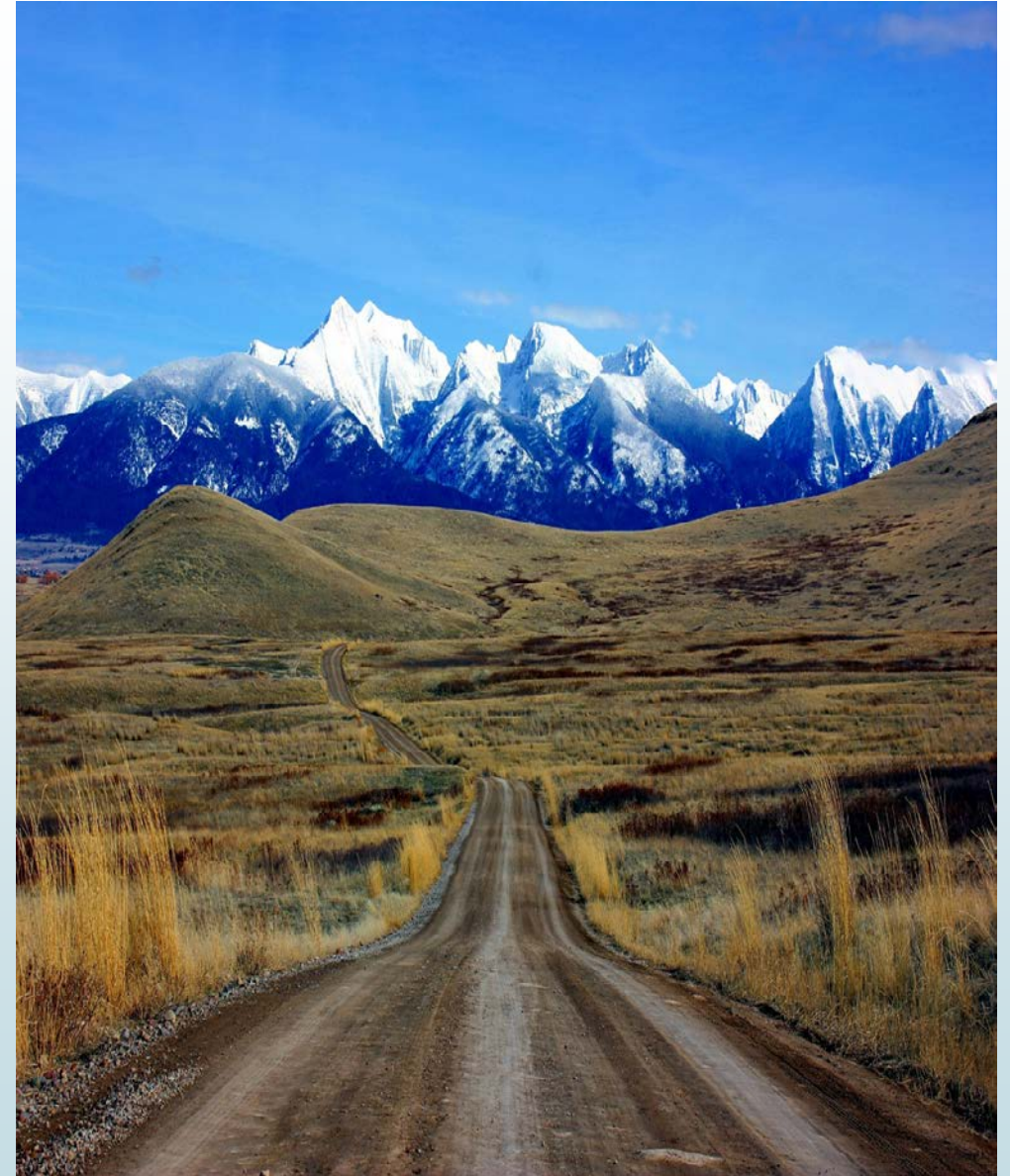


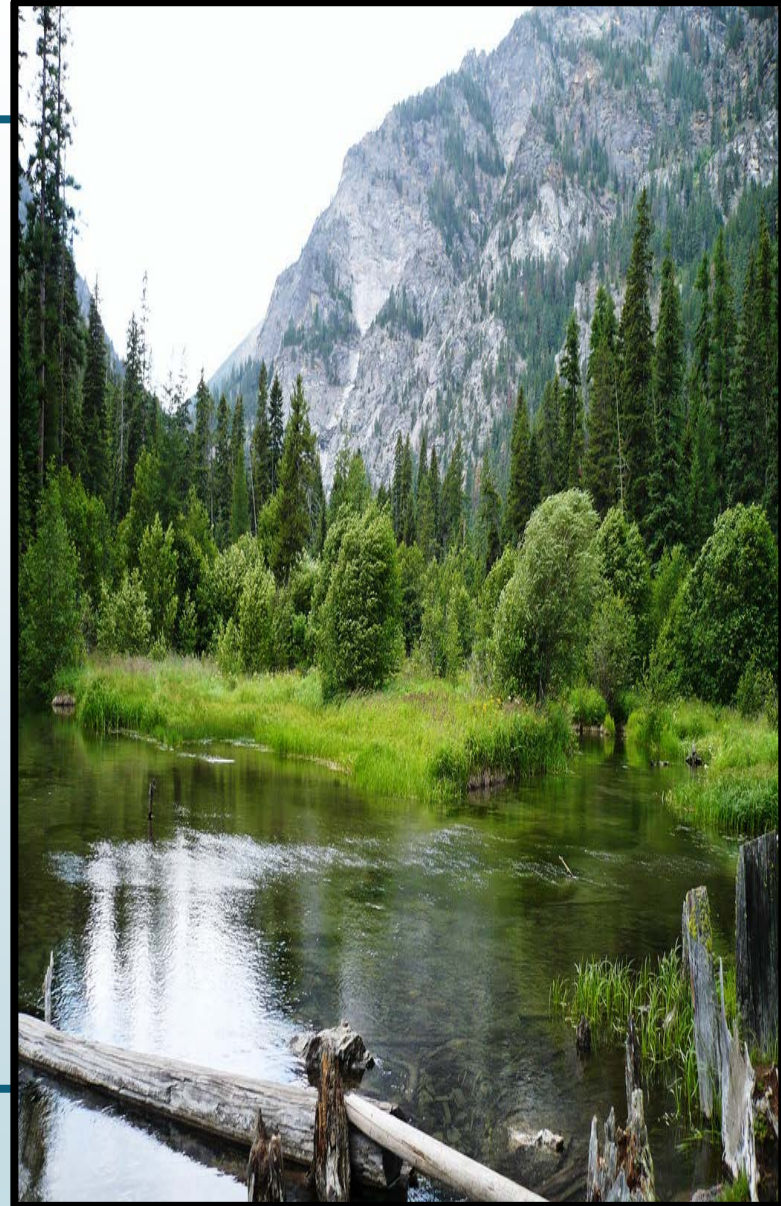


MONTANA

PAINED LIVES MATTER

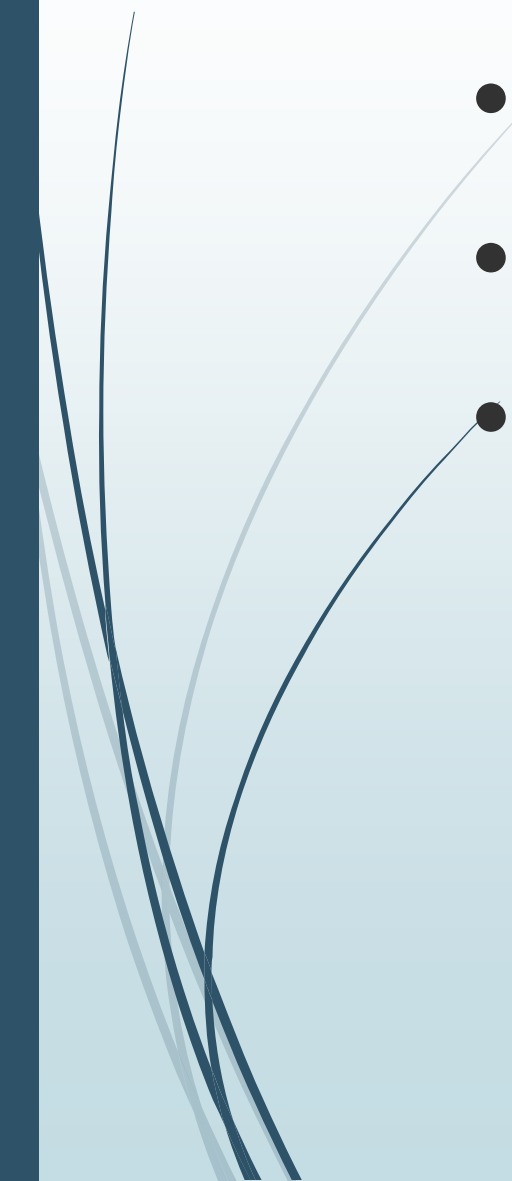


We are a diverse group of chronic pain patients advocating for a Montana Pain Patients' Bill of Rights. Treatment of our chronic and intractable pain is a fundamental human right.





Our Goals

- Promote safe, effective non-invasive treatment of pain patients;
 - Educate healthcare providers and patients regarding the unfounded claims against opioid overdoses in Montana;
 - Assist Montana pain patients in accessing health care providers including alternative treatments as the first step to treating pain.
- 

Is CDC Focused on the Wrong Epidemic?

2013 CDC DATA:

- Heart disease: 611,105
- Cancer: 584,881
- Chronic lower respiratory diseases: 149,205
- Accidents (unintentional injuries): 130,557
- Stroke (cerebrovascular diseases): 128,978
- Alzheimer's disease: 84,767
- Diabetes: 75,578
- Influenza and Pneumonia: 56,979
- Nephritis, nephrotic syndrome, and nephrosis: 47,112
- **Intentional self-harm (suicide): 41,149**



The Problem: CDC Misclassified Opioid Overdose Deaths in 2014

- CDC reported there was a spike in overdoses, and overdoses increased to 28,647, which was a 14% increase from prior year (2014).
- CDC Director Tom Frieden explained the data may change after CDC has a chance to review and parse out cases of people who died with both heroin and prescription drugs in their systems. Even if some individuals were counted twice, Frieden explained: "It's clear that the opiate epidemic from 2013 to 2014 got worse, not better" (Washington Post, 2015).
- However, "Heroin deaths might be misclassified as morphine because morphine and heroin are metabolized similarly, which might result in an underreporting of heroin overdose deaths." (Molohon, Pain News Network, 2016).



