The National Committee for Quality Assurance (NCQA) has designated Health Plan Hawaii's commercial HMO as one of an elite group of health plans to earn its new “Excellent” accreditation status.

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**MAUI**
- Hawaii IPA—Maui Physicians
- The Maui Medical Group, Inc.

At Health Plan Hawaii, quality is at the heart of everything we do. Our heartfelt thanks to the participating health centers and physicians whose commitment to excellence sets the standard for quality care in our island community.
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Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

Pele, Hi'iaka and Lohiau

Perhaps the greatest example of pain, both mental and physical, in Hawaiian mythology was the rejection and burning of Lohiau by Pele. Hi'iaka, sister of Pele and skilled in the art of healing later restored Lohiau to Health.
It's Here! The Special Issue on Pain

It has taken more than two and a half years in preparation, but we finally have produced the Special Issue on Pain. The genesis of this issue began when Governor Cayetano appointed a Blue-Ribbon Panel on Living and Dying with Dignity.1 As a member of that Panel and appointee to head a focus group on pain management with Dr. Max Botticelli, Emeritus Chief of the Department of Medicine at the John A. Burns School of Medicine, we conducted monthly meetings with our focus group members:

- Lynn Dahl MD
- Reginald Ho MD
- Kathleen Kang
- Kaulupali PharmD
- Linda Landau RN
- Gary Okamoto MD
- Joseph Pepping PharmD
- Gary Rinzler MD
- John Stiller MD
- Shawn Gafford PharmD
- Patricia Kalua RN
- Amy Kruger RN
- Keith Kamida, Chief, NEA
- Hob Osterlund, RN
- Don Purcell MD
- Barbara Shirland RN
- Jon Streltzer MD
- Jeff Wang MD

We set goals and objectives to develop the following:

- Measurable standards for pain management in the dying patient
- Mechanisms for monitoring compliance
- Recommendations for State executive action
- Recommendations for legislative action

The summary of our report to the Governor appears on page 91.

The Hawaii Pain Society

The Hawaii Pain Society is an organization of professionals interested in pain management and palliation. It is open to everyone, but according to founder and president, Don Purcell MD, membership is subject to approval.

The Society is also forming a patient support/educational program. Dues are set at $12 per year to help defray the cost of mailing a newsletter, "The Forum", and additional announcements.

Donations to further this educational program are also welcome.

Interested readers can write to the Society for membership and further information.

Hawaii Pain Society
800 South Beretania Street, Suite 240,
Honolulu, Hawaii 96813

A Special Cover

Our cover for this Special Pain Issue, created by Big Island artist Dietrich Varez, is “Pele, Hi’iaka and Lohiau”. According to Hawaiian mythology, this block print illustrates the highest level of mental and physical pain; the rejection and burning of Lohiau by Pele. Hi’iaka, sister of Pele, a kahuna skilled in the art of healing, later restored Lohiau to health.

Mahalo nui loa to Varez for dedicating his professional life to visually translating Hawaiian lore for future generations to appreciate.

Hob Osterlund, RN., M.S., C.H.T.P. contributed an initial article, Pain Relief as a Basic Human Right, which appeared in the August 1997 issue of the Journal.2 (See her current articles on pages 94 and 101.)

Thanks to Osterlund, the clinical coordinator of The Queen’s Pain Management Services, and to the Intravenous Therapy Specialist-Hawaii Inc. for producing the buttons, permission to publish their logo, and for relief of pain options available for today’s physicians to prescribe when needed.

References
Pain As A Paradigm

Don Purcell MD

Pain is an experience that reaches far beyond the symptom itself. Often, it has its own language by which those who are afflicted with it talk to us. If you listen carefully, and learn to read “between the lines” you will eventually reach a place beyond pain and enter the realm of suffering. This is where you need to go. If you are going to treat pain, then you must also address the suffering it brings. In my experience, neglecting this aspect of care will only take you part of the way. You have to complete the job.

When I approach an individual in pain I first ask myself “What are they really telling me?”, “What is the underlying theme?” If you simply ask someone “Where does it hurt?”, most people will point to one area or another and give you a very matter of fact answer. But if you ask them “How has this affected your life?”, you will likely get a very different response. Some will say the pain won’t allow them to do the things they did before... the way it took things from them, the losses. Still others will lead you to a place far away from where you began, and tell you of things that happened long ago and are now all but forgotten. It is in these places that suffering has its origins. But it is also here that true healing can take place, thereby relieving pain at its root source.

Because the experience of pain can be many faceted, we often call upon an interdisciplinary team of specialists from different fields to address the physical, emotional, social, cultural and spiritual aspects of its treatment. Likewise, if we are to approach a community model that addresses this concern, then we must first allow for better collaboration between the professions at all levels of healthcare. This may take the form of a permanent, standing, interdisciplinary pain council that allows for free exchange of ideas, as well as a forum for conjointly-sponsored community educational endeavors. In this way, we may be able to realize a broader scope of care for those in pain by addressing its many aspects from the vantage point of a number of different disciplines.

And so, pain is a paradigm; a model for something that it represents on a deeper level. Like a many sided gem, we can see into the center from a number of places if we just take the time to go beyond its surface; a process that begs our commitment to work together to alleviate the suffering that it brings.

Editor’s Note:

Don Purcell MD, is an internist who specializes in pain management. He recently organized a very comprehensive Pacific Pain Symposium sponsored by the Dannemiller Medical Education Foundation, Hospice Hawaië at Home, and his Regency Pain Center.

The meeting, held at the Hawaii Convention Center September 17-19, 1999, was very well attended by physicians representing many specialties (even a dermatologist), general practitioners, nurses and other health care providers.

Mahalo, Don, for your efforts to educate us about pain management, and for your paradigm.

Norman Goldstein MD, Editor

In the field of health care, the management of pain has become an exploding arena of diagnostic techniques, treatment research, and burgeoning hypotheses in search of comprehensive multidisciplinary care. Drawing upon numerous of the basic sciences (anatomy, physiology, biochemistry) and clinical disciplines (anesthesia/surgery, psychiatry/neurology, family medicine), Pain Management is a specialty which requires both global knowledge and the specific awareness of the unique patient’s situation and experience. It is no coincidence that, in the past six months, I have been asked to review three separate and unrelated books each in some way addressing the origins of pain, its dynamics and sequelae.

Attempting to provide a reasonable basis for addressing problems in the management of pain of patients, this volume chooses a pragmatic approach while maintaining rigorous academic standards. The great number of contributors (nearly 90), spanning theoretical disciplines and orientations, diverse geographies, and transcending medical and non-medical fields attests to the consciousness with which the editors approached this subject. Interestingly a reference of this magnitude even necessitated three of those editor-type individuals who each helped to shape and determine the contents of the final product.

A flaw that this writer has observed in comparable tomes of this magnitude is a tendency to pontificate on the nature of pain; to compromise the clinical intention with philosophical diatribe; to dilute the successful paradigms of understanding and treatment. Here, the practitioner focus is maintained throughout; the points are as clear as the writing itself; and even the Preface and Foreward are succinct and attention-grabbing.

Unlike many such ambitious projects, “Handbook of Pain Management” flows relatively smoothly, though not quite as if penned by a single source. It is more redundant than one would like to see in a book of this pedigree, and the duplication manifests in proximate chapters, underscoring the uneven editing.

I was similarly disappointed to discover that the 58 chapters were subdivided into the five nebulous categories of Foundations, “Therapeutic Modalities,” “Pharmacologic Interventions,” “Pain Management in Selective Disorders [sic, should this not be “Selected Disorders”?],” and “Selected Topics.” Where more definitive divisions might have led the reader to consider alternative classifications of pain and interventions to reduce it, the ones offered in fact force the reader to search the Index (which does happen to be excellent) for specific topics: in other words not to be able to easily read through from beginning to end or even from one chapter to its neighbor.

Moreover, the reader must often peruse several remote areas in order to be sufficiently apprised of the latest technology and think-
Among the plethora of information, what may be the most common pain presentation worldwide, Chapter 27, “Differential Diagnosis of Low Back Pain,” provides a navigable clinical approach to this oft-seen problem. The remainder of this extended section on “Pain Management in Selective Disorders” includes arthropathy, neuropathy, genital pain (male and female), post-herpetic conditions, phantom pain, and pain of malignancy, in no particular order and with no special emphasis.

The “Handbook” ends with some economic concerns, grouped together under “Selected Topics.” From primary care to inpatient settings, the key to successful intervention with complaints of pain seems to be empathy, precise history-taking, broad-based and multidisciplinary approach, liberal consultation with experts, occupational rehabilitation, and legal aspects.

“Handbook of Pain Management” is an ambitious book which is well-written and poorly organized. Most topics of general interest are covered, and some specialized concerns addressed in detail. Discussion exists on a multitude of issues about how to proceed when a patient with pain comes for relief, but there is no summary suggestion as to how to take a Pain History, establish a Pain Clinic, or implement a Pain Team. The research data presented are up-to-date and comprehensively presented by the respective authors but in a format too loosely-structured to either demonstrate the chronologic development of ideas or the retrospective logical review of approaches tried and discarded or adopted. Finally, this writer was hoping to encounter a definitive integrated explanation for the existence of pain from editors as prestigious and experienced as these, and the lack of even a simple statement on the status of the thinking and approach of pain was dispiriting.

Editors note:

This book review was written by the Chair of the Department of Psychiatry, Commonwealth Health Center, Saipan and Medical Director, Division of Mental Health and Social Services in the Commonwealth of the Northern Mariana Islands.

Dr. Post is a full-time practicing psychiatrist specializing in addiction medicine, forensic evaluations, human sexuality, traumatic stress and holistic health. She was recently awarded First Prize in the Arizona Authors’ Association National Literary Contest for her piece “Strike One” – about battering relationships. She may be contacted at P.O. Box 5424, Saipan, MP 96950–5424.

Many thanks, Dr. Post, for a very thorough book review.

Norman Goldstein MD, Editor
Many of us have heard the news that the complete DNA sequence of several human chromosomes is now known. Local physicians may be acquainted or have collaborated with individual scientists working on single genes or families of genes, such as those causing colon cancer, thalassemia, neurodegenerative diseases, and immune disorders. They may also know that the Howard Hughes Medical Institute supports physicians seeking training in molecular biology through MD/Ph.D. programs. But they may not be aware of the fundamental role in the Human Genome Project that was played by the Wellcome Trust, the world’s largest independent medical research charity. Such support from the medical profession here and abroad is stimulating the new field of molecular medicine, and is one of the reasons why the John A. Burns School of Medicine (JABSM) has recently instituted a new graduate program in Cell and Molecular Biology.

Medical scientists have been involved fundamentally in the process of sequencing the human genome from the beginning and continue to lead the efforts to understand complex diseases like cancer, hypertension, mental illness, and aging. In the case of the Wellcome Trust, scientists working at the Sanger Centre outside of Cambridge (UK) are part of a larger international collaboration that involves assembling a complete rough draft of the entire human genome by February 2000. This working draft will provide information about the very basis of life, health, and disease for biomedical researchers around the world, and is almost a year ahead of schedule. This example illustrates how the medical profession is adjusting to and utilizing new information to transform certain fields and discover better means of disease prevention, diagnosis and treatment.

