Community Pain Management

Cameron Cunningham, MD

Blue Ridge Pain Specialists, Hickory and Valdese, NC
UNC Health Blue Ridge, Morganton, NC

Disclosures

- none

Introduction & Objectives

1. A brief history
2. Identify which pain patients should remain in primary care vs. when referral is appropriate
3. Identify non-opioid treatments for chronic pain management
4. Identify standard opioid prescribing thresholds and limits

Multimodal

First Line Therapy–physical therapy, pilates, yoga

First Line Therapy–NSAIDS

- Ibuprofen
- Naproxen
- Meloxicam
- Diclofenac
- Celecoxib

First Line Therapy–Neuromodulating Medications

- Gabapentin
- Pregabalin
- Amitriptyline
- Nortriptyline
- Duloxetine

First to Second Line Therapy

- Activity modification
- Topicals
- Low Dose Naltrexone
- Behavioral health/pain psychology
- Sleep and weight assessment
- Tobacco cessation


MEDICAL CENTER

Imaging & Diagnostics

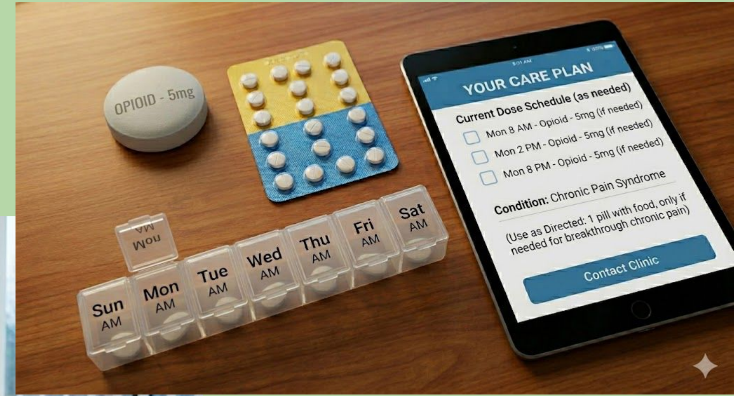
- X-rays
- MRI
- EMG/NCS
- Labs

When First Line Therapy Fails

Injection

Referral to specialist

Other medications

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The Scope of Pain Management & Why Early Referral Matters

What Interventional Pain Management does

- Diagnosis-driven care
- Image-guided injections, neuromodulation, radiofrequency ablation, nerve blocks, etc.
- Multimodal pain strategies
- Complex opioid decision-making

Why referrals matter

- Prevent opioid initiation and escalation
- Improve function, not just pain scores
- Reduce regulatory and medico-legal risk for PCPs
- Improve access to non-opioid interventions

Interventional Procedures

- Epidural steroid injections
- Nerve blocks
- Joint injections
- Radiofrequency ablation
  - Spine, knee, hip, shoulder, SI joint, Meralgia paresthetica, neuroma
- Neuromodulation
  - Spinal cord stimulator, peripheral nerve stimulator, dorsal root ganglion stimulator
- Botox
- Intradiscal injection
- PRP or stem cell
- Indirect or minimally invasive lumbar decompression
- Minimally invasive SI joint fusion
- Ketamine infusion
- Intrathecal drug delivery device
- Qutenza

Interventional limitations

- Concerning psychiatric history
- Uncontrolled diabetes mellitus
- Pacemaker/defibrillator (RFA, PNS)
- Infection
- Blood thinners

Periprocedural Antithrombotic Management (ASRA / Narouze et al.)

