ng the Concept of the Integrated linic Means Demonstrating Verifiable ncy

ry approach to pain management produces the best outcomes for patients. Clinicians who this approach must avoid repeating the mistakes of the past and concentrate on providing service.

Discrepant Goals in Pain ent: Strategies for Balancing ysician, and Other r Needs" (SIS-19)

hael E. Schatman, PhD, CPE, DASPE
y, September 8
n – 12:10pm
el 4, Mont-Royal Ballroom

rdisciplinary pain clinics are an endangered patient numbers keep dwindling, and their utting, all because financial considerations of- velfare.

ernment would compel hospitals to main- rce insurers to cover treatment, says Mi- n, PhD, CPE, DASPE, Executive Director of r Ethics in Pain Care. Until such mandates

Schatman. "This strategy works because interdisciplinary pain management really does help nearly all stakeholders. The trick is learning to demonstrate that."

To illustrate the challenges pain specialists face, Schatman will start by tracing the sad decline of interdisciplinary pain management and explaining why a nation that had more than 1,000 integrated clinics in 1998 has fewer than 100 today.

Integrated pain management clinics initially opened, both inside hospitals and independently, because researchers consistently found that coordinated teams of complementary pain specialists—usually a physician, a psychologist, a physical therapist, a nurse practitioner, and possibly several others—provide the best care for serious chronic pain.

Indeed, the research looked so good that insurers became (by their standards) positively enthusiastic about pain clinics, many of which responded to the easy money by adding services and padding bills. Worse, the flow of insurance money inspired underqualified (and occasionally dodgy) practitioners to open their own clinics to make a quick buck.

Costs rose. Outcomes worsened. Insurers began slashing reimbursement rates and dropping coverage altogether. Clinics began losing money. Then many of them shut their doors. Needlessly, according to Schatman.

"Patients suffered because everyone got greedy," Schatman

is to see things from the other rspective and show how he benefits ur desired course of action. This works because interdisciplinary nagement really does help nearly holders. The trick is learning to rate that.

ever, Schatman has some advice for cli- to revive the integrated pain program, are today at PAINWeek 2012 during his

RECAP

Research into the Int of Music and Neuro tion May Unlock Ne Treatments

New data is demonstrating the heali of music and suggesting new applica management

Several presentations during PAINWeek on the ways in which the brain interacts by, pain. On Tuesday, Michael B. Ellr Daniel F. Cleary presented on the ways in whi can help to alleviate pain. On Wednesday, Reb spoke about how our brains can be positively pain differently. The trend continued Friday m ture by Mark J. Tramo, MD, PhD, Director Ins Brain Science; Department of Neurology, D of Medicine at UCLA. His presentation, "The Neuromodulation of Pain Responses," provided how the human brain processes sound. While T cialize in the management of pain, he has pa studies that have examined the correlation b that way it impacts our bodies.

Tramo began by telling the audience tha sic as a healing power dates back thousand mythology, Apollo was associated with both Asclepius, a Greek god of healing, was believ help rid sick patients of their disease. While th cal figures, the fact is that there have been anecdotal reports over the centuries about th ameliorate pain and suffering across a wide eases, and clinical settings. Yes, it is important when dealing with any kind of anecdotal da some of these recounted experiences have h study of the correlation of music and healing

There is also a growing body of evidence ized-controlled trials demonstrating music's ef agement, said Tramo. He went on to discus ing the pathways by which the brain proces that, basically, our brains have an auditory v

(con

Experience the expanded Living Beyo a "multimedia showcase that present

t Pain Management in America

nents touch on all aspects of the delivery of quality pain care—from the research laboratory to the exam room, from the courtroom ambers across the nation.

vents in Law and Public lications for Pain Care rs" (SIS-20)

hael C. Barnes, JD
y, September 8
:20pm
el 4, Mont-Royal Ballroom

arch isn't the only thing that will change how cialists treat patients in the upcoming year. range of recent legal, financial, and cultural en more to affect standards of care.

nes, JD, managing partner of DCBA Law ngton, will outline the most relevant recent n what they could mean for pain clinicians in his presentation this evening, "Current d Public Policy: Implications for Pain Care

legislators, regulators, and journalists have terested in pain management recently, and uch in the past year to exercise their power ts and their patients.

Pain specialists may think they can't possibly hear any more about the dangers of opioid abuse, but they haven't heard anything yet. The issue has finally reached a tipping point in terms of mainstream media coverage.

potentially influential events is huge: hun-eds each year, certainly," says Barnes. "The sense of them is to look for trends, and I've nes that people who treat pain really should nderstand."

ccording to Barnes, is that more Americans are starting to worry about prescription drug abuse. He says that "Pain specialists may think they can't possibly hear any more about the dangers of opioid abuse, but they haven't heard anything yet. The issue has finally reached a tipping point in terms of mainstream media coverage, which means coverage will perpetuate itself, probably until the problem is 'solved'" in the public mind. Barnes notes that in the past year or two, "nearly every major newspaper in America has published articles highlighting the fact that prescription opioid overdoses kill more people each year than car crashes in some states," along with other now-familiar factoids about the effects of prescription opioid abuse and misuse. In the wake of these news reports, celebrity overdoses continuing to make headlines, and sensational media accounts of "addicted babies," Barnes says that "we've already seen an uptick in opioid-related legislation, regulation, litigation, and prosecution. And more is coming. Probably a lot more."

Another important trend is that pain advocacy groups are losing funding and power. Barnes says that concerns about the opioid abuse problem were already deterring donors, even before this year's public relations nightmare in which investigations shined a spotlight on the close ties between some pharmaceutical companies and advocacy groups. Oddly, these investigations come just as drug makers—worried that efforts to curtail opioid abuse will slash overall sales and profits—are cutting expenditures on pain advocacy. Pain advocacy groups are thus losing money from all sides at the very moment when their message about the importance of treating pain is falling out of favor. As a consequence, Barnes warns that pain specialists and advocates could see their ability to influence legislatures, insurers, and the public decline.

Addiction treatment may become a major component of pain care. Because their expertise would, in theory, allow them to spot opioid abuse (or even potential abu patients overcome any problems that develo selors strike many as a natural fit for pain cli few insurers cover addiction treatment, whi a non-starter, until the Affordable Care Ac law mandates coverage for addiction treatm financially feasible opportunities for pain p to serve patients better (and, potentially, r ity), either by hiring their own counselors or third-party treatment programs.

"Most of the people in the audience prob to like hearing most of what I have to say," Ba is different. This is a real opportunity for care

The greater legal risks faced by clinicians oids "too freely" is another trend that should attendees, says Barnes. Criminal prosecutions mills and "careless" practitioners are on the California stood trial for second-degree murd patients overdosed. The local DA argued that ment that there was nothing she could do to from taking a month's worth of pills in one da ful omission, and thus justified the murder cho

Civil suits are also on the rise, both against do companies. In one case, a family landed surviv workers' compensation policy after their relative opioids for an on-the-job injury overdosed. Insu ginning to increase restrictions on coverage of o

According to Barnes, tamper-resistant op make-or-break moment. This is an issue beco studies suggest that new formulations do ind often quite dramatically—financial considerati from the market unless the government mand become tamper resistant. Today's tamper re are more expensive, branded products. Man pay for them, and most generic drug makers licensing fees to make their products tamper r

Finally, Barnes says that clinicians who pr soon need extra training courses. A couple ready mandated new educational program prescribes controlled substances. Many othe ering it, as is the US Congress.

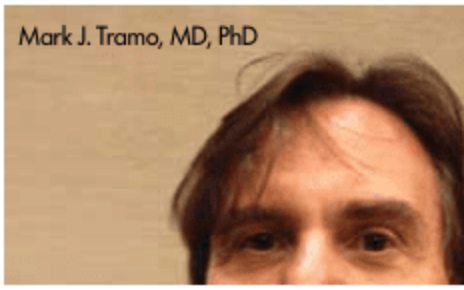
"The first trend — growing public concern drug abuse — underlies all the others," Barnes bly drive more changes to the industry than a

ued from cover)

ly respond to or get excited by sound. Based terprets these sounds, our body gives a natural had the experience of going to the dentist and drill our teeth. How many of us have grabbed clenched our hands to try and decrease the rt we are having in our mouths? Any of us who evoking the gate theory for pain. We are allo-

observe the effects in a controlled environment. Although it was a small-scale study (seven control babies, seven test babies), Tramo said it prodcued some interesting results. The music "created a lot of stability and lowered the blood pressure of those infants that it was played for." Although only two of the four babies who had not heard the music stopped crying following the heel stick, all four infants who had been able to hear the music stopped crying.

Tramo told the audience to keep an eye on a relatively new journal


Mark J. Tramo, MD, PhD

AINWeek?

e to the fourth and final day of the conference. chedule today features the four sessions of this Complementary and Alternative Medicine presentation that focus on pain medicine nurs- resented by pain management experts from the ation, the second half of the pharmacotherapy dule also includes a trio of sessions on regional cluding pelvic pain, arm and hand pain, and ("phantom tooth pain"). The Special Interest cover topics in pharmacy-based pain services, fferences in pain management, new develop- ublic policy, and the influence of various pain holders on the physician-patient relationship.

t 7:00am with **Hal S. Blatman, MD**, present- utrition and pain that will explain the ways in s in our patients' diets actually stop their bod- nd get in the way of rehabilitation." Blatman ecific nutrients that will augment healing and/ duce pain." **Debra J. Drew, MS, ACNS-BC,** he the challenges associated with pain assess- care setting, especially in special populations. **er, PharmD, BCPS**, will give a talk on phar- pharmacokinetic pain and pallia- **M. Fitzgerald,** e epidemiology le chronic pelvic s in pathophysi- diagnosis, and s and treatment drome.

ert A. Bonak- iew the preva- nd most com- apies as well as he patient con- complementary rapies in pain management. **Helen N. Turner, NS-BC**, on the use of multimodal analgesia in She will also cover various nonpharmaceutical to be effective additions to multimodal pain **McPherson, PharmD, BCPS**, will elucidate cokinetic and pharmacodynamic properties of mysterious methadone," covering a range of propriate titration strategies as well as how to nverted from another drug to methadone."

first of three satellite programs scheduled for Patients and Your Practice: The Role of Drug ain and Risk Management," sponsored by Alere ture **Jennifer E. Bolen, JD**, and **Jeffery A.** ussing practical approaches to incorporating comprehensive chronic pain and risk manage-

obert A. Bonakdar, MD, continues the nd Alternative Medicine track with "Overview Dietary Supplements," during which he will nce of supplement use in specific pain condi- medication facts." **Roger B. Fillingim, PhD**, will discuss sex and gender differences in pain management and explore possible answers to the question "Do we need pink and blue pills?" **Carri-Ann Gibson, MD**, and **Ilene R. Robeck, MD**, will examine key topics and challenges in evaluating and treating chronic pain in veterans following deployment.

Following the morning break, at 11:10am, **Lora McGuire, MS, RN**, will explore topics in the management of postoperative pain, including preemptive analgesia, special methods of delivery of pain control, and nonopioid, opioid, and adjuvant analgesics. **Srinivas Nalamachu, MD**, will discuss the clinical characteristics, assessment, diagnosis, and treatment of arm and hand pain. **Michael E. Schatman, PhD**, will talk about the evolving influence of non-patient and non-physician stakeholders in pain management (insurance, hospital, pharmaceutical, implantable device, and urine drug testing industries, etc) and explain why these various actors must coalesce into a "mutually cooperative system" if the suffering of pain patients is to be ameliorated.

