Presenting Faculty

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Faculty Disclosures
Commercial Support

This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies (RPC). This activity is intended to be fully compliant with the Opioid Analgesic REMS education requirements issued by the US Food & Drug Administration.

Learning Objectives

1. Summarize key concepts and practices in managing pain and preventing opioid misuse, abuse, and addiction
2. Assess patients with pain to inform treatment planning, monitor treatment response, ensure safe use when opioid analgesics are appropriate, and detect opioid abuse or addiction
3. Develop individualized pain treatment plans, including nonpharmacologic and/or pharmacologic (non-opioid and opioid analgesics) as appropriate
4. Identify strategies to safely and effectively initiate, modify, and discontinue use of opioid analgesics
5. Manage patients with opioid use disorder, or identify patients requiring referral to a specialist in addiction medicine

Exit Tickets

At the end of each section, you will be asked to complete one of the multicolored exit tickets located in your packet of handouts.

Once you complete an exit ticket, please place it in the center of your table and it will be collected.
How to Use Your Phone to Answer Polling Questions

FIRST start a new text message to this number: 22333

THEN type a message that says TFF3 and hit Send

You’re ready to go!
Simply text A, B, C…to answer when you see a question slide pop up

Let’s test it!

TEST: How many cups of coffee did you have this morning?
What is your profession?

- Physician
- Advanced Practice Nurse
- Physician Assistant
- Dentist
- Podiatrist
- Nurse
- Pharmacist
- Optometrist
- Psychologist
- Other healthcare professional

Which best describes your practice area?

- Anesthesiology
- Critical Care
- Emergency
- Family Medicine
- General
- Hematology
- Hospice and/or Palliative Care
- Internal Medicine
- Neurology
- Obstetrics/Gynecology
- Oncology
- Surgery - General
- Surgery - Orthopedic
- Surgery - Other
- Urology
- Other
- N/A

Indicate if you are able (licensed) to prescribe controlled substances (CS).

- Yes
- No
Based on the FDA's Risk Evaluation and Mitigation Strategies (REMS)

ASA PAIN: Anesthesiologists' Tailored Approach to Patient Safety Considerations When Using Opioid Analgesics

Basics of Pain Management and Opioid Use Disorder
Richard Rosenquist, MD
American Society of Anesthesiologists

Pretest 1. Which of the following BEST describes neuropathic pain?

A. Pain that is self-limited and associated with sympathetic nervous system activation
B. Pain that persists after all tissue healing is complete
C. Severe pain reported in response to a normally mild painful stimulus (e.g., a pin prick)
D. Pain reported directly in an area of recent tissue injury (e.g., pain at the site of a new surgical incision)
Scope of the Problem

- NCHS 2017
  - >70,000 drug overdose deaths
  - 47,600 of the deaths involved opioids—a 45% increase from 2016
  - On average, 130 deaths per day from overdoses involving opioids
- NSDUH 2016
  - ~11.5 million Americans aged ≥12 years misused prescription pain relievers, most often hydrocodone, oxycodone, and codeine products
  - ~2.1 million Americans aged ≥12 years had OUD

NCHS = National Center for Health Statistics; NSDUH = National Survey on Drug Use and Health.
Scholl L et al. MMWR. 67(5152);1419–1427.
SAMHSA. Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA); 2017. HHS publication SMA 17-5044, NSDUH Series H-52.
Why Comprehensive Pain Education Is Needed

- Understanding risks associated with opioids provides opportunities to consider all pain management options
  - Nonpharmacologic
  - Pharmacologic: non-opioid and opioid
    - Consider opioids only when non-opioid options are inadequate and benefits outweigh risks
- Knowledge of the risks of opioid misuse and abuse can inform development of patient counseling and other strategies to reduce risks


Biological Significance of Pain

Acute vs Chronic Pain

- Acute pain
  - Provoked by a specific disease or injury
  - Serves a useful biologic purpose
  - Associated with skeletal muscle spasm and sympathetic nervous system activation
  - Self-limited
- Chronic pain
  - Persistent pain that may or may not have a known cause
  - Unhelpful; a disease state

Nociceptive vs Neuropathic Pain

- Nociceptive pain
  - Adaptive response resulting from suprathreshold stimulation of nociceptors
  - Immediate physical response is reflexive, protective
  - Persists while the injurious agent remains or until healing occurs
  - Prolonged input can cause central hypersensitization and spontaneous or amplified pain

- Neuropathic pain
  - Results from lesion in or dysfunction of the sensory nervous system
  - Triggered by:
    - Nerve compression, injury, or severance
    - Disorders affecting the neural axis
  - Patients may have combined neuropathic and nociceptive pain

Neuropathic Pain

- Allodynia: pain resulting from normally painless stimuli
- Hyperalgesia: heightened sense of pain to noxious stimuli

Elements of an Initial Assessment of the Patient With Pain

- Patient history
- Physical examination
  - Underlying cause
  - Location
  - Pain bow/Intensity
  - Chronic pain – chronic neuropathic pain
- Query to state PDMP*
- Functional assessment
- Psychological/social evaluation
- Status/intent regarding pregnancy or breastfeeding
- Diagnostic studies when needed
- Screening for risk of OUD
## Tools for Assessing Pain Level

<table>
<thead>
<tr>
<th>Tool</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faces Pain Scale</td>
<td>- Easy to use</td>
<td>- May measure pain affect, not just pain intensity</td>
</tr>
<tr>
<td>Numeric Rating Scale (NRS)</td>
<td>- Can be used in people with mild-to-moderate cognitive impairment</td>
<td>- May be difficult to understand when used in people with cognitive impairment</td>
</tr>
<tr>
<td>Visual Analog Scale (VAS)</td>
<td>- Easily translated into multiple languages</td>
<td>- May be affected by visual impairment</td>
</tr>
<tr>
<td>Verbal Rating Scale/Graphic Rating Scale</td>
<td>- Easy to use but must be presented carefully</td>
<td>- Cannot be used in patients with cognitive impairments</td>
</tr>
</tbody>
</table>

