

Using Opioids To Treat Chronic Pain

AKOMA/ACP-AK CME
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Washington
Chapter



Regional Health Partnership



Objectives

- Identify risk factors for opioid use disorders and explain risks of opioid therapy
- Apply recent CDC guidelines for opioid prescribing to patient care



Panakeia or Siren's Song?



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Morbidity and Mortality Weekly Report (MMWR)

CDC • 100888

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Recommendations and Reports / March 18, 2016 / 65(1):1–49

49 PAGES!

On March 15, 2016, this report was posted online as an MMWR Early Release.

Please note: An erratum has been published for this report. To view the erratum, please click [here](#).

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[View suggested citation](#)

Summary

This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer

MMWR Recommendations and Reports. March 18, 2016. 65(1):1–49

Case 1

A 42 year old male patient with a personal history of alcohol abuse and chronic neck, shoulder and back pain following a lifting injury at work is transferring his care but arrives late without any medical records. He reports that he takes 10 -15 tablets of 5mg oxycodone each day. He will be out of oxycodone tomorrow and requests that you refill his medication for one month as he is leaving town to visit his family for "a few weeks". The plan you offer is:

- a. Switch to oxycodone SR 30mg every 12 hours.
- b. Refer the patient to a pain clinic.
- c. Refill the oxycodone and start venlafaxine.
- d. Avoid prescribing opioids at this visit, offer clonidine, and ask patient to facilitate transfer of medical records.
- e. Tell the patient he clearly has a problem with drug abuse.

- It is OK to Say "No" -

- Many patients with chronic pain are poor candidates for chronic opioids.
- If you say "No" you can offer:
 - exercise program.
 - counseling to work on coping.
 - treating other medical problems such as depression.
 - using NSAID's, acetaminophen, TCA's, anti-convulsants.

New Patients Already On Opioids

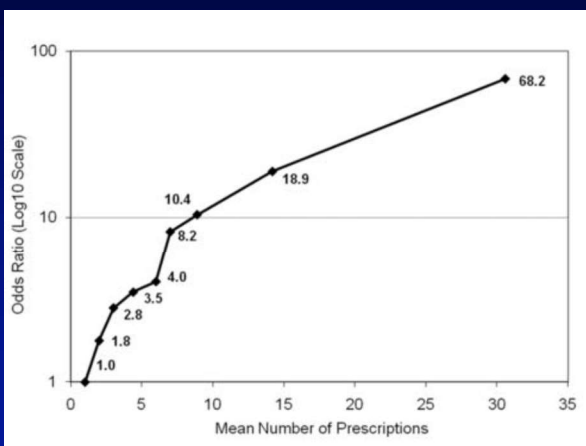
- If uncertain if good candidate - resist pressure to prescribe on 1st visit.
- Patients often switch providers due to non-adherence with care plans.
- Contact past providers and obtain outside records - confirm past doses, treatment history.
- Remember treatment of chronic pain is not an emergency - opioid withdrawal is not life threatening.

Case 2

A 45 year old man comes to clinic complaining of low back pain. Over the last 6 months he has been seen 4 times in acute care settings for "flares of back pain" and each time he has gotten a prescription for hydrocodone/acetaminophen. The last time he got a prescription for 60 tablets of 10mg hydrocodone and he has been taking 4 tablets/day. This past week his wife lost her job, which has been their principal source of income as he has struggled to hold down work because of his back problems. He is clearly distressed.

What do you do next?

1. Prescribe hydrocodone/apap 10mg/325mg every 6 hours for breakthrough pain.
2. Prescribe carisoprodol 350mg every 6 hours.
3. Prescribe extended release morphine 15mg every 12 hours.
4. Schedule short-term follow-up and refer to a counselor if patient amenable.



Association of Number of Prescriptions for Controlled Substance with Risk of Unintentional Drug Overdose

Pain Medicine 2012; 13:87-95

Red Flags - poor candidates for starting or continuing opioids

- History of substance abuse – including alcohol.
- Vague pain history or pain "all over".
- Polypharmacy with multiple other medications with CNS effects.
- History of frequent requests for early refills or dose increases.
- High doses of opioids (above 180mg morphine or morphine equivalent).
- History of medications lost or stolen more than once.
- Risks of harm (e.g. sleep apnea, CKD)
- Younger patients

HOW DID WE GET HERE?

THE FIVE WORDS

The Cancer Pain Model

- Historical under-treatment leading to comprehensive patient education efforts.
- Patients have a "right to pain control".
- Pain as "5th vital sign".
- Clinical experience dominated by acute and advancing disease.
- Improvements in treating cancer pain extrapolated to chronic non-cancer pain in the outpatient setting.

