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

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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

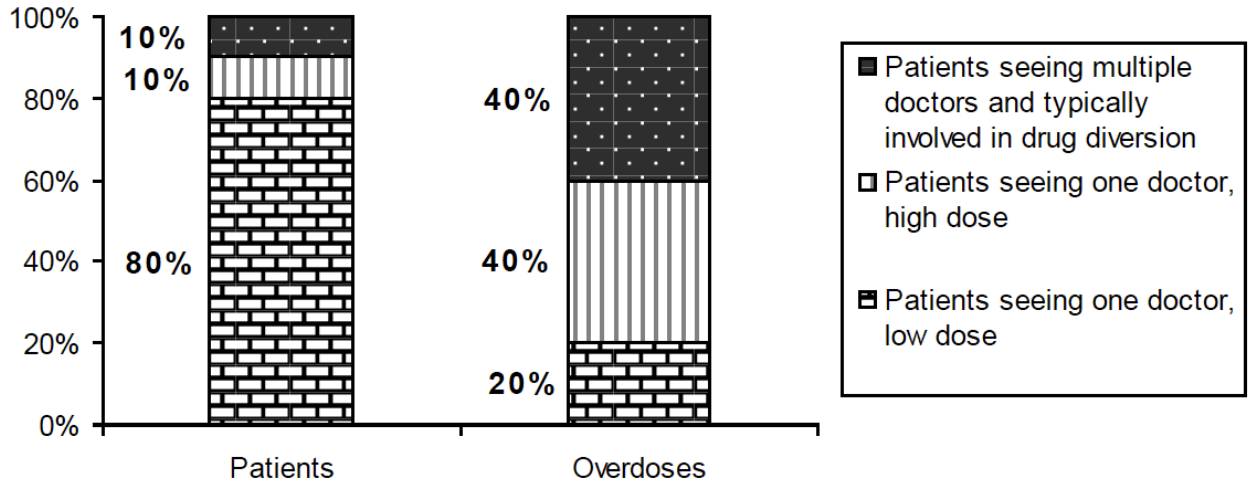

Fig. 2. *Percentage of patients and prescription drug overdoses, by risk group – United States.*

Source: Centers for Disease Control and Prevention. CDC grand rounds: Prescription drug overdoses – a U.S. epidemic. MMWR Morb Mortal Wkly Rep 2012; 61:10-13 (39).

But this also means that….

- ~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?

Misinterpretation of guidelines

- "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

State of California—Health and Human Services Agency
California Department of Public Health

SUSAN FANELLI
Acting Director

GAVIN NEWSOM
Governor

Statewide Opioid Safety Workgroup Member Agencies*

Board of State and Community Corrections
CA Board of Podiatry Medicine
CA Board of Registered Nursing
CA Conference of Local Health Officers
CA Department of Aging
CA Department of Consumer Affairs
CA Department of Corrections and Rehabilitation
CA Department of Health Care Services
CA Department of Industrial Relations
CA Department of Justice
CA Department of Managed Health Care
CA Department of Motor Vehicles
CA Department of Public Health
CA Department of Social Services
CA Health and Human Services Agency
CA Health Care Foundation
CA Naturopathic Medicine Committee
CA Public Employees' Retirement System – CalPERS
CA State Board of Pharmacy
California Rural Indian Health Board, Inc.
California Society of Addiction Medicine
California State Assembly
Center for Health Leadership and Practice
County Health Executives Association of CA - CHEAC
Covered California
Dental Board of CA
Emergency Medical Services Authority
Health Management Associates Medical Board of CA
Office of Statewide Health Planning and Development-OSHPD
Office of Traffic Safety
Osteopathic Medical Board of CA
UC Davis Medical Center
US Drug Enforcement Administration
Veterinary Medical Board of CA
*Agencies listed for information only

August 27, 2019

Dear Provider,

Health care providers are essential partners in ending the opioid epidemic in California. Working together, we want to ensure that providers have access to resources and support to help improve patient pain management, while avoiding opioid overdose and dependence.

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.

On behalf of the Statewide Opioid Safety (SOS) Workgroup and partners, I am contacting you to offer resources to assist you in addressing these critical treatment issues with your patients:

- 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.

Please visit the link or access the QR code to find resources on each of these topics. Summary information on each topic is included below.

Opioid Prescribers Resource Sheet

Consider All Pain Management Options before Starting Patients on Opioids
The Centers for Disease Control and Prevention (CDC) recommends exploring multiple treatment options (including non-pharmaceutical alternatives) to address chronic pain management before starting patients on opioids. Speak with your patients' health plans to find out what alternatives are available.

