

THE *ALL NEW* Disability NEWSLETTER

The Educational Newsletter of the American Academy of Disability Evaluating Physicians

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Russell L. Travis, MD, FAADEP

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A Primer for the Disability Evaluating Physician”

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FAADEP

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AADEP CEDIR Exam

PUBLISHED BY

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THE *ALL NEW* AADEP DISABILITY NEWSLETTER

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The Educational Newsletter of the American Academy of Disability Evaluating Physicians

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“THE APPROPRIATE USE OF PAIN MEDICATION”

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WE'RE MOVING!



**THE AADEP CENTRAL OFFICE IS MOVING TO ITS
BRAND NEW LOCATION NOVEMBER 2007!**

PLEASE MAKE A NOTE OF OUR NEW ADDRESS:

**223 West Jackson Blvd
Suite 1104
Chicago, IL 60606**

**Please use PO Box To register for Louisville
Course or Annual Meeting:**

**PO Box 06530
Chicago, IL 60606-6530**

**AADEP 21st ANNUAL SCIENTIFIC SESSION AND BUSINESS MEETING
SCHEDULE 2008
MARK YOU CALENDARS NOW!**



**NEW TIME – THIRD WEEKEND IN JANUARY 2008
NEW SITE – SAN ANTONIO RIVERWALK HYATT**

YOU WILL NOT WANT TO MISS HEARING

INTERNATIONAL EXPERTS

***KIM BURTON, DO, PhD
EUGENE CARRAGEE, MD
NORTIN HADLER, MD
SOHAIL K. MIRZA, MD
DONALD SINCLAIR, JD***

AND
THE BEST AADEP ACTIVE CLINICIANS

GRAB THIS FIRST '08 OPPORTUNITY FOR GREATER MEDICAL KNOWLEDGE WITH
AADEP!

- **BEST NEW EVIDENCE-BASED PRACTICES**
- **“LATEST/GREATEST” SCIENTIFIC KNOW-HOW**
 - **HIGHER MARKETPLACE VALUE**

Preceded by one-full day of Advanced Skills Training of Your Choice – choose from six different topics on Thursday, January 17, 2008 – mix and match! Friday – Saturday, January 18 –19, 2008 Hyatt Riverwalk, San Antonio, Texas

AADEP Continuing Medical Education Mission Statement

PURPOSE

The Mission of the CME Program of the American Academy of Disability Evaluating Physicians is to provide pre-eminent continuing education which will enhance the skills, ensure appropriate disability evaluation and impairment ratings, qualify selected physicians, and promulgate a standardized process of evaluation and in disability management.

In addition, the Academy will aggressively assess and evaluate the complexities of the *Disabled State*, and its causation, designing educational activities to reverse the medical, legal, and social issues contributing to the workers' condition.

The Academy will further this Mission by designing new tools to measure outcomes and the results produced, creating mutually beneficial partnerships with other medical institutions and organizations, continuing to explore and to produce technological innovations for the delivery of continuing medical education, as well as, to produce and provide a relevant, responsive, validated CME Program.

The AADEP CME Program shall focus on improvements to the respective systems, promote the highest quality impairment ratings and return to work recommendations, ensuring greater safety for the injured person.

CONTENT

CME Activity content will include, but is not limited to, disability evaluation, functional evaluation, impairment rating, return to work process, causation, apportionment, scientific basis as it becomes available, societal issues of the disabled worker, and development of the business of disability evaluation. The Academy will continuously strive to validate content, establish scientific basis, and ensure relevancy to the practice of medicine in the disability arena.

TARGET AUDIENCES

The primary audience for AADEP continuing medical education activities will be those MDs and DOs who perform or wish to perform impairment assessments and disability evaluations in their respective venues. Secondary audiences will include, but are not limited to, chiropractors, particularly in those geographic regions in which they play a significant role, ancillary healthcare professionals who support the practice of assessing impairment and disability, attorneys, regulators, legislators, insurance professionals, and medical school personnel.

TYPES OF ACTIVITIES

AADEP will provide live CME activities, including, but not limited to, *Guides* training, Comprehensive Training Courses, Certificate courses, Advanced/Specialty topics, Skills modules, Medical Evidence Conferences, and an Annual Scientific Session. These activities range from one day to four days in length and award Certifications as designed.

These activities may also become available as distance learning modules or activities and may include CD-ROM, audiotape, VHS, DVD, as well as, teleconferences, on-line activities or other electronic formats, all in compliance with ACCME standards.

GOALS

The Academy has set current educational operating goals, which include, but are not limited to:

- Changing the focus of CME activities from disability evaluation and impairment rating to disability management
- Addressing disabled worker in society dilemma collaborating to resolve issues involved
- Increasing learner-faculty interactivity
- Developing multiple formats for each content area
- Designing an electronic evaluation method
- Developing yearlong curricula more consistently
- Assisting faculty members to improve syllabus materials/speaking skills
- Publishing a Newsletter on disability
- Developing self-assessment tools
- Providing an introductory teaching tool for Residency Program Directors

OUTCOMES/RESULTS

In addition to the outcomes encompassed in the introductory paragraph, AADEP will work to ensure improved impairment evaluations, enhanced learning from didactic lectures, improved report writing, better deposition skills, greater support of medical opinions from the legal profession, increased recognition of AADEP by industry and enhancement of Academy members' practices. Results may include well-trained and credentialed disability and impairment evaluation professionals, greater standardization of evaluations, uniformity in disability and impairment evaluation skills and techniques, and increased practice revenues.

Potential for measurement of these outcomes and results will be considered on an annual basis at the Academy's Strategic Planning Retreat. Determination of which activities and results lend themselves to being measurable for the following year's program will be made at that time. Measurement will be evaluated as CME activities evolve and appropriate tools are designed or become available to ensure the greatest impact on the quality and validity of the American Academy of Disability Evaluating Physicians CME Program.

Adopted: May 19, 2005

Reaffirmed: November 11, 2005 /s/



Douglas Martin, MD, President and AADEP CME Medical Coordinator

MESSAGE FROM THE PRESIDENT

RUSSELL L. TRAVIS, MD, FAADEP
LEXINGTON, KY

Your 21st Annual Scientific Session program committee has been hard at work finalizing plans to bring the most outstanding disability evaluating professionals in the world to San Antonio, Texas in January 2008. **Remember**, there is **no** Annual Scientific Session in 2007. The 21st Annual and Advanced Skills programs are **Thursday-Saturday, January 17-19, 2008**. As most of you know, the San Antonio River Walk is an exciting place to be. Our hotel, the Hyatt Regency San Antonio on the Riverwalk is in the middle of all the activity. You can mix some fun in with the exceptional learning only AADEP can offer. By changing the date and the type of facility, we are improving your AADEP access--from both the calendar standpoint as well as an economic perspective. We want to allow you to attend all the important CME activities on your schedule. In January 2008, we will share the best new evidence-based practices and latest scientific studies.

International medical experts presenting in San Antonio include: *Kim Burton, Eugene Carragee, Nortin Hadler, Sohail Mirza*. Check the full schedule of activities for 2008 later in this newsletter. You will want to mark your calendar now. Save the dates of **January 17-19, 2008** to join us in San Antonio.

AADEP now has a foundation. VERITAS MEDICUS has been approved by the IRS as a 501c3 corporation. You may deduct your charitable contribution to this new foundation. Take a minute to evaluate all AADEP has given you during your membership. You can help AADEP continue to excel as an accredited CME provider and the only exclusive provider with both impairment and disability prevention and management expertise. This is your opportunity to be part of the solution to the disability crisis by supporting AADEP's development of specific CME activities to open the way to practice pattern improvements.

Since our last publication, thanks to the hard work of *Doctors Marc Taylor, Douglas Martin, David Randolph, and Executive Director Sandy Yost* we have met and expanded our responsibilities to AADEP Fellows and as an approved Texas CME provider.

Since October 1, 2006, AADEP produced eight Texas-specific impairment rating courses with a daylong session

on the new concepts in the Texas law, including Return to Work, Causation, Extent of Compensable Injury, and Functional Restoration. In addition, Texas doctors were mandated as of May 1, 2007 to use ODG (Official Disability Guidelines) for treatment and the MDA (Medical Disability Advisor) for return to work issues. Doctor Martin, Cecile Childrose of Reed Review Services, and Sandra Yost traveled to offer four half-day sessions in April—two in Houston and two in Dallas. Doctor Trang Nguyen, MD, FAADEP taught this course in July. We expect more Texas courses will be offered to meet the need created by legislative mandate.

In addition, fifty physicians registered in Seattle in mid-April to learn and reinforce their knowledge of the *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition. *Doctors Martin, Charles Brooks and Harold Stockbridge* presented topics specific to the State of Washington and followed trends in the field.

Once again, AADEP will cooperate with the AOCOPM (American Osteopathic College of Occupational and Preventive Medicine) to co-sponsor impairment and disability prevention and management training at the **AOA Annual Meeting on September 29-30, 2007 in San Diego**. *Doctors Martin and Zipper* will again present this program along with *Richard Vatt, DO*.

Many AADEP Fellows are working toward the publication of the Sixth Edition of the *AMA Guides to the Evaluation of Permanent Impairment* due out in December 2007.

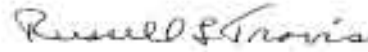
AADEP continues to pursue its recognition by the American Medical Association. Since the Academy's seating in the AMA House of Delegates in June 2005, Delegate David Randolph and Alternate Delegate Douglas Martin have worked to demonstrate AADEP's level of commitment to AMA and its value to the United States Work Force. AADEP was accepted to provide a two-hour CME session at the 2006 AMA Interim Meeting and presented to the Council of Scientific Affairs and Public Health at the 2007 Annual Meeting in June. Doctors Randolph, Martin, and Travis, and Sandra Yost attended to support this exciting effort.

At its January work session, the AADEP Board strengthened its Vision Statement. Pursuing a *vision* to "aspire to be the premiere society for the prevention and management of disability" We are in the process of assessing whether the name, American Academy of Disability Evaluating Physicians, reflects these activities, from impairment rating to the prevention and management of disability. We are also analyzing structure to determine

just what is best suited as we move forward. As you are well aware, AADEP continues increasing its value to members.

I am very excited about the talent coming to San Antonio in January 2008 and look forward to seeing you there.

It has been a busy time since last we communicated. Thanks to a very talented and dedicated Board of Directors and other members much has been accomplished but we still have "Miles to go before we sleep."



Russell L. Travis, MD, FAADEP

TEAR ALONG PERFORATED LINE



To promote truth in medicine for Disability Evaluating Physicians, I hereby Pledge the sum of \$ _____ to the **American Academy of Disability Evaluating Physicians (AADEP)** and agree that this sum shall be paid upon The issuance of an invoice for a tax-deductible contribution in the following manner:

Please Type or Print Clearly

Name: _____

Billing Address: _____

City/State/Zip: _____

TYPE OF PAYMENT CHECK VISA MASTER CARD AMEX

CARD NUMBER _____

CARD VERIFICATION # (3 or 4 digit code on front/back of card): _____

EXP DATE _____ Or CHECK No. _____ (attached)

SIGNATURE _____

This contribution is made in memory of _____

THANK YOU!

Mail or fax this pledge card to the AADEP office at
150 North Wacker Drive, Suite 1420, Chicago, Illinois 60606-1606
Toll-Free: 800/456-6095, Direct: 312.658.1171, Fax: 312.658.1175, E-Mail: aadep@aadep.org, Web Site: www.aadep.org

It's always New! We invite you to send your contributions for future newsletters to aadep@aadep.org.

