

Complex Chronic Pain: Tips and Tools for Frontline Providers

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- I have no disclosures to report.



Objectives

- To develop empathic and sensitive ways of communicating with patients suffering from chronic pain
- To review the “four quadrants” of chronic pain treatment
- To improve recognition and diagnosis of an opioid use disorder in patients with chronic pain on opioids
- To be able to explain the risks associated with long-term opioid therapy to patients

Case 1

- 46yo M with a history of HTN, depression, generalized anxiety disorder, asthma/COPD, chronic low back pain on opioid therapy, HCV, hx “polysubstance abuse”, and homelessness is admitted to the hospital with a COPD flare and acute kidney injury (Cr 1.6, from 0.8).
- He was taking: gabapentin, venlafaxine ER, amlodipine, inhalers, docusate, senna, and the following opioids:
 - ◆ Morphine sulfate CR 30mg po tid
 - ◆ Oxycodone IR 15mg po qid
 - ◆ MED = 180mg daily
 - ◆ <http://agencymeddirectors.wa.gov/mobile.html>

Case 1 continued

- He received treatment for his asthma/COPD exacerbation and intravenous fluids with improvement in his creatinine to 1.3.
- He reported doing well – taking his pain pills and abstaining from cocaine. He was buying diazepam off the street (10/d). He is homeless & estranged from family. Has few trustworthy friends.
- His main complaint is severe, uncontrolled pain in his back (sharp and tight, paraspinal), and closely watched the clock for his next PRN.
- He was seen by Pain Consult and described poor pain control. He'd been buying methadone off the street and that was helping much more than the morphine. He had been out of his gabapentin.

Case continued

- Which of the following represents the best management plan with regard to his pain?
 - ◆ A) Stop morphine sulfate ER and switch to methadone + short acting PRN
 - ◆ B) Continue morphine sulfate ER and oxycodone and add non-opioid pain relievers
 - ◆ C) Stop all opioids and refer to methadone maintenance treatment
 - ◆ D) Increase dose of morphine sulfate ER + short acting PRN agent

Case continued

- Which of the following represents the best management plan with regard to his pain?
 - ◆ A) Stop morphine sulfate ER and switch to methadone + short acting PRN
 - ◆ B) Continue morphine sulfate ER and oxycodone and add non-opioid pain relievers
 - ◆ C) **Stop all opioids and refer to methadone maintenance treatment**
 - ◆ D) Increase dose of morphine sulfate ER + short acting PRN agent

Case continued

- The patient was transitioned from morphine sulfate ER to methadone 20mg po TID + hydromorphone 8mg po q4hrs PRN in discussion with the PCP, pain consult, and hospitalist.
- The patient missed his initial follow-up appointment but then got repeat labs showing an increase of his creatinine back to 1.6. He could not be contacted by phone despite several attempts.
- 5 days after discharge he was found dead.
- Cause of death: acute mixed drug intoxication
 - ◆ Serum methadone = 1600ng/mL

Lessons: the New Epidemic

- Drug overdose
 - ◆ Leading cause of injury death in 2014 (>47,000 deaths), surpassing motor veh. accidents in 25-64 year olds
 - ◆ 51% of deaths related to prescription drugs
 - ☞ ~19,000 deaths from prescription opioid pain relievers
 - ☞ 10,000 deaths from heroin
 - ◆ Rx-opioid overdose: quadrupled (2000-2014)
 - ◆ Increased risk: high dose, hx of substance use or mental health disorder

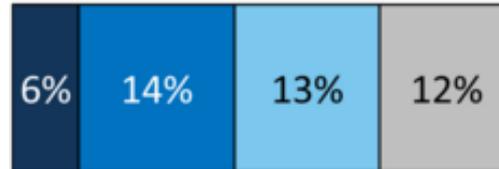
CDC Rx
Opioids.

Is this New?

■ Themselves
 ■ Family Member
 ■ Close Friend
 ■ Acquaintance/ Someone else

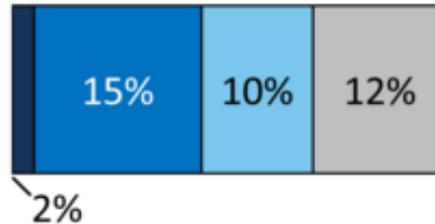
**TOTAL
KNOW ANYONE**

Ever taken a prescription painkiller that was not prescribed to them



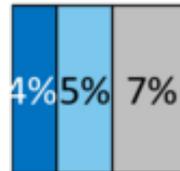
45%

Ever been addicted to prescription painkillers



39%

Died from a prescription painkiller overdose



16%

**259
million**

SCHOOL OF MEDICINE • UNIVERS

KFF Health Tracking Poll Nov 2015



Lessons



- Distinguishing between pain and an opioid use disorder?
 - ◆ Opioid use disorder
 - ☞ 4 Rs
 - Risk of bodily harm **Benzos + opioids**
 - Relationship trouble
 - Role failure **Homeless, disconnected from family**
 - Repeated attempts to cut back
 - ☞ 4 Cs
 - Loss of Control
 - Continued use despite harm
 - Compulsion (time & activities) **Time/hustle to buy street pills**
 - Craving **I need more; pain pills are not holding me**
 - ☞ Withdrawal and tolerance

