CHRONIC PAIN & THE OPIOID DILEMMA

- What is chronic pain?
- What is the problem and how did we get here?
- What are the facts?
- What are opioids?
- What is the opioid conundrum?
- How do we identify risk factors for abuse?
- What are treatment approaches?
  - Detoxification & Chronic Pain Management

PAIN PREVALENCE

- Pain is one of the most common reasons patients seek medical attention and one of the most prevalent medical complaints in the US
- ~ 116 million Americans with chronic pain
- Pain associated with:
  - High utilization of health care
  - Loss in productivity associated with persistent pain
  - Annual economic cost exceeds $560 billion

2011 Institute of Medicine Report—Relieving Pain in America

GOAL OF CHRONIC PAIN TREATMENT

- Reduced pain
- Increased function (ADL)
- Return to everyday life activities
- Avoid/Minimize comorbidities from treatment
- Cost-effective medical care
- Stay at Work (SAW) / Return to Work (RTW)

ANALGESICS FOR CHRONIC PAIN (CP)

- Pills most common method of CP treatment
- Pain meds can be a blessing for some in chronic pain, but they are not universally effective and in many cases result in increased disability and dysfunction
THE OPIOID DILEMMA
- Marked increase in prescription drug Rx
- Increased drug use associated with:
  + Decreased function
  + Increased medical costs
  + Lower return to work rates
  + Increased claim duration and costs
- No scientific medical evidence to support effectiveness of opioids in chronic pain

HISTORICAL TURNING POINTS
- 1980s - Portenoy and Foley opined long acting opioids for chronic pain was safe, effective, <1% addiction risk, no upper dose limit
- 1999 - Oregon Board of Medical Examiners disciplined MD for not prescribing enough pain meds - other lawsuits for pain under-treatment
- 2000 - VA launched pain as “5th Vital Sign”
- 2000 - JCAHO issued pain management standard requiring rights of patients to pain management
- 2001 - California jury convicted MD of elder abuse for undertreating pain

UPSHOT
- “The combination of physician promotion, industry marketing and regulatory activities appears to have inadvertently launched the greatest reported iatrogenic and advocagenic epidemic of fatalities in U.S. history.”

OPIOID / BENZODIAZEPINE MIX - DEADLY
- Opioids prescribed 2013:
  + Non-doctors: 30 million opioid prescriptions
  + Doctors: 92 million opioid prescriptions
- Benzodiazepines prescribed 2013:
  + 53 million primary care doctors
  + 13 million psychiatrists
  + 11 million NPs and PAs
- 2010: 30% of the 16,651 opioid deaths also had taken a benzodiazepine

OPIOID MEDICATION SIDE-EFFECTS
- Nausea, vomiting, constipation, swelling, urinary retention, and respiratory depression
- Tiredness & daytime sleepiness (fatigue)
- Internal organ problems (liver, kidney, etc.)
- Poor coordination and balance
- Cognitive (memory/concentration) difficulties
- Depression
- Hormonal imbalance (endocrine problems)
- Weight gain
- Sexual dysfunction

IMPORTANT TERMS
- Physical dependence
- Withdrawal
- Tolerance
- Addiction
- Hyperalgesia
DEPENDENCE
- Physical dependence is a normally induced state such that abrupt stopping medication results in withdrawal symptoms
- Psychological dependence occurs when the individual becomes emotionally tied to taking a specific drug and develops anxiety with planned drug cessation

WITHDRAWAL
- Withdrawal is defined as a set of normal physiologic consequences (things that happen to your body) that occur as a response to abrupt cessation of a drug
- Symptoms consistent with withdrawal include increased heart rate, sweating, body aches, nausea, vomiting, diarrhea, and abdominal pain and mood changes

TOLERANCE
- Tolerance is a simple observation of requiring larger opioid doses to produce the same effect
- In other words, it takes more pills to get the same or less pain relief
- Increase dose may lead to side-effects & dependence

