



Pain is not a Monolith:

Safe & Effective Approaches to Different Types of Pain

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Eisenhower Health Grand Rounds

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The speaker has no financial disclosures



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HEALTH**

Who needs Pain?



A World Without Pain



Pain is Good!

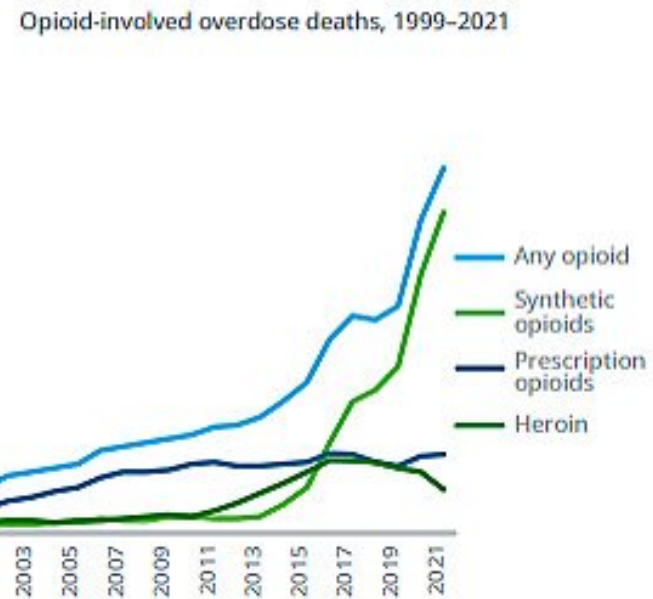
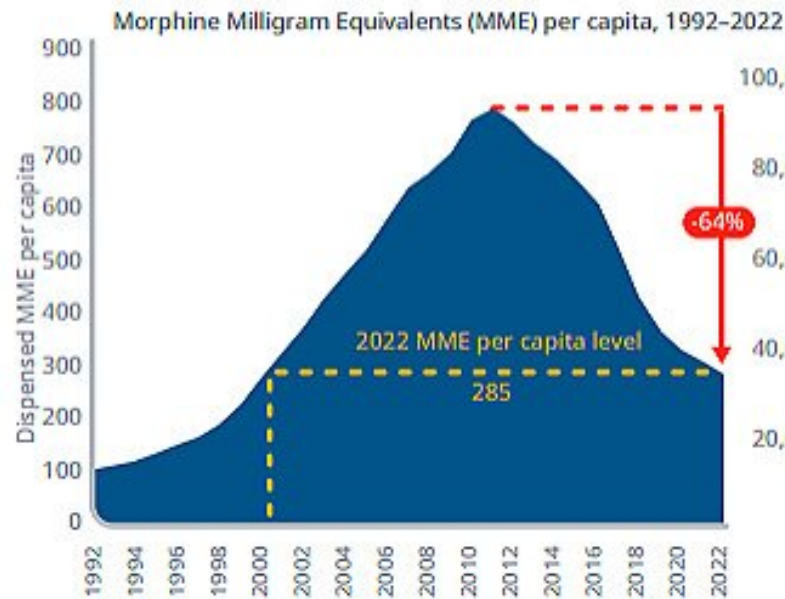
- Leprosy
- Diabetic Neuropathy
- Congenital Insensitivity to Pain with Anhidrosis



Uncontrolled Pain is *BAD!*

- Huge QOL impact
- Depression, anxiety
- Disability, missed work
- Decreases immune function
- Delirium
- Improved treatment:
 - Decreases hospital stays
 - Decreases post-op morbidity and mortality





Source: IQVIA Xponent, IQVIA National Prescription Audit, Sep 2022; IQVIA Institute, Mar 2023; National Institute on Drug Abuse, Feb 2023.

- 1996-2012
 - Vastly **increased** opioid prescribing
 - *Increasing* burden of chronic impairing low back pain
 - *"The prevalence of chronic, impairing LBP rose from 3.9% in 1992 to 10.2% in 2006."*
 - 35% of Cancer pain under- treated
- 2012 - present
 - Dramatic **decrease** in opioid prescribing
 - More undertreatment of cancer pain but still some inappropriate tx.)
 - Extremely rapid increase in opioid OD deaths

Why is it so hard to get pain treatment “right”?

