

The Appropriate Management of Opioid Therapy

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No Disclosures

Objectives:

- Develop an understanding of established guidelines and current literature concerning the balanced approach to management and risks of opioid therapy
- Gain knowledge in the risk assessment of the chronic pain patient and the appropriate management of these patients in a multi-modal treatment plan
- Better understand the implications of opioids in the management of acute and chronic pain and how this impacts your practice
- Review appropriate risk mitigation strategies to avoid abuse and diversion

Oklahoma Statutes for Opioid Prescribing:

63 O.S. 2-309

**Compliance and Best Practices Statement for the Use of Opioids with
Relevant Statutory Codes**

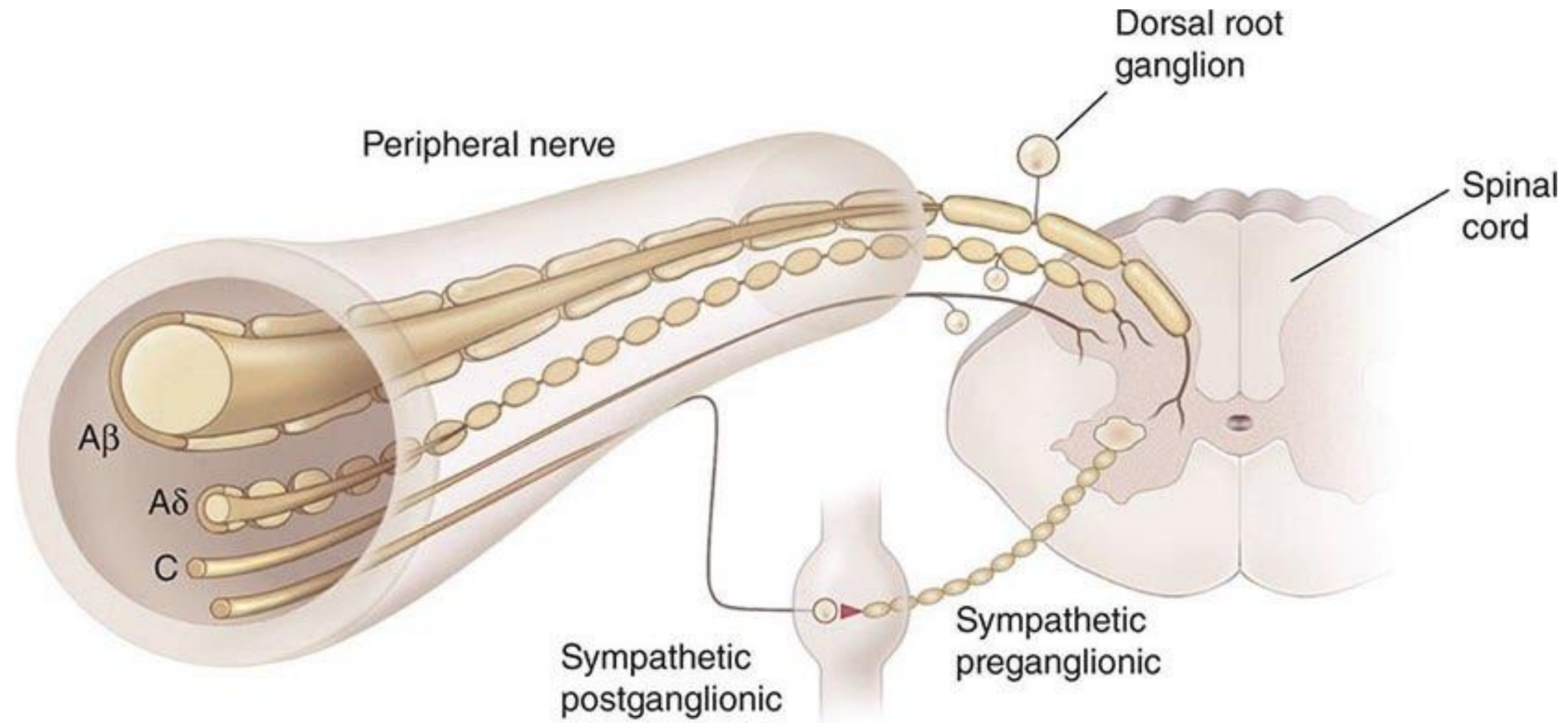
oklahoma.gov/osboe

okmedicalboard.org

“The ongoing opioid crisis lies at the intersection of two substantial public health challenges - reducing the burden of suffering from pain and containing the rising toll of the harms that can result from the use of opioid medications”

HHS 2019. “Pain Management Best Practices”

