Pain Medicine for FP

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Objective

- Support clinicians prepared to diagnose, appropriately assess, treat, and monitor patients with chronic pain.
- Appreciate the need for an individualized, patient-centered approach based on a biopsychosocial model as opposed to the biomedical model that is more commonly employed.

Pain: The Basics for Managing

- A patients' reporting of pain is variable (Ward 8-9-10 Scale)
- A common assumption about pain is that it always results from the presence of underlying organic pathology.
- Assessment of patients who report pain requires attention to psychosocial, behavioral, and organic factors.
- Consider Neuropathic, Nocioceptive, Central / Perceptual

Types of Pain

- three distinct pain mechanisms: (1) peripheral nociceptive—caused by tissue damage, ischemia or inflammation, (2) peripheral neuropathic—damage or dysfunction of peripheral nerves, and (3) centralized—characterized by a disturbance in the processing of pain by the brain and spinal cord (plasticity, neurobiologic, receptive field, emotional)

State of Pain in USA

- Chronic pain affects an estimated 100 million Americans, or one-third of the U.S. population.
- Pain is the primary reason that Americans 4 are on disability
- Societal costs of chronic pain are estimated at between $560 and $630 billion per year as a result of missed work days and medical expenses
- Opiate addiction, 17,000 OD in 2011, 29,000 Neonatal Withdrawal

Physiatry, Anesthesia, Psychiatry, FP

- How a physician thinks about pain affects the way in which he or she **assesses** a patient who presents with pain.
- Reliance on imaging to identify pathology?
- Reliance on therapist for functional limits
- Reliance of psychologist / LCSW

Key Questions

1. What is the long-term effectiveness of opioids?
2. What are the safety and harms of opioids in patients with chronic pain?
3. What are the effects of different opioid management strategies?
4. What is the effectiveness of risk mitigation strategies for opioid treatment?

Burden of living with Pain

Can negatively affect a person's ability to:

- maintain **gainful employment** or achieve meaningful advancement professionally. It affects **relationships** with spouses and significant others and limits engagement with friends and other social activities. The prospect of living a lifetime with pain induces **fear** and demoralization and can lead to diagnoses of **anxiety and depression**.

FDA

(FDA) & opioid medications

- All current, **extended-release opioids have been approved for acute and chronic pain based on 12-week adequate and well-controlled efficacy studies**. A number of **immediate-release opioids** had been on the market without prior approval; however, in recent years, all of them have received FDA approval for acute pain. In other words, the FDA has approved these drugs for long-term use, but they **have not been evaluated for safety and efficacy for longer than 12 weeks.**

Reimbursement Model

- There is little reimbursement for models of care that include a **chronic care management team and ancillary services, despite the evidence base that these are the most effective approaches to chronic pain management**. As a result, the **burden** of care management frequently falls on the individual clinician, in particular the **primary care** physician. With an average of 15 or 20 minutes per visit, the most expeditious way to manage pain while also attending to other medical conditions is to prescribe an opioid.

Striking a Balance

Two ethical principles: beneficence and doing no harm

- clinically indicated prescribing of opioids on one hand
- the desire to prevent inappropriate prescription, abuse, and harmful outcomes on the other.

Risk Predictors

- Data are limited on effective risk prediction instruments for identifying patient at highest risk for the development of adverse outcomes (e.g., overdose, development of an opioid use disorder) . Longitudinal studies have demonstrated risk factors (e.g., **substance use disorders**, other comorbid psychiatric illnesses) that are more likely to be associated with these harmful outcomes

Initial Evaluation Strategy

- Include an appraisal of **pain intensity**, **functional status**, and **quality of life**, as well as assessment of known **risk factors** for potential harm, including **history of substance** use **disorders** and current substance use; presence of **mood**, stress, or anxiety **disorders**; **medical comorbidity**; and concurrent use of **medications with potential drug-drug interactions.**
- **CRISP, UDT**

Treatment Options

- Acute
  - OMM (treat disease process)
  - RICE
  - NSAID / Acetaminophen / Tramadol / Topical, Opiate
- Chronic
  - physical therapy, behavioral therapy, and/or complementary and alternative medicine
  - SNRI, TCA, AED, Transdermal, Opiate (IR/ER),

Treatment Strategies

- X-ray?
- Physical therapy?
- NSAIDs? nsNSAID / Cox II, Acetaminophen
- Muscle Relaxors?
- Opioids? Tramadol? Nucynta?
- Injections?
- Surgery?

