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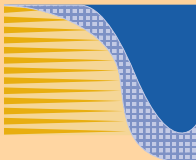
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NATIONAL INITIATIVE ON PAIN CONTROL™



OPIOID ANALGESIA AND THE ELDERLY PATIENT

PART II:

Maintaining the Patient on Opioid Therapy

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Pain in the older patient is more difficult to address than in a younger population, as barriers to care are more frequent in this age group. Elderly patients who have pain are less likely to talk to family and friends about pain, are more likely to cite getting older as the cause of their pain, and in more than 20%

of cases believe there is no solution to their pain.¹ Treatment also is more difficult. Nonsteroidal anti-inflammatory drugs, the most common medications used to treat arthritis-associated pain, often lead to serious morbidity and mortality in older adults.^{2,3} Polypharmacy is common for the myriad of diseases elderly patients

experience, and leads to greater risk of drug-drug interactions and side effects.

Despite the complexity of pain treatment in the older patient in general, the questions most commonly asked about treatment options revolve around the use of opioid analgesics. This two-part series addresses these concerns. The intent is not to

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Assessing Patients With Chronic Pain: A Comprehensive Approach

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Pain is a complex problem with psychosocial as well as physical components. As pain persists for longer periods, the psychosocial factors begin to play a greater role in the perpetuation and exacerbation of pain and the deterioration in physical and emotional functioning. Consequently, comprehensive assessment of patients with chronic pain is needed as a basis for developing a rational approach to treatment and successful outcome.¹ The elements of a

proper pain assessment include the following:

- Pain history
- Physical examination
- Psychosocial assessment

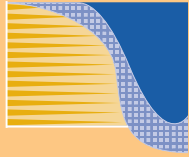
Pain History

Assessment of all patients with chronic pain should begin with a thorough history of underlying illness and symptoms. No single symptom or sign is pathognomonic, and a detailed history of each symptom, type of pain, treatment received, treatment effectiveness, and adverse responses to treat-

ment should be elicited. Evaluating the characteristics of pain (ie, onset, duration, severity, location, patterns, description, amplifying and alleviating factors) and other symptoms associated with pain is the first step. Pain intensity scales (eg, a numeric scale that rates the severity of pain from 0 = no pain to 10 = worst possible pain) can be used to establish a baseline against which the success of treatments may be judged. Clinicians should be familiar with several of these scales in order

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**NATIONAL INITIATIVE
ON PAIN CONTROL™**



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LETTER FROM THE CHAIRMAN

Dear Colleague:

It is now estimated that chronic or persistent pain may be experienced by nearly 10% of the adult population in the United States (approximately 25 million adults). In most cases, the primary care physician is the first to encounter the patient with chronic pain, making it crucial that the PCP be able to provide adequate assessments and select appropriate treatment options for these patients.

The National Initiative on Pain Control™ (NIPC™) is dedicated to educating physicians who contend daily with the serious impact of unresolved pain on their patients' health and psychological well-being. This latest issue of *Pain Management Today™* is designed to be clinically useful in your day-to-day practice by providing the latest diagnostic information and therapeutic strategies in pain management.

The articles, written by distinguished members of the NIPC, are timely and relevant in dealing with such clinical issues as:

- The essential elements of a proper pain assessment for successful outcome
- The latest advances in topical therapies
- Tips on managing the pain patient after specialty consultation

Also included in the newsletter are a posttest and an evaluation form to complete and return in order to receive CME credit. For complete CME instructions, turn to page 9.

Finally, it is with great enthusiasm that the NIPC announces the recent launch of its new, innovative slide module *Opioid Analgesia: Practical Treatment of the Patient With Chronic Pain*. Designed to offer hands-on information, the module includes a treatment algorithm and an integrated sample case study used throughout to demonstrate key clinical points. The presentation has met with resounding success in its initial sessions, and we anticipate that it will be just one of many educational tools the NIPC will offer in helping physicians meet the many challenges of initiating and maintaining opioid therapy. Specific information on the upcoming DINNER DIALOGUES® series featuring the new Opioid Analgesia module can be found on page 12 of this issue.

All of us at the NIPC encourage you to take advantage of our future CME activities, including audio-conferences, dinner meetings, seminars, and Webcasts. For the latest details about all NIPC programs, log on to the NIPC Web site partner, PainEDU.org (www.painedu.org), a premier pain management resource for clinicians.

Sincerely,

Nathaniel P. Katz, MD
NIPC Chairman



CME evaluation form and posttest appear on pages 9 and 10.

ABOUT THE NIPC

The National Initiative on Pain Control™ (NIPC™) is an integrated CME education initiative that was established in 2001 to help physicians improve outcomes for their patients who have pain. Living with chronic pain has deleterious effects on many aspects of the patient's life including deterioration of physical functioning, the development of psychological distress and psychiatric disorders, and impairment of interpersonal functioning. In fact, approximately 40 percent of patients with chronic pain also experience major depression. The program heightens physician awareness of the impact of pain on patient's daily living in terms of quality of life, lost workdays, and societal/familial consequences.

Of special concern, more than 1 million cases of neuropathic pain are reported each year, which accounts for between 25 and 50 percent of all visits to pain clinics. Unfortunately, less than optimal training of physicians in pain disorders has led to the underassessment and undertreatment of patients who are living with pain.

NIPC addresses the barriers to achieving pain control by providing potential pathways for action and expected amelioration of their patients' pain. By providing physicians with the latest advances and strategies in pain management, they will be better able to translate clinical data into clinical practice.

All NIPC programs are developed and continuously evaluated by the NIPC Education Council, an expert, multidisciplinary team of specialists, researchers, and practicing physicians in pain management.

You have received this mail because we believe it may be of interest to you. If you would like your name to be removed from our mailing list, please follow these instructions:

Call 1 (800) 873-1362 and leave a message with your name and address indicating that you would like to be removed.