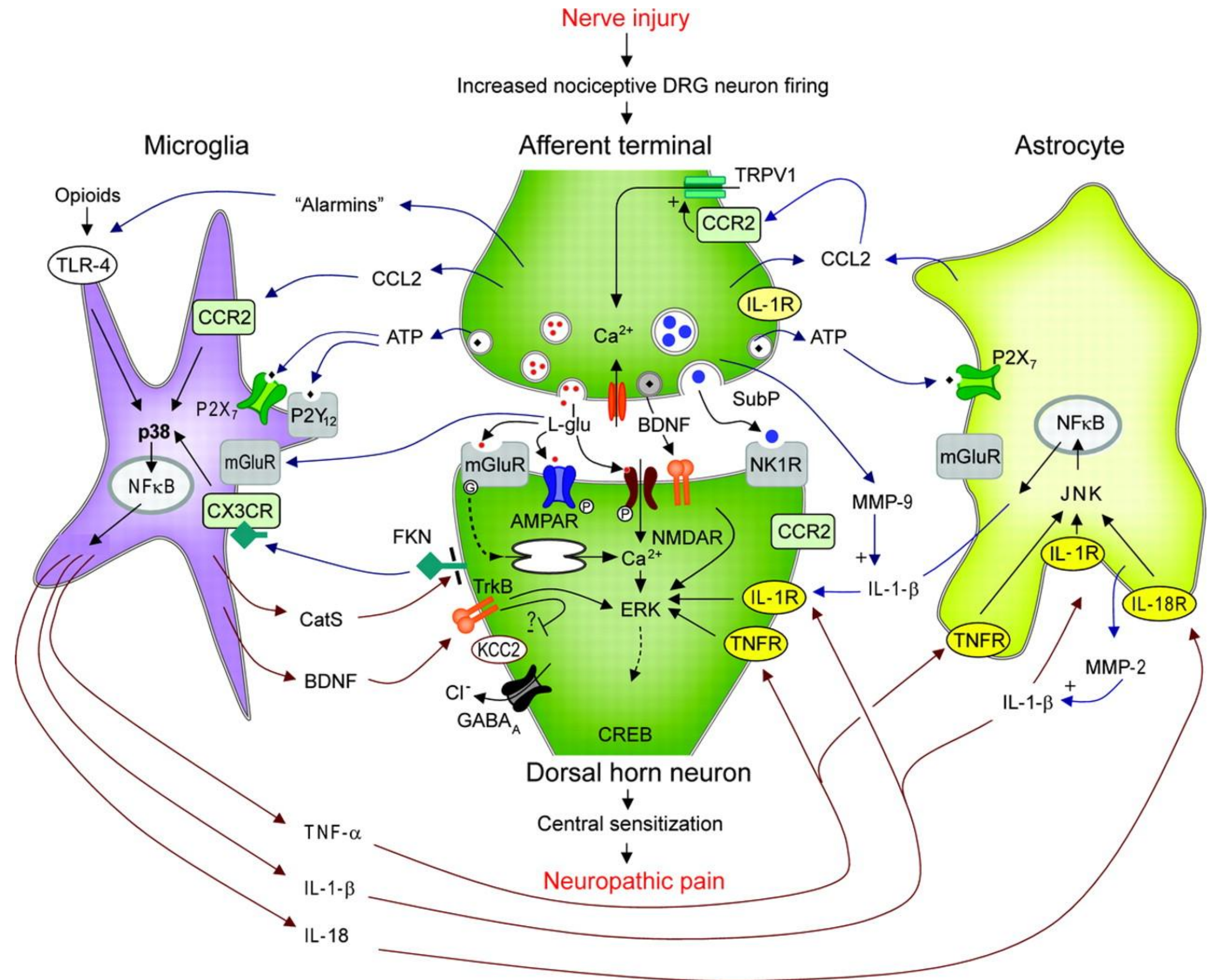
The Pathway of Pain





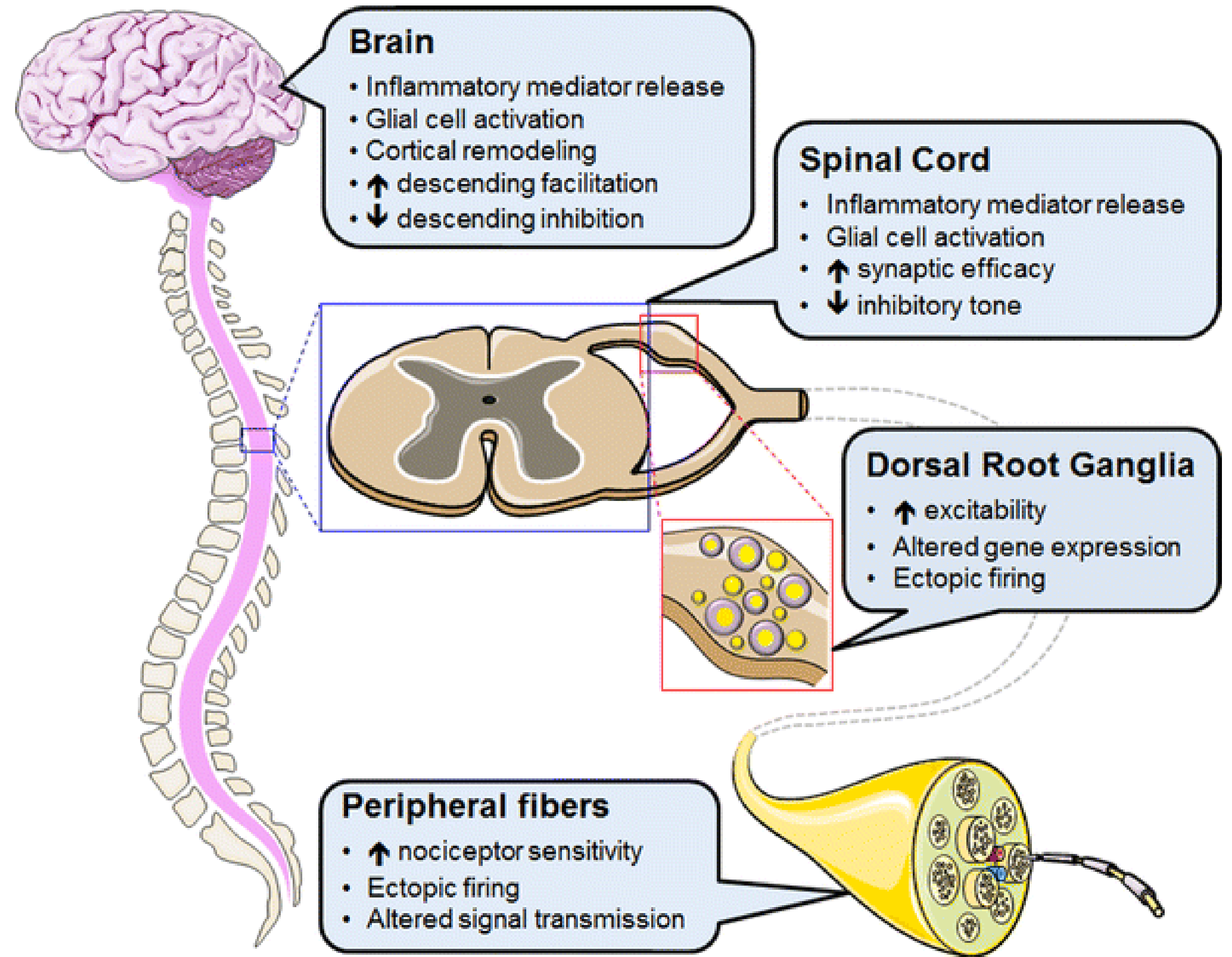
Pain:

A physiologic response to a noxious stimuli that can become pathologic



Pain Excitation:

- Peripheral and central
- Nociceptor changes
- Increasing excitability
- Decreasing protective paths
- Glial cell inflammation
- Long term changes

