
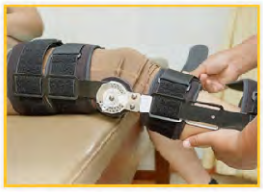


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"When injuries happen, we've got your back."

Massachusetts Pain Initiative Fall 2017 Educational Program
10/26/2017
Managing Pain from the Inside and Out

Presented by Maurice R. Bernaiche, D.O.

Experience

PHYSICAL MEDICINE & REHABILITATION SPECIALIST

Maurice R. Bernaiche, D.O.

Dr. Bernaiche, D.O. is a graduate of the University of New England College of Osteopathic Medicine. He completed residency training at Michigan State University in Physical Medicine and Rehabilitation. After his residency, Dr. Bernaiche completed a very competitive and challenging fellowship in Interventional Pain Management at Emory University.

Dr. Bernaiche has over 15 years of training and practice specializing in the non-surgical treatment of sports injuries, musculoskeletal disorders, repetitive-use disorders as well as neuromuscular diseases. He is highly skilled in minimally invasive spinal injections, which help manage back and neck disorders and pain.

Dr. Bernaiche is board certified by the American Board of Physical Medicine and Rehabilitation, the American Osteopathic Board of Physical Medicine and Rehabilitation, the American Board of Interventional Pain Physicians, the World Institute of Pain, as well as the American Board of Electrodiagnostic Medicine.

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- I have no disclosures.

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"When injuries happen, we've got your back."

Our mission is to improve the lives of the patients we serve by reducing and treating pain utilizing leading edge technology and treatments. Our purpose is to promote healthier and more productive lives while offering outstanding customer service and bedside manner.

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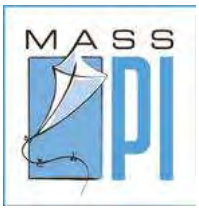

- Our Mission
- The Massachusetts Pain Initiative (MassPI) is a statewide, nonprofit, volunteer organization dedicated to ending needless suffering from persistent and acute pain and to improving the quality of life for all people affected by pain.

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- I am board certified by
  - American Board of Osteopathic PMR-AOBPMR
  - American Board of PMR- ABPMR
  - American Board of Electrodiagnostic Medicine –ABEM
  - American Board of Interventional Pain Physicians- ABIPP
  - Certificate World Institute of Pain-WIP, FIPP.

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- The management of musculoskeletal or other types of pain is complex and time-consuming. Pain care carries risks and rewards. Can you practice pain management without being a criminal? Can you protect and care for you neighbors following your Hippocratic oath? These are my thoughts and protocols.

- Objectives:
- 1. Maximize non-opioids.
- 2. Minimize opioids.
- 3. Minimize overdose risk.
- 4. Follow up closely.

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- Do we have to debate pain is real? Acute or Chronic?
- Do we need to go over the various conditions that cause “pain”?
- How do we manage “pain” from any condition? Neuropathy, Cancer, Pancreatitis, CNCP?
- Managing pain is wicked hard.
- History of pain…
  - https://www.practicalpainmanagement.com/treatments/history-pain-brief-overview-19th-20th-centuries
  - https://www.practicalpainmanagement.com/pain/history-pain-brief-overview-17th-18th-centuries
- History of opium…
  https://faculty.unlv.edu/mccorkle/www/Opium,%20Cocaine%20and%20Marijuana%20in%20American%20History.pdf

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- To begin with If you don't read about Pain everyday, you should. It is the number one complaint in Primary care offices.
- Here are some resources- unbiased, no financial relationships or otherwise. This is what I do every night.
  - http://www.painmedicinenews.com/
  - https://www.medpagetoday.com/painmanagement
  - http://www.painmed.org/library/research-in-the-news/
  - https://www.practicalpainmanagement.com/
  - http://www.painphysicianjournal.com/
  - http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1526-4637
  - http://www.wmpllc.org/ojs-2.4.2/index.php/jom/
- Tomes
  - Bonica's Management of Pain.
  - Wall and Melzack's Textbook of Pain.

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- The epidemic, crisis, phobia.
- Slides of the American deaths rates
- Slides of the opioid death rates
- Slides of the US-AG

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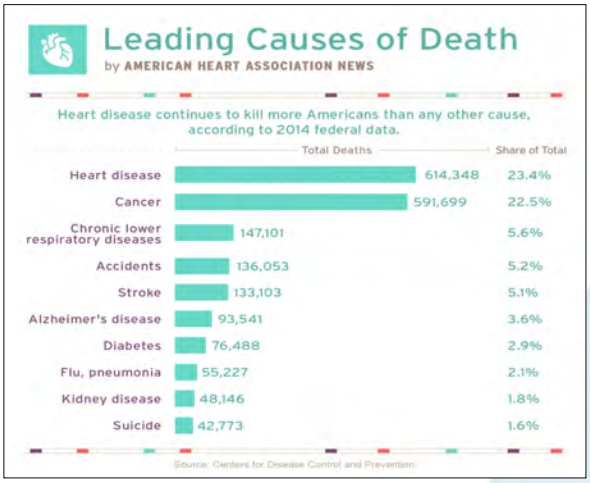

