# Ethical Management of Pain in the Real World-- Do They Deserve Drugs?

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# Ethical Principles

- Justice
- Autonomy / Shared decision making
- Beneficence (Do good)
- Non-maleficence (Do no harm)
- Veracity
  - Treatment options and expectations
- Fidelity / Advocacy

Fitzgerald, 1999

# Attitudes and Consequences

- When patients have withdrawal from tricyclics, corticosteroids, and other meds, we think nothing of it
- Patients take many different meds chronically--insulin, BP meds, and are not punished for that
- Twelve “cured” cancer patients committed suicide because of untreated pain related to their cancer or its treatment

# Prescriber Issues

- Is this pain?
- Is this addiction?
- Is this pseudoaddiction?
- Is this diversion?
- Is this psychiatric disease?

# Patient Fears

- Dying
- Being labeled a “bad” patient
- Isolation
- Loss of control
- Becoming an “addict”

# The Drug Problem

- <2% of the American population are hard core drug addicts, 3-4% are drug-abusers
- 94% of the population do not "do drugs"
- The incidence of addiction is the same today as 100 years ago.
- The incidence of addiction is the same in all groups and strata of the American society.

# Biases

## both patients and health care professionals

- Cultural
- Religious
- Familial
- Existential

# Cultural Biases

- Young African-Americans or Hispanics will receive ½ the total dose of analgesic given to middle-aged whites for the same surgery

  Morgan, 1988

- Pharmacies in predominantly African-American and Hispanic areas in New York City do not stock Schedule II opioids

  Morrison, *NEJM,* 2000

# Cultural Biases

- Females of minorities over the age of 70 years are more likely to endure undertreated pain, even *untreated pain* in SNFs

  Bernabei, *JAMA,* 1998

- African-Americans in ERs, with solitary long-bone fractures, are 66% more likely to be refused pain medicine

  Todd and Deaton, *Annals of Emergency Medicine, 2000*

# Cultural Biases

- Conservatively reared African-Americans look down and to the side to show respect to doctors, nurses, and the clergy
- Whites distrust persons who do not look them “in the eye.”

# Religious Biases

- Is pain redemptive?
- Does it wipe clean the slate of one's sins?
- The most difficult aspect of this bias is that religiosity that allows us to righteously judge the worthiness of individuals

# Familial Biases

- Stoics do not talk about pain
  - They dislike listening to pain complaints
- The majority of health care professionals are stoics
- Epicureans talk endlessly about their pains, thinking it was nice of us to ask
  - They quickly become “bad” patients

# Existential Biases

Each of us can remember the first time that we were “scammed” by a drug seeker.

Unfortunately, we resolve that it will never happen again. This makes us feel right in refusing requests for medication for pain.

# True Addiction

- Compulsive use despite harm
- Quality of life is not improved by the medication

# Pseudoaddiction
## the end result of undertreatment of pain

- Drug-seeking behaviors
- Drug hoarding
- Usually going to more than one pharmacy and one physician
- Usually "cured" by increasing the daily dose of opioid and monitoring the patient

Weissman and Haddox. *Pain, 1989.*

# Physical Dependence

- Occurs in all patients on chronic opioids
- Withdrawal will be produced by the administration of an antagonist agent such as pentazocine, buprenorphine, nalbuphine, or butorphanol -- or by stopping medications abruptly
- Withdrawal is a sign of mismanagement, not of addiction

