1 - $100

- 6 things to document when describing EVERY pain syndrome for the first time

- Duration, Location, Quality, Intensity, Ameliorating Factors, Exacerbating Factors

1 - $200

- The best way to discover a patient's prior pain treatment use and trials

- Ask. Document the answers.
- Multiple studies demonstrate that in pain populations, patients are misusing their meds (including non-opioids) more than half of the time
- Physical therapy, acupuncture, CBT, Chiropractic

1 - $300

- What pain type is commonly described as stinging, numbness, tingling, shooting, or burning?

- Neuropathic pain.
- Regardless of the CAUSE, in many cases the treatment is the same
- Often entirely unresponsive to opioids

1 - $400

- The patient states a history of a “slipped disk” and has been on disability for 12 years as a result. What aspect of his pain assessment is most important to document?

- Function is more useful in following chronic pain than pain self-reports
- Consider barriers to work, secondary gains
- Use function to determine and follow treatment goals

1 - $500

- The patient states he has a “high pain tolerance.”
- What can you take away from that statement, clinically?

- Absolutely nothing.
- Self-assessments of pain toleration are almost always wrong, even in environments where it can be measured
- No clinical impact on decision-making

2 - $100

- In a patient who is either taking opioids or you suspect of taking opioids, this part of the body gives the fastest assessment of whether the drug is on-board during exam

- pupil size.
- with mu receptor occupation, nearly 100 percent of patients will have pupillary constriction, and that effect does not tolerate with time
- Bonus: what other drug or drug class does that?

2 - $200

- The patient is a difficult historian. She seems mildly agitated, tangential, and has a strong somatizing focus during history and physical. Do you document this, and if so, how?

- yes. don't say the patient is “pleasant”
- use neutral but accurate language.
- consider documenting “cooperative” or not, “inconsistent historian” and always comment on mood and affect.

2 - $300

- You’re seeing a patient for back pain radiating to one leg. Your physical exam should include documentation of what, at a minimum?

- Strength, Sensation, Reflexes, and Gait
- Let’s pause and I’ll give an example - this is fast!

2 - $400

- The patient is grimacing, howling in pain even to light touch of the skin, when complaining of chronic lower back pain. This diagnosis explains it.

- Factitious disorder or malingering
- Even fibro patients don't typically have local hyperalgesia of the skin
- CRPS can cause hyperalgesia of the skin, but almost never involves the back
- Bonus: Physical Exam maneuver to test this?

2 - $500

- You are not a witch. You are a gremlin. These additional physical exam "tricks" will help you make a diagnosis, especially if you think the patient's stated pain and dysfunction is out-of-proportion to the anatomy
- Sham Exam/ distracted exam/ bang into patient
- Observe the patient (walking in, walking out, in the parking lot). Move yourself around the room.
- Drop something
- Lift the patient's bag

3 - $100

- Cannabinoids have a potential role in these kinds of pain diagnoses.
- I am NOT asking about nausea, but pain.

- Neuropathic pain syndromes
- Central pain syndromes like MS
- BONUS: Is there medical evidence supporting cannabinoids for back pain?
- BONUS: Is there a benefit to cannabinoids for patients on opioids?

3 - $200

- This is the usual drug of choice as first-line for neuropathic pain. Describe the pain pattern, and then prescribe the starting regimen to the person to your left.

- Gabapentin. There are few contraindications to its use, and it is cheap.
- It should be titrated. Patients needs to be educated how to start it and reasonable expectations of use (not PRN!)
- 100 mg for elders or fragile, 300 mg for others

3 - $300

- A 39 year old M, otherwise healthy, presents to the ER with acute non radiating low back pain.
- He has no acute process that is worrisome
- What should you prescribe? (may be multi-drug)

- There are many reasonable answers. But there is one that is wrong, outmoded, and contraindicated. BONUS: What do I hate? (now you are not a witch but a mindreader!)
- Almost always an NSAID. If there is a known disk process, consider steroid pulse.
- Consider a "muscle relaxer" BONUS: what does that mean?
- If pain is severe, consider a few days of tramadol TRUE PRN

3 - $400

- Seizures and serotinin syndrome are a risk with these two drugs commonly used for pain.
- What are they, and why?
- Tramadol and tapentadol bind both the mu receptor AND inhibit serotonin and norepinephrine reuptake
- They ARE thus functionally opioids and should be monitored as such, even though their chemical structure is different
- Caution in patients on SSRI or SNRI drugs (like duloxetine!) BONUS: other uses for duloxetine?

3 - $500

- The patient presents with fibromyalgia. This combination of drugs would be reasonable, "rational polypharmacy."

