Complex Chronic Pain: Cases from the Field
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Objectives
- To develop empathic and sensitive ways of communicating with patients suffering from chronic pain
- To review the “four quadrants” of chronic pain treatment
- To improve recognition and diagnosis of an opioid use disorder in patients with chronic pain on opioids
- To be able to explain the risks associated with long-term opioid therapy to patients

Case 1
- 62yo M with hx of COPD, CAD, DM (poorly controlled), HTN, HCV, HL, remote “substance abuse”, R knee trauma s/p surgery with ongoing chronic pain on opioids, and seizure disorder coming for follow-up with PCP.
- Primary complaint is poorly controlled pain:
  - Requesting early refill of opioids (repeatedly)
  - Reports taking friend’s methadone to control his pain
- Current meds:
  - Oxycodone 20mg 1-2 tabs po TID
  - Morphine sulfate CR 60mg po tid
  - Clonazepam 2mg PO tid
  - MEQ = 300mg/day
**Case 1**

- Over the past 6 months patient has struggled with outpatient follow-up & chronic disease management:
  - No-shows to appointments (DM clinic, orthopedics to discuss knee replacement, neuro to discuss seizure regimen)
  - Does not bring meds for med reconciliation
  - Seen in ED for seizure – etoh level neg
  - Reports to PCP that he passed out a week ago and fell down stairs w/LOC – HCT neg. Sleepy at apt.
- Urine drug screens are frequently abnormal: neg oxycodone, pos methadone, neg BZD
- Pain is excruciating; newly in wheelchair, depressed “all I do is lay in bed and sleep”

**Case Continued**

- Which of the following would be the best approach to this patient?
  - A) Make opioid refills contingent on attendance at appointments
  - B) Taper off opioids
  - C) Treat depression and continue opioids

- Patient was referred to clinic controlled substance review committee. Committee recommended:
  - Utox at next visits and if abnormal, taper meds
  - Review controlled substance agreement
  - Discuss methadone
  - Rx naloxone
  - Patient had repeat utox that was abnormal (pos methadone, neg oxy). PCP did not elect to taper meds given complaints of uncontrolled pain.
  - Patient found dead 3 months later.
  - Cause of death: opioid overdose
Lesson 1: More Overdose

Overdose & Public Health
- Surgeon General’s Report on Drugs and Alcohol: Facing Addiction in America
  - Turnthetidex.org
- CARA (Comp Addic & Recov Act) legislation passed in 2016
- CDC Opioid Prescribing Guidelines 2016
- ACA: substance use treatment as a guaranteed benefit

Lesson 2: Pain v. Addiction

Distinguishing between pain and an opioid use disorder?
- Opioid use disorder
  - 4 Rs
    - Risk of bodily harm
    - Relationship trouble
    - Role failure
    - Repeated attempts to cut back
  - Laying in bed all day, doing nothing
- 4 Cs
  - Loss of Control
  - Continued use despite harm
  - Compulsion (time & activities)
  - Craving
  - I need more pills, early refill requests
  - Sleepy at visits
  - Time’s for methadone

Lesson 2: Pain v. Addiction

Opioid Use Disorders
- 2012 estimates (NSDUH)
  - 2.1 million rx pain relievers
  - 467,000 heroin
  - Needles/heroin = addiction
  - goo.gl/NNpwgx

By Jen Simon
I’m a stay-at-home mom. I’m an addict.
Lesson 3: Depression & Pain

- Depression and pain often linked
  - Study of outpatients at university-based outpatient pain clinic (n=2104):
    - 55% with current opioid use \( \rightarrow \) 43% depressed (v. 26%)
    - 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


Lesson 4: Prevention

- Does it Work?
  - Nonrandomized intervention study of naloxone provided in safety-net primary care clinics in SF
    - Patients receiving naloxone had 63% fewer opioid-related ED events in yr after receipt
  - Communication
    - "worst case scenario"

Which of the following would be the best approach to this patient?

- A) Make opioid refills contingent on attendance at appointments – Active opioid use disorder is contraindication to prescription opioids for pain
- B) **Taper off opioids – CORRECT – and treat for opioid use disorder**
- C) Treat depression and continue opioids – Yes, treat depression, but opioids should be tapered

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**But this pain...do you want me to start shooting dope??**

- No, I don't want you to start injecting heroin. I don't think you want that either. You should feel proud that you don't use needles anymore.
- My job is to take care of you and make sure you're safe.
- I don't think you can safely continue on opioid pain pills. I want to give you a better, safer treatment because I think you have severe, uncontrolled pain, and an opioid use disorder.
- I'm not going to leave you. I know you are suffering right now.
- The treatments I can offer you are methadone maintenance programs, or buprenorphine-naloxone. Do you want to hear more about those?

