Pain Management Strategies for Patients with Substance Use Disorder

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Objectives

1. Describe three common misconceptions about pain management for patients with underlying substance use disorder

2. Discuss three strategies for effective pain management for patients with substance use disorder

3. Illustrate how to overcome the misconceptions about pain management for patients with SUD and strategies to overcome these barriers for learners

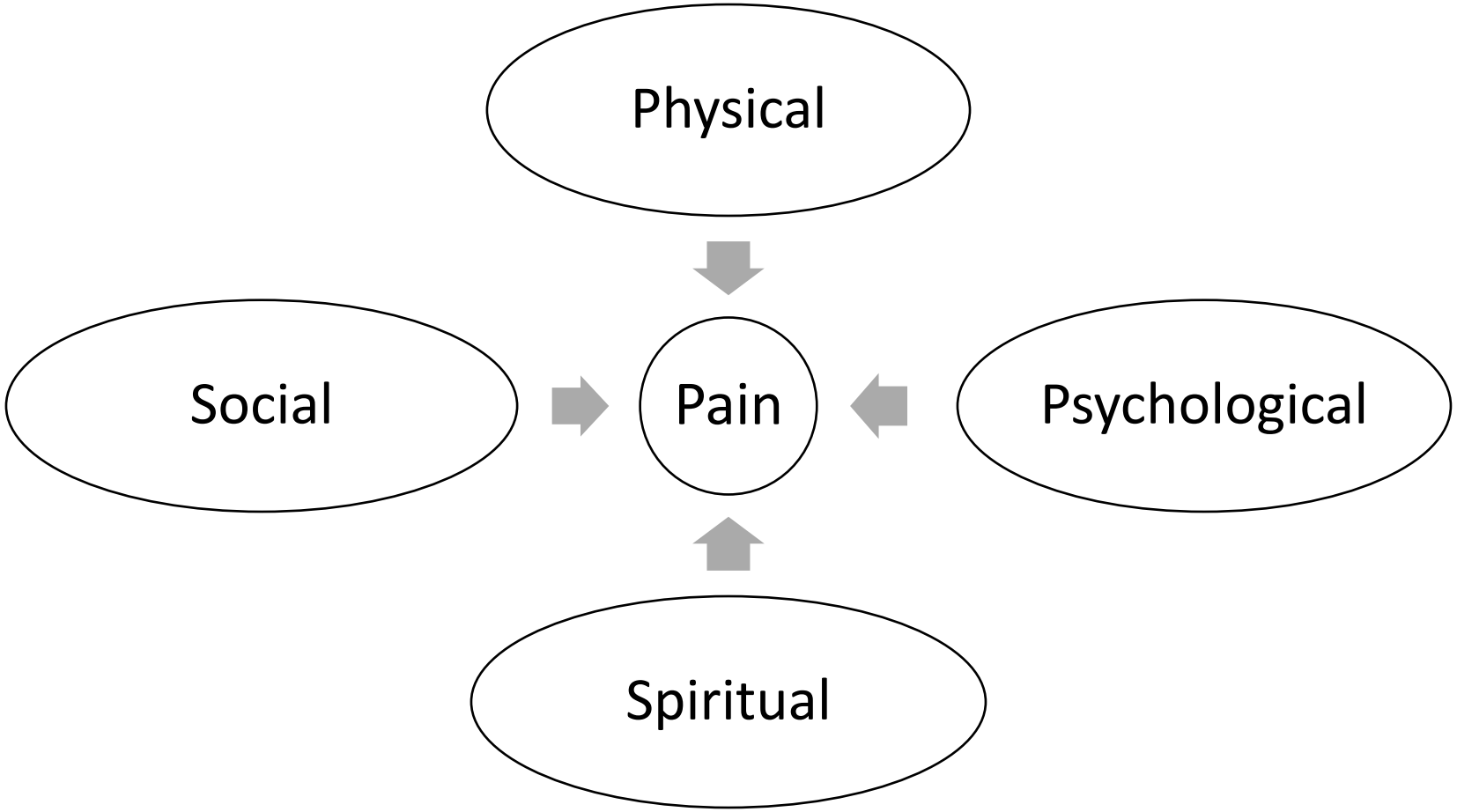
Pain

Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage and expressed in terms of such damage"
- The International Association for the Study of Pain (IASP)

