PAIN POINTS FOR THE COMMUNITY HEALTH CENTER: INTEGRATION OF ADDICTION-INFORMED PAIN MANAGEMENT SERVICES INTO PRIMARY CARE

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DISCLOSURES

- No conflicts to disclose

- The off-label use of sublingual buprenorphine for chronic pain control will be discussed

LEARNING OBJECTIVES

- Participants will understand an evidence-based approach to the evaluation and treatment of co-morbid non-cancer pain syndromes and substance use disorders
- Participants will be given screening tools to help determine which patients are appropriate for long term opioid therapy
- Policies, procedures and treatment strategies to minimize drug-seeking behavior, misuse and diversion of opioid analgesics will be discussed
- Participants will understand the current recommendations for treatment of chronic non-cancer pain in patients on medication assisted therapy (MAT) for opioid dependence
- Participants will gain greater knowledge of the use of non-opioid medications for the treatment of pain

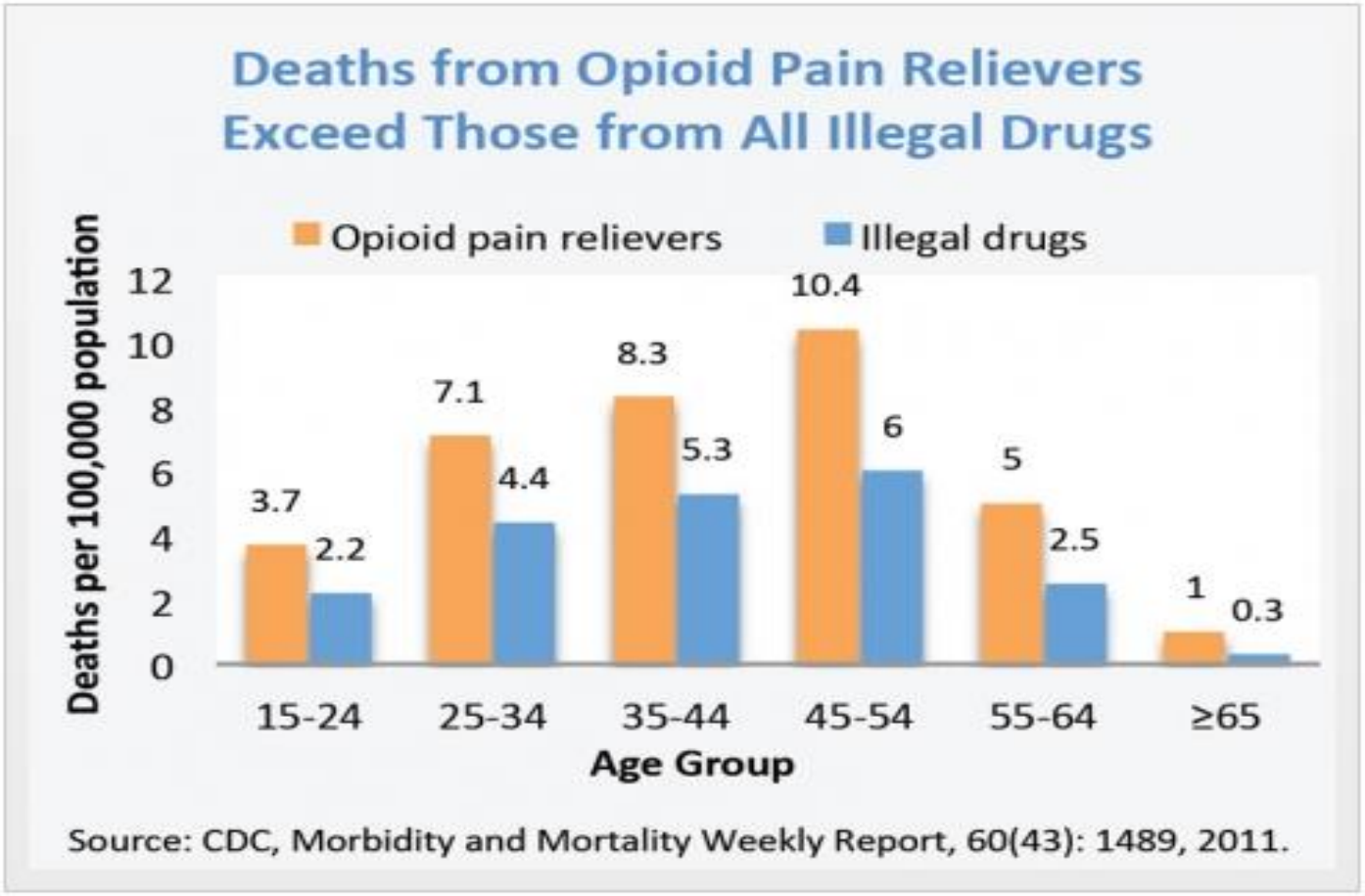
SCOPE OF PROBLEM

Table 2. Misused or Abused Drugs Most Commonly Involved in Emergency Department (ED) Visits: 2010

