Physiatrist's Voice

NEWSLETTER DECEMBER 2012

Enhancing Health And Function Through Education And Research In The Field Of Physical Medicine And Rehabilitation

In this issue

What Has Your Society Done For You

Rigoberto Puente-Guzman, MD

With 2012 nearing its end, Americans voted for the status quo with the re-election of President Obama, continued Democratic control of the Senate and Republican control of the House. With the potential catastrophic financial cliff approaching, expiration of Bush tax cuts and further implementation of Obama-care resulting in an uncertain economy, and healthcare changes coming to fruition, one may ask, "What has FSPMR done for me?"

FSPMR has a voice in local, state, and national settings. We are actively involved in forming coalitions with other state societies, having representation at the FMA, the national PMR academy, and other venues. In collaboration with state societies, we combine our resources to support and help modify pain legislation assuring the inclusion of physiatrists as one of the specialties trained in the field of pain medicine. We are also involved, through our representatives, in pushing back efforts by local county's/city's attempts to pass ordinances that supersede state and federal laws that would unfairly hurt legitimate pain medicine practices.

FSPMR helped pass concussion legislation that delineates the need for evaluation and release to play to the expertise of MDs and DOs. Through our Medicare contractor advisory committee (CAC) representation we have identified potential local coverage determination (LCDs) changes that could negatively affect ultrasound use in guidance of injections and aspiration procedures. We have brought this to the attention of our national academy and are working with other specialty state societies in order to educate and work with First Coast service options, at CMS, to prevent such changes. We remain active in scope of practice issues involving CRNAs, ARNPs, PTs and chiropractors through our FMA and AAPMR representatives. Since similar challenges occur throughout different states, and we can learn from each other. In the most recent council of state PMR society presidents meeting, we formed coalitions with other PMR state societies to help each other learn strategies to deal with issues affecting our specialty.

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What Has Your Society Done For You

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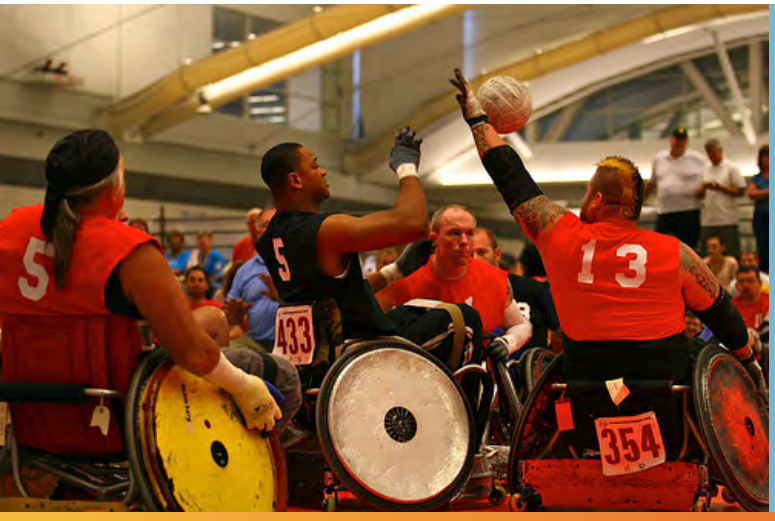
FSPMR is improving communication for our members and community through the development of a new and evolving web site (www.fspmr.org), quarterly newsletter, and interim alerts. Members are able to use the web site to post job opportunities for free. The web site also offers resources for patients to find Florida physiatrists. FSPMR in association with FAPM will hold its annual meeting in June 2013.

Looking forward, FSPMR is developing a resident section for future leaders in our field. Additionally, through a joint Florida Society of Neurology (FSN) and FSPMR committee, we continue exploring ways to deal with EMG scope of practice issues. We have a long road ahead with multiple issues coming to the forefront, including recent CMS release of new code values for NCS/EMG that may result in more then 50% cut in some services in January 2013.

In addition, the final ruling by CMS allowing CRNAs to bill as physicians for interventional pain procedures, leaving individual states to determine the CRNA's scope of practice issues, will require further legislative work through the FMA in Tallahassee.

You're invited to participate and help provide direction and support. Now more then ever, in order to influence possible outcomes, we need to be involved and united, speak as one voice.

Sincerely,
Rigoberto Puente-Guzman, MD
FSPMR President



Tampa Bay to Host 33rd National Veterans Wheelchair Games

July 13-18, 2013

The largest annual wheelchair sporting event in the world requires a tremendous amount of time—about two years' worth—so Tampa Bay get ready; the city has been chosen to host the 33rd National Veterans Wheelchair Games July 13-18, 2013.

