BEFORE OPIATES: Treatment of CHRONIC PAIN

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STATISTICS

- It's estimated that between 26.4 and 36 million people abuse opiates worldwide with an estimated 2.1 million people in the U.S. suffering from substance use disorders related to prescription opioid pain relievers in 2012.
- Opiate abuse is now considered an epidemic according to the U.S. Centers for Disease Control and Prevention. 91 people die every day from an opioid overdose. In 2015, more than 33,000 lives were lost to opioids. In fact, overdoses from opioids kill more people each year than guns or car accidents.

STATISTICS

- Deaths from prescription opioids alone have more than quadrupled since 1999.
- Deaths from synthetic opioids alone, such as fentanyl jumped 72% from 2014 to 2015.
- According to the National Institutes of Health (NIH), three-quarters of new heroin users start by abusing prescription drugs.

STATISTICS

- According to the Centers for Disease control, overdose deaths for women due to prescription pain killers have jumped more than 400% in the past few years while overdose deaths for men have increased by 265%. This may be due to the fact that women in general are more likely to be diagnosed with chronic pain and prescribed pain killing narcotics at higher dosages and durations.

STATISTICS

- Overdose rates are highest among people ages 25-54. Higher among Non-Hispanic Whites and Native Americans and Alaskan Natives compared to Non-Hispanic Blacks and Hispanics.
- As many as 1 in 4 people who received prescriptions for opioids long-term for non-cancer pain in primary care setting struggles with addiction.

MOST COMMON DRUGS INVOLVED IN OPIOID DEATHS

- Oxycodone (i.e. OxyContin) – A semi-synthetic opioid synthesized from the Persian Poppy. A moderately potent analgesic developed in Germany in 1917. One of the foremost medications involved in the current opiate epidemic. Easy to develop a tolerance, in which one must take more of the drug to achieve the same pain relief. The tolerance can result in Paradoxical Hyperalgesia in which the individual develops an increased sensitivity to pain.

MOST COMMON DRUGS INVOLVED IN OPIOID DEATHS

- Hydrocodone (i.e. Vicodin, Norco) – Used to treat pain and as a cough reliever. Also, a semi-synthetic opioid from the opium poppy.

MOST COMMON DRUGS INVOLVED IN OPIOID DEATHS

- Methadone - an opioid used to treat pain and as maintenance treatment or to help people with opioid dependence – such as heroin. Developed in Germany around 1937, and approved for use in the U.S. in 1947. Not expensive.

MOST COMMON DRUGS INVOLVED IN OPIOID DEATHS

- The issue is the length of time individuals use these medications – why most people who use Hydrocodone cough syrup do not become addicted. They stop after the cough has gone away. People with chronic pain continue to use and can ultimately become addicted if not stopped by their doctors.

EFFECTS ON THE MEDICAL SYSTEM

- Physicians are increasingly being held accountable for their patients who become addicted to opioids. Some are even facing murder charges.
- In 2015, Dr. Hsiu-Ying "Lisa" Tseng became the first physician to be convicted of murder charges for the overdose deaths of four of her patients. She was sentenced to 30 years to life in prison by a Los Angeles Judge. It was found that she prescribed without cause for financial gain.

EFFECTS ON THE MEDICAL SYSTEM

- The number of physicians penalized by the U.S. Drug Enforcement Agency (DEA) has grown more than 5-fold in recent years.
- The DEA took action against 88 physicians for over prescribing opioids in 2011, and 479 physicians in 2016.
- A Study done in 2015 by researchers from Harvard Medical School and the Boston University School of Medicine found that 91% of people with non-fatal opioid overdoses were dispensed opioids again. Clearly, there is a problem.

EFFECTS ON THE MEDICAL SYSTEM

- According to the CDC, opioid prescribing by primary care physicians continues to fuel the epidemic. Today, nearly half of all U.S. opioid overdose deaths involve a prescription opioid.
- It is important to remember that these prescriptions were primarily for non-malignant (non-cancer) pain. Treatment for cancer pain is another story.

