



# Care of the Soldier with Chronic Pain

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# Objectives

At the end of this session, providers should be able to:

- 1) Understand the operational challenges that arise when treating Soldiers for chronic pain conditions
- 2) Describe the rules and regulations that govern the management of Soldiers with chronic pain
- 3) Know the key elements involved in writing a profile for Soldiers with chronic pain conditions



# Ground Rules

- Interactive discussion among professional colleagues.
- Feel free to ask questions
- Recognize that this topic is an area that is in development, and that there are going to be differences of opinion that we must respect.



# Case #1

- CW is a 31 y/o M AD Army E7 Special Forces Soldier injured during combat operations in Afghanistan (polytrauma from IED).
- Received only IM morphine for pain control at POI and during evacuation.
- Initial surgery at FST, revised at Kandahar, Landstuhl, and Walter Reed prior to arrival at Madigan.



# Case #1

- Required large quantities of short acting pain medications.
- PCM transitioned him to long acting opiates with limited success.
- SM attempted self-d/c of opiates multiple times with ER visits for withdrawal sx.
- Eventually completed inpatient detox and rehab treatment for 6 weeks.
- Now opiate-free for over 3 months.



## Case #2

- MS is a 27 y/o M AD Special Forces E7 with multiple combat deployments and chronic bilateral shoulder pain.
- He received multiple Rx's for short acting opiates from a variety of providers when his sx would "flare," which happened with increasing frequency.
- PCM noticed this pattern and confronted patient, with limited success.



## Case #2 (cont)

- After multiple “lost prescription” stories, the Soldier finally admitted that he had a problem and enrolled in ASAP.
- Sole provider and regular visits coupled with CAM and relaxation therapy resulted in progressively lower doses of opiates.
- He remains functional on low does of long-acting opiates ICW ongoing complementary modalities.

# Troops reportedly popping more painkillers

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By [Gregg Zoroya](#), USA TODAY

WASHINGTON — Narcotic pain-relief prescriptions for injured U.S. troops have jumped from 30,000 a month to 50,000 since the Iraq war began, raising concerns about the drugs' potential abuse and addiction, says a leading Army pain expert.

The sharp rise in outpatient prescriptions paid for by the government suggests doctors rely too heavily on narcotics, says Army Col. Chester "Trip" Buckenmaier III, of Walter Reed Army Medical Center in Washington.

By 2005, two years into the war, narcotic painkillers were the most abused drug in the military, according to a survey that year of 16,146 servicemembers.

**MORE:** [Prescription drug abuse hits Mo. Army unit hard](#)

Among Army soldiers, 4% surveyed in 2005 admitted abusing prescription narcotics in the previous 30 days, with 10% doing so in the last 12 months. Researchers said the results may have been skewed by respondents mistakenly referring to legal use of pain medication. A 2008 survey has not been released.

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"You don't have to throw narcotics at people to start managing pain," says Buckenmaier, who pioneered technology that eases the pain of wounded soldiers.



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What's this?

# General's story a warning about use of painkillers

By Gregg Zoroya, USA TODAY

Updated 11h 57m ago |  52 |   Share

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Lt. Gen. David Fridovich talks about dependency on pain meds following injuries associated with his post in special forces, and his rehab and recovery.



Standing before a packed hall of 700 military doctors and medics here, the deputy commander of the nation's elite special operations forces warned about an epidemic of



# Combat Pain Control



- Early management of acute pain in the combat wounded Soldier can help prevent chronic pain later.
- Special Operations Forces have had several initiatives to start aggressive pain management early:
  - Combat pill pack (includes meloxicam 15mg)
  - Oral Transmucosal Fentanyl Citrate (OTFC)
  - Regional anesthesia
  - Ketamine



# Provider Challenges

- Must differentiate acute from chronic pain
- Look for
  - Physical Dependence
  - Withdrawal Symptoms
  - Increasing Tolerance
- Think about
  - Addiction
  - Pseudoaddiction
  - Self-medication for other issues (e.g. PTSD, depression)



