Opioid Prescribing for Chronic Pain: An Evidence-Based Approach
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Outline

- Prevalence of Chronic Pain and Chronic Opioid Therapy (COT)
- Risk Factors for Developing Chronic Pain and Starting COT
- Efficacy of Opioids for Chronic Pain
- Risks of COT
- Safe Opioid Prescribing and Monitoring
Case

- A 54yo F with a history of low back pain, obesity, depression, and DM presents for follow-up. Her main complaint is low-back pain. It is a dull, achy and tight pain (8/10) in her bilateral low back with no radiation into the leg. She has no history of malignancy and denies fevers, chills, bowel or bladder incontinence, or pain that wakes her from sleep. She works as a secretary and states she’s been having to take sick days.
- Exam is notable for a normal neuro exam and tenderness to palpation in the bilat. paraspinal muscles.
- X-rays show mild-moderate lumbo-sacral degenerative joint disease
- She states she has tried ibuprofen with no effect. She pleads that this pain is “killing me” and asks if she can be given Percocet.

Chronic Pain

- Extremely common – 100 million people; 25% of the US population
- Most common causes
  - Low back pain (27%)
  - Severe headache or migraine (15%)
  - Neck pain (15%)
- Low back pain
  - Mean point prevalence 18%
  - Lifetime prevalence 39%
  - Average of 50% of sufferers – pain will become chronic
  - Obvious causes of pathology found in only ~15%


Table 1. Prevalence of Chronic Low Back Pain in North Carolina, 1992 and 2006

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>1992 (n=6957)</th>
<th>2006 (n=9924)</th>
<th>Increase, %</th>
<th>PRR (2.5%-97.5% CI)</th>
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<tbody>
<tr>
<td>Total</td>
<td>3.9 (3.4-4.4)</td>
<td>2.2 (2.0-3.1)</td>
<td>152</td>
<td>2.92 (2.21-3.93)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>3.8 (3.3-4.4)</td>
<td>5.0 (4.6-5.3)</td>
<td>176</td>
<td>2.76 (2.11-3.75)</td>
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<tr>
<td>Female</td>
<td>4.0 (3.0-5.0)</td>
<td>12.0 (10.9-13.5)</td>
<td>154</td>
<td>2.94 (2.13-3.93)</td>
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<tr>
<td>Age, y</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>21-34</td>
<td>4.3 (3.8-4.8)</td>
<td>4.3 (3.0-5.6)</td>
<td>201</td>
<td>3.01 (1.95-5.17)</td>
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<tr>
<td>35-44</td>
<td>4.5 (3.3-6.3)</td>
<td>9.2 (7.2-11.3)</td>
<td>92</td>
<td>1.20 (1.15-2.86)</td>
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<tr>
<td>45-54</td>
<td>4.2 (3.0-5.5)</td>
<td>13.5 (11.4-15.7)</td>
<td>219</td>
<td>3.19 (2.29-4.59)</td>
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<tr>
<td>55-64</td>
<td>5.3 (4.2-6.3)</td>
<td>15.4 (13.9-17.9)</td>
<td>146</td>
<td>2.46 (1.73-3.53)</td>
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<td>65+</td>
<td>5.9 (4.5-7.3)</td>
<td>12.3 (10.2-14.4)</td>
<td>109</td>
<td>2.15 (1.56-2.93)</td>
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<tr>
<td>Race/Ethnicity</td>
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<td></td>
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</tr>
<tr>
<td>Non-Hispanic white</td>
<td>4.1 (3.5-4.7)</td>
<td>10.5 (9.4-11.5)</td>
<td>155</td>
<td>2.55 (2.13-3.05)</td>
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<tr>
<td>Non-Hispanic black</td>
<td>3.0 (2.0-4.0)</td>
<td>9.0 (8.0-10.4)</td>
<td>226</td>
<td>3.26 (2.32-4.96)</td>
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<td>Hispanic</td>
<td>3.6 (2.8-4.4)</td>
<td>6.3 (5.0-7.7)</td>
<td>119</td>
<td>2.79 (1.73-4.44)</td>
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<tr>
<td>Other</td>
<td>4.1 (3.4-4.8)</td>
<td>9.1 (8.1-10.2)</td>
<td>120</td>
<td>2.04 (1.16-3.59)</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; PRR, prevalence rate ratio.

