Objectives

- Understand and discuss the types of pain seen in clinical practice
- Understand and discuss the precipitants, components, and influences of the Pain Experience.
- Demonstrate an increased knowledge of the goals and tools used in the clinical assessment of patients with regard to chronic pain
- Understand what is required to appropriately prescribe opiates chronically

Don’t Believe Everything...

No Intentional Disinformation

- Clinical Guidelines American Pain Society / American Academy Pain Medicine / Canadian Medical Association – recently revisited
  - Included on the CD
  - Strong Recommendation – Low level of evidence

The Challenge of Pain

- Pain is a perceptional experience
  - It is what the patient says it is
  - Combination of cognition, emotion, and memory
- Half of a painful experience is a memory
- Recall call of pain “lights up” fMRI the same as active pain process
- What are the memories/experiences that make up the perception
- They the price, we name the terms
IASP Definition of Pain

• An unpleasant sensory AND emotional experience associated with actual or potential tissue damage, or described in terms of such damage.
• Sensory – Sensory Discriminative
• Emotional – Affective Motivational
• Actual/Potential Tissue Damage – Eudynia
• Described as such – Maldynia / Persistent Pain

The Evolution of Pain

• Cartesian “Bell Ringer”
  • Intensity of signal = amount of damage
  • Mind & body exist as separates
• Wall & Melzack-The Gate Control Theory
• Science 1965 “Pain Mechanisms: A New Theory”
  • Rejected for publication three times
• Now thought of a “Neuromatrix / Hologram”

Case One

New Patient Appointment

• 44yo CF recently relocated from CA. establishing care, needing refills
• PMHx - MVA 83 & 2001
• PSHx - R femur ORIF/ R knee scope
• Epidural steroid injections, neurolysis of L3, 4, 5, & S1, neurolysis of C-spine C4-5
• Social - Married, Disabled, Smokes ½ ppd, (2ppd), Past hx of EtOH & IV drug use (Recovery since 1995)
• PHx of adolescent sexual abuse

Imaging Results

• Degenerative Disk Disease /c a sm-mod bulge & mild spinal stenosis @C5-6
• Sm. bulge @ C6-7 level
• No evidence of cord compression
• R protrusions @ L4-5/L5-S1 level @ in mild right L4-5 & mild right L5-S1 neuroforaminal narrowing both /c radial annular tears.
• No evidence of central canal stenosis.
• Pt is ultimately referred for a morphine pump

Case Two

• 23 yo CM B knee pain worsening over last year.
• 6 prior knee surgeries
• Surgery 12/17/10 Rx HC/APAP 10/325 # 60 +1
• Refilled on 12/17/2011, 1/08/, 1/13/,1/26 (+ 1), 2/01/ called to change sig to Q 4
• Ortho changed to HC/APAP 5/500 #60 2 refills told to start transition to NSAID
• 2/23 turfed to PCP for “Chronic Pain Management”
• Told PCP I don’t want to be on these medications
Case Two

- Started Gaba over the phone titrated up to 3600mg
- Moved to Pregabilin 75mg Bid & Nortriptyline 25mg
- Called 7/14 for early refill going out of the country (honeymoon). Early refill ok but called when returned and said that 50 stolen out of luggage
- 8/08 Favor called in & he was referred to me
- 8/10 given HC/APAP10/325 # 60 by PCP
- 8/18 sees me in PM ran out of HC in am Taking about 80mg HC a day

Pain Types

- Sensory Discriminative -- allows for precise characterization of the signal
- Affective Motivational – the signal’s meaning
- American Academy of Pain Medicine
  - Eudynia
  - Maldynia
  - Persistent Pain

Good Pain: Eudynia

- Good Pain!
  - Pain as symptom
  - Warnings of damage
  - Makes Sense!
- Deal with it & it goes away
- Inflammatory Pain
  - Part of the healing process
  - May go away

