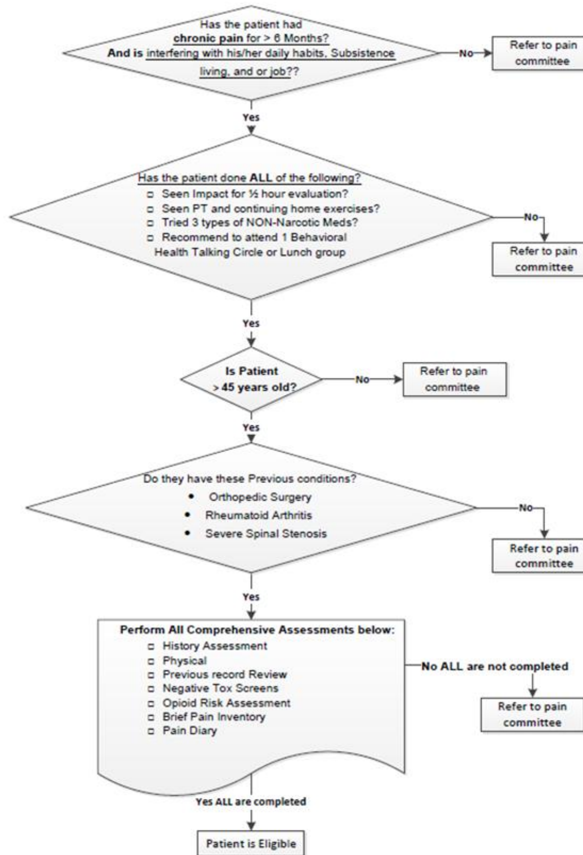
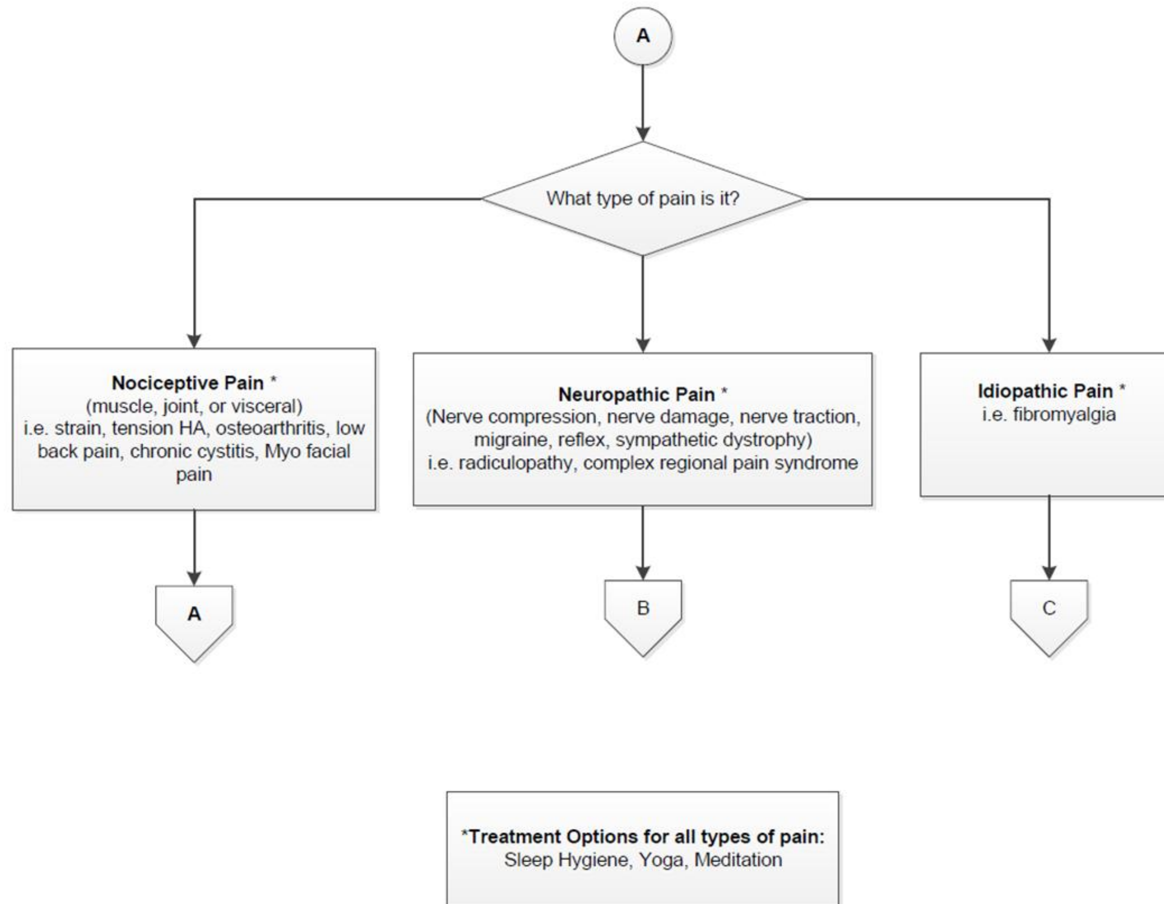
Brief Overview Chronic Pain

