

Responsible Opioid Prescribing



**This program is made possible
through an educational grant from the
Horizon Foundation of New Jersey**



Disclaimer

- This program is not about telling you how to treat your patients.
- What it is about is information and recommendations.
- Treating pain is subjective, you know your patients best.



Overview

- The dilemma of chronic pain
- Barriers to more effective pain management
- Treating the whole patient
- Strategies for success
- Minimizing risk of diversion
- Reducing pain, restoring function

Learning Objectives

1. Define addiction, pseudo-addiction, and dependence
2. Implement the function-based approach to the management of pain
3. Identify and address psychosocial issues associated with chronic pain and its management
4. Explain the basic components of an effective management plan for chronic pain
5. Employ key strategies to minimize the risk of drug misuse, abuse, and diversion
6. Reference the most recent consensus-based and evidence-based treatment recommendations for the treatment of cancer and non-cancer pain

Key Terms

- **Chronic Non-cancer Pain (CNCP):** All chronic pain disorders outside of cancer pain or pain at end of life.
- **Chronic Opioid Therapy (COT):** Daily or near-daily use of opioids for at least 90 days, often indefinitely.

Scope of the Problem

- ~70 million people suffer from chronic pain in the U.S. alone
- Research has shown that cancer survivors continue to experience chronic pain
- The annual total (direct and indirect) costs for chronic pain are estimated to be as high as \$294.5 billion per year (American Chronic Pain Association)

National Center for Health Statistics. 2006 With Chartbook on Trends in the Health of Americans.
Principles and Practice of Pain Medicine 2nd Ed. Warfield CA, and Bajwa ZH., Eds. 2004.
Rosenblum A, Joseph H, Fong C, et al. *JAMA*. 2003;289:2370 - 2378.



Psychosocial Issues

“Pain upsets and destroys the nature of the person who feels it.” --Aristotle

“Pain is inevitable. Suffering is optional.” --Unknown



Psychosocial Issues

- Chronic pain can lead to depression, anxiety, sexual dysfunction, and other psychosocial comorbidities
- These comorbidities need to be treated in addition to managing the pain
- Complete evaluation of pain involves looking beyond the pain signals to the *effects* that those signals are having on physical and psychosocial functioning

Opioids: Myth vs. Fact

- **Myth:** “If I don’t prescribe opioids I won’t have to worry about liability or investigations.”
- **Fact:** Physicians have been successfully sued for refusing to treat pain and for over-prescribing. The best way to lessen the risk of prescribing opioids is to prescribe them responsibly

Opioids: Myth vs. Fact

- **Myth:** Opioid doses inevitably rise over time because of physical tolerance
- **Fact:** Unless the underlying cause of pain gets worse (e.g. increasing spinal stenosis) patients are likely to remain on the same dose or only need small increases over time.

Lipman AG, Jackson KC. Opioid Pharmacotherapy. In *Principles & Practice of Pain Medicine, 2nd Ed.* 2004, p. 594.



Opioids: Myth vs. Fact

- **Myth:** Opioids make it harder to function normally
- **Fact:** When used correctly for appropriate conditions, opioids may make it *easier* for people to live normally
- Neuropathic and non-neuropathic pain conditions appear in general to respond similarly COT

Fishman SM. *Responsible Opioid Prescribing: A Physician's Guide*. 2007. p. 39.



Opioids: Myth vs. Fact

- **Myth:** Patients with CNCP should all receive a long-acting opioid as part of COT.
- **Fact:** There is insufficient evidence to recommend short-acting versus long-acting opioids, or as-needed versus around-the-clock dosing of opioids.

Test Your Knowledge

- In 2008, approximately how many Americans were estimated to be abusing prescription drugs?
 - a. 1 million
 - b. 5 million
 - c. 10 million
 - d. 20 million

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2005-2008 National Survey on Drug Use and Health: National Findings*.



Key Terms

- **Addiction:** disease state in which a person can no longer control their use of a drug
 - Characterized by impaired control over drug use, continued use despite harm, and craving. Using the drug *decreases* functioning.
- **Pseudo-addiction:** Drug-seeking behavior in a patient not consuming adequate doses of pain relief medication.
 - Functioning *increases* when proper dose is obtained.

