than by inhalation.

Key words: Cannabis, CBMs, chronic pain, postoperative pain, review, meta-analysis

Pain Physician 2017; 20:E755-E796

- Systematische Übersicht und Meta-Analyse
- 43 RCTs wurden gefunden, 24 konnten ein-geschlossen werde (1300 Patienten).
- Studien mit einer Dauer von einem Tag und < einer Woche wurden eingeschlossen

Ergebnis

- Begrenzter Hinweis für eine Wirksamkeit, mehr Schmerzreduktion gegenüber Placebo insbesondere wenn inhaliert
- Keine Studie konnte eine klinisch zumindest (halbwegs)relevante Schmerzreduktion zeigen
- In nur 7 Studien wurde ein vorheriger Konsum erfasst
- In der Mehrzahl der Studien zeigte sich KEIN Effekt der Cannabis-Medikation

Interpretation (Cave!)

- Cannabinoide sind möglicherweise effektiv, eingeschränkte Empfehlung

diese Schlussfolgerung vollkommen unverantwortlich

ORIGINAL ARTICLE

Cannabinoids in Pain Management and Palliative Medicine

An Overview of Systematic Reviews and Prospective Observational Studies

Winfried Häuser, Mary-Ann Fitzcharles, Lukas Radbruch, Frank Petzke

Dtsch Arztebl Int 2017; 114: 627–34

SUMMARY

Background: There are conflicting interpretations of the evidence regarding the efficacy, tolerability, and safety of cannabinoids in pain management and palliative medicine.

Methods: We conducted a systematic review (SR) of systematic reviews of randomized controlled trials (RCT) and prospective long-term observational studies of the use of cannabinoids in pain management and palliative medicine. Pertinent publications from January 2009 to January 2017 were retrieved by a selective search in the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effects, and Medline. The methodological quality of the SRs was assessed with the AMSTAR instrument, and the clinical relevance of quantitative data syntheses was assessed according to the standards of the Cochrane Collaboration.

Results: Of the 750 publications identified, 11 SRs met the inclusion criteria; 3 of them were of high and 8 of moderate methodological quality. 2 prospective long-term observational studies with medical cannabis and 1 with tetrahydrocannabinol/cannabidiol spray (THC/CBD spray) were also analyzed. There is limited evidence for a benefit of THC/CBD spray in the treatment of neuropathic pain. There is inadequate evidence for any benefit of cannabinoids (dronabinol, nabilone, medical cannabis, or THC/CBD spray) to treat cancer pain, pain of rheumatic or gastrointestinal origin, or anorexia in cancer or AIDS. Treatment with cannabis-based medicines is associated with central nervous and psychiatric side effects.

Conclusion: The public perception of the efficacy, tolerability, and safety of cannabis-based medicines in pain management and palliative medicine conflicts with the findings of systematic reviews and prospective observational studies conducted according to the standards of evidence-based medicine.

As of 10 March 2017, according to the of the "Act to Amend Narcotic Dr sions and Other Related Provisions", phy Germany may prescribe cannabinoids— covered by statutory health insurances— with severe diseases and no alternative tre tions available, as dried cannabis flowers medical cannabis or medical marijuana), ized extracts (compounded medication d finished medicinal product THC/CBD [t cannabinol/cannabidiol] spray) or synth analog (finished medicinal product nab *(Box)*. Recently, an article in *Deutsches* stated that chronic—especially neuropat spasticity in multiple sclerosis and loss o nausea and vomiting are considered "es indications for cannabis-based medicines

Systematic reviews (SRs) with quantitativ (meta-analysis) of randomized clinical tri and overviews of SRs have the highes evidence in evidence-based medicine (3). efficacy and long-term risk can be as prospective observational studies (4).