*The PRRs and CIs were estimated via bootstrapping. 97.5% CIs were reported rather than to assume normality.

†Unable to estimate owing to small cell count (n < 5).
High Prevalence of Chronic Opioid Users

- Disabled Medicare beneficiaries <65yo (random sample)
  - Any opioid use: peaked at 44% (2010) → 43.7% (2011)
  - Proportion with chronic use: 21% (2007) → 23% (2011)
    - Mean morphine equivalent dosage (MED) = 81mg
    - 30% receiving >100mg MED daily
    - Variability based on region

Unfit for Work: The startling rise of disability in America. www.npr.org
The Chronology of Opioid Prescribing for Chronic Pain

1970s:
- *Opioids used only for cancer-related pain due to concerns about addiction

1995:
- *Studies showing low rates of addiction

1996:
- *Oxycontin released to market

2001:
- *New Joint Commission standards for pain.
- *5th vital sign

2011:
- MMWR on Prescrip. Opioid Overdose

2015:
- *Re-evaluation of chronic pain management
- *Safe Opioid Prescribing
- *Confused patients
- *Insur./Pharm/Legislator oversight and activism

Risk Factors for Developing Chronic Pain

- Population-based prospective study (n=3171 adults), England, mailed survey 0, 15 mos.
  - Who developed chronic widespread pain (CWP)
    - ~10% of the sample (9.9% M, 10.5% F)
    - Predictors of developing new chronic widespread pain:
      - Illness behavior (health-seeking for health problems)
      - Multiple physical symptoms
      - Sleep problems
      - Adverse life events
  - Prospective cohort study (the 1958 British Birth Cohort) – surveys at birth, continuing through 45yo.
    - Risk factors for CWP (cont. for adult SES & psych status):
      - Children hospitalized for an MVA
      - Resided in institutional care (OR 1.7)
      - Maternal death (OR 2.0)
      - Financial hardship (OR 1.6)
  - Determinants of low back pain disability
    - Psychosocial factors versus MRI findings in a population at-risk; 5 year f/u (q6 mo visits)
    - Predictors of disability and health care usage
      - Psychosocial profile at baseline
      - Current smoking
      - Fear avoidance beliefs
      - Previous workers compensation claims

Risk Factors for Being Prescribed Opioids for Chronic Pain

- Back pain and opioids
  - Greater psychological distress
  - Poorer health and unhealthy lifestyles
  - Health utilization
- High dose opioids for back pain (>100mg MED)
  - Mental health and substance use disorders
  - Concurrent sedative hypnotic use
  - High health service utilization
  - Report poorer health

Similar risk factors for aberrant drug-related behaviors (ADRB) AND for substance use disorders AND Unintentional OD


“Adverse Selection”

Efficacy of Opioids for Chronic Low Back Pain

- Cochrane review
  - "there is evidence that the use of tramadol or strong opioids result in improved pain and moderate changes in function in the short-term in people with chronic low back pain compared to placebo."
  - "several factors, including the strict inclusion criteria, high drop-out rates, poor description of the study population regarding duration of pain, concurrent treatments, work status, and compensation, limit the reported results. Notably, a number of important outcomes that capture patient function were absent (such as return-to-work). Finally, there is strong evidence that nausea is more common in patients treated with opioids compared to placebo."