- Chronic pain (pain existing > 3 months) affects 20.4% of U.S. adults[1]
- Screening tools exist to help clinicians assess opioid misuse risk
- Undertreated chronic pain can lead to misuse of opioids
- Managing chronic pain is a balancing act

1. CDC. Opioid Crisis Statistics. https://www.hhs.gov/opioids/about-the-epidemic/opioid-crisis-statistics/index.html

Total Pain



Substance Use Disorder (SUD)

Complex condition in which there is uncontrolled use of a substance despite harmful consequences

- Substances include (not limited to): alcohol, caffeine, prescription medications, tobacco, illicit drugs
- In recent years:
  - 11.7% of persons aged 12 and older in the U.S report using illicit drugs[1]
  - Over 70% of the drug overdose deaths in the US involved an opioid[2]
  - More than 11.5 million Americans reported misusing prescription opioids in the previous year[3]

1. CDC. Illicit Drug Use. https://www.cdc.gov/nchs/fastats/drug-use-illicit.htm; 2. Mattson CL, Tanz LJ, Quinn K, Kariisa M, Patel P, Davis NL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. MMWR Morb Mortal Wkly Rep 2021;70:202–207. ; 3. Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report 2pdf icon. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018.

Opioid Use Disorder (OUD)

Complex conditions in which there is uncontrolled use of opioids despite harmful consequences

- Opioids include (not limited to): morphine, fentanyl, heroin, oxycodone, methadone
- In 2017, opioid epidemic in the U.S. was declared a national public health emergency
- Affects over 2.1 million people in the U.S.[1]
- Medications for opioid use disorder have found to reduce morbidity and mortality associated with OUD[2]

1. Dydyk AM, Jain NK, Gupta M. Opioid Use Disorder. [Updated 2020 Nov 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK553166/ ; 2. Chang HY, Kharrazi H, Bodycombe D, Weiner JP, Alexander GC. Healthcare costs and utilization associated with high-risk prescription opioid use: a retrospective cohort study. BMC Med. 2018 May 16;16(1):69.

Introductory Definitions

Dependence

Tolerance

Addiction

Pseudoaddiction

Dependence

<u>Normal</u> adaptive state that results in a withdrawal syndrome when a medication is abruptly discontinued or an antagonist is administered

GI distress
Diaphoresis
Shivers
Tachycardia
Irritability

Tolerance

Physiologic state from regular medication use in which an increased dosage is needed to produce the same effect

Addiction

Neurobiologic <u>disease</u> characterized by impaired control, compulsive drug use, use despite harm, and craving

Opioid Use Disorder (OUD)

- Language in DSM-5 changed from “opioid abuse” and “opioid dependence” to “opioid use disorder”
- Problematic pattern of opioid use leading to clinically significant impairment or distress
  - Chronic primary neurobiologic disease with genetic, psychosocial, and environmental dimensions
    - Impaired control over drug use
    - Compulsive use
    - Cravings
    - Continued use despite harm/consequences
- 3 FDA-approved medications approved for OUD
  - Methadone, buprenorphine, naltrexone

Pseudoaddiction

Phenomenon of undertreated pain that is portrayed as “drug seeking” or “clock watching”

Relief-seeking behaviors resolve after initiating effective analgesic therapy

<u>Objective 1</u>:
Misconceptions Surrounding Pain Management for Patients with Underlying Substance Use Disorder

“Drug Seeking Behavior”

[Patient A] is drug-seeking, I know they have a substance use disorder…

[Patient Z] is constantly watching the clock and they ask for their opioids RIGHT when the next dose is due

[Patient M] is asking me to increase the dose of their oxycodone for two days straight now

“Drug Seeking Behavior” Demystified

- This behavior could be a sign of **undertreated** pain
- Collecting information is essential
  - Pain Assessment
    - Ask yourself, “is this regimen putting them at risk for undertreated pain?”
  - Substance use history
    - Aids in understanding of tolerance to adequately manage pain
  - Monitoring

Aberrant Behaviors

- Substance misuse
  - Use not consistent with medical purpose and way prescribed
  - Increase dose and/or frequency outside of clinician direction
  - Use with other illicit and/or high-risk substances not reported to clinician
  - Diversion, including “sharing” with loved ones for a medical reason
  - Risk factors:
    - History of alcohol or drug misuse
    - Family history of alcohol or drug misuse
    - Major psychiatric disorder
    - Poor support system
    - Younger age
- Not all misuse is due to a substance use disorder!

