وزارة الصحة
Ministry of Health

كويت جديدة
NEWKUWAIT

Title: The Ministry of Health Operational Policy for Pain Assessment and Management	
Policy Owner: MOH committee on hospital clinical services and policies	**Policy code: C-ANS/RAD/ORTH/IM/NS-001**
Section location: General and specialized health care facilities in MOH and non- MOH healthcare facilities	**Effective date: 01-02-2024**
Applies to: Physicians covering pain clinics in MOH and non- MOH healthcare facilities.	**Revision dates: 01-02-2026**
Approvals:	**Signature/Date**
Approved by: MOH committee on hospital clinical services and policies	
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1.Introduction

Despite best efforts to reduce the burden, pain disorders continue to be a problem of epidemic proportions. In addition, inadequate treatment of pain also continues to be a public health problem that is reaching epidemic proportions in the State of Kuwait and around the world. The knowledge and understanding of this complex entity, including diagnosis and treatment, are in their infancy, despite modern developments in medicine.

Pain is a multimodal paradigm, of which specialization, multidisciplinary care and interventional procedures are important aspects. Practice policies are statements developed to assist physician and patient decisions about appropriate health care related to pain disorders utilizing a combination of evidence and consensus-based techniques to increase patient access to treatment, improved outcomes, appropriate care, and lastly to optimize cost effectiveness. These policies are professionally derived recommendations for practices in the diagnosis and treatment of pain disorders with the overall goal of Interventional procedures to

improve the patient's quality of life and to provide effective pain management.

As pain assessment and management may be provided by a number of trained clinical specialties (e.g. anesthesia, interventional radiology, spine and neurosurgery) governing and guiding practice policies become paramount to organize and standardize care for patients in pain, requiring expert opinion in the state of Kuwait.

2. APPLICATION:

2.1 This policy applies to all specialists with certification, credentials, or licensing (in accordance with the MOH decree 77/2021) to provide pain management services in Kuwait.

2.2 This policy applies mainly to pain management for acute intractable or chronic pain presenting to pain clinics, or as inpatients within facilities. It does not apply to acute pain amenable to first line management by the treating physician or facility general anesthesia team.

2.2.1 The policy applies to acute and chronic pain in the ambulatory settings presenting to pain clinics.

2.2.2 Management of acute pain in the inpatient /ward settings secondary to pathologies, or for peri procedural or palliation reasons, is within the scope of services of the index facility licensed health care providers (e.g. treating most responsible physician, anesthesia department etc.).

2.3 Pain specialists are to adhere to all of the criteria and standards of best practice with regard to pain management services set forth in this policy to ensure optimal care of patients.

2.4. Health care facility leaderships, Chief Medical Officers , heads of units and clinical department chairs under whom pain management services are provided, are responsible for ensuring all personnel involved in pain management within the facility are aware and adhere to this policy.

3. Statement.

It should be acknowledged that guidelines cannot be exhaustive nor be able to

address all potential clinical circumstances. They are provided as a guide to assist in the interpretation of levels of pain and respective management. Clinical expertise and judgment are required in all circumstances to ensure the best care is provided in the most appropriate facility and setting.

4. PURPOSE

4.1 The purpose of the policy is to provide guidance for the assessment and management (through non- pharmacological interventions, pharmacological treatments, and interventional procedures) of patients suffering from the spectrum of pain disorders.

4.2 The objectives set forth by this policy include:

4.2.1 The definition of pain and its different entities: acute, chronic, malignant, and non- malignant.

4.2.2 The definition of pain physicians/specialist and the basis or process of credentialing to practice pain medicine or manage pain.

4.2.3 Outlining the responsibilities of pain specialists.

4.2.4 Outlining the assessment and evaluation of pain patients.

4.2.5 Defining the different management approaches to patients in pain; nonpharmacological interventions, pharmacological treatments, and interventional procedures: diagnostic and therapeutic.

4.2.6 Defining interventional procedures done for pain management and the safe service setup requirements with standards of care.

