Addiction Medicine: The Good, the Bad and the Ugly

Darrin Mangiacarne, DO, MPH, CPE
Financial Disclosures

• Still over $200,000 in debt from medical school
• This talk is sponsored by no one
Objectives

- Introduce the emerging field of addiction medicine
- Relieve you of the misconception that opioids are necessary for chronic pain management
- Understand the backdrop to the opioid epidemic and how we can get out of it
- Understand that heroin use is the natural consequence of the gross over-prescribing of opiates
- Make you more comfortable treating patients with opioid use disorder
THE GOOD—AN EMERGING SPECIALITY
Formal Board Recognition

- ASAM certification offered in 1995
- ABAM started in 2008
- Over 3,000 diplomats currently
- Addiction Medicine is now recognized as a medical specialty by the ABMS
- April 12, 2016, AOA followed suit
There are 40 accredited addiction medicine fellowships.  
  - Goal is to have 65 by 2020 and 125 by 2025.

Addiction Fellowships are sprouting all over the country.
Buprenorphine Prescribing Limit

- DATA 2000 amended as of August 8, 2016
- New Limit is 275 patients
  - Physician must possess a current waiver to treat up to 100 patients
  - must have maintained that waiver without interruption for at least one year
  - and meet one of the following requirements
    - Board Certified in Addiction Medicine or Addiction Psychiatry
    - Practice in a “qualified practice setting”
What is a “Qualified Setting”?

- Provides coverage for patient medical emergencies during hours when the practitioner’s practice is closed
- Provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services
- Uses electronic health records to store, share, and analyze health information
- Is registered for their State prescription drug monitoring program (PDMP)
- Accepts third-party payment for costs in providing health services
• Opioids are not first-line or routine therapy
• Establish and measure goals for pain and function
• Check PDMP
• Use UDS’s
• Avoid concurrent benzo & opioid prescribing
• Arrange treatment for opioid use and disorder if needed.

www.cdc.gov/drugoverdose/prescribing/guideline.html
CDC Suggestions to Reduce Overdose Deaths

- Limit initiation into opioid misuse and addiction through education of healthcare providers;

- Expand access to evidence-based treatment of substance use disorder, including medication-assisted treatment, for people with opioid use disorder;

- Protect people who have opioid use disorder by expanding access to and use of naloxone;

- Get state and local public health agencies, medical examiners and coroners, and law enforcement agencies to work together to improve detection of and response to illicit opioid overdose outbreaks.

Source: http://www.cdc.gov/media/releases/2015/p1218-drug-overdose.html
NARCAN

- FDA approved to treat opioid overdose
- Voice activated
- Analogous to epinephrine pen
- Need to link patients given Narcan to treatment programs
2014 Survey of Primary Care Physicians

• 580 primary doctors surveyed in 2014
• 85% “say they believe that opioids are overused in clinical practice.”
• “Surprisingly, despite concerns about overprescribing, nearly all physicians surveyed (88 percent) expressed confidence in their own ability to prescribe opioids appropriately.”
• “Prior studies have shown that most doctors believe their colleagues’ prescribing decisions are swayed by pharmaceutical marketing and promotion, yet they themselves are immune to such effects.”

Source: jhsph.edu
• "I think we have overestimated the benefits of prescription opioids and underestimated their risks"
• "Although opioids have many risks, their addictive potential is of especially great concern."
  ▪ Caleb Alexander, MD

Opioid and heroin crisis triggered by doctors overprescribing painkillers - Science Daily 2014
"Whereas there is evidence for significant short-term pain relief, there is no substantial evidence for maintenance of pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction."