Key Terms

- **Physical dependence:** non-disease state in which one's body adjusts to a medication
 - Manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Opioids: Myth vs. Fact

- **Myth:** Opioid medications are always addicting.
- **Fact:** Many studies show that opioids are *rarely* addicting when used properly for the management of chronic pain.

Pseudo-addiction vs. Addiction

- Requesting analgesics by name
- Demanding, manipulative behavior
- Clock watching
- Taking opioid drugs for an extended period
- Obtaining opioid drugs from more than one physician
- Hoarding opioids

Elizabeth

Addiction or Pseudo-addiction

- 40 year-old female breast cancer survivor with type 1 diabetes complicated by depression and hypertension
- Complains of severe persistent burning pain in both lower extremities
- Physical findings consistent with neuropathy
- Uses alcohol to self-medicate
- Received prescriptions for pregabalin, duloxetine, and oxycodone/APAP 10/325.
- Insists oxycodone helps most, but needs medication > three times per day
- Pharmacy notifies you that she received three prescriptions for oxycodone/APAP from local emergency departments in the past month.

Elizabeth

Addiction or Pseudo-addiction

- Laboratory Test Report
 - UDS positive for oxycodone but negative for opiates, morphine, THC, cocaine, and amphetamines
- After written informed consent, you initiate treatment with oxycodone sustained release 20 mg BID with oxycodone IR 5 mg q 6 hrs prn
- One month later
 - Elizabeth reports pain decrease from 8/10 to 5/10
 - Increased activity and less depression
 - Patient's family corroborates improved function, stating that she is much less irritable.

Practice Recommendation

- “Chronic non-cancer pain is often a complex bio-psychosocial condition. Clinicians who prescribe continuous opioid treatment should routinely integrate psychotherapeutic interventions, functional restoration, interdisciplinary therapy, and other adjunctive nonopioid therapies.” *APS/AAPM 2009*
 - **Source:** Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. *The Journal of Pain*, Vol 10, No 2 (February), 2009.
 - **Website:** [http://www.jpain.org/article/S1526-5900\(08\)00831-6/abstract](http://www.jpain.org/article/S1526-5900(08)00831-6/abstract)
 - Strong recommendation, moderate quality evidence



The Nature of Pain

- The measurement of pain is untestable
- Real pain to a patient will always remain subjective to the physician.
- “Pain is what a patient says it is.”

Cancer and Non-Cancer Pain

While cancer pain and non-cancer pain may seem like two different things, in reality their treatment follow the same principles



Cancer and Non-Cancer Pain

- Primary care clinicians will see cancer survivors who are no longer under the care of an oncologist
- You must know how to treat cancer related chronic pain as well as general chronic pain



Managing Pain

- Opioid selection, initial dosing, and titration should be individualized according to the patient's health status, previous exposure to opioids, attainment of therapeutic goals, and predicted or observed harms
 - Strong recommendation, low-quality evidence
 - Source: APS/AAPM Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. *The Journal of Pain*, Vol 10, No 2 (February), 2009.

Managing Pain

WHO Recommendations for Cancer Pain:

“If pain occurs, there should be prompt oral administration of drugs in the following order: nonopioids then, as necessary, mild opioids (codeine), then strong opioids such as morphine, until the patient is free of pain. To calm fears and anxiety, additional drugs – “adjuvants” – should be used. To maintain freedom from pain, drugs should be given “by the clock”, that is every 3-6 hours, rather than “on demand.”