4.2.7 Defining interventional procedures' complications, their management and responsibilities and referrals.

4.2.8 Defining the frequency of injections, multiple and /or concurrent interventions.

5. DEFINITIONS:

5.1 **Pain:** An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Pain is always subjective, however patients without the ability to communicate may still experience pain. Pain has sensory, emotional, cognitive, spiritual, and behavioral components that are interrelated with environmental, developmental, sociocultural, and contextual factors.

5.2 **Pain screen:** determines if pain is present or absent or if there is a recent history of pain by utilizing verbal acknowledgment of pain by a patient/proxy or utilizing a pain measurement tool.

5.3 **Acute Pain:** A normal, predicated physiologic response to an adverse clinical, thermal, or mechanical stimulus. It is time-limited and is maybe responsive to opioid and non- opioid therapy. Note: Acute pain episodes may be present in patients with chronic pain.

5.4 **Chronic Pain:** Malignant or non-malignant pain that exists beyond its expected period for healing (more than 3 months) or where healing may not have

occurred. It is persistent pain that is not amenable to routine pain control methods. Note: Patients with chronic pain may have episodes of acute pain.

5.5 **Malignant pain:** is defined as pain caused by the primary cancer itself or metastases (chronic cancer pain) or its treatment (chronic post cancer treatment pain).

5.6 **non-malignant pain:** Any pain conditions that are not related to cancer or cancer complications.

5.7 **Pain Assessment:** An evaluation of the patient's pain including but not limited to: location, intensity, duration of pain, aggravating and relieving factors, effects on activities of daily living, sleep patterns and psychosocial aspects of the patient's life, and effectiveness of current strategies. Pain assessment includes assessment of the patient's vital signs and the rating from the pain screen, as age appropriate, or pain assessment findings. Assessment also includes requesting any necessary laboratory investigations and/or radiological / nuclear imaging examinations and/or special investigations. No referral needed from other specialties to request such investigations.

5.8 **Pain Management:** The use of pharmacological and interventional procedures to manage the patient's identified pain. Pain management extends beyond pain relief, encompassing the patient's quality of life and ability to work productively, to enjoy recreation.

5.9 **Self – Referral patient:** any patient that willingly decides to visit a pain service or clinic to seek a consultation or treatment without a referral from another healthcare institute or personnel.

5.10 **Pain Medicine Physician or Specialist:** is a physician of the rank of specialist and above who have had specialized training in pain medicine or pain management and has had their training approved by their respective council and ministry leadership in accordance with the MOH decree 77/2021, with a valid medical license issued title of "Pain Specialist "or "Pain Medicine Specialist "from the Ministry of Health Medical Licensing Directorate.

5.10.1 **Interventional pain physicians or specialists**:
are specialist or above-ranking physicians who have had specialized training in pain medicine or pain management , in accordance with article 5.10 , and are responsible for assessing (by physical examination, any lab, imaging, or any special investigations required), to diagnose, and manage patients with acute and chronic pain (e.g. anesthesiologists with pain fellowship/training and interventional radiologists with musculoskeletal interventional radiology training) using minimally invasive image guided interventions to treat primary conditions causing pain and reduce pain related to acute and chronic conditions.

5.11 **Interventional pain procedures:** are minimally invasive interventions employed by interventional pain specialists to diagnose and treat pain and its underlying causes. These procedures are performed under image guidance, enhancing treatment precision, optimizing outcomes, and minimizing complications. They are usually considered when conventional therapies, such as medication and physical therapy, have proven ineffective.

5.12 **Specialists Providing Pain Management**; are physicians of the rank of specialist and above who's core training (residency or fellowship) and ensuing scope of services involves pain related procedures in a particular field (e.g. orthopedic surgeons and the knee injections of corticosteroids or plasma,

rheumatologists, and joint injections of steroids, orthospine and endoscopic discectomy etc.). They have not completed training, specialization and credentialing in pain medicine but have expertise in pain related procedures related to their core discipline training.

5.13 **Attending**: Any physician of the rank of specialist and above.

