

ECHO IDAHO

Substance Use in Idaho

Treating Chronic Pain

7/9/26

Eli Harris, MD

Pain Management System

Saint Alphonsus Health System

None of the planners or presenters for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Background

College: Brown University

Medical school: University of Washington

Internship: Boise VA internal medicine residency

Residency in Anesthesiology: University of New Mexico

Fellowship in Pain Management: University of Virginia

Board Certifications: Anesthesiology and Pain Management

8 years at Saint Alphonsus Comprehensive Pain and Spine

Disclosures

- None

Objectives



Understand Chronic Pain



General treatment strategies



Specific treatment interventions

Pain

- An unpleasant physical or emotional sensation often associated with actual or potential tissue damage

Acute pain

- Serves as a protective function

Chronic Pain

- **Definition:** Pain that persists beyond normal tissue healing time, typically >3 months.
- **The Shift:** Acute pain acts as an alarm (protective); chronic pain acts as a malfunctioning alarm system (pathologic).
- **Key Distinction:** Not only a symptom, but recognized as a distinct disease state. Serves no protective function.

Chronic Pain: Economic Burden

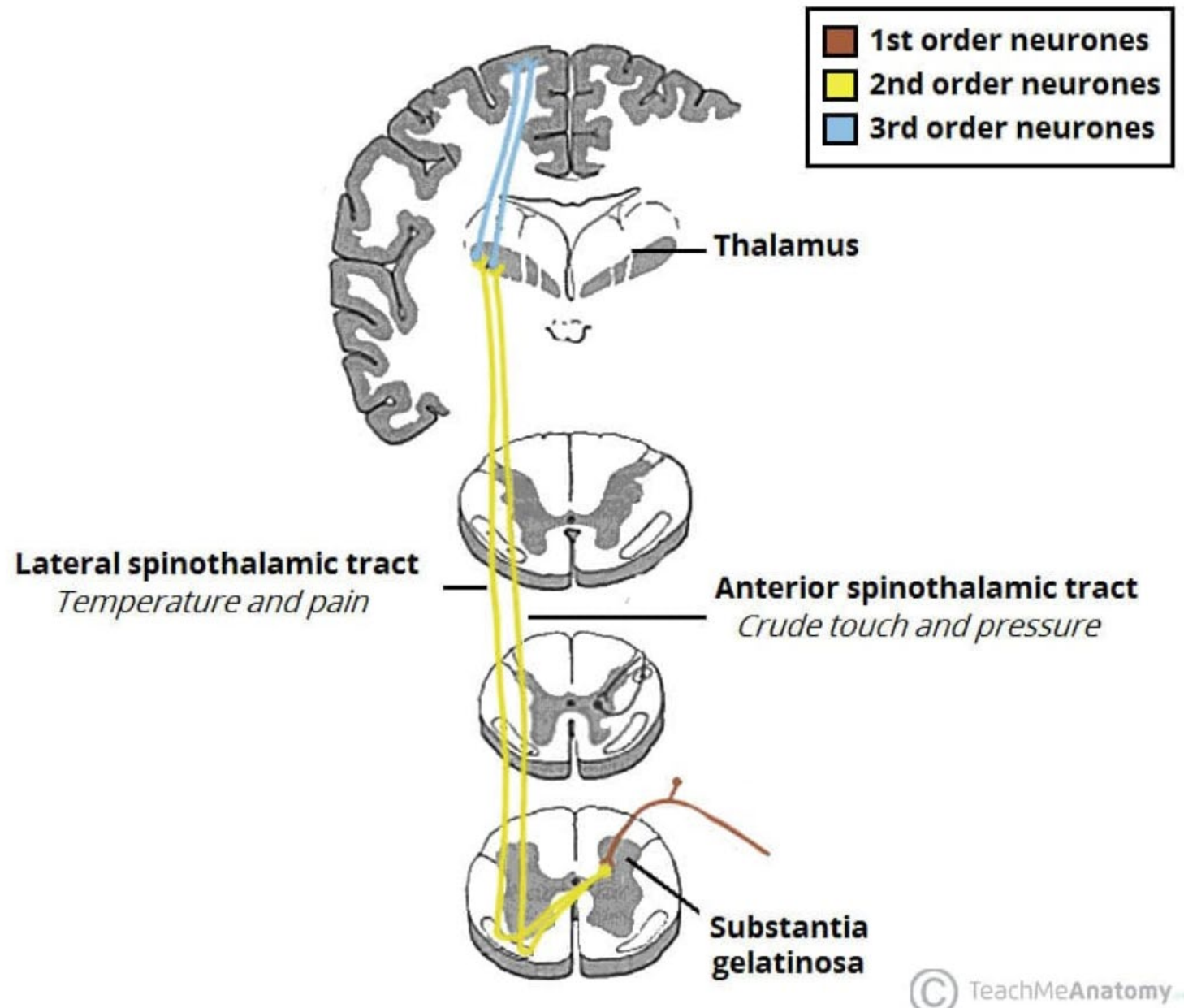
➤ **\$722 billion annually**

- **\$531 billion in direct medical care costs**
- **\$192 billion in lost work productivity**

Pain becomes pathologic

Pain processing
becomes abnormal
(neuropathic pain
syndromes)

Nociceptive pain is
sustained (arthritis)



Peripheral Mechanisms



NOCICEPTOR SENSITIZATION: CONSTANT STIMULATION CAUSES SPECIALIZED NERVE ENDINGS IN TISSUES TO LOWER THEIR THRESHOLD FOR ACTIVATION.



INFLAMMATORY SOUP: IMMUNE CELLS RELEASE CHEMICALS (E.G., PROSTAGLANDINS, HISTAMINE, BRADYKININ) THAT MAKE LOCAL NERVES HIGHLY EXCITABLE.



RESULT: NORMAL TOUCH OR MOVEMENT BEGINS TO TRIGGER PAIN SIGNALS (ALLODYNIA)

Central sensitization

- Repeated C fiber neural activation sensitizes spinothalamic neurons
- Leads to:
 - Spontaneous impulse activity and lower pain threshold
 - Exaggerated response to impulses
