# Chronic Pain Management in an Opioidphobic Society

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Integrated Pain Care of Bedford

## Topics for Discussion

- What is Pain?
- Background/Significance of Pain in America.
- Opioid Epidemic
- Federal legislation /guidelines for the use of opioids.
- Treatment with Opioids/ Pharmacology
- Treatment Agreements/compliance Monitoring

## What is Pain?

- International Association for the Study of Pain Definition: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage
- Margo McCaffery's Definition: "Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does".

## TYPES OF PAIN

| Duration | Cause | Location |
|---|---|---|
| Acute | Nociceptive | Somatic |
| Chronic | Neuropathic | Visceral |

## Duration



- Relatively brief duration
- Etiology known
- Pain proportionate to damage
- ~ Transient objective signs
- Anxiety, anger, fear common

- Longer duration
- Etiology ~ unknown
- Pain ~disproportionate
- Often no objective sign
- Depression is common

## Background and Significance

- Chronic pain is one of the most common presenting medical problems among adults.
- Approximately 50 million adults in the US have Chronic Pain.
- 19 million adults experience high impact chronic pain
- Women, older adults, currently unemployed but were previously working, adults living in poverty, adults living in rural settings, and adults on public insurance had a higher prevalence of chronic pain.

## Background & Significance Cont.

- According to the Institute of Medicine Report on Relieving Pain in America 2011:
  - $560 to 635 billion per year in healthcare costs an lost productivity.
  - Chronic pain will continue to rise as a result of: age, obesity, advances in medicine, poor management of surgical pain, recognition of the disease.

## Consequences of Unrelieved Pain

- Physical stress, emotional distress, & suffering
- Insomnia
- Immobility & de-conditioning
- Impaired hormonal & immune function
- Atelectasis, hypoxia, & increase cardiac workload
- Increases morbidity and mortality
- Sensitization & neuroplasticity

## Consequences Continued

- Impact of pain on activities (meaningful, pleasurable)
- Relationships with family members / friends
- Abusive relationships?
- Assistance given / received from others
- Use of alcohol, drugs, tobacco
- Talk with patient and S.O.'s
- Self awareness re: therapeutic relationship

## Opioid Epidemic

- Mid 1990's: American Pain Society classifies pain as the 5th vital sign
- October 31, 2000, the 106th U.S. Congress passed H.R. 3244; title VI, Sec. 1603 established the "Decade of Pain Control and Research.
- 2001: Joint Commission introduced standard to improve treatment of pain, including use of opioids.
- Opioid RX nearly tripled from 1991 (76 million) to 2011 (219 million).

## Opioid Epidemic

- From 1999-2017 400,000 Americans died of a opioid related drug overdose (RX and Illicit).
- 68 percent of the 70,000 plus overdoses in 2017 involved the use of an opioid.
- 2017 death rate from an opioid overdose is 6x higher than it was in 1999.
- On average, 130 Americans die of an opioid overdose on a daily basis.

# Opioid Guidelines

- CDC Guidelines for Primary Care Providers prescribing opioids for non-malignant pain.
- 1. when to initiate/continue opioid therapy for chronic pain management
- 2. Opioid type, dosage, duration of use, frequency of visits, and discontinuation.
- 3. Risk /Harms assessment of opioid use

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

# CDC Guidelines Continued

- **1**. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate
- 2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- 3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy
-

# CDC Guidelines Continued:

- 4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
- 5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day
- 6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed

# CDC Guidelines Continued:

- 7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids
- 8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present

# CDC Guidelines Continued:

- 9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
- 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs
- 11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- 12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

# General Opioid Prescribing Guidelines

1 Appropriate Diagnosis

- 2. Comprehensive health assessment physical examination.
- 3. Discuss plan of care and treatment goals
- 4. Informed Consent/Treatment agreement
- 5. Initiate an appropriate trial of an opioid
- 6. Ongoing assessment of Pain and Functional Status
- 7. Random UDS and Pill Counts
- 8. Adapt Treatment as needed.
- 9. Consult outside Specialist.
- 10. Thorough documentation of condition and treatment.
- 11. Follow Universally accepted guidelines and laws.

## Helpful Links for Prescribers:

- MA Medical Society: http://www.massmed.org/Advocacy/Key-Issues/Opioid-Abuse/Mass--Opioid-Legislation-Practice-Guide/#.V3wCkdIrLcs
- NH Medical Society
- https://www.nhms.org/resources/opioid

## Prescribers of Opioids

- Know how to start, modify, and discontinue opioids.
- Know how to convert from SA to LA or change from on SA to another SA or a LA to another LA.
- Understand that equal analgesic tables are a guide and are not 100% correct. Take into account incomplete cross-tolerance.

## Risk Assessment for Opioid Use

- Pros

-Protects the patient, the public, and your practice.

-Helps determine most appropriate treatment protocol.

