Diagnosing and Treating Pain Based on the Underlying Mechanism

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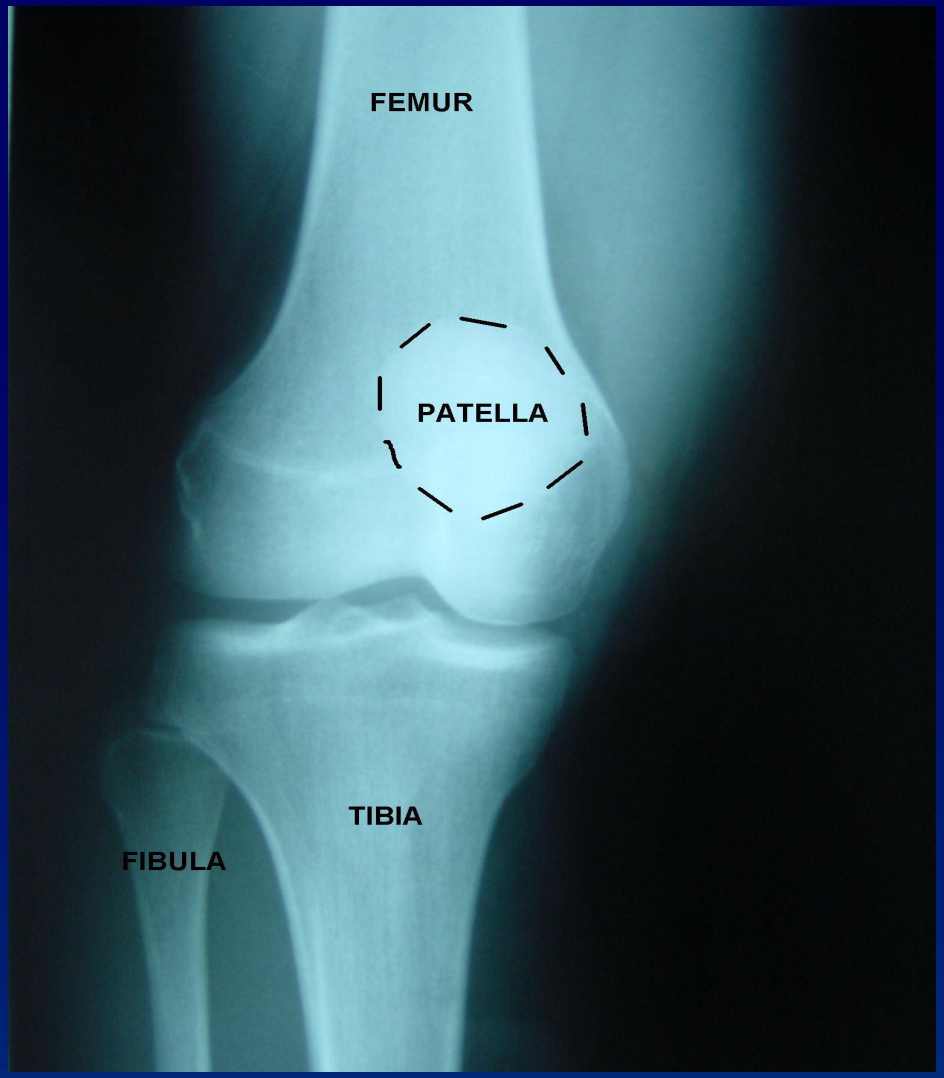
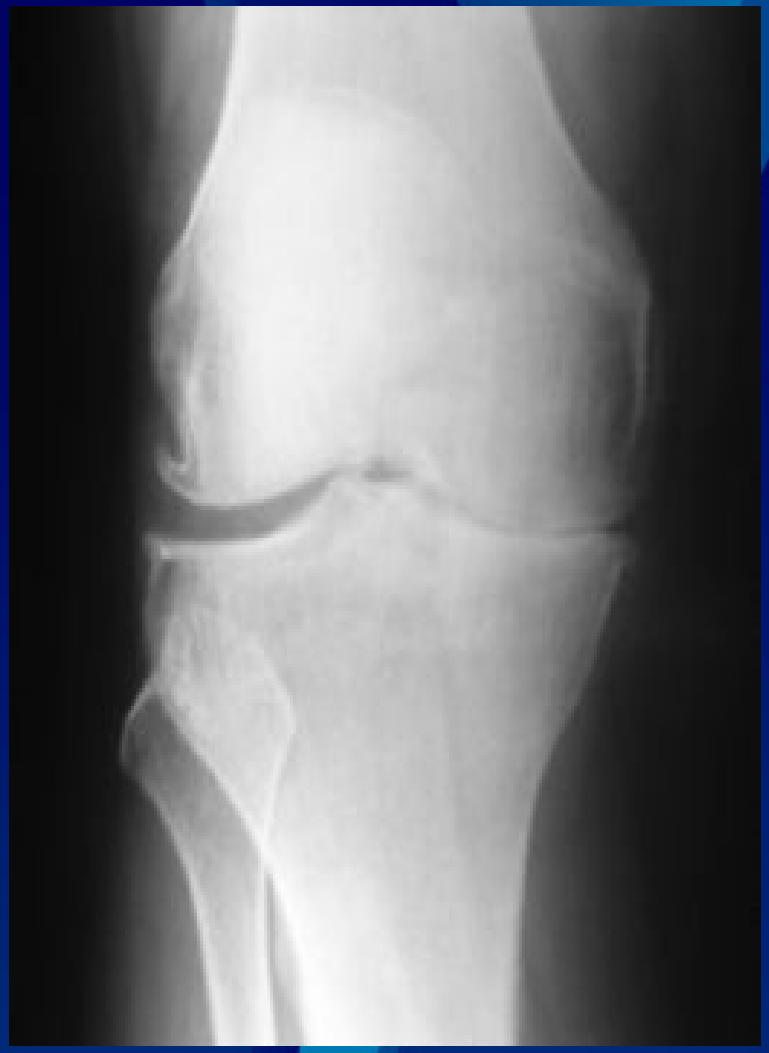
Disclosures

- Consulting
  - Pfizer, Tonix, Theravance, Zynerba, Samumed, Aptinyx, Daiichi Sankyo, Intec, Regeneron, Teva
- Research support
  - Pfizer, Cerephex, Aptinyx

Which person has pain?





Osteoarthritis of the knee - I

- Classic “peripheral” pain syndrome
- Poor relationship between structural abnormalities and symptoms[1]. In population-based studies:
  - 30 – 40% of individuals who have grade 3/4 K/L radiographic OA have no symptoms
  - 10% of individuals with severe pain have normal radiographs
- Psychological factors explain very little of the variance between symptoms and structure[2]
- We sometimes delude ourselves into thinking that our current therapies are adequate
  - NSAIDs, acetaminophen, and even opioids have small effect sizes[3,4]
  - Arthroplasty does not predictably relieve pain

(1) Creamer P, et. al. Br J Rheumatol 1997; 36(7):726-8. (2) Creamer P, et. al. Arthritis Care Res 1998; 11(1):60-5. (3) Bjordal JM, et. al. Eur J Pain 2007; 11(2):125-38. (4) Zhang W, et. al. Ann Rheum Dis 2004; 63(8):901-7.

Evolution of Thinking Regarding Fibromyalgia

American College of Rheumatology (ACR) Criteria

- Discrete illness
- Focal areas of tenderness
- Pathophysiology poorly understood and thought to be psychological in nature

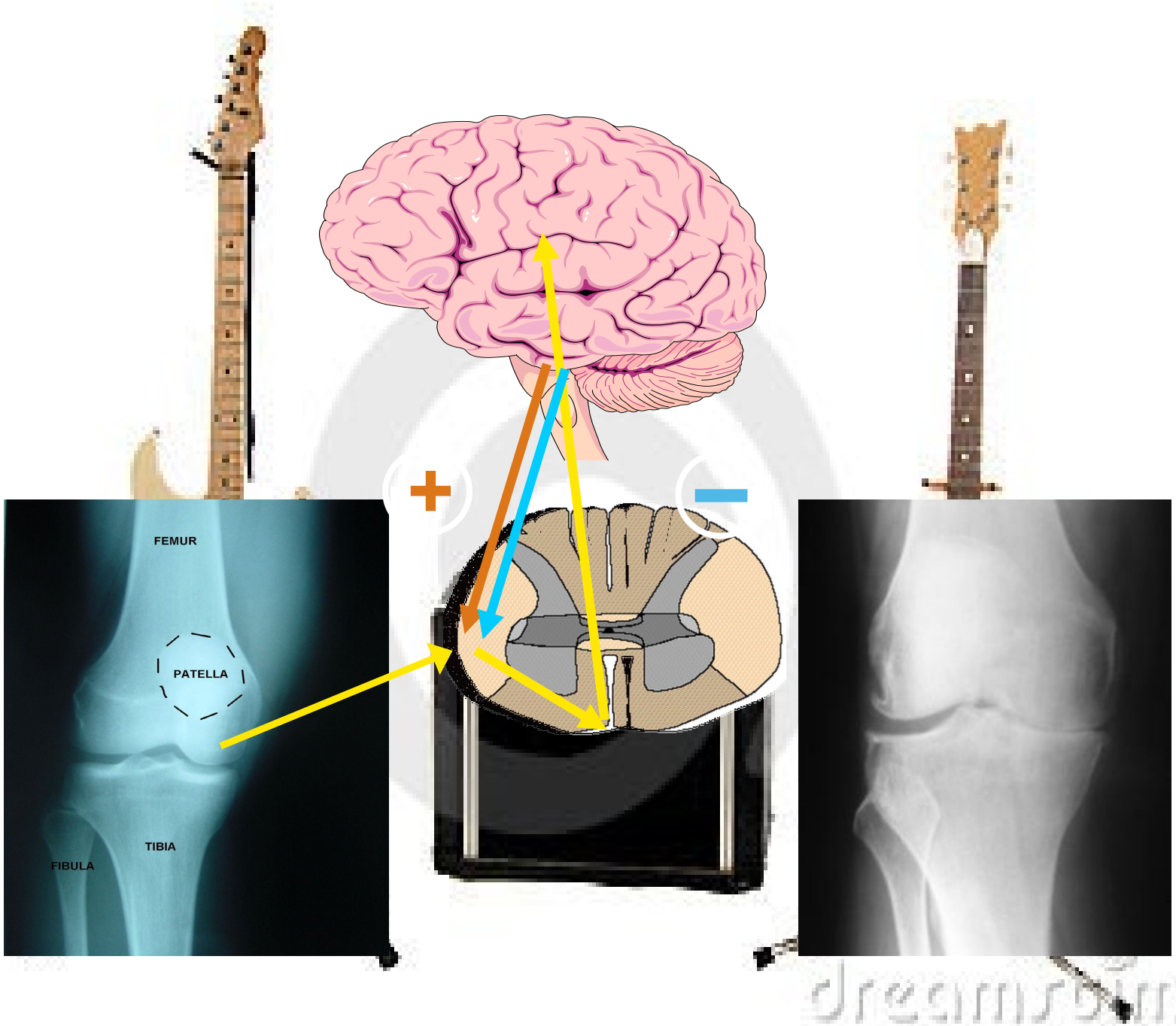
- Chronic widespread pain
- Tenderness in ≥11 of 18 tender points

- Final common pathway (i.e. pain centralization)
- Part of a much larger continuum
- Not just pain
- Pathophysiology fairly well understood and is a CNS process that is independent from classic psychological factors

Mechanistic Characterization of Pain

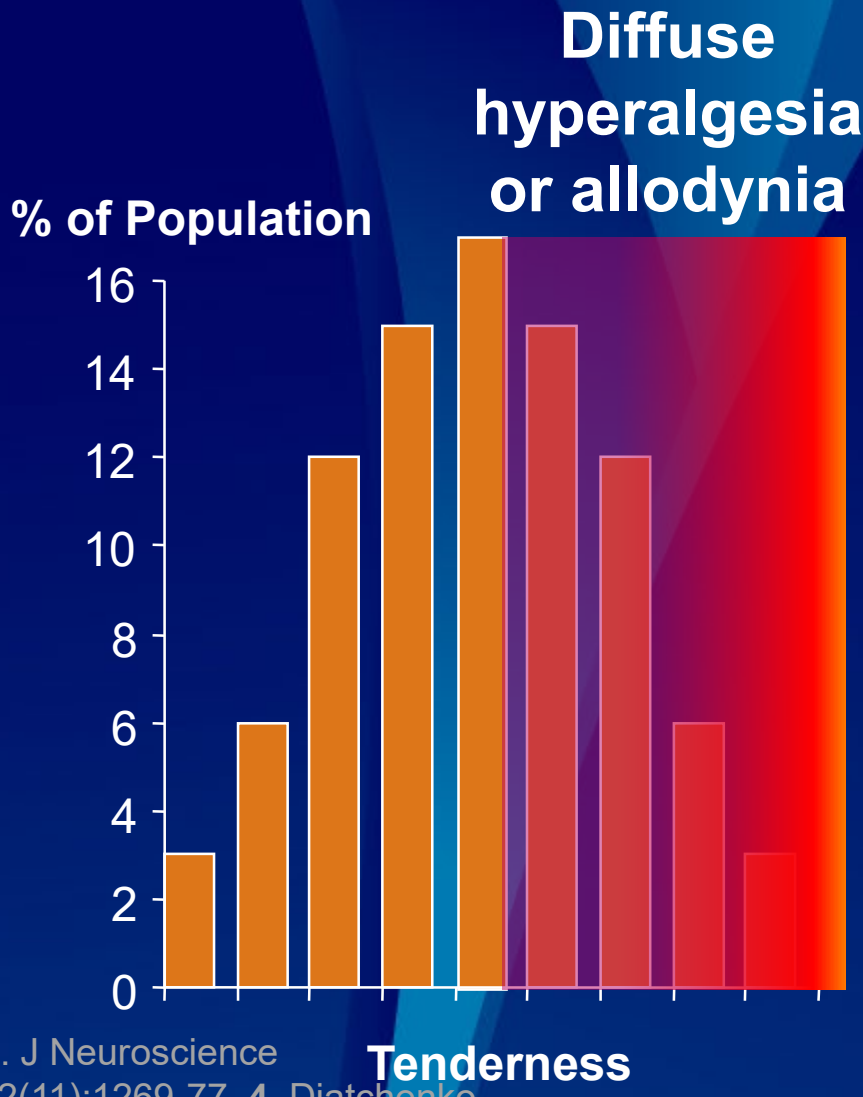
Variable degrees of any mechanism can contribute in any disease