Drug	Number of ED Visits*	ED Visits per 100,000 Population
Alcohol—In Combination with Other Drugs	564,796	182.5
Alcohol—Underage Drinking**	189,060	215.4
Illicit Drugs	1,171,024	378.5
Cocaine	488,101	157.8
Heroin	224,706	72.6
Marijuana	461,028	149.0
Pharmaceuticals	1,345,645	434.9
Anti-anxiety and Insomnia Drugs	472,769	152.8
Benzodiazepines	408,021	131.9
Antidepressants	105,229	34.0
Pain Relievers	659,969	213.3
Narcotic Pain Relievers	425,247	137.4
Hydrocodone Products	115,739	37.4
Oxycodone Products	182,748	59.1

* Because a visit may involve multiple drugs, the sum of visits by drug will be greater than the total.
**Underage drinking includes both use of alcohol in combination with other drugs and use of alcohol only for patients aged 20 or younger.
Source: 2010 SAMHSA Drug Abuse Warning Network (DAWN).

OPIOID-RELATED MORTALITY



OPIOIDS FOR NON-CANCER PAIN IN PATIENTS WITH SUBSTANCE USE DISORDERS

- Presents challenges to clinicians
- Concerns about relapse while on chronic opioid therapy
- Confusion between "drug-seeking" behaviors and addiction
- Lack of evidence-based guidelines for management of pain in patients with a history of substance use disorder

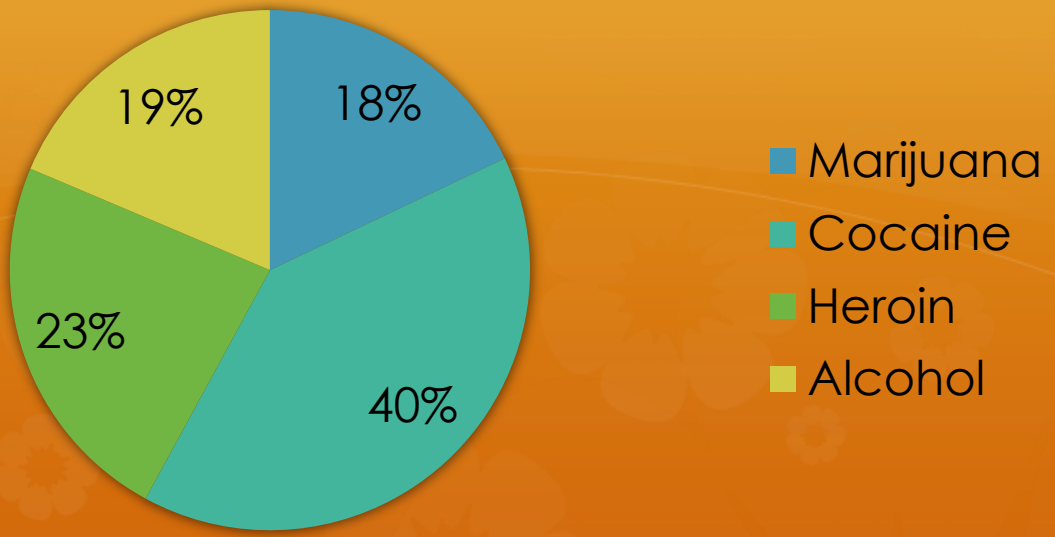
Dobscha et al. Pain Med 2008, 9(5):564-571

Keller et al. Substance Abuse 2012, 33(2):103-113

Wolfert et al. Pain Medicine 2010, 11(3):425-434

HELP/PSI STATISTICS

- In the last 6 months
  - 264 new patient encounters
  - 74% of these patients reported history of substance abuse



TRUE OR FALSE

- Patients with a history of substance abuse have increased sensitivity to pain
- A family history of substance abuse is the biggest risk factor for developing opioid addiction
- **Physical dependence** (manifested by withdrawal syndrome after abrupt drug cessation) and **tolerance** (continued exposure to drug resulting in diminution of drug effect) are indicators of opioid addiction

CLINICAL SCENARIO
(Continued)

- **HPI:**
  - TE is a 42 y/o W with history of comminuted ankle fracture in 2012, s/p complicated ankle reconstruction
  - Functional status limited by moderate to severe pain when ambulating- uses a cane but can only walk for 2-3 blocks before becoming uncomfortable. Pain more severe over last few months for unclear reasons.
  - Reports difficulty sleeping because of pain.
  - Reports an underlying history of depression and anxiety but states pain has made this much worse.

