Appropriate Opioid Pharmacotherapy for Chronic Pain Management: A Multimedia CME Program

Primer With Posttest

Co-Chairpersons:
Richard Payne, MD and Russell K. Portenoy, MD
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Dear Colleagues:

We are very excited to invite you to participate in an important educational endeavor, *Appropriate Opioid Pharmacotherapy for Chronic Pain Management*, a multimedia activity for physicians and other medical professionals who treat pain.

Pain is a complex and challenging phenomenon that varies in etiology and presentation and requires individualized treatment. Persistent pain is a major health problem in the United States and is one of the most common reasons people seek medical care. Health policy makers, health professionals, regulators, and the public have become increasingly interested in the provision of better pain therapies.

Opioid therapy is an essential element in the treatment of selected patients with chronic pain. Unfortunately, many physicians lack skills in pain management and are particularly uncomfortable with opioid therapy. Achieving state-of-the-art knowledge and skills in a rapidly changing discipline requires activities such as this, the first in a series of continuing education activities under the auspices of the National Pain Education Council (NPEC).

To maximize the impact of this activity, NPEC will employ a combination of innovative and traditional approaches to professional education. The most exciting new activity will be a website that includes an interactive and multimedia strategy for education in pain management.

Participation in this activity will assist healthcare professionals in assessing and treating chronic pain. We trust that you will find your participation challenging and, ultimately, rewarding.

Sincerely,

Richard Payne, MD
Chief
Pain and Palliative Care Service
Memorial Sloan-Kettering Cancer Center
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Russell K. Portenoy, MD
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APPROPRIATE OPIOID PHARMACOTHERAPY FOR CHRONIC PAIN MANAGEMENT

NPEC ACTIVITY OVERVIEW

Appropriate Opioid Pharmacotherapy for Chronic Pain Management consists of several self-contained elements employing various media. Most activities are available online at our website: www.npecweb.org. By participating in the activities, you will gain valuable insights into the appropriate management of chronic pain, thus enabling you to create more meaningful pain treatment plans for your patients. This activity is the first in a series to be offered by the National Pain Education Council (NPEC).

NPEC Primer with Posttest

This primer is designed to allow you to assess your current knowledge level about the diagnosis and management of chronic pain.

In the primer you will find a 40-item posttest, along with an overview of chronic pain management.

You may participate online at www.npecweb.org; a confidential e-report of your performance will be sent via e-mail.

After completing this primer, you will be able to identify subject areas that warrant your particular attention throughout the course of the entire activity.

Website: www.npecweb.org

This multimedia web-based learning experience is the official NPEC hub. Accessible to participants in all specialties, the site serves as a CME/CE clearinghouse, containing all materials necessary for accreditation, including pre- and posttests, and online submission and reporting for all activities, including Appropriate Opioid Pharmacotherapy for Chronic Pain Management. All CME/CE activities are archived for ready access by those who wish to read them without formally participating in the educational activity.

In addition, the website includes, but is not limited to:

- Events-calendars for all major societies whose members are involved in pain management
- Links to individual State Medical Boards
- Published Pain Management Guidelines
- Downloadable slides for those who wish to use them during speaking engagements
- A library of the most current published literature on pain management

Interactive Web-based Case Studies

The six case histories have been developed as individualized learning tools. You will navigate through each case as though you were, in fact, treating your patient. You will make decisions; access both case management “clinical consults” from the Curriculum Committee (who developed the cases) and evidence-based supportive data; and follow your virtual patient’s progress. The following cases are currently offered: Cancer Pain, Low Back Pain, Osteoarthritis Pain, Diabetic Neuropathy Pain, Fibromyalgia Pain, and Burn Pain.

Chronic Pain Monograph Series

A CME/CE three-part monograph series, complete with posttest, is available for each of three key areas of pain management:

1. Optimizing Treatment of Chronic Pain with Opioid Therapy; (2) Assessment and Management of Aberrant Drug-Related Behavior; and (3) Management of Pain in Patients with Progressive Medical Diseases. The monographs will be mailed directly to interested participants; they will also be available online at our website.
Modular Slide Kit with Teaching Points
More than 75 slides with teaching-style lecture notes are available for downloading from our website for healthcare professionals who wish to educate themselves and their colleagues using NPEC materials. The slides contain all teaching points covered in the monographs.

ACTIVITY PURPOSE
The purpose of the CME activity is to advance the clinical management of pain through education and communication, with the ultimate goals of relieving patients’ suffering and improving their health and quality of life.

Under the leadership of co-chairs Russell K. Portenoy, MD, and Richard Payne, MD, a distinguished faculty of pain experts has developed a comprehensive CME curriculum, Appropriate Opioid Pharmacotherapy for Chronic Pain Management.

STATEMENT OF NEED
The following needs assessment in the area of chronic pain is derived from various sources, including guidelines and standards for care developed by the American Pain Society, the American Association of Pain Medicine, the Joint Commission on the Accreditation of Healthcare Organizations, and the National Comprehensive Cancer Network. The recommendations and guidelines are supported by clinical implications gleaned from scientific articles and expert opinion.

Chronic pain is pain of any origin that persists beyond normal tissue healing time, or beyond a period of 3 to 6 months. Chronic pain commonly impairs the functioning or well being of a patient. Pain is one of the most common reasons that people seek medical help and is the second leading cause of absenteeism from work; as such, pain has become a major health problem in the United States. Yet chronic pain frequently is undertreated, resulting in significant personal and social costs: needless suffering, lost productivity, and excessive healthcare expenditures.