5.14 **MRP**: most responsible physician: The designated most responsible physician. Generally, refers to the physician or other regulated health care professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point of time.

5.15 **MOH**: ministry of health

5.16 **ERP**: emergency room physician

6. Pain Assessment and Management (Scope of Responsibilities and Roles):

6.1 This applies to physicians practicing Pain Management including interventional procedures.

6.1.1 Physicians practicing pain management and providing pain related services or interventions should practice within their scope of expertise, training , and licensing in accordance with the ministerial decree and any restrictions set by their respective councils , ministerial oversight committees or medical licensing directorate.

6.1.1.1 The respective councils (and or designated ministerial oversight committees) and the medical licensing directorate should ensure that requirements and standards are officially set for credentialing to either (a) acquire the designated title of "pain specialist "or (b) the respective privileges to perform pain related interventions.

6.2 Physicians should refer to updated guidelines if locally available or refer to recognized international standards including but not limited to:

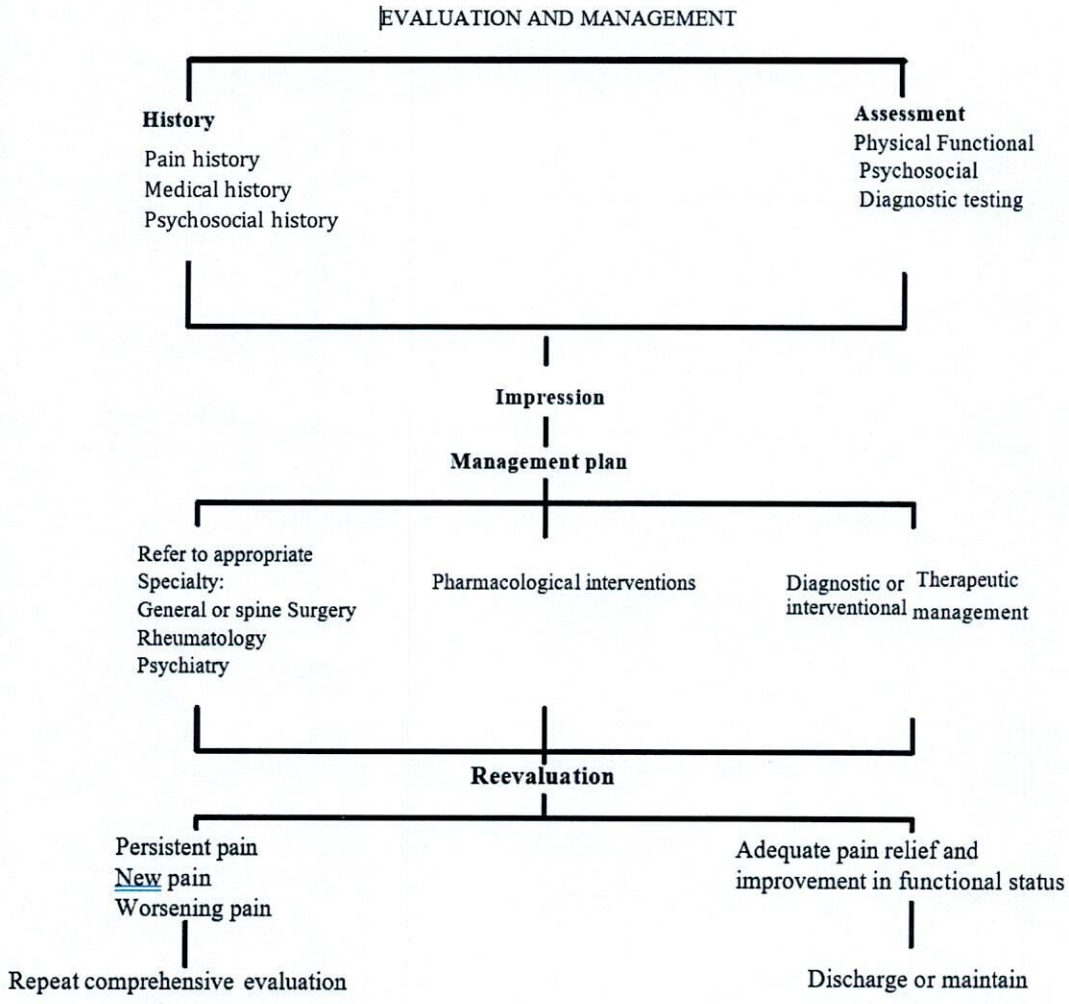
6.2.1 International Association for the Study of Pain
6.2.2 The American Society of Regional Anesthesia and Pain Medicine
6.2.3 Spine Interventional Society Guidelines for Spinal Diagnostic and Treatment
6.2.4 Canadian Opioid Prescribing Guidelines
6.2.5 Canadian Neuropathic Pain Guidelines
6.2.6 British Pain Society and Faculty of Pain Medicine
6.2.7 Royal College of Anaesthetists
6.2.8 European Society of Regional Anaesthesia and Pain Therapy
6.2.9 International Pain and Spine Intervention Society
6.2.10 Canadian Neuropathic Pain Guidelines

