



# SPS NEWS

The Official Publication of The Southern Pain Society

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## Disaster Preparedness; Are your Pain Patients and Practice Ready?

Donna Bloodworth, MD

*(Editorial Note: Dr. Bloodworth is a specialist in Physical Medicine and Rehabilitation, and pain. Based in Houston, she was at the forefront of caring for Hurricane Katrina victims, and has written and lectured on such disaster preparedness. She is an active member of the SPS).*

Even under the eminent threat of a hurricane, only about half of the households will have a plan of action to respond to the possible disaster. In order to help medical professionals plan for themselves and their patients, three topics are offered for consideration relevant to the practice of pain medicine. First, pain care and scheduled medications for the treatment of pain may not be widely available after a weather disaster, and therefore and as a second point, our patients should be prepared to explain their medical condition and needs to an emergency healthcare provider. The individual pain patient must also be able to manage his or her pain independent of the medical system. Lastly, physicians and allied health professionals have to prepare not only their patients, but also their businesses, homes and families for the severe weather event.

At the Astrodome in Houston, Texas, which was one of the largest shelters in the United States to receive evacuees from Southeastern Louisiana after Hurricane Katrina, one in thirty medical visits involved pain of acute or chronic natures. Headache was the most common pain reported but pain diagnosis varied from the acute pain of new onset hip fracture to chronic low back pain. Security concerns led incident commanders at the Astrodome to decide to stock only non-controlled substances for the treatment of pain at the clinic serving the shelter. Tramadol, acetaminophen and a variety of non-steroidal anti-inflammatories were available at the Astrodome. Patients with pain due to unstable medical conditions, like fractures, were transported to area hospitals with full formularies. For outpatients who required medications not available at the Astrodome, prescriptions could be written that could be filled at local pharmacies. However, at the point of initial contact in an emergency shelter for disaster victims, both patients and responding health care personnel may have to make due with a limited formulary. For patients with highly specialized technologies like implantable pumps, assistance may be hard to find outside the setting of a medical university or tertiary-care facility.

At the Substance Abuse and mental Health Services Administration (SAMHSA) Spirit of Recovery conference held in New Orleans in May 2006, nine months after Hurricane Katrina, the variable quality of pain care after Hurricane Katrina was discussed. Anecdotes from the audience related that some patients on long-term opioids sought care for pain at opioid-maintenance programs. Pain patients were separated from their providers, providers were displaced from their practices and communications were disrupted. Patients seeking care had few or no accompanying medical records. Hesitation to provide controlled substances for pain relief existed even among experienced pain practitioners. Professional and patient advocacy societies quickly collaborated to develop recommendations for the treatment of pain patients displaced by the Hurricane which can be found at the SAMHSA's website.

For our patients, we need to anticipate a limited availability of pain care in the aftermath of a large weather-related disaster. This limitation will have less impact on our patients if we prepare them better to be separated from their traditional health care provider or system. It is important to remember that a large scale disaster like Katrina is not required to separate a patient from his or her physician. For example, a personal inconvenience like a flat tire on a Friday afternoon going into a long holiday weekend can keep a patient from seeing their doctor. Health care providers who specialize in pain management need to instruct patients about what medications can be stopped abruptly, and techniques to manage pain without medications for special circumstances like weather and personal emergencies.

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## Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

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# Editor's Desk

Ike Eriator, MD, MPH



The Southern Pain Society annual conference this year is centered on evaluating and treating the pain patient with complex problems. This is quite timely and appropriate, as pain practitioners are not only having to deal more and more with older and sicker patients with multiple medical problems, but such practitioners are also having to contend with younger patients with complex issues including substance abuse. These days, the abuse of pre-

scription opioids is rising by leaps and bounds. Recent Substance and Mental Health Services Administration (SAMHSA) data indicate that the emergency room visits for overdoses of prescription medications is almost equal to those of cocaine and heroin combined (see News from the Pain World). Top on the list of these prescription medications causing overdoses is opioid, the badge of many pain practitioners. Opioids have been around for much of the recorded history of mankind. They have been used to assuage suffering, pain and melancholy. And the social history of mankind shows that people do not often separate pain from suffering or melancholy. So our patients present with pain and expect evaluation and treatment. We know there are sensory, emotional and cognitive aspects to every pain, with variable contribution from each aspect in different patients. Our goal as pain practitioners is to elucidate the contributions from each aspect and direct therapy accordingly. One treatment modality does not fit all. A multidisciplinary approach is the way to go. The conference this year is organized around this concept. It promises speakers from different specialties contributing to the care of that most desolate of all mankind – the patient with pain.