Injury and Violence Prevention Branch, MS 7214, P.O. Box 997377, Sacramento, CA 95899-7377
(916) 552-9800
California Department of Public Health

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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.*

Adverse effect	Number of Studies	Incidence in Opioid Group	Incidence in Placebo Group	Difference (95% CI)
Nausea	38	28%	9%	17% (13% to 21%) P<0.00001
Constipation	37	26%	7%	20% (15% to 25%) P<0.00001
Somnolence/drowsiness	30	24%	7%	14% (10% to 18%) P<0.00001
Dizziness/vertigo	33	18%	5%	12% (9% to 16%) P<0.00001
Dry-skin/ itching/pruritus	25	15%	2%	10% (5% to 15%) P<0.0001
Vomiting	23	15%	3%	11% (7% to 16%) P<0.00001

Source: Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain© 2010 National Opioid Use Guideline Group (NOUGG) (224).

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

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
- Establish goals for pain and function
- Discuss risks and benefits
- Use immediate release opioids when starting
- Use lowest effective dose
- Prescribe short durations for acute pain

- Evaluate benefits and harms frequently (4As)
- Use strategies to minimize risk
- Review PDMP (CURES) data
- Use urine drug testing
- Avoid concurrent opioid/benzodiazepine dosing
- 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

Legend	SUMMARY	
	Prescribed	Not Prescribed / Inconsistent
✓ = Consistent ✗ = Inconsistent ◆ = Prescribed	✓Oxycodone ✓Norco™ ✗Clonazepam	

Test Ordered	Result	Cutoff	medMATCH ™	Lab
PAIN MANAGEMENT PROFILE I W/ CONFIRMATION, URINE				SLI
Amphetamines	Negative	500 ng/mL		
Barbiturates	Negative	300 ng/mL		
Benzodiazepines	Negative Confirmed	100 ng/mL		
Alphahydroxyalprazolam	Negative	25 ng/mL		
Alphahydroxymidazolam	Negative	50 ng/mL		
Alphahydroxytriazolam	Negative	50 ng/mL		
◆Aminoclonazepam	Negative	25 ng/mL	INCONSISTENT	
Hydroxyethylflurazepam	Negative	50 ng/mL		
Lorazepam	Negative	50 ng/mL		
Nordiazepam	Negative	50 ng/mL		
Oxazepam	Negative	50 ng/mL		
Temazepam	Negative	50 ng/mL		
Marijuana Metabolite	Negative	20 ng/mL		
Cocaine Metabolite	Negative	150 ng/mL		
Methadone Metabolite	Negative	100 ng/mL		
Opiates	Positive	100 ng/mL		
Codeine	Negative	50 ng/mL		
◆Hydrocodone	>20000 H	50 ng/mL		
Hydromorphone	Negative	50 ng/mL	See Note 1	
Morphine	Negative	50 ng/mL		
Norhydrocodone	Negative	50 ng/mL	See Note 2	
Oxycodone	Positive	100 ng/mL		
Noroxycodone	Negative	50 ng/mL	See Note 3	
◆Oxycodone	>20000 H	50 ng/mL		

Test Ordered	Result	Cutoff	medMATCH ™	Lab
Oxymorphone	Negative	50 ng/mL	See Note 4	
Phencyclidine	Negative	25 ng/mL	See Note 5	

	Test Ordered	Result	Reference Range
Specimen Validity Testing	Creatinine	48.9	>= 20.0 mg/dL
	pH	6.5	4.5-9.0
	Oxidant	Negative	< 200 mcg/mL

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

MedMATCH comments are:
- present when drug test results may be the result of metabolism 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	Medical Risk	Psychological Risks	Functional Issues
▪ Early refills	▪ Polypharmacy	▪ Depression	▪ Disability
▪ Lost (Stolen) med	▪ Sleep apnea	▪ Anxiety	▪ Inability to manage comorbidity
▪ Escalating dose requests	▪ Endocrine	▪ Relationship issues	▪ Falls
▪ ER visits	▪ Bone density	▪ Cognitive decline	▪ MVA
▪ Substance abuse	▪ EKG changes		
▪ Multiple prescribers	▪ GI/GU		