6.3 The patient's self-report of pain is the primary source of assessment.

6.4 The responsibilities of the Physician include but are not limited to:

6.4.1 Assessing (via physical examination, any lab, imaging, or special investigations required)

6.4.2 Diagnosing and Managing patients with acute and chronic pain, malignant and non-malignant pain conditions in the Inpatient and outpatient settings, including wards and clinics, as shown in following algorithm (Fig 1).



6.4.3 Patients will be screened for the presence or absence of pain using standardized pain scales for patient specific populations.

6.4.4 If pain is identified on initial screening, a more detailed assessment of pain will be performed.

6.4.5 Full assessment of the patient's clinical condition includes physical examination and requesting any appropriate lab and/or relevant radiological or special investigations (e.g. X-ray, Ultrasound, CT, MRI, electromyography, or nerve conduction studies).

6.5 Pain conditions include but are not limited to:

6.5.1 Musculoskeletal pain related to joint, muscle and tendon disorders.
6.5.2 Pain related to spine disorders.
6.5.3 Pain related to peripheral and axial neuropathies.
6.5.4 Pain related to malignancies.
6.5.5 Pain related to failed surgeries including but not exclusive to failed back syndrome and post arthroscopy and arthroplasty pain.
6.5.6 Complex Regional Pain Syndrome (CRPS)
6.5.7 Central pain syndromes (e.g. fibromyalgia etc.)

6.6 Treatment strategies for pain may include pharmacological, non-pharmacological management and interventional procedures.

6.7 Strategies should reflect a patient-centered approach and consider the patient's current presentation.

6.8 non-pharmacological management of pain includes behavioral, physical, and psychological methods, and, if deemed necessary by the interventional pain physician, should be sought by referring patients to these services.

6.9 Pharmacological management (when appropriate) includes and not limited to:

6.9.1 Simple analgesics (Acetaminophen, Nonsteroidal Anti-inflammatory Drugs)

6.9.2 Weak Opioids: Tramadol, Codeine

6.9.3 Strong Opioids: Morphine, Oxycodone, Hydromorphone (Immediate or sustained release formats)

6.9.4 Adjuncts: Anticonvulsants (Pregabalin and Gabapentin) and antidepressants (TCA, SSRI, SNRI)

6.9.5 Cannabinoids

6.9.6 Psychotropic medications

6.10 Controlled substances (narcotics and psychotropics) must be prescribed by a physician aware of their risks/benefits and specialized in pain management in accordance with MOH existing policies. These include oral and patch forms of medications (e.g. buprenorphine and fentanyl patches.)

6.10.1 Specific MOH policies exist for:

6.10.1.1 **Gabapentin**: MOH decrees 27/2019 and 2/2024

6.10.1.2 **Pregablin**: MOH decree 27/2019 and 2/2024

6.11 These medications and especially narcotics and psychotropics should be prescribed by a specialized pain physician to limit misuse.