What Is Chronic Pain?

- Complex condition with a myriad of causes and perpetuating factors including psychiatric co-morbidity.
- Little correlation between pain complaints, findings on physical exam, and results of diagnostic testing.
- A poorly understood, challenging to treat, chronic disease state.
- It is not acute pain or pain of malignancy!

How Is Chronic Non-Cancer Pain Different From Cancer Pain?

- Treatment horizon is much longer.
- Treatment goals different – need to target functional status rather than comfort only.
- Goal is not "no pain".
- Chronic pain is stable – no need for rapid adjustments in treatment strategy.
- Limited or no role for breakthrough dosing of medications.

Case 3

You are seeing one of your primary care patients for routine follow-up. He is 59 years old. His medical problems include well-compensated systolic heart failure due to ischemic heart disease (EF 45%), type II DM, obesity, and stage III CKD. He has struggled to exercise in recent years due to severe post-traumatic osteoarthritis of his right knee for which he has tried PT, scheduled acetaminophen, and corticosteroid injection – none of which provided lasting relief. He has also seen an orthopedist who tells him his current weight makes him a poor candidate for knee replacement.

Case 3 continued . . .

In clinic your patient shares, "You know doctor a few weeks ago I was doing some landscaping and had to move this big rock then that night I had terrible back pain. I would have come and seen you but it got better so quickly over the weekend. Anyway, that evening the pain was so bad that I took one of my wife's pain pills left over from her surgery (hydrocodone 10 mg/acetaminophen 325mg) and it really helped my knee – I was even able to walk around a bit that evening without my usual limp."

Case 3 continued . . .

He goes on to share, "We've been watching my granddaughter after school since her parents are working. She keeps asking me to take her down to the park but I have to tell her, 'Pop can't walk that far because of his knee.' I really wish I could take her down to the park but my knee hurts every day." Your patient has no history of substance abuse and no significant mental health problems.

Case 3 continued . . .

In light of his goal, which would be the best option for ongoing management of his knee pain?

1. Controlled release morphine 15mg twice daily
2. Hydrocodone 5mg/acetaminophen 325mg three times daily as needed
3. Methadone 5mg three times daily as needed
4. Diclofenac 75mg twice daily as needed
5. Refer back to physical therapy

General Principles in Managing Chronic Non-Cancer Pain

1. Recognize CNCP is a chronic disease fundamentally different from acute pain or cancer pain. Take adequate time to develop a treatment plan.
2. Validate symptoms and empathize. Consider reversible physical causes. Adequately document details of CNCP.
3. Address the problem from biopsychosocial perspective - psychiatric co-morbidity is the rule. Avoid making a distinction between physical and psychological causes of pain.

General Principles in Managing CNCP - Continued

4. Detailed assessment of functional status. Establish a time line for achieving specific, realistic goals.
5. Correct misconceptions if present. Educate about core strategy. Negotiate a treatment plan with regular clinical follow-up.
6. Incorporate non-pharmacological approaches to the treatment plan emphasizing regular physical activity.
7. Re-evaluate polypharmacy. Recommended evidenced-based pharmacotherapy.

Recognize CNCP is a chronic disease fundamentally different from acute pain or cancer pain.
Take adequate time to develop/modify a treatment plan.

Correct misconceptions if present.
Educate about core strategy.
Negotiate a treatment plan with regular clinical follow-up.

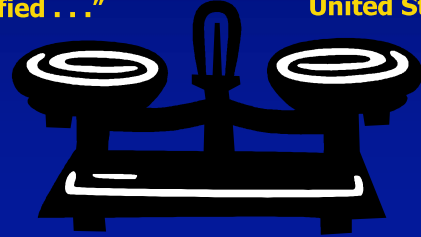
Embarking on Treatment

- Reinforce that goal of complete resolution of pain unrealistic.
 - *"We hope to get the pain out of the driver's seat and into the back seat."*
- Like other chronic diseases requires multi-faceted approach.
 - lifestyle modification
 - emphasis on coping skills
 - non-pharmacological modalities
 - pharmacological modalities
 - specialty care
- Negotiate with patient elements to include.
 - *"We can try that medication as long as you agree to walk most days of the week and keep a log of your activity."*

The challenge of opioids

"The undertreatment of pain in today's society is not justified . . ."

"From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States."