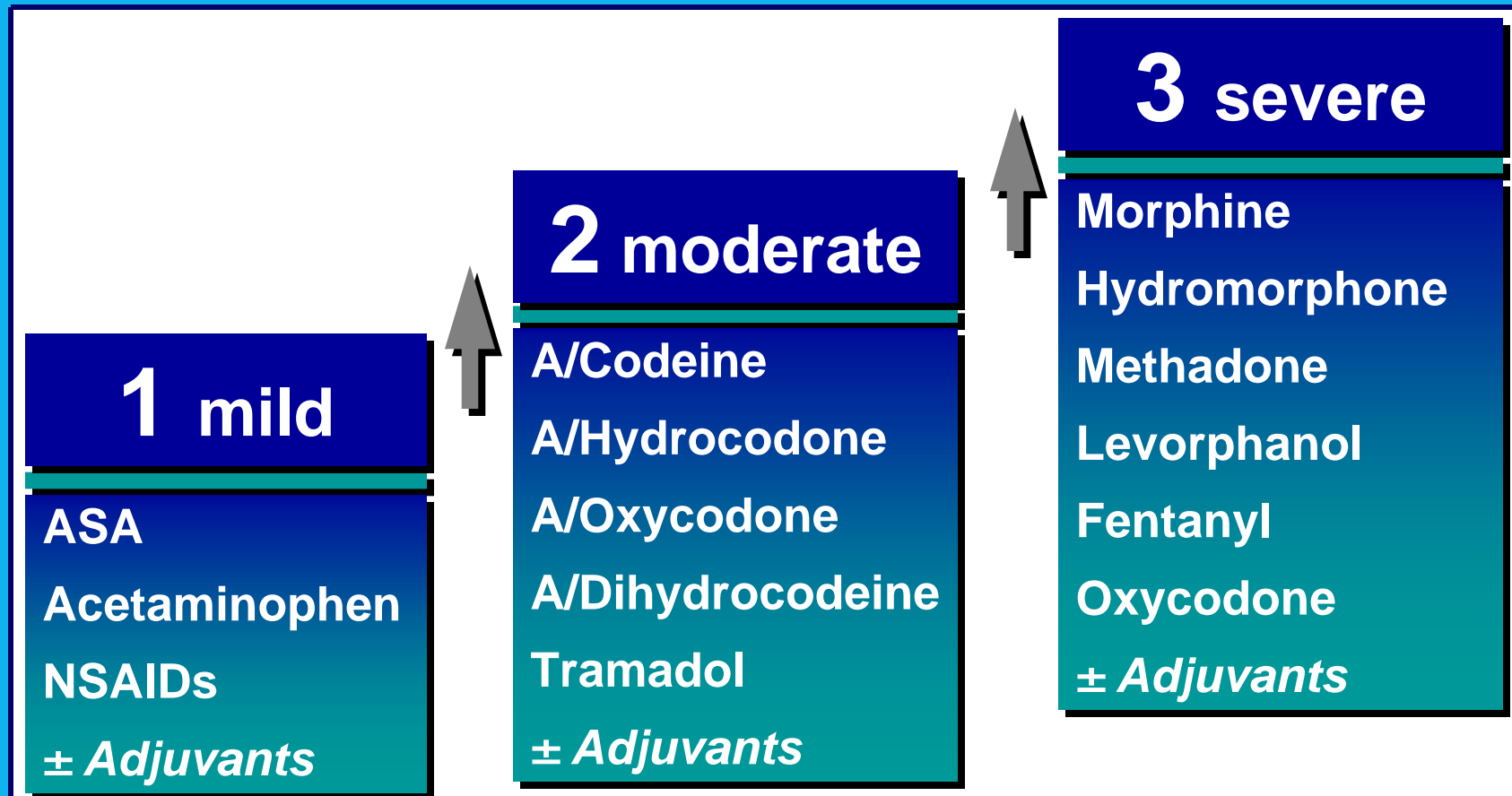
Source: <http://www.who.int/cancer/palliative/painladder/en/>



Clinical Recommendation

- In patients on around-the-clock COT with breakthrough pain, clinicians may consider as-needed opioids based upon an initial and ongoing analysis of therapeutic benefit versus risk.
 - Source: Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. The Journal of Pain, Vol 10, No 2 (February), 2009