PRACTICAL SOLUTIONS FOR DISABILITY MEDICINE

Thursday, January 17, 2008
Hyatt Regency San Antonio

SYLLABUS WILL BE CD-ROM

BRING LAPTOP TO FOLLOW POWERPOINT SLIDES

Advanced Clinical Skills: Bettering Your Bottom Line By Adding Expertise

OR

Career Transition IMEs/Peer Review Boot Camp

OR

Using MDA/ODG Guidelines Effectively

- Practical solutions for the problems you face
- Sweeping changes in disability management
- Ever growing source of science
- The deciphering of the guidelines

NEW AADEP FEATURES

TEXAS DESIGNATED DOCTOR AND PHYSICIAN TRAINING COURSE

CAREER TRANSITIONS - A Who, What, Where of IMEs and Disability Evaluation for those physicians interested in developing a consultative disability practice

USING MDA/ODG MORE EFFECTIVELY

YOU HAVE COME TO EXPECT

SPEAKERS - Who have active clinical practices in disability evaluation to answer your questions

BACK BY POPULAR DEMAND - Starting off on Thursday, January 17, 2008 with the evolving advanced clinical skills you need to continue improving your bottom line through expertise and practice development

- Freeman and Waldner - The Legal System's Impact on YOUR Practice
- Talmage and Travis – Discograms SCS, Lumbar Fusion, ADR and IDET
- Blair, Doyne, Pilley and Zipper – Opportunities Trends, Deposition Skills, Legal Pitfalls
- Novak and Nemeth - Pharmacologic Abuse: Injections, Facets, Stimulators, Pumps, Narcotics for Neuropathic Pain
- Taylor and Tonn – Critical Case Analysis – From Injury to Outcome

LET AADEP HELP YOU SEE THE REAL OPPORTUNITY FOR YOUR PROFESSIONAL FUTURE AND YOUR PRACTICE!

MAKE IT YOUR SOURCE FOR SCIENTIFIC EVIDENCE

TWENTY-FIRST ANNUAL SCIENTIFIC SESSION

PRELIMINARY AGENDA

Friday - Saturday
January 18-19, 2008
Hyatt Regency San Antonio

PICKING YOUR BATTLES: FIGHTING THE GOOD FIGHT USING EVIDENCE

SYLLABUS WILL BE CD-ROM
BRING LAPTOP TO FOLLOW POWERPOINT SLIDES

Reception/Banquet Dinner
Friday, January 18, 2008

EVIDENCE AND DISABILITY

Russell Travis, MD, FAADEP/Douglas Martin, MD, Moderators

8:00 am	Welcome and Announcements <i>Russell Travis, MD, FAADEP/Douglas Martin, MD</i>
8:10 am	Keynote Address Insights in Discography, and MRIs For Low Back Pain <i>Eugene Carragee, MD</i>
8:50 am	Questions/Answers
9:00 am	The Relation of Minor Trauma to Disability <i>Eugene Carragee, MD</i>
9:40 am	Questions/Answers
9:50 am	BREAK <i>Melissa Tonn, MD, MPH, MBA, FAADEP/Alan Colledge, MD, FAADEP, Moderators</i>
10:15 am	“Work is Good for Your Health” <i>Kim Burton, DO, PhD</i>
10:50 am	Questions and Answers
11:00 am	“The Last Well Person” <i>Nortin Hadler, MD</i>
11:50 am	Questions and Answers
12:00 noon	Tentative BONUS LUNCH (Watch for Topic Announcement) <i>Melissa Tonn, MD, MBA, FAADEP, Moderator</i>
	TITLE (TBA) <i>Donald Sinclair, JD</i>
	<u>SURGICAL INTERVENTIONS</u> <i>Russell Travis, MD, FAADEP/Mark Doyne, MD, FAADEP, Moderators</i>
1:30 pm	Does the Increase in Spine Surgery Reflect an Increase in Disease? <i>Sohail Mirza, MD</i>
2:10 pm	Questions/Answers

2:15 pm **What the Evidence Shows: Spinal Fusion in Workers' Comp**
Trang Nguyen, MD, FAADEP

3:00 pm **BREAK**
David Randolph, MD, MPH, FAADEP/Mark Pilley, MD, FAADEP, Moderators

3:15 pm **Rising Rate of Back Surgery and its Effect on Disability in the Workplace**
Sohail Mirza, MD

4:00 pm **Fellow Presentations (2)**

4:30 pm **Outgoing Presidential Address**
Russell L. Travis, MD, FAADEP

4:40 pm **Incoming Presidential Address**
Edwin Klimek, MD, FAADEP

4:50 pm **Annual Business Meeting**

5:30 pm **RECESS**

7:30 pm **RECEPTION**

8:30 pm **DINNER**

Saturday, January 19, 2007

Using this Conference to Improve Your

Exams/Reports

Mark Melhorn, MD, FAADEP/Elizabeth Genovese, MD, MBA, FAADEP, Moderators

8:00 am **Pharmacologic Abuse: Narcotics**
Suzanne Novak, MD, PhD, FAADEP

8:30 am **The Washington State Opioid Guidelines**
Hal Stockbridge, MD

9:00 am **Comparison of ODG/ACOEM Guidelines**
Douglas Martin, MD, FAADEP

9:30 am **Panel Discussion of Guidelines**
Faculty

9:45 am **BREAK**
Marc T. Taylor, MD, FAADEP, Moderator

10:15 am **Can I Send Joe Back to Work?**
James B. Talmage, MD, FAADEP

11:45 am Questions/Answers

Noon **Medical/Legal Interface: How to Use It To Your Advantage**
Don C. Sinclair II, JD

1:00 pm **ADJOURNMENT**

2:00 pm **CEDIR EXAM**

2007 CALENDAR OF LIVE CME ACTIVITIES

(All courses, Titles, Schedules, Dates, and locations, subject to change)

Bettering Your Bottom Line: Through Good Medicine

Designed for Human Resource Professionals, Risk Managers & Benefit Coordinators
(Special Discount for Members of SHRM)
 November 30, 2007
 (Friday)
 The Brown Hotel
 A Camberley Hotel
 Louisville, KY

The Injured Worker – Do No Harm

December 1-2, 2007
 (Saturday-Sunday)
 The Brown Hotel
 A Camberley Hotel
 Louisville, KY

2008 CALENDAR OF LIVE CME ACTIVITIES

(All courses, Titles, Schedules, Dates, and locations, subject to change)

Designated Doctor and Physician Training Course

March 1-2, 2008
 (Friday-Saturday)
 Intercontinental Houston Hotel
 Houston, TX

Designated Doctor and Physician Training Course

May 2-3, 2008
 (Friday – Saturday)

Concurrently with Annual Comprehensive Training Program

May 3-5, 2008
 (Saturday - Monday)
 Renaissance Austin Hotel
 Austin, TX



OFFICE USE ONLY

Meeting Code: _____

Amount charged _____

\$ _____

2007-2008 Registration Form

PLEASE TYPE OR PRINT CLEARLY

↓ First Name: _____ Middle Initial - Name: _____

↓ Last Name: _____ Nickname: _____

↓ Degree/Title: (MD,DO,DC,RN,PT,OT, If other- please specify) _____ ↓ Specialty: _____

↓ Postal Address: _____

↓ City / State / Postal Code: _____ ↓ Country: _____

↓ Work Phone: _____ / _____ ↓ Work Fax: _____ / _____ ↓ Email: _____

Payment Information:	Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Amex							
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PLEASE NOTE: SOME MEETING DATES ARE SUBJECT TO CHANGE

Please X the box for specific meeting that you wish to register for.

The Syllabus will be provided on CD-ROM. Bring a Laptop if you would like to follow PowerPoint slide presentation.

X	Meeting date(s)	Course Title and Location	AADEP Pre-registration cut-off date Register On-Site after this date	Registration Status	FEES:	
					Pre-reg	On-site
	November 30 (Thursday)	Bettering Your Bottom Line: Through <i>Good</i> Medicine Louisville, KY	Nov 21, 2007	<input type="checkbox"/> Members of Society of Human Resource Management (SHRM) Alexandria, VA www.shrm.org	\$295	\$370
				<input type="checkbox"/> Non-Members of Society of Human Resource Management (SHRM) Alexandria, VA www.shrm.org	\$395	\$470
	December 1-2 2007 (Saturday-Sunday)	The Injured Worker – Do No Harm Louisville, KY	Nov 21, 2007	All Attendees	\$475	\$550
		<i>Meeting Code: 072100</i>		<input type="checkbox"/> CME Special Contribution (optional donation)	\$30	
		<i>Meeting Code: 070900</i>				

January 17 2008 Thursday Advanced Skills Development	<input type="checkbox"/> Advanced Skills Development <i>Meeting Code: 080100</i> OR <input type="checkbox"/> Career Transitions <i>Meeting Code: 080200</i> OR <input type="checkbox"/> MDA/ODG Guidelines <i>Meeting Code: 080500</i> San Antonio, TX	Jan 4, 2007	<input type="checkbox"/> Full Day (Physicians and Attorneys)	\$475	\$550
			<input type="checkbox"/> Full Day (Non Physicians) Ask about Multiple Registration Discounts	\$250	\$325
			<input type="checkbox"/> Half Day (Includes Lunch) Please Choose AM or PM: <input type="checkbox"/> AM <input type="checkbox"/> PM	\$345	\$420
January 17-18 2008 Thursday-Friday	Designated Doctor and Physician Training Course San Antonio, TX <i>Meeting Code: 080300</i>	Jan 4, 2007	<input type="checkbox"/> Physician (MD, DO, DC) TWO DAY COURSE	\$495	\$545
			<input type="checkbox"/> Other Health Care (PT, OT) ONE DAY COURSE (FRIDAY)	\$295	\$345
January 18-19 2008 Friday-Saturday	21st Annual Scientific Session and Business Meeting San Antonio, TX <i>Meeting Code: 080400</i>	Jan 4, 2007	<input type="checkbox"/> Non-Member Physicians	\$595	\$670
			<input type="checkbox"/> AADEP, Member	\$545	\$620
			<input type="checkbox"/> AADEP, Fellow	\$495	\$570
			<input type="checkbox"/> Other Med Prof.	\$495	\$570
			<input type="checkbox"/> Non-Med Prof.	\$495	\$570
			<input type="checkbox"/> CME Special Contribution (optional donation)	\$50	N/A
Additional Annual Meeting Fees	21st Annual Scientific Session and Business Meeting San Antonio, TX	Jan 4, 2007	<input type="checkbox"/> Nurse Case Managers	\$195	270
			<input type="checkbox"/> Insurance Claims Representatives	\$195	270
			<input type="checkbox"/> Spouse Registration	\$150	N/A
			<input type="checkbox"/> Friday Bonus Lunch	\$50	N/A
			<input type="checkbox"/> Additional Reception Guest	\$85	N/A
			<input type="checkbox"/> Additional Banquet Guest	\$75	N/A

