Safe and Effective Prescribing: Opioids for Chronic Pain

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Disclosures

- I have no actual or potential conflict of interest in relation to this program/presentation.

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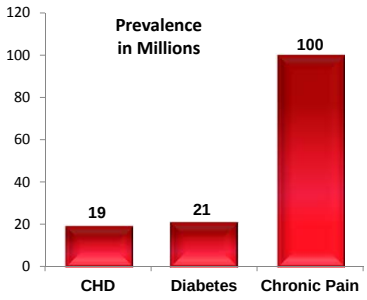
- Daniel Alford, MD MPH
- Ilana Hardesty
- Boston University School of Medicine Continuing Medication Office

Scope of the Problem

100 Million in U.S. with Chronic Pain

- 42% with pain lasting over one year
- 33% report pain as disabling
- 63% have seen primary care physician for help



$600 Billion Annual Costs

- Healthcare expenses
- Lost income
- Lost productivity

American Academy of Pain Medicine www.painmed.org
Institute of Medicine. 2011 Relieving Pain in America. Washington DC

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Chronic Pain is Complex

Genetic Predispositions
- Structure and function of the nervous system
- Molecular basis for response to pain and/or analgesia

Environmental Stressor Effects
- Work, home

Social Effects
- Socially determined constructs of pain, suffering and disability
- Beliefs about pain treatment

Apkarian AV et al. Pain 2011; 152 (3 Suppl): S49-S64.
Bennett RM. Mayo Clin Proc 1999;74:385-398.

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Chronic Pain Affected by Co-Morbidities

Condition	Incidence Chronic Pain Patients	References
Depression	33 - 54%	Cheatle M, Gallagher R, 2006 Dersh J, et al., 2002
Anxiety Disorders	16.5 - 50%	Knaster P, et al., 2012 Cheatle M, Gallagher R, 2006
Personality Disorders	31 - 81%	Polatin PB, et al. 1992 Fischer-Kern M, et al., 2011
PTSD	49% veterans 2% civilians	Otis, J, et al., 2010 Knaster P, et al., 2012
Substance Use Disorders	15 - 28%	Polatin PB, et al. 1992 Cheatle M, Gallagher R, 2006

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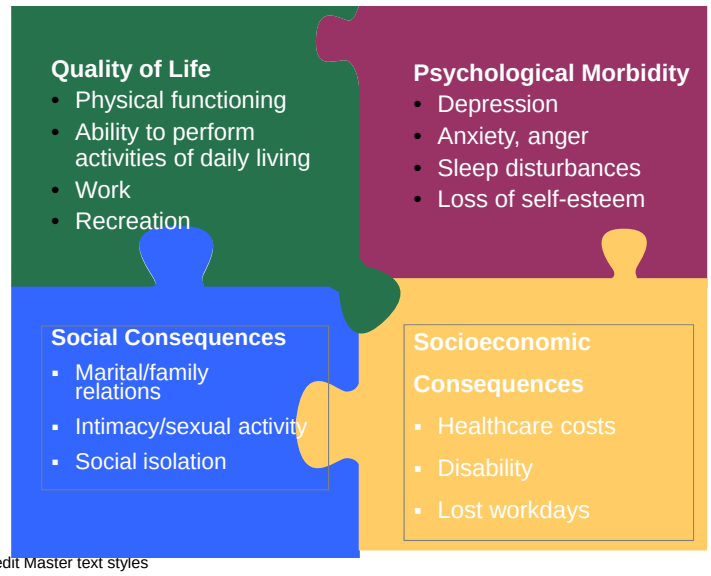
Domains of Chronic Pain



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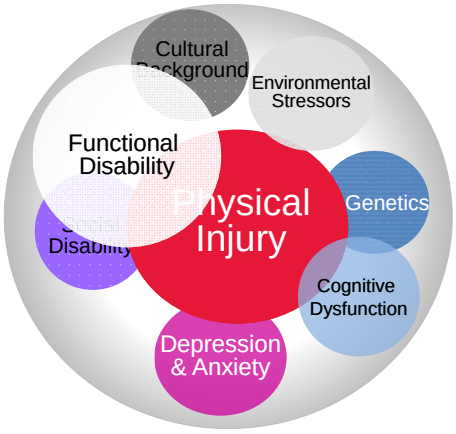
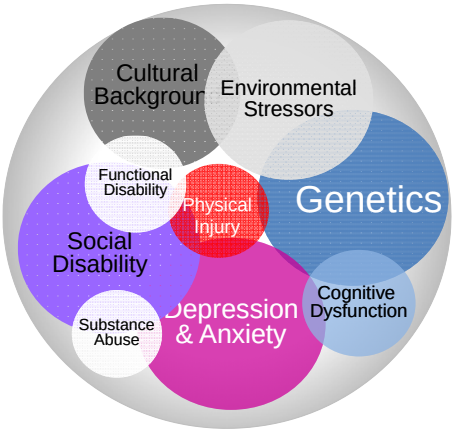
Individual Experience of Pain

Patient "A" Pain 8/10



Patient "B" Pain 8/10



Gatchel RJ. Am Psychol. 2004 Nov;59(8):795-805.

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How confident are you in your ability to effectively and efficiently assess pain in a new patient?

Building Trust

Patient Issues

Patients will assume that you don't believe their pain complaints

Often demonstrated by exaggerating pain scores

Building Trust

Patient Issues

Some patients with adequate pain relief believe
it is not in their best interest to report pain relief

Fear that medication will be reduced

Fear that physician may decrease efforts to diagnose problem

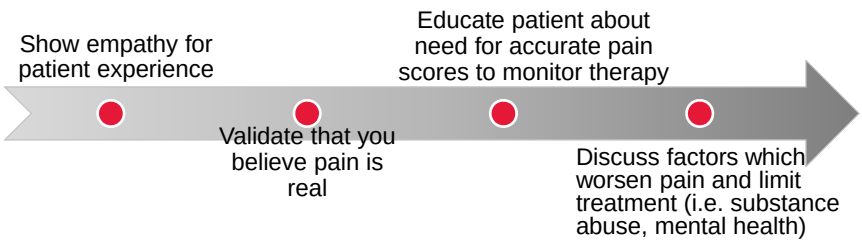
Evers GC, et al. Support Care Cancer. 1997 Nov;5(6):457-60.