CDC Ignores Preventable Medical Harm

Preventable Medical Harm is now the 3rd Leading Cause of Death and kills as many as **440,000 people each year** according to a July 2014 Senate Subcommittee on Primary Health and Aging:

“The Chairman of this Senate hearing stated: *“Medical harm is a major cause of suffering, disability, and death – as well as a huge financial cost to our nation.”*

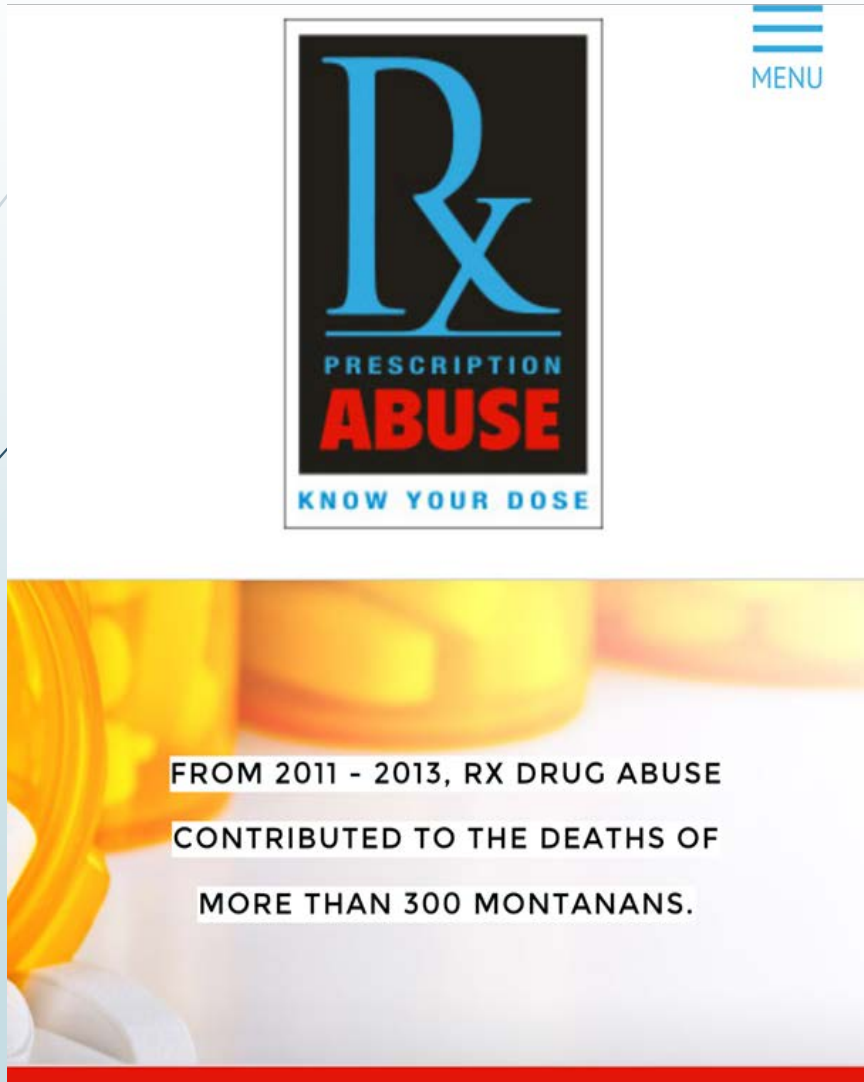




Montana Leads the Nation in Suicides

- In 2014 there were 243 completed suicides
- Almost 25% of completed suicides involved Veterans
- Uncontrolled pain contributes to these tragic outcomes
- Severe chronic and intractable chronic pain conditions become **mental health issues** when left untreated.

Montana Know Your Dose: Our Concerns



Rx
PRESCRIPTION
ABUSE
KNOW YOUR DOSE

MENU

FROM 2011 - 2013, RX DRUG ABUSE
CONTRIBUTED TO THE DEATHS OF
MORE THAN 300 MONTANANS.

1. Unable to verify 300 overdoses.
2. Autopsies should be done on every suicide. Only done on 70 percent (approximate).
3. According to Karl Rosston, 40 percent of Montana's completed suicides involved people with severe medical problems, including terminal illness or chronic pain (Missouliau, 2015).
4. Toxicology reports reveal deaths are often linked to polypharmacy, yet poisonings are counted as "opioid overdose" when one dies with a half-dozen other drugs in their body.
5. Families who lose their loved ones to suicide may not report as this would null and void any insurance benefits.

Montana 2015: 5 out of 10 autopsies had pain medication in their system.

Out of those 5 patients with opioids, patients were on more than one antidepressant. Based on how deaths are classified, the state would likely find these deaths cannot be ruled as an opioid overdose since all had mental health medications. Also note that 4 of the 10 poisonings had alcohol in their system.

1. Quetiapine, Lamotrigine, Paroxetine
2. Alcohol, Quetiapine, Fluoxetine
3. Amitriptyline, Nortriptyline, Oxycodone, Diphenhydramine, Fentanyl, Norfentanyl, Acetaminophen
4. Citalopram/Escitalopram, Oxycodone, Desmethylocitalopram
5. Alcohol, Fluoxetine, Quetiapine, 7-Amino-Clonazepam
6. Alcohol, Diazepam, Mirtazapine, Nordiazepam, Morphine
7. Pentobarbital, Venlafaxine, Hydrocodone, Diltiazem, Norvenlafaxine
8. Alcohol, Venlafaxine, Bupropion
9. Diphenhydramine, Lamotrigine (Lamictal), Tramadol (pain), Sertraline (Zoloft)
10. Bupropion, Metoprolol



Forest Tennant M.D., Dr. P.H.