At 12:30pm, the schedule features the final two satellite events of PAINWeek 2012. The faculty of "Persistent and Breakthrough Pain: Responsible Opioid Prescribing for Multidimensional Disorders" will consolidate clinically relevant scientific studies and evidence-based guidelines into practical approaches to persistent pain and breakthrough pain assessment, responsible opioid prescribing, and repeated re-evaluation of patient outcomes. "Mission: Pain Management – The Efficient First Visit (An IDEAL® Clinical Encounter)" will discuss nociceptive, neuropathic, and centrally-mediated chronic pain; the risks and benefits of nonpharmacologic and pharmacologic treatments for chronic pain; barriers to the optimal use of opioid analgesics in chronic pain; and methods for screening and risk mitigation in the initial and follow-up care of patients with chronic pain.

At 2:10pm, **Hal S. Blatman, MD**, will present "a wide range of options for treatment, recovery, and body maintenance for a healthy and pain-free life" for women at midlife. **Bill Paquin**, CEO of Vertical Health, will explore "the pivotal role that Web and mobile applications will play to both increase the efficiency of physician practices and improve patient outcomes" in pain management. **Edward S. Lee, MD**, and **Tu A. Ngo, PhD, MPH**, will offer a plenary session focusing on managing psychiatric comorbidities in chronic pain. **Gary W. Jay, MD**, will present a master class on the differential diagnosis and management of migraine and tension-type headache.

Following the afternoon break, **Carol P. Curtiss, MSN, RN-BC**, will discuss key principles involved in balancing effective pain management and screening for risk of substance misuse and addiction in persons with pain. **Peter A. Foreman, DDS**, will examine the difficult diagnostic and treatment challenges associated with orofacial neuropathies. **Mary Lynn McPherson, PharmD**, and **Kathryn A. Walker, PharmD**, will duke it out as

Today's Schedule of Recommended Cou for First-time PAINW Attendees

7:00am-8:00am

Nutrition and Pain: Simple R for Pain-Free Health

Hal S. Blatman, MD

7:00am-8:00am

Pelvic Pain

Colleen M. Fitzgerald, MD

8:10am-9:10am

Analgesia: What are the Op

Helen N. Turner, DNP, RN-BC, PCN

9:20am-10:20am

Speed Dating with Pharmaci 50 Top Medication Tips at E

Mary Lynn McPherson, PharmD, BC

Kathryn A. Walker, PharmD, BCPS

11:10am-12:10pm

Pre- and Postop Pain Manag

Lora McGuire, MS, RN

2:10pm-3:10pm

Women on the Verge: Sleep, and Pain at Midlife

Hal S. Blatman, MD

5:20pm-6:20pm

VA Health Care: This is Not Your Father's VA

Lucile Burgo-Black, MD, and Steph MD, MPH

ffect in Patients Taking Opioids for ic Pain

prescribe opioids should be aware of the symptoms of opioid-induced constipation s of the pharmacologic options for managing this condition

pioid-induced Constipation: Considerations to propriate Early Targeted Therapy for Better Pa- omes," a CME-accredited session yesterday at at focused on opioid-induced constipation, its and the pharmacologic options that are cur- treat this condition, presenters Bill McCarberg, O; and Michelle Rhiner, RN-BC, MSN, provided mation that clinicians can apply to daily practice. e session by talking about the scope of the induced constipation (OIC). Because prescrip- most commonly used medications in the pain alliative care settings, and because OIC is "one of the most common adverse side effects associated with chronic opioid therapy," Rhiner said that most patients with chronic pain will experience OIC to some degree. In fact, OIC is reported in up to 90% of patients with cancer pain and 80% of patients with chronic nonmalignant pain. She noted that because chronic pain patients rarely develop a tolerance to OIC, most of them will require some form of pharmacologic therapy for constipation (up to 94% of patients with advanced illness who take opioids need laxatives, the most commonly used therapy for OIC).

ients with chronic experience OIC to gree. In fact, OIC ed in up to 90% nts with cancer l 80% of patients onic nonmalignant cause chronic pain

Untreated or undertreated OIC can compromise pain management in patients with cancer. Rhiner said that surveys have shown that OIC can cause patients to switch to switch to a different opioid, reduce their opioid dose (either in conjunction with their health care provider, or on their own without telling their provider), or even stop taking opioids altogether. Patients with OIC also use more health care resources (they have more hospital admissions and doctor visits, use more home health services, etc). Rhiner said that OIC also has a negative impact on quality of life and functionality in patients with chronic noncancer pain, leading to missed work, reduced productivity, and compromised mental and physical health.

Rhiner concluded her portion of the session by briefly reviewing normal colorectal functional processes. She said that bowel function is "governed by the enteric brain, an organ comprised of billions of neurons," and that any disruption in the neurotransmitters and mechanisms that regulate bowel function (such as those produce by opioids) can lead to constipation and bowel dysfunction. She said that OIC results when opioids bind with periphery sensors in the gut and in the enteric system. This affects not only the colon, but other components of the bowel/gastrointestinal system, producing a spectrum of opioid-induced bowel dysfunction. This can include cramping, bloating, decreased appetite, nausea and other symptoms in addition to constipation. She said that many of these symptoms are often missed by patients and providers and not attributed to the patient's opioid therapy.

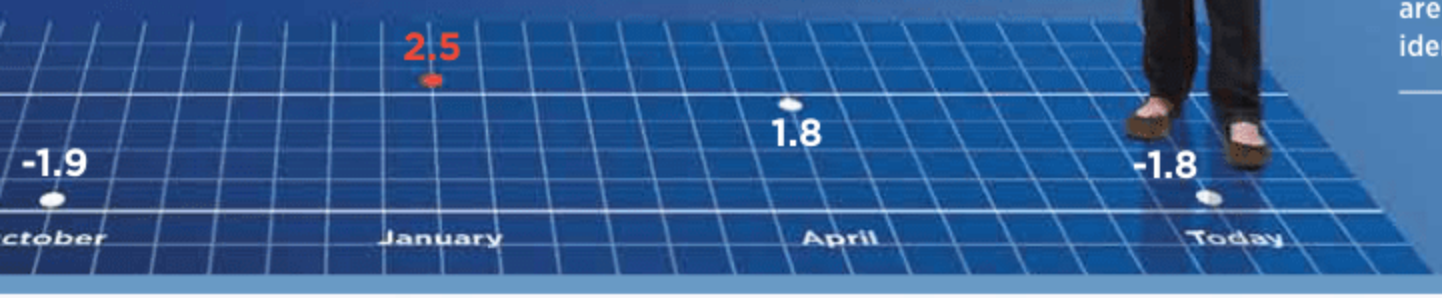
Assessing patients for OIC and selecting an appropriate management option

During his portion of the presentation, McCarberg discussed the assessment and management of OIC. He said that "there are no good diagnostic criteria for OIC." Although many patients and clinicians focus on stool frequency when discussing OIC, McCarberg said that this might not provide a complete picture because "there is wide variability in stool frequency" from patient to patient. Thus, when assessing patients for OIC, clinicians should also focus on other factors, such as those outlined in the Rome III criteria for functional constipation. McCarberg reminded the audience that these "are not necessarily for OIC, just for functional constipation. There are no OIC-specific criteria."

When assessing patients for OIC, taking a history is important to find out the patient's normal bowel/defecation routine in order to establish a baseline. "You have to ask the right questions" about the patient's previous and current bowel pattern and activity level, their amount of daily fiber and fluid intake, and laxative use prior

...itoring gives you the ...IGHT of Rx Guardian CD℠

...g you to compare your patient to a database ...nts clinically assessed for adherence.



The Rx Guardian ... (normalized drug ... with other clinical ... indicate that if yo... pain patient falls:

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Your patient's sta... are tracked over t... identify patterns.

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...cally advanced urine drug monitoring system is brought to you by Ameritox, the leade... ...ledication Monitoring℠. Together with your expertise, **Rx Guardian CD℠ with the Rx Gu... ...Report** can help you make clinical decisions to enhance the care of your chronic pain ...

...y Booth #114, to learn more about Rx Guardia...

EFTA01114707

ain-fighting diet that calls for eliminating trans fats, artificial sweeteners, nutritionally deficient foods, digestive tract disruptors, and oth
dients, patients may be able to effectively reduce the severity of their pain without the use of prescription medications.

and Pain: Simple Rules for Health" (CAM-01)

S. Blatman, MD, DAAPM, ABIHM
y, September 8
00am
el 3, Castellana 1

e owes much of its success to a quality that's
l among foodstuffs: an utter inability to sup-
ost forms of life.
o eat it. Mold takes no root inside it. Even
e it a miss. Industrial food makers, who have
s a miracle ingredient that can cut costs and
have made it one of the most common ingre-

humans
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nd Pain:
Pain-Free

actively
Others
l stop our
what they are designed to do: heal them-
prevent medications from working properly,"
o runs the Blatman Pain Clinic in Cincinnati.
oods and your patients will hurt less. They'll
er to opioid medications—and develop less
can prescribe lower doses and stop worrying
king down your door."
ent the past couple of decades testing ingre-
fighting diet he will outline during his talk. He
very credible book and study he can find on
he conducts tiny experiments, first on himself,
l friends, and finally on patients.
of testing have left him with a reasonably
delines that seem to provide at least some
every patient who sticks to them for any
tman says that he cannot scientifically prove
eness because he recommends it to every
n maintaining control groups, but he be-

hypothesize from what I've read about the mechanisms by which particular compounds increase pain. But case after case demonstrates a major impact. It's common for my patients with fibromyalgia to report that pain goes down by as much as half when they eliminate all artificial sweeteners," Blatman says.

The insufficiently nutritious category includes many of the usual suspects: sugar, potatoes, fruit juices, and many other foods with high glycemic indexes.

As for the digestive tract disruptors, the list there includes excessive red meat and all wheat products. "The gut plays an incredibly important role in good health," Blatman says. "The good flora that are inside of it break down your food so you can absorb nutrients properly. They also keep your immune system working right, which is why patients with autoimmune diseases get particular relief when they start eating a gut-healthy diet."

Blatman's dietary recommendations are simple. Sticking to them, however, can be tricky. Many diets advise patients to cut back on certain foods and ingredients. Blatman tells patients to avoid them completely, a maxim that requires not only iron self-discipline but also frequent detective work. Many of the forbidden ingredients are found in a wide variety of foods, and often turn up in unexpected places. Blatman remembers one patient who "gave up" wheat but saw no health benefits--because she had no idea about the wheat in her favorite soy sauce.

Patients must also be willing to wait long p
start to see any benefits. Blatman cautions
foods take weeks to work their way entirely
Others take as long as four months, and a
bite of the wrong thing can set the clock bac
can see significant benefits just by cutting ba
ingredients I advise against, but in most case
only come from total abstinence," Blatman s

Many patients, obviously, will sabotage th
ing here and there. Many end up simply ab
altogether.

"Patients obviously have the right to cho
but I make it clear to them that they are doi
ing to be in pain. I also make it clear to the
changes come before any unusually large
Blatman says.

"If they follow the diet religiously and the
try what I can to fix that. But if the pain isn't e
a patient to eat better, then it certainly isn't b
to risk his or her health by increasing the op
and again," Blatman says. "This diet isn't an e
anything, but it produces very impressive res
and it can do the same for yours."

"Eliminate problem foods and ingredients and your patients will hurt less. They'll also respond better to medications—and develop less tolerance—so you can prescribe lower doses and stop worrying about the kicking down your door."

fective **24-hour pain control**[1]

nce-daily oral dosing with
e evening meal[1]

ow incidence of dizziness
nd somnolence[1]

tration to an 1800 mg dose
2 weeks[1]

was a reported incidence of dizziness
% vs 2.2% placebo) and somnolence
vs 2.7% placebo) at 1800 mg once daily.[1]

more information,
se visit **Booth 316**.

