PAIN MEDICINE

PALM SPRINGS

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FEBRUARY 23–26, 2012
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A Non-narcotic Option for Patients Who Require Analgesia at the Opioid Level

SPRIX® (ketorolac tromethamine) Nasal Spray is indicated for the short-term (up to 5 days) management of moderate to moderately severe pain that requires analgesia at the opioid level.

WARNING: LIMITATIONS OF USE, GASTROINTESTINAL, BLEEDING, CARDIOVASCULAR, and RENAL RISK

Limitations of Use—SPRIX® (ketorolac tromethamine) Nasal Spray, a nonsteroidal anti-inflammatory drug (NSAID), is indicated for short-term (up to 5 days in adults) management of moderate to moderately severe pain that requires analgesia at the opioid level. Do not exceed a total combined duration of use of SPRIX® and other ketorolac formulations (IM/IV or oral) of 5 days.

SPRIX® is not indicated for use in pediatric patients and it is not indicated for minor or chronic painful conditions.

Gastrointestinal Risk—Ketorolac tromethamine, including SPRIX®, can cause peptic ulcers, gastrointestinal bleeding and/or perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Therefore, SPRIX® is contraindicated in patients with active peptic ulcer disease, in patients with recent gastrointestinal bleeding or perforation, and in patients with a history of peptic ulcer disease or gastrointestinal bleeding. Elderly patients are at greater risk for serious gastrointestinal events.

Bleeding Risk—Ketorolac tromethamine inhibits platelet function and is, therefore, contraindicated in patients with suspected or confirmed cerebrovascular bleeding, patients with hemorrhagic diathesis, incomplete hemostasis and those at high risk of bleeding.

Cardiovascular Risk—NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk.

SPRIX® is contraindicated for treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.

Renal Risk—SPRIX® is contraindicated in patients with advanced renal impairment and in patients at risk for renal failure due to volume depletion.

Please visit us at Booth 424.

Please see BOXED WARNING above and following pages for Important Safety Information and Brief Summary of Prescribing Information.
Effective
- The only intranasal NSAID that provides pain relief at the opioid level\(^1\)
- Reduces the need for morphine

Non-narcotic
- Ketorolac does not bind to opiate receptors

Well absorbed
- Reaches peak plasma concentration in as little as 30 minutes, with a median \(t_{\text{max}}\) of 45 minutes

Innovative delivery
- Innovative presentation of ketorolac provides hospital-strength analgesia both inside and outside of the hospital\(^1\)

IMPORTANT SAFETY INFORMATION

WARNING: LIMITATIONS OF USE, GASTROINTESTINAL, BLEEDING, CARDIOVASCULAR, and RENAL RISK

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Gastrointestinal Risk—Ketorolac tromethamine, including SPRIX\(^\circledR\), can cause peptic ulcers, gastrointestinal bleeding and/or perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Therefore, SPRIX\(^\circledR\) is contraindicated in patients with active peptic ulcer disease, in patients with recent gastrointestinal bleeding or perforation, and in patients with a history of peptic ulcer disease or gastrointestinal bleeding. Elderly patients are at greater risk for serious gastrointestinal events.

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SPRIX\(^\circledR\) is contraindicated for treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.

Renal Risk—SPRIX\(^\circledR\) is contraindicated in patients with advanced renal impairment and in patients at risk for renal failure due to volume depletion.

SPRIX\(^\circledR\) is contraindicated in patients with known hypersensitivity or history of asthma, urticaria, or other allergic-type reactions to aspirin, ketorolac, other NSAIDs or EDTA. However, anaphylactoid reactions may occur in patients with or without a history of allergic reactions to aspirin or NSAIDs. SPRIX\(^\circledR\) is contraindicated in patients as a prophylactic analgesic prior to major surgery; or in labor, delivery, or nursing mothers because of the potential adverse effects of prostaglandin-inhibiting drugs on neonates.

SPRIX\(^\circledR\) should not be used concomitantly with IM/IV or oral ketorolac, aspirin, or other NSAIDs, or with probenecid or pentoxifylline. When ketorolac is administered with aspirin, its protein binding is reduced, although the clearance of free ketorolac is not altered. The clinical significance of this interaction is not known; however, as with other NSAIDs, concomitant administration of SPRIX\(^\circledR\) and aspirin is not generally recommended because of the potential of increased adverse effects.

Do not use SPRIX\(^\circledR\) in patients for whom hemostasis is critical.

Clinical studies, as well as postmarketing observations, have shown that ketorolac can reduce the natriuretic effect of furosemide and thiazides in some patients.

Concomitant use of ACE inhibitors and/or angiotensin II receptor antagonists may increase the risk of renal impairment, particularly in volume-depleted patients. NSAIDs may diminish the antihypertensive effect of ACE inhibitors and/or angiotensin II receptor antagonists. Consider this interaction in patients taking SPRIX\(^\circledR\) concomitantly with ACE inhibitors and/or angiotensin II receptor antagonists.

Ketorolac can cause serious GI adverse events including bleeding, ulceration, and perforation. Elderly patients are at increased risk for serious GI events.

Use SPRIX\(^\circledR\) with caution in patients with impaired hepatic function or a history of liver disease.

The pharmacologic activity of SPRIX\(^\circledR\) in reducing inflammation and fever may diminish the utility of these diagnostic signs in detecting infections.
SPRIX® is a non-narcotic option for patients who require analgesia at the opioid level

In a study of post-abdominal or -orthopedic surgery, SPRIX® provided significantly greater pain reduction vs placebo.

![Graph showing pain intensity difference over 48 hours](image)

Patients taking SPRIX® required 34% less morphine (51.4 mg vs 77.4 mg) over 48 hours, P < 0.001

A phase 3 randomized, double-blind, placebo-controlled study to evaluate the analgesic efficacy and tolerability of single- and multiple-dose SPRIX® in major abdominal and orthopedic surgery patients remaining in hospital for 2–5 days. Patients were randomly assigned in a 2:1 ratio to receive SPRIX® 31.5 mg or matching placebo following surgery (day 0). All patients had access to morphine sulfate (MS) by patient-controlled analgesia (PCA) beginning on day 0. The study was designed with a multidose regimen of SPRIX® 31.5 mg or matching placebo administered three times per day for up to 5 days. Backup analgesia was permitted. Total hysterectomies were the majority of abdominal surgery procedure (72%). Hip replacements were the most common orthopedic procedure (72%). Other procedures were ovarian cystectomy, laminecctomy, rotator cuff repair, fracture reduction and fixation, salpingo-oophorectomy, breast reconstruction, appendectomy, and knee and ankle replacement.

After surgery, intravenous opioid was administered at the discretion of the investigator. Patients recorded pain intensity (PI) ratings using a Visual Analog Scale (VAS) of 0 (no pain) to 100 mm (worst pain). When PI ratings equaled at least 40 on the VAS, patients received SPRIX® or placebo.

SPRIX® (ketorolac tromethamine) Nasal Spray is indicated in adult patients for the short-term (up to 5 days) management of moderate to moderately severe pain that requires analgesia at the opioid level.

Avoid contact of SPRIX® with the eyes. If eye contact occurs, wash out the eye with water or saline, and consult a physician if irritation persists for more than an hour.

Ketorolac can cause renal injury. SPRIX® Nasal Spray should be used with caution in patients with advanced renal disease or patients at risk for renal failure due to volume depletion and should be used with caution in patients taking diuretics or ACE inhibitors. Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury such as interstitial nephritis and nephrotic syndrome.

NSAIDs can cause serious dermatologic adverse reactions such as exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis, which can be fatal. These serious events may occur without warning. SPRIX® should be discontinued immediately in patients with skin reactions.

During pregnancy, use of SPRIX® beyond 30 weeks’ gestation can cause premature closure of the ductus arteriosus, resulting in fetal harm (Pregnancy Category D). Prior to 30 weeks’ gestation, SPRIX® should be used during pregnancy only if potential benefit justifies the potential risk to the fetus (Pregnancy Category C).

NSAIDs can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of cardiovascular events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs. Fluid retention, edema, retention of NaCl, oliguria, and elevations of serum urea nitrogen and creatinine have been reported in clinical trials with ketorolac. Only use SPRIX® very cautiously in patients with cardiac decompensation or similar conditions.

The most common adverse reactions (incidence ≥ 2%) in patients treated with SPRIX® and occurring at a rate at least twice that of placebo are nasal discomfort, rhinalgia, increased lacrimation, throat irritation, decreased urine output, increased ALT and/or AST, hypertension, and rhinitis.

Treat patients for the shortest duration possible, and do not exceed 5 days of therapy with SPRIX®.

References:
SPRIX® (ketorolac tromethamine) Nasal Spray  
Rx Only

HIGHLIGHTS OF PRESCRIBING INFORMATION

• • • •

WARNING: LIMITATIONS OF USE, GASTROINTESTINAL, BLEEDING, CARDIOVASCULAR, and RENAL RISK

See first page for complete boxed warning

• Limitations of Use – The total duration of use of SPRIX and other ketorolac formulations should not exceed 5 days.

• Gastrointestinal (GI) Risk – Ketorolac can cause peptic ulcers, GI bleeding, and/or perforation of the stomach or intestine, which can be fatal. SPRIX is CONTRAINDICATED in patients with peptic ulcer disease or history of GI bleeding.

• Bleeding Risk – SPRIX inhibits platelet function and is CONTRAINDICATED in patients with suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis, or high risk of bleeding.

• Cardiovascular (CV) Risk – NSAIDs may cause an increased risk of serious CV thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with CV disease or risk factors for CV disease may be at greater risk. SPRIX is CONTRAINDICATED for treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.

• Renal risk – SPRIX is CONTRAINDICATED in patients with advanced renal impairment and in patients at risk for renal failure due to volume depletion.

SPRIX® is available as an intranasal spray product containing the active ingredient (ketorolac tromethamine) and the excipients edetate disodium (EDTA), monobasic potassium phosphate, sodium hydroxide, and water for injection. Each single-dose nasal spray bottle contains a sufficient quantity of solution to deliver 8 sprays for a total of 128 mg of ketorolac tromethamine. Each spray delivers 15.75 mg of ketorolac tromethamine.

INDICATIONS AND USAGE

SPRIX® is indicated in adult patients for the short term (up to 5 days) management of moderate to moderately severe pain that requires analgesia at the opioid level. (1)*

• Use as a prophylactic analgesic before any major surgery (4, 5.3)

CONTRAINDICATIONS

• Anaphylactoid reactions may occur in patients with or without a history of allergic reactions to aspirin or NSAIDs. SPRIX® should be discontinued immediately in patients with allergic reactions. (4, 5.5, 5.7, 5.11)

• Serious and potentially fatal cardiovascular thrombotic events, myocardial infarction, and stroke can occur with NSAID treatment. (5.6)

• Fluid retention and edema have been observed in patients taking NSAIDs. SPRIX® should be used with caution in patients with cardiac decompensation or similar conditions. (5.4, 5.6)

• NSAIDs can cause serious dermatologic adverse reactions such as exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis, which can be fatal. SPRIX® should be discontinued immediately in patients with skin reactions. (4, 5.7)

• During pregnancy, use of SPRIX® beyond 30 weeks gestation can cause premature closure of the ductus arteriosus, resulting in fetal harm. (5.8)

ADVERSE REACTIONS

The most common adverse reactions (incidence ≥ 2%) in patients treated with SPRIX® and occurring at a rate at least twice that of placebo are nasal discomfort, rhinalgia, increased lacrimation, throat irritation, oliguria, rash, bradycardia, decreased urine output, increased ALT and/or AST, hypertension, and rhinitis. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact American Regent, Inc. at 1-800-734-9236 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS

• Concomitant use with anticoagulants may increase the risk of serious GI bleeding. (7.1)

SEE ADDITIONAL INFORMATION BELOW AND FULL PRESCRIBING INFORMATION.

Limitations of Use.
The total duration of use of SPRIX® alone or sequentially with other formulations of ketorolac (IM/IV or oral) must not exceed 5 days because of the potential for increasing the frequency and severity of adverse reactions associated with the recommended doses. Treat patients for the shortest duration possible, and do not exceed 5 days of therapy with SPRIX®. SPRIX® must not be used concomitantly with other forms of ketorolac or other NSAIDs.

CONTRAINDICATIONS

• Use in patients with active peptic ulcer disease, in patients with recent gastrointestinal bleeding or perforation, and in patients with a history of peptic ulcer disease or gastrointestinal bleeding.

• Use in patients with a history of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs.

• Use as a prophylactic analgesic before any major surgery.

• Use during the perioperative period in the setting of coronary artery bypass graft (CABG) surgery. Use in patients with advanced renal disease or patients at risk for renal failure due to volume depletion.

• Use in labor and delivery. Through its prostaglandin synthesis inhibitory effect, ketorolac may adversely affect fetal circulation and inhibit uterine contractions, thus increasing the risk of uterine hemorrhage.

• Use in nursing mothers because of the potential adverse effects of prostaglandin-inhibiting drugs on neonates.

• Use in patients with suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis, or those for whom hemostasis is critical.

• Known hypersensitivity to ketorolac, aspirin, other NSAIDs, or EDTA (4, 5.5, 5.7, 5.11)

• Use in patients with active peptic ulcer disease, recent GI bleeding or perforation, or a history of peptic ulcers or GI bleeding (4, 5.2)

• Use in patients with a history of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs (4, 5.5, 5.7, 5.11)

• Use as a prophylactic analgesic before any major surgery (4, 5.3)

• Use during the perioperative period in the setting of coronary artery bypass graft (CABG) surgery (4, 5.6)

• Use in patients with advanced renal disease or patients at risk for renal failure due to volume depletion (4, 5.4, 5.6)

• Use in labor and delivery (4, 5.8)

• Use in patients with suspected or confirmed cerebrovascular bleeding, patients with hemorrhagic diathesis, incomplete hemostasis, and those at high risk of bleeding (4, 5.3)

WARNING AND PRECAUTIONS

Gastrointestinal (GI) Effects - Risk of Ulceration, Bleeding, and Perforation

SPRIX® is contraindicated in patients with previously documented peptic ulcers and/or GI bleeding. Ketorolac tromethamine can cause serious GI adverse events including bleeding, ulceration, and perforation of the stomach, small intestine, or large intestine, which can be fatal. The incidence and severity of GI complications increases with increasing dose of, and duration of treatment with, ketorolac. In addition to past history of ulcer disease, other factors that increase the risk for GI bleeding in patients treated with NSAIDs include concomitant use of oral corticosteroids or anticoagulants, longer duration of NSAID therapy, smoking, use of alcohol, older age, and poor general health status. Most spontaneous reports of fatal GI events are in elderly or debilitated patients, and therefore, special care should be taken in treating this population. To minimize the potential risk for an adverse GI event, the lowest effective dose should be used for the shortest possible duration. For high risk patients, consider alternate therapies that do not involve NSAIDs. Use great care when giving SPRIX® to patients with a history of inflammatory bowel disease (ulcerative colitis, Crohn’s disease) as their condition may be exacerbated.

Hematological Effects.

Use caution with use of ketorolac tromethamine in patients who have coagulation disorders, and monitor these patients carefully. Postoperative hematomas and other signs of wound bleeding have been reported in association with perioperative use. Therefore, use SPRIX® with caution in the postoperative setting when hemostasis is critical. Do not use SPRIX® in patients for whom hemostasis is critical.

Renal Effects.

Ketorolac and its metabolites are eliminated primarily by the kidneys.
with reduced creatinine clearance will have diminished clearance of the drug. SPRIX® is coadministered in patients with advanced renal impairment. Patients treated with SPRIX® should be adequately hydrated. Use SPRIX® with caution in patients with impaired renal function, heart failure, liver dysfunction, those taking diuretics or ACE inhibitors, and the elderly. Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury such as interstitial nephritis and nephrotic syndrome.

**Anaphylactoid Reactions.** As with other NSAIDs, anaphylactoid reactions may occur in patients with or without a history of allergic reactions to aspirin or NSAIDs and in patients without known prior exposure to ketorolac. SPRIX® should not be given to patients with the aspirin triad.

**Cardiovascular Effects**

- **Cardiovascular (CV) Thrombotic Events**
  Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious CV thrombotic events, myocardial infarction and stroke, which can be fatal. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, the lowest effective dose should be used for the shortest duration possible.

- **Hypertension**
  NSAIDs can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs.

- **Congestive Heart Failure and Edema**
  Fluid retention, edema, retention of NaCl, oliguria, and elevations of serum urea nitrogen and creatinine have been reported in association with NSAIDs. Inflammatory reactions, including edema, pleural effusion, and pericardial effusion, have been reported in patients treated with ketorolac.

- **Skin Reactions.** NSAIDs, including ketorolac, can cause serious skin adverse events such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Inform patients about the signs and symptoms of serious skin manifestations, and discontinue use of the drug at the first appearance of skin rash or any other sign of hypersensitivity.

- **Eye Exposure**
  Avoid contact of SPRIX® with the eyes. If eye irritation occurs, wash out eye with water or saline, and consult a physician if irritation persists for more than one hour.

**Inflammation and Fever.** The pharmacological activity of SPRIX® in reducing inflammation and fever may diminish the utility of these diagnostic signs in detecting infections.

**Preexisting Asthma.** Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross reactivity, including bronchospasm, between aspirin and other NSAIDs has been reported in such aspirin-sensitive patients, do not administer SPRIX® to patients with this form of aspirin sensitivity, and use with caution in patients with preexisting asthma.

**Eye Exposure.** Avoid contact of SPRIX® with the eyes. If eye irritation occurs, wash out eye with water or saline, and consult a physician if irritation persists for more than one hour.

**ADVERSE REACTIONS**

The most frequently reported adverse reactions were related to local symptoms, i.e., nasal discomfort or irritation. These reactions were generally mild and transient in nature. The most common drug-related adverse events leading to premature discontinuation were nasal discomfort or nasal pain (rhinagia). The data described below reflect exposure to SPRIX® in patients enrolled in placebo-controlled efficacy studies of acute pain following major surgery. Most patients were receiving concomitant opioids, primarily PCA morphine.

Table 1. Post-operative Patients with Adverse Reactions Observed at a rate of 2% or more and at least twice the incidence of the placebo group.

<table>
<thead>
<tr>
<th>SPRIX® (N=455)</th>
<th>Placebo (N= 245)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal discomfort</td>
<td>15%</td>
</tr>
<tr>
<td>Rhinagia</td>
<td>13%</td>
</tr>
<tr>
<td>Laceration increased</td>
<td>5%</td>
</tr>
<tr>
<td>Throat irritation</td>
<td>4%</td>
</tr>
<tr>
<td>Urea output decreased</td>
<td>2%</td>
</tr>
<tr>
<td>ALT and/or AST increased</td>
<td>2%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2%</td>
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<td>Ritrinit</td>
<td>2%</td>
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</tbody>
</table>

In controlled clinical trials in major surgery, primarily knee and hip replacements and abdominal hysterectomies, seven patients (N=455, 1.5%) treated with SPRIX® experienced serious adverse events of bleeding (4 patients) or hematoma (3 patients) at the operative site versus one patient (N=245, 0.4%) treated with placebo (hematoma). Six of the seven patients treated with SPRIX® underwent a surgical procedure and/or blood transfusion and the placebo patient subsequently required a blood transfusion.

**DRUG INTERACTIONS**

Ketorolac is highly bound to human plasma protein (mean 99.2%). There is no evidence in animal or human studies that ketorolac induces or inhibits hepatic enzymes capable of metabolizing itself or other drugs.

**Warfarin, Digoxin, Salicylate, and Heparin.** Therapeutic concentrations of digoxin, warfarin, ibuprofen, naproxen, piroxicam, acetaminophen, phenytoin, and tolbutamide did not alter ketorolac protein binding.

**Aspirin.** When ketorolac is administered with aspirin, its protein binding is reduced, although the clearance of free ketorolac is not altered. The clinical significance of this interaction is not known; however, as with other NSAIDs, concomitant administration of SPRIX® and aspirin is not generally recommended because of the potential of increased side effects.

**Diuretics.** Clinical studies, as well as postmarketing observations, have shown that ketorolac can reduce the natriuretic effect of furosemide and thiazides in some patients.

**Probenecid.** Concomitant administration of oral ketorolac and probenecid resulted in decreased clearance and volume of distribution of ketorolac and significant increases in ketorolac plasma levels (total AUC increased approximately threefold from 5.4 to 17.8 mcg*h/mL), and terminal half-life increased approximately twofold from 6.6 to 15.1 hours. Therefore, concomitant use of SPRIX® and probenecid is contraindicated.

**Lithium.** NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. The mean minimum lithium concentration increased 15%, and the renal clearance was decreased by approximately 20%. Thus, when SPRIX® and lithium are administered concurrently, observe patients carefully for signs of lithium toxicity.

