



Pain Management at Ground Zero

Mark Garofoli, PharmD, MBA, BCGP, CPE

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Faculty

- Mark Garofoli, PharmD, MBA, BCGP, CPE
 - Experiential Learning Director & Clinical Assistant Professor, WVU School of Pharmacy
 - Clinical Pain Management Pharmacist, WVU Medicine Integrative Pain Center
 - Coordinator, WV Pain Management Expert Panel (SEMP Guidelines)
 - WV PDMP Advisory Panel Member
 - CDC Grant Reviewer



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Disclosures

- Advisory Board: DSI

This presentation was not a part of the presenter's official duties at the WVU and does not represent the opinion of WVU




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Ground Zero Transcending to the Entire Nation...

HEALTH INC.
Drug Distributors Penalized For Turning Blind Eye In Opioid Epidemic
 January 27, 2017 - 9:00 AM ET
 CHARLES ORNSTEIN FROM

Charleston Gazette-Mail
Charleston, West Virginia's Largest Newspaper A Few Clouds 69.6 °F

HOME NEWS BUSINESS OPINION SPORTS LIFE AAZ OUTDOORS BLOGS OBITUARIES MULTIMEDIA WEATHER CL

WV Supreme Court says addicts can sue doctors and pharmacists
 KATE WHITT, Staff Writer May 13, 2015


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2016 Murder Conviction

Dr. Hsiu-Ying "Lisa" Tseng guilty of second-degree murder (30 years to life)


First time a doctor had been convicted of murder in the United States for overprescribing drugs





PainWeek <http://www.hilltimes.com/local/news/15-11-16-1/doctor-murder-overdose-drugs-conviction-20160905-0101.html>

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63,400 US Drug Overdose Deaths (2016)



8 minutes



Age-adjusted Drug Overdose Death Rates (per 100K)


West Virginia	52
New Hampshire, Ohio, & D.C.	39
Pennsylvania	38

PainWeek WVH in: et al. Drug Overdose Deaths in the United States, 1999-2014. NCHS Data Brief No. 282, December 2015

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2016 West Virginia Safe & Effective Management of Pain (SEMP) Guidelines







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West Virginia Expert Pain Management Panel

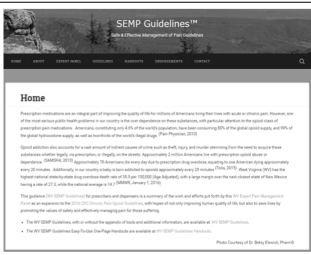
Panel Member	Organization/Title
Mark Garofoli, PharmD, MBA, BCGP, CPE (Coordinator)	Pharmacist
Timothy Deer, MD (Chairperson)	Medical Doctor
Richard Vigilant, MD (Vice Chairperson)	Medical Doctor
Ahmet Osturk, MD	Medical Doctor
Denise Hawkberry, MD	Medical Doctor
Bradley Hall, MD	Medical Doctor
Matt Cupp, MD	Medical Doctor
Rahul Gupta, MD	Medical Doctor (Public Health)
Michael Mills, DO	Osteopathic Doctor
Jimmy Adams, DO	Osteopathic Doctor
Richard Gross, PhD	Psychologist
Jason Roush, DDS	Dentist
Stacey Wyatt, RN	Registered Nurse
Vicki Cunningham, RPh	Pharmacist (Insurance)
Felice Joseph, RPh	Pharmacist (Insurance)
Stephen Smart, RPh, MS	Pharmacist
Patty Johnston, RPh	Pharmacist
Charles Ponte, PharmD, CPE	Pharmacist
James Jeffries, MS	Health & Human Resources
Michael Goff	Retired State Policeman & PDMP Administrator





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2016 West Virginia Safe & Effective Management of Pain (SEMP) Guidelines