6.12 Prior to prescribing opioids, the patients must be screened by the treating interventional pain physician or designated nurse for abuse and misuse. This could include a validated screening tool or/and urine drug test.

6.13 Screening Tools may include but not limited to one of the following:

6.13.1 Current Opioid Misuse Measure (COMM)

6.13.2 Opioid Risk Tool (ORT)

6.13.3 Pain Medication Questionnaire (PMQ)

6.13.4 Screener and Opioid Assessment for Patients with Pain Revised (SOAP-PR).

6.14 Psychotropic and narcotic medications cannot be prescribed for longer than 60 days at a time, and refill of these medications maybe provided every 2 months (up to 6 months in total duration of course) with reassessment of the patient's condition in the pain clinic performed every 60 days (up to 180 days at maximum).

7. Consultations and referral of patients to the pain service: units and clinics:

7.1 Pain specialists (and specialists providing pain management related services and interventions e.g. orthospine surgeons) may accept walk-in (self-referral) patients complaining of acute, chronic, malignant, and non-malignant pain and can be assessed as new patients. (this is subject to the specialist discretion, facility leadership and human/hospital resources).

7.2 Pain specialists may accept referrals (with a completed formal consultation) from other specialties for patients complaining of intractable pain, pain not responding to simple analgesics and pain requiring treatment with specialized interventional procedures.

7.3 A referral to a pain specialist is considered for patients with poorly controlled pain despite proper management for either malignant or nonmalignant pain.

7.3.1 The pain clinic can assess a variety of pain conditions including and not limited to: nociceptive, nociplastic and neuropathic pain.

7.4 Due to the limited number of pain clinics and services in the MOH health care facilities in Kuwait, the following are the designated pain clinics and their respective catchment areas:

7.4.1 Al-Amiri Hospital: Can receive patients from both Al-Amiri and Al-Jahara catchment areas.

7.4.2 Jaber Hospital: Can receive patients from both Jaber and Mubarak catchment areas.

7.4.3 Al-Adan Hospital: Can receive patients from both Al-Addan and Al-Farwaniya catchment areas.

7.4.4 Ibin Sina Hospital: Can receive patients from Al-Sabah area.

7.4.5 Kuwait Cancer Control Centre; for cancer patients of the center.

7.4.6 Mubarek Al Khabeer Hospital Interventional pain clinic; receives patients from Hawally catchment area.

7.4.7 Al Razi Hospital interventional pain clinic.

7.5 A patient can be seen by a pain clinic that does not belong to his regional healthcare area if the treating pain physician accepts the referral.

7.6 Pain specialists may redirect a self-referral if deemed inappropriate or manageable by treating physicians or other specialties.

7.7 At times, residents in training or physicians of the rank of registrars and above maybe delegated to attend and assist in the pain service clinic, and respective procedures. This should be done under the direct supervision, oversight, and guidance of the attending pain specialist.

7.8 Guiding and regulating policies should be established by the respective pain service providing disciplines (e.g. orthospine, interventional radiology, anaesthesia) regarding the above set article 7.7.

7.9 Pain clinics are to adhere to the standards of the MOH outpatient services policy A-ADM-11 with appointment triaging and auditing of waiting times accordingly.

