STUDIES IN PAIN MANAGEMENT

JAMES HUDSON, MD

DECLARATIONS

- ABFP CERTIFIED FAMILY PHYSICIAN AND MEDICAL DIRECTOR OF THE PAIN CENTER AT MARY FREE BED HOSPITAL AND REHABILITATION CENTER.
- FELLOW OF THE AMERICAN COLLEGE OF PAIN MEDICINE
- CLINICAL INSTRUCTOR IN FAMILY PRACTICE MICHIGAN STATE COLLEGE OF HUMAN MEDICINE

- NO FINANCIAL INTERESTS OR COMMERCIAL CONTRACTS RELATED TO THIS TOPIC OR PRESENTATION.

BASICS; HOW DO I DO THIS?

- WHAT PROVIDERS ASK FOR MOST – HOW TO GET PATIENTS OFF OF OPIOIDS?

- IMPORTANT FACTS–MOST CHRONIC PAIN PATIENTS AREN'T ON OPIOIDS. THE ONES THAT ARE GET MOST OF OUR ATTENTION.
- WHO ARE THE OTHERS? THOSE ON CHRONIC PAIN INTERVENTIONS LIKE EVERY 3 MONTH EPIDURAL STEROIDS, CHRONIC CHIROPRACTIC CARE, SERIAL SURGERIES, SOCIAL SECURITY DISABILITY, SPINAL CORD STIMULATORS, INTRATHECAL PUMPS, CHRONIC MUSCLE RELAXERS, GABAPENTIN, MIGRAINE PREVENTIVES, DULOXETINE, STIMULANTS, BENZODIAZEPINES ETC..

BASICS

THREE IMPORTANT STEPS TO RELIEVING CHRONIC PAIN

1) EDUCATION ABOUT THE BODIES PAIN SYSTEM

2) REASSURANCE THAT YOU ARE NOT ABANDONING THEM WITH THEIR PAIN

3) CHANGING THE FOCUS FROM RELIEVING PAIN TO RESTORING FUNCTION

BASICS – EDUCATION - IF YOU DON'T UNDERSTAND THIS YOU CAN'T TEACH IT TO YOUR PATIENTS

- SEE INFORMATION FROM DR. CLAUW AND DR. WILLIAMS
- ADDITIONAL RESOURCES:
    - EXPLAIN PAIN BOOK OR ON LINE; DR DAVID BUTLER AND DR. LORIMER MOSELY – AUSTRALIA
    - DR CLAUW – YOUTUBE VIDEOS
    - "PAIN IS WEIRD" WEBSITE/BLOG
    - LAMP WORKBOOKS – DR BEVERLY E. THORN – UNIVERSITY OF ALABAMA (LEARNING ABOUT MANAGING PAIN FOR GROUPS)
    - NEURALPATHWAYS PAIN – YOUTUBE –

REASSURANCE THAT YOU ARE NOT GOING TO ABANDON THE PATIENT

INITIATE THE PROCESS WITH A 45 MINUTE VISIT (FIRST VISIT IN ½ DAY OR LAST VISIT)

HAVE THE PATIENT COMPLETE A DETAILED REVIEW OF SYSTEMS ALONG WITH A PAIN DIAGRAM. GATHER ANY RECORDS THAT YOU NEED, HAVE A MAPS REPORT PRINTED UP, HAVE NURSE COMPLETE A PHQ-2 AND 9 IF INDICATED AND CONSIDER ANOTHER SCREENING TOOL FOR SUBSTANCE USE DISORDER SUCH AS DAST AND POSSIBLY A PAIN MANAGEMENT URINE DRUG SCREEN.

HAVE A COPY OF A CLINICAL OPIATE WITHDRAWAL SCALE HANDOUT TO GIVE THE PATIENT IF THEY ARE ON OPIATES.

THE CHRONIC PAIN EVALUATION

OPEN ENDED QUESTIONS; WHEN DID YOU LAST FEEL WELL AND HEALTHY? THEN WHAT HAPPENED?

WHAT TREATMENTS HAVE BEEN TRIED? HOW HAVE THEY WORKED?

