CCNC Opioid SPARC ECHO

High-Dose Opioid Management

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High Dose??

➢ CDC guidelines
  o #5, Use lowest possible dose, determine cost/benefit if >50 MME and avoid >90 MME
  o Level 3 data, observational studies

➢ Pain patient study
  o 80% of death is >100MME

➢ NC data 2010
  o No change in curve after 100MME

CDC 2016, Dasgupta 2010
Why Not High Dose?

- Death
- Diversion
- SUD vs. Misuse
- Side effects
  - Constipation
  - Hormonal dysregulation
  - Immunologic dysregulation
  - Sedation
  - Stimulation
  - OIH
- Tolerance
Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use Among Past Year Users Aged 12 or Older: 2010

Source Where Respondent Obtained

- One Doctor (79.4%)
- More than One Doctor (2.1%)
- Bought/Took from Friend/Relative (16.2%)
- Drug Dealer/Stranger (4.4%)
- Bought on Internet (0.4%)
- Other\(^1\) (4.6%)

Source Where Friend/Relative Obtained

- One Doctor (3.6%)
- More than One Doctor (6.3%)
- Bought/Took from Friend/Relative (6.5%)
- Drug Dealer/Stranger (2.3%)
- Bought on Internet (0.2%)
- Other\(^1\) (1.7%)

Source: NSDUH 2010

\(^1\)The Other category includes the sources "Wrote Fake Prescription," "Stole from Doctor’s Office/Clinic/Hospital/Pharmacy," and "Some Other Way."
Substance Use Disorder (SUD)

- Rate in pain “last year” for 2016, SAMHSA
  - 7.5% of population with SUD (20.1 million)
    - 75% with ETOH
    - 37% with illicit drug
    - 12% with both
- Rate in Pain and Primary Care
  - 8% - 12% (Systematic review from 38 studies, with 26% primary care settings, 53% pain clinics)
- Chronic pain in opioid addiction is 29% to 60%

Substance Related Disorders

➢ Pharmacological indicators
  o Tolerance
  o Withdrawal

➢ Impaired control
  o Greater amount and longer use
  o Unable to quit
  o Time to obtain extensive
  o Craving

➢ Social impairment
  o Role failure
  o Use with known social harm
  o Social loss due to use

➢ Risky use
  o Use in spite of physical danger
  o Use with continued psych/social harm

Severity score:
- Mild (2-3)
- Moderate (4-5)
- Severe (6 and more)
Opioid Misuse

➢ Rate in pain last year for 2016, SAMHSA
  o 4.4% of population (11.8 mil)
    • No change from 2009-2016
  o 80% say that their misuse is for pain, tension, sleep, or mood
  o 12% say they use to “get high” or “feel good”

➢ Rate in Pain and Primary Care
  o 21% - 29% (Systematic review from 38 studies, with 26% primary care settings, 53% pain clinics)

➢ Misuse is not SUD

2017 NSDUH Report, Vowles 2015
High-Dose Opioid Management

First things to do:

- Avoid getting there
  - Treatment based on function, not pain score
  - Realistic expectations
    - 30% - 50% max relief
  - Interventional options
  - Adjunctive meds
  - Opioid rotation
    - Early and repeatedly
    - Use for MME reduction
Pharmacologic Treatments

Alpha-2-delta ligands, SNRI’S, tricyclics, beta-blockers, antidepressants
NE agents, etc. Tramadol, Tapentadol
Avoid opioids in Migraine and Fibromyalgia

<table>
<thead>
<tr>
<th>NSAIDS</th>
<th>Alpha-2-delta ligands</th>
</tr>
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<tbody>
<tr>
<td>oral Topical</td>
<td>SNRI’s</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>Tricyclics</td>
</tr>
<tr>
<td>Tramadol</td>
<td>Anticonvulsants</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>NMDA antagonists</td>
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<tr>
<td>Opioids last option</td>
<td>Etc</td>
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</tbody>
</table>

Avoid opioids in Migraine and Fibromyalgia
Overlapping Pathophysiology

- Fibromyalgia • Irritable Bowel Syndrome • Functional Dyspepsia • Interstitial Cystitis • Neck & Back Pain (without structural pathology) • Myofascial Pain (TMJ) • Pelvic Pain Syndrome • Restless Leg Syndrome • Headaches • Complex Regional Pain Syndrome

