Chronic Nonmalignant Pain
Case 1

- 55 y/o male with chronic low back pain. In the past several months his focal back pain has intensified, absent any radicular symptoms, leading him to accelerate his use of pain medications. He presents to the clinic in pain requesting early refills of his pain medications.
Case 2

- 50 y/o female is new to your clinic with complaints of neck, back, hip, knee, hands, and forearm pain for several years. Patient describes pain as burning, stabbing, radiating, soreness, tightness. Patient has tried chiropractic, acupuncture, and massage. Patient has been unable to work for 3 1/2 years and is applying for disability.
Epidemiology

- 100 million American have chronic pain
  - 1/3 of Americans will have chronic pain at some point (postoperative, cancer, or noncancer)

- Estimated annual healthcare cost: $261-300 billion/yr (14% of Medicare costs)
  - Total $560-635 billion/yr

- 40-50% report unsatisfactory pain control

- 27-60% experience depression
Objectives

- Discuss the psychosocial dilemmas associated with managing chronic nonmalignant pain.

- Discuss the core principles of chronic pain management.

- Discuss the role and proper use of chronic opiates in the management of chronic nonmalignant pain.

- Review Federation of State Medical Boards Criteria for chronic pain management.
Roles

- Victims
- Villains
- Crock
- Crooks
Victims

- **Patient:**
  - Chronic, unremitting pain
  - Inadequate support system
  - Financial hardship
  - Ineffective coping skills
  - Low pain threshold
  - Medication intolerance
  - Judgmental providers
  - Pseudo-addiction

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Victims

- Provider
  - Government regulations
  - Noncompliant, demanding, manipulative, or deliberately dishonest patients
  - “No shows”
  - Third-party payer policies
  - Insufficient training
  - Lack of objective measuring tools
Villains

- Patient
  - Office routine disrupters
  - Liars
  - Work avoiders
  - Recreational substance users
  - Fakers
  - Drug seekers
Villains

- Physician
  - Moral Judgments
  - Patient abandonment
  - Comfort over commitment
  - Suspicious or adversarial attitudes
- Biases
  - Ethnic
  - Socioeconomic

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Patient
- Dysfunctional Personality
- Hypochondria
- Depression
- Psychophysiological illness
- Manipulative behavior
Crocks

- Physician
  - Unsubstantiated fear
  - Misguided suspicion
  - Educational deficit
  - Inaccurate information
Crooks

- **Patient**
  - Drug Diversion
  - Prescription forgery

- **Physician**
  - Drug Diversion
  - Practice standard violation
Systematic Approach

- **Step 1: Comprehensive Evaluation**
  - Determine Biological Mechanism of Pain
- **Step 2: Treatment Plan**
  - Patient Education
  - Realistic Goal Setting
- **Step 3: Pain Contract**
  - Physician/Patient Agreement
  - Informed Consent
- **Step 4: Follow Up**
  - 4 A’s
  - 6 Month Review
Step 1: Comprehensive Evaluation

- General H&P (Grade B)
  - Comorbidities (Depression, Diabetes, etc) *
  - History of past or current substance abuse *
- Pain History (Grade B)
  - Subjective Pain (Multidimensional tools)
  - Current and past pharmacologic and nonpharmacologic treatments and effectiveness
  - Obtain prior records
  - Big Three: Mental Health, Sleep, Activity
Step 1: Comprehensive Evaluation

- Pain Physical (Grade B)
  - Musculoskeletal Exam (Inspect, Palpate, ROM, Specific Tests)
  - Neurological Exam
  - Baseline Functional Assessment *
- Diagnostic Testing (Grade B)
Strength of Recommendation

- Grade A: Good quality patient-oriented evidence
- Grade B: Inconsistent or limited-quality patient-oriented evidence
- Grade C: Consensus, usual practice, opinion, disease-oriented evidence, case series
Multidimensional Tools