And in this issue of the Newsletter, the scientific editor examines the evidence for two approaches to care for back pain. It is interesting that population studies show that here in the United States we perform five more surgeries for back pain compared to Sweden, without any indication that our patients have better outcome in terms of improvement in pain, functionality or disability. Patient selection and culture may be at the heart of some of these differences. Also in this issue of the Newsletter, Dr. Donna Bloodworth provides tips for preparing and caring for pain patients in emergencies like hurricanes. The lessons of Hurricane Katrina are all too real, and we must take good care to ensure that the pain and suffering does not happen again. See you in Nashville for what promises to be an outstanding pain conference in the renowned city of Nashville... Warm regards... and happy reading.

# Helping Patients Make an Informed Choice Between Back Surgery and Interdisciplinary Pain Management

Leanne Cianfrini, PhD



In general, randomized controlled trials comparing outcomes of back surgery with non-surgical interventions such as comprehensive pain management programs are scarce due to the complexity of the study design. However, a few recent studies have suggested that the interdisciplinary chronic pain management approach might be as effective in treating lower back pain as back surgery.

A small randomized study conducted by a Norwegian team investigated 64 patients with evidence of severe lumbar disc degeneration<sup>(1)</sup>. The patients were randomly assigned to undergo either a posterior lumbar fusion with instrumentation and post-operative physical therapy or a modified chronic pain management program. The non-surgical intervention was primarily cognitive-behavioral in nature and consisted of an educational session designed to address fear of movement and re-injury, along with daily physical therapy, group sessions, etc., similar to components of many comprehensive interdisciplinary pain management programs. The results of the study are summarized as follows:

- There were no significant differences between the two groups in terms of pain, use of pain medicines, emotional distress, or ability to return to work.
- At 1-year follow up, both groups reported significant improvements in function, as measured by the Oswestry Disability Index, but there were no differences between groups on this measure (i.e., the surgical group score decreased from 41 to 26 and the non-surgical group from 42 to 30).
- Lower limb pain was reduced more in patients given surgery; Pain-related fear and avoidance beliefs were reduced significantly more in the pain management group compared to the surgery group.
- The back surgery group had an early complication rate of 18% (e.g., wound infections, venous thrombosis).

Similar results were shown in patients who had previously undergone back surgery and continued to present with lower back pain<sup>(2)</sup>. Additional support for the use of interdisciplinary chronic pain management was confirmed in a larger, multi-center, randomized trial by Fairbank and colleagues in the

United Kingdom<sup>(3)</sup>. This study included 349 patients with pain of at least 1 year duration who were considered candidates for spinal fusion but were uncertain of whether to pursue surgery or a more conservative option. These patients were randomly assigned to either spinal fusion surgery or “intensive rehabilitation” (a daily, 3-week chronic pain management program consisting of exercise and education based on cognitive-behavioral techniques). Study participants were followed for 24 months, with the following findings:

- The patients treated with spinal stabilization surgery showed a slightly greater statistical improvement ( $p = 0.045$ ) in function as measured by the Oswestry Disability Index, but no other differences between the two groups were significant.
- Intra-operative complications occurred in 19 patients who underwent back surgery, and 11 patients needed a second surgery during the 2-year follow-up period.
- The percentage of patients returning to work two years after the start of treatment was equivalent between the groups.

A follow-up study of these same patients found that the cost of chronic pain management was far less than that for back surgery by approximately 45%<sup>(4)</sup>. Turk and Burwinkle confirmed and extended this finding in a separate review of the literature, specifically noting that the interdisciplinary pain management program approach, compared to surgery, is 26 times more cost-effective in returning patients to work<sup>(5)</sup>.

