Dr. Ruth Adewuya:

Hello, you're listening to Stanford MedCast, Stanford CME's podcast where we bring you insights from the world's leading physicians and scientists. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya. this episode is part of the COVID-19 mini series addressing up-to-date insights on COVID-19. In today's conversation, I'm joined by Dr. Michael [Leon 00:00:00:39], a specialist in pain, medicine, and Clinical Professor of Anesthesiology and Pain Medicine at Stanford University, Dr. Ravi Prasad a psychologist and Clinical Professor in the Division of Pain Medicine at UC Davis, and Dr. Scott Pritzlaff, an assistant clinical professor in the Department of Anesthesiology and Pain Medicine at UC Davis. Michael, Ravi, and Scott, thank you so much for chatting with me today.

Dr. Scott Pritzlaff:

Thanks for having us.

Dr. Ruth Adewuya:

I would like to start our conversation by asking each of you to maybe speak on what have you seen in your practice around how pain patients are affected by the coronavirus pandemic. Scott, if you can start and then we can go to Ravi and Michael.

Dr. Scott Pritzlaff:

Sure, so thanks for having us. I mean, we had this conversation probably about four or five months ago, and I think one of the take homes has been access, really. Initially there was this massive shutdown and so patients weren't able to get the procedures that they needed, and I think really, and Ravi and Mike could also speak to this, there's pretty much been a period where we've just been trying to catch up from a lot of the backlog of volume. And so I think the interpretation of what is urgent and emergent can be highly subjective, and certainly pain is a subjective experience. And so, it definitely has been a challenge trying to catch up and really try to see as many patients as we can. So that's really one of the ways I think my practice has been affected and certainly the others could elaborate as well.

Dr. Ravi Prasad:

I would say from my perspective, as a psychologist, the only psychologist and our panel here, I would say that my practice has actually become much more full. And part of that is because of the telehealth we've been able to reach many patients who live further away from our facility, folks who, had we had regular practices, usual it may have been more of a challenge for them to drive into our medical center, but now we're only as far away as their living room. So the schedule has actually been completely packed, and so we're seeing more patients. In terms of the impact of the patients, I think that was one of the questions that you had asked, I think that it's become challenging for a lot of the patients, certainly from an emotional perspective; there's a lot of ambiguity associated with COVID. And so that's taken some folks who have a tendency toward anxiety and it's exacerbated some of that anxiety. People that are usually generally well-functioning people that have started to exhibit some signs of anxiety, frustration, aspect of distress, just associated with all of us being in this unprecedented time. And so we are seeing some increased emotional distress, that's continuing to persist as the whole pandemic and its implications are persisting. So it'll be interesting to see how this continues to evolve over the course of time.

Dr. Micheal L.:

Ravi I wanted to add one more thing, which is that I think the anxiety and the fear doesn't just extend to patients and the public itself, I think there's been some concern among any healthcare provider, and anyone who works at the hospital or clinics. We really don't know everything that we need to know or feel comfortable knowing about COVID-19, and how it works and how it affects all of us. Initially, I think people were very cautious and concerned, and it's true people were in general, quite understanding, but as it's gone on over a period of time, we've had to really start to keep going forward and doing appropriate medical care, not just for critical patients, but for everyone, otherwise you won't get any care at all. So there's been some good things that have come out of this. It's kind of hard to say that it's been good for the general global population, but there have been some good things, which you mentioned like the telemedicine.

Actually, our volume, even among physicians has actually increased as well because we have more access and we can do video visits. I'm not fully satisfied with all video visits, especially on new patients, because the whole aspect of the physical exam for physicians is actually quite important. And video visits only give a partial element, even if you try your best in order to have someone do a physical exam in front of you.

The second thing is that we've had to scale back the amount of people that are present in any facility at a time. So although we have started back on our procedures, even really sophisticated ones like neuromodulation, where we put these electric wires near the spinal cord and near the peripheral nerves as an alternative to opioids, we've had to re-institute that with some precautions, and our patients have been actually fairly good about getting COVID testing and things like that 72 hours ahead, because they know it's not just the safety of them, but it's safety of everyone around them.