	Nociceptive	Neuropathic	Centralized
Cause	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
Clinical features	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
Screening tools		PainDETECT	Body map or FM Survey
Treatment	NSAIDs, injections, surgery, ? opioids	Local treatments aimed at nerve (surgery, injections, topical) or CNS-acting drugs	CNS-acting drugs, non-pharmacological therapies
Classic examples	Osteoarthritis Autoimmune disorders Cancer pain	Diabetic painful neuropathy Post-herpetic neuralgia Sciatica, carpal tunnel syndrome	Fibromyalgia Functional GI disorders Temporomandibular disorder Tension headache Interstitial cystitis, bladder pain


FEMUR
PATELLA
TIBIA
FIBULA
+
−

Pain and sensory sensitivity in the population

- Like most other physiological processes, we have a “volume control” setting for how our brain and spinal cord processes pain[1]
- This is likely *set* by the genes that we are born with[2-4], and *modified* by neurohormonal factors and neural plasticity
- The higher the volume control setting, the more pain we will experience, irrespective of peripheral nociceptive input



1. Mogil JS. PNAS, 1999;96(14):7744-51. **2.** Amaya et. al. J Neuroscience 2006;26(50):12852-60. **3.** Tegeder et.al., NatMed. 2006;12(11):1269-77. **4.** Diatchenko et. al. HumMolGenet. 2005;14(1):135-43.

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Overlapping Chronic Pain Conditions: Implications for Diagnosis and Classification

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Abstract: There is increasing recognition that many if not most common chronic pain conditions are heterogeneous with a high degree of overlap or coprevalence of other common pain conditions along with influences from biopsychosocial factors. At present, very little attention is given to the high degree of overlap of many common pain conditions when recruiting for clinical trials. As such, many if not most patients enrolled into clinical studies are not representative of most chronic pain patients. The failure to account for the heterogeneous and overlapping nature of most common pain conditions

Chronic Overlapping Pain Conditions

- Most highly prevalent pain conditions in individuals under age 50
  - Headache
  - Fibromyalgia
  - Irritable bowel
  - TMJ Disorder
  - Interstitial cystitis
  - Low back pain
  - Endometriosis
  - Vulvodynia
  - Chronic fatigue syndrome
- Same central mechanisms play significant roles in all pain conditions, even those with known peripheral contributions

Fibromyalgia-ness

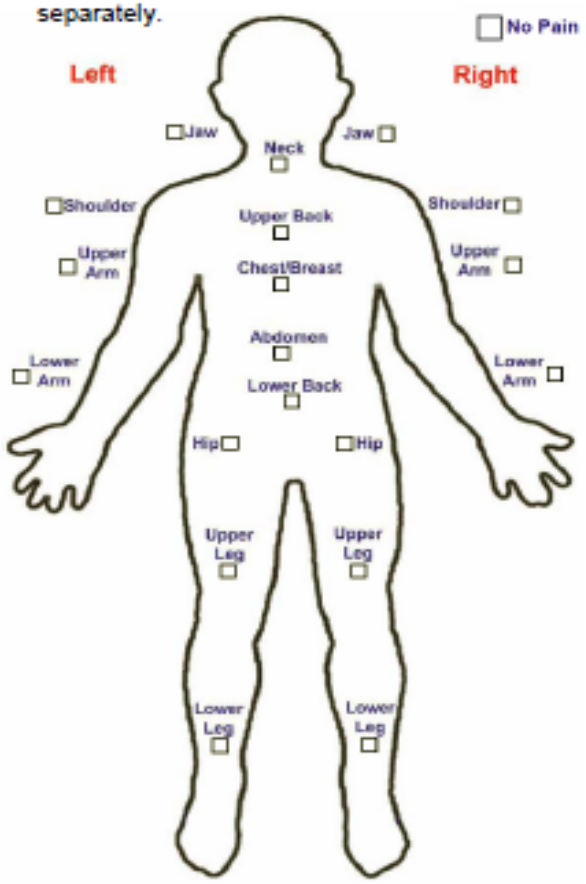
- Term coined by Wolfe to indicate that the symptoms of FM occur as a continuum in the population rather than being present or absent [1]
- In rheumatic disorders such as osteoarthritis, rheumatoid arthritis, lupus, low back pain, etc. this score is more predictive of pain levels and disability than more objective measures of disease [2,3]
- Domain overlaps with somatization in many regards, and there are many questionnaires that collect somatic symptom counts as a surrogate for this construct

1.Wolfe et. al. *Arthritis Rheum.* Jun 15 2009;61(6):715-716. 2. Wolfe et. al. *2.J Rheumatol.* Feb 1 2011. 3. Clauw DJ. JAMA, 2014.

Concept of "Fibromyalgia-ness"

Fibromyalgia Symptoms (Modified ACR 2010 Fibromyalgia Diagnostic Criteria)

1. Please indicate below if you have had pain or tenderness over the past 7 days in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.



2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

No problem
Slight or mild problems: generally mild or intermittent
Moderate: considerable problems; often present and/or at a moderate level
Severe: continuous, life-disturbing problems

	No problem	Slight or mild	Moderate	Severe
a. Fatigue	☐	☐	☐	☐
b. Trouble thinking or remembering	☐	☐	☐	☐
c. Waking up tired (unrefreshed)	☐	☐	☐	☐

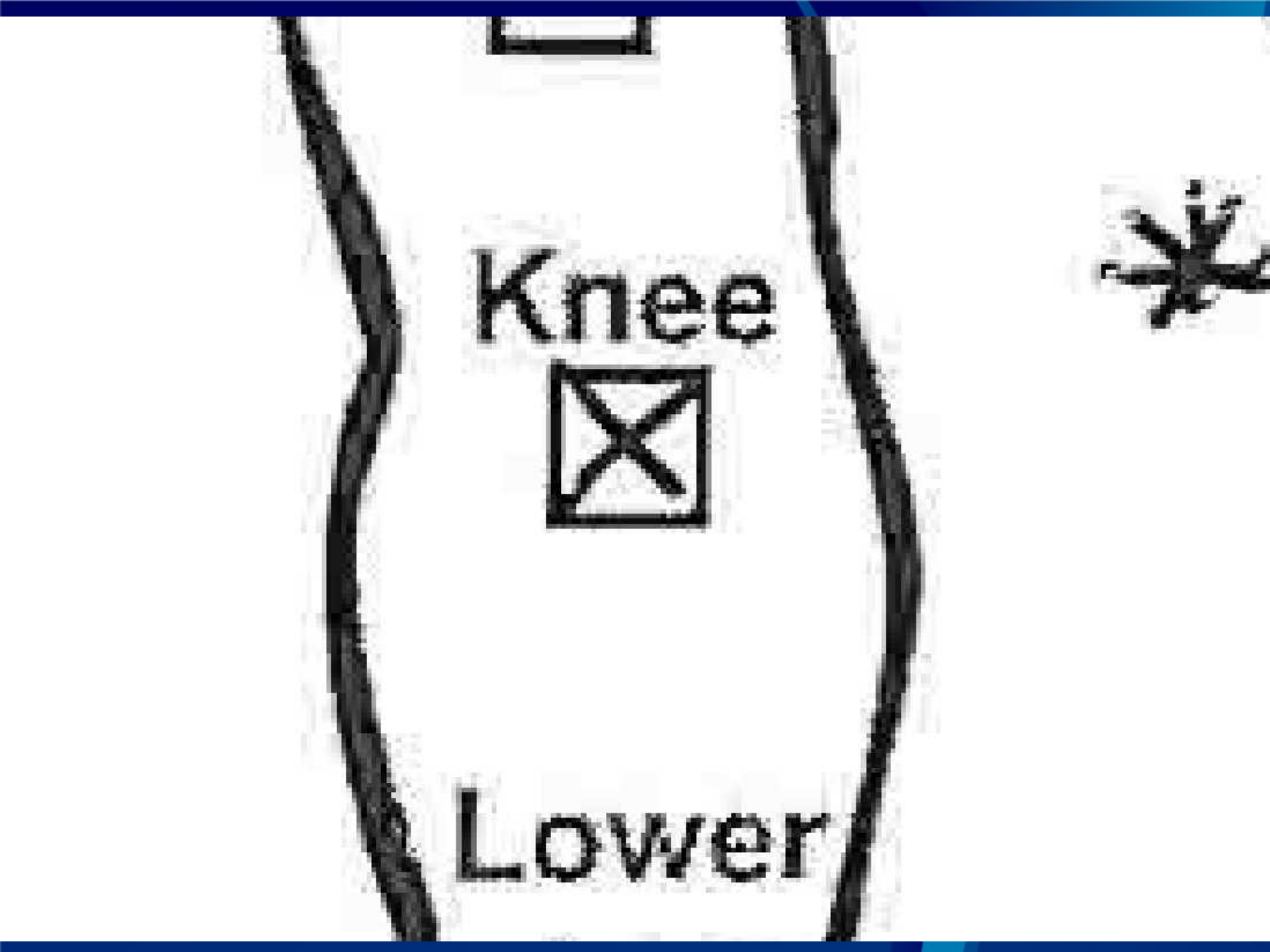
3. During the past 6 months have you had any of the following symptoms?

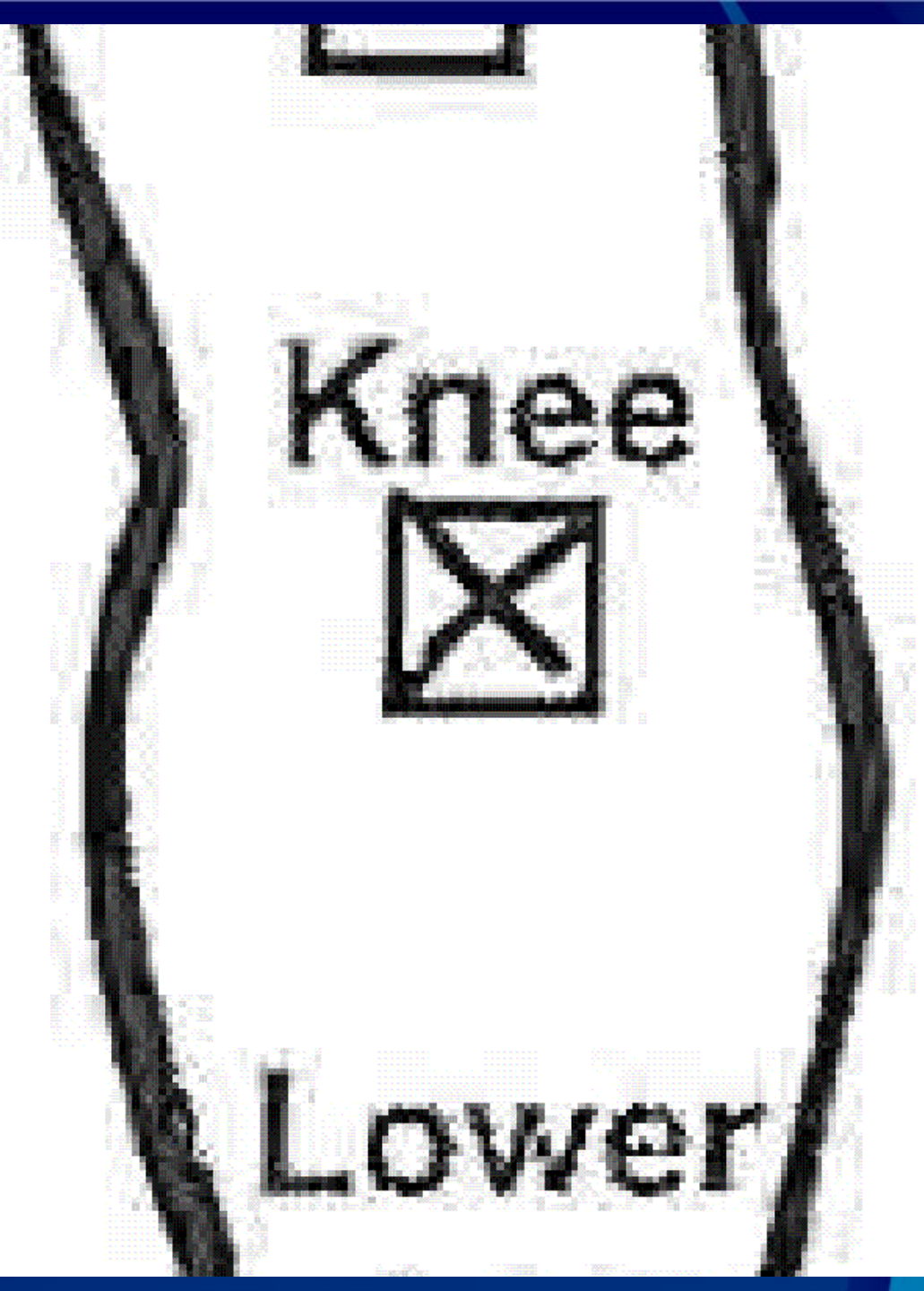
	No	Yes
a. Pain or cramps in lower abdomen	☐	☐
b. Depression	☐	☐
c. Headache	☐	☐

4. Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months? **No** ☐ **Yes** ☐

5. Do you have a disorder that would otherwise explain the pain? **No** ☐ **Yes** ☐

1. Wolfe et. al. *Arthritis Rheum.* Jun 15 2009;61(6):715-716. 2. Wolfe et. al.
2. *J Rheumatol.* Feb 1 2011. 3. Clauw DJ. JAMA, 2014.