Drug	High / Intermediate Risk – STOP	Low Risk – STOP	RESTART After Procedure
Fondaparinux	4 days	Shared risk assessment	24 h
Clopidogrel	7 days	No	12 h
Prasugrel	7–10 days	No	24 h
Ticagrelor	5 days	No	24 h
Cangrelor	3 hours	Shared risk assessment	24 h
Dabigatran	4 days*	Shared risk assessment	24 h
Rivaroxaban	3 days	Shared risk assessment	24 h
Apixaban	3 days	Shared risk assessment	24 h


OPIOID - 5mg
YOUR CARE PLAN
Current Dose Schedule (as needed)
Mon 8 AM - Opioid - 5mg (if needed)
Mon 2 PM - Opioid - 5mg (if needed)
Mon 8 PM - Opioid - 5mg (if needed)
Condition: Chronic Pain Syndrome
(Use as Directed: 1 pill with food, only if needed for breakthrough chronic pain)
Contact Clinic
Sun AM
Mon AM
Tue AM
Wed AM
Thu AM
Fri AM
Sat AM

Indications for Opioids for Chronic Non-Cancer Pain

- None, strictly speaking
- Treatment of last resort
- Medium term treatment (4-24 weeks)
    - Arthritis, inflammatory disease

Indications for Opioids for Chronic Non-Cancer Pain

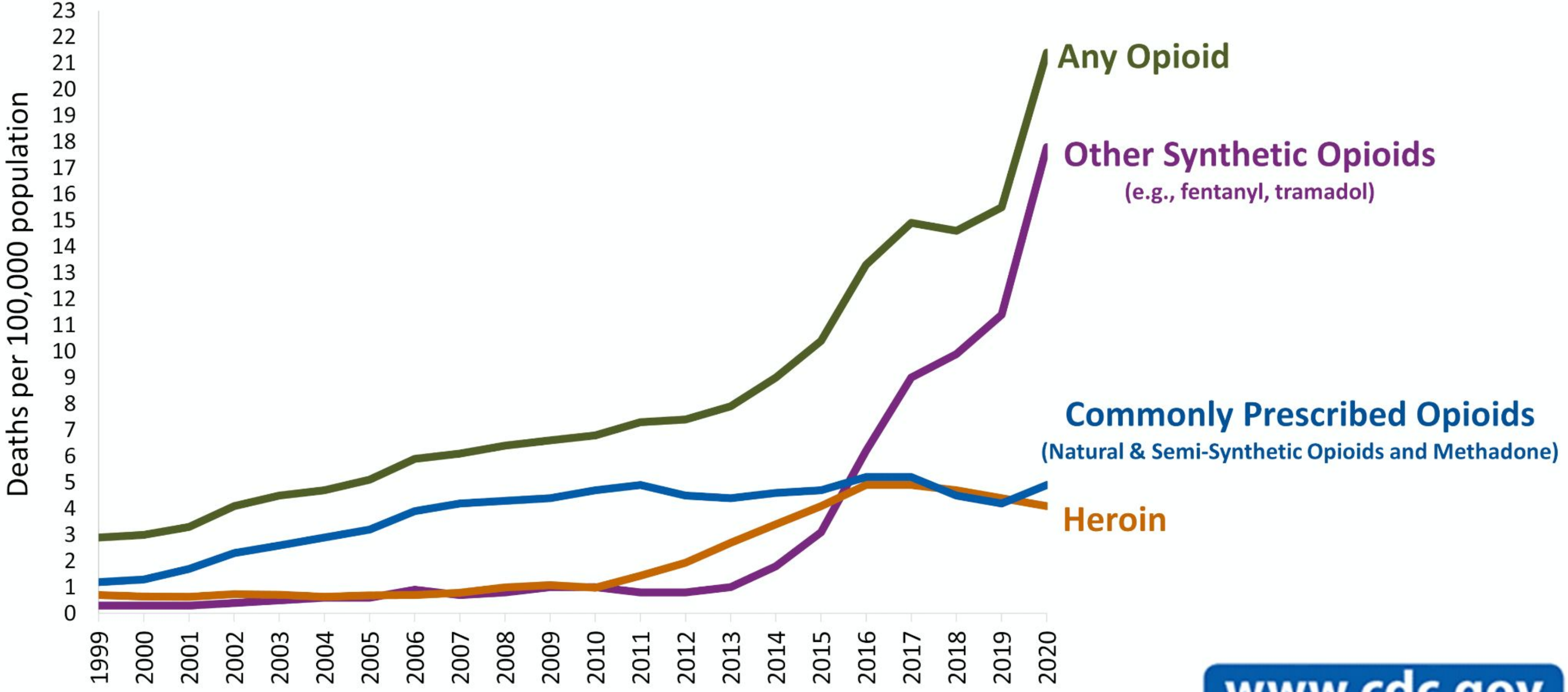
- The SOTA Meta-Analysis (Busse et al., 2018)
- Cochrane review high dose opioids (Els et al., 2017)
- Dose Escalation vs. Maintenance (Black et al., 2020)