Watch how GRALI technology works

Scan the barcode to view the video at [redacted]

ation and Usage

ISE® is indicated for the management of
erpetic neuralgia (PHN). GRALISE is not
hangeable with other gabapentin products
se of differing pharmacokinetic profiles
ffect the frequency of administration.

rtant Safety Information

ISE is contraindicated in patients who have
nstrated hypersensitivity to the drug or its ingredients.

ileptic drugs (AEDs) including gabapentin, the active ingredient in GRALISE, increase
suicidal thoughts or behavior in patients taking these drugs for any indication. Patient
d with any AED for any indication should be monitored for the emergence or worsenin
pression, suicidal thoughts or behavior, and/or any unusual changes in mood or behav

ost common adverse reaction to GRALISE (≥5% and twice placebo) is dizziness.

s all GRALISE clinical trials the other most common adverse reactions (≥2%) are
olence, headache, peripheral edema, diarrhea, dry mouth, and nasopharyngitis.
pes and incidence of adverse events were similar across age groups except for
eral edema, which tended to increase in incidence with age.

see next page for Brief Summary of Prescribing Information.
scribing Information and Medication Guide are available at [redacted]

Gralise®

EFTA01114709

limum of one week or longer (at the discretion of the prescriber).
Dose should be adjusted in patients with reduced renal function. GRALISE should not be
h CrCl less than 30 or in patients on hemodialysis.
erpetic neuralgia, GRALISE therapy should be initiated and titrated as follows:

commended Titration Schedule

Day 2	Days 3-6	Days 7-10	Days 11-14	Day 15
600 mg	900 mg	1200 mg	1500 mg	1800 mg

S

ated in patients with demonstrated hypersensitivity to the drug or its ingredients.

sage Based on Renal Function

	Once-daily dosing
nL/min)	GRALISE dose (once daily with evening meal)
	1800 mg
	600 mg to 1800 mg
	GRALISE should not be administered
odialysis	GRALISE should not be administered

CAUTIONS

angeable with other gabapentin products because of differing pharmacokinetic profiles that
administration. The safety and effectiveness of GRALISE in patients with epilepsy has not been

avior and Ideation Antiepileptic drugs (AEDs), including gabapentin, the active ingredient in
risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients
r any indication should be monitored for the emergence or worsening of depression, suicidal
nd/or any unusual changes in mood or behavior.

ation for Antiepileptic Drugs (including gabapentin, the active ingredient
oled Analysis

	Epilepsy	Psychiatric	Other	Total
vents per 1000 patients	1.0	5.7	1.0	2.4
nts per 1000 patients	3.4	8.5	1.8	4.3
of events in e in placebo patients	3.5	1.5	1.9	1.8
nal drug patients atients	2.4	2.9	0.9	1.9

cidal thoughts or behavior was higher in clinical trials for epilepsy than in clinical trials
conditions, but the absolute risk differences were similar for the epilepsy and psychiatric
nsidering prescribing GRALISE must balance the risk of suicidal thoughts or behavior with
ess. Epilepsy and many other illnesses for which products containing active components
gabapentin, the active component in GRALISE) are prescribed are themselves associated
tality and an increased risk of suicidal thoughts and behavior. Should suicidal thoughts and
g treatment, the prescriber needs to consider whether the emergence of these symptoms
y be related to the illness being treated. Patients, their caregivers, and families should be
contains gabapentin which is also used to treat epilepsy and that AEDs increase the risk of
ehavior and should be advised of the need to be alert for the emergence or worsening of the
depression, any unusual changes in mood or behavior, or the emergence of suicidal thoughts,
bout self-harm. Behaviors of concern should be reported immediately to healthcare providers.
pentin Gabapentin should be withdrawn gradually. If GRALISE is discontinued, this should
a minimum of 1 week or longer (at the discretion of the prescriber). **Tumorigenic Potential**
in vivo lifetime carcinogenicity studies, an unexpectedly high incidence of pancreatic acinar
identified in male, but not female, rats. The clinical significance of this finding is unknown.
pentin therapy in epilepsy comprising 2,085 patient-years of exposure in patients over
mors were reported in 10 patients, and preexisting tumors worsened in 11 patients, during
discontinuing the drug. However, no similar patient population untreated with gabapentin was
kground tumor incidence and recurrence information for comparison. Therefore, the effect
on the incidence of new tumors in humans or on the worsening or recurrence of previously
known. **Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)/**
nsitivity Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS), also known
nsitivity, has been reported in patients taking antiepileptic drugs, including GRALISE. Some
een fatal or life-threatening. DRESS typically, although not exclusively, presents with fever,
enopathy in association with other organ system involvement, such as hepatitis, nephritis,
alities, myocarditis, or myositis, sometimes resembling an acute viral infection. Eosinophilia
use this disorder is variable in its expression, other organ systems not noted here may be
t to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy,
hough rash is not evident. If such signs or symptoms are present, the patient should be
. GRALISE should be discontinued if an alternative etiology for the signs or symptoms
Laboratory Tests Clinical trial data do not indicate that routine monitoring of clinical
s necessary for the safe use of GRALISE. The value of monitoring gabapentin blood
been established.

S

ence Because clinical trials are conducted under widely varying conditions, adverse reaction
linical trials of a drug cannot be directly compared to rates in the clinical trials of another
ct the rates observed in practice. A total of 359 patients with neuropathic pain associated
algia have received GRALISE at doses up to 1800 mg daily during placebo-controlled clinical
in patients with postherpetic neuralgia, 9.7% of the 359 patients treated with GRALISE
nts treated with placebo discontinued prematurely due to adverse reactions. In the GRALISE
ost common reason for discontinuation due to adverse reactions was dizziness. Of GRALISE-
perienced adverse reactions in clinical studies, the majority of those adverse reactions were
ate". Table 4 lists all adverse reactions, regardless of causality, occurring in at least 1% of
ic pain associated with postherpetic neuralgia in the GRALISE group for which the incidence
placebo group.

mergent Adverse Reaction Incidence in Controlled Trials in Neuropathic Pain
therpetic Neuralgia (Events in at Least 1% of all GRALISE-Treated Patients and
in the Placebo Group)

Dizziness	10.9	2.2
Somnolence	4.5	2.7
Headache	4.2	4.1
Lethargy	1.1	0.3

In addition to the adverse reactions reported in Table 4 above, the following adverse reactions with a
relationship to GRALISE were reported during the clinical development for the treatment of posthe
Events in more than 1% of patients but equally or more frequently in the GRALISE-treated patient
the placebo group included blood pressure increase, confusional state, gastroenteritis viral, herpe
hypertension, joint swelling, memory impairment, nausea, pneumonia, pyrexia, rash, seasonal all
respiratory infection. **Postmarketing and Other Experience with other Formulations of Ga**
addition to the adverse experiences reported during clinical testing of gabapentin, the following ad
have been reported in patients receiving other formulations of marketed gabapentin. These adverse
not been listed above and data are insufficient to support an estimate of their incidence or to establi
listing is alphabetized: angioedema, blood glucose fluctuation, breast hypertrophy, erythema multifo
liver function tests, fever, hyponatremia, jaundice, movement disorder, Stevens-Johnson syndrome.
following the abrupt discontinuation of gabapentin immediate release have also been reported. The
reported events were anxiety, insomnia, nausea, pain and sweating.

DRUG INTERACTIONS

An increase in gabapentin AUC values has been reported when administered with hydrocodone
with morphine. An antacid containing aluminum hydroxide and magnesium hydroxide reduced th
of gabapentin immediate release by about approximately 20%, but by only 5% when gabapentin
2 hours after antacids. It is recommended that GRALISE be taken at least 2 hours following antaci
There are no pharmacokinetic interactions between gabapentin and the following antiepileptic drug
carbamazepine, valproic acid, phenobarbital, and naproxen. Cimetidine decreased the apparent or
gabapentin by 14% and creatinine clearance by 10%. The effect of gabapentin immediate release
was not evaluated. This decrease is not expected to be clinically significant. Gabapentin immediate
three times daily) had no effect on the pharmacokinetics of norethindrone (2.5 mg) or ethinyl estra
administered as a single tablet, except that the C_{max} of norethindrone was increased by 13%. This
considered to be clinically significant. Gabapentin immediate release pharmacokinetic parameters
with and without probenecid, indicating that gabapentin does not undergo renal tubular secretion b
that is blocked by probenecid.

USE IN SPECIFIC POPULATIONS

Pregnancy Pregnancy Category C: Gabapentin has been shown to be fetotoxic in rodents, causi
ossification of several bones in the skull, vertebrae, forelimbs, and hindlimbs. There are no adequate
controlled studies in pregnant women. This drug should be used during pregnancy only if the potent
justifies the potential risk to the fetus. To provide information regarding the effects of *in utero* exposu
physicians are advised to recommend that pregnant patients taking GRALISE enroll in the North A
Antiepileptic Drug (NAAED) Pregnancy Registry. This can be done by calling the toll free number 1-8
and must be done by patients themselves. Information on the registry can also be found at the webs
aedpregnancyregistry.org/. **Nursing Mothers** Gabapentin is secreted into human milk following ora
A nursed infant could be exposed to a maximum dose of approximately 1 mg/kg/day of gabapentin.
effect on the nursing infant is unknown, GRALISE should be used in women who are nursing only if
clearly outweigh the risks. **Pediatric Use** The safety and effectiveness of GRALISE in the manag
postherpetic neuralgia in patients less than 18 years of age has not been studied. **Geriatric Use**
of patients treated with GRALISE in controlled clinical trials in patients with postherpetic neuralgia
which 63% were 65 years of age or older. The types and incidence of adverse events were simila
groups except for peripheral edema, which tended to increase in incidence with age. GRALISE is
substantially excreted by the kidney. Reductions in GRALISE dose should be made in patients wit
compromised renal function. [see Dosage and Administration]. **Hepatic Impairment** Because g
metabolized, studies have not been conducted in patients with hepatic impairment. **Renal Impai**
is known to be substantially excreted by the kidney. Dosage adjustment is necessary in patients wit
function. GRALISE should not be administered in patients with CrCL between 15 and 30 or in patien
hemodialysis [see Dosage and Administration].

DRUG ABUSE AND DEPENDENCE

The abuse and dependence potential of GRALISE has not been evaluated in human studies.

OVERDOSAGE

A lethal dose of gabapentin was not identified in mice and rats receiving single oral doses as high as
Signs of acute toxicity in animals included ataxia, labored breathing, ptosis, sedation, hypoactivity, c
Acute oral overdoses of gabapentin immediate release in humans up to 49 grams have been reporte
cases, double vision, slurred speech, drowsiness, lethargy and diarrhea were observed. All patients
supportive care. Gabapentin can be removed by hemodialysis. Although hemodialysis has not been
the few overdose cases reported, it may be indicated by the patient's clinical state or in patients wit
renal impairment.

