



Case Study Mary Williams

Current History

- Leg and back pain worse in past month
- Started taking an extra ER/LA oxycodone in the afternoon and ran out early
- Went to ER 1 week ago to obtain an early ER/LA oxycodone refill
- Concerned “body has become used to current dose”; doesn’t seem to work all day anymore
- Husband says she has become “addicted”
- Difficult to go to work due to severe pain
- Trouble sleeping as sheets touching her feet now cause pain
- Requests increase in her dose

42 yo woman with T2DM

Chronic, painful diabetic neuropathy and back pain

ER/LA oxycodone 20 mg bid and gabapentin

Previous 11 months:

- Adherent with monitoring
- Pain, function improved



SCOPE of Pain
Safe and Competent Opioid Prescribing Education

Assessing and Managing Aberrant Medication Taking Behavior



Learning Objectives: Essential Content 3

- Assess differential diagnosis for aberrant medication taking behavior
- Assess lack of benefit, increased risk and/or harm
- Determine whether to continue, change or discontinue opioid therapy
- If changing opioids, determine how to rotate opioids
- If discontinuing opioids, determine whether and how to taper opioids

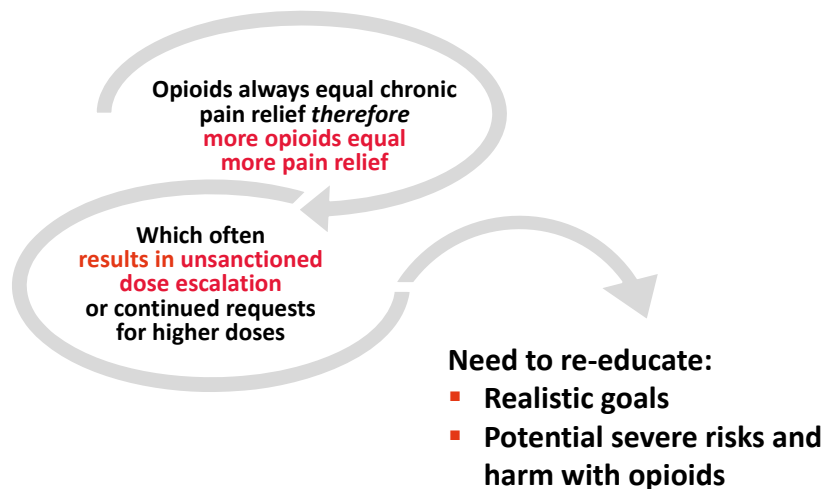
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Managing Expectations



Opioids and Unrealistic Expectations

Patients often have unrealistic expectations that...

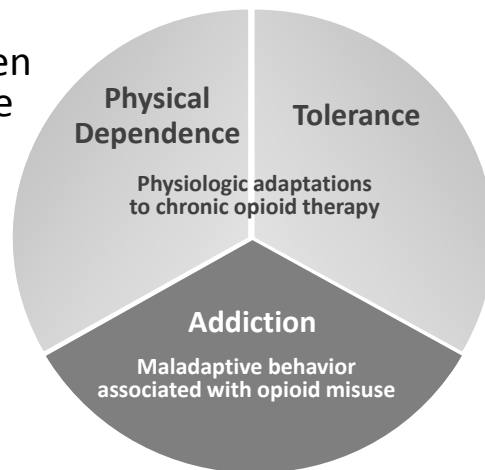


Alford DP. JAMA. 2013 Mar 6;309(9):919-25.

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Opioids and Misunderstandings

- Family members (and patients) often misunderstand the differences
- Need to re-educate



Savage SR, et al. J Pain Symptom Manage. 2003 Jul;26(1):655-67.

