Updates in Pain Management 2017

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Agenda

- Opioid Epidemic
- Incidence & Costs of Pain
- Scope & Rationale
- CDC Guidelines
- WV State Law
- The Role of Pain Management
- Summary

Incidence of Pain

- According to the Institute of Medicine, chronic pain affects more than 100 million Americans, an incidence rate which outpaces heart disease, cancer, and diabetes combine.

Costs of Pain

- Unrelieved pain can result in:
    1. Longer hospital stays
    2. Increased rates of re-hospitalization
    3. Increased outpatient visits
    4. Decreased ability to function fully leading to lost income and insurance coverage.

Costs of Pain

- Institute of Medicine Report: *"Relieving Pain in America:*

A Blueprint for Transforming Prevention, Care, Education, and Research"

Pain is a significant public health problem that costs annually, an amount equal to about $2,000.00 for everyone living in the U.S.. This includes the total incremental cost of healthcare due to pain ranging between $261 to 300 billion and $297-$336 billion due to lost productivity (based on days of work missed, hour of work lost, and lower wages).

Chronic Pain IS EXPENSIVE

- Chronic pain disables more people than cancer or heart disease and costs the American people more than both combined.
- 515 Million workdays lost annually
- 40 Million doctor visits annually
- Pain problems now cost over $300 billion a year in medical costs, lost working days, and workers' compensation.

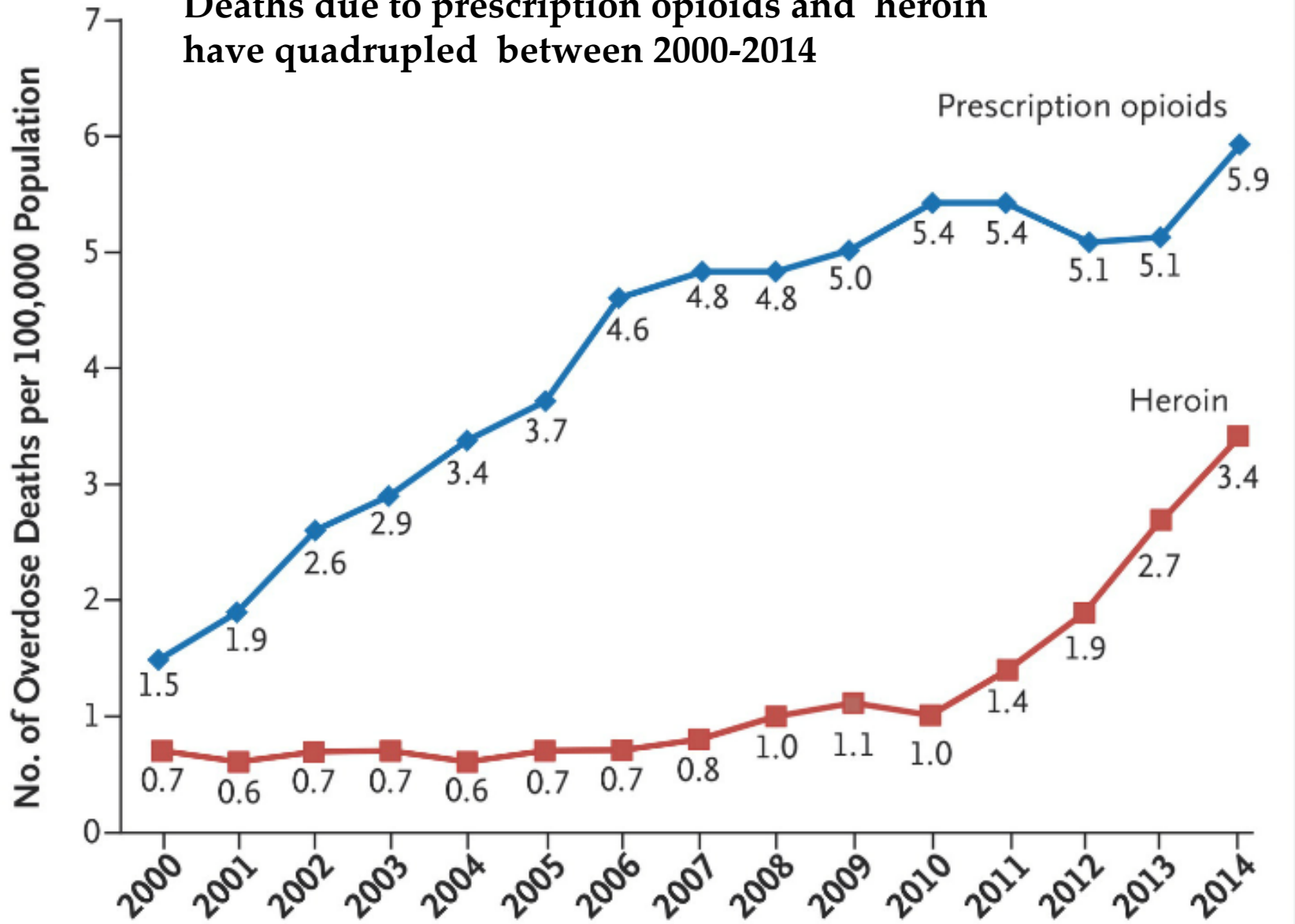
Impact on Quality of Life

- Almost two-thirds (59%) reported an impact on their overall enjoyment of life.
- More than three quarters of patients (77%) reported feeling depressed.
- 70% said they have trouble concentrating.
- 74% said their energy level is impacted by their pain.
- 86% reported an inability to sleep well.

