Question for Plenary: Cognitive Behavioral Approaches to Chronic Pain (O’Connell)

In Acceptance and Commitment Therapy approaches, the key insight is:

A. Pain patients quickly become drug dependent
B. The doctor must come up with good arguments for decreasing pain meds
C. The conversation about pain must be expanded from reducing pain as a prerequisite to any other life changes to living the best life possible despite the likely persistence of waxing and waning discomfort. (CORRECT ANSWER)
D. Once you have taken patients' pain away they will naturally start to fulfill desired life goals
E. An unyielding tough love stance is needed to push patients towards change.

Question for Breakout session: Cognitive Distortion (O’Connell)

What is the most likely cause of the Dr-Pt. conversation about pain becoming dysfunctional:

A. The patient is probably lying.
B. The doctor lacks courage to stand up to the patient
C. The doctor is in too big a hurry to fully understand the situation
D. Distortions in the patient’s own thinking about his/her situation confuse the conversation between the patient and doctor (CORRECT ANSWER)
E. The doctor is too sympathetic with the patient’s discomfort.

Question for Breakout session: Bringing Mindfulness and Compassion to your Practice (Lin)

Among patients with chronic low back pain or other chronic pain

A. Cognitive Behavioral Therapy (CBT) is more efficacious than MBSR for low back pain patients
A. Long term pain and functioning outcomes of patients with low back pain demonstrate benefits of both MBSR and CBT versus usual care
B. Mindfulness-Based Stress Reduction (MBSR) improves short term pain and physical functioning among patients with low back pain, when compared with usual care (CORRECT ANSWER)
C. Good quality studies show that mindfulness is effective for patients with chronic pain such as fibromyalgia.
Question for Plenary Session: Balanced Approach to Chronic Pain Mgmt (Kroenke)

What non-pharmacological therapy for chronic pain has the LEAST evidence:

A. Acupuncture  
B. Chiropractic  
C. **Ultrasound** (CORRECT ANSWER)  
D. Massage  
E. Yoga

Question for Breakout Session: Managing Pain in the Patient with Anxiety and/or Depression (Kroenke)

In treating a patient with chronic low back pain and depression, which treatment as the best evidence?

A. Venlafaxine  
B. Escitalopram  
C. Amitriptyline  
D. **Duloxetine** (CORRECT ANSWER)  
E. Milnacipran

Question for Plenary Session: Getting down from great heights (Rieb)

A 46-year-old male millwright with a history of chronic low back pain without neurological findings has been off work for a year, has stopped exercising, hardly leaves house anymore, and leaves all the chores to his wife and young kids. He rates his pain 8-10/10 and is snoring while he sleeps 4 hrs./night. Opioids were the only medication category that he felt worked but despite a number of dose increases it seems to now “only take the edge off”. He is on oxycodone IR 120mg divided QID (180 mg MEDD).

What is the most realistic and safe outpatient opioid adjustment schedule for this gentleman?

A. Increase the daily dose of oxycodone IR by 10 mg/week until pain drops to 3/10  
B. Change oxycodone IR to XR and increase by 10% per month until the pain is tolerable  
C. **Opioid rotate him to buprenorphine plus naloxone and taper off** (CORRECT ANSWER)  
D. Switch him to an equivalent dose of hydromorphone and stabilize
Question for Plenary Session: Pain and Substance use disorders (Rieb)

A 36-year-old woman on methadone 100mg per day has tooth pain and says the dentist told her she needs a root canal, which she cannot afford.

What is your best advice?

A. Add an antibiotic, and a short acting opioid until she can afford to see the dentist  
B. Add an antibiotic, and a non-steroidal anti-inflammatory, and refer her to a subsidized dental clinic (CORRECT ANSWER)  
C. Increase the methadone to 110mg/d  
D. Opioid rotate her to buprenorphine plus naloxone

Question for Breakout Session: Marijuana for Medical Purposes (Rieb)

A 25-year-old Caucasian construction worker presents to your walk-in clinic asking for “medical marijuana” for hand pain secondary to a boxers fracture four weeks ago. He had follow-up yesterday with the orthopedic specialist who took x-rays that showed good alignment and initial healing and gave a prescription for ibuprofen 400 mg i-ii q8h prn. Upon questioning he has used cannabis 2 grams of Sativa strain nearly daily since the age of 15 and gets anxious and craves it if he stops.