In the last several years, however, health policy makers, health professionals, regulators, and the public have become increasingly interested in providing better pain management. Guidelines for pain management have been issued by the U.S. Department of Health and Human Services and medical specialty societies. Because chronic pain has multiple and various causes, proposed treatment strategies consist of a number of approaches, including behavioral, rehabilitative, surgical, and pharmacologic options. These guidelines, as well as numerous publications by pain specialists on chronic pain management, state that opioids are an important part of a multifaceted treatment program for pain management. Despite these advances, patient-, system-, and physician-related barriers continue to limit the use of opioids for the relief of pain. Patients frequently are reluctant to use opioids, or “narcotic analgesics”; the healthcare system places a low priority on and provides inadequate reimbursement for pain treatment; and many physicians have concerns about addiction, tolerance, and side effects, and fear regulatory scrutiny.

Most physicians have little or no formal training in pain pathophysiology, pain management, or the clinical pharmacology of analgesic drugs. To prepare physicians to treat chronic pain appropriately, educational activities must focus on the pathophysiology, assessment, and management of pain, and provide information on the risks and benefits of opioid analgesics in pain management. Additionally, these activities should present the most current information on regulatory issues and guidelines related to opioid prescribing, to help physicians make appropriate and informed decisions regarding the treatment of pain.
TARGET AUDIENCE

- **Specialists:** Anesthesiologists, Geriatricians, Hospitalists, Neurologists, Oncologists, Pain Specialists, Physiatrists, Psychiatrists, Rheumatologists
- **Primary Care Providers:** Family Physicians, General Internists, General Practitioners
- **Allied Healthcare Professionals:** Case Managers, Nurse Practitioners, Oncology Nurses, Pain Management Nurses, Pharmacists, Physician Assistants

NATIONAL PAIN EDUCATION COUNCIL MISSION STATEMENT

The National Pain Education Council (NPEC) aims to advance the clinical management of pain through education and communication, with the ultimate goals of relieving patients’ suffering and improving their health and quality of life.

Under the leadership of co-chairs Russell K. Portenoy, MD, and Richard Payne, MD, a distinguished faculty of pain experts has developed a comprehensive CME curriculum, *Appropriate Opioid Pharmacotherapy for Chronic Pain Management*.

LEARNING OBJECTIVES

Upon completion of this national CME initiative, *Appropriate Opioid Pharmacotherapy for Chronic Pain Management*, the participant should be able to:

- Describe the disruptive and often devastating impact of chronic pain on the lives of patients and their caregivers, as well as the enormous costs to the healthcare system and society
- Explain why chronic pain far too often goes undiagnosed or undertreated
- Assess and identify patients with chronic pain
- Explain the increasing role of opioid analgesics in chronic pain management
- Differentiate the benefits and risks associated with specific opioid analgesics
- Formulate safe, effective, and individualized treatment strategies incorporating opioid analgesics for patients with chronic pain, including those with chemical dependency issues
- Demonstrate appropriate follow-up of chronic pain patients treated with opioid analgesics
CURRICULUM COMMITTEE AND DISCLOSURES

Discovery International’s Division of Continuing Medical Education requires that the faculty participating in a continuing medical education activity disclose to the participant any significant financial interest or other relationship (1) with the manufacturers of any commercial product(s) and/or provider(s) of commercial services discussed in an educational presentation, and (2) with any commercial supporters of the activity.

Faculty may have disclosed one or more of the following: honorarium/expenses; grants; consultant role; speaker’s bureau member; stock ownership and other special relationships. Faculty members have provided the following information on sources of funding for research, consulting agreements, financial interests, and stock ownership.

CO-CHAIRS

Richard Payne, MD
Chief, Pain and Palliative Care Service
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- **Sources of Funding for Research:** National Institutes of Health, Langeloth Foundation, Purdue-Frederick Pharmaceuticals, Janssen Pharmaceutica Products, L.P.; Elan Pharmaceuticals; St. Charles Pharmaceuticals
- **Current Consulting Agreements:** Pfizer Inc., Pharmacia, Inc.; Nastech; Whitehall-Robins; Merck & Co., Inc.; Janssen Pharmaceutica Products, L.P.
- **Current Financial Interests/Stock Ownership:** Shire-Richwood Inc.

Russell K. Portenoy, MD
Chairman, Department of Pain Medicine and Palliative Care
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- **Sources of Funding for Research:** Parke-Davis, Boehringer Ingelheim, Elan Corporation, Ortho-Biotech Inc., Endo Pharmaceuticals, AMETEK Advanced Measurement Technology, Medtronic, Inc., Purdue Pharma LP, Pfizer, Inc., Janssen Pharmaceutica Products, L.P., Abbott Laboratories

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Pain and Palliative Care Program
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Boston, Massachusetts

- **Sources of Funding for Research:** Research grant from the Pew National Trusts, R25 for Palliative Care Fellowship (from NIH)
- **Current Consulting Agreements:** Consultant to Medtronic Speaker’s Bureau, Purdue Pharma, Ortho-Biotech, Janssen Pharmaceutica Products, L.P.
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Sources of Funding for Research:
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Current Consulting Agreements:
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Mental Health Administration, Center
for Substance Abuse Prevention,
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Richard L. Brown, MD, MPH
Tenured Associate Professor
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Madison, Wisconsin

Sources of Funding for Research: National
Institute on Alcohol Abuse and Alcoholism,
Health Resources and Services Administration

Current Consulting Agreements: Janssen
Speakers Bureau, Purdue Speakers Bureau

June L. Dahl, PhD
Professor of Pharmacology
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Madison, Wisconsin

Sources of Funding for Research: National
Cancer Institute;
Robert Wood Johnson Foundation;
Project on Death in America;
US Cancer Pain Relief Committee

Present Offices in Professional Associations:
Director, Resource Center of the American
Alliance of Cancer Pain Initiatives; Board of
Scientific Advisors, American Pain Foundation

Perry G. Fine, MD
Professor of Anesthesiology
National Medical Director, Vista Care
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Current Consulting Agreements:
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Janssen Speakers Bureau, Merck and Co., Inc.
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Judith A. Paice, PhD, RN, FAAN
Research Professor of Medicine
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Sources of Funding for Research:
National Cancer Institute

Current Consulting Agreements:
Janssen Speakers Bureau, Ortho-Biotech
Speakers Bureau, Purdue Speakers Bureau

Present Offices in Professional Associations:
Secretary, American Pain Society; Board
Member, Midwest Pain Society

Steven Passik, PhD
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Sources of Funding for Research:
National Institute on Drug Abuse,
Eli Lily and Company, Pfizer Inc.,
Janssen Pharmaceutica Products, L.P.,
Ortho-Biotech Inc., Soros Foundation,
Organon Inc., USA, Forest Laboratories, Inc.