A few additional points should be considered:

- 1) Surgical complications were identified in the studies summarized above, which is consistent with the fact that there are medical risks associated with any invasive procedure. In contrast, no surgical complications were identified in any of the rehabilitation programs. (This is, of course, mentioned somewhat “tongue-in-cheek”.) However, when comparing any non-surgical intervention to surgery, it is only fair and balanced to include a comparison not only of beneficial outcome figures but of potential “side effects” or risks involved. A consideration that might fall on the “con” side of the list for surgery (e.g., “possible infection”) could be placed on the “pro” side for a pain management program (e.g., “not likely to get an infection during relaxation therapy”).
- 2) We live in a “quick fix” society, in which therapies that promise an overnight cure today (with an implied role of patient as passive subject) pervade, no matter what the financial costs or risks. The authors of the 2003 study indicated that in their sample, beliefs in surgery were about twice as high as beliefs in non-surgical treatment prior to the intervention. Surgery understandably carries strong implications of success; a procedure is done by an expert physician to the patient in order to physically stabilize the anatomy. Pain management programs involve much more active physical, mental, and emotional par-

ticipation on the part of the patient. In addition, these programs often span several weeks requiring daily involvement, and they often target psychosocial factors that unfortunately may not appear to patients as clearly relevant to pain control.

In addition, patients are likely to interpret their insurance carrier's willingness to reimburse for a particular intervention as an endorsement of that procedure's efficacy without researching the alternatives. An 18% complication rate and no clear outcome advantage does not make a good case for spinal fusion as a first line treatment, but if that is what the patient's insurance will cover, their options are limited by a force outside of the patient-physician relationship.

3) Interdisciplinary pain management programs may be preferable for certain types of patients. For example, in patients with clear-cut neurological compromise (e.g., lower extremity weakness, bowel or bladder problems) and minimal comorbidities, spinal stabilization is likely the best choice. In fact, the key limitation to the studies described above is that the best candidates for surgery were excluded, which may have artificially minimized potential group differences. However, many patients with chronic low back pain or diffuse lumbar disc degeneration do not have a clearly identified pain generator and may be uncertain about whether back surgery is the best strategy. Certain characteristics may make a patient a better candidate for a non-surgical intervention, including those who:

- a) have an identified psychosocial risk such as high levels of pain-related fear or anxiety. Back surgery does not address these issues, whereas one of the goals of an interdisciplinary program is to help the patient reach acceptance and build coping skills to pursue meaningful activities despite associated discomfort.
- b) expect poor outcomes from back surgery, either because of fear or a previous failed back surgery.
- c) are addicted to or dependent upon opioid analgesics. Since substance abuse or overuse is associated with poorer spine surgery outcomes, patients with such problems would likely be better served by participation in a chronic pain management program than by having back surgery.

Although intensive rehabilitation looks promising for some patients, we should be looking at better means of selecting those who will benefit from rehabilitation and those for whom surgery really is the only option. For more guidance on this issue, an updated version of evidence-based practice guidelines for patient selection and treatment for chronic nonmalignant pain syndrome patients is available <sup>(6)</sup>.

4) Finally, comprehensive pain management programs do not necessarily have to be part of an either/or decision, although insurance reimbursement issues might limit the reality of this proposition. An option is to use a pain management program to better evaluate and prepare a patient

for future surgery. For example, a patient can learn stabilization exercises and develop a home-based exercise routine for post-surgical rehabilitation. An interdisciplinary team working within the cognitive-behavioral model prior to lumbar fusion surgery can also target: (a) inappropriate or unrealistic expectations about surgery, (b) modification of unhealthy behaviors that might reduce the chance of surgical success (e.g., smoking, substance use, improper activity pacing), and (c) reduction of psychological distress (e.g., depression, anxiety, anger) to enhance surgical outcomes.

In summary, there is no clear evidence that spinal fusion (no matter the specific surgical technique) is more beneficial than intensive rehabilitation based on cognitive-behavioral principles. The evidence from the studies summarized in this article supports the use of rehabilitation programs as a viable alternative to spinal fusion surgery in the management of chronic low back pain. Hopefully the results of these trials will give clinicians a more balanced view when they present therapeutic options to patients, so that patients are empowered and informed to make their own choice.

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## Disaster: Continued from page 1

The process of patient preparedness includes several steps. Along the Gulf Coast, where the most significant weather emergency is a hurricane or flooding, the late Spring or early Summer is probably an opportune time to discuss preparedness with patients. Preparedness steps include providing patients with updated copies of their long-term opioid consent forms, opioid treatment contracts and diagnostic summaries, and updated medication lists with special discussion of medications that should not be stopped abruptly. Instructions are given to keep these papers in a safe place with other materials with which the patient would travel or evacuate, like passports, drivers licenses, and medications. Non-medical techniques to cope with pain are reviewed with the patient also.

