

A Practical Guide to the Use of Opioids for Chronic Pain

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Agenda

- Introduction to chronic pain & its treatment
- Opioids: side effects; tolerance; addiction & physical dependence; pseudoaddiction
- Principles of opioid prescribing
- Preventing opioid misuse
- Treating patients w active or remote addiction hx
- Pharmacist's role: Patient education; information source for prescribers

Pain

“Pain is the most powerful and tangible force in life. The threat of torture, for instance, is stronger than the threat of death. Execution can be faced, but pain is corrosive, like an acid eating at the personality. Pain, as anyone with a toothache knows, drives out all other emotions and sensations before it. Pain is priority. It may even be man’s strongest and most undeniable reality.”

Tom Boswell in *The Washington Post*, quoted by Howard Heit

Chronic Pain

Pain that lasts 3-6 months or longer and that no longer serves as a physiological warning sign.

Chronic pain is a multifaceted experience that involves sensation, emotion, cognition, memory, and context.

Goals of Chronic Pain Treatment

- **Decrease pain**
- **Increase function**
- **Use medications that do not have unacceptable side effects**

Chronic Pain Types

- **Somatic: Osteoarthritis, back pain, headaches, rheumatoid arthritis, osteomyelitis, post-surgical**
- **Visceral: Chronic pelvic pain, interstitial cystitis, endometriosis**
- **Neuropathic: CRPS, post-herpetic neuralgia, peripheral diabetic neuropathy, phantom limb pain, post-stroke, fibromyalgia, trigeminal neuralgia**

The Gold Standard of Assessing Severity of Chronic Pain

- The patient's word
- "On a scale of 1 to 10, where 0 is no pain and 10 is the worst possible pain, how much pain are you having now?"
- Document, and follow patient's progress

Treatment Modalities for Chronic Pain

- Exercise, physical activity, yoga
- Acupuncture
- Hypnosis
- TENS, ice/heat, traction
- Massage
- Cognitive/behavioral, meditation
- Medications
- Invasive procedures

Medication Treatment of Chronic Pain

- Acetaminophen
- NSAIDS
- Muscle relaxants
- Opioids
- Antidepressants
- Anticonvulsants
- Stimulants
- Sedative-hypnotics

Professional's Barriers to Opioid Prescribing

- Lack of education about opioids and current standards for pain management
- Fear of toxicity
- Fear of addiction
- Fear of being “had” or “scammed”
- Fear of regulatory agency scrutiny

Patient Barriers to Opioid Prescribing

- **Fear of focusing on symptoms rather than cause**
- **Belief that pain is inevitable**
- **Fear of side effects**
- **Fear of addiction**

Adverse Effects of Opioid Therapy

- **No evidence of major organ toxicity**
- **Constipation is most prominent side effect**
- **Tolerance usually develops to sedative and cognitive effects**
- **Nausea/vomiting, itching, sweating, dry mouth**
- **High doses can lower testosterone levels**

Adverse Effects of Opioid Therapy: Rx

- **Nausea: Phenergan etc.**
- **Constipation: Daily bowel regimen of bowel stimulant plus stool softener. Lactulose prn**
- **Sedation: modafinil, methylphenidate**
- **Testosterone replacement**

Questions?

Tolerance

- **“Tolerance is 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.”**

– American Academy of Pain Medicine, American Pain Society, and American Society of Addiction Medicine consensus document, 2001.

Tolerance

- **The need for increasing doses to get the same effect**
- **Tolerance to sedation and nausea is common**
- **Tolerance to constipation and pain relief is uncommon**

Tolerance to pain relief with opioids is uncommon. Patients stabilized on a given dose of opioid typically continue on the same dose for years unless there is a change in their underlying disease state.

“Extensive clinical experience has documented that the doses of methadone required to maintain analgesia typically stabilize in the absence of progressive disease. . . Tolerance is seldom a problem in the clinical setting. . . When a need to increase the dose does materialize, the clinician should search for worsening disease rather than assume that analgesic tolerance has occurred.”

Scimeca, Savage, Portenoy, & Lowinson, 2000. Mt. Sinai Journal of Medicine 47:412-422.

