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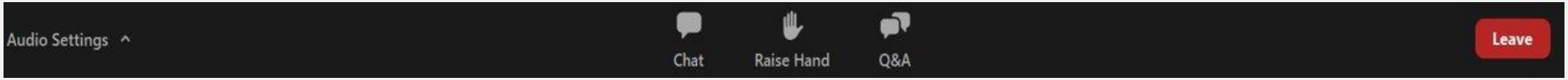

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In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. **1.25 hours is approved for this course**.

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DISCLAIMER (CONT.)

Today's speaker will be discussing how they provide pain management at a COE. This information is to support understanding of practices at other COEs. Attendees should consult with leadership at their own COE before implementing any pain management practices discussed today or before providing medical recommendations that are out of scope for their COE role.

GROUP AGREEMENT

- TBD

Karen E. Arscott, D.O., M.Sc.

PAIN MANAGEMENT FOR PATIENTS RECEIVING MEDICATION ASSISTED TREATMENT

OBJECTIVES

- Describe pain management for patients on baseline MAT.
- Discuss why a person with a history of Substance Use Disorder requires pain management in addition to their baseline MAT.
- Discuss a plan for management of MAT and pain management for a patient with pending elective surgery.
- Describe ways that COEs can collaborate with onsite pain management specialists
- Discuss ways to develop relationships with pain management referral partners

NO FINANCIAL CONFLICTS OR CLAIMS

WHY DO WE NEED TO KNOW HOW TO TREAT THESE PATIENTS?

Type of care, by number and percent

	Facilities		Clients in treatment on March 29, 2019					
			All clients				Clients under the age of 18 years	
	No.	%	No.	%	Median no. of clients per OTP facility	Median no. of clients per non-OTP facility	No.	%
Outpatient	**13,044**	**81.7**	**1,355,024**	**92.8**	**284**	**40**	**53,636**	**89.6**
Regular	12,114	75.9	642,554	44.0	64	30		
Intensive	7,325	45.9	130,343	8.9	20	15		
Day treatment or partial hospitalization	2,255	14.1	19,973	1.4	13	10		
Detoxification	1,752	11.0	21,460	1.5	5	5		
Methadone/buprenorphine maintenance or naltrexone treatment	5,256	32.9	540,694	37.0	261	20		
Residential (non-hospital)	**3,794**	**23.8**	**91,592**	**6.3**	**35**	**17**	**5,468**	**9.1**
Short term (≤ 30 days)	2,386	14.9	33,698	2.3	29	12		
Long term (> 30 days)	2,958	18.5	49,265	3.4	36	15		
Detoxification	1,410	8.8	8,629	0.6	15	5		
Hospital inpatient	**898**	**5.6**	**14,090**	**1.0**	**20**	**12**	**750**	**1.3**
Treatment	680	4.3	7,832	0.5	20	11		
Detoxification	806	5.0	6,258	0.4	15	6		
Total	**15,961**		**1,460,706**	**100.0**	**261**	**35**	**59,854**	**100.0**

Note: Facilities may provide more than one type of care.

N-SSATS and are based on the survey's reference date, March 29, 2019

2019 NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES UNITED STATES

Substance abuse problem treated, by number and percent

	Facilities[1]		Clients in treatment on March 29, 2019		
			Clients[2]		Clients[2] per 100,000 pop. aged 18 years or older
	No.	%	No.	%	
Clients with both alcohol and drug abuse	10,414	88.5	476,065	33.4	174
Clients with drug abuse only	10,192	86.6	743,828	52.2	280
Clients with alcohol abuse only	9,123	77.5	205,402	14.4	75
Total			**1,425,294**	**100.0**	**529**

[1] Numbers of facilities may sum to more than the total, and percentages may sum to more than 100 percent, because facilities may be included in more than one category.
[2] States report *substance abuse problem treated* in terms of percentages of clients, from which the numbers of clients in this table are derived; their sum may not agree with the total due to rounding.