- If it is mostly somatic-type pain (aching, soreness in the muscles and joints), a trial of NSAID, continued if it works (and stopped if it doesn't). SNRI's (duloxetine, milnacipran, venlafaxine). BONUS: Do SSRI's help pain?
- IF there is insomnia, consider amitriptyline at night (warn about increased appetite!) BONUS: which muscle relaxer is contraindicated alongside it?
- IF neuropathic type pains or hyperalgesia, consider gabapentin or pregabalin

4 - $100

- This injection procedure relies on the action of the needle itself and NOT what is injected

- Trigger point injections
- Let's review indication, how to do them, what to inject

4 - $200

- This procedure is indicated in patients with radicular pain explained by anatomical findings.

- Epidural steroid injections
- While contentious, they ARE evidence supported when patient selection is good
- Let's review indications, process of procedure, outcomes, and bad press… (cast a truth spell!)

4 - $300

- "I always thought that there's nothing that can be done for chronic low back pain, and I refuse to have surgery" "This is arthritis, I'm just old."
- Is this person potentially a candidate for intervention?
- YES.
- spondylosis or facet syndrome - clinical pattern
- axial mostly, a.m. stiffness, worst with standing or inactivity
- very treatable with radio frequency neurotomy - let's talk about that!

4 - $400

- These are contraindications to most injection modalities for pain

- The patient doesn't consent
- There's no clear indication, no relationship between the anatomy and the pain pattern, or the patient hasn't failed a combination of first line approaches
- The patient's disease process requires surgery now
- The patient is on blood thinners that cannot be stopped
- There is an active, or potentially active, infection

4 - $500

- This is an underutilized option for intractable chronic pain, especially neuropathic or vascular in origin, especially in the extremities

- Spinal Cord Stimulation
- Indications include:
  - Failed back surgical syndrome
  - Neuropathies and myelopathies
  - Vascular origin pain

Let's review what the process is like, when to refer

5 - $100

- These are the 5 basic elemental ingredients to consider when casting spells to treat chronic pain

- Medications (not just oral!)
- Physical modalities (PT, heat, ice, TENS, more)
- Injections and Pain Interventions
- CAM modalities (mindfulness, acupuncture, etc)
- "other stuff" (stimulators and implants, braces and assist devices, CBT, coping, sleep, distraction, meditation, ketamine infusions, Qutenza, diet change…)

5 - $200

- Be a mind-reader: Do I think it is rational to try to "stay ahead of the pain" and use short-acting medications on a schedule?

- NO! TOTALLY IRRATIONAL
- why? style point: match the pattern and duration of the pain and its occurrence to med use
- a story: an elderly lady and her midnight wake up call

5 - $300

- Patient satisfaction will be lower if I decline to prescribe opioids
- Not necessarily true, but there are pitfalls.
- Be a magician: don't say no. Just start with "why" and redirect. Express that you are listening
- Practice words that work for you so discussions are easy.
- Some of my personal incantations
  - "Because I care about you and your health, I cannot in good conscience do something that I think is incorrect or might harm you"
  - START WITH WHY and not with WHAT
  - Give options
  - Let patient know that you will keep trying

5 - $400

- The patient states that he cannot take NSAIDs as a result of it causing "red blood in my stool as soon as I take one." If that is true, the blood is likely coming from here.

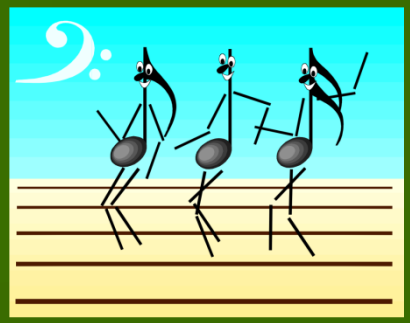
- TRICK QUESTION: that is probably not true.
- If it is true, it's probably a hemorrhoid unless the patient had a massive GI bleed
- BONUS: Why?
- EXTRA BONUS: Can you give NSAIDS to patients with history of gastric bypass? Cardiac history? Real NSAID-induced GI Bleed history? renal failure?

5 - $500

- This non-drug modality works as well as medications in multiple clinical trials for chronic pain

- cognitive behavioral therapies
- pacing
- avoidance of catastrophizing

Final Jeopardy



- There is now an "opioid crisis" but there was never a national "pain crisis" suddenly precipitating it. Some social and societal factors likely changed our ideas about social acceptability of pain. Is pain the "Fifth Vital Sign?"

- In an acute setting, Pain is a very reasonable and correct thing to assess (like blood pressure), whether one treats it or not.
- BUT
- PAIN is a symptom and not usually a disease and aggressively eating it with drugs, with the expectation that it can be fully eliminated, is potentially harmful.