Physical Dependence

- **“Physical dependence is a state of adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.”**

– American Academy of Pain Medicine, American Pain Society, and the American Society of Addiction Medicine consensus document, 2001

Physical Dependence

- **A property of opioids - and other drug classes**
- **Withdrawal symptoms occur with abrupt cessation**
- **Easily preventable**

Addiction

- **“Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.”**

– American Academy of Pain Medicine, American Pain Society, and the American Society of Addiction Medicine consensus document, 2001

Addiction is Characterized by:

- **Loss of control (compulsive use)**
- **Continuation despite adverse consequences**
- **Obsession or preoccupation with obtaining and using the substance.**
- **Adapted from DSM IV, 1994, p. 181, “Criteria for Substance Dependence.”**

Pseudoaddiction

Pseudoaddiction is a syndrome that can develop from undertreated pain. Give the patient a 1-week supply of what he says is adequate and have him/her return after 6 days with the prescription bottle.

Aberrant Drug-Taking Behaviors Less Predictive of Addiction

- **Aggressive demand for more drug**
- **Drug hoarding (e.g. obtaining drug from more than one source)**
- **Unsanctioned dose escalation**
- **Unapproved use of drug**

Aberrant Drug-Taking Behaviors More Predictive of Addiction

- **Selling prescription drugs**
- **Forging prescriptions**
- **Stealing drugs**
- **Frequent prescription “loss”**
- **Injecting oral/topical formulations**
- **Concurrent abuse of illicit drugs**

Differential Diagnosis of Aberrant Drug-Taking Behaviors

- **Addiction**
- **Pseudoaddiction [undertreated pain]**
- **Other psychiatric diagnoses**
- **Criminal intent [diversion]**

Risk Factors Associated with Misuse

- History of addiction or substance misuse
- Current risky use of alcohol
- Current use of any illicit substance
- Concurrent psychiatric illness
- Family history of addiction
- History of incarceration
- Major social, financial, or legal stressors

Savage, S et al. *J Pain Symptom Manag* 2003;26:655-667.

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Opioid Risk Assessment Tools

- Opioid Risk Tool (ORT)
- Screener & Opioid Assessment for Patients in Pain (SOAPP)
- Pain Medication Questionnaire

Webster & Webster, *Pain Med* 2005;6:432-442; Coombs & Jarry, *Pain Res Manag* 1996;1:155-162; Butler et al. *Pain* 2004;112:65-75, Holmes et al., *Pain Pract* 2006;6:74-88.

Opioid Risk Tool

1. Family history of Substance Abuse 1-4
2. Personal hx of substance abuse 3-5
3. Age 16-45 1 1-3=low, 4-7=mod, 8=high
4. Female, hx of preadoles sexual abuse 3
5. Psych disease: ADD, OCD, bipolar, schizophrenia, depression 1-2

Webster & Webster, *Pain Med* 2005;6:432-442.

Chronic Pain Patient vs. Addict

- **In control of meds vs. out of control**
- **Quality of life expands vs. constricts**
- **Decreases dose if S.E. vs. does not**
- **Follows opioid agreement vs. does not**
- **Often has meds remaining vs. uses up early**

Questions?

Principles of Opioid Prescribing

- **Initiate therapy with a conservative dose.**
- **Titrate upwards as appropriate**
- **No upper limit for pure mu opioid agonists**
- **SR opioids for round-the-clock pain**
- **For breakthrough pain, use short-acting analgesics as needed.**

Advantages of Long-Acting Opioids

- **All are single entity - no acetaminophen or aspirin, so avoids toxicity of these drugs**
- **Smoother blood levels**
- **Stable pain relief**
- **Longer duration/fewer doses**

Long-acting Opioids

- **Oral sustained-release:**
 - morphine: Avinza, Kadian, MS Contin, MS ER
 - oxycodone: OxyContin, oxycodone ER
 - oxymorphone: Opana ER
 - tramadol: Ultram ER
 - Hydromorphone: Exalgo
- **Transdermal: fentanyl (Duragesic, fentanyl generic)**
- **Long-half life: methadone, levorphanol**

Methadone

- **Once-daily dose prevents withdrawal, but need 3-4 doses/day for pain relief**
- **Inexpensive**
- **Requires careful upward titration**
- **Non-linear conversion from other opioids**
- **High doses may cause torsade de pointes**
- **To prescribe for pain, need only DEA license**
- **Increased risk of death when initiating methadone rx**

Breakthrough Pain Causes

- **Precipitating factors: activity, weather, mood**
- **End-of-dose failure**
- **Idiopathic**

Predictable vs. unpredictable; sudden v. gradual

Short-acting Opioids

- **Combinations: Vicodin, Percocet, Percodan, Tylenol #3**
- **Single-entity drugs: MS-IR, OxyIR, Opana, Actiq, Fentora, tramadol, Dilaudid**
- **Used mainly for acute pain, for dose finding during initial treatment, & for “rescue” dosing.**
- **Can be used for long-term management in selected patients.**
- **Not preferred: meperidine, propoxyphene, & agonist/antagonist drugs.**

