# The Difficult Patient

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# Disclosures

- James North
- Boston Scientific: consultant
- Kaleo: Consultant, speakers bureau
- SPR: Consultant

- The set up (stressors of pain, regression)
- Basics of problem and solution
- Who and How (personality traits)
- Specific solutions
- Illustrative cases

# What is Pain?

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage, or both.

American Society of Anesthesiologists 2002

# SOMATIC REALITY

Constant aversive message that your body is damaged or being harmed.

- No other medical condition like it due to
  - Persistence
  - Intrusiveness
  - Behavior change unavoidable moment to moment
- Self perpetuating and self enhancing

# FELT SENSE OF CONTROL

- Central need for ongoing function
- A primary force for keeping egos intact

- Pain is the antithesis of “felt sense of control”
  - Taunting, distracting, limiting behavior, mood modifying

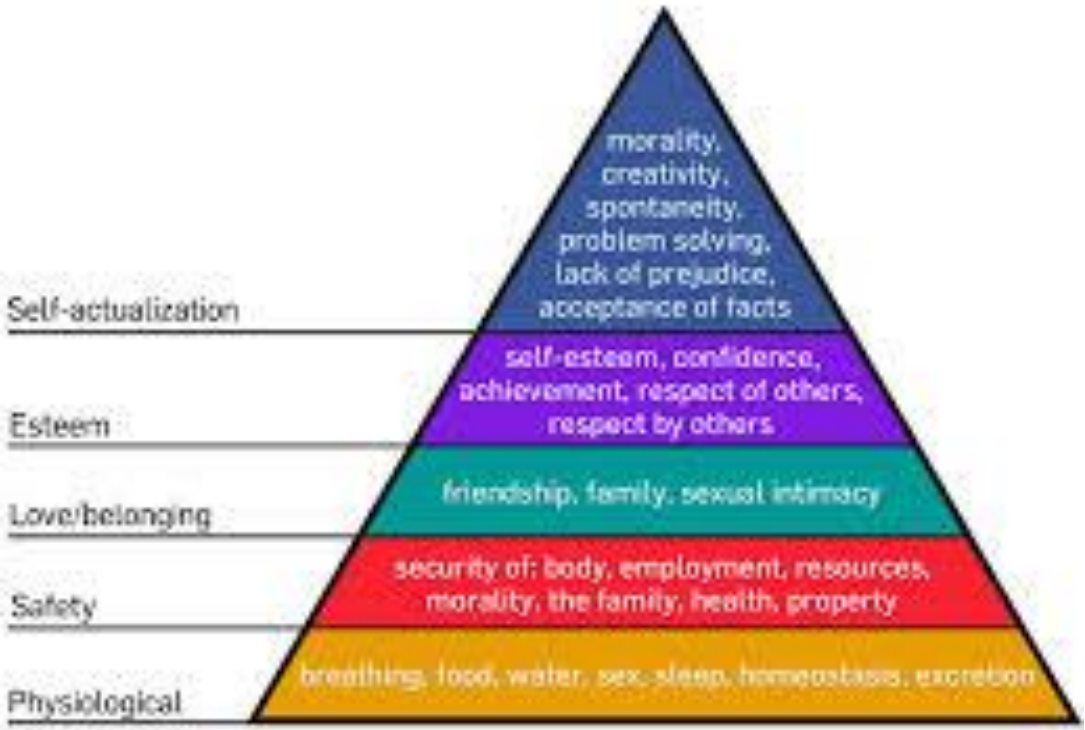
# Maslow's Hierarchy of Needs

-Health forms base

-Abandonment of higher level needs

-Dysfunctional behaviors

- -Normal to be struggling for control
- -Regression predictable



# COMORBIDITIES

- Depression
- Anxiety
- PAIN with fight or flight and physical agitation
- Personality with impulsivity, irritability, obsessing
  - Believing what you think, how best to tx self??
  - Not the same as addiction??
- Cognitive impairment from mood, anxiety, sleep disturbance, other meds.