“Maintenance dosing helps with pain”

[Patient] shouldn’t need to keep asking for pain medications in addition to their [Methadone/Suboxone]

They are on medication [Suboxone®, Methadone] to treat their OUD, it should be helping their pain, too

“Maintenance dosing helps with pain” Demystified

- Maintenance medications can be used for pain, but **not** on a once daily regimen
- Methadone and buprenorphine’s analgesic effect only lasts ~6-8 hours
- Theoretically, can split the dosing of medications for OUD to Q8H
  - Beware: this is tricky!
- “X DEA Number”
  - Needed for treating opioid use disorder with medications like methadone and buprenorphine
  - **NOT** needed if prescribing these medications for pain

“Suboxone will cancel out the opioids”

I keep telling [Patient] that we can’t give them opioids because their Suboxone will block the opioids from working

What’s the use of giving breakthrough opioids when they won’t work anyway?

Let's review:
Suboxone® (buprenorphine/naloxone)

Buprenorphine: partial mu-opioid agonist with HIGH binding affinity to mu receptors

Naloxone: opioid antagonist with LOW (<2%) oral bioavailability

- Sublingual tablet or film
- Developed to decrease IV buprenorphine misuse
  - Precipitate withdrawal if film is manipulated and injected
- Withdrawal can occur when initiating Suboxone if also utilizing full opioid agonists
- Withdrawal will not occur if adding full opioid agonist on top for pain control

POP QUIZ

Which term best describes this situation: Johnny's pain has been worsening and he has been requiring to take doses of oxycodone more often than prescribed in order to effectively manage his pain.

A. Addiction
B. Opioid Misuse
C. Substance Use Disorder
D. Dependence

<u>Objective 2:</u> Discuss three strategies for effective pain management for patients with substance use disorder

Pain Syndromes

Pain Syndrome	Definition	Descriptors
Somatic Pain	Pain arising from damage to muscle, bone, or skin; well localized	Sharp, intense, throbbing, localized
Visceral Pain	Pain arising from damage to organs; not well localized-can be referred	Gnawing, cramping, squeezing, diffuse, distant
Neuropathic Pain	Pain arising from a lesion or disease of the somatosensory nervous system	Shooting, burning, numb, tingling, enhanced sensitivity to heat/cool

Strategies for Acute and Chronic Pain Management

Adjuncts

- Non-pharmacologic strategies:
  - Heat/ice, physical therapy, yoga/stretching, massage, acupuncture, music therapy, Transcutaneous electrical nerve stimulation (TENS) unit
  - ***Cognitive behavioral support and counseling***
- Topical agents
  - Diclofenac, lidocaine patches/ointments, capsaicin creams/patches
- Over the counter agents
  - Acetaminophen, NSAIDs
- Steroids
- Gabapentinoids: although these are controversial…
- Antidepressants
  - Tricyclic Antidepressants (TCAs), Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- Interventional approaches
  - Nerve blocks , spinal infusion or stimulation

Adjuncts and Pain Syndromes

Pain Syndrome	Descriptors	Adjuncts
Somatic Pain	Sharp, intense, throbbing, localized	Non-pharm, NSAIDs, APAP, Steroids, Diclofenac
Visceral Pain	Gnawing, cramping, squeezing, diffuse, distant	Non-pharm, NSAIDs, APAP, Steroids, nerve blocks
Neuropathic Pain	Shooting, burning, numb, tingling, enhanced sensitivity to heat/cool	Non-pharm, Gabapentinoids, Antidepressants, Lidocaine, Capsaicin, TENS

Acute and Chronic Pain Management Strategies

- Utilize a team-based approach to pain management
- Collaborate with clinician treating OUD (if applicable), behavioral medicine, social work to work toward achieving “total pain” control
- Discuss expectations surrounding opioid therapy
- Utilize risk assessment tools and employ risk mitigation strategies
- Monitor for analgesic affect and risk

Acute Pain Management Strategies

Acute Pain Management Strategies

If on Suboxone® or Methadone:
Continue medication for OUD
Discuss acute pain management strategy with clinician managing OUD
Utilize adjuncts and multimodal therapy
Use breakthrough, short-acting full opioid agonists (oxycodone, morphine, hydromorphone, fentanyl)
Be prepared that higher doses of opioids may be needed to achieve adequate pain control • Tolerance • Buprenorphine's partial agonist mechanism
Prescribe naloxone and counsel on its use
Identify a clinician who will treat the pain as outpatient prior to discharge

Pain Manag Nurs. 2020 Feb;21(1):26-34.