# Who is the Addict-To-Be?

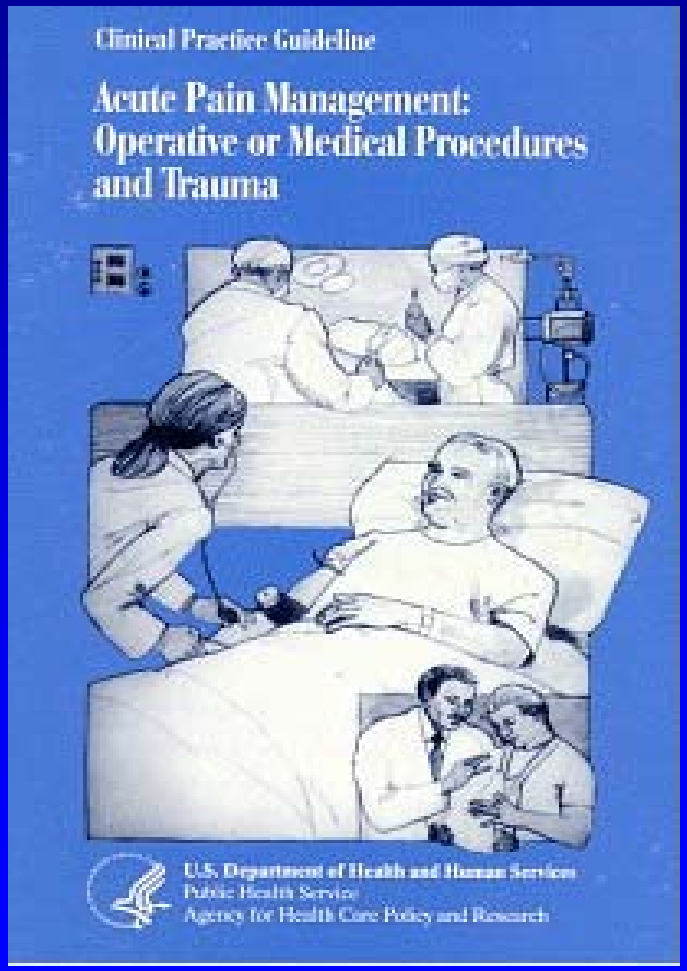
- Regular, recent use of illicit drugs
- History of alcoholism or treatment
- History of drug-related treatment and problems
- Loss of jobs due to drug use
- History of mental illness
  - Major depression--five times as likely to abuse medications

# Reasons for Poor Pain Control

- No accountability for poor pain management
- Failure to routinely assess and document pain
- Lack of practical treatment protocols
- Perception of pain as insignificant symptom in face of disease

Dahl, 1999

# Acute Pain Treatment Guidelines




Agency for Healthcare Research and Quality

1-800-358-9295

www.ahrq.gov

# Federal Guideline Compliance

| | |
|---|---|
| Pre-op discussion of pain relief options | 13% |
| Regular evaluations of pain, operative day | 51% |
| Use of pain assessment tool, operative day | 46% |
| Use of behavioral techniques | 11% |
| Use of medications to maintain baseline control | 55% |
| Use of Demerol® as first-line analgesic | 51% |

*IPRO*, 1997

# JCAHO Standards

"The patient's right to pain management is respected and supported.

The HCO plans, supports, and coordinates activities and resources to assure the pain of all patients is recognized and addressed appropriately."

# JCAHO Standards

- Every patient will have a “screening” interview about pain on admission
- Pain as the “5th vital sign” -- only if pain is a problem before our procedures
- “Dedicated” pain professional available for all patients
- Pain management protocols in place
- All staff will have in-services twice yearly

# Assessment

- Believe the patient
- Listen to the patient
- Have the patient rate the pain
- Do a good history and physical exam
- Give the patient pain relief while completing the workup
- Reassess frequently to assure the best outcome