CLINICAL PHARMACOLOGY

Pharmacokinetics *Absorption and Bioavailability* Gabapentin is absorbed from the proximal small
saturable L-amino transport system. Gabapentin bioavailability is not dose proportional; as the dose
bioavailability decreases. When GRALISE (1800 mg once daily) and gabapentin immediate release
times a day) were administered with high fat meals (50% of calories from fat), GRALISE has a highe
AUC at steady state compared to gabapentin immediate release. Time to reach maximum plasma co
for GRALISE is 8 hours, which is about 4-6 hours longer compared to gabapentin immediate releas

NONCLINICAL TOXICOLOGY

Carcinogenesis, Mutagenesis, Impairment of Fertility Gabapentin was given in the diet to m
600, and 2000 mg/kg/day and to rats at 250, 1000, and 2000 mg/kg/day for 2 years. A statistic
increase in the incidence of pancreatic acinar cell adenoma and carcinomas was found in male rat
high dose; the no-effect dose for the occurrence of carcinomas was 1000 mg/kg/day. Peak plasm
of gabapentin in rats receiving the high dose of 2000 mg/kg/day were more than 10 times higher
concentrations in humans receiving 1800 mg per day and in rats receiving 1000 mg/kg/day peak
concentrations were more than 6.5 times higher than in humans receiving 1800 mg/day. The panc
carcinomas did not affect survival, did not metastasize and were not locally invasive. The relevance
to carcinogenic risk in humans is unclear. Studies designed to investigate the mechanism of gabap
pancreatic carcinogenesis in rats indicate that gabapentin stimulates DNA synthesis in rat pancrea
in vitro and, thus, may be acting as a tumor promoter by enhancing mitogenic activity. It is not kno
gabapentin has the ability to increase cell proliferation in other cell types or in other species, includ
Gabapentin did not demonstrate mutagenic or genotoxic potential in 3 *in vitro* and 4 *in vivo* assays.
effects on fertility or reproduction were observed in rats at doses up to 2000 mg/kg (approximatel

ache Classifications and Treatments

sis and treatment requires an understanding of the signs, symptoms, and clinical presentation of the multiple forms of tension-type headache

and Tension-Type
Differential Diagnosis and
ent" (MAS-06)

y W. Jay, MD, FAAPM, DAAPM
y, September 8
10pm
el 4, Nolita 3

ssfully address
' needs and to
ducing treatment-
adverse outcomes,
ns need to be able
mine the type of
e their patient is

The way headache specialists think about the relationship between tension-type and migraine headaches has shifted considerably over the last several decades. "At one point, not that far back, people thought of headaches as a spectrum; a straight line with tension-type headaches (TTHA) at one end and migraines at the other end. Everything in between were gradations," says Gary W. Jay, MD, FAAPM. He says that the question nowadays is whether they are essentially one headache with two different clinical pictures.

To bring attendees of PAINWeek 2012 up to speed on the latest trends in headache medicine, Jay will present a two-hour master class, "Migraine and Tension-Type Headache: NOT Two Ends of a Spectrum!," on Saturday afternoon. During this comprehensive session, he will review the pathophysiologies and varieties of migraine headaches and TTHAs, as well appropriate treatment options.

According to Jay, a major challenge faced by health care providers who treat patients with headache is recognizing the multiple forms of TTHAs and migraines. "I will review what we know about what happens in the brain, particularly different forms of migraine headaches," says Jay.

When many people think about migraines, they still think of the *classical* migraine headache—typically, a woman with a one-sided throbbing headache who has pain that is triggered by sound or light. Jay says that there are "multiple types of migraine and they can occur with or without aura." He also notes that the nature of aura varies widely, "Aura is visual in 80 to 85 percent of patients; patients can have neurological aura that may elicit speech difficulty or even hemiplegia."

To successfully address patients' needs and to avoid inducing treatment-related adverse outcomes, physicians need to be able to determine the type of headache their patient is experiencing. As an example, triptans and ergot alkaloids are typical abortive treatments for migraines. "Both of these are vasoconstrictors and you never want to offer them to a patient that may have significant aura secondary to vasoconstriction," says Jay. "This can cause further vasoconstriction and neurological deficit and very possibly lead to long-term or permanent damage. It can induce infarction."

The ability to differentiate between symptoms and possible causes can have a profound impact on outcomes and quality of life. "If a patient calls you in the middle of night and tells you something is happening, you need to be able to make a decision on whether to meet them at the emergency room as soon as possible," Jay says. In some visual auras, patients may develop transient monocular vision loss. This presents similarly to amaurosis fugax, a transient ischemic attack involving a retinal artery. During his session, Jay will discuss strategies for confidently and accurately assessing these types of episodes and others.

Earlier this year, the American Academy of Neurology and the American Headache Society jointly published updated evidence-based guidelines on preventive pharmacologic treatment for episodic migraine headaches. The guideline authors used stringent evaluation criteria to review existing evidence.

ops," he says. "So what starts as possibly ju
becomes centralized."

In addition to reviewing TTHA pathophys
ments, Jay will talk about diagnostic criteria
mon TTHAs. Certain types of headaches a
reproducible patterns of pericranial muscle te
ger point activation. "Pericranial muscle ten
multiple etiologies, but arises most commonl
myofascial pain syndrome," says Jay. Myofa
along the masseter muscle refer pain to the
Trigger points may also elicit autonomic dysfu
in the sternocleidomastoid muscle where trig
sociated with lacrimation and redness, in ad

"An example of what often happens is
comes in with temporomandibular joint (TMJ
multiple surgeries for it, and the real problem
the TMJ is being referred by a muscle," says

In cases like this, "It is the job of the physi
what the patient needs." Physicians need to
origin of the pain. Jay hopes to convey the m
the right questions is an important part of tre
headaches. "Patients don't know what to tell
them what you need to know," he says.

Gary W. Jay is a neurological consultan
in pain and disorders of the central nerv
president-elect of the Eastern Pain Associati
tion of the American Pain Society. He is a f
the American Academy of Pain Manageme
Academy of Pain Medicine. He was one of t
the American Academy of Pain Medicine in

pain assessment means going beyond matching a patient's pain to a number on a scale; it requires clinicians to consider
ors and approaches.

sment in Acute Care" (NRS-01)

ora Drew, MS, ACNS-BC, RN-BC
y, September 8
:00am
el 3, Gracia 7

ent is gaining traction as an important foun-
ement of pain management. In August 2012,
ommission issued a Sentinel Event Alert re-
se of opioids in the hospital setting. This pub-
he need to assess and monitor pain as part
management program.

specialists on this topic, Debra Drew, MS,
, will present "Pain Assessment in Acute Care"
eek 2012. The presentation will provide an
assessment, including tools and approaches
cial populations relevant to acute care set-
eed to understand the complexities of the
nd all its facets before they can design a plan
comfortable," says Drew.

asize the importance of viewing pain assess-
that involves much more than administering
uestionnaire to assign a score to the patient's
tion of good pain management begins with
assessment," says Drew. "Is the 0–10 pain in-
u think of when you think of pain assessment?
hat is 'yes,' you may be missing the boat."

entation, Drew will review the latest findings
r pain assessment and discuss some of the
ted with pain assessment in special popula-
children and the elderly), as well as patients
ous, ventilated, or developmentally delayed.
patients who can't verbalize their pain, who
ds what they are feeling or can't speak," says
cuss how to optimally assess pain when you
lenging population."

pain of patients in the intensive care unit
iologic measures like blood pressure or pulse

are often used to measure patient pain—represents one example of a challenging pain assessment scenario. Because blood pressure and pulse are not reliable pain indicators, providers are often left feeling helpless when trying to manage pain in this setting. "There are some observational tools that can be introduced in the ICU that provide a better way to assess whether or not a patient has pain, rather than relying on unreliable variables," she says. "Pain assessment and management become complex when a patient cannot tell you what they are feeling. The fact that pain is a totally subjective and complex experience amplifies the difficulties."

For some challenging populations, nurses and physicians may believe that pain assessment is not possible. But, Drew asserts that there is no such thing as a patient who cannot be assessed. "I would like to debunk that notion," she says. "There is always something you can consider for each patient; some patients are more complex than others, but they can all be assessed." Drew will recommend approaches to consider for a variety of special populations.

Drew's presentation will also offer attendees a summary of assessment tools with which many providers are not comfortable or familiar. Along with general background information on these tools, she will provide a framework for how and when to use them in practice. She will also offer clinical examples throughout the presentation to supplement the information provided.

She will also relate assessment to patient selection for chronic opioid analgesia. The Diagnosis, Intractability, Risk, Efficacy (DIRE) scale is an example of a tool that can be used to help practitioners decide whether their patient is a good candidate for long-term opioid therapy. It takes into account factors like substance abuse history and characteristics of the home set-

ting. During her presentation, Drew will provi
for using the DIRE scale. "Primary care phys
very helpful because they are trying to make
guess on how to help their patients after the
of the hospital," she says.

Drew cautions that comprehensive pain as
time to do properly. "But a good pain asses
time in the end because it will get a patient
without adverse events in the beginning," sh
try to take shortcuts because we are busy c
assessment up front, it can lead to a lot of
redundancy later on and a lot of adverse ou
tient." She compares assessment with obtain
cal history and conducting a thorough phy
"These take time, too; yet if you miss some

**I think as a pain community we are realizing how li
those simple, unimodal pain measures are, especia
patients with chronic pain. I think there is going to
evolution where we will be focusing more and mor
pain and functional status.**

badly for the patient."

Drew also plans on talking about the eme
of functional status as it relates to pain. Ini
ment focused on pain intensity. "I think as a p
are realizing how limited those simple, unimo
are, especially for patients with chronic pain,"
there is going to be an evolution where w
more and more on pain and functional sta
some of these earlier tools." The focus will sh
patients with activities of their daily lives.

Debra Drew, MS, ACNS-BC, RN-BC is a
cialist for pain management at the Univer
Medical Center, Fairview. In addition to he
bilities, she is involved in patient and staff e
and institutional committees on pain and pa

tinued from cover)

l serve the patients who very much need us,
the stakeholders what's changed and what
in care can do for them."

very starts with verifiable efficiency.

will never roll again, so Schatman notes that
to provide integrated pain care must learn to
hey confine their efforts to clinically-validated
ed at reasonable costs.

clinicians can responsibly offer payers far bet-

ers' compensation policy, and the insurer's primary goal will be returning the patient to productive employment. In such cases, pain clinicians should bombard the insurer with studies that show how interdisciplinary pain treatment restores patient function better than any alternative.

If, on the other hand, a patient is injured at home, the medical bills will fall to a regular health insurer that will focus primarily on minimizing long-term costs. In such cases, caregivers should bombard the insurer with studies that show cost

costs a fortune because he keeps seeking new
for years on end."

Hospitals, likewise, have their own spec
cerns, which caregivers need to consider bef
open (or, in many cases, reopen) pain clini
no plausible way to argue that hospital po
become directly profitable again, but he d
pain clinics could generate indirect profits
able hospital employees from their existing

cation in this area of pharmacology is necessary for improving outcomes and maximizing treatment options.

The conference room where Thomas B. Gregory, PharmD, BCPS, DASPE, CPE, gave his presentation "Opioids A to Z" was so jam-packed on Friday morning that Gregory joked that "You guys are such hardcore pain guys that you bypassed the breakfast spread just to be in here early this morning." (Luckily there were still leftover urns of coffee and trays of croissants for those who waited for the session to end to grab breakfast.)

If there is one thing that serves as a common denominator for all PAINWeek 2012 attendees—which includes physicians, pharmacists, nurse practitioners, physician assistants, and even social workers—it is a unified interest in the dosing strategies, side effects, and patient and medication variables associated with opioids. That is exactly what Gregory spoke about during his engaging presentation.

Beginning with the patient and medication variables, Gregory started by discussing the importance of knowing the distinction between opioids that are pure agonists, which have no ceiling effect and are not problematic in terms of increasing dosage (until side effects become intolerable) and those that are partial agonists, which can have a ceiling effect (ie, once a plateau dose is achieved, there will be no further analgesic activity).

Gregory also touched on many different aspects of patient variables in opioid therapy. He said that clinicians who are prescribing or administering opioids must consider a patient's age, particularly because metabolic enzymes in our bodies
Muscle mass must also be considered due to
patterns. Comorbidities must be taken into co
renal dysfunction, for instance, can cause seric
patients on chronic opioid therapy. The cost of
be a factor, and not just in terms of the pat
about whether the medication allows the patie
mal daily routine," said Gregory.

As far as medication pharmacokinetics is
sorption rate of opioids must be considered
istered transdermally via a patch, Gregory s
will vary depending on age. During this part
one of the audience members asked Gregory
to be the best method for disposing of opioid
said that although there is no one correct a
rules and regulations governing disposal vary
he thinks that patches should be absorbed
and that the diffused drug should then be
drain. He added that attendees should mak
out what their states' rules and regulations
they were abiding by the law.

