Addressing the Opioid Epidemic: Prescribing Opioids for Non-Cancer Pain

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Epidemiology of prescription opioid addiction
Focus on the decision to prescribe opioids for chronic pain at the point of care
Identifying those at risk of “opioid problems”
Adjusting to these risk factors in outpatient care
How Back Pain is Taking Over the World (especially in the USA)

- #2 Cause of disability-adjusted life-years in rich nations.
- 100 million US adults with chronic pain
- 50 million with low back pain
- ~35 million seek healthcare for LBP
- 50% of patients with CLBP prescribed opioids


Opioid overdose death and hospital admissions have risen with rates of opioid prescribing

US accounts for
- 4.6% of the world’s population
- 80% of global opioid supply
- 99% of global hydrocodone supply

Sources: Paulozzi et al Journal of Safety Research 2014;
https://www.asipp.org/documents/ASIPPFactSheet101111.pdf
Western PA is in the upper 25% of rates of opioid prescribing and the upper 25% of opioid deaths—CDC, 2016

- We have an opportunity and an obligation to do something profound to solve the crisis here
4-fold increase in opioid overdose since 2000

Age-adjusted death rates from CDC reported in Compton

NEJM 2016
Opioid Prescribing is Decreasing

Morbidity and Mortality Weekly Report (MMWR)
CDC
Weekly / July 7, 2017 / 66(26);697–704
2 Key Patient Categories

• 1. Non Medical use of prescription opioids in people \textbf{without} pain for psychoactive effects

• 2. Medical use of prescription opioids in patients \textbf{with} pain leading to addiction

• The availability of prescription opioids to both groups (those with and without pain) is a key driver of the opioid epidemic
The epidemics of pain and opioid addiction are entwined

**PAIN**
--100 million people with chronic pain
--$635 billion in costs
--25-40 million are prescribed opioids
--5-15% will develop an opioid addiction disorder

**Opioid Addiction**
--2.4 million have a prescription opioid substance use disorder
--80% of heroin users started with RX opioids
--50% in opioid addiction treatment have pain

Common
--Pain/Reward/Mood circuits overlap in the brain
--Both are chronic diseases
Addiction

A state in which an organism engages in a compulsive behavior

- behavior is reinforcing (rewarding or pleasurable)
- loss of control in limiting intake
Addiction Disorders and Motivated Behavior

Choice

Physiological Drive  Conditioned Learning

- Not a totally free choice.
- The disease of addiction (the biological components) drives the bad choices to use the harmful substance.
Opioid Use Disorder and the 5Cs

- DSM-V Opioid Use Disorder Category
  - Now on a continuum—mild, moderate, severe
  - Continuum maps to misuse, abuse, addiction

- ASAM and AAPM criteria for prescription opioid addiction:
  - Chronic
  - Compulsive use
  - Control - impaired
  - Craving
  - Continued use despite harm
General approaches to opioid prescribing

- What **conditions** respond better to opioids?
- Will the patient, as an **individual** respond well?
- Who will have good, sustained relief at moderate doses?
- Who will follow the rules—no early refills, opioids from 1 MD, no inappropriate self-medication, no drugs, no addiction, no diversion? **THERAPY ADHERENCE**
  - Social risk factors
  - Propensity for misuse or addiction
  - Psychiatric comorbidity
    - Ongoing addiction disorder
    - Depression/anxiety/personality pathology
What does Good Analgesia Mean in Chronic Non-Cancer Pain?

• Approach is improvements for chronic pain which are sustainable (not short-term relief)

• **Sustained improvement in pain**—at least 30% improvement and >3 months
  – Pain \( \leq 4/10 \)---patients can do most things

• Significant improvement in function

• Standardized measures
  – Pain, Enjoyment, General Activity Scale

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**ASSESSING PAIN & FUNCTION USING PEG SCALE**

**PEG score** = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

**Q1**: What number from 0–10 best describes your pain in the past week?
  0 = “no pain”, 10 = “worst you can imagine”

**Q2**: What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
  0 = “not at all”, 10 = “complete interference”

**Q3**: What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
  0 = “not at all”, 10 = “complete interference”

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Farrar J, 2001; Ballantyne J, 2003; Fields HL, 2005
THE CONDITION

