Pain Management at Ground Zero

Mark Garofoli, PharmD, MBA, BCGP, CPE
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- 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
Disclosures

- Consultant/Independent Contractor: Daiichi Sankyo, Clinical Pharmacists Advisory Panel, Member

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

- Discuss the 2016 CDC Chronic Pain Opioid Guidelines directly into clinical practice.

- Describe the best practices within pain management with particular attention to risk reduction strategies.

- Recall multi-modal pain management treatment plan options.
US Opioid Prescribing & Heroin Distribution

US Drug Overdose Deaths

Ground Zero Transcending to the Entire Nation...

Drugs Distributors Penalized For Turning Blind Eye In Opioid Epidemic

January 27, 2017 · 5:00 AM ET

CHARLES ORNSTEIN

FROM ProPublica

WV Supreme Court says addicts can sue doctors and pharmacists

May 15, 2015

Kate White, Staff Writer
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

63,400 US Drug Overdose Deaths (2016)

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

<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Virginia</td>
<td>52</td>
</tr>
<tr>
<td>New Hampshire, Ohio, &amp; D.C.</td>
<td>39</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>38</td>
</tr>
</tbody>
</table>

“Opioid Epidemic” Literature

1. Chasing the Scream by Johann Hari
2. Drug Dealer, MD by Anna Lembke, MD
3. American Pain by John Temple
4. Dreamland: The True Tale of America’s Opiate Epidemic by Sam Quinones
5. Narcconomics: How to Run a Drug Cartel by Tom Wainwright
2016 CDC Chronic Pain Opioid Guidelines

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be used in combination with nonopioid pharmacologic therapy and nonpharmacologic therapies, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider that opioid therapy will be continued if benefits do not outweigh harms. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients their harms and benefits to avoid risks of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain.
- Establish and maintain goals for pain and function.
- Discuss benefits and risks and availability of nonopioid therapies with patient.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids at an understanding of starting, using (OUD) doses.

5. When opioids are started, clinicians should prescribe the lowest effective dose.

6. Clinicians should taper opioids when dosages are decreased or discontinued, as needed to reduce adverse effects.

7. Follow-up and re-evaluation of harm: reduce dose or taper and discontinue if needed.

ASSESSING RISK AND ADDRESsing HARMs OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate risk management strategies to mitigate risk, including consideration of offering nonopioid therapies that are indicated for the treatment of chronic pain.

9. Assess for patient's history of contraindications or additional interventions that increase the risk of opioid use disorder.

10. Patients should receive educational materials that describe the risks and benefits of opioid therapy.

11. Patients should be monitored for adverse effects of opioid therapy.

12. Patients should be evaluated for the treatment of opioid use disorder if needed.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms.
- Check POMP for high doses and prescriptions from other providers.
- Use urine drug testing to identify prescribed substances and undisclosed use.
- Avoid concurrent benzodiazepine and opioid prescribing.
- Arrange treatment for opioid use disorder if needed.

LEARN MORE: www.cdc.gov/drugoverdose/prescribing/guideline.html

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
CDC Chronic Pain **Opioid** Guidelines

### Opioid Use Decision
1. Non-Pharm, Non-Opioid, then Opioid
2. Treatment Goals
3. Risk Assessments & Side Effects

### Type/Amount/Time of Opioid
4. IR not ER
5. MME \(\geq 50\) day: Use caution
   - MME \(\geq 90\) avoid unless justified
6. Acute pain: Short duration
7. Re-evaluate 1 month, then every 3 months.

### Risk/Harms of Opioid Use
8. Higher risk \(\rightarrow\) naloxone
9. PDMP initially + every 1-3 months
10. UDT initially + annually
11. Avoid combining opioids & benzos
12. Opioid Use Disorder: Offer MAT

