Optimizing Care When Managing Acute and Chronic Pain in 2024

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Objectives

To help the provider to improve treating acute and chronic pain in 2024 with better understanding:

1. How to use multi-modal pain treatment approaches to avoid excessive and prolonged doses of opioids
2. Recently updated definitions for pain
3. Pain signaling pathways and therapeutic targets
4. The new 2022 CDC Guidelines for Using Opioids
5. Principles of assessment and treatment for acute and chronic pain
6. When to consider using buprenorphine for chronic pain
7. Additional considerations

CONFLICTS: None

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GOAL FOR ADEQUATE PAIN CONTROL

The goal for pain control should not be zero pain, but rather a tolerable level of pain that allows physical and emotional function. Often this means balancing analgesia with achieving functional goals, while avoiding preventable complications.

PRINCIPLES

1. Create an individualized plan for pain management based on the expected degree of pain and patient factors that may affect the plan
2. Offer multimodal analgesia, adding opioids only as necessary
3. Provide patient education
4. Adjust the pain management plan based on adequacy of pain relief and the occurrence of adverse events

TACTICAL APPROACH

1. **Use multimodal analgesia** — Use a multimodal approach to analgesia for acute pain, with nonpharmacologic techniques, regional anesthesia techniques as appropriate, nonopioid analgesics, and opioids only as necessary. Multimodal analgesia involves the use of two or more agents that employ different mechanisms for pain management, thereby reducing overreliance on and adverse effects from a single class of agents, most importantly opioids.
2. **Use opioids safely** — An overarching principle of acute pain management is to avoid excessive or prolonged use of opioids. Opioids are associated with short term side effects (eg, respiratory depression, sedation, nausea and vomiting, pruritus, urinary retention, constipation) and long term adverse effects (eg, tolerance, dependence, opioid induced hyperalgesia, withdrawal upon conclusion of therapy, opioid use disorder, and overdose).

Adopted from a program developed by the University of Washington Anesthesia and Pain Medicine Department, Seattle, WA Published in UpToDate (Last Checked 5/19/24)

1. Understanding Updated Pain Definitions

2020 Revised Definition of Pain

Pain
An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.
Notes
• Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
• Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
• Through their life experiences, individuals learn the concept of pain.
• A person's report of an experience as pain should be respected.
• Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
• Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

1.Declaration of Montréal. International Association for the Study of Pain. Available at: https://www.iasp-pain.org/DeclarationofMontreal (Accessed on 5/18/2024). From: Raja SN, Carr DB, Cohen M, et al. The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. PAIN 2020; 161:1976. DOI: 10.1097/j.pain.0000000000001939.

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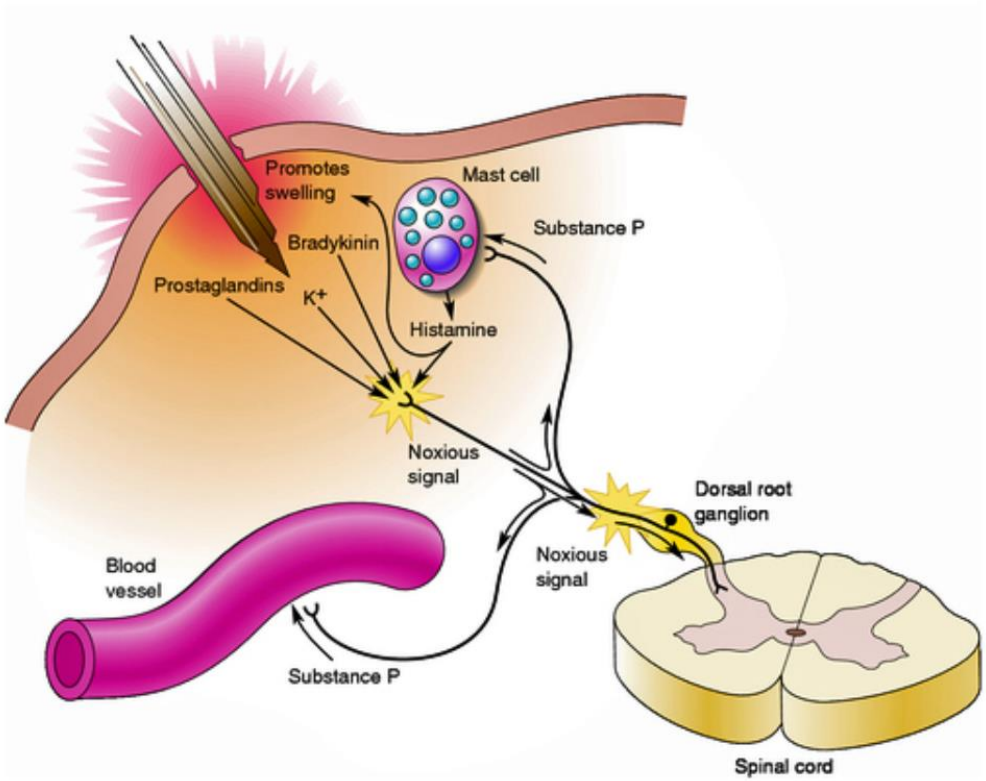
Pain Terms and Definitions

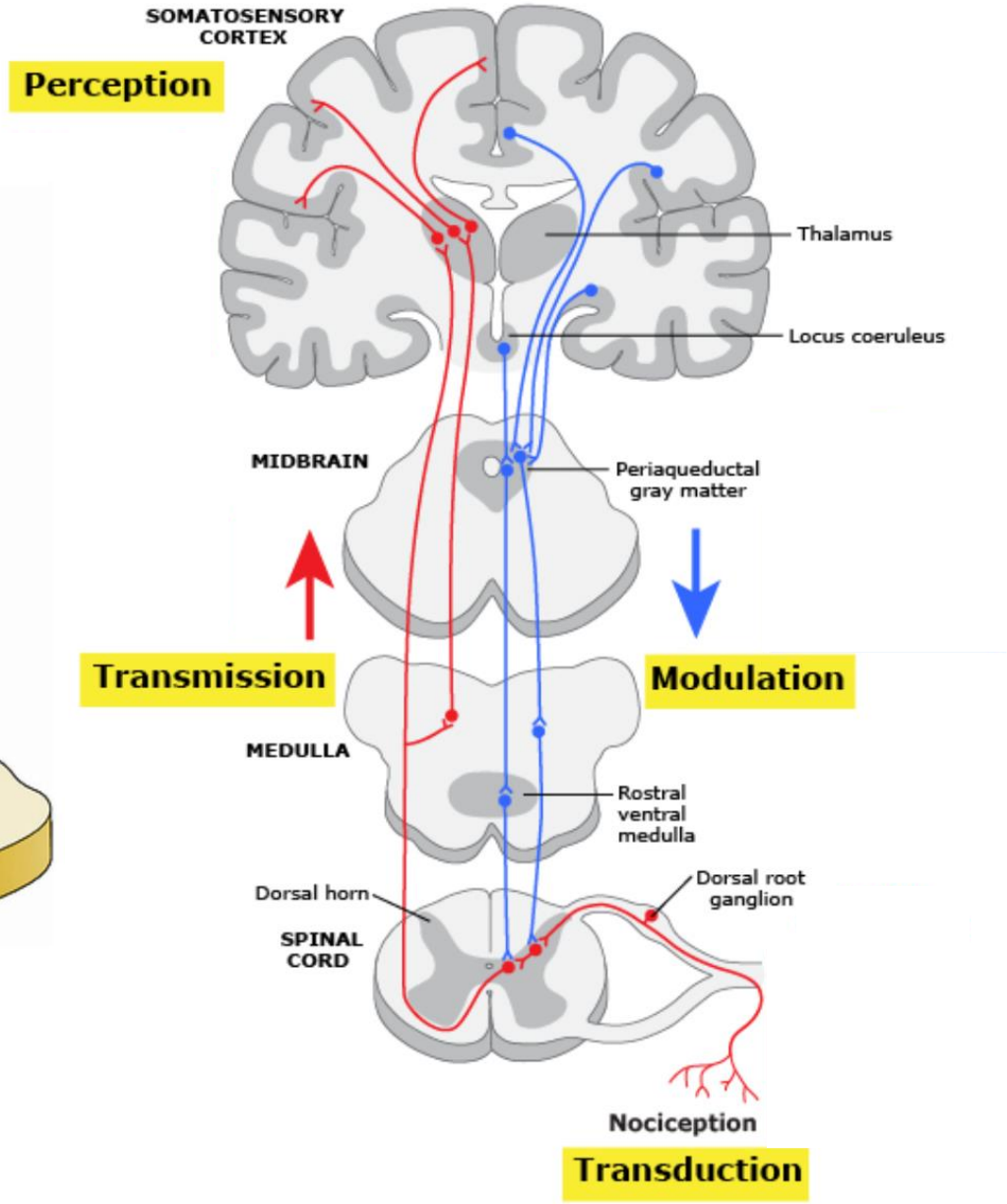
• **Allodynia:** Pain due to a stimulus that does not normally provoke pain.
• **Hyperalgesia:** Increased pain from a stimulus that normally provokes pain.
• **Nociceptive pain:** Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors.
• **Central sensitization:** Increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthreshold afferent input.
• **Neuropathic pain:** Pain caused by a lesion or disease of the somatosensory nervous system.
• **Nociplastic pain:** Pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain.

