(132) Depression, anxiety and disabling pain leading to the diagnosis of dercum's disease

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Originally described in 1892, Dercum's disease is a rare disorder of unknown etiology associated with chronic, often disabling, analgesics-resistant pain. It presents with wide range of clinical manifestations, making the diagnosis difficult. 47 year old female presented with a longstanding history of treatment resistant depression. Over the last few years she developed intolerable generalized body pain which resulted in different diagnoses such as fibromyalgia, chronic pain syndrome and chronic fatigue syndrome. She had several treatments for pain with little or no response. Within this period she had multiple physicians, with whom she frequently became frustrated, resulting in her firing several doctors. In turn she was also fired by several doctors due to their perception that she was demanding. Over the last year she developed multiple painful nodular swellings all over her body, especially concentrated around her abdomen and joints. She had a biopsy of one of the nodules and histology showed adipose tissue. A diagnosis of adiposis dolorosa (Dercum's disease) was made. Up until the time of the present admission, she responded poorly to all treatments for pain. Dercum's disease is a rare condition characterized by multiple, painful subcutaneous lipomas. Diagnosis is frequently missed due to its myriad manifestations including significant neuropsychiatric symptoms. Dercum's disease is difficult to treat. Multiple pain control trials have not been promising for long term pain control. Multidisciplinary approach including pain consultants is required to effectively manage these patients. This case highlights the difficulties in diagnosis and treatment of Dercum's disease.

(133) Lax lower extremity pain syndrome

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Lax Lower Extremity Pain Syndrome (LLEPS) describes a constellation of active pain generators affecting the back and lower extremity united by a common pathophysiologic process. The pain generators have been well-described as individual entities occurring in isolation, but a single unifying process has yet to be described. In LLEPS, laxity and weakness in the lower extremity lead to postural changes which alter the kinetic chain and increase biomechanical stress on certain structures (i.e. joints, ligaments). Painful conditions attributable to LLEPS may include lumbar facet arthropathy, sacroiliitis, trochanteric bursitis, piriformis strain, iliotibial band syndrome, patellofemoral syndrome, ankle degeneration, plantar fasciitis and metatarsalgia. Treatment should include physical therapy to address postural changes due to weakness and laxity, with the goal of optimizing biomechanical forces along the kinetic chain. Medical or interventional management of pain is also essential for effective participation in physical therapy. Orthoses may be beneficial for laxity which does not improve with strengthening. Recognition of LLEPS as a clinical syndrome provides a framework for understanding the pathophysiologic process underlying many common pain complaints. Identification of these clinical features may improve diagnostic precision, allow for more a comprehensive treatment plan and possibly prevent future pain in other related structures.

A06 Internet and Computer Databases

(134) Impact of an electronic pain and opioid risk assessment on documentation and clinical workflow

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PainCAS™ Beta is a clinical tool that assesses and tracks pain patients over time. It offers initial and follow-up pain assessments and produces reports for inclusion in the electronic medical record. This study hypothesized that painCAS Beta would increase the frequency of risk assessment administration and documentation, and improve clinical workflow. Two specialty pain treatment settings utilized painCAS™ Beta instead of the paper-pencil assessments. Study participants, including providers and administrative staff, were interviewed at baseline and post-intervention about communication, opioid risk assessments, score calculation, documentation, painCAS Beta reports, important data elements and overall processes and workflow related to assessing patients' pain and risk of aberrant drug related behavior. During the intervention phase, patients received the painCAS Beta assessments for 3 clinical visits and the painCAS Beta reports were attached to records in the EMR. In addition, usability testing was conducted with participants from both clinics. Perceived benefits of using the painCAS Beta system to assess patients were identified as well as challenges and barriers to implementation. Improvements to painCAS Beta that could enhance its efficiency in assessing patients and incorporation into existing clinical workflows were identified. Usability testing uncovered system processes that created workflow inefficiencies and were barriers to use and the System Usability Scale scored higher than the goal score of 80 with an average score of 83.3. Incorporating painCAS Beta into existing clinical workflows was a challenge, although some time saving benefits were noted. Specific enhancements are needed to painCAS Beta to improve its ability to integrate into clinical workflow. It is worth noting that significant increases were observed in the documentation of opioid risk assessments after painCAS Beta was implemented. This research was supported by an educational grant from Endo Pharmaceuticals.

(135) Perceptions about clinical value of electronic pain assessment data

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As health care settings adopt Electronic Medical Records, it is important for pain assessments to be available in an electronic format. Electronic assessments offer the opportunity to access aggregate/de-identified data. Through interviews conducted in this study we aimed to understand how clinical settings could benefit from data collected by electronic pain assessments. Semi-structured interviews were conducted with clinicians and clinical administrators from a number of clinical settings that focused on what assessment data would be valuable, how these data would be used, and what the barriers to data collection would be. Interviews were conducted over the phone and through online conferences. All participants reported existing processes for assessing patients and identified challenges in conducting assessments. Specific data elements considered important by at least 50% of the participants included: psycho/social situation, quality of life, pain level, history and/or current substance abuse, and medication dosage. Most participants (88%) reported that the capacity to track change in data over time would be valuable. Participants indicated that these data would be used for: treatment planning, justification of treatment services, evaluation of clinician performance, and tracking of individual patient progress. In addition, 38% of participants would be interested in being able to compare data from their clinic with other clinics, and 50% saw value in sharing data. If reports presenting aggregate assessment data were available 38% of participants preferred longer narrative reports, while38% preferred the shorter dash-board reports. While there were concerns around adopting new technology to complete the electronic pain assessments, uncertainty as to how assessment data would influence organizational change and concerns about the reliability of patient data were the biggest barriers. Although some specific data elements of value were identified, more interviews need to be conducted to confirm these initial findings. This research was supported by an educational grant from Endo Pharmaceuticals.