WALK ME THROUGH YOUR USUAL DAY STARTING WITH -WHAT TIME DO YOU GET OUT OF BED?

ASK ABOUT HOW MUCH TIME IS SPENT RESTING?
DO YOU EXERCISE?
WHEN DO YOU GO TO BED?
HOW WELL DO YOU SLEEP?
WHAT WOULD YOU DO DIFFERENTLY IF YOUR PAIN WAS BETTER CONTROLLED?

GO THROUGH THE REVIEW OF SYSTEMS WITH THE PATIENT LOOKING FOR RED FLAGS.(BOWEL AND BLADDER CONTROL, WEIGHT LOSS, HISTORY OF CANCER, FEVER, MENTAL HEALTH AND MOOD DISTURBANCES AND MAJOR PSYCHOSOCIAL STRESSORS.

THE CHRONIC PAIN EVALUATION

EXAMINE THE PATIENT

EVALUATE FOR OBJECTIVE FINDINGS SUCH AS LIMITED JOINT OR SPINE MOBILITY BOTH ACTIVE AND PASSIVE, LOSS OF STRENGTH OR REFLEXES, EXPLAINING THE MEANING OF YOUR FINDINGS TO THE PATIENT.

DECIDE IF YOUR FINDINGS WARRANT FURTHER WORK UP. AVOID ORDERING FURTHER STUDIES BASED SOLELY ON COMPLAINTS OF PAIN PARTICULARLY WHERE THE SAME STUDIES HAVE BEEN DONE BEFORE, BECAUSE AS WE HAVE SEEN THERE IS NOT A GOOD CORRELATION BETWEEN PAIN AND PATHOLOGY.

TWO THINGS THAT ALMOST ALWAYS REQUIRE OUTSIDE REFERRAL, SUBSTANCE USE DISORDER AND UNSTABLE PSYCHIATRIC PATIENT WITH ACTIVE SUICIDAL PLAN OR PSYCHOTIC SYMPTOMS.

IF STRONG SUSPICION FOR DIVERSION YOU MAY NEED TO IMMEDIATELY STOP PRESCRIBING.

THE CHRONIC PAIN EVALUATION

ASSESS READINESS FOR CHANGE

THE MORE MISERABLE THE PATIENT IS THE MORE LIKELY THEY ARE TO CHANGE.

CHANGE ALWAYS INCREASES ANXIETY – LET THE PATIENT KNOW THAT YOU UNDERSTAND THAT THEY ARE ANXIOUS AND CONSIDER THAT NORMAL.

EXPLAIN THAT YOU WOULD LIKE TO FOCUS ON HELPING THEM RESTORE FUNCTION (IE – HELP THEM GET THEIR LIFE BACK)

SHARED DECISION MAKING – WHERE WOULD THEY LIKE TO START? DECREASING MEDS? IMPROVING THEIR SLEEP? IMPROVING THEIR MOOD – DECREASING DEPRESSION OR LOWERING ANXIETY? ADDING BACK IN ACTIVITIES THAT THEY HAVE STOPPED?

AVOID PASSIVE APPROACHES, HELP PATIENT FOCUS ON THINGS THEY CAN LEARN TO CONTROL. IT MAY BE AS SIMPLE AS GETTING DRESSED EVERY DAY, STOPPING NAPS, DECREASING THEIR NARCOTICS, NO LONGER TALKING ABOUT THEIR PAIN WITH FRIENDS AND FAMILY. LEARNING NOT TO CATASTROPHIZE. READING AND STUDYING ABOUT PAIN OR THEIR DIAGNOSIS.

