RATIONAL APPROACHES FOR A NATIONAL PROBLEM

CHRONIC PAIN: THEIR PAIN OR YOURS?

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Why Us? The Role of Emergency Physicians in the Care of Chronic Pain

Managing chronic pain is a challenge in the ED. Finding the right balance between too much and too little is key to good patient management.

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by JIM DUCHARME, MD, CM, FRCP

The figures are well-established: more than a quarter of people will suffer from chronic pain during their lifetime. It is the disease state with the highest economic impact on society in terms of lost workdays. The average annual family income of patients with chronic pain is less than $25,000, which is below the poverty line. But why do emergency physicians need to know about chronic pain?

Few physicians among us understand the myriad of pain conditions that fall under the label "chronic pain." Fewer still recognize the pathologic changes in personality associated with chronic pain as being part of the disease symptom complex, just as peripheral neuropathy is a manifestation of diabetes. Most family physicians are ill-equipped to provide the multidisciplinary care required; most patients cannot afford the paramedical care provided by physiotherapists, psychologists, social workers, etc. Pain management is further complicated by the issues related to opioids—opiophobia, diversion, and addiction—even though only one-third of chronic-pain patients require opioids as part of their care.

The consequence? Chronic-pain patients are poorly understood and poorly treated. As a result of not having their pain properly controlled and not having been taught adequate coping skills, these patients modify their behavior in an attempt to get the physician to provide the necessary care—aberrant behaviour called *pseudoaddiction*. Distinguishing aberrant behavior linked to pseudoaddiction from that associated with true addiction is difficult at best; it may take a pain-medicine expert months to identify the underlying reason for the aberrant behavior. It is almost never possible to do so in an isolated visit to the emergency department.

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Table 1: Opioid Risk Tool from the Canadian Opioid Guideline

ITEM	MARK EACH BOX THAT APPLIES	ITEM SCORE IF FEMALE	ITEM SCORE IF MALE
Family History of Substance Abuse			
Alcohol	[ ]	1	3
Illegal Drugs	[ ]	2	3
Prescription Drugs	[ ]	4	4
Personal History of Substance			
Alcohol	[ ]	3	3
Illegal Drugs	[ ]	4	4
Prescription Drugs	[ ]	5	5
Age (mark box if 16-45)	[ ]	1	1
History of Preadolescent Sexual Abuse	[ ]	3	0
Psychological Disease Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia	[ ]	2	2
Depression	[ ]	1	1
TOTAL			
Total Score Risk Category **Low Risk:** 0 to 3 **Moderate Risk:** 4 to 7 **High Risk:** 8 and above			

More information is available at http://nationalpaincentre.mcmaster.ca/opioid.

Source: *Furlan AD, Reardon R, Weppler C, for the National Opioid Use Guideline Group (NOUGG). Opioids for chronic noncancer pain: a new Canadian practice guideline.* CMAJ. *2010;182: 923-930.*

The emergency department is the safety net of our system—impoverished patients in pain receiving inadequate (or no) care from a primary-care provider have nowhere else to turn. In the Pain and Emergency Medicine Initiative (PEMI) study involving 18 academic centers across Canada and the United States, 20 percent of patient visits had chronic pain as the *primary* reason for their visit to the emergency department. That is the largest percentage of visits to the emergency department for any one pathology; paradoxically, it is decried by most emergency physicians as a condition that is "not part of emergency medicine." It is clear the emergency department cannot provide ongoing care to chronic-pain patients any more than it can do so for patients with diabetes. It is equally clear that we must be involved in their care to some degree, just as we are involved to some degree in the care of many patients with a chronic disease—that is the nature of our horizontal specialty. What is our role?

Caring for patients with chronic pain is part of the ED mandate. Distinguishing them from patients with problems of addiction is difficult, but they are not the same patients and should not be treated similarly.

