UNC-CH School of Social Work/Wake AHEC Clinical Lecture Series
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Pain Medicine, Addiction, and Evolving Standards of Care

Assessing and treating chronic pain in clients at risk for substance use disorders

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Disclosures

- Pfizer Speakers' Bureau by virtue of Chronic Pain Initiative lecturer

Objectives

- Review of the clinical and regulatory climate that sets the stage for current pain medicine practice
- Briefly discuss pain disorder classification and relevant physiology
- Outline the elements of an adequate approach to risk stratification prior to prescribing opioids (i.e. estimate risks) and therapeutic agreement (i.e. reduce risks)
- Outline tailoring an opioid program based on individual's level of risk (including individuals with addiction, cognitive impairment, and past aberrant behaviors)
- Discuss the 4 A's of pain medicine
- Define the range of aberrant medication behaviors, and outline steps to intervene that are tailored to the particular behavior
- Use case examples to apply these clinical skills.

FDA Goal
"Strike the Right Balance"

"We at the Food and Drug Administration (FDA) have been engaging physicians, pharmacy groups, patients, and other stakeholders in an ongoing effort to ***strike the right balance*** *between two important goals: on the one hand, providing access to pain medications for those who need them, and on the other hand, managing the variety of risks posed by analgesic drugs."*

Janet Woodcock, M.D.
Director, Center for Drug Evaluation and Research
A Difficult Balance – Pain Management, Drug Safety, and the FDA.
N Engl J Med. 2009 Nov 26;361(22):2105-7

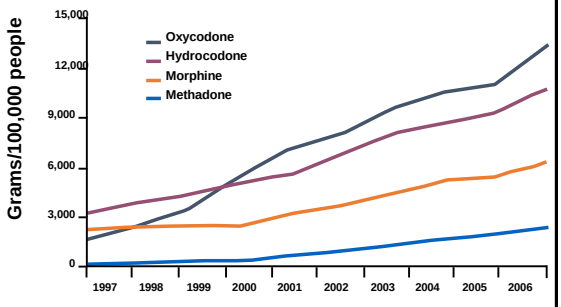
Prescription Medication Abuse: An Epidemic with Many Potential Causes

- *Some* inappropriate prescribing of controlled medications and *much* prescribing done without adequate screening or monitoring
- Dramatically *increased rates of prescribing* opioid analgesics
  - Expansion into chronic non-malignant pain
  - Past criticism of prescribers as "opioid-phobic"
  - Regulatory changes (e.g. Pain as the "5th vital sign")
  - Aggressive marketing by pharmaceuticals
- *Public expectations* regarding treatment
  - Preference for "pill to get rid of pain" vs pain management
  - Perception that pain treatment=opioid treatment
  - Preference for quick fix rather than behavioral or situational change
  - Experience with complete resolution of acute pain syndromes

1990's Regulatory and Ethical Climate

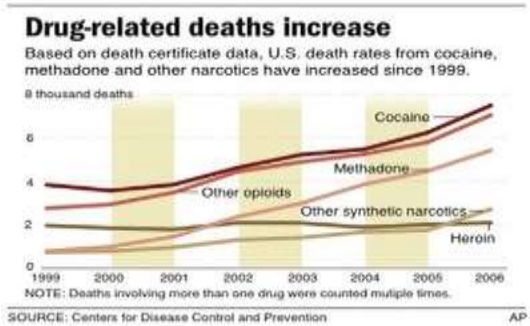
- Renewed adherence to old definition of pain
  - "Pain is what the person says it is and exists whenever he or she says it does" [Margo McCaffrey, 1968].
- JCAHO Standards for Pain Management
  - RI.1.2.8: "Patients have the right to appropriate assessment and management of pain.
- **FSMB** *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain, April 1998*
  - Endorsed by the American Academy of Pain Medicine, the Drug Enforcement Administration, the American Pain Society, and the National Association of State Controlled Substances Authorities
  - "There is a significant body of evidence suggesting that **both acute and chronic pain continue to be undertreated**….The under treatment of pain is recognized as a serious public health problem that results in a decrease in patients' functional status and quality of life"
  - "Appropriate pain management is the **treating physician's responsibility**. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations"

US Therapeutic Opioid Use

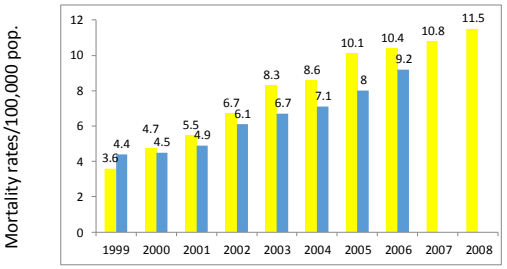


Manchikanti L, Singh A. *Pain Physician.* 2008;11(2 Suppl):S63-S88.

