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Strategies to Manage Pain in Patients At Risk for Substance Abuse

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The International Association for the Study of Pain defines chronic pain as "pain that persists beyond normal tissue healing time, which is assumed to be three months." Over the last two decades there has been a rise in opioid prescriptions which is thought to be linked to the increasing consensus that opioid therapy is appropriate for chronic noncancer pain (CNCP).

It is important to recognize that not all pain is responsive to opioid therapy and that the mean pain relief is about 30%.[1,2] In addition, modern medicine (drugs, surgeries, and other medical procedures) decrease pain by about 30% in only about 40-50% of patients.[3]

Recent studies indicate an increase in accidental deaths from prescription opioids with rates currently exceeding those from cocaine overdoses.[4] This review will summarize recommendations for opioid use for CNCP and provide strategies to manage patients at risk for substance abuse.

Chronic Pain Management: Recently new guidelines for CNCP were developed by an expert panel convened by the American Pain Society and the American Academy of Pain Medicine. The guidelines were based on a systematic review of evidence (14 systematic reviews and 57 primary studies) on chronic opioid therapy for CNCP performed at the Oregon Evidence-based Practice Center.[5] Numerous areas of pain management were discussed including patient selection and risk assessment, principles of prescribing opioids and management plans, and assessment tools to aid in prediction of aberrant drug-related behaviors.

Selecting and Assessing the Patient: Evidence from randomized trials showing the benefits of opioids is limited to patients with moderate to severe pain who have not responded to nonopioid therapies.[5] Prior to initiation of chronic opioid therapy (COT) a benefit-to-harm analysis should be completed to include: collection of a thorough history, physical exam, evaluation for an underlying pain condition, risk assessment for substance abuse, misuse, and other aberrant drug-related behaviors. The strongest risk factors for opioid misuse or abuse are a family history of or past substance abuse. Available assessment tools will be discussed later in this article.

Principles of prescribing opioids: The prescribing of opioids in patients with a history of substance abuse has traditionally been viewed by many prescribers as contraindicated due to an individual's history. Yet there is a lack of evidence that providing opioid analgesia in this instance worsens addiction. In general, treatment with opioids is indicated in patients with current or past substance abuse. Treatment should not be withheld provided that the clinician is able to manage the risk adequately through an appropriately structured follow-up and monitoring program. Distinguishing between patients with *present* addiction from those with *past* addiction problems makes pain management much clearer. Patients can generally fall into one of four of the following categories according to risk for opioid misuse or abuse (Table 1). In all cases discussion between patient and prescriber should take place regarding the history of addiction, and if applicable, current recovery process, signs of abuse and relapse.[6]

Concurrent Methadone Maintenance Therapy (MMT): Often additional analgesia for pain is needed despite high methadone doses due to a lower pain tolerance and/or decreased opioid sensitivity. The use of a different opioid for pain treatment is advised. Other suggestions include coordinating with the MMT program when prescribing COT and avoiding the induction of acute withdrawal by not prescribing mixed opioid agonist-antagonists such as buprenorphine, pentazocine or nalbuphine. The concurrent use of Subutex® (buprenorphine) or Suboxone® (buprenorphine and naloxone), both indicated for opioid dependence, with other opioids has been particularly disconcerting. A recent analysis of Suboxone® use in Oregon Medicaid FFS indicates that 45% of patients were also concomitantly on an opioid.

Table 1 – Risk Categories and Recommendations[6]

Low Risk for Opioid Misuse/Abuse

For all patients review & update treatment plans, create contracts with patients & caregiver and:

- Use consistent pain assessment process.
- Use patient pain diary or graph pain intensity over time.[7]
- Use simple regimen
- Avoid fast-onset drugs with short half-lives (produce euphoria)
- Use opioids on scheduled basis (not prn).
- Document all aspects of pain management
- Discontinue opioids if there is no adherence to treatment plan.

