

Pain management, prescription drug abuse, and risk evaluation and mitigation strategies (REMS): What clinicians need to know

Visit the [NPWH Online Continuing Education Center](#) to access this three-part series of CE E-Newsletters. These E-Newsletters aim to help you to (1) address the needs of patients who experience chronic pain, (2) prevent diversion or misuse of opioids, and (3) increase responsible prescribing.

This program was developed to meet needs uncovered as a result of a 2010 preconference activity at the National Association of Nurse Practitioners in Women's Health (NPWH). Additional surveys of the NPWH email database demonstrated that 425 (42.8%) of 992 respondents were not at all confident in their ability to manage patients with chronic pain. In a separate survey, clinicians were queried regarding their level of comfort in diagnosing and managing patients with chronic pain. Only 14% expressed a high level of self-confidence.

E-Newsletter 1

New patient requests opioid refills: How can you protect your practice and provide effective patient care?

How would you manage this case? A new patient with low back pain schedules an appointment to request refills of oxycodone, hydrocodone/acetaminophen, and oxycodone/acetaminophen. You have never seen this patient and do not have her health records. Should you simply refill her prescriptions? No. You are not obligated to prescribe any medication at this first visit. This newsletter provides valuable

information to protect yourself, your staff, and your practice and to help you provide compassionate—and responsible—care. It reviews recommended next steps:

- Evaluate risk factors using validated instruments
- Access your state's prescription drug monitoring program to find out if the patient is obtaining medications from other providers
- Obtain permission to access the patient's previous records to confirm her stated history and better evaluate the potential for misuse or diversion of opioids
- Perform urine drug testing to verify the patient's reported opioid use
- Make a differential diagnosis to identify pain syndromes and the most appropriate treatment options

Although this patient's history sounds reasonable and her physical examination findings are consistent with her stated history, many questions remain unanswered. For more practical pearls and guidance to help you manage complex pain patients—and successfully navigate legal and regulatory issues—read the first newsletter in this series.

E-Newsletter 2

Long-time patient demonstrates increasing pain and potential for risk: Can you manage a patient who exhibits troubling behavior patterns?

What do you do when a long-time patient develops troubling symptoms of alcohol and opioid abuse? This case-based e-newsletter helps you develop strategies to provide quality care and protect yourself, your staff, and your practice. In this scenario, you consider a patient whose life has, over many years, become increasingly



stressful. She experiences multiple physical complaints—constant achiness coupled with fatigue, poor sleep, lack of energy, abdominal pain with crampy diarrhea followed by constipation, tension headaches, and numerous other symptoms. At first, a diagnosis of fibromyalgia and a pharmacologic and nonpharmacologic treatment plan begin to put her on the path to recovery. However, other factors interrupt her progress.

The patient becomes frustrated that her recovery is too slow, and she starts to drink alcohol at night to fall asleep. Next, she complains to a co-worker about feeling tired. The co-worker lends her an oxycodone/acetaminophen formulation, which results in increased energy and reduced pain levels. She believes this medication is the “answer” to her problems and expresses a strong desire for a prescription. You know that the use of opioids is not generally beneficial for patients with fibromyalgia, but you also know that this patient has not benefited from FDA-approved medications or other nonopioid interventions.

An evaluation using the Opioid Risk Tool demonstrates that this patient has a high level of risk for substance abuse. The state prescription drug monitoring program shows no unusual activity in her case. You have known this patient for two decades. Should you prescribe an opioid for her? If so, should you give her a short-term prescription? What should be your plan for follow-up? What do you require of her in terms of exercise or physical therapy? If you do prescribe an opioid, how and when should you implement an exit strategy?

E-Newsletter 3

Elderly patient with established pain is at risk for potential diversion of opioids: How do you address patient and family issues?

What do you do when an elderly patient benefits from opioids to manage osteoarthritis—



Learning

but other factors make you question whether this treatment option is optimal? After many years of pain and multiple trials of medication and lifestyle modifications, this patient has been stabilized on a low-dose opioid regimen. She has been physically comfortable enough to resume social activities and exercise, and she enjoys a good quality of life. You and she are both satisfied at the progress resulting from her hard work to manage her health. But the situation changes when her granddaughter, who has financial problems, moves in with her.

Once again, the patient withdraws from activities and reports increased pain, despite more frequent refills of her prescriptions. You suspect that she, like many elderly patients, may be the victim of diversion, wherein her granddaughter is siphoning off her opioids. How do you assess what is happening to your patient? Is there potential for elder abuse? Although your patient benefits from opioid administration, is the best course to not provide additional medication until you are satisfied that no diversion is taking place?

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