- **Brief Pain Inventory (BPI)**
- Chronic Pain Grade (CPG)
- Neuropathic Pain Scale (NPS)
- Body Outline Marking

**RETURN**
Depression Screening

- Beck Depression Inventory
- PHQ-9
- SIG E CAPS
- Zung Depression Rating

RETURN
Substance Abuse Screening

- **CAGE-AID**
- **Alcohol Use Disorders Identification Test (AUDIT)**
- **Opioid Risk Tool -5**
- Screener and Opioid Assessment for Patient with Pain-Revised (SOAPP-R) -24
- **DIRE Score**
- Addiction Behaviors Checklist (ABC) -20
- Current Opioid Misuse Measure (COMM) -17
- **RETURN**
Functional Assessment Tools

- Palliative Performance Scale
- Pain Disability Index
- Oswestry Low Back Disability Index
- SF-36
- U.S. Department of Labor Physical Demand Table
- American Pain Foundation Scale
- Physical Function Ability Questionnaire (FAQ5)
- RETURN
Perform and document a medical history and physical examination that includes:

- Nature and intensity of pain
- Current and past treatment of pain
- Underlying and coexisting disease and conditions
- Effect of pain on function (physical & psychiatric)
- History of substance abuse
- Documentation if a controlled substance is indicated medically

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Step 1: Determine Biological Mechanisms of Pain (Grade C)

- Neuropathic
- Inflammatory
- Myofascial
- Mechanical/Compressive
Neuropathic Pain

- Examples: Sciatica, Diabetic Peripheral Neuropathy, Trigeminal Neuralgia, Postherpetic Neuralgia

- Subjective
  - Burning, stabbing, shooting
  - Follows nerve distribution

- Objective
  - Numbness, Allodynia, coolness of skin (sympathetically mediated pain)
Inflammatory (Nociceptive)

- Examples: Inflammatory Arthritis, Infection, Injury, Post-operative

- Subjective: localized pain at site of injury

- Objective: heat, redness, swelling
Myofascial Pain

- Examples: Fibromyalgia, Trigger points

- Subjective:
  - Soreness, stiffness, aching, painful muscles and soft tissues
  - Fatigue, poor sleep, depression, headaches, irritable bowel syndrome

- Objective:
  - Fibromyalgia: widespread pain, 11/18 tender points, >3 months
  - Trigger points

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Mechanical/Compressive Pain

- Examples: Muscle/ligament Strain, Sprain, Disc Degeneration, Compression Fractures

- Subjective:
  - localized pain to injury
  - Pain worse with activity, improves with rest
Care Plan Tips:

- Chronic nonmalignant pain is never an emergency
- Develop a working patient-physician relationship
- Validate the patient’s pain experience
- Negotiate a comprehensive treatment plan
- Focus foremost on improving functional status
- Ask the patient to list concrete goals of treatment
- Require patient participation in all facets of the treatment plan
Core Principles

- Develop plan of care and set goals using the biopsychosocial model (Grade A) *
  - Physical rehabilitation with functional goals (Grade A)
  - Psychosocial management with functional goals (Grade A)
  - Big 3: Mood, Sleep, Activity

Other

- Pharmacologic
- Interventional
- Complementary
State Medical Board Criteria

- **Treatment Plan**
  - Must be written
  - Should state **objectives** that will be used to determine treatment success
  - Should indicate if any **further diagnostic evaluations** or **other treatments** are planned
  - Individualized
  - May include other treatment modalities, depending on the etiology of the pain
Level I Management

- Treat Underlying Cause, Screen
- Physical Rehabilitation (Grade A)
- Behavioral Management (Grade A)*
- Drug Therapy (Grade C)
- Interventional (Grade C)
Cognitive Behavioral Therapy

- Validate Pain & Correct Flawed Thinking
- Reassure
  - Not life-threatening
  - Cannot make worse by resuming normal activities (Educate)
- Set Parameters
  - Never emergency
  - No need for rapid changes or breakthrough medications
  - Goal is not pain free but to live with pain and improving function