7.10 For inpatient consultation the pain service consults are subject to the MOH medical consultation policy A-ADM-001.

8. Interventional Procedures

8.1 This article applies to procedures performed by interventional pain physicians.

8.2 The pain clinic scope of services may include a variety of pain interventions to diagnose, reduce or eliminate pain.

8.3 Interventional pain procedures provided include but are not limited to the following:

8.3.1 Trigger point injections
8.3.2 Myofascial injections (including Botox)
8.3.3 Epidural Steroid injections (Interlaminar, Transforaminal, Caudal...)
8.3.4 Diagnostic and therapeutic injections of the Facet joints
8.3.5 Diagnostic and therapeutic injections of the Sacroiliac joints.
8.3.6 Radiofrequency Ablations of the facet and sacroiliac joints
8.3.7 Pulsed Radiofrequency
8.3.8 Genicular Nerve blocks
8.3.9 Spinal Cord Stimulators (available only in Al-Addan and Ibn Sina hospitals)
8.3.10 Peripheral Nerve Stimulators
8.3.11 Intrathecal pumps
8.3.12 Sympathetic Nerve Blocks
8.3.13 Percutaneous vertebral augmentation (Kyphoplasty, Vertebroplasty and spine jack...etc.)
8.3.14 Peripheral Nerve Injections and neurolysis
8.3.15 Joint aspiration and injections
8.3.16 Lidocaine and Ketamine infusions
8.3.17 Chemical or RF plexus ablation
8.3.18 Selective peripheral and nerve root blocks
8.3.19 Sympathetic Ganglion neuromodulation and blocks

8.3.20 Epidural endoscopy and lysis of adhesions

8.3.21 Discography

8.3.22 Percutaneous disc decompression and augmentation

8.3.23 Minimally invasive lumbar decompression (MILD procedure)

8.4 Interventional pain procedures are dependent on the availability of the appropriate equipment, the specialist's competency and scope of services acknowledged by the respective council and licensed by the Medical Licensing Directorate.

8.5 Interventional procedures are divided into three categories (A, B and C) based on the setup requirements to perform the procedure, standard of care and potential for complications.

8.6 These categories serve as a benchmark for **minimum** criteria necessary to perform a procedure under the category which they are listed in (Fig 2).

8.6.1 **Category A**

8.6.1.1 **Setup**: Procedure performed using ultrasound imaging equipment in licensed facilities.

8.6.1.2 **Standards of care:**

8.6.1.2.1 Procedure can be performed in an outpatient clinic / ambulatory service provided they have full resuscitation equipment, and staff with ACLS training (e.g. crash cart, DC cardioversion, resuscitation stretcher, ECG monitor, Oxygen source and Suction device)

8.6.1.2.2 Procedure does not require a long stay (more than 12

hours), admission services or overnight stay.

8.6.1.2.3 No sedation should be given in an outpatient clinic setting.

8.6.2 **Category B**

8.6.2.1 **Setup:** Procedure performed using ultrasound or fluoroscopy imaging equipment in licensed facilities (e.g. C-arm equipped room in radiology department or center, angiography suite or operating theater)

8.6.2.2 **Standards of care:**

8.6.2.2.1 Procedure can be performed as outpatient clinic/ ambulatory services or as a day case (up to 12 hours stay), provided they have full resuscitation equipment and staff with ACLS training (e.g. crash cart, DC cardioversion, resuscitation stretcher, ECG monitor, Oxygen source and Suction device).

8.6.2.2.2 Procedure does not require long stay, admission services or overnight stay.

8.6.2.2.3 Sedation and admission is subject to patients' specifics, clinical conditions, and the treating interventional pain specialist clinical judgment provided a backup / on call Anesthesiologist is available.

8.6.3 **Category C**

8.6.3.1 **Setup:** Procedure performed using fluoroscopy imaging equipment in licensed facilities (e.g. C-arm equipped room in radiology department or center, angiography suite or operating theater)

8.6.3.2 **Standards of Care:**

8.6.3.2.1 Procedure must be done in a day- case center or hospital setting after patient admission.

8.6.3.2.2 They should have full resuscitation equipment and staff with ACLS training (e.g. crash cart, DC cardioversion, resuscitation stretcher, ECG monitor, Oxygen source and Suction device).

8.6.3.2.3 The day case center or hospital should have in- house Intensive care unit and anesthesia services available.

8.6.3.2.4 Post procedure the patient is placed under observation in a long stay recovery area or ward.

8.6.3.2.5 Sedation is subject to patients' specifics, clinical conditions, and the treating interventional pain specialist clinical judgment provided a backup / on call anesthesiologist is available.