CASE EXAMPLE –HEADACHE

- 54-YEAR-OLD MAN WITH CHRONIC HEADACHE FOR ~10 MONTHS
  - ONSET AFTER WORK-RELATED HEAD INJURY
  - SYMPTOMS: CONSTANT PAIN AROUND EYES AND TEMPLES BILATERALLY (4 OUT OF 10), INTERMITTENT SEVERE PAIN IN RIGHT TEMPLE (8 OUT OF 10), TINNITUS
- TREATMENT HISTORY
  - COMPLETED POST CONCUSSION PROGRAM AT MARY FREE BED FOLLOWING ACCIDENT
  - NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS FOR PAIN
- CURRENT FUNCTIONING
  - WORKS FULL TIME
  - DECREASED ENGAGEMENT IN PHYSICAL AND SOCIAL ACTIVITIES
  - ANXIETY AND DEPRESSED MOOD RELATED TO PAIN; ANGER ASSOCIATED WITH WORK-RELATED INJURY AND COMPANY'S RESPONSE
  - CONTINUED COGNITIVE SYMPTOMS (E.G., WORD-FINDING PROBLEMS, FORGETTING TO DO THINGS)
  - FEELS EXTREMELY FATIGUED AFTER WORK SHIFTS
  - SIGNIFICANT SLEEP DISTURBANCE INVOLVING INTERRUPTED SLEEP. NEGATIVE EVALUATION FOR SLEEP APNEA.

CASE EXAMPLE – HEADACHE

- MEDICAL HISTORY
  - HYPERTENSION, DIABETES, CROHN'S DISEASE
  - CHRONIC PAIN IN LEG DUE TO PRIOR INJURY; THIS IS NOT DISTRESSING OR IMPAIRING AT PRESENT
- MENTAL HEALTH HISTORY
  - NO PRIOR MENTAL HEALTH PROBLEMS OR TREATMENT
  - CURRENTLY A HIGH DEGREE OF CATASTROPHIC THINKING ABOUT PAIN AND ADJUSTMENT-RELATED DEPRESSED MOOD AND ANXIETY
- SOCIAL HISTORY
  - CURRENTLY MARRIED – FEELS GUILTY THAT HIS WIFE HAS TO HELP HIM WITH TASKS
  - CHILDHOOD NEGLECT AND ABUSE – TENDS TO SUPPRESS ANGER AS AN ADULT DUE TO THIS LEARNING HISTORY
  - MOTIVATED TO CONTINUE WORKING

CASE EXAMPLE – HEADACHE

- TREATMENT PROGRESS
  - RETURNED TO PREVIOUSLY VALUED ACTIVITIES (CAMPING, HUNTING, EXERCISE)
  - IDENTIFIED A LINK BETWEEN SUPPRESSED ANGER AND HEADACHES. LEARNED EFFECTIVE COPING STRATEGIES.
  - DECREASED HEADACHE-RELATED VIGILANCE AND CHECKING BEHAVIORS (E.G., "OBSESSING" OVER WHAT MAY INFLUENCE HEADACHE). INCREASED PAIN ACCEPTANCE AND DECREASED CATASTROPHIZING.
  - PATIENT REPORTED: MORE RELAXED, LESS PAIN, GREATER SELF-EFFICACY TO MANAGE PAIN, IMPROVED COGNITIVE FUNCTIONING
  - AT TIME OF DISCHARGE, 2 WEEKS WITH NO SIGNIFICANT HEADACHES
  - DISABILITY (NDI)
    - INTAKE: 52%; DISCHARGE: 24%
  - AVERAGE PAIN OVER PAST MONTH (0-10 SCALE)
    - INTAKE = 4; DISCHARGE = 2
  - DEPRESSED MOOD (CES-D)

    INTAKE = 33 (MODERATE-SEVERE); DISCHARGE = 6 (NORMAL RANGE)
  - ANXIETY (BURNS)
    - INTAKE = 27 (MODERATE); DISCHARGE = 11 (BORDERLINE/SUB-THRESHOLD)
  - PAIN CATASTROPHIZING (PCS)
    - INTAKE = 39 (SEVERE); DISCHARGE = 6 (NORMAL RANGE)