The discussion segued into various opioid do

(contin

ange in patient condition, or even health care Gregory reminded the audience that when they nge a patient's dosage formulation or route of necessary to review opioid equianalgesic dos- said should "serve as a guide and not a gos- as cross tolerance is not universal in nature. He of specific scenarios, such as what health care e aware of when switching patients from one

ditionally, bioequivalence between routes of administration must be considered before beginning the 5-step opioid conversion process:

1. Globally assess pain complaint.
2. Determine total daily dose of current opioid.
3. Decide which opioid analgesic will be used for the new agent and consult established conversion tables to determine new dose.

Gregory conveyed a significant amount of tion about opioids during his session, and le number of excellent instructions, resources, an mation on dosing, conversion charts, and man

ementary and Alternative Medicine: Putting Evidence In e

mplementary and alternative medicine (CAM) use among chronic pain patients range from 30 to ing to try CAM approaches, including for pain management.

entary and Alternative Overview and Effective n Pain" (CAM-02)

ert Bonakdar, MD
y, September 8
10am
el 3, Castellana 1

cult to define because it consists of diverse ns and it is constantly changing. Many oaches have gained attention as safe and ves or adjuncts to pharmacologic interven- agement of chronic pain. With increasing of CAM and integrative medicine is men- sed in evidence-based guidelines. Despite ations, many practitioners remain hesitant into their own practice or to discuss CAM

r, MD, will present "Complementary and Alter- verview and Effective Therapies in Pain" on Sat- NWeek 2012. His presentation will review exist- mmendations for CAM use and offer guidance nt these recommendations in practice. "The key engage patients and discuss CAM approaches most out of them in conjunction with everything nending," says Bonakdar.

ration of CAM as part of mainstream treat- w paradigm for many physicians. "In many are learning these approaches on the fly, nts we may not have learned about in sidency, or fellowship," says Bonakdar. This ncies and fellowships are starting to incor- nodologies into their training programs. In s Bonakdar, "Physicians need to get more CAM, especially if the evidence is saying we

In fact, Bonakdar says that discussions about CAM happen so infrequently that the National Institutes of Health has developed a packet to guide doctors and patients on how to approach the topic of CAM. He will review this and other resources to guide CAM usage during his talk.

He plans to address many of the factors that contribute to providers' lack of motivation to use CAM. The presentation will include useful information about a variety of CAM interventions that are backed by strong evidence. "I will go into a host of treatments and help providers know what to consider, and more importantly, how to coordinate care," says Bonakdar. He will provide guidance on accessing and obtaining products and services, dosing, side effects, and potentially dangerous interactions.

The inclusion of CAM in practice guidelines represents advancement in the fields of CAM and pain management.At the same time, this development has actually posed some barriers to implementation because not all of the guidelines are in agreement. "Part of my talk will be about how to arrive at a bottom line you are comfortable suggesting to your patient," says Bonakdar. "Along with practical advice for how to use the guidelines, I will talk about who is a good candidate for CAM."

Providers also need to be updated and aware of important safety issues related to CAM usage. When using CAM approaches that are backed by trial evidence, for example, Bonakdar recommends using the standardized version used in the trial. He will review this and other safety considerations that must be kept in mind during patient selection and follow up.

Financial considerations may play a role in whether patients and providers pursue CAM therapies. "If you ask most physicians who have not considered billing through their office whether any of these interventions would be covered, they would think *no*," says Bonakdar. "My clinic tries to put everything through insurance and we have found reasonable reimbursement." He will discuss reimbursement and other financial factors that may be posing a barrier to integrating CAM recommendations into clinical practice.

In terms of cost-effectiveness of CAM, not many analyses have been performed. Bonakdar says, "There can be cost savings, but the care needs to be coordinated." Cost savings will not be achieved if a patient goes to a CAM provider three times a week indefinitely. "If a patient is self-choosing a CAM therapy, it may not be cost-effective because there is no over-

In many cases, physi are learning about C approaches on the fl especially treatment may not have learne about in medical sch residency, or fellows Physicians need to g comfortable with CA

AY EVENTS

nts and Your Practice: The Role of Chronic Pain and Risk Management
September 8, 8:25-9:55am
era Ballroom
: NO
S (breakfast)
equired: NO
re Toxicology
ation, Jennifer E. Bolen, JD, and Jeffery A. Gudin, MD, will discuss practical approaches to incorporating drug screening into comprehensive chronic pain and risk management plans. They will also address key topics in legal and regulatory considerations for drug testing frequency, documentation, and the interpretation of results.

Persistent and Breakthrough Pain: Responsible Opioid Prescribing for Multidimensional Disorders
Time: Saturday, September 8, 12:30-2:00pm
Room: Level 4, Gracia 1
CE/CME certified: YES
Meal served: YES (lunch)
Preregistration required: N/A
Supported by an educational grant from Teva Pharmaceutical Industries Ltd.
This activity was designed to "consolidate clinically relevant scientific studies and evidence-based guidelines into practical approaches to persistent pain and BTP assessment, responsible opioid prescribing, and repeated re-evaluation of patient outcomes." The faculty of Michael J. Brennan, MD; Jeffrey A. Gudin, MD; Douglas C. Schottenstein, MD; and David M. Simpson, MD, FAAN, will discuss the diagnostic criteria for BTP pain and clinical characteristics of its subtypes, strategies for individualizing opioid therapy for persistent pain

and BTP, and multidisciplinary approaches tha
range of biopsychosocial causes and sympton
persistent pain and BTP.

Mission: Pain Management – The First Visit (An IDEAL® Clinical En
Time: Saturday, September 8, 12:30-2:00p
Room: Level 4, Gracia 1-4
CE/CME certified: YES
Meal served: YES (lunch)
Preregistration required: N/A
Supported by educational grants provided by [redacted] and Mallinckrodt, the pharmaceuticals bus
The faculty will discuss the underlying pathopl transmission mechanisms associated with noci pathic, and centrally-mediated chronic pain; e tive risks and benefits of nonpharmacologic a treatment options for chronic pain; explain hov barriers to the optimal use of opioid analgesi chronic pain; and assess methods for screenin tion in the initial and follow-up care of patient

EFTA01114715

ic Pain and Comorbidities

istration hospitals have a unique and extensive expertise when it comes to treating post-deployment chronic pain and its associated co
enary session, PAINWeek attendees will learn more about what the VA has to offer and how clinicians in the private sector can improv
nts by liaising with the VA.

oyment Chronic Pain
ies" (VHA-02A)

rri-Ann Gibson, MD, and Ilene R.

y, September 8
0:20am
el 4, Nolita 1

s in Iraq and Afghanistan have had a tre-
s impact on US troops and their loved ones.
eterans are returning home with physical in-
motional difficulties, such as post-traumatic
SD).
2012, two specialists in caring for returning
nn M. Gibson, MD, DAAPM, Chief of Spe-
ion, Mental Health and Behavioral Sciences
mes A. Haley Veterans' Hospital in Tampa,
beck MD, Co-Chair of the National Primary
rce in St. Petersburg, FL will be presenting
Chronic Pain Comorbidities" in a Plenary

n will review the prevalence of PTSD and
heoretical models that explain the mainte-
nditions, and the challenges faced by pro-
s who care for these patients. In addition,
k will present *Department of Veterans Affairs (VA)/Department of Defense (DOD) VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress*, with special attention to chronic pain.

"Limited scientific evidence supports specific care and treatment of PTSD and chronic pain, and this challenges providers to investigate and research potential treatment options. This presentation will focus on the techniques and strategies to address not only PTSD and chronic pain, but other conditions, including substance dependence and depression," Gibson says.

All veterans who have honorably served our country have earned and truly deserve the most comprehensive, individualized, and holistic treatment approaches that can be made available to address their physical and emotional conditions.

"We have many patients coming back fr
Iraq and Afghanistan with chronic pain probl
"Many people assume that all of these patien
by the VA; however only 50% of returning
foot into a VA. The rest are cared for by outsi
many of the patients who do get seen by VA
seek care by outside providers, so outside
understand the dynamics of what happens
and their comorbidities, even if they are being
way by the VA."

Importantly, 100% of the family member
erans are seen by outside providers, and a
the VA. Unfortunately, many of the problems
veterans also impact their families, Robeck n
important for non-VA providers to understa
what is involved in terms of chronic pain in
and their families."

It can be challenging to treat post-deploy
with comorbidities, and this makes it imperati
viders to learn what the VA has learned ab
returning veterans, Robeck says.

"The important thing to keep in mind is t
patients are young and resilient and when
ately, they respond to treatment. This fact fu
importance of learning about their problem
what the VA has learned about treating t
what resources are available for co-manage
she says.

Outside providers should know that it is
patients to get care at both the VA and thei
clinics. They should also know that if they wo
tients established at the VA, this does not me
will get all of their care at the VA. What it do
is that the non-VA provider can then work wi
the VA and be able to access the VA service
access, Robeck says.

"The VA welcomes the partnership or th
outside provider. We understand that some
remain with their own family doctor and th
but their own family doctor may end up feel
equipped to do everything, so I think there
she says.

"That family doctor knows the family or
that patient for years. We don't want to los
But we also want to make sure that the full
available to these patients is understood, an
misconceptions about how to access care a
to make sure that our desire to be able to co
with the outside provider is well understood,

"All veterans who have honorably served
earned and truly deserve the most compreher
and holistic treatment approaches that can be
address their physical and emotional condition

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An early-bird registration fee of $249
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using code 2013.

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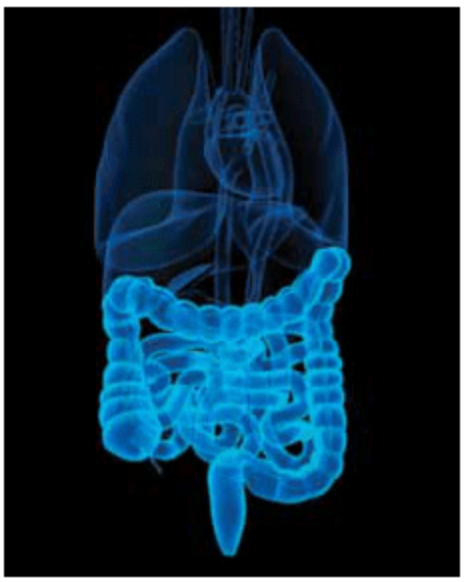
2013

ans do to manage OIC? McCarberg said that with OIC requires a "professional and sensitive ize any potential embarrassment for patients." patients, especially older patients, are uncom- out defecation. Many will attempt to self-treat and other medications.

ons are "the current stan- revention and treatment berg. Although there are guidelines for the use of cCarberg said that the is to initiate treatment of stool softeners and recommended that clini- f bulk-forming agents in fails to produce a satis- cians can treat with PEG approach doesn't work, try an opioid receptor nethylnaltrexone. Doses r all forms of treatment. OIC, but you have to loses of bowel stimulants rberg said.



of laxative use include pain, flatulence, nausea, perianal soreness. Another important consider- medications is onset of action. McCarberg said prefer laxative agents that have a shorter onset owel predictability is very important for patients, er the faster acting treatment." Saline laxatives ours to take effect, bowel stimulants take 6-12 usate and osmotic laxatives can take 1-3 days.

e and other agents for opioid-induced

ed issues in the management of OIC during ssion, offering information about the clinical side effects of oral nalxone, methylnaltrexone, iprostone, and other agents.

produce symptoms of opioid withdrawal). Several short-term trials using a range of doses and frequency of administration of oral naloxone in patients with OIC have produced mixed results, with some producing significant increases in stool frequency and improvement in symptoms. Some reversal and analgesia and/or opioid withdrawal symptoms were observed in most of the trials.

