Introduction

The unpleasant and subjective sensation resulting from a noxious sensory stimulus defines the phenomenon of pain. The podiatric physician is no stranger to the difficulties in achieving optimal pain therapy. Podiatric physicians must develop analgesic regimens to treat patients with acute, chronic, and post-operative pain. The topic of pain management remains a minor component of the formal education and training of residents and physicians in the United States. Misguided attitudes concerning acute and chronic pain management, in addition to reservations about the legal aspects of pain management, often translate into a “fear of the unknown” when it comes to narcotic prescriptions.

On an average day in the United States, more than 650,000 opioid prescriptions are dispensed. Further, the United States accounts for 4.6% of the world’s population yet it is estimated that the United States consumes 80 percent of the global opioid supply as well as approximately 99% of hydrocodone. The United States is in the grips of an “Opioid Crisis” described by staggering data. Of the 20.5 million American...
ics 12 years old or older that had a substance use disorder in 2015, two million had a substance use disorder involving prescription pain relievers and 591,000 had a substance use disorder involving heroin.³

Podiatric physicians during their role of patient pain management frequently prescribe opioids. Podiatrists have an ethical obligation to prescribe responsibly yet cautiously to diminish the potential for opioid diversion and to help minimize the growth of the current epidemic of opioid abuse. The Podiatry Management 35th annual survey of 1,039 respondents reported data on podiatric physicians’ prescribing habits.⁴ Respondents admitted to prescribing 6.1 prescriptions weekly. The amount of oral analgesic prescriptions prescribed data reveals the following percentages: Norco⁵ (13%), Percocet⁶ (13%), Hydrocodone (11%), Ultram⁷ (4%), Tylenol#3⁸ (4%), Vicodin⁹ (3%), Lortab¹⁰ (1%). Notable difference between 2016 and 2017 data were a 2% increase in Percocet prescriptions and a 4% decrease in Vicodin prescriptions.⁹

Through alterations in the attitudes of patients and podiatric physicians, the podiatrist can manage the pain of the patient while minimizing diversion potential through careful procedural techniques, non-steroidal anti-inflammatory drug use, and limited opioid prescriptions of appropriate quantities when deemed necessary. In patients who might possibly have or develop a physical or psychological dependence on these drugs. There is a dilemma for the podiatric physician regarding balancing patient treatment with opioids and avoiding adverse effects contributing to the opioid crisis. This review focuses on the prescribing strategies of opioid analgesics to treat lower-extremity pain.

Prescribing Opioid Strategies in Podiatry
Algesic opioid therapy has been the cornerstone of the pharmacologic management of acute and chronic pain. Ideally, opioid analgesics are prescribed by balancing the beneficial and adverse effects. Although often overlooked as a source of opioid medications, podiatric and orthopedic surgical interventions are often painful during the post-operative period; therefore, these specialists are frequent opioid prescribers. Ringwalt, et al. accentuates this assertion by their findings centered on medical specialty opioid prescribing for non-chronic, non-cancer pain.⁷ They reviewed 1.28 million

---

**Opioid Equivalency**

<table>
<thead>
<tr>
<th>Opioid Products</th>
<th>Oral Route</th>
<th>IV/SC/IM Routes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>130 mg</td>
<td>75 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg</td>
<td>1.5 mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>5-15 mg</td>
<td>2.5-10 mg</td>
</tr>
<tr>
<td>Meperidine</td>
<td>300 mg</td>
<td>75 mg</td>
</tr>
<tr>
<td>Levoorphanol</td>
<td>4 mg</td>
<td>2 mg</td>
</tr>
<tr>
<td>Oxymorphine</td>
<td>10 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Pentazocine</td>
<td>50 mg</td>
<td>30 mg</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>20 mg</td>
<td>N/A</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
<td>N/A</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>N/A</td>
<td>0.3-0.4 mg</td>
</tr>
<tr>
<td>Butorphanol</td>
<td>N/A</td>
<td>2 mg</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>N/A</td>
<td>0.1 mg</td>
</tr>
<tr>
<td>Nalbuphine</td>
<td>N/A</td>
<td>10 mg</td>
</tr>
</tbody>
</table>

---

On an average day in the United States, more than 650,000 opioid prescriptions are dispensed.
Opioid (from page 162)

filled prescriptions for an opioid analgesic over a one year time frame. They concluded that general practitioner/family medicine specialists and internists were least likely to prescribe opioids, while orthopedists were most likely to prescribe opioids. While there is currently no direct evidence, a contribution to non-medical opioid misuse is presumed to be a result of normal prescribing for orthopedic surgical interventions.