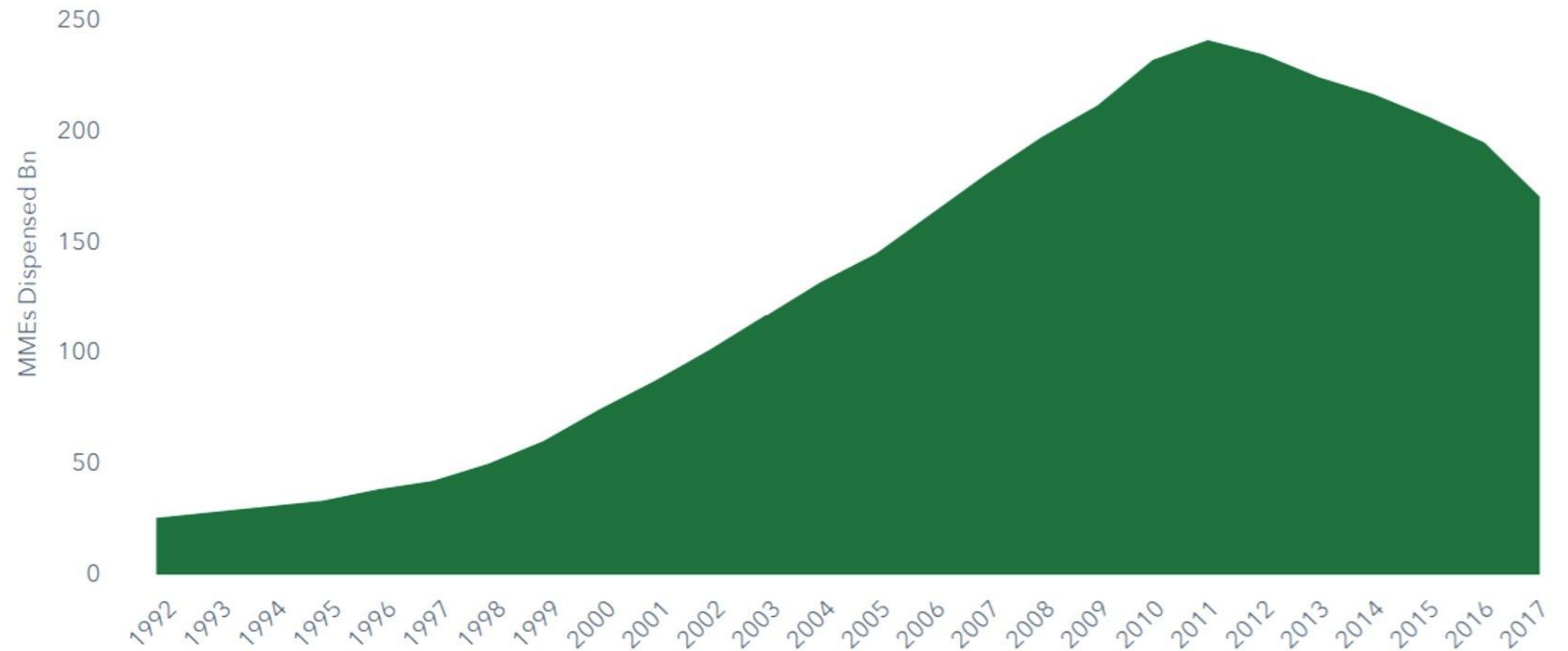


The Perfect Storm: 1996-2011

- Physician education on pain
- “Under treatment” of pain
- Introduction of ER opioids
- Minimal risk
- Addiction less than 1%
- 5th vital sign
- Pain scores

Prescription opioid volume peaked in 2011 at 240 billion milligrams of morphine equivalents and have declined by 29% to 171 billion

Chart 16: Narcotic Analgesic Dispensed Volume in Morphine Milligram Equivalents (MME) Bn



Source: IQVIA "SMART - Launch Edition", Dec 2017

CDC 2016 Guidelines: The Good and The Bad

- Recommendations were voluntary and intended to be flexible
- Rigid policies regarding MME
- Extension to patient populations not covered by the guidelines
- Some policies have been notably inconsistent
- Rapid tapers, duration limits and abandonment (FDA warning 2019)
- Applied to OUD treatment

“These actions are not consistent with the guidelines and have contributed to patient harm, under treatment, withdrawal, psychological distress, overdose and suicide”

2022 CDC Opioid Prescribing Guidelines

The Forgotten Patient:

- Previous guidelines did not address these vulnerable patients
- Compliant and functional on opioids
- Often higher dose therapy
- Long-standing opioid therapy
- Often exposed to forced tapering or abandonment with withdrawal
- Increased risks of psychological distress, overdose and suicide



2022 CDC Guidelines: Emphasis on Patient

- Patient selection
- Understanding various pain states
- Understanding high dose opioids
- Having an “exit plan”
- Guidelines for tapering
- Avoiding abandonment
- Awareness of OUD and misuse



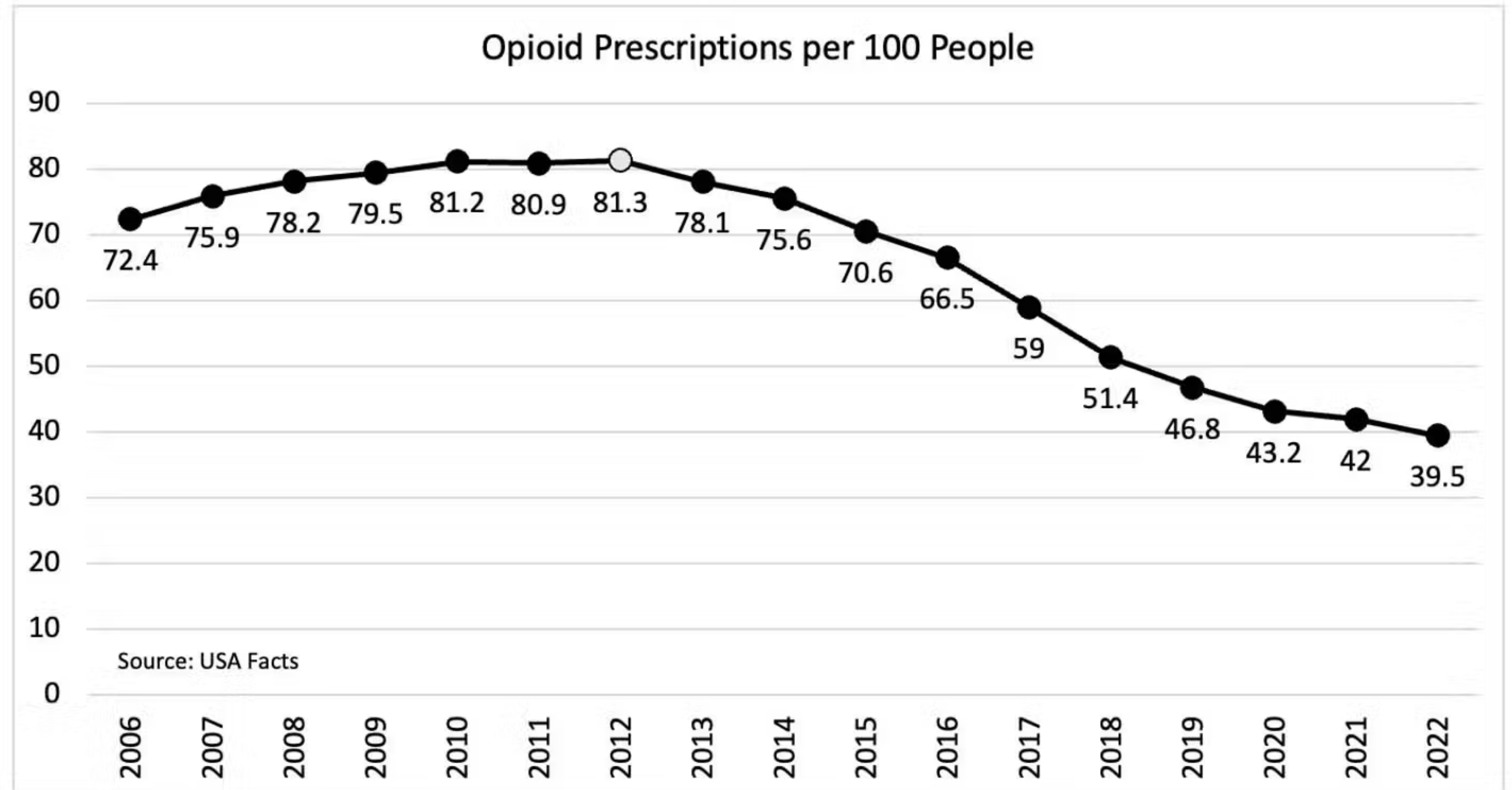
The Goals of Oklahoma Opioid Laws:

- Abuse and addiction harm reduction
- Overdose deaths from prescription opioids
- Decreasing risks of acute pain leading to chronic opioid therapy
- Alternative therapies attempted
- Dose reduction and cessation if not clinically contraindicated
- Emphasis on lower MME's
- Documentation of care and treatment decisions

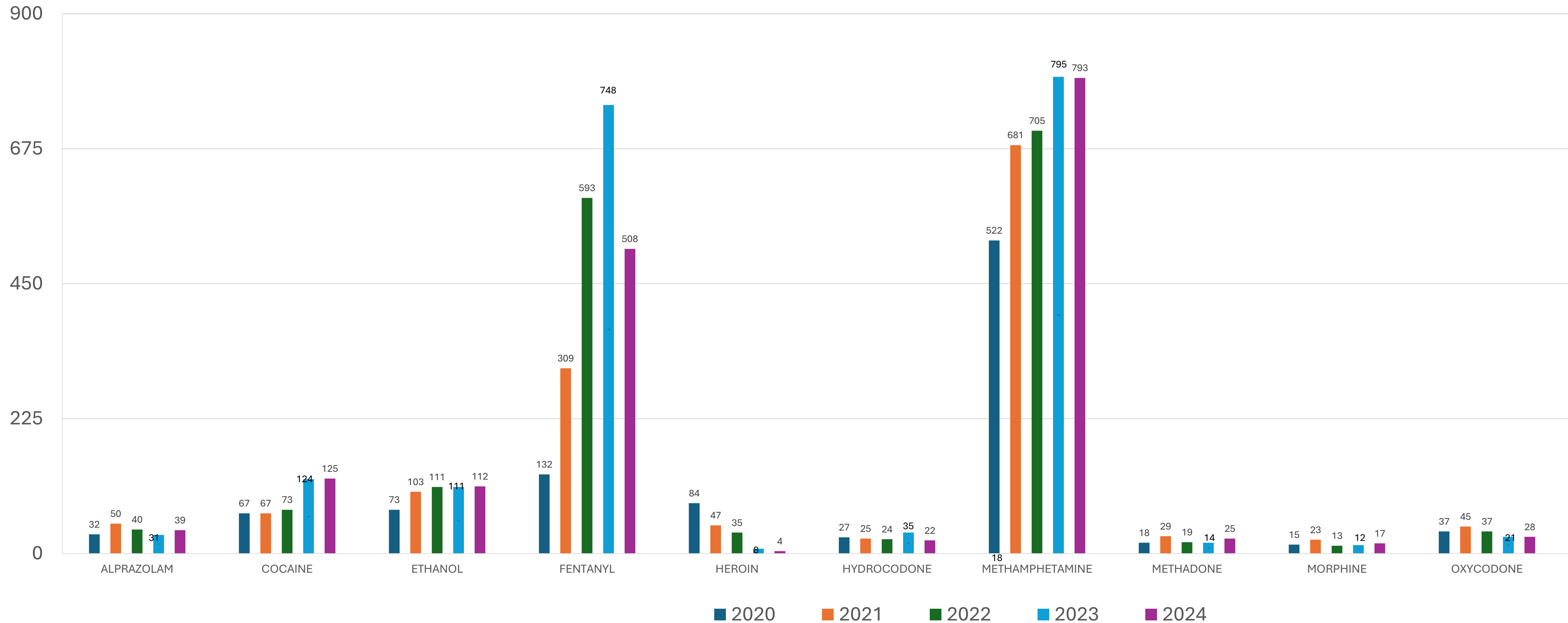
Why the Reduction?

