





TIPS FOR MANAGING CHALLENGING CONSULTS

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 OCTOBER 16, 2016



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**"This prescription won't make you feel better
 but it will stop your whining and make
 everyone else feel better."**

Questions to Ask Yourself

- **Diagnosis**
 - What do I think is wrong with my patient?
 - Is this degree of pain consistent with my experience and understanding of this particular illness or injury?
 - What is the normal progression of this type of pain?
- **Treatment**
 - Are opioids evidence-based for this type of pain?
 - What are non-opioid alternatives that I can use prior to or concurrently with opioids?

Acute Pain is Normal

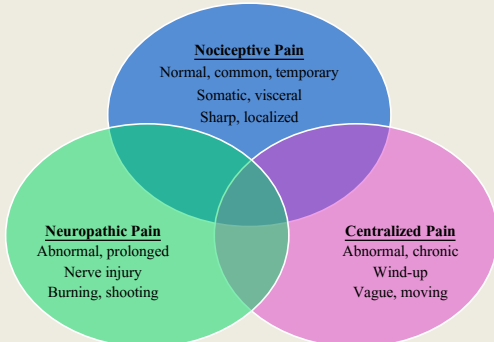
- **Adaptive pain** – contributes to survival by protecting people from injury and/or promoting healing when injury has occurred
 - Common in all patients
 - 75-80% of patients experience pain after surgery
 - Timing
 - Up to 3 months post-operatively – usually considered appropriate time for tissue healing
 - Examples – nociceptive and inflammatory pain
- **Abnormal Progression**
 - Maladaptive or chronic pain – characterizes pain as disease, which represents pathologic functioning of the nervous system
 - Timing
 - 3-6 months post-operatively – subacute pain
 - Greater than 6 months – chronic pain
 - Examples – neuropathic and dysfunctional pain

Apfelbaum J.L et al, 2003

Pain is a Biopsychosocial Problem

Nociceptive Pain
 Normal, common, temporary
 Somatic, visceral
 Sharp, localized

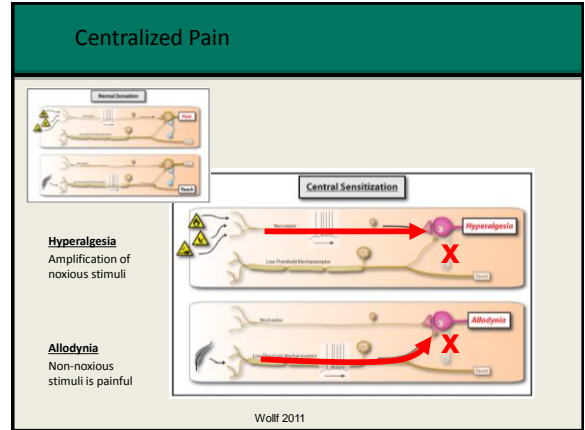
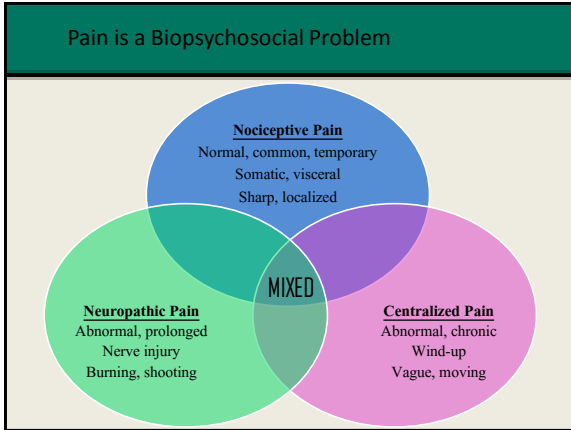
Pain is a Biopsychosocial Problem



Nociceptive Pain
 Normal, common, temporary
 Somatic, visceral
 Sharp, localized

Neuropathic Pain
 Abnormal, prolonged
 Nerve injury
 Burning, shooting

Centralized Pain
 Abnormal, chronic
 Wind-up
 Vague, moving



Psychosocial Component of Chronic Pain

- San Francisco Spine Study
- Risk factors
 - Physical abuse
 - Sexual abuse
 - Drug/alcohol abuse
 - Abandonment
 - Emotional neglect or abuse