Foley, *NEJM*. 1985

1. What do you think causes your pain?

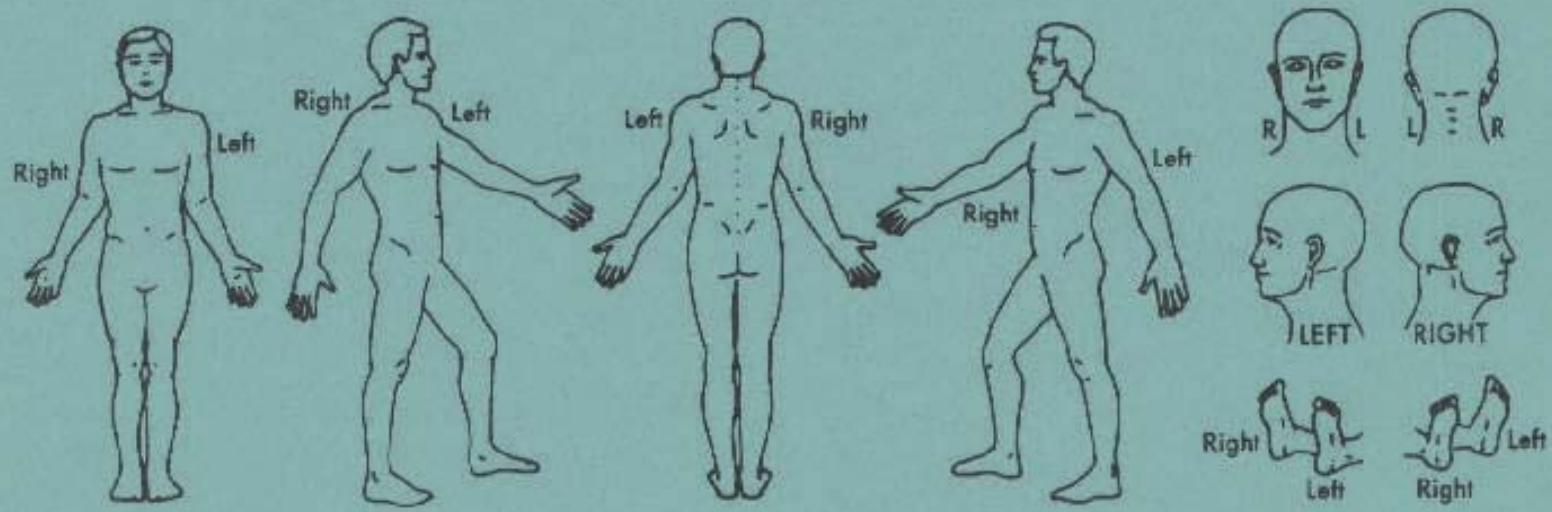
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
0 1 2 3 4 5 6 7 8 9 10

**No Pain** **Moderate Pain** **Worst Possible Pain**

2. Using the scale above, what is your pain at present? (Severity 0-10) _____

a) Worst it gets _____ (Severity 0-10) b) Best it gets _____ (Severity 0-10) c) Desired comfort _____ (Severity 0-10)

3. Looking at the pictures below, where is your pain?



4. **What does your pain feel like?** (prickling, ache, burning, sharp throbbing,dull, cramping, pressure, shooting?)
5. **Is your pain?** brief, constant, comes and goes?
6. **Your view of pain:**

   Does pain affect your energy level?

   Does pain affect moving?

   Does pain interfere with sleep?

   Does pain affect emotions and mood?

   Does pain affect communication?

   Does pain cause nausea/vomiting?

   Does pain affect breathing?
7. **Are you taking any pain medications?**

   If yes, what are they? _____
8. **How often do you take this medication(s)?**
9. **Do you need medication for breakthrough pain?**

   **How often?** _____
10. **What else relieves pain?** (i.e.., music, positioning, relaxation, exercises)
11. **What causes or increases your pain?**

# Pain Treatment Options

- Spiritual
- Psychological
- Physical
- Surgical / Anesthetic
- Pharmacological

# Spiritual Interventions

- "Ministry of Presence"
- Listening
  - Average length of "opening statement" by the patient is only 3 minutes
- Planning
- Sharing
- Prayer

# Am I a Good Listener?

- 77% of patient opening statements to the physician are interrupted (Beck and Frankel, 1984)
- 94% of interruptions conclude with the physician obtaining the floor (Frankel, 1984)
    - Only 1 of 52 patients went on to complete his statement of concern
    - Patient/Physician agreement of presenting complaint was 76% for somatic complaints, but only 6% for psychosocial problems

# Psychological / Psychiatric Interventions

- Biofeedback
- Relaxation
- Imagery
- Hypnosis and self-hypnosis
- Group and / or individual therapy

# Physical Interventions

- Manipulation
- Massage
- Acupuncture
- Topical preparations applied by the patient and family
- Self-directed exercises through physical therapy

# Surgical / Anesthetic

- Use with greatest caution
  - Chemical
    - Blocks, Ablations
  - Surgical
    - Peripheral Neurectomy, Rhizotomy, Methylmethacrylate
- Be aware of the long-term effects of some interventions

# Pharmacological Interventions

- Antidepressants
- Anticonvulsants
- Anti-inflammatories
- Analgesics

# Antidepressants
## Tricyclics

- amitriptyline, *nortriptyline*
- imipramine, *desipramine*
- doxepin
- trazodone

