Care Management for Depression & Chronic Pain

MHIP Webinar
November 21, 2013

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UW Psychiatry and Behavioral Sciences
Agenda

- Physical and Emotional Pain
- Collaborative Care and Care Management for Pain
- Treatments for Pain
  - Pharmacological
  - Nonpharmacological
- Opioid Prescribing in Primary Care
How Common is Pain?

• “Life is Pain”

• 20 – 30% of younger and 60 – 80% of older adults report pain on a daily basis

• 15% of those with chronic pain say they cannot work because of it

• Pain medications are the #1 group of medications prescribed to patients on WA-MHIP
Pain Classification by Mechanism

- Nociceptive
  - Bone fracture
  - Hiatal hernia
  - Acute Pain
- Inflammatory
  - Rheumatoid Arthritis
  - Chronic Sinusitis
- Neuropathic
  - Diabetic Neuropathy
  - Phantom Limb
  - MS
- Dysfunctional
  - TMD/J
  - Fibromyalgia
  - Irritable Bowel Syndrome

It is possible that more than one mechanism is present!

Physical and Emotional Pain

Pain → Depression & Anxiety

Pain ← Depression & Anxiety
Pain and Depression / Anxiety

- 2/3 of people with chronic pain show symptoms of depression and anxiety
- People with chronic pain are 2-4 times more likely to have major depression than those without pain
- Pain may cause depression and anxiety, and depression may worsen the experience of pain
Depression / Anxiety and Pain Have Combined Effects

- Pain **AND** depression / anxiety associated with greater functional impairment than pain alone
The ‘Cycle of Depression’

STRESSORS
- Medical Illness
- Family Problems
- Work Problems

THOUGHTS & FEELINGS
- Negative thoughts
- Feeling unmotivated
- Low self esteem
- Feeling Overwhelmed
- Sadness/Hopelessness

PHYSICAL PROBLEMS
- Poor sleep
- Pain
- Increased Pain
- Low Energy
- Poor concentration

BEHAVIOR
- Isolating From Others
- Decreased Activity
- Getting Less & Less Done

DEPRESSION
Cycle of Decreasing Function

Increased DEPRESSION, ANXIETY, PAIN

Decreased ACTIVITY & FUNCTION
Collaborative Care Approach
Our Goal: Continually improving life function—recognizing that function can be defined in a number of different ways at different times.

- Treatment for Pain & other Symptoms
- Increase Physical Activity
- Increase Social Activity & Connection

Improved Physical & Mental Function

Do all this at the same time with Care Team Support
Collaborative Care

PCP supported by Care Coordinator

Practice Support

Informed, Active Patient

Effective Collaboration

Outcome Measurement

Caseload-focused consultation

Training
Case Study

Collaborative Care Management for Pain & Depression
Intake Assessment

• Mary
  – 56 yrs old
  – African American
  – Female
  – Past Medical History
    • HTN, Diabetes
    • Arthritis knee pain over 10 yrs

– Family tree/history

– No previous treatments for depression
Social Assessment

• Current social circumstances
  – New to town
  – Retired from government job
  – Moved from out of state and now living with her daughter and her family

• Stressors
  – Looking for new house to accommodate her
  – Moving in with daughter
  – Not feeling comfortable to drive in new city

• Strengths/Resources
  – Church (faith)
  – Good friendships with family
  – Close to daughter

• Pleasurable Activities
  – Visiting friends
  – Spending time with grandson
  – Crafts
  – Reading
Baseline Assessments

- Pain Assessment Form (PAF)
- Pain Diary
- PHQ-9
Treatments

• Antidepressants
  – SNRI (Venlafaxine)
  – Pain medication fine-tuning & education
    – regular use of acetaminophen

• Behavioral Activation
  – Walking, pool

• Medical Advocacy
  – Orthopedic evaluation for knee replacement
Progression

- PHQ over time

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Week 2</th>
<th>Week 4</th>
<th>Week 6</th>
<th>Week 8</th>
<th>Week 12</th>
<th>Week 16</th>
<th>Week 20</th>
</tr>
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<tbody>
<tr>
<td>PHQ</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