www.sempguidelines.org

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www.sempguidelines.org

	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1 st Line	Non-Pharmacological (Active & Passive) Acute Trial of NSAID/COX-2 Acute Trial of Opioid (Short-Acting) Acute Trial of NSAID/COX-2/Opioid	Non-Pharmacological (Active & Passive) Acute Trial of NSAID/COX-2 Acute Trial of Opioid (Short-Acting) Acute Trial of NSAID/COX-2/Opioid	Non-Pharmacological (Active & Passive) Acute Trial of NSAID/COX-2/Opioid
2 nd Line	Non-Pharmacological (Active & Passive) Tricyclic Antidepressant (TCA) Controlled Substance Class IV Consider Referral to Specialist	Anti-Epileptic Drug (AED) Controlled Substance Class IV Consider Referral to Specialist	gabapentin Controlled Substance Class IV Tricyclic Antidepressant (TCA) Controlled Substance Class IV Consider Referral to Specialist
3 rd Line	Combination of 1 st & 2 nd Line Agents Atypical Antipsychotic (AAP) Controlled Substance Class II Controlled Substance Class III Controlled Substance Class I (opioid) Refer to Specialist/Resist	Combination of 1 st & 2 nd Line Agents Atypical Antipsychotic (AAP) Controlled Substance Class II Controlled Substance Class III Controlled Substance Class I (opioid) Refer to Specialist/Resist	Combination of 1 st & 2 nd Line Agents Atypical Antipsychotic (AAP) Controlled Substance Class II Controlled Substance Class III Controlled Substance Class I (opioid) Refer to Specialist/Resist
4 th Line	Refer to Specialist/Resist Refer to Specialist/Resist Refer to Specialist/Resist Refer to Specialist/Resist	Refer to Specialist/Resist Refer to Specialist/Resist Refer to Specialist/Resist Refer to Specialist/Resist	Refer to Specialist/Resist Refer to Specialist/Resist Refer to Specialist/Resist Refer to Specialist/Resist

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Risk Reduction Strategy

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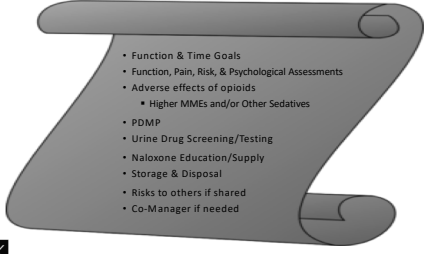
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Risk Reduction Strategy

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Patient & Provider Agreement Items



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Pain Reduction & Function Improvement Goal

Pain = 5th Vital Sign ???

Analgesic ???

The goal is NOT necessarily to eliminate pain

➤ The goal is to Improve Function & Reduce Pain

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PEG Scale

PEG Pain Screening Tool

1. What number best describes your pain on average in the past week?
 0 1 2 3 4 5 6 7 8 9 10
 No pain Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?
 0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?
 0 1 2 3 4 5 6 7 8 9 10
 Does not interfere Completely interferes

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking change over time. The PEG score should decrease over time after therapy has begun.

PEG Scale
 Pain intensity (P)
 Interference with Enjoyment of life (E)
 Interference with General activity (G)

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Risks E. et al. Development and Initial Validation of the PEG - a Three-Item Scale Assessing Pain Intensity and Interference. J Gen Intern Med 2010; 25:3-8

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Graded Chronic Pain Scale

Graded chronic pain scale: a two-item tool to assess pain intensity and pain interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be". (That is, your usual pain at times you were in pain.)

No pain Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."

No interference Unable to carry on any activities

0 1 2 3 4 5 6 7 8 9 10

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1-4	5-6	7-10
Pain-related interference with activities	1-3	4-6	7-10



<http://www.veterans.va.gov/painmanagement/docs/GradedChronicPainScale.pdf>

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DVPRS

Defense and Veterans Pain Rating Scale

DoD/VA PAIN SUPPLEMENTAL QUESTIONS
For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITY**.
0 Does not interfere 10 Completely interferes
2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**.
0 Does not interfere 10 Completely interferes
3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**.
0 Does not affect 10 Completely affects
4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**.
0 Does not contribute 10 Contributes a great deal



http://www.va.gov/PAINMANAGEMENT/docs/DVPRS_Patient.pdf

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End of Therapy Goal

- | |
|---|
| <p>Acute Goal</p> <ul style="list-style-type: none"> Expected time frame of healing |
| <p>Chronic Goal</p> <ul style="list-style-type: none"> Resolution of the syndrome is not always expected Prevent long term medication issues (possibly d/c) <ul style="list-style-type: none"> Adverse effects, dependency, etc. |

- S** Specific
- M** Measurable
- A** Attainable
- R** Relevant
- T** Time-Bound





www.semopainclinics.org

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Proper Medication Storage



Bathroom Medicine Cabinets → NO

- Humidity
- Unsecure
- Typically accessed at "groggy" times of day (AM/PM)

Lockable Safe Boxes → YES

- Away from children and pets
- Secure
- Still must incorporate into daily routine


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Proper Medication Disposal

EPA

1st Choice



Drug Take-Back Event

2ND CHOICE: HOUSEHOLD DISPOSAL STEPS*

1. Take your prescription drugs out of their original containers.
2. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds.
3. Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a sealable bag.
4. Conceal or remove any personal information, including Rx number, on the empty container by covering it with permanent marker or duct tape, or by scratching it off.
5. The sealed container with the drug mixture, and the empty drug containers, can now be placed in the trash.

