Treating Pain in Patients with Substance Use Disorders Part II: Chronic Pain

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Objectives

- Review pertinent terminology
- Explore the relationship between chronic pain and addiction
- Examine patient risk stratification
- Review recommendations for the treatment of chronic pain in patients with addiction
- Make recommendations for VAPHS

Pertinent Terminology

1. Tolerance
    - A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time
2. Physical Dependence
    - A state of adaptation that is manifested by a withdrawal syndrome
3. Addiction/ Substance Use Disorder (SUD)
    - A primary, chronic, neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestations

Journal of Pain and Palliative Care Pharmacotherapy. 2003; 17 (1): 15-29

Pain and Addiction

- The presence of one condition seems to influence the expression of the other
  - Acute pain seems to decrease the euphorogenic qualities of the opioid
  - Addiction seems to worsen the experience of pain
- Comorbid Addiction and Chronic Pain Prevalence
  - 32% of chronic pain patients may have an addictive disorder
  - 29-60% of people with opioid addiction report chronic pain

Ann Intern Med 2006; 144: 127-134. SAMHSA, 2014.

Relationship Between Chronic Pain and Addiction

- Neurobiological conditions with CNS dysfunction
- Mediated by genetics and environment
- May have significant behavioral components
- Potentially seriously harmful consequences if untreated
  - Often require multifaceted treatment
- Neither condition is static
  - Fluctuate in intensity over time and under different circumstances

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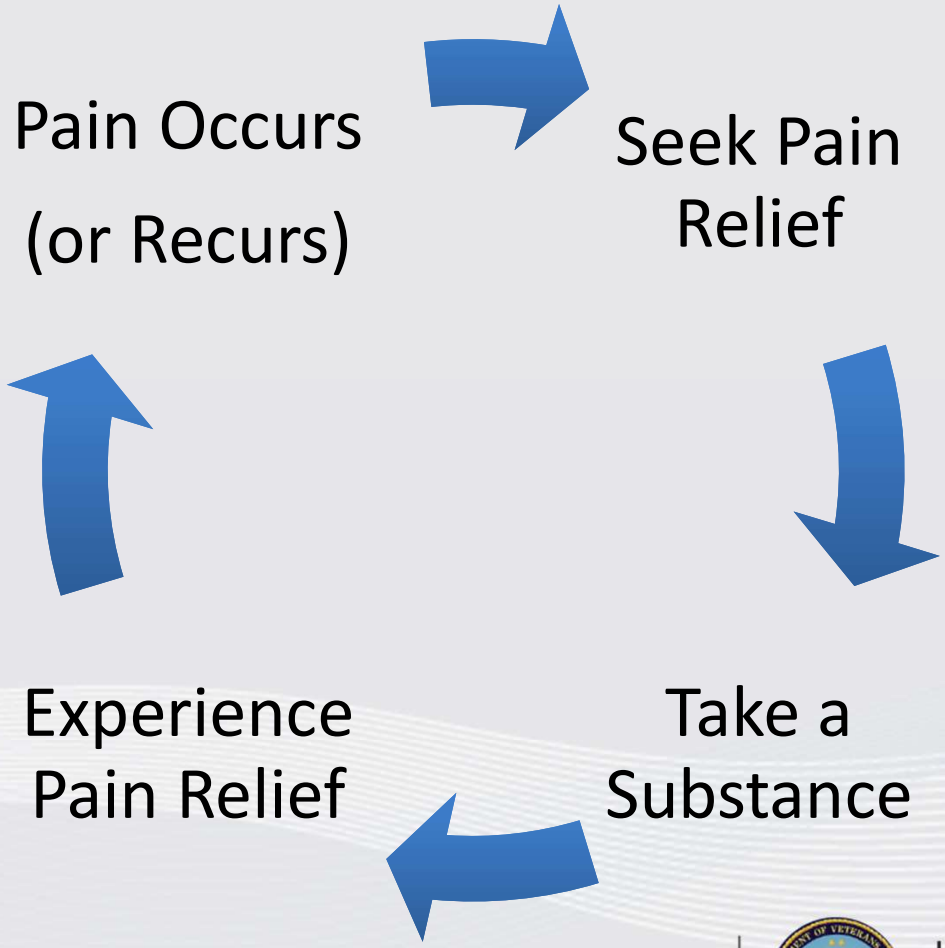
SAMHSA, 2014.

The Cycle of Chronic Pain and Addiction



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SAMHSA, 2014.

Treatment Confounders

- Is the patient…
  - Actively using?
    - An illicit substance?
    - Misusing a controlled substance?
  - In recovery?
    - Abstinence-based?
    - Medication-assisted recovery?
- What type of pain is the patient experiencing?
  - Acute vs. Chronic

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Ries, 2014.

Low-Risk Patients

1. No past or current history of SUD
2. No family history significant for SUD
3. Lack major or untreated psychopathology

Aberrant Behavior: May present with discrepant pill counts or openly admit to taking extra

→ May require motivational interviewing and should have more frequent follow up

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Population Health Management 2014; 17:79-89.

High-Risk Patients

1. Active SUD
   - Fresh injection marks
   - Excoriations
   - Evidence of withdrawal
   - Signs of nasal insufflation
   - Intoxication
2. Major untreated psychiatric disorder

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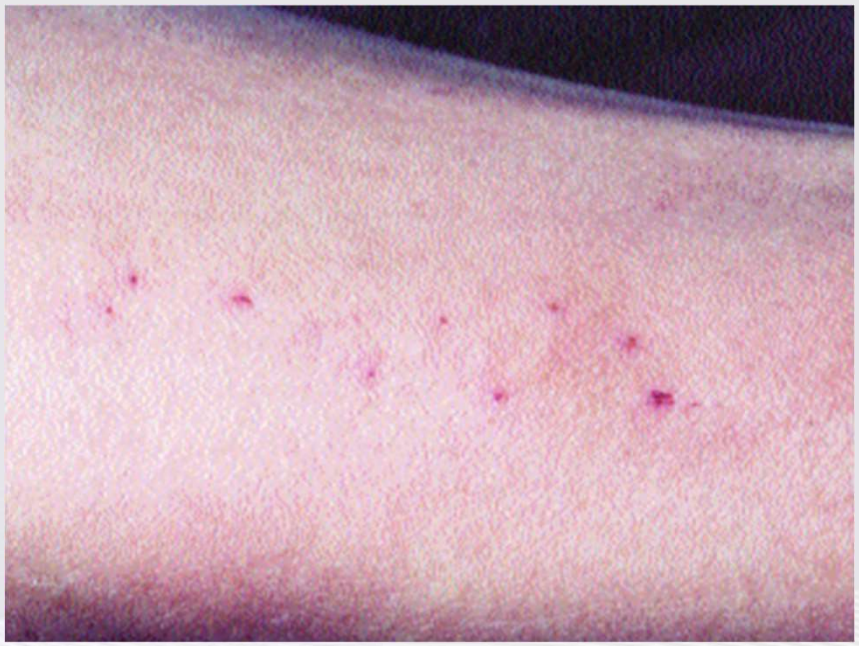
Population Health Management 2014; 17:79-89.