CLINICAL SCENARIO
(Continued)

- **MH**- Notable for AIDS (CD4- 190), Asthma, Polysubstance abuse (cocaine, heroin, alcohol- reports cocaine use a few months ago) and Bipolar disorder (reports multiple hospitalizations for suicide attempts- most recent in 2013)
- **SH** -per HPI
- **Allergies**: NKDA
- **Medications**: **Oxycodone IR 30mg- 1 tablet 4 times daily**, Complera, Albuterol, Spiriva, Topamax, Seroquel, Zoloft

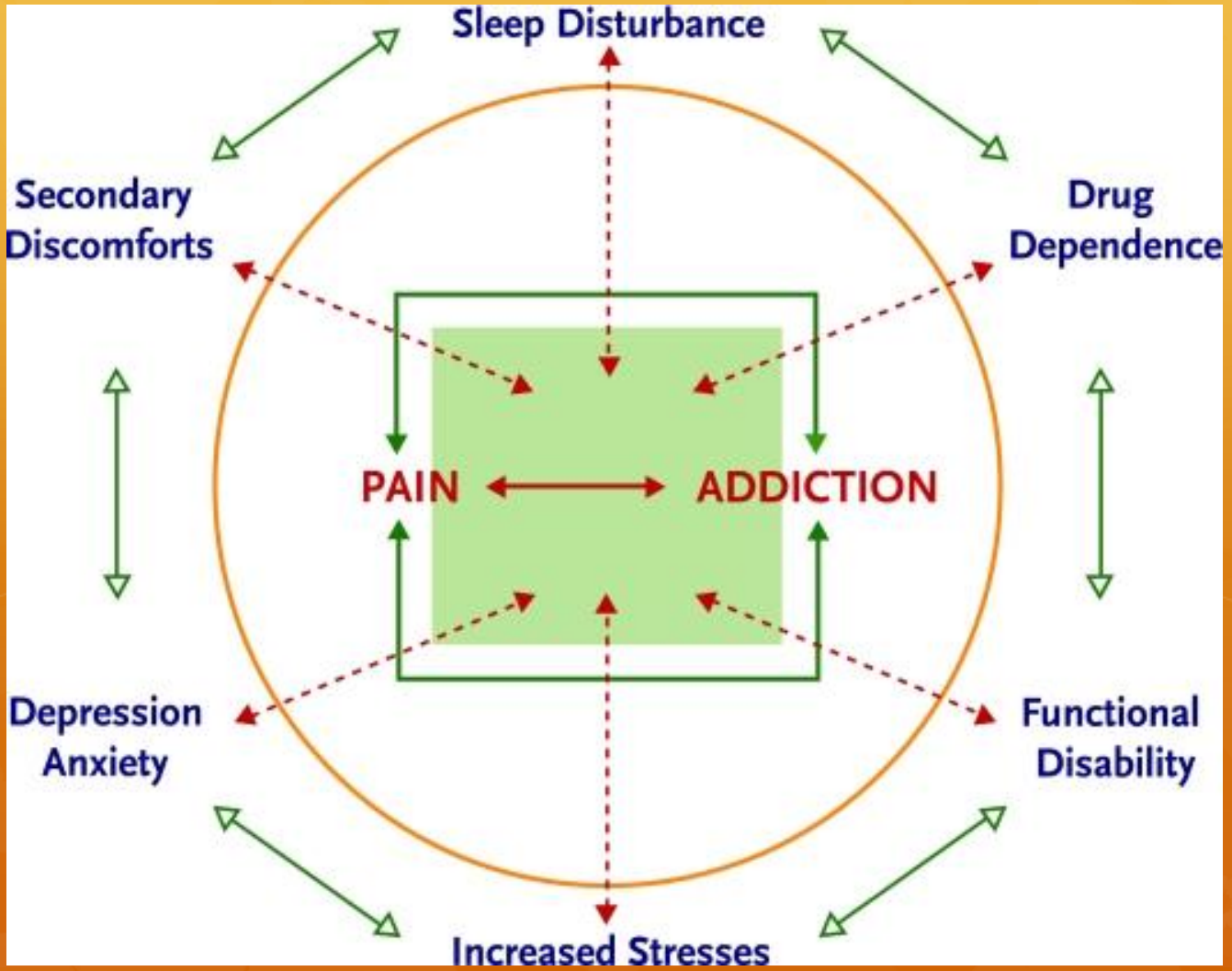
CLINICAL SCENARIO
(Continued)