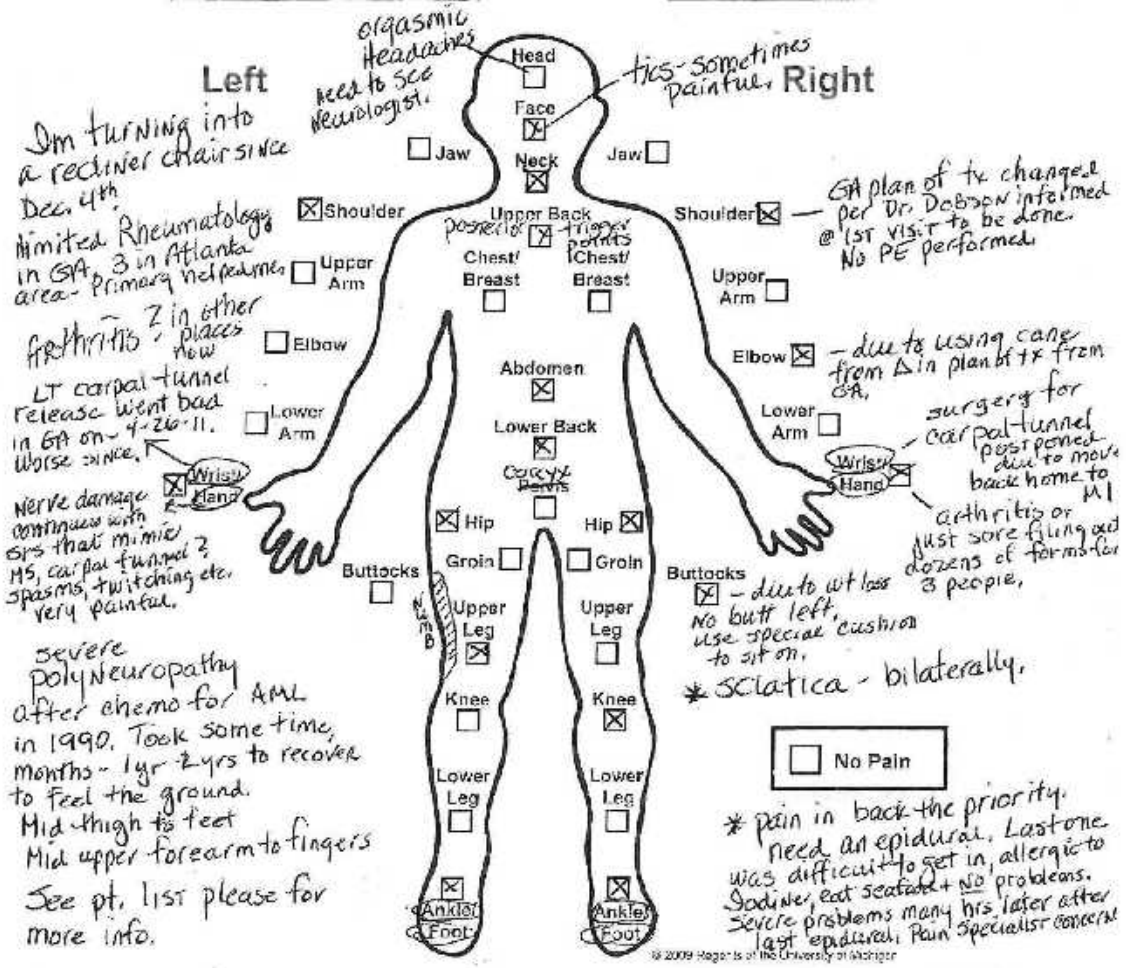

Knee
Lower


Knee
Lower

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS	NAME
Anesthesiology	REG NO.
New Patient Questionnaire - Back and Pain Center	BIRTHDATE

Michigan Body Map

On the image below, identify **all** the areas of your body where you have felt ***persistent or recurrent pain*** present for the last ***3 months or longer***.



Im turning into a recliner chair since Dec. 4th.

limited Rheumatology in GA, 3 in Atlanta area- primary not pediatric

Arthritis? 2 in other places now

LT carpal tunnel release went bad in GA on ~ 4-26-11. Worse since.

Nerve damage continues with Grs that mimic MS, carpal tunnel? spasms, twitching etc. very painful.

severe PolyNeuropathy after chemo for AML in 1990. Took some time, months ~ 1yr 2yrs to recover to feel the ground.
Mid thigh to feet
Mid upper forearm to fingers
See pt. list please for more info.

GA plan of tx changed per Dr. Dobson informed @ 1ST visit to be done. No PE performed.

- due to using cane from Δ in plan of tx from GA.

surgery for carpal tunnel postponed due to move back home to MI

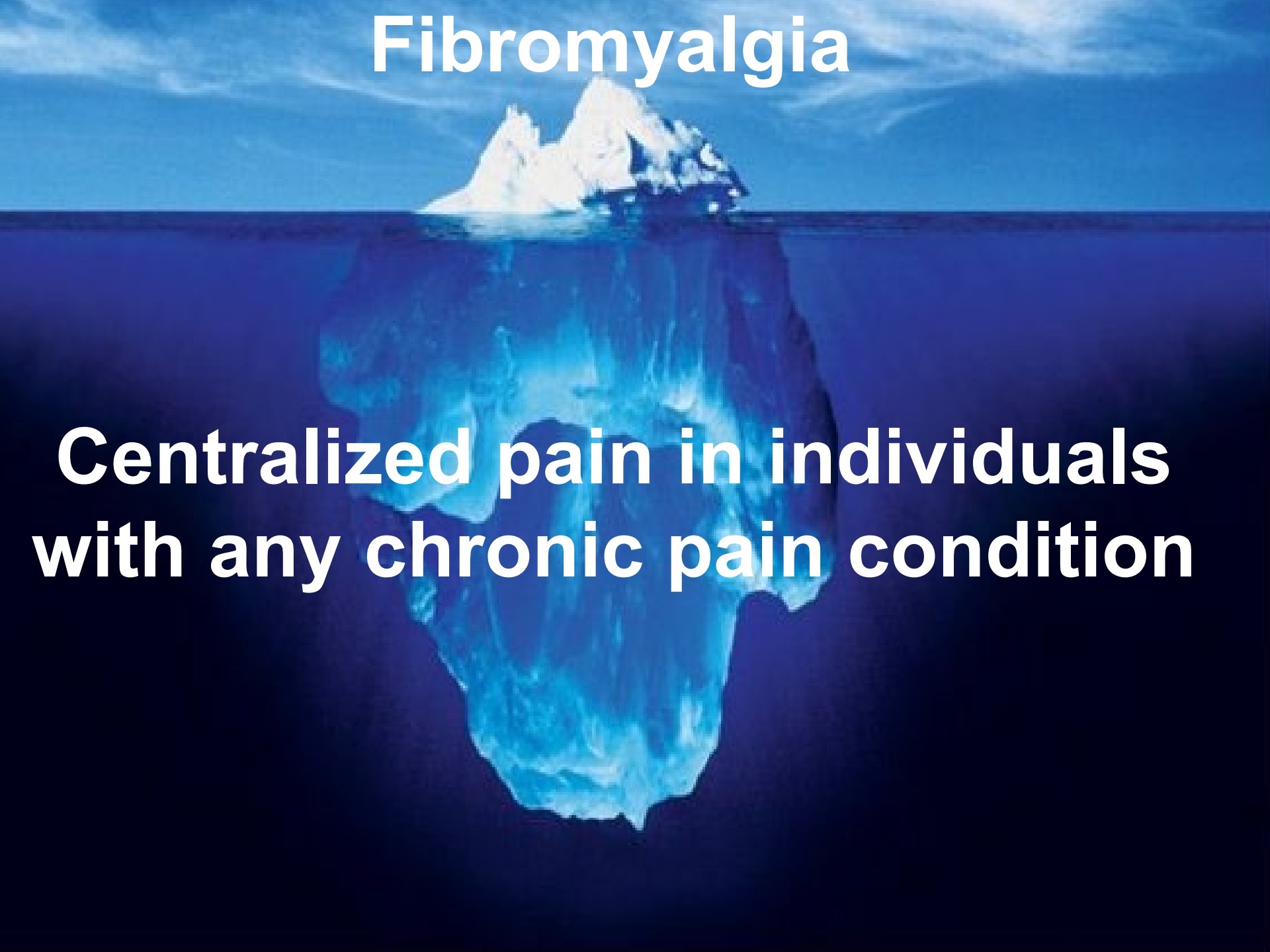
arthritis or just sore filing and dozens of forms for 3 people.

- due to wt loss No butt left, use special cushion to sit on.

* sciatica - bilaterally.

* pain in back the priority. need an epidural. Last one was difficult to get in, allergic to Iodine, eat seafood + No problems. Severe problems many hrs later after last epidural. Pain Specialist concerned

Fibromyalgia



Centralized pain in individuals with any chronic pain condition

Sub-threshold FM is Highly Predictive of Surgery and Opioid Non-responsiveness in Patients Undergoing Arthroplasty and Hysterectomy

- Primary hypothesis of studies is the measures of centralized pain in OA (FMness) will predict failure to respond to arthroplasty and hysterectomy
- Extensive preoperative phenotype using validated self-report measures of pain, mood, and function
- Two outcomes of interest:
  - Postoperative opioid consumption
  - Pain relief from procedure at 6 months

1. Brummett, C.M., et al., Anesthesiology, 2013. **119**(6): p. 1434-43.
2. Brummett, C.M., et al., Arthritis Rheumatol, 2015. 67(5):1386-94.
3. Janda, A.M., et al., Anesthesiology, 2015. **122**(5): p. 1103-11.

Variables Analyzed

- Age
- Sex
- Surgery (Knee vs Hip)
- Primary anesthetic (GA vs neuraxial)
- Home opioids (IVME)
- Pain severity (BPI)
  - Overall
  - Surgical site
- Neuropathic pain score (PainDETECT)
- Depression (HADS)
- Anxiety (HADS)
- Catastrophizing
- Physical function-WOMAC

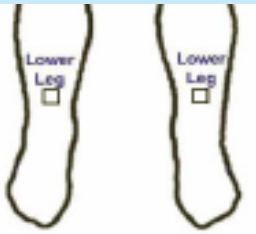
“Fibromyalgia-ness” can be scored 0-31

Fibromyalgia Symptoms (Modified ACR 2010 Fibromyalgia Diagnostic Criteria)

1. Please indicate below if you have had pain or tenderness over the past 7 days in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.

☐ No Pain

Left Right



19/31 potential FM score derived from how widespread pain is

2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

No problem
Slight or mild problems: generally mild or intermittent
Moderate: considerable problems; often present and/or at a moderate level
Severe: continuous, life-disturbing problems

