

SCOPE of Pain Webinar

October 22, 2026

Questions and Answers

1. When a patient cannot take an NSAID due to kidney problems, is there a substitute?

Mark Pasanen: Great question - there are definitely folks who can't take NSAID due to kidney issues, hx of GI issues, etc. So in those situations I'd make sure the APAP is optimized - and might use very short course of an opioid.

2. Are there cardiac side effects, arrhythmia concerns or contraindications for suzetrigine?

Daniel Alford: Because suzetrigine is a selective NaV1.8 sodium channel inhibitor designed to target peripheral pain-signaling neurons rather than cardiac or central nervous system sodium channels, it generally demonstrates high selectivity (>30,000-fold) with limited direct impact on the heart. However, long-term cardiovascular safety data are still under evaluation.

3. When someone demonstrates significant FEAR of pain, exacerbating the pain, how do you help them?

Mark Pasanen: Such a challenging situation - and I do think it starts with hearing that from the patient and start to think about the ways self-management can be part of your strategy (along with some of the modalities mentioned by Dr Alford)

Daniel Alford: I think this is when a behavioral pain specialist can be very helpful. They can train the patient to reframe how they interpret their pain through pain reprocessing for example. Tell the patient that the pain is amplified by the brain and the psychologist will help them turn down the pain signal

4. Do you run endocrine screening? Do we have guidelines to help identify which pts? Eg testosterone levels?

Mark Pasanen: I am unaware of any recommendations to do endocrine screening in patients on chronic opioids. Will see if Dr Alford has other thoughts.

Daniel Alford: the recommendations are to routinely ask patients on chronic opioids about signs of sex hormone deficiency before starting therapy and at follow-up visits. For men such as decreased libido, erectile dysfunction, fatigue, depression, reduced muscle mass, and infertility. For women such as reduced libido, amenorrhea, irregular menstruation, hot flashes, fatigue, and depression. If these symptoms are found it

would be reasonable to test for hypogonadism. If found it might be a good reason to decrease the opioid dose and add nonopioids and see if symptoms improve

5. Have any of you ever delayed opioid treatment until the patient received evaluation OSA?

Daniel Alford: I certainly will ask the STOP BANG screener if there are symptoms of OSA. If positive I would have the patient undergo a sleep study before starting an opioid and/or increasing an opioid dose

6. When you do the urine checks, are they random so that the patient won't be able to do something to produce a false negative result?

Daniel Alford: I do them randomly during regular visits but usually do not call patients in randomly when they don't have an appointment already scheduled. I realize that patients might plan before visits but I also realize that patients who have a substance use disorder are not able to control their use even if they know that they may be asked to leave a urine.

7. Gabapentin is sedating; is its effect, when taken with an opiate, less dangerous for a particular pharmacologic reason?

Mark Pasanen: I do not think gabapentin is less dangerous when taken with an opioid. In fact, there are some data suggesting increased risk when taken together. But as we talked about earlier, pain can be improved. So I think when using together, important to be using lower doses of both, following closely and continue to assess the risk/benefits.