- **FH**- Reports history of alcoholism and illicit drug abuse (cocaine, heroin) in first degree relatives and siblings.
- **SocH:**
  - Raised in an abusive home- sexually abused by uncle from age 8-12.
  - Started using drugs at age 13 as a way to cope.
  - Involved with multiple physically and sexually abusive partners during adolescence and adulthood.
  - Multiple encounters with the legal system.
  - Reports smoking 1 ppd.

CLINICAL SCENARIO (Continued)

- PE
  - Vitals: BP 130/88, HR 84, RR 16, SpO2 98%, T 97.6
  - Exam notable for:
    - grossly deformed right ankle (medial and lateral malleolus)
    - markedly limited ROM in all planes- dorsiflexion and plantar flexion limited to 5 degrees, absent inversion and eversion.
    - Allodynia and hyperalgesia noted
    - Gait is markedly antalgic. Weight bearing ability is limited by pain.
  - LABS
    - Review of last 3 urine drug screens have all been positive for both oxycodone and cocaine- as recently as 2 weeks prior to this visit.

SYNDROME OF PAIN FACILITATION



SYNDROME OF PAIN AND ADDICTION

- Pain identified as a contributing factor to addiction
  - Untreated pain= risk factor for continued abuse or relapse.
- *Conversely*, chronic use (greater than 3 months) of opioids in patients with histories of SUDs puts them at risk for opioid abuse and/or relapse.
  - 3.3% to 11.5% of chronic pain patients with a history of SUD may develop opioid addiction/abuse VERSUS 0.19%-0.59% of patients without a prior or current history- *Fishbain et al. Pain Me 2008, 9(4):444-459*

IF WE ARE GOING TO PRESCRIBE OPIOIDS FOR CHRONIC NON-CANCER PAIN WE NEED TO MINIMIZE RISK

OPIOID-INDUCED HYPERALGESIA

- Patients with a history of SUD tend to be more sensitive to pain stimuli
- With higher doses of chronically prescribed opioid analgesics there is the potential to develop OIH
- Definition
  - Increased nociceptive sensitization caused by exposure to opioids
- Pain tends to become more widespread over time
- Quality of pain may change
- Diagnosis
  - Patient maintained on opioids AND pain worse despite no change in source of pain
- Patient needs to be weaned off opioids

Adapted from Opioid-Induced Hyperalgesia- Brian Johnson, MD

UNIVERSAL PRECAUTIONS

1. Make a diagnosis with appropriate differential
2. Perform a psychological assessment, including risk of addictive disorders
3. Use a treatment agreement
4. Obtain informed consent
5. Conduct assessment of pain level and function before and after intervention
6. Begin trial of medication. Start with opioid analgesic if condition is appropriate and functional status is moderately or significantly impaired. Try to use adjunctive medications and therapies as tolerated
7. Reassess pain score and level of function
8. Regularly assess the **4"As"** of pain management: **A**nalgesia, **A**ctivity, **A**dverse effects, and **A**berrant behavior
9. Periodically review diagnosis and co-occurring conditions, including addiction
10. **DOCUMENT** initial evaluation and follow-up visits

RISK ASSESSMENT

- Comprehensive risk assessment includes
  - Determining known risk factors for opioid addiction
    - **Personal history of opioid abuse**
    - Personal history of other substance abuse
    - Family history of substance abuse
    - Childhood emotional trauma
    - Mental health disorders (depression or PTSD)
  - Other factors: sleep disorder, current cigarette smoking, involvement in the legal system, younger age (less than 65), emotional distress-particularly in women.
- Risk stratification attempts to identify patients who may be appropriate for chronic opioid therapy.
  - **The greater the number or risk factors, the greater the chance of opioid abuse.**