In 16 states, drug deaths overtake traffic fatalities (USA Today, 9/30/2009)



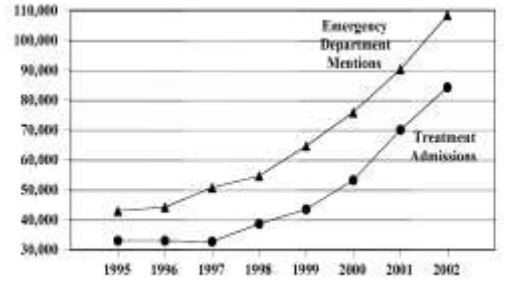
Fatal Unintentional Overdose Mortality Rates: NC (yellow) and US (blue), 1999-2008



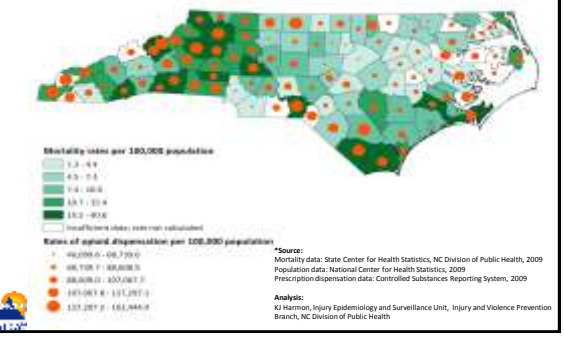
Source: Mortality data - US 1999-2005 – WI S Q ARS, obtained 9/1/08. NC rates, NC State Center for Health Statistics, 2006-2007, obtained 8/17/2008

Emergency department mentions and admissions to addiction treatment related to prescription opioids

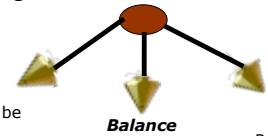
Source: CDC, National Vital Statistics System, 2006



Mortality Rates of Unintentional and Undetermined Opioid Overdoses and Dispensation Rates of Opioid Analgesics*: North Carolina Residents, 2009



Pushing Back the Pendulum?



Avoidance

Will not prescribe opioids:

- Fear of regulatory action
- Antiquated views of addiction
- Exaggerated perception of risk

Balance

Rational pharmacology: application of basic principles of medicine:

- Therapy tailored to risk stratification
- Tx adapted based on monitoring and outcome

Widespread Misuse

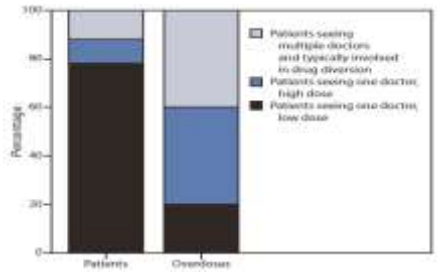
Prescribing without attention to dangers:

- Inadequate monitoring
- Excessive dosing
- Failure to respond to abuse

Regulatory Shifts

- FSMB currently revising its Model Guidelines
- Washington State Agency Medical Directors' Group Guidelines
  - "intended as a resource for primary care providers treating patients with chronic noncancer pain"
  - The total daily dose of opioids should not be increased above 120mg oral MED without either the patient demonstrating improvement in function and pain or first obtaining a consultation from a practitioner qualified in chronic pain management.

Overdose Risk Related to Dose and Number of Prescribers



- Low dose is defined as <100 morphine equivalent dose per day.
- Most patients (80%) are on low dose, prescribed by one doctor.
- **80% of overdoses are patients on high dose:** half one doctor, half multiple doctors.

(CDC: Morbidity and Mortality Weekly Report: Jan. 13, 2012)

NC Medical Board Policy on Chronic Pain Management

- **Current NCMB policy statement (2004):**
  http://www.ncmedboard.org/position_statements
- Revision pending: Federation of State Medical Boards 2013

Anticipated changes:

- discouragement of use as first line tx. and high risk dosing
- encouragement of "therapeutic trial" approach
- emphasis on demonstrated functional improvement
- more attention to risk assessment, monitoring, and use of referral
- routine use of prescription monitoring programs (CSRS)
- expected interventions for identified abuse, including use of addiction treatment referrals

Opioid Efficacy in Chronic Pain

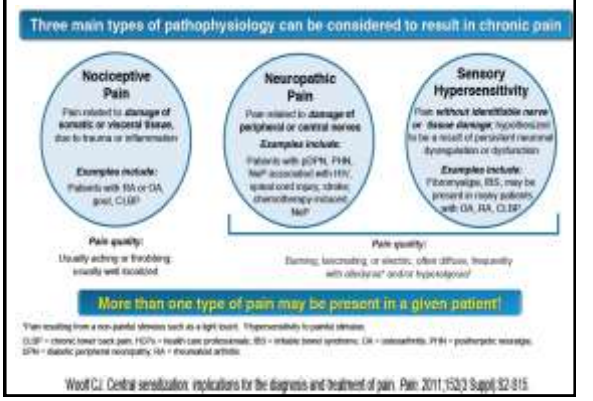
- Most literature surveys & uncontrolled case series
- RCTs are short duration <4 months with small sample sizes <300 pts
- Mostly pharmaceutical company sponsored
- Pain relief modest
  - Some statistically significant, others trend towards benefit
  - One meta-analysis decrease of 14 points on 100 point scale
- Limited or no functional improvement demonstrated