- BPI over time

| Average Pain Intensity | 8 | 5 | 5 | 6 | 8 | 3 | 3 | 3 |
Relapse Prevention Plan

• Continue antidepressant
• Continue activities (church)
• Watch for signs and symptoms of depression
Care Coordinator Role

• Trusting relationship
  • Adjusting to and trusting care system

• Time to talk
  • a sense of not being rushed
  • an advocate with the rest of the health care team

• Education about pain and depression
  • Pain, depression, anxiety, sleep, time management, use of medications, how to work with the health care team

• Other resources
  • PT
CHRONIC PAIN MANAGEMENT IN PRIMARY CARE PILOT

**PCP**

**PATIENT**

**CARE MANAGER**

- Screening
- Tracking
- Coordination
- MHITs

**CP**

- Weekly CM consultation
- Evidence Based Med recommendations

**REFER**

- Pain Specialist
- PT PMR Neuro OS
- OTHER
- SA/CD Rx

**PRIMARY CARE SETTING**

Bentham 2012: MHIP-CP

*PT-Physical Therapy; PMR-Physical Medicine & Rehabilitation; Neuro- Neurology/Neurosurgery; OS-Orthopedist; Other- eg. Rheumatology; SA/CD Rx- Substance Use/Chemical Dependence Treatment*
Managing Persistent Pain

• Listen: “all pain is real”
• Negotiate treatment goals: focus on functional improvement
  – What does the pain keep you from doing?
  – How do you cope with this?
• Encourage regular (physical, social) activity
• Support adequate trials of analgesic medications
• Coordinate and consult with other providers
<table>
<thead>
<tr>
<th>MHIP-CP Initial Care Manager Appointment Check-List</th>
</tr>
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<tbody>
<tr>
<td><strong>Health Assessment</strong></td>
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<tr>
<td>○ Current Medical Conditions</td>
</tr>
<tr>
<td>○ Current Medications</td>
</tr>
<tr>
<td>○ Allergies</td>
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<tr>
<td>○ BMI</td>
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<tr>
<td>○ Blood Pressure</td>
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<tr>
<td>○ Baseline Laboratory Studies (CBC, CMP, TSH, Fasting Lipid Profile, Fasting Serum Glucose, Urine Toxicology screen)</td>
</tr>
<tr>
<td>○ Results of recent physical examination</td>
</tr>
<tr>
<td><strong>Pain Assessment</strong></td>
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<tr>
<td>○ MHIP-CP Pain Assessment Tool</td>
</tr>
<tr>
<td>○ Current Pain Medications</td>
</tr>
<tr>
<td>○ Past Pain Medications</td>
</tr>
<tr>
<td><strong>Psychiatric Assessment</strong></td>
</tr>
<tr>
<td>○ Current Symptoms</td>
</tr>
<tr>
<td>○ Screening (PHQ9, GAD7, CIDI, etc.)</td>
</tr>
<tr>
<td>○ Substance Use History</td>
</tr>
<tr>
<td>○ Past Psychiatric Medications</td>
</tr>
<tr>
<td>○ Past Psychiatric Treatments</td>
</tr>
<tr>
<td>○ Past Suicide Attempts</td>
</tr>
<tr>
<td>○ Self-harm behavior</td>
</tr>
<tr>
<td><strong>Psycho-social Assessment</strong></td>
</tr>
<tr>
<td>○ Stressors</td>
</tr>
<tr>
<td>○ Effect of Pain on relationships</td>
</tr>
<tr>
<td>○ Strengths &amp; Resources</td>
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<tr>
<td>○ Current Social Circumstances</td>
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<td>○ Pleasurable Activities</td>
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<td>○ Cultural Considerations</td>
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<tr>
<td><strong>Psycho-education</strong></td>
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<tr>
<td>○ Role of care manager &amp; care team</td>
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<tr>
<td>○ Impacts of pain, mental health on overall function</td>
</tr>
<tr>
<td>○ Patient education materials</td>
</tr>
</tbody>
</table>
Measuring Progress