POLICIES AND PROCEDURES FOR RISK MANAGEMENT IN OPIOID PRESCRIBING

- Opioid agreement- outlining expectations of BOTH patient and prescriber. Informs patient of the policies and procedures involved in treatment
- Prescription Drug Monitoring (bi-weekly/monthly)
  - I-STOP inquiry
- Toxicology screens
- Pill count protocol
- HIPAA releases for communication with external providers- mental health, medication assisted therapy (methadone or buprenorphine)

PILL COUNT GUIDELINES

- Generally advised to have patient return 3-7 days prior to date that medication will run out
- Give patient 24-48 hours notice
- Additional staff member should be present to witness this procedure
- Count medication on clean flat surface using clean gloves
- Examine color, shape and imprint of tablet
  - Use pill identifier chart to identify medication
  - Contact pharmacist if in doubt
- Document requested pill count, outcome and witness' name in the record
- Refusing or failing to provide medication after several requests will result in termination from the practice

- Adopted from Doctorssafeguard.com

RISK STRATIFICATION

- Allows identification of high, medium and low-risk patients.
- A number of validated screening tools exist (both objective and subjective)- Opioid Risk Tool (ORT), Pain Medication Questionnaire (PMQ), Current Opioid Misuse Measure (COMM).
- Different approaches to management are recommended based on level of risk.

OPIOID RISK TOOL

Mark each box that applies	Female	Male
1. Family hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 1 ☐ 2 ☐ 4	☐ 1 ☐ 2 ☐ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 3 ☐ 4 ☐ 5	☐ 3 ☐ 4 ☐ 5
3. Age (mark box if 16-45)	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 3
5. Psychologic disease ADD, OCD, bipolar, schizophrenia Depression	☐ 2 ☐ 1	☐ 2 ☐ 1
Scoring totals:		

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

Toxicology Screening

- Why is the test being ordered?
- How will the results be interpreted?
  - Maintain open lines of communication with toxicologist
- Will clinical changes be made depending on the result of the test?
  - There should be a plan in place for persistently aberrant or unclear results
    - Termination of opioids and referral for inpatient/outpatient detoxification
    - Opioid rotation for improved analgesia

Adopted from The Art of Urine Drug Testing: A Patient-Centered Approach- Douglas Gourlay, MD June 25, 2013

ABERRANT DRUG BEHAVIORS

- Definition- **any behavior on the part of a patient that raises the possibility of abuse**
  - Passik et al. J. Pain and Symptom Management 2000; 19(4) 274-286
- Multiple studies have identified various aberrant drug-related behaviors (ADRBs)
  - History of substance abuse
  - Tobacco use
  - Using multiple doses of opioids at the same time
  - Requesting opioids for multiple pain complaints
  - Multiple phone calls requesting opioids
  - Reports of lost or stolen medications or prescriptions
  - Having multiple prescribers
    - J. Opioid Management 2013; 9(5) 315-324
    - J. Opioid Management 2012; May-June

