Chronic Pain Management in an Opioidphobic Society

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Topics for Discussion

• What is Pain?
• Background/Significance of Pain in America.
• Opioid Epidemic
• Federal legislation /guidelines for the use of opioids.
• Treatment with Opioids/ Pharmacology
• Treatment Agreements/compliance Monitoring

What is Pain?

• International Association for the Study of Pain Definition: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage
• Margo McCaffery’s Definition: “Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does’.

TYPES OF PAIN

<table>
<thead>
<tr>
<th>Duration</th>
<th>Cause</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>Nociceptive</td>
<td>Somatic</td>
</tr>
<tr>
<td>Chronic</td>
<td>Neuropathic</td>
<td>Visceral</td>
</tr>
</tbody>
</table>

Duration

Acute pain
- Relatively brief duration
- Etiology known
- Pain proportionate to damage
- ~ Transient objective signs
- Anxiety, anger, fear common

Chronic pain
- Longer duration
- Etiology ~ unknown
- Pain ~disproportionate
- Often no objective sign
- Depression is common

Background and Significance

• Chronic pain is one of the most common presenting medical problems among adults.
• Approximately 50 million adults in the US have Chronic Pain.
• 19 million adults experience high impact chronic pain
• Women, older adults, currently unemployed but were previously working, adults living in poverty, adults living in rural settings, and adults on public insurance had a higher prevalence of chronic pain.
Background & Significance Cont.

- According to the Institute of Medicine Report on Relieving Pain in America 2011:
  - $560 to 635 billion per year in healthcare costs and lost productivity.
  - Chronic pain will continue to rise as a result of: age, obesity, advances in medicine, poor management of surgical pain, recognition of the disease.

Consequences of Unrelieved Pain

- Physical stress, emotional distress, & suffering
- Insomnia
- Immobility & de-conditioning
- Impaired hormonal & immune function
- Atelectasis, hypoxia, & increase cardiac workload
- Increases morbidity and mortality
- Sensitization & neuroplasticity

Consequences Continued

- Impact of pain on activities (meaningful, pleasurable)
- Relationships with family members / friends
- Abusive relationships?
- Assistance given / received from others
- Use of alcohol, drugs, tobacco
- Talk with patient and S.O.’s
- Self awareness re: therapeutic relationship

Opioid Epidemic

- Mid 1990’s: American Pain Society classifies pain as the 5th vital sign
- October 31, 2000, the 106th U.S. Congress passed H.R. 3244; title VI, Sec. 1603 established the “Decade of Pain Control and Research.”
- 2001: Joint Commission introduced standard to improve treatment of pain, including use of opioids.
- Opioid RX nearly tripled from 1991 (76 million) to 2011 (219 million).

Opioid Epidemic

- From 1999-2017 400,000 Americans died of an opioid related drug overdose (RX and Illicit).
- 68 percent of the 70,000 plus overdoses in 2017 involved the use of an opioid.
- 2017 death rate from an opioid overdose is 6x higher than it was in 1999.
- On average, 130 Americans die of an opioid overdose on a daily basis.
Opioid Guidelines

• CDC Guidelines for Primary Care Providers prescribing opioids for non-malignant pain.
• 1. When to initiate/continue opioid therapy for chronic pain management
• 2. Opioid type, dosage, duration of use, frequency of visits, and discontinuation.
• 3. Risk/Harms assessment of opioid use

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

CDC Guidelines Continued

• 1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh the risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate
• 2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
• 3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CDC Guidelines Continued:

• 4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
• 5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
• 6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

General Opioid Prescribing Guidelines

1. Appropriate Diagnosis
• 2. Comprehensive health assessment physical examination.
• 3. Discuss plan of care and treatment goals.
• 4. Informed Consent/Treatment agreement
• 5. Initiate an appropriate trial of an opioid
• 6. Ongoing assessment of Pain and Functional Status
• 7. Random UDS and Pill Counts
• 8. Adapt Treatment as needed.
• 9. Consult outside Specialist.
• 10. Thorough documentation of condition and treatment.
• 11. Follow Universally accepted guidelines and laws.
Helpful Links for Prescribers:

- NH Medical Society
  https://www.nhms.org/resources/opioid

Prescribers of Opioids

- Know how to start, modify, and discontinue opioids.
- Know how to convert from SA to LA or change from on SA to another SA or a LA to another LA.
- Understand that equal analgesic tables are a guide and are not 100% correct. Take into account incomplete cross-tolerance.

Risk Assessment for Opioid Use

- Pros
  -Protects the patient, the public, and your practice.
  -Helps determine most appropriate treatment protocol.
  -Compliance monitoring (frequency of pill counts and UDS)
- Cons
  -Difficult to find a provider to screen patients.
  -Assessments can be open to interpretation.
  -Cost can be prohibitive for patients if not covered on insurance plan.
  -How to chose which patients need to be screened.