## Tools for Assessing Several Dimensions of Pain

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Pain Inventory (BPI)</td>
<td>- Short form better for clinical practice</td>
<td>University of Texas School of Nursing at Houston</td>
</tr>
<tr>
<td>McGill Pain Questionnaire</td>
<td>- Short form easier to administer</td>
<td>Pain Balance</td>
</tr>
<tr>
<td>Pain Disability Index</td>
<td>- Measures chronic pain and chronic pain interference in daily life</td>
<td>National Primary Care Research and Development Centre, University of Manchester, UK</td>
</tr>
<tr>
<td>Rolan-Morris Disability Questionnaire</td>
<td>- Measures perceived disability from low back pain</td>
<td>Oswestry Back Pain and Disability Questionnaire, University of Huddersfield, UK</td>
</tr>
<tr>
<td>WOMAC Index</td>
<td>- Measures pain, stiffness and physical function in patients with osteoarthritis</td>
<td>WOMAC.org</td>
</tr>
</tbody>
</table>

## Tools for Assessing Function

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katz Basic Activities of Daily Living Scale</td>
<td>- Rates independence by assessing six areas of daily activities</td>
<td>University of Texas School of Nursing at Houston</td>
</tr>
<tr>
<td>Pain Disability Index</td>
<td>- Measures chronic pain and chronic pain interference in daily life</td>
<td>Pain Balance</td>
</tr>
<tr>
<td>Roland-Morris Disability Questionnaire</td>
<td>- Measures perceived disability from low back pain</td>
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<td>WOMAC Index</td>
<td>- Measures pain, stiffness and physical function in patients with osteoarthritis</td>
<td>WOMAC.org</td>
</tr>
</tbody>
</table>
Definition of Addiction

• Primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations

• Typically characterized by one or more of the “3 Cs”
  – Impaired control over drug use or compulsive use
  – Continued use despite harm
  – Craving


Opioid Use Disorder

• DSM-5 definition: a problematic pattern of opioid use leading to clinically significant impairment or distress
• Previously classified as opioid abuse or opioid dependence (DSM-IV)
• Also referred to as opioid addiction


Neurobiology of OUD: Initial Changes

- Heroin and prescription opioids act primarily as µ-opioid receptor agonists with a relatively short duration of action
- Activation of the dopaminergic mesocortical, mesolimbic, and nigrostriatal systems appears to be a common neurobiological consequence of exposure to drugs of abuse

Changes After Initial Opioid Exposure

- Short- and long-term regulatory changes occur in major neurotransmitter and neuropeptide systems at the mRNA or protein level
- Long-term regulatory changes persist even after prolonged drug-free periods and may underlie the chronic relapsing nature of addictive diseases

Changes After Initial Exposure (Continued)

- Chronic exposure to drugs of abuse upregulates the K opioid receptor-dynorphin system
  - Thought to be the basis of aversion, dysphoria/anhedonia, and depression-like or anxiety-like neuropsychiatric states
  - May mediate negative reinforcement aspects of withdrawal
  - May exacerbate chronic relapsing nature of addictive diseases
<table>
<thead>
<tr>
<th>Risk</th>
<th>Patient Characteristics</th>
</tr>
</thead>
</table>
| Low   | • No history of substance abuse  
       • Minimal, if any, risk factors  
| Medium| • History of non-opioid substance use disorder  
       • Family history of substance abuse  
       • Personal or family history of mental illness  
       • History of non-adherence to scheduled medication therapy  
       • Poorly characterized pain problem  
       • History of injection-related diseases  
| High  | • Active substance use disorder  
       • History of prescription opioid abuse  
       • Patient previously assigned to medium risk exhibiting aberrant behaviors  

SAMHSA. Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA); 2012. HHS publication (SMA) 12-4671.

Risk of Developing OUD

Tools for Screening for OUD Risk

- Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients with Pain—Revised (SOAPP-R)
- CRAFFT Screening Interview (for adolescents)


Opioid Risk Tool (ORT)

- Can be administered and scored in < 1 minute
- Validated in both male and female patients (but not in non-pain populations)

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid use history</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Socially high-risk</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>History of substance use</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Family history of substance use</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>High-risk</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Scoring: 6-9: low risk 4-6: moderate risk 0-3: high risk

CRAFFT Screening Interview

- Developed specifically for use among adolescent medical patients
- Validated in patients ages 14-18 years seeking routine health care (and in other adolescent populations)
- Most thoroughly studied substance abuse screen for adolescents

**CRAFFT Screening Interview**

- During the PAST 12 MONTHS, did you:
  1. Drink any alcohol (other than wine with a meal) or not count sips of alcohol during family or religious events?
- Did you ever ride in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
- Do you ever use alcohol or drugs while you are by yourself, or ALONE?
- Do you ever FORGET things you did while using alcohol or drugs?
- Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
- Have you ever gotten into TROUBLE while you were using alcohol or drugs?

**Scoring:** Each “yes” response in Part B scores 1 point. A total score of ≥2 is considered a positive screen.

**Part A**

1. Drink any alcohol (other than wine with a meal) or not count sips of alcohol during family or religious events?
   - Yes
   - No

2. Smoke any marijuana or hashish?
   - Yes
   - No

3. Use anything else to get high? (“Anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)
   - Yes
   - No

**Part B**

1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
4. Do you ever FORGET things you did while using alcohol or drugs?
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

**When selecting among treatment options for opioid use disorder, all of the following should be considered EXCEPT?**

- Patient’s preferences
- Past treatment history
- Treatment setting
- Patient’s occupation

**Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)**

- Validated in chronic pain patients
- < 10 minutes to complete
- Simple to score

Diagnosing OUD: DSM-5 Criteria

Check all that apply (within a 12-month period)

- [ ] Opioids are often taken in larger amounts or over a longer period than was intended.
- [ ] There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- [ ] A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects.
- [ ] Craving or a strong desire or urge to use opioids.
- [ ] Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home.
- [ ] Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- [ ] Important social, occupational or recreational activities are given up or reduced because of opioid use.
- [ ] Recurrent use in situations in which it is physically hazardous.
- [ ] Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- [ ] Exhibits tolerance.
- [ ] Exhibits withdrawal.

Total checked: ___________________

If OUD is diagnosed (³ 2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe (³ 6 criteria met).

Diagnosing OUD: Definitions

Tolerance

- A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
- A markedly diminished effect with continued use of the same amount of an opioid.

