Are You Seeing the Big Picture?: A Multimodal Approach to Pain Management.

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CMEO Podcast Transcript

Steven Stanos:

Hello. My name is Dr. Steven Stanos. On behalf of CME Outfitters, I'd like to welcome you and thank you for joining us for the second part of a three-part REMS CMEO briefcase series. Today's episode is titled, "Are You Seeing the Big Picture?: A Multimodal Approach to Pain Management." This case is a continuation of episode one, where we met Sam and began the telehealth assessment of his pain.

Today's activity is part of a series of risk evaluation and mitigation strategies, or REMS education, covering the FDA blueprint, Opioid Analgesic REMS education blueprint for health care providers involved in the treatment and monitoring of patients with pain. REMS compliant education is a critical component of the ER/LA Opioid Analgesic REMS program to provide education to clinicians on safe opioid practices, as well as current regulations and guidelines on treating pain and prescribing opioids appropriately.

To meet the requirements for REMS, at the end of the activity, complete the post-test and evaluation to receive your CME CE credit. CME Outfitters will submit your completion information to the FDA. It's that easy.

Again, I'm Dr. Steven Stanos, Medical Director of the Swedish Health System Pain Medicine Services in Seattle, Washington, and past president of the American Academy of Pain Medicine. We have two learning objectives for today's activity. Our first goal is to provide you with some best practice strategies that you can incorporate into your clinical workflow to optimize safe and competent prescribing for patients with pain. The second objective is to educate patients about their pain to optimize safe and effective multimodal treatment plans. In the second segment, we're going to move towards more treatment of Sam. We gave you a background in the first segment with regards to psychosocial and physical assessment about Sam. So I thought it'd be good to kind of revisit that to make sure we have a good background of what Sam is experiencing, and what we're going to need to focus on.

Again, Sam is a 37-year-old. He's had a previous laminectomy. He was doing well, but then developed severe low back and right leg pain. An MRI was done showing a small L5-S1 disc herniation. His surgeon does not want to do surgery again, and he was referred for conservative treatment. He attempted physical therapy, but it was too painful, so he only went to one session. He was started on naproxen 500 milligrams twice a day, and cyclobenzaprine, a muscle relaxer, three times a day. He works as a customer service representative where he's standing, working in a car lot selling cars. So he's standing, he's got a lot of back and leg pain throughout the day, which has also been a problem, even before COVID. He's reporting poor sleep, and a lot of distress related to his pain.

With his past medical history, he's got ADHD, but he's been stable on medications. His father has a history of low back pain and spine surgery, which also kind of makes him nervous. He has a social history of undergoing some counseling in his early twenties related to a divorce. And at that time had significant levels of anxiety.

From a substance use standpoint, he reported heavy drinking in college, but he currently consumes three drinks per week. He smokes occasionally marijuana, and he's not a regular tobacco user.

Our assessment was that he had a severe right S1 radiculopathy. That actually fit the findings on his MRI. He also has pretty severe myofascial pain, which also could be contributing to the leg pain and back pain. Again, he's got sleep disturbance and significant distress.

Steven Stanos:

So with that background, what would you prescribe for Sam?

Before we dive deeper in putting together our management plan for Sam, it's going to be important to really take a couple of moments to go over opioid pharmacology, and some issues around what opioids actually do to our brain and how we function. If we think of opioids, and we can agree that opioids cause analgesia, but they also can cause altered mood. They can decrease anxiety. There's also a respiratory depression, GI motility inhibition. Some of those things were common for us to understand. There's also reinforcing effects of opioids, reduced anxiety, decreased boredom. In some cases decreased aggression. So that's going to be important when you start thinking about an opioid, is it effective, what are the potential side effects? And as also considering what are the risks for addiction.

In the middle is a schematic from NIDA, it really nicely describes the kind of stages of the addiction cycle, but that cycle, those three stages also are very close to not just substance abuse problems in pain, but also the kind of survival of human organisms. So on the top, we see the basal ganglia. The basal ganglia is important for rewarding or pleasurable effects of any substance. To the right, we see the extended amygdala, which is important with stress and feelings of unease or anxiety. And then to the left, is the prefrontal cortex, which is really important with executive function, prioritizing tasks. And we think in some cases with opioids, in misuse of opioids, that those pathways can be somewhat hijacked. And so it's going to be important when you're starting opioids, when you're tapering patients to be thinking of these areas, of those three areas of the brain and how they're interacting in this kind of overlap between reward mechanisms and pleasure. Because again, it's going to be important when you're asking not only just their pain score, but what else is the opioid causing for them?