Recovering Patient (abstinent > 12 mths. with addiction treatment)

- Pain medication should not be withheld and pain management should be assessed and adjusted on a regular basis.
- Discuss fear of opioids and/or relapse
- Discuss relapse prevention planning such as re-engaging with treatment, meeting or sponsor

At Risk (1-12 mths abstinent)

- Be direct and concrete about addiction
- Monitor for signs and symptoms of opioid intoxication or withdrawal.
- Consult with addiction counselor or mental health professional
- Prescribe generics (less "street-value").
- Write out the prescription quantity versus using numerals.
- Contact patient's health plan and/or pharmacist to restrict or "lock" opioid prescriptions to one or few providers and pharmacies. *See end of article on how to refer a patient.*
- Prescribe < 1 mth supplies to assist patients with staying within quantity limits (weekly or bi-monthly)
- Requests for/use of benzodiazepines, promethazine or carisoprodol should raise suspicions
  - A urine drug screen should be performed and consultation with an expert on results is recommended.[8]
- Designate a trusted family member as being in charge of opioids. (i.e. pill counts, adding a dated label to a fentanyl patch, etc.)

Actively Using (< 1 mth. abstinent)

- Require addiction evaluation & treatment in exchange for pain treatment.
- Prescribe 7 days supply to allow for intake into an addiction program
- Provide refills only after updates from addiction treatment program.
- If addiction treatment is not indicated, proceed as above for "at risk" patients

Informed Consent (IC) & Opioid Management Plans: The purpose of IC is to assist patients in making medical decisions that are consistent with their preferences and values. The IC form can be obtained at the beginning of COT initiation with follow-up documentation on goals, expectations, potential risks, and alternatives to COT. Although not required by the State of Oregon, a written COT management plan provides documentation of physician and patient responsibilities, expectations, and aids in patient education regarding COT. IC is recommended for all patients receiving COT.

Starting and titrating COT[6]: Opioids should not be initiated as primary therapy or monotherapy. Acetaminophen, salicylates, non-steroidal anti-

inflammatory drugs and non-analgesic adjuvants for specific pain types are to be used as first-line agents. Analgesics and adjuvants should be started sequentially, not at the same time in order to evaluate the effectiveness of a given agent. Maximization of the adjuvant analgesic dose should occur prior to declaring treatment failure or changing the current analgesic or dose.

Medications should be used on a scheduled basis versus as "rescue" for intermittent chronic pain to increase function in patients when engaging in activities known to increase pain. Those with continuous chronic pain (pain ATC or >12 hrs in 24 hr period) should be prescribed analgesics regularly ATC.

Initiation of COT should be viewed as a therapeutic trial where the dose is individualized for the patient based on response. There is a lack of evidence of opioid superiority over another for initial therapy[5]. Medication allergies, opioid side effect profiles, response to therapy and cost can aid in choosing the right opioid. Patient's report of allergies should be further questioned to distinguish between a true allergy (rash, anaphylaxis) and medication intolerance (nausea, vomiting) or histamine release (itching). Incomplete cross-tolerance between opioids should also be considered when changing from one opioid to another in patients who have been on COT to avoid use of starting doses that are too high and to prevent or minimize adverse events. More information on this topic is available elsewhere.[9]

Although there is a lack of evidence for starting a short-acting versus a long-acting opioid, use of a short-acting opioid in the opioid naïve allows for easier dose titration. Potential benefits of switching to a long-acting agent once an adequate dose is established are more consistent pain control, less frequent dosing, improved adherence and a lower risk of addiction or abuse.[5]

Once stabilization on opioid treatment occurs, reevaluation of the total daily dose and dose interval should be done. If there are frequent breakthrough doses, a limit on the number of as needed doses per month can be placed. This can aid in preventing inappropriate self-dose escalations by the patient. Reevaluation should also take place in those who are not opioid responsive to avoid unnecessary dose escalations. Non-responsiveness may be evident by a lack of relief for acute pain or lack of increasing pain relief with increasing opioid dose. Under these circumstances, alternative treatment options should be explored .

Monitoring: Periodic assessment should be performed based on evolving circumstances (change in health status and/or pain control) along with documentation of pain intensity, level of functioning, progress of reaching therapeutic goals, adverse events, and prescription adherence. Repeated dose escalations should be evaluated to assess for benefits versus harms and as a possible indication of a substance abuse disorder or diversion. Those with a high risk for of adverse outcomes (history of addiction, elderly, comorbid conditions) may need more frequent monitoring. All patients should be monitored for adherence to the plan of care. Random urine drug screens can aid with this. There is wide variability in drug screens across labs and prescribers should be familiar with the standard imitations and interpretations from the labs they use. Confirmatory testing and consultation can be done with a certified Medical Review Officer and can be located at http://www.aamro.com/locate/. In cases of repeated nonadherance or serious aberrant behavior, tapering of opioid therapy and referral for opioid detoxification and withdrawal management should be considered.