Severe

a. Fatigu ☐
b. Troub reme ☐
c. Wakir (unre ☐

3. During th symptoms?

a. Pain
b. Depre
c. Head

4. Have the at a similar level for

5. Do you h n?

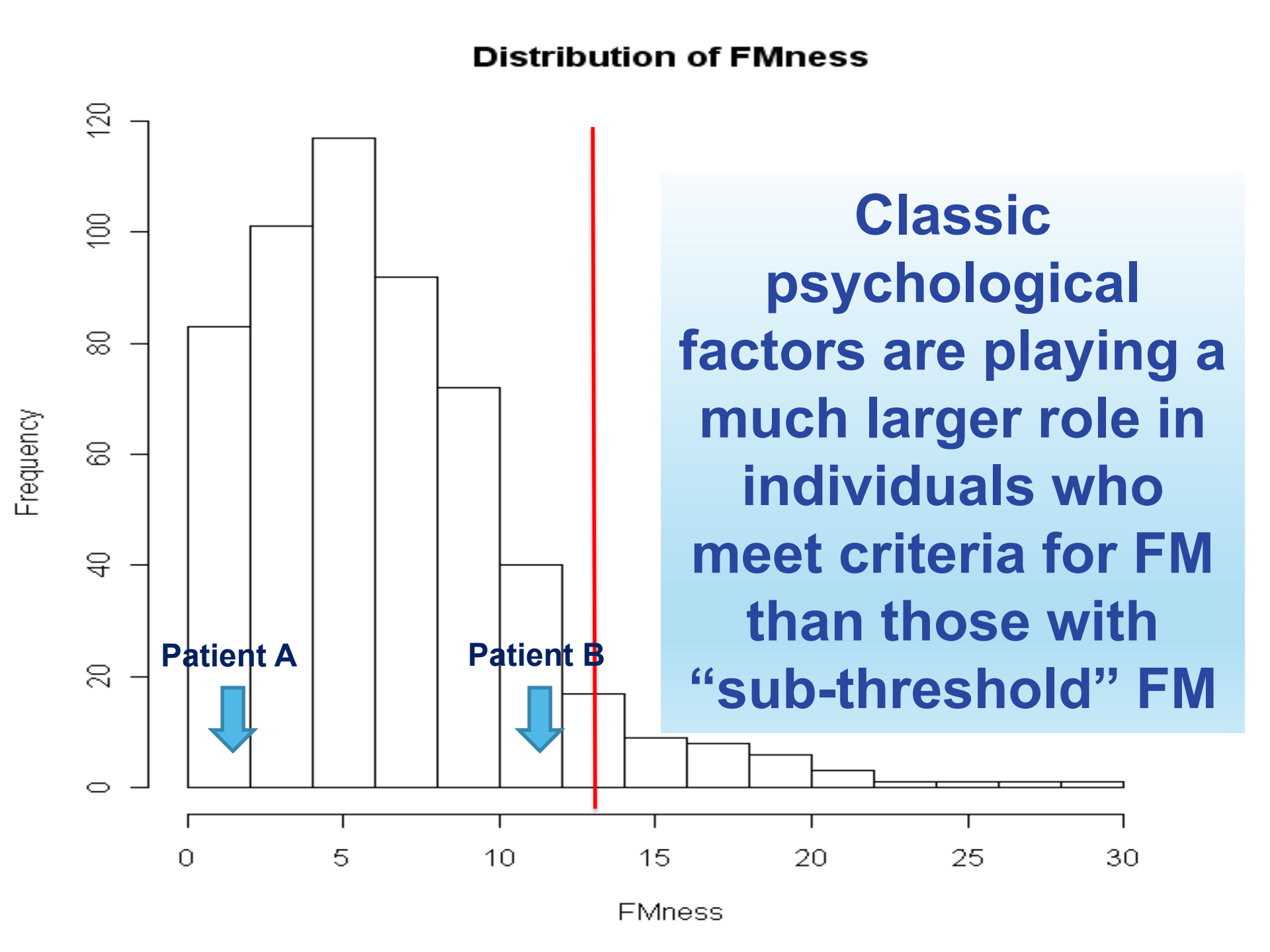
No ☐ Yes ☐

12/31 potential FM score derived from co-morbid CNS-derived symptoms that accompany CNS pain

1. Wolfe et. al. *Arthritis Rheum.* Jun 15 2009;61(6):715-716. 2. Wolfe et. al. *J Rheumatol.* Feb 1 2011. 3. Clauw DJ. JAMA, 2014.

Each one point increase in fibromyalgianess led to:

- 9 mg greater oral morphine requirements during acute hospitalization (8mg greater when all individuals taking opioids as outpatients excluded)
- 20 – 25% greater likelihood of failing to respond to knee or hip arthroplasty (judged by either 50% improvement in pain or much better or very much better on patient global)
- These phenomenon were linear across entire scale up to a score of approximately 18 - and equally strong after individuals who met criteria for FM were excluded
- This phenomenon was much stronger than and largely independent of classic psychological factors


Distribution of FMness
Frequency
0
20
40
60
80
100
120
0
5
10
15
20
25
30
FMness
Patient A
Patient B
Classic psychological factors are playing a much larger role in individuals who meet criteria for FM than those with "sub-threshold" FM

Mechanistic Characterization of Pain

Variable degrees of any mechanism can contribute in any disease

	Nociceptive	Neuropathic	Centralized
Cause	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
Clinical features	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
Screening tools		PainDETECT	Body map or FM Survey
Treatment	NSAIDs, injections, surgery, ? opioids	Local treatments aimed at nerve (surgery, injections, topical) or CNS-acting drugs	CNS-acting drugs, non-pharmacological therapies
Classic examples	Osteoarthritis Autoimmune disorders Cancer pain	Diabetic painful neuropathy Post-herpetic neuralgia Sciatica, carpal tunnel syndrome	Fibromyalgia Functional GI disorders Temporomandibular disorder Tension headache Interstitial cystitis, bladder pain

Mixed Pain States

Centralization Continuum

Proportion of individuals in chronic pain states that have centralized their pain

The widespreadedness of pain (half of the 2011 FM criteria) predicts increased responsiveness to duloxetine in Low Back Pain

- In LBP, responsiveness to duloxetine was strongly related to number of sites on the Michigan Body Map.
  - Average number of sites of pain in this LBP study was 3 – 4
  - At 14 weeks, using any measure of pain improvement, individuals with more body sites of pain were significantly more likely to respond
  - Relative response rate for responders (30% improvement in pain)
    - MBM pain sites = 1 RR = **1.07**
    - MBM sites = 2 **1.30**
    - MBM sites = 3 **1.34**
    - MBM sites = 4 **1.47**
    - MBM sites > 5 **1.60**

1. Alev et. al. Clinical Journal of Pain, 2017

In RA, the residual pain and fatigue seen despite treatment with biologics can be treated as such

- In a large cohort of RA patients being treated at a US academic medical center, 47.3% continued to report having moderate to high levels of pain and fatigue. Most of these patients had minimal signs of inflammation but high levels of FM or Fmness.[1]
- Using quantitative sensory testing, active inflammation was associated with heightened pain sensitivity at joints (peripheral sensitization), whereas poor sleep was associated with diffuse pain sensitivity as noted in FM (central sensitization or centralized pain).[2]
- In a cross-over trial of six weeks of milnacipran in RA patients, in the overall group there was no statistical improvement, but in the subgroup with the least inflammation (swollen joint count </= 1) milnacipran decrease average pain intensity more than placebo (95% CI -2.26 to -0.01, p = 0.04).[3]

1. Lee YC, et. al. *Arthritis Res Ther.* 2009;11(5):R160. 2. Lee YC, et. al. *Arthritis & rheumatology.* 2014;66(8):2006-2014. 3. Lee YC, et. al. *J Rheumatol.* 2016;43(1):38-45.

Samumed WNT inhibitor shows differential responsiveness in OA based on pain centralization

- A small molecule, intra-articular, Wnt pathway inhibitor in development for the treatment of knee OA[1,2]
- In preclinical studies, inhibited inflammation, decreased cartilage degradation, and regenerated cartilage[1]
- In preclinical studies, demonstrated sustained local exposure and no observable systemic toxicity[1,2]
- Previous phase 1 study suggested a single intra-articular SM04690 injection appeared well-tolerated and showed potential for improving symptoms and maintaining joint space width in knee OA subjects[2]

1.Hood J. (2016) Abstract. *Ann Rheum Dis.* 2. Yazici Y. (2016) Abstract. *Ann Rheum Dis.*

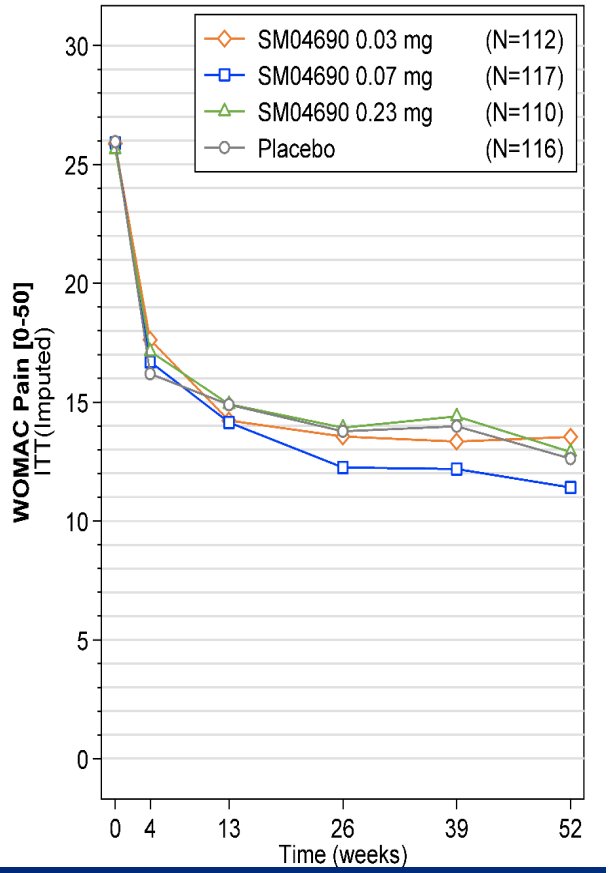
WOMAC Pain [0-50]

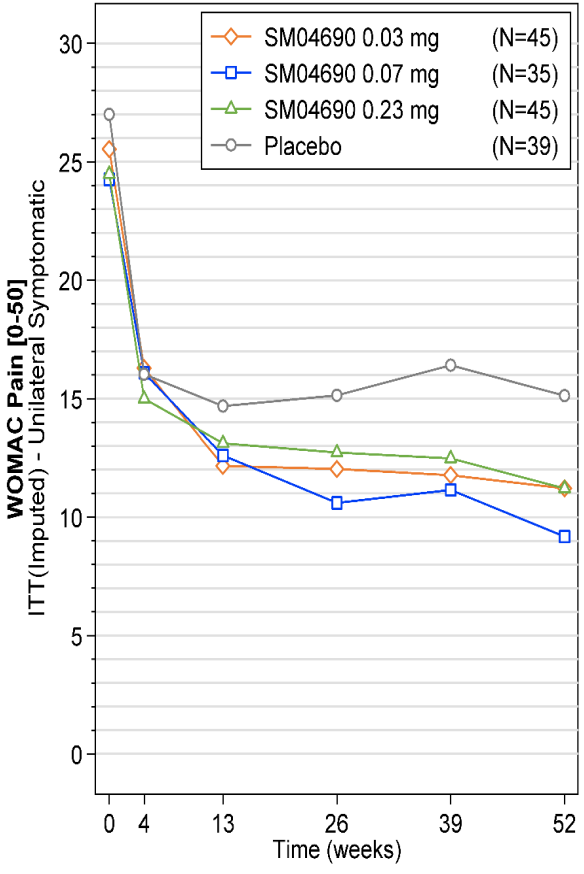
Actual scores (mean)

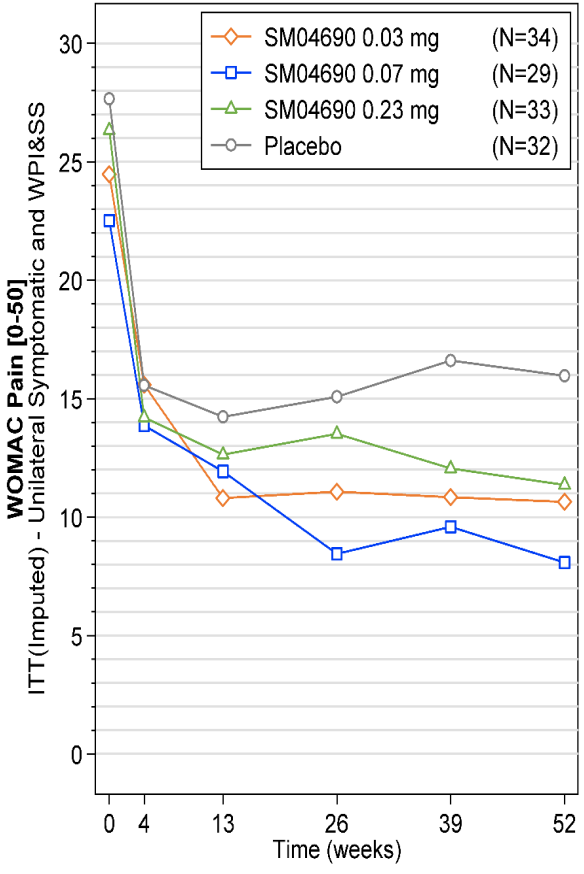
ITT

Unilateral Symptomatic

Unilateral Symptomatic w/o Widespread Pain





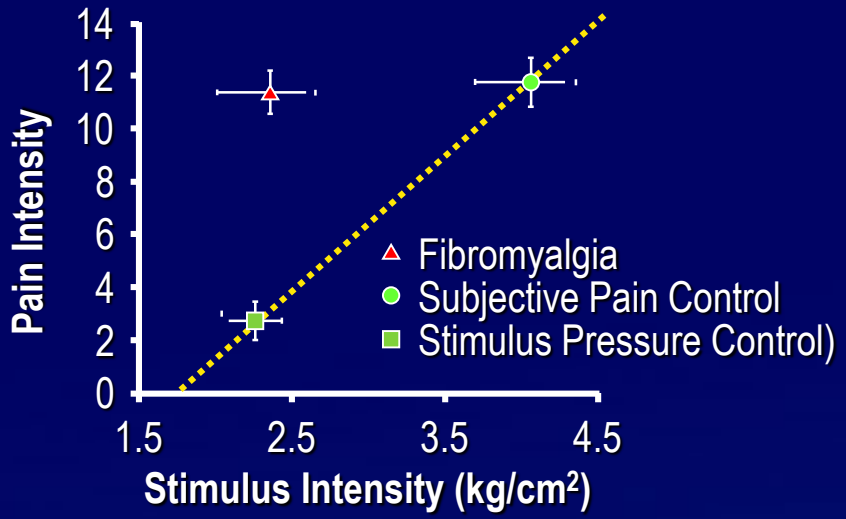


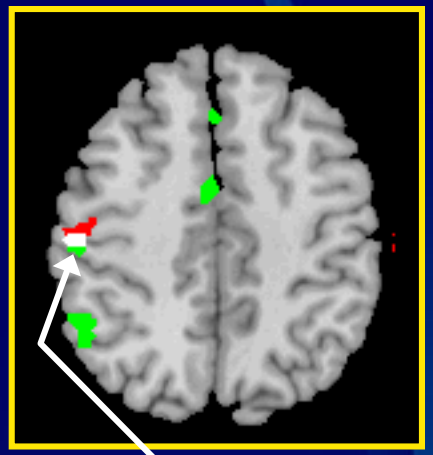
Pathophysiology of centralized pain states

