Considering Opioid Use Disorder in Patients with Chronic Pain

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An “Inherited” Case

• 55 yo man with history of failed back surgery on high dose opioids, whose primary care physician recently retired
• Currently taking long-acting oxycodone 90 mg BID and short-acting oxycodone 15 mg 4/day
• Few urine tests done, but each was appropriate
• PDMP shows no additional prescriptions
• PHQ-9 is 16 “because I hurt so much”
• Inactive because “PT makes it worse”
Considering Opioid Use Disorder in Patients with Chronic Pain

- Recent opioid epidemic trends
- Pain history pearls for patients on high doses
- Talking to patients about high dose opioids
- Making an opioid use disorder diagnosis
- Switching to OUD medication
- Treating chronic pain
Opioid Epidemic

• In 2017, 1.7 million US adults had prescription OUD and 0.7 million had heroin-involved OUD
• This is an underestimate
• Of 70,237 drug-caused deaths in 2017, two-thirds (47,600) were opioid-related
• New increases noted in HIV and HCV cases in rural areas and among young adults due to injection use of opioid
Origins of the Opioid Epidemic

- 1990s norm that all pain should be eliminated
  - Pain as the “5th vital sign”
- Pharmaceutical company promotion
- Opioid over-prescribing
- Diversion, and widespread non-medical use of opioids, especially among youth
- Heroin widely available and less costly
- Limited access to medication treatment

Dreamland: The True Tale of America’s Opiate epidemic by Sam Quinones
Opioid Sales, Admissions for Opioid-Abuse Treatment, and Deaths Due to Opioid Overdose in the United States, 1999-2010.

Unintentional Prescription Opioid Involved Overdoses
Washington State

Source: Jennifer SabelPhD Epidemiologist, WA State Department of Health, May 2016
Pain and Addiction: Common Threads

• Similar risk factors
• Similar neurobiology
• Chronic, recurrent problems
• Treatment involves medication, self-management, and social support
• High dose opioid prescribing more common in patients with mental health and addiction issues
• High doses are the main problem for patients
Pain History Pearls

• Pain story from the beginning – use reflection!
• Current level of function (activities, sleep)
• Pain related goals
• Co-morbid conditions (apnea, hypogonadism, depression, inactivity)
• Upbringing (ACEs, addiction history going way back)
• “Side effects:” constipation, low energy, poor concentration, thinking about opioids, concerns about addiction/loss of control, others are worried

CDC-Kaiser ACE Study
Raising the Issue

• “What have you heard about the risks of opioids?”
• “We didn’t know of these problems when you started”
• “Guidelines suggest avoiding opioids for chronic pain”
• “I am worried about your safety and health over time”
  – Overdose, loss of control, apnea, falls, mood, less sexual satisfaction, increased pain sensitivity
• “Lower doses are safer and many patients have more energy after a taper”
• “There are lots of alternatives that may help”
• “We have time to try different things, and go slowly”
Opioid Use Disorder – DSM-5

**OPIOID USE DISORDER**
Larger amounts than intended
Persistent desire to cut down or quit
Significant time spent taking, obtaining
**Craving or urge to use**
Failure to fulfill obligations
Continued use despite negative interpersonal consequences
Reduced social, recreational activities
Use in physically hazardous situations
Use despite knowledge of harms
Tolerance *(excludes rx medication)*
Withdrawal *(excludes rx medication)*
* Recurrent legal problems deleted

**SEVERITY**
No SUD: 0-1
Mild: 2-3
Moderate: 4-5
Severe: >5

Moderate-severe OUD ≈ opioid dependence (DSM-IV)

Key principles:
- Negative consequences
- Cravings
- Tolerance
- Withdrawal
Diagnosing Opioid Use Disorder

• OUD diagnostic criteria can be difficult to apply clearly in patients on high dose opioids for chronic pain
• Four or more criteria constitutes a moderate to severe opioid use disorder and warrants OUD medication treatment
• OUD medications are highly effective medications that save lives!
Diagnosing Opioid Use Disorder

• “Are you concerned about addiction or loss of control of your medication?” “Have others been concerned?”
• “Do you sometimes have worse pain and take more medication, then go without later to make it up?”
• “Have you wanted to cut down or quit?” “Why?”
• “Do you find yourself thinking a lot about your pain medication?”
• Is reduced function a result of pain or opioids?
• Are side effects included in the “continued use in spite of consequences” criteria?
Rationale for Switching to OUD Rx

- Medication treatment for OUD with buprenorphine or methadone is safer than high dose opioids
- Data is limited, but many patients do well with a transition to OUD treatment
- Side effects from opioids, in particular sedation and withdrawal, are often reduced, increasing function
- Stabilizing the patient’s opioid systems allows for other forms of pain treatment
“But I’m not an addict!”
“I don’t have a safety problem!”

- Acknowledge that it is about what happened to them, not who they are
- “Many patients develop OUD as a result of pain treatment”
- Review DSM-5 criteria
- Acknowledge stigma of OUD and high dose opioids
- “No one thinks they will die from an overdose”
- “Do you imagine you will be on high doses of opioids for the rest of your life?”
Who Should Switch to Buprenorphine?

- Anyone with an opioid use disorder that is leading to unsafe medication use – yes!
- Patients with opioid use disorder and chronic pain whose function has not improved with high dose chronic opioid therapy – yes
- Any patient with opioid use disorder on high dose opioids – probably
- Any patient on high dose opioids – maybe*
- Patients getting functional improvement with low dose opioids – no (maybe taper, maybe not)

* Most buprenorphine products not FDA approved for pain treatment
Taper or Switch?

• Offering buprenorphine or taper is a reasonable approach for many patients
• 10% reduction should avert most withdrawal, but go slowly if you can
• Target clinic or state dosage goals initially
• OUD diagnostic criteria can emerge as doses are tapered
• Safety problems warrant a more directive approach
Learn to Treat Chronic Pain

• Educate patients that chronic pain is a disorder not well explained by tissue damage
• Diagnose and treat depression and anxiety
  – Improves pain outcomes
• Use non-opioid pain medications
  – Tricyclic antidepressants for sleep, pain
  – Anticonvulsants for neuropathic pain
• Emphasize non-medication treatments, especially physical activity and coping (CBT)
  – “There are no physical therapy failures”

Krebs EE et al. JAMA 2018 Mar 6;319(9):872-82
Do Not Abandon Your Patients!

- They are very vulnerable
- They are at risk to die
- They need your support
- Learn to use buprenorphine so you don’t have to discontinue opioids and refer
- Make it clear that whatever the opioid plan may be, you want to remain their provider
Considering Opioid Use Disorder in Patients with Chronic Pain

• High dose opioid therapy for pain is not safe
• OUD treatment with buprenorphine or methadone is much safer
• Conversations to uncover DSM-5 criteria for OUD are important
• Learn to treat OUD with buprenorphine
• Don’t forget to treat chronic pain effectively