- Osteoarthritis
- Rheumatoid Arthritis
- Tendonitis, Bursitis
- Ankylosing Spondilitis
- Gout
- Inflammatory Myositis
- Sjogren’s Syndrome
- Cushing’s Disease
- Tumor-related nociceptive pain
- Neck & Back Pain with structural pathology
- Sickle-cell Disease
- Inflammatory Bowel Disease

- Postherpetic neuralgia
- Diabetic Peripheral Neuropathy
- Sciatica / Stenosis
- Entrapment Syndromes
- Spinal Cord Injury Pain
- Tumor-related neuropathy
- Chemotherapy-induced neuropathy
- Small fiber neuropathy
- Post-Stroke Pain
- MS Pain

High-Dose Opioid Management

- If you are there, what do you do?
  - Reevaluate repeatedly
    - Mood, pain, SUD, function, UDS, CSRS, etc.
  - Functional assessment of all medication
    - What used for, including side effects
  - Trials of medication reduction
    - Opioids, benzos, etc.
  - Misuse of meds as cues to functional need
    - Treat more directly the functional need they tx’ed
    - Misuse is not SUD
- Be aware of atypical effects of meds
Unexpected Medication Responses

- Beneficial for symptoms, deleterious for function
  - Adjunctives
    - AED’s, muscle relaxants, AD’s, etc.
  - Opioids
  - Benzodiazepines

- Atypical medication reactions
  - Expect sedation, get stimulation
    - Opioids, topiramate, pregabalin, benzodiazepines, etc.
  - Expect stimulation, get sedation
    - Stimulants, NE agents, etc.

- Generic medication changes
Opioid Stimulation Syndrome
Opioid Induced Somatic Activation

- Somatic and cognitive activation
  - Increased talking
  - Sleep disturbance
    - Sedative use/overuse
  - Irritability
    - Discharge from clinic
    - Irritable mania possible
  - Impulsivity
    - Medication misuse
  - Addiction
  - Opioid induced hyperalgesia?
Opioid Stimulation Syndrome

Does it exist?
- Duke Pain HU study, N=570, top and bottom 100 of the cohort
- Overall average of 5 opioid trials per patient
- 48% at least 1 opioid stimulating
- 62% at least 1 opioid sedating
- Oxycodone 24% stim vs MS 9% stim

What is the etiology
- Mu receptor
- Glial cell
- Unknown

Influence on addiction

Influence on OIH
Stimulation from Opioids

- Oxycodone
- Hydrocodone
- Fentanyl
- Buprenorphine
- Tapentadol (Nucynta)
- Tramadol (Ultram)
- Oxymorphone
- Morphine
- Hydromorphone
- Methadone

Most Stimulating

Most Sedating
Opioid Misuse Scenarios; “Short”

Patient short on medication, again!

➢ Curious as to why, when, how much, etc.

➢ Most common reasons (decreasing order)
  o Pain control
  o Impulsivity
  o Poor memory
  o Selling

➢ Intervention
  o 3 bottle system
  o Reduced availability
    • Partner holding, shorter scripts
  o Fully random UDS/pill count
Opioid Misuse Scenarios; UDS w/o CII

- Curious, what is the story?
- Common reasons
  - Short
  - UDS not accurate
  - Selling
- Intervention
  - Admission of being short?
    - Then back to previous slide
  - UDS at different parts of script cycle
  - UDS not accurate?
    - No meds of any kind
      - Observed UDS in future
    - Make sure UDS test looks for the missing opioid
Opioid Misuse Scenarios; UDS With Additional Meds

**UDS with meds not currently prescribed**

- Curious as to reason
- Common reasons
  - Misuse, then to previous slide (pain, mood, etc.)
  - Impulsivity
  - “Have to have”
    - SUD vs. misuse of other medication
  - Other prescriber
- Intervention
  - Clarification of med list or prescribing roles
  - Limitation of current meds if dangerous
  - Medication destruction of old scripts
    - House sweeps by others
Opioid Misuse; What to do?

Use as Cue to Functional Need!

- **Opioid stim**
  - Treating depression or ADHD?
  - Helping them function?
  - (Careful with sleep aides if opioids stim)

- **Opioid sedation**
  - Treating anxiety?
  - Sleeping aide?

- **Misuse a cue about what they feel is needed**
  - So replace it
  - Likely not SUD
Substance Misuse;
Also a cue to Functional Need?

