CHRONIC PAIN MANAGEMENT IN PRIMARY CARE

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Workshop Goals:

- Greater understanding of the pathophysiology and psychological interplay in chronic pain
- Complete understanding of state rules regarding the treatment of chronic pain with opioids
- Leave with a system of care and tools that you can take back to your practice
- You leave more confident that structured, evidence based chronic pain treatment is possible!

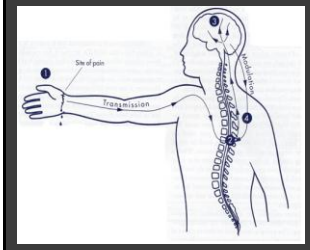
What is chronic pain?

- 50 million Americans
- #1 cause of long term disability
- Prevalence in primary care 5-33%*
- 10-20% of primary care visits
- 41% of pts state that their pain is not controlled

*Carrington Reid M, Use of opioid medications for chronic noncancer pain syndromes in primary care. *J Gen Intern Med* 2002;17:173-179.

Other stats from Nicholson B, Treatment of chronic moderate-to severe non-malignant pain with polymer-coated extended-release morphine sulfate capsules. *Curr Med Res Opin* 2006;22:539-550.

The Continuum of Acute into Chronic Pain



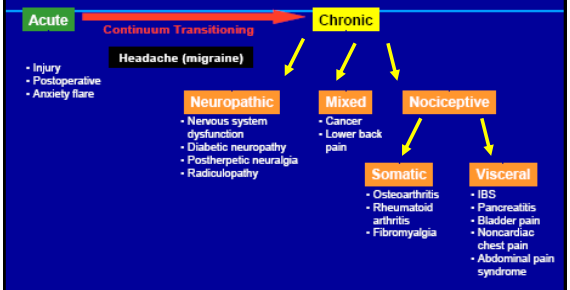
Acute tissue damage

1. Inflammatory mediators
2. C fibers stimulate glutamate release at SC
3. Up to higher CNS
4. Feedback via endorphins, GABA inhibits glutamate

If Inflammation Persists

- Glutamate release persists
- NMDA receptors stimulate Substance P
- New dendrites, resistant
- **Chronic pain**

Pain Classification



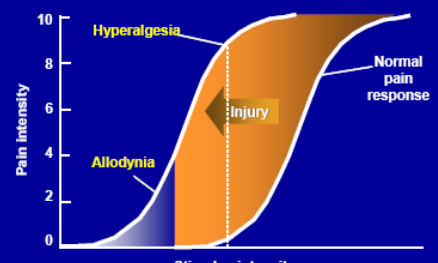
Section 14: Neurological Disorders. Chapter 167: Pain Topics. In: Beers MH, R, eds. *The Merck Manual of Diagnosis and Therapy*. 17th ed. White House Station, NJ: Merck & Co., Inc.; 2004.

FP-PEP

Chronic Neuropathic Pain:

- Pain initiated or caused by a primary lesion in the CNS or PNS
- Remodeling at the spinal cord level
- Modulation less effective
- If anti-nociceptives (anti-inflammatories) are less effective, you have evidence of a neuropathic component

Sensitization



Gottschalk A, Smith MD. *Am Fam Physician*. 2001;63:1979-1986.
Figure, Copyright 2001, David M. Klemm.

FP-PEP

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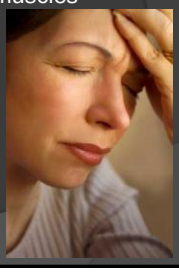
Psychological interplay…

Limited activity → Weak tight muscles

Depression

Deconditioning

Social Withdrawal



Perception of Pain

- Conscious experience of pain
- Emotional component

When Chronic Pain becomes a Chronic Illness

Functional Status
- Physical functioning
- Ability to perform activities of daily living
- Recreation
- Work

Psychological Morbidity
- Depression
- Anxiety, anger
- Sleep disturbances
- Loss of self-esteem

Social Consequences
- Marital/family relations
- Intimacy/ sexual activity
- Social isolation