Mail or Fax this form	AADEP Attn: Registration PO Box 06530 Chicago, IL 60606-6530	Phone: (312) 658-1171 OR (800) 456-6095 Fax: (312) 658-1175 **Please note: If you fax your registration form, please do not mail a hard copy**
TX CEDIR EXAM	DWC Approved Impairment Rating Testing – Given at all Texas DD Courses	Fee: \$475 Request Separate Registration Form
AADEP CEDIR EXAM	Certification in Evaluation of Disability and Impairment Rating – Given at all Courses	Fee: Non-Members: \$475; Members: \$375; Fellows: \$275 Request Separate Registration Form
Cancellation Policy	There is a \$100 service fee (unless otherwise noted) for all cancellations received from the time of registration until two weeks before the scheduled meeting dates. No refunds will be given after this date and no refunds will be given for no shows.	
How did you hear of this meeting?	<input type="checkbox"/> Mailing <input type="checkbox"/> Web Site <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other _____	
Emergency Contact Information	Name: _____ Phone Number: _____	
Hotel Information	<u>Be available for networking by staying in the host hotel.</u> <u>Hotel and meeting location information to be announced as the year progresses.</u> <u>Hotel Information will be sent with your confirmation letter.</u>	

2007-2008 HOTEL INFORMATION

Meeting date(s)	Course Title and Location	Hotel Name & Address, Phone & Fax	Hotel Rates & Reservation cut-off dates
Dec 1-2, 2007	AMA Guides Impairment Rating Course 5 th Edition Louisville, KY	The Brown Hotel A Camberley Hotel 335 West Broadway Louisville, KY 40202 Toll-Free: 888-888-5252 Direct: 502-583-1234	<u>Hotel Rates:</u> \$119 Single/Double Occupancy <u>Hotel Deadline:</u> October 31, 2007
Jan 17, 2008 Jan 18-19, 2008	Advanced Skills Development/Career Transitions/MDA/ODG Guidelines 21 st Annual Scientific Session and Business Meeting San Antonio, TX	Hyatt Regency San Antonio On the Riverwalk at Paseo del Alamo 123 Losoya Street San Antonio, TX 78205 Toll-Free: 800/233-1234 Direct: (210) 222-1234	<u>Hotel Rates:</u> \$189 Single/Double Occupancy <u>Hotel Deadline:</u> December 26, 2007



A National Physician Service Network

www.messolutions.com

MES Solutions, the nationwide leader in facilitating Independent Medical Evaluations and Peer Reviews since 1978, seeks providers to perform IMEs and Peer Reviews in the following benefit delivery systems: Workers' Compensation, Auto Liability, Personal Injury, Disability, Longshore and Harbor and other federal examinations.

MES Solutions handles all administrative and management functions associated with IMEs and Peers, including:

- Scheduling
- Transcription
- Quality Review
- Billing/Collections
- Marketing

IMEs are an excellent way to supplement your income and **MES Solutions** offers very competitive compensation, paid twice monthly, upon receipt of your report.

AADEP OFFERS

USING MDA AND ODG GUIDELINES IN TEXAS WORKERS' COMPENSATION

AADEP Guidelines Education Courses
INTERACTIVE Computer Lab Courses

To make your use of **ODG/MDA** more accurate and faster

Thursday – January 17 8am

San Antonio

SPACE IS LIMITED TO 20
At least 10 must register per session to
 AVOID CANCELLATION REGISTER NOW

Course Objectives:

In completing this course, the learner should be able to:

- **Understand EVIDENCE-BASED MEDICINE concept and its importance**
- **Apply MDA/ODG Guidelines accurately**
- **Perform hands-on search and application of Guidelines**
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FEATURE ARTICLE

“The Appropriate Use of Pain Medications - A Primer for the Disability Evaluating Physician ”

Steven Mandel, MD, FAADEP

Clinical Professor of Neurology at Jefferson Medical College

Olga A. Katz, MD, PhD

Clinical Assistant Professor

Nikita B. Katz, MD

Clinical Assistant Professor

Most of the drugs of abuse are in medications for which the primary use is the alleviation of pain. This chapter is about the appropriate use of pain medications and is presented as a guide for professionals who are struggling with the question of what is appropriate and what is the inappropriate use of these medications.

This chapter will cover the definition, physiology, measurement, and function of pain; the classification of pain and need for pain relief; the AAPM and the APS consensus statement; and the use of opioids in pain management.

DEFINITION OF PAIN

In order to treat pain, one should be able to define and classify it. Remarkably, there are numerous definitions, even though the sensation of pain is familiar to almost all human beings. The only way to objectively define and determine what pain may be is offered by the advances in functional neurology, that is, the measurement and scientific analysis of the relationship between the subjective experience of pain and objective manifestations of it, such as the firing of the specific neurons in the spinal cord and the brain or changes in the patient's physiological and biochemical parameters.

Any attempt to divorce the experience of pain from the neurology of pain is going to be misleading and potentially harmful, as well as logically unsound. Such attempts lead to formulation of definitions of pain that are meaningless because pain is a very personal and subjective experience that is defined as whatever the patient says it is and exists wherever he or she says it does. They are also potentially harmful

given the fact that all existing pain remedies have side effects. Many will cause rebound of pain if discontinued, and the most potent pain relief medications are almost universally addictive.

PHYSIOLOGY OF PAIN

The term *pain* is a subjective experience that typically accompanies nociception. However, pain may also arise in the absence of any stimulus, and thus the proper definition of pain should include the emotional response to an actual or potential harm. Nociception, on the other hand, is a purely neurophysiological term that denotes specific activity in nerve pathways. (Table 7.1) (1,2,3)

Nociceptive inputs are mediated through a complex system of receptors and pathways. From the affected organ, the nociceptive signal is transmitted through the first order neuron via the dorsal root to a synapse in the spinal cord from where the second order neuron ascends through the spinothalamic tract. The main pathway ascends through the dorsal horn of the spinal cord, crosses the midline to the opposite side of the spinal cord, and reaches the brain's thalamus through the anterolateral white matter. From the thalamus, the signal is transmitted through the third order neuron to the somatosensory cortex.

Modern, highly reliable, and sophisticated neuroimaging techniques such as positron emission tomography (PET) have helped to identify the cortical networks involved in processing of nociceptive stimuli. For example, a number of studies showed that the activity in the periaqueductal gray matter (PAG) in the midbrain increased during a cold pressor test. Remarkably, these areas are also parts of the brain "punishment" pathway. Areas of the cortex, such as primary and secondary somatosensory cortex, the anterior cingulate cortex, and the rostral insula are directly involved in perception and evaluation of the painful stimulus.(1)

Many studies concentrate on the role that the anterior cingulate cortex plays in the processing of the psychological (affective) component of pain and attempt to quantify the suffering and unpleasantness experienced by the patient through objective measurement of brain activation.(2) We may safely assert that there is a way to measure pain and pain relief. Even though the cost of PET and other modern techniques of visualizing activity of the brain are currently prohibitive for widespread use, future

physicians may be able to objectively measure both the pain and the pain relief offered by a specific medication, thus eliminating the reliance on subjective measures and self-reporting.

MEASUREMENT OF PAIN

There are two qualitative descriptors of perceived pain: pain threshold and pain tolerance. Pain threshold is the lowest level at which the individual perceives the stimulation as painful, and tolerance is the highest level tolerated of a perceived painful stimulus. These descriptors depend on the ability to measure and scale pain as experienced by the patient.(3)

There are many different types of pain scaling techniques, usually classified as nominal scales, ordinal scales, and ratio-interval scales. All are potentially useful but also have limitations.

The nominal pain scale is a scale where the dependent variable only differs in quality, not in absolute order or relative size, such as “pain” or “no pain” as a way to determine threshold in response-dependent trials. This scale is very easy to use and easy to understand but is easily influenced by instruction, placebo effect, and bias of the patient.

The ordinal scale provides a ranking of scores, such as “no pain,” “mild,” “moderate,” or “severe” pain. This scale is normally easy to understand for the patient and easy to use for the examiner. An example of a more developed approach is the McGill Pain Questionnaire (MPQ), which incorporates, among other features, an ordinal scale measuring pain intensity. Furthermore, the patients can choose descriptions of their pain from 20 word groups to specify their subjective pain experience, such as jumping, flashing, shooting, nagging, nauseating, agonizing, dreadful, or torturing. The patient’s responses are primarily divided into three subclasses that reflect the sensory, affective, and evaluative components of the pain experience. Together, all the values can be added to give a pain assessment value between 1 and 77.(4)

The ratio-interval scales can measure the order, number, difference, and ratio between scores. An example of this type of scale is the visual analogue scale (VAS). The VAS is widely used in pain studies and consists of a line or scale, at each end labeled with statements appropriate for describing the extreme values of the sensation: one

end is often labeled “no pain” and the other end is often labeled “worst possible pain.” The subjects rate the perceived pain by placing a marker or simply tick the line in relation to the two extremes. The VAS has been shown to be useful for separate measures of pain intensity and unpleasantness and has been modified for use with children and other special categories of patients.

FUNCTION OF PAIN

As pain is a critical component of the body’s defense system, the ability to experience pain or irritation is observed in all animals. Pain encourages an organism to disengage from the noxious stimulus associated with the pain. Preliminary pain can serve to indicate that an injury is imminent, such as the ache from a soon-to-be-broken bone. Pain may also promote the healing process, since most organisms will protect an injured region in order to avoid further pain. Rarely, people are born with congenital insensitivity to pain. These persons usually have short life spans and suffer numerous dangerous ailments such as unnoticed broken bones, bedsores, and chronic infections.

CLASSIFICATION OF PAIN

Pain has been classified in many ways. Based on pain’s duration, we classify pain as acute (usually of short duration, less than 6 months) or chronic pain (usually more than 6 months). Based on anatomy, pain may be classified as originating in specific parts of the body, such as abdominal pain. Many physicians also use the mechanism-based classification of pain in which a distinction is made between transient pain and persistent pain. Transient pain refers to the response to a painful (noxious) stimulus that does not produce long-term consequences, while chronic pain is the response that does produce long-term consequence.

Pain is not a single-dimensional experience. There is evidence that the pain experience can be viewed as the product of at least two dimensions: the sensory-intensive and the affective component.(5)

The sensory-intensive dimension of pain is a measure of how intensely the pain is perceived (perceived pain intensity), and the affective component describes how much the pain bothers the subject (unpleasantness). The two dimensions of pain can successfully be quantified by the use of various scales and must never be confused. In fact, recently,

the affective component of the pain experience has been proposed to be divided into the primary unpleasantness, associated directly to the stimulus, and a secondary unpleasantness linked with higher levels of activity and emotion.(6)

Further complicating the effort to measure pain and assess the progress of the patient and the efficacy of pain relief is the experimentally established fact that the same painful stimulus is perceived differently in an experimental set-up compared with a clinical situation.(7)

NEED FOR PAIN RELIEF

Pain relief is necessary for millions of patients. It is the physician's duty to establish a pain management plan for every patient who complains of pain or who, due to an inability to communicate, does not complain but is observed to be suffering from pain. Pain management in the addicted patient, including Drug Court clients, presents unique challenges.

Pain management benefits from a multidisciplinary approach that includes:

1. Pharmacologic measures: Analgesics such as non-steroidal anti-inflammatory drugs and opioids.
2. Pain modifiers: Antidepressants, anticonvulsants, or anesthetics such as lidocaine.
3. Interventional procedures: Epidural steroid injections, joint injections, neurolytic or anesthetic blocks, spinal cord stimulation, and intrathecal (into the spinal cord) drug delivery systems.
4. Non-pharmacologic measures: Physical therapy, ice, and heat.
5. Psychological measures: Biofeedback, cognitive therapy, and coping-oriented counseling.(8,9)

AAPM AND THE APS CONSENSUS STATEMENT

In 1996 two leading American professional organizations, the American Academy of Pain Medicine (AAPM) and the American Pain Society (APS) approved a proclamation regarding the use of opioids in management of chronic pain. This was a milestone in recognition of the risks and benefits of the use of these effective but potentially addictive medications and their potentially toxic side effects.

