SCOPE of Pain

Safe and Competent Opioid Prescribing Education

Part 3 of 3

BOSTON UNIVERSITY
Boston University School of Medicine
Continuing Medical Education

Case Review: Mary Williams

- Diabetic, obese, hypertensive, smoker with remote history of alcohol dependence
- Past year: took gabapentin and oxycodone/acetaminophen for pain
- New primary care provider prescribes ER/LA oxycodone
- Implements office policy
- Discusses opioid risks, goals of care and monitoring

Mary Williams
Case Study

Summary to Date

- Started on ER/LA oxycodone 15 mg bid, titrated up and stabilized at 20 mg bid
- For subsequent 11 months – all benefit and no harm
  - Coming every 28 days for refills (sees nurse)
  - PCP appointment every 2-3 months
  - Adherent with monitoring
  - Pain, function improved and stable
- Then - ER visit for early refill and in opioid withdrawal

Mary Williams
Case Study

Urgent PCP Office Visit for Early Refill

- Leg and back pain has worsened in past month
  - Started taking an extra ER/LA oxycodone in the afternoon and ran out early.
- Concerned “body has become used to current dose”; doesn’t seem to work all day anymore
  - Husband says she has become “addicted”
- Difficult to go to work due to severe pain
- Trouble sleeping as sheets touching her feet now cause pain
- Requests increase in her dose