→ hyperalgesia, allodynia, spontaneous pain
- Cortical remapping occurs; areas of the brain processing pain expand, and descending inhibitory pathways become less effective.

Biopsychosocial Model



BIOLOGICAL



PSYCHOLOGICAL



SOCIAL

Approach to seeing a patient clinically

- Pain assessment: VAS, Brief pain inventory, PEG scale, ODI
- Pain History
- Specific limitations (behavioral, functional)
- Physical exam

Treatment of Chronic Pain

Education about chronic pain and long-term expectations

Treatment of Chronic Pain

Multidisciplinary

Psychological & Behavioral Interventions.

Therapeutic modality	Description of treatment
Operant-behavioral therapy	Treatment focuses on extinguishing maladaptive behavioral responses and fostering of adaptive behavioral responses to pain. Behavioral responses are altered through reinforcement and punishment contingencies and extinction of associations between threat value of pain and physical behavior.
Cognitive-behavioral therapy (CBT)	Treatment applies biopsychosocial approach to pain that targets behavioral and cognitive responses to pain. CBT protocols involve psychoeducation about pain, behavior, and mood, strategies for relaxation, behavioral pacing, behavioral activation, positive event scheduling, effective communication, and cognitive restructuring for distorted and maladaptive thoughts about pain.
Mindfulness-based stress reduction	Treatment promotes a nonjudgmental approach to pain and uncoupling of physical and psychological aspects of pain; teaches “nonstriving” responses to pain through experiential meditations and daily mindfulness practice intended to increase awareness of the body and proprioceptive signals, awareness of the breath, and development of mindful activities.
Acceptance and commitment therapy	Based on psychological flexibility model, treatment focuses on development of acceptance of mental events and pain and ceasing of maladaptive attempts to eliminate and control pain through avoidance and other problematic behaviors; emphasizes awareness, defusion, and acceptance of thoughts and emotions as well as behavioral engagement in pursuit of personal goals.

