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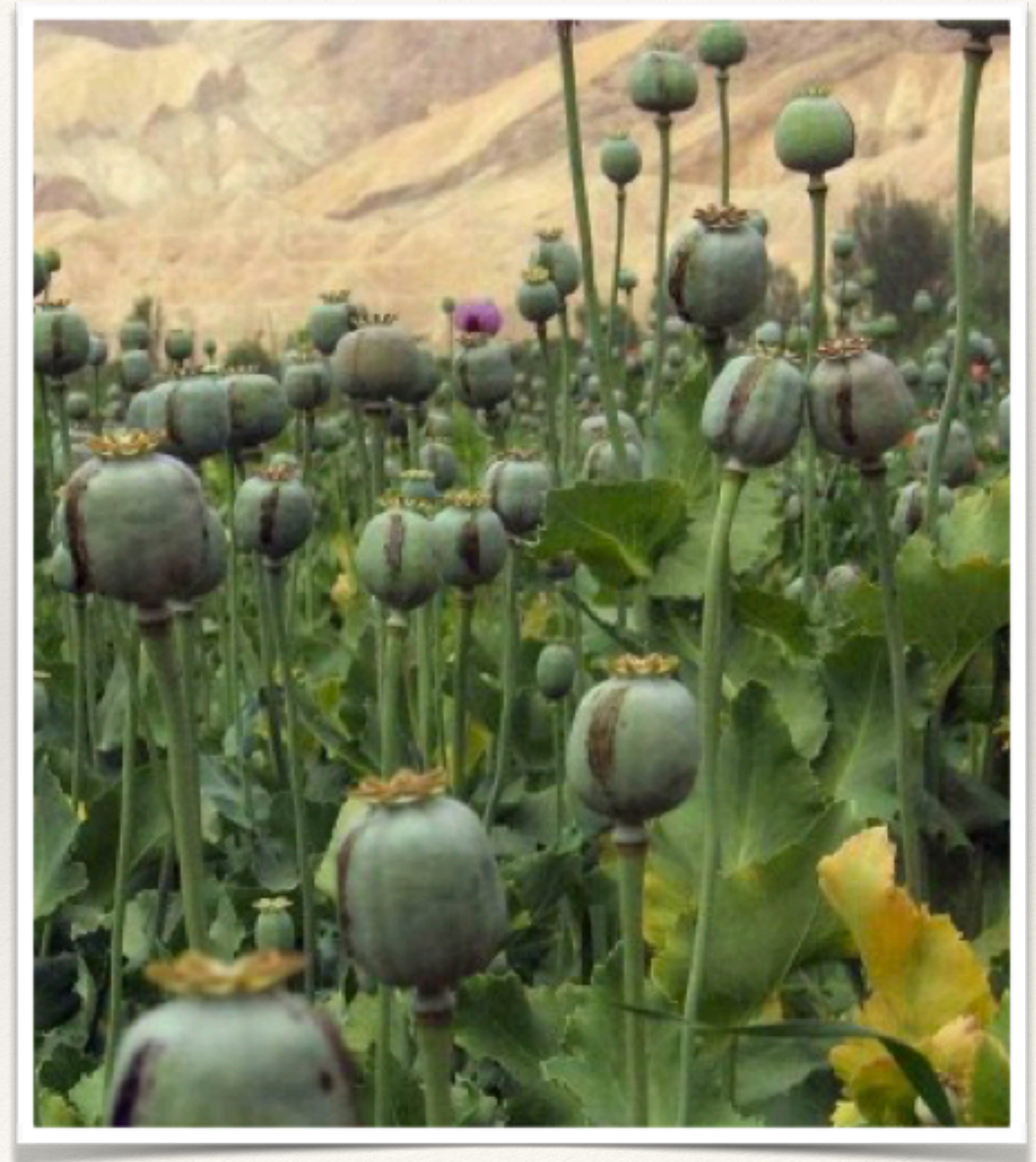
Practical Magic

Delivering Compassionate and Effective Pain Care…

Without Opioids

Is It Really Witchcraft?

- The use of magic, sorcery, or supernatural powers to influence or predict events



Modern-day magic…

- Influence the patient and the pain -
  - medications
  - injections and interventions
  - physical or topical modalities
  - cognitive behavioral approaches
  - creativity and the patient relationship

After this conversation, you should be able to…

- identify common patterns and types of pain
- tailor non-opioid medications to pain type(s)
- provide rationale for thoughtful polypharmacy
- avoid common risks and pitfalls of multi drug regimens
- describe patient selection for interventional pain care
- possess a basic knowledge of the range of interventional pain care

Predicting the future is a magical power…

- Format: This is a fast primer
- Then we're going to play a game that will magically and painlessly foster this conversation
- Abracadabra!