Assessing and Managing Aberrant Medication Taking Behavior

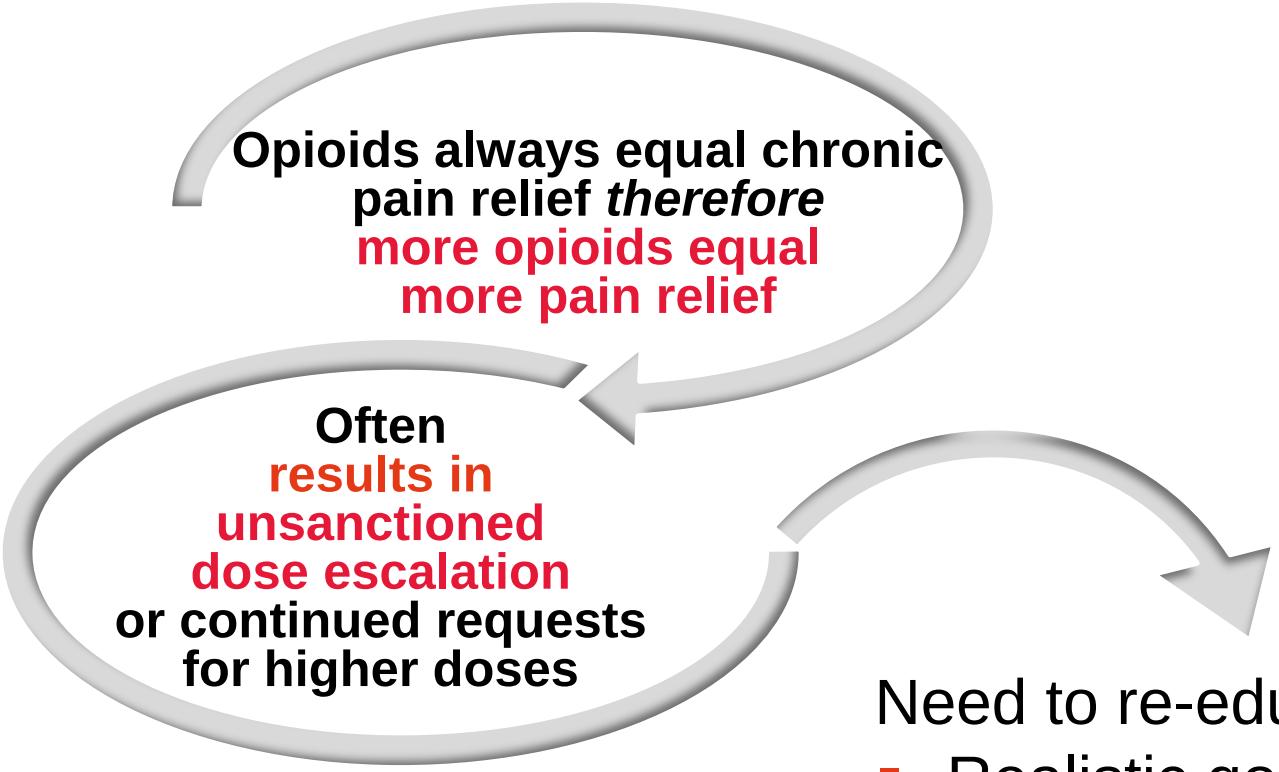
Learning Objectives: Presentation 3

- Assess differential **diagnosis for aberrant medication taking behavior**
  - Pain relief vs drug seeking
- Assess **lack of benefit**, increased risk and/or harm
- Determine whether to **continue, change or discontinue** opioid therapy
- If changing opioids, determine how to **rotate opioids**
- If discontinuing opioids, determine whether and how to **taper opioids**

Managing Expectations

Opioids and Unrealistic Expectations

Patients often have unrealistic expectations that…

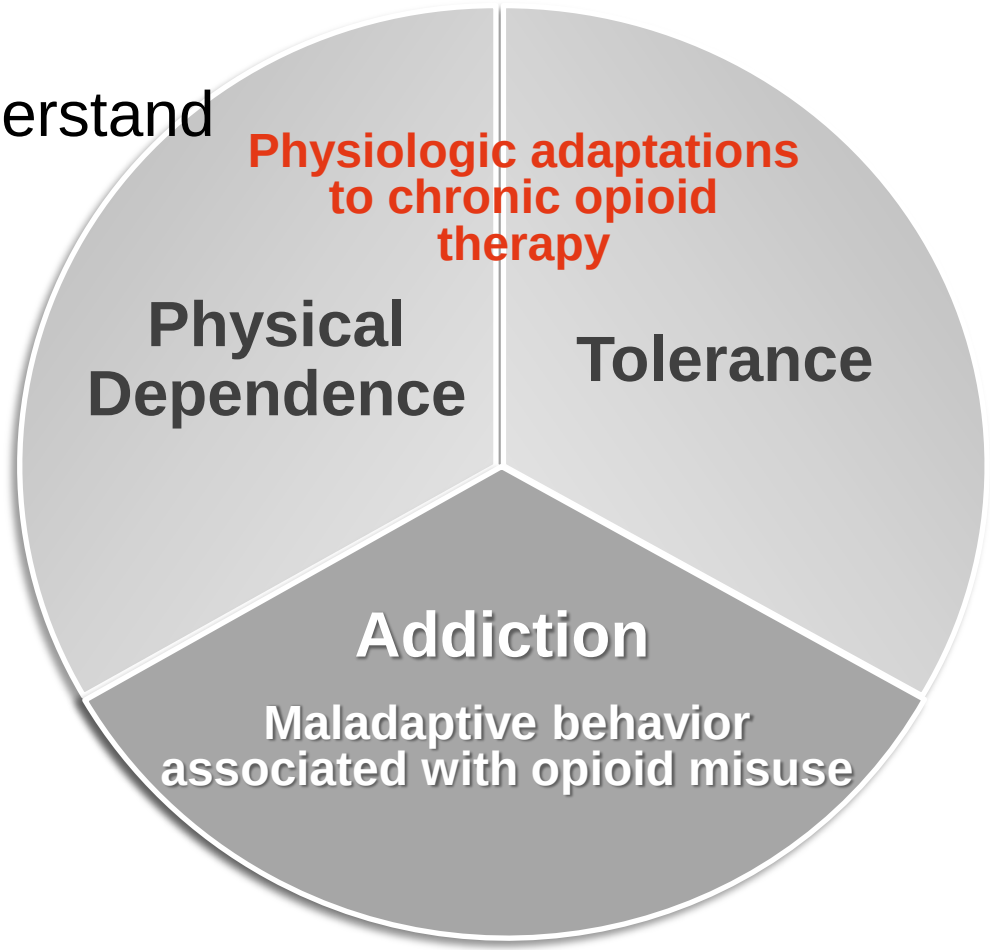


Need to re-educate:

- Realistic goals
- Potential severe risks and harm with opioids

Opioids and Misunderstandings

- Family members (and patients) often misunderstand the differences
- Need to re-educate



Savage SR et al. J Pain Symptom Manage. 2003;26:655-667.