Opioid analgesics are classified as agonist or antagonist drugs depending on their ability to bind or block opioid receptors. Each opioid produces a wide spectrum of pharmacologic effects, including analgesia, dysphoria, euphoria, somnolence, respiratory depression, diminished gastrointestinal motility, altered circulatory dynamics, urinary retention, histamine release, and physical dependence.

The podiatric physician must remember that comfort is the ultimate goal when using any medication, including opioids, to manage pain. Before podiatric clinicians consider an opioid analgesic, they need to ensure that a complete psychosocial and physical evaluation of the patient has been performed. Opioid therapy should be prescribed appropriately to avoid under-treating patients with painful symptoms.

Opioid Selection

Opioid selection is based on patient-specific factors, such as age and renal function. When selecting an opioid, immediate-release formulations are safer than extended-release or long-acting opioids, regardless of whether the drug is used for acute or long-term treatment. In the setting of acute pain, some podiatric clinicians become competent in the prescribing and use a few opioid analgesics. Although no opioid seems to be superior in relieving pain, certain products are clearly inferior because of increased risks of toxic effects.

In some circumstances, pain control is inadequate despite dosage increases. MacPherson reviewed the concept of opioid rotation. This method is characterized by the replacement of the current opioid regimen with another. Analgesic equivalence is the central theme when considering opioid substitution.

Mercadante defines the concept of opioid rotation as the substitution of another opioid for a previous one to obtain a more favorable response. Two types of opioid rotation strategies have been used: a change in opioid product or a change in the route of administration. Morphine-equivalent tables have been developed, and their purpose is to assist clinicians in determining equianalgesic doses of various opioid agents when changing therapy. A table of opioid equianalgesic doses is presented in Figure 1.

The last key to the rotation strategy of opioid analgesic therapy that the podiatric physician must consider is the route of administration. Various methods of drug delivery have been used to treat patients in pain. Selecting the route of administration must be precise and tailored to the patient’s needs and tolerability.

The Institute for Clinical Systems Improvement published an acute pain assessment and appropriate opioid prescribing protocol in 2014. The podiatric physician may find the following clinical points essential when prescribing opioids for acute pain. Providers should avoid prescribing more than three days or 20 doses to a patient. Select the lowest dose and

According to Podiatry Management’s 35th annual survey, 13% of podiatrists wrote prescriptions for Norco. Continued on page 164

FIGURE 2: Risk Factors for Prescription Drug Abuse

- Past or present addictions to other substances, including alcohol and tobacco
- Family history of substance abuse problems
- Lack of knowledge about prescription drugs and their potential harm
- Age group 16 to 45 Younger age, especially the teens or early 20s greater risk
- Exposure to peer pressure or a social environment where there’s drug use
- Easier access to prescription drugs, such as having prescription medications in the home medicine cabinet
- Certain pre-existing psychiatric conditions
  - Bipolar Affective Disorder
  - Attention Deficient Affective Disorder
  - Generalize Anxiety Disorder
  - Major Depressive Disorder
  - Obsessive Compulsive Disorder
  - Personality Disorder
- Having multiple health problems and taking multiple drugs can put seniors at risk of misusing drugs or becoming addicted.
the shortest acting opioid product.12
Consider that tramadol is an atypical opioid and should be managed appropriately.12 Never prescribe long-acting/extended release opioid for acute pain. Exercise caution when prescribing opioids to the elderly patient.12 Schedule the patient to follow up within three to five days.12 Share decision-making and review responsible use, driving, work, storage and disposal with the patient.12 According to Dowell, et al. treatment for three or fewer days is often sufficient for most patients with acute pain and more than seven days is rarely required.13

Published clinical-based evidence has described the effects of employing local anesthetic products to reduce post-operative pain and reduce the need for opioid analgesics.14-16 Kim, et al. investigated 30 consecutive patients who underwent bilateral proximal osteotomies for the correction of hallux valgus deformities.14
Each patient acted as their own control as one foot received local infiltration of a test solution made with ropivacaine, morphine, ketorolac and epinephrine while the other foot received the same amount of normal saline.14

A visual pain analogue scale was used to assess at four hours after the surgical intervention and throughout the night of the first post-operative day.14 The difference in visual analogue scale values between the two sides was most notable at eight hours after the operation and then gradually decreased through the first and second post-operative day.14 These investigators concluded that the local multi-drug cocktail was easy to perform, safe, and effective in reducing pain and enhancing patient satisfaction after hallux valgus surgery.14

