NEDERLANDSE
VERENIGING VAN
REVALIDATIEARTSEN

IMSR bij chronische pijn

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NEDERLANDSE
VERENIGING VAN
REVALIDATIEARTSEN

1. IMSR; de uitgangspunten
2. AANLEIDING
3. PICO
4. OPNIEUW
5. HUIDIGE STAND VAN ZAKEN
6. HOE VERDER
7. VRAGEN EN OPMERKINGEN

NEDERLANDSE
VERENIGING VAN
REVALIDATIEARTSEN

1. IMSR
De uitgangspunten

ICF-MODEL

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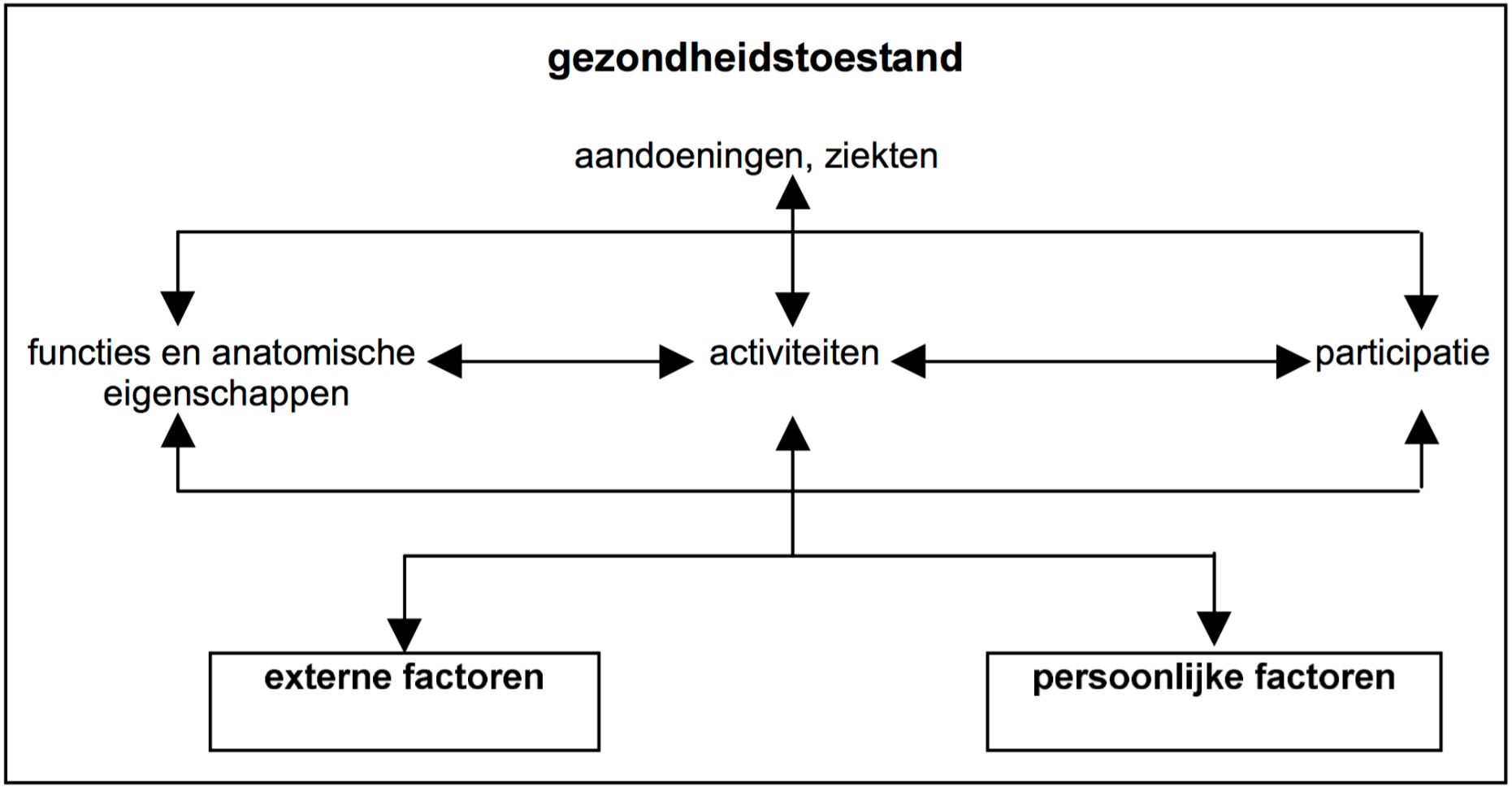
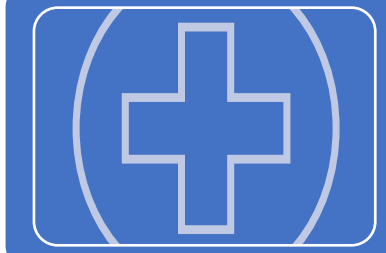
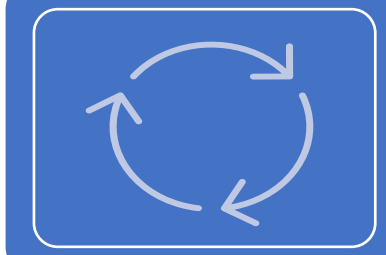


