UTFP CONFERENCE

GENERAL THEMES ON TREATMENT OF CHRONIC PAIN AND PAIN MANAGEMENT PRACTICES

DISCLOSURES: NONE

WHAT A PAIN CLINIC SHOULD NOT LOOK LIKE

- Opioid Management Only
- “Block Shops” that only do injections
- Where patients go when all else has failed and there is nothing left to offer

WHAT SHOULD A GOOD PAIN CLINIC LOOK LIKE

Comprehensive Care

Evidence Based Treatment

Care coordination with other specialties- PT, Surgery, PCP, Psychology

DIAGNOSTIC WORK UP AND TREATMENT PLAN

QUESTIONS DURING THE PAIN PATIENT WORK UP

- Who needs an MRI?
- Who needs surgery?
- Who needs PT and or CBT?
- Who needs counselling and or psychology referral?
- Who needs medication and who does not?
- Why do you hurt?

DIAGNOSIS???

History: where, when, and how; exacerbating and alleviating factors, quality of pain; don't over look psychological and social aspects of a patient's pain history

Exam-

Diagnostic studies: Plain film radiographs, MR*I, EMG, laboratory data*

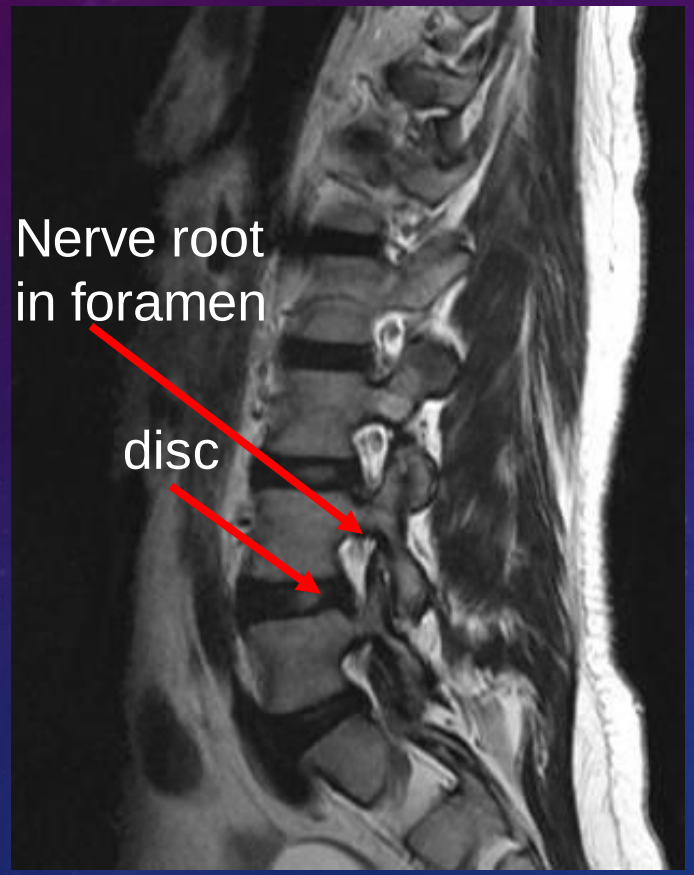
Try to identify whether the pain is **NOCICEPTIVE** (acute injury, DDD and OA), **NEUROPATHIC** (peripheral neuropathy or trigeminal neuralgia), **CENTRALIZED** (sensitization or disinhibition), or **MIXED**