In Office Assessment of Addiction

- Tools available:
  - ORT (Opioid Risk Tool)
  - SOAPP-R
  - COMM (Current Opioid Misuse Measure)
    http://mytopcare.org/wpcontent/uploads/2013/05/COMM.pdf

High Risk: Likelihood of Misusing Opioid Medications.

- May chose to use only non-opioid medications and alternate treatment modalities.
- If prescribing of opioids is initiated, use longer acting products, smaller quantities, frequent visits, more frequent UDS, and random pill counts.
- Re-screen if any signs of aberrant behaviors.
- Consider NA and/or AA services if needed.
- Role of Methadone/Suboxone Clinics for detoxification.

Low Risk: Unlikely to misuse opioid medications.

- Set clear expectations for treatment with opioids and sign treatment agreement.
- UDS on day of first RX to ensure compliance with current and/or reported medication regimen and to ensure no other illicit or prescribed drugs are present.
- Perform random UDS and pill counts.
Opioid Benefits:

• Highly effective, sometime the only effective Rx
• Promotes healing
• Improves mood
• Products with low or “no” ceiling
• Accumulation ~ occur
• Pure agonists have no known end-organ damage

Opioids: Potential Problems

• Side effects
  – Respiratory depression
  – Sedation
  – Nausea / vomiting
  – Urinary retention
  – Hormonal changes
  – Sexual dysfunction
  – Constipation

• Risks
  – Addiction
  – Physical dependence
  – Tolerance
  – Safety concerns (driving)
  – Drug interactions

A Range of Products

• Weak or Mixed Opioids
  – Codeine
  – Propoxyphene
  – Tramadol
  – Pentazocine
  – Nalbuphine

• Strong Opioids
  – Hydrocodone
  – Oxycodone
  – Morphine
  – Levorphanol
  – Hydromorphone
  – Fentanyl
  – Oxymorphone
  – Tapentadol

Prescribers of Opioids

• Know how to start, modify, and discontinue opioids.
• Know how to convert from SA to LA or change from on SA to another SA or a LA to another LA.
• Understand that equal analgesic tables are a guide and are not 100% correct. Take into account incomplete cross-tolerance.

Commonly Used SA Opioids

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosing Strengths mg</th>
<th>Dosing Frequency</th>
<th>Maximum Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxydodeone</td>
<td>5, 10, 15, 20, 30</td>
<td>5 to 30 mg q4 prn</td>
<td>Not defined</td>
</tr>
<tr>
<td>Aspirin</td>
<td>2.5, 5, 10, 15</td>
<td>2.5 to 10 mg q4 to 6 prn</td>
<td>Not defined</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>400, 4000</td>
<td>q8 to q12 prn</td>
<td>4 grams Acet. in 24 hr.</td>
</tr>
<tr>
<td>Hydrocodone/acetaminophen/ibuprofen</td>
<td>5 to 750, 75</td>
<td>2.5 to 10 mg q4 to 6 prn</td>
<td>Not defined</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2, 4, 8</td>
<td>2-8 mg q3 to q4 prn</td>
<td>Not defined</td>
</tr>
<tr>
<td>Morphine IR</td>
<td>10, 30</td>
<td>10-30 mg q3 to 4 prn</td>
<td>Not defined</td>
</tr>
<tr>
<td>Narcopta</td>
<td>50, 75, 100</td>
<td>50 to 100 mg q4 to 6 prn</td>
<td>Not defined</td>
</tr>
</tbody>
</table>

Long-Acting Opioids Commonly Used

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosing Interval</th>
<th>Available Strengths</th>
<th>Administration</th>
<th>Bolus</th>
<th>Ceiling dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>KADIAN® Hydrocodone Extended Release Capsule</td>
<td>q12hr</td>
<td>20, 30, 50, 60, 100 mg</td>
<td>Capsule, Sprinkle, G-Tube</td>
<td>No</td>
<td>–</td>
</tr>
<tr>
<td>AVINZA® Morphine Extended Release Capsule</td>
<td>q24h</td>
<td>30, 60, 90, 120 mg</td>
<td>Capsule, Sprinkle</td>
<td>Yes</td>
<td>1000 mg/day</td>
</tr>
<tr>
<td>MS Contin® OxyContin® Hydrocodone Extended Release Capsule</td>
<td>q12h</td>
<td>10, 20, 40, 80, 160 mg</td>
<td>Tablet</td>
<td>Yes</td>
<td>–</td>
</tr>
<tr>
<td>Duragesic® Fentanyl Transdermal System</td>
<td>q48h</td>
<td>12, 25</td>
<td>Transdermal</td>
<td>No</td>
<td>–</td>
</tr>
</tbody>
</table>
Long-Acting Opioids (continued)