IASP Terminology. International Association for the Study of Pain. Available at: https://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1698 (Accessed on December 1, 2019).

2. Understanding Pain Signaling Pathways and Therapeutic Targets

Pain Signaling Pathways





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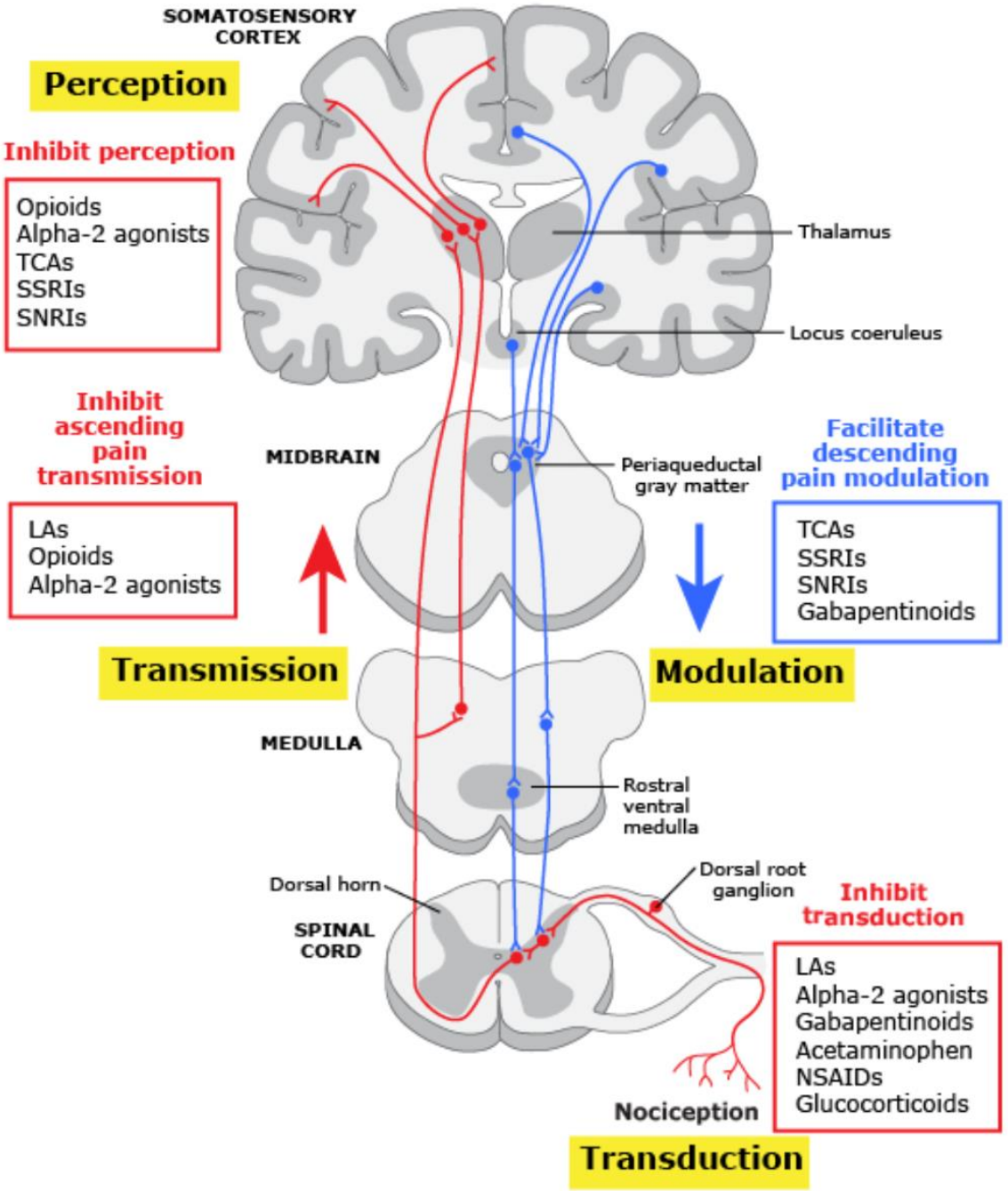

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Pharmacologic treatment based on type of pain

Type of pain	First-line therapy	Considerations for opioid use
Nociceptive	NSAIDs	When other treatment options are inadequate, for pain severe enough to require potentially daily, round-the-clock, long-term treatment. Limit dose and duration whenever possible. Encourage as-needed use linked to meeting specific activity goals.
Neuropathic	Antidepressants (TCAs or SNRIs) or Antiseizure medications	
Central sensitization	Antidepressants (TCAs or SNRIs) or Antiseizure medications	Avoid whenever other multidisciplinary treatment options have not been systematically, sufficiently, and consistently trialed. Opioids often worsen central sensitization treatment outcomes.

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Relevant Comorbidities for Drug Selection

Drug class	Comorbidities favoring use	Comorbidities favoring avoidance
• Serotonin-norepinephrine reuptake inhibitors (SNRIs): •Duloxetine •Venlafaxine	• Depression • Anxiety	• Restless legs syndrome • Sexual dysfunction (for venlafaxine) • Angle-closure glaucoma • Severe hepatic or renal disease
• Tricyclic antidepressants (TCAs): • Nortriptyline • Desipramine • Amitriptyline	• Depression • Anxiety • Insomnia (particularly for amitriptyline)	• Cardiac disease • Prolonged QTc • Orthostatic hypotension • Sexual dysfunction • Urinary retention • Angle-closure glaucoma
• Gabapentinoid anticonvulsant medications: • Pregabalin • Gabapentin	• Restless legs syndrome • Essential tremor • Insomnia	• Substance abuse • Peripheral edema • Severe renal disease

3. So What About Using Opioids - The 2022 CDC Guideline For Prescribing Opioids

CDC Clinic Practice Guideline for Prescribing Opioids – United States, 2022

Summary

This Guidelines is

- **A clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together**
- **Intended for primary care clinicians and other clinicians providing pain care for outpatients aged ≥18 years old with:**
  - acute pain (duration <1 month);
  - subacute pain (duration of 1-3 months); or
  - chronic pain (duration of >3 months)
- **Intended to be flexible to enable person-centered decision-making, taking into account an individual's expected health outcomes and well-being.**

This clinical practice guideline is not

- **A replacement for clinical judgment or individualized, person-centered care**
- **Intended to be applied as inflexible standards of care across patients, and/or patient populations by healthcare professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or discontinuation of opioids for patients**
- **A law, regulation, and/or policy that dictates clinical practice or a substitute for FDA-approved labeling**
- **Applicable to the following types of pain treatment:**
  - sickle cell disease-related pain
  - cancer pain
  - palliative care
  - end-of-life care

URL - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 (Accessed 5/20/23)
URL - Prescribing Opioids for Pain — The New CDC Clinical Practice Guideline | NEJM (Accessed 5/20/23)