Monitoring for Misuse

Monitoring for Opioid Misuse

- Patient questionnaire
  - Current Opioid Misuse Measure (COMM)
- Other strategies
  - Pill counts (scheduled vs random)
  - Urine drug tests (scheduled vs random)
  - Prescription drug monitoring program data
- History from “reliable” family members
  - Beware of family members with secondary gain for giving inaccurate information

Current Opioid Misuse Measure (COMM)

Assessing Opioid Misuse Risk

- 17 items
- Takes ~10 minutes to complete
- Helps for deciding level of monitoring
- Score range: 0 – 68
- Scores ≥9 detect probable opioid misuse with sensitivity of 77% and specificity of 66%

Key Elements:

- Over-sedation
- Consequences of overuse
- Multiple prescribers
- Medication misuse
- Active mental health issues
- Compulsive use
- Obtaining meds from someone else
- Loss of control

Butler SF, Budman SH, Fernandez KC, et al. Pain. 2007;130:144-156.

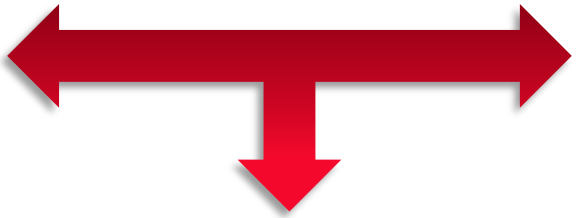
Mary Williams
Case Study

COMM Score Results

- Her COMM score was 12
- Confirms concern about misuse

Aberrant Medication-Taking Behaviors

Differential Diagnosis



Pain Relief Seeking

- Disease progression
- Poorly opioid responsive pain
- Withdrawal mediated pain
- Opioid analgesic tolerance
- Opioid-induced hyperalgesia

Pain Relief and Drug Seeking

(e.g. pain with co-morbid addiction, patient taking some for pain and diverting some for income)

Drug Seeking

- Addiction
- Other psychiatric diagnosis
- Criminal intent (diversion)

Opioid Tolerance

Pain Relief Seeking

- Right shift of the dose-response curve
- Tolerance to antinociceptive effects are demonstrated in animal models but less common in clinical settings
- Longitudinal studies in cancer and noncancer populations find opioid doses typically stabilize for extended periods
- Increased dose overcomes decreased analgesic effectiveness

Schug SA, et al. Drug Saf 1992; 7(3):200-213.
Portenoy RK and Foley KM. Pain 1986; 25(2): 171-186.
Chang G, et al. Med Clin N Am. 2007;91:199-211.
Joseph EK et al. J Neurosci. 2010;30(13):4660-4666