Another example is Malaria which has reemerged as a major health problem around the world, yet the understanding of disease pathogens and efficient vectors that transmit them would be crippled without information about hypervirulent Plasmodium strains and Polymerase Chain Reaction (PCR)-based tests to diagnose specific infections. In order to face malaria in the new century, public health, epidemiology, molecular genetics, pharmacology, biochemistry, and physiology need to be taught as a common package in a multidisciplinary setting and reinforced by real-life applications. This has not been possible in a traditional graduate education program that focused on narrow sub-fields of biological science, and kept students in the classroom. From the identification of killer E. coli to the control of GI infections in a neonatal nursery, molecular biology has changed the art of infectious disease diagnosis.

The new Cell and Molecular Biology Program will help to teach basic scientists in a non-traditional format along with medical students, and we hope that it will stimulate education in both groups by bringing together students with a common goal: lifelong learning and discovery. Innovations like the Problem-Based Learning (PBL) format make it easier to discuss the ethical issues surrounding informed consent as well as the molecular basis for the particular disorder underlying a certain disease. A case in point: Oncogenes and tumor suppressers were considered unusual topics in medical education ten years ago until the mapping of specific mutations allowed medical practitioners to devise better patient care protocols. JABSM’s medical students are now taught that most cases of cystic fibrosis are caused by a single common mutation in the DNA sequence of a protein forming part of an ion channel. They learn that certain populations, owing to their unique history and place of origin, have elevated risks of diabetes, hypertension, blood disorders, and kidney disease. The students are also beginning to pay as much attention to a family pedigree as they are to a thorough physical exam, but it has been difficult to incorporate some of this new knowledge into an effective medical curriculum.

The goal of the Cell and Molecular Biology program is to produce a new generation of research scientists equipped with the tools to innovate, explore, and utilize biotechnology. Available are laboratories and research projects that are particularly strong in teaching students how to use model systems, such as the humble mouse or fruit fly, as a surrogate for a human. This simplifies a number of issues, ethical and practical in nature. It allows students to tinker with a gene, a protein, even a whole organ, and study what specific changes take place if a DNA or RNA sequence coding for an important candidate gene is removed, blocked, or altered. There are researchers on the faculty particularly interested in understanding how the structures of new drugs might be designed, based on knowledge of the place where a particular molecule must cross a cell membrane or bind to a particular cellular product. It is hoped that the new program will produce researchers equipped with these necessary skills.

Finally, many people are aware of the exciting new reports of genes that fundamentally alter life span, in some cases, doubling and tripling it. At least 4 different genes are known to affect the life-span of animals now, and many researchers speculate what consequences such information might have on human life, if found and manipulated in the human species. Such speculation is closer to scientific reality than the media hype surrounding human cloning. There is need for a new generation of scientists that can deal with the complex issues of gene manipulation for life enhancement and gene therapy, as well as assisted reproduction. In a traditional academic setting, such topics would be difficult to integrate. Knowledge that the genes controlling aging in animals are a consequence of their essential function in the growth and development of the embryo can only be put into an appropriate context by teachers and mentors who respect each others specific training.

A comprehensive course on human aging must have contributions from molecular developmental biologists, psychiatrists, physiologists, nutritionists, population geneticists, and epidemiologists, and would greatly benefit by the input of an economist as well. JABSM’s faculty will now offer a new Cell and Molecular Biology program.
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Who is the best judge of a patient’s pain? It now is standard dogma among pain relief specialists that this person is the patient himself or herself.

The patient should describe when, how and where it hurts – then expect relief in just about all cases. If it doesn’t come, the trouble most likely is with the provider, not the patient. A change of provider may be in order.

This applies to all cases, not just terminal cases, says a policy directive of the American Cancer Society, pushed through by Dr. Reginald Ho of Honolulu when he was national president.

Last year Governor Cayetano’s Blue Ribbon Panel on Living and Dying with Dignity reported that pain control continues to be lousy for many Hawaii sufferers, partly due to their failure to demand it, partly due to their doctors’ failure to provide it.

Some physicians are inhibited by fear of overdosing, which any competent doctor can learn to avoid. Others are just plain ignorant about what can be done.

Some fear addiction in terminal patients – as if that mattered.

Skies are brightening for patients.

The most influential national organization shaping health care policy is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). All major Hawaii hospitals bear its seal of approval.

This year it adopted broadened standards that say pain control is the right of all patients, not just terminal patients.

It describes measures to tell if a health-care organization is complying. Noncompliance will affect future accreditations.

Ken Zeri of Hospice Hawaii formerly was associated with JCAHO. He expects its new rules – to which he contributed – to be very positive in their impact.

So does Pat Kalua, chairman of the Hawaii Cancer Pain Initiative and patient/family care coordinator for the St. Francis system.

Patients and their supporters should speak up if they feel pain control is inadequate, even change physicians or providers.

The new JCAHO rules say patients should be taught that pain management is an essential part of their treatment.

Catholic doctrine long has held pain management that hastens death is acceptable so long as there is no underlying intent to cause death.

Early articles in this series have focused primarily on policy improvements in care for the terminally ill. One is a new model law that facilitates surrogates in acting for the best interest of patients unable to speak for themselves.

Another is a pending new law that should help expand hospice care.

Pain control is for everyone, whether terminally ill or not. In all areas we will be more assured of getting the better care enshrined in new laws and regulations if we are aware of our options and demand the best from our health-care providers.

Don’t be shy.

A.A. Smyser is the contributing editor and former editor of the Star-Bulletin.

Editor’s Note:
This column, “The Patients Need to Control Pain” is the last in a series by A. A. “Bud” Smyser appearing June 10, 1999 in the Honolulu Star-Bulletin and reprinted here with permission. The other articles are “Health Care in Final Days” (June 1, 1999), “Improving the Law on Living Wills” (June 3, 1999) and “Legislature Acted to Help Hospice Care” (June 8, 1999). For all of his medical writings over the years, I propose that Bud Smyser be presented with an Honorary M.D. L. (Medical Doctor of Letters) degree by the University of Hawaii and lauded by the Hawaii Medical Association for 53 years of service to the community.

Norman Goldstein MD, Editor
A Plan to Improve Pain Management for Dying Patients

A proposal by the Governor’s Blue Ribbon Panel on Living and Dying With Dignity

Members: Norman Goldstein MD and Max Botticelli MD, Co-Chairmen; Gary Okamoto MD, Committee Director; Jeffrey Wang MD; Reginald Ho MD; Jon Streitzer MD; Don Purcell MD; John Stiller MD; Lynn Dahl MD; Pat Kalua RN, BSN; Barbara Shirland RN; Shawn Gafford PharmD; Amy Krueger RN; Hob Osterlund RN; Linda Landau RN; Keith Kamita, Chief, NEA; and Gary Rinzler MD, MPH (Recording Secretary)

Introduction

Dying is often accompanied by pain which is severe enough to make living unbearable. An interdisciplinary approach to the palliation of pain can, in most instances, bring sufficient relief and assure comfort and dignity during one’s final days. This degree of pain relief should be available to all. To assure that it is, the following recommendations are made:

• That the Agency for Healthcare Policy and Research and American Pain Society guidelines for the treatment of pain be accepted as the standard of care for all healthcare providers.1,2

• That the right to skilled pain management in the dying patient be included in the “Patient’s Bill of Rights” at all DOH certified and/or licensed facilities.

• That the Department of Health be empowered and directed by legislation or executive action to use these standards in developing measurable, enforceable objectives by which the adequacy of pain management in those institutions and by those providers can be measured.

• That these measurements be carried out routinely as part of the DOH periodic reviews and that citations be issued to those failing to comply.

• It is the intention of the committee that the term “Cancer Pain” be broadened to include all patients dying with pain.

Minimum Standards

1. Evidence that specially designated caregivers are available to dying patients with pain who have been trained in pain control and who have the authority to administer this care.

2. That an assessment of pain be made part of the initial assessment of all patients dying with pain.

• 3. To assure optimal pain management, formal means should be developed and used within each institution for evaluating pain management practices and for obtaining patient feedback to gauge the adequacy of its control. The quality of pain management should be evaluated in all settings where patients (with cancer) receive care.

• 4. The quality of (cancer) pain management should be evaluated at the points of transition on the provision of services (e.g., from the hospital to the home) to determine that optimal pain management is achieved and maintained.

• 5. For pain management to be effective, each practice setting should designate who will be responsible for pain management.

• 6. Policy and standard procedures, which define the acceptable level of patient monitoring and appropriate roles and limits of practice for health care providers, should govern the use of specialized analgesic technologies.

• 7. To ensure optimal pain management, formal means should be developed and used within each institution for evaluating (cancer) pain management practices and should include feedback regarding the adequacy of pain relief. Optimal pain management requires the interaction of all members of the health care team, including the patient. A formal process should be developed to evaluate the quality of management across all stages of the disease and across all practice settings.

(*Standards No.3 through No.7 are verbatim from the “Management of Cancer Pain,” 1997 page 143).

Institutions to be Monitored

1. Acute care hospitals
2. Skilled nursing/intermediate care facilities
3. Community based settings (e.g. Residential care homes)
4. Hospice programs
5. Home health/home-care agencies

Other Recommendations

1. Problems exist in the referral practices Hospice Care and must be addressed. This includes the restrictive prognostication guidelines of “Six months of life or less” and therefore we recommend that the State of Hawaii mandate benefits for Hospice Care with a one year or less life expectancy.

Continued on p.93
Pain Management and Palliative Care in Hospice

Barbara Shirland RN, CRNH,
Director of Clinical Operations, Hospice Hawaii, Chair, Hawaii Cancer Pain Initiative

“There is nothing more we can do.” Every physician, nurse, and social worker hates to have to be the one to deliver the bad news when a disease has reached the terminal phase and when further curative measures are futile. No one wants to deprive the patient and family of hope. This is understandable. However, most patients know quite well what is going on. The experience of not being told frequently results in the patient’s feeling isolated. What patients often want is the simple truth and reassurance that their physician whom they have grown to trust, will not abandon them at the end.1

Fortunately, the statement “There is nothing more we can do,” is not a true statement. In fact, there is a lot we can do during this final phase of life to alleviate pain and suffering in all of its forms. The first step in helping the patient and family accept this potential palliation of suffering is for the professional community to fully understand all that can be done during the final months of someone’s life. We can indeed relieve pain and other uncomfortable physical symptoms. We can facilitate the completion of the “end of life tasks.” We can support the family in processing the loss they are about to endure, and we can help people in this stage of life reach their potential of a peaceful and natural completion of their life.

