SCOPE of Pain Webinar July 16, 2026
Questions and Answers

#	Question	Answer	Answer Name
1	when the patient is new to you but has already undergone diagnostics do you repeat them if you have the records?	Good question. Generally, no need to repeat diagnostic studies if they have undergone an appropriate, comprehensive evaluation.	Matthew Bair, MD
3	Are there resources for CBT for chronic pain?	There are a variety of resources. The American Psychological Association has a "psychologist locator"that can filter by. geography, insurance, and if they do CBT pain. A local pain physician may know of particularly effective therapists. There are other resources like app's and digital programs and workbooks that patients could try on their own. For self guided care, I would want to follow up with the patient on how this is going... depending on your practice, that could be done by a nurse or social worker or by the provider themselves.	Michael Clay, MD
3		Check out our brief podcast (available on the Supplemental Tranings tab at the website), Season 5, which is a discussion with two Behavioral Health Pain Specialists, who offer a great deal of information about the role of the psyche in pain.	Ilana Hardesty | BU CCE
4	Is there a difference in risk for resipiratory depression between natural, semisynthetic and synthetic opioids?	Great question! I am not aware of a relationship between respiratory depression and the different categories of opoids. However, there is a strong relationship between opioid potency and opioid dose and respiratory depression. As you probably know, fentanyl (synthetic) is more potent than morphine (natural).	Matthew Bair, MD

4		buprenorphine is unique, relative to other opioids, in the risk of respiratory depression. There is a ceiling effect on respiratory depression, meaning overdose from respiratory depression due to buprenorphine alone is very rare. It could happen if patient is on multiple sedatives and buprenorphine. Buprenorphine, in fact, attenuates the respiratory depression induced by fentanyl	Michael Clay, MD
6	hi I am staff pharmacist at the Bronx VA in NY. When I do discharge med recs for patients who recently got surgery I don't know how to tell if certain surgeries required more opioids than another. For example there was a patient who had an ENT surgery and the doctor prescribed > 90 MME and patient had recently been admitted for psych and given benzodiazepine and possible hx of substance use. The only thing I did was	Tough case! I can only generally say that major surgeries (CV, ortho, cancer) may require more opioids but that is only a generalization. Typically a ENT sinus surgery would not be considered major surgery and necessitate such a high MME. It's futher complicated by the coprescribing of benzo. Definitely agree with you about co-prescribing narcan.	Matthew Bair, MD
6		I review cases like this at the Ann Arbor VA. I would try to talk to your pain pharmacy leadership - there should e a PMOP coordinator at your VA who might be able to help and see if this is a pattern of unsafe prescribing.	Michael Clay, MD
7	thanks, I didn't know if I could have done anything more. I guess I did my due	I think you did great! I guess you could have asked the ENT surgeon their expectations for post-op pain	Matthew Bair, MD
8	would you do a UTS?	yes, I would	Matthew Bair, MD
9	Any utility rTMS for chronic pain ?	Yes, there is some evidence of rTMS for chronic pain	Matthew Bair, MD
10	Are you aware of any ongoing research for injectable bup for chronic pain? (buprenex now unavailable—> buprenorphine	Dr. Clay meant to respond: he does not know of any studies.	Ilana Hardesty | BU CCE
11	Do you have the study for where the guidelines were derived to taper to <30MME	I do not know of a study that has looked at that cut point of MME.	Matthew Bair, MD

11		I also don't know the study that lead to that standard of care. There are other techniques for rotating patients to buprenorphine who are on high dose opioids. This is the "microinduction" or "Bernese" or "overlap "method. One of our other faculty members published on this in JAMA Internal Medicine 2025 Becker WC et al	Michael Clay, MD
12	So did they do away with the 40 mg methadone tablets?	I rarely prescribe methadone for chronic pain these days. I have not seen the 40 mg tablets but that does not mean they don't exist. I think it may depend on formularies and setting (OUD settings may be more likely prescribe 40 mg qd)	Matthew Bair, MD
13	With all of the states that allow THC recreational what do you do when patients test positive for THC before and while using	we will get into this a little bit more. If we don't answer your question, we generally discuss at the end of the session since this is such a common concern	Michael Clay, MD
14	Can you comment on medical drugs like PPIs, that can give false positive drug test.	Yes. There are lots of medicatioins that can cause false positive on the usual screening test. I have to look up websites/articles on this regularly. Confirming the results with GCMS is one strategy. Retesting off the medication if possible, or perhaps changing PPI. The UDS is just one point of data in a patient's health and function and life so would not make changes based on 1 test generally.	Michael Clay, MD
15	You guys are full of it. You lowered her daily opiates when changing to ER. Then even further with changing to Morphine. Bit surprise. All the empathy in the world will not help. middle aged woman trying to maintain her work and ADLs while spiraling her MME down with platitudes. Good Luck, get real. She isn't doing anything wrong.	Have you been talking with my wife? She says I'm full of it too. These are representative cases not real patients. Thanks for expressing your opinion	Matthew Bair, MD
16	If pain docs cannot determine what a pain patient needs, who can. I thought that is what our specialty was saying. Send them	I wish there were more pain docs. There aren't enough pain docs for us in primary care to refer to.	Matthew Bair, MD

17	I agree taper pts who are experiencing harm but what about the rest. I've done this for 30+years. Where are the advocates for pts that were doing well and now can't get meds because nothing else works. We don't have procedures for everything.	We often work with the Chronic Pain Foundation - a patient advocacy group. We did not want to imply that Michele is the problem. In one scenario, her non-responsive pain is the problem.	Matthew Bair, MD
18	I understand but recent the thrust of every conversation is to taper off. Pain patient's are not the problem, just low hanging fruit. Much easier to demonize them then the cartels that are feeding drug addiction. One of the early slides showed non-prescribed meds as responsible for OD were many times less then illegal/synthetic drugs. those come from Cartels, not doctors, but we have our names onthe door. Easy to accuse, but not the problem. I appreciate your efforts but we need to have a REAL	Completely agree! Patients with pain are not the problem!	Matthew Bair, MD
19	Could we make a short cut and start paint treatment with MOUD.	live answered	Ilana Hardesty | BU CCE
21	How soon after an opiate dose increase do you allow patient to resume drivintg?	live answered	Ilana Hardesty | BU CCE
22	Do you have recommendations for orthopedic postoperative pain control in addition to intraopertaive nerve block	live answered	Ilana Hardesty | BU CCE