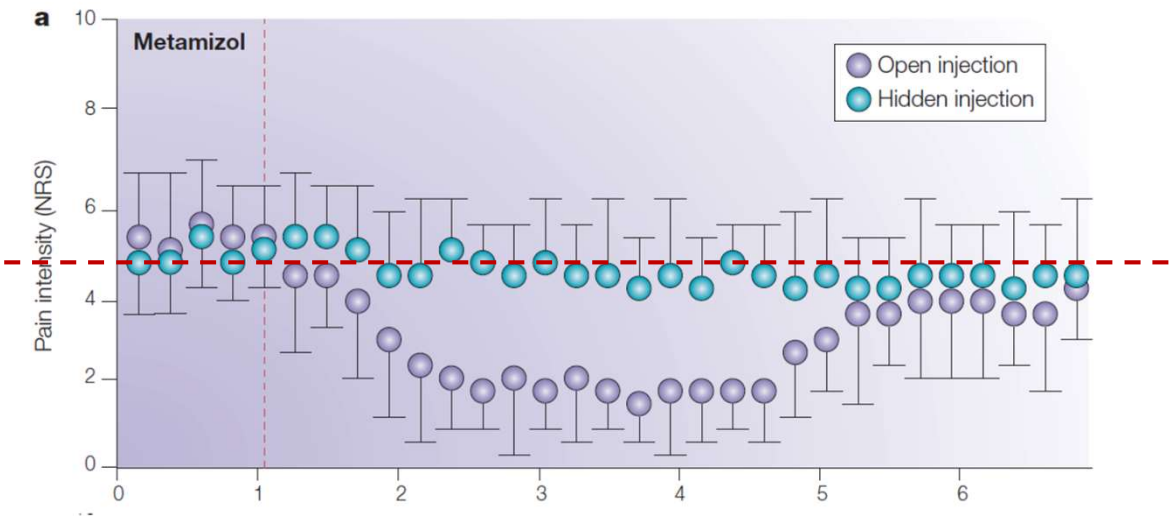
Thus, the aim of this paper is to identify p dications for, but also risks of cannabinoi management and palliative medicine, based atic reviews of RCTs and prospective (≥ 6 months) observational studies.

- Übersicht zu systematischen Reviews (RCTs), plus prospektive Beobachtungsstudien
- Alle Behandlungsansätze haben eine höchstens moderate Wirksamkeit
- Insgesamt wurden 750 Publikationen identifiziert, 11 systematische Reviews; 3 mit hoher, 8 mit mittlerer Qualität
- 2 prospektive Langzeit-Beobachtungsstudien

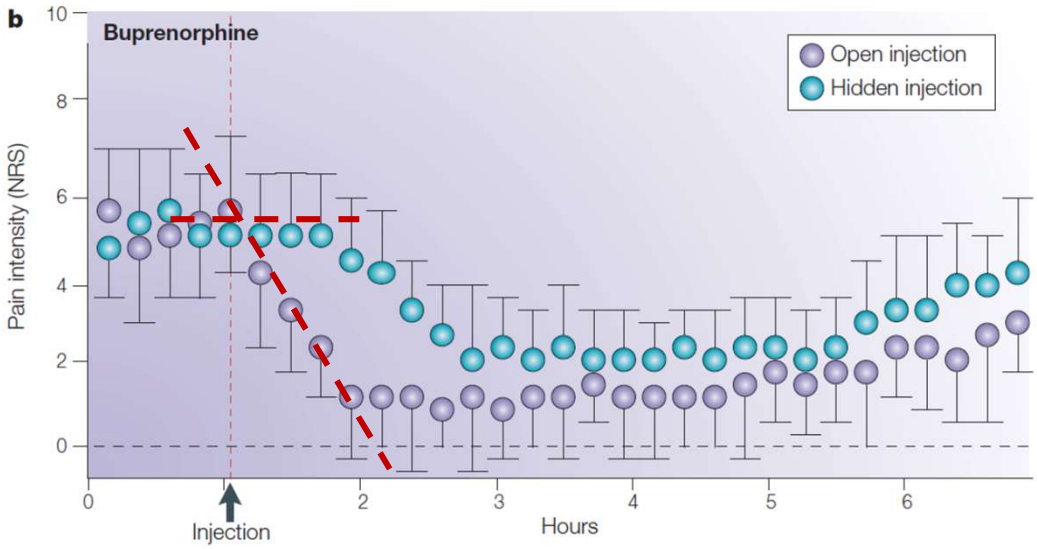
Fazit

- Widerspruch zwischen öffentlicher Meinung hinsichtlich Effektivität, Verträglichkeit und Sicherheit der Cannabinoide und wissenschaftl. Evidenz fehlender/extrem fraglicher Wirkung sowie schwerwiegender NW

- Keine Empfehlung für den Einsatz von Cannabinoiden in der Schmerztherapie



Colloca, Benedetti, Nature Reviews Neuroscience, 6, 2006



Colloca, Benedetti, Nature Reviews Neuroscience, 6, 2006

29

..... IN DEN MÜHLEN DES SYSTEMS

„Verwachsungsbauch" /Adhaesiolyse

Swank et al. Lancet, 2003

Bauchspiegelung mit „Adhaesiolyse" versus nur Bauchspiegelung bei Verwachsungsbauch
n = 200