Everyone who has had serious pain fears pain. Our first responsibility to the terminally ill patient is excellent pain management. Traditionally, physicians’ attitudinal barriers to pain management have included fears of addiction and serious toxicity including respiratory depression, fears of the consequences of poor outcomes such lawsuits and fears of scrutiny by regulatory bodies.2 Fortunately, in our community these factors are less of a problem among physicians than they are in many other places. Patients and families often seem to worry about addiction, however. In hospice care we will frequently differentiate between necessary medical use of opiates and addiction with such phrases as “An addict uses drugs to escape from life, you are taking the medication so you can better participate in your life.” Reassurance and differentiation between physical tolerance and addiction are often needed to encourage patients to take the pain medication as prescribed.

Many patients still fear abandonment during the terminal phase, and this often gets translated into a lack of confidence that their pain will be well managed until their death. Quality of life issues also surface and pain management is essential to quality of life. Increased incorporation of palliative care principles into medical practice is timely in light of the current public eye on quality of life during the endstage. To further this end, new training programs would be useful to help health care professionals improve these critical skills.3 The public also needs to be educated to understand that comfort during the final stages of life is a reasonable expectation.

Constipation, a result of immobility, reduced PO intake of food and fluids, and narcotic analgesia may be successfully treated with a wide variety of dietary measures, medications and treatments. There is also a place in symptom management care for complementary therapies such as application of superficial heat and cold, massage, acupuncture, healing touch, relaxation techniques, guided imagery, and distraction.5

The alleviation of suffering, paramount to excellent hospice care, means much more than effective symptom management. Indeed, in any setting, caring for those with suffering due to advanced disease, whether physical, psychosocial or spiritual, is best addressed by an interdisciplinary team of specially trained professionals.6 Many hospitals today are also establishing palliative care units or creating palliative care teams that address suffering in all of its forms, even prior to the terminal phase of a disease. The interdisciplinary team is basic to hospice care. Teams consist of the patient’s own personal physician, and various hospice professionals including a Registered Nurse Case Manager, a Medical Social Worker, a Home Health Aide, a Chaplain, and specially trained volunteers. Together the team addresses, in addition to physical symptomology, the psychosocial and spiritual dimensions of suffering.

To address suffering in all its dimensions, Hospice Hawaii has begun a specialized program called Na Hoa Malama (Friends Who Care). This program is based on the work of Dr. Ira Byock, an emergency room physician and medical director of a hospice in Missoula, Montana. Dr. Byock identifies “developmental milestones and tasks at the end of life” that relate directly to the usual causes of non-physical suffering. Failure to complete these end of life tasks, in one way or another, is generally at the root of the non-physical suffering in the terminal phase. Dr. Byock says the tasks include reaching a sense of completion with worldly affairs, a sense of completion in relationships with community, a sense of meaning about one’s individual life, an experience of the love of self and of others, a sense of completion in relationships with family and friends, acceptance of the finality of life, a sense of a new self beyond personal loss, finding a sense of meaning about life in general, and a surrender to the transcendent, the unknown — “letting go.”10

Every patient is an individual and each has his or her own goals, agenda and abilities. Working with the patient’s own goals is essential in helping to facilitate the completion of this stage of life. The values of the patient and family determine how they perceive what is happening to them and helps to frame what they define as “suffering.” It quickly becomes obvious that the full interdisciplinary team is needed to guide a patient and family through and beyond their suffering. It can be done. Peaceful death is a realistic possibility.

We are born surrounded by our families and friends and sur-
rounded by love. With the support of a hospice team, patients can die the same way. If the stages are to be believed, love is the only thing that goes with us into death.

Hospice care is generally delivered in the patient’s own home. Many families worry that patients must be in the hospital for pain management to be effective. Although pain management is quite effective in the home setting, the less “technical” methods of administration of pain medication tend to work better in the home with family members as caregivers. A restriction hospices have been facing since the inception of the Hospice Medicare Benefit is cost containment. This restriction is also rapidly coming to the forefront in the hospital setting. In hospice, the pain must be effectively managed at the lowest possible cost, since reimbursement to hospices is given on a per-diem basis, with no consideration given to the particular treatments offered. In the home setting, the challenge is to keep the interventions “human scale.” That means that in general highly technological interventions create much anxiety among lay caregivers. This concept is supported by the World Health Organization and the U.S. Public Health Service. By keeping the methods of medication administration away from the highly technical in the hospice setting, both the goals of reducing family anxiety and cost containment are met.

Transdermal fentanyl is an efficacious medication in the terminal setting. Its advantages include infrequent dosing, fewer side effects compared to PO opiates, ability to continue dosing when the oral route is not available (such as when death is imminent) and good control of pain. Hospices consider the relative high cost of this medication to be outweighed by its advantages. On the other hand, PCA pumps or other parenteral modalities can be intimidating to families in the home setting and are even more costly. Occasion PCA pumps are necessary, but use on a large scale would make it impossible for most hospices to operate within the financial constraints with which they must function. The proper use of adjuvant medications such as NSAIDS and/or steroids for bone cancer pain, and anticonvulsants or antidepressants for neuropathic pain along with the opiates can also be critical factors in the comfort and therefore quality of life during the endstage.

An often overlooked route of administration not only for opiates but other medications is the rectal route. Though PO administration remains the preferred route, the rectal route is a simple technique of administration with a comparable reliability of absorption and low cost as the oral route. The rectal route is also available when the patient can no longer swallow as death approaches. Most family members can be easily taught rectal administration.

Respiratory problems frequently require palliation in the hospice setting. Lung cancer is the most common terminal cancer diagnosis. Many lethal cancers tend to metastasize to the lungs. Radiation or chemotherapy may result in compromised pulmonary function. Ascites from abdominal cancers may contribute to dyspnea. Comfort is often restored with low dose morphine, anxiolytics, oxygen administration, steroids, possibly PO antibiotics in the case of pneumonia, and/or paracentesis for ascites.

Other uncomfortable symptoms often addressed in the hospice setting include nausea and constipation. Fortunately medical management of nausea is a realistic goal today with the variety of effective medications available. Even difficult to control nausea often responds to “BDR” suppositories, consisting of Benadryl 25mg, Decadron 4mg, and Reglan 20mg.

References

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2. Benefits for Medicare and Medicaid accepted pain management services (including but not limited to, surgical and/or radiation intervention) needs to be provided independently from the daily hospice coverage allowance.

3. Educational coursework in pain management should be encouraged and supported in the Continuing Education curricula at all DOH reviewed facilities for all licensed healthcare personnel.

4. Although it is recommended that pain management services be readily available and easily accessed, it is not the intent of this panel to legislate mandatory referral of patients to a “Pain Specialist.” Through appropriate education and awareness of services already available, the patient’s primary physician should be able to treat pain adequately. If the primary physician is unable to control the patient’s symptoms, referral to the appropriate services (eg. pain management specialist, hospice, pain team, etc.) should be made.

5. We recommend that existing professional organizations be directed to develop standards for pain management and that they incorporate methods to assure quality in this area (eg. Peer review, Continuous Quality Improvement. Quality Assurance, etc.)

References
Healing Touch

Hob Osterlund RN, MS, CHTP

Introduction
Healing Touch (HT) is a collective of techniques involving the use of hands to increase the recipient’s sense of well-being. Practitioners trained in HT techniques use their hands to consciously direct an energy exchange with the patient, often for the purpose of pain and anxiety reduction. This treatment modality as well as its precursor, Therapeutic Touch (TT), have experienced increasing popularity with patients over the last decade. HT and TT are noninvasive procedures for which there is no medical counterpart and are compassionate options to offer to appropriate patients. Modalities that are congruent with the current trend in holistic health care, they are useful forms of communication between patient and health care practitioner while requiring only minimal financial and resource utilization.

Theory/Assumptions
Pharmaceutical and invasive pain techniques are based on a Newtonian model of medicine. This model sees the body as an intricate mechanism which is controlled by the brain and the peripheral nervous system, functioning like a complex machine. Interventions are geared toward the removal or repression of pain by chemical or surgical alteration of the workings of that machine.

Energy-based techniques such as Healing Touch and Therapeutic Touch are based on the paradigm of Albert Einstein, which sees human beings as networks of complex energy fields. These energy fields are constantly interacting with the physical body. They are both more subtle as well as more easily influenced than the human body. HT and TT are specialized forms of treatment geared toward affecting the energy system that may be imbalanced due to disease states. Practitioners work to restore balance by assisting the energy system of another individual to normalize, thus helping to regulate cellular physiology and to provide relaxation as well as pain relief.

Both HT and TT are practices based in modern nursing practice and research, and are meant to be integrated with allopathic medical care rather than used in isolation from it.

Healing Touch
There is a growing body of literature currently available on Healing Touch. According to Healing Touch International in Colorado, there are approximately 60 studies approved, in process or completed nationally, including a multi-site Air Force study on lingering post-op pain; the impact of HT on pain and joint motility after total knee replacements; the impact of HT on depression; HT and oxygenation/cardiovascular variables in critically ill patients; HT’s effect on recovery levels in PACU after abdominal hysterectomy; the impact of HT on post-Cesarean-section wound infection; the effect of HT on salivary immunoglobulinA; and two studies at The Queen’s Medical Center in Honolulu on post-operative mastectomy pain and on pain in employees with back injuries. In an unpublished satisfaction survey of 198 patients at The Queen’s Medical Center, patients rated their average reduction in pain 2.8 on a 0-10 scale after a 20-minute treatment. The average increase in relaxation was 1.8 on a 1-4 scale. Of these patients, 94.9% rated themselves very satisfied (83.3%) or satisfied (11.6%) with their last HT treatment.

Healing Touch’s reports that more than 3000 treatments were done in 1998 with routine reports of pain reduction.

Therapeutic Touch, which is one of the specific techniques used in HT, has been studied relative to hemoglobin levels (Krieger, 1972), enzymatic activity (Smith, 1972), wound healing (Wirth, 1972), pain and anxiety (Kenesian, 1995), (Samarel, 1998). In addition, an article on the effect of distant healing (Sicher, 1998) on patients with AIDS reported significantly fewer doctor visits, lower illness severity and fewer days of hospitalization in the double-blinded treatment group. The following is a review of the literature on the use of TT to reduce anxiety and pain.

Anxiety
Heidt’s 1981 study of anxiety levels in 90 hospitalized adult cardiovascular patients compared patients receiving TT, casual touch and no touch (Heidt, 1981). The group receiving TT experienced a significant reduction in post-state anxiety compared with those who had received intervention by casual touch or no touch. Quinn (1982) partially replicated Heidt’s study by examining the effects of TT performed by nurses trained in TT and a simulation of TT performed by nurses who had no knowledge of TT. Among the 60 hospitalized cardiovascular patients in this study the group that received TT again showed a significant decrease in anxiety (Quinn, 1982).

Parkes studied the effect of TT in 60 hospitalized elderly patients. One group received non-contact TT, one another form of mimic TT and one no touch (Parkes, 1985). There was no difference in the pre- and post-state anxiety scores in any group. Olson, et al. studied the effects of TT on stress among 23 individuals who experienced posttraumatic stress following Hurricane Hugo (Olson, 1992). Using physiologic measures and two visual analogue scales to rate psychological stress the researchers found that subjects receiving

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TT showed a decrease in mean anxiety scores after TT.