-Compliance monitoring (frequency of pill counts and UDS)

- Cons

-Difficult to find a provider to screen patients.

-Assessments can be open to interpretation.

-Cost can be prohibitive for patients if not covered on insurance plan.

-How to chose which patients need to be screened.

## In Office Assessment of Addiction

- Tools available:
- ORT (Opioid Risk Tool) http://www.agencymeddirectors.wa.gov/files/opioidrisktool.pdf
- SOAPP-R http://www.ccwjc.com/Forms/Chronic%20Pain/SOAPP-R.pdf
- COMM (Current Opioid Misuse Measure)

http://mytopcare.org/wpcontent/uploads/2013/05/COMM.pdf

## High Risk: Likelihood of Misusing Opioid Medications.

- May chose to use only non-opioid medications and alternate treatment modalities.
- If prescribing of opioids is initiated, use longer acting products, smaller quantities, frequent visits, more frequent UDS, and random pill counts.
- Re-screen if any signs of aberrant behaviors.
- Consider NA and/or AA services if needed.
- Role of Methadone /Suboxone Clinics for detoxification.

## Low Risk: Unlikely to misuse opioid medications.

- Set clear expectations for treatment with opioids and sign treatment agreement.
- UDS on day of first RX to ensure compliance with current and/or reported medication regimen and to ensure no other illicit or prescribed drugs are present.
- Perform random UDS and pill counts.

## Opioid Benefits:

- Highly effective, sometime the only effective Rx
- Promotes healing
- Improves mood
- Products with low or "no" ceiling
- Accumulation ~ occur
- Pure agonists have no known end-organ damage

## Opioids: Potential Problems

- Side effects
  - Respiratory depression
  - Sedation
  - Nausea / vomiting
  - Urinary retention
  - Hormonal changes
  - Sexual dysfunction
  - Constipation
- **Risks**
  - Addiction
  - Physical dependence
  - Tolerance
  - Safety concerns (driving)
  - Drug interactions

## A Range of Products

- Weak or Mixed Opioids
  - Codeine
  - Propoxyphene
  - Tramadol
  - Pentazocine
  - Nalbuphine
- Strong Opioids
  - Hydrocodone
  - Oxycodone
  - Morphine
  - Levorphanol
  - Hydromorphone
  - Fentanyl
  - Oxymorphone
  - Tapentadol

## Prescribers of Opioids

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## Commonly Used SA Opioids

| Drug | Dosing Strengths mg | Dosing Frequency | Maximum Daily Dose |
|---|---|---|---|
| Oxycodone<br>Oxycodone/ Acetaminophen<br>Aspirin<br>Ibuprofen | 5,10,15,20,30<br>2 .5,5,7.5,10<br>325 to 650<br>4.8/ 325<br>5/400 | 5 to 30 mg q4 prn<br>2.5 to 10 mg q4 to 6 prn<br>q6 prn<br>qd to qid prn | Not defined<br>4 grams Acet. In 24 hr.<br>12 per 24 hr.<br>4 per 24 hr. |
| Hydrocodone/ Acetaminophen<br>Ibuprofen | 2.5,5,7.5,10<br>300 to 700 mg<br>200 | 2.5 to 10 mg q4 to 6 prn<br>q4 to 6 h prn | 4 grams Acet. in 24 hr.<br>Max 5 qd |
| Hydromorphone | 2,4,8 | 2-8 mg q3 to 4 prn | Not defined |
| Morphine IR | 15,30 | 10-30 mg q3 to 4 prn | Not defined |
| Nucynta | 50,75,100 | 50 to 100 mg q4 to 6 prn | Not defined |

## Long-Acting Opioids Commonly Used

| Drug | Dosing Interval | Available Strengths | Administration | Bolus | Ceiling dose |
|---|---|---|---|---|---|
| KADIAN® Morphine Extended-Release Capsule | q12hr<br>q24hr | 20, 30, 50, 60, 100 mg | Capsule, Sprinkle, G-Tube | No | – |
| AVINZA® Morphine Extended-Release Capsule | q24hr | 30, 60, 90, 120 mg | Capsule, Sprinkle | Yes | 1600 mg/day |
| OxyContin® Oxycodone Hydrochloride Extended Release hcl | q12hr | 10, 20, 40, 80, 160 mg | Tablet | Yes | – |
| MS Contin® | q8hr<br>q12hr | 15, 30, 60, 100, 200 mg | Tablet | No | – |
| Duragesic® | q48 hr | 12, 25, | Transdermal | | |

## Long-Acting Opioids (continued)

| | | | | | |
|---|---|---|---|---|---|
| **Opana ER®** Removed June 8th 2017 | Q 12hr | 5, 10, 20, 40 | Tablet | No | - |
| **Exalgo ®** Hydromorphone HCL Extended Release | Q 24 hr | 8,12,16 mg | Tablet | No | - |
| **Butrans®** Buprenorphine Transdermal System | Q week | 5, 10, 20 mcg/hr | Transdermal Patch | No | - |
| **Nucynta ER®** Tapentadol Extended –Release Tablets | Q 12 hr | 50,100,150, 200, 250 | Tablet | No | - |
| **Methadone Dolophine** | Q 8 hours | 5, 10 | tablet | No | - |