Methylnaltrexone is approved for the treatment of OIC in patients with advanced illness who are receiving palliative care and have demonstrated insufficient response to laxative therapy. It is currently available for subcutaneous administration. Peppin said that methylnaltrexone "does not stimulate the bowel, it just returns it to normal," which is why it is important to take the patient's history to know what the patient's normal bowel process and routines are.

In one study, nearly half of patients with OIC treated with methylnaltrexone plus laxative therapy achieved rescue-free laxation after three doses (0.15 mg/kg) administered over five days. In another study, patients with advanced illness (including patients with cancer, cardiovascular disease, COPD, and Alzheimer's disease or dementia) who were receiving opioid therapy and who also had OIC were treated with repeated dosing of either placebo plus laxatives or methylnaltrexone plus laxatives. Nearly half (48%) of patients treated with methylnaltrexone demonstrated laxation response within four hours of receiving their first dose. More than half (52%) of patients treated with methylnaltrexone demonstrated laxation response within four hours after two or more of their first four doses of the medication. Peppin noted that the data indicates that "you may have to try up to four doses before seeing a response."

In another trial involving patients with chronic noncancer pain (including back pain, cervical/neck pain, fibromyalgia, hip pain, and osteoarthritis) who were receiving opioid therapy and who also had OIC were treated with either placebo or methylnaltrexone (12 mg QD or QOD). More than one-third (34%) of patients achieved rescue-free bowel movement within four hours after receiving their

The most common adverse effects associ altrexone use reported by patients in contr abdominal pain (28.5% of patients), flatulenc sea (11%). Other adverse effects reported diarrhea, and hyperhidrosis.

Another option for OIC, alvimopan, does n brain barrier and demonstrates higher binding ceptors than methylnaltrexone. It is approved f time to upper and lower GI recovery followi surgery." Peppin said that alvimopan is "a hos states (ie, only surgeons can write for it).

The chloride-channel activator lubiproston proved for use in chronic idiopathic constipa women. In one 12-week trial of lubiprostone in ic noncancer pain and OIC, 26% of patients bowel function. The most common adverse eff nausea, and abdominal pain.

According to Peppin, there are currently sev therapies in trials for OIC, including prucalopr which is an oral PEGylated naloxol conjuga promising results in a short-term trial of patie ducing increased frequency of spontaneous b patients during the first week of therapy.

Peppin concluded the presentation by remindin

- OIC is a significant and increasingly comm tients with chronic pain
- OIC can compromise a patient's quality of effectiveness of pain management
- Laxatives are the main therapy for preventio of OIC, but their usefulness may be limited b adverse effects
- There is not much data on treatment for OI
- Peripheral mu-opioid receptor antagonists in reversing analgesia, producing "rapid laxat advanced illness without inducing opioid with central analgesic effects"
- There are a number of pharmacologic agent strated benefit for the treatment of OIC

osing, Assessing and Treating Diabetic Gastroparesis

f diabetes is increasing worldwide, according to the International Diabetes Federation. In 2007 alone, the United States spent $218 bil es, with more than 50% of spending related to hospitalization for diabetes-related complications.

ough, when it comes to diabetes and GI symptoms, "we tend to think of them as GI symptoms," Michael Bottros, MD, said during his PAINWeek 2012 presentation, and GI Pain." His talk focused on the prevalence of GI symptoms associated with sed treatment options as well as possible future research areas to prevent or treat with diabetes.

the session was of particular use and interest because of the effect this particular s having in health care as they have repeated hospital admissions. "These patients hospital and they describe upper GI pain," Bottros said. "They have nausea, they so we tend to think that most of the problems… occur in the upper GI tract. That's

d the neuronal degeneration and changes that affect the gastrointestinal tract ttros said that, in this patient population, the prevalence of upper and lower GI s and there is a considerable amount of turnover in symptoms. Over time, as a

pain. So, when you talk about GI pain in relation to diabetes, you're essentially tal gastroparesis."

Bottros stressed the importance of performing a thorough differential diagno It will enable the physician to be sure that they have not missed any major prob with these patients, as it will be a diagnosis of exclusion. To make a diagnosis, phy a physical examination and imaging studies to rule out other causes. Scintigrap objectively measure gastric emptying.

Although advances have been made in understanding the cellular changes t condition, there are few treatments for diabetic gastroparesis. Pharmacologic tr the condition include antiemetic agents, tricyclic antidepressants, and anticonvul that opioids should be used sparingly with these patients. "Management of dia needs to focus on assessing the severity of the disorder, correcting nutritional dysfu ing symptoms," he said.

analgesic development can be arduous. Clinicians need to be aware of the necessary guidelines and regulations to follow so that the c
prehensive, ethical, and offer societal benefit.

k 2012 presentation, "Analgesic Development: From Bench to Bedside and Back," ce, MD, highlighted the process of clinical trial design. During the session, Wallace al trial phases, discussed the purpose and role of institutional review boards, and nts of informed patient consent.

clinical trials related to the development of analgesics, Wallace said physicians of institutional review board guidelines and federal regulations as well as ethical earch with human subjects. "One of the biggest hurdles with trial design is the issue Wallace said.

hat the history behind institutional review board regulations dates back to Nazi development of the Nuremberg Code. "Individuals should be treated as autono- s a group," Wallace told attendees. "So we do these clinical trials, and we tend ings in the population, and you forget the individual. You have to look at each ical trial."

ated that some patient populations are entitled to certain protections that sic clinical trial design and development more difficult. Children, people lities, and prisoners require special consideration. "[redacted] seeing more and more the pediatric population," Wallace said. "There is actually a movement of should be. We need better analgesics for children. We shouldn't be excluding

urdle for clinicians designing clinical trials in pain management is finding partici- part to doing clinical trials is patient recruiting," Wallace told the audience. "It's just

Physicians should remember that any procedure done solely to determine eligi a part of the research and requires patient consent before the procedure.

Wallace also highlighted the guiding principles of the Belmont Report on the e for the protection of participants in clinical trials, which include:

- **Beneficence**: Clinical trials should do no harm, maximize possible benefits and should be applied at an individual level for participating patients as well as at
- **Justice**: Clinical trials should have fair distribution of the benefits and burdens the participant selection should involve groups that will benefit from the resea nient' populations.

Wallace emphasized to attendees that if the risks outweigh the benefits, the trial be approved by the institutional review board. He also stressed the importance o The general accepted principle is that, if it is practicable to get consent, consen and documented.

Some of the elements of informed consent include an explanation of the purpo a description of the procedures, the risks and benefits, the expected duration of reminder that participation is voluntary.

Wallace's presentation examined the difficulties of designing clinical trials while tance of maintaining participant autonomy and maximizing societal benefit.

By

CME/CE Credit Instructions for PAINWeek

To obtain your CME/CE certificates, you will be required to complete evaluations for each cours as well as an overall PAINWeek evaluation. These evaluations must be completed online (eg, or smartphone, or in the Cyber Café).

When entering a session, please scan the square bar code on your name badge, which will rec attendance for ease of completing evaluations. Each evening of the conference (starting with W you will receive an e-mail notification indicating you have evaluations to complete.

Please click the link in the e-mail, and you will be taken to a listing of evaluations for courses in w have participated. In the event courses are missing or additional courses have been recorded, y the ability to edit the courses you wish to evaluate.

To ensure accuracy and streamline issuing of credit for the various disciplines at PAIN certificates will be issued electronically after the evaluation system closes.

The evaluation system will be available until OCTOBER 31, 2012. You will only be el receive credit for sessions if the respective evaluations are completed by this date.

Regrettably we will be unable to grant any extensions or make any exceptions to th

SPECIAL NOTE TO PHARMACISTS:

Please note: pharmacy learners will not be eligible to receive partial credit. Individual courses m attended in their entirety in order to be eligible to receive credit for those 1.0 or 2.0 credit hour s If you still need to create an NABP e-Profile and obtain an ID number, please visit http://www.n https://store.nabp.net/OA_HTML/xxnabpibeGblLogin.jsp.

specialist and I do not want to be. I am a fam- try to care for my patients in as comprehen- as possible. While I certainly value and make believe that in many cases a patient's medical fectively satisfied within the boundaries of a dical home. Furthermore, my patients are un- nsured. I am fortunate to have the support of cilitates my patients' access to medical supplies his access is limited. Finally, by education and aining, I am as much a humanist as a scientist. g on specific diseases or injuries, my job is to my patients' medical reality within the context romote their well-being.

ners recently observed that I have a particu- management. It is true that I have made an e myself with orthopedic and rheumatologic that I perform a fair number of injections— nd some of my partners' patients—and that I re comfortable and willing to prescribe pain her narcotic, non-narcotic, disease-modify- an some other physicians. My interest in the stems from my belief that I am obligated to t of my ability those processes that threaten eing. To deny these obligations would be no ring their heart disease or diabetes.

nomic and demographic factors lead to an te of endocrine and cardiovascular disease s, these same patients suffer from a high in- rthermore, my patients have a great deal of c, and addictive comorbidity. Even when my ss to an orthopedist, rheumatologist, or pain onsultants are limited in what interventions d are sometimes hesitant to do so for eco- ico-legal and logistical reasons. My practice at I treat medical disease to a level at which patients elsewhere would have been referred to specialists. While I believe that my partners and I usually rise to the occasion and meet this demand, I fear that this is not often enough the case when it comes to chronic pain. This is detrimental to our patients' health and well-being.

I, like most of my peers, learned little about the management of chronic pain in medical school or residency training. I have been actively trying to increase my knowledge in this area through face to face, online, and print resources, as well as interacting with specialists, but I have much yet to learn. I have also recently had the opportunity to join a regional collaborative focusing on the safe treatment of chronic pain in a primary care setting, but this program focuses on systems and processes more than therapeutic strategies. I hope that through resources like PainEDU and attending PAINWeek I can increase my skills, knowledge base, and strategies. I am especially interested in increasing my comfort with treating pain in patients with medical, psychiatric, and addictive comorbidities, and in learning how to collaborate with specialists t goals. I am also working on ways to make these patients in the primary care setting primary care practitioners.

Rudolph Virchow—a pioneer in social me pathology—observed that "medicine is poli medicine on a grand scale." This is nowhere s tersection of socio-economic need, medical i pain. I am neither a pain specialist nor a pain family doctor and a patient advocate. I have in the treatment of chronic pain because i patients need and will not get elsewhere. W my patients had pain, it is a fact of their—ar lives, and managing it is not only an ethical many of the social and existential issues that to primary care medicine. I do the best I ca and I am trying to improve my skills in this the help I can get.

"I, like most of my peers, learned little about the management of chronic pain in medical school or r training. I have been actively trying to increase my knowledge in this area through face to face, online print resources, as well as interacting with specialis I have much yet to learn."

Congratulations to the 2012 PainEDU.org PAINWeek Scholarship Recipients

Visit the PainEDU.org website (www.PainEDU.org) to learn more about the scholarship and read several of the prize-winning essays.