National Safety Council White Paper Evidence for the Efficacy of Pain Medications

NNT for one person to get 50% pain relief post-operatively

NO EVIDENCE of Benefit for Opioids used >4mo

No evidence of decreased suffering- No overall improvement in back & neck pain disability

Denmark Study- COT users higher pain, lower QOL, less functional

Long-Acting Opioids Increase Mortality in Patients With Chronic Non-cancer Pain

• Retrospective cohort study between 1999 and 2012 of Tennessee Medicaid patients with chronic non-cancer pain and no evidence of palliative or end-of-life care
• Prescription of long-acting opioids for chronic non-cancer pain, compared with anticonvulsants or cyclic antidepressants, was associated with a significantly increased risk of all-cause mortality, including deaths from causes other than overdose
• Risk was 1.64 times greater than that for matched patients starting an analgesic anticonvulsant or a low-dose cyclic antidepressant, corresponding to 69 excess deaths per 10 000 person-years of therapy.

How did we get here?
THE BAD—OPIOIDS AND CHRONIC PAIN
PAIN

• A *perception* which begins with a stimulus and is subject to physical and psychological influence

• May be inhibited if fear for survival is strong enough

• May be magnified if psychological need for pain is great enough
PAIN

• Beecher attempted to define and quantify pain (1957)
• Exhaustive Review
• Cited 850 references
• Conclusion:

  • BEECHER, H. K. The measurement of pain. Pharm. Rev., 1957, 9, 59-209
“because pain is subjective it cannot be described so that it is meaningful to another person”
PAIN

- Acute Pain
- Chronic Pain
  - Pain of Malignant Origin
  - Pain of Benign or Non Malignant Origin
PAIN

NEUROPHYSIOLOGIC

PSYCHIATRIC
ACUTE PAIN

• Response to tissue damage
• Important biological function
• Treatment directed to Etiology Rest, Analgesics (1-3 weeks)
• Opioids are effective
OPIOIDS

• Indicated for Acute Pain Only
• Every Pharmacokinetic Study:
  based on acute pain model
  based on noxious stimulus
Chronic Pain (Benign Origin)

- Tissue Damage at Onset
- Becomes chronic at 6 month mark
- Persists due to:
  - Tissue not returning to normal function
  - Psychological and/or Pharmacological factors
- **Treatment: Rehabilitation**
  As with any other disability
Chronic Pain (Malignant Origin)

• Tissue damage due to malignancy
• Tissue damage due to treatment
• Combination of recurring Acute Pain and Chronic Pain factors
• Treatment
  ▪ Pharmacologic
  ▪ Escalate opioids in response to tolerance
  ▪ Parenteral/intrathecal administration
  ▪ Physical and psychological rehab
Factors that Worsen Pain:

- Opioids & other Narcotics (Long, 1975, Gildenberg, 1996)
- Depression
- Physical Regression
- Psychological Regression
- Intolerance to Stress
OPIOIDS

• Negative Effects with Chronic Use:
  ▪ Tolerance eliminates analgesia
  ▪ Withdrawal increases pain
  ▪ Suppress endorphins
  ▪ Suppress testosterone, estradiol
  ▪ Worsen depression
  ▪ ADDICTION

• Pain Improves with Detox
NARCOTICS

PAIN

MORE
NARCOTICS

MORE
PAIN

WITHDRAWAL
Benzodiazepines

- Tolerance & Withdrawal
- Increase Pain
- Disrupt Normal Sleep
- Accidental Overdose with Opioids
- ALMOST NEVER INDICATED
- ALMOST ALWAYS PRESCRIBED

-The Practice of Neurosurgery Vol. III
Tindall, Cooper, Barrow
SEDATIVES

ANXIETY

MORE SEDATIVES

MORE ANXIETY

WITHDRAWAL
Depression

- Heightens pain perception
- Consequence of disability (in a motivated patient)
- Intensified by:
  - Family disruption
  - Financial loss
  - Legal problems
  - Bureaucratic stresses
- Pain improves with Anti-depressants

- The Practice of Neurosurgery Vol. III
  - Tindall, Cooper, Barrow
DEPRESSION → HEIGHTENED PAIN PERCEPTION → MORE PAIN → MORE DEPRESSION
Physical Regression

- Patient Driven
  - Decreased activity due to pain
- Physician Driven
  - Instructed to decrease activity
- Muscle Weakness
- Pain Increases with Activity
Psychological Regression