Balantyne JC, Mao J. NEJM 2003

Know Your Role

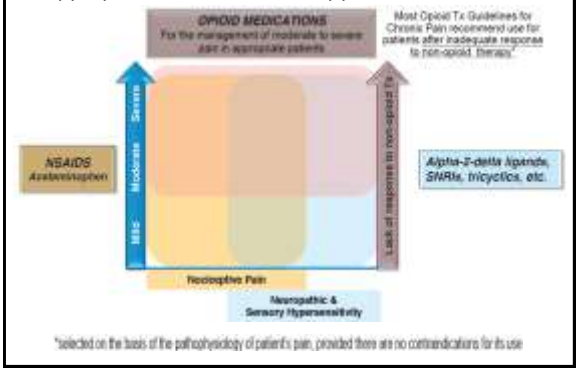
- Pain provider (may be PCP)
  - Accepts responsibility for treating pain
- Consultant
  - Makes recommendations
- Surgeon or Emergency provider treating acute pain syndrome
  - May wish to collaborate with or inform pain provider
- Inpatient team addressing unrelated condition
  - Responsible for addressing pain issues (per JCAHO)
  - Usually continue outpatient plan and meds for chronic pain
    - Med regimen can be verified with pharmacy, provider, or NCCSRS
  - Not recommended to start new controlled meds unless verified that an outside provider will continue treatment
  - Avoid prescribing usual meds since patient should have supply from outside provider

Know Basic Pain Pathophysiology



Woolf CJ. Central sensitization: implications for the diagnosis and treatment of pain. Pain. 2011;152(3 Suppl):S2-15.

Assessment of Pain Pathophysiology Can Help Guide Appropriate Medication Therapy

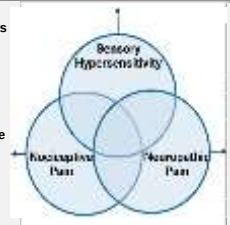


*selected on the basis of the pathophysiology of patient's pain, provided there are no contraindications for its use

Patients with Chronic Pain Often Present with More Than One Type of Pathophysiology

• Fibromyalgia • Irritable Bowel Syndrome • Functional Dyspepsia • Interstitial Cystitis • Neck & Back Pain (without structural pathology) • Myofascial Pain (TMJ) • Pelvic Pain Syndrome • Restless Leg Syndrome • Headaches • Complex Regional Pain Syndrome

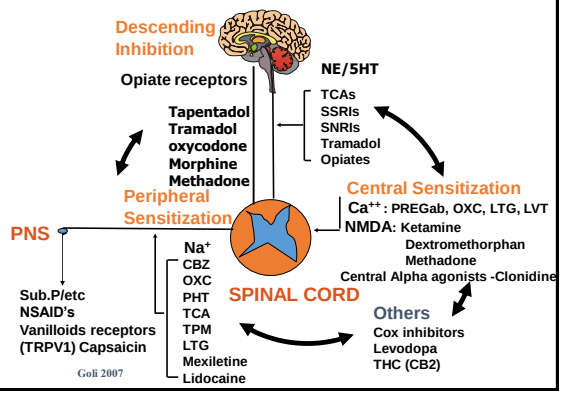
- Osteoarthritis
- Rheumatoid Arthritis
- Tendonitis, Bursitis
- Ankylosing Spondilitis
- Gout
- Inflammatory Myositis
- Sjogren's Syndrome
- Cushing's Disease
- Tumor-related nociceptive pain
- Neck & Back Pain *with* structural pathology
- Sickle-cell Disease
- Inflammatory Bowel Disease



- Postherpetic neuralgia
- Diabetic Peripheral Neuropathy
- Sciatica / Stenosis
- Entrapment Syndromes
- Spinal Cord Injury Pain
- Tumor-related neuropathy
- Chemotherapy-induced neuropathy
- Small fiber neuropathy
- Post-Stroke Pain
- MS Pain
- Persistent Postoperative Pain

Woolf CJ. Central sensitization: implications for the diagnosis and treatment of pain. Pain. 2011;152(3 Suppl):S2-S15.; Dworkin 2011

Mechanistic Approach to Treatment



Know about Universal Precautions?

1	Diagnosis With Appropriate Differential
2	Psychological Assessment, Including Risk of Addictive Disorders
3	Informed Consent
4	Treatment Agreement
5	Pre- and Post-Intervention Assessment of Pain Level and Function
6	Appropriate Trial of Opioid Therapy With/Without Adjunctive Medication
7	Reassessment of Pain Score and Level of Function
8	Regularly Assess the "4 A's" of Pain Medicine
9	Periodically Review Pain Diagnosis and Comorbid Conditions, Including Addictive Disorders
10	Documentation

Gourlay DL, et al. *Pain Med.* 2005;6(2):107-112.

Standard: Perform a Risk Assessment to Identify Patients at Increased Risk

- Adequate history and physical exam
- Standardized Instruments: Opioid Risk Tool (ORT)
- Release of Information and contact prior or current providers
- Prescription Monitoring or Controlled Substances Reporting Systems

Another Approach to Risk Stratification - *Stay in Your Comfort Zone*

Characteristic	Low Risk	Moderate Risk	High Risk
Substance abuse	Never	Past	Current
Smoking (nicotine)	Never	Past	Current
Family hx of addiction	None	Significant	Significant
Psychosocial factors	No major dx; minor dx treated or stable	Past major dx; current issues w/ minor dx	Current major dx untreated or unstable
Age	Older	N/A	Younger
History of sexual abuse	No	N/A	Yes
Controlled Rx lost or stolen	No	N/A	Yes
Unauthorized substances in urine drug screens	Consistently negative	Initially positive	Consistently positive
Recommendations based on risk stratification			
Healthcare setting	**Primary care**	**Primary care with specialist support**	**Specialty pain management**

Gourlay DL, et al. *Pain Med.* 2005;6(2):107-112; Weaver MF, Schnoll SH. *Adv Pain Manage.* 2008;2(2):68-75.