WHO 3-Step Ladder



Practice Recommendation

- Before initiating COT, clinicians should conduct a history, physical examination and appropriate testing, including an assessment of risk of substance abuse, misuse, or addiction. In addition, a benefit-to-harm evaluation - including a history, physical examination, and appropriate diagnostic testing - should be performed and documented before and on an ongoing basis during continuous opioid treatment.
 - **Source:** Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. *The Journal of Pain*, Vol 10, No 2 (February), 2009.
 - **Website:** [http://www.jpain.org/article/S1526-5900\(08\)00831-6/abstract](http://www.jpain.org/article/S1526-5900(08)00831-6/abstract)
 - Strong recommendation, low quality evidence



Screening Tools

- Screener and Opioid Assessment for Patient with Pain – Revised (SOAPP-R)
 - 24-item questionnaire in the public domain
 - Includes questions about
 - Alcohol use patterns
 - Drug Use history
 - Psychiatric symptoms (e.g. boredom, worry, ‘tension’ perceived self-efficacy, mood swings)
 - History of being abused
 - Legal problems
 - Valid and reliable screening tool
 - Cross validated to similar tools used to predict aberrant drug-related behavior in pain patients

Please answer these questions using the following scale:

0=Never 1=Seldom 2=Sometimes 3=Often 4=Very often

1. How often do you have mood swings?

2. How often do you smoke a cigarette within an hour after you wake up?

3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?

4. How often have any of your close friends had a problem with alcohol or drugs?

5. How often have others suggested that you have a drug or alcohol problem?

6. How often have you attended an Alcoholics Anonymous or Narcotics Anonymous meeting?

7. How often have you taken medication other than the way it was prescribed?

8. How often have you been treated for an alcohol or drug problem?

9. How often have your medications been lost or stolen?

10. How often have others expressed concern over your use of medication?

11. How often have you felt a craving for medication?

12. How often have you been asked to give a urine screen for substance abuse?

13. How often have you used illegal drugs (eg, marijuana, cocaine) in the past 5 years?

14. How often, in your lifetime, have you had legal problems or been arrested?

Screening Tools

- Opioid Risk Tool
 - Easy to use
 - Risk factors associated with substance abuse
 - Patient scores grouped into categories
 - Sensitive and specific

1. Family history of substance abuse

- | | | |
|--------------------|----------------------------|----------------------------|
| Alcohol | <input type="checkbox"/> 1 | <input type="checkbox"/> 3 |
| Illegal drugs | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Prescription drugs | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
-

2. Personal history of substance abuse

- | | | |
|--------------------|----------------------------|----------------------------|
| Alcohol | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 |
| Illegal drugs | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| Prescription drugs | <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
-

3. Age (mark box if between 16 and 45 years) 1 1

4. History of preadolescent sexual abuse 3 0

5. Psychological disease

- | | | |
|---|----------------------------|----------------------------|
| ADD, OCD, bipolar disorder, schizophrenia | <input type="checkbox"/> 2 | <input type="checkbox"/> 2 |
| Depression | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
-

SCORING TOTALS:

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING

- 0-3: low risk (6%)
- 4-7: moderate risk (28%)
- >8: high risk (>90%)

Goals of Pain Management

- Goal of pain treatment is not total *elimination* of pain, but decrease in pain and improvement in *function*
- Most people live with some degree of pain
- Determine the risk/benefit of pain vs. function

Fishman SM. *Responsible Opioid Prescribing: A Physician's Guide*. 2007. p. 32



Goals of Pain Management

- An effective treatment plan looks beyond pain sensations to how those sensations affect quality of life
- A Function-Based approach to pain management asks “How is a patient’s pain affecting his or her function daily life?”

Fishman SM. *Responsible Opioid Prescribing: A Physician’s Guide*. 2007. p. 32.



Patient Evaluation

- Take the time required to listen carefully to patients in pain
- Use reflective listening skills
- Be alert to patients minimizing or magnifying their pain symptoms
- Be aware of cultural differences

Patient Evaluation

- Pain-specific components of a patient history:
 - Location of pain
 - Character of pain
 - Lowest and highest pain on 0 -10 scale on a typical day
 - Usual pain on 0 -10 scale on a typical day
 - How and when pain started
- With chronic pain you will not see autonomic nervous system changes

Patient Evaluation

- Pain-specific components of a patient history
 - Exacerbating and relieving factors
 - Effect of pain on sleep
 - Effect of pain on mood
 - Effect of pain on functioning at work
 - Effect of pain on quality of personal life
 - Is the patient involved in any legal process?
 - What does the patient expect from treatment?

