Physician Pain Management Competency

Pain management is an important and challenging component of care of the hospitalized patient. It is essential that physicians are educated and knowledgeable in appropriate modalities of pain assessment and treatment. The following information is intended to increase and supplement the knowledge of physicians on pain management. It includes a section summarizing recent warnings regarding appropriate use of Duragesic® (fentanyl) patches, as well as a brief summary of important facts about another potent opioid medication, hydromorphone. Since these are both high risk medications, it is important to be aware of warnings, precautions, and dosing recommendations associated with each of them.

Pain Assessment

Careful and accurate assessment of pain is critical for successful diagnosis and treatment. Some important steps include identifying some key points with respect to the patient’s pain:

- The description of painful symptoms (e.g., burning, throbbing)
- The location of the pain
- The temporal nature of the pain
  - Acute vs. Chronic
  - Time of occurrence and duration
- The severity of pain
  - Impact on activities of daily living
  - Psychological impact
  - Social impact
- Exacerbating and alleviating factors
- Steps taken before managing the pain
  - Reduction in activity
  - Medication use before visit

Pain assessment is not a one-time occurrence. According to the JCAHO standards pain is now considered to be the fifth vital sign and should be assessed initially and reassessed on a scheduled and regular basis. St. Vincent Healthcare has a policy on Pain Assessment/Reassessment. (PE-004) In this document, several commonly used pain assessment tools are reviewed. If you would like a copy of the Policy, please contact Brett Stubson, Pharmacy Clinical Coordinator, at 237-8112.

Duragesic (fentanyl) Patch Warnings

In July 2005, the FDA issued a Public Health Advisory and Information for Healthcare Professionals that emphasized the appropriate and safe use of fentanyl transdermal systems. Despite these efforts, the FDA has continued to receive reports of death and life-threatening adverse events related to fentanyl overdose that have occurred when the patch was used to treat pain in opioid-naïve patients and when opioid-tolerant patients have applied more patches than prescribed, changed the patch too frequently, or exposed the patch to a heat source. In late 2008, the FDA reissued and strengthened its warning about appropriate use of fentanyl patches.

It is important to remember that the fentanyl patch is indicated for the management of persistent, moderate to severe chronic pain in opioid-tolerant patients 2 years of age and older who require a total daily opioid dose of at least equivalent to fentanyl transdermal system 25 mcg/h. Opioid-tolerant patients are those who have been taking daily for a week or longer at least 60 mg of morphine, 30 mg oral oxycodone, at least 8 mg oral hydromorphone or an equianalgesic dose of another opioid. It is contraindicated in the management of post-operative pain, mild pain, or intermittent pain because of risk for serious or life-threatening respiratory depression. Concomitant use of the fentanyl patch with any
cytochrome P450 3A4 inhibitors (ketoconazole, erythromycin, nefazodone, diltiazem, grapefruit juice) may result in increased fentanyl plasma concentrations, which may cause potentially fatal respiratory depression.

At the request of the FDA, the manufacturers of fentanyl transdermal systems have revised the prescribing information and patient instructions for use and are developing a new Medication Guide for patients containing the above information. At St. Vincent Healthcare, pharmacists will be reviewing orders for fentanyl patches and ensuring that the patient meets criteria for fentanyl patch use. Pharmacists will contact prescribers to discuss any concerns regarding Duragesic use. If you would like additional information regarding these recommendations or warnings, please do not hesitate to contact Brett Stubson at 237-8112.

**Other Links to Pain Assessment/Management/Policy**

- Academy of Hospice and Palliative Medicine (AAHPM)
- American Academy of Pain Medicine (AAPM)
- Alliance of State Pain Initiatives (ASPI)
- American Cancer Society (ACS)
- American Chronic Pain Association (ACPA)
- American Pain Foundation (APF)
- American Pain Society (APS)
- Center to Advance Palliative Care
- Drug Enforcement Administration (DEA) Diversion Control Program
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- National Palliative Care Research Center (NPCRC)
- PainACTION
- PainEDU.org Manual
- Robert Wood Johnson Foundation
**Hydromorphone (DILAUDID) Facts**

**GENERAL GUIDELINES FOR USE**
- FDA approved for moderate to severe chronic or acute pain
- Appropriate doses:
  - Acute pain, opioid naïve: 1-2mg IM/SC or 2-4mg PO q4-6 hours
  - Chronic pain, opioid naïve: 3-4mg IM/SC or 2-4mg PO q3-4 hours
  - Opioid tolerant: based upon dose of previous opioid therapy

**FACTS ABOUT DILAUDID**
- Equally effective to morphine at equianalgesic doses; reasonable alternative when morphine is causing adverse effects or is not providing sufficient pain relief
- Compared to morphine, metabolites are *not as likely* to cause neuroexcitation, hyperalgesia, and myoclonic tremors
- May be *more likely* to cause drowsiness and sedation than morphine or methadone
- Onset of action is **30 minutes** if given PO, or **15 minutes** if given parenterally; should not be given more frequently than this
- Duration is **3.5-5 hours**, comparable to most opioids, but shorter than methadone and longer than meperidine (DEMEROL) and fentanyl

**MANAGEMENT OF COMMON ADVERSE EFFECTS**
- **Drowsiness/sedation**: More common with DILAUDID than many other opioids; monitor carefully upon initiation; do not coadminister with sedating drugs (antihistamines, benzodiazepines, sedatives/hypnotics)
- **Nausea/vomiting**: May add antiemetics such as promethazine, prochlorperazine, ondansetron
- **Constipation**: Chronic use of DILAUDID should be accompanied by a stimulant laxative (bisacodyl, senna); stool softener (docusate) may also be included; ensure adequate fluid intake

**MANAGEMENT OF OVERDOSE**
- If *oversedation* or *respiratory depression* occur:
  - Give naloxone 0.4-2mg IV, IM, or SC
  - Repeat as needed q2-3 minutes; maximum of 10mg total

**SPECIAL POPULATIONS**
- **Pregnancy**: Use is *not advised*; can cause physical dependence, respiratory depression, or retarded growth in child; may be used in cases of severe pain, but *exposure should be limited*
- **Lactation**: DILAUDID does pass into breast milk, but in clinically insignificant amounts; considered *safe in breastfeeding*
- **Elderly**: Increased risk of oversedation and falling; *dose cautiously*
- **Sleep Apnea**: Increased risk of severe apnea; *dose cautiously*

**EQUIANALGESIC DOSING OF OPIOIDS**

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**REFERENCES**
Abramowicz M. Drugs for pain. Treatment Guidelines From the Medical Letter 2007;5(56).