TRI STATE Pain Partners Newsletter

OLIVER HEADACHE & PAIN CLINIC

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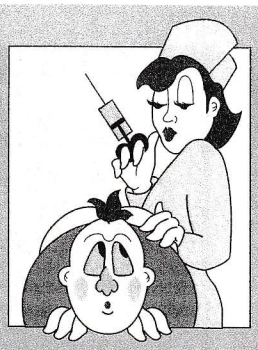
*Welcome to the second **Tri-State Pain Partners** newsletter. The Pain Partners network was developed by and for the tri-state's leading pain specialists to give us a forum to communicate with one another and a trusted referral system for comprehensive treatment of pain. Any incite, comments or contributions are invited. The pain binders will be delivered in September.*

Demerol: Limited Use in Pain Control

by Dr. Randall L. Oliver, M.D.



Unfortunately, there is very little training in medical school and residency regarding pain control with the exception of using the same dose of Demerol that the old surgeon we trained under used. Demerol is one of the worst analgesics that we have available to us. The sedative effects of Demerol is much greater than the analgesic effect. I have had physicians tell me that they do not like to give pain medication to their postop patients because the patient will become sedated. This sedation places the patient at increased risk of developing DVT or Pneumonia. The sedation, however, is from the type of pain medication that they are using--that is, Demerol. If a different analgesic, such as Morphine, is used the patient would get better pain relief with less sedation. Instead of the patient being bed-bound with pain, he or she would be able to ambulate or at least sit up due to increased pain control.

Demerol also has a huge individual variability. A dose of 25mg in one person may not be equivalent to 75mg in another. Therefore, patients tend to be improperly dosed. A much better pain medication is IV Morphine. Morphine is best dosed intravenously. If a patient is in a hospital setting and has an IV access, it is much preferable to use that IV access, than to give IM injections routinely every four hours. Not only is the pain control quicker and more even, most patients would prefer their pain medication be given IV, than to receive a painful intramuscular shot every four hours. *Remember, the more routine a pain medication is given, the better the control.*

The continuous IV pump is the preferable method of pain control. Barring this, intravenous medication is preferable to IM medication. Morphine sulfate is the preferential intravenous medication. It is easily titrated from low doses for mild to moderate pain up to high doses for severe pain. Demerol is difficult to dose, has a great sedative effect, and even is associated with Demerol toxicity.

Most pain physicians actually feel that Demerol has very little use in the treatment of pain in the modern age.

Chronic Narcotic Evaluation Checklist

by Dr. Randall L. Oliver, M.D.

Signs of Opioid Addiction

1. ❑ Overwhelming concern for drug
2. ❑ Frequent phone calls
3. ❑ Office visit devoted to discussing drug
4. ❑ Early refills
5. ❑ Stories
6. ❑ Concurrent use of other addictive drugs, such as tranquilizers
7. ❑ Concurrent use of other illicit drugs, such as Marijuana
8. ❑ History of alcohol abuse
9. ❑ Obtaining opioids or other narcotics from other physicians or from the street
10. ❑ Acceleration of drug use other than prescribed
11. ❑ Self-pay
12. ❑ No referring M.D
13. ❑ Out of town
14. ❑ Intolerant or dislike of other opioids except their drug of choice
15. ❑ Intolerant of Duragesic patch in particular
16. ❑ Preference of short-acting opioids
17. ❑ Short acting opioids work better than long acting opioids at equivalent doses
18. ❑ Inconsistent opioid response (such as, the opioid does not last as long as it should) For example Lortab works one hour or Oxycontin only lasts four hours *(Pay particular attention to the patch effect which lasts less than seventy-two hours.)*
19. ❑ Inconsistent opioid response (such as, the pain level decreasing only marginally; it takes the edge off)
20. ❑ A wide ranging pain scale (such as, the pain going from 2 out of 10 to an 8 out of 10 during the same month)

Team Approach to Back Pain

by Max Ahlers, D.C.

What is the best approach to acute back pain? Recent studies have shown that rest and NSAID's have limited effectiveness. Physical therapy can often exceed the patient's tolerance. Without medical diagnostics, chiropractic may miss underlying pathology and muscular imbalance.

We have found the best approach to be a coordinated "team" approach, using a treatment plan and outcomes established between disciplines and combining medical, chiropractic and physical therapy. Two-year studies have shown better results, less overall treatment time, reduced cost, and less chance of exacerbation using this method.

The Ahler's Chiropractic Clinic in west Evansville works closely with other disciplines, including medical, massage, and physical therapy to address the individual concerns of each patient. If you have a patient that would benefit from a team approach, Dr. Ahlers is available to discuss treatment options. He can be reached at (812) 426-1131.

Routine Dosing Versus PRN

by Randall L. Oliver, M.D.

It is much better to use every four hour routine dosing of pain medication than to use intermittent intravenous control of pain. Studies have shown that when someone receives pain medication every four hours on a PRN schedule, such that he or she asks for the pain medication, the nurse has to obtain the pain medication, and then deliver the pain medication.

