



JOHNS HOPKINS  
M E D I C I N E

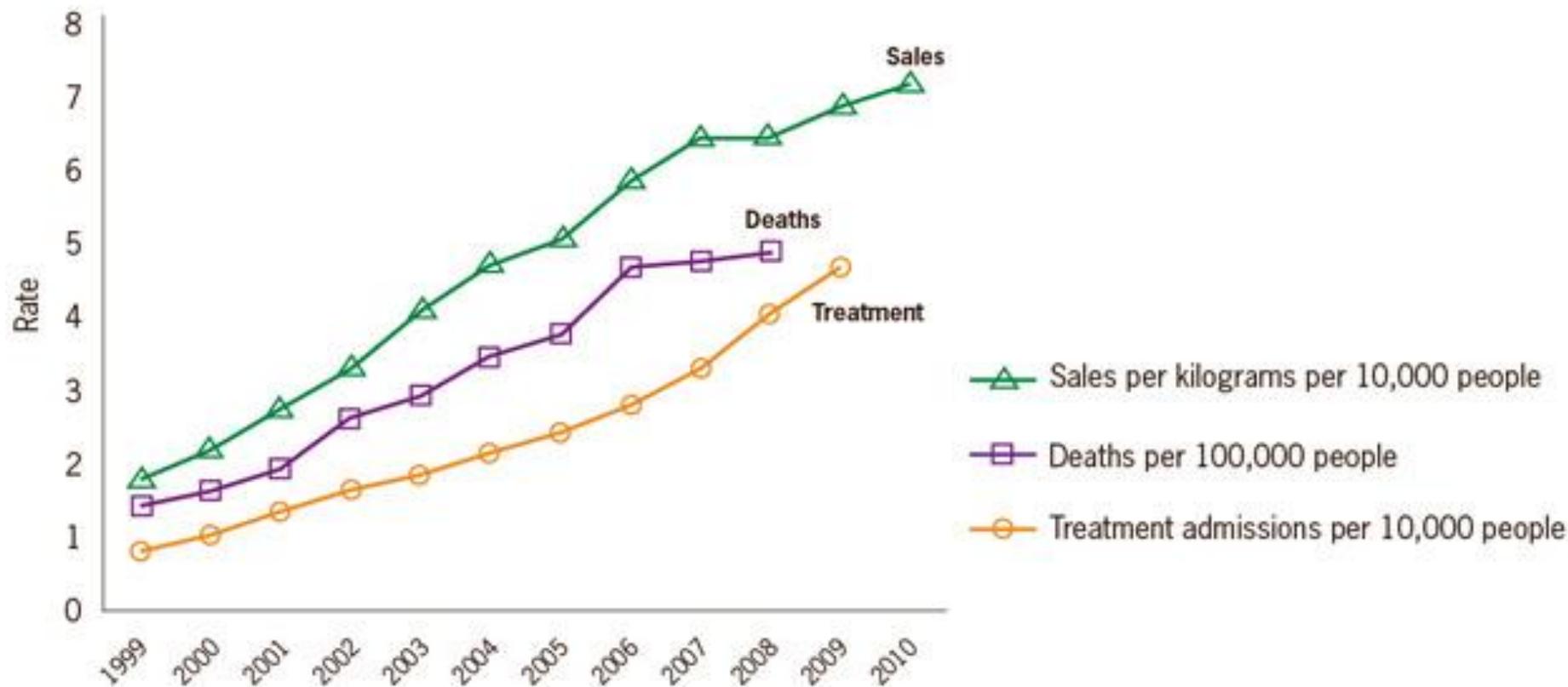
# The Challenging Patient with Chronic Opioid Usage. 2018 MD ACP Meeting

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# Prescribing Opioids: A question of balance

- Opioids are an effective treatment for acute pain.
- However, these drugs carry significant risks and their effectiveness, when used chronically, is questionable at best.

