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.

Table 1: Opioid Risk Tool from the Canadian Opioid Guideline

<table>
<thead>
<tr>
<th>ITEM</th>
<th>MARK EACH BOX THAT APPLIES</th>
<th>ITEM SCORE IF FEMALE</th>
<th>ITEM SCORE IF MALE</th>
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<tr>
<td>Prescription Drugs</td>
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<td>Personal History of Substance</td>
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<td>Alcohol</td>
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<td>Illegal Drugs</td>
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<td>History of Preadolescent Sexual Abuse</td>
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<td>Psychological Disease</td>
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<td>Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia</td>
<td>[ ]</td>
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<td>Depression</td>
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<td>1</td>
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<tr>
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More information is available at http://nationalpaincentre.mcmaster.ca/opioid.

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 pathologic-paradoxically, it is decided 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 are not suffering from a new acute pathology. Intervening with ketamine in analgesic doses can abort the acute flare-up in CRPS. For patients with FM, reassurance they are not suffering from a new acute condition unrelated to their chronic pain condition—the latter does not make them immune to other pathology.

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.

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 about chronic pain and addiction will allow us to provide the necessary care.

Hands On: Chronic-Pain Management at Hands on Care
A few years ago, in Mackenzie, I was directly overseeing 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 that requires 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 were used. This approach has been quite effective and include limiting patients to a single prescription, 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.

The Official Voice of Emergency Medicine
CARENOW.COM
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 160 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 personal disorder 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.

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, © Shutterstock.com
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.

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.

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

by JIM DUCHARME, MD, CM, FRCPC

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.

CHRONIC PAIN: THEIR PAIN OR YOURS?

by DR. DUCHARME

Approach Pain: Chronic nalizing Decriminations and nowhere else to go end up in the 12

pain and has no analgesic prescriptions. rapidly tapered her off opioids (in 10 days), for cocaine twice—she admits this because physician because her urine tested positive

ADASUVE® (loxapine) inhalation powder 10 mg

THE FIRST AND ONLY...

Orally inhaled medicine indicated for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults

INDICATIONS AND USAGE

ADASUVE® (loxapine) inhalation powder, for oral inhalation use, is a typical antipsychotic indicated for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults. Efficacy was demonstrated in 2 trials in acute agitation: one in schizophrenia and one in bipolar I disorder.

Limitations of Use: As part of the ADASUVE Risk Evaluation and Mitigation Strategy (REMS) Program to mitigate the risk of bronchospasm, ADASUVE must be administered only in an enrolled healthcare facility.

IMPORTANT SAFETY INFORMATION

WARNING: BRONCHOSPASM and INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Bronchospasm
ADASUVE can cause bronchospasm that has the potential to lead to respiratory distress and respiratory arrest. Administer ADASUVE only in an enrolled healthcare facility that has immediate access on-site to equipment and personnel trained to manage acute bronchospasm, including advanced airway management (intubation and mechanical ventilation). Prior to administering ADASUVE, screen patients regarding a current diagnosis, history, or symptoms of asthma, COPD and other lung diseases, and examine (including chest auscultation) patients for respiratory signs. Monitor for signs and symptoms of bronchospasm following treatment with ADASUVE. Because of the risk of bronchospasm, ADASUVE is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ADASUVE REMS. Increased Mortality in Elderly Patients With Dementia-Related Psychosis
Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. ADASUVE is not approved for the treatment of patients with dementia-related psychosis.

• ADASUVE is contraindicated in patients with the following:
  – Current diagnosis or history of asthma, chronic obstructive pulmonary disease (COPD), or other lung disease associated with bronchospasm
  – History of bronchospasm following ADASUVE treatment
  – Known hypersensitivity to loxapine or amoxapine. Serious skin reactions have occurred with oral loxapine and amoxapine
• ADASUVE must be administered only by a healthcare professional
• Prior to administration, all patients must be screened for a history of pulmonary disease and examined (including chest auscultation) for respiratory abnormalities (eg, wheezing)
• Administer only a single 10 mg dose of ADASUVE within a 24-hour period by oral inhalation using the single-use inhaler

HOW LONG CAN YOU WAIT?

