Pain Management in Medical Dermatology

Robert G. Micheletti, MD
Assistant Professor of Dermatology and Medicine
Director, Cutaneous Vasculitis Clinic, Penn Vasculitis Center
Co-Director, Inpatient Dermatology Consult Service
University of Pennsylvania
DISCLOSURE OF RELEVANT RELATIONSHIPS WITH INDUSTRY:

I have no relevant relationships with industry to disclose
Overview

1) Philosophical points

2) Practical points

3) Being systematic

4) Knowing your limits

5) Case examples
Philosophical Points
Disclosure:

I am not a pain specialist...

...but I do take care of people who have pain
As dermatologists, we are the experts when it comes to treating certain conditions which are characteristically painful:

- Pyoderma gangrenosum
- Hidradenitis suppurativa
- Calciphylaxis
- Vasculitis and vasculopathy
- Post-herpetic neuralgia
- Post-surgical pain
- Others...
When treating these conditions, we should be willing to treat the pain that goes with them, at least within our scope of practice.

It isn’t really fair to the primary care physician or patient to defer pain management to the PCP:

- Inefficiency of care
- Pain is less likely to be addressed in a timely fashion
- PCP is not the expert in the condition:
  - Won’t know whether it is supposed to be painful
  - Or when it is improving and should no longer be
So, as experts caring for painful skin disease, sometimes it falls to us to address pain as an important component of that disease.
At the same time, we know that:
• Prescribing opioids for acute pain increases the likelihood of long-term opioid use
• Higher dose and duration of exposure increases risk of long-term use and overdose
• Overprescription leads to leftover pills which can be abused

Opioids should be prescribed only when necessary, at the lowest effective dose, and for the shortest possible duration
Dermatologist’s role in pain management

So, with the current opioid epidemic, we must be careful...

...But not recognizing and addressing pain is not the answer; this does not make the problem disappear

...Patients are going to seek relief somewhere; ideally, this is a knowledgeable and responsible medical provider (and there aren’t enough pain specialists to go around)
Practical Points
1) Know your patient and his / her medical situation before prescribing:

- Patient Age, Gender, Weight
- Hepatic, Renal, or Respiratory impairment
- History of prior opioid use
- History of depression, substance abuse, or psychiatric issues
- Other medications
  - Drug-drug interactions
  - Co-administration with other CNS depressants

Cannot always predict how someone will respond, so proceed and titrate slowly (less is more)
34yo man seen in ER for swollen, painful, rapidly expanding purple-gray necrotic plaque

Diagnosed with pyoderma gangrenosum and started on 60mg/day prednisone and clobetasol ointment
What should be done for pain?

1) Know your patient:
   • Young, otherwise healthy
   • No prior opioid or substance use
   • No other medications
Appropriate selection of pain strategy

2) Assess the need:
   – Degree and duration of expected pain
   – Expectation for planned follow-up and reassessment

<table>
<thead>
<tr>
<th>Acute Pain</th>
<th>Chronic Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pain medicine should be a temporary</td>
<td>• Some amount of ongoing pain is expected</td>
</tr>
<tr>
<td>solution to a temporary problem</td>
<td></td>
</tr>
<tr>
<td>– Want to choose agent commensurate</td>
<td>– Find ways to optimize the use of alternative</td>
</tr>
<tr>
<td>with pain severity</td>
<td>analgesic agents</td>
</tr>
<tr>
<td>– Set expectation that need will be</td>
<td>– Address contributing medical and</td>
</tr>
<tr>
<td>temporary</td>
<td>psychosocial issues</td>
</tr>
</tbody>
</table>
What should be done for pain?