This is actually from a newer study that looked at the kind of opioid mu receptors, delta receptors, and kappa receptors. And so this is a schematic of the receptors, even though they're all analgesic, they have a different set of sub effects on the person. So again, they are homologous from an analgesic standpoint, but when you start looking at other areas, there can be a differentiation in how they affect how patients function.

If we look at the top, and again, this is going to explain kind of this continuum of what we call this mood hedonic continuum, or mood pleasure continuum. So at the top, morphine or the MOR receptor is primarily responsible for euphoria and stress coping. To the right, kappa is more responsible for dysphoria, stress, and negative affect. And then to the left, the delta opioid receptor has more anxiolytic and positive effects. So I think this helps underscore the complexity of opioids, how they interact differently with every patient, and it may be actually different from within a patient, depending on which type of opioid they're on. So again, it's going to be important, not just to think of analgesia, but what are the anxiolytic effects? What are the dysphoric effects? Are they having irritability, and other things related to their response to an opioid?

So moving forward, we want to talk now on the evidence-based approach to pain management. And again, how do we apply a bio-psychosocial model, as well as mitigating risk for addiction, misuse, and other adverse effects that patients may have. If you're going to think they're a good candidate for opioids and need to be on opioids for pain management. The CDC in 2016 put together recommendations for chronic prescribing. There was also recommendations for acute. Those are also going to be undergoing review as we speak, but the CDC guideline has given us a nice kind of background on where we need to focus. It looks at determining need for opioids, who are those patients, opioid selection, dosage, and duration of therapy, and the last set of recommendations, more on assessing risk and addressing harm.

Steven Stanos:

From our case here with Sam, opioids would not be a first-line, and should not be used in isolation, but he's also had other problems. So opioids in this case may be appropriate as part of his other treatment program. The recommendations also state to start low and go slow, use immediate release opioids when starting opioid treatment, and then reassess patients, whether you're increasing that dose over time and being very careful at 50 milligrams and even 90 milligrams. And if you're going to go higher in those doses to really justify increasing doses. And when, like I said, it's going to be important to really focus on are they getting a functional improvement with the opioids early on in the trial, as well as mitigating any other adverse effects on their mood, as well as potentially misuse of medicines.

The HHS inter-agency task force, again, highlighted the importance of a bio-psychosocial approach. And so in our case, we did a good patient history. We looked at functions, psychosocial function, as well as pain. We did a physical exam through our televisit, and we also used screening tools. Going forward, we're going to need to check the prescription drug monitoring program if we're going to prescribe opioids, and use other tests that are going to be able to hopefully help screen and monitor for misuse of medicines. And then with that, try to risk stratify patients, whether they're low, medium, or high risk for aberrant behaviors. And based on that, risk stratification. You can individually decide how often you need to see the patient, how often you need to do urine screens, how often you need to check the PMP. Now that may vary from state to state. Different states have different rules, but in general, you pretty much need to risk stratify patients. So it can give you a better guidance in how you're going to individually look at these patients in the safest manner.

We have a lot of pain management options. I like to break it down into medications, behavioral medicine, physical modalities, physical therapy, and those types of interventions, as well as monitoring and education. I mean patient education, unfortunately in this presentation, we can't talk a lot about, but it can be very valuable for your patients. There's a number of different tools out there as well, but we're going to focus on medications, behavioral health, and physical modalities for Sam, as we guide you through his treatment.

That being said, we decided to use the opioid risk tool, which is a screening tool for aberrant behaviors. It looks at five areas, a family history of substance abuse, personal history of substance abuse, age, a history of pre-adolescent sexual abuse, psychologic disease. With Sam's score, he was able to report his father had a history of alcohol abuse, and he has a history of attention deficit disorder. So his total score is 3+1, or four. A four places him at moderate risk for aberrant behaviors. So in this case, maybe we would be doing more frequent urine monitoring, and just being aware that he's got psychologic risk factors that may put him at risk for misuse of medicines and potentially overdose.