Luiten, et al. investigated their hypothesis that a continuous peripheral nerve block would reduce pain scores more effectively than systemic analgesics, improve recovery, and lead to reduced hospital length of stay.15 They retrospectively analyzed three years of data centered on patients who underwent open reduction and internal fixation of talar or calcaneal fractures who either received intravenous opioid patient-controlled analgesics or continuous peripheral nerve block.15 Their findings reveal that the patient-controlled analgesic group required about 30-fold more opioids compared to the continuous peripheral nerve block group on the first post-operative day.15

Gadek and Liszka evaluated the influence of local anesthetic infiltration before hallux valgus surgery on

Continued on page 165

FIGURE 3:
Opioid Risk Tool Patient Form

Name: ______________________________________
Age: __________________

<table>
<thead>
<tr>
<th>Mark Each Box That Applies</th>
<th>Score If Female</th>
<th>Score If Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Family History of Substance Abuse</td>
<td>• Alcohol</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>• Illegal Drugs</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>• Prescription Drugs</td>
<td>—</td>
</tr>
<tr>
<td>2) Personal History of Substance Abuse</td>
<td>• Alcohol</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>• Illegal Drugs</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>• Prescription Drugs</td>
<td>—</td>
</tr>
<tr>
<td>3) Age (Mark Box if 16-45 Years)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>4) History of Preadolescence Sexual Abuse</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>5) Psychological Disease</td>
<td>• Attention Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
<td>—</td>
</tr>
</tbody>
</table>

Total Score: ________________ Risk Category: ________________

Low Risk 0–3
Moderate Risk 4–7
High Risk >7

Continued on page 165
post-operative pain and the need for analgesics. Their study group consisted of 134 patients who underwent chevron or mini-invasive Mitchell-Kramer osteotomy of the first distal metatarsal. Each patient was randomized to receive either 7 mL of local anesthetic (4 mL of 0.25% bupivacaine and 3 mL of 2% lidocaine) or normal saline 15 minutes prior to skin incision. Each patient’s level of pain was assessed by the visual analogue scale at hours 2, 4, 8, 12, 16, 24, and 72 hours after release of the tourniquet. They concluded that pre-emptive local anesthetic infiltration significantly decreased pain during the first 24 hours after hallux valgus surgery.

National Academies of Sciences and Engineering and Medicine Strategies

On July 13, 2017, the Board on Health Sciences Policy of the Health and Medicine Division of the National Academies of Sciences Engineering and Medicine (NASEM) issued a report titled “Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use.” The US Food and Drug Administration (FDA) commissioned this comprehensive report to provide an update on current evidence on research, care, and education in the pain field, and to identify actionable measures for the FDA to more adequately address the ongoing opioid epidemic. The report highlights the fact that “A sustained, coordinated effort is necessary to stem the still-escalating prevalence of opioid-related harms, including a culture change in prescribing for chronic non-cancer pain, aggressive regulation of opioids by the FDA, and multi-pronged policies by state and local governments.”

Many treatments are available to manage pain. Some non-opioid therapies are likely to be as effective as opioids, or even more so, and potentially carry lower risk when used appropriately. Any meaningful effort to improve pain management will require a basic culture shift in the nation’s approach to mandating pain-related education for all health professionals who provide care to people with pain. Prescribing guidelines may be most effective when accompanied with education, and so an evidence-based national approach to pain education, including pharmacologic and non-pharmacologic treatments and materials on opioid prescribing, is needed. Insurance-based policies have substantial potential to reduce the use of specific prescription drugs. Coverage for and access to comprehensive pain management that includes both pharmacologic and non-pharmacologic options should be expanded. Pre-

The White House Office of National Drug Control Policy recommended the use of prescription drug monitoring programs to reduce abuse in 2011.

Continued on page 166
Opioid (from page 165)

pharmacies. Although prescription drug monitoring programs have existed for many years, the White House Office of National Drug Control Policy recommended the use of prescription drug monitoring programs to reduce abuse in 2011. Congress passed the National All Schedules Prescription Electronic Reporting Act (NASP2R) requiring the Secretary of Health and Human Services (HHS) to award grants to states to establish or improve PDMPs.