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- The epidemic, crisis, phobia.
- https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf
- Heart disease: 633,842
- Cancer: 595,930
- Chronic lower respiratory diseases: 155,041
- Accidents (unintentional injuries): 146,571
- Stroke (cerebrovascular diseases): 140,323
- Alzheimer's disease: 110,561
- Diabetes: 79,535
- Influenza and Pneumonia: 57,062
- Nephritis, nephrotic syndrome and nephrosis: 49,959
- Intentional self-harm (suicide): 44,193

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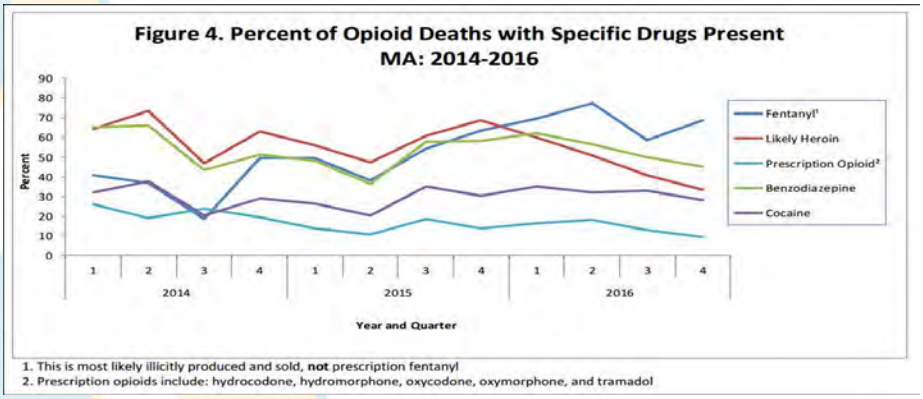

- http://www.mass.gov/eohhs/docs/dph/stop-addiction/current-statistics/data-brief-overdose-deaths-may-2017.pdf

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- The epidemic, crisis, phobia.
- US-AG http://www.masslive.com/news/boston/index.ssf/2017/09/attorney_general_jeff_sessions.html
- .....A longtime opponent of m..... legalization, Sessions held back on any talk of the newly-legalized drug in Massachusetts. He instead turned his focus to the state's opioid epidemic.
- Sessions pointed equal blame at "dirty" doctors, pharmacists and drug dealers.
- "This nation is prescribing too many pain pills," Sessions said. "It's causing too much addiction...we're sending additional resources in the field to prosecute, prosecute dirty doctors, drug dealers, pharmacists, anyone else in the supply chain."
- He added that law enforcement officials stand by "all of those who are suffering addiction" and seeking treatment.
- Massachusetts Attorney General Maura Healey, a frequent Sessions critic, said the Trump administration needs to offer "more than lip service" on the opioid crisis.....

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- The epidemic, crisis, phobia.
- There is no doubt that we have a massive problem.
- The facts are undeniable.
- We as medical providers have an obligation to protect and to serve the public.
- How can we do that?
- We have to be better than we are today. We have to medicalize our protocols and not politicize our protocols.

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- Warning- Opioids
- The use of opioids can lead to dependence, tolerance, neonatal abstinence syndrome, addiction, overdose, respiratory depression, brain damage, coma and death.
- Concomitant use with benzodiazepines, alcohol, and other prescribed and non-prescribed central nervous system depressants may result in sudden profound sedation, respiratory depression, coma, and death.
- Use opioids exactly as prescribed without alteration of the medication dose, route, frequency as any change not authorized by your provider can lead to rapid release, excess build-up and absorption and lead to a rapid fatal overdose-death.

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- Basic Rules, “Universal Precautions”, Universal processes
- Know the laws of the state and the federal government.
- FSMB-
- DEA-
- Mass.gov-
- CDC.gov-
- Never write a prescription for yourself or a direct family member. NEVER. JUST DON’T DO IT.
- Never write a prescription in the parking lot. Never do a patient interview in the parking lot.
- Never write a prescription for a “quick consult”, a favor for a friend or colleague.
- Lock up your rx pad. Every day, every night.
- Use E-rx if you can. Token.