Current Consulting Agreements:
Food and Drug Administration, National
Institute on Drug Abuse

This activity is funded through an educational grant from Janssen Pharmaceutica Products, L.P.
MEET THE NPEC FACULTY

Chairpersons

Richard Payne, MD, Co-Chair
Chief, Pain and Palliative Care Service
Memorial Sloan-Kettering Cancer Center
New York, New York

Dr. Richard Payne, MD, is Attending Neurologist and Chief of Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center, where he also holds the Anne B. Tandy Chair in Neurology. Dr. Payne is also Professor of Neurology and Pharmacology at Cornell Medical College. Previously, Dr. Payne held the positions of Professor of Neurology and Chief of the Pain and Symptom Management Section at the University of Texas, Department of Neuro-Oncology, MD Anderson Cancer Center in Houston, Texas. A graduate of Yale University and Harvard Medical School, Dr. Payne completed postgraduate training in Internal Medicine at the Peter Bent Brigham Hospital in Boston and in Neurology at the New York Hospital-Cornell University Medical College. In addition, he completed a Fellowship in Neuro-Oncology and Pain Management at Memorial Sloan-Kettering Cancer Center. Currently he is President-Elect of the American Pain Society and a Director of the Intercultural Cancer Council. Dr. Payne has authored and co-authored more than 150 journal articles and numerous book chapters and serves on the editorial boards of several peer-reviewed pain journals, including the Journal of Pain and Symptom Management, Pain, and Journal of Pain.

He has chaired and served on numerous government advisory boards, including the Institute of Medicine and the National Pain Policy Board, and is a sought-after lecturer at distinguished medical meetings throughout the world.

“The major objective of the NPEC initiative is to relieve the burden of human suffering by educating physicians about the latest aspects of pain assessment and management. We have designed an innovative, exciting program to educate physicians in the management of chronic pain, with particular emphasis on the use of opioid medications. Although we have come a long way in addressing the issues around and treatment of chronic pain, we have an obligation to continue to educate ourselves and to improve our pain management skills.”

Russell K. Portenoy, MD, Co-Chair
Chairman, Department of Pain Medicine and Palliative Care
Beth Israel Medical Center
New York, New York

Russell K. Portenoy, MD, is chairman of the Department of Pain Medicine and Palliative Care at Beth Israel Medical Center and Professor of Neurology at the Albert Einstein College of Medicine. He received his medical degree from the University of Maryland School of Medicine, and completed a residency in neurology at the Albert Einstein College of Medicine and a fellowship in pain management at Memorial Sloan-Kettering Cancer Center. Before assuming his current position, he was Co-Chief of the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center. Dr. Portenoy is a past president of the American Pain Society, and the recipient of that society’s Wilbert E. Fordyce Clinical Investigator
Award and the Distinguished Service Award. He recently received the Founder’s Award from the American Academy of Pain Medicine. He currently serves as Secretary of the International Association for the Study of Pain, Vice Chairman of the American Board of Hospice and Palliative Medicine, and Director of both the American Pain Foundation and the National Hospice Foundation. Dr. Portenoy has authored or edited 15 books and more than 350 papers on topics related to pain and analgesics, treatments for symptoms other than pain, symptom assessment and quality of life. He is Editor-in-Chief of the Journal of Pain and Symptom Management; Associate Editor for the palliative care section of both Cancer Investigation and The Oncologist; and Associate Editor for the clinical sciences section of the journal Pain.

“Pain is commonly undertreated. There is a profound need for education, advocacy, and research dedicated to improving clinician skills, access to care, and optimal treatment. Better management of pain can improve quality of life for vast numbers of patients and their families, and yield huge benefits for society as a whole. Congress has designated this the Decade of Pain Control and Research, which makes this a particularly timely moment for the creation of the National Pain Education Council. NPEC is a creative program that can potentially provide the continuing education necessary to improve pain management skills.”

Faculty

Janet L. Abrahm, MD
Director, Pain and Palliative Care Program
Department of Adult Oncology
Dana Farber Cancer Institute
Boston, Massachusetts

Dr. Janet L. Abrahm began her career as a hematologist-oncologist, before specializing in pain and palliation and end-of-life care. In addition to her work at the Dana Farber Cancer Institute, she is the Associate Director of the Harvard Medical School Center for Palliative Care, and was instrumental in designing the new palliative care and psychosocial oncology elective for fourth-year HMS students. Dr. Abrahm has written over 40 publications on palliative medicine and contributed to the ASCO and ACP palliative care curricula. She was named to the ACP End-of-Life Consensus Panel in 1997.

“The mission of the National Pain Education Council is to help relieve the suffering of patients with chronic pain and of the families trying to care for them. The major issues in pain relief center on communication: the patient or the family has to tell us about their pain, and we as their physicians have to communicate what we can do to help them. We especially need to provide much more education for the practitioners who are caring for these patients—they need to know what therapeutic options are available and how to explain these options to their patients. Our plan for the NPEC programs, and for the website in particular, is to provide practitioners with state-of-the-art information to help them to care for patients suffering from chronic pain.”
An oncologist by degree, Dr. Daniel Brookoff has done an enormous amount of research into pain and its management, both in cancer and in nonmalignancy. He has published many articles in peer-reviewed journals; written and co-written books, pamphlets, and chapters; and is extremely active in patient education, particularly in the areas of interstitial cystitis and sickle cell anemia. Dr. Brookoff is an active member of many professional societies, including the American College of Physicians, the American Medical Association, the American College of Emergency Physicians, and the American Pain Society.