8.6.3.2.6 For pre- planned elective procedures requiring admission, the MRP is the treating pain specialist.

8.6.3.2.7 The pre-procedure assessment and preparation is conducted primarily by the interventional pain physician. However, if deemed necessary by the physician performing the procedure, additional assessments may be required from other specialties such as Anesthesia, Cardiology, etc.

8.7 Procedure Frequency and Number of Injections or Interventions:

8.7.1 This article applies to procedures performed by Interventional pain specialists (including epidural, facet joint interventions and peripheral blocks).

8.7.2 This article does not apply to procedures related to surgical and non-surgical anesthesia.

8.7.3 Diagnostic Injections

8.7.3.1 The interval between Injections given should, generally, not be before 1 to 2 weeks from the initial injection.

8.7.3.2 Exceptions to the above article are for cancer pain or continuous administration of local anesthetic for reflex sympathetic dystrophy.

8.7.3.3 The accepted limit is 4 injections, 6 for reflex sympathetic dystrophy.

8.7.4 Therapeutic Injections

8.7.4.1 Interventional procedures may be applied at 3 months intervals (or longer) provided that >50% pain relief is achieved for 6 to 8 weeks per intervention.

8.7.4.2 Neural blockade for different regions, encompassing transforaminal epidural and peripheral nerve blocks, maybe be performed at 1-2 weeks.
intervals (not earlier).

8.7.4.3 Therapeutic frequency remains at least 2 months for each region.

8.7.4.4 Concurrent treatment of all affected regions is permissible,

provided it adheres to safety guidelines.

(e.g. in cases where a patient presents with spine facet arthropathy and right knee osteoarthritis, simultaneous injections in both areas are feasible, contingent upon the total therapeutic dose of the blockade material remaining within the established safety threshold).

8.7.4.5 Interventional procedures to a site maybe repeated as necessary, up to a maximum of (6) times.

8.7.5 Unusual Circumstances

8.7.5.1 For recurrent injury, carcinoma, or reflex sympathetic dystrophy, blocks may be repeated at 6-week intervals after diagnosis/stabilization.

8.7.6 Combinations of Blocks/Interventions

8.7.6.1 More than one block may be combined if necessary (This could include an epidural for the cervical region and facet-joint blocks for the lumbar region, or epidural and facet-joint blocks for the same region.)

8.7.7 Number Per Setting

8.7.7.1 Multiple regions can be treated in the same setting if deemed safe and feasible by the pain specialist.

8.7.8 Multiple Blocks

8.7.8.1 Multiple blocks maybe provided with proper evaluation to determine pain generator(s).

8.7.8.2 No repeat interventions should be directed at a structure proven to be

negative after the first block.

8.7.9 Pending review of this policy, analgesic infusions are for the time being restricted to in facility care (home IV infusion of analgesia is *NOT* to be practiced until further ministerial legislation and regulations are set).

Category	A	B	C
Procedures	• Joint, muscle, tendon and ligament injections • Paravertebral and erector spinae blocks • Joint or cyst aspiration • Trigger point injections. • Myofascial injections (including Botox) • Genicular Nerve blocks • Peripheral Nerve Injections and hydro dissection • Pulsed Radiofrequency for peripheral nerves	• Epidural endoscopy and lysis of adhesions • Discography • Epidural Steroid injections (Interlaminar, Transforaminal, Caudal...) • Diagnostic and therapeutic injections of the Facet joints • Selective nerve root block • Dorsal root ganglion pulsed radiofrequency • Diagnostic and therapeutic injections of the Sacroiliac joints. • Radiofrequency Ablations of the facet and sacroiliac joints • Large Peripheral joint denervation • Sympathetic Nerve Blocks • Chemical or RF plexus ablation • Percutaneous disc decompression and augmentation • Peripheral Nerve Stimulators	• Spinal Cord Stimulators (available only in Al-Addan and Ibn Sina hospitals) • Minimally invasive lumbar decompression (MILD procedure) • Myelography • Spine biopsy • Percutaneous vertebral augmentation (Kyphoplasty, Vertebroplasty and spine jack...etc.) • Lidocaine and Ketamine infusions • Intrathecal pumps