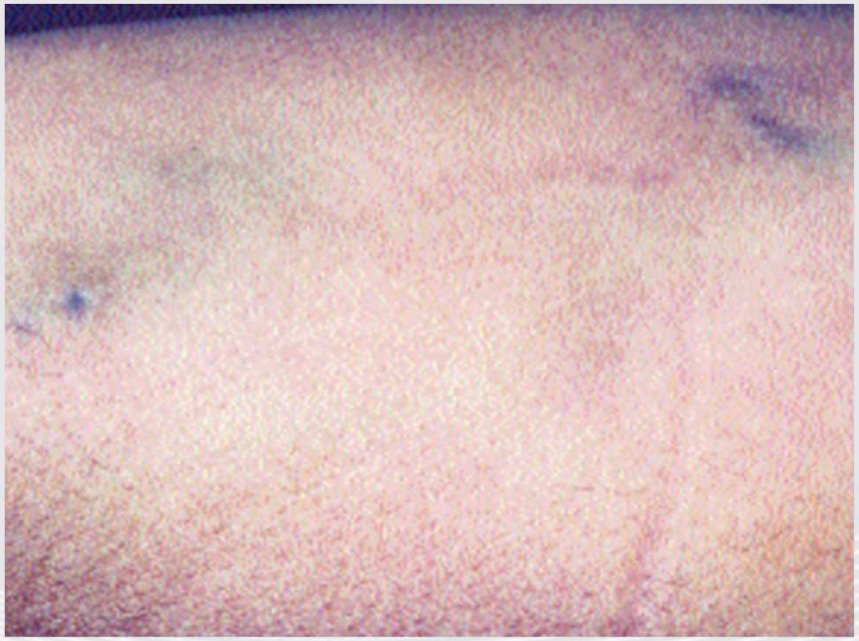
Injection Marks

Recent



Alaska Native, Right Forearm

Old



Hispanic/ Latino, Left Forearm

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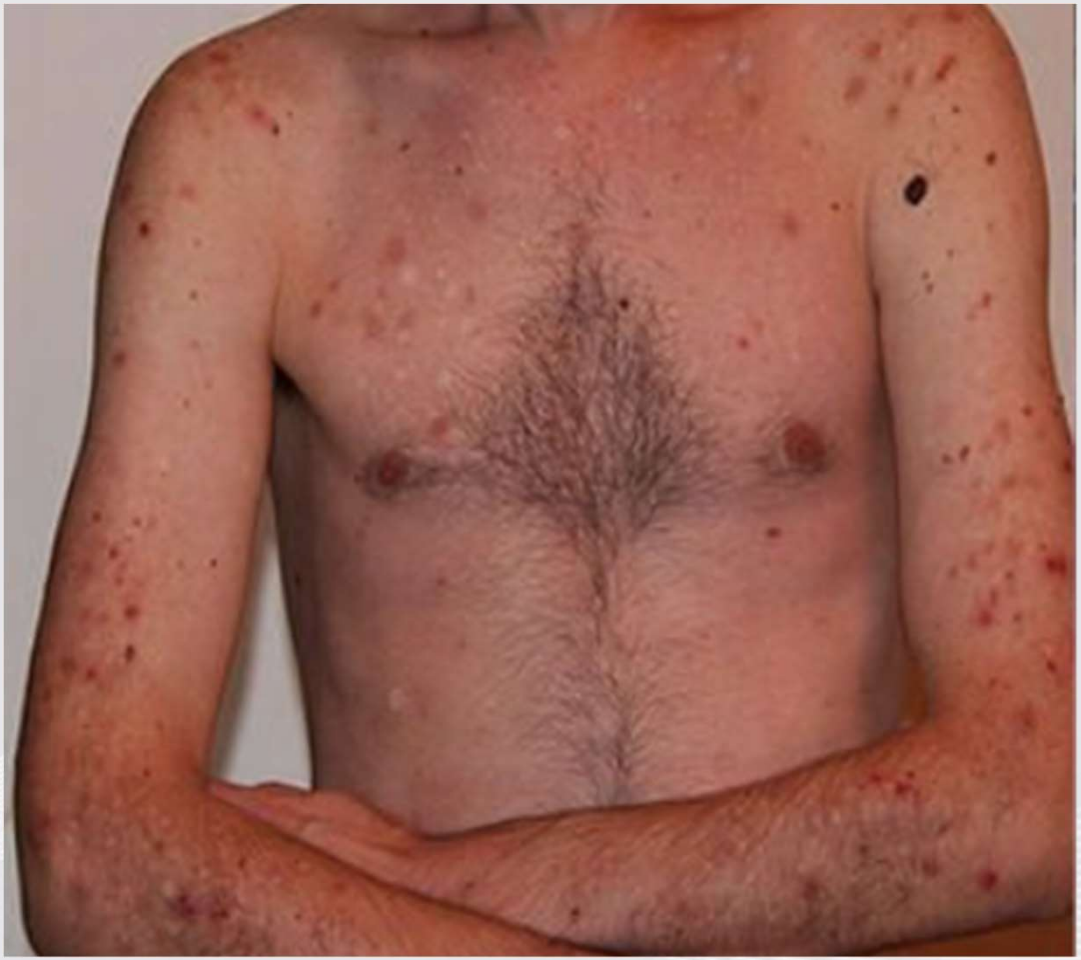
www.ou.edu Accessed 12/13/17.

Excoriations



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www.reference.medscape.com Accessed 12/13/17.

Opioid Withdrawal

Symptoms of EARLY Withdrawal

- Agitation
- Anxiety
- Muscle aches
- Increased tearing
- Insomnia
- Runny nose
- Sweating
- Yawning

Symptoms of LATE Withdrawal

- Abdominal cramping
- Diarrhea
- Dilated pupils
- Goosebumps
- Nausea
- Vomiting

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https://medlineplus.gov/ency/article/000949.htm. Accessed 12/26/17.

Alcohol Withdrawal

- Anxiety
- Depression
- Fatigue
- Irritability
- Mood swings
- Insomnia
- Nightmares
- Clouded thinking
- Clammy skin
- Sweating
- Dilated pupils
- Headache
- Loss of appetite
- Pallor
- Rapid HR
- Tremor
- N/V

Delirium Tremens

Agitation Seizures

Hallucinations

Severe confusion

Fever

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https://medlineplus.gov/ency/article/000764.htm. Accessed 12/26/17

Moderate-Risk Patients

1. Past history of problematic drug use
2. Strong FH of problematic drug use
3. May also have a co-occurring moderate psychiatric disorder

→ Collaboration with an addiction specialist (one-time consult or ongoing)

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Population Health Management 2014; 17:79-89.

