Managing Pain with and without Opioids in the Primary Care Setting

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Overview

1. Basic principles
2. Clinical scenarios
3. Principles of chronic opioid therapy
4. Basic principles reiterated

BASIC PRINCIPLES

- **Opioids have proven efficacy and (relative) safety for treating acute pain and pain during terminal illness**

- **Opioids do NOT have proven efficacy or safety for treating chronic pain long-term**

1. Ballantyne JC, Shin NS. Efficacy of opioids for chronic pain: a review of the evidence. *Clin J Pain.* 2008;24(6):469-478.
2. Ballantyne JC. Clinical and administrative data review presented to FDA May 30th and 31st 2012. 2012.
3. Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid management for chronic noncancer pain. *Cochrane Database Syst Rev.* 2010(1):CD006605.
4. Eriksen J, Sjogren P, Bruera E, Ekholm O, Rasmussen NK. Critical issues on opioids in chronic non-cancer pain: an epidemiological study. *Pain.* 2006;125:172-179.
5. Dillie KS, Fleming, MF, Mundt, MP, French, MT. Quality of life associated with daily opioid therapy in a primary care chronic pain sample. *J Am Board Fam Med.* 2008;21(2):108-117.
6. Toblin RL, Mack KA, Perveen G, Paulozzi LJ. A population-based survey of chronic pain and its treatment with prescription drugs. *Pain.* Jun 2011;152(6):1249-1255.

PHYSICIANS FOR RESPONSIBLE OPIOID PRESCRIBING
www.responsibleopioidprescribing.org

Cautious, Evidence-Based Opioid Prescribing

Despite low-quality evidence supporting practice change,[1-6] use of chronic opioid therapy (COT) for chronic non-cancer pain increased dramatically over the past two decades.[34-36] Concurrently, opioid analgesic overdose deaths, addiction, misuse and diversion have increased markedly.[20,37]

COT may provide modest, variable short-term pain relief for some patients with chronic pain. Long-term benefits of COT for chronic pain have not been established. Potential medical and behavioral harms of opioids are an important concern, particularly at higher dosage levels and in higher risk or medically complex patients. While COT at lower doses may be a useful treatment for some patients, it should only be considered for carefully evaluated, closely monitored patients when a cautious, structured and selective approach is employed, and clear benefits for pain and function are documented. COT always entails risks for patients, their families and the community, so vigilance and caution are essential.

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Source: Physicians for Responsible Opioid Prescribing http://www.supportprop.org/educational/PROP_OpioidPrescribing.pdf

90 days is a key point

- 90 days is often used in definitions of chronic pain
- Studies show that after 90 days of continuous use, opioid treatment is more likely to become life-long
- Studies show that patients who continue opioids >90 days tend to be high-risk patients

1. Turk DC, Okifuji A. Pain terms and taxonomies. In: Fishman SM, Ballantyne JC, Rathmell, JP eds Bonica's Management of Pain (4th ed) Lippincott Williams and Wilkins pp 14-23. 2010.
2. Braden JB, Fan MY, Edlund MJ, Martin BC, DeVries A, Sullivan MD. Trends in use of opioids by noncancer pain type 2000-2005 among Arkansas Medicaid and HealthCore enrollees: results from the TROUP study. *J Pain.* Nov 2008;9(11):1026-1035.
3. Korff MV, Saunders K, Thomas Ray G, et al. De facto long-term opioid therapy for noncancer pain. *Clin J Pain.* Jul-Aug 2008;24(6):521-527.
4. Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. *J Gen Intern Med.* Dec 2011;26(12):1450-1457.
5. Volinn E, Fargo JD, Fine PG. Opioid therapy for nonspecific low back pain and the outcome of chronic work loss. *Pain.* Apr 2009;142(3):194-201.

Opioids are powerful drugs and should be reserved for serious pain

What is serious pain?

- **Pain with a clear pathoanatomic or disease basis**
- **Underlying cause is disabling**
  - Cannot be improved by primary disease treatment or lifestyle changes
- **Goal of pain treatment is comfort**
- **All other treatments (best efforts) have failed**

NOTE: 90% of pain complaints do not meet these criteria

1. Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain.* Feb 2009;10(2):113-130.
2. Sullivan MD, Ballantyne JC. What are we treating with chronic opioid therapy? *Arch Int Med.* 2012;172(5):433-434.

