#CHAIR2014

7TH ANNUAL

CHAIR SUMMIT

neuroscience CME

Master Class for Neuroscience Professional Development

September 11 – 13, 2014 | Westin Tampa Harbour Island

Sponsored by

CME Outfitters

#CHAIR2014

Aligning Patient Goals to Treatment in Pain Management

William S. Jacobs, MD
Medical College of Georgia,
Georgia Regents University
Augusta, GA

David L. Caraway, MD, PhD
Center for Pain Relief
Huntington, WV

William S. Jacobs, MD

Disclosures

- Dr. Jacobs has no disclosures to report.

David L. Caraway, MD, PhD

Disclosures

- ***Research:*** Jazz Pharmaceuticals, Inc.; Mallinckrodt; Medtronic, Inc.
- ***Speakers Bureau:*** Jazz Pharmaceuticals, Inc.; Medtronic, Inc.
- ***Consultant:*** Jazz Pharmaceuticals, Inc.; Medtronic, Inc.

#CHAIR2014

Learning Objective 1

Apply advanced knowledge about the mechanisms of pain and the various treatment approaches to improve the management of patients with chronic pain.

#CHAIR2014

Learning Objective 2

Improve the clinician-patient communication dynamic to include the voice of the patient in establishing realistic treatment goals for managing chronic pain.

#CHAIR2014

Learning Objective 3

Devise individualized treatment plans that include an assessment of all available therapies, pharmacological and non-pharmacological, for the optimal management of chronic pain.

Jennifer Charles

- Ms. C is a 33 year old, Caucasian, female
- Office manager for the University Psychiatry Outpatient Clinic
- Involved in a motor vehicle accident 3 years ago
- She was rear-ended but was wearing her seat belt and airbags deployed

Medical Review

- She had persistent right upper extremity C6 radicular symptoms which did not respond to conservative treatment including:
  - → NSAIDs, muscle relaxants, a 10-day course of immediate release oxycodone followed by a methylprednisone acetate 5-day dose pack
- Cervical MRI showed right-sided, herniated discs at C5 and C6 consistent with her radicular symptoms
- She underwent an Anterior Cervical Decompression and Fusion with hardware from C4 to C6

Medical Review

- Repeat imaging showed stable fusion and hardware and the patient is not considered to be a candidate for further surgery
- She is referred for management of her chronic neck pain

Evaluation for Pain Management

- The initial evaluation including substance abuse risk assessment, revealed she has a CAGE Questionnaire adapted to include drugs (CAGE-AID) score of 3 out of 4 and an Opioid Risk Tool (ORT) score of 10 suggesting a significant risk for aberrant behavior
- She volunteers that she has been in recovery from heroin and alcohol abuse for the past 6 years and has been abstinent and attending 12-step meetings 3 times a week

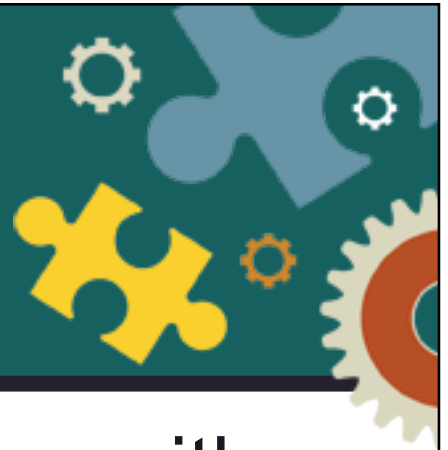
Evaluation for Pain Management

- Unfortunately, treatment with nonopioid analgesic pharmacotherapy and aggressive physical therapy has failed to meaningfully reduce her pain
- She used the initial post accident oxycodone as prescribed but volunteers that she was afraid she would not be able to continue to do so had it been continued. In addition, her AA Sponsor told her she was no longer sober
- She wants to continue to work, but has only been able to do so on a part-time basis

Key Learning

- Clearly there is risk, but how significant is the risk, and more importantly, what is the best way to manage her disabling pain in light of it?

Developing a Treatment Plan



- Start her on an opioid treatment plan with close monitoring
- Consider intrathecal pain management with a pain specialist

Two paths to treatment

- Pt does well as presented thus far

Patient continues to do well with current regimen and consistent support

- Pt does not do well as presented thus far

- Alternate path to improve pain management

Increased Pain Path

- Ms. Charles' pain continues to interfere with her functioning. Dosage increase helped for a short time
- Breakthrough pain continued
- Ms. C could not continue to work but she did maintain AA and other support system
- Side-effects from opioid treatment bothersome

Change in Delivery System and Pain Medication

- She consulted with an intrathecal pain specialist
- Suggested intrathecal system
- Trial of ziconitide (non-opioid) to evaluate dosing
- Dosage adjusted slowly over 2 months
- No change in dosage in the last 2 years

Results and Follow-up

- Pain managed to improve her level of functioning
- Ms. C able to return to work
- Maintains AA and support network

Key Learning

- With appropriate Interventional Pain Consultation:
  - → Careful medication selection
  - → Set limits and boundaries
  - → Clearly identified treatment goals
- Monitoring her pain may be managed effectively

Key Learning

- It is important to clarify, from the outset
  - → What Ms. C can expect from her treatment team
  - → What her treatment team will expect of her
- Specifically, patients suffering from chronic pain need to take an active role in their own pain management plan including
  - → Management of possible risks for aberrant behavior
  - → How she can use her recovery program in light of her new challenges.

Treatment Approaches

- By making Ms. C an integral part of the treatment team, we can explain the nature of a therapeutic trial of opioid analgesics and specifically define success of treatment
- In addition, we can determine what strategies for exit management are available if opioid analgesics are shown to no longer be effective or a safe option for continued use

Integrated Treatment

- Given the elevated risk in this case, coordinated care between her Interventional Pain Specialist and an Addiction Medicine Specialist are mandatory
- Once therapeutic goals are achieved, the patient can be transferred back to the primary care physician with regular and as needed follow up with these specialty services

Routine Follow-up

- Urine drug testing (UDT) plays an important role in managing risk in any treatment plan
- Beyond its obvious role in risk management, UDT also allows for objective and credible advocacy for the patient with relevant third-parties such as insurers or concerned family members and her 12-step support group

Follow-up

- The prescribing physician should avoid treatment with morphine and codeine, because it would result in the presence of morphine in the urine and make it difficult to identify a relapse to heroin

Follow-up

- As the patient progresses through treatment, she is able to gradually return to full-time employment with routine pain scores in the 3 to 4 out of 10 range
  - → Through the appropriate use of a combination interventional procedures and opioid and nonopioid analgesic pharmacotherapy
- She continues to remain active in recovery programs
- All objective and subjective measures continue to support the impression of clinical stability

Application

- When assessing such a high-risk patient, it is important to establish your own level of comfort early on
- By carefully assessing your experience and resources:
  - → It becomes easier to decide who to manage, co-manage, or refer on to specialty levels of care

Application

- As part of your assessment, keep in mind that:
  - → Predisposed does not mean predestined
  - → An elevated risk profile complicates therapy, but it does not preclude it
- Risk management is a shared responsibility between the patient and the pain treatment team
- Failure to establish an open relationship based on mutual trust and honesty can undermine even the most basic treatment goals

Clinical Connections

- Knowledge of pain mechanisms informs treatment choices to improve the management of patients with chronic pain.
- The clinician-patient communication and patient participation in treatment is critical to successful management of chronic pain
- Consider all available non-pharmacological and pharmacological options for the treatment of chronic pain
- Risk management is a shared responsibility between the patient and the pain treatment team

#CHAIR2014

Questions & Answers