TREATING PAIN, PRESCRIBING SAFELY, THE DIFFICULT CASES

CHOMP GRAND GROUNDS
SEPTEMBER 17, 2014

PREScribESAFE@CHOMP.ORG
BACKGROUND INFORMATION

• Prescription drug abuse is the Nation’s fastest-growing drug problem

• Prescription drugs are the second most abused category of drugs after marijuana

• Prescription drug related deaths now outnumber those from heroin and cocaine combined

• Prescription drug overdose deaths exceed motor vehicle-related deaths in 29 states and in Monterey County

• Misuse and abuse of prescription drugs costs the country an estimated $53.4 billion a year in lost productivity, medical costs and criminal justice costs
BACKGROUND INFORMATION

• Emergency Physicians nationwide are being asked to provide these medications daily for patients complaining of both acute and chronic pain.

• Emergency Medicine professional societies (ACEP and AAEM) recommend against treating chronic pain in the ED and for acute painful conditions recommend short course and lowest practical dosing of medications with close attention to the risk for misuse, abuse or diversion.

• Given the risks associated with these potentially dangerous medications, Emergency Departments across the country have formulated guidelines for “Safe Pain Medication Prescribing in Emergency Departments.”
BACKGROUND INFORMATION

- In Monterey County, a team consisting of representatives from the following organizations came together to create our local guidelines which are in use in all four Emergency Departments today
  - CHOMP
  - SVMH
  - NMC
  - Mee Memorial
  - Monterey County Sheriff/Coroner’s office
  - Hospital Council of Northern and Southern California,
  - Monterey County District Attorney’s Office
  - Monterey County Public Health Department
  - Doctors on Duty
  - Central Coast Alliance for Health
  - Monterey County Medical Society
  - Monterey County Fire Chief’s Association

- The Prescribe Safe Task Force was formed
BACKGROUND INFORMATION

- We have addressed the problem as it relates to our Emergency Departments

- We have removed one of the main “suppliers”

- That was step one......

- We are here today to start step two......

- How can primary and specialty providers address the greater issues of pain and it’s safe management
OUR EXPERT PANEL

Lee Goldman, MD
CHOMP Chemical Dependency Services, Medical Director

Eric Jacobson, MD
CHOMP Behavioral Health, Medical Director

Caroline Kennedy, MD
Monterey County Department of Health, Clinical Services Bureau, Medical Director

Victor Li, MD
P.R.I.M.E. Pain Management Institute, Medical Director

Maureen Miner, MD
South County Pain and Rehabilitation, Medical Director

Moderated by:
Reb Close, MD
CHOMP Emergency Physician
OUR GOALS FOR THIS GRAND ROUNDS

• Understand patient/provider contracts, how to set expectations/goals/limitations and clinic policies
• Education regarding necessary tools to pain medication prescribing (UTOX, CURES, Morphine Equivalent Dosing recommendations)
• Share Safe Prescription Practices “COP RUN”
• Realize that chronic pain can be successfully treated
• Education regarding reestablishing proper diagnosis and establishing a multifaceted treatment plan for functional restoration
• Provide a “recipe” for comprehensive care
• Consider the role that underlying psychiatric illness plays in pain perception and treatment
• Recognize aberrant medication use patterns, substance use disorders (SUDS)
• Understand the differences between addiction and pseudo-addiction
• Consider not creating new addicts, explore alternative treatment modalities that can be used at an initial or acute presentation
• Create experts in the safety and dangers of chronic pain management
GOALS AND OBJECTIVES

• Review 5 cases of challenging pain management

• Identify and discuss solutions to challenges in pain management

• Discuss the roles of primary care, pain medicine, physical medicine and rehabilitation, psychiatry, and addiction medicine in the management of chronic pain
CASE 1 – NEW PRIMARY CARE APPOINTMENT

53-year-old female – New primary care appointment

• Past medical history
  • Astrocytoma of C-spine, with history of resection and radiation therapy in 2004
  • Chronic neck pain
  • Low back pain
  • Opioid dependency noted by oncologists
  • Anxiety
  • Pulmonary Sarcoid
  • Seizures
  • COPD
CASE 1 – NEW PRIMARY CARE APPOINTMENT

