Chronic Non-Cancer Pain (CNCP), Opioids, Treatment and the Evidence

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Diplomate of the American Board of Preventive Medicine—Addiction M
Fellow of the American Psychiatric Association
Fellow of the American Society of Addiction Medicine
Sample case

- Carolina, 52 yo, has been prescribed long term opioid therapy for chronic pain for 15 years. Her primary pain issue is chronic lower back pain with history of 2 failed back surgeries. As she ages, she complains of arthritic pain in knees and hands. Her provider has referred her to RN for assessment of possible switch to buprenorphine for pain management but also for assessment of OUD and co-occurring alcohol misuse.

- Pt has been on a slow taper of both Long-acting opioid MS Contin (currently 30 TID and short-acting opioid for breakthrough such as Percocet 10/325 mg up to 5 tabs daily as needed = 165 MME). She is angry, defensive and unhappy with her provider because she is not tolerating the taper and is now forced to obtain additional opioid pills to get her through the last week of her monthly scripts. “I am being treated like a drug addict. I have a right to have my pain managed.”

- During the initial assessment, patient admits to drinking more wine at night to get to sleep because “the pain is worse at night” and on days when she is running out of pills so managing increased pain related to opioid withdrawal symptoms. Pt reports 2 trips to the ED in the past 6 weeks to see if she can get her pain better managed.
Chronic Non-Cancer Pain (CNCP)

- CNCP = pain typically lasts >3 months or past the time of normal tissue healing

- May be due to:
  - Underlying medical disease or condition
  - Injury
  - Medical treatment
  - Inflammation
  - Unknown cause
Current evidence for treating pain

• ~20% patients presenting to PCP’s with CNCP symptoms or pain-related diagnosis (acute and chronic pain) receive an opioid prescription

• Evidence for SHORT-term efficacy of opioids for reducing pain and improving function in noncancer pain

• Insufficient evidence to determine the effectiveness of long-term opioid therapy for improving chronic pain and function.

• Evidence supports a dose-dependent risk for serious harms... But risk is NOT zero at lower doses
Risk associated with chronic opioids for CNCP

- 1/3 of chronic pain patients may not use prescribed opioids as prescribed or may abuse them
  - Illicit drug use is higher in these patients
- Rates of addiction averaged between 8-12%
- ~60% of fatalities originate from opioids prescribed within guidelines (see chart)
  - 40% of fatalities occurring in 10% of drug abusers
  - 40% of fatalities occurring in 10% of patients in treatment but on HIGH dose pain meds

Fig. 2. Percentage of patients and prescription drug overdoses, by risk group – United States.

• ~70% of patients on opioids for CNCP do not misuse them

• Addiction is a SERIOUS risk... However not all will develop opioid use disorder (e.g. addiction) who suffer from CNCP

• Questions emerge....
  • Should everyone be tapered off chronic opioids?
  • How to do you determine when it is best to taper opioids?
  • How do I interpret current guidelines on this subject?
  • How do we best treat this complex patient population?
Clinicians should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

- Does NOT address or suggest discontinuation of opioids already prescribed at higher dosages
  - Yet it has been used to justify abruptly stopping opioid prescriptions or coverage.
- Does NOT apply to MAT for OUD
- NEJM article clarification on next slide
NEJM correcting interpretation of guidelines

“The guideline offers guidance for caring for patients who are already taking opioid dosages of 90 MME or more per day long term, including guidance on when tapering the dose might be appropriate, the importance of empathetically reviewing risk associated with continuing high-dose, maximizing non-opioid treatment and tapering slowly enough to minimize withdrawal symptoms. Patients exposed to high dosages for years may need slower tapers (e.g., 10% per month, though the pace of tapering may be individualized). Success might require months to years. Though some situations, such as the aftermath of an overdose, may necessitate rapid tapers, the guideline does not support stopping opioid use abruptly.”
CA. Dept. of Public Health guideline clarification

One of the most challenging situations reported by prescribers is how to respond to patients already on high doses of opioids (> 90 MMEs) or with possible addiction symptoms. These patients are at higher risk and may need your assistance more than ever. Recent concerns about over-prescribing of opioids has led to some misinterpretation resulting in abruptly terminating the use of opioids, which can cause health risks for patients. I want to stress that some pain management situations may involve the use of opioid medications if alternative approaches are not available or effective. It is my hope that we can offer resources to support you as you continue your clinical relationship with your patients to ensure their overall well-being.