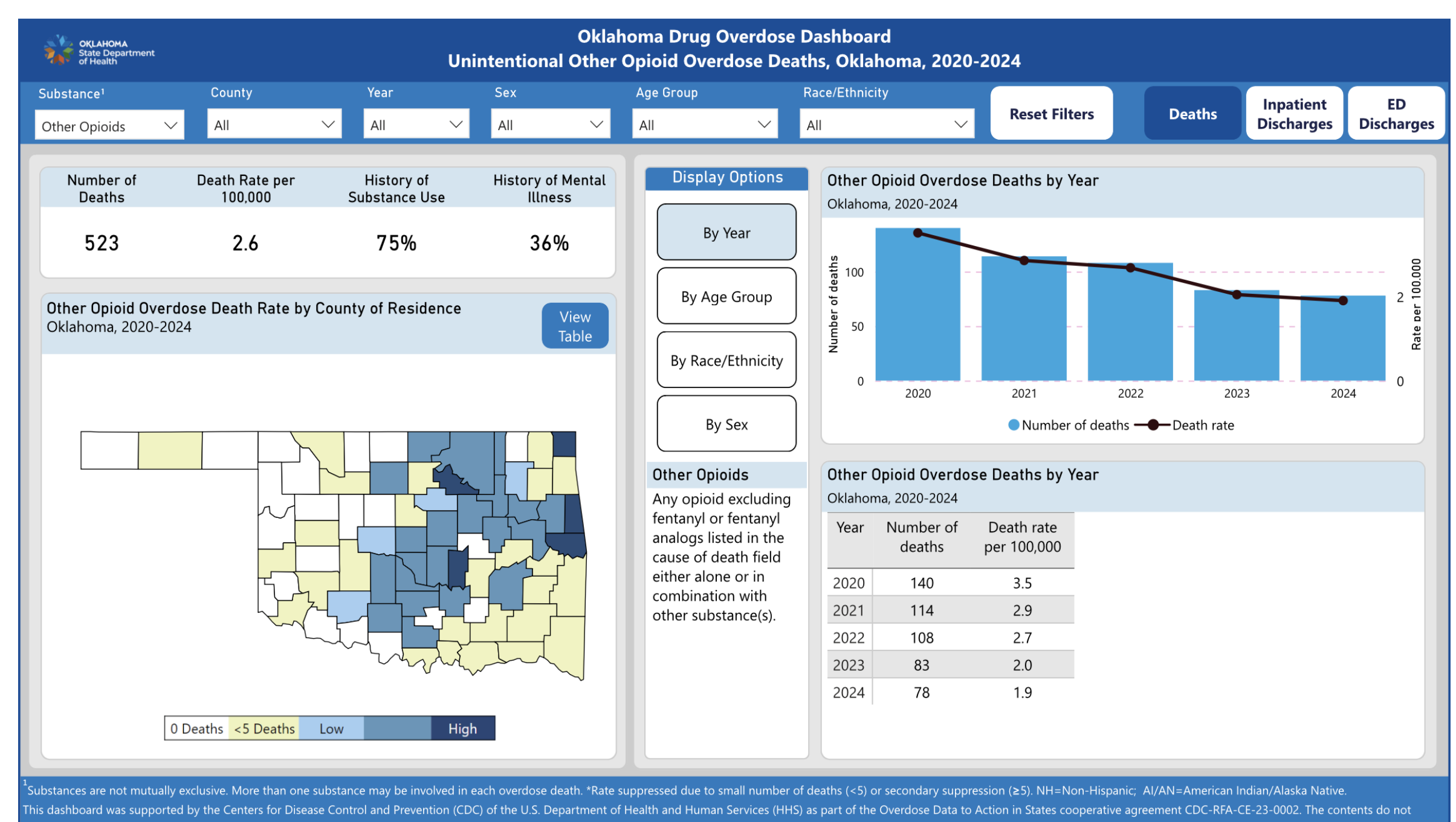
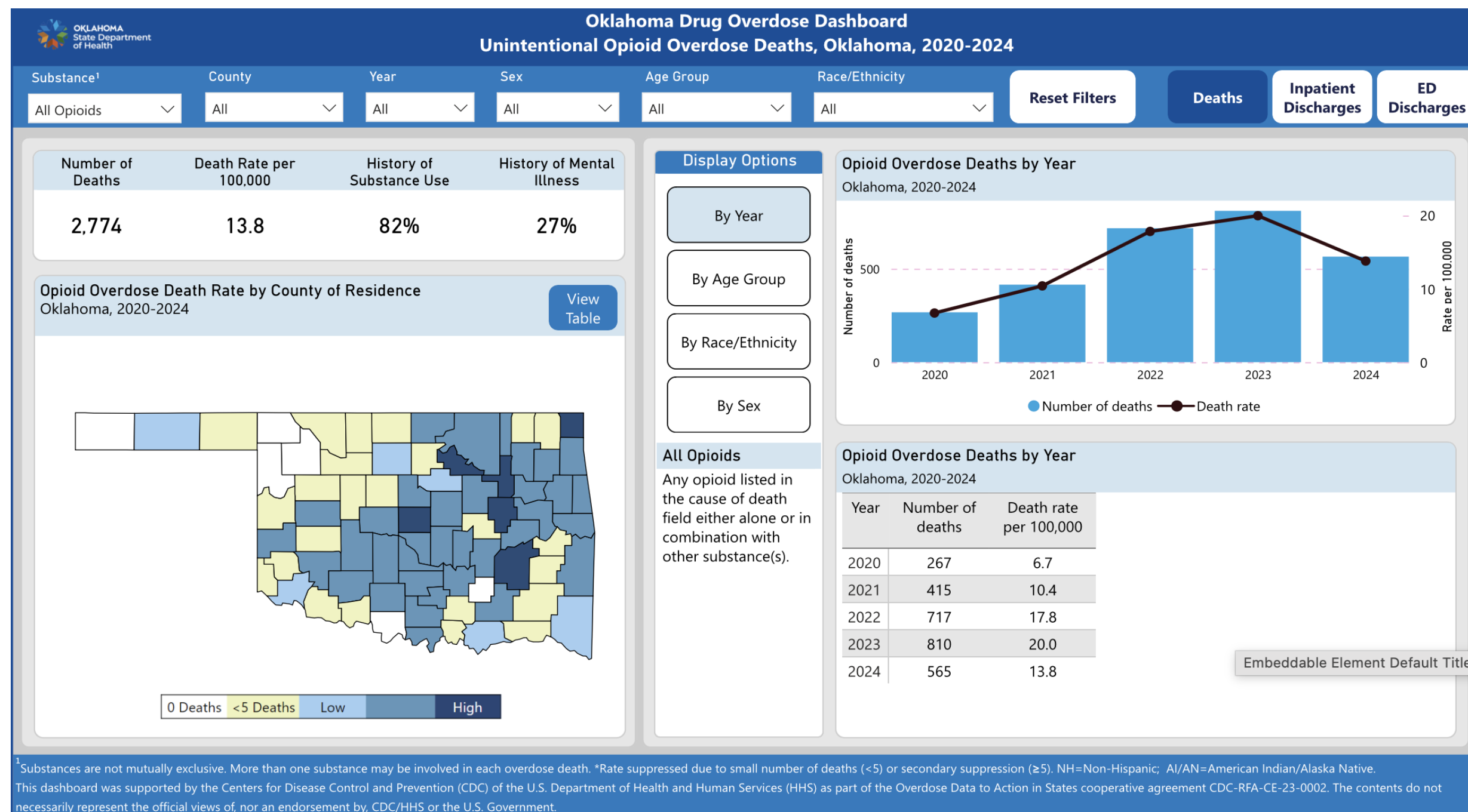
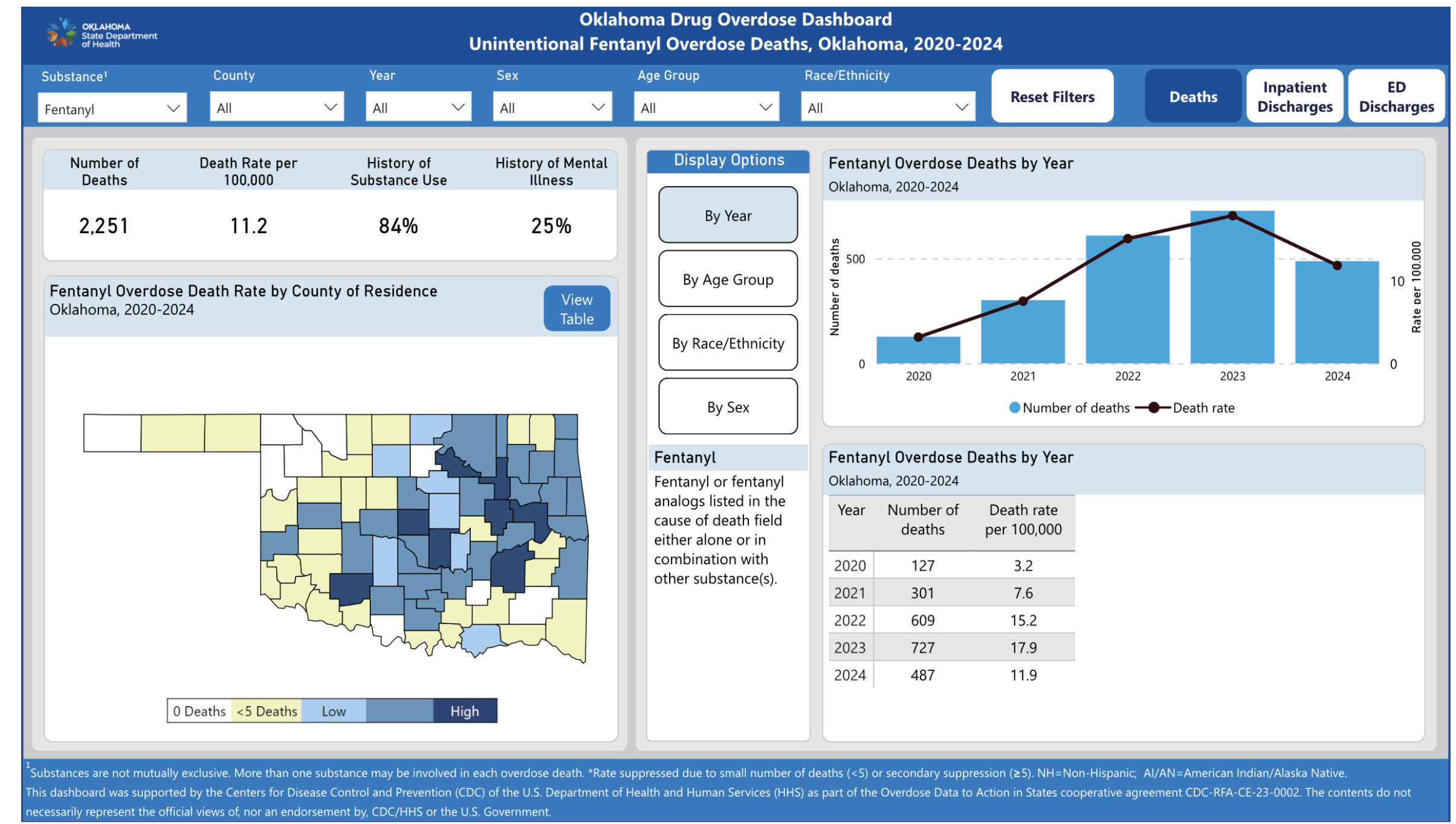