* Drug Disposal Guidelines, Office of National Drug Control Policy, October 2009

<http://www.epa.gov/epaosopr/opd/section707115-2009/section707115-2009-01-disposal-guidelines.pdf>


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Proper Medication Disposal

FDA

1. DEA Sponsored Take-Back Programs (*Same as EPA*)
2. Household Trash (*Same as EPA*)
3. DEA Authorized Collector
 - Pharmacies can Register
 - <https://apps.deadiversion.usdoj.gov/webforms2/spring/disposal.cfm?execution=21>
4. Flushing a list of ~40 CII's
 - Drugs enter water systems through human excretion
 - No sign of environmental damage from flushing drugs yet



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Psychological Evaluation PHQ-2 & PHQ-9

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ-2 Score $\geq 3 \rightarrow$ Take PHQ-9

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, waking up too early, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or that you let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed (or the opposite – been moving around a lot more than usual)	0	1	2	3
9. Thoughts that you would be better off dead – or of hurting yourself in some way	0	1	2	3

PHQ-9 Score $\geq 15 \rightarrow$ Psychotherapy +/- Antidepressant

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PHQ-2: http://www.painweek.org/our_pho2.pdf
PHQ-9: http://www.painweek.org/our_pho9.pdf

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Opioid Risk Screenings

Opioid-Naïve
Patients Being Considered for Opioid Therapy

- Opioid Risk Tool (ORT)
- Drug Abuse Screening Test (DAST)
- Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)

Opioid Experienced
Patients Already Receiving Opioid Therapy

- Current Opioid Misuse Measure (COMM)
- Pain Medication Questionnaire (PMQ)
- Prescription Drug Use Questionnaire (PDUQ)
- Others

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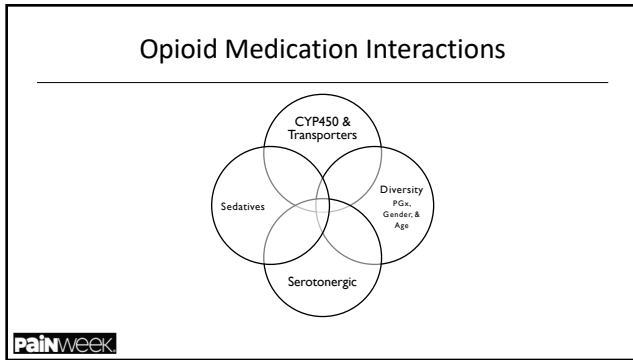
Opioid Risk Screenings

Opioid Naïve	Opioid Experienced
<p>Self Reported</p> <ul style="list-style-type: none"> • Drug Abuse Screening Test (DAST) • Screener & Opioid Assessment for Patients with Pain (SOAPP) <p>Provider Reported</p> <ul style="list-style-type: none"> • Opioid Risk Tool (ORT) • Diagnosis, Intractability, Risk, & Efficacy Score (DIRE) 	<p>Self Reported</p> <ul style="list-style-type: none"> • Current Opioid Misuse Measure (COMM) • Pain Medication Questionnaire (PMQ) • Prescription Drug Use Questionnaire, Patient (PDUQp) <p>Provider Reported</p> <ul style="list-style-type: none"> • Prescription Drug Use Questionnaire (PDUQ)

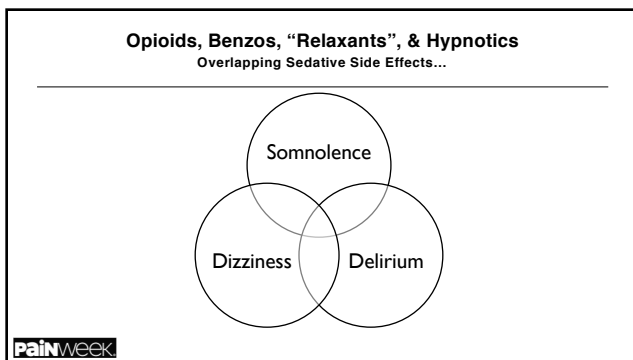
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Opioid-Sedative Interactions "Name Game"