• Past surgical history
  • 2004 resection of astrocytoma with rod placed C4-7
  • 2004 bone graft from hip to cervical spine

• Medications
  • Methadone 150 mg daily
  • Alprazolam 2 mg TID
  • Temazepam 30 mg qHS
  • Lipitor 40 mg daily
  • Topamax 50 mg BID
  • Advair 50/500 2 puffs BID
  • Albuterol PRN
CASE 1 – NEW PRIMARY CARE APPOINTMENT

• Social
  • Tobacco = never
  • Alcohol = distant history of abuse
  • Illicit drugs = None
CASE 1 – NEW PRIMARY CARE APPOINTMENT

• Physical exam
  • Vital signs = normal
  • General = walks with a cane
  • Neck = tenderness to palpation over scar on posterior
  • Remainder of exam done and found to be unremarkable

• Additional data
  • PHQ-2 negative (depression screen – on USB)
  • CURES report – no early refills of medications or prescriptions from the Emergency Department
  • Patient agrees to a pain management contract
CASE 1 – NEW PRIMARY CARE APPOINTMENT

• What are the key issues in assuming the pain management of a patient in a primary care setting?

• What are key strategies in initiating a pain management contract?

• How to assess risk of abuse, and what to do in high risk cases of abuse?

• How to approach new patient relationship when informed patient only has 2 days of chronic medications remaining?

• When does a patient need referral to another provider for additional interventions?
CASE 1 – NEW PRIMARY CARE APPOINTMENT
WHAT CAN WE LEARN FROM THIS CASE?

PRIMARY CARE APPROACH TO CHRONIC PAIN

Caroline I. Kennedy, MD
American Board of Family Practice
Medical Director, Clinic Services Bureau
Monterey County Department of Health
CASE 1 – NEW PRIMARY CARE APPOINTMENT
WHAT CAN WE LEARN FROM THIS CASE?

Create a safe prescribing environment

• Always prescribe opioids safely by monitoring with frequent CURES reports and periodic tox screens

• All patients must have a medication agreement

• Try many other non-narcotic drug classes and treatments in order to minimize the use of opioids

• Clearly communicate with the patient the risks and long-term effects of the medications
  • Don’t assume that just because they are on a high dose now that they know the risks
  • An annual medication agreement can be the perfect time to review this
CASE 1 – NEW PRIMARY CARE APPOINTMENT
WHAT CAN WE LEARN FROM THIS CASE?

Create a safe prescribing environment

• Involve behavioral health early on for patients with psychiatric diagnoses and especially if you plan to taper down on the medications

• Communicate directly about any planned decrease in medications well in advance and consider writing it into the medication agreement

• Review the consequences of a broken pain contract or missed appointments before they occur.

• Consider having a written office policy of opioid prescribing for non-cancer pain with a maximum daily morphine equivalent dose

• Set limits for verbally abusive patients.
CASE 1 – NEW PRIMARY CARE APPOINTMENT
WHAT CAN WE LEARN FROM THIS CASE?

Monterey County Health Department--Clinic Services Division
Pain Management for Chronic Pain in Non-Cancer Patients
04/23/14

• **Medication Specifics**
  • Morphine Equivalent Dose should not exceed 100mg/day
  • Peer review of all patients with MED of 300mg/day or methadone 60mg/day
  • Preferred short-acting: oxycodone and hydrocodone
  • Preferred long-acting: methadone and extended release morphine
  • No diazepam combination with methadone
  • Short acting max of #120/month
  • Pt should not be 2 different short-acting
  • No opioids if patient is using alcohol or drugs (except marijuana)
  • Avoid combining with soma, benzo, phenergan, ambien or barbiturates

• **Other expectations**
  • Yearly urine tox screen
  • Yearly pain contract/consent
  • Yearly PAR
  • Alcohol/drug portion of chart filled out
  • Hx of drug abuse (illicit or prescription) on problem list—needs Opioid Risk Tool
  • Trial of non-narcotic medication such as cymbalta/neurontin
  • Active treatment of depression
  • Meds should be tapered if tox screen positive or pain contract violation
CASE 2 – COMPLEX PAIN MANAGEMENT