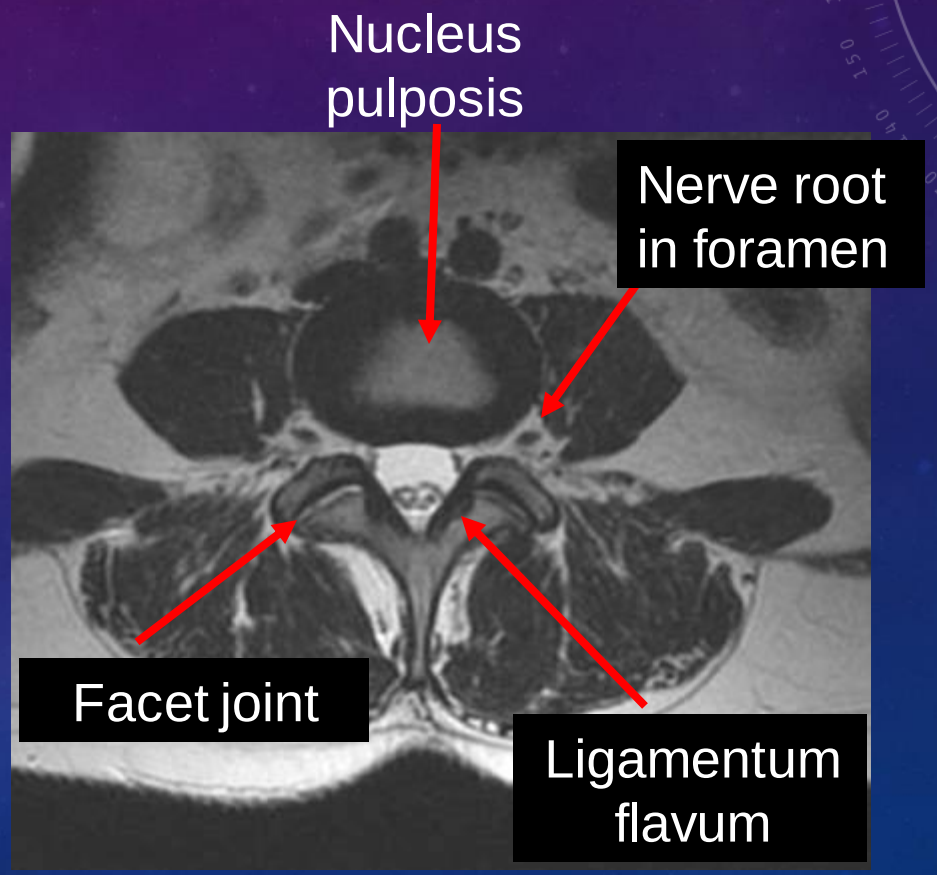
Chronic Pain Syndrome?

DIFFERENTIAL DIAGNOSIS OF LOW BACK PAIN

- Lumbar spondylosis
- Lumbar disc disease
- Radiculitis
- Spondylolysis
- Spondylolisthesis
- Spinal fracture
- Spinal infection
- Cancer
- Spondyloarthropathy
- Spinal Canal Stenosis
- Multiple non-spinal causes of lower extremity pain

Anatomy


Nerve root
in foramen
disc


Nucleus
pulposis
Nerve root
in foramen
Facet joint
Ligamentum
flavum

“CHICKEN LITTLE MRI”

Dr. Nikolai Bogduk at IASP 9th World Congress: Preventing acute [back] pain from turning into chronic pain is often a matter of ‘treating the patient nice and convincing him that there is nothing so horribly wrong.’

TREATMENT OPTIONS

Broad Spectrum of options

-Behavioral and Lifestyle Modification

-Physical Therapy

-Injections

-Minimally Invasive Procedures

-Surgical Options

-Medical Management

-Counselling and Management of Psychological Comorbidities

MULTIPLE DIFFERENT TYPES OF SPINE INJECTIONS

- Epidural steroid Injections
- Sacroiliac Joint injections
- Ablation of the nerves that innervate a painful joint- Blocking transmission of nociceptive signal
- Spinal Cord Stimulation- now indicated for DPN
- Intrathecal Drug Delivery-Cancer pain and for cases of intractable pain that has failed other options