**Methotrexate.** NSAIDs have been reported to competitively inhibit methotrexate accumulation in rabbit kidney slices. This may indicate that they could enhance the toxicity of methotrexate. Use caution when SPRIX® is administered concomitantly with methotrexate.

**ACE Inhibitors/Angiotensin II Receptor Antagonists.** Concomitant use of ACE inhibitors and/or angiotensin II receptor antagonists may increase the risk of renal impairment, particularly in volume-depleted patients. Reports suggest that NSAIDs may diminish the antihypertensive effect of ACE inhibitors and/or angiotensin II receptor antagonists. Consider this interaction in patients taking SPRIX® concomitantly with ACE inhibitors and/or angiotensin II receptor antagonists.

**Antiepileptic Drugs.** Sporadic cases of seizures have been reported during concomitant use of ketorolac and antiepileptic drugs (phenytoin, carbamazepine).

**Psychoactive Drugs.** Hallucinations have been reported when ketorolac was used in patients taking psychoactive drugs (fluoxetine, thiothixene, alprazolam).

**Pentoxifylline.** When ketorolac is administered concurrently with pentoxifylline, there is an increased tendency to bleeding. Therefore, concomitant use of SPRIX® and Pentoxifylline is contraindicated.

**Nondepolarizing Muscle Relaxants.** In postmarketing experience there have been reports of a possible interaction between ketorolac and nondepolarizing muscle relaxants that resulted in apnea.

**Selective Serotonin Reuptake Inhibitors (SSRIs).** There is an increased risk of gastrointestinal bleeding when selective serotonin reuptake inhibitors (SSRIs) are combined with NSAIDs.

**Fluocinone/Epoxymethazoline.** The rate and extent of absorption of ketorolac from SPRIX® administration were assessed in subjects with allergic rhinitis before and after the administration of a single daily dose of fluocinone and oxymethazoline. There was no effect on the pharmacokinetic characteristics of SPRIX® that can be considered clinically significant.

**DRUG ABUSE AND DEPENDENCE**

Ketorolac does not bind to opiate receptors.

**Symptoms and Signs.** Symptoms following acute NSAID overdose are usually limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression, and coma may occur, but are rare.

**Treatment.** Manage patients using symptomatic and supportive care following an NSAID overdose. There are no specific antidotes.

**PATIENT COUNSELING INFORMATION**

Instruct patients to read the NSAID Medication Guide that accompanies each prescription dispensed.
WIN AN APPLE iPAD*

EXCLUSIVE MEMBERS-ONLY iPAD DRAWING
This drawing is for AAPM members who attend the State of Our Academy Meeting/AAPM Awards Presentation on Saturday, February 25.

*An Apple store gift card will be issued.
WELCOME!
As co-chairs of the AAPM 28th Annual Meeting Planning Committee, we are pleased to extend a warm welcome to all of you. We are excited about this year’s annual meeting, which continues the Academy’s 28-year tradition of focusing on emerging issues in pain medicine that are presented by experts in the field. Faculty will offer an outstanding array of sessions covering the latest pain science and the practice of pain medicine in a dynamic healthcare environment. Below are just a few of the meeting’s highlights.

PRECONFERENCE SESSIONS AND ADDITIONAL EDUCATIONAL OPPORTUNITIES
Before the AAPM’s Annual Meeting formally begins, we will offer 2 days of world-class educational sessions, including the renowned Essential Tools for Treating the Patient in Pain™ course, the 1-day Cadaver Workshop, and Ultrasound Guidance for the Pain Physician.

KEYNOTE PLENARY SPEAKER, LINDA R. WATKINS, PHD, ON FRIDAY, FEBRUARY 24, 8:15–9 AM
World renowned for her groundbreaking work in glial cells and in understanding the mechanisms and potential control of pain, Linda R. Watkins, PhD, was awarded one of Spain’s Prince of Asturias Awards for Technical and Scientific Research in 2010. She has written and cowritten more than 250 book chapters, review articles, and journal articles. Dr. Watkins gives incredibly dynamic and educational lectures that bridge the basic and clinical sciences.

SCIENTIFIC SESSIONS
AAPM’s targeted scientific sessions are intended to broaden your understanding of such special pain topics as myofascial pain, palliative medicine, psychological screening, public health, and military pain. Together we will explore the newest pain science and techniques and update you on regulatory, legislative, and practice management issues that affect the specialty of pain medicine every day.

SCIENTIFIC RESEARCH
The Academy continues to advance the science of pain medicine by presenting cutting-edge scientific research abstracts in a Plenary Research Highlights Session. The 2012 Scientific Poster Abstract Committee selected three of the highest ranking poster submissions for presentation. New this year is a Friday afternoon concurrent session with three additional high-ranking poster submissions. In addition to attending these presentations, please view the posters and talk to their authors in the exhibit hall Thursday evening through Saturday morning (there will be two sets of poster displays and presentations, so be sure to visit every day). The winning posters will also be available for viewing in the registration area.

NETWORKING WITH COLLEAGUES
This meeting offers a tremendous opportunity for you to network with your fellow pain medicine practitioners. Take advantage of face-to-face dialogue with world-class pain medicine experts and colleagues.

LEARN ABOUT NEW PRODUCTS
Take a first look at innovative products on the pain medicine market and much, much more.

We are delighted to extend this welcome to the 28th Annual Meeting, and we feel confident you will find this educational experience personally and professionally rewarding.

Lynn R. Webster, MD
Medical Director
Lifetree Clinical Research
Salt Lake City, UT

Sean Mackey, MD PhD
Chief, Pain Management Division
Stanford University Medical Center
Palo Alto, CA

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**ABPM Liaison Director**  
Michel Y. Dubois, MD

**Representative of Past Presidents**  
Richard L. Stieg, MD

**Director-at-Large**  
Donna M. Bloodworth, MD

**Editor-in-Chief**  
Pain Medicine  
Rollin M. Gallagher, MD MPH

**Executive Director**  
Philip A. Saigh, Jr

**Director-at-Large**  
Allen W. Burton, MD

**Director-at-Large**  
Timothy R. Deer, MD

### COUNCIL OF PAST PRESIDENTS

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<tr>
<th>Year</th>
<th>Name</th>
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<tr>
<td>1985</td>
<td>Benjamin L. Crue, Jr., MD FACS</td>
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<td>1986</td>
<td>Joel L. Seres, MD</td>
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<td>1987</td>
<td>Robert G. Addison, MD</td>
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<td>1988</td>
<td>Philipp M. Lippe, MD</td>
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<td>1989</td>
<td>Jack J. Pinsky, MD</td>
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<td>Andrew G. Shetter, MD</td>
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<td>1991</td>
<td>Sridhar V. Vasudevan, MD</td>
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<td>1992</td>
<td>E. Richard Blonsky, MD (Deceased)</td>
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<td>1993</td>
<td>Peter R. Wilson, PhD MBBS</td>
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<td>1994</td>
<td>Richard L. Stieg, MD</td>
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<td>Hubert L. Rosomoff, MD DMedSc FAAPM (Deceased)</td>
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<td>Steven D. Feinberg, MD</td>
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<td>Gerald M. Aronoff, MD</td>
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<td>J. David Haddox, DDS MD (Vice-Chair)</td>
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<td>Norman J. Marcus, MD</td>
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<td>Edward C. Covington, MD</td>
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<td>Albert L. Ray, MD</td>
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<td>2002</td>
<td>Marc B. Hahn, DO</td>
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<td>2003</td>
<td>Melvin C. Gitlin, MD (Chair)</td>
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<td>2004</td>
<td>Samuel J. Hassenbusch, MD PhD (Deceased)</td>
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<td>Scott M. Fishman, MD</td>
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<td>2006</td>
<td>Frederick W. Burgess, MD PhD</td>
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<td>B. Todd Sitzman, MD MPH</td>
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<td>Kenneth A. Follett, MD PhD</td>
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<td>Rollin M. Gallagher, MD MPH</td>
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<td>2010</td>
<td>Eduardo M. Fraifeld, MD</td>
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2012 PROGRAM COMMITTEE AND DISCLOSURES

Session Co-Chairs

Lynn R. Webster, MD
Medical Director
Lifetree Clinical Research
Salt Lake City, UT

Adolor Corp. (research), Alkermes, Inc. (research), Allegan, Inc. (research), AstraZeneca (consultant, honoraria, advisory board), Bayer Healthcare (research), BioDelivery Systems International (consultant, honoraria, advisory board, research), Boston Scientific (consultant, honoraria, advisory board, research), Cephalon (consultant, honoraria, advisory board, research), Collegium Pharmaceuticals (research), Covidien (research), Covidien Mallinckrodt (consultant, honoraria, advisory board), Eisai (research), Elan Pharmaceuticals (research), Gilead Sciences (research), GlaxoSmithKline (research), Janssen Pharmaceutical K.K. (consultant, honoraria, advisory board), King Pharmaceuticals (consultant, honoraria, advisory board, research), Meagan Medical (research), Medtronic (research), Nektar Therapeutics (consultant, honoraria, advisory board, research), NeurogesX, Inc. (consultant, honoraria, advisory board, research), Nevo Corporation (consultant, honoraria, advisory board, research), Pharmaco, Inc. (consultant, honoraria, advisory board), Purdue Pharma (consultant, honoraria, advisory board), Shionogi USA, Inc. (research), St. Renatus (research), Sucampo Pharma Americas, USA (research), TEVA Pharmaceuticals Sub-I (research), Theravance, Inc. (consultant, honoraria, advisory board, research), Xanodyne Pharmaceuticals (research)

Sean Mackey, MD PhD
Chief, Pain Management Division
Stanford University Medical Center
Palo Alto, CA

No relevant financial relationships

Essential Tools for Treating the Patient in Pain™ Co-Chairs

Farshad M. Ahadian, MD
Medical Director, Center for Pain Medicine
University of California–San Diego
La Jolla, CA

Boston Scientific (consulting fees, workshop director, speaker), NeurogesX (consulting fees, consultant, speaker)

Gagan Mahajan, MD
Associate Professor
University of California–Davis School of Medicine
Sacramento, CA

No relevant financial relationships

Scientific Poster Abstract Chair

Jeffrey M. Tiede, MD MAJ MC USA
Interdisciplinary Pain Management Center
Dwight D. Eisenhower Army Medical Center
Fort Gordon, GA

Nevo (salary, stock options, consultant)

Committee Members

Edward T. Hope, MD (AAFP)
Director, Primary Care Residency Program
Chalmers P. Wyile Veteran’s Affairs Ambulatory Care Center
Columbus, OH

No relevant financial relationships

Hisani R. Brandon-edwards, BSN-BC RN
Acute Pain Nurse Manager
Defense and Veterans Center for Integrative Pain Management
Rockville, MD

No relevant financial relationships

Chester C. Buckenmaier, III, MD COL MC USA
Program Director
Defense and Veterans Pain Management Initiative
Rockville, MD

No relevant financial relationships

Allen W. Burton, MD
Houston Pain Associates
Houston, TX

Azur, Inc. (honorarium—speaker), Boston Scientific (hourly rate—consulting), Cephalon, Inc. (honoraria—speaker), Medtronic, Inc. (hourly rate—consulting), NeurogesX, Inc. (honoraria—speaker), Pfizer, Inc. (honoraria—speaker), Piranha, Inc. (honoraria—speaker)

Gerardyn Datz, PhD
Director, Pain Management Program
Forrest General Hospital
Hattiesburg, MS

No relevant financial relationships

Martin Grabois, MD
Chairman, Department of Physical Medicine and Rehabilitation
Baylor College of Medicine
Houston, TX

Endo (honoraria—expert panel), King (honoraria—expert panel), Purdue (honoraria—expert panel)

Tim J. Lamer, MD
Past Conference Co-Chair
Associate Professor, Department Chair
Mayo Clinic
Rochester, MN

No relevant financial relationships

Michael S. Leong, MD
Scientific Session Chair
Clinic Chief, Division of Pain Management
Stanford University
Palo Alto, CA

Covidien (honorarium—advisory board), Mertz (honorarium—advisory board)

Yu (Woody) Lin, MD PhD
NIH Program Director
National Institute on Drug Abuse
Bethesda, MD

No relevant financial relationships

John D. Markman, MD
Associate Professor
University of Rochester
Rochester, NY

Affentor (honoraria—advisory board), Alkermes (honoraria—advisory board), Endo (research), Johnson & Johnson (research), NeurogesX (honoraria—advisory board), Sanofi (honoraria—advisory board)

Bill H. McCarberg, MD (AAFP)
Scientific Session Chair
Kaiser Permanente Primary Care
Escondido, CA

Endo (honoraria—speaker), Forest (honoraria—speaker), NeurogesX (honoraria—speaker), Piranha (honoraria—speaker)

John F. Peppin, DO FACPM
Director, Clinical Research Division
The Pain Treatment Center of the Bluegrass
Lexington, KY

Aiko Technology (lectures, consulting, advising), Alpharma Pharmaceuticals (clinical research), Amerex Laboratories (lectures, consulting, advising), Asstelles Pharmaceutical (lectures, consulting, advising), Astellas Pharmaceutical (clinical research), Cephalon Pharmaceuticals (clinical research)

AAPM Staff

Philip A. Saigh, Jr.
AAFM Executive Director
No relevant financial relationships

Susie Flynn
AAFM Director of Education
BioSante (stock), Celgene (stock)

Mary O’Keefe
AAFM Education Coordinator
No relevant financial relationships

Ravi Prasad, PhD
Scientific Session Chair
Assistant Director, Division of Pain Management
Stanford University School of Medicine
Redwood City, CA

No relevant financial relationships

Jerome Schofferman, MD
SpineCare Medical Group, Inc.
Daly City, CA

No relevant financial relationships

Steven P. Stanos, DO
Scientific Session Chair
Medical Director, Center for Pain Management
Rehabilitation Institute of Chicago
Chicago, IL

Covidien (advisory board, consultant), Endo Pharmaceuticals (speaker, advisory board, consultant), Forest Pharmaceuticals (Speaker), Garenthal (advisory board, consultant), King Pharmaceuticals (speaker, advisory board, consultant), Lilly (speaker, advisory board, consultant), Ortho-McNeil (speaker, advisory board, consultant), MyMatrix (advisory board, consultant), Nuovo (advisory board, consultant), Pfizer (speaker, research), Purdue Pharma (speaker, advisory board, consultant)

Mark S. Wallace, MD
Vice Chair, Division of Pain Medicine
University of California–San Diego
La Jolla, CA

Archmedes (research support, private investigator), Azur (honorarium, speaker), Biodelivery Sciences (research support, private investigator), Boston Scientific (honorarium, consultant), NeurogesX (research support, private investigator)

Tony L. Yaksh, PhD
Professor, Department of Anesthesiology
University of California–San Diego
La Jolla, CA

Advanced Targeting (contract), Adynm (contract, SAB), Arsenal (NIH grant), Hydra (contract), ISS (SAB—honorarium), Johnson & Johnson (contract), Nektar (contract), Solstice (contract), Stryker (contract), Xemcore (contract, SAB, honorarium)
PROGRAM INFORMATION

SCHEDULE OF EVENTS
Please note that the schedule of events included in this program book was current at the time of publication and includes several program changes that have occurred since the mailing of the meeting brochure. Please check the day-at-a-glance schedule, available at the registration desk, for room locations and any last-minute program changes.

OBJECTIVES
After attending this meeting, participants should be better able to
• Assess, diagnose, and evaluate patients with a variety of acute and chronic pain disorders.
• Develop appropriate goals and longitudinal treatment plans for patients with acute and chronic pain.
• Identify, treat, or appropriately refer patients with addiction and other psychological disorders.
• Implement new therapies, techniques, and diagnostic procedures in pain management.
• Improve safety and decrease risks associated with established pain medicine treatment plans and interventions.
• Improve the assessment, evaluation, and treatment of chronic pain patients with psychological issues.
• Evaluate the legal, ethical, and regulatory issues surrounding the practice of pain medicine.
• Implement strategies and processes for providing patient-centered pain care in a changing healthcare environment.
• Maximize efficiencies and improve the business model of pain medicine.

CONTINUING MEDICAL EDUCATION CREDITS
Accreditation Council for Continuing Medical Education
The American Academy of Pain Medicine (AAPM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians.
AAPM designates all AAPM CME activities associated with the 28th Annual Meeting for a maximum of 30.25 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

AAPM 28th Annual Meeting and Related Education Programs
28th Annual Meeting ........................................... 14.25 credits
Essential Tools for Treating the Patient in Pain™ .............. 16 credits
Cadaver Workshop ............................................. Not eligible for CME credits
Ultrasound Guidance for the Pain Physician ...................... 4 credits
Note. Attendees cannot receive credit for simultaneous sessions, including preconference sessions and concurrent workshops. The highest number of credits can be earned by combining the 28th Annual Meeting and Essential Tools for Treating the Patient in Pain™, which will provide a maximum of 30.25 CME credits.

American Academy of Family Physicians (AAFP)
The AAFP is approved by the American Academy of Family Physicians (AAFP) to offer continuing medical education for the 28th Annual Meeting. This activity has been reviewed and is acceptable for up to 12.75 prescribed credits by the AAFP.

This live activity, Essential Tools for Treating the Patient in Pain: What Every Primary Care and Pain Specialist Needs to Know™, with a beginning date of February 22, 2012, has been reviewed and is acceptable for up to 16 Prescribed credit(s) by the AAFP. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This Live activity, American Academy of Pain Medicine’s 28th Annual Meeting—Advancing the Science and Practice of Pain Medicine, from February 24, 2012—February 25, 2012, has been reviewed and is acceptable for up to 14.25 Prescribed credit(s) by the AAFP.

Since some sessions run concurrently, no more than 14.25 credits may be reported. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Academy of Physician Assistants (AAPA)
The American Academy of Physician Assistants (AAPA) accepts Category 1 CME credit from the American Osteopathic Association Council on Continuing Medical Education (AOACCME), prescribed credit from AAFP, and AMA PRA Category 1 Credit™ for the Physician’s Recognition Award (PRA) organizations accredited by ACCME.

How to Obtain CME Credit
An evaluation form of the 28th Annual Meeting will be available online to each registrant. To receive CME credit for each session you attend, you must evaluate that session in the appropriate section of the online evaluation. You will be able to print your certificate once you complete the evaluation.

COMMERCIALLY SUPPORTED SATELLITE SYMPOSIA
Satellite symposia will be offered during breakfast, lunch, and dinner hours during the annual meeting. These independently managed satellite symposia are supported by AAPM’s Corporate Relations Council members. The programs have been reviewed by the AAPM Program Committee and approved for presentation as part of the Satellite Symposium program.

These sessions are offered free of charge to all meeting registrants; however, those who have preregistered will be seated first. A limited number of seats will also be available on a first-come, first-served basis. Check for availability at the registration desk outside the session room 30 minutes before the scheduled start of the program.

EVALUATIONS
Attendees will be asked to submit evaluations online for the 2012 Annual Meeting sessions. Please use the space provided to make any notes about the sessions you attend to help you fill out the online evaluation form, which will be provided to all annual meeting registrants.

DISCLOSURE
It is the policy of AAPM to plan and implement educational activities in accordance with ACCME’s Essential Areas and Elements to ensure balance, independence, objectivity, and scientific rigor. As an ACCME-accredited provider, AAPM is eligible to receive commercial support from commercial interests but cannot receive guidance, either nuanced or direct, on the content of the activity or on who should deliver the content.

All program faculty and planners are required to disclose all financial relationships they may have or have had within the last 12 months with commercial interests whose products or services are related to the subject matter of the presentation. Any real or apparent conflicts of interest must be resolved prior to the presentation. Planning committee disclosures are listed in this brochure. All confirmed faculty disclosure information will be made available to attendees on the AAPM Annual Meeting website and in the program book. Faculty will also be expected to disclose this information to the audience both verbally and in print (slide presentation) at the beginning of each presentation.

Faculty is also required to inform program participants if any unlabeled uses of products regulated by the U.S. Food and Drug Administration will be discussed.