So I think you're right; access maybe has been better, some understanding and maybe thoughtfulness medical care, rather than just the rushing to be seen, "I need to be seen within one week" aspect, but it's been challenging.

Dr. Scott Pritzlaff:

And just to piggyback on what you're saying, Mike, I mean, I think as a clinician, just focusing on the dynamic environment in which we practice, I mean, we essentially went from March where we weren't seeing any patients and everything was virtual, to opening up sometime in May, to now essentially all clinicians and even our office staff are wearing face shields and masks, and so it's really a moving target, both for clinicians and patients with regard to how we're practicing, how patients are coming in, if they're being screened at the door. And so change has really been the norm.

Dr. Ruth Adewuya:

It's clear there's been a lot of changes in your practice. There has been the impact and the use of telemedicine, and also the anxiety of not only the patient, but also the clinicians, and this whole concept of risk for the patients and protecting the patients, as well as their family members. So I wanted to maybe ask a question around the risk piece first. When it comes to chronic pain patients, should they be thinking that they're more susceptible to COVID-19? Are they at a higher risk for it than the general population? Do they face other consequences around COVID-19?

Dr. Micheal L.:

Maybe I can start a little bit on that. So I think that the risk of contracting COVID-19 really depends on the patient's overriding medical condition in the first place. So I don't think just having chronic pain per se, is an extra risk of getting increased infection for COVID-19 or having a problem. However, if you have

chronic pain and lung problems and heart problems and maybe diabetes, which can predispose you to have some immunosuppression, then yeah, you could have an increased risk. It depends on the age group too. I realized that COVID-19 can affect anybody in any age group, but it seems to, at least from recent data, still suggests that people who are on the older end have a higher risk than on the younger end. So where risk comes into play for a lot of pain management interventional physicians is with the use of steroids. And so the question always comes out, whether should we do this procedure, like an epidural steroid injection or a hip steroid injection, if it's going to change your response if you do get COVID-19?

And the truth is we have to weigh the risks and benefits, whether someone has already done interdisciplinary care. I mean, obviously if you can do no risk or low risk, such as physical therapy, that's guided by video and no-one has touched the patient and no-one has exposed them to any other thing, that's the easiest and perhaps the safest way of treating back pain and some of the other joint problems first, before you go forward with injections. However, we have reopened for interventional procedures, both in the clinic, as well as in the operating room. With regards to steroids, it's controversial; some people would think that if you give extra steroids that theoretically there is a risk of immunosuppression for COVID-19, but we've elected for specific procedures, especially like epidural steroids, where you really do need to give a steroid in order to cause a benefit. We use a drug called decadron or dexamethazone, that seems to have the least potential of changing the adrenal access or your response to stress. And also decadron is used for patients who unfortunately get COVID-19 and are being treated and hopefully improved with it. And so that's why we feel comfortable in using decadron if we have to pick a steroid.

Dr. Scott Pritzlaff:

And, Mike, you bring up a very good point, and I think it goes without saying one of the modalities that we use in pain medicine is steroid, and Mike brought that up, with epidural steroids being one of the more common procedures that we do. And so when we first reopened, pain physicians everywhere kind of opined, and really thought critically about what should we really be doing? You know, should we be giving epidural injections? And, the reality is this epidural injections do have systemic effects, and it's sometimes hard to really quantify what that may be, but there's not a data. We really have a paucity of data and really insufficient evidence to say whether a single steroid injection puts someone at increased risk of a COVID-19 infection, and so we really don't know. And I think what all of us have been really trying to do is think critically about necessity, and then secondarily, if you were going to give a steroid injection, can you give the smallest dose possible to really mitigate that risk?

But I know even at my own institution, if a patient is going to get an epidural steroid injection or even a steroid injection say, in their shoulder or their hip, we are still COVID testing them, just because we really want to make sure their negative, one, but two, no one knows. You know, if you give that single dose of steroids, could that potentially increase risk of either COVID-19 infection, or if someone is infected making that worse. So that's really been one of the kind of burning issues in the field right now is about steroid.