- Pain is Not a Monolith.
- We are often using
 - The wrong strategies
 - The wrong medications
 - Given the wrong way
- Because we don't understand:
 - What kind of pain we are treating
 - Different approaches for different pain syndromes
 - The different effects of opioids on the brain

Overview

- How to identify and treat different types of pain
 - Somatic, Visceral, Bony Tumor
 - Neuropathic
 - “Total Pain”
 - Acute, Chronic, Cancer
- Chronic Pain Spectrum
- Two effects of opioids on brain & how to use



Total Pain/ Suffering

Physical

Emotional

Social

Spiritual/
Existential

Neuropathic

Nociceptic

Peripheral

(Central)

Somatic

Visceral
(Distension of
hollow organ)

Inflammatory/
Bony Tumors

Need to know what we are treating!

Specific Causes of Pain

- Warning
- *Position*
- Always consider tx of BOTH the cause *and* the pain
 - even in hospice!



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Somatic Pain

Somatic

- “Typical” pain
- Highly localizable
- (Threatened) Tissue damage

- Ice, splinting, positioning,...
- Acetaminophen, NSAIDs
- (muscle relaxants, gabapentinoid?)

- Opioids



Somatic vs Visceral Pain

Somatic

- “Typical” pain
- Highly localizable
- (Threatened) Tissue damage

- Ice, splinting, etc
- Acetaminophen, NSAIDs
- (muscle relaxants, injections...)

- Opioids

Visceral

- Distension of hollow organ
- Cramping, waves
- Vague localization

- Heat, positioning,
- Address constipation, urinary retention

- Anticholinergics
(*hyoscyamine, dicyclomine*)

- Opioids

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Anticholinergic
(*hyoscyamine/dicycl*)
(constipation/UR...)
Opioid

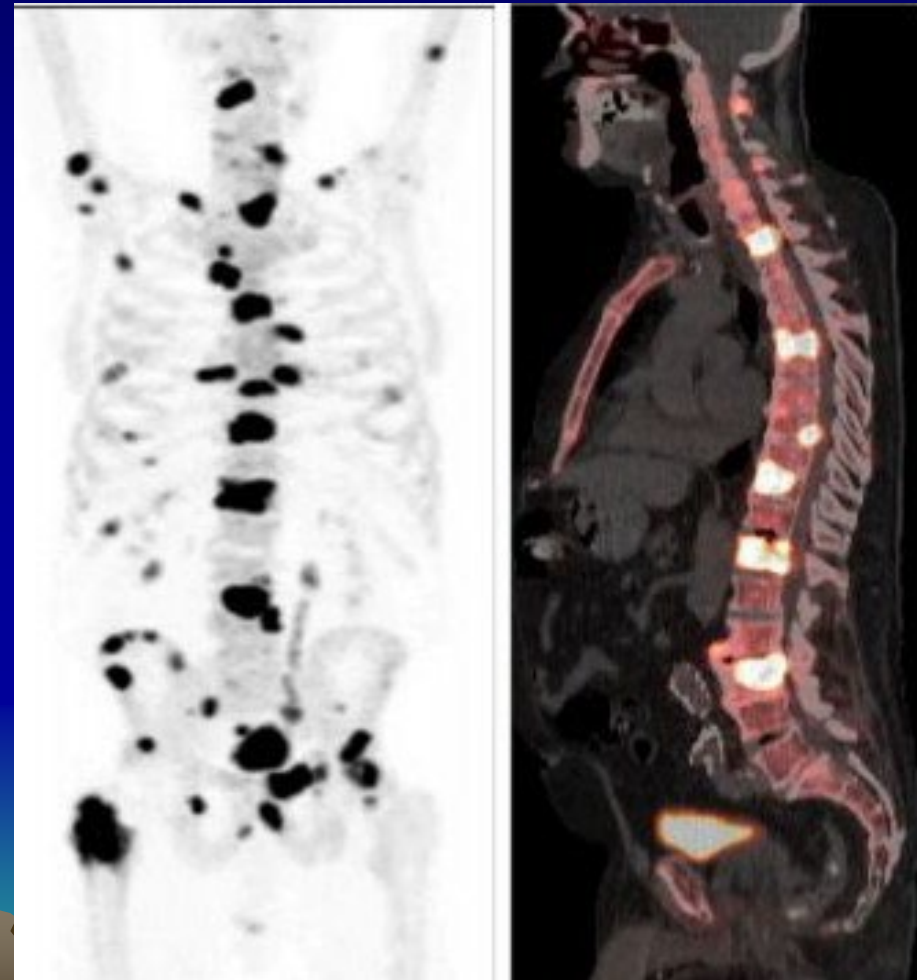
Inflammatory/
Bony Tumor



Bony Tumor & Inflammatory pain

- Bony tumors, pleuritic pain,...
- Deep ache.
- Less Localization
- morning?

