

# Chronic Pain and Prescription Opioid Use: What Addiction Docs Need to Know

Lisa Bromley MD, CCFP, FCFP

# Avoiding Abuse, Achieving a Balance:

## Tackling the Opioid Public Health Crisis



College of  
Physicians and Surgeons  
of Ontario



## 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 patient-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 (the agency's Anesthetic and Life Support Drugs Advisory Committee and Drug Safety and Risk Management Advisory Committee) voted 25 to 10 against the FDA's 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 a 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 under-treated 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 bar graph) and are the second-leading cause of accidental death, with 27,658 such deaths recorded in 2007. That increase has been propelled by a rising number of overdoses of opioids (synthetic versions of opium), which caused 11,409 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,<sup>1</sup> and admissions to substance-abuse treatment programs increased by 400% between 1998 and 2008, with prescription 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



Brockville inquest 2:12

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."



Addiction specialist Dr. Mel Kahan says the ubiquity of OxyContin makes it a popular drug for teens. CBC

Bertrand's doctor, Alan Redekopp, told the inquest on June 15 that he





# Objectives

- Understand safe prescribing practices when using opioids for CNCP as recommended in the Canadian Opioid Guideline
- Understand Cluster 5 of the Guideline, options for treating pain in the opioid addicted patient
- Understand how to be a resource to FPs and pain docs in your community

# Financial Disclosures

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CCFP, FCFP

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# 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

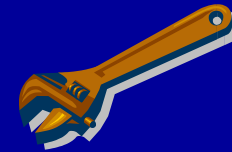
# Cluster 1, Initiating Opioid Therapy

## R01: Documentation and comprehensive assessment

“Before initiating opioid therapy, ensure comprehensive documentation of the patient’s pain condition, general medical condition and psychosocial history, psychiatric status, and substance use history”

# R01: Documentation and comprehensive assessment

- Pain condition  B-9
- General Medical and Psychosocial History
- Psychiatric Status
- Substance Use History



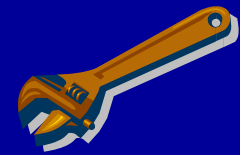
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## R01: Documentation and comprehensive assessment

“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”

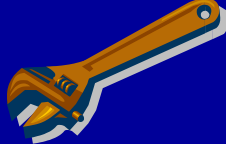
# R02: Addiction risk screening

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



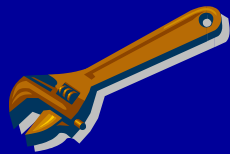
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# R02: Addiction risk screening

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

# R03: Urine Drug Screening

“When using UDS to establish baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results”



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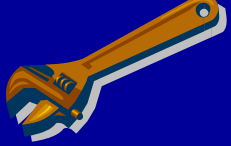
# R03: Urine Drug Testing

- Suggested to use at baseline for high risk patients, or patients who are not well-known to physician
- Addictions docs can be a resource to FDs in using and interpreting UDTs

## R05: Risks, adverse effects, complications

“Before initiating opioid therapy, ensure informed consent by explaining potential benefits, adverse effects, complications, and risks. A treatment agreement may be helpful”

# R05: Risks, adverse effects, complications

- Goal-setting and patient expectations
- Written handout can be helpful  B-4
- Adverse effects: nausea, constipation, somnolence, dizziness, itching, vomiting
- Complications: neuroendocrine abnormalities, sleep apnea, opioid-induced hyperalgesia
- Risks: overdose, diversion, addiction, withdrawal

# R06: Benzodiazepine tapering

“For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering. If a trial of tapering is not indicated or not successful, opioids should be titrated more slowly and at lower doses”



B-6

# R06: Benzodiazepine tapering

- Combo of opioids and BZDs increases risk of sedation, overdose, and diminished function, especially as age increases
- BZDs increase risk of opioid toxicity and overdose
- BZDs *can* be successfully tapered in a primary care setting, with improved health outcomes

# R11: Risk of opioid misuse

“When initiating a trial of opioid therapy for patients at higher risk of misuse, prescribe only for well-defined somatic or neuropathic pain conditions, start with lower doses and titrate in small dose increments, and monitor for ADRBs”

# Risk of opioid misuse

- If treating a patient at higher risk of misuse, anticipate ADRBs and be prepared to respond
- Structured Opioid Therapy (SOT, R21) can work very well for these patients = tighter boundaries, closer monitoring, shorter dispensing interval, establishing that opioid is definitively improving function, +/- UDTs

# Risk of Opioid Misuse

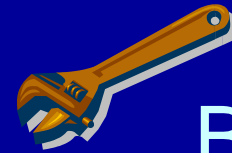
- Informed consent: in high risk patient, if function deteriorates and pt not able to achieve abstinence, opioid maintenance may be the only feasible “exit strategy”
- Advise patient!
- Opioid maintenance (MMT or buprenorphine) can be very restrictive

# Cluster 3, monitoring

- ADRBs
- Add docs can assist in evaluating ADRBs

# R12: Monitoring LTOT

“When monitoring a patient on long term therapy, ask about and observe for opioid effectiveness, adverse effects or complications, and ADRBs”



B-10

# R12: Monitoring LTOT ADRBs

- ADRBs fall into three groups:
  - escalating dose
  - altering route of delivery
  - illegal activities: multiple doctoring, Rx fraud, buying, selling stealing drugs

# Cluster 5, Managing Opioid Misuse and Addiction in CNCP Patients

# R21: Addiction Treatment Options

“For patients with CNCP who are addicted to opioids, three treatment options should be considered:

→methadone or buprenorphine maintenance treatment,

→structured opioid therapy, or

→abstinence based treatment.”

# R21: Addiction Treatment Options

## Structured Opioid Therapy (SOT)

- Improves outcomes in patients who have exhibited ADRBs
- SOT = use of opioids other than MTD or bup to treat CNCP with specific controls in place, including patient education, written treatment agreement, shorter dispensing intervals, and frequent monitoring

# ...Structured Opioid Therapy Candidate:

- Not currently addicted to alcohol or other drugs
- Not, to physician's knowledge, accessing opioids from other sources, injecting or crushing oral opioids, or diverting

# Structure around opioid prescribing can be viewed along a continuum

low risk  
patient,  
“baseline”  
controls



actively  
addicted  
patient, MMT  
structure

# Abstinence

- Not as effective as maintenance, but many patients prefer it, and may be viable for those with good prognostic factors
- Medically assisted WD management: clonidine, tapering MTD or bup
- Best if immediately followed by formal addiction treatment
- Caution patients re loss of tolerance, and risk of OD if they relapse

# Opioid Agonist Maintenance

- Methadone or buprenorphine
  - Indicated for patients who have failed or are not good candidates for SOT
  - Bup can be prescribed by any doc with appropriate training
- addiction doc stabilize and send back to FD??

# ...Opioid Agonist Maintenance

- Duration of analgesic action of MTD and bup is 6-8 hours, BUT...
- ...Once daily dosing suggested initially
- Patients often experience substantial pain relief with once-daily dosing as WD symptoms subside
- After dose titration and stabilization, dose can be split if necessary