The 90% of chronic pain for which opioids have not proven helpful

Axial low back pain without a pathoanatomic diagnosis

Fibromyalgia

Headache

CLINICAL SCENARIOS

Clinical scenarios

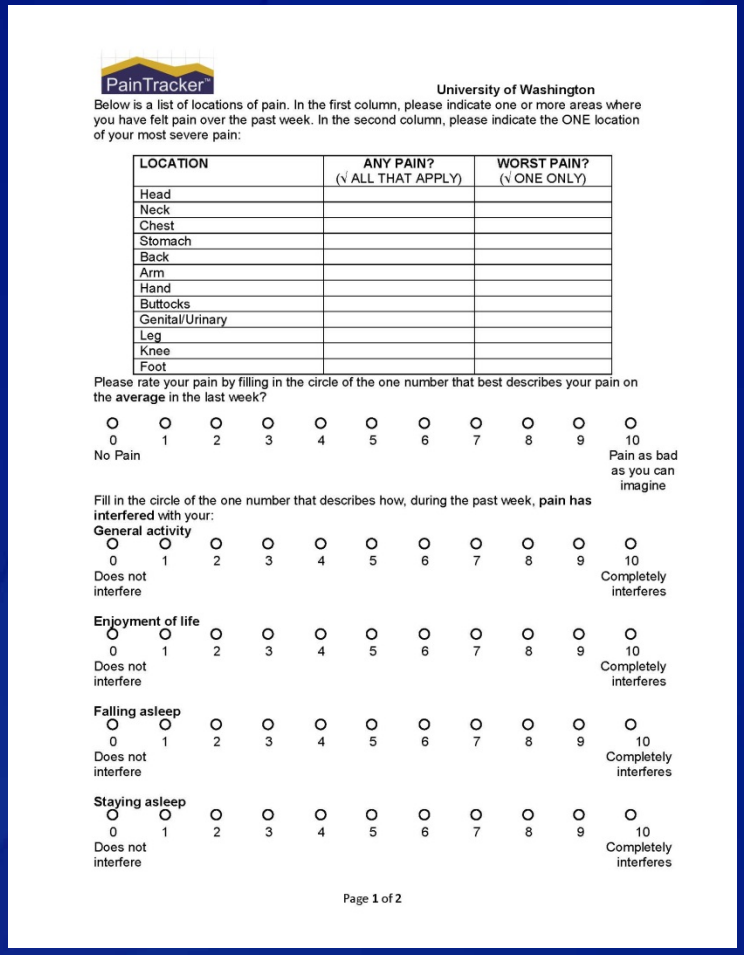
1. Treating chronic pain
2. You get to 90 days—is the patient a suitable candidate for chronic opioid therapy?
3. You inherit a patient already on opioids (>90 days)

Treating chronic pain

- **Chronic pain is never simple**
- **Use measurement tools as a means of understanding the scope of the problem**
  - Patient Health Questionnaire (PHQ-9) (depression)
  - Generalized anxiety disorder (GAD) (anxiety)
  - Opioid Risk Tool (ORT)
- **Primary treatments for chronic pain**
  i. Motivation/activation/*self-help*
  ii. Counseling
- **Secondary treatments for chronic pain**
  i. Low risk analgesics (e.g., gabapentin)
  ii. Psych meds for depression/anxiety/post-traumatic stress disorder (PTSD)/psychosis

Source: University of Washington Medicine, Anesthesiology and Pain Medicine
http://depts.washington.edu/anesth/education/pain/index.shtml

University of Washington's brief chronic pain measurement tool: **PainTracker**



PainTracker™

University of Washington

Below is a list of locations of pain. In the first column, please indicate one or more areas where you have felt pain over the past week. In the second column, please indicate the ONE location of your most severe pain:

LOCATION	ANY PAIN? (√ ALL THAT APPLY)	WORST PAIN? (√ ONE ONLY)
Head		
Neck		
Chest		
Stomach		
Back		
Arm		
Hand		
Buttocks		
Genital/Urinary		
Leg		
Knee		
Foot		

Please rate your pain by filling in the circle of the one number that best describes your pain on the **average** in the last week?

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine)

Fill in the circle of the one number that describes how, during the past week, **pain has interfered** with your:

General activity

0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

Enjoyment of life

0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

Falling asleep

0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

Staying asleep

0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

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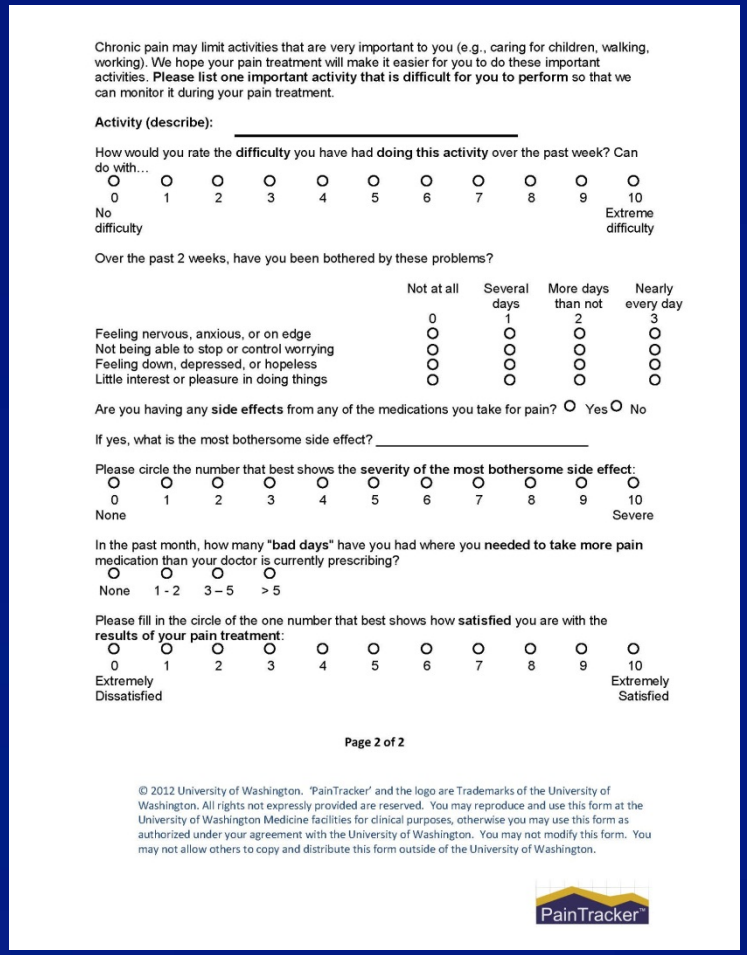

Chronic pain may limit activities that are very important to you (e.g., caring for children, walking, working). We hope your pain treatment will make it easier for you to do these important activities. **Please list one important activity that is difficult for you to perform** so that we can monitor it during your pain treatment.

Activity (describe): _____

How would you rate the **difficulty** you have had **doing this activity** over the past week? Can do with…

0 (No difficulty) 1 2 3 4 5 6 7 8 9 10 (Extreme difficulty)

Over the past 2 weeks, have you been bothered by these problems?

	Not at all (0)	Several days (1)	More days than not (2)	Nearly every day (3)
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Feeling down, depressed, or hopeless				
Little interest or pleasure in doing things				

Are you having any **side effects** from any of the medications you take for pain? Yes No

If yes, what is the most bothersome side effect? _____

Please circle the number that best shows the **severity of the most bothersome side effect**:

0 (None) 1 2 3 4 5 6 7 8 9 10 (Severe)

In the past month, how many **"bad days"** have you had where you **needed to take more pain** medication than your doctor is currently prescribing?

None 1 - 2 3 – 5 > 5

Please fill in the circle of the one number that best shows how **satisfied** you are with the **results of your pain treatment**:

0 (Extremely Dissatisfied) 1 2 3 4 5 6 7 8 9 10 (Extremely Satisfied)

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PainTracker™

Source: University of Washington Medicine, Anesthesiology and Pain Medicine
http://depts.washington.edu/anesth/education/pain/index.shtml

You get to 90 days

Is the patient a suitable candidate for opioids?

BENEFIT

- Intractable pain-producing disease
- Goal is comfort

RISK

- Substance abuse history
- Family history subabuse
- Childhood sexual abuse
- PTSD
- Anxiety
- Depression
- Other maintenance hemodialysis (MHD)

1. Sullivan MD, Ballantyne JC. What are we treating with chronic opioid therapy? *Arch Int Med.* 2012;172(5):433-434.
2. Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. *J Gen Intern Med.* Dec 2011;26(12):1450-1457.
3. Schwartz AC, Bradley R, Penza KM, et al. Pain medication use among patients with posttraumatic stress disorder. *Psychosomatics.* Mar-Apr 2006;47(2):136-142.
4. Seal KH, Shi Y, Cohen G, Maguen S, Krebs EE, Neylan TC. Association of mental health disorders with prescription opioids and high-risk opioid use in US veterans of Iraq and Afghanistan. *JAMA.* 2012;307(9):940-947.

You inherit a patient already on opioids (>90 days)

- Refuse to prescribe
- Treat for chronic pain with opioid dependence

Ballantyne JC, Sullivan MD, Kolody A. Opioid dependence vs. addiction: a distinction without a difference? *Arch Int Med* 2012:1-2.