MANAGING CHRONIC PAIN

Moderate Risk Patients

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Guidance for Clinical Practice

1. SAMHSA Treatment Improvement Protocol: Managing Chronic Pain in Adults With or In Recovery From Substance Use Disorders
2. APS/ AAPM Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-Cancer Pain (CNCP)
3. VA/DoD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain

SAMHSA Treatment Improvement Protocol: Managing Chronic Pain in Adults With or In Recovery From Substance Use Disorders

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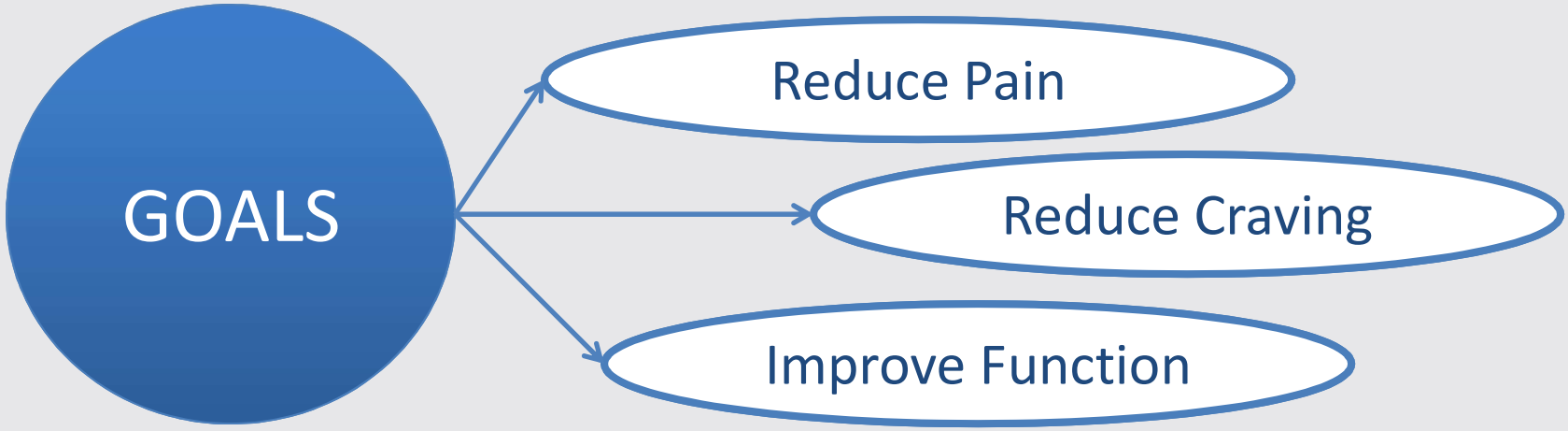
SAMHSA TIP #54 (2014)

- Developed by the Center for Substance Abuse Treatment (CSAT)
- Best-practice guidelines for the prevention and treatment of substance use and mental health disorders
- Draw on experience and knowledge of clinical, research and administrative experts

SAMHSA, 2014.

Treating Pain in Patients in Recovery



1. Treat with non-opioid analgesics
2. Recommend non-pharmacologic therapies
3. Treat co-morbidities
4. Assess treatment outcomes
5. Possibly initiate an opioid

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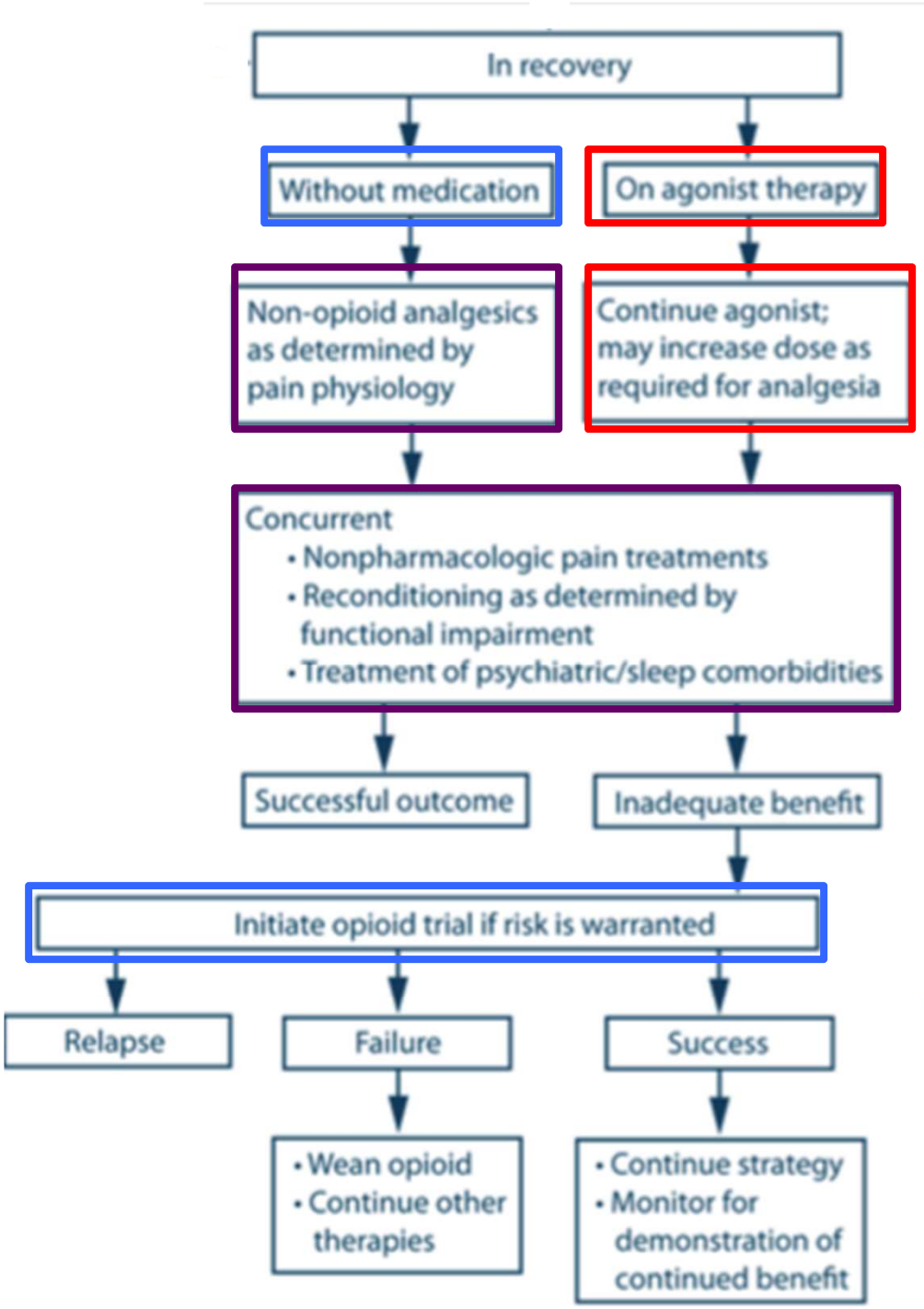
SAMHSA, 2014.



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SAMHSA, 2014.