55-year-old male presenting with a follow-up chronic pain management visit

- Past medical history
  - 15 years of chronic low back pain

- Past surgical history
  - Lumbar laminectomy and L4-S1 fusion
CASE 2 – COMPLEX PAIN MANAGEMENT

• Previous therapies for pain control
  • Surgery
  • Physical therapy
  • Injections
  • Acupuncture
  • Medications

• Medications (previous)
  • Oxycontin
  • Fentanyl patches
  • Gabapentin
  • Lyrica
  • Cymbalta
CASE 2 – COMPLEX PAIN MANAGEMENT

• Medications (current)
  • Methadone 40 mg q12
  • Dilaudid 4 mg TID prn breakthrough pain
  • Soma 350 mg TID for spasm

• Social issues
  • Patient has previously been managed by an MD who has since moved to Hawaii
  • Patient has been out of medications x 3 months
  • Has been buying Dilaudid and Methadone on the street
CASE 2 – COMPLEX PAIN MANAGEMENT

• **Exam**
  • General = antalgic gait
  • Back = limited flexion and extension of the lumbar spine with muscle spasm in the lumbar paraspinal musculature
  • Neurologic = right foot drop with decreased sensation to touch

• **Oh by the way, Doc...**
  • Patient has a history of IV heroin use
  • Money is running out – patient is considering transitioning over to heroin from street purchased Methadone and Dilaudid (as it’s cheaper)

• How to proceed?
CASE 2 – COMPLEX PAIN MANAGEMENT

- When should referral to a pain management specialist be considered?

- What are strategies for dealing with patients with poor compliance to both medical care and pain contracts and/or histories of self medication with street drugs (prescription and non-prescription)?

- How can we handle violations of pain management contracts both in the primary care setting and in the pain management setting?

- When does a patient need referral to another provider for additional interventions?
CASE 2 – COMPLEX PAIN MANAGEMENT
WHAT CAN WE LEARN FROM THIS CASE?

PAIN MANAGEMENT APPROACH TO CHRONIC PAIN

Victor Li, MD
Board Certification in Anesthesiology
Board Certification in Pain Medicine
International Spinal Intervention Society
American Society of Interventional Pain Physicians
North American Association of Laser Therapy
American Society for Laser Medicine and Surgery
American Society of Clinical Hypnosis
CASE 2 – COMPLEX PAIN MANAGEMENT
WHAT CAN WE LEARN FROM THIS CASE?

Use Safe Prescription Practices “COP RUN”

- Cures Report
- Opioid Agreement
- Pharmacy/Previous Provider’s Records
- Referral to Pain Specialist/Psychiatrist
- Urine Toxicology Screen
- Not every patient needs to be on opioids
CASE 2 – COMPLEX PAIN MANAGEMENT
WHAT CAN WE LEARN FROM THIS CASE?

Chronic Pain Can be Successfully Treated

- There are many options to treat pain
  - Fluoroscopically-Guided Injections
  - Laser Therapy
  - Acupuncture
  - Myofascial Therapy
  - Hypnosis
  - Osteopathic adjustments
- You can learn more at www.Primepain.com
CASE 2 – COMPLEX PAIN MANAGEMENT
WHAT CAN WE LEARN FROM THIS CASE?

Clinical Pearls

• Methadone – 72 h ½ life, conversion ratios to morphine change with changing doses associated with dangerous arrhythmias

• Fentanyl Patches – avoid overheating (hot tubs, hot baths). 100 times stronger than morphine on mg/mg basis: 100 mcg/h patch equivalent to 240 mg of morphine (80 mg tid), 50 mcg/h patch = 40 mg tid; 25 mcg/h=20 mg tid

• Dilaudid is 5 times stronger than morphine

• Oxycodone is 1.5 times stronger than morphine

• Avoid Tramadol with SSRIs – increased risk of seizures

• Be aware of total doses of Acetaminophen with Percocet/Vicodin/Norco/Lortab (don’t exceed 3000mg of APAP/day; perform LFTs)
CASE 3 – CHRONIC ANKLE PAIN

36-year-old male presents to the CHOMP ED with a chief complaint of right ankle pain

- No history of trauma
- Ran out of pain medication, can’t get a prescription until tomorrow