So our treatment recommendations for Sam were to initiate low dose opioid. He was not doing well on naproxen. His significant pain was impacting his daily life. We decided to put them on oxycodone five milligrams, three times per day. We started trazodone for sleep, 50 milligrams. We also referred him to physical therapy. I also instructed him to start walking every day for 15 to 20 minutes at the same time a day, just to get his confidence up, get him out of his house, get him moving again before he gets started in his physical therapy program.

I also offered him some two different apps that we've been using in our clinic that we've been providing information to our patients about. The one app includes both meditation and some very simple relaxation techniques, including diaphragmatic breathing. And I told Sam to actually kind of spend some time at the app and see what he likes. Again, letting the patient be active in trying to figure out what kind of care they want to continue with.

Steven Stanos:

So now we're going to go back to our two-week follow-up with Sam. And so Sam is going to be kind of conducting a virtual visit with me, and we're just going to just kind of check in on how he's been progressing across those different areas of his treatment program.

Sam, it's good seeing you. Thanks for setting up the virtual visit. Wanted to check in with you. I know I saw you last time two weeks ago and wanted to kind of cover how your pain has been, your mood, your sleep, and kind of catch up with you on how things will be going with work and physical therapy. So from a pain standpoint, how's your pain been and were you able to tolerate the oxycodone and the trazodone we started you on?

Sam:

Yeah, it's been a lot better. I started the oxycodone. I've been taking it as you prescribed, three times a day, 8:00 AM, noon, and then at five. And it's been a lot better. I think my pain's reduced by about two points out of 10. My pain reduces for about three to four hours. Yeah. It's helped me a lot just to function throughout the day.

Steven Stanos:

Okay. Were you able to check out the relaxation app?

Sam:

Yeah, I did that too. I was actually kind of surprised at how much it's helped me to be able to sleep better, or just really fall asleep more easily. I'm not as anxious. I'm a little more calm and enabled us to fall asleep after doing some of those breathing exercises. So that was pretty neat. That was pretty neat.

Steven Stanos:

Okay. And then did you start the trazodone for sleep? The 50 milligrams?

Sam:

Yeah, I did. Yeah, that's also helped. I stopped the muscle relaxant, and that's helped too, because I was kind of groggy and was really, really tired with that, but I started the trazodone and that's also helped my sleep. I'm not waking up as much with pain, I think probably half as much.

Steven Stanos:

Okay good. Good, and unfortunately, sometimes cyclobenzaprine could be sedating. So that may have been making you more tired during the day. Did you start physical therapy yet?

Sam:

Yeah, I did. It's going better this round. The guy has gotten me going in a couple of exercises. I'm doing like... I think my favorite ones, I've got like this core exercise where I'm on all fours. I'm kind of engaging my core and raising an arm and a leg. He calls it a bird dog. And then I'm doing something for these really tight hamstrings I've got on my right side. If it helps with my nerve, that's been helping to. Easing up my calf pain, and some other things too. But those are my favorite ones.

Steven Stanos:

Okay. Excellent. And from a work standpoint, I know a lot of places are opening back up. And what are your plans with work for now?

Sam:

Yeah, so it's good. Things are picking back up. My employer said I can start back work three days a week for like five hour shifts, which is exciting, because I got to start making money and I want to get back to full-time soon. So, that'll be starting up real soon. And I'm feeling up for it. I'm feeling up for it.

Steven Stanos:

Okay. Okay. Well, I think just to make some kind of minor changes, and I'm going to actually have you come back in a month, but in the short term, I'm going to have you continue on the oxycodone for now, five milligrams up to three times a day. I checked the state prescription drug monitoring database, and it looks like your prescription is due in two days. So I'll send that so you can pick it up in two days. I want you to increase the trazodone to just one and a half pills, so 75 milligrams. And then we can talk about that when I see you back in a month. And I'm looking forward to the physical therapist to keep working with you to advance your home program. And we'll kind of go from there. I do want to thank you for leaving that urine sample. We'll process that and go over the results. And I can go over that with you when I see it at the next follow-up.

But really good job, but we'll just kind of keep chipping away at this. And if you want to use the app a little bit more and kind of continue with that, those are things we can talk about in our next follow-up. So thanks a lot. Great job.

Sam:

Yeah. Thank you. I'm feeling better. So I appreciate it.

Steven Stanos:

Okay. Well, I'll touch base soon. Take care.