Methadone Patients

- Once-daily dosing ≠ adequate analgesia
  - Analgesic effects (6 hrs) vs. the half-life (36 hrs)
- Pain patients may take >10 days to stabilize
  - Titrate slowly
  - Balance the risks of insufficient analgesia vs. OD
  - Advise patient to stop treatment upon sedation
- Only providers with thorough familiarity
  - QTc prolongation, drug interactions, accumulation

SAMHSA, 2014.

Buprenorphine Patients

- To optimize analgesic efficacy
  - Dose buprenorphine TID
- High doses can attenuate the effects of concomitant pure mu agonists
  - Tend to reduce the reinforcing effects of inappropriately consumed opioids
  - May reduce the effectiveness of opioids given for additional analgesia (i.e. trauma)
- No X-waiver required to prescribe for pain
  - Specify “for pain”

SAMHSA, 2014.

Naltrexone Patients

- Should not be prescribed outpatient opioids
- Naltrexone displaces opioids agonists from binding sites
  - Opioid agonists= ineffective
- Increasing opioid dose to overcome the effects
  - Increases risk of respiratory arrest
- Pain relief requires non-opioid modalities

SAMHSA, 2014.

Non-Opioid Analgesics

Analgesic	Addictive	Notes
Topical analgesics	No	No open wounds
Acetaminophen	No	Hepatic disease: Max 2g/day
NSAIDs	No	Caution CKD and HF
Antidepressants SNRIS TCAs	No	 TCA: Risk of fatal overdose d/t cardiac toxicity
Anticonvulsants	No	
Muscle relaxants	Yes	Carisoprodol is addictive; others have abuse potential
Benzodiazepines	Yes	NOT RECOMMENDED
Cannabinoids	Yes	NOT RECOMMENDED

SAMHSA, 2014.

Non-Pharmacologic Treatments

Benefits

- Pose no risk of relapse
- May be more consistent with the patient's values vs. medications
- May reduce pain and improve quality of life
- Should be included in most treatment plans

Options

- Therapeutic exercise
- **Physical therapy**
- **Cognitive-Behavioral Therapy**
- Complimentary/ Alternative
  - **Chiropractic therapy**
  - Massage therapy
  - **Acupuncture**
  - Relaxation strategies

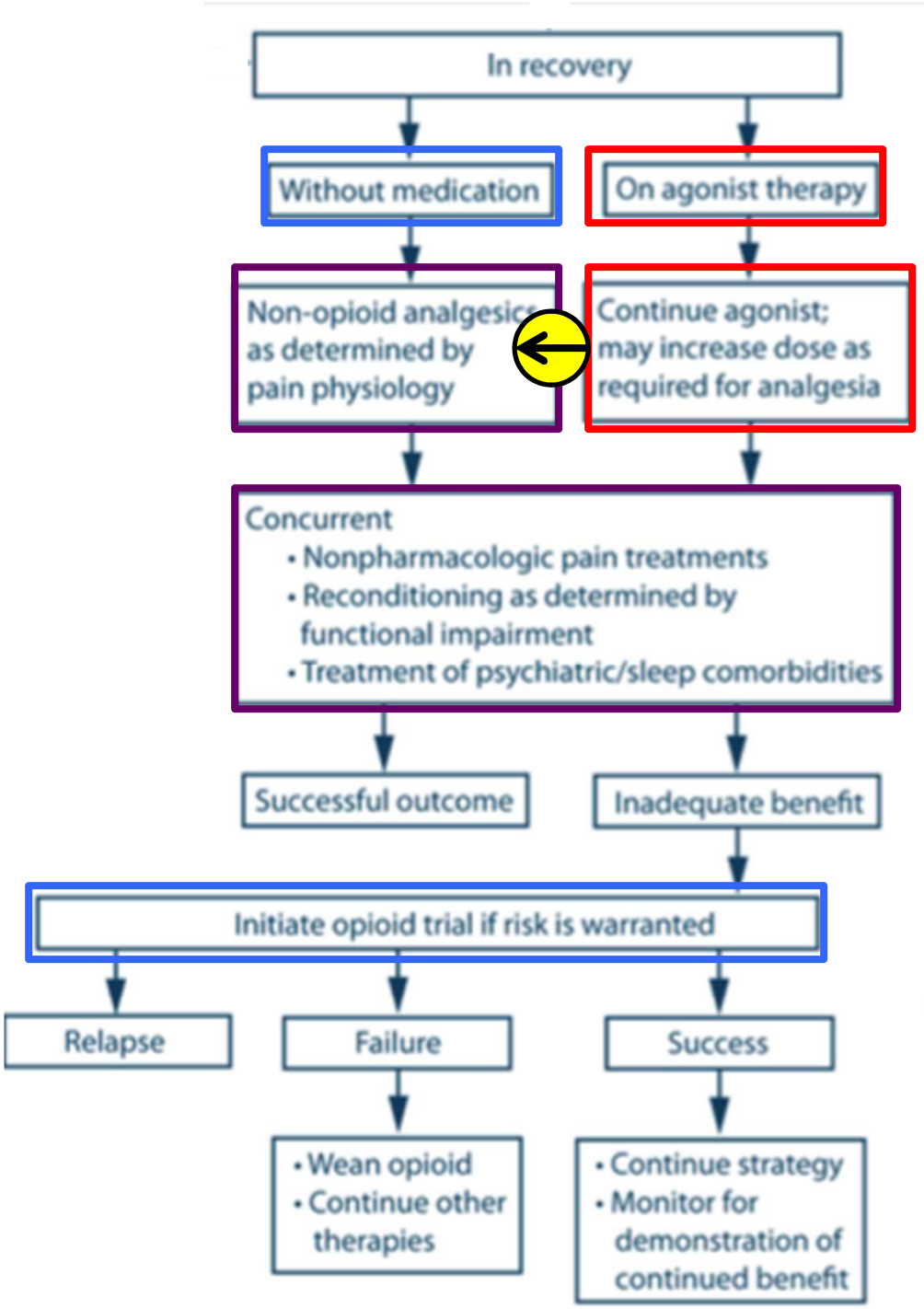
SAMHSA, 2014.

Treat Comorbidities

- Untreated psychopathology is associated with poor pain treatment outcomes
  - Management of patients who have CNCP **MUST** include intervention for comorbid psychopathology

Select psychiatric diagnoses treatable with adjuvant analgesics	
Psychiatric Diagnosis	**Treatment Options**
Anxiety	Pregabalin, SNRIs and TCAs
Depression	SNRIs and TCAs
Panic disorder	Valproic acid
PTSD	Lamotrigine
Social phobia	Gabapentin and Pregabalin

SAMHSA, 2014.



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SAMHSA, 2014.

Opioid Analgesics

- Initiate ONLY…
  - If the potential benefits outweigh the risks
  - For as long as it is unequivocally beneficial
- SUD co-occurring with CNCP
  - The benefits of opioids are not well-established
  - The risk of relapse is increased
    - Studies indicate that most patients who are currently addicted to prescription opioids had a prior SUD
    - Especially with prior OUD

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SAMHSA, 2014.