- Past medical history
  - Chronic right ankle pain, s/p surgery for a traumatic injury 6 months ago
  - Chronic low back pain
CASE 3 – CHRONIC ANKLE PAIN

- Medications
  - Oxycodone
  - Morphine

- Social history
  - Occasional smoker
  - No alcohol or illicit drug use
CASE 3 – CHRONIC ANKLE PAIN

• Physical Exam
  • Vital signs = normal
  • General = no acute distress
  • Cardiac = RRR, 2+ pulses in all extremities
  • Pulmonary = no respiratory distress
  • Neurologic = full strength/sensation in RLE
  • Extremities = right ankle mildly swollen, mild diffuse tenderness to palpation, no focal area of tenderness, no external signs of trauma, no erythema

• ER MD reviews CURES...
  • 22 records of controlled substances in the past 6 months
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- **Number of Records:** 22
- **Start Date:** 03/11/2014
- **End Date:** 09/11/2014

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CASE 3 – CHRONIC ANKLE PAIN

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Disclaimer: The Patient Activity Report (PAR) is compiled from information maintained in the Department of Justice’s Controlled Substance Utilization Review and Evaluation System (CURES). The CURES maintains Schedule II, Schedule III and Schedule IV prescription information that is received from California Pharmacies and is therefore only as accurate as the information provided by the Pharmacies. If data was submitted with errors or have unknowns within a field, it will not be displayed within this report.
CASE 3 – CHRONIC ANKLE PAIN

• For ankle pain, in the past 6 months, the patient has received

• 1870 tablets of morphine
  • For a total of 91800 mg in 6 months

• 396 tablets of oxycodone
  • For a total of 11880 mg in 6 months

• 280 tablets of hydromorphone
  • For a total of 2240 mg in 6 months
CASE 3 – CHRONIC ANKLE PAIN

- In morphine equivalents
  - 91,800 mg of morphine in 6 months
  - 11,880 mg of oxycodone roughly equals 17,820 mg of morphine in 6 months
  - 2240 mg of hydromorphone roughly equals 8,960 mg of morphine in 6 months

- GRAND TOTAL
  - 112,640 mg morphine equivalents in 6 months
  - 618 mg morphine equivalents per day
  - Approximately a quarter pound of morphine
CASE 3 – CHRONIC ANKLE PAIN

• In patients who have poorly controlled pain despite high dose opiate therapy, what are other modalities for pain treatment to avoid high opiate use?

• What types of conditions best respond to rehabilitation and physical therapy?

• What types of interventions or procedures are available for long term pain management?

• When does a patient need referral to another provider for additional interventions?
CASE 3 – CHRONIC ANKLE PAIN
WHAT CAN WE LEARN FROM THIS CASE?

PHYSIATRIC APPROACH TO CHRONIC PAIN

Maureen D. Miner, MD
Diplomate American Board Of PM&R
Subspecialty Board Certified Pain Medicine
Subspecialty Board Certified Spinal Cord Medicine
Diplomate American Board Of Pain Medicine
Qualified Medical Evaluator
CASE 3 – CHRONIC ANKLE PAIN

WHAT CAN WE LEARN FROM THIS CASE?

CHRONIC PAIN

TISSUE OR NERVE INJURY

INCREASED NEURAL ACTIVITY AT SITE OF INJURY

- Excitatory AA release
- Neuropeptide release
(sP, CGRP, etc)

INCREASED DEPOLARIZATION AT NMDA RECEPTOR SITES IN DORSAL HORN

EXCESSIVE DEPOLARIZATION

EXCITOTOXICITY

Cell Dysfunction

LOSS OF INHIBITION

EXPANDED RECEPTOR FIELDS

INCREASED PAIN

Raj, P 138
CASE 3 – CHRONIC ANKLE PAIN
WHAT CAN WE LEARN FROM THIS CASE?

Biopsychosocial Pain Model
CASE 3 – CHRONIC ANKLE PAIN
WHAT CAN WE LEARN FROM THIS CASE?

FUNCTIONAL RESTORATION:

DEFINITION:

Functional restoration is an established treatment approach that aims to minimize the residual complaints and disability resulting from acute and/or chronic medical conditions.