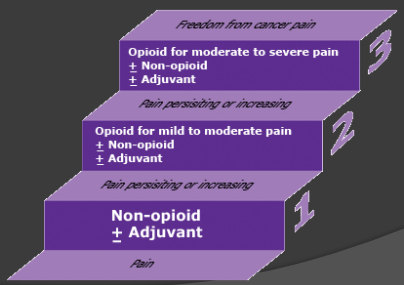
Socioeconomic Consequences
- Healthcare costs
- Disability
- Lost workdays

Therapeutic Strategies for Pain and Disability

- Lifestyle changes
- Rehabilitative approaches
- Psychological approaches
- Anesthesiology approaches
- Surgical approaches
- Neurostimulatory approaches
- Complementary and alternative approaches
- **Pharmacotherapy**

Pain 202 Lecture – Colorado Pain Initiative

Often we have to use pills…



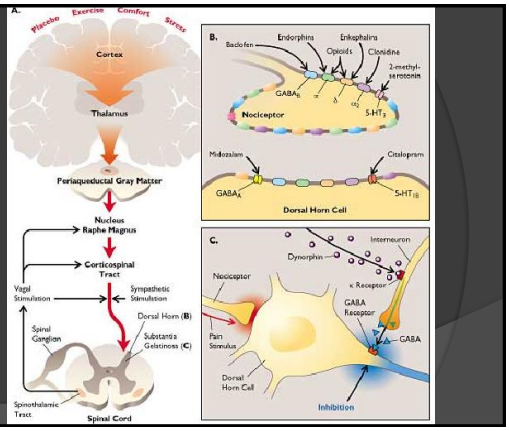
Source: WHO Palliative Care and Cancer Project 1986

Chronic Nociceptive Component:

- Acetaminophen
  - 2-4 gm per day
  - Caution with ETOH / hepatitis / elderly
- NSAIDs
  - Stronger evidence for acute pain
- Muscle Relaxants
  - Moderate evidence for use in the first 4 days
  - Baclofen for chronic pain

Adjuncts are very helpful!

- Anti-depressants
  - TCAs
    - 10-100 mg QHS
    - 55-65% effective
  - SSRIs
    - 70-80% effective
    - Headache
  - SNRIs
    - Cymbalta
    - Effexor
- Anti-epileptics
  - Sodium Channel Blockade
    - Carbamazepine
    - Phenytoin
    - Lamotrigine
    - Oxcarbazepine
    - Topiramate
  - Calcium Channel Blockade
    - Gabapentin
    - Pregabalin
  - Valproic acid
- Clonidine
- Tramadol



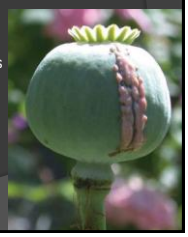
Opiate - Refers to morphine and related alkaloids derived from the poppy

Opioid - Broader term includes exogenous substances with morphine-like properties

Narcotic - Legal and regulatory meaning applied to any substance that can cause dependence

Considering Opioids

- Benefits
  - They work
  - Moderate to severe pain
  - Stimulate descending modulation and inhibition of pain
  - Complement other modalities
- Risks
  - Side effects
  - Abuse
  - Addiction
  - Diversion
  - Inducing pain
  - Contraindications



Quality of Life Associated with Daily Opioid Therapy in a Primary Care Chronic Pain Sample

Kathryn Sullivan Dillie, PhD, Michael F. Fleming, MD, MPH, Marlon P. Mundt, PhD, and Michael T. French, PhD

Background: **Daily opioid therapy is widely used in the treatment of chronic noncancer pain, yet there is limited empirical evidence on the relationship of opioid dosing and health-related quality of life (HRQoL) in primary care settings.**

Methods: **An analysis was conducted to assess the relationship of opioid dose to quality of life. The sample consisted of 801 chronic pain patients who were prescribed daily opioids and 93 non-opioid users recruited from the practices of 235 primary care physicians. Eight HRQoL domain scores were calculated and compared with US norms and across opioid use groups. A new modeling technique, propensity score matching analysis, was performed to adjust for potential confounding factors across 4 morphine-equivalent opioid dose groups (<20 mg, 20–40 mg, 41–105 mg, >105 mg).**