Childhood Psychological Trauma Correlates with Unsuccessful Lumbar Spine Surgery

Johna Schoffner, MD, David Anderson, MD, Robert Hayes, MD, George Smith, MD, and John Wether III

Background: The presence of childhood psychological trauma (CPT) may be a result of the chronic pain state rather than a cause of chronic pain. This study was designed to determine whether CPT is associated with poor surgical outcomes in patients undergoing lumbar spine surgery. Methods: Data from the San Francisco Spine Study were analyzed to determine the association between CPT and surgical outcomes. Results: Patients with CPT had significantly lower rates of successful surgical outcomes compared to those without CPT. Conclusion: The presence of CPT is associated with poor surgical outcomes in patients undergoing lumbar spine surgery. This finding suggests that CPT may be a risk factor for poor surgical outcomes and should be considered in the management of chronic pain.

Number of Risk Factors	Number of Patients	Number of Successes	Observed Probability of Success	Estimated Probability of Success
0	19	12	63%	60%
1	12	8	67%	73%
2	14	6	43%	50%
3	14	5	36%	38%
4	9	3	33%	32%
5	9	3	33%	32%
	85	39	46%	50%

0-2 risk factors = 75% success
3-5 risk factors = 15% success

Psychiatric Theory

- San Francisco Spine Study reinforces theory that large component of chronic pain is due to abnormality in reward pathway
- Childhood abuse/neglect keeps child from normal limbic system development
- As adult, he/she seeks to receive reward pathway stimulation that was not received in childhood
- Pain promotes caregiver and physician attention and sympathy, i.e., reward pathway stimulation
- Without pain, these are absent, as before
- Abnormal and primal coping mechanism by the psyche is to perpetuate the pain
- Hence, the adult develops chronic and incurable pain

Prior to Treatment

- Review the medical history
 - Rule out ominous causes of pain (surgical complication, infection, re-injury, fracture dislocation, wound dehiscence)
 - Review records from previous providers
 - Screen for substance abuse (ORT screen)
 - Identify patients in active recovery (high risk of being "triggered" by even small amounts of opioids)
- Identify other prescribed medications or conditions that contraindicate co-prescribing opioids
 - Benzodiazepines – synergistic effect (CDC Guidelines recommend against co-prescribing due to elevated risk of sedation and overdose)
- Check the Texas Prescription Monitoring Program (<https://texas.pmpaware.net/login>)
- Risk stratify
 - Consider report of pain, degree of functional limitation, other psychiatric risk factors
 - Determine if new or exacerbation of baseline chronic pain
 - Confirm non-opioid adjuncts are optimized

RISK STRATIFICATION FOR PATIENTS PRESCRIBED OPIOIDS

Risk Level	Characteristics
Low Risk	<ul style="list-style-type: none"> Definable physical pathology with objective signs and reliable symptoms Clinical correlation with diagnostic testing, including MRI, physical examination, and interventional diagnostic techniques With or without mild psychological comorbidity With or without minor medical comorbidity No or well-defined and controlled personal or family history of alcoholism or substance abuse Age 45 years or older High levels of pain acceptance and active coping strategies High motivation and willingness to participate in multimodal therapy and attempting to function at normal levels
Medium Risk	<ul style="list-style-type: none"> Significant pain problems with objective signs and symptoms confirmed by radiological evaluation, physical examination, or diagnostic interventions Moderate psychological problems, well controlled by therapy Moderate coexisting medical disorders that are well controlled by medical therapy and are not affected by chronic opioid therapy (e.g., central sleep apnea) Develops mild tolerance but not hyperalgesia without physical dependence or addiction Pain history of personal or family history of alcoholism or substance abuse Pain involving more than three regions of the body Defined pathology with moderate levels of pain acceptance and coping strategies Willing to participate in multimodal therapy, attempting to function in normal daily life
High Risk	<ul style="list-style-type: none"> Widespread pain without objective signs and symptoms Pain involving more than three regions of the body Aberrant drug-related behavior History of alcoholism or drug misuse, abuse, addiction, diversion, or dependence Major psychological disorders Age younger than 45 years IV-related pain High levels of pain exacerbation and low levels of coping strategies Unwilling to participate in multimodal therapy, not functioning close to a near normal lifestyle IV = human immunodeficiency virus; MRI = magnetic resonance imaging