# Anticonvulsants
## for membrane stabilization

- *Gabapentin (Neurontin)*
- *Oxcarbazepine (Trileptal)*
- *Topiramate (Topamax)*
- *Lamotrigine (Lamictal)*
- Valproic acid (Depakote)
  - watch for hepatic toxicity
- Carbamazepine (Tegretol)
  - watch for hepatic and bone marrow toxicities

# Anti-inflammatories

## Use with great caution!

- NSAIDs caused 16500 deaths in ‘98 and ‘99
- 107000 admissions to hospitals
- Use non-acetylated salicylates if intolerant of traditional NSAIDs
  - choline magnesium trisalicylate
  - salsalate
- Consider Cox-2 inhibitor or misoprostol/diclofenac combination tablet

# Opioid Analgesics

- Use long-acting opioids for the baseline level in scheduled doses
  - This achieves nearly constant blood levels to treat the constant level of pain
- Use short-acting opioids only for pre-emptive or rescue dosing
  - This permits patients to participate in activities that would otherwise be too painful, e.g. physical therapy, shopping, etc.

# Intramuscular Opioids

- Interpatient variability
  - Peak plasma level: 2-5 fold variability
  - Time to peak level: 3-7 fold variability
- Intrapatient variability
  - Peak plasma level: 2 fold variability
- Pain cycles

Austin, *Pain,* 1980

# "Patient Controlled" Analgesia
## Concentrations

- Morphine - 1 mg/ml
- Fentanyl - 10 mcg/ml
- Hydromorphone - 0.2 mg/ml
- Meperidine - not recommended by federal guidelines

# "Patient Controlled" Analgesia

- Loading dose - repeat until patient comfortable
  - morphine - 50 mcg/kg  q 5-10 minutes
  - fentanyl - 0.5 mcg/kg  q 5 minutes
  - hydromorphone - 10 mcg/kg  q 10 minutes

# "Patient Controlled" Analgesia

- Maintenance dose
  - morphine - 20 mcg/kg  q 5 minutes
  - fentanyl - 0.2 mcg/kg  q 5 minutes
  - hydromorphone - 4 mcg/kg  q 10 minutes

# PCA at Night

- At 2200h, add up the total mg of PCA opioid given since 0600h that same day. Divide this total by 16 to give the average hourly dosing with the PCA.
- Set the PCA to run at this rate continuously during the night
- At 0600h, resume regular PCA settings.

# Changing from PCA to Oral

- What was the total dose of PCA opioid used during the previous 24 hours?
  - Convert to oral morphine equivalents, then use morphine or oxycodone in 1:1.5 dosage
    - Patient used 40 mg PCA MS (or 8 mg Dilaudid) on day before switch
    - Convert as 120 mg ORAL MS
      - CR oxycodone 40 mg q 12 hours with 15 mg rescue doses
      - OR CR morphine 60 mg q 12 hours with 15 mg rescue doses

# What's Wrong with this Order?

- Morphine, 2 mg IV per hour. Titrate to comfort.
- Patient is a 47 years old male with terminal pancreatic cancer. His dose of MSContin at home was 300 mg q 12 h, roughly 8 mg IV per hour.
- 48 hours after admission, his dose of MS IV was 98 mg/hr. Patient had respiratory arrest

# How Best to do it?

- The order should read “nurse/pharmacist to determine hospital dose based on home dose.”
- DO NOT TITRATE IV RATE
- Offer rescue dose q 20 minutes that is equal to the hourly dose to titrate for comfort.
- Basal rate of IV infusion can be adjusted on a daily basis

# Mild to Moderate Pain

**1-3/10 on visual analog scale**

Adjuvant Analgesics

- Acetaminophen 650 mg PO or PR q 4 h
- Ibuprofen 400-600 PO q 6 h
- Choline magnesium trisalicylate 750-1500 mg PO bid
- Ketorolac 15-30 mg IV q 6 h (Maximum 3 days)