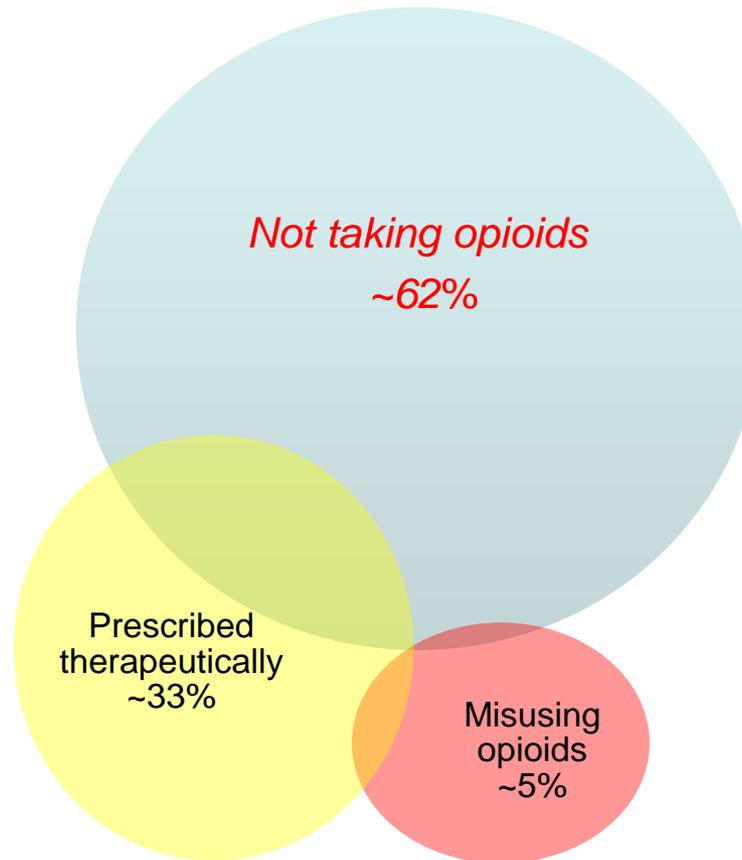
# Prescription Opioids: Sales, Deaths, Treatment Admissions



SOURCE: CDC, Prescription Painkiller Overdoses in the US, 11/1/2011

March 12, 2018

# Preventing Opioid Misuse



# Patient 1

- A 35 year old male with ankylosing spondylitis and chronic back pain reports that he has persistent pain despite treatment with NSAIDs and adalimumab (Humira).
- He wants to know if you can prescribe “something stronger” for pain.

# When to prescribe opioids?

- Benefit vs. Risk
  - Benefits uncertain/unproven.<sup>1</sup>
  - Risks established.
  - Patient-centered approach.

*1. Martell BA, et al. Ann Intern Med 2007;146:116.*

# Primary prevention: More judicious use of opioids

- Opioids should not be the first choice for treatment of pain.
  - Opioids have limited efficacy
  - Opioids have significant risks
  - Short-term exposure leads to long-term use