The AAPM and APS asserted that the management of pain has become a high priority in the

United States. In the last several years, health-policymakers, health professionals, regulators, and the public have become increasingly interested in the provision of better pain therapies. This is evidenced, in part, by the U.S. Department of Health and Human Services' dissemination of Clinical Practice Guidelines for the management of acute pain and cancer pain.(8,9)

These publications, which have been endorsed by AAPM and APS, stated that opioids, sometimes called narcotic analgesics, are an essential part of a pain management plan. There is currently no nationally accepted consensus for the treatment of non-cancer chronic pain, yet the economic and social costs of chronic pain are substantial.

In the opinion of the AAPM and the ASP, pain is often managed inadequately despite the ready availability of safe and effective treatments. They also assert that pain is one of the most common reasons people consult a physician, yet it frequently is inadequately treated, leading to enormous social cost in the form of lost productivity, needless suffering, and excessive healthcare expenditures.(8)

The authors of the proclamation admit that the impediments to the prescribing and use of opioids include concerns about addiction, side effects, tolerance, diversion, and fear of regulatory action.

One of the most important myths that the AAPM and ASP seek to amend is the issue of addiction. They assert that "Misunderstanding of addiction and mislabeling of patients as addicts result in unnecessary withholding of opioid medications." To a physician, any patient in pain is first and foremost a patient who needs care, compassion, and pain relief. Further, although the issue of addiction is bound to complicate the boundaries of necessary and sufficient, it should not be viewed as an insurmountable issue. Neither should the issue of tolerance.

The authors recognized diversion of pharmaceuticals to illegal use as the most erosive and dangerous problem associated with the use of opioids for pain management, especially chronic pain management. However, they seek a more permissive view of the problem. According to the statement, diversion of controlled substances should be a concern of every health professional, but efforts to

stop diversion should not interfere with prescribing opioids for pain management.(9)

Finally, among other concepts, the AAPM and the APS attempted to establish the principles of good medical practice that should guide the prescribing of opioids. They believe that guidelines for prescribing opioids should be an extension of the basic principles of good professional practice.

Such basic principles include:

1. Careful evaluation of the patient.
2. Treatment tailored to the individual and presenting problem.
3. Consultation if warranted.
4. Periodic review of treatment efficacy.
5. Documentation of the evaluations and plan.

Careful Evaluation of the Patient

The evaluation of the patient may include a history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous interventions, a drug history, and an assessment of coexisting diseases or conditions. An opioid trial should not be done in the absence of a complete assessment of the pain complaint.

Treatment Tailored to the Individual and the Presenting Problem

The treatment plan is tailored to both the individual and the presenting problem. According to AAPM and APS, consideration should be given to different treatment modalities, such as a formal pain rehabilitation program, the use of behavioral strategies, the use of noninvasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. If a trial of opioids is selected, the physician should ensure that the patient or the patient's guardian is informed of the risks and benefits of opioid use and the conditions under which opioids will be prescribed. Some practitioners find a written agreement specifying these conditions to be useful.

Consultation if Indicated

Consultation may be indicated, depending on the expertise of the practitioner and the complexity of the presenting problem. The management of pain in patients with a history of addiction or a comorbid psychiatric disorder requires special consideration,

but does not necessarily contraindicate the use of opioids.

Periodic Review of Treatment Efficacy

Review of treatment efficacy should occur periodically to assess the functional status of the patient, continued analgesia, opioid side effects, quality of life, and indications of medication misuse. Periodic reexamination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life as a result of opioid use.

Careful Documentation

Documentation is essential for supporting the evaluation, the reason for opioid prescribing, the overall pain management treatment plan, any consultations received, and periodic review of the status of the patient.

USE OF OPIOIDS IN PAIN MANAGEMENT

The goals of pharmacologic and nonpharmacologic pain interventions in chronic pain are to reduce pain and to enhance rehabilitation through clinically significant improvements in functional status. The World Health Organization analgesic ladder model has been proven useful for the pharmacologic management of chronic pain (Table 7.2).(10)

According to this model, the choice of analgesic therapy is based on pain intensity:

1. Mild-to-moderate: Should be treated with nonopioids, such as acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs).
2. Moderate-to-severe: Should be treated with a combination of a nonopioid and a weak opioid.
3. Persistent severe: Should be treated with a strong opioid and NSAID combination, plus a drug for breakthrough pain, if such pain is observed in the patient.

According to the APS guidelines, in chronic noncancer pain, opioids should only be used when nonopioid medications and nonpharmacologic methods are ineffective at controlling pain or negatively affect quality of life. The WHO also recommends consideration of opioid therapy for chronic noncancer pain conditions when pain is not sufficiently controlled.(9,10)

Portenoy proposed guidelines for the use of opioids in noncancer chronic pain which focus on achieving optimal efficacy and safety and take into account the potential risks for substance abuse with long-term therapy. According to these guidelines, providers should consider using opioids only after treatment with all other analgesics has been unsuccessful or if all other analgesics are inappropriate given the intensity of pain experienced. However, the guidelines also suggest that on the basis of the type of pain experienced (somatic or visceral) and severity (moderate to severe), opioids are not to be thought of as a treatment of last resort. It is also noted that opioid use may not be appropriate for patients with a history of substance abuse or severe character pathology. In addition, the guidelines recommend that a single provider be responsible for pain treatment, that the provider establish goals of treatment before therapy begins, and that the risks for treatment be discussed with each patient. Lastly, the guidelines state that evidence of abuse may require prompt discontinuation of therapy and intervention by an addiction specialist, and that proper and complete documentation is mandatory, including a comprehensive reassessment of abuse with each visit.(11)

As the AAPM and APS noted, the concern cited most frequently by providers, patients, and the lay public in regard to the use of opioids to treat chronic pain is their potential for abuse. This concern is reflected and emphasized by their classification as scheduled narcotics. Considering that prescription opioid abuse is 400 percent higher today than it was in the 1980s, this concern is warranted.(11)

Although the social acceptance of prescribed opioids is generally greater for chronic cancer pain, healthcare providers should not assume that cancer or noncancer pain patients are less likely than the general adult population to abuse opioids. A history of substance abuse is as significant a risk factor for cancer patients as for others, so physicians should consider individual vulnerabilities and monitor their patients closely while undergoing treatment.

It is important to remember that the risk of addiction is inherent in the patient, not in the drug, and relies on a complex interaction among genetic, behavioral, and pharmacologic factors. Therefore, if the clinician decides that the patient's drug-taking

behavior is aberrant, a differential diagnosis should include:

1. **Addiction:** The most commonly abused opioids are short-acting and potent agents, such as oxycodone and hydrocodone, as the ability to induce euphoria is related to the rate at which the drug enters the brain, which is very high for these medications.
2. **Pseudoaddiction:** Seeking higher doses of the drug to relieve pain that is under-controlled due to inadequate amounts of prescribed analgesic.
3. **Neurological and psychiatric conditions:** Including encephalopathy, borderline personality disorder, depression, and anxiety.
4. **Criminal intent:** Not all aberrant behaviors are indicative of criminal intent and not all of them are equally alarming, although an aggressive, loud patient demanding a pain medication may seem to be more aberrant and is more likely to be suspected of criminal intent. Potentially more dangerous is the patient who quietly solicits the drug in increasing quantities, possibly facilitating hoarding and diversion.

Strategies to Address Abuse and Addiction

The prevalence of drug abuse, dependence, or addiction in noncancer pain patients is estimated to range between 3 percent and 19 percent, depending on the history of substance abuse and the length of exposure to opiates. Aberrant drug-taking behaviors occur more frequently in patients with a history of substance abuse.(12)

In a well-designed study, Passik discovered that approximately 40 percent of patients with chronic noncancer pain have 1 or 2 aberrant drug-taking behaviors within a 6-month period, whereas 20 percent of patients have 3 or more aberrant behaviors during this period.(13)

There are several useful and methodologically sound approaches to prescreening patients that may be at risk of drug abuse and identifying patients in whom opioids can be used safely and effectively. All candidates for opioid therapy should be screened and selected for specific therapy that corresponds to their pain characteristics and psychosocial and behavioral specifics. In addition, it is important to optimize drug

administration and conduct ongoing, long-term monitoring of multiple behavioral domains.

Screening measures include the 24-item self-administered Screener and Opioid Assessment for Patients with Pain (SOAPP) questionnaire created by a panel of 26 pain and addiction experts who reached consensus on the most important characteristics that predict future medication misuse. The resulting questionnaire (SOAPP) was later validated and shortened to 14 questions that may be used for prescreening patients who may be at risk for substance abuse and addiction.(14)

Another questionnaire, the Opioid Risk Tool (ORT), consists of only 5 questions but has been shown to effectively predict aberrant behaviors and classify potential risk on opioid therapy as high, moderate, or low. The authors of this questionnaire note that ORT significantly predicted aberrant behaviors among chronic pain patients at 1-year follow-up; more than 90 percent of patients who displayed aberrant behaviors had been classified as likely to abuse opioids. Furthermore, men were significantly more likely than women to display at least 1 aberrant behavior.

Another rapid and short questionnaire is the Screening Instrument for Substance Abuse Potential (SISAP), which also includes only 5 questions but has been shown to be effective in identifying patients with a substance abuse history on the basis of criteria from the National Drug Abuse Survey. In an initial validation study, the authors found that this questionnaire was highly accurate at classifying substance abusers. However, it was also found to have exceedingly strong prosecutorial bias: 18 percent of patients were falsely classified as substance abusers. As such, the authors concluded that "SISAP may have the greatest clinical utility when used as adjunct to more comprehensive measurement instruments and in cases when the patient is well known to the provider."(15,16)

A longer, more labor-intensive instrument is the Pain Medication Questionnaire (PMQ), a 26-item self-report instrument to assess opioid misuse by patients while on therapy. This is a needed development, as the previous instruments are limited to patients not receiving any opioids and thus are only useful in prescreening. The PMQ, according to the authors, may have additional value in identifying

pain patients for whom multidisciplinary pain care is indicated, although this claim remains to be validated.(17)

In a recent study, Lusher assessed the relationship between hypothesized drug-use behaviors, pain-coping strategies, and the risk for analgesic addiction or pseudoaddiction in patients with sickle cell disease. The investigators found that disputes and arguments about analgesics, use of over-the-counter analgesics, and certain active coping strategies, were associated with pseudoaddiction, while the frequency and type of aberrant behaviors strongly predicted opioid abuse and addiction. However, many researchers in the field consider these findings to be preliminary and in need of validation. A methodological flaw that assigns equal validity to all behaviors if they can be construed as belonging to a specific subculture, regardless of whether the specific subculture is aligned with the cultural values of the whole society or not, might have compromised the findings of this study. Clearly, more research in that specific field is needed.(18)

Another effective means of preventing abuse of opioids is the use of the patient-provider agreement (PPA). In our practice, we have developed and used the agreement for patients who were found to be at risk for aberrant behaviors or scored unfavorably during prescreening but were not otherwise identified as at risk (see Appendix B).