Drug-Drug Interaction	Proposed Name
Opioid + Benzodiazepine Sedative	"Bozo"
Opioid + "Muscle Relaxant" Sedative	"Relaxoid"
Opioid + Sedative Hypnotic	"Hypoid"
Opioid + One Other Sedative	"Deadly Duo"
Opioid + Two Other Sedatives	"Unholy Trinity"
Opioid + Three Other Sedatives	"Quattro Killer"
Benzodiazepine & Sedative Hypnotic	"Hypzo"
Benzodiazepine & "Muscle Relaxant" Sedative	"Relaxzo"

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Naloxone Products

Product	Generic Injectable	Generic Intranasal	Narcan® Nasal Spray	Evzio® Auto-Injector
Dose	0.4mg IM	1mg in each nostril	4mg in one nostril	0.4mg/2mg IM/SQ
Dosing	Inject 1mL in shoulder/triangular, may repeat in 2-3min. Use 3mL, 23G syringe & 1" needle	Spray 1mL (half of syringe) in each nostril with atomizer, may repeat in 2-3 min	Spray 0.1mL into one nostril, may repeat in 2-3 min with 2nd device in alternate nostril	Press black side firmly onto outer thigh through clothing, hold 5 seconds, may repeat in 2-3 min
Availability	0.4mg/mL, 4mg/10mL	2mL prefilled Luer-Jet syringe + Atomizer (Item # MAD-301)	0.4mg/0.1mL	0.4mg/0.4mL, 2mg/0.4mL
Manufacturer	Pfizer, West-Ward, & Mylan	IMS/Amphastar	Adapt	Kaleo
Cost	\$	\$\$	\$\$	\$\$\$\$\$
NDC	0909-1215-01 0909-1216-01 6767-0292-01 0961-0332-35	76329-3369-01	69547-0263-02	60842-0030-01 60842-0051-01
Picture				



Adapted from: Todenka V, Williams S. Naloxone for Opioid Overdose and the Role of the Pharmacist. Consult Pharm. 2018 Feb; 13(2):98-104

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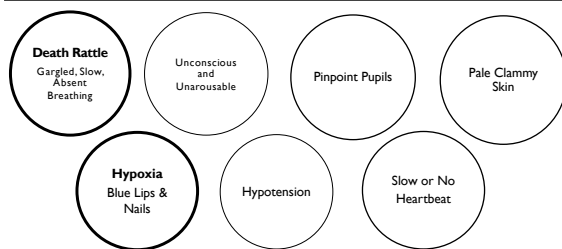
Naloxone Candidates

Any patient receiving ≥ 50 mg MME	Opioid Rotation	Recent Opioid Overdose	Opioid Use Disorder	Personal/Family History Substance Abuse
Respiratory Condition COPD/Asthma Sleep Apnea Smoking of Anything	Heavy Alcohol Use	Benzodiazepine or Other Sedatives	Difficult Access to EMT (Rural)	Voluntary Request (Patient/Caregiver)



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Opioid Overdose Symptoms




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Naloxone Administration

SAMHSA Guidelines

1. Check for signs of opioid overdose
2. Call EMS to access immediate medical attention*
3. Administer naloxone (rescue position)*
4. Rescue breathe if patient not breathing*
5. Stay with the person and monitor their response until emergency medical assistance arrives.
After 2-5 minutes, repeat the naloxone dose if person is not awakening or breathing well enough (10 or more breaths per minute)

*Order depending on the source of guidance




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Pill Counts

- Randomized or Scheduled
- Goals
 - Improve proper medication adherence
 - Prevent and/or detect medication diversion
- Recommend not to have support staff perform
- Use a counting tray
 - Realize Pills can be rented/borrowed (online/street)



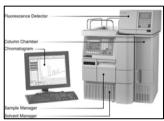

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Vicconi CM, et al. Pill counts and pill rental: unintended entrepreneurial opportunities. The Clinical Journal of Pain. 29(7):623-624, JUL 2013

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Urine Drug Screening/Testing

- Randomized or Scheduled
- Goals
 - Improve proper medication adherence
 - Prevent and/or detect medication diversion
- Witnessed or private
 - Realize Urine can be purchased online or shared
 - www.thewhizzinator.com

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Urine Drug Screening/Testing



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Urine Drug Screening versus Testing