Building Trust

Provider Strategies

Assume patient fears you think pain is not real or very severe

- After you take a through pain history:



- Believing patient's pain complaint does not mean opioids are indicated

Pain Assessment

- Pain scales
  - Numeric rating
  - Visual analog
  - Faces scale
- Multidimensional instruments
  - McGill Pain Questionnaire
  - Brief Pain Inventory (BPI)

  } Impractical for routine use in primary care

  - Pain, Enjoyment, General activity (PEG) scale

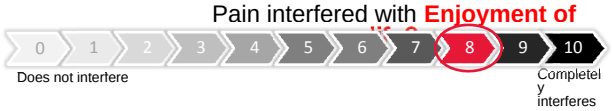
Brevik H et al. Br J Anaesh 2008;101:17-24.
Krebs EE et al. J Gen Intern Med 2009;24(6):733-8.

PEG Scale Assessment

In the past week:

Pain on average?

Pain interfered with **Enjoyment of**



Pain interfered with **General activity?**

Screening for Unhealthy Substance Use

Alcohol

- "Do you sometimes drink beer wine or other alcoholic beverages?"
- "How many times in the past year have you had 5 (4 for women) or more drinks in a day?"

(+ answer: > 0)

Drugs

- "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"

(+ answer: > 0)

Smith PC, et al. Gen Intern Med. 2009 Jul;24(7):783-8.
Smith PC, et al. Arch Intern Med. 2010 Jul 12;170(13):1155-60.

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Screening for Mental Illness

- Patient Health Questionnaire (PHQ 2, PHQ 9)
- Other psychiatric history – anxiety, PTSD
- Suicidal, homicidal
- Mental status and competency

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Screening for Depression

PHQ2 Patient Health Questionnaire

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless

Scoring:
- 0 Not at all
- 1 Several days
- 2 More than half the days
- 3 Nearly every day

- Interpretation
  - Positive if 3 or more points
- Administer PHQ9 if positive
- Efficacy
  - Test Sensitivity: 83%
  - Test Specificity: 92%

Kroenke K, Spitzer RL, Williams JB.Med Care. 2003 Nov;41(11):1284-92.

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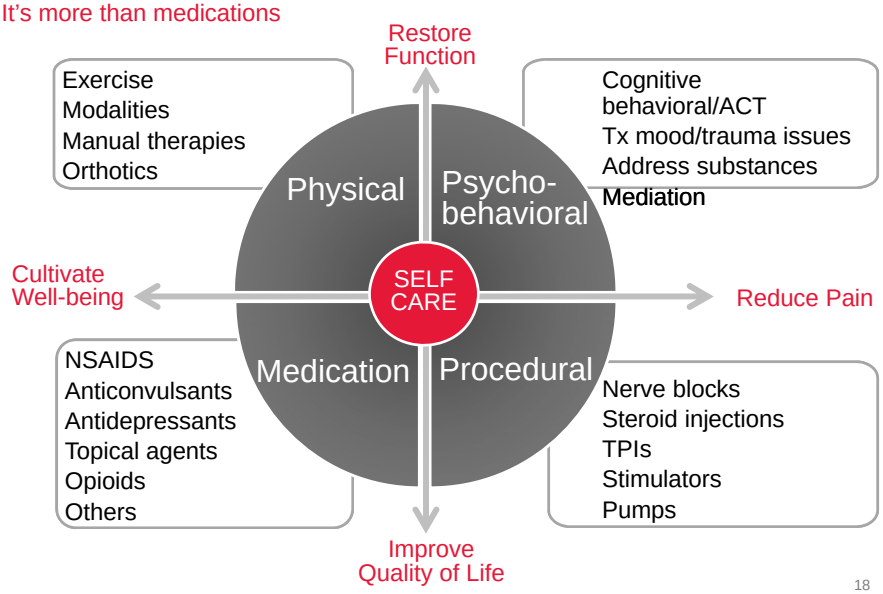
Multidimensional Care

It's more than medications



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Focus of today's talk

- **Pharmacotherapy- opioids**
- Interventions (nerve block, etc.)
- Surgery
- Behavioral therapy
  - Cognitive behavioral therapy
- Physical Therapy
- Integrative medicine
  - Accupuncture
  - Massage
  - Yoga
- Occupational training

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How confident are you in your ability to efficiently assess the potential benefit and the potential risk of opioids for chronic pain in a new patient?

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When are Opioids Indicated?

- Pain is moderate to severe
- Pain has significant impact on function
- Pain has significant impact on quality of life
- Non-opioid pharmacotherapy has failed
- If already on opioids, is there documented benefit

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How Good are Opioids for Chronic Pain?

- Most literature: surveys and uncontrolled case series
- RCTs are short duration <8 months with small samples <300 pts
- Mostly pharmaceutical company sponsored
- Outcomes
  - Better analgesia with opioids vs. controls
  - Pain relief modest
  - Mixed reports on function
  - Addiction not assessed

Ballantyne JC, Mao J. N Engl J Med. 2003 Nov 13;349(20):1943-53.
Kelso E, et al. Pain. 2004 Dec;112(3):372-80.
Eisenberg E, McNicol ED, Carr DB. JAMA. 2005 Jun 22;293(24):3043-52.
Furlan AD, et al. CMAJ. 2006 May 23;174(11):1589-94.
Noble M, et al. Cochrane Database Syst Rev. 2010 Jan 20;(1):CD006605.

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Variable Response to Opioids

Not all patients respond to the same opioid in the same way

Not all pain responds to the same opioid in the same way

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Opioid Risks

Opioid Tolerance and Physical Dependence

Both tolerance and physical dependence are physiological adaptations to chronic opioid exposure

Tolerance:

- Increased dosage needed to produce specific effect
  - Develops readily for CNS and respiratory depression
  - Less so for constipation
  - Unclear about analgesia

Physical Dependence:

- Signs and symptoms of withdrawal by abrupt opioid cessation, rapid dose reduction

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Opioid Safety and Risks

- **Allergies** – Rare
- **Organ Toxicities** – Rare
  - Suppression of hypothalamic-pituitary-gonadal axis
  - >50 mg (MSO_4 equivalents) assoc. with 2x increase fracture risk
- **Adverse Effects** – Common
  - Nausea, sedation, constipation, urinary retention, sweating
  - Pruritis (histamine release)
  - Respiratory depression – sleep apnea

Benyamin R, et al. Pain Physician 2008; 11:S105-S120.
Saunders KW,, et al. J Gen Intern Med. 2010;25:310-315.

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Respiratory Depression

- Depression of the medullary respiratory center
- Decreased tidal volume and minute ventilation
- Right-shifted CO2 response
- Hypercapnea, hypoxia and decreased oxygen saturation
- Various agonist-type opioids do appear to differ in potential for ventilatory depression in humans
- Immediately life threatening
- The key to remember is that sedation occurs before respiratory depression therefore it is a warning sign that the patient is overmedicated

Dahan A, et al. Anesthesiology 2010;112:226-238.