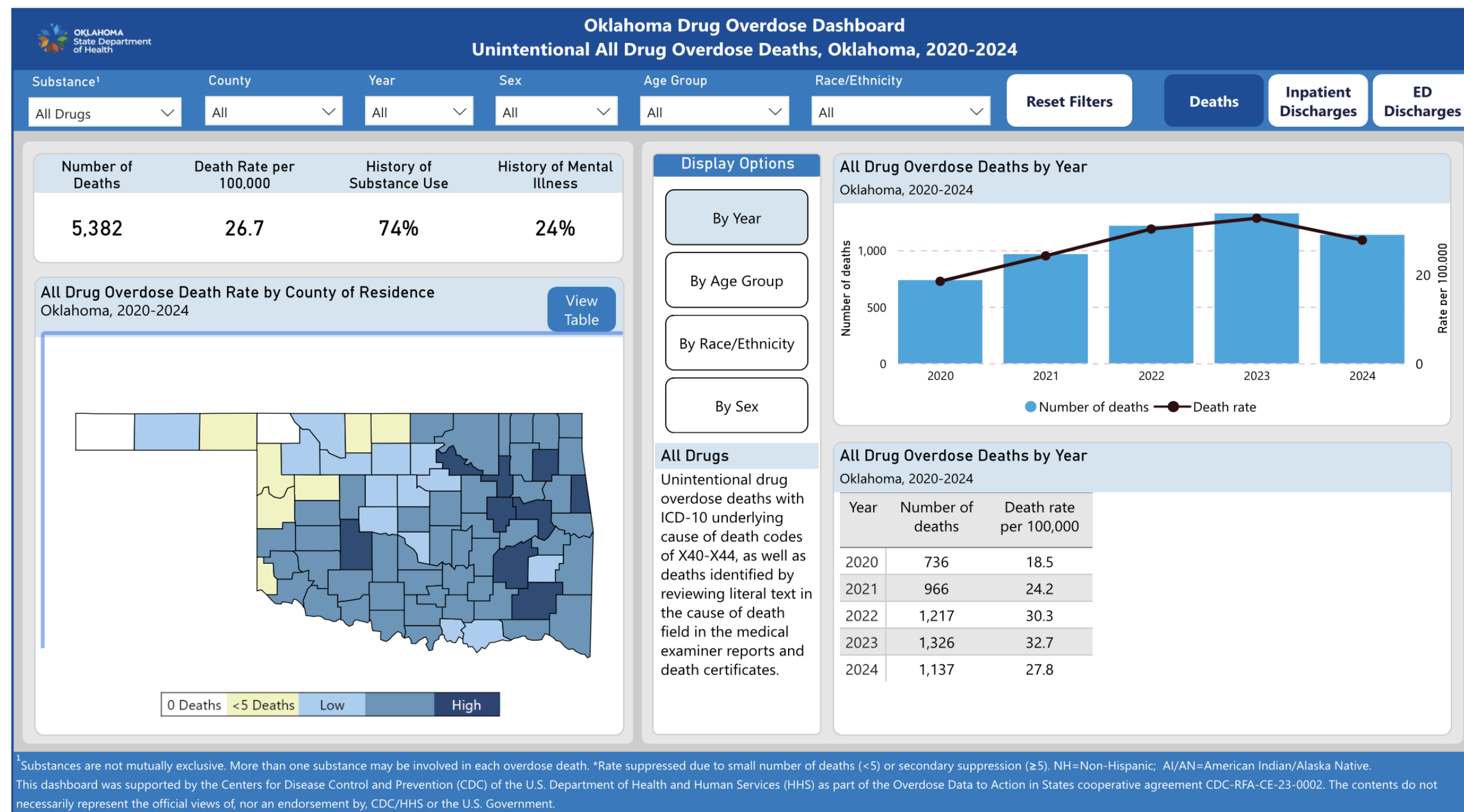
- Education
- Oversight
- Understanding
- Vigilance
- Awareness
- Fear

