Oregon Pain Guidance Coalition

Monthly Meeting: August 17, 2016
Chaired by John Kolsbun and Laura Heesacker

Naloxone in Brief: Sara Smith, RN

Naloxone is an important medical resource in a context where 1 person dies of an overdose every 12 minutes, and prescription opioids cause twice as many deaths as heroin. Making naloxone widely available can't end addiction. It can save lives by enabling a person who witnesses an overdose to intervene: calling 911, beginning rescue breathing, administering naloxone either through injection or through an inhaler, and giving an additional dose if required.

The stigma attached to naloxone is an important consideration for patients and the community. The best way to remove this obstacle is the "universal precautions" approach to co-prescribing naloxone, which frames the medication as a basic safety measure, much like the epi-pen, an inhaler, or a fire extinguisher. A provider can present naloxone – not as a negative judgment about a patient's likelihood of overdosing – but as a caring response to the dangers inherent in opioid use.

Access to naloxone is especially critical for patients with risk factors such as a previous overdose, concurrent use of opioids and benzodiazepines, an MED > 50, or life circumstances such as recent release from prison.

The Medford Police Department, which has carried naloxone for 18 months, has made 13 saves. The ARC has trained 39 people to use naloxone and clients have reported 2 saves.

The Board of Pharmacy is hoping to have guidelines in place by the end of the year which implement legislation allowing pharmacists to dispense naloxone without a prescription.

The slides for this presentation are on the OPG website at
http://professional.oregonpainguidance.org/opioid-prescribers-group/previous-meetings/

Opioid Risk Stratification: Identifying the Central Pain Phenotype, Paul Coelho, MD

Central sensitization is a pain phenotype that should be added to the familiar categories of nociceptive and neuropathic pain. Widely overlooked, CS is a spectrum disorder which most commonly presents in the form of fibromyalgia syndrome, chronic low back pain, or tension/migraine headache. The sources of CS pain cannot be detected through physical exam, imaging studies, or lab work-ups. This type of pain is not responsive to procedures or opioids.

Most screening tools are not effective in identifying CS. The Pain Catastrophizing Scale is an exception. This short, self-administered test reliably identifies patients who are predisposed to negative outcomes and are likely to ruminate on, magnify, and feel helpless in the face of pain. The results of the PCS can predict the likelihood that a patient will misuse opioids, and experience increased pain sensitivity/severity, post-operative opioid use, failure of spinal injection (for back pain), delayed recovery, and dissatisfaction with treatment. These adverse outcomes are all associated with CS.

Pain catastrophizing appears to be a state, not a trait. It clusters in families, as a learned style of behavior and it appears to characterize 60-80% of chronic non-cancer pain sufferers.

In response to questions, Paul explained that pain catastrophizing has been recognized since the 1960's and is evident across cultures and geographical regions. The pivotal change came in the 1990's in this country when the medical community began treating it with opioids. He argued that while it's important not to stigmatize patients, the PCS is a major resource that enables providers to stratify risk and personalize treatment.

Group discussions followed Paul's presentation of a cast study. The slides for Paul's talk are available at:

http://professional.oregonpainguidance.org/opioid-prescribers-group/previous-meetings/

Next OPG Meeting Date: 9-21-16

Minutes prepared by K. Loram, 8-31-16