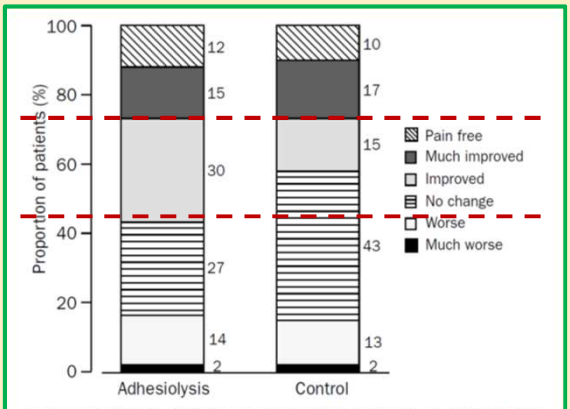


Figure 2: **Change of pain (VRCS score) in patients in adhesiolysis and control group at 12 months compared with baseline**

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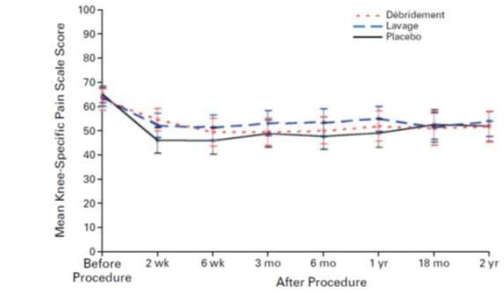
intervals for the differences between the placebo group and the intervention groups exclude any clinically meaningful difference.

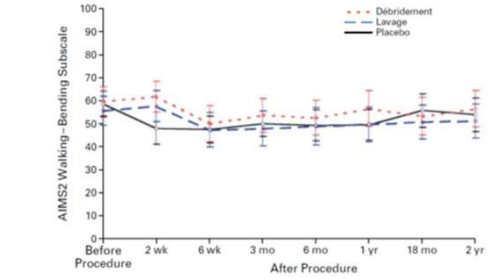
Conclusions In this controlled trial involving patients with osteoarthritis of the knee, the outcomes after arthroscopic lavage or arthroscopic débridement were no better than those after a placebo procedure. (N Engl J Med 2002;347:81-8.)

From the Houston Veterans Affairs Medical Center (J.B.M., K.O., N.I.P., T.J.M., D.H.K., C.M.A., N.P.W.); the Department of Orthopedic Surgery (J.B.M.), the Department of Medicine, Section of Health Services Research (K.O., N.I.P., T.J.M., C.M.A., N.P.W.), and the Center for Medical Ethics and Health Policy (B.A.B.), Baylor College of Medicine; and International Survey Research (D.H.K.) — all in Houston; and the Laguna Honda Hospital, San Francisco (J.C.H.). Address reprint requests to Dr. Wray at the Section of Health Services Research, Baylor College of Medicine, 2002 Holcombe Blvd. (MLR 152), Houston, TX 77030, or at nwray@bcm



No. at Risk

Placebo	60	59	57	56	57	53	52	55
Lavage	61	59	57	59	59	57	56	55
Débridement	58	59	59	58	56	50	51	53



No. at Risk

Placebo	60	59	57	56	57	54	52	55
Lavage	61	59	57	59	59	57	57	56
Débridement	58	58	59	58	55	51	51	53

EJP
European Journal of Pain

ORIGINAL ARTICLE

Pain and somatic symptoms are sequelae of sexual assault: Results of a prospective longitudinal study

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Conflicts of interest
None declared.

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Abstract

Background: Cross-sectional studies have shown that chronic musculoskeletal pain and somatic symptoms are frequently reported by sexual assault (SA) survivors; however, prospective studies examining pain and somatic symptoms in the months after SA have not been performed.

Methods: Women SA survivors 18 years of age or older who presented for care within 48 h of SA were recruited. Pain in eight body regions (head and face, neck, breast, arms, abdomen, back, genital and pelvic, and legs) and 21 common somatic symptoms (e.g., headache, nausea, insomnia, persistent fatigue) were assessed (0–10 numeric rating scale in each body region) at the time of presentation, 1-week, 6-week and 3-month interview. Post-traumatic stress disorder (PTSD) symptoms were assessed at the 6-week and 3-month interview.

Results: Clinically significant new or worsening pain (CSNWP) symptoms were common among study participants 6 weeks after SA [43/74, 58% (95% CI, 47–69%)] and 3 months after SA [40/67, 60% (95% CI, 48–71%)] and generally occurred in regions not experiencing trauma. Women SA survivors also experienced an increased burden of many common somatic symptoms: 8/21 (38%) and 11/21 (52%) common somatic symptoms showed a significant increase in severity 6 weeks and 3 months after SA, respectively. Correlations between PTSD, CSNWP and somatic symptoms were only low to moderate, suggesting that these outcomes are distinct.