Combating Diversion/Abuse

- Recommendation
 - May consider COT for patients with CNCP and history of drug abuse, psychiatric issues, or serious aberrant drug-related behaviors **only...**
 - if they are able to implement more frequent and stringent monitoring parameters
 - Clinicians should strongly consider consultation with a mental health or addiction specialist



Source: Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. The Journal of Pain, Vol 10, No 2 (February), 2009.



Combating Diversion/Abuse

- Risk of abuse and/or drug diversion is always possible
- No convincing data support focusing on any one specific population or setting
- “Universal precautions” in pain care assumes any patient may have a drug abuse problem.
- Treating everyone with the same screens, diagnostic tests, and administrative procedures can remove bias and level the playing field

Fishman SM. *Responsible Opioid Prescribing: A Physician's Guide*. 2007. p. 22.



Combating Diversion/Abuse

- **CAGE questionnaire**
 - C: Has patient wanted or needed to cut down on drinking or drug use?
 - A: Has patient been annoyed or angered by others complaining about the patient's drinking or drug use
 - G: Has patient felt guilty about the consequences of the patient's drinking or drug use?
 - E: Has patient ever taken a drink in the morning as an “eye opener” to decrease hangover or withdrawal?
- A single positive response suggests a potential for abuse and addiction - ***not*** that **opioid use will become problematic/contraindicated.**

Combating Diversion/Abuse

- Urine Drug Testing (UDT) is an important tool in combating diversion and misuse.
 - Studies of chronic opioid treatment that employ UDTs show a much higher rate of misuse than those that did not include UDT
 - Urine drug screening is likely to result in a higher yield in patients with risk factors for drug abuse or diversion
 - However, targeted (nonuniversal) urine drug screening will miss some proportion of patients who engage in aberrant drug-related behaviors, as predictors of such behaviors are relatively weak

Eric

To Treat or Not to Treat

- 35-year-old male with a history of severe, daily low back and knee pain - Injuries as a young adult, including fractures and back injuries
 - MRIs showing multi-level lumbar and cervical disc disease
 - Sometimes pain is radicular
 - Pain is daily ranging for 6-9/10
 - Unable to work due to pain
 - Lacks health insurance
 - Has received oxycodone/APAP and carisoprodol prescriptions for back pain and spasms

Eric

To Treat or Not to Treat

- Physical examination
 - decreased ROM in the LS spine with spasm, consistent with complaints
 - UDT dip-slide in the office is positive for THC and oxycodone, negative for opiates and cocaine
 - Smokes marijuana on occasion to help with back pain
- Decision: Do you treat Eric with opioids?

Informed Consent & Agreement

- An agreement, or patient care contract, can cover risk/benefit assessment, informed consent, administrative policies, or other educational issues
- A clearly-written agreement helps to enlist patient adherence, even in regimens that do not include opioids
- Be sure agreements are completely acceptable, attainable, and consistent with your practice

Functional Assessment

- Baseline functional ability assessment can provide objectively verifiable information about a patient's quality of life and ability to participate in normal life activities.
- This information may then be used for:
 - Identifying significant areas of impairment or disability
 - Establishing specific functional outcome goals within a care plan
 - Measuring the effectiveness of the care plan or treatment interventions

Functional Assessment

Functional Goal	Evidence
Begin physical therapy	Letter from physical therapist
Sleeping in bed as opposed to lounge chair	Report by family member or friend (either in-person or in writing)
Participation in pain support group	Letter from group leader
Increased activities of daily living	Report by family member or friend
Walk around the block	Pedometer recordings or written log of activity
Increased social activities	Report by family member or friend
Resumed sexual relations	Report by partner
Returned to work	Pay stubs from employer or letter confirming the patient is off of disability leave.
Daily exercise	Gym attendance records or report from family member or friend

Functional Assessment

However...