Opioid Prescribing Basics

Painful conditions where use of chronic opioids is highly discouraged

- Fibromyalgia
- Headache disorders
- Neuropathic pain
- Chronic pelvic pain
- Chronic abdominal pain
- Temporomandibular joint disorders
- Non-cancer myofascial pain
- General chronic low back pain

Overdose Death Rates Involving Opioids, by Type, United States, 1999-2020



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://wonder.cdc.gov/.

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Opioid Prescribing

Regulatory prescribing expectations

- Know your state licensing board opioid prescribing rules/recommendations
- Importance of:
    - Opioid Risk Tool updates
    - Documented indication
    - Functional goals
    - Risk–benefit discussion
    - PDMP review
    - Urine drug screen monitoring
    - Opioid treatment agreement/contract
    - Frequency of in office visits (North Carolina 90 days)

Opioid Risk Tool

Full name: ______________________________ **Date submitted:** ______________________

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies:	◯ Female	◯ Male
Family history of substance abuse		
Alcohol	◯ 1	◯ 3
Illegal drugs	◯ 2	◯ 3
Rx drugs	◯ 4	◯ 4
Personal history of substance abuse		
Alcohol	◯ 3	◯ 3
Illegal drugs	◯ 4	◯ 4
Rx drugs	◯ 5	◯ 5
Age between 16–45 years	◯ 1	◯ 1
History of preadolescent sexual abuse	◯ 3	◯ 0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	◯ 2	◯ 2
Depression	◯ 1	◯ 1
Scoring totals		

Low risk: *0 to 3* ***Moderate risk:*** *4 to 7* ***High risk:*** *8+*

Notes

Webster, L. R., & Webster, R. M. (2005). Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Med.* 6(6): 432.

For further consideration

State Licensing Board Sanctions

- Documentation failures
- Inadequate monitoring
- Escalation without justification

Opioid Prescribing

A. MME fundamentals

- **Define Morphine Milligram Equivalents (MME)**
- Emphasize cumulative daily dose risk
- Example
    a. Percocet 10 mg QID
        i. 40 mg oxycodone/day × 1.5 = **60 MME**
- Chronic non-cancer pain risk threshold commonly referenced: **180 MME (our limit)**
- **Primary care recommended ceiling: 90 MME**

Drug	Brand	Relative strength	100 mg/d MED
Morphine	MS Contin, etc	1	100
Hydrocodone	Norco, Vicodin	1	100
Oxycodone	OxyCodone, Roxycodone	1.5	66
Hydromorphone	Dilaudid	4	25
Oxymorphone	Opana	5	20
Methadone	Methadose	8-12	10
Fentanyl transdermal patch	Duragesic	100	42

[a] Sometimes referred to as morphine milliequivalents (MME). Oral administration unless otherwise specified. Calculations were made using the Washington State Agency Medical Directors' Group's Opioid Dose Calculator (available from www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm).[29]

Opioid Prescribing

For your consideration:

- Opioid induced hyperalgesia
- Lowest effective dose
- Opioid/drug holiday
- Always be titrating

Even more to consider

THC / CBD

- Counseling-first approach
- Automatic dismissal
- Clear language:
    - Safety concerns
    - Federal vs. state discrepancies
    - Expectations for continued opioid therapy

When opioids are declined

- Communicate clearly and non-punitively
- Provide patients:
    - Non-opioid pain strategies
    - Behavioral health resources
    - Education on chronic pain expectations

What to do?