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AAPM&R Job Fair: Moving Ahead

Lindsay Shroyer, MD
Tampa, Florida

For my entire career, my goal of becoming a PM&R physician was clear. All of the decisions, sacrifices, travel and geographic relocations where decided with one purpose in mind. Every step of the way, through medical school, internship, and residency I willingly relocated form one community to another leaving familiar surroundings behind. After completing residency, not satisfied with all I had accomplished, I focused my attention on completing my training interventional pain medicine at an ACGME fellowship program; ready to move once again. Location was never a question. There was always a finite amount of time for each step in this process, and you can do anything for 4 years. Now after 4 years of college, 4 years of medical school, 4 years of residency and 2 years of fellowship, I am finally ready to start my career. At 33 years of age, for the first time in my life the focus is not on the immediate result but on long term plans. I began by placing my attention on stratifying different factors like type of practice, people who I will be working with, living environment, community activities, compensation, potential partnership and much more. As exciting as this next step is in my journey, I find myself with much trepidation. How will I know what the right fit will be? Where do I want to live? Do I want to work in private practice or academics?

There are many of us finishing residency and fellowship facing this next critical step. The job fair for the AAPMR is an excellent starting place to answer some of these questions. The AAPM&R national meeting always hosts a job fair. It is usually held on the first day of the conference. This year the job fair was Wednesday, November 14, 2012 at the Hilton Atlanta. It was hosted between 6 pm to 9 pm.

Potential employers from all over the country, looking to hire a new graduate, in interventional pain, general physiatry, EMG/NCS, musculoskeletal, pediatrics, spinal cord injury, traumatic brain injury, etc. The event is cleverly organized by region: South, West, Midwest and East. I think this was a nice touch for the job fair, as participants could go directly to the areas where they wish to live. Job seekers are encouraged to have their CV printed out, to be able to hand to potential employers. The job fair is a nice way to shake hands with potential employers and have face time, without taking off vacation days to travel to see them. It was an excellent format to conduct small interviews, to determine if the position was what you were looking for.

At first, the job fair was overwhelming. First, many of us traveled that day, and a day of travel can be exhausting. After meeting so many people it's a challenge to remember everyone you have spoken to. It feels like 50 first dates, as you're trying to impress future employers, expressing who you are and what you're interested in.

The pros of the job fair far outweighed the cons. I met potential employers who I had never heard of through job postings or recruiters. I believe you can learn a great deal about people within the first few minutes of meeting them, just with a hand shake and a conversation. Most of the potential employers had business cards and paperwork describing the position they were offering, and included information about the area they worked in. I found myself taking notes on these pieces of paper they provided, so that I could remember the core of the interview after. I really found it helpful when the pamphlets had pictures of the physicians and of their practice, or included websites with this information.

The fact that the job fair was on the first day of the conference allowed for the following days to be interview days. I handed out my CV to some of the employers at the job fair, and the next day I was already receiving phone calls from physicians who wanted to speak to with me further about the positions they had to offer. I met several physicians over coffee during the conference, in an informal type interview.

Many of the potential job seekers wore professional dress, just like they would for a job interview. I encourage residents even at the PGY-1 level to go to these events. It's an excellent format to practice interviewing skills, learn about the PM&R Job market, make future contacts and learn how to promote themselves. Be prepared and use the opportunity to make you known and learn about the employers. Predetermine what you are looking for and have pertinent questions ready for them, remember they are also interviewing to be your employer and potential partners in the future. Searching for jobs is like buying a house. You have to go see several before you really understand what the perfect fit is for you, and when the right one comes along, you just know.

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The Unintended Consequences of Pill Mill Legislation

Ricky Lockett, DO, MBA, MPH
Board Certified Physical Medicine & Rehabilitation
Board Certified Pain Medicine

As a Florida practicing physician I am thrilled about the 2011 legislation to limit our prescription drug abuse problem. It was way overdue. Thankfully, our leadership pushed through this legislation.

My concern is where the approach now places our most medically complex and at risk population in desperate positions. The group I refer to are the elderly, disabled, people in chronic pain and those with mental health conditions. This is the group that makes up the brunt of my practice.

The legislation's multifocal approach has been successful. There are fewer prescription medication related deaths. The problem I have seen is an increase in individual suffering. Citizens with little hope other than to have a better quality of life and to be able to function and care for their daily needs are unable to obtain the medications they depend on.

The legislation's focus on eliminating dispensing from physician offices was probably the best tactic. There were simply too many pills that were too easily distributed with little control. The prescription monitoring system has also been of tremendous value. We needed help in seeing what our patients were getting from other physicians.

