

Trainwreck: Addressing Complex Pharmacotherapy With the Inherited Pain Patient

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Disclosures

Nothing to disclose

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2

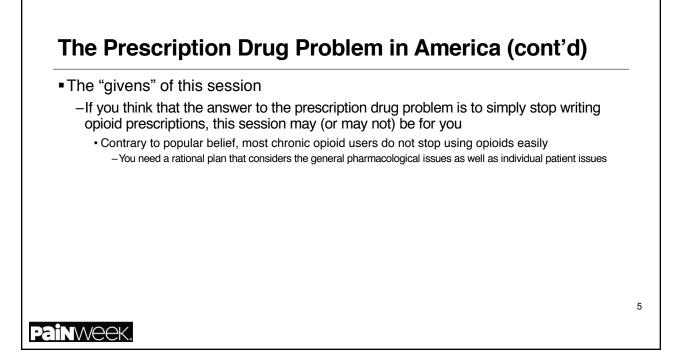
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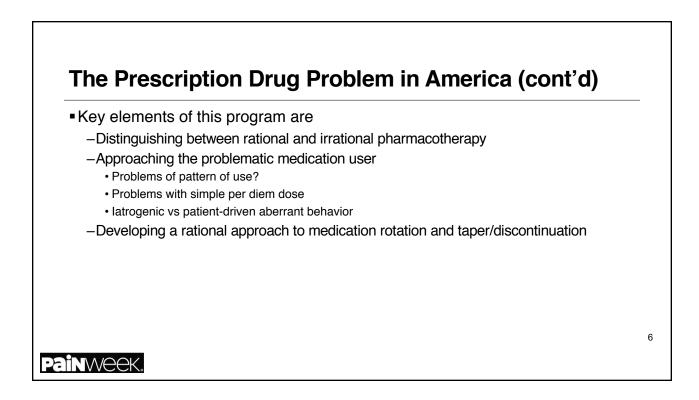
Learning Objectives

- Assess the prescription drug problem in America
- Discuss the CDC guidelines on opioids in chronic pain
- Appraise what is pharmacological instability?
- Judge the importance of documentation

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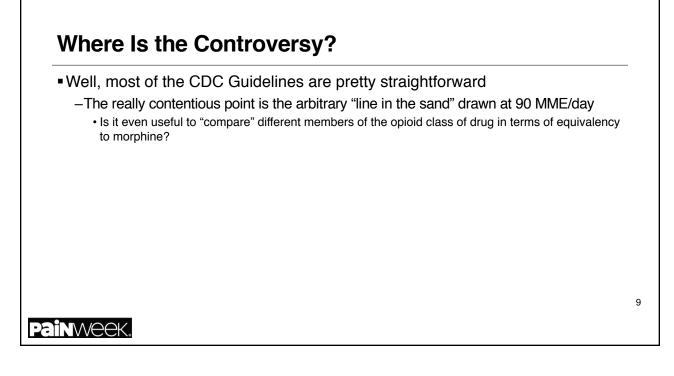
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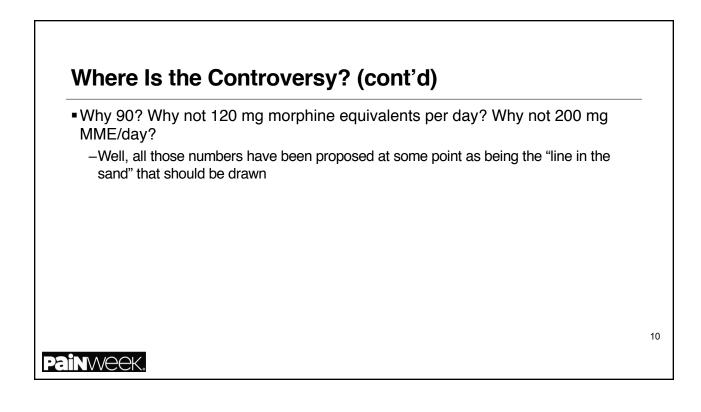
CDC Guidelines Summary