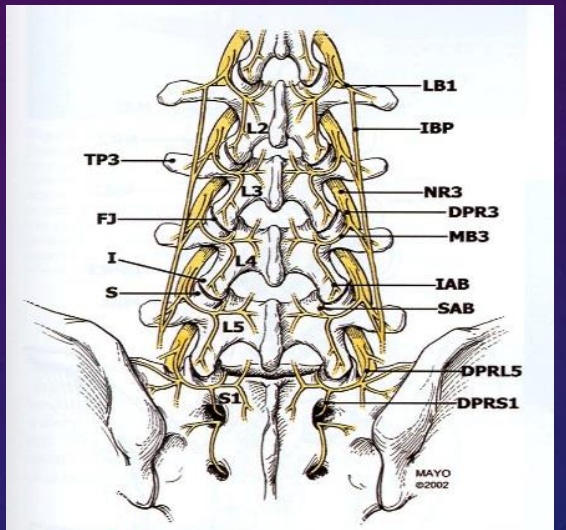


Figure 2-7 ▪ Illustration of posterior view of lumbar spine and posterior neural structures. Laminae of L2 through S1 are labeled. *Left*: TP3 = transverse process of L3; FJ = facet (zygapophysial) joint L3-4; I = inferior articular process of L4, S = superior articular process of L5. *Right*: LB1 = lateral branch of dorsal primary ramus of L1; IBP = intermediate branch plexus; NR3 = third lumbar nerve root; DPR3 = dorsal primary ramus of L3; MB3 = medial branch of dorsal primary ramus of L3; IAB = inferior articular branches from L3 medial branch (supplies L4-5 facet joint); SAB = superior articular branches from L4 (supplies L4-5 facet joint also); DPRL5 = dorsal primary ramus of L5; DPRS1 = dorsal primary ramus of S1.

