Chronic Pain & Analgesic Abuse

NHOULA
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Tim Judge MD & Jeffery Grubbe MD, FACP
Chief Medical Director
Allstate Insurance Company
Pain... its relative

“Snapshots at jasonlove.com

“A high-pain job? Yes, I believe we have that.”
“You can work in Underwriting!”
Chronic Pain & Analgesic Abuse

Outline:

- Painful questions
- Pain overview:
  - Definitions, mechanisms and treatments
- Prescription drug abuse overview:
  - Incidence, risk factors and implications
- Underwriting “chronic pain” cases
- Case Studies
- Review of questions
Painful questions

1) The “typical” prescription drug abuser...
   a) Is 18 -25 years old
   b) Lives in an urban area
   c) Has stolen the medication from a pharmacy
   d) None of the above

2) Differences between acute pain and chronic pain...
   a) Acute pain has no biologic function, chronic pain does
   b) Chronic pain sufferers tend to rate their pain levels higher
   c) There is no difference other than the duration of pain
   d) The cause for chronic pain is more easily identified and treated
3) Those more likely to overdose on prescription medication...
   a) Often obtain medications from multiple providers: “Doctor shoppers”
   b) Often use multiple medications and in higher doses
   c) Have a history of mental illness or substance abuse
   d) All of the above

4) The incidence of prescription drug abuse and overdose...
   a) Has leveled off although the number of prescriptions continue to increase
   b) Is rising fastest in middle age adults
   c) Is highest in Illinois
   d) b & c
Painful questions

5) The incidence of cocaine and heroin overdoses are rising faster and higher than that due to prescription opioids
   a) True
   b) False

6) In the last three years the Federal Drug Administration has taken aggressive action to curtail the steep rise in prescription drug abuse and overdose
   a) True
   b) False
Painful questions

7) Pain is easily defined, characterized and quantified
   a) True
   b) False

8) The elderly have additional risks and concerns when using prescription medication, especially with multiple medications and narcotics
   a) True
   b) False
Pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”

International Association for the Study of Pain
Pain is never permanent. (Saint Teresa of Avila)

Illusions commend themselves to us because they save us pain and allow us to enjoy pleasure instead. We must therefore accept it without complaint when they sometimes collide with a bit of reality against which they are dashed to pieces. (Sigmund Freud)

Whoever is spared personal pain must feel himself called to help in diminishing the pain of others. We must all carry our share of the misery which lies upon the world. (Albert Schweitzer)

The worst pain a man can suffer: to have insight into much and power over nothing. (Herodotus)
“Nociceptive” vs. “Neuropathic” Pain

“Nociceptive”

- Activation of nociceptors in tissues and organs
  - Nociceptors are highly specialized sensory neurons that respond only to pain
  - Sensation passes thru pain fibers and the dorsal horn of the spinal cord to pain centers in the brain (thalamus, sensory cortex)
  - Neuroreceptors and neurotransmitters in tissues, organs and the nervous system all play a part
- Superficial vs. Deep
  - Deep Somatic
    - Ligaments, bones, fascia, muscles. Tends to be dull and poorly localized
  - Visceral
    - Organs. More often localized
Convergence of sensory nerves from the visceral and superficial areas onto the same neurons in spinal cord.

This is the major route by which pain and temperature information ascend to the cerebral cortex. 

“Nociceptive” vs. “Neuropathic” Pain

“Neuropathic”

- Disease, damage or dysfunction of the nervous system
  - Sympathetically mediated: autonomic
    - Reflex sympathetic dystrophy
  - Peripheral:
    - Post-herpetic neuralgia, diabetic neuropathy
  - Central:
    - Brain or spinal cord injury, MS
Reflections on pain
from the athlete...