My problem rests with efforts to reduce the supply as outlined in the State of Florida's Attorney General's Report of April 2012. In particular, Goal 1: Objective 5: Eliminate rogue pharmacies. The intent appears to hold pharmacists more accountable for the medications they actually dispense. In our community the pharmacist and especially those working in national chains have taken a hardline with their customers. They use the phrase "I don't feel comfortable filling that prescription" as a way to deny giving patients the medication's they may have been on for years.

Another phase of the multipronged approach has been to arbitrarily limit the number of pills an individual pharmacy can purchase. The result has been a form of "Medical Prohibition." This tactic has led to a different "Public Health Crisis". Chronic pain sufferers are unable to obtain the medications that provide them with some quality of life.

The medication shortage forces them to either:

- Wait a week or more to get prescriptions filled;
- To travel to multiple pharmacies (I have heard up to 30) in order to get their medications;
- To go through withdrawal;
- Go to the Emergency Room when the pain or withdrawal symptoms overwhelm them;
- To seek medications from friends, family, dealers.

The one physician one pharmacy rule has had to go by the wayside.

Like diabetes, obesity and heart disease, addiction is a preventable disease. We cannot stop this problem by limiting access to those that use the medications such that they can function better in their daily lives.

Medical Prohibition leads to greater morbidity for vulnerable populations. There is increased anxiety, depression, withdrawal, pain, suffering and suicides. I have seen them all happen since the new legislation was implemented. How much more should our citizens in chronic pain suffer due to the addiction (disease) of others.

The pain management community must now advocate for our patients. They are suffering more now than ever. To be denied properly prescribed medication based on a governmentally directed shortage is unfair - Particularly, when it was done to protect others who were and still are obtaining the medications illegally, to be used for non-medical purposes.

To be denied medications prescribed by board certified physicians due to fear amongst pharmacists or when a pharmacist decides they do not like the physician's prescribing habits, is an excuse to allow profiling of sufferers and not fair to any of the parties involved.

Like you, I prescribe to individuals that I believe will benefit from the medications. At the moment I prescribe it is my intent to follow the letter of the law while doing the best for my patient. I have done so with a thorough knowledge of the individual in front of me. Few pharmacists have that advantage. Knowing the drugs is not enough. No physician without the appropriate staff support can detox a patient. A pharmacist that does not provide prescribed medication is initiating a "Rapid Detox."

The shortages of medication our communities are facing through medical prohibition has caused unintended consequences. Help me to get this dangerous part of the legislation corrected so that we can more intelligently approach the problem of addiction without harming those that benefit from the appropriate medicinal use of prescription drugs.

UPDATE
FMA BOARD OF GOVERNORS MEETING
HELD ON 10/26/12:

Jeffrey Zipper, MD
FSPMR CAC Representative

1) FMA will seek legislation for State Law to preempt local city and county ordinances, concerning governance of pain management clinics in Florida. The FMA will actively work together with the legislative Chairs and lobbyists for FSPM&R, FAPM, FSIPP, FSN and FSR to facilitate legislation this session.

2) Concerning scope of practice issues: The FMA will assist State medical societies in seeking legislation stating "Interventional Pain Management is the practice of medicine". A joint position statement from FSPM&R, FAPM, FSIPP and FSA will be submitted to the FMA for further action on this issue. This legislation is required to prevent unqualified CRNA's from, independently performing and getting reimbursed for IPM procedures by MC.

Regards,
Jeffrey A. Zipper, M.D.

GET INVOLVED
JOIN A COMMITTEE OR VOLUNTEER SOME TIME!

WEB SITE & NEWSLETTER COMMITTEE
Rigoberto Puente-Guzman, MD
Andrew Sherman, MD
Lindsay Shroyer, MD
Bella Chokshi, DO
Jesse A. Lipnick, MD
Katrina Lesher, MD
Wilda Murphy, MD
Quang "Wayne" Nguyen, MD
Lorry S. Davis, MEd (Exec Director)
Stephen Denas (Web Master)

EMG TASK FORCE
Matthew Imfeld, MD
Robert Dehgan, MD
Lindsay Shroyer, MD

IF YOU ARE INTERESTED IN HELPING OR JOINING ONE OF THESE COMMTTEES PLEASE CONTACT LORRY DAVIS AT DIRECTOR@FSPMR.ORG

FSPM&R CONGRATULATES FLORIDA PHYSIATRISTS

ABPMR's Earl C Elkins Scholarship Award

Awarded for obtaining the highest score on the 2012 Part I Examination - to Gloria Hon, MD, of Jacksonville, Florida.