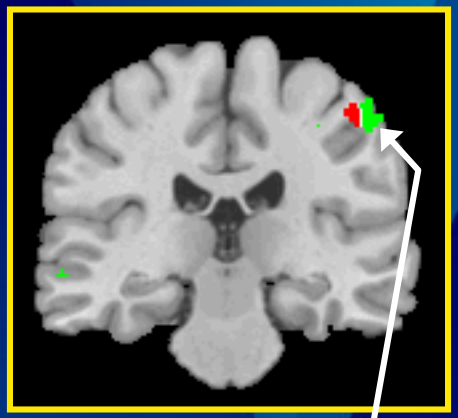
- Most patients display augmented pain and sensory processing on quantitative sensory testing and functional neuroimaging[1,3]
- Manifest by increased connectivity to pro-nociceptive brain regions and decreased connectivity to anti-nociceptive regions[2,3]
- These abnormalities are being driven by imbalances in concentrations of CNS neurotransmitters that control sensory processing, sleep, alertness, affect, memory[3,4]
- Autonomic, HPA, and peripheral abnormalities likely play a prominent role in some individuals

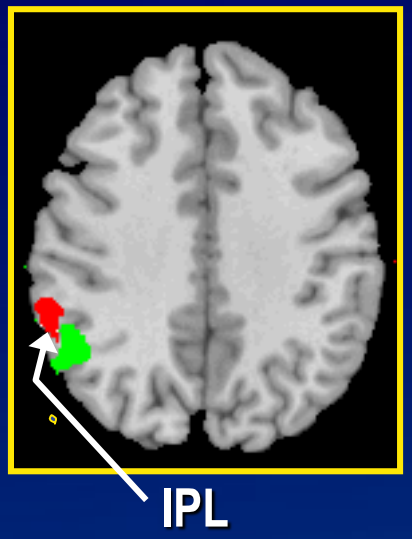
1. Phillips, K. and D.J. Clauw. Arthritis Rheum, 2013. **65**(2): p. 291-302. 2. Napadow, V., et al., Arthritis Rheum, 2012. **64**(7): p. 2398-403. 3. Harris, R.E., et. al. Anesthesiology, 2013. **119**(6): p. 1453-1464. 4.Schmidt-Wilcke, T. and D.J. Clauw, Nature reviews. Rheumatology, 2011. **7**(9): p. 518-27.

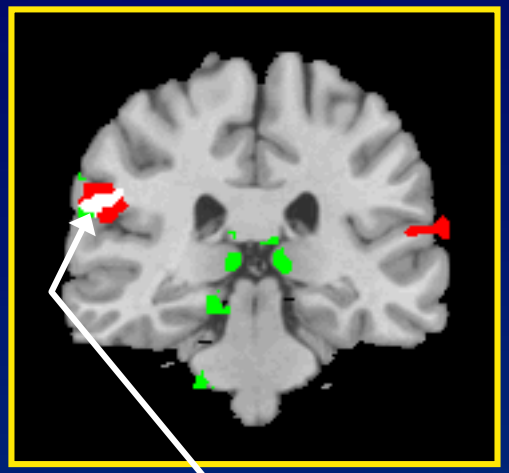
fMRI in Fibromyalgia

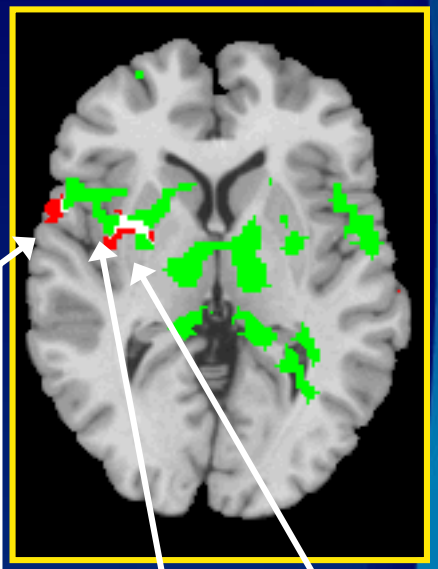


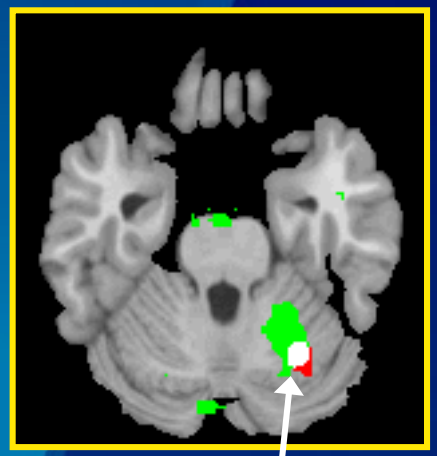








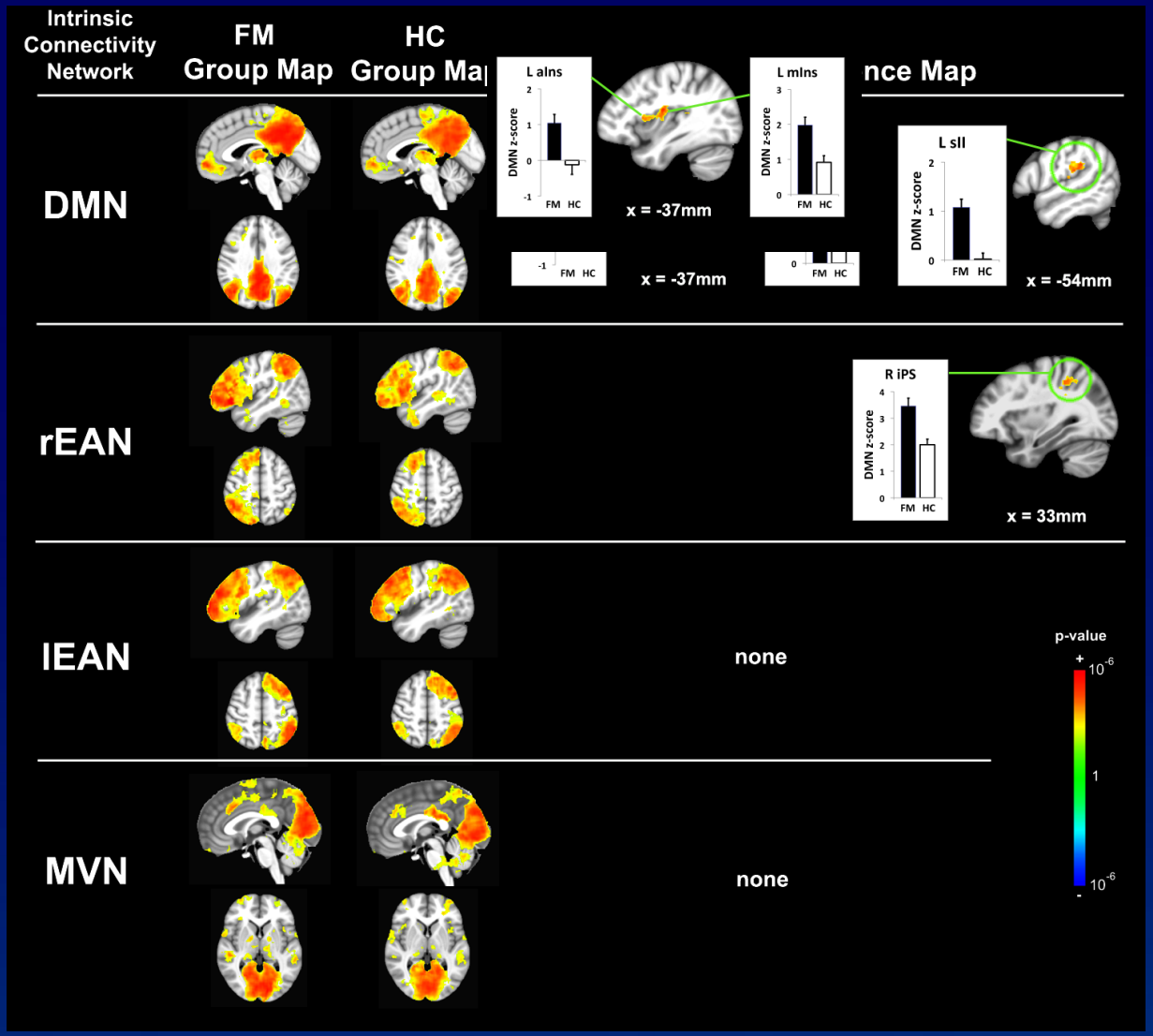




STG=superior temporal gyri; SI=primary somatosensory cortex
SII=secondary somatosensory cortex; IPL=inferior parietal lobule.

Gracely. *Arthritis Rheum*. 2002;46:1333-1343.

Intrinsic Brain Connectivity is Altered in FM patients



- In FM, DMN and rEAN show greater intrinsic connectivity within component DMN (PCC), and rEAN (iPS) as well as limbic (insula), and sensorimotor (SII) regions outside conventional network boundaries.

- All FM vs. HC differences driven by greater connectivity for FM patients.

Napadow et al, *Arthritis Rheumatism* 2010

Changes in size and shape of brain regions indicate CNS neuroplasticity in chronic pain

- Apkarian[1] was first to show that chronic pain may be associated with decrease of size of brain areas involved in pain processing
- More recently seen in virtually all other chronic pain states including headache,[2] IBS,[3] FM[4]
- May be partially due to co-morbid mood disturbances[6]
- Data from NIH MAPP network presented at 2016 IASP (Kutch et. al.) suggests *increase* in size of and connectivity to S1 may represent neural signature for widespreadedness of pain

1. Apkarian et al. *J Neurosci*. 2004;24:10410-5. 2. Schmidt-Wilcke et al. *Pain*. 2007;132 Suppl 1:S109-16.
3. Davis et al. *Neurology*. 2008;70:153-4. 4. Kuchinad et al. *J Neurosci*. 2007;27:4004-7.
5. Chen et al. *Psychiatry Res*. 2006;146:65-72. 6. Hsu et. al. *Pain*. Jun 2009;143(3):262-267. 7. Kutch et. al. IASP 2016

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AMERICAN COLLEGE OF RHEUMATOLOGY

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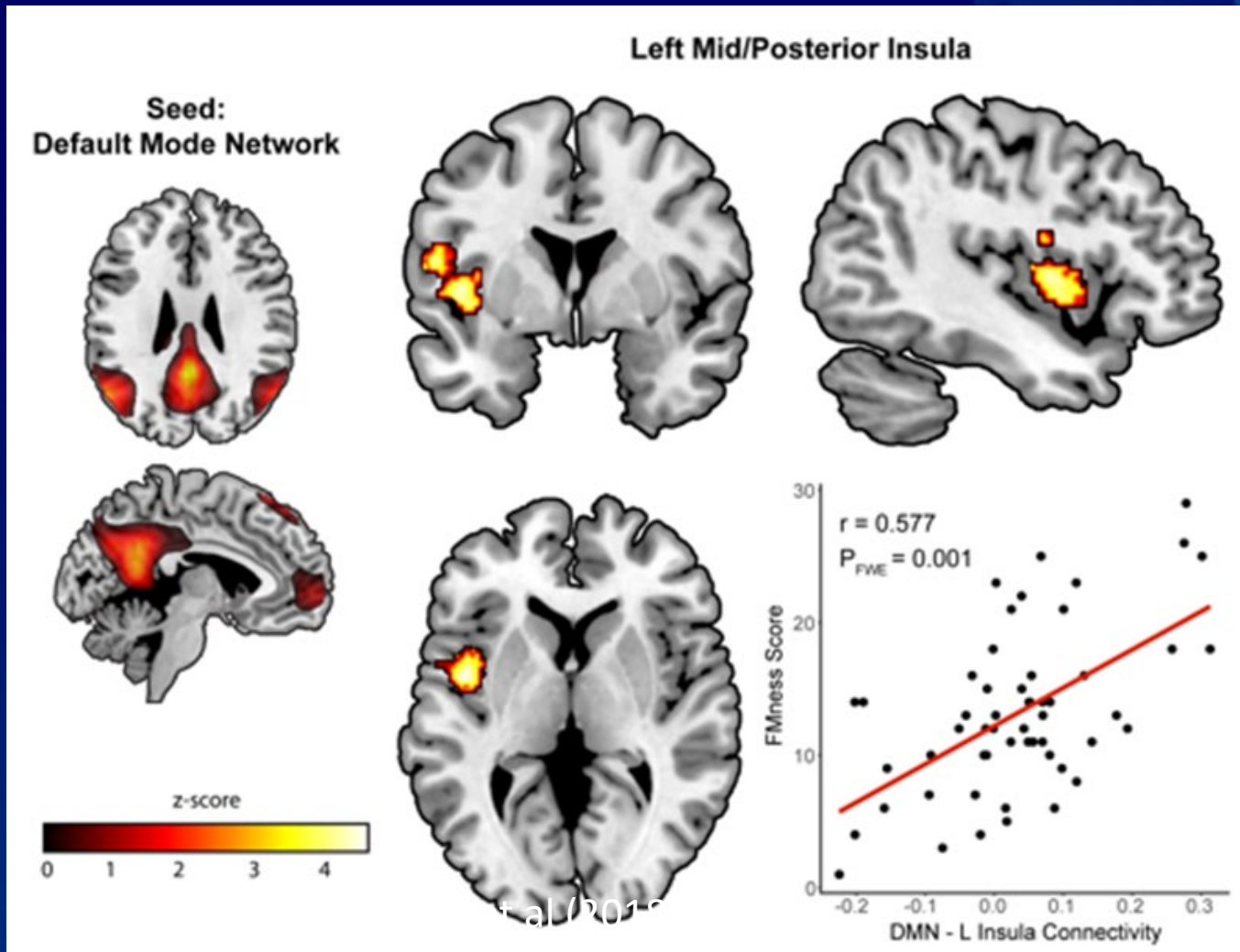
Neurobiologic Features of Fibromyalgia Are Also Present Among Rheumatoid Arthritis Patients