# Basic Problem

- Personality based
  - Feels personal
    - Not about you, same with others
  - Will not be changed by your intervention
    - predictable
- Emotional dysregulation
  - Poor affective constancy
- Practitioners emotional response
  - Don’t’ believe everything you think

# Basic Solutions

- Set the stage early
  - Football field
  - Contracts
- Repetition
- Written instructions
  - documentation
- Clear and persistent limits
  - Statements, not threats

# Personalities: the Who and What

- Cluster A
  - Strange… out of left field, assigning odd meaning, paranoid
- Cluster B
  - Irritating… demanding, emotionally driven, believe what they think, deeply felt and shallowly thought
- Cluster C
  - Anxious… controlling, overthinking, catastrophyzing,

# Cluster A approach

- Be very concrete
- Clarify repeatedly
- Write things down
- Don’t be surprised
- Will stay “odd”

# Cluster C approach

- Educate
- Repetition
- Preciseness
- Writing down

# Cluster B approach

- More common and difficult
- Set the stage early
- Make it about them
  - Clear limits and goals
- Educate
- Repeat
- Name the game

# Not all difficult patients are difficult

- Empathy
- Front desk, ancillary staff
- Consistentancy
- Availablitlty
- It friggen hurts!
- Extenders
- The truth is almost always in the middle…

# Case 1

- 50 y/o male with post laminectomy syndrome (surgery 5 years ago) and R radicular leg sx's, Constant 6-7/10 pain that is starting to affect his work.

- Interventional
  - Failed ESI and facet injections
  - Considering SCS but does not trust surgery

- Pharmacology
  - Lyrica of some help, 300mg per day
  - Failed cymbalta
  - Tramadol and NSAID's of little help

# Case 1

- Social hx
  - Never married
  - Working in IT
  - No SUD hx in self or family
- He requests opioids
  - Has done internet searches
  - Wants to start oxycodone or hydrocodone
- UDS, CSRS all normal

# Case 1

- Oxycodone 5mg 1-2 every 8hr prn, 4 per day max, #120
- Recheck in a month with following report….

# Case 1

"I realized I could see pretty clearly what other people were feeling.  It was Ok at first but but then I got kind of uncomfortable at work and once a guy made me really mad in traffic".

"Did you do this on purpose?"  "Why would you do this to me, you should know better?"

Never returned to clinic.

# Case 1A

- 65 yo hospital executive with clear, EMG/NCS verified, idiopathic, demyelinating, polyneuropathy.  Neurologist is very enabling.
- Trialed with gabapentin, pregabalin, topiramate, levitriatitam, oxycarmazipine, duloxetine, tramadol, opioids, methadone, tapentadol, TCA's, mematidine, lidocaine infusions, mexalintine, LSB's, SCS, IT zicontitide, clonidine, bupivacaine, adenosine, morphine, dilaudid, fentanyl, clonidine.

# Case 1A

- Everything works for 2 months
- SCS best ever for 6 months, the the paresthesia is painful.
- Try high frequency stim, works for two months, then complete loss of efficacy.
- Add Baclofen to his pump, SCS now great, but once again transient.
- Staff hates when he is scheduled, just a total negative experience.

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# Case 1A

- Just listening and giving hope, always turns his attention to the positive
- Giving him goals – taking his wife out to dinner
- Portable heater available to him
- Listening, realizing much of what we do is validating and encouraging.

# Case 2

- 45 y/o female with R hip pain with DJD secondary to fall off bike (w/ fracture) during competition 2 years ago. Has been competitive rider in last 10 years and wants to return to her previous abilities. Pain is variable but tends to move up to 7-8/10 with any prolonged activity.

# Case 2

- Interventional
  - Previous injection trial with no benefit
  - Trying to avoid surgery if possible
- Pharmacology
  - NSAID's of some help
  - Ambien for episodic insomnia, 3-4 per week
  - Tramadol of minimal help
  - Tapentadol recent start with benefit, just added ER to IR preparation and now at 300mg total per day.

# Case 2

- Social history
  - Working as attorney full time
  - Married with 2 children
  - Wine 5 nights a week, up to 3 glasses on weekend nights.

# Case 2

One month later she returns reporting her pain is 3-4/10 most of the time, but…

“I read that this is not like other pain pills, that it is not as strong.  I was pretty clear that I wanted something for pain that worked well so that I could get my life back.  Why are you doing this to me? Don’t you trust me? What have I done to make you not trust me?  I talked to my therapist about this and she did not understand it either.”