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- Know the laws of the state and the federal government.
- FSMB-
  - http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain_policy_july2013.pdf
  - https://www.fsmb.org/Media/Default/PDF/Advocacy/Opioid%20Guidelines%20As%20Adopted%20April%202017_FINAL.pdf
- DEA-
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- FSMB-

  DEA – 2006 This manual has been prepared by the Drug Enforcement Administration, Office of Diversion Control, to assist practitioners (physicians, dentists, veterinarians, and other registrants authorized to prescribe, dispense, and administer controlled substances) in their understanding of the Federal Controlled Substances Act and its implementing regulations as they pertain to the practitioner's profession.

  https://www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html
- Mass.gov…..
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- DEA –
- Mass.gov-
  - http://www.mass.gov/eohhs/docs/borim/policies-guidelines/policy-15-05.pdf
  - http://www.mass.gov/chapter55/
  - https://www.mass.gov/news/governor-baker-signs-landmark-opioid-legislation-into-law
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- What makes you a legitimate Medical provider.
- 1- You are performing a service in the scope of medical practice
- 2- You perform a history and physical exam.
- 3- You order tests, x-rays, Ct scan, MRI, EMG/NCS, U/S, SSEP/MEP, biopsies.....
- 4- You arrive at a diagnosis or a differential diagnosis .....
- 5- You form a care plan for the condition/conditions....
- 6- You follow up, re-assess, re-evaluate, re-organize....
- 7- You get help, ask for consultations on the conditions, or symptoms.....
- 8- You keep notes i.e records , document rationale, document progress to the goals of the condition....
  - Any comments on this....? Any disagreements...?

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- 7- You get help, ask for consultations on the conditions, or symptoms.....
- 8- You keep notes i.e records, document rationale, document progress to the goals of the condition....
- 9- To prescribe medications that are opioid or non-opioid now you have to risk stratify each patient.
  - New stuff.........!!!

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- Risk Stratification Tools
  - COMM
  - DAST
  - ORT
  - SOAPP-r
  - PHQ-9
  - Audit-c
  - CAGE
  - PCS

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- Acute pain Protocols
  - Inpatient
  - Outpatient
- Chronic pain Protocols

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- Acute pain Protocols
  - Inpatient
    - Pain CODE
    - Pain control
    - Discharge function/P.T., O.T.
    - Pain meds at discharge
  - Outpatient
- Chronic pain Protocols

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- Acute pain Protocols
  - Inpatient-done
  - Outpatient

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- Acute Pain Protocol outpatient
  - Focal, specific history, physical exam
  - Diagnosis or list a differential diagnosis
  - Prognosis
  - Set Expectations, Set goals to the end point of the condition
  - Use Physical modalities, Non-opioids,
  - New Stuff !!!
  - Check PMP
  - Perform a risk assessment
    - ORT
    - DAST
    - CAGE
    - SOAPP-5
      - Assign Risk Level day 1.

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Acute pain Protocol

- Options for pain care
  - PRICE, Heat, TENS
  - Brace, crutches, slings, splints, boots..
  - Relative rest 3 days, ...
  - P.T., OMT/OMM, Chiro, Accu, Massage, Education
  - NSAIDS: Naproxen, Ibuprofen, etodolac, diclofenac, piroxicam, meloxicam, celebrex, diclofenac gel, lidocaine gel/oint/patch, toradol
  - Tylenol (MAPAP)
  - Muscle relaxers: cyclobenzaprine, skelaxin, robaxin, tizanidine, baclofen, (SOMA)(Diazepam)
  - MSA: Gabapentin, topiramate, pregabalin, levetiracetam (DRESS), Carbamazipine (SJS)
  - TCA: amitriptyline/nortriptyline, doxepin, desipramine,
  - Injection: Ketorolac, cortisone
  - PID; 3-7 days revaluate, educate, set goals, expectations, adjust opioid dose/freq
  - PID; 8-21 days reevaluate, educate, set goals, expectations, reduce opioid dose/freq

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Acute pain Protocol

- What do you do when all of the prior options have failed? VAS >7/10?
- Options for pain care
  - Opioid options, risk assessment?, education, med agreement, black box warning
  - I po TID, max. (why?)
  - Tramadol
  - tapentadol
  - Hydrocodone
  - Morphine
  - oxycodone
  - levorphenol
  - hydromorphone

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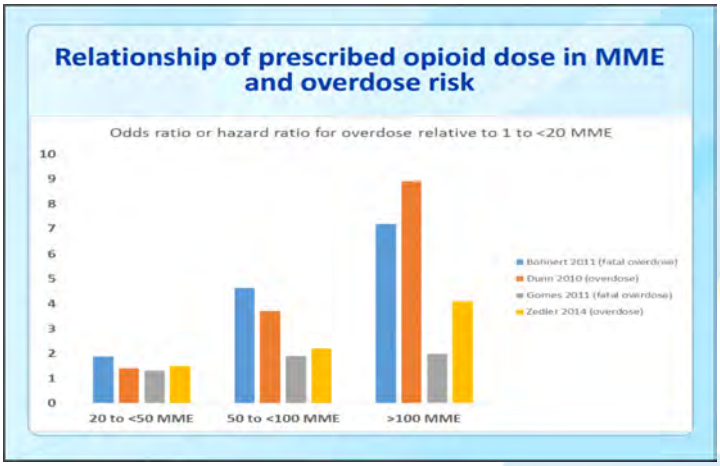