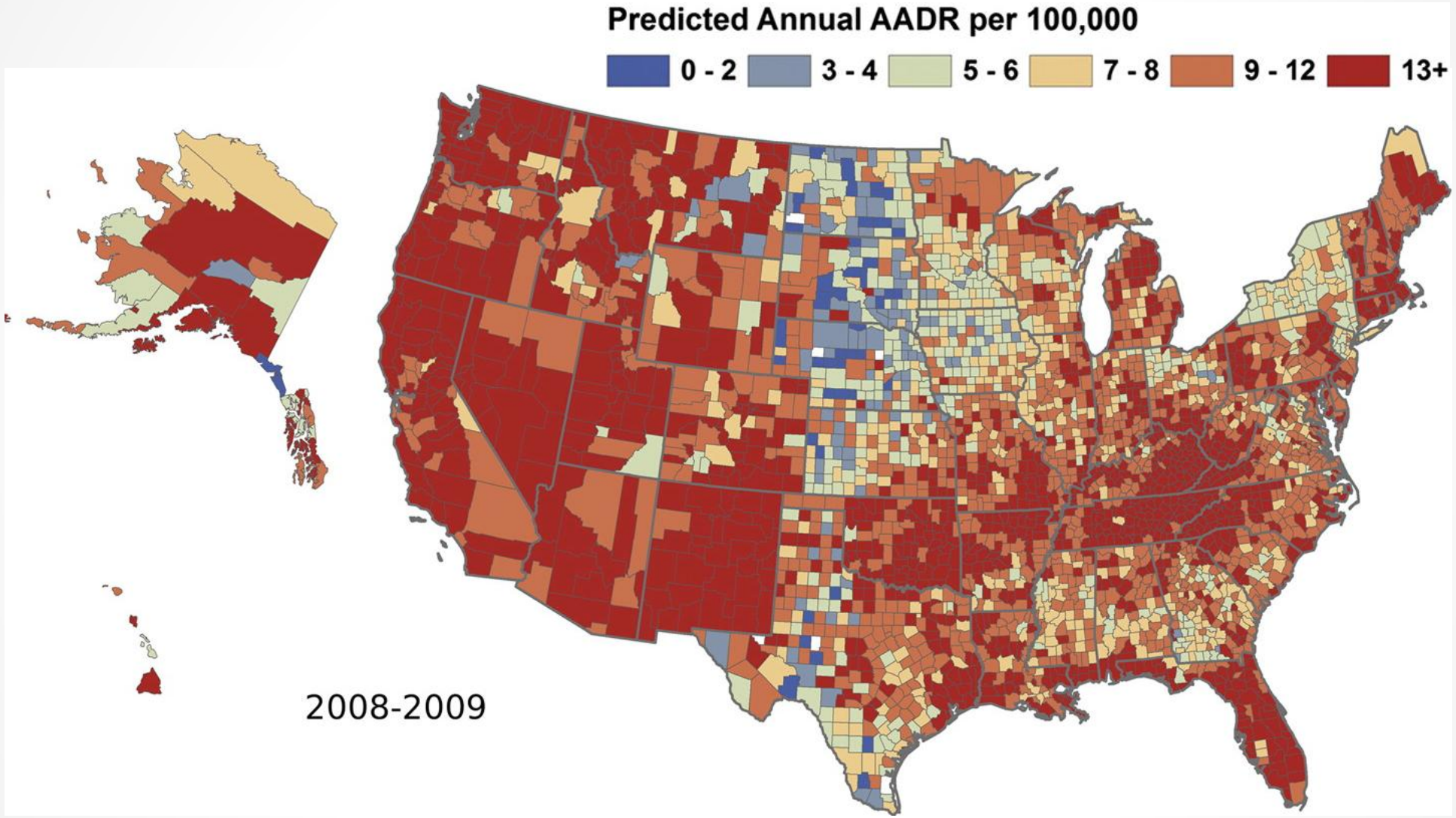
Opioid Epidemic

- In 2012, healthcare providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills.
- Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties.
- US makes up 4.6% of world population, but consumes 80% opioids and 99% hydrocodone. In 2014, nearly 2M Americans abused or were dependent on opioids
- Drug overdose was the leading cause of accidental death in 2012, exceeding MVA's from age 25-64 y/o. From 1999-2014 >165,000 people have died from Rx opioid overdoses

Deaths due to prescription opioids and heroin have quadrupled between 2000-2014



The NEW ENGLAND JOURNAL of MEDICINE


Predicted Annual AADR per 100,000
0 - 2
3 - 4
5 - 6
7 - 8
9 - 12
13+
2008-2009

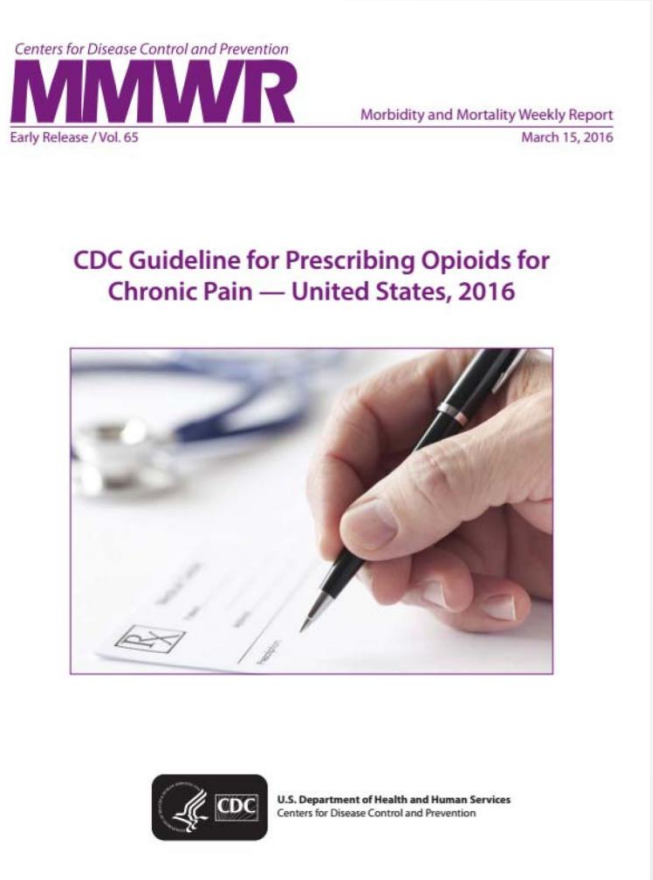
CDC Solution: Scope & Rationale

Scope

- Intended for Primary Care Physicians treating chronic pain as defined by > 3 months in duration
- Excludes active cancer tx, end-of-life, palliative care, and age < 18

Rationale

- PCP concerns over patient misuse and abuse
- PCP report having insufficient training in prescribing opioids
- It is believed that addiction is a common consequence of prolonged use, and that long-term opioid therapy often is overprescribed for patients with chronic non-cancer pain