# Limited efficacy of opioids: short-term

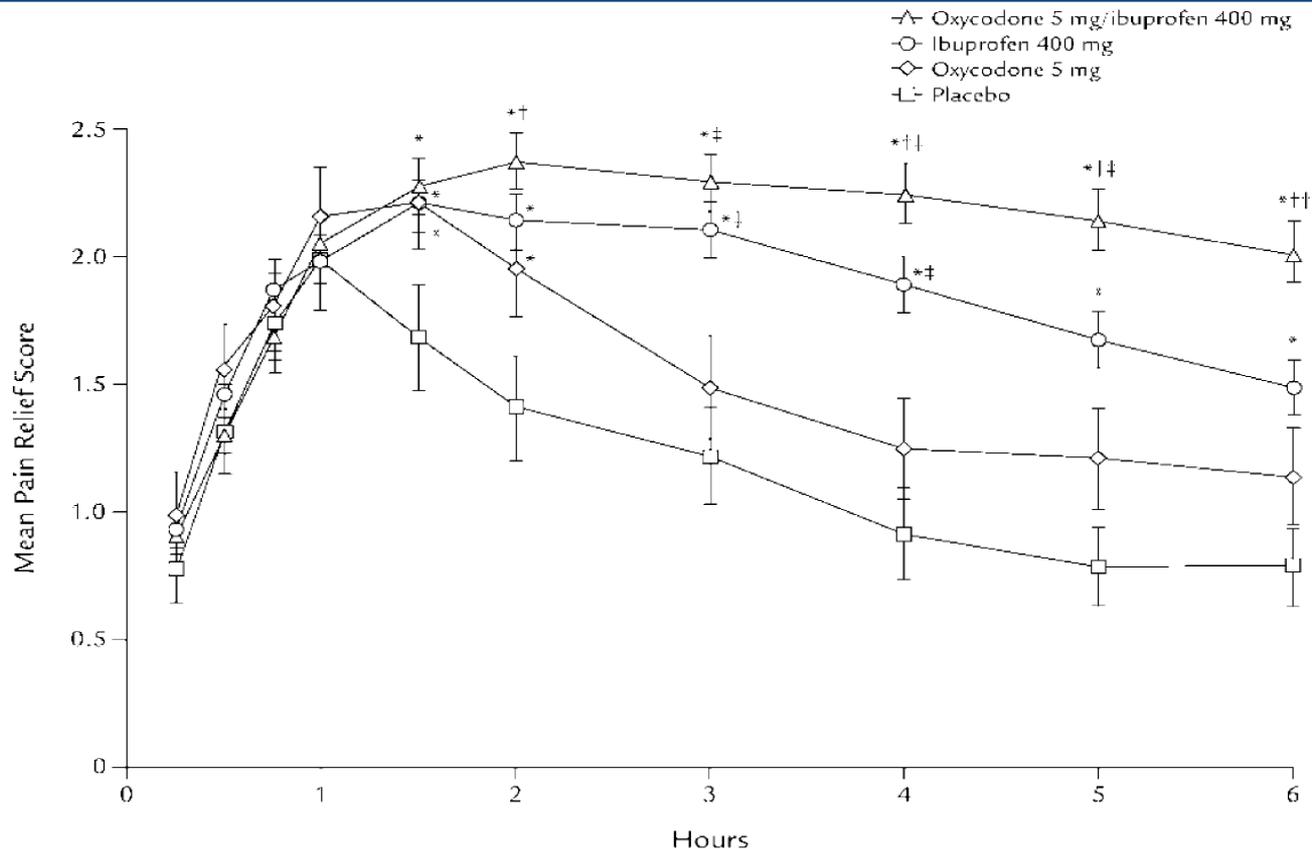
