Opioids in Chronic Non-Cancer Pain: Starting and Stopping

Lisa Bromley, MD, CCFP, FCFP
Objectives

• Understand what is entailed in a comprehensive assessment prior to starting (or continuing) an opioid prescription. Predict which patients are likely to do well on opioids.

• Understand how to monitor long term opioid therapy.

• Understand in which situations it may be beneficial to taper or discontinue opioids, how to motivate patients to taper, and acquire strategies to taper or discontinue opioids when indicated, in the face of patient apprehension or reluctance.
Financial Disclosures

Content created by Lisa Bromley, MD, CCFP, FCFP

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Avoiding Abuse, Achieving a Balance:
Tackling the Opioid Public Health Crisis
A Flood of Opioids, a Rising Tide of Deaths

Susan Okie, M.D.

Faced with an epidemic of drug abuse and overdose deaths involving prescription opioid pain relievers, the Food and Drug Administration (FDA) plans to require opioid makers to provide training for physicians and patients education materials on the appropriate prescribing and use of extended-release and long-acting versions of these drugs. But since July, FDA officials have been scrambling to revise their proposed Risk Evaluation and Mitigation Strategy (REMS), after an advisory panel of the agency's Anesthetic and Life Support Drugs Advisory Committee and Drug Safety and Risk Management Advisory Committee voted 25 to 10 against the REMS plan, saying it didn't go far enough. Advisors urged that training in appropriate use of opioids be made mandatory for all physicians who prescribe them.

In the eyes of many patients, these opioids "are essentially legal heroin," advisory committee member Lewis Nelson of New York University School of Medicine commented during the panel's discussion. "We need to think about how we would construct a REMS if we were going to be marketing heroin." With more than 25 million prescribers of controlled substances registered with the Drug Enforcement Administration (DEA) and about 4 million U.S. patients receiving long-acting or extended-release opioids each year, the FDA's opioid REMS will affect far more people than any existing REMS for high-risk medications.

Any discussion of restricting the use of pain medicines provokes emotional debate, with some advocates warning that people in chronic pain may be underestimated or stigmatized and others arguing that access to powerful painkillers leads to thousands of deaths each year.

There is ample evidence that action is needed. According to the Centers for Disease Control and Prevention (CDC), deaths from unintentional drug overdoses in the United States have been rising steeply since the early 1990s (see line graph) and are the second-leading cause of accidental death, with 27,648 such deaths recorded in 2007. That increase has been propelled by a rising number of overdoses of opioids (synthetic versions of opium), which caused 11,400 of the deaths in 2007 — more than heroin and cocaine combined (see line graph). Visits to emergency departments for opioid abuse more than doubled between 2004 and 2008, admission rates to substance-abuse treatment programs increased by 40%, between 1998 and 2008, with prescriptions painkillers being the second most prevalent...
Prescription drug overdoses common in Ontario: expert

CBC News  Posted: Jun 20, 2011 8:24 PM ET  |  Last Updated: Jun 20, 2011 8:24 PM ET

An addiction specialist testifying at a Brockville, Ont., inquest into prescription drug overdoses says Ontario is facing a deadly epidemic of overprescription.

"There are many doctors who are prescribing way too much," said Dr. Mel Kahan, who works at St. Joseph's Hospital in Toronto.

Kahan was called in to review the medical file of Donna Bertrand, who died in a Brockville apartment in 2008 from an overdose of prescription drugs. The mother and former nurse died at the age of 41, just days after the death of 19-year-old Dustin King, an acquaintance who also died of a prescription drug overdose in the same downtown apartment.

The inquest in Brockville, ordered by the province's chief coroner, will lead to recommendations aimed at preventing similar deaths.

Kahan said the situation, while sad, is common. "In Ontario, there's hundreds of people dying every year of opiate-related overdoses," he told CBC News. "And they're mainly dying from opiates prescribed to them by doctors."

