Treatment of Chronic Pain with Opioids: Risk Management and Addiction

Anne Pylkas, MD
Internal Medicine and Addiction Medicine
Hennepin County Medical Center
Minneapolis, MN
• I have no financial disclosures
Outline

• **Defining the problem(s)**

• **Risk management strategies**
  1) Diagnosis
  2) Risk Assessment
  3) Informed Consent/Treatment Agreements
  4) Opioid Choice
  5) Monitoring function and adherence
  6) Aberrant Behaviors

• **Exit strategies**

• **Addiction**
Defining the Problem(s)

• Definition of chronic pain
  – International Association for Study of Pain (IASP): pain that persists beyond expected time frame for healing
  – National Health Survey (NHANES): >3 months of pain
  – American Society if Interventional Pain Physicians (ASIPP): >6 months after an injury and beyond the usual course of an acute disease...
  – VS Chronic pain SYNDROME: Complex pain condition with physical, psychological, emotional and social components, may have NO identifiable etiology for pain
Defining the Problem(s)

• HUGE Public health problem
  — Alford et al 2010
    — Affects >75million in US
    — 20% OP visits
    — 12% of all Rx related to pain
    — >$100 Billion annually in direct and indirect health care costs, exceeds that for cancer, heart disease and diabetes combined

  — IOM Report on Relieving Pain
    — >100 million Americans with pain that persists for weeks- years
    — costs range from $560-630 billion per year
Defining the Problem(s)

Unintentional drug overdose deaths from 1970-2007, NSDUH 2010
Defining the Problem(s)

• Do opioids work for chronic pain?
  – Most of the literature is uncontrolled, case series
  – RCTs are SHORT duration (6 weeks), with small samples
  – Mixed reports on improvement in function

Manchikanti et al. Pain Physician July 2012; 15:S1-S66
The bottom line...

We have a diagnosis (chronic pain):
1) That is poorly defined,
2) and difficult to diagnose,
3) but EXTREMELY common,
4) with huge public health implications.

And a treatment:
1) That we aren’t sure works,
2) and that we know can be dangerous, or deadly.
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Risk Management

• Universal Precautions
  – Gourlay DL. Pain Med 2005;6(2) 107-112
    • Make a clear diagnosis for the pain
    • Make an assessment of risk
    • Inform patient of risks and benefits and sign treatment agreement
    • Continually re-evaluate the pain and level of functioning
    • Continually monitor adherence to treatment
    • Document
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Diagnosis

• Make a clear diagnosis after a comprehensive evaluation
  – Types of Chronic Pain
    • Neuropathic
    • Musculoskeletal
    • Inflammatory
    • Mechanical/compressive
  – Chronic pain syndrome: Complex pain condition with physical, psychological, emotional and social components, may have NO identifiable etiology for pain
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Risk Assessment

• Make an assessment of risk prior to starting or continuing any opioid prescription
  – Good History
  – Tools: ORT, DIRE, SOAPP
  – Records
  – PMP:
  – ?Intake UDS:
Risk Assessment

• Which risk assessment tool is best?

<table>
<thead>
<tr>
<th>Method</th>
<th>Sensitivity</th>
</tr>
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<tbody>
<tr>
<td>Clinical Interview</td>
<td>0.77</td>
</tr>
<tr>
<td>SOAPP</td>
<td>0.72</td>
</tr>
<tr>
<td>ORT</td>
<td>0.45</td>
</tr>
<tr>
<td>DIRE</td>
<td>0.17</td>
</tr>
<tr>
<td>Clin Int + SOAPP</td>
<td>0.90</td>
</tr>
</tbody>
</table>

Moore et al. Pain Medicine 2009; 8(10) 1426-33
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Informed Consent

• The process by which a fully informed patient can participate in choices about health care
• Develop treatment agreement from informed consent
• Includes:
  – The nature of the treatment, what to expect from treatment
  – Responsibilities of both parties
  – Reasonable alternatives
  – Benefits
  – Risks/Side Effects
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Opioid Choice

• Duration and onset
  – Short acting- most reinforcing: Hydrocodone, hydromorphone, oxycodone, morphine, oxymorphone
  – Long acting- least reinforcing: Fentanyl, ER formulations of morphine, oxycodone, methadone, oxymorphone
  – Must also consider potency, ie fentanyl versus hydrocodone and the abuse potential of the formulation (crushed OxyContin, fentanyl matrix vs gel)

• Patient preference
  – There are differences in mu opioid receptors, causes some variability in response to opioids
Opioid Choice

• Methadone takes special considerations
  – Long, variable half life- 12h to 150h- Time to steady state (4-5 half lives) can be days to weeks after initiation or change in dose
  – Do not adjust dose more frequently than every 5-7 days
  – Also potency can be far higher than estimated by equi-analgesic tables, reduce calculated dose by 75-90%
  – Can prolong QTc
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Monitor Function and Adherence

• Monitor/Document the 4 As:
  • Analgesia
  • ADLs
    • Better able to do things? Housework, walk dog, etc?
  • Adverse effects
    • Constipation, falls, sedation?
  • Aberrant behaviors
Monitor Function and Adherence

• What CAN drug tests do?
  – Identify recent drug use- Prescribed/Non-Prescribed/Illegal
    • Self reports of drug use are unreliable in pain patients (14, 15)
  – Identify non-adherence- Improves adherence? (17, 18)

• What CAN’T drug tests do?
  – Detect addiction, abuse, misuse
Monitor Function and Adherence

- **Drug tests are 2 steps**
  - Immunoassay - highly sensitive but not very specific
  - Gas or liquid chromatography/mass spectroscopy confirmation - both sensitive and specific