Moshe Usadi, MD (grand prize winner)
Charlotte Medical Center - Biddle Point
Charlotte, NC

Kelly Brewer, LCSW
Center for Wellness & Pain Management
Kalispell, MT

Maria Foglio, RN
Ashtabula County Medical Center
Ashtabula, OH

Maria Maldonado, M
Stamford Hospital
Stamford, CT

e Dahring, MSN, RN, CP

Toni L. Glover, MSN, FNP-BC

Rebecca A. Maxson, Pharm

ry four women of reproductive age suffers from chronic pelvic pain. Pain Clinicians who want to provide comprehensive care to this po
nd the general diagnosis of chronic pelvic pain and learn more about the subtypes and etiologies of this complex condition.

n" (REG-01)

een M. Fitzgerald, MD
y, September 8
00am
el 4, Nolita 3

ions of pelvic pain are wide ranging. The gatively affects quality-of-life, jobs, relation- nction. Additionally, it puts women at greater invasive procedures such as laparoscopy

vic Pain" symposium on Saturday morning 2, Colleen Fitzgerald, MD, will provide an related to clinical management of the condi- tion will be broad in scope," says Fitzgerald. ubtypes and etiologies; risk factors; patient symptoms; differential diagnosis—including ons, imaging, and other workups; treatment; gerald will also talk about pregnancy-related

medical help for pelvic pain are labeled iagnoses that can be gynecologic, urologic, usculoskeletal, or psychological in nature. epends on the type of specialist seen. The hen evaluating a woman who presents with tzgerald, is not to assign a general diagnosis ain. "It should be broken down into a real or, in some cases, more than one diagnosis," uld like to help the audience think beyond gnosis and be more specific in terms of sub- gy, because it makes a difference in terms gnosis of pelvic pain can be confusing. For may present as a musculoskeletal response problem with an internal organ such as the

eview treatment options, including medica- njections, surgical interventions, and comple- mentary alternative medicine possibilities. She plans on spending a significant amount of time talking about rehabilitation and reasonable therapeutic goals.

"Anyone who treats women with chronic pelvic pain knows that these are some of our toughest cases," says Fitzgerald. She attributes this to lack of training and guidelines and to the complexity of the problem. "Any time pain persists for more than six months, there is a large psychological overlay," she says. "I am hopeful that many will attend the session just because pelvic pain is such an unknown; the field is really in its infancy in terms of understanding of causes."

"The field is so new in research; we have some guidelines, but we don't have guidelines based on subtype yet," says Fitzgerald. "Minimal guidelines exist for musculoskeletal causes." Pelvic girdle pain guidelines, such as the "2008 European Guidelines on Pelvic Girdle Pain," may not be applicable for every patient; it really depends on their diagnosis. In 2011, the American Urological Association published guidelines for interstitial cystitis/bladder pain syndrome. The group suggests general relaxation and stress management as first-line treatment, followed by second-line physical therapy and oral medication (eg, amitriptyline, cimetidine, hydroxyzine, or pentosan polysulfate).

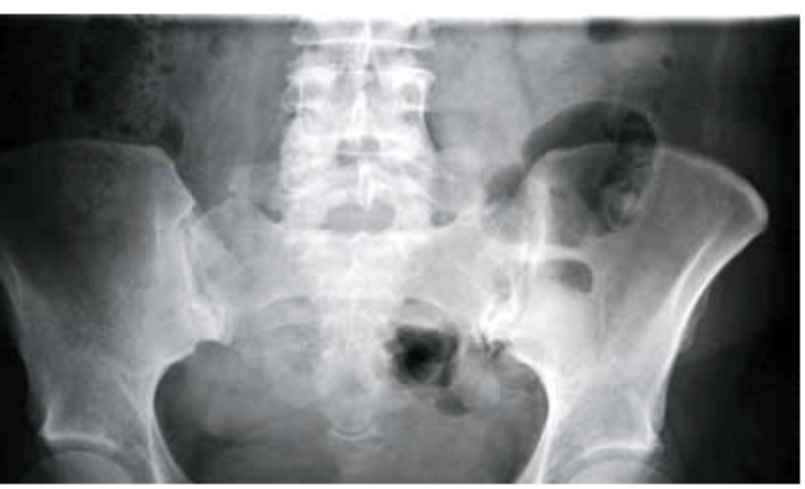
Fitzgerald contrasts those recommendations with standards-of-care for women with pelvic floor or myofascial pain. For those diagnoses, immediate first-line physical therapy is recommended. Since the evidence shows that physical therapy works, practitioners should try to avoid complex medications and potential drug-related side effects.

To help attendees truly understand how to apply the information in practice, Fitzgerald will walk through the physical exam, differential diagnosis, and treatment selection using specific patient examples.

Fitzgerald will also offer some insight into the future of the field and talk about some recent progress made in understanding chronic pelvic pain. She says that "One of the things we are working on in research is to look at not just the organ as the problem—for example, the uterus, bladder, or muscle—but really looking at the whole patient as one who has gone into chronicity as a neurologic pain processing problem."

Fitzgerald is part of a team that is using neuroimaging to evaluate the neurobiology of chronic pelvic pain. Their research has showed that women with chronic pelvic pain actually have a different way of processing pain compared with the brains of normal healthy control women. "We found changes in the central nervous system that suggest the way to address this may be along the neuroaxis," says Fitzgerald. "Maybe the insult was initially to an organ or muscle, but over time, as pain signals get transmitted and perpetuated, the body's abil- how the central nervous system changes as pelvic pain.

Colleen Fitzgerald, MD, is an associate p rics and gynecology and female pelvic medi versity of Chicago and associate professor o and rehabilitation at Northwestern Universit of Medicine. She specializes in treating and nancy-related musculoskeletal disease, wom pain, and pelvic floor disorders.



The important thing evaluating a woman presents with pelvic is not to assign a ger diagnosis of chronic pain. It should be br down into a real prin diagnosis or, in some more than one diagn

aches to Pain Management

xist to treat pain and awareness is growing that non-pharmacologic approaches can be just as effective, if not more so, than pharmac this talk, clinicians will learn about some of the newer non-pharmacologic options for treating pain, and will also learn how combining t n a sensible medication plan can result in optimal pain relief.

: What are the Options?"

en N. Turner, DNP, RN-BC,
AN
y, September 8
10am
el 3, Gracia 7

urner, DNP, RN-BC, PCNS-BC, FAAN, Clinical ecialist, Pediatric Pain Management, Oregon d Science University in Portland, OR, will be pre- What are the Options?" today at PAINWeek talking about newer, non-analgesic approaches nt and how they can best be combined with tra- l approaches to provide good pain relief.

d topic and days could be spent on analgesic ys. There are two general categories of pain rmacologic and non—pharmacologic—and strong effort recently to get clinicians to use es together.

ere has been a very heavy use of the pharma- d we know that some of the non-pharmaco- an in fact stand on their own. We also know er, you can often use much less medication, less dangerous for the patient," she says.

n-pharmacologic analgesia include physical , massage, transcutaneous electronic nerve , relaxation methods, biofeedback, hypnosis, uided imagery, and virtual reality. "We use a rtual reality with kids," Turner says. "You can her mindset."

volves having the child wear what looks like a lmet that has a screen inside. "You put the hel- n watch something. One of the more common on a mountain, skiing, and it comes with all of . Their minds are able to actually go there on be present in that virtual space, and those kids can block out almost everything going on around them. One of the children's hospitals in Ohio actually uses virtual reality when they are doing burn care, with phenomenal results. Their use of medication in doing that has declined significantly," Turner says.

Turner adds that people are just beginning to understand the connection between body and mind. "There are tons of knowledge out there around opioids and the traditional pain medicines, and there's getting to be more understanding about some of the adjuvants, like antidepressants and anticonvulsants. But knowledge about non-pharmacologic methods is still a little behind," she says.

"Even something like acupuncture is still considered to be voodoo by some people; however, there is a lot of science now to support that acupuncture is not voodoo. But it's taking time to catch on," Turner says.

In her presentation, Turner says a main goal will be to show her audience how the non-drug and drug modes of analgesia can work well together. She says, "We shouldn't just reach for the medications; we need to incorporate those other modalities, as well."

Turner is a pediatric pain specialist. She says that it is harder for adults to adapt to non-pharmacological methods of pain control "because we have forgotten how to play. We dampen our imagination, and we can be very skeptical. Some of these non-drug modalities can be harder to believe in for older people, whether you are the provider or the patient, and that can be challenging to deal with. I've got it really easy with kids; they are open to anything. Plus, a lot of the non-pharmacological approaches are technologically based, which kids love."

Different types of pain respond to different types of analgesia, and this can often be due to the person's past experience of pain, she says. "Pain is a very subjective experience and is based on the individual's life experience with pain and pain treatment, and all of that plays into how they deal with pain and how their body and mind have been programmed. If pain is very fear-based, it will be completely different than pain in someone who doesn't mind getting hurt because they were doing rock climbing or something they really want to do," says Turner.

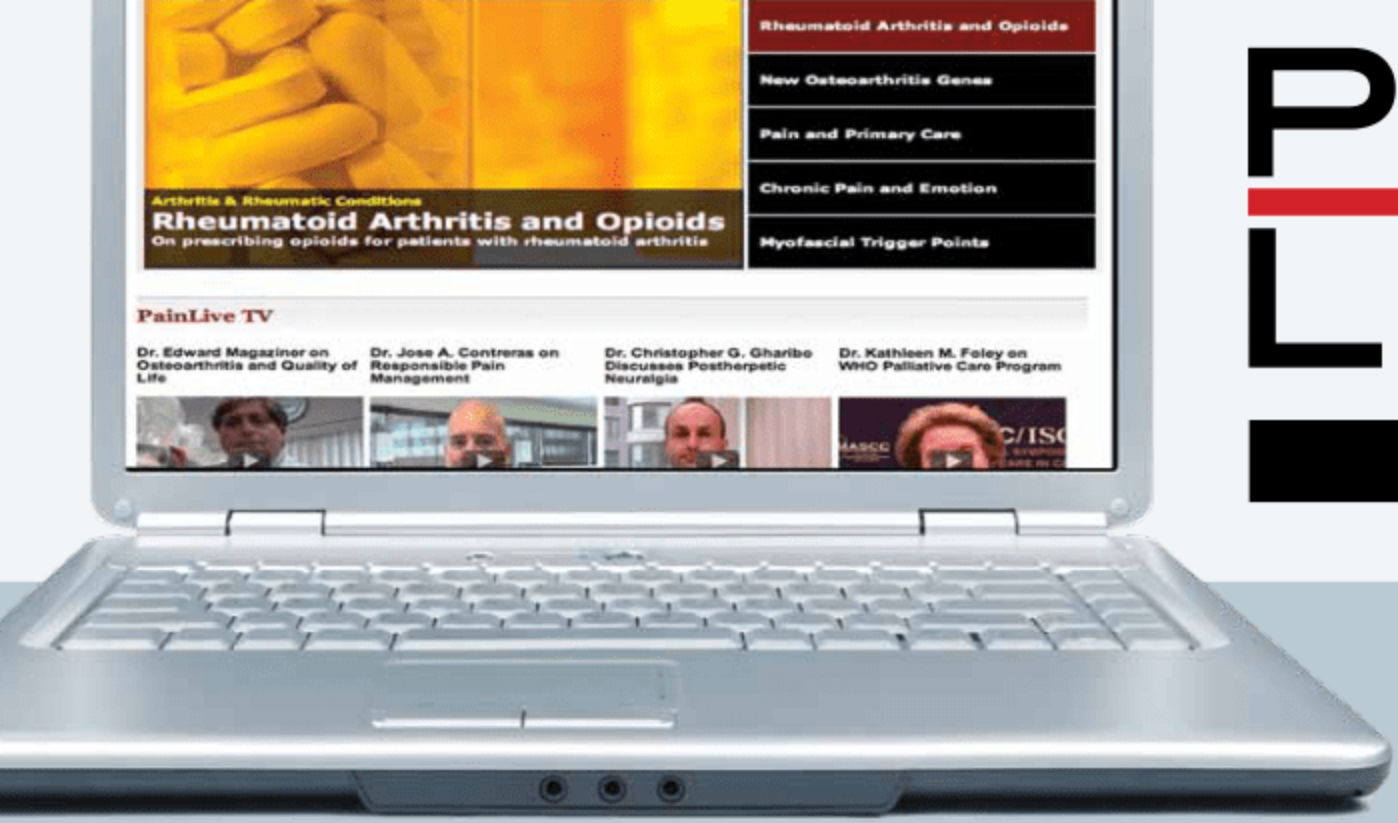
Being able to identify what the patients' stressors are, and helping them manage those stressors, are important aspects of pain management. "It's incredibly complex. ■ hardly scratching the surface with this talk, because there is so much you can go into. My intent is more to increase awareness and to think about adding these other modalities of trea to reach for the medications," she says.