Bertrand's doctor, Alan Redekopp, told the inquest on June 15 that he...
Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART A

Executive Summary and Background

Published by the National Opioid Use Guideline Group (NOUGG): a collaboration of:

- Federation of Medical Regulatory Authorities of Canada
- College of Physicians & Surgeons of British Columbia
- College of Physicians and Surgeons of Alberta
- College of Physicians and Surgeons of Saskatchewan
- College of Physicians & Surgeons of Manitoba
- College of Physicians and Surgeons of Ontario
- College des médecins du Québec
- College of Physicians and Surgeons of New Brunswick
- College of Physicians and Surgeons of Nova Scotia
- College of Physicians and Surgeons of Prince Edward Island
- College of Physicians and Surgeons of Newfoundland and Labrador
- Government of Nunavut
- Yukon Medical Council

April 30 2010 Version 4.5

http://nationalpaincentre.mcmaster.ca/opioid/
“Oh, no, not another guideline!”
The Canadian Guideline on the Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

• Released May 3rd 2010, online at http://nationalpaincentre.mcmaster.ca/opioid

• Federation of Medical Regulatory Authorities of Canada (FMRAC) created the National Opioid Use Guideline Group to oversee development of a clinical practice guideline
Guideline recommends:

- judicious use of opioids
- emphasis on risk stratification
- monitoring of continued therapy
- appropriately address ADRBs
Five actions that should always be done when prescribing opioids for CNCP:

1. Start with a comprehensive assessment to ensure opioids are a reasonable choice and to identify risk/benefit balance for the patient.

2. Set effectiveness goals with the patient and inform patient of their role in safe use and monitoring effectiveness.

3. Initiate with a low dose, increase gradually and track daily dose in morphine equivalents – use ‘watchful dose’, 200mg meq as a flag to re-assess.

4. Watch for any emerging risks/complications to prevent unwanted outcomes including misuse and addiction.

5. Stop opioid therapy if it is not effective or risks outweigh benefits.
…Five Essential Actions

- Assess: pain and addiction risk
- Set goals
- Pause
- Monitor
- Stop if necessary
Practice Tools in Guideline

• Appendix B
• Opioid Manager
The Opioid Manager Addresses the following clinical questions:

• What do I need to consider before writing an opioid script?
• How do I do a trial of opioids?
• How do I monitor long term opioid use?
• When and how do I taper or discontinue opioids?
OPIOID MANAGER

The Opioid Manager is designed to be used as a point of care tool for providers prescribing opioids for chronic non-cancer pain. It condenses key elements from the Canadian Opioid Guideline and can be used as a chart insert.

Before You Write the First Script

Patient Name: ____________________________

Pain Diagnosis: __________________________

Date of Onset: ____________________________

Overdose Risk

Provider Factors
- Early on, benzodiazepines
- Neonatal intervention
- Maternal intervention
- History of substance abuse
- COPD
- Sleep apnea
- Opioid withdrawal

Opioid Factors
- Codeine: low risk
- Opioids: lower dose than IR

Prevention
- Select the opioid carefully
- Monitor for withdrawal
- Avoid opioid withdrawal
- Schedule dose in advance

Goals decided with patient:

Initiation Checklist

- Are opioids indicated for this patient condition?
- Explain potential benefits
- Explain adverse effects
- Explain risks
- Patient given information sheet
- Signed consent form
- Opioid treatment agreement (as needed)
- Urine drug screening (as needed)

Opioid Risk Tool

<table>
<thead>
<tr>
<th>Item</th>
<th>Score If Female</th>
<th>Score If Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Opioids</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>4</td>
<td>4</td>
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</tbody>
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</tr>
<tr>
<td>Opioids</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Psychological Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Disorder, Opiate or Comorbid Depression,</td>
</tr>
<tr>
<td>or Bipolar Disorder, Schizophrenia etc.</td>
</tr>
</tbody>
</table>

Total Score Risk Category: Low Risk: 0 to 3, Moderate Risk: 4 to 7, High Risk: 8 and above

Stepped Approach to Opioid Selection

<table>
<thead>
<tr>
<th>Step</th>
<th>Opioid</th>
<th>Strength</th>
<th>Route</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Codeine</td>
<td>30 mg q 6 h</td>
<td>PO</td>
<td>2 tablets</td>
</tr>
<tr>
<td>2</td>
<td>Oxycodone</td>
<td>5 mg q 4 h</td>
<td>PO</td>
<td>2 tablets</td>
</tr>
<tr>
<td>3</td>
<td>Morphin</td>
<td>10 mg q 6 h</td>
<td>PO</td>
<td>2 tablets</td>
</tr>
<tr>
<td>4</td>
<td>Hydromorphone</td>
<td>10 mg q 4 h</td>
<td>PO</td>
<td>2 tablets</td>
</tr>
<tr>
<td>5</td>
<td>Fentanyl</td>
<td>25 mcg q 12 h</td>
<td>Transdermal</td>
<td>2 patches</td>
</tr>
</tbody>
</table>

Initiation Trial

A closely monitored trial of opioid therapy is recommended before deciding whether a patient is prescribed opioids for long term use.