Maldynia: Pain as disease

- Neuroplastic changes result in sensitization
- Sensory fields expand
- Sensitization occurs
  - Peripheral nerves
  - Spinal cord
  - Brain
- Pain is “nonsense” – doesn’t provide useful information

Eudynia: normal pain transmission

Ugly Pain: Persistent Pain

Combination of the two totally sensitized system
May be peripheral 1st then central
DPN FM
Chronic Migraine
Chronic Low Back Pain
**Persistent Pain: the “ugly”**

- Brain sensitization
- What fires together, wires together
  - Recruitment of A-beta fibers to nociception
- What fires apart, wires apart
- Use it or lose it
- Fascial cells 10X neurons
  - Continual information highway from head to toe

**Pain Pathways**
**Mapping the Interventions**

- Perception – Pushing the “I don’t care” button
- Modulation – Dialing down the response
- Transmission
  - 2nd order neurons
  - 1 neurons
- Transduction

**Interventions by Pathways**

**Perception – The I Don’t Care button**

- Opiates
- Alpha2 agonists
- TCA
- SNRI
- SSRI

**Modulation**
Dialing down the response

- TCA
- SNRI
- SSRI

**Transmission**

- 2nd order Neurons
  - Local Anesthetics
  - alpha2 agonist
- 1st order neurons
  - opiates
Transduction
• Local Anesthetics
• Capsaicin
• Membrane Stabilization
• NSAIDs
• ASA
• APAP
• Nitrate

Development of Acute Pain
Injury
  └─ Inflammation
      └─ Learning
          └─ Acute pain
              └─ Reflex muscle spasm
                  └─ Protection

Resolution of Acute Pain
Healing
  └─ Inflammation
      └─ Learning
          └─ Acute pain
              └─ Reflex muscle spasm
                  └─ Protection

Progression to Chronic Pain
Injury Memory
  └─ Nonsense Information
      └─ Chronic pain
          └─ Reflex muscle spasm
              └─ Nonsense Information

Pain Modifiers

AAFP NATIONAL CONFERENCE
Marcus DA Chronic Pain 2008 p39
Osler’s Razor

• It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has
  Sir William Osler

Limbic Influences in Migraine

• All Pain has meaning
• The Sorrow that hath no vent in tears may make organs weep— Henry Maudsley
• (When) the mind is hurt the body cries out
  Italian Proverb
• The body remembers what the mind forgets— J.L. Moreno

San Francisco Spine Study

Who does well with surgery for disc pathology?

• SF – where study was done
• Spine – Journal
• 86 pts /c proven severe lumbar disc herniation were preoperatively interviewed regarding five possible childhood traumas
• Physical abuse
• Sexual abuse
• Emotional neglect/ abandonment
• Loss of one or both parents (divorce, death)
• Drug abuse at home (EtOH, Rx drugs etc.)

San Francisco Spine Study

• The patients were assigned to 3 different groups:
• No risk factors - 95% improvement
• 1 or 2 risk factors – 73% improvement
• 3 or more risk factors – 15% improvement

Even Lucy knows that

Gender Differences in Pain

Ethnic Differences in Pain

- African American
- Hispanic
- Non-Hispanic
- Caucasian


Ethnic Difference in Medication

- Caucasians
- African American


Tobacco & Pain

- Smokers
- Non-smokers

Ackerman WE, Ahmad M. J. Ark Med Soc 2007; 104:19-21

Sensitization

- May occur with a single intense event
- May occur with continuous low level stimulation

Genotype & Phenotype

Pathological mechanisms
- Inflammation
- Peripheral Sensitization
- Central Sensitization

History / Social
- Prior Pain Experiences
- Reaction to pain by SO

Cognitive Factors
- Meaning of Nociception
- Coping Style

Emotional Factors
- Fear of pain
- Degree of Anxiety

Pain

Open Pain Gates – Increases Pain
- Fatigue
- Boredom
- Anger, Frustration, Stress
- Physical Deconditioning
- Focus, Dwelling on Pain

Closed Pain Gates
- Feeling energetic, happy, and calm
- Being relaxed
- Physically Fit
- Being distracted or occupied with non-pain activities
- Having Positive Pain Expectations