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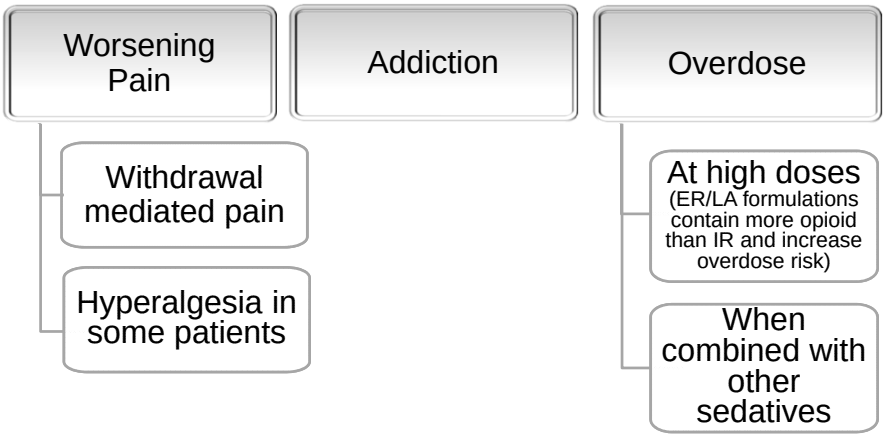
Opioid Safety and Risks



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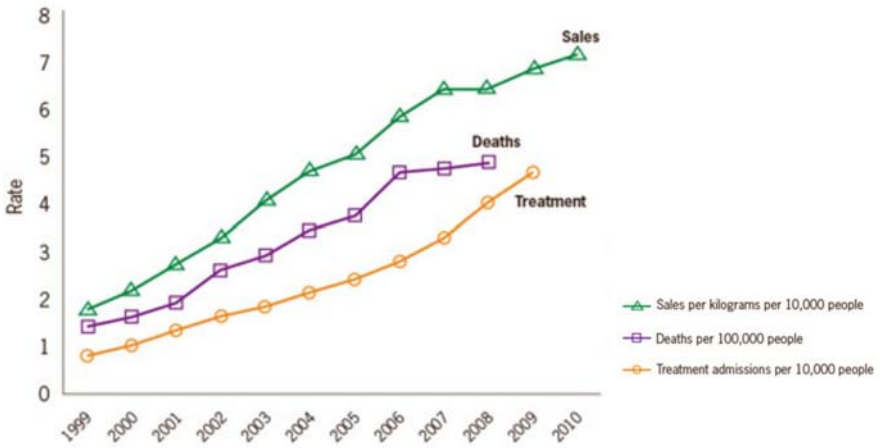
Rates of Prescription Opioid Sales, Deaths and Substance Abuse Treatment Admissions



National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009.

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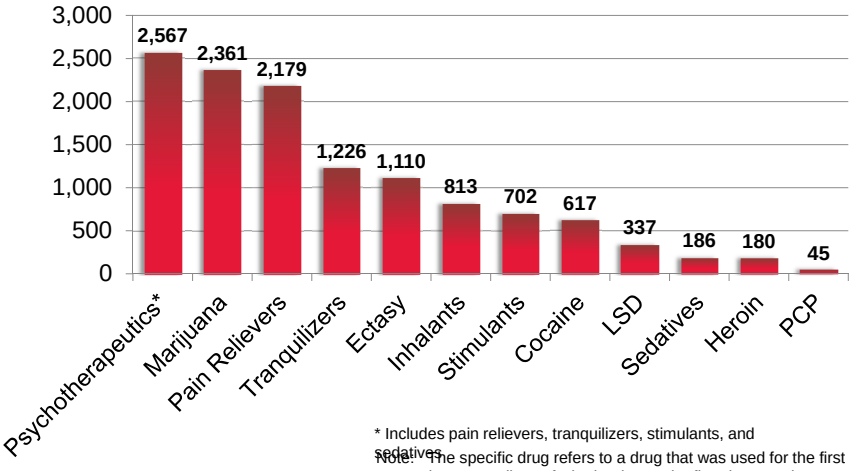
New Users: Specific Illicit Drugs



* Includes pain relievers, tranquilizers, stimulants, and sedatives

Note: The specific drug refers to a drug that was used for the first time, regardless of whether it was the first drug used or not.

SAMSHA, 2009 National Survey on Drug Use and Health (September 2010).

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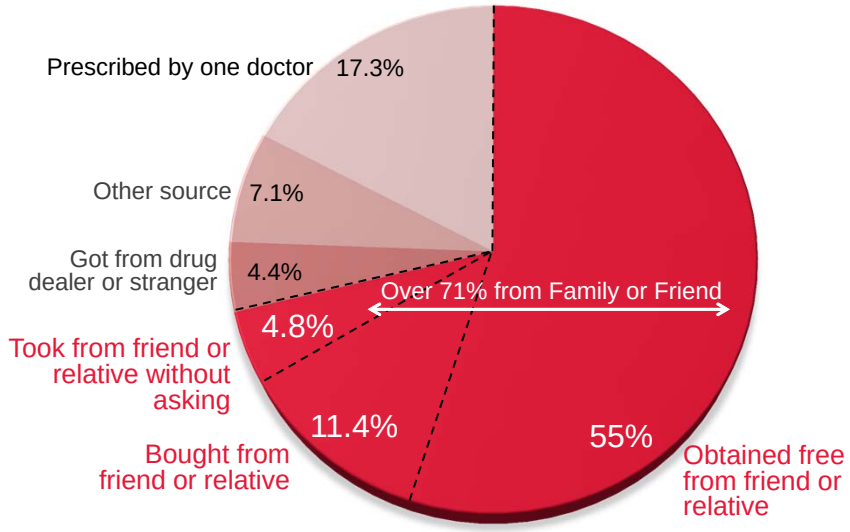
Where Pain Relievers Were Obtained

Over 71% from Family or Friend



2010 National Survey on Drug Use and Health: SAMHSA, Office of Applied Studies; 2011

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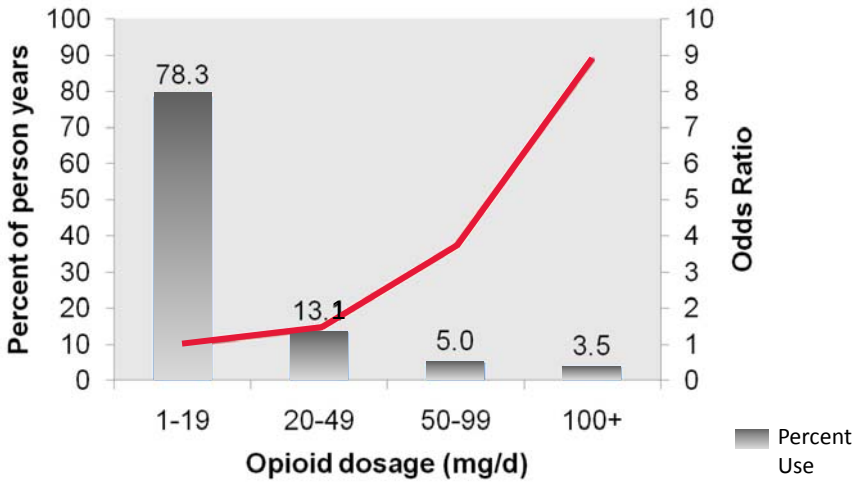
Collateral Opioid Risk