De I= IMSR bij chronische pijn

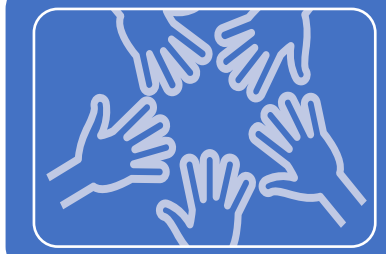


Behandeling
* Gezamenlijke filosofie
* Biopsychosociaal model
* Cognitieve gedragstherapie (ACT)

Actieve participatie van de patiënt
* Trainen
* Thuis oefenen
* Taak-georiënteerd



Behandelproces
- Revalidatiearts + ≥2 behandelaars
- Duur behandeling
* Gestructureerde team overleggen/evaluatie



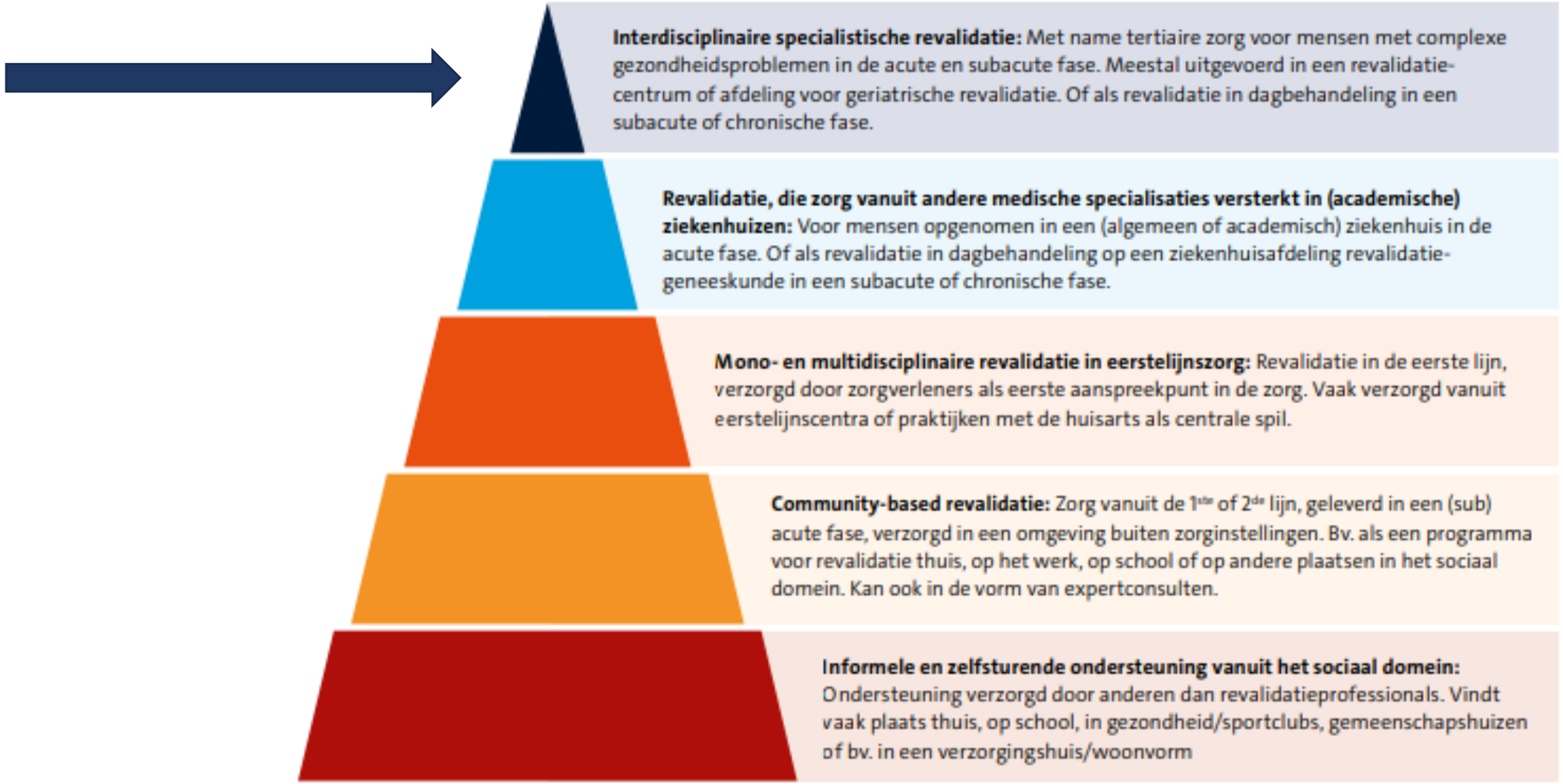
Organisatie van zorg
* Adviesconsult
* Expertconsult
* iMSR volgens principes van stepped care