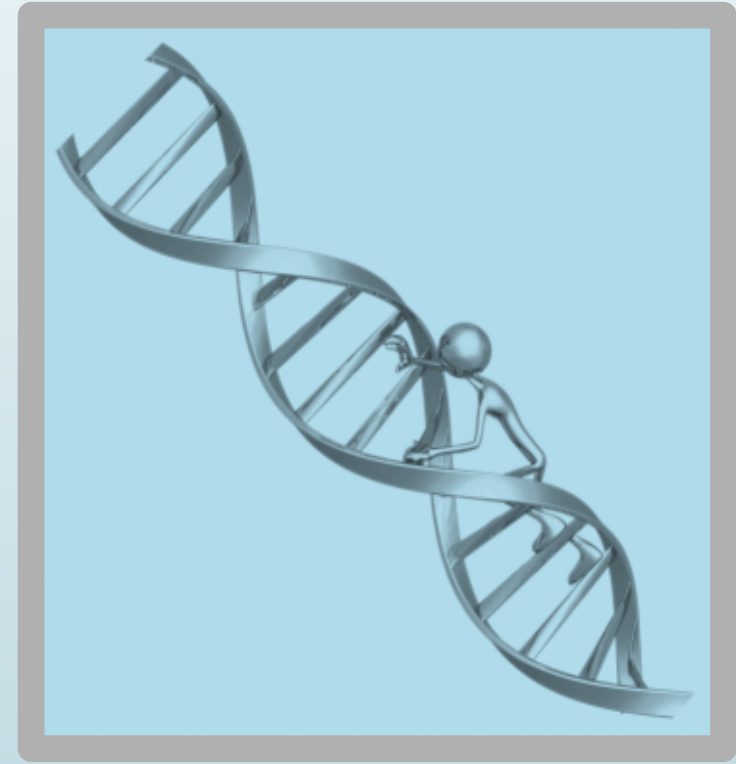
My position on the opioid controversy is quite simple and I ask all concerned to consider:

- 1. We have a long-standing standard known as the World Health Organization 3 Step Analgesic Ladder (1982).**
- 1. There cannot be a cap on dosages as patients vary.**
- 1. Patients who are currently on opioids and doing well should be left on them.**



World Health Organization Pain Ladder

1. If pain occurs, there should be prompt oral administration of drugs in the following order: non-opioids
1. Then, as necessary, mild opioids
1. Then strong opioids such as morphine, until the patient is free of pain.



Montana Pain Patients' Bill of Rights

- A. The state has a right and duty to control the illegal use of opioids;
- B. Opioids can be an accepted treatment for patients in severe chronic and/or intractable pain who have not obtained relief from any other means of treatment;
- C. A patient suffering from severe chronic and/or intractable pain has the option to request or reject the use of any or all modalities to relieve his or her pain, including the option to refuse opiate and non-opiate medications;
- D. Inadequate treatment of acute, chronic, intractable pain, and centralized pain originating from cancer or noncancerous conditions is a significant public health crisis;

Montana Pain Patients' Bill of Rights

- E. For chronic and/or intractable pain patients, pain management and opioid therapy is the single most important treatment a medical practitioner can provide;
- F. A patient suffering from chronic and/or intractable pain should have unobstructed access to safe and effective treatment of his or her pain within a reasonable time frame;
- G. In the hands of knowledgeable and ethical medical practitioners, opioids administered for severe chronic pain and/or severe intractable pain patients can be safe and effective;
- H. A medical practitioner treating a patient who suffers from severe chronic and/or intractable pain may prescribe a dosage deemed medically necessary to relieve the patient's pain and prescribing is in conformance with Montana States Codes and Procedures;

Montana Pain Patients' Bill of Rights

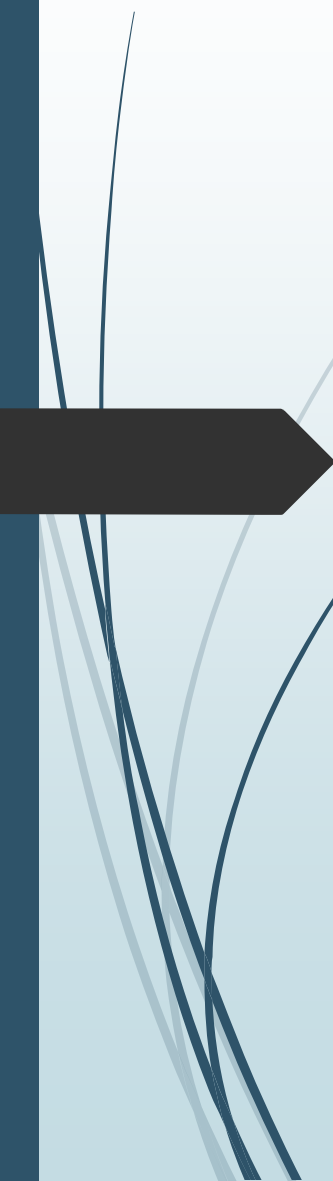
- I. To protect medical practitioners who may prescribe, administer or dispense controlled substances for a therapeutic purpose to a person diagnosed with severe chronic and/or intractable pain;
- J. The Board of Medical Examiners, Board of Nursing and Board of Pharmacy seeks to assure that no Montanan requiring narcotics for pain relief is denied them because of a physician's real or perceived fear that the Board of Medical Examiners will take disciplinary action based solely on the use of narcotics to relieve pain;
- K. A medical practitioner treating a patient who suffers from severe chronic and/or intractable pain may prescribe a dosage deemed medically necessary to relieve the patient's pain;
 - 1. Consideration for the patient's pharmacogenomics testing shall be accounted for when prescribing dosages that are above standard levels;
- L. Opioids should be reserved for severe chronic and/or intractable pain patients whom have failed all alternative methods; opioids may also be used in conjunction with complementary and alternative therapies;