ENTER TO WIN AN APPLE IPAD AT THE MEMBERS’ MEETING
WEDNESDAY, FEBRUARY 22

7:15 am–5:30 pm
Essential Tools for Treating the Patient in Pain™: What Every Primary Care and Pain Specialist Needs to Know: Day 1 (PME)
Farshad M. Ahadian, MD; Charles E. Argoff, MD; Scott M. Fishman, MD; Kai S. MacDonald, MD; Sean Mackey, MD PhD; Gagan Mahajan, MD; Robert M. McCarron, DO; Mark S. Wallace, MD; Lynn R. Webster, MD

THURSDAY, FEBRUARY 23

7:15 am–5:30 pm
Essential Tools for Treating the Patient in Pain™: What Every Primary Care and Pain Specialist Needs to Know: Day 2 (PME)
Robert A. Bonakdar, MD; Donna M. Bloodworth, MD; Perry G. Fine, MD; Kenneth A. Follett, MD PhD; Carter Jones, MD PhD; Gagan Mahajan, MD; Samir J. Sheth, MD; Steven P. Stanos, DO; Kale Wedemeyer, MD

7:30–11:30 am
Ultrasound Guidance for the Pain Physician (001)
Marco Bodor, MD; Michael J. Derr, DO; Medric M. Hall, MD; Bryan C. Hoelzer, MD; Mark-Friedrich B. Hurdle, MD; Susan M. Moeschler, MD; Samer Narouze, MD MSc; Matthew J. Pingree, MD; James C. Watson, MD; Steven J. Wisniewski, MD

FRIDAY, FEBRUARY 24

8:15–9 am
Keynote Presentation
Glia as the “Bad Guys”: Clinical Implications of Glial Dysregulation of Pain, Opioids, and Other Drugs of Abuse (102)
Linda R. Watkins, PhD

10–11 am
Plenary Session
Central Mechanisms in Pain Syndromes (103)
Daniel J. Clauw, MD

11–11:45 am
Plenary Research Highlights (104)
Sarah E. Hayes; Marco Loggia, PhD; Jarred W. Younger, PhD
1:30–2:30 pm  
**Department of Defense/Veterans Health Administration Pain Task Force Update (201)**  
Chester C. Buckenmaier, III, MD COL MC USA; Rollin M. Gallagher, MD MPH; Kevin T. Galloway, MHA BSN RN

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1:30–2:30 pm  
**Decisions and Conundrums: Ethics and the Practice of Pain Medicine (202)**  
Larry C. Driver, MD; Ben A. Rich, JD PhD; Jerome Schofferman, MD

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1:30–2:30 pm  
**Palliative Medicine and the Pain Physician (203)**  
John F. Peppin, DO FACP

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1:30–2:30 pm  
**Opioid-Induced Respiratory Depression and Sleep Apnea (204)**  
John J. Greer, PhD; Lynn R. Webster, MD

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3:30–4:30 pm  
**Neuromodulation in the Military (205)**  
Timothy R. Deer, MD; Anthony L. Dragovich, MD; Thomas J. Weber, DO

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3:30–4:30 pm  
Dave Domann, MS RPh; Linda M. VanHorn, MBA

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3:30–4:30 pm  
**Poster Research Highlights (207)**  
Kenneth D. Candido, MD; Jianguo Cheng, MD Ph; Andrea L. Rubinstein, MD
3:30–4:30 pm
Psychopathology and Chronic Pain: Clinical Pathways and Practical Tools (208)
Geralyn Datz, PhD; Ravi Prasad, PhD; Binit J. Shah, MD

4:45–5:45 pm
Injured Warriors: Posttraumatic Stress Disorder (PTSD), Brain Trauma, Pain, Traumatic Brain Injury (TBI), and Mental Health (209)
Michael E. Clark, PhD; Robert L. Ruff, MD PhD

4:45–5:45 pm
Pain Outcomes Across Multiple Domains: What Should Be Measured and the National Institutes of Health (NIH) PROMIS Initiative (210)
Karon F. Cook, PhD; Sean Mackey, MD PhD

4:45–5:45 pm
Evidence Basis for Practice Parameter Guidelines in Neuropathic Pain Medications (211)
Martin Grbois, MD; Scott M. Fishman, MD; R. Norman Harden, MD

4:45–5:45 pm
Project ECHO™ (Extension for Community Healthcare Outcomes): Bridging the Gap Between Urban Healthcare Specialists and Providers in Rural Settings (212)
Sanjeev Arora, MD; Chester C. Buckenmaier, III, MD COL MC USA; Joanna G. Katzman, MD MSPH

SATURDAY, FEBRUARY 25

8–8:45 am
Plenary Session
Public Policy on Prescription Opioids: Are We Trapped Between Scylla and Charybdis? (105)
Keith N. Humphreys, PhD
9:45–11:15 am

Plenary Session

Relieving Pain in America: Institute of Medicine Pain Presentation (106)
Olivia Carter-Pokras, PhD; Kenneth A. Follett, MD PhD; Sean Mackey, MD PhD; Melanie Thernstrom; Lonnie K. Zeltzer, MD

2–3:30 pm

Acupuncture for Chronic Low Back Pain: Clinical Evidence, the Science, and the Challenge (301)
Richard Harris, PhD; Jiang-Ti Kong, MD MS; Lixing Lao, PhD; Yu (Woody) Lin, MD PhD

2–3:30 pm

Acute Pain Medicine: What It Is, Why It Is Needed, and How We Train for It (302)
Andre P. Boezzaart, MD PhD; Chester C. Buckenmaier, III, MD COL MC USA; Laura Clark, MD

2–3:30 pm

Evidence-Based Guidelines for Implantable Devices: Intrathecal Drug Delivery and Spinal Cord Stimulation (303)
Timothy R. Deer, MD; Paul G. Kreis, MD; Robert M. Levy, MD PhD; Joshua P. Prager, MD MSc; B. Todd Sitzman, MD MPH

2–3:30 pm

Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Mindfulness: New Developments for Chronic Pain Management (304)
Jeremy Bartz, PhD; Ravi Prasad, PhD; John T. Sorrell, PhD

3:45–5:15 pm

Future Direction of Pain Medicine (305)
Gary J. Brenner, MD PhD; Michel Y. Dubois, MD; Sean Mackey, MD PhD; Benson S. Munger, PhD; Thomas E. Norris, MD; James P. Rathmell, MD

3:45–5:15 pm

Why Skin Matters: New Assessment and Treatment Tools for Acute and Chronic Pain (306)
Charles E. Argoff, MD; Burkhard Gustorff, MD; Marco Pappagallo, MD; John Peppin, DO FACP; Frank L. Rice, PhD; Mark S. Wallace, MD
3:45–5:15 pm
Improved Pain Medicine Outcomes Through Implantable Devices (307)
Timothy R. Deer, MD; Joshua P. Prager, MD MSc

3:45–5:15 pm
Sacroiliac (SI) Joint Pain: Anatomy and Neuroablative Therapies (308)
Steven P. Cohen, MD; Scott M. Fishman, MD; Leonardo Kapural, MD PhD; Frank H. Willard, PhD

SUNDAY, FEBRUARY 26
8:30–9:30 am
Intrathecal Medications for Chronic Pain: An Update (401)
Tony L. Yaksh, PhD

8:30–9:30 am
The Role of the Primary Care Provider in Comprehensive Pain Management (402)
Stephen A. Eraker, MD MPH FACP; Rollin M. Gallagher, MD MPH; Bill H. McCarberg, MD

8:30–9:30 am
The Interface Between Pain Medicine and Hospice and Palliative Medicine: Critical Partnership Opportunities (403)
J. Cameron Muir, MD FAAPHM; B. Todd Sitzman, MD MPH

8:30–9:30 am
Evidence Bases for Alternatives in the Treatment of Chronic Pain (404)
Donna M. Bloodworth, MD; Martin Grabois, MD; Albert L. Ray, MD

9:45–10:45 am
2012: Coding Update and Preparing for ICD-10 (405)
Eduardo M. Fraifeld, MD; Linda M. VanHorn, MBA
9:45–10:45 am
Psychological Screening and Disease Phenotyping: Predictive of Interventional Pain Procedures Outcomes? (406)
Claudia M. Campbell, PhD; Robert N. Jamison, PhD; Kayode A. Williams, MD MBA FFARCSI

9:45–10:45 am
The Great Debate: Medical Marijuana for the Treatment of Chronic Pain (407)
Donald I. Abrams, MD; Steven D. Passik, PhD; Jodie A. Trafton, PhD

9:45–10:45 am
Myofascial and Muscle Pain: Assessment and Treatment Innovations (408)
Mehul J. Desai, MD MPH; Jay P. Shah, MD

11 am–12:30 pm
National Institutes of Health (NIH) Pain Research: Optimizing Funding Through Grant Writing (409)
Yu (Woody) Lin, MD PhD; Sean Mackey, MD PhD; Weijia Ni, PhD

11 am–Noon
Pediatric Pain (410)
Tim F. Oberlander, MD FRCP; Lonnie K. Zeltzer, MD

11 am–12:30 pm
Pain Medicine and Criminal Litigation (411)
John J. Coleman, PhD; Perry G. Fine, MD; Elaine A. Lankford, FNP-C

11 am–Noon
Headache and Facial Pain: An Update (412)
Zahid H. Bajwa, MD; Robert P. Cowan, MD; Samir Narouze, MD MSc
FOUNDERS AWARD

The Founders Award is given to an individual for outstanding contributions to the science or practice of pain medicine. The award is given for continued contributions for the basic or clinical science of pain medicine or for the demonstration of clinical excellence or innovation in the practice of pain medicine.

Howard L. Fields, MD, PhD
Howard L. Fields, MD PhD, is professor in residence at the University of California, San Francisco (UCSF), Department of Neurology, and director of the Wheeler Center for the Neurobiology of Addiction. He is also a principal investigator at the Ernest Gallo Clinic and Research Center.

Dr. Fields received his MD and PhD in neuroscience at Stanford. After a year of internal medicine training at Bellevue Hospital in New York, he spent 3 years as a research neurologist at the Walter Reed Army Institute of Research. Following clinical training in neurology at the Boston City Hospital Service of Harvard Medical School in 1972, he joined the faculty of UCSF.

Dr. Fields’ major interests are in nervous system mechanisms of pain, opioid analgesia, and alcoholism and addiction. He was a founder of the UCSF pain management center and has made major contributions to understanding and treating post-herpetic neuralgia, including demonstrating the clinical effectiveness of opioids and topical lidocaine. In laboratory studies he discovered and elucidated a pain modulating neural circuit.

Furthermore, his research group discovered that pain relief as a result of placebo administration can be blocked by an opioid antagonist, opening the way to a neurobiological explanation of placebo analgesia.

Dr. Fields has recently turned his attention to the problem of addiction. His team has discovered nerve cells in the striatum that selectively encode the magnitude of a reward. They have also shown how the neurotransmitter dopamine contributes to motivation and reward-based choice.

Dr. Fields has received numerous awards in recognition of his contributions including the National Migraine Foundation Award, the Bristol-Myers Award for Pain Research, a Merit Award from the NIH, the Kerr Award of the American Pain Society, and the Cotzias Award of the American Academy of Neurology. He also gave the Beecher Lecture (in anesthesiology) and the Adams Lecture (in neurology) at Harvard Medical School. In 1997, he was elected to membership in the Institute of Medicine and in 2010 to the American Academy of Arts and Sciences.

DISTINGUISHED SERVICE AWARD

The Distinguished Service Award is given to an individual for commitment and contributions to the American Academy of Pain Medicine. The award is given to an individual for specific outstanding contributions.

B. Todd Sitzman, MD MPH
B. Todd Sitzman, MD MPH, is medical director of Advanced Pain Therapy, a comprehensive pain clinic located in Hattiesburg, MS. He also serves as the medical consultant for the pain management program at Forrest General Hospital and Forrest General Cancer Center.

Dr. Sitzman is an active member of numerous national and international pain societies and is a past president of AAPM and the Southern Pain Society (SPS). Dr. Sitzman has served on multiple committees, as well as the board of directors of AAPM, North American Neuromodulation Society, SPS, and Mississippi Pain Society. He has authored more than 70 scientific publications, including abstracts, manuscripts, and book chapters, and serves on the editorial boards of the Pain Medicine and Pain Practice journals. He is actively involved in patient advocacy and postgraduate medical education and lectures worldwide on topics related to pain pharmacology and interventional pain therapies. He has been interviewed and quoted in Parade Magazine, ABC News, the New York Times, USA Today, WebMD, Pain Medicine News, and American Medical News.

Dr. Sitzman received his MD and MPH from Tulane University. Following an internship in internal medicine at the Hospital of the University of Pennsylvania in Philadelphia, he received anesthesiology and pain management training at the University of Virginia Health Sciences Center in Charlottesville, VA. Dr. Sitzman is board certified in anesthesiology and pain medicine.
PATIENT ADVOCACY AWARD

The Patient Advocacy Award recognizes activity of an individual in advocating for appropriate evaluation and treatment of patients suffering from pain. This award was created to honor those healthcare professionals whose deeds reflect their recognition of the importance and impact of the specialty of pain medicine.

Robert J. Saner, II, JD


Mr. Saner has been instrumental in guiding AAPM’s efforts in the nation’s Capital. His input has been critical to the emerging specialty of pain medicine.

Mr. Saner’s health practice focuses heavily on physician organizations, including professional societies, associations, medical groups, academic practices, and integrated systems. His environmental and public health practice focuses on the regulation of municipal water utilities under the federal Safe Drinking Water Act and includes emerging issues in public infrastructure protection and homeland security.

Prior to joining Powers Pyles, Mr. Saner was a partner in White, Verville, Fulton, and Saner. From 1972 to 1974 he served in the Department of Health, Education, and Welfare and the Executive Office of the President.

Mr. Saner writes and lectures frequently on fraud and abuse, corporate compliance, physician self-referral, and Medicare reimbursement issues. Mr. Saner served as the President of Powers Pyles Sutter & Verville and chair of its Executive Committee from 2000 through April 2007. He continues to serve as Washington Counsel for the Medical Group Management Association, General Counsel of the National Organization on Disability, and General Counsel of the Association of Metropolitan Water Agencies. He is a member of the District of Columbia Bar and the American Health Lawyers Association.

PHILIPP M. LIPPE, MD, AWARD

The Philipp M. Lippe, MD, Award is given to a physician for outstanding contributions to the social and political aspects of pain medicine. Social and political accomplishments could be those that benefit the science, practice or recognition of the specialty.

Philipp M. Lippe, MD

The Philipp M. Lippe, MD, Award is given to a physician for outstanding contributions to the social and political aspects of pain medicine. Social and political accomplishments could be those that benefit the science, practice or recognition of the specialty.

Philip A. Pizzo, MD

Philip A. Pizzo, MD, is the Dean of the Stanford University School of Medicine and the Carl and Elizabeth Naumann Professor of Pediatrics and Microbiology and Immunology. He also serves on the Board of Directors of Stanford Hospital & Clinics and of Lucille Packard Children’s Hospital.

Dr. Pizzo served as a clinical associate at the Pediatric Oncology Branch of the National Cancer Institute (NCI) and as a pediatric oncology investigator at the National Institutes of Health. He served as chief of pediatrics at NCI since 1981 and as acting scientific director of NCI’s Division of Clinical Sciences since 1995. He also served as director of the Infectious Disease Section at NCI and as professor of pediatrics at the Uniformed Services University of the Health Sciences in Bethesda, MD. He is a member of the Advisory Board at Adaptive Therapeutics, Inc. and a policy advisor and member of the Board of Advisors of Common Sense Media, Inc.

Dr. Pizzo’s research efforts have focused on the treatment of childhood cancers and on the diagnosis, management, and prevention of infectious complications in immunocompromised hosts. He and his colleagues also developed new treatments for children with symptomatic HIV infection. He is the author of more than 500 articles and editor of 16 books, serves on numerous national and international advisory and editorial boards, and has received many awards for his scientific work. He is a member of numerous distinguished societies, including the Institute of Medicine of the National Academy of Sciences.

Dr. Pizzo became dean of the School of Medicine at Stanford University in April 2001; he was the physician-in-chief and chair of the Department of Medicine at Children’s Hospital, Boston; and he was the Thomas Morgan Rotch Professor and chair of pediatrics at Harvard Medical School. Dr. Pizzo received his BA from Fordham College and graduated Phi Beta Kappa and cum laude and received his MD with Honors and Distinction in Research from the University of Rochester School of Medicine, after completing his residency in pediatrics at Children’s Hospital, Boston.

This AAPM award is supported by Pfizer.
PRESIDENTIAL COMMENDATIONS

**Kenneth A. Follett, MD PhD**

Kenneth A. Follett, MD PhD, is professor and chief of neurosurgery at the University of Nebraska. Dr. Follett is board certified by the American Board of Neurological Surgeons and the American Board of Pain Medicine (ABPM).

His areas of special interest are stereotactic/functional neurosurgery and neurosurgical pain management. He is the national chair of a multicenter clinical trial of deep brain stimulation for Parkinson’s Disease that is sponsored by the Department of Veterans Affairs and the National Institute of Neurological Disorders and Stroke.

In addition to his interest in the clinical applications of deep brain stimulation for the treatment of movement disorders, he is interested in the basic science and clinical management of pain. He has published numerous articles related to his clinical and research activities and is the editor of the textbook *Neurosurgical Pain Management*. He has given numerous national and international presentations relevant to his areas of interest.

Dr. Follett has been active in national neurosurgery and pain medicine organizations, and he is an AAPM Past President. He also is past president of the ABPM. He was honored with the AAPM Philipp M. Lippe, MD, Award in 2005. He has served on numerous local, regional, and national committees, including those associated with the American Association of Neurological Surgeons and Congress of Neurological Surgeons. Dr. Follett was also recognized as one of “America’s Top Surgeons” by the Consumers’ Research Council of America in 2007.

Dr. Follett completed his residency in neurosurgery at the University of Iowa Hospitals in Iowa City. He earned both his MD and his PhD from the University of Nebraska Medical Center.

**Sean Mackey, MD PhD**

Sean Mackey, MD PhD, is an associate professor of anesthesiology (and of neurology and neurological sciences, by courtesy) and chief of the pain management division at Stanford University. He is also director of Stanford Systems Neuroscience and Pain Lab, co-director of Stanford Pain Research and Clinical Center, and co-director of the Pain Working Group for the Neuroscience Institute at Stanford.

Dr. Mackey completed his BA and MA in bioengineering at the University of Pennsylvania in Philadelphia, PA, and received a PhD in electrical engineering and subsequently his MD at the University of Arizona in Tucson, AZ. He went on to Stanford where he completed his anesthesiology residency and was chief resident. He then completed his fellowship in pain management and subsequently joined the faculty. While there, he co-founded and directed the Regional Anesthesia program. He is currently the chief of the Stanford Pain Management Division and the Pain Fellowship Program Director.

As director of the Stanford Systems Neuroscience and Pain Lab, Dr. Mackey’s primary research interest involves the use of advanced research techniques such as functional and structural neuroimaging, psychophysics, and neurobehavioral assessment, to investigate the neural processing of pain and neuronal plasticity in patients with chronic pain. The research mission of the lab is to “Predict, Prevent and Alleviate Pain.” He has served as principal investigator and investigator for multiple National Institutes of Health (NIH), foundation, and industry-sponsored grants to investigate chronic pain and to investigate novel analgesics for acute and chronic pain. He is also the director of two large research endowments that allows him the discretionary funding to investigate truly novel research questions. Additionally, Dr. Mackey has recently received an NIH K24 grant that is focused on mentoring junior investigators to have successful careers. He is a member of several professional organizations, including his current role as vice president for scientific affairs for AAPM. Also, Dr. Mackey is a permanent member of the NIH NIDA study section, serves on the editorial board, and is a reviewer for multiple scientific journals. He has published more than 60 peer-reviewed articles and book chapters. He annually presents papers and lectures at both national and international pain medicine, neuroscience, and anesthesiology meetings and has been interviewed extensively by the popular press.
PRESIDENTIAL COMMENDATIONS

Jerome Schofferman, MD
Jerome Schofferman, MD, is the director of research and education of the Spine Care Institute of San Francisco. He has been in practice for more than 20 years and is a specialist in the diagnosis and non-operative treatment of painful disorders of the spine. He is certified by both the American Board of Pain Medicine and Internal Medicine. Dr. Schofferman has a particular interest in whiplash injury, whiplash-associated disorders, and low back pain after motor vehicle collisions. He has lectured and written on these topics for orthopedic surgeons, neurosurgeons, neurologists, physiatrists, and specialists in pain medicine.

Dr. Schofferman is currently completing his term on the Board of Directors for AAPM, where he has served for 6 years. He has been a member of the North American Spine Society (NASS) for 15 years. He is chair of the NASS Clinical Care Council, former chair of the NASS Multidisciplinary Care Committee, leader of the NASS special interest group on whiplash, and has led symposia on whiplash at numerous scientific meetings. He is also a member of the International Society for the Study of the Lumbar Spine and International Association for the Study of Pain. He has authored more than 40 articles, 20 textbook chapters, and many editorials related to the diagnosis and treatment of painful spinal disorders. He is on the editorial boards and is a reviewer for several medical journals including Pain Medicine, Spine, and The Spine Journal.

R. Gil Kerlikowske
R. Gil Kerlikowske was nominated by President Obama and confirmed by the U.S. Senate as the director of the Office of National Drug Control Policy (ONDCP). In his position, Mr. Kerlikowske coordinates all aspects of federal drug control programs and implementation of the President’s National Drug Control Strategy.