Having negative pain expectations
- “There’s nothing I can do to help my pain”
Factors Predicting Chronic Pain

<table>
<thead>
<tr>
<th>Physical Findings</th>
<th>Back pain associated with restricted lumbar flexion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Non localized pain</td>
</tr>
<tr>
<td></td>
<td>Insidious pain onset</td>
</tr>
<tr>
<td></td>
<td>Back Pain radiates to leg</td>
</tr>
<tr>
<td>Psychosocial factors</td>
<td>Depression or psychological distress</td>
</tr>
<tr>
<td>Personal issues</td>
<td>Female gender</td>
</tr>
<tr>
<td></td>
<td>Prior trauma or chronic pain history</td>
</tr>
<tr>
<td></td>
<td>Delay before consultation (&gt;30days)</td>
</tr>
<tr>
<td></td>
<td>Dissatisfaction with consultant</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Nicotine use</td>
</tr>
<tr>
<td>Family issues</td>
<td>Lack of social support</td>
</tr>
<tr>
<td></td>
<td>Family de-legitimizes pain</td>
</tr>
<tr>
<td></td>
<td>Family history of chronic pain</td>
</tr>
<tr>
<td>Occupational issues</td>
<td>Dissatisfaction with work status</td>
</tr>
<tr>
<td></td>
<td>Previous job change related to pain</td>
</tr>
</tbody>
</table>

When Pain Becomes Chronic

- Acute transitions to Chronic between 3–6m
- Adopt the Chronic disease model
- Diabetes/Thyroid/Allergic Rhinitis
- Have the conservation -- What is causing your pain?
- Know what you are going to do.

Standard of Care

Opiates in Chronic Pain

- Legitimate Disagreement
- All agree on importance of pt. selection
- Consider stratification for Addiction
- Opioid Risk Tool, Screener & Opioid Assessment for Pts. /c Pain.
- While the risk of addiction is low in the properly assessed patient...
- Addicts have a high incidence of pain & comorbid psych conditions.

Chronic Pain in Opioid Users

- 110 pt presenting for inpt. Detox
- 91.2% reported pain in the last week.
- 42.8% had Chronic Pain
- Chronic Pain pts had significantly greater depressive symptom severity, pain- related functional interference
- More likely to be disabled

Problems with Opiates

- Long term opiate users worse psych distress & worsened txt outcomes
- Opiates users display more disability, higher Health Care utilization, higher tobacco & other Substance Abuse rates and higher rates of depression
- Opiate users had higher pain rating despite their use

Increasing Female Overdose Deaths

- 23000♂ 15,300♀ 2010 deaths
- 40% Opiate deaths♀
- Increased 5X 1999-2010
- Believed 70% unintentional
- Greatest ↑♀ 45-54yr & 55-64yr

Source: CDC

Dersh, et al, Spine 2008; 33: 2219-2227
Opiates linked to Cancer Spread

- Opiate & receptor interaction can increase proliferation, migration and invasion of tumor cells
- Endogenous or exogenous opioids appear to have a significant & direct proliferative effect on cancer cells, aside from their effect suppressing immunity

Problems with Opiates

- Review of WA. Wk Comp claims for Low Back injury 34.1% had Opiate Rx in 1st 6 wks
- Opiates >7days/6wks ↑ disability LBP injury
- Opiate Rx for 7d/6wks ↑ 2.2X of long term disability
- 2 Rxs for Opiates/6 wks ↑ 1.8X risk of long term disability

Chronic Pain

- Goal is not to be “pain free”
- RCTs indicate average improvement is about 10–20 mm on 100mm scale
- Focus on function – ADLs
- Disease from Distress – Fear of discomfort – pts need to become comfortable with being uncomfortable

Waddell Signs

- Superficial/diffuse and/or non-anatomic tenderness
- Simulation tests: axial loading, simulated rotation
- Distracted Straight Leg Raising
- Non-anatomical regional motor or sensory changes
- Overreaction to provocative test

Waddell Signs

- Argues that it is misused –
- Five Categories
- 1 or 2 signs not a strong non-organic component.
- 3 positive considered clinically significant.
- 3 ≥ positively correlated with high scores for depression, hysteria, & hypochondriasis on MMPI.