- Consider all pain management options before starting patients on opioids.
- Recognize when and understand how to taper patients at risk.
- Offer medication assisted treatment (MAT) to your patients.
- Provide patient referrals to MAT and addiction recovery programs.
When to consider tapering

- Inability to achieve or maintain anticipated
  - Pain relief
  - Functional improvement
- Persistent nonadherence with pain treatment plan
- Deterioration in physical, emotional, or social functioning attributed to opioid therapy
- Resolution or healing of painful condition
- Intolerable adverse effects side effects
- Developing an Opioid Use Disorder (OUD) → MAT for OUD

Table 5. Adverse effects of opioids.

<table>
<thead>
<tr>
<th>Adverse effect</th>
<th>Number of Studies</th>
<th>Incidence in Opioid Group</th>
<th>Incidence in Placebo Group</th>
<th>Difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>38</td>
<td>28%</td>
<td>9%</td>
<td>17% (13% to 21%) P=0.00001</td>
</tr>
<tr>
<td>Constipation</td>
<td>37</td>
<td>26%</td>
<td>7%</td>
<td>20% (15% to 25%) P=0.00001</td>
</tr>
<tr>
<td>Somnolence/drowsiness</td>
<td>30</td>
<td>24%</td>
<td>7%</td>
<td>14% (10% to 18%) P=0.00001</td>
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<tr>
<td>Dizziness/vertigo</td>
<td>33</td>
<td>18%</td>
<td>5%</td>
<td>12% (9% to 16%) P=0.00001</td>
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<tr>
<td>Dry-skin/itching/pruritus</td>
<td>25</td>
<td>15%</td>
<td>2%</td>
<td>10% (5% to 15%) P=0.00001</td>
</tr>
<tr>
<td>Vomiting</td>
<td>23</td>
<td>15%</td>
<td>3%</td>
<td>11% (7% to 16%) P=0.00001</td>
</tr>
</tbody>
</table>

Opioid tapers... A team based approach helps

- 22-week taper support intervention for patients on long-term opioid therapy for chronic pain and interested in tapering their opioid (excluded active substance use disorder)
  - Psychiatric consultation
  - Opioid dose tapering
  - 18 weekly meetings with physician assistant to explore motivation for tapering and learn pain self-management skills
- Improved significantly more than usual care in self-reported
  - Pain interference
  - Pain self-efficacy
  - Prescription opioid problems at 22 weeks
- THM: Taper support intervention is feasible and shows promise in reducing opioid dose while not increasing pain severity or interference.
Tapers in the setting of CNCP and ADDICTION

Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence

A 2-Phase Randomized Controlled Trial

Roger D. Weiss, MD; Jennifer Sharpe Potter, PhD; David A. Fiellin, MD; Marilyn Byrne, MSW; Hilary S. Connery, MD, PhD; William Dickinson, DO; John Gardin, PhD; Margaret L. Griffin, PhD; Marc N. Gourevitch, MD, MPH; Deborah L. Haller, PhD; Albert L. Hasson, MSW; Zhen Huang, MS; Petra Jacobs, MD; Andrzej S. Kosinski, PhD; Robert Lindblad, MD; Elinore F. McCance-Katz, MD; Scott E. Provost, MSW; Jeffrey Selzer, MD; Eugene C. Somoza, MD, PhD; Susan C. Sonne, PharmD; Walter Ling, MD

• Medication-Assisted Treatment
  • Gold Standard for addiction treatment even in the setting of CNCP
  • Do NOT taper off MAT if Addiction is present
  • Unlike prior slide, even with adjunctive counseling support, rate of unsuccessful outcomes EXCEEDS 90% if MAT is tapered.
CNCP, chronic opioids and Mental Health

- Complex relationship between
  - Chronic opioid use
  - Worsening of chronic pain
  - Symptoms of depression
- Studies of chronic opioid therapy show:
  - 90-180 days of opioids had 25% increased risk of depression
  - > 180 days of opioids had > 50% increase risk of depression
- Opioids are often discovered in a person’s possession at the time of suicide-related drug overdose.
  - In one study, 23% of deaths (most suicide related) tested + for antidepressants, and 20.8% tested positive for opioids
Meet The Experts