Mr. Kerlikowske brings 37 years of law enforcement and drug policy experience to the position. He most recently spent 9 years as the Chief of Police for Seattle, WA. When he left, crime was at its lowest point in 40 years. Previously, he was deputy director for the U.S. Department of Justice, Office of Community Oriented Policing Services, where he was responsible for more than $6 billion in federal assets. Mr. Kerlikowske was also police commissioner of Buffalo, NY. The majority of his law enforcement career was spent in Florida, where he served in the St. Petersburg Police Department.

He was elected twice to be president of the Major Cities Chiefs, which comprises the largest city and county law enforcement agencies in the United States and Canada, and was also elected president of the Police Executive Research Forum. He has received numerous awards and recognition for leadership, innovation, and community service. He served in the U.S. Army where he was awarded the Presidential Service Badge.

He served as the chair of the Board of Directors of Fight Crime: Invest in Kids, a national organization that advocates for evidence-based programs that prevent youth from being involved in crime. He has also served on the advisory boards of the Salvation Army in Buffalo and Seattle.

Mr. Kerlikowske received the American Medical Association’s Dr. Nathan Davis Award for Outstanding Government Service in 2011.

Mr. Kerlikowske holds a BA and MA in criminal justice as well as an honorary doctorate in Humane Letters from the University of South Florida.
PRESIDENTIAL COMMENDATIONS

Regina M. LaBelle
Regina M. LaBelle is the policy director at the Office of National Drug Control Policy (ONDCP). In this role, she assists the director of National Drug Control Policy in implementing the administration’s national drug control strategy. She is also the lead for the director’s prescription drug abuse strategic initiative. Before arriving at ONDCP, Ms. LaBelle served for 8 years as legal counsel to Mayor Greg Nickels of Seattle, WA. In that role, she advised the Mayor on significant issues in his administration, including public safety, criminal justice, and legal policies. Ms. LaBelle has worked on the local, state, and federal level in numerous political and policy positions and practiced law in a private Seattle law firm. In addition, she was an adjunct professor at Seattle University Institute for Policy Studies where she taught ethics and legislative policymaking. A magna cum laude graduate of Boston College, Ms. LaBelle received her law degree from Georgetown University Law Center.

Senator Jay Rockefeller
Senator Jay Rockefeller has served the people of West Virginia for more than 40 years. Senator Rockefeller first came to West Virginia in 1964 as a 27-year-old VISTA volunteer, serving in the small mining community of Emmons. As a long-time advocate of accessible and quality healthcare, Senator Rockefeller is recognized as one of the strongest champions for healthcare reform. He has an extensive and distinguished career of fighting to reduce the number of uninsured children and working families, protecting and improving senior and veteran health care, and fighting for the promised health benefits of retired coal miners and steelworkers.

Senator Rockefeller is the chairman of the Senate Committee on Commerce, Science, and Transportation; chairman of the Health Care Subcommittee on Finance; and a member of the Senate Select Committee on Intelligence. He also serves on the Senate Committee on Veteran Affairs.

Senator Rockefeller introduced the Prescription Drug Abuse Prevention and Treatment Act of 2011 to prevent the unsafe use of prescription drugs and reduce the number of deaths from prescription drugs by promoting physician and patient education and creating a uniform reporting system for painkiller-related deaths.

Senator Rockefeller graduated from Harvard University in 1961 with a BA in far eastern languages and history. In 1964, he came to Emmons, where he began his public service career. In 1966, he was elected to the West Virginia House of Delegates and to the office of West Virginia Secretary of State in 1968. He served as president of West Virginia Wesleyan College from 1973 to 1976. In 1976, Senator Rockefeller was elected Governor of West Virginia and was re-elected in 1980. In 1984, he was elected to the U.S. Senate and re-elected in 1990, 1996, 2002, and 2008.
Senator Sheldon Whitehouse

U.S. Senator Sheldon Whitehouse advocates for the people of Rhode Island on issues ranging from jobs and economic development to health care and the environment.

In the senate, and before that as Rhode Island’s Attorney General and U.S. Attorney, Senator Whitehouse has focused on the well-being of families, children, and seniors; protecting consumers; helping small businesses grow and create jobs; and assisting the unemployed and all those hit by the recession.

One focus for Senator Whitehouse has been the high cost of health care for everyone, from families and seniors who need care to all those who provide it. He is a leader in the effort to expand the use of information technology in health care to lower cost and improve the quality of care, helping Rhode Island become a national leader in the development and implementation of this technology.

In his role as a member of the Senate Judiciary Committee, Senator Whitehouse chaired a Subcommittee hearing on prescription drug abuse, “Responding to the Prescription Drug Epidemic: Strategies for Reducing Abuse, Misuse, Diversion, and Fraud.”

A graduate of Yale University and the University of Virginia School of Law, Senator Whitehouse served as a policy advisor and counsel to the Governor of Rhode Island and as the state’s director of business regulation before being nominated by President Bill Clinton to be Rhode Island’s U. S. Attorney in 1994. He was elected state attorney general in 1998, a position in which he served from 1999 to 2003. On November 7, 2006, he was elected to the senate, where he serves on the Budget Committee; the Environment and Public Works (EPW) Committee; the Judiciary Committee; the Health, Education, Labor, and Pensions Committee; and the Special Committee on Aging. He chairs the Judiciary Subcommittee on Crime and Terrorism and the EPW Subcommittee on Oversight.

Lynn R. Webster, MD

Lynn R. Webster, MD, is co-founder and chief medical director of Lifetree Clinical Research. His research interests are diverse. He is keenly interested in working with the industry to develop safer and more effective therapies for chronic pain and addiction. He is a leading researcher in exploring the relationship of medications and sleep, with particular interest in analgesic-induced sleep-disordered breathing.

Dr. Webster is board certified in anesthesiology and pain medicine and is also certified in addiction medicine. He earned his MD from the University of Nebraska Medical Center and completed his residency in the University of Utah Medical Center’s department of anesthesiology.

He lectures extensively on the subject of preventing opioid abuse and criminal diversion in chronic pain patients and has authored numerous scientific abstracts, journal articles, textbook chapters, and the book Avoiding Opioid Abuse While Managing Pain: A Guide for Practitioners. Dr. Webster is co-editor of Pain Medicine’s section on opioids, substance abuse, and addiction and serves as a reviewer for numerous peer-reviewed journals. He was the Interventional Therapies section editor for Practical Pain Management for 2006 and 2007.

Dr. Webster co-founded LifeSource, a non-profit foundation established in 2006 to educate physicians, patients, and communities on health issues (with an emphasis on pain-related, scientific and social issues), as well as to fund and conduct research to discover new solutions and hope for improved life. LifeSource’s first project was “Zero Unintentional Deaths.” The campaign was developed to educate physicians, chronic pain sufferers, and all communities about the increasingly serious issue of unintentional overdose deaths relating to methadone and other prescription medications, and it aims to eliminate unintentional overdoses from prescribed methadone. His medical expertise has contributed to national news stories addressing the dangers of methadone and other prescription medications, including ABC News’ “20/20” and Court TV’s “Catherine Crier Live.”

Dr. Webster serves on the AAPM Board of Directors and was instrumental in launching the Utah chapter.
# PAST AWARD RECIPIENTS

## PHILIPP M. LIPPE, MD, AWARD
- **1995** Philipp M. Lippe, MD
- **1996** Joel Saper, MD
- **1997** Richard Stieg, MD
- **1998** Sridhar Vasudevan, MD
- **1999** Hubert Rosomoff, MD
- **2000** J. David Haddox, DDS MD
- **2001** Kathleen M. Foley, MD
- **2002** Michael Ashburn, MD MPH
- **2003** Daniel B. Carr, MD
- **2004** Robert G. Addison, MD
- **2005** Kenneth A. Follett, MD PhD
- **2006** Samuel J. Hassenbusch, MD PhD
- **2007** Scott M. Fishman, MD
- **2008** Benjamin L. Crue, Jr, MD FACS
- **2009** Albert L. Ray, MD
- **2010** Michel Y. Dubois, MD
- **2011** Douglas Throckmorton, MD

## FOUNDERS AWARD
- **1995** Benjamin Crue, MD
- **1996** Wilbert Fordyce, PhD
- **1997** Peter Wilson, MBBS PhD
- **1998** Tony Yaksh, PhD
- **1999** Steven Feinberg, MD
- **2000** Rollin M. Gallagher, MD MPH
- **2001** Gary J. Bennett, PhD
- **2002** Russell Portenoy, MD
- **2003** Donald D. Price, PhD
- **2004** James C. Eisenach, MD
- **2005** Edward C. Covington, MD
- **2006** Gerald F. Gebhart, PhD
- **2007** Richard B. North, MD
- **2008** Michael J. Cousins, MD DSc FANZCA FRCA FACHPM(RACP) FFPMANZCA
- **2009** Nikolai Bogduk, MD PhD DSc
- **2010** David Joranson, MSSW
- **2011** Daniel B. Carr, MD

## DISTINGUISHED SERVICE AWARD
- **1996** Patricia Owen
- **1997** Not Awarded
- **1998** Paul Gebhard, JD; Kristie Haley
- **1999** Peter Wilson, MBBS, PhD; Ruth Tiernan
- **2000** Not Awarded
- **2001** Joel R. Saper, MD FACP FAAN
- **2002** Elliot Krames, MD
- **2003** Samuel J. Hassenbusch, MD PhD; Jeffrey W. Engle
- **2004** Albert L. Ray, MD
- **2005** Rollin M. Gallagher, MD MPH
- **2006** Edward C. Covington, MD
- **2007** Eduardo M. Fraifeld, MD
- **2008** David A. Fishbain, MD DFAPA
- **2009** Colleen M. Healy
- **2010** Scott M. Fishman, MD
- **2011** Timothy R. Deer, MD

## PATIENT ADVOCACY AWARD
- **2001** Warner Wood, MD
- **2002** Robert Biscup, MS DO
- **2003** Not Awarded
- **2004** Kenneth Moritsugu, MD MPH
- **2005** John (Jack) C. Lewin, MD
- **2006** Not Awarded
- **2007** Louis W. Sullivan, MD
- **2008** Robert D. Kerns, PhD
- **2010** Myra Christopher
- **2011** Will Rowe
LETTER FROM AAPM MEMBERSHIP CHAIR

Keep Your Membership Active and Get Involved in AAPM

Dear Colleague,

The whole practice of pain medicine is changing, culturally and politically. It has become a medical specialty all to itself, focused on treating the pain patient with “consultant grade” capability. Integrating the clinical wisdom and experience of a large number of individual medical specialties can be full of social and intellectual complexities. Governmental agencies, insurance carriers, fellow physicians, and society at large are all slowly discovering the talents and needs for the pain medicine specialist. To accomplish this successfully requires advocacy and education, quality assurance (by way of board certification), and commitment to clinical excellence.

It is the goal of AAPM to foster the professional development of the pain medicine specialist with

• educational opportunities, such as AAPM’s Annual Meeting, showcasing preconference workshops and plenary and concurrent sessions on the latest pain therapies and procedures

• access to current information from a dynamic website and biweekly e-News

• social, political, and professional advocacy, such as formal representation within the American Medical Association (AMA), giving you a voice in these changing times; the Pain Care Coalition, providing representation and advocacy in Washington, DC; and patient education materials, including online videos on the AAPM website

• a world-class medical journal, Pain Medicine, the premier source of peer-reviewed research and commentary on the multidisciplinary clinical practice of pain medicine

• interaction with other skilled pain medicine physicians with shared goals and concerns on local, state, and national levels in AAPM’s interactive online Member Community.

I encourage you to take a more active role in this robust and vigorous professional organization in 2012 as we seek to encourage the highest levels of clinical practice for some of the most difficult patients in the world in a dynamic intellectual, technical, social, and cultural environment. Join or renew your membership online at www.painmed.org or by calling 847.375.4731.

Thomas L. Yearwood, MD PhD
Chair, Membership Committee

JOIN OR RENEW YOUR MEMBERSHIP ONLINE AT WWW.PAINMED.ORG OR BY CALLING 847.375.4731
**CYBER CAFÉ**
Keep in touch with your home or office during the annual meeting. Visit the Cyber Café located near the AAPM Registration Desk. Several computers will be available with Internet access to check your e-mail. The Cyber Café is supported by Purdue Pharma, L.P.

**VIRTUAL EXHIBIT HALL**
The final exhibitor list and floor plan are available at http://awebsource.com/expocad/shows/aapm2012/start.html. The AAPM virtual floor plan allows you to search by company, product type, or booth location. Links to exhibitor websites are also available on this page. The floor plan and exhibit list will be posted for 3 months after the meeting.

**PAPERLESS MEETING**
Registrants are able to view, download, and print faculty slides and presentation information at http://persweb.connect2amc.com/aapm/tabid/182/Default.aspx 1 week before the 28th AAPM Annual Meeting and after the meeting. A printed schedule of sessions and events will be provided to each attendee at registration.

**PROGRAM EVALUATION TOOL**
AAPM offers its meeting evaluation in an online format. Meeting registrants can access the evaluation by visiting the AAPM website, http://persweb.connect2amc.com/aapm/tabid/182/Default.aspx, and clicking on the Evaluation link. The online evaluation may be completed during the meeting or after attendees have returned home. Participants will receive their continuing medical education certificate immediately when they submit their evaluations online. Certificates also can be sent from the system to participants’ e-mail addresses for printing later or saving electronically. All attendees are encouraged to complete the meeting evaluation regardless of whether they are seeking continuing education credits. If you have any questions, please call 847.375.4731.

**NETWORKING OPPORTUNITIES**

<table>
<thead>
<tr>
<th>THURSDAY, FEBRUARY 23</th>
<th>FRIDAY, FEBRUARY 24</th>
<th>SATURDAY, FEBRUARY 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:15–6:45 pm</td>
<td>8–8:15 am</td>
<td>1–1:45 pm</td>
</tr>
<tr>
<td>Welcome Reception</td>
<td>AAPM Welcome Address</td>
<td>AAPM Members’ Business Meeting</td>
</tr>
<tr>
<td>Join friends and colleagues for the Welcome Reception in Oasis 1 and 2. Exhibits and Poster Sessions (Group 1) will be available for visitation.</td>
<td>5:45–7:15 pm</td>
<td>AAPM Awards Presentation</td>
</tr>
<tr>
<td>Reception</td>
<td>Visit the Exhibits and Poster Sessions (Group 2) in Oasis 1 and 2.</td>
<td></td>
</tr>
</tbody>
</table>

**CYBER CAFÉ**

![Cyber Café Sign](image1.jpg)

**VIRTUAL EXHIBIT HALL**

![Virtual Exhibit Hall Banner](image2.png)

**PAPERLESS MEETING**

![Paperless Meeting Icon](image3.png)

**PROGRAM EVALUATION TOOL**

![Program Evaluation Tool Icon](image4.png)

**NETWORKING OPPORTUNITIES**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:15–6:45 pm</td>
<td>Welcome Reception</td>
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<tr>
<td>8–8:15 am</td>
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<tr>
<td>5:45–7:15 pm</td>
<td>Reception</td>
</tr>
<tr>
<td>1–1:45 pm</td>
<td>AAPM Members’ Business Meeting</td>
</tr>
</tbody>
</table>

**AAPM 2012 ANNUAL MEETING**
## SCHEDULE AT A GLANCE

### Wednesday, February 22, Preconference Sessions, Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:15–11:30 am</td>
<td>Essential Tools for Treating the Patient in Pain™: What Every Primary Care and Pain Specialist Needs to Know Day 1 (PME)</td>
</tr>
<tr>
<td>11:45 am–1 pm</td>
<td>SATELLITE LUNCHEON SYMPOSIUM</td>
</tr>
<tr>
<td>1:15–5:30 pm</td>
<td>Essential Tools for Treating the Patient in Pain™: What Every Primary Care and Pain Specialist Needs to Know Day 1 (PME)</td>
</tr>
</tbody>
</table>

### Thursday, February 23, Preconference Sessions, Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:15–7:30 am</td>
<td>Essential Tools for Treating the Patient in Pain™: What Every Primary Care and Pain Specialist Needs to Know—Day 2 (PME)</td>
</tr>
<tr>
<td>7:30–11:30 am</td>
<td>Cadaver Workshop (CW12) Ultrasound Guidance for the Pain Physician (001)</td>
</tr>
<tr>
<td>11:15–11:30 am</td>
<td>Break</td>
</tr>
<tr>
<td>11:45 am–1 pm</td>
<td>SATELLITE LUNCHEON SYMPOSIUM 1.25 CME</td>
</tr>
<tr>
<td>1:15–5:15 pm</td>
<td>Essential Tools for Treating the Patient in Pain™: What Every Primary Care and Pain Specialist Needs to Know—Day 2 (PME)*</td>
</tr>
<tr>
<td>5:15–6:45 pm</td>
<td>AAPM 28TH ANNUAL MEETING WELCOME RECEPTION</td>
</tr>
<tr>
<td>6:45–8 pm</td>
<td>SATELLITE DINNER SYMPOSIUM 1.25 CME</td>
</tr>
</tbody>
</table>

### Friday, February 24, Meeting Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:30–7:45 am</td>
<td>SATELLITE BREAKFAST SYMPOSIUM 1.25 CME</td>
</tr>
<tr>
<td>8–8:15 am</td>
<td>AAPM President’s Welcome Address (101)</td>
</tr>
<tr>
<td>8:15–9 am</td>
<td>Keynote Presentation (102)</td>
</tr>
<tr>
<td>9–10 am</td>
<td>Break</td>
</tr>
<tr>
<td>10–11 am</td>
<td>Exhibits and Poster Sessions (Group 1)</td>
</tr>
<tr>
<td>11–11:45 am</td>
<td>Plenary Session—Central Mechanisms in Pain Syndromes (103)</td>
</tr>
<tr>
<td>Noon–1:15 pm</td>
<td>SATELLITE LUNCHEON SYMPOSIUM 1.25 CME</td>
</tr>
<tr>
<td>1:30–2:30 pm</td>
<td>Department of Defense/Veterans Health Administration Pain Task Force Update (201)</td>
</tr>
<tr>
<td>2:30–3:30 pm</td>
<td>Break</td>
</tr>
<tr>
<td>3:30–4:30 pm</td>
<td>Neuromodulation in the Military (205)</td>
</tr>
<tr>
<td>4:30–4:45 pm</td>
<td>Break</td>
</tr>
<tr>
<td></td>
<td>Plenary Research Highlights (104)</td>
</tr>
<tr>
<td></td>
<td>Opioid-Induced Respiratory Depression and Sleep Apnea (204)</td>
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<tr>
<td></td>
<td>Decisions and Conundrums: Ethics and the Practice of Pain Medicine (202)</td>
</tr>
<tr>
<td></td>
<td>Palliative Medicine and the Pain Physician (203)</td>
</tr>
<tr>
<td></td>
<td>Psychopathology and Chronic Pain: Clinical Pathways and Practical Tools (208)</td>
</tr>
</tbody>
</table>
### SCHEDULE AT A GLANCE

#### Friday, February 24, Meeting Day 1 (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:45–5:45 pm</td>
<td>Injured Warriors: Posttraumatic Stress Disorder (PTSD), Brain Trauma, Pain, Traumatic Brain Injury (TBI), and Mental Health (209)</td>
</tr>
<tr>
<td></td>
<td>Pain Outcomes Across Multiple Domains: What Should Be Measured and the National Institutes of Health (NIH) PROMIS Initiative (210)</td>
</tr>
<tr>
<td></td>
<td>Evidence Basis for Practice Parameter Guidelines in Neuropathic Pain Medications (211)</td>
</tr>
<tr>
<td></td>
<td>Project ECHO™ (Extension for Community Healthcare Outcomes): Bridging the Gap Between Urban Healthcare Specialists and Providers in Rural Settings (212)</td>
</tr>
<tr>
<td>5:45–7:15 pm</td>
<td>AAPM 28TH ANNUAL MEETING RECEPTION EXHIBITS AND POSTER SESSIONS (GROUP 2)</td>
</tr>
<tr>
<td>7:15–8:30 pm</td>
<td>SATELLITE DINNER SYMPOSIUM 1.25 CME</td>
</tr>
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#### Saturday, February 25, Meeting Day 2