Mild: 2-3 criteria
 Moderate: 4-5
 Severe: 6+

Lessons

- Methadone
 - ◆ serum half life: 15-60 hours; variable bioavailability; metabolized by CYP3A4
 - ◆ 1999-2008: methadone poisoning increased 600%
 - ◆ American Pain Society recs: 2.5mg q 8, inc q week

Conversion table from morphine to methadone (most commonly used in the USA)

24 hour total dose of oral morphine	Conversion ratio (oral morphine: oral methadone)
<30mg	2:1 (2mg morphine to 1mg methadone)
31-99mg	4:1
100-299mg	8:1
300-499mg	12:1
500-999mg	15:1
1000-1200mg	20:1
>1200mg	Consider consult with palliative care or pain specialist

www.compassionandsupport.org;

Chou R, et al. J Pain. 2014;15(4):338-65

- **Example:**

- ◆ Morphine sulfate 60mg po bid → total 15mg methadone daily
- ◆ Morphine sulfate 200mg po tid → total 40mg daily

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If you can...prevention



\$15 → 30 → 45



\$500



\$75/2 for Medicaid



\$0

But this pain...do you want me to start shooting dope??

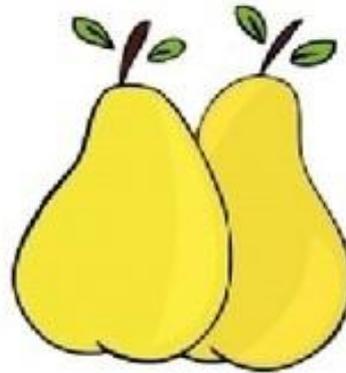
- A quick diversion into **motivational interviewing...**
 - ◆ **Open-ended questions**
 - ◆ **Affirmations**
 - ◆ **Reflections**
 - ◆ **Summary**



But this pain...do you want me to start shooting dope??



Think...



Pair...



Share!!!

But this pain...do you want me to start shooting dope??

- No, I don't want you to start injecting heroin. You don't want that either. You should feel proud that you don't use needles anymore.
- My job is to take care of you and make sure you're safe.
- I don't think you can safely continue on opioid pain pills. I want to give you a better, safer treatment because I think you have severe, uncontrolled pain, and an opioid use disorder.
- I'm not going to leave you. You are suffering right now.
- The treatments I can offer you are methadone maintenance programs, or buprenorphine-naloxone.

Treatment Program Locator

- Buprenorphine-certified providers:
 - ◆ <http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>
 - ◆ To get trained: www.buppractice.com
- Opioid treatment program directory:
 - ◆ <http://dpt2.samhsa.gov/treatment/directory.aspx>
- Substance use treatment warm line: **1-855-300-3595**. 10a-6pm EST

Take-home points

- Be the most sensitive and empathetic you can be when communicating discontinuation of opioids.
- Run towards the patient, not away.
- Avoid opioids in individuals with active substance use disorders given safety risks. Show caution with methadone, benzodiazepine, and alcohol use.

Case 2

- A 34yo marginally-housed F with a history of depression, obesity, PCOS, and low back pain presenting for primary care follow-up. She describes sharp pain in L back, 8/10, with occasional radiation down her leg x2 weeks. She denies weakness and numbness and has a normal neurologic exam.
- She says the pain is excruciating and she's had difficulty at work. She's been using her husband's pain pills (hydrocodone-acetaminophen) and is wondering if you can prescribe some.
- You try NSAIDs, ice/heat, massage and basic wall exercises and ask her to return in 2 weeks.