- Pain is temporary. It may last a minute, or an hour, or a day, or a year, but eventually it will subside and something else will take its place. If I quit, however, it lasts forever. (Lance Armstrong)

- The last three or four reps is what makes the muscle grow. This area of pain divides the champion from someone else who is not a champion. That's what most people lack, having the guts to go on and just say they'll go through the pain no matter what happens. (Arnold Schwarzenegger)

- I go out there and get my eyes gouged, my nose busted, my body slammed. I love the pain of the game. (Dennis Rodman)
Pain descriptors:

- Intensity: Mild to severe
  - Subjective
- Sensation: burning, shooting, aching, electrical etc.
- Quality: discomfort, soreness, tightness, stiffness etc.
- Frequency and duration: fleeting, intermittent, persistent or constant, fluctuating etc.
Pain perception

- Pain effects men and women differently
  - Women tend to recover more quickly, seek help sooner and less likely to allow pain to interfere with their lives
  - May be related to hormone differences, coping skills, support resources
  - Different medications work better in women (kappa-opioids)

- Psychological and cultural factors effect how we respond to pain
  - Children cuddled and comforted vs. encouraged to “tough it out”
Measuring pain

- World Health Organization: “Pain ladder”
  - Three levels:
    - **Mild**: self-limited, goes away with little or no treatment (rest & OTC)
    - **Moderate**: interferes with function and daily activities but resolves with treatment (OTCs or mild short acting analgesic)
    - **Severe**: interferes with some or all activities, often confining and requires continuous treatment (Opioids & adjuvant therapies)
Faces Pain Scale – Revised, ©2001, International Association for the Study of Pain
www.iasp-pain.org/FPSR
Adolescent pain scale

No Pain        Mild Pain     Nagging Pain     Miserable Distressing
Annoying      Uncomfortable Horrible

Intense        Worse          Pain
      Dreadful      Unbearable

Worse

Pain

Unbearable

Horrible

Dreadful

Intense

Miserable

Distressing

Nagging

Pain

Uncomfortable

Annoying

Mild Pain

Pain

No Pain
The Grubbe Pain Scale

“IT’s a Good Day in Huskerville!”

“HR says I was supposed to do what first?”

“I bet on the Broncos…”

“Nobody remembered my birthday.”

“What do you mean it’s not on Technology’s priority list?”

“No...we’re not going to waive that requirement!!”

“Tell them I’m busy!”

“Yet another lecture on pain”
Evaluation of pain

- History:
  - Characteristics:
    - Location
    - Intensity
    - Consistency
    - Onset & duration
    - Triggers
    - Relieving factors
  - Associated symptoms
    - Restriction of motion, swelling, stiffness
    - Color or temperature changes
    - Changes in muscles strength
    - Changes in sensation
Evaluation of pain

History continued:

- Impact of pain
  - Sleep
  - Occupation
  - Mood, affect, anxiety
  - Relationships
  - Social or recreational activities
  - Exercise
  - Activities of daily living

- Previous evaluations and treatments
  - Surgeries
  - Medication history
  - Non-medication modalities
Evaluation of pain

- Complete physical exam including:
  - Full physical assessment
  - Neurologic assessment
  - Functional capacity
  - Endurance & strength
Evaluation of pain

- Diagnostic testing:
  - Blood work:
    - Directed at suspected source of pain
    - Inflammatory markers; CRP, ESR
  - Imaging:
    - Directed at suspected source and location of pain
    - Ultrasound, x-rays, CT scan, GI and renal scans, MRI etc.
  - Neurophysiologic studies:
    - NCV/EMG
    - Nerve blocks
  - Psychiatric
    - PTSD, depression, addictions, anxiety
    - Psychosocial assessments & support systems
    - Cognitive issues
Reflections on pain
from the comedian...

- In those days the best painkiller was ice; it wasn't addictive and it was particularly effective if you poured some whiskey over it. (George Burns)

- My mother was a professional sick person; she took a lot of pain pills. There are many people like that. It's just how they are used to getting attention. I always remember she's the daughter of alcoholics who'd leave her alone at Christmas time. (Jim Carrey)

- I’m not into working out. My philosophy is no pain, no pain. (George Carlin)
Acute vs. Chronic Pain

- Acute pain: normal sensation to alert you to the possibility of injury
  - “Is a vital, protective mechanism the permits us to live in an environment fraught with potential dangers” (Woolf CJ, AIM 2004; 140:441)
  - Typically comes on suddenly and self-limited
  - The cause can usually be recognized and treated

Chronic pain: persists weeks, months even years

- “Pain without biologic value that has persisted beyond the normal tissue healing time (usually 3 months)”: International Association for the Study of Pain
- It may start as an acute injury but then persist
- May have multiple concurrent causes or no readily identifiable cause
- Often made worse by environmental and psychological factors
- Often resistant to medical treatment
- The prognosis often depends on the cause &/or the individuals perception of the pain

