Collaborative Pain Management-
Treating Pain Effectively

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Financial Disclosure

Nothing to Disclose
Objectives

- Differentiate between various pharmacologic and non-pharmacologic options for pain management
- Identify appropriate measures necessary for prescribing opioid pain medications
- Recognize the importance of a multidisciplinary approach to pain management and the effects of inappropriate pain management has on the healthcare system
Case Study

- Patient, M.G., is a 36-year-old female who comes to your office for her annual exam.

- She mentions pain in her back, that has persisted for the last year following a fall.

- Physical exam shows no apparent physical or mechanical cause for her pain.

- Imaging from the local hospital doesn’t indicate a cause.
Case Study

• Patient appears to be in no acute distress and functions normally

• Patient reports a pain level of 8/10.

• She is requesting oxycodone 30mg tabs, for she is allergic to Vicodin and morphine.

• When you question her about other options for pain management, she states that “nothing else seems to help her pain.”

• As her primary care provider, how should you help her?
But first, please answer the following question?

1. I do NOT prescribe opioids for chronic pain
2. I do prescribe opioid pain medications for chronic pain.
As her primary care provider, how should you help her?

1. She is suffering in pain; provide her with the requested prescriptions
2. She is obviously drug seeking, refuse to prescribe the requested narcotics
3. Prescribe the requested medication, this time, but no further refills until you obtain her PMH and do a comprehensive evaluation.
4. No Rxs today, but pursue a comprehensive assessment / evaluation first.
5. Refer her to a pain specialist
Last Questions

• Which of all the following are true?

  1. M.G. is a patient simply seeking a prescription for narcotics
  2. Oxycodone is an appropriate medication for her seemingly chronic back pain
  3. Further imaging is necessary to determine the cause of her pain.
  4. The patient deserves appropriate pain management for her pain level of 8/10.
  5. All the above are false

• What other questions do we need answered?
Effects of Pain On Society

- 100 million US adults\textsuperscript{1}
- National Cost-$560-635 billion/yr\textsuperscript{1}
- Chronic pain is a disease in itself.\textsuperscript{1}
- Poor pain management effects all facets of life
- Individualized Pain Management
- Moral imperative
- The need for effective, interdisciplinary pain management services and communication among all providers
- Many patients fall through the cracks of our healthcare system
- A small number of patients result in a significant portion of healthcare expenses
- Few programs available for uninsured and patients with addiction problems
- Roles of patients and clinicians.\textsuperscript{1}
- Value of health and community-based approach.\textsuperscript{1}
Receptors in Pain

- TCAs/SSRIs/SSNRIs
- \( \alpha_2 \)-adrenergic antagonists
- tramadol, oxycodone CR
- Descending fibers
- Dextromethorphan
- 5HT opioid \( \alpha_2 \)
- Calcium channels
- Substance P
- Substance gelatinosa
- NMDA AMPA
- GABA
- GABA\( \alpha \)
- GABA\( \beta \)
- Interneuron
- topiramate/pregabalin gabapentin/carbamazepine TCAs/insulin/lamotrigine
- A delta fiber
- Sodium channels
Physiological Response of Pain

• Pain can cause
  - Elevated BP
  - Tachycardia
  - Hyperglycemia
  - Protein catabolism
  - Sodium and water retention
  - Increased risk of thromboembolic event
  - Decreased GI motility
  - Decreased immune response
Pain Types

• Chronic vs Acute

• Palliative Care vs Hospice

• Common pain syndromes
  – Fibromyalgia
  – Migraines
  – Low Back Pain
  – Abdominal Pain
  – Neuropathy
  – Bone Pain

• Current guidelines will help lead therapy
Other Causes of “Pain”

- Anxiety/Depression
- Nausea/Vomiting/Gas
- Sleep Deprivation
- Poor Coping Skills
- Stress
- Psych Condition
- Social Concerns
  - Financial problems
  - Relationship difficulties
Pain Assessment

**Patient Education Necessary**

- Vitals
- Pain History Assessment
  - Location
  - Quality
  - Intensity
  - Modifying Factors
  - Timing
- Reassessment
Pain Treatment Options

- Interventional Pain Management
- Surgery
- Alternative Care
  - Acupuncture
  - Massage
  - Stress Management/Relaxation
  - Reiki
  - Holographic Memory
  - Biofeedback
  - Medicine Men or other “healers”
- Medications
Medications

• Analgesics
• Anti-inflammatory Medications
• Anticonvulsants
• Antidepressants
• Muscle Relaxants
• Sodium Channel Blocker
• Alpha-2 Adrenergic Agonists
• Cannabinoids
• Various Topicals
• Opioids
Opioid Agonists

- Mu, Delta, Kappa
- Pure Mu agonists
  - Morphine, codeine, hydrocodone, oxycodone, oxymorphone, levorphanol
- Partial Mu agonists
  - Buprenorphine, butorphanol
- Mixed agonist/antagonist
  - Nalbuphine, pentazocine
- Central (Mu+NE/5HT)
  - Tramadol, tapentadol
Conversions are for education purposes only and clinicians should use sound clinical judgment on an individual basis.