Look Who Passed the 2012 Part II (Oral) of ABPMR on May 19 & 20

Alvarez, Gemayaret MD, Miami
Andrews, Sheryce Marie MD, Tampa
Baeza Dager, Junney Maria MD, Miami
Castheley, Dionne Docile DO, Pinecrest
Derr, Michael James MD, Jacksonville
Eichenbaum, Annette DO, St Petersburg
Gandara, Luis A MD, Sunrise
Hamilton, Alan Scott MD, Gainesville
Karam, Claudia MD, Port St Lucie
Masa, Luiz Maria De Mello MD, Jacksonville
Miranda Grajales, Hector Alejandro MD, Jacksonville
Nation, Pete-Gaye Victoria Eugenie MD, Miami
Nguyen, Quang Thanh MD, Orlando
Ojeda Correal, German MD, Miramar
Pearce, Heather MD, Palmyra
Sherman, Scott MD, Orlando
Shroyer, Lindsay Nicole MD, Tampa
Sunn, Gabriel H. MD, Miami
Tan, Huaiyu MD PhD, Gulf Breeze
Weiner, Michelle Erin DO, Miami
Zaremski, Jason MD, Gainesville

Received Subspecialty Pain Medicine Certification for 2012

Bethel, Adrian B MD, Temple Terrace
Bhandary, Avi Krishna MD, Orlando
Friedman, Jarrod David, Boca Raton
Le, Thanh Thien MD, Seminole
Mina, Michelle Ruiz MD, Boca Raton
Miranda Grajales, Hector Alejandro MD, Jacksonville
Tan, Huaiyu MD PhD, Gulf Breeze
Weiner, Michelle Erin DO, Miami

Accomplished Recertification for 2012 Maintenance of Certification (MOC) in PM&R

Hussain, Jawed MD, Jacksonville, FL
Krueger, David Wilbur MD, Naples
Lochner, Jacob Lewis DO, Tequesta, FL
O'Connell, John Alex MD, Coral springs
Ojeda Correal, German MD, Miramar, FL
Panganiban, Rudolfo Aquino MD, Tampa, FL
Pearce, Carisa MD, Greenacres, FL
Placer, Carlos Jose MD, Orlando, FL
Porrata, Humberto MD, Wellington, FL
Potochny, Nicholas Simon DO, West Palm Beach,FL
Qian, Tie MD, Weston FL
Santos, Maria Bernadette B MD, Leesburg, FL
Sivakanthan, Jamuna MD, Tallahassee, FL
Smith, Mathew Thomas MD, Winter Park
Staley, Tyler MD, Daytona Beach
Wright, Jay Norris MD, Windermere
Zahnle, Marichris MD, Lake City

Received Subspecialty Sports Medicine Certification for 2012

Gandara, Luis A MD, Sunrise
O'Connell, John Alex MD, Coral Springs
Patel, Bharat Chunilal MD, Merritt Island
Staley, Tyler MD, Daytona Beach
Zaremski, Jason MD, Gainesville

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SPORTS MEDICINE SUBSPECIALTY EXAMINATION DEADLINE REMINDER

Sports medicine is one of the most common fields of practice covered by physiatrists. We see athletes from professional, college, school sponsored and in the recreational arena. For the physiatrists who are practicing and want board certification in this subspecialty, time is running out. According to the American Board of Physical Medicine and Rehabilitation, after the 2013 Sports Medicine Subspecialty Examination, all candidates applying for certification must have completed a 12 month training program in an ACGME accredited sports Medicine program with an ACGME-accredited residency program in Physical medicine and Rehabilitation, Family Medicine, Emergency Medicine, Internal Medicine, or Pediatrics. The window of opportunity is coming to an end for those who are interested in having the certification without first going through a residency fellowship program. If you have over 5 years of sports medicine practice by July 31 of 2013 and completed 30 Continuing Medical Education (CME) credits related to this field in those five years you're eligible to sit for the exam. If interested, do not delay any longer and sign up for the 2013 exam.

SAVE THE DATE

2013 ANNUAL MEETING
JUNE 28-30, 2013

IN CONJUNCTION WITH THE
FLORIDA ACADEMY OF PAIN MEDICINE

PHYSIATRIST'S VOICE
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RESIDENTS SECTION

Bella Chokshi, D.O.
Co-Chief Resident
Physical Medicine & Rehabilitation, PGY-4
University of South Florida Program

Welcome to the first ever Resident's Section in our quarterly FSPM&R newsletter. This section was created with a goal to discuss ideas, issues, and topics that pertain to physical medicine and rehabilitation residents. In our inaugural year, I would like to introduce our two Florida based PM&R residency programs: the University of Miami and the University of South Florida. Go Canes and Go Bulls!!

