Opioid Failure

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Disclosures

- Dr. Robbins and Dr. Marshall have nothing to disclose

Learning objectives

- Describe **universal precautions** for prescribing opioids in primary care
- Define **opioid failure** in the context of use for chronic pain
- Name 2 patient-centered options for **discontinuation** of chronic full-agonist opioids

Janet

45 year-old woman with past medical history of diabetes c/b neuropathy, tobacco use and low back pain

Medications:

- Oxycodone 5 mg 10/day
- Nortriptyline 10 mg QHS
- Statin
- Low-dose aspirin
- Insulin glargine
- Metformin

Janet

45 year-old woman with past medical history of diabetes c/b neuropathy, tobacco use and low back pain

Psych history:

- Anxiety; PTSD from intimate partner violence in first marriage

Social:

- not working, one teenage boy, husband (2nd) owner-operator of tractor trailer, no EtOH or other drugs

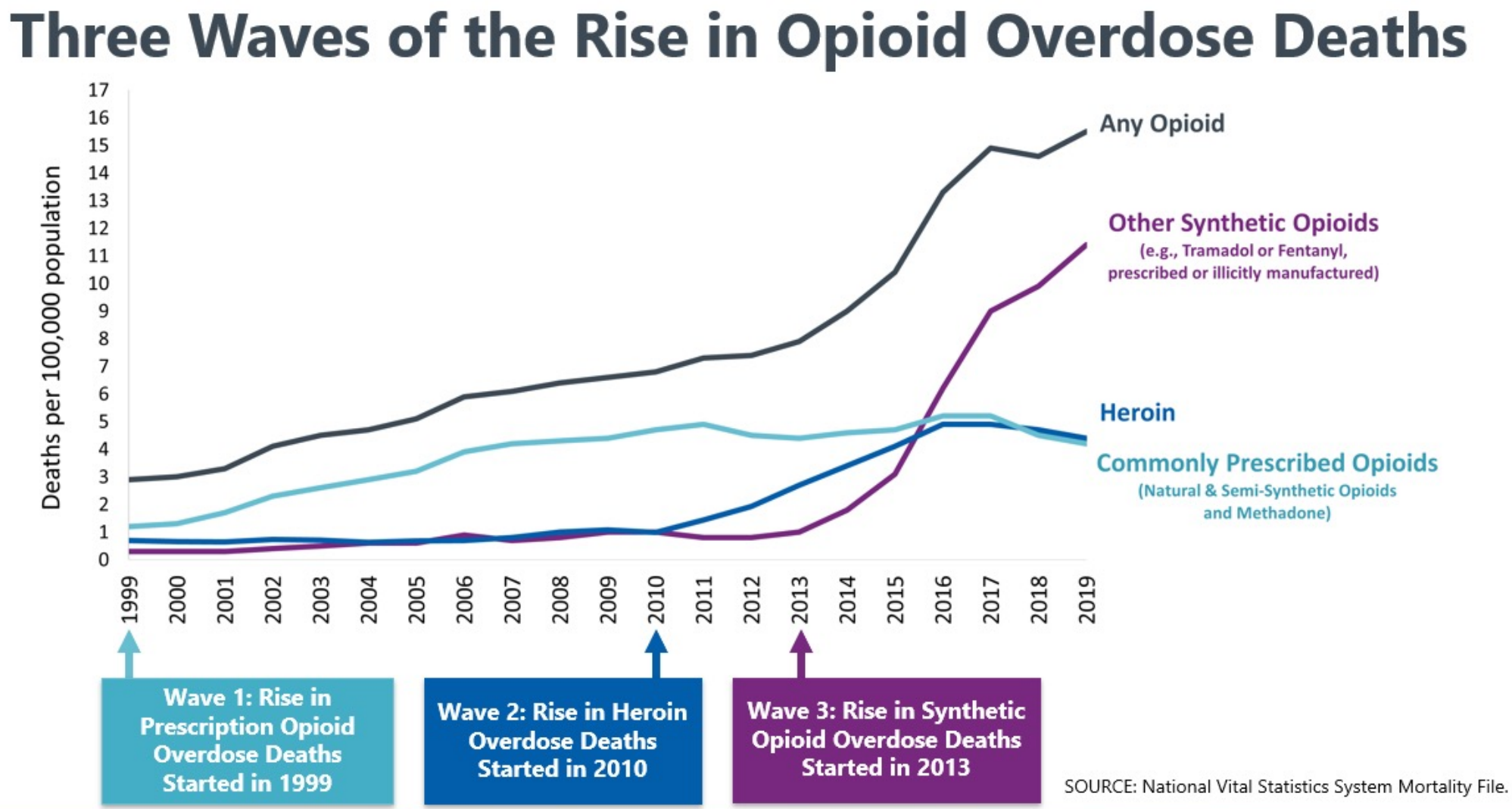
Janet

45 year-old woman with past medical history of diabetes c/b neuropathy, tobacco use and low back pain

Chief complaint:

- “I’m mostly worried you’re going to treat me like a drug addict.”