Recommendation 1

- 1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Recommendation 2

- 2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Recommendation 3

- 3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Recommendation 4

- **4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.**

Recommendation 5

- 5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Recommendation 6

- 6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Recommendation 7

- 7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Recommendation 8

- 8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

Recommendation 9

- 9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

Prescription Drug Monitoring Site

- https://www.csapp.wv.gov

Recommendation 10

- 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Recommendation 11

- 11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Recommendation 12

- 12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

WV State Law
Ch. 16 Article 5H

- Special license needed if over 50% of patient population is prescribed or dispense an opioid or other controlled substance
- One physician owner needs to complete ACGME approved fellowship or equivalent training
- Physician needs to hold current board certification by the American Board of Pain Medicine, or current board certification by the American Board of Anesthesiology
- Felony charges obviate employment at pain management clinic

Required Records

- Medical history and physical exam
- Diagnosis of chronic pain, including signs, symptoms and causes
- Plan of treatment with response and modifications noted
- Dates medications are prescribed, dispensed or administered, including the patient demographics, and amount given.
- A physical exam shall be performed on the day a prescription for a controlled substance is initially written and at least four times a year thereafter.
- Maintain control and security of blank prescriptions.

The Role of Pain Management

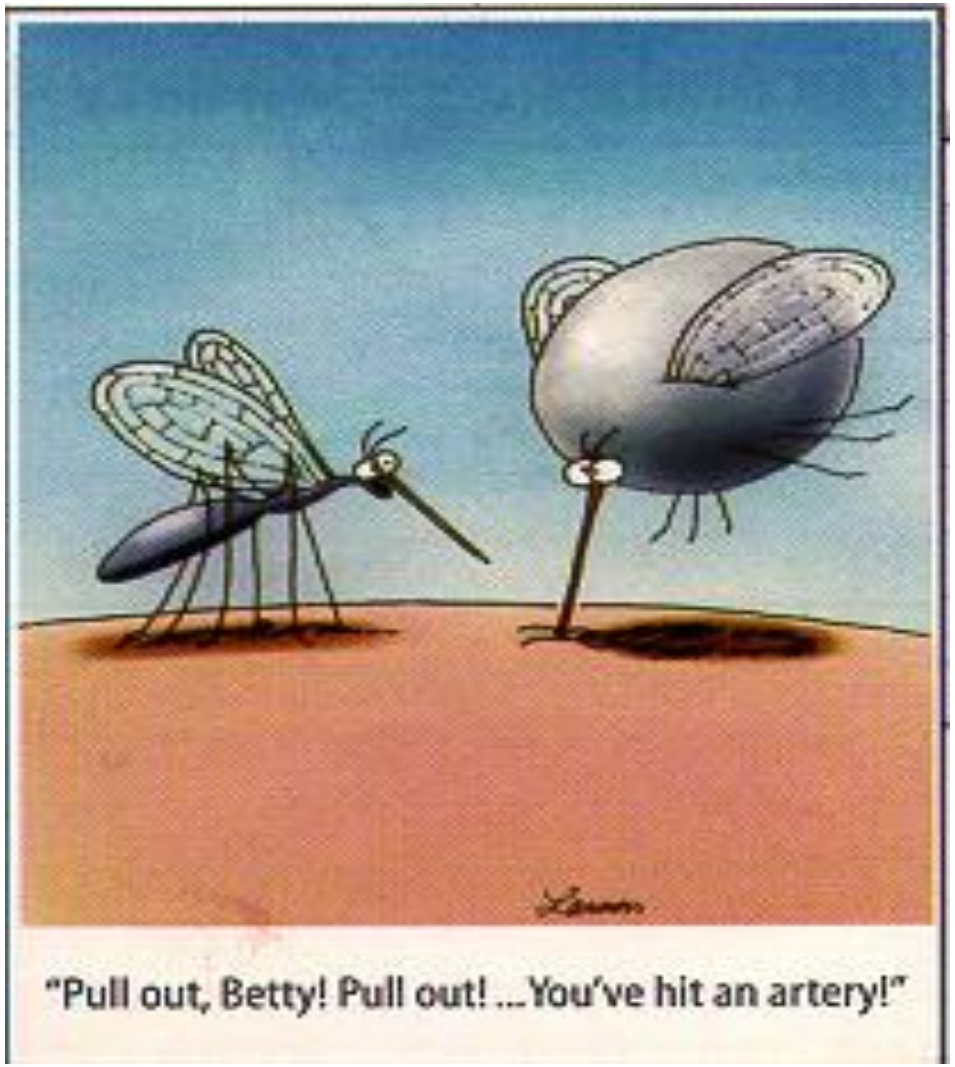
There are definitely times when opioid pain medication may play a vitally important role in the successful treatment of pain.

If either the dose or the duration needs to be increased, the patient should ideally be evaluated by an experienced pain physician, who would assess if the pain would be better controlled with alternate techniques beyond just increasing pain medication dosing, such as interventions or other adjunct pain medications.