In our first blog, we wanted to speak of our respective programs and individual mission. The Division of Physical Medicine and Rehabilitation at the University of South Florida Morsani College of Medicine offers an ACGME accredited four-year categorical residency program. We were the first rehab residency program in the state of Florida! We are now one of two programs in the sunshine state. Our program's mission is to train Physiatrists who will provide the highest level of clinical care through research and education in Physical Medicine and Rehabilitation. Our rotations are completed at the following clinical facilities: Tampa General Hospital, Tampa VA Hospital, H. Lee Moffitt Cancer Center, Carol and Frank Morsani Center and Tampa VA Research Center of Excellence.

Please visit our website for more information at http://health.usf.edu/medicine/neurology/pmr/index.htm

Our residency program welcomes medical students for elective rotations. Students enrolled at Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) accredited medical schools may apply for clinical elective courses at the University of South Florida Morsani College of Medicine.

Please apply at
http://hsc.usf.edu/medicine/registrar/new/visiting_students.htm

As we gear up for interview season, please note applications are accepted through the Electronic Residency Application System (ERAS) from September 15 through December 1. Applicants are encouraged to apply as early as possible. Interviews usually take place between November and January.

Please apply at https://www.aamc.org/students/medstudents/eras/

Jackson Cohen, M.D.
Physical Medicine & Rehabilitation, PGY-3
University of Miami Program

Seven years ago, the Department of Rehabilitation Medicine at Leonard M. Miller School of Medicine -University of Miami created a three-year ACGME accredited advanced residency program in Physical Medicine and Rehabilitation as well as a one-year ACGME accredited Spinal Cord Injury Medicine fellowship through Jackson Memorial Hospital. Over the years, the residency grew from four to 18 residents and has a full 5 year accreditation from the ACGME. The program has successfully graduated 25 residents and 9 fellows from the programs over the years and is proud of the high quality of the graduates practicing PM&R. This year all six PGY 4 residents and many PGY 3 residents presented posters at the AAPMR Annual Assemby. The goal of the department and educational program is to excel in our mission of patient care, education, and research by providing patient-family centered quality care to persons with musculoskeletal and neurological diseases and disabilities.

The rotations are completed at the following clinical facilities in Miami: Jackson Memorial Hospital/Jackson Health System, University of Miami Hospital and Clinics, Mount Sinai Medical Center of Florida, University of Miami Hospital, and Miami VA Healthcare System.

Please visit the website for more information at http://www.jhsmiami.org/body.cfm?id=9131

The Department also welcomes medical students and observers for elective rotations. Students enrolled at Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) accredited medical schools may apply for elective rotations at the Leonard M. Miller School of Medicine -University of Miami, Department of Rehabilitation Medicine. Please contact our program coordinator, Coretha Davis, at cdavis@med.miami.edu for more details.

Please stay tuned to our next blog where we will discuss board preparation, licensure, and job search.

FSPMR
FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION
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CHANGING TIMES

Jesse Lipnick, MD

Times have certainly changed. What we used to think of as safe is no longer so secure. We used to believe that narcotics were safe to prescribe, both for us and for our patients. We were told in the 1990s that doctors were not sensitive enough to their patients' complaints of pain. We were taught that narcotics have a high therapeutic index, that is, the dose difference between effective and toxic is very great. We also learned that they do not have a ceiling effect, so there is no mandatory maximum dosage. As a result of these beliefs, our use of these medicines grew to become a mainstay of treatment for chronic pain patients. Unfortunately, a number of undesirable changes have come along with the increased use of these medications. Florida developed the highest death rate from narcotic overdose in the USA until the advent of Florida's new prescribing laws. In addition, Florida saw an explosion of narcotic medication diversion. Highway 75 became the "Oxy Express," and there were more pain clinics in Broward County than there were McDonalds.

There has been a growing body of literature, which attempts to define the limits of prescribing narcotics for the management of chronic non-malignant pain. We used to believe that we could take away most, if not all, of a patient's pain by using these medications. Now we understand that the benefit is more limited. As a result, it is no longer appropriate to increase these medications in an attempt to reach a pain free state. This is no longer the goal of treatment. These patients will never reach a pain free state by using these medications. In fact, treatment goals are now defined by functional measurement tools and not just by subject report alone.

It stands to reason that there is a risk benefit curve relating to the prescription of narcotic medications. That is – patient benefits increase up until a certain point, and beyond this point, these benefits no longer justify the risks of prescribing these medications. We see a great deal of initial improvement in pain scores and in patient function when we begin to prescribe narcotics in the treatment of chronic non-malignant pain. But there comes a point in prescribing these meds where we do not see incremental increases in function or incremental decreases in reported pain scores.