Chronic Pain

- One of the most common reasons for seeking medical attention
- Affects over 100 million in the U.S.
  - 30%+ U.S. population has chronic or persistent pain
- Accounts for 20% of outpatient visits & 12% of all prescriptions
- Most chronic pain sufferers rate their pain as moderate to severe
- 80% report a disruption of daily activities and in 66%, a negative effect on relationships
- Most common cause for long term disability with over 50 million lost work days per year in the U.S.
- Estimated at over $100B annually for direct and indirect costs

www.uptodate.com
Common causes of chronic pain

- Back pain: 10.1%
- Leg/foot pain: 7.1%
- Arm/hand pain: 4.1%
- Headache: 3.5%
- Regional pain: 11.1%
- Wide spread pain: 3.6%
- Multiple sources: ~60%

Chronic pain: Associated symptoms

- Fatigue
- Sleeplessness
- Withdrawal from activities, relationships, work
  - Non-productive, socially withdrawn
- Mood changes:
  - Hopelessness, fear, depression, irritability, anxiety, stress etc.
- Immune suppression:
  - inhibition natural killer cells which can delay healing and allow cancers to grow
  - Cytokine levels can be affected
- Functional limitations and disability
Chronic pain management

- Tends to be complex
- Focuses on functional improvement and pain reduction rather than full recovery and complete pain relief

- Includes:
  - Exercise
  - Various therapies: physical, occupational and behavioral
    - Manipulation, neuro-stimulators, biofeedback,
  - Pharmaceutical treatment
Chronic pain treatment

- Medications may include:
  - Non-steroidal anti-inflammatory drugs (NSAIDS), Tramadol & Acetaminophen
    - Mild to moderate pain
    - Potential SE: bleeding, ulcers, kidney and liver failure
  - Anti-depressants: Tricyclics (amitriptyline, doxepin), SNRIs (Cymbalta, Effexor)
    - Neuropathic pain
    - Potential SE: sedation, confusion, constipation, hepatic dysfunction, arrhythmias & low BP, seizures, ataxia
  - Anti-epileptic drugs: Lyrica, Neurontin, carbamazepine (Tegretol)
    - Neuropathic pain
    - Potential SE: sedation, confusion, syncope, weight gain & edema, serious drug reactions
  - Muscle relaxants: cyclobenzaprine (Flexeril), baclofen, carisoprodol (Soma)
    - Potential SE: sedation, dizziness, confusion, fatigue, arrhythmias
Chronic pain treatment

Medications cont:

- Opioid analgesics: narcotics
  - Short acting: hydrocodone (Vicodin) & oxycodone (Percocet) for more severe intermittent pain
  - Long acting: methodone, fentanyl (Duragesic), sustained-release morphine (MS-Contin) & oxycodone (OxyContin) for more chronic constant pain
  - Infusion pumps: “Patient-controlled anesthesia” PCA pumps for severe intractable pain
  - Potential SE: sedation, confusion, nausea and vomiting, dizziness, constipation, respiratory & cardiac depression, physical dependence, tolerance & addiction
# Opioid Potencies

**Table 1: Equianalgesic Dose**

<table>
<thead>
<tr>
<th>Drug</th>
<th>PO Dose</th>
<th>PO:SC/IV Ratio</th>
<th>SC/IV Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10 mg</td>
<td>2:1</td>
<td>5 mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>100 mg</td>
<td>2:1</td>
<td>50 mg</td>
</tr>
<tr>
<td>Oxycodone*</td>
<td>5 mg</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2 mg</td>
<td>2:1</td>
<td>1 mg</td>
</tr>
<tr>
<td>Methadone†</td>
<td>1 mg</td>
<td>--</td>
<td>too irritating</td>
</tr>
<tr>
<td>Fentanyl‡ - infusion</td>
<td>--</td>
<td>--</td>
<td>0.05 mg</td>
</tr>
<tr>
<td>Fentanyl patch</td>
<td>use chart supplied by manufacturer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