Results: **HRQoL scores were significantly lower in chronic noncancer pain patients relative to the US general population regardless of opioid use. In unadjusted comparisons, those using up to 20 mg/d of opioids had the highest HRQoL scores, whereas those using >105 mg/d had the lowest. After adjusting for potential confounders, those in the 20 mg to 40 mg/d dosing group had significantly better HRQoL scores than their non opioid-treated or higher dosed counterparts.**

Conclusion: **Use of low- to moderate-dose opioid therapy provides an improvement in HRQoL scores for chronic noncancer pain patients compared to no opioid therapy, while high-dose opioids have a smaller positive effect that is limited to mental health quality of life and patient satisfaction, and that may not justify treatment. (J Am Board Fam Med 2008;21:108–117.)**

Barriers to Opioid Pain Management

- Inadequate education in pain and addiction medicine
- Misunderstanding of common definitions used in pain and addiction
- Societal influences
- Fear of abuse/addiction secondary to prescribing of opioids
- Fear of the regulatory agencies

- Tolerance
  - state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time
- Dependence
  - state of adaptation that is manifested by a drug-class-specific withdrawal syndrome
- Aberrant bahaviors
  - Variety of behaviors ranging from
    - Misuse – use different from prescription
    - Abuse – use for non-medical reasons
    - Diversion

AMA Pain Management, The Online Series, Module 3, September 2007

- Addiction
  - characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving
  - A chronic, neurobiological condition
- Pseudoaddiction
  - patient behaviors that may occur when pain is undertreated
  - behaviors resolve when the pain is effectively treated.

What does the DEA say?

- "As a condition of being a DEA registrant, a physician who prescribes controlled substances has an obligation to take reasonable measures to prevent diversion…"

DEA Office of Diversion Control; 2006 Policy Statement: Dispensing Controlled Substances for the Treatment of Pain

What does the DEA say?

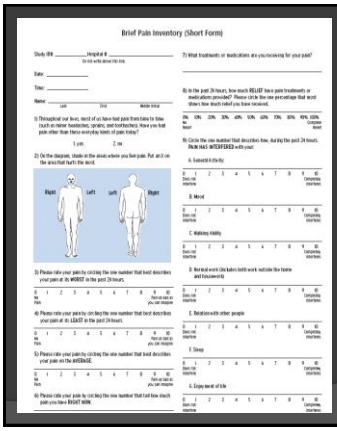
- "The longstanding requirement under the law that physicians may prescribe controlled substances only for legitimate medical purposes in the usual course of professional practice should in no way interfere with the legitimate practice of medicine or cause any physician to be reluctant to provide legitimate pain treatment."

DEA Office of Diversion Control; 2006 Policy Statement: Dispensing Controlled Substances for the Treatment of Pain

Universal Precautions in Pain Medicine

1. **Diagnosis with appropriate differential**
2. **Pain and function assessments**
3. **Psychological assessment, including risk of addictive disorders**
4. **Consideration of trial of opioid therapy**
5. **Informed consent**
6. **Treatment agreements**
7. **Reassessment of pain, function, and behavior**
8. **Regular reassessment of the 4 A's: Analgesia, Activities of daily living, Adverse events, Aberrant drug-taking behavior**
9. **Periodic review of diagnosis and comorbidities**
10. **DOCUMENTATION**

Gourlay DL, et al. *Pain Med.* 2005;6:107-112.

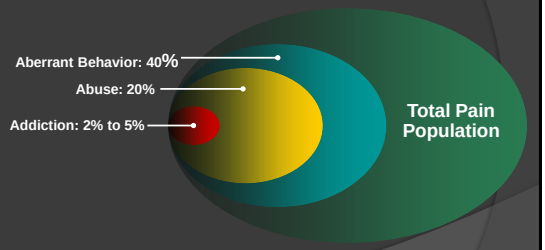

Brief Pain Inventory (Short Form)

Brief Pain Inventory
www.mdanderson.org

Psychological Assessment

- Psyche co-morbidities
- Past / current history of substance abuse
  - Cage-AID
- Risk of future problems / "aberrancies"
  - Opioid Risk Tool (ORT)

Most Who Use Do Not Abuse



Used with permission from Webster's "Structuring Opioid Therapy," *Practical Pain Management*, Vol. 7, Issue 7 (9/07) pp.12-16.