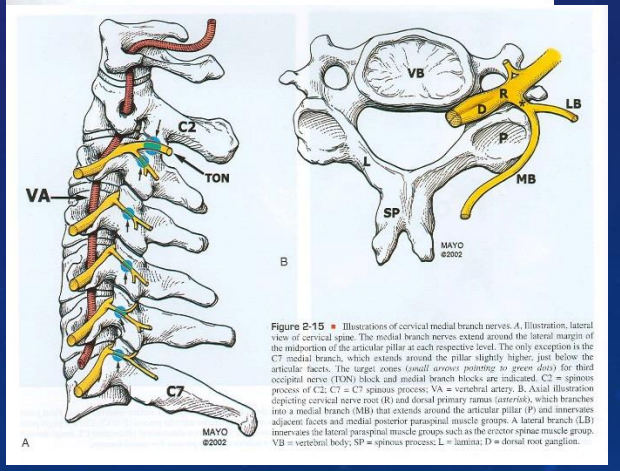


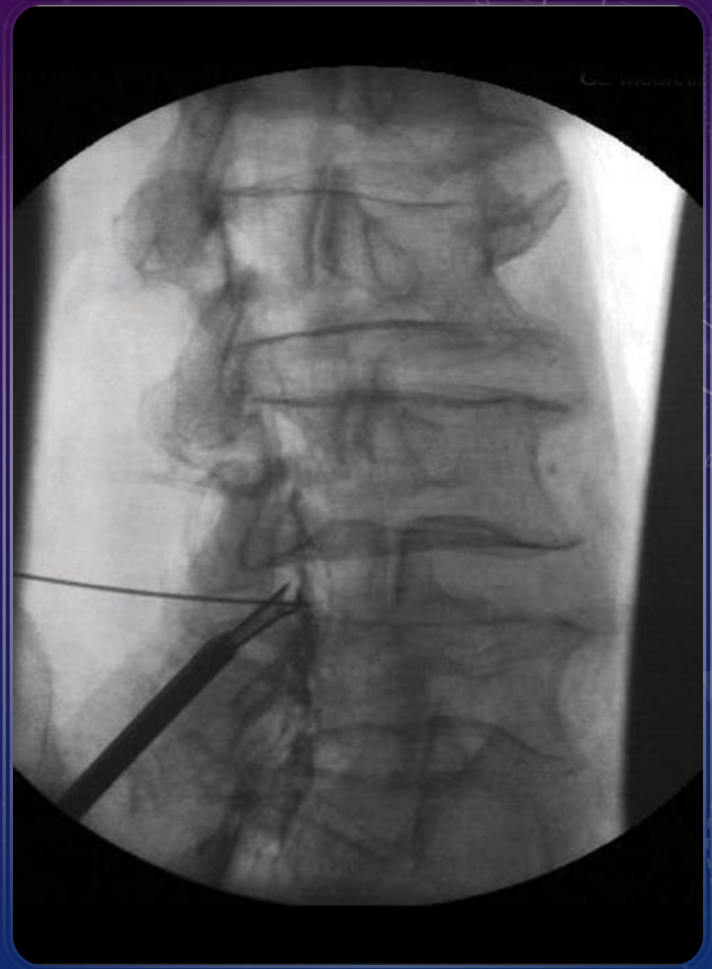
Figure 2-15 ▪ Illustrations of cervical medial branch nerves. *A*, Illustration, lateral view of cervical spine. The medial branch nerves extend around the lateral margin of the midportion of the articular pillar at each respective level. The only exception is the C7 medial branch, which extends around the pillar slightly higher, just below the articular facets. The target zones (*small arrows pointing to green dots*) for third occipital nerve (TON) block and medial branch blocks are indicated. C2 = spinous process of C2; C7 = C7 spinous process; VA = vertebral artery. *B*, Axial illustration depicting cervical nerve root (R) and dorsal primary ramus (*asterisk*), which branches into a