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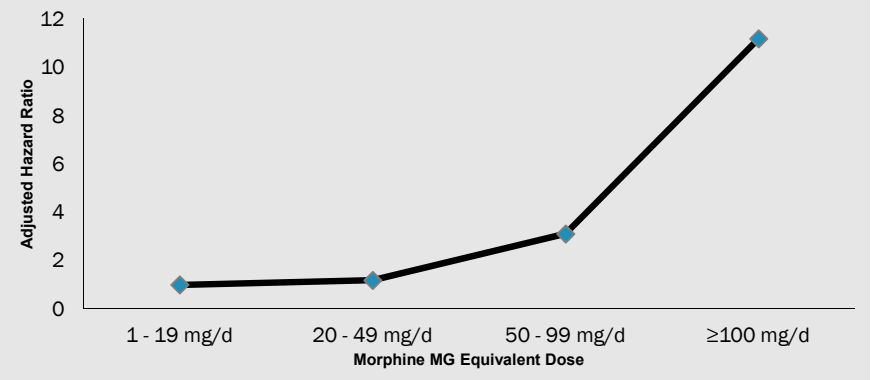

* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

Dunn et al. Opioid prescriptions for chronic pain and overdose. *Ann Int Med* 2010;152:85-92.

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Acute pain Protocol

- Options for pain care
  - Opioid options, risk assessment?, education, med agreement, black box warning
  - I po TID, max.
  - Tramadol - 50 mg I po TID, #15-21
  - Tapentadol - 100 mg I po TID, #15-21
  - Hydrocodone- 5/325 mg I po TID, #15-21
  - Morphine- 15 mg I po TID, #15-21
  - Oxycodone- 5/325 I po TID.....her
  - Levorphanol- 2 mg I po TID.....
  - Hydromorphone- 2 mg I po TID.....

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Acute pain Protocol

- Options for pain care
  - Opioid options, risk assessment?, education, med agreement
  - I po TID, max.
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  - Hydrocodone- 5/325 mg I po TID, #15-21
  - Morphine- 15 mg I po TID, #15-21
  - Oxycodone- 5/325 I po TID.....
  - Levorphanol- 2 mg I po TID.....
  - Hydromorphone- 2 mg I po TID.....

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- Acute pain Protocols
  - PID: One month reassess, reevaluate, reorganize…
  - Get Consultation advice, guidance, recommendations
  - Start reducing dose and freq of opioids
  - Eliminate all barriers to health, smoking, drinking, in-activity
  - Expand the conservative treatments
    - Pool therapy
    - Qui gong, tai chi, meditation
  - PID: 3 months- now have chronic pain syndrome
    - Referral to PM for advise, guidance, recommendations, management
- Chronic pain Protocols

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- Acute pain Protocols
  - Inpatient-done
  - Outpatient-done
- Chronic pain Protocols
  - Risk Stratify
  - COMM, DAST, SOAPP, ORT, CAGE, AUDIT, PHQ-9, ABC
  - Controlled substance use agreement- better verbiage than Med Contract.
  - Follow up…..

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- Chronic pain Protocols 1
  - Tips (review the case ahead of patient interview, review the PMP, look at social media…)
  - Interview must me thorough and comprehensive.
    - H&P usually takes an hour or more……
    - Review prior treatments
    - Establish Diagnosis and medical necessity.
    - Controlled substance agreement
    - Education regarding the use of opioids (tell them they will become tolerant, dependent, potentially addicted, possibly overdose and die)
    - Specimen collection agreement
    - Lockbox agreement
    - Naloxone agreement
    - MED/BMI/VAS

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- Chronic Pain Protocol, 2
  - COMM
  - DAST
  - ORT
  - SOAPP-r
  - PHQ-9
  - Audit-c
  - CAGE
  - PCS
  - ODI
  - NDI
  - MHAQ

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- Chronic Pain Protocol, 3
  - Urine tox- review the preliminary POC results.
  - Oral tox- delay oral medication induction. (3-7day)
  - PGT- for high dose high risk patients
- Assign Risk, establish their protocol for care including tox testing, random testing, pill counting.
  - Low Risk-every third visit.
  - Medium Risk- every other visit
  - High Risk- each visit
- Establish Goals:

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- Chronic Pain Protocol, 4
  - Establish Goals:

- Goals: Mutually agreed upon goals of functional restoration outlined in this paragraph will be the fundamental primary data point for continued opioid utilization for chronic non-malignant pain.
- 6a- All aspects of the Medication use agreement are maintained.
- 6b- VAS scores reach less than 5/10, with a MED ≤100 mg. (Agreed)
- 6c- ADL's, IADL's are Independent at the end of the trail. (Agreed)
- 6d- ODI improves by 50%. (Agreed)
- 6e- BMI decreases by 20%. (Agreed)
- 6f- Two minute walk test is improved by 50%. (Agreed)
- 6g- Cognition (MMI) is intact and equal to pre-opioid state. (Agreed)
- 6h- No self escalations, or early refill request occur during the trial phase.(Agreed)
- 6i- PHQ9/Depression improves 50%. (Agreed)

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- Chronic Pain Protocol, 5
  - Plan or discuss treatment options
    - Confirm or perform testing, xray, MRI, U/S, CT scan, EMG, Injections= Confirm diagnosis
    - P.T. , O.T., CHIRO, OSTEO, ACCU, CBT, Tai chi, Qui Gong, Yoga, Bracing, TENS, Injections, Surgery.
  - Give patient 3 months (12 weeks) to reach goals.
    - If Goals are not met than d/c, taper opioids
    - If Goals are met than follow up every month, PMP every prescription, UDT on protocol, Random pill counts, random UDT ?

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- Chronic Pain Protocol, 6
- Review the past treatments and maximize non-opioids. Change opioids to ER-ad forms..
  - P.T., OMT/OMM, Chiro, Accu, Massage, Education
  - Brace, Crutches, slings, splints, scooter, wheelchair, TENS
  - NSAIDS: ASA, Ibuprofen, etodolac, diclofenac, piroxicam, meloxicam, celebrex, diclofenac gel, lidocaine gel/oint/patch, toradol
  - Tylenol (MAPAP)
  - Muscle relaxers: cyclobenzaprine, skelaxin, robaxin, tizanidine, baclofen
  - MSA: Gabapentin, topiramate, pregabalin, Keppra (DRESS), Carbamazipine (SJS)
  - TCA: amitriptyline/nortriptyline, doxepin, desipramine,
  - Tramadol -
  - Tapentadol -
  - Buprenorphine
  - Hydrocodone-
  - Morphine-
  - Oxycodone-
  - Levorphanol-
  - Hydromorphone-

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- Chronic Pain Protocol, 7
- REDUCE THE RISKS.....AMAP
- Review the past treatments and maximize non-opioids. Change opioids to ER forms..
- Tapentadol ER: Nucynta
- Buprenorphine: Butrans, Belbuca, Bunavail, Subutex, Suboxone.
- Naloxone NS.

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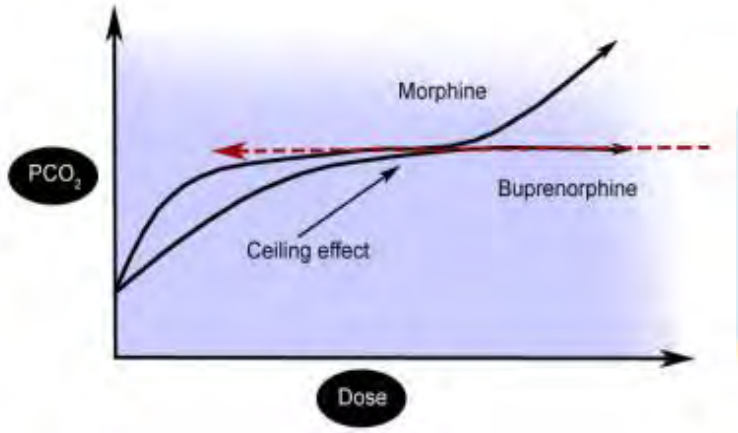

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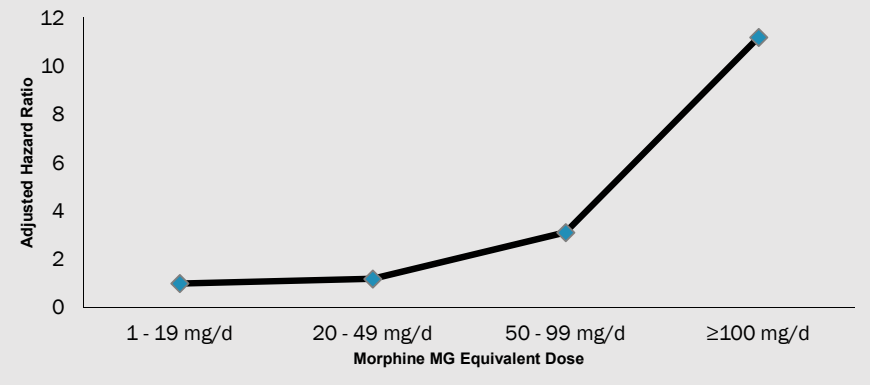

* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

Dunn et al. Opioid prescriptions for chronic pain and overdose. *Ann Int Med* 2010;152:85-92.