Volume 3, Number 2, released November 2003, is the second part of a two-part CME activity. This issue includes a posttest and evaluation form that will cover the contents of both issues. Physicians who wish to receive credit should do the following: (1) read each newsletter, (2) review all the articles in their entirety, (3) complete the posttest and mail the evaluation form to Thomson Professional Postgraduate Services®, CME Dept. #B248, 150 Meadowlands Parkway, PO Box 1505, Secaucus, NJ 07096-1505. Within 8 weeks of receipt of the evaluation form, applicants will be sent a letter of completion from Thomson Professional Postgraduate Services®. To receive CME credit, the evaluation form must be returned by March 31, 2004. This activity is valid for CME credit through March 31, 2004.

CME INFORMATION

This CME activity is sponsored by Thomson Professional Postgraduate Services®, Secaucus, NJ. Thomson Professional Postgraduate Services® is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Thomson Professional Postgraduate Services® designates this educational activity for a maxi-

mum of 2 category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the activity.

The National Initiative on Pain Control™ (NIPC™) and its educational components are supported by an unrestricted educational grant from Endo Pharmaceuticals.

After reading the two-part newsletter series for 2003, participants should be able to:

- Identify and select appropriate medications to be used in combination in the treatment of neuropathic pain, including evidence-based treatment recommendations.
- Explain the appropriate use of long- and short-acting opioids in chronic pain management.
- Understand the mechanism of action of the topical delivery system and latest topical advances.
- Assess the patient in pain and know when to refer to the pain specialist.
- Understand how to work with a pain specialist and how to transition a patient from pain specialist to primary care specialist.

- Partner with the patient in pain management using a patient care agreement.
- Evaluate and treat people with painful diabetic neuropathy
- Determine how and when to use opioids for pain management in the elderly, how to start an opioid plan, and how to manage side effects, and ongoing treatment for this population.

This educational activity is a component of the NIPC™ and is designed to heighten the knowledge of physicians and other healthcare providers about the serious impact of unresolved pain on patient care. Some of the agents included in this newsletter are discussed in the context of uses for which they have not been approved by the FDA.

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The Latest in Topical Therapies

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Over the past several years, the treatment of neuropathic pain has continued to evolve as our understanding of nerve injury-related pathophysiology has improved.¹ Numerous studies of inflammatory and neuropathic pain have demonstrated that central sensitization is partially sustained by peripheral A-delta and C-fiber activities. Studies involving chronic neuropathic pain, such as postherpetic neuralgia (PHN), have identified subtypes of functionally abnormal peripheral nociceptors that may contribute to ongoing central sensitization.

Advantages of Topical Analgesics

Current treatments with oral medications have demonstrated only 35% pain reduction in 40% to 50% of patients in controlled studies of opiates, antidepressants, and anticonvulsants.² Topical analgesics achieve pain relief with a much lower incidence of side effects than systemic agents.³ Local applications of the lidocaine patch 5%, as well as lidocaine combined with prilocaine as EMLA® (eutectic mixture of local anesthetics) cream, and capsaicin, doxepin, aspirin, and nonsteroidal anti-inflammatory drug (NSAID) preparations in cream, ointment, or gel form have all demonstrated efficacy for the treatment of acute, chronic, and neuropathic pain.³

Topical analgesia presents an approach through “targeted peripheral analgesia” that may improve patient outcomes by suppressing peripheral mechanisms of pain.³ Combination studies with the local anesthetic lidocaine and several topical opiates have demonstrated synergy in the radiant heat in animal studies.⁴ Peripheral applications of amitriptyline, dextromethorphan, and ketamine have demonstrated efficacy in the acute pain models. When given by local injection, tricyclic antidepressants have proposed mechanisms that include the well-known ability to inhibit reuptake of serotonin and norepinephrine as well as lesser-known qualities as potent Na⁺ channels blockers.⁵ Other mechanisms of action include N-methyl-D-aspartate receptor antagonists and

interaction with adenosine receptors. Recent trials comparing cutaneous applications of lidocaine with amitriptyline demonstrated concentration-dependent analgesia. Nociceptive blockade to pinprick was maintained with amitriptyline base (at 500 mM concentration) for more than 20 hours without any systemic effects in animal studies.⁶

Topical Analgesics and Neuropathic Pain

Use of the lidocaine patch 5% has been shown to be effective as a targeted peripheral analgesia for the treatment of neuropathic pain. Several studies have demonstrated that topical lidocaine will suppress the allodynia related to peripheral nerve injury in patients with PHN. Open-label data from 16 patients with various chronic neuropathic pain disorders, including postthoracotomy pain, painful diabetic neuropathy, postmastectomy pain, postamputation pain, and neuralgia paresthetica, reported that 81% experienced improvement in their pain.⁷ The efficacy of the topical lidocaine patch 5% on distinct neuropathic pain qualities in 60 patients with diabetic neuropathy has been demonstrated in an open-label prospective trial.⁸

Recent clinical trials also have evaluated the use of the lidocaine patch 5% for the treatment of low back pain. An open-label study of 120 patients with acute (<6 weeks), subacute (<3 months), short-term chronic (3-12 months), and long-term chronic (>12 months) low back pain was completed at eight US centers. During the 6-week study period, as many as four lidocaine patches 5% were applied every 24 hours. Analysis of the data after 2 weeks noted significant improvements in pain intensity and relief, as well as worse pain; Brief Pain Inventory scores for pain interference and Beck Depression Inventory scores were significantly reduced.⁹ In addition, the continuous 24-hour-a-day use of four lidocaine patches 5% for 72 hours recently has been demonstrated to be safe and without any systemic reactions.¹⁰

EMLA cream has not received FDA approval for any neuropathic pain disorder; however, two uncontrolled studies

have suggested that EMLA cream may be an effective agent for patients with PHN.¹¹⁻¹² The pain associated with a number of neuropathic pain disorders, such as diabetic neuropathy, PHN, and postmastectomy pain, has been reported to be lessened by the use of capsaicin cream.¹³