medial branch (MB) that extends around the articular pillar (P) and innervates adjacent facets and medial posterior paraspinal muscle groups. A lateral branch (LB) innervates the lateral paraspinal muscle groups such as the erector spinae muscle group. VB = vertebral body; SP = spinous process; L = lamina; D = dorsal root ganglion.

INTRACEPT PROCEDURE

- Vertebrobasilar Nerve Ablation
- Long term treatment for degenerative disc disease
- Modic type I and type II changes on MRI

VERTOS- MINIMALLY INVASIVE DECOMPRESSION

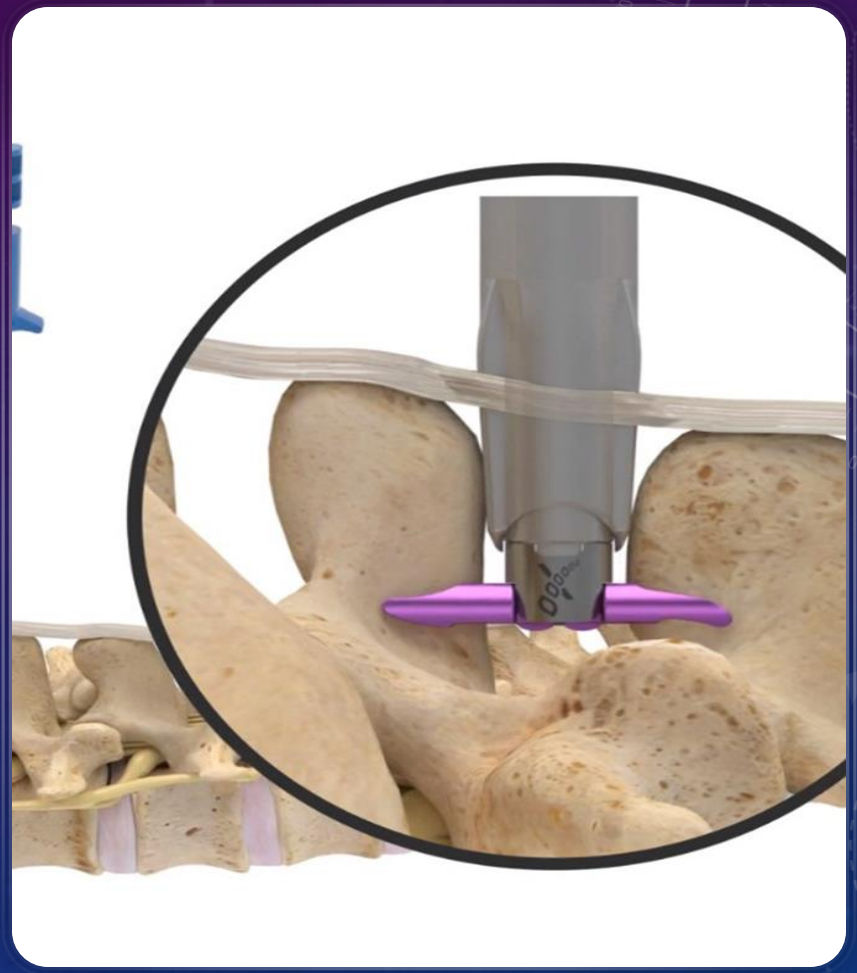
- Treatment for spinal canal stenosis in patients who are not a candidate for open decompression or general anesthesia
- Debulking the Ligamentum Flavum that has become hypertrophied is causing spinal canal stenosis