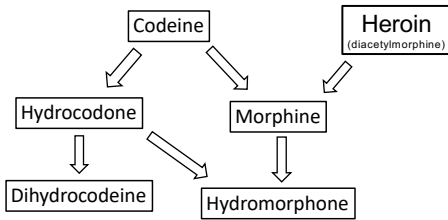
Urine Drug Screening (UDS)	Urine Drug Testing (UDT)
Immunoassay screen (i.e. Cup)	GC-MS or LC-MS/MS
In-office, point-of-care, or lab-based	Laboratory, highly specific & sensitive
Results within minutes	Results in hours or days
Detects a few legal & illicit medications by structural class	Measures concentrations of all drugs & metabolites
Guidance for preliminary treatment decisions	Definitive identification & analysis
Cross-reactivity common: more false positives	False-positive results are rare
Higher cutoff levels: more false negatives	False-negative results are rare
\$	\$\$\$

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Adapted from the WV SEMP Guidelines: www.wvsemp.org

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Opioid Metabolism Active Metabolites




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Adapted from the WV SEMP Guidelines: www.wvsemp.org

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Urine Drug Screening Panels








Urine Drug Screening Panels				
7 Panel	Marijuana (THC)	Methadone Propoxyphene Quaaludes	Ecstasy & Oxycodone	Fentanyl & Meperidine
10 Panel	Cocaine Opiates/Derivatives			
12 Panel	PCP Amphetamines			
Pain 13 Panel	Benzodiazepines Barbiturates			

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Opioid Structural Classes

Phenanthrenes	Benzomorphans	Phenylpiperidines	Dipheylheptanes	Phenylpropylamines
5 Rings	4 Rings	3 Rings	2 Rings	2 Rings
				
Buprenorphine Codeine Diacetylmorphine Hydrocodone Morphine Naloxone Oxycodone Oxycodone	Butorphanol Levorphanol	Diphenoxylate Loperamide Pentazocine	Fentanyl Meperidine	Methadone Propoxyphene
				Tapentadol Tramadol

PainWeek Adapted from Yukawa ND, McLeish AT. NHPH 2014; 374:1351-1363

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Urine Drug Screening Cross-Reactants

Chemical	Cross-Reactant
Cannabinoids	NSAIDs, dronabinol, promethazine, & pantoprazole
Opioids	poppy seeds, chlorpromazine, rifampin, dextromethorphan, quinolones, diphenhydramine, & quinine
Amphetamines	methyphenidate, trazodone, bupropion, amantadine, propranolol, labetalol, ranitidine, & menthol
PCP	ibuprofen, tramadol, chlorpromazine, venlafaxine, thioridazine, meperidine, dextromethorphan, diphenhydramine, & doxylamine
Benzodiazepines	oxaprozin, sertraline, & some herbals
Alcohol	asthma inhalers
Methadone	quetiapine

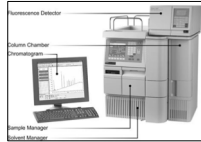
PainWeek Adapted from WV SEMP Guidelines. www.sempguidelines.org

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Urine Drug Screening/Testing



Conversation Starters



Conversation Leaders



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Prescription Drug Monitoring Programs (PDMPs)



www.pdmpassist.org

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State	PDMP Legislation	PDMP Operational	State	PDMP Legislation	PDMP Operational
California	1939	1939	North Carolina	2005	2007
Hawaii	1943	1943	Connecticut	2005	2008
Idaho	1967	1967	Arizona	2007	2008
Illinois	1961	1968	Louisiana	2006	2008
New York	1972	1973	South Carolina	2005	2008
Pennsylvania	1972	1973	Vermont	2006	2009
Rhode Island	1978	1979	Ohio	2009	2009
Texas	1981	1982	Minnesota	2007	2010
Michigan	1988	1989	New Jersey	2008	2011
Oklahoma	1990	1991	Alaska	2008	2011
Massachusetts	1992	1994	Oregon	2009	2011
West Virginia	1995	1995	Washington	2007	2011
Utah	1995	1996	Kansas	2008	2011
Nevada	1995	1997	South Dakota	2010	2011
Indiana	1997	1998	Florida	2009	2011
Kentucky	1998	1999	Nebraska	2011	2011
Virginia	2002	2003	Delaware	2010	2011
Maine	2003	2004	Montana	2011	2012
Wyoming	2004	2004	Guam	1998	2013
New Mexico	2004	2005	Wisconsin	2010	2011
Mississippi	2005	2005	Arkansas	2011	2013
Ohio	2005	2006	Georgia	2011	2013
Alabama	2004	2006	Maryland	2011	2013
Tennessee	2003	2006	New Hampshire	2012	2014
Colorado	2005	2007	District of Columbia	2014	2016
North Dakota	2005	2007	Missouri	2016	2017



www.pdmpassist.org

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Verifying Identification Cards Magnetic Strip Swipe