### Opioid Conversions

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<th>Drug</th>
<th>IV/IM/SQ</th>
<th>PO/SL/PR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mg</td>
<td>mg</td>
</tr>
<tr>
<td>Morphine (Avinza, Embeda, Kadian, MS Contin, Oramorph SR, Roxanol, MSIR)</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Oxycodone (Oxycontin, OxyFast, Roxicodone, Percocet, Endocet)</td>
<td>--</td>
<td>20</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid, Exalgo)</td>
<td>1.5</td>
<td>7.5 (3 PR)</td>
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<tr>
<td>Hydrocodone (Lorcet, Lortab, Norco, Vicodin)</td>
<td>--</td>
<td>30</td>
</tr>
<tr>
<td>Methadone (Methadose, Dolphine)</td>
<td>10</td>
<td><strong>24 hr MSO4 methadone</strong></td>
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<tr>
<td></td>
<td></td>
<td>&lt; 30 mg  2:1</td>
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<td>31-99 mg 4:1</td>
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<td>100-299 mg 8:1</td>
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<td>300-499 mg 12:1</td>
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<td></td>
<td>500-999 mg 15:1</td>
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<tr>
<td></td>
<td></td>
<td>&gt; 1000 mg 20:1</td>
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<tr>
<td>Oxymorphone (Opana)</td>
<td>1</td>
<td>10</td>
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<tbody>
<tr>
<td></td>
<td>mg</td>
<td>mg</td>
</tr>
<tr>
<td>Meperidine (Demerol)</td>
<td>100</td>
<td>300</td>
</tr>
<tr>
<td>Buprenorphine (Buprenex, Subutex, Suboxone)</td>
<td>0.3</td>
<td>0.4 (SL)</td>
</tr>
<tr>
<td>Codeine (Tylenol #3, etc)</td>
<td>130</td>
<td>200</td>
</tr>
<tr>
<td>Tramadol (Ultram, Ryzolt, Rybix ODT)</td>
<td>100</td>
<td>120</td>
</tr>
<tr>
<td>Tapentadol (Nucynta)</td>
<td>No current equianalgesic dosing</td>
<td></td>
</tr>
<tr>
<td>Nalbuphine (Nubain)</td>
<td>20</td>
<td>--</td>
</tr>
<tr>
<td>Pentazocine (Talwin)</td>
<td>30</td>
<td>--</td>
</tr>
</tbody>
</table>
Opioid Concerns

- Allergy vs Pseudoallergy
- Tolerance vs Dependence vs Addiction
- Hyperalgesia
- Allodynia
- ER vs IR dosing
  - Recommendations are 80% ER and 20% IR for chronic cancer pain and past addiction problems
  - Decrease development of tolerance
Opioid Concerns

- Methadone Treatment and Pain Management
- Psychiatric Conditions and Pain Management
- PROMPT vs PROP
- Hydrocodone as C-II?
- Diversion- Street Value
- Weaning-decrease by no more than 30% every 3 days
Risk Evaluation and Mitigation Strategies (REMS)

- Medication Guide with each prescription
- “REMS-compliant” training for providers
- Educate patients on risks vs benefits of LA opioid medications
  - Increased risk of overdose
  - Abuse/Tolerance
  - Drug Interactions
- Assess risk of abuse and psychiatric conditions
  - Screening tools for addiction
  - Refer to pain management specialists if necessary
  - Document all treatment plans and patient interactions
Risk Evaluation and Mitigation Strategies (REMS)

- Use appropriate medications and doses
  - Cross-tolerance and equianalgesic doses
  - Side effects to monitor
  - Drug-drug interactions
  - When to wean patient off opioids

- Managing Therapy
  - Establish analgesic and functional goals of therapy and reassess regularly
  - Consider patient provider agreements (PPAs)
  - Recognize, document, and address aberrant behavior.
  - Use appropriate drug testing
  - Utilize prescription drug monitoring programs
  - Refer to addiction treatment if needed
Risk Evaluation and Mitigation Strategies (REMS)