In fact, high dose prescribing carries a whole new set of risks, some more serious than others. To begin, chances of drug to drug interactions increases with increasing doses of these medications. Patients who take CYP2D6 inhibitors (such as Fluoxetine, Buprenorphine or Cimetadine) or inducers (such as grapefruit juice, Dexamethasone or Rifampicin) can no longer predict therapeutic or toxic effect at high doses. We have all heard of respiratory depression with these meds, but who has a good idea of when this depression poses a real clinical threat to a patient? We are also concerned about narcotic induced hyperalgesia, an idea that should make us all more sensitive to prescribing increasing doses of medication in the absence of measurable benefit to our patients. Also, we have all become painfully aware that the street value of these medications makes us hesitate when prescribing to even our most trusted patients. Finally, the one new risk that we must all consider is the idea that high dosage prescribing may mark the treating doctor as a prescribing outlier within our pain management community. None of us wishes to get onto some regulatory radar screen for "high prescribers". We are all aware that community standards are out there, and if we are not aware of the prescribing practices of others within our communities, then you should have confidence that the regulatory organizations, which certify and follow our medical practices, are keenly aware of norms and outliers.

So how do you stop the upward progression of narcotic dosage that a patient may want you to prescribe? We have all been there. You are in the room with your patient. You have prescribed as much narcotic as you think is appropriate for you're your patient's condition, and the patient tells you the dose needs to be higher. You have already increased the dose each visit for the last few months and you really are not comfortable going any higher. What to do? Here are some ideas that maybe helpful. First, be honest with your patient. Tell him that you do not feel comfortable raising the prescription any further and site any or all of the risks listed in the last paragraph. Also, it is important to set patient expectations for the use of these medications. Tell your patient that there comes a point in prescribing these medications where the benefits no longer justify the risks of prescribing and you have reached that point. Tell the patient that you personally have narcotic limits, so any further reduction in pain will need to come from non-narcotic, physical, or interventional strategies. You can use this discussion as an opportunity to maximize all of these strategies that may pose less risk. If a patient needs more than you can prescribe from your "comfort zone", then maybe he needs another pain physician.

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CHANGING TIMES

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Those of us who work with mid-level practitioners face a related, but unique set of challenges. Midlevels are often volume driven in their production, so they want to see as many patients as possible. They (and all of us) must resist the urge to refill medications as a matter of course and be willing to go over even well established patients with fresh eyes looking for any unturned stone in history or treatment. As the supervising physician, you must closely regulate all prescriptions, and hopefully, your physician assistant or ARNP shares your prescribing philosophy, complete with judicious hesitation, a clear understanding of risk and the knowledge that times have changed for all of us in the pain management community of Florida.

In the face of these growing risks, I would suggest that each of us go through a self-assessment. What level of narcotic medication prescription do you feel is appropriate? Where does your level of discomfort begin? If your records were to be placed before your peers, could you defend the level and the progression of narcotic prescribing? Have you documented the need for them? Have you maximized the workup, treatment and documentation of the medical condition you are treating with narcotic medications, or have you jumped strait to narcotic management and relegated the practices of conservative and surgical intervention to the background? Changing times should make us all more acutely aware of the non-narcotic options we learned in our training. Do not forget that our first job as physicians is to do no harm.

LET YOUR VOICE BE HEARD

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DEPARTMENT OF REHABILITATION MEDICINE AT THE UNIVERSITY OF MIAMI MILLER SCHOOL ACHIEVES GOAL IN ITS 10TH ANNIVERSARY YEAR WITH FEDERAL GRANTS FOR TRAUMATIC BRAIN INJURY (TBI) AND SPINAL CORD INJURY (SCI) MODEL SYSTEMS

Andrew L Sherman, MD,MS

A research team in the Department of Rehabilitation Medicine at the University of Miami Miller School of Medicine was recently awarded a federal Traumatic Brain Injury (TBI) Model Systems grant for more than $2 million. The team was led by led by Doug Johnson-Greene, Ph.D., M.P.H., ABPP, associate professor and Associate Vice Chair of Rehabilitation Medicine. Funded by the National Institute on Disability and Rehabilitation Research (NIDDR), the five-year grant will enhance rehabilitation services and research. The aim is to meet the specific and ever changing needs of TBI individuals progressing through the clinical continuum of care, from emergency care, through inpatient and outpatient rehabilitation, to community re-entry.

This Grant award was achieved soon after another research team in the same Department of Rehabilitation Medicine led by Dr. Diana D. Cardenas, M.D., M.H.A., professor and chair of the Department of Rehabilitation Medicine, won a similar federal Spinal Cord Injury (SCI) model systems grant.

The Department of Rehabilitation Medicine at the University of Miami Miller School of Medicine is among only 7 sites nationally that were awarded the both U.S. Department of Education grants through a highly competitive selection process.