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- Objectives
  - Maximize Non-opioids
    - Use as many or all the groups of non-opioids at the same time (rational poly-pharmacy).
    - Watch for side effects
  - Minimize opioids
    - Don't prescribe more than 90 MED without consulting Pain Management
  - Minimize overdose risk
    - Educate patient and family regarding overdose signs, symptoms
    - Prescribe (Narcan Nasal spray 4mg/ml, I spray to nostril, as directed for suspected opioid overdose PRN, #1 box (2pack- One refill)
  - Follow up closely. (follow up monthly).
  - 7-A's

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- Objectives
  - Follow up monthly.
  - 7-Assessments of each chronic pain medication renewal.
    1. Analgesia
    2. Activity
    3. Adverse effects
    4. Aberrant behaviors
    5. Acknowledge medication are opioids
    6. Acknowledge the risks, accept the risks
    7. Accept responsibility obligations
- CASE #1

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- CASE #1
- 69-year-old male, chief complaint upper lower limb major joint pain and axial skeletal pain.
- Referred by PCP 2013, for chronic pain management.
- Onset initial injury 1998, slip and fall, as a roofing siding specialist. VAS 7-10/10.
- Prior treatments include his therapy, NSAIDs, muscle relaxers, injections, spinal fusion and opioids (MED 420 mg). (oxycontin 80 mg bid, oxycodone 30 mg qid)
- Imaging studies of the axial skeleton C-T-L, shoulders, elbows, wrists, hips, knees, ankles confirmed severe degenerative joint disease, spondylosis, degenerative disc disease,
- Laboratory studies reveal significant uric acid levels, elevated CRP levels,
- Physical exam reveals gross bony overgrowth, elbows, acromioclavicular joint, hands, knee and ankles
- Diagnosis: Multilevel axial skeletal spondylosis, degenerative disc disease, facet arthropathy syndrome, cervical herniated nucleus pulposus, lumbar herniated nucleus pulposus, gouty arthritis, repetitive overuse syndrome.
- Prognosis: Poor
- COMM=0, DAST=0, ORT=0, SOAPP=2, CAGE=0, RISK Assessment= Low risk.
- PHQ9=1, ODI=50%, NDI=48%, PCS=18, MHAQ=1.5
- Medical necessity supported by H&P/Imaging/testing: Yes.
- Controlled substance use agreement signed, lockbox agreement signed, specimen collection agreement signed. Naloxone education,

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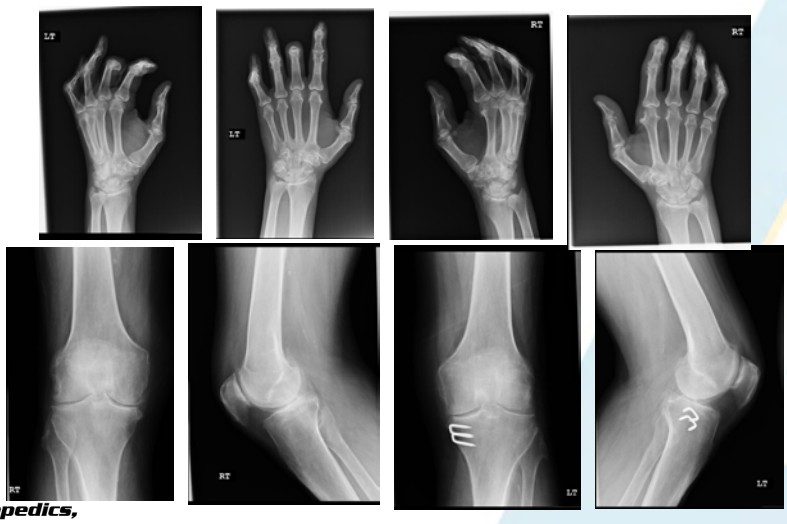

