Case Studies for Managing the Chronic Pain Patient

Pennsylvania
MEDICAL SOCIETY®

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Case Study #1 - Kevin

- 38-year-old man with chronic low back and leg pain
- Involved in serious motor vehicle crash 3 years ago
- Operated on by local orthopedic surgeon
- Post-operatively was placed on PRN oxycodone
- Physician is retiring, and he is referred to you for continuation of care
- Reported opioid dose was oxycodone 15 mg, 5 times a day
- He reports “fair” pain relief
- Review of records unremarkable
- Prescription Drug Monitoring Program (PDMP) report appropriate
- Initial Urinary Drug Screen (UDS) was positive for oxycodone and oxymorphone

Case Study #1 - Kevin

What should be your first thoughts?

Case Study #1 – Kevin

- ✓ What is the diagnosis?
- ✓ Should this be treated with opiates?
- ✓ Are there other non-opiate options?
- ✓ Is this patient appropriate, what are his risk factors for opiate misuse?
- ✓ If this patient is only getting FAIR relief, is that due to underdosing or is his MED high so he is tolerant and the opiates no longer work?
- ✓ Does he have other concerning medical issues, sleep disorder, anxiety, mood disorder, or new or worsening dx?

Case Study #1 - Kevin

Is a UDS result showing oxycodone and oxymorphone in a patient taking only oxycodone appropriate?

- ✓ Yes, the oxymorphone is a metabolite.

Kevin is taking oxycodone 15 mg, 5 times a day. What is his MED (morphine equivalent)?

- ✓ If Kevin is taking oxycodone 15 mg, 5 times a day, his MED = 112mg/D (Calculation: 15mg X 5 times a day =75mg, 75mg of oxycodone X 1.5 (conversion factor) = 112.5 mg morphine)

Why does it matter?

- ✓ Studies show issues with hyperalgesia from opiates with MED> 90.

Case Study #1 - Kevin

What are your dosing options?

- ✓ Wean, convert to long acting. You need to ask about how the patient takes the medication—is he spreading it out over the day, or only taking it early or late in the day?

What are the possible advantages / disadvantages to different options (short acting vs. long acting)

- ✓ Long-acting opiates have less spike in blood levels and give a baseline level of pain control.

Any reason / value to moving away from oxycodone?

- ✓ This patient is probably tolerant and another opiate compound with a different structure may be more effective.

Case Study #2 - Jane

- 41-year-old nursing aid who presents with deep and achy back pain that is constant.
- She states she has had the back pain for years and it has progressively worsened.
- Been managed by her PCP for the last 4 years using NSAIDS, muscle relaxants, physical therapy, and home exercises.
- Over the last year, it has progressed where these modalities are no longer effective, and it is beginning to interfere with her ability to work.
- MRI done 3 weeks ago showed moderate to severe DDD at L45 and L5S1.

Case Study #2 - Jane

What should be your first thoughts?

Case Study #2 - Jane

- ✓ Need to send for surgical opinion
- ✓ Complete an opiate risk assessment
- ✓ Obtain information regarding sleep
- ✓ Confirm any mood disorders
- ✓ Determine if any interventional options are appropriate

Case Study #2 - Jane

- One week ago the pain was so severe she went to the emergency room and a prescription for a 5-day supply of hydrocodone 5 /325 every 8 hours as needed was provided.
- She states that during those 5 days she had minimal pain and was able to function at work.
- Given the benefit she received, she presents to you for continued maintenance of opioid therapy.

Case Study #2 - Jane

Initial thoughts/concerns?

✓ Possibly try anti-neuropathic meds first, along with an injection, before going on to opiates.

- You explain to Jane that while opioids may be a viable treatment option, you will need to see a UDS and check the PDMP before you can start a trial of opioids for her chronic pain.
- The UDS and PDMP are appropriate.

Case Study #2 - Jane

You decide to prescribe opioids, what are the next steps in starting opioid therapy?

- ✓ Determining appropriate starting opioid dose
- ✓ Identifying any other necessary therapy
- ✓ Clarifying appropriate behaviors – “rules of the road”
- ✓ Discussing goals of treatment
- ✓ Establishing ongoing monitoring plan

Case Study #3 - Michael

- 62- year-old retired construction worker presents for a new patient evaluation, complaint of chronic bilateral shoulder pain that has worsened over the past few years and now decreases his ability to do light housework and yardwork.
- Past medical history of hypertension that is well controlled with hydrochlorothiazide.
- No surgical history.
- Denies any psychiatric history.
- Former smoker and drinks 1-2 drinks per night approximately 4 days per week.

Case Study #3 - Michael

- Denies any history of illicit drug use, addiction, or alcohol abuse.
- Taken Tylenol without relief.
- Referred to an orthopedic surgeon in the past and had a steroid injection that only provided 3 weeks of relief.
- Normal neurologic exam including motor strength and normal range of motion of his shoulders but complains of pain with abduction and flexion greater than 90 degrees.
- Imaging shows moderate to severe glenohumeral joint arthritis with no evidence of fracture or dislocation.

Case Study #3 - Michael

What should be your plan for Michael at his first visit?

Case Study #3 - Michael

- ✓ Trial nonpharmacologic and nonopioid therapy first
  - Physical Therapy
  - Ice
  - NSAIDs

Case Study #3 - Michael

- Michael returns 5 weeks later for follow up.
- Started physical therapy and is now performing his home exercise program 6 days per week.
- Ice has helped some following these exercises.
- Taken naproxen 500 mg every 12 hours as you prescribed at your initial visit, but he is unsure if it helps at all.
- Somewhat frustrated with physical therapy and his home exercise program, because the same housework and yardwork continue to cause him significant pain.

Case Study #3 - Michael

You decide to treat Michael with a trial of meloxicam, but you are considering a trial of opioids if he returns again with no improvement. What are your next steps?

- ✓ Obtain a urine drug screen at this visit. Ask him what you will find in the sample and be specific – "Should I expect to see results indicating any marijuana products, ETOH (blood alcohol concentration), illicit drugs, or prescription drugs not on your standard list of medications?"
- ✓ Do an opiate risk assessment
- ✓ Show him an opiate contract and review the risks of opiate use over time to set him up with good information

Case Study #3 - Michael

- Michael returns 4 weeks later and reports that his pain is unchanged since taking meloxicam daily since his last visit.
- He continues his home exercise program and applies ice after any exertion that causes his pain to increase.
- His urine drug screen was negative for opioids, benzodiazepines, or illicit drugs.

Case Study #3 - Michael

You decide the time may be right to trial opioids. What do you need to do first?

- ✓ Evaluate risk factors for opioid-related harm
- ✓ Review the available prescription drug monitoring program data
- ✓ Review risks and benefits of opioid therapy with him and sign opiate contract
- ✓ Establish reasonable physical and pain goals for opioid therapy

Case Study #3 - Michael

After a discussion of risks and benefits of opioids with Michael, you:

- Prescribe oxycodone-acetaminophen 5-325 as needed, up to twice daily.
- Specifically reinforce that this should be taken only as needed and he should avoid drinking alcohol at all on days when he takes this medication.

Case Study #3 - Michael

What are your follow-up plans?

- ✓ Have him return in 1 month
- ✓ Repeat UDS at that time
- ✓ Record his relief, ask about activity level, and ask about any side effects
- ✓ Review and document any treatment goals reached
- ✓ Be sure he understands that this still a trial, and you will continue to monitor and make adjustments in the future based on his health outcomes and lifestyle choices

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