Neil Basu MD, PhD, Chelsea M. Kaplan PhD, Eric Ichesco BS, Tony Larkin BS, Richard E. Harris PhD, Alison Murray MD, PhD, Gordon Waiter PhD, Daniel J. Clauw MD



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A multi-modal MRI study of the central response to inflammation in rheumatoid arthritis

Andrew Schrepf, Chelsea M. Kaplan, Eric Ichesco, Tony Larkin, Steven E. Harte, Richard E. Harris Alison D. Murray, Gordon D. Waiter, Daniel J. Clauw & Neil Basu

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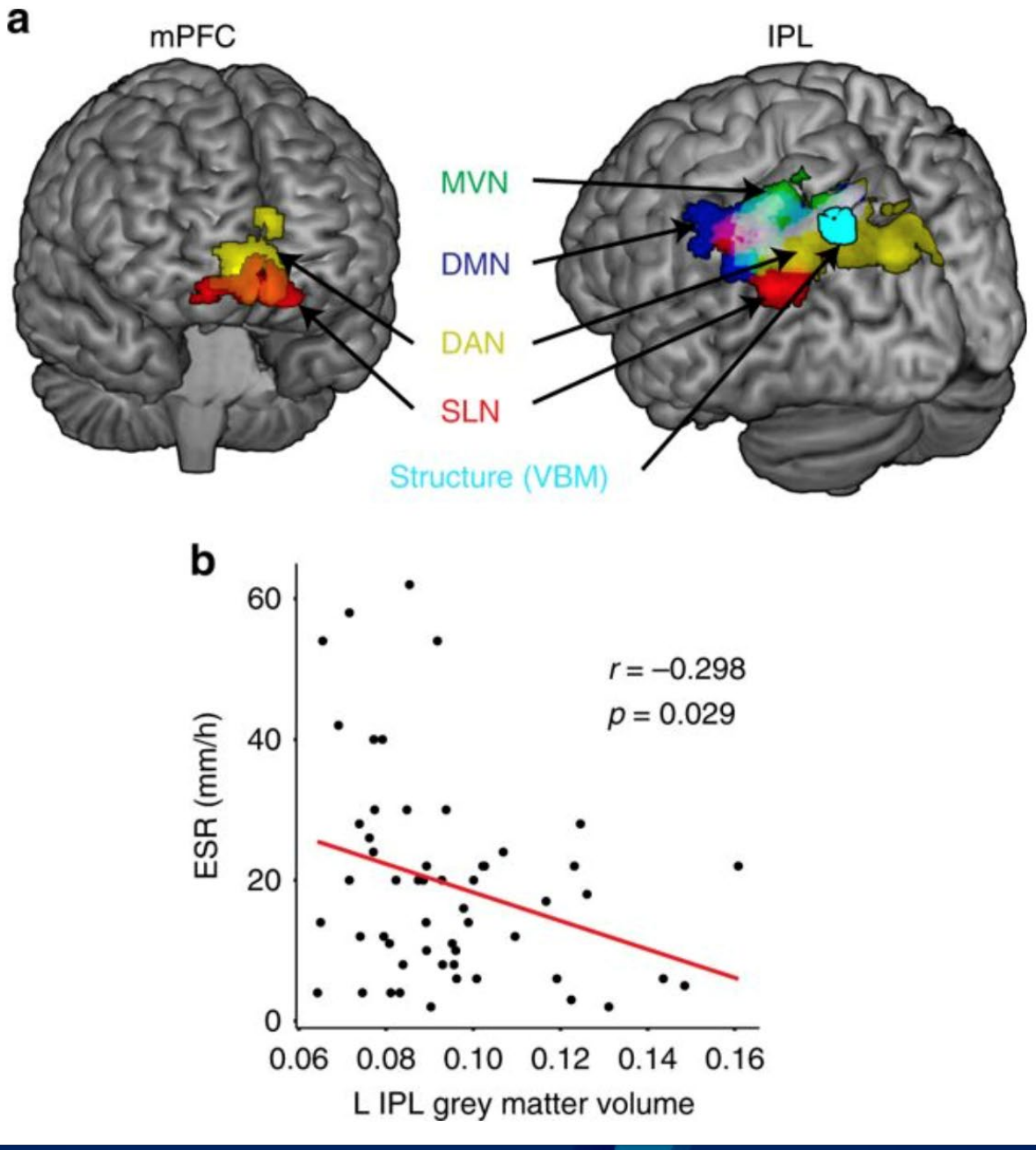

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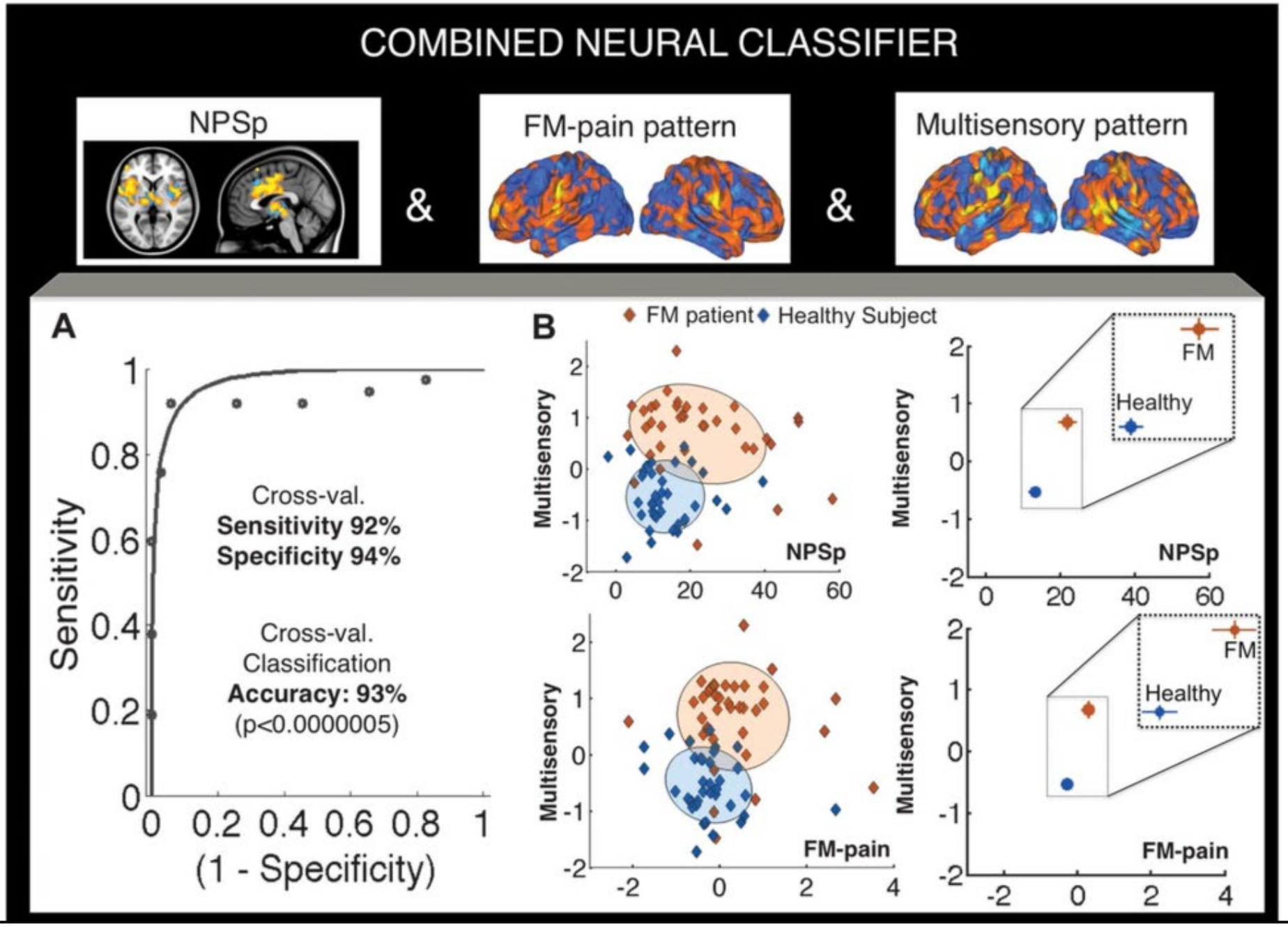
Towards a neurophysiological signature for fibromyalgia

Marina López-Solà[a,b,*], Choong-Wan Woo[a,b], Jesus Pujol[c], Joan Deus[c,d,e], Ben J. Harrison[f], Jordi Monfort[g], Tor D. Wager[a,b]

Abstract

Patients with fibromyalgia (FM) show characteristically enhanced unpleasantness to painful and nonpainful sensations accompanied by altered neural responses. The diagnostic potential of such neural alterations, including their sensitivity and specificity to FM (vs healthy controls) is unknown. We identify a brain signature that characterizes FM central pathophysiology at the neural systems level. We included 37 patients with FM and 35 matched healthy controls, and analyzed functional magnetic resonance imaging responses to (1) painful pressure and (2) nonpainful multisensory (visual–auditory–tactile) stimulation. We used machine-learning techniques to identify a brain-based FM signature. When exposed to the same painful stimuli, patients with FM showed greater neurologic pain signature (NPS; Wager et al., 2013. An fMRI-based neurologic signature of physical pain. N Engl J Med 2013;368:1388–97) responses. In addition, a new pain-related classifier ("FM-pain") revealed augmented responses in sensory integration (insula/operculum) and self-referential (eg, medial prefrontal) regions in FM and reduced responses in the lateral frontal cortex. A "multisensory" classifier trained on nonpainful sensory stimulation revealed augmented responses in the insula/operculum, posterior cingulate, and medial prefrontal regions and reduced responses in the primary/secondary sensory cortices, basal ganglia, and cerebellum. Combined activity in the NPS, FM pain, and multisensory patterns classified patients vs controls with 92% sensitivity and 94% specificity in out-of-sample individuals. Enhanced NPS responses partly mediated mechanical hypersensitivity and correlated with depression and disability ($P_{uncorrected} < 0.05$); FM-pain and multisensory responses correlated with clinical pain ($P_{uncorrected} < 0.05$). The study provides initial characterization of individual patients with FM based on pathophysiological, symptom-related brain features. If replicated, these brain features may constitute objective neural targets for therapeutic interventions. The results establish a framework for assessing therapeutic mechanisms and predicting treatment response at the individual level.

Keywords: Fibromyalgia, fMRI, Brain, Chronic pain, Multisensory, Pressure, Machine learning, Predict


COMBINED NEURAL CLASSIFIER
NPSp
&
FM-pain pattern
&
Multisensory pattern
A
Sensitivity
(1 - Specificity)
Cross-val.
Sensitivity 92%
Specificity 94%
Cross-val.
Classification
Accuracy: 93%
(p<0.0000005)
B
FM patient
Healthy Subject
Multisensory
NPSp
FM-pain
FM
Healthy

Pharmacological Therapies for Fibromyalgia (i.e. Centralized Pain)

Strong Evidence	▪ Dual reuptake inhibitors such as
	  ▪ Tricyclic compounds (amitriptyline, cyclobenzaprine)
	  ▪ SNRIs and NSRIs (milnacipran, duloxetine, venlafaxine?)
	▪ Gabapentinoids (e.g., pregabalin, gabapentin)

Modest Evidence	▪ Tramadol ▪ Older less selective SSRIs ▪ Gamma hydroxybutyrate ▪ Low dose naltrexone ▪ Cannabinoids
Weak Evidence	▪ Growth hormone, 5-hydroxytryptamine, tropisetron, S-adenosyl-L-methionine (SAMe)
No Evidence	▪ Opioids, corticosteroids, nonsteroidal anti-inflammatory drugs, benzodiazepine and nonbenzodiazepine hypnotics, guanifenesin

Modified from Clauw *JAMA*. 2014

CNS Neurotransmitters Influencing Pain

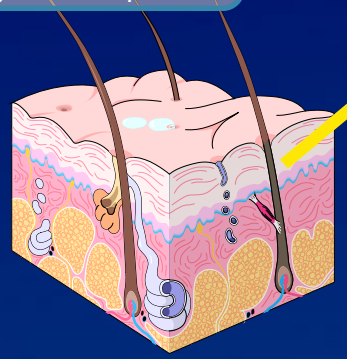
Arrows indicate direction in Fibromyalgia