A recent study comparing the analgesic effect of a combination topical preparation containing doxepin 3.3% and capsaicin 0.075% demonstrated superiority over placebo for patients with a diagnosis of chronic neuropathic pain.¹⁴

Polypharmacy has become the standard of care for treatment of neuropathic pain because of the moderate efficacy of any of the single-agent approaches. Support for such an approach was presented in a recent open-label prospective 2-week trial with combinations of peripherally acting analgesics such as lidocaine patch 5% and centrally acting gabapentin. Significant reductions were demonstrated in pain intensity, pain relief, and quality-of-life indicators for patients with PHN, diabetic neuropathy, and low back pain.¹⁵ The lidocaine patch 5% was safe and well tolerated; topical and systemic side effects were reported in only 21 of 107 patients studied. Adverse events were mild to moderate, with the most frequently reported being somnolence, paresthesia, and dermatitis.

As our understanding of the mechanisms underlying chronic pain improves, the interest in new approaches for the treatment of pain will expand. Novel uses for familiar drugs will continue to grow, requiring prospective placebo-controlled studies to support current prospective observational reports.

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Extended-Release vs Short-Acting Opioids in the Management of Pain

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In 1986, the national consumption of opioids for medical use began to increase significantly in the United States due to increased prescribing.¹ Many articles appeared in the lay press, medical literature, and national symposia on the extensive clinical experience with the use of long-term opioid therapy for severe, unremitting cancer pain.²⁻⁶ These discussions were fueled by a growing knowledge of pain anatomy and physiology, opioid pharmacology, and an improved understanding of opioid tolerance and addiction.⁷⁻⁹ With this increased awareness came more widespread use of opioid analgesics for the treatment of chronic noncancer pain. Opioid prescribing for the clinical management of pain continues to increase. There remains, however, a wide range of prescribing practices and no consensus on when to use short- vs long-acting opioids in pain management.

It is a generally accepted practice to use pain-contingent short-acting opioids for the treatment of acute and cancer pain; however, there is controversy about pain-contingent short-acting opioid treatment of chronic noncancer pain. It has been suggested that the use of short-acting agents on a long-term basis will lead to drug tolerance—a problem that is not observed with time-contingent long-acting opioids.¹⁰ It is unclear whether this tolerance is a true physiologic response or a behavioral response. However, it is clear that patients using fast-onset and short-acting opioids will have more peaks and valleys in both plasma level and physiologic response; therefore, there are both positive and negative reinforcements that occur in pain control. This management issue is not observed with the use of long-acting opioids.

Guidelines for Acute Pain

As the standard of care for the treatment of acute pain, short-acting analgesics are widely used.¹¹ Acute pain usually will resolve over 4 to 8 weeks, and pain-contingent short-acting opioids can be tapered

as the pain resolves; therefore, tolerance is not an issue in acute pain management. The choice of which short-acting opioid to prescribe will depend on the pain intensity. For mild-to-moderate pain, opioids such as hydrocodone, codeine, or propoxyphene can be used. For moderate-to-severe pain, stronger opioids such as oxycodone, morphine, hydromorphone, or fentanyl should be considered.

Dosages of tablets combining acetaminophen and an opioid are limited according to the nonopioid component. If an acetaminophen-containing opioid is used, the total daily dose of acetaminophen should not exceed 4 g. Newer formulations have recently been introduced that contain less acetaminophen,

The treatment of chronic noncancer pain should rely more on time-contingent long-acting opioids

for example oxycodone in 5-, 7.5-, and 10-mg doses combined with 325-mg acetaminophen. If a daily dose of 4 g of acetaminophen is exceeded, a stronger, nonacetaminophen-containing opioid should be used. If the total daily opioid dose exceeds 30 mg of oral morphine equivalent, a time-contingent long-acting opioid should be considered, with a short-acting opioid used for breakthrough pain. This profile is usually observed in patients with severe pain or opioid tolerance.

Guidelines for Cancer Pain

The guidelines for the treatment of acute pain also apply to cancer pain¹²; however, it is more common to use both time-contingent long-acting opioids and pain-contingent short-acting opioids. Opioid tolerance usually is not an issue with patients with cancer pain, as the opioid requirement increase often reflects the advancement of the disease rather than true physiologic tolerance.

Guidelines for Chronic Noncancer Pain

A trial of opioids for chronic noncancer pain should be considered after other reasonable attempts at analgesia have failed. The treatment of chronic noncancer pain should rely more on time-contingent long-acting opioids and less on pain-contingent short-acting opioids. After drug selection, doses of the opioid should be given on a time-contingent basis and titrated to effect. During times of increased pain, additional doses on top of the daily dose may be allowed, but these dosages should be tightly controlled and limited. Failure to achieve at least partial analgesia with relatively low initial doses in nontolerant patients raises the question of whether the pain will be treatable with opioids.¹³

Opioid Rotation in Chronic Pain Management

If one opioid is ineffective or significant side effects prevent further escalation of a dose, another opioid may prove to be effective.¹⁴ This is due either to differences in how the opioids are metabolized or to the opioid receptor subtypes and their variable binding. Doses of the long-acting opioid medications that prompt me to rotate to another opioid include morphine at 270 mg, oxycodone at 240 mg, methadone at 80 mg, and fentanyl patch at 100 µg. These are empirical doses based on experience and are not intended to be standard practices. If these maximum doses are reached and pain relief is inadequate or significant side effects occur—whichever comes first—the opioids should be rotated. This algorithm will result in about a 90% overall success rate with doses at or below those mentioned above. If inadequate pain relief results from the maximum doses of all the long-acting opioid analgesics, the physician should closely evaluate the patient (ie, conducting a comprehensive multidisciplinary examination) before administering higher doses.¹⁵

Physician knowledge of the information contained in these practice guidelines should encourage more effective clinical management of pain through the use of appropriate opioids.