Our current moment



Our current moment

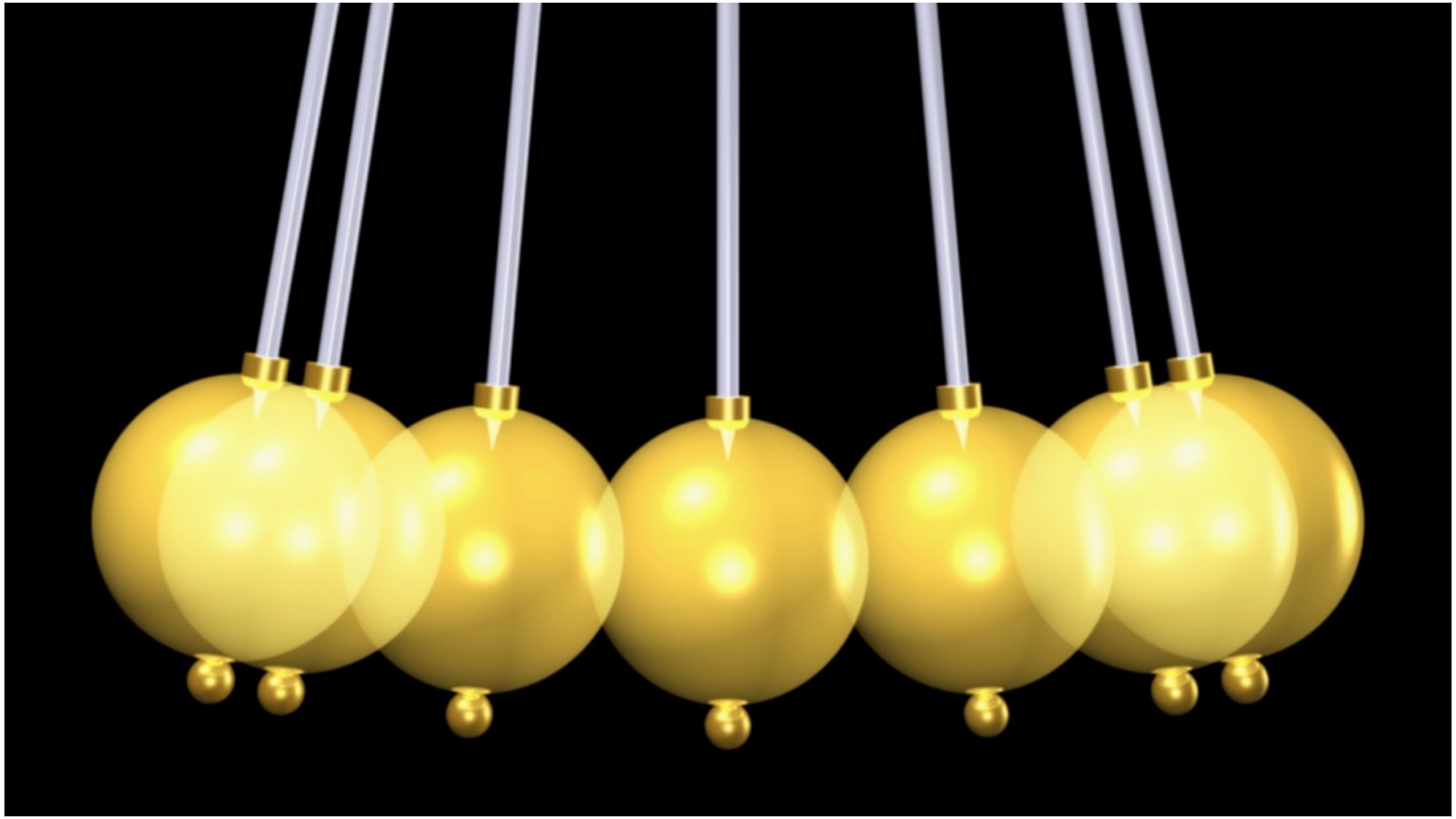


Image source: Wikimedia commons

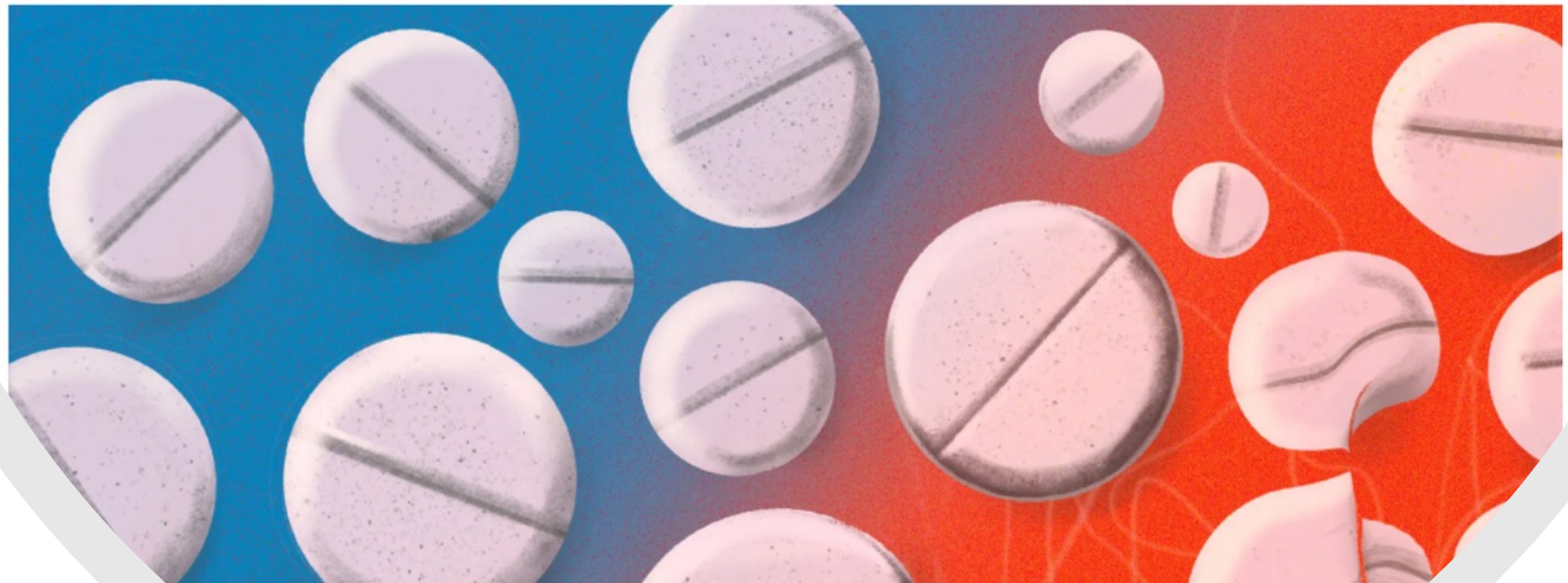
The New York Times

OPINION

GUEST ESSAY

What the Opioid Crisis Took From People in Pain

March 7, 2022



Our current moment

- The United States has the highest per-capita opioid consumption of any nation[1]
- “Opioids have a dual nature as both a benefit and a risk to health, function, and wellbeing. This dual nature should be taken into account in drug regulation, prescribing, and opioid stewardship.”[1]
- Current information on the efficacy of long-term opioid use for chronic pain is inadequate[2]

(1) The Stanford-Lancet Commission Recommendations on the Opioid Crisis in North America and Beyond: Humphreys, et al., 2022;
(2) CDC Guidelines for Opioid Prescribing, 2016.

Image source: Wikimedia commons

Universal Precautions for Opioid Prescribing

1. Assess Risk
2. Set Expectations
3. Monitor
4. Assess for Benefit

CDC Guidelines for Opioid Prescribing, 2016.
Image source: Wikimedia commons

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1 Assess Risk

Risk of use other than as prescribed

- Opioid Risk Tool (5 items)