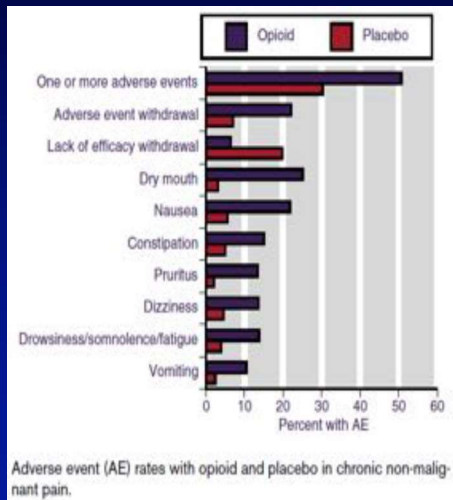


Risks of Opioids



Physiological Risks

- Acute
 - GI adverse effects
 - GU adverse effects
 - Falls
 - Respiratory Depression -> Death
- Chronic
 - Hormonal
 - Sexual Dysfunction
 - Hyperalgesia

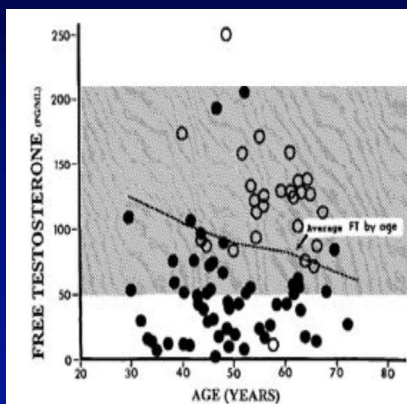


Arthritis Research & Therapy 2005; 7:R1046-R1051

Prevalence Opioid AE's in RCT's

Chronic Physiologic Effects

- Opioids inhibit the production of multiple hypothalamic, pituitary, gonadal, and adrenal hormones.
- A growing body of literature, based on animal and human studies, indicates that chronic exposure to opioids alters pain sensitivity.



Opioid P Induced Androgen Deficiency

Journal of Pain 2002; 3:377-384

Substance Abuse and Opioids

- Prevalence of substance use disorders in studies has varied widely – 0% to 50%.
 - 801 adults, daily opioid therapy from primary care practices of 235 FPs and internists in 6 health care systems in Wisconsin. Point prevalence:
 - Any substance use disorder = 9.7%
 - Opioid use disorder = 3.8%
- Risk of de novo addiction is still felt to be relatively low.

Journal of Pain 2007; 8:573-582

Opioid Misuse

1 year incidence of opioid misuse in a cohort of patients enrolled within an academic GIM practice. (N=196)

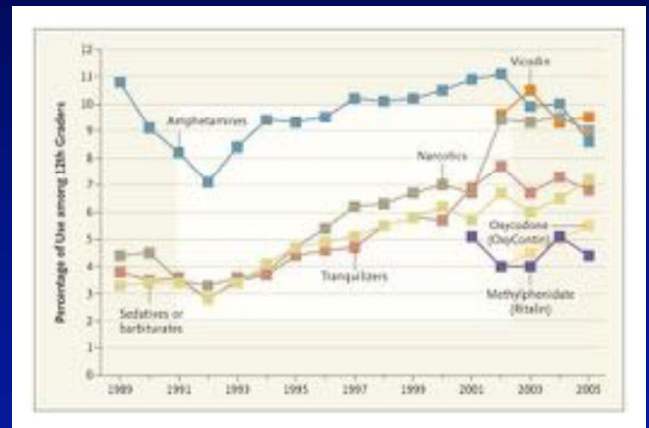
Any Opioid Misuse	Number (%)
Stimulants	25 (40.3)
Negative Urines	15 (24.2)
Multiple Prescribers	10 (16.1)
Inconsistent Urines	9 (14.5)
Prescription Forgery	2 (3.2)
Diversion	1 (1.6)

Table 5: Multivariate Analysis: Predictors of Opioid Misuse *

Model**	Odds Ratio (95% CI)	p-value
Age	0.95 (0.90 – 0.99)	0.027
Drug or DUI Conviction	2.58 (1.01 – 6.59)	0.030
History of Cocaine Abuse	4.30 (1.76 – 10.4)	0.001
History of Ethanol Abuse	2.60 (1.12 – 6.26)	0.048

BMC Health Services Research 2006; 6:46

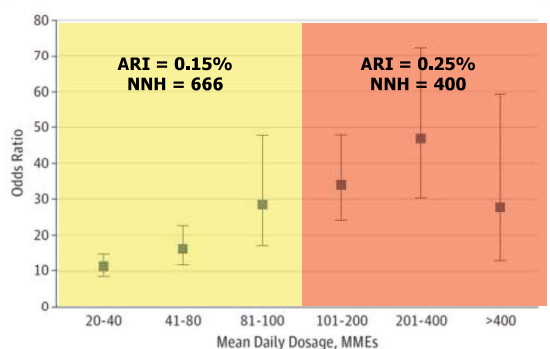
Prevalence of Use of Prescription Drugs without Medical Supervision among 12th Graders



N Engl J Med 2006; 354:1448-1450

The NEW ENGLAND JOURNAL of MEDICINE

Figure 3. Association of Mean Daily Dosage of Opioid Analgesics With Risk of Unintentional Opioid-Related Overdose Death



Association of Mean Daily Dosage of Opioid Analgesics With Risk of Unintentional Opioid-Related Overdose Death

JAMA Intern Med 2014;174(5):796-801.