Functional restoration is the process by which the individual acquires the skills, knowledge and behavioral change necessary to avoid preventable complications and assume or re-assume primary responsibility ("locus of control") for his/her physical and emotional well-being post injury.

The individual thereby maximizes functional independence and pursuit of vocational and avocational goals, as measured by functional improvement.
CASE 3 – CHRONIC ANKLE PAIN
WHAT CAN WE LEARN FROM THIS CASE?

Functional Restoration

• Create a “RECIPE” that best fits your patient’s needs
• Physician’s role:
  – Verify the diagnosis
  – Determine what treatments have been tried/have worked
  – Determine if what has not worked in past is reasonable to consider now
  – Optimize medications
  – Review and clear the exercise program
  – Facilitate pain-psyche techniques
  – Implement modalities
  – Keep the patient accountable
  – REGIMINE SHOULD BE WRITTEN AND FINE-TUNED
CASE 3 – CHRONIC ANKLE PAIN
WHAT CAN WE LEARN FROM THIS CASE?

MULTIDISCIPLINARY FUNCTIONAL RESTORATION

FUNCTIONAL IMPROVEMENT

- MODALITIES
- EXERCISE
- COGNITIVE BEHAVIORAL THERAPY
- SURGERY
- EDUCATION
- INTERVENTIONAL
- MEDICATION
- PACING
- OTHER

WHAT CAN WE LEARN FROM THIS CASE?
CASE 4 – IT ALL STARTED WITH MIGRAINES

A narrative of the clinical course of a patient, currently 39 years old

- Past medical history
  - Bipolar disorder II
  - Migraine headaches
  - Pulmonary embolism
  - Prescription misuse

- Occupation: RN
CASE 4 – IT ALL STARTED WITH MIGRAINES

- **2003**
  
  - First patient contact, seen in the ER for migraines

- **June 2005**
  
  - Hospitalized by primary care for refractory migraines
  
  - DC medications: Hydrocodone/APAP, Phenergan, Zofran, Diphenhydramine

- **October 2005**
  
  - Referred to psychiatry from primary care
  
  - On escitalopram for depression and zolpidem for sleep
  
  - Referred to neurology for migraines, being treated with Midrin and Bupropion
CASE 4 – IT ALL STARTED WITH MIGRAINES

• July/September 2006
  • Hospitalized for intractable migraines
  • Treated with DHE in the ER, IV opiates during admission
• Late 2006
  • Diagnosis has been made of Bipolar
  • Started on Lithium, Lamotrigine, Lorazepam, and opiates for migraine

• 2007
  • Patient has been working nights as an RN
  • Followed by psychiatrist and therapist
  • Medications
    • Seroquel prn for anxiety
    • Lyrica
    • Lamotrigine
    • Modafinil
  • She receives medications from psychiatry, primary care, and neurology at the same time
CASE 4 – IT ALL STARTED WITH MIGRAINES

- **2008-2009**
  - Patient begins making multiple ER visits for migraines, mostly treated with opiates
  - Also diagnosed with hypothyroidism

- **2010**
  - Continued ER visits for migraines

- **August 2010**
  - First psychiatric hospitalization
  - Patient has now gained weight, and is obese
  - Medications
    - Lunesta
    - Gabapentin
    - Lorazepam
    - Butrans
    - Seroquel
    - Oxcarbazepine
    - Modafinil
CASE 4 – IT ALL STARTED WITH MIGRAINES

• 2011
  • Multiple ER visits for migraines continue
  • Fired from place of work for appearing intoxicated with benzodiazepines
  • Filing for divorce
  • Working locum tenens
  • Increasing depression

• 2012 and 2013
  • Psychiatrist, neurologist, and primary care all confront patient about medication overuse
  • ER visits for migraines continue

• November 2012
  • Admitted to psychiatry (after medical evaluation)
CASE 4 – IT ALL STARTED WITH MIGRAINES

• 2013
  • Continued ER visits for migraines
  • Diagnosed with pulmonary embolism

• July 2014
  • Admitted to psychiatry with marked mood instability and deterioration in overall ability to function
  • Migraines had become chronic daily headaches