- **MRJ**
  - Treating anxiety, depression, pain, nausea?
  - Giving energy and better function?

- **Alcohol**
  - Treating anxiety or depression?

- **Cocaine**
  - Treating ADHD, anxiety, or depression?

- **Heroin**
  - Treating pain, depression, or anxiety?
Morphine and/or fentanyl = heroin
  - Fentanyl in many SUD products now

Metabolites not present
  - Just took pill
  - Dipped pill
  - Not tested for
  - P450 issue

Pill count accuracy suspect
  - Pills available for count, street contract
Misuse? Abuse? Not Sure?

Send for SUD evaluation

- They will apply criteria
- Find someone that understands pain and opioids

Choose safer opioid

- Tramadol
- Tapentadol
- Buprenorphine
### Risk Management Tools

<table>
<thead>
<tr>
<th>LOWER RISK</th>
<th>HIGHER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UDS</strong> --</td>
<td>Any infraction</td>
</tr>
<tr>
<td><strong>CSRS</strong> --</td>
<td>IR prep</td>
</tr>
<tr>
<td><strong>Scripts</strong> --</td>
<td>ER prep</td>
</tr>
<tr>
<td><strong>Medication</strong> --</td>
<td>Once</td>
</tr>
<tr>
<td><strong>Collateral</strong> --</td>
<td>Q 6 months</td>
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<tr>
<td><strong>Visits</strong> --</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>SUD tx-</strong></td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Psych tx-</strong></td>
<td>Ongoing tx</td>
</tr>
</tbody>
</table>

- **Risk Management Tools**
  - Any infraction
  - IR prep
  - ER prep
  - Once
  - Evaluation
  - Evaluation
  - Ongoing tx
  - Ongoing tx
  - Never
  - Q 3 months
  - Q 3 Months
  - Quarterly
  - Quarterly
  - Quarterly

- **Project ECHO**

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Stopping Opioids

➢ **Tapering**
  - Lack of efficacy or functional improvement
  - Side effects
  - Breaking contract
  - Increasing risk factors
    - Psychiatric
    - Medications

➢ **Stopping**
  - Recreational use
  - Diversion
  - Forging
  - Dangerous behavior
  - Active SUD
Opioid Tapering Strategies

- AAPM 2005, Disaster Work Group
  - Reduction of daily dose by 10% each day, or...
  - Reduction of daily dose by 20% every 3-5 days, or...
  - Reduction of daily dose by 25% each week

- Opiophile
  - Cut by 33% every 3 days, until done

- VA/DOD in 2/2017
  - 5% - 20% every 4 weeks is suggested

- Clinically Driven
  - As needed, depending on situation
Approach to the Patient
Optimal Approach

➤ Curious, not authoritarian
  o Let them teach you what they are doing
    • Avoid telling them what they are doing
  o Normalize behaviors, not judgement
    • Overuse, impulsivity, irritable all normal
  o Translate the message they are sending
  o Avoid playing “gotcha”
    • Tactical
    • Patient hiding
  o Share control

➤ Establish clear limits
  o Functional goals in pain
  o “Football field” analogy
Clinical Patient Interactions

- **Feels personal**
  - Transference
  - Assumptions will be made about you
  - Regardless of outcome, they will do it again
    - Predictable

- **Personality contributions**
  - Poor affective constancy
    - Impulsivity
  - Irritability, anxiety, depression
  - Makes it predictable, unchanging

- **Practitioners’ emotional response**
  - You will make assumptions
    - Don’t believe all you think
    - Consciousness of state of mind is optimal
Difficult Conversations

All related to safety or function

- Never about you, Med Board, CDC, etc.
  - “Have new data now”

- Includes........
  - UDS failures
    - Substances or additional medication
  - When limiting/stopping meds
    - Cultural or patient safety
  - Wanting too aggressive of treatment
    - Realistic expectations
    - “More” can be dangerous
  - Time for discharge
Safer Opioids

Pain

- Tramadol (Ultram)
  - SNRI primary
  - Opioid minimal, in metabolite only

- Tapentadol (Nucynta)
  - NE and full agonist
  - 50mg - 75mg = 10mg oxycodone *clinically*

- Buprenorphine
  - Partial agonist, ceiling effect
  - Transdermal Patch (Butrans)
  - Buccal (Belbuca)
Questions?
Thank you