PAIN MANAGEMENT WITHOUT A TEAM

80 YEAR OLD FEMALE RETIRED LPN WHO LAST WORKED IN 1990. HAS POOR MEMORY OF PAST MEDICAL HISTORY. BETWEEN 1990 AND 1994 HAD MULTIPLE BACK SURGERIES BY ORTHOPEDIC SPINE SURGEON. MANAGED BY ANESTHESIA BASED PAIN CLINIC SINCE 2000. GRADUAL ESCALATION OF OPIATE PAIN MEDICATIONS ULTIMATELY TAKING > 500 MG MORPHINE EQUIVALENTS(MME) PER DAY. HER PRIMARY CARE PHYSICIAN BEGAN TAPERING OPIATES AND AT TIME OF REFERRAL TO MARY FREE BED SHE WAS AT 220 MME CONSISTING OF OXYCODONE ER 60 MG BID AND HYDROCODONE/ACETAMINOPHEN 10/325 TWO TABLETS BID.

LIVES ALONE CAREGIVERS COME TWICE A DAY FOR 2 HOURS TO ASSIST WITH ADLS.

GETS OUT OF BED AT 10:30 AM ONLY GETS DRESSED ON DAYS GOING OUT FOR APPOINTMENTS ABOUT ONCE A MONTH. SHE REPORTS INCREASED SYMPTOMS OF DEPRESSION SINCE TAPERING OPIATES DESPITE PAROXETINE AND MIRTAZAPINE. HAD PRIOR HOME PT BUT ADMITS DOESN'T DO ANY OF HER HOME EXERCISE PROGRAM. GOES TO BED BETWEEN 11PM AND 11:30. REPORTS SLEEPING WELL BUT NOT AS WELL SINCE TAPERING OPIATES.

PAIN MANAGEMENT WITHOUT A TEAM

PMH: AFIB, PULMONARY EMBOLI, HTN, STAGE III KIDNEY DISEASE, HIGH CHOLESTEROL AND BLADDER INCONTINENCE.

SOCIAL HX: SMOKES 1 PPD X 60 YEARS. ETOH 1-2 TIMES PER YEAR, TRIED MEDICAL MARIJUANA BUT HAS NOT CONTINUED.

OTHER MEDICATIONS: ASA 81MG, DOCUSATE 100MG BID, ENSURE, LINACLOTIDE 145MG, PAROXETINE 20MG, MIRTAZAPINE 15MG HS, ALPRAZOLAM 0.5 QID, WARFARIN QDAY, CARVODILOL 12.5 BID, HCTZ-TRIAMTERENE 25-37.5 MG Q D .

EXAM: ALERT AND ORIENTED. NAD.

AMBULATES WITH WHEELED WALKER. SIGNIFICANTLY LIMITED CERVICAL RANGE OF MOTION, THORACIC KYPHOSIS WITH BILATERAL HIP AND KNEE CONTRACTURES, UNABLE TO TOLERATE SUPINE POSITION, SLEEPS SITTING UP IN HOSPITAL BED.

PAIN MANAGEMENT WITHOUT A TEAM

TREATMENT COURSE:

INITIAL EVALUATION 02/09/2017. MONTHLY VISITS DECREASING OXYCODONE ER BY 20MG PER DAY EACH MONTH UNTIL DOWN TO 20 MG PER DAY THEN DROPPING 10 MG PER DAY PER MONTH UNTIL OFF IN AUGUST. A REFERRAL WAS PLACED FOR HOME PT SERVICES WHICH RESULTED IN THE PATIENT BECOMING ABLE TO LAY FLAT IN BED AND WALKING MUCH BETTER WITH HER WALKER. AT THAT TIME SHE REPORTED LESS PAIN AND FEELING MORE ENERGY AND SHE THANKED ME FOR NOT GIVING UP ON HER. NEXT HYDROCODONE/ACETAMINOPHEN WAS TAPERED FROM10/325 QID TO 7.5/325 ON 10/26/17 AND THEN 5/325 QID THEN TID.

SHE HAS REPORTED INCREASED PAIN AT EACH APPOINTMENT AND COMPLAINED BITTERLY ABOUT HAVING TO GO DOWN ON HER MEDICATIONS. WE STILL HAVE TO WORK ON HER BENZODIAZEPINE BUT I ANTICIPATE THAT BEING DONE EVEN MORE SLOWLY. I HAVE ENCOURAGED HER TO SEE ONE OF OUR PAIN PSYCHOLOGISTS BUT SHE HAS RESISTED.