Adapted from: [https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm)
2016 West Virginia
Safe & Effective Management of Pain (SEMP) Guidelines
<table>
<thead>
<tr>
<th>Panel Member</th>
<th>Organization/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Garofoli, PharmD, MBA, BCGP, CPE (Coordinator)</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Timothy Deer, MD (Chairperson)</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>Richard Vaglienti, MD (Vice Chairperson)</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>Ahmet Ozturk, MD</td>
<td>Medical Doctor</td>
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<tr>
<td>Denzil Hawkinberry, MD</td>
<td>Medical Doctor</td>
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<tr>
<td>Bradley Hall, MD</td>
<td>Medical Doctor</td>
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<tr>
<td>Matt Cupp, MD</td>
<td>Medical Doctor</td>
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<tr>
<td>Rahul Gupta, MD</td>
<td>Medical Doctor (Public Health)</td>
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<tr>
<td>Michael Mills, DO</td>
<td>Osteopathic Doctor</td>
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<tr>
<td>Jimmy Adams, DO</td>
<td>Osteopathic Doctor</td>
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<td>Richard Gross, PhD</td>
<td>Psychologist</td>
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<td>Jason Roush, DDS</td>
<td>Dentist</td>
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<tr>
<td>Stacey Wyatt, RN</td>
<td>Registered Nurse</td>
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<td>Vicki Cunningham, RPh</td>
<td>Pharmacist (Insurance)</td>
</tr>
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<td>Felice Joseph, RPh</td>
<td>Pharmacist (Insurance)</td>
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<td>Stephen Small, RPh, MS</td>
<td>Pharmacist</td>
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<td>Patty Johnston, RPh</td>
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<tr>
<td>Charles Ponte, PharmD, CPE</td>
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<tr>
<td>James Jeffries, MS</td>
<td>Health &amp; Human Resources</td>
</tr>
<tr>
<td>Michael Goff</td>
<td>Retired State Policeman &amp; PDMP Administrator</td>
</tr>
</tbody>
</table>
2016 West Virginia Safe & Effective Management of Pain (SEMP) Guidelines

Home

Prescription medications are an integral part of improving the quality of life for millions of Americans living their lives with acute or chronic pain. However, one of the most serious public health problems in our country is the over dependence on these substances, with particular attention to the opioid class of prescription pain medications. Americans, constituting only 4.6% of the world’s population, have been consuming 80% of the global opioid supply, and 99% of the global hydrocodone supply, as well as two-thirds of the world’s illegal drugs. (Pain Physician, 2016)

Opioid addiction also accounts for a vast amount of indirect causes of crime such as theft, injury, and murder stemming from the need to acquire these substances whether legally, via prescription, or illegally, on the streets. Approximately 2 million Americans live with prescription opioid abuse or dependence. (SAMSHA, 2015) Approximately 78 Americans die every day due to prescription drug overdoses, equating to one American dying approximately every 20 minutes. Additionally, in our country a baby is born addicted to opioids approximately every 25 minutes. (Ciccarone, 2016). West Virginia (WV) has the highest national state-by-state drug overdose death rate of 35.5 per 100,000 (Age Adjusted), with a large margin over the next closest state of New Mexico having a rate of 27.3, while the national average is 14.3 (MMWR, January 1, 2016).

This guidance (WV SEMP Guidelines) for prescribers and dispensers is a summary of the work and efforts put forth by the WV Expert Pain Management Panel as an expansion to the 2016 CDC Chronic Pain Opioid Guidelines, with hope of not only improving human quality of life, but also to save lives by promoting the values of safety and effectively managing pain for those suffering.

- The WV SEMP Guidelines, with or without the appendix of tools and additional information, are available at WV SEMP Guidelines.
- The WV SEMP Guidelines Easy-To-Use One-Page Handouts are available at WV SEMP Guidelines Handouts.

Photo Courtesy of Dr. Betty Etzioni, PharmD

www.sempguidelines.org
## Nociceptive Pain

- **1st Line**
  - Non-Pharmacological (Active & Passive)
  - Acute Trial of NSAID/Acetaminophen
  - Add on Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Gabapentinoids
  - Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Total Antidepressant (TCA)

- **2nd Line**
  - Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)
  - Tri cyclic Antidepressant (TCA)
  - Consider Referral to Specialist

- **3rd Line**
  - Combination 1st & 2nd Line Agents
  - Acute Add-On Muscle Relaxer
  - Controlled Substance Class III
  - Intervventional Therapy
  - Controlled Substance Class II (IR)
  - Referral to Specialist Needed

- **4th Line**
  - Spinal Cord/Dorsal Root Ganglion Stimulation
  - Controlled Substance Class II (ER)
  - Implantable Intrathecal (T)
  - Morphine/Bromfenac/Clonidine
  - Consider Clinical Trial

## Neuropathic Pain

- **1st Line**
  - Non-Pharmacological (Active & Passive)
  - Acute Trial of NSAID/Acetaminophen
  - Add on Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Gabapentinoids
  - Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Total Antidepressant (TCA)