Gagne and Tome studied 31 inpatients in a Veteran's Administration psychiatric facility (Gagne, 1994). One group received TT, one received relaxation therapy and one group a mimetic TT. While both the relaxation therapy and TT group reported a significant reduction of anxiety by self-report and by an observer's rating of pre- and postmotor activity, the reduction in self-reported anxiety was greater in the TT group.

Samarel and colleagues (1986) studied 31 women scheduled for mastectomies. One group received TT touch and dialogue; the other dialogue and quiet time. The TT experimental group showed a lower preoperative pattern manifestation of state anxiety than dialogue and quiet time.

**Pain**

Meehan studied pain in 108 post-operative adults who received either TT, mimetic TT or standard treatment of IM narcotic injection (Meehan, 1993). Pain was measured using a visual analogue scale and a Pain Intensity Descriptor form. There was no significant difference in the posttest pain scores for the TT and the mimetic TT group. Scores of the group who received narcotic were significantly lower: the mean posttest score of the narcotic group was 36.63, the TT group mean was 52.74, and the mimetic TT group mean was 61.72.

Keller and Bzdek studied the effect of TT on tension headaches among 60 adults known to suffer from tension headaches (Keller, 1986). One group received TT and one a placebo TT. Five minutes after the intervention 70% of the TT group had a significant reduction in pain score while only 37% of the placebo group demonstrated a reduction. Four hours later a significant difference continued. Fifty percent of the placebo group required further intervention to relieve pain; only 17% of the TT group required further intervention.

As noted, the studies reported are investigations of Therapeutic Touch. Therapeutic Touch is a specific technique developed by Dolores Kreiger, RN, PhD and Dora Kunz over 20 years ago. Many people are building upon Kreiger's foundational work, including Janet Quinn of the University of Colorado Health Sciences Center, who conducted the first federally funded project on TT and Daniel Wirth of Healing Sciences Research International. Their programs have demonstrated growth, evolution in thinking and recent publication in scholarly journals (Wilson, 1995).

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**References**


Invasive Techniques Utilized in Chronic Pain Management

Jeffrey S. Wang MD

Abstract
A multidisciplinary approach to the treatment of chronic pain has been one of the most effective means of restoring the ability of a patient to return to an increased level of function. Many techniques used for diagnostic and therapeutic levels have been utilized as part of this approach. This paper will describe some of the more common invasive techniques used in the treatment of chronic pain.

Invasive Techniques Utilized in Chronic Pain Management
Pain management has received much attention in the media lately with discussions ranging from physician assisted suicide to narcotic use in the chronic pain patient. Treatment of the chronic pain patient is best accomplished with a multidisciplinary approach as pain is a complex multidisciplinary problem. Proper treatment will often require input and therapy from anesthesiology, medicine, urology, oncology, psychiatry, physical and occupational therapy, psychology, surgery, and nursing services. Some of the more common treatments which have been performed by the anesthesiologist will be discussed. These therapies include nerve blocks, epidural injections, dorsal column stimulators, and subcutaneous infusion pumps. Many of these techniques are used daily for surgical anesthesia or post operative pain management. They are also useful in treatment of various chronic pain syndromes. Invasive therapies are only one aspect of pain treatments, and other treatment modalities will not be described in this article.

The epidural space is a potential space between the dura and the ligamentum flavum and lamina. It is present from the foramen magnum to the sacrococcygeal membrane. Injection into the epidural space may occur between any of the vertebrae down to the caudal space. Various medications have been injected into the epidural space for anesthesia and/or analgesia. These medications include local anesthetics, narcotics, steroids, Clonidine, neurolytic agents, autologous blood, and hypertonic saline to name a few. Injections can be performed as a one time injection, or an epidural catheter may be placed for continuous infusions. The indications for an epidural injection in the acute setting include: surgery, obstetrics, postoperative pain, fractured ribs, pancreatitis, frostbite, herpes zoster, ischemic pain, and post dural puncture headaches. Indications for chronic pain include: low back and cervical pain, postherpetic neuralgia, chronic regional pain syndrome, malignancy, phantom limb, and diagnostic or prognostic blockade. Epidural injections are usually placed at the closest dermatome to the level which is involved with their symptoms. There are various types epidural needles which can be used. The needle is placed on the midline or a paramedian approach to the epidural space. Confirmation of the epidural space may be made by loss of resistance technique or a hanging drop technique prior to the injection of the agents. Complications associated with this technique, although rare, may be attributed to either the needle placement or the specific agent injected. Insertion of the needle may injure the epidural veins which may result in an epidural hematoma, and bacterial contamination may cause an epidural abscess or meningitis. If these are not recognized quickly and treated effectively, nerve damage or paralysis may occur. Insertion of local anesthetics may cause hypotension secondary to sympathetic blockade. Since large volumes are often used, an unintentional subarachnoid injection may result in a total spinal anesthetic which would require circulatory and ventilatory support. Narcotics may cause respiratory depression immediately after injection or delayed respiratory depression up to 12 hours later. Any medication injected into the epidural space should be preservative free since most preservatives are considered neurotoxic.

Epidural injections were first reported in 1901 as treatment for lumbar nerve root compression. There have been numerous reports since then trying to delineate indications and efficacy of epidural steroid injections (ESI). The difficulty and controversy that arises is due in part to the inability of most researchers to control the variables. This would include the cause of the symptoms, duration of symptoms, history of surgical procedure, previous treatments, and the treatments being evaluated. Even in comparing studies which are considered to be well designed, the results are inconsistent. ESIs have been utilized in the treatment of annular tears, chronic lumbar degenerative disc disease, herniated nucleus pulposa (HNP) without neurologic deficits, HNP with nerve root irritation, HNP with nerve root compression, spondylolysis, spondylolisthesis, facet arthropathy, scoliosis, ankylolisthesis, spinal stenosis, functional low back pain, and back pain following spine surgery. There have been varying success rates which are mostly dependent on the cause of the symptoms. Acute radiculopathies seem to respond to ESIs better than chronic conditions. Success rates range from 83% to 100% if the symptoms have been present for less than three months. This decreases to 67% to 81% at six months, and 46% if symptoms have been present greater than a year. This was reported in uncontrolled studies. Dilke reports through a prospective, randomized, double blind study the efficacy of ESI in the treatment of patients with disc problems. They had follow up to six days after the ESI and used a volume of 10ml. Another prospective, randomized, double blind study showed no statistical significance between the ESI and placebo, however, the objective and subjective feelings of improvement were higher in the ESI group. The difference between these two studies was that 2 ml of the steroid solution was placed, and follow up evaluation occurred after two to three days compared to the larger volume and longer follow up period of Dilke. Complications from ESIs have consis-
ently been shown to be rare. Unintentional dural puncture occurs 1% of the time. Cushing’s syndrome\textsuperscript{13} and congestive heart failure\textsuperscript{14} have been reported, but these are extremely rare.

Specific nerve root blocks with steroids may be placed with fluoroscopic guidance. This may be therapeutic as well as diagnostic.\textsuperscript{15} If the patient has relief of his symptoms with a single nerve root injection, this would confirm the level that may require surgical correction. Peripheral nerve blocks with local anesthetic may be used for diagnostic purposes prior to surgical, chemical or thermal neuroablation.\textsuperscript{16} Neurolysis has been traditionally recommended for use in patients with life expectancies of less than one year. Chemical neurolysis may be accomplished with the injection of phenol 6% - 8% in glycerol or alcohol 33% - 100%. The effects of these solutions may include precipitation of lipoproteins and mucoproteins, disruption of myelin, extraction of cholesterol, and phospholipids, and coagulation of proteins. Duration of these injections range from three to six months before regeneration of the nerve tissue. Complications from these injections are usually due to injury to surroundings structures. Alcohol may be painful during the injection and cause an alcohol neuritis with high concentration injections. Phenol may cause convulsions and renal toxicity. Doses are to be kept below 100 mg. Thermal neuroablation includes cryoanalgesia and radiofrequency ablation. Both of these methods require the insertion of a probe to apply heat or cold to the neuron. The equipment required can be costly and requires knowledge of its use. Radiofrequency techniques heat the nerve tissue to 60°C - 100°C for coagulation. Cryoanalgesia will cool the nerve tissue to -60°C for destruction of the myelin sheath. These techniques have minimal tissue damaged, lack of neuritis or neurona formation, and cryoanalgesia is reversible after three to six months. Difficulties with these procedures include sensory and motor deficits that are bothersome to the patient and recurrence of their symptoms.

The sympathetic nervous system is frequently blocked with local anesthetics in the treatment of various pain syndromes. In addition to the sympathetic chain which is innervated with fibers from T1 to L3, there are several distinct ganglia which are of use in the treatment of pain. These include the stellate ganglion (SG), celiac plexus (CP), and the hypogastric plexus (HGP). Sympathetic blocks have been used in the treatment of circulatory insufficiency which includes Raynaud’s syndrome, arterial embolism, and vasospasm, chronic regional pain syndrome, herpes zoster, pain due to abdominal malignancies, and phantom limb pain.\textsuperscript{17}

The SG formed from fibers the first thoracic nerve and occasionally the second thoracic nerve. It provides sympathetic innervation to the head and upper extremity. The ganglion lies in front of the transverse process of the seventh cervical vertebra. The block is usually performed at the transverse process of the sixth cervical vertebra to minimize the risk of puncture to the vertebral artery and the dome of the pleura. Injection of 10 ml to 20 ml of local anesthetic is adequate for blockade of the SG. Horner’s syndrome, ptosis, myosis, and enophthalmos, will indicate sympathetic blockade to the head, but not necessarily the upper extremity. Complications of this block may include temporary hoarseness, brachial plexus block, pneumothorax, vertebral artery injection, seizures, hematoma, subarachnoid block, and injury to any of the surrounding anatomical structures.

The celiac plexus is made up of one to five discreet ganglia which derives its innervation from T5 to T12. It provides sympathetic innervation to the abdominal viscera, stomach, small bowel, large bowel to the splenic flexure, omentum, liver, gallbladder, pancreas, spleen, adrenal glands, and kidneys. The CP is located anterior to the aorta at the level of the celiac artery which corresponds to the T12 or L1 level. Blockade may be performed from an anterior or posterior approach. This may be accomplished by using anatomical landmarks, fluoroscopy, or CT guidance. Injection of 30 ml to 50 ml of local anesthetic will be sufficient to block the celiac plexus for diagnostic purposes. Neurolytic blocks with alcohol or phenol may be placed with CT guidance with greater precision. The classic example for this is the use of a neurolytic CP block in the treatment of pain associated with pancreatic cancer. Complications which may occur are diarrhea, hypotension, aortic or vena caval injection, renal puncture, and hemotoma.

The HGP are formed from fibers from and lumbar sympathetic chain and aortic ganglia. It provides sympathetic innervation to the rest of the colon and the pelvic contents. The HGP is the most diffuse of the ganglia. It is located at the bifurcation of the common iliac arteries which is located at L5. Blockade of the HGP may be performed using anatomical landmarks, fluoroscopy, or CT guidance. Uterine or rectal pain due to unresetable malignancies have been treated effectively with this procedure.