Basic Pain Patterns

- Most pain can, mostly by history, be categorized
  - Somatic (aching, sore, localizable, sometimes sharp)
  - Neuropathic (numbness, tingling, shooting, burning, electrical shocks, often harder to as precisely localize)
  - Visceral (nausea, distention, often dull and very poorly localized or may refer in classic organ patterns)
  - Mixed
  - Atypical (some headaches, allodynia, hyperalgesia, can be sympathetically mediated)

Somatic Pains

- Often related to derangement in tissue of the skin, muscle, integument, or bone
- Usually localizable, often described as sharp, aching, sore, tight, or throbbing.
- Often movement or positionally induced or reduced
- Treat these by trying to modulate the stimulus:
  - if it is inflamed, consider anti inflammatory or Tylenol or injecting steroid
  - if it is feeling achy or stiff, try heat and stretching
  - if it feels more acute, sharp, or swollen, try ice
  - may respond to physical therapy, rest, support (like bracing or compression garments) and TENS
  - if it is at the level of the skin, consider topical anesthetics
  - short term use of muscle relaxers can help if there’s tightness or spasticity
  - superficial localized muscle pains can often be treated with trigger point injections
  - spasticity can be treated with Botox in some cases
  - usually are opioid responsive in short term use

Neuropathic Pains

- take root anywhere along the nerve pathway - centrally (like post-thalamic stroke pain) to peripherally (like small fiber neuropathy)
- numbness, tingling, shooting, burning, electrical shocks, and some patterns of referred pain
- usually not especially well-covered by opioids
- classic drug choices include medications that stabilize membranes (less likely to "fire") like anti seizure drugs and those that increase descending inhibition (like SNRI's, TCA's)
- may respond to cannabinoids
- still, consider the target: if the pain's origin is in the skin, consider topical anesthetics or capsaicin. If the target is in the spinal nerve root, consider steroid injections
- drugs in this spell kit include: gabapentin, pregabalin, amitriptyline or nortriptyline, duloxetine, milnacipran, and some unusual meds like topical capsaicin, carbamazepine, topiramate, others.

Visceral Pain

- usually mediated by inflammation, infection, hypoxia, invasion (like by tumor) or distention of an internal organ
- symptoms can be highly variable, often poorly localizable, and associated with underlying illness
- first rule: treat the cause if you can
- usually not responsive to NSAID (exception: kidney stones)
- think creatively about ways to halt or mask the cause (simethicone for gas, phenazopyridine for bladder irritation)
- drugs in this toolkit: classically amitriptyline for GI pains, otherwise match the stimulus and its intensity and quality and duration to the drug choice.
- usually are opioid responsive, but opioids also increase visceral symptom side effects (constipation, nausea)

Rational Polypharmacy

- consider carefully the individual patient and his other presenting symptoms
- If there's insomnia, add something sedating that also helps the pain type for bedtime use
- beware of co-prescribing meds that have additive effects or interactions
- Often better to tailor a lower-dose multi drug regimen than use a single drug class at higher dose
- The patient may have more than one pain type, more than one pain generator. Consider these collectively when choosing multi drug regimens
- test your rationale when prescribing: what's the indication, analgesia, Side effects, and functional benefit to EACH drug.
- Avoid "favorite drug" habits. If you don't know how it works, look it up!
- A tool: try drawing out a flow chart of the patient's pain day, And what is being given when. Does the indication, duration of action, dose and frequency, and patient response to each drug make sense? Is there a wear-off? Middle of the night use?

Techniques in the interventionist's spell book

- injections can be diagnostic, therapeutic, or both.
- trigger injections, peripheral nerve blocks, epidural injections, nerve root blocks, sacroiliac joint blocks, hip and shoulder blocks, intercostal nerve blocks, radiofrequency ablation for spinal arthritis (and for chronic knee arthritis!), sympathetic plexus blocks, and spinal cord stimulation are all part of the options.
- We can stick a needle almost anywhere. But usually it is not the needle that does the work, but the drug. (exceptions: trigger point injections and acupuncture)

Last minute style points

- Kindness, showing compassion by active listening, and explaining WHY helps.
- Don’t say “no.” Say, “instead… and…”
- Have a “Plan B.”
- Patients absolutely need teaching, often written, of how to use medications properly. They do not read bottles, and do not know what “As needed” means
- Pain as the “Fifth Vital Sign”?
- Pain relief as a “Basic Human Right?”
- Concept: Don’t shoot the messenger

To cast a “spell” you need a recipe

- Target(s)
- Goals and Intent
- Tools
- Timeline
- Alternatives
- Relationship