Gatchel, 2014;
VRA, 2018;
Kaiser, 2017

Patiënt karakteristieken wpn 3

- Duur klachten: 38 % > 5 jaar, 25 % 2- 5 jaar
- NRS pijn 7.69 (0.04)
- PDI 38,85 (0,26)
- PCS (SF-12) 31.19 (0.14)
- MCS (SF-12) 36.61 (0.21)
- 63% gebruikt pijnmedicatie
- 68% betaald werk
  - 30% geen verzuim
  - 35% parttime verzuim
  - 35% volledig verzuim

Revalidatie in gezondheidszorgsystemen



Figuur 1: WHO-Rehabilitation in health systems/ Revalidatie in gezondheidszorgsystemen: aangepast naar de Nederlandse situatie[75]

WETENSCHAP EN DE PRAKTIJK

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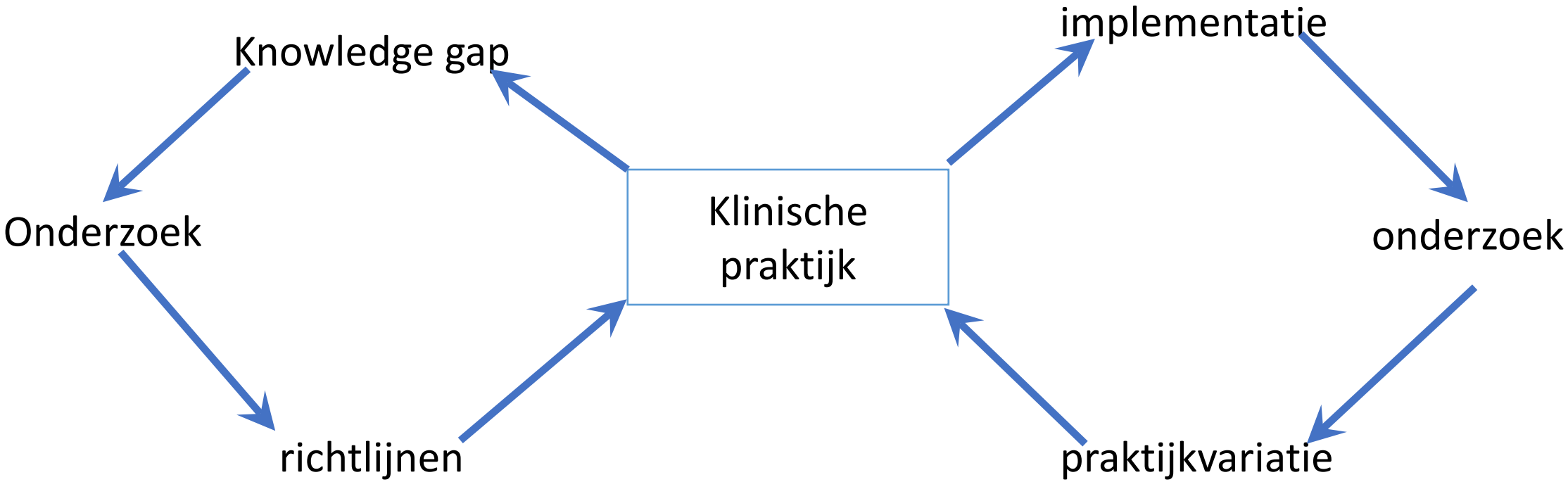