*the primary source of functional
assessment is
the Patient*

A Function-Based Approach

- Advantages
 - Treatment goals become more objective and measurable
 - Individual differences among patients are respected
 - Evidence base is created for making risk/benefit decisions
 - Prescribing decisions are tied to objectively-verifiable outcomes
 - Documentation becomes natural



Fishman SM. *Responsible Opioid Prescribing: A Physician's Guide*. 2007. p. 32.



A Function-Based Approach

- **Clinical Recommendation:** A written plan of care is the essential tool for ensuring a comprehensive approach to treatment of a patient with chronic pain.

A Function-Based Approach

- Components of an Function-based Management Plan
 - Informed consent and agreement for treatment
 - Periodic review of the management plan
 - Consultation in the event of unforeseen outcomes or difficult patients
 - Thorough documentation
 - Compliance with controlled substances laws and regulations

Periodic Review

- Physicians must closely attend to treatment outcomes and be alert to potential adverse effects
- Monitoring a patient's progress toward a set of functional goals requires a means of measuring the progress
- Create realistic functional treatment goals and a means of charting progress
- Responsibility of attaining goals and presenting “hard data” lies with the *patient*

Periodic Review

- Listen carefully and compassionately
- Pay attention to the entire patient, not just their pain
- Refer to other professionals as needed to support a treatment plan
- Adjust pain medications if indicated and reasonable
- Modify functional goals if needed
- Revise the doctor/patient agreement as needed

Escalating Dose Requirements

- When relatively high doses of COT are used, clinicians should
 - Evaluate for unique opioid-related adverse effects
 - Changes in health status
 - Make sure of adherence to the COT treatment
 - Consider more frequent follow-up visits
- When repeated dose escalations occur in patients on COT, clinicians should evaluate potential causes and reassess benefits relative to harms

Opioid-Induced Hyperalgesia

- In some individuals what is perceived as opioid tolerance is nociceptive sensitization
 - Condition referred to as opioid-induced hyperalgesia (OIH)
 - Not caused by desensitization to opioid effects
 - Caused by paradoxical increased sensitivity to painful stimuli caused by opioids
 - In clinical practice, it may be difficult to distinguish these 2 phenomena
 - Typically encountered with long-term, usually high-dose opioid use
 - If OIH is suspected, the opioid dose should be reduced or eliminated

Practice Recommendation

- Clinicians should taper or wean patients off of COT who engage in repeated aberrant drug-related behaviors or drug abuse/diversion, experience no progress toward meeting therapeutic goals, or experience intolerable adverse effects
 - **Source:** Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. The Journal of Pain, Vol 10, No 2 (February), 2009.
 - **Website:** [http://www.jpain.org/article/S1526-5900\(08\)00831-6/abstract](http://www.jpain.org/article/S1526-5900(08)00831-6/abstract)
 - Strong recommendation, low quality evidence

Documentation

- Documentation is
 - Important when opioids are used as part of pain management
 - A record of one's rationale for a particular treatment regimen
 - Protection for the treating clinician
- Flow sheets (written or EMR) can allow you to spot trends over time

Documentation

- The Federation of State Medical Boards recommendations for inclusion in medical records:
 - Medical history and physical examination
 - Diagnostic, therapeutic and laboratory results
 - Evaluations and consultations
 - Treatment objectives
 - Discussion of risks and benefits
 - Informed consent
 - Treatments & medications
 - Instructions and agreements
 - Periodic reviews

When it is Time to Consult

- Family Physicians are often most able to coordinate pain management care
 - Studies show that patients do better when they have continuous access to a clinician who provide comprehensive care for the large majority of their health care needs and who coordinates care when the *services of other health care professionals are needed.*

When it is Time to Consult

- **Recommendation:** Clinicians should pursue consultation, including interdisciplinary pain management, when patients with CNCP may benefit from additional skills or resources that they cannot provide
 - Strong recommendation, moderate-quality evidence

When it is Time to Consult

- Don't delay
- Be specific
- Know your consultants
- Have a plan
- Expect communication

Source: Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic non-cancer Pain. The Journal of Pain, Vol 10, No 2 (February), 2009.