The sympathetic chain itself, may be blocked with fluoroscopic guidance to the appropriate level to affect the ipsilateral side. Lumbar sympathetic blocks with 15 ml to 20 ml of local anesthetic are the most frequent block of this type. This would be effective in treating disorders of a single lower extremity. The blockade of a single extremity may be beneficial in the patient who would not tolerate complete sympathetic blockade of both lower extremities that can occur with an epidural or subarachnoid block.

Chronic regional pain syndrome (CRPS), formerly referred to as reflex sympathetic dystrophy or sympathetic mediated pain is an uncommon pain syndrome which usually affects the extremities. CRPS may occur after an injury to the limb. The patient will develop a burning sensation which may or may not follow a specific nerve distribution. They will have hyperpathia, increased sensitivity, and allodynia, pain to a stimulus which is normally without pain. The affected limb has decreased blood flow which may result in decreased temperature and cyanosis. Eventually, there will be loss of hair and skin changes associated with ischemia. The limb becomes painful to move, and even wind blowing on the limb will cause exacerbating pain. This leads to immobility, contractures, and loss of bone density. Treatments are aimed at early diagnosis and early aggressive treatment.\textsuperscript{18} Sympathetic blocks or IV regional blocks with Guanethidine or Breylium have been used as treatments for CRPS. Clonidine, an alpha-2 agonist, has also been used with success. Other treatments for neuropathic pain such as the antidepressant and anticonvulsant medications have been used. Physical therapy is an integral part of the patient’s care to maintain range of motion and strength. If these modalities fail, implantable devices may be considered.

With advances in technology, dorsal column stimulators (DCS) have become a good therapeutic option in some patients. This may help to prevent a neuroablative procedure. DCS has been utilized in the treatment of failed laminectomies, CRPS diabetic neuropathy, ischemic pain and PHN.\textsuperscript{19} Candidates for this therapy will have
failed other more conservative modalities including oral pharmacotherapy, nerve blocks, and TENS. Proper patient selection will be made prior to the implantation with the patient’s pain pattern being at the center of this evaluation. A DCS electrode has one to eight leads on it, each of which can be programmed positive, negative, or off. The generator itself may also be programmed as one of the leads. The electrode may be placed percutaneously or via a hemilaminotomy. Final position will be attained with fluoroscopic guidance and verbal confirmation with the patient. The patient will have a trial of the DCS for one to two weeks. They should have at least a 50% reduction in their symptoms before deciding on the final placement of the subcutaneous generator. In this regard, there are two systems available. One is completely subcutaneous with the pulse generator/battery unit implanted on the abdominal wall or buttock. There is an external hand held unit to turn the DCS on, off, up, or down within the preprogrammed variables. The other system type has a generator coil implanted subcutaneously with an external telemetry Unit to provide the energy for stimulation. The external unit will utilize 9 volt batteries. Once the electrode has scarred in place, there should be minimal maintenance of the system. The patient should return to physical therapy for rehabilitation.

When the pain pattern covers more than several dermatomes, a DCS would be only partially effective. Spinal opioids would be next in the line of treatment modalities from less invasive to more invasive. Opioids administered into the epidural or intrathecal space have provided analgesia which is superior to that of parenterally administered opioids.26 Neuraxial opioids have been used in post operative pain, cancer pain, herpes zoster, myocardial infarction, thrombophlebitis, ischemic pain, low back pain, obstetrics, and chronic regional pain syndrome to name a few. Intrathecal and epidural infusion will use much less medication than the oral route. Patients who were unable to take large doses of narcotics due to side effects may be able to tolerate the lower doses with improved pain relief.21,22 Selection of the narcotic to be used is based on the pharmacodynamics and pharmacokinetics of the narcotic in the intrathecal or epidural space. Onset of action is shorter it the narcotic is more lipophilic, such as Fentanyl.

Morphine is a more hydrophilic narcotic and has a slower onset of action and longer duration of action that the other opioids. Neuraxial opioids may be administered as single shot doses or continuously through a catheter. Adverse effects of spinal opioids may occur at the time of injection. Epidural doses are larger than intrathecal doses by 10 to 16 times, and systemic side effects are more likely in the epidural route. Non-systemic effects more commonly associated with neuraxial opioids are urinary retention, pruritis, and delayed respiratory depression. Pruritis can be treated effectively with antihistamines or naloxone. This usually disappears after several days. Naloxone and/or catheterization may be used in treating urinary retention. Early respiratory depression may occur from systemic absorption of opioids. Delayed respiratory depression may occur several hours after administration of neuraxial opioids due to rostral spread in the cerebral spinal fluid. Although this is very rare, it is more common with hydrophilic narcotics compared to the more lipophilic narcotics. This is easily treated with small doses of Naloxone.

An epidural catheter may be tunneled subcutaneously to decrease the incidence of infection, or it may be attached to a subcutaneous port. The intrathecal catheter may be connected to a subcutaneous infusion pump (SCIP). Narcotics are usually infused through these systems. Other medications such as Baclofen, Clonidine, and local anesthetics have also been placed in the epidural or intrathecal space via a SCIP. An epidural port infusion would require an external infusion pump and larger volumes with refills one to two times a week. An intrathecal infusion with a SCIP may be refilled every three months. The main consideration in choosing an epidural catheter with a subcutaneous port or intrathecal catheter with a subcutaneous infusion pump would be the life expectancy of the patient. Both modalities are very effective, but the cost of each system varies. The epidural and port system is inexpensive initially, but with time, the cost of medication, supplies, and nursing support will become greater than the cost of the subcutaneous infusion pump. These cost lines cross at approximately three months time. A patient with a life expectancy of three to six months should have an epidural catheter with a port, and a life expectancy of greater than three months should have the intrathecal catheter and subcutaneous infusion pump.

There are many options in the treatment of chronic pain. The majority of patients will respond to the more traditional therapies of oral pharmacotherapy or surgical correction of an anatomic abnormality that causes the pain. Up to 20% of patients will not respond well to these therapies. If these methods are ineffective or they cause adverse reactions, there are other treatment modalities available. Knowledge of these modalities will help to insure the adequate and compassionate care of the patient with intractable pain.

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Pain Management: A Synopsis
Joseph Pepping PharmD

Pain is a SUBJECTIVE experience in which psycho-emotional as well as somatic factors have a direct bearing on perception and outcome.

Always ASK the patient to rate his/her pain on a scale of 0-10, zero being no pain at all and 10 being the worst pain they can imagine. BELIEVE the patient when they give you their pain scale rating. If psycho-emotional factors seem to "exaggerate" their perception of pain you should be able to use the "power of Persuasion", as well as medications, to effectively decrease the patient's pain.

The most important aspect of pain management is ESTABLISHING A POSITIVE RELATIONSHIP with the patient. You must CONVINCE them that you know what you’re doing and that YOU CAN MAKE THEM BETTER. Once you have their trust and support you’re half way there.

Next you must GET THEM TO COOPERATE as a “Pain Team Member”. They need to know that successful pain management depends on THEM as well as you. Their job is to let you know how effective your therapy plan is working and to ASK for PRN medication when they need it (if inpatients).

Follow up with them OFTEN (daily until stabilized) to let them know you haven’t forgotten them and to “fine tune” their pain management regimen.

Chronic Pain
Most pain management consults are for chronic pain cases (cancer, back/spinal pain, AIDS, etc.). The following guidelines are for the chronic pain patient.

Chronic pain management is like building a house. First you lay the foundation, then you frame the house, then you put on the roof.

The Foundation is ALWAYS a non-narcotic analgesic. Use an NSAID unless contraindicated (Hx. of Gl bleed, renal compromise, Hx. of allergy, anti-coag Tx.). My NSAIDs of choice are Naprosyn 500 mg Q8H-Q12H with food or Motrin 800 mg Q8H with food. If the patient cannot take NSAIDS then give Tylenol 975 mg (3 tabs) Q8H (unless pt. has severe hepatic problems). These non-narcotics must be given ROUTINELY, not on a PRN basis.

The frame of the house is a SUSTAINED RELEASE OPIOID, preferably morphine sulfate. Our current formulary item is Oramorph-SR 30 mg. To determine HOW MUCH sustained release narcotic to give them you must add up all the current narcotics they are taking and use a DOSAGE CONVERSION CALCULATOR to convert to a single agent. I use the one from Jannsen Pharmaceutica Inc., the makers of Duragesic Patches. You simply add up the EQUIVALENT dosages of all opioids that the patient is taking and convert them to the SINGLE agent of your choice. If someone can take medications orally I recommend using Morphine as a first line agent. If they are allergic to morphine or cannot take meds by mouth then use Duragesic (which is more cumbersome and much more expensive).

Sustained release opioids are ALWAYS taken ROUTINELY, never PRN.

The roof of our pain management house is an immediate release opioid for breakthrough pain. You must ALWAYS give chronic pain patients an agent for breakthrough pain. NO EXCEPTIONS. Try to use the same agent as the sustained release medication. My favorite is Morphine 15 mg sublingual tablets by Lilly. They are very small, rapidly absorbed under the tongue, fast acting and can be given to patients who are basically NPO. The dosage of the immediate release narcotic should be one-third to one-half of the dose of the sustained release narcotic.

For example, if your patient is taking Oramorph-SR 30 mg Q8H, the MSIR dose would be 15 mg SL Q1-2H prn. If he/she is taking Oramorph-SR 60 mg Q6H, the MSIR dose would be 15-30 mg Q1-2H prn.

Dosage Adjustments: Have the patient note on a calendar the amount and time of day that he/she takes any breakthrough pain meds. This will give you an idea when the pain is worse on a 24 hour cycle. The GOAL is to have a patient take no more than 3 doses of breakthrough narcotic per day. Your job is to add up all the breakthrough doses in 24 hours and “convert” one-third to one-half of this into the sustained release narcotic.

For example: If your patient is taking Oramorph-SR 30 mg Q8H and he/she is taking between 60-90 mg of MSIR per day (4-6 15 mg SL tabs) you would increase his/her Oramorph dose to 60 mg Q12H.

Important notes
• Individualize and adjust the route, dosage, and schedule as needed to obtain a consistent pain scale rating of 2-3.
• Always administer analgesics ROUTINELY for chronic pain patients.
• Give infants and children adequate opioid doses. Follow patients closely (daily by phone, etc.), particularly when beginning or changing analgesic regimens.
• When changing from one opioid to another, use equi-analgesic doses, then modify the dosage based on the clinical situation and response to the new medication.
• Recognize and treat side effects: NSAIDS: GI bleed, gastritis, platelet inhibition. Opioids: obtundation (rare with chronic narcotic users), mental status changes (more common with Duragesic), itching (all nars), and constipation (all nars). For constipation I suggest starting with 6-8 dried prunes a day and titrating up to a bowel movement at least every other day. If prunes are not effective,
don’t stop them, just add Lactulose 30 ml BID until the “great movement” occurs, then back off to QD until stools loose, then DIC (but keep taking the prunes).

• Never use mixed agonists-antagonists (Talwin, Stadol, etc.). Never use Demerol in patients with ANY kind of renal compromise. Never use Darvocet or Tramadol (Ultram).