Acute Flare-up of Chronic Pain

Certain conditions, such as fibromyalgia (FM) or complex regional pain syndrome (CRPS), generate new pain or acute worsening of that pain state. Our role is to first ensure that patients are not suffering from a new acute condition unrelated to their chronic pain condition—the latter does not make them immune to other pathology. Intervening with ketamine in analgesic doses can abort the acute flare-up in CRPS. For patients with FM, reassurance they do not have a new medical problem will usually result in their returning home satisfied, reluctantly accepting that their new pain is, indeed, part of their FM.

Acute New Pain Pathology

Patients who take medications for chronic pain (including opioids) require proper pain management just like everyone else when they suffer, for example, an acute fracture. If they already take opioids, they will require their usual daily dose *plus* dosing for their new pain; often, identifying what their usual PRN dose is will give a starting point for the first dose of opioids in the emergency department, with titration after that. Physicians have to recognize that the doses of opioids required to provide adequate analgesia in chronic-pain patients taking long-term opioids will almost always be higher than the doses we use for patients not taking such opioids.

Medication Requests

Patients receiving care from pain physicians require a minimum of two to three *months* to get their pain controlled. Emergency physicians should, therefore, not feel an obligation to provide or initiate a medication for someone's chronic pain during a single emergency department visit, nor should they feel any urgent need to manage that chronic pain in the emergency department. Patients receiving long-term opioids have an agreement or contract with a primary provider wherein only that provider will prescribe their opioids. If patients were to go to their primary provider and say they had "run out" a few days early, the provider would reiterate that the patients are responsible for their medication usage and not renew the prescription until the next scheduled time interval. In the emergency department, the physician should restate this "single provider" principle and feel very comfortable declining to provide opioids, all the while offering to help patients in any other way possible.

Adverse Events or Drug-Drug Interactions

Most emergency physicians are unfamiliar with either the medications prescribed or the (high) doses prescribed for chronic-pain management. While most physicians will not exceed 75 mg of amitriptyline, for example, patients with neuropathic pain

may require up to 250 mg. Higher than normal dosing carries a higher risk of adverse events. Another example of risk is seen in patients prescribed methadone for pain or addiction. These patients will have a markedly prolonged QT interval from the methadone. Multiple case reports of sudden death have been reported after patients taking methadone were prescribed a fluoroquinolone. It is critical during the emergency visit that we ensure patients will not suffer from such an adverse event.

Why is abnormally high dosing often required when medications are used to manage pain? For many patients in pain, their nervous system has undergone "plastification" as a result of the pain. Functional MRI often shows multiple areas of the brain with abnormal function. Be it the development of tolerance with opioids or the higher doses of non-opioid medications required to deactivate abnormal synaptic transmissions, patients with chronic pain often require dosing higher than what may be considered therapeutic for other conditions. These higher doses should not lead to suspicion of misuse or drug dependency but should lead to careful evaluation to identify possible adverse effects.

Providing Support

In chronic-pain patients who have been properly screened for addiction risk using the Opioid Risk Tool (see Table 1, p. 9), the risk of addiction for those who are scored at low risk is less than 0.2 percent—60 times *lower* than the general public rate of addiction. When these patients arrive in our emergency departments, they do not know where else to turn. Simply saying "no" is not a solution. Guiding them to support services, advising them of community resources, demonstrating understanding, and educating them on the role of the emergency department in their care are all key roles for emergency physicians to play. We advise smokers to stop smoking and guide them to programs; we encourage alcoholics to get into detox programs; we advise diabetics about diet, exercise, and community programs—surely, we can do the same for patients with chronic pain.

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Mandate for Care

Caring for patients with chronic pain is part of the emergency department mandate. Distinguishing them from patients with problems of addiction is difficult, but they are not the same patients and should not be treated similarly. They have very different needs because they suffer from very different pathologies. Learning more about chronic pain conditions will allow us to provide the necessary care.