There is significant time span where every four hours becomes every five or six. This allows a drop in the pain control level in the patient and allows for intermittent pain. A much better idea is to give the medication every four hours on a routine basis with special notation for the nursing staff to watch for signs of sedation or hypoventilation.

Another thing to remember is that you must give a bolus dose of your IV analgesic in order to reach a steady state. That means that if someone is postop and receiving a medication every four hours for pain, it would take them four doses or sixteen hours to reach a steady state of pain relief. For example, a patient is receiving IV Morphine 2mg every four hours for pain, they would need a 10mg bolus dose to reach a steady state and remain pain free from the first hour.

21. ❑ A hysterical or overrated pain scale (such as, the pain is a 10 out of 10 all of the time)
22. ❑ Psych abnormalities (such as:severe depression, severe anxiety, bipolar disorder, personality disorder, psychosis)
23. ❑ Lack of other chronic pain indicators (such as:little or no depression, anxiety, fatigue or insomnia)
24. ❑ Normal physical exam
25. ❑ Normal laboratory, x-ray, or other testing parameters; that is — no objective findings
26. ❑ No significant improvement in pain or function with significant dose increases
27. ❑ Unemployment, Workman's Comp., Disability
28. ❑ Pending legal claim
29 ❑ Fibromuscular disease
30. ❑ Accusatory of other physicians
31. ❑ Hysterical exam (such as a patient who moans and groans and otherwise relates a severe amount of pain and discomfort during the exam)

Signs of Opioid Success

1. ❑ Decreasing depression
2. ❑ Decrease in fatigue
3. ❑ Decrease in anxiety
4. ❑ Pain decrease response to dose or proportional to dose escalation
5. ❑ Function and/or activity increased significantly, especially in proportion to dose escalation
6. ❑ Patient contentment with medication
7. ❑ Relative or friend support improvement in pain/function (such as, improvement in personal relationships)
8. ❑ No development of tolerance
9. ❑ Level pain scale
10. ❑ Patient follows-up with ongoing psychological treatment, which shows improvement in psychological mental health function.

Avoid Talwin, Nubain or Stadol in a Chronic Narcotic State

by Randall L. Oliver, M.D.

Do not mix the agonist/antagonist with your agonist medications. Talwin, Nubain and Stadol are all agonist/antagonist medications. They work agonistically at the Kappa receptor and antagonistically at the MU receptor. All other pain medication from aspirin to Tylenol, up to Morphine, work agonistically at the MU receptor. Agonist/antagonist will antagonize the MU receptor and block the action of all medications that work at the MU receptor. This is particularly important if you have someone on a chronic narcotic such as Oxycontin, MS Contin, or Duragesic. If you add Nubain, Talwin or Stadol to them, you will block the action at the MU receptor and immediately place the patient into withdrawal. With IV Nubain or IV Stadol, this will be an immediate effect.

If you admit someone who is on a chronic narcotic such as the Duragesic patch, it is important that you leave the patient on the Duragesic patch throughout their hospital stay and add or supplement analgesic on top of that. Stopping or decreasing their chronic narcotic will only lead to acute withdrawal symptoms. This will complicate the pain control problem.

JACHO Pain Control Recommendations

Randall L. Oliver, M.D.

JACHO, the organization that regulates hospitals, has recently come out with a set of standards for hospital management of pain. It has even went to the point of recommending that most hospitals set up pain control committees. JACHO is now recognizing pain as the "fifth vital sign." Several studies have bore out interviews with patients after hospitalizations revealing that patients think they were undertreated in their pain management. Whereas, interviews with the attending nursing staff indicates that they were treated adequately. The evidence shows that patients have their pain under treated. Certainly, in the acute hospital stay, such as the postop stay, where pain is at a more malignant nature, it behooves us to be more complete in our pain control.

Coming Events

Oliver Headache & Pain Clinic
Family Practice Symposium & Health Expo
November 10, 2001
Mariott — Evansville, IN

Tri-State Orthopaedics Golf Outing
Monday, September 17, 2001
Evansville Country Club
11:30 - 12:30 - Lunch
A Shotgun Start will immediately follow the lunch
For more information call (812) 477-1558

Published Articles

Physicians Fears of Addiction
Randall L. Oliver, M.D.
Fibromyalgia Network
July 2001

The Art of Thorough Assessment in Chronic Pain Syndrome
Randall L. Oliver, M.D.
April Taylor RN, BSN
American Journal of Pain Management
Upcoming this fall

Resources

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Pain Terms

Neuralgia — Pain in distribution of nerve or nerves

Neuropathic pain — Any pain syndrome in which the predominating mechanism is a site of aberrant somatosensory processing in the peripheral or central nervous system. Some clinical neuroscientists restrict this definition to pain originating in peripheral nerves or nerve roots.

Neuropathy — A disturbance of function or pathologic change in a nerve.

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