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

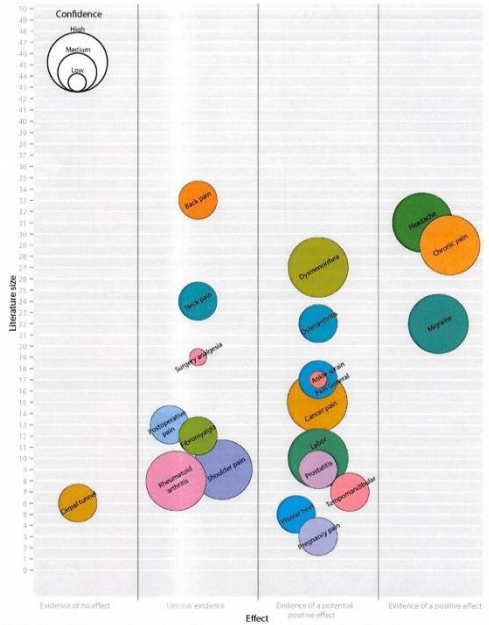
5. ESTABLISH FIRM MEDICAL DIAGNOSIS

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

Evidence Maps of Acupuncture

EVIDENCE MAP OF ACUPUNCTURE FOR PAIN

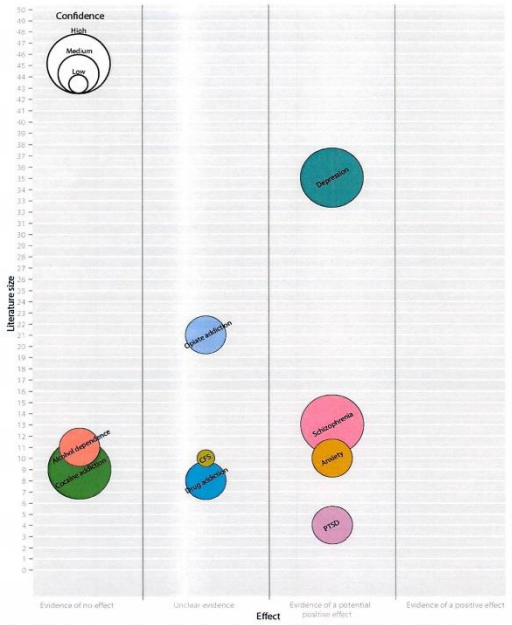
The results for the clinical indication Pain are presented in the bubble plot and a text summary below. The bubble plot summarizes the results of 59 systematic reviews for 21 distinct indications relevant to the outcome pain [search date: March 2013].



Legend: The bubble plot shows an estimate of the evidence base for pain-related indications judging from systematic reviews and recent large RCTs. The plot depicts the estimated size of the literature (y-axis, number of RCTs included in largest review), the estimated effect (x-axis), and the confidence in the estimate (bubble size).

EVIDENCE MAP OF ACUPUNCTURE FOR MENTAL HEALTH

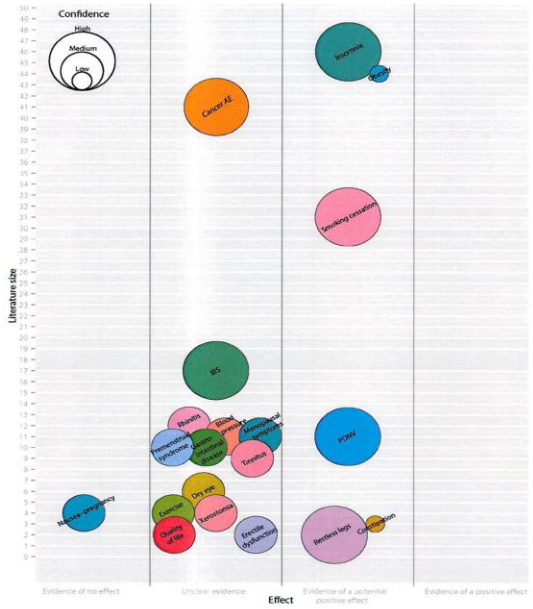
The results for mental health indications are presented in the bubble plot and text summary below. The bubble plot represents 17 systematic reviews summarizing evidence for 9 clinical indications relevant to mental health [search date: March 2013].



Legend: The bubble plot shows an estimate of the evidence base for mental health-related indications judging from systematic reviews and recent large trials. The plot depicts the estimated size of the literature (y-axis, number of RCTs included in largest review), the estimated effect (x-axis), and the confidence in the estimate (bubble size).