- SOAPP-R (24 items)

Opioid Risk Tool

Administration:

- On initial visit
- Prior to opioid therapy

Scoring:

- 0-3: low risk (6%)
- 4-7: moderate risk (28%)
- > 8: high risk (> 90%)

Mark each box that applies	Female	Male
1. Family history of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal history of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Age (mark if between 16-45 yrs)	☐ 1	☐ 1
4. History of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychological disease		
ADO, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring totals	_____	_____

Webster & Webster. Pain Med. 2005;6:432.

1 Assess Risk

- **Allergies** are rare
- **Side effects** are common
  - Nausea, sedation, constipation, urinary retention, sweating
  - Respiratory depression – sleep apnea
- **Organ toxicities** are rare
  - Suppression of hypothalamic-pituitary-gonadal axis
- **Worsening pain** *(hyperalgesia in some patients)*
- **Overdose**
  - when combined w/ other sedatives
  - at high doses

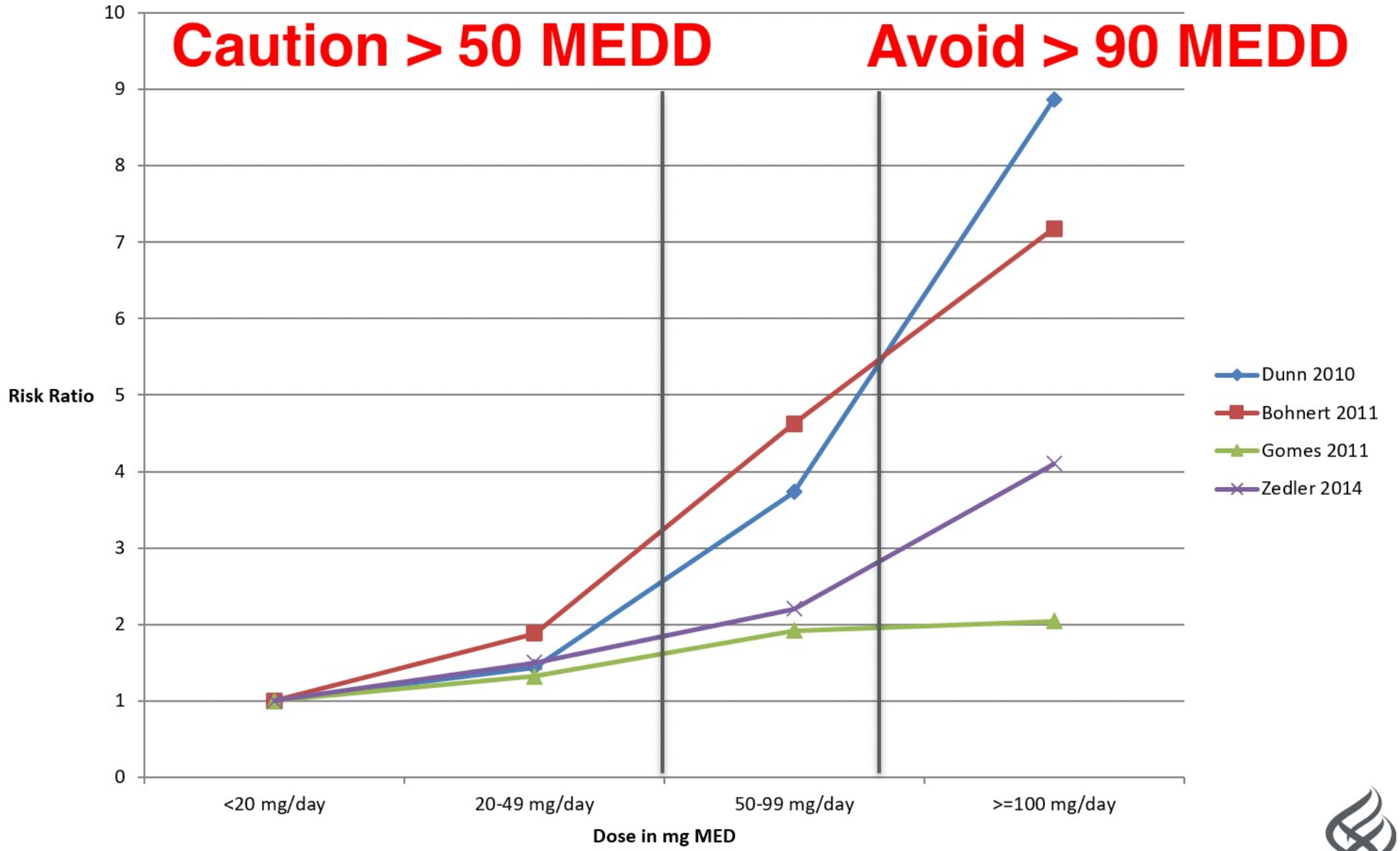
Dunn KM et al. Ann Intern Med 2010; Li X et al. Brain Res Mol Brain Res 2001; Doverty M et al. Pain 2001 ; Angst MS, Clark JD. Anesthesiology 2006