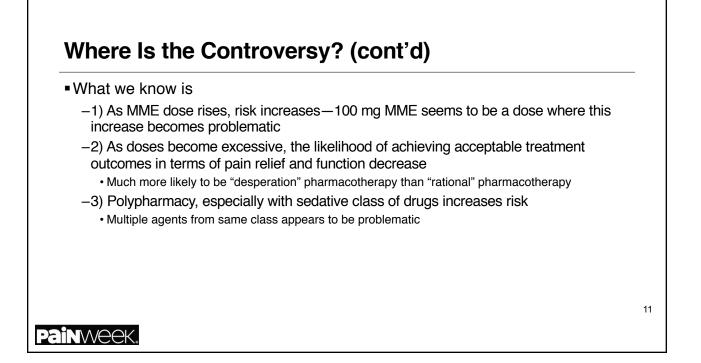
- Nonpharmacotherapy/nonopioid therapy preferred
- Before opioids, establish realistic treatment goals (pain/function)
- Risk/benefits assessment/discussion with patient
- Begin with IR rather than SR opioid preparations
- Start at lowest effective dose (avoid doses >90 MME/day)
- Acute pain <3 days (rarely >7 days)

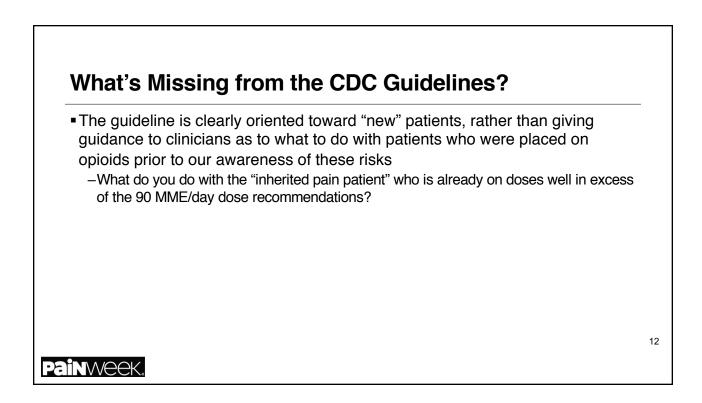
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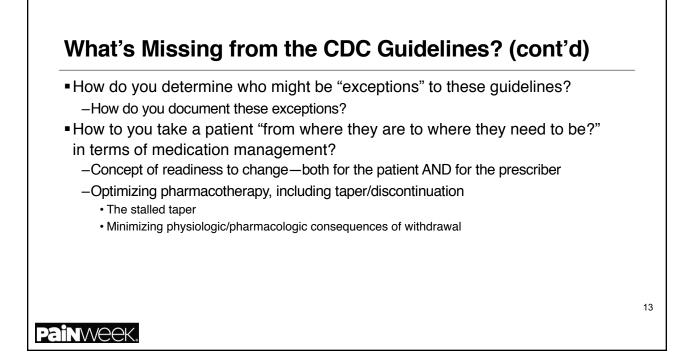
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Documentation Requirements

The importance of documentation can't be overstated

- -Your medical record must clearly establish the thought process used to come to the proposed treatment plan
 - Detox \neq Tapering as a legal concept



15

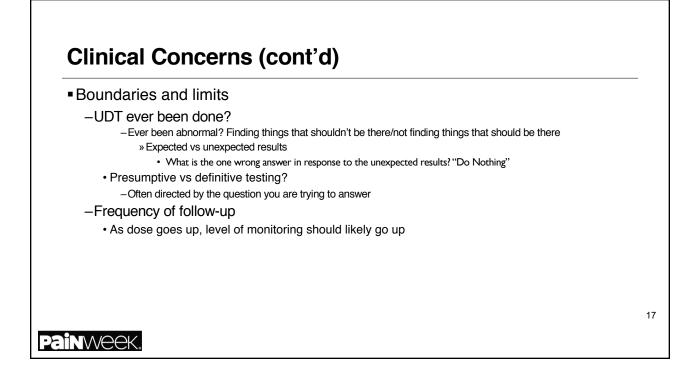
Documentation Requirements (cont'd)

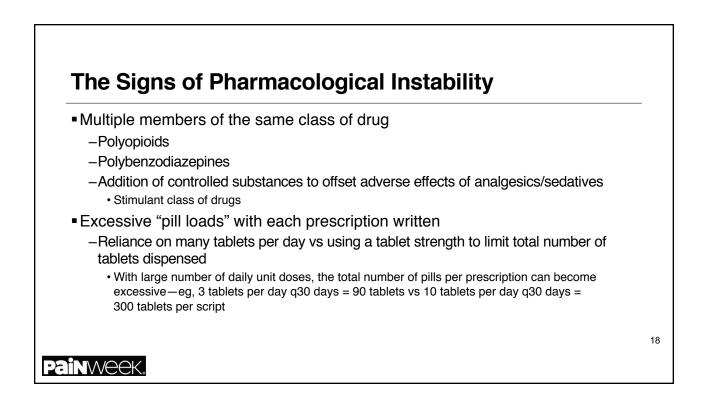
 If your treatment plan departs from currently accepted guidelines, it must be clear WHY this departure is appropriate or if this departure is part of a longer term plan to bring the patient into compliance