• Patient Counseling
  – Safe usage of LA opioid pain medications
  – Side effects (including death)
  – What to do about missed doses
  – Contact the provider when pain not controlled
  – Swallow whole and do not cut patches
  – Avoid hypnotics, anxiolytics, CNS depressants, illegal drugs, and alcohol
  – Do not stop abruptly
  – Selling or giving opioids away is illegal
How to Protect Yourself

• Individualized pain management
• Communicate with your patient and providers
• Document EVERYTHING
• Physical assessment
• TREAT THE CAUSE if possible
• Have the TALK-history of addiction, etc
• Listen to your patient and establish functional goals
• Screen for addiction
• Refer out-PT, specialist, counseling, etc
How to Protect Yourself

• Prescribe the right drug for that patient’s pain
  – AVOID large quantity of IR opioids (“Dr Feelgood”)
• If opiates prescribed, develop long-term plan and use patient provider agreements
• Monitor for aberrant behavior
• Use drug-testing regularly and randomly
• Utilize the AZ PDMP website with each visit
• Address frequent ED visits and hospital admissions
• Counsel patients appropriately
• DOCUMENT EVERYTHING
AZ PDMP Specifics

- What meds are included?
  - All CII-CIV medications filled in outpatient pharmacies.
  - ANY suppliers (mail orders, etc) who ship meds into AZ ARE included in the website.
  - BUT methadone or treatment clinics, VAs, and IHS ARE NOT included
- Things to consider:
  - There is a time delay in data availability that can be 7-14 days!
  - **If the patient did not pick up the script, it DOESN'T take it off the record (without the pharmacy providing the data to the state voluntarily)
  - Data should be available from April 2008
  - Used as one tool in making clinical decisions
AZ PDMP Specifics

• Common errors:
  - Date dispensed entered in DOB field
  - Mike vs Michael (Search by "begins with" and use "M")
  - Incorrect DOB provided to pharmacy (Use "search by 2 years")
  - Hyphenated last names (try each one separately)
  - Newly married or recent name change? (Must rely on patient information)
  - Spaces entered at the start of either the first or last name
  - Same script number on the same day displayed twice-likely transmission error

• Assistants (Rx techs, RNs, etc) CAN NOT access data.
• Providers will receive a letter if their patients have seen 7+ providers OR 7+ pharmacies
  - 15 patients triggered in one month, with 143 letters sent
  - AHCCCS does audits on their members also.
AZ PDMP Specifics

• Other helpful tricks
  - When many different files show up when searching, click "sort by date" on the screen with the many names (at the bottom). (Control click will pick individual ones)
  - Medical marijuana card holders have "MMC" (medical marijuana card) next to their name

• Most states have passed legislation for a similar site (Missouri only one not included), but many haven't started collecting data
  - If searching these databases, you need the patient's exact name (which can differ, depending on the accuracy at entry, see below)
  - Possible centralized database through NABP in near future

• Questions? Call Dean Wright, State Board of Pharmacy, (602) 771-2744
Multidisciplinary Approach

- Primary Care Provider
- Medical Specialist (Neurology, Rheumatology, etc)
- Pain Management Specialist
- Pharmacist
- Nursing
- Psychiatry and Counseling
- Physical Therapy
- Relaxation Therapy
- Alternative Approaches
- Interventionalists
- Surgeons
- Spiritual Leaders
- Social Workers
- Palliative Care/Hospice
Back to the Case Study

• What do you need to do to protect yourself, but also treat the patient’s current condition? (Check all that apply)

  A. Check the AZ Prescription Monitoring Program Website
  B. Obtain and document a full history of the current pain
  C. Provide a thorough physical assessment
  D. Obtain and document past history of abuse or psychiatric conditions
  E. Refer to patient to a pain management specialist
Back to the Case Study

• What about M.G.’s allergies?

• Is an MRI indicated?

• Why was the patient admitted to the hospital?

• How does her pain level of 8 correlate to her functioning?

• Is oxycodone 30mg the most appropriate drug and dose?

• What else would you recommend?
Conclusion

- Pain management is subjective
- Pain is what the patient says it is
- Treating the cause is ideal
- Do your research
- Treatment plans should include all pharmacologic and non-pharmacologic options
  - Right Person, Right drug, Right dose, Right duration.
  - Use extended release opioid products if long term tx.
- Documentation is the key
- Re-evaluate the plan regularly
- Complete the loop of communication
- Refer the patient
- Continued education for you and your patients
Questions?
References