1 Assess Risk

Of patients aged 15–64 years receiving opioids for chronic noncancer pain:

- 1 in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription
- 1 in 32 patients who escalated to opioid dosages >200 morphine milligram equivalents (MME) died from opioid-related overdose

Kaplovich et al., PLoS One, 2015.



Courtesy Gary Franklin, Roger Chou

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2 Set Expectations

2 Set Expectations

Oregon Health & Science University
Hospitals and Clinics
Internal Medicine

OHSU

CHRONIC OPIOID TREATMENT INFORMED CONSENT AND NOTICE OF MATERIAL RISKS

Page 1 of 1

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

You have been diagnosed with this condition: diabetic nerve pain, low back pain

I have recommended long-term treatment with the following opioid medicine(s): Oxycodone 5mg

It is realistic to expect a reduction of pain during short-term use of opioid medication. However, opioids do not always improve pain or function with long-term use, and complete relief of pain is unlikely. Improved function should be your primary goal from opioid treatment.

Goal(s) for improvement in function: go back to work, do basic house work, walk around block

Alternatives to opioid medicine that could improve your pain include:

- ☐ nonsteroidal anti-inflammatory drugs (NSAIDs)
- ☒ acetaminophen (Tylenol®)
- ☒ antidepressants
- ☒ neuropathic (nerve) pain medicines
- ☐ steroids (oral or injected)
- ☐ disease-specific drug treatments
- ☐ partial opioid (buprenorphine)
- ☐ muscle relaxants
- ☒ topical therapies
- ☐ nerve block
- ☐ surgery
- ☐ other: _____

Additional (non-drug) therapies that may be necessary for you to reach your goal(s) include:

- ☒ physical therapy
- ☒ exercise
- ☒ weight loss
- ☐ counseling/mental health visits
- ☒ pain psychology/support groups
- ☒ acupuncture
- ☒ massage
- ☒ meditation / mindfulness
- ☐ brace or splint
- ☒ other: water therapy