Manchikanti L, et al – Part 2, 2012

Young and debilitated with widespread/diffuse pain, aberrant behavior, history of substance abuse, or psychiatric disorders

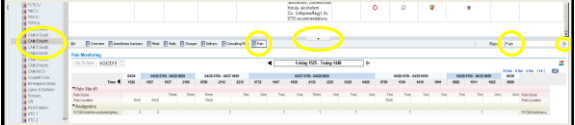
Addiction/Overdose Potential

- Risk factors for overdose
 - Patient non-adherence to regimen
 - Unrecognized mental health comorbidities
 - Co-administration of other CNS depressants/alcohol
 - Sleep apnea
 - Obesity (>30 BMI)
- Overdose risk in perspective
 - 33,000 annual opioid deaths
 - Percentage opioid overdoses mirrors increased prescribing over the past 10 years
 - 75% of overdoses did not have valid prescription at the time of overdose
 - Heroin is the most common opioid for overdose
 - 79% test positive for alcohol/other drugs

Kenen et al, 2012, CDC 2017

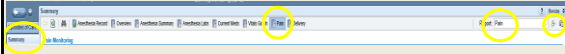
Evaluation of Pain Scores Using EPIC

- View pain scores from the patient list prior to entering the chart
- Add quick button using "wrench" feature



Evaluation of Pain Scores Using EPIC

- Alternatively, view pain scores from the "Summary" tab after entering the patient's chart
- Add quick button using "wrench" feature within the chart



- Patients with chronic pain have higher post-operative pain scores and require higher doses of opioids than opioid naïve patients
- 49% of patients taking chronic opioids continue to report high acute pain scores (7/10 or greater)

Wasserman et al, 2014; Bruhl et al, 2014

Biopsychosocial Solution



Principles of Pharmacotherapy in Acute Pain

- Administer analgesics regularly (not PRN) if pain is present most of day
- Give weak oral opioids and all adjuncts prior to (or concurrently with) administering IV strong opioids
- Become familiar with dose and time course of several strong opioids
 - Morphine Peak 30-60 min; DOA 3-4 hours
 - Hydromorphone Peak 15-30 min; DOA 2-3 hours
 - Fentanyl Peak 3-5 min; DOA 0.5-1 hour
- Give the lowest effective dose to avoid side effects
- Follow patients closely, particularly when beginning or changing analgesic regimens
- Recognize and treat side effects
- Avoid long-acting or sustained release formulations for opioid naïve patients
- DE-ESCALATE when acute pain has had adequate time for resolution

Target Specific Types of Pain

- Nociceptive pain – normal response to noxious stimuli (post-op, acute injury, acute illness)
 - APAP
 - NSAIDs
 - Opioids
- Inflammatory pain – normal response to tissue injury or infection (post-op, cellulitis)
 - NSAIDs
 - Cold therapy
- Neuropathic pain – abnormal maladaptation to nervous system when pain is prolonged (chronic back pain, sciatic nerve injury)
 - Antineuropathics
 - Antidepressants
- Dysfunctional pain – result of heightened nociceptive sensitivity without detectable stimulus (fibromyalgia, IBS, functional abdominal pain)
 - Antineuropathics
 - Antidepressants

Opioid Tolerant Patients

Table 7. Guidelines for Effective Treatment of the Opioid-Tolerant Patient

Recognize the opioid-tolerant patient
 Maintain baseline opioid therapy
 Upward compensation in perioperative opioid dosing
 Use of peripheral and central neural block
 Administration of nonopioid analgesics

- If not NPO postoperatively, start home regimen immediately
- If NPO postoperatively, start PCA with a basal rate to cover home regimen
- Basal rate should be the IV equivalent to approximately 1/3 to 1/2 of their daily PO dose; breakthrough demand dose should exceed the 24 hour equivalent to home PO dose to effectively cover postoperative pain in addition to chronic pain
- Convert the PCA back to PO as soon as patient is taking PO dependably

Rathmell et al, 2006

Create Preference Order Sets

Link Orders

Effective Care Model

- Encourage proactive intervention
- Promote wellness and health maintenance, rather than being reactive
- Smoking cessation – persistent pro-inflammatory state
- Educate regarding modifiable chronic diseases
 - Obesity-related pain in loadbearing joints
 - Discuss weight reduction as strategy for pain reduction
 - Pain often directly proportional to load
 - Analogy – Would you consider squatting *** pounds in the shape your knees/hips/back is in?
 - Pre- or post-joint replacement surgery – discuss maintenance of physical activity as strategy to limit joint immobility
 - Diabetic peripheral neuropathy or diabetic poor wound healing – discuss glucose management to reduce chronic pro-inflammatory state caused by elevated glucose
- Some damage is irreversible, but pain improved health may prevent further damage from occurring

