

INSIDE THIS ISSUE

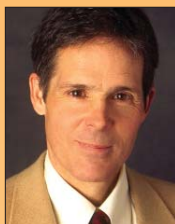
2 CME Information

3 Assessing the Patient With Chronic Low Back Pain Anthony H. Wheeler, MD

8 Selected Abstracts, Joint APS/Canadian Pain Society Meeting Neal E. Slatkin, MD

Schedule for Upcoming National Initiative on Pain Control™ DINNER DIALOGUES®

on page 11



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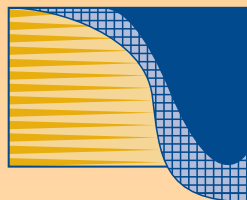
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NIPC
NATIONAL INITIATIVE ON PAIN CONTROL™



Improving Quality of Life for Chronic Pain Patients

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Nearly 80 million Americans suffer from chronic pain, including low back pain and other musculoskeletal pain, headache, neuropathic pain, and cancer-related pain. Chronic pain disables more people and adds more costs to our healthcare economy than heart disease and cancer combined.¹

Basic Facts About Chronic Pain

In contrast to acute pain, the exact cause of chronic pain may be difficult to identify. The term chronic pain is often used to describe pain that lasts 3 months or more. In reality,

chronic pain is pain that persists beyond the time of normal healing. By this definition, patients in certain settings might begin to experience chronic pain 1 month after the initial onset of acute pain if complete healing was anticipated by that time.

Chronic pain will likely have a significant negative impact on a patient's ability to function physically and emotionally. Work, recreation, and even normal activities of daily living will be adversely affected. As a result of chronic pain, people may develop, or have exacerbation of, depression, anxiety,

sleep disturbances, and loss of self-esteem.^{2,3} Employment is often compromised by the presence of chronic pain, with resulting lost workdays and disability.⁴ Thus, it is vital that the impact of chronic pain on a patient's quality of life be assessed as early as possible.

The goals of chronic pain management must be realistic: reduce pain and improve quality of life to the fullest extent possible. The evaluation and treatment of chronic pain is not only about finding the proper medicine or nerve block to "cure" the pain, which is not

Continued on page 4



Current and Emerging Pharmacologic Therapies

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The last decade has borne witness to an increasing rate of approval of new drug entities, including novel compounds such as cyclooxygenase (COX)-2 selective nonsteroidal anti-inflammatory agents and unique heterocyclic antidepressants, as well as medications for many chronic diseases. Such new drug entities provide an expanding armamentarium in the war against disease, and also increase the complexity of existing knowledge. Furthermore, new uses are being found for older drugs.

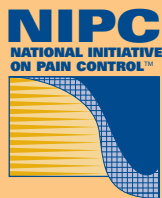
We must struggle to keep current with new information and assessment of the appropri-

ate role(s) of each new agent. As with other disorders, this trend is occurring in the field of pain management—offering physicians and patients a greater choice but increasing confusion with regard to first-line, second-line, and other treatment options. While it is impossible to review all potential uses of new and existing drug entities in a newsletter, the table on pages 6 and 7 was designed to assist practitioners in developing treatment schemes for their patients with chronic pain. The table addresses many drug classes and summarizes the type of data supporting the use of the medications for various conditions. Off-label uses of several drug

classes (tricyclic antidepressants, corticosteroids, counterirritants, and methylxanthines) for certain pain syndromes are included because they represent "common usage," or widely accepted prescribing practices for pain management.

In most cases, the indicated uses of drugs are supported by at least a few randomized, controlled clinical trials. Generally, the control agent is placebo. Some drugs may have only a few methodologically adequate supportive trials, as is the case for newer agents or adjunct medications, such as lamotrigine, tizanidine, dextromethorphan, and others.

Continued on page 6



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LETTER FROM THE CHAIRMAN

Dear Colleague,

Inadequate pain relief continues to be a serious health problem in the United States, and continuing education plays an integral role in helping physicians stay up to date with the latest treatments and innovations in pain management. The faculty of the National Initiative on Pain Control™ (NIPC™) has been working diligently in their efforts to educate health-care professionals in primary care on strategies to improve the assessment and alleviation of pain. They recognize that primary care clinicians are on the front line of care for most patients who suffer with chronic pain.

The Spring 2004 Audioconference Series, DINNER DIALOGUES® Series, and Saturday Seminars, sponsored by the NIPC, proved to be very successful in helping physicians keep abreast of the latest developments in pain treatment and control. We received highly positive feedback on our programs from you, and we would like to thank you for your participation in these activities. As a result of your feedback, we developed and launched our low back pain slide module, which provides an overview of treatments, assessment techniques, and management models for patients with low back pain. The module has met with resounding success in its initial sessions, and new programs are scheduled for the fall.

Our newest and most innovative educational offering is the Opioid Analgesia Tool Kit: A Resource for Managing Your Patients With Chronic Pain. Available as a CD-ROM in October 2004, the Tool Kit will provide clinicians treating patients with pain a wealth of practical resources designed to improve patient outcomes. Crafted by experts in pain management, I think that you will find the Tool Kit to be very useful in your practice. Information and an order form for the Opioid Analgesia Tool Kit can be found on page 12.

This issue of the NIPC newsletter provides clinically useful information for assessing and treating pain. Members of the NIPC have written articles that offer practical and cutting-edge information that you can implement in your own practice, including:

- Assessing the patient with low back pain
- Ensuring quality of life for patients with pain
- Current and emerging pharmacologic therapies for treatment of pain available in a convenient tabloid format.

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 pages 9 and 10.

Early this year, the NIPC activated its pain control Web pages, which are housed on our collaborative Web site with PainEDU (www.painedu.org). The site provides up-to-date information about NIPC events, activities, and publications, and you can now view a schedule of our upcoming NIPC events online. The Opioid Analgesia Tool Kit will also be available online in November.

We hope that you will take advantage of these exciting educational opportunities in the upcoming months, and, as always, we welcome your comments and suggestions.

Sincerely,

Perry G. Fine, MD
NIPC Chairman



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

Volume 4, Number 2, released September 2004, 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. #B294, 150 Meadowlands Parkway, PO Box 1505, Secaucus, NJ 07096-1505. Within 4 weeks of receipt of the registration 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, 2005. This activity is valid for CME credit through March 31, 2005.

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 maximum of 2 category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those credits 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 2004, participants should be able to:

- Identify a balanced approach to the use of opioid analgesia in the treatment of chronic pain.