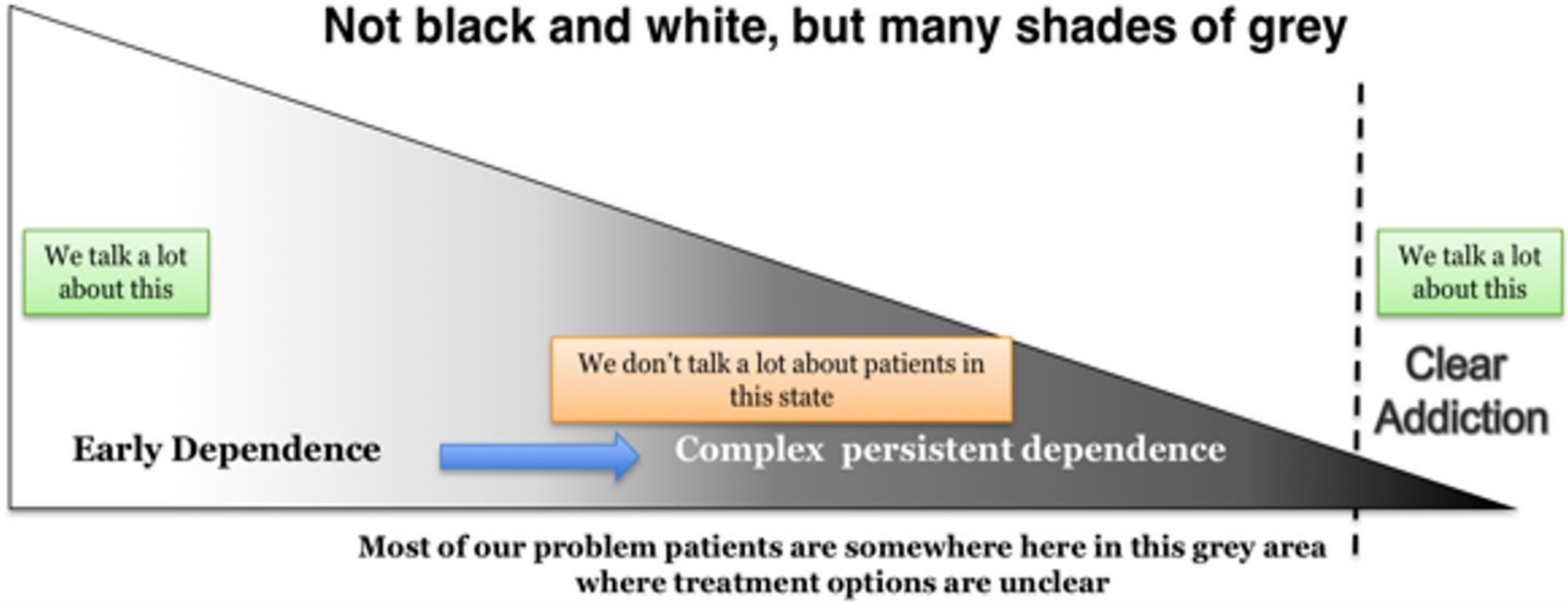
Long-term opioid use may be associated with the following risks

3 Monitor

- **Follow up at least every 3 months**
  - Face to face preferred
- **Intermittently assess for use other than as prescribed**
  - Pill counts
  - Urine drug testing
  - Prescription Drug Monitoring Program (PDMP) checks

Diagnostic convention Vs. reality for patients

Clearly No OUD/Addiction	Clear OUD/Addiction
Particular set of behaviors absent	Particular set of behaviors present
Clear treatment options	Clear treatment options

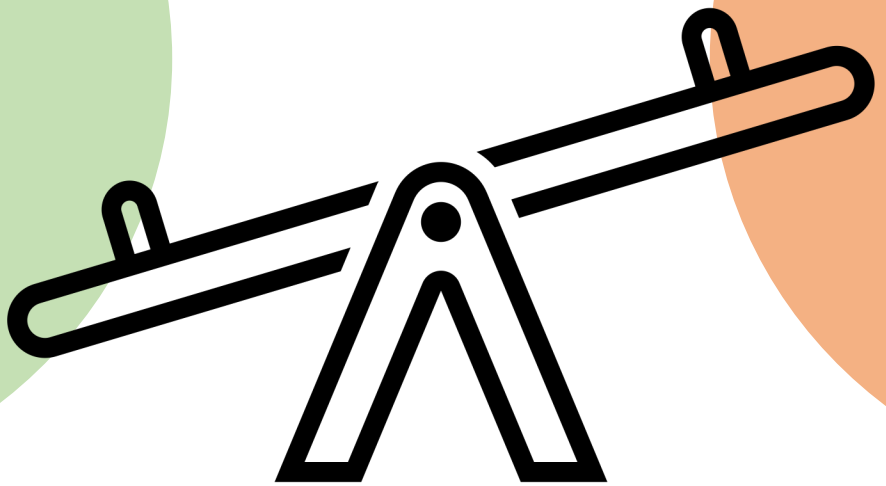


4 Assess for Benefit

Efficacy

Safety

Alternatives



Side effects

Addiction

Overdose risk

Hyperalgesia

PEG Scale

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Krebs EE, et al. J Gen Intern Med. 2009

Widespread Pain Index

OPG
OREGON PAIN GUIDANCE

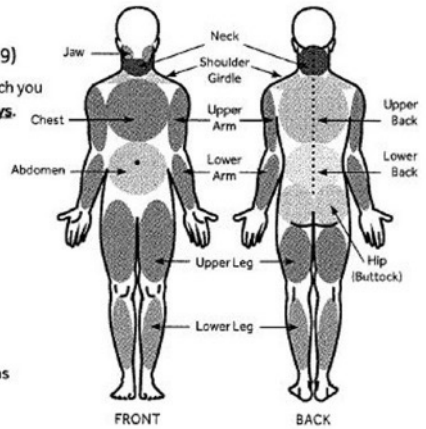
Widespread Pain Index (WPI)

(1 point per check box; score range: 1–19)

Please check the boxes below for each area in which you have had pain or tenderness **during the past 7 days**.

- [ ] Shoulder girdle, left
- [ ] Shoulder girdle, right
- [ ] Upper arm, left
- [ ] Upper arm, right
- [x] Lower arm, left
- [x] Lower arm, right
- [ ] Hip (buttock) left
- [ ] Hip (buttock) right
- [ ] Upper leg left
- [ ] Upper leg right
- [x] Lower leg left
- [x] Lower leg right
- [x] Jaw left
- [ ] Jaw right
- [ ] Chest
- [x] Abdomen
- [x] Neck
- [x] Upper back
- [x] Lower back
- [ ] None of these areas

WPI score: 9



Symptom Severity (score range: 1–12)

For each symptom listed below, use the following scale to indicate the severity of the symptom **during the past 7 days**.