# Moderate Pain

**4-7/10 on visual analog scale**

## Opioid +/- adjuvant

Scheduled Long-Acting Agents

- CR oxycodone 10-20 mg PO q 12 h
- CR morphine 15-30 mg PO q 12 h
- Levorphanol 2 mg PO q 6 h
- Methadone 2.5-5 mg PO q 6 h
- Transdermal fentanyl, 25 mcg/hr

# Moderate Pain
## Opioid +/- adjuvant

Pre-emptive or Rescue doses for breakthrough

- IR oxycodone 5 mg, 1-2 PO q 4 h prn
- IR morphine 15 mg, 1-2 PO q 4 h prn
- IR hydromorphone 2-4 mg PO q 4 h prn
- Hydrocodone 10 mg/APAP 500 mg, q 3 h prn (Not recommended)

# Severe Pain

**7-10/10 on visual analog scale**

**Stronger opioid dose +/- adjuvant**

Longer-acting opioids, scheduled dosing

Titrate up as necessary every 24 hours for comfort

- CR oxycodone 40-80 mg q 12 h (No ceiling dose)
- CR morphine 60-100 mg q 12 h (No ceiling dose)

Titrate up as necessary only very slowly

- Methadone 5-10 mg q 6-8 h
- Levorphanol 4 mg q6 h
- Transdermal fentanyl 50-75 mcg/hr q 72 h

# Severe Pain

**Stronger opioid dose +/- adjuvant**

**Titrate up as necessary every 24 hours for comfort**

Shorter-acting agents for breakthrough pain

- The rescue dose of the immediate release agent should be approximately 15-20% of the total daily dose.

# Potential for Abuse

- EVERY opioid has the potential to be abused by those determined to do so
- Sale or diversion to street market
- Altering the mode of delivery
  - Removing the CR coating of OxyContin
  - Cutting the corner off Duragesic patches to suck out the fentanyl or making “chiclets”
  - “Dope on a rope” to produce “Liquid Gold”

# Can opioids be prescribed for any chronic pain?

- The Controlled Substances Act of 1970 specifically states that opioids may be prescribed for ***pain***, but not for ***addiction***
- To be precise, encourage the prescriber to put "for pain" in the *sig.* of the prescription. This will help avoid calls from the DEA
- Remind the prescriber to write "chronic pain patient" or "terminally ill" on the prescription blank

# Medication Management Agreements

- Medication is the responsibility of the patient
- No use of illicit substances is allowed
- Only one physician prescribes opioids
- Only one pharmacy and one pharmacist is used
- Patient waives right to privacy regarding medications
- Unannounced urine drug screens are used

# Do These Things and Stay Out of Trouble

- History and physical examination
- Treatment plan and objectives
- Records
- Consultation
- Periodic review
- Informed consent / Medication agreement
- Compliance with controlled substance laws and regulations

# Pain Treatment Goals

- Restoration and maintenance of hope
- Helping the patient grieve for the “former self” that has been changed forever
- Reduction of the pain experienced by 50%
- Becoming strong advocates for the well-being of our patients

# Pain Treatment Goals

- Restoration and maintenance of hope
- Helping the patient grieve for the “former self” that has been changed forever
- Reduction of the pain experienced by 50%
- Facilitate continued employment
- Becoming strong advocates for the well-being of our patients

# "Re-medicalizing the problem"

**Spanos, 1998**

- Patient with a pain problem
- Subjective report
- Objective findings
- Assessment
  - Pain? Pseudoaddiction?
  - Addiction?
  - Diversion?
  - Psychiatric disease?

# Case Study

- 37-year-old male with intractable pain in the epigastrium
- Six months post “cure” of esophageal carcinoma
- Patient referred because of refusal to be tapered off opioids (CR oxycodone, 80 mg BID)

# Case Study

- Referral to original surgeon for re-evaluation of the nodule
- Recurrent carcinoma
- As disease became worse, eventual dose of CR oxycodone 720 mg q 12 h
- Patient maintained control of his company until two days before his death

# Aberrant Behaviors
## Less Predictive of Addiction

- Aggressive complaining about need for more medication
- Drug hoarding during periods of less pain
- Requesting specific drugs
- Openly acquiring similar meds from other providers

# Aberrant Behaviors
## More Predictive of Addiction

- Selling prescription medications
- Prescription forgery
- Stealing or “borrowing” from others
- Injecting oral formulations
- Obtaining medications from “the street”
- Concurrent use of alcohol or illicit drugs