PATIENT INTERVIEW - CHRONIC BACK PAIN

- 59-YEAR-OLD MAN WITH A 15-YEAR HISTORY OF CHRONIC BACK PAIN
  - "CONSTANT ACHING" IN SPINE, HANDS, SHOULDERS
  - NUMBNESS AND TINGLING IN UPPER AND LOWER EXTREMITIES
- DAILY ORAL MORPHINE EQUIVALENCE: 185-250MG
  - MEDICATIONS ALSO INCLUDE MORPHINE SULFATE ER 15MG 3 TABS TID, HYDROMORPHONE 4MG 2 TABS QD, DIAZEPAM 5MG Q AM, TEMAZEPAM 30MG HS PRN, LISDEXAMFETAMINE 70MG,, BUPROPION XL 450 MG DAILY, MELATONIN 5MG HS, LISINOPRIL-HCTZ 10/12.5 QD, TESTOSTERONE TOPICAL 10MG QAM.
- TREATMENT HISTORY
  - MULTIPLE BACK SURGERIES, PHYSICAL THERAPY, CHIROPRACTICS, NERVE BLOCKS, MENTAL HEALTH COUNSELING, MASSAGE, ICE/HEAT
- CURRENT FUNCTIONING
  - WORKS PART TIME
  - PROLONGED PERIODS OF REST/INACTIVITY
  - SIGNIFICANT SLEEP DISTURBANCE
  - WORSENING DEPRESSION
  - WOULD LIKE TO RETURN TO FULL-TIME WORK AND RECREATIONAL ACTIVITIES (FISHING, GOLFING, SWIMMING)

PATIENT INTERVIEW – BACK PAIN

- MEDICAL HISTORY
  - HYPERTENSION, OBSTRUCTIVE SLEEP APNEA, VIRAL HEPATITIS C
- MENTAL HEALTH HISTORY
  - DEPRESSION, ANXIETY, ADHD
  - PRIOR SUICIDE ATTEMPT
  - MULTIPLE PSYCHIATRIC HOSPITALIZATIONS
- SUBSTANCE USE HISTORY
  - "VARIOUS SUBSTANCES" SINCE AGE 9
  - PAST ALCOHOL USE DISORDER AND HEROIN USE DISORDER
- SOCIAL HISTORY
  - HISTORY OF CHILDHOOD TRAUMA
  - U.S. ARMY VETERAN
  - CURRENTLY MARRIED

PATIENT INTERVIEW – BACK PAIN

- TREATMENT PROGRESS
  - COMPLETED OPIOID TAPER – OFF ALL NARCOTICS BY END OF TREATMENT
  - RETURNED TO PREVIOUSLY VALUED ACTIVITIES (GOLFING, HOME ACTIVITIES, EXERCISE)
  - PATIENT REPORTED: MORE POSITIVE AFFECT, MORE ENERGY, DECREASED PAIN, USING BEHAVIORAL STRATEGIES IN EVERY DAY LIFE TO MANAGE PAIN EFFECTIVELY
  - DISABILITY (ODI)
    - INTAKE: 52%; DISCHARGE: 38%
  - AVERAGE PAIN OVER PAST MONTH (0-10 SCALE)
    - INTAKE = 6; DISCHARGE = 3
  - DEPRESSED MOOD (CES-D)

    INTAKE = 22 (MILD); DISCHARGE = 11 (NORMAL RANGE)
  - ANXIETY (BURNS)
    - INTAKE = 50 (SEVERE); DISCHARGE = 16 (MILD)
  - PAIN CATASTROPHIZING (PCS)
    - INTAKE = 42 (SEVERE); DISCHARGE = 8 (NORMAL RANGE)

CASE REVIEW

- 62 YEAR OLD NURSE 4 YEARS POST MASTECTOMY FOR BREAST CANCER. NO EVIDENCE OF RECURRENT DISEASE.
- HAD PLANNED BREAST RECONSTRUCTIVE SURGERY BUT THIS HAD BEEN PUT ON HOLD BECAUSE OF SEVERE POST-MASTECTOMY PAIN IN THE RIGHT ANTERIOR CHEST WITH PARESTHESIAS INTO THE RIGHT HAND HER PAIN WAS MANAGED WITH HYDROCODONE/APAP 10-325MG QID.