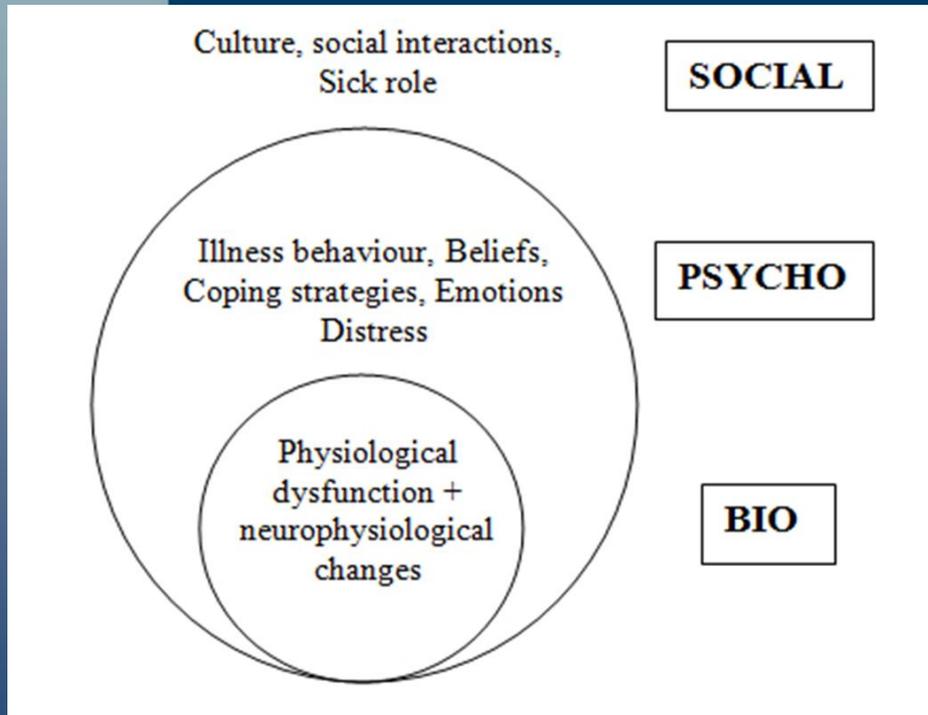
Case 2 continued

- She returns in 2 weeks and says the pain is still very severe (8/10), “tight and throbbing”, almost constant. She tried the ibuprofen which had some effect, as does ice/heat, but it’s only temporary. She is still using her husband’s hydrocodone-acetaminophen and says that’s her preferred agent. She’s having difficulty sleeping, which is making her more tired throughout the day.
- She denies depressed mood or lack of interest in daily activities. She continues to feel stress and anxiety about life at home. She does not smoke or use drugs or alcohol.

Evaluation

- Empower
 - ◆ What are you doing to control your pain?
 - ◆ Acknowledge suffering while focusing on strength and recovery
- Educate
 - ◆ Back pain is common (mean point prevalence 18%; lifetime prevalence 39%)
 - ◆ At 1 mo. ~1/3 with mod. pain (20% activity); 1 year, ~1/3 with mod. pain
 - ◆ Opioid efficacy
 - ◆ Chronic pain in 5 minutes video
- Evaluate
 - ◆ Function (work, apt), substance use, and psychiatric

Treatment: The Broader Context of Pain



Husband disabled. Sole wage earner. IHSS hours decreased.

*Tired. Stressed. Depressed.
Worried something is wrong with her body.*

Lumbosacral strain

What Are My Alternatives?

Pharmacologic

Physical

Complementary and
Alternative Medicine

Cognitive and
Behavioral

Pharmacologic

- NSAIDs
- Neuroleptics
- Antidepressants
- Muscle relaxants
- Topicals
- Opioid medications/Tramadol
- Pumps (baclofen, lidocaine)
- Buprenorphine

Physical

- Physical Therapy
- Joint injections
- Directed Exercise Program
- Pacing daily activity
- Heat or ice
- Trigger point injections

Complementary and Alternative Medicine

- Acupuncture (community and schools)
- Mindfulness Based Stress Reduction and meditation
- Yoga
- Massage
- Supplements (glucosamine chondroitin, SAM-e)
- Guided imagery
- Breathing exercises

Cognitive and Behavioral

- Pain Groups
- Cognitive and behavioral therapy
- Visualization, deep breathing, meditation
- Sleep hygiene
- Gardening, being outdoors, going to church, spending time with friends and family, etc.
- Pain ToolKit

Can it work?

- Biopsychosocial Treatment
 - ◆ Patients with chronic neck or back pain >3mos (taken sick leave)(~50% depressed)
 - ◆ 3 week **inpatient** multidisciplinary treatment (5d/w; 8h/d)
 - ☞ Physical exercises
 - ☞ Ergonomic training
 - ☞ Psychotherapy
 - ☞ Patient education
 - ☞ Behavioral therapy
 - ☞ Workplace-based interventions
 - ◆ At 6 months: 67% returned to work; SF-36 score improved

Case cont'd

- She was offered low-dose baclofen given her complaints of tightness in her muscles. She was referred to the Healthy Spine clinic.
- You check in with her by phone 1 week later and she says the baclofen is making her sleepy and she still has pain. She's been trying to do her exercises, think positively, and use the ice/heat and massage. She also got some muscle rub.