Acute Pain Management Strategies

If not on medication for OUD:
Utilize adjuncts and multimodal therapy
Assess desire of patient to begin medication for OUD and refer to OUD specialist for initiation, if desired
If not interested in beginning medication for OUD and opioids are necessary: Use short-course, lowest and effective dose of opioids Employ risk mitigation tools
On discharge: • Provide naloxone • Offer counseling, referral to appropriate psychological supports • Solidify a clinician who is willing to treat pain as outpatient, if needed

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Chronic Pain Management Strategies

Chronic Pain Management Strategies

If on Suboxone® or Methadone:
Collaborate with clinician managing OUD
Could consider splitting medication for OUD into Q8H dosing not without collaboration with input from clinician managing OUD
Utilize adjuncts and multimodal therapy
Employ risk mitigation strategies
Be prepared that higher doses of opioids may be needed to achieve adequate pain control • Tolerance • Buprenorphine's partial agonist mechanism

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Chronic Pain Management Strategies

If not on medication for OUD:
Utilize adjuncts and multimodal therapy
Assess desire of patient to begin medication for OUD and refer to OUD specialist for initiation, if desired
If not interested in beginning medication for OUD and opioids are necessary: Use lowest and effective dose of opioids, consider long-acting opioid Employ risk mitigation tools Prescribe naloxone Offer counseling, referral to appropriate psychological supports

Pain Manag Nurs. 2020 Feb;21(1):26-34.

Chronic Pain Management Strategies

- May consider titrating to long-acting opioid earlier as short-acting medications may contribute to or trigger cravings
- Utilize abuse-deterrent formulation

Brand Name	Generic Name
Hysingla ER	Hydrocodone
Vantrela ER	Hydrocodone
Zohydro ER	Hydrocodone
Exalgo	Hydromorphone
Arymo ER	Morphine
Morphabond ER	Morphine
Embeda	Morphine/naltrexone
Oxaydo	Oxycodone
Oxycontin	Oxycodone
Roxybond	Oxycodone
Xtampza ER	Oxycodone

Assessing and Monitoring Risk

Validated Opioid Risk Assessment Tools

- **Screener and Opioid Assessment for Patients with Pain (SOAPP)**
  - Evaluate risk for developing OUD
  - < 7: negative, ≥ 7: positive
- **Opioid Risk Tool (ORT)**
  - Assess future aberrant behaviors
  - <3: low risk, 4-7: moderate risk, >8: high risk
- **Current Opioid Misuse Measurement (COMM)**
  - Monitor Chronic pain patients on opioid therapy, current aberrant behaviors
  - < 9: negative, ≥ 9: positive

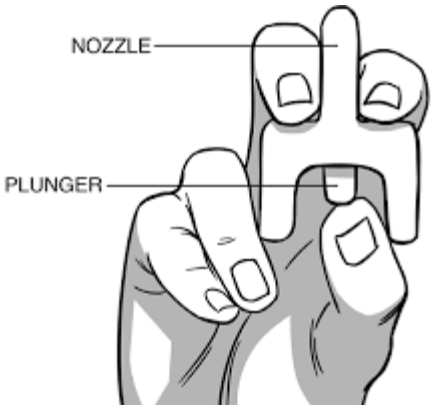
Risk Mitigation Strategies

Short prescription course

7-day versus 30-day supply

Lock box

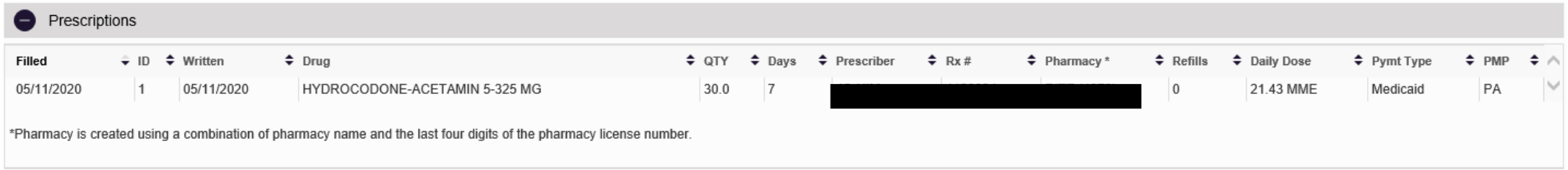
Naloxone (Narcan®) co-prescribing



Pill counts

Monitoring

- Prescription Drug Monitoring Programs (PDMPs)