Unfortunately, the amount of funding to support this program has been limited, and the plan to fully integrate the prescription drug monitoring programs for the entire country has yet to be realized. Currently, 48 states and one territory either have PDMPs or have passed legislation to implement them. Clinicians should review PDMP data, if available, at the start of therapy as well as throughout therapy to help determine if the patient is actually using the opioid as prescribed or if there are any dangerous combinations that put their patients at high risk for overdose.

Opioid Aberrant Behaviors

Yorkgitis and Brat recently reported that many opioid prescription medications after surgery go unused, with the potential for diversion and misuse. Further, they assert as surgeons become increasingly aware of their role in opioid misuse, better tools are needed to guide behavior. Based on an extensive review of recent literature, they developed the acronym

RIGHTT: Risk for adverse event, Insight (it is important that surgeons recognize the potential for opioid misuse in their patients), Going over pain plan, Halting opioids, Tossing unused opioids and Trouble identification.

The following terms are used to describe aberrant opioid behaviors: Misuse of a medication in a manner other than as specifically directed by a healthcare professional. Self-titration due to poor pain control or anxiety. Abuse—deliberate nonmedical use: crushing, snorting, injecting, diversion (buying/selling/stealing). All these behaviors have contributed to opioid-related deaths. The biggest identified risk factors for substance abuse are presented in Figure 2.

Podiatric physicians can screen for risk factors before prescribing opioids. It is ideally done on the patient's first visit or before prescribing opioids, although even patients who have been taking opioids for long periods of time should be routinely screened. Choice of substance abuse risk assessment tools may depend on time available, substance involved, format to be used (paper, computer, interview), and depth desired.

There are a number of screening tools that have been developed specifically to screen for risk of opioid misuse in the context of chronic pain treatment and that have been demonstrated to have predictive value; these tools may be helpful in determining relative risk in addition to the medical history.

A recent review found that the opioid risk tools, diagnosis, intractability, risk, efficacy, the screener and opioid assessment for patients with pain-revised assessment tools appear to have good validity. A generic opioid risk tool patient form is presented as Figure 3.

Conclusions

Podiatric physicians during their role of patient acute pain management frequently prescribe opioids. Podiatrists have an ethical obligation to prescribe responsibly and cautiously to diminish the potential for opioid diversion and to help minimize the growth of the current opioid abuse epidemic. This review focuses on the prescribing strategies of opioid analogues to treat lower-extremity pain.

Also presented were non-opioid acute post-operative treatment options to potentially decrease the use of opioid therapy during a recovery from surgical interventions. Then, to enrich the podiatric physician's body of knowledge, the National Academies of Sciences and Engineering and Medicine for opioid prescribing strategies were presented. Finally, building on the opioid prescribing strategy foundation, monitoring tools and strategies was presented to recognize and reduce the risk of aberrant opioid misuse and abuse.

References


Opioid (from page 166)


Donoghue SK. PM’s 35th annual survey: boosting the bottom line. Podiatry Management 2018; February 37(2):83-118.


Dowell D, Haegerich TM, Chou R. CDC guidelines for prescriber's role to improve opioid prescription writing strategy, which statement is FALSE?

A) Enforce a strict refill policy and guidelines on lost prescriptions.
B) Adhere to strict policies regarding prescribing.
C) Safeguard license and DEA numbers and only utilize them as required by state law.
D) Give unlimited refills on Schedule II Narcotics

Donoghue SK. PM’s 35th annual survey: boosting the bottom line. Podiatry Management 2018; February 37(2):83-118.

2) Which one of the following percentages from Podiatry Management’s 35th annual survey on the amount of oral analgesic prescriptions written is true?

A) Percocet—22%
B) Norco—13%
C) Ultram—4%
D) Hydrocodone—28%

3) Reflecting on the four strategies addressing the opioid epidemic, which strategy does the podiatric medical physician have direct influence over?

A) Restricting the lawful supply of opioids
B) Reducing demand
C) Influencing prescribing practices
D) Reducing harm

5) Reflecting on the prescriber’s role to improve opioid prescription writing strategy, which statement is FALSE?

A) Enforce a strict refill policy and guidelines on lost prescriptions.
B) Adhere to strict policies regarding prescribing.
C) Safeguard license and DEA numbers and only utilize them as required by state law.
D) Give unlimited refills on Schedule II Narcotics

6) According to Figure 1, a podiatric physician is considering opioid rotation using morphine equivalents to switch oxycodone 20 mg to hydrocodone. What would be the hydrocodone dose?

A) Hydrocodone—10 mg
B) Hydrocodone—15 mg
C) Hydrocodone—20 mg
D) Hydrocodone—25 mg

CME EXAMINATION

SEE ANSWER SHEET ON PAGE 169.