Initiation Trial Chart

- Goals achieved: Yes, No, Partially
- Pain intensity: Improved, No Change, Worsened
- Adverse effects: Nausea, Constipation, Dryness, Irritability

To access the Canadian Guideline for Safe and Effective Use for Non-Chronic Cancer Pain, to download the Opioid Manager and to provide feedback visit: http://nationalpaincentre.mcmaster.ca/opioid/

May 2010
The Guideline
5 Clusters

• Cluster 1: Deciding to Initiate Opioid Therapy
• Cluster 2: Conducting an Opioid Trial
• Cluster 3: Monitoring Long Term Opioid Therapy (LTOT)
• Cluster 4: Treating Specific Populations with LTOT
• Cluster 5: Managing Opioid Misuse and Addiction in CNCP Patients
Cluster 1, Initiating Opioid Therapy
Highlights of Cluster 1

• Do a comprehensive assessment of pain problem including addiction risk screening (R01)
• Opioids don’t work for all types of pain or for all patients. Set goals and expectations (R 04)
• Chronic opioids therapy has adverse effects, risks, and complications (R05) Ensure informed consent
R01: Documentation and comprehensive assessment

- Pain condition B-9
- General Medical and Psychosocial History
- Psychiatric Status
- Substance Use History B-1, B-2
“Opioid addiction is estimated to have an overall prevalence of 3.3% in patients receiving opioids for CNCP, with wide variation… ADRBs have a much higher prevalence. The major risk factor for addiction is a current or past history of addiction”
R02: Addiction risk screening

“Before initiating opioid therapy, consider using a screening tool to determine the patient’s risk for opioid addiction”
R02: Addiction risk screening

- E.g. Opioid Risk Tool
- High sensitivity and specificity, but samples were small
- Personal history remains the strongest predictor of opioid misuse and abuse
…Highlights of Cluster 1

• Taper benzodiazepines as much as possible, especially in elderly. Patients get better when BZDs are tapered (R06)

• Warn patients not to drive until they are sure they are tolerant to opioid and not sedated (R07)
Cluster 2, Opioid Trial
Highlights of Cluster 2

Opioid therapy is a trial. Present it as such to patient. If it doesn’t work, end the trial.
Highlights of Cluster 2

What opioid should I choose?

Start with “weak” opioid if it will do (R 08)
Don’t over-treat with strong opioid if not necessary

Rationale? Better safety and fewer potential adverse effects
…Highlights of Cluster 2

What is the right opioid dose? (R 09)

= The “optimal” dose: balance of effectiveness, plateauing, & adverse effects/ complications
...Highlights of Cluster 2

How high should I go? (R10)

The “watchful dose” is 200 mg morphine equivalent daily

If there is poor or no response at this dose, going higher likely will not help.
Going above watchful dose?
Considerations:

• Dx accurate?
• Opioid effective for patient’s type of pain?
• Need further investigation, referral?
• Non-opioid options available?
• Inadequately treated mental health disorder?
...Considerations

- Opioid effective so far? (30 % ↓ in pain, etc)
- Complications or adverse effects? E.g. opioid induced hyperalgesia? Hypogonadism more frequent at higher doses
- Risk of misuse? ADRBs?
...Highlights of Cluster 2

If patient is at higher risk of opioid misuse: make sure the pain Dx is clear. Anticipate ADRBs and be prepared to respond (R11)
Risk of opioid misuse

Structured Opioid Therapy (SOT, R21) can work very well for higher risk patients or patients exhibiting ADRBs

= tighter boundaries, closer monitoring, shorter dispensing interval, establishing that opioid is definitively improving function, +/- UDTs
Structure around opioid prescribing can be viewed along a continuum

- Low risk patient, “baseline” controls
- Actively addicted patient, MMT structure
Cluster 3, Monitoring
Highlights of Cluster 3

When prescribing long term opioid therapy, continue to monitor (R 12)
Brief Pain Inventory®

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than those everyday kinds of pain today?
   1. Yes
   2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.
   
<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain as bad as you can imagine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

4. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.
   
<table>
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<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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5. Please rate your pain by circling the one number that best describes your pain on average.
   