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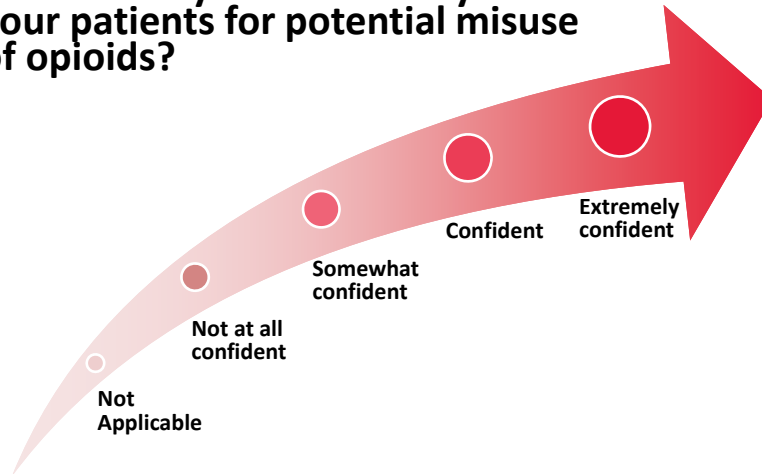
Monitoring for Opioid Misuse

- Patient questionnaire
 - Current Opioid Misuse Measure (COMM)
- Other strategies
 - Pill counts (scheduled vs random)
 - Urine drug tests (scheduled vs random)
 - Prescription drug monitoring program data
- History from “reliable” family members
 - Beware of family members with secondary gain for giving inaccurate information

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POLLING QUESTION

How confident are you in your ability to effectively and efficiently assess your patients for potential misuse of opioids?



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Current Opioid Misuse Measure (COMM)

Assessing for Opioid Misuse

- 17 items, self-administered
- Takes ~10 minutes to complete
- Helps for deciding level of monitoring
- Score range: 0 – 68
- Scores ≥ 9 detect probable opioid misuse with sensitivity of 77% and specificity of 66%

Key Elements:

Over-sedation

Consequences of overuse

Multiple prescribers

Medication misuse

Active mental health issues

Compulsive use

Obtaining meds from someone else

Loss of control

Butler SF, et al. Pain. 2007 Jul;130(1-2):144-56.

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Case Study Mary Williams

COMM Score Results

- Her COMM score was 12
- Confirms your concern for opioid misuse

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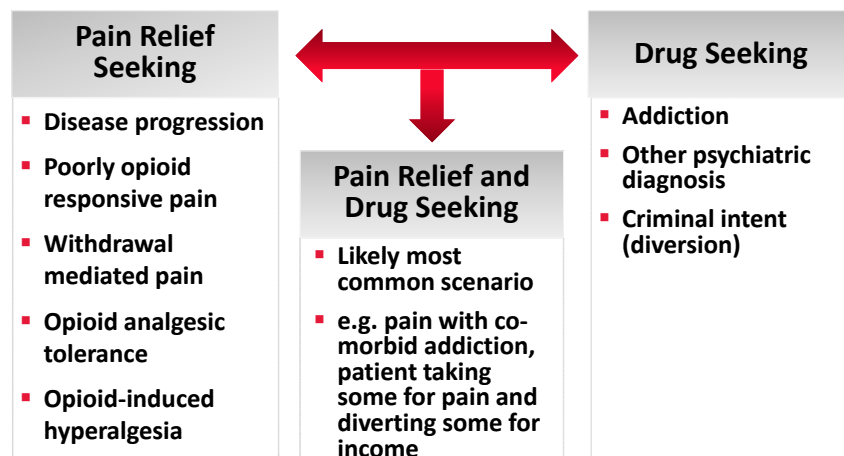
Previous 11 months:

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Aberrant Medication-Taking Behaviors

Differential Diagnosis



Alford DP. JAMA. 2013 Mar 6;309(9):919-25.

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Pain Relief Seeking

Opioid Tolerance

- Right shift of the dose-response curve
- Tolerance to antinociceptive effects are demonstrated in animal models but less common in clinical settings
- Longitudinal studies in cancer and noncancer populations find opioid doses typically stabilize for extended periods
- Increased dose overcomes decreased analgesic effectiveness

Schug SA, et al. Drug Saf. 1992 May-Jun;7(3):200-13.
Portenoy RK and Foley KM. Pain. 1986 May;25(2):171-86.
Chang G, et al. Med Clin North Am. 2007 Mar;91(2):199-211.
Joseph EK, et al. J Neurosci. 2010 Mar 31;30(13):4660-6.