VERTIFLEX

-Treatment for central canal and foraminal stenosis

-Placement of an interspinous device that spares motion in the vertebral body segment

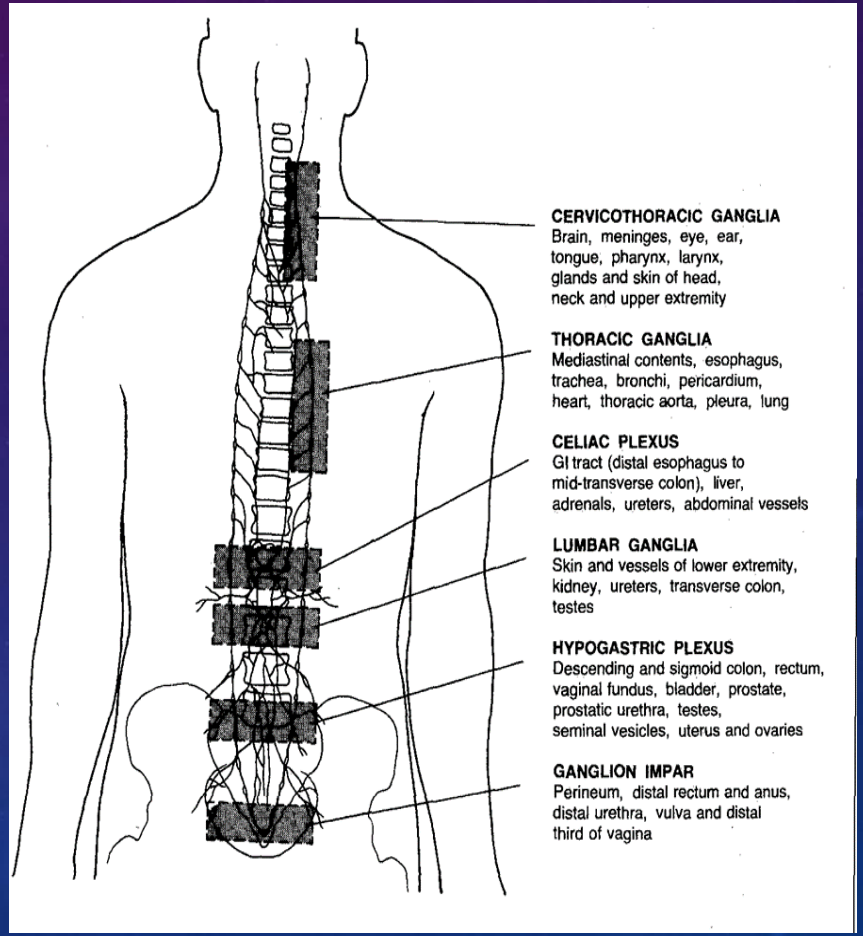


PERIPHERAL NERVE NEUROPATHIES

- Intercostal Nerve Block: Indicated for Acute Zoster and PHN, Rib fracture, Rib and liver metastasis, pleurisy, post-thoracotomy pain
- Ilioinguinal Neuralgia
- Occipital Neuralgia
- Suprascapular Neuralgia
- Supraorbital Nerve Block: acute zoster and PHN
- Other Neuroma: post amputation, Morton's neuroma
- Neurolysis with RFL, alcohol, or phenol or Peripheral Nerve Stimulator

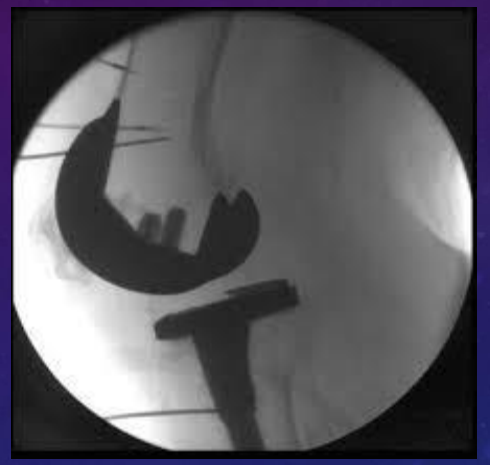
SYMPATHETIC BLOCKS

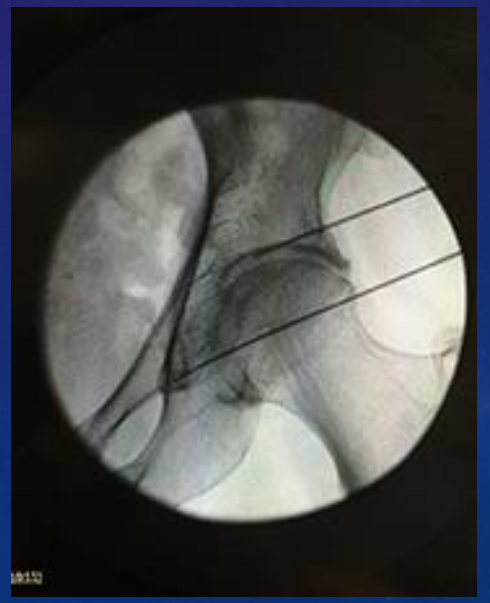
- Stellate Ganglion: CRPS, acute Zoster and PHN, PAD
- Celiac Plexus: Pancreatitis, Cancer, Abdominal Pain
- Lumbar: PAD, CRPS, Phantom Pain
- Superior Hypogastric: pelvic pain, Pelvic Inflammatory Disease, Endometriosis
- Ganglion Impar: perineal pain and coccygodynia



LARGE JOINT RADIOFREQUENCY ABLATION

- RFA of genicular nerves for chronic knee pain
- RFA of articular braches of obturator and femoral nerves for hip pain
- Refractory joint pain in post-arthroplasty patients or severe OA in non-surgical candidates





PSYCHOLOGICAL AND BEHAVIORAL COMPONENTS OF CHRONIC PAIN

- Pain is not the same thing as nociception, suffering is not the same thing as pain
- Diagnosis and treatment of comorbid psychological disorders- bipolar, depression, anxiety, PTSD
- Cognitive Behavioral Therapy
- Neuroscience Education
- Fear avoidance training
- Mindfulness
- Physical therapy- postural and gait training
- Weight loss
- Smoking cessation