What is your answer to his request for medical marijuana?

A. Marijuana for medical purposes federal annual exemptions are not indicated for acute pain conditions  
B. He is ineligible due to a cannabis use disorder  
C. He is ineligible due to safety sensitive work  
D. All of the above (CORRECT ANSWER)

A 22-year-old binge drinking female university student presents to emergency with a painful, swollen, tender ankle, after a twist 3 days prior. She appears sedated yet restless. Her PharmaNet profile shows Ritalin and lorazepam, while her urine drug screen shows amphetamine, morphine, and benzodiazepines. She admits to chewing acetaminophen with codeine over the counter and snorting her Ritalin to try to get pain relief. X-ray shows no fracture.

What is your clinical approach?

A. Wrap the ankle and refer for an addiction medicine consultation. (CORRECT ANSWER)  
B. Ask her to leave and come back when she is sober.  
C. Wrap the ankle and send her home with 20 x oxycodone 5mg with acetaminophen 325mg to take 1 every 6 hours.  
D. Leave her in emerge for your colleagues to deal with her next shift.
2 Questions for Compassionate refusal breakout

A patient 6 weeks post-laminectomy says, “You doctors are all the same. If you felt what I’m feeling you would write that prescription in a minute!”

Your best response is:

A. I can understand that you’d have trouble trusting someone you felt didn’t appreciate your level of pain.
B. I got off the pain meds 1 week after my laminectomy.
C. Post-operative pain shouldn’t last 6 weeks. We need to figure out why you’re still hurting.
D. I’m willing to taper you off over the next 2 weeks.

A patient on chronic opioid therapy has non-prescribed, illicit drugs in her UDS.

Your best response is:

A. I’m willing to treat you for your non-pain problems, but not prescribe opiates for you.
B. I’m willing to continue as your doctor, but not prescribe opiates for you.
C. I need to refer you to a pain clinic in order to continue your opioid medication.
D. I would like to switch you to buprenorphine plus naloxone therapy
E. I will excuse this one slip since you have done well for 2 years, but another dirty urine and I need to discontinue your opiate therapy.

Chadha: non-opiate approaches:

12) A 45-year old patient has chronic low back pain secondary to degenerative disc disease and associated sciatica. He is otherwise fit and well and has no history of asthma, GERD, or renal dysfunction. He has followed your advice over the last 4 weeks by taking periodic acetaminophen, increasing physical activity and stopping smoking. He is seeing a physiotherapist on a regular basis. He has come to see you today to find out if there is anything else he can do for management of his pain. You offer him the following options:

A. PRN acetaminophen + diclofenac + gabapentin + cyclobenzaprine
B. PRN acetaminophen + pregabalin + duloxetine + topical diclofenac
C. Maximum dose acetaminophen + gabapentin + topical lidocaine
D. Maximum dose acetaminophen + PRN diclofenac + pregabalin
E. PRN acetaminophen + PRN diclofenac + duloxetine

13) In the primary care setting, clinical indications for benzodiazepines include ALL of the following:

A. Chronic insomnia, seizure disorder, refractory depression
B. Acute insomnia, dyspnea of end-stage COPD, alcohol detoxification
C. Panic attacks, alcohol detoxification, chronic insomnia
D. Terminal agitation, acute insomnia, alcohol detoxification
E. Dyspnea of end-stage COPD, acute insomnia, refractory depression

Patterson questions:

14) The following is (are) myths about Hypnosis:

A. People will talk more in hypnosis and it acts as a truth serum in ways
B. Hypnosis enhances memory
C. People will commit antisocial acts under hypnosis
D. Most people fall asleep during hypnosis
E. A and B
F. C and D
G. All of the above

15) Which of the following (is) are not true about hypnosis and pain?

A. It is been demonstrated to be superior to or different than placebo
B. Brain processing are seen in hypnosis
C. Hypnosis is more effective for treating chronic as opposed to acute pain
D. Hypnosis is different than meditation as well as relaxation and imagery
E. C and D

Farnan:
Which of the following is not a characteristic of a co-dependent physician?

A. have trouble saying no
B. feel safest while giving
C. receptive to accepting help
D. attract, be attracted to needy people
E. neglect own needs, feel stressed