	No problem	Slight or mild problem	Moderate problem	Severe problem
Points	0	1	2	3
A. Fatigue	☐	☐	☐	☒
B. Trougle thinking or remembering	☐	☐	☐	☒
C. Waking up tired (unrefreshed	☐	☐	☐	☒

During the **past 6 months** have you had any of the following symptoms?

	Points	0	1
A. Pain or cramps in lower abdomen		☐ No	☒ Yes
B. Depression		☒ No	☐ Yes
C. Headache		☐ No	☒ Yes

SS score: 11

Additional criteria (no score)

Have the symptoms listed on this sheet, and widespread pain been present at a similar level for **at least 3 months**?

☐ No ☒ Yes

TOTAL score: 20

OREGON PAIN GUIDANCE (OPG) OF SOUTHERN OREGON www.oregonpainguidance.org

https://professional.oregonpainguidance.org/wp-content/uploads/sites/2/2017/05/Fibromyalgia_Screening_Tool.pdf

5 Assess for Benefit

Before writing the next prescription, you should be convinced that:

- there is benefit
- benefits outweigh observed harms/risks

5 Assess for Benefit

"It's important for clinicians to judge the opioid treatment rather than the patient….discontinuing it means abandoning not the patient but merely an inappropriate treatment.

"When a clinician changes the treatment approach…that response is not about punishing the patient, but about changing the treatment plan on the basis of a new risk."

- Daniel Alford, MD, MPH

Opioid Prescribing for Chronic Pain — Achieving the Right Balance through Education *NEJM* 2016

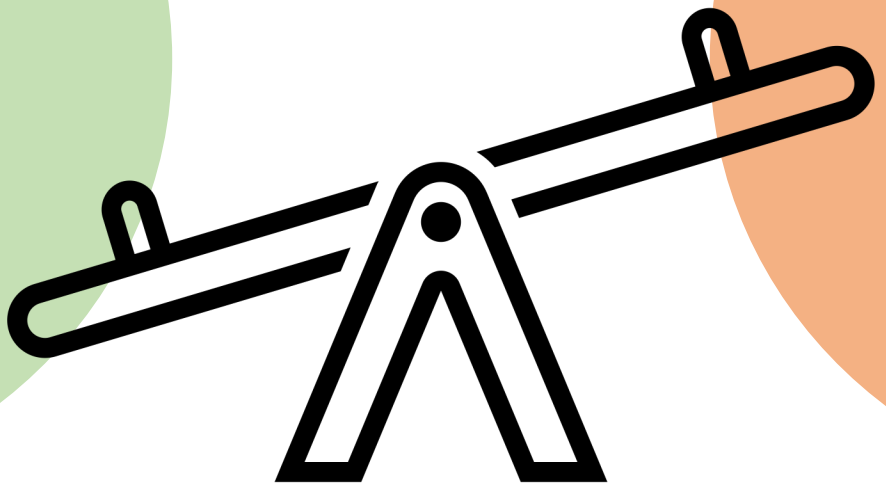
What happened to Janet?

Upcoming changes to CDC Guidelines

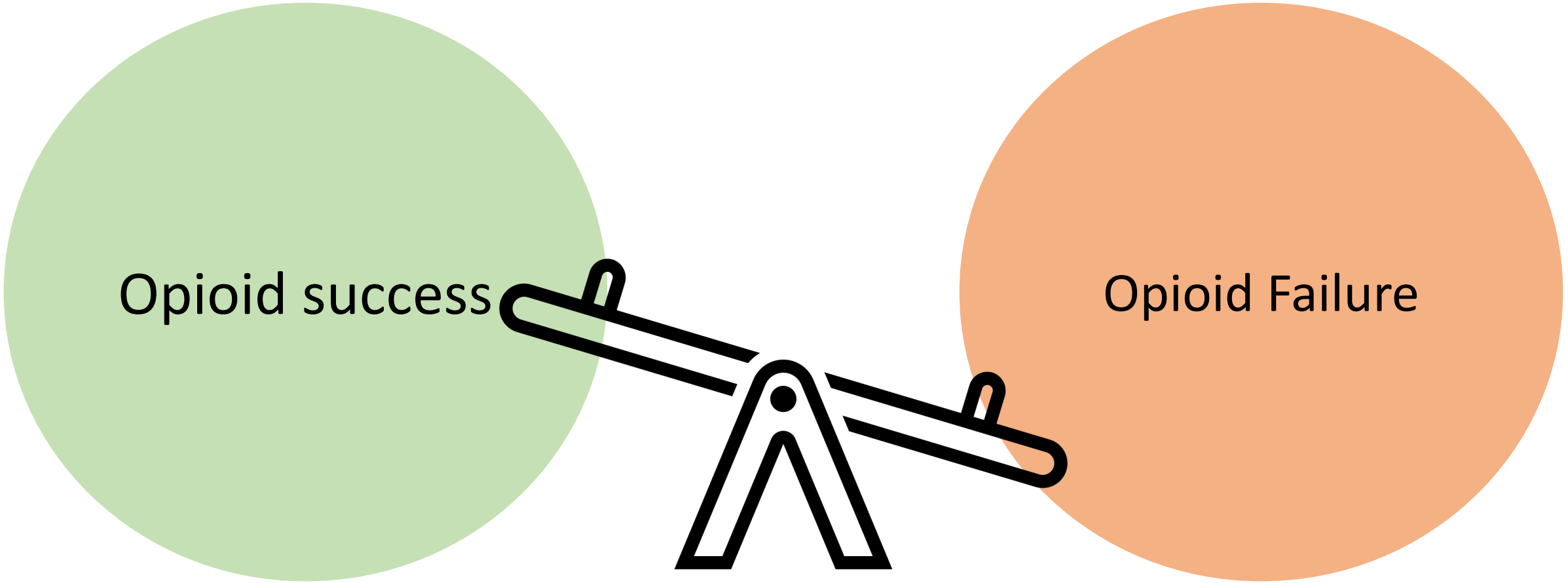
2016	2022 (draft)
Clinician assesses risk of starting opioids	Encourages shared decision-making
Explicit on risk of opioid harms	Adds risk of harm from discontinuation into risk/benefit calculation
“Recommended” dose limits	Now under “Implementation considerations”
“Avoid” benzodiazepine co-prescription	“Caution” benzodiazepine co-prescription
“Should use” urine drug testing	“Consider” toxicology testing “Prescribers should explain to patients that…results will not be used punitively”
Excludes sickle cell, cancer, end-of-life from guideline	“[Exclusion of certain diagnoses from] this guideline does not imply that any other types of pain are less worthy of effective treatment”
“Caution” >50 MME, “Avoid” >90 MME	“Caution” >50 MME
Encourages medication for OUD when present	Notes agonist therapy has better evidence than antagonist therapy for OUD