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**Take-home points**

- Active substance use disorders or mental health disorders are a contra-indication to chronic opioid therapy for pain.
- This is hard, but you MUST be on the lookout for development of an opioid use disorder in your pain patients.
- Prescribe naloxone to patients on chronic opioid therapy.
- Be the most sensitive and empathetic you can be when communicating discontinuation of opioids.
- Run towards the patient, not away.

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**Treatment Program Locator**

- Buprenorphine-certified providers:
  - To get trained: [www.buppractice.com](http://www.buppractice.com)
- Opioid treatment program directory:
  - [http://dpt2.samhsa.gov/treatment/directory.aspx](http://dpt2.samhsa.gov/treatment/directory.aspx)
- Substance use treatment warm line: 1-855-300-3595. 10a-6pm EST
Case 2

A 34yo F with a history of depression, obesity, PCOS, and low back pain presenting for primary care follow-up. She describes sharp pain in L back, 8/10, with occasional radiation down her leg x2 weeks. She denies weakness and numbness and has a normal neurologic exam.

She says the pain is excruciating and she’s had difficulty at work. She’s been using her husband’s pain pills (hydrocodone-acetaminophen) and is wondering if you can prescribe some.

You try NSAIDs, ice/heat, massage and basic wall exercises and ask her to return in 2 weeks.

Case 2 continued

She returns in 2 weeks and says the pain is still very severe (8/10), “tight and throbbing”, almost constant. She tried the ibuprofen which had some effect, as does ice/heat, but it’s only temporary. She is still using her husband’s hydrocodone-acetaminophen and says that’s her preferred agent. She’s having difficulty sleeping, which is making her more tired throughout the day.

She denies depressed mood or lack of interest in daily activities. She continues to feel stress and anxiety about life at home. She does not smoke or use drugs or alcohol.

Evaluation

Empower
- What are you doing to control your pain?
- Acknowledge suffering while focusing on strength and recovery

Educate
- Back pain is common (mean point prevalence 18%; lifetime prevalence 39%)
- At 1 mo. ~1/3 with mod. pain (20% activity); 1 year, ~1/3 with mod. pain
- Opioid efficacy

Evaluate
- Function (work, apt), substance use, and psychiatric

Treatment: The Broader Context of Pain

Husband disabled. Sole wage earner. IHSS hours decreased.

Tired. Stressed. Depressed.
Worried something is wrong with her body.

Lumbosacral strain

What Are My Alternatives?

Pharmacologic

• NSAIDs
• Neuroleptics
• Antidepressants
• Muscle relaxants
• Topicals
• Opioid medications/Tramadol
• Pumps (baclofen, lidocaine)
• Buprenorphine

Physical

• Physical Therapy
• Joint injections
• Directed Exercise Program
• Pacing daily activity
• Heat or ice
• Trigger point injections

Complementary and Alternative Medicine

• Acupuncture (community and schools)
• Mindfulness Based Stress Reduction and meditation
• Yoga
• Massage
• Supplements (glucosamine chondroitin, SAM-e)
• Guided imagery
• Breathing exercises

Cognitive and Behavioral

• Pain Groups
• Cognitive and behavioral therapy
• Visualization, deep breathing, meditation
• Sleep hygiene
• Gardening, being outdoors, going to church, spending time with friends and family, etc.
• Pain Toolkit

Can it work?

- Biopsychosocial Treatment
  - Patients with chronic neck or back pain >3mos (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

Case cont’d

- She was offered low-dose baclofen given her complaints of tightness in her muscles. She was referred to the Healthy Spine clinic.
- You check in with her by phone 1 week later and she says the baclofen is making her sleepy and she still has pain. She’s been trying to do her exercises, think positively, and use the ice/heat and massage. She also got some muscle rub.