ABERRANT DRUG BEHAVIORS

J. Pain and Symptom Management 2011; 42(6):893-902

MAJOR

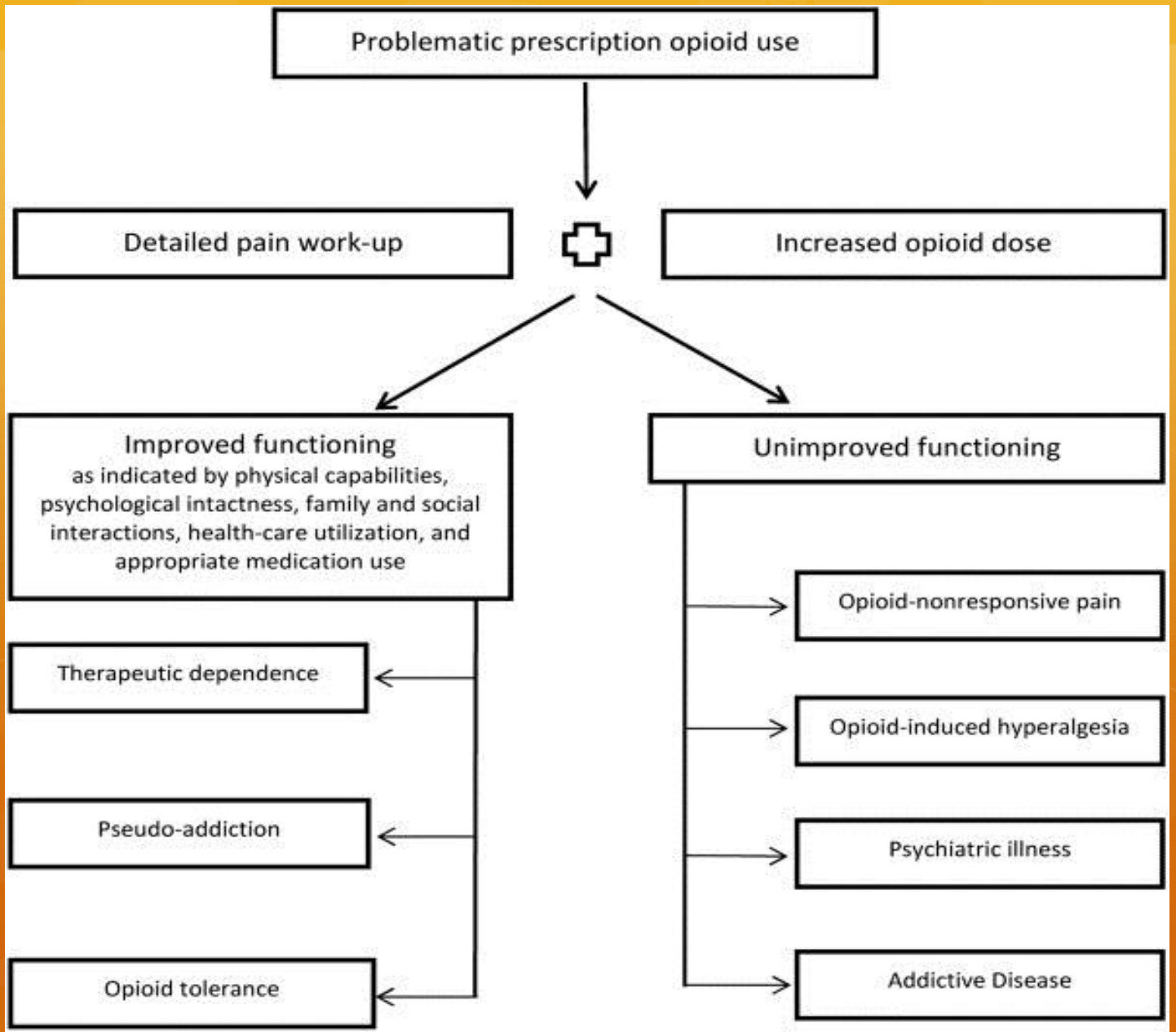
- *High risk to society because of potential for overdose or legal problems*
  - Using opioids to get high
  - Trading street drugs to obtain opioids
  - Snorting, crushing, sniffing, smoking opioids
  - Selling or stealing opioids
  - Exchanging opioids for sex or other drugs