Other Common Causes of Chronic Pain

<table>
<thead>
<tr>
<th>Other Common Cause of Chronic Pain</th>
<th>Outcomes</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibromyalgia</td>
<td>No effect</td>
<td>- High risk of bias in included studies</td>
</tr>
<tr>
<td>Diabetic Neuropathy</td>
<td>No effect</td>
<td>- High-risk of bias in included studies; short follow-up</td>
</tr>
<tr>
<td>Chronic Headache</td>
<td>No LT benefit demonstrated [74% of patients did not improve or were discontinued for clinical reasons]</td>
<td>- American Academy of Neurology position paper (9/14) recommending against chronic opioid therapy</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>- Opioids superior by 0.7cm on 10-cm visual analogue scale - Opioids superior for function on WOMAC scale by 0.6 units (0-10)</td>
<td>- High risk of bias - Adverse events: 22% of participants in opioid arm v. 15% placebo; - more drop-outs (6.4 v. 1.7%), - More serious side effects (1.3% v. 0.4%) &amp; withdrawal (2.4%)</td>
</tr>
</tbody>
</table>

**Sub-optimal Evidence**

- **External validity**
  - Khoroni study, exclusion criteria:
    - serious med illness,
    - urologic disease,
    - preg,
    - hx depression requiring anti-dep in past 6 mos or BDI >20,
    - hx narcotic or alcohol abuse,
    - glaucoma,
    - seizure d/o,
    - fibromyalgia,
    - pain of greater intensity in any other location than the low back or leg,
    - polyneuropathy & PVD associated with sx of numbness or burning in LEs,
    - multisomatoform disorder (PHQ-15),
    - unwillingness to be tapered off opioids & be drug free for 2 weeks leading up to study
  - Clinically important outcome: change in pain score rather than objective functional outcome
  - Short duration trials (most <12 weeks)
  - Funding source
  - Small sample size
  - High drop-out rate (~20%)
  - There has been no study of opioid therapy versus no opioid therapy evaluated long term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction.

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**What about Function: Return to Work?**

- Retrospective cohort of workers compensations claims for low back pain:
  - after controlling for injury severity, morphine equivalent dose associated with longer disability, greater med cost, and increased risk of surgery.

- Prospective, population-based cohort study of low back injury:
  - after adjustment for injury severity and other factors, opioids >7d was associated with work disability at 1 yr.

- Low back pain, workers comp claims:
  - After adjustment for covariates, odds of chronic work loss 11-14 times greater for claimants with opioid prescriptions of any type ≥ 90 days; higher medical costs in opioid users ($20K)

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In contrast…

- Biopsychosocial Treatment
  - Patients with chronic neck or back pain >3 mos (taken sick leave) (~50% depressed)
  - 3 week *inpatient* multidisciplinary treatment (5d/w; 8h/d)
    - Physical exercises
    - Ergonomic training
    - Psychotherapy
    - Patient education
    - Behavioral therapy
    - Workplace-based interventions
  - At 6 months: 67% returned to work; SF-36 score improved


259 million prescriptions written in 2012…

Number of painkiller prescriptions per 100 people

- 52.71
- 72.82.1
- 82.2-95
- 96-143

Source: IMS, National Prescription Audit (NPA™), 2012.
Risks of Chronic Opioid Therapy

- Unintentional Overdose
  - Case-cohort study, VA
    - Unintentional overdose in 0.04% of patients
      - White
      - Middle-aged
      - Do NOT have cancer
      - History of mental health disorder
      - History of substance use disorder
    - Increased risk by dosage
  - Retrospective analysis, HMO patients, fatal/non-fatal OD
    - Increased risk by dosage (0.2%/year 0-20mg;
      0.7%/year 21-100mg)
  - Cohort study from the VA of unintentional OD deaths:
    - Long-acting opioids (HR 2.3)


Morphine-Equivalent Dosage (MED)

- On-line calculator:
  - http://agencymedirectors.wa.gov/mobiledosage.html
- 100mg MED
  - Oxycodone ~60mg/day
  - Oxymorphone ~30mg/day
  - Fentanyl 12.5mcg patch (=129mg MED)