Risk *Stratification* Prior to Prescribing Opioids for Chronic Pain (A standard of care)

	Low Risk	Medium Risk	High Risk
Etiology of Pain	Clear/Identified		Vague / Non-specific
Substance Abuse	Negative family or personal hx.	Past history but stable recovery	Active abuse or addiction
Psychiatric History	None	Few/stable	Multiple/unstable
Environment	Stable/Supportive Resources		Unstable/ Few resources
Activity Engagement	Employed/Active/ Engaged in tx.		Unemployed/ Inactive/Med only

Screening Tools for Opioid Misuse Risk

- CAGE Adapted to Include Drugs (CAGE-AID)
- Opioid Risk Tool (ORT)
- Pain Medication Questionnaire (PMQ)
- Screener and Opioid Assessment for Patients with Pain (SOAPP)

Opioid Risk Tool (ORT)

Webster LR, Webster RM. Pain Med. 2005.

	Female	Male
1. Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Prescription drugs	4	4
2. Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
3. Age (between 16 to 45 yrs)	1	1
4. History of preadolescent sexual abuse	3	0
5. Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1

Total: 0-3=low risk, 4-7=moderate risk, 8+ =high risk

Therapeutic Agreement Tailored to Individual Patient ("Modified Universal Precautions")

- Agree upon realistic treatment goals, particularly regarding function
- Determine which nonopioid meds and nonpharmacologic interventions you expect from your patient
  - Determine whether participation in addiction treatment or mental health treatment is expected
- Determine which opioids you are willing to prescribe in light of relative risk
  - Long acting (including once daily) vs. short acting
  - Transdermal vs. oral, tamper-resistant?
  - Full or partial agonist
- Agree upon whether patient will be in charge of own medications

DM

Therapeutic Agreement Tailored to Individual Patient ("Modified Universal Precautions") cont.

- Consider how often patient is expected to be seen and how frequently prescriptions must be obtained
- Consider how often monitoring should be implemented (e.g. drug screens, pill counts, check of controlled substance reporting system) in light of risk factors specific to *patient* and to *treatment plan.*
- Identify a source of collateral information, sign release
- Opioid Treatment Agreement

DM

Short- vs. Long-Acting Opioids

Short-Acting Opioids	Long-Acting Opioids
• Codeine (Tylenol #3, #4) • Hydrocodone (Vicodin, Lortab, Norco, etc.) • Hydromorphone (Dilaudid) • Morphine (MSIR, Roxanol) • Oxycodone IR (Percocet, Percodan, Roxicodone) • Oxymorphone (Opana) • Fentanyl (Actiq)	• Fentanyl (transdermal) • Levorphanol • Methadone • Morphine (MS Contin, Kadian, Avinza) • Oxycodone (Oxycontin) • Oxymorphone (Opana ER)

- ❑ Acute pain syndrome
- ❑ Incident pain
- ❑ Breakthrough pain
- ❑ To permit activity (e.g., PT; travel)

- ❑ Persistent moderate to severe pain
- ❑ Mainstay of chronic pain treatment
- ❑ "Pharmaceutically" long-acting opioids can be tampered with

Cherny NI. *Drugs*. 1996;51:714-37.
Goodman & Gilman's: The Pharmacological Basis of Therapeutics. 10th ed. 2001.

Von Korff M, Saunders K, Ray GT, et al. *Clin J Pain*. 2008;24(6):521-527.

Availability and Consequences of IR Opioid Abuse and Misuse

- IR non-medical use estimated to be 10 times greater than ER*
  - Quick time to Cmax = euphoria
  - Dispensed prescriptions IR 15 times greater than ER**
  - Dispensed tablets and capsules IR 13 times greater than ER**
- IR historically higher street value***

*Derived from SAMHSA Issue 22, 2006.
**IMS Health, National Prescription Audit, 2009.
***Savage SR. J Pain Symp Management. 1996;11(5):274-86

Opioid Treatment Agreements (Written) (becoming standard of care)

- Statement of risks of meds as well as potential benefits
- *Trial* of Medication: pain management and functional improvement
- Need for adequate monitoring: effectiveness and safety
- Education regarding storage and disposal
- Only one doctor/clinician prescribes controlled med/s
- Taken as prescribed unless prior discussion with doctor/clinician
- States clear policy on refills (none/limited)
- Patient agrees to consultation/counseling as needed
- Patient agrees to not use illegal drugs
- Patient agrees to urine drug testing and/or pill counts
- Patient agrees to open communication (family, clinicians)
- Understands CSRS will be monitored

Case Examples: Initial Treatment Plans

TR:

- 29 yo man with chronic rectal pain due to Stage 3B CA, depression, and Rx opioid dependence allegedly in sustained full remission
- Admitted to hospital for stupor related to OD of meds
- Regimen included MSIR 15 mg po qid, lyrica 100 mg po tid, and prozac 20 mg po qd.
- Plan devised for him to convert to once daily morphine to be administered by mother.
- ROI signed.
- Followup was arranged with substance abuse counselor and psychiatrist.

