MANAGING PAIN BUT MINIMIZING RISK

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Disclosure

- Indivior, Teaching Advocate, 2016 - present
Objectives

- Review CDC Guideline for prescribing opioids for chronic pain
- Be able to use methods for screening and assessment for opioid prescribing
- Be able to effectively monitor patients prescribed opioids
- Be able to make diagnosis of opioid use disorder and then either treat (preferred) or refer
- Review 2 Case Studies
Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of non-opioid therapies with patient
- Check PDMP (MAPS)
- Use urine drug testing (at least annually)
- Avoid concurrent benzodiazepines when possible
- Arrange for treatment of opioid use disorder if necessary
What the Guidelines Are

- Recommendation to start low and go slow
- For acute pain, prescribe no more than needed
  - If needed for acute pain use immediate release, not ER/LA opioids
- Reminder to have follow-up and re-evaluate risk of harm
  - Reduce dose or taper and discontinue if needed
What the Guidelines Are Not

- Reason to abandon patients
- Reason to stop all opioid and controlled substance prescribing
- Reason to retire from medicine altogether
Efforts to implement prescribing recommendations to reduce opioid-related harms are laudable. Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations.
Some healthcare players inflexible application of recommended dosage (<50MME for example) can lead to abrupt tapering when the guidelines did not actually endorse those policies.

Strict limits can leave patients who have been on stable dosages for years unable to stay on their regimen and has in some cases pushed them to illicit opioids or even suicide.
Harm reported from sudden discontinuation of opioid pain medications

Label changes needed to guide prescribers on gradual, individualized tapering
The tide is slowly turning

- Steady increase in opioid prescriptions dispensed by U.S. pharmacies from 76 million in 1991 to the peak of 217 million in 2011
  - The Joint Commission’s Pain Standards: Origins and Evolution. May 5, 2017
- Decreased prescribing is obviously a good start, but …
  - Now the driver of opioid related deaths is illicit fentanyl and heroin (along with an increase in cocaine and methamphetamine related deaths).
Common Universal Precautions

- Comprehensive pain assessment including opioid risk assessment
- Formulation of pain diagnosis/es
- Initial opioid prescription should be considered a test or trial; continue or discontinue based on ongoing reassessment of risks and benefits
  - Decision to continue or discontinue opioid therapy should be made regularly (e.g., every 2-3 months)
- Regular face-to-face visits
- Clear documentation

Franklin GM et al. Neurology 2014;83:1277-84.
Patient Selection and Risk Stratification

- Risk assessment in all patients prior to initiating opioids
- Aberrant drug-related behaviors in up to 50% of patients prescribed opioids for chronic pain
  - Strongest predictor personal or family history of alcohol or drug abuse
  - Psychological comorbidities also a factor
- Only consider opioids in patients in whom benefits likely outweigh risks
  - Opioids are not always appropriate
- Tools for risk stratification available
Objective information needed

- For HTN patients we check blood pressures
- For diabetic patients we check blood sugars
- For pain patients …
  - We get a number from 1 to 10!
Review of 725,679 UDS from individuals 50 and over:

- 28.1% of UDS contained non-prescribed drug
- 31.8% of UDS where prescribed drug was not detected
- 7.6% contained illicit drug

Screening Tools

- Choose 1 or do both!
  - DIRE Score
  - ORT
**D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia**

For each factor, rate the patient’s score from 1-3 based on the explanations in the right hand column.