CASE REVIEW

- THE PATIENT HAD RETURNED TO WORK BUT STRUGGLED AT WORK BECAUSE OF PAIN AND HAD STOPPED DOING MANY OF HER PREVIOUS VALUED ACTIVITIES.
- ADMISSION TESTING SHOWED SIGNIFICANT DEPRESSION, PAIN RELATED ANXIETY, HURT HARM SCORE AND HIGH LEVELS OF PERCEIVED DISABILITY.
- HER PHYSICAL EXAM REVEALED SCALENE MUSCLE TENDERNESS REPRODUCING PARESTHESIA OF THE RIGHT HAND. LIMITED CERVICAL RANGE OF MOTION AND LEFT SHOULDER RANGE WITH FORWARD HEAD AND NECK POSTURE AND BLUNTED AFFECT. SHE HAD RIGHT UPPER EXTREMITY LYMPHEDEMA WITH A COMPRESSION SLEEVE.
- SHE PARTICIPATED IN OUR 10 WEEK PAIN REHABILITATION PROGRAM WHILE CONTINUING TO WORK FULL TIME. AT THE END OF TREATMENT SHE WAS OFF ALL OPIATES, WAS HAVING NO DIFFICULTY AT WORK, HAD RESUMED MORE OF HER RECREATIONAL AND COMMUNITY ACTIVITIES AND RATED HE PAIN AT 0-2/10. HE SHOULDER RANGE OF MOTION AND CERVICAL RANGE WERE BOTH WITHIN FUNCTIONAL LIMITS. HE DEPRESSION AND ANXIETY WERE WITHIN NORMAL LIMITS.

CHRONIC PAIN PATIENT INTERVIEWS

- COMPLEX REGIONAL PAIN SYNDROME
- 32 Y.O. FEMALE EMT INJURED IN PARKING LOT AT WORK SLIPPING AND FALLING ON BLACK ICE ON FEB 9, 2013. DIAGNOSED WITH SPRAIN BY OCCUPATIONAL HEALTH. PLACED IN SPLINT AND CRUTCHES. PLACED ON WORK RESTRICTIONS INITIALLY TREATED WITH IBUPROFEN AND TRAMADOL AND SENT FOR PT. PAIN INTENSIFIED AND SHE WAS RX HYDROCODONE/APAP AND CYCLOBENZAPRINE. IN MARCH MRI SHOWED NON-DISPLACED FRACTURE OF TIBIA WITH MODERATE BONE MARROW EDEMA AND SMALL JOINT EFFUSION.

CHRONIC PAIN PATIENT INTERVIEWS

- COMPLEX REGIONAL PAIN SYNDROME
- FOOT AND ANKLE SPECIALIST DIAGNOSED SYNDESMOSIS. ORIF ON 3/25/13. ATTEMPTED RTW MAY 2013 BUT WAS UNSUCCESSFUL SECONDARY TO PAIN.
- PAIN ANESTHESIOLOGIST DX CRPS, DEPRESSION AND ANXIETY. MULTIPLE SYMPATHETIC BLOCKS PERFORMED IN JUNE AND JULY 2013.
- IME BY ORTHOPEDIC SPINE SURGEON CONFIRMED DIAGNOSIS AND DESENSITIZATION TECHNIQUES RECOMMENDED.
- VARIOUS MEDS TRIED INCLUDING MIDAZOLAM INJECTIONS, GABAPENTIN, OPIOIDS, AND DULOXETINE.