When it is Time to Consult

- Physicians should consider referral:
 - To a psychologist or LCSW trained in CBT
 - when patients are “stuck” in a “sick role”
 - To a comprehensive inpatient interdisciplinary programs
 - when complexity of care management cannot reasonably be accomplished on an outpatient basis.
 - To an addiction treatment facility or specialist
 - when substance abuse is repeated or serious
 - when assistance is needed with treatment termination/detoxification

When to Terminate

- Physicians should consider termination when:
 - There is a lack of apparent benefit to treatment; in such cases opioids should gradually be withdrawn
 - Drug diversion is strongly suspected or proven (e.g. negative UDT for substance prescribed)
 - Repeated or serious contract violations
 - When apparent adverse effects are deemed to outweigh benefits

When to Terminate

- Can't abandon the patient
- Does not mean that you must prescribe opioids
- Must give patient 30 days notice
- Send certified letter explaining reasons for termination

Legal Compliance

- Become familiar with New Jersey state regulations about controlled substances and adhere strictly to them
- Be familiar with relevant Federal regulations
- Information on relevant state laws is available through the Federation of State Medical Boards website, www.fsmb.org.

Pain & Policy Studies Group. University of Wisconsin Comprehensive Cancer Center. 2003.



New Jersey Regulations NJAC 13:35-7

- A Treatment Plan will:
 - Document the provision of effective pain management tailored to the needs of the patient
 - Indicate a detailed discussion with the patient guardian or authorized representative, including benefits and risks of the controlled substance
 - Include objective for evaluating treatment success (i.e. pain relief or improved function), and further diagnostic/treatment plans, as indicated

New Jersey Regulations

NJAC 13:35-7

- Practitioners requirements
 - Review treatment course/objective
 - minimum 3 months
 - Evaluate physical/psychological dependence
 - Decrease/discontinue or assess for alternative modalities, if clinically indicated
 - Re-evaluate and/or refer if treatment objectives are not achieved
 - Develop written agreement regarding use of controlled substance and the consequences of misuse



New Jersey Regulations

NJAC 13:35-7

- Written documentation
 - Name, address, DOB, Medical history, physical
 - Indication for controlled substance
 - Complete name of controlled substance
 - Dosage, strength and frequency
 - Completion of consultations and evaluations
 - Informed consent
 - Contracts Period review
 - DEA and State license number

New Jersey Regulations NJAC 13:35-7

- Providers may exceed the 120 dosage unit prescribing limitation for Schedule II controlled substances for a patient under a treatment plan suffering from cancer pain, intractable pain or a terminal illness
- The 30 day supply limit still applies

New Jersey Regulations NJAC 13:35-7

- Providers may exceed the 30 day supply limit when the patient is prescribed an implantable infusion pump which can provide up to a 90 day supply provided the provider evaluates and documents the continued need of the patient

New Jersey Regulations New Legislation for Schedule II

Assembly Bill 3799 / Senate Bill 2550

- Approved by the NJ Legislature: June 2009
- Approved by Governor Corzine November 20, 2009, and in effect on March 1, 2010.
- Bill authorizes physicians to write up to 3 prescriptions for Schedule II controlled substances in order for the patient to receive up to a 90 day supply.
- The physician may provide 3 prescriptions with "future prescribing dates" (do not fill before DATE) on the 2nd and the 3rd (assuming the first would be filled right away).
- Previously, physicians were limited to writing a 30 day supply for controlled substances



Case Studies

(Participants review case studies)



Conclusions

- Chronic pain can be treated
- Evaluate the patient
- Design a management plan
- Re-evaluation every 3 months
- Opioids are legitimate and effective agents of pain relief
- Clinicians must base decisions to use or withhold opioids on a risk/benefit analysis

Conclusions

- Following published guidelines may reduce hesitation about prescribing opioids
- Maintaining clinical vigilance particularly important for patients receiving COT
- A clear framework for assessing, treating and tracking patients can improve odds of achieving an optimal therapeutic outcome

Questions



Further Readings

- American Pain Society. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic
- non-cancer Pain. *The Journal of Pain*, Vol 10, No 2 (February), 2009.
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Further Reading

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Thank you

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