- States with Magnetic Stripes

AL, AZ, AR, CA, CO, FL, KS, LA, MI, MN,
MS, NH, NM, OH, PA, SC, TX, & VT

- Fast Scanning: 1 second for response

- ~\$500 Device Cost



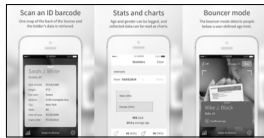
2D Bar Code (PDF 417)
Magnetic Stripe
<http://www.idempower.com/modules/magnetic-stripe-id-reader/>



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Verifying Identification Cards Barcode Reader

- Process via smartphones/pads
- Link directly to state ID databases



<https://www.hampshirestate.com/colleges/id-scanner>
<http://www.pdourall.com/learning/accipr/management-3140>



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DEA Red Flags Prescribers

- Cash only patients and/or no acceptance of worker's compensation or insurance
- Prescribing of the same combination of highly-abused drugs
- Prescribing the same (high) quantities of pain drugs to most/every patient
- High number of prescriptions issued per day
- Out-of-area patient population



➢ NABP "Red Flags" Video (<https://nabp.org/learning/accipr/management-3140>)



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DEA Red Flags Dispensers

- Dispensing a high percentage controlled to non-controlled drugs
- Dispensing high volumes of controlled substances generally
- Dispensing the same drugs & quantities prescribed by the same prescriber
- Dispensing to out-of area or out-of-state patients
- Dispensing to multiple patients with the same last name or address
- Sequential prescription #s for highly diverted drugs from the same prescriber
- Dispensing for patients of controlled substances from multiple practitioners
- Dispensing for patients seeking early prescription fills



➤ NABP "Red Flags" Video (<https://nabp.pharmacy/initiatives/aware/pharmacist-resources/>)



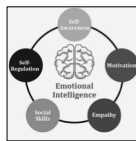
<https://www.painweek.com/2019/09/26/2019-09-26-01/>

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When Drug Seeking or Diversion is Suspected

- Eliminate personal or judgmental biases
- Calm, collected, knowledgeable, and well researched approach
 - "Never pick up a phone until you've completed research"
- Conversation with other respective healthcare professionals
 - May not even be aware of the use of his/her name
- Conversation with respective patient
 - "There's two sides to every coin"
 - "False positives"

??? Responsibility ???



??? Comfort Level ???



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Once Drug Seeking or Diversion is Confirmed

- Refer to a substance-use disorder (addiction) specialist/program
- Contact law enforcement if concern for the safety of the patient or others exists
- Treatment can continue with alternative therapies (e.g. non-controlled substances)
- Reference the patient and provider agreement/contract
 - Avoid patient abandonment concerns (e.g. provide 30 days of additional treatment)
- Respect all involved while complying with federal and state laws



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Reporting to the DEA

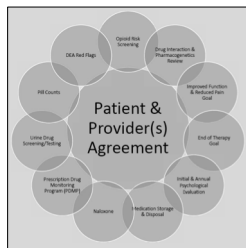


<https://apps.dea/diversion.usdoj.gov/rxapr/sprintr/main?execution=131>
1-877-RX-Abuse (1-877-792-2873)



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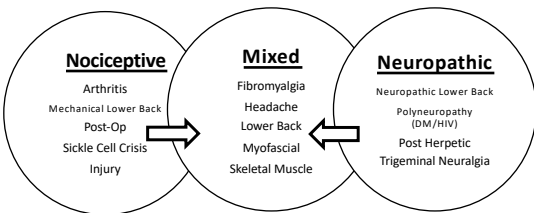
Risk Reduction Strategy



www.painweek.com

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3 Main Types of Pain



www.painweek.com

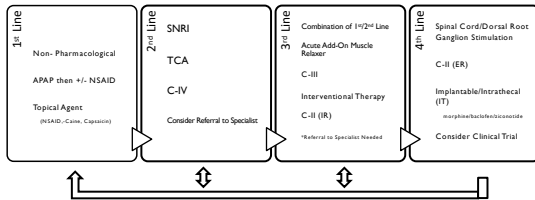
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Clinical Treatment Algorithms