## Products to avoid
(or use cautiously)

- **DO NOT USE PLACEBOS**
- **Avoid**
  - Demerol
- **Use Cautiously**
  - Codeine
  - Tramadol
  - Agonist/antagonist drugs
  - Methadone

## Pain Treatment Agreements

Positives
- -Clear expectations
- -Informed Consent
- -Documentation
- -Patient safety
- -Safe Guarding Practice

Negatives
- -Patient Perceptions about agreements
- -Open to interpretation.
- -Time and staff power needed to keep agreements up to date.

**PAIN TREATMENT AGREEMENT**

**Patient Name:** _____ **Date:** _____

Opioid (Narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to perform daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling and/or or other therapies and treatments. Vocational counseling may also be provided to assist in your return to work effort. The success of treatment depends on mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risk and benefits of using opioids to treat pain.

***Please initial each line after reading.***

I _____, understand that compliance with the following guidelines is important in continuing pain treatment with Integrated Pain Care.

1. I understand that I have the following responsibilities.

_____ a: I will take medications only at the dose and frequency prescribed.

_____ b: I will not increase or change medications without the approval of this provider.

_____ c: I will actively participate in Return to Work efforts if applicable, and in any program designed to improve function (including social, physical, psychological, and daily or work activities).

_____ d: I will not request, obtain opioids or any other controlled medications or any other pain medicine from friends, family, emergency departments or healthcare providers, without permission from my IPC provider. This provider will approve or prescribe all pain medications.

_____ e: I will inform this provider of all other medications that I am taking, since opioid medications can interact with over-the-counter medications and other prescribed medications (particularly cough syrup that contains alcohol, codeine or hydrocodone). I will notify my provider of any changes made to my medication regimen.

_____ f: I will obtain all medication from one pharmacy, when possible, known to this provider with full consent to talk with the pharmacist given by signing this agreement.

_____ g: I will protect my prescriptions and medications from loss or theft by keeping them in a safe and secure place. No lost or stolen prescriptions and/or medications will be replaced. Stolen medications should be reported to the police and to your provider immediately.

_____ h: I will keep all medications away from and out of reach of children.

_____ i: I will obtain all prescriptions for my medications during a scheduled office visit every 28-30 days unless otherwise specified by my provider. **NO refills** of any medication will be done during the evening or on weekends through the paging system.

_____ j: At any time and without notice, I may be require to return any unused opioid medications prescribed by my provider in the original bottles and provide a urine sample if called in to do so within a four hour period.

_____ k: I agree to participate in psychiatric or psychological assessments, if necessary.

_____ l: I will not use illegal or street drugs or alcohol. If I have an addiction problem, this provider may ask me to follow through with program to address this issue. Such programs may include following:

- 12 Step program and securing a sponsor
- Individual Counseling
- Inpatient or Outpatient treatment

_____ I, will not destroy or dispose of any discontinued or currently prescribed medications written by Integrated Pain Care unless specifically instructed to do so.

_____2. I understand that in the event of an emergency, this provider should be contacted and the problem will be discussed with the emergency room or any other treating provider. I am responsible for signing consent to request a record transfer to this provider. I will not accept any pain medications from any other treating providers.

_____3. I understand that I will consent to random drug screen testing. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool. The presence of a non-prescribed drug(s) or illicit(s) or the absence of drugs prescribed by your provider can be grounds for termination of the provider/patient relationship.

_____4. I will keep my scheduled appointments and/or cancel my appointment a minimum of **at least 24 hours prior to the appointment**. Otherwise I will be charged a fee and repeated episodes could result in administrative discharge from the practice.

_____5 I understand that this provider may stop prescribing opioids, change the treatment plan, or terminate the patient/provider relationship if:

a. I do not show any improvement in pain from opioids or my physical activity has not improved.
b. My behavior is inconsistent with the responsibilities outlined in #1 above.
c. I give, sell or misuse opioid medication.
d. I develop rapid tolerance or loss of improvement from the treatment.
e. I obtain opioids from someone other than this provider.
f. I refuse to cooperate when asked to get a drug screen or a pill count.

g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
h. I am unable to keep follow-up appointments with Integrated Pain Care and other facilities outlined in my individual treatment plan.
i. I test positive for illicit substances, which include but are not limited to cocaine, PCP, LSD, marijuana, ecstasy, methamphetamine or heroin.
j. If I stop my medication without instruction to do so from my provider and/or fail to inform my provider of any side effects or adverse reactions to any of my medications.