- Risks
  - Young children ingestion and overdose
  - Adolescents experimentation leading to overdose and addiction
- Mitigating risk
  - Safe storage and disposal
  - Educate family members
  - Have poison control number handy

Risk of Opioid Overdose



Group Health Consort Study, 1997-2005; Dunn KM, et al. Ann Intern Med. 2010 Jan 19;152(2):85-92.

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Opioid Addiction Risk

- True incidence and prevalence of addiction in chronic pain populations prescribed opioids is unknown due to different criteria used to define addiction in different studies
- The range in prevalence reported is 0-50%

Højsted J, Sjøgren P. Eur J Pain. 2007 Jul;11(5):490-518.

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Opioid Misuse Risk

Known Risk Factors

Good Predictors for problematic prescription opioid use

- Young age (less than 45 years)
- Personal history of substance abuse
  - Illicit, prescription, alcohol, nicotine
- Family history of substance abuse
- Legal history
  - DUI, incarceration
- Mental health problems
- History of sexual abuse

Akbik H, Butler SF, Budman SH, et al. J Pain Symptom Manage 2006;32(3):287-293.
Ives J, et al. BMC Health Serv Res. 2006 Apr 4;6:46.
Liebschutz JM et al. J Pain. 2010 Nov;11(11):1047-55.
Michna E, et al. J Pain Symptom Manage. 2004 Sep;28(3):250-8.
Reid MC, et al. J Gen Intern Med. 2002 Mar;17(3):173-9.

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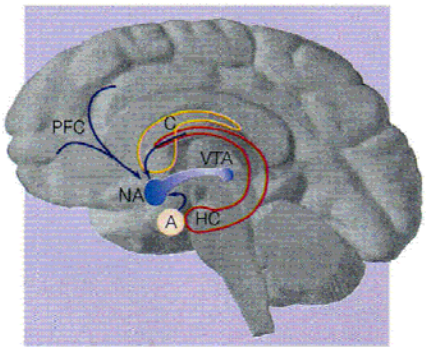
Why Patients Become Addicted to Opioids

Opioids activate mu receptors in midbrain = "reward pathway" causing euphoria

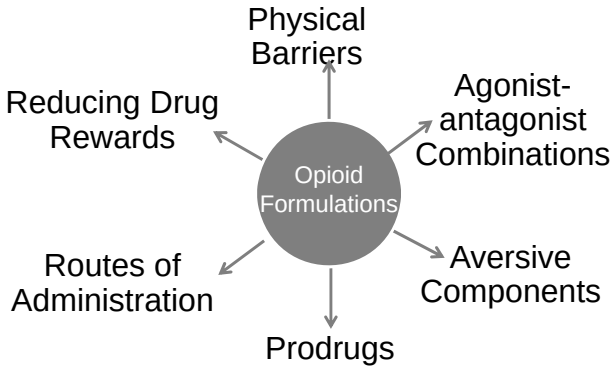
- Dopaminergic system that is very reinforcing
- Most rewarding are fast onset opioids
- ER/LA should be less rewarding if taken as prescribed but are very rewarding if adulterated (e.g., crushed, chewed)



Kosten TR, George TP. Science and Practice Perspectives – July 2002:13

Abuse Deterrent/Resistant Formulations

In Development



Currently there are NO PROVEN abuse deterrent/resistant opioids or formulations

Passik SD. Mayo Clin Proc. 2009 Jul;84(7):593-601.
Stanos SP et al. Mayo Clin Proc. 2012;87(7):683-694.

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Risk Assessment

Assess for Opioid Misuse Risk

Prior to Prescribing

- Validated questionnaire
- Urine drug testing
- Check state prescription drug monitoring program data (if available)
- Review old medical records
- Talk to previous provider (if possible)

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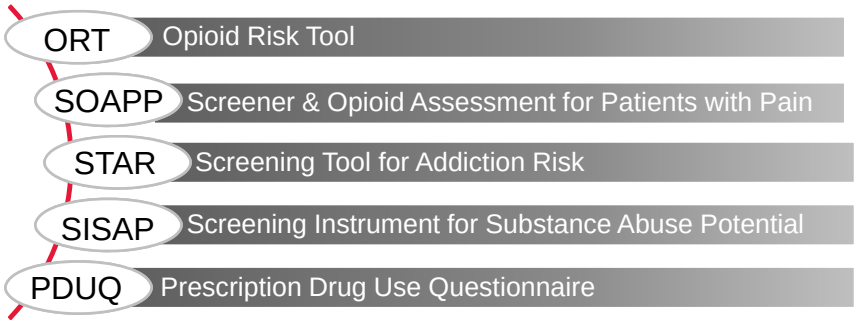
Validated Questionnaires



No “Gold Standard”
Lack of rigorous testing

Moore TM, et al. Pain Medicine 2009;10(8): 1426-1433.

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Opioid Risk Tool Score

		Female	Male
Family history of substance abuse			
	Alcohol	❑1	❑3
	Illegal drugs	❑2	❑3
	Prescription drugs	❑4	❑4
Personal history of substance abuse			
	Alcohol	❑3	❑3
	Illegal drugs	❑4	❑4
	Prescription drugs	❑5	❑5
Age between 16-45 years		❑1	❑1
History of preadolescent sexual abuse		❑3	❑0
Psychological disease			
	ADHD, OCD, bipolar, schizophrenia	❑2	❑2
	Depression	❑1	❑1

SCORING
0-3 Low Risk
4-7 Moderate Risk
>8 High Risk

Webster LR, Webster RM. Pain Med. 2005 Nov-Dec;6(6):432-42.

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Opioid Misuse Risk Stratification

How should it be used?

Level of concern that should be communicated to the patient

- "Despite being in recovery from alcoholism, you are at higher risk for developing problems with the opioid pain medication."