Question

- Which of the following is the best course of action?
  - A) Continue with plan explaining it takes time to see improvement
  - B) Add diazepam for muscle pain
  - C) Check a urine drug screen
  - D) Start extended-release opioid medication
  - E) Something else

Case continued

- Patient returned for follow-up 2 weeks later. In that time she did not have to take additional sick days. She was taking ~1-3 pills per day. Her sleep had improved. She attended her healthy spine appointment & was taught additional exercises.
- Epilogue: Patient continued on opioid for ~3 months, taking less over time and with no concerning behaviors. Patient had also been doing basic fertility treatments and became pregnant, and stopped opioids completely.
Remember the Guidelines

- CDC Opioid Guidelines*
  - Opioids not 1st line
  - Non-pharm. and non-opioid tx are preferred
  - Chronic opioids often start with acute rxs. Use lowest dose, <3d
  - Limit MME to <50mg daily
  - Monitor closely: urine drug screen, PDMP, risk/benefit


Take Home Point

- Think of the four quadrants when developing treatment options with your patients. Cultivate their resilience & strength.
- Opioids may still be required for patients that have failed multi-modal therapy and who do not have active substance use or mental health disorders.

Case 4

- JF is a 66yo M with hx of chronic low back pain (sciatica s/p epidural injections), BPH, depression, remote alcohol and dextromethorphan abuse referred to CSI committee by new PCP.
- Meds:
  - Fentanyl 75mcg TD q 48hrs
  - Oxy-APAP 5-325 #180/month
  - temazepam 15mg q hs
  - Testosterone gel
  - Dextroamphetamine 10mg q day
- MED = 225mg daily

Question

- All of the following are risks of long-term, high-dose chronic opioid therapy except:
  - A) sleep disordered breathing
  - B) hypogonadism
  - C) unintentional overdose
  - D) pneumonia
  - E) BPH
  - F) osteoporotic fracture
**Question**

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**Risks of High Dose**

- Unintentional overdose (~0.7%/year 20-100MED)
- Addiction (~20% risk)
- Secondary Hypogonadism (~50% of men)
  - Dec bone mineral density & inc. fracture risk
- Sleep-disordered breathing (60-70% of patients) – OSA, central hypoventilation, high CO2
- Pneumonia in older adults (case-control)
- Others
  - Opioid-induced hyperalgesia?
  - Cardiac toxicity with methadone


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**Approaches to High Dose**

- Open conversations with patients about risks and benefits
  - BEST work-up?
- Offer naloxone
- Get feedback:
  - Pain specialist
  - Peer review (controlled substance review committees)
- If tapering, go slow & see person often (10% per week-month). Remember, we started the meds.
High dose opioids (>100MME)

Concerning Behaviors?

Yes
- Evaluate for opioid use disorder
- Present?
  - Yes
    - Treat
  - No
    - No Evidence of Toxicity?
      - No
        - Give warning. If behavior continues, taper
      - Yes
        - Yes Evidence of Toxicity?
          - No
            - Give warning. If behavior continues, taper
          - Yes
            - Taper

No Evidence of Toxicity?
- Yes
  - Taper
- No
  - Continue meds & monitoring

Case Continued
- Patient referred to CSI committee
- Open to tapering
- Recs provided to PCP
- Epilogue: Patient started taper, but then reported difficulty. Provider has slowed down pace and continues to discuss it with the patient at every visit.

Take Home Point
- All patients should be counseled and warned about possible side-effects and adverse events of opioids, including
  - Risk of addiction
  - Osteoporosis
  - Sleep apnea
  - Death from overdose

Summary
- Chronic pain is extremely common and severely debilitating for our patients.
- Applying the biopsychosocial model to chronic pain helps inform management.
- Treatment for pain should be multi-modal and include pharmacologic, physical, complementary and alternative, and cognitive and behavioral techniques.
- Chronic opioid therapy is commonly prescribed. Emphasis should always be on safety and weighing the risks and benefits of treatment.
Summary cont’d

- In patients with an active substance use or mental health disorder, these should be treated/stabilized prior to prescribing chronic opioid therapy.
- Be aware of the long-term risks associated with chronic opioid therapy.
- Keep in mind your patients are suffering every day. Empower them to do the best they can via their own strengths and resources.

Questions?

Resources

- Patients:
  - Chronic Pain Facebook Groups
  - YouTube videos to educate patients about pain:
    - Chronic pain in 5 minutes: https://www.youtube.com/watch?v=C_3phB9JxvI
    - Treatment options: https://vimeo.com/74825810
- Providers:
  - SFHP patient/provider resources: http://www.sfhp.org/providers/pain-management/resource-tools/