**YOUR SAFETY WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS**

***Please initial each line after reading.***

_____You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible dangers associated with the use of opioids while operating heaving equipment or driving. Integrated Pain Care does not advise driving while taking opioid medications and/or other medications prescribed for your pain that may impair your driving abilities.

_____Patients are advised to check with local laws regarding driving on any medications they may be taking.

**SIDE EFFECTS OF OPIOIDS:**

- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous
- Breathing too slowly – overdose can stop your breathing and lead too death
- Nausea
- Constipation
- Sleepiness or drowsiness
- Aggravation of depression
- Vomiting
- Dry Mouth

**These side effects may be made worse if you mix opioids with other drugs, including alcohol.**

RISKS:

1. **Physical Dependence** means that if the opioid medication is abruptly stopped or not taken as directed a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but are not limited to, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.
2. **Tolerance** means a state of adaption in which exposure to the drugs induces changes that result in decreased effectiveness of one or more of the drug's effects over time. The dose of the opioid may have to be adjusted up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.
3. **Addiction** is primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development manifestation. It is characterized by behavior that induces one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.
4. **Problems with pregnancy**. If you are pregnant or contemplating becoming pregnant, discuss this with your provider.

_____ (If applicable) I will inform my provider if I become pregnant while under their care.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above. Please list pharmacy name and phone number below where you will fill all of your prescribed medications from IPC. Should a pharmacy change be required you agree to inform the IPC staff.

Patient Signature _____ Date _____

Provider Signature _____ Date _____

Witness Signature _____ Date _____

Pharmacy _____ Pharmacy Phone _____

The purpose of this agreement is for me, _____, to understand and agree with my pain care provider on the following:

The pain management program at **Integrated Pain Care** is designed to help me learn to cope with my pain. The goals include changing those actions and attitudes that are associated with the pain, and learning to manage my life and work in ways that will be more productive and satisfying.

An overall goal is to gain control of my pain problem so that I can do more things that are considered normal for a person of my age. Specifically, I have the following goals:

1. _____
2. _____
3. _____
4. _____

_____ I recognize that members of my family and others significant to me are considered essential in helping me to break old habits and to learn new ways to live with the pain. As a result, I will actively encourage these individuals to participate in my program. I understand that you may, with my consent, speak with members of my family if that will improve the chances of my attaining my goals. I understand that I will be informed before other people are contacted.

_____ I understand that I am expected to attend all scheduled sessions and to participate in all at-home activities. Pain is no excuse. I further understand that my absence for a total of **three days** will be grounds for dropping me from the program due to non-compliance.

_____ I understand that my provider will outline a plan of care based on my own individual needs and I am expected to attend all scheduled visits in my treatment plan. Including but not limited to:

- Physical/Occupational Therapy
- Nutrition
- Psychology
- Interventional Procedures
- Acupuncture/Bowenwork
- Diagnostic Imaging

_____ I further understand that my absence for a total of **three scheduled sessions** of any aspect of my treatment plan with these independent providers will be grounds for dropping me from the program due to non-compliance.

_____ I will immediately inform the staff about all other medical appointments outside the program. I will immediately inform the staff about any change in use of medication obtained outside this program.

_____ On the basis of my treatment needs, I and members of the treatment team will decide what the follow-up of the program will be and how long follow up will continue. I understand that that all costs of this program are paid for by my workers compensation insurer, conditional upon my continued eligibility for workers compensation benefits.

_____ I understand and agree to the above conditions, and I acknowledge that the Pain Management Program has now been explained to my satisfaction.

_____ _____
Patient Signature Date

_____
Printed Name

_____ _____
Integrated Pain Care Provider Date

## Compliance Monitoring

| Positives | Negatives |
|---|---|
| • Necessary to protect the patient, provider, and society.<br>• Monitors adherence to treatment protocol | • Cost<br>• Staffing<br>• Time<br>• Patient complaints |

## Laboratory Information

- Know the cut off levels for a given drug.
- Know which drugs are screened for on a standard panel and which need to be added.
- If using a commercial lab, ensure that pricing information is available for a given panel and add ons.
- Have a go to person to address problems or concerns.

## Toxicology Report Examples

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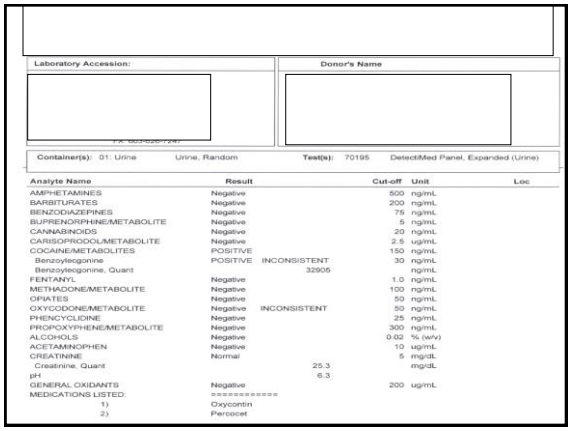
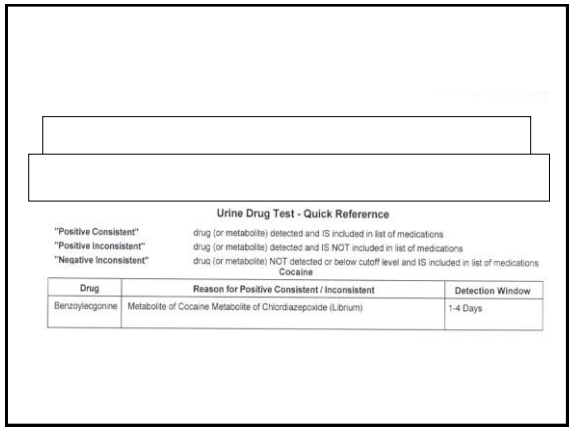