Elizabeth Roll / Nick Flickingner

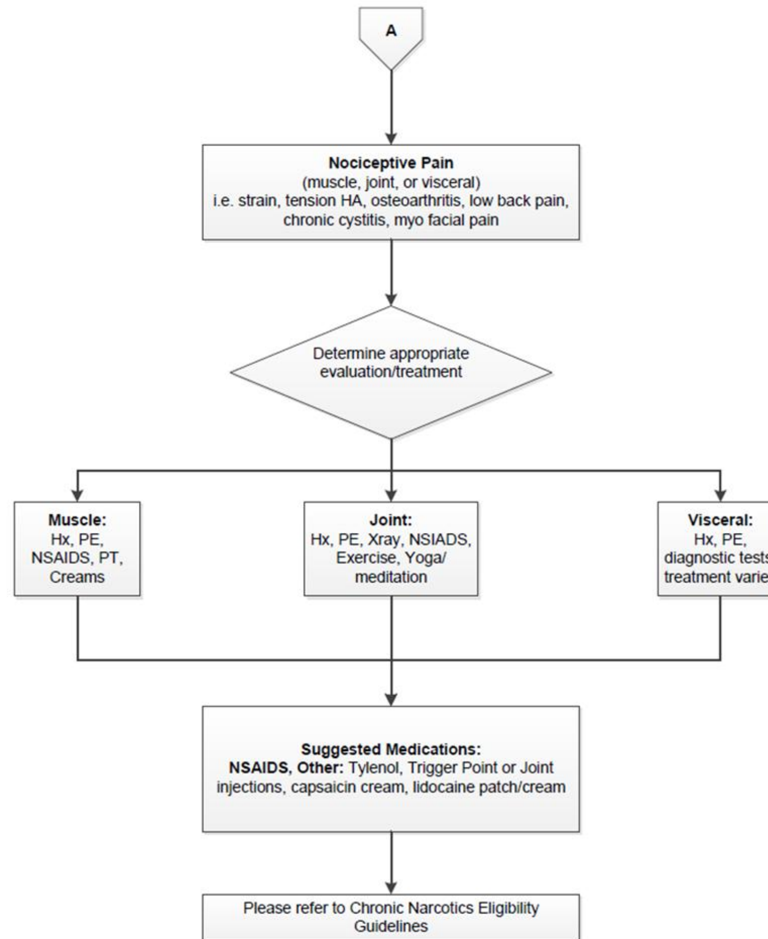
Chronic Pain Narcotic Eligibility

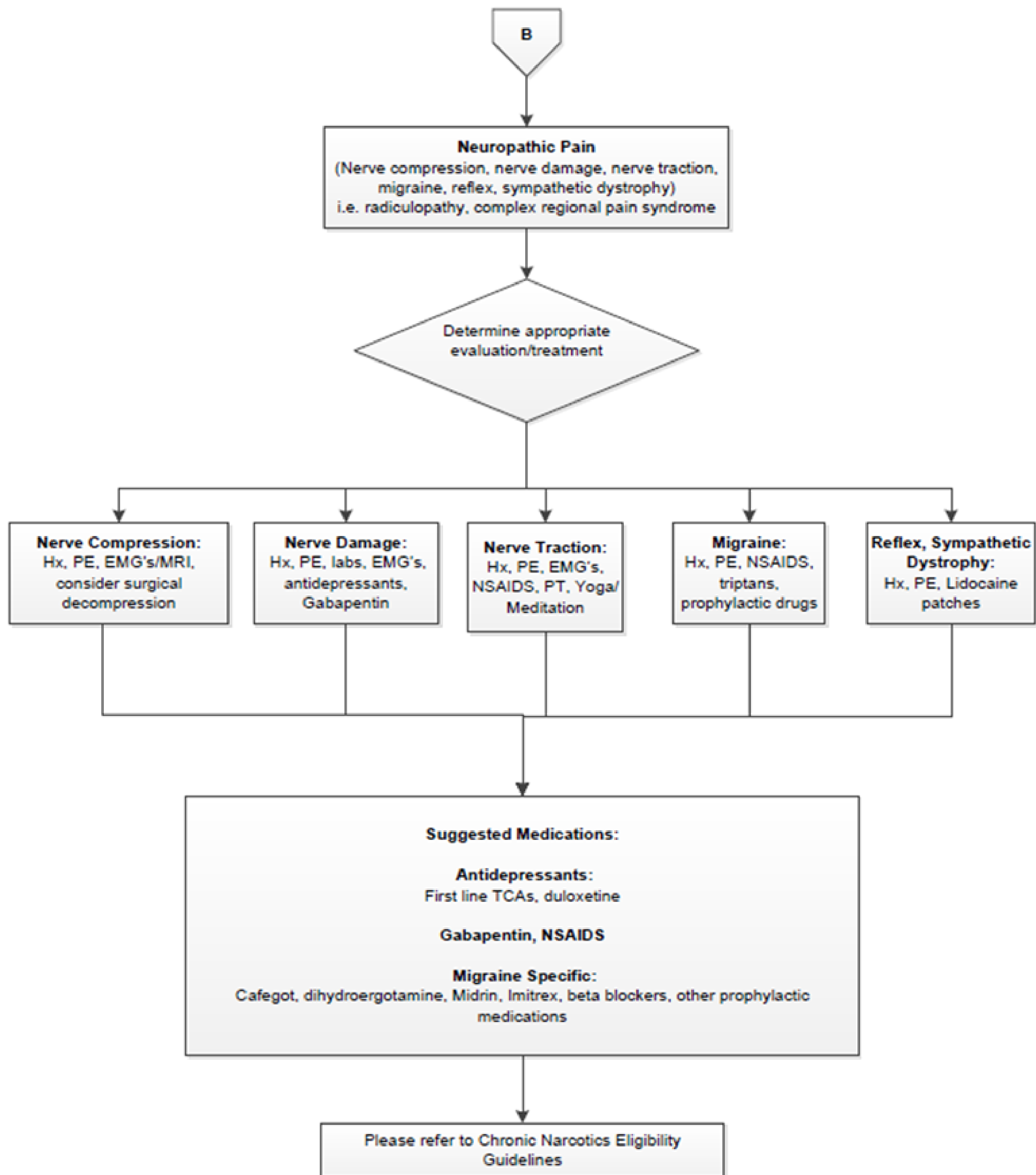


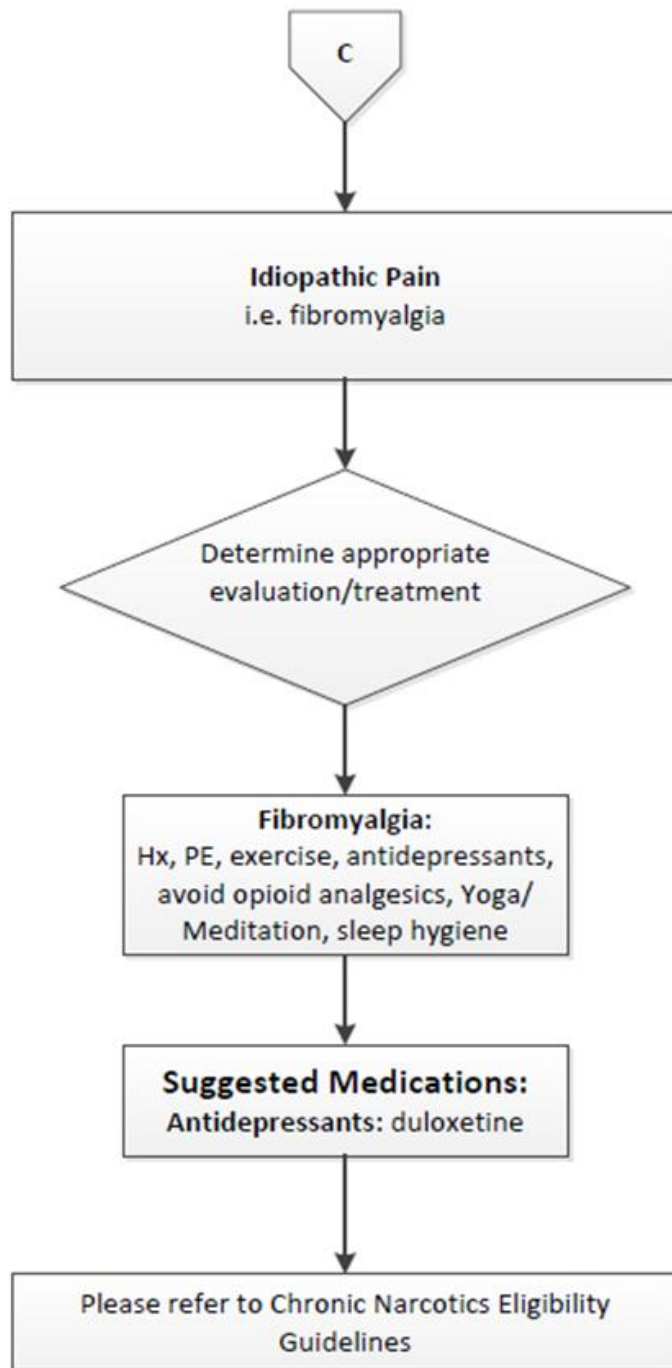
Definitions of Pain

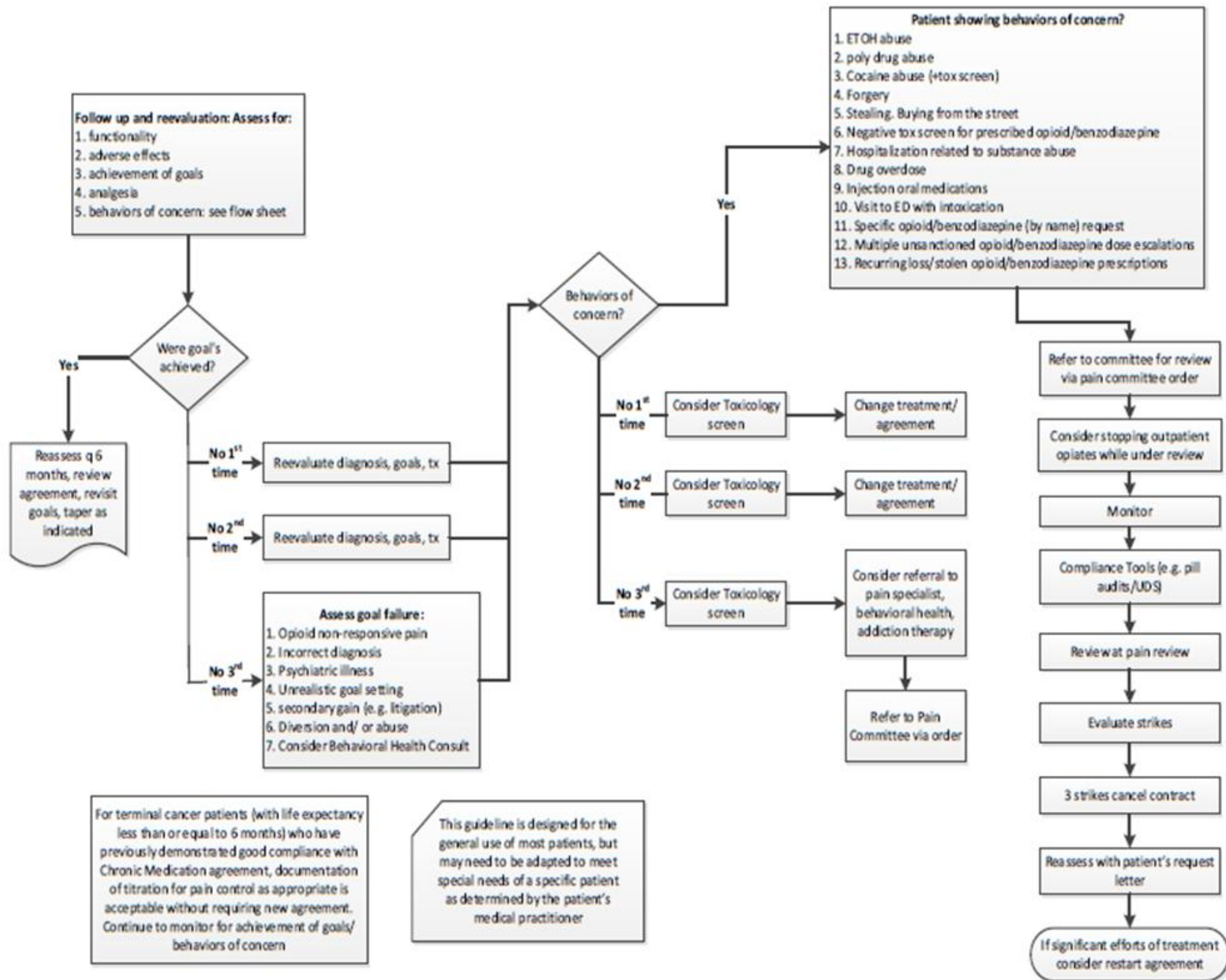


Nocioceptive Pain




B
Neuropathic Pain
(Nerve compression, nerve damage, nerve traction, migraine, reflex, sympathetic dystrophy)
i.e. radiculopathy, complex regional pain syndrome
Determine appropriate evaluation/treatment
Nerve Compression:
Hx, PE, EMG's/MRI, consider surgical decompression
Nerve Damage:
Hx, PE, labs, EMG's, antidepressants, Gabapentin
Nerve Traction:
Hx, PE, EMG's, NSAIDS, PT, Yoga/ Meditation
Migraine:
Hx, PE, NSAIDS, triptans, prophylactic drugs
Reflex, Sympathetic Dystrophy:
Hx, PE, Lidocaine patches
Suggested Medications:
Antidepressants:
First line TCAs, duloxetine
Gabapentin, NSAIDS
Migraine Specific:
Cafegot, dihydroergotamine, Midrin, Imitrex, beta blockers, other prophylactic medications
Please refer to Chronic Narcotics Eligibility Guidelines


C
Idiopathic Pain
i.e. fibromyalgia
Determine appropriate evaluation/treatment
Fibromyalgia:
Hx, PE, exercise, antidepressants, avoid opioid analgesics, Yoga/ Meditation, sleep hygiene
Suggested Medications:
Antidepressants: duloxetine
Please refer to Chronic Narcotics Eligibility Guidelines


Follow up and reevaluation: Assess for:
1. functionality
2. adverse effects
3. achievement of goals
4. analgesia
5. behaviors of concern: see flow sheet
Were goal's achieved?
Yes
Reassess q 6 months, review agreement, revisit goals, taper as indicated
No 1st time
Reevaluate diagnosis, goals, tx
No 2nd time
Reevaluate diagnosis, goals, tx
No 3rd time
Assess goal failure:
1. Opioid non-responsive pain
2. Incorrect diagnosis
3. Psychiatric illness
4. Unrealistic goal setting
5. secondary gain (e.g. litigation)
6. Diversion and/ or abuse
7. Consider Behavioral Health Consult
Behaviors of concern?
Yes
Patient showing behaviors of concern?
1. ETOH abuse
2. poly drug abuse
3. Cocaine abuse (+tox screen)
4. Forgery
5. Stealing. Buying from the street
6. Negative tox screen for prescribed opioid/benzodiazepine
7. Hospitalization related to substance abuse
8. Drug overdose
9. Injection oral medications
10. Visit to ED with intoxication
11. Specific opioid/benzodiazepine (by name) request
12. Multiple unsanctioned opioid/benzodiazepine dose escalations
13. Recurring loss/ stolen opioid/benzodiazepine prescriptions
No 1st time
Consider Toxicology screen
Change treatment/ agreement
No 2nd time
Consider Toxicology screen
Change treatment/ agreement
No 3rd time
Consider Toxicology screen
Consider referral to pain specialist, behavioral health, addiction therapy
Refer to Pain Committee via order
Refer to committee for review via pain committee order
Consider stopping outpatient opiates while under review
Monitor
Compliance Tools (e.g. pill audits/UDS)
Review at pain review
Evaluate strikes
3 strikes cancel contract
Reassess with patient's request letter
If significant efforts of treatment consider restart agreement
For terminal cancer patients (with life expectancy less than or equal to 6 months) who have previously demonstrated good compliance with Chronic Medication agreement, documentation of titration for pain control as appropriate is acceptable without requiring new agreement. Continue to monitor for achievement of goals/ behaviors of concern
This guideline is designed for the general use of most patients, but may need to be adapted to meet special needs of a specific patient as determined by the patient's medical practitioner

Initial non narcotic pain Treatments

- **Identify and treat specific local pain generators, if present**
- Cutaneous stimulators (e.g., transcutaneous electrical nerve stimulation) – can be obtained by PT.
- Local treatment (e.g., physical therapy, manipulation, massage, heat, acupuncture)
- Joint Injections
- Topical anesthetics (e.g., lidocaine ointment or patches)
- Refer to Comprehensive Pain Clinic run by the ANMC-South Central Foundation Pain Anesthesiologist for Nerve Blocks.

Non Narcotic Life Changes to affect pain

- **Promote healthy behaviors**
- **Physical activity**
- **Weight control**
- **Restore sleep**
  - Depending on coexisting problems, useful agents may include trazodone,
  - tricyclic antidepressants,
  - gabapentin (Neurontin), pregabalin (Lyrica),
  - mirtazapine (Remeron),
  - melatonin
  - quetiapine (Seroquel); use of benzodiazepines or their analogs should be avoided because of tolerance and abuse potential

Start adjuvant pain medications - Antidepressants

- Tricyclic antidepressants are indicated for neuropathic pain;
  - nortriptyline (Pamelor),
  - desipramine (Norpramin),
  - amitriptyline, and
  - doxepin are also useful for localized or generalized pain with coexisting headache, depression, panic disorder, or tobacco addiction
- Serotonin-norepinephrine reuptake inhibitors are indicated for neuropathic pain;
  - duloxetine (Cymbalta) and milnacipran (Savella) are most effective for localized or generalized pain with depression or anxiety,
  - venlafaxine (Effexor) less so; doses for treatment of pain tend to be higher than those for depression

Start adjuvant pain medications (listed in order of recommended treatments)

- Pregabalin is approved by the U.S. Food and Drug Administration for neuropathic pain and fibromyalgia;
- Gabapentin has similar effectiveness, is available generically, and is more widely used, but it is sedating, and dosing is complex; may be synergistic when combined with tricyclic antidepressants
- Anticonvulsants; carbamazepine (Tegretol) is a first-line agent for trigeminal neuralgia, but third-line (with oxcarbazepine [Trileptal] and lamotrigine [Lamictal]) for other neuropathic pain
- Migraine chemoprophylaxis
  - beta blockers,
  - calcium channel blockers,
  - tricyclic antidepressants,
  - topiramate [Topamax])

Treat comorbid psychiatric illness

- Use of pharmacologic and psychotherapeutic measures is essential for improvement of symptoms and function
- Commonly associated disorders include
  - anxiety,
  - depression,
  - posttraumatic stress disorder in persons who have experienced physical, sexual, or emotional trauma;
  - treatment should include psychotherapy, biofeedback, mindfulness training, posttraumatic stress disorder therapy, relationship counseling, social and financial counseling, and substance abuse counseling (BEHAVIORAL HEALTH REFERRAL)

Trial of opioid therapy (initiation or continuation)

Candidates for starting Opioids –

- **Patients over 45**
- **Patients with a Opioid Risk Tool 3 or under**
- **Patients who have higher PEG scores – see the following/**
- **Patients with chronic pain – over 6 months- Patients with no red flags from their Prescription Drug Monitoring**

Web link to the Prescription Drug Monitoring Program

- https://alaska.pmpaware.net/login/?

PEG

- What number best describes your Pain on Average?
- What number best describes how Pain interfered with your enjoyment of life
- What number best describes how Pain interfered with your General Activity

- After giving someone narcotic medication – repeat this 2-4 weeks later- if not seeing a

Example of Opioid Risk Tool

Table 2. Opioid Risk Tool

Item	*Score (females)*	*Score (males)*
Family history of substance abuse		
Alcohol	1	3
Illicit drugs	2	3
Prescription drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illicit drugs	4	4
Prescription drugs	5	5
Age 16 to 45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological condition		
ADHD, obsessive-compulsive disorder, bipolar disorder, schizophrenia	2	2
Depression	1	1
Total score	____	____

NOTE: *Score of 0 to 3 = low risk; 4 to 7 = moderate risk; 8 or more = high risk.*

ADHD = attention-deficit/hyperactivity disorder.

Adapted with permission from Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. *2005;6(6):433.*

Assessment of Pain patient- After several visits focusing on the previous non narcotic Tx.

- Detailed history with review of records/ Prescription Data Base
- Review PT records –
- Review Behavioral Health Records/IMPACT records
- Need to assess Opioid Dependence
  - Opioid Risk tool
  - SOAPP /Brief Pain Inventory – IMPACT
  - Chronic Pain Questionaire
- Urine Tox screen/Gas Chromatography – and looking at what previous urine screens have been

Use the UDS regularily

- CDC Recommendation 10:
  - When prescribing opioids for chronic pain, clinicians should use UDS before starting opioid therapy and consider UDS at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs
  - Category B

Recommended Prescriptions

- Use long acting medications – if on at least 4-6 short term tabs a day.
  - MS Contin XR
  - Oxycontin

  Could use a short amount of breakthrough for the first month while titrating dose.

  Follow up these patients in 2-4 weeks.

Check list- prior to Narcotic Dispensation

- Signed Pain agreement/ Signed informed Consent
- Urine Tox screen
- Has already seen Physical Therapy and IMPACT
- Filled out the Chronic Pain Questionaire
- Filled out the Referral to ANMC Comprehensive Pain Clinic- Dr. Weidner
- Give education about Meditation, and Pain agreement education on RAVEN
- Discuss side effects and how to get refills- call Case Manager.
- See patient back if possible in 2-4 weeks for follow up.

Follow up Visit for Chronic Pain

- Urine Tox screen
- Document in your note what medications they took that day.
- Address the 4 As – see next slide.
- Address function – repeat the Pain Intensity and Interference questionaire
  - Pain on Average
  - Pain effects on Enjoyment of Life
  - Pain Effects on General Activity

4 A's of Chronic Pain Evaluation

- Analgesia – How is your pain?
- Activities of Daily Living- with these pain meds are you able to wash Dishes …
- Adverse side effects- Constipation, sedation?
- Aberrant Drug Taking Behavior – do you ever use your pills for sleep, or if you have a fight with your partner?

Example of HPI –Chronic Pain

- Pt is a 65 year old female with a hx of chronic back pain. She is currently on Oxycontin 30 mg BID and she took it this morning. (Analgesia)
- With this pain medication she is now able to sweep/do the dishes and garden her vegetables. (Activities of Daily Living)
- She does have some constipation that she is using miralax to help. (Adverse side effects)
- She denies using Oxycontin to help her sleep or to take at times of emotional upset – she only uses it daily for pain . (Aberrant Drug taking Behavior)

Summary on Treating Pain

- Evaluate pt for chronic pain – over several appts – using non-narcotic tx intially
- Prior to starting Narcotics – recommend BH and PT evaluation- review OPT/ PEG/ Function
- Always get urine tox screens prior to starting pain agreements. Get a urine every visit
- Use Brief Opioid risk assessment prior to starting a pain contract and do not use opioids if scores above 3.
- When starting narcotics use Start with short terms- Can use short terms.

Summary on Treating Pain

- Guideline is to encourage more cautious prescribing and to reduce the number of patients exposed to opioids
- Not an excuse to dismiss these patients
- Identify and treat the pain
- Focus on functional goals…set realistic goals
- Evaluate and discuss benefits and risks
- Start low and go slow
- Refer for >90 MME/day

Summary

- 3-7 days for acute pain
- Frequent follow up
- Avoid concurrent benzodiazepines
- Naloxone for everyone
- Run through PDMP
- Treat OUD

Next STeps

- Making interdisciplinary pain committee rounds a priority
  - Review all 600-700 pain contracts
- Letter from YKHC leadership addressing opioid epidemic
- Chasing the dragon playing out in the waiting room
- Apply for your PDMP
- Consider obtaining your buprenorphine waiver