Question

- Which of the following is the best course of action?
- A) Continue with plan explaining it takes time to see improvement
- B) Add diazepam for muscle pain
- C) Check a urine drug screen
- D) Start extended-release opioid medication
- E) Something else

Question

- Which of the following is the best course of action?
- A) Continue with plan explaining it takes time to see improvement
- B) Add diazepam for muscle pain
- C) **Check a urine drug screen**
- D) Start extended-release opioid medication
- E) Something else

Case continued

- Discussion about risks/benefits of opioids. Urine drug screen normal. Prescription activity report with no prescriptions. Decision to prescribe opioids (hydrocodone-acetaminophen) as treatment trial.
- Patient returned for follow-up 2 weeks later. In that time she did not have to take additional sick days. She was taking ~1-3 pills per day. Her sleep had improved. She attended her healthy spine appointment & was taught additional exercises.
- Epilogue: Patient continued on opioid for ~3 months, taking less over time and with no concerning behaviors. Patient had also been doing basic fertility treatments and became pregnant, and stopped opioids completely.

Take Home Point

- Think of the four quadrants when developing treatment options with your patients. Cultivate their resilience & strength.
- Opioids may still be required for patients that have failed multi-modal therapy and who do not have active substance use or mental health disorders.

Case 3

- 46yo M with a history of chronic homelessness and incarceration, severe stimulant use disorder, moderate opioid use disorder, poorly-controlled insulin-dependent DM, and a history of osteomyelitis of the R hip (now with fused joint) and a recent fracture of the L hip s/p surgical repair 4 months ago. He ambulates with a cane.
- He is homeless
 - ◆ Has no entitlements (including GA)
 - ◆ On parole
- He complains of excruciating pain in his bilateral hips. States that Dilaudid™ is most effective for his pain.

REG/ADM	DISCH		HSP D/C		ATTENDING	RENDERING	EVT	
DATE	DATE	SITE	CLINIC	SVC	DSP	DOCTOR NAME	PROVIDER NAME	TYPE
●03/24/16	/ /	SFGH	GMCBH	GMC		PHYSICIAN ,STATI	IVEY ,GRACE	OA
●03/24/16	/ /	SFGH	GMC	GMC		PHYSICIAN ,STATI	GREENE ,CHRISTIN	OA
●03/16/16	03/16/16	SFGH	ERWTR	EMR	HR	THOMAS ,CHLOE		EA
●03/15/16	03/15/16	SFGH	ERWTR	EMR	HR	HOFFMAN ,STEPHEN		EA
●03/09/16	03/12/16	SFGH	ERWTR	MED	HR	CRITCHFIELD ,JEF		ID
●03/08/16	03/08/16	SFGH	ERWTR	EMR	HR	MONGELLUZZO ,JIL		EA
●02/19/16	02/19/16	SFGH	ERWTR	EMR	TF	MONGELLUZZO ,JIL		EA
●02/17/16	/ /	SFGH	ORALSURG	OSC		GORDON ,NEWTON	LUGO ,RICARDO	OA
●02/10/16	/ /	TWHC	OSRES	TWC		MOZELSIO ,MICHEL		OA
●02/04/16	02/17/16	SFGH	ERWTR	MED	HR	GOLDMAN ,SETH		ID
●02/04/16	/ /	TWHC	OSRES	TWC		NANCE ,MICHELLE	NANCE ,MICHELLE	OA
●02/02/16	/ /	TWHC	OSRES	TWC		NANCE ,MICHELLE	NANCE ,MICHELLE	OA
●01/13/16	02/02/16	SFGH	ERWTR	ORT	HR	MCCLELLAN ,ROBER		ID
●01/06/16	01/06/16	SFGH	ERWTR	EMR	HR	WHETSTONE ,WILLI		EA
●01/02/16	01/02/16	SFGH	ERWTR	EMR	HR	TENNER ,ANDREA G		EA
●12/29/15	12/29/15	SFGH	ERWTR	EMR	HR	ISAACS ,ERIC		EA
●12/10/15	12/12/15	SFGH	ERWTR	MED	HR	HABER ,LAWERENCE		ID
●12/05/15	/ /	SFGH	URGCARE	URC		GORE ,MELISA A.	GORE ,MELISA A.	OA
●11/29/15	11/29/15	SFGH	ERWTR	EMR	HR	HSIA ,RENEE		EA
●11/17/15	11/25/15	SFGH		MED	HR	ORTIZ ,GABRIEL		ID
●11/17/15	/ /	SFGH	GMC	GMC		PHYSICIAN ,STATI	BAER ,MARTHA	OA
●11/16/15	/ /	SFGH	GMC	GMC		SIEGEL ,REBECCA	SIEGEL ,REBECCA	OA
●11/16/15	/ /	SFGH	GMC	GMC		PHYSICIAN ,STATI	WHEELER ,MARGARE	OA
●11/15/15	11/16/15	SFGH	ERWTR	EMR	HR	ISAACS ,ERIC		EA