The PPA is a lengthy document that has been carefully designed to conform to the following principles:

1. It can be understood by the majority of patients with average intelligence.
2. It can be read aloud.
3. It provides an evaluation of consequences.
4. It is as free as possible from either positive or negative bias.

In the preparation of the PPA, we recognized four specific domains as most relevant for ongoing monitoring of chronic pain patients taking opioids:

1. Efficacy of analgesia.
2. Improvement or restoration of normal activities of daily living.
3. Presence of controllable or uncontrollable adverse effects and side effects.

4. Presence or absence of aberrant drug-taking behaviors.

In addition, following Heit and Gourlay (9), we included the paragraph that allows for drug screening of patients. In literature and in our own practice it has been shown that urine toxicology screens are useful to determine whether the patient is diverting drugs. The patient who tests positive for illicit substances but negative for the presence of prescribed opioids is most likely exchanging prescribed opioids for various illegal substances. Such patients will need a thorough evaluation by a specialist in the field of addiction and may need to be managed with non-addictive pain medications and/or various adjunct medications.(19)

Alternatives to Opioids and Dosage Reduction with Adjunct Medications

The problem of the unlawful diversion of prescribed opioids is real and severe. As research shows, the medical use of opioids grew dramatically between 1997 and 2002, with prescriptions for fentanyl, hydromorphone, and oxycodone increasing by 227 percent, 96 percent, and 403 percent, respectively. (20)

Unfortunately, there is also the concurrent tendency for increased incidence of opioid abuse among the general population. Data from the Drug Abuse Warning Network (DAWN), a national surveillance system that monitors trends in drug-related emergency department visits and deaths, showed that, between 1997 and 2002, the number of abuse incidents increased by 642 percent, 342 percent, and 347 percent respectively for fentanyl, hydromorphone, and oxycodone. Clearly, there is no absolute direct correlation (otherwise, the number of oxycodone incidents would have been higher than that of fentanyl); however the problem needs addressing. (20,21)

The most radical approach is to explore the use of non-addictive alternatives to opioids, therefore extending the first step of the analgesic ladder. This means attempting to control the persistent severe pain with combinations of non-steroidal anti-inflammatory drugs (NSAIDs) and atypical pain relievers, such as antidepressants, antiepileptics, partial opioid receptor agonists or antagonists (Tramadol/Ultram®), and other medications, often not approved by the FDA for the purposes of pain control. (22)

Although we remain optimistic about the possibility of adequate pain control without the use of opioids, this task at the moment appears to be far from final. Issues that need to be addressed include the high cost of medications, multiple drug interactions, and, most important, the issue of adverse side effects. As always observed in polytherapy, side effects of multiple drugs may amplify each other and cause more severe and more numerous adverse effects than expected.

Table 7.3 presents the common side effects of frequently prescribed analgesics (including opioids) and adjunct medications. Only common side effects are marked with "yes;" a blank entry does not imply that the specific side effect is never observed but rather that it is uncommon.(23)

While numerous worthwhile clinical points were made in the discussion of use of adjuvant drugs for the treatment of persistent pain, it is necessary to understand that, for instance, among antidepressants, studies have not shown much effect of selective serotonin reuptake inhibitor drugs (such as Fluoxetine/Prozac®) for treatment of pain. Tricyclic antidepressants, such as Doxepine/Sinequan® or Amitriptyline/Elavil® may be much more effective, but often have unacceptable side effects. Other adjuvant drugs may be effective, but all currently available adjuvant treatments, including antidepressants, anticonvulsants, and antiarrhythmics, have potentially serious side effects and require careful attention that may not prevent the undesirable and even tragic outcomes.

An often cited specific guideline in pain management is formulated by the American Geriatric Society (AGS). Some of their observations are relevant in regard to the prevention of unnecessary and erroneous use of potentially addictive medications. For instance, the AGS guideline highlights three drugs of concern: propoxyphene, tramadol, and methadone. Propoxyphene has shown to be no more effective than some of the NSAIDs, but it is more toxic and addictive.(26)

Tramadol has opioid activity with apparently low abuse potential, and use is not restricted to the same extent as that of opioids. It is reportedly about as effective and safe as codeine or hydrocodone, but has the additional low risk of inducing seizures. Methadone has a long and variable half-life, making

it difficult to titrate. A positive aspect not mentioned in the guideline is that methadone can provide a very low cost solution for some situations of chronic pain, especially when one considers the widespread use of methadone in the risk-reduction modality of management of opioid addiction.

CONCLUSIONS

Though everyone understands that the use of opioids in the treatment of pain is unavoidable due to their high efficacy, the risk of abuse, addiction, and diversion also remains very high. Rational and persistent application of the principles outlined in this chapter may allow effective prevention of psychological dependency and addiction while ensuring adequate relief of pain.

The judicious use of opioids in patients with severe chronic pain is accepted by most professional organizations. It is true that the use of opioids is a balancing act. However, the goal of achieving freedom from pain and restoration of normal activities is definitely worth the effort.

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Table 7.2. The World Health Organization Pain Ladder

Step	Type of pain	Types of medications
1	Mild to moderate	NSAIDS + adjuncts + non-pharmacological approaches
2	Moderate	Step 1 remedies + opioid prn
3	Moderate to severe	Step 1 Plus continuous long acting opioids
	Breakthrough pain	Step 3 + Short acting opioid for breakthrough

Source: Data from WHO (10).

Table 7.1. The Nociceptive Pathway

Step	Process	Location	Process
1	Transduction	Affected organ	Translation of pain stimuli into nerve impulses that are sent into the spinal cord along the Ad and C fibers.
2	Transmission	Spinal cord	The nerve impulses are transmitted into the brain along the sensory tracts of the spinal cord.
3	Modulation	Spinal cord and brain	The nerve impulses are dampened or amplified in the spinal cord and in the brain.
4	Perception of pain	Brain	The modulated result of the physical (nociception) and the psychological (suffering) components results in the conscious awareness of the pain.

Source: Data from Pedtrovic et al. (1), Frankenstein et al. (2), and Weisenberg (3).

Table 7.3. Side Effects of Common Pain Medications

	Acetaminophen /Tylenol®	Aspirin	NSAIDS (Ibuprofen/Advil®, Meloxicam/Mobic®, Diclophenac/Voltaren® etc.)	Ketorolac /Toradol®	Tramadol /Ultram®	Opioids (Morphine, Codeine, Methadone, Fentanyl etc.)
Abdominal Pain		YES	YES	YES	YES	
Bleeding		YES	YES	YES		
Constipation			YES	YES	YES	YES
Drowsiness				YES	YES	YES
Edema		YES	YES	YES		
Headache			YES	YES	YES	
Hypertension				YES		
Liver Damage	YES (in higher doses)			YES	YES	
Mental Status Changes		YES			YES	YES
Nausea, Vomiting		YES	YES	YES	YES	YES
Skin Rash or Persistent Itching		YES	YES	YES	YES	YES
Urinary Retention					YES	YES
Xerostomia (dry mouth)					YES	YES
Withdrawal symptoms if the patient is on other opioids					Possible	Possible

Table 7.3. Side Effects of Common Pain Medications (con't)

	Anti-Arhythmics (Mexiletine /Mexitil®)	Antidepressants (Amitriptyline /Elavil®, Nortriptyline /Pamelor®, Doxepin /Sinequan® etc.)	Steroids (Prednisone, Dexamethasone, etc.)	Anticonvulsants (antiepileptics)		
				Carbamazepine /Tegretol®	Gabapentine /Neurontin®	Valproic acid (Depacote® etc.)
Abdominal Pain	YES		YES	YES		YES
Bleeding				YES		YES
Constipation	YES	YES		YES		
Drowsiness		YES		YES	YES	YES
Edema			YES	YES	YES	
Headache			YES	YES		
Hypertension		YES	YES	YES		YES
Mental Status Changes	YES	YES	YES	YES		YES
Nausea, Vomiting	YES			YES		YES
Skin Rash or Persistent Itching	YES			YES	YES	
Urinary Retention		YES		YES		
Xerostomia (dry mouth)		YES		YES		

Source: Data from Physicians Desk Reference (23), Brunton et al. (24), DiPiro et al. (25)

ABSTRACTS AT YOUR FINGERTIPS

Elizabeth Genovese, MD, MBA, FAADEP

Videman, T. and M. C. Battie (1999). "The influence of occupation on lumbar degeneration." Spine 24(11): 1164-8.

Occupational factors suspected of accelerating spinal degeneration include accident-related trauma; heavy physical loading and materials handling, including lifting, bending, and twisting; prolonged sitting; and sustained nonneutral work postures and vehicular driving. There is evidence to suggest that occupational exposures have an effect on disc degeneration. However, these factors explain little of the variability in degeneration found in the adult population. Furthermore, the lack of a clear dose-response relation between time spent in various occupational loading conditions and degenerative findings adds to doubts about a strong causal link. The contribution of suspected occupational risk factors appears to be particularly modest when compared with familial influences, which reflect the combined effects of genes and early childhood environment. These findings challenge the dominant role assumed for occupational loading in disc degeneration and associated back problems, and suggest a more complex etiology.

While this information may not always be helpful in those states that do not apportion, it should be useful in cases when there hasn't even been an injury.

Boos, N., S. Weissbach, et al. (2002). "Classification of age-related changes in lumbar intervertebral discs: 2002 Volvo Award in basic science." Spine 27(23): 2631-44.

A histologic study on age-related changes of the human lumbar intervertebral disc investigated comprehensively age-related temporospatial histologic changes in human lumbar intervertebral disc in order to develop a practicable and reliable classification system for age-related histologic disc alteration.... A semiquantitative analysis provided clear histologic evidence for the detrimental effect of a diminished blood supply on the endplate, resulting in the tissue breakdown beginning in the nucleus pulposus and starting in the second life decade. Significant temporospatial variations in the presence

and abundance of histologic disc alterations were observed across levels, regions, macroscopic degeneration grades, and age groups. A practicable classification system for age-related histologic disc alterations was developed, resulting in moderate to excellent reliability. Application of the classification system to cadaveric and surgical specimens demonstrated a significant correlation with age (< 0.0001) and macroscopic grade of degeneration (< 0001).... Diminished blood supply to the intervertebral disc in the first half of the second life decade appears to initiate tissue breakdown.

Which might seem to "explain" why regular physical activity helps PREVENT back pain .. since this increases nutrient flow to the disc.

Videman, T., M. C. Battie, et al. (2003). "Associations between back pain history and lumbar MRI findings." Spine 28(6): 582-8.

A retrospective monozygotic twin cohort study investigated the associations between different spinal MRI findings and current, past year, and lifetime low back pain after adjusting for occupational physical loading, smoking, genetics, and early family influences. The study participants consisted of 115 monozygotic male twin pairs 35 to 69 years of age. The qualitatively assessed MRI parameters were as follows: disc height, bulging, herniations, annular tears, osteophytes, spinal stenosis, and endplate changes. Signal intensity was measured quantitatively. After controlling for age, disc height was associated with all back pain variables studied and annular tears with LBP frequency and intensity during the 12 months before imaging. Both were associated with lifetime frequency of low back pain interfering with daily activities, disability, and intensity of the worst lifetime pain episode. Other MRI findings did not explain the various symptom histories. Adjusting for physical loading in the past 12 months increased the associations of annular tears and "low back pain today" and 12-month low back pain parameters. After controlling for genotype and other familial influences, the within-pair differences in disc height and annular tears accounted for 6% to 12% of the total variance in the within-pair differences of low back pain variables. These findings raise new questions about the underlying mechanisms of LBP. The sensitivities of the only significant MRI parameters, disc height narrowing

and annular tears, are poor, and these findings alone are of limited clinical importance.