Dr. Ruth Adewuya:

I would like to switch gears and ask you Ravi, if you can talk about how pre-procedural screening has changed due to the pandemic.

Dr. Ravi Prasad:

Sure. So before patients have spinal cord stimulators and intrathecal pumps or implantable therapies, our usual course of action is to have them have a psychological evaluation. And the purpose of the evaluation is to ensure that they're the most ideal candidates for the procedure, and if there are any aspects of care that need to be optimized before they move forward with the implant, that we undertake those things so that they have the best chance of success with that particular procedure. So patients have a comprehensive psychological evaluation before they do these procedures, and there was some concern about once the whole pandemic issue were to change, is there going to be a lag in terms of being able to implant devices in people, are we going to have a huge backlog of people who are waiting for this process? But the reality is, is because of telehealth we have been able to maintain a stream of people completing these pre-procedure evaluations through telehealth.

And so many patients have actually verbalized a high level of contentment. They were very anxious that there are care to be put on hold as a result of the pandemic, and there's a lot of gratitude that they've expressed that they're able to continue to move forward. And what's been nice about this is, for a number of patients there may be some other pieces that they do need to do to further optimize their care. So for example, there may be slightly higher levels of depression, or aspects of anxiety that I feel that might be a little bit high that could impact the magnitude of success that they get from a trial. And given that during the period of time that we weren't doing any implants, they could use that time to get plugged in with mental health resources to address those factors, and get re-evaluated so that they're not losing any time, but they can use this time when everything is on shutdown.

Dr. Micheal L.:

Scott and Ravi has testing changed for patients coming into either the clinic, or to getting interventional procedures for COVID-19? Because it's changed at Stanford; we had to do testing for everybody at some points, and then some points it changed to only certain procedures, and not in different areas. What's happened over there?

Dr. Scott Pritzlaff:

When we resumed procedures back in May, and mind you across the board. I mean, there wasn't a lot of evidence per se, and I know at our institution, the hardest thing was capacity; meaning we had a machine, but we had limited capacity. And so what we decided early on was the patients coming in for implants, so things like spinal cord stimulators, intrathecal pumps, that sort of thing would be tested, as well as patients getting some sort of steroid injection, and that would include things like epidurals and large joint injections, peripheral nerve blocks of steroids. And so that policy has largely been unchanged.

What has changed from the testing perspective is at least for inpatients, meaning if we're doing procedures on inpatients, the turnaround time is gone say from 24 to even 30 hours down to about six hours, which has been great. But the thing that we have toiled with and I have toiled with is if, even for say a trigger point injection, if a patient is coming in for another non-steroid based procedure or even clinic patients, which we haven't been testing, should they be tested? And I think once again, it goes back to capacity, et cetera. And that would be a question for you as well; are you testing your clinic patients when they come in for follow-ups?

Dr. Micheal L.:

Unless there's a reason to do so, no. And so for follow-ups we assume probably just like you do that, everyone could be a carrier and that everyone needs to wear a mask, hence that's when the clinicians, anyone who's a healthcare provider in the clinic has to wear a mask. Any patient who comes in the door

will be given a mask when they check in with all the other screening questions that you mentioned before about fever or cough, and things like that.

What I can mention though, is I think that our testing has evolved with capacity, like you said, and what I mean by that is in the beginning, if we had a patient that came in and didn't get their 72 hour pretest of COVID, and they just sort of arrived and they just couldn't get it for some reason, we would do something called a rapid test. Well now with the volume of people that are coming through the Emergency Department, and the volume of people that may need mandatory urgent testing, we are instructed, we can't rapid test everybody who comes into the operating room.

Dr. Ravi Prasad:

I've got a question for both of you related to that, obviously I'm not involved in that procedure side, but curious to know what are the practices, both at our institution and at Stanford, in terms of retesting patients who were COVID positive, who weren't able to get a procedure? Do you retest the patients if they were COVID positive? And it's been last 90 days?