• Don’t use placebos to assess the nature of pain.

• The worse the pain is, the more difficult to alleviate and the more narcotics you’ll have to use initially to alleviate it. Urge patients to take their breakthrough meds at the first signs of “discomfort” (above the 2-3 pain scale) and not to wait until they can’t stand the pain.

• Watch for the development of tolerance and treat appropriately.

• Be aware of the development of physical dependence and prevent withdrawal by assuring the patient has an adequate supply of narcotics. When you wean them, do it slowly; keeping the pain scale rating at 2-3 throughout the process.

• Do not label a patient “addicted” (psychologically dependent) if you merely mean physically dependent on, or tolerant to, narcotics. “Drug Seeking Behavior” is VERY different from physical dependence.

• If signs and symptoms of DEPRESSION persist after adequate pain management is obtained then treat with SSRI’s or other appropriate agents.

**Commonly Prescribed Adult Doses of Oral Analgesics**

**General Philosophy**

Whenever possible in cases of acute pain, and always in cases of chronic pain, use non-narcotic analgesics as a base. Use routinely when appropriate.

**Non-Narcotic Analgesics (mild to moderate pain).**

NSAIDS (the best due to anti-inflammatory effects). Always given with food.

Ibuprofen (Motrin, Advil):

400-800 mg q6h prn. Use routinely for first 24-48 hours in acute pain cases, then PRN. Use routinely in chronic pain patients unless contraindicated.

Naproxen (Naprosyn, Alleve):

500 mg BID. Personally I like 500-750 mg BID but this exceeds “traditional” dosing. Use routinely in chronic pain patients unless contraindicated.

Acetaminophen (Tylenol, APAP):

Often included in narcotic analgesics for synergistic effects. Not as effective as the NSAIDS, but fewer serious side effects like GI bleeding. Remember: maximum daily dose is 4 gms in adults.

**Narcotic Analgesics (moderate to severe pain).**

Many physicians underprescribe narcotics due to fear of addiction (which is extremely rare) and lack of pain management understanding.

Remember: Pain is a very subjective and variable phenomenon, you have to believe and accept your patients’ assessment of their pain; and treat accordingly

Remember: The most difficult situation in pain management is to have to play “pain catch up”, that is, to initially underprescribe analgesics, then try to alleviate the pain you could have dealt with more appropriately from the beginning.

Darvocet N-100 (propoxyphene/APAP) Ineffective. Do not recommend.

Tylenol w/Codeine (APAP 325 mg w/Codeine, TC#2 = 15 mg, TC#3 = 30 mg, TC#4 = 60 mg). (TC#3 is most common) 1-2 tabs Q4-6H pm pain. An effective analgesic for moderate pain. Limited in use by codeine side effects of nausea/vomiting, and mentation changes.

Vicodin (APAP/Hydrocodone) 1-2 tabs Q4-GH pm pain. More powerful than Tylenol w/Codeine. Has the advantage of not requiring a C-II duplicate Rx.

Percocet (APAP/Oxydcodeone) Moderate: 1 tab Q3-4H pm pain. Severe: 1-2 tabs 04h pm pain. The gold standard of narcotic analgesics for more severe pain. Excellent pain relief with few side effects. Percocet’s disadvantage is that it requires a C-II duplicate Rx. Do not hesitate to use in cases of moderate to severe pain.

Morphine (immediate release) 15 & 30 mg tabs. 15-30mg SL Q3-4H pm pain. Very useful in cases of severe pain that does not respond to Percocet. Advantage is that Lilly makes a sublingual tablet that can be given to patients with nausea/vomiting or restricted PO intake. May use in very high doses for patients with significant narcotic tolerance.

Sustained release Morphine. Only used in chronic pain mgmt.

Usually dosed Q8H routinely. Recommend MS Contin, which comes in 15, 30, 60, 100 and 200 mg strengths (each color coded to minimize dosing errors) or Oramorph-SR. No maximum dose.

Duragesic Patch (Fentanyl). Only used in chronic pain mgmt.

Usually dosed Q72H. Comes in 25, 50, 75 and 100 mcg/hr patches. Max. dose approx. 400 mcg/hr.

*Continued on p. 103*
Pain management is often complex and always multifactorial. Culture, emotional state and previous pain experiences all play a part in a person’s response to a painful stimulus. Since these and many other factors are difficult to predict and measure, the practitioner is often left with confusion as to the best treatment option. Access to education is one key to optimal choices. If the practitioner has had minimal exposure to current principals in cancer pain management, for example, he or she may still have concerns about the patient’s potential for drug habituation. The debate over use of opiates in chronic nonmalignant pain may leave the practitioner in an “either/or” mindset, uncertain how to individuate pain management specifically for each patient. Resources for the Hawaii practitioner are listed in an attempt to support skilled pain management in Hawaii.

**Home Infusion Agencies**

**Home Care Hawaii, LLP**  
Home pain management infusions  
All islands: 677-1288

**Infusion Services of Maui**  
Home pain management infusions  
Maui: 871-5894

**Intravenous Therapy Specialists (ITS)**  
Home pain management infusions  
All islands: 836-0365

**Kuakini Infusion Service**  
Home pain management infusions  
Oahu: 547-9456

**Pharmacare**  
Home pain management infusions  
All islands: 488-9446

**Wailuku Professional Pharmacy**  
Home pain management infusions  
Maui: 244-9099

**Hospice of Kona**  
At-home hospice pain consultations  
Ellen Schumann, RN,C  
Hawaii: 334-0334

**Hospice Maui, Inc.**  
At-home hospice pain consultations  
Gregory LaGoy, ND  
Maui: 244-5555

**Kauai Hospice**  
At-home hospice pain consultations  
Kathleen Boyle  
Kauai: 245-7277

**North Hawaii Hospice**  
At-home hospice pain consultations  
Nancy Bouvet  
Hawaii: 885-7547

**St. Francis Hospice**  
At-home and inpatient hospice pain consultations  
Pat Kalua, RN, BSN, MAOM  
Oahu: 595-7566

**Medical Centers**

**Kaiser Medical Center**  
Inpatient and outpatient consultations  
Joe Pepping, Pharm.D.  
834-9190

**Kapiolani Medical Center for Women and Children**  
Inpatient and outpatient consultations  
Alan Britten, MD  
Chair, Pain Management Team  
973-8597

**St. Francis Medical Center**  
Inpatient consultations  
Amy Krueger, RN, MSN, FNP  
547-6109

**St. Francis Medical Center West**  
Clifton Liu, Pharm.D.  
678-7035

**Straub Clinic and Hospital**  
Anesthetic approaches to malignant and nonmalignant pain, Jerry Prentiss, MD  
Neurosurgical approaches to malignant and non-malignant pain, Yoshio Hosobuchi, MD  
522-4000

**The Queen’s Medical Center**  
Inpatient consultations  
Jeffrey S. Wang, MD, Medical Director  
Hob Osterlund, RN, MS, CHTP, Clinical Coordinator, Pain Management Services  
Lydia Kumasaka, RN, MS. Clinical Nurse Specialist  
Joan Maeshiro, RN, Instructor  
Lynn Kobashigawa, RN, Instructor  
547-4726

**Tripler Army Medical Center**  
Inpatient and outpatient consultations  
Lynn Dahl, MD  
433-1323

Inpatient pain management nurses  
549-5667 (beeper)

**Speciality Services**

**Cancer Information Service**  
Source of latest information regarding pain management for professionals and lay public, supportive care clinical trial and protocol searches, outreach for programs to the medically underserved  
1-800-4-CANCER
Hawaii Cancer Pain Initiative
Speakers’ Bureau for professional and lay cancer pain education
Barbara Shirlan, RN, CRNH
Chair, Executive Council
924-9255

State Narcotics Enforcement Division
Information about legal guidelines, Uniform Controlled Substance Act, licensing, suspected drug-seeking behavior, pharmacy alerts
Keith Kamita
594-0150

Publications and Organizations
Agency for Health Care Policy and Research (AHCPR) publications:
Acute Pain Management in Adults:
Operative Procedures (AHCPR92-0019)
Acute Low Back Problems in Adults (AHCPR95-0642)
Management of Cancer Pain (AHCPR94-0592)
Managing Cancer Pain:
Patient Guide (AHCPR94-0595)
Pain Control After Surgery:
A Patient’s Guide (AHCPR92-0021)
AHCPR Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547
800-358-9295

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101 Columbia
Aliso Viejo, CA 92656

American Academy of Hospice and Palliative Medicine
P.O. Box 14228
Gainesville, FL 32604
(352)377-8900
(352)371-2349 Fax
aahpm@aahpm.org
web: www.aahpm.org

American Academy of Pain Management
13947 Mono Way #A
Sonora, CA 95370
209-533-9744
Annual certification examination in pain management
Recommended text for examination:

Pain: The Journal of the International Association for the Study of Pain
Elsevier Science Publishers B.V.

P.O. Box 211
1000 AE Amsterdam
Netherlands
nlinfo-f@elsevier.nl

Palliative Care Newsletter
Roxane Laboratories
P.O. Box 16532
Columbus, Ohio 43216
614-276-4000 ext 2287
614-276-8061 fax

Resources on the Internet
Agency for Healthcare Policy and Research
Lists various resources on pain and cancer pain
http://www.ahcpr.gov/cgi-bin/allsrch.pl
http://www.ahcpr.gov/(HOME PAGE)

American Cancer Society, National Cancer Institute
Questions and answers about pain control
http://nysernet.org/bcic/nci/adult.pain.4518/pain,questions.html

Roxane Pain Institute
Educational materials on cancer and AIDS pain management
http://www.Roxane.COM/Roxane/PRI

The International Association for the Study of Pain
Dictionary of pain terminology; outline for curriculum on pain in medical schools
http://weber.u.washington.edu/~crc/iasp.html

University of Iowa College of Nursing
Cancer pain education for patients and families
http://coninfo.nursing.uiowa.edu/wwww/nursing/virtnurs/cncrpain/toc.html

Worldwide Congress on Pain
Pain management educational web site
www.pain.com

HAWAII MEDICAL JOURNAL, VOL 59, MARCH 2000
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Pain Glossary

Narcotic
“Narcotic” is a legal, not a scientific term which denotes some of the drugs that are controlled under the Single Convention on Narcotic Drugs, 1961, and the U.S. Controlled Substances Act (CSA). Under the Single Convention and CSA, substances such as the opioids are classified as narcotics. Marijuana and cocaine are also legally classified as “narcotics.” When discussing pain relief, we avoid use of “narcotic”, preferring “opiate” or “opioid”.

Opiate
“Opiate” refers to drugs whose origin is the opium poppy, including codeine and morphine.

Opioid
“Opioid” is a scientific term denoting both natural (codeine, morphine) and synthetic (methadone, fentanyl) drugs, and whose pharmacological effects are mediated by specific receptors in the nervous system. “Opioid” also applies to agonists and antagonists with morphine - like activity.

