Considering Opioid Use Disorder in Patients with Chronic Pain

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An “Inherited” Case

- 55 yo man with history of failed back surgery on high dose opioids, whose primary care physician recently retired
- Currently taking long-acting oxycodone 90 mg BID and short-acting oxycodone 15 mg 4/day
- Few urine tests done, but each was appropriate
- PDMP shows no additional prescriptions
- PHQ-9 is 16 “because I hurt so much”
- Inactive because “PT makes it worse”

Considering Opioid Use Disorder in Patients with Chronic Pain

- Recent opioid epidemic trends
- Pain history pearls for patients on high doses
- Talking to patients about high dose opioids
- Making an opioid use disorder diagnosis
- Switching to OUD medication
- Treating chronic pain

Opioid Epidemic

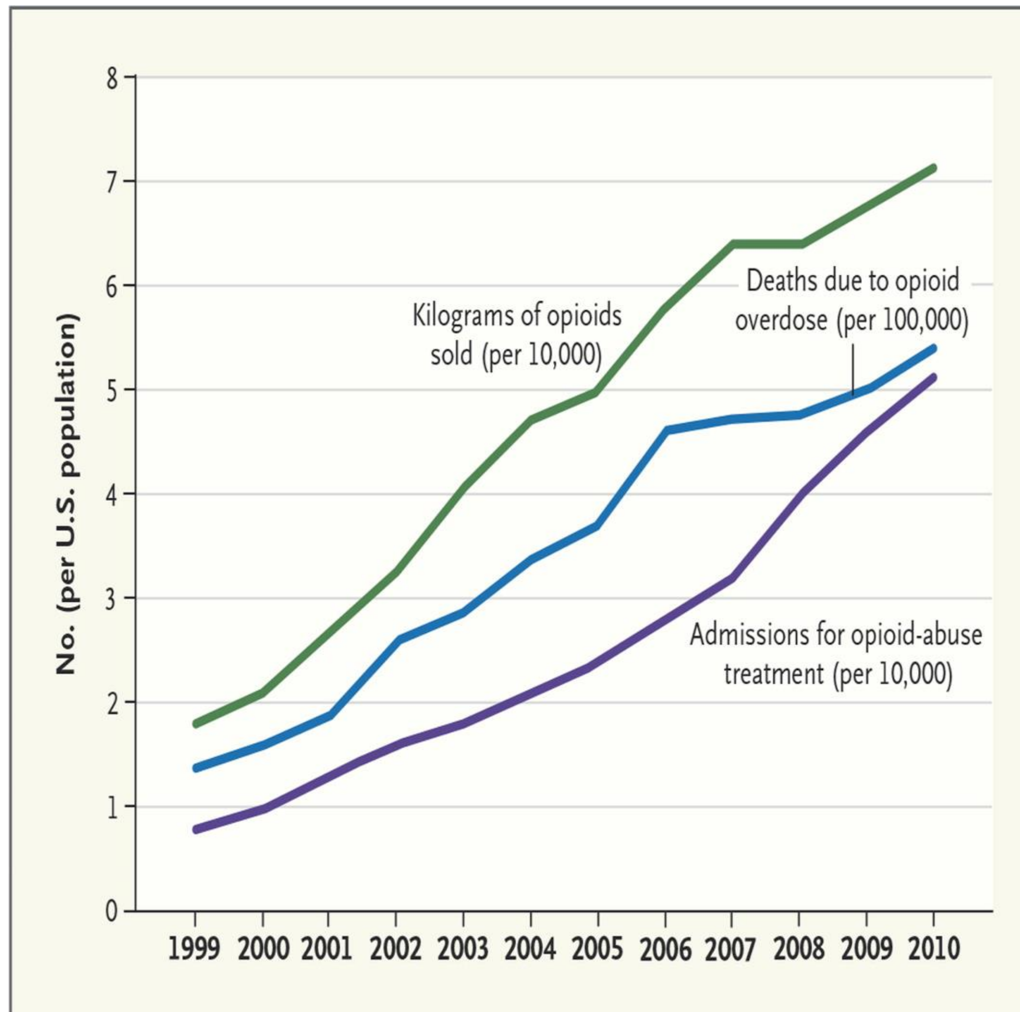
- In 2017, 1.7 million US adults had prescription OUD and 0.7 million had heroin-involved OUD
- This is an underestimate
- Of 70,237 drug-caused deaths in 2017, two-thirds (47,600) were opioid-related
- New increases noted in HIV and HCV cases in rural areas and among young adults due to injection use of opioid