Dr. Scott Pritzlaff:

We followed the CDC guidance here at UC Davis, which is largely based on time of when symptoms first appeared, meaning the CDC guidance for patients who have mild to moderate illness and who aren't severely immunocompromised is that you should wait at least 10 days since symptoms first appeared, and at least 24 hours have passed since the last fever, as opposed to patients who had critical or severe illness. And the recommendation is at least 10 days, or even up to 20 days since symptoms first appeared, and once again, 24 hours have passed since the last fever.

You know, interestingly, we have not had a lot of patients who have tested positive, but I think ultimately the question is: should a patient test negative, I know anecdotally some of my physician colleagues at other institutions have been infected with COVID, and several weeks after feeling better, still were testing positive, and so I think we don't necessarily know what does that mean if someone is still testing positive many weeks later, and so I don't think that that's been well-defined for us, and certainly Mike may have an opinion on that as well.

Dr. Micheal L.:

Well, actually my opinion's very similar to yours, it's a little controversial. We have to follow the CDC guidelines as well, because that's really the best that we have, and isn't an approximately 20, 21 days or so from first contact, and all patients have to be screened for COVID-19 and be negative 72 hours ahead of any procedure, wherever that may be.

Dr. Scott Pritzlaff:

I think the broader question is: would I feel comfortable proceeding with an implant or a higher level procedure with someone testing positive? That's a difficult question, but I would say that a lot of these procedures are falling more into an elective category. They're definitely necessary, but that is a hard question to answer if someone is still testing positive many weeks afterward, but for sure, making sure that that appropriate period in accordance with CDC guidance has lapsed from their appearance of symptoms.

Dr. Micheal L.:

Scott, can I ask you one question? So if you're a patient, what do you expect when you come to see your pain management physician at UC Davis? I'm just curious, because I know what we do at Stanford, but it may not be exactly the same.

Dr. Scott Pritzlaff:

Yeah. So I think similarly to a lot of institutions, patients now expect that when they walk in the door, they're going to be given a mask, their temperature screened and complete a brief questionnaire, whether or not they've had fevers or contacts. I think for patients who have caregivers, that's been a dramatic change, meaning we don't have people waiting in the waiting room anymore. So if a patient is coming for a clinic visit, oftentimes the caregiver's waiting in the car and that's really to protect other patients and other people coming in. As you mentioned already, Mike, at least for in-person visits, there's an element of social distancing and spacing that needs to happen, and so actual in-person volume, I would say, has been reduced somewhat. And they're seeing providers who are wearing PPE, both a face shield and a mask, and there's always a lot of discussion now about risk, and is it the right time to perhaps do a procedure versus waiting?

And so I think there's a lot more caution. There's definitely a lot more discussion about risk and really making sure that the patient and families understand in person encounters are not benign, but certainly we're trying to continue in a similar, I guess, new fashion of delivering the same sort of care, but really in a different environment.

Dr. Ravi Prasad:

One of the ironic things that's come up, at least in the delivery of mental health services is with all the PPE that people are wearing now, it certainly changed the dynamic of how the psychological evaluations take place. You know, it used to be the case that when folks would come in for the evaluation, just coming in for the evaluation was part of the intervention in and of itself, right? Having somebody get dressed to engage in some sort of functional activity that make it to an appointment. And so the preference would be to try to have people coming in in person rather than doing things by video.

But now it's actually switched the other way around where the preferences for people to do the appointments by video, because when patients are wearing their mask, we lose a lot of the nonverbals, not able to see a lot of the facial expressions that were usually a part of the evaluation itself. And so with the quality of the resolution of the video that we have now, we actually are able to get more information on those nonverbals when somebody logs in from home rather than when they're here in person. So that's been an interesting twist that we've seen.

Dr. Ruth Adewuya:

I'm just curious from the three of you, if you had to give a percentage of how much you use telehealth, telemedicine, pre-COVID, I guess that less than 10%, 5% to now during COVID?

Dr. Ravi Prasad:

I use 0% telehealth we have the platform built in, it was available, but I used it 0%.

Dr. Micheal L.:

At Stanford. The physicians were really using it 0% as well. We just didn't have a structure for it. And the one benefit for COVID-19 is that we had to create a structure, not just for pain medicine, but for the

entire university medical center very, very quickly, and it's become fairly commonplace now with all departments and divisions.