“I once heard a pain specialist say that pain is something that happens to a body, and suffering is something that happens to a person. And we’re treating people, so we’re treating pain, as well as something much larger than pain. In order to do this effectively we need to understand the physiology—the scientific rationale—for what we do. One important goal of the NPEC program is to be a repository of pain information, where leading experts will offer, in a variety of innovative and useful formats, an understanding of pain, the physiology of pain, and the rationale for its treatment.”

Dr. Richard L. Brown is the author of numerous journal articles, book chapters, abstracts, and educational software on pain, addiction and treatment. He has served on the editorial boards, as a reviewer, and was the principal investigator on many research projects devoted to substance abuse and pain management and has developed several curricula in these areas. He is the Society of Teachers of Family Medicine’s delegate to the Physicians Leadership on National Drug Policy. He is a Diplomate of the American Board of Family Practice and the National Board of Medical Examiners, and a member of the AAFP, the Society of Teachers of Medicine, and the Association of Medical Education and Research on Substance Abuse, where he served as its president.

“Pain specialists and pain clinics do great work—it’s imperative that they exist. However, we have far too much chronic pain out there just to rely on pain specialists and pain clinics to handle. We also have many managed care programs that don’t provide access to these wonderful resources. So we need to get the word out to primary care physicians that opioids are an effective treatment, but also make them aware of the need for balance—balance between effective pain control and responsible monitoring. We need to educate clinicians and other healthcare professionals about some of the issues that they need to watch for, and offer them education about proper assessment, appropriate prescribing, and regular monitoring.”
Dr. June L. Dahl received her PhD in chemistry from Iowa State University and has spent many years in basic research. Since the mid-1980s, she has focused attention on advocacy and educational efforts to improve pain management. She is a co-founder of the Wisconsin Cancer Pain Initiative and Past President of the American Alliance of Cancer Pain Initiatives. She served for ten years as chair of the Wisconsin Controlled Substances Board, the state’s drug regulatory authority. Her current work is focused on removing regulatory and institutional barriers to effective pain management. Most recently she worked with the Joint Commission on Accreditation of Healthcare Organizations to incorporate pain assessment and management into the standards they use to accredit the nation’s healthcare facilities.

“We interviewed a patient at a best-practice site that I visited, where they do a superb job of assessing, managing, and monitoring their patients to achieve quality pain management. This patient said, ‘Now I can enjoy my day. I can enjoy my meals. I can go to bed and I can sleep through the night. I’m a real person now. I’m not just pain walking around.’—and that’s what this is all about.”

Dr. Perry Fine is a clinician who has widely published findings regarding several aspects of pain management, notably involving the care and management of chronic pain in the elderly. Active in many professional societies, Dr. Fine has served on the Board of Directors for the American Pain Society, Americans for Better Care of the Dying, and, currently, The Partnership for Caring and the Vista Hospice Care Foundation. He chaired the Comfortable Dying Task Force for the National Hospice and Palliative Care Organization, and chairs its Ethics Committee. Dr. Fine co-authored the clinical guideline on management of persistent pain in older individuals for the American Geriatrics Society. He has published numerous articles and abstracts, and authored or co-authored several books and book chapters dealing with pain and its management.

“NPEC will rapidly help physicians catch up on current approaches to effective management of chronic pain. This clinically applicable program, which leads physicians through many cases that represent different chronic pain syndromes, will help arm clinicians to assess and manage their patients suffering with chronic pain. The best thing that I can say to my colleagues about the NPEC program is that you will be able to use what you learn to take care of the very next patient that you see who has the type of problem that you will encounter in these realistic interactive case studies.”
Dr. Judith A. Paice is a Research Professor of Medicine at the Palliative Care and Home Hospice program. She received her PhD in Philosophy of Nursing Science after completing her thesis on the role of dorsolateral pontine tegmentum in modulating nociception. Dr. Paice is active in many professional societies, including the American Pain Society, where she is currently the Secretary and chairs the continuing education committee. She has authored or co-authored many peer-reviewed articles, as well as book chapters and monographs, related to assessing and managing chronic pain. She played a key role in the development of the cancer pain guidelines issued by the Agency for Healthcare Policy and Research.

“Patients continue to suffer from inadequate pain relief. Much of this undertreatment is due to lack of education. The skills needed to assess pain in a comprehensive manner and develop a plan of care are rarely taught in schools of medical, nursing, or pharmacy. NPEC is one way to allow clinicians to acquire these important skills. The ultimate benefit will be improved pain relief, and quality of life, for patients with chronic pain.”

Dr. Steven Passik has been very active in researching the devastating effects of pain on the patient’s life, particularly resultant depression and fatigue. He has more than 150 publications, book chapters, and abstracts under his authorship, and plays a vital role in several scientific and psychological societies. He is currently a member of the Advisory Boards of the Journal of Pain and Symptom Management and the Association of Cancer Online Resources. Most recently, Dr. Passik has investigated aberrant drug-taking behaviors and their effects on optimal pain management.

“The NPEC initiative affords some unique approaches to continuing medical education. Web-based, interactive, ongoing case studies involve the physician and other healthcare professionals in a way that hasn’t been done before. Experiencing the ongoing care of a hypothetical patient that leads down many potential avenues is very exciting, closely approximating reality and allowing physicians to see how their interventions influence the care of ‘real’ patient, and to ‘consult’ with colleagues in the field about the case and their decisions. This approach offers a unique opportunity for an alternative in-service experience.”
Appropriate Opioid Pharmacotherapy for Chronic Pain Management: A Multimedia CME Program

Date of Release: 6/17/02

TERM OF OFFERING

This activity has a release date of 6/17/02 and is valid for 2 years. Requests for credit must be received no later than 6/17/04. This CME activity was planned and produced in accordance with the ACCME Essential Areas and Policies. Please refer to the posttest located at the end of this activity for further instruction regarding credit.