Case Examples: Initial Treatment Plans

JM:

- 51yo woman with h/o chronic daily headaches, fibromyalgia, rheumatoid arthritis with undifferentiated connective tissue disease, and depression
- Referred for consultation collectively by outpatient psychiatrist and neurologist.
- She's had treatment refractory common migraines and ultimately ended up on extensive short-acting opioid regimen of dilaudid 4 mg IM prn headache (45 a month) after failing other interventions.
- Collateral from husband confirms she is much more functional when she takes dilaudid IM and she has demonstrated no aberrant behaviors or any history of illicit or Rx drug misuse.
- Recommendations = Agree with current management, sign OTA (including secure storage) and ROI to talk with husband anytime, frequent UDS and check of CSRS.

Continuing the Treatment Plan Standard of Care: Regular Monitoring and Adapting Treatment as Needed

Regular assessment of the **4 A's**:

- **A**nalgesia
- **A**ctivity/function
- **A**dverse effects
- **A**berrant behaviors

- Best if identified and reinforced at *start* of treatment
- Use patient report *and* ancillary information to monitor and adapt treatment as needed.

Four A's: Passik SD, Weinreb HJ. Adv Ther. 2000.

CPI Tool Kit: Chronic Pain Management Progress Note


Chronic Pain Management Progress Note

Patient Name:_____ Date of Visit:_____
DOB:_____ Chart Number:_____

ANALGESIA

Scale of 0-10 (0 = no pain, 10 = worst pain imaginable) rank:

1. What was your pain level on average during the past week?
2. What was your pain level at its worst during the past week? _____
3. Compare your average pain during the past week with the average pain you had before you were treated with your current pain relievers. What percentage of your pain has been relieved?
4. Is the amount of pain relief you are now obtaining from your current pain relievers enough to make a real difference in your life?
Yes_____ No_____

ACTIVITIES OF DAILY LIVING

Physician observation comparing usual functioning during the past month with usual functioning before being treated with current pain relievers:

B = Better S = Same W = Worse

Physical functioning: _____
Family relationships: _____
Social relationships: _____
Sleep patterns: _____

ADVERSE EVENTS

Is patient able to tolerate current pain relievers?
Yes_____ No_____

Is patient experiencing any side effects from current pain relievers? (i.e. constipation, itching, mental clouding, other):
Yes_____ No_____

Detail:

POTENTIALLY ABERRANT DRUG-RELATED BEHAVIOR

Using Rx(s)?	Yes	No
Using illicit drugs?	Yes	No
Requests frequent early refill-rxs	Yes	No
Increased dose without authorization	Yes	No
Reports lost or stolen prescriptions	Yes	No
Attempts to obtain prescriptions from other doctors	Yes	No
Changes route of administration	Yes	No

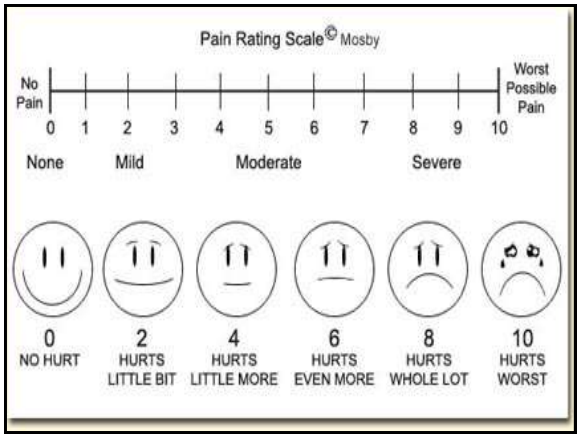
CPI Toolkits Chronic Pain Management Progress Note continued

- Available online: http://www.communitycarenc.com/patient-management-tools/conditions/chronic-pain

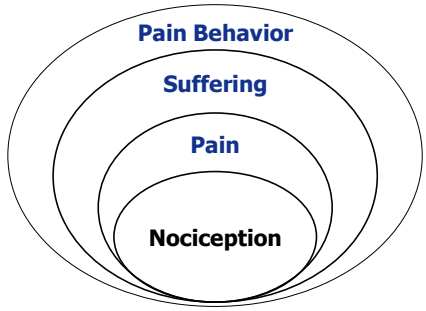
Analgesia

Numerical Pain Scale (NPS) Score

- Can use self-report form (e.g. Brief Pain Inventory) or elicit information in interview
- "Best" including under what conditions and how much of the time or how reliably can this be achieved
- "Worst" including under what conditions and how often this occurs and for how long
- "Typical" or "average" or "usual day to day routine"
- Some patients prefer to think in terms of how many "good days" vs. "average days" vs. "bad days", and this can incorporate functional status



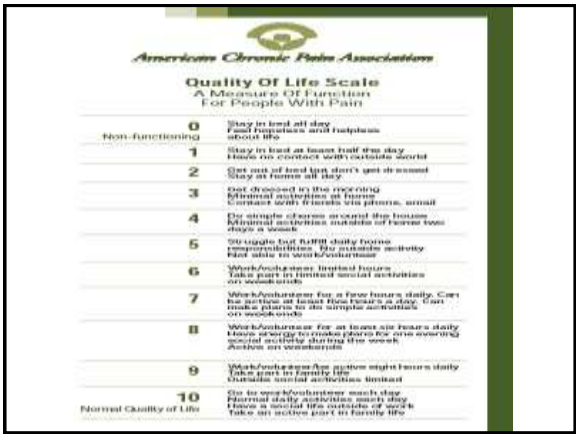
Multidimensional Model of Pain



Loeser JD. In: *Bonica's Management of Pain.* Philadelphia; Lippincott Williams & Wilkins: 2001.