Opioid rotation: While the evidence is controversial, opioid rotation (process of switching from one opioid to another) may be considered when intolerable adverse effects occur or if there is inadequate pain relief despite dose increases. The idea is based on incomplete cross-tolerance to analgesic and nonanalgesic effects across opioids and an individual's variation of response to different opioids. More studies are needed to guide this practice despite the availability of dose conversion tables and rotation protocols.

Assessment tools for opioid misuse and abuse: Current tools for risk stratification and monitoring for aberrant drug-related behaviors include clinical evaluation, formal instruments, and others (urine drug screens, pill counts, prescription drug monitoring programs).

Some of the formal instruments available to predict aberrant drug-related behavior include: the Revised Screener and Opioid Assessment for patients with pain (SOAPP-R), Screener and Opioid Assessment for Patients with Pain (SOAPP), Opioid Risk Tool (ORT), and the Current Opioid Misuse Measure (COMM). These instruments have limited evidence of accuracy for predicting clinical outcomes and there is uncertainty on their ability to improve patient outcomes, but they may help provide structure to the clinical evaluation and appear to have face validity.[10]

Prescription Drug Monitoring Program (PDMP): Senate Bill 355 (2009) authorizes Oregon to develop a PDMP. The PDMP will allow prescribers to access prescription fill data for controlled substances from all Oregon pharmacies which will aid in the containment of controlled substance abuse, misuse, and diversion. More information is posted to:
http://www.das.state.or.us/DHS/ph/ipe/test_pdmp.shtml
http://www.oregon.gov/DHS/pain/presc-monitor-prog-info.shtml

Additional Resources:

Pharmacy Management (lock –in) Program .
Enroll patients via fax directed to Pharmacy Management Program at 503-947-1119. Please include the patient's name, date of birth and Medicaid identification number with your name, National Provider Identification number and contact information.

Oregon Alcohol & Other Drug Services Directory .
http://egov.oregon.gov/DHS/addiction/publications/provider-directory.pdf. .

DHS Addiction services homepage .
http://www.oregon.gov/DHS/addiction/index.shtml.

Conclusion: CNCP is prevalent, yet the availability of evidence-based guidelines on its management to optimize pain relief and monitor for misuse is limited. Assessment tools to aid in addiction screening and pain management are available to aid the prescriber.

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References

1. Kalso E., Edwards JE, Moore RA, et al. Opioids in chronic non-cancer pain: systematic review of efficacy and safety. Pain 2004; 112:372-80
2. Furaln AD, Sandoval JA, Mailis-Gagnon A, Tunks E. Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects. CMAJ 2006;174(11):1589-94.
3. Hampton T. Pain and the Brain: Researchers Focus on Tackling Pain Memories. JAMA 2005; 293: 2845-2846.
4. CDC Unintentional Poisoning Deaths --- United States, 1999—2004. MMWR 2007; 56(05); 93-96.
5. Chou R, Fanciullo GJ, Fine PG, et al.: Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. J Pain 2009; 10:113-130.
6. Labby D, Koder M, Amann T. Opioids and Chronic Non-malignant Pain: A Clinicians' Handbook. Oregon Health Plan. Available at: http://www.ohsu.edu/ahec/pain/home.html. Accessed August 10, 2009.
7. Slatkin, NE. Pain Profile Graph in "Pain Management Today". 2008; 9(8).
8. WA State Agency Medical Directors' Group. Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain: an educational pilot to improve care and safety with opioid treatment. Olympia (WA): WA State Department of Labor and Industries; 2007 Mar. 14.
9. Oberholtzer D. An Overview of the Safety of Methadone Use and Recommendations for Judicious Use. Oregon DUR Board Newsletter. V11I2 June 2009. http://pharmacy.oregonstate.edu/drug_policy/index.php?nav=newsletter
10. Chou R, Fanciullo G, Fine P, Miaskowski G, et al.: Opioids for chronic noncancer pain: Prediction and identification of aberrant drug-related behaviors: A review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. J Pain 2009; 10:131-146.