Laboratory Accession: [redacted]

Donor's Name: [redacted]

Container(s): 01: Urine Urine, Random Test(s): 70195 DetectiMed Panel, Expanded (Urine)

| Analyte Name | Result | | Cut-off | Unit | Loc |
|---|---|---|---|---|---|
| AMPHETAMINES | Negative | | 500 | ng/mL | |
| BARBITURATES | Negative | | 200 | ng/mL | |
| BENZODIAZEPINES | Negative | | 75 | ng/mL | |
| BUPRENORPHINE/METABOLITE | Negative | | 5 | ng/mL | |
| CANNABINOIDS | Negative | | 20 | ng/mL | |
| CARISOPRODOL/METABOLITE | Negative | | 2.5 | ug/mL | |
| COCAINE/METABOLITES | POSITIVE | | 150 | ng/mL | |
| Benzoylecgonine | POSITIVE | INCONSISTENT | 30 | ng/mL | |
| Benzoylecgonine, Quant | | 32905 | | ng/mL | |
| FENTANYL | Negative | | 1.0 | ng/mL | |
| METHADONE/METABOLITE | Negative | | 100 | ng/mL | |
| OPIATES | Negative | | 50 | ng/mL | |
| OXYCODONE/METABOLITE | Negative | INCONSISTENT | 50 | ng/mL | |
| PHENCYCLIDINE | Negative | | 25 | ng/mL | |
| PROPOXYPHENE/METABOLITE | Negative | | 300 | ng/mL | |
| ALCOHOLS | Negative | | 0.02 | % (w/v) | |
| ACETAMINOPHEN | Negative | | 10 | ug/mL | |
| CREATININE | Normal | | 5 | mg/dL | |
| Creatinine, Quant | | 25.3 | | mg/dL | |
| pH | | 6.3 | | | |
| GENERAL OXIDANTS | Negative | | 200 | ug/mL | |
| MEDICATIONS LISTED: | ========== | | | | |
| 1) | Oxycontin | | | | |
| 2) | Percocet | | | | |



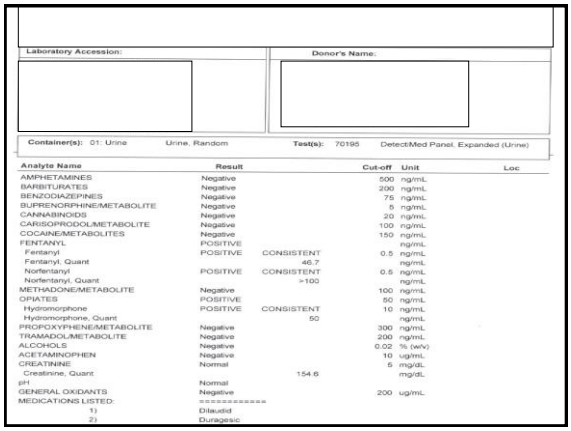
[redacted]

**Urine Drug Test - Quick Referernce**

| | |
|---|---|
| **"Positive Consistent"** | drug (or metabolite) detected and IS included in list of medications |
| **"Positive Inconsistent"** | drug (or metabolite) detected and IS NOT included in list of medications |
| **"Negative Inconsistent"** | drug (or metabolite) NOT detected or below cutoff level and IS included in list of medications |

**Cocaine**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Benzoylecgonine | Metabolite of Cocaine Metabolite of Chlordiazepoxide (Librium) | 1-4 Days |

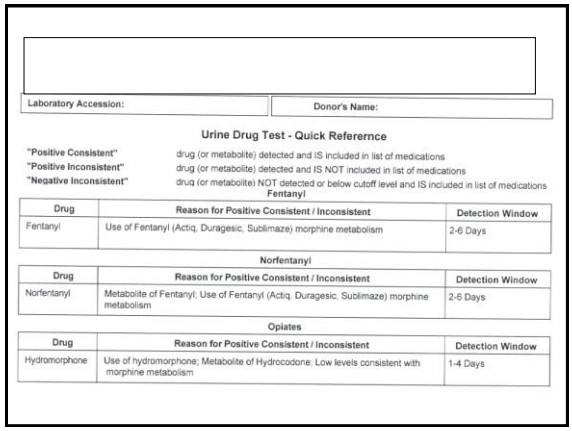


Laboratory Accession: [redacted]