CDC Clinic Practice Guideline for Prescribing Opioids – United States, 2022

Summary

1. **For all patients with acute, subacute, or chronic pain**
   - Initiate the lowest dose to achieve expected results
   - For opioid naïve patients, start with immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
   - Use extreme caution when prescribing opioids, benzodiazepines and other sedating substances concurrently
     - consider whether benefits outweigh risks
     - Taper cautiously to a less risky dose or discontinue
   - Check the state prescription drug monitoring program (PDMP) also known as the Michigan Automated Prescription Service (MAPS), to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose
     - When initiating therapy
     - Periodically when continuing
   - Consider toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances
   - Offer naloxone and other overdose mitigation strategies when risk factors for opioid overdose are present
2. **For acute pain, consider initiating opioid therapy only if benefits are anticipated to outweigh risks to the patient**
   - Nonopioid therapies are effective for many common types of acute pain
   - Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids

URL - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 (Accessed 5/20/23)

CDC Clinic Practice Guideline for Prescribing Opioids – United States, 2022

Summary

3. **For subacute and chronic pain, consider initiating opioid therapy only if expected benefits for pain and function are anticipated to outweigh risks to the patient**
   - Work with patients to establish treatment goals for pain and function
   - Nonopioid therapies are preferred
   - Discuss the known risks and realistic benefits of opioid therapy
   - Consider how opioid therapy will be discontinued when benefits do not outweigh risks
   - If opioids are continued
     - use caution when prescribing opioids at any dosage
     - avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients
     - re-evaluate benefits and risks after starting opioid therapy or when escalating dose
     - Initially at 1 to 4 weeks
     - Then every 3 months (or more frequently as indicated)

4. **Carefully weigh benefits and risks for patients already receiving higher opioid dosages**
   - Do not abruptly discontinue opioid therapy unless there are indications of a life-threatening issue, such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech)
   - Exercise care when reducing or continuing opioid dosage
   - Work closely with patients to optimize other therapies
   - Gradually taper to lower dosages if risks outweigh benefits of continued opioid therapy
   - Taper and discontinue opioids if warranted based on the individual clinical circumstances of the patient
   - Consider transitioning to buprenorphine if opioids cannot be sufficiently tapered or discontinued

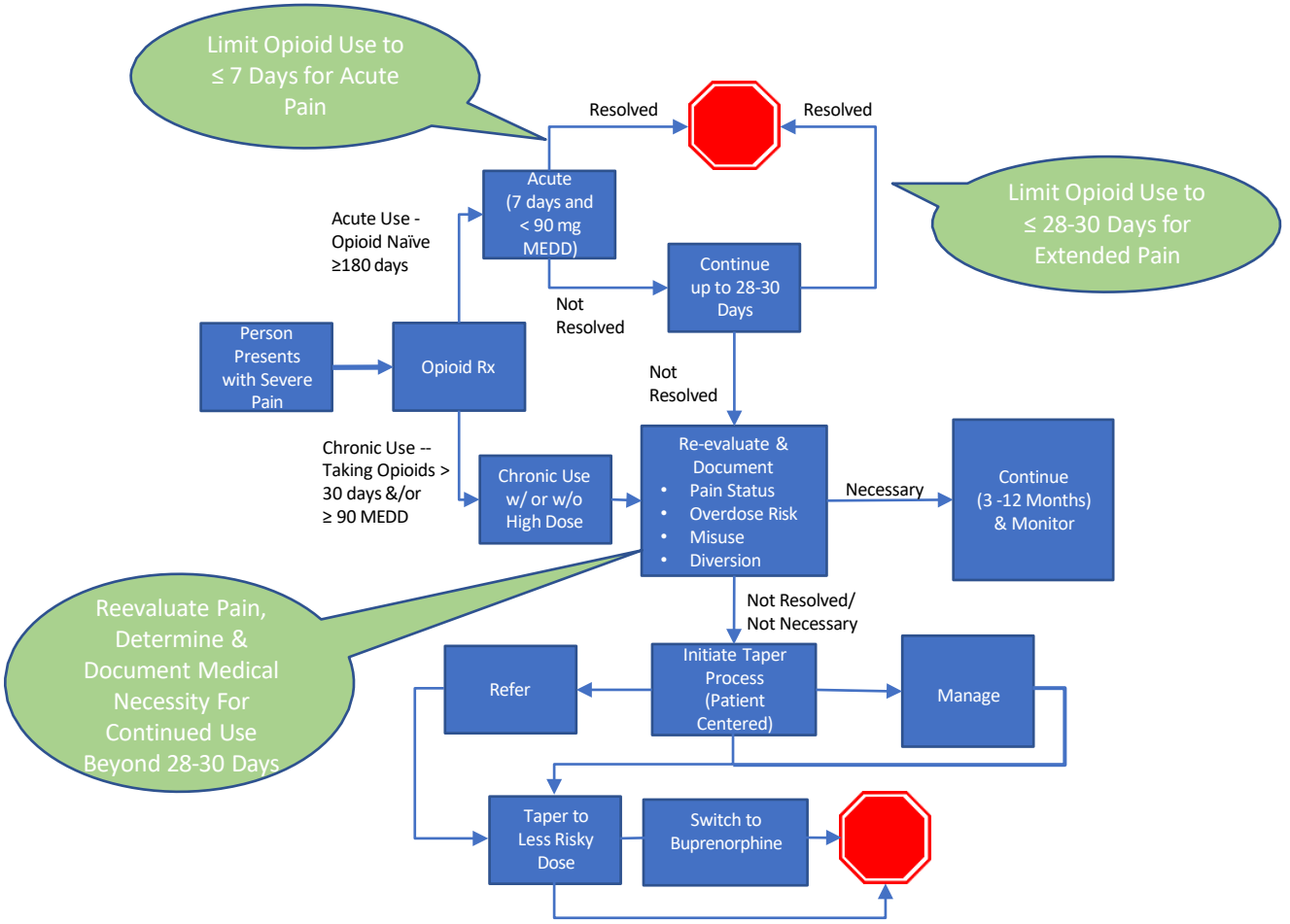
5. **Offer Medications for Opioid Use Dosorder (MOUD) to patients without pain and exhibiting opioid used disorder (OUD)**

URL - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022
(Accessed 5/20/23)

Bottom Line - When Prescribing Opioids, Minimize Their Use

Recommendations

1. Assess Severity and Anticipated Duration of Pain
2. Assess Overdose Risk
3. Limit Initial Dose & Ongoing Duration
4. Securely Store Medications
5. Promote Disposal of Unused Doses



4. Pain Evaluation

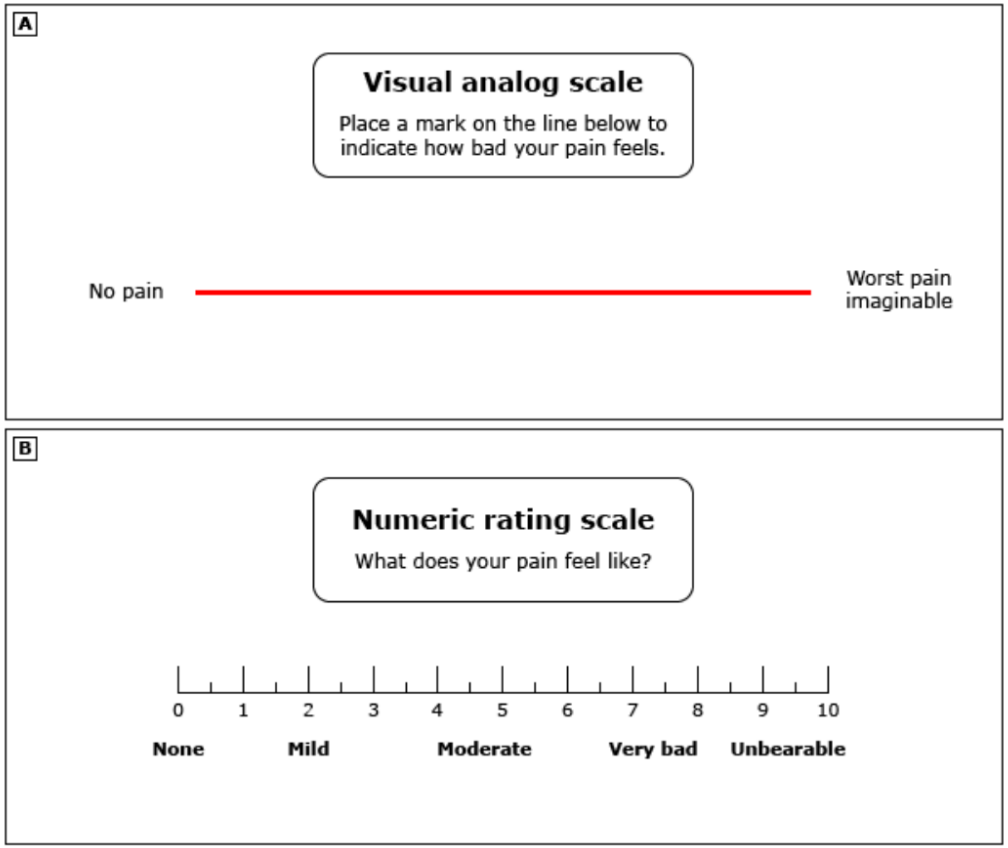
History and Physical
• Identify possible pain etiology
• Identify comorbidities that may affect treatment options
• Examine for allodynia and/or sensory changes in painful body part