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2. AANLEIDING

DE GESCHIEDENIS

NEDERLANDSE VERENIGING VAN REVALIDATIEARTSEN

2016: ZN constateert toename IMSR bij chronische pijn

1-3-2017: Zembla programma CIRAN

Zorgverzekeraars nemen steekproeven

Rechter: ZN mag niet op stoel arts zitten

2018: ZN vraagt ZIN om duiding

ZIN duiding: wel / niet in basispakket

INDICATIESTELLING CHRONISCHE PIJN

NEDERLANDSE VERENIGING VAN REVALIDATIEARTSEN

WPN	Invloed participatie	Psychosociale problematiek	Belemmering functioneren
1	Nee	Geen/minimaal	Nauwelijks
2	Matig	Minimaal	In enige mate
3	Matig tot ernstig	Aanwezig	Ernstig
4	Ernstig	Ernstig	Zeer ernstig

DE EVIDENTIE PIRAMIDE

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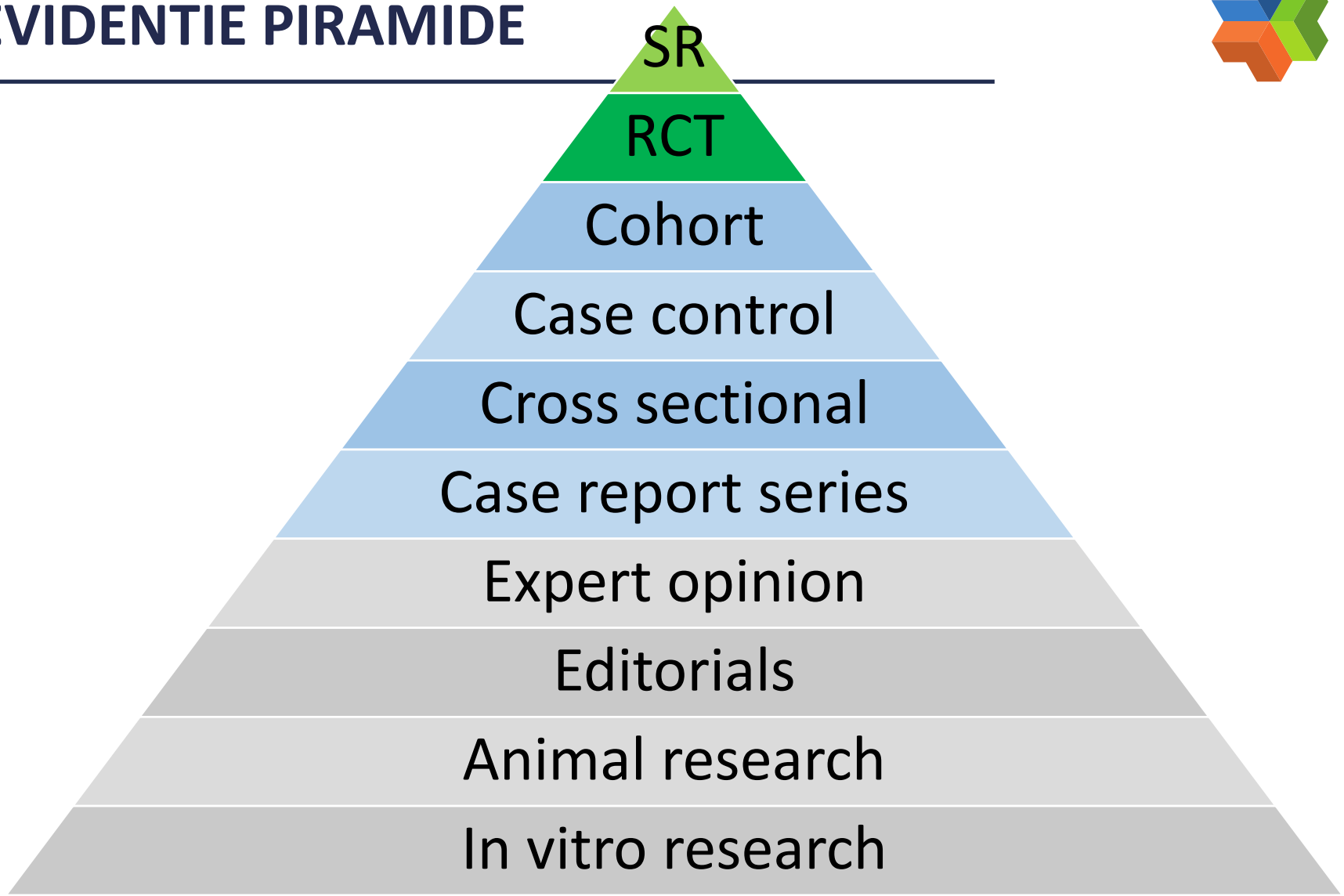