- **2nd Line**
  - Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)
  - Tri cyclic Antidepressant (TCA)
  - Consider Referral to Specialist

- **3rd Line**
  - Combination 1st & 2nd Line Agents
  - Acute Add-On Muscle Relaxer
  - Controlled Substance Class III
  - Intervential Therapy
  - Controlled Substance Class II (IR)
  - Referral to Specialist Needed

- **4th Line**
  - Spinal Cord/Dorsal Root Ganglion Stimulation
  - Controlled Substance Class II (ER)
  - Implantable Intrathecal (T)
  - Morphine/Bromfenac/Clonidine
  - Consider Clinical Trial

## Mixed Pain

- **1st Line**
  - Non-Pharmacological (Active & Passive)
  - Acute Trial of NSAID/Acetaminophen
  - Add on Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Gabapentinoids
  - Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Total Antidepressant (TCA)

- **2nd Line**
  - Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)
  - Tri cyclic Antidepressant (TCA)
  - Consider Referral to Specialist

- **3rd Line**
  - Combination 1st & 2nd Line Agents
  - Acute Add-On Muscle Relaxer
  - Controlled Substance Class III
  - Intervential Therapy
  - Controlled Substance Class II (IR)
  - Referral to Specialist Needed

- **4th Line**
  - Spinal Cord/Dorsal Root Ganglion Stimulation
  - Controlled Substance Class II (ER)
  - Implantable Intrathecal (T)
  - Morphine/Bromfenac/Clonidine
  - Consider Clinical Trial
Risk Reduction Strategy

Patient & Provider(s) Agreement

1. Opioid Risk Screening
2. Drug Interaction & Pharmacogenetics Review
3. DEA Red Flags
4. Improved Function & Reduced Pain Goal
5. End of Therapy Goal
6. Initial & Annual Psychological Evaluation
7. Naloxone
8. Medication Storage & Disposal
9. Pill Counts
10. Urine Drug Screening/Testing
11. Prescription Drug Monitoring Program (PDMP)

www.sempguidelines.org
Risk Reduction Strategy
Patient & Provider Agreement Items

- Function & Time Goals
- Function, Pain, Risk, & Psychological Assessments
- Adverse effects of opioids
  - Higher MMEs and/or Other Sedatives
- PDMP
- Urine Drug Screening/Testing
- Naloxone Education/Supply
- Storage & Disposal
- Risks to others if shared
- Co-Manager if needed
Pain Reduction & Function Improvement Goal

Pain = 5\textsuperscript{th} Vital Sign ???

Analgesic ???

The goal is NOT necessarily to eliminate pain

- The goal is to Improve Function & Reduce Pain
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 changes over time. The PEG score should decrease over time after therapy has begun.

Pain intensity (P)
Interference with Enjoyment of life (E)
Interference with General activity (G)
**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"? 

<table>
<thead>
<tr>
<th>No pain</th>
<th>Pain as bad as could be</th>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
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<tr>
<td>2</td>
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<td>8</td>
<td>9</td>
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<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

**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."

<table>
<thead>
<tr>
<th>No interference</th>
<th>Unable to carry on any activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
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<tr>
<td>2</td>
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<td>8</td>
<td>9</td>
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<tr>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

**Pain Rating Item**

<table>
<thead>
<tr>
<th>Pain Rating Item</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average/Usual Pain Intensity</td>
<td>1–4</td>
<td>5–6</td>
<td>7–10</td>
</tr>
<tr>
<td>Pain-related interference with activities</td>
<td>1–3</td>
<td>4–6</td>
<td>7–10</td>
</tr>
</tbody>
</table>
End of Therapy Goal

**Acute Goal**
- Expected time frame of healing

**Chronic Goal**
- Resolution of the syndrome is not always expected
- Prevent long term medication issues (possibly d/c)
  - Adverse effects, dependency, etc.
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
Proper Medication Disposal

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 containers 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

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/disposalLogin?execution=e2s1](https://apps.deadiversion.usdoj.gov/webforms2/spring/disposalLogin?execution=e2s1)

4. **Flushing a list of ~40 CIIs**
   - Drugs enter water systems through human excretion
   - No sign of environmental damage from flushing drugs yet

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https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm#steps
Psychological Evaluation