Case 2

- Which of the following represents the best management approach?
 - ◆ A) Intensive case management program
 - ◆ B) Given uncontrolled pain, start long-acting opioid and Dilaudid™ for breakthrough pain
 - ◆ C) Given uncontrolled pain, refer for physical therapy and free acupuncture
 - ◆ D) Refer for substance use treatment
 - ◆ E) More than one of the above

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 - ◆ A) **Intensive case management program**
 - ◆ B) Given uncontrolled pain, start long-acting opioid and Dilaudid™ for breakthrough pain
 - ◆ C) Given uncontrolled pain, refer for physical therapy and free acupuncture - *maybe, once stable*
 - ◆ D) **Refer for substance use treatment**
 - ◆ E) **More than one of the above**

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●11/17/15	/ /	SFGH	GMC	GMC		PHYSICIAN ,STATI	BAER ,MARTHA	OA
●11/16/15	/ /	SFGH	GMC	GMC		SIEGEL ,REBECCA	SIEGEL ,REBECCA	OA
●11/16/15	/ /	SFGH	GMC	GMC		PHYSICIAN ,STATI	WHEELER ,MARGARE	OA
●11/15/15	11/16/15	SFGH	ERWTR	EMR	HR	ISAACS ,ERIC		EA

2/17
Rx opioid

2/2
Rx opioid

12/28
Rx opioid

11/25
Rx opioid

Is disease control better?

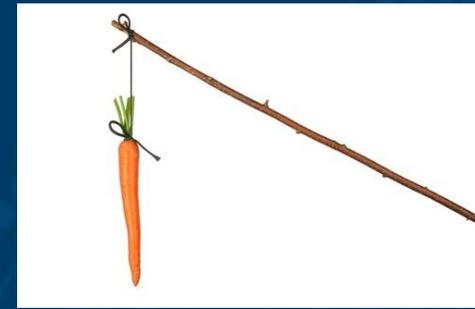


Table 4. Completion of Diabetes Performance Measures Among 268,668 Subjects for Whom Opioid Dosage Information Was Available^a

Variable	Opioid Dose Quartile (95% Confidence Interval) ^b					Test for Linear Trend P
	Controls (n = 220,912)	Lowest (n = 10,670)	Lower (n = 10,675)	Higher (n = 10,677)	Highest (n = 10,678)	
Process measures						
A1C level measured	1 [Reference]	0.82 (0.72-0.93)	0.74 (0.66-0.83)	0.63 (0.56-0.71)	0.55 (0.49-0.62)	<.001
LDL-C level measured	1 [Reference]	0.76 (0.68-0.84)	0.73 (0.66-0.81)	0.67 (0.61-0.74)	0.64 (0.57-0.72)	<.001
Eye examination performed	1 [Reference]	0.90 (0.84-0.96)	0.80 (0.75-0.85)	0.77 (0.73-0.83)	0.72 (0.67-0.77)	<.001
Outcome measures						
A1C level ≤9.0%	1 [Reference]	1.03 (0.94-1.11)	0.92 (0.85-1.00)	0.82 (0.75-0.90)	0.79 (0.71-0.88)	.002
LDL-C level ≤130 mg/dL	1 [Reference]	0.93 (0.85-1.02)	0.86 (0.79-0.93)	0.83 (0.76-0.89)	0.82 (0.74-0.90)	.003

A1C indicates glycosylated hemoglobin; LDL-C, low-density lipoprotein cholesterol.

SI conversion factors: To convert A1C level to proportion of total hemoglobin, multiply by 0.01; to convert cholesterol level to millimoles per liter, multiply by 0.0259.

^aResults are adjusted for sociodemographics, pain diagnoses, comorbidities, and number of primary care visits in fiscal year 2004. Regression analyses were performed using generalized estimating equations to account for the clustering of outcomes by site of care.