Table 5. MED for Selected Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Approximate Equianalgesic Dose (oral &amp; transdermal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (reference)</td>
<td>30mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>200mg</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
<td>12.5mcg/hr</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>Chronic: 4mg†</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20mg</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10mg</td>
</tr>
</tbody>
</table>

*Adapted from VA 2003 & FDA labelling
†Equianalgesic dosing ratios between methadone and other opioids are complex, thus requiring slow, cautious conversion (Ayonninda 2000)
Caution with Methadone

- Long half-life (15-60 hours; up to 120h)
  - 1999-2008: methadone poisoning increased 600%
  - 2006: FDA safety alert about methadone and risk of death from cardiac arrhythmia (starting dose should never exceed 30mg/d)
  - American Pain Society recs: 2.5mg q 8, inc q week
  - Risk factors for methadone-associated death:
    - Overuse of methadone
    - Concomitant BZD or illicit drugs
    - Recent initiation of methadone

<table>
<thead>
<tr>
<th>Conversion table from morphine to methadone (most commonly used in the USA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hour total dose of oral morphine</td>
</tr>
<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td>&lt;30mg</td>
</tr>
<tr>
<td>31-99mg</td>
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<tr>
<td>100-299mg</td>
</tr>
<tr>
<td>300-499mg</td>
</tr>
<tr>
<td>500-999mg</td>
</tr>
<tr>
<td>1000-1200mg</td>
</tr>
</tbody>
</table>

Public Health Risk: Unintentional Overdose

- Prescription opioid overdose has increased significantly in the United States
  - 15,000 cases/year
  - More people die from prescription opioids than heroin & cocaine combined
  - High proportion of deaths occur in patients receiving opioids for chronic pain, but also in patients with opioid dependence
  - Drug poisoning from opioid has exceeded motor vehicle accidents as cause of accidental death in many states

http://www.cdc.gov/drugoverdose/
**Other Side Effects**

- **Opioid-induced hyperalgesia (OIH)**
  - Heightened perception of pain from the use of opioids in the absence of disease progression or opioid withdrawal
  - MOA: excess NMDA receptor activation $\rightarrow$ hyperactive state & aberrant nerve activity $\rightarrow$ sensitize peripheral nerve endings & inc descending pain signals
  - No consensus definition or diagnostic criteria for the clinical syndrome in humans
  - Several management options (low-quality data): opioid tapering, opioid switching, NMDA antagonists (ketamine, methadone), and adding non-opioid adjuvants (NSAIDs).
  

- **Opioid-Induced Androgen Deficiency (OPIAD)**
  - Mechanism: due to inhibitory action of morphine on gonadotropin releasing hormone (GnRH) in the hyp $\rightarrow$ decreased gonadotropin secretion $\rightarrow$ decreased gonadal hormone secretion
  - Retrospective cohort of Kaiser patients, N. California seen in a chronic pain clinic (2009-10)
    - 53% hypogonadal (AM total serum testosterone <250ng/dL)
    - In men receiving long-acting opioids – 74% hypogonadal (v. 34% in men on short-acting opioids)
    - High BMI also associated with hypogonadism (OR 1.13)
    - Other studies show relationship to dose
  - Sequelae: decreased bone mineral density & ↑fracture risk (RR 1.88)
  - Treatments: discontinuation (reversible); supplemental testosterone

Other Side Effects

- **Sleep Disordered Breathing**
  - Sample of 24 patients on chronic opioid therapy versus patients referred for sleep study. 92% on additional CNS-active agent for pain
  - 71% (17/24) had clinically significant sleep disordered breathing
    - 11/24 (46%): severe sleep apnea (AHI >30) - ↑ risk BMI, MEQ
    - 4/24 (16%): central sleep apnea (central apnea index >5/h) ↑ risk MEQ
  - Slower reaction times in opioid patients (correlated with averca SpO2 <90% and % sleep time with SpO2 <90%)
  - 45% with daytime hypercapnea (despite ~normal lung function)
  - Treatment: CPAP, BiPAP with back up rate (may require complex settings)