Withdrawal

- Criterion A: Either of the following: (1) cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or (2) administration of an opioid antagonist after a period of opioid use.
- Criterion B: Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection or sweating; diarrhea; yawning; fever; or insomnia.

Interventions for OUD

- Methadone, buprenorphine, naltrexone
- Setting is as important as drug selection: office-based opioid treatment vs. inpatient opioid treatment program
- Office-based opioid treatment (medication provided on a prescribed weekly or monthly basis) is limited to buprenorphine
- Psychosocial intervention is a critical component of opioid treatment programs
- Referral to a specialist in addiction medicine may be necessary
Conclusions: Key Takeaways

• Pain is a normal, physiologic, protective response to acute injury
• Pain may be acute or chronic, nociceptive and/or neuropathic
• Initial assessment of a patient in pain should include determination of the underlying cause and assessment of pain location and severity
• Consideration of opioids for the treatment of pain should take into account risk for developing OUD
  – Screening tools to identify and monitor patients at risk for OUD are available and simple to use
• OUD is a disease with a well-identified underlying neurobiology
• Management of OUD must be tailored to each patient’s needs, with careful selection of setting and medication for withdrawal management
• Multiple factors—including patient history, preferences, and compliance—should be considered when deciding whether to refer to an addiction specialist

Please complete your exit ticket...

...and place it in the center of your table

Creating the Pain Treatment Plan
Alaa Abd-Elsayed, MD, MPH
A 66-year-old, retired engineer with a history of HTN, CAD, CHF and progressive renal insufficiency has severe ongoing right hip pain due to severe acetabulofemoral arthritis. He is not considered a surgical candidate due to his renal and cardiovascular disease. He is requesting help with pain control so that he can participate in aquatherapy and try to improve his overall level of function.
Steps in Creating an Effective Pain Treatment Plan

- Establish goals of treatment
  - Discuss degree of pain relief
  - Discuss functional improvement
- Plan for periodic review of treatment goals
- Consider nonpharmacologic interventions
- Consider pharmacologic interventions, when appropriate
- When prescribing opioids, establish prescriber and patient responsibilities and use patient provider agreements (PPAs)

**Opioid Patient Prescriber Agreement (PPA). FDA website.**

Choosing Treatments
**Nonpharmacologic interventions**
- Psychological interventions
  - Preoperative education/expectation setting
  - Guided imagery
  - Progressive relaxation
- Physical modalities
  - Physical therapy/occupational therapy
  - Ice/heat/elevation/positioning
- Surgical interventions

Choosing Treatments: Non-opioid Analgesics (with examples)*
- Acetaminophen (APAP)
- NSAIDs (ibuprofen, celecoxib, indomethacin, ketorolac, naproxen)
- Oral corticosteroids (prednisone, dexamethasone, methylprednisolone)
- Topical agents
  - Local anesthetics (lidocaine, bupivacaine, ropivacaine, prilocaine, tetracaine)
- Drugs for neuropathic pain
  - Anticonvulsants (carbamazepine, gabapentin, lamotrigine, valproate)
  - Antidepressants – tricyclics (imipramine, nortriptyline)
  - Tricyclic antidepressants – Nortriptyline, desipramine, nortriptyline
  - Muscle relaxants (transaxic)

*For formulations, indications, contraindications, adverse events, and drug interactions please consult individual agents on DailyMed:
When Should Opioid Treatment Be Considered?

- For acute pain or trauma if non-opioid analgesics are insufficient, ineffective, or contraindicated
- For chronic pain if all other pharmacologic and nonpharmacologic approaches have failed or there are medical contraindications to non-opioid analgesics
- For pain related to cancer or other advanced illnesses in those near end-of-life

Opioid Analgesics: Mechanisms in Pain Relief

- Bind µ-opioid receptors in the periaqueductal gray region and the rostroventral medulla of the brain
- Increase descending inhibitory signals that modulate incoming pain signals

Available Opioid Medications (Examples)

- Buprenorphine
  - Buccal film (Belbuca)
  - Transdermal system (Butrans)
- Fentanyl transdermal system* (Duragesic)
- Hydrocodone bitartrate
  - ER tablets (Hydrogels)
  - ER capsules (Zohydro)
- Hydromorphone HCI
  - ER tablets (Kadian)
- Methadone HCl
  - Tablets (Dolophine)
  - Oral concentrate* 
- Morphine sulfate
  - CR tablets (MS Contin)
  - ER tablets* (Arymo, MorphaBond)
  - ER capsules* (Aveco, Kadian)
- Morphine sulfate/naltrexone (Embeda)*
- Oxycodone
  - CR tablets (OxyContin)*
  - ER capsules (Xtampza)*
- Oxymorphone HCl ER tablets (Opana)
- Tramadol,* tramadol ER* (Ultram, Ultram ER, Conzip)

*Available as generic. 
†Abuse-deterrent formulation (ADF)
Opioid Drug Interactions

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Possible Effect</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNS suppressants</td>
<td>• Potentiation of opioid-induced sedation and respiratory depression</td>
<td>• Alcohol</td>
</tr>
<tr>
<td></td>
<td>• Increase in respiratory depression</td>
<td>• Benzodiazepines</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors</td>
<td>• Serotonin syndrome</td>
<td></td>
</tr>
<tr>
<td>Cardiac glycosides</td>
<td>• Reduction in cardiac output via inhibition of antidiuretic hormone</td>
<td>• Digoxin</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>• Increase or decrease in systemic opioid levels</td>
<td>• Amantadine</td>
</tr>
<tr>
<td>Selective serotonin</td>
<td>• Suppression of CYP-2D6 metabolism of opioid (eg, hydrocodone) and reducing pain</td>
<td>• Clonidine</td>
</tr>
<tr>
<td>inhibitors (SSRIs)</td>
<td></td>
<td>• Methadone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Naltrexone</td>
</tr>
</tbody>
</table>

Long-Acting Opioids: Special Concerns

- Greater risk than short-acting opioids for overdose and abuse
- Oral tablets/capsules should not be broken, crushed, chewed or snorted; patches should not be cut or torn prior to use
  - May lead to rapid release and overdose/death
- If patient cannot swallow a capsule whole, refer to package insert to determine if the contents can be sprinkled on applesauce or given via feeding tube