^bOpioid dosage information was missing for 10.6% of subjects. The other 89.4% were categorized into quartiles by dosage.

Overall Outcomes

- Patients receiving long-term opioid therapy
 - ◆ What happens if you adhere to the guidelines?
 - ◆ Retrospective study of VA patients between 2000 and 2010 (HIV + and neg)
 - ☞ Received psychotherapeutic or physical rehabilitation therapies – **decreased** risk of all cause mortality
 - ☞ BZD + opioids – **increased** risk of mortality (HR 1.39)
 - ☞ Among patients with a substance use disorder, those receiving SUD treatment had a **lower** risk of mortality

What is real engagement?

- Caring providers
- Assistance with entitlements
- Access to drug treatment programs (if ready)
- Support with criminal justice problems
- Access to housing, food, safety from violence
- Mental health services
- Intensive case management programs

Case 3

- 56yo M with a history of depression, alcohol use, retinal detachment from prior trauma, DM, and obesity with low back pain. He described excruciating, severe pain, 10/10, in the center of his back, causing difficulty getting out of bed or walking normally. He was started on opioids for acute pain management (oxy-APAP 1-2 tabs q6hr PRN pain).
- He returned for follow-up appointments describing huge relief from the medication. He was very grateful for the care. 3 months later he was still requiring/requesting opioid prescriptions.
- Over the next 3 mos. he started to exhibit the following concerning behaviors:
 - ◆ Poor adherence to other parts of treatment plan
 - ◆ Poor PCP follow-up
 - ◆ Frustration about any discussion of non-opioid agents

Outcome

- Patient has been in-taked to methadone maintenance treatment. Trying to be linked to an intensive case management program. Working on housing. Discussing drug treatment.
- Hasn't been in the hospital/ER for 15days.

Case 3, continued

- His provider monitored him closely:
 - ◆ Urine drug screens were appropriate
 - ◆ Prescription activity report showed no outside providers
 - ◆ He had no new ED visits or hospitalizations
- The patient's functional status: disabled, lives alone (no partner), goes out for basic errands, periodically sees family
- He continues to describe excruciating pain.

Question

- How would you manage this patient?
 - ◆ A) Discontinue chronic opioid therapy
 - ◆ B) Re-discuss the contents of the patient-provider agreement and your treatment expectations of him
 - ◆ C) Start morphine sulfate ER 15mg po BID + short-acting PRN agents
 - ◆ D) Switch him to buprenorphine-naloxone

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Monitoring

- Patient-provider agreements
 - ◆ no evidence they decrease misuse. *Useful to facilitate communication and set expectations.*
- Recommended by:
 - ◆ CDC Guidelines (2016)
 - ◆ Chronic Opioid Treatment Guidelines (APS, AAPM; 2009)
 - ☞ Informed Consent (strong rec, low-quality evidence)
 - ☞ Treatment agreements (weak rec, low-quality evidence)
 - Goals, expectations for follow-up and monitoring, indications for stopping treatment, etc.
 - ◆ State Medical Board of California: Guidelines for Rx Controlled Substances for Pain (Nov 2014)
- Examples:
<http://www.agencymeddirectors.wa.gov/Files/txagreement.pdf>

Assessment

■ Risks

- ◆ Alcohol use
- ◆ Depression
- ◆ ?Not attending appointments
- ◆ ?Not participating in other forms of treatment
- ◆ Not spending time with family