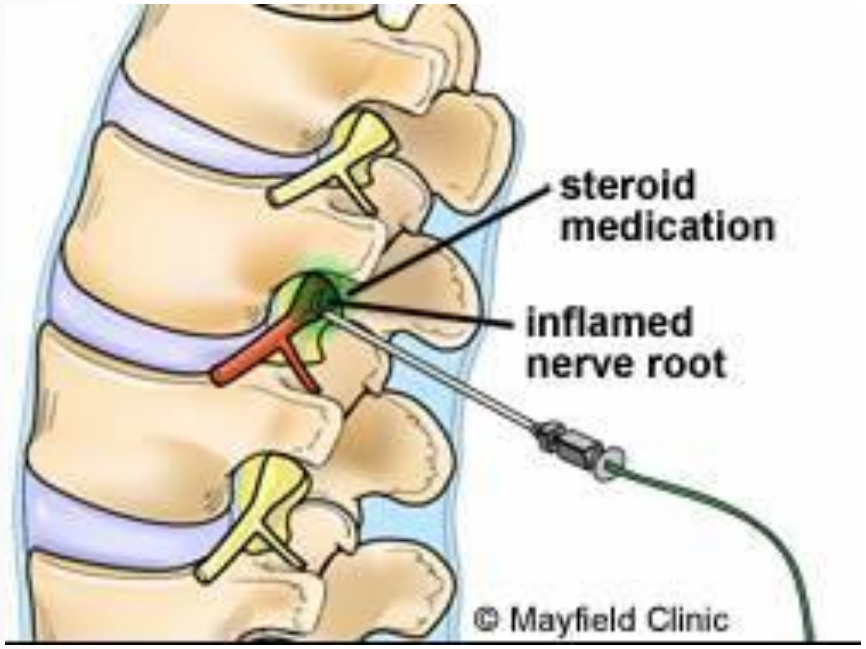
Interventional Options

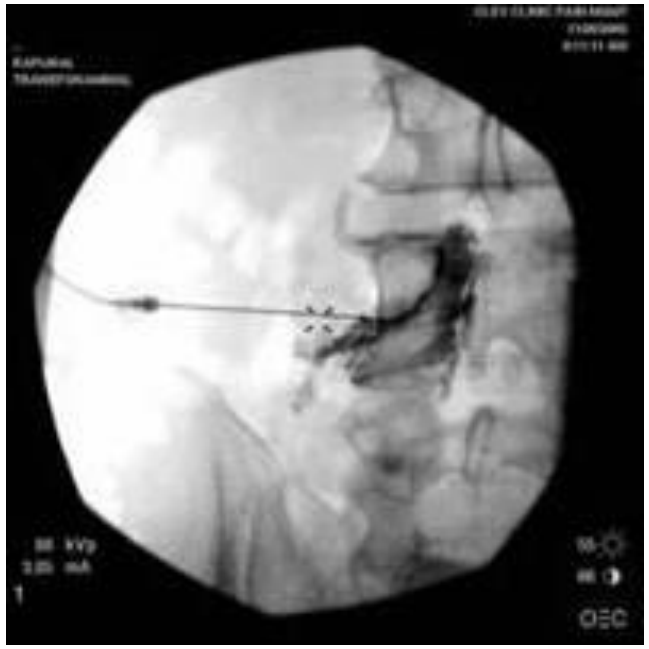
- Epidural Steroid Injection
- Facet Joint Injections
- SI Joint Injections
- Radiofrequency Ablation
- Discography
- Neuromodulation
  - Spinal Cord Stimulation
  - Dorsal Root Ganglion Stimulation