Psychotherapeutic Co-Interventions

- Pain is a “Brain disease”
- Comorbidities must be addressed
- Functional restoration-Not “Pain Freedom”
- Physical Therapy
- Adjunctive treatments
5 Coping Skills for CP Patients

- Understanding
  - Educate, Hurt ≠ Harm, Prognosis, Plan
- Accepting – William James
  - Why Me?, Stop Catastrophizing, Don’t Should on yourself
- Calming
  - Dial back fight/flight. What ever works
- Balancing
  - In & Out, Don’t overdo, get good sleep
- Coping
  - Plan for pain, Distraction

Common psychological & behavioral techniques for CNCP

- Reconceptualisation of the patient’s pain from uncontrollable to manageable
- Fostering optimism, combat demoralisation
- Promotion of patient feelings of success, self-control, and self-efficacy
- Encouragement of patients to attribute success to their own role
- Education in the use of specific skills such as pacing, relaxation, and problem solving
- Emphasis on active patient participation and responsibility

The Brian in Pain

- Designed for action
- Reflex, no time to think about it
- Doesn’t comprehend the negative or absence
- Self talk needs to be positive

Psychological Testing

<table>
<thead>
<tr>
<th>Depression, Anxiety &amp; Pain Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Beck Depression Inventory</td>
</tr>
<tr>
<td>• Pain Catastrophing Scale</td>
</tr>
<tr>
<td>• West Haven Yale Multidimensional Pain Inventory</td>
</tr>
<tr>
<td>• Pain Beliefs and Perceptions Inventory</td>
</tr>
<tr>
<td>• Survey of Pain Beliefs - Revised</td>
</tr>
</tbody>
</table>

Chronic Pain

Evidence-Based treatment basics

- Opioid Treatment Guidelines-APS, AAPM
- H & P /c approp, dx /c Mod-Severe pain affecting fxn
- Psych assess including assessment for Substance Abuse, Aberrant Drug Taking Behavior, etc...
- Obtain informed consent & treatment agreement
- Perform pre / post intervention pain level & function
- Assess for Opiate Benefits > Risks
- Start appropriate opioid trial /c or /s adjunctives
- Reassess above during Continuous Opioid Therapy

Chronic Pain Treatment Basics

- Reassess pain score and level of function
- Regularly assess the 4 A’s (analgesia, ADLs, adverse events, aberrant drug-taking behaviors
- Periodically review pain diagnosis & comorbid conditions including addiction
- Provide documentation
Consent & Management

- Avoid “contract” – Really more of an informed consent
- Opiates are not benign
- Identify goals, expectations, risks, benefits and alternatives
- Written management plan

Documentation tools

- Controlled substance registry
- Prescription Access Texas Website
- Search “PAT” & DPS
- Password protected, generates a report of all controlled substances prescribed for a defined time period

Documentation requirements

- Assess Addiction risk
- Impaired activities of daily living (function)
- Failed other forms of pain control