OPIOIDS IN PAIN

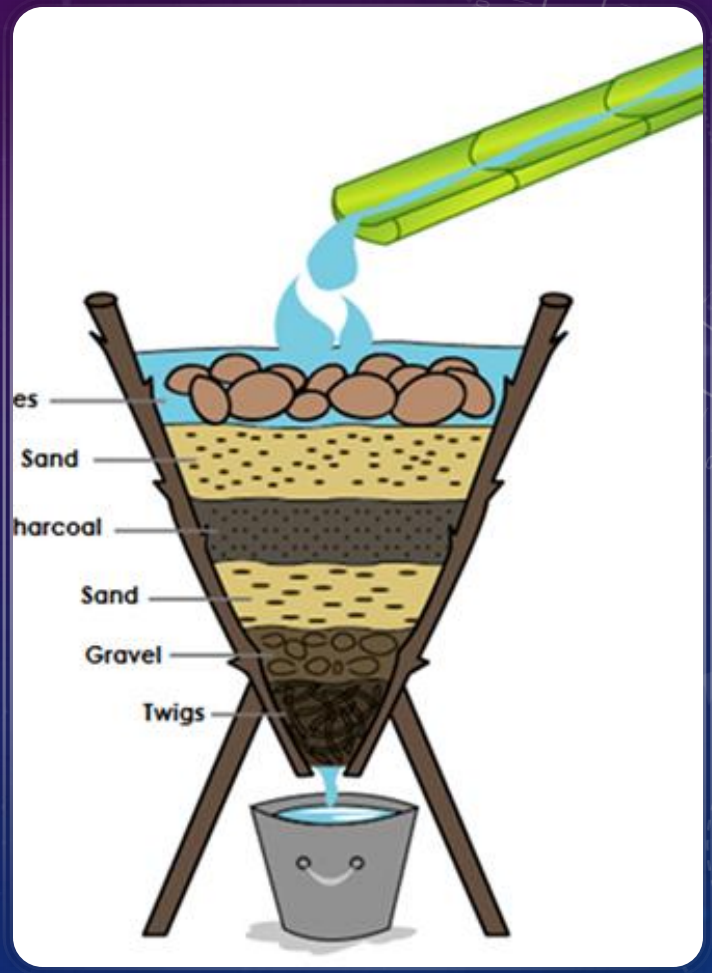
- Opioids are not first line treatment
- Dangerous side effect profile- including addiction and death
- Other options include muscle relaxers, SNRI, NSAIDs, acetaminophen, membrane stabilizers and anti-convulsants
- Risks are present for both the patient and the prescriber

PATIENT SELECTION FOR OPIOID THERAPY

1.Patients to consider for chronic opioid therapy:
-Chronic pain, with identified cause
-Pain is causing functional limitation
-Not adequately improving with non-narcotic, multi-modal treatment

2.Risk Assessment
-Risk assessment tools (ORT, SOAPP, BRQ, etc)
-Urine Drug Screen prior to initiation of opioids
-Controlled Substance Monitoring Database

3.Disease/Comorbidity Assessment
-Obstructive sleep apnea/Pulmonary function
-Fall risk
-Renal/Hepatic function
-Metabolism variability



FAKE PERCOCET CONTAINS FENTANYL

Public warning issued in May, 2015
Patients will find a way to treat their pain

GOALS OF TREATMENT

- From: TN chronic Pain Guidelines, 2nd ed.

"The primary goal of treatment should be clinically significant improvement in function."

- Treatment goal assessment – PEG scale
  - **P**ain average
  - Interference with **E**njoyment of life
  - Interference with **G**eneral activity

- *"The patient should be counselled that the goal of chronic opioid therapy is to **increase function** and **reduce pain, not to eliminate pain**."*

TREATMENT GOALS FOR CHRONIC PAIN

MULTIMODAL AND EVIDENCED BASED CARE

- Improve Function
- Improve Quality of Life
- Provide an environment where patients feel genuinely cared for
- Pain Centered Medical Home

WHEN TO TAPER? WHEN RISKS OUTWEIGH BENEFITS

When patient wants to reduce or discontinue opioids: Side effect, social stigma, cost