-Many of these cases are going to be "inherited," ie, initiated under the old model of "no ceiling means no limit" in terms of acceptable agonist dose

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The Signs of Pharmacological Instability (cont'd)

- Running out early
 - Failure to specify how long a prescription should last makes it very difficult to objectively assess "early refills"
- Excessive sedation/somnolence on current medication regimen
 - -Consider 3rd party sources of information, eg, spouse/family
- Diminished rather than improved function
 - -"continued use despite harm"
- Decreased duration of action +/- AM withdrawal symptoms associated with pharmacologic instability

 Need to increase dosing frequency to achieve stability (eg, once daily medication taken BID; TID; even QID)

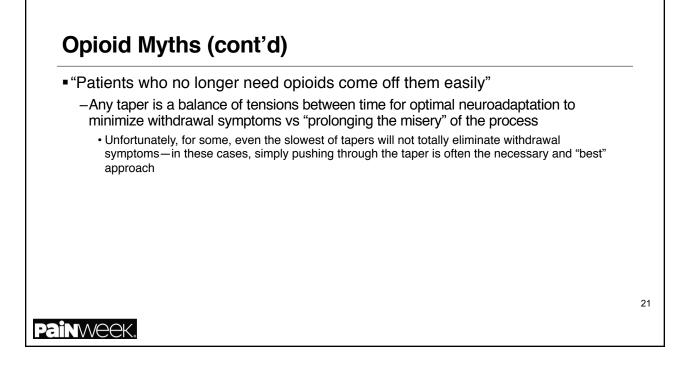
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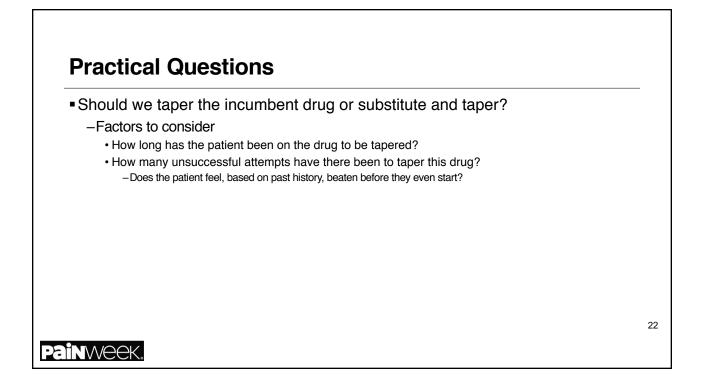
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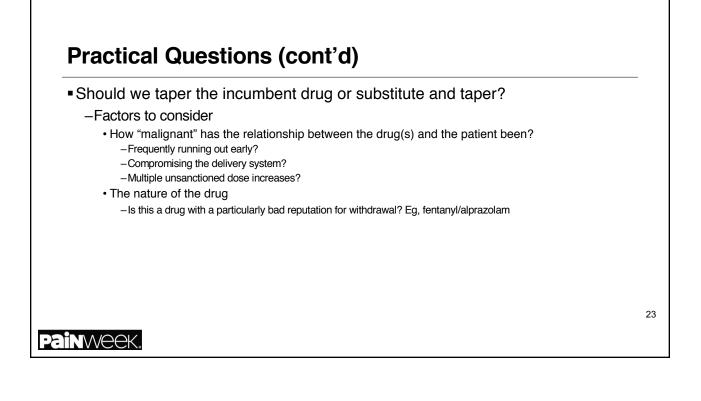
Opioid Myths

- "Patients who no longer need opioids come off them easily"- NO
 - -For the most part, this is nonsense
 - -Physical dependency and accompanying withdrawal is largely person-specific but certain truths should be considered
 - As dose goes up and duration on the drug increases, the degree of withdrawal often increases (but not always the case)
 - The ease with which the taper goes at the beginning rarely predicts how easy/difficult the taper will be at the end (eg, when they are finally off the medication altogether)









Conclusions

Clearly, there are more questions than answers to this challenging topic
We hope that today's session has expanded on some of these issues

 In the context of "desperation pharmacotherapy" the status quo is rarely the correct answer

QUESTIONS?

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24

References

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25