So, if one has an annular tear and does physical work one is slightly more likely to complain of back pain, which is why we often pick up these as causally related to work even though they are not ..but the real message is, again, that the causal relationship between findings on MRI and symptoms is weak at best.

Kopec, J. A., E. C. Sayre, et al. (2004). "Predictors of back pain in a general population cohort." Spine 29(1): 70-7; discussion 77-8.

The study used longitudinal data from the first and second cycles (1994-1995 and 1996-1997) of the Canadian National Population Health Survey to derive prediction models for back pain in the general male and female household populations. The study cohort consisted of all respondents aged 18+ years who reported no back problems in the 1994-1995 National Population Health Survey cycle (N = 11,063). Potential predictors of chronic back pain were classified into nine groups and entered into stepwise logistic regression models. The overall incidence of back pain was 44.7 per 1,000 person-years and was higher in women (47.0 per 1,000 person-years) compared with men (42.2 per 1,000 person-years). In men, significant predictors of back pain were age (peak effect in 45-64 years), height, self-rated health, usual pattern of activity (especially heavy work), yard work or gardening (negative association), and general chronic stress. In women, significant factors were self-reported restrictions in activity, being diagnosed with arthritis, personal stress, and history of psychological trauma in childhood or adolescence. Overall health and psychosocial factors are important predictors of back pain in both men and women. Other risk factors differ between the two sexes.

There are tons of article like this in the literature.... Yet many doctors tend to ignore (for many reasons) the role of psychosocial factors once they start treating patients...

Battie, M. C., T. Videman, et al. (2004). "Lumbar disc degeneration: epidemiology and genetic influences." Spine 29(23): 2679-90.

A literature review was conducted of the prevalence of disc degeneration. Studies of the etiology of disc degeneration were summarized, with particular attention given to studies of genetic influences. There are extreme variations in the reported prevalence of specific degenerative findings of the lumbar spine among studies, which cannot be explained entirely by age or other identifiable risk factors (e.g., prevalence figures for disc narrowing varied from 3% to 56%). It is likely that these variations are due, in great part, to inconsistencies in case definitions and measurements, which are impeding epidemiologic research on disc degeneration. Research conducted over the past decade has led to a dramatic shift in the understanding of disc degeneration and its etiology. Previously, heavy physical loading was the main suspected risk factor for disc degeneration. However, results of exposure-discordant monozygotic and classic twin studies suggest that physical loading specific to occupation and sport has a relatively minor role in disc degeneration, beyond that of upright postures and routine activities of daily living. Recent research indicates that heredity has a dominant role in disc degeneration, explaining 74% of the variance in adult populations studied to date. Since 1998, genetic influences have been confirmed by the identification of several gene forms associated with disc degeneration.

Hestbaek, L., I. A. Iachine, et al. (2004). "Heredity of low back pain in a young population: a classical twin study." Twin Res 7(1): 16-26.

Important genetic influence on intervertebral disc degeneration has been shown previously. However, the role of the disc in pain production is not clear and the genetic influence on the development of the symptoms of low back pain is largely unknown. Therefore, data on lifetime prevalence of low back pain from the young cohort in The Danish Twin Registry (aged 12-41) were analyzed with respect to heredity. Casewise concordance rates, odds ratios, tetrachoric correlation coefficients and biometric liability models were estimated in relation to gender and age. Finally, age-adjusted heritability of liability estimates were obtained. Both concordance rates and odds ratios show significant genetic influence on the liability to develop low back pain. Also, tetrachoric correlation coefficients show genetic influence, but this is not

statistically significant for all age groups. The biometric modeling demonstrates shared environment to be a strong component in the youngest age group (12-15), but not above age 15, and it also demonstrates some non-additive genetic effects in the older age groups. Age-adjusted heritability of liability is estimated to 44% (37-50) for males and 40% (34-46) for females aged 16 to 41. Thus, the various analyses all demonstrate significant genetic influence on the liability to low back pain. The shared environment is an important component until age 15. After age 15, this component is unimportant. As people grow older, the effect of the non-shared environment increases and non-additive genetic effects become more evident, indicating an increasing degree of genetic interaction as age increases. *It is the interaction between genetics and environment that is relevant.*

Jarvik, J. G., W. Hollingworth, et al. (2005). "Three-year incidence of low back pain in an initially asymptomatic cohort: clinical and imaging risk factors." *Spine* 30(13): 1541-8; discussion 1549.

Few prospective studies have examined clinical and anatomic risk factors for the development of LBP, or the incidence of new imaging findings and their relationship to back pain onset. We randomly selected 148 Veterans Affairs out-patients (aged 35 to 70) without LBP in the past 4 months. We compared baseline and 3-year lumbar spine MRI. Using data collected every 4 months, we developed a prediction model of back pain-free survival. After 3 years, 131 subjects were contacted, and 123 had repeat MRI. The 3-year incidence of pain was 67% (88 of 131). Depression had the largest hazard ratio (2.3, 95% CI = 1.2-4.4) of any baseline predictor of incident back pain. Among baseline imaging findings, central spinal stenosis and nerve root contact had the highest, though nonsignificant, hazard ratios. We did not find an association between new LBP and type 1 endplate changes, disc degeneration, annular tears, or facet degeneration. The incidence of new MRI findings was low, with the most common new finding being disc signal loss in 11 (9%) subjects. All five subjects with new disc extrusions and all four subjects with new nerve root impingement had new pain. *True pathology (as described in guidelines) consistently caused back pain in the small number of individuals who had it, whereas depression and*

NOT MRI findings were the cause of low back pain in a far larger group of individuals WITHOUT MRI findings.

Carragee, E. J., T. F. Alamin, et al. (2005). "Discographic, MRI and psychosocial determinants of low back pain disability and remission: a prospective study in subjects with benign persistent back pain." *Spine* J 5(1): 24-35.

One hundred subjects with known mild persistent low back pain and a 2:1 ratio of chronic (non-lumbar) pain syndrome were recruited from a study population with a predisposition to disc degenerative disease, to undergo baseline examination, testing and 5-year follow-up. Observations were made at 6-month intervals over 4 to 6 years (mean, 5.3) for the after primary outcomes measures: episodes of serious back pain (visual analogue scale [VAS] > or =6), episodes of occupational disability less than 1 week, episodes of occupational disability for 1 week, remission episodes of all back pain symptoms at least 6 months and medical visits primarily for LBP evaluation and treatment. Lumbar magnetic resonance imaging (MRI), lumbar provocative discography (in psychometrically normal subjects), physical examinations, medical and work histories and psychometric testing were performed at baseline. Imaging and psychometric testing were graded by blinded examiners. A scripted interview was conducted every 6 months during follow-up by independent research assistants who also were blinded to patient baseline data. The interview covered interval medical, occupational and accident or injury histories. Psychosocial variables strongly predicted both long- and short-term disability events, duration and health-care visits for LBP problems (p<0.0001-0.004). The likelihood of a sustained remission from the baseline persistent (subclinical) LBP appeared to be linked to occupation factors (leaving a heavy labor occupation; p=0.0001), neurophysiologic variables (chronic nonlumbar pain; p=0.0002) and psychometric profiles at baseline (DRAM and FABQ-PA; p=0.003-0.002). Of the structural findings measured only moderate or severe Modic changes of the vertebral end plate were weakly associated with an adverse outcome. A positive provocative discogram at baseline did not predict any future adverse event. The development of serious LBP disability in a cohort of subjects with

both structural and psychosocial risk factors was strongly predicted by baseline psychosocial variables. Structural variables on both MRI and discography testing at baseline had only weak association with back pain episodes and no association with disability or future medical care.

Consistent with everything else. ..

Virtanen, I. M., J. Karppinen, et al. (2007). "Occupational and genetic risk factors associated with intervertebral disc disease." Spine 32(10): 1129-34.

Cross-sectional epidemiologic study to evaluate the interaction between known genetic risk factors and whole-body vibration for symptomatic intervertebral disc disease (IDD) in an occupational sample... Eleven variations in 8 genes (COL9A2, COL9A3, COL11A2, IL1A, IL1B, IL6, MMP-3, and VDR) were genotyped in 150 male train engineers with an average of 21-year exposure to whole-body vibration and 61 male paper mill workers with no exposure to vibration. Subjects were classified into IDD-phenotype and asymptomatic groups, based on the latent class analysis... The number of individuals belonging to the IDD-phenotype was significantly higher among train engineers (42% of train engineers vs. 17.5% of sedentary workers; $P = 0.005$). IL1A -889T allele represented a significant risk factor for the IDD-phenotype both in the single marker allelic association test ($P = 0.043$) and in the logistic regression analysis ($P = 0.01$). None of the other allele markers was significantly associated with symptoms when analyzed independently. However, for all the SNP markers considered, whole-body vibration represents a nominally significant risk factor. The results suggest that whole-body vibration is a risk factor for symptomatic IDD. Moreover, whole-body vibration had an additive effect with genetic risk factors increasing the likelihood of belonging to the IDD-phenotype group. Of the independent genetic markers, IL1A -889T allele had strongest association with IDD-phenotype.

As expected from the internal medicine literature (with which I am quite familiar!!), when examining the interaction between back pain and occupational activities, individuals with a given genetic (and psychological) "make-up" have difficulty tolerating stressors which others may tolerate quite well. But what do we do with this?

Carragee, E., T. Alamin, et al. (2006). "Are first-time episodes of serious LBP associated with new MRI findings?" Spine J 6(6): 624-35.

Common degenerative findings are often interpreted as recent developments and the probable anatomic cause of the new symptoms. ... 200 subjects with a lifetime history of no significant LBP problems, ... were studied at baseline with physical examination, plain radiographs, and MR imaging. Subjects were followed every 6 months for 5 years with a detailed telephone interview. Subjects with a new severe LBP episode ($LBP \geq 6/10, >1$ week) were assessed for new diagnostic tests. New MR imaging, taken within 6 to 12 weeks of the start of a new LBP episode, was compared with baseline (asymptomatic) images. Two independent and blinded readers evaluated each baseline and follow-up study. During the 5-year observation period of 200 subjects, 51 (25%) subjects were evaluated with a lumbar MRI for clinically serious LBP episodes, and 3/51 (6%) had a primary radicular complaint. These 51 subjects had 67 MR scans. Of 51 subjects, 43 (84%) had either unchanged MR or showed regression of baseline changes. The most common progressive findings were disc signal loss (10%), progressive facet arthrosis (10%), or increased end plate changes (4%). Only two subjects, both with primary radicular complaints, had new findings of probable clinical significance (4%). Subjects having another MR were more likely to have had chronic pain at baseline (odds ratio [OR]=3.19; 95% confidence interval [CI] 1.61-6.32), to smoke (OR=5.81; 95% CI 1.99-16.45), have baseline psychological distress (OR 2.27; 95% CI 1.15-4.49), and have previous disputed compensation claims (OR=2.35; 95% CI 0.97-5.69). Subjects involved in current compensation claims were also more likely to have an MR scan to evaluate the LBP episode (risk ratio=4.75, $p < .001$), but were unlikely to have significant new findings. New findings were not more frequent in subjects with LBP episodes developing after minor trauma than when LBP developed spontaneously. Findings on MR imaging within 12 weeks of serious LBP inception are highly unlikely to represent any new structural change. Most new changes (loss of disc signal, facet arthrosis, and end plate signal changes) represent progressive age changes not associated with acute events. Primary

radicular syndromes may have new root compression findings associated with root irritation.