PHQ-2 & PHQ-9

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

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

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
# Opioid Risk Screenings

## Opioid Naïve

### Self Reported
- Drug Abuse Screening Test (DAST)
- Screener & Opioid Assessment for Patients with Pain (SOAPP)

### Provider Reported
- Opioid Risk Tool (ORT)
- Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)

## Opioid Experienced

### Self Reported
- Current Opioid Misuse Measure (COMM)
- Pain Medication Questionnaire (PMQ)
- Prescription Drug Use Questionnaire, Patient (PDUQp)

### Provider Reported
- Prescription Drug Use Questionnaire (PDUQ)
Opioid Medication Interactions

- CYP450 & Transporters
- Diversity (PGx, Gender, & Age)
- Sedatives
- Serotonergic
Opioids, Benzos, “Relaxants”, & Hypnotics
Overlapping Sedative Side Effects...

- Somnolence
- Dizziness
- Delirium
# Opioid-Sedative Interactions

**“Name Game”**

<table>
<thead>
<tr>
<th>Drug-Drug Interaction</th>
<th>Proposed Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid + Benzodiazepine Sedative</td>
<td>“Bozo”</td>
</tr>
<tr>
<td>Opioid + “Muscle Relaxant” Sedative</td>
<td>“Relaxoid”</td>
</tr>
<tr>
<td>Opioid + Sedative Hypnotic</td>
<td>“Hypoid”</td>
</tr>
<tr>
<td>Opioid + One Other Sedative</td>
<td>“Deadly Duo”</td>
</tr>
<tr>
<td>Opioid + Two Other Sedatives</td>
<td>“Unholy Trinity”</td>
</tr>
<tr>
<td>Opioid + Three Other Sedatives</td>
<td>“Quattro Killer”</td>
</tr>
<tr>
<td>Benzodiazepine &amp; Sedative Hypnotic</td>
<td>“Hypzo”</td>
</tr>
<tr>
<td>Benzodiazepine &amp; “Muscle Relaxant” Sedative</td>
<td>“Relaxzo”</td>
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</tbody>
</table>
# Naloxone Products

<table>
<thead>
<tr>
<th>Product</th>
<th>Generic Injectable</th>
<th>Generic Intranasal</th>
<th>Narcan® Nasal Spray</th>
<th>Evzio® Auto-Injector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose</td>
<td>0.4mg IM</td>
<td>1mg in each nostril</td>
<td>4mg in one nostril</td>
<td>0.4mg/2mg IM/SQ</td>
</tr>
<tr>
<td><strong>Dosing</strong></td>
<td>Inject 1mL in shoulder/thigh, may repeat in 2-3min</td>
<td>Spray 1mL (half of syringe) in each nostril with atomizer, may repeat in 2-3 min</td>
<td>Spray 0.1mL into one nostril; may repeat in 2-3 min with 2nd device in alternate nostril</td>
<td>Press black side firmly onto outer thigh through clothing; hold 5 seconds, may repeat in 2-3 min</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td>0.4mg/mL 4mg/10mL</td>
<td>2mL prefilled Luer-Jet syringe + Atomizer (Item # MAD-301)</td>
<td>0.4mg/0.1mL</td>
<td>0.4mg/0.4mL 2mg/0.4mL</td>
</tr>
<tr>
<td><strong>Manufacturer</strong></td>
<td>Pfizer, West-Ward, &amp; Mylan</td>
<td>IMS/Amphastar</td>
<td>Adapt</td>
<td>Kaleo</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>$</td>
<td>$$</td>
<td>$$</td>
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### Naloxone Candidates

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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<tbody>
<tr>
<td>Any patient receiving &gt;/=50mg MME</td>
<td></td>
</tr>
<tr>
<td>Opioid Rotation</td>
<td></td>
</tr>
<tr>
<td>Recent Opioid Overdose</td>
<td></td>
</tr>
<tr>
<td>Opioid Use Disorder</td>
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</tr>
<tr>
<td>Respiratory Condition</td>
<td>COPD/Asthma, Sleep Apnea, Smoking of Anything</td>
</tr>
<tr>
<td>Heavy Alcohol Use</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepine or Other Sedatives</td>
<td></td>
</tr>
<tr>
<td>Difficulty Access to EMT (Rural)</td>
<td></td>
</tr>
<tr>
<td>Personal/Family History Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Voluntary Request (Patient/Caregiver)</td>
<td></td>
</tr>
</tbody>
</table>
Opioid Overdose Symptoms