As part of these grants, the investigators from the Department of Rehabilitation Medicine with Jackson Health System, HealthSouth Rehabilitation Hospital of Miami, and a number of community organizations — including the Brain Injury Association of Florida, the Florida Department of Health's Brain and Spinal Cord Injury Program, and the WellFlorida Council — will establish the South Florida Traumatic Brain Injury Model System (SF-TBIMS) in addition to the South Florida Spinal Cord Injury Model Systems (SF-SCIMS).

Obtaining these highly sought after and recognized grants was long a goal of Dr Cardenas In a recent article published in the University of Miami electronic newsletter in 2011, Dr Cardenas, who will serve as the SCI grants principal investigator said: "It is an excellent achievement and recognition for the Department of Rehabilitation Medicine to receive such a grant. The award speaks to the high level of research that we have proposed and to the commitment and excellence of our SCI (and TBI) teams at Jackson Memorial Hospital, where we provide acute trauma care, in-patient rehabilitation, and community follow-up. With this grant we will be able to expand our educational efforts to patients with spinal cord injury and to other health care professionals."

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THE QUEST FOR TBI TREATMENT

Wilda Murphy, MD

Traumatic Brain Injury is an important national and global health issue, affecting civilian and military populations. The main causes of TBI are motor vehicle collisions, sports injuries, falls, work-related injuries, assaults, firearm injuries, explosives and other weapons.

It is estimated that in the United States 235,000 patients are hospitalized for nonfatal TBI, 1.1 millions are treated in the Emergency Room and 53,000 die each year. Trauma, which often includes TBI is the leading cause of non-cancer related deaths among Americans younger than 40 years old. Following hospitalization for TBI approximately 43% of patients in the US have residual disability. 3.2 million Americans are now living with disability following hospital admission for TBI.

Reducing the severity of TBI morbidity once trauma has occurred and improving recovery from TBI are major challenges. There is no single intervention that may alter the peace of recovery or improve functional outcomes on patients. Neuropharmacologic therapies are commonly used off label to enhance arousal and behavioral responsiveness.

On March 2012 Giacino JT and colleagues. published in the New England Journal of Medicine a double -blind, placebo controlled trial of Amantadine for severe TBI. Their study showed that Amantadine accelerated the pace of functional recovery during active treatment in patients with post-traumatic disorders of consciousness. Exposure to Amantadine was associated with more rapid emergence of basic cognitively mediated behaviors that facilitate functional independence.

This is great evidence for treatment of severe TBI, but what about mild to moderate TBI treatment? The CORBIT study of Citicoline treatment was anticipated to close this gap. On November 2012 Zafonte RD and colleagues published in the Journal of the American Medical Association the Effect of Citicoline on Functional and Cognitive Status Among Patients With Traumatic Brain Injury. This was a phase 3, double-blind study comparing Citicoline vs placebo. The study did not demonstrated any benefits of Citicoline treatment. A prior international trial also failed to demonstrate the extent or speed of recovery following acute stroke.

The rehabilitation of patients who suffered TBI is challenging due to the complex and diverse nature of the injuries sustained. Individualized treatment plans and multimodal treatment interventions will continue to be needed to improve recovery.

Sources: JAMA, November 21, 2012-Vol308, No.19, pp1993-2000, 2032-2033. NEJM, March1, 2012-Vol366, No.9, pp 819-826

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Recognizing Aberrant Drug Behavior in the Chronic Pain Patient

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The patient with chronic pain presents various challenges. Among these are the potential for aberrant drug behavior, be it tolerance/physical dependence, addiction/abuse or diversion. It is essential to recognize the differences between physical dependence and tolerance from addiction. The first two are states of adaptation where every patient taking opioids for a particular period of time will experience, and is not associated with a specific disease process. Addiction is a primary chronic neurobiologic disease with a variety of influencing factors (e.g., genetic, psychosocial, and environmental).1 Addiction behaviors include impaired control over drug use, compulsive and continued use despite harm and cravings.

Aberrant Drug Behaviors

Aberrant drug behaviors have been postulated by Passik, Portenoy and Ricketts and divided into less predictive and more predictive types of behavioral patterns.2 They proposed that among the less predictive are: Aggressive complaining of need to increase dose, drug hoarding, requesting specific drugs, acquisition from other physicians, unsanctioned dose escalation (one or two times), unapproved use of the drugs to treat another symptom, reporting unintended psychic effects. Among the probably more predictive behaviors associated with aberrant drug use are selling prescription drugs, prescription forgery, stealing or borrowing another patient's drugs, injecting oral formulations, obtain prescription drugs from nonmedical sources, concurring abuse of related illicit drugs, multiple unsanctioned dose escalations, and recurrent prescription losses. These need to be taken into consideration when starting opioid therapy as well as continued prescribing. They should be assessed at every visit as well as between visits. The patient's aberrant behavior may manifest itself with increasing needs to refill early, repeated phone calls to front office, etc.