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Maintaining the Patient on Opioid Therapy

Continued from page 1

imply that opioids are the only treatment for pain nor to suggest that they are the preferred treatment. Rather, this article addresses a common concern among providers who care for this growing segment of the population. Many of the issues discussed pertaining to opioid therapy apply to other available treatments as well.

The elderly present several challenges to the physician's ability to use opioid analgesics for pain management. Like other adults, elderly patients have need of aggressive pain assessment and management. On the other hand, there are important distinctions between older and younger patients in opioid pharmacokinetics and pharmacodynamics. Elderly patients with pain are more likely to have other chronic diseases that affect opioid therapy, to be taking other medications that have the potential to interact with opioids, or to experience more than one source of pain.

Commonly Used Opioid Analgesics

Let us consider the opioids commonly used to treat chronic pain in the elderly.

Morphine is often called the "gold standard" of opioid therapy. Although this appellation mistakes chronologic priority for therapeutic pre-eminence, we will consider this treatment first in honor of its bicentennial (morphine was derived from opium 200 years ago). Although the oral bioavailability of morphine is unaffected by a patient's age, the medication has a greater pharmacodynamic effect in the elderly than in the young. As is true of many other opioids, morphine metabolites are excreted renally.⁴ The major metabolite of morphine is morphine-3-glucuronide (M3G). It has no analgesic activity, but may contribute to excitatory central nervous system (CNS) activity. The minor metabolite, morphine-6-glucuronide (M6G), is analgesic and has a significantly longer half-life than the parent compound. Thus, elderly patients with compromised renal function are at increased risk both of exaggerated opioid effect and adverse CNS effects from morphine.⁵

Oxycodone, too, has an active

metabolite, but it plays a minor role in the overall analgesic activity of the medication. Age has little impact on oxycodone's pharmacokinetics.⁶ However, renal dysfunction may significantly raise the peak serum level of the analgesic and its area under the time-concentration curve.⁷

Transdermal fentanyl dosing also must be adjusted for a patient's age.

Because fentanyl is lipophilic, a lower serum concentration of the drug is needed to have measurable impact on brain function.⁸ In addition, the serum concentration of the opioid rises more slowly after patch application in the elderly than in the young.⁹

Titrating Opioid Dose

In titrating opioids, age considerations are important, though they play a secondary role to the need for individual dose titration. Opioid dosing should aim at maximizing the ratio of benefits to adverse effects. Assiduous management of adverse effects, especially in the elderly, is vitally important.

Delirium is a significant potential problem in opioid therapy for the elderly. Slow dose escalation reduces the risk of this effect. Nonetheless, some patients will experience delirium as a dose-limiting side effect. In trying to achieve good pain control while preventing delirium, the clinician has several interventions to consider (see Table). General delirium-controlling measures include treating infection, fever, and dehydration. If possible, other CNS-active drugs should be discontinued. Adding a nonopioid analgesic to the regimen may allow dose reduction of the opioid and diminution of delirium. A more specific (and potentially useful) approach is to continue the opioid while adding haloperidol or another antipsychotic.¹⁰ Similarly, rotating to a different opioid may maintain analgesia with reduced side effects.¹¹

The usefulness of opioid rotation is not intuitively obvious. After all, if there is only one mu-opioid receptor gene, why should choosing a different agonist to bind to that receptor affect the toxicity of the therapy? There are at least two

likely answers to this question. First, as noted above, some opioids have toxic metabolites that others do not have. Second, the mu-opioid receptor gene is expressed in a range of splice variants. Each of these splice variants acts as a mu-opioid receptor subtype, with variable distribution in the CNS and variable binding to opioid agonists.¹²

Interventions for Management of Opioid-Induced Delirium in Elderly Patients

Hydration

Reduction of fever

Treatment of infection

Quiet environment

Addition of nonopioid analgesic with dose reduction of opioid

Addition of haloperidol or other antipsychotic agent

Rotation to a different opioid

Constipation is a problem for many elderly people who do not take opioid analgesics; it is an even greater problem for those who do. "Stool softeners" cannot be recommended as the sole therapy of opioid-induced constipation: they "give the *moosh* without the push."¹³ Cathartics are preferred for management of this problem.

Respiratory suppression, while often cited by clinicians as a concern in opioid therapy, is, in fact, a relatively minor problem in practice. Slow dose escalation allows sufficient time for patients to grow tolerant to opioid doses that might otherwise prove lethal in patients not acclimated to the agent. The myth that terminally ill patients can achieve analgesia only with opioid doses that threaten to stop their breathing is false and pernicious.¹³

The elderly should be considered at risk for the undermanagement of pain because of inappropriate beliefs about the ability to treat them with opioids. With proper attention to dosing and management of side effects, opioids can be utilized as safely and effectively in the elderly as they are in the young.¹⁴

**Author note: I am indebted to Arthur Lipman, PharmD, for this colorful expression, which he attributes to Dr Brian Ginsberg.*

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Managing Pain Associated With Whiplash/Fibromyalgia Syndrome