All inquiries should be directed to:
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(847) 374-4600

CME STATEMENT

The enclosed posttest offers the opportunity for you to assess retention of the information presented in this activity, titled Appropriate Opioid Pharmacotherapy for Chronic Pain Management: A Multimedia CME Program, and to earn credit at the same time.

A review committee has determined that this material can be completed in 1 hour. It is in accordance with this estimated study time that the credit for this enduring material has been made.

Discovery International designates this educational activity for a maximum of 1 hour in category 1 credit towards the AMA Physician’s Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

ACCREDITATION STATEMENT

Discovery International is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CONTINUING EDUCATION UNIT STATEMENT

Discovery International has been reviewed and approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET) and will award 0.10 CEUs to participants who successfully complete this activity. Authorized Provider # 101056.

CONTINUING PHARMACEUTICAL EDUCATION STATEMENT

Discovery International is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education. This activity has been assigned the ACPE Universal Program Number # 246-000-02-002-H01 and has been approved for 1 contact hour (0.10 CEUs) of continuing education credit.

Participants must complete the posttest and evaluation form and a minimum score of 70% must be achieved on the posttest in order for credit to be awarded. There is no fee to participate in this program or for the generation of the certificate. Certificates will be mailed within six weeks of the receipt of the posttest.

Initial release date: June 17, 2002
CME/CE POSTTEST DESCRIPTION

Please complete this activity and answer the following questions. Indicate your answers on the enclosed scannable answer sheet located at the back of this booklet by completely shading in the circle indicating your response. Use a black or blue ink pen or pencil. Answer ALL the questions.

To earn credit, a completed enrollment form and scannable answer sheet must be received and a minimum score of 70% must be achieved on the posttest. Completed forms should be mailed to the Division of Continuing Medical Education, Discovery International. This posttest may be submitted only once for credit consideration and must be submitted by June 17, 2004. All posttest results are strictly confidential and intended for self-assessment only. Release Date: June 17, 2002. Expiration Date: June 17, 2004. Faxed information will not be accepted.

PAIN MANAGEMENT PRIMER

Background

More than 50 million Americans are totally or partially disabled by chronic pain. At least 8 million Americans have or have had cancer. Severe back pain affects 4 out of 5 adults at some time in their lives, and is second only to headache as the most frequent pain location. Unrelieved pain causes unnecessary suffering, seriously compromising patients’ quality of life and increasing the risk of lost livelihood and social integration. Because it diminishes activity, appetite, and sleep, pain can further weaken patients who are already debilitated. Chronic pain also has a serious impact on society, with estimated annual costs, including medical expenses, lost income, and lost productivity, of about $100 billion. Reportedly, approximately 700 million workdays are lost each year to pain-related disabilities.

Pathophysiology

Chronic pain is not a distinct entity, but varies in etiology and presentation. Although pain is typically considered an indication of underlying tissue damage, it can also be present in the absence of apparent tissue damage. Nociceptive pain is the activity induced in neural pathways by potentially tissue-damaging stimuli. Neuropathic pain occurs when pathophysiologic changes in the peripheral or central nervous system, caused by an injury to neural or non-neural tissues, sustain a chronic pain state independent of the initiating event.

Assessment

Evaluation of chronic pain includes a pain history, a directed physical examination, a review of previous diagnostic studies and their interventions, a drug history, and an assessment of coexisting diseases or conditions. Many patients have difficulty describing their pain, although some pain characteristics may be sug-
gestive of specific pain states. For example, pain described as “burning” suggests neuropathic origin, whereas nociceptive pain is generally felt as an aching or sharp sensation. The frequency of pain (e.g., constant or intermittent), as well as exacerbating or relieving factors (incidence of predisposing influences) may offer additional diagnostic clues. The impact of pain on the patient’s ability to perform activities of daily living, along with its impact on familial and social relationships, is an important part of the pain assessment, as it ultimately helps the patient and the clinician agree on realistic goals of therapy.

Barriers to Effective Pain Management

Impediments to effective pain treatment, and more specifically, to the use of opioids for pain relief, exist at the patient, physician, and healthcare system levels. Additionally, research studies suggest that demographic factors might be important as a factor in the undertreatment of pain; racial and ethnic minorities are even more likely to be under-treated for pain than white patients.

Patient-Related Barriers

Patient obstacles to obtaining effective pain relief center on communication, psychological, and attitudinal issues. In a survey of cancer patients receiving services from an outpatient social service clinic, the patients who reported communication problems with their physicians experienced significantly worse pain than those who did not. Psychological states, such as anxiety, depression, anger, and dementia, can influence pain treatment by masking symptoms. Preconceived attitudes about pain and its treatment often present the most difficult barriers to effective management.

Physician-Related Barriers

Pain management is given low priority in medical schools and residency programs, thus the practice of pain management is often substandard. Common physician barriers to effective pain management are:

- Inadequate pain assessment skills
- Inadequate knowledge of pain management approaches and options
- Lack of knowledge about opioid pharmacology
- Mistaken beliefs about opioid addiction
- Concern about side effects of opioids
- Confusion about drug-related behaviors and fear of addiction
- Fear of regulatory scrutiny and even loss of license

Patients are reluctant to report pain for many reasons:

- Stoicism
- Concern about distracting physicians from treating the underlying disease
- Fear that increasing pain means worsening disease
- Concern about not being a “good patient”
- Fear of addiction, tolerance, and side effects
- Family pressure to avoid taking opioids, often because of the societal stigma associated with drug use
- Elderly patients may exhibit generational issues toward pain:
  - pain is a sign of “weakness”
  - pain is a normal part of ageing and should be tolerated
  - reluctance to “bother” the physician or nurse
  - fear of being a “bad” or “uncooperative” patient
  - fear of mental clouding
System-Related Barriers

The healthcare system imposes practical, financial, and drug availability barriers on effective pain management:

- Absence of a neighborhood pharmacy that dispenses opioids
- Increasing co-payments
- Limited reimbursement policies
- Limited number of refills allowed
- Prescription monitoring programs (special forms, electronic monitoring, or both)
- Fear of regulatory scrutiny, which often prohibits physicians from prescribing opioids in strengths sufficient to adequately relieve patients’ pain.