PRINCIPLES OF CHRONIC OPIOID THERAPY

Expect it to be time consuming and resource heavy!

- **Develop clear understanding of risks and benefits (use care agreement)**
- **Use single prescriber, single pharmacy**
- **Regular pick up**
- **Monitor**
  - Pain and function
  - Psych status
  - Prescription monitoring service (if available)
  - Urine drug testing
- **Continue counseling**

1. Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain.* Feb 2009;10(2):113-130.
2. Source: Agency Medical Directors' Group http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf

General principles for care agreements

- **Prescriptions cannot be refilled early**
- **Refills require a clinic visit by appointment**
- **No urgent requests for refills**
  - Call to make appointments in advance
- **Lost or stolen meds or scripts cannot be refilled**
  - They must be safeguarded
- **Failure to follow these policies may result in discontinuation of pain meds**

1. Fishman SM, Kreis PG. The opioid contract. *Clin J Pain.* Jul-Aug 2002;18(4 Suppl):S70-75.
2. Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain.* Feb 2009;10(2):113-130.

Urine drug testing (UDT)

- **Spot checks are unreliable**
- **Laboratory methods are also plagued by false negatives and false positives, though less so**
- **Always check with the lab before acting on a UDT**
- **Frequency?**
  - First visit or first prescription UDT should be mandatory
  - Thereafter choose:
    - Random
    - For cause
    - Regular
- **What do you do with the information?**

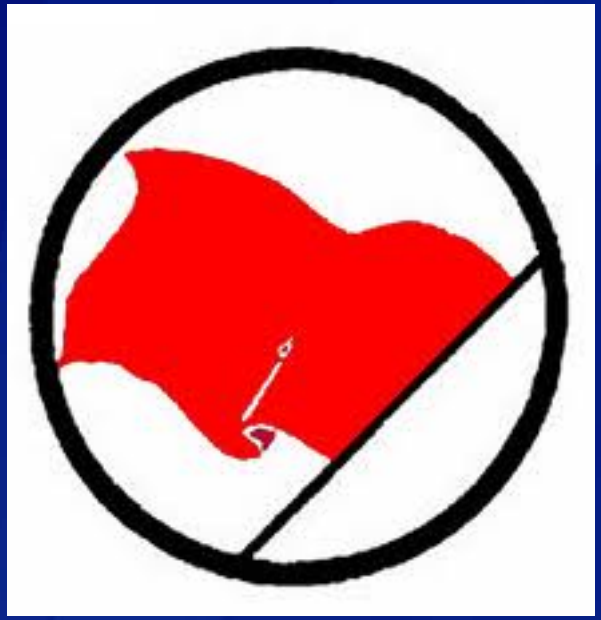
1. Katz NP, Sherburne S, Beach M, et al. Behavioral monitoring and urine toxicology testing in patients receiving long-term opioid therapy. *Anesth Analg.* 2003;97:1097-1102.
2. Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain.* Feb 2009;10(2):113-130.
3. Berland D, Rodgers P. Rational use of opioids for management of chronic nonterminal pain. *Am Fam Physician.* Aug 1 2012;86(3):252-258.

General principles for dosing

- At treatment initiation, establish effective dose
- Dose escalation may be needed to overcome tolerance, but should be modest
- Doses >100 mg daily morphine or morphine equivalence require close scrutiny because safety is markedly compromised at this dosing level

1. Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* Jan 19 2010;152(2):85-92.
2. Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. *J Gen Intern Med.* Dec 2011;26(12):1450-1457.
3. Edlund MJ, Martin BC, Fan MY, Devries A, Braden JB, Sullivan MD. Risks for opioid abuse and dependence among recipients of chronic opioid therapy: results from the TROUP study. *Drug Alcohol Depend.* Nov 1 2010;112(1-2):90-98.
4. Saunders KW, Dunn KM, Merrill JO, et al. Relationship of opioid use and dosage levels to fractures in older chronic pain patients. *J Gen Intern Med.* Apr 2010;25(4):310-315.

Doses >100 mg minimal effective dose (MED) are a red flag



- Pain is not responsive
- Insurmountable tolerance (no dose is ever enough)
- Difficulty controlling use
- Misuse
- Addiction
- Diversion

1. Morasco BJ, Duckart JP, Carr TP, Deyo RA, Dobscha SK. Clinical characteristics of veterans prescribed high doses of opioid medications for chronic non-cancer pain. *Pain.* Dec 2010;151(3):625-632.
2. Edlund MJ, Martin BC, Fan MY, Devries A, Braden JB, Sullivan MD. Risks for opioid abuse and dependence among recipients of chronic opioid therapy: results from the TROUP study. *Drug Alcohol Depend.* Nov 1 2010;112(1-2):90-98.
3. Weisner CM, Campbell CI, Ray GT, et al. Trends in prescribed opioid therapy for non-cancer pain for individuals with prior substance use disorders. *Pain.* Oct 2009;145(3):287-293.