	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1 st Line	<ul style="list-style-type: none"> Non-Pharmacological (Heat & Paracetamol) APAP (max 4000mg) Topical Agent (NSAID, Capsaicin, Lidocaine) 	<ul style="list-style-type: none"> Non-Pharmacological (Heat & Paracetamol) Acute Trial of Gabapentin/Pregabalin Substitution** Topical Agent (NSAID, Capsaicin, Lidocaine) 	<ul style="list-style-type: none"> Non-Pharmacological (Heat & Paracetamol) Acute Trial of Gabapentin/Pregabalin Topical Agent (NSAID, Capsaicin, Lidocaine)
2 nd Line	<ul style="list-style-type: none"> Systemic Non-steroidal Anti-inflammatory Drugs (NSAIDs) Tricyclic Antidepressants (TCAs) Considered Substantive Class IV Consider Referral to Specialist 	<ul style="list-style-type: none"> Anti-Epileptic Drugs (AEDs) Considered Substantive Class IV Consider Referral to Specialist 	<ul style="list-style-type: none"> Substitution** Systemic Opioids (MOR) Tricyclic Antidepressants (TCAs) Considered Substantive Class IV Consider Referral to Specialist
3 rd Line	<ul style="list-style-type: none"> Combination of 1st & 2nd Line Agents Acute Add-On Muscle Relaxant* Considered Substantive Class II Interventional Therapy Considered Substantive Class I (R) Refer to Specialist Required 	<ul style="list-style-type: none"> Combination of 1st & 2nd Line Agents Acute Add-On Muscle Relaxant* Considered Substantive Class II Interventional Therapy Considered Substantive Class I (R) Refer to Specialist Required 	<ul style="list-style-type: none"> Combination of 1st & 2nd Line Agents Acute Add-On Muscle Relaxant* Considered Substantive Class II Interventional Therapy Considered Substantive Class I (R) Refer to Specialist Required
4 th Line	<ul style="list-style-type: none"> Spinal Cord/Intrathecal Opioid Stimulation Considered Substantive Class I (R) Refer to Specialist Required 	<ul style="list-style-type: none"> Spinal Cord/Intrathecal Opioid Stimulation Considered Substantive Class I (R) Refer to Specialist Required 	<ul style="list-style-type: none"> Spinal Cord/Intrathecal Opioid Stimulation Considered Substantive Class I (R) Refer to Specialist Required

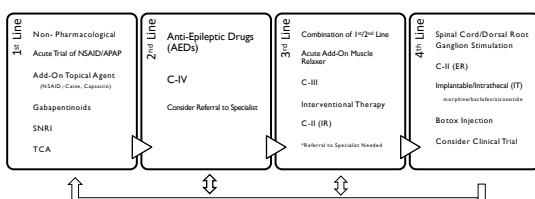
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Nociceptive Pain Clinical Treatment Algorithm

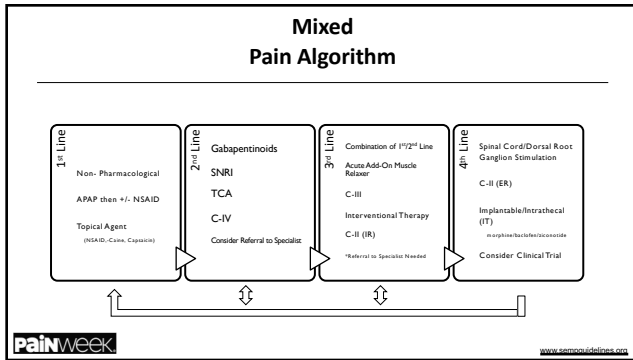


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Neuropathic Pain Clinical Treatment Algorithm



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www.sempguidelines.org

Patient & Provider(s) Agreement

Drug Interaction & Pharmacogenetics Review
 Shared Decision Making
 OLA Risk Stratification
 PII Counts
 Live Drug Monitoring/Testing
 Medication Management
 End of Therapy Plan
 Patient & Annual Psychological Evaluation
 Medication Management & Therapy