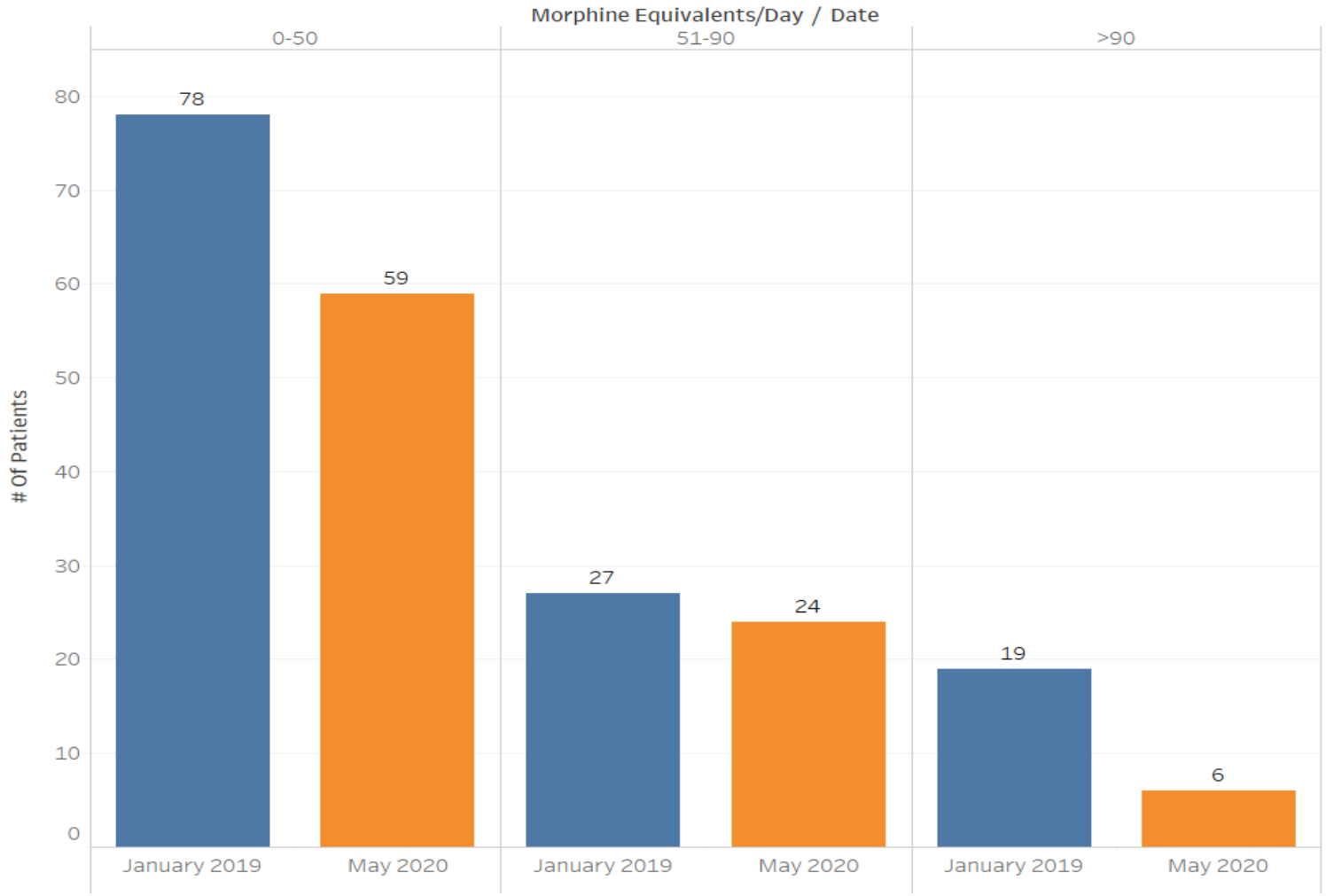
EVIDENCE MAP OF ACUPUNCTURE FOR WELLNESS

The results for Wellness-relevant indications and outcomes are presented in the bubble plot and text summary below. The bubble plot represents 43 systematic reviews and 3 recent large RCTs not yet incorporated in existing reviews summarizing effects for 20 distinct clinical indications relevant to Wellness [search date: March 2013].



Legend: The bubble plot shows an estimate of the evidence base for wellness-related indications judging from systematic reviews and recent large trials. The plot shows the estimated size of the literature (y-axis, number of RCTs included in largest review), the estimated effect (x-axis), and the confidence in the estimate (bubble size).

https://www.hsrd.research.va.gov/publications/esp/acupuncture.pdf


Morphine Equivalents/Day / Date
0-50
51-90
>90
Of Patients
80
70
60
50
40
30
20
10
0
78
59
27
24
19
6
January 2019
May 2020
January 2019
May 2020
January 2019
May 2020

Katie Bell

Case Presentation

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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

- https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm#B1_down
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