Opioid Risk Tool

- by Lynn Webster, MD
- Stratifies risk
- Low 0-3
- Moderate 4-7
- High > 7

Risk Stratification

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Patients</td>
<td>Primary Care Patients With Specialist Support</td>
<td>Pain Specialist Patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family History</th>
<th>Alcohol, Illegal Drugs, Rx Drugs</th>
<th>Personal History</th>
<th>Alcohol, Illegal Drugs, Rx Drugs</th>
<th>Age 15-45</th>
<th>Presence or past substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>No past or current history of substance use disorder</td>
<td>1</td>
<td>No past or current history of problematic drug use</td>
<td>3</td>
<td>1</td>
<td>No past or current psychopathology.</td>
</tr>
<tr>
<td>No family history of past or current substance use d/o</td>
<td>3</td>
<td>May have past history of substance use disorder.</td>
<td>4</td>
<td>4</td>
<td>May have family history of problematic drug use.</td>
</tr>
<tr>
<td>No major or untreated psychopathology. Consistent UDS.</td>
<td>4</td>
<td>May have past or current psychopathology.</td>
<td>5</td>
<td>5</td>
<td>May have past or current psychopathology.</td>
</tr>
<tr>
<td>PMP consistent. Pain mild to moderate.</td>
<td>6</td>
<td>Not actively addicted. Usually consistent UDS.</td>
<td>7</td>
<td>7</td>
<td>Not actively addicted. Inconsistent UDS.</td>
</tr>
<tr>
<td>Active substance use disorders. Major, untreated psychopathology. Poor social support.</td>
<td>8</td>
<td>Usually consistent UDS.</td>
<td>9</td>
<td>9</td>
<td>Usually consistent UDS.</td>
</tr>
<tr>
<td>Active substance use disorders. Major, untreated psychopathology.</td>
<td>10</td>
<td>Mild to severe pain.</td>
<td>11</td>
<td>11</td>
<td>Mild to severe pain.</td>
</tr>
</tbody>
</table>

Screener for Opiates APP

- Designed to predict aberrant drug taking in Chronic Pain Patients
- Self Report
- Available in 5, 14, & 28 questions
- http://www.inflexxion.com/SOAPP/
Deception

Nothing New Under The Sun

• Caucasian model of The Whizzinator
• Female model also available

“Google” the dreaded pill count

Googled “the dreaded pill count”

• Pt called in for a random pill count
• f***in' nosey doctor
  • Tell her to TRY to keep a reserve out of every script, one or two pills, which adds up and is a life-saver if another ‘come in TODAY for a pill count’ call is received... or @ least she'll have some stashed for a rainy day
  • I’d make the most of a bad situation. Make your,sorry her, next appointment as usual and when there apologies for being out of town(have a good story of where she's been) and ask if she’d like to arrange a pill count soon, appear as if she wants to cooperate. I’d also keep my fingers crossed and look into other sources......just in case
  • make sure she's ready for a “whiz quiz.” She should make sure she has OC in her system on her next visit.

Follow Up

• Required – but not defined by the TMB
• Response to therapy – Brief Pain Inventory, PADT (Patient Assessment & Documentation Tool)
• 4 - A’s: Analgesia, ADLs, Adverse Events, Aberrant Drug Taking
• Red Flags for Abuse
• Document rationale for changing doses.

Dose Escalations

• Ask why dose is going up
• High doses increase risk of Adverse Events
• Consider Opioid rotation
• Taper / wean off pts who engage in ADTB

Chronic Pain

Managing Difficult Patients

• Highly structured approach
• Frequent office visits (at least monthly)
• Limited supply of meds
• Pill counts
• Selected use of rescue
• Urine drug testing
• Written treatment agreement
• Referral and co manage pt. /c addictionologist
• Maintain rigorous documentation

Physician Pain Resources

• Practical Pain Management – throwaway journal free with registering www.practicalpainmanagement.com
• www.painedu.org
• www.emergingsolutionsinpain.com
Physician Pain Resources

- ***** 1 review
- •***1/2  18 reviews
- 12 Step approach to Chronic Pain

John Sarno, MD

Shoulders of Giants

Books by Sarno: Mind over Back Pain
Healing Back Pain, The Mind Body Prescription, The Divided Mind

Books Inspired by Sarno
The Great Pain Deception
Pain Free For Life - Scott Brady MD
Freedom From Fibromyalgia - Nancy Selridge, MD
To Be or Not To Be Pain Free - Marc Sopher, MD

Chronic Pain: Bibliotherapy

• They Can't Find Anything Wrong
  • www.Stressillness.com
  • ****1/2  18 reviews