morphine 10 mg po = codeine 100 mg po
  = oxycodone 5-7.5 mg po
  = hydromorphone 2 mg po
  = methadone 1 mg po
<table>
<thead>
<tr>
<th>Schedule I Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- High potential for abuse</td>
</tr>
<tr>
<td>- No currently accepted medical use in the U.S.</td>
</tr>
<tr>
<td>- Lack of accepted safety for use of the drug under medical supervision</td>
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<table>
<thead>
<tr>
<th>Schedule II Drugs</th>
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<tbody>
<tr>
<td>- High potential for abuse</td>
</tr>
<tr>
<td>- Currently accepted medical use in the U.S.</td>
</tr>
<tr>
<td>- Abuse may lead to severe psychological or physical dependence</td>
</tr>
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<table>
<thead>
<tr>
<th>Schedule III Drugs</th>
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</thead>
<tbody>
<tr>
<td>- Potential for abuse less than schedule I and II drugs</td>
</tr>
<tr>
<td>- Currently accepted medical use in the U.S.</td>
</tr>
<tr>
<td>- Abuse may lead to moderate or low physical dependence or high psychological dependence</td>
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<table>
<thead>
<tr>
<th>Schedule IV Drugs</th>
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<tbody>
<tr>
<td>- Lower potential for abuse less than schedule III drugs</td>
</tr>
<tr>
<td>- Currently accepted medical use in the U.S.</td>
</tr>
<tr>
<td>- Abuse may lead to limited physical or psychological dependence relative to schedule III substances</td>
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<tr>
<th>Schedule V Drugs</th>
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<tbody>
<tr>
<td>- Low potential for abuse relative to schedule IV substances</td>
</tr>
<tr>
<td>- Currently accepted medical use in the U.S.</td>
</tr>
<tr>
<td>- Abuse may lead to limited physical or psychological dependence relative to schedule IV substances</td>
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</table>

Heroin, marijuana, mescaline, methaqualone, psilocybin

Cocaine, codeine, oxymorphone, dextropropoxyphene, hydrocodone, Methadone, morphine, oxycodone, opium
Amphetamine, methamphetamine, barbiturates, phencyclidine (PCP)

Codeine+, hydrocodone+, Morphine+, opium+, peragoric
Butalbital ketamine, thiopental, pentobarbital+

Alprazalam, barbital, chloral hydrate, diazepam, lorazepam, phenteramine, zolpidem, buprenorphine

Paragabalin (Lyrica), Lomotil, Phenergan with codeine & numerous other antitussives/anti-emetics
Reflections on pain from the Pro!

- There is no more lively sensation than that of pain; its impressions are certain and dependable, they never deceive as may those of the pleasure......

Marquis de Sade
Why the concern?

- Prescription painkiller overdoses killed nearly 15,000 people in the US in 2008. This is more than 3 times the 4,000 people killed by these drugs in 1999.
- In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
- Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.

Prescription Drug Overdose, Centers for Disease Control and Prevention [www.cdc.gov](http://www.cdc.gov)
Analgesic & Prescription Drug Abuse

Certain groups are more likely to abuse or overdose on prescription painkillers.

- Many more men than women die of overdoses from prescription painkillers.
- Middle-aged adults have the highest prescription painkiller overdose rates.
- People in rural counties are nearly twice as likely to overdose on prescription painkillers as people in big cities.
- Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers.
- About 1 in 10 American Indian or Alaska Natives aged 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 whites and 1 in 30 blacks.

Prescription Drug Overdose, Centers for Disease Control and Prevention [www.cdc.gov](http://www.cdc.gov)
Analgesic & Prescription Drug Abuse

The supply of prescription painkillers is larger than ever.

- The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors’ offices was 4 times larger in 2010 than in 1999.
- Many states report problems with "pill mills" where doctors prescribe large quantities of painkillers to people who don’t need them medically. Some people also obtain prescriptions from multiple prescribers by "doctor shopping."

Prescription Drug Overdose, Centers for Disease Control and Prevention [www.cdc.gov](http://www.cdc.gov)
Analgesic & Prescription Drug Abuse

Some states have a bigger problem with prescription painkillers than others.

- Prescription painkiller sales per person were more than 3 times higher in Florida, which has the highest rate, than in Illinois, which has the lowest.
- In 2008/2009, nonmedical use of painkillers in the past year ranged from 1 in 12 people (age 12 or older) in Oklahoma to 1 in 30 in Nebraska.
- States with higher sales per person and more nonmedical use of prescription painkillers tend to have more deaths from drug overdoses

Prescription Drug Overdose, Centers for Disease Control and Prevention [www.cdc.gov](http://www.cdc.gov)
Analgesic & Prescription Drug Abuse

Addicts are going to look in your medicine cabinet for the bottle of Vicodin you didn’t finish after you had your wisdom teeth out in 2006. Get rid of it.