- Discuss evidence-based treatment recommendations for the pharmacologic management of chronic neuropathic pain.
- Assess the patient with low back pain and select appropriate diagnostic tests.
- Describe the role of a comprehensive treatment plan for patients with chronic pain that includes biopsychosocial approaches.
- Differentiate between the distinctive biochemical properties and potential mechanisms of major classes of pain medications in the treatment of neuropathic pain.
- Understand how to transition a patient through continuation/maintenance therapy and discontinuation of opioids.
- Document opioid usage and monitor progress and treatment outcomes in patient management.

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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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% 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% 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, experts, multidisciplinary team of specialists, researchers, and practicing physicians in pain management.

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Assessing the Patient With Chronic Low Back Pain

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Low back pain (LBP) is the “most expensive benign condition in industrialized countries.”¹ It is the most common cause of activity limitation among young adults (less than age 45),² affecting an estimated 15% to 20% of Americans³ with approximately 2% to 8% developing more chronic, disabling pain.⁴ Low back pain is the second most common reason to visit a physician for a chronic condition, the third most common reason for a surgical procedure, and the fifth most frequent cause of hospitalization.⁵ Productivity losses from chronic LBP translate into approximately \$28 billion annually in the United States.²

Chronic pain is defined as pain that persists longer than 3 months or beyond the expected period of healing. Degenerative or traumatic conditions of the spine are among the most common causes of chronic pain.⁶ Degenerative change and injury to pain-sensitive spinal structures can produce axial lumbar and radicular pain that demonstrate similar physiologic characteristics and behaviors. These “activity-related” back pain syndromes are typically described by the term “mechanical.”⁷ Mechanical LBP (mLBP) is usually aggravated by static loading of the spine (prolonged sitting or standing), long-lever activities (vacuuming or sweeping), or levered postures of the trunk (bending forward); it is eased when the spine is unloaded (reclining in bed) or with dynamic loading (walking or frequently changing positions).⁷ Degenerative disc disease, spondylosis, osseous fractures, and muscular conditions are examples of mLBP, which accounts for up to 98% of all cases⁷⁻⁸ (see Table).

Several studies, however, have been unable to demonstrate a clear relationship between symptoms of mLBP and structural abnormalities (including disc herniation, spinal degeneration, and spondylosis) on computed tomography or magnetic resonance imaging; therefore, a strictly structural or pathoanatomic explanation for these lumbar and radicular pain syndromes is inadequate.⁹⁻¹² These discrepancies have led to research that suggests mLBP occurs when biochemical and inflammatory mediators of pain sensitize primary nociceptors in spinal tissues to biomechanical stimuli that previously accompanied asymptomatic movements or lifting tasks.¹³⁻¹⁷ Other explanations have focused on the role of nonphysical variables, such as workplace conditions (eg, job satisfaction), psychological factors (eg, stress, fear), and influences associated with compensated injury.¹⁸

Early studies suggested rapid recovery of mLBP in up to 80% cases within 1 month, but

more recent studies of primary care patients in both Great Britain and the United States have demonstrated one third to one fourth of patients continue to have problems after 1 year.^{6,19-21} When LBP becomes chronic, structural and neurochemical changes can be maladaptive and interfere with the individual's capacity to function—physically and emotionally. Chronic LBP is multifaceted, involving structural, biomechanical, biochemical, medical, psychosocial, and behavioral influences, resulting in clinical syndromes of such complexity that evaluation, treatment, and rehabilitation are often difficult or ineffective.^{17,22-24}

Evaluating LBP Patients

The physician must first establish that the patient's chronic LBP is mechanical by history and observation.¹² Patients with severe mLBP are often reclining on the examining table, pacing, or constantly shifting positions during the doctor-patient interchange. A patient with a history of mLBP who sits perfectly still and complains bitterly demonstrates verbal pain behaviors that do not match nonverbal cues. This inconsistency may suggest contributing psychological or behavioral factors, not to be misinterpreted as the absence of pain or the presence of malingering.²³

Pain behaviors may also be greatly magnified in patients with vertebral fracture/subluxation or neural involvement. Appropriate diagnostic (imaging) studies and triage strategies (subspecially or surgical consultation) should be considered when patients experience intractable leg pain, persistent or progressive neurologic deficit, or a change in bowel or bladder control.⁷

As in other chronic conditions, physicians should consider other etiologies and contributors to a patient's LBP especially if pain or symptom

characteristics change acutely (see Table). Certain physical symptoms or signs may indicate potentially serious underlying causes and conditions. For example, chronic mLBP sufferers usually lie quietly and motionless on the ER stretcher, in contrast to a patient who may present writhing in pain due to a vascular catastrophe, such as a ruptured abdominal aortic aneurysm. Other clinical and behavioral signs that should alert the physician to nonmechanical disorders of the spine are outlined below^{7,24}:

- Pain unrelieved by rest or any postural modification
- Pain unchanged or worsening after 2 to 4 weeks of treatment
- Malaise, fatigue, or weight loss associated with pain
- Severe morning stiffness
- Immunosuppressed status or accompanying fever
- Known or previous cancer
- Visceral disorders associated with colicky pain, such as cholelithiasis or nephrolithiasis
- Age over 50 years

Psychosocioeconomic Factors

When evaluating patients who have a compen-

Continued on page 5

Causes and Contributors to Low Back Pain

Mechanical Low Back Pain

- Degenerative disc disease and spondylosis
- Isolated discogenic or facet syndrome
- Radiculopathy due to structural cause
- Spinal instability from spondylolisthesis, spondylolysis, or fracture
- Vertebral or osseous element fracture
- Spinal canal or foraminal stenosis
- Arachnoiditis, including postoperative scarring
- Myofascial pain disorders, primary or referred
- Psychosocial factors

Nonmechanical Low Back Pain

• Systemic Disorders

- Benign or malignant neoplasms (myeloma), primary or metastasized
- Osseous, discal, or meningeal infections
- Inflammatory spondyloarthropathy
- Metabolic bone disease, including osteoporosis
- Vascular disorders, such as atherosclerosis causing abdominal aortic aneurysm or arteritis affecting neural/visceral structures

• Neurologic Syndromes

- Myelopathy from intrinsic or extrinsic processes
- Myelitis due to inflammation (infection and multiple sclerosis)
- Lumbosacral plexopathy, especially from diabetes or vaculitis
- Neuropathy, including acute or chronic inflammatory demyelinating types
- Mononeuropathy, including causalgia
- Myopathy, including myositis

• Visceral Disorders

- Gastrointestinal obstruction, neoplasm, and ischemia
- Genitourinary disorders, including nephrolithiasis, prostatitis, and pyelonephritis
- Gynecologic disorders, including ectopic pregnancy and pelvic inflammatory disease
- Pancreatitis and cancer

• Referred Pain

- From other adjacent osseous or joint structures (thoracic cage, pelvis, hips, knees)

• Psychosocial Factors

- Emotional distress
- Job dissatisfaction
- Reinforcement by significant others

Improving Quality of Life for Chronic Pain Patients

Continued from page 1

likely to happen in most cases; rather, the management of chronic pain involves a detailed assessment of the problem, that includes both medical and nonmedical aspects, and the development of a comprehensive treatment plan. Medical, physical rehabilitative, and psychosocial treatment strategies are all appropriate in this plan.