• Unlearn Your Pain
  • www.unlearnyourpain.com
  • ***** 52 reviews

Chronic Pain: Bibliotherapy

Managing Pain Before It Manages You

**** 25 reviews

The Pain Survival Guide

**** 26 reviews

Chronic Pain: Bibliotherapy

Fit as Fido walking diary
Chronic Pain: Bibliotherapy

- **** 15 reviews
- The Great Pain Deception
- www.paindeception.com
- ***** 52 reviews

- Conquering Your Child's Chronic Pain
- **** 16 reviews

Chronic Pain: Bibliotherapy

- A Headache in the Pelvis
- **** 96 reviews
- Pain Free Egoscue Method
- ****1/2 395 reviews

Chronic Pain

Many of us spend our whole lives running from feeling with the mistaken belief that you cannot bear the pain. But you have already borne the pain. What you have not done is feel all you are beyond the pain.

Saint Bartholomew

Case 2

- Started of Suboxone 8mg ½ film SL Q AM, 1 film SL QPM
- Transitioned to Suboxone 8mg 1 film QPM
- Reported improved sleep, pain control, & ADLs
- 5 visits over 2 months, then apt Q 2 months.
- Last seen 2/29 doing well
- Missed appointment 3 times in June – I refused to provide refills
- Moved to another state
- Called on 8/31 told couldn’t find doc to Rx – directed to website

Concluding Thoughts

- More than nociceptive input
- Pain freedom is not a goal.
- Focus on function
- Opiates are not benign
- No demonstrated benefit beyond 6 months
- Patient selection is paramount for Continuous Opiate Therapy

Case 2

- Started of Suboxone 8mg ½ film SL Q AM, 1 film SL QPM
- Transitioned to Suboxone 8mg 1 film QPM
- Reported improved sleep, pain control, & ADLs
- 5 visits over 2 months, then apt Q 2 months.
- Last seen 2/29 doing well
- Missed appointment 3 times in June – I refused to provide refills
- Moved to another state
- Called on 8/31 told couldn’t find doc to Rx – directed to website
Putting it all Together

- Accept the Pain
- Plan activities that distract from the pain
- Get angry at your pain if it seems to be getting the best of you
- Take medicine on schedule and gradually taper off
- Get physically fit
- Practice relaxation techniques regularly
- Keep busy and don’t allow your pain to determine your plans
- Pace your activities
- Elicit support from family and friends
- Communicate openly with your doctor
- Share experiences with others who have pain remain hopeful

Chronic Pain

Typical Features of Noncompliance with Opioid Therapy

- Concurrent use of non-rx psychoactive substances / illicit drugs or EtOH
- Urine drug tests negative for prescribed drug and positive for other nonprescribed drugs
- Lack of effectiveness of noncontrolled substances
- Failure to follow dosage schedule / Frequent requests for dose increases
- Failure to adhere to concurrently recommended treatments
- Frequently reported loss of prescriptions or medications
- Missed follow up appointments / Frequent extra appointments at clinic for prescriptions
- Frequent visits to the ER for opioid therapy
- Tampering with prescriptions / Prescriptions obtained from a second provider / pharmacy
- Specific drug requests / Diversion dealing, stealing drugs
- Functional deterioration / Isolative behavior

Chronic Pain patients who do not do well

- Certain pt’s behaviors have been linked to development of problems in managing opioid intake
- Poly substance abuse
- Focus on opioids
- Nonfunctional status due to pain
- Exaggeration of pain
- Cigarette dependency
- Social patterns of drug use
- Legal problems

Lynn Webster, MD

Chronic Pain patients who do not do well with chronic opiates

- Personal hx of substance abuse increases risk 7X
- Family Hx of SA strongly vulnerable to genetic influences
- Age (young) 22% SA d/o -- tolerance develops faster
- Hx of preadolescent sexual abuse
- Mental disease
- Psychological stress
- Lack of 12 step
- Poor social support
- Hx of repeated drug / EtOH rehab
- Chronic pain syndromes
- Unclear etiology for pain

Lynn Webster, MD

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