Introducing CBT to Patients

- Outline expectations in the initial consultation
- Explain that chronic pain is like any other chronic disease (ex: diabetes)
 - It will likely always be there to some degree
 - Lifestyle modification will help manage
 - Denying it will only make suffering worse
 - Taking ownership of pain will empower you to more effectively manage it
 - You are not to blame for your pain and it is normal to feel sad, angry, or anxious about the disruption the pain has caused in your life
- Define roles
 - You must play an active role in your own recovery
 - If you commit 30-60 minutes per day to purposeful pain appraisal, it will improve (not resolve, but improve)
 - We are in this together and I will do what I can to help you

Purposeful Thinking

- Explain to give insight
 - Pain is not "all in your mind", but you can use your mind to improve your perception of pain
 - Thoughts, attitudes, ideas, expectations, memories, beliefs, images: these are all related and cascade into others very rapidly
 - Thoughts and feelings dictate behavior
- Teach new approach to cognitive processing
 - View thoughts as "guesses" to be tested against reality rather than fact
 - Distinguish thoughts from feelings
 - Example thought reprocessing – I can't move today (thought) and my life is hopeless (feeling) → I can sit up on the side of the bed and stand for 15 seconds without assistance (thought). My limitations today are surmountable with hard work (thought overriding feeling). No one is guaranteed tomorrow, but I will do what I can to make the most of the part of life I can control (thought overriding feeling).
- Distinguish helpful thinking from positive thinking, which can be just as unhelpful as negative thinking; the goal is realistic thinking

*David 2013

Purposeful Behavior

- Mindful relaxation – alternate tense/relax directed muscle groups
- Set plan for paced activity – simple, realistic, achievable
 - Realistic starting point → build gradually
 - Start at baseline → escalate → return to baseline during flairs (do not discontinue activity)
 - Examples – hobby activity, household activity/chores
- Set plan for graded exercise – schedule specific times
 - Same concept
 - Examples
 - Extremely debilitated – 10 bedside squats and 10 reps 2 lb weights push ups, rest, 2-3 minutes continuous walking
 - Demotivated but not debilitated – 3 sets 8 reps squats and push ups, rest, 5-6 minutes of continuous walking → build up
- Follow plan for activity regardless of whether you feel like it

*David 2013

Tips for Success

- Pain diary
 - Describe *starting point*, *ideal ending point*, and *acceptable or realistic ending point*
 - Use as a roadmap for activity/exercise planning
 - Journal at least 3 times daily regarding pain
 - Location, quality, severity, radiation, modifying/relieving factors
 - Include activity, environmental factors, and emotional response to pain
 - Include all medications taken and response
 - Behavioral experiments – test unhelpful beliefs about risk of activity
- Sleep hygiene (everything is worse when you are tired!)
 - Set a routine by an alarm clock
 - Limit naps to 1 for <30-45 minutes
 - If you can't sleep, get up and do something relaxing for 30-45 minutes and retry; worrying about not sleeping can keep you awake

*David 2013

Case 1

- You are called on a 28 year-old, 120 kg muscular male, with polytrauma, now 1 hour post-operative from tib/fib fracture repair. He has received 6 mg hydromorphone in PACU for pain. He complains of severe (8/10) pain when awake and his SpO₂ is 97%, but falls asleep when additional medication is administered (1 mg increments). When he is asleep, his loud snoring can be heard throughout PACU and his SpO₂ falls to 85% despite 5L NC
 - What are your concerns?
 - What should his post-operative pain regimen include?
 - Does he require any additional therapy or monitoring during his post-operative course?