• Brief Pain Inventory or PEG
• Pain Management Diary
• PHQ-9 / GAD-7
MHACP PAIN ASSESSMENT QUESTIONNAIRE-Initial Assessment

NAME: ___________________________ DATE: _____________

PEG Three-item scale\(^2\) & Activity Limitation\(^3\)

1. What number best describes your pain on average in the past week:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pain as bad as you can imagine</td>
</tr>
</tbody>
</table>

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Completely interferes</td>
</tr>
</tbody>
</table>

3. What number best describes how, during the past week, pain has interfered with your general activity.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Completely interferes</td>
</tr>
</tbody>
</table>

4. Chronic pain may limit activities that are very important to you (eg. Caring for children, walking the dog). We hope your pain treatment will make it easier for you to do these important activities. Please list one important activity that is difficult for you to perform so that we can monitor it during your pain treatment.

Activity:

You said that you are having difficulty with ___________________________.

Please rate how able you are to do this activity as of today.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to perform at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Able to perform at same level as before the pain began</td>
</tr>
</tbody>
</table>

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\(^1\) Krebs DD, Lorenz KA, Bair MJ et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med 2009;24(6):733-738

\(^2\) Items from the Current Pain Tracker reproduced with permission from Mark Sullivan, MD
Pain Location and Patient Perspective

1. Where is your most important pain (you may choose more than one)?
   - Head, face, and mouth
   - Neck
   - Upper shoulders or arms
   - Midback (between shoulder blades)
   - Abdomen (stomach area)
   - Low back, buttocks, tailbone
   - Legs
   - Pelvic area
   - Around anus and genital area (penis. Testes, vagina)

   Total #

2. What do you think causes your pain?

3. What treatments do you think would be most helpful?
Pain Assessment Form (PAF) - Baseline

University of Washington Research Study Impact

Study ID # ___________________________ Date ___________________________

**Description of Pain**

Pain Location: _______________________________________________________

Most likely cause of pain: ____________________________________________

**Average intensity of pain in past week (1-10)?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None “no pain”</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
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<td>5</td>
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<td>8</td>
<td></td>
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<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Severe “worst pain my life”</td>
</tr>
</tbody>
</table>

AI score _______

**Maximum intensity (1-10)?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None “no pain”</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
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<td>8</td>
<td></td>
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<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Severe “worst pain my life”</td>
</tr>
</tbody>
</table>

MI score _______

**How much does pain keep you from doing activities (1-10)?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None “no interference”</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
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<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Severe “prevents me severely–unable to do anything”</td>
</tr>
</tbody>
</table>

PI score _______

**Treatment Goals**

What does your pain and/or depression keep you from doing that you most want to do?

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________

If it is not possible to get you back to 100% with these activities, what would be a substantial improvement?

1. ____________________________________________________________
2. ____________________________________________________________

What would help to make these improvements?

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

PAF – baseline 12/14/2004
Psychosocial Assessment

• Current social circumstances
• Affect of pain on relationships
• Stressors
• Strengths / resources
• Pleasurable activities
Supporting Pain Management

• Behavioral activation / pleasant event scheduling

• Pain medications
  – Support effective use of medications
  – Watch for side effects
  – Support ‘stepped care’ and systematic changes in treatment if medications not effective

• Medical advocacy
Pain Medications

• Acetaminophen (Tylenol)
• Non-steroidal anti-inflammatory drugs (NSAIDS)
  – Aspirin, NSAIDs
• Opioids (Narcotics)
• Adjuvant medications
  – Anticonvulsants
  – Antidepressants
Pain Classification by Mechanism

It is possible that more than one mechanism is present.