- NSAID or Steroid
 - *Note: NOT multiple myeloma*
 - Gabapentinoids
- Opioids
 - *Specifically for tumors:*
 - Zoledronic Acid/denosumab
 - Radiation



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Zoledronic Acid
Radiation
Gabapentinoid
Opioids

Neuropathic Pain?



"I keep getting pins and needles in my arms"

[Peripheral] Neuropathic Pain

- Damage/ dysfunction of *nerve itself*
- Classic vs atypical presentation.
- Cancer.
- Chronic pain.



How to Treat Neuropathic Pain

- Adjuvants
 - Tricyclic (*Nortriptyline...*) / SNRI (*duloxetine...*)
and/or:
 - Gabapentin or pregabalin
 - Titrate every 3 days as tolerated
- Topical Lidocaine
- Opioids (*methadone*)
- Steroids if acute?
- Many “treatments of desperation”
 - Other AED’s
 - Antiarrhythmics: Lidocaine, mexilitine
 - NMDA blocker: methadone, ketamine
 - Mirror therapy, various other meds, ...

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Neuropathic

Gabapentinoids

SNRI or TCA
(duloxetine, nortriptyline)

Topical lidocaine

Opioids *(?methadone)*

Other *(mexilitine, AED's...)*

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(hyoscyamine/dicycl)
(constipation/UR...)
Opioid

**Inflammatory/
Bony Tumors**

NSAID/Steroid
Zoledronic Acid
Radiation
Gabapentinoid
Opioids



Total Pain/ Suffering

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Neuropathic

- Gabapentinoids
- SNRI or TCA
(duloxetine, nortriptyline)
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- Opioids *(?methadone)*
- Other *(mexilitine, AED's...)*

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Inflammatory/
Bony Tumors

- NSAID/Steroid
- Zoledronic Acid*
- Radiation*
- Gabapentinoid*
- Opioids

Opioids?

—quote—

"Don't you want me to feel better?"

*"They're going to die anyway—
who cares about addiction? Just
let them be happy!"*





Opioids have BOTH...

Good Effects:

Analgesia

- Key for severe physical pain
- Many still undertreated
-

Low doses for dyspnea

and

Bad Effects:

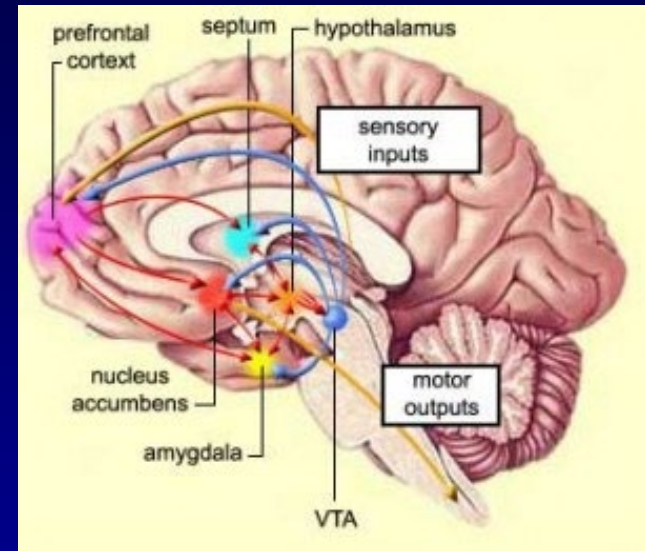
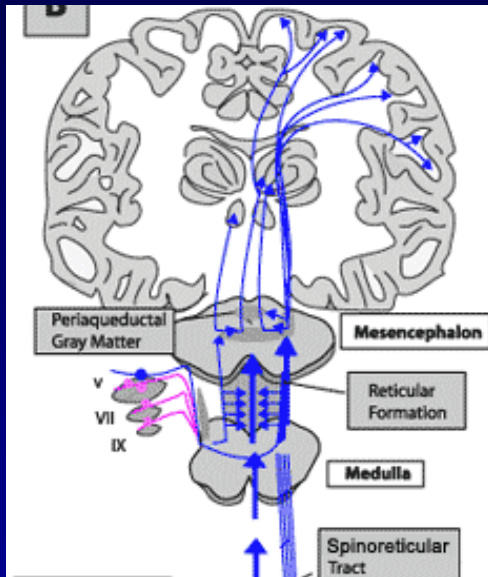
Addiction, Misuse and Abuse

- Deaths
- Destroyed lives, families
- Suffering/ Dysphoria
- Often ineffective (or harmful) in chronic pain
 - Hyperalgesia
 - Prolonged disability, pain
 - ?Decreased function & mentation
- (Adrenal insuff & hypogonadism)

Can we get the one effect without the other?