Lack of clinical benefit: no functional improvement, opioid non-responders, opioid induced hyperalgesia

Decreased pain: underlying disease state has improved or responded to other measures

Safety: fall risk, respiratory suppression, renal insufficiency, OSA, near miss event, sedation, combination with benzodiazepine

Abuse, misuse, and diversion- aberrant behaviors (pill counts, UDS, CSMD, lost/stolen meds)- risk may be to community as well as patient

Signs of Substance Use Disorder

CDC: Dose > 50MME without benefit or opioids in combination with benzodiazepines

HOW TO TAPER

- Ultra-rapid Detox (requires general anesthesia; Inpatient Detox (failed outpatient, medically unstable, non-compliant, psychiatric comorbidities, poly-substance detox); Outpatient Taper
- Outpatient Tapering: VA, Mayo Clinic, CDC
- VA Protocol: Slow Taper-20-50% reduction of original dose weekly—Fast Taper- 20-50% reduction of original dose daily until 45 MEDD then slow to Q2-5 day reductions by same amount
- Mayo Clinic Protocol: 10% reduction of original dose Q5-7 days until 30% of original dose is reached, then move to 10% weekly reduction of that remaining dose
- CDC Protocol: 10% weekly reduction of original dose. Can be slowed down for patients with long history of opioid use.

HOW TO TAPER

- Withdrawal Syndrome: Usually start 2-3 half-lives (6-36 hours) after the last dose, most severe at 24-72 hours- can persist up to 6 months but usually last 3-7 days
- Signs and Symptoms: “flu-like” sweats, chills, headache, myalgia, arthralgia, nausea, vomiting, diarrhea, anxiety, insomnia- can be extremely unpleasant but usually not life threatening
- Clonidine 0.1mg PO BID prn (up to QID max)- caution on hypotension and taper clonidine if used daily for over 7 days
- NSAIDS for arthralgia and myalgia
- Loperamide for diarrhea
- Dicyclomine (20mg PO QID) for abdominal cramping
- Benadryl or trazodone for insomnia
- Zofran or dimenhydrinate for nausea

HOW TO TAPER

- Psychological support and maintain relationship with patient- patients may turn to illicit drugs during this process
- Counsel that tolerance may be lost in as little as one week and this can predispose a patient to overdose if they go back to previous dose
- Consider rotating patients from transdermal fentanyl to another opioid before tapering because of wide gaps in available strengths. I don't advise rotating patients to longer half life drugs such as methadone before tapering because of potential for overdosing patients with conversion with high variability of sensitivity to methadone
- Benzo withdrawal can be fatal- consider inpatient if medically unstable- if needing to do opioids and benzo's as outpatient then do opioids first
- Pregnancy: ACOG still recommends avoiding detox during pregnancy although there is some evidence that discontinuing opioids has not been associated with harm

CO-PRESCRIBE NALOXONE WHEN CLINICALLY APPROPRIATE

- The AMA Opioid Task Force encourages physicians to consider co-prescribing naloxone when it is clinically appropriate. Factors to consider include:
  - Does the patient history or prescription drug monitoring program (PDMP) show that my patient is on a high opioid dose?
  - Is my patient also on a concomitant benzodiazepine prescription?
  - Does my patient have a history of substance use disorder?
  - Does my patient have an underlying mental health condition that might make him or her more susceptible to overdose?
  - Does my patient have a medical condition, such as a respiratory disease, sleep apnea or other co-morbidities, which might make him or her susceptible to opioid toxicity, respiratory distress or overdose?
  - Might my patient be in a position to aid someone

QUESTIONS?

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- References:

Rules of theDepartment of Health Division of Pain Management Clinics, Chapter 1200-34-01-.11

Tennessee Chronic Pain Guidelines: Clinical Practice Guidelines for Outpatient Management of Chronic Non-Malignant Pain, 3-TR Edition December 27, 2019