9. Complications

9.1 As pain management maybe provided by licensed specialists of numerous core disciplines (e.g. interventional radiology , anesthesia , ortho spine ,physical medicine and palliative care) and as complications maybe prescription related or procedure related , site or intervention specific , general or systemic , and as the pain specialist might not have the training ,expertise or licensing to manage certain pathologies related to their complications (not to mention admission privileges) ,it should be acknowledged that the pain specialist should ensure the following:

9.1.1 Practicing within their scope of expertise, training, and licensing in accordance with the ministerial decree and any restrictions set by their respective councils, ministerial oversight committees or medical licensing directorate.

9.1.2 Acquiring informed consent from the patients with disclosure of risks, benefits, and all possible complications prior to the commencement of the proposed management or interventional plan.

9.1.3 Assuming responsibility of assessment of any complications presented to them by the patient, resulting from their management of the patient, and providing the necessary care within their scope of expertise, training, and licensing up to and including management, or referral to other respective specialists or the emergency room and follow up of their progress until care, management and a treatment plan is appropriately and accordingly provided.

9.1.4 That all interventional pain physicians must be aware of the potential complications associated with image-guided interventional procedures and to take steps to minimize the risk of adverse events, which include the following:

9.1.4.1 Adhering to established MOH guidelines for infection prevention.

9.1.4.2 Discontinuing anticoagulants or antiaggregants as recommended by international and local guidelines.

9.1.4.3 Being knowledgeable about the specific strategies and techniques used for each procedure.

9.2 Complications may be divided according to (a) severity (minor vs major complications) or according to (b) time of presentation with relation to the procedure (early vs delayed complications) .

9.2.1 **Minor complications:** are related to the original symptom or confined to the procedure site, with intact general function and normal hemodynamics e.g. headaches or neuropathic pain.

9.2.2 **Major complications:** are systemic complications or complications resulting in loss or impaired function with possible need of admission or intervention (e.g. paralysis)

9.2.3 Patients presenting to the emergency department with major complications secondary to pain management, should be assessed by the ERP who will consult the clinical service according to the organ/site most affected and the service/specialty likely to best serve the patient's condition.

9.2.3.1 For specific complications (e.g. discitis) the patient referral to the respective specialist (e.g. orthopedic spine or neurosurgeon) is to be done after the relevant clinical, investigative, or radiological confirmation of the complication is acquired.

9.2.3.2 Pain specialists with the training, competency, expertise, and licensing to manage their specific complications or complications resulting from within their specialty/ discipline are expected to provide the care and intervention accordingly. (e.g. discitis secondary to pain related intervention performed by orthospine or interventional radiology, confirmed by MRI, are to be cared by ortho spine unless -pain intervention was performed by neurosurgery in which case it is cared by the neurosurgery team).

9.3 A reference with summary of the primary complications associated with commonly performed image-guided (fluoroscopic- or ultrasound-guided) interventional procedures and relative incidences is provided.

10. Attachments:

10.1 Sickle Cell MOH policy

10.2 Ministry of Health decree No. 77/2021

10.3 Pregabalin MOH policy No. 2/2024

10.4 Gabapentin MOH policy No. 2/2024

11. References:

11.1 International Association for the Study of Pain (www.iasp-pain.org)

11.2 The American Society of Regional Anesthesia and Pain Medicine (www.asra.com)

11.3 Spine Interventional Society Guidelines for Spinal Diagnostic and Treatment (www.ipsismed.org)

11.4 Canadian Opioid Prescribing Guidelines (www.canadianpainsociety.ca)

11.5 Canadian Neuropathic Pain Guidelines www.canadian pain society.ca)

11.6 British Pain Society and Faculty of Pain Medicine (www.britishpainsociety.org)

11.7 Royal College of Anaesthetists (www.rcoa.ac.uk)

11.8 MOH Council Of Anesthesia, ICU and Pain management Policy proposal to the MOH Technical Affairs Department on 17/4/2024

Track #12895507

11.9 MOH decree 77/2021