Two Different Systems



Nociception / Analgesia

- Spinothalamic tract / periaqueductal gray →
- Thalamus (VPN...) →
- Cortex

Reward/Addiction

- Limbic system
 - Nucleus accumbens
 - Amygdala,
 - Locus ceruleus,
 - Ventral pallidum (globus)

| | | |
|-----------------------|--|--|
| Opioid Effect: | Analgesia | |
| Effect: | Decreased physical pain (and dyspnea.) | |
| Depends on: | Concentration in CSF | |
| Opioid wears off: | Pain returns | |
| Tolerance: | No significant. | |



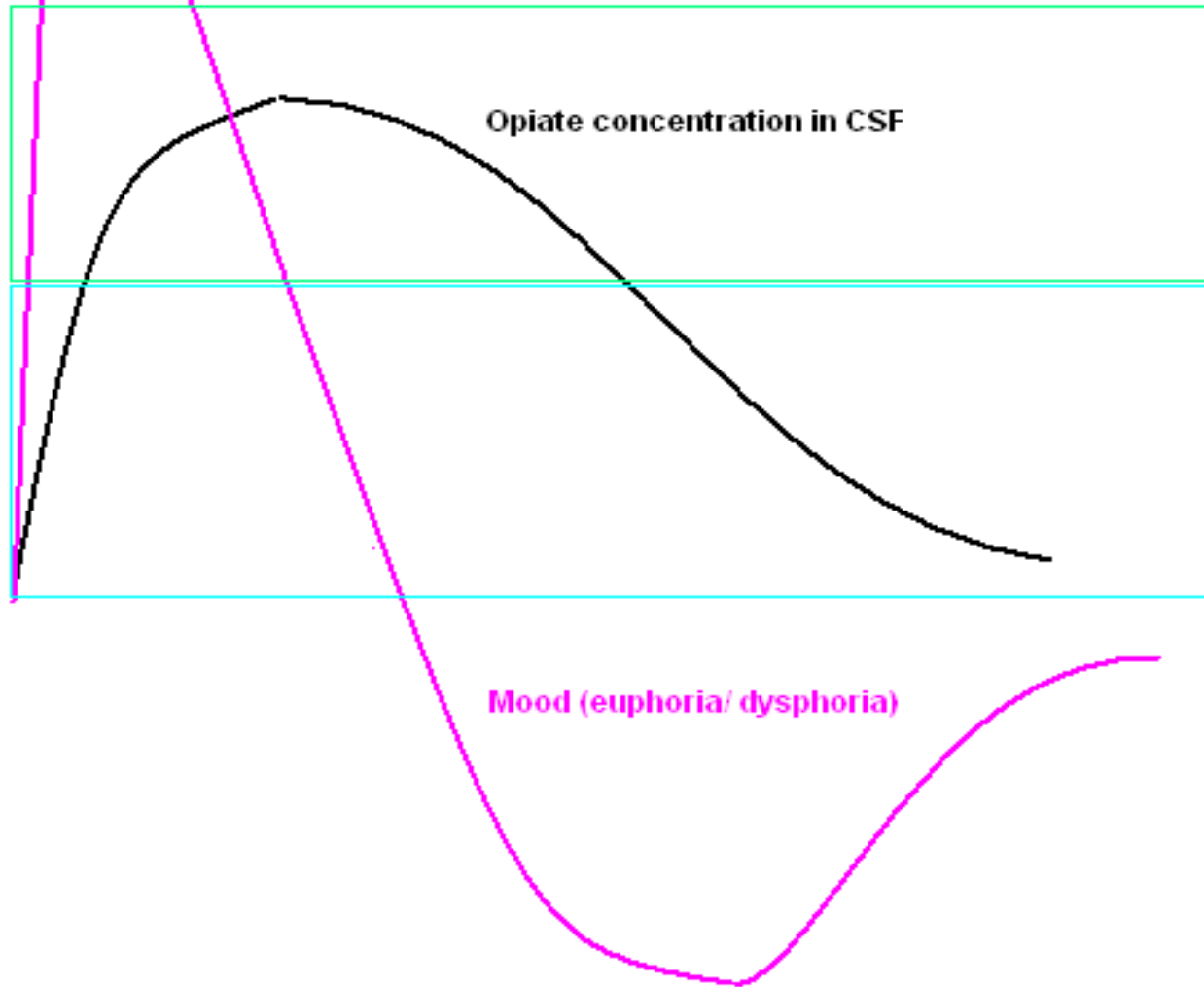
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Euphoria following IV/ rapid onset opiate



| | | |
|-----------------------|--|---|
| Opioid Effect: | Analgesia | Euphoria (Dysphoria) |
| Effect: | Decreased physical pain (and dyspnea.) | Relief of emotional pain. Relax, focus, energy. Sleep |
| Depends on: | Concentration in CSF | Rate of rise (or fall.) |
| Opioid wears off: | Pain returns | Dysphoria. ("Dying!") |
| Tolerance: | No significant. | Rapid. |

"Analgesia Good. Euphoria Bad."