- Medication-Assisted Treatment (MAT)
  - Buprenorphine
  - Methadone
- Ask patient to reconsider other treatment options
- Discourage shotgun referrals


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Chronic Pain Pathways & Shared Care Model

When to transition opioid prescribing to Pain Management

- Considering starting opioids
- Failed non-opioid modalities
- Inadequate pain relief at maximum comfortable MME
- Complex opioid regimens
- High-risk monitoring needs

Opioid Referral Vetting

- PDMP review
- Criminal record
- History of substance abuse, suicidal ideation/attemt
- Current MME
- Records from previous pain clinic (discharge, UDS, behavior, etc.)

Monitoring Expectations for Chronic Opioid Therapy

Our clinic expectations

- **No opioids at initial visit**
- **Visit cadence:** ~every **60 days (no longer than 90 days between visits)**
- **Pill counts:** consider performing every visit
  - "Off" counts = **minor violation**
  - Requires documentation + follow-up workflow
- **Urine Drug Screens**
  - Universal order set

Consistency and documentation protect both patient and provider.

Chronic Pain Pathways & Shared Care Model

Shared care expectations

- Pain Management provides:
    - Diagnosis
    - Interventional plan
    - Opioid recommendations and/or prescribing
- PCP continues:
    - +/- Medication management
    - Comorbid condition care
- Clear communication loop and documentation

Case #1

27 year old male. History of bilateral lower extremity trauma requiring multiple orthopedic surgeries 10 years ago. Recent insidious onset low back pain. States leg pain and back pain are equal at 8/10. No recent trauma. No relief from NSAIDS or tylenol. No comorbidities. Started on oxycodone 5 mg BID, then TID, now QID. Still with inadequate relief.

Case #2

68 year old male with axial low back pain of 10 years. No relief from PT. Recently started apixaban for atrial fibrillation and can no longer take NSAIDS to treat low back pain, which had previously worked well for him. X-ray and MRI lumbar spine reveal spondylosis and facet arthropathy in lower lumbar spine with mild foraminal stenosis. Has started hydrocodone 5 mg one to two times per day and gets modest relief, but also gets constipated and does not like taking narcotics.

Case #3

50 year old female with painful diabetic neuropathy. Diabetes diagnosed 5 years ago. Lost weight upon learning about diagnosis and is only mildly overweight. Diabetes has been well controlled with HgA1C under 6 for two years, but pain persists from toes up to mid calf. Has had no relief from max doses gabapentin, pregabalin, amitriptyline, nortriptyline, duloxetine, topiramate.

Case #4

80 year old female presents for chronic right knee pain following total knee arthroplasty performed 2 years prior. She followed surgeon’s recommendations post-op, but has had significant pain ever since. She has been evaluated by two different surgeons who specialize in total joint replacement both of whom state there is nothing wrong with the hardware and do not recommend further surgery. She has done three rounds of physical therapy without improvement. Gets little relief from tylenol. Has a history of GI bleed; therefore, NSAIDs have been discouraged.