Mark Goodwin, M.D. and Katie Bell, R.N.
Sonoma County Indian Health Project, Inc.
Chronic Pain Clinic

Mark C. Goodwin, MD
Medical Director
July 2020
BACKGROUND

2018 – Large panel of chronic opioid patients
  • 280 total across all providers (6)
  • 139 (50%) to one provider
  • Average 85 MED, Totaling 278,000 Morphine equivalents

Need for updated approach to chronic pain

Need for consistency of care

Need for safety
FIRST STEPS
1. ESTABLISHED and REVIEWED COT PATIENT PANELS

- Identified outliers – Provider & Patient
- Initial focus on high MED (>90/Day)
- Concurrent benzodiazepines
2. Created Interdisciplinary Pain Team

- Physician
- Clinical Pharmacist – Rational Polypharmacy
- Clinical Social Worker / Behavioral Health Consultant
- Nurse Case Manager
- Experienced, Confident Medical Assistant
- Team visits with patient
3. Reviewed / Updated Pain Policies to Reflect Most Current CDC Guidelines:

| • Opioids are not first line therapy | • Evaluate benefits and harms frequently (4As) |
| • Establish goals for pain and **function** | • Use strategies to minimize risk |
| • Discuss risks and benefits | • Review PDMP (CURES) data |
| • Use immediate release opioids when starting | • Use urine drug testing |
| • Use lowest effective dose | • Avoid concurrent opioid/benzodiazepine dosing |
| • Prescribe short durations for acute pain | • Offer treatment for Opioid Use Disorder |
Core Philosophy of Pain Program
1. Safely Manage Patients on COT

• Revised agreement to Informed Consent
• Frequent use of GC/MS testing +/- alcohol metabolites
• Is this diversion?
• Risk /Benefit Analysis
• Focus on function, not pain scores
• Rational polypharmacy
# medMATCH® Drug Monitoring Report

### SUMMARY

<table>
<thead>
<tr>
<th>Legend</th>
<th>Prescribed</th>
<th>Not Prescribed / Inconsistent</th>
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<table>
<thead>
<tr>
<th>Test Ordered</th>
<th>Result</th>
<th>Cutoff</th>
<th>medMATCH™</th>
<th>Lab</th>
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<tbody>
<tr>
<td><strong>PAIN MANAGEMENT PROFILE I W/ CONFIRMATION, URINE</strong></td>
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<td>Amphetamines</td>
<td>Negative</td>
<td>500 ng/mL</td>
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<td>Barbiturates</td>
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<td>Benzodiazepines</td>
<td>Negative, Confirmed</td>
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<td>Alprazolam</td>
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<td>Amodiazone</td>
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<td>INCONSISTENT</td>
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<td>Hydroxyzine</td>
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<td>Lorcainide</td>
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<td>50 ng/mL</td>
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<td>Nordiazep</td>
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<td>50 ng/mL</td>
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<td>Oxazepam</td>
<td>Negative</td>
<td>50 ng/mL</td>
<td></td>
<td></td>
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<tr>
<td>Temazepam</td>
<td>Negative</td>
<td>50 ng/mL</td>
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<tr>
<td>Morphine Metabolite</td>
<td>Negative</td>
<td>20 ng/mL</td>
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<td>Cocaine Metabolite</td>
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<td>Methadone Metabolite</td>
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<td>Opiates</td>
<td>Positive</td>
<td>100 ng/mL</td>
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<tr>
<td>Codeine</td>
<td>Negative</td>
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<tr>
<td><strong>Hydromorphone</strong></td>
<td>=30000 H</td>
<td>50 ng/mL</td>
<td>See Note 1</td>
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<td>Hydromorphone</td>
<td>Negative</td>
<td>50 ng/mL</td>
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<tr>
<td>Hydrocodone</td>
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<td>Hydromorphone</td>
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<td>100 ng/mL</td>
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<tr>
<td>Noroxycodone</td>
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<td>50 ng/mL</td>
<td>See Note 3</td>
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<td><strong>Oxycodone</strong></td>
<td>&gt;30000 H</td>
<td>50 ng/mL</td>
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### Test Ordered | Result | Cutoff | medMATCH™ | Lab |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Oxycodone</strong></td>
<td>Negative</td>
<td>50 ng/mL</td>
<td>See Note 4</td>
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</table>