DENNIS C. TURK, PHD

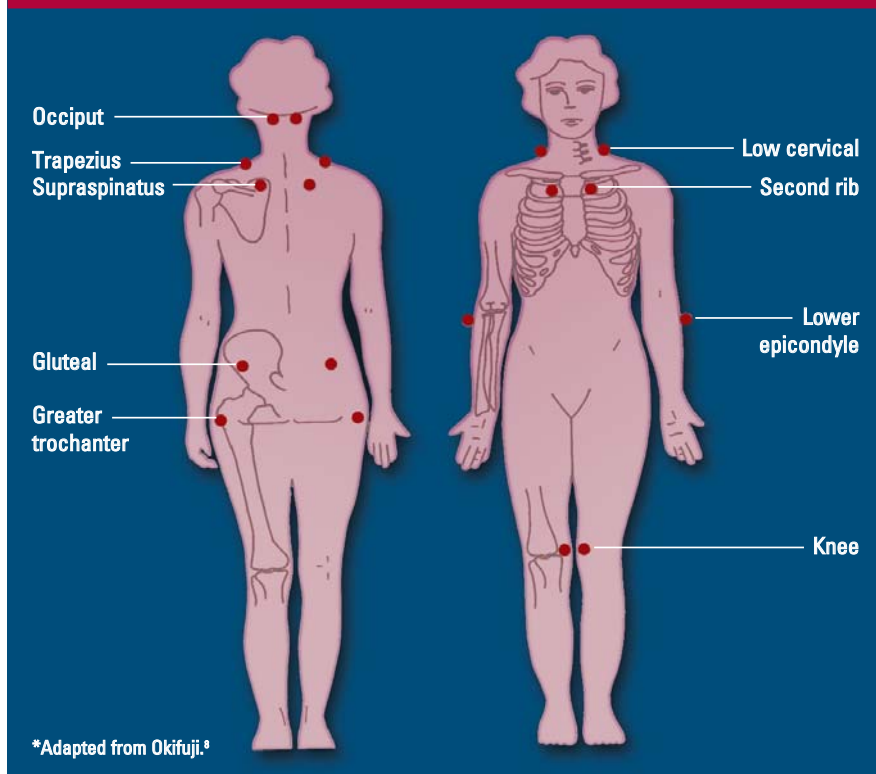
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Dr Turk serves on the advisory boards for Pfizer, Merck, Novartis, Lilly, Endo, Janssen, Ligand, and Pharma.

A 39-year-old woman, Mrs C, was involved in a minor rear-end collision and reported moderate pain in her upper neck and shoulder on the day after the auto accident. A physical examina-

tion 3 days later by her family physician revealed no positive neurologic findings, but there were some musculoskeletal signs of stiffness and tenderness. She had no history of previous neck pain, frequent headaches, or chronic illnesses. According to the criteria for whiplash-associated disorders established by the Quebec Task Force,¹ Mrs C was classified as having level II disorder. Her physician encouraged her to rest, refrain from physical activities that worsened her pain, and take ibuprofen.

Tender Point Locations*



tion 3 days later by her family physician revealed no positive neurologic findings, but there were some musculoskeletal signs of stiffness and tenderness. She had no history of previous neck pain, frequent headaches, or chronic illnesses. According to the criteria for whiplash-associated disorders established by the Quebec Task Force,¹ Mrs C was classified as having level II disorder. Her physician encouraged her to rest, refrain from physical activities that worsened her pain, and take ibuprofen.

When there was no improvement after 2 weeks, Mrs C's physician ordered a cervical computed tomography scan, with negative results. He informed her that she

might have a subtle but potentially serious problem; consequently, he recommended that she continue to limit her activities. Mrs C became fearful and began to restrict her movements, requesting a

leave from her job and avoiding household activities that aggravated her pain.

Treatment Approach

Because the impact of the accident was minor and the physical examination revealed no physical pathology or neurologic deficits, there was no reason to order extensive radiographs² or to prescribe a soft cervical collar (if prescribed, it should be worn for 72 hours at most).³ There is some evidence that physical therapy within the first week of a musculoskeletal injury may not provide any positive benefit and may actually contribute to greater disability.⁴ Mrs C's physician should have reassured her

that she most likely did not have a serious problem and encouraged her to engage in routine activities that did not increase her discomfort significantly.⁵

The absence of any progressive neurologic deficits or history of cancer suggests the computed tomography scan probably was unnecessary. Her physician should have pointed out that the failure to identify any physical pathology was good news. Despite the negative findings, it is reasonable for Mrs C to be worried about her persistent symptoms. A referral to a psychologist, however, would be premature. Her physician should have asked about her concerns and addressed them, making every effort to reduce Mrs C's fears, as they may contribute to her restriction of activities and thus foster disability.⁶ He should have informed her that "hurt" and "harm" are not the same things, and encouraged her to remain active even though it might cause some pain. Increased activities restore muscle strength and the pain should gradually decline.⁵

Transition to Fibromyalgia Syndrome

Eighteen months after the initial visit, Mrs C's symptoms were worse and included widespread pain, fatigue, non-restorative sleep, frequent headaches, irritability, and depression. Her physician referred her to a rheumatologist, who performed a tender point examination (see Figure). Based on her symptoms and this examination, the rheumatologist diagnosed fibromyalgia syndrome (FMS).⁷ (For more detailed information on the examination, Okifuji et al review the standardized tender point survey developed for FMS.⁸)

Management of FMS

A comprehensive evaluation includes assessment of the impact of FMS on Mrs C's physical and emotional functioning and responses by significant others. Several standardized self-report measures have been developed and are used frequently for patients with FMS. Two of the most common are the Fibromyalgia Impact Questionnaire⁹ and the Multidimensional Pain Inventory.¹⁰ These self-report measures should be viewed as useful for screening patients, but should be supplemented by structured interviews

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Assessing Patients With Chronic Pain

Continued from page 1

to tailor their use to patients' needs and capabilities. Examples include the visual analog scale (a 10-cm line with the extremes anchored with the phrases "no pain" to "worst possible pain"), verbal rating scale (mild, moderate, severe), and the FACES scale, which is especially useful for those who have difficulty communicating as well as for average or usual pain. Patients may also be asked to mark the location of their pain on a figure. This information may prove useful to guide the clinician in examining the patient with pain.²

Physical Examination

There is no definitive test to confirm the presence or severity of the pain reported. Careful physical examination will provide crucial information. Neurologic and musculoskeletal exams will assist in defining neuropathic and non-neuropathic contributions to the patient's pain, and the distinction may be useful in making treatment decisions. Topographical distribution is especially helpful in guiding the neurological examination. If the patient has indicated the pain location(s) on the figure described above, this may direct the physical examination and may confirm the location.