Hands On: Chronic-Pain Management at McKesson Canada

As part of my role within McKesson, I directly oversee the running of nine community-based pain centers where patients with chronic non-cancer pain are treated. Unlike what is commonly thought, only one-third of the patients treated there received opioids as part of their care. The optimal approach to chronic-pain management is a combination of multidisciplinary clinical care, self-management programs to learn proper coping skills, medications, and nerve blocks (the last is effective in roughly 20 percent of all chronic-pain patients). Identifying patients with pain at risk for addiction is a key screening element and part of a 21-page initial evaluation tool completed by patients. In those patients identified as "at risk," care pathways without opioids or with methadone are explored. Patient agreements are routine and include limiting patients to a single prescriber of opioids, no early renewals, and random urine drug testing (frequency determined by their score on the Opioid Risk Tool). All physicians have to undergo our standard training and be supervised for their first year of practice (provincial regulation) in pain management.

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A Rational Approach to the Opioid-Seeking Patient

by JIM DUCHARME, MD, CM, FRCP

Drug Diversion and Abuse Is a Major Societal Problem

In 2012, an estimated 23.9 million Americans age 12 or older—or 9.2 percent of the population—had used an illicit drug or abused a psychotherapeutic medication (such as a pain reliever, stimulant, or tranquilizer) *in the past month* (www.drugabuse.gov/publications/drugfacts/nationwide-trends). Marijuana is the gateway drug. Despite being declared by many to be a benign recreational drug, the odds of going on to addictive drugs such as opioids or methamphetamine are 140 times greater for those having used marijuana than having not used it. Despite the publicity of the rise in misuse of prescription opioids, the 25 percent increase in marijuana use since 2007 is the largest increase for any category of drugs of abuse. Nevertheless, prescription opioids are now fourth behind marijuana, alcohol, and cigarettes in prevalence of abuse among adolescents. They rank second behind marijuana in terms of rate of abuse in society. Given their much greater risk of morbidity and mortality, as well as the association with organized crime, the growing misuse of prescription opioids has created ever-increasing concern.

Chronic Non-Cancer Pain Management Is Failing Miserably

It is the complex disease state with the highest prevalence in society, has the highest economic impact on the workforce, and results in poverty-level existence for the average family that has someone suffering from it. Unable to pay for the multidisciplinary care required, more than 90 percent of patients with chronic non-cancer pain (CNCP) receive inadequate care for their pain. Lacking any other resource, many CNCP patients turn to the ED. This specific issue was addressed in the previous article, "Why Us? The Role of Emergency Physicians in the Care of Chronic Pain" (*ACEP Now*, January 2014, p. 9).

> Emergency physicians believe we can identify people coming to the ED for addiction or diversion, but *this is not true.*

Oligoanalgesia Rampant Across Health Care

Education in medical schools about pain management is less than one-third of similar training in veterinary schools. There is even less education about addiction and how to interact with people suffering from personality disorders. The average physician enters practice undereducated and ill-equipped to deal with any of the very difficult situations described above. The natural reaction to this lack of preparation is to be defensive and overly suspicious and find encounters with patients seeking opioids to be emotional and stressful. It's hoped this article can provide some suggestions about a rational approach to such patients to minimize that stress and avoid confrontations while meeting patient needs.

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Distinguishing People in Pain Seeking Opioids from People Seeking Opioids for Addiction or Diversion

Patients with pain as their primary complaint represent up to 75–80 percent of emergency patients. After 7 p.m., up to 70 percent of motor vehicle collisions are related to alcohol use. Similarly, the prevalence of patients with addiction as a medical disorder rises in patients presenting to the ED after 7 p.m. Even in inner-city hospitals at night, the ratio of patients in pain to those with addiction or diversion issues remains greater than three-to-one. The age of the patient is not of value; people visiting the ED for opioid abuse come from *all* age groups, including young children (Center for Behavioral Health Statistics and Quality, SAMHSA, Drug Abuse Warning Network, 2009).