1) Know your patient:
   • Young, otherwise healthy
   • No prior opioid or substance use
   • No other medications

2) Assess the need:
   • Expect acute needs to decrease rapidly with effective medical management
3) Know your options (mild to moderate pain):

- NSAIDs and Acetaminophen (Tylenol)
  - More effective when scheduled than when taken as-needed
  - More effective in combination than alone
  - Generally safe and well-tolerated
    - Peptic ulcer disease, renal impairment (NSAIDs)
    - End-stage liver disease (Tylenol)
3) Know your options (moderate to severe pain):
   • Oxycodone (5mg every 4-6 hours; 3-4 pills per day)
     – Common choice (comfort with dosing, reliability)
   • Tramadol (50mg every 4-6 hours; 3-4 pills per day):
     – Opioid agonist that is also a serotonin and norepinephrine reuptake inhibitor, so may better address features of neuropathic pain
     – Need to be aware of risk of serotonin syndrome with other SSRIs

Most patients require less pain medicine for shorter duration than we think they do.
A script for 20 or fewer tabs may be reasonable, with plan to reassess.
Appropriate selection of pain strategy

Optimize non-opioid analgesics

Ice, heat, rest, elevation

Topical pain relief

Prescribe opioids only when necessary and for shortest duration needed
Considering our patient, his pain, and the available options, what should be done for pain?

- Rest, elevation
- Ibuprofen and acetaminophen alternating every 4-6 hours
- If necessary, can provide a short oxycodone script (e.g., 5mg q6 hours; 12 total pills)
- Close follow-up from ER (1 week)
76yo woman with pyoderma gangrenosum occurring at the site of preceding herpes zoster

Started on prednisone and clobetasol
Case Example

What should be done for pain?

1) Know your patient:
   • No renal or hepatic impairment
   • Not taking CNS depressants
   • Opioid naïve; age is a factor

2) Assess the need:
   • We expect with proper medical management acute PG will improve rapidly, with decreasing pain and inflammation
   • However, she complains of a burning sensation as well
3) Know your options (chronic or neuropathic pain):
   • Alternatives to opioids, like gabapentin or duloxetine for neuropathic pain (burning, tingling pain)
     – Be aware of potential drug interactions and initiate / titrate slowly to ensure tolerability
     – Must also taper slowly to discontinue
What should be done for pain?

- Ibuprofen and acetaminophen alternating every 4-6 hours may be sufficient

- Consider adding gabapentin for symptoms of post-herpetic neuralgia

- Can consider short script of oxycodone, but carefully consider age, comorbidities, risk of polypharmacy

- Follow-up in 1-2 weeks
Case Example

70yo man with end-stage renal disease, not yet on dialysis

Onset of extremely painful retiform purpura on the lower legs following aortic valve replacement and starting warfarin

Biopsy supports the clinical impression of calciphylaxis
What should be done for pain?

1) Know your patient:
   • Renal failure
   • Not taking CNS depressants
   • Age is a factor

2) Assess the need:
   • Calciphylaxis causes severe pain, and that pain is ischemic (mixed nociceptive and neuropathic)
   • It is also chronic in the sense that the resulting wound will not heal quickly
What should be done for pain?

• Initiation of appropriate medical therapy (e.g., sodium thiosulfate, pentoxifylline) may help

• Rest, elevation, local wound care

• Acetaminophen every 6 hours
  → avoid NSAIDs in renal insufficiency

• Because of the neuropathic component of ischemic pain, gabapentin can be added
What should be done for pain?

• If these are insufficient, tramadol could be considered (mixed nociceptive / neuropathic)

• All dosing should be done with care due to renal insufficiency and risk of CNS depression

• Can be titrated during hospital admission to provide a sense of need

• Close follow-up and decrease over time as the condition improves
Appropriate selection of pain strategy

Address other contributing factors:
- Depression and anxiety can contribute significantly to the perception of chronic pain
- Psychosocial factors can significantly affect adherence and engagement in medical care
- Such issues are not uncommon in diseases like hidradenitis, calciphylaxis, etc.
- Be prepared to acknowledge and address them; refer to psychiatry or primary care for assistance
- Do not underestimate the psychosocial benefit of offering hope in treating the medical condition and addressing other issues affecting the patient
23yo woman with hidradenitis

Has previously had painful flares, but now relatively inactive on spironolactone

Before the exam is performed, she complains of significant pain and is asking for pain medication

Pain characterized as burning / throbbing
Hidradenitis can be severe and painful and may require non-opioid and opioid analgesia.

However, sometimes we see patients who are doing well medically but have pain out of proportion to the clinical exam.
What should be done for pain?

1) Know your patient:
   • Otherwise healthy, no other medications
   • Depressed and anxious (strongly associated with hidradenitis)

2) Assess the need:
   • Understand the contribution of depression and anxiety to pain perception
   • Importance of addressing those factors for successful management
What should be done for pain?