Importance of Identifying Pain Generators

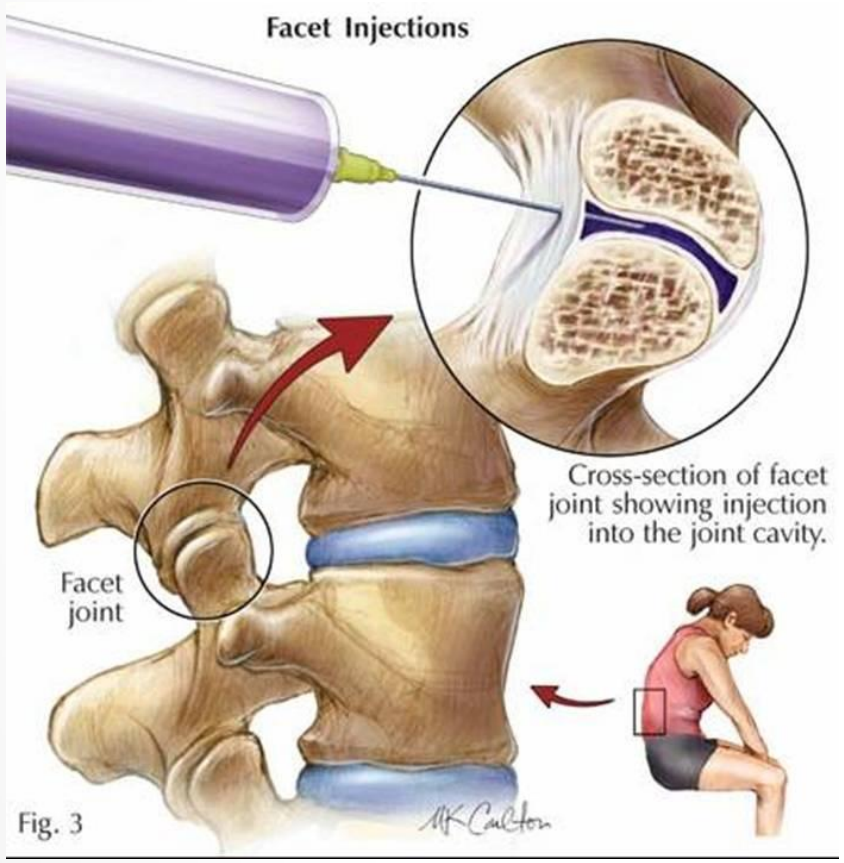


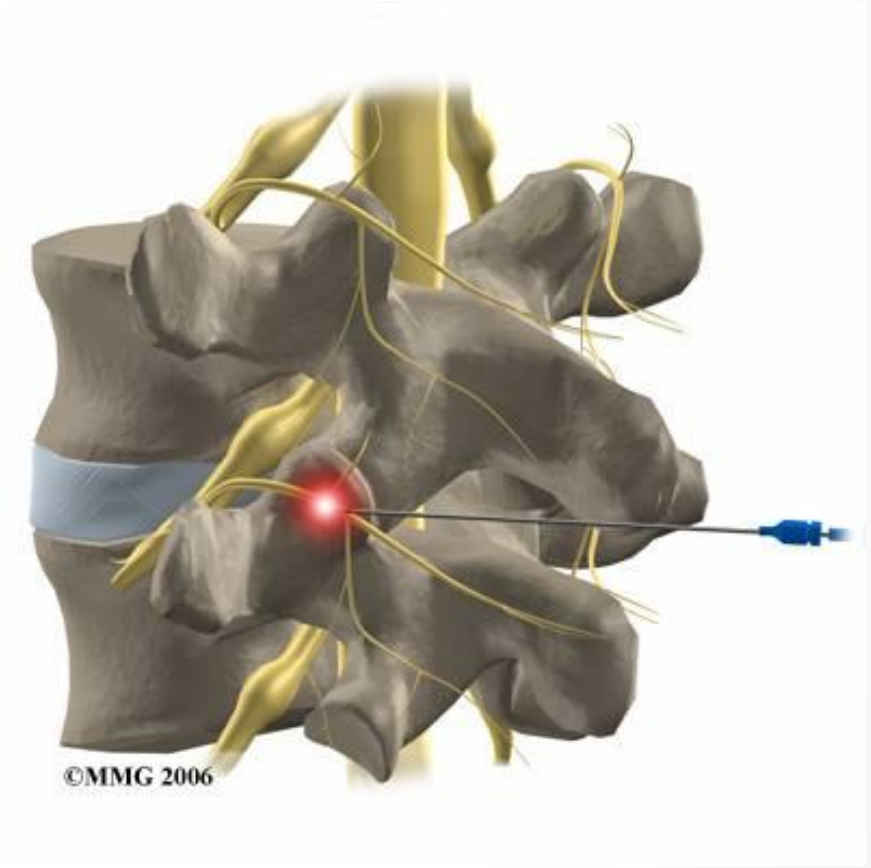
Epidural Steroid Injections



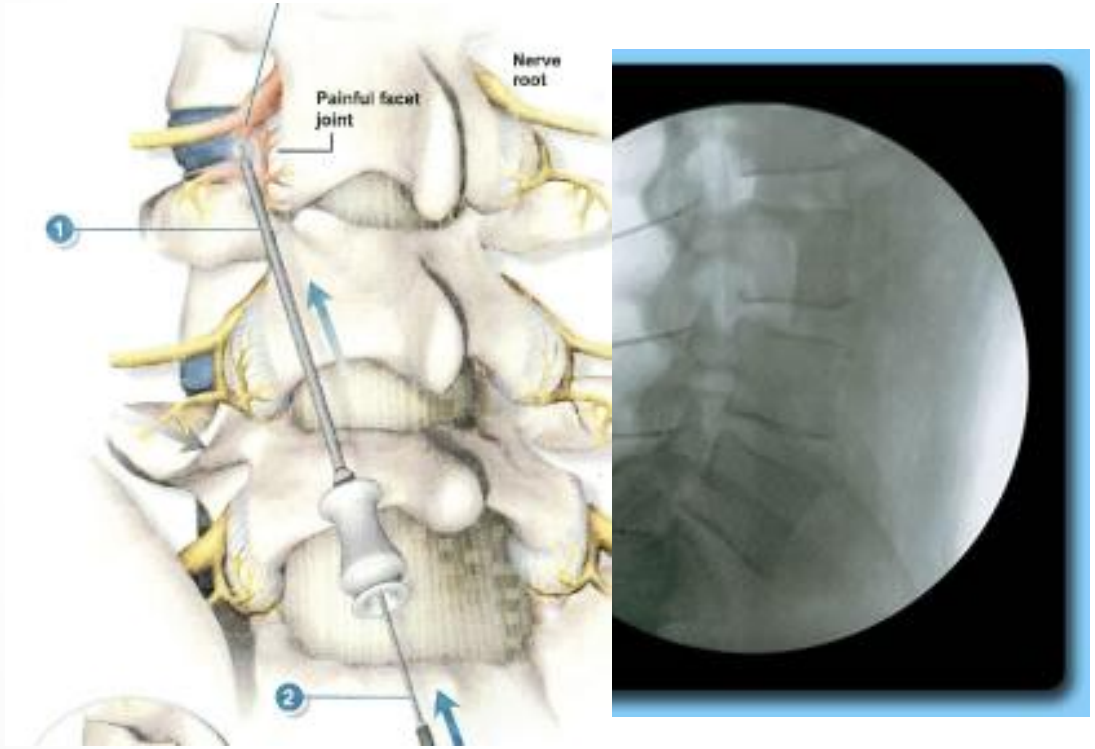


Facet Blocks/Medial Branch Blocks

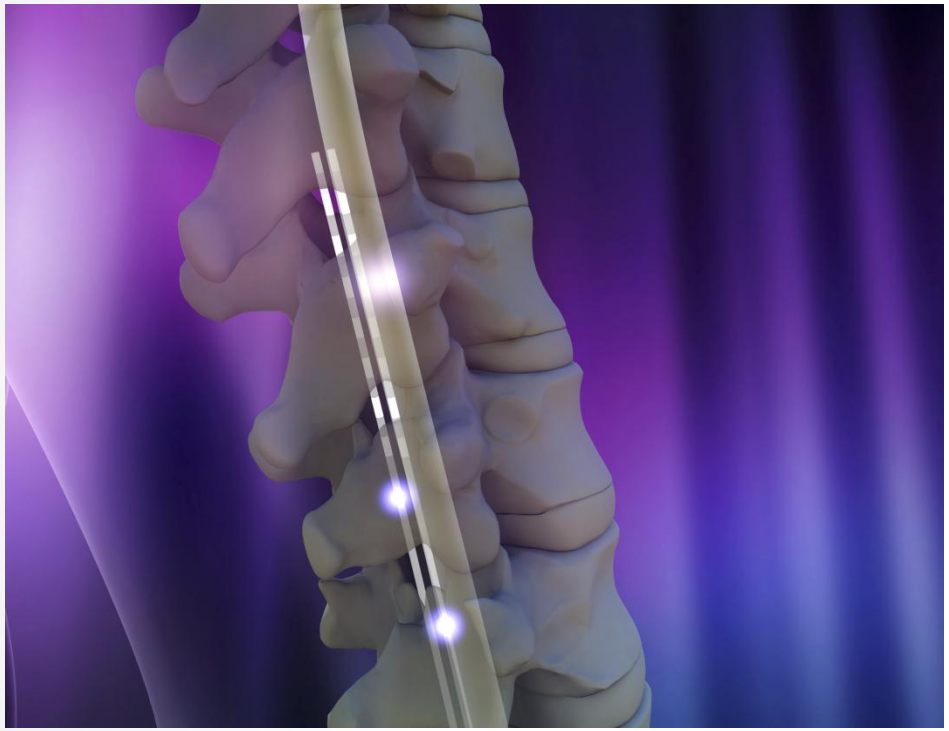