The BEST Workup

- **B**one Mineral Density testing
- **E**cg
- **S**leep apnea testing
- **T**estosterone

Adapted from Rubinstein, Kaiser Permanente
Risk of Opioid Therapy

- Development of **Opioid Use Disorder** (Abuse or Dependence)
  - Estimates vary dramatically: 4-30% of patients
  - Efficacy trials underestimate risk
  - Risk factors for misuse:
    - Young age
    - Hx of substance use disorders
    - Hx of mental health disorder
    - Family hx of substance use


Aberrent Drug-Related Behaviors

- Differential diagnosis for ADRBs:
  - Under-treated pain ("pseudoaddiction")
  - Addiction
  - OIH
  - Tolerance
  - Diversion
  - New disease process or disease progression

- Be clear about your expectations of the patient and indications for discontinuation

- **DSM-5: substance use disorder**
  - Mild (2-3), mod (4-5), or severe (≥6)
    - Risky use **
    - Relationship problems
    - Role failure
    - Exceed own limits **
    - Withdrawal
    - Tolerance
    - Loss of Control
      - Repeated attempts to quit
    - Compulsion to use
      - ↑ time spent using
      - Give up activities to use
    - Continued use despite harm
      - Med/psych problems from use
    - Craving
So What Should I Do?

- Practice Safe Opioid Prescribing
  - Existing Patients on Chronic Opioid Therapy
    - RISKS VERSUS BENEFITS
    - MONITORING

**Inappropriate**

- Is the patient good or bad?
- Does the patient deserve pain meds?
- Should this patient be punished or rewarded?
- Should I trust him/her?

**Appropriate**

- Do the benefits of this treatment outweigh the risks for this patient and/or society?

Adapted from Alford

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Safe Opioid Prescribing

- Monitoring
  - Sign a treatment agreement
  - Sign informed consent
  - Check urine drug screens
  - Check a prescription activity report
  - Evaluate 4 As: Analgesia, Activities of Daily Living, Adverse Events, Aberrant Drug Related Behaviors
  - Explain to your patient why you’re doing this
Treatment Agreements & Informed Consent

- **Evidence**: no evidence that agreements decrease opioid misuse. Useful to facilitate communication and set expectations.
- **Recommended by**:
  - Chronic Opioid Treatment Guidelines (APS, AAPM; 2009)
    - Informed Consent (strong rec, low-quality evidence)
    - Treatment agreements (weak rec, low-quality evidence)
      - Goals of treatment, expectations for clinic follow-up and monitoring, how meds prescribed and taken, indications for stopping treatment, etc.
  - State Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain (Nov 2014)
- **Examples**:
  - [http://www.agencymeddirectors.wa.gov/Files/txagreement.pdf](http://www.agencymeddirectors.wa.gov/Files/txagreement.pdf)

Urine Drug Screen Monitoring

- Abnormal behavior does not predict abnormal urine toxicology testing – need both
- **Frequency based on risk**
  - Low risk: 1x/year
  - Medium risk: 2x/year
  - High risk (MED >100mg): 3-4 x/year
  - Aberrent behavior: at time of event

| Table 2. Proportions of Patients with Behavioral Issues or Positive Urine Toxicology Screening |
|---------------------------------|------------------|------------------|------------------|
| Urine toxicity                  | Yes (%)          | No (%)           | Totals (%)       |
| Positive                        | 10 (8%)          | 26 (21%)         | 36 (29%)         |
| Negative                        | 17 (14%)         | 69 (57%)         | 86 (71%)         |
| Total                           | 27 (22%)         | 95 (78%)         | 122              |