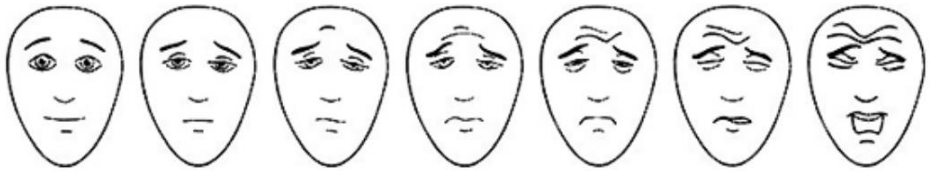
• For patients who use opioids or patients with risk factors for opioid misuse or use disorder:
  • Check PDMP
  • Screen for opioid risk with ORT, SOAPP, COMM, or similar

PDMP: prescription drug monitoring programs; ORT: Opioid Risk Tool; SOAPP: Screener and Opioid Assessment for Patients with Pain; COMM: Current Opioid Misuse Screen

Body diagram
•Useful for all patients
•For patients with multisite pain, screen for chronic widespread pain disorders with Widespread Pain Index and Symptom Severity Score
Pain history
OLDCARTS
• **O**nset ("When did your pain start?")
• **L**ocation ("Where does it hurt?")
• **D**uration ("How long does your pain last?")
• **C**haracter ("How does your pain feel?", ie, aching, burning, shooting, tingling)
• **A**lleviating/**A**ggravating ("What makes your pain better/worse?") and **A**ttribution ("What do you think is the cause?")
• **R**adiation ("Does this pain spread anywhere else?")
• **T**emporal pattern ("Does your pain vary over the course of a day?")
• **S**ymptoms associated ("How does your pain impact your physical function, your mood, your sleep?")

Visual Pain Scales





Schematic representation of the faces pain scale, rated from 0 to 6 left to right.

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Identify and Treat the Pain Source (Starting with a Good History)

Patient Instructions: Please fill out both sides of this questionnaire as completely as possible.

1. HISTORY OF THE PAIN

YES

► *Do you believe the pain is due to:*

- ☐ a car accident
  - date: ____/____/____
  - time: ____:____ a.m. / p.m.
- ☐ a work-related injury
  - date: ____/____/____
  - time: ____:____ a.m. / p.m.
- ☐ physical trauma (*examples: a fall, a fight, sports injury, etc.*)
- ☐ other: _____
  - date: ____/____/____
  - time: ____:____ a.m. / p.m.
- ☐ unknown cause

► *How long have you had this pain?*

- ☐ hours — how many? _____
- ☐ days — how many? _____
- ☐ weeks — how many? _____
- ☐ months — how many? _____

► *Did the pain appear:*

- ☐ suddenly
- ☐ gradually

► *Right now, is the pain:*

- ☐ better
- ☐ worse
- ☐ unchanged

2. LOCATION AND INTENSITY OF PAIN

► *The most intense pain is located:* _____

► *On the diagrams to the right:*

- mark an X or a series of X's where you feel pain.
- shade the areas where you have numbness.
- use arrows to point to where the pain radiates or travels to.

► *Has the pain changed in its location?*

_____

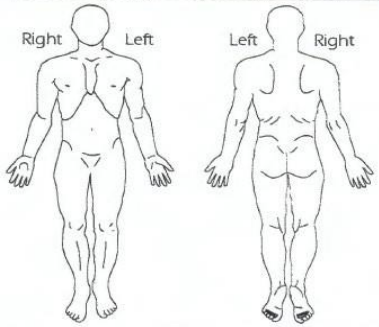
_____

_____

► *On the scale below, mark an X where it best describes the intensity of your pain:*

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Possible Pain



3. DESCRIPTION OF THE PAIN

YES

► *Is the pain:*

- ☐ continuous (*no relief*)
- ☐ intermittent (*periods of relief*)
  - amount of time **pain** usually lasts: _____
  - amount of time **relief** usually lasts: _____
- ☐ other _____

► *Would you describe the pain as:*

- ☐ sharp, stabbing
- ☐ dull, aching
- ☐ throbbing
- ☐ burning like a hot poker
- ☐ steady, persistent
- ☐ waxing and waning
- ☐ feeling like a tight band
- ☐ easy to pinpoint
- ☐ difficult to pinpoint
- ☐ other _____

► *Does pain occur:*

- ☐ upon awakening
- ☐ in the morning
- ☐ in the afternoon
- ☐ in the evening
- ☐ 2-3 hours after falling asleep
- ☐ any time day or night
- ☐ only on weekends
- ☐ only at work
- ☐ only at home
- ☐ other _____

→

4. DO YOU ALSO HAVE:

YES

- ☐ runny, bloodshot eyes
- ☐ blurred or double vision
- ☐ nasal congestion/runny nose
- ☐ high blood pressure
- ☐ muscle weakness
- ☐ numbness in arms or hands
- ☐ numbness in legs or feet
- ☐ felt a "sudden snap"
- ☐ felt a "tearing" sensation
- ☐ muscle aches and pains
- ☐ joint pains
- ☐ morning joint stiffness
- ☐ fever
- ☐ abdominal pain
- ☐ nausea or vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ bloody stools
- ☐ frequent or burning urination
- ☐ sudden loss of urine
- ☐ inability to urinate
- ☐ bloody urine
- ☐ weight gain or loss
- ☐ depression
- ☐ other: _____

► *Female patients only:*

- ☐ vaginal discharge
- ☐ heavy menstrual bleeding
- ☐ bleeding between periods
- ☐ pelvic infection
- ☐ ovarian cysts
- ☐ uterine fibroids
- ☐ painful intercourse
- ☐ hot flashes
- ☐ other: _____

► *Male patients only:*

- ☐ prostate trouble
- ☐ restricted or painful urination
- ☐ interrupted sleep to urinate
- ☐ swollen or painful testicles
- ☐ penis discharge
- ☐ other: _____

5. PREVIOUS MEDICAL WORKUP INCLUDES:

YES

- ☐ seeing other doctors name(s): _____
- ☐ skull x-rays
- ☐ neck x-rays
- ☐ lumbar and pelvis x-rays
- ☐ EEG/brain wave study
- ☐ CT scan
- ☐ brain scan
- ☐ MRI
- ☐ Evoked potentials
- ☐ EMG
- ☐ blood work
- ☐ other: _____

6. DOES ANY BLOOD RELATIVE HAVE A HISTORY OF:

YES

- ☐ arthritis
- ☐ diabetes
- ☐ aortic aneurysm
- ☐ cerebral aneurysm
- ☐ migraines
- ☐ high blood pressure
- ☐ stroke
- ☐ brain tumor
- ☐ spinal cord tumor
- ☐ poor leg circulation
- ☐ disk problems
- ☐ spinal stenosis
- ☐ multiple sclerosis (MS)
- ☐ muscular dystrophy
- ☐ arteriovenous malformation
- ☐ Lou Gehrig's disease
- ☐ other neurological disease: _____