MINOR

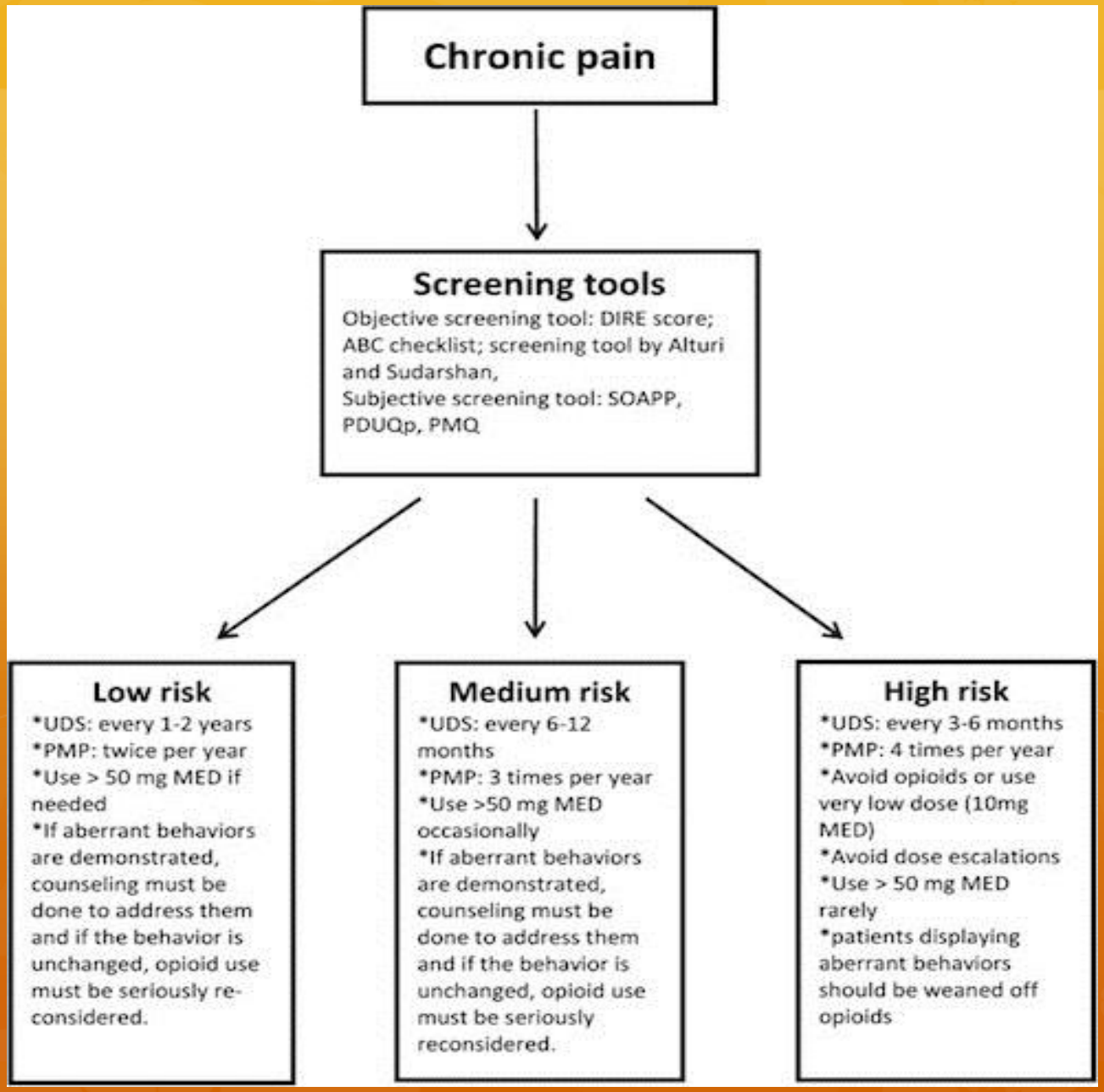
- *Pose less risk to society- may even be related to unrelieved pain*
  - Saving unused pills
  - Borrowing or buying opioids
  - Magnifying the degree of pain in order to get opioids
  - Fabricating side effects/allergies to get a specific drug

MAKING SENSE OF THE BEHAVIOR

Addiction Science and Clinical Practice 2013; 8(21)



TREATMENT ALGORITHM



ADDITIONAL RECOMMENDATIONS

- Mandate participation in on-going addiction treatment (12-step meetings, outpatient treatment, or individual counseling/therapy) and support recovery efforts
- More frequent office visits are necessary
- Prescribe opioids in smaller quantities
- Involve family member in the treatment plan with patient's permission
- Consistent follow up with mental health provider
- Consider cognitive-behavioral interventions

ASSESSMENT OF RELAPSE

Table 4

Questions to assess risk for relapse

• How long has patient been in recovery?
• How engaged is the patient in addiction recovery efforts/treatment (i.e., supportive counseling
• What type(s) of drugs were abused?
• What are current stressors that might precipitate relapse? These include unrelieved pain; slee symptoms; psychiatric symptoms, interpersonal conflicts.
• What are current protective factors against relapse, including improved coping responses and
• How stable does patient feel in recovery?

TREATING CHRONIC NON-CANCER PAIN IN SETTING OF ACTIVE SUD

- Patients with chronic pain and active addiction, regardless of substance(s) abused, are **NOT** candidates for opioid therapy.
  - Untreated addiction results in poor functional status. This inevitably results in poor pain outcomes.
  - Patients need referral to substance abuse treatment providers.
  - Exhaust all non-opioid/non-pharmacologic treatment options

NON-OPIOID ANALGESICS

Adapted from Non-Opioid Pharmacologic Management of Chronic Pain: A Primer- K. Severino; June 2014

- Acetaminophen- hepatotoxic in doses >3.5 g per day
- NSAIDS
  - Non-Selective COX inhibitors- cardiac, GI, renal toxicity, platelet inhibition. Naproxyn- lower cardiotoxic profile
  - COX-2 Selective inhibitors- Increased cardiotoxicity but safer GI profile
- Effective for nociceptive pain; limited use in neuropathic pain