Other Dose Related AE's

- Opioid Use Disorder
- Depression
- Fracture
- MVA
- Suicide

Ann Int Med 2017;167:181-191.

Benefits of Opioids

Evidence for Use of Opioids

- Anecdotal evidence emerged in the 1980's.
- By 1992 eight surveys described a total of 642 patients. Efficacy was "good" in greater than 75% of patients. Doses of opioids were generally low.
- Consensus statement from American Academy of Pain Medicine and American Pain Society adopted in 1996, "the use of opioids for the relief of chronic pain is a legitimate medical practice."
- Now approximately 25 RCTs.

Summary of RCT's Oral Opioids

1. Around 1000 highly selected subjects excluding any with history of problems with drug/alcohol abuse.
2. Studies done mostly in specialty clinics further biasing the population and limiting generalizability.
3. Average duration of these studies is just over 6 weeks. None > 1 year.
4. Results typically show decreases in pain on visual analog scales at the cost of significant side effects. Withdraw rates in treatment arms are high.
5. Average reduction in pain is about 30%.
6. Limited improvement in measures of functional status within certain domains but results are inconsistent.

Impact of Opioids in Danish Population

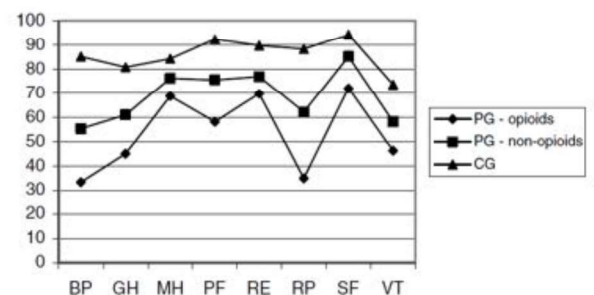


Fig. 2. SF-36 scores in the various investigation groups. PG, pain group; CG, control group. BP, bodily pain; GH, general health; MH, mental health; PF, physical function; RE, role emotional; RP, role physical; SF, social function; VT, vitality.

Is it possible to effectively use opioids for chronic pain in the primary care clinic?

Yes, in some cases.

2009 American Pain Society Guidelines

"Chronic opioid therapy can be an effective therapy for carefully selected and monitored patients with chronic non-cancer pain. However, opioids are also associated with potentially serious harms, including opioid-related adverse effects and outcomes related to the abuse potential of opioids."

Balancing Risks and Benefits Patient Selection

- Realistic expectations of patient
- No red flags for opioid misuse
- Clear goals of functional improvement
- Adequately treated depression
- Willingness to engage in all facets of treatment plan, e.g. regular exercise

The most overlooked aspect of chronic pain management in primary care setting is need to establish concrete metric of functional improvement.

"What were you hoping to get done today that your pain keeps you from doing?"

Long Range Treatment Goals

- Improve functional role.
- Enhance interpersonal relationships and psychological integrity.
- Increase physical activity.
- Decrease reliance on health care system.
- Improve quality of life.

Depression and Chronic Pain

- Numerous studies have shown, “strong associations between chronic pain and psychiatric comorbidity”.
- Depression affects clinical presentation and treatment response.
- Depression is undertreated.
- Co-existing pain and depression may be a final common presentation reached by a number of pathways – reciprocal relationship.

Exercise and Chronic Pain

- All patients with chronic pain should try to do some regular exercise.
- Consider PT referral to help set up a plan.
- If the patient says, “I can’t exercise because of my pain” say:
 - *“Although exercise may hurt at first, there’s a good chance that by starting with a little daily exercise and slowly increasing the amount you do, your body will get stronger and you’ll be better able to cope with your pain.”*

Patients for opioid trial

1. Pain complaint is well-defined and regional (e.g. spinal stenosis).
2. No history of substance abuse including alcohol.
3. Depression is adequately treated.
4. Engaged in regular physical activity.
5. Failed all other treatment strategies.