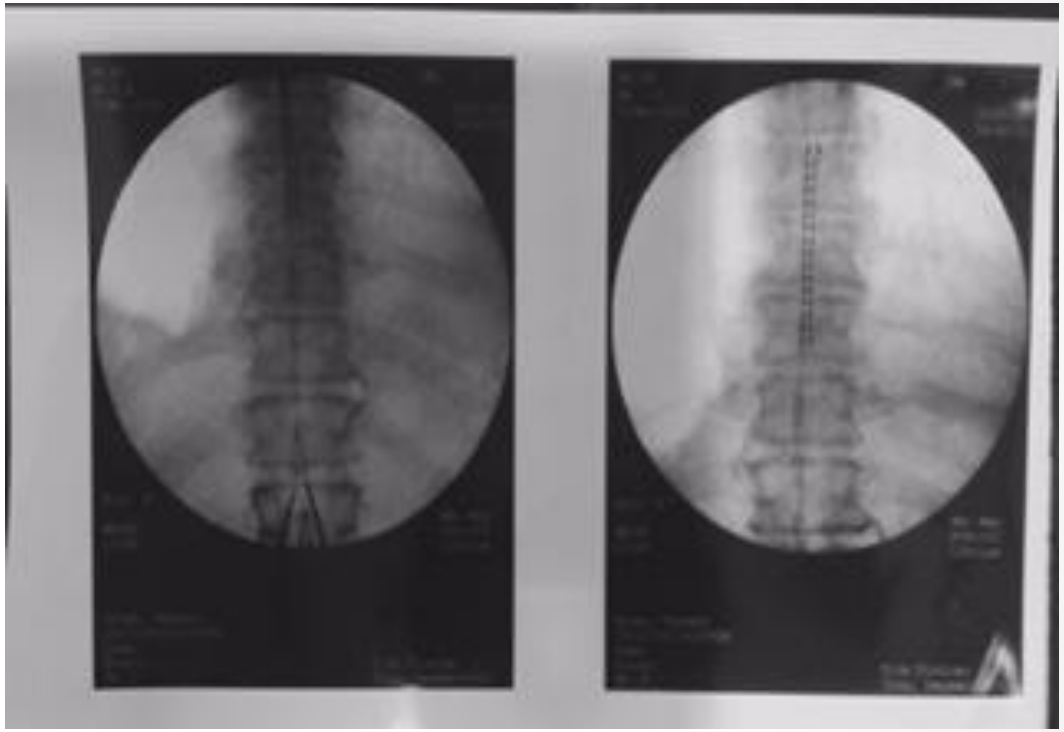


Radiofrequency Ablation



Spinal Cord Stimulator





The Dorsal Root Ganglion:

The DRG: A collection of bipolar cell bodies of neurons surrounded by glial cells and the axons of the DRG sensory cells that form the primary afferent sensory nerve