Opioid Analgesics: General Precautions

- Common side effects of opioids: sedation, dizziness, nausea, vomiting, constipation, respiratory depression, physical dependence, tolerance, withdrawal
- Risks of misuse, abuse, opioid use disorder (OUD), overdose, death even at prescribed doses
- Consult prescription drug monitoring program (PDMP) before deciding to prescribe opioids
- Consider OUD criteria (DSM-5) and concepts of abuse vs. misuse
- Consider concepts of tolerance vs physiological dependence vs OUD (addiction)
- Prolonged use/OUD has a direct relationship to duration of initial prescription

Long-term Medical Effects of Opioid Use

- Depression
- Hallucinations
- Confusion
- Drowsiness
- Dizziness
- Headache
- Seizures
- Nausea/vomiting
- Constipation
- Reduced liver function
- Arrhythmia
- Infection
- Hyperhidrosis
- Hives/rash
- Mood swings
- Dependence
- Tolerance
- Addiction
- Muscle weakness
- Edema
- Slowed breathing
- Difficulty breathing
- Falls and fractures
- Hepatitis
- HIV/AIDS

Faculty Discussion

Opioid Pain Management – Considerations for Special Populations

- Possible pregnancy/pregnancy/post-partum
- Patients with renal or hepatic impairment
- Children and adolescents
- Older adults
- Patients with sleep disorders
- Patients with psychiatric disorders
- Opioid-tolerant patients

Before Initiating Opioid Therapy

- Perform a comprehensive assessment and document it
- Establish an appropriate physical diagnosis (and obtain psychological diagnosis, if available). Consider imaging, physical diagnosis and psychological status, as appropriate, to corroborate subjective complaints
- Establish medical necessity based on average score indicating moderate to severe pain (4 - 6 on a scale of 0 -10), disability, functional impairment
Before Initiating Opioid Therapy

- Check the PDMP
- Consider/Obtain baseline and periodic urine drug testing (UDT)
- Establish treatment goals including pain relief and improvement in function
- Educate patients and caregiver on efficacy and risks/adverse events
- Obtain a robust opioid agreement to be followed by all parties (clinician-patient-caregiver)

Initiating Opioid Treatment

- Start with short-acting drugs
  - Short course (3-7 days) for acute pain
- Recommend long-acting or high-dose opioids only in specific circumstances with severe intractable pain in patients who are not opioid naïve
- Prescribe the lowest effective dose
  - Low dose: <40 MME
  - Moderate dose: 41-90 MME
  - High dose: >91 MME
- Titrate gradually to achieve best efficacy with few or no side effects
- Evaluate benefits and harms within 1-4 weeks of opioid initiation or dose escalation
- Re-evaluate benefits and harms every 3 months
  - If benefits do not outweigh harms, optimize other pain therapies and taper/discontinue

Key Safety Strategies

- Dosing instructions (with daily maximum)
- Concurrent drug or alcohol use
- Age-related dose reductions
- Naloxone products for home use
- Safe storage: inaccessible by children, friends, family members
- Intervention strategies for accidental poisoning vs. overdose (intentional harm vs. recreational use)
- Proper disposal
Naloxone Guidance

Clinicians should co-prescribe naloxone to individuals at risk for opioid overdose, including but not limited to:

- Those on relatively high doses of opioids
- Those who take other medications that enhance opioid complications
- Those with underlying health conditions


Case 1: Elise

(Case information located in your handouts)
Case 1: Elise

Patient Findings
• 26-year-old female
• Distal left radius fracture sustained in a fall, non-displaced, casted in the ED

Patient History
• No prior fractures or serious injuries
• “Sprained ankle” 3 years ago, no medical treatment sought (treated with OTC pain relievers)
• Overall excellent physical health

Case 1: Elise

Work with your table as a team to address the following:
1. Assessment of pain
2. Goals of pain treatment
3. Pain treatment plan
4. Follow-up

Case 1: Elise

Share your thoughts!
Case 1: Elise

Considerations for this case:
1. What tool(s) would you use to assess pain?
2. What is the goal for pain management?
3. What interventions would you consider for pain management?
   - Nonpharmacologic
   - Pharmacologic: Nonopioid? Opioid?
4. Should you assess the patient for risk of opioid use disorder?
5. Should you consult the PDMP?
6. Do you need a PPA?
7. What alterations might you make if initial interventions did not effectively manage her pain?
8. What challenges do you anticipate? How would you manage them?

Case 2: Ron

Patient Findings
- 56-year-old male
- Presents to the hospital with acute pain related to multiple rib fractures sustained in a motor vehicle collision
- Difficulty taking deep breaths and walking due to pain
- History:
  - CAD treated with stents
  - HTN (148/94 mm Hg), type 2 diabetes and reduced kidney function (GFR = 60 mL/1.73 m²)
  - Current medications: clopidogrel, lisinopril, atenolol, and metformin
- Not a good candidate for regional analgesic approaches due to clopidogrel
- Not a good candidate for NSAIDs due to HTN and reduced GFR
- No history of opioid abuse
Case 2: Ron

Work with your table as a team to address the following:

1. Assessment of pain
2. Goals of pain treatment
3. Pain treatment plan
4. Follow-up

Case 2: Ron

Share your thoughts!

Case 2: Ron

Considerations for this case:

1. What tool(s) would you use to assess pain?
2. What is the goal for pain management?
3. What interventions would you consider for pain management?
   • Nonpharmacologic
   • Pharmacologic: Nonopioid? Opioid?
4. Should you assess the patient for risk of opioid use disorder?
5. Should you consult the PDMP?
6. Do you need a PPA?
7. What alterations might you make if initial interventions did not effectively manage her pain?
8. What challenges do you anticipate? How would you manage them?
Conclusions / Key Takeaways

• Many minor, acute pain conditions can be successfully managed with nonpharmacologic and/or non-opioid pharmacologic approaches
• Opioids remain useful tools when acute pain is not responsive to other therapies, but should be used when indicated for the shortest period of time necessary
• Opioids can be used to manage chronic pain that is not responsive to other therapies or when other therapies are contraindicated
• All opioids have side effects that range from constipation to respiratory depression and death
• Increased risk for long-term use of opioids is directly related to the duration of the initial prescription

Please complete your exit ticket...

