Appendix A

An Approach to Managing Chronic Non-Terminal Pain

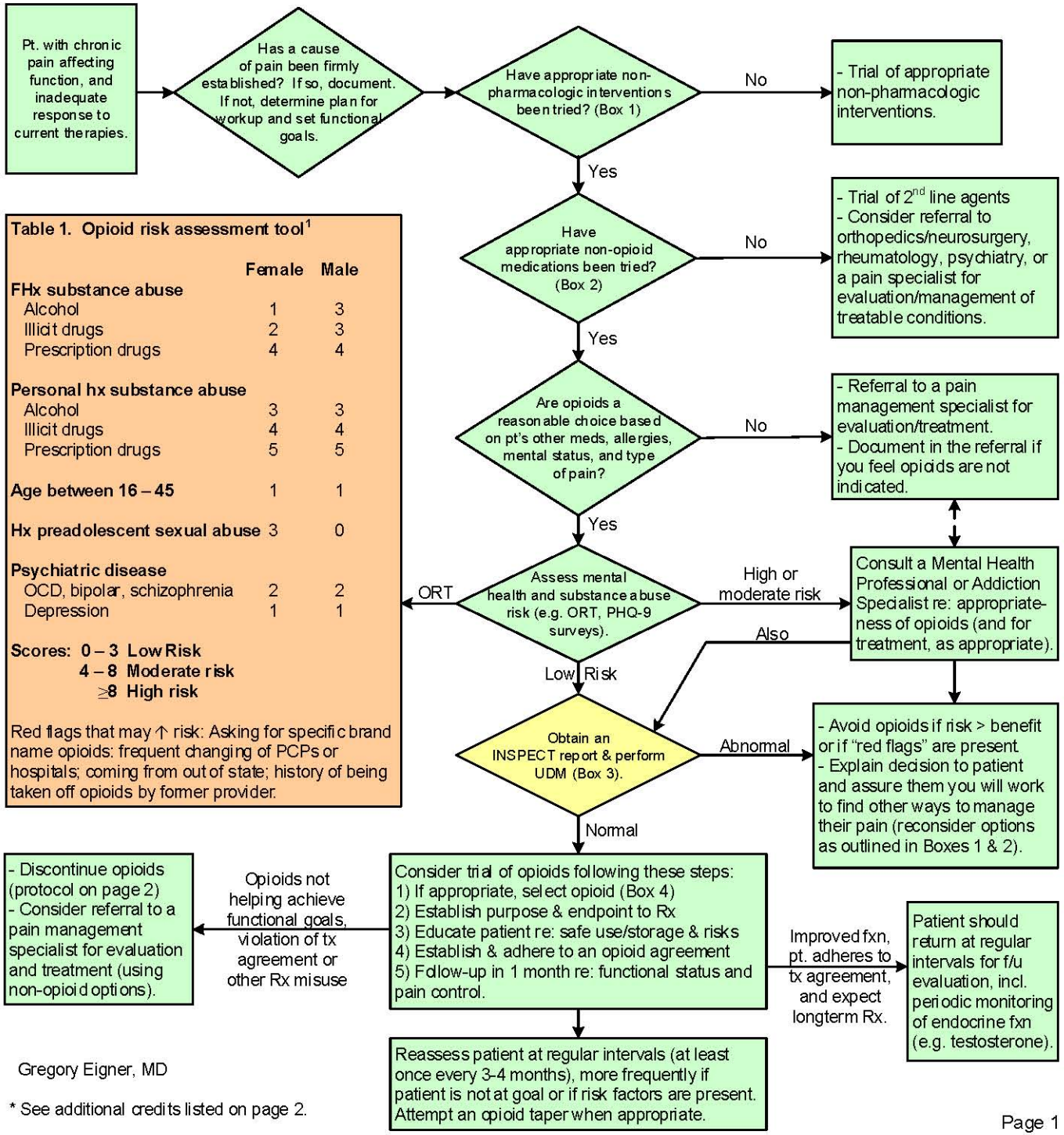

Table 1. Opioid risk assessment tool[1]