Donor's Name: [redacted]

Container(s): 01: Urine Urine, Random Test(s): 70195 DetectiMed Panel, Expanded (Urine)

| Analyte Name | Result | | Cut-off | Unit | Loc |
|---|---|---|---|---|---|
| AMPHETAMINES | Negative | | 500 | ng/mL | |
| BARBITURATES | Negative | | 200 | ng/mL | |
| BENZODIAZEPINES | Negative | | 75 | ng/mL | |
| BUPRENORPHINE/METABOLITE | Negative | | 5 | ng/mL | |
| CANNABINOIDS | Negative | | 20 | ng/mL | |
| CARISOPRODOL/METABOLITE | Negative | | 100 | ng/mL | |
| COCAINE/METABOLITES | Negative | | 150 | ng/mL | |
| FENTANYL | POSITIVE | | | ng/mL | |
| Fentanyl | POSITIVE | CONSISTENT | 0.5 | ng/mL | |
| Fentanyl, Quant | | 46.7 | | ng/mL | |
| Norfentanyl | POSITIVE | CONSISTENT | 0.5 | ng/mL | |
| Norfentanyl, Quant | | >100 | | ng/mL | |
| METHADONE/METABOLITE | Negative | | 100 | ng/mL | |
| OPIATES | POSITIVE | | 50 | ng/mL | |
| Hydromorphone | POSITIVE | CONSISTENT | 10 | ng/mL | |
| Hydromorphone, Quant | | 50 | | ng/mL | |
| PROPOXYPHENE/METABOLITE | Negative | | 300 | ng/mL | |
| TRAMADOL/METABOLITE | Negative | | 200 | ng/mL | |
| ALCOHOLS | Negative | | 0.02 | % (w/v) | |
| ACETAMINOPHEN | Negative | | 10 | ug/mL | |
| CREATININE | Normal | | 5 | mg/dL | |
| Creatinine, Quant | | 154.6 | | mg/dL | |
| pH | Normal | | | | |
| GENERAL OXIDANTS | Negative | | 200 | ug/mL | |
| MEDICATIONS LISTED: | ========== | | | | |
| 1) | Dilaudid | | | | |
| 2) | Duragesic | | | | |



Laboratory Accession: [redacted]

Donor's Name: [redacted]

**Urine Drug Test - Quick Referernce**

| | |
|---|---|
| **"Positive Consistent"** | drug (or metabolite) detected and IS included in list of medications |
| **"Positive Inconsistent"** | drug (or metabolite) detected and IS NOT included in list of medications |
| **"Negative Inconsistent"** | drug (or metabolite) NOT detected or below cutoff level and IS included in list of medications |

**Fentanyl**

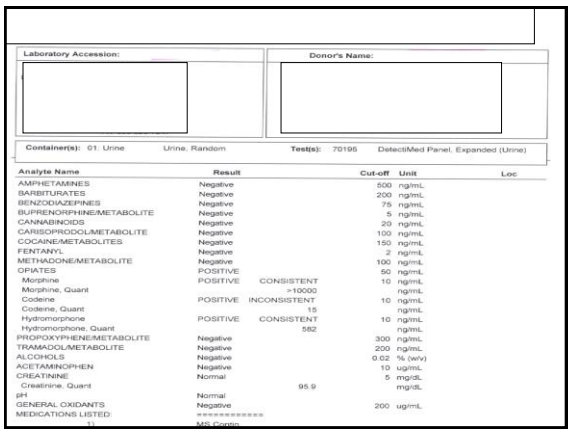
| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Fentanyl | Use of Fentanyl (Actiq, Duragesic, Sublimaze) morphine metabolism | 2-6 Days |

**Norfentanyl**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Norfentanyl | Metabolite of Fentanyl; Use of Fentanyl (Actiq, Duragesic, Sublimaze) morphine metabolism | 2-6 Days |

**Opiates**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Hydromorphone | Use of hydromorphone; Metabolite of Hydrocodone; Low levels consistent with morphine metabolism | 1-4 Days |

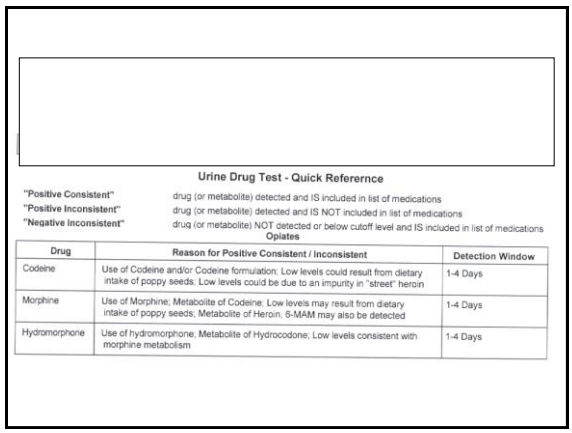


Laboratory Accession: [redacted]