Sam:

Okay. Thank you doctor.

Steven Stanos:

So in summary for Sam's two week follow-up, even that short period of time, we were able to see some improvements. We still have some things to work on. I think it's easy to kind of break this down into three core areas. And remember over time, over subsequent visits, you may have a different focus or priority on those different areas. And so in most cases, I like to focus on analgesia, mood and stress, and the third type, sleep. From a progress standpoint, checking on, in Sam's case, his physical therapy progress and what's happening with work. But again, the progress check may be for another patient, different goals that they're working on, whether it's improving their activity at home, or being more active outside of the home. So again, progress check just reminds me to really look at those other areas of their function in life.

Steven Stanos:

Monitoring and compliance includes, in this case, checking the PMP, doing urine monitoring, anything else that you need to do to really be screening patients effectively and following up on that to really try to mitigate any misuse of medications, and really potential limitations for any types of overdose or adverse effects.

Now Sam provided us a urine sample. In many clinics, you can do point of care testing. Point of care testing is usually an immunoassay, they're probably lower sensitivity and specificity, but it can give you a quick answer. And then if you need to get a confirmation, you could send that out. It's important if you're doing testing to understand metabolism of opioids, and so in this case, codeine has broken down to morphine. Hydrocodone is broken down to hydromorphone. So in a confirmation test, you would see those substances, and oxycodone is broken down to oxymorphone. So again, be familiar with the basic metabolites of all of these different opioids, as well as drugs of abuse, like heroin, because that's going to be important when you're assessing the results of confirmation testing.

Now again, most point of care tests are immunoassays, and with Sam's case, he's taking oxycodone. Oxycodone notoriously is missed on some of the point of care tests. So you may have a negative test, but have to send that for confirmation. So again, spend time and make sure you have a good understanding, and if you do have questions, call the lab, and they many times can be very helpful with kind of walking you through results.

So Sam, thanks for coming back. I know I saw you last month and I am happy you were able to come back today. Kind of a lot has happened over the last six months, so just wanted to touch base. How's it been going? I know we had recommended you taper off the oxycodone, and we made some other adjustments. How have things been over the last four weeks?

Sam:

Been going really well, yeah. I tapered off the oxycodone like you said. It took me three or four days, and I didn't have any sickness, no nausea. It actually went really smoothly, which is great. And then, you said to kind of look up on a website where to return my pain meds to, or the oxycodone. So I found that website and I actually found like a take-back facility in this pharmacy near me. And so I brought them back, and they took back the extra pain medications. So that was good. And yeah, I mean, overall I'm just, I mean, I haven't really had any right leg pain. I've got like occasional low back pain, but really not too often, like once every couple of weeks at most I'd say.

Steven Stanos:

Okay, good. So your leg pain's resolved, or hopefully the nerve root irritation has gone away, and you're getting some back pain once in a while. How's your sleep and your mood been?

Sam:

Sleeps pretty good. It's a lot better. I would say maybe just a couple of times a week, I'm waking up with some pain, but I still take the trazodone just occasionally to help with that. So it's pretty well in check. I can't say it really bothers me that much anymore. So a lot better. And yeah, mood as well, like I don't feel, now that I'm back working full-time and I'm using that app as well. I'm just calmer. I'm not as anxious. I'm not as just worked up and agitated. So I'm doing pretty well there as well.

Steven Stanos:

Okay, good. Good. And have you been getting them back into an aerobic program? Are you doing stationary bike? Have you started jogging?

Sam:

Yeah, the physical therapist, he got me going on a stationary bike program. I've got a stationary bike in my building. So I'm at about 15 to 20 minutes on that pretty regularly, and it's feeling good. I'm just starting to jog a little bit. I can't say I'm doing it too much, but it's going, and it's feeling okay so far. And then he still kind of got me going on different core exercises and progressions, and there's other stuff. And it's feeling good. So I'm pretty happy.

Steven Stanos:

That's excellent. Well, you've put a lot of time into this, and you've been patient with getting through everything and really, I think, applying a lot of different techniques that maybe you didn't even have before you had the back pain. So that's been excellent. Why don't we do this? I'll kind of check back with you in maybe two months. I just want to make sure how much we need to progress you with your PT program. If you have any problems earlier than that, please feel free to get back to me, and it'd be great to see you in person so we can repeat the exam and go over some things. So really good luck to you. You've really put some great time into this, and keep it up, and be in touch with me sooner if any other problems arise. So thanks again, you did a good job.

