Multimodal Approach to the Treatment of Chronic Pain
Live CHAMPS Webcast, February 17, 2010
Outstanding Questions/Comments from Q&A Session
Kris Robinson, PhD, RN

1	**Neurochemical remodeling of the brain resulting in better ability to cope w/pain: is this not possible with non-pharmacological means?**
To me, this is similar to asking," *can you change the underlying pathophysiology of type 2 diabetes with non-pharmacological means?"* Just as I would not treat uncontrolled diabetes with non-pharmacologic means alone, neither would I treat uncontrolled pain with non-pharmacologic measures alone. It is essential to break the cycle of pain to prevent further neurochemical remodeling. Non-pharmacologic treatments are excellent towards prevention, initial treatment, and adjunct therapy. Once the pain is controlled, some individuals may be able to manage their baseline or breakthrough pain (BTP) without drugs. At this time, I know of no research that demonstrates that non-pharmacologic treatment corrects the underlying disease process of chronic pain.	
2	**What do you mean by addiction? Addiction is characterized by tolerance and withdrawal with the substance used. Rather than thinking of it as a moral issue (addict vs. non-addict), aren't all narcotics addictive?**
You are confusing addiction with the physiological effects of tolerance and withdrawal. Tolerance and withdrawal may occur with opioid **and** non-opioid medications. Please see handout p. 64 for definition.	
3	**I'm being approached by older teens and young adults complaining of low back pain and expecting opiate therapy as part of the mgmt. Physical examination typically consistent with "mechanical" LBP. Now you state that failure to treat pain in a timely manner increases the likelihood of more severe, chronic pain. How did you handle these situations?**
Prompt treatment does not equate to treatment with opioids. For LBP, I recommend a combination of NSAIDS and topical creams or patches (capsaicin, menthol rubs, Lidocaine patch, etc) or a combination of tramadol prn and an NSAID patch along with non-pharmacologic treatment – heat/cold, yoga, proper lifting, etc.	
4	**How do you handle referral to physical therapy for unfunded patients/?**
I am sorry, I cannot help you with this one other than working with PTs in the community who will work pro bono or small fee.	
5	**Can you use a face scale for Spanish-speaking adults?**
Yes, as long as you use the faces scale **for adults.** There is a Spanish version of the brief pain inventory and educational materials and assessments of pain in Spanish on the American Pain Foundation website (www.painfoundation.org).	
6	**Is there any abuse potential for Lyrica? Cogentin?**
Lyrica (pregablin) does affect mentation in some individuals (feelings of fogginess, sleepiness, etc). I am confused about the question regarding cogentin. There is probably abuse potential for many medications as well as physical dependence, which is not the same as abuse. It just means that you need to titrate medication down when stopping certain medications just as you titrate medication up when first prescribing.	

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7	**If the evidence suggests/supports the use of injection therapy during the acute phase, how do you determine the best location of injection without the supporting documentation from neuroimaging? What about masking more severe problems?**

Injection therapy for selective nerve root blocks selective nerve root blocks with cortisone or local anesthetics is recommended for acute LBP. The best location is determined by thorough history and physical. These blocks differ from epidural blocks. Please see references below.

Chou, R, et. al (2007). Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Annals of Internal Medicine, 147*(7), 478-491.

Armon, C., Argoff, C. E., Samuels, J., & Backonja, M. M. (2007). Assessment: use of epidural steroid injections to treat radicular lumbosacral pain: report of the American Academy of Neurology. *Neurology, 68*(10), 723-729.

Buenaventura, R.M., Datta, S., Abdi, S., & Smith, H.S. (2009) Systematic review of therapeutic lumbar trans foraminal epidural steroid injections. *Pain Physician, 12*(1), 233-251.

Stuart, J.B., deBie, R.A., deVet, H. C., Hildebrandt, J., & Nelemans, P. (2009). Injection therapy for subacute and chronic low back pain: an updated Cochrane review. *Spine, 34*(1), 49-59.