# Case Study

- 42 years old single male lawyer admitted with spontaneous rupture of diverticulum of sigmoid colon
- Post-op received 180 mcg/hr epidural fentanyl for 48 hours (equivalent to 1800 mcg/hr IV)
- After epidural out, switched to Vicodin, 5/500, 1-2 q 3h prn
- Patient given Demerol, 100 mg IV with 1 hour of relief, then confusion
- Toradol, 30 mg IV given QID x 6 days

# Case Study

- After 8 days, patient referred to chronic pain service by a cardiologist/friend of his fiancée
- Pt started on OxyContin 80 mg BID
- Discharged 2 days later on OxyContin 20 mg, 1-2 BID with rescues
- Patient tapered off medications over two weeks period

# Case Study

- When patient admitted for takedown of colostomy, he went home after 23 hours on OxyContin 10 mg, 1-2 BID with rescues
- Patient returned to work 1 week after surgery
- Patient tapered himself off the OxyContin two weeks after the surgery

# Post-Operative Pain

- 37 y o female with 22 prior surgeries to correct congenital deformity of the right upper extremity, last was 4 days prior to consult
- Pt receiving demerol 100 mg IM q 4-6 h
- Pain rating 10/10
- In getting ready for discharge, pt changed to hydrocodone /APAP 7.5/750, 1-2 q 3 h prn
- Discharge prescription for 12 tablets in front of chart

# Getting Them Home

- Had been on CR morphine at home prior to this hospitalization, 60 mg q 12 hours
- Home Rx--CR morphine 100 mg q 12 hours PLUS immediate release morphine 30 mg q 3h if needed for breakthrough pain
- Anticonvulsant, tiagabine 4 mg at h s with snack added for “shooting, stabbing” sensation
- Scheduled for follow-up in office in 6 days
- Next surgery, patient went home 21 hours after surgery

# Keeping Them Home

- 33 y o female with post-op pelvic tumor removal seen in ER on 3 occasions in 2 days for uncontrolled pain
- Admitted for pain control, had repeat surgery, with nothing found
- Pt receiving Percocet, 2 tabs q 4 hours
- After 3 weeks in hospital, chronic pain consult obtained

# Keeping Them Home

- Pt sent home that day on CR oxycodone 40 mg q 12 hours with rescue dose of IR oxycodone, 15 mg q 3 hours for breakthrough pain
- Follow-up in office in 5 days

# Non-Cancer Neuropathic Pain

- 28-year-old female with RUE “burning and electric” pain as result of a 300 pound patient falling on her
- 67 stellate ganglion blocks in 6 months
- Pain unchanged
- Medication--Vicodin ES, 1 q 4h prn

# Non-Cancer Neuropathic Pain

- Desipramine, 25 mg daily
- Neurontin, 100 mg daily
- CR oxycodone, 10 mg 1-2 BID
- IR oxycodone, 5 mg, 1 q 3 h prn
- Referral to psychologist for evaluation of secondary gain and possible marital problems

# Non-Cancer Neuropathic Pain

- 38 year old male referred by IPD Narcotics division for phoning in his own Lortab prescriptions
- Works for construction crew
- Married, two children
- No arrest record

# Non-Cancer Neuropathic Pain

- Post-traumatic deformity of the right tibia with distortion of the ankle
- No insurance
- Desipramine, 50 mg daily
- Methadone, 10 mg TID
- Working regular hours
- Pain scores have decreased from 7/10 to 3/10

# Non-Cancer Neuropathic Pain

- 40-year-old-female referred by psychiatrist
- Non-functional, depressed, previous suicide attempt
- Two children, ages 10 and 12
- Husband is a lawyer
- Taking 12-16 Vicodin per day
- Also on Prozac, 80 mg per day

# Non-Cancer Neuropathic Pain

- Pain rating 10/10
- Seven failed back surgeries--last was removal of fixation hardware
- Previous cervical fracture (MVA) with foraminal compromise and neuropathic symptoms

# The Beginning

- See patient with husband to enlist his help in monitoring her care
- Add small dose TCA to regimen--desipramine
- Ask what is the MOST analgesic ever taken in one day (16)
- INCREASE that by 50% (Give 24 per day)
- Use IR oxycodone to avoid APAP toxicity

