



MEDICATION MANAGEMENT FOR A BIOPSYCHOSOCIAL PAIN /FATIGUE-MANAGEMENT PROGRAM (For medical and psychiatric disorders)

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Almost all the patients referred to my program are on a drug-management plan that is appropriate for medical management of pain in the absence of a behavioral program. But behavioral pain-management is so effective that it adds a new dimension to the management of chronic pain. It requires a separate approach to medical management. It is not a new theory; it was the standard of care in all accredited, inpatient, pain-management programs in the 1970-1980's.

What this program offers that is new is the combination of behavioral sleep retraining combined with behavioral management of pain, mood and fatigue. All of this is tailored specifically for patients with **fibromyalgia syndrome (FMS)** or **myofascial pain syndrome (MFP)**. Although this program is considered "behavioral," it is not based on psychological theory but on the principles of neurophysiology and behavioral-change theory.

This program offers both behavioral pain and mood management and behavioral sleep retraining as viable options for reducing symptoms and improving quality of life for people with chronic pain, depression and central sensitization. The average, severe patient experiences a 40-50% reduction in symptoms in 12 weeks. But this outcome often requires the treating physicians and psychiatrists to reevaluate or redesign their medication plans so that drug management is not only supportive of a behavioral pain-and-sleep program but integrates this behavioral intervention into their overall approach with the patient. *This program expands the options for the treating physician.*

The patient does not have to be off of all drugs to start this program. The program is designed to support the patient in the withdrawal process and eliminate the need for non-essential drugs or drugs that prevent wellness.

It is impossible to teach patients how to: 1) behaviorally manage pain, if they are taking analgesics; 2) behaviorally manage sleep, if they are on drugs that increase or disturb sleep; and 3) behaviorally manage fatigue, if they are on drugs that increase fatigue or stimulate the patient.

DRUGS THAT PREVENT THE PATIENT FROM FULLY BENEFITING FROM A BEHAVIORAL PAIN/ SLEEP PROGRAM:

Generally these are drugs that increase fatigue, cognitive impairment, depression, insomnia and other symptoms of FMS or MFP. They also include drugs that cause rebound pain or mask pain and enhance mood in a way that allows engagement in activities beyond tolerance, drugs that can cause dependency without much efficacy, drugs that pose health risks, such as daily high-dose, non-steroidal, anti-inflammatory drugs (NSAID's) and drugs that can "flatten" appetite (Even if the patient needs to lose weight, this is not a healthy way to achieve that goal. Patients need to eat a healthy diet to become physiologically hearty.)

Chronic Pain

Fibromyalgia

Fatigue

Sleep
Disorders

Rheumatic
Diseases

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The following is personal commentary and analyses of medications based primarily on my experience of treating thousands of patients with chronic pain and fibromyalgia, who tend to be hypersensitive to medications.

This information may not fully apply to patients with acute pain or solely orthopedic, rheumatologic, neurologic or primary psychiatric disorders.

Many of these insights were gained from patients after they had withdrawn from medications and regained restorative sleep, in other words: from the perspective of 20-20 hindsight.

Analgesics: (opioids): Generally these are avoided because they cause dependence and tolerance and, therefore, are considered *ineffective* for management of chronic pain, especially FMS. One Vicodin is said to have the analgesic property of a shot of whiskey. If our patients reported they were coping with their pain by taking 4-8 shots of whiskey a day, it would be clear they were not coping at all. Even one or two opioids can enhance the patient's sense of well being and mask pain in a manner that *allows them to engage in activities beyond their physical tolerance but that perpetuate their chronic pain*, especially myofascial pain syndrome. This is a common problem and difficult to detect if the medication is allowing the patient to do "normal" activities (like grocery shopping, laundry or mall shopping) that are beyond the patient's physical tolerance, activities that would not normally be considered "excessive." *We want patients to be active, but the activity has to be within their actual physical tolerance, or it perpetuates pain and dysfunction.*

Tramadol (Ultram) is a synthetic opioid. Although it has less risk of addiction (<8 qd), it can cause other problems. It can have mood-enhancing properties that encourage dependence and abuse, not necessarily with the goal being to get high but to have energy and a better mood. This often allows the patient to engage in activities beyond their tolerance and perpetuate their chronic pain. Taking it solely to improve mood or gain energy is technically abuse and not an effective way to manage depression. If it increases alertness, it should not be used before sleep. Also, for some people, it is sedating, causing fatigue during the day. For patients who benefit from tramadol, the goal is often to reduce daily dosing to the PRN level.