Case 1 Discussion

- Concerns
 - Poor pain control despite excessive opioid
 - Evidence of upper airway obstruction when sedated with desaturation
 - Inappropriate application of NC oxygen
- Suggested post-operative pain regimen
 - Regional block/catheter
 - Ketorolac IV, acetaminophen IV, ketamine, adjuncts, ice, compression, elevation, guided imagery, relaxation, mindfulness
 - Oral weak opioid should be added as soon as patient can stay awake and tolerate PO
- Additional therapy or monitoring
 - Appropriate application of supplemental oxygen
 - CPAP or BiPAP initiated immediately with instructions not to transfer from PACU until available on the floor
 - Continuous SpO₂ monitoring for at least the first 24 hours and continue as long as the patient requires large doses of IV opioids

Case 2

- You are called to evaluate a 58 year-old female with widely metastatic ovarian cancer who is in PACU after a palliative diverting ostomy. She is chronically opioid dependent for her cancer pain and is currently well-controlled on morphine SR 150 mg PO BID and morphine IR 30 mg PO Q4H. She usually only takes 2 breakthrough doses per day. She will likely be NPO for at least 3 days post-operatively.
 - What are your concerns?
 - What should her post-operative pain regimen include?
 - Does she require any additional therapy or monitoring during her post-operative course?

Case 2 Discussion

- Concerns
 - Oral opioid equivalent will have to be delivered via PCA basal rate
 - Additional PCA dose will have to be added for breakthrough
 - IV PCA dose will have to be reconverted to PO equivalent when patient is reliably tolerating PO
- Suggested post-operative pain regimen
 - TAP block, ketorolac, IV acetaminophen, ketamine, ice, abdominal binder, mindfulness, physical therapy
 - Opioids
 - PO morphine equivalent $\rightarrow 150+150+60 = 360 \text{ mg/day}$ (conservative)
 - Reduction by $\frac{1}{2}$ for cross-tolerance $\rightarrow 360/2 = 180 \text{ mg/day}$
 - IV equivalent morphine dose $\rightarrow 180/3 = 60 \text{ mg/day}$
 - IV equivalent hydromorphone dose $\rightarrow 60/5 = 12 \text{ mg/day}$
 - Hourly basal hydromorphone dose $\rightarrow 12/24 = 0.5 \text{ mg/hour}$
 - Breakthrough dose should be 10-15% of daily dose $\rightarrow 1-1.5 \text{ mg Q20 minutes}$ and titrate according to daily usage
- Additional therapy or monitoring – as indicated
- Recommend palliative care consult to get patient plugged in

Case 3

- You have a 28 year-old female with a past medical history of anxiety/depression and multiple abdominal surgeries, who was admitted for abdominal pain. She has been ruled out for organic causes for her pain. She reported good pain control in the hospital with Norco 10/325 mg every 6 hours and was started on duloxetine and gabapentin. She was very receptive to starting non-opioid adjuncts for her pain control.
 - What are your concerns?
 - What should her discharge pain regimen include?
 - Does she require any additional therapy or monitoring after discharge?

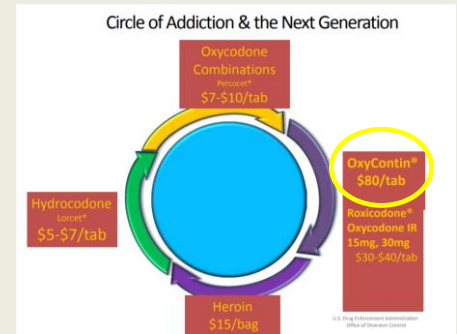
Case 3 Discussion

- Concerns
 - High risk for opioid misuse (young, high levels of pain exacerbation, psychological disorder)
 - Recurrent surgeries for functional abdominal pain
- Suggested discharge pain regimen
 - Oral weak opioid with APAP for 1 week with explicit instructions for wean
 - NSAIDs if effective (weak evidence for use in FAP)
 - Continue duloxetine and gabapentin
 - Add nortriptyline if suboptimal results or sleep disturbances
 - Recommend psych follow-up to initiate psychotherapy/cognitive behavioral therapy, which is highly effective for functional abdominal pain
- Additional therapy or monitoring
 - Short term opioid contract
 - Clear documentation in discharge instructions of intended period of use
 - Close primary care follow-up

Case 3B

- You have a 28 year-old female with a past medical history of anxiety/depression and multiple abdominal surgeries, who was admitted for abdominal pain. She has been ruled out for organic causes for her pain. She asks for a prescription on discharge for Oxycontin because that is what she says works the best for her pain. During the hospital stay, she refused your suggestion of starting non-opioid adjuncts because she said she has "taken all of them and none of them work".
 - What are your concerns?
 - What should her discharge pain regimen include?
 - Does she require any additional therapy or monitoring after discharge?