■ Benefits

- ◆ Patient report



Case Continued

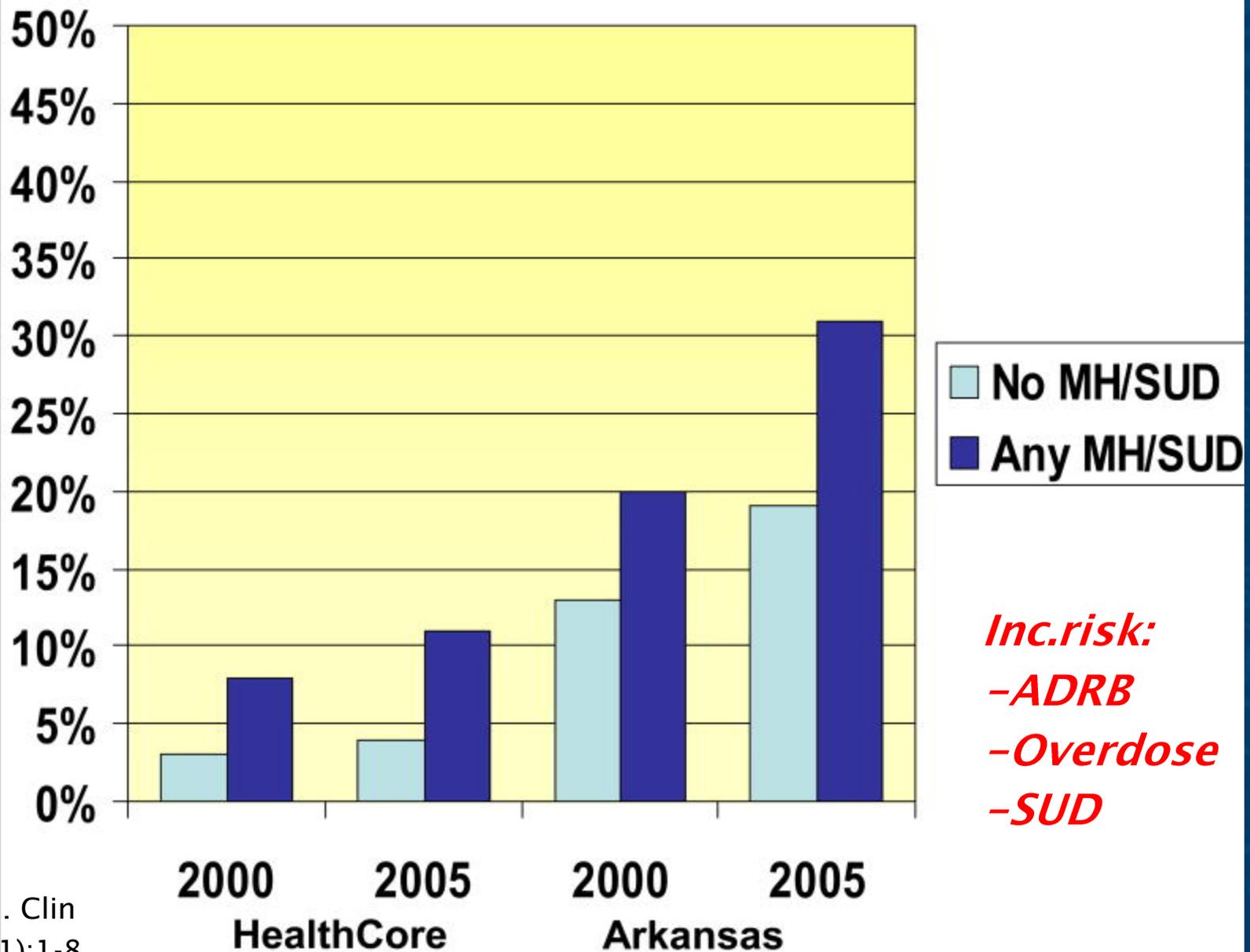
- The provider had actually been very clear with the patient in signing the treatment agreement. She was worried about his depression and so wanted him to connect with the behavioral health and to attend physical therapy. Despite repeated attempts at outreach/reminders, he did not attend.
- The provider explained that opioids would be discontinued. The patient became angry and verbally abusive toward the provider.
- Epilogue: He was transferred to me ~4 weeks later. Pain & previous history not discussed. Getting treatment for his DM, alcohol use disorder and severe depression.

Depression & Pain

- Depression and pain often linked
 - ☞ Study of outpatients at university-based outpatient pain clinic (n=2104):
 - **55%** with current opioid use → **43% depressed** (v. 26%)
 - If depressed, prob of opioids didn't depend on pain severity.
 - ☞ Outcomes in depressed patients
 - Mod-high negative affect groups in a RCT trial of opioid therapy: *decreased benefit* from opioid therapy

“Adverse Selection”

% of patients receiving chronic opioid therapy



Take-home point

- Severely depressed or anxious patients often do poorly on chronic opioid therapy. They may be inadvertently using opioids to treat their anxiety/depression symptoms, and hence feel very upset when medication is discontinued.

Case 4

- JF is a 66yo M with hx of chronic low back pain (sciatica s/p epidural injections), BPH, depression, remote alcohol and dextromethorphan abuse referred to CSI committee by new PCP.
- Meds:
 - ◆ Fentanyl 75mcg TD q 48hrs
 - ◆ Oxy-APAP 5-325 #180/month
 - ◆ temazepam 15mg q hs
 - ◆ Testosterone gel
 - ◆ Dextroamphetamine 10mg q day
- MED = 225mg daily

Question

- All of the following are risks of long-term, high-dose chronic opioid therapy except:
- A) sleep disordered breathing
- B) hypogonadism
- C) unintentional overdose
- D) pneumonia
- E) BPH
- F) osteoporotic fracture