They’re going to take the Percocet the doctor prescribed after your C-section last year. Throw it out.

They might be over for a dinner party — or they might be at your table every night.

Scary, right? But even more scary: Most of the time they don’t have to steal them — you’re giving your pills away.

More than half of people who abuse prescription painkillers — 55 percent — get them free from a friend or relative, according to the Centers for Disease Control and Prevention.

Another 18 percent have prescriptions from doctors, 5 percent steal the drugs and another 11 percent buy them from someone they know.

A Wilber family wants people to think about the implications of that.

Krystal and Ray Uher’s youngest daughter was 26 when she went out with friends and mixed alcohol with prescription drugs.

Melanie Uher Flom was taking Lexapro prescribed for depression, her mother said last week. The night she died, she swallowed hydrocodone — a painkiller given to her by an acquaintance — and washed it all down with alcohol.

They baptized her baby girl the day of her funeral. Jace is 21 months old now, being raised by her father in Minnesota. And Melanie’s parents and siblings are trying to make something good come from her mistakes.

Last year, they talked to townsmen and school kids in Wilber.

And this fall, they shared Melanie’s story with People magazine. It was featured along with three others last month, all variations on the same theme: Prescription drug abuse is a growing and deadly problem.

You don’t have to Google far to verify that.
Where the drugs come from

- Almost all prescription drugs involved in overdoses come from prescriptions originally.
- Very few come from pharmacy theft. However, once they are prescribed and dispensed, prescription drugs are frequently diverted to people using them without prescriptions.
- More than three out of four people who misuse prescription painkillers use drugs prescribed to someone else.
- Most prescription painkillers are prescribed by primary care and internal medicine doctors and dentists, not specialists. Roughly 20% of prescribers prescribe 80% of all prescription painkillers.
People who abuse prescription painkillers get drugs from a variety of sources:

- Obtained free from friend or relative: 55%
- Prescribed by one doctor: 17.3%
- Bought from friend or relative: 11.4%
- Took from friend or relative without asking: 4.8%
- Got from drug dealer or stranger: 4.4%
- Other source: 7.1%
Prescription Drug Overdose

Who is most at risk

- People who obtain multiple controlled substance prescriptions from multiple providers—a practice known as “doctor shopping.”
- People who take high daily dosages of prescription painkillers and those who misuse multiple abuse-prone prescription drugs.
- Low-income people and those living in rural areas.
  - People on Medicaid are prescribed painkillers at twice the rate of non-Medicaid patients and are at six times the risk of prescription painkillers overdose. One Washington State study found that 45% of people who died from prescription painkiller overdoses were Medicaid enrollees.
- People with mental illness and those with a history of substance abuse.

Prescription Drug Overdose, Centers for Disease Control and Prevention [www.cdc.gov](http://www.cdc.gov)
Prescription Drug Overdose


National Conference of State Legislatures www.ncsl.org/
Figure 3. Death rates for poisonings involving opioid analgesics, by age: United States, 1999–2006

Multiple reasons exist for why older adults are especially impacted by “polypharmacy”:

- Older individuals are at greater risk for adverse drug events due to metabolic changes and decreased drug clearance associated with aging; this risk is compounded by increasing numbers of drugs used.

- Increases the potential for drug-drug interactions.

- An independent risk factor for hip fractures in older adults associated with falls (e.g., CNS active drugs)

- Increases the possibility of “prescribing cascades” A prescribing cascade develops when an adverse drug event is misinterpreted as a new medical condition and additional drug therapy is then prescribed to treat this medical condition.

- Use of multiple medications can lead to problems with medication adherence, compounded by visual or cognitive compromise in many older adults.