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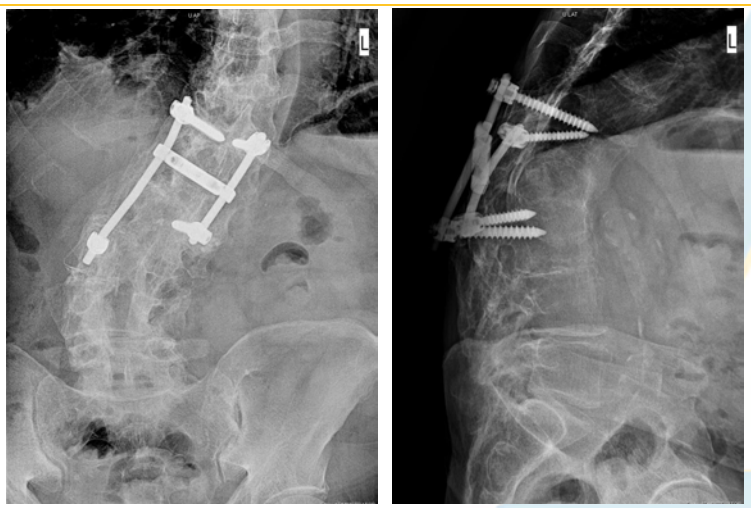

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- CASE #1
- Controlled substance use agreement signed, lockbox agreement signed, specimen collection agreement signed. Naloxone education,
- MED/BMI/VAS

10/12/2017: 150/34/6
09/14/2017: 150/33/6
08/17/2017: 195/33/6
07/20/2017: 195/33/6
06/22/2017: 195/33/7
05/25/2017: 225/33/6
04/27/2017: 225/32/6
03/20/2017: 225/33/6
02/02/2017: 225/32/5
01/05/2017: 225/33/6
12/08/2016: 300/31/5

PMP=
10/12/2017: Concordant
09/14/2017: Concordant
08/17/2017: Concordant
07/20/2017: Concordant
06/22/2017: Concordant
05/25/2017: Concordant
04/27/2017: Concordant
03/20/2017: Concordant
02/02/2017: Concordant
01/05/2017: Concordant
12/08/2016: Concordant

UDT=
10/12/2017: Concordant
09/14/2017: Concordant
08/17/2017: Concordant
07/20/2017: Concordant
06/22/2017: Concordant
05/25/2017: Concordant
04/27/2017: Concordant
03/20/2017: Concordant
02/02/2017: Concordant
01/05/2017: Concordant
12/08/2016: Concordant

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- CASE #1

Treatment plan:

1. Naloxone HCL injection solution, I spray per nostril prn, (1 box- 2 units) use in case of suspected opioid overdose.
2. Morphine sulfate extended release 30 mg 1 by mouth twice a day, #56, no refills,-M47.817
3. Oxycodone 20 mg 1 by mouth 3 times a day, #84, when necessary, no refills,-M47.817
4. GABAPENTIN 300 mg 1 by mouth 3 times a day, 2 by mouth daily at bedtime, #140.
5. Allopurinol 100 mg 1 by mouth daily.
6. Colchicine 0.6 mg 1 by mouth daily.
7. Lidocaine ointment 5%, one topical application 3 times a day, #30 gram Tube, II per month.
8. Meloxicam 7.5 mg 1 by mouth twice a day.
9. Cervical epidural corticosteroid injection, lumbar epidural corticosteroid injection, bilateral knee Toradol injection, lumbar facet joint nerve ablation, cervical facet joint nerve ablation, TPI's toradol/dex
10. Pool therapy
11. Aspirin 81 mg 1 by mouth daily.
12. TENS unit- Knees, lbp

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- CASE #2
- 59 year old male, chief complaint low back pain, right hip pain, right leg pain.
- Referred by PCP 2016, for chronic pain management.
- Onset initial injury 22 years of age, gradual onset right leg pain, left hip pain, right hip pain.
- Prior treatments include Physical therapy, NSAIDs, muscle relaxers, injections, L-THA and opioids (MED 1580 mg). (methadone 10 mg 30 pills per day, fentanyl 100 mcg II Q48, oxycodone 20 mg 6/d.)
- Imaging studies of the axial skeleton T-L spine, hips, knees confirmed severe degenerative joint disease, right hip avn, L-THA, L-spondylosis, degenerative disc disease,
- Laboratory studies reveal high CRP
- Physical exam reveals gross bony limits on decreased R- hip PROM, SLR+ (R), Scleroderma, deep morphia.
- Diagnosis: right hip degenerative joint disease, avascular necrosis right hip femoral head, lumbar degenerative spondylosis, chronic lumbar radiculopathy, scleroderma, deep morphia.
- Prognosis: Grave
- COMM=0, DAST=0, ORT=0, SOAPP=2, CAGE=0, RISK Assessment= Low risk.
- PHQ9=1, ODI=76%, NDI=24%, PCS=10, MHAQ=1..5
- Medical necessity supported by H&P/Imaging/testing: Yes.
- Controlled substance use agreement signed, lockbox agreement signed, specimen collection agreement signed. Naloxone education,