• Medications in July 2014
  • Lorazepam
  • Buspirone
  • Latuda
  • Oxcarbazepine
  • Propranolol
  • Amitriptyline
  • Butrans
CASE 4 – IT ALL STARTED WITH MIGRAINES

• Status since discharge
  • Unable to work
  • Working to reduce benzodiazepine intake
  • Continues to seek care in outside ERs
  • Mood/bipolar more stable

• Most recent medication list (doing better)
  • Clonazepam
  • Lorazepam
  • Fanapt
  • Oxcarbazepine
  • Zolpidem
  • Amitriptyline
  • Lyrica
  • Lyrica
  • Fiorcet
  • Hydrocodone/APAP
  • Zomig
CASE 4 – IT ALL STARTED WITH MIGRAINES

• What are high risk psychiatric conditions associated with prescription misuse or dependence?

• When should primary care providers consider psychiatric referral?

• What are strategies for addressing behavioral health disorders in patients that do not believe they have psychiatric illness?

• When does a patient need referral to another provider for additional interventions?
CASE 4 – IT ALL STARTED WITH MIGRAINES
WHAT CAN WE LEARN FROM THIS CASE?

PSYCHIATRIC APPROACH TO CHRONIC PAIN

Eric Jacobson, MD
Board Certification in Psychiatry
Expertise in Genetic Predisposition to Disease
Medical Director, CHOMP Behavioral Health
CASE 4 – IT ALL STARTED WITH MIGRAINES
WHAT CAN WE LEARN FROM THIS CASE?

Consider the role that psychiatric illness plays in chronic pain

• Screen for and identify mental illness in all patients early in treatment
  • Screening tools, PHQ-9, assist in identifying illness, but are not diagnostic

• Fully treat or refer to a psychiatrist for consultation
  • Refer:
    • Bipolar patients
      • 50-80% have concurrent histories of drug abuse
    • Refer refractory depressed patients
    • Refer suicidal patients
CASE 4 – IT ALL STARTED WITH MIGRAINES
WHAT CAN WE LEARN FROM THIS CASE?

Psychiatric illness must be treated to remission, if possible

- Incomplete treatment is the best predictor of recurrence
- Most mental illnesses are chronic and recurrent
- Patients must be maintained after acute treatment
- Co-morbid use of opiates and other abuse or misuse of other drugs is rampant in inadequately treated patients with mental illness
CASE 4 – IT ALL STARTED WITH MIGRAINES
WHAT CAN WE LEARN FROM THIS CASE?

Pain: is emotional pain different from physical pain?

• The same areas of the brain are activated in physical pain and depressed patients who describe their illness as painful.
• Patients with depression are much more sensitive to painful stimuli
• Pain is a common symptom in psychiatric patients
• SNRI’s (duloxetine, venlafaxine, and others) activate the descending pain regulation pathways
• Pain perception is highly influenced by suggestion
CASE 5 – SUBSTANCE USE DISORDER

A 73-year-old male with chronic pain primarily related to degenerative disease of the neck and lumbar spine

• Taking hydrocodone for years and drinking alcoholically for 50 years until 2 months ago when he stopped drinking
• Wife reports often patient would either be asleep or altered because of drinking and taking excessive pills
• Recently with a number of falls and a flurry of ER visits primarily related to refills of analgesics
CASE 5 – SUBSTANCE USE DISORDER

- Patient reports he is always in pain but recently neck pain is “horrendous”
- Recent CT of neck shows stable degenerative changes

- Medications
  - While drinking
    - #90 10mg hydrocodone/month taken erratically but always orally (not injected or insufflated)
  - Recently PMD prescribed oxycodone which patient consumed a 10 day supply in 3 days
    - This resulted in his PMD withdrawing treatment of pain and urgently referring to CD
CASE 5 – SUBSTANCE USE DISORDER

• Past medical history
  • HTN
  • Cardiomyopathy
  • Pacemaker
  • Hyperlipidemia
  • Depression

• Social/Family history
  • Married
  • Father was an alcoholic
CASE 5 – SUBSTANCE USE DISORDER

• Physical exam
  • Vital signs = normal
  • Generally = no acute distress
  • Cardiac = RRR
  • Pulmonary = CTAB
  • Neurologic = A+O x 3, no tremulousness
  • Psych = normal mood, full affect, linear thought

• Important issues in caring for this patient
  • Risks for substance abuse
  • Aberrant drug related behaviors
  • Hyperalgesia
  • Pseudoaddiction
  • Treatment
CASE 5 – SUBSTANCE USE DISORDER

• When a patient is identified as having prescription drug misuse, what are medications that can be started safely by the average* physician to help manage symptoms of withdrawal?

