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Managing chronic pain patients at the time of COVID-19 pandemic

Flaminia COLUZZI *[1], Franco MARINANGELI [2], Joseph PERGOLIZZI[3]

1 Department of Medical and Surgical Sciences and Biotechnologies, Sapienza University of Rome, Polo Pontino, Latina, Italy

2 Anesthesiology, Intensive Care, and Pain Therapy. University of L'Aquila, L'Aquila, Italy

3 NEMA Research Inc., Naples, FL, USA

**Corresponding author:*

Prof. Flaminia Coluzzi, MD

Department of Medical and Surgical Sciences and Biotechnologies Sapienza University of Rome, Polo Pontino

Corso della Repubblica 79, 04100 Latina, Italy

Tel: +39 3392441090

flaminia.coluzzi@uniroma1.it

ORCID Numbers

Prof. Flaminia COLUZZI 0000-0001-7184-5519

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Pain control has been described as a fundamental human right,[1,2] yet coronavirus COVID-19 pandemic has caused many pain clinics to shut down.[3] The American Academy of Pain Medicine (AAPM) has published guidance advocating telemedicine when possible to manage chronic pain patients and the use of N95 masks along with other personal protective equipment (PPE) for face-to-face consultations with patients with diagnosed or suspected COVID-19 infection.[4] The stress, anxiety, and difficulties associated with the isolation imposed by the pandemic may worsen painful symptoms, increase anxiety, and lead to functional decline.[3] These problems are not trivial; untreated chronic pain can exacerbate depression in 50% of patients and lead to suicidal ideation is 35%.[5]

Triage of pain patients may be helpful in terms of differentiating those who may be adequately treated by telemedicine versus in-clinic consultations. Triage factors include acuity and severity of pain, whether or not the patient has comorbid psychiatric conditions, occupational considerations (such as whether the patient is a first responder), and social situation (such as whether the patient is also a caregiver or has children).[4] In the United States, regulations and reimbursement are being adjusted to accommodate the expansion of telemedicine services for COVID-19 patients, although there are few protocols in place.[6] Telemedicine is safe, but requires the patient to have access to the internet and the ability to use a smartphone or computer. Even in times of pandemic, some pain patients will need in-person care.[7] In such cases, patients and healthcare providers should be screened for COVID-19 symptoms, and appropriate protective measures taken.[7]

Drug Therapy

Opioids

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In the United States, a waiver was granted so that clinicians may use telemedicine to prescribe opioids.[4] While safe prescribing practices for opioids remain appropriate, during this pandemic it may be necessary for pharmacists to extend prescriptions for a limited period of time or to accept verbal physician's orders for refills of controlled substances. In some cases, opioids may be sent or delivered to the patient's home to facilitate the isolation.[7] Despite these changes, patients should still be counseled on the risks and benefits of opioid therapy. Chronic pain patients on long-term opioid therapy may develop distressing withdrawal symptoms if they run out of opioids, which may necessitate a face-to-face visit to help manage withdrawal, stabilize the patient, and resume pain treatment.

Opioids are a class of drugs that can affect the immune system but different opioids may have greater or lesser effects.[8-10] Patients on chronic opioid therapy are more susceptible in general to secondary infections, and it is presumed they are more susceptible to COVID-19 infection as well. Furthermore, the respiratory symptoms of COVID-19 may be exacerbated in patients who take opioids, as these patients are at elevated risk for respiratory depression. There are no recommendations to discontinue opioids in patients on chronic opioid therapy, but clinicians should be aware of their immunosuppressive properties.

Steroids

Steroids suppress the immune system even more than opioids, making their use potentially dangerous in high-risk patients.[4] The AAPM states that physicians may continue to perform epidural and steroid injections in appropriate patients during the COVID-19 pandemic but should use the lowest possible effective dose and patients should be informed about their risk for infection and suppressed immune responses.[4] Steroids are associated with secondary adrenal insufficiency and altered immune system response.[11] Steroids are to be used only with caution in COVID-19 patients.[12]

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Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

While there is controversy about NSAIDs for the treatment of COVID-19 symptoms of fever, headache, and myalgia, neither the Food and Drug Administration (FDA) of the United States nor the European Medicines Agency (EMA) have found an association between NSAIDs and worsened COVID-19 symptoms.[13,14] While this topic is not yet thoroughly elucidated, it seems premature to avoid or discontinue NSAIDs in COVID-19 patients.[15] It has been recommended that chronic pain patients on NSAID therapy should continue their NSAIDs and not rotate to opioids.[16]

Aspirin

Although aspirin is typically not taken as an analgesic, patients taking low-dose aspirin for cardiovascular health should continue aspirin therapy during this time. The anti-inflammatory effects of aspirin occur only at higher doses, about 1 to 4 g per day.[17]

Device Therapy

Intrathecal Drug Pumps

Implanted intrathecal pumps that deliver opioids, baclofen, bupivacaine, clonidine, and ziconotide directly to the intrathecal space, pose an important problem during the pandemic. Such pumps must be refilled by a qualified healthcare professional, typically every 30 days, and the abrupt discontinuation of certain medicines can be associated with severe, even life-threatening, symptoms. In-home refills may be performed by a trained visiting clinician. In those cases where imaging is needed to assure proper refill (for example, for obese patients), the patient may be required to come in to the clinic or hospital.[4]

Neuromodulatory Devices

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Neuromodulation may be continued, but new trials are considered elective and should be deferred until after the pandemic.[7] Patients with difficulties or technical problems with neuromodulation may be able to consult remotely with a clinician or technician for guidance, and the need for an in-clinic visit determined on an individual basis.[7] An in-person visit might be required for suspected device infection, loss of function leading to intolerable pain, and so on. A deeply infected device or lead must be explanted as soon as possible.[18]

Palliation

The concept of specialty palliative care for COVID-19 patients is both new and challenging. For hospitals with robust palliative care units, COVID-19 palliative care may be delivered by telemedicine when possible although round-the-clock remote care must be available.[19] For direct encounters or in-hospital palliation, clinicians would require personal protective equipment (PPE) and such care would likely exclude family.[19] The optimal COVID-19 palliative care model is interdisciplinary but there is little guidance on how to best offer such care.[20]

Conclusion

COVID-19 is imposing unprecedented stress on our healthcare system but in some cases these changes, such as more telemedicine for pain management, may be valuable paradigm shifts that shape the future of modern medicine. Pain does not stop for the pandemic and pain care must continue as well.

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