- **Death Rattle**: Gargled, Slow, Absent Breathing
- **Hypoxia**: Blue Lips & Nails
- **Unconscious and Unarousable**
- **Pinpoint Pupils**
- **Pale Clammy Skin**
- **Hypotension**
- **Slow or No Heartbeat**

https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone
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

https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone
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)

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

www.sempguidelines.org
Urine Drug Screening/Testing

“I could go on and on about this. And I will. Get comfortable.”
# Urine Drug Screening versus Testing

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

Adapted from the WV SEMP Guidelines. [www.sempguidelines.org](http://www.sempguidelines.org)
Opioid Metabolism
Active Metabolites

- Heroin (diacetylmorphine)
- Morphine
- Hydromorphone
- Dihydrocodeine
- Hydrocodone
- Codeine

Adapted from the WV SEMP Guidelines. www.sempguidelines.org
# Urine Drug Screening Panels

<table>
<thead>
<tr>
<th>Panel</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Panel</td>
<td>Marijuana (THC), Cocaine, Opiates/Derivatives, PCP, Amphetamines</td>
</tr>
<tr>
<td></td>
<td>Benzodiazepines, Barbiturates</td>
</tr>
<tr>
<td>10 Panel</td>
<td>Methadone, Propoxyphene, Quaaludes</td>
</tr>
<tr>
<td>12 Panel</td>
<td>Ecstasy &amp; Oxycodone</td>
</tr>
<tr>
<td>Pain 13 Panel</td>
<td>Fentanyl &amp; Meperidine</td>
</tr>
</tbody>
</table>

http://www.mobilehealth.net/screening/drug-screening/5-panel/the-different-drug-panels/
# Opioid Structural Classes

<table>
<thead>
<tr>
<th>Phenanthrenes</th>
<th>Benzomorphans</th>
<th>Phenylpiperidines</th>
<th>Dipheylheptanes</th>
<th>Phenylpropylamines</th>
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<tbody>
<tr>
<td>5 Rings</td>
<td>4 Rings</td>
<td>3 Rings</td>
<td>2 Rings</td>
<td>2 Rings</td>
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<tr>
<td>Buprenorphine</td>
<td>Codeine</td>
<td>Diphenoxylate</td>
<td>Fentanyl</td>
<td>Methadone</td>
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<tr>
<td>Butorphanol</td>
<td>Levorphanol</td>
<td>Diphenoxylate</td>
<td>Methadone</td>
<td>Tapentadol</td>
</tr>
<tr>
<td>Diacetylmorphine</td>
<td>Hydrocodone</td>
<td>Loperamide</td>
<td>Propoxyphene</td>
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<tr>
<td>Morphine</td>
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<td>Pentazocine</td>
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<td>Oxycodone</td>
<td>Oxymorphone</td>
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<tr>
<td>Oxymorphone</td>
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Adapted from Volkow ND, McLellan AT. NEJM 2016; 374:1253-1263.
### Urine Drug Screening

#### Cross-Reactants

<table>
<thead>
<tr>
<th>Chemical</th>
<th>Cross-Reactant</th>
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<tbody>
<tr>
<td>Cannabinoids</td>
<td>NSAIDs, dronabinol, promethazine, &amp; pantoprazole</td>
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<tr>
<td>Opioids</td>
<td>poppy seeds, chlorpromazine, rifampin, dextromethorphan, quinolones, diphenhydramine, &amp; quinine</td>
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<tr>
<td>Amphetamines</td>
<td>methylphenidate, trazodone, bupropion, amantadine, propranolol, labetalol, ranitidine, &amp; menthol</td>
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<tr>
<td>PCP</td>
<td>ibuprofen, tramadol, chlorpromazine, venlafaxine, thioridazine, meperidine, dextromethorphan, diphenhydramine, &amp; doxylamine</td>
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<tr>
<td>Benzodiazepines</td>
<td>oxaprozin, sertraline, &amp; some herbals</td>
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<tr>
<td>Alcohol</td>
<td>asthma inhalers</td>
</tr>
<tr>
<td>Methadone</td>
<td>quetiapine</td>
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</tbody>
</table>

Adapted from WV SEMPP Guidelines. [www.sempguidelines.org](http://www.sempguidelines.org)
Urine Drug Screening/Testing

Conversation Starters

Conversation Leaders
Prescription Drug Monitoring Programs (PDMPs)

Status of Prescription Drug Monitoring Programs (PDMPs)

* Click on state abbreviation to view PDMP contacts *

[Map showing the status of PDMPs across the United States]