- Decreased recreational, social and adult responsibilities
- Increasingly more dependent on caregivers
- Live centered on pain
- Physical therapy/recreational therapy
INACTIVITY

PAIN

MUSCLE WEAKNESS

MORE INACTIVITY

PAIN WITH ACTIVITY
Stress

• Muscle Tension/Spasm
  ▪ Financial Strain
  ▪ Insurance Companies
  ▪ Legal Proceedings
  ▪ Daily Annoyances
  ▪ Biofeedback/Relaxation Techniques
STRESS

MORE PAIN

MUSCLE TENSION

MORE STRESS

MORE PAIN

www.fairbankscd.org
Chronic Pain Management

PROBLEM

- Narcotics
- Depression
- Physical/Psychological Regression
- Stress

SOLUTION

- Discontinue/Treat Addiction
- Antidepressants and Counseling
- Increase Activity
  - P.T., Exercise, Massage, Yoga, Recreational Therapy, Acupuncture
- Biofeedback, Relaxation
- Guided Imagery

-Neurological Surgery Vol. 6 (Pain)
Youman
Surgical Options

• Rarely Indicated
• Identifiable Etiology
• Implantable Stimulators
• Dorsal Root Entry Zone Leisoning
  ▪ (brachial plexus avulsion pain, spinal cord pain)
• Cordotomy
  ▪ (malignancy related pain)
• Deep Brain Stimulators
• Sympathetic Block/Sympathectomy
• Epidural Steroids/Facet Block
• Intrathecal Infusion Pumps – NEVER!!!
If they don’t work, why are they so popular?
Factors Influencing Opioid Use in Chronic Benign Pain

• “Pain Experts”
  • Junk Science
  • Pharmaceutical Company Influence
  • JCAHO
PORTENEOY

- Internist, NYC, 1980s
- Undertreated pain-cancer patients
- Promotes liberal use of opioids
- Adds non-cancer patients
  - addiction only rare-occurring drawback
“Pain is a little science, a lot of intuition and a lot of art”

-Russell Portenoy, MD

Now admits the “research” used to promote long acting opioids was pseudoscience.

(He is on Purdue Pharmaceutical Payroll)
“the terminology of substance abuse, as discussed elsewhere in this volume, was developed by specialists in addiction, whose frame of reference is the addict, rather than the medical patient receiving opioids for pain. It is necessary to clarify this terminology when applying it to the assessment of medical patients.”

-Substance Abuse, Lowinson, et al, 4th edition
Factors Influencing Opioid Use in Chronic Benign Pain

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“Get your facts first, and then you can distort them as much as you please.”

- Mark Twain

Boston Collaborative Drug Surveillance Project
- Reviewed 39,946 hospital records
- 11,882 received narcotics
- Only 4 documented cases of addiction
  - 2 meperidine, 1 oxycodone, 1 hydromorphone
ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter
Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154


17,000 U per square meter, with remissions (except for the cranial-nervous-system therapy with intrathecal injections of methotrexate in both). During complete remission (70 mg per square meter each week), this might take three to four months.

Results are shown in Table 1. Janet Bitran that in T-cell leukemia has a poor outlook, because of the limited number of remissions, they are not widely used. The incidence of lymphoblastic anemia in association with induction therapy but also poor prognosis could be improved further with better immunotherapy. However, the time being it may be possible to do with established criteria, such as age and
“There are three kinds of lies: Lies, Damn Lies, and Statistics.”

- Mark Twain
SUDs & Chronic Pain

• Portenoy and Foley, 1986, *Pain*
  ▪ 5% addiction with chronic opioid treatment
SUDs & Chronic Pain

  - Review article, upper limit of addiction rates at 19%
>30% of patients in the Chronic Pain Rehabilitation Program have an active Substance Use Disorder.