Case #5

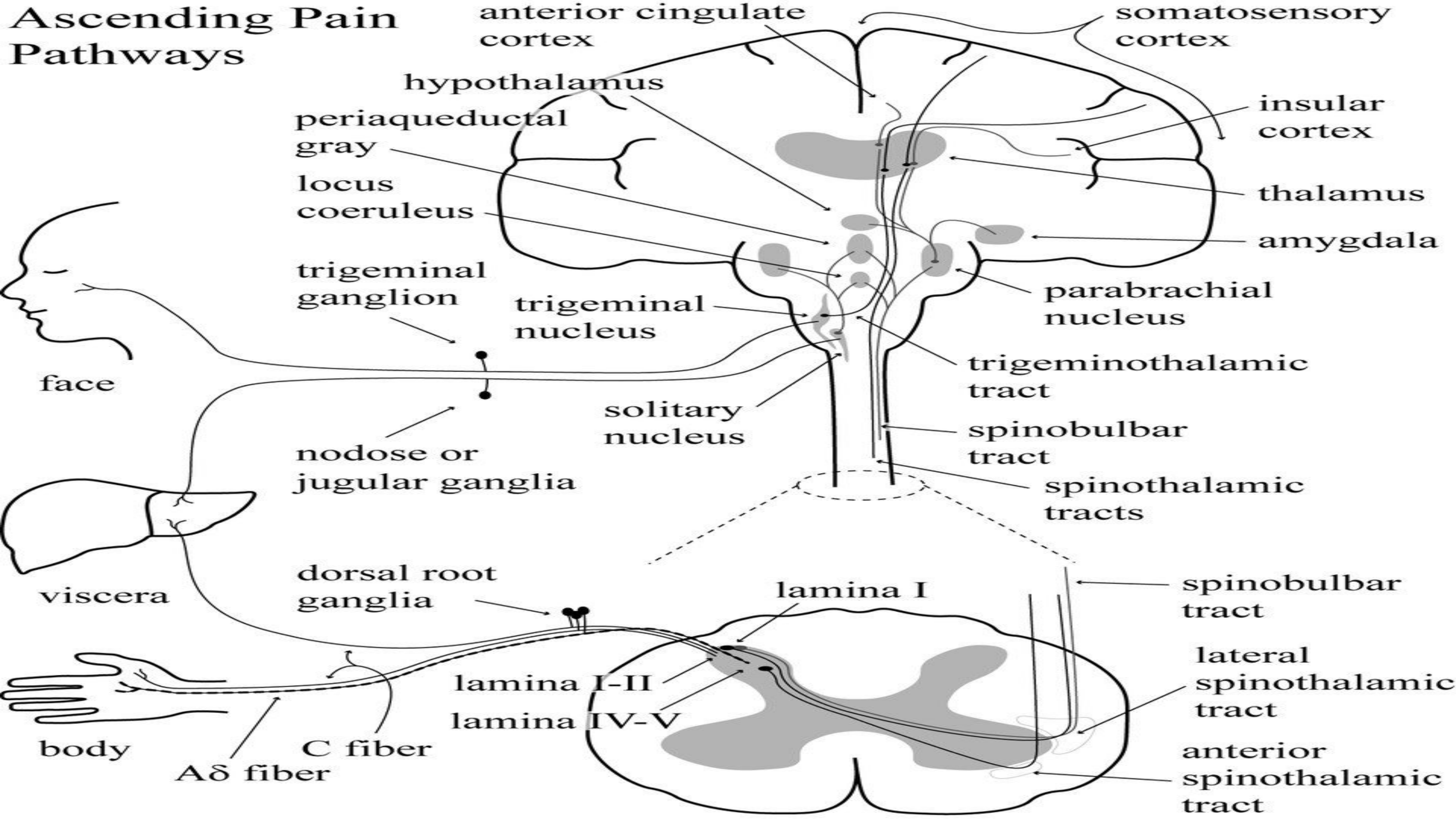
56 year old male referred to assume prescribing chronic opioids. Patient has been on 20 mg oxycodone five times per day for years. Was recently discharged from another pain clinic in the area for “inappropriate UDS,” per referring provider. Upon further review, patient has a criminal history of multiple DUI. Patient deemed not to be a good candidate for continuing opioid therapy, but offered a consultation to discuss other treatment options including multiple possible interventional therapies.

Closing & Q&A

Key takeaways

- Early referral prevents opioid escalation
- Documentation matters as much as prescribing
- Non-opioid strategies are essential
- Pain Management is a partner, not a handoff

Ascending Pain Pathways



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