Pain Classification by Mechanism

Nociceptive
- NSAIDs
- Opioids

Inflammatory
- NSAIDs
- Opioids
- Corrective procedures

Neuropathic
- Analgesic (p, c)
- Antidepressants
- Anticonvulsants

Dysfunctional
- Analgesics (c)
- Antidepressants
- NOT NSAID or opioid

Multimodal therapy can be a reasonable approach!!

How to Use Pain Medications (PCP)

• Use / change one drug at a time
• Careful with total daily dose
  – Acetaminophen or ibuprofen may be taken OTC but are also contained in many prescription drugs
• Start low but go to target doses
• Give adequate trial (adequate dose, frequency, and duration)
• Regular rather than prn dosing. Take medications before pain gets bad
• Manage side effects
• Change treatment if no effect after 10 – 14 days at target dose
• Combine medications and other treatments if only partial response
Referral to Physical Therapy (PCP)

- Assess current activity level, gait, strength, fitness, preferences
- Create individualized physical activity plans
  - Preserve or restore range of motion / flexibility
  - Increase aerobic conditioning
  - Increase muscle strength / endurance
  - Include physical activities into daily life
- Be aware of physical deconditioning
  - > gradual increase in frequency and intensity (pacing)
- Pay attention to rewards and positive reinforcers
- Address fears and concerns about physical activity
- Example: osteoarthritis
  - Non weight-bearing exercise: walking, warm-water pool exercise
Other Treatments Options

• Relaxation / Meditation / Guided Imagery
• Electrical counter-stimulation (TENS)
• Acupuncture
• Nerve blocks or infiltrations
• Neurosurgical procedures
• Orthopedic (e.g., hip, knee, or shoulder replacement)
Fundamental Principles

- Understand that there are different categories of pain
  - Acute vs. Persistent
- Assess pain systematically
- Identify co-occurring conditions
  - Medical AND psychosocial
- Track pain AND function over time
  - Treatment effectiveness and adjustment
- Know when to refer to a specialist
But ... what about the difficult patients
Difficult Patients and Drug Seeking Behavior

✔ First ‘do not harm’ (limit damage)
✔ Help maintain safe limits
✔ Negotiate and Contract
✔ Focus on functioning instead of pain
✔ Communicate with team members and other providers
✔ Consult
Managing Patients on Opioids in Primary Care

Mark Sullivan, MD, PhD
Pain Relief Center
Psychiatry and Behavioral Sciences
University of Washington
Which boundaries are appropriate for opioid prescribing?
Opioid prescriptions as the ‘ticket out of the exam room’

• Patients demand pain relief
• PCP provides prescriptions for opioid
• The result may be many poorly justified refills and dose increases
America loves opioids

• Americans are 4.6% of the world's population, but consume 80% of the world's opioids and 99% of the world's supply of hydrocodone (i.e., Vicodin).
• 2-3% of Americans use opioids chronically
• >95% of all prescribed opioids are prescribed for non-cancer pain
Opioid Trends and Risks

• Trends in opioid use
  – Chronic Opioid Treatment for Chronic Non Cancer Pain
    • Doubled 1980-2000, doubled again 2000-2010
    • Now 2-3% of US adult population, 10 million

• Risks of increased opioid use
  – Most common cause accidental overdose
    • more deaths in WA than Motor Vehicle Accidents
  – Fastest growing form of drug abuse

Sullivan 09-10
Adverse selection

• Chronic opioid use increasing rapidly
  – 3x more likely in those with hx depression
  – 5-10x more likely in those with substance abuse
• Initiation, continuation, high dose use more likely in high risk patients
• Opioid use highly concentrated
  – In BC/BS 5% of CNCP pts. use 70% opioids
  – In Medicaid 5% of CNCP pts. use 48% opioids
Unintentional opioid overdose deaths parallel per capita sales in U.S., 1997-07

Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS
* 2007 opioid sales figure is preliminary.