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Pain Relief Seeking

Opioid-Induced Hyperalgesia

- Enhanced pain sensitivity to same opioid dose
- Paradoxically more opioid will worsen pain
- Central and peripheral sensitization of *pronociceptive* process
- Increased dose may improve analgesia but only temporarily

Chang G, et al. Med Clin North Am. 2007 Mar;91(2):199-211.
Pain Physician. 2011 Mar-Apr;14(2):145-61.

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Drug Seeking

Addiction

Clinical syndrome presenting as...

- ☐ Loss of **C**ontrol
- ☐ **C**ontinued use despite harm
- ☐ **C**raving

**Aberrant Medication
Taking Behaviors**
(pattern and severity)

**Addiction is NOT the same
as physical dependence**

Savage SR, et al. J Pain Symptom Manage. 2003;26:655-667.

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Concerning Behaviors for Addiction

Spectrum: Yellow to Red Flags

- ☐ Requests for increase opioid dose
- ☐ Requests for specific opioid by name, "brand name only"
- ☐ Non-adherence w/other recommended therapies (e.g., PT)
- ☐ Running out early (i.e., unsanctioned dose escalation)
- ☐ Resistance to change therapy despite AE (e.g. over-sedation)
- ☐ Deterioration in function at home and work
- ☐ Non-adherence w/monitoring (e.g. pill counts, UDT)
- ☐ Multiple "lost" or "stolen" opioid prescriptions
- ☐ Illegal activities – forging scripts, selling opioid prescription

Modified from Portenoy RK. J Pain Symptom Manage. 1996 Apr;11(4):203-17.

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Drug Seeking

Psychiatric Diagnoses

Chemical Coping

- Patients knowingly or unknowingly inappropriately use opioids to treat a comorbid disease such as depression or anxiety
- Usually self-medicating a mental health disorder or stress

Others

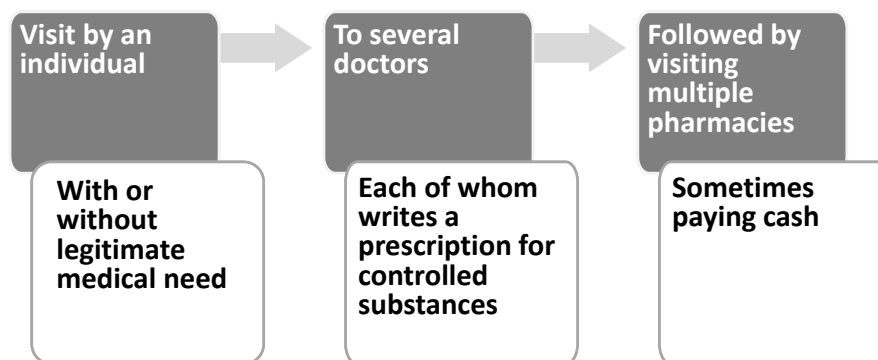
- Personality disorder; borderline personality
- Depression/anxiety/situational stressors

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners*. 1st Edition. North Branch, MN: Sunrise Press; 2007.

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Drug Seeking

Diversion



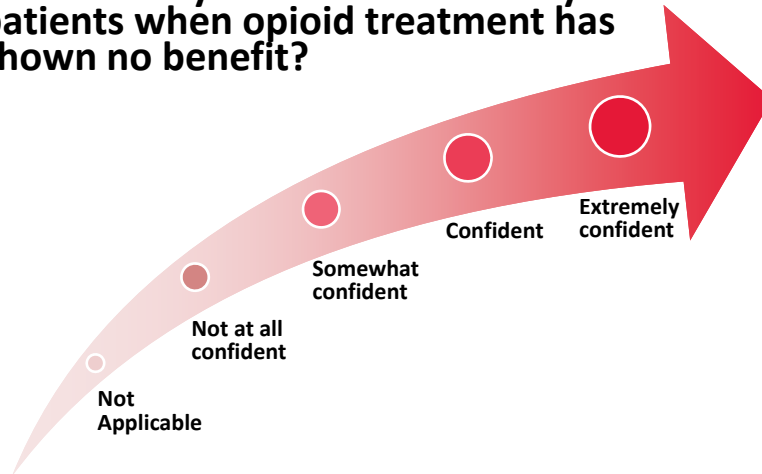
ER/LA opioids can be converted into rapid-onset (IR/SA) opioids by altering the tablet or patch

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners*. 1st Edition. North Branch, MN: Sunrise Press; 2007.