Dr. Scott Pritzlaff:

I know speaking for me, probably I was doing one or two visits a month, and just purely on what the regulation and rules, where these had to be established patients. And so I would say probably now it's closer to 40 or 50% mixture of virtual versus in-person, but the hope is this won't change, and we can continue this.

Dr. Ruth Adewuya:

I want to touch on opiod usage and COVID-19, and this is a bit of a two-part question. So first my understanding is that there were some DEA requirements that were waived to allow for the prescribing of controlled substances without in-person visits. First I wanted to ask, is that true? And if so, has that changed your practice at all? The second part of my question is whether in your opinion, is the coronavirus pandemic impacting or worsening the opioid epidemic. I'm just curious to get all of your thoughts on this. And so Michael, if you can start, and then we can go to Ravi and Scott.

Dr. Micheal L.:

I'll be truthful, I expect that the COVID-19 pandemic to cause a big change, and I really haven't seen that just because of the implementation of telemedicine. So in our practice and our experience, we have not seen any patients who are already established on opioids, have a problem in maintaining that. Traditionally our pain medicine center doesn't prescribe opioids exclusively or predominantly. So we usually had it in combination with their primary care physician or another provider, but maintenance and visits can always be done by video visit, checking on the prescription monitoring boards, our cure system, that's still in place, and our systems for tracking and having our nurses make sure that compliance is in place really haven't changed all that much. So honestly, opioid prescriptions haven't been altered in our pain clinic that much, or as much as maybe we might've suspected.

Dr. Scott Pritzlaff:

Just to add to what Michael is saying, I mean, the DEA was pretty clear back in March of 2020, really giving some latitude to clinicians, both for refills, allowing clinicians to give prescriptions for say a 90 day refill, allowing monitoring to be done virtually, as well as other areas, including areas around buprenorphine and substance use disorder, meaning initiating therapy without an in-person visit. And to my knowledge, none of this has changed. I also have not seen per se an uptick in the increased demand for opiates, but I think it can't be underestimated that there were a lot of patients for a long period of time who have chronic pain, who really were in a rock and a hard place. Weren't able to get, say a knee replacement or a hip replacement, and so that kind of unintended consequence of delaying a lot at some of these procedures that are even extend outside of the pain medicine realm probably led to patients needing opiates or being on opiates for a longer period of time, and so I don't think we fully understand, or have seen to this point what the full fallout of that period of time, especially in that spring timeframe will be. But nonetheless, the question will be: how long will some of these, the VA regulations of relaxed regulations last?

Dr. Ravi Prasad:

I'm really looking forward to seeing what the national figures look like over the course of time in terms of how has COVID impacted opiod use? How has it impacted accidental overdoses, things along those

lines? One of the concerns that I have is, as I mentioned earlier on in the podcast, is that we have seen some increased emotional distress just related to the ambiguity associated with the pandemic. And certainly we know that emotional distress can turn around and worse than the physical pain. If the primary tool that a patient is using is medication to manage their pain, and they haven't been able to avail themselves of other tools, other psychological, behavioral tools to manage them. If theoretically, it would make sense that you may see an uptick in overuse of medication, or increased medication loading. So I'd be curious to see what those figures look like over the course of time.

Dr. Ruth Adewuya:

Ravi, you had mentioned earlier in our conversation, the reality of anxiety for not only our patients, but also healthcare providers. And I'm curious to get a personal perspective from each of you on how you navigate continuing to do your work during this time. How are you handling that?

Dr. Scott Pritzlaff:

Certainly as a pain physician, and also still as a practicing anesthesiologist, I would say that there's definitely increased anxiety, particularly when you're doing or around aerosol generating procedures. You know, you hear that term now AGP, which are high risk, right? Particularly if I'm in the OR around patients who have an unknown status, or even patients who may be positive, it's something that sits in the back of your mind. And I know I've debriefed this with a few people, but even when I go home, instead of the typical routine of going in the door, I leave my clothes in the garage and go straight in to shower off because you worry. You worry that, potentially could you have COVID on your skin and expose your family? And so I know as a practitioner that that's something that's in the back of my mind. Certainly we have a better than ER, physicians, nurses, and all the people working say in that environment, or even say in the ICU, but I think it really takes its toll when you think about these things.