7. IS THE PAIN MADE WORSE OR BETTER BY:

FEELS WORSE	FEELS BETTER		FEELS WORSE	FEELS BETTER		FEELS WORSE	FEELS BETTER	
☐	☐	inactivity or sleep	☐	☐	lifting _____ lbs.	☐	☐	menstrual periods
☐	☐	mild activity	☐	☐	carrying _____ lbs.	☐	☐	massage
☐	☐	exercising or stretching	☐	☐	stooping	☐	☐	heat
☐	☐	heavy work	☐	☐	twisting	☐	☐	trying to forget about it
☐	☐	climbing stairs	☐	☐	reaching overhead	☐	☐	spinal manipulation
☐	☐	walking	☐	☐	coughing/sneezing	☐	☐	spinal injections (blocks)
☐	☐	standing	☐	☐	sudden movement	☐	☐	physical therapy
☐	☐	sitting	☐	☐	other movement: _____	☐	☐	surgery
☐	☐	car riding				☐	☐	other: _____
☐	☐	straining at stool	☐	☐	touching a certain point: _____	☐	☐	other: _____
☐	☐	reclining or lying down						*Medications:*
☐	☐	lying on a firm bed or on the floor	☐	☐	sexual intercourse	☐	☐	_____
			☐	☐	drinking alcohol	☐	☐	_____
☐	☐	lying on one side	☐	☐	emotional tension	☐	☐	_____
☐	☐	getting up from bed	☐	☐	fatigue	☐	☐	_____
☐	☐	bending forward	☐	☐	changes in weather	☐	☐	_____

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Mood assessment

PHQ-4

Over the past 2 weeks, have you been bothered by these problems?	Not at all	Several days	More days than not	Nearly every day
•Feeling nervous, anxious, or on edge	0	1	2	3
•Not being able to stop or control worrying	0	1	2	3
•Feeling down, depressed, or hopeless	0	1	2	3
•Little interest or pleasure in doing things	0	1	2	3

•**Scoring:**Add total score
•**For score >5**, screen for anxiety, depression, and post-traumatic stress, with GAD-7, PHQ-9, and PTSD-5

Sleep assessment

Sleep initiation and maintenance

•Does pain interfere with falling asleep?
•Does pain interfere with staying asleep?

Screen for obstructive sleep apnea (OSA) – STOP-Bang[2,3]

Yes	No	**S**nore – Do you snore loudly (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?
Yes	No	**T**ired – Do you often feel tired, fatigued, or sleepy during the day?
Yes	No	**O**bserved – Has anyone observed you stop breathing or choking/gasping during sleep?
Yes	No	**P**ressure – Do you have or are you being treated for high blood pressure?
Yes	No	**B**ody mass index >35 kg/m^2?
Yes	No	**A**ge older than 50 years?
Yes	No	**N**eck size large (male: ≥17 inches, female: ≥16 inches)?
Yes	No	**G**ender = male?

•**Scoring:**Low risk of OSA: Yes to 0 to 2 questions
•Intermediate risk of OSA: Yes to 3 to 4 questions
•High risk of OSA: Yes to ≥5 questions

1.Reproduced from: Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: The PHQ-4. Psychosomatics 2009; 50:613. Table used with the permission of Elsevier Inc. All rights reserved.
2.Chung F, Subramanyam R, Liao P, et al. High STOP-Bang score indicates a high probability of obstructive sleep apnoea. Br J Anaesth 2012; 108:768.

Confirm Appropriateness for Prescribing Opioids (DIRE Score)

Name: _____ DOB___/____/___

DIRE 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

SCORE	FACTOR	EXPLANATION
	DIAGNOSIS	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific 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 = Most 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 coper (uses medications to cope with stress) or history of chemical dependence (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/close 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 several ways (or insufficient info - hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and 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 good candidate for long-term opioid analgesia

NOTES

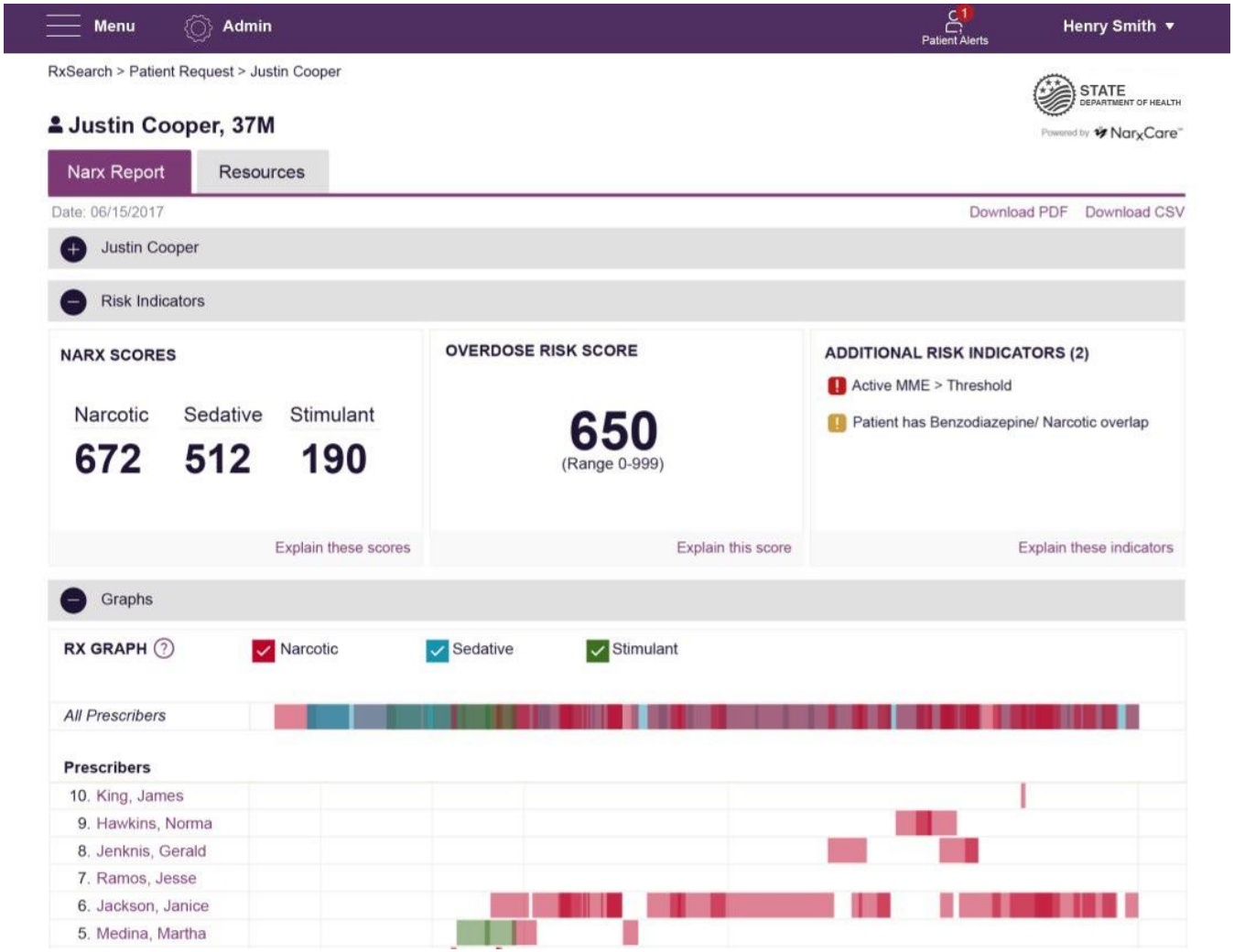
A DIRE Score of :513 indicates that the patient may not be suited to long-term opioid pain management. Used with permission by Miles J. Belgrade, MD |

Assess Risk for Overdose (Using RIOSORD)

Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)		
Question	**Points for Positive Response**	**Actual Response**
In the past 6 mo, has the patient had a health care visit (outpatient, inpatient, or emergency department) involving any of the following health conditions		
Substance use disorder (abuse or dependence), including alcohol, amphetamines, antidepressants, cannabis, cocaine, hallucino- gens, opioids, and sedatives	25	
Bipolar disorder or schizophrenia	10	
Stroke or other cerebrovascular disease	9	
Kidney disease with clinically significant renal impairment	8	
Heart failure	7	
Nonmalignant pancreatic disease (e.g., acute or chronic pancreatitis)	7	
Chronic pulmonary disease (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)	5	
Recurrent headache (e.g., migraine)	5	
Does the patient use any of the following substances?		
Fentanyl	13	
Morphine	11	
Methadone	10	
Hydromorphone	7	
Does the patient use an extended-release or long-acting formulation of any prescription opioid?	5	
Prescription benzodiazepine (e.g., diazepam, alprazolam)	9	
Prescription antidepressant (e.g., fluoxetine, citalopram, venlafaxine, amitriptyline)	8	
Is the patient's current maximum prescribed daily morphine- equivalent dose ≥100 mg for all opioids used on a regular basis?	7	
Total possible score	**146**	

Risk Classes and Predicted Probability of Serious Opioid-Induced Respiratory Depression during the Next 6 Months.			
Risk Class	**RIOSORD Score**	**Average Predicted Probability (Percent)**	**Actual Observed Incidence (Percent)**
1	<5	1.9	2.1
2	5–7	4.8	5.4
3	8–9	6.8	6.3
4	10–17	15.1	14.2
5	18–25	29.8	32.2
6	26–41	55.1	58.8
7	≥42	83.4	82.4

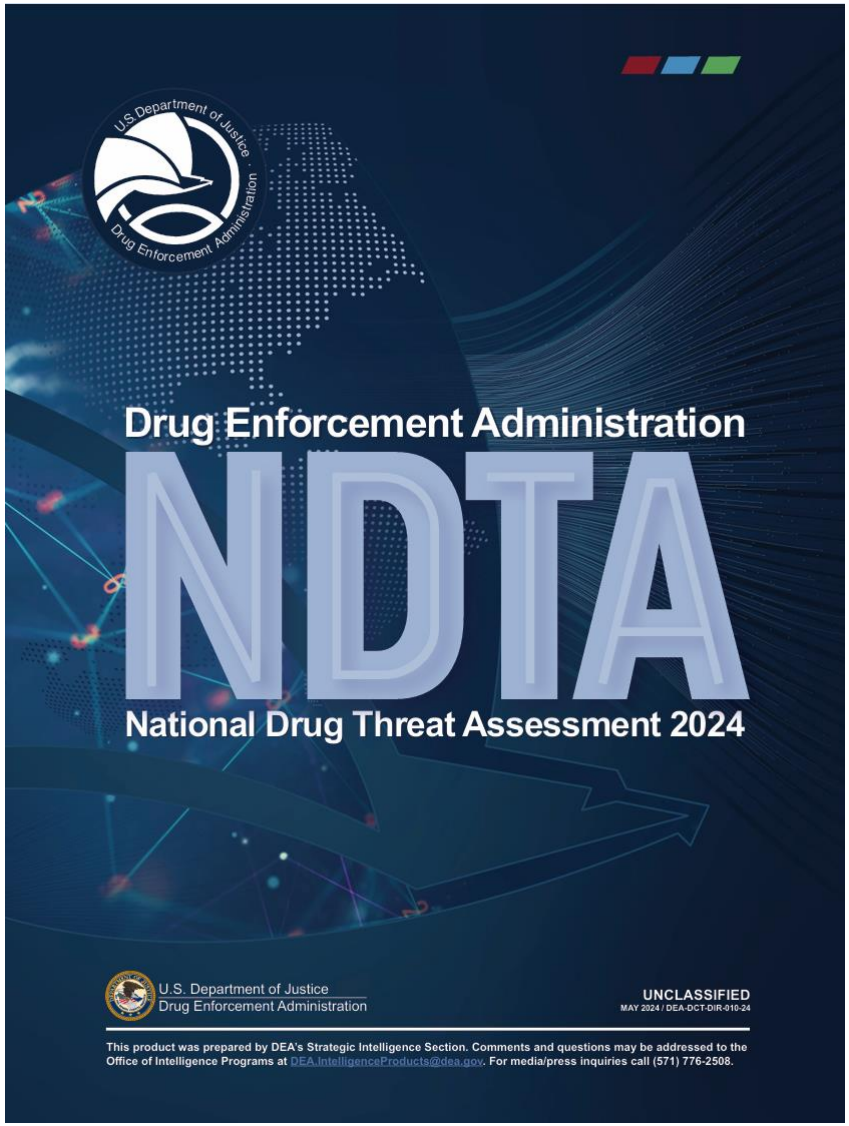
Check the Michigan Automated Prescription Service (MAPS) to Assess for Potential Misuse, Abuse, Diversion, or Overdose Risk



https://michigan.pmpaware.net

2. Consider What Else the Patient May Be Misusing

DEA: Synthetic Drugs Driving the Overdose Landscape

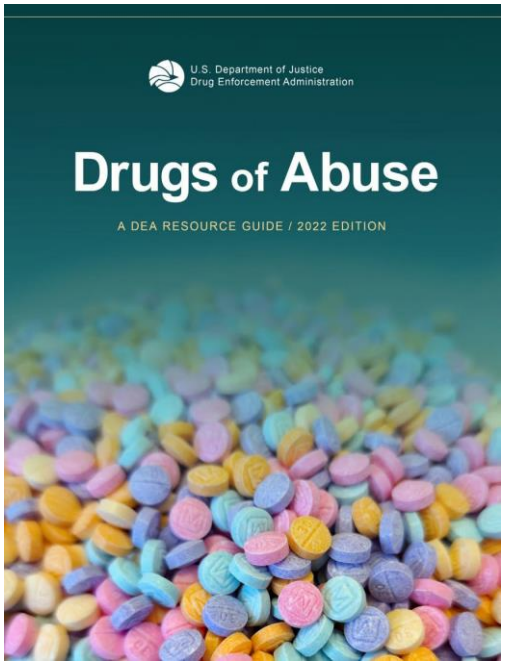


"The shift from plant-based drugs, like heroin and cocaine, to synthetic, chemical-based drugs, like fentanyl and methamphetamine, has resulted in the most dangerous and deadly drug crisis the United States has ever faced,"

Thirty-one percent of the drug-related deaths in the United States include psychostimulants – mostly methamphetamine.

URL - NDTA_2024.pdf (dea.gov) (accessed 5/17/24)

DEA: Multiple Drugs of Abuse on the Street




Counterfeit Oxycodone Tablet Containing Fentanyl

Contents

11/8/2022 New - Xylazine

URL - Drugs of Abuse (dea.gov) (accessed 7/2/23)

Agency for Healthcare Research and Quality

The Academy
Integrating Behavioral Health & Primary Care

Polysubstance Use is Common

- Polysubstance use has markedly increased throughout the entire global pandemic (2020 – 2023)
- According to the National Survey On Drug Use and Health from 2019, people who use one substance often use another.
- Many individuals with one substance use disorder are at risk of having a concurrent substance use disorder.
- Among people with a cocaine use disorder, nearly 60% have a co-occurring alcohol use disorder and over 20% have a marijuana use disorder, and among people with an opioid use disorder, more than 25% have at least two other substance use disorders.
- Finally, people with mental health disorders have been found to have higher rates of substance use and substance use disorders versus the general population.
- Having a mental disorder can increase the risk for developing multiple substance use disorders.