Clinical Assessment

The first step in the management of chronic pain is to assess the pain as a disease with a complicated pathophysiology. The goals of the clinical assessment include not only making the diagnosis of chronic pain but also attempting as specific a diagnosis as possible regarding its cause. The following questions are important to ask:

- When did the pain start?
- Is the specific onset of the pain remembered (as for example, following a trauma or a specific infection, such as with post-herpetic neuralgia)?
- Is there a specific cause to the pain (eg, specific injury or acute herpetic neuralgia/shingles)?
- Are there already known medical or surgical conditions for the patient (eg, diabetes, osteoarthritis, osteoporosis, connective tissue disease) that can provide clues as to the etiology of the chronic pain?
- For how long has the pain existed?
- Where is the pain located?
- What does the pain feel like, ie, is it sharp, stabbing, throbbing, aching, burning, knife-like or a combination of these?
- What makes it better (eg, rest, movement)? What makes it worse (eg, activity, emotional arousal)?
- What impact on physical function is associated with the pain?
- Are there medical, neurologic, or psychosocial factors involved in the exacerbation or maintenance of the pain?
- What diagnostic testing is required to assist in the assessment?

The clear purpose of diagnostic testing is to help make as specific a diagnosis as possible. *It is not to be used to validate or invalidate the report of pain.* A normal result does not rule out a chronic pain problem. In my experience, I have encountered too many instances in which a negative test result, particularly a normal electrophysiologic exam (EMG/NCV), was equated to the absence of pain. This practice is not only scientifically

invalid but also ethically inappropriate.

The assessment of pain is aided by the use of several currently available pain questionnaires. Patients also often report widely different pain levels for similar conditions and similar degrees of functional impairment. Therefore, it is important to always assess both pain intensity level and the degree of functional impairment in a person with chronic pain. The Brief Pain Inventory attempts to address not only the pain level but also the impact of that pain on various functional domains.⁵ It takes minutes to complete, and it may be a practical way to address chronic pain in a busy, nonpain-management-specific (eg, primary care) practice. Use of other tools, such as the Visual Analog Scale or the Pain Intensity Scale,^{6,7} look solely at pain and leave out its effect on function. Use of the Faces scale⁸ may be appropriate for patients who are cognitively impaired or speak a language that you are not conversant in.

There are a large number of measures that have been developed to assess patients with diverse chronic pain syndromes; different ones can be selected depending on your purpose and the nature of the disease (for a review, see Turk and Melzack)⁹. Failure to conduct a comprehensive assessment of the chronic pain patient will impede the development of a successful treatment plan.

Rational Polypharmacy

After completing a comprehensive assessment of the person with a chronic pain problem, an effective treatment plan needs to be developed that provides acceptable analgesia and functional improvements with an acceptable side-effect profile. There is growing empirical evidence that “rational” polypharmacy may be most successful for patients with chronic pain. No matter how effective an agent may be, it rarely eliminates pain completely; therefore, various medications may need to be combined in a rational fashion. As in other areas of medical care (eg, cancer, hypertension, and coronary artery disease management), combinations of therapies (targeted peripheral analgesics and systemic agents) are often believed to be more effective than a single agent.

Challenges of Treatment

So how do you develop a comprehensive treatment plan? A key is to maintain realistic expectations. Patients should understand that regardless of the treatment(s) provided, they will likely continue to have some residual discomfort. You should begin with established and accepted guidelines, based upon a consensus of unbiased expert opinion for the condition(s) that you are treating.^{10,11} Unfortunately, such guidelines are not available for all chronic pain syndromes. When evidence-based guidelines are not available, choose among approaches that have established efficacy through a vari-

ety of means, including published, multicenter, randomized controlled studies, as well as consensus statements by reputable and unbiased professional groups.

Assess tolerability when initiating and maintaining treatment: immediate and long-term side effects (especially if the condition is chronic); the likelihood of drug-drug interactions; the ease of dosage timing and medication use. Consider also the severity of the side effects, for example, the nonsteroidal anti-inflammatory (NSAID) agent, piroxicam, although effective in reducing symptoms associated with inflammation, is also associated with potentially fatal gastrointestinal complications, thereby making it less than ideal for conditions in which an NSAID would be appropriate.¹

Wherever possible, you should choose the approach (assuming equal efficacy and toxicities) that requires the least laboratory monitoring (eg, drug level checks, monitoring for hepatic, renal, or bone marrow effects). If using one agent at a time, titrate for therapeutic efficacy vs side effect(s) in a manner consistent with the pharmacokinetics of the agent. (For example, doubling the dose of the transdermal fentanyl patch daily until comfort is achieved is likely to be associated with significant side effects, as it takes far longer than 1 day to determine the effect of the patch on the patient.¹²) Increase the dose of the agent until acceptable analgesia is experienced or adverse effects limit further use of the agent. Remember that each patient is different, even if both have similar radiological findings and the same pain level, because one patient with chronic low back pain may benefit from 25 mg of valdecoxib daily, while another may require a 50-mg dose. Remember also that truly “whole-istic” care means integrating medical care with appropriate interventional, physical rehabilitative, and behavioral pain management approaches, as well as potentially with complementary medical approaches.

Each treatment that you offer a patient (medical or otherwise) should be considered a trial therapy. If you just read the latest article stating that drug X is the best choice for diabetic neuropathy, you must still individually assess and reassess the effect of that agent on each individual patient. If, after a period of treatment, you and the patient believe that the treatment is both safe and effective, then continue. If not, then either amend how the treatment is offered (increase the dose, change the route of delivery) or change the treatment. Keep in mind the balance among tolerability, efficacy, and functional outcomes.

Exit Strategy

Treatment goals should include an understanding that your patients may need to be titrated and managed with more than one agent and one type of treatment. Patients need to know that you are not “married” to

the same treatment forever, particularly if it does not provide the desired effect. They need to expect that the treatment will be altered if it is not effective.