1) On an average day in the United States more than _____ opioid prescriptions are dispensed.

A) 1,000,000
B) 350,000
C) 888,000
D) 650,000

2) Which one of the following percentages from Podiatry Management’s 35th annual survey on the amount of oral analgesic prescriptions written is true?

A) Percocet—22%
B) Norco—13%
C) Ultram—4%
D) Hydrocodone—28%

3) Reflecting on the four strategies addressing the opioid epidemic, which strategy does the podiatric medical physician have direct influence over?

A) Restricting the lawful supply of opioids
B) Reducing demand
C) Influencing prescribing practices
D) Reducing harm

4) The White House Office of National Drug Control Policy recommended the use of prescription drug monitoring programs to reduce abuse in _____.

A) 2016
B) 2012
C) 2011
D) 2013

5) Reflecting on the prescriber’s role to improve opioid prescription writing strategy, which statement is FALSE?

A) Enforce a strict refill policy and guidelines on lost prescriptions.
B) Adhere to strict policies regarding prescribing.
C) Safeguard license and DEA numbers and only utilize them as required by state law.
D) Give unlimited refills on Schedule II Narcotics

6) According to Figure 1, a podiatric physician is considering opioid rotation using morphine equivalents to switch oxycodone 20 mg to hydrocodone. What would be the hydrocodone dose?

A) Hydrocodone—10 mg
B) Hydrocodone—15 mg
C) Hydrocodone—20 mg
D) Hydrocodone—25 mg

www.podiatrym.com JUNE/JULY 2018 | PODIATRY MANAGEMENT
PM’s CME Program

Welcome to the innovative Continuing Education Program brought to you by Podiatry Management Magazine. Our journal has been approved as a sponsor of Continuing Medical Education by the Council on Podiatric Medical Education.

Now it’s even easier and more convenient to enroll in PM’s CE program!

You can now enroll at any time during the year and submit eligible exams at any time during your enrollment period.

CME articles and examination questions from past issues of Podiatry Management can be found on the Internet at http://www.podiatrym.com/cme. Each lesson is approved for 1.5 hours continuing education contact hours. Please read the testing, grading and payment instructions to decide which method of participation is best for you.

Please call (631) 563-1604 if you have any questions. A personal operator will be happy to assist you.

Each of the 10 lessons will count as 1.5 credits; thus a maximum of 15 CME credits may be earned during any 12-month period. You may select any 10 in a 24-month period.

The Podiatry Management Magazine CME program is approved by the Council on Podiatric Education in all states where credits in instructional media are accepted. This article is approved for 1.5 Continuing Education Contact Hours (or 0.15 CEU’s) for each examination successfully completed.

PM’s privacy policy can be found at http://podiatrym.com/privacy.cfm.

CME EXAMINATION

B) Hydrocodone—20 mg
C) Hydrocodone—30 mg
D) Hydrocodone—54 mg

7) Reflecting on Kim et al., investigation of hallux valgus deformities of patients who received local infiltration of a test solution: Which product was not part of the test solution?
   A) Lidocaine
   B) Morphine
   C) Ketorolac
   D) Epinephrine

8) There are a number of screening tools that have been developed specifically to screen for risk of opioid misuse in the context of chronic pain treatment and that have been demonstrated to have predictive value. Identify which tool(s) may be helpful in determining relative risk in addition to the medical history.
   A) Opioid Risk Tools
   B) Diagnosis, Intractability, Risk, Efficacy
   C) The Screener and Opioid Assessment for Patients with Pain-Revised
   D) all of the above tools are used in determining risk in addiction

9) The acronym “RIGHTT” relates to symptoms the patient may experience prior to sleep apnea diagnosis and treatment. Match the “Letter” with its corresponding correct word meaning.
   A) “R”—Rate of adverse event
   B) “G”—Getting rid of pain
   C) “H”—Halting Opioids
   D) “I”—Interviewing family members

10) Reflecting on the podiatric prescriber’s role to improve opioid prescription writing strategy, which statement is true?
   A) Take caution in the manner that prescriptions are written or dispensed.
   B) Limit the number of pills prescribed.
   C) Write out the number of pills prescribed (“ten” instead of “10”).
   D) All the above strategies are true

SEE ANSWER SHEET ON PAGE 169.

The author(s) certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers’ bureaus; membership, employment, consultancies, stock ownership, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge, or beliefs) in the subject matter or materials discussed in this manuscript.