This preparedness exercise is not a chore, but provides an opportunity to check compliance with state and federal requirements for the practice of pain medicine. For example, in Texas a discussion of the risks and benefits of long-term opioid treatment as well as a discussion of treatment alternatives is required if opioids are used to treat intractable pain. By going over risks and benefits on the consent form, and alternative treatments to pain, the health care provider is not only giving the patient valuable information but is fulfilling state board requirements. A formal review of medications addresses JACHO requirements to confirm all medications the patient is taking, and review that a single provider and pharmacy are being used for scheduled medications. Physicians can tailor their preparedness exercise to fulfill an individual state's requirements for the practice of pain medicine.

Medication review is particularly useful. Pain patients are often treated with a variety of medications, both labeled for use in the treatment of pain, as well as used adjuvantly, or "off-label," in the treatment of pain. The variety of medications spans opioids, neuroleptics, benzodiazepines, beta- and alpha-blockers, anti-spasticity agents, serotonin reuptake inhibitors, and other medications which should not be stopped abruptly because of serious or life-threatening sequelae. A discussion of medications, documented in the patient's chart serves to demonstrate that the physician disclosed the off-label medications used for the relief of pain; neuroleptics, in particular fall in this category when treating pain patients. Patients are often surprised to find out they are on a "seizure drug" and that stopping it suddenly may induce seizures. This "surprise" may exist despite physician's discussing these facts when the medication was started. Preparedness discussions provide an annual opportunity for the patient to understand the purpose and adverse effects of medications prescribed, as well as an opportunity for the patient to clear up misunderstandings about the nature and correct use of the medications used to relieve pain. The physician can review special instructions about not cutting, chewing, breaking or otherwise altering the tablets of long acting opioids and of other modified release preparations.

In addition, the patient is taught how to introduce him or herself to an emergency medical provider, and how to advocate

for his or her own care. Pain care consent forms and contracts, as well as diagnostic summary sheets and medication lists may be useful to a healthcare professional staffing an emergency shelter clinic or providing provisional care to a patient separated from his or her health care provider. The goal of the patient self advocacy is not so much to demand more medication for the treatment of pain, but to explain effectively to a professional that may not be experienced in pain care, that the patient uses certain medications to relieve pain, and is trying to manage the painful condition, and avoid the potential adverse effects of discontinuing certain medications. These preparations with pain patients engender a better-informed individual, with increased personal control of their circumstances.

Finally, the health care provider must not only prepare patients for emergencies, but also prepare home, business, employees and families. Excellent resources exist to guide disaster preparedness, and specifically hurricane preparedness. The CDC's hurricane preparedness website details items needed to prepare one's family for a weather disaster. It cannot be over-emphasized that disaster response is local first. Familiarity with the process and prerequisites of disaster declaration will help the prudent person anticipate the limitations of the system of disaster relief, and implement the necessary steps to prepare for a weather emergency. The Federal Emergency management Agency (FEMA) website concerning "Disaster Declaration" provides a civics lesson in the local, then state and finally federal steps that must sequentially occur before a federal disaster can be declared, and before federal assistance can be deployed. An individual should anticipate that in a severe weather emergency, he or she may have to survive for three to five days before external help can arrive. Supplies need to be collected. Rotating shifts at work and bringing patients in for early refills several days ahead of a predicted storm may allow everyone an opportunity to get their affairs in order.

Because Mother Nature has a way of making modern conveniences more like a ball and chain in a disaster, anticipate that everything from ATM machines to gas pumps to credit cards to electronic medication dispensers and electronic patient elopement systems are not going to work if the electricity fails. An article by Cocanour describes running a large level one trauma hospital with no utilities and failed generator-backup after devastating flooding due to a tropical storm. This article provides useful information for any healthcare professional.

Disaster preparedness involves preparing patients, home and office, self, family and co-workers. Ideally, patients should always be able to explain their circumstances to an emergency health care worker. Emergency medical care in the aftermath of Hurricane Katrina has taught us that patients with pain may face limited formulary choices and hesitant providers. Pain patients should practice non-medical techniques to relieve pain, understand their medications and be able to explain to an emergency health care provider why they are using certain medications and that they require assis-

tance in managing those medications—either safely tapering medications like benzodiazepines, beta-blockers, lioresal, SSRIs and neuroleptics, or obtaining prescriptions to continue medications. Review of care plans annually with patients may fulfill specific federal mandates and state medical board regulations.