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>6:30–7:45 am</td>
<td>SATELLITE BREAKFAST SYMPOSIUM 1.25 CME</td>
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<tr>
<td>8–8:45 am</td>
<td>Plenary Session—Public Policy on Prescription Opioids: Are We Trapped Between Scylla and Charybdis? (105)</td>
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<tr>
<td>8:45–9:45 am</td>
<td>BREAK \nExhibits &amp; Poster Sessions (Group 2)</td>
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<tr>
<td>9:45–11:15 am</td>
<td>Plenary Session—Relieving Pain in America: Institute of Medicine Pain Presentation (106)</td>
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<tr>
<td>11:15–11:30 am</td>
<td>BREAK</td>
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<tr>
<td>11:30 am–12:45 pm</td>
<td>SATELLITE LUNCHEON SYMPOSIUM</td>
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<tr>
<td>1–1:45 pm</td>
<td>AAPM Members' Business Meeting \nAAPM Awards Presentation</td>
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<tr>
<td>1:45–2 pm</td>
<td>BREAK</td>
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<tr>
<td>2–3:30 pm</td>
<td>Acupuncture for Chronic Low Back Pain: Clinical Evidence, the Science, and the Challenge (301)</td>
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<td>Acute Pain Medicine: What It Is, Why It Is Needed, and How We Train for It (302)</td>
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<td>Evidence-Based Guidelines for Implantable Devices: Intrathecal Drug Delivery and Spinal Cord Stimulation (303)</td>
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<td></td>
<td>Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Mindfulness: New Developments for Chronic Pain Management (304)</td>
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<td>3:30–3:45 pm</td>
<td>BREAK</td>
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<tr>
<td>3:45–5:15 pm</td>
<td>Future Direction of Pain Medicine (305)</td>
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<td>Why Skin Matters: New Assessment and Treatment Tools for Acute and Chronic Pain (306)</td>
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<td>Improved Pain Medicine Outcomes Through Implantable Devices (307)</td>
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<td>Sacroiliac (SI) Joint Pain: Anatomy and Neuroablative Therapies (308)</td>
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<tr>
<td>5:30–6:45 pm</td>
<td>SATELLITE DINNER SYMPOSIUM 1.25 CME</td>
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#### Sunday, February 26, Meeting Day 3

<table>
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<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7–8:15 am</td>
<td>SATELLITE BREAKFAST SYMPOSIUM 1.25 CME</td>
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<tr>
<td>8:30–9:30 am</td>
<td>Intrathecal Medications for Chronic Pain: An Update (401)</td>
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<td>The Role of the Primary Care Provider in Comprehensive Pain Management (402)</td>
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<td>The Interface Between Pain Medicine and Hospice and Palliative Medicine: Critical Partnership Opportunities (403)</td>
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<td>Evidence Bases for Alternatives in the Treatment of Chronic Pain (404)</td>
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<tr>
<td>9:30–9:45 am</td>
<td>BREAK</td>
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<tr>
<td>9:45–10:45 am</td>
<td>2012: Coding Update and Preparing for ICD-10 (405)</td>
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<td>Psychological Screening and Disease Phenotyping: Predictive of Interventional Pain Procedures Outcomes? (406)</td>
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<td>The Great Debate: Medical Marijuana for the Treatment of Chronic Pain (407)</td>
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<td>Myofascial and Muscle Pain: Assessment and Treatment Innovations (408)</td>
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<tr>
<td>10:45–11 am</td>
<td>BREAK</td>
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<tr>
<td>11 am–Noon</td>
<td>National Institutes of Health (NIH) Pain Research: Optimizing Funding Through Grant Writing (409)</td>
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<td>Pediatric Pain (410)</td>
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<td></td>
<td>Pain Medicine and Criminal Litigation (411)</td>
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<td>Headache and Facial Pain: An Update (412)</td>
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<tr>
<td>Noon–12:30 pm</td>
<td>VISIT THE EXHIBIT HALL FOR THE LATEST PRODUCTS AND INNOVATIONS</td>
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**EXHIBITS AND POSTER HOURS**

The six highest ranking poster authors have been selected to present their posters at a plenary research highlights session or a concurrent scientific session as noted below.

- Plenary Research Highlights—Friday, February 24, 11–11:45 am
- Concurrent Scientific Session—Friday, February 24, 3:30–4:30 pm

Scientific posters will be on display in the Oasis 1–2 Exhibit Hall at the Palm Springs Convention Center. There will be two presentation groups of posters this year. Be sure to visit the exhibit hall to visit both groups, as they are available to be viewed on different days. Copies of the six highest-ranking posters will also be displayed in the lobby.

**GROUP 1**

This presentation group, with posters numbered 100–197A, includes posters categorized by the following clinical topics:
- procedures
- psychosocial/rehabilitation.

These posters will be on display from Thursday, February 23 at 5:15 pm, and will remain on display through 11:15 am on Friday.

**AUTHOR-ATTENDED SESSIONS**

**Welcome Reception with Poster Session**
Thursday, February 23, 5:15–6:45 pm

**Exhibit and Poster Break**
Friday, February 24, 9–10 am

**ADDITIONAL VIEWING (NOT AUTHOR ATTENDED)**
Friday, February 24, 7–9 am
Friday, February 24, 10–11:15 am

**GROUP 2**

This presentation group, with posters numbered 198–291, includes posters categorized by the following clinical topics:
- epidemiology/health policy/education
- pharmacological
- translational.

These posters will be on display from Friday, February 24 at 5:45 pm, and will remain on display through 11:15 am on Saturday.

**AUTHOR-ATTENDED SESSIONS**

**Reception with Poster Session**
Friday, February 24, 5:45–7:15 pm

**Exhibit and Poster Break**
Saturday, February 25, 8:45–9:45 am

**ADDITIONAL VIEWING (NOT AUTHOR ATTENDED)**
Saturday, February 25, 7–8:45 am; 9:45–11:30 am
Saturday, February 25, 9:45–11:30 am
PRECONFERENCE SESSIONS

WEDNESDAY, FEBRUARY 22– THURSDAY, FEBRUARY 23

Essential Tools for Treating the Patient in Pain™ (PME)

What Every Primary Care and Pain Specialist Needs to Know* Essential Tools for Treating the Patient in Pain™ is designed for clinicians interested in obtaining an overview of some of the fundamentals of pain medicine in addition to practical approaches to the treatment of common pain disorders. The course offers clinically focused lectures and case presentations on the assessment, diagnosis, and treatment of patients with various acute, cancer, end-of-life, and chronic pain syndromes.

Co-Chairs
Gagan Mahajan, MD
Farshad M. Ahadian, MD

DAY 1, WEDNESDAY, FEBRUARY 22
7:15–11:30 am, 1:15–5:30 pm

TOPICS
• The Difficult Pain Patient: Defining the Barriers to Success with Chronic Opioid Therapy
• Acute and Persistent Pain: Neuroanatomy and Neurophysiology
• Pain Psychiatric Interview: A Quick Approach
• Understanding and Treating Neuropathic Pain
• Headache: Evaluation, Examination, and Treatment
• Chronic Opioid Therapy: Strategies for Success
• The Role of UDT, Opioid Consent, and Opioid Agreement in Chronic Opioid Therapy
• Guide to Aberrant Drug Behaviors
• Strategies for Managing the Patient with Addiction and Pain
• Pain and the Law
• The Science Behind Marijuana as an Analgesic
• Case Studies

DAY 2, THURSDAY, FEBRUARY 23
7:15–11:30 am, 1:15–5:30 pm

TOPICS
• Cervical and Lumbosacral Spine: Assessment and Physical Exam
• Shoulder and Hip Pain: Assessment and Physical Exam
• The Role of Imaging and Electrodiagnostic Studies in Evaluation of Spine Pain
• Interventional Therapies for Spine Pain
• Spine Surgery: Who Needs It?
• Myofascial Pain and Fibromyalgia
• Abdominal and Pelvic Pain
• Cancer-Related Pain and Palliative Care
• Physical Rehabilitation and Modalities
• Complementary and Alternative Therapies
• Case Studies

THURSDAY, FEBRUARY 23
7:30–11:30 am, 1:15–5:15 pm

Cadaver Workshop (Non-CME Activity) (CW12)*
The goals of interventional pain medicine physicians are to relieve, reduce, or manage pain and to improve a patient’s overall quality of life through minimally invasive techniques specifically designed to diagnose and treat painful conditions. AAPM presents an excellent hands-on opportunity to learn and perform basic and advanced interventional pain medicine procedures in a simulated setting. Participation in this workshop is essential to improving patient safety and patient outcomes in the interventional pain setting.

Building on the success of AAPM’s 2011 Cadaver Workshop, this year’s program promises to be a highlight of AAPM’s preconference educational activities. Cadaver Workshop attendees will be able to select the type of procedures (minimum of 2) that are most relevant to their interventional pain practice.

Co-Chairs
Lora L. Brown, MD
Salim M. Hayek, MD PhD

Faculty
Kenneth D. Candido, MD
David Caraway, MD PhD
Jianguo Cheng, MD PhD
Miles Day, MD
Meuhl J. Desai, MD MPH
Sudhir Diwan, MD

This workshop has been supported by education grants from Parenteral and Ocular Therapeutics Society; Exsion, Inc.; Covidien; Medtronic, Inc.; Medtronic; Stryker Interventional; Stryker; Globus Medical; and Vertos Medical.

7:30–11:30 am
Ultrasound Guidance for the Pain Physician (001)

This workshop provides the ultrasound novice with a hands-on application to practice real-time techniques for common ultrasound procedures and the opportunity to review evidence-based literature regarding feasibility, safety, and outcomes. Attendees will improve both cognitive and practical skills related to the use of ultrasound technology for regional anesthesia and interventional pain procedures.

Building upon the Academy’s strong commitment to advance multidisciplinary treatment modalities for chronic pain, attendees who complete the ultrasound imaging workshop (with live models) will have the additional opportunity to simulate and evaluate the effectiveness of ultrasound imagery versus fluoroscopy for multiple joints (e.g., sacroiliac [SI], hip, knee, and shoulder) and paravertebral, intercostal, andstellate ganglion blocks in a cadaver workshop setting. This innovative hands-on learning experience will engage attendees with the distinct advantages and disadvantages between ultrasound imaging and fluoroscopy for each of these interventional chronic pain procedures.

Co-Chairs
Mark-Friedrich B. Hurdle, MD
Matthew J. Pingree, MD

Faculty
Marko V. Bodor, MD
Michael J. Derr, DO
Mederic M. Hall, MD
Samir Narouze, MD Msc

This workshop has been supported by education grants from Esaote North American, Inc.; Siemens Healthcare; Sonosite, Inc.; and Tersason.

ENTER TO WIN AN APPLE IPAD AT THE MEMBERS’ MEETING 26
FRIDAY, FEBRUARY 24

8–8:15 am
AAPM President’s Welcome Address (101)

Perry G. Fine, MD
AAPM President Perry G. Fine, MD, is a professor in the department of anesthesiology of the School of Medicine at the University of Utah, where he serves on the faculty in the Pain Research Center and is an attending physician in the Pain Management Center. Dr. Fine serves as the external strategic advisor for Capital Hospice, Washington, DC, and is a consultant to the Center for Advanced Illness Coordinated Care in Albany, NY. He was also selected to serve as the chair of the National Initiative on Pain Control from 2003 to 2008. Dr. Fine is widely published in the fields of pain management and end-of-life care and serves on the editorial boards of several peer-reviewed medical journals. He has also been a team physician for the University of Utah football team for the last 18 years and was a medical officer for the 2002 Winter Olympics in Salt Lake City. He is the recipient of the 2007 American Academy of Hospice and Palliative Medicine Distinguished Hospice Physician Award and the 2008 American Pain Society John and Emma Bonica Public Service Award.

8:15–9 am
Glia as the “Bad Guys”: Clinical Implications of Glial Dysregulation of Pain, Opioids, and Other Drugs of Abuse (102)

Linda R. Watkins, PhD
Glia activation is now broadly recognized as an important contributor to neuropathic pain in animal models. Recently, their importance in dysregulating the actions of opioids and other drugs of abuse has been discovered as well. Therapeutics targeting glial activation and, specifically, key glial activation receptors are now approaching clinical trials aimed at relieving pain, increasing the clinical efficacy of opioids, and treating drug abuse.

World renowned for her groundbreaking work in understanding the mechanisms and potential control of pain, Linda R. Watkins, PhD, was awarded one of Spain’s Prince of Asturias Awards for Technical and Scientific Research in 2010. In addition to her research she has written or cowritten more than 250 book chapters, review articles, and journal articles.

10–11 am
Central Mechanisms in Pain Syndromes (103)

Daniel J. Clauw, MD
Various treatment options exist for chronic pain syndromes such as fibromyalgia, irritable bowel syndrome, temporomandibular joint disorders, and pelvic pain. This session examines the concepts and understanding of various treatment options available in treating these and other pain syndromes.

Daniel J. Clauw, MD, is currently co-principal investigator for the University of Michigan Discovery Site for the Multidisciplinary Assessment of Pelvic Pain (MAPP) network, focusing on identifying the underlying mechanisms for interstitial cystitis and chronic prostatitis. In addition, he serves as the chair of the MAPP network, which includes six discovery sites, as well as a data and tissue coordinating center.

11–11:45 am
Plenary Research Highlights (104)

Jeffrey M. Tiede, MD MAJ MC USA
Increasing both the quality and quantity of scientific pain research remains a primary goal for the 28th Annual Meeting Planning Committee. The reputation of AAPM as a premier professional service and scientific organization continues to result in a significant increase in the quality of cutting-edge scientific research abstracts. The Scientific Poster Abstract Committee has selected three of the highest ranking poster submissions for presentation in this plenary venue. New this year is a Friday afternoon concurrent session with three additional highest ranked poster submissions.

Major Jeffrey M. Tiede, MD, is chair of the department of pain medicine at Eisenhower Army Medical Center in Fort Gordon, GA. His research interests include novel developments of spinal cord stimulation and functional restoration of wounded warriors. Dr. Tiede has served as chair of the AAPM Scientific Poster Abstract Committee and on the Annual Meeting Program Committee since the 2008 Annual Meeting.

Chronic Pain and Substance Use: Treatment Outcomes for High-Risk Chronic Pain Patients Following Intensive Interdisciplinary Pain Rehabilitation (Poster 194)

Sarah E. Hayes

Chronic Low Back Pain Patients (CLBP) Display-Altered Brain Connectivity in the Default Mode Network: An Alterioral Spin Labeling (ASL) MRI Study (Poster 290)

Marco Loggia, PhD

Low-Dose Naltrexone Reduces the Symptoms of Fibromyalgia: A Double-Blind and Placebo-Controlled Crossover Study (Poster 251)

Jarred W. Younger, PhD

VISIT THE EXHIBIT HALL FOR THE LATEST PRODUCTS AND INNOVATIONS
PLENARY SESSIONS

SATURDAY, FEBRUARY 25

8–8:45 am
Public Policy on Prescription Opioids: Are We Trapped Between Scylla and Charybdis? (105)

Keith N. Humphreys, PhD

Prescription opioid prescribing has increased dramatically in the United States since 1998, bringing long-needed pain relief to some and addiction and overdose to others. Public policy debates about how to maximize the benefits and minimize the risks of these potent medications are often polarized, with some viewing all controls as a heartless "war on drugs" and others as reckless endangerment of public health and safety. This presentation explores the basic tensions and tradeoffs of public policy in this area and will also highlight initiatives that could provide a reasonable balance between the need for pain management and the need to avoid addiction to and overdose from prescription opioids.

Keith N. Humphreys, PhD, took a 1-year leave from his VA and Stanford University duties to serve as senior policy advisor at the White House Office of National Drug Control Policy. In this position, he advised the director and deputy director on the prevention, early intervention, and treatment of substance use disorders; health insurance for such care; the place of substance use and mental health disorders in healthcare reform; the improvement of correctional facilities and community parole/probation systems; and the research on general drug policy. He was also responsible for producing the demand reduction components of President Obama’s National Drug Control Strategy and served as a member of the overarching committee of the White House Office of National AIDS Policy that designed President Obama’s National HIV/AIDS Strategy.

9:45–11:15 am
Relieving Pain in America: Institute of Medicine Pain Presentation (106)

Sean Mackey, MD PhD

The 2010 Patient Protection and Affordable Care Act required the Department of Health and Human Services (HHS) to enlist the Institute of Medicine (IOM) in examining pain as a public health problem. The IOM report, Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, presented the IOM study committee’s findings and recommendations on treating pain as a public health problem. This session, with a panel consisting of IOM study participants, discusses the report findings and actions that must be taken to address the national challenges of better preventing, assessing, treating, and understanding pain of all types.

Moderator
Sean Mackey, MD PhD

Burden of Pain
Olivia D. Carter-Pokras, PhD

Clinical Care of Pain
Lonnie K. Zeltzer, MD

Pain Education
Kenneth A. Follett, MD PhD

Pain Research
Sean Mackey, MD PhD

Patient’s Perspective of Pain
Melanie Themstrom

The moderator and panel of this plenary session served as members of the Committee on Advancing Pain Research, Education, and Care of the National Academies of Science’s IOM.

Sean Mackey, MD PhD, is an associate professor for the departments of anesthesia, neuroscience, and neurology, and chief of the division of pain management at Stanford University School of Medicine in Palo Alto, CA.

Olivia D. Carter-Pokras, PhD, is an associate professor of epidemiology and biostatistics at the University of Maryland College Park School for Public Health in College Park, MD.

Lonnie K. Zeltzer, MD, is a professor of pediatrics, anesthesiology, psychiatry, and biobehavioral sciences at the David Geffen School of Medicine at UCLA, director of the Pediatric Pain and Palliative Care Program at the Mattel Children’s Hospital at UCLA, past associate director of the Patients and Survivors Program, UCLA’s Jonsson Comprehensive Cancer Center, and past medical director of Trinity KidsCare Pediatric Hospice.

Kenneth A. Follett, MD PhD, is a professor and chief of neurosurgery at the University of Nebraska Medical Center in Omaha, NE.

FRIDAY, FEBRUARY 24
1:30–2:30 pm
**Department of Defense/Veterans Health Administration Pain Task Force Update (201)**
The Army Pain Management Task Force report was completed in May 2010. The report recommendations were designed to support the task force’s vision statement of “providing a standardized Department of Defense and Veterans Health Administration (VHA) vision and approach to pain management to optimize the care for warriors and their families.” This session elaborates on the 2011 AAPM Annual Meeting presentation that provided an overview of the final report and the corresponding comprehensive pain medicine strategy by reviewing accomplishments and challenges a year after the report’s release and correlating challenges within attendees’ systems to establish multidisciplinary pain programs within their own communities.

**Moderator**
Chester C. Buckenmaier, III, MD COL MC USA
Defense and Veterans Pain Management Initiative
Chester C. Buckenmaier, III, MD COL MC USA

The Pain Task Force: A Cultural Change
Kevin T. Galloway, MHA BSN RN (invited)
VHA: Partners in the Pain Continuum
Rollin M. Gallagher, MD MPH

1:30–2:30 pm
**Decisions and Conundrums: Ethics and the Practice of Pain Medicine (202)**
The issue of ethics is addressed daily when practicing pain medicine during which goals of care may be in conflict or ambiguous expectations may hamper the decision-making process or blur outcomes. Well-intentioned professionals sometimes bring obvious, perceived, or even veiled conflicted interest to their interactions with patients and other healthcare professionals.

This session presented by the AAPM Ethics Council provides insights into ethical decision making at the bedside and in the boardroom, with parallel goals of informing and provoking thoughtful consideration and discussion of the ongoing issues in improving the practice of pain medicine.

**Moderator**
Larry C. Driver, MD
Principles for Ethical Decision Making
Larry C. Driver, MD

Difficult Decisions in Clinical Pain Management
Ben A. Rich, JD PhD

Industry Interactions with Integrity
Jerome Schofferman, MD

1:30–2:30 pm
**Palliative Medicine and the Pain Physician (203)**
Palliative medicine is not just for end of life but also for patients with chronic diseases and symptoms. The specialty of palliative medicine has been recently recognized as an American Board of Internal Medicine (ABIM) certification, with its own special set of skills and literature. Many patients could benefit from a palliative medicine consultation for chronic symptoms, such as nausea, pruritis, constipation, pain, or depression.

This scientific session utilizes case studies to discuss symptoms, diagnosis, and workup, while also demonstrating how sufferers of these symptoms would greatly benefit from treatment through an integrated approach with quality palliative care.

**Moderator and Faculty**
John F. Peppin, DO FACP

1:30–2:30 pm
**Opioid-Induced Respiratory Depression and Sleep Apnea (204)**
The beneficial use of opioids to reduce chronic pain can be offset by serious side effects, with respiratory repression and sleep apnea being among the most serious. Respiratory repression, a result of the suppression of central respiratory drive by opioid analgesics, is a clinical problem for which improved therapeutic treatments are needed. This potentially life-threatening condition results in a major clinical challenge of anesthesiology, pain, and intensive care—balancing the trade-off between analgesia and sedation and respiratory depression. Central sleep apnea due to sleep-disordered breathing, another result of opioid usage in chronic pain patients, can result in a higher risk of morbidity and mortality.