RVS 2017 piramide van betrouwbaarheid

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3. PICO

P: patiënt met chronische pijn
WPN 3 of 4

I: revalidatiearts + 2 disciplines (=IMSR)
volgens richtlijn VRA

C: therapie in 1e lijn
niet mogelijk

O: functioneren

DE UITKOMST VAN DE DUIDING

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Cochrane 2022: 8 RCT’s - 5 niet van toepassing = 3 RCT’s

ZIN 2022: 2 uit 3 RCT’s positief = positieve duiding

2024: 2 positieve Italiaanse RCT’s teruggetrokken
1 neutrale Franse RCT over

Eind 2024: negatieve duiding op basis van marginale toets

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4. OPNIEUW….

PROCES in 2025 (1)

NEDERLANDSE
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6 jan	VRA bij 1vandaag, dreiging kort geding
7 jan	“bestuurlijk” overleg VRA-ZIN-ZN-RN-NZa
20 jan	overleg VRA-ZIN

Uitkomst:

- Alle informatie mag worden aangeleverd
- Kort geding VRA van tafel (NB: TZG zet door)
- Marginale toets mag niet leiden tot stopzetten vergoedingen
- Vergoeding tot 1-7-25 gegarandeerd

Commentaar PICO

NEDERLANDSE VERENIGING VAN **REVALIDATIEARTSEN**

Herhalen commentaar PICO (zie dia 13)

Veel aandacht voor C:

Patiënten in ander deel spectrum

1e lijns behandeling niet zinvol

RCT	IMSR	vs	1e lijn	=	niet ethisch
	1e lijns	vs	IMSR	=	niet zinvol

STAND VAN WETENSCHAP EN PRAKTIJK

NEDERLANDSE VERENIGING VAN **REVALIDATIEARTSEN**

Kwaliteitsstandaard

Richtlijn Chronische pijn rev.

WHO Cochrane (lage Rugklachten)

Position paper
Visie van de VRA

Onderzoek
Cohorten, SCEDs, RCT's etc.

Richtlijn int. Eular (fibromyalgie)

Behandelkader

Multidisciplinaire leidraad

WHO standpunt

Single Case Experimental Design: Exposure in vivo behandeling

PAIN 153 (2012) 2109–2118

PAIN

www.elsevier.com/locate/pain

Reduction of pain-related fear and increased function and participation in work-related upper extremity pain (WRUEP): Effects of exposure in vivo

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Sponsorships or competing interests that may be relevant to content are disclosed at the end of this article.

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Keywords:
Work-related upper extremity pain
Pain-related fear
Graded exposure in vivo
Cognitive-behavioural treatment

abstract

There is increasing evidence that pain-related fear influences the development and maintenance of pain disability, presumably mediated through the fear-related avoidance of valued activities. Individually tailored graded exposure in vivo (GEXP) has been demonstrated to reduce pain-related fear and increase functional abilities in patients with chronic low back pain, neck pain, and complex regional pain syndrome. The current study aimed to test whether these effects generalize to patients with work-related upper extremity pain. A sequential replicated and randomized single-case experimental phase design with multiple measurements was used. Within each participant, GEXP was compared to a no-treatment baseline period and a no-treatment 6-month follow-up period. Eight patients who reported a high level of pain-related fear were included in the study. Daily changes in pain catastrophizing, pain-related fear, and pain intensity were assessed using a diary, and subjected to randomization tests. Before the start of the baseline period, just after GEXP, and at 6-month follow-up, clinically relevant changes of pain catastrophizing, pain-related fear, perceived harmfulness of physical activity, pain disability, and participation/autonomy were verified. When GEXP was introduced, levels of pain catastrophizing and pain-related fear decreased significantly. Clinically relevant improvements were observed for pain disability, perceived participation, and autonomy. These favourable changes were maintained until 6-month follow-up. The findings of the current study underscore the external validity of a cognitive-behavioural GEXP treatment for patients with chronic pain reporting increased pain-related fear.