Opioid Diversion



Case 3B Discussion

- Concerns
 - High risk for opioid misuse (young, high levels of pain exacerbation, aberrant behavior, psychological disorder)
 - Recurrent surgeries for functional abdominal pain
- Suggested discharge pain regimen
 - Counsel on reasons opioids will not be initiated (poor effectiveness in FAP) vs. consider tramadol due to effectiveness in other dysfunctional pain syndromes (fibromyalgia)
 - NSAIDs if effective (weak evidence for use in FAP)
 - Recommend duloxetine and gabapentin +/- nortriptyline
 - Referral to chronic pain clinic to evaluate for sympathetic blockade
 - Recommend psych follow-up to initiate psychotherapy/cognitive behavioral therapy, which is highly effective for FAP
- Additional therapy or monitoring
 - Close primary care follow-up (2-3 weeks)
 - If patient is on opioids, refer back to prescriber for opioid wean

Biopsychosocial Treatment Plan – DM II/Cellulitis

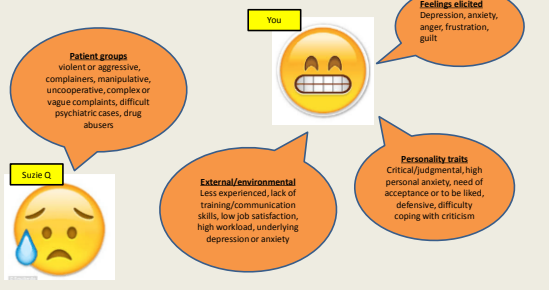
Pharmacologic:	Resume all home meds
Antibiotics	Most important medication in treatment plan.
NSAID (if renal function ok)	Ibuprofen, naproxen, celecoxib
Acetaminophen	Alone or combined product
Antineuropathic	Gabapentin, pregabalin
Antidepressant	Amitriptyline (sleep/pain), duloxetine
PO Opioid	Norco 10/325 Q4H scheduled and PRN (give first); never SR for opioid naive
IV Opioid	PCA → convert to intermittent → convert to oral
Side effects	Ondansetron, diphenhydramine, laxative, CPAP
Non-pharmacologic:	
Ice, compression, elevation	Ice, elevation
Physical therapy/ambulation	Out of bed to chair TID and encourage ambulation
Relaxation/sleep hygiene	Avoid overnight interruptions
Weaning plan	Discuss with outpatient PCP
Educate	Bad infection. Pain normal. Healing takes time. Tolerance. Habit-forming. Tight glucose control!

APMS Algorithm for Acute on Chronic Pain Consults

- APMS Chart review
 - Is the patient is taking all home meds?
 - Does the regimen include all optimal adjuncts?
 - Is the patient complaining of acute pain that is in proportion to situation?
- If no:
 - Call the primary team and make verbal recommendations
 - Make written recommendations in the chart with reference to the name of the primary team contact: "After thorough chart review, the patient is not optimized on home meds and adjuncts. After starting x, y, and z, if the patient's pain is still not well controlled, APMS will see the patient and make further recommendations. Otherwise, the PMT nursing team will follow and make further recommendations."
 - Call the PMT nursing team and add the patient to their list of extra patients to see
- If yes, or the pain remains poorly controlled after recommendations implemented, proceed with APMS in-person evaluation and make further recommendations as indicated

Managing Heartsink

- Subjective negative reaction within a health professional when faced by a particular patient, situation, or colleague



Change Yourself (Not Your Patient) to Manage Heartsink

- Introspection to get insight into thoughts and behaviors
 - What goes through my mind? Is it an accurate reflection of reality?
 - Why do I act this way? How could I handle this better?
- Ways to reduce stress and anxiety during visit
 - You can't control anyone else but yourself (you are not perfect)
 - Try to be more tolerant and flexible (your patients aren't perfect either)
 - Think rationally and empathize (they are suffering)
 - Focus your patient on long-term goals (they may have setbacks)
 - Accept that you will not always be liked by everyone
- Be sure "your own house is in order"
 - Cultivate home life, faith, hobby
 - Weight reduction (desire, discipline, dietary compliance)
 - Don't let your identity be your work