	Female	Male
FHx substance abuse		
Alcohol	1	3
Illicit drugs	2	3
Prescription drugs	4	4
Personal hx substance abuse		
Alcohol	3	3
Illicit drugs	4	4
Prescription drugs	5	5
Age between 16 – 45	1	1
Hx preadolescent sexual abuse	3	0
Psychiatric disease		
OCD, bipolar, schizophrenia	2	2
Depression	1	1

Scores: 0 – 3 Low Risk
4 – 8 Moderate risk
≥8 High risk

Red flags that may ↑ risk: Asking for specific brand name opioids: frequent changing of PCPs or hospitals; coming from out of state; history of being taken off opioids by former provider.

Box 1. Non-pharmacologic interventions[3]

MSK/inflammatory pain:
- Ice or heat packs
- Progressive exercise, stretching, yoga, relaxation, meditation
- Physical therapy, TENS therapy, hypnosis
- Manipulation (D.O., chiropractor)
- Occupational therapy, work conditioning
- Massage, acupuncture, biofeedback, Cognitive Behavior Therapy
- Surgical evaluation (e.g. joint replacement for OA)
- Interventional pain modalities
- Self-care; new mattress, new shoes
- Counseling (tobacco cessation, nutrition/weight loss)

Visceral pain:
- Dietary and other GI interventions

General:
- Review sleep hygiene

Box 2. Non-opioid medications for chronic pain[2]

MSK/inflammatory pain:
- Acetaminophen (max. 3-4 g/day)
- NSAIDs (in select nonelderly pts, monitoring GI/renal toxicity)
- Topical anesthetics (lidocaine – cream, ointment, patch)
- Anti-inflammatory creams (diclofenac cream, gel)
- Steroid injections
- Muscle relaxants (cyclobenzaprine)

Neuropathic pain:
- Tramadol (weak opioid)
- TCA's (SOR-A): nortriptyline, desipramine
- Topical anesthetics, Neuropathic creams
- SNRI's (SOR-A): duloxetine (Cymbalta®), milnacipran (Savella®)
- Anticonvulsants: gabapentin (Neurontin®), pregabalin (Lyrica®)

Visceral pain:
- NSAIDs and/or acetaminophen
- Antispasmodics (e.g. dicyclomine)

Restore sleep:
- Melatonin, TCA's, trazadone
- Avoid BZD's due to tolerance/abuse risk

Box 3. Urine Drug Monitoring (UDM) – see Toxicology Section
- Obtain urine drug screen at start, then random testing ≥ once/yr
- List controlled substances that the patient is prescribed on lab requisition, including dose/frequency & time/date of last dose.
- "Opioids" reported on UDM are codeine and morphine only.
- Specific assay required for synthetic opioids (hydro/oxycodone).

Box 4. Opioid selection[2] **(augmenting other treatments)**
- Lack of evidence for long-term benefit in chronic non-cancer pain (e.g. low back pain). Avoid use in chronic H/A, fibromyalgia, IBS.
- Begin with a short-acting opioid (e.g. hydrocodone/oxycodone → morphine) while titrating up; transition to a single, long-acting form (e.g. MS Contin®) when a stable daily dose is established.
- When switching to a different opioid, calculate the Morphine Equivalent Dose (MED) and reduce by 25-50% initially for safety.
- Avoid MED > 50-100 mg/day dose to minimize overdose risk.
- Breakthrough dosing has not been shown to improve outcomes.
- Avoid concurrent use of multiple opioids or co-tx with BZD's.
- Brand name formulations (e.g. Percocet®, Oxycontin®, Opana®) have high street value and may pose increased diversion risk.
- Avoid methadone for safety (ADR's, long variable T-½, OD risk).

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* See additional credits listed on page 2.