Cleveland Clinic
(2010)

Meta-analysis of 38 studies

Prevalence of SUD in chronic back pain patients receiving opioids with a lifetime prevalence as high as 54%
SUDs & Chronic Pain

Drug Misuse in Chronic Pain
100 Consecutive patients admitted to Johns Hopkins Pain Treatment Program in the mid 1970s

- Addicted to Narcotics 90%
- Misusing/Abusing Narcotics 90%
- Misusing/Abusing Psychotropics 80%
- Prescriptions from multiple physicians >50%
- Withdrawal symptoms 90%
- Inappropriate combinations of drugs or inappropriate ingestion 97%
Opioids for Chronic Pain

• No study demonstrating long term functional improvement
• No study demonstrating long term analgesia
Opioid Induced Hyperalgesia

• Methadone maintenance patients have lower pain thresholds than controls, cocaine addicts and former heroin users not on methadone

Factors Influencing Opioid Use in Chronic Benign Pain

- “Pain Experts”
- Junk Science
- *Pharmaceutical Company Influence*
- JCAHO
Morphine

Early 1800s

- Developed as a less addictive alternative to opium
- Civil War vets treated
- “Soldiers Disease”
  - Civil War Vet Addicts
- Named after Morpheus
  - (god of dreams)
  - 300,000 addicts in 1900
Heroin

- Developed in 1898
- Bayer
- Less addictive alternative to Morphine
Dilaudid

- Developed in 1930
- Touted as less addictive
Percodan

• Developed in 1950 by Endo
• 1963 – Attorney General of California states Percodan responsible for $\frac{1}{4}$ of all addiction statewide

• Endo’s Response
  ▪ Percodan has little or no addictive potential
OxyContin

- Developed in 1996 – Purdue Pharma
- FDA Examiner, Curtis Wright, MD okayed this label
  
  “Delayed absorption as provided by OxyContin tablets is believed to reduce the abuse liability of the drug”

- Curtis Scores Big Job at Purdue!!
- “Medical Newsletter” widely distributed to Physicians reports a “study” reveals ONE in every household is suffering from undertreated pain – 2 weeks later OxyContin is introduced
• David Haddox, MD, DDS – Emory/Atlanta, Psychiatry/Addiction coined term “pseudo-addiction”
  ▪ Now the VP, Health Policy at Purdue Pharma
  ▪ Does damage control
    • Incidence of Addiction <1%

• “We do not want to niche OxyContin just for cancer pain,” a marketing executive explained to employees planning the drug’s debut, according to minutes of the 1995 meeting.
Thebaine

• From Poppy Plant
• Used to Produce Oxycodone
• Thebaine rich poppy grown in Tasmania
• Production and export to U.S. after OxyContin release increases so much it draws the attention of the International Narcotics Control Board
PAIN KILLER

A "WONDER" DRUG'S TRAIL OF ADDICTION AND DEATH

BARRY MEIER
Purdue Pharmaceuticals produces OxyContin
Johnson & Johnson

Janssen produces Duragesic
Ortho McNeil produces Tylox

Dupont

ENDO produces Percodan/Percocet

Abbott

Knoll produces Vicodin

American Pain Foundation
American Pain Foundation

American Pain Society
American Academy of Pain Medicine
Factors Influencing Opioid Use in Chronic Benign Pain

- “Pain Experts”
- Junk Science
- Pharmaceutical Company Influence

- JCAHO
IMPLEMENTATION STRATEGIES
JCAHO Pain Standards

• Include pain treatment in patient Bill of Rights
• Screen all patients for pain on admission and regularly thereafter
• Ensure competency of staff and physicians in pain assessment and management
• 5th Vital Sign
• Ask every patient on admission: “Do you have pain now?” If yes, obtain additional data (Initial Pain Assessment Tool).