Prior to Starting Opioids

- Opioid use agreement
- Prescription Monitoring Program review
- Urine Drug Screen

Patient Care Agreements

- Consensus guidelines detail the necessity of informed consent.
- Consent can be accomplished using written agreement describing conditions under which opioids are prescribed.
- "[Agreements] are widely used in chronic opioid therapy." Efficacy not established though has become standard of care.
- Most important points to focus on:
 - No early refills.
 - No pain medications from other clinics or providers.
 - No refills by phone.
 - Urine toxicology.
 - Adherence to schedule of dosing.
 - Change in pain intensity requires re-evaluation.

The screenshot shows the official website of the Alaska's Prescription Drug Monitoring Program (PDMP). The header includes the Department of Commerce, Community, and Economic Development, Division of Corporations, Business, and Professional Licensing. The main navigation bar lists HOME, CORPORATIONS, BUSINESS LICENSING, PROFESSIONAL LICENSING, and INVESTIGATIONS. The PDMP logo is prominently displayed, along with the URL PDMP.ALASKA.GOV. A sidebar on the right lists quick links such as PDMP Home Page, Applications & Forms, Frequently Asked Questions, Registration, Resources, and Instructions, Legislative Reports & Media Releases, PDMP Board Reports, Prescribing Resources, Legislation & Regulations, State & National Organizations, and IHS, VA, Military Registration Instructions, and Use Exemptions. The main content area provides information about the PDMP, including a thank you message and a link to the Initial Payment Form.

Urine Toxicology Pearls

- Monitoring for illicit drug use
 - Host of drugs can cause false positive amphetamines
- Adherence testing
 - Oxycodone not detected on many routine toxicology screens
 - Hydrocodone metabolized to hydromorphone
- Discrepant result \neq discharge from clinic

Using Opioids

- Start low dose, short-acting opioids only.
- Let patients know that this is a test and arrange for early follow-up for dose titration.
- Explicitly define a ceiling dose at outset of treatment. Avoid high-dose opioid therapy.
- Anticipate monthly follow-up visits.
- Document functional status and/or quality of life goals.
- NO benzodiazepenes
- Consider prescribing naloxone

1 month follow-up

- An assessment period of 1 month may sufficient to determine responsiveness to opioid therapy
- Lack of response at 1 month strongly predicts subsequent non-response
- 30% reduction in PEG?
 - average pain intensity (P)
 - interference with enjoyment of life (E)
 - interference with general activity (G)

BMC Medicine 2007; 5:39 doi:10.1186/1741-7015-5-39
J Gen Intern Med 24(6):733-8

3 Month Reassessment

- Does COT continue to meet functional treatment goals?
- Has pt experienced AEs?
- Any signs of opioid use disorder?
- Do benefits still outweigh risks?
- Can opioid dosage be reduced/discontinued?

Documentation Requirements at Every Visit

- Location, intensity, and cause of pain.
- Effect on functional status.
- Dose, frequency, quantity prescribed of medications – particularly schedule II drugs.
- Specific follow-up.

Case 3 revisited . . .

- 59 yo with well-compensated systolic HF due to ischemic heart disease (EF 45%), type II DM, and stage III CKD
- Severe post-traumatic OA of his knee - he has tried PT, acetaminophen, and corticosteroid injection – none of which provided relief
- Orthopedist who tells him he should “lose some weight before knee replacment”
- Hydrocodone helped knee pain
- Wishes he could take granddaughter to the park but knee prevents that . . .
- Has no history of substance abuse and no significant mental health problems

Case 3 revisited . . .

In light of his goal, which would be the best option for ongoing management of his knee pain?

1. Controlled release morphine 15mg twice daily
2. Hydrocodone 5mg/acetaminophen 325mg three times daily as needed
3. Methadone 5mg three times daily as needed
4. Diclofenac 75mg twice daily as needed
5. Refer to physical therapy

Key Points

- CNCP is best understood as a chronic disease dissimilar to cancer pain and is never an emergency.
- Therapy should focus on improving quality of life by improving function and decreasing pain but complete resolution of the pain is unrealistic.
- The mainstay of non-pharmacological treatment is physical exercise.
- Depression is common. Data supports the use of medication in almost all patients even if overt depression is not obvious.

Key Points - Continued

- Other therapy includes anticonvulsants and topical agents.
- The data supporting opioid use are severely limited by duration of studies. Chronic opioid analgesics may benefit a small subset of patients. Use short-acting opioids at low dose.
- The risk of adverse events is substantial. Data strongly suggests significant safety risks at MED > 100 mg/day.
- Widespread use of opioids in the primary care setting is not indicated. It is okay to say “no” – however don’t abandon patients.