8	**What do you know about the neurobiology of addiction, in light of the evidence that people prone to addiction are at risk of addiction to multiple substances, and how does this knowledge affect your management of chronic pain patients with addictions?**

I am not an expert in the neurobiology of addiction. However, individuals with history of addiction and chronic pain are to be treated. A referral may be warranted preferably to an expert in chronic pain and addiction medicine. Treatment would include pain contract, urine drug testing, etc. See p. 67 of handout for Responsible Opioid Prescribing CME activity for further training. http://www.fsmb.org/pain/

9	**Do you have any information on the comparative efficacy of spinal decompression therapy for herniated discs, low back pain, etc.?**

No. I recommend checking out the following web sites to compare evidence and effectiveness of these treatments

National Guideline Clearinghouse http://ngc.gov/

Agency for Healthcare Research and Quality http://www.ahrq.gov/

Cochrane Collaboration http://www.cochrane.org/cochrane-reviews

10	**Who decides when a patient is to have a drug screen?**

This is part of the contract. Frequency depends on risk. See handout for more information on universal precautions (p. 35), urine drug screening (p.49), and assessing risk (pp. 41-42)

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11	**How do you handle patients that are on opioids and either miss or don't schedule appointments and then present or call requesting refills?**

There is no easy answer.

What you do depends on your relationship with the patient and handled on a case-by-case basis. There may be many reasons why someone misses appointments, including inadequate pain treatment, lack of access to pharmacy, travel, etc. Developing trust and implementing informed, shared decision-making early in the patient-provider relationship is essential.

Schedule 2 drugs may be prescribed for 90 days and require a written, dated prescription. Schedule 3-5 controlled substances may be prescribed for 6 months. Using mail-order or pharmacy that provides reminders for refills may be helpful.

You may need to include consequences of missed appointments in contract, pill counts, and urine drug testing.

What I would not do is call-in a 30 day prescription or leave a signed prescription for pick-up. If the person is well-enough to come to the clinic, that person is well enough to be seen.

12	**Are you familiar with the Partners Against Pain from Purdue Pharmaceuticals? partnersagainstpain.com very helpful for information and CD with all forms included.**

Yes, I am. I agree this is an excellent resource.

13	**You previously mentioned that acetaminophen is not helpful unless the dose is maxed--what is the point of using opioids that include this medication in combination, especially when the total intake will far short of 4,000 mg?**

I was referring to the use of acetaminophen alone. Adding acetaminophen in smaller doses provides an additive analgesic effect when used with opioids, as does the NSAIDs.

14	**Given the ease of "popping pills" vs. the relatively high level of motivation and effort required for behavioral and physical therapy (yoga, home exercise program, mindfulness meditation, etc.), pts are inclined to the former. In my experience, strongly inclined to it. They don't want to even quit smoking (many of my chronic pain patients smoke, typically cigarettes, often marijuana as well). What approach would you take?**

First, nicotine is one of the most (if not the most) addictive substances, so smoking cessation is difficult and I do not recommend it until pain is fairly-well managed. I find that the patients I work with are happy to implement or try non-opioid and non-drug treatments as long as the plan is reasonable. It takes time to negotiate inclusion of healthy behaviors. I tend to use informed and shared decision-making with an emphasis on facilitating the patient's health. With that in mind, I ask what the person plans to do to nourish themselves before the next visit (in 2-4 weeks or sooner). I document our discussion and then we review what went well, what could have gone better at the next visit. Use of a health diary or journal helps with adherence and evaluation of activity within the context of the patient's life.

It takes time to change the focus from "pain" to function, quality of life, and health. Once we start talking about optimizing health or quality of life, I find it fairly easy to add in alternative treatments or lifestyle changes at a slow and steady pace.

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15	**What about the increased risk with fentanyl use? Should this not be used cautiously by providers that understand the risk, physiology and have an established well documented clinical evaluation?**
I am sorry I do not understand this question. We use the fentanyl patch without problems for baseline pain control; and, the physician I work with prefers to use fentanyl over morphine for use with pain pumps.	
16	**Do the drug providing programs require MD/DO orders for anti-trust, prejudicial, or liability reasons or something else?**
Sorry, I do not understand this question.	

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