• Standardize the use of pain scales
The UGLY—OUR PATIENTS ARE DYING
“There are 50 million people in this country who are undertreated for pain”

-Howard Heit, MD

2009 ASAM Annual Conference
New Orleans, LA
Data from N.C. Controlled Substance Reporting System  
(6 month review 2007)

<table>
<thead>
<tr>
<th>Controlled Substances</th>
<th>No. Scripts</th>
<th>Controlled Substances</th>
<th>No. Scripts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Oxycodones</td>
<td>935,394</td>
<td>12. Concerta</td>
<td>144,143</td>
</tr>
<tr>
<td>3. Alprazolam</td>
<td>712,680</td>
<td>13. Temazepam</td>
<td>111,520</td>
</tr>
<tr>
<td>5. Clonazepam</td>
<td>421,155</td>
<td>15. Lunesta</td>
<td>102,874</td>
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<tr>
<td>6. Propoxyphene</td>
<td>401,674</td>
<td>16. Amphetamine Sulfates</td>
<td>80,047</td>
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<tr>
<td>7. Lorazepam</td>
<td>364,569</td>
<td>17. Fentanyl</td>
<td>77,252</td>
</tr>
<tr>
<td>8. Diazepam</td>
<td>247,763</td>
<td>18. Methadone</td>
<td>70,284</td>
</tr>
<tr>
<td>10. Ambien</td>
<td>151,317</td>
<td>20. Codeine Compounds</td>
<td>45,545</td>
</tr>
</tbody>
</table>

Preliminary data, The Controlled Substances Reporting System, March 2008 (20)

North Carolina Population in 2007: 9,061,032
CDC Statistics

259M
Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.

Source: http://www.cdc.gov/drugoverdose/data/prescribing.html
### Medication numbers in prescriptions 2010 (in millions)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medication and Formulation</th>
<th>Type</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Hydrocodone/Acetaminophen</td>
<td>Drug of abuse</td>
<td>131.8</td>
</tr>
<tr>
<td>2.</td>
<td>Simvastatin</td>
<td></td>
<td>94.1</td>
</tr>
<tr>
<td>3.</td>
<td>Lisinopril</td>
<td></td>
<td>87.4</td>
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<tr>
<td>4.</td>
<td>Levothyroxine sodium</td>
<td></td>
<td>70.5</td>
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<tr>
<td>5.</td>
<td>Amlodipine</td>
<td></td>
<td>57.2</td>
</tr>
<tr>
<td>6.</td>
<td>Omeprazole</td>
<td></td>
<td>53.4</td>
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<tr>
<td>7.</td>
<td>Azithromycin</td>
<td></td>
<td>52.6</td>
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<tr>
<td>8.</td>
<td>Amoxicillin</td>
<td></td>
<td>52.3</td>
</tr>
<tr>
<td>9.</td>
<td>Metformin</td>
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<td>48.3</td>
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<tr>
<td>10.</td>
<td>Hydrochlorothiazide</td>
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<td>47.8</td>
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<tr>
<td>11.</td>
<td><strong>Alprazolam</strong></td>
<td>Drug of abuse</td>
<td>46.3</td>
</tr>
<tr>
<td>12.</td>
<td>Lipitor</td>
<td></td>
<td>45.3</td>
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<tr>
<td>13.</td>
<td>Furosemide</td>
<td></td>
<td>43.4</td>
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<tr>
<td>14.</td>
<td>Metoprolol tartrate</td>
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<td>38.9</td>
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<tr>
<td>15.</td>
<td><strong>Zolpidem tartate</strong></td>
<td>Drug of abuse</td>
<td>38</td>
</tr>
<tr>
<td>21.</td>
<td>Oxycodone/Acetaminophen</td>
<td>Drug of abuse</td>
<td>31.9</td>
</tr>
</tbody>
</table>
Some states have more painkiller prescriptions per person than others.

Number of painkiller prescriptions per 100 people

- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.

http://www.cdc.gov/vitalsigns/opioid-prescribing
The use of therapeutic opioids—natural opiates and synthetic versions—increased 347% between 1997 and 2006, according to this U.S. Drug Enforcement data.
117 “pain clinics” (pill mills)
70 McDonald’s Restaurants
Orlando Sentinel, Feb. 2011
OPIOIDS THE DARK SIDE

• Between 1999 and 2002
  ▪ Oxycodone prescriptions increased 50% to 29 million
  ▪ Fentanyl prescriptions increased 150% to 4.6 million
    • 80% Fentanyl patches prescribed for nonmalignant pain-approved only for cancer pain
  ▪ Morphine prescriptions increased 60% to 3.8 million
Pharmaceutical drug distribution:
1997-equivalent 96mg morphine/person
2007-equivalent 700mg morphine/person
>600% increase
This is enough for everyone in the U.S. to take 5mg hydrocodone Q 4hr for 3 weeks
-JAMA, 2-22/29-2012
OPIOIDS THE DARK SIDE