Activites (Functional Status, Quality of Life)

- Can use self-report scale or elicit information in interview
- Tie this back to treatment goals
- Best to individualize this to each patient
  - How many aisles at Walmart can you walk down before you have to quit shopping? How long can you ride in the car without stopping? How much time are you spending in bed each day? How many days a week do you stay in your pajamas?
- Make sure to distinguish functional impairment related to pain from that from depression, impaired ROM, etc.



Assessment of Improvement/Benefit

PEG (Pain, Enjoyment, General Activity) Scale: 0-10

1. What number best describes your pain on average in the past week?
   (No pain-Pain as bad as you can imagine)
2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?
   (Does not interfere-Completely interferes)
3. What number best describes how, during the past week, pain has interfered with your general activity?
   (Does not interfere-Completely interferes)

Krebs EE, et al. J Gen Intern Med. 2009

Adverse Events/Effects of Opioids

- Respiratory depression and sedation
  - Tolerance develops quickly
  - Synergistic with benzos and other CNS depressants
  - More of an issue in respiratory disorders like COPD
  - Can treat with stimulants in some cases (e.g. cancer)
- Constipation
  - Tolerance does not develop
  - Frequently must be treated with stool softeners, stimulant laxatives
- Pruritis (degranulation of mast cells – not allergy)
  - Treat with antihistamines
- Hypogonadism
  - Check and replete testosterone

Risks of Opioid Prescription ("Aberrant Behaviors")

- Misuse/abuse by patient
  - "Chemical coping", particularly with short-acting opioids
  - Addiction (including "fake patient") , rate overall low
  - Look for negative urine drug screen, fluctuating levels, nonprescribed drugs in urine (must know metabolites)
- Unintentional overdose by patient
  - Concomitant sedating meds increases risk
    - Look for nonprescribed drugs in urine (must know metabolites)
- Unintentional diversion
  - Including unintentional overdose by nonpatient
- Intentional diversion
  - Professional ("fake patient")
  - Opportunistic
  - Look for negative urine drug screen or fluctuating levels

Aberrant Medication Taking Behaviors Differential Diagnosis

- Misuse
  - Confusion, poor understanding or regimen or rules
- Pseudoaddiction[1]
  - Disease progression
  - Opioid resistant pain (or pseudo-resistance)[2]
  - Opioid-induced hyperalgesia[3]
  - Opioid analgesic tolerance and escalating use[3]
- Abuse/Addiction
- Chemical coping
  - Self-medication of stress and psychiatric and physical symptoms other than pain
- Diversion
  - Opportunistic vs. professional

[1] Weissman DE, Haddox JD. 1989
[2] Evers GC. 1997
[3] Chang C et al 2007

Abuse

- Use of a medication outside the normally accepted standard for that drug.
- Recurrent problems in multiple life areas.
- Continued use in spite of negative consequences.
- Preoccupation with the drug, drug seeking behavior, loss of control of use.
- Tolerance or physical dependence may or may not be present.

Adapted from DSM IV, APA,1994

Drug Dependence or "Addiction" is…

- A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations
- A clinical syndrome presenting as…
  - Loss of Control
  - Compulsive use
  - Continued use despite harm
  - Craving

Aberrant Medication Use Behaviors

Savage SR et al. J Pain Symptom Manage 2003

Distinct from "Physical" Dependence

- Withdrawal syndrome when the drug is withdrawn acutely.
- May or may not be associated with increasing doses and increasing tolerance to the drug.
- May or may not be associated with abuse of the drug.

Problematic Behaviors that are Less Likely to Indicate Addiction

Yellow Flags

- Complaints about a need for more medication
- Drug hoarding when symptoms abate
- Requests for specific pain medications
- Openly acquiring similar medications from other providers
- Occasional unsanctioned dose escalation
- Unapproved use of the drug to treat other symptoms
- Non-adherence to other recommendations for pain therapy

Aberrant Behaviors that are More Likely to Indicate Addiction

Red Flags

- Deterioration in function at work or socially
- Illegal activities (eg, selling, forging scripts, or buying from non-medical sources)
- Injection or snorting medication
- Multiple episodes of "lost" or "stolen" scripts
- Resistance to a change therapy despite adverse effects
- Refusal to comply with random drug screens
- Concurrent abuse of alcohol of illicit drugs
- Use of multiple physicians and pharmacies

Intervening for Unintentional Misuse

- Explore the patient's concerns or difficulties.
- Simplify regimen, have family member dispense.
- Clarify/restate the therapeutic instructions and expectations on patient; may review OTA
- Explain any medication changes and give written instructions

Intervening for Pseudo-Addiction

Restate or reframe therapeutic agreement and increase surveillance/monitoring
- More frequent visits
- More tightly managed prescriptions (perhaps dispensed by caregiver)
- Urine drug screening, pill counts, NCCSRS
- Collateral info from family

- Adjust regimen, optimize
  - lower risk medication including long-acting
  - May actually increase total dosage equivalents
  - Optimize adjunctive meds and non-med treatment
- Referral/consultation
  - pain management
  - Psych or CD evaluation MAY be relevant to R/O mental health issue or addiction