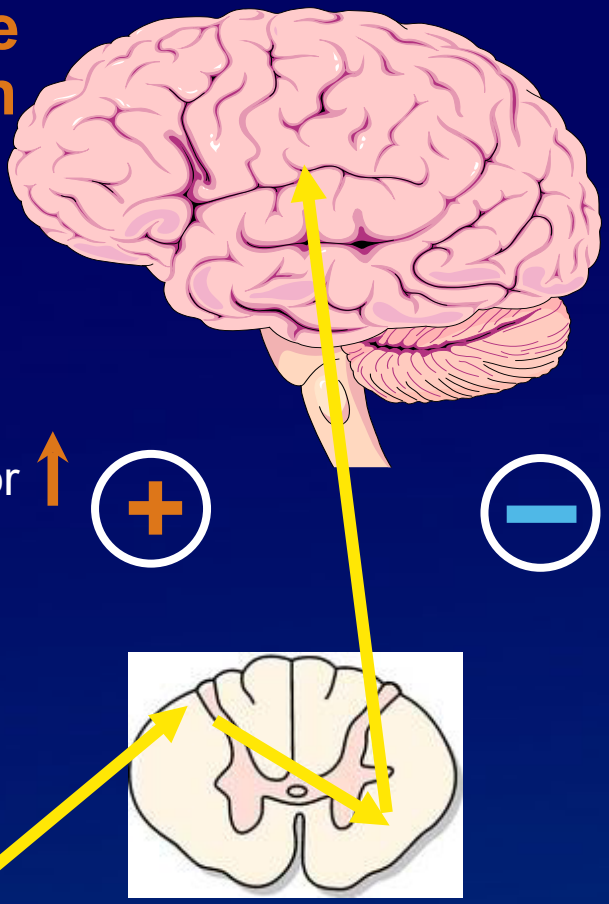
Generally facilitate pain transmission

Gabapentinoids, ketamine, memantine

- Glutamate ↑
- Substance P ↑
- Nerve growth factor ↑
- Serotonin ($5HT_{2a,\ 3a}$)

Anti-migraine drugs (–triptans), cyclobenzaprine





Generally inhibit pain transmission

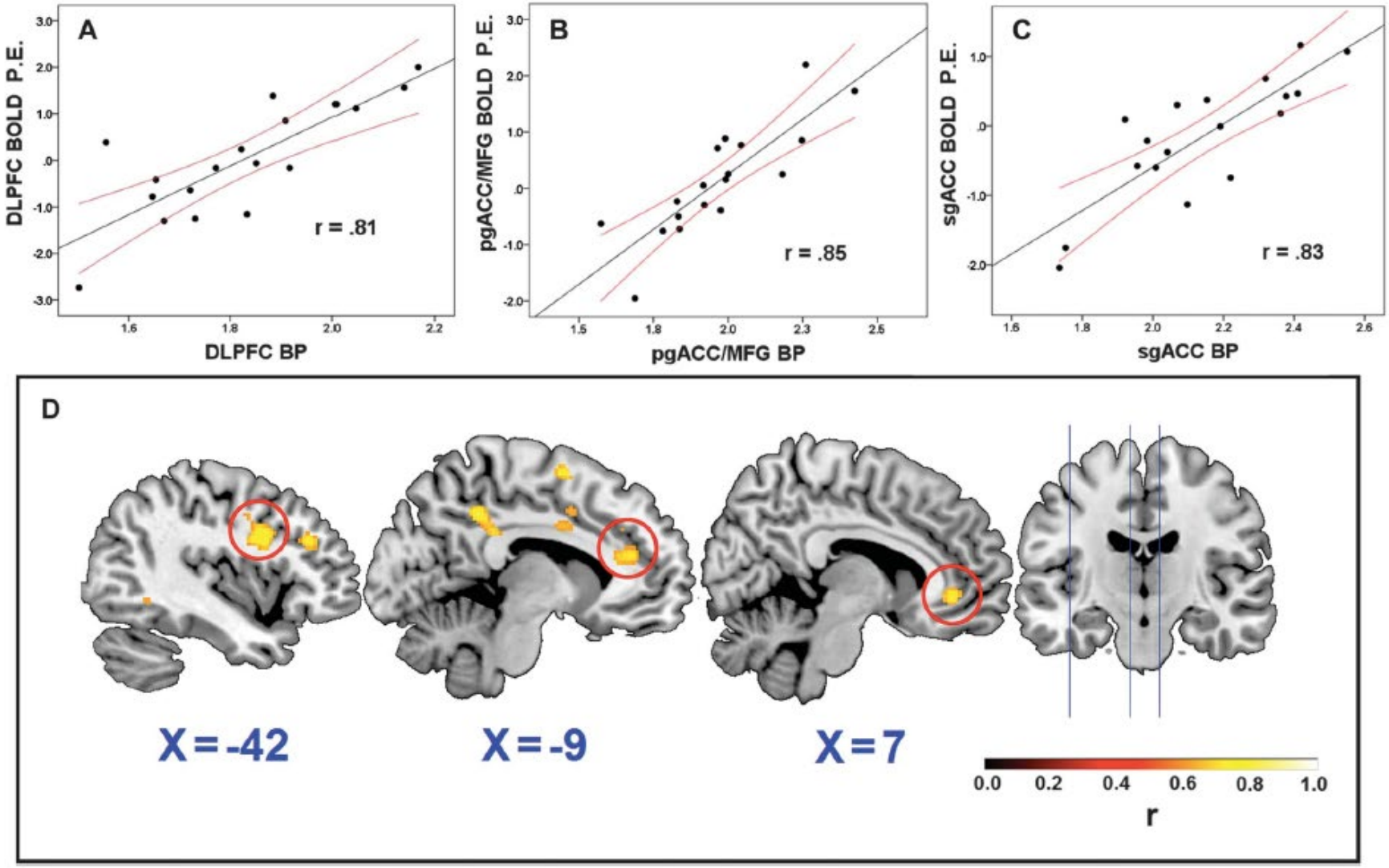
- Descending anti-nociceptive pathways
  - ↓ Norepinephrine-serotonin ($5HT_{1a,b}$), dopamine
    - Tricyclics, SNRIs. tramadol
  - ↑ Opioids
    - Low dose naltrexone
  - Cannabinoids
  - ↓ GABA
    - Gammahydroxybutyrate moderate alcohol consumption
    - No knowledge of endocannabinoid activity but this class of drugs is effective

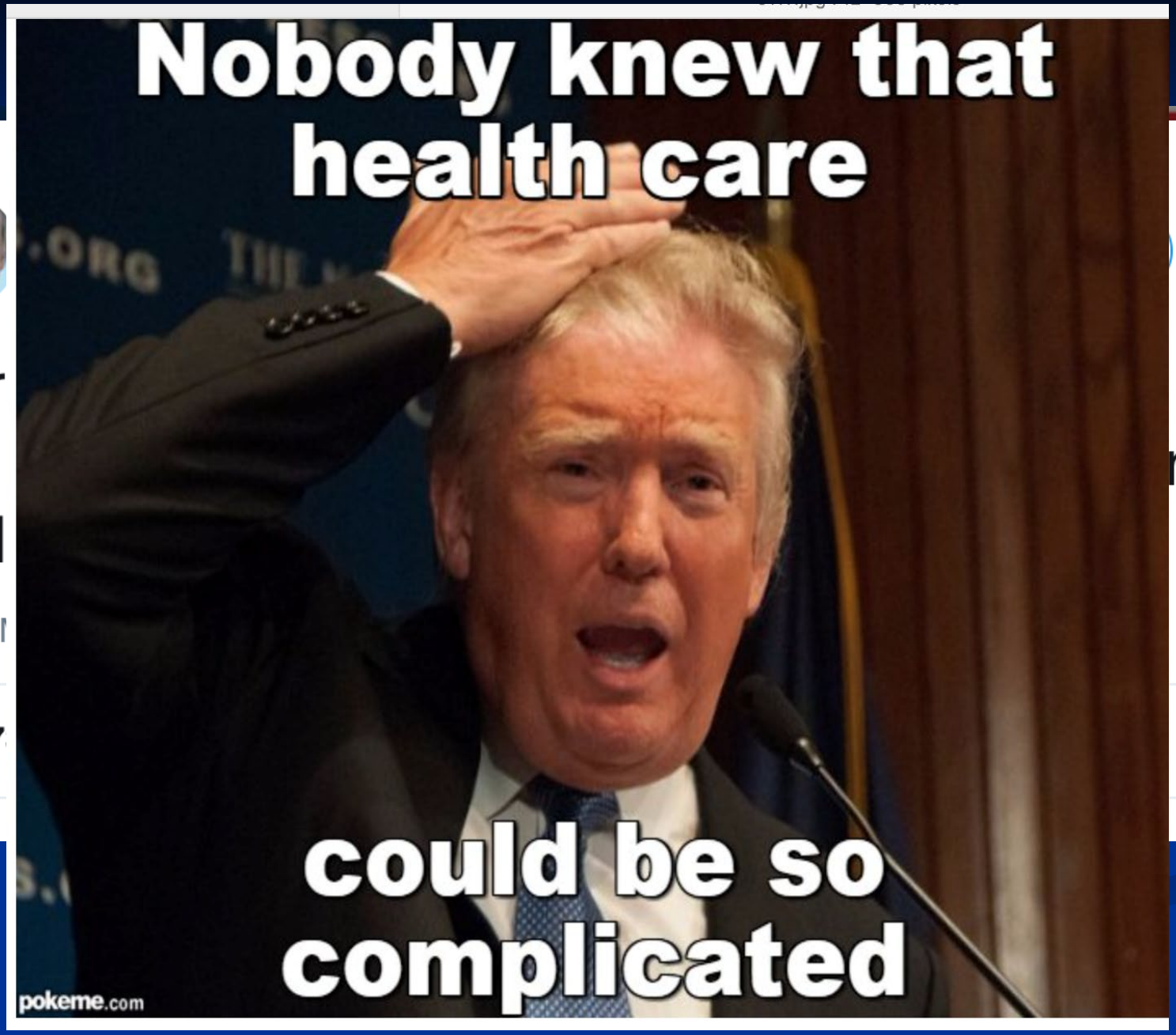
1. Schmidt-Wilcke T, Clauw DJ. *Nat Rev Rheumatol.* Jul 19 2011.
2. Clauw DJ. JAMA. 2014.

PAIN

Endogenous opioidergic dysregulation of pain in fibromyalgia: a PET and fMRI study

Andrew Schrepf[a,*], Daniel E. Harper[a], Steven E. Harte[a], Heng Wang[a], Eric Ichesco[a], Johnson P. Hampson[a], Jon-Kar Zubieta[b], Daniel J. Clauw[a], Richard E. Harris[a]




Nobody knew that
health care
could be so
complicated
pokeme.com

Commentary

PAIN®

Hijacking the endogenous opioid system to treat pain: who thought it would be so complicated?

Daniel Clauw

In this issue, there is an especially interesting and important special review by Ballantyne and Sullivan entitled, "The discovery of endogenous opioid systems: what it has meant for the clinician's understanding of pain and its treatment".[1] This review adds to these authors' significant prior contributions to the pain field, as they are now proposing that many of the problems associated with opioid therapy can be understood mechanistically as being off-target effects on the endogenous opioid system. They describe how our emerging understanding of the endogenous opioid system might allow us to better understand how exogenous opioids can "hijack" this system to produce unexpected and undesired consequences, both when they are used for pain relief, and when they are misused or abused. They especially focus on how acute or chronic opioid therapy (COT) may impair some of the nonanalgesic functions of the endoge-

These issues of excess death and addiction, combined with a lack of any evidence of long-term efficacy,[3] have led many of us in the pain field to question whether opioid should ever be used to treat chronic nonmalignant pain. We know of some patients with chronic pain who are on long-term high-dose opioid therapy who are doing well (ie, have good pain control and good functional status), but these patients are exceedingly rare. Instead, we see large numbers of individuals who want to keep taking opioids, although after we assess them, we conclude that the long-term side effects of these drugs far exceed any benefit they are receiving.

This review highlights why we may see some of the more insidious problems that occur with COT, which are summarized below.

Individuals on COT may continue to "need" opioids to replicate the functions of endogenous opioids that are no longer being

And what about those patients already on opioids?

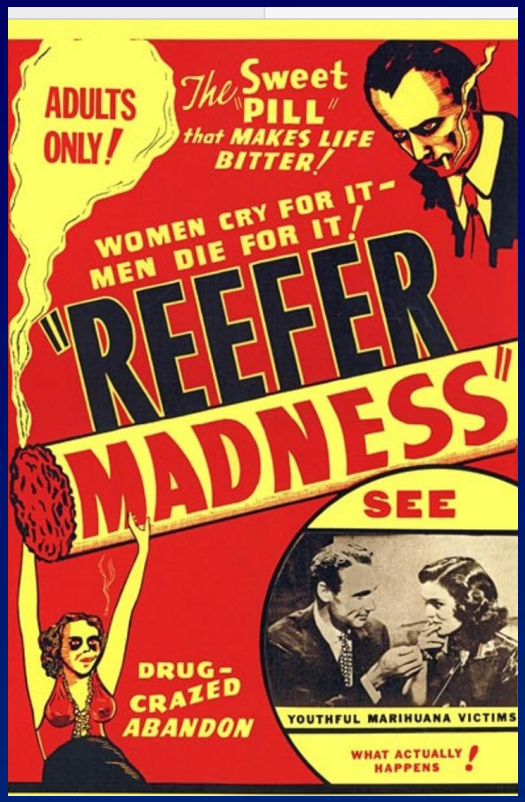
- Don't try to take them away – try to convince the patient that the risk outweighs the benefit
  - US consumes over 80% of world's opioids annually
  - 30% increase in annual all-cause mortality[1]
- A slow gradual taper of opioids rarely leads to worsening of chronic pain
  - Use the patients own history to point out that opioids have not improved pain and function, or are leading to side effects
- Discern what symptom(s) opioids are treating
- Consider opioid-sparing drugs
  - Mixed opioids (tapentadol, buprenorphine)
  - Gabapentinoids
  - Cannabinoids[2]

1. Ray et. al JAMA 2016 2. Boehnke et. al Pain 2016

How useful do you feel cannabinoids are for treating pain?

