Guidelines on the Management of Chronic Pain in Children

COG Supportive Care Endorsed Guidelines

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The "Guidelines on the management of chronic pain in children" developed by the World Health Organization was endorsed by the COG Supportive Care Guideline Committee in July 2021.

The source clinical practice guideline is published (Guidelines on the management of chronic pain in children. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.) and is available at: https://www.who.int/publications/i/item/9789240017870

The purpose of the source clinical practice guideline is to assist World Health Organization Member States and their partners in developing and implementing national and local policies, regulations, pain management protocol and best practices. The source clinical practice guidelines focus on physical, psychological and pharmacological interventions for the management of primary and secondary chronic pain in children 0 to 19 years old. The guiding principles, recommendations and best principles of the source clinical practice guideline are presented in the tables below.

Table 1. Guiding Principles for Guidelines on the Management of Chronic Pain in Children

GUIDING PRINCIPLES
1. Access to pain management is a fundamental human right.
2. Children have the right to enjoyment of the highest attainable standard of health.
3. Member States and healthcare providers should ensure that children, and their families and caregivers, know their rights to self-determination, non-discrimination, accessible and appropriate health services, and confidentiality.

Table 2. Summary of Recommendations on the Management of Chronic Pain in Children

RECOMMENDATIONS	Strength of Recommendation and Quality of Evidence*
1. In children with chronic pain, physical therapies may be used, either alone or in combination with other treatments.	Conditional recommendation Very low certainty evidence
2.a) In children with chronic pain, psychological management through cognitive behavioural therapy and related interventions (acceptance and commitment therapy, behavioural therapy and relaxation therapy) may be used. b) Psychological therapy may be delivered either face-to-face or remotely, or using a combined approach.	Conditional recommendation Moderate certainty evidence Conditional recommendation Moderate certainty evidence
3. In children with chronic pain, appropriate pharmacological management tailored to specific indications and conditions may be used.	Conditional recommendation Low certainty evidence

RECOMMENDATIONS	Strength of Recommendation and Quality of Evidence*
4.a) Appropriate pharmacological management tailored to specific indications may include the use of morphine under the principles of opioid stewardship, for end-of-life-care.	Conditional recommendation Very low certainty evidence
b) In children with chronic pain associated with life-limiting conditions, morphine may be given by appropriately trained healthcare providers, under the principles of opioid stewardship.	Conditional recommendation Very low certainty evidence

*see Appendix 1

Table 3. Summary of Best Practices on the Management of Chronic Pain in Children

BEST PRACTICES FOR THE CLINICAL MANAGEMENT OF CHRONIC PAIN IN CHILDREN
1. Children with chronic pain and their families and caregivers must be cared for from a biopsychological perspective; pain should not be treated simply as a biomedical problem.
2. A comprehensive biopsychosocial assessment is essential to inform pain management and planning. As a component of this assessment, healthcare providers should use age-, context- and culturally appropriate tools to screen for, and monitor, pain intensity and its impact on the quality of life of the child and family.
3. Children with chronic pain must have a thorough evaluation of any underlying conditions and access to appropriate treatment for those conditions, in addition to appropriate interventions for the management of pain. Chronic pain in childhood often exists with comorbid conditions affecting the child's health, and social and emotional well-being, which require concurrent management.
4. Children presenting with chronic pain should be assessed by healthcare providers who are skilled and experienced in the evaluation, diagnosis and management of chronic pain.
5. Management, whether with physical therapies, psychological or pharmacological interventions, or combinations thereof, should be tailored to the child's health; underlying condition; developmental age; physical, language and cognitive abilities; and social and emotional needs.
6. Care of children with chronic pain should be child- and family-centred. That is, the child's care should: i. focus on, and be organized around, the health needs, preferences and expectations of the child, and their families and communities; ii. be tailored to the family's values, culture, preferences and resources; and iii. promote engagement and support children and their families to play an active role in care through informed and shared decision-making.
7. Families and caregivers must receive timely and accurate information. Shared decision-making and clear communication are essential to good clinical care. Communication with patients should correspond to their cognitive, development and language abilities. There must be adequate time in a comfortable space for discussions and questions regarding care management plans and progress.

BEST PRACTICES FOR THE CLINICAL MANAGEMENT OF CHRONIC PAIN IN CHILDREN
8. The child and their family and caregivers should be treated in a comprehensive and integrated manner: all aspects of the child's development and well-being must be attended to, including their cognitive, emotional and physical health. Moreover, the child's educational, cultural and social needs and goals must be addressed as part of the care management plan.
9. In children with chronic pain, an interdisciplinary, multimodal approach should be adopted which is tailored to the needs and desires of the child, family and caregivers, and to available resources. The biopsychosocial model of pain supports the use of multiple modalities to address the management of chronic pain.
10. Policy-makers, programme managers and healthcare providers, as well as families and caregivers must attend to opioid stewardship to ensure the rational and cautious use of opioids. The essential practices of opioid stewardship in children include: i. Opioids must only be used for appropriate indications and prescribed by trained providers, with careful assessments of the benefits and risks. The use of opioids by individuals, their impact on pain and their adverse effects must be continuously monitored and evaluated by trained providers. ii. The prescribing provider must have a clear plan for the continuation, tapering or discontinuation of opioids according to the child's condition. The child and family must be apprised of the plan and its rationale. iii. There must be due attention to procurement, storage and the disposal of unused opioids.

Appendix 1: GRADE

Strength of Recommendations:

Strong Recommendation	When using GRADE, panels make strong recommendations when they are confident that the desirable effects of adherence to a recommendation outweigh the undesirable effects.
Weak or Conditional Recommendation	Weak or conditional recommendations indicate that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but the panel is less confident.

Strength of Recommendation Determinants:

Factor	Comment
Balance between desirable and undesirable effects	The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a weak recommendation is warranted
Certainty in evidence	The higher the quality of evidence, the higher the likelihood that a strong recommendation is warranted
Values and preferences	The more values and preferences vary, or the greater the uncertainty in values and preferences, the higher the likelihood that a weak recommendation is warranted
Costs (resource allocation)	The higher the costs of an intervention—that is, the greater the resources consumed—the lower the likelihood that a strong recommendation is warranted

Certainty in Evidence or Quality of Evidence

High Certainty/Quality	Further research is very unlikely to change our confidence in the estimate of effect
Moderate Certainty/Quality	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
Low Certainty/Quality	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate
Very Low Certainty/Quality	Any estimate of effect is very uncertain

Guyatt, G.H., et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations.* BMJ, 2008; 336: 924-926.
Guyatt, G.H., et al., *GRADE: going from evidence to recommendations.* BMJ, 2008; 336: 1049-1051.