Figure 1



Top Drugs Listed in Cause of Death: 2020-2024 (OCME)





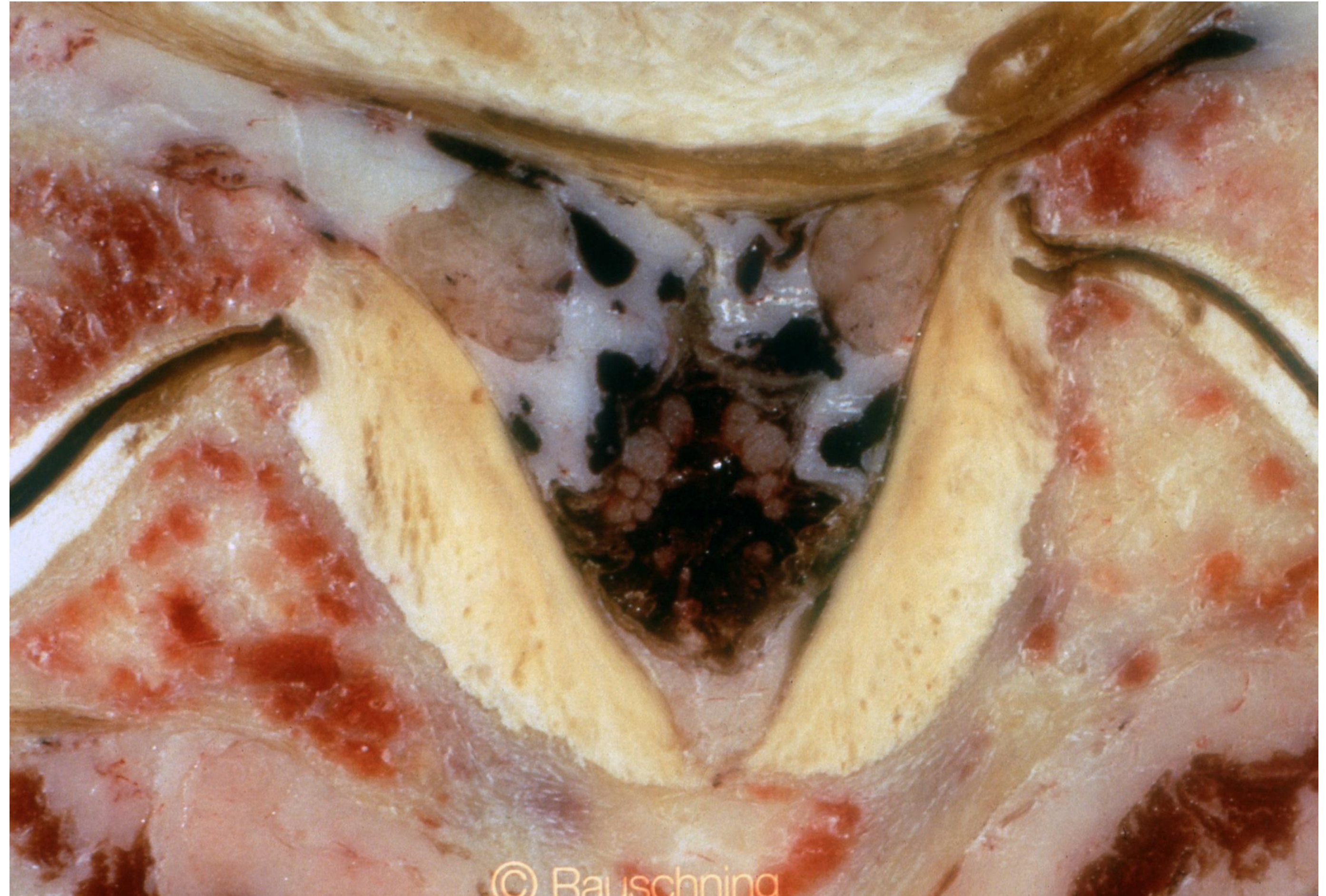
A “Biased” View of Opioids:

- Functionality
- Compliance
- Safety
- Caution
- Gravitas of the situation
- Respect and trust
- Dignity



An Opposing View of Opioids:

- “Legalized heroin”
- “No legitimate purpose”
- Risks outweigh any benefits
- All patients on chronic opioids will develop addiction
- Risks of devalued status and stigma
- Troubling encounters



What's Your Diagnosis?

- Not as simple as “chronic neck pain”
- What are we actually treating?
- “Work up” the pain complaint
- Important for determining patient selection for appropriate therapy
- Important for documentation
- Very common error



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First Line Approach

- Need to document therapies that patient has attempted
- Non-opioid approach
- Emphasis on
 - Behavioral therapies
 - Functional therapies
 - Adjunctive medications
 - Interventional therapies



Common Prescribing Mistakes:

- Continued escalation of opioid despite no evidence of improvement
- Opioids used in pain syndromes poorly responsive
- Failure to document thoroughly
- Not addressing psychosocial issues
- Lenient with abuse behavior
- Failure to use monitoring systems
- Laissez-faire attitude toward appropriate prescribing

Important Opioid Caveats:

- Insight based on available evidence:
 - **Opioid use may be the most important factor impeding function recovery**
 - **Opioids may not consistently relieve pain and can decrease quality of life**
 - **Routine use of opioids cannot be recommended**
- *Appropriate only for select patients with moderate-severe pain that significantly affects quality of life*

Opioids for Acute Pain

- Differences of acute vs. chronic pain
- Typically no central sensitization
- Most commonly inflammatory nociceptive pain
- Acute neuropathic pain often better managed with adjunctive medications
- There are still known risks utilizing opioids for acute pain including addiction
- Caution with patients having known SUD or OUD

Prescribing Opioids for Acute Pain

- A major emphasis of Oklahoma state law
- Goal is to limit quantity and use lowest effective dose
- Initial prescription not to exceed 7 days and must state “acute pain”
- Document rationale for script, alternatives and caution of addiction and risks
- Check the PMP
- 2nd 7 day script after visit or phone call with documentation of rationale unless confined
- PPA required after 3rd prescription or if the patient is a minor, pregnant or using benzodiazepines

Chronic Opioid Therapy:

- Consensus agreement that it may be useful in carefully selected patients with severe pain in a multimodal setting
- Demands
 - Compliant patient
 - Thorough documentation
 - Close monitoring through follow up
 - Vigilant monitoring for side effects, abuse and addiction
 - Understanding of opioid use in chronic pain

Important Points:

- Complete relief of pain is most likely ***not*** attainable
- Goals are increased function and not pain scores
- Patients should demonstrate a high level of responsibility
- Appreciate the gravity of opioid treatment
- Care should be based on mutual trust
- Strong patient-physician relationship is incredibly helpful

Physician Empathy and Chronic Pain Outcomes

[John C. Licciardone, DO, MS, MBA¹](#); [Yen Tran, BS²](#);
[Khang Ngo, BSA²](#); [et al](#)

JAMA Netw Open

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2024;7;(4):e246026. doi:10.1001/jamanetworkopen.2024.6026

Physician empathy was more strongly associated with favorable outcomes than were nonpharmacological treatments, opioid therapies and lumbar spine surgery

Patient Selection and Risk Stratification:

- History, physical examination and diagnostic testing
- Documentation of previous modalities and therapies
- Psychosocial risk factor screening
- Controlled substance agreement depending on several factors
- Ongoing assessment of patient for abuse
- Expectations: Patient *and* physician

Points to Emphasize:

- ER/LA formulations should be used very cautiously
- “Start low and go slow”
- Methadone
- COPD and sleep apnea
- Underlying health issues and the elderly
- Caution with high dose opioids
- Benzodiazepines with opioids

CDC Recommendation 11:

Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants (recommendation category: B; evidence type: 3).