Limitations of Opioids

- Diminished efficacy over time
- Intolerable adverse effects
- Opioid-induced hyperalgesia
- Serotonin Syndrome
  - SSRIS/ SNRIS, MAOIs, HIV medications, St. Johns Wort
  - ED/ Surgery: Fentanyl, Meperidine and Pentazocaine
- Risk of addiction/ relapse
- Pain reduced by 1/3 in most studies>18 months

SAMHSA, 2014.

Prior to Opioid Initiation

1. Educate the patient/ family about treatment options, sharing the decision about the goal and expected outcome of therapy
2. Discuss the treatment agreement with the patient and family
3. Obtain a written opioid agreement
4. Determine the treatment plan
5. Initiate a trial of opioid therapy
6. Document details of therapy and results

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SAMHSA, 2014.

Opioid Selection

- Select minimally rewarding opioids
  - Tramadol, Codeine
- Avoid supra-therapeutic doses
  - Demonstrated by sedation, lethargy, functional impairment
- If higher potency opioids required
  - Slow onset, prolonged duration of action
- Formulations not easily injected (transdermal)
  - Refills upon returning used, un-damaged patches

SAMHSA, 2014.

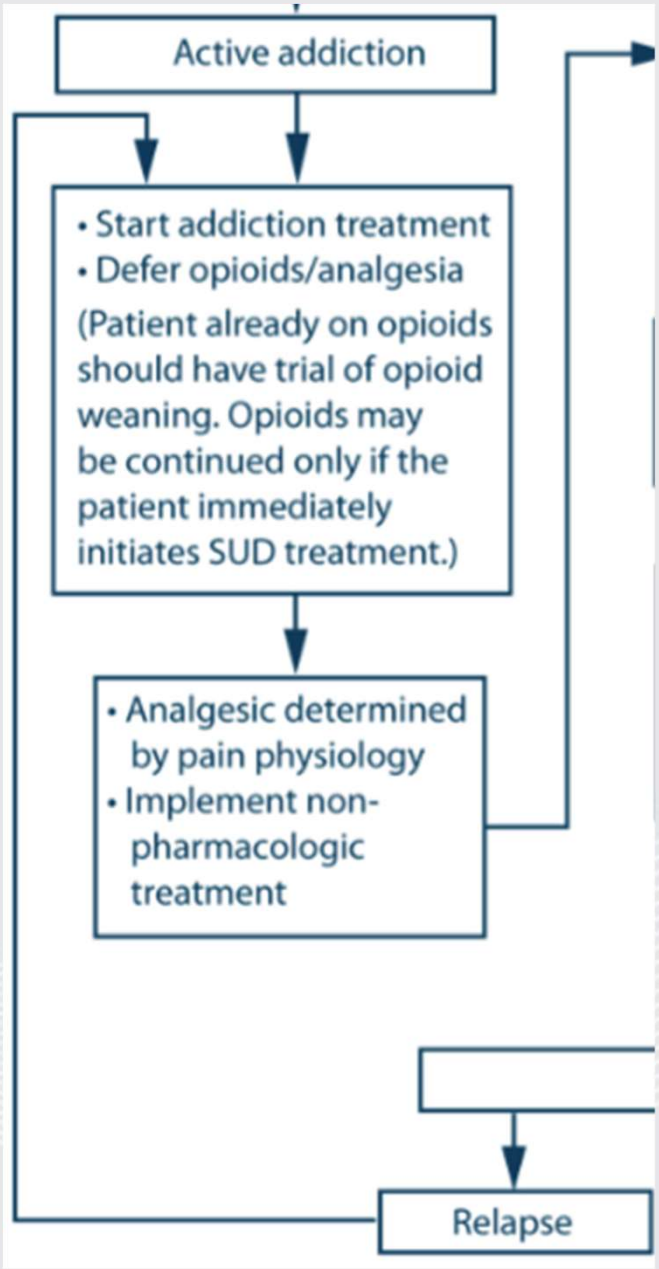
Dose Finding

- Complicated due to pre-existing, or rapidly developing, tolerance
- If low dose opioids are initiated for severe pain
  - Titrate rapidly to avoid subjecting the patient to a prolonged period of dose-finding
- If high dose opioids are initiated
  - Titrate slower and based on the half-life
  - May lead to decreased functioning

SAMHSA, 2014.

Relapse

- Minor relapse or “Slip”
  - Quickly regain stability
  - Counseling may suffice
  - If opioids are continued
    - Short dispensing intervals
    - Frequent DAUs
- Major relapse to OUD
  - Refer to a methadone program
  - Buprenorphine



SAMHSA, 2014.

APS/AAPM 2009 Guidelines: Chronic Opioid Therapy in Chronic Non-Cancer Pain

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APS/AAPM 2009 Guidelines: Chronic Opioid Therapy in CNCP

- Developed by a multidisciplinary panel of 21 experts
- Intended to provide evidence-based recommendations for the use of chronic opioid therapy for chronic noncancer pain in primary care and specialty settings

The Journal of Pain 2009; 10(2): 113-130.

APS/AAPM: High-Risk Patients

Evidence is lacking on the best methods for managing patients with **suspected aberrant behaviors**, **psychosocial comorbidities** and a **history of substance abuse**

The Journal of Pain 2009; 10(2): 113-130.

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APS/AAPM: Recommendation #6.1

Consider chronic opioid therapy ONLY if able to implement more frequent and intense monitoring

- Prescribe limited quantities
- Strongly consider consultation with an addiction specialist

- May minimize potential risks
- Strong recommendation, low-quality evidence

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The Journal of Pain 2009; 10(2): 113-130.

APS/AAPM: Recommendation #6.2

Evaluate patients with aberrant behavior for…

- Restructuring of therapy
  - More frequent/ more intense monitoring
  - Temporary or permanent tapering
  - Addition of psychological therapies or other non-opioid therapies
- Referral
- Discontinuation

➢Strong recommendation, low-quality evidence

The Journal of Pain 2009; 10(2): 113-130.

APS/AAPM: Aberrant Behavior

- Relatively non-serious
  - Patient not assessed as high-risk & 1-2 dose escalations
  - ➢ Provide patient education and enhance monitoring
- More serious
  - Repeatedly non-adherent
    - Cocaine use
    - Use of un-prescribed opioids
    - Obtaining opioids from multiple sources
  - ➢ May require consultation, major restructuring of therapy and discontinuation of opioids

The Journal of Pain 2009; 10(2): 113-130.

Fleming et al (2007)

Aberrant Behaviors	OUD (N=30; 3.7%)	SUD (N=79; 9.7%)
Increased dose on own	26; 86.7%	58; 73.4%
Felt intoxicated from pain medication	24; 80.0%	50; 63.3%
Requested early refills	23; 76.7%	55; 69.6%
Purposefully oversedated oneself	23; 76.7%	49; 62.0%
Used opioids for purpose other than pain	19; 63.3%	36; 45.6%

The Journal of Pain 2007; 8 (7): 573-582.

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VA/DoD 2017 Guidelines

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VA/DoD 2017 Guidelines

- Developed by a panel of multidisciplinary experts
- Based on a systematic review of clinical and epidemiological evidence
- Designed to provide information and assist decision making

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www.healthquality.va.gov. Accessed 12/13/17.