Question

- All of the following are risks of long-term, high-dose chronic opioid therapy except:
- A) sleep disordered breathing
- B) hypogonadism
- C) unintentional overdose
- D) pneumoinia
- **E) BPH**
- F) osteoporotic fracture

Risks of High Dose

- Unintentional overdose (~0.7%/year 20-100MED) and re-exposure (91% w/rx at 10mos. post OD)
- Secondary Hypogonadism (~50% of men)
 - ◆ Dec bone mineral density & inc. fracture risk
- Sleep-disordered breathing (60-70% of patients)
- Pneumonia in older adults (case-control)
- Others
 - ◆ Opioid-induced hyperalgesia?
 - ◆ Cardiac toxicity with methadone

Miller M, et al. JAMA Intern Med. 2015;175(4):608-15. Rose AR, et al. J Clin Sleep Med. 2014;10(8):847-52. Guilleminault C, et al. Lung 2010;188(6):459-68. Rubinstein AL, et al. Clin J Pain. 2013;29(10):840-5. Dublin Setal. JAGS. 2011;59(10): 1899.

Smith HS, Elliott JA. Pain Physician. 2012;15(3 Suppl): ES145-56. Teng Z et al. Plos One. 2015;10(6)

Factors Associated with Overdose and Addiction

Medication-related	
Daily dose >100 MME*	Overdose, ⁸ addiction ⁸
Long-acting or extended-release formulation (e.g., methadone, fentanyl patch)	Overdose ^{14,41}
Combination of opioids with benzodiazepines	Overdose ⁴²
Long-term opioid use (>3 mo)†	Overdose, ⁴³ addiction ⁴⁴
Period shortly after initiation of long-acting or extended-release formulation (<2 wk)	Overdose ⁴⁵
Patient-related	
Age >65 yr	Overdose ⁴⁶
Sleep-disordered breathing‡	Overdose ⁴⁷
Renal or hepatic impairment§	Overdose ⁴⁸
Depression	Overdose, addiction ⁴⁹
Substance-use disorder (including alcohol)	Overdose, ⁵⁰ addiction ⁴⁹
History of overdose	Overdose ⁵¹
Adolescence	Addiction ⁵²

Volkow and McLellan. NEJM 2016.

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Approaches to High Dose

- Open conversations with patients about risks and benefits
 - ◆ BEST work-up?
- Offer naloxone, if possible
- Get feedback:
 - ◆ Pain specialist
 - ◆ Peer review (controlled substance review committees)
- If tapering, go slow & see person often (10% per week-month). Remember, we started the meds.

Case Continued

- Patient referred to CSI committee
- Open to tapering
- Recs provided to PCP

Summary

- Chronic pain is extremely common and severely debilitating for our patients.
- Applying the biopsychosocial model to chronic pain helps inform management.
- Treatment for pain should be multi-modal and include pharmacologic, physical, complementary and alternative, and cognitive and behavioral techniques.
- When opioids are not indicated, patient engagement is a priority.
- Chronic opioid therapy is commonly prescribed. Emphasis should always be on safety and weighing the risks and benefits of treatment.

Summary cont'd

- In patients with an active substance use or mental health disorder, these should be treated/stabilized prior to prescribing chronic opioid therapy.
- Be aware of the long-term risks associated with chronic opioid therapy.
- Keep in mind your patients are suffering every day. Empower them to do the best they can via their own strengths and resources.

Questions?



Resources

■ Patients:

◆ Pain Toolkit:

[http://www.paintoolkit.org/downloads/Pain Toolkit patient booklet copy Short Versions.pdf](http://www.paintoolkit.org/downloads/Pain_Toolkit_patient_booklet_copy_Short_Versions.pdf)

◆ Chronic Pain Facebook Groups

◆ You tube videos to educate patients about pain:

☞ Chronic pain in 5 minutes:

https://www.youtube.com/watch?v=C_3phB93rvI

☞ Treatment options: <https://vimeo.com/74825810>

■ Providers:

◆ Washington Agency Medical Directors Guidelines:

<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

◆ SFHP patient/provider resources:

<http://www.sfhp.org/providers/pain-management/resource-tools/>

- Mindfulness Based Stress Reduction & Yoga

- ◆ UCLA site:

- <http://marc.ucla.edu/body.cfm?id=22>

- UCSD:

- <http://health.ucsd.edu/specialties/mindfulness/programs/mbsr/Pages/audio.aspx>

- And from Kaiser:

- http://www.healthjourneys.com/kaiser/files/successfulSurgery/04_Imagery_For_Healing.mp3

- ◆ Spanish:

- <http://www.rebapinternacional.com/mp3cds.html>