This scientific session examines recent research studies and findings, as well as ways of identifying those at risk, while balancing this risk against the potential for improved quality of life in chronic pain patients.

**Moderator**
Lynn R. Webster, MD

Alleviating Opioid-Induced Respiratory Depression
John J. Greer, PhD

Opioid-Induced Sleep Apnea
Lynn R. Webster, MD
Neuromodulation in the Military (205)

Neuromodulation has been well documented as a tool to fight chronic pain syndromes, but it is often viewed by many physicians as a treatment of last resort and as a relative contraindication to rigorous physical activity. Since 2006, the United States Military has utilized aggressive and judicial use of neuromodulation to return more than 100 injured soldiers to preinjury status.

This scientific session examines a population of very physically active and extremely motivated active-duty military patients who have received aggressive and judicial use of neuromodulation therapy, resulting in them being returned to preinjury status. These examples and reasons to "think outside of the box" will enable pain physicians to expand their selection and placement of potential neuromodulation candidates.

Moderator
Thomas J. Weber, DO

Faculty
Thomas J. Weber, DO
Timothy R. Deer, MD
Anthony L. Dragovich, MD


Three pieces of legislation collectively referred to as Healthcare Reform passed in 2009 and 2010 and have fundamentally changed the U.S. healthcare system. Many of these rules will be phased in during the next 3 years. By the end of implementation in January 2015, physician practices will be operating under many new rules that, although passed into law, have yet to be defined. This session will explain the implications that these new healthcare reform rules will have on your pain practice.

Moderator
Dave Domann, MS RPh

Healthcare Changes: How ACO Will Impact the Future of Pain Medicine
Dave Domann, MS RPh

Implementing Healthcare Reform in Your Practice
Linda M. VanHorn, MBA

Psychopathology and Chronic Pain: Clinical Pathways and Practical Tools (208)

Although studies have documented the efficacy of interdisciplinary treatment for individuals with chronic pain, psychiatric and psychological care often is not included in the treatment plan for many patients. There is a high prevalence of psychiatric disorders within chronic pain populations (e.g., an estimated 33%–66% of pain patients have comorbid depression), and evidence-based literature suggests that patient outcomes improve when pain and psychiatric issues are addressed concurrently.

This session will discuss the assessment and management of common psychiatric comorbidities and the clinical role that psychiatry and psychology play in addressing these issues.

Moderator
Binit J. Shah, MD

Rationale and Assessment Strategies of Psychopathology
Geralyn Datz, PhD

Etiology and Diagnosis of Psychopathology
Ravi Prasad, PhD

Pharmacologic Management of Psychiatric Co-Morbidity in Pain
Binit J. Shah, MD
Injured Warriors: Posttraumatic Stress Disorder (PTSD), Brain Trauma, Pain, Traumatic Brain Injury (TBI), and Mental Health (209)

Military veterans returning from combat experience complex pain patterns with a complex intertwining of physical injuries and traumatic stress reactions that often produces pain, posttraumatic stress disorder (PTSD), mild traumatic brain injury (TBI), and other concurrent symptom presentations. The treatment of these veterans is complicated by issues that pose significant challenges to traditional pain treatment approaches because treatment must address both types of trauma in ways that are acceptable to veterans’ needs and the way they wish to be treated.

This scientific session explores the treatment of severe pain caused by both physical and psychological trauma, recognizing both types of trauma as well as the complexities of multiple physical and emotional comorbidities. In addition, because physical pain and psychological trauma impair sleep, methods of improving sleep to enhance pain management will be explored.

Moderator
Michael E. Clark, PhD

Epidemiology and Treatment of Postdeployment Multisymptom Disorder (PMD)
Michael E. Clark, PhD

Neuropathophysiology/Pathology and TBI/HA Treatment
Robert L. Ruff, MD PhD

4:45–5:45 pm
Pain Outcomes Across Multiple Domains: What Should Be Measured and the National Institutes of Health (NIH) PROMIS Initiative (210)

Pain practitioners are increasingly required to provide evidence of improved pain patient outcomes. The need for providing outcomes data becomes more urgent due to the increasing need to provide scientifically valid demonstrations of treatment efficacy. Various tools and systems can be utilized in the measurement of pain outcomes. One system, the Patient Reported Outcomes Measurement Information System® (PROMIS) implemented by the National Institutes of Health (NIH), uses questions to measure patients’ functional ability and wellness, resulting in tools that can be utilized across a variety of chronic diseases and conditions to provide important patient-related information about the effects of therapy that cannot be found in traditional clinical measures.

This session discusses various outcomes tools that can be used in the measurement of pain outcomes, such as analyzing statistical versus clinical significance, length-of-measurement packets, along with the domains that need to be captured. Faculty explain how these tools, when used correctly, provide pain practitioners with reliable and valid measurements of pain outcomes that can be utilized in designing treatment plans and for patient-doctor communication in maintaining control of chronic pain disorders.

Moderator
Sean Mackey, MD PhD

Pain Outcomes: What to Measure and Why
Sean Mackey, MD PhD

NIH PROMIS Outcomes Results
Karon F. Cook, PhD

Evidence Basis for Practice Parameter Guidelines in Neuropathic Pain Medications (211)

With increasing practice parameter guidelines being developed by various organizations, it is important for the pain medicine physician to understand how these guidelines were developed, their recommendations, and their impact on the treatment of neuropathic pain.

This scientific session explores how current practice guidelines were developed for neuropathic pain medications, how they are utilized in current clinical practice, their limitations, and how they can be improved upon in the pharmaceutical management of neuropathic pain.

Moderator
Martin Grabois, MD

Review of Practice Parameters for Neuropathic Pain Medications
Scott M. Fishman, MD

Pharmaceutical Management of Neuropathic Pain
R. Norman Harden, MD
Acupuncture for Chronic Low Back Pain: Clinical Evidence, the Science, and the Challenge (301)

Chronic low back pain (CLBP) affects almost 10% of the population and imposes a high financial burden of about $90 billion annually on the United States. Despite the availability of a broad range of treatment options such as physical therapy, injections, and surgeries, many cases remain resistant to conventional treatment strategies. Acupuncture is gaining increasing recognition as a promising pain management strategy, particularly in CLBP. When appropriately applied, stimulation of acupuncture points can activate physiological changes that reduce pain and improve function for months after the treatment.

This scientific session outlines the role, mechanisms, and controversies of acupuncture in the management of CLBP and also provides an evidence-based study of acupuncture clinical trials. Faculty explore the clinical evidence for the efficacy and presumed mechanisms of acupuncture in CLBP and cover treatment specifics including patient selection, timing, point selection, and adjunct modalities. Controversies regarding the role of placebo in mediating response to acupuncture, duration of efficacy, and translation of physiological effects in preclinical and clinical observations to therapeutic outcomes in clinical trials will also be presented.

Moderator
Yu (Woody) Lin, MD PhD

The Role of Acupuncture in Treating Chronic Low Back Pain
Jiang-Ti Kong, MD MS

Brain Encoding of Acupuncture Analgesia
Richard Harris, PhD

Acupuncture Clinical Trial: Challenges and Opportunities
Lixing Lao, PhD

Acute Pain Medicine: What It Is, Why It Is Needed, and How We Train for It (302)

In 2009, Pain Medicine, AAPM's official journal, launched the acute pain management section of the journal—the first journal to do so—in response to the growing evidence that poorly managed acute pain could develop into chronic pain. Unlike the more established and mature subspecialty of chronic pain, the rapidly developing subspecialty of acute pain medicine focuses on managing pain in the perioperative period following trauma or surgery. Although anesthesiologists are uniquely qualified for leadership roles within this specialty, like all branches of pain medicine, acute pain medicine requires a multidisciplinary approach for optimal outcomes for the patient.

This session defines the new practice of acute pain medicine and the available evidence supporting the establishment of an acute pain service (APS) within medical institutions, addressing the personnel, technology, and facility required to operate a successful APS. Faculty will further examine the cultural and financial challenges and barriers to APS establishment; define the unique educational requirements for physicians, nurses, and ancillary personnel who make up an effective APS; and examine the future directions for the field.
2–3:30 pm  
**Cognitive-Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Mindfulness: New Developments for Chronic Pain Management (304)**

Chronic pain requires effective biopsychosocial interventions to address each aspect of the challenges toward adequate pain management. Two psychological and behavioral approaches to chronic pain management are utilized by pain psychologists. One approach, cognitive-behavioral therapy (CBT), which involves education and skills training toward symptom reduction and adaptive coping to increase physical and psychological functioning, has been documented as providing beneficial effects. A second approach, acceptance and commitment therapy (ACT), has shown promise in helping to improve functional capacity among chronic pain populations and has recently been identified as a supported treatment for a number of problems including chronic pain. By using acceptance and mindfulness processes with commitment and behavior change processes, the ACT approach can create psychological flexibility in the presence of previously avoided aversive thoughts, emotions, and physical sensations. Although there are documented benefits of both treatment approaches for chronic pain, there is uncertainty in regard to the superiority and potentially preferred use of one therapy over the other for patients with chronic pain.

This scientific session reviews CBT and ACT approaches to pain management along with supporting research for these psychological interventions. Faculty will highlight key theoretical and practical components of CBT, discuss the current state of research supporting CBT use with chronic pain, review the theoretical underpinnings of ACT, and share new data comparing CBT and ACT. Additional recommendations for psychological care of patients with chronic pain using these therapies will be presented.

**Moderator**  
John T. Sorrell, PhD

**Panel**  
Gary J. Brenner, MD PhD  
Michel Y. Dubois, MD  
Sean Mackey, MD PhD  
Thomas E. Norris, MD  
James P. Rathmell, MD

3:45–5:15 pm  
**Why Skin Matters: New Assessment and Treatment Tools for Acute and Chronic Pain (306)**

The treatment of neuropathic pain presents a unique and difficult challenge for the pain professional because there are pathophysiologic aspects to this pain as well as emotional and behavioral components. Although oral medications have been the cornerstone treatment of neuropathic pain, new approaches utilizing topical treatment have become more common, presenting unique and possibly safer approaches to the treatment of this pain disorder. In addition, recent translational research has led to increased understanding of the role of epidermal innervation in the assessment and treatment of chronic pain. Postherpetic neuralgia, complex regional pain syndrome, and painful diabetic peripheral neuropathy are each associated with epidermal pathologies.

This scientific session discusses the physiology of neuropathic pain as it relates to topical treatments, reviewing the current pharmacology, delivery systems, and supportive clinical research for medications that can be applied transdermally and topically. Faculty will provide updates on new neuropathic pain topical treatments, including topical lidocaine and non-local anesthetic topical analgesics. The session also provides cutting-edge research and new insights on the epidermal-based mechanisms of pain, as well as new findings in the skin that provide clues to the mechanism of various clinical pain states, practical information for all pain practitioners regarding pain-assessment tools, and currently available and potential future treatment strategies.

**Moderator**  
John F. Peppin, DO FACP

**New Insights Regarding Epidermal-Based Mechanisms of Pain: The Basics**  
Frank L. Rice, PhD

**Translating New Insights Regarding Epidermal-Based Mechanisms of Pain into Clinical Practice**  
Charles E. Argoff, MD

**Non-Local Anesthetic Topical Analgesics: Efficacy and Safety**  
Marco Pappagallo, MD

**Topical Lidocaine: Patches, Creams, and Solutions**  
John F. Peppin, DO FACP

**Topical Treatments in Neuropathic Pain: Who Responds?**  
Burkhard Gustorff, MD

**How Can Human Models of Cutaneous Pain and Hyperalgesia Help Us to Better Treat Our Patients?**  
Mark S. Wallace, MD
Improved Pain Medicine Outcomes Through Implantable Devices (307)

New advancements in the field of pain medicine allow pain physicians to offer a greater range of treatment options for patients while offering a safe alternative to full surgical interventions. Advancements in percutaneous placement of paddle leads for spinal cord stimulation are opening new doors for the treatment of chronic pain conditions. Best practices in the use of intrathecal therapy treatment result in reduced morbidity and mortality. New advances and devices targeting dorsal root ganglion stimulation appear to provide another safe and effective treatment option for chronic pain patients.

This scientific session explores recent technical advances in improving treatment modalities in the use of implantable devices, providing better safety outcomes measures and increasing the continuity of patient care.

Moderator: Timothy R. Deer, MD

A Game Changer in Spinal Cord Stimulation: The Percutaneous Paddle Lead
Timothy R. Deer, MD

Best Practices for Intrathecal Therapy
Joshua P. Prager, MD MSc

New Advances in Dorsal Root Ganglion Stimulation
Timothy R. Deer, MD

Sacroiliac (SI) Joint Pain: Anatomy and Neuroablative Therapies (308)

Sacroiliac (SI) joint pain, which originates from degeneration or altered joint mobility in the SI joint, can be difficult to diagnose and differentiate from other spinal disorders (e.g., facet joint arthropathy, degenerative disc disease, spinal stenosis), leaving sufferers in pain and at risk for further joint deterioration. Although there is no validated physical examination maneuver or individual test that definitively identifies SI joint-mediated pain, numerous tests used in combination can better assist pain medicine providers in diagnosing SI joint dysfunction.

This scientific session discusses anatomy, possible pain mechanisms, symptoms, evaluation, diagnosis, and treatments for SI joint-mediated pain, including the approaches and techniques in utilizing radiofrequency ablation to best provide long-term relief of SI joint-mediated pain.

Moderator: Scott M. Fishman, MD

Introduction and Overview of SI Joint-Mediated Pain
Scott M. Fishman, MD

SI Joint Anatomy, Biomechanics, and Pathology
Faculty TBD

Diagnosis and Patient Selection for Radiofrequency Ablation
Steven P. Cohen, MD

Cooled Radiofrequency Ablation, Bipolar Radiofrequency Ablation, and Other Novel Approaches
Leonardo Kapural, MD PhD

Intrathecal Medications for Chronic Pain: An Update (401)

Implanted intrathecal drug delivery systems (IDDS) are widely used in the treatment of chronic pain when conservative therapies have failed and surgery is not a viable option. Choosing the appropriate medication to use for each patient can be a daunting task for most physicians. Recent studies on medication safety provide valuable updates relevant to successfully delivering pain management using IDDS.

This scientific session reviews the science and practice of intrathecal medication for chronic pain, providing the latest updates for intrathecal medications and delivery relevant to pain clinicians.

Moderator and Faculty: Tony L. Yaksh, PhD

The Role of the Primary Care Provider in Comprehensive Pain Management (402)

Pain management continues to be a challenge for most primary care providers (PCPs). Lack of knowledge and time, fears of prescription abuse, and regulatory oversight contribute to the difficulty in providing compassionate long-term care in a typical primary care office. Pain specialists attempt to visualize the primary care office as an extension of their own care styles, but with limited resources and increasing demands, the office-based practice reality is very different than that visualization.

This session explores how to best interact with the PCP to improve pain management for the patient, while simplifying the process for the PCP. Interactions within a variety of practice settings, including the Veterans Administration, university-based practice, and a typical family medicine outpatient facility, will be reviewed to improve and facilitate better communication between the PCP and pain specialist.

Moderator: Bill H. McCarberg, MD

What the Primary Care Provider Really Wants
Bill H. McCarberg, MD

A Model for Collaboration with Primary Care
Stephen A. Eraker, MD MPH FACP

Educating Primary Care Physicians to Be Better Pain Providers: Academic Detailing and Project ECHO™ (Extension for Community Healthcare Outcomes)
Rollin M. Gallagher, MD MPH
CONCURRENT SESSIONS

8:30–9:30 am
The Interface Between Pain Medicine and Hospice and Palliative Medicine: Critical Partnership Opportunities (403)
Using a case-based approach in a didactic learning session, key opinion leaders from pain medicine and hospice and palliative medicine will explore the multitude of opportunities for improving the knowledge and bridging the practice gaps necessary to improve access and the quality of care delivered to the advanced illness population.

Moderator
J. Cameron Muir, MD FAAHPM
Faculty
J. Cameron Muir, MD FAAHPM
B. Todd Sitzman, MD MPH

8:30–9:30 am
Evidence Bases for Alternatives in the Treatment of Chronic Pain (404)
Various alternative treatments are available and successfully utilized by patients suffering chronic pain. Newer treatment modalities include transcutaneous electrical nerve stimulation (TENS), biofeedback, and hypnosis. In TENS, an electronic current is provided by portable stimulators to stimulate nerves for therapeutic purposes, resulting in the reduction of both acute and chronic pain. In biofeedback, patients use their minds to control body functions, providing them with the skills to lessen their pain. In hypnosis, hypnotic suggestions have been effective in affecting selective areas of the brain to relieve pain. However, these treatments can be costly and many times are not covered by insurance, leaving the pain practitioner unsure of the benefit of their use.

This session explores these pain relief treatments, reviewing the indications, contraindications, complications, and most importantly the cost effectiveness and efficacy based on the available evidence-based literature. The session will assist pain practitioners as they consider whether the utilization of these modalities will benefit the patient, practitioner, and third-party payees.

Moderator
Martin Grabois, MD
TENS: Role in Managing Chronic Pain
Martin Grabois, MD
Biofeedback: Rationale for Use in Treating Chronic Pain
Donna M. Bloodworth, MD
Hypnosis: Recent Advances in Treating Chronic Pain
Albert L. Ray, MD

9:45–10:45 am
2012: Coding Update and Preparing for ICD-10 (405)
2012 has brought changes to CPT® pain coding, including new bundled services that should not be coded separately. ICD-10, which will go into effect on October 1, 2013, is structurally different from ICD-9. Pain practitioners need to understand these changes to update coding and reimbursement processes they use in their practices.

This session provides attendees with the latest coding changes, along with an opportunity to discuss any challenging coding and reimbursement they may face in their practice. Faculty will explore the structural differences of ICD-10, the General Equivalence Mappings (GEMs), and what pain practitioners can do now to prepare for ICD-10 implementation. This session also reviews new HIPAA 5010 X12 standards, which incorporate ICD-10, and went into effect on January 1, 2012.

Moderator
Eduardo M. Fraifeld, MD
Coding Update: 2012
Eduardo M. Fraifeld, MD
How to Prepare for ICD-10
Linda M. VanHorn, MBA

9:45–10:45 am
Psychological Screening and Disease Phenotyping: Predictive of Interventional Pain Procedures Outcomes? (406)
Invasive procedures and implantable devices (e.g., spinal cord stimulation, idiopathic thrombocytopenic purpura) are the mainstays of interventional pain medicine, but there remains a lack of consensus regarding the best approach to screen for suitable candidates in order to maximize chances for positive treatment outcomes. Psychological conditions such as somatization, depression, anxiety, and poor coping are important predictors of negative outcomes, and specific testing may assist the clinician in selecting the “right patients” for certain interventions. These characterizations of disease mechanisms through use of quantitative sensory testing (QST) may provide an important and clinically meaningful index of success. To date no studies have examined central nervous system plasticity or dynamic QST procedures thought to assess the integrity of central pain processing mechanisms and the efficiency of descending systems.

This scientific session provides an evidence-based framework for the optimal use of a psychological assessment and presents information on the contribution of disease phenotyping in improving procedural outcomes in interventional pain care.

Moderator
Kayode A. Williams, MD MBA FFARCSI
Psychological Screening: Interventional Pain Procedures
Robert N. Jamison, PhD
Disease Phenotyping: Spinal Cord Stimulation
Kayode A. Williams, MD MBA FFARCSI
Claudia M. Campbell, PhD
**9:45–10:45 am**

**The Great Debate: Medical Marijuana for the Treatment of Chronic Pain (407)**

Despite the legalization of medical marijuana for the treatment of pain in some regions of the United States, evidence of efficacy has not been firmly established and consequently continues to present significant challenges for the pain medicine practitioner. Additional ethical and professional issues related to cultivation, possession, and distribution of medical cannabis in accordance with state-approved medical marijuana programs can be viewed as a violation of federal marijuana laws and subject to prosecution by federal authorities.

In this interactive pro con forum, the pharmacology and efficacy of marijuana use in the treatment of acute and chronic pain and medical and legal risks posed by the complexities of this alternative pain treatment regimen will be discussed. Additional challenges related specifically to prescribing, scope of practice issues, and clinical addiction and dependence issues will also be addressed.

**Moderator**
Steven D. Passik, PhD

**Debaters**
Jodie A. Trafton, PhD
Donald I. Abrams, MD

**9:45–10:45 am**

**Myofascial and Muscle Pain: Assessment and Treatment Innovations (408)**

Muscle pain in the context of myofascial pain syndrome (MPS) is a common condition in contemporary pain practice. Recently, there have been tremendous breakthroughs in elucidating the pathophysiology of MPS, including the quantification of biochemicals involved in this process. Furthermore, the role of sensitization in the development of MPS has increasingly been examined.