Tolerance
“Tolerance” refers to the physical adaptation of the body to an opioid resulting in the need to increase the dose to achieve the same effect, as in “analgesic tolerance”, or as in the reduction in a response (such as sedation) with repeated administration of drug.

Physical dependence
“Physical dependence” also describes the physical adaptation of the body to the presence of an opioid; it is characterized by signs of withdrawal when use of an opioid is stopped abruptly, or when an opioid antagonist is administered to an individual who has been on chronic opioid therapy.

Psychological dependence
“Psychological dependence” is a behavioral pattern characterized by a compulsion to obtain a drug for mood altering effects.

Addiction
“Addiction” is a sociologic term which refers to compulsive drug use, psychological dependence, and continuing use despite harm. Neither physical dependence nor tolerance are sufficient to define “addiction.” In the past as well as in present day language “addiction” is frequently and incorrectly equated with physical dependence and withdrawal. “Addiction” and related terms such as “addict” are used in narcotic control laws and are sometimes inappropriately defined to include physical dependence, thereby confusing pain patients with addicts.


Continued from p. 100

Remember: Whenever you are using a sustained release narcotic analgesic you must write additional orders for immediate acting narcotics for breakthrough pain.

Equivalencies:

<table>
<thead>
<tr>
<th>Narcotic</th>
<th>Equi-analgesic Dose (Only oral potencies listed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>60 mg</td>
</tr>
<tr>
<td>Morphine</td>
<td>15 mg</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>10 mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>7.5 mg</td>
</tr>
<tr>
<td>Duragesic</td>
<td>25 mcg = 30-60 mg oral morphine</td>
</tr>
</tbody>
</table>

**Editor’s Note**
Joseph Pepping PharmD, is Pharmacist in Charge Decentralized Services and Pain Management Consultant with Kaiser Permanente Moanalua. Joe was a member of our Pain Task Force of the Governor’s Blue-Ribbon Panel. In addition to serving as a Pain Management Consultant, he is very interested in herbs and natural supplements as complementary adjuncts to our allopathic treatments. Mahalo, Joe.

Norman Goldstein MD, Editor
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You are invited to attend...

– Friday Noon Conference –
Anatomy of a Medical Malpractice
Frank L. Tabrah, MD
April 14, 2000, 12:30 - 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants will be able to:
• Describe your role as the defendant and the various outcomes on how this claim can/will be settled.
• Gain knowledge on how to deal with a malpractice suit. Understand the entire process of how a simple patient complaint could turn into a claim against a practitioner.
• Recognize the red flags signaling a potential claim.

– Friday Noon Conference –
Environment of Care 2000:
Safety Issues that Impact Physicians
Kevin Matsukado, Norma Cassity, Clayton Takara, & Michelle Fisher
April 21, 2000, 12:30 – 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants will be able to:
• Understand/identify infection control, tuberculosis, and bloodborne pathogens.
• Gain knowledge in radiation safety procedures, and prevent back injuries.
• Summarize emergency procedures: how to report unsafe conditions and suspicious activities, how to use a fire extinguisher, plan red, and the 5 phases of plan blue.

– Friday Noon Conference –
Weight Loss Agents
John Spangler, MD
April 28, 2000, 12:30 - 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants will be able to:
• Identify the herbs and supplements being sold over the counter for weight loss.
• Review relevant scientific information about the effectiveness and safety of these agents.
• Formulate a coherent treatment plan for the patient seeking to lose weight with the aid of over the counter supplements.

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A.K.A. Arlene Meyers, MD, MPH

- Wahiawa pediatrician since 1979
- Associate Clinical Professor, JABSOM
- 1998 Roscoe Pound award winner in health care law
- President & founder of the Hawaii Coalition For Health

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Life in these Parts...
Dr. Laura Gets in to A Patient’s Head...
A 23 year old Salt Lake woman was at St. Francis Medical Center for surgical removal of a benign gall-ball-sizied brain tumor (by world renowned neurosurgeon Takamori Fukushima from Duke University). When the doctors switched on an “evoked potential machine” which detects electrical activity in neurons, Dr. Laura’s popular program came on...The St. Francis staff called KHVH and the station reduced its 10,000 volts to 2500 volts so the surgery could proceed without Dr. Laura’s moralizing voice.

Millennium Predictions by Eddie Sherman
“Dermatologist Norm Goldstein opens a Nihihau Clinic — ‘Pimples R Us’...Hawaii is often acknowledged as the islands of romance, but one —Nihihau—is the last repository of unsullied Hawaiians.”

Life in these Parts...
Ah Quon McElrath, non-lawyer and retired social worker with International Long Shore and Warehouse Union was presented the Hawaii Women Lawyer’s “Life Time Achievement Award”...AQ was recognized for her dedication to advancing the rights of workers and her activism on community issues, including health care and criminal justice. The award recognized AQ’s involvement in advocating legislation for hospice care, abortion rights, repeal of the death penalty and issues involving the poor. AQ was also influential in the Governor’s blue ribbon panel on dying with dignity...

Conference Notes...
Introduction: Diabetes is the leading cause of blindness, end stage renal disease, lower extremity amputation and 2 to 4 times higher CVD...

Prevention Macrovascular Disease:
- a. Aggressive lipid control
- b. BP control
- c. Daily ASA
- d. Stop Smoking
e. Tight glycemic control

Cholesterol Management in Type II:
- a. All type II should be on a low fat diet
- b. Without CAD, CVD or PVD: Initiate drug Rx if LDL>130; aim for LDL<100.
c. With CAD, CVD or PVD: Aim for LDL<100.

Type II & CHD:
- a. Non-Diabetic: 3.5 to 18.8% MI
- b. Diabetic: DM, No MI: 28.2% MI...
- DM ≥ MI: 45.0% MI...

Lipid Lowering Agents in DM:
- a. Niacin not well tolerated
- b. Bile Acid Sequestrants: raises triglycerides
- c. Fibric Acid Derivatives: ↓triglyceride & ↑HDL; ± ↓LDL
- d. HMG-Co A ↓LDL; ± ↑triglycerides; ± ↑HDL (Six statins available for DM Patients; Recommend Mavacor, Pravachol and Zocor, but Lipitor is most potent for ↓LDL...)

| Lipitor | 10mg, 20mg, 40mg, 80mg, ↓LDL ↓41 ↓44 ↓50 ↓61 |

Prevention Macrovascular Disease:
- a. Keep BP < 130/85: renal disease, ↓retinal complication, ↓CVI; ↓cardiovascular events...

Prevent Diabetic Nephropathy:
- a. Tight glycemic control
- b. Tight BP control
- c. Low protein diet
d. Use ACE (renal protection) or Ca CB (renal protection)
e. ARB’s

Hypertensive Agents Beneficial to Diabetes:
- Goal: <130/80

MI Prevention t ASA:
- U.S. Physician Health Study (Sub group analysis t DM pts)
- 61% relative risk reduction t ASA

Improved Control (Kumamoto Study)
- a. Retinopathy: 65%
- b. Severe retinopathy 40%
- c. Overall risk nephropathy: 70%
- d. Microalbuminurea: 57%
- e. Combined cardiac, CVI, Peripheral vascular events: 54%

UKPDS:
- a. Microvascular end points: 25%
- b. MI: 10%

Goals Glycemic Control:
- Normal: <4-6%
- Aim: <7%
- Alternative Goal: < > 8%

Potpourri...
An 80 year old couple was having problems remembering things. Their doctor checked them out and tells them they were physically okay, but wants them to start writing things down to help them remember.
Later that night while watching TV, the old man got up to go to the kitchen.
The wife asks, “Will you get me a bowl of ice cream?”
“Sure,” he replies.
She then says, “Don’t you have to write it down so you can remember it?”
He says, “No, I can remember that.”
She then says, “Well I also would like some strawberries on top. You better write that down so you can remember it!”
He replies angrily, “I don’t need to write that down.” And storms into the kitchen...
About 20 minutes later, he returns from the kitchen with a plate of bacon and eggs. She stares at the plate for a moment and says, “You forgot my toast.”

Patsy Matsuura, RN (from Hilo)

Potpourri...
My sister is an assistant in a psychologist’s office and as he makes rounds in several institutions, she’s frequently required to contact him on a pager...
One particularly stressful morning, she made numerous attempts to contact the doctor without response...
He finally walked in late in the morning, frustrated by the number of messages piled up...
“Why didn’t you page me?” he asked sternly and my sister replied that she had paged him many times. He had worn his pager all morning...
He reached in his pocket and tossed an object on the desk...
“Check the batteries — Maybe that’s the problem.” On my sister’s desk lay the doctor’s TV remote control.

Conference Notes...
“Altering the Natural Hx of Type II...Reducing the Burden of Macrovascular Disease.” Steve Edelman, Associate Prof of Medicine, UC San Diego... KMC PB4, 2/4/2000.
Introduction: Diabetes is an epidemic esp between the ages 65 and 74. Diabetes is a continuum...We must pick it up early...

Progression of Type II:
- Genetics → Insulin Resistance ← Obesity ↓ Hyperinsulinemia ↓ Sedentary Aging ↓ Compensated Insulin Resistance ↓ Normal Glucose Tolerance ↓ Impaired Glucose Tolerance ↓
- Genes → B Cell Failure ← Acquired Glucose Output ↑ Hepatic Glucose Output Type II Diabetes → Toxicity
**Discussion:** Sulfonylureas are no longer first line therapy... The first line therapy is Glucophage, Insulin sensitizers and CHO Inhibitors. **Sulfonylureas are unphysiologic viz they cause weight gain, hypoglyemia, Beta cell exhaustion, and accelerate atherosclerosis... Sulfonylurea failure occurs within 5 years...**

**Lipid control in Type II:** Keep TC<200; HDL>45; LDL<130 acceptable; <100 optimal; Triglycerides<200; <150 optimal; BMI<25

**Troglitazone Rx:**

a. Troglitazone increases the size of LDL
b. Decreases visceral fat distribution in Type II
c. Improves cardiac function by increasing cardiac output and stroke volume.
d. Reduces diastolic pressure in HTN
e. Statistics: - 37% reduction in microvascular events
   - 44% reduction in strokes
   - 60% reduction in heart failures

**re Idiosyncratic Hepatic Damage with Troglitazone... (Diagnosis by ALT elevation)

a. 1.8 million people on Rezulin
b. 90% of cases occur in the first 3 to 8 mos.
c. No relation to gender and age.
d. No incidence after 11 months.

**Prevention of Macrovascular Disease in Type II:**

a. Keep HbA1c < 7%
b. Treat hyperlipidemia and hypertension
c. Put patient on ASA

**Potpourri...**

The young Scotsman went to study at an English University and was living in a residence hall with other students. After he had been there a month, his mother came to visit, “How do you find the English students, Donald?” she asked.

“Mother,” he replied, “They’re such noisy people. The one on that side keeps banging his head on the wall and the one on the other side screams all night.”

“How do you manage to keep up with such noisy neighbors?”

“I ignore them,” he said, “I just mind my own business, playing my bag pipes.”

**Potpourri...**

The Manager of a megastore checked on his new salesman... “How many customers did you serve today?” The manager asked...