- Beers Criteria of potentially inappropriate medication use in older adults
  - Published in 1991 but recently updated in the J Am Geriatriac Society 2012
Underwriting chronic pain

- Increased mortality risk due to:
  - Associated depression and other psychiatric disorders
  - Suicides & Accidents: (HR 5.21)
  - Excessive use of drugs and alcohol
  - Adverse drug effects
  - Higher risk of death due to malignancy and all causes when diffuse, widespread pain is present
    - Multiple studies (HR 1.32 - 2.07)
      - Andersson. Disability and Rehabilitation 2009;31:1980
  - Yet unidentified condition contributing to pain
Mild

Localized, well-defined source of pain with minimal physical and functional impairment. Socially engaged, reasonably active, with leisure or work interests. No associated depression or other psychiatric diagnoses. Medications used intermittently or if continuous, one or two medications at low dosages. No benzodiazepine prescription. Stable pain symptoms with only minimal medication changes or dosage increases. No concerns about medication or alcohol misuse.

Moderate

Well-defined source of pain with minimal or moderate physical and functional impairment. May use walking aids. Working or if considered disabled, continues to be socially engaged and reasonably active. May have associated mild to moderate depression. Continuous or intermittent medication use at moderate dosages. Stable pain symptoms with only minimal medication changes or dosage increases. No concerns about medication or alcohol misuse.

Severe

Diffuse or ill-defined sources of pain with physical mobility or other functional limitations. Socially isolated, limited activities, unemployed, receiving disability benefits. May have multiple medications at high dosages or frequent changes in medications. Associated moderate to severe depression. Infusion pump medication delivery system. Benzodiazepine use. Multiple physicians for pain symptoms or prescriptions. Concerns about medication or alcohol misuse.
## Present on Treatment

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</table>

## History of, no further treatment

<table>
<thead>
<tr>
<th>&lt; 1 year</th>
<th>&gt; 1 year</th>
</tr>
</thead>
</table>

## Additional Factors

- Assoc. mood or psych disorder
- Treatment with medicinal cannabis
  - With valid prescription
- Associated alcohol or substance abuse
- Benzodiazepine use
<table>
<thead>
<tr>
<th>Favorable features</th>
<th>Unfavorable features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localized, well-defined source</td>
<td>Diffuse, poorly localized &amp; ill-defined</td>
</tr>
<tr>
<td>Pain present &lt; 2 years</td>
<td>Pain present &gt; 2 years. Longer the worse</td>
</tr>
<tr>
<td>Minimal physical or functional impairment</td>
<td>Limited physical mobility or function</td>
</tr>
<tr>
<td>Socially engaged, active in work or leisure</td>
<td>Socially isolated, limited activities, disabled</td>
</tr>
<tr>
<td>No associated depression, psychiatric or other medical diagnoses</td>
<td>Associated depression, psychiatric or other medical diagnoses</td>
</tr>
<tr>
<td>Managed primarily by one physician</td>
<td>Managed by multiple physicians or referral to a pain treatment center</td>
</tr>
<tr>
<td>Prescriptions written by one physician</td>
<td>Prescriptions written by multiple physicians or referral to a pain treatment center</td>
</tr>
<tr>
<td>Intermittent or continuous use of one of two medications at low doses</td>
<td>Continuous use of multiple medications at high doses or with frequent changes</td>
</tr>
<tr>
<td>No benzodiazepine use</td>
<td>Benzodiazepine use, especially alprazolam (Xanax)</td>
</tr>
<tr>
<td>No physician expressed concerns regarding medication or alcohol abuse</td>
<td>Physician expressed concerns about medications or alcohol abuse</td>
</tr>
</tbody>
</table>
Painful Case Study #1

70 YOF non-smoker:
- Treated hypertension with good control,
- Hx of OSA but no sleep study available
- Hx of syncope in ’08:
  - Holter: 5 pauses > 2.0 sec, rare extrasystoles
  - Stress test neg, Echo grade 1 diastolic dysfunction, mild AI
- Build and vitals WNL
- Senior assessment WNL
- Quoted Preferred; underwriter suggesting SNS
Painful Case Study #1

APS review:
- HTN controlled with losartan/hctz (noted on app)
- HLP controlled with simvastatin (noted on app)
- 2008: syncope while driving resulting in MVA
  - Holter review- unremarkable (lead displacements)
  - MPI- wnl
  - Carotid dopplers- minimal ds
  - Echo-EF nl, minimal AI & MR related to aging
  - Cardiology note: “OSA dx’ed in 1992 with no follow up”
  - Conclusion: “syncope non-cardiac & related to the combination of hypoglycemia and Lortab use”
- No recurrent syncope noted in APS since ‘08
Painful Case Study #1