Interventional Strategies: Treatment

- SI joint injection
- Epidural Steroid Injection
  - Caudal, Translaminar, Transforaminal
- Facet block with Steroid / Facet injection w/S
- Radiofrequency Neurotomy of nerve to facet joint / SI joint or of peripheral nerve
- Neuromodulation (SCS trial / implant)
- Discoplasty, IDET, Discotheroplasty

Clinical Opiate Management

There is **little evidence to guide a clinician** once they have made the decision to initiate opioids for chronic pain therapy. Data on selection of specific agents based on opioid characteristics, dosing strategies, and titration or tapering of opioids are insufficient to guide current clinical practice

Opioid rotation in which one changes from an existing opioid regimen to another with the goal of improving therapeutic outcomes and minimizing tolerance if chronic use occurs.

Opiate Rotation Theory

- three known classes of opioid receptors—mu (μ), kappa (κ), and delta (Δ)—have been identified, multiple receptor subtypes within each of these classes in fact can alter the effect of opioids based on receptor subtype binding. This led to a discussion between workshop speakers of the concept of incomplete cross-tolerance, in which providers may need to reduce the dose by 25 to 30 percent when converting between one opioid and another.

Adverse Events and Side Effects

Chronic administration of opioids are associated with adverse effects

- increased risk of falls and fractures,
- hypogonadism with resultant sexual dysfunction,
- increased risk of myocardial infarction.
- Opiate substance use disorders (misuse / abuse / diversion

Risk Mitigation Strategies

Data are limited on the efficacy of various risk mitigation strategies.

- Patient agreements, urine drug screening, and pill counts
- Naloxone for overdose treatment (patient / family)
- Prescribe fewer pills to be taken over a shorter but clinically reasonable timeframe

Assessment of Outcome

Patient assessments should be ongoing, including both positive and negative outcomes.

Items on assessments might include pain intensity and pain frequency, using both a short and long time reference for comparative purposes, functional status including impact on functions of daily living, quality of life, depression, anxiety, and other measures that mimic those items obtained during the initial clinical risk profiling. These frequent reassessments should guide maintenance or modification of the current treatment regimen, and patients who are failing to meet the mutually agreed upon clinical outcomes should be considered for discontinuation of opioid therapy

Challenges for Primary Care

- Poor support for team-based care and specialty pain clinics
- Over-burdened primary care providers
- A lack of knowledge and decision support for chronic pain management
- Financial misalignment favoring the use of medications
- Fragmentation of care across different providers
- DEA, BPQA, Litigation

Administrative Burden

- Growing requirements for documentation in the electronic health record are consuming a larger portion of the office visit. Hence, time-consuming but important clinical tasks—such as **conducting multidimensional assessments**, developing **personalized care plans**, and **counseling**—have given way to ***care processes that can be accomplished quicker and with fewer resources***, such as **prescription writing** and **referrals**.
- Formulary Restrictions (IR<ER), Pre-authorizations

Consequences

- Loss of patient access to quality care
- Radicalization of views (None writers verses pill mills
- Excessive reliance on imaging
- Increase utilization of interventional approach
- Increase surgeries
- Increased suffering

The mind reading expectation

- physicians are unable to distinguish among individuals who would use opioids for pain management, those who would use them for pain management and then become addicted, and those who use because of primary substance use disorders
- Study in 2010 concluded 14-19 % treating w/ in pain clinic met criteria for addiction

BPQA: Reprimand, Fine, Suspension, Revocation

In response to the Board's questions:

1) Did the Respondent sell, prescribed, give away or administer drugs for illegal or illegitimate medical purposes?

2) Engage in unprofessional conduct in the practice of medicine?

3) Do the facts in this case raise a substantial likelihood of risk of serious harm to the public health, safety or welfare of patients in Maryland?

It is a diverse peer group who will judge. "If it looks like a duck, swims like a duck and smells like a duck" cardinal rule

Questions

Thank you for supporting the MAOP efforts to enhance and strengthen the presence of Osteopathy in Maryland