- Although in some circumstances it might be appropriate to prescribe opioids to a patient who is also prescribed benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently. In addition, clinicians should consider whether benefits outweigh risks for concurrent use of opioids with other central nervous system depressants (e.g., muscle relaxants, non-benzodiazepine sedative hypnotics, and potentially sedating anticonvulsant medications such as gabapentin and pregabalin).

•CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States 2022

•Recommendations and Reports / November 4, 2022 / 71(3);1-95

Documentation: Tell a Story

- Any new information about the etiology of the pain and course of treatment
- The course of treatment including non-opioid modalities
- Carefully document decisions to start, continue or increase opioid
- Periodically make reasonable efforts, unless clinically contraindicated, to reduce or stop
- Assess the patient for potential abuse or psychological dependence
- Make a point of documenting normal/abnormal monitoring and rationale for changes
- With electronic charts this can be a trap

Moderate to High Dose Opioids

- 50 - 100 MME
- Benefits >50 not well established
- “Clinical pause” should be taken at 50 MME
- Risks of overdose are dose dependent
- Higher MME requires more frequent visits and perhaps consultation
- Documentation of rationale for higher doses is imperative

High Dose Opioid Therapy:

- Typically greater than 100 MME
- Documentation *must justify* the higher doses
- Be extremely careful and cautious
- Strong evidence linked with poor outcomes
- Good evidence linked to OIH
- 9X increased risk of overdose death
- Remember that elimination of pain is not the goal

Opioid Induced Hyperalgesia

- Caused by high dose opioid therapy and rapid dose escalation
- Perhaps up to 10-20% of opioid therapy patients (including malignant pain)
- Activity at the both the peripheral and central pathways
- Glial cell activation and inflammation at the mu-receptor
- Increased sensitivity to non-noxious and noxious stimuli
- Commonly confused with tolerance
- Treatment is slow dose reduction

“Forced” Reduction:

- No evidence for this approach
- Vulnerable patient population
- Evidence shows harm (FDA warning)
- Increased disability, overdose, illicit drug use and suicide
- Destroys patient-physician trust
- **Only** exception is severe opioid side effects



“I Felt Like I Had a Scarlet Letter”

- Three elements of structural stigma identified with tapering/discontinuing opioids
 - Overlooked subjects of the U.S. opioid crisis
 - Felt invalidated by cultural norms linking chronic pain to stereotypes
 - During and after tapers feelings of marginalization were enhanced
- Patients felt orphaned by the system
- Tapering initiatives reinforced devalued status of patients with chronic pain, reduced well-being and confidence in the medical system
- Conclusions found tapering may exacerbate the burden of stigma in those with chronic pain

Tapering Considerations:

- Patient education and discussion of risks and benefits
- Patient agreement and interest is paramount
- Patient collaboration on plan to include length of taper and possible pause
- Typically can take weeks to months
- Key is to avoid withdrawal
- Goal may not be cessation but rather lower dose
- Needs frequent follow up

Why the Poor Response to Opioid Therapy:

- Perhaps the biggest mistake clinicians make is continued escalation of doses
- Think of the differential diagnosis for poor response
 - Patient selection
 - Pain syndrome
 - Unrealistic expectations
 - Lack of multimodal approach
 - Opioid induced hyperalgesia
 - Abuse and diversion

Success

- Compliant patient who understands the concept of the therapy and importance of close observation
- Rare dose increases
- Often open to tapering dose
- Honest and straightforward when problems arise
- Functionality improves
- Understands the goal of therapy
- Realistic expectations

“The catalyst of the opioid crisis was a denial of the addictive potential of prescription opioids”

HHS 2019. “Pain Management Best Practices”

Opioid Use Disorder:

Predicting risk is challenging and available tools are not reliable to test for risk of OUD (CDC: 2022)

- A major emphasis across the spectrum
- 3-26% incidence (controversial)
- Inability to reduce or control opioid use
- “Craving”
- Reduced function despite opioids
- Often poor insight and social support
- Management is with medications for OUD and counseling

Factors Associated with OUD:

- Poor pain control (65% per CDC)
- History of substance use disorder
- Taking medications to feel good or decrease withdrawal symptoms
- Initial exposure to opioids at a young age
- Adverse childhood experiences
- Manipulative behavior
- Higher opioid dose and longer use

Risk Mitigation:

- Predicting risk is challenging
- PMP
- UDS, pill counts
- Monitor based on risk
- Address and document
- Regular monitoring critical as risks and benefits do not remain static



Urine Drug Screening:

- Immunoassay in office all new patients and then random based on risk
- Prone to false positives
- Detects opiates
- Is the drug in the system?
- Are illicit drugs present?
- Trigger events (signs of abuse, suspicious activity, phone calls)
- Confirmatory testing?

Physician Protect Thyself

- Pay attention to a pattern of activity that suggests abuse and address
- Monitor closely through follow up
- Use available tools for risk mitigation and document findings
- Diligent charting of prescribed opioids with attention to lost, stolen or early requests
- Obligated to protect yourself, your patient and society from opioid abuse and diversion
- “Under no circumstances may a physician dispense with the knowledge the drug will be abused or diverted” (*DEA 2006*)

Helpful Hints:

- Develop a template for your chart system
- Have a mechanism to contact patients for concerns
- Check PMP before refills
- Justify any dose increase
- Have open communication with mid-level provider
- Listen to the pharmacist
- Trust your gut

Grace...

Empathy...

Understanding...



References:

- 2022 CDC Clinical Practice Guidelines. Nov 4, 2022. ([cdc.gov](https://www.cdc.gov))
- HHS Pain Management Best Practices Task Force. ([hhs.gov](https://www.hhs.gov))
- Oklahoma Senate Bills and statutory codes
- OCME Presentation to Attorney General Community Task Force on Substance Abuse. 2024