- N-SSATS and are based on the survey's reference date, March 29, 2019

WHAT MEDICATIONS ARE INCLUDED IN THIS GROUP

- Buprenorphine oral
- Buprenorphine topical
- Buprenorphine/Naloxone oral
- Buprenorphine/Naloxone long acting
- Naltrexone oral
- Naltrexone long acting
- Methadone

WHO IS INVOLVED?

- Patients currently involved in Medication Assisted Treatment
  - Buprenorphine
  - Methadone
  - Naltrexone
- Patients with a previous Substance use Disorder
- Patients with:
  - Acute Pain
  - Chronic Pain
  - Post-op Pain
  - Presurgical Management

IMPORTANT NOTE

- Patients with opioid Dependence have a higher TOLERANCE for opiates and will REQUIRE HIGHER DOSES – this is NOT "drug seeking behavior"
- This higher dose requirement is a ***physiological disturbance*** and should be treated as outside the patient's control
- Patients with Substance Use Disorder deserve adequate pain management as does everyone with pain.

Reference: Veazie S, Mackey K, Bourne D, Peterson K. Evidence Brief: Managing Acute Pain in Patients with Opioid Use Disorder on Medication-Assisted Treatment. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2019. Posted final reports are located on the ESP

PATIENTS RECEIVING BUPRENORPHINE

- Does not matter if Buprenorphine/Naloxone or Buprenorphine

- Pre-operative care: ***DO NOT HOLD*** Dose prior to surgery

Reference:Veazie S, Mackey K, Bourne D, Peterson K. Evidence Brief: Managing Acute Pain in Patients with Opioid Use Disorder on Medication-Assisted Treatment. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2019. Posted final reports are located on the ESP

DON'T FORGET NONPHARMACOLOGIC PAIN TREATMENTS

- Ice – Anti-inflammatory and Analgesic
- Acetaminophen "Arthritis Strength" (may need to purchase brand name) 650 mg caplets take 2 every 8 hours
- Ibuprofen – *alternate* with Acetaminophen – dose as follows
  - 800 mg every 8 hours – 2 weeks maximum
  - 600 mg every 6 hours
  - 400 mg every 4 hours
- Ketorolac (removed from market in France and Germany) – only for ages 17-65 years old:
  - IV 30 mg single dose or every 6 hours as needed
  - IM 60 mg IM as single dose or 30 mg IM every 6 hours as needed
  - Oral 20 mg once followed by 10 mg every 4-6 hours as needed (Max 40 mg/day) for 5 days total

PATIENTS RECEIVING BUPRENORPHINE

- Acute Pain/Postoperative Pain
  - Continue regular Buprenorphine dose – *remember that this is their baseline maintenance dose and not for pain management* –

    with following modifications:

  - Mild/Moderate Pain (Pain scale 0-5)
    - Divide buprenorphine into smaller and more frequent doses
      - For Example: Patient on 8-2 mg Buprenorphine/naloxone twice daily – divide into 4-1 mg (1/2 tab/film) and take it every 4 hours four times per day.
    - May increase amount of buprenorphine per day if needed up to a maximum of 32 mg (most of the time it is not necessary to go this high) per day *for a short period of time*
      - Usual dose is 8-2 mg Bup/Naloxone twice daily – try the 4-1 mg Q 4 hours if not sufficient may increase to 8-2 mg Three times a day and then if needed up to 8-2 mg four times a day

PATIENTS RECEIVING BUPRENORPHINE

- Moderate/Severe Pain (Pain Scale >5)
  - Add a short acting full agonist (oxycodone or hydromorphone)
  - Patient will require higher doses due to tolerance – not because they are drug-seeking!
  - Patient-Controlled Analgesia (PCA) may be given as a bolus while on baseline buprenorphine
  - Regional blocks by anesthesia are very effective – may need higher doses than usual
  - Discharge on Buprenorphine/Naloxone dose divided frequently (every 4 hours) throughout the day.