SOCIAL AND EMOTIONAL IMPACT OF OPIOID ADDICTION

- How opiates work
- Physical and emotional effects of opiate addiction
- Social effects

New MTUS GUIDELINES Effective12-1-17

- What is the MTUS? A set of Treatment Guidelines adopted by the DWC which must be followed by physicians who treat patients with work injuries or illnesses.

MTUS GUIDELINES Effective 12-1-17

- These Guidelines recommend treatments and provide details on which treatments are effective for certain injuries, how often the treatment should be given, etc.

MTUS GUIDELINES

- Allied Health Therapies:
  - 1. Pharmacological treatment with non-opioid pain medication (e.g. NSAIDs, acetaminophen)
  - 2. Physical activity, including rest, passive and active range of motion, physical therapy and occupational therapy with graded exercise to match the injury.
  - 3. Complementary/alternative modalities such as acupuncture and massage.

MTUS GUIDELINES

- 4. Psychosocial screening and possible testing if indicated.
- 5. Cognitive behavioral therapy is recommended in some cases.

PHARMACOLOGICAL TREATMENT WITH NON-OPIOID PAIN MEDICATION

- Physicians strongly recommended not to prescribe an opioid for initial acute non-severe pain post injury. (e.g. low back pain, sprains, or minor injury without signs of tissue damage)

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- Opioids are recommended for severe acute pain. But should be tapered off in one to two weeks, and with the lowest effective dose.
- Page 14 MTUS Opioid Guidelines Effective 12-1-17
- "When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed. (CDC, 2016)"

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- *"Indications* – Patients should meet all of the following:
- 1. Severe injury with a clear rationale for use (objective functional limitations due to pain resulting from the medical problem, e.g. extensive trauma such as forearm crush injury, large burns, severe radiculopathy)."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "2. Other more efficacious treatments should have been instituted, and either:
  - 2a)documented to have failed and/or
  - 2b) have reasonable expectations of the immediate need for an opioid to obtain sleep the evening after the injury.
  - 3. Prescription databases usually referred to as Prescription Drug Monitoring Program (PDMP) should be checked and not show evidence of concomitant prescriptions, conflicting opioid prescriptions from other providers or evidence of misreporting. Any of these are strong contraindications for a prescription, especially in the absence of severe objective injury. When the PDMP indicate other opioids medications have been recently used, yet there is need for a second prescription of opioids, a few days of prescription at a low dose (e.g. 20mg morphine equivalent dose (MED)) may be reasonable with close monitoring."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "Non-opioid prescriptions (e.g. NSAIDs, acetaminophen) absent contraindication(s) should nearly always be the primary treatment and accompany an opioid prescription. Due to greater than 10-fold elevated risks of adverse effects and death, considerable caution is warranted among those using other sedating medications and substances including:
  - i. benzodiazepines
  - Ii) anti-histamines (H_1-blockers), and/or
  - Iii) illicit substances. Patients should not receive opioids if they use illicit substances unless there is objective evidence of significant trauma or at least moderate to severe injuries."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "Considerable caution is also warranted among those who are or have:
- i) older age (>65 yrs.)
- ii)pregnant
- iii) sleep apnea
- iv) psychiatric/mental health disorder (anxiety, depression, personality disorder, suicidal)
- v) drug-seeking behavior
- vi) current or past substance abuse
- vii) consuming alcohol in combination with opioids
- viii) renal insufficiency
- ix) hepatic insufficiency, and those who are
- x) unemployed (10-fold risk of death)"