Hypnotics: The older benzodiazepine hypnotics such as Dalmane and Halcion are not recommended by sleep specialists for chronic insomnia. Temazepam (Restoril) is newer but also a benzodiazepine. Hypnotics result in tolerance and rebound insomnia during withdrawal. Zolpidem (Ambien) has a short half-life and can cause rebound insomnia in 3-4 hours when it metabolizes and may cause amnesia when combined with other drugs. Generally patients in my clinic are having insomnia or nonrestorative sleep on Ambien, Lunesta, Serezone and Restoril. Patients with chronic pain have a wide range of sleep disorders beyond difficulty falling and staying asleep because of hyperarousal or pain. They often have circadian-rhythm imbalances, delayed sleep-phase onset, poor sleep hygiene habits, excessive daytime sleeping or resting, obsessive thinking, fear of not sleeping, excessive use of stimulants, smoking, alcohol intake, bladder problems, poor nutrition, inactive lifestyle, stiffness impeding a comfortable position and medications that disturb sleep.

Research has shown that behavioral treatment for insomnia is more effective than hypnotics for long term benefit.

Stimulants: All of these drugs can disturb sleep and increase anxiety and panic attacks, aggravate bladder disorders and increase muscle tension. People with tight muscles or muscle spasms should not be on them.

Modafinil (Provigil) is now frequently used to decrease fatigue and improve alertness. But these drugs interfere with behavioral fatigue-management training and circadian-rhythm entraining. In a sleep-retraining program patients have to reduce the lag time between awakening and being fully alert from 2+ hours to 30 min; and they have to shift their peak energy, e.g. from 1-4 PM to 8-12 AM, all behaviorally without drugs. Sleep is controlled by a 24-hour biorhythm not by an 8-

hour rhythm. Peak energy in the morning is linked to deep sleep at night. But, again, if this drug is truly beneficial in a given patient, we make it the last drug to withdraw.

OTC Energy supplements and Energy Drinks: Beverages like Red Bull, Venom, Adrenaline Rush, 180, ISO Sprint, and Whoopass contain large doses of caffeine and other legal stimulants, such as ephedrine, guarana, and ginseng. Energy drinks may contain as much as 80 mg of caffeine, the equivalent of a cup of coffee (compared to the 37 mg. of caffeine in a Mountain Dew, or the 23 mg. in a Coca-Cola Classic). Energy drinks' stimulating properties can boost the heart rate and blood pressure (sometimes to the point of palpitations), dehydrate the body, and, like other stimulants, prevent or interfere with sleep. Energy drinks should not be used while exercising because the diuretic property of the caffeine and the fluid loss from sweating can combine to leave the user severely dehydrated. Packets of "energy supplements" have the same ingredients as the drinks, plus stimulants like Ma Huang (Chinese speed) and bitter orange. These drinks also can aggravate irritable bladder.

Caffeine: Although there are many magazine articles on sleep that permit caffeinated beverages before noon for people with insomnia, *patients with pain and sleep disorders are so hypersensitive that even a morning caffeine drink can disturb their sleep*. Initially we have patients wean down to one serving in the morning. But ultimately they have to discontinue caffeine so that they can learn to manage their sleep and energy behaviorally. Once their sleep is fully corrected, they can return to morning caffeinated drinks. The effect of caffeine on hypervigilance is present even if patients do not "feel" energy from the drink.

Tricyclic antidepressants and desyrel (Trazodone): These drugs were initially the main treatment for improving sleep in FMS. Two studies have shown that quality of life does not improve on these drugs over three years. In patients with central sensitization, these drugs increase daytime fatigue and impair cognition. They often cause a hangover effect in the morning, which makes achieving ideal AM alertness time difficult. In addition, they generally cause weight gain in the chronic-pain population. This, of course, increases depression most people. *Every patient in my practice that has withdrawn from tricyclics and Trazodone has felt better and been mentally sharper, even if their insomnia increased slightly*.

Antidepressants that increase somnolence, e.g. mirtazapine (Remeron): This drug interferes with behavioral sleep retraining. Remeron is usually recommended to help with both depression and insomnia. Once a patient is in a behavioral sleep program, this drug needs to be changed to another SSRI that can be taken in the morning.

Antidepressants (SSRI's): Patients with persistent depression and anxiety generally do better when treated with an SSRI that can be taken in the morning. Drugs that cause somnolence are not good for FMS or MFP patients because night-time dosing interferes with sleep retraining. The drugs of choice for these patients are the SSNRI's or dual inhibitors, e.g. Effexor and Cymbalta, as they increase alertness. However, they can also increase anxiety and frequently cause bruxism. In my caseload most patients cannot tolerate Cymbalta and have to discontinue because of adverse effects of headaches, irritability or flattened affect. **All of these drugs can disturb sleep**. So from a behavioral perspective, they should be monitored for efficacy and only used if they are having significant impact. The side effects are too great to use these drugs for energy. Often patients who fully implement a behavioral sleep program are not able to achieve deep restorative sleep until they discontinue the SSRI. A trial withdrawal of the SSRI may be indicated because deep sleep increases serotonin and decreases depression.

Neuronal stabilizing agents (Anti-seizure drugs): In general these drugs tend to cause fatigue, which can further compromise cognitive impairment. They can also cause more side effects in patients with central sensitization than in patients with solely orthopedic, neurologic or psychiatric illnesses.

