EDITORIAL

Thinking outside of the pelvis: Managing chronic urological pain

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In this issue of *Canadian Urological Association Journal*, readers will encounter an important paper by Tripp et al outlining an uncommonly explored issue in urological care: suicidal ideation in those with chronic pelvic pain. The authors survey patients with interstitial cystitis/chronic bladder pain (IC/CBP) in a high-volume tertiary care chronic pain clinic using validated questionnaires, including depression scales. The unique part of this inquiry is the unabashed focus on self-harm, with the paper describing a concerning rate of suicidal ideation in 26% of women compared to around 6% of healthy controls.[1] Despite the limitations of any such self-report survey, the results would suggest that urological practitioners need to have a decent understanding of the issues surrounding concomitant depression, and specifically catastrophizing of situations/symptoms, in order to facilitate assessment and management of these patients' psychosocial needs (alongside their functional and pain issues).

It may seem obvious and somewhat trite to say, but this paper highlights the need for all of us to think much more holistically about our care of urological patients with chronic non-cancer pain. This discussion is well-timed, given the recent explosion of headlines in the lay press surrounding a myriad of issues involving pain management in North America. Many of these reports describe significant access problems and undertreatment of those who suffer from chronic non-cancer pain. As most readers in Canada will know, the recent Supreme Court of Canada unanimous ruling on physician-assisted dying was brought forward by the family of Kay Carter, who suffered from chronic pain due to degenerative spinal stenosis. Subsequently, many of you may be keenly aware of your respective institutions' preparations to address requests for medical assistance in dying.

The opioid abuse crisis, however, is likely even more top-of-mind, given the recent increase in reported opioid overdose deaths both in Canada and the U.S. According to data accumulated for the Globe and Mail, about 2000 opioid-related deaths per year occur in Canada alone.[2] Although focus has been mostly fuelled by the street use of highly potent synthetic opioids, such as fentanyl (with the disastrous threat of the even more potent illicit drug carfentanyl), physician over-prescription of opioids for chronic pain and the subsequent issues of abuse and diversion is likewise a shameful blemish on the medical community. North American use of opioids far exceeds that in other first-world nations. As described in a recent publication from the Canadian Medical Protection Agency (CMPA), it has been estimated that Canadian doctors write approximately 50 prescriptions for every 100 citizens, with a dramatic and baffling increase over the last decade.[3]

The appropriate outcry and subsequent response from institutions such as the U.S. Center for Disease Control and Prevention should reinforce the need for all of us to review our knowledge and practices when it comes to the management of chronic non-cancer pain.[4] The CMPA has put out several excellent publications outlining the issues and best practices for the management of chronic non-cancer pain, including for those of us with more of a hospital-based practice. As the majority of us with a typical urological practice manage numerous patients with IC/CBP, as well as men with chronic prostatitis/chronic pelvic pain or scrotal pain syndromes, these efforts should be required reading.

Unfortunately, despite the frequency with which urologists manage men and women with chronic pain, there appears to be precious little formal education of the optimal management of chronic pain in our training programs. In a survey by Pace et al in 2013, chief residents in Canadian training programs had reported very little comfort in managing chronic non-cancer pain, with minimal knowledge of opioid prescribing guidelines.[5] The majority reported that they got most of their knowledge around use of opioid prescribing from their senior residents. These issues need to be addressed by our community and the efforts by the CMPA and our provincial colleges should help. Furthermore, the upcoming radical changes in our post-graduate education in Canada could result in an excellent opportunity to ensure the urological community is even more prepared to effectively and conscientiously assist our patients with chronic pain.

References

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