Sullivan 09-10
1. Sets standards of care for Washington State Department of Health Boards and Commissions (ie Medical/Osteopathic/Nursing/Pediatric/Dental) to use when considering state licensing disciplinary action against providers (in response to complaints)

2. Rules directed only to Chronic Opioid Treatment in Chronic Non-Cancer Pain
   
   a. Excludes: treatment of acute pain, surgical pain, palliative care, cancer pain

3. Requires key history (including elements of an Informed Consent treatment agreement) and frequency (clinical follow-up ≤6 -12 months) that must be documented in history and ongoing treatment plan:
   
   a. Pain diagnosis and indications for chronic opioid treatment
   b. Abuse risk assessment
   c. Psychiatric status
   d. Medical co-morbidities (ie sleep apnea)
   e. Treatment effect on Pain, Physical and Psychosocial function
   f. Aberrancy monitoring: protocol for urine toxicology screens, periodic review of available Emergency Department information and Prescription Drug Monitoring programs

4. CME (4 hours lifetime) should be obtained by all prescribers of long-acting opioids – available free online from DOH (Google AMDG+Opioid)

5. Dose criteria above which clinicians must consult with pain specialist.
   
   a. Threshold is ≥ 120 mg morphine equivalents daily (MED).
   b. Dose calculator provided online (Google AMDG+Opioid)

6. Dose criteria exemptions - consultation not needed if:
   
   a. Function improved, dose stable, no special risks
   b. On tapering schedule
   c. Acute time-limited increase
   d. Clinician has (q 2yrs) ≥ 12 hrs of CME on pain treatment
   e. Provider practices in a multidisciplinary pain treatment center
   f. Provider has ≥ 3 years clinical experience and works ≥30% in direct provision of pain care.

7. Guidance on access to Pain Specialists
   
   a. Defines pain specialist qualifications
   b. Enables telephonic, electronic, and televideo format, as appropriate
   c. Exempt when fail reasonable attempts to obtain consultation
The *Secret* of effective chronic pain care

• The ultimate goal of chronic pain care is **not** reducing pain, but improving life.
  – If the patient’s pain is reduced, but the patient’s life does not move forward, then the treatment has not succeeded.
  – If the patient’s life moves forward, even if pain intensity is not reduced, then the treatment has succeeded.
Negotiating goals of care

- Negotiating goals for treatment helps establish that you are on the patient's side in his/her battle with pain.

- A patient who feels that you share his/her goals for care will show much more flexibility in negotiating the means to get to those goals.
Negotiating goals of care: strategies

• Most important: Avoid the word "pain" in the overall goal of care
  – This is not because we do not care about our patient’s pain, but because reduction of our patient’s pain is only a means to improving the patient's overall life.
  – If pain is reduced, but overall life is not improved (e.g., no decrease in 'couch time'), then we have not succeeded.
Example of conversation

• Patient states they want “no pain” or even “less pain”
• You ask, “How would your life be different if that became true?”

• Patient describes resumption of enjoyable activities and relationships
• You explain, “That is our real goal, the ultimate goal for all of us. Attempting to relieve your pain with opioids may or may not get us closer to that goal.”
Responding to opioid requests

• A patient's request for an opioid prescription may express a need for:
  – pain relief (no pain, less pain)
  – validation of her pain as real,
  – understanding about struggling with pain
  – emotional support.

• It is best to acknowledge and address these separate legitimate needs before writing a prescription.
Saying ‘no’ to a request for opioids

• Writing a prescription for opioids is not the only way to validate a patient's pain and suffering.

• One of the most difficult skills is to say 'no' to a prescription while you say 'yes' that you believe the patient is in pain.

• Even the most empathic provider will not succeed at this every time.
What about depression?

