

NEW CSAM POSITION?



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Disclosure: Dr. el-Guebaly has nothing to disclose

Dr. Lim has nothing to disclose



Canadian Society of Addiction Medicine
La Société Médicale Canadienne sur l'Addiction

CSAM's New position on Opioids for the Treatment of Chronic Pain

Developed in response to

- 1. Concerns regarding Patient and Public Safety Risks from Opioid Misuse**
- 2. Rising rates of prescription opioid abuse**
- 3. Physicians and other stakeholders seeking guidance regarding safe and effective use of opioids**
- 4. lack of systematically developed national guidelines on opioid use for CNCP**

**NOUGG in 2010 did a full review and published a set of
24 recommendations**

NOUGG Resources

- **A Research Group**
 - **physician/epidemiologist,**
 - **four physician-researchers,**
 - **research librarian**
- **A National Advisory Panel (NAP)**
 - **49 individuals from across Canada of healthcare providers, patients with CNCP, clinical expertise, and academia.**
- **The National Faculty comprising approximately 35 people (representing 9 provinces, 1 territory, and 8 national associations)**

NOUGG OUTPUTS

- **6,580 studies were identified**
- **184 met inclusion criteria**
- **49 draft recommendations.**
- **24 practice recommendations that were organized into five clusters:**
 - **1. Deciding to Initiate Opioid Therapy**
 - **2. Conducting an Opioid Trial**
 - **3. Monitoring Long-Term Opioid Therapy (LTOT)**
 - **4. Treating Specific Populations with LTOT**
 - **5. Managing Opioid Misuse and Addiction in CNCP Patients.**

Concerns regarding Patient and Public Safety Risks from Opioid Misuse

More patients are receiving opioids in larger quantities.

- Canada's recorded prescription-opioid consumption increased by about 50% between 2000 and 2004 (International Narcotics Control Board 2006)
- Canada is currently the world's third-largest opioid analgesic consumer per capita (International Narcotics Control Board 2009).
- In Ontario, oxycodone prescriptions rose by 850% from 1991 to 2007, from 23 prescriptions/1000 individuals per year to 197/1000 per year
- The average amount per prescription of long-acting oxycodone increased from 1830 mg to 2280 mg (Dhalla 2009).

Concerns regarding Patient and Public Safety Risks from Opioid Misuse

It has been argued that legitimate prescribers bear little direct responsibility for this, because overdose deaths and addiction arise primarily from drug diversion.

- (Dhalla 2009) showed that of 1095 overdose deaths in Ontario, 56% of patients had been given an opioid prescription within four weeks before death.
- In a study of opioid-dependent patients admitted to the Centre for Addiction and Mental Health in Toronto, 37% received their opioid from physician prescriptions, 26% from both a prescription and “the street,” and only 21% entirely from the street (Sproule 2009).
- A United States national study found that, of 1408 patients entering treatment of opioid abuse, 79% of male and 85% of female patients were first exposed to opioids through a prescription to treat pain (Cicero 2008).
- Furthermore, the total amount of diverted opioids is directly related to the total amount of prescribed opioids (Dasgupta 2006).

Concerns regarding Patient and Public Safety Risks from Opioid Misuse

- The increase in opioid prescribing has been accompanied by simultaneous increases in abuse, serious injuries, and overdose deaths (Kuehn 2007).
- From 1991 to 2004 in Ontario, the mortality rate due to unintentional opioid overdose increased from 13.7/million to 27.2/million/year (Dhalla 2009).
- Prospective Canadian study found that illicit opioid users are more likely to use prescription opioids than heroin (Fischer 2006).

Opioid addiction in CNCP patients

In patients with a history of substance abuse

- prevalence of aberrant drug-related behaviours (11.5%)
- urine drug screens with illicit drugs (14.5%)
- urine drug screens with no opioid present suggesting possibly diversion (20.4%)
- prevalence of opioid abuse or addiction (3.3%)

When there was no history of substance abuse or addiction, the above rates reduced significantly (Fishbain 2008)

Prevalence of problematic substance use, including alcohol, is higher among patients on long-term opioid therapy for CNCP than in the general population (Edlund 2007)

Evidence of Opioid Efficacy

Examples of CNCP conditions for which opioids *were shown to be effective* in placebo-controlled trials

A limitation of these trials was that the duration of opioid therapy was a maximum of three months

- Diabetic neuropathy
- Peripheral neuropathy
- Postherpetic neuralgia
- Phantom limb pain
- Spinal cord injury with pain below the level of injury
- Lumbar radiculopathy
- Osteoarthritis
- Rheumatoid arthritis
- Low-back pain
- Neck pain

Examples of CNCP conditions that *have NOT been studied* in placebo-controlled trials

- Headache
- Irritable bowel syndrome
- Pelvic pain
- Temporomandibular joint dysfunction
- Atypical facial pain
- Non-cardiac chest pain
- Lyme disease
- Whiplash
- Repetitive strain Injury