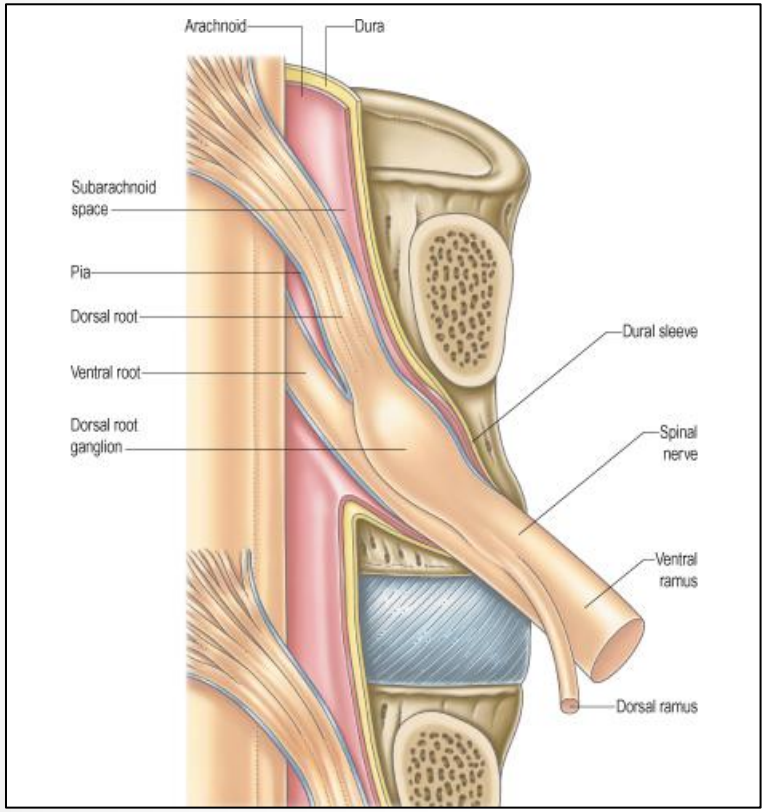


Image from: Standring S. Gray's Anatomy. 2005

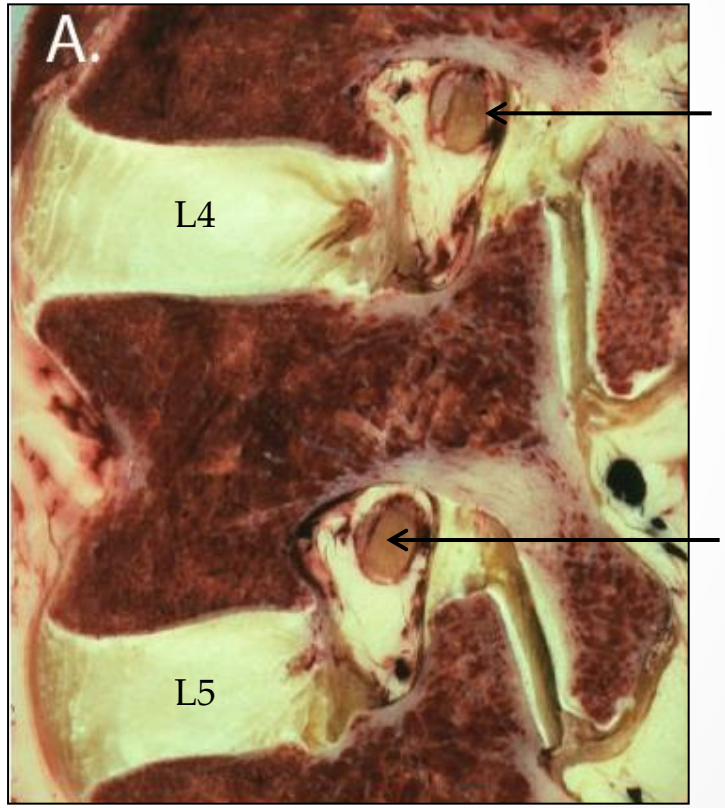
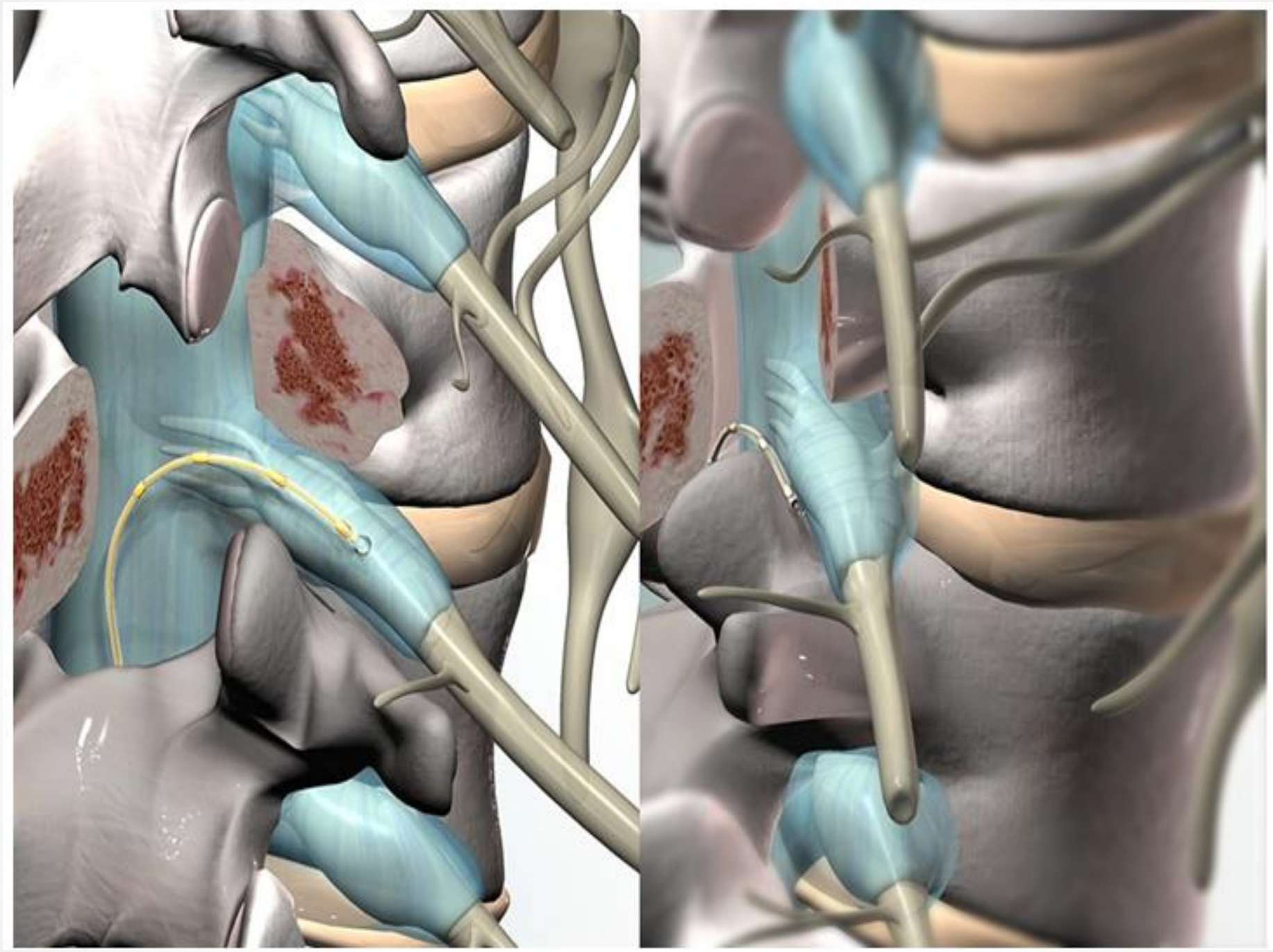
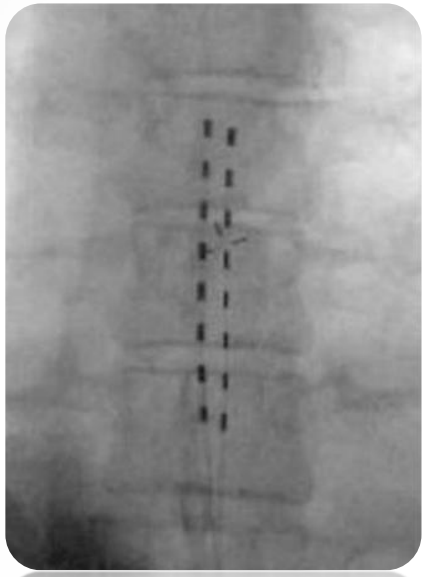


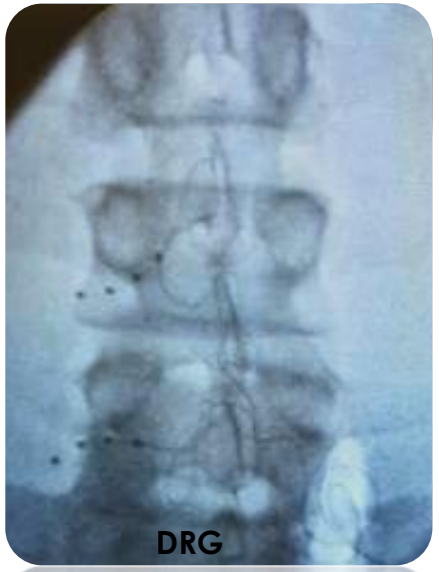
Image from: Hogan Q. Reg Anesth Pain Med. 2010.