• For the past 5 years (2001-2006) the most prescribed medication of any category in the US has been:
  - Hydrocodone/Acetaminophen – over 100 million prescriptions in 2005

• In 2004, the United States used 99% of the world’s supply of hydrocodone

- JAMA, 1-17-2007
Opioid Prescriptions Drop for First Time in Two Decades

- Opioid prescriptions have fallen in 49 states since 2013
  - Sorry North Dakota
- Hydrocodone has been the largest decline
- Fatal overdoses from opioids have continued to rise, taking more than 28,000 lives in 2014

Don’t Forget About Benzodiazepines

• The number of adults using a benzodiazepine increased from 8.1 million prescriptions in 1996 to 13.5 million prescriptions in 2013.
• There has been a 5 fold increase in the overdose death rate associated with benzodiazepine use during this time.
• Most commonly prescribed for anxiety and insomnia
• Involved in 31% of fatal prescription drug overdose deaths
Supplemental Figure A. Percentage of adults filling a benzodiazepine prescription, quantity filled, and overdose mortality involving benzodiazepines by age, sex, and race/ethnicity in the United States, 1996-2013

Legend: Points represent raw data; lines represent modeled trends via joinpoint regression
National Overdose Deaths
Number of Deaths from Benzodiazepines

Source: National Center for Health Statistics, CDC Wonder
• As we have been more reluctant to prescribe high dose opiates to patients, the heroin market has taken off
National Overdose Deaths

Number of Deaths from Heroin

- Total
- Female
- Male

Source: National Center for Health Statistics, CDC Wonder

www.fairbankscd.org
National Overdose Deaths
Number of Deaths from Prescription Opioid Pain Relievers

Source: National Center for Health Statistics, CDC Wonder
Deaths from Prescription Opioid Pain Relievers

Number of Deaths Benzodiazepines

Source: National Center for Health Statistics, CDC Wonder

2014 CDC Statistics
Who Is Today's Average Heroin User?

- Average Age: 32 years old
- Ethnicity: 79% White
- Sex: 56% Male
- Location: 75% Small Urban or Rural Region

Source:
MVA vs. Poisoning Deaths Nationally

NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data

Source: Centers for Disease Control and Prevention, WISQARS Database
• Accidental Overdose Rx Painkillers
  4,000 in 1999
  20,000 in 2004
  27,000 in 2007
• MORE common than MVA deaths
• For every fatal overdose there are 7 nonfatal overdose
• $72.5b direct health care costs/yr
  - JAMA, 5-26-2010 & 2-22/29-2012
OPIOIDS THE DARK SIDE

• North Carolina MB/PHP 2011
• 3 deaths/day
  ▪ Accidental Rx drug overdose
  ▪ Highest percentage of deaths:
    
    *Pts on high daily doses of opioids Rx’d by their own Family MD*

Forum North Carolina Medical Board
Winter 2012
“I’ve seen the needle and the damage done a little part of it in everyone but every junkie’s like a setting sun…”

The needle and the damage done

Neil Young
Heroin Bindles ($15 to $25 will buy you 1/10 gram)
Indianapolis Heroin Balloons $10 each
10% to 50% Pure
Philadelphia Marketing Stephen Curry $25 each
Imodium
“for every complex problem there is a solution that is simple, neat and wrong.”

H.L. Mencken
SOLUTIONS

- Education
- Medical/Dental School, providers, public
- Pharmaceutical Industry
- Regulate/provide addiction treatment
- Prescription monitoring
- DEA
SOLUTIONS
Prescribing for Chronic Pain

- Evaluation
- Treatment Plan
- Informed Consent
- Periodic Review
- Consultation

68 cases public discipline 2010 NCMB
“improper prescribing”
Questions?