Emergency physicians believe we can identify people coming to the ED for addiction or diversion, but *this is not true.* In a case-controlled study, 21 percent of patients requesting analgesia and 13 percent of controls tested positive for drug addiction using the DAST-20 survey (of those who agreed to participate). There was no correlation between the pain score and the DAST score. Almost one-half of patients scoring positive for addiction had a history of multiple ED visits and requests for specific opiates or "allergies" to opiates—*but more than half did not*. (*California J EM*. 2005;6:3-8). This inability to identify such patients usually results in labeling all patients seeking pain relief or requesting analgesics as "opioid seekers" for diversion rather than people suffering from inadequate pain management.

In my next column, I will discuss standardizing the ED approach to patients seeking opioids.

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Standardizing Our Approach to Patients Seeking Opioids: Part 2

A test positive for cocaine is a true positive for that drug—and no patients testing positive for cocaine should receive opioids. Patients stating they have a prescription for an opioid but who test negative for that opioid should raise concern about diversion.

by JIM DUCHARME, MD, CM, FRCP

*Last time, we explored the research and statistics on pain management and opioid addiction (*ACEP Now *March, p. 22). In this column, we will explore some standard strategies to use when patients seek opioids in the ED.*

In the management of chronic non-cancer pain (CNCP), the current recommendation is to use "universal precautions" for all patients. Just as we assume in the ED that any patient might have a blood-borne pathogen and so we take universal precautions, the baseline assumption in chronic pain is that anyone can be at risk for diversion or addiction. This does not mean that no patients receive an opioid for pain care; rather, it means that a standardized approach is used for all patients. This type of approach can be used in the ED.

A 37-year-old male presents at 2 am on a Saturday complaining of dental pain and insisting on getting some "Percs" for his pain. What to do?

- **Offer a *valid* alternative**. Dental pain can be severe, and it cannot tell time. During working hours, such patients can get to a dentist, but such service is not available in the middle of the night. Rates of addiction are higher, and there is no way to test objectively for pain. To ensure pain is addressed while also allaying any concerns over diversion, the best option is to offer a dental block with bupivacaine. The anesthetic will last six to eight hours and allow patients to see a dentist in the morning; it is a valid analgesic approach to opioids. You should raise, in a nonconfrontational manner, your suspicions of nonmedical use of opioids with any patients who refuse such therapy and offer to provide support for substance abuse if they admit to that problem. Invalidated concerns of misuse do not mean no management of pain; they mean that the pain should be properly managed with alternatives to opioids. Do not allow patients to suffer because of our (unjustified) suspicions.

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- **Establish the risk of abuse or diversion.** The Opioid Risk Tool is an excellent screening tool for establishing risk of abuse and can be done in one to two minutes. Low-risk patients have less than 0.2 percent risk of abuse.
- **Consider a urine drug screen**. While urine drug screening has many limitations in assessing patients with psychiatric disorders or with altered mental status, it can be of value in patients seeking opioids. A test positive for cocaine is a true positive for that drug—and no patients testing positive for cocaine should receive opioids. Patients stating they have a prescription for an opioid but who test negative for that opioid should raise concern about diversion. Further discussion is required before any consideration of opioids for such patients.

A 44-year-old woman with 10 years of low-back pain and who states she takes a sustained-release morphine preparation (and has done so for four years) comes to the ED saying she has "run out" and needs some pills for the next three days until her doctor gets back in town.

- **Avoid giving a short-acting opioid in the ED**. Injections of short-acting opioids can lead to acceleration of tolerance and create institutional dependency, worsening catastrophizing. There is no upside to this practice. If patients who take opioids for chronic pain have a new pathology requiring additional opioids, the best approach is a PCA pump that is locked—inadequate pain relief in these situations increases risk of abuse in previously stable patients.
- **Do not prescribe opioids at discharge**. Patients on long-term opioids have an identified primary prescriber and should have their opioids prescribed *only* by that provider. They should not receive a prescription to "hold them over" until they see their caregiver; they would receive the identical response from their primary prescriber if they presented before their scheduled appointment and asked for additional opioids. Several guidelines suggest that if you do choose to provide opioids at discharge, it should be a dose with which you are comfortable in a quantity that suffices until the next business day. Even if this option is chosen, it should never be repeated a second time.
- **Make use of any existing state drug database.** This is the only practical way to identify double doctoring and dates of prescriptions. This has had a dramatic effect on physicians' ability to identify patients seeking additional prescriptions and allows for a "level playing field" in the discussion with patients.