Research is current as of August 24, 2017

*Missouri does not have a state-wide PDMP

www.pdmassist.org
<table>
<thead>
<tr>
<th>State</th>
<th>PDMP Legislation</th>
<th>PDMP Operational</th>
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<tr>
<td>District of Columbia</td>
<td>2014</td>
<td>2016</td>
</tr>
<tr>
<td>Missouri</td>
<td>2016</td>
<td>2017</td>
</tr>
</tbody>
</table>
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

http://www.idscanner.com/products/magnetic-stripe-id-swiper/
Verifying Identification Cards
Barcode Reader

- Process via smartphones/pads
- Link directly to state ID databases
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.pharmacy/initiatives/awarxe/pharmacist-resources/)
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/awarxe/pharmacist-resources/)
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”

---

[Diagram showing various brain functions: Self-Awareness, Self-Regulation, Social Skills, Motivation, Empathy, Emotional Intelligence]
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
Reporting to the DEA

https://apps.deadiversion.usdoj.gov/rxaor/spring/main?execution=e1s1

1-877-RX-Abuse (1-877-792-2873)
Risk Reduction Strategy

Patient & Provider(s) Agreement

- Opioid Risk Screening
- Drug Interaction & Pharmacogenetics Review
- DEA Red Flags
- Improved Function & Reduced Pain Goal
- End of Therapy Goal
- Initial & Annual Psychological Evaluation
- Medication Storage & Disposal
- Naloxone
- Prescription Drug Monitoring Program (PDMP)
- Urine Drug Screening/Testing
- Pill Counts

www.sempguidelines.org
3 Main Types of Pain

**Nociceptive**
- Arthritis
- Mechanical Lower Back
- Post-Op
- Sickle Cell Crisis
- Injury

**Mixed**
- Fibromyalgia
- Headache
- Lower Back
- Myofascial
- Skeletal Muscle

**Neuropathic**
- Neuropathic Lower Back
- Polyneuropathy (DM/HIV)
- Post Herpetic
- Trigeminal Neuralgia
Clinical Treatment Algorithms

<table>
<thead>
<tr>
<th>Nociceptive Pain</th>
<th>Neuropathic Pain</th>
<th>Mixed Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Pharmacological (Active &amp; Passive)</td>
<td>Non-Pharmacological (Active &amp; Passive)</td>
<td>Non-Pharmacological (Active &amp; Passive)</td>
</tr>
<tr>
<td>APAP then +-NSAID*</td>
<td>Acute Trial of NSAID/APAP</td>
<td>Acute Trial of NSAID/APAP</td>
</tr>
<tr>
<td>Topical Agent (NSAID, Lidocaine, Capsaicin)</td>
<td>Age on Topical Agent (NSAID, Lidocaine, Capsaicin)</td>
<td>Topical Agent (NSAID, Lidocaine, Capsaicin)</td>
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<tr>
<td>Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)</td>
<td>Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)</td>
<td>Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)</td>
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<tr>
<td>Tricyclic Antidepressant (TCA)</td>
<td>Tricyclic Antidepressant (TCA)</td>
<td>Tricyclic Antidepressant (TCA)</td>
</tr>
<tr>
<td>Anti-Epileptic Drugs (AEDs)</td>
<td>Anti-Epileptic Drugs (AEDs)</td>
<td>Anti-Epileptic Drugs (AEDs)</td>
</tr>
<tr>
<td>Gastroenteroids**</td>
<td>Gastroenteroids**</td>
<td>Gastroenteroids**</td>
</tr>
</tbody>
</table>

1st Line:
- Combination 1st & 2nd Line Agents
- Acute Add-On Muscle Relaxer***
- Controlled Substance Class III
- Interventional Therapy
- Controlled Substance Class II (IR)
- Referral to Specialist

2nd Line:
- Combination 1st & 2nd Line Agents
- Acute Add-On Muscle Relaxer***
- Controlled Substance Class III
- Interventional Therapy
- Controlled Substance Class II (IR)
- Referral to Specialist

3rd Line:
- Spinal Cord/Dorsal Root Ganglion Stimulation
- Controlled Substance Class II (ER)
- Implantable Intrathecal (IT) Meditrac/Infusaid Zeonide
- Botulinum Toxin (BTX A)
- Consider Clinical Trial

