

# OPIOIDS IN THE TREATMENT OF CHRONIC NON-CANCER PAIN

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#### DISCLOSURE & CONFLICTS

- I have no financial or other conflicts of interest to disclose.
- The views expressed are my own and or derived from current evidence-based medical literature and opioid guidelines and do not reflect the position or administrative policies of the Montana State Fund or its affiliates.

#### COURSE OBJECTIVES

- Anatomy of the opioid epidemic
- Opioid side effects (OIH, OIE)
- Discuss mechanism of action of opioids
- Indications for chronic opioid therapy (COT)
- Patient assessment/evaluation
- Management strategies
- Review MT U&T and 2016 CDC Guidelines



#### OPIOID USE ESCALATION IN USA

- USA (2009) 5% worlds population, yet:
- 56% global morphine
- 80% oxycodone
- 99% hydrocodone
- 85% ALL opioids

• Manchikanti, L et al. *Pain Physician*, 2010

Prevalence of opioid use at least once during past year



#### ACCIDENTAL OPIOID OD DEATHS USA

- 60% Prescription (Rx) deaths attributed to opioids
- Since 1999 deaths have increased 4X

cdc.gov

- 2000-20015 500,000 deaths from drug OD
- 91 Americans die every day from opioid OD (33,000 deaths/year)

#### ACCIDENTAL OPIOID OD DEATHS

- 75% Heroin users previously abused opioids
- Heroin deaths have dramatically increased last 10-15 years
- 12,989 deaths in 2015
- WHY?:
- 1) decreased access to opioids
- 2) increased availability
- 3) low price

FDA Boosts Warning On Danger Of Combining Opioids And Anxiety Meds



• cdc.gov

#### ACCIDENTAL OPIOID OD DEATHS

- 2014: 2 million Americans abused or were dependent on opioids
- 25% on COT for non-cancer pain struggle w/addiction





#### OPIOID ESCALATION IN USA

- 2013: MD's wrote >250,000,000 opioid Rx's
- Enough opioids for every American (30 pills/month/person)
- Most common opioid OD's:
- 1) methadone
- 2) oxycodone
- 3) hydrocodone
- Accidental opioid OD deaths in US have exceeded MVA deaths
- cdc.gov

## Opioids in Montana

28,000

people in Montana used perscription pain medications for nonmedical purposes &

17,000

needed treatment for illegal drug use but failed to receive it.



#### **FDA News Release**

FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use Action to better inform prescribers and protect patients as part of Agency's Opioids Action Plan



in MT could be traced to drug overdoses in 2014.

#### **OPIOID DEATHS IN THE USA--2015**

- <u>Opioid</u> Oxycodone/hydrocodone •
- Fentanyl/tramadol •
- Methadone •

•

- Heroin ٠
- Henry J. Kaiser Family Foundation •

<u>USA</u> **Montana** 26 12,727 9,580 3,301 12,989



#### HOW DID THIS HAPPEN?

- Pain Management: "A fundamental human right"
- Pain treatment became an ethical, social, cultural and religious issue
- Promoting pain management as a legal/constitutional right
- Failure to provide pain management constitutes professional misconduct

• Brennan F, Cousins M and Carr DB. Anesth Analg., 2007

#### THE DECADE OF PAIN

- 2000's heralded the "Decade of Pain"
- Pain became "The Fifth Vital Sign"
- Pain Meetings throughout the US:
- "Dose to effect or side effect"
- "If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly." –James N. Campbell, MD (*American Pain Society, 2007*)

- American Academy of Pain Medicine
- American Pain Society

#### GROUND-BREAKING JURY VERDICT AWARDS \$1.5 MILLION: UNDER TREATMENT OF PAIN EQUALS ELDER ABUSE

- California jury sends message of accountability to health care providers in Alameda County
- Bergman v. Chin: Why an Elder Abuse Case is a Stride in the Direction of Civil Culpability for Physicians Who Undertreat Patients Suffering from Pain
- "I think we are at a new place in law and medicine...[where] failure to treat pain is something that physicians are held accountable for..." (Compassion in Dying Federation spokesperson, June 13<sup>th</sup>, 2001)

#### SECRETARY PRICE ANNOUNCES HHS STRATEGY FOR FIGHTING OPIOID CRISIS

- Thomas E. Price, M.D.
- National Rx Drug Abuse and Heroin Summit
- April 19, 2017
- Atlanta, Georgia
- At HHS, we're ready to fight alongside ... the millions of Americans who are trying to find recovery or help their loved ones do so ... The Trump Administration is committed to bringing everything the federal government has to bear on this health emergency.

### OPIOID INDUCED HYPERALGESIA (OIH)

- Increased pain caused by exposure to opioids (i.e., increased sensitization)
- Can occur at any dose
- Opioid gradually cause an increase in baseline pain with a reduction in mood altering effects
- Pain usually more widespread than initial symptoms
- Patients typically request higher dose due to increased pain w/o antecedent cause
- Patients maintained on morphine or methadone are more pain sensitive
- Higher the opioid dose = higher pain sensitivity

- Lee M et al., Pain Physician 2011
- Mao, J. Pain 2002



#### OIH-DOES IT GO AWAY?

- Cold Pressor Test for Heroin addicts sober for 5 months:
- Controls: 134 seconds
- Addicts/abstinent: 85 seconds
- Take home: Opioids may be causing long-term hyperalgesia
- Ren ZY et al., *Psychopharm* 2009



#### METHADONE & BUPRENORPHINE MAKES OIH WORSE

- Cold Pressor Test:
- Controls
   43 seconds
- Buprenorphine 17 seconds
- Methadone 14 seconds
- Addiction maintenance patients: "Everything hurts"

• Compton, et al., Pain 2012

#### EFFECTS OF DETOXIFICATION ON PAIN PERCEPTION

- 53 pts detox w/ clonidine and diazepam
- No opioids were given
- Average 3.7 years on opioid for:
- 1) LBP 66%
  2) HA 13%
  3) Ortholinium ( 00%)
- 3) Ortho injury 9%
- 4) FMS 8%
- 5) Toothache 4%
- Miller, NS et al. Am J Therapeutics. 2006



### CHANGE IN PAIN SCORES (0-10/10) DURING DETOX

	<u>Hydrocodone</u>	<u>Oxycodone</u>
Admission	4.7	7.5
• Day 2	4.8	7.0
• Day 3	4.7	6.0
• Day 4	3.8	5.3
<ul> <li>Discharge</li> </ul>	2.8	4.6

- PAIN IMPROVED OFF OPIOIDS
- Miller NS, Swiney T and Barkin RL. Am J Therapeutics, 2006

### CNS CHANGES AND COT



- MRI brain in patients with CLBP
- 30 days treated w/morphine 120 mg/day
- Decreased grey matter volume in amygdala, hippocampus, hypothalamus and cingulate gyrus
- Brain changes did not reverse after 5 months abstinence
- Controls w/CLBP not treated with opioids showed no change in grey matter volume

#### OPIOID PHARMACOLOGY

- Opioid receptors (mu -1, mu-2, kappa, delta)
- Located in brain, SC, GI tract and WBC's
- Activation of receptors:
- 1) analgesia
- 2) sedation
- 3) respiratory depression
- 4) constipation
- 5) physical dependence





Opiates change the limbic system that control emotions & increases feelings of pleasure

Opiates change the brain stem, areas that controls automatic body functions

Opiates block pain messages transmitted by the spinal cord from the body

#### OPIOID PHARMACOLOGY

"Brain Morphine" = enkephalin, endorphin & dynorphin

Opioids shut down your own endogenous brain morphine



#### OPIOