

SGIM National Meeting: SESSION WG05
Saturday May 14th, 2005
WORKSHOP ABSTRACT

Session Title: Teaching Chronic Pain Management to Resident Physicians

Category: Medical Education

Session Coordinator:

Ian Chen, MD, Eastern Virginia Medical School (chenia@evms.edu)

Additional Faculty:

Jaishree Hariharan, MD, Medical College of Wisconsin
Michael Picchioni, MD, Tufts University School of Medicine
Jennifer Gibson, MD, Oregon Health and Science University
Mukta Panda, MD, University of Tennessee-Chattanooga

Registration Size: 40

Sponsor: Pain Medicine Interest Group

Summary:

Chronic pain is a major health issue worldwide that has a profound effect on quality of life. Although the treatment of pain and suffering has been a high priority, it is well established that pain is not optimally treated. Many barriers exist to the optimal treatment of chronic pain, and targeting physician attitudes, knowledge and skills is an important part of overcoming these barriers. Teaching physicians in training how to manage chronic pain and do it well adds additional complexities. We will discuss the barriers in teaching chronic pain management to resident physicians and the different strategies to overcome these barriers. The faculty will share their experiences in developing teaching programs in pain management, and will provide tools to enhance the practice and teaching of pain management at participants home institutions. [Word Count 131: Limit 150]

Learning Objectives:

After completing this workshop, participants will be able to:


1. Understand the need for curriculum development regarding chronic pain management
2. Describe the challenges that occur in trying to teach pain management to resident physicians
3. Learn strategies to effectively teach pain management in the inpatient and outpatient settings
4. Promote the exchange of ideas and perspectives through the sharing of experiences in teaching pain management
5. Address specific challenges in pain management such as physician dissatisfaction and complex or demanding patients

Program Schedule/Agenda:

- | | |
|--------------|---|
| 5 minutes | Introduction |
| 5 minutes | Presentation: "Pain Management: The Need to Teach and the Barriers We Face" |
| (45 minutes) | Teaching Pain Management to Residents |
| | <u>Theme #1: The Curriculum</u> |
| 15 minutes | Small Group Exercise #1: Knowledge and skills in the inpatient/outpatient settings |
| | <u>Theme #2: The Tools</u> |
| 30 minutes | Small Group Exercise #2: Strategies in teaching pain management |
| 15 minutes | Large Group Discussion: Experiences in developing pain management curriculum with Question/Answer |
| 20 minutes | Large Group Discussion: Addressing specific challenges in teaching pain management |
| | a. Resident affect and satisfaction |
| | b. How to handle "The Difficult Patient" |

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CHEN – INTRO PPT


Slide 1



**Teaching Chronic Pain
Management to Resident Physicians**

Society of General Internal Medicine
National Meeting – New Orleans, LA
Workshop G5
Saturday, May 14th, 2005

Slide 2




Special Thanks

- Session Coordinator:
 - Ian Chen, M.D. – Eastern Virginia Medical School

- Workshop Faculty:
 - Jaishree Hariharan, M.D. – Med College of Wisconsin
 - Michael Picchioni, M.D. – Tufts University
 - Jennifer Gibson, M.D. – Legacy Health System
 - Mukta Panda, M.D. – University of Tennessee, Chattanooga

- Co-sponsor: Pain Medicine Interest Group

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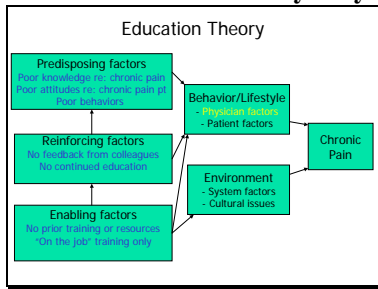


Schedule

- Introduction, "The Need for Curriculum Development" – Dr. Chen
- Large Group Exercise, "The Challenges and Needs of Teaching Resident Physicians" – Dr. Picchioni
- Large Group Presentation, "Tools for Teaching"
- Small Group Exercise – Using the Tools in Small Group Cases
- Large Group Discussion –
 - Experiences
 - Resident Affect and Satisfaction
 - "The Difficult Patient"

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? Poor Knowledge, Attitudes, Behaviors and Skills

- 22% of primary care patients report chronic pain, economic loss of up to \$61 billion/year
- Primary care physicians have lack of knowledge, training
- "Rely on experience and guesswork"
- Physicians: Low expectations and low satisfaction

Gurje O. Persistent pain and well being. JAMA. 1998;280:147-151.
 Stewart W. Lost productive time. JAMA. 2003;290:2443-2454.
 Damer J. More Training Needed in Chronic Care. Acad Med. 2004;79:541-8.
 Olson Y. Chronic Pain and Narcotics. JGIM. 2002;17:238-240.
 Gajchen M. Chronic Pain. J Amer Board of Fam Pract. 2001;14:211-8.
 Morley-Foster PK. Attitudes toward opioid use. Pain Res Manag. 2003;189-94.
 Green CB. Pain Med. 2001;2:237-27.

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? Poor Knowledge, Attitudes, Behaviors and Skills

Adequacy of Formal Education (n=228)**

Category	Percentage
Very met	4%
Adequate	21%
Somewhat	39%
Not met	36%

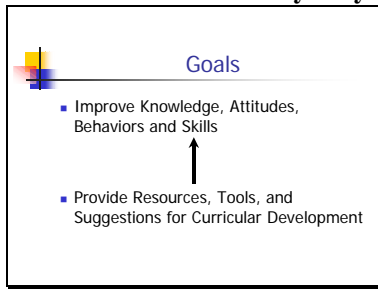
Physician Perceptions (n=572)**

Statement	% Agreeing
Benefit from More Education	87
Had More than a Single Lecture	65
No patients satisfied with my care	26
Confident in my abilities to treat	27

* Informal survey - Healthcare providers, Norfolk, VA. Lucasio, M. 2003
 ** Panda et al. Physicians Attitudes and Beliefs. JGIM. 2003;18(5):251.

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PICCHIONI - POWERPOINT

Slide 1

The Pain Curriculum
Content and Process

SGIM 2005

Michael Picchioni, MD
Division of General Medicine/Geriatrics
Baystate Medical Center
Tufts University School of Medicine

Slide 2

The Challenges

- Residents are poorly prepared
- Faculty are poorly prepared
- Chronic pain is inherently challenging
 - Poorly understood
 - Poor response to treatment
 - Great deal of psychosocial overlay
 - Substance abuse issues
 - Regulatory issues

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More Challenges

- Resident Clinic
 - Multiple part time providers
 - Very challenging patient population
- Inpatient wards
 - Service patients "unknown"
 - Often very challenging as well

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Support Systems

- Acknowledge we all face systematic barriers
- Acknowledge the need for systems that support chronic pain management
- Focus here will be on the curriculum despite these barriers

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Curriculum: Content

- Knowledge
- Skills
- Attitudes and Behaviors

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Knowledge

- Pathophysiology of pain
- Chronic pain vs. acute pain
- Common pain syndromes
- Pain assessment
- Non-opioid analgesics
- Opioid analgesics
- Constipation

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More Knowledge

- Adjuvants
- Non-pharmacologic treatments
- Interventions
- Mental Health
- Substance Abuse
- Referral sources

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Skills

- Communication
- Documentation
- Pain Assessment
 - Interpreting subjective complaints
- Counseling skills
- Relationship skills
- Setting limits
- Teamwork

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Attitudes/Behaviors

- Compassion
- Positive Regard
- Avoiding Judgment
- Professional Responsibility
- Advocacy

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Curriculum: Process

- Knowledge
 - Didactics
 - References

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Curriculum: Process

- Skills
 - Standardized patients
 - Role play
 - Observation/feedback
 - Demonstration

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Curriculum: Process

- Attitudes
 - Small group interactive sessions
 - Observation/feedback
 - Video-tape review

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Curriculum: Process

- Bolus
- Drip

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Curriculum: Process

- Faculty Development
 - Need a champion of the cause
 - Others must be on board for success
 - Generally interested in learning more

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EXAMPLE TOOLS FOR CURRICULUM

- 1) Pain Management Foldout**
- 2) Example: Narcotic Contracts (3)**
- 3) Example: Question Bank**
- 4) Example: Case studies of Opioids in Chronic Non-Malignant Pain**
- 5) References and Articles**
- 6) Miscellaneous**

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NON OPIOID FORMULATIONS / STRENGTHS (avoid NSAIDs in elderly, renal impairment, GI bleed risk)

Drug	Strengths	Duration of Effect	Dosing Guideline*	* Maximum dai
Acetaminophen	325mg, 500mg Elixir 160mg/5ml Supp 325,650	4 hours	650-1000mg q 4 or 6 hr	Max 4gm/24hr
Aspirin	81mg, 325mg, 500mg Supp 120,200,300,600	4-6 hours	325-650mg q 4 hr	Max 4gm/24hr
Naproxen	250mg, 375mg, 550mg	7 hours	250-550mg q 6 or 8 hr	Max 1500mg/24hr
Ibuprofen	200, 400, 600, 800mg Elixir 100mg/5ml	4-6 hours	200-800 q 6 or 8 hr	Max 3200mg/24hr
Ketorolac (Toradol)	10mg tab, 30mg/ml injection, 60mg/2ml	5-6 hr for oral, 4-6 hr for injection	Oral: 10mg q 4 or 6 hr Max 40mg/24hr IV, IM: < >65yo, renal impairment , <50kg: 15mg q 6 hr Max	
Celecoxib (Celebrex)	100mg, 200mg, 400mg	11 hours	100mg po bid	Max 400mg/24hr Liver
Propoxyphene (Darvon)	65mg, 100mg (Darvocet or Darvon Compound)	4-6 hours	65mg q 4 hr	Max 390mg/24hr
Ultram	50mg (Ultracet 325/37.5)	4-6 hours	PO: 50mg po q6	Max: 400mg/d Liver: m

OPIOID FORMULATIONS / STRENGTHS

Drug	Short Acting (mg)	Long Acting (mg)	Dosing Guideline*
Morphine	Tab s 15, 30mg Caps 15, 30mg Oral Solution 10mg/5ml; 20mg/ml Supp 5, 10, 20, 30 mg IV 2, 4, 8, 10mg/ml	MS Contin (15, 30, 60, 100, 200 bid) Oramorph SR (15,30,60,100 bid) Kadian (20,30,50,60,100 SR bid) Avinza (30,60,90,120 SR qd)	IV: usual 2-10mg PR: 10- IR tab: 5-30mg q 4 hr Solutio MS Contin: initial 15mg q12hr (opioid naiv Renal dosing: CrCl 10-50, decrease 25%, C
Oxycodone	Tab s and Caps 5, 15, 30 mg Oral Solution 5mg/15ml Oxyfast 20mg/ml Roxicodone 5mg/ml, 20mg/ml	Oxycontin (10, 20, 40, 80, 160 bid)	IR: 5-15mg q 4 or 6 hr (opioid naive pt) 10-30mg q 4 hr (usual adult dose) Oxycontin: 10mg q 12hr (initial)
Hydromorphone (Dilaudid)	Tab s 2, 3, 4, 8 mg Oral Solution 1mg/ml Supp 3mg	Palladone (12, 16, 24, 32mg SR) opioid tolerant, caution liver/kid	IM, IV, SQ: 1-2mg q 4 or 6 hr (IV over 2-3; PO: 2-4mg q 4 or 6 hr PR: 3mg q
Codeine	Tab s 15, 30, 60mg Elixir 15mg/5ml		PO, SC, IM: 15-60mg q 4 hr Renal: 10-;
Fentanyl	Actiq transmucosal – opioid tolerant 200,400,600,800,1200,1600mcg	Transdermal Patch (mcg/hr) 25, 50, 75, 100	Dose according to preexisting opioid toleran patients. See page 2 for transdermal patch o
Methadone	5, 10, 40mg Elixir 5mg/5ml, 10mg/10ml	*Caution at > 100mg/d	PO: initial 2.5mg po q8

COMBINATION OPIOIDS

Drug	Formulation / Strength	Dosing Guideline*
Hydrocodone / acetaminophen	Tab s 5/325,5/500,7.5/325,7.5/500,10/325 Elixir 7.5/162 mg/5 ml (Hycopap, Maxidone, Lortab, Lorcet, Vicodin, Norco, Zydone)	5/325-10/325mg q 4 or 6 hr Max 4000
Oxycodone / acetaminophen	Tab s 5/325, 7.5/325, 7.5/500, 10/325, 10/650 Elixir 325/5/5ml (Endocet, Percocet, Roxicet, Tylox)	5/325-10/325mg q 6 hr Max 4000
Codeine/acetaminophen	Tab s 15/300 (#2), 30/300 (#3), 60/300 (#4) Elixir 12 /120 mg/5 ml	15/300-60/600 q 4 hr Max 4000 Elixir: 15ml q 4 hr (36/360mg)

* Dosing guidelines are a guide for therapy. Dosing range is listed. Initial dosing should be individualized. Please do not order pain medication as a ran

Oral and Parenteral Opioid Analgesic Equivalencies and Relative Potency of Opioids as Compared with Morphine

When converting from one opioid to another, you may use 50-75% of the equivalent dose. Allow for incomplete cross-tolerance between different opio
use prn dose to ensure effective analgesia for the first 24 hours). Avoid IM injection because of inconsistent absorption and patient discomfort.

Opioid Agonists	Parenteral (mg)	Oral (mg)	Duration of Effect
Morphine	10	30	3-7 hours
Oxycodone	NA	20-30	3-6 hours
Hydromorphone	1.5	7.5	4-6 hours
Meperidine	75	300	2-4 hours
Fentanyl	0.1	NA	1-2 hours
Codeine	130	200	2-4 hours
Hydrocodone	NA	20-30	4-6 hours
Methadone	5	10	6-8 hours

DOSE CONVERSION GUIDELINES

1. Calculate the total daily dose of all opioids used.
2. If the patient is taking more than one opioid, convert all agents to an equivalent dose of morphine.
3. Determine equivalent dose of new opioid.
4. Initiate new opioid at 1/2 of the calculated dose as tolerance is not complete from one opioid to another. Titrate up or down depending upon pain relief and development of side effects (such as sedation)
5. Provide for "rescue" doses. (Each rescue should be 10-20% of the total daily maintenance dose and should be administered every 2-4 hours as needed for pain).

*These are rough approximations; individual patients may vary. Meperidine is not a first line opioid. It should not be used longer than 48 hours or more
Parenteral opiate: onset of action, 5 min; peak, 15 min Oral opiate: onset of action, 15-30 min; peak, 45-60 min

CONVERTING TO TRANSDERMAL FENTANYL

Use for patients who are unable to take oral medicine or have chronic cancer pain. Determine the 24 hour parenteral morphine equivalent. Dose patch at 50-75% of the previous 24 hour opioid used. Prescribe a short acting opioid for breakthrough pain (5-15%) of 24 hour dose q 3 hours. Patch duration is 72 hours. Increase the patch dose based on the average amount of additional short acting opioid required in the previous 72 hours. Wait at least 48 hours before adjusting the dose. For dosages of transdermal fentanyl over 100 mcg/hr multiple patches can be used.

Parenteral Morphine Equivalent mg/24 hr	Transdermal Fentanyl Equivalent mcg/hr
8-22	25
23-37	50
38-52	75
53-67	100
68-82	125
83-97	150

Note: The patch takes 12-24 hours to achieve full effect. When removing a patch, remember the analgesic effect can still last 24 hours.

EXTRA NOTES

BOWEL REGIMEN

With few exceptions, all patients on opioid therapy need individualized bowel regimens. Start with the step 1 regimen. When an effective regimen is found, it must be continued for the duration of the opioid therapy.

Step 1- Begin with a stool softener and laxative. For example:

- 1) Docusate 100mg po bid (or 200mg po qd) +/- MOM 30 cc po qd
- 2) Docusate 100mg po bid +/- Senna 1 tab po qd

Step 2- Docusate 100mg po bid + Senna 2 tabs bid

Step 3- Docusate 100mg po bid + Senna 3 tabs bid

Step 4- Docusate 100mg po bid + Senna 4 tabs bid + Lactulose 15ml po bid

Step 5- Docusate 100mg po bid + Senna 4 tabs bid + Lactulose 30ml po bid

Step 6- Docusate 100mg po bid + Senna 4 tabs bid + Lactulose 30ml po qid

ADJUVANT MEDICATIONS

Drug	Usual starting dose
Amitriptyline	25 mg po qhs
Nortriptyline	25 mg po qhs
Carbamazepine	100 mg po bid
Clonazepam	0.25 – 0.5 mg po tid
Gabapentin	100 mg po TID increase 100mg TID q3d
Phenytoin	100mg po TID
Valproic Acid	125mg po TID
Alprazolam	0.25 – 0.5 mg qd-tid
Diazepam	5-10 mg po qd-bid
Lorazepam	0.5-2mg po qd-tid
Buspirone	5mg po tid
Dexamethasone	4-12 mg/d
Baclofen	5-10mg po tid-qid
Pamidronate	90mg IV

EASTERN VIRGINIA MEDICAL SCHOOL



PAIN THERAPY GUIDELINES

General Principles of Pain Management:

- 1) **Assess pain using a standardized pain scale.** Ask the patient. If the patient is unable to communicate, assess pain based on behavioral cues. Frequency of assessment should be initial, every 8 hours, or every 2 hours if pain is severe.
- 2) Non opioids may be used to treat mild pain. Short acting opioids should be used to control acute, moderate, or severe pain. Long acting preparations should be started after the pain is controlled by short acting opioids.
- 3) **Titrate the opioid dose** at least every 24 hours and as often as every 2 hours when the pain is severe. Increase the dose by 25-50% or by 50-100% with severe pain. **Do not use range orders.**
- 4) Manage breakthrough pain with short acting opioids using 1/3 of the single dose amount or 10-20% of the total daily dose. **Use Around The Clock** pain medicine not prn for ongoing pain. Use the KISS principle - Keep It Same and Simple (e.g. use the same opioid for short and long term pain control.)
- 5) Manage opioid side effects. Constipation must be treated prophylactically (see bowel regimen).
- 6) Naloxone should be used only for life-threatening opioid induced respiratory depression. When naloxone is needed, dilute 1 vial (0.4 mg) in 10 cc NS and administer 1 cc every minute prn. This careful titration will reverse respiratory depression without causing withdrawal symptoms. The half-life of naloxone (one hour) is shorter than the half-life of opioid agonists; therefore, careful monitoring and additional doses of naloxone might be needed.

Special Thanks to Dr. Mukta Panda, University of TN, Chattanooga for helping develop this guide

METHADONE IN CHRONIC PAIN

BENEFITS

- Inexpensive
- Less potential for addiction, lower street value
- Possible benefit in neuropathic pain
- Able to use in renal failure

RISKS

- Duration of analgesia much shorter than elimination half life
 - increased risk of toxicity if dosed too frequently or adjusted too quickly

DOSING

- Start low and go slow
 - start with low dose or "down dose" if switching from different opioid medication
 - do not make dose adjustments more often than every 5 to 7 days
- Equianalgesic dosing ratios between methadone and other opiates are imprecise
 - individualize doses and monitor each patient closely

DRUG INTERACTIONS

- Medications which increase methadone concentration
 - amitryptiline, SSRIs (Effexor least likely to interact)
 - fluconazole, ketoconazole
- Medications which decrease methadone concentration
 - antiretrovirals, antiepileptics
- Medications which may increase adverse effects of methadone
 - St Johns wort
 - benzodiazepines

PEARLS

- Use caution in these patients
 - elderly
 - patients with chronic lung disease
 - patients with chronic liver disease
 - patients who cannot follow directions appropriately
- Suggest that methadone only be administered by patient
 - ensures that the patient is awake/alert at the time of dosing

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METHADONE DOSING – VETERANS ADMINISTRATION RECOMMENDATIONS

Dosing methadone for patients receiving codeine preparations or no previous opioids			
Dosing strategy	Initial Methadone dose	Increments	Comments
Gradual titration (For CNCP and patients monitored less frequently)	2.5 mg q 8 hours	2.5 mg q 8 h every 5 to 7 days	<i>As a general rule, start low and go slow.</i>
Faster titration (For cancer pain and patients monitored frequently)	2.5 mg q 6 or 8 hours	2.5 mg q 6 or 8 h as often as every day over about 4 days	

Dosing recommendations for patients previously receiving other opioids			
Gradual Conversion (For CNCP and patients monitored less frequently)			
MOR-Equiv [mg/d]	Calculated MET dose [mg /d]	<u>Initial MET dose</u>	<u>Increment</u>
< 200	15 mg	5 mg q 8 h	Increase by calculated MET dose every 5–7 days
200 – 500	~ 7% of MOR-Equiv *	Calculated MET dose given in divided doses q 8 h	Increase by calculated MET dose every 5–7 days
>500	~ 7% of MOR-Equiv*	1/3rd of calculated MET dose given in divided doses q 8 h	Add 1/3rd of calculated MET dose every 5 days Decrease previous opioid by 1/3rd every 5 days (Complete conversion period = 15 days)
Rapid Conversion (For cancer pain and patients monitored frequently)			
MOR-Equiv mg/d]	MET-to-MOR-Equiv Ratio [%]	<u>Initial MET dose</u>	<u>Increment</u>
< 200	10% - 30%	Calculated daily MET dose in divided doses q 8 h (up to a maximum 50 mg q 8 h)	<p align="center">Phased Conversion: Replace 1/3 of MOR-Equiv dose with calculated dose of MET every day (complete conversion in 3 days)</p> <p align="center">Rapid (Stop-and-Go): Discontinue MOR-Equiv and start calculated dose of MET on day 1</p>
200 – 500	10% - 20%		
500 – 1000	5% - 10%		
> 1000	5% or less		
CNCP = Chronic noncancer pain HMO = Hydromorphone MET = Methadone; MOR = Morphine MOR-E = Morphine-equivalent OXY = Oxycodone			

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EXAMPLES

Gradual Conversion (For CNCP and patients monitored less frequently)

* Calculation of MET dose based on oral oral morphine-equivalent [MOR-Equiv] doses:

Methadone	[MET]	2 mg	Examples:
Morphine	[MOR]	30 mg	250 mg/d MOR = $250 \times 2 / 30 = 17$ mg/d MET ~ 5 mg q 8 h
Hydromorphone	[HMO]	8 mg	60 mg/d HMO = $60 \times 2 / 8 = 15$ mg/d MET = 5 mg q 8 h
Oxycodone	[OXY]	15 mg	120 mg/d OXY = $120 \times 2 / 15 = 16$ mg/d MET ~ 5 mg q 8 h

600 mg/d MOR = $600 \times 2 / 30 = 40$ mg/d MET
or about 15 mg/d

1/3rd of 40 mg/d = 13 mg/d

Give:

- MET 5 mg q 8 h + MOR 400 mg/d (in divided doses) x 5 d
- MET 10 mg q 8 h + MOR 200 mg/d (in divided doses) x 5 d
- MET 15 mg q 8 h + discontinue MOR

Rapid Conversion (For cancer pain and patients monitored frequently)

600 mg/d MOR = 30 to 60 mg/d MET (or about 45 mg/d)
1/3rd of MET dose = 10 to 20 mg/d (or about 15 mg/d)

- Day 1: MET 5 mg q 8 h + MOR 400 mg/d (in divided doses)
- Day 2: MET 10 mg q 8 h + MOR 200 mg/d (in divided doses)
- Day 3: MET 15 mg q 8 h + discontinue MOR

EXAMPLE NARCOTIC CONTRACTS

UMA (UNIVERSITY MEDICAL ASSOCIATES)

Agreement For Controlled Substances Prescriptions in the
Management of Chronic Conditions

(Place Pt. Label here)

My provider _____ and I agree that a controlled substance is a necessary part of my treatment. I understand that medication is only one part of the overall treatment plan and I agree to participate in all recommended treatments and follow-up.

RISKS

- I am aware that this medication has a potential for addiction, abuse, withdrawals, or dangerous consequences.
- I have been informed of the benefits, specific risks and side effects of my medication.
- (For women) I understand that if I become pregnant while taking this medication, my baby may be born dependent on the medication and other risks to the child may exist.

CONDITIONS

- I will take the medication only as prescribed: _____
(initial)
- I will not get prescriptions **for pain medication or other controlled substances** from anyone except University Medical Associates' physicians.
- If an emergency occurs or I get hospitalized and for some reason another doctor must prescribe my medications, I will inform a nurse at University Medical Associates as soon as possible.
- I will use only one pharmacy to fill these prescriptions and that will be:
_____. Phone number _____.
My provider has permission to speak with the pharmacy about prescriptions at any time.
If I choose to change pharmacies for any reason, I will first notify my provider.

- I agree to try alternative pain control methods, as they become available.
- I understand that periodic adjustments in dosage including dose reduction may be performed to optimize my treatment.
- I have fully informed my provider of any current or prior use of alcohol, medications, or illegal

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drugs.

- I will not abuse alcohol or use any illegal drugs while taking this medication. I agree to let my provider check my urine or blood at any time for alcohol or drugs.
- I will not sell these medications or share them with anyone.
- I understand that prescriptions may not be refilled before they are due even if lost or stolen. It is my responsibility to keep track of the medication.
- I am aware some prescriptions may not be provided for more than one month at a time and that refills are not available at nights, on weekends, or by telephone. It is my responsibility to obtain prescription refills before they run out.
- (For women) I will inform the UMA immediately if I learn that I am pregnant.
- I give the UMA permission to communicate with any of my other providers or family members about my use of controlled substances, other medications and alcohol.

I understand that if I fail to fulfill this agreement my care at University Medical Associates will be terminated.

Patient: _____

Date: _____

Physician: _____

Date: _____

Nurse: _____

Date: _____

High Street Health Center – Adult Medicine

**CONTRACT FOR CONTROLLED SUBSTANCES PRESCRIPTIONS IN THE
MANAGEMENT OF CHRONIC CONDITIONS**

(Place Pt. label here)

My provider, _____, and I agree that a controlled substance is a necessary part of the treatment for my chronic condition. I understand that medication only one part of the overall treatment plan and I agree to participate in all recommended treatments and follow-up.

RISKS

- I am aware that this medication has a potential for addiction, abuse, or dangerous consequences if taken improperly.
- I have been informed of the specific risks and side effects of my medication including:

- (For women) I understand that if I become pregnant while taking this medication, my baby may be born dependent on the medication and other risks to the child may exist.

CONDITIONS

- I will take the medication only as prescribed: _____
(medication and dosing instructions)
- I will not get prescriptions for this or any similar medication from anywhere except the IMC.
- If an emergency occurs or I get hospitalized and for some reason another doctor must prescribe my medications, I will inform the IMC as soon as possible.
- I will use only one pharmacy to fill these prescriptions and that will be:
_____. Phone number: _____. My provider has permission to speak with the pharmacy about prescriptions at any time. If I choose to change pharmacies for any reason, I will first notify my provider.
- I have fully informed my provider of any current or prior use of alcohol, medications, or illegal drugs.
- I will not abuse alcohol or use any illegal drugs while taking this medication. I agree to let my provider check **my pill count** or my urine or blood at any time for alcohol or drugs upon request.
- I will not sell these medications or share them with anyone.

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- I understand that prescriptions will not be refilled before they are due even if lost or stolen. It is my responsibility to keep track of the medication.
- I am aware that prescriptions will not be provided for more than one month at a time and that refills are not available at nights, on weekends, or by telephone. It is my responsibility to obtain prescription refills before they run out.
- I will inform the IMC immediately if I learn that I am pregnant.
- I give the IMC permission to communicate with any of my other providers about my use of controlled substances.
- I will refrain from any abusive, threatening or inappropriate behavior with any clinic staff or patients.

I understand that if I fail to meet all the agreements of this contract that the IMC may need to stop prescribing any of this type of medication for me and that I may need to enter a chemical dependence program to avoid withdrawal.

Patient: _____ Date: _____

Physician: _____ Date: _____

Nurse: _____ Date: _____

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Legacy Clinics
Intractable Pain Treatment Contract

Deleted: ¶

¶

Deleted: ¶

Name: _____

Chart#: _____ DOB: _____ Physician/NP _____

I have agreed to use opioids (morphine like drugs) as part of my treatment for chronic pain. These medications **may improve my symptom control** and allow me to be more active, but **may not eliminate my pain**. I understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/nurse practitioner is prescribing this opioid medication to help manage my pain, I agree to the following conditions **(PLEASE INITIAL ALL)**:

- _____ **AS PRESCRIBED:** I agree to take the medication only as prescribed. I understand that increasing my dose without close supervision **could lead to drug overdose**, causing severe sedation, respiratory depression, and death. I understand that decreasing or stopping my medication without the close supervision of my physician **could lead to withdrawal**.
- _____ **NO SHARING OR SELLING:** I understand that the opioid medication is strictly for my own use. It should never be given to others.
- _____ **ONE DOCTOR:** I will not request or accept **this medication or any other controlled substance** from any other physician or individual while I am being treated at this clinic. If I require medical treatment for other problems, requiring opioids, I will communicate this to my doctor.
- _____ **ONE PHARMACY:** My prescriptions will always be filled at the same pharmacy. Pharm Phone #: _____
Pharmacy name: _____
- _____ **ONE MONTH SUPPLY:** Prescriptions for a 1 month supply of this medication need to be picked up **in person**.
- _____ **REFILLS DURING OFFICE HOURS ONLY:** Prescription refills will be made during regular office hours, Monday through Friday, from 9:00AM – 4:30PM. Refills will **not be written at night, on holidays or on weekends**. Refill requests should be made **at least 3 working days** prior to pick-up.
- _____ **NO EARLY REFILLS:** I am responsible for keeping track of my medication. Refills will **not** be made if I **run out early or lose a prescription**. If my medication is stolen, I will report this to my local police department and obtain a **stolen item report**. Replacement prescriptions will be given **at the discretion of my physician/nurse practitioner**.
- _____ **REGULAR APPOINTMENTS:** During the time that my opioid dose is being adjusted, I will **return to the clinic as instructed** by my physician/nurse practitioner. After I have been placed on a stable dose, I will return to the clinic for a medical evaluation **at least every 3-6 months**.
- _____ **NO MORE THAN 3 NO SHOWS OR LATE CANCELATIONS:** Per standard clinic policy, if I am unable to keep my appointment, I will call the clinic by 2:00 the prior business day to cancel. Otherwise this will be considered a no-show. **More than 3 no shows** within 12 months will result in **tapering and discontinuation** of your medication as well as **discharge from this clinic**.
- _____ **URINE/BLOOD SCREENS:** I agree to **abstain from all illegal and recreational drugs** and will provide urine or blood samples at any time to monitor compliance.
- _____ **ALTERNATIVE/ADDITIONAL THERAPIES:** I will participate in other treatments at the direction of my physician/nurse practitioner, including **behavioral medicine**, and **physical therapy**, and will be agreeable to **taper or discontinue the opioid** as other treatments become available or if current treatment is not working.
- _____ **DISCONTINUE IF UNABLE TO FOLLOW THESE RULES:** I understand that if I do not follow all of the above conditions, I may be **gradually taken off** this medication. I may also be **discharged from this clinic** with a one month supply of medication(s).

Diagnosis/Condition being treated: _____
Medication/Dose/Schedule: _____

I, _____, have read the above information or it has been read to me, and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. We have discussed potential side affects and possible alternatives in as much detail as I wanted. I hereby give my consent to participate in this therapy.

Patient Signature: _____ Date: _____

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Physician/NP Signature: _____

Date: _____

EXAMPLE: QUESTION BANK

Pain Pathophysiology and Assessment

1. The pain experience can be characterized as which of the following?
 - a. A multi-level experience which is composed of a sensory-discriminatory, motivational-affective, and cognitive-evaluative components.
 - b. Always correlates with an identifiable causative injury.
 - c. Difficult for clinicians, because there are no objective measures
 - d. A&C**
 - e. All of the above

2. Which of the following statements are TRUE regarding pain pathophysiology?
 - a. Nociceptive pain involves the abnormal activation of the nociceptive system (A-delta and C-fibers) by noxious stimuli.
 - b. Somatic pain is typically localized, and described as aching, squeezing, stabbing, or throbbing.
 - c. Visceral pain is generalized, and often described as cramping, gnawing, and often associated with referred pain.
 - d. B&C
 - e. All of the above are true.**

3. Characteristics of neuropathic pain include which of the following?
 - a. Typically described as a continuous, burning pain, or lancinating or electrical pain
 - b. Associated with allodynia, hyperalgesia, or hyperpathia
 - c. Often a result of damaged axons regrowing multiple nerve sprouts that form connections to other efferent nerves.
 - d. A&B
 - e. All of the above**

4. Which of the following elements is NOT important in the assessment of a patient with chronic pain
 - a. Obtaining a detailed history including assessment of pain characteristics and intensity, and physical emphasizing the neurological and musculoskeletal exam
 - b. A repeated evaluation of the painful site with an up-to-date laboratory or radiographic evaluation

- c. Obtaining a psychosocial evaluation including impact on activities, sleep pattern, and relationships.
- d. Quantification of intensity of pain using a validated pain scale.
- e. ALL of the above are important.**

5. Which of the following is the BEST indicator of the intensity of a patient's pain?

- a. Clinician assessment of patient
- b. Evaluation of facial expressions
- c. Caregiver accounts
- d. Patient self-report on pain scale**
- e. Vital signs or signs of sympathetic hyperactivity

6. The primary source of assessment of pain in a patient should be:

- a. Abnormal vital signs
- b. Physical exam findings
- c. Patient's self-report of pain**
- d. Patient's facial grimacing
- e. Physician's perception of patient's pain

7. Which of the following is not essential part of every pain assessment:

- a. Severity rating
- b. Physical examination
- c. Patient's description of pain
- d. Laboratory and/or radiology tests**

8. Which of the following are components of the pain experience:

- a. Sensory-discriminatory
- b. Motivational-affective
- c. Cognitive-evaluative
- d. All of the above**
- e. None of the above

9. Which of the following statements is FALSE regarding the pathophysiology of pain:

- a. Nociceptive pain involves the normal activation of the nociceptive system by noxious stimuli.
- b. Neuropathic pain is associated with injury or dysfunction within the peripheral and/or central nervous system.

c. Nociception associated with chronic inflammation may be involved in chronic pain associated with persistent tissue injury.

d. Pain that appears to be idiopathic need not to be fully investigated, as there is no physical cause.

10. Which of the following is the best indicator of a patient's pain:

- a. **Patient self-report**
- b. Caregiver accounts
- c. Evaluation of facial expressions
- d. Sympathetic signs and symptoms

11. Which of the following assessment tools provide a measure of pain intensity:

- a. Faces Pain Scale
- b. Numeric Rating Scale
- c. Visual Analog Scale
- d. Brief Pain Inventory
- e. **All of the above**

12. Passik describes that the four important assessments of a patient are the 4 "A's". Which of the following is not included in the 4 "A's"

- a. Analgesia
- b. Activities of Daily Living
- c. Adverse effects of Medicines
- d. Aberrant drug taking behaviors
- e. **Adjuvant drug use**

13. Which of the following best exemplifies nociceptive pain:

- a. **Arthritis**
- b. Phantom Limb Pain
- c. Postherpetic neuralgia
- d. Carpel tunnel syndrome
- e. Migraines

14. Which of the following best exemplifies neuropathic pain?

- a. Gouty arthritis
- b. Degenerative joint disease of the spine
- c. Chronic abdominal pain
- d. **Post-herpetic neuralgia**
- e. Migraines

15. Which of the following behaviors is usually not associated with chronic pain?
- a. Irritability or depression
 - b. Assuming a comfortable position
 - c. Signs of hyperactivity (tachycardia, hypertension)**
 - d. High intensity rating of pain
 - e. Low intensity rating of pain
16. Which of the following are Multidimensional type pain scales?
- a. Numeric Rating scale
 - b. Brief Pain Inventory**
 - c. Visual Analog Scale
 - d. Faces rating scale
17. Which of the following is the least important in assessing a pain history?
- a. Temporal pattern
 - b. Intensity of pain
 - c. Topography or location of pain
 - d. Quality description of pain
 - e. Exacerbating or relieving factors of pain
 - f. All are important**
18. Chronic pain always has an identifiable lesion as it's originator.
- a. False**
 - b. True

Pain Management

1. Which of the following are TRUE regarding the WHO 3-step model for the management of cancer pain, as applied to guide treatment for all painful conditions?
- a. Nonopioid analgesics should only be used for the treatment of mild to moderate pain
 - b. Adjuvant treatments such as antidepressants or anti-convulsants should not be used because they are not FDA approved for the treatment of chronic pain
 - c. Opioid medications are generally used as an adjunct for moderate to severe pain unresponsive to conventional treatment
 - d. A&C**
 - e. ALL of the above are true.

2. The most appropriate adjuvant analgesic for use when treating neuropathic pain is:

- a. **Amitriptyline (Elavil)**
- b. Clonidine (Catapres)
- c. Dexamethasone (Decadron)
- d. Ibuprofen (Motrin)
- e. Lorazepam (Ativan)

3. All of the following general treatment principles for opioid-induced side effects are recommended **except**:

- a. Switching opioids
- b. **Discontinuing opioids**
- c. Changing the route or dosing regimen
- d. Counteracting side effects with other medications
- e. Adding acetaminophen and lowering the dose of opioids

4. According to the WHO ladder, the first step for mild pain generally includes an opioid combined with an adjuvant analgesic:

- a. TRUE
- b. **FALSE**

5. Which class of opioids is preferred for the treatment of chronic pain.

- a. **Pure mu agonists**
- b. All agonist-antagonists
- c. Partial agonists
- d. Mixed agonist-antagonists

6. Which of the following is recommended for the treatment of breakthrough pain:

- a. **Short-acting opioids**
- b. Sustained-release opioids
- c. Extended-release opioids
- d. Nonopioid analgesics

7. Which of the following statements are true regarding nonpharmacologic strategies in managing pain:
- a. Management of most patient's pain begins with nonpharmacologic treatment modalities
 - b. Optimal pain management includes psychological, physical rehabilitation, and sometimes invasive strategies.
 - c. Psychological interventions include biofeedback, relaxation, and imagery.
 - d. Physical rehabilitation includes exercise, posture training, and attention to ergonomics.
 - e. All of the above.**
8. Which of the following statements is true of chronic back pain:
- a. It is always a nociceptive syndrome.
 - b. It is always a neuropathic syndrome.
 - c. It is best treated with traditional adjuvant medications.
 - d. It rarely has an easily identifiable and clear etiology.**
9. Which of the following is true for patients with chronic pain:
- a. Physical therapy can worsen pain and should be generally avoided.
 - b. Physical therapy can restore functioning and reduce disability**
 - c. Transcutaneous electrical nerve stimulation (TENS) is beneficial in all patients.
 - d. Physical therapy must be used in conjunction with pharmacologic treatment.
10. Which is true of NSAIDs:
- a. They are the first-line therapy based on the WHO ladder in the treatment of chronic somatic pain syndromes.**
 - b. They are preferred in elderly patients because they have a low side effect profile.
 - c. They are highly effective in neuropathic pain syndromes.
 - d. They have no ceiling dose.
11. Which is true when using opioid therapy for chronic pain:
- a. Effective doses do not vary much between patients.
 - b. It is not necessary to use short-acting opioids for breakthrough pain if patients are already using a sustained-release preparation.
 - c. Doses should be individualized for the patient.**
 - d. There is a maximal dose for each opioid that should not be exceeded.

12. Poor opioid responsiveness refers to:
- a. Inadequate pain relief at a dose of an opioid that produces intolerable side effects.
 - b. Low intrinsic efficacy of an opioid at its receptor.**
 - c. A patient's reluctance to use an opioid for pain relief.
 - d. A physician's reluctance to use an opioid for the treatment of chronic pain.
13. The most reliable dosing route for pain medications is
- a. Intravenously
 - b. Intramuscularly
 - c. Orally**
 - d. Rectally
14. Opioid medications are non-effective for neuropathic pain.
- a. False**
 - b. True

Pharmacology and Medications

1. A patient has been taking 300 mg of long-acting morphine every 12 hours and an additional 120 mg of prn doses of short acting morphine. You want to start him on an equivalent dose of an intravenous morphine infusion; what is the equivalent morphine hourly rate:
- a. 5 mg per hour
 - b. 10 mg per hour**
 - c. 15 mg per hour
 - d. 20 mg per hour
 - e. 25 mg per hour
2. A man is receiving oral hydromorphone (Dilaudid) 10 mg every 4 hours. He needs to be NPO. What would be the best equivalent intravenous dose of Dilaudid, administered as a continuous infusion?
- a. 0.1 mg per hour
 - b. 0.5 mg per hour**
 - c. 1.0 mg per hour
 - d. 1.5 mg per hour
 - e. 2.5 mg per hour

3. A patient is taking 12 oxycodone/acetaminophen tablets (5/325) per day with only partial relief. The most appropriate next step in drug therapy for this patient would be to discontinue Percocet, and start:

- a. Oral hydrocodone (e.g. Vicodin, Lortab)
- b. Oral propoxyphene (Darvocet, Darvon)
- c. Oral long-acting morphine (e.g. MS Contin, Oramorph SR)**
- d. Oral ibuprofen (Motrin)
- e. Oral tramadol (Ultram)

4. A patient is taking 2 oxycodone/acetaminophen tablets (5mg/325mg), 6 times a day. What is the equivalent dose of a long-acting morphine preparation?

- a. 15 mg po q12h
- b. 15 mg po q 8h
- c. 30 mg po q12h
- d. 60 mg po q12h
- e. 45 mg po q12h**

5. The most appropriate equianalgesic conversion ratio between IV morphine and oral morphine is:

- a. 1.0 mg IV = 0.25mg PO
- b. 1.0 mg IV = 0.5 mg PO
- c. 1.0 mg IV = 1.0 mg PO
- d. 1.0 mg IV = 3.0 mg PO**
- e. 1.0 mg IV = 4.0 mg PO

6. At a total daily dose of 240mg. of long-acting morphine, the most appropriate order for rescue (breakthrough) short-acting morphine (MSIR) is:

- a. 15mg PO q 2h
- b. 30mg PO q 2h**
- c. 15mg PO q 4h
- d. 30mg PO q 4h
- e. 45mg PO q 4h

7. The maximum recommended daily dose of acetaminophen is:
- a. 2 grams
 - b. 4 grams**
 - c. 6 grams
 - d. 8 grams
 - e. 10 grams
8. All of the following are characteristics of oral opioid analgesics **except**:
- a. Effective for localized and generalized pain
 - b. Easily administered
 - c. Stigma and fears associated with use
 - d. Ceiling effect to analgesia**
 - e. None of the above
9. The most common adverse side effect of opioid therapy is:
- a. Constipation**
 - b. Nausea and vomiting
 - c. Sedation and cognitive dysfunction
 - d. Respiratory depression
10. Which class of drugs shares these characteristics: (1) Dose-dependent side effects (2) Ceiling dose (3) do not cause tolerance or dependence:
- a. Opioid analgesics
 - b. Adjuvant analgesics
 - c. Non-steroidal anti-inflammatory agents**
 - d. Non-opioid analgesics
 - e. None of the above
11. Sustained-release preparations are not available for which opioids:
- a. Fentanyl
 - b. Morphine sulfate
 - c. Hydrocodone**
 - d. Oxycodone

12. Which of the following is TRUE of time-released opioid formulations
- a. They are often used to treat breakthrough pain.
 - b. They are Schedule IV drugs because of their low potential for abuse.
 - c. They can be inhaled**
 - d. They have a relatively increased potential for abuse in chronic pain patients
13. Which of the following medications has a very high risk for seizure activity
- a. Demerol**
 - b. Morphine
 - c. Ibuprofen
 - d. Oxycodone
 - e. Toradol
14. Which of the following medications has the longest half-life and must be watched very carefully when changing doses?
- a. MS Contin
 - b. Methadone**
 - c. Oxycontin
 - d. Avinza
15. Tolerance does not develop to which of the following side effects of opioid therapy:
- a. Constipation**
 - b. Nausea and vomiting
 - c. Sedation and cognitive dysfunction
 - d. Respiratory depression
16. Which of the following medications interferes with the cardioprotective effects of aspirin.
- a. Naproxyn
 - b. Ibuprofen**
 - c. Celebrex
 - d. Toradol
 - e. Tylenol

17. A patient is currently taking 300mg of Demerol orally for his pain. You would like to convert him to a better regimen. The equivalent dose of oral Morphine is:
- a. 10 mg po
 - b. 15 mg po
 - c. 30 mg po**
 - d. 45 mg po
-

Miscellaneous Questions

1. A 67 y/o man with prostate cancer has increasing pain over the left hip over the past six weeks requiring increasing doses of opioid analgesics. The pain is constant, aching and well localized; there is no referred pain. Pain in this patient most likely represents.
- a. Drug seeking behavior
 - b. Depression
 - c. Opioid addiction
 - d. Opioid tolerance
 - e. Worsening metastatic cancer**
2. Which of the following conditions does not warrant referral to a pain specialist.
- a. Chronic pain that is not controlled, even with analgesia
 - b. Inability to assess pain thoroughly**
 - c. Excessive side effects with adequate pain control
 - d. Acute pain, inadequately controlled with analgesia
3. Drug-seeking behavior that ceases when pain is controlled is called:
- a. Tolerance
 - b. Addiction
 - c. Physical dependence
 - d. Pseudoaddiction**
4. Behavior that includes one or more of the following-impaired control over drug use, compulsive use, continued use despite harm, and craving-is called:
- a. Tolerance
 - b. Physical dependence
 - c. Pseudoaddiction
 - d. Addiction**

5. The risk of drug addiction in patients without histories of drug abuse who are taking opioid analgesics for disease-related pain is very low.
- True**
 - False
6. Which describes physical dependence in the chronic pain patient:
- Addiction that occurs when opioids are prescribed for chronic pain.
 - Aberrant behavior that includes drug seeking and drug craving.
 - A withdrawal syndrome upon opioid discontinuation.**
 - Tolerance to the physiological effects of opioids.
7. Increasing the dose of opioids to maintain adequate analgesic effect will alleviate:
- Tolerance
 - Pseudoaddiction**
 - Physical dependence
 - Addiction
8. Which of the following statements about tolerance is TRUE:
- Tolerance to the analgesic effects is an inevitable consequence of opioid use.
 - Tolerance develops at the same rate for analgesic and side effects of opioids.
 - Tolerance is a precursor to the development of physical dependence.
 - The term tolerance is not applicable when increasing doses of opioids are necessary to maintain analgesia due to worsening pathology.**
9. Which of the following statements is FALSE regarding the use of pharmacotherapy in older patients:
- Use the least invasive route.
 - Start at the lowest dose and titrate slowly to effect.
 - NSAIDs should be used with caution due to side effects.
 - Opioid medications are not effective for moderate to severe pain.**
 - Pharmacologic therapy is most effective when combined with nonpharmacologic therapy
10. Which of the following statements about opioid analgesic use in older patients is **FALSE**.
- Elderly patients should be monitored for neurologic, cognitive-behavioral, and gastrointestinal effects.

b. Serious side effects (e.g. respiratory depression, delirium) are common when opioids are started at low doses and titrated slowly for effect.

c. Meperidine should be avoided in the elderly.

d. Safer and equally effective alternatives to propoxyphene should be used in elderly patients.

e. Tramadol should be used cautiously in older patients with a history of seizure disorders.

11. If your patient is using Fentanyl patch for chronic pain relief, and your urine drug screen turns up negative for opioids, you should suspect that your patient is diverting the medicines.

a. False

b. True

OPIOID USE IN CHRONIC NON-MALIGNANT PAIN

CASE 1

Objective: Design a multi-faceted treatment plan for a patient with chronic non-malignant pain

A 44-year old obese female presents to establish care with you. She tells you that her main problems are low back pain, bilateral knee pain, and right sided shoulder pain. The back pain has been present for the past five years and is associated with shooting pain down her legs and numbness and tingling in her feet at times. She has never had bowel or bladder dysfunction and is able to obtain relief while supine. She has had an MRI of her back, which showed a slightly bulging disc at L4-S5. The knee pain bothers her the most when she is walking and xrays of her knees show moderate medial compartment degenerative joint disease. Her shoulder pain began a few months ago and is worse when she reaches overhead. She has tried Tylenol and Ibuprofen without any affect. She is not currently working, but when she was, she tried going to the gym but found the bike and treadmill to be too hard on her knees. On further questioning you discover that she is not sleeping well and is having family problems at home. Her exam is consistent with: lumbar sacral strain, knee OA and rotator cuff tendonitis. Design a multi-faceted treatment approach towards this patient's pain complaints.

CASE 2

Objective: Demonstrate familiarity with guidelines regarding the use of opiates to treat chronic pain.

A 64 year old male presents to your office and describes a four year history of back pain due to spinal stenosis. He tells you that his last doctor had him on a pain contract and that he received a supply of 60 tablets of Vicodin a month. He feels that this medication has worked well for him in the past allowing him to stay active at work and at home. A thorough exam reveals no abnormalities other than mild paravertebral muscle tenderness. What would your plan be? If this plan involves the further use of an opioid medication, what kinds of things might you want to discuss with this patient before considering chronic treatment with an opioid?

CASE 3

Objective: Use an opioid trial to determine if a patient will be a good candidate for chronic narcotics

You have been following a 68-year-old female with severe degenerative joint disease for several years. She has been following your treatment plan faithfully (which includes Tylenol, stretching and regular water aerobics) but has recently had worsening pain. She is not a surgical candidate. What would you like to do with this patient? If you are considering starting an opioid medication, how would you go about doing this?

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CASE 4

Objective: Start a patient on Methadone for chronic non-malignant pain

A 54-year-old male with a history of chronic pain due to well-documented degenerative disk disease has partially responded to the maximum daily dose of Vicodin. He has a new job and desires long-acting medication so he won't be "always taking pills". Because of his new income he may lose his Medicaid eligibility and will have to pay out-of-pocket. What approach would you like to take with this patient?

CASE 5

Objective: Switch patient from short acting formulation to long acting formulation

A 34 year-old woman with a history of SLE and disabling aseptic necrosis of the hip from chronic steroid use is followed by her rheumatologist. He has prescribed Vicodin 5/500 one tablet qid. She is returning to her primary care provider for ongoing management. Her records indicate that she has been compliant with appointments and has not asked for early medication refills. Her chief complaint is that her pain is not always well-controlled throughout the day.

Her 80-year-old mother is also a patient of yours. She has severe spinal stenosis and is currently taking OxyContin 20 mg bid for this condition. She has very good pain control with this and has been able to remain quite functional. Unfortunately her insurance is no longer covering OxyContin and she is asking you about switching to a different medication.

CASE 6

Objective: Identify and treat a patient with possible drug seeking behavior

A 32 year old male presents to you for a follow up visit. Six months previous to this visit he had been started on oxycodone by a previous resident for back pain. Reviewing old notes you see that he had specifically requested oxycodone at the time, saying that Tylenol upset his stomach. Since that time he has had several no-show appointments, including a missed physical therapy appointment. In addition he has been to urgent care on two separate occasions requesting additional narcotics. Today he comes in asking for an early refill as he is going out of town to visit his sick grandmother.

OPIOID USE IN CHRONIC NON-MALIGNANT PAIN: ANSWERS

CASE 1

Objective: Design a multi-faceted treatment plan for a patient with chronic non-malignant pain

A 44-year old obese female presents to establish care with you. She tells you that her main problems are low back pain, bilateral knee pain, and right sided shoulder pain. The back pain has been present for the past five years and is associated with shooting pain down her legs and numbness and tingling in her feet at times. She has never had bowel or bladder dysfunction and is able to obtain relief while supine. She has had an MRI of her back, which showed a slightly bulging disc at L4-S5. The knee pain bothers her the most when she is walking and xrays of her knees show moderate medial compartment degenerative joint disease. Her shoulder pain began a few months ago and is worse when she reaches overhead. She has tried Tylenol and Ibuprofen without any affect. She is not currently working, but when she was, she tried going to the gym but found the bike and treadmill to be too hard on her knees. On further questioning you discover that she is not sleeping well and is having family problems at home. Her exam is consistent with: lumbar sacral strain, knee OA and rotator cuff tendonitis. Design a multi-faceted treatment approach towards this patient's pain complaints.

CASE 1 (Answer)

You begin by offering her stretching and strengthening exercises for both her back and her knees. Since she is interested in going to the gym, you encourage her to try low impact exercise such as swimming and provide her with a list of programs in the area. In addition you provide her with a list of low cost alternative treatments for pain such as chiropractic, massage, acupuncture schools and you ask her if she is interested in the back class or the seven week chronic pain group offered at this hospital. As her insurance will cover physical therapy for osteoarthritis, you refer her to PT for her treatment of her knee pain. You continue her on scheduled Tylenol and for her insomnia and sciatic nerve pain, you discuss starting a low dose TCA. You also provide her with a lidocaine patch to be used topically for her low back pain. You refer her to a low cost counseling service to help deal with stressful issues at home and suggest that she consider joining the chronic pain support group. For her rotator cuff tendonitis, you provide a set of exercises and schedule her an appointment at the joint injection clinic.

Non-pharmacologic therapies

- exercise, stretching, physical therapy
- psychotherapy, cognitive behavioral therapy
- biofeedback, acupuncture, massage, relaxation, meditation, self hypnosis
- back pain class, pain group series, support group

Non-opioid analgesics

- NSAIDs, Tylenol

Adjuvant medications

- TCAs (Amitriptyline, Nortriptyline)
- neuroleptics (Tegretol, Depakote, Neurontin)
- muscle relaxants (for up to 2 weeks only, avoid Soma)
- topical agents (Capsaicin cream, lidocaine)

Less potent opioids

- tramadol, codeine, oxycodone, hydrocodone

More potent opioids

- morphine, hydromorphone, fentanyl, methadone
- meperidine (avoid due to toxic metabolite, addiction potential)

Co-morbid conditions

- psychiatric (depression, anxiety)

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CASE 2

Objective: Demonstrate familiarity with guidelines regarding the use of opiates to treat chronic non-malignant

A 64 year old male presents to your office and describes a four year history of back pain due to spinal stenosis. He tells you that his last doctor had him on a pain contract and that he received a supply of 60 tablets of Vicodin a month. He feels that this medication has worked well for him in the past allowing him to stay active at work and at home. A thorough exam reveals no abnormalities other than mild paravertebral muscle tenderness. What would your plan be? If this plan involves the further use of an opioid medication, what kinds of things might you want to discuss with this patient before considering chronic treatment with an opioid?

CASE 2 (Answer)

You provide the patient with a two week supply of Vicodin and ask him to fill out a release of information to obtain his old records. He returns two weeks later and you review his old records. His imaging reports document moderate to severe spinal stenosis and chart notes document prior compliance with all treatment suggestions. You decide that it would be appropriate to continue this patient on his current medications. Before doing so, you review the policies of the OBME and realize that a material risk notice is required and a pain contract is strongly suggested. You therefore complete these with the patient and make a notation of this in Echart. You give him a 3 month supply of medication and ask him to plan on seeing you regularly, approximately every three months.

Clinic guidelines

- No early refills (unless OK with PCP or covering MD)
- No pain medications from other clinics/MDs
- No refills after hours
- No replacement of lost or stolen medications
- No modifications to dose or frequency (unless OK with PCP or covering MD)

Board Of Medical Examiner Requirements (Oregon)

- Material risk notice
- Regular assessment and documentation of pain complaint
- Pain contract is not required but is recommended

CASE 3

Objective: Use an opioid trial to determine if a patient will be a good candidate for chronic narcotics

You have been following a 68-year-old female with severe degenerative joint disease for several years. She has been following your treatment plan faithfully (which includes Tylenol, stretching and regular water aerobics) but has recently had worsening pain. She is not a surgical candidate. What would you like to do with this patient? If you are considering starting an opioid medication, how would you go about doing this?

CASE 3 (Answer)

You decide that he may benefit from a trial of a low potency opiate. You document that he has been tried on alternative therapies and that his pain complaint has been well investigated. You discuss the patient's goals with him. He tells you that his current pain is usually about a 6/10 and that he would be happy with a pain level of 4/10. He also tells you that he would like to be able to improve his physical function so that he is able to walk the dogs regularly and do the grocery shopping. He currently relies on his brother for these tasks. You review the risks and benefits of the medication you will be starting and show him a copy of the clinic's pain contract and material risk notice. You start him on a low dose of oxycodone and ask him to use only the dose and frequency prescribed. You ask him to make note of the times that he feels less than adequate relief. On his return visit you determine that he has been compliant with instructions and shows improvement in his symptoms. You document the effects thus far and titrate his dose up further. When you reach an appropriate point, where he has achieved improved pain control with minimal side effects, you complete a material risk notice and pain contract and document this in Echart.

Opiate Trial Instructions

Documentation of reasons for trial

- well documented pain complaint (symptoms, functional impairment, exam, diagnostics)
- pain not controlled despite multiple other treatment tried

Discussion with patient

- review adverse effects of narcotics (refer to/sign material risk notice)

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- set time frame and goals (goals should be specific and initiated by patient)
- review clinic rules and policies (refer to/sign pain contract)
- review indications to stop trial (pain not responsive to opioids, patient not following rules)

Document baseline condition of patient

- pain severity level
- functional capacity (social, physical, emotional)

Use short acting opioid to begin with

Increase dose until one of the following happens

- pain at an acceptable level or limiting side effects
- pain determined to be unresponsive to opiates (no graded improvement with dose increase)
- patient non-compliant with guidelines

Document effects of medication

- pain level, level of function, progress towards goals
- side effects

Determine average daily dose requirement if patient responds well to medication

Consider switching to long acting formulation

- if pain is continuous rather than episodic

Fill out pain contract and material risk notice (if not already done)

CASE 4

Objective: Start a patient on Methadone for chronic non-malignant pain

A 54-year-old male with a history of chronic pain due to well-documented degenerative disk disease has partially responded to the maximum daily dose of Vicodin. He has a new job and desires long-acting medication so he won't be "always taking pills".

Because of his new income he may lose his Medicaid eligibility and will have to pay out-of-pocket. What approach would you like to take with this patient?

CASE 4 (Answer)

You review his history and determine that he has no liver, kidney, or pulmonary disease. You decide to start him on Methadone 5 mg q 8 hours and warn him that it may take up to 5 days before he feels the full benefit. You continue him on Vicodin for rescue therapy, suggesting he will need to take it less often as the methadone reaches steady state drug levels. You caution that he may notice increasing sedation as the methadone takes effect and that he can cut the methadone dose or increase to a q 12 hour interval if he notices side effects. You schedule a follow up in one week.

Facts about the drug

- inexpensive, low abuse potential
- starting low and going slow will help avoid side effects
- may need to adjust dose:azole antifungals, SSRIs, TCA, phenytoin, carbamazepine, rifampin
- takes 5 to 7 days to reach steady state, duration of action is 4 to 8 hours
- redistributes into fat and muscle so may accumulate with repeat dosing

Start at 2.5 to 5 mg every 8 hours, increase by same amount every 5 to 7 days

- see handout if converting from other narcotic and on > 200mg/day

Provide short acting agent to use for break through pain and decrease doses as approach steady state

Counsel patient that they will not achieve full effect for 5 to 7 days

If side effects occur hold or decrease next dose

Use caution if

- renal dysfunction, liver disease, pulmonary disease
- age > 65, converting from high doses of another narcotic

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CASE 5

Objective: Switch a patient from short acting formulation narcotic to a long acting formulation.

A 34 year-old woman with a history of SLE and disabling aseptic necrosis of the hip from chronic steroid use is followed by her rheumatologist. He has prescribed Vicodin 5/500 one tablet qid. She is returning to her primary care provider for ongoing management. Her records indicate that she has been compliant with appointments and has not asked for early medication refills. Her chief complaint is that her pain is not always well-controlled throughout the day.

Her 80-year-old mother is also a patient of yours. She has severe spinal stenosis and is currently taking OxyContin 20 mg bid for this condition. She has very good pain control with this and has been able to remain quite functional. Unfortunately her insurance is no longer covering OxyContin and she is asking you about switching to a different medication.

CASE 5 (Answer)

You decide to switch the 34-year-old to a long acting opioid to better control her pain. As hydrocodone and morphine are equianalgesic (and thus converted on a 1:1 basis) you switch her to a total dose of 30 mg of morphine using a 15 mg bid dose and schedule.

You decide to switch her mother to a long acting morphine, which is covered by her insurance. Oxycodone and morphine are equianalgesic on a 2:3 basis. You therefore increase her from a total daily dose of 40mg of oxycodone to a daily dose of 60 mg of morphine. You decide to give her a prescription for long-acting morphine 30 mg bid.

Dose equivalency

-hydrocodone (Vicodin/Lortab): long acting morphine is 1:1

-oxycodone: long acting morphine is 2:3 (increase total daily oxycodone dose by 50%)

Do not cut long acting medications in half (but OK to split Methadone)

CASE 6

Objective: Identify and treat a patient with possible drug seeking behavior

A 32 year old male presents to you for a follow up visit. Six months previous to this visit he had been started on oxycodone by a previous resident for back pain. Reviewing old notes you see that he had specifically requested oxycodone at the time, saying that Tylenol upset his stomach. Since that time he has had several no-show appointments, including a missed physical therapy appointment. In addition he has been to urgent care on two separate occasions requesting additional narcotics. Today he comes in asking for an early refill as he is going out of town to visit his sick grandmother.

CASE 6 (Answer)

You are worried that this patient may be exhibiting drug seeking behavior and decide to do a random urine drug screen on him. His urine comes back with no controlled substances present (including the oxycodone and trazadone that he is supposedly taking). You suspect that he is either diverting his medications or that he may have submitted another person's urine sample. You tell him that he has broken his pain contract and that you can offer him a two week supply of medications with instructions as to how to taper off his oxycodone. You let him know that withdrawal from oxycodone can be uncomfortable but is not life threatening. You may also consider disenrollment from the clinic at this time.

Red Flags: Possible Abuse

- Not cooperative with non-opioid treatment or evaluation
- Repeated episodes of lost or stolen medications
- Requests for specific medications (especially brand names i.e Soma, Klonopin, Phenergan)
- Use of multiple physicians or pharmacies
- Multiple drug requests after hours
- Frequent visits to ED or urgent care with pain complaints
- Modifying dose or frequency of medications without consulting with MD
- Frequent requests for early refills
- Insistence on rapid acting formulations

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-Using analgesics to relieve symptoms other than pain

Less likely to be addictive (although usually not addiction if medications are being used to treat pain)

- long acting substances
- scheduled dosing rather than prn

Steps to take to avoid diversion

- use generic drug (has less street value)
- ask health plan to "lock" to one MD and one pharmacy

Nausea and vomiting while on narcotics

- use Reglan instead of Phenergan

Tapering Instructions

- Narcotics decrease by 10-20% every 4 to 7 days
- Benzodiazepines decrease by 10% every 1-3 day

HELPFUL REFERENCES

Partners Against Pain www.partnersagainstpain.com
PainEdu www.painedu.org
Pain www.pain.com
PainMed at Beth Israel www.stoppain.org
AMA Pain Management Series
Online 12 modules www.ama-assn.org/ama/pub/category/5008.html
National Pain Educational Council www.npecweb.org/main.asp

Wisconsin Pain Management
Guidelines www.wisconsinmedicalsociety.org/uploads/wmj/pain_manageguides.pdf

Hopkins Opioid
Program www.hopkinskimmeltcancercenter.org/specialtycenters/hop.cfm?facilityid=27

SELECTED ARTICLES

Dworkin RH, Turk DC, Farrar JT, et al. Core outcome measures for chronic pain clinical trials: IMMPACT recommendations. *Pain*. Jan 2005;113(1-2):9-19. [Tools to measure outcomes on chronic pain patients]

Passik SD, Kirsh KL, et al. A new tool to assess and document pain outcomes in chronic pain patients receiving opioid therapy. *Clin Ther*. Apr 2004;552-561.

Butler SF, Budman SH, Fernandez K, Jamison RN. Validation of a screener and opioid assessment measure for patients with chronic pain. *Pain*. Nov 2004;112(1-2):65-75. [SOAPP tool, to possibly help detect opioid abuse (i.e. like CAGE)]

Bonakdar R, Bresler DE. Do CAM therapies work for pain management. *Patient Care*. Sept 2004;52-59. (Whole issue also devoted to Pain Management)
<http://www.patientcareonline.com/patcare/article/articleDetail.jsp?id=123443>

Passik SD, Kirsh KL. Assessing aberrant drug-taking behaviors in the patient with chronic pain. *Curr Pain Headache Rep*. Aug 2004;8(4):289-294.

Woolf CJ. Pain: moving from symptom control toward mechanism-specific pharmacologic management. *Ann Intern Med*. Mar 16 2004;140(6):441-451.

Liddle SD, Baxter GD, Gracey JH. Exercise and chronic low back pain: what works? *Pain*. Jan 2004;107(1-2):176-190.

Green CR, Anderson KO, Baker TA, et al. The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Med*. Sep 2003;4(3):277-294. [Racial disparities review article]

Portenoy RK, Ugarte C, Fuller I, Haas G. Population-based survey of pain in the United States: differences among white, African American, and Hispanic subjects. *J Pain*. Aug 2004;5(6):317-328.

USE OF OPIOIDS

Rowbotham MC, Twilling L, Davies PS, Reisner L, Taylor K, Mohr D. Oral opioid therapy for chronic peripheral and central neuropathic pain. *N Engl J Med*. Mar 27 2003;348(13):1223-1232.

Ballantyne JC, Mao J. Opioid therapy for chronic pain. *N Engl J Med*. Nov 13 2003;349(20):1943-1953.

Kalso E, Edwards JE, Moore RA, McQuay HJ. Opioids in chronic non-cancer pain: systematic review of efficacy and safety. *Pain*. Dec 2004;112(3):372-380.

Morrison RS, Wallenstein S, Natale DK, Senzel RS, Huang LL. "We don't carry that"--failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. *N Engl J Med*. Apr 6 2000;342(14):1023-1026.

CHRONIC PAIN EDUCATION

Campbell WI. What do medical students know about chronic pain and its management? *Ulster Med J*. Oct 1992;61(2):139-143.

Green CR, Wheeler JR, LaPorte F, Marchant B, Guerrero E. How Well is Chronic Pain Managed? Who Does it Well? *Pain Med*. Mar 2002;3(1):56-65.

Green CR, Wheeler JR, Marchant B, LaPorte F, Guerrero E. Analysis of the physician variable in pain management. *Pain Med*. Dec 2001;2(4):317-327.

Grossman SA, Sheidler VR. Skills of medical students and house officers in prescribing narcotic medications. *J Med Educ*. Jul 1985;60(7):552-557.

Morley-Forster PK, Clark AJ, Speechley M, Moulin DE. Attitudes toward opioid use for chronic pain: a Canadian physician survey. *Pain Res Manag*. Winter 2003;8(4):189-194.

Mortimer JE, Bartlett NL. Assessment of knowledge about cancer pain management by physicians in training. *J Pain Symptom Manage*. Jul 1997;14(1):21-28.

Turner GH, Weiner DK. Essential components of a medical student curriculum on chronic pain management in older adults: results of a modified delphi process. *Pain Med*. Sep 2002;3(3):240-252.

Ury WA, Rahn M, Tolentino V, et al. Can a pain management and palliative care curriculum improve the opioid prescribing practices of medical residents? *J Gen Intern Med*. Aug 2002;17(8):625-631.

Weinstein SM, Laux LF, Thornby JI, et al. Physicians' attitudes toward pain and the use of opioid analgesics: results of a survey from the Texas Cancer Pain Initiative. *South Med J*. May 2000;93(5):479-487.

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Weinstein SM, Laux LF, Thornby JI, et al. Medical students' attitudes toward pain and the use of opioid analgesics: implications for changing medical school curriculum. *South Med J*. May 2000;93(5):472-478.

Weisse CS, Sorum PC, Dominguez RE. The influence of gender and race on physicians' pain management decisions. *J Pain*. Nov 2003;4(9):505-510.

Lebovits AH, Florence I, Bathina R, Hunko V, Fox MT, Bramble CY. Pain knowledge and attitudes of healthcare providers: practice characteristic differences. *Clin J Pain*. Sep 1997;13(3):237-243.

Turk DC, Brody MC, Okifuji EA. Physicians' attitudes and practices regarding the long-term prescribing of opioids for non-cancer pain. *Pain*. Nov 1994;59(2):201-208.

van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Soc Sci Med*. Mar 2000;50(6):813-828.

Gallagher R, Hawley P, Yeomans W. A survey of cancer pain management knowledge and attitudes of British Columbian physicians. *Pain Res Manag*. Winter 2004;9(4):188-194.

Olsen Y, Daumit GL. Opioid prescribing for chronic nonmalignant pain in primary care: challenges and solutions. *Adv Psychosom Med*. 2004;25:138-150.

Stannard C, Johnson M. Chronic pain management--can we do better? An interview-based survey in primary care. *Curr Med Res Opin*. 2003;19(8):703-706.