Sam:

Hey, thank you for all your help. I really appreciate it.

Steven Stanos:

Okay. To summarize, for our six month follow-up with Sam, he's really done really well, which doesn't always happen, but it's good. I mean, many times, if you, I think, you apply the right type of program, you can see those results. His pain is really low. He's got no leg pain any longer. We were able to taper him off his oxycodone. He's just taking the trazodone intermittently for sleep. Definitely his mood is better. We talked about and he's progressed through his physical therapy program. And now getting to that kind of final stage of his aerobic program and really advancing that. He's working full time. We're able to do all of his compliance and doing urine screens, checking the PMP, and everything actually worked out very well. So again, it's really important to be putting together a bio-psychosocial assessment and use that same assessment, that same bio-psychosocial model as you follow up with the patient, and keep adjusting the treatment program.

So when tapering patients, you want to really look at this in kind of an individual manner. Consider all of their underlying comorbidities, a taper in a patient with psychologic or psychiatric conditions could actually cause worsening of those symptoms. You want to be really careful. You really want to kind of balance the benefits of the therapy that they're undergoing with regards to reducing their dose. Slow tapers are also very important, but really getting good buy-in from your patients. In Sam's case, he was able to go off the medicines and do a really pretty quick taper, even though he was on pretty low doses. There's been a number of guidelines, and most recently HHS put out clinical guidance last year, which I think does a really good job of kind of breaking down different reasons why you would consider tapering. Again, in Sam's case, he was doing better, he didn't need to be on opioid therapy, but in other cases, patients may have worsening function on opioids. They may be on high doses despite really improvement in function. They may develop a substance abuse problem, or an opioid use disorder.

Steven Stanos:

So again, this guidance really helps kind of give good tips on how to assess patients, and as well as how to do this from a medication standpoint, as well as integrating behavioral health interventions with regards to tapering.

Also with any patient that's on a controlled substance, including opioids, when those patients are finished with their treatment, whether it be for acute pain or chronic pain, how do they dispose of those medicines? There's takebackmymeds.com, other websites that you can use in your area that helps identify places that patients can take their unused medicines. Again, any controlled substances back to. Also when you're putting patients on opioids, remember you should counsel them about safe storage of medicines. They should keep those medicines locked up. You want to decrease any risk of those medicines getting in the hands of a person with a substance abuse problem, accidental exposure by a child, or even an animal in the house, all sorts of things can happen. So you really want to make sure patients are keeping their medication safe, and when they no longer need those medications not leaving those in the medicine cabinet, but giving them guidance on how they can dispose of those medicines safely through drug take back programs.

So in putting together everything we went through with our discussion and case presentation two, what are the smart goals? Again, specific, measurable, attainable, relevant, and timely. We learned that you can mitigate risk for opioid therapy with a comprehensive patient centered approach. And I kind of think of this comprehensive approach would be with any patient, whether they're on opioids or not, but including opioids, you really want to be careful. Integrate non-pharmacologic interventions, including behavioral health, and we just touched upon a simple app, but getting your patients to see a psychologist, a counselor, a psychiatrist, if they need to. But really being more aware of those disciplines and those specialists that can help you with your patients. Use active therapies like physical therapy, occupational therapy, to really help advance patients as well.

If you're going to consider opioids, again, integrate tools to assess for misuse and abuse, the opioid risk tool is one tool that you can use, but be aware of those. You can also use alcohol screening and other addiction screening tools within your practice. We mentioned the CDC guideline for opioid prescribing, we also mentioned the HHS tapering guidance, which again are all good documents that, again, besides their content, have good references, they can really kind of keep you up to date in these important areas around pain management.

Thank you for joining us today for episode two of our three part REM CMEO briefcase series. To view additional case-based education on pain management, please visit www.cmeoutfitters.com. Please also visit the opioid education hub. You'll find other REMS activities, as well as a broad range of educational activities and resources for healthcare providers and patients. And as a reminder to meet the requirements for REMS, complete the post-test and evaluation to receive your CME CE credit. CME Outfitters will submit your completion information to the FDA.

We hope you'll be able to integrate these pain assessment and management strategies into your clinical practice. Thank you.