VA/ DoD: Recommendation #4a

We recommend against initiating long-term opioid therapy for pain in patients with **UNTREATED** substance use disorder

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www.healthquality.va.gov. Accessed 12/13/17.

Determining Appropriateness

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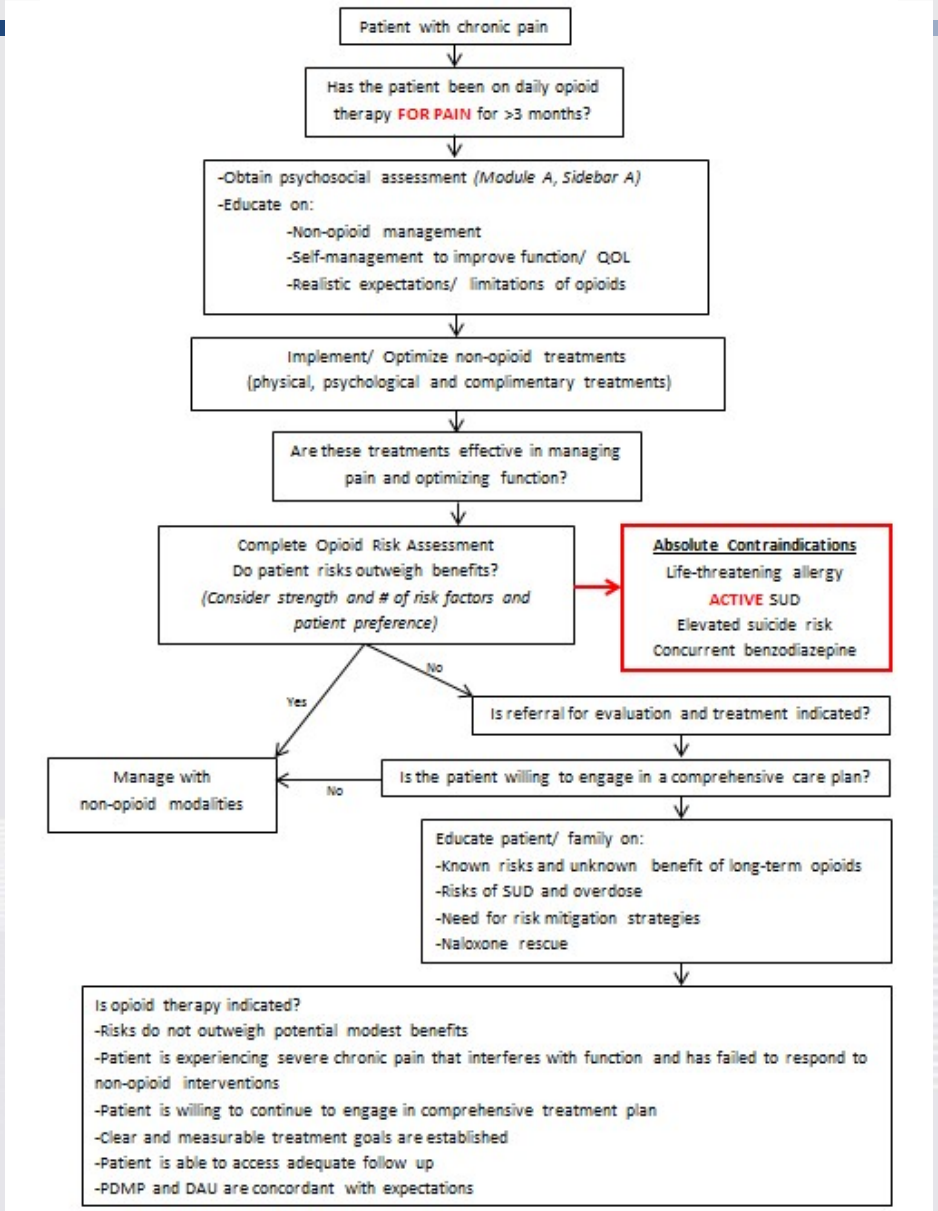

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Treatment with Opioids

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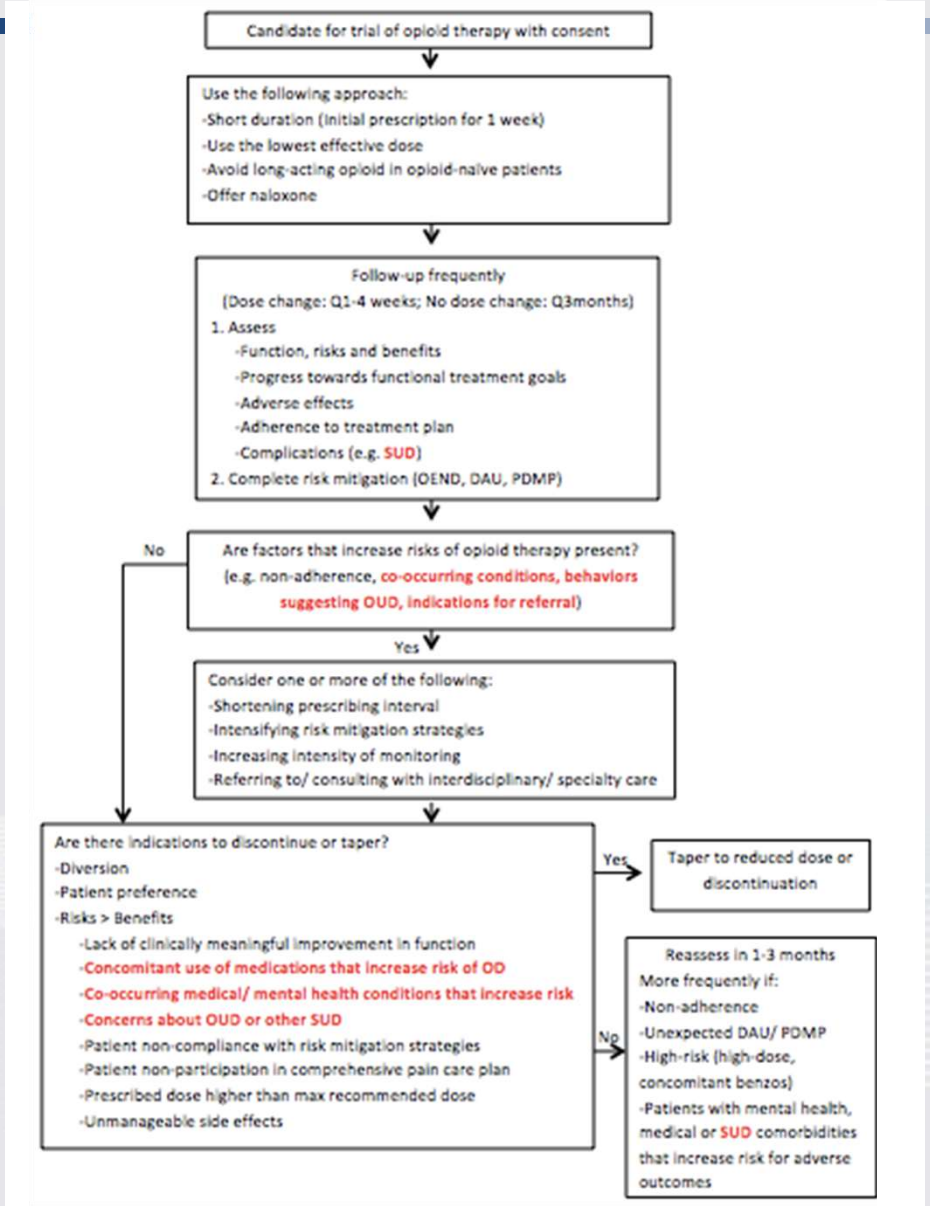