Fibromyalgia

- There are no randomized trials of strong opioids for fibromyalgia
- There are two randomized trials of the weak opioid, tramadol. They showed small benefits in reducing pain (Russell 2000, Bennett 2003)
- The EULAR (European League Against Rheumatism) guidelines for the treatment of fibromyalgia recommend tramadol but not strong opioids (Carville 2008)

Nociceptive pain of musculoskeletal origin (e.g., osteoarthritis, low-back pain, neck pain)

- **Opioids showed only small to moderate benefits for nociceptive pain in improving function and relieving pain (Furlan 2006, Furlan unpublished 2010, Nuesch 2009).**
- **If opioids are required, patients generally respond to moderate doses**
- **Acetaminophen, NSAIDs and non pharmacological treatments are often effective**
- **A recently published Cochrane review**
 - **small-to moderate beneficial effects of non-tramadol opioids for osteoarthritis are outweighed by large increases in the risk of adverse events**

Neuropathic pain

- Opioids showed only small to moderate benefits for neuropathic pain (Furlan 2006, Furlan 2009, Eisenberg 2005).
- neuropathic pain may require higher opioid doses, in combination with tricyclic antidepressants (Khoromi 2007) or anticonvulsants (Gilron 2005)
- Medium effect size for pain relief and small for functional outcomes

Migraine, tension headache, functional GI problems

Opioids are usually not indicated for migraine or tension headaches, or for patients with functional gastro-intestinal problems such as irritable bowel syndrome (Bigal 2009)

Discontinuing Opioids

- Opioids should be tapered and discontinued if the patient's pain remains unresponsive after a trial of several different opioids
- Patients who receive high opioid doses and remain incapacitated by pain should be considered treatment failures, even if the opioid “takes the edge off” the pain
- Several observational studies have demonstrated
 - patients with severe pain on high opioid doses, tapering results in improved reduced pain and improved mood

CSAM's New Position and Recommendations

USE OF OPIOIDS FOR THE TREATMENT OF CHRONIC PAIN

(Oct 2000)

Definition of Addiction in the context of Pain Treatment

- Continued opioid use despite adverse consequences
- Loss of Control
- Preoccupation with obtaining opioids despite adequate analgesia
- Denial of problem

Difference between Acute & Chronic Pain Management

Recommendations:

Physicians choosing to prescribe opioid analgesics should:

- Be appropriately trained
- Perform a documented, comprehensive assessment
- Following the above, they should not be responsible for patients' willful & deceptive behavior
- Medicolegal reviews should be made by experts in Pain & Addiction Medicine
- Medical schools should include adequate curriculum

Opioid prescribing for chronic non-cancer pain (A)

M. Kahan, R. Lim, N. el-Guebaly – Sept 2011

- Dramatic increase in prescription opioid misuse & addiction
- Recommended opioid prescribing practices (*Consistent with Can Guideline for Safe & Effective Prescribing*)
 1. **Careful Patient Selection:** Non-responsive to non-opioid
Pain shown responsive to opioids
 2. **First-line Opioids:** Low potent opioids first (WHO Pain Ladder) i.e., codeine, tramadol
Long acting preparation preferred except for
“breakthrough” pain
 3. **Dose Titration:** To avoid overdose, addiction, trauma, sedation, central sleep apnea
Optimal dose improves function & reduces pain by at least 30%(10pt scale),
mostly well below the “watchful dose” of 200mg morphine eqv/day
 4. **Overdose Prevention:** Safe storage, titration & avoidance of sedatives

(B)

6. **Opioid Tapering:** When lack of response to high doses or major side effects

7. **Management of high risk of addiction:**

only if well-documented pain unresponsive to non-opioids
current addictions should be treated
close monitoring with regular drug screens
avoid higher abuse opioids, like oxycodone
titrate cautiously (mostly below 200 mg morphine eqv)

8. **Management of suspected addiction:**

do not maintain high doses of opioids indefinitely
consider methadone or BUP treatment or even abstinence

9. **Treatment options:**

a. **Structured Opioid Therapy:**

Taper dose if high; dispense frequently (daily); urine & aberrant behaviors monitoring

If unsuccessful, switch to methadone or BUP

b. **Opioid Agonists**

Extra access of opioids or failure of structure, refer to methadone or BUP

c. **Abstinence Base Treatment:**

Medical detox & psychosocial counseling

Not as effective as agonist treatment but may be preferred if strong social support

Opioid prescribing for chronic non-cancer pain

(C)

• PUBLIC HEALTH RECOMMENDATIONS

Education: a comprehensive strategy, focus on high prescribers & related communities

Overdose prevention: for high risk patients including naloxone kits & emergency contacts

Regulation & Funding:

Provincial prescribing databases, mandatory education of prescribers, de-funding 80mg Oxycontin tabs & funding ceiling above certain daily doses; removal of over-the-counter codeine preparations

Addiction Treatment:

Accessible buprenorphine treatment spec. if higher risk of methadone toxicity; shorter opioid use; adolescents & young adults; communities without methadone clinic;

coverage should not be restricted to physicians with methadone exemption

Access to comprehensive methadone treatment