Montana Pain Patients' Bill of Rights

M. A patient who suffers from severe chronic and/or intractable pain has the option to request or reject the use of any or all modalities in order to relieve his or her pain. Complementary and alternative treatment options should be considered to treat long term chronic pain conditions. However, some complementary and alternative treatment options may not be effective for severe cases of intractable pain, and may require opioids in addition to alternative options (ex: opioids in combination with hormone therapy). Alternative treatment options include but are not limited to:

1. Acupuncture;
2. Biofeedback;
3. Chiropractic treatment;
4. Cranio sacral therapy;
5. Drug-gene Testing/Pharmacogenomics;
6. Hormone therapy;
7. Naturopathic medicine;
8. Physical therapy;
9. Prolotherapy;
10. Therapeutic Massage;
11. And/or any other non-invasive therapy that assists with reducing the pain condition;

Montana Pain Patients' Bill of Rights



N. A patient who suffers from severe chronic and/or intractable pain has the option to choose opiate medications to relieve the pain without first having to submit to an invasive medical procedure, which is defined by but not limited to: implantation of medical devices including neurostimulators and drug-delivery systems, radio-frequency ablation and spinal injections including but not limited to myelograms, epidural steroid injections, “diagnostic/therapeutic” spinal injections, and spinal taps. Procedures that involve destruction of a nerve or other body tissue by surgical or injectable manipulation are considered to be invasive. A medical practitioner cannot dismiss a patient from care for their refusal to submit themselves to such invasive medical procedures;

1. It shall be recognized that if a patient chooses to undergo invasive procedures such as an Epidural Steroid Injection or other invasive procedure the medical practitioner must recognize there could be irreversible damage done creating more pain than the patient initially had, this may result in long-term pain management;

Montana Pain Patients' Bill of Rights

N. Continued:

2. It shall be recognized that if a patient has an implantation of a drug delivery system that patient may still need “breakthrough” pain medications;
3. It shall be recognized that if a patient is on a pain management protocol and the patients base line pain is controlled the practitioners must recognize that if an acute condition arises, i.e. dental work, surgery, etc. the patient may require additional acute opioid pain medications to treat their acute pain condition;

Montana Pain Patients' Bill of Rights

N. Continued:

- 4. Nothing in this section shall do either of the following:**
 - a. Limit any reporting or disciplinary provisions applicable to medical practitioners and surgeons who violate prescribing practices or other provisions;**
 - b. Limit the applicability of any federal statute or federal regulation or any of the other statutes or regulations of this state which regulate dangerous drugs or controlled substances;**

DEFINITIONS OF PAIN

Acute Pain is defined, as pain that comes on quickly, can be severe, but lasts a relatively shorter period of time. This legislation does not address patients suffering acute pain.

Chronic Pain is defined as pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician and by objective proof of the etiology of the pain including relevant and necessary diagnostic tests that may include but are not limited to the results of an x-ray, computerized tomography scan, or magnetic resonance imaging.

Intractable Pain is defined as pain that is excruciating, constant, incurable, and of such severity that it dominates virtually every conscious moment, produces mental and physical debilitation and may produce a desire to commit suicide for the sole purpose of stopping the pain. A bonafide intractable pain patient suffer profusely and are fundamentally bed or house bound in the absence of intense medical management. Unfortunately, the cause of pain cannot be eliminated or successfully treated without the use of controlled substance therapy.



DEFINITIONS OF PAIN CONTINUED

Centralized Pain is defined as inflammatory mediators generated in the peripheral injury site (activation of glial and opioid receptors) enter the spinal cord and central nervous system (CNS) creating an inflammatory/pain response. If the inflammatory response is excessive (and not treated quickly), tissue destruction occurs in the CNS. In this process, the memory of the pain becomes encoded or “trapped.” If the neuroinflammation generated by glial cell activation is not contained, a number of pathologic changes take place. They include cellular and receptor overstimulation (“sensitization”), tissue loss, hypothalamic-pituitary activation, and excess autonomic efferent and sympathetic discharge. In essence, the pain develops an inflammatory site within the CNS that encodes and produces hyper arousal of the autonomic nervous system. A good way to grasp this phenomenon is to know that phantom pain is the quintessential example of “centralized” pain.

DEFINITIONS OF PAIN CONTINUED

Blood serum is the fluid portion of the blood obtained after removal of the fibrin clot and blood cells, distinguished from the plasma in circulating blood. Sometimes used as a synonym for antiserum or antitoxin.

Biofeedback or applied psychophysiological feedback, is a patient-guided treatment that teaches an individual to control muscle tension, pain, body temperature, brain waves, and other bodily functions and processes through relaxation, visualization, and other cognitive control techniques.

Craniosacral therapy includes the skull and sacrum, brain stem and sacral spinal cord, origin of parasympathetic preganglionic neurons. Craniosacral therapy is a form of massage that purports to cure ailments by redirecting the flow of cerebrospinal fluid or manipulating the cranial sutures.

DEFINITIONS OF PAIN CONTINUED

Drug-Gene Testing or Pharmacogenomics (Pharmacogenetic) All terms characterize the study of how your genes affect the patient's' response to medications. The word "pharmacogenomics" is combined from the words pharmacology (the study of the uses and effects of medications) and genomics (the study of genes and their functions). Your body has thousands of genes that you inherited from your parents. Genes determine which characteristics you have, such as eye color and blood type. Some genes are responsible for how your body processes medications. Pharmacogenomics tests look for changes or variants in these genes that may determine whether a medication could be an effective treatment for you or whether you could have side effects to a specific medication.