# Instructions to Patient

- Lay out 24 tablets every morning
- When you take a dose of medication, write down even just one word to describe your pain--at least one word per day
- Return in one week with pill bottle, written journal, and husband

# Is This An Addict? NO!

- Patient returned as scheduled
- Patient had pills left over
  - Able to control use
- Patient had prepared two meals for her family during that week

# The Following Period

- On CR oxycodone 80 mg BID
- IR oxycodone 30 mg q 3 h prn
- Runs a carpool, chairs her parish committee
- In charge of St Vincent de Paul Society for the parish
- President of Parents Association at the school

# Post Trauma Pain

- 92 y o female in auto accident
- Fracture of left ribs 2-5 and fracture of sternum
- Darvocet N-100, 1 6 h prn for pain
- 36 hours after admission, patient begins to be confused, disoriented, and disheveled
- Physical therapy started, but patient “not cooperative”

# Post Trauma Pain

- O2 sats 80, Rales in bases
- Son insisting that her pain regimen be more aggressive (OxyContin 20 mg po q 12 h with 10 mg IR Oxycodone q3h prn AND 1 hour before PT)
- Attending physician afraid that dose would cause her death

# Post Trauma Pain

- Patient home less than 48 hours after regimen started. Home dose was CR oxycodone 10 mg q 12 h with 5 mg IR rescues
- Patient was able to drive herself to PT
- Two weeks later, patient was using only topical ketoprofen for local pain and sleeping on her “magnet” mattress pad

# Medication Management Agreements

- Medication is the responsibility of the patient
- No use of illicit substances is allowed
- Only one physician prescribes opioids
- Only one pharmacy and one pharmacist is used
- Patient waives right to privacy regarding medications
- Unannounced urine drug screens are used

# Avoiding Problems

- Require picture ID at first visit
- Require Picture ID of anyone picking up a prescription for a home-bound patient
- No opioids are prescribed on nights and weekends
- Lost or stolen medications are NOT replaced

# Pain Treatment Goals

- Restoration and maintenance of hope
- Helping the patient grieve for the “former self” that has been changed forever
- Reduction of the pain experienced by 50%
- Becoming strong advocates for the well-being of our patients

# Avoiding Problems

- Patient unable to urinate for drug screen
  - "No pee, no prescription"
- If a male patient leaves the office to "get a coke" to stimulate urine production, be inclined to get estrogens checked on the urine.

# Considering an opioid?

- Patient may improve and want more of this
- Side effects may cause the patient to have an accident or cause injury Vainio, *Lancet,1995.*
- Pharmacist may report you to the authorities if s/he does not agree with the regimen
- If an opioid is started, and the patient improves, what will my peers think of my prescribing and treatment plans?

# Tolerance

- Some of these patients are hard to tolerate
- Medication tolerance is not a great problem
  - Sometimes it's hard to get the patient up to the best dose without losing your nerve
- The tolerance that develops is most often to the side effects--sedation, pruritis, nausea
- Tolerance *never* develops to constipation

# How do I deal with it?

- Learn to laugh with others and at yourself
- Conscious relaxation
- Rhythmic breathing
- Set aside time for yourself
- Limit caffeine and other stimulants
- Exercise

# What exercise is the most relaxing for you?

- Try to find an exercise that is enjoyable
  - Use several different exercises
- Don’t try to be a champion
- Don’t try to lose weight

# How to live a long life

- WEAR YOUR SEAT BELT !!!!!
- Choose long-lived parents
- Don’t smoke
- Watch your diet
- Don’t drink alcohol and drive
- Limit stress

# Imagery Exercise

**To be done before you leave the parking lot**

- Write down mentally on a piece of paper the things that are troubling you when you leave the office
- Tear off that piece of paper
- Wad the piece of paper, roll down the car window, and throw the paper outside
- Roll up the window

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**Spanos, 1998**

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# Suggested Reading


- Fields H and Liebeskind, J, eds. *Pharmacological Approaches to the Treatment of Chronic Pain: New Concepts and Critical Issues*. IASP Press, Seattle, 1994.
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