Physical therapy and rehabilitation

- Graded exposure and pacing
- Therapeutic Exercise
- Manual Therapy
- Functional/Neuromuscular Re-Education
- Adjunct Modalities
 - Dry Needling
 - TENS
 - Water PT

“Pain Management”



Chronic Pain Treatment – One approach

- Recognize type of pain
 - Nociceptive
 - Neuropathic
 - Centralized

Nociceptive

- NSAIDS
- Acetaminophen
- Opioids if appropriate
- Suzetrigine
- Topicals

Neuropathic

- Topical medications
- Tricyclic antidepressants
- SNRIs
- Anti-epileptic drugs
 - Gabapentin
 - Lyrica
 - Carbamazepine/Oxcarbazepine (facial pain)
 - Topiramate (headaches)
- Consider Opioid treatments, but with significant caution due to potential for induced hypersensitivity.

Centralized

- TCAs
- SNRIs
- AEDs
- Low dose naltrexone
- Avoid opioids due to opioid-induced hypersensitivity

Anticonvulsants

→ Gabapentin

→ Pregabalin



Antidepressants

→ Duloxetine and other SNRIs

→ TCAs



Topicals

- Lidocaine
- Diclofenac
- Capsaicin
- Compounded



Fibromyalgia

- 1st line: Cymbalta, Lyrica
- Consider: Gabapentin, TCA, Cyclobenzaprine, LDN
- If failure and low risk, consider tramadol
- No benefit: Opioids, NSAIDs

Muscle Relaxers

- No indication for chronic use
- Carisoprodol: “no use for any indication”
- Benzodiazepines: No analgesic efficacy for chronic pain
- Low back pain: Evidence shows minimal efficacy

- **Conclusions** Considerable uncertainty exists about the clinical efficacy and safety of muscle relaxants. Very low and low certainty evidence shows that non-benzodiazepine antispasmodics might provide small but not clinically important reductions in pain intensity at or before two weeks and might increase the risk of an adverse event in acute low back pain, respectively. Large, high quality, placebo controlled trials are urgently needed to resolve uncertainty.

BMJ meta-analysis 2021

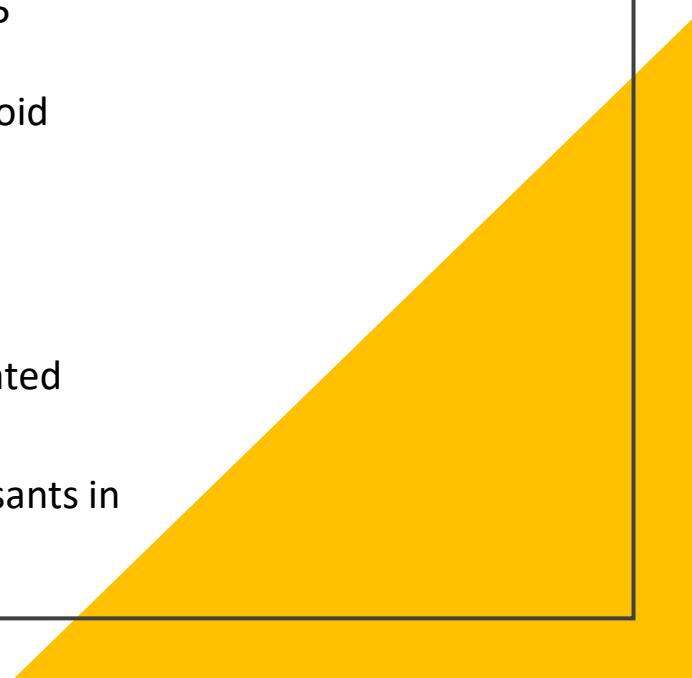
Muscle Relaxers

- Cyclobenzaprine: TCA-like, indicated as chronic treatment for fibromyalgia
- Baclofen/Tizanidine: Indicated for spasticity
- Methocarbamol
- Low back pain: Evidence shows minimal efficacy

Opioids

- Indicated for severe acute pain
- Not indicated for chronic pain

Medscape review article on Opioids for CNCP (Chronic Non-Cancer Pain)

- All patients with CNCP do not respond to opioid analgesics, only 30–50% of carefully screened subjects report decrease in pain with opioids
 - The results of RCT's cannot be generalized because clinical trials do not include CNCP patients with multiple pain complaints, anxiety, depression or other psychiatric comorbidities – the type of patient most likely to be on long-term and high dose opioid therapy
 - Opioids do not eliminate pain, initial pain relief is around 30% in most studies
 - There is no controlled study that has evaluated long term efficacy
 - Studies show a high attrition rate over time (typically declining analgesia vs drug related adverse effects)
 - Opioid analgesics are not superior to NSAIDs, tricyclic antidepressants or anticonvulsants in reducing pain.
- 
- A large yellow triangle is positioned in the bottom right corner of the slide, pointing towards the top right.