Opioid-Induced Hyperalgesia

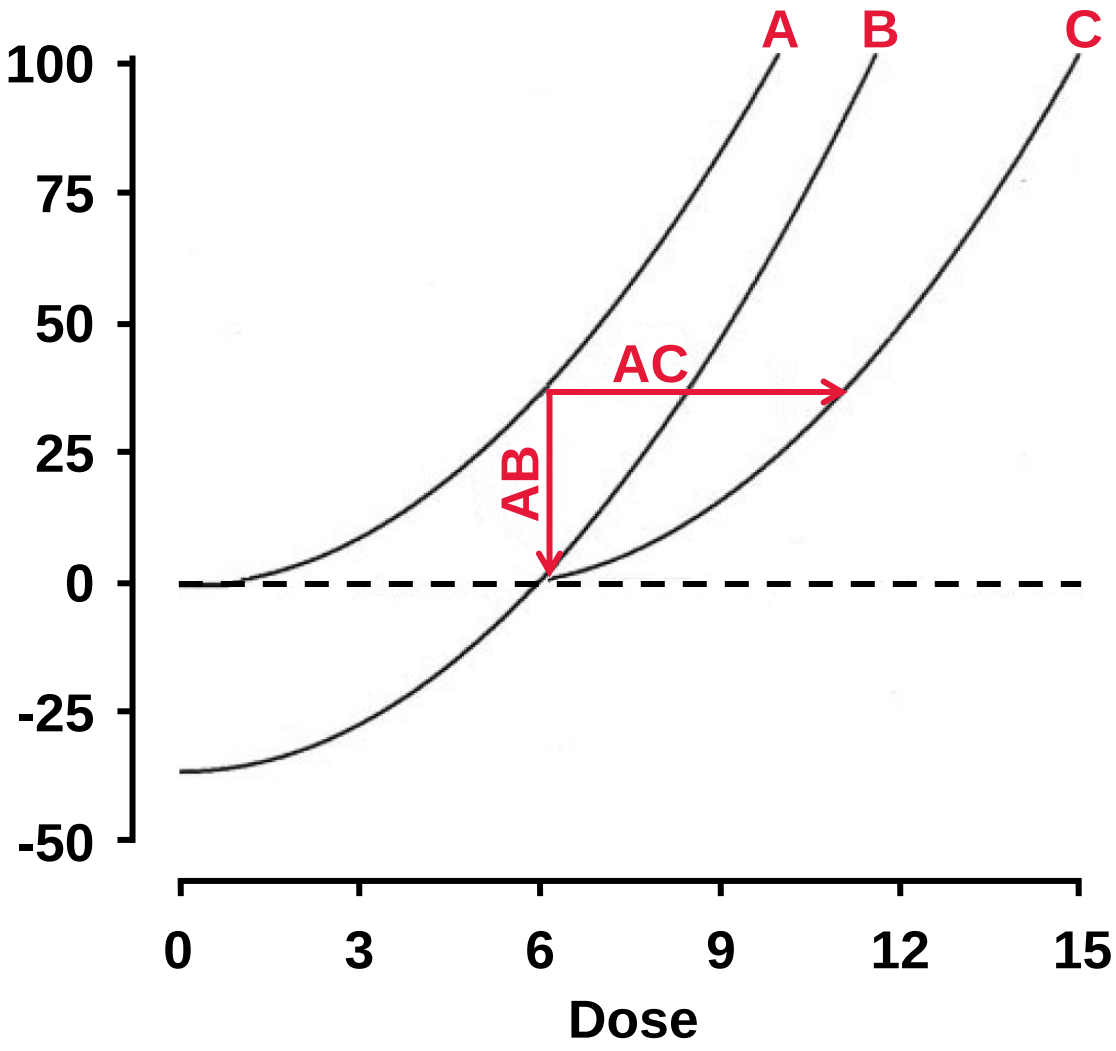
Pain Relief Seeking

- Enhanced pain sensitivity to same opioid dose
- Increased sensitivity can be overcome with increased opioid dose temporarily
- Paradoxically more opioid will worsen pain
- Central and peripheral sensitization of *pronociceptive* process

Chang G, et al. Med Clin N Am. 2007;91:199-211.
Lee M et al. Pain Physician 2011;14:145-161.

Opioid Tolerance vs Opioid-Induced Hyperalgesia

Tolerance and Opioid-Induced Hyperalgesia



Angst MS, Clark JD. Anesthesiology. 2006 Mar;104(3):570-87.

Aberrant Medication-Taking Behavior

Drug Seeking

Drug Seeking

Differential Diagnosis

Addiction

Psychiatric Diagnosis

- Organic mental syndrome
- Personality disorder
- Chemical coping
- Depression/ anxiety/situational stressors
- Psychosocial or emotional issues

Diversion

Drug Seeking

Addiction

Clinical syndrome presenting as…

- Loss of ***C***ontrol
- ***C***ompulsive use
- ***C***ontinued use despite harm
- ***C***raving

Aberrant Medication Taking Behaviors
(pattern and severity)

Addiction is **NOT** the same as physical dependence

Biological adaptation with signs and symptoms of withdrawal (e.g., pain) if opioid is abruptly stopped

Savage SR, et al. J Pain Symptom Manage. 2003;26:655-667.