<table>
<thead>
<tr>
<th>Score</th>
<th>Factor</th>
<th>Explanation</th>
</tr>
</thead>
</table>
|       | **Diagnosis**            | 1 = Benign chronic condition with minimal objective findings or no definite medical diagnose. Examples: fibromyalgia, migraine headaches, nonspecific back pain.  
2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain.  
3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis. |
|       | **Intractability**       | 1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process.  
2 = Multi customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness).  
3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response. |
|       | **Risk**                 | (R = Total of P + C + R + S below)                                                                                                             |
|       | **Psychological**        | 1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues.  
2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder.  
3 = Good communication with clinic. No significant personality dysfunction or mental illness. |
|       | **Chemical Health**      | 1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse.  
2 = Chemical coping (uses medications to cope with stress) or history of CD in remission.  
3 = No CD history. Not drug-focused or chemically reliant |
|       | **Reliability**          | 1 = History of numerous problems: medication misuse, missed appointments, rarely follows through.  
2 = Occasional difficulties with compliance, but generally reliable.  
3 = Highly reliable patient with meds, appointments & treatment. |
|       | **Social Support**       | 1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles.  
2 = Reduction in some relationships and life roles.  
3 = Supportive family/dose relationships. Involved in work or school and no social isolation. |
|       | **Efficacy Score**       | 1 = Poor function or minimal pain relief despite moderate to high doses.  
2 = Moderate benefit with function improved in a number of ways (or insufficient info - hasn’t tried opioid yet or very low doses or too short of a trial.  
3 = Good improvement in pain function and quality of life with stable doses over time. |

Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia  
Score 14-21: May be a candidate for long-term opioid analgesia

Source: Miles DeLambre, Fairview Pain & Palliative Care Center © 2005.
**OPIOID RISK TOOL**

<table>
<thead>
<tr>
<th></th>
<th>Mark each box that applies</th>
<th>Sub Score</th>
<th>Total Score 0</th>
<th>Total Score 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse</td>
<td></td>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Illegal Drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prescription Drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse</td>
<td></td>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Illegal Drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prescription Drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (Mark box if 16 – 45)</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of Preadolescent Sexual Abuse</td>
<td></td>
<td></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological Disease</td>
<td>Attention Deficit Disorder</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Obsessive Compulsive Disorder</td>
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<td></td>
<td>Bipolar</td>
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<td></td>
<td>Schizophrenia</td>
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<tr>
<td></td>
<td>Depression</td>
<td></td>
<td>1</td>
<td>1</td>
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</tbody>
</table>

**TOTAL**

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<thead>
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**Total Score Risk Category**

- **Low Risk**: 0 – 3
- **Moderate Risk**: 4 – 7
- **High Risk**: ≥ 8
Need for drug testing

- If you don’t check you will have no idea.
- Many controlled substances that are prescribed are:
  - Taken incorrectly (snorted, injected, etc.)
  - Shared
  - Sold
- Many substances are available for illicit use
  - Other people’s prescription
  - Illicits (Methamphetamine, cocaine, heroin, etc.)
Drug testing Options

- Qualitative ("urine drug screen" or saliva test)
  - Test either positive or negative
  - Immunoassay

- Quantitative (lab analysis)
  - Test measures concentration of drug
  - GC/MS or LC/MS
  - Urine, Blood or Saliva

- In office testing
  - Urine Drug Test: Witnessed or unwitnessed (point of care or send out)
  - Saliva Test: Witnessed (point of care or send out)
  - Breathalyzer (Alcohol)
Point of care saliva test
Art of practice issue.

Suggestions:
- Every visit or most visits for patients on buprenorphine maintenance treatment
- 1-4 times per year for all others based on perceived risk
- Increase frequency of testing if tests are inconsistent
  - Also consider change in treatment plan if risk outweighs benefit
Accountability for medications

- Request medication counts
  - If there is a report of diversion
  - If you are in any way concerned
  - Higher level accountability practices can be added to your practice: Randomized checks for all patients

- Med count at office or pharmacy
The diagnosis of Opioid Use Disorder under DSM V can be applied to someone who uses opioid drugs and has at least two of the following symptoms within a 12 month period:

- Taking more opioid drugs than intended.
- Wanting or trying to control opioid drug use without success.
- Spending a lot of time obtaining, taking, or recovering from the effects of opioid drugs.
- Cravings opioids.
- Failing to carry out important roles at home, work or school because of opioid use.
- Continuing to use opioids, despite use of the drug causing relationship or social problems.
- Giving up or reducing other activities because of opioid use.
- Using opioids even when it is physically unsafe.
- Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway.
- Tolerance for opioids.
- Withdrawal symptoms when opioids are not taken.
OUD: Mild, Moderate or Severe?