Epidural Steroid Injection (ESI) is an injection near the spine that usually includes a combination of a corticosteroid with a local anesthetic pain relief medicine. Corticosteroids are strong anti-inflammatory medicines used to relieve swelling and inflammation. When administered by the epidural route, corticosteroids are used "off-label" or "off-license" which means the medication is being used in a manner not specified in the FDA's approved packaging label, or insert.

Hormone therapy is the treatment of diseases with hormones obtained from endocrine glands or substances that stimulate hormonal effects. Also called endocrine therapy.

DEFINITIONS OF PAIN CONTINUED

Neurostimulation involves implantation of a surgically placed medical device that is designed to disrupt pain signals traveling between the spinal cord and the brain. Neurostimulators deliver mild electrical signals to the epidural space near patient's spine through one or more thin wires, called leads.

Myelogram uses [x-rays](#) and a special dye called [contrast material](#) to make pictures of the bones and the fluid-filled space (subarachnoid space) between the bones in your spine (spinal canal). During the test, a dye is put into the subarachnoid space with a thin needle. The dye moves through the space so the nerve roots and spinal cord can be seen more clearly.

Radiofrequency ablation (or RFA) is a procedure used to reduce pain. An electrical current produced by a radio wave is used to heat up a small area of nerve tissue, thereby decreasing pain signals from that specific area.

Spinal taps- A local anesthetic (pain-relieving medication) will be injected into the area on your back. You may feel a slight burning sensation. When the area becomes numb, a hollow needle will be inserted in the lower back between two lumbar vertebrae. This sometimes causes a feeling of pressure. The spinal canal will be penetrated and fluid will be collected or medication will be injected.

Montana Standard of Care

Overuse of Epidural Steroid Injections & Spinal Surgeries

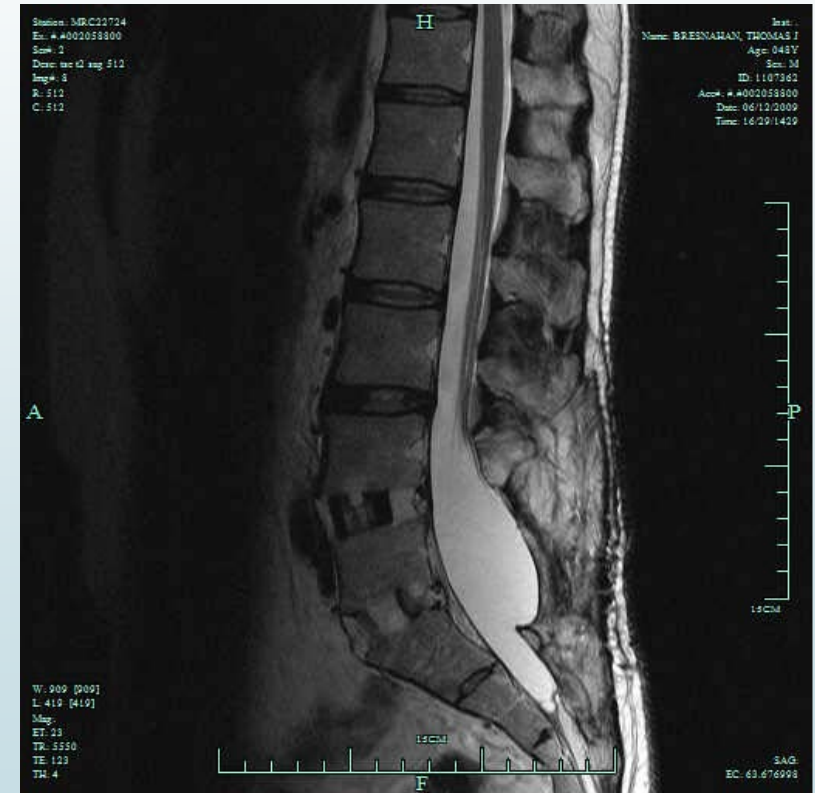
Karl Rosston, Missoulian (2015):

“We have to change something
with this issue...