Avoid Labelling Patients or Turning Them Away

Patients with addiction disorders have a medical condition requiring care, just as do alcoholics and smokers. It is part of our mandate to identify this condition and offer support. Patients who use drugs intravenously are at high risk for serious infections; addicts are always at risk for overdose or acute withdrawal. Placing signs in the waiting room advising patients that opioid prescriptions are not renewed not only breaches EMTALA regulations but risks turning away very sick patients (with an addiction disorder) who feel they will not be cared for. It also encourages patients in severe pain to leave without receiving care.

Patients with an addiction disorder are not immune to painful conditions. They are not mutually exclusive. Identifying patients as addicts or "drug seeking" often precludes any further consideration of comorbidity. Addiction is but one medical condition, just as is diabetes, and does not prevent the presence of a second illness. To the contrary, they are *more* at risk because of their primary condition.

A Final Suggestion

Most people with personality disorders have less refined interpersonal social skills. They succeed in getting what they want through more obvious manipulation, such as overpraising or creating feelings of guilt or anger. Every physician has to recognize that such feelings are not normal during a patient encounter and should be recognized for what they are: manipulation by the patient. Rather than reacting to those emotions, the physician should recognize them as a sign of a personality disorder and respond accordingly with no emotional responses and the establishment of limits for that encounter. A typical response could be: "I understand that you say you are in a lot of pain. I am going to do everything I can to help you get that pain under control now and after discharge. What I am not able to do, however, is provide opioids for this particular situation. I am certain that we will still be able to take steps to get your pain better controlled."

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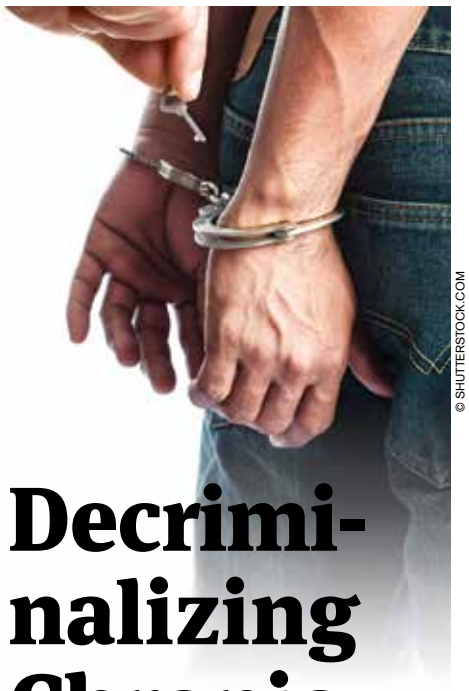

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Decriminalizing Chronic Pain: How to Approach Those Without Adequate Follow Up

by JIM DUCHARME, MD, CM, FRCP

SCENARIO 1: Mr. Smith is a 42-year-old male who has come to the ED because he is in severe pain from a chronic low back condition lasting at least 10 years. He cannot stand upright. He moved into town when his company closed two months ago so he could stay with his sister. He is unemployed. He says his meds—duloxetine, tramadol, and celecoxib—are running out. There is no pain clinic in the community, and he has no family physician.

SCENARIO 2: Mrs. Smith is a 51-year-old female with 15 years of chronic neuropathic leg pain. She has been discharged by her family physician because her urine tested positive for cocaine twice—she admits this because she is desperate to get care. The physician rapidly tapered her off opioids (in 10 days), and she has just finished a horrible week of withdrawal. She comes into the ED with severe pain and has no analgesic prescriptions.