OPIOID DOSE CALCULATOR

Optional:	Patient name:	
	Today's date:	**September 15, 2012**
Instructions:	Fill in the mg per day* for whichever opioids your patient is taking. The spreadsheet will automatically calculate the total morphine equivalents per day.	

Opioid (oral or transdermal):	**mg per day*:**	**Morphine equivalents:**
codeine		0
fentanyl transdermal (in mcg/hr)		0
hydrocodone		0
hydromorphone		0
methadone		
up to 20mg per day		0
21 to 40mg per day		0
41 to 60mg per day		0
>60mg per day		0
morphine		0
oxycodone		0
oxymorphone		0
TOTAL daily morphine equivalent dose (MED) =		0

* **Note: All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mcg per hour**

If this value is less than 120mg Morphine Equivalent Dose (MED), please follow Part I of the AMDG Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. Referral for pain management consultation is required before exceeding 120mg MED daily. See:

www.agencymeddirectors.wa.gov/opioiddosing.asp

www.doh.wa.gov/hsqa/professions/painmanagement/

If this value is greater than 120mg MED, please follow Part II of the AMDG Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. See:
www.agencymeddirectors.wa.gov/opioiddosing.asp

CAUTION: This calculator should NOT be used to determine doses when converting a patient from one opioid to another. This is especially important for fentanyl and methadone conversions. Equianalgesic dose ratios are only approximations and do not account for genetic factors, incomplete cross-tolerance, and pharmacokinetics.

This opioid dose calculator was developed by the Washington State Agency Medical Directors' Group to be used in conjunction with the Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. For more information, please refer to the guideline at:
http://www.agencymeddirectors.wa.gov/opioiddosing.asp

Source: University of Washington Medicine, Anesthesiology and Pain Medicine
http://depts.washington.edu/anesth/education/pain/index.shtml

Reasons for dose restriction

- **Higher rates of overdose and death**
- **Less likelihood of being able to wean if necessary**
  - Difficulty controlling acute pain, surgical recovery, terminal pain
  - Continued use during pregnancy—neonatal abstinence
- **Higher rates of mental health and substance use disorder, less able to control usage**
- **Higher rates of falls and fractures in the elderly**
- **Less likelihood of returning to function or work**
- **Higher rates of endocrinopathy affecting fertility, libido, and drive**
- **Higher rates of immune dysfunction**

1. Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* Jan 19 2010;152(2):85-92.
2. Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. *J Gen Intern Med.* Dec 2011;26(12):1450-1457.
3. Miller M, Sturmer T, Azrael D, Levin R, Solomon DH. Opioid analgesics and the risk of fractures in older adults with arthritis. *J Am Geriatr Soc.* Mar 2011;59(3):430-438.
4. Daniell HW. Opioid endocrinopathy in women consuming prescribed sustained-action opioids for control of nonmalignant pain. *J Pain.* Jan 2008;9(1):28-36.
5. Darnall BD, Stacey BR. Sex differences in long-term opioid use: cautionary notes for prescribing in women. *Arch Intern Med.* Mar 12 2012;172(5):431-432.
6. Afsharimani B, Cabot P, Parat MO. Morphine and tumor growth and metastasis. *Cancer Metastasis Rev.* Jun 2011;30(2):225-238.
7. Tavare AN, Perry NJ, Benzonana LL, Takata M, Ma D. Cancer recurrence after surgery: direct and indirect effects of anesthetic agents. *Int J Cancer.* Mar 15 2012;130(6):1237-1250.

Harm reduction

- Weight loss
- Sleep hygiene, treat sleep apnea
- Reduce or eliminate other central nervous system depressants
- Enforce or encourage adherence
- Encourage safe keeping
- Take back programs

OPIOIDS ARE DANGEROUS AND ADDICTIVE

Berland D, Rodgers P. Rational use of opioids for management of chronic nonterminal pain. *Am Fam Physician.* Aug 1 2012;86(3):252-258.

Basic principles reiterated

- Opioids do NOT have proven efficacy and safety for treating chronic pain
- Opioids are powerful drugs and should be reserved for serious pain
- Chronic pain is never simple—approach *holistically*
- *Measurement based care* is the gold standard
- Chronic opioid therapy is not a simple solution; expect it to be time and resource heavy
- *90 days* is a key point for reassessment
- *>100 mg MED* is a red flag