This scientific session details the development of novel diagnostic techniques including microdialysis, magnetic resonance elastography, and ultrasound in the treatment of MPS.

**Moderator**
Mehul J. Desai, MD MPH

**Neurobiology of Muscle Pain and Clinical Evaluation of Myofascial Pain**
Jay P. Shah, MD

**Treatment Options for Myofascial and Muscle Pain**
Mehul J. Desai, MD MPH

**11 am–12:30 pm**

**National Institutes of Health (NIH) Pain Research: Optimizing Funding Through Grant Writing (409)**

A successful application for research funding requires careful planning and a keen understanding of grant writing within the appropriate funding system. This scientific session outlines the grant writing, peer review, and funding processes of grant application at the National Institutes of Health (NIH). Faculty will provide critical information on NIH funding opportunities in pain research and define funding mechanisms, peer-review processes, and referral processes within the NIH.

This scientific session provides an excellent opportunity to investigate NIH grant writing opportunities from a principal investigator’s perspective.

**Moderator**
Yu (Woody) Lin, MD PhD

**Funding Opportunities and Mechanisms at NIH**
Yu (Woody) Lin, MD PhD

**NIH Grant Writing from a Principal Investigator’s Perspective**
Sean Mackey, MD PhD

**NIH Grant Applications: Referral and Review**
Weijia Ni, PhD

**11 am–Noon**

**Pediatric Pain (410)**

A 2010 University of Florida College of Medicine study found that many pediatricians do not believe it is their responsibility to treat severe, chronic pain in their patients, particularly as they have more concerns about severe side effects than the pain experienced by their patients. Of those pediatricians surveyed regarding who should treat their patients’ chronic pain, pain specialists were the most popular choice at 58.1%. Pain management specialists who work with children and adolescents need to understand how pain manifests itself in this population to ensure best practices in treating this particularly special and vulnerable group.

This scientific session provides a template/framework for evaluating a child/adolescent with ongoing or recurrent pain, explores patient evaluation based on a biopsychosocial method of assessment, and discusses a treatment plan based on an integrative model that considers primary pain causes and contributors all within a developmental framework. It focuses on pain in children and adolescents with autism spectrum disorders as an example of one common developmental disorder in a population at high risk for pain problems.

**Moderator**
Lonnie K. Zeltzer, MD

**Clinical Evaluation and Treatment Approaches to Chronic Pain in Children and Adolescents**
Lonnie K. Zeltzer, MD

**Chronic Pain in Children with Developmental Disabilities**
Tim F. Oberlander, MD FRCPC
11 am–12:30 pm
**Pain Medicine and Criminal Litigation (411)**

In optimizing their patients’ health status, pain practitioners’ professional conduct, intent, and motivations must align with the current interpretations of the Controlled Substances Act and the state statutes regulated through the Federation of State Medical Board’s Model Policy. Both of these statutes are open to broad interpretation regarding standards of care versus criminal conduct (“normal course of medical practice” and “legitimate indication for prescribing”). In this changing area of regulation, physicians must be aware of the ever increasing need to take appropriate steps to protect themselves and their practices.

This session reviews the true-life cases of a physician who suffered the closing of her practice due to misconduct by a colleague in that practice and also provides the view of litigation from the perspective of a former U.S. Drug Enforcement Agency (DEA) expert, providing instructive guidance for “safe harbor” in prescribing.

**Moderator**
Perry G. Fine, MD

**Panel**
Perry G. Fine, MD
Elaine A. Lankford, FNP-C
John J. Coleman, PhD

11 am–Noon
**Headache and Facial Pain: An Update (412)**

Headache and facial pain are common complaints in both the emergency and outpatient settings, resulting in a critical need to understand, appropriately diagnose, and treat these disorders. This session reviews the diagnosis and treatment of various primary and secondary headaches, facial pain, and neck pain disorders, with an emphasis on utilizing a multidisciplinary approach in formulating a multimodal treatment plan for these pain disorders. It also explores when to use Botox injections and other various interventional and neuromodulatory techniques.

**Moderator**
Samer Narouze, MD MSc

**Intractable Headaches: Interventional Perspectives**
Samer Narouze, MD MSc

**Intractable Headaches: Medical Perspectives**
Zahid H. Bajwa, MD

**Multidisciplinary Headache Management**
Robert P. Cowan, MD
Donald I. Abrams, MD
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Charles E. Argoff, MD
Director, Comprehensive Pain Program
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Coviden (consulting fee–consultant); Endo Pharmaceuticals (honorarium, consulting fees, grant–speaker, consultant, research grant); Nuvo Research (consulting fee–consultant)

Sanjeev Arora, MD
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Director, University of New Mexico Health Sciences Center
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Genentech (clinical trials–principal investigator); Gilead (clinical trials–principal investigator); Pharmasset (clinical trials–principal investigator); Tibilities (clinical trials–principal investigator); Vertex (clinical trials–principal investigator); ZymoGenetics (clinical trials–principal investigator)

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<th>Institution</th>
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<td>Samer Narouze, MD MSc</td>
<td>Chairman, Center for Pain Medicine</td>
<td>Summa Western Reserve Hospital, Cuyahoga Falls, OH</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Wei-Jia Ni, PhD</td>
<td>Scientific Review Administrator</td>
<td>National Institutes of Health, Bethesda, MD</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Thomas E. Norris, MD</td>
<td>Acting Chair, Department of Family Medicine</td>
<td>University of Washington, Seattle, WA</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Tim F. Oberlander, MD FRCP</td>
<td>Professor</td>
<td>University of British Columbia, Vancouver, BC, Canada</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Marco Pappagallo, MD</td>
<td>Professor</td>
<td>New York, NY</td>
<td>Grunenthal, Germany (salary–strategic US market expert in pain medicine)</td>
</tr>
<tr>
<td>Steven D. Passik, PhD</td>
<td>Professor</td>
<td>Vanderbilt Medical Center, Nashville, TN</td>
<td>Amentox (consulting); Cephalon (honorarium–speaker, consulting); Covidien (research funding–research, consulting); Endo (consulting); Janssen (honorarium-speaker, consulting); Millennium (honorarium–speaker, consulting); Purdue Pharma (consulting); Pharmacofofe (consulting); Pfizer (consulting); Quest (honorarium–speaker, consulting)</td>
</tr>
<tr>
<td>John F. Peppin, DO FACP</td>
<td>Director, Clinical Research Division</td>
<td>The Pain Treatment Center of the Bluegrass, Lexington, KY</td>
<td>Aiko Technology (lectures, consulting, advising); Alpharma Pharmaceuticals (research contract–research); Amentox Laboratories (lectures, consulting, advising); Astellas Pharmaceuticals (research, consulting, advising); Astra Zeneca Pharmaceuticals (clinical research); Cephalon Pharmaceuticals (clinical research); Covidien Pharmaceuticals (lectures, consulting, advising); El Lilly Pharmaceuticals (consulting, advising); Johnson &amp; Johnson Pharma (clinical research); King Pharmaceuticals (clinical research, lectures, consulting, advising); NeurogesX (clinical research, lectures, consulting, advising); Pfizer (consulting, advising); Progenics Pharmaceuticals, Inc. (clinical research, lectures, consulting, advising); Shionogi Incorporated (lectures, consulting, advising); Theravance Incorporated (lectures, consulting, advising); Xenon Pharmaceuticals (clinical research), Zogenix Incorporated (lectures, consulting, advising)</td>
</tr>
<tr>
<td>Matthew J. Pingree, MD</td>
<td>Professor</td>
<td>Mayo Clinic, Rochester, MN</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Joshua P. Prager, MD MSc</td>
<td>Assistant Director, Division of Pain Management</td>
<td>Stanford University School of Medicine, Redwood City, CA</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>James P. Rathmell, MD</td>
<td>Director, MGH Center for Pain Medicine</td>
<td>Massachusetts General Hospital, Boston, MA</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Albert L. Ray, MD</td>
<td>Medical Director</td>
<td>The Lite Center, Miami, FL</td>
<td>No relevant financial relationships</td>
</tr>
<tr>
<td>Frank L. Rice, PhD</td>
<td>President, CEO, Chief Scientist, Research and Development</td>
<td>Integrated Tissue Dynamics LLC, Albany, NY</td>
<td>Eli Lilly–Forest Pharmaceuticals (research contract–research); Endo Pharmaceuticals (research contract–research); Forest Pharmaceuticals (research contract–research); Integrated Tissue Dynamics LLC (consulting fees–co-owner, president, CEO, scientific), Merck (research contract–research); Vertex Pharmaceuticals (research contract–research)</td>
</tr>
</tbody>
</table>
Ben A. Rich, JD PhD  
Professor and Endowed Chair of Bioethics  
University of California–Davis School of Medicine  
Sacramento, CA  
KOL, LLC (honorarium–manuscript contributor, consultant); MediCom Worldwide, Inc. (honorarium–videotaped interview)

Andrea L. Rubinstein, MD  
Physician  
Permanente Medical Group  
Santa Rosa, CA  
No relevant financial relationships

Robert L. Ruff, MD PhD  
Neurology Director  
Veterans Administration Cleveland  
Lyndhurst, OH  
No relevant financial relationships

Jerome Schofferman, MD  
SpineCare Medical Group  
Daly City, CA  
No relevant financial relationships

Binit J. Shah, MD  
Senior Instructor  
University Hospitals Case Medical Center  
Cleveland, OH  
Oxford University Press (honorarium–book reviewer)

Jay P. Shah, MD  
Senior Staff Physician  
National Institutes of Health  
Bethesda, MD  
No relevant financial relationships

Samir J. Sheth, MD  
Assistant Professor  
University of California–Davis School of Medicine  
Sacramento, CA  
No relevant financial relationships

B. Todd Sitzman, MD MPH  
Medical Director, Pain Medicine  
Advanced Pain Therapy, PLLC  
Hattiesburg, MS  
URL Pharma (consultant fee–consultant)

John T. Sorrell, PhD  
Clinical Psychologist  
Stanford University  
Redwood City, CA  
No relevant financial relationships

Steven P. Stanos, DO  
Medical Director, Center for Pain Management  
Rehabilitation Institute of Chicago  
Chicago, IL  
Depomed (Honorarium–Consultant); Endo (Honorarium–Consultant/Speaker); Grunenthal (Honorarium–Consultant); Lilly (Honorarium–Speaker); Nuva (Honorarium–Consultant); Orthe-McNeil/Janssen (Honorarium–Consultant/Speaker); Pfizer/King (Honorarium–Consultant/Speaker); Purdue (Honorarium–Consultant/Speaker)

Melanie Thernstrom  
Author, Independent Consultant  
Palo Alto, CA  
No relevant financial relationships

Jeffrey M. Tiede, MD MAJ MC USA  
Interdisciplinary Pain Management Center  
Dwight D. Eisenhower Army Medical Center  
Fort. Gordon, GA  
Neuro (salary, stock options–consultant)

Jodie A. Trafton, PhD  
Director  
VA Program Evaluation and Resource Center  
Menlo Park, CA  
No relevant financial relationships

Linda M. VanHorn, MBA  
President/CEO  
21st Century Edge  
Kansas City, MO  
21st Century Edge (president, CEO); Boston Scientific (consultant); St. Jude Medical (consultant)

Mark S. Wallace, MD  
Vice Chair, Division Pain Medicine  
University of California–San Diego  
La Jolla, CA  
Archmedes (research support, private investigator); Azur (honorarium, speaker); Biodelivery Sciences (research support, private investigator); Boston Scientific (honorarium, consultant); NeogesX (research support, private investigator)

Linda R. Watkins, PhD  
Director, Interdepartmental Neuroscience PhD Program  
University of Colorado at Boulder  
Boulder, CO  
No relevant financial relationships

James C. Watson, MD  
Consultant  
Department of Neurology  
Mayo Clinic  
Rochester, MN  
No relevant financial relationships

Thomas J. Weber, DO  
Chief, Pain Medicine  
WOMACK Army Medicine  
Spring Lake, NC  
St. Jude Medical (honorarium–speaker, consultant)

Lynn R. Webster, MD  
Medical Director  
Lifetree Clinical Research  
Salt Lake City, UT  
Adara Corp. (research); Allermed, Inc (research); Allergan, Inc (research); AlphaBioCom (consultant, honoraria, advisory board); Astellas (research); AstraZeneca (consultant, honoraria, advisory board, research); Bayer Healthcare (research); BioDelivery Systems International (research); Boston Scientific (consultant, honoraria, advisory board, research); Cephalon (consultant, honoraria, advisory board, research); Collegium Pharmaceuticals (research); Covidien (research); Covidien Mallinckrodt (consultant, honoraria, advisory board); Eisa (research); Elan Pharmaceuticals (research); Gilead Sciences (research); GlaxoSmithKline (research); Identigene (Sorenson) (research); King Pharmaceuticals (research); Meagen Medical (research); Medtronic (research); Merck (research); Naurex (research); Nektar Therapeutics (research); NeogesX, Inc (research); Nevo-Corporation (consultant, honoraria, advisory board); Navarta (research); Pfizer (research); SchyBar (research); Shionogi USA, Inc (research); St. Renatus (research); SuCampo Pharma Americas, USA (research); Takeda (research); TEVA Pharmaceuticals (Sub–I) (research); Theravance, Inc (consultant, honoraria, advisory board, research); Vanda (research); Vertex (research); Xanodyne Pharmaceuticals (research)

Kayode A. Williams, MD MBA FFARCSI  
Director, Blaustein Pain Center  
Johns Hopkins University School of Medicine  
Baltimore, MD  
No relevant financial relationships

Steven J. Wisniewski, MD  
Assistant Professor  
Mayo Clinic  
Rochester, MN  
No relevant financial relationships

Tony L. Yakesh, PhD  
Professor, Department of Anesthesiology  
University of California–San Diego  
La Jolla, CA  
Advanced Targeting (contract); Adynxx (contract, SAB); Arsenal (NIH grant); Hydra (contract); ISIS (SAB–honorarium); Johnson & Johnson (contract); Nektar (contract); Solstice (contract); Stryker (contract); Xeno (contract, SAB, honorarium)

Jarred W. Younger, PhD  
Assistant Professor  
Stanford University School of Medicine  
Palo Alto, CA  
No relevant financial relationships

Lonnie K. Zeltzer, MD  
Director, Pediatric Pain Program  
David Geffen School of Medicine at UCLA  
Los Angeles, CA  
Hospira (consulting agreement fee); Purdue Hospira (consulting agreement fee)
Satellite symposia will be held in conjunction with the annual meeting. These independently sponsored, commercially supported symposia are open to meeting registrants. The AAPM Program Planning Committee has reviewed and approved the symposia after determining the topics are relevant to the audience and complementary to the official AAPM program. There is no additional fee to attend these symposia, but preregistration is required. Seating will be available on a first-come, first-served basis. Program details and speakers are subject to change. Satellite symposia will be both CME and non-CME offerings. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Please preregister at www.symposiareg.org/aapm or with Connie Riefke at 847.375.4397 or criefke@connect2amc.com.

*Satellite symposia are tentatively scheduled for the days and times listed on the schedule at a glance on pages 22–23. A complete list of satellite symposia is available at the Annual Meeting section of the AAPM website at www.painmed.org or at www.symposiareg.org/aapm.

FRIDAY, FEBRUARY 24

Noon–1:15 pm
CME Lunch Symposium

Opioid-Induced Androgen Deficiency: Approaches to Diagnosis and Management

Even though the effects of opioids on the endocrine system have long been known, they have not been well integrated into the medical lexicon of chronic opioid therapy. Of all the endocrine effects of chronic opioid use, androgen deficiency (hypogonadism), primarily in men, has been recognized the longest and is the best described. The prevalence of opioid-induced hypogonadism in men is very high. There is a growing understanding of the role of testosterone and, conversely, the consequences of hypogonadism in men’s health, including its relationship with highly prevalent chronic diseases such as metabolic syndrome, insulin resistance, diabetes, obesity, hypertension, and hyperlipidemia, in addition to the better-known effects on sexual function and bone health. Maintaining normal physiological concentrations of testosterone in patients on chronic opioid therapy has important consequences for their overall health. There is a lack of evidence that testosterone replacement therapy (TRT) increases the risk of prostate cancer. It is important to diagnose hypogonadism, counsel patients, and collaborate with other healthcare providers regarding TRT in patients on chronic opioid therapy who can benefit from testosterone replacement.

Learning Objectives

After completing this activity, the participant should be better able to

• recognize the role of testosterone in overall health and characterize the consequences of opioid-induced hypogonadism
• implement approaches to diagnose opioid-induced hypogonadism
• identify evidence-based approaches to testosterone replacement therapy
• educate patients about opioid-induced hypogonadism and options for treatment.

Chairperson
Michael J. Brennan, MD
Medical Director
The Pain Center of Fairfield
Fairfield, CT

Faculty
Abraham Morgentaler, MD FACS
Director, Men’s Health Boston
Associate Clinical Professor of Urology
Harvard Medical School
Boston, MA

André T. Guay, MD FACP FACS
Tufts University School of Medicine
Director, Center for Sexual Function/Endocrinology
Lahey Clinic North Shore
Peabody, MA

CME Contact
Jennifer Engelhardt
Program Manager, Postgraduate Institute for Medicine
jengelhardt@pimed.com
720.895.5333

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of The Postgraduate Institute for Medicine and Miller Medical Communications, LLC. The Postgraduate Institute for Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The Postgraduate Institute for Medicine designates this live activity for a maximum of 1.25 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This educational activity is jointly sponsored by The Postgraduate Institute for Medicine and Miller Medical Communications, LLC.

This activity is supported by an educational grant from Endo Pharmaceuticals Inc.

Join AAPM in thanking the following companies for supporting a satellite symposium:

Endo Pharmaceuticals, Inc • Janssen Pharmaceuticals, Inc • Pfizer Inc • Purdue Pharma L.P. • TEVA Pharmaceuticals
Thursday, February 23, 4–8 pm • Friday, February 24, 6:30 am–7 pm • Saturday, February 25, 6:30–11:30 am

Mission: Pain Management

Time Efficient First Visit

The IDEAL™ Certified-CME Learning Center is a novel interactive activity that has been designed to improve the diagnosis and management of the broad spectrum of pain disorders seen in routine clinical practice. As you enter, you will begin the program with technologically advanced visual and auditory self-guided education, culminating in a live patient practice session in an exam room with an expert facilitator and small group of colleagues. The goal of this activity is to enhance your knowledge and skills in managing patients with chronic pain and facilitate a positive environment for interactive learning that encourages improved patient outcomes. This CME/CE activity will take 1 hour; please attend at your convenience anytime during the hours listed above.

Needs Assessment Overview

When a patient presents for chronic pain treatment, clinicians have the daunting task of navigating across the three major classes of pain disorder to identify the likely diagnosis. The ultimate diagnosis has significant implications for appropriate selection of pharmacologic and non-pharmacologic treatment options. Additionally, clinicians must evaluate and address the psychosocial aspects of chronic pain because these are intimately linked to overall outcomes. This often presents a challenge within the constraints of the typical 15–20 minute office visit.

This unique format provides professionals with an interactive course following the team-based learning concept that encourages improved outcomes through increased awareness, earlier and more accurate diagnosis, and prompt intervention. Experts have indicated that interactive learning sessions using multiple methods of instruction for small groups are more likely to enhance knowledge and skill. Furthermore, recent experiences have demonstrated extremely high learning and practice impact value for participants with this instructional method. As opposed to typical large symposia, direct interaction and personal learning from experts facilitates an environment for participants to discuss techniques and apply the methods learned in practice with greater focus.

This activity will provide an effective way to meet the educational needs of learners who prefer multimodal teaching techniques, “hands-on” practicum experience, and the use of up-to-date technology. The activity employs adult learning methods that not only increase participants’ knowledge but also empower them to take appropriate action in their own practices.

Objectives

• Analyze patients’ use of pain descriptors and pain medicine histories to differentiate between nociceptive, neuropathic, and centrally mediated pain conditions.
• Differentiate the evidence-based pharmacologic and nonpharmacologic treatment strategies for nociceptive, neuropathic, and centrally mediated pain conditions.
• Identify practice tools to be incorporated into routine management of pain patients.
• Employ techniques for delivering optimal multimodal management in chronic pain patients.

Faculty

Bill H. McCarberg, MD, Program Chair
Founder of the Chronic Pain Management Program
Kaiser Permanente, San Diego
Escondido, CA

Jeffrey A. Gudin, MD
Director, Pain and Palliative Care
Englewood Hospital and Medical Center
Englewood, NJ

Paul Arnstein, PhD RN FAAN
Clinical Nurse Specialist for Pain Relief
Massachusetts General Hospital
Boston, MA

Medical Education Company: Educational Awareness Solutions*
Accredited Providers: University of Cincinnati and Global Education Group
Credit Hours: 1.00
NON-CME CORPORATE SYMPOSIA

AAPM has opened its door to the following not-for-credit session. The focus of this session is uniquely different from others at the meeting. Those presenting at this session either represent or will be discussing the views of a commercial interest. The session does not meet continuing education requirements and offers no continuing medical education credit.