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## News from the Pain World:

Kirk Kinard, MD and Ike Eriator, MD, MPH.

### ***Massage Therapy Effective for Osteoarthritis:***

Consider massage therapy for that osteoarthritis of the knee. Perlman and his coworkers from the Institute for Complementary and Alternative Medicine at the University of Medicine and Dentistry in New Jersey conducted a randomized controlled trial involving 68 patients with radiographically confirmed osteoarthritis of the knee to study the efficacy of massage therapy. They assigned the patients to either the treatment group (twice weekly sessions of standard Swedish massage in weeks 1-4 and then once a week in weeks 5-8) to control (delayed intervention) and showed significant improvements in the mean pain scores, stiffness, physical function domains as well as in osteoarthritis index. Further studies to examine cost effectiveness and duration of treatment effect are needed. See *Arch Int Med*, 2006; 166: 2533-8.

### ***Pregabalin (Lyrica) for Fibromyalgia:***

Many pain practitioners find pregabalin helpful in patients with neuropathic component to their pain. This medication was recently given a boost when it was approved by the FDA for the treatment of fibromyalgia. It is also a boost for such patients who have been searching for recognition and relief. Pregabalin is the first drug to get approval for this indication (see Wood, P.B.: *Practical pain management*, 2007; Vol. 7 issue 6: 54-56). Studies demonstrated improvement in pain and daily functions

for some patients with fibromyalgia. An 8 week double blind multi-centered randomized placebo -controlled trial involving 529 patients showed mild reduction in average pain score in patients on 450mg daily dose of pregabalin compared to the placebo group. Pregabalin at 300mg and 450mg was also associated with improvement in sleep, fatigue and global measures of change (Crofford, L.J. and Rowbotham, M.C.: *Arthritis Rheum.* 2005, 52(4): 1264 – 1273). In clinical trials, about 19% of patients discontinued treatment prematurely due to side effects like dizziness, excessive sleepiness, fatigue, weight gain and balance disorder. Recommended doses, according to the manufacturer's prescribing information range from 300-450mg daily in divided doses.

Pregabalin is a structural derivative of gamma-aminobutyric acid (GABA), an inhibitory neurotransmitter, but it does not alter rat brain GABA concentrations nor does it have any acute effects on GABA uptake or degradation. But in cultured neurons, long term application of pregabalin increases the density of GABA transporter protein and rate of functional GABA transport.

### ***National and Global Surge in Prescription Drug Abuse***

“Abuse” of prescription drugs worldwide will soon exceed illicit drug use. The International Narcotic Control Board (INCB) monitors the global pattern of drug abuse and in its 2006 report noted that medications containing narcotic or psychotropic drugs are becoming the drugs of choice for many abusers. This is similar to the national trend. Between 1992 and 2003, the number of individuals in the United States alone abusing prescription drugs increased from 7.8 million to 15.1 million (see Kuehn, B. M.: *JAMA*, 2007; 297: 1306). And according to the recent Drug Abuse Warning Network (DAWN) report, emergency room visits involving the abuse or misuse of pharmaceutical agents including narcotics jumped 21% from 2004 to 2005. Emergency rooms reported 613,053 treatments involving cocaine and heroin overdoses in 2005, compared with 598,542 visits involving misuse of pharmaceuticals. Among such pharmaceuticals, opioids such as oxycodone, hydrocodone and methadone were the most common drugs involved in overdoses. Their overdose jumped 24% overall. Methadone overdoses jumped 29%.

“Nearly 60% of the people who reported misusing pain relievers said they got it from a friend or relative” says Robert Lubran, Director of the division of pharmacologic therapies for the Substance and Mental Health Services Administration (SAMHSA).

Drug traffickers are responding to demand through increased diversions and production of counterfeit drugs. Growing use of the internet as a global drug market has also increased the availability of prescription drugs and their counterfeit (see [http://www.incb.org/incb/en/annual\\_report\\_2006.html](http://www.incb.org/incb/en/annual_report_2006.html)).

Another interesting and concerning trend described in the INCB report is the growing abuse of prescription anorec-

tics – stimulants with an appetite suppressing effects, used for treating obesity, narcolepsy or Attention Deficit Disorder. The increase in prescription drug abuse means that prevention and treatment programs may have to change their approaches to dealing with addictions.