SCS vs DRG



Tonic conventional



DRG Lead

Subthreshold Sub study

- The dorsal root ganglion (DRG) is an exciting target for neuromodulation that has shown to provide superior pain relief, when compared to traditional tonic SCS, without the need of paresthesia coverage.[1] Deer/Levy
- Programming of DRG stimulation has been predicated on supra-threshold stimulation.
- The aim of this study was to compare efficacy outcomes between patients with either the absence or presence of paresthesia in DRG stimulation.

Complex Regional Pain Syndrome (CRPS)

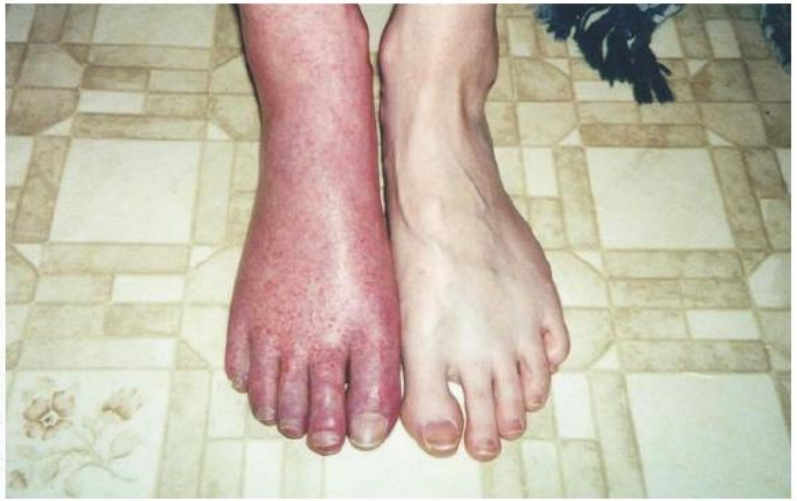
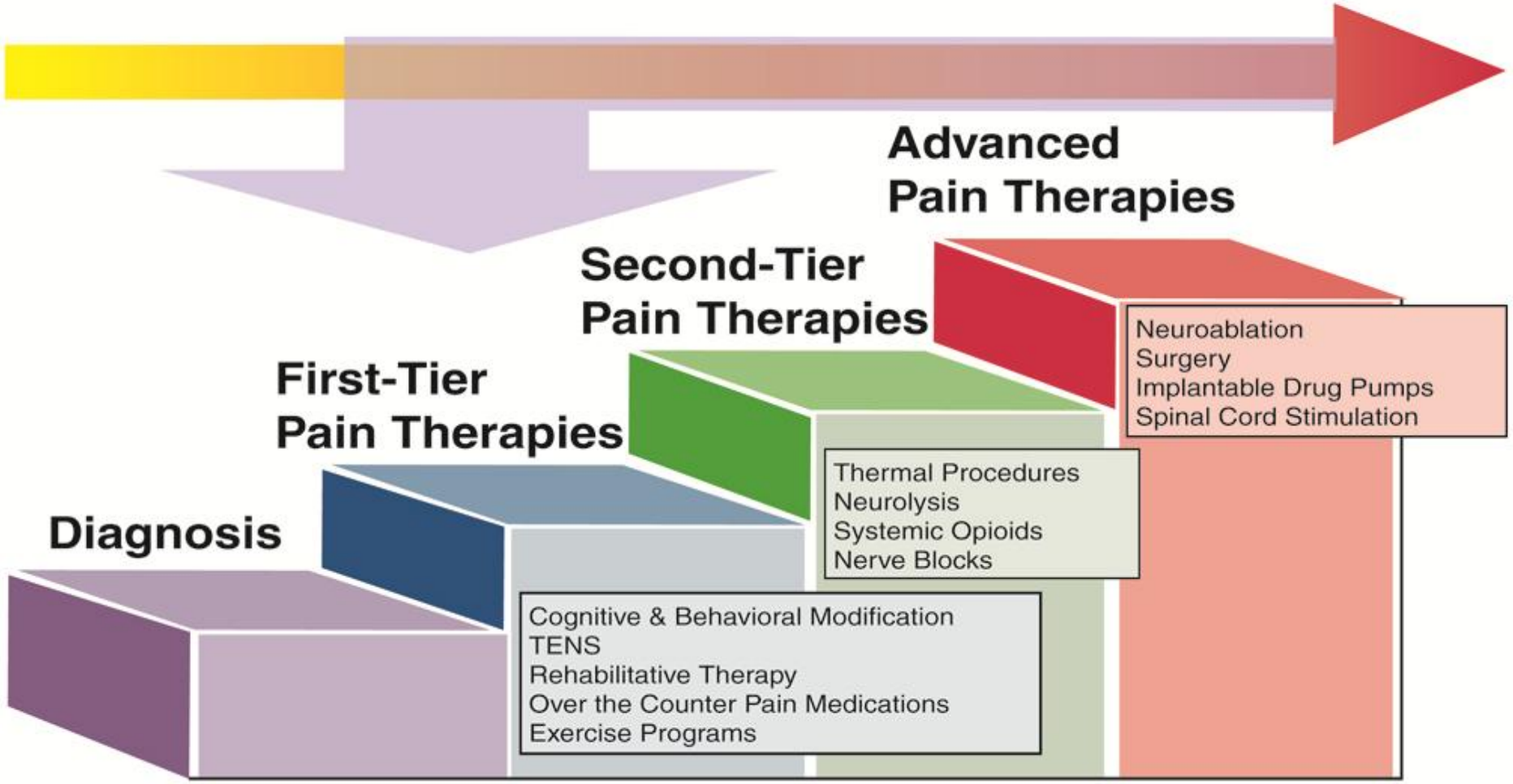


Photo courtesy of Dr. Steven Richeimer.

Figure 1. Image of a patient with lower extremity complex regional pain syndrome.

The opportunity is moving device therapy earlier in the continuum of care.



Summary

- Clinical guidelines represent one strategy for improving prescribing practices and health outcomes
- It is now more important than ever to join together and offer chronic pain patients alternative treatment options to escalating opioids they may be currently taking
- Pain management as a specialty that has evolved dramatically in its ability to successfully treat pain

Questions?

Sources

http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html

http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

https://treatingpain.com/news/9076/learning-from-prince-untimely-death