You should have an exit strategy in mind when you begin treatment. Whatever the pharmacologic agent(s) or modalities, both you and the patient should have a realistic sense of what constitutes treatment success or failure. Lack of pain relief or functional improvement clearly constitutes treatment failure, but a report of minimal pain and a return to usual activities certainly constitutes treatment success. Most of our experiences with patients lie somewhere in between. In fact, this has been recently carefully studied in patients with postherpetic neuralgia treated with gabapentin. Substantial improvement, as reported by patients, was associated with neither 100% nor 50% pain reduction, but with "only" 30% pain reduction.¹³ These data emphasize that successful treatment outcome is likely to occur without absolute pain cessation and, perhaps even more importantly, it is not realistic to expect total or even 50% pain reduction in chronic pain treatment.

Conclusions

In conclusion, the management of chronic pain should be viewed in the same way as any other chronic disease.

Assessing the Patient With Chronic Low Back Pain

Continued from page 3

sable cause of injury, are out of work, or are seeking disability, psychosocial and economic factors may influence LBP chronicity and disability. Prognostic red flags should be hoisted to at least half-mast when evaluating patients who^{7,23,24}:

- Are unable to ambulate or care for themselves
- Exhibit nonphysiologic signs or symptoms
- Have failed repeated surgical or medical treatments for mLBP
- Are seeking opioids or other psychoactive medications
- Are involved in abusive relationships
- Have psychiatric disorders, including depression, anxiety, delusional pain, and some personality disorders (eg, borderline, antisocial)

The pitfalls and challenges of chronic LBP, a common, yet complex, disorder mandate comprehensive evaluation and management of this physical condition that might also be appropriately described as a neuro-physiopsychosocioeconomic malady of Western industrialized culture.^{17,22,24}

- Determine the cause to the fullest extent possible and institute a treatment plan that has established efficacy and acceptable side effects
- Assess and reassess not only the benefits of the treatment but also the possibility of adverse effects
- Do not continue treatments that are ineffective or have unacceptable side effects; always be ready to exit one treatment and begin another if needed
- Reduce pain and improve function as much as possible
- Polypharmacy and combinations of both pharmacologic and nonpharmacologic treatments are likely to be the most rational approaches and are common practices among physicians who treat patients with chronic pain

Finally, NEVER GIVE UP. There are numerous options for the treatment of chronic pain. If you feel you have exhausted all treatment strategies, it is almost certain that one of your colleagues may be able to help with a different approach. Therefore, referral to a specialized center should be considered for the difficult-to-manage patient—there is always something more to be done in the treatment of chronic pain.

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Current and Emerging Pharmacologic Therapies *Continued from page 1*

Drug Class*	Representative Agent(s)	Pain-Related Indications [NB: Common uses are not necessarily approved uses.]	Levels of Evidence/Efficacy	Proposed Mechanisms of Action	Side Effects/Safety
Opioids	Morphine Hydromorphone Oxycodone Fentanyl	Moderate-to-severe acute pain Moderate-to-severe chronic pain Cancer-related pain Methadone: Management of severe pain Controlled-release agents are indicated for continuous management of moderate-to-severe pain when an opioid analgesic is needed for an extended period of time	Multiple randomized controlled clinical trials Few randomized controlled trials, except oxycodone, sustained-relief morphine, levorphanol Multiple randomized controlled clinical trials Small randomized controlled trials	<ul style="list-style-type: none"> Central: binding to CNS¹ opioid receptors inhibits ascending transmission of nociceptive information; activation of descending pain control pathways in midbrain Spinal inhibition of pain transduction Peripheral: binding to opioid receptors on peripheral nerves decreasing pain signaling Presynaptic inhibitor of signaling via sodium and calcium channels; post-synaptic inhibitor at potassium channels 	<p>Typical Side Effects: Sedation, drowsiness, dizziness/vertigo, nausea, constipation, itching/hives, urinary hesitancy, sexual dysfunction due to decreased sex hormone levels</p> <p>Safety Concerns: Respiratory depression (rare in ambulatory setting), immune suppression via lymphocyte dysfunction</p>
Nonsteroidal Anti-inflammatory Drugs (NSAIDs)	Ibuprofen Naproxen Diclofenac Salsalate Ketorolac	Rheumatoid arthritis, osteoarthritis Dysmenorrhea, mild-to-moderate pain Ibuprofen: acute migraine headache Naproxen, diclofenac: ankylosing spondylitis Ketorolac: indicated ONLY for short-term (≤5 days) management of moderate-to-severe acute pain requiring analgesia at the opioid level	Multiple randomized controlled clinical trials Multiple randomized controlled clinical trials Multiple randomized controlled clinical trials Multiple randomized controlled clinical trials Multiple randomized controlled clinical trials	<ul style="list-style-type: none"> Variable inhibition of cyclooxygenase (COX)-1 and -2 enzymes; possible inhibition of COX-3 enzyme Central inhibition of kainate, AMPA¹ and/or NMDA¹ 	<p>Typical Side Effects: Gastrointestinal discomfort (nausea, cramping, dyspepsia), drowsiness, increased blood pressure, bruising/petechiae, lower extremity edema</p> <p>Safety Concerns: Gastrointestinal erosion, irritation, ulceration or bleeding; renal impairment; kidney damage; hepatic impairment (rare); bleeding/impaired coagulation</p>
COX-2 selective NSAIDs	Celecoxib Rofecoxib Valdecoxib	Rheumatoid arthritis, Osteoarthritis Valdecoxib: Dysmenorrhea	Multiple randomized controlled clinical trials Few randomized controlled trials	<ul style="list-style-type: none"> Preferential inhibition of COX-2 enzyme, reducing inflammation Possible NMDA inhibition 	<p>Typical Side Effects: Gastrointestinal discomfort, drowsiness, increased blood pressure, lower extremity edema</p> <p>Safety Concerns: Possible higher risk of cardiovascular events than traditional NSAIDs (rofecoxib)</p>
Paraphenol Analgesic	Acetaminophen	Treatment of mild-to-moderate pain	Multiple randomized controlled clinical trials in headache and non-neuropathic pain conditions	<ul style="list-style-type: none"> Inhibits the synthesis of prostaglandins in the central nervous system Peripherally blocks pain impulse generation 	<p>Typical Side Effects: Well tolerated</p> <p>Safety Concerns: Renal and/or hepatic dysfunction (may be irreversible) with chronic use</p>
Membrane Stabilizers: Local anesthetics and analgesics	Lidocaine Mexiletine	Lidocaine (injection): Production of local or regional anesthesia by infiltration, intravenous and central neural techniques Topical lidocaine patch 5%: Relief of pain associated with postherpetic neuralgia (PHN) Mexiletine: NO pain indications	Few randomized controlled clinical trials (intravenous). Multiple controlled trials with regional (peripheral or central) analgesia Equivocal findings in limited randomized trials	<ul style="list-style-type: none"> Blocks both initiation and conduction of nerve impulses by decreasing the neuronal membrane's permeability to sodium ions, which results in inhibition of depolarization with resultant blockade of conduction 	<p>Typical Side Effects: Lip numbness or tingling with IV infusion of lidocaine</p> <p>Topical lidocaine patch 5% well tolerated but may cause rash or skin irritation</p>
Membrane Stabilizers: Anticonvulsants	Gabapentin Carbamazepine	PHN Trigeminal or glossopharyngeal neuralgia	Multiple randomized controlled clinical trials for PHN and diabetic neuropathy Multiple controlled trials for trigeminal neuralgia	<ul style="list-style-type: none"> Calcium-channel blockade and possible GABA¹ agonism through unique binding site Has anticholinergic, muscle relaxant and antiarrhythmic properties; may depress activity in the nucleus ventralis of the thalamus or decrease synaptic transmission or decrease summation of temporal stimulation leading to neural discharge by limiting influx of sodium ions across cell membrane or other unknown mechanisms Inhibits release of glutamate (an excitatory amino acid) and inhibits voltage-sensitive sodium channels; has weak inhibitory effect on the 5-HT₃ receptor Increases efflux or decreases influx of sodium ions across cell membranes in the motor cortex during generation of nerve impulses; shortens membrane action potential 	<p>Typical Side Effects: Drowsiness, dizziness, GI upset, ataxia/nystagmus at high doses</p> <p>Safety Concerns: Carbamazepine and first-generation anticonvulsants: bone marrow suppression/blood dyscrasias, hypersensitivity/anaphylaxis, hepatic dysfunction, SIADH¹</p> <p>Stevens-Johnson syndrome</p> <p>Anticonvulsant hypersensitivity syndrome (AHS); blood dyscrasias; hepatic dysfunction</p>
Tricyclic Antidepressants (TCA)	Amitriptyline Nortriptyline Desipramine Doxepin	NO pain indications Common Uses: migraine, phantom limb pain, diabetic neuropathy, cancer-related pain, trigeminal neuralgia, cancer-related pain, painful peripheral neuropathy, arthritis pain	Multiple randomized controlled clinical trials in diabetic peripheral neuropathy, PHN, and other chronic pain syndromes	<ul style="list-style-type: none"> Sodium-channel blockade Inhibition of serotonin and norepinephrine reuptake (pre-synaptic) Synergy with met-enkephalin (endogenous opioid) Possible central and peripheral alpha-adrenergic effects Possible calcium-channel blockade 	<p>Typical Side Effects: Drowsiness, dizziness, forgetfulness, constipation, blurred vision, dry mouth, weight gain, sexual dysfunction</p> <p>Safety Concerns: Cardiac conduction changes, orthostatic hypotension, serotonin syndrome (with other serotonergic agents)</p>