0 — 10

Worthless — Wonderful



Pragmatic Advice for Using Cannabinoids in 2019

- Where possible use a cannabinoid or cannabinoid extract of consistent and known potency
- Start with 5 – 10 mg of CBD twice daily and go up to as high as 50 – 100mg per day
- If CBD alone ineffective then go to low dose of low THC:high CBD strain and go up slowly
- Emerging evidence of U-shaped curve
- Oral dosing better once stable dose and strain identified
- The strongest recommendation based on current benefit: risk data is for the use of cannabinoids instead of opioids for neuropathic or centralized pain states
  - Data from US suggest that legalizing cannabis in a state leads to fairly dramatic reductions in opioid overdoses[1]

CBD, cannabidiol; THC, tetrahydrocannabinol

1. Bachhuber MA, et. al. JAMA Int Med 2014;174:1668-73.

Proposed marketing program for medical cannabis

Cannabis plant talking to opium producing poppy plant

We don't suck as bad as you do

Treating Based on Mechanisms

Any combination may be present

	Peripheral (nociceptive)	Neuropathic	Centralized Pain
NSAIDs	+	-	-
Opioids	+	+	-
Surgery/ Injections	+	+	-
Tricyclics	+	+	+
SNRIs	+	+	+
Gabapentinoid	-	+	+
CBD	+	-	-
THC	-	+	+

Symptoms of Pain, Fatigue, etc.

- Nociceptive processes (damage or inflammation of tissues)
- Disordered sensory processing

Functional Consequences of Symptoms

- Increased stress
- Decreased activity
- Poor sleep
- Obesity
- Maladaptive illness behaviors

Dually Focused Treatment

- Pharmacological therapies to improve **symptoms**
- Nonpharmacological therapies to address **dysfunction**

Clauw and Crofford. *Best Pract Res Clin Rheumatol*. 2003;17:685-701.

Nonpharmacological Therapies are similar to those for any Chronic Pain State

Strong Evidence	▪ Education ▪ Aerobic exercise ▪ Cognitive behavior therapy
Modest Evidence	▪ Strength training ▪ Hypnotherapy, biofeedback, balneotherapy, yoga, Tai Chi ▪ Neuromodulation ▪ Acupuncture, chiropractic, manual and massage therapy
Weak Evidence	▪ Trigger point injections
No Evidence	▪ Doing nothing

Modified from Clauw *JAMA*. 2014

www.fibroguide.com

- Program features 10 CBT modules:
  - Understanding Fibromyalgia
  - Being Active
  - Sleep
  - Relaxation
  - Time for You
  - Setting Goals
  - Pacing Yourself
  - Thinking Differently
  - Communicating
  - Fibro Fog

- In a RCT of 118 FM patients comparing the earlier version of this website plus usual care, to usual care alone, Williams demonstrated statistically significant improvements in pain (29% in the WEB group had 30% improvement in pain vs 8% in usual care, p=.009) and function (i.e., 31% in WEB-SM had .5 SD improvement in SF-36 PF vs. 6% in standard care, p<.002) Williams et. al. Pain. 2010;151(3):694-702

Emerging Issues in Chronic Pain

- Vitamin D
- Small fiber neuropathy
- Neuroinflammation/Glial activation
- Diet/nutrition

Can we use diet/nutrition to treat chronic pain?

Andrew Schrepf,* Steven E. Harte,* Nicole Miller,† Christine Fowler,† Catherine Nay,† David A. Williams,* Daniel J. Clauw,* and Amy Rothberg†,‡

*Chronic Pain and Fatigue Research Center, Department of Anesthesiology,†Department of Internal Medicine, ‡School of Public Health, University of Michigan, Ann Arbor, Michigan.

Abstract: **Weight loss is known to improve pain localized to weight-bearing joints but it is not known how weight loss affects the spatial distribution of pain and associated somatic symptoms like fatigue. We sought to determine if weight loss using a low-calorie diet improves pain, affect, and somatic symptoms commonly associated with chronic pain conditions in an observational study. We also documented changes in inflammatory markers in serum before and after weight loss. Participants were 123 obese individuals undergoing a 12- to 16-week calorie restriction weight loss intervention. The spatial distribution of pain, symptom severity (eg, fatigue, sleep difficulties), depression, and total fibromyalgia scale scores were measured before and after weight loss. Pain ($P = .022$), symptom severity ($P = .004$), depression ($P < .001$), and fibromyalgia scores ($P = .004$) improved after weight loss; men showed greater improvement than women on somatic symptoms and fibromyalgia scores (both $P < .01$). Those who lost at least 10% of body weight showed greater improvement than those who lost <10%. Levels of the regulatory cytokine interleukin-10 increased after the intervention ($P = .002$). Weight loss may improve diffuse pain and comorbid symptoms commonly seen in chronic pain participants.**

Perspective: ***This article presents the effect of a weight loss intervention on characteristics of chronic pain, including the spatial distribution of pain and comorbid somatic symptoms. Weight loss appeared to produce larger improvements in somatic symptoms for men.***

VA/DoD Stepped Care Model for Pain Management

Stepped Care Model for Pain Management (SCM-PM)

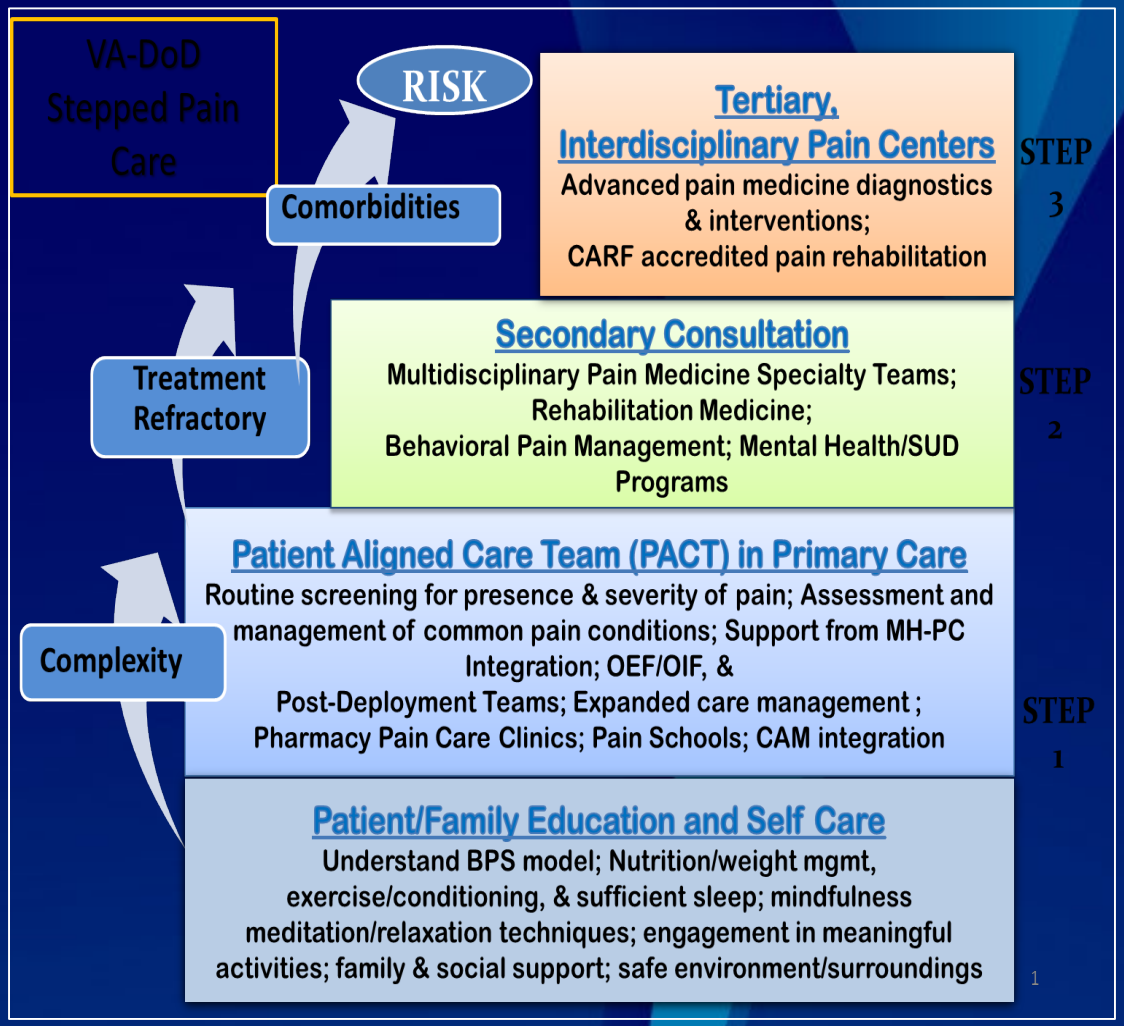
Foundational Step: Self-Care/Self-Management

Primary Care (PACT) = Medical Home

- Coordinated care and a long-term healing relationship, instead of episodic care based on illness
- Primary Care Mental Health Integration (PCMHI) at all facilities

CARA Legislation:

- Full implementation of the SCM-PM at all VHA facilities
- Pain Management Teams at all facilities



VA/DoD Collaborative Pain Care

Primary Care Teams (PACT)

Roadmap for providers and leadership

- Access to multimodal therapy options
- Primary Care supported by Pain Management Teams (and other specialties including OUD treatment).
- Care coordination and case management

Pain Management Teams (PMT) to support Primary Care

- **Evaluation and follow-up of pts with complex pain conditions**
- **Medication management and actual prescribing** of pain meds, as needed (for complexity/risk)
- **OSI Reviews**: Review of patients with high risk opioid prescriptions with provision of recommendations to clinical providers

At a minimum, the composition of the PMT must include:

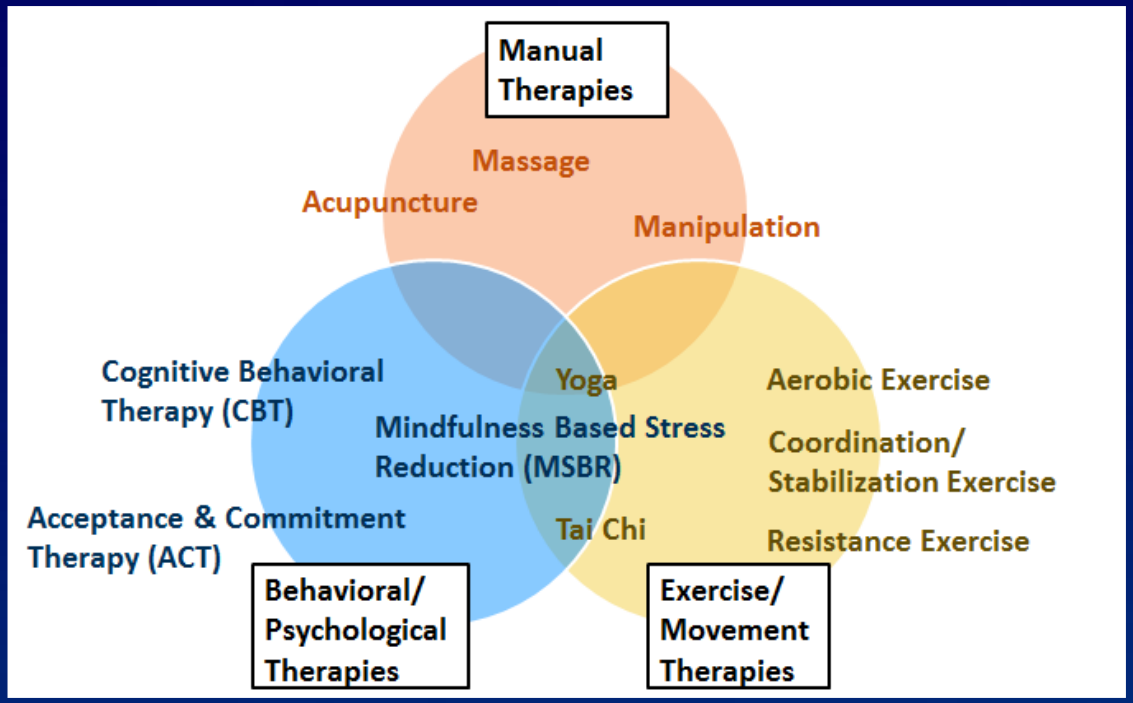
- **Medical Provider with Pain Expertise**
- **Addiction Medicine expertise** to provide evaluation for Opioid Use Disorder (OUD) and access to Medication-Assisted Treatment (MAT)
- **Behavioral Medicine** with availability of at least one evidence-based behavioral therapy.
- **Rehabilitation Medicine** discipline.

Optional: Interventional pain provider, Nursing, Case/Care manager, Pharmacist, etc.

Non-Pharmacological Pain Treatments in VHA

VA State of the Art Conference Nov. 2016: Evidence-based non-pharmacological approaches for MSK pain management

- Evidence to support CIH and conventional therapies.
- Provision of multi-modal therapies accessible from Primary Care.



VHA Directive 1137: Advancing Complementary and Integrative Health (May 2017)

- List 1: Approaches with published evidence of promising or potential benefit.
  - Acupuncture
  - Massage Therapy
  - Tai Chi
  - Meditation
  - Yoga
  - Clinical Hypnosis
  - Biofeedback
  - Guided Imagery

Chiropractic Care was approved as a covered benefit in VHA in 2004 and is part of VA whole health care.
To be made available across the system, if recommended by the Veteran's health care team.