Concurrent Substance Use

Substance	Marijuana	Opioid	Cocaine	Methamphetamine	Alcohol
Heavy Alcohol Use	45%	9.2%	11%	1.7%	
Heavy Marijuana Use		16%	16.3%	3.3%	16.2%
Opioid	53%		15.6%	8.7%	14.7%
Methamphetamine	68.1%	43.7%	32.2%		13.4%

URL - Polysubstance Use & Integrated Behavioral Health | AHRQ
(Accessed 9/9/23)

Check for Anticipated and Unanticipated Medications and Other Substances

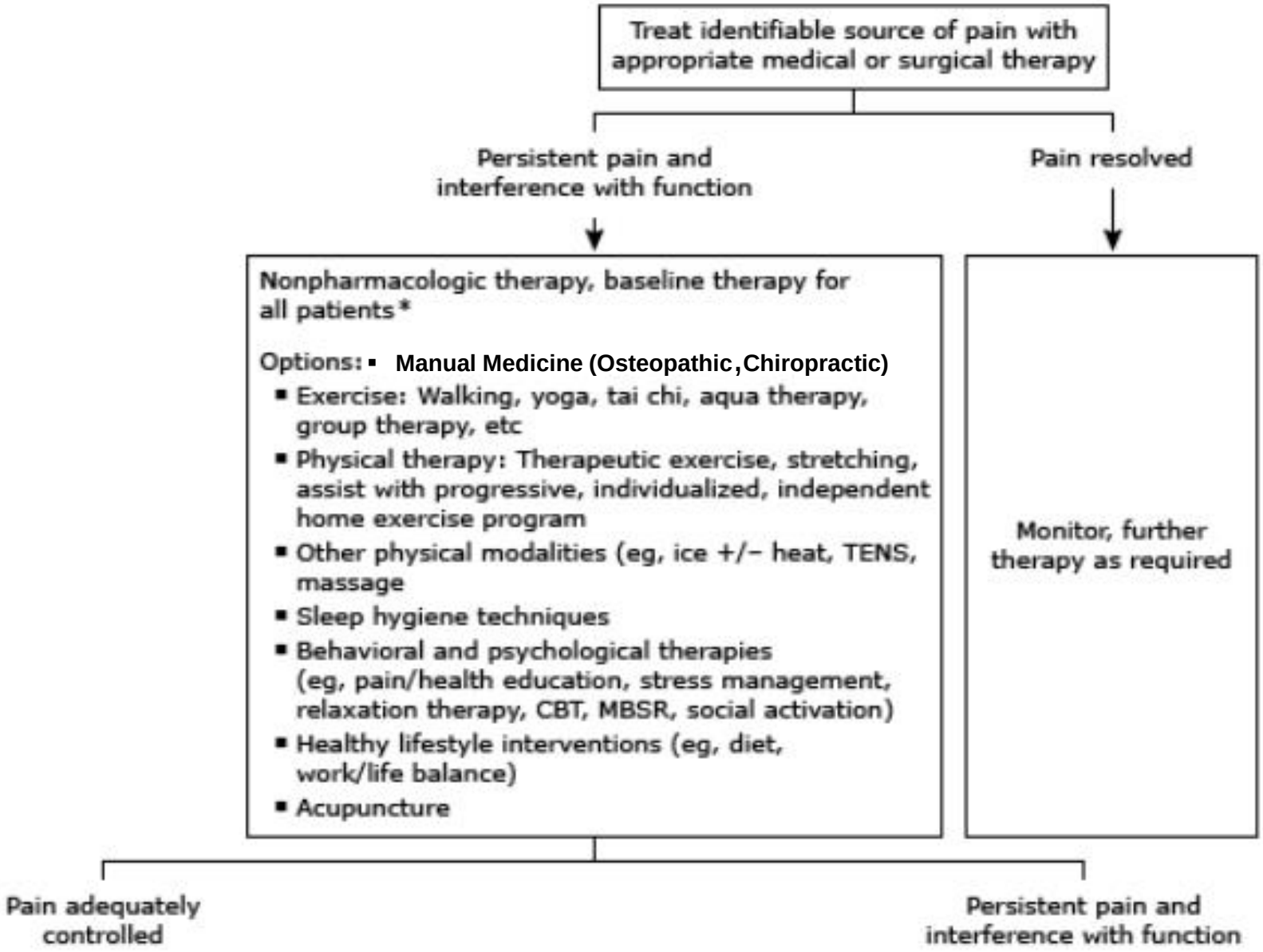
- If you don't check, you will have no idea.
- Qualitative - in Office
  - Test either positive or negative
  - Immunoassay
- Quantitative (in Lab)
  - Test measures concentration of drug
  - GC/MS or LC/MS
  - Can check for all psychoactive substances prescribed and unprescribed
  - Matrix - Urine, Saliva, Blood, Hair, Exhaled Air (breathalyzer), etc.

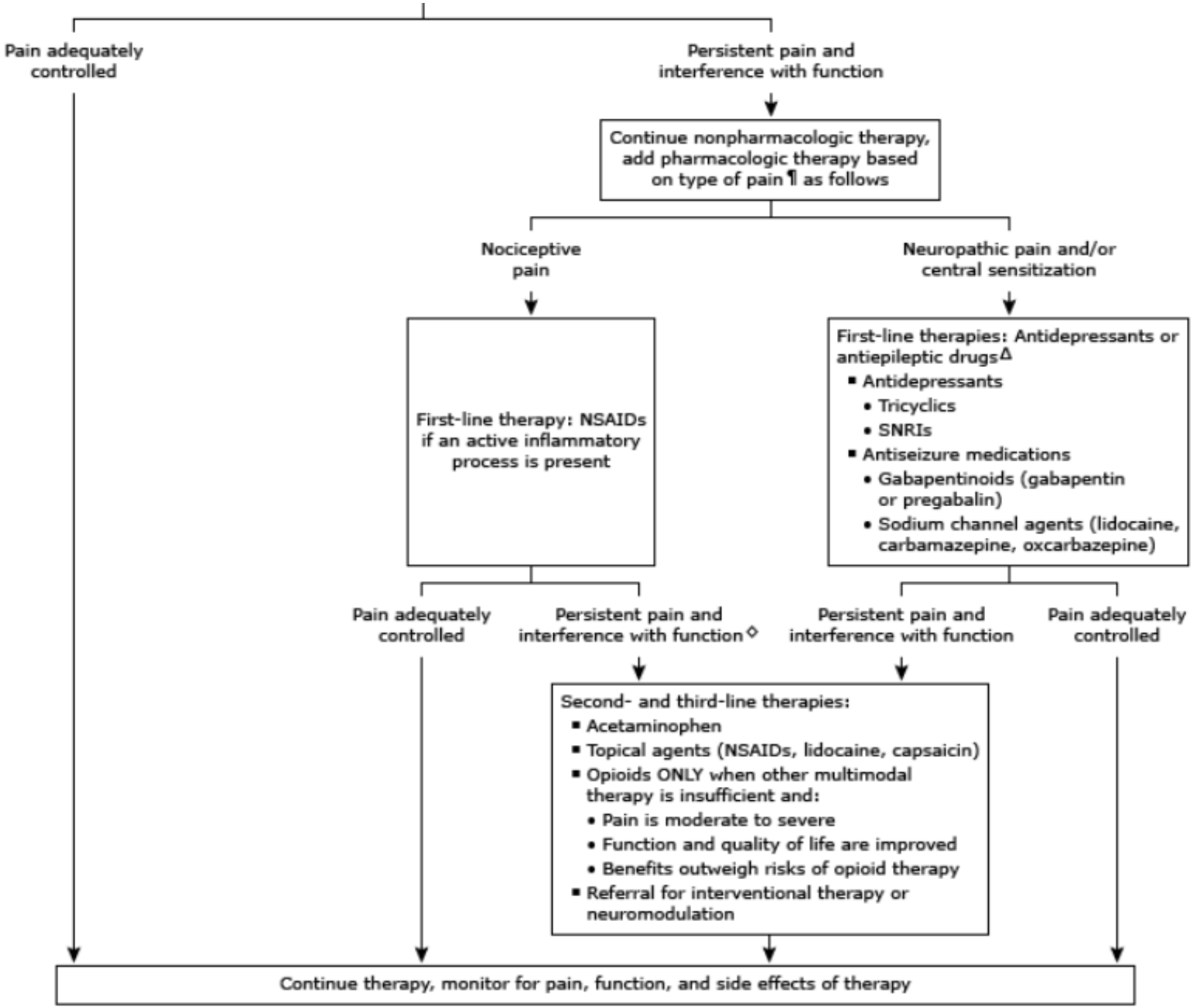
5. Approaches to Treat Acute Pain

Acute Perioperative or Injury Related Pain Management in Adults

6. Approaches to Treat Chronic Pain

Algorithm: Chronic non-cancer pain diagnosis-targeted therapy




Pain adequately controlled
Persistent pain and interference with function
Continue nonpharmacologic therapy, add pharmacologic therapy based on type of pain ¶ as follows
Nociceptive pain
Neuropathic pain and/or central sensitization
First-line therapy: NSAIDs if an active inflammatory process is present
First-line therapies: Antidepressants or antiepileptic drugs Δ
Antidepressants
Tricyclics
SNRIs
Antiseizure medications
Gabapentinoids (gabapentin or pregabalin)
Sodium channel agents (lidocaine, carbamazepine, oxcarbazepine)
Pain adequately controlled
Persistent pain and interference with function ◇
Persistent pain and interference with function
Pain adequately controlled
Second- and third-line therapies:
Acetaminophen
Topical agents (NSAIDs, lidocaine, capsaicin)
Opioids ONLY when other multimodal therapy is insufficient and:
Pain is moderate to severe
Function and quality of life are improved
Benefits outweigh risks of opioid therapy
Referral for interventional therapy or neuromodulation
Continue therapy, monitor for pain, function, and side effects of therapy