(1) CDC Guidelines for Opioid Prescribing, 2016
(2) CDC Guidelines for Opioid Prescribing: Opioid Workgroup Report and CDC Response, 2022

Opioid success



Opioid Failure

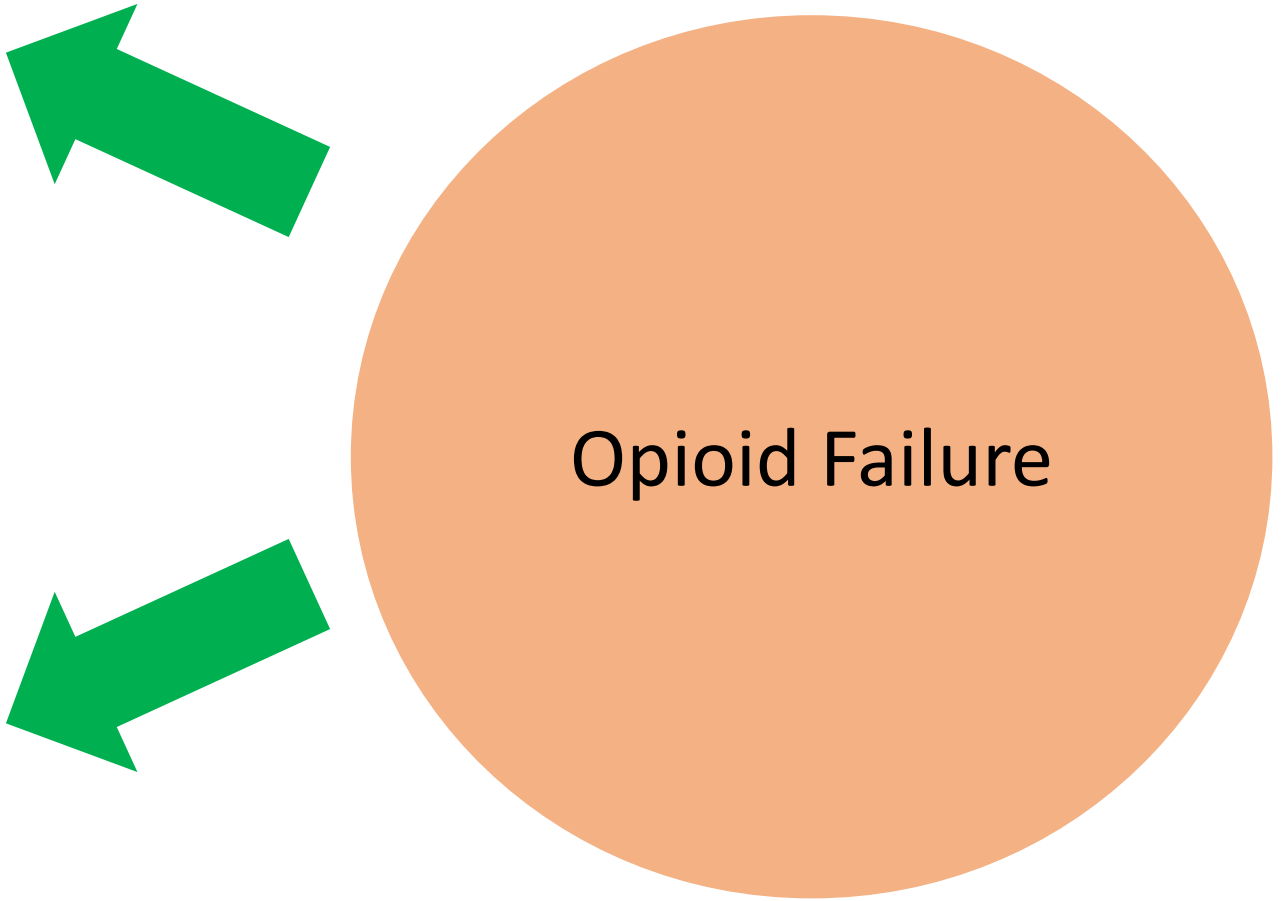

Opioid success
Opioid Failure

Taper

- Rapid (over 2-3 weeks)
- Standard (5-10% monthly)