Level of monitoring that should be implemented

- Frequency of visits, urine drug testing, etc.
- High risk patients may need to agree to random call-backs

Need for pain and/or addiction consultant

- If available

Some patients may be too risky for opioids analgesics

- e.g., patient with recent opioid addiction

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Prescription Drug Monitoring Programs

Clinical tool that supports safe prescribing and dispensing

May help prevent or stop harm from drug diversion, misuse and abuse

Specifics vary from state to state

Can provide:

- Patient's prescription history for Schedule II–V
- Solicited reports online; real time or delay of days to weeks
- Unsolicited reports on patients with "questionable activity"

Perrone J, Nelson LS. N Engl J Med 2012; 366:25:2341-2343.

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Summary Points

Opioids:

- can be beneficial for some
- side effects are common but can be managed
- can be harmful for some
- carry significant risk including overdose and addiction
- misuse risk can be assessed using systematic approach which includes validated risk assessment questionnaires

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Initiating Opioid Therapy Safely

Learning Objectives

- Describe **universal precautions** and their role in chronic opioid therapy
- Describe **monitoring and documentation** strategies for chronic opioid therapy
- Describe **initiating** opioid therapy
- Apply **counseling and communication** strategies to ensure appropriate and safe use of opioid medications

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Universal Precautions in Pain Medicine

Part of a Controlled Substance Policy for your Office

- Opioid misuse risk prediction is imprecise
  - Protects all patients
  - Protects the public and community health
- Consistent application of precautions
  - Takes pressure off provider during time of stress
  - Reduces stigmatization of individual patients
  - Standardizes system of care
- Resonant with expert guidelines
  - American Pain Society/American Academy of Pain Medicine
  - American Society of Interventional Pain Physicians
  - Canadian National Pain Centre

Gourlay DL, Heit HA, Almahrezi A. Pain Med. 2005 Mar-Apr;6(2):107-12.

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Common Universal Precautions

- Comprehensive pain assessment including opioid misuse risk assessment
- Formulation of pain diagnosis/es
- Opioid prescriptions should be considered a test or trial; continued based on assessment and reassessment of risks and benefits
- Patient Prescriber Agreements (PPA) with informed consent and plan of care
- Regular face-to-face visits
- Monitoring for adherence, misuse, and diversion
  - Urine drug testing
  - Pill counts
  - Prescription drug monitoring program data (when available)
- Clear documentation

Federation of State Medical Boards Guidelines 2004, www.fsmb.org
Gourlay DL, Heit HA, Almahrezi A. Pain Med. 2005 Mar-Apr;6(2):107-12.
Chou R, et al. J Pain. 2009;10(2):147-159.

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Patient Prescriber Agreements (PPA)

Two Components

Informed Consent	Plan of Care
▪ Educational re: potential risks ▪ Establishes targeted benefits or goals of care	▪ Documents mutual understanding of clinical care plan ▪ Takes pressure off providers to make individual decisions ▪ Articulates monitoring procedures and responses to unexpected findings

- Efficacy not well established
- No standard or validated form
- Printed copy, signed by both patient and prescriber, given to the patient may serve as a **Patient Counseling Document**

Cheatle MD, Savage SR. Informed Consent: A Potential Obligation, J P&SM 2012. 44(1):105-116.

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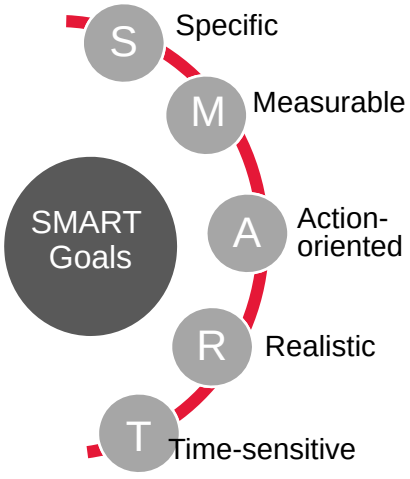
PPA Informed Consent

Common Components - Benefits

Targeted benefits/ goals of opioids:

- Reduce pain, not eliminate
- Increased function (individualized and SMART goals)



Nicolaidis C. Pain Med 2011;12(6):890-897.
Cheatle MD, Savage SR. J Pain Symptom Manage. 2012 Jul;44(1):105-16

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PPA Informed Consent

Common Components - Risk

Risks of opioids

- Side effects (short and long term) – call provider
- Physical dependence, tolerance
- Drug interactions/over-sedation
- Potential for impairment e.g., risk of falls, working with heavy machinery and driving
- Abuse, addiction, overdose with misuse
- Pregnancy and risk of Neonatal Abstinence Syndrome
- Possible hyperalgesia (increased pain)
- Victimization by others seeking opioids

Paterick TJ, et al. Mayo Clin Proc. 2008 Mar;83(3):313-9
Cheatle MD, Savage SR. J Pain Symptom Manage. 2012 Jul;44(1):105-16

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PPA Plan of Care

Common Components

- Engagement in other recommended pain care and other treatment activities
- Follow up visit and appointment policies
- Monitoring polices - urine drug testing and pill counts
- Permission to communicate with key others – providers, family members
- No illegal drug use, avoid sedative use
- Notifying provider of all other medications and drugs including OTC and herbal preparations

Fishman SM, Kreis PG. Clin J Pain. 2002 Jul-Aug;18(4 Suppl):S70-5.
Arnold RM, Han PK, Seltzer D. Am J Med. 2006 Apr;119(4):292-6.

52

PPA Plan of Care

Common Components

Medication Management

- One prescriber, one pharmacy
- Use as directed (dose, schedule, guidance on missed doses)
  - No adulteration of pills or patches
  - ER/LA opioid analgesic tablets must be swallowed whole
- Don't abruptly discontinue opioids
- Refill, renewal policies
- Safe storage (away from family, visitors, pets), protected from theft
- Safe disposal (read product specific information for guidance)
- No diversion, sharing or selling (illegal and can cause death in others)

Fishman SM, Kreis PG. Clin J Pain. 2002 Jul-Aug;18(4 Suppl):S70-5.
Arnold RM, Han PK, Seltzer D. Am J Med. 2006 Apr;119(4):292-6.

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Use a Health-Oriented, Risk-Benefit Framework

Judge the opioid treatment – not the patient

NOT…

- Is the patient good or bad?
- Does the patient deserve opioids?
- Should this patient be punished or rewarded?
- Should I trust the patient?

RATHER…

Do the benefits of opioid treatment outweigh the untoward effects and risks for this patient (or society)?

Nicolaidis C. Pain Med. 2011 Jun;12(6):890-7.