• Appropriate medical therapies for HS

• Topicals and local wound care

• Optimize non-opioid pain management: acetaminophen and ibuprofen

• Address depression and anxiety as key contributors to chronic pain in HS (e.g., duloxetine, other SSRIs)
Appropriate selection of pain strategy

Options which may be less-preferred:

• Hydrocodone (Vicodin):
  – Only available with acetaminophen or ibuprofen, so difficult to use in combination with those agents (same with Percocet)
  – Want to encourage use of NSAIDs, Tylenol

• Codeine:
  – Tend to avoid due to wide variability in metabolism to morphine, risk both of adverse events as well as unreliable pain relief

• Fentanyl and other highly-potent formulations:
  – Beyond the scope of the dermatology practitioner

• Long-acting formulations:
  – Avoid long-acting opioids for acute pain and for the opioid naïve
  – Less easily titrated and greater risk of overdose
  – Best left to the pain specialist
58yo woman with ESRD on dialysis, also alcoholic cirrhosis, presenting with multifocal retiform purpura

Extremely painful, widespread

Calciphylaxis: 50% mortality at 1 year, 80% at 2 years
→ higher in a patient like this
What should be done for pain?

- Medically complicated patient with pain control needs expected to be significant and ongoing

- This is a patient for pain management or palliative care (with derm providing perspective)
  - Fentanyl, hydromorphone, methadone

- Fentanyl PCA in the hospital and transitioned to hospice
Ultimately, we want to choose a strategy which is:

- Commensurate with the patient’s pain level
- Safe for the patient’s medical and psychiatric comorbidities
- Multimodal and opioid-sparing (including Tylenol, NSAIDs, and nonpharmacologic therapies)
- Sufficient but short and frequently reassessed
Be Systematic
Documentation

It is generally good practice to document the level of pain from visit-to-visit using a simple numerical rating scale.

Make sure to document all conversations, thought process, and medication orders related to pain management.
Set Expectations Up Front

1) We are treating pain due to condition X, which is expected, and which we want to help manage

2) Expectation is not for zero pain; use of opioids should be reserved for when they are really needed

3) We expect pain needs to diminish over time as we treat the underlying medical condition

4) One prescriber will be in charge of prescribing pain medication

5) Pain scripts are provided with zero refills, so there will be constant reassessment of ongoing pain needs

6) Refill requests should be received at least a few days before the medicine is expected to run out
Set Expectations Up Front

A good way to reinforce these guidelines is through a pain contract

This documents the discussion and limits the risk of miscommunication
Controlled Medication Agreement

You are being prescribed a medication to help with your pain. Opiate and other medications are controlled for medical and legal reasons. Our office must manage these medications in ways that are medically appropriate and that meet all federal and state regulations. Please read the following carefully. By signing it, you are agreeing to follow all of the stipulations it contains.

- I will come to my scheduled appointments with Dermatology. If I miss my follow-up appointments, I am aware that my physician may stop prescribing me pain medication.

- I will notify my doctor if I am started on any pain management medications by another physician.

- I will notify my doctor if another physician refills my medication.

- I acknowledge that at the time of writing my prescription my physician will run a check of my recent pain medication prescriptions through the Prescription Drug Monitoring Program, as required by the state of Pennsylvania.

- I agree to see pain management if recommended.

- I will tell my doctor if the medicine is not helping me, and will not take more medicine on my own or run out early.

- To get more medicine, I need a paper prescription. These medicines cannot be called into the pharmacy, or filled on a night, holiday, or weekend by my primary care provider.

- I may get the prescription from my doctor at my regular appointment, or by calling the practice at least 3 business days before I run out. I may not just walk into the office and ask for a refill.
The CDC and various states have issued guidelines for pain management.

All states (with few exceptions) have prescription drug monitoring programs and either require or strongly encourage checking the database prior to prescribing opioids.
PREScription DRUG MONITORING PROGRAM

LATEST UPDATES

- The Pennsylvania Prescription Drug Monitoring Program (PDMP) is integrating the PDMP system with the electronic health records (EHRs) and pharmacy management systems of all eligible health care entities in Pennsylvania. For more information and to sign up, visit our Integration page.
- As of November 28, 2017, the Pennsylvania Prescription Drug Monitoring Program is sharing data with 16 other states and D.C. Interstate sharing of data helps prescribers and pharmacists get a more complete picture of their patients’ controlled substance prescription histories, regardless of which state they filled their prescription in.
- New tutorial for users on how to search for your patients across state lines.