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "Due to elevated risk of death and adverse effects, caution is also warranted when considering prescribing an opioid for patients with any of the following characteristics: use of other psychotropic medications, current tobacco use, attention deficit hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD), impulse control problems, thought disorders, chronic obstructive pulmonary disease (COPD), or recurrent pneumonia."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "Additional risks and/or adverse effects are thought to be present from other comorbidities such as chronic hepatitis and/or cirrhosis, coronary artery disease, dysrhythmias, cerebrovascular disease, orthostatic hypotension,. Asthma, thermoregulatory problems, advanced age (especially with mentation issues, balance problems, fall risk, debility), osteopenia, osteoporosis, constipation, prostatic hypertrophy, oligomenorrhea, human immunodeficiency virus (HIV), ineffective birth control, herpes, allodynia, dementia, cognitive dysfunction and impairment, gait problems, tremor, concentration problems, insomnia, coordination problems, and slow reaction time. There are considerable drug-drug interactions that have been reported."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "5) Patients should be educated on the proper storage and disposal of opioids at the time of the initial prescription and at every visit, as secondary fatalities from misuse and accidental poisonings of children are common.
- *Frequency/Duration*-Generally, opioids should be prescribed at night or while not working. Lowest effective, short-acting opioid doses are preferable as they tend to have the better safety profiles, less risk of escalation, less risk of lost time from work, and faster return to work. Low-dose opioids may be needed in the elderly who have greater susceptibility to the adverse risk of opioids. Those of lower body weight may also require lower opioid doses. Short-acting opioids are recommended for treatment of acute pain and long-acting opioids are not recommended. Recommend opioid use as required by pain, rather than in regularly scheduled dosing (except severe pain such as extensive burns."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "Dispensing quantities should be only what is needed to treat the pain. Generally, the first prescription should not exceed 3 days treatment, and rarely more than 7 days (Surgeon General August 2016; CDC 16;MMWR 2017). Emergency departments and urgent care clinics without continuity should generally not dispense refills. At 3 to 7 days, continuity should either be established or in the process of establishment with reassessment recommended to ascertain curative treatment(s), function, progress, other adjunctive treatments to consider."

PHARMACOLOGICAL TREATMENT WITH OPIOID MEDICATION

- "If parenteral administration is required, ketorolac has demonstrated superior efficacy compared with opioids for acute severe pain, although ketorolac's risk profile may limit use for some patients. Parenteral opioid administration outside of obvious acute trauma or surgical emergency conditions is rarely required.
- *Indications for Discontinuation*-Resolution of pain, sufficient improvement in pain, intolerance or adverse effects, non-compliance, surreptitious medication use, consumption of medications or substances advised to not take concomitantly (e.g. sedating medications, alcohol, benzodiazepines), or use beyond 2 weeks."

Initial Screening

- Initial screening of patient before prior to initiation of opioid prescription
- **American Society of Addiction Medicine** has information on screening and assessment
  - https://www.asam.org/education/live-online-cme/fundamentals-of-addiction-medicine/additional-resources/screening-assessment-for-substance-use-disorders/screening-assessment-tools
- **National Institute on Drug Abuse has a short screening tool to assess a patient's risk level:** https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf

Opioid Risk Tool

Post-Operative Pain

- Limited use of opiates is recommended for post-operative pain management as an adjunctive therapy to more effective treatments.
- Screening is recommended for patients requiring continuation of opiates for post operative pain beyond second week.

Opioids for Treatment of Chronic Severe Pain

- Opiates would be prescribed only for those patients who meet strict requirements.

ALLIED HEALTH THERAPIES

- PHYSICAL ACTIVITY
- Appropriate physical activity in important in pain management
- Patient fears of physical activity includes fears or re-injury and that they will not appear injured. Concerned about possible sub-rosa tapes.
- Physical and Occupational Therapy.

ALLIED HEALTH THERAPIES

- Acupuncture - Found to be especially helpful for back, neck, headache - including migraine pain.
- Massage – A study found robust support for low back pain relief and moderate support for shoulder and headache pain. Important for treatment to be consistent over a period of time. One session will not work.

COGNITIVE BEHAVIORAL THERAPY

- A form of talk therapy that helps people identify and develop skills to change negative thoughts and behaviors.
- Effective in helping individuals with chronic pain take control of their pain and finding effective ways to cope.
- Helps to decrease anxiety and depression which have a neurochemical impact on pain perception.

CHALLENGES TO IMPLEMENTATION OF MTUS GUIDELINES

- Ease of medication over action
- Adoption of alternative therapies – cultural, financial, access
- Support