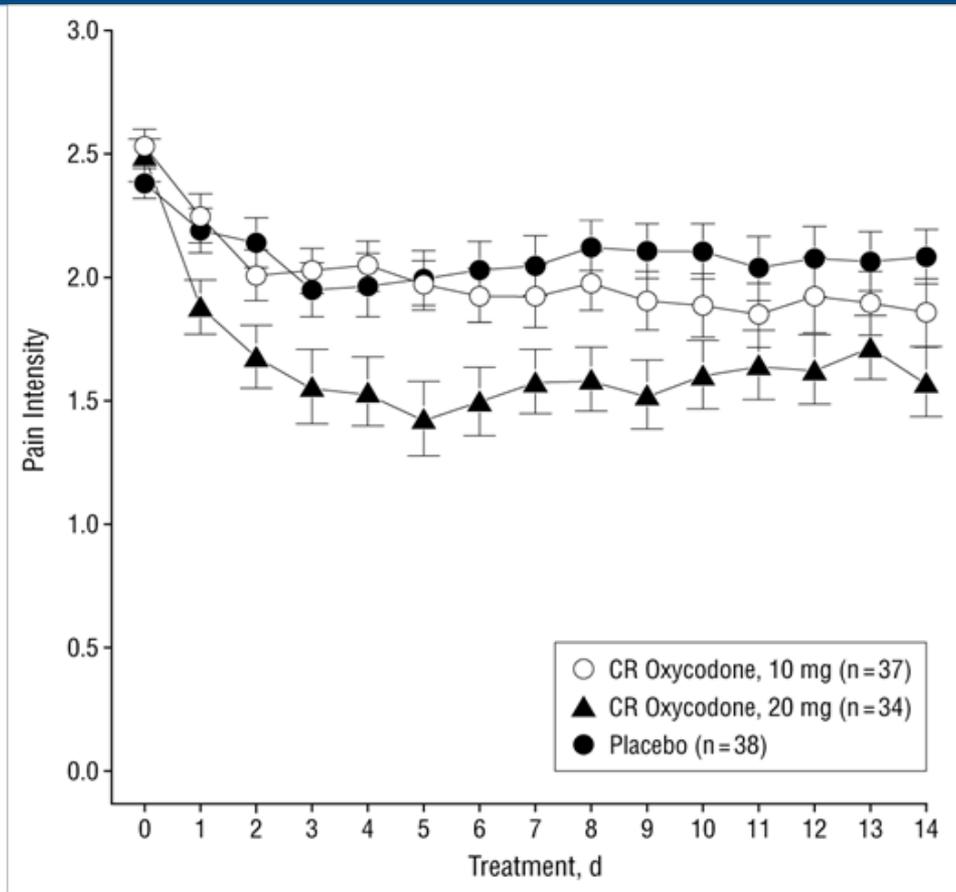