Bohnert et al. 2011

- Compared with <20 MME, HR for overdose death:
 - 20-<50 MME/d----- 1.88
 - 50-<100 MME/d----- 4.63
 - ≥ 100 MME/d----- 7.18

Dunn et al. 2010

- Compared <20 MME/d, HR for overdose:
 - 20-<50 MME/d----- 1.4
 - 50-<100 MME d----- 3.7
 - >100 MME/d----- 8.9

If you are going to prescribe opioids for CNCP

- Opioid Risk Tool: benefits must outweigh risks
- Utox for baseline and throughout therapy
- Opioid contract initially and throughout therapy
- Establish baseline pain and function (Brief Pain Inventory, PEG score)
- Set functional treatment goals
- If treatment goals not met, taper off
- Regular office visits (1-3 months)
- Do not combine with sedatives
- Narcan

Treatment – Interventional Procedures

Injections
(Nerve blocks,
ESI, Joints, etc)

Investigational
injections

RFA

Corrective
procedures

Spinal cord
stimulation

References

- Sturgeon JA. Psychological therapies for the management of chronic pain. *Psychol Res Behav Manag*. 2014 Apr 10;7:115-24. doi: 10.2147/PRBM.S44762. PMID: 24748826; PMCID: PMC3986332.
- Ferreira et al. **Efficacy, safety, and tolerability of antidepressants for pain in adults: overview of systematic reviews.** *BMJ* 2023;380:e072415. doi: <https://doi.org/10.1136/bmj-2022-072415>
- Cashin et al. **Efficacy, acceptability, and safety of muscle relaxants for adults with non-specific low back pain: systematic review and meta-analysis.** *BMJ* 2021;374:n1446. doi: <https://doi.org/10.1136/bmj.n1446>
- https://www.medscape.com/viewarticle/813875_2
- Dalal S, Chitneni A, Berger AA, Orhurhu V, Dar B, Kramer B, Nguyen A, Pruitt J, Halsted C, Kaye AD, Hasoon J. Buprenorphine for Chronic Pain: A Safer Alternative to Traditional Opioids. *Health Psychol Res*. 2021 Aug 6;9(1):27241. doi: 10.52965/001c.27241. PMID: 34746493; PMCID: PMC8567798.
- Rauck RL, Potts J, Xiang Q, Tzanis E, Finn A. Efficacy and tolerability of buccal buprenorphine in opioid-naïve patients with moderate to severe chronic low back pain. *Postgrad Med*. 2016 Jan;128(1):1-11. doi: 10.1080/00325481.2016.1128307. Epub 2015 Dec 22. PMID: 26634956.
- Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. *MMWR Recomm Rep*. 2022 Nov 4;71(3):1-95. doi: 10.15585/mmwr.rr7103a1. PMID: 36327391; PMCID: PMC9639433.
- Guy GP Jr, Miller GF, Legha JK, Rikard SM, Strahan AE, Mikosz C, Florence CS. Economic Costs of Chronic Pain-United States, 2021. *Med Care*. 2025 Sep 1;63(9):679-685. doi: 10.1097/MLR.0000000000002181. Epub 2025 Jul 3. PMID: 40730349; PMCID: PMC13284907.
- <https://teachmeanatomy.info/neuroanatomy/pathways/ascending-tracts-sensory/>
- Herrero JF, Laird JM, López-García JA. Wind-up of spinal cord neurones and pain sensation: much ado about something? *Prog Neurobiol*. 2000 Jun;61(2):169-203. doi: 10.1016/s0301-0082(99)00051-9. PMID: 10704997.

Comments and Questions