ADDITION
- Addiction is an abnormal behavioral syndrome induced by a certain medication or drug in a susceptible patient
- Findings necessary to make a diagnosis of addiction include:
  - Abnormal behavior focused on acquiring the offending drug
  - Evidence of harm with the use of the drug
  - Continued drug use despite the individual's awareness of harm with use

OPIOID HYPERALGESIA
- Opioid-induced hyperalgesia (OIH) refers to a phenomenon whereby opioid administration results in a lowering of pain threshold, clinically manifest as apparent opioid tolerance, worsening pain despite accelerating opioid doses, and abnormal pain symptoms such as alldynia (pain from stimuli which are not normally painful)

ACOEM OPIOID GUIDELINES
- 80-94% of opioid trials have industry conflicts
- People in safety sensitive jobs should not take opioids
- Suggests a 50mg morphine equivalent dose is the appropriate limit
**ACOEM OPIOID GUIDELINES**

- No comparative trial shows that an opioid is superior to another medication.
- Most in opioid trials do not tolerate opioids and drop out in various phases of the trials.
- No evidence shows the long-term efficacy of opioids - the longest placebo controlled trial lasted only 4 months.

**OPIOID FACTS**

- Opioid analgesics decrease pain in <50% patients with chronic non-cancer pain.
- Those who respond to opioids, report approximately 30% decrease in pain from baseline.
- Most studies show small to medium effect size for pain relief in the short term.
- **There is no convincing evidence on long-term efficacy of opioids.**


**OPIOID FACTS**

- Opioids are not superior to NSAID, tricyclic or anticonvulsant drugs in decreasing pain or disability.
- Opioid analgesic efficacy is not always sustained during continuous and long-term opioid therapy, even in patients with stable disease and despite dose escalation.


**OPIOID FACTS**

- Evidence for improved physical, emotional or cognitive function with long-term opioid therapy is inconclusive.
- There may be a greater risk for driving related accidents and psychomotor impairment in patients who have recently begun opioid therapy or who have recently increased their opioid dose.


**OPIOID FACTS**

- Opioid therapy is associated with high rates of multiple side effects in majority of patients.
- Treatment with long-acting opioids causes hypogonadotropic hypogonadism in both males and females.
- A strong association is reported between daily opioid dose and mortality, even at intermediate doses.
- Methadone causes prolonged QTc interval and heart arrhythmias in susceptible individuals.

**OPIOID FACTS***
- Treatment with high daily doses (>120 mg/day MED), greater day supply of prescription opioids and use of short-acting schedule II drugs increases risk of opioid misuse.
- Risk factors for abuse are younger age, white males, history of mental health disorder, and personal or family history of substance abuse.


**WHAT IS APPROPRIATE OPIOID USE?**
- The issue of appropriate use of opioids in the treatment of Chronic Pain is complex, controversial, and timely.

**THE OPIOID CONUNDRUM**
1. Ever increasing problem of increasing deaths and dysfunction from the inappropriate use of prescription opioids - versus -
2. Needs of patients for adequate pain control to facilitate comfort, activity, function, and return to work

**THE OPIOID CONUNDRUM**
- For the medical practitioner and patient, achieving a balance across the spectrum of outcomes from pain alleviation and increased function as opposed to untoward side effects, aberrant drug-related behavior, drug addiction, drug abuse, drug diversion and potential death, remains problematic

**THE 4 A’S***
- Analgesia (pain relief)
- Activities of Daily Living (physical and psychosocial functioning)
- Adverse Events (untoward side effects)
- Aberrant Drug-Taking Behaviors (addiction-related outcomes)


**SYSTEMATIC APPROACH TO USING OPIOIDS**
- Opioid over prescribing
- The focus of this presentation
- Reluctance to prescribe opioids
  - Clinicians with little training in the area of pain management
  - Patients with fears of addiction or dependence on opioids
  - Negative media coverage about high profile opioid overdoses fuel public and clinician uncertainty
  - Clinicians have fear of regulatory scrutiny and investigation
- Finding a balanced approach
In 2005, Gourlay, Heit, et al., proposed a "universal precautions" approach to the use of opioids in the pain patient.