APS review cont:
- Hip replacements in ’06 & ‘08
- 2008: L4 compression fracture resulting in chronic pain
  - Rx: PT, sleepers, NSAIDS, pain meds
Painful Case Study #1

Script Check: 2006-2012

- 11 prescribing physicians
- Various pain meds prescribed by 5 physicians
- 2 States (S. Carolina & Florida)
- Meds:
  - Sleepers: Lunesta, Ambien, Restoril, Seroquil
  - Muscle relaxants: butalbital (Esgic), cyclobenzaprine (Flexeril)
  - Narcotics: Lortab, Norco, hydrocodone, tramadol
Painful Case Study #1

- Positive factors?
- Negative Factors?
- Agree with the initial assessment?
- Final assessment?
Painful Case Study #2

51 yof, ex-smoker,
BP 132/80, 5’9”, 190#.

App. History:
Disabled since broke back 6 years ago -- rx oxycotine & gabapentin
Quit tob: 4/12

Agent Quoted: SNS
Painful Case Study #2

APS review summary:
Nov. 12, 2010: New patient exam:

- Urinary incontinence
- Hypertension: 160/100
- Chronic LBP, disabled after MVA 2006
- Laminectomy ’06
- “Depression due to pain”
- Rx: PT, lidocaine patch, Mobic, oxycodone, back support, incontinence pads
Painful Case Study #2

APS review summary cont:

- Marked elevation of BPs (180s/110s+) begun on enalapril, clonodine, nifedipine.
- Back pain: MRI, past lami, severe spinal stenosis/DJD
- Cough: CXR neg. “Bronchitis”
- Multiple visits for back pain issues...
Painful Case Study #2

Multiple visits for back pain issues...

11-26-2011- renewed oxycontin 30mg (#120), referral to neurosurgeon (no record)
12-2010—increased oxycontin (#120) and Flector patch (topical NSAID)
01-10-2011- added Percocet 10/325 (#240) and Oxycontin
02-14-2011—increased dose oxycontin 30mg (#240), Percocet (#120) “pain management & Neurosurgeon (no records)
03-28-2011—“no oxycontin at the pharmacy and so got Opana (oxymorphone) and will return the scrip for Oxy tomorrow”
04-22-2011— added Ambien to oxycontin (#120)
04-25-2011- “anxiety/insomnia” clonazepam 0.25 added
05-16-2011—“lost the scrip” and needed it rewritten (oxycontin #120)
05-27-2011—“lost the scrip” again and now Opana written (#120)
06-17-2011—didn’t buy Opana (“too expensive”) and needed oxy again. Referral to pain management and psychologist (no records)
07-06-2011—“pain mgmt. is on vacation” and so he had to write the scripts again
04-09-2012—back for more meds as more pain
Painful Case Study #2

- Positive factors?
- Negative Factors?
- Agree with the initial assessment?
- Final assessment?
Painful questions

1) The “typical” prescription drug abuser...
   a) Is 18 -25 years old
   b) Lives in an urban area
   c) Has stolen the medication from a pharmacy
   d) None of the above

2) Differences between acute pain and chronic pain...
   a) Acute pain has no biologic function, chronic pain does
   b) Chronic pain sufferers tend to rate their pain levels higher
   c) There is no difference other than the duration of pain
   d) The cause for chronic pain is more easily identified and treated
3) Those more likely to overdose on prescription medication...
   a) Often obtain medications from multiple providers: “Doctor shoppers”
   b) Often use multiple medications and in higher doses
   c) Have a history of mental illness or substance abuse
   d) All of the above

4) The incidence of prescription drug abuse and overdose...
   a) Has leveled off although the number of prescriptions continue to increase
   b) Is rising fastest in middle age adults
   c) Is highest in Illinois
   d) b & c
Painful questions

5) The incidence of cocaine and heroin overdoses are rising faster and higher than that due to prescription opioids
   a) True
   b) False

6) In the last three years the Federal Drug Administration has taken aggressive action to curtail the steep rise in prescription drug abuse and overdose
   a) True
   b) False
Painful questions

7) Pain is easily defined, characterized and quantified
   a) True
   b) False

8) The elderly have additional risks and concerns when using prescription medication, especially with multiple medications and narcotics
   a) True
   b) False