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Monitoring Strategies

Office Visits

Opioid Risk Review

- How is patient actually using prescribed opioids?
  - Take 24-hour inventory
- Review emotional, psychiatric and social issues
- Health care use patterns
- Objective information
  - Observe for signs medication or substance misuse
  - Check PDMP (if available)
  - Urine drug tests
  - Pill counts
- Revise treatment as indicated

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Office Visits

Pain Management Review

- Assess progress towards goals
  - Function
  - Pain
- Review engagement in self care
  - Exercise, stress reduction, use of modalities (e.g., cold, heat, stretch)
  - Recovery activities if indicated
- Review non-opioid pain treatment
  - Behavioral counseling
  - Physical therapy
  - Interventionalist treatment

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Monitoring: Urine Drug Tests

- Objective information that can provide
  - Evidence of therapeutic adherence
  - Evidence of use or non-use of illicit drugs
- Subjective reports may not be accurate if patient is:
  - Challenged by substance use or mental health disorders
  - Or is purposely diverting
- Natural medical discussion if framed as a personal and public health issue
- Random, scheduled and/or when concerns arise

Heit HA and Gourlay DL. J Pain Symptom Manage 2004;27:260-267
Christo PJ et al. Pain Physician 2011;14:123-143

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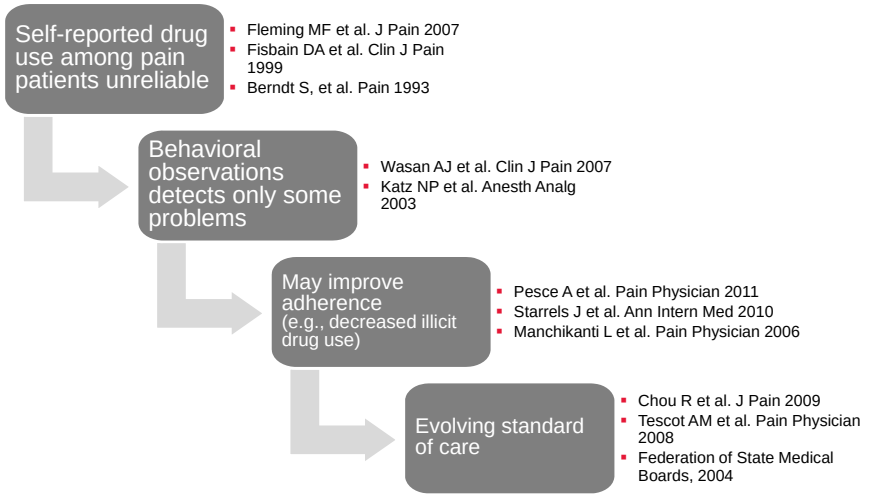
Why Drug Test?



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Urine Drug Testing

- Urine drug **screens** are usually immunoassays
  - Can be done at point of care or in a lab
  - Quick and relatively inexpensive
  - Need to know what is included in testing panel
  - Risk of false negatives due to cut offs
  - Risk of false positives due to cross reactions
  - All unexpected findings should be sent for confirmation by GC/MS

Reisfield GM et al. Bioanalysis 2009;1(5):937-952.

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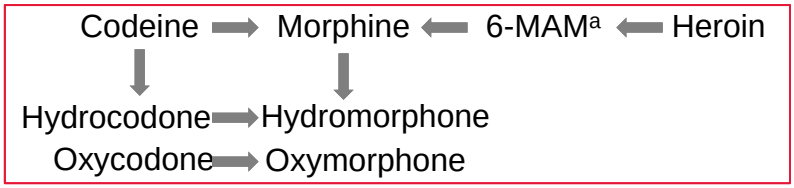
Urine Drug Testing

- Gas Chromatography/Mass Spectroscopy **confirmation**
  - Identifies specific molecules
  - Sensitive and specific
  - More expensive
  - Must be aware of opioid metabolism to interpret



Not comprehensive pathways, but ,may explain the presence of apparently unprescribed drugs
6-MAM: 6-monoacetylmorphine; an intermediate metabolite

Peppin JF et al. Pain Medicine 2012;13:886-896
Heit HA, Gourlay DL. J Pain Symptom Manage. 2004 Mar;27(3):260-7.
Heit HA, Gourlay DL, Caplan YH. Urine Drug Testing in Clinical Practice; Pharmacom Group Inc., May 2010.

Urine Drug Testing

Caveats

- One medical data point to integrate with others
- Cannot discriminate elective use, addictive use and diversion
- Small risk for mislabeling, adulteration, other error
- Consult toxicologist/clinical pathologist before acting if patient disputes findings
- Dedicated deceivers can beat the system

Heit HA, Gourlay DL, Caplan YH. Urine Drug Testing in Clinical Practice; Pharmcom Group Inc., May 2010.

Monitoring: Pill Counts

- Intended to:
  - Confirm medication adherence
  - Minimize diversion

Strategy	
	28 day supply (rather than 30 days)
	Prescribe so that patient should have residual medication at appointments
	Ask patient to bring in medications at each visit
	For identified risks or concerns, can request random call-backs for immediate counts

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Discussing Monitoring with Patients

Discussing Monitoring

- Review the personal and public health (community health) risks of opioid medications
- Note medical responsibility to look for early signs of harm
- Discuss agreements, pill counts, drug tests, etc. as ways that you are helping to protect patient from getting harmed by medications
- Use consistent approach, but set *level* of monitoring to match risk

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Patients with Past Addiction History

- Frame addiction as a challenging health issue
- Express admiration for her recovery
- Acknowledge patient's desire to "never go there" again
- Encourage active recovery engagement
- Discuss higher risk
- Partner with patient to reduce risk

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Patients with Past Addiction History

Tighten Structure of Care as Indicated

- Setting of care (care coordination and expertise)
- Supports for substance/mental health recovery
- Selection of treatments (less rewarding)
- Supply of medications
- Supervision intensity (frequency of visits, UDT, pill counts, other monitoring and support)

Savage SR, Kirsch KL, Passik SD. Addict Sci Clin Pract. 2008 June; 4(2): 4–25

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Office Systems

Optimize Office Systems

Save Time and Stress

Develop and implement

- Office controlled substance policies, reflected in Patient Prescriber Agreement
- Management flow sheet
- Lists of referral and support resources (pain, mental health, addiction)