To Maximize Euphoria:

Big peaks & troughs

IV push

High, infrequent IR dosing

Combine with BZD's, soma,
IV diphenhydramine/promethazine ...

Focus on pain level

Low, frequent IR
or long-acting

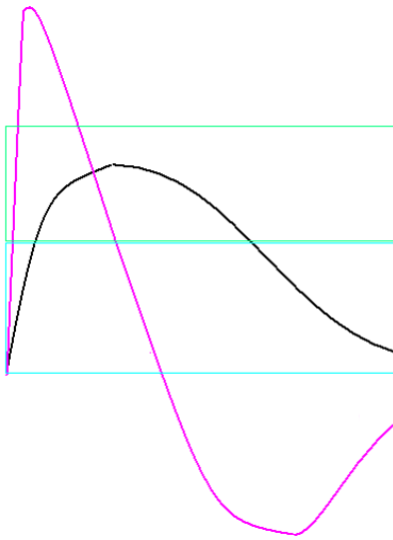
Steady blood level

IV push

Sched. or PRN
frequent, low dose PRN *if any*

Use adjuvants, co-analgesics,
nonpharm. Avoid BZD's

Focus on function, living fully



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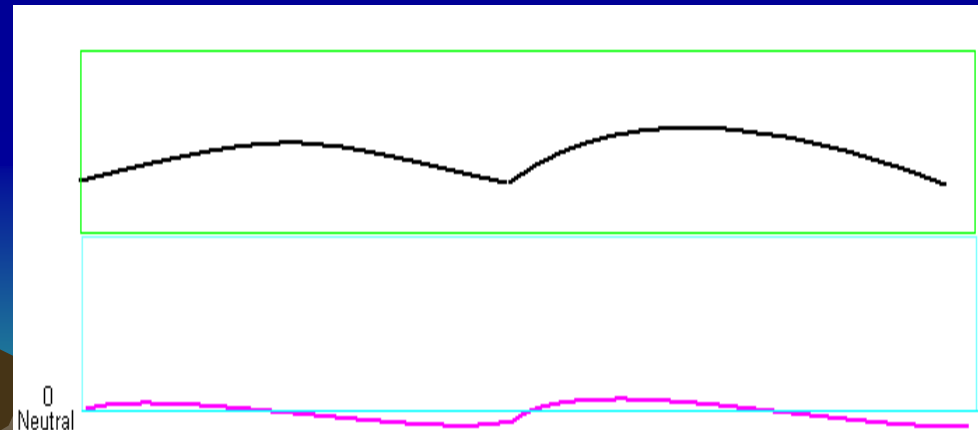
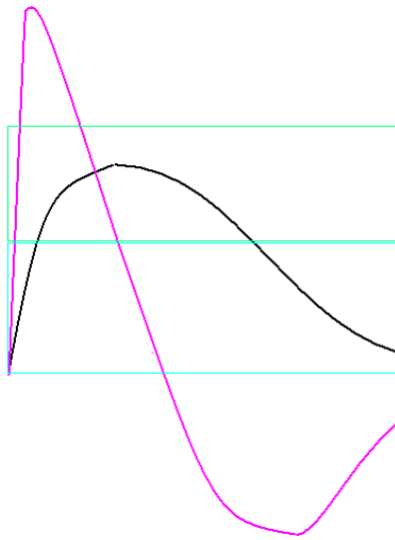
PO *or* PCA

SR scheduled

Frequent, low dose PRN *if any*

Use adjuvants, co-analgesics,
non-pharm. Avoid BZD's

Focus on function, living fully



Total Pain/ Suffering

Physical

Emotional

Social

Spiritual/
Existential

CBT, Grieving, Mindfulness
Avoid opioids!

Neuropathic

Gabapentinoids
SNRI or TCA
(duloxetine, nortriptyline)
Topical lidocaine
Opioids *(?methadone)*
Other *(mexilitine, AED's...)*

Nociceptive

Somatic

NSAID, APAP
Heat/ice/splint
Opioids

Visceral

Anticholinergic
(hyoscyamine/dicycl)
(constipation/UR...)
Opioid

Inflammatory/
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NSAID/Steroid
Zoledronic Acid
Radiation
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Case: 58 year old chest wall pain from recurrent NSCLC. Only med is hydrocodone, taking max dose with no relief. He is frustrated, wife desperate.

