SCOPE of Pain Webinar
1/25/2025
Questions and Answers

Question	Answer
Seems like some of the recenter recommendations focus on _topical_ NSAIDs	I've found topical NSAIDs to be quite useful for focal pain that is superficial like prepatellar bursitis of knee or lateral epicondylitis
How frequently does lidocaine patch show incorrectly as cocaine in urine drug screen?	this is extremely rare as most EMIT/ELISA (Screening tests) are fairly specific for cocaine, i.e. few false positives even from other type 1 anesthetics like lidocaine
Agree with Dr. Becker. Most tests look specifically for Benzoylecgonine, a metabolite specific to cocaine, not other 'caines	thanks for that detail -- spot on!
Should genetic testing be considered in patients with refractory chronic pain due to the mu receptor differences?	I think the technology here is emerging... my two cents is the current assays are costly and are not going to meaningfully direct therapy. BUT i do know that studies are underway.
Keep in mind, an INSTANT test may test as non-negative and should be sent off to a certified lab for the battery of tests that can differentiate the specific drug found	Great point -- we will touch on this later in the presentation as well
It is my understanding, Buprenorphine based pain med is recommended for COPD, asthma or lung issues. What is your recommendation? TY>	some guidelines -- for example VA/Dept of Defense recommend that *if* one is going to prescribe an opioid long-term for someone with chronic lung disease, buprenorphine would be favored over full agonists. but this recommendation is not universally adopted yet.
would fatty liver be concerned liver disease when concerned about opioid clearance issues?	if fatty liver becomes more advanced and transitions to cirrhotic disease, absolutely.
Often pt's QOL is not changed but when asked pt often request increased dose. So unfortunately, shared decision sometimes do not work. What can clinician do at that time? TY	Great question. Endless dose escalation is rarely safe or effective, but it may be reasonable to trial higher doses in a very limited way. Ultimately, the assessment of safety needs to be made by the prescriber and shared decision-making plays less of a role when there is no evidence of benefit or evidence of harm.

would you clarify MME - I am not clear on it and how to use it	This acronym refers to "morphine milligram equivalents", essentially the equivalent dose of morphine to whatever other opioid you are prescribing. Later on we will discuss how to use equianalgesic opioid conversion tables to calculate this. Higher MME = higher risk. Hope that helps!
what about the drug orphan who wants a specific drug that is moderate, reports allergy to NSAIDS, gabapentin and intolerance to tricyclics? Pain is not controlled satisfactorily	Sounds like a challenging situation. As always, the answer will vary based on the specifics of the case and opioids may or may not be appropriate here. For example, have nonpharmacologic treatments been optimized? How about non-opioid medications such as acetaminophen and SNRIs? Is there a procedural intervention to do? Is the underlying pain etiology something that can be addressed? In complex cases, a pain medicine consult may be helpful. Hope this reflection is useful to you.
UDS is recommended in outpt setting. How about in Long-term pt setting? TY.	These recommendations are really intended to focus on best practices in ambulatory care settings. If the patient lives in an supervised medical setting or is in the hospital, the plan of care will undoubtedly be driven by the care needs. That said, even in supervised settings there can be diversion or drug misuse, sometimes facilitated by visitors, and opioid use disorders can still develop. It is a good idea to continue with safety monitoring in all settings. Hope that helps.
I have noted that PMP do not report MMTP programs? How should a clinician verify something like that? TY	I think Will just addressed this, but this is indeed a challenge! Urine drug testing may help to identify this if the information isn't volunteered or otherwise available, so that's a consideration.
Challenges I am facing is mostly a surgical candidate for back or knee or hip who do not want the surgery and wants to stay on opioids that was prescribed by previous providers. Any chance physiatry can help in this case? What will be their role in these cases?	I think Physiatrists can be very helpful. Individual practices may vary but many offer peripheral and axial spine injections that may be helpful. Trigger point injections as well. They may also add another voice to the patient of recommending surgery if indicated.
Scenario 1b makes me wonder if the patient has 1. depression and/or 2. PTSD	That's a very reasonable concern and reassessing for the presence of comorbid mental health disorders is a key step in

	the assessment.
Is it REALLY stigma or is it PERCEIVED stigma?	It could be either, although there are certainly some words and behaviors that prescribers, the media, and others use that perpetuate the problem. I'll be sharing a slide on this soon.
Isn't opioid diversion a felony in most jurisdictions?	I'm not fully qualified to answer but there is a wide spectrum of diversion behavior. someone can be giving a few pills to their spouse or stockpiling and selling large quantities, each have different legal ramifications I would imagine
Does patients with opioid use disorder tend to have poor response to acute pain relief with opioids?	actually, this is very understudied aspect of medicine but I can say anecdotally -- no difference once you make sure you are already giving them basal MOUD
So, just because patients OME is > 50 doesn’t mean we “have to” get it under 50 ome?	correct!