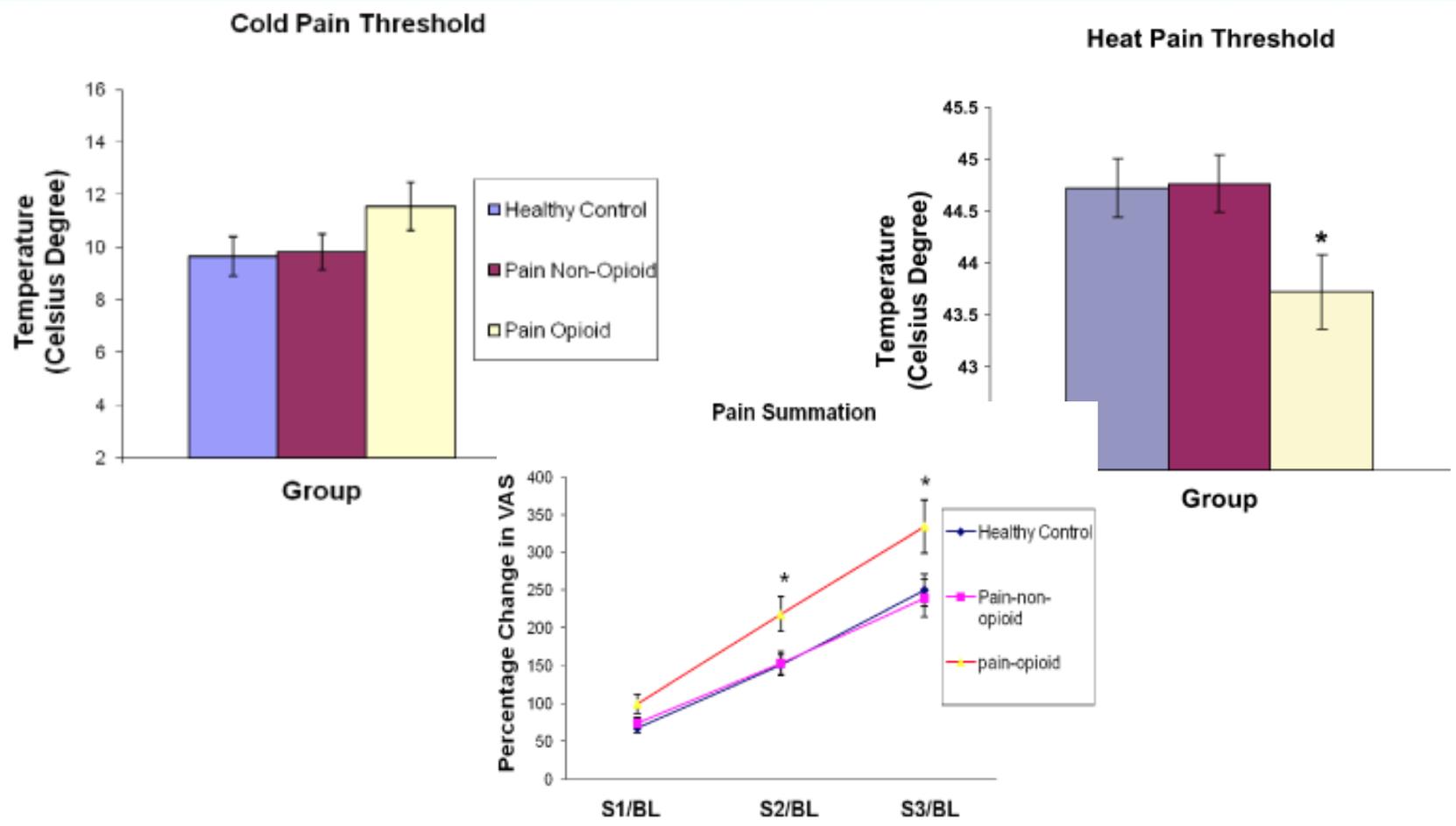
Figure 2. Sum of pain relief scores over time in the intent-to-treat population (last observation carried forward).  
\* $P < 0.05$  versus placebo; † $P < 0.05$  versus ibuprofen; ‡ $P < 0.05$  versus oxycodone.