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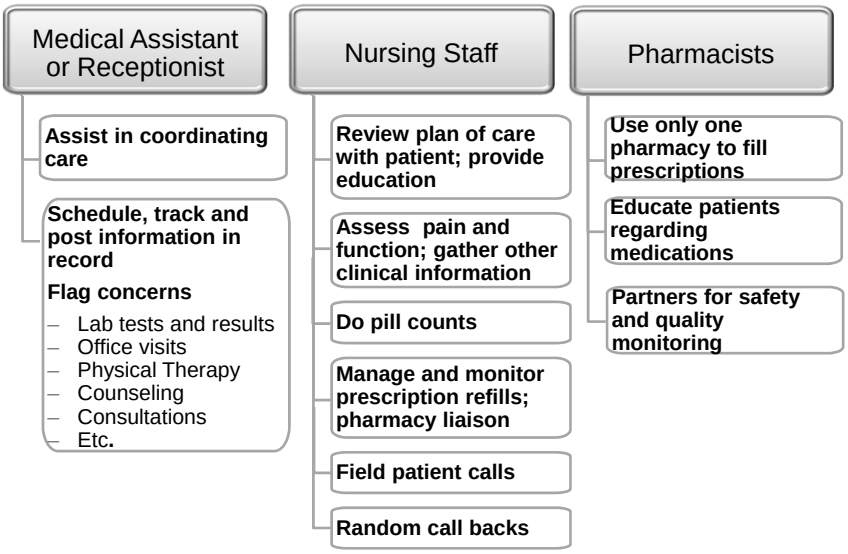
Optimize Office Systems

Save Time and Stress



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Video #1

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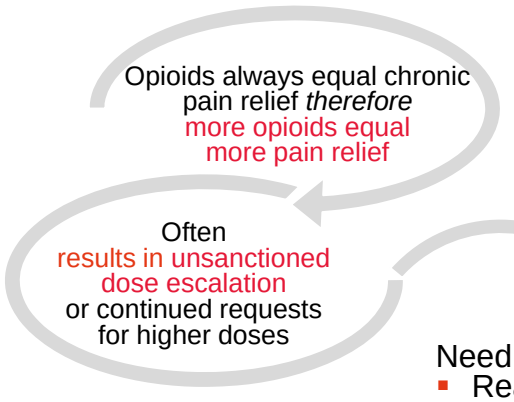
Managing Expectations

Opioids and Unrealistic Expectations

Patients often have unrealistic expectations that…



Need to re-educate:
- Realistic goals
- Potential severe risks and harm with opioids

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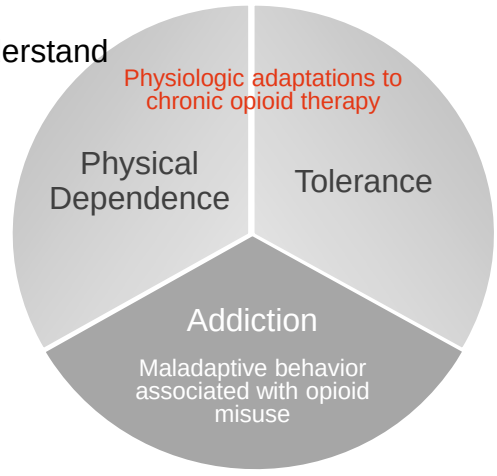
Opioids and Misunderstandings

- Family members (and patients) often misunderstand the differences
- Need to re-educate



Savage SR et al. J Pain Symptom Manage. 2003;26:655-667.

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Monitoring for Misuse

Monitoring for Opioid Misuse

- Patient questionnaire
  - Current Opioid Misuse Measure (COMM)
- Other strategies
  - Pill counts (scheduled vs random)
  - Urine drug tests (scheduled vs random)
  - Prescription drug monitoring program data
- History from “reliable” family members
  - Beware of family members with secondary gain for giving inaccurate information

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Current Opioid Misuse Measure (COMM)

Assessing Opioid Misuse Risk

- 17 items
- Takes ~10 minutes to complete
  - Throw in 2-3 representative questions here
- Helps for deciding level of monitoring
- Score range: 0 – 68
- Scores ≥9 detect probable opioid misuse with sensitivity of 77% and specificity of 66%

Key Elements:

- Over-sedation
- Consequences of overuse
- Multiple prescribers
- Medication misuse
- Active mental health issues
- Compulsive use
- Obtaining meds from someone else
- Loss of control

Butler SF, Budman SH, Fernandez KC, et al. Pain. 2007;130:144-156.

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Aberrant Medication-Taking Behaviors

Differential Diagnosis

Pain Relief Seeking

- Disease progression
- Poorly opioid responsive pain
- Withdrawal mediated pain
- Opioid analgesic tolerance
- Opioid-induced hyperalgesia

Pain Relief and Drug Seeking

(e.g. pain with co-morbid addiction, patient taking some for pain and diverting some for income)

Drug Seeking

- Addiction
- Other psychiatric diagnosis
- Criminal intent (diversion)

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Aberrant Medication-Taking Behavior

Drug Seeking

Drug Seeking

Differential Diagnosis

Addiction

Psychiatric Diagnosis

- Organic mental syndrome
- Personality disorder
- Chemical coping
- Depression/ anxiety/situational stressors
- Psychosocial or emotional issues

Diversion

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Drug Seeking

Addiction

Clinical syndrome presenting as…

- ☐ Loss of Control
- ☐ Compulsive use
- ☐ Continued use despite harm
- ☐ Craving

} Aberrant Medication Taking Behaviors (pattern and severity)

Addiction is **NOT** the same as physical dependence

Biological adaptation with signs and symptoms of withdrawal (e.g., pain) if opioid is abruptly stopped

Savage SR, et al. J Pain Symptom Manage. 2003;26:655-667.

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Concerning Behaviors for Addiction

Spectrum: Yellow to Red Flags

- o Requests for increase opioid dose
- o Requests for specific opioid by name, "brand name only"
- o Non-adherence w/ other recommended therapies (e.g., PT)
- o Running out early (i.e., unsanctioned dose escalation)
- o Resistance to change therapy despite AE (e.g. over-sedation)
- o Deterioration in function at home and work
- o Non-adherence w/ monitoring (e.g. pill counts, urine drug tests)
- o Multiple "lost" or "stolen" opioid prescriptions
- o Illegal activities – forging scripts, selling opioid prescription

Modified from Portenoy RK. J Pain Symptom Manage. 1996 Apr;11(4):203-17.

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Other Psychiatric Diagnoses

Drug Seeking

Psychiatric Diagnosis

Chemical Coping

- Patients knowingly or unknowingly inappropriately use opioids to treat a comorbid disease such as depression or anxiety
- Usually self-medicating a mental health disorder or stress

Others

- Organic mental syndrome schizophrenia
- Personality disorder; borderline personality
- Depression/anxiety/situational stressors

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners.* 1st Edition. North Branch, MN: Sunrise Press; 2007.