<table>
<thead>
<tr>
<th>Product</th>
<th>Dosage</th>
<th>Formulation</th>
<th>Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opana ER®</td>
<td>Q 12hr</td>
<td>5, 10, 20, 40 Tablets</td>
<td>No</td>
</tr>
<tr>
<td>Exalgo®</td>
<td>Q 24 hr</td>
<td>8, 12, 16 mg Tablets</td>
<td>No</td>
</tr>
<tr>
<td>Subutex®</td>
<td>Q week</td>
<td>5, 10, 20 mg Tablets</td>
<td>Transdermal</td>
</tr>
<tr>
<td>Methadone Dolaphine</td>
<td>Q 8 hrs</td>
<td>5, 10, 20 Tablet</td>
<td>No</td>
</tr>
</tbody>
</table>

Products to avoid (or use cautiously)

- DO NOT USE PLACEBOS
- Avoid
  - Demerol
- Use Cautiously
  - Codeine
  - Tramadol
  - Agonist/antagonist drugs
  - Methadone

Pain Treatment Agreements

Positives
- Clear expectations
- Informed Consent
- Documentation
- Patient safety
- Safe Guarding Practice

Negatives
- Patient Perceptions about agreements
- Open to interpretation
- Time and staff power needed to keep agreements up to date

PAIN TREATMENT AGREEMENT

[Formal and detailed agreement text]

YOUR SAFETY WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS

Please list each time after reading:

1. Avoid other agents that may elicit a state of euphoria.
2. Do not exceed individual pain management threshold.
3. Do not exceed individual pain management threshold.
4. Avoid other agents that may elicit a state of euphoria.
5. Do not exceed individual pain management threshold.
6. Avoid other agents that may elicit a state of euphoria.
7. Do not exceed individual pain management threshold.
8. Avoid other agents that may elicit a state of euphoria.
9. Do not exceed individual pain management threshold.
10. Avoid other agents that may elicit a state of euphoria.
Compliance Monitoring

**Positives**

- Necessary to protect the patient, provider, and society.
- Monitors adherence to treatment protocol.

**Negatives**

- Cost
- Staffing
- Time
- Patient complaints

Laboratory Information

- Know the cut off levels for a given drug.
- Know which drugs are screened for on a standard panel and which need to be added.
- If using a commercial lab, ensure that pricing information is available for a given panel and add ons.
- Have a go to person to address problems or concerns.

Toxicology Report Examples
<table>
<thead>
<tr>
<th>Analyte Name</th>
<th>Result</th>
<th>Cut-off</th>
<th>Unit</th>
<th>Loc</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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**Urine Drug Test - Quick Reference**

**Positive Consistent**
- Drug (or metabolite) detected and IS included in list of medications

**Positive Inconsistent**
- Drug (or metabolite) detected and IS NOT included in list of medications

**Negative Consistent**
- Drug (or metabolite) NOT detected or below cutoff level and IS included in list of medications

**Negative Inconsistent**
- Drug (or metabolite) NOT detected or below cutoff level and IS NOT included in list of medications

**Drug** | **Reason for Positive Consistent / Inconsistent** | **Detection Window**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbiturates</td>
<td>Metabolite of Cocaine</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Carbon Tetrachloride</td>
<td>Metabolite of Codeine</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Metabolite of Codeine</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Metabolite of Hydrocodone</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Opiates</td>
<td>Metabolite of Hydrocodone</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Opiates</td>
<td>Metabolite of Methadone</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Opiates</td>
<td>Metabolite of Morphine</td>
<td>1-4 Days</td>
</tr>
<tr>
<td>Opiates</td>
<td>Metabolite of Oxycodone</td>
<td>1-4 Days</td>
</tr>
</tbody>
</table>

**Laboratory Accession:**

**Donor's Name:**

<table>
<thead>
<tr>
<th>Analyte Name</th>
<th>Result</th>
<th>Cut-off</th>
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</table>
Ethical Considerations

- Undertreatment of pain and following the CDC Guidelines Opioid dosing.
- Some Chronic pain patients have been on high dose opioids for decades.
- Reducing Opioids can significantly impact pain intensity, QOL, and Functional Status.
- Labeling of patients on opioids as being addicted to their medications (Friends, Family, Medical Providers, Government, and Society).

Sociocultural Issues

- Primary issue is access to care for patients with acute and chronic pain conditions (ER, PCP, Specialty).
- Pain management approaches utilizing opioids are becoming more limited for patients and they are seeking alternate means to manage their pain (Self Medicating).
- Patients who have been on high dose opioids for many years are now being tapered off or greatly reduced, considered “Pain Refugees”.
- Government agencies creating guidelines that are a one size fits all approach, not taking into consideration the treating providers knowledge base, experience, and relationship with his/her patient.

References:

References Continued