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Tapering of Opioid

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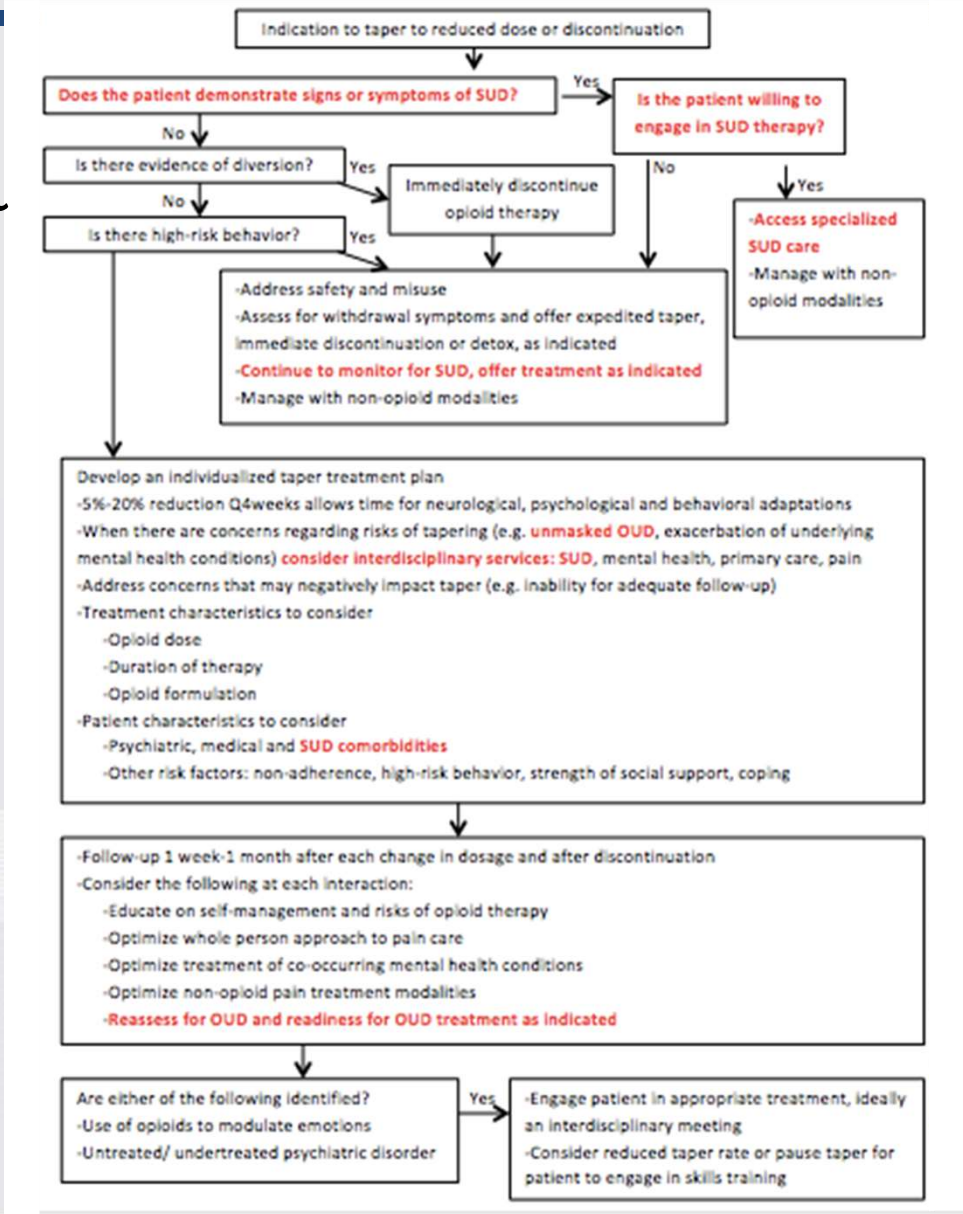

www.healthquality.va.gov. Accessed 12/13/17.

VA/ DoD: Recommendation #4b

For patients currently on long-term opioid therapy with evidence of **UNTREATED** SUD, we recommend close monitoring

- Engagement in SUD treatment
- Discontinuation of opioid therapy for pain WITH APPROPRIATE TAPERING

www.healthquality.va.gov. Accessed 12/13/17.

Patients Currently on Opioids

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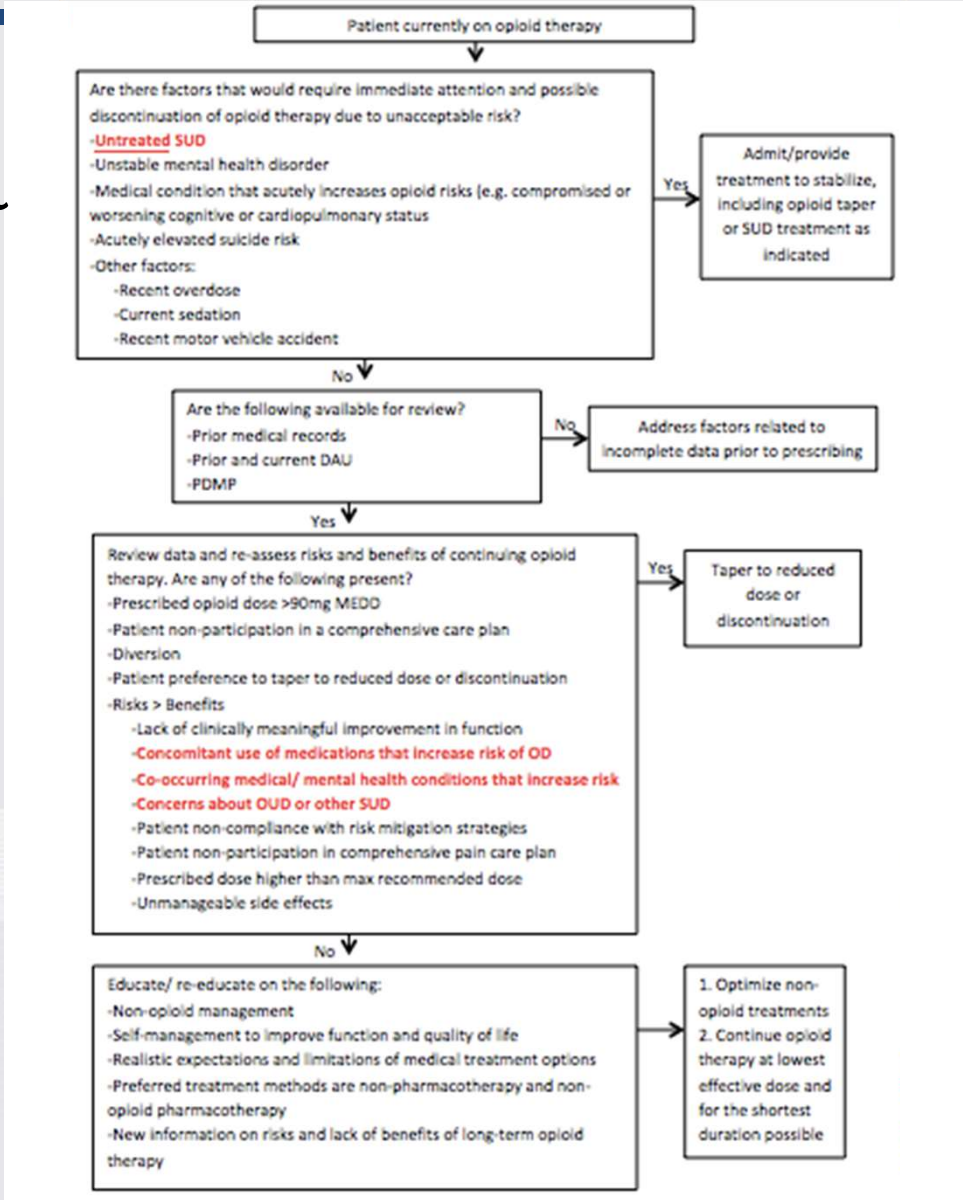