Which is why we shouldn't order them for new onset radicular pain in the absence of "red flags."

Waris, E., M. Eskelin, et al, M. Eskelin, et al. (2007). "Disc degeneration in low back pain: a 17-year follow-up study using magnetic resonance imaging." *Spine* 32(6): 681-4.

In 1987, 75 male Finnish conscripts aged 20 years, with low back pain hindering their military service, were studied using MRI at 0.02 T. In 2003, 32 patients were reexamined with MRI at 1.0 T. The history of low back illness during the follow-up and current functional outcome were recorded. In 1987, 69% of the 32-patient cohort had DD in one or more lumbar discs. In 2003, all subjects had DD in MRI. The mean number of degenerated discs in each subject increased from 1.1 to 3.0. A total of 76% of discs degenerated in 1987 were herniated in 2003, whereas only 29% of well-hydrated discs in 1987 were herniated at the time of follow-up ($P = 0.0002$). During 17 years of follow-up, 3 patients had undergone spinal surgery. Early DD in adolescent patients with low back pain predicted the evolution of enhanced DD and herniation in adulthood, but it was not associated with severe low back pain or increased frequency of spinal surgery.

Genetics againbut note the lack of association between anatomic changes and symptoms ... which is because, in many individuals, prolonged or disabling symptoms are NOT caused by anatomic pathology per se.

Carragee, E., T. Alamin, et al. (2006). "Does minor trauma cause serious low back illness?" *Spine* 31(25): 2942-9.

Prospective, 5-year, cohort study of working subjects. To assess whether the occurrence of common minor trauma events affects the risk of developing serious low back pain (LBP) and LBP disability in subjects with and without degenerative changes to the lumbar spine. Although some theories suggest that minor traumatic events in combination with preexisting degenerative changes commonly cause significant structural injury to spinal segments and serious LBP illness, no prospective data exist on the relationship of minor trauma, detailed structural changes, and outcome measures of serious LBP

episodes and occupational disability. Two hundred subjects without clinical LBP problems were recruited, and underwent baseline clinical and imaging studies. Every 6 months, subjects completed a scripted, algorithm-based interview assessing interval back pain episodes, severity, medical treatment, occupational disability, and the subject's perceived relation of this LBP episode to any preceding event. If a serious LBP episode clinically required a new magnetic resonance examination, the follow-up imaging was obtained and compared to baseline for interval changes. There was no association of minor trauma to adverse LBP events. For each 6-month study interval, the risk of developing a serious LBP episode was 2.1% unassociated with minor trauma and 2.4% following minor trauma ($P = 0.59$). Neither the frequency of minor trauma events nor the reported severity of the event correlated with adverse outcomes. Subjects with advanced structural findings were not more likely to become symptomatic with minor trauma events than with spontaneously evolving LBP episodes. Follow-up magnetic resonance imaging evaluating new serious LBP illness rarely revealed new clinically significant findings. Age and sex-adjusted prediction models, including abnormal psychometric testing, smoking, and compensation issues, accurately identified 80% of serious LBP events and 93% of LBP disability events. In this study cohort, minor trauma does not appear to increase the risk of serious LBP episodes or disability. The vast majority of incident-adverse LBP events may be predicted not by structural findings or minor trauma but by a small set of demographic and behavioral variables.

So what can we do about this?

Hartvigsen, J. and K. Christensen (2007). "Active lifestyle protects against incident low back pain in seniors: a population-based 2-year prospective study of 1387 Danish twins aged 70-100 years." *Spine* 32(1): 76-81.

Twins free from LBP at baseline (no LBP during the past month) were included, and interview data on physical activity, overall physical function, and LBP at baseline and follow-up were obtained. Associations between levels of physical activity and LBP were estimated using logistic regression for the entire cohort, and using a matched case-control design for twin pairs discordant for physical activity.

Absolute risk and relative risks for incident LBP in relation to physical activity were calculated for participants with higher or lower than average physical function at baseline. Absolute risk for LBP was also calculated for participants based on whether they remained active or inactive between baseline and follow-up or changed activity level. A total of 1387 persons aged 70-100 at baseline were included in the analyses, including 86 twin pairs discordant for physical activity at baseline. In the total sample, 83% were engaged in light physical activity, and 42% of men and 35% of women were engaged in strenuous physical activity at least weekly. Being engaged in strenuous physical activity at baseline was strongly protective in relation to both having had any LBP (odds ratio 0.21, 95% confidence interval 0.12-0.37 for intra-pair analysis) and having had LBP lasting more than 30 days altogether during the past year at follow-up (odds ratio 0.08, 95% confidence interval 0.03-0.18 for intra-pair analysis). Statistically significant dose-response associations between increasing frequency of strenuous physical activity and magnitude of this protective effect were found. Participants with poor initial physical function experienced the strongest protective effect of strenuous physical activity. Finally, LBP does not appear to be an important factor affecting whether participants remained engaged in strenuous physical activity at baseline and follow-up or vice versa. Strenuous physical activity at least once a week is protective for incident LBP in seniors.

But was it the activity, or whatever it is/was that led the person to choose to be active in the first place?

Brage, S., I. Sandanger, et al. (2007). "Emotional distress as a predictor for low back disability: a prospective 12-year population-based study." *Spine* 32(2): 269-74.

A randomly drawn cohort of 1152 occupationally active persons aged 20-55 years was interviewed with a comprehensive psychosocial questionnaire in 1990, and was followed for 12 years in national registers over sickness, rehabilitation, and disability benefits. Data on emotional distress, earlier low back pain (LBP), education, life style, psychosocial, and work-related factors were collected at baseline. Long-term benefits due to low back disability were granted to 131 persons (11.4%) in the follow-up period. In multivariate analysis, earlier LBP, emotional distress, low grade of education, and

high physical job stress were associated with low back disability. Persons with both emotional distress and earlier back pain were most at risk for disability (hazard ratio 2.91, 95% confidence interval 1.60-5.29). Persons with emotional distress but no earlier episodes of LBP had no increased risk for low back disability (hazard ratio 0.71, 95% confidence interval 0.34-1.45). Emotional distress is a predictor for low back disability in persons with earlier LBP, but not in persons without. To prevent low back disability, emotional distress should be considered and treated in persons with LBP.

Yet another article indicating that ignoring psychological issues in those with back pain does NOT minimize long-term problems. But insurers need to feel that psychologically-based interventions such as cognitive behavioral therapy will be kept under control, and not become yet another escalating medical cost unaccompanied by objective evidence of functional benefit for the patient.

Woby, S. R., N. K. Roach, et al. (2007). "The relation between cognitive factors and levels of pain and disability in chronic low back pain patients presenting for physiotherapy." *Eur J Pain*.

The aim of this study was to determine the extent to which a number of distinct cognitive factors were differentially related to the levels of pain and disability reported by 183 chronic low back pain (CLBP) patients presenting for physiotherapy. After adjusting for demographics, the cognitive factors accounted for an additional 30% of the variance in pain intensity, with functional self-efficacy ($\beta = -0.40$; $P < 0.001$) and catastrophizing ($\beta = 0.21$; $P < 0.01$) both uniquely contributing to the prediction of outcome. The cognitive factors also explained an additional 32% of the variance in disability after adjusting for demographics and pain intensity (total $R(2) = 0.61$). Higher levels of functional self-efficacy ($\beta = -0.43$; $P < 0.001$) and lower levels of depression ($\beta = 0.23$; $P < 0.01$) were uniquely related to lower levels of disability. Our findings clearly show that there is a strong association between cognitive factors and the levels of pain and disability reported by CLBP patients presenting for physiotherapy. Functional self-efficacy emerged as a particularly strong predictor of both pain intensity and disability. In view of our findings it would seem that targeting

specific cognitive factors should be an integral facet of physiotherapy-based treatments for CLBP.

Same comments as in the last two abstracts ... so should we treat the mind to treat the body or encourage activity, using a motivational approach, to treat the mind?

Gooch, K., B. F. Culleton, et al. (2007). "NSAID use and progression of chronic kidney disease." Am J Med 120(3): 280 e1-7.

The effects of nonselective and selective cyclooxygenase-2 specific (COX-2) nonsteroidal anti-inflammatory drug (NSAID) use on the progression of chronic kidney disease (CKD) is uncertain. Due to the high prevalence of both CKD and NSAID use in older adults, we sought to determine the association between NSAID use and the progression of CKD in an elderly community-based cohort. All subjects > or =66 years of age who had at least one serum creatinine measurement in 2 time periods (July-December, 2001 and July-December, 2003) were included. ... A total of 10,184 subjects (mean age 76 years; 57% female) were followed for a median of 2.75 years. High-dose NSAID users (upper decile of cumulative NSAID exposure) experienced a 26% increased risk for the primary outcome (odds ratio [OR] 1.26, 95% confidence interval [CI], 1.04-1.53). A linear association between cumulative NSAID dose and change in mean GFR also was seen. No risk differential was identified between selective and nonselective NSAID users. High cumulative NSAID exposure is associated with an increased risk for rapid CKD progression in the setting of a community-based elderly population. For older adult patients with CKD, these results suggest that nonselective NSAIDs and selective COX-2 inhibitors should be used cautiously and chronic exposure to any NSAID should be avoided.

The recent flurry of interest in NSAIDs and CAD should not lead us to forget that they have other systemic effects (aside from those on the GI tract) as well.

Keitz, S. A., K. M. Stechuchak, et al. (2007). "Behind Closed Doors: Management of Patient Expectations in Primary Care Practices." Arch Intern Med 167(5): 445-452.

Background Managed care restrictions on resource use may affect communication between

patients and health care professionals. ..Fifty-five physicians from 20 randomly selected primary care practices in a managed care network and 211 patients who voiced specific expectations in a previsit survey were included. From the recorded clinic visits we determined modes of negotiation of patient expectations and requests. From the surveys we determined patient previsit expectations, post-visit fulfillment of expectations, satisfaction, and trust. Two-hundred fifty-six self-reported expectations were captured in 200 audiotape-recorded encounters. Of the pre-visit expectations, 97.3% were discussed during the encounter. Expectations were expressed by direct patient request (40.6%), mentioning of symptoms related to request (29.7%), or physician-initiated discussion (27.0%). Most expectations were met (66.8%); physicians suggested an alternative 21.6% of the time. Expectations for medications and tests were met more frequently than expectations for referrals (75.6% and 71.4% vs 40.8%). Patient satisfaction and trust remained high regardless of whether expectations were met. Physicians reported that they would not have ordered 62 (44.9%) of 138 requests had the patients not directly asked, and they were uncomfortable filling 8 requests (12.9%). ... Patients generally received what they asked for and altered physician behavior nearly half of the time ...regardless of whether the physician agreed that they were necessary. BUT, given that patients were satisfied regardless, did the doctors really have to "give in" ...

Carey, T. S. and T. J. Mielenz (2007). "Measuring outcomes in back care." Spine 32(11 Suppl): S9-14.