# Case 2A

55 yo AA male with moderate pain secondary to L4 laminectomy with continued mixed nocisepetive and neuropathic pain in the back and left LE. Trialed gabapentin , pregabalin, duloxatine, tramadol, all with SE's. 3rd visit. He is Rx'ed Percocet 7.5/325 QID with a with med NRS of 2, 9/10 without. Not interested in CBT nor SCS.

His visit, at first is straight forward. No's SE's great pain control…. Then he pulls the recorder out.

# Case 3

- 38 y/o female with fibromyalgia for 12years, this following the birth of her second child. She has migraine HA's in addition. She was treated by her PMD the last 15 years with opioids and triptans. Her baseline pain is 6-7/10, worse with HA's.

# Case 3

- Interventional
  - Occipital blocks without help
  - Recent botox trial with marginal benefit

- Pharmacologic
  - PMD giving 40mg oxycontin tid last 3 years
  - Oxycodone 15 mg 6 per day for BTP
  - Triptans with benefit most of the time
  - Cymbalta 30mg per day 2 years, not sure of benefit
  - Failed Lyrica, neurontin and Depakote

# Case 3

- Social hx
  - Now married for 3rd time, he is pharma rep
  - Worked as bar tender, then in numerous sales positions, finally brief stint as pharma rep and no longer working due to “pain and fatigue”.
  - Mother married 4 times, “I think she is bipolar”, not in contact with family “they don’t understand my condition”.
  - First child OOW at 19, second in second marriage.

# Case 3

The intake is very positive, she is attentive and understands your concern for opioids relative to rebound HA's and poor outcomes in fibromyalgia. She is willing to start a slow taper of opioid and increase the cymbalta.

On her first return she is feeling better, HA's dropping, hopeful about the reduction in opioid. She has not dropped opioids as far as had been planned but wants to continue. She brings you a gift of food and a letter of appreciation written by her but signed by her daughter. In the room she tells you "You are the first one to really talk to me about my pain! I had no idea there were doctors like you. Thank heavens I have found someone that can finally help me!" She is in tears telling you of her appreciation. You reinitiate the opioid taper and plan to see her in 6 weeks.

# Case 3

Second visit she has now reduced the opioid by 30%, no additional improvement. She reports her fibromyalgia pain is slightly worse. Following a long discussion you mutually agree to continue the opioid taper by 10% every 1-2 weeks, planning on return in 6-8 weeks.

2 weeks later you get message that her HA's are somewhat worse and you encourage her to continue with the plan.

# Case 3

She returns urgently in 3 weeks, has returned to her original dose of opioid and states …

“My pain is out of control, it’s a 10 all the time now and I can’t get anything done. My husband thinks you don’t know what you are doing. He is even thinking of leaving me again. How could you do this to me, and I really trusted you!!!! If you have treated others like this I bet you have had problems with the Medical Board before”

# Case 3A

- 47 yo WF with 20 yr h/o diffuse, whole body pain.
- Everything hurts, all the time.  Dx'ed with fibromyalgia by a world renowned expert, and Rx'ed oxycodone 30mg qid.
- Failed duloxetine, amitriptyline, pregabalin multiple opioids except oxycodone.
- Sent to me for continued care

# Case 3A

- PE: no clonus, or hyperrefelxia
- No Chari malformation signs, MRI brain review, WNL
- Pressured speech and denial of depression, despite being under the care of a psychiatrist
- “I don’t understand, my PCP sent me to you for my OXYCODONE.”
- Discussed autoimmune workup, differential for fibromyalgia, yet during the middle of the discussion, she abruptly stands up and walks out of room calling me a quack…

# Case 4

- 32 yo male with 4 year h/o neck pain
- MVA, litiagation, no objective signs of pathology.
- MRI, nl, EMG/NCS wnl
- My last doctor in Florida really understood me.
- Rx: hydromorphone 8 mg, 2 po q 3 hrs. Alprazolam 2 mg qid, amphetamine 20 mg tid.

# Case 4

- MRI demonstrates no stenosis, some mild kyphosis
- DTR's wnl
- Patient hyper focused on hydromorphone and how that is the only thing that works.
- While checking his bicep reflex, noted track marks.
- Discuss lack of objective findings for chronic opioid use and the concern for misuse.

# Case 4

- “There is no objective way to measure of pain”
- “You need to trust your patient’s complaints”
- “You don’t care”
- “You don’t understand”
- “Someday you will understand”