Intervening for Chemical Coping

- Restate or reframe therapeutic agreement and increase surveillance/monitoring
- Use fewer or no short acting opioids
- Explore alternative strategies (medication and/or behavioral) for symptoms being self-medicated (sleep, "stress," energy)
- Refer for psychological evaluation: psychiatric or psychotherapeutic (CBT, DBT)
- Consider referral for substance abuse evaluation

Intervening When Abuse/Addiction is Suspected

- Express your behavior-specific concerns
- Ask further questions about drug use (how much, how often, increasing doses, need to supplement, symptoms of withdrawal)
- Ask about other drug or alcohol abuse
- Restate or reframe therapeutic agreement and increase surveillance/monitoring
- Include family members if available
- Look for a pattern

Intervening When Abuse/Addiction is Confirmed

Express your specific concerns in terms of the patient's well-being:

"I know that you have a problem with pain…but I believe you also have a problem with how you are using your medication. These are the things I've noticed that worry me…."

"Do you agree that this is a problem for you?"

Weigh the risks of continuing therapy with opioids or other controlled drugs.

Intervening When Abuse/Addiction is Confirmed (continued)

- Restate or reframe therapeutic agreement and increase surveillance/monitoring (if continuing on opioids)
- Require a referral for addiction evaluation and treatment
- Consider the need for inpatient treatment
- If the patient is opioid-dependent, consider a referral for substitution or agonist treatment

Intervening When the Patient is Unwilling or Unable to Comply

- Express your concern in terms of patient's well-being
- State that the particular medication is no longer safe or indicated and you will not continue to prescribe it (arrange taper or referral)
- Explore other therapeutic options
- Assess for withdrawal risk
- Refer for specialized addiction treatment

Opioid Dependence/Addiction: Treatment Alternatives

- Refer for taper or detox: outpatient (methadone or buprenorphine) or inpatient
- Increased substance abuse treatment and monitoring while tapering
- Refer for substitution therapy with methadone (opioid treatment program)
- Refer or transfer to buprenorphine/naloxone (office based)

Opioid Dependence: Treatment with Substitution Therapy

- Appropriate for illicit *or* prescription opioid abuse
- Rationale for agonist therapy:
  - Cross-tolerance: prevents withdrawal and relieves craving
  - Blocks euphoric effects of other opioids
  - Demonstrated efficacy related to recovery
  - Provides analgesia if continuing chronic pain
- Available alternatives:
  - Methadone
  - Buprenorphine
  - Buprenorphine/naloxone

Intervening with Aberrant Behaviors: Conclusions

- Intervention for aberrant medication behaviors should be tailored to the *specific* level of problem.
- When *abuse* is identified, a higher level of treatment engagement and monitoring is necessary or the medications may need to be discontinued.
- Methadone or buprenorphine/naloxone are *useful alternatives* for opioid addiction, particularly in the setting of chronic pain and/or psychiatric instability.

Exit Strategy

- Common opioid trial failure criteria include*:
  - lack of significant pain reduction
  - lack of improvement in function
  - persistent side effects
  - persistent noncompliance
- Prescription or nonprescription drug abuse does not necessarily warrant stopping opioids
  - Consider referral for substance abuse treatment
- Stopping opioids does not mean stopping treatment
- Professional diversion warrants stopping opioids and stopping treatment

*Cherny NI. *Drugs*. 1996;51:714-37.

"An initial course of treatment with opioids for chronic non-cancer pain (CNCP) should be viewed as a short-term, therapeutic trial lasting from several weeks to several months. The decision to proceed with COT should be intentional and based on careful consideration of outcomes during the trial. ***Outcomes to consider include progress toward meeting therapeutic goals, presence of opioid-related adverse effects, changes in the underlying pain condition, changes in psychiatric or medical comorbidities, and the identification of aberrant drug-related behaviors, addiction, or diversion.***"

APS/AAPM Guidelines

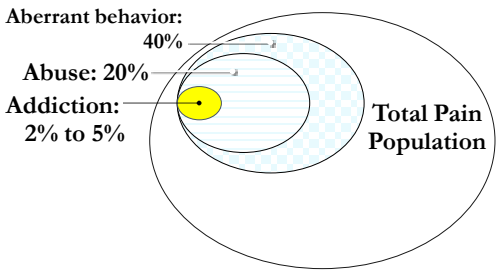
The Rough Guide to Sorting It Out

What's the **pattern**? **See the Big Picture**!

- In control of meds/use as prescribed vs. out of control
- Quality of life/functionality expanding vs. constricting
- Psych co-morbidities managed or out of control and/or increasing med dose/s with little attention to non-med alternatives
- Following treatment agreement vs. not following agreement

Schnoll S, Finch JW. J Law Medicine Ethics. 1994.

