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Division of Documents Management (HFA-305)
Food and Drug Administration
5630 Fishers Lane
Room 1061
Rockville, MD 20852


To Whom It May Concern:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to submit comments regarding this request for comments, Assessment of Analgesic Treatment of Chronic Pain – A Public Workshop (77 Fed. Reg. 6567, February 8, 2012). The AANA is submitting comments in the following areas:

- Q4. What is known about the sources of chronic pain, the populations affected by it, and trends in current use of pharmaceuticals in its treatment?
- Q6. What data are available from other sources on the use of pharmaceuticals in the treatment of chronic pain?
- Q7. Can populations and individuals who would benefit from chronic use of pharmaceuticals be identified?
- Q8. Can individuals at high risk for adverse effects be identified?
- Q9. What more should be known about the use of pharmaceuticals to treat chronic pain?

Background of the AANA and CRNAs

The AANA is the professional association for more than 44,000 Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists representing more than 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice nurses who personally administer more than 32 million anesthetics given to patients each year in the United States, according to the 2010 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia in the United States for nearly 150 years, and high quality, cost-effective CRNA services continue to be in high demand.
CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services. CRNA services include providing a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.1 Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites, obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

The Institute of Medicine estimates that 100 million Americans suffer from chronic pain at an annual economic and healthcare cost to the United States of up to $635 billion.2 CRNAs, as expert advanced practice registered nurses, are uniquely situated to be part of the solution to the growing national pain problem. Treating pain is within the professional scope of practice of CRNAs.

**RESPONSES TO QUESTIONS POSED IN REQUEST FOR COMMENTS**

Q4. What is known about the sources of chronic pain, the populations affected by it, and trends in current use of pharmaceuticals in its treatment?

Chronic pain can develop from a variety of sources. Chronic pain is associated with progressive skeletal degenerative changes and on-going inflammatory and neurological processes. Pain may arise from bone, nerves, muscle and associated fibers, the sympathetic nervous system, visceral organs, or it may have an underlying psychogenic feature. Chronic pain is distinct from acute pain primarily due to its on-going  

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nature. If acute pain is left untreated, chronic pain can develop over time. Such pain causes both psychological and emotional distress as well as limited functioning. Lack of access to pain care for treatment during an acute phase may also lead to a chronic pain state. Untreated and undertreated pain causes unneeded suffering for both the patient and the patient's family. The Institute of Medicine estimates that 100 million Americans suffer from chronic pain at an annual economic and healthcare cost to the United States of up to $635 billion.2

In addition to the above sources of pain, there may be chronic pain reported without ongoing underlying degenerative or pain-producing disease processes. In these cases, pain may be difficult to identify or may seem excessive for what would commonly be expected to be associated with existing pathological findings. In these situations other factors such as secondary gains, addiction patterns, learned helplessness, personality and psychiatric disorders must be investigated. Primary pain-relieving pharmaceutical medications, such as opioids, anti-inflammatory, and anti-seizure medications should rarely be used in these instances. Unfortunately these patients are often prescribed opioid medications without demonstration of significant benefits and with associated significant health risks.

Proper management of pain requires an appreciation of the role of multiple professional disciplines and multiple treatment modalities. CRNAs are pain practitioners that treat patients with a wide range of chronic pain conditions and in various practice settings. CRNAs are often the sole provider in rural settings. The root basis of anesthesia is pain management. As a result of their education and training, CRNAs are able to treat patients in a holistic manner, as well as perform invasive pain management procedures because they are skilled with needle insertion into delicate areas of the body. If appropriate for the patient, CRNA pain practitioners can administer epidural injections for both therapeutic and diagnostic indications. CRNA pain management practitioners are part of an interprofessional team that may include a coordination of providers throughout the continuum of care. As part of the continuum of care, communication with the patient’s interprofessional team is a key aspect of treating the patient.

CRNA pain management practitioners take a multimodal approach to treating their patients using pharmacologic and non-pharmacologic pain mitigation strategies. CRNAs perform patient histories, evaluations, and order necessary lab work in assessment of the patient. As part of their assessment of the patient, pain practitioners should take into account the patient’s psychological and emotional stability. Learning more about the patient’s family history and motivation may give the pain practitioner additional
insight into the patients perception of pain. For example, a patient who grew up in a family with parents suffering from chronic pain may be conditioned to immediately report pain. Since pain is subjective for each patient, the visual analog score may be an initial indication of pain, but the practitioner should evaluate the patient’s functional abilities as well.

CRNAs treat their chronic pain patients using a graduated multimodal approach. Non-pharmacologic pain mitigation techniques may be employed in treatment of chronic pain such as patient education about pain and behavioral changes (e.g., weight loss, smoking cessation, daily exercise, and stretching), physical therapy to recondition patients, altering a patient’s gait, or chiropractic therapy. These therapies may not be sufficient as monotherapy but have a significant impact when used in a complementary manner. Currently, chronic pain treatment also includes the use of pharmaceuticals such as opioids and other analgesic and adjuvant medications. The current trend includes treatment that may use opioids in conjunction with other active therapies or as a sole agent when other treatment options have been exhausted (e.g., oral non-opioid agents). Those practitioners incorporating pharmaceuticals, especially opioid medications, have a responsibility to prescribe them judiciously, clearly inform patients of risk factors, routinely monitor patient health parameters, and realize a responsible role in preventing abuse and illegal diversion. Mental health services should also be fully engaged as part of the multidisciplinary patient team.