Prescriptions

Filled	ID	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy *	Refills	Daily Dose	Pymt Type	PMP
05/11/2020	1	05/11/2020	HYDROCODONE-ACETAMIN 5-325 MG	30.0	7	[redacted]			0	21.43 MME	Medicaid	PA

*Pharmacy is created using a combination of pharmacy name and the last four digits of the pharmacy license number.

- Opioid Agreements
- Urine Drug Testing
- 6A’s of Analgesia

Monitoring Patients on Opioids

Analgesia	Affect	Activities
Adjuncts	Adverse effects	Aberrant behavior

1. Executive Committee of the Federation of State Medical Boards of the United States, Inc. Model policy on the use of opioid analgesics in the treatment of chronic pain. July 2013. (Sourced 25/2/14) www.fsmb.org/pdf/pain_policy_july2013

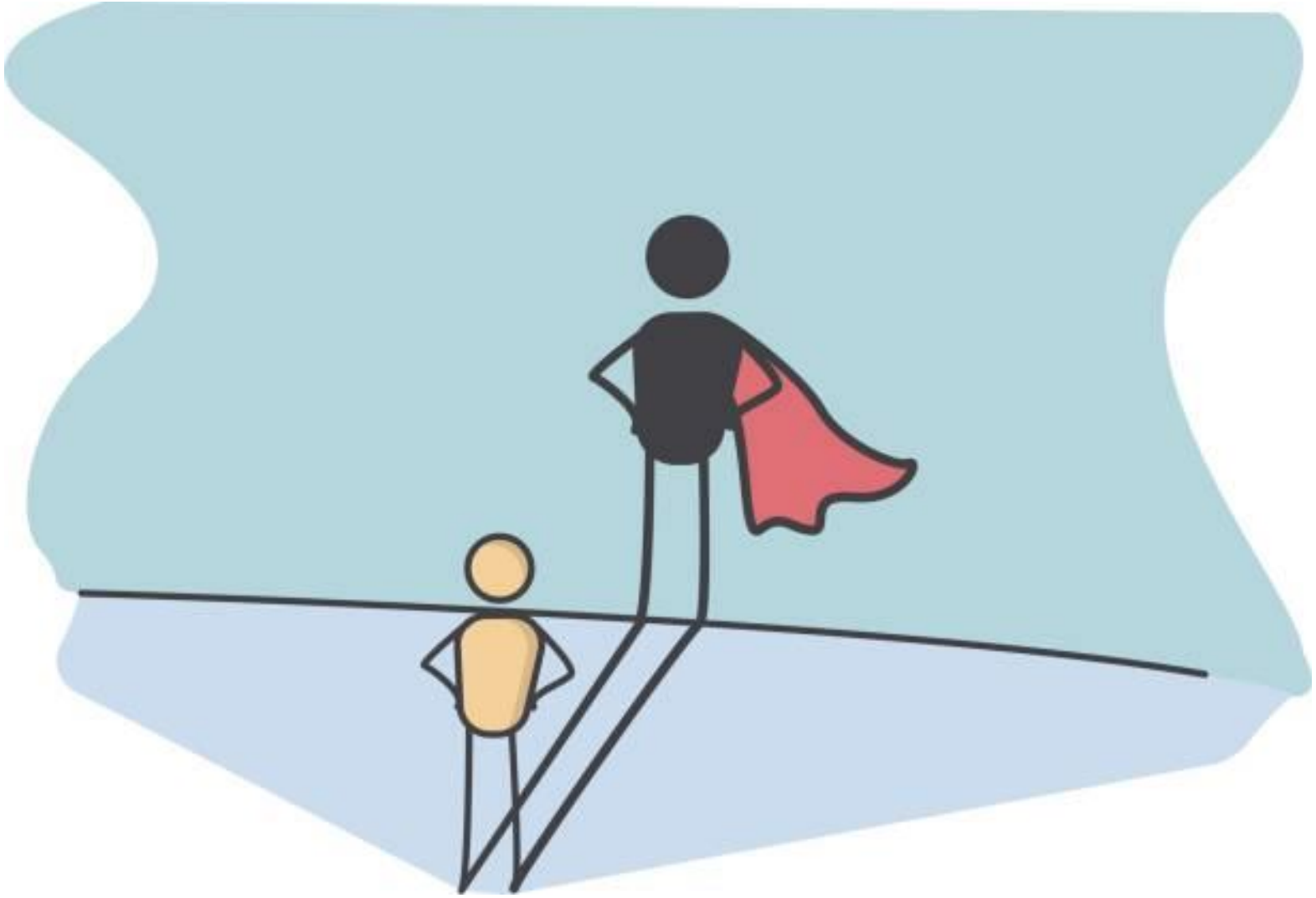
POP QUIZ

Only providers with “X” waiver can prescribe methadone or buprenorphine.

A. True
B. False

<u>Objective 3</u>: Illustrate how to overcome the misconceptions about pain management for patients with SUD and strategies to overcome these barriers for learners

Modeling and Reinforcing



Promote Safe Environment

- Utilize Motivational Interviewing Technique to recognize patient's strengths and previous adversities and establish trust
  - Express empathy
  - Develop discrepancy
  - Roll with resistance
  - Support self-efficacy

O	Open-ended questions
A	Affirmation
R	Reflective Listening
S	Summarize

Henry-Edwards S, Humeniuk R, Ali R, Montiero M, Poznyak V. Brief Intervention for Substance Use: A Manual for Use in Primary Care (Draft Version 1.1 for Field Testing). Geneva, World Health Organization. 2003; 4. Available at: www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf Accessibility verified 6/1/12

Language Matters

Phrases to **avoid**	Consider using instead…	Rationale
Addict	Person with substance use disorder	Using person-first language helps patients have access to quality treatment and care. Person-first language does not define a person based on any medical disorder they may have. It's nonjudgmental, neutral, and diagnosis is purely clinical.
Drug abuse	Drug misuse, harmful use	
Dirty/Clean	Actively using/Abstinent, not actively using	