And you know, the other thing, and Ravi brought it up earlier is PPE is kind of changed everything; it changes how you interact with patients and it sometimes makes in-person patient encounters less personable and sometimes even more stressful for both parties involved, because the message and the nuance of seeing someone's face is lost. And so these are all realities that we have to deal with, and I think with quarantine and everything that we've all had to deal with, taking care of your health, getting good sleep, exercise, all these things really have taken a new importance, taking care of yourself, taking care of the people around you all take a new precedence and meaning.

Dr. Micheal L.:

I want to follow up to what Scott said, I think that everyone's had to adjust. And so from a professional standpoint, I'll add that besides the kind of interface that we have, wearing face shields when we see patients in the clinic, how many to assume that we or anyone in the community can be carrying COVID and not have symptoms, but still have the ability to transmit it, it's difficult. And you know why it's been difficult is, over the past six months, I think there've been changes. There have been changes, not just nationally, but also at institutions about who should get COVID testing before procedures, what the policy is at the clinics. In the beginning, did you have to wear a mask? What kind of masks do you wear? Does it have to be one of these high-tech N95 masks? So we were always in a place of a little bit of dancing around or imbalance as well, just like patients, they can't go and do their things that help them for pain. They can't go to a swimming pool. They can't go to a gym. They can't go to places that will give them some socialization and bring them out of the house.

Well, for our wellness, we really can't do that either. And I ended up just from a personal standpoint, walking a lot, and really, because that's the only thing that I can do and be six feet apart and

distance. And I don't even walk in the usual parks and things that I would have wanted to in the past. So you had to adjust your whole schedule, even with my kids; are teenagers are doing their own thing right now, even when we get together, sometimes we'll meet outside and have a lobster roll, a couple feet away, and that closed contact and things like that, it really is kind of odd and disturbing.

Dr. Ravi Prasad:

One of the biggest things that's really important in the midst of all of the COVID work is making sure that clinicians are taking care of themselves. It's very easy to prioritize our patients, but the reality is that if we're not taking good care of ourselves, there's nothing for us to give to our patients and our families. In our lifetimes, we haven't seen anything of this magnitude, something that affects so many different sectors of our lives. You know, it effects our entertainment industry, it affects travel, it affects hospitality. And there's really virtually no area of life that hasn't been touched by this. And so appreciating not just the impact that it has on the clinician, but on significant others on the family members, on kids, things along those lines, the ability to interact with kids. Also because some kids are being homeschooled because there's no school for some kids at home, and because people are stuck at home, there's unfortunately also an uptick and some domestic violence; if there was already unhealthy environments that people were in, now they're captives in those environments. And so there's been an uptick in some unhealthy situations as well.

So it's really now more important than ever that people pay attention to their own wellness and do the things that they need to do to take care of themselves. There are a wide range of different resources that are available online to try to help people with navigating some of those different things.

Dr. Ruth Adewuya:

Thank you all for such a great conversation today. Any last key takeaways that you would like to share?

Dr. Ravi Prasad:

COVID-19 has certainly been a dark cloud that brought a lot of challenging and unprecedented issues, but in that dark cloud was the silver lining, and we're learning a lot of new things that are helping to advance several aspects of our practice.

Dr. Micheal L.:

I think that COVID-19 has really shown patients and physicians the value of medical care, both in-person, and as well as far from telemedicine. And there are certain advantages for each way, but I think it's really an honor to be able to treat people in their presence and with touch, and I think that some of my patients who have not been able to get that feel the same way too. And I think all of us hope that in the future, when things settle down, that that aspect of medical care will return.

Dr. Scott Pritzlaff:

I would say for me, one of the things that I've learned is that pain care is certainly a fundamental in a lot of ways, human right, that patients should have their pain treated, and COVID-19 really shed light on that, that pain care is essential and we need to be innovative and finding ways to deliver care, despite the challenges of the pandemic.

Dr. Ruth Adewuya:

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