Drugs used specifically to treat FMS pain, e.g. pregabalin (Lyrica): In the FMS, MFP population this drug has not been well tolerated. If it is effective, it poses the same problem for a behavioral program as opioids, that is, enhancing mood, and masking pain, thus allowing engagement in

activities beyond tolerance. It can also cause dizziness, sleepiness, distal-limb swelling, weight gain, weakness (asthenia), blurred vision, diarrhea and impaired cognition. Some patients report “voracious eating” not just cravings. But if it is effective in a specific patient, it could be the last one withdrawn.

Drugs used to treat RSD, e.g. gabapentin (Neurontin), zonisamide (Zonegran) and Pregablin: *If they are effective for RSD, they facilitate a behavioral program, especially if they can be taken during the day to reduce impact on sleep. Many patients with RSD have been able to reduce their dosage of these medications with a behavioral program. Any drug that helps RSD is allowed.*

Drugs used to “stabilize mood,” e.g. valproate (Depakote, carbamazepine (Tegretol) or gabapentin (Neurontin): These are often given at night because they increase somnolence, but these drugs interfere with behavioral sleep retraining. It is hoped that once the patient is on a behavioral self-management plan, these drugs will no longer be necessary.

Drugs used to treat headaches, e.g. topiramate (Topamax). Although this drug can be helpful for headaches in FMS and chronic pain patients it can interfere with behavioral treatment if it causes fatigue, sleepiness, dizziness and impaired cognition. Loss of appetite can result in poor nutrition.

Anti-psychotic drugs, e.g. quetiapine (Seroquel), risperidone (Risperdal), aripiprazole (Abilify), ziprasidone (Geodon): Typically these drugs are given at night because they cause somnolence. For FMS/MFP patients they are usually used to decrease obsessive thoughts. Once patients are in a behavioral program that includes cognitive-behavioral training (CBT) for obsessive-compulsive tendencies, medication management for these psychiatric problems needs to be reevaluated. When the drug is beneficial, we do as much psychiatric therapy as possible with the drug in place. When patients have made considerable improvement, they are referred back to their psychiatrist for consideration of a gradual withdrawal, so that they can learn how to manage the remaining symptoms. Teaching patients how to stop negative, obsessive thinking is a critical part of this pain program. They are taught meditation, CBT and other self-regulation techniques.

When the drugs are used for treatment of psychotic features of depression, the treatment plan has to be individualized.

Muscle relaxants, e.g. Soma, Flexeril, Baclofen, Skelaxin, Zanaflex: If taken PRN for spasms that are non-responsive to behavioral management, these drugs do not interfere with the program. Taken daily, however, these drugs can cause fatigue and cognitive impairment and are, therefore, generally problematic. Most patients get better results with behavioral management because improved sleep, reduced anxiety, thermal modalities and relaxation training can reduce most muscle spasms without negative side effects. For severe, debilitating spasms, Alpha-Stim® microcurrent stimulator is often more effective than drugs and has no side effects. (See www.Alpha-Stim.com for more information.)

Anxiolytics: Benzodiazepines, e.g. Ativan, Xanax, Klonopin, and Valium: These are appropriate for severe anxiety attacks, until the patient improves enough to manage them behaviorally. Many patients take these instead of alcohol to wind down in the evening, and this is abuse. Drugs with a short half-life can cause rebound anxiety or insomnia when they wear off. Generally anxiety is primarily treated with an SSRI. If benzodiazepines are truly needed for anxiety, we can work around them by having the patient take them during the day so they have less impact on sleep. Later in treatment after sleep has improved and anxiety is reduced, the necessity of these drugs can be reassessed.

NSAID’S: Prior to 2005, these were allowed in moderate doses. But today due to the risk of cardiac problems, gastric distress, bleeding ulcers and cognitive impairment in frail people, our program has the goal of eliminating the need for daily dosing for FM or MFP. These drugs can also cause

rebound pain and headaches as they wear off. FMS patients are so sensitive that they can often substitute one acetaminophen plus one ibuprophen instead of two ibuprophen, thus cutting their dose in half but achieving the same efficacy. In this program, patients are learning a wide range of techniques besides medications for reducing pain. **NSAID'S for inflammatory disorders generally do not interfere with the program.**

EPILOGUE

After reading this, I am sure that some physicians/clinicians will think, "If I were the patient, I wouldn't want to make all of the above behavioral changes but would rather just take a pill." In fact, many patients do feel exactly that way. But by the time they come to this program, they have already taken lots of pills that didn't work, helped only a little or made them worse. Therefore, painful experience has primed them for another solution. When they come to this program--almost desperately in come cases--they are looking for a real and lasting solution and generally are willing to do the work necessary to get well.

Solutions for Wellness provides a biopsychosocial approach to pain/symptom management for a wide range of orthopedic, rheumatic and neurologic disorders. For information about these programs or a detailed description about the Industrial Rehabilitation Program for chronic pain or fibromyalgia, **please call 310-306-4247 or email: JLMelvin@ca.rr.com.**

Thank you for your interest in the Solutions for Wellness Pain Program.

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