Ethnic and Racial Barriers

Inadequate pain management for minority patients may result both from physician- and patient-related factors. Some barriers that contribute to substandard pain management in ethnic and racial minority patients include:

- Greater difficulty in assessing pain because of differences in language and cultural backgrounds
- Physicians’ perceptions that patients in minority groups have fewer financial resources to pay for prescriptions
- Physicians’ perceptions about a higher potential for drug abuse in minority groups

Inadequate treatment may also result from the patients’ fear of aggressive treatment and their lack of assertiveness in seeking any treatment, as well as a lack of expertise of those who treat pain patients at the sites used by many patients belonging to minority groups. These findings highlight the importance of conducting aggressive research and presenting timely and focused physician education activities to improve pain treatment for all people and to eliminate the disparities in pain treatment for ethnic and racial minorities.

Opioid Therapy

Chronic pain is not just a prolonged version of acute pain. Thus, its management is a complex process requiring specialized, intensive, and comprehensive services for optimal treatment outcomes. Together, patients and practitioners should set and agree on realistic goals of therapy. When choosing among opioid analgesics, preparation, route of administration, and dosing schedule are key considerations.

The distinction between “weak” and “strong” opioids is determined by usage rather than by pharmacology. The “weak” opioids include oxycodone when administered in combination with acetaminophen or aspirin, codeine, and propoxyphene, among others; “strong” opioids include morphine, fentanyl, and oxycodone not combined with another analgesic.

For chronic pain management, around-the-clock dosing schedules are preferred over “as needed” (prn) administration because it is more effective to prevent the recurrence of pain than to treat pain that has recurred. In general, long-acting agents are preferred for management of chronic pain because they improve adherence and convenience, and may optimize pain control. However, short-acting agents may be used for breakthrough pain on a prn schedule. The most important tenet for pain management is individualization. There is no ceiling effect with the pure agonist opioids; rather, doses are titrated until there is an optimal balance between pain relief and side effects.

Adjuvant analgesics are sometimes used with opioid analgesics to enhance opioid efficacy, to provide additional analgesia, and to treat concomitant disorders such as depression or anxiety. For example, concurrent use of anticonvulsants with opioids may enhance analgesia in neuropathic pain states. Nonpharmacologic approaches are also used, particularly cognitive-behavioral interventions such as imagery, relaxation, and cognitive...
distraction/reframing. These skills may help provide a sense of control to the patient. They also help patients develop coping skills necessary to deal with chronic pain.

Side effects of opioids may include constipation, nausea, vomiting, confusion, and sedation. It is common to co-prescribe a bowel regimen at the beginning of therapy to avoid or minimize constipation. While constipation is common in both oral and transdermal opioids, studies have suggested that the transdermal route of administration has a lower incidence of constipation than the oral route. The healthcare professional should work with the patient to develop an appropriate treatment plan for this side effect, should it occur. Respiratory depression is rare during chronic pain therapy, and rarely occurs without prior manifestation of excessive sedation. In general, any known opioid-related side effects should be anticipated and treated aggressively.

Monitoring Patients on Opioid Therapy

Outcomes assessment is an important component of the treatment plan. One effective approach is to assess patients based on the so-called “4-A’s”: Analgesia, Activities of daily living, Adverse events, and Aberrant drug-taking behaviors.

Analgesia

Pain should be documented at baseline and regularly throughout the course of therapy, preferably by using one of the many pain scales available today, including visual analogue scales (VAS), numeric pain scales, and descriptive word scales.

Activities of Daily Living

Improvement (or lack of) in functionality and psychosocial health should be assessed in tandem with the monitoring of pain intensity.

Adverse Events

Even with prophylactic treatment, side effects may occur. The goal is to afford the patient optimal analgesia while minimizing the side effect profile. The emergence of side effects may necessitate dosage reductions or a trial with a different opioid.

Aberrant Drug-Taking Behaviors

The literature suggests that the risk of addiction among patients without a prior history of substance abuse is minor during the treatment of acute pain and chronic cancer pain. However, the literature pertaining to chronic nonmalignant pain has not adequately clarified the question in this area. The probability of addiction overall is presumably small, but is likely to be influenced by a number of predictors which have not yet been established empirically. Based on clinical experience, factors that raise concern about the potential for aberrant drug-related behavior include a personal history of substance abuse, family history of substance abuse, younger age, personality factors, family dynamics, and social factors.

To optimize the use of opioid therapy, clinicians should become familiar with the principles of addiction medicine, beginning with an understanding of the definitions of physical dependence, tolerance, addiction and pseudoaddiction. Misunderstanding of addiction and mislabeling of patients may further encourage undertreatment.

Addiction

Addiction is a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, the continued use of which results in a decreased quality of life. Addiction is suggested when drug use is characterized by compulsive drug-taking, craving, loss of control over the drug, and continued use despite harm.
Pseudoaddiction
Behaviors that mimic those of true addition, but in reality may reflect undertreatment, are known as pseudoaddictive. This may include drug-seeking behavior, taking larger than prescribed doses—therefore running out of medications prematurely—tolerance, and withdrawal. Although adequate pain relief should eliminate the abnormal behavior if it is truly pseudoaddictive, it is important to recognize that pseudoaddiction and addiction can coexist. 19,21

Dependence
Physical dependence is a pharmacologic effect characteristic of opioids, whereby withdrawal or abstinence syndrome manifests upon abrupt discontinuation of the medication. Neither the dose nor the duration necessary to produce this phenomenon are known, however, it is assumed that physical dependence occurs within days of continuous opioid use. Patients may be successfully weaned from opioid therapy by gradual downward titration. 22 It is important for the physician to distinguish physical dependence from addiction.