Q6. What data are available from other sources on the use of pharmaceuticals in the treatment of chronic pain?

Data on chronic pain and chronic pain management may be found in registries. These registries include, but are not limited to, the National Outcomes Registry for Low Back Pain,3 Oxycodone User Registry,4 or National Neurosurgery Quality and Outcomes Database.5 Additionally, European registries that may contain information regarding acute or chronic pain include Pain-Out6 and Quality Improvement in Postoperative Pain Management (QUIPS).7 Registries are proposed for development in the United States

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and abroad including the International Pain Registry, an NIH Pain Consortium national pain registry, and a National Fibromyalgia Association Fibromyalgia-specific registry. Additionally, state level prescription drug monitoring programs may serve as a source of information regarding prescribing activities for scheduled medications.

Pharmacy and medical claims can also provide a robust source of pharmaceutical drug usage. Medicare claims may be a readily available source to identify usage of chronic pain medications. Compiling medical and pharmacy claims data allows for additional detail in claims analysis, as it would allow the analyst to look at trends of pharmaceutical use for specific disease states. Pharmaceutical data also allows for drug utilization review and polypharmacy analysis. Private medical insurers and pharmacy benefits managers also have medical and pharmacy claims available for analysis, but because of proprietary information, further regulatory review would need to be done in order to determine whether entities, such as the FDA, can obtain and use that data. Registry, medical claim, and pharmacy claim data are not without their limitations; nonetheless these sources may provide insight into current trends in pharmaceutical use related to chronic pain.

Q7. Can populations and individuals who would benefit from chronic use of pharmaceuticals be identified?

The experience of pain and the challenges faced when dealing with pain are unique to each individual. Pain practitioners must assess each patient and his or her unique situation to determine the most appropriate course of treatment. Treatment plans may involve a multimodal approach, which includes education, physical therapy, adjuvant medications, interventional pain managing techniques, and opioids where appropriate. Based on a patient’s unique situation, previous treatment (e.g., pharmaceutical, physical therapy, or surgery), and varied options of potential treatment, it is not easy to identify a specific population that would benefit from chronic use of pharmaceuticals.

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Q8. Can individuals at high risk for adverse effects be identified?

A known adverse effect associated with opiate use for chronic pain management is the potential for substance misuse and abuse. Behavioral monitoring in conjunction with urine toxicology screening has been used to determine behaviors attributed with inappropriate drug seeking among chronic non-cancer pain patients with pain controlled by prescription opiate medication. In a small study, 43% (53 of 122) of patients demonstrated the potential for substance misuse and abuse by either a positive urine toxicology screen (i.e., illicit substance use, ethanol, or non-prescribed controlled drugs) or at least one behavioral problem. Age and gender were two significant characteristics among those with a positive urine toxicology test and/or behavioral problem after pain was controlled with opioids. In this case, men were more likely to have a positive test, and patients younger than 40 years old were more likely to have a behavioral problem. More robust research is needed to better understand the risk factors associated with the likelihood of abuse in chronic non-cancer pain patients.

Although the study discussed above did not assay the prescribed opiate, some clinicians may choose to routinely test urine to determine opiate levels even though urine toxicology screening has limitations. For example, in a 2004 case report, a refractory migraine patient prescribed with oxycodone was screened for appropriate use by urine immunoassay. The test results were negative, and the patient was later dismissed from the pain clinic with the assumption that the patient was not taking the medication as prescribed and was diverting the drug. The test interpretation was based on a preset minimum detection value of 2000 ng/ml for opiates. The patient demanded that a more sensitive follow-up gas chromatography-mass spectrometry (GC-MS) urine test be performed, and subsequently oxycodone, at 1124 ng/ml, was detected indicating that the patient was taking the opiate as prescribed. This case report demonstrates the negative impact on patient care when a false negative urine immunoassay test has been obtained despite the patient consuming oxycodone as prescribed. Clinicians should have a firm understanding of urine immunoassays, GC-MS, and limits of detection in order to appropriately monitor their patients.

Q9. What more should be known about the use of pharmaceuticals to treat chronic pain?

While opioids play an important role in chronic non-cancer pain management, CRNA pain practitioners often use non-opioid injections as a treatment option when appropriate. Opioids prescribed as the sole treatment modality should not be considered the primary treatment of choice without first exhausting other treatment options.

Additionally, while a concern exists regarding drug diversion and addiction to medications, such as opioids, we question whether the current mechanism of scheduling medications reduces the incidence of misuse and diversion. Scheduled substances continue to be abused and diverted. The AANA encourages the FDA to create an evidence-based mechanism to aid in prevention of substance abuse and diversion, while allowing those patients who truly benefit from medications, such as opioids, to have access to the care they need.

We thank you for the opportunity to comment on the request for comments for Assessment of Analgesic Treatment of Chronic Pain – A Public Workshop; Request for Comments (77 Fed. Reg. 6567, February 8, 2012). The AANA has valuable input to offer the FDA in addressing this and other issues that affect anesthesia and pain care. We look forward to continuing to serve as a resource to the FDA, and we request that the FDA include the AANA in all communication and dialogue on this issue. Please do not hesitate to contact AANA Executive Director Wanda O. Wilson, CRNA, PhD, at (847) 655-1100 or wwilson@aana.com if you have any questions or comments.

Sincerely,

Debra P. Malina, CRNA, DNSc, MBA
AANA President

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
    Ewa Greenier, MPH, MBA, AANA Professional Practice Specialist