ABOUT

To help prevent prescription drug abuse and protect the health and safety of our community, Pennsylvania’s Prescription Drug Monitoring Program (PDMP) collects information on all filled prescriptions for controlled substances. This information helps health care providers safely prescribe controlled substances and helps patients get the treatment they need.
State reporting

These guidelines and rules are meant to protect the provider and the patient and remove the room for ambiguity

While it might add another step, there is no reason not to participate; really, you fail to do so at your own risk

Dermatologists may be unlikely to stand out among providers from other specialties in terms of prescribing habits, but you never want to be an outlier among your peers without very good reason
Know Your Limits
Recognizing Limits and When to Refer

Understand your comfort zone and don’t stray outside it; stay within your scope of practice

• A dermatologist’s comfort zone shouldn’t be Fentanyl
• Prescribe only medicines which you understand

• Patients who have need of higher potency pain medication, frequent refills, or large quantities of pain medication...
• Patients who do not follow expected course of recovery with decreasing pain following improved medical condition...
• Patients who exhibit “red flag” behaviors...

Should be referred to pain management or other qualified provider
Case Example

50yo woman with pyoderma gangrenosum x 3 years
• Also high-titer ANA and antiphospholipid antibody positivity

Has asked for pain medicine in the past at various points; previously some behavioral issues with the clinic staff

Doing very well from a PG perspective...
...Then develops new retiform purpura
Before we talk about pain, what is happening here medically?

- Biopsy; shows clot / vasculopathy
- Is this antiphospholipid antibody syndrome?
- Another hypercoaguable state?

I always suggest urine drug screen as part of the retiform purpura work-up →

Hers was positive for cocaine

Cocaine / levamisole-associated vasculopathy in a predisposed patient
What should be done for pain?
→ Well, it’s complicated

1) Know your patient:
• Opioid-experienced with Hx of drug abuse
• Some prior concerning behavior

2) Assess the need:
• Acutely painful condition, though should be self-limited
• Resulting wounds may continue to be painful
What should be done for pain?

• With evidence of drug abuse or diversion, this is a patient who should see pain management, have a formal pain contract, get regular urine drug screens, etc.
What should be done for pain?

• Just because a patient is difficult doesn’t mean he / she is abusing narcotics

• Just because a patient has psychosocial issues doesn’t mean he / she doesn’t have real pain

• However, failure to follow rules or documented drug abuse are obvious red flags

• With a patient like this, need to stick to clearly outlined expectations and know your limits
Recognizing Limits and When to Refer

In this respect, being a dermatologist has its advantages:

• Pain management is not our expertise, so it is reasonable to defer to a pain specialist when patients exhibit significant pain needs or, certainly, drug-seeking behavior.

• Can treat pain as part of the condition we are managing but have a natural transition point should we become uncomfortable or feel prescribing is inappropriate.
Summary and Conclusions

I have found most patients to whom I prescribe opioid pain medications:

1. Truly need them and have a medical condition which is active and has every right to be painful
2. Are understanding and reasonable and adhere to expectations for timing and quantity of prescribing
3. Need less and less pain medicine over time as we work to improve the underlying medical condition

As a result, I have not had the need to prescribe narcotic pain medicine chronically, and if such a need arose, I would refer to pain management to help address any other issues going on
Keys to successful care of a patient with painful skin disease:

• Acknowledge and validate the presence of pain when present
• Support the patient in caring for this aspect of their disease alongside medical therapies
• Consider patient characteristics and accurately assess pain needs
• Address other contributing factors
• Choose a conservative regimen which utilizes non-opioids and avoids over-reliance on narcotics—we often prescribe more than is needed
• Set clear expectations and do not stray outside your comfort zone; know when to refer
The Dermatology Foundation has supported & advanced my career.
Thank you

Robert.Micheletti@uphs.upenn.edu
Cutaneous Vasculitis Clinic, Penn Vasculitis Center
University of Pennsylvania