IMPORTANT!!!!

- If the Buprenorphine/naloxone is stopped and full agonist medication is used for pain management alone:
  - The patient will need higher than normal amounts due to tolerance – NOT drug seeking
  - The full-agonist will need to be weaned off completely prior to restarting the Buprenorphine/Naloxone baseline medication!! This patient will go through withdrawal while this is happening. It will be painful and very uncomfortable – and if patient is compromised it could be dangerous as well.
  - Best practices are do not stop the Buprenorphine while managing pain in the hospital

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OTHER POSSIBLE OPTIONS

- Buprenorphine as a pain medication!

- Buprenorphine Patch – Butrans ® (7.5, 10, 15, 20 micrograms per hour) – if no risk for diversion or intravenous use
  - Less respiratory depression

CHRONIC PAIN MANAGEMENT

- Have patient take Buprenorphine or Methadone in smaller split doses.
- If patient not already on Buprenorphine or Methadone – consider Buprenorphine transdermal patch for pain management. Safer option for elderly
- Alternate NSAIDs and Acetaminophen
  - NSAIDs: Ibuprofen 600 mg every 6 hours (800 mg is every 8 hours – not for chronic use as it should continue past 2 weeks.
  - Acetaminophen – advise arthritis strength 650 mg each tablet - take 2 every 8 hours.

CHRONIC PAIN MANAGEMENT

- Nonpharmacologic Alternatives
  - Ice – natural anti-inflammatory analgesic
  - Gentle stretching – yoga
  - Cognitive Behavioral Therapy
  - Eye Movement Desensitization and Reprocessing (EMDR) therapy
    - https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing
  - Acupuncture
  - Physical Therapy – Water therapy
  - Auricular pressure

PATIENTS ON NALTREXONE

- Preoperative management:
  - Oral Naltrexone – discontinue 72 hours prior
  - Long-acting injectable – stop one month prior to surgery and convert to oral naltrexone which can be stopped 72 hours prior
  - If on Naltrexone for Alcohol Use Disorder – consider switching to Acamprosate
- Acute Injury or Surgery
  - Discontinue as soon as possible
  - Will require higher doses of opiates to overcome the antagonistic effect – monitor pulse ox closely
  - DO NOT Restart Naltrexone until patient is off all opiates for 14 days

Herron A, Brennan T. The ASAM Essentials of Addiction Medicine Third edition. 2020

PATIENTS ON METHADONE

- Continue usual dose of methadone
- If NPO – give ½ daily dose in divided 2-4 doses per day
  - Example: patient on 120 mg Methadone – give 20 mg three times a day
- Breakthrough pain:
  - Mild pain (<4) split normal daily dose into three separate doses
  - Add non-opioid analgesics
  - Moderate to Severe Pain(>5): Maintain usual daily dose and add one short-acting full opioid agonist – higher doses may be necessary
  - PCA and regional blocks may be needed

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WORKING WITH PAIN MANAGEMENT PROVIDERS

WORKING WITH CLIENTS

- Evaluation
- Education
- Continuing support

COORDINATING INTERNALLY

- Considerations for pain management
  - Severity of pain
  - Length of condition
  - Other factors
- Coordination of care
  - Communication
  - Follow up

COORDINATING EXTERNALLY

- Developing partnerships
- Referral process
- Follow up

QUESTIONS?

REFERENCES

- Data in this profile are from facilities that reported to the N-SSATS and are based on the survey's reference date, March 29, 2019. All material in this profile is in the public domain and may be reproduced without permission from SAMHSA.
- Veazie S, Mackey K, Bourne D, Peterson K. Evidence Brief: Managing Acute Pain in Patients with Opioid Use Disorder on Medication-Assisted Treatment. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2019. Posted final reports are located on the ESP
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