*Singla N, et al. Clin Ther 2005;27:45-57*

# Limited efficacy of opioids: long-term use



# Limited efficacy of opioids: Opioid-induced hyperalgesia



# Primary prevention: Patient Satisfaction?

- In an outpatient survey, clinician denial of a request for pain medicine was associated with poorer satisfaction.<sup>1</sup>
- In a comparison of opioid prescribing by hospitals after surgery, hospitals with higher prescribing quantities did not score better on patient surveys for “pain management” and “pain dimension”.<sup>2</sup>

*1. Jerant A, et al. JAMA Intern Med 2018;178:85-91.*

*2. Lee JS, et al. JAMA 2017;317:2013.*

# Primary prevention

## “Short-term” scripts lead to long-term use

- Among opioid-naïve older adults who have minor surgery and are prescribed an opioid, 10% are still taking opioids a year later.<sup>1</sup>
- Patients treated in an ED by a “high-intensity” opioid prescriber are 30% more likely to be taking opioids long term than those treated by a “low intensity” prescriber.<sup>2</sup>

1. Alam A, et al. *Arch Intern Med* 2012;172:425-30.

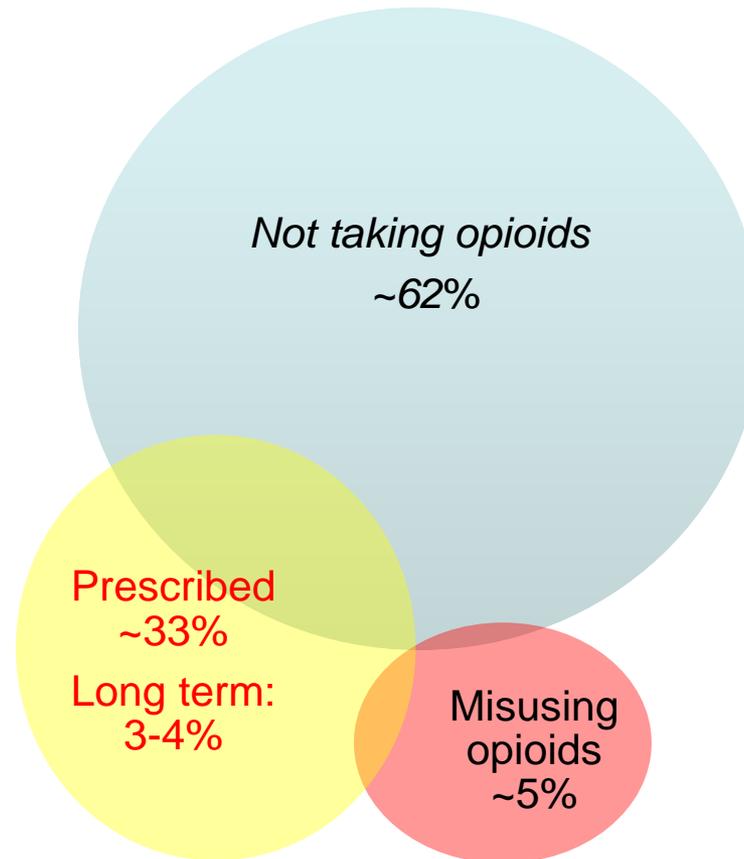
2. Barnett ML, et al. *N Engl J Med* 2017;376:663-73.

# If you do prescribe...

- Advise patient on risks and limitations
  - CDC handout for patients:  
[https://www.cdc.gov/drugoverdose/pdf/guidelines\\_factsheet-patients-a.pdf](https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-patients-a.pdf)
- If prescribing for chronic pain:
  - Focus on functional outcomes
    - Pain medicine is not a solution for the problem
    - Pain will not “go away”
  - Prescribing is a trial to assess benefits and harms
  - Start low and go slow

*Dowell D, et al. CDC Guidelines for Prescribing Opioids for Chronic Pain MMWR 2016;65:1-49.*

# Preventing Misuse/Harm



# Patient 2

60 year-old male with chronic back pain comes for an initial visit.

He has been prescribed oxycodone 30 mg four times daily for pain, and alprazolam 0.5 mg as needed for anxiety.

He was seeing a pain management physician in the DC suburbs and he would like to see someone closer to where he lives.

Review of CRISP is consistent with his report.

# When to prescribe opioids?

- Initiation vs. Continuation
  - Difficult to assess benefit for patients who have been taking opioids chronically.
  - Focus on risk (use disorder/overdose)

# Prescription Drug Misuse: Risk Factors

- Other substance use disorder (inc. smoking).
- Imprisonment/legal problems.
- Greater pain-related impairment.
- Family history of substance use disorders.
- Psychiatric disorders (esp. PTSD).
- Younger age.
- Back pain/multiple locations of pain.

# Risk Factors for Overdose

- Higher doses of medication.<sup>1,2</sup>
- Substance use disorder history.<sup>2,3</sup>
- Other psychiatric disorders.<sup>2</sup>
- Concurrent use of other substances.<sup>3</sup>
- Receiving opioids from multiple providers<sup>3</sup> and pharmacies.
- Long-acting opioids, esp. methadone.<sup>3</sup>

1. Dunn KM, et al. *Ann Intern Med* 2010;152:85-92.

2. Bohnert ASB, et al. *JAMA* 2011;305:1315.

3. Hall AJ, et al. *JAMA* 2008;300:2613-20.

# Patient 3

- A 55 year-old male comes for an initial visit.
- He has chronic knee pain from OA
- He was taking Percocet 5/325 three times daily for his pain and says it helped him continue working part-time doing home improvement.
- His primary care MD at the VA told him he would no longer prescribe Percocet and that he would have to see pain management if he wanted to continue.