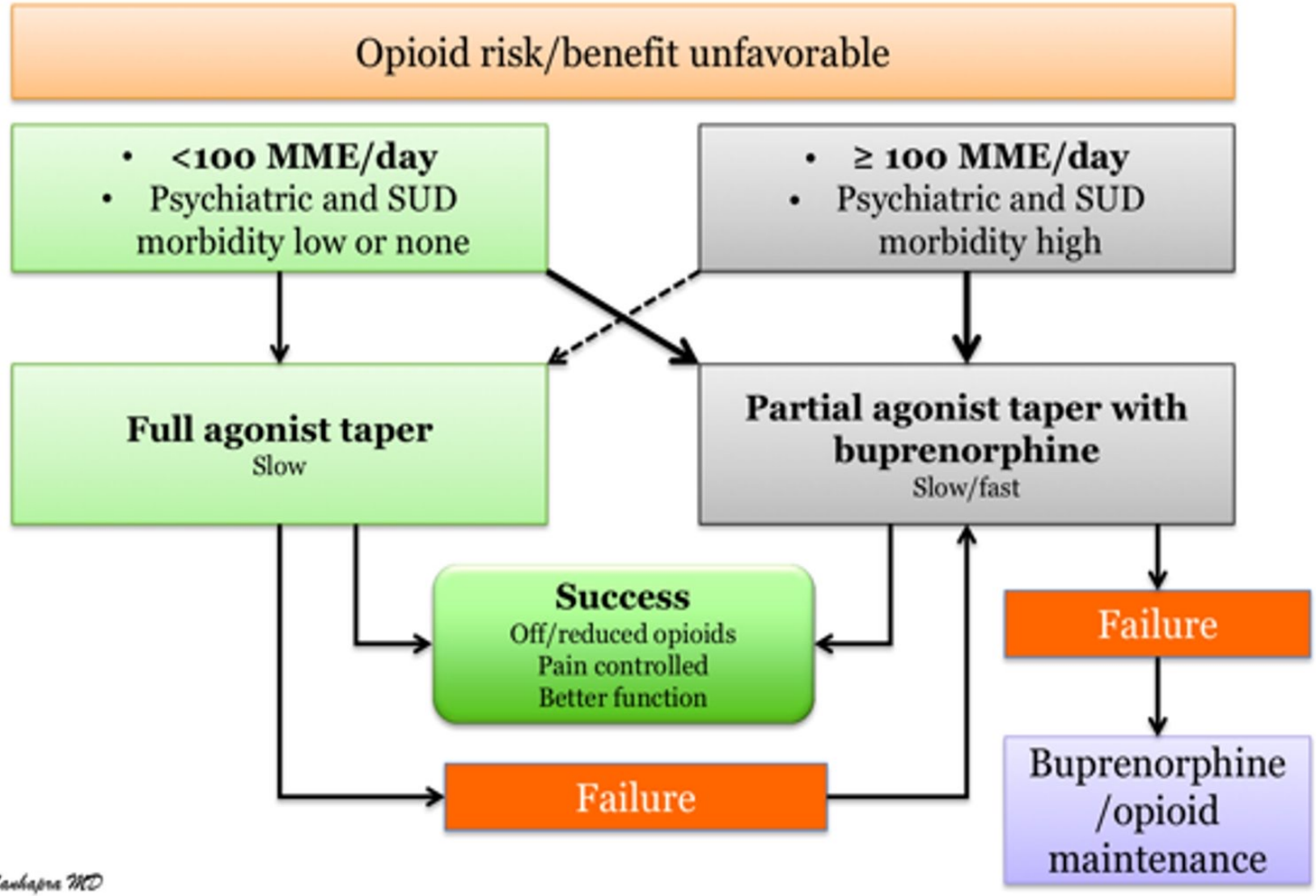
Transition

- Buprenorphine



http://www.cdc.gov/drugoverdose/prescribing/common-elements.htm
http://www.agencymeddirectors.wa.gov/guidelines.asp

Patient centered taper plan from addiction perspective



Manhapra, et al.

Buprenorphine Initiation

Traditional Initiation	Microdose/Low Dose Initiation
COWS >12 and/or 12-24 hours since last short-acting opioid Day 1: 4mg q1h prn up to 16mg TDD Day 2: Day 1 dose + 4mg prn up to 20mg TDD Day 3: Day 2 dose + 4mg prn up to 24mg TDD	Day 1: full agonist + 0.5mg bup Day 2: full agonist + 0.5mg bup BID Day 3: full agonist + 1mg bup BID Day 4: full agonist + 2mg bup BID Day 5: full agonist + 4mg bup TID Day 6: no full agonist + 4-8mg bup TID

Conclusion

- Universal precautions for chronic opioids include risk assessment, setting expectations, monitoring, and ongoing risk/benefit assessment
- Opioid failure occurs when risk of therapy outweighs benefit
- Patient-centered options for discontinuation of chronic full-agonist opioids include slow taper and transition to buprenorphine

References

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