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POLLING QUESTION

How confident are you in your ability to effectively communicate with your patients when opioid treatment has shown no benefit?



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Managing Lack or Loss of Benefit

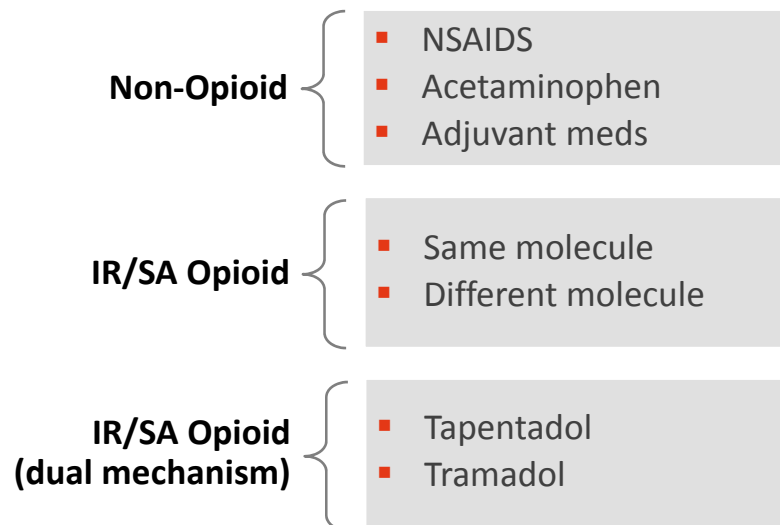


Lack or Loss of Benefit

- Reassess factors affecting pain
- Re-attempt to treat underlying disease and co-morbidities
- Consider escalating dose as a “test”
- Consider adding or increasing adjuvant medications for synergy
- Consider adding breakthrough medications
- Consider opioid rotation

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Consider Breakthrough Medication



Davies AN, et al. Eur J Pain. 2009 Apr;13(4):331-8.

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Consider Opioid Rotation

- Switch to another opioid as means of restoring analgesic efficacy or limiting adverse effects
- Based on large intra-individual variation in response to different opioids
- Different variants of mu-opioid receptors
- Based on surveys and anecdotal evidence
- Promising but needs validation

Inturrisi CE. Clin J Pain. 2002 Jul-Aug;18(4 Suppl):S3-13.
Fine PG and Portenoy RK. J Pain Symptom Manage. 2009 Sep;38(3):418-25.

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Opioid Conversion Tables

- Derived from relative potency ratios using single-dose analgesic studies in opioid naïve pts
- Based on limited doses or range of doses
- Does not reflect clinical realities of chronic opioid administration
- Are not reliable due to individual pharmacogenetic differences
- Most tables do NOT adjust for incomplete cross-tolerance

Drug	Route	Equianalgesic Dose (mg)
Morphine	IM	10
Morphine	PO	30
Codeine	IM	130
Codeine	PO	300
Oxycodone	IM	-
Oxycodone	PO	30
Hydromorphone (Dilaudid)	IM	1.5
Hydromorphone (Dilaudid)	PO	7.5

Safer Approach: Assume no or minimal cross tolerance and start every new opioid at a dose used for opioid naïve patients

Webster LR, Fine PG. Pain Med. 2012 Apr;13(4):562-70.
Pereira J, et al. J Pain Symptom Manage. 2001 Aug;22(2):672-87.

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Managing Continued Lack of Benefit



Continued Lack of Benefit

Remember:

- ☐ Not all pain is opioid responsive
- ☐ More opioid is not always better
- ☐ More opioid may increase risk of adverse effects

Patient may have developed opioid induced hyperalgesia and will improve off opioids

Discussing Continued Lack of Benefit

Stress how much you believe /empathize with patient's pain severity and impact

Express frustration re: lack of good pill to fix it

Focus on patient's strengths

Encourage therapies for "coping with" pain

Show commitment to continue caring about patient and pain, even without opioids

Schedule close follow-ups during and after taper

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Pain Management Specialist

When to Refer

When you are...