- Do not ignore major depression. It will keep the best pain treatment plan from working.
  - Opioids are not adequate long-term treatment for depression or anxiety, even if the 'pain caused the depression.'
  - Use antidepressant medications, behavioral activation, and other evidence-based treatment strategies for depression.
Treating Depression and Anxiety

• Antidepressant Medications
  – SNRIs, TCAs for neuropathic pain
  – SSRIs

• Psychotherapy
  – Behavioral Activation
  – CBT
  – Other
FDA-Approved Antidepressants

Serotonin Reuptake Inhibitors (SSRIs)
fluoxetine (Prozac), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), fluvoxamine (Luvox)

Newer Antidepressants (atypical)
bupropion SR (Wellbutrin), mirtazapine (Remeron), venlafaxine XR (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)

Tricyclics (TCAs)
secondary amines: nortriptyline, desipramine
tertiary amines: imipramine, doxepin, amitriptyline
Not recommended for older adults
Antidepressants: SNRIs

**SNRI side effects:** GI distress (*NAUSEA, diarrhea*), *insomnia, restlessness, agitation, fine tremor, headache, dizziness, constipation, decreased appetite, sexual dysfunction.*

*Small risk of elevation of blood pressure at higher doses => check BP.*

*mg

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses avail.*</th>
<th>Therapeutic dose*</th>
<th>Usual dose*</th>
<th>Starting dose*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venlafaxine</td>
<td>25, 37.5, 50, 75, 100</td>
<td>12.5-150 bid</td>
<td>25-100 bid</td>
<td>25 daily</td>
</tr>
<tr>
<td></td>
<td>XR 37.5, XR 75, XR 150</td>
<td>37.5-225 daily (XR)</td>
<td>75-225 daily (XR)</td>
<td>37.5 daily (XR)</td>
</tr>
<tr>
<td>Comments</td>
<td>Once daily dosing with XR preparation.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Desvenlafaxine** *(no generic)*

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses</th>
<th>Therapeutic dose*</th>
<th>Usual dose*</th>
<th>Starting dose*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desvenlafaxine</td>
<td>50, 100</td>
<td>50 – 100</td>
<td>50 daily</td>
<td>50 daily</td>
</tr>
<tr>
<td>Comments</td>
<td>Active metabolite of venlafaxine; similar side effect profile.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Antidepressants: SNRIs – II

*SNRI side effects: GI distress (NAUSEA, diarrhea), insomnia, restlessness, agitation, fine tremor, headache, dizziness, constipation, decreased appetite, sexual dysfunction.
Small risk of elevation of blood pressure at higher doses => check BP.*

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses avail.*</th>
<th>Therapeutic dose*</th>
<th>Usual dose*</th>
<th>Starting dose*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duloxetine</td>
<td>20, 30, 60</td>
<td>40 – 60 daily</td>
<td>40 – 60 daily</td>
<td>30 daily</td>
</tr>
</tbody>
</table>

Comments
Nausea, dry mouth, constipation, decreased appetite, fatigue, sweating, sexual dysfunction.
Enteric coated. *DO NOT break tablets!*
Secondary Amine Tricyclics (TCAs)

Common side effects in all TCAs (>10 %): arrhythmias (particularly with pre-existing conduction defects), dry mouth, constipation, blurry vision, orthostatic hypotension, and weight gain.

*mg

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Unit doses avail.*</th>
<th>Therap dose*</th>
<th>Usual dose*</th>
<th>Starting dose*</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nortriptyline</td>
<td>10, 25, 50, 75</td>
<td>40-150</td>
<td>50-100</td>
<td>10 qhs</td>
<td>Weakness/fatigue</td>
</tr>
<tr>
<td>Desipramine</td>
<td>10, 25, 50, 75, 100, 150</td>
<td>75-200</td>
<td>100-200</td>
<td>25 daily</td>
<td>Tachycardia, insomnia, agitation</td>
</tr>
</tbody>
</table>
Survival Tips:
Things to remember for the toughest cases

• Chronic pain is NEVER an emergency

• Do not prescribe chronic opioids to a patient with current substance abuse.

• If you must say NO to a patient's request for opioids, explain that this is because you believe that these medications will not improve his overall quality of life.

• Offer to continue to treat the patient with non-opioid strategies.
Thank You

http://integratedcare-nw.org