4th Line:
- Spinal Cord/Dorsal Root Ganglion Stimulation
- Controlled Substance Class II (ER)
- Implantable Intrathecal (IT) Meditrac/Infusaid Zeonide
- Botulinum Toxin (BTX A)
- Consider Clinical Trial

For more information, visit www.sempguidelines.org

PAINweek
Nociceptive Pain

Clinical Treatment Algorithm

1st Line
Non-Pharmacological
APAP then +/- NSAID
Topical Agent
(NSAID, Caine, Capsaicin)

2nd Line
SNRI
TCA
C-IV
Consider Referral to Specialist

3rd Line
Combination of 1st/2nd Line
Acute Add-On Muscle Relaxer
C-III
Interventional Therapy
C-II (IR)
*Referral to Specialist Needed

4th Line
Spinal Cord/Dorsal Root Ganglion Stimulation
C-II (ER)
Implantable/Intrathecal (IT)
morphine/baclofen/ziconotide
Consider Clinical Trial

www.sempguidelines.org
Neuropathic Pain
Clinical Treatment Algorithm

1st Line
Non-Pharmacological
Acute Trial of NSAID/APAP
Add-On Topical Agent
( NSAID,-Caine, Capsaicin)
Gabapentinoids
SNRI
TCA

2nd Line
Anti-Epileptic Drugs
(AEDs)
C-IV
Consider Referral to Specialist

3rd Line
Combination of 1st/2nd Line
Acute Add-On Muscle
Relaxer
C-IV
C-III
Interventional Therapy
C-II (IR)
*Referral to Specialist Needed

4th Line
Spinal Cord/Dorsal Root
Ganglion Stimulation
C-II (ER)
Implantable/Intrathecal (IT)
morphine/baclofen/ziconotide
Botox Injection
Consider Clinical Trial

www.sempguidelines.org
Mixed Pain Algorithm

1st Line

Non-Pharmacological
APAP then +/- NSAID
Topical Agent (NSAID-, Caine, Capsaicin)

2nd Line

Gabapentinoids
SNRI
TCA
C-IV
Consider Referral to Specialist

3rd Line

Combination of 1st/2nd Line
Acute Add-On Muscle Relaxer
C-III
Interventional Therapy
C-II (IR)
*Referral to Specialist Needed

4th Line

Spinal Cord/Dorsal Root Ganglion Stimulation
C-II (ER)
Implantable/Intrathecal (IT)
morphine/baclofen/ziconotide
Consider Clinical Trial

www.sempguidelines.org
# Pain Management Algorithm

## Patient & Provider(s) Agreement

**1st Line**
- **Nociceptive Pain**
  - Non-Pharmacological (Active & Passive)
  - APAP then − NSAID
  - Topical Agent (NSAID, Lidocaine, Capsaicin)
- **Neuropathic Pain**
  - Non-Pharmacological (Active & Passive)
  - Acute Trial of NSAID/APAP
  - Add on Topical Agent (NSAID, Lidocaine, Capsaicin)
  - Gabapentinoids
- **Mixed Pain**
  - Non-Pharmacological (Active & Passive)
  - Acute Trial of NSAID/APAP
  - Topical Agent (NSAID, Lidocaine, Capsaicin)

**2nd Line**
- Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)
- Triyclic Antidepressant (TCA)
- Consider Referral to Specialist

**3rd Line**
- Combination 1st & 2nd Line Agents
  - Acute Add-On Muscle Relaxer
  - Controlled Substance Class III
  - Interventional Therapy
  - Controlled Substance Class II (IR)
  - Referral to Specialist Needed

**4th Line**
- Spinal Cord/Dorsal Root Ganglion Stimulation
- Controlled Substance Class II (ER)
- Implantable Intrathecal (IT)
  - Medtronic/Intermedics
  - Botox Injection
- Consider Clinical Trial

---

**PainWeek**

www.sempguidelines.org
The West Virginia Way
Almost Heaven...
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**
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
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
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
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
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 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 form afar that would indicate an opioid (Heroin) overdose?

a) Slow Heart Rate
b) Pin Point Pupils
c) The Death Rattle
d) Hypoxia
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 form afar that would indicate an opioid (Heroin) overdose?

a) Slow Heart Rate
b) Pin Point Pupils
c) The Death Rattle
d) HYPOXIA
63,400 US Drug Overdose Deaths (2016)
Discussion

Mark Garofoli, PharmD, MBA, BCGP, CPE
LinkedIn: Mark Garofoli