- unsure of pain diagnosis
- unsure of other pharmacological treatment options including adjuvant medications
- unsure of nonpharmacological treatment options including interventional treatment
- want 2nd opinion on safety and efficacy of opioids for individual patient
- unsure how to safely rotate to different opioid

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Finding a Pain Management Specialist

- State Medical Association web sites
- American Academy of Pain Medicine web site
— www.painmed.org



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Managing Opioid Risks and Harms



Too Much Risk or Harm

Opioid-related

- Adverse events
 - Side effects; toxicity
- Opioid induced hyperalgesia
 - Increased dose or opioid rotations without benefit
- Addiction

Psychosocial

- Psychiatric instability
- Unsafe housing or storage
- Nonadherent with monitoring procedures
- Nonadherent with office procedures
- Use of other non opioid drugs of abuse
- Diversion or criminal behavior

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Discussing Possible Addiction

Stay in the Risk/Benefit mindset:

- Give specific and timely feedback why patient's behaviors raise your concern for possible addiction e.g., loss of control, compulsive use, continued use despite harm
- Remember patients may suffer from both chronic pain and addiction
- May need to "agree to disagree" with the patient
- Benefits no longer outweighing risks
- "I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good."
- Always offer referral to addiction treatment

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Addiction Medicine Specialist

When to Refer

When patient:

- is using illicit drugs
- is experiencing problems with other prescription drugs (benzodiazepines)
- abuses or is addicted to alcohol
- agrees they have an opioid addiction and wants help such as referral to medication-assisted treatment (e.g., methadone, buprenorphine, naltrexone)
- has dual or trio diagnosis of pain, addiction, and psychiatric disease

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Making Addiction Treatment Referrals

- Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator 
- State resources (Department Public Health)
 - Acute treatment services (detoxes)
 - Medication assisted treatment
 - Methadone maintenance treatment programs
 - Office-based opioid treatment with buprenorphine or naltrexone
- AA/NA free, widely available and effective

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Discussing Possible Diversion

- Discuss why you are concerned about diversion
 - e.g., nonadherence with pill counts, Urine Drug Test negative for prescribed opioid
- Discuss your inability to prescribe opioids if there is any evidence of opioid diversion

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Discontinuing Opioids



Discontinuing Opioids

- Do not have to prove addiction or diversion - only assess and reassess the risk-benefit ratio
- If patient is unable to take opioids safely or is nonadherent with monitoring then discontinuing opioids is appropriate even in setting of benefits
- Need to determine how urgent the discontinuation should be based on the severity of the risks and harms

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Discontinuing Opioids

- Document rationale for discontinuing opioids (e.g., lack of benefit, opioid misuse, nonadherence with monitoring, active illicit drug use)
- Distinguish between abandoning the opioid therapy and abandoning the patient
- Determine if the opioid needs to be tapered due to physical dependence

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Discontinuing Opioids

- Determine degree of physical dependence to determine withdrawal risk
- Higher intensity withdrawal from:
 - Higher steady state levels
 - Longer term exposure
 - Faster rate of medication clearance
 - Long vs. short half life agents

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Tapering IR/SA Opioids

- Decide if you need a taper at all
 - Is there physical dependence?
- Decrease strength or number of tablets each week
- Build up alternative pain treatment modalities