Concerning Behaviors for Addiction

Spectrum: Yellow to Red Flags

- **Requests for increase opioid dose**
- **Requests for specific opioid by name, "brand name only"**
- **Non-adherence w/ other recommended therapies (e.g., PT)**
- **Running out early (i.e., unsanctioned dose escalation)**
- **Resistance to change therapy despite AE (e.g. over-sedation)**
- **Deterioration in function at home and work**
- **Non-adherence w/ monitoring (e.g. pill counts, urine drug tests)**
- **Multiple "lost" or "stolen" opioid prescriptions**
- **Illegal activities – forging scripts, selling opioid prescription**

Modified from Portenoy RK. J Pain Symptom Manage. 1996 Apr;11(4):203-17.

Other Psychiatric Diagnoses

Drug Seeking

Psychiatric Diagnosis

Chemical Coping

- Patients knowingly or unknowingly inappropriately use opioids to treat a comorbid disease such as depression or anxiety
- Usually self-medicating a mental health disorder or stress

Others

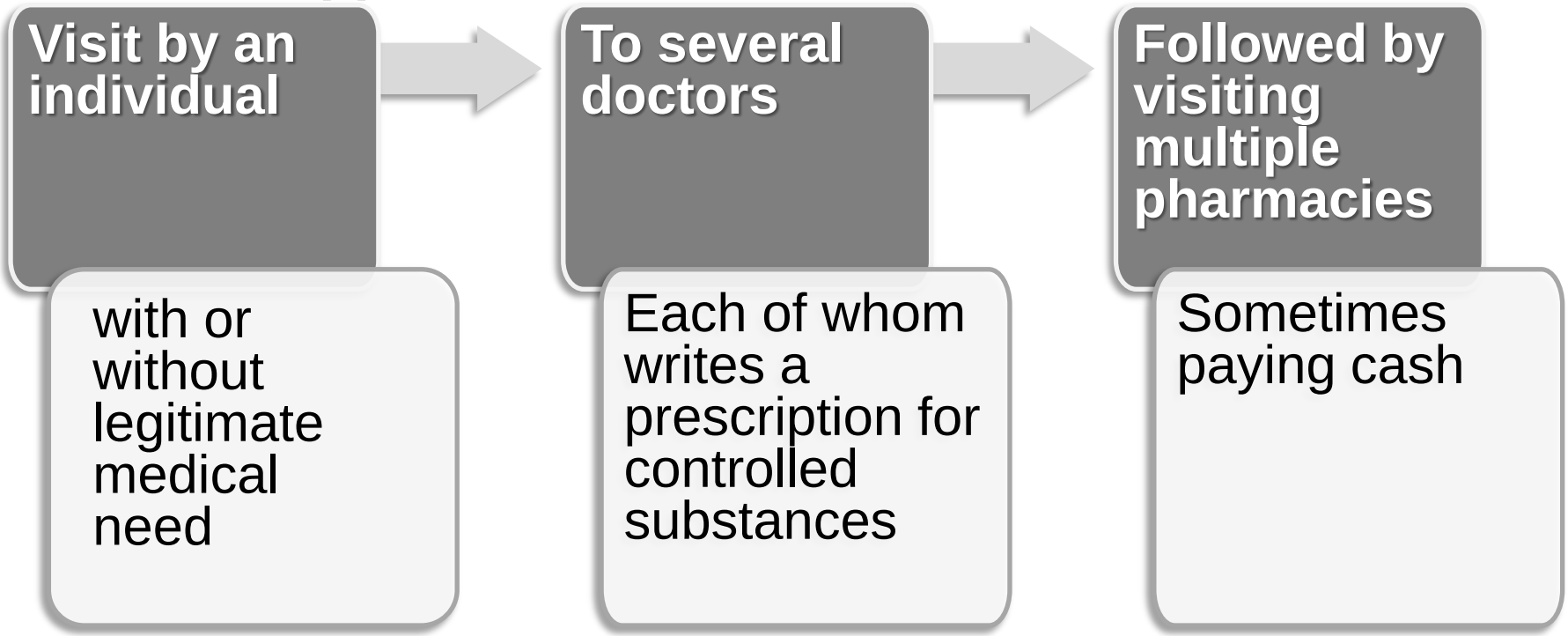
- Organic mental syndrome schizophrenia
- Personality disorder; borderline personality
- Depression/anxiety/situational stressors