Outcomes measurement in back pain has advanced substantially over the past decade. Researchers and clinicians now have multiple instruments that can assess patient outcomes with adequate psychometric properties. The domains generally assessed include: biologic measures (range of motion, fusion rate); patient-reported outcomes (functional status, quality of life); process measures (hospital days, medication use); and outcomes of interest to society (days off work, health care costs). When research is conducted in the context of advocacy work, care is needed to avoid introduction of bias into the work. Bias in outcomes assessment can occur through multiple phases of the research process, including selection of the research question,

study design, measurement, choice of the outcome measures used, and analysis. Bias can also occur in assessing outcomes across studies in literature synthesis. Transparency in research methods and clear communication can avoid many of the described pitfalls in outcomes assessment, allowing researchers to advocate appropriately for improvement in patient care.

I prefer to assume that most studies are biased until proven otherwise...

Kolstad, F., O. P. Nygaard, et al. (2007).
"Segmental motion adjacent to anterior cervical arthrodesis: a prospective study." Spine 32(5): 512-7.

STUDY DESIGN: Prospective, observational study. OBJECTIVE: The present study describes in a prospective setting the kinematics changes occurring at segments adjacent to a one-level cervical arthrodesis. SUMMARY OF BACKGROUND DATA: The development of adjacent segment disease has been noticed by many clinicians. Whether symptoms develop due to fusion induced accelerated spondylosis or due to a natural development in a predisposed person is currently under debate. The motivation for introducing motion preservation procedures in the neck is primarily to protect the patients from developing symptomatic adjacent disc disease. To accept this rationale, it has to be demonstrated that a fusion creates an unfavorable biomechanical situation at adjacent levels. METHODS: Forty-six patients underwent standard anterior cervical decompression and fusion using a cylindrical cage implant. Lateral radiographic views of the cervical spine in flexion and extension were obtained before surgery, and at 12 months of follow-up. Employing Distortion Compensated Roentgen Analysis, rotational and translational motion at adjacent levels was quantified prospectively. RESULTS: Rotational and translational motion at adjacent cranial and caudal levels did not exhibit a significant change between the preoperative state and the state 12 months after the operation. CONCLUSION: The assumption of an iatrogenically caused increased mobility by a one-level cervical fusion could not be confirmed 12 months after surgery.

Hilibrand, A. S. and M. Robbins (2004).
"Adjacent segment degeneration and adjacent

segment disease: the consequences of spinal fusion?" Spine J 4(6 Suppl): 190S-194S.

This article reviews documented evidence on adjacent segment degeneration and disease as it relates to cervical and lumbar arthrodesis. There appears to be an incidence of adjacent segment degeneration and disease after arthrodesis that may be related to natural degeneration or the adjacent fusion. It remains to be seen whether restoration of motion with disc arthroplasty will alter the rate of adjacent segment degeneration or disease.

Clarke, M. J., R. D. Ecker, et al. (2007). "Same-segment and adjacent-segment disease following posterior cervical foraminotomy." J Neurosurg Spine 6(1): 5-9.

OBJECT: The cervical foraminotomy was pioneered in the 1940s to address radicular symptoms via a posterior approach, but the long-term outcome has not been adequately studied. METHODS: The authors retrospectively analyzed data obtained from 303 patients (188 male and 115 female, mean age 49.2 years) who had consecutively undergone a single-level posterior foraminotomy for cervical radiculopathy between 1972 and 1992. The median follow-up duration was 7.1 years. The major end point studied was the development of symptomatic adjacent- or same-segment disease. Incidence rates per 1000 person-years were calculated, and the natural history of the disease was predicted using Kaplan-Meier survivorship analysis. In 15 (4.9%) of 303 patients, symptomatic adjacent-segment disease developed, yielding a rate of 6.4/1000 person-years at risk. This included nine (2.9%) of 303 patients requiring reoperation, yielding a rate of 3.8/1000 person-years. Kaplan-Meier survivorship analysis suggested a relatively stable annual 0.7% rate for developing adjacent-segment disease, with a 10-year rate of 6.7%. Ten patients developed same-segment disease, yielding a risk rate of 3.9/1000 person-years. Kaplan-Meier survivorship analysis demonstrated a 5- and 10-year risk rate of developing same-segment disease of 3.2 and 5.0%, respectively. CONCLUSIONS: Although additional study is needed, analysis of the present data suggests that posterior foraminotomy is associated with a low rate of same- and adjacent-segment disease.

Pellise, F., A. Hernandez, et al. (2007).
"Radiologic assessment of all unfused lumbar

segments 7.5 years after instrumented posterior spinal fusion." *Spine* 32(5): 574-9.

Adjacent segment degeneration (ASD) after lumbar fusion may be a consequence of biomechanical stress or result from constitutional factors. Most studies analyzing ASD only investigate the motion segments immediately above and below the fusion. None compares adjacent segments to all the other unfused segments after instrumented posterior fusion. **METHODS:** Using the distortion-compensated roentgen analysis method, disc height, dorsoventral displacement, and lordosis were measured in 212 unfused segments from 62 patients, on digitized standing radiographs taken before fusion surgery and after a mean follow-up of 7.5 years (range, 4-11 years). The effect of covariables, such as age, length of follow-up, fusion level, number of fused segments, and sagittal and spinopelvic parameters on the preoperative to follow-up changes, were analyzed using a repeated-measurement model.

RESULTS: No changes were observed at the segments located below the fusion. All the unfused segments above the fusion showed the same significant loss of disc height. Loss of disc height did not depend on fusion parameters, correlated weakly with age and length of follow-up, and correlated highly across adjacent unfused segments.

CONCLUSIONS: After posterior lumbar instrumented fusion, radiographic changes suggesting disc degeneration appear homogeneously at several levels cephalad to fusion and seem to be determined by individual characteristics.



**Official Call For Nominations
Deadline: October 15, 2007**

Pursuant to ARTICLE VII, Section 1, of the Bylaws of the American Academy of Disability Evaluating Physicians, a **CALL FOR NOMINATIONS** for the 2007-2008 AADEP officers and directors is issued to all Fellows for the following offices:

- Vice-President/President-Elect (Subject to Bylaw Amendments)
- Directors (3) serving a three-year term (Subject to Bylaw Amendments)
- Other vacancies as may occur

If you are interested, please apply or be nominated by a letter signed by an AADEP Fellow outlining your qualifications before October 15, 2007. Another Fellow should submit a "second" to the nomination. Address communication to the Nominating Chair:

Douglas Martin, MD, FAADEP
C/O AADEP
150 North Wacker Drive
Suite 1420
Chicago IL 60606-1606

The 2007-2008 term of office will commence at the close of the San Antonio Meeting with a Board meeting at 5:00pm Friday, January 18, 2008.

The 2008-2009 term of office will commence at the close of the Palm Springs Annual Meeting in January with a Board meeting at 5:00pm Friday, January 9, 2009.



**Call for Fellow Presentations
Deadline: October 15, 2007**

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Complete and return this page by October 15, 2007.

Presentations will likely be given the afternoon of Friday, January 11. You can attend the Annual Scientific Session and have your registration fee waived just by submitting your work product and experience for consideration. Oral presentations are 20 minutes long.

All slides should be in Microsoft PowerPoint. You must submit your complete presentation either by e-mail at aadep@aadep.org or on a floppy disc, CD-ROM, or Flash drive before the meeting to AADEP, 150 N. Wacker Drive, Suite 1420, Chicago IL, 60606-1606, by October 15, 2007, to be included as a handout.

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AADEP NEWS

THE EXECUTIVE EDGE

Sandra L. Yost, MBA
AADEP Executive Director

CHANGE creates positive energy.
CHANGE makes everything fresh.

FIRST, DON'T MISS THE 21ST ANNUAL SCIENTIFIC SESSION—
January 18-19, 2008 at the Hyatt Regency Riverwalk in San Antonio. Annual Meeting Vice Chair Melissa Tonn's and President Russell Travis' securing of educational grants has made it possible to bring in six international experts in the field of disability. And leaders are still looking for additional grants. If you have an idea who might support an AADEP program, give us a call.

January 2008 is your chance to hear the newest research outcomes directly from the people conducting those studies. Register today!

The 21st Annual Scientific Session **HAS MOVED TO JANUARY**, and will continue in the second week of January until change is warranted. This change was designed to space several competing medical meetings more evenly. While our Fellows may always have conflicts, the November time period, nearer the holidays, was most problematic. Fall is just a busier time of year. You will be able to participate in all your educational opportunities.

AND IN RESPONSE TO YOUR REQUESTS, it is one day shorter. You can participate in every annual meeting activity with just two days out of the office. A central location brings the meeting closer to more AADEP members, shortening travel time.

Room rates are more negotiable in resort settings and destination cities in early January than November. That benefit has shifted in

the 13 years this exec has been with AADEP. While not everyone likes the resort option, it does offer our Midwesterners and East Coast Fellows an escape from winter. An earlier date for AMA's Interim Meeting conflicted directly with the AADEP Annual.

Planners will promote an inclusive focus by offering tier registrations for all those non-physicians who are part of the disability team. Consider bringing your staff to San Antonio. Ask us about additional multi-registrant discounts.

SECOND, AADEP will move its headquarters in November—just down the street. A smaller, more efficient office, reflecting AADEP's new business model will result in a 60% cost savings on rent alone. One of the AADEP officers suggested that the additional half-mile added to your executive's current one-mile walk might be an enhancement to the AADEP Wellness Program.

Bring your energy and passion for disability evaluation to the 21st Annual. We look forward to seeing a record-setting crowd in San Antonio.



AADEP OFFICE STAFF

The AADEP Central Office Staff is pleased to assist you with any questions or concerns at (800) 456-6095 or (312) 658-1171:

- Sandra L. Yost, MBA** ext. 21
Executive Director
- Rochelle M. Roberts** ext. 22
Meetings Coordinator
- Debbi Frigo** ext. 23
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BOOK REVIEW

The A-Z Guide to Expert Witnessing
Steven Babitsky, Esq., James J. Mangraviti, Jr., and
Alex Babitsky, MBA SEAK, Inc.
Falmouth, Massachusetts, 2006
ISBN: 1-892904-29-2

By David A. Fetter, MD
Member, American Academy of Disability Evaluating
Physicians

This is a very comprehensive book that encompasses an enormous amount of medical-legal information within the 626 pages. Beginning with the fundamental elements of a lawsuit, through the discovery process, and through direct and cross examinations, the reader will be further educated as to the legal thought process by an attorney as relates to the Physician expert witness.

In the appendices, there are further resources, including a list of legal journals, with an updated online directories with an extremely in depth list of references. You will be educated in regard to Daubert and other important challenges that face a practicing physician.

My criticism, however, of this text, is that the book may be most appropriate for a Physician who is advanced in the medical-legal arena and wishes to "fine tune" his expert witness skills. This reference is complex for the every day practicing clinician, and may best serve as a reference for occasional use. However, with this being said, I would recommend the text to any physician who may come into contact with the legal system as a helpful guide, particularly in regard to complex medical-legal procedures.

ASSOCIATE MEMBERSHIP

The Board of the Academy of Disability Evaluating Physicians opened membership to all professionals in disability management/evaluation in 2003.

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FELLOW WATCH

Have you seen Dr. Trang Nguyen's article "Non-Specific Low Back Pain and Return to Work – What's the Evidence?" In *American Family Physician* – coming soon!

IN MEMORIAM

AADEP extends its sympathies to the families of the following:

Cecil E. G. Caines, MD, ORS, FAADEP since 1994, passed away 2006

Leonard J. Infranca, MD, ORS, FAADEP since 1994, passed away 2007

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