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

Total Pain

Physical

Social

Pain

Psychological

Spiritual
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\(^3\)

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 OUD²

Introductory Definitions

- Dependence
- Tolerance
- Addiction
- Pseudoaddiction
Dependence

Normal 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 disease 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
Objective 1: 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 M] is asking me to increase the dose of their oxycodone for two days straight now

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

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

[Patient] shouldn’t need to keep asking for pain medications in addition to their [Methadone/Suboxone]
“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
Objective 2: Discuss three strategies for effective pain management for patients with substance use disorder
# Pain Syndromes

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

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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

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

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

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<th>If on Suboxone® or Methadone:</th>
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<tbody>
<tr>
<td>Collaborate with clinician managing OUD</td>
</tr>
<tr>
<td>Could consider splitting medication for OUD into Q8H dosing not without collaboration with input from clinician managing OUD</td>
</tr>
</tbody>
</table>

*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

## Chronic Pain Management Strategies

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<thead>
<tr>
<th>If not interested in beginning medication for OUD and opioids are necessary:</th>
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<tr>
<td>Use lowest and effective dose of opioids, consider long-acting opioid</td>
</tr>
<tr>
<td>Employ risk mitigation tools</td>
</tr>
<tr>
<td>Prescribe naloxone</td>
</tr>
<tr>
<td>Offer counseling, referral to appropriate psychological supports</td>
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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

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysingla ER</td>
<td>Hydrocodone</td>
</tr>
<tr>
<td>Vantrela ER</td>
<td>Hydrocodone</td>
</tr>
<tr>
<td>Zohydro ER</td>
<td>Hydrocodone</td>
</tr>
<tr>
<td>Exalgo</td>
<td>Hydromorphone</td>
</tr>
<tr>
<td>Arymo ER</td>
<td>Morphine</td>
</tr>
<tr>
<td>Morphabond ER</td>
<td>Morphine</td>
</tr>
<tr>
<td>Embeda</td>
<td>Morphine/naltrexone</td>
</tr>
<tr>
<td>Oxaydo</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>Oxycontin</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>Roxybond</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>Xtampza ER</td>
<td>Oxycodone</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Filed</th>
<th>ID</th>
<th>Written</th>
<th>Drug</th>
<th>QTY</th>
<th>Days</th>
<th>Prescriber</th>
<th>Rx #</th>
<th>Pharmacy*</th>
<th>Refills</th>
<th>Daily Dose</th>
<th>Print Type</th>
<th>PMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/11/2020</td>
<td>1</td>
<td>05/11/2020</td>
<td>HYDROCODONE-ACETAMIN 5-325 MG</td>
<td>30.6</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>21.43 MME</td>
<td>Medicaid</td>
<td>PA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

POP QUIZ

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

A. True
B. False
Objective 3: 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

<table>
<thead>
<tr>
<th>O</th>
<th>Open-ended questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Affirmation</td>
</tr>
<tr>
<td>R</td>
<td>Reflective Listening</td>
</tr>
<tr>
<td>S</td>
<td>Summarize</td>
</tr>
</tbody>
</table>
# Language Matters

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

<table>
<thead>
<tr>
<th>P</th>
<th>Precipitating/Palliating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q</td>
<td>Quality</td>
</tr>
<tr>
<td>R</td>
<td>Region/Radiating</td>
</tr>
<tr>
<td>S</td>
<td>Severity</td>
</tr>
<tr>
<td>T</td>
<td>Timing/Temporal</td>
</tr>
<tr>
<td>U</td>
<td>Utilization</td>
</tr>
<tr>
<td>V</td>
<td>Values</td>
</tr>
</tbody>
</table>

- 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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