Origins of the Opioid Epidemic

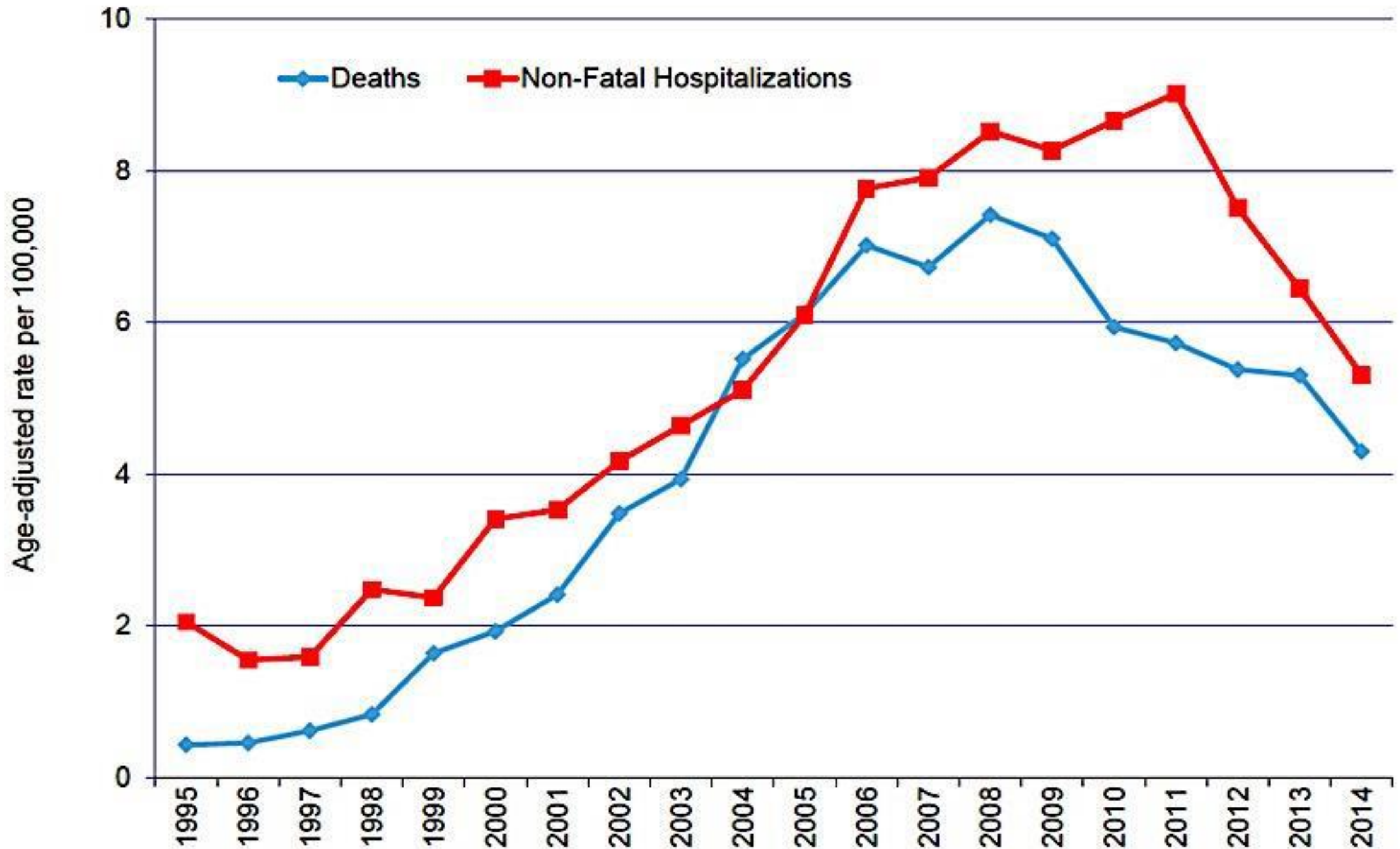
- 1990s norm that all pain should be eliminated
  - Pain as the "5th vital sign"
- Pharmaceutical company promotion
- Opioid over-prescribing
- Diversion, and widespread non-medical use of opioids, especially among youth
- Heroin widely available and less costly
- Limited access to medication treatment

Dreamland: The True Tale of America's Opiate epidemic by Sam Quinones

Opioid Sales, Admissions for Opioid-Abuse Treatment, and Deaths Due to Opioid Overdose in the United States, 1999-2010.