1. Introduction

Work-related upper-extremity pain disorders (WRUEDs) are associated with great socioeconomic and personal costs due to sickness absence, medical expenses, and persistent interference with the performance of daily life activities (eg, [24,61]). In the United States, work-related musculoskeletal disorders (of which 23% is upper extremity pain) accounted for 29% of lost work days in 2007 [77]. In The Netherlands, 20%-40% of the working population report complaints in the upper extremities, with neck and shoulder pain being most prevalent [7]. Despite its high prevalence, it remains unclear what mechanisms contribute to reduced task performance and pain disability in WRUED [1]. Nevertheless, there is some evidence that pain-related fear influences physical performance levels in these patients [22,34,38,39]. These findings are in line with the accumulating evidence that fear of movement-related pain can be acquired through associative learning [51] and that fearful appraisals of pain predict future work loss [26,28,37] and self-reported disability levels [46,73,91] in patients with chronic musculoskeletal pain. Pain-related fear also affected performance levels in healthy individuals [27,75], as well as patients with acute [43,72,92] and chronic pain [33,36,54,55].

Not only is pain-related fear associated with poorer performances, functional improvements during rehabilitation programs are shown to be mediated by reduction of pain catastrophizing, suggesting that these treatment efforts might be improved by more systematically targeting catastrophic thinking and pain-related fear [86]. Recently, a graded exposure in vivo treatment (GEXP) has been developed especially for patients with chronic back pain

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PAIN

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Reduction of pain-related fear in complex regional pain syndrome type I: The application of graded exposure in vivo

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Abstract

Fear of (re)injury/movement has been identified as a potential predictor of chronic disability in complex regional pain syndrome type I (CRPS-I). In order to reduce pain-related fears and pain disability, graded exposure in vivo (GEXP) is likely to be an appropriate treatment. Indeed, there is evidence that in chronic pain patients reporting substantial fear of (re)injury/movement, GEXP is successful in reducing pain disability. However, the efficacy of exposure-based protocols in the treatment of CRPS-I patients for reducing pain disability has not been tested. The main research question of this study was whether the reduction of pain-related fear through GEXP also resulted in a decrease of disability in a subgroup of patients with CRPS-I who report substantial pain-related fear. A single-case experimental ABCD-design was used with random determination of the start of the intervention. Eight patients with CRPS-I were included in the study. To assess daily changes in pain intensity, pain-related fear, pain catastrophizing, and activity goal achievement, a diary was used. Standardized questionnaires of pain-related fear, pain disability, and self-reported signs and symptoms of CRPS-I were administered before and after each intervention, and at 6-month follow-up. The current study supports a GEXP approach to chronic CRPS-I. The GEXP was successful in decreasing levels of self-reported pain-related fear, pain intensity, disability, and physiological signs and symptoms. These results support the hypothesis that the meaning people attach to a noxious stimulus influences its experienced painfulness, and that GEXP activates cortical networks and reconciles motor output and sensory feedback.

Keywords: Pain-related fear; Graded exposure in vivo; Complex regional pain syndrome type I

1. Introduction

Complex regional pain syndrome type I (CRPS-I) is a poorly understood chronic pain disorder with regard to pathophysiology and treatment. A limited number of studies have focused on the psychological factors that may modulate the development of chronic disability in CRPS-I. One factor that has been suggested as a potential predictor of disability is fear of injury, as patients with CRPS-I are often unaware that their pain condition resulted from a minor trivial event (Nelson, 2002). This fear, combined with the increased pain sensitivity may lead to excessive guarding and overprotective behaviors that may worsen the pain problem. Indeed, there is evidence that in other musculoskeletal pain disorders such as back and neck pain,

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ELSEVIER

Reduction of Pain-Related Fear and Disability in Post-Traumatic Neck Pain: A Replicated Single-Case Experimental Study of Exposure In Vivo