PainWeek

	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1st Line	Non-Pharmacological (Behavior & Physical) APAP then +/- NSAID Topical Agent (NSAID, Capsaicin, Capsaicin)	Non-Pharmacological (Behavior & Physical) Acute Add-On Muscle Relaxer Add on Topical Agent (NSAID, Capsaicin, Capsaicin) Gabapentinoids SNRI TCA C-IV Topical Agent (NSAID, Capsaicin, Capsaicin) Topical Anesthetics (TCA)	Non-Pharmacological (Behavior & Physical) Acute Add-On Muscle Relaxer Topical Agent (NSAID, Capsaicin, Capsaicin)
2nd Line	gabapentinoids SNRI TCA C-IV Controlled Substance Class IV Consider Referral to Specialist	Anti-Epileptic Drugs (AEDs) gabapentinoids SNRI TCA C-IV Controlled Substance Class IV Consider Referral to Specialist	gabapentinoids SNRI TCA C-IV gabapentinoids SNRI TCA C-IV Controlled Substance Class IV Consider Referral to Specialist
3rd Line	Combination 1 st & 2 nd Line Agents Acute Add-On Muscle Relaxer Controlled Substance Class IV Interventional Therapy Controlled Substance Class II (IR) Referral to Specialist Needed	Combination 1 st & 2 nd Line Agents Acute Add-On Muscle Relaxer Controlled Substance Class IV Interventional Therapy Controlled Substance Class II (IR) Referral to Specialist Needed	Combination 1 st & 2 nd Line Agents Acute Add-On Muscle Relaxer Controlled Substance Class IV Interventional Therapy Controlled Substance Class II (IR) Referral to Specialist Needed
4th Line	Spinal Cord/Dorsal Root Ganglion Stimulation C-II (ER) Implantable/Intrathecal (IT) Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation C-II (ER) Implantable/Intrathecal (IT) Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation C-II (ER) Implantable/Intrathecal (IT) Consider Clinical Trial

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The West Virginia Way Almost Heaven...

PainWeek

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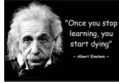
Pain Management Best Practices

People Respect What You Inspect, Not What You Expect

An Ounce of Prevention, is Worth a Pound of Treatment

Never Stop Learning

Hippocratic Oath: Do No Harm



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Audience Question #1

After reading headline after headline regarding our nation's opioid crisis, Dr. Payne has decided to begin to mandate patient and provider agreements for all of his patients being prescribed opioid medications. Which of the following would **NOT** be recommended to include in the patient and provider agreement for his office?

- a) Review of the Prescription Drug Monitoring Program (PDMP)
- b) Random Urine Drug Screening and/or Testing
- c) Mandatory cash payments for office visits
- d) Review of the negative effects of utilized medications



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Audience Question #1 (ANSWER)

After reading headline after headline regarding our nation's opioid crisis, Dr. Payne has decided to begin to mandate patient and provider agreements for all of his patients being prescribed opioid medications. Which of the following would **NOT** be recommended to include in the patient and provider agreement for his office?

- a) Review of the Prescription Drug Monitoring Program (PDMP)
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- c) MANDATORY CASH PAYMENTS FOR OFFICE VISITS
- d) Review of the negative effects of utilized medications



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Audience Question #2

Ms. Fay Kinet was recently diagnosed with diabetic peripheral neuropathy, a very common form of neuropathic pain. According to the West Virginia Safe & Effective Management of Pain (SEMP) Guidelines, which of the following medications would be an appropriate first line treatment?

- a) Muscle Relaxant
- b) TCA or SNRI Antidepressant
- c) Mixed Action Opioid
- d) Botox Injection



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Audience Question #2 (ANSWER)

Ms. Fay Kinet was recently diagnosed with diabetic peripheral neuropathy, a very common form of neuropathic pain. According to the West Virginia Safe & Effective Management of Pain (SEMP) Guidelines, which of the following medications would be an appropriate first line treatment?

- a) Muscle Relaxant Medication
- b) TCA OR SNRI ANTIDEPRESSANT
- c) Mixed Action Opioid Medication
- d) Botox Injection



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Audience Question #3

While at a loud club on Las Vegas Boulevard (i.e. The Strip), your friend is sitting in a VIP area 20 yards away and looks like he may have had too much to drink since he is practically asleep. What do you not know is that he inadvertently added laced Heroin to his beverage when he thought he added a sweetener. What symptom could you notice from afar that would indicate an opioid (Heroin) overdose?

- a) Slow Heart Rate
- b) Pin Point Pupils
- c) The Death Rattle
- d) Hypoxia



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Audience Question #3 (ANSWER)

While at a loud club on Las Vegas Boulevard (i.e. The Strip), your friend is sitting in a VIP area 20 yards away and looks like he may have had too much to drink since he is practically asleep. What you do not know is that he inadvertently added laced Heroin to his beverage when he thought he added a sweetener. What symptom could you notice from afar that would indicate an opioid (Heroin) overdose?

- a) Slow Heart Rate
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- c) The Death Rattle
- d) HYPOXIA



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63,400 US Drug Overdose Deaths (2016)



Holly W. et al. Drug Overdose Deaths in the United States, 1999-2016. NCHS Data Brief No. 284, December 2017

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Discussion



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LinkedIn: Mark Garofoli



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