These types of scenarios are not rare in emergency medicine. After all, we are the safety net for health care. Patients with varying types of chronic medical conditions and nowhere else to go end up in the emergency department and are routinely seen in county hospitals. Emergency physicians have had no training in any chronic medical condition, including chronic pain with its inherent biases and risks of opioid misuse. Just as we do not provide ongoing care for patients with insulin-dependent diabetes, we should not provide ongoing care for patients with chronic pain. There is a difference, however: patients with the former can continue to receive insulin and can often be cared for in hospital or community clinics, whereas the latter are shunned. Further, emergency physicians have received zero training in chronic pain and so often have a starting viewpoint that this is "not our problem."

When you talk to patients with chronic pain who have been successfully managed, they will usually state how they have learned to deal with their problem and how their coping skills have improved. They will tell you that medications ultimately played a minor role—essential for getting the pain under control at the start but less important as other steps are taken. The American Pain Society will tell you that mindfulness is an essential primary aspect of care for these patients. Patients with fibromyalgia will experience a 75 percent decrease in pain if they complete and maintain a four-day-a-week exercise program for at least four to six weeks. How does this help us in the ED? We need to sit down with these patients and help them review how they are in charge of their illness; dependency on others is a sign of failure. Specifically, areas patients need to work on include:

1. Learning about their illness/condition. We need to help educate them about the (minimal) role of the ED as well as what their condition is and why they have pain.

2. Developing coping skills. Catastrophizing, social isolation, and despair all lead to marked worsening of the pain. Dealing with flare-ups in their pain by coming to the ED demonstrates a failure to understand their condition and how to deal with the worse days. You might want to ask a social worker to get involved for this discussion, as well.

3. Learning what the community has to offer. That means the staff in the ED needs to know what is available: social work, support groups for fibromyalgia, etc.

It is my experience that this type of discussion rarely takes more than 10 to 15 minutes and is worth every minute. If we do not take the time to explain their responsibilities and the role of the ED, these patients will keep returning, expecting to get a prescription and developing an ever-increasing institutional dependency—a poor coping trait and a growing burden on the ED.

We are all responsible for every script we write. No physician in the ED should initiate opioids for patients with chronic pain, renew prescriptions of opioids for such patients, or provide short-acting opioids to "get them out of the ED."

Managing Medications

We are all responsible for every script we write. No physician in the ED should initiate opioids for patients with chronic pain, renew prescriptions of opioids for such patients, or provide short-acting opioids to "get them out of the ED." The latter creates institutional dependency and also accelerates tolerance. There is no positive for patients other than

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perhaps a two-hour decrease in pain, a pain they have had for years. Opioids should be reserved in opioid-dependent patients for acute breakthrough pain or for acute new injuries or conditions, such as a new fracture.

Other medications for pain, such as a tricyclic or gabapentinoid for new zoster-related neuropathic pain, may be of benefit and worth initiating. A SSRI, such as duloxetine for chronic osteoarthritis or low back pain, combined with acetaminophen or a NSAID may provide valid relief. Patients can follow up in a medical clinic without fear of bias and start on the long road to stabilization. We do the same for patients with hypertension, so why not for chronic pain? To do so, however, means we have to learn more about chronic pain conditions and the medications and doses required. Dosing for chronic pain may be very different than for other indications, for example:

- 300 mg gabapentin a day for seizure disorders but up to 3,600 mg for pain
- 25–75 mg nortriptylline for depression but up to 250 mg for neuropathic pain

> It is not our role to care for them on an ongoing basis but to educate them and start them in the right direction.

Still, all patients with chronic pain are treated the same way with medications: "start low and go slow," avoiding adverse effects and identifying the lowest effective dose possible. The starting dose you are comfortable prescribing will be the same starting dose a pain physician would use, but they then take up to three months to get to the right dose and combination of medications.

It is up to the ED group as a whole to work with the hospital and community to identify potential resources for patients with chronic pain; that way, the nursing staff and the physicians can guide the patients properly. It is not our role to care for them on an ongoing basis but to educate and start them in the right direction. We are also there for acute worsening of their pain and to identify other pathologies as causes of new or worsening pain. In the end, our role for patients with chronic pain is almost the same as for every other chronic medical condition.