Tolerance
Decreasing pain relief with the same dosage over time has not proven to be a prevalent limitation to long-term opioid use. Experience with treating cancer pain has shown that what initially appears to be tolerance is usually disease progression. Conversely, tolerance to many of the side effects associated with opioid administration (such as sedation) occurs rapidly and is desirable. 18

Optimal chronic pain management requires following the principles and guidelines established by the medical community for opioid prescribing, monitoring and aggressively treating side effects, and documenting patient progress. In addition, these same criteria will help practitioners avoid regulatory scrutiny. The job of the physician treating patients with chronic pain is to improve pain relief and to do so without contributing to diversion. By the same token, the primary goal of the regulatory agencies and law enforcement is to prevent or address diversion, but to do so without interfering with pain relief. The ultimate goal is to achieve a balance that will satisfy both criteria.

Referring the Patient in Pain
A team approach may be advisable for patients with intractable pain or progressive medical disorders, and for known substance abusers experiencing chronic pain. The multidisciplinary approach to pain management may involve a physician who is a pain specialist, a specialist in addiction, a mental healthcare provider, a specialist in rehabilitation, and others. A well-defined plan will enhance treatment outcomes while avoiding drug-seeking behaviors arising from the undertreatment of pain—this is the critical balance that physicians must strive toward to achieve effective management of chronic pain.
CME/CE Posttest

For the following questions, only one alternative is correct. Please select the best answer and blacken the corresponding circle on the scannable answer sheet. The scannable answer sheet for the posttest and evaluation form responses is located at the back of the booklet.

1. Throughout their adult lives, how many patients will experience at least one episode of severe back pain?
   a. 50%  b. 60%  c. 70%  d. 80%

2. Chronic pain is reportedly responsible for estimated annual costs of:
   a. $8 billion  b. $50 billion  c. $100 billion  d. $700 million

3. Which of the following is a consequence of unrelieved pain?
   a. Risk of loss of livelihood  b. Decreased appetite  c. Poor sleep  d. All of the above

4. Chronic pain that persists independent of the initiating event is called:

5. The undertreatment of pain in the United States is a function of physician-, patient-, and health system-related barriers.
   a. True  b. False

6. The distinction between nociceptive and neuropathic pain is:

7. Injury-induced chronic pain is most likely caused by:
   a. Poor healing  b. Structural CNS changes  c. Psychosis  d. Muscle tightening

8. Temporal features of pain refer to:
   a. Medical history  b. Severity, location, and quality  c. Predisposing factors  d. Onset, course, and daily pattern

9. Radicular, unilateral pain that is described as “constant” and “burning” would most likely suggest pain of what origin?

10. Which of the following receptor sites is NOT associated with opioid analgesics?

11. When choosing an opioid analgesic for chronic pain, the type most commonly used is:

12. Propoxyphene is considered to be a weak opioid.
    a. True  b. False

13. Once an opioid analgesic is selected for use, upward titration should begin until:
    a. The ceiling is reached  b. Addiction occurs  c. Side effects emerge  d. There is a favorable balance between analgesia and side effects

14. In general, opioids used for chronic pain should be dosed:
    a. As needed  b. Around-the-clock

15. “As needed” dosing has no role in the treatment of chronic pain.
    a. True  b. False

16. Which opioid-related side effect is most commonly encountered in clinical practice?
    a. Myoclonus  b. Respiratory depression  c. Sedation  d. Both b and c
17. Generally speaking, an opioid prescription should be accompanied by:
   a. A bowel regimen  b. A psychostimulant prescription
c. A vitamin regimen  d. An exercise regimen

18. “Weak” and “strong” opioids are identified by distinct pharmacologic differences.
   a. True  b. False

19. Short-acting opioids are the preferred treatment for:
   a. Chronic cancer pain  b. Chronic nonmalignant pain
c. Breakthrough pain  d. None of the above

20. Tolerance to opioid-related sedation occurs:

21. Which of the following has not been identified as a factor of concern for potential aberrant-drug related behavior:
   a. Age  b. Personality factors
c. Occupation  d. Family dynamics

22. Opioid-induced cognitive impairment is:
   a. Rare  b. Common
c. Of undetermined prevalence  d. Highly prevalent prevalence

23. If you were to apply the WHO ladder for cancer pain to chronic severe pain of a nonmalignant nature, the patient who has failed nonopioid therapy and is seen by you for the first time, should be prescribed:
   a. Another nonopioid plus an adjuvant analgesic
   b. A weak opioid plus a nonopioid
   c. A strong opioid with or without a nonopioid
   d. A nerve block

24. For a patient with peripheral neuropathy only mildly relieved by opioid analgesia, what can be done?
   a. Nothing; neuropathic pain is not responsive to opioids
   b. Add an antidepressant or an anticonvulsant
   c. Increase the dosing schedule of the opioid
   d. Add a psychostimulant

25. Most physicians believe that unrelieved pain is not a problem in their own practices.
   a. True  b. False

26. A relatively new patient with chronic pain for whom you have prescribed an opioid analgesic returns to your office stating that he cannot find his pills, and requests a new prescription. What would be your most appropriate response?
   a. Write a new prescription, accepting the patient’s reason
   b. Refuse to write a new prescription, since usually patients cannot be believed in these situations
   c. Interview the patient and his family members to better assess the situation
   d. Switch the patient to a nonopioid analgesic for one month