Donor's Name: [redacted]

Container(s): 01: Urine Urine, Random Test(s): 70195 DetectiMed Panel, Expanded (Urine)

| Analyte Name | Result | | Cut-off | Unit | Loc |
|---|---|---|---|---|---|
| AMPHETAMINES | Negative | | 500 | ng/mL | |
| BARBITURATES | Negative | | 200 | ng/mL | |
| BENZODIAZEPINES | Negative | | 75 | ng/mL | |
| BUPRENORPHINE/METABOLITE | Negative | | 5 | ng/mL | |
| CANNABINOIDS | Negative | | 20 | ng/mL | |
| CARISOPRODOL/METABOLITE | Negative | | 100 | ng/mL | |
| COCAINE/METABOLITES | Negative | | 150 | ng/mL | |
| FENTANYL | Negative | | 2 | ng/mL | |
| METHADONE/METABOLITE | Negative | | 100 | ng/mL | |
| OPIATES | POSITIVE | | 50 | ng/mL | |
| Morphine | POSITIVE | CONSISTENT | 10 | ng/mL | |
| Morphine, Quant | | >10000 | | ng/mL | |
| Codeine | POSITIVE | INCONSISTENT | 10 | ng/mL | |
| Codeine, Quant | | 15 | | ng/mL | |
| Hydromorphone | POSITIVE | CONSISTENT | 10 | ng/mL | |
| Hydromorphone, Quant | | 582 | | ng/mL | |
| PROPOXYPHENE/METABOLITE | Negative | | 300 | ng/mL | |
| TRAMADOL/METABOLITE | Negative | | 200 | ng/mL | |
| ALCOHOLS | Negative | | 0.02 | % (w/v) | |
| ACETAMINOPHEN | Negative | | 10 | ug/mL | |
| CREATININE | Normal | | 5 | mg/dL | |
| Creatinine, Quant | | 95.9 | | mg/dL | |
| pH | Normal | | | | |
| GENERAL OXIDANTS | Negative | | 200 | ug/mL | |
| MEDICATIONS LISTED: | ========== | | | | |
| 1) | MS Contin | | | | |



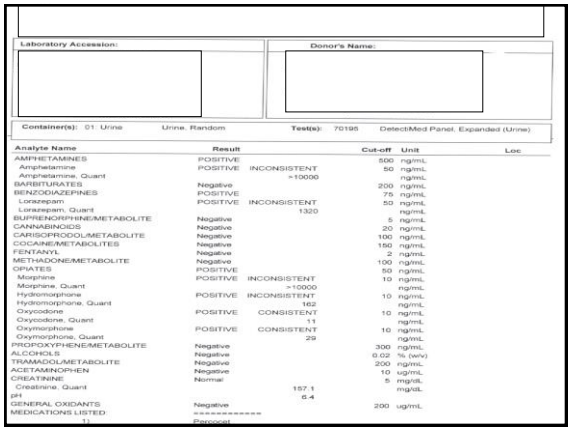
[redacted]

**Urine Drug Test - Quick Referernce**

| | |
|---|---|
| **"Positive Consistent"** | drug (or metabolite) detected and IS included in list of medications |
| **"Positive Inconsistent"** | drug (or metabolite) detected and IS NOT included in list of medications |
| **"Negative Inconsistent"** | drug (or metabolite) NOT detected or below cutoff level and IS included in list of medications |

**Opiates**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Codeine | Use of Codeine and/or Codeine formulation; Low levels could result from dietary intake of poppy seeds; Low levels could be due to an impurity in "street" heroin | 1-4 Days |
| Morphine | Use of Morphine; Metabolite of Codeine; Low levels may result from dietary intake of poppy seeds; Metabolite of Heroin, 6-MAM may also be detected | 1-4 Days |
| Hydromorphone | Use of hydromorphone; Metabolite of Hydrocodone; Low levels consistent with morphine metabolism | 1-4 Days |

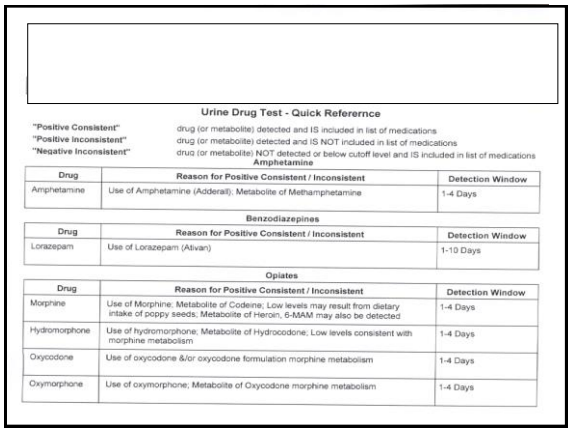


Laboratory Accession: [redacted]