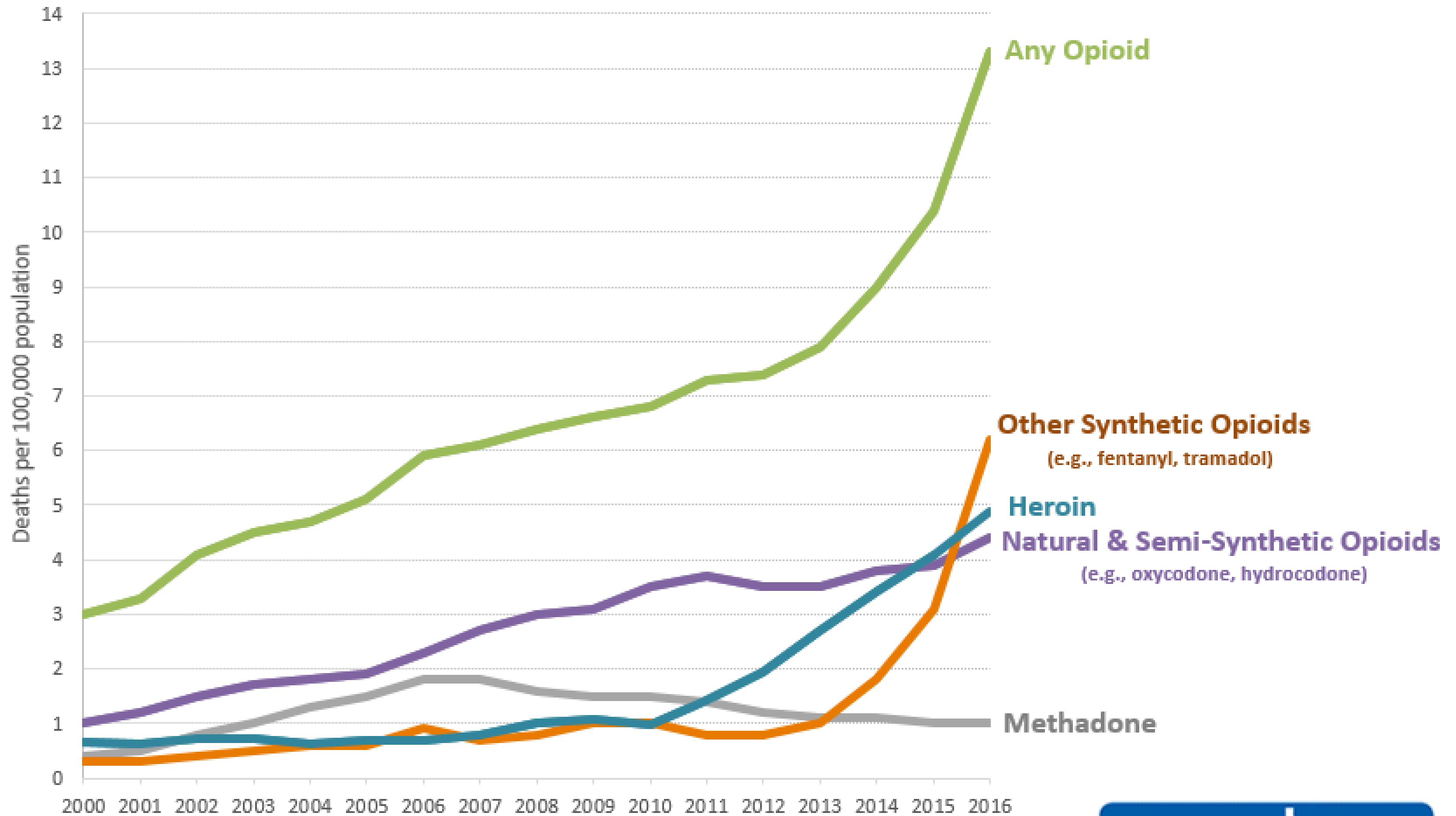


Volkow ND et al. N Engl J Med 2014;370:2063-2066.



Source: Jennifer SabelPhD Epidemiologist, WA State Department of Health, May 2016

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Ser vices, CDC; 2017. https://wonder.cdc.gov/.