...and place it in the center of your table
Case 1: Carla – Acute Pain

- 26-year-old female with left radius fracture after a fall
- Initial treatment plan
  - Goal: relief of acute pain + sufficient pain control to permit sleep and normal ADL
  - Treatment selection: IV or oral ketorolac in the ED, ketorolac 10 mg PO QID for five days followed by naproxen 375 mg PO BID PRN
  - Review efficacy during orthopedic surgery office visit in 2 days for cast evaluation
  - Elevate the extremity, consider using intermittent ice for the first 48 hours
  - Provide educational material about expected healing process following fracture to reduce anxiety
Case 1: Carla – Current Status

- 2 days post-fracture
- Patient feedback
  - Moderate to severe pain (7/10) despite ongoing naproxen treatment
  - Difficulty participating in physical therapy
- Physical exam shows swelling, local pain

Acute Pain: When Opioid Treatment Is Appropriate (and When It Is Not)

- Medical necessity of acute pain treatment
  - Allows the patient to meet functional goals of care
  - Facilitates recovery
- Physical examination consistent with limitation of movement due to pain inadequately controlled with non-opioid options
- Failure or contraindication of non-opioid (eg, regional block, epidural, etc.) and nonpharmacologic options
- General principle: Listen to your patient, follow the examination and exhaust all practical non-opioid approaches first
Guidance for Use of Opioids for Acute Pain

- Check the prescription drug monitoring program (PDMP)
- Discuss benefits and risks of opioid use with the patient
- Choose from immediate-release opioids
  - Morphine immediate-release
  - Codeine
  - Oxycodone +/− APAP
  - Hydromorphone
- Prescribe the lowest effective dose, with no greater quantity than needed for the expected duration of severe pain requiring opioids
- ≤ 3 days is sufficient; > 7 days will rarely be needed

Case 2: Mr. Coles – Chronic Pain

- Mr. Coles is a 55-year-old male referred by his PCP for chronic rectal pain secondary to Crohn’s disease and complicated by several painful surgeries.
- He reports moderate-to-severe (7/10) pain, inability to work effectively as a data manager and pain that awakens him from sleep several times a night. He says he is desperate for any relief.
- He has tried multiple pain medications over the past year, including naproxen, acetaminophen, and gabapentin, without success. His gastroenterologist has maximized his Crohn’s disease medications.

- Physical examination reveals he is unable to stay in a seated position for even a short time, with constant grimacing.
- As the encounter progresses, the patient becomes tearful and distraught. He reports significant anxiety due to constant pain and poor quality of life.
- The PDMP reveals a remote history of a short course of tramadol, likely postsurgical.
Case 2: Mr. Coles – Considering Opioids for Chronic Pain

- Assessment of the patient’s pain, function and quality of life prior to prescribing opioids
- Assess baseline risk of opioid misuse (e.g., using SOAPP, ORT or other screening tools)
- Determine if potential benefits of opioid analgesics outweigh potential risks (side effects, misuse, dependence/addiction)


ORT: Mr. Coles’ Score = 1

After a detailed conversation with the patient about the risks and benefits of opioid therapy, which of the following would be the MOST appropriate next step?

- Attempt to convince the patient that opioids have no role in his type of pain
- Refer to a pain psychologist for further risk stratification
- Offer a short-acting opioid trial for one month
- Offer a long-acting opioid trial for three months
- Agree to start short-term opioid therapy but not on the first visit
Faculty Discussion

• After a detailed conversation with the patient about the risks and benefits of opioid therapy, which would be the MOST appropriate next step?

Universal Precautions in Chronic Pain Management

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess patient's risk for aberrant behaviors relating to an opioid prescription (ie, signs of misuse, abuse or diversion)</td>
<td>Consider using the ORT or the SOAPP-R</td>
<td>Assess the patient for psychological disorders, which may increase risks of opioid therapy</td>
<td>Consider using the Patient Health Questionnaire 2 (PHQ-2) to assess depression</td>
</tr>
<tr>
<td>Conduct regular urine drug testing in the context of abnormal laboratory values</td>
<td>Consult labelling for the selected medication</td>
<td>Conduct regular baseline urine drug testing to assess for the presence of prescribed or illicit substances</td>
<td>Consult labelling for the selected medication</td>
</tr>
<tr>
<td>Conduct regular urine drug testing in the context of abnormal laboratory values</td>
<td>Review your state's PDMP (if available) to document patient's history of prescriptions for controlled substances</td>
<td>Conduct regular baseline urine drug testing to assess for the presence of prescribed or illicit substances</td>
<td>Review your state's PDMP (if available) to document patient's history of prescriptions for controlled substances</td>
</tr>
<tr>
<td>Conduct regular urine drug testing in the context of abnormal laboratory values</td>
<td>Conduct regular baseline urine drug testing to assess for the presence of prescribed or illicit substances</td>
<td>Conduct regular urine drug testing in the context of abnormal laboratory values</td>
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</tr>
<tr>
<td>Conduct regular urine drug testing in the context of abnormal laboratory values</td>
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<td>Conduct regular baseline urine drug testing to assess for the presence of prescribed or illicit substances</td>
</tr>
</tbody>
</table>

Case 2 (Chronic Pain: Mr. Coles’ Follow-up)

• Mr. Coles is in the office for a regularly scheduled follow-up.
  • He states that he has been tolerating short-acting opioid therapy (oxycodone 5mg TID) well for the last 6 months and reports that his pain is a “5/10.”
  • However, for the last 2 months, he has been requesting early refills.
  • He also reports significant stressors at work requiring more frequent use of his pain medication.
  • The PDMP demonstrates no suspicious activity.
Management of Worsening Pain

*Before changing the regimen*

- Determine whether there is a change in the underlying condition
- Check adherence using the PDMP and questioning patient about their pattern of opioid use
- Screen for signs of OUD

---

**DSM-5 Criteria for OUD: Mr. Coles**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Number Met</th>
<th>Total Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids are often taken in larger amounts or for a longer period than was intended</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>There is a persistent desire to cut down or control opioid use</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>A great deal of time is spent obtaining opioids, using, or recovering from their effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craving, or a strong desire or urge to use opioids</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Recurrent opioid use resulting in failure to fulfill role obligations at work, school, or home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent use while unemployed or in a prescribed situation (eg, medical treatment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent use in situations in which it is physically hazardous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhibits tolerance*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhibits withdrawal*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total checked: 6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If OUD is diagnosed (³2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe (³6 criteria met).
Management of Worsening Pain (Continued)

• Consider switching medications
  – Consider opioid-induced hyperalgesia
  – Remember there is incomplete cross-tolerance when switching to another opioid
  – Consider use (and limitations) of conversion and equianalgesic dosing tables

Faculty Discussion

• When might you consider switching medications?

