participants missed a total of 191 work hours due to BTP (mean = 1.9 work hours lost per participant). Many were unable to work due to disability (n = 45; 31.7%) and disability was more common in patients with 2 or more painful conditions (p = 0.004). Anxiety and depression were noted to be prevalent (22.5% reported anxiety, 24.6% reported depression, 16.2% reported both), particularly among those with headache alone or 2 or more painful conditions (p = 0.035). **CONCLUSION:** Patients with BTP frequently seek care to control their pain and also experience productivity loss. Anxiety and depression may add to the economic burden of BTP.

PAIN—Health Care Use & Policy Studies

PPN8

CHRONIC PAIN TREATMENT WITH OPIOIDS: PRACTICE DOES NOT FOLLOW POLICY

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OBJECTIVES: To examine the use of extended release (ER) opioids relative to immediate release (IR) opioids in chronic opioid treatment episodes. **METHODS:** Data from the i3 Innovus Lab/Rx Database were used in this analysis. Enrollees having at least one pharmacy claim for a combination opioid, extended release opioid or immediate release opioid between June-2003 and May-2006 and having at least one year of continuous enrollment beyond the date of their first observed opioid pharmacy claim were included in this analysis. Opioid-related treatment episodes were created by combining contiguous days of therapy allowing for a maximum of a 7-day gap between medication refills. Opioid-containing preparations were classified as either ER or IR formulations. Outcomes are reported in the form of probabilities and odds-ratios. **RESULTS:** A total of 3,993,011 opioid treatment episodes were derived from 1,967,898 patients. Overall, treatment episodes involving IR preparations (97.7%) are more prevalent than treatment episodes using ER preparations (2.3%). The odds of an ER preparation being prescribed chronically (> = 60 days) was approximately 11 times that of an IR preparation, OR = 10.7. The data were further stratified by prescriber-type (designated as pain specialist or non-specialist). The probability of a pain specialist prescribing ER opioids in these chronic episodes was 19.1%; whereas the probability for non-specialists was 13.7%. In comparing the two prescriber groups, pain specialists are about 50% more likely to prescribe ER opioids relative to non-specialists, OR = 1.49. **CONCLUSION:** These data suggest that clinical practice does not follow accepted pain treatment guidelines for chronic pain. Further research will need to be conducted to better understand physician prescribing behaviors as they relate to chronic pain treatment and why the existence of treatment guidelines may not alone be sufficient to promote a medication regimen that will optimize pain care for appropriate patients.

PAIN—Methods and Concepts

PPN9

PERCEPTION OF BREAKTHROUGH PAIN IN PATIENTS WITH CHRONIC PAINFUL CONDITIONS

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OBJECTIVES: To understand how patients with chronic non-cancer pain define and describe breakthrough pain (BTP). **METHODS:** This prospective study included outpatients from a large U.S. tertiary medical center who suffer from chronic pain due to headache, arthritis/rheumatism, musculoskeletal problems, or sickle cell anemia. Data were collected using a 1-week pain diary with questionnaire that captured their perceptions of BTP. Participants were asked to choose a term that best describes a pain flare and a definition of the term they selected. Pain scores were captured using a 10-point visual analog scale (VAS). **RESULTS:** The study cohort included 161 patients (36 with headache, 19 with arthritis/rheumatism, 17 with sickle cell anemia, 8 with musculoskeletal problems, and 70 with ≥2 pain conditions). Most were female (80.1%), white (67.7%), and experienced BTP during the diary week (90.5%). The mean pain level reported during the diary week was 6, and the mean age was 49.3 years. The terms used to describe BTP were "pain flare" (34%), "acute pain episode" (29.1%), "pain crisis" (19.9%), "sudden new pain episode" (16.5%), and "breakthrough pain" (11.9%). There were no differences by pain source except among headache patients, where more than half (52.8%) termed BTP as "an acute pain episode." Most commonly selected definitions for BTP were "sudden pain more than your chronic pain" (31.3%), "a period of pain worse than your controlled pain" (26%) and "a brief episode of pain more intense than your usual pain" (21.3%). There were no differences in preferred BTP definition by pain source. **CONCLUSION:** Patients with chronic pain prefer to use the terms "pain flare" and "acute pain episode" rather than "breakthrough pain" when referring to BTP. The concepts of "brief" and "sudden" appear to be important when defining BTP. Results will be helpful to outcomes researchers who study pain.

PPN10

LINGUISTIC ADAPTATION INTO SPANISH AND PSYCHOMETRIC VALIDATION OF THE NEUROPATHIC PAIN SCREENING QUESTIONNAIRE: ID PAIN

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OBJECTIVES: To achieve a linguistic adaptation and psychometric validation into Spanish of the ID Pain questionnaire for the screening of differential diagnosis of pain with a neuropathic component. **METHODS:** Cross-sectional validation study carried out in two phases: cultural adaptation into Spanish language and validation study to test psychometric properties of the scale in men and women >18 years, with neuropathic (NP) and noniceptive (NNP) chronic pain for more than 6 months. Scale properties of feasibility, reliability and validity were evaluated according to clinical and LANNS scale reference diagnosis. Factor and ROC curves analysis, agreement with reference diagnosis and determination of sensitivity and specificity values were assessed. **RESULTS:** A total of 283 subjects (64.4% women; mean age: 59.1 + 14.9 years), 145 (51.2%) with NP and 138 (48.8%) with NNP were included in the study. Time to completion of questionnaire was 4.2 (3.0) minutes, and 15% of patients needed some help to complete it only. Factor analysis showed a one-dimension scale only, explaining the 37.5% of total variance. The instrument was time-stable (test-retest r-Pearson = 0.98, p < 0.0005). Mean score differentiated NP from NNP patients; 3.5 (1.2) vs. 1.2 (1.4); p < 0.0005. Optimum cut-off value was >3