• What are strategies for confronting patients that do not realize (or are not willing to admit) they are dependent on or addicted to their prescription medications?

• When is inpatient detoxification needed or warranted?

• What are the highest and lowest risk medications for abuse and dependence?

• When does a patient need referral to another provider for additional interventions?
CASE 5 – SUBSTANCE USE DISORDER
WHAT CAN WE LEARN FROM THIS CASE?

CHEMICAL DEPENDENCY APPROACH TO
CHRONIC PAIN

Lee M. Goldman, MD
American Board of Family Practice
California Society for Treatment of Alcoholism
California Society of Addiction Medicine
American Society for Addiction Medicine
Medical Director, CHOMP Chemical Dependency Services
CASE 5 – SUBSTANCE USE DISORDER
WHAT CAN WE LEARN FROM THIS CASE?

Substance Use Disorders (SUDS)

• Uncomplicated – use in spite of adverse consequence

• Complicated – use in spite of adverse consequence plus physiologic dependence and one or more complications (alcohol use plus seizure, heroin use plus withdrawal and abscess)

• SUDS Risks
  • Current or past use
  • Genetic Predisposition
  • Age
  • Psychiatric comorbidities
  • PTSD
  • Gastric Bypass
CASE 5 – SUBSTANCE USE DISORDER
WHAT CAN WE LEARN FROM THIS CASE?

Aberrant Drug-Related Behaviors

• Deviation from plan
• Early Refills
• Lost or Altered Prescriptions
• Doctor Shopping (CURES)
• Pharmacy Shopping (CURES)
• ER Visits
• Using Illicit Drugs or Alcohol, TCH?
• Diversion
• IV, chewing, snorting, inhaling
Addiction and pseudoaddiction

**ADDICTION**
- Behaviors associated with SUDS
- Craving, Withdrawal
- Tolerance
- Aberrant Substance Related behaviors

**PSEUDOADDICTION**
- The appearance of aberrant drug related behaviors in a patient whose pain or perception of pain is felt by the patient not to be well managed
CASE 5 – SUBSTANCE USE DISORDER
WHAT CAN WE LEARN FROM THIS CASE?

Pseudoaddiction scenario

• Patient: “Doc, I hurt all over”
• Physician: “I’m telling you that I’m giving you enough medicine to kill an elephant”

• Possible etiologies
  • Progression of underlying disease
  • Tolerance
  • Hyperalgesia
  • Evolution/genetics (maybe we are supposed to feel pain...)
CASE 5 – SUBSTANCE USE DISORDER
WHAT CAN WE LEARN FROM THIS CASE?

Treatment options

• Medically and surgically stable?
• Discuss tolerance and hyperalgesia
• Propose detox
• Treat underlying mood disorder
• Consider alternative medications
• Consider adjunctive modalities
• Consider alternative therapies
• Refer to treatment program
CASE 5 – SUBSTANCE USE DISORDER
WHAT CAN WE LEARN FROM THIS CASE?

BUPRENORPHINE

• A unique opioid partial agonist antagonist which activates the mu opioid receptor but with less activity than pure opioid agonists

• It also activates other opioid receptors and antagonizes others especially those receptors that seem to be involved with craving and compulsive use

• These unique properties tend to not make people “high” yet experience a level of pain relief and prevention of withdrawal

• Less hyperalgesia especially in combination with naltrexone
A FEW OTHER QUESTIONS FOR THE PANEL

• What is the appropriate indication (if any) for muscle relaxants?

• What is the appropriate indication (if any) for Soma (carisoprodol)?