CHRONIC PAIN PATIENT INTERVIEWS

- COMPLEX REGIONAL PAIN SYNDROME
- SPINAL CORD STIMULATOR PLACED ON 9/13/13 WITH INITIAL PARTIAL RELIEF.
- ANKLE HARDWARE REMOVED 10/14/13.
- RADIOFREQUENCY RHIZOTOMY 11/25/13.
- CONTINUED TO FEEL “LIKE STEPPING ON A CACTUS” AND COULD ONLY TOLERATE WALKING FOR 20 MINUTES BEFORE HAVING TO ELEVATE FOOT.
- DULOXETINE CAUSED HER TO ”NOT CARE ABOUT ANYTHING”. THIS WAS CHANGED TO VENLAFAXINE.
- APPLIED FOR SSDI BUT WAS DENIED.

CHRONIC PAIN PATIENT INTERVIEWS

- COMPLEX REGIONAL PAIN SYNDROME
- SHE WAS SEEING A PAIN PSYCHOLOGIST REGULARLY AND FOLLOWING WITH ANOTHER COUNSELLOR.
- EVALUATED BY REHABILITATION INSTITUTE OF CHICAGO WHO RECOMMENDED OPIATE TAPER AND CLEVELAND CLINIC WHO RECOMMENDED KETAMINE INFUSIONS.
- MEDS : TIZANIDINE 4MG HS, MORPHINE ER 30 MG BID, TAPENTADOL ER 125MG HS, VENLAFAXINE ER 150 MG IN AM, TERAZOSIN 1MG HS.
- MULTIDISCIPLINARY PAIN TREATMENT WAS RECOMMENDED BUT PATIENT DECIDED TO PURSUE KETAMINE INFUSION AT CLEVELAND CLINIC.

CHRONIC PAIN PATIENT INTERVIEWS

- COMPLEX REGIONAL PAIN SYNDROME
- RETURNED TO MARY FREE BED PAIN CENTER 01/07/2015 THEN 23 MOS POST INJURY.
- HAD COMPLETED SEVERAL KETAMINE INFUSIONS WITH PARTIAL PAIN RELIEF BUT SIGNIFICANT COGNITIVE SIDE EFFECTS AND WAS NOT GOING TO CONTINUE. SHE HAD ALSO STARTED LIDOCAINE INJECTIONS IN HER BACK.
- MORPHINE ER HAD BEEN CHANGED TO OXYMORPHONE ER. SHE WAS ALSO ON TOPIRAMATE 100MG QD, DULOXETINE 60MG, LIDOCAINE PATCH AND OFF TAPENTADOL. AND VENLAFAXINE
- SHE REQUESTED HELP IN WEANING OF OPIATES AND HELP WITH DEPRESSION WITH GOAL OF RETURNING TO PART TIME WORK.

CHRONIC PAIN PATIENT INTERVIEWS

- COMPLEX REGIONAL PAIN SYNDROME
- BEGAN MULTIDISCIPLINARY PAIN PROGRAM USING GRADED MOTOR IMAGERY 03/12/2015.
- DISCHARGED FROM TREATMENT ON 05/07/2015 ON DULOXETINE 30 MG Q AM AND TOPIRAMATE 100MG Q HS.
- WAS JOGGING, INDEPENDENT IN HOME EXERCISE PROGRAM AND USING A MIRROR BOX TO TREAT INTERMITTENT FLARE UPS OF FOOT AND ANKLE PAIN.
- SEEN 09/16/15 FOR FOLLOW UP, EMPLOYED ON NO MEDICATIONS, HAVING A FLARE UP OF ANXIETY DUE TO MULTIPLE STRESSORS AND UNDERWENT BRIEF COGNITIVE BEHAVIORAL INTERVENTION AND CONTINUED SUBSEQUENTLY WITH HER OWN SELF MANAGEMENT INCLUDING RELAXATION EXERCISES AND MIRROR BOX.

PATIENT – CASES

- HTTPS://YOUTU.BE/82GTN4MXIWE
- HTTPS://YOUTU.BE/JC-FOGCA3CC
- HTTPS://WWW.YOUTUBE.COM/WATCH?V=9U3KJIN4E4G
- HTTPS://YOUTU.BE/HEJVSBYUZZK