CASE RECOMMENDATION FORM

Presenter Credential: __MD_____

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Summary: 65-year-old female Medicare patient with a complex medical and psychiatric history, including major depressive disorder, insomnia, chronic cervical spine and back pain following a motor vehicle accident 35+ years ago, and significant abdominal pain related to a right lower quadrant end ileostomy with a painful parastomal hernia deemed non-operable by two surgeons. She has a history of physical trauma, prior opioid and benzodiazepine use, and an unintentional overdose during a transition from oxycodone to morphine. Her current pain regimen of Norco 5-325mg four times daily provides inadequate relief, and a recent taper has worsened her functioning. She uses THC (edibles and smoking) most days for pain and currently smokes cigarettes. She is medication-adherent and seeks guidance on non-opioid treatment options for her chronic, non-surgical pain.

Recommendations:

- **Explore localized treatments** for peristomal hernia pain:
  - Consider a trial of topical diclofenac gel.
  - Consider steroid injections near the painful site, if appropriate.
  - Evaluate potential for a celiac plexus block as a more targeted interventional option.
- **Reassess systemic medications:**
  - Trial of acetaminophen, especially the arthritis formulation (650 mg BID), as a potentially safer adjunct.
  - Consider switching duloxetine to nortriptyline for dual benefit of neuropathic pain coverage and sedation to improve sleep.
    - Titrate nortriptyline cautiously (start ~10 mg) and taper duloxetine accordingly.
    - Monitor with therapeutic drug levels to optimize pain control.
  - If neuropathic mechanisms are suspected, gabapentin or pregabalin may be viable alternatives.
- **Address and re-evaluate sleep disturbances:**
  - Assess current sleep quality more thoroughly at next visit.
  - Consider whether improving sleep could indirectly reduce perceived pain intensity.
- **Medication caution and transitions:**
  - Be cautious with Tramadol due to its serotonergic activity, especially if continuing duloxetine.
  - If trialing Tramadol, duloxetine would need to be reduced or discontinued to avoid serotonin syndrome risk.
- **Consider low-dose naltrexone or buprenorphine** as a later-line option:
  - Especially if pain is deemed more centralized or fibromyalgia-like.
  - Requires compounding and slow titration.

Consider presenting follow-up for this patient case or any other patient cases at a future ECHO Clinic session.

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