- **Know the limits of UDS**
  - Pill amounts/prn dosing
  - Cutoff levels
  - False positives common
    - Amphetamines - bupropion, labetalol, pseudoephedrine, trazodone
    - Benzos - sertraline
    - Opiates - Fluoroquinolones, poppy seeds, rifampin
Monitor Function and Adherence

• Opiate: 1-3 days
  – OPIATE positive: morphine, codeine, heroin
  – Variable OPIATE positivity: Semi-synthetic = hydrocodone, hydromorphone, oxycodone
  – Little or no OPIATE positivity: Synthetics = fentanyl, meperidine, methadone, buprenorphine
  – Specific immunoassays available for oxycodone, methadone, buprenorphine

• Benzos: 1-4 days, not very reliable

• Amphetamines: 1-3 days, Many false positives

• Cocaine: 2-3 days

• Marijuana:
  – Single Joint -2 days
  – Chronic use- up to 30 day
Monitor Function and Adherence

• Strategies for enhanced monitoring
  – Set level of monitoring to match risk
    • Frequent visits, small prescribed amounts
    • Random call backs and pill counts, 28 day supply
    • Frequent UDS
    • Requirement that others in family/spouse be contacted for collateral information
    • PMP
  – System fixes- highly structured approach for high risk patients
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### Aberrant Behaviors

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<thead>
<tr>
<th>Abberant Behaviors</th>
<th>Probably More Predictive</th>
<th>Probably Less Predictive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selling Rx drugs</td>
<td></td>
<td>Aggressive complaining about need for higher dose</td>
</tr>
<tr>
<td>Stealing or borrowing another patient’s Rx</td>
<td></td>
<td>Drug hoarding during times of less symptomatology</td>
</tr>
<tr>
<td>Injecting</td>
<td></td>
<td>Requesting specific drugs</td>
</tr>
<tr>
<td>Obtaining drugs from non medical sources</td>
<td></td>
<td>Acquisition of similar drugs from other medical sources</td>
</tr>
<tr>
<td>Concurrent abuse of illicit drugs</td>
<td></td>
<td>Unsanctioned dose escalation 1-2 times</td>
</tr>
<tr>
<td>Multiple unsanctioned dose escalations</td>
<td></td>
<td>Unapproved use of the drug to treat another symptom (insomnia)</td>
</tr>
<tr>
<td>Recurrent prescription losses (darn that toilet)</td>
<td></td>
<td>Reporting psychic effects not intended by the clinician</td>
</tr>
</tbody>
</table>
Aberrant Behaviors

• Differential Diagnosis of Aberrant Behaviors:
  – Pathology progression
  – Opioid induced hyperalgesia
  – Other psychiatric diagnoses
  – Cognitive dysfunction
  – Criminal intent/diversion or sharing
  – NORMAL behavior
  – Abuse/misuse/intoxication
  – “Pseudoaddiction”
  – Addiction
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Exit Strategies

• The reason for discontinuation will determine the length of the taper
  – Immediate discontinuation, no taper
  – Dramatic dosage reduction, re-evaluation
  – Short term taper: 10 days
  – Medium Taper: 30-45 days
  – Prolonged taper: 6 months
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Addiction

• Physical dependence vs addiction
  – Addiction is defined by behavioral symptoms
    • Loss of control, compulsive use, craving, continued use despite harm
  – All patients on opioids > about 4 weeks
    • Withdrawal/physical dependence
    • Some tolerance, most chronic pain patients will hit a dose that works
  – Physical dependence is a part of the diagnosis of addiction, but not necessary
Addiction

• Opioid Dependence/Addiction: DSM IV
  – Dependence requires meeting ≥ 3 criteria:
    • Tolerance
    • Withdrawal
    • Taking larger amounts over longer periods of time than intended
    • Persistent desire to cut down, or unsuccessful attempts to stop/control use
    • Great deal of time spent in using, obtaining or recovering
    • Important social, occupational or recreational activities are given up or reduced because of use
    • Continued use despite knowledge of harm
Addiction

• What do I do if I suspect addiction?
  – Try to diagnose opioid dependence/addiction
  – If the patient meets criteria they can be referred for treatment- Rule 25 or Insurance Company
  – Probably immediate discontinuation (if no pain dx) or short term taper (if pain dx) if dx of opioid addiction can be made
  – The treatment of choice for opioid addiction is **opioid agonist therapy** (methadone or buprenorphine (Suboxone™))
Addiction

• What if I can’t diagnose addiction but I suspect something?
  – Try to figure out why the aberrant behaviors are occurring, remember the differential of aberrant behaviors
  – Tailor the plan to the aberrant behavior and the differential diagnosis
    • Enhance monitoring, shorter term follow up, weekly prescriptions, call backs, psychiatric care, interventional pain care
  – If aberrant behaviors continue discontinue opioid therapy
  – Take some time to think about the case, discuss with colleagues
    • HCMC Opioid Oversight Committee
Addiction

What do I do if a patient has a history of addiction?

- Addiction (to any substance) alters the pain experience
  - Hedonic tone can be altered for YEARS after discontinuation of a drug or alcohol
  - Consider the reasons they became addicted to drugs- Trauma? Abuse? - These also alter the pain experience
- Does not rule them out, but be very cautious, consider short term rx only
- Consider less reinforcing types or opioids (long acting only, Butrans patch)
Take Home Points

• Risk Management
  – Make a diagnosis, assess risk, follow function and adherence closely and don’t be afraid to use your exit strategies
  – Remember the differential of aberrant behaviors and tailor the plan to the diagnosis

• Addiction
  – All patients on opioids for a long period will develop physical dependence, which does not = addiction
  – Diagnose and refer for treatment of addiction