When agitation escalates...

RESEARCH

The most common adverse reactions (incidence ≥2% and greater than placebo) in clinical studies in adults with schizophrenia or bipolar I disorder included:

– Hypotension
– Orthostatic hypotension
– Syncope
– Seizures
– Increased mortality in elderly patients with dementia-related psychosis

ADASUVE was statistically significantly superior to placebo in the following efficacy measures:

– Reduction from baseline in agitation症状2,3
– Statistically significant, with improvement at 10 minutes (SECONDARY)
– AT 10 MINUTES

The mean baseline PEC scores in all treatment groups were 17.3 to 17.7.

ENDPOINT

Reduction from baseline in agitation symptoms2,3

(PRIMARY)

SCHIZOPHRENIA

27%53%

BIPOLAR I DISORDER

33%49%

ACEP NOW JULY 2014

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10

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ADASUVE® (loxapine) inhalation powder, for oral inhalation use, is a typical antipsychotic indicated for the treatment of acute agitation associated with schizophrenia or bipolar I disorder in adults. Efficacy was demonstrated in a double-blind, placebo-controlled, fixed-dose trial including 344 patients who met DSM-IV criteria for schizophrenia and in another study, 314 patients who met DSM-IV criteria for bipolar I disorder. Patients were randomized to receive loxapine 10 mg or placebo for 100 days. The mean baseline PEC scores in all treatment groups were 17.3 to 17.7.

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 those who need long-term opioid therapy.

CONTINUED on page 14
It is not our role to care for them on an ongoing basis but to educate them and start them in the right direction.

Because clinical trials in patients with asthma or COPD demonstrated that the degree of bronchospasm, as indicated by changes in forced expiratory volume in 1 second (FEV1), was greater following a second dose of ADASUVE, limit ADASUVE use to a single dose within a 24-hour period.

ADASUVE can cause bronchospasm that has the potential to lead to respiratory distress and respiratory arrest. Administer ADASUVE only to patients in an enrolled healthcare facility that has immediate access on-site to equipment and personnel trained to manage acute bronchospasm, including advanced airway management (intubation and mechanical ventilation) (see Warnings and Precautions (5.1, 5.2)).

Prior to administering ADASUVE, screen patients regarding a current diagnosis, history, or symptoms of asthma, COPD and other lung diseases, and examine (including chest auscultation) patients for respiratory signs. Monitor for signs and symptoms of bronchospasm following treatment with ADASUVE (see Dosage and Administration (2.2, 2.3) and Contraindications (4)).

Because of the risk of bronchospasm, ADASUVE is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ADASUVE REMS. (see Boxed Warning and PRECAUTIONS (5.1)) Required components of the ADASUVE REMS are:

- Healthcare facilities that dispense and administer ADASUVE must be enrolled and comply with the REMS requirements. Certified healthcare facilities must have on-site access to equipment and personnel trained to provide advance airway management, including intubation and mechanical ventilation.
- Wholesalers and distributors that distribute ADASUVE must enroll in the REMS and distribute only to enrolled healthcare facilities.

Further information is available at www.adasuverems.com or 1-855-755-0400.

5.3 Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients receiving antipsychotic treatment for agitation associated with dementia, defined death as occurring in the presence of other serious medical conditions (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotics can result in deaths associated with increased mortality. The risk of death was generally lower for atypical compared to conventional antipsychotic drugs, but it was notable that all antipsychotics are at increased risk of death. Analyses of 17 placebo-controlled trials of ADASUVE, there were no reports of seizures. In the 17 placebo-controlled clinical pulmonary safety trials in healthy volunteers, one death occurred in a patient who stopped taking the medication. The death was considered to be a consequence of bronchospasm and mechanical ventilation. Other deaths were considered to be a result of the underlying disorder.

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