Switching Opioid Treatment: Equianalgesic Dosing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equianalgesic Doses (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parenteral</td>
</tr>
<tr>
<td>Meperidine</td>
<td>10</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>6.3</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>100</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>50</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>10-75</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>100</td>
</tr>
<tr>
<td>Oxycodeine</td>
<td>10</td>
</tr>
<tr>
<td>Morphine</td>
<td>10</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>50</td>
</tr>
</tbody>
</table>

5-Step Conversion Chart Process

1. Globally assess the patient’s pain complaint.
2. Determine the total daily dose of current long- and short-acting opioids.
3. Decide which opioid agonist will be used as the new agent, then refer to established conversion tables to determine the new dose.
4. Individualize the dose based on patient assessment information gathered in step 1.
5. Continuously reassess patient for 7–14 days after the initial new dose.
Equianalgesic Dosing and Conversion Tables: Limitations

- Multiple versions
- Online calculators, e.g., https://opioidcalculator.practicalpainmanagement.com
- High variability
- Starting point for drug rotation
- Use with caution
- Consult drug PIs

Choosing the Dose of the New Opioid

- Calculate equianalgesic dose of new opioid from EDT
- Reduce calculated equianalgesic dose
  - Generally: 25–50% reduction
  - Methadone: 75–90% reduction
  - Use clinical judgment

Case 2: Mr. Coles – Follow-up Visit

- After improvement following oxycodone dose escalation (increase from 5 mg TID to 10 mg TID) two months ago, Mr. Coles presents for an early follow-up visit.
- He states he was recently seen in an urgent care facility for worsening rectal pain. He says he went there because he ran out of medications early, because the pain was unbearable.
- He describes his pain as a “constant 9/10” despite the increased dose.
- He has also added neuropathic agents at their highest recommended dose but says that did not improve the pain.
**Case 2: Mr. Coles – When to Discontinue Opioids**

- Have a frank discussion about the aberrant opioid use
- Discuss treatment goals
  - Pain relief or more pills?
- Discuss the lack of benefit despite increased opioid dose
- Outline your intent to discontinue opioid therapy
  - Determine strategies for tapering by mutual cooperation and level of comfort
  - Clarify that you are not discharging him but will be using non-opioid for pain control in the future
  - Reassure him that you will continue to manage his pain without opioids

---

**When to Taper Opioids**

- Patient requests dosage reduction
- Patient does not have clinically meaningful improvement in pain and function
- Patient is on dosages ≥ 50 MME/day without benefit or opioids are combined with benzodiazepines
- Patient shows signs of substance use disorder
- Patient experiences overdose or other serious adverse event
- Patient shows early warning signs for overdose risk, such as confusion, sedation or slurred speech

---

**How to Taper Opioids***

- **Go Slow**: A decrease of 10% of the original dose per week is a reasonable starting point
  - Patients who have taken opioids for a long time may need to taper more slowly
- **Consult**: Coordinate with specialists and treatment experts, as needed
  - Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal
- **Support**: Refer patients to appropriate psychosocial support
  - If needed, work with mental health provider, arrange for treatment of opioid use disorder, offer resources for overdose prevention
- **Encourage**: Tell patients that most people have improved function without worse pain after tapering opioids; some even have improved pain after a taper (though pain might briefly get worse at first). Tell patients “I know you can do this.”

*Tapering plans should be individualized and should mimic the symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacological interventions and nonopioid medications.

---

Case 3: James H. – “Legacy” Patient

• James presents to establish care with your practice through a referral from his PCP who no longer wishes to prescribe opioids in his practice due to new state regulations.
• Chief complaint is chronic low back pain.
• History includes multiple spinal surgeries.
• Recent surgical consultation suggests nothing further can be done surgically.

Case 3: James H. – “Legacy” Patient (Continued)

• He describes his pain as 8/10 globally, stating that “everything hurts, all the time.” He says that his opioid regimen is “the only thing that allows me to function” and that he has been on opioids for many years.
• Current regimen:
  – Transdermal fentanyl 75 mcg q 48h
  – Oxycodone 25 mg QID
  – Gabapentin 600 mg TID
  – Alprazolam 1 mg BID
  – Trazadone 100 mg QHS for sleep

What is the MOST appropriate next step in your treatment of this patient?

- Refuse to accept him as a patient.
- Maintain his current opioid dose.
- Taper opioids to FDA dosing recommendations.
- Develop a treatment plan in collaboration with the patient and referring provider.
- Refer to an addiction medicine specialist.
What to Do with “Legacy” Patients

- Listen to the patient’s entire story first to learn what they hope to gain from your care. Often (but not always) their hope is that you will maintain their current treatment plan.
- Determine if the treatment is effective.
- Focus the conversation on risks, known systemic and endocrine side effects, known pharmacology, and lack of true efficacy.
- Explain how our understanding of the risks associated with chronic opioid therapy have changed in recent years.

What to Do with “Legacy” Patients (continued)

- When the treatment is ineffective or inappropriate, explain that
  - Their current regimen is not an approach you use or recommend,
  - You are not willing to continue, along with the reasons why
- Outline your recommended short-term and medium-term treatment approach.
- Remember that referral by the prescribing PCP does not mean you have to endorse the therapy or take over prescription writing.
  - The original prescriber is obligated to maintain or safely taper their patient off opioids if they choose to no longer prescribe them.