### ***Regarding Morphine, More may not be More Effective for Pain:***

The standard teaching is that there are no ceiling effects for schedule II opioids. We expect higher doses to provide more relief. Many studies have shown that the generally accepted dose of 0.10mg/kg of morphine given to patients in the emergency department may be inadequate in controlling severe acute pain. How about boosting the dose to 0.15mg/kg? Would such a 50% increase produce significantly more analgesia and side effects? Birnbaum and her colleagues at the Department of Emergency medicine, Albert Einstein College of Medicine, in Bronx, New York, randomly assigned 138 patients to receive 0.10mg/kg of morphine and another 142 to the 0.15mg/kg (in two divided doses). One hour later, 53% of patients in the higher dose group, compared to 44% in the lower dose group reported a 50% or greater reduction in their pain. The additional dose did not provide the expected increase in pain relief or side effects. It is possible that patients may need to exceed a threshold amount of morphine in order to clinically recognize and report important improvement in pain. The researchers recommended titrating morphine to the individual patients, and a systematic evaluation of morphine dosing (Birnbaum, A. et al.; *Ann Emerg med*, 2007; 49: 445 – 453).

### ***American Pain Society Centers of Excellence in Pain Management Awards:***

The American Pain Society (APS) is a multidisciplinary community that brings together a diverse group of scientists, clinicians and other professionals to increase the knowledge of pain and transform public policy and clinical practice to reduce pain-related suffering. Towards this end, the APS created the Clinical Centers of Excellence in Pain Management Awards, aimed at recognizing forward-thinking teams of health care professionals who address critical needs in pain management in their communities. In April, 2007, the organization announced 6 recipients of this award. The recipients were the NYU Medical Center / Hospital for Joint Diseases, Bellevue Hospital Center, Comprehensive Pain Management Center, New York, the Rosomoff Comprehensive Pain Center, Miami, the Brigham and Women's Hospital, Pain Management Center, Department of Anesthesiology, Perioperative and Pain Medicine, Boston, the UCSF Pain Management Center and UCSF PainCARE, Center for Advanced Research and Education, San Francisco, the Cincinnati Children's Hospital Medical Center, Division of Pain Management and the James A. Haley Veterans Affairs Hospital, Chronic Pain Rehabilitation Program, Tampa.

“As APS celebrates its 30th anniversary this year, the Clinical Centers of Excellence Awards pay tribute to the organization's ongoing advocacy on behalf of multidisciplinary pain care” said APS President Judith Paice, Ph.D., R.N., F.A.A.N., Any US-based, multidisciplinary, clinical program that pro-

vides direct patient care and focuses primarily on pain management was eligible to apply.

### ***Grand Jury Clears Physician in Hurricane Katrina Murder trial***

History is remarkable for repeating itself. But history often becomes more remarkable when it presents us with an event, the like of which will not be seen in a long time. As the second anniversary of Hurricane Katrina comes around, we still marvel at the magnitude of the destruction, suffering and anomie. The events of Hurricane Katrina called on several inner qualities from many. For four days following Hurricane Katrina, Dr. Anna Maria Pou, an otolaryngologist worked under 100 degree temperatures, limited food and water, the stench of human wastes and remains and no power to care for pains stranded in New Orleans' Memorial medical center by 15 feet of floodwater. And for more than one year afterwards, Dr. Pou fought accusations that she murdered 4 patients with a “lethal cocktail” of morphine and midazolam. Dr. Pou argued that she was providing appropriate palliative care to very ill patients (see [www.amednews.com](http://www.amednews.com), August 13, 2007). An Orleans Parish grand jury recently declined to indict her on nine murder counts. On hearing the news, Dr. Pou said “This is not a triumph, but a moment of remembrance for those who lost their lives during the storm. We need to remember the magnitude of human suffering that occurred in the city of New Orleans in the wake of Hurricane Katrina so that we can ensure that this never happens again – and that no health care professional should ever go through this again.”

*(Dr. Kirk Kinard is a pain fellow at the University of Mississippi Medical Center, Jackson, Mississippi).*

## Newsletter Submissions

All submissions to SPS News should be typewritten and double spaced with title and name of author(s). The article should be copy-ready. Please include biographical information.

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Southern Pain Society

P. O. Box 5033  
Cary, North Carolina 27512

Phone: (919) 303-3100  
Fax: (919) 303-9666  
info@southernpainsociety.org

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Many thanks!