A Systematic Approach to the Use of Opioids in the Treatment of Chronic Pain, Kevin Zacharoff, M.D., 2/19/14

https://www.painedu.org/articles_timely.asp?Article Number=19

Informed consent

Treatment agreement

Pre-and post-intervention assessment of pain level and function

Appropriate trial of opioid therapy +/- adjunctive medication

Reassessment of pain score and level of function

Regularly assess the 4 A’s of pain medicine

Periodically reviewed pain diagnoses and comorbidities and conditions, including addictive disorders

Documentation

Careful assessment and formation of an appropriate diagnosis

Diagnosis to explain pain cause

Medical comorbidities addressed

Address history of substance use disorder

Address history of psychiatric comorbidity

Does the physical pathology support opioid prescription

Assessment of the benefit and the risk of likelihood of abuse, misuse, or addiction

Past personal and family history of substance misuse

Use of appropriate screening tools

Urine drug testing (UDT) – not meant to be punitive but to identify illicit or non-prescribed licit drugs and to offer further assessment for possible substance use disorders

Define goals, expectations, obligations and responsibilities of both the patient and the treating practitioner

Defined risks and alternatives

Monitoring the patient including UDT

Educate patient about proposed treatment plan with opioids including anticipated benefits, foreseeable risks, and concerns at a level appropriate to the individual patient
ASSESSMENT OF PAIN LEVEL AND FUNCTION

- Pre- and post-intervention assessment of pain level and function
- Initiation of opioid therapy should always be considered a trial

APPROPRIATE TRIAL OF OPIOIDS +/- ADJUNCTIVE MEDICATION

- Opioids may or may not be the first treatment of choice, and will most likely be used with other adjunctive medications
- Must be individualized
- Trial success is measured by less reported pain and actual increased function
- Is there evidence of compliance?
- Are adverse events manageable?

PAIN SCORE AND FUNCTION REASSESSMENT

- Regular reassessment of the patient is critical to support continuation or discontinuation of the therapy
- Is there progress toward goals set by the patient and the physician?

REGULARLY ASSESS 4 A’S OF PAIN MEDICINE

- Routine assessment of Analgesia, Activity, Adverse effects, and Aberrant behavior will help to direct therapy and support pharmacologic options taken

PERIODICALLY REVIEW DIAGNOSIS AND COMORBIDITIES CONDITIONS

- It is critically to continually assess the patient’s condition and behavior over time.
- Response to opioids change over time.
- Diagnostic tests change over time.
- If there is an underlying addictive disorder, pain treatment with opioids will fail over time.

DOCUMENTATION

- It is critical for quality patient care to provide careful and complete documentation
- Thorough documentation can reduce medical legal exposure and risk of regulatory sanction
IDENTIFYING AT RISK PATIENTS

- Predictive tools
- Aberrant behaviors
- Urine drug testing
- Prescription monitoring programs
- Severity and duration of pain v. objective pathology
- Pharmacist communication
- Family and friends

RISK ASSESSMENT TOOLS

- ORT: Opioid Risk Tool
- SOAPP: Screener and Opioid Assessment for Patients with Pain
- DIRE: Diagnosis, Intractability, Risk, Efficacy
- COMM: Current Opioid Misuse Measure
- PMQ: Pain Medication Questionnaire
- DAST-10: Drug Abuse Screening Test

RISK ASSESSMENT TOOLS

- ORT, SOAPP & DIRE
  - Best assess abuse potential among those being considered for long-term opioid therapy
- COMM & PMQ
  - Characterize degree of medication misuse or aberrant behavior once opioids are started
- DAST-10 & PMQ
  - More suitable for assessing current alcohol and/or drug abuse than potential for such abuse


