FRIDAY

2012 PAINWEEK® news

The Cosmopolitan of Las Vegas
Las Vegas, NV

PREVIEW

False Arguments and False Hope: An Iconoclastic Take on the Battle over Prescription Opioids

Steven D. Passik, PhD, thinks a needless battle—begat by dishonesty, mistrust, and a desire by all sides to seek simple solutions to complex problems--poses a genuine threat to millions of Americans with chronic pain.

Passik predicts that if caregivers, drug makers, insurance companies, police officers, and lawmakers keep talking past one another, rather than working rationally together as stakeholders, the safe and legal availability of opioid medications for those who need them will not be assured.

Today at PAINWeek 2012, during his provocatively titled presentation, "Jesus, Bacon, and Hyperalgesia: Intellectual Honesty and Dishonesty in Opioids for Chronic Pain Management" Passik, a professor of psychiatry and anesthesiology at the Vanderbilt University School of Medicine, hopes to warn the pain management community of the existential threat to opioids and to suggest a path for compromise. "People have returned to talking about opioids in religious terms, as if the drugs themselves are good or evil, and those emotions lead them to say, and even believe, things that are demonstrably false," Passik says. "Therefore, I'm going to start by debunking some of the common lies that both sides tell themselves."

For example, pain specialists who observed opioids nearly eliminate cancer pain chose to believe, without support from research, that opioids could provide a similar solution to nearly any painful condition. Patients and insurers, who also wanted to believe in easy solutions, quickly joined the faith. Worse, the early converts also trivialized the dangers of addiction and abuse.

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"Jesus, Bacon, and Hyperalgesia: Intellectual Honesty and Dishonesty in Opioids for Chronic Pain Management" (SIS-15)

Presenter: Steven D. Passik, PhD
Day: Friday, September 7
Time: 2:10-3:10pm
Location: Level 4, Mont-Royal Ballroom

Unfair? Many of the specialists at PAINWeek 2012 might think so. The pain community may well have helped create the opioid problem with such naive beliefs, but that was years and years ago. Surely everyone in the community today understands both the limits and the dangers of opioids. Surely everyone except the prescribers who run the pill mills exercises proper caution.

Passik disagrees. "Caregivers tell themselves they've changed, that they're assessing risks and using the multi-modal, individualized model that experts recommend. But the numbers say they're still being dishonest with themselves and everyone else," Passik says.

He notes that "There are 8.8 million Americans who take opioids for chronic pain and 5.5 million of them take exactly the same thing: short-acting hydrocodone. Words can hardly describe how badly that reflects on this community. With all the different opioids out there, no one drug would account for more than a small percentage of the market if doctors actually treated patients as individuals. And even if you're going to prescribe the same pill for everyone out of force of habit, no doctor who really worries about opioid abuse would choose short-acting opioids as the magic pill of choice."

Another common belief among members of the pain management community that Passik hopes to discredit is that the addiction lives inevitably in the drugs themselves and not in a complex relationship between drugs and people.

In fact, research shows it takes three things to create a drug abuse problem: a vulnerable person, at a vulnerable time, with

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RECAP

Re-wiring the Chronic Pain Brain: Coaching as a Means to Patient Transformation

Chronic pain sufferer, advocate, and health coach Rebecca Curtis, ACC, says that the brain is the most powerful pain management tool that we have.

While PAINWeek 2012 features some of the brightest physicians and researchers sharing the latest research and patient care techniques in pain medicine, attendees may be equally impressed with some of the presenters who have no medical background at all. These presenters are the ones who live with chronic pain and have taken it upon themselves to not only find ways to improve their condition, but have also translated their experiences into a full-time profession helping others like them. Rebecca L. Curtis, ACC, is one such presenter, and on Thursday morning at PAINWeek 2012 she presented "Re-wiring the Chronic Pain Brain: Coaching as a Means to Patient Transformation" to an attentive audience that was eager to hear about her experiences with chronic pain patients.

Curtis began by talking about her personal experience with chronic pain, sharing photos of herself lying in a hospital bed and her totaled Jeep Grand Cherokee in a shop following an accident that occurred when she fell asleep at the wheel. Curtis was ejected from the vehicle and thrown over 100 yards. The accident broke her neck and left her unable to experience hot, cold, sharp, or dull sensations on the right side of her body. Additionally, she suffered a burning nerve pain from her neck down to her toes for years. After an emotional and lengthy rehabilitation process that failed to provide adequate relief, she attended a pain clinic, where she learned about pain management strategies and activities designed to help ease her pain.

Curtis spoke about how most people treat pain as "an acute experience." She said that in other words, they believe that if you suffer an injury you can go through a rehabilitation process or have a procedure and eventually that pain will go away. Un-

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EXHIBIT HALL HOURS FOR FRIDAY, SEPTEMBER 7

9:00am - 12:30pm
1:30pm - 5:30pm
5:30pm - 8:30pm

Also, PAINWeek 2012 attendees can get a complimentary massage in the exhibit hall near booths 111 and 114.