27. In cancer patients, dose escalations during long-term use of opioids are usually:
   a. Due to tolerance  b. Due to disease progression
c. Inevitable  d. A sign of emerging addiction

28. During a follow-up visit with a chronic pain patient for whom you have prescribed an opioid, the patient reports unsanctioned dose escalation for several days during the prior week. This is most likely a result of:
   a. Tolerance  b. Dependence
c. Addiction  d. Pseudoaddiction

29. After prescribing opioid analgesics for chronic nonmalignant pain, the patient should be monitored for:
   a. Dependence  b. The “4-As”
c. The “3Rs”  d. Blood levels

30. A “VAS” is:
   a. A duct located in the kidney
   b. A receptor in the cerebral cortex
c. A pain assessment tool  d. An addiction-monitoring tool
31. The goal of pain management is complete relief of pain.
   a. True   b. False

32. An important indicator of the efficacy of the dose you prescribe for a long-acting opioid analgesic is:
   a. Lack of tolerance  
   b. Patient’s blood level  
   c. Amount of breakthrough medication used  
   d. All of the above

33. Your chronic pain patient is prescribed morphine, and develops intractable constipation. This shows that, for this patient, opioids are undesirable.
   a. True   b. False

34. You have prescribed hydrocodone (Vicodin®) for your chronic pain patient on a prn schedule. At the next follow-up visit, she reports taking 8 hydrocodone tablets per day, which only moderately relieve her pain. After formally assessing this patient, and finding nothing to suggest either aberrant behavior or escalating disease, your next step is:
   a. A long-acting opioid  
   b. Hydrocodone around-the-clock  
   c. Hydrocodone plus an NSAID effect  
   d. Assure patient that there is no ceiling

35. Undertreatment of pain is a common problem throughout the United States, with equally substandard treatment among the entire patient population.
   a. True   b. False

36. Which of the following routes for intraspinal drug administration has the most advantageous risk/benefit ratio for patient-controlled analgesia?
   a. Percutaneous temporary catheter  
   b. Subcutaneous reservoir  
   c. Implanted programmable pump  
   d. Permanent silicone-rubber epidural

37. Aggressive complaining about the need for more drugs, unapproved use of a drug to treat another symptom, and resistance to change in therapy are more suggestive of true addiction emergence than of pseudoaddictive behaviors.
   a. True   b. False

38. Asking about current or prior use of illicit drugs is an important consideration when evaluating the appropriateness of opioid use for chronic nonmalignant pain.
   a. True   b. False

39. According to the Drug Enforcement Agency (DEA), opioid analgesics may be prescribed:
   a. For short-term use in nonmalignant pain  
   b. Never in nonmalignant pain  
   c. As recommended by established pain management guidelines  
   d. At your own risk

40. State Medical Boards have absolute authority over the DEA.
   a. True   b. False

41. If investigated, opioid prescribers should have:
   a. Documentation of the patient’s history  
   b. Documentation of the patient’s treatment plan  
   c. Documentation of the patient’s assessment plan  
   d. All of the above
ENROLLMENT FORM

Upon completion, please mail the scannable answer sheet and this enrollment form for processing. A score of at least 70% must be achieved for credit to be awarded. A certificate of credit will be returned to you within six weeks. The forms must reach the Division of Continuing Medical Education, Discovery International by June 17, 2004.

Should you have questions, call (847) 374-4600.

Please indicate the length of time it took for you to complete this activity________

Each participant should claim only those hours of credit that he/she actually spent studying this material.

Mail to: Division of Continuing Medical Education (#11805)
Discovery International
520 Lake Cook Road, Suite 250
Deerfield, Illinois  60015

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FOR DCME USE ONLY

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EVALUATION FORM

Please mark your responses to the evaluation questions on the same scannable answer sheet you used for the posttest. Answer ALL the questions.

OVERALL ENDURING MATERIAL EVALUATION

1=Poor, 2=Fair, 3=Satisfactory, 4=Good, and 5=Excellent

Using the above scale, please evaluate this activity by marking the appropriate response

42. Amount of information presented
43. Level of instruction
44. Current information
45. Scientific rigor
46. Overall objectivity and balance of materials
47. Usefulness of materials

LEARNING OBJECTIVES

1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly Agree

Using the above scale, indicate whether after completing this activity you are better able to:

48. Describe the disruptive and often devastating impact of chronic pain on the lives of patients and their caregivers, as well as the enormous costs to the healthcare system and society
49. Explain why chronic pain far too often goes undiagnosed or undertreated
50. Learn how to appropriately assess and identify patients with chronic pain
51. Explain the increasing role of opioid analgesics in chronic pain management
52. Differentiate the benefits and risks associated with specific opioid analgesics
53. Formulate safe, effective, and individualized treatment strategies incorporating opioid analgesics for patients with chronic pain, including those with chemical dependency issues
54. Implement appropriate follow-up of chronic pain patients treated with opioid analgesics

QUALITY ASSESSMENT

1=Not at All, 2=Not Very, 3=Somewhat, 4=Very, and 5=Extremely

Using the above scale, indicate how important the following reasons are for your participation in educational activities

55. Topics
56. Editor’s reputation
57. CME credit

58. As a result of participating in this activity, did you learn anything that would cause you to make a change in your clinical practice? (Choose only one)

1 = Yes; I am going to try and incorporate some of the information presented into my clinical practice
2 = No; I learned some new information, but the information presented is not applicable to my clinical practice
3 = No; but the information presented confirmed my current management practices
4 = No; I did not find the information useful and I will not change my current management practices
5 = Don’t know

59. If YES, how soon do you intend to incorporate changes in your practice as a result of this CME activity?

1 = Immediately
2 = In one month
3 = In three months
4 = In six months
5 = Don’t know

60. Using the above scale, indicate whether you would recommend this activity to others.

1 = Yes
2 = No

Note: The scannable answer sheet for the posttest and evaluation form responses is located at the back of this booklet.
References