Pain and Addiction: Common Threads

- Similar risk factors
- Similar neurobiology
- Chronic, recurrent problems
- Treatment involves medication, self-management, and social support
- High dose opioid prescribing more common in patients with mental health and addiction issues
- High doses are the main problem for patients

Pain History Pearls

- Pain story from the beginning – use reflection!
- Current level of function (activities, sleep)
- Pain related goals
- Co-morbid conditions (apnea, hypogonadism, depression, inactivity)
- Upbringing (ACEs, addiction history going way back)
- "Side effects:" constipation, low energy, poor concentration, thinking about opioids, concerns about addiction/loss of control, others are worried

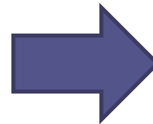
CDC-Kaiser ACE Study

Raising the Issue

- "What have you heard about the risks of opioids?"
- "We didn't know of these problems when you started"
- "Guidelines suggest avoiding opioids for chronic pain"
- "I am worried about your safety and health over time"
  - Overdose, loss of control, apnea, falls, mood, less sexual satisfaction, increased pain sensitivity
- "Lower doses are safer and many patients have more energy after a taper"
- "There are lots of alternatives that may help"
- "We have time to try different things, and go slowly"

Opioid Use Disorder – DSM-5

OPIOID USE DISORDER
Larger amounts than intended
Persistent desire to cut down or quit
Significant time spent taking, obtaining
Craving or urge to use
Failure to fulfill obligations
Continued use despite negative interpersonal consequences
Reduced social, recreational activities
Use in physically hazardous situations
Use despite knowledge of harms
Tolerance (excludes rx medication)
Withdrawal (excludes rx medication)
* Recurrent legal problems deleted



SEVERITY
No SUD: 0-1
Mild: 2-3
Moderate: 4-5
Severe: >5

Moderate-severe OUD ≈ opioid dependence (DSM-IV)

Key principles:
- Negative consequences
- Cravings
- Tolerance
- Withdrawal

Diagnosing Opioid Use Disorder

- OUD diagnostic criteria can be difficult to apply clearly in patients on high dose opioids for chronic pain
- Four or more criteria constitutes a moderate to severe opioid use disorder and warrants OUD medication treatment
- OUD medications are highly effective medications that save lives!

Diagnosing Opioid Use Disorder

- "Are you concerned about addiction or loss of control of you medication?" "Have others been concerned?"
- "Do you sometimes have worse pain and take more medication, then go without later to make it up?"
- "Have you wanted to cut down or quit?" "Why?"
- "Do you find yourself thinking a lot about your pain medication?"
- Is reduced function a result of pain or opioids?
- Are side effects included in the "continued use in spite of consequences" criteria?

Rationale for Switching to OUD Rx

- Medication treatment for OUD with buprenorphine or methadone is safer than high dose opioids
- Data is limited, but many patients do well with a transition to OUD treatment
- Side effects from opioids, in particular sedation and withdrawal, are often reduced, increasing function
- Stabilizing the patient’s opioid systems allows for other forms of pain treatment

“But I’m not an addict!”
“I don’t have a safety problem!”

- Acknowledge that it is about what happened to them, not who they are
- “Many patients develop OUD as a result of pain treatment”
- Review DSM-5 criteria
- Acknowledge stigma of OUD <u>and</u> high dose opioids
- “No one thinks they will die from an overdose”
- “Do you imagine you will be on high doses of opioids for the rest of your life?”

Who Should Switch to Buprenorphine?

- Anyone with an opioid use disorder that is leading to unsafe medication use – yes!
- Patients with opioid use disorder and chronic pain whose function has not improved with high dose chronic opioid therapy – yes
- Any patient with opioid use disorder on high dose opioids – probably
- Any patient on high dose opioids – maybe*
- Patients getting functional improvement with low dose opioids – no (maybe taper, maybe not)

* Most buprenorphine products not FDA approved for pain treatment

Taper or Switch?

- Offering buprenorphine or taper is a reasonable approach for many patients
- 10% reduction should avert most withdrawal, but go slowly if you can
- Target clinic or state dosage goals initially
- OUD diagnostic criteria can emerge as doses are tapered
- Safety problems warrant a more directive approach

Learn to Treat Chronic Pain

- Educate patients that chronic pain is a disorder not well explained by tissue damage
- Diagnose and treat depression and anxiety
  - Improves pain outcomes
- Use non-opioid pain medications
  - Tricyclic antidepressants for sleep, pain
  - Anticonvulsants for neuropathic pain
- Emphasize non-medication treatments, especially physical activity and coping (CBT)
  - "There are no physical therapy failures"

Krebs EE et al. JAMA 2018 Mar 6;319(9):872-82

Do Not Abandon Your Patients!

- They are very vulnerable
- They are at risk to die
- They need your support
- Learn to use buprenorphine so you don’t have to discontinue opioids and refer
- Make it clear that whatever the opioid plan may be, you want to remain their provider

Considering Opioid Use Disorder in Patients with Chronic Pain

- High dose opioid therapy for pain is not safe
- OUD treatment with buprenorphine or methadone is much safer
- Conversations to uncover DSM-5 criteria for OUD are important
- Learn to treat OUD with buprenorphine
- Don’t forget to treat chronic pain effectively