www.healthquality.va.gov. Accessed 12/13/17.

VA/ DoD: Patient Education

- "New information has taught us that long-term opioid use can lead to multiple problems including loss of pain relieving effects, increased pain, unintentional death, OUD, and problems with sleep, mood, hormonal dysfunction and immune dysfunction"
- "We now know that the best treatments for chronic pain are not opioids…[they] are non-drug treatments such as psychological therapies, rehabilitation therapies and non-opioid medications"

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www.healthquality.va.gov. Accessed 12/13/17.

VA/DoD Guidelines

Recommendation #16

- We recommend interdisciplinary care that addresses pain, SUDs and/or mental health problems for patients presenting with high risk and/or aberrant behavior

Recommendation #17

- We recommend offering medication-assisted treatment for opioid use disorder (OUD) to patients with chronic pain and OUD

www.healthquality.va.gov. Accessed 12/13/17.

VA/DoD Clinical Pearls

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VA/ DoD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain: Clinical Pearls

1. Chronic pain is a complex human experience strongly influenced by psychosocial factors including the patient's relationship with the healthcare system
   a. Opioid prescribing is a powerful way to communicate about the goals, methods, and responsibilities of chronic pain management.
   b. Teach your patient that self-management, not effortless relief with medications, is the foundation of high quality pain care.
2. Safety is always more important than urgent pain relief
   a. Titrating to effect is not a rational prescribing strategy.
   b. When risk outweighs benefit or adequate risk mitigation is not possible, opioids should not be used.
3. As risks increase, mitigation and monitoring increases
   a. Opioid risks and benefits change over time.
   b. Opioid prescribing requires ongoing evaluation and documentation of risks and benefits.
4. Generally avoid initiating long-term opioid therapy for chronic pain; however, when opioids are prescribed and when titrating up, start low and go slow
   a. Do not exceed 50mg MEDD unless you are able to closely follow and monitor risks.
   b. Avoid titrating to doses >90mg MEDD.
5. Improved function, not pain relief, is the primary clinical goal
   a. Opioids should only be continued when patients demonstrate functional benefit and are actively engaged in self-management of pain.
   b. Opioid prescribing should be conducted as an ongoing trial documenting high benefit and low risk.
6. When your patient is not benefitting, being exposed to undue risk, or misusing, the question is not "if" the patient should be tapered but "how"
   a. When tapering down, be clear about the rationale, be specific about the process, and be empathic but not apologetic. Bad care is not an option.
   b. Your goal is to ensure safety while supporting and educating your patient. Offer alternative pain treatments and be prepared to address other problems such as OUD or suicidality.

www.healthquality.va.gov. Accessed 12/13/17.

Recommendations for VAPHS

Chronic Pain

1. Consider multimodal analgesia
    - Non-opioids
    - Non-pharmacological
2. Treat psychiatric comorbidities
    - Prescribe an agent approved to treat both pain and the patient's psychiatric diagnosis
    - Refer to Behavioral Health
3. If patient has an active SUD (high-risk), refer for treatment

Recommendations for VAPHS

Chronic Pain- MAT

4. Methadone patients
    - Consider supplementing with an additional afternoon/ evening dose up to 90 MME
5. Buprenorphine patients
    - Consider increasing the dosing interval to q6-q8

Recommendations for VAPHS

Chronic Pain- Assessing for Opioids

6. In assessing patients for potential opioid therapy, be sure to ask for their specific ***functional*** goals
7. Prior to prescribing an opioid, query the PDMP and obtain a DAU
8. Always send DAU results for confirmation
9. Only prescribe opioids if benefits > risks
10. Provide naloxone education and a kit

Recommendations for VAPHS

Chronic Pain- Opioid Selection

11. Preferable opioids are those with minimal euphoric effects
    - Tramadol or Codeine
12. Prescribe an initial supply of one week
    - Follow-up in one week to assess effectiveness
13. If a higher potency opioid is required, select one with a slower onset of action
    - Methadone

Recommendations for VAPHS

Chronic Pain- Opioid Monitoring

14. Only prescribe opioids if frequent monitoring is possible
    - No change in therapy? Every 1- 3 months
    - Change in therapy? Within 1- 4 weeks
15. Collaborate with CTAD, if possible
    - Pill counts, DAUs, individual appointments, outpatient groups

Recommendations for VAPHS

Chronic Pain- Assessing for Opioid Taper

16. Understand the difference between a "slip" and a full relapse as these should be met with different responses
    - "Slip"/ minor aberrant behavior
        - » Shorten the prescribing interval
        - » Consider counseling/ referral to BH
    - Relapse/ serious aberrant behavior (diversion)
        - » Taper opioid to discontinuation
        - » Refer to SUD treatment

Summary

	Acute Pain (Surgery/ Trauma)	Chronic Pain
Active SUD *(High Risk)*	Multimodal Approach -Non-opioids -Non-pharmacologic treatments -Anesthetic-based techniques -Opioids	Non-opioid treatments Refer to SUD Treatment
Abstinence-Based Recovery *(Moderate Risk)*		Multimodal Approach
Medication-Assisted Recovery *(Moderate Risk)* Methadone Buprenorphine Naltrexone	Multimodal Approach + Continue/ Supplement Continue as q6-q8 Switch to methadone Avoid opioids	Non-opioid treatments + Supplement: PM dose Increase dosing interval ---

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