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners.* 1st Edition. North Branch, MN: Sunrise Press; 2007.

Drug Seeking

Diversion

Doctor Shoppers



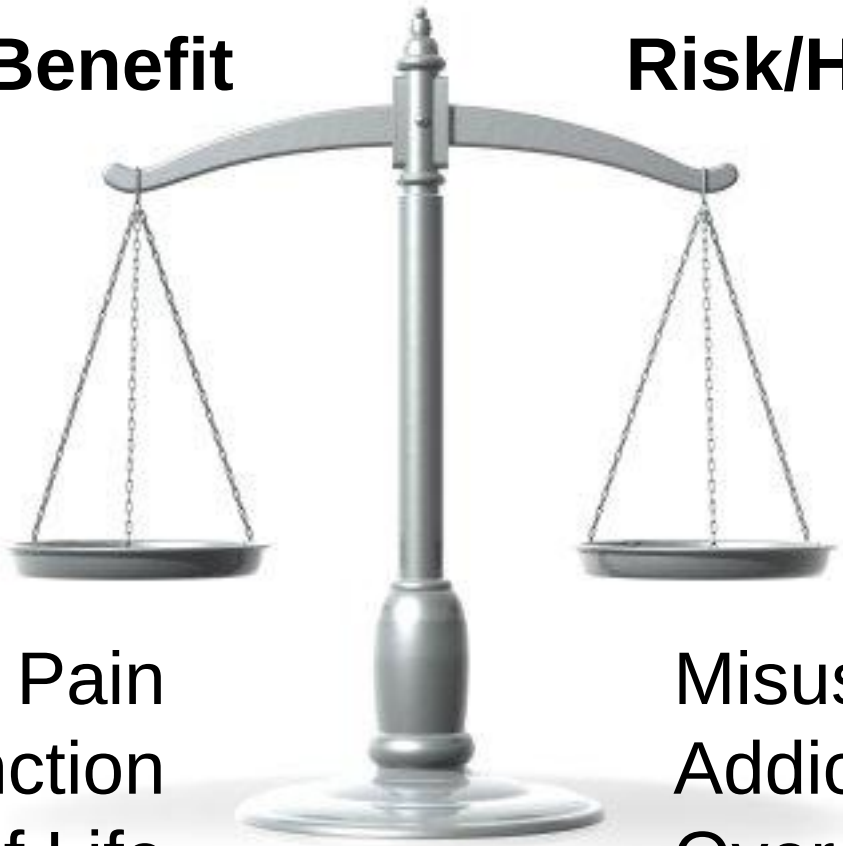
ER/LA opioids can be converted into rapid-onset (immediate release) opioids by altering the tablet or patch

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners.* 1st Edition. North Branch, MN: Sunrise Press; 2007.

Risk Benefit Framework

For Continuing or Discontinuing Opioids

Benefit **Risk/Harm**



Pain
Function
Quality of Life

Misuse
Addiction
Overdose
Adverse Effects

Lack or Loss of Benefit

- Reassess factors affecting pain
- Re-attempt to treat underlying disease and co-morbidities
- Consider escalating dose as a “test”
- Consider adding adjuvant medications for synergy
- Consider adding breakthrough medications
- Consider opioid rotation

Consider Breakthrough Medication

Immediate Release Opioid (Mu agonist)

- Same molecule
- Different molecule

Immediate Release Opioid (dual mechanism)

- Tapentadol
- Tramadol

Non-Opioid Medications

- NSAIDS
- Acetaminophen
- Adjuvant meds

Davies AN et al. European J of Pain 2009;13:331-338.