Allodynia (pain caused by a stimulus that does not normally provoke pain) is assessed to determine if there is a painful response to static, dynamic, or thermal pressure. These assessments can be conducted through a light touch with the fingertip or a cotton swab, by applying perpendicular pressure slowly with a cotton swab, and with a warm or cold tuning fork. Hyperalgesia is diagnosed if the patient has an *exaggerated* response to single or multiple pinpricks.³

A critical part of the chronic pain patient's evaluation is examination of the musculoskeletal system. The motor elements (muscle bulk, tone, strength) are examined to detect both negative (weakened muscles, lowered endurance, hypotonia) and positive signs (increased muscle tone, tremor, dystonia, dyskinesia). Patients should be examined for coordination, ataxia, and apraxia. Other musculoskeletal symptoms and signs

include decreased range of motion and stiffness of joints, spontaneous muscle spasms, localized muscle tenderness, and myofascial trigger points.³

Neuropathic Pain

When combined with a history and laboratory tests suggesting a specific etiology, the finding of negative and positive sensory phenomena in the same area as damaged nerve system pathways usually confirms the diagnosis of neuropathic pain. Patients may have sensory deficits to one modality (such as pinprick sensitivity) and allodynia (such as light brush) to another in the same nerve distribution. The clinician may have difficulty in recognizing this paradoxical finding, but patients are even more perplexed by the complexity of their sensory experiences. Patients may often have difficulty describing the unusual nature of their symptoms and fear that their reports of unusual symptoms will not be believed.

Psychosocial Assessment

Suffering may be attributable to many factors besides physical reports. Chronic pain patients often meet the criteria for assessment of psychological comorbidity (eg, depression, anxiety). The clinician should ask about such psychological factors as sleep disturbance, work-related issues, treatment expectations, rehabilitative needs, and the availability of social support from family and friends. Details can be elicited by asking questions such as:

- Does the patient suffer from depression? anxiety?
- How is the patient coping with pain?
- How are work and daily activities affected?
- Is the patient active in recreational pursuits?
- Are family responsibilities affected?
- How do significant others respond to the patient's reports of pain, physical functioning, and emotional distress?

Clinical assessment of a patient with chronic pain should endeavor to identify

through patient history and physical examination the underlying cause(s) of pain, factors that influence the reporting of pain, and comorbid conditions and to evaluate psychosocial factors and functional status. A treatment plan and specific goals should be based on the clinical findings. Diagnosing a particular pain is frequently challenging, and complex presentations may necessitate involvement of a pain medicine specialist, psychologist, physical therapist, occupational therapist, and vocational counselor. Accurate diagnoses would reduce patients' pain (even when pain cannot be completely eliminated) and improve the quality of their lives.

Comprehensive assessment should aid in diagnosis and assist in treatment planning (see Table). When dimensions are assessed, the choice of which requires treatment priority will depend on the severity of that dimension for each particular patient. For example, a patient with peripheral diabetic neuropathy (PDN) whose diabetic comorbidities are under control and who is coping well but cannot work full-time because of

Comprehensive Assessment of Pain and Associated Comorbidities

Category/Dimension	Specific Parameters
Pain mechanisms	Neuropathic, inflammatory, myofascial, mixed, other
Medical morbidity	Etiological morbidity and comorbidities
Psychiatric comorbidity	Psychiatric comorbidities and coping skills
Function, HRQOL	Disabilities, impaired HRQOL
HRQOL=health-related quality of life.	

severe pain will need his pain treated most urgently. On the other hand, a PDN patient with moderate pain whose medical comorbidities are under control, but who is severely anxious and depressed would require treatment of anxiety and depression more urgently, even while pain therapies are initiated and management of comorbidities continues.

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Seven Tips for Managing Pain Patients After They Return From a Specialist

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Consultation with a specialist is often needed for a patient with pain and a complex medical condition such as diabetes or congestive heart failure. When the patient returns to the primary care provider (PCP), the condition has been evaluated, the workup completed, the treatment initiated, and the problem stabilized. If difficult or complex treatment strategies are offered, the patient is followed on a long-term basis by the specialist instead.

In patients with chronic pain, the pain does not disappear after specialty referral. Aggressive strategies still may be used (injections, complex drug regimens, and

Patients with chronic pain are suffering not just from pain but also from fear, depression, and isolation—among many other issues.

high-dose opioid management), yet the long-term care responsibilities lie with the PCP. The differences seen in pain care vs specialty care for complex problems result from many factors, including unfavorable reimbursement from third-party payers. To provide quality continuing care for pain patients with complications, the following tips may be helpful.

- 1 Cultivate a relationship with the referral doctor to help guide future patient care as the PCP. Make sure the specialist delineates what is the best course to follow for a patient's continued care or during pain flares: Should breakthrough medication be used or should the patient return to the specialist during these times of crisis? Discussing the treatment plan with the specialist and reaching an understanding of the expected course and follow-up arrangements will lead to consistent quality care. The pain specialist will also understand what level of comfort and expertise you have in dealing with these patients, and future referrals will be returned at the appropriate time in treatment with the necessary care information.
- 2 After the specialist has exhausted all treatment strategies, patients with continued pain often become distressed and fearful. Returning to the PCP can be particularly stressful when cure is not achieved. Reassurance and compassionate listening are often very therapeutic in these cases. When cure is not anticipated, patients expect us to validate their discomfort, answer concerns about alternative therapies, and not abandon care. For example, avoid statements such as "There is nothing more I can do." After specialty care is completed, another referral to physical therapy or an update of an MRI likely will not be helpful. You can carry on an effective therapeutic relationship with simple reassurance, caring, and hope.
- 3 When patients return with continued pain, certainly ask about their pain, but concentrate on their physical and emotional functioning as well. All pain treatment is ultimately aimed at improving patient functioning. Emphasize the need for functional gains to the patient and be sure to document pain levels and improved function in the chart.
- 4 Keep patients active. Exercise in any form practiced regularly improves function, sleep, sense of well-being, and depression. Continue to ask your patients about exercise and encourage this activity.
- 5 Be motivational. Interdisciplinary specialty care providers use a variety of treatment strategies including medication, physical rehabilitation, injections, activity modification, and exercise. Emphasize the importance of self-management skills with your patients. As with any chronic disease, successful self-management is key to success. Self-management skills (relaxation, exercise, pacing, strategic rest) give better outcomes than passive therapies. Passive, unmotivated patients who expect to be taken care of or cured do not improve and are difficult to treat.
- 6 Be alert to the lingering psychosocial issues, especially depression and anxiety, that are commonplace in chronic pain patients. Even after specialty evaluation, inadequate assessment and treatment of the psychosocial comorbidities can occur because of reimbursement strategies and managed care carve-outs for psychosocial services.¹ All physicians provide psychosocial treatments for our patients; however, chronic pain patients require a high index of sensitivity.
- 7 Schedule regular appointments for chronic pain patients. Avoid waiting until a pain problem spirals out of control and becomes much more difficult to treat. Regularly scheduled appointments help to keep the problems lists manageable. Patients may not be as anxious or feel as abandoned if welcomed with a regular appointment. Even though this may seem like more work for the PCP, the result will be shorter, more productive interactions.