RETURN
Level 1: Neuropathic Pain

- Treat underlying cause
- Medication *
- Physical rehabilitation
- Behavioral techniques
Neuropathic Pain Medications

- **First Line**
  - Gabapentin 100-300mg TID
    - Increase by 300-400mg q 5-7d to 3600mg daily divided 3-4 doses (fair trial= 1800mg/day for 2-3 weeks)
  - TCAs 10-25mg qhs
    - Increase 10-25mg every 7d to 100-150mg qhs; titration can continue following blood levels (stay below 500ng/ml) and EKG
  - Tramadol 50mg qd or BID
    - Increase by 50mg every 5-7d to max 100mg QID (fair trial= scheduled for >2-4 weeks)
Neuropathic Pain Medications

- Topical Agents
  - Lidoderm 5%
    - Apply 12 hours a day
  - Capsaicin Cream 0.075%
    - Apply TID or QID
    - May be considered first line or adjuvant
Treatment Recommendations

- **Second Line**
  - Lamotrigine 25mg qd or BID
    - After 2 wk, increase by 25mg q wk to 100-200mg BID
  - Carbamazepine 100-200mg qd or BID
    - Increase by 100-200mg q wk to 600mg qd in divided doses. Titration can continue following blood levels
  - Bupropion SR 150mg qd
    - After 1 wk, increase to 150mg BID
  - Venlafaxine XR 75mg qd
    - Increase by 75mg q wk to 150-225mg qd
  - Duloxetine 30mg qd
    - Increase to 60mg after 1 wk, max 120mg
  - Pregabalin 150mg BID or TID (PHD) TID (DPN)
    - Increase to 300mg in 1 wk to 600mg in 2-4 wks
    - Stop if no improvement in pain after 1 wk
  - Opiates short acting QID PM
    - After 1-2 weeks replace with longer-acting agent qd or BID

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Neuropathic Pain Interventional

- Epidural Steroid Injection
- Intrathecal Adenosine
- Selective Nerve Root Injection
- Discography
- Sympathetic plexus block
- Intradiscal Electrothermal Therapy (IDET)
- Spinal Cord Stimulation
- Neuroablation

RETURN
Level 1: Inflammatory Pain

- Diagnose and Treat Underlying Condition
  - ESR, RF, ANA
- Physical Rehabilitation
- Behavioral Management
- Drug Therapy
Level 1: Myofascial Pain

- Screen for serious medical pathology, psychological and social factors
- Cognitive Behavioral Therapy:
  - depression/stress, relaxation, chemical dependency
- Physical Rehabilitation:
  - fitness, body mechanics, modalities, aquatic therapy
- Drug therapy:
  - opiate rarely indicated!!!
- Intervenotional:
  - trigger point injections
Level 1: Mechanical/Compressive Pain

- Diagnose and Treat the underlying condition
- Physical Rehabilitation
- Behavioral Management
- Drug Therapy
Side Note: Opiates

- Is the patient a good candidate? *
- Remind patient that this is a trial.
  - Goal is to improve function, not pain
  - Have an exit strategy
- Encourage patient to inform you if they start using the medication to get high or relieve stress.
- Educate patient on risks and benefits *
- Educate patient on the conditions *
Side Note: Opiates

- Opioid Risk Tool
- Screener and Opioid Assessment for Patient with Pain-Revised
- DIRE Score
- Addiction Behaviors Checklist (ABC)
- Current Opioid Misuse Measure (COMM)
- RETURN
Opiate Risks

- Addiction
- Probability of dependence and withdrawal
- Sedation
- Decreased Respiration
- Constipation
- Nausea/Vomiting
- Risk of impairment
- Pregnancy Risk
- Hormone impairment
  - Depression, Disturbed sleep cycles, Decreased sex drive, Fatigue