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Abstract: For patients with acute post-traumatic neck pain (PTNP), pain-related fear has been identified as a potential predictor of chronic disability. If such is the case, fear reduction should enhance the prevention of further pain disability and distress after traumatic neck pain disability. However, exposure-based treatments have not been tested in patients with PTNP. Using a replicated single-case crossover phase design with multiple measurements, this study examined whether the validity of a graded exposure in vivo, as compared with usual graded activity, extends to PTNP. Eight patients who reported substantial pain-related fear were included in the study. Daily changes in pain intensity, pain-related fear, pain catastrophizing, and activity goal achievement were assessed. Before and after each intervention, and at 6-month follow-up, standardized questionnaires of pain-related fear and pain disability were administered, and, to quantify daily physical activity level, patients carried an ambulatory activity monitor. The results showed decreasing levels of self-reported pain-related fear, pain intensity, disability, and improvements in physical activity level only when graded exposure in vivo was introduced, and not in the graded activity condition. The results are discussed in the context of the search for customized treatments for PTNP.

Perspective: *This is the first study showing that the effects of graded exposure in vivo generalize to patients with chronic PTNP reporting elevated levels of pain-related fear. This could help clinicians to customize treatments for PTNP.*

Key words: *Pain-related fear, graded exposure in vivo, graded activity, post-traumatic neck pain disability.*

An increasing number of both experimental and clinical studies, mainly performed in patients with chronic low back pain (CLBP), have shown that pain-related fear is one of the most potent predictors of observable physical performance, self-reported disability levels in daily life situations, and work loss.[11,26,33,80] The basic tenet of the fear-avoidance model of pain is that the way in which pain is interpreted may lead to 2 different pathways. When dysfunctional beliefs about pain exist, a number of safety behaviors are initiated that may be adaptive in acute pain but paradoxically worsen the problem in the case of long-lasting pain. Typical safety behaviors are avoidance/escape behaviors and hypervigilance and the prolonged use of them maintains the fear level rather than reduces it. Fearful patients have a risk of getting mired in a downward cycle of pain, fear, avoidance, and increased disability. In contrast, when acute pain is perceived as less threatening, patients are likely to maintain their engagement in daily activities, through which functional recovery is promoted.[5,80] The fear-avoidance model has been successfully tested in patients with back pain,[51,70,71] osteoarthritis,[28] and burn injuries.[61]

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1526-5900/$34.00

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Nationale en internationale richtlijnen

Naast het zoeken naar artikelen waarin relevante studieresultaten worden gerapporteerd, ***zoeken we naar nationale en internationale richtlijnen.*** *Deze vinden wij in databases zoals Diliguide, de Richtlijnendatabase van de Federatie Medisch Specialisten44,* ***de websites van wetenschappelijke verenigingen, of via de World Health Organization (WHO)*** *of het Guidelines International Network (GIN).45 In sommige gevallen kunnen ook beoordelingsrapporten van buitenlandse zusterorganisaties relevant zijn voor de beoordeling. In het geval van geneesmiddelenbeoordelingen maken de rapporten van de European Medicines Agency (EMA), zoals de European Public Assessment Report (EPAR) en de Summary of the Product Characteristics (SPC), ook onderdeel uit van de beoordeling.*

ADHESIEBETUIGINGEN

NEDERLANDSE
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Wetenschappelijke verenigingen

Huisartsen

Paramedici

Patiënten

(inter)nationaal

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4. HUIDIGE STAND VAN ZAKEN

PROCES in 2025 (2)

NEDERLANDSE VERENIGING VAN **REVALIDATIEARTSEN**

14 feb bezwaar VRA en evidence ingediend

7 apr “bestuurlijk” overleg VRA-ZIN-ZN-RN-Nza

- Onderscheid matched en stepped care
- Vergoeding tot zomer 2025
- Aanscherping indicatiestelling aanleveren vóór 1-7-25
- Opzetten MER (ZN primair verantwoordelijk)
- Nader onderzoek nodig, mag SCED zijn.

REACTIE VRA

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24 apr VRA bezwaar

- Bezwaar matched – stepped care
- MER: co-creatie
- Bezwaar interpretatie SW&P
- Bezwaar duiding wetenschap

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6. HOE VERDER

HOE VERDER VRA

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REVALIDATIEARTSEN

Nadere invulling indicatiestelling

WPN inventariseert rode lijn in thans gangbare protocollen

MER co-creatie

Wetenschappelijk onderzoek

- Eerst MER opzetten
- Verminderen praktijkvariatie
- Gezamenlijke proces- en uitkomstmaten
- Samenwerking WPN met NPN

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7. VRAGEN EN OPMERKINGEN

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