Opioid initiation and titration

- **At onset, focus on side effects rather than pain relief**
- **Consider starting with IR opioid, then converting to SR**
- **Educate patients about tolerance to nausea & sedation**
- **Increase as tolerated, and no more than 50% at a time**
- **Increase more slowly if opioid has longer half-life**
- **Ask about degree of pain relief at each visit**
- **Expect a need for higher dose as activity level rises**
- **If pain level is unchanged as dose rises, reassess.**

Opioid Rotation

- **Inadequate pain relief may reflect genetic variability in opioid responsiveness. Consider changing opioids.**
- **Conversion tables are only a guide.**
- **After calculating equipotent dose, initiate at 50% while supplementing with previous drug as needed.**
- **Example: morphine:oxycodone = 1.5:1. 120 mg morphine = 80 mg oxycodone, but begin with 40 mg.**

Elements of Opioid Agreement- 1

- **Physician will educate patient about opioids**
- **Patient facilitates obtaining old records**
- **Only one doctor prescribes opioids**
- **Patient uses only one pharmacy**
- **Patient does not change dose w/o prior discussion with physician**

Elements of Opioid Agreement- 2

- **Physician will not give early refills**
- **Patient agrees to consultations**
- **Patient does not use illegal drugs**
- **Patient agrees to urine drug testing whenever physician wants it.**

Urine Drug Screen

- **“Opiates” in Standard UDS will pick up only natural opiates, such as codeine, morphine, hydrocodone and heroin. It will miss methadone, fentanyl, oxycodone, oxymorphone.**
- **Best strategy: order “standard UDS plus. . .) whatever drugs patient is prescribed.**

Patient Education

- **Sudden stopping may cause withdrawal symptoms**
- **Supervening acute pain requires additional pain medication**
- **Continued attention to bowel program to avoid constipation**
- **Addiction v physical dependency**
- **Expect to be stigmatized**

Positioning Opioid Therapy

- **Are opioids likely to work well?**
- **What are reasonable alternatives?**
- **Is there moderate to severe pain?**
- **Is responsible use likely?**

Evaluating Treatment Outcomes

- **Analgesia**
- **Activities of daily living**
- **Adverse effects**
- **Aberrant drug-related behaviors**
- **(Affect)**

Exit Strategies in Opioid Treatment: Reasons

- Opioids may be more likely to harm than help
- No convincing evidence of benefit despite attempts at optimal therapy
- Unacceptable side effects
- Persistent adherence problems

Exit Strategies in Opioid Treatment: Elements

- Consider offering continued pain treatment w/o opioids.
- Taper opioids to avoid withdrawal symptoms. Consider buprenorphine
- If fire, offer urgent treatment in next 30 days.
- Give 30 days of meds unless diversion, active addiction, or risk of unsafe use.
- If addiction, refer for addiction treatment.

Treating an Addicted Patient for Pain with Opioids

- Refer to recovery program & monitor
- Increase structure for patient
- More frequent office visits
- Ask patient to bring prescription bottles
- Obtain urine drug testing
- Smaller quantity of drug per script

Opioid therapy w drug abuse hx

- Good outcomes = 11; bad outcomes = 9
- Primarily alcohol use v polysubstance
- Good family support v poor support
- Membership in AA or similar groups, v no support group

Dunbar & Katz, 1996

Position Papers on Opioid Prescribing

- **American Academy of Pain Medicine/
American Pain Society/American Society of
Addiction Medicine**
- **American Society of Addiction Medicine**
- **American Geriatric Society**
- **Federation of State Medical Boards**

Model Guidelines for Use of Controlled Substances for Pain

- **Patient evaluation**
- **Treatment plan**
- **Patient education**
- **Periodic review**
- **Consultation**
- **Documentation**

– Federation of State Medical Boards of the U.S., 1998

Pharmacist's Role: Advocacy and Safety

- **Advocate for patients, most of whom are legitimate. Assume the best unless evidence otherwise.**
- **If in doubt about appropriateness of dose, consult a pharmacist before calling the physician.**
- **Reporting an MD to the Board is a desperate move!**
- **Communication with patients and physicians is important**
- **If red flags, contact the physician**

Pharmacist's Role: Balance Advocacy and Safety

- **Treat patient with respect.**
- **Educate the patient about: not stopping opioid abruptly; addiction vs physical dependence; preventing and treating constipation; that baseline dose won't prevent acute pain; importance of keeping meds in a secure place.**