Donor's Name: [redacted]

Container(s): 01: Urine Urine, Random Test(s): 70195 DetectMed Panel, Expanded (Urine)

| Analyte Name | Result | | Cut-off | Unit | Loc |
|---|---|---|---|---|---|
| AMPHETAMINES | POSITIVE | | 500 | ng/mL | |
| Amphetamine | POSITIVE | INCONSISTENT | 50 | ng/mL | |
| Amphetamine, Quant | | >10000 | | ng/mL | |
| BARBITURATES | Negative | | 200 | ng/mL | |
| BENZODIAZEPINES | POSITIVE | | 75 | ng/mL | |
| Lorazepam | POSITIVE | INCONSISTENT | 50 | ng/mL | |
| Lorazepam, Quant | | 1320 | | ng/mL | |
| BUPRENORPHINE/METABOLITE | Negative | | 5 | ng/mL | |
| CANNABINOIDS | Negative | | 20 | ng/mL | |
| CARISOPRODOL/METABOLITE | Negative | | 100 | ng/mL | |
| COCAINE/METABOLITES | Negative | | 150 | ng/mL | |
| FENTANYL | Negative | | 2 | ng/mL | |
| METHADONE/METABOLITE | Negative | | 100 | ng/mL | |
| OPIATES | POSITIVE | | 50 | ng/mL | |
| Morphine | POSITIVE | INCONSISTENT | 10 | ng/mL | |
| Morphine, Quant | | >10000 | | ng/mL | |
| Hydromorphone | POSITIVE | INCONSISTENT | 10 | ng/mL | |
| Hydromorphone, Quant | | 162 | | ng/mL | |
| Oxycodone | POSITIVE | CONSISTENT | 10 | ng/mL | |
| Oxycodone, Quant | | 11 | | ng/mL | |
| Oxymorphone | POSITIVE | CONSISTENT | 10 | ng/mL | |
| Oxymorphone, Quant | | 29 | | ng/mL | |
| PROPOXYPHENE/METABOLITE | Negative | | 300 | ng/mL | |
| ALCOHOLS | Negative | | 0.02 | % (w/v) | |
| TRAMADIOL/METABOLITE | Negative | | 200 | ng/mL | |
| ACETAMINOPHEN | Negative | | 10 | ug/mL | |
| CREATININE | Normal | | 5 | mg/dL | |
| Creatinine, Quant | | 157.1 | | mg/dL | |
| pH | | 6.4 | | | |
| GENERAL OXIDANTS | Negative | | 200 | ug/mL | |
| MEDICATIONS LISTED: | [redacted] | | | | |
| 1) | Percocet | | | | |



**Urine Drug Test - Quick Referernce**

| | |
|---|---|
| "Positive Consistent" | drug (or metabolite) detected and IS included in list of medications |
| "Positive Inconsistent" | drug (or metabolite) detected and IS NOT included in list of medications |
| "Negative Inconsistent" | drug (or metabolite) NOT detected or below cutoff level and IS included in list of medications |

**Amphetamine**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Amphetamine | Use of Amphetamine (Adderall); Metabolite of Methamphetamine | 1-4 Days |

**Benzodiazepines**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Lorazepam | Use of Lorazepam (Ativan) | 1-10 Days |

**Opiates**

| Drug | Reason for Positive Consistent / Inconsistent | Detection Window |
|---|---|---|
| Morphine | Use of Morphine; Metabolite of Codeine; Low levels may result from dietary intake of poppy seeds; Metabolite of Heroin, 6-MAM may also be detected | 1-4 Days |
| Hydromorphone | Use of hydromorphone; Metabolite of Hydrocodone; Low levels consistent with morphine metabolism | 1-4 Days |
| Oxycodone | Use of oxycodone &/or oxycodone formulation morphine metabolism | 1-4 Days |
| Oxymorphone | Use of oxymorphone; Metabolite of Oxycodone morphine metabolism | 1-4 Days |

## Ethical Considerations

- Undertreatment of pain and following the CDC Guidelines Opioid dosing.
- Some Chronic pain patients have been on high dose opioids for decades.
- Reducing Opioids can significantly impact pain intensity, QOL, and Functional Status
- Labeling of patients on opioids as being addicted to their medications (Friends, Family, Medical Providers, Government, and Society)

## Sociocultural Issues

- Primary issue is access to care for patients with acute and chronic pain conditions (ER, PCP, Specialty)
- Pain management approaches utilizing opioids are becoming more limited for patients and they are seeking alternate means to manage their pain (Self Medicating)
- Patients who have been on high dose opioids for many years are now being tapered off or greatly reduced, considered "Pain Refugees"
- Government agencies creating guidelines that are a one size fits all approach, not taking into consideration the treating providers knowledge base, experience, and relationship with his/her patient.

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