Consider Buprenorohine For Chronic Pain Management

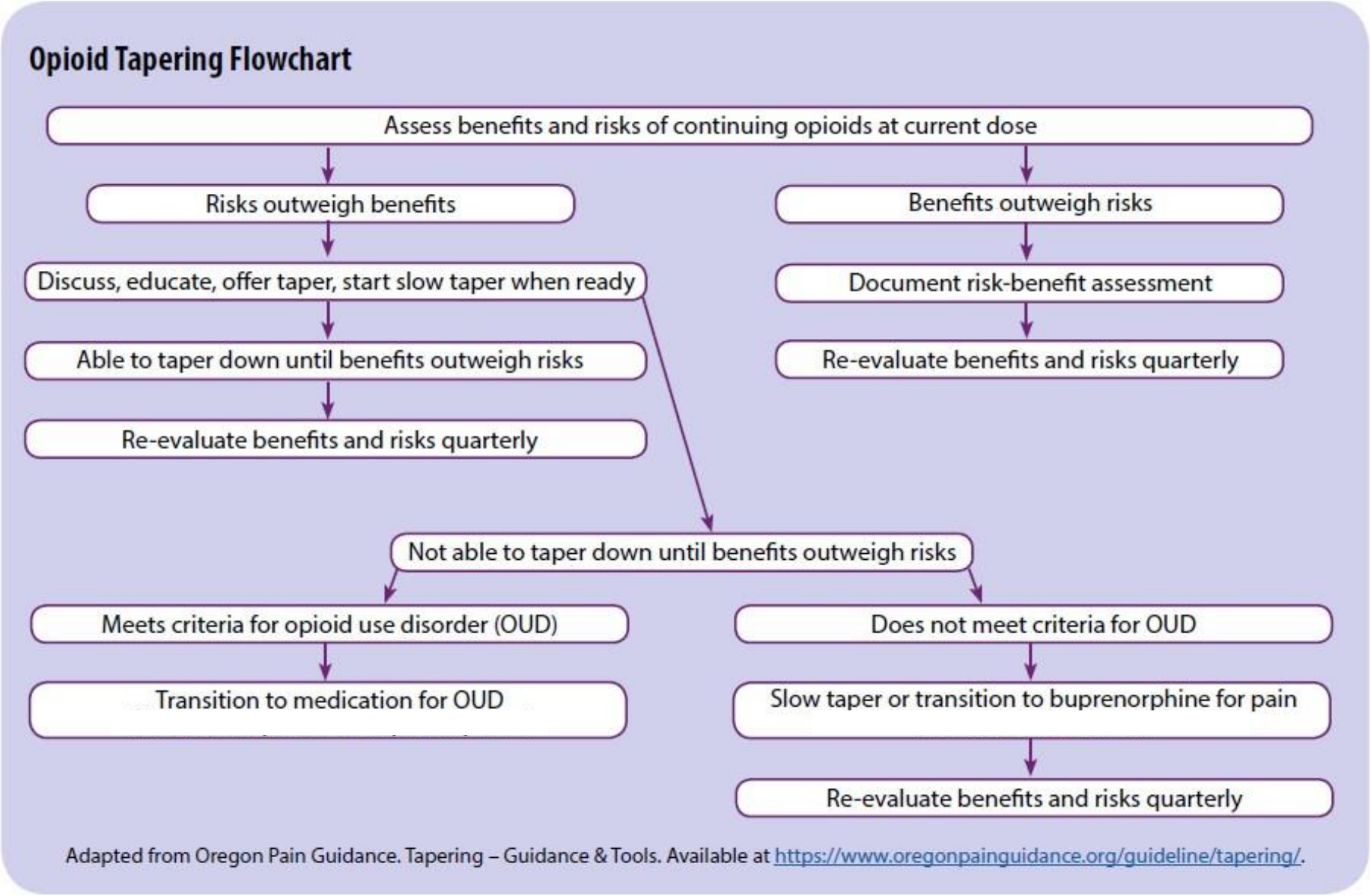
Pharmacologic Benefits

- **Full/Partial Agonist Properties**
- **Strong Receptor Binding Activity**
- **Highly lipophilic, 96% globulin-protein bound**
- **Primarily excreted via bile and stool**
- **Hepatic metabolism**
  - CYP3A4 (phase 1) → nor-buprenorphine
    - High affinity agonist for mu, kappa, and delta-opioid receptors
    - Poor blood-brain-barrier penetration
    - Hydrophilic; removed via urine
  - Glucuronidation (phase 2)
    - Affects both buprenorphine and nor-buprenorphine
    - Inactivates them
  - Extensive first pass metabolism

It's better than the rest!

6. Other Considerations

When Using Opioids Long-term – Consider a Taper or Switch to Buprenorphine If and When Possible, Then Go Slow



Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/.

Don't Ignore or Abandon Inherited "Legacy" Pain Patients Already on Opioids

Inherited Patients Taking Opioids for Chronic Pain — Considerations for Primary Care

Phillip O. Coffin, M.D., and Antje M. Barreveld, M.D.

Steps in Caring for Patients with Chronic Pain Who Have Received Long-Term Opioid Therapy from a Previous Clinician.

1. **Review the case with the former clinician if possible.** Try to develop a treatment plan that slowly adjusts to your style of management while avoiding a radical divergence from the previous plan of care.
2. **Consider providing a therapeutic bridge for the patient until a plan of care is determined, given the risks associated with stopping opioid therapy.** Abruptly tapering or stopping opioid therapy can be dangerous for multiple reasons. Opioids may be crucial for the patient's condition (e.g., sickle-cell disease), and the patient may be at risk for other harms when opioids are tapered or discontinued (see figure).
3. **Develop a patient-centered care plan.** If a taper is needed, empower the patient to make decisions, including which medications to taper first and how fast. Successful tapers may take years.
4. **Assess the patient for opioid use disorder and start discussing medication options right away.** Patients may find it challenging to accept an opioid use disorder diagnosis; give them time.
5. **Document opioid stewardship and the rationale for the treatment plan.** Investigations into opioid prescribing are often based on insufficient documentation.

Orient Patients to Dispose of Expired or Unused Medications to Avoid Pilfering and Accidental Overdose

[Safe Opioid Disposal - Remove the Risk Outreach Toolkit | FDA]
(Accessed 9/5/22)

Offer Narcan (Naloxone) or Opvee (Nalmefene) to Reverse Overdose

1. Opvee contains nalmefene as its active ingredient, while Narcan contains naloxone.
2. Opvee and Narcan are both effective opioid overdose reversal medications.
3. Narcan can wear off before the opioid does.
4. Opvee's half-life is about 11 hours and Narcan's half-life is about 2 hours.
5. This means Opvee stays in the body longer — a potential advantage for reversing an overdose from synthetic opioids like fentanyl that can last longer in the body.
6. Opvee may require less doses than Narcan for the same amount of fentanyl ingested by the person overdosing.
7. Opvee restored breathing about 2 times better than Narcan within 5 minutes of administering the nasal spray.

Summary

This program was intended to optimize clinical practice by helping the clinician better understand:

1. How to use multi-modal pain treatment approaches to avoid excessive and prolonged doses of opioids
2. Recently updated definitions for pain
3. Pain signaling pathways and therapeutic targets
4. The new 2022 CDC Guidelines for Using Opioids
5. Principles of assessment and treatment for acute and chronic pain
6. When to consider using buprenorphine for chronic pain
7. Additional considerations for pain management

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Hospital Association

Thank You!