RETURN
Step 3: Pain Contract & Informed Consent

- One provider and One pharmacy
- Taking steps to guarantee protection/security of prescriptions
- Providing urine or serum samples when the practice requests
- Being available for additional unscheduled visits, which may include pill counts
- Agreeing to follow policies of practice (keeping appointments, no seeking early refills, etc)
- Acknowledging this is a trial only and may be discontinued if treatment goals are not met.
Informed Consent and Agreement for Treatment

- Discuss the risks and benefits of the use of controlled substances *
- Patient should agree to receive prescriptions from 1 physician and 1 pharmacy whenever possible *
- For a person at high risk for medication abuse or with a history of substance abuse, a written agreement between the physician and the patient should include:
  - Urine/Serum medication level screening
  - Number and frequency of all prescription refills
  - Reasons for which drug therapy may be discontinued (eg. Violation of agreement)
Side Note: Opiates

SHORT ACTING OPIATES

LONG ACTING OPIATES
Side Note: Opiates

- What to do if pain increasing and medication not working?
  - Screen for new diagnosis/condition
  - Review the Big 3
  - Are goals being met?
  - Consider:
    - Titration
    - Opioid Rotation
    - Opioid Vacation
    - Opioid Withdrawal
Withdrawing Opiates

- Treatment goals not achieved after several dose adjustments over several weeks and/or after opioid rotation
- Side effects not acceptable
- Pain improved by surgery or other intervention
- Patient prefers to discontinue
- Patient nonadherence
Step 4: Follow Up

- 4 A’s
  - Analgesia
  - Adverse Drug Reactions
  - Activity
  - Adherence

- Adjuncts
- Aberrant behavior
Step 4: Follow Up

- 6 month review
  - Update Comprehensive Evaluation
  - Update Care Plan
  - Big 3: Mood, Sleep, Activity
Periodic Review

- The **course of pain treatment** and any **new information** about the etiology of the pain...
- Continuation or modification of controlled substances for pain management therapy depends on **progress toward treatment objectives**
- Satisfactory response may be indicated by the patient’s decreased pain, increased level of function, or improved quality of life
- Objective evidence of improved or diminished function should be monitored...
- If the patient’s progress is unsatisfactory, assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities
Level II Management (Grade C)

- Referral to interdisciplinary team and pain specialist
- Surgery
- Palliative interventions (nucleoplasty, spinal cord stimulation*, intrathecal medication delivery)
  - Neuropathic Pain Interventional *
- Multidisciplinary pain rehabilitation
Consultation

- **Referral should be made as necessary** for additional evaluation and treatment in order to achieve treatment objectives
- Special attention should be given to those at risk for medication misuse, abuse, or diversion
- Patients with a **history of substance abuse** or with a **comorbid psychiatric disorder** may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients
State Medical Board Criteria

- Medical Records
  - Keep accurate and complete records, which include:
    - Medical history and physical examination
    - Diagnostic, therapeutic, and laboratory results
    - Evaluations and consultations
    - Treatment objectives
    - Record of discussion of risks and benefits
    - Informed consent
    - Treatments
    - Medications (including date, type, dosage, and quantity prescribed)
    - Instructions and agreements
    - Periodic reviews

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State Medical Board Criteria

- Compliance with Controlled Substance Laws and Regulations
  - The physician must be licensed in the state and comply with applicable federal and state regulations
  - Physicians are referred to the Physicians Manual of the US DEA and any relevant documents issued by the state medical board for specific rules governing controlled substances as well as applicable state regulations
Implanted Nerve Stimulator

- **Indications**
  - Complex Regional Pain Syndrome
  - Failed Back Surgery Syndrome
  - Neuropathic Pain from peripheral nerve damage?
  - Pain secondary to peripheral vascular disease?
  - Refractory angina?
  - Brachial plexopathy?
  - Chronic Low Back Pain?
  - Chronic Lower Extremity Pain?