# Prescription Drug Misuse: Secondary Prevention

- Patient education
  - Controlled substance agreements
- Closer monitoring
  - Aberrant medication taking behaviors
  - Prescription drug monitoring programs (CRISP)
  - Urine drug testing
  - Pill counts
- Limiting dosage (90-120 ME/day = 60-80 mg oxy/day)
- Co-prescribing naloxone

# Secondary Prevention: Controlled Substance Agreements

- Documentation of a discussion of risks and expectations.
- Recommended by guidelines
- Not much evidence that these agreements prevent or mitigate misuse.<sup>1</sup>

1. *Starrels JL, et al. Ann Intern 2010;152:712-20.*

# Patient 4

- A 33 year-old female comes for initial visit – she says her previous doctor has cancer.
- She has chronic back pain and has been prescribed oxycodone 15 mg four times daily and carisoprodol at bedtime.
- She says she last filled these scripts about a month ago, but CRISP shows no scripts in the past 6 months.

# Secondary Prevention: Prescription Drug Monitoring Programs

- Identifies individuals receiving controlled substance prescriptions from multiple sources.
- However, most individuals who are misusing opioids obtain them from one physician or through routes other than prescriptions.
- Use is increasingly mandated.
- Some evidence of decrease in misuse in states after implementation of PDMPs, but often combined with other measures.<sup>1</sup>

1. Johnson H. *MMWR* 2014;63:569-74.

# Secondary Prevention: Urine Drug Testing

- Can help identify individuals who are misusing other drugs or not taking prescribed medications.
- Requires knowledge of test characteristics: interpretation can be complicated by cross-reactions and false positives.
- Ideally, unexpected results should be an opportunity to open further discussion, not to make arbitrary decisions.
- Limited evidence that drug testing helps.<sup>1</sup>

# Secondary Prevention: Limiting dosage

- Higher dosages are associated with increased risk of overdose.
- Guidelines recommend limiting dose and payers are requiring prior authorization for doses that exceed a threshold (e.g., 90 mg MME/day).
- Guidelines have an effect on prescribing, but have not been shown to reduce the harms associated with opioids.

# Secondary Prevention: Co-prescribing naloxone

- Naloxone is a safe and effective treatment for overdose.
- Guidelines recommend co-prescribing of naloxone for individuals who are prescribed opioids, particularly higher doses.
- Opportunity to have a discussion about risk.
- There is evidence that naloxone distribution reduces overdose deaths on a community-based level.

# Patient 5

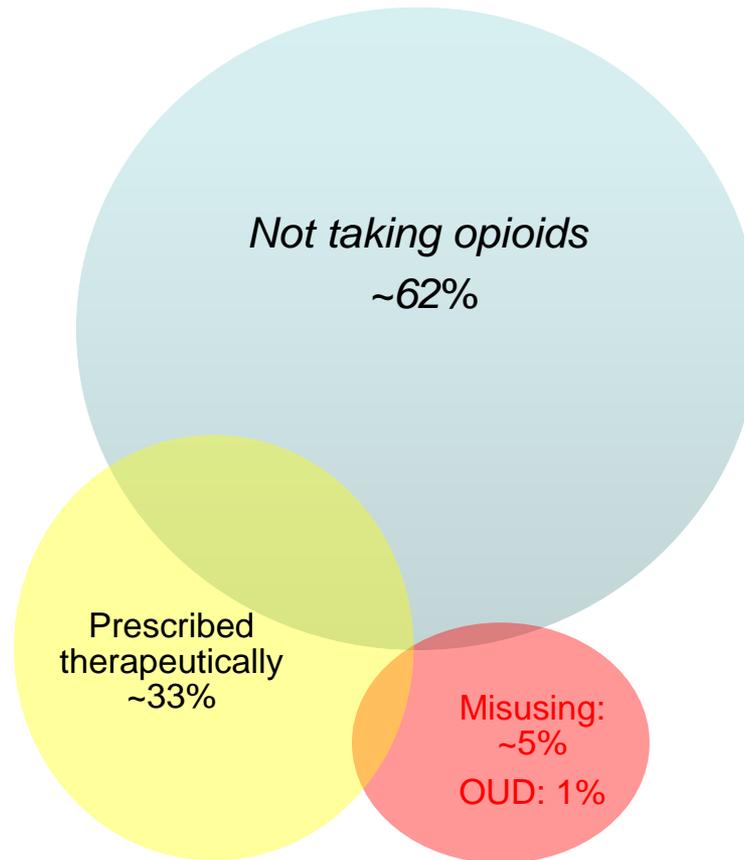
41 year old male with SLE and multiple complications, including vasculitis leading to chronic wounds and serial amputations.