Nevertheless, Turner will be discussing me adjuvant medications that, when added to tra as the opioids and anti-inflammatories, can he effectively. She will also discuss the role of ove gesics. "Many consumers think that the types you can buy in the drug store without a docto weaker. That is not necessarily the case. Indee

"Pain is a very subje experience and is ba the individual's life e with pain and pain t and all of that plays they deal with pain a their body and mind been programmed."

especially if you have inflammation, a non-st to get that inflammation down," she says.

Her talk promises to give lots of food for th "I won't have time for a lot of detail, but awareness about all of the options. Right n common buzz word in the pain world, and analgesia'. It's using multiple methods to get and it encompasses a wide variety of aspects psycho, social, and spiritual aspects of the p



PAI
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nd Palliative Care

potential drug-drug interactions in the pain and palliative care settings requires a proactive approach that relies on the proper tools ar
he patient's medications and pain care needs.

kinetic and
dynamic Drug Interactions in
alliative Care" (PHM-06)

hryn A. Walker, PharmD, BCPS, CPE
y, September 8
:00am
el 3, Castellana 2

erapy for patients with chronic pain or re-
liative care is typically complex and prone
for drug-drug interactions (DDIs). In 2011,
ucted a retrospective chart review (N =
ed 631 potential drug interactions among
nts in a palliative care setting. Patients in
en have advanced disease and are receiv-
cations. In the 2011 study, a median of 14
prescribed per patient during the hospital

ker, PharmD, BCPS, CPE, will present "Phar-
Pharmacodynamic Drug Interactions in Pain
e" this morning at PAINWeek 2012. During
he will review the basic pharmacology of fre-
ant drug interactions relevant to these popu-
y, she will offer guidance on how to monitor
interactions.

ortant when seeing a pain or palliative care
ving an issue to rule out whether it is some-
e is causing or something that needs to be
ker. "Whether to order additional medication
nedication is not a straightforward decision."
erstanding drug interactions plays a big part
oblems, "I will review the kinds of drug inter-
ders should worry about in these settings."
a on DDIs among pain and palliative care
substantive imparts a particular challenge to
or these patients.

at some providers assume that pharmacists
DI before prescriptions are filled and admin-
"I don't see a lot of providers routinely con-
in practice," she says. But, pharmacists may
er is aware of the interaction and, practically
not call the doctor for every potential drug
to convince people that it is better to think
ant DDIs for these populations *before* pre-
ns and to keep in mind the red flag drugs
oblems," says Walker. Automated DDI check-
ut providers are often overwhelmed by the
al DDIs flagged by these systems; deciding
nically relevant is difficult.

ew how to check for DDIs using recommend-

Walker says that if the potential for DDI exists, "it does not mean that you cannot use the drug, you just have to use it with a plan." This means that if a provider decides to use a medicine with a potential for interaction, he or she needs to know what to monitor and consider dosing and administration schemes that may prevent or minimize interactions. "For example, some interactions are based on timing," she points out. "If you give the drugs at different times, you may avoid an interaction."

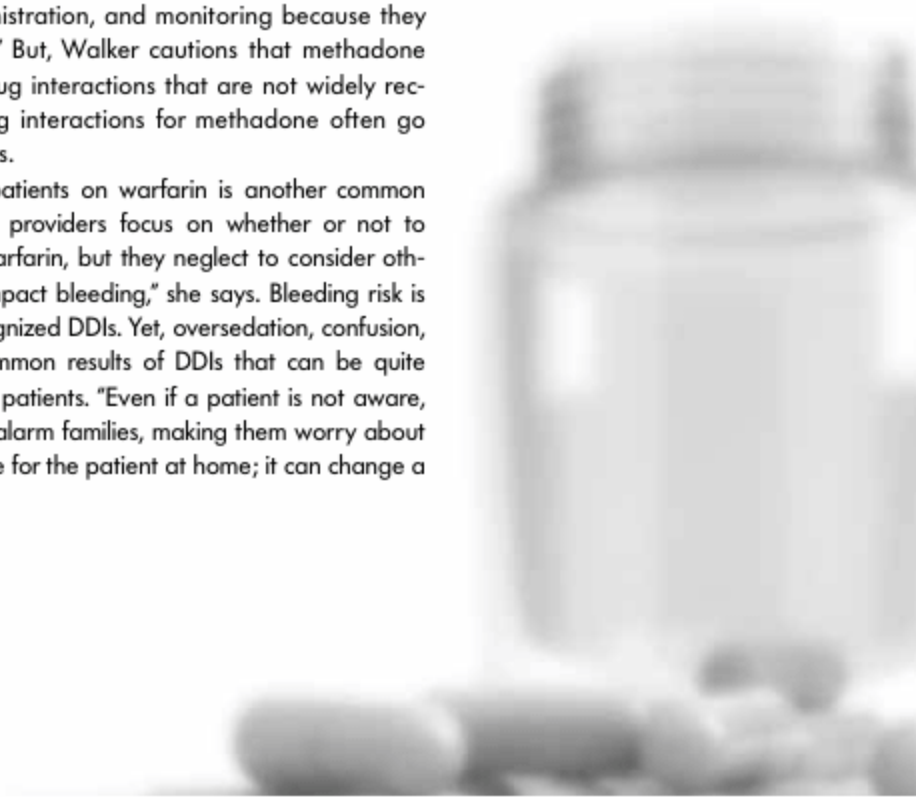
For many drugs, providers only pay attention to a subset of potential interactions or complications related to that drug. One example of this is methadone. "It is a complicated drug to use, in general," says Walker. "People worry about dosing, administration, and monitoring because they are all complicated." But, Walker cautions that methadone is prone to many drug interactions that are not widely recognized. "Many drug interactions for methadone often go overlooked," she says.

Bleeding risk for patients on warfarin is another common concern. "Sometimes providers focus on whether or not to keep a patient on warfarin, but they neglect to consider other things that may impact bleeding," she says. Bleeding risk is one of the most recognized DDIs. Yet, oversedation, confusion, and delirium are common results of DDIs that can be quite scary to families and patients. "Even if a patient is not aware, these symptoms can alarm families, making them worry about whether they can care for the patient at home; it can change a family's whole plan for end-of-life care."

"Palliative care patients are so complex; a
to prevent additional burden to these pati
says Walker. Drug effects can make a big dif
of-life experience. "Our duty is still to do n
days a patient has left, a time that may be t
in their life," she says.

Kathryn A. Walker, PharmD, BCPS, CPE is
fessor at the University of Maryland Schoo
a palliative care clinical specialist at MedSta
Hospital. She serves on the palliative med
and oversees the hospital's pain consult tea

"I am hoping to convince people that it is better to think about th important drug-drug interaction these populations *before* prescri medications and to keep in mind flag drugs that may cause proble



ly and modern Las Vegas French brasserie with an emphasis on quality ingredients" d traditional fare that is "accessible yet provocative, delicious yet chic." Daily spe- clude beef wellington, housemade sausage, a selection of offal, and dayboat scal- e tarte flambeé, steak tartare, roasted beets, and French onion soup. Lunch entrees dame, oxtail benedict, steamed mussels, and roasted lamb sandwich. Diners can e-course "Quick Lunch." Dinner standouts include the roasted bone marrow and ox- ecommended!), brick roasted chicken, slow-cooked veal, a classic bouillabaisse, and r. Comme Ça also offers a multi-flight "Bistronomy" tasting menu. Diners will also find ers in Las Vegas, handmade pastas, delectable charcuterie and cheese plates, and ixe menu. The tipplers among our readers will not want to miss Comme Ça's menu rafted classic cocktails shaken with Chef David Myers› modern sensibility."

tion:
00pm (Monday-Thursday)
00pm (Friday-Sunday)
00pm (Friday-Sunday)

Jaleo

Looking to take a break from steaks, pastas, and heavier fare? Then an evening of at Joleo may be just what you're looking for. Choose from a selection of small (sausages and cured meats, including the famous Jamón Ibérico ham made fr quesos (including several varieties of sheep's and goat's milk cheeses), *bocadillos* es), *frituras* (chicken, ham, dates—just about everything tastes better fried), and dishes), and other classic tapas. And, as the menu says, Chef José Andrés "knows plates, too," including some of the best paella you will ever have (in fact, Jale changes throughout the day).

Hours of Operation:

Sunday-Thursday: 5:00pm-11:00pm
Friday-Saturday: 5:00pm-12:00am

urger concept" that was "tailor-made for The Cosmopolitan of Las Vegas with esh, natural and organic ingredients," Holsteins serves custom-crafted specialty de sausage, and "riffs on traditional American snacks and appetizers, as well as hakes and sides." Start things off with a high-octane "bam-boozled shake" (one of Bowl," combines [redacted] Crunch cereal with Absolut Vanilla) and a selection from hoices include southern fried chicken fingers-n-waffles, buffalo wings, onion rings, The "Tiny Buns" menu features sliders, crispy pork belly, lobster rolls, and meat-

Scarpetta

Described as a modern Italian restaurant with an earthy-yet-sophisticated cuisine, Scarpetta features "a satisfying and soulful menu of seasonally-inspired Itali offerings include braised short ribs, creamy polenta with mushrooms, and other course selections include duck & foie gras ravioli, black tonarelli with king crab an and short rib agnolotti. For the main course (*piatti*), diners at Scarpetta can cho of northern Italian-inspired dishes, including several fish entrees, Colorado lam duck breast. Scarpetta also offers a delectable "signature tasting menu," as well

HEALTH CONCERN

Pain Society

healthy women
informed. empowered.
www.healthywomen.org

American Chronic Pain Association

EDUCATE before YOU MEDICATE
The NCPIE Coalition-working together to promote safe medicine use
National Council on Patient Information and Education
www.talkaboutrx.org

National Kidney Foundation

erican Academy of
SICIAN ASSISTANTS
ecting PAs, Transforming Care

American Academy of Nurse Practitioners

Alliance for Rational Use of NSAIDs

The management of pain and inflammation—whether acute or chronic—requires proper consideration and attention to individu patients' therapeutic needs and the issues that may affect appro and effective treatment. Nonsteroidal anti-inflammatory drugs (N whether over the counter (OTC) or by prescription, are some of t most commonly used and effective drugs for pain relief, but, like medication, only appropriate use can maximize their therapeu benefit while minimizing risk.[1,2]

Unfortunately, prescription and OTC NSAID use often falls out of explicit but simple guidance. The US Food and Drug Admin European Medicines Agency, and numerous medical societies recommend their use at the lowest effective dose for the shor period of time required to provide therapeutic effect.[3]

Data demonstrate an unequivocal relationship between dose duration of NSAID use and the increased risk of gastrointestin renal, and cardiovascular adverse events.[4] Only by following g for use, taking patients' clinical needs and risk factors into acc fully understanding what medications patients may be taking, educating them about what NSAIDs are, and facilitating an on dialogue can we maximize the therapeutic benefits of NSAIDs minimize the likelihood of adverse events, and prevent patients from living in pain due to fear of pain medications.

The Alliance for Rational Use of NSAIDs—a public health coali aims to bridge the gap between guidance and clinical practice educating health care professionals and the public at-large to ensure appropriate and safe use of NSAIDs.

Please join us in our efforts to ensure appropriate and relief for people with pain. To download educational ma and learn more about the Alliance for Rational Use of N visit [redacted]

Bill McCarberg, MD
Chairman. Alliance for Rational Use of NSAIDs