Clean Drug Screen	Testing negative for substance use	

Elicit Appropriate History

- Speak to the patient [yourself], do not rely on chart review alone
- Collect collateral information
- Pain assessment
  - Physical examination findings
- Histories important to gather:
  - Past and present substance use
  - Past or current enrollment in a treatment program aimed at maintaining recovery in the context of substance use disorder(s)
  - Medication history and current medication list
  - Previous strategies trialed and their efficacy
  - Co-occurring condition and disorders (physical and mental

Detailed Pain Assessment

P	Precipitating/Palliating
Q	Quality
R	Region/Radiating
S	Severity
T	Timing/Temporal
U	Utilization
V	Values

- Make pain as objective as possible
- Review imaging studies
- Remember that not all pain is opioid-responsive!

Promote Safety

- Risk Assessment
  - ORT, COMM*, SOAPP
- Risk Mitigation
  - Small medication supply, lock box, naloxone
  - Communication with collaborating providers in community
- Monitoring
  - PDMPs, Opioid agreements, UDTs

6A's of Analgesia Therapy

Analgesia	Affect	Activities
Adjuncts	Adverse effects	Aberrant behavior

Summary

- Accurate and comprehensive pain assessment is essential to effective treatment of pain
- Patients currently prescribed medications for their substance use disorder may require full opioid agonists on top of their maintenance treatment for adequate pain management
- Utilizing adjunct medications can help target other pain receptors and improve pain outcomes, reducing overall medication-related risk for patients
- Team-based approach to pain management is crucial
- Employing risk assessments, risk mitigation techniques, and monitoring helps provide a safe environment for our patients

POP QUIZ

What would be the most appropriate acute pain management recommendation for a patient on Suboxone to optimize their pain relief?

A. Discontinue Suboxone
B. Discontinue Suboxone and start full opioid agonist (ie. Oxycodone)
C. Continue Suboxone and add full opioid agonist (ie. Oxycodone)
D. Modify Suboxone dose

Questions?

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