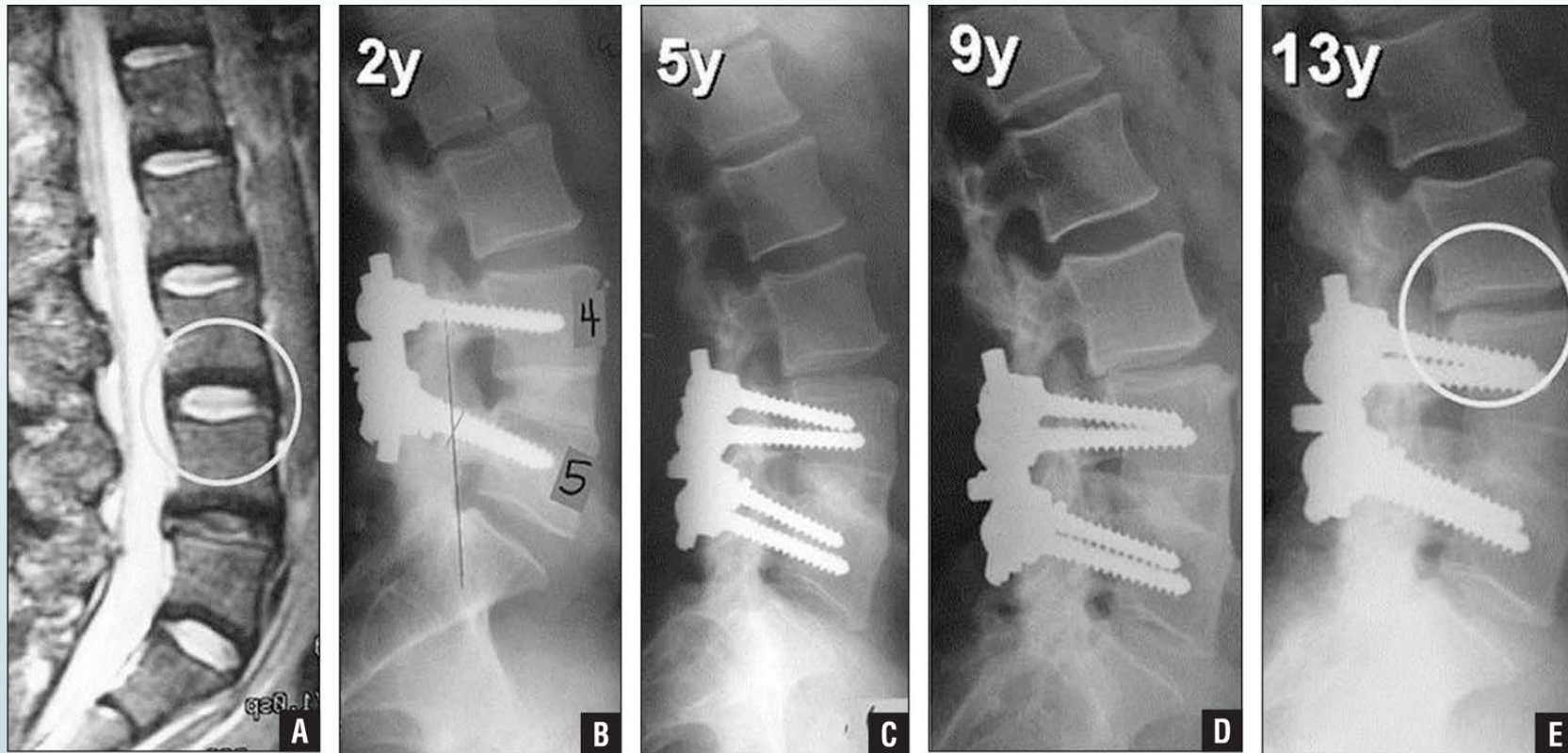
with people who are tired of the
pain who didn't want to have
another surgery.”



Patient Harm: Adhesive Arachnoiditis

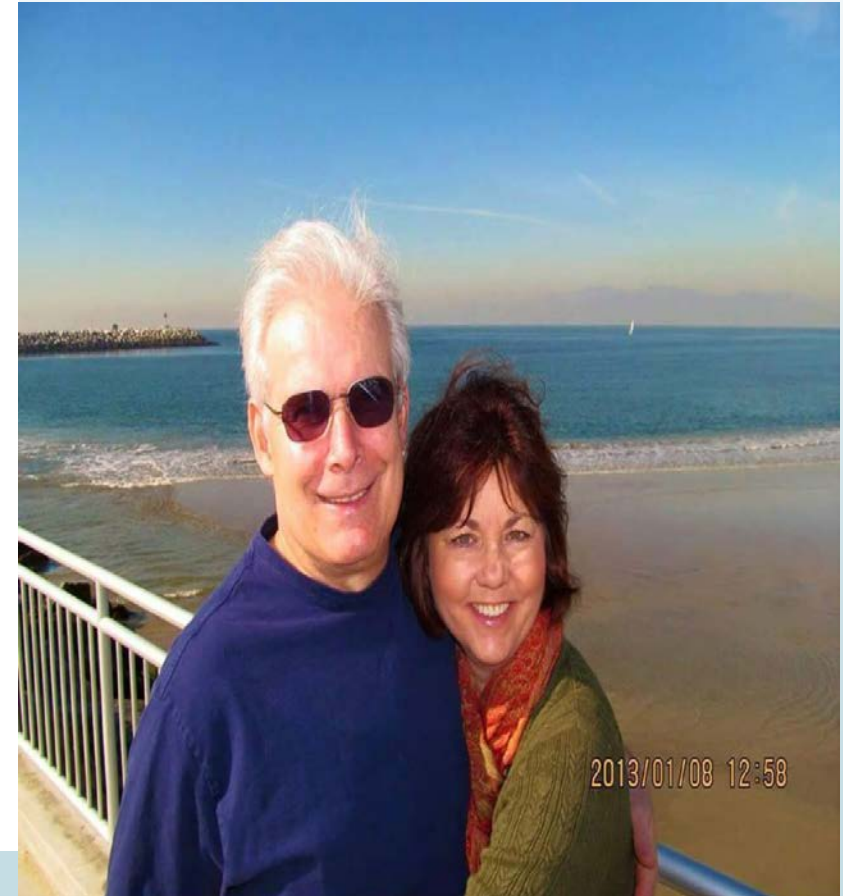
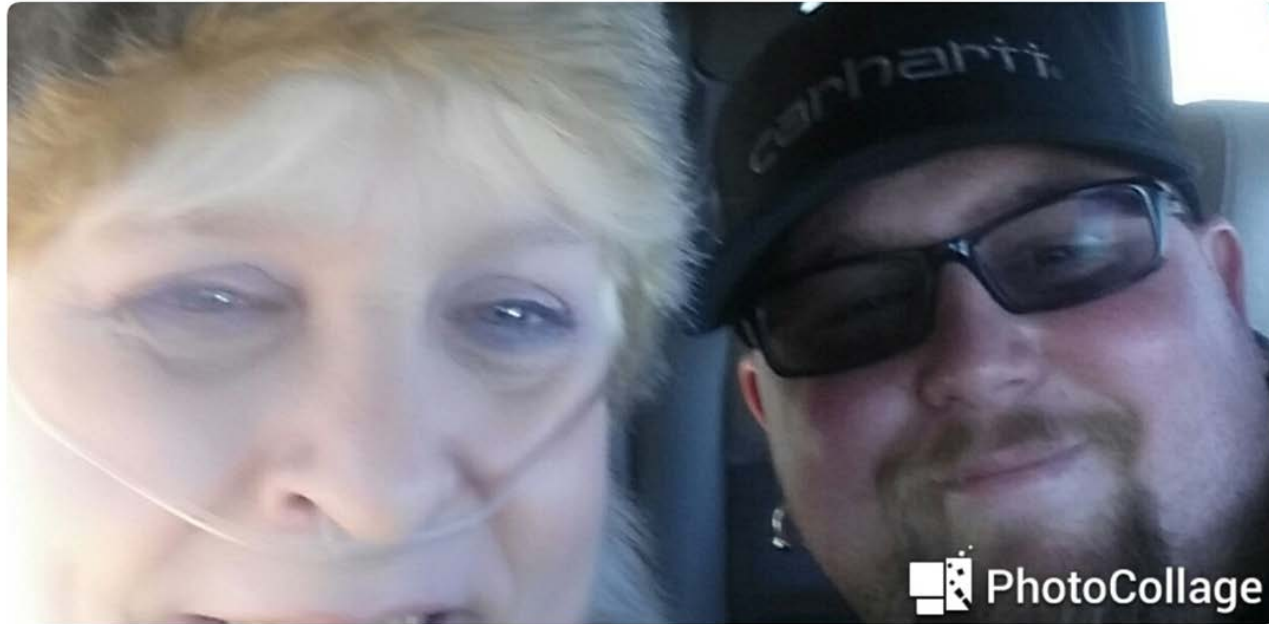
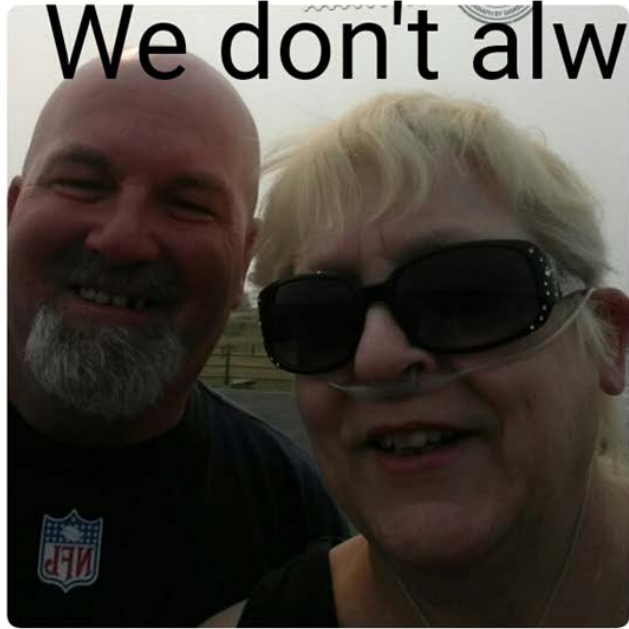