Home Study CME credits now accepted in Pennsylvania
Enrollment/Testing Information and Answer Sheet

Note: If you are mailing your answer sheet, you must complete all info. on the front and back of this page and mail with your credit card information to: Program Management Services, P.O. Box 490, East Islip, NY 11730.

TESTING, GRADING AND PAYMENT INSTRUCTIONS
(1) Each participant achieving a passing grade of 70% or higher on any examination will receive an official computer form stating the number of CE credits earned. This form should be safeguarded and may be used as documentation of credits earned.
(2) Participants receiving a failing grade on any exam will be notified and permitted to take one re-examination at no extra cost.
(3) All answers should be recorded on the answer form below. For each question, decide which choice is the best answer, and circle the letter representing your choice.
(4) Complete all other information on the front and back of this page.
(5) Choose one out of the 3 options for test grading: mail-in, fax, or phone. To select the type of service that best suits your needs, please read the following section, “Test Grading Options”.

TEST GRADING OPTIONS
Mail-In Grading
To receive your CME certificate, complete all information and mail with your credit card information to: Program Management Services, P.O. Box 490, East Islip, NY 11730. PLEASE DO NOT SEND WITH SIGNATURE REQUIRED, AS THESE WILL NOT BE ACCEPTED.

Facsimile Grading
To receive your CME certificate, complete all information and fax 24 hours a day to 631-532-1964. Your CME certificate will be dated and mailed within 48 hours. This service is available for $2.50 per exam if you are currently enrolled in the annual 10-exam CME program (and this exam falls within your enrollment period), and can be charged to your Visa, Mastercard, American Express, or Discover. If you are not currently enrolled, the fee is $27 per exam.

Phone-In Grading
You may also complete your exam by using the toll-free service. Call 1-800-232-4422 from 10 a.m. to 5 p.m. EST, Monday through Friday. Your CME certificate will be dated the same day you call and mailed within 48 hours. There is a $2.50 charge for this service if you are currently enrolled in the annual 10-exam CME program (and this exam falls within your enrollment period), and this fee can be charged to your Visa, Mastercard, American Express, or Discover. If you are not currently enrolled, the fee is $27 per exam.

In the event you require additional CME information, please contact PMS, Inc., at 1-631-563-1604.

Please print clearly...Certificate will be issued from information below.

Name __________________________________________________________________________ Email Address ________________________________
Please Print: First                        Mi                        Last
Address _______________________________________________________________________________________________________________
City________________________________________________ State_______________________ Zip________________________________
Charge to: _____ Visa   _____ MasterCard   _____ American Express
Card #________________________________________________ Exp. Date____________________ Zip for credit card_________________
Note: Credit card is the only method of payment. Checks are no longer accepted.
Signature________________________________________________ Email Address_________________________ Daytime Phone_____________________
State License(s)___________________________ Is this a new address? Yes________ No________
Check one:  ____ I am currently enrolled. (If faxing or phoning in your answer form please note that $2.50 will be charged to your credit card.)
____ I am not enrolled. Enclosed is my credit card information. Please charge my credit card $27.00 for each exam submitted. (plus $2.50 for each exam if submitting by fax or phone).
____ I am not enrolled and I wish to enroll for 10 courses at $219.00 (thus saving me $51 over the cost of 10 individual exam fees). I understand there will be an additional fee of $2.50 for any exam I wish to submit via fax or phone.

Over, please
EXAM #5/18
Opioid Prescribing: Podiatric Implications
(R. Smith)

Circle:
1. A   B   C   D  
2. A   B   C   D  
3. A   B   C   D  
4. A   B   C   D  
5. A   B   C   D  
6. A   B   C   D  
7. A   B   C   D  
8. A   B   C   D  
9. A   B   C   D  
10. A  B   C   D

This CME activity is free from commercial biases and is under the overall management of Podiatry Management Magazine.

Medical Education Lesson Evaluation

|--------------------|-----------|-------------|--------------|-----------------------|

1) This CME lesson was helpful to my practice ______
2) The educational objectives were accomplished ______
3) I will apply the knowledge I learned from this lesson ______
4) I will make changes in my practice behavior based on this lesson ______
5) This lesson presented quality information with adequate current references ______
6) What overall grade would you assign this lesson?
   A   B   C   D
How long did it take you to complete this lesson?
   _____ hour _____ minutes

What topics would you like to see in future CME lessons?
Please list:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________