NON-OPIOID ANALGESICS

- ANTICONVULSANTS
  - Gabapentin- best studied for post herpetic and diabetic neuropathies
  - Pregabalin- FDA approved for fibromyalgia
  - Carbamazepine, Oxcarbazepine, Lamotrigine,

- ANTIDEPRESSANTS
  - Can be first line agents for neuropathic pain
    - Tricyclic antidepressants (TCA)- effective in neuropathic pain, low back pain, fibromyalgia, headaches
      - Side effect profile improved with secondary amines (nortriptyline, desipramine)
      - Usually effective at lower daily doses than used for depression

NON-OPIOID ANALGESICS

- ANTIDEPRESSANTS
  - 5HT/NE (SNRIs)- Venlafaxine, Duloxetine
    - Better side effect profile than TCAs
    - First or second line agents for neuropathic pain
  - SSRIs appear to be less effective than SNRIs and TCAs for analgesia
- ANTISPASMODICS
  - Cyclobenzaprine (TCA)- efficacy in fibromyalgia
  - Baclofen (GABA-B agonist)- limited support
- ANTIHYPERTENSIVES
  - Calcium channel blockers, alpha-2 agonists

CONSIDERATIONS FOR CHRONIC PAIN MANAGEMENT IN PATIENTS ON MEDICATION ASSISTED THERAPY FOR OPIOID DEPENCENCE

TRUE OR FALSE

- Analgesic effect of methadone lasts 12-24 hours
- Analgesic effect of buprenorphine lasts 6-8 hours
- Methadone will block the euphoric effects of opioid analgesics
- A DEA waiver is needed to prescribe sublingual buprenorphine for chronic pain

CLINICAL SCENARIO

- 38 y/o woman with AIDS (CD4 120), DMII (on insulin), hepatitis C, depression and back pain on MMT 80mg per day for the last year
  - Pain present for 2 years- gradually worsening (7-8/10 on average); very limited functional status because of burning, stabbing pain
  - Also on gabapentin 800 mg tid, venlafaxine 75mg bid, naproxyn. Previous trials include acetaminophen, tramadol, capsaicin, lidocaine-prilocaine cream
  - Exam reveals non-dermatomal sensory deficits and diminished DTRs in upper and lower extremities

CLINICAL SCENARIO

- Analgesia from methadone lasts 6-8 hours
- Morning dose of methadone may be an indicator of opioid responsiveness
  - Ask patient if she obtains any relief from morning methadone dose
    - Yes- but it only lasts for part of the day
      - May respond to additional methadone or addition of another opioid later in the day
    - No- no relief at all
      - may suggest that the pain is opioid-resistant and non-opioid analgesics should be prescribed
- No established guidelines exist
- Unclear how to manage patients who are on higher doses (100-200mg per day) of methadone

APPROACH TO SUPPLEMENTING METHADONE

- Most MMTPs only administer methadone in the morning
  - Some patients are allowed a "split dose"
    - Is this patient a candidate?
- Potential exists for sharing the responsibility of prescribing methadone
  - Fraction of daily dose in the morning from MMTP and the rest prescribed by clinic physician
  - Requires a lot of co-ordination
  - Observe same precautions of opioid prescribing

Managing acute and chronic pain in patients on MAT- Daniel Alford, MD 2014

BUPRENOPRHINE FOR CHRONIC NON-CANCER PAIN

- Systematic review of 10 studies (low quality) reported effectiveness of buprenorphine in treating chronic pain

  Cotes J, Montgomery L. 2014

- Attempt to kill 2 birds with one stone
  - Can be prescribed for both opioid dependence AND management of chronic pain
  - For opioid dependence- requires DEA waiver
  - For chronic pain- no waiver needed BUT may not be covered by insurance
  - For pain, buprenorphine should be dosed every 8 hours
  - Use opioid prescribing precautions

  Gourlay DL et al. 2005

A PATIENT ON BUPRENORPHINE FOR OPIOID DEPENDENCE WANTS OXYCODONE FOR CHRONIC BACK PAIN

- Is it reasonable to add a full opioid agonist in this setting?
  - No evidence exists to support this practice
  - Exhaust all non-opioid/non-pharmacologic options

REFERENCES

- Addiction Science & Clinical Practice 2013, 8:21
- J Pain Symptom Management 2011 December; 42(6): 893-902
- Clin J Pain 2010 January; 26(1): 1-8
- PCSS-O.org