Conclusions: New and/or clinically worsening pain and somatic symptoms, lasting at least 3 months, are sequelae of SA. Further studies investigating pain and somatic symptoms after SA are needed.

Eur J Pain **18** (2014) 559–566

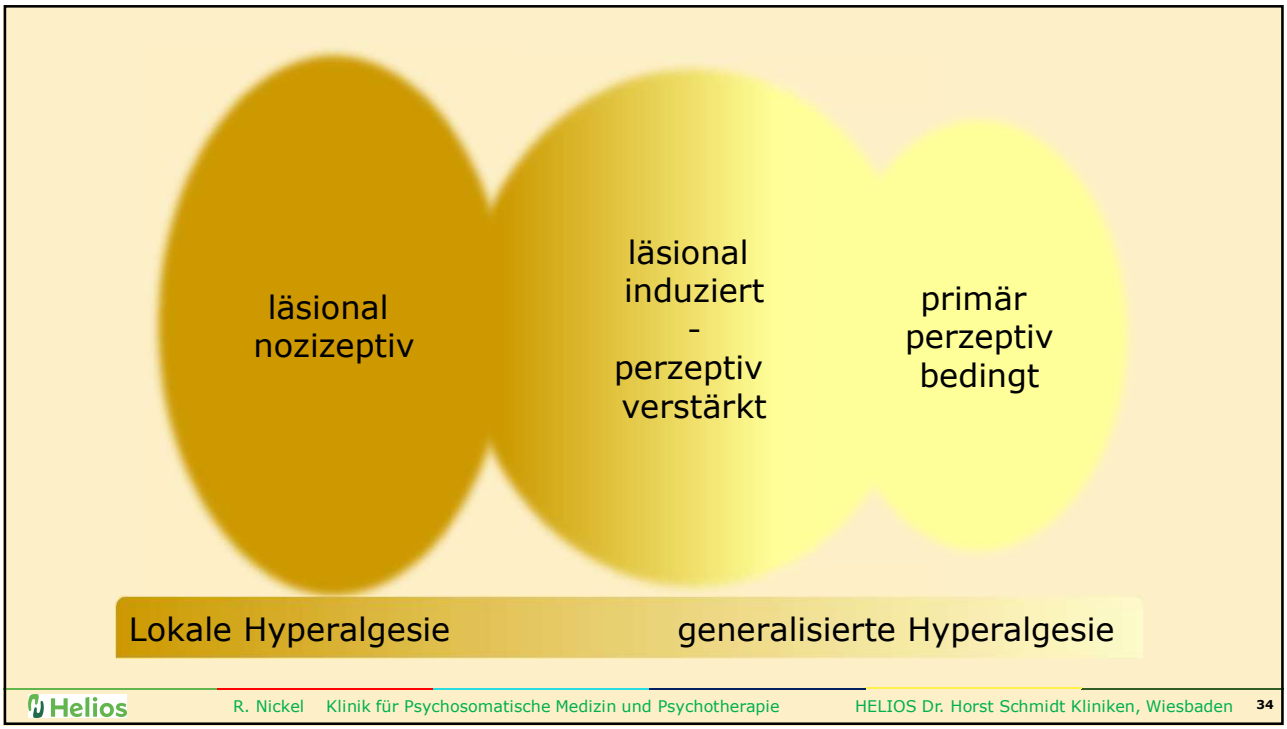
Instant relief

unbewusste Wünsche

Schmerzvorerfahrung

passiv - aktiv

... und die Erwartung Ihrer PatientInnen?



Chronisches Schmerzsyndrom

Nozizeptiv / neuropathisch		Funktionelles Schmerzsyndrom			Psychische Störung / Leitsymptom Schmerz
keine psychische Komorbidität	psychische Komorbidität	ohne Angst-störung	mit Angst-störung	Anankastische Persönlichkeitszüge	• Somatoforme Schmerzstörung • Somatisierungsstörung • PTBS • Depression • Hypochondrie • Zönästh. Psychose

PSYCHOSOMATISCHE SCHMERZTHERAPIE

Take Home Message

Kenntnis der allgemeinen und spezifischen Einflussfaktoren

Aktuelles Schmerzverständnis als Basis der Behandlung

Nicht akuten mit chronischem Schmerz verwechseln

Genaue Diagnostik und Differenzialdiagnostik

Schmerzedukation bei allen Patienten

Individuelle Therapieziele

Vielen Dank für Ihre Aufmerksamkeit

Helios