Patients with chronic pain are suffering not just from pain but also from fear, depression, and isolation—among many other issues. The PCP can use the pain specialist for help, but the continuing care ultimately returns to the PCP. We must provide empathetic, quality care for patients in pain. I believe we are uniquely trained—with broad medical knowledge and longevity—to be able to give the best care.

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EDUCATIONAL OBJECTIVES (Please indicate the extent to which each of the following objectives was met.)

By reading the two issues of *Pain Management Today™*, this activity met the stated objectives in such a way that I am better able to:

	Not Met			Completely Met		
1. Identify and select appropriate medications to be used in the treatment of neuropathic pain, including evidence-based treatment recommendations.	1	2	3	4	5	6
2. Explain the appropriate use of long- and short-acting opioids in chronic pain management.	1	2	3	4	5	6
3. Understand the mechanism of action of the topical delivery system and latest topical advances.	1	2	3	4	5	6
4. Assess the patient in pain and know when to refer to the pain specialist.	1	2	3	4	5	6
5. Understand how to work with a pain specialist and how to transition a patient from pain specialist to primary care physician.	1	2	3	4	5	6
6. Partner with the patient in pain management using a patient care agreement.	1	2	3	4	5	6
7. Evaluate and treat people with painful diabetic neuropathy.	1	2	3	4	5	6
8. Determine how and when to use opioids for pain management in the elderly, how to start an opioid plan, and how to manage side effects and ongoing treatment for this population.	1	2	3	4	5	6

EDUCATIONAL ACTIVITY CONTENT/FORMAT (Please rate the following statements.)

	Strongly Disagree			Strongly Agree		
1. The format/teaching methods were appropriate to meet the activity objectives	1	2	3	4	5	6
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3. I am better prepared to treat patients who are experiencing pain	1	2	3	4	5	6

What additional information/topics do you feel should be included in future issues of *Pain Management Today™*?

**CME
POSTTEST****CME Questions for Pain Management Today[™]****MULTIPLE CHOICE****Backonja article**

1. Neuropathic pain can manifest as
 - a. Negative sensory phenomenon
 - b. Positive sensory phenomenon
 - c. Both a and b
 - d. None of the above

Forde article

2. The concept of polypharmacy does *not* include
 - a. Single-receptor mechanism of action
 - b. More potent pain relief
 - c. Smaller amount of each medication
 - d. Limited adverse effects, overall

Wallace article

3. Opioid rotation, or switching the patient with chronic pain to another opioid, should be considered for the following reason(s)
 - a. Prevention of addicts' access to the same medication
 - b. Lower equivalent doses of another opioid may provide better pain relief
 - c. Significant side effects prevent further escalation of dose
 - d. New receptor available for the medication
 - e. a and d
 - f. b and c

Nicholson article

4. According to recent clinical data on low back pain, the lidocaine patch 5% can be used for
 - a. 6 hours on and 6 hours off
 - b. 24 hours on and 24 hours off
 - c. 12 hours on and 24 hours off
 - d. None of the above

King article

5. Referral to a multidisciplinary pain center should usually result in
 - a. High tech diagnostic testing
 - b. Psychological counseling
 - c. Sequential treatment options
 - d. Complementary therapies
 - e. a, b, c
 - f. b, c, d

Fishman article

6. Which feature(s) might be part of structuring an agreement for opioid therapy?
 - a. Routine substance testing
 - b. Restriction to a single pharmacy
 - c. Treatment limited to a pain specialist
 - d. a and b
 - e. All of the above

Vaillancourt/Gallagher article

7. Which of the following descriptors are commonly used by patients with diabetic neuropathic pain?
 - a. Burning
 - b. Searing
 - c. Cramping
 - d. a and b
 - e. All of the above

Cohen/Chevlen articles

8. Polypharmacy should be avoided in the treatment of chronic pain in the elderly for all of the following reasons EXCEPT
 - a. Topical agents have limited efficacy for pain in the elderly
 - b. Risk of sedation
 - c. Potential withdrawal symptoms upon discontinuation
 - d. Higher risk of causing delirium
 - e. Abuse potential

TRUE/FALSE**McCarberg article**

9. After specialty referral, common psychological issues lingering in chronic pain patients include depression, anxiety, and isolation.
TRUE FALSE

Turk article

10. The fibromyalgia syndrome (FMS) patient should be advised to use nonpharmacologic techniques alone rather than concurrently with pain medications.
TRUE FALSE