At most recent discharge from the hospital, he is taking methadone 100 mg/daily and oxycodone 30 mg six times daily (~750 MME/day)

# Tapering patients on high doses?

- We do not know if forcing patients who are on high doses of opioids to taper is beneficial.
- Involuntary, precipitous tapering may be harmful (case reports).
- There are studies that have reported improvements with opioid dose reduction or discontinuation, but they are heterogeneous and poor quality; subjects were generally volunteers who were provided intensive support during the change.

# Preventing Misuse



# Patient 6

A 45 year-old male with chronic knee pain is taking oxycodone 15 mg four times daily.

He calls and asks for an early refill. He says he “had to” take more than 4 pills daily for the knee pain over the past month.

# Aberrant Medication-Taking Behavior

Less Likely to be Suggestive of Addiction

Yellow  
Flags

- Complaints about need for more medication
- Drug hoarding
- Requesting specific pain medications
- Openly acquiring similar medications from other providers
- Occasional unsanctioned dose escalation
- Nonadherence to other recommendations for pain therapy

# Aberrant Medication-Taking Behavior

More Likely to be Suggestive of Addiction

**Red  
Flags**

- Deterioration in functioning at work or socially
- Illegal activities – selling, forging, buying from nonmedical sources
- Injection or snorting medication
- Multiple episodes of “lost” or “stolen” scripts
- Resistance to change therapy despite adverse effects
- Concurrent abuse of alcohol or illicit drugs
- Use of multiple physicians and pharmacies

# Addressing Aberrant Medication-Taking Behavior

Use a patient-centered approach:

- Non-judgmental stance.
- Open-ended questions; explore the patient's perspective.
- State your concerns about the behavior.
- Examine the patient for signs of flexibility
  - Are they focused on opioids or pain relief?

# Addressing Aberrant Medication – Taking Behavior.

- **Match action to problem:**
  - Miscommunication of expectations: *patient education*
  - Unrelieved pain: *consider other modalities/meds or refer to specialist*
  - Addiction: *offer addiction treatment*
  - Diversion/Overdose: *STOP medication*

# Addressing Aberrant Medication – Taking Behavior.

**Other strategies, when you suspect there is a problem, but are not sure:**

- *More frequent visits*
- *Closer monitoring*
- Reconsider why you are prescribing opioids. Is there a compelling indication?
- You do not have to “prove” that there is a problem to make a change.

# Patient 7

55 year old female prescribed oxycodone for chronic pain in a variety of locations.

She has had a urine drug test positive for cocaine recently and reported losing her medication at least once in the past year.

She calls and says her oxycodone was stolen.

# Discussing Possible SUD

- Explain why aberrant behaviors raises your concern for substance use disorder.
- Benefits no longer outweighing risks
  - “I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good.”
- Offer SUD treatment or referral.
- Stay in “Benefit/Risk of Med” mindset.

# Why do some physicians over-prescribe?

- Medication mania
- Hypertrophied enabling
- Confrontation phobia
  
- *“Duped, dated, dishonest”*

# Patient 8

58 year old female with a history of cervical cancer and urinary obstruction with nephrostomy tubes. She is prescribed oxycodone 15 mg four times daily for chronic pain.

Since her last visit, she was admitted to an outside hospital after an opioid overdose. She admits that she used heroin.

# Opioid Use Disorder

- Simply cutting off patients does not solve their problem.
- Opioid agonist treatment is generally the most effective and safest option<sup>1</sup>.
- Buprenorphine is often the best choice and is available to all physicians.
- Having buprenorphine in your tool kit makes difficult discussions easier.

# Questions?