The material discussed at the session does not represent the views or opinions of AAPM. This satellite event is not considered an official educational offering of the AAPM Annual Meeting. There is no fee to attend; however, preregistration is encouraged. Seating will be available on a first-come, first-served basis.

SUNDAY, FEBRUARY 25

11:30 am–12:45 pm
Lunch Non-CME Corporate Satellite Symposium

New Perspectives in the Management of Moderate to Severe Acute and Chronic Pain

Topics will include
• proven efficacy
• proven safety profile
• favorable tolerability profile
• discontinuation rates.

Faculty
Sunil J. Panchal, MD
President, National Institute of Pain
Lutz, FL

This activity is funded through an educational grant from Janssen Pharmaceuticals Inc.

CORPORATE SHOWCASE SCHEDULE—NON-CME EVENTS*

We invite you to attend one of the Corporate Showcases that are being offered this year. These are industry-supported events. Come and learn about the new products, services, and programs that are being offered. Showcase descriptions and times are listed below; please refer to the onsite listing for the most current schedule. The events will be taking place in the Oasis I and II.

FRIDAY, FEBRUARY 24

9:15–9:45 am
A Unique Approach to the Delivery of Rapid-Onset Opioids

This program includes a unique transmucosal fentanyl that has been shown to be effective for treating breakthrough cancer pain in opioid-tolerant patients. We will give healthcare providers insight into how this medication can be used effectively and appropriately in their own practice to manage breakthrough pain in patients with cancer.

Supported by ProStakk

*Corporate showcases are subject to change. Please refer to the addendum or meeting sign copy for additional listings.
EXHIBIT HALL FLOOR PLAN

THE NEW PALM SPRINGS CONVENTION CENTER
OASIS: 1–2
PALM SPRINGS, CA

VISIT THE EXHIBIT HALL FOR THE LATEST PRODUCTS AND INNOVATIONS
The AAPM exhibit program features more than 120 booths from companies showcasing their products and services specifically designed for leaders in the study and treatment of pain. By visiting these vendors, you will learn more about advancements that can keep you and your organizations at the forefront of your field. AAPM exhibitors feature products and information in pharmaceuticals, medical supplies and equipment, medical publications, and alternate delivery systems, among others.

* American Academy of Pain Medicine
111 Salix Pharmaceuticals, Inc.
112 Stryker Interventional Spine
115 Immunalysis
117 Horizon Pharmaceuticals
119 VertiFlex
120 North American Spine Society
125 Medtox Laboratories
127 Linear Medical Solutions
128 Pain Medicine News
130 MD Logic EMR
133 National Toxicology Management Group
135 CPAIN
201 Lilly USA, LLC
209 Purdue Pharma L.P.
210 GE Healthcare
214 The Pain Group
215 Boston Scientific
216 AIT Laboratories
224 Terason
225 C.A.R.E.S. Alliance (Covidien sponsored)
226 AllMeds
228 Aegis Labs
229 Covidien
232 Prime Clinical Systems, Inc.
233 MD Connect Online Marketing
234 MicroLiter Analytical Supplies
235 Cumberland Pharmaceuticals Inc.
301 Medtronic, Inc.
311 eLab Solutions
319 Janssen Pharmaceuticals, Inc.
324 Millennium Laboratories
325 Cosman Medical, Inc.
327 StreamlineMD
328 Journal of Opioid Management
328b Azur Pharma, Inc.
329 MasterPharm Compounding Pharmacy
330 Carolina Liquid Chemistries
331 ProStrakan, Inc.
332 Kimberly-Clark Health Care
333 Quest Diagnostics
334 RS Medical
401 Ameritox
409 Depomed, Inc.
415 St. Jude Medical
421 Dominion Diagnostics
424 Regency Therapeutics
425 Practice Partners in Healthcare, Inc.
426 AnazaoHealth Corporation
427 Physician Therapeutics
427b Medi USA
428 Alere/Capital Toxicology
429 Epimed International, inc.
432 Advanced Infusion Solutions
433 Meda Pharmaceuticals
434 CompuGroup Medical
435 Vertos Medical Inc.
450 American Screening Corp.
457 Harvest Technologies Corp.
509 NECC (New England Compounding Center)
511 Bay Recovery Center
513 Laboratory Corporation of America Holdings
515 Physicians Business Network
520 Clinical Reference Laboratory, Inc. (CRC*)
521 TEVA Pharmaceuticals (formerly Cephalon)
522 SonoSite
525 Practical Pain Management
526 Data Unlimited International, Inc.
526b Richard Wolf Medical Instruments Corporation
527 NeuroTherm, Inc.
528 INSYS Therapeutics, Inc.
529 Physician Partner
532 PainDX, Inc.
533 Siemens Healthcare
534 Medtab Software Inc.
600 Custom Compounding Centers
602 The Gideons International
603 Callaway Labs
606 Wiley-Blackwell
607 Automated HealthCare Solutions
609 M-Weber Medical
610 Phamatech Laboratories & Diagnostics
611 Physicians Rx Network
612 Intellisphere LLC
613 Pikeville Medical Center, Inc.
614 LiteCure, LLC
615 Esaote North America
616 Choice Laboratory Services
620 PainEDU.org
622 NeurogesX, Inc.
624 Express Diagnostics
626 LifeSource Not-for-Profit
628 Physician Rx Management Inc.
629 American Chronic Pain Association
631 Hartley Medical
632 Elsevier Inc.
635 North American Neuromodulation Society
*Booth by Registration
### EXHIBITORS BY PRODUCT CATEGORY

#### ALTERNATIVE DELIVERY SYSTEM
- Azur Pharma, Inc.
- Bay Recovery Center
- CompuGroup Medical
- CPAIN
- Horizon Pharmaceuticals
- Linear Medical Solutions
- MD Connect Online Marketing
- MicroLiterate Analytical Supplies
- NeurogesX, Inc.
- The Pain Group
- Physician Rx Management Inc.
- Physician Rx Network
- Physician Therapeutics
- Prime Clinical Systems, Inc.

#### BUSINESS MANAGEMENT SERVICES
- Practice Partners in Healthcare, Inc.

#### COMPounding PHARMACY
- AnazaoHealth Corporation
- MasterPharm Compounding Pharmacy

#### DIAGNOSTIC DRUG TESTING
- Express Diagnostics

#### EDUCATION
- American Academy of Pain Medicine
- American Chronic Pain Association
- C.A.R.E.S. Alliance (Covidien sponsored)
- LifeSource Not-for-Profit
- North American Neuromodulation Society
- North American Spine Society
- PainEDU.org

#### ELECTRONIC HEALTH RECORDS
- MD Logic EMR
- Meditab Software Inc.

#### LABORATORY TESTING
- Aegis Labs
- AIT Laboratories
- Alere/Capital Toxicology
- Ameritox
- Calloway Labs
- Carolina Liquid Chemistries
- Choice Laboratory Services
- Clinical Reference Laboratory
- Dominion Diagnostics
- eLab Solutions
- Immunalysis
- Laboratory Corporation of America Holdings
- Medtox Laboratories
- Millennium Laboratories
- National Toxicology Management Group
- Quest Diagnostics

#### MEDICAL DEVICES
- Medtronic, Inc.
- St. Jude Medical

#### MEDICAL EQUIPMENT/SUPPLIES
- American Screening Corp.
- Boston Scientific
- Cosman Medical, Inc.
- Harvest Technologies Corp.
- Kimberly-Clark Health Care
- LifeCure, LLC
- M-Weber Medical
- Medi USA
- NeuroTherm, Inc.
- PainDX, Inc.
- Pharmatech Laboratories & Diagnostics
- Richard Wolf Medical Instruments Corporation
- RS Medical
- Stryker Interventional Spine
- VertiFlex
- Vertos Medical Inc.

#### MEDICAL PUBLISHING/JOURNALS
- Elsevier, Inc.
- Intellisphere LLC
- Journal of Opioid Management
- Practical Pain Management

#### OFFICE MANAGEMENT
- AllMeds
- Data Unlimited International, Inc.
- Physicians Business Network
- StreamlineMD

#### PAIN MANAGEMENT
- Epimed International, Inc.
- Regency Therapeutics

#### PHARMACEUTICALS
- Advanced Infusion Solutions
- Covidien
- Cumberland Pharmaceuticals Inc.
- Custom Compounding Centers
- Depomed, Inc.
- Hartley Medical
- INSYS Therapeutics, Inc.
- Janssen Pharmaceuticals, Inc.
- Lilly USA, LLC
- Meda Pharmaceuticals
- NECC (New England Compounding Center)
- ProStrakan, Inc.
- Purdue Pharma L.P.
- Salix Pharmaceuticals, Inc.
- TEVA Pharmaceuticals (formerly Cephalon)

#### PREPACKAGED PHARMACEUTICALS
- Physician Partner

#### PUBLISHING
- The Gideons International
- Pain Medicine News
- Wiley-Blackwell

#### RECRUITMENT
- Pikeville Medical Center, Inc.

#### SOFTWARE
- Automated HealthCare Solutions

#### SURGICAL IMAGING
- GE Healthcare

#### ULTRASOUND
- Esaote North America
- Siemens Healthcare
- SonoSite
- Terason

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#### EXHIBIT SCHEDULE

**THURSDAY, FEBRUARY 23**
Opening Reception with Exhibits and Posters 5:15–6:45 pm

**FRIDAY, FEBRUARY 24**
Exhibits Open 8:45–10:45 am
Break with Exhibits and Posters 9–10 am
Exhibits Open 2:30–7:15 pm
Break with Exhibits and Posters 2:30–3:30 pm
Break with Exhibits and Posters 4:30–4:45 pm
Reception with Exhibits and Posters 5:45–7:15 pm

**SATURDAY, FEBRUARY 25**
Exhibits Open 8:30–11:30 am
Break with Exhibits and Posters 8:45–9:45 am
Break with Exhibits 11:15–11:30 am
EXHIBITORS

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BOOTH 226
AllMeds
151 Lafayette Drive, Suite 401
Oak Ridge, TN 37830
865.482.1999 fax 865.481.0921
www.allmeds.com

Booth—By Registration
American Academy of Pain Medicine
4700 West Lake Avenue
Glenview, IL 60025
847.375.4731 fax 847.375.6477
www.painmed.org

BOOTH 629
American Chronic Pain Association
PO Box 850
Rocklin, CA 95677
916.632.0922 fax 916.632.3208
www.theacpa.org
The American Chronic Pain Association has been helping people live fuller lives in spite of their pain for 32 years. Our goal is to provide them with the tools they need, in addition to what their healthcare providers offer, so that they can improve their skills in the self-management of their chronic pain. We focus on helping the person with pain become an active partner on the healthcare team.

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318.798.3306 fax 318.798.3386
www.americanscreeningcorp.com

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Ameritox
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Ameritox is the nation’s leader in Pain Medication Monitoring Solutions®. Ameritox offers the most thorough pain medication monitoring lab process—Rx GuardianSM—with Rx Guardian CD, the only pain medication monitoring solution with a proprietary normalization algorithm and a reference database of pain patients assessed for medication adherence.

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www.anazaohealth.com

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Indication and Usage
GRALISE™ is indicated for the management of postherpetic neuralgia (PHN). GRALISE is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

Important Safety Information
GRALISE is contraindicated in patients who have demonstrated hypersensitivity to the drug or its ingredients.
Antiepileptic drugs (AEDs) including gabapentin, the active ingredient in GRALISE, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.
The most common adverse reaction to GRALISE (≥5% and twice placebo) is dizziness.
Across all GRALISE clinical trials the other most common adverse reactions (≥2% vs placebo) are somnolence, headache, peripheral edema, diarrhea, dry mouth, and nasopharyngitis. The types and incidence of adverse events were similar across age groups except for peripheral edema, which tended to increase in incidence with age.

Please see adjacent page for Brief Summary of Prescribing Information.
Full Prescribing Information and Medication Guide are available at GRALISE.com.
GRALISE™ (gabapentin) tablets

BRIEF SUMMARY: For full prescribing information, see package insert.

INDICATIONS AND USAGE
GRALISE is indicated for the management of Postherpetic Neuralgia (PHN). GRALISE is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

DOSEAGE AND ADMINISTRATION
Postherpetic Neuralgia
• Titrate GRALISE to an 1800 mg daily taken orally once daily with the evening meal. GRALISE tablets should be swallowed whole. Do not split, crush, or chew the tablets.
• If GRALISE dose is reduced, discontinued, or substituted with an alternative medication, this should be done gradually over a minimum of one week or longer (at the discretion of the prescriber).
• Renal impairment: Dose should be adjusted in patients with reduced renal function. GRALISE should not be used in patients with CrCL less than 30 or in patients on hemodialysis.
• In adults with postherpetic neuralgia, GRALISE therapy should be initiated and titrated as follows:

<table>
<thead>
<tr>
<th>Day</th>
<th>1</th>
<th>2</th>
<th>3-6</th>
<th>7-10</th>
<th>11-14</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily dose</td>
<td>300 mg</td>
<td>300 mg</td>
<td>900 mg</td>
<td>1200 mg</td>
<td>1500 mg</td>
<td>1800 mg</td>
</tr>
</tbody>
</table>

CONTRAINdications
GRALISE is contraindicated in patients with demonstrated hypersensitivity to the drug or its ingredients.

Table 2 GRALISE Dosage Based on Renal Function

<table>
<thead>
<tr>
<th>Indication</th>
<th>Total</th>
<th>Oral</th>
<th>Oral 1800 mg</th>
<th>Oral 1200 mg</th>
<th>Oral 900 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo patients with events per 1000 patients</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Drug patients with events per 1000 patients</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Patients receiving hemodialysis</td>
<td>GRALISE should not be administered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WArnings And PRecautions
GRALISE is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration. The safety and effectiveness of GRALISE in patients with epilepsy has not been studied.

Suicidal Behavior and Ideation
Patients with epilepsy treated with antiepileptic drugs (AEDs), including gabapentin, the active ingredient in GRALISE, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.

Table 3 Risk by Indication for Antiepileptic Drugs (including gabapentin, the active ingredient in Gralise) in the Pooled Analysis

<table>
<thead>
<tr>
<th>Indication</th>
<th>Total</th>
<th>Oral</th>
<th>Oral 1800 mg</th>
<th>Oral 1200 mg</th>
<th>Oral 900 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo patients with events per 1000 patients</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Drug patients with events per 1000 patients</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Patients receiving hemodialysis</td>
<td>GRALISE should not be administered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Musculoskeletal and Connective

Tissue Disorders
Pain
Forehead pain
Back pain

Nervous System Disorders
Dizziness
Somnia
Headache
Lethargy

In addition to the adverse reactions reported in Table 4, the following adverse reactions with an uncertain relationship to GRALISE were reported during the clinical development for the treatment of postherpetic neuralgia.

Drug Interactions

Gabapentin is absorbed in gastrointestinal mucosa with oral administration and may be subject to first-pass metabolism. Plasma concentrations of gabapentin in patients receiving the high dose of 2000 mg/day were more than 10 times higher than plasma concentrations in humans receiving 1800 mg per day and in rats receiving 1000 mg/kg/day peak plasma concentrations were more than 6.5 times higher. In an intravenous pharmacokinetic study in rats, the plasma clearance of gabapentin was more than 100 fold (about 1000-fold) lower than in humans. The low clearance indicates that the drug is not extensively metabolized. The major route of gabapentin elimination is via renal excretion. Therefore, it is reasonable to conclude that the primary reason for gabapentin’s long duration of action is related to its low clearance.

In patients with renal failure, gabapentin clearance decreases. When GRALISE (1800 mg once daily) and gabapentin immediate release (600 mg three times a day) were administered with high fat meals (50% of calories from fat), GRALISE has a higher Cmax and lower AUC at steady state compared to gabapentin immediate release. Therefore, the metabolism of gabapentin done by the gut is likely a key factor for the differences in the bioavailability of gabapentin between the two formulations.

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. General information about some of the most common adverse reactions observed in the clinical trials of gabapentin and the differences between gabapentin and GRALISE tablets are shown in Table 2.

Table 4 Treatment-Emergent Adverse Reaction Incidence in Controlled Trials in Neuropathic Pain Associated with Postherpetic Neuralgia (Events in at Least 1% of all GRALISE-Treated Patients and More Frequent Than in the Placebo Group)

<table>
<thead>
<tr>
<th>Body system</th>
<th>GRALISE N=399, %</th>
<th>Placebo N=384, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear and Lymphatic Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vertigo</td>
<td>1.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>3.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>2.8</td>
<td>1.4</td>
</tr>
<tr>
<td>Constipation</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>General Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral pain</td>
<td>9.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Infections and Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary infection</td>
<td>2.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Cardiovascular disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight increased</td>
<td>1.9</td>
<td>1.9</td>
</tr>
</tbody>
</table>

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Know Where They Stand

-2.17
potential diversion?

+2.38
potential overuse?

Your Rx Guardian™ results report will show that if your chronic pain patient falls:

- Within the two standard scores, there may be a higher likelihood of adherence; approximately 95% of adherent patients in the reference database fall within this range.

- Outside of the two standard scores, there is a possibility of nonadherence; less than 5% of adherent patients in the reference database fall outside this range.

Introducing RxGuardianCD™

Powered by the most comprehensive database of adherent chronic pain patients

Ameritox, the leader in pain medication monitoring, helps you assess where your chronic pain patients stand in their opioid use. With Rx Guardian CD™, you’ll get comprehensive urine drug test results you can trust.

- An advanced proprietary algorithm adjusts for physiologic variables like height, weight, and hydration to produce a normalized drug level for each patient.

- A robust reference database of pain patients clinically assessed for adherence to their opioid treatment regimens, against which your patients’ normalized values are compared.

- Easy-to-interpret, detailed results in an Rx Guardian™ results report help you assess opioid use and optimize patient care.

Ameritox is establishing a higher standard in pain medication monitoring with its new Rx Guardian CD™, so you can be more assured in your assessment of where your chronic pain patients stand with their opioid use.

To learn more about Ameritox and Rx Guardian™, with next-generation Rx Guardian CD™, visit booth #401 at the AAPM Meeting in Palm Springs, call 888-495-3221 or visit ameritox.com/AAPM2012

Win an iPod® Nano® at Booth #401!

To learn more about Ameritox and the distinct advantage of Rx Guardian CD™ in assessing chronic pain patients’ opioid use, stop by Booth #401 and register to win an iPod® Nano®.
On behalf of Janssen Pharmaceuticals, Inc., you are cordially invited to attend an informative lunch presentation focusing on

**New Perspectives in the Management of Moderate to Severe Chronic Pain**

**Palms Springs Convention Center**
**Saturday, February 25, 2012**
**Primrose Ballroom A**
**11:30 AM – 12:45 PM**

**Description/Objective:**
An Effective Treatment Option for Chronic Pain in Adults

**Topics will include:**
- Proven efficacy
- Proven safety profile
- Favorable tolerability profile
- Discontinuation rates

**Sunil Panchal, MD**
President, National Institute of Pain
Lutz, Florida

An official independent satellite symposium held in conjunction with the American Academy of Pain Medicine’s 28th Annual Meeting.

This is a non-CME educational event.

In adherence with PhRMA guidelines, spouses or other guests are not permitted to attend company-sponsored programs.

If you are licensed in any state or other jurisdiction, or are an employee or contractor of any organization or governmental entity, that limits or prohibits meals from pharmaceutical companies, please identify yourself so that you (and we) are able to comply with such requirements. Your name, the value, and purpose of any educational item, meal or other items of value you received may be reported as required by state or federal law. Once reported, this information may be made available for public review. Thank you for your cooperation.

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Opioid-Induced Androgen Deficiency: Approaches to Diagnosis and Management

Friday, February 24, 2012
12:00 NOON to 1:15 PM

Primrose Ballroom A
Palm Springs Convention Center

Program Chair
Michael J. Brennan, MD
Medical Director
The Pain Center of Fairfield
Fairfield, Connecticut

Registration
There is no registration fee for attending this symposium; however, seating is limited. Pre-register online at www.symposiareg.org/aapm or contact Connie Riefke at (847) 375-4397. Pre-registration may be available on-site, at the AAPM registration area, space permitting. Pre-registration does not guarantee seating. We recommend arriving at the symposium location early.

Credit Designation
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This educational activity is jointly sponsored by the Postgraduate Institute for Medicine and Miller Medical Communications, LLC.

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