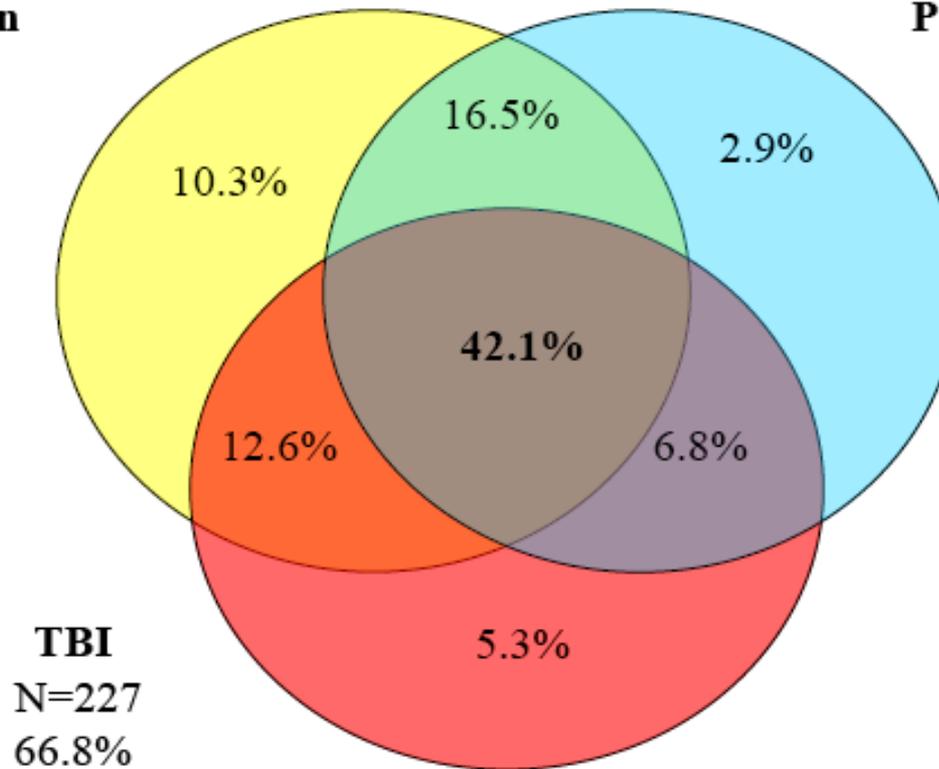
## Prevalence of Chronic Pain, PTSD and TBI in a sample of 340 OEF/OIF veterans with polytrauma

**Chronic Pain**

N=277  
81.5%

**PTSD N=232**

68.2%



**TBI**  
N=227  
66.8%

Lew, Otis, Tun et al., (2009). Prevalence of Chronic Pain, Post-traumatic Stress Disorder and Post-concussive Symptoms in OEF/OIF Veterans: The Polytrauma Clinical Triad. *JRRD*.



# Acute Pain

- Response to tissue damage
- Protects body from harm
- Contributes to survival
- Stops when tissue heals
- Treatment includes
  - Medications
  - Immobilization and rest
  - Surgery to try to correct the source of the pain



# Chronic Pain

- Unpleasant sensory and emotional response
- Does NOT serve a protective function
- Occurs past the point of tissue healing
- Lasts more than 3 to 6 months
- Started as acute pain



# 3 C's and the Soldier



- Consequences (Harm)
  - Over sedation, decreased function, impaired coordination, family or work place complaints of impairment
- Loss of Control
  - Lost Rx's, early refills, multiple prescribers, ER visits, appears in office without appt
- Compulsive Use
  - Life centers on Rx's, missed appts, avoids UDS, pain not improved, insistence on immediate release  
Opioids



# Treating the Soldier

- Maximize non-opiate meds (e.g. NSAIDs, TCA's, gabapentin)
- Use tramadol with caution
- Maximize use of non-pharmacologic interventions (e.g. CAM modalities)
- Look for comorbid conditions
- Early referrals to behavioral health, pain clinic as appropriate
- Expectation management is key



# Madigan Clinical Policy



- Clinical Policy #47 dated 27 July 2009
- Defines chronic opiate use as daily narcotic use for > 3 months, or >30 tabs/month for > 3 months.
- Specifically requires
  - Sole provider
  - Signed opiate agreement
  - Pain profile on DA Form 3349
  - Attend pain class
  - Specialty referral if unable to wean from opiates



# Profiling for Pain

- Issues to consider:
  - Driving or operating machinery
  - Use of weapons
  - No alcohol use
  - Soldier's MOS and assignment
  - Other military duties
- Must document on e-Profile as of 1 Feb 11
- Discuss specific profile limitations with Soldier's commander if any questions.



# Rules and Regulations



- Army Regulation - AR 40-501, Ch 5-14.f.(17) regarding the use of chronic narcotic analgesics:

“Medications used for serious and/or complex medical conditions are not usually suitable for extended deployments... A complete medical evaluation should be initiated...”
- CENTCOM PPG MOD 10, para I(9) states that chronic use of “Opioids, opioid combination drugs, or tramadol (Ultram®)” requires a waiver to deploy.



# Deployment Waivers



- For non-SOF personnel, waivers are sent to CENTCOM surgeon for approval.
- Waiver requirements are in MOD 10, and are available online at:  
<http://usasam.amedd.army.mil/MOD10/USCC%20MOD%20TEN%20TAB%20B%20WAIVER%20FORM.pdf>
- Crucial to any waiver is demonstrating that the Soldier's condition will not deteriorate as a result of deployment, or potentially place others at risk.



# Deployment Waivers

- Waiver requests are processed through the JBLM SRP site.
- Waivers require an evaluation by a provider that addresses the following:
  - Clinical hx
  - Date of onset
  - Prior/current tx
  - Limitations
  - Prognosis
  - Follow-up requirements
  - Potential effects of deployment on the condition



# Summary

- Chronic pain is a significant problem among Soldiers
- Recognize chronic pain early and identify comorbid conditions
- Employ all available modalities
- Realistic expectation management for Soldiers and commanders
- Chronic pain can limit duty and deployment, and chronic narcotic use requires a profile



QUESTIONS?