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Unfortunately, still need more information!

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| Pain Duration | Pain Type <small>(physical, emotional...)</small> | Addiction/ Misuse Risk? | Treatments of choice <small>(Also always address cause!)</small> | Opioid Form & Schedule |
|---------------------------------------|--|----------------------------|---|---------------------------|
| Acute Pain: | | | | |
| Chronic <i>non-cancer</i> Pain: | | | | |
| Cancer Pain: | | | | |

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|---|--|----------------------------|---|---------------------------|
| Acute Pain: | Physical (?Somatic) | Lower Risk BUT caution | | |
| Chronic non-cancer Pain: | | | | |
| Cancer Pain: | | | | |

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| Acute Pain: | Physical (?Somatic) | Lower Risk BUT caution | Acetaminophen, NSAID Physical Modalities Opioids | PRN IR PCA (no basal) <i>Exception: if pt unable to communicate need</i> |
| Chronic non-cancer Pain: | | | | |
| Cancer Pain: | ALL | Low Risk <i>but...</i> <i>(Survivorship)</i> | All of above | <i>Both SR sched + IR PRN or PCA w/ basal</i> |

Suggested Inpatient Acute Pain Regimen

- **Acetaminophen 1000 TID scheduled** (*if having pain*)
 - *Liver impairment*
 - *Neutropenia*
- **Oxycodone 5mg q2 PRN moderate or severe pain**
 - *Hydrocodone?*
- **Senna 2 HS**
 - (*doxusate*)
- *IV bolus ONLY if can't take PO*
- PCA (no basal rate) if uncontrolled



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| Chronic non-cancer Pain: | Emotional Social Spiritual/ Existential <i>?Physical?</i> | HIGH RISK! <i>? 1 in 3?</i> | | |
| Cancer Pain: | | | | |

How to Treat Chronic Pain

1. Mind

- Education
- CBT, mindfulness

2. Body

- PT, core body strengthening, massage, etc
- Procedures

3. Address Comorbidities & Vicious Cycles

- *Depressed, helpless, hopeless*
- *Sleep cycle disturbance, inactivity, disabled, social isolation..*

4. Adjuvants, Co-Analgesics

5. ?MAYBE opioid as *part*



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| Cancer Pain | | | | |

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| Cancer Pain | ALL types | Low Risk but ... <i>(*Survivorship)</i> | | |

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| Cancer Pain: | ALL types | Low Risk but ... <i>(*Survivorship)</i> | All of above | <i>Both</i> SR sched + IR PRN <i>or</i> PCA w/ basal |

- *But isn't cancer pain a form of chronic pain?*



Chronic Pain Spectrum

*No Obvious
Physical Source of
Pain*

*Obvious Physical
Source of Pain*

Fibromyalgia

Cancer



Chronic Pain Spectrum

*No Obvious
Physical Source of
Pain*

Fibromyalgia, IBS
Chronic daily headaches
Chronic Abd/pelvic Pain

*Obvious Physical
Source of Pain*

Chronic wounds
Destructive arthritis
Chronic Ischemia

Cancer

*Opioids likely
harmful*

*Opioids may
be helpful*

Case: Chronic LBP with bulging disk?

Chronic Pain Spectrum

*No Obvious
Physical Source of
Pain*

Fibromyalgia, IBS
Chronic daily headaches
Chronic Abd/pelvic pain
Chronic Low Back Pain (most)

*Obvious Physical
Source of Pain*

Severe physical injuries, wounds
Destructive arthritis
Chronic Ischemia
Cancer

*Opioids likely
harmful*

*Opioids may
be helpful*

To Maximize Euphoria:

Big peaks & troughs

IV push

High, infrequent IR dosing

Combine with BZD's, soma,
IV diphenhydramine/promethazine ...

Focus on pain level

To Maximize Analgesia:

Steady blood level

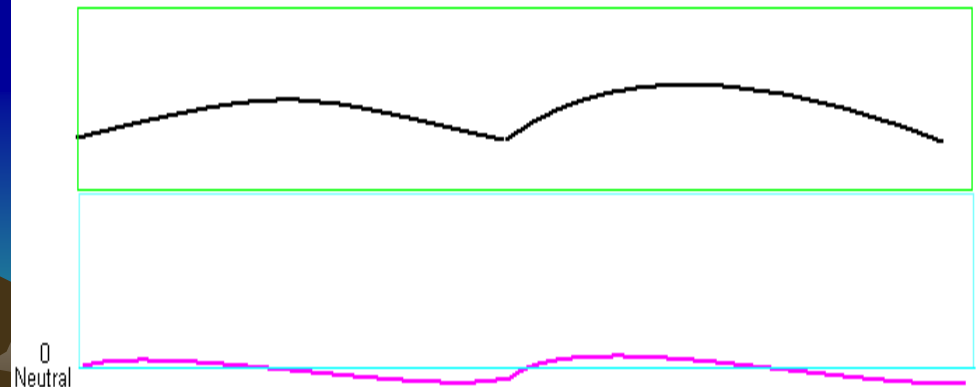
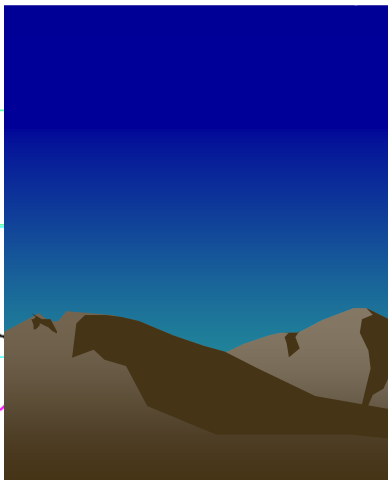
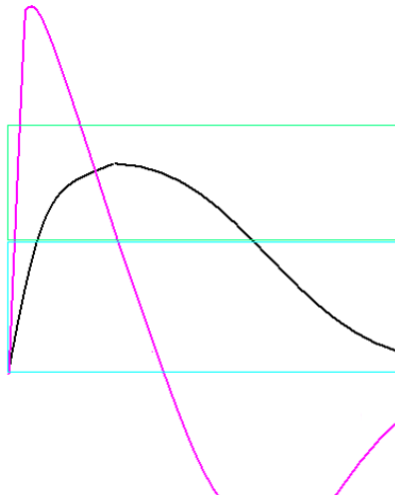
PO *or* PCA

If chronic: SR sched

If acute: **Frequent, low dose
oral PRN**

Use adjuvants, co-analgesics,
non-pharm. Avoid BZD's

Focus on function, living fully



Total Pain/ Suffering

Physical

Emotional

Social

Spiritual/
Existential

CBT, Grieving, Mindfulness. Avoid opioids!!

Neuropathic

Gabapentinoids
SNRI or TCA
(duloxetine, nortriptyline)
Topical lidocaine
Opioids (?methadone)
Other (*mexilitine, AED's...*)

Nociceptive

Somatic

Acet, NSAID
Heat/ice/splint
Opioids

Visceral

Anticholinergic
(hyoscyamine/dicycl)
(constipation/UR...)
Opioid

Inflammatory/
Bony Tumor

NSAID/Steroid
Opioids
Gabapentinoid
Zoledronic Acid /Rad

| <i>Duration</i> | Pain Type <i>(physical, emotional...)</i> | Addiction/ Misuse Risk? | Treatments of choice <i>(Also always address cause!)</i> | Opioid Form & Schedule |
|--|---|--|---|--|
| Acute Pain | Physical <i>(?Somatic)</i> | Lower Risk but caution | Acetaminophen, NSAID Physical Modalities Opioids | PRN IR <i>or</i> PCA <i>Exception: if pt unable to communicate need</i> |
| Chronic non-cancer Pain | Emotional Social Spiritual/ Existential <i>?Physical?</i> | HIGH RISK! <i>? 1 in 3?</i> | 1. Mind: Education & CBT 2. Physical Modalities 3. Address Comorbidities <i>(depression, sleep cycle, inactivity, helplessness...)</i> 4. Adjuvants, Co-Analgesics 5. <i>?MAYBE opioid as part</i> | <i>If constant:</i> Schedule SR <i>If only occasional:</i> PRN IR |
| Cancer Pain: | ALL types | Low Risk but ... <i>(*Survivorship)</i> | All of above | <i>Both SR sched + IR PRN or PCA w/ basal</i> |

Fibromyalgia

Chronic pain

Cancer

Questions?



