How We Treat Chronic Pain

By Dr. Richard A. Kirkpatrick

Some authorities believe that 50 million Americans have chronic pain that is poorly controlled. Obviously, it's no big deal if you have a little stiffness in your hands, but on the other hand if you have chronic neck or spine pain, residual symptoms from a surgery or injury, or chronic pain after shingles or any other nerve damage…then pain can be a major problem for you.

Doctors are taught to ask people to state their pain level on a scale of 0 to 10, where 10 is the worst pain imaginable. Most people can function normally with pain in the 4-6 range unless activities aggravate it. On the other hand, with pain in the 7-8 level, patients have trouble sleeping or relaxing. And, a patient's entire life literally goes on hold if they experience a pain level at 9 or 10.

Many things, such as lack of sleep, arthritis/inflammation, and depression, aggravate the pain, and focusing on them may be very helpful in lowering the pain intensity. Hence, we can often help by giving them sleep-aids (amitriptyline), anti-inflammatories, or anti-depressants (Effexor or Cymbalta).

Some patients find that they can minimize their awareness of pain on the surface by using ice or Lidoderm patches.

Also, many people feel less pain when they're taking an anti-convulsant like gabapentin (Neurontin), pregabulin (Lyrica), or Lamictal, Trileptal, Tegretol, or Depakote. The problem here is that many insurers won't pay for medications that are utilized for purposes that have not been endorsed by the FDA.

Now, if these measures are inadequate, we must use narcotics. Narcotics can be short- or long-acting drug, depending on the type. Most authorities prefer to focus on long-acting medications because blood levels and pain relief are steady/prolonged. Examples include Duragesic (or generic fentanyl) patches that last 2 to 3 days, Avinza or Kadian (morphine), or Ultram ER (tramadol) that have 24 hour duration, and twice/thrice daily narcotics like Oxycontin, Oxycodone CR, Morphine ER or SR, Tylox. Short acting medications include morphine IR, darvocet/propoxyphene APAP, hydrocodone (Vicodin, Norco, Lortab), oxycodone (Percocet, Roxicet), Atique or Fentaro (fentanyl), or Demerol. Generally, hydromorphone (Dilaudid) is reserved for near-death situations.

Generally speaking, we use long-acting medications and supplement with occasional short-timers if pain suddenly increases. If the pain worsens due to any number of factors, and the patient is using lots of short-acting medications, then we increase the dose of the long-lasting one, to re-establish control of the pain.

If things just aren't working out, and we're already using antidepressants, anti-inflammatories, sleep-aids, topicals, etc., then we may need to change to a different narcotic. Sometimes this is necessary because of side effects, too. Regardless, when we do that, we do not substitute 100%

equivalent doses of the new drug. Why? Because people become accustomed to narcotics, resulting in a reduction in potency…when the patient takes a different drug totally new to them, the dose potency is usually much higher. So, many authorities recommend cutting to a dose ½ the potency of the old medication. Sometimes, we rotate every few months from one narcotic to another.

If all medications are failing, or if there are intolerable side effects (confusion, constipation or nausea are the most common), then we often refer for nerve blocks, spinal cord stimulators, epidurals, and other technical procedures.

For as long as I can remember, we doctors have had a major dilemma when it comes to treating chronic pain and it is spelled N-A-R-C-O-T-I-C-S.

The Federal Drug Enforcement Agency (DEA), almost every branch of law enforcement, and most Pharmacy Boards–in short, anybody who is responsible for monitoring pills (and especially diversion of prescription medications into the street market of illegal drugs), believes deep in their heart that "People with chronic pain should never be treated with narcotics or tranquilizers because of the risk of diversion or addiction." When official regulations of the State of Washington's Board of Pharmacy proclaim that, most doctors fear prosecution and loss of license.

The contrafoil is every professional medical group, members of which provide medical care for patients who have chronic pain. The American Pain Association, the AMA, the American College of Physicians and others all say that "chronic pain is tragically undertreated" and that "millions of Americans go to bed in pain every night." Case law now states that doctors have been sued for malpractice because they undertreated patients' pain.

Treat and you lose your license…Don't treat and you get sued.

This conflict has not been resolved, and as the parties struggle to be tolerant of each other, most medical clinics have to decide whether or not they will take care of people with chronic pain, who need daily narcotics. Like others who have pledged to help patients who need aid, we face all sorts of increased surveillance and potential harm for doing it.

Like everybody else, we do not want to be manipulated by criminals posing as injured workers. We're bothered when anonymous callers state "Mrs. Jones is selling her prescription pain pills." But at the same time, we want to help those in need. So we have a variety of procedures to try to discourage people from illegal activity.

1. Every patient must sign an agreement every 3 to 6 months that outlines our rules.
2. At every monthly visit, they must fill out a two-page form that details where their pain is, how bad it is, etc.
3. We check the "drug hotline," an informal system that detects people using multiple offices and pharmacies to obtain narcotics.
4. We require police reports in order to replace prescriptions that are lost or stolen; filing a false police report is a FELONY offense with stiff penalties.

5. We Xerox all narcotic prescriptions so we can tell if they are altered in any way.
6. We require periodic urine drug tests; the report tells us whether a patient is taking his/her drugs…or if NOT; it can also tell if people are taking some of their pills and selling the rest.
7. At every visit, we check all medications.
8. When people violate our signed agreement, we usually dismiss them from our practice.
9. We do not provide prescriptions for narcotics to patients who are taking illegal drugs.
10. Periodically various providers discuss cases; especially when suspicious behavior occurs.
11. Whenever professors hold seminars on "Pain Treatment," we attend, ask questions, and share notes.

This takes time and effort and we are sorry to require so much paperwork and office visits that sometimes seem to have little value. But, if we don't take major precautions, eventually the State or the DEA could restrict our prescription-writing privileges

Tags: chronic pain

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