Consider Opioid Rotation

- Switch to another opioid as means of restoring analgesic efficacy or limiting adverse effects
- Based on large intra-individual variation in response to different opioids
- Different variants of mu-opioid receptors
- Based on surveys and anecdotal evidence
- Promising but needs validation

Inturrisi CE. Clin J Pain. 2002 Jul-Aug;18(4 Suppl):S3-13.
Fine PG and Portenoy RK. J Pain Symptom Manage 2009;38:418-425.

Opioid Conversion Tables

- Derived from relative potency ratios using single-dose analgesic studies in opioid naïve patients
- Based on limited doses or range of doses
- Does not reflect clinical realities of chronic opioid administration
- Are not reliable due to individual pharmacogenetic differences
- Assume no cross tolerance and start every new opioid at a dose used for opioid naïve patients

Webster LR, Fine PG. Pain Med. 2012 Apr;13(4):562-70
Pereira J, et al. J Pain Symptom Manage. 2001 Aug;22(2):672-87.

Continued Lack of Benefit

Remember:

- Not all pain is opioid responsive
- More opioid is not always better
- More opioid may increase risk of adverse effects

Patient may have developed opioid induced hyperalgesia and will improve off opioids

Discussing Continued Lack of Benefit

- Stress how much you believe /empathize with patient's pain severity and impact
- Express frustration re: lack of good pill to fix it
- Focus on patient's strengths
- Encourage therapies for "coping with" pain
- Show commitment to continue caring about patient and pain, even without opioids
- Schedule close follow-ups during and after taper

Pain Management Specialist

Pain Management Specialist

When to Refer

When…

- unsure of treatment options
- interventional treatment may be considered
- unsure how to safely rotate to different opioid
- uncomfortable with managing risk
- unsure how to manage aberrant behaviors

How to Find a Pain Management Specialist

- State Medical Association web sites
- American Academy of Pain Medicine web site
  - www.painmed.org

Too Much Risk

Opioid-related

- Adverse events
  - Side effects; toxicity
- Opioid induced hyperalgesia
  - increased dose or opioid rotations without benefit
- Addiction

Psychosocial

- Psychiatric instability
- Unsafe housing or storage
- Nonadherent with monitoring procedures
- Nonadherent with office procedures
- Use of other non opioid drugs of abuse
- Diversion or criminal behavior

Possible Addiction

Stay in the Risk/Benefit mindset:

- Give specific and timely feedback why patient's behaviors raise your concern for possible addiction e.g., loss of control, compulsive use, continued use despite harm
- Remember patients may suffer from both chronic pain and addiction
- May need to "agree to disagree" with the patient
- Benefits no longer outweighing risks
- "I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good."
- Always offer referral to addiction treatment

Addiction Medicine Specialist

When to Refer

When patient:

- is using illicit drugs
- is experiencing problems with other prescription drugs (benzodiazepines)
- abuses or is addicted to alcohol
- agrees they have an opioid addiction and wants help
- has dual or trio diagnosis of pain, addiction, and psychiatric disease

Making Addiction Treatment Referrals

- Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator
- State resources (Department Public Health)
  - Acute treatment services (detoxes)
  - Medication assisted treatment
    - Methadone maintenance treatment programs
    - Office-based opioid treatment with buprenorphine or naltrexone
- AA/NA free, widely available and effective

Possible Diversion

- Discuss why you are concerned about diversion
  - e.g., nonadherence with pill counts, Urine Drug Test negative for prescribed opioid
- Discuss your inability to prescribe when there is any chance of diversion

Discontinuation of Opioids

- Do not have to prove addiction or diversion - only assess and reassess the risk-benefit ratio
- If patient is unable to take opioids safely or is nonadherent with monitoring then discontinuing opioids is appropriate even in setting of benefits
- Need to determine how urgent the discontinuation should be based on the severity of the risks and harms