Patient Harm: Adjacent Segment Disease





We don't always look sick





PhotoCollage

Invisible Disabilities



PhotoCollage

Leading Authority on Intractable Pain, Forest Tennant MD

“Be clearly advised that the anti-opioid movement is well-funded by such financial interests as interventional pain physicians, surgeons and surgical hospitals, mental health professionals, and the heroin cartel. We need demands that data be objective. For example, they call it an "opioid overdose" when someone dies with a half-dozen other drugs in the body.”



Questions?

Contact Information:

mtpainedlivesmatter@gmail.com



At this time we need letters, not only demanding humanitarian care and rights, but demands for equal representation on government committees and the resignation/firing of obvious vocal opioid haters.

– Forest Tennant MD



References

1. Lohman et al. BMC Medicine (2010) Access to pain treatment as a human right.
<http://bmcmmedicine.biomedcentral.com/articles/10.1186/1741-7015-8-8>
<http://apps.who.int/medicinedocs/documents/s18774en/s18774en.pdf>
1. ADA Amendments Act of 2008. PL 110-325 (S 3406)
<http://www.eeoc.gov/laws/statutes/adaaa.cfm>
1. Vargas-Schaffer MD G. US National Library of Medicine National Institutes of Health. (2010) Is the WHO analgesic ladder still valid? <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902929/>
4. Tennant F. Pain and Pain Management. Position on Opioid Controversy, November, 2015. (2015)
<http://www.foresttennant.com>
5. Molohon D (2016) Pain News Network. How the CDC Misclassifies Opioid Overdoses. Molohon D (2016) Pain News Network. How the CDC Misclassifies Opioid Overdoses.
<http://www.painnewsnetwork.org/stories/2016/1/12/how-the-cdc-misclassifies-opioid-overdose-deaths-1?rq=how%20the%20cdc%20misclassifies%20op>
6. Bernstein L (2015) Deaths from Opioid overdoses set a record in 2014
<https://www.washingtonpost.com/news/to-your-health/wp/2015/12/11/deaths-from-heroin-overdoses-surged-in-2014/>
7. Benoit Z (2015) Missoulian. 81 percent of Montana were males; nearly 25 percent were veterans
http://missoulian.com/news/state-and-regional/percent-of-montana-suicides-in-were-males-nearly-percent-were/article_c5ab2cdf-0b7f-54af-b2fb-23bb2cd3cd0c.html