RETURN
Urine Drug Screening

- Automatic random selection process *
- If high risk
  - Consider increasing frequency
  - Consider adding pill counts
  - Shorten prescriptions
Urine Drug Screening

- All current recommendations are Class C:
  - Screen with Immunoassay
  - Reflex test with gas chromatography
  - Extended opiate panel needed to screen for all narcotics, including tramadol
  - Appropriate collection techniques can decrease the risk of tampering
Amphetamines

- Duration: 2-3 days
- False Positive
  - Amantadine (Symmetrel), bupropion (Wellbutrin), chlorpromazine, desipramine (Norpramin), fluoxetine (Prozac), L-methamphetamine (*in nasal decongestants*), labetalol (Normodyne), methylphenidate (Ritalin), phentermine, phenylephrine, phenylpropanolamine, promethazine (Phenergan), pseudoephedrine, ranitidine (Zantac), thioridazine, trazodone (Desyrel)
  - * Current immunoassays have corrected for L-methamphetamine
Benzodiazepines

- **Duration:** 3 days short-acting - 30 days long-acting
- **False Positives:**
  - Oxaprozin (Daypro), sertraline (Zoloft)
Cocaine

- **Duration:** 2-3 days occasional use, 6 days with chronic use
- **False Positive:**
  - Topical anesthetics containing cocaine
THC

- Duration: 3 days single use, 5-7 days 4x/wk use, 10-15 days daily use, >30 days with long-term heavy use
- False Positives:
  - Dronabinol (Marinol), nonsteroidal anti-inflammatory drugs§, proton pump inhibitors (pantoprazole[Protonix])
  - § notably ibuprofen, naproxen, sulindac

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Signs of Tampering

- **General:**
  - Temperature $< 90^\circ$F or $>100^\circ$F
  - Unusual appearance (e.g., bubbly, cloudy, clear, dark)

- **Adulterated**
  - Nitrite concentration $>500$ mg per dL (4.2 mmol per L)
  - Urine pH $< 3$ or $\geq 11$

- **Diluted**
  - Creatinine concentration $\geq 2.0$ mg per dL but $< 20$ mg per dL (176.8 mmol per L)
  - Specific gravity $> 1.0010$ but $< 1.0030$

- **Substituted**
  - Creatinine concentration $< 2.0$ mg per dL (17.68 mmol per L)
  - Specific gravity $\leq 1.0010$ or $\geq 1.0200$
Case 1

- 55 y/o male with chronic low back pain. In the past several months his focal back pain has intensified, absent any radicular symptoms, leading him to accelerate his use of pain medications. He presents to the clinic in pain requesting early refills of his pain medications.
Case 1: Management

- This is not an emergency!
  - Assess Risk of Withdrawal
- Screen for new pathology
- Review Plan/Goals
  - Depression?
  - Sleep?
  - Activity?
- Review Contract
- Document
- Refill prescription on regular schedule
  - Pseudoaddiction?
  - Tolerance?
  - Decrease short-acting use and increase long-acting
Case 2

50 y/o female is new to your clinic with complaints of neck, back, hip, knee, hands, and forearm pain for several years. Patient describes pain as burning, stabbing, radiating, soreness, tightness. Patient has tried chiropractic, acupuncture, and massage. Patient has been unable to work for 3 1/2 years and is applying for disability.
Case 2: Assessment

- General H&P
  - Psychiatric Illness? .....Screen
  - Substance Abuse? .....Screen
- Pain H&P
  - Multidimensional Test
  - Functional Assessment
- Obtain Records
- Determine Biological Mechanism of Pain
- Develop Relationship
  - Validate Pain
  - Negotiate a Treatment Plan with Goals

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Case 2: Management

- Develop a comprehensive plan
- Level I Management
  - Myofascial Pain
  - Opiates?
    - D.I.R.E.
    - Contract
- Level II Management
  - Referral?
Resources


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