Always Plan for Potential "Exit Strategy"

- Emphasize criteria for tapering in initial patient-prescriber agreement
  - Documentation of lack of pain reduction and/or lack of functional improvement
  - Documentation of opioid medication or prescription misuse or abuse
  - Positive urine drug test for any illegal substance
  - Failure to comply with all aspects of treatment program
- Distinguish between abandoning opioid therapy, abandoning pain management, and abandoning patient
- Taper off opioid therapy, with or without specialty assistance

Discontinuing Opioids

Determine Degree of Physical Dependence to Determine Withdrawal Risk

Higher intensity withdrawal from:

- Higher steady state levels
- Longer term exposure
- Faster rate of medication clearance
  - Long vs. short half life agents

Tapering Opioids

Immediate Release Opioids

- Decide if you need a taper at all
  - Is there physical dependence?
- Decrease strength or number of tablets each week
- Build up alternative pain treatment modalities

Tapering Opioids

ER/LA Opioids

- Decrease by 10-20% each week
  - Long acting pill formulations dictate increments of dose decrease that are possible
  - Rate of decrease determined by circumstances of withdrawal: emergency vs. controlled taper
- Can use short acting opioids to treat “breakthrough” symptoms
- Build up alternative pain treatment modalities

Opioid Exit Strategy – Possible Paths

Patient's behavior consistent with drug addiction

- Refer for addiction management or comanagement

Patient unable or unwilling to cooperate with outpatient taper

- Provide sufficient opioid for 1-month taper
- Refer to inpatient or outpatient program or similar service, as available

No apparent addiction problem

Patient able to cooperate with office-based taper

- Taper gradually over 1-2 months
- Implement non-opioid pain management (psychosocial support, CBT, PT, non-opioid analgesics)

CBT, cognitive behavioral therapy; PT, physical therapy.

Katz N. *Patient Level Opioid Risk Management: A Supplement to the PainEDU.org Manual*. Newton, MA: Inflexxion, Inc.; 2007.

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners.* 1st Edition. North Branch, MN: Sunrise Press; 2007.

Using Risk/Benefit Mindset to Avoid Pitfalls

Keep in the Risk/Benefit mindset when responding to:

- But I really, really need opioids.
- Don’t you trust me?
- I thought we had a good relationship/
  I thought you cared about me?
- If you don’t give them to me, I will
  drink/use drugs/hurt myself
- Can you just give me enough to find a new doc?

Next Steps

Mary Williams Case Study

Opioid Rotation from Oxycodone: Options

Different opioid chemical class

Methadone

- Full mu agonist and NMDA antagonist
- May have improved efficacy in neuropathic pain
- Inexpensive and small dosages

Fentanyl Patch

- Full mu agonist

Same opioid chemical class

Oxymorphone or morphine or hydromorphone

Buprenorphine Patch

- Partial mu agonist
- Good safety profile but possible less analgesic efficacy

Mary Williams Case Study

ER/LA Oxycodone to Methadone: Example

Taper ER/LA oxycodone over 2-3 weeks

- **Use IR oxycodone for bridge until therapeutic dose of methadone is achieved**
- **Use clonidine (tablets or patch) if symptoms of withdrawal during rotation**

Titrate methadone slowly over 3-4 weeks

- Analgesia duration is 4-8 hours while serum half life is up to 100 hours resulting in sedation and respiratory depression until tolerance develops
- Begin dose at 2.5 mg TID or 5 mg BID
- Can titrate dose to 5mg TID
- Do not increase dose more frequently than weekly

Mary Williams
Case Study

Over Next 6 Months

- Her pain and function improved
- She was adherent with the treatment and monitoring
- There was no aberrant medication taking behavior

Summary Points: Presentation 3

- Aberrant medication taking behavior can signify pain-relief or drug seeking behaviors or a combination of both
- It is important to fully assess and then respond to aberrant behaviors
- Decisions to continue or discontinue opioids should be based on reassessment of the risks and benefits of the treatment