Rational Approach to the Treatment of Chronic Pain: Appropriate Opioid Prescribing

Mel Pohl, M.D., DFASAM
Chief Medical Officer
Las Vegas Recovery Center

Acute vs. Chronic Pain

Fallacies and Facts

Simple Approach to Treating Non-Malignant Pain

If it hurts…..	• Give ibuprofen
If it hurts a lot…	• Give hydrocodone
If it REALLY hurts…	• Give something stronger
If it still REALLY hurts…	• Give more
"Hmmm. Something is just not right."	
If it REALLY hurts for a long time….	• Keep giving more
If it' s getting worse no matter what I prescribe…	• Discharge patient

Responsible Opioid Prescribing?

- There is a national epidemic occurring involving the misuse, abuse and diversion of prescription opioids.
- The majority of these medications enter circulation through the legitimate prescription by physicians from all specialties. (259 million rx in 2012)
- Prescribers must be aware that their opioid prescription could potentially end up being used for reasons not prescribed (sold, snorted, traded).

Appropriate Opioid Prescribing – Utilizing CDC Guidelines

Never vs. Always vs. It depends?

Should be part of a larger, comprehensive management program based on assessment, trust, relationship, and verification.

Conscientious, judicious use.

Balance risks and benefits.

Informed consent and agreement.

Communicate and connect.

Assess and Document 5 A's -- Analgesia, ADL's, Adverse Side Effects, Aberrancy, Addiction.

CDC: #1 Risks vs benefits, multimodal Rx

. ***Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.*** Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

CDC: #2 Establish Goals

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

CDC: #3 Establish responsibilities

Before starting and periodically during opioid therapy, clinicians should ***discuss with patients known risks and realistic benefits*** of opioid therapy and patient and clinician responsibilities for managing therapy.

Consider written opioid usage agreements (outlining patient responsibility).

- Prescriptions to be obtained from one physician only.
- Prescriptions to be obtained from one pharmacy whenever possible.
- Urine Toxicology / Pill counts.
- Emphasize improvement in ***function*** as a primary goal and that function can improve even when pain is still present.

CDC: #4 Short acting seems better, safer

- When starting opioid therapy for chronic pain, clinicians should prescribe ***immediate-release*** opioids instead of extended-release/long-acting (ER/LA) opioids.
- Methadone and Fentanyl patch have difficult to predict pharmacokinetic properties.

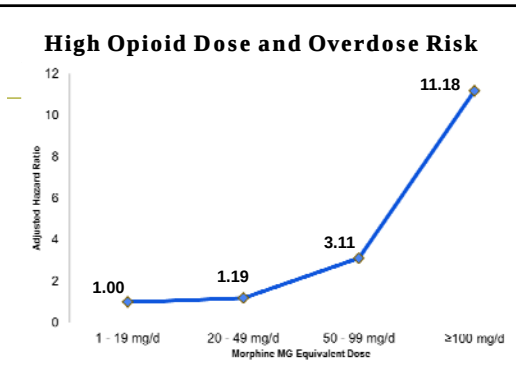
CDC: #5 Use lowest effective dosage

When opioids are started, clinicians should prescribe the ***lowest effective dosage***.

Clinicians should use caution when prescribing opioids at any dosage,

should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day,

and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.



* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

Dunn et al. Opioid prescriptions for chronic pain and overdose. *Ann Int Med* 2010;152:85-92.

CDC: #6 3-7 Day Guideline

Long-term opioid use often begins with treatment of acute pain.

Clinicians should prescribe the ***lowest effective dose*** of immediate-release opioids

and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

Three days or less will often be sufficient;

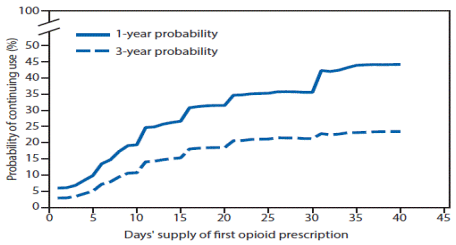
more than seven days will rarely be needed.

Eyes open to the risks: Slippery Slope

The longer you use opioids, the greater the risks– and the risks seem to rise fast.

Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1

One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



CDC: #7 Evaluate benefits vs harms

Evaluate benefits and harms with patients ***within 1 to 4 weeks of starting opioid therapy*** for chronic pain or of dose escalation.

Re-evaluate benefits and harms of continued therapy with patients ***every 3 months or more frequently.***

If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

CDC: #8 Assessing Risk and Harms

- Before starting and periodically during continuation of opioid therapy, clinicians should ***evaluate risk factors for opioid-related harms***.
- Clinicians should incorporate into the management plan strategies to mitigate risk, including **considering offering naloxone** when factors that increase risk for opioid overdose, such as:
  - history of overdose,
  - history of substance use disorder,
  - higher opioid dosages (≥50 MME/day), or
  - concurrent benzodiazepine use.

CDC: #9 Check PDMP/MAPS

- Clinicians should review the patient's history of controlled substance prescriptions using state ***prescription drug monitoring program (PDMP)*** data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

CDC: #10 Urine drug testing

When prescribing opioids for chronic pain, clinicians should use ***urine drug testing before starting opioid therapy*** and consider urine drug testing at least ***annually*** to assess for prescribed medications as well as other controlled prescription drugs and illicit drug).

CDC: #11 Avoid Benzodiazepine-Opioid Combination

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

CDC: #12 Refer when appropriate

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CDC: considerations for long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, dependence, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
  - Consult with collateral information sources.

CDC: considerations for long-term opioid therapy

- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale – pain, enjoyment, general activity).
- Schedule initial reassessment within 1– 4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling;
- Match duration to scheduled reassessment.
- If RENEWING without patient visit check that return visit is scheduled ≤ 3 months from last visit.

CDC: EVIDENCE ABOUT OPIOID THERAPY

• Benefits of long-term opioid therapy for chronic pain not well supported by evidence.

• Short-term benefits small to moderate for pain; inconsistent for function.

• Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

CDC: NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

• Non-opioid medications (e.g. NSAID's, TCA's, SNRI's, anticonvulsants, topicals).

• Physical treatments (e.g. exercise therapy, weight loss).

• Behavioral treatment (e.g. CBT, DBT, ACT, mindfulness).

And don't forget to talk to your patients and believe them…

Your trust, time, and touch may more important than your pills.

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

Maya Angelou

THANK YOU

Mel Pohl, MD, DFASAM
702-271-1734
mpohl@centralrecovery.com
Drmelpohl.com