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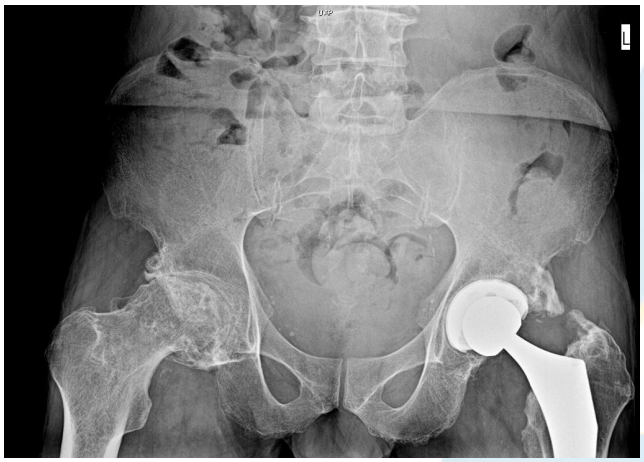

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- CASE #2
- Controlled substance use agreement signed, lockbox agreement signed, specimen collection agreement signed. Naloxone education

MED/BMI/VAS	PMP	UTD
09/19/2017: 180/25/8	09/19/2017: Concordant	09/19/2017: non- concordant
08/22/2017: 180/25/8	08/22/2017: Concordant	08/22/2017: non-concordant
07/25/2017: 180/26/7	07/25/2017: Concordant	07/25/2017: non-concordant
06/27/2017: 180/26/7	06/27/2017: Concordant	06/27/2017: Concordant
05/30/2017: 180/26/7	06/30/2017: Concordant	05/30/2017: Concordant
05/03/2017: 180/26/9	05/03/2017: Concordant	05/03/2017: Concordant
12/08/2016: 380/27/9	12/08/2016: Concordant	12/08/2016: Concordant
11/10/2016: 380/29/10	11/10/2016: Concordant	11/10/2016: Concordant
10/08/2016: 495/29/10	10/08/2016: Concordant	10/08/2016: Concordant
03/15/2016: 520/25/10	03/15/2017: Concordant	10/08/2016: Concordant
03/10/2016: 1280/25/10	03/10/2016: Concordant	03/10/2016: concordant

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- CASE #2

Treatment plan:

1. Naloxone HCL injection solution, I spray per nostril prn, (1 box- 2 units) use in case of suspected opioid overdose.
2. Methadone 10 mg 2 by mouth 3 times a day #168, no refills, for pain,-M47.817.
3. GABAPENTIN 600 mg 1 by mouth 4 times a day, #112. refills
4. Cymbalta 20 mg 1 by mouth twice a day
5. Tizanidine 4 mg 2 by mouth daily at bedtime.
6. Doxepin 10 mg I po QHS.
7. Memantine 20 mg I po BID.
8. Meloxicam 7.5 mg 1 by mouth twice a day.
9. 4 wheel rolling walker, Power chair, TENS, Pool therapy
10. Methotrexate 10 mg I po Qweek.

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- Buprenorphine
- Tapentadol

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- Discuss MED, MME, MEDD?
- MED MYTHS'
- MED= 45 mg
- MED= 60 mg
- MED= 90 mg
- MED= 120 mg
- MED= 300 mg
- WHAT ABOUT BENZO'S?
- WHAT ABOUT GABAPENTIN?

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- Discuss MED, MME, MEDD?
- MED MYTHS'
- MED= 45 mg
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- MED= 90 mg
- MED= 120 mg
- MED= 300 mg
- WHAT ABOUT BENZO'S?
- WHAT ABOUT GABAPENTIN?

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- MED= 45 mg
  - Hydrocodone/apap: 5/325, 10/325 (9-4/day)
  - Oxycodone/apap: 5/325, 10/325 (6-3/day)
  - MSIR: 15 mg, 30 mg (3-1/day)
- MED= 60 mg
  - Hydrocodone/apap: 5/325, 10/325 (12- 6/day), ?APAP
  - Oxycodone/apap : 10/325 (4/day), ? APAP
  - MSIR 15mg : (4/day)
  - MSER 15 mg , 30 mg (4/day, 2/day)

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- MED= 90 mg
  - Oxycodone 20 mg I PO TID= 90 MED
  - Oxycontin 30 mg I PO BID= 90 MED
- MED= 120 mg
  - Oxycodone 20 mg I PO BID= 60 MED
  - Oxycontin 20 mg I PO BID= 60 MED
- MED= 200 mg
  - Nucynta IR 100 mg I PO TID= 80 MED
  - Nucynta ER 150 mg I PO BID= 120 MED

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- Buprenorphine
- Tapentadol

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- References:
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- 2- http://www.mass.gov/eohhs/docs/dph/stop-addiction/current-statistics/data-brief-overdose-deaths-may-2017.pdf

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