WA State Interagency Opioid Guidelines.
Urine Drug Screen Monitoring

- Ask for help on interpretation
- Decide what to do with results:
  - Recent VA study:
    - 69% pos marijuana, 25% pos unprescribed opioid → document plan to change rx 52% → only done in 24%

Review a Prescription Activity Report

- Provides a list of prescriptions for Schedule 2-5 medications filled by a patient
- Legally mandated in 22/49 states prior to prescription
  - Reductions in opioid prescribing and doctor shopping
- State of California providers:
  - Must submit an application for approval to access prescription records before JANUARY 1, 2016.
  - CURES (Controlled Substance Utilization Review and Evaluation System) 2.0 to have better interface & easier use
  - Application: [https://pmp.doj.ca.gov/pmpreg/RegistrationType_input.action](https://pmp.doj.ca.gov/pmpreg/RegistrationType_input.action)
  - Must submit notarized copy of the application & copies of DEA certificate, medical license, and photo ID
Risks & Benefits

- 36yo F with hx of obesity, PCOS, infertility, and depression with low back pain.
- Tried NSAIDs, physical therapy, pool therapy, massage; went to Healthy Spine clinic. Attends all appointments.
- Working full time.
- Started on hydrocodone-acetaminophen 5-325 for severe pain, which allows her to get through tough days at work.
- Did not dose escalate. Started on treatment for anovulation and stopped opioids. Now pregnant.

- 32yo F with mixed connective tissue disorder, non-specific low back pain, and depression. Family history of substance use disorders.
- MRI & diagnostics normal.
- Started on opioids & rapidly titrated up: oxycodone 45mg IR q4hr + morphine CR 30mg bid. Very resistant to alternative treatments.
- Since opioid therapy:
  - 2 ED visits,
  - applying for disability,
  - intermittently coming to appointments
- Urine drug screens are appropriate.

Finding the Right Language

- "We have been trying the strong pain medication and I don’t think it’s helping you. I understand you disagree, but my job as your provider is ensure that you are safe. Right now I don’t think this is a safe medicine for you to take."
- "I understand you are frustrated with me, but I really want to continue to be your doctor and work on treatments that may help your pain."
- "Opioids work by making you unaware of pain. They don’t help what is actually going on. I’d rather try something that will attack the underlying cause of the pain."
- "Many of my patients get dependent on the pills and after a while, they don’t get pain relief, but instead, they have to take them just to feel normal. It can be a terrible cycle where your life revolves around the pills."
- "I want to be your doctor. I’m not abandoning you. I want to work on a different solution."
What About New Patients Being Considered for Chronic Opioid Therapy?

- Prior to consideration of opioid therapy
  - Consider the natural history of the illness
    - 85% of patients with low back pain improve significantly in the first month
    - Empower your patient: “Tell me about how you’re controlling your pain right now?” [position/activity change, hot shower, massage, changing posture]
  - Trial of several, multi-modality non-opioid treatments for pain
  - Screen and assess for mental health and substance use disorders
  - Risk Assessment Tool

What Are My Alternatives?

<table>
<thead>
<tr>
<th>Pharmacologic</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complementary and Alternative Medicine</td>
<td>Cognitive and Behavioral</td>
</tr>
</tbody>
</table>
Pharmacologic
• Neuroleptics
• Antidepressants
• Anesthetics (lidocaine patch)
• Muscle relaxants
• Topicals (capsaicin)
• Opioid medications/Tramadol
• Specialty Pain clinics
  • baclofen pumps, lidocaine pumps
  • Buprenorphine

Physical
• Physical Therapy/Physiatry consults
• Joint injections
• Spine injections
• Surgery
• Stretching/strengthening exercises
• Recommendations for pacing daily activity
• Heat or ice
• Trigger point injections

Complementary and Alternative Medicine
• Acupuncture (community and schools)
• Mindfulness Based Stress Reduction and meditation
• Community yoga classes
• Tai-chi classes
• Massage schools
• Anti-inflammatory diets and herbs
• Supplements (glucosamine chondroitin, SAM-e)
• Guided imagery
• Breathing exercises

Cognitive and Behavioral
• Pain Groups
• Individual therapy
• Brief cognitive and behavioral interventions in clinic
• Visualization, deep breathing, meditation
• Sleep hygiene
• Gardening, being outdoors, going to church, spending time with friends and family, etc.