PREVIEW

The Right Approach to Diagnosing Back Pain

Back pain is one of the most common problems that bring people to their health practitioner, yet the approach to diagnosing its etiology is often flawed. In this presentation, PAINWeek attendees will learn the tools to diagnose the causes of back pain and how to apply patient-centered approaches to treatment.

"Differential Diagnosis of Back Pain" (MAS-05)

Presenter: David M. Glick, DC, DAAPM, CPE, FASPE
Day: Friday, September 7
Time: 2:10-4:10pm
Location: Level 3, Castellana 2

The key thing to remember when diagnosing the cause of back pain is that it is a symptom, and not a condition, says David M. Glick, DC, DAAPM, CPE, managing director of PainRx in Richmond, VA. Glick, a Fellow of the American Society of Pain Educators (ASPE) who serves on its Board of Directors, specializes in the diagnosis of musculoskeletal pain conditions, particularly those associated with the spine.

This afternoon at PAINWeek 2012, Glick will present a session, titled "Differential Diagnosis of Back Pain," that he says "will give clinicians the tools to help them diagnose the causes of back pain, and then teach them how to tailor the treatment to that patient in more of a patient-centered approach so that they increase the likelihood of a successful outcome for treating that problem."

Glick says that too often, clinicians treat back pain like a condition, when it should be viewed as a symptom. They then provide a generic treatment or protocol which may or may not be right for that particular patient's case. The result can be a less than stellar outcome, or even clinical failure.

"All pain is not caused by disc herniations or 'pinched nerves,' and there is no single treatment to address back pain. Failure to adequately diagnose and treat back pain can often result in chronic back pain," Glick says.

The most important tools for making the differential diagnosis of back pain are a careful history, the clinical examination, and the experience of the clinician. However, time constraints, where the volume of patients may limit face-to-face time with the clinician, and lack of clinical experience can be obstacles to making the right diagnosis.

According to Glick, clinicians often rely too much on imaging studies, such as magnetic resonance imaging. However, he says that severe chronic low back pain can often be due to inflammation of a nerve root, which does not show up on an MRI or other imaging studies. These studies can provide valuable structural information, but they do not necessarily reflect whether a pathology is clinically relevant.

"For example, in one study, they took MRIs of 100 asymptomatic individuals. Of those, 52% had at least one disc bulge, 27% had a frank protrusion or herniation, and 38% had abnormalities at more than one level with disc bulge or herniations. So half of the asymptomatic group had disc pathologies, and half of the symptomatic group had pathologies on the imaging studies. So sometimes, instead of ordering an MRI, you might just as well flip a coin," Glick says.

Back pain can be generally classified in two main categories: Mechanical or musculoskeletal, and non-mechanical. The non-mechanical category generally consists of etiologies that should raise a red flag, such as infection, cancer, referred pain, and rheumatologic causes.

The mechanical causes can be discogenic, ligamentous, muscular, stenotic, facet mediated, degenerative, or osteogenic. Inflammatory causes of back pain can be arthritic or spondylitic. Infections causes include osteomyelitis, epidural abcess, or discitis. "The purpose of this session is to help the clinician better differentially diagnose the cause of low back pain in a particular patient," says Glick.

"My examination starts when I go to greet the patient in the waiting room. Watching how the patient gets up from the chair and walks to the exam room tells you a lot. For example, if they have a spinal stenosis, they are going to be leaning forward. Patients with disc herniation will have similar characteristics, they are usually leaning forward to take pressure off of the nerve. Patients with a problem with the facet joint will lean backwards. A person with a hip problem will have an affected gait because they are protecting the hip. So it is important to observe the patient's gait, physical stance, alteration of position, and general behavior," says Glick.

Temporal factors can also be important clues as to the diagnosis, he says. No relief with bed rest or worsening pain at night may raise the flag for cancer or profound root compression. Morning stiffness suggests an inflammatory problem such as a facet syndrome.

Factors that worsen or improve the pain may provide insight as to its origin. For example, forward flexion relieving the pain may indicate spinal stenosis or disc herniation as the etiology; coughing, sneezing, or the Valsalva maneuver that elicits pain may indicate a herniated disc is the cause of the pain, increased pain on flexion may indicate facet or sacroiliac etiologies, and increased pain on extension can mean nerve root compression as well as facet pathologies.

"There is no single way to perform a complete physical examination. Clinicians must develop a method or routine that works for them," says Glick. "Structure the examination so that you have a reasonable chance of identifying or defining the problem and be consistent in performing the examination because it helps reduce inadvertent omissions. Also be efficient in your examination, using economy of movement for both you as the clinician as well as the patient."

If Glick has his way, clinicians will start looking at and thinking about back pain the same way they do with patients with knee pain, and tailor those treatments to be more specific to the pathology.

By Fran Lowry

The most important tools for making the differential diagnosis of back pain are a careful history, the clinical examination, and the experience of the clinician.