### Phencyclidine

<table>
<thead>
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<th>Test Ordered</th>
<th>Result</th>
<th>Cutoff</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phencyclidine</td>
<td>Negative</td>
<td>25 ng/mL</td>
<td>See Note 5</td>
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### Specimen Validity Testing

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Result</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine</td>
<td>48.0</td>
<td>&gt;20.0 mg/dL</td>
</tr>
<tr>
<td>pH</td>
<td>6.5</td>
<td>6.5-7.0</td>
</tr>
<tr>
<td>Uric Acid</td>
<td>Negative</td>
<td>&lt;500 mg/dL</td>
</tr>
</tbody>
</table>

**Note 1**
- This metabolite is not present at or above the cutoff.

**Note 2**
- This metabolite is not present at or above the cutoff.

**Note 3**
- This metabolite is not present at or above the cutoff.

**Note 4**
- This metabolite is not present at or above the cutoff.

**Note 5**
- This metabolite is not present at or above the cutoff.

**medMATCH comments area**

- present when drug test results may be the result of metabolites of one or more drugs or when results are inconsistent with prescribed medication(s) listed.
- may be blank when drug results are consistent with prescribed medication(s) listed.
### Identifying Clinical Risk of Opioid Use

#### Abuse & Diversion
- Early refills
- Lost (Stolen) med
- Escalating dose requests
- ER visits
- Substance abuse
- Multiple prescribers

#### Medical Risk
- Polypharmacy
- Sleep apnea
- Endocrine
- Bone density
- EKG changes
- GI/GU

#### Psychological Risks
- Depression
- Anxiety
- Relationship issues
- Cognitive decline

#### Functional Issues
- Disability
- Inability to manage comorbidity
- Falls
- MVA
2. Educate Patient (and Family)

- Acute pain and chronic pain are different
- Physiologic changes – Chronification of pain
- Need for self-care
- Patient as active collaborator
- Relationship building is fundamental
3. Train the Pain Team

- Physician Lead to U.C. Davis Pain Fellowship
- Collaborative complex case management
- Weekly team huddles
- Pain Committee - Quarterly reviews
- Pain specialist via telemedicine
- Treatment Review Panel
4. "Menu" of Non-Pharmacologic, Patient-Driven Pain Management Options

- In-house Physical Therapy
  - “Tried that and it didn’t work”
- Restorative, Longitudinal Therapy
- Encouraged to work past Kinesiophobia
- Not curative but functional – start “away” from the pain.
- Consider group program for maintenance
Behavioral Health
• Embedded therapist – Available for WHO, MBSR, CBT

Chiropractic Care
• Two Providers – D.C., P.A.
• Osteopath for OMT

Complementary Alternative Medicine
• Established Wellness Center – Grant Funded
• Acupuncture
• Herbal Clinic
• Massage Therapy
• Tai Chi
• Yoga/Nutrition
5. ESTABLISH FIRM MEDICAL DIAGNOSIS

- No Chronic Lower Back Pain!
- Determine need for advanced imaging after excellent History & Physical
- Diagnosis will guide higher level of Pain Management/Interventional/Surgery
Katie Bell
Case Presentation

• Carolina, 52 yo, has been prescribed long term opioid therapy for chronic pain for 15 years. Her primary pain issue is chronic lower back pain with history of 2 failed back surgeries. As she ages, she complains of arthritic pain in knees and hands. Her provider has referred her to RN for assessment of possible switch to buprenorphine for pain management but also for assessment of OUD and co-occurring alcohol misuse.

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Case Discussion

- Pain contracts and how to execute them
- When to use buprenorphine for pain management
- Treating patients with chronic pain and a vague diagnosis
- Alternative treatments: how to integrate into primary care, financial sustainability
- Co-occurring disorders
- How to navigate pain and addiction
- Risk associated with tapering patients and misinterpretation of guidelines

- Join the conversation!
- Use the chat box or unmute (*6) to share your experience
??? Questions ???
Appendix
References