Opioid Risk Tool

	FEMALE	MALE
Family history of substance abuse		
• Alcohol	[ ] 1	[ ] 3
• Illegal Drugs	[ ] 2	[ ] 3
• Prescription Drugs	[ ] 4	[ ] 4
Personal history of substance abuse		
• Alcohol	[ ] 3	[ ] 3
• Illegal Drugs	[ ] 4	[ ] 4
• Prescription Drugs	[ ] 5	[ ] 5
Age (mark box if between 16 and 45)	[ ] 1	[ ] 1
History of preadolescent sexual abuse	[ ] 3	[ ] 0
Psychological disease		
• ADD, OCD, bipolar, schizophrenia	[ ] 2	[ ] 2
• Depression	[ ] 1	[ ] 1

Risk Category is (circle one):
LOW (Score 0-3: 6% chance of aberrant behavior)
MODERATE (Score 4-7: 28% chance of aberrant behavior)
HIGH (Score >=8: >90% chance of aberrant behavior)

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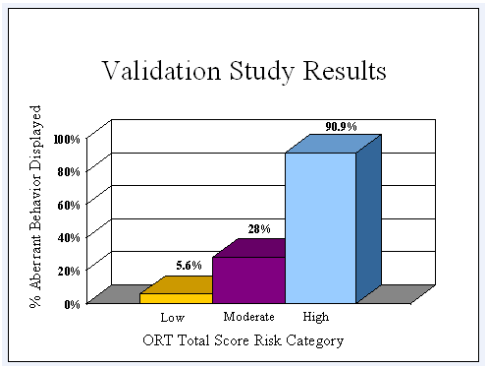

Low Risk (Routine)	Moderate Risk	High Risk
Opioid treatment agreement	All low risk guidelines plus:	All low and moderate risk guidelines plus:
Get old records	Monthly or biweekly visits and scripts	Strongly consider having a pain specialist assume care
Initial prescription database check	Have family in to discuss treatment plan	Weekly visits / scripts
Initial urine drug screen	Semi-annual prescription database checks	Have family in to discuss treatment plan
Brief Pain Inventory	Initial and random urine drug screens	Quarterly prescription database checks
Use flow sheet for every visit	Consider co-morbid mental disease	Scheduled and random drug screens
Document the "Four A's"	Consider a pain or psychiatric consult for co-management	Third party administration (spouse)
Monthly visits to start, then may back off if doing well	Consider medication counts	Psychiatric and addiction evaluations required
Step up risk if significant aberrancy seen	Consider limiting rapid onset opioids	Medication counts
	Step up risk if significant aberrancy seen	Limit rapid onset opioids
		Consider limiting short acting opioids

Adapted with permission from Webster's "Structuring Opioid Therapy," *Practical Pain Management*, Vol. 7, Issue 7 (9/07) pp.12-16.

Informed Consent / Treatment Agreement

- Signed by patient and provider
- Side effects
- Tolerance, Dependence, Abuse, Addiction and Pseudoaddiction
- Patient role
- Office Policies
  - Refills
- Out-clause

Reassessment at every visit!

- Document the "4 A's"
  - Analgesia
  - Activity
  - Adverse Effects
  - Aberrant Behaviors
- Occasionally repeat the BPI, ORT
- Respond appropriately to aberrancies!!!

10. Documentation in the Medical Record:

- ✓ The most specific diagnosis possible
- ✓ Pain / function assessment
- ✓ Psychological assessment
- ✓ Initial treatment plan
- ✓ Informed Consent / Opioid agreement
- ✓ Reassessment at every visit
  - ✓ Flow sheet
- ✓ Reasoning behind any changes to the tx plan / referral / tapering / dismissal