Misuse Is Not Necessarily Addiction



Opioid Weaning

- Decrease by 10% of the original dose per week is usually well tolerated (conservative)
- Most patients can be tapered more rapidly without problems -- over 6 to 8 weeks (moderate)
- If rapid taper is needed (e.g. aberrant behavior present) opioid withdrawal may develop, but is very rarely medically serious
  - Nausea/vomiting – phenergan
  - Diarrhea – immodium
  - Muscle pain -- clonidine 0.1-0.2 mg orally every 6 hours
  - Insomnia /anxiety – quetiapine (avoid benzodiazepines)
- Symptoms of mild opioid withdrawal may persist for six months, particularly after methadone
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

Opioid Weaning (continued)

- Extremely challenging behavioral issues may emerge during an opioid taper.
  - Some patients will use a wide range of interpersonal strategies to derail the opioid taper
    - Guilt provocation ("You are indifferent to my suffering")
    - Threats of various kinds
    - Exaggeration of their actual suffering in order to disrupt the progress of a scheduled taper

Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain Washington State Agency Medical Directors' Group, 2007

Case Example: Initial and Ongoing Treatment Plan

- "Hank": 58 yo WM referred for chronic LBP and "lumbar disc disease" with comorbidities of oxygen dependent COPD and GAD. Primary pain issue is constant diffuse widespread achy pain involving low back, legs, arms, and shoulders associated with allodynia and fatigue. Pain exacerbated by activity, cold weather, and "stress."
- On oxycontin 10 mg bid and lortab 10/500 q4hrs prn pain (NTE 6 a day) as well as xanax 1 mg qid for anxiety.
- No personal h/o addiction
- Lives at home with wife and mother-in-law, adult stepdaughter and her husband and son; reports multiple conflicts with family members and uncontrolled anxiety. Spends time watching TV and reading in bed.
- Lumbar MRI shows central L5-6 disc bulge with annular tear without central or neuroforaminal stenosis and mild to moderate facet joint inflammation.

Case Example: Initial and Ongoing Treatment Plan (continued)

- At intake visit, hx and PE leads to high index of suspicion for fibromyalgia or some degree of central sensitization which calls into question whether opioids are first line. Duloxetine started for FM/GAD and naproxen started for nociceptive LBP.
- Hank deemed high risk for chemical coping (due to anxiety and unhealthy SH) and oxycontin increased to 20 mg bid and lortab 10/500 reduced to bid prn for activity-related exacerbations of LBP (lower total MED, less short-acting = a step in the right direction). Alprazolam changed to clonazepam 2 mg bid for smoother control of anxiety with suggested goal of tapering once cymbalta therapeutic.
- Therapeutic goals discussed which included getting out of the house to men's group at church, going to flea markets, and potentially driving short distances in future. Functional goals limited by impairment from COPD.

Case Example: Initial and Ongoing Treatment Plan (continued)

- At next two subsequent visits, UDS positive for oxycodone and oxymorphone but negative for hydrocodone or clonazepam.
- Limited progress made towards therapeutic goals, and when confronted about this, patient indicates poor motivation to participate in activities, as well as phobia of running out of oxygen when away from house.
- Diffuse achy pain and particularly allodynia is mildly improved but no improvement or worsening of achiness in lumbar area.

Case Example: Initial and Ongoing Treatment Plan (continued)

- Hank is confronted about testing negative for hydrocodone twice, and he admits that he typically runs out a week early despite lack of exertion or activity (Chemical coping? Pseudoaddiction? Warrants discussion).
- Lortab is discontinued but oxycontin is increased to 30 mg bid (overall increase in MED to address potential pseudoaddiction but less risk of chemical coping, etc.)
- ROI signed to talk with wife
- Referrals made to PT and CBT
- Cymbalta increased for FM and GAD.

Case Example: Initial and Ongoing Treatment Plan (continued)

- Hank's wife is called and she indicates that she has been concerned about Hank and believes he often takes too many oxycontin, clonazepam, and other medications due to confusion and maybe due to c/o persistent severe pain. She has seen him fall asleep at dinner table intermittently.
- Hank and his wife agree that she will dispense oxycontin to him and attend future visits. Hank is informed that this is a requirement of his continued opioid management. Naloxone intranasal rescue kit ordered.
- Hank has made some progress in CBT and is less overtly anxious about leaving house.
- PT notes indicate Hank is compliant and exerting appropriate effort.

Case Example: Initial and Ongoing Treatment Plan (continued)

- At subsequent visits, Hank's wife indicates he is no longer confused or falling asleep at dinner.
- Hank continues to report severe lumbar achy pain, but diffuse pain and allodynia now infrequent. He has been compliant with PT but is not meeting any of his therapeutic goals.
- PE demonstrates pain with lumbar facet loading, and Hank is referred for facet blocks (median branch blocks).
- Oxycontin is continued.

Case Example: Initial and Ongoing Treatment Plan (continued)

- Since facet blocks, Hank reports reduction in lumbar pain to point where he is more comfortable at rest and with day to day activities, although he still significantly rations his activities and is not leaving house except occasionally for errands with wife.
- The possibility of reduction in opioids was discussed and Hank reacts with anxiety and is not amenable.
- Hank's wife has taken a new job and will be traveling for three days at a time every week, and she is concerned about Hank's potential for med noncompliance.

Case Example: Initial and Ongoing Treatment Plan (continued)

- Oxycontin was discontinued in favor of duragesic transdermal patches; Hank was opposed but was counseled at length about the reasons for switch.
- Functional issues and initial treatment goals revisited, and he agrees to try going to mens' group at church.
- NC Controlled Substances Reporting System checked and shows no surprises.

Case Example: Initial and Ongoing Treatment Plan (continued)

- At subsequent visit, Hank and his wife report that he is doing fairly well on duragesic with some periods of no pain at rest but unchanged NPS with day to day routine.
- He has gone to church group twice a month and met a friend who wants to take him to local flea market. He is no longer going to PT but per wife is doing some of the exercises at home a few times a week.
- NC Controlled Substances Reporting System checked and shows no surprises. UDS positive for fentanyl only.