“Default” Opioid Order Changes

- PRN opioids: more consistent doses
- smaller intervals.
- Continuous IV infusions




Palliative Medicine Elective

- Communication Skills
 - Family Meetings, Decision-making
 - Difficult patients & families
 - Much more
- Pain Management
- Symptom Management
- EOL care
- “Vital skills I didn’t learn anywhere else”



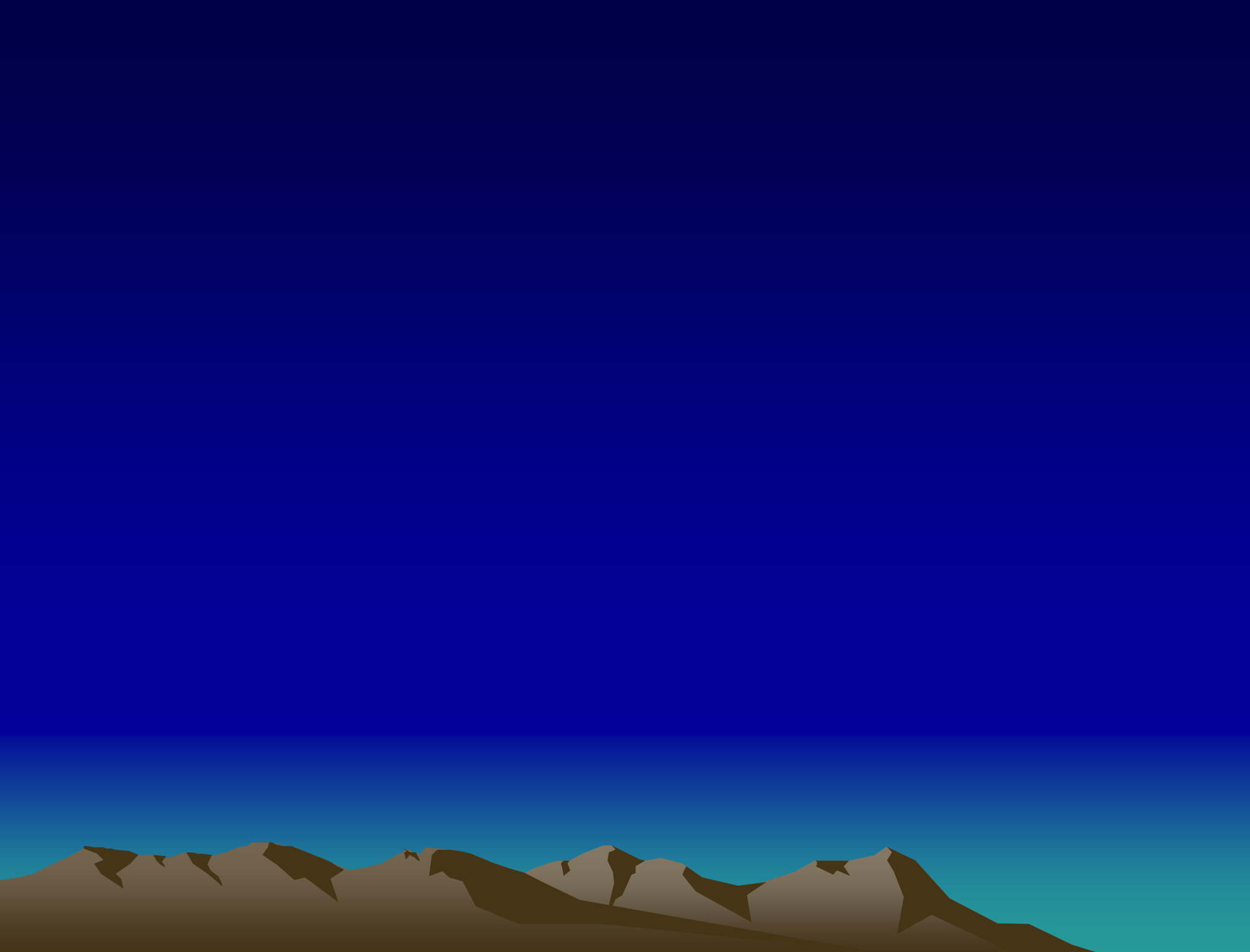
Palliative Medicine

- “Maximize QOL at any stage of illness,
 - helping ensure that their medical care makes sense for *them*.”
 - *Avoiding Regrets*
 - *Not pushing something. Not about stopping.*
 - Serious, advanced, or potentially life-threatening illnesses
 - Suffering or uncertainty
 - Frequent admissions
- 

Palliative Medicine

- Too early?
- Appropriate?
- Just like voting in Chicago
- *Note: chronic non-malignant pain.*





Total Pain/ Suffering

Physical

Emotional

Social

Spiritual/
Existential

Neuropathic

Nociceptic

Peripheral

(Central)

Somatic

Visceral

Inflammatory/
Bony Tumors

Total Pain/ Suffering

Physical

Emotional

Social

Spiritual/
Existential

Neuropathic

Nociceptic

Peripheral

(Central)

Somatic

Visceral

Bone

Acute

Chronic

Cancer

Physical Pain
Duration

Physical Pain
Cause(s)

Physical Pain
Severity

Mild

Moderate

Severe

Meaning
of Pain to Patient