• What are specific medications or interventions that you request should be essentially avoided in all patients (potential for harm far outweighs any potential for good)?
TAKE HOME POINTS/OUR GOALS

• Understand patient/provider contracts, how to set expectations/goals/limitations and clinic policies
• Education regarding necessary tools to pain medication prescribing (UTOX, CURES, Morphine Equivalent Dosing recommendations)
• Share Safe Prescription Practices “COP RUN”
• Realize that chronic pain can be successfully treated
• Education regarding reestablishing proper diagnosis and establishing a multifaceted treatment plan for functional restoration
• Provide a “recipe” for comprehensive care
• Consider the role that underlying psychiatric illness plays in pain perception and treatment
• Recognize aberrant medication use patterns, substance use disorders (SUDS)
• Understand the differences between addiction and pseudoaddiction
• Consider not creating new addicts, explore alternative treatment modalities that can be used at an initial or acute presentation
• Create experts in the safety and dangers of chronic pain management
THANK YOU

prescribesafe@chomp.org

http://www.chomp.org/for-healthcare-professionals/prescribe-safe/

Special thanks to Casey Grover, M.D.
For his expertise in slide preparation and data compilation
The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring

A PHQ-2 score ranges from 0-6. The authors identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

Psychometric Properties

<table>
<thead>
<tr>
<th></th>
<th>Major Depressive Disorder (7% prevalence)</th>
<th>Any Depressive Disorder (18% prevalence)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHQ2 Score</td>
<td>Sensitivity</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>97.6</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>92.7</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>82.9</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>73.2</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>53.7</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>26.8</td>
</tr>
</tbody>
</table>

* Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.

## Patient Health Questionnaire (PHQ-9)

**NAME:**

**DATE:**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "*" to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add columns

Total:

(add healthcare professional: for interpretation of total, please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

**PHQ-9 Patient Depression Questionnaire**

**For initial diagnosis:**

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 "*"s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

**Consider Major Depressive Disorder**
- if there are at least 5 "*"s in the shaded section (one of which corresponds to Question #1 or #2)

**Consider Other Depressive Disorder**
- if there are 2-4 "*"s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

**To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up "*"s by column. For every "*": Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

**Scoring:** add up all checked boxes on PHQ-9

For every "*" Not at all = 0 Several days = 1 More than half the days = 2 Nearly every day = 3

**Interpretation of Total Score**

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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A26628 10-04-2005
Monterey County Health Department—Clinic Services Division
Pain Management for Chronic Pain in Non-Cancer Patients
04/23/14

Medication Specifics

- Morphine Equivalent Dose should not exceed 100mg/day
- Peer review of all patients with MED of 300mg/day or methadone 60mg/day
- Preferred short-acting: oxycodone and hydrocodone
- Preferred long-acting: methadone and extended release morphine
- No diazepam combination with methadone
- Short acting max of #120/month
- Pt should not be 2 different short-acting
- No opioids if patient is using alcohol or drugs (except marijuana)
- Avoid combining with soma, benzo, phenergan, ambien or barbiturates

Other expectations

- Yearly urine tox screen
- Yearly pain contract/consent
- Yearly PAR
- Alcohol/drug portion of chart filled out
- Hx of drug abuse (illicit or prescription) on problem list—needs Opioid Risk Tool
- Trial of non-narcotic medication such as cymbalta/neurontin
- Active treatment of depression
- Meds should be tapered if tox screen positive or pain contract violation
HELPFUL WEBSITES

- Washington State Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain
  - [http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf](http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf)
- Available psychological assessment materials
  - [http://www4.parinc.com/Company/about_PAR.aspx](http://www4.parinc.com/Company/about_PAR.aspx)
- **Morphine Milligram Equivalent (MME) Calculator**
- Prescribers’ Clinical Support System for Opioid Therapies (PCSS-0)
  - [http://www.safeopioids.org/manage-use/treatment-guidelines](http://www.safeopioids.org/manage-use/treatment-guidelines)
- Free online CME and education that meets CA requirements for pain management CME
  - [http://www.paincarelive.com](http://www.paincarelive.com)
  - [http://www.coperems.org](http://www.coperems.org)
FINAL THOUGHTS

• You don’t know what you don’t know until you have looked

• Always be aware of increased risks for “special groups”
  • Elderly
  • Those at risk for falls
  • Those with increased respiratory risk (OSA, COPD, Obesity/hypoventilation)