STRATIFYING THE RISK

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
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</thead>
<tbody>
<tr>
<td>No past/current history of substance abuse</td>
<td>History of treated substance abuse</td>
<td>Active substance abuse</td>
</tr>
<tr>
<td>Noncontributory family history of substance abuse</td>
<td>Significant family history of substance abuse</td>
<td>Active addiction</td>
</tr>
<tr>
<td>No major or untreated psychological disorder</td>
<td>Past/comorbid psychological disorder</td>
<td>Major untreated psychological disorder</td>
</tr>
<tr>
<td>Not actively addicted</td>
<td>Significant risk to self and practitioner</td>
<td></td>
</tr>
</tbody>
</table>

HIGH RISK PATIENTS

- Refer to Pain Specialist or addictionologist
- NB: not just any pain specialist will do!
  - Part of the problem versus part of the solution
URINE DRUG TESTING

- **Advantages**
  - Can confirm that prescribed drug is taken and that other drugs are not
  - Makes a strong statement potentially useful in monitoring
- **Disadvantages**
  - Cannot confirm that the proper dose is taken
  - Can be misinterpreted
  - Can be stigmatizing
- **When to Test?**

URINE DRUG TESTING (UDT)

- Initial testing (lab or POC) done with class-specific immunoassay drug panels
  - Typically do not identify individual drugs within a class (rapid results, not quantitative, low specificity)
- Followed by a technique such as GC/MS
  - To identify or confirm the presence or absence of a specific drug and/or its metabolites


U.S. DEPT. OF JUSTICE DEA OFFICE OF DIVERSION CONTROL

- What is a prescription drug monitoring program (PDMP)?
  - A PDMP is a statewide electronic database which collects designated data on substances dispensed in the state.
  - The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency.
  - The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession.

ASPMP

- The Alliance of States with Prescription Monitoring Programs (ASPMP) provides a forum for the development, discussion and exchange of information and ideas regarding all aspects of Prescription (Drug) Monitoring Programs (PMPs/PDMPs) and gives support to these same programs in their mission to curtail the misuse, abuse and diversion of controlled substances while simultaneously serving as a valuable tool for the appropriate prescribing of controlled substances and other drugs of concerns.

http://pmpalliance.org/

PDMP (CURES)

- The California Prescription Drug Monitoring Program (PDMP) - Controlled Substance Utilization Review and Evaluation System (CURES)
  - https://pmp.doj.ca.gov/pdmp/index.do
  - http://oag.ca.gov/cures-pdmp
**MEDICATION OPTIMIZATION**
- Weaning
- Detoxification
- Medication optimization

**TREATMENT APPROACHES**
- Don’t start if no need
- Always start with a trial
- Limit/avoid opioid usage absent clear and continued efficacy
- Identify at risk patients for delayed recovery
- Treatment
  - Detoxification / Weaning
  - Biopsychosocial functional restoration approach per EBM

**BROOM HILDA**

**BIOMEDICAL MODEL**
- Explains pain through etiologic factors (e.g., injury) or disease whose pathophysiology results in pain  Cause →→ Effect
- This classic biomedical approach to understanding and treating pain is incomplete

**BIOMEDICAL MODEL**
- Its exclusive application can result in
  - Unrealistic expectations on the part of the physician and patient
  - Inadequate pain relief
  - Excessive disability in those with pain that persists well after the original injury has healed
  - Unnecessary & preventable chronic pain syndrome
BIOPSYCHOSOCIAL MODEL
- Recognizes that pain is ultimately the result of
  - Pathophysiology
  - Psychological state
  - Childhood and life experiences
  - Relationship/interactions with the environment
    - workplace, home, disability system, and health care providers

CHRONIC PAIN MEDICAL CARE
- It is important to get a sense of the depth and breadth of the person's past and ongoing life experiences and current social situation
- What are the individual's beliefs about the cause, meaning, impact, expectation, perceptions and goals regarding the pain

SIR WILLIAM OSLER (7/12/1849 - 12/29/1919)
- The good physician treats the disease
- The great physician treats the patient who has the disease
- It is more important to know about the patient who has the disease than about the disease the patient has

FUNCTIONAL RESTORATION APPROACH
- Functional restoration is an approach not a specific (expensive) chronic pain program
- FR has been proven cost-effective in the scientific evidence-based medical literature