Managing Opioid Use Disorder (continued)

- Detox with withdrawal management
  - Inpatient vs. outpatient
- Moderate-to-severe OUD: consider inpatient stabilization and involvement of a specialist in addiction medicine
- Severe OUD: consider medication assisted therapy (MAT)
  - Can be implemented in outpatient settings
  - AAP offers eight-hour MAT course
  - MAT maintenance produces better outcomes than detox alone

Deciding on Treatment Options

- Consider patient preferences, past treatment history, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone in the treatment of addiction involving opioid use.

- Use shared decision making.

- Setting is as important as the medication selected:
  - Intensive outpatient
  - Partial hospitalization within a specialty addiction treatment facility, community mental health center, or similar setting
  - Residential treatment facility or hospital


Managing Opioid Use Disorder: Medication Assistance Therapy (MAT)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Naltrexone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class/Mechanism</td>
<td>Agonist (fully activates opioid receptors)</td>
<td>Partial agonist</td>
<td>Antagonist</td>
</tr>
<tr>
<td>Brand Names</td>
<td>Dolophine, Methadose</td>
<td>Subutex, Suboxone, Zubsolv</td>
<td>Depade, ReVia, Vivitrol</td>
</tr>
<tr>
<td>Administration</td>
<td>Oral or injection</td>
<td>Oral or sublingual</td>
<td>Oral</td>
</tr>
<tr>
<td>Effects</td>
<td>Reduces cravings and withdrawal symptoms</td>
<td>Relieves cravings and withdrawal symptoms</td>
<td>Diminishes the reinforcing effects of opioids</td>
</tr>
<tr>
<td>Advantages</td>
<td>High strength and efficacy as long as oral dosing</td>
<td>Good option for patients who have no response to other medications</td>
<td>Eligible to be prescribed by certified physicians (increases availability/eliminates need to visit specialized treatment centers)</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>Mostly available through approved outpatient treatment programs</td>
<td>Subutex: measurable abuse liability (Suboxone diminishes the risk by including naloxone to induce withdrawal if the drug is injected)</td>
<td>Poor patient compliance (but Vivitrol should improve)</td>
</tr>
</tbody>
</table>

Efficacy of MAT Interventions

Long-term follow-up of patients treated with buprenorphine/naloxone for addiction to opioid analgesics

- At 18 months:
  - 50% reported abstinence
- At 42 months (3.5 years):
  - 61% reported abstinence
  - < 10% met diagnostic criteria for dependence on opioids
When to Consider Referral to a Substance Abuse Specialist

- Patient is using 80 to 100 MME
- Patient is using multiple sedatives (e.g., benzodiazepines, muscle relaxants, anticonvulsant agents)
- Patient continually requires more opioids (verbal requests, early refills, emergency room visits)
- Patient is using non-authorized substances (illegal or non-prescribed drugs detected in urine)
- Patient is abusing or misusing the pain treatment regimen (as indicated by sedation, reduced functioning, third-party reports, missed appointments)
- Patient refuses nonopioid measures or reduction of opioid dosage

Conclusions: Key Takeaways

- Opioid therapy is often unnecessary for managing acute pain.
- Initiation of opioid therapy for patients with chronic pain should be a deliberate and well-informed choice.
- As part of informed consent or a PPA, discuss pain management goals, functional goals, the length of opioid trial, and the plan for discontinuation.
- Monitor response to opioid treatment
- Monitor for signs of OUD
- When OUD treatment is needed, tailor it to patients’ specific needs and/or refer to a specialist in addiction medicine

Please complete your exit ticket...

...and place it in the center of your table
The Importance of Patient Education

Samer Narouze, MD, PhD

Pretest 7. Which of the following tools for assessing risk of opioid abuse was developed specifically for adolescent use?

- COMM
- CRAFFT
- DSM-5 Checklist
- SOAPP-R

Pretest 8. Which of the following medications for treatment of opioid use disorder works by diminishing the reinforcing effects of opioids?

- Naltrexone
- Methadone
- Ketamine
- Buprenorphine
Case Scenario: Kayla

Your patient is a 16-year-old female who presents to your office with left ankle pain. About three months ago, she fractured her medial malleolus while playing in a high school softball game. She was casted in the ED for pain management, she was advised to elevate the foot and was given acetaminophen. The cast was removed at six weeks, but the pain continued.
Patient Name: Kayla C.
Date: 03-18-19

Opioid Risk Tool

Scoring:
- 3: low risk
- 4–7: moderate risk
- 8+: high risk

Do you think this teen is at risk for developing opioid use disorder?

Yes
No
Possibly

Sedation-related questions (please answer truthfully)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Possibly</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of substance abuse</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family history of addiction</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Age 12 or younger</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Age 13–17 years</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Age 18–24 years</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>History of an arrest</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>History of a treatment for opioid use disorder</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Opioid use at any point</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Antidepressant use</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Antianxiety use at any point</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Antipsychotic use</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Prescribed opioids</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Prescribed benzodiazepines</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Prescribed stimulants</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Scoring: 4–7: moderate risk; 8+: high risk
Educating Patients About Opioid Use:

**Key Topics to Cover**

- Use medications exactly as prescribed
- Use smallest dose necessary for shortest amount of time
- Common side effects
- Risks of addiction and serious/deadly adverse events
- Known risk factors for serious adverse events
- Handling missed doses
- Importance of disclosing all medications to all HCPs
- Risks of use with alcohol, benzodiazepines, other opioids
- Product/drug delivery-specific directions: what NOT to do
- Never share (and why)
- Risk of theft
- Safe storage and disposal
- Tapering to avoid withdrawal
- How/when to use naloxone
- When to seek emergency treatment

FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain. Published September 2018.
Naloxone Guidance

• Clinicians should co-prescribe naloxone to individuals at risk for opioid overdose, including but not limited to:
  – Those on relatively high doses of opioids,
  – Those who take other medications that enhance opioid complications,
  – Those with underlying health conditions.

Practice Changes to Protect our Patients: Overdose Prevention and Reversal

- Specific strategies for poisoning vs. intentional harm vs. recreational use
  - Awareness of potential for accidental exposure and overdose in children ages 0-5 years
  - Increased availability of naloxone

San Francisco Department of Public Health. Opioid safety and how to use naloxone: a guide for patients and caregivers.