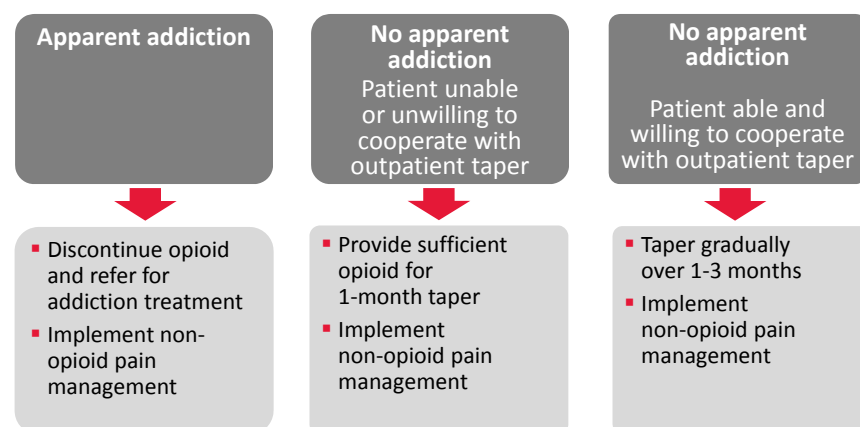
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Tapering ER/LA Opioids

- Decrease by 10-20% each week
 - Long acting pill formulations dictate increments of dose decrease that are possible
 - Rate of decrease determined by circumstances of withdrawal: emergency vs. controlled taper
- Can use IR/SA opioids to treat “breakthrough” symptoms
- Can use a centrally-acting alpha-adrenergic agonist (e.g., clonidine, tizanidine) to treat withdrawal symptoms
- Build up alternative pain treatment modalities

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Opioid Exit Strategy – Possible Paths



Katz N. *Patient Level Opioid Risk Management: A Supplement to the PainEDU.org Manual*. Newton, MA: Inflexxion, Inc.; 2007.
Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners*. 1st Edition. North Branch, MN: Sunrise Press; 2007.

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Risk Benefit Framework

Useful in Decision to Continue or Discontinue Opioids



Useful to Avoid Pitfalls

- “But I really, really need opioids.”
- “Don’t you trust me?”
- “I thought we had a good relationship/I thought you cared about me.”
- “If you don’t give them to me, I will drink/use drugs/hurt myself.”
- “Can you just give me enough to find a new doc?”

RESPONSE: “I cannot continue to prescribe a medication that is not helping you (or is hurting you or both).”

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Next Steps



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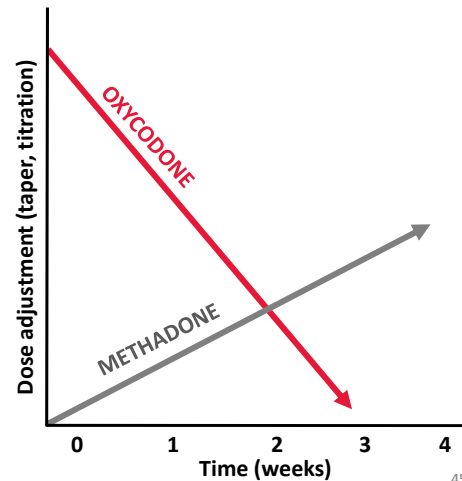
An alternative approach to opioid rotation (oxycodone to methadone) NOT using equianalgesic tables

- **Taper ER/LA OXYCODONE over 2-3 weeks**

- Use IR/SA oxycodone for bridge until therapeutic dose of methadone is achieved
- Use clonidine to treat symptoms of withdrawal during taper

- **Titrate METHADONE over 3-4 weeks**

- *Remember duration of analgesia is 4-8 hrs while serum half life can be up to 100 hrs resulting in sedation and respiratory depression*
- Begin dose at 2.5 mg tid
- Can titrate up to 5 mg tid
- Do not increase dose more frequently than weekly



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Over the next 12 months

- Medications were adjusted
 - Titrated methadone to 10mg 3x/day
 - Titrated gabapentin to 600mg 3x/day
 - Added amitriptyline 10mg at night
 - Added acetaminophen 500mg every 8 hours for breakthrough pain
- She joined a monthly chronic pain support group
- Her PEG scores remained between 4 and 6
- She was adherent with the treatment plan and monitoring
- There were no aberrant medication taking behaviors

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Summary Points: Essential Content 3

- Aberrant medication taking behavior can signify pain-relief or drug seeking behaviors or a combination of both
- It is important to fully assess and then respond to aberrant behaviors
- Decisions to continue or discontinue opioids should be based on reassessment of the risks and benefits of the treatment

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