Screening Questionnaires

There are a multitude of validated screening questionnaires which assist in identifying patients at risk for aberrant drug behavior. The CAGE questionnaire3 originally used for alcohol abuse has adjusted to include drug use (CAGE-AID). It consists of four basic questions:

1. Have you ever thought you should Cut down on your drug use?
2. Have you ever felt Annoyed by criticism of your drug use?
3. Have you ever felt Guilty of your drug use?
4. Do you frequently having a morning Eye opener?

Brown et.al. found three positives equal a 75% probability of aberrant drug behavior and 81% of the variance would lie within the first two questions.4 Another validated test is the Michigan Alcohol Screening Test which also has been modified to identify aberrant drug users (MAST and DAST). The Opioid Risk Tool (ORT); is also validated, simple to use, takes 1 minute to complete and is adjusted for gender. Other validated screens includes the Addiction Behaviors Checklist (ABC: tracks prescription drug behaviors in pain patients), the NIDA-modified alcohol smoking substance involvement screening test, version 2.0 (ASSIST: developed by World Health Organization, validated and has been updated to include prescription drug abuse), the Prescribed Opioids Difficulty Scale (PODS: addresses problems encountered by the patient receiving opioids) and the Current Opioid Misuse Measure (COMM: has a low cut-off score and over identifies misusers on purpose in order to not miss potential abusers).

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RECOGNIZING ABERRANT DRUG BEHAVIOR IN THE CHRONIC PAIN PATIENT

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Urine Drug Screening

An objective method of monitoring patients receiving controlled substances is Urine Drug Screening (UDS). It has a longer detection window than blood screening, is less costly and less invasive. It does not require a detailed drug history with respective to the timing of the medications taken but has significant cross-reactions with many over-the-counter drugs and herbals (Table). Communication with the testing center is necessary if a questionable result appears, especially with office point of care testing.

Opiates	**Quinolone antibiotics, poppy seeds (< 2000ng/ml)**
Marijuana (THC)	**Pantoprazole (Protonix®), Ibu/ketoprofen, naproxen**
Amphetamines	**Ephedrine/pseudoephedrine, Ranitidine (Zantac®)**
Methadone	**Phenothiazines, Doxylamine (Nyquil®)**
Phencyclidine (PCP)	**Venlafaxine (Effexor®), Seroquel**

Pharmacologic impurities, which may produce confusing results, need to be taken into consideration prior to determining that patient is abusing a non-prescribed or abusing illicit drug. Most notable among these are a relatively recent finding that hydromorphone is metabolite of morphine. Furthermore, codeine can be found with morphine testing and vice versa.5 Point of care false negatives are very important when monitoring the patient in the office. Drugs routinely not included in office point of care testing include oxycodone, fentanyl, butalbital, and carisoprodol. Drug metabolites do not normally react with point of care testing. In these, very high thresholds are used so lower levels of nonprescribed drugs may not be identified and will have to wait until the mass spectrometry confirmation. In this regard, especially with initial evaluation, it is not unreasonable to withhold prescription until confirmation is obtained, usually 2-5 days. Interpatient variabilities create variable urine drug levels and can impact the UDS. These include nausea and vomiting, organ function affecting diseases, drug drug or drug food interactions (e.g., grapefruit juice is a potent cytochrome P-450 3A4 inhibitor and 200ml raises methadone levels 17%6), acute weight loss, heat application, dehydration/fluid status, and timing of collection.

The Patient With A Known Drug Abuse History

The chemically dependent patient may very well have chronic intractable pain and requires treatment. The management of these particular patients needs to de different and maximally structured. The patient with chemical dependency requires more frequent office visits, a limited supply of medication, management primarily with long acting opioids with a very low street value, routine urine toxicology, and mandatory participation in a recovery program and psychotherapy. It is of utmost importance to follow these patients with an addictionologist and proceed with care, assuring the safest and most appropriate manner of therapy including interventional analgesic and complementary techniques (e.g., TENS, acupuncture, chiropractic, physical therapy, CBTs [for coping skills], etc). While these should also be considered in the non-abusing patient, it is here that the concept of interdisciplinary care is highlighted and offers significant advantages.

Summary

Recognizing the differences between tolerance, dependence and addiction is important in determining an appropriate treatment/management plan. While clinical assessment is important, relying solely on the clinical exam will miss some patients with aberrant drug behaviors. Use of validated screening questionnaires and objective measurements such as UDS will increase the likelihood of identifying patients with aberrant drug behaviors.

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