Practice Changes to Protect Our Patients: Disposal

- Include disposal instructions at discharge
- Advise storage in locked cabinets
- Provide educational material about local disposal resources
- Organize/incentivize disposal at the main hospital, satellites
- Establish public/private partnerships
- Identify state/county/city/suburb-level disposal locations

Follow-up call
One year later

- Kayla sustains another injury to her ankle
- X-ray showed no signs of fracture
- Splinted and sent home with acetaminophen
- 2 weeks post-injury, pain is 9/10
- Physical exam is positive for point tenderness over the lateral malleolus
- Asking for same pain medication as last year
- ORT score still = 1, but PDMP shows that she received 3 other opioid prescriptions in the past few months

Visit one year later
Warning Signs of OUD

- Frequent requests for opioid medication
- Requesting a particular medication by name
- Pain out of proportion to mechanism of injury and physical exam findings
- Decrease in functioning (eg, school, work)
- Missing school or work
- Suspension from school or job loss due to drug-related activity
- Withdrawal from social and recreational activities
- Avoiding friends or family
- Changes in behavior or mood
- Financial problems
- Bad or reckless decisions
- Avoiding friends and family

DSM-5 Criteria for OUD: Kayla

Check all that apply

- C1. Opioids are often taken in larger amounts or over a longer period than was intended
- C2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use
- C3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects
- C4. Craving or a strong desire or urge to use opioids
- C5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home
- C6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
- C7. Continued opioid use despite being aware of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the effects of opioids
- C8. Exhibits tolerance*
- C9. Exhibits withdrawal*

Total checked: 4

If OUD is diagnosed (³ 2 criteria met), assess severity as mild (2-3 criteria met), moderate (4-5 criteria met) or severe (³ 6 criteria met).
Starting the Conversation About Ending Opioids

- Best approach: frank and direct conversation about the facts
- Discuss opioid-abuse behaviors in a nonjudgmental manner
- Focus on the behaviors that make you concerned
- Reiterate PPA policies
- Focus on patient safety and reiterate long-term effects of opioid medications
- Identify practical solutions

Managing Opioid Use Disorder

- Detox with withdrawal management
  - Inpatient vs. outpatient
- Moderate to severe OUD: consider inpatient stabilization and involvement of addiction specialist
- Severe OUD: Medication assisted therapy (MAT)

What’s next for cases like Kayla’s?

- Develop a patient-provider agreement
- Switch patient to non-opioid pain management
- Try cognitive behavioral therapy to try to reduce pain
- Work closely with the pediatrician

Summary / Key Takeaways

- Patient/caregiver education is a critical aspect of opioid pain management to ensure adherence and reduce risks of opioid misuse and abuse
  - Patients and caregivers need to understand how to use, store and dispose of opioid analgesics
  - Patients and caregivers need to know how and when to use naloxone
- Patients and caregivers need to understand the benefits and risks of opioid pain management
- Clinicians who prescribe opioids for pain management need to know
  - Warning signs of OUD
  - When and how to taper opioids safely
  - How to treat OUD or when to refer to a substance abuse specialist

Please complete your exit ticket...

...and place it in the center of your table

What’s left to claim your credit?

1. Answer 8 posttest questions
2. Create an Action Plan
3. Complete the Paper Evaluation
Posttest 1. Which of the following BEST describes neuropathic pain?

- Pain that is self-limited and associated with sympathetic nervous system activation
- Pain that persists after all tissue healing is complete
- Severe pain reported in response to a normally mildly painful stimulus (e.g., a pin prick)
- Pain reported directly in an area of recent tissue injury (e.g., pain at the site of a new surgical incision)

Posttest 2. Which term is defined by "impaired control over drug use, compulsive use, continued use despite harm, and/or craving"?

- Physical dependence
- Addiction
- Misuse
- Abuse

Posttest 3. Which of the following is the BEST reason for educating patients about never breaking, chewing, or crushing an oral long-acting or extended-release opioid?

- It will increase first pass liver metabolism, leading to lower blood levels
- It is required by FDA labeling
- It increases the potential for abuse
- It may lead to rapid release of the opioid and to overdose or death
Pretest 4.
A 66-year-old, retired engineer with a history of HTN, CAD, CHF and progressive renal insufficiency has severe ongoing right hip pain due to severe acetabulo femoral arthritis. He is not considered a surgical candidate due to his renal and cardiovascular disease. He is requesting help with pain control so that he can participate in aquatherapy and try to improve his overall level of function.

Posttest 4. Which of the following medications is MOST likely to allow him to achieve this goal?

- Gabapentin
- Celecoxib
- Oxycodone
- Nortriptyline

Posttest 5. When switching from another opioid to methadone, by how much should the calculated equianalgesic dose of methadone be reduced?

- 75-90%
- 50-75%
- 25-50%
- 0% (conversion tables account for incomplete cross-tolerance)
Posttest 6. Which of the following is NOT one of the CDC’s four recommended steps in tapering opioids?

- Go Slow: For many patients a decrease of 10% of the original dose per week is reasonable.
- Consult: Coordinate with specialists and treatment experts as needed.
- Support: Make sure patients receive appropriate psychosocial support.
- Discourage: Advise patients not to deviate from the tapering regimen due to increased overdose risk.

Posttest 7. Which of the following tools for assessing risk of opioid abuse was developed specifically for adolescent use?

- COMM
- CRAFFT
- DSM-5 Checklist
- SOAPP-R

Posttest 8. Which of the following medications for treatment of opioid use disorder works by diminishing the reinforcing effects of opioids?

- Naltrexone
- Methadone
- Ketamine
- Buprenorphine
How to develop an ACTION PLAN

Creating a “SMART” Action Plan:
Decide on One Specific Performance or System Gap You’d Like to Change

- Describe your goal clearly
- How will you evaluate whether your goal is met?
- Is this goal achievable in your current environment?
- How will achieving your goal improve patient care?
- When can your goal be achieved?

What are the first steps you will take?

- Step 1:
- Step 2:
- Step 3:

Take a few moments to create a plan
Access the Action Plan on your phone by typing in the link below…

www.REMSactionplan.com/WSA

OR

…using the QR code located in your handouts

Questions?

Please complete your evaluation!

All credit claiming instructions are located in your handouts. Your credit will be available to claim as of 9/8/19.