- Mild: 2-3 criteria met
- Moderate: 4-5 criteria met
- Severe: 6-11 criteria met
Tolerance and withdrawal criteria do not count if patient is under appropriate opioid medication management
For purposes of ICD-10 coding
  - Opioid Use Disorder=Opioid Dependence

Can also use:
  - F11.21 Opioid dependence in remission
  - F11.21 Opioid dependence on agonist therapy
Case Study 1

- 45 Year Old Male with chronic back pain following back injury in 2002 at work when he was lifting heavy steel scaffolding. He established with me in March 2013 when he moved from Hillsdale area.
  - Lumbar fusion surgery in 2002 and hardware removed in 2007
  - Has temporary benefit from injections
  - Completed PT, does home exercises
  - Minimal benefit from NSAIDs
- Stable opioid dosages for 10+ years:
  - MS Contin 100mg q12 and MSIR 30mg q6 as needed
  - Has failed dose reductions below this
  - No adverse side effects reported
- Also takes Lyrica 150mg twice daily
More history

- FH: No AUD, OUD; brother and sister both died in late 40s from lung cancer
- Prescribed ativan for anxiety with occasional panic attacks following divorce and #20 tabs lasted >1 year
- He started drinking alcohol with new girlfriend in 2017 and had episode of gastritis and pancreatitis that led to hospitalization
  - He has been abstinent since
DIRE score is 19, ORT is 4 (alcohol mis-use hx and age 45)

UDS every 3-4 months have been consistent

One pharmacy, MAPS appropriate

Appointments every 2 months

Has been on disability since 2002 but is able to work part-time as a self-employed carpenter

Stable mood. Good relationship with his daughter who just had a baby.

He just found out he had a son who just turned 18.
74 year old male with cervical and lumbar spinal stenosis; neck surgery in 2001; many flare-ups of lumbar radiculitis over the years. Some PT attempts have been made. Refuses to consider back surgery.

- PSH: Cervical Fusion in 2001
- PMH: PTSD, depression, anxiety with panic attacks, COPD, chronic pain
- FH: no substance use disorders; Dad died at age 72 from CAD and CHF; Mother who is 105 years old; 46 year-old daughter died in 2013 six days after her second back surgery
- SH: On disability since 2001, divorced wife of 22 years in 1987, quit smoking in 2018, no alcohol, likes watching golf on TV (big fan of Tiger Woods)
More History

- Was on chronic opioid pain medication for >20 years. I was his prescriber for most of last 10 or so of those years.
- Every 2 week fills for opioid pain medication due to running out early if given full 30 days.
- UDS: were consistent
- Had dose reduction attempts that had some success; without adequate pain relief he could hardly get out of bed or function.
- DIRE Score: 16, ORT is 6 (retroactive check)
- Hospitalization in January 2019 for …
Opioid withdrawals and overuse of klonopin to manage withdrawals

- Follow-up in office following hospitalization
- Oxycodone dose and klonopin doses were greatly reduced
Unable to tolerate dose reductions and ended up in ER with hypertensive crisis

- This led to DSM 5 diagnosis of OUD. Surprisingly he had severe OUD; (I was predicting moderate); ACE score - 7
- Started on Zubsolv 5.7/1.4
  - Started at 1 tab daily and this was increased to 1.5 tab and then 2 tabs daily after 1 and 2 week follow-ups respectively; He had several sessions with psychologist that helped as well.
  - Now seen every 3-4 weeks; supportive counseling at each appointment.
  - Reduced Klonopin to 0.5mg dose twice daily
  - Inadequate symptom control with other psychotropics
- He has better function in daily activities
  - Better endurance
  - Sleeping better
  - Better Mood
  - More livable space in apartment (he did significant flare up in pain from clearing out years of clutter)
Solid compliance monitoring can reduce but not eliminate risk
- Need good history taking and documenting to justify treatment plan.
- Follow CDC guidelines, state prescribing laws
- Controlled substance treatment agreement
- Risk Tool: DIRE, ORT
- Drug testing, med counts

If Risk outweighs benefit then check DSM 5 OUD criteria and if positive for OUD:
- Then it is prudent to discontinue opioid prescribing
- Can start opioid replacement therapy or refer out
Thank You.

- Questions/Discussion.
- dkbest_2000@yahoo.com