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Drug Seeking

Diversion

Doctor Shoppers

Visit by an individual → with or without legitimate medical need

To several doctors → Each of whom writes a prescription for controlled substances

Followed by visiting multiple pharmacies → Sometimes paying cash

ER/LA opioids can be converted into rapid-onset (immediate release) opioids by altering the tablet or patch

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners.* 1st Edition. North Branch, MN: Sunrise Press; 2007.

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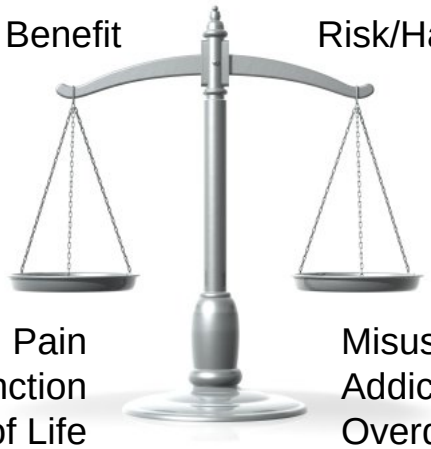
Risk Benefit Framework

For Continuing or Discontinuing Opioids



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Video # 2- Aberrant Behavior

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Polling Question

How confident are you in your ability to effectively communicate with your patients when treatment has shown no benefit?

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Lack or Loss of Benefit

- Reassess factors affecting pain
- Re-attempt to treat underlying disease and co-morbidities
- Consider escalating dose as a “test”
- Consider adding adjuvant medications for synergy
- Consider adding breakthrough medications
- Consider opioid rotation

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Continued Lack of Benefit

Remember:

- Not all pain is opioid responsive
- More opioid is not always better
- More opioid may increase risk of adverse effects

Patient may have developed opioid induced hyperalgesia and will improve off opioids

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Discussing Continued Lack of Benefit

- Stress how much you believe /empathize with patient's pain severity and impact
- Express frustration re: lack of good pill to fix it
- Focus on patient's strengths
- Encourage therapies for "coping with" pain
- Show commitment to continue caring about patient and pain, even without opioids
- Schedule close follow-ups during and after taper

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Too Much Risk

Opioid-related	Psychosocial
▪ Adverse events – Side effects; toxicity ▪ Opioid induced hyperalgesia – increased dose or opioid rotations without benefit ▪ Addiction	▪ Psychiatric instability ▪ Unsafe housing or storage ▪ Nonadherent with monitoring procedures ▪ Nonadherent with office procedures ▪ Use of other non opioid drugs of abuse ▪ Diversion or criminal behavior

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Possible Addiction

Stay in the Risk/Benefit mindset:

- Give specific and timely feedback why patient's behaviors raise your concern for possible addiction e.g., loss of control, compulsive use, continued use despite harm
- Remember patients may suffer from both chronic pain and addiction
- May need to "agree to disagree" with the patient
- Benefits no longer outweighing risks
- "I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good."
- Always offer referral to addiction treatment

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Addiction Medicine Specialist

When to Refer

When patient:

- is using illicit drugs
- is experiencing problems with other prescription drugs (benzodiazepines)
- abuses or is addicted to alcohol
- agrees they have an opioid addiction and wants help
- has dual or trio diagnosis of pain, addiction, and psychiatric disease

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Making Addiction Treatment Referrals

- Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator
- State resources (Department Public Health)
  - Acute treatment services (detoxes)
  - Medication assisted treatment
    - Methadone maintenance treatment programs
    - Office-based opioid treatment with buprenorphine or naltrexone
- AA/NA free, widely available and effective

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Possible Diversion

- Discuss why you are concerned about diversion
  - e.g., nonadherence with pill counts, Urine Drug Test negative for prescribed opioid
- Discuss your inability to prescribe when there is any chance of diversion

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Discontinuation of Opioids

- Do not have to prove addiction or diversion - only assess and reassess the risk-benefit ratio
- If patient is unable to take opioids safely or is nonadherent with monitoring then discontinuing opioids is appropriate even in setting of benefits
- Need to determine how urgent the discontinuation should be based on the severity of the risks and harms

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Always Plan for Potential "Exit Strategy"

- Emphasize criteria for tapering in initial patient-prescriber agreement
  - Documentation of lack of pain reduction and/or lack of functional improvement
  - Documentation of opioid medication or prescription misuse or abuse
  - Positive urine drug test for any illegal substance
  - Failure to comply with all aspects of treatment program
- Distinguish between abandoning opioid therapy, abandoning pain management, and abandoning patient
- Taper off opioid therapy, with or without specialty assistance

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Discontinuing Opioids

Determine Degree of Physical Dependence to Determine Withdrawal Risk

Higher intensity withdrawal from:

- Higher steady state levels
- Longer term exposure
- Faster rate of medication clearance
  - Long vs. short half life agents

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Tapering Opioids

Immediate Release Opioids

- Decide if you need a taper at all
  - Is there physical dependence?
- Decrease strength or number of tablets each week
- Build up alternative pain treatment modalities

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Opioid Exit Strategy – Possible Paths

Patient's behavior consistent with drug addiction	Patient unable or unwilling to cooperate with outpatient taper	No apparent addiction problem Patient able to cooperate with office-based taper
▪ Refer for addiction management or comanagement	▪ Provide sufficient opioid for 1-month taper ▪ Refer to inpatient or outpatient program or similar service, as available	▪ Taper gradually over 1-2 months ▪ Implement non-opioid pain management (psychosocial support, CBT, PT, non-opioid analgesics)

CBT, cognitive behavioral therapy; PT, physical therapy.

Katz N. *Patient Level Opioid Risk Management: A Supplement to the PainEDU.org Manual*. Newton, MA: Inflexxion, Inc; 2007.
Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners.* 1st Edition. North Branch, MN: Sunrise Press; 2007.

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Using Risk/Benefit Mindset to Avoid Pitfalls

Keep in the Risk/Benefit mindset when responding to:

- But I really, really need opioids.
- Don't you trust me?
- I thought we had a good relationship/ I thought you cared about me?
- If you don't give them to me, I will drink/use drugs/hurt myself
- Can you just give me enough to find a new doc?

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Video #3

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Summary Points

- Aberrant medication taking behavior can signify pain-relief or drug seeking behaviors or a combination of both
- It is important to fully assess and then respond to aberrant behaviors
- Decisions to continue or discontinue opioids should be based on reassessment of the risks and benefits of the treatment

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SCOPE OF PAIN

- www.SCOPEOFPAIN.com
- www.opioidprescribing.com

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Physician's Clinical Support System

pcss-o.org

PCSS-O Training

Prescribers' Clinical Support System for Opioid Therapies

pcssb.org

PCSS-B Training

Physicians' Clinical Support System – Buprenorphine

Questions? Comments?
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