“One,” replied the new guy. “Only one?” said the boss. “How much was the sale?”

The salesman answered, "$58,334.”

The manager was flabbergasted and asked him to explain.

“First I sold the man a fish hook. “The salesman said. “Then, I sold him a rod and reel.” Then I asked him where he was planning to fish and he said down the coast. So I suggested he’d need a boat - he bought the 20 foot runabout. When he said his Volkswagen might not be able to pull it, I took him to our automotive department and sold him a big SUV.”

The amazed boss asked, “you sold all that to a guy who came in for a fish hook?”

“No,” the new salesman replied... “He actually came in for a bottle of aspirin for his wife’s migraine.” I told him, “Your weekend’s shot... You probably should go fishing.”

**Potpourri...**

**His First Time...** The gastroenterology service had just acquired two new first year residents...

The first day was high-lighted by spending the entire morning assisting with 20 sigmoidoscopies... One of the young residents was handed the sigmoidoscope after watching the staff gastroenterologist perform one. His wildest dream had come true: he was about to perform his first sigmoidoscopy. He maneuvered the exam table so the patient was on the “bottom up” position and draped properly. He picked up the sigmoidoscope and aimed it... After a minute or two getting the scope properly pointed, the resident bent over to look and he was amazed to see a large polypoid mass!

“This is a large rectal polyp!” he reported to the staff man and moved aside for the staff gastroenterologist to verify the finding. The staff man peered into the scope and exploded, “You idiot! That’s her cervix!”

**Court Jesters...**

**Confusion In Court About Names**

What’s in a name? That which we call a rose... By any other name would smell as sweet... — William Shakespeare

Believe me, in a court of law, names can cause no end of confusion and consternation for judges, lawyers, and court reporters who have to know who the hell is who...”

Q: Where do you live?
A: 2442 Oseawatamie Street

Q: How do you spell that street?
A: “S-T-R-E-E-T”

Q: Other than traffic court convictions, have you ever pleaded guilty to or been convicted of a felony or misdemeanor?

A: Mr. Who?
A: Misdemeanor
A: Who’s Mr. Meanor?

Q: Where do you live?
A: I moved.
Q: Do you have a middle name?
A: No, I lost it.

Q: Did you see any other doctors at the time?
A: Yes, the neck doctor I went to see was a Dr. Lowell.
Q: Is that the first name or last name?
A: Last name. I don’t know his first name... His first name is doctor.

What’s in a name?” one asks again. Andrew Le Mesurier, a lawyer in St. John, N.B. advised me in that city, in Dec 1985, a man named Outhouse was sentenced to 30 days in jail for stealing three cases of ExLax.

**Medical Tid Bits...**

The popular heart burn drug Propulsid can cause dangerous irregular heart beats and even sudden deaths, according to a recent FDA report. The FDA warning suggests that patients should be put on Propulsid only after an EKG... The FDA warning comes in the wake of 70 deaths and 200 other reports of irregular heart rhythm since 1993... JAMA reports that menopausal women on estrogen and progestin have a 20% higher risk of breast cancer than those on estrogen alone... When research in the 1980’s linked estrogen to uterine cancer, progestin was added to block the estrogen effect on the uterine lining...

The study gathered data from 46,355 women participating in a nationwide breast cancer screening project from 1980 through 1995. The survey identified 2,082 breast cancer cases... At an American Society of Anesthesiologist’s conference, Dr. Charles McLesky reported on a survey of 979 presurgical patients. 17% said they took one or more herbal products. The most common, Ginko biloba, garlic and ginger — all of which prevent clot formation. Two others, St. John’s wort and kava kava may prolong anesthetic’s sedative effect. The ASA suggests that patients stop taking such products at least two
which will challenge the emerging demands in medical education. They recognize that new discoveries that lead to the accumulation of new facts are not enough. Those discoveries should lead to changes in the kind and quality of patient care that can be provided by a new generation of physicians.

The information age has forever altered the speed at which new knowledge in the biomedical sciences can be shared and evaluated. With our new program, we will be able to eagerly anticipate improved standards of medical care, rather than cope with or react to changes as they come about.
Welcome To The Jungle.

Many refractive surgeons (perhaps some right here in paradise-city) have established “co-management” agreements with optometrists or ophthalmologists whereby the co-managing doctor is paid significantly more than the 80/20 split typically allowed under Medicare global fee rules. Most refractive surgeons assume that the Stark II and anti-kickback laws do not apply since the arrangements are not reimbursed by Medicare or Medicaid. However, if the Dept. of Health and Human Services Office of Inspector General feels that the lucrative referral share produces a stream of contracted or other Medicare referrals to the refractive surgeon, then the over-market fee split may be treated as an illegal kickback and not legitimate co-management. And still another area of vulnerability is the malpractice threat when the co-manager may not be competent regarding possible injuries related to the surgery. Some members of the American Society of Cataract and Refractive Surgery are concerned about the exorbitant kickback fees, but any open discussion about co-management fees could be interpreted as price fixing. In a nearly forgotten medical world, doctors were concerned only with patient care and professionalism.

Delay Is The Deadliest Form Of Denial.

In Britain, Prime Minister Tony Blair’s government may fall due to a breakdown in their beloved National Health Service. A 73 year old female patient with throat cancer needed prompt surgery to remove the malignant growth, but the procedure was postponed four times over five weeks due to a lack of beds. By the time space was available the tumor had spread and was no longer operable. The public was outraged as the media highlighted the system’s failure, and the inability to cope with the annual outbreak of influenza which stretched the hospitals. The U.K. spends about 8% of its GDP on health care, compared with America’s 14% (although many medical expenses in the US are considered social in Britain). Now, Mr. Blair says that an increase in the small but growing private care would solve the NHS’s difficulties. Contrarily, across the Atlantic our government is doing its best to destroy our cherished private sector of medicine. Go figure.

The Possession Of Power Inevitably Spoils The Free Use Of Reason.

Cataract surgery is easily the most common operation for Medicare patients, and those wonderful people at HCFA are constantly searching for ways to reduce costs. Suggestions have been made that monitored anesthesia is not necessary for cataract surgery, because the operation has evolved into a very safe and predictable procedure. Not so! A study of over 1000 consecutive cataract operations by Rosenfeld et al., found that patients under 60 required intervention 61% of the time while those older than age 60 needed intervention 36.5% of the cases. The operative risk could not be predicted, but obviously an older population, often with a history of heart, pulmonary, renal, vascular or other systemic condition, is fragile. Intervention varied from physical restraint and respiratory assistance to simple verbal assurance.

Experience Is A Good Teacher, But He Sends Terrific Bills.

Harvard Pilgrim, a nonprofit HMO that consistently has been rated near the top in quality of medical care, was placed under Massachusetts state receivership as a result of spiraling losses and errors in accounting. Rising medical and drug costs plus heavy price competition among HMOs and insurers produced losses. Original figures were about $100 million, but were actually found to be from $150 to $177 million. The losses also had the effect of squelching a $147 million state bond issue that had been scheduled. The state planned to sell the bonds to private investors and use the money to buy five of the HMO’s buildings and lease them back.

Quicker And Sicker – ‘Em Up! Head ‘Em Out!

Bean counters at health care consulting firms HCIA Inc. of Baltimore and William M Mercer, Inc. of New York came up with a stupid, stupid list of “Top 100 Hospitals,” by measuring financial performance. The ranked hospitals showed significantly shorter lengths of stay, lower in-hospital costs and lower rates of readmission within 180 days (the patients probably died) for cardiac patients. However, analysts found that there was no significant difference in quality of care compared with un-ranked hospitals. Meanwhile, the “top” hospitals rushed to promote themselves in what is a public relations bonanza for attracting customers and bargaining with managed-care organizations. At the same time, U.S. News and World Report published another well-regarded hospital ranking, scoring patient care exclusively, evaluating mortality rates, available technology, and nurses-to-beds ratio. Johns Hopkins Hospital and Mayo Clinic were among their top hospitals.

It Is Worse Than A Crime. It Is A Blunder.

In Florida, patients who are planning a malpractice suit against a physician must notify the Department of Health of their intention. The DOH wants to make the information publicly available when the complaint is received. Previously, the state only made the complaint public after an investigation found probable cause or after the suit had actually been filed. The Florida Medical Association and Osteopathic Association were unsuccessful in obtaining a temporary injunction. The state attorney general said there was no violation of law, so tough luck, Doc. “The information would unfairly identify physicians who may be threatened with frivolous and unfounded lawsuits,” according to their request. Any disgruntled patient can make an unwarranted complaint and the Florida Department of Health will announce it to the media. Lucky you live Hawaii.


In these days of reduced physician income, HMO manipulations, struggles to confront insurance goliaths, and abiding and often abusive government inference, a stupid display of ostentatious wealth surely doesn’t help the doctor’s image. In Barrington, a Chicago suburb, a husband and wife doctor couple paid $180,000 cash for a home for their high school student son to park his 1999 Honda in the driveway near the school. Work on the school parking lot had created a shortage of space. Buying a parking place for your high school child’s car is not uncommon in Chicago’s suburbs, but this episode went beyond the pale. How can physicians expect any sympathy for declining income, and loss of medical control when episodes like this get nationwide publicity?

Excuse For The Millennium – “The Check Is In The E-Mail.”

E-mail medicine (cybercare?) is only in embryo, but the virtual house call is going to be part of more practices in the not distant future. A patient can prick the finger, squeeze a drop of blood onto a glucose meter about the size of a floppy disk, hook up the meter to the computer and click it off to the doctor’s lab for analysis and medical direction. It is happening today in Silicon valley, and such exams take place daily at DiabetesWell.com which treats over 700 patients across the U.S. In addition, many web sites already have shaken up medical care by giving patients access to great amounts of material, some legitimate and a lot of it fanciful. Bearing this information patients are appearing in the doctors’ offices armed with questions, challenges and therapeutic expectations.

Deja Moo: The Feeling That You’ve Heard This Bull Before.

Political correctness has hit the box of Crayolas. Binnie & Smith, Inc., DejaMoo: The Feeling That You’ve Heard This Bull Before.


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Political correctness has hit the box of Crayolas. Binnie & Smith, Inc., makers of Indian red crayons, is changing the name of the reddish-brown hue after teachers complained that many children (or is it the teacher?) think the color refers to the skin color of Native Americans. Wrong! In fact the number usually refers to a pigment used by fine artists, found in clay in regions of India. The National Congress of American Indians had not complained about the color, however they applauded the increased sensitivity “to images and symbols which have been perceived as offensive to Native Americans.” Please give me a break, non-gender, non-racial, non-sexually-oriented, chairperson.

ADDENDA

❖From 1987 to 1996, the number of women smokers of child-bearing age, dropped from 16.3% to 11.8%.
❖Since 1979, eighteen American amateur soccer players have been killed by falling goalposts.
❖46% of U.S. women “wish they could do something about their thighs.”
❖Change is inevitable, except from vending machines.
❖It is alleged that sties are caused by watching your dog defecate.
Aloha and keep the faith —rtstst.
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