Check out: http://healthinsight.org/intera/assets/SMART/Pain%20Guidelines%20alternative%20to%20opioids-final.pdf

Bio-psychosocial model of pain
Screening for Mental Health and Substance Use Disorders

- Mental health disorders
  - Depression and pain often linked
    - Study of outpatients at university-based outpatient pain clinic (n=2104):
      - 55% with current opioid use → 43% depressed (v. 26%)
      - Increased pain severity was associated with increased probability of taking opioids, and this was moderated by depression. If depressed, prob of opioids didn’t depend on pain severity.
    - Outcomes in depressed patients
      - Mod-high negative affect groups in a RCT trial of opioid therapy: decreased benefit from opioid therapy

Screening for Substance Use Disorders

- CAGE questions (Adapted to Include Drugs; CAGE-AID):
  - In the last 3 months, have you felt that you cut down or stop drinking or using drugs?
  - In the last 3 months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
  - In the last 3 months, have you felt guilty or bad about how much you drink or use drugs?
  - In the last 3 months, have you been waking up wanting to have a drink or use drugs?
  - Score 1 point = positive screen
Use a Risk Assessment Tool

- Opioid Risk Tool (ORT)
  - 5-item initial risk assessment
  - Stratifies risk into low (6%), moderate (28%) and high (91%)
    - Family History
    - Personal History
    - Age
    - Preadolescent sexual abuse
    - Past or current psychological disease
  - Available at: [https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf](https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf)
- Several alternative options: DIRE, SOAPP, others

Flow-Chart

Chronic pain refractory to meds, PT, surgery, etc

Assess for Risk with Screening Tool → High risk

Screen for Un/undertreated MH or Subst Use disorders

Discuss Treatment Plan
- Goal: increase function
- Treatment expectations
- Monitoring
- Reasons to Stop Meds

Written Informed Consent and Agreement

Short Trial of Opioids

Evaluate Function, Side Effects, Problem Behaviors

Treat MH / sub use disorder

Refer to specialist or NOT a candidate for opioids

No improvement in Function, or Aberrant Behavior

Ongoing Treatment

All of this in a 20 minute visit??

- This is extremely difficult
  - Often, there is no good solution.
    - Take the pressure OFF OF YOURSELF to fix everything.
  - Iterative process; small goals; frequent follow-up
  - Make sure your patient knows you care.
- Name the emotions
  - We don’t like to see our patients upset.
  - We want them to like us and think we are great.
  - Patients can say hurtful things to us.
  - Dreading the follow-up visit does not make you a bad person. People are capable of change every day. Affirm their strengths.

Summary

- Chronic pain is very common (~20% of Americans), as is chronic opioid therapy.
- Prescribing of opioids has increased significantly in the past decade, as have treatment admissions for opioid dependence and death from overdose.
- Individuals with mental health and substance use disorders are at increased risk for receiving opioid therapy.
- There is no evidence that long-term chronic opioid therapy leads to substantive functional improvement in patients with chronic pain.
- There are several risks of chronic opioid therapy, including unintentional overdose, hypogonadism, hyperalgesia, and the development of opioid use disorders.
Summary

- Safe opioid prescribing requires close monitoring and assessment of patients via treatment agreements, informed consent, urine drug screens, and prescription activity reports.
- The decision to start or continue opioid therapy requires constant re-evaluation of the risks and benefits of treatment.
- Given the biopsychosocial underpinnings of chronic pain, treatment should be multi-modal.
- Empower your patients to do the best they can via their own strengths and resources.