FUNCTIONAL RESTORATION APPROACH
- Multidisciplinary & Interdisciplinary
- Individualized
- Educational
- Functionally oriented (not pain oriented) to reengage in home and work activities
- Locus of control shifts to individual

TREATMENT GOALS
- Provide each patient with education and a range of tools that assist them confidently and more effectively to manage pain, increase function, and return to everyday life activities including work
**EDUCATION ISSUES**

- Understanding the cause and meaning of pain
- Learning to live with chronic pain
- Takes responsibility for own health
  - Locus of control within the person
- Understand the disability system
- Becoming a person with a manageable pain problem rather than a chronic pain patient
- Education to prevent relapse (backsliding)

**PHYSICAL RESTORATIVE SERVICES**

- Active & Functional
  - Improved body mechanics
  - Spine stabilization, stretching & strengthening
  - Aerobic conditioning
  - Aquatics therapy
  - Tai Chi, Yoga, Qi Gong, etc.
  - Flare-up management
  - Self-directed fitness program

**COGNITIVE-BEHAVIORAL TREATMENT**

- Interventions to change perception or emotional response to pain
  - Acceptance / Reduce negative thought patterns
  - Cognitive restructuring, relaxation training, guided imagery, meditation, desensitization, & pacing
  - Communication skills training
  - Promotion of a self-management perspective
  - Reduce anger and entitlement issues

**CONCLUSIONS**

- Use of opioids may be appropriate
  - Pathology that fits the problem
  - Improved and maintained level of function and increased ADLs
  - Decreased pain
  - Manageable side effects
- But best to avoid long term use of opioids
- Focus on function

**ACPA RESOURCE GUIDE TO CHRONIC PAIN MEDICATION & TREATMENT**

- or
REFERENCES

- Managing Chronic Pain with Opioids in Primary Care, 2nd Edition
  http://download.journals.thiemehealth.com/pdfs/journals/1229-5905160/0/2558298386815.pdf
- Guideline For the Use of Chronic Opioid therapy in Chronic Non-Cancer Pain by The American Pain Society in Conjunction with The American Academy of Pain Medicine
- Responsible Opioid Prescribing: A Physician’s Guide by Scott M. Fishman, MD, Federation of State Medical Boards, 2013
  http://www.fsmb.org/pain-overview.html
- Opioid Prescribing Toolkit by Nathaniel Katz, MD, Oxford University Press, 2011
- Opioid Clinical Management Guide by CARES Alliance
  http://www.caresalliance.org
- A Systematic Approach to the Use of Opioids in the Treatment of Chronic Pain, Kevin Zacharoff, M.D., 2/19/14
  http://www.painedu.org

INTERNET RESOURCES

- General Pain Sites
  - painACTION – http://www.painaction.com
  - American Pain Society (APS) – http://www.painmed.org
  - International Association for the Study of Pain (IASP) – http://www.iasp-pain.org
- For a more complete list go to www.FeinbergMedicalGroup.com and click on References and then Internet Links

INTERNET RESOURCES

- Laws or Legal Issues Regarding Opioid Treatment
  - Federation of State Medical Boards – http://www.fsmb.org
  - Drug Enforcement Administration, Office of Diversion Control – http://www.deadiversion.usdoj.gov
  - The Legal Side of Pain – http://www.legalasidepain.com
  - University of Wisconsin Pain & Policy Studies Group – http://www.painpolicy.wisc.edu
- Risk Assessment Tools
- Resources for Chronic Pain Patients
  - American Chronic Pain Association – http://www.theacpa.org

OPIOIDS & PAIN MANAGEMENT

STEVEN D. FEINBERG, MD, MPH
Board Certified, Physical Medicine & Rehabilitation
Board Certified, Pain Medicine
Adjunct Clinical Professor, Stanford School of Medicine
Feinberg Medical Group
Functional Restoration Programs
Palo Alto, California 94301
stevenfeinberg@hotmail.com
www.FeinbergMedicalGroup.com