ANSWERS

1. c. When combined with a history and laboratory test suggesting a specific etiology, the finding of negative and positive sensory phenomena in the same area as damaged nerve system pathways usually confirms the diagnosis of neuropathic pain. [Volume 3, number 2, page 11]
2. a. Polypharmacy is often a rational approach to pain management, and it is an acceptable and common practice among physicians who treat patients with chronic neuropathic pain. The combination of medications usually potentiate the pain relief, and it is often possible to use smaller doses of each, thereby limiting adverse events. [Volume 3, number 1, page 8]
3. f. If one opioid is ineffective or significant side effects prevent further escalation of dose, rotation to another opioid may prove to be effective. The opioid should be rotated when maximum doses of opioids are reached and pain relief is inadequate. Symptoms of dose-limiting toxicity are nausea, vomiting, myoclonus; signs of neuropsychiatric toxicity are cognitive failure, sedation, hallucinations, delirium. [Volume 3, number 2, page 4]
4. b. Recent clinical trials have evaluated the use of the lidocaine patch 5% for the treatment of low back pain. An open-label study of 120 patients with low back pain (acute, subacute, short-term chronic, and long-term chronic) was completed at eight US centers. During the 6-week study period as many as four lidocaine patches 5% were applied every 24 hours. In addition, the continuous 24-hour-a-day use of four lidocaine patches 5% for 72 hours recently has been demonstrated to be safe and without any systemic reactions. [Volume 3, number 2, page 3]

5. f. A pain specialist at a multidisciplinary pain center should be able to determine whether or not diagnostic testing will provide useful information. High tech tests are indicated for a very few patients; tests are often overused and may be of limited benefit in determining ongoing care. For example, patients with chronic back pain often receive magnetic resonance imaging, although this test does not provide additional practical information in many cases. [Volume 3, number 1, page 6]

6. d. Opioid agreements should be created with provisions that everyone (patient, primary care physician (PCPs), and pain specialist) can live with, and clinicians can adhere to. PCPs and pain specialists have long complained that chronic opioid therapy was difficult because of lack of clarity about who had what role. A solution to this problem is a Trilateral Opioid Agreement, which includes the PCP's agreement with the plan of care and his agreement to take the patient back once stabilized. [Volume 3, number 1, page 10]

7. e. Pain is usually described by patients with diabetic neuropathy as burning, searing, tingling, or jabbing; but it may also be described as cramping, or a feeling of swollen and tight feet, or walking on gravel. Pain may be worse at night when patients are not bearing weight. [Volume 3, number 1, page 3]

8. a. Physiologic changes of aging can raise blood levels of opioid medications and intensify opioid effects. Decreased renal function, cardiac output, hepatic function, and protein binding of opioids are examples of such age-related changes. With the exception of topical agents, polypharmacy can produce drug interactions and intensify side effects, especially delirium. Constipation, sedation, and urinary retention can become especially problematic side effects. [Volume 3, number 1, page 9]

9. True. Chronic pain patients are suffering not just from pain but from fear, depression, and isolation. Primary care practitioners need to be alert to the lingering psychosocial issues that are commonplace in chronic pain patients. Even after specialty evaluation, inadequate assessment and treatment of the psychosocial comorbidities can occur because of reimbursement strategies and managed care carve-outs. All physicians provide psychosocial treatments for their patients, however, chronic pain patients require a high degree of sensitivity. [Volume 3, number 2, page 8]

10. False. Management of FMS should focus on both pharmacologic and nonpharmacologic treatments. Currently, the best approach is a comprehensive treatment program combining patient education about the nature of the illness, reassurance, a moderate exercise-strengthening regimen, cognitive-behavior therapy, treatment of existing sleep disorders, and administration of a tricyclic antidepressant. [Volume 3, number 2, page 7]

See page 9 for CME evaluation form.

Managing Whiplash/ Fibromyalgia Pain

Continued from page 6

and other assessments indicated by the initial screening. These self-report measures also may be used on a periodic basis to evaluate patient progress. Patients' responses might lead to adjuvant psychotherapeutic support in an interdisciplinary setting with referral to a psychologist who is knowledgeable about FMS and adaptation to chronic illnesses.

Management of FMS should focus on both pharmacologic and nonpharmacologic treatments. Currently, the best approach is a comprehensive treatment program combining patient education about the nature of the illness, reassurance, a moderate exercise/muscle strengthening regimen, cognitive-behavioral therapy, treatment of existing sleep disorders, and administration of a tricyclic antidepressant. When prescribing tricyclic antidepressants, it is important to note that selective serotonin reuptake inhibitors have been shown to be less effective than the other tricyclic agents.

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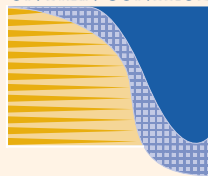
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- **Advances and Treatment Recommendations in Neuropathic Pain**
Robert H. Dworkin, PhD
- **Principle of Balance in Prescribing Opioids for Chronic Pain**
Nathaniel P. Katz, MD
- **When to Consider Diagnostic Tests for Pain**
Daniel A. Brzusek, DO
- **Schedule for new Spring series of DINNER DIALOGUES® and Saturday Seminars**

AGENDA

Registration and Dinner	6:00 – 6:45 PM
Clinical Presentation	6:45 – 8:15 PM
Q&A and Discussion	8:15 – 8:30 PM

Advance Registration Recommended (No Guests Please)

Call 1-877-251-0984 for more information and to register

Good for up to 1.5 hours of category 1 credit toward the AMA Physician's Recognition Award

LEARNING OBJECTIVES

- Evaluate the potential risks/benefits of using opioids in the treatment of patients with chronic pain.
- Initiate and assess a trial of opioid therapy to determine next steps in chronic pain treatment.
- Optimize the analgesic potential of opioid therapy through titration, rotation, conversion, and adjunctive therapy in the management of chronic pain.
- Discuss the role of short- and long-acting opioids as well as the potential advantages of new delivery systems and emerging therapies in chronic pain management.
- Understand the basic documentation and medico-legal requirements necessary to support appropriate opioid prescribing.
- Distinguish among addiction, tolerance, and physical dependence, as well as understand pseudoaddiction, and know how to manage each appropriately.

Pain Management **Today™**

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