<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</table>

6. Please rate your pain by circling the one number that tells you how much pain you have right now.
   
<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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NOTE: For further information about using the BPI and to obtain copies for clinical use: www.mdanderson.org/departments/oncology/symptom-assessment-tools/brief-pain-inventory-bpi
...Highlights of Cluster 3

ADRBs (R 12) fall into three groups:

- escalating dose
- altering route of delivery
- illegal activities: multiple doctoring, Rx fraud, buying, selling, stealing drugs
Highlights of Cluster 3

Physicians and Pharmacists can collaborate for improved patient outcomes (R 12)

No special consent required for doc and pharmacist to talk to one another. Circle of care.
...Highlights of Cluster 3

• If a patient is not doing well on one opioid, you can switch or discontinue (R 13)
• If switching, start with 50-75% of the equi-analgesic dose of the new opioid due to unpredictable cross-tolerance
• Won’t patients do worse if opioids are discontinued? In fact, in certain cases, they may do better
…Highlights of Cluster 3

R 15: What about the patient who comes to you on opioids (the inherited opioid patient?)

→ Start at the beginning to make sure therapy is rational
When must I discontinue opioids?

→ When it’s not safe

e.g. injection drug use, serious other substance use disorder with loss of control of use e.g. alcohol, BZDs, cocaine

Why? → this situation puts the patient at risk of severe adverse consequences e.g. overdose, severe impairment of personal, family, work obligations
…When **must** I discontinue opioids?

- Persuasive evidence of diversion
  - high risk to community
...When **must** I discontinue opioids?

- Serious risks or complications
  → open discussion with patient
But my patient does not want to taper or switch

• Tell them the truth: there is a good chance they will feel better
• It can be a unilateral decision on part of physician: “I am obligated to provide the best patient care and I don’t think that this Rx is in the best interests of your health”
...But my patient does not want to taper or switch

Motivational interviewing

“REDS:”

• Roll with resistance
• Express empathy
• Develop discrepancy
• Support self-efficacy
...But my patient does not want to taper or switch

• Support and give the patient other tools and options to manage their distress
• Concept of the “chemical coper”
“Chemical Coper”

- Esp in patient with psychiatric Dx
- “Alexithymia”
- Opioids are mood elevating and anxiolytic
- Problem is that tolerance develops quickly to these psychoactive effects
R13: Switching or discontinuing opioids

“For patients experiencing unacceptable adverse effects or insufficient opioid effectiveness from one particular opioid, try prescribing a different opioid or discontinuing therapy”
R13: Switching or discontinuing opioids

• If switching, start with 50-75% of the equianalgesic dose due to unpredictable cross-tolerance
R13: Switching or discontinuing opioids

Discontinuing

• Patients on high doses and remain incapacitated by pain should be considered treatment failures

• Patients sometimes report improvements in mood and pain reduction with tapering. Reasons not fully understood. Withdrawal-mediated pain? Hyperalgesia?
Cluster 5, Managing Opioid Misuse and Addiction in CNCP Patients
Highlights of Cluster 5

People with opioid addiction can have pain. People with pain can have opioid addiction (R 21)

For a this combined patient, you can do three things:
Addiction in the Chronic Pain Patient? (R 21)

→ methadone or buprenorphine maintenance treatment,

→ structured opioid therapy, or

→ abstinence based treatment
Further Resources

• Home of the Guideline: www.nationalpaincentre.mcmaster.ca
...Resources

• Centre for Addiction and Mental Health
  www.camh.net/
  Courses, publications, resources for professionals and patients
Addiction Clinical Consultation Service
1-888-720-ACCS (2227)
A service of CAMH

For health professionals seeking advice on management of patients with addictions disorders. Calls are triaged and consultant will call back within 4 hours
MMAP

- Medical Mentoring for Addictions and Pain
- Program of OCFP
- www.ocfp.on.ca/mmap
Take-home points

• Take an alcohol and drug history prior to prescribing opioids for chronic non-cancer pain. Substance use Hx increases risk of addiction, ADRBs

• Take a psychiatric history prior to . Positive psychiatric Hx increases risk of addiction, ADRBs, and poor response to opioids
Take-home points

Remember your 5 actions…
• Assess: pain and addiction risk
• Set goals
• Pause
• Monitor
• Stop if necessary
Take-home points

• It’s OK to taper or stop an opioid Rx if it is clearly harmful or not in the patient’s best interests
Continuum of opioid prescribing structure

low risk patient, “baseline” controls

actively addicted patient, MMT structure
Thank you!

Lisa Bromley MD, CCFP, FCFP