- Cancer pain +++
- Post-operative pain +++
- Acute pain with a clear etiology +++
- Chronic non-cancer pain—summary of trials
  + Musculoskeletal pain of clear etiology—arthritis, ++
  + CLBP +/- Often hard to know etiology—many levels of nervous system involved
  + Neuropathic Pain (due to nerve injury) +
Psycho-Social Selection Process

- Detailed substance use history
  - No active SUD
- Family Sub use Hx
- Current and past psychiatric history
  - Depression or anxiety disorders, personality pathology
- SOAPP—checklist of risk factors
- COMM--checklist of risk factors
- Urine tox at baseline
- PDMP
Checklist for prescribing opioids for chronic pain
For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

**When CONSIDERING long-term opioid therapy**

- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (e.g., addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (e.g., PEG scale).
- Schedule initial reassessment within 1-4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

---CDC, 2016

Aberrant Drug-Related Behaviors—Look for clusters of symptoms

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<thead>
<tr>
<th>More Predictive of ADDICTION or Diversion</th>
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<tr>
<td>□ Selling prescription drugs</td>
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<td>□ Prescription forgery</td>
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<td>□ Stealing or “borrowing” drugs from another patient</td>
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<td>□ Injecting oral formulations</td>
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<td>□ Obtaining prescription drugs from non-medical sources (street)</td>
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<td>□ Concurrent abuse of illicit drugs</td>
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<td>□ Multiple unsanctioned dose escalations</td>
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<td>□ Repeated episodes of lost prescriptions</td>
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<th>Less Predictive</th>
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<tr>
<td>□ Complaining about the need for higher doses</td>
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<td>□ Drug hoarding during periods of reduced symptoms</td>
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<td>□ Requesting specific drugs</td>
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<tr>
<td>□ Prescriptions from other physicians **questionable</td>
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<td>□ Unsanctioned dose escalation</td>
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<td>□ Unapproved use of the drug</td>
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<td>□ Reporting psychic effects not intended by the physician</td>
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Jaffee 1996
TAPERING AND DISCONTINUING OPIOID THERAPY

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:

1. **Go Slow**
   - To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).

2. **Consult**
   - Work with appropriate specialists as needed—especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.

3. **Support**
   - During the taper, ensure patients receive psychosocial support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

NONOPIOID TREATMENTS FOR CHRONIC PAIN

--Pain education, medications, physical therapy, mental health care, yoga, acupuncture
• Reported that >120 mgs per day of morphine equivalents is associated with greater rates of opioid misuse, inadvertent overdose, and death.

• Recent evidence suggests that many of these complications involved co-prescribing of BZD’s (Ativan, Xanax, Valium, Klonipin) and opioids, particularly in patients with major depression and/or anxiety disorders.

• So total dose may be less important than the subgroup who is prescribed opioids and BZD co-prescribing.

What to do?

• For any aberrant behavior evaluate for other possible comorbidities—
  – Worsening of the physical condition (cancer, for example)
  – Depression/anxiety/PTSD
  – Missed psych risk factors—Past history of physical or sexual abuse
  – Patients may be self-medicating anxious or depressive feelings
  – Cancer patients may be self-medicating a sense of suffering (not pain per se)

• Misuse—
  – Prescribing smaller quantities (1 or 2 week supply)
  – More strict prn dosing parameters for PO meds
  – Tighter monitoring and more frequent visits
What to do?

• Misuse—
  – More frequent urine tox screens
  – Opioid adherence visits with a medical or behavioral health provider
  – Adherence counseling via motivational interviewing
  – Opioid agreements

• Addiction
  – Consult an addiction medicine provider
  – Even if there is an acute pain situation, the patient is at an increased risk of death due to inadvertent overdose, so precautions are important
Population-Based Strategies at UPMC to Manage Opioids

- HIGHLIGHTS
- 2500 providers completed online opioid education
  - ~500 PCPs and 2000 NPs and PAs
- Expanding multidisciplinary pain and addiction treatment resources in primary care and pain clinics
  - Psychology/Psychiatry/Social Workers with addiction training
Conclusions

- Addiction is a bio-behavioral illness in which the addicted patient only has partial control over his/her behavior.
- Providers can follow a structured selection process to decide whether to prescribe opioids for non-cancer pain.
- You can use various factors to decide if the patient is at a low, moderate, or high risk of opioid misuse.
- There are strategies to manage or decrease opioid misuse.
- Good care of chronic pain takes time and expertise, but providers of all specialties can do it.
- Guidance materials available.
- Good opioid care takes time and resources.