Drug Class*	Representative Agent(s)	Pain-Related Indications [NB: Common uses are not necessarily approved uses.]	Levels of Evidence/Efficacy	Proposed Mechanisms of Action	Side Effects/Safety
Serotonin-Norepinephrine Reuptake Inhibitors (SNRI)	Venlafaxine	NO pain indications	Equivocal findings in limited randomized trials of neuropathy and neuralgia	<ul style="list-style-type: none"> Inhibition of serotonin and norepinephrine reuptake (pre-synaptic) Possible sodium-channel blockade Possible calcium-channel blockade 	<p>Typical Side Effects: Drowsiness, dizziness, GI upset, activation or agitation</p> <p>Safety Concerns: SIADH, suicide risk</p>
Central Analgesics: Opioid-like	Tramadol Tramadol/acetaminophen	Tramadol: Relief of moderate-to-moderately severe pain Tramadol/APAP: Acute pain (limited to 5 days)	Multiple randomized controlled trials	<ul style="list-style-type: none"> Serotonin, norepinephrine reuptake Weak mu-opioid receptor agonism Possible sodium-, calcium-, and/or potassium-channel blockade 	<p>Typical Side Effects: Drowsiness, dizziness, GI upset, agitation</p> <p>Safety Concerns: Seizures (usually in overdose); serotonin syndrome with antidepressants</p>
Central Analgesics: Alpha-adrenergic Agonists	Clonidine Tizanidine (central muscle relaxant)	Clonidine (injectable): For continuous epidural administration as adjunctive therapy with intraspinal opiates for treatment of cancer pain in patients tolerant to or unresponsive to intraspinal opiates Skeletal muscle relaxant used for treatment of muscle spasticity	Multiple clinical trials of intrathecal administration in post-operative pain Fewer trials with other pain conditions Few randomized trials for chronic pain	<ul style="list-style-type: none"> Sympatholytic effect mediated by alpha-2 receptors Inhibits substance P activity Reduction in excitatory neurotransmission Decreases excitatory input to alpha motor neurons Centrally acting muscle relaxant at the spinal cord Possible synergism with endogenous opioid receptors 	<p>Typical Side Effects: Dry mouth, dizziness, orthostatic hypotension</p> <p>Safety Concerns: Clonidine: Hypotension or rebound hypertension on withdrawal Tizanidine: Cardiac conduction disturbances, hepatic dysfunction</p>
Centrally-acting Muscle Relaxants	Baclofen	Baclofen: Orphan drug for intrathecal treatment of intractable spasticity caused by spinal cord injury, multiple sclerosis, and other spinal disease (spinal ischemia or tumor, transverse myelitis, cervical spondylosis, degenerative myelopathy)	Multiple randomized controlled trials with spasticity	<ul style="list-style-type: none"> GABA-B agonism inhibits pain signaling Inhibits the transmission of both monosynaptic and polysynaptic reflexes at the spinal cord level, possibly by hyperpolarization of primary afferent fiber terminals 	<p>Typical Side Effects: Drowsiness, dizziness, GI upset, ataxia, cognitive impairment</p> <p>Safety Concerns: Respiratory depression with unintentional overdose</p>
Counter-irritant	Capsaicin	Temporary relief of minor aches and pains of muscles and joints associated with simple backache, arthritis, strains, bruises, and sprains Common Uses: Topical treatment of pain associated with postherpetic neuralgia, arthritis, diabetic and other neuropathies	Multiple controlled trials	<ul style="list-style-type: none"> Vanilloid-receptor antagonist suppresses spinal pain signaling Depletes the neuron of substance P and prevents reaccumulation 	<p>Typical Side Effects: Burning, irritation at site of administration</p> <p>Safety Concerns: Few with topical administration; may cause burning of mucous membranes if applied inadvertently</p>
N-methyl-d-aspartate (NMDA) Inhibitors	Ketamine Dextromethorphan Amantadine	Induction and maintenance of general anesthesia, sedation; analgesia NO pain indications NO pain indications	Few controlled trials with parenteral and topical administration Few controlled trials—variable results Limited trials and case reports (poor evidence)	<ul style="list-style-type: none"> Direct action on the cortex and limbic system Releases endogenous catecholamines (epinephrine, norepinephrine) Reduces polysynaptic spinal reflexes 	<p>Common Side Effects: Drowsiness, dizziness, dysphoria, dissociation psychotomimetic effects (eg, hallucinations)</p> <p>Safety Concern: Hypersensitivity</p>
Corticosteroids	Prednisone Dexamethasone Triamcinolone	NO labeled pain indications Common Use: Metastatic bone disease	Multiple controlled trials in cancer-related pain syndromes	<ul style="list-style-type: none"> Inhibit synthesis of arachidonic acid end-products (eg, prostaglandins) thereby decreasing pain sensitization Suppression of migration of polymorphonuclear leukocytes and reversal of increased capillary permeability 	<p>Common Side Effects: Mood changes, increased appetite, insomnia</p> <p>Safety Concerns: Osteoporosis, avascular necrosis, hypertension, muscle atrophy, Cushingoid syndrome, immune suppression</p>
Serotonin Receptor Agonists	Sumatriptan Naratriptan Rizatriptan Almotriptan Eletriptan Frovatriptan	Migraine headache (acute treatment)	Multiple randomized controlled trials	<ul style="list-style-type: none"> Variable selectivity for central serotonin receptor agonism (types 1B, 1D, +/- 1A, 1F, or 7) Calcitonin gene-related peptide (CGRP) agonism 	<p>Common Side Effects: Chest tightness/discomfort, cognitive changes</p> <p>Safety Concerns: Cardiac vascular constriction, hemiplegic migraine is contraindication, serotonin excess with other serotonergic agents</p>
Ergotamine Derivatives	Dihydroergotamine (DHE) Ergotamine	Treatment of migraine headache with or without aura DHE (injection): also indicated for treatment of cluster headaches	Multiple randomized trials	<ul style="list-style-type: none"> Ergot alkaloid alpha-adrenergic blocker directly stimulates vascular smooth muscle to vasoconstrict peripheral and cerebral vessels Partial agonist and/or antagonist activity at tryptaminergic, dopaminergic and alpha-adrenergic receptors, depending on their site Depression of central vasomotor centers 	<p>Common Side Effects: Chest tightness/discomfort, cognitive changes</p> <p>Safety Concerns: Cardiac vascular constriction, hemiplegic migraine is contraindication, serotonin excess with other serotonergic agents</p>
Methylxanthines	Caffeine	NO separate pain indication Common Use: Migraine combination products (eg, with aspirin, acetaminophen, etc)	Multiple clinical trials with migraine headache and few with lumbar puncture headache	<ul style="list-style-type: none"> Increases levels of 3'5' cyclic AMP[†] by inhibiting phosphodiesterase Competitive inhibition of adenosine 	<p>Common Side Effects: Agitation, nervousness, sweating, increased heart rate, rebound headache, increased blood pressure values</p> <p>Safety Concerns: Tachycardia, increased blood pressure</p>
TNF-alpha Inhibitors	Etanercept Adalimumab Infliximab	Rheumatoid arthritis Etanercept only: Ankylosing spondylitis, psoriatic arthritis	Clinical trials in arthritis indicated a pain-reducing benefit though studies concentrated on joint swelling and function	<ul style="list-style-type: none"> Etanercept: Soluble TNF receptor binds circulating TNF-alpha Adalimumab, Infliximab: Monoclonal antibodies directed at TNF-alpha 	<p>Common Side Effects: Local irritation at injection site</p> <p>Safety Concerns: Immune suppression leading to sepsis or severe infection</p>

* Drug classes appear in descending order according to general range of indications for pain and weight of supporting evidence. Some products under discussion have not yet been approved for use in the United States.

[†] Abbreviations: AMP = adenosine monophosphate; AMPA = alpha-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid; CNS = central nervous system; GABA = gamma-aminobutyric acid; NMDA = N-methyl-d-aspartate; SIADH = syndrome of inappropriate secretion of antidiuretic hormone; TNF = tumor necrosis factor.

SELECTED ABSTRACTS


Second Joint Scientific Meeting of the American Pain Society and the Canadian Pain Society

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No significant financial interests or affiliations.

Note: The following is a perspective by NIPCC faculty member Neal E. Slatkin, MD, on a limited selection of the many abstracts and posters from the recent combined meeting of the American and Canadian Pain Societies. The article is the first in a series that will focus on new developments in the field of pain management.

The combined American/Canadian Pain Society meeting, held in Vancouver in early May, was rich in both scientific and clinical content. On the therapeutic side, sessions and posters explored a variety of new approaches to

pain treatment. A summary of some of these treatments appears below with specific poster numbers to enter into the search criteria for the 2004 American Pain Society (APS) abstract database. To search complete meeting abstract postings, direct your Internet browser to: <http://www.ampainsoc.org/cgi-bin/abstract2004/search.pl>

- The application of high-dose (0.25%) capsaicin (vs the 0.025% or 0.075% concentration used in common practice) was reported to decrease pain in a small uncontrolled study of patients with neuralgia arising from diabetic polyneuropathy or prior herpes zoster infection. Burning pain was controlled with topical application by suspending the capsaicin in a lidocaine-containing vehicle. (Poster #894)
- Pregabalin was demonstrated to improve pain, sleep, and mood in patients with postherpetic neuralgia. Patients (N = 238) were randomized to receive pregabalin, a novel α_2 -delta calcium channel ligand, dosed (TID) at 150 mg/d, 300 mg/d, or placebo for 8 weeks.

Both pregabalin-treated groups showed reductions in pain and sleep disturbance, and the 300-mg dose group also had significant improvement in mood, observed at week 1 and continuing throughout the study. (Poster #795)

- Four posters commented upon the use of the lidocaine patch 5% in the treatment of such diverse conditions as osteoarthritis, low back pain, and neuropathic pain. In a "naturalistic" study by Fishbain and colleagues, a beneficial response to the lidocaine patch 5% was seen in more than 75% of patients and predicted by pain that awoke the patient from sleep, patch placement covering sites other than the lower back, and patient not involved in litigation. (Posters #896, #897, #898, #899)
- Many posters presented new efficacy and safety data for the transdermal fentanyl patch in chronic pain control; two focused on its expanded role in the treatment of low back pain and osteoarthritis. In a study of strong opioids in the treatment of chronic low back

Continued on page 11

Current and Emerging Pharmacologic Therapies

Continued from page 7

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CME
POSTTEST

CME Questions for Pain Management Today®

MULTIPLE CHOICE

Brzusek article

1. What is the best measure for determining treatment effectiveness for acute or chronic pain?
- Physical examination
 - Provocative test
 - Functional status of patient
 - Visual pain analog scales

Dworkin article

2. First-line treatment for neuropathic pain is
- Gabapentin
 - Lidocaine patch 5%
 - Opioid analgesics
 - Tramadol
 - Tricyclic antidepressants
 - All of the above

Katz article

3. What does the term “balance” mean with regard to the use of opioid analgesia to treat chronic pain?
- There must be recognition of the legitimate role of these drugs and the potential for opioid abuse
 - The occurrence of addiction and pseudoaddiction must be balanced during treatment
 - The risk of addiction must be balanced against the lesser cost of opioid therapy
 - When the development of tolerance is balanced against the higher doses of opioids, the physician must stop prescribing

Moskowitz article

4. Which of the following statements is FALSE concerning documentation of opioid use in pain management?
- Clinical guidelines for treatment of chronic pain with opioids and its documentation are excellent and comprehensive
 - Interpretation of positive results of urine drug screens is straightforward
 - Controlled substance agreement and informed consent are the same documents
 - All of the above
 - None of the above

Wheeler article

5. One of the major differences between chronic pain and acute low back pain is that chronic pain represents
- A change in the structure of the spine
 - A change in the neurochemistry of the nervous system
 - A normal activation of nociceptors
 - Both a and b
 - None of the above

Argoff article

6. Chronic pain disables more people and adds more to healthcare costs than
- Heart disease
 - Cancer

- Heart disease and cancer combined
- Stroke
- None of the above

7. What is the treatment goal in chronic pain?

- Curing the pain
- Eliminating the need for combinations of medications
- Instituting a successful treatment plan that does not require an exit strategy
- Reduction of pain and improvement in quality of life
- a, b, and c

Reisner article

8. Which of the following statement(s) is TRUE regarding the treatment of postherpetic neuralgia?
- Acetaminophen provides highly effective and proven pain relief
 - The topical lidocaine patch 5% provides effective treatment of pain and is well tolerated
 - TCAs are effective, but patient may experience cardiac conduction changes as safety concerns
 - Gabapentin is not an effective treatment
 - a and d
 - b and c

TRUE OR FALSE

Katz article

9. There is enough clinical and anecdotal evidence to verify that most opioid trials are successful and a majority of pain patients experience long-term benefits, making an exit strategy unnecessary.
- TRUE FALSE

ANSWERS

1. c. It is the functional status of the patient that is the best determination of treatment effectiveness. (Volume 4, number 1, page 3)
2. f. All of the above. The efficacy of each of the five pharmacologic treatments in patients with neuropathic pain has now been demonstrated by the results of multiple consistent, randomized trials. These five therapies provide the clinicians with an evidence-based approach for the first-line treatment of neuropathic pain. Clinical circumstances exist in which each therapy can be used in the initial treatment of patients with neuropathic pain. (Volume 4, number 1, page 7)
3. a. According to David Jorenson’s “principle of balance,” until more information is available to direct policy to limit prescription opioid abuse, policy approaches should ensure that access of pain patients to opioids is maintained. However, physicians must recognize and share responsibility for the potentially devastating problems of prescription opioid abuse and engage in a partnership with regulators to address this issue. (Volume 4, number 1, page 10)
4. d. All of the above. Good clinical guidelines for treating chronic noncancer pain with opioids and documenting their use are sorely lacking. Controlled substance agreements and informed consent are not the same. Controlled substance agreements delineate patient responsibility and practice expectations while informed consent documents risks and benefits, side-effect profile, clinical controversies, and abstinence syndrome. Prescribing physicians should consider consulting an addiction expert for help in interpretation of positive results of urine drug screens, which may be complicated. (Volume 4, number 1, pages 1, 6)
5. d. When low back pain becomes chronic, structural and neurochemical changes can be maladaptive and interfere with the individual’s capacity to function physically and emotionally. Chronic low back pain is multifaceted, involving structural, biomechanical, biochemical, medical, psychosocial, and behavioral influences resulting in clinical syndromes of such complexity that evaluation, treatment, and rehabilitation is often difficult or ineffective. (Volume 4, number 2, page 3)
6. c. Chronic pain disables more people and adds more costs to our healthcare economy than heart disease and cancer combined. (Volume 4, number 2, page 1)
7. d. The goals of chronic pain management must be realistic: reduce pain and improve quality of life to the fullest extent possible. The evaluation and treatment of chronic pain is not only about finding the proper medicine or nerve block to “cure” the pain, which is not likely to happen in most cases. Rather, the management of chronic pain involves a detailed assessment of the problem, including both medical and nonmedical aspects, and the development of a comprehensive treatment plan. Medical, physical rehabilitative, and psychosocial treatment strategies are all appropriate in this plan. (Volume 4, number 2, pages 1, 4)
8. f. The efficacy and safety of the topical lidocaine patch 5% has been proved in multiple, randomized controlled clinical trials. TCAs have also proven effective in multiple randomized controlled clinical trials but patients may experience cardiac conduction changes, orthostatic hypotension, and serotonin syndrome (with other serotonergic agents). Gabapentin is another successful agent, but doses required for pain relief also cause somnolence. (Volume 4, number 2, page 6)
9. False. Each physician has to judge, partly with patient input, whether an opioid trial is successful. In any opioid trial, an exit strategy is vital so that both provider and patient should agree (before treatment begins) as to when and how the trial is to terminate. (Volume 4, number 1, page 10)

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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	2	3	4	5	6
1. Identify a balanced approach to the use of opioid analgesia in treatment of chronic pain.	1	2	3	4	5	6
2. Discuss evidence-based treatment recommendations for the pharmacologic management of chronic neuropathic pain.	1	2	3	4	5	6
3. Assess the patient with low back pain and select appropriate diagnostic tests.	1	2	3	4	5	6
4. Describe the role of a comprehensive treatment plan for patients with chronic pain that includes biopsychosocial approaches.	1	2	3	4	5	6
5. Differentiate between the distinctive biochemical properties and potential mechanisms of major classes of pain medications in the treatment of neuropathic pain.	1	2	3	4	5	6
6. Understand how to transition a patient through continuation/maintenance therapy and discontinuation of opioids.	1	2	3	4	5	6
7. Document opioid usage and monitor progress and treatment outcomes in patient management.	1	2	3	4	5	6

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

	Strongly Disagree			Strongly Agree		
	1	2	3	4	5	6
1. The format/teaching methods were appropriate to meet the activity objectives	1	2	3	4	5	6
2. Overall, the activity was presented in a fair-balanced manner	1	2	3	4	5	6
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*[®]?

SELECTED ABSTRACTS*Continued from page 8*

pain, 680 patients were assessed over a period of 13 months. Approximately half of the patients were treated with the 3-day fentanyl patch and the remainder received sustained-release morphine (SRM). The fentanyl patch was significantly better than SRM at providing pain relief at rest and at night; both provided similar levels of pain relief at other times. In addition, 65% of patients taking SRM experienced constipation, compared with 52% of those on the transdermal fentanyl patch. In the second study, 65% of patients with moderate-to-severe osteoarthritis (n = 62) treated with the fentanyl patch reported "improved" or "much improved" pain control. Age had no effect on the incidence of adverse events, which were mild to moderate in intensity. (Posters #844, #840)

- Levetiracetam, a new anticonvulsant medication, was investigated as add-on therapy in patients having "stable, minimally satisfied

chronic pain" who were already taking a variety of analgesic regimens. Pain improvement was reported in a large percentage of patients, with improvements in sleep and anxiety also observed. (Poster #789)

- Botulinum toxin has long been used off-label for the treatment of a variety of myofascial pain syndromes and, more recently, for the treatment of migraine headache. Two reports from the Minneapolis VA Medical Center indicated the value of intra-articular injection for joint pain. Five patients with arthritic knee or ankle pain derived benefit from the intra-articular botulinum A; the relief lasted up to 6 months. (Poster #805)

- The analgesic benefit and safety of opiates may be confounded by their metabolism by P450 enzymes, such as occurs with codeine and hydrocodone. Oxymorphone has been shown to decrease cancer and osteoarthritis pain when administered in extended release form. One potential advantage of oxymorphone is that it does not inhibit or induce CYP450 enzymes at pharmacotherapeutic concentrations, thereby decreasing its

potential for interaction with other medications. (Poster #829)

- Tetrodotoxin, a highly potent sodium channel blocker harvested from the puffer fish, decreased refractory pain in a study of 25 Canadian cancer patients. Treatment benefit, seen in approximately 75% of patients, often lasted for 2 or more weeks.

A larger multi-institutional trial of this agent is now underway. (Session #304)

- Ketamine, an anesthetic agent with analgesic and antihyperalgesic properties, has been reported to decrease pain when administered via a variety of systemic routes. A study from our group at City of Hope indicated the benefit of topical ketamine in decreasing skin and mucosal pain arising from inflammatory conditions associated with cancer and its treatment. (Poster #771)

Notably, the APS annual meeting is an arena for interdisciplinary exchange among pain scientists and healthcare professionals. Next year's APS meeting, to be held in Boston from March 30 to April 2, also promises to be an exciting one.

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OPIOID ANALGESIA TOOL KIT

A Resource for Managing Your Patients With Chronic Pain



Due to be released in October, the *Opioid Analgesia Tool Kit: A Resource for Managing Your Patients With Chronic Pain* is a comprehensive compilation of practical tools and references for managing patients on opioid therapy. Culled together by experts in pain management, the CD-ROM contains highly relevant and appropriate resources designed to improve patient outcomes. It will facilitate your efforts to bring pain relief to your patients in a high-quality and responsible manner, while protecting your patients and your practice. The user-friendly CD-ROM is steered by an intuitive and interactive algorithm that serves as a menu, linking to the appropriate tool(s). Printable templates of various tools are provided as a time-saving option that will be invaluable in your busy practice.

- **Medication Flow Chart** helps you to manage your chronic pain patient's current medication regimen by reviewing strengths, instructions, days' supplies, and date each medication is due to run out. The at-a-glance organization offered by this chart will also serve as a useful historical record in your busy practice.
- **Pain Assessment and Documentation Tool (PADT)** is a structured progress note for patients on opioid therapy, developed and published by a group of experts in the field. The form is designed to assist you in routinely creating the documentation you need to support opioid therapy, and to assist you in making decisions about how to manage individual patients on opioid therapy.
- **Patient Medication Management Agreement** can improve adherence and enhance therapeutic relationships by initiating an alliance between you and your patient. The Agreement clearly identifies the parameters of the treatment, thereby establishing clear-cut terms and expectations for the patient's continuation, modification, or discontinuation of opioid therapy.
- Tables from **American Pain Society's Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain, Fifth Edition** provide rapidly accessible references to assist you in the management of common situations that arise in opioid therapy.
- **Urine Drug Testing in Primary Care** and its accompanying **Quick Reference** provide information on proper methods, uses, limitations, and evaluation of urine drug testing in order to rationally employ testing in clinical practice to improve patient care.
- **Patient Assessment Tools** include the Brief Pain Inventory, the full-text article "Pain Assessment: Global Use of the Brief Pain Inventory" by Cleeland and Ryan, 18 Multi-language Pain Assessment Scales, and other various pain assessment scales such as the Numeric Pain Rating Scale, Visual Analog Scale, Verbal Pain Intensity Scale, and Neuropathy Pain Scale.
- **Patient Education Brochures** include *Understanding Your Pain: Taking Oral Opioid Analgesics* and *Using a Pain Rating Scale*. A knowledgeable patient can understand and communicate the nature of his/her pain to you more clearly.
- **Pain Notebook** is a useful guide for your patients to keep track of the progression of their chronic pain. It will ultimately help determine each patient's pain progress

and subsequent therapeutic management, and will help your patients communicate a great deal of information in a more rapid and reliable manner rather than relying purely on recall.

- **Federal and State Regulation Resources** include *Achieving Balance in Federal & State Pain Policy: A Guide to Evaluation, Second Edition*; Database of State Laws, Regulations, and Other Official Governmental Policies; Model Policy for the Use of Controlled Substances for the Treatment of Pain, revised May 2004; and Prescription Pain Medications: Frequently Asked Questions and Answers, released August 2004.
- **Screener and Opioid Assessment for Patients With Pain (SOAPP) Version 1.0** will help determine which patients are most likely to be manageable in a primary care setting vs those who would do best in a specialty setting with more intensive patient monitoring and management capabilities.
- **Side Effects Chart of Opioid Therapy** will help you rapidly identify a patient's side effects and the most effective management strategies for those side effects.
- **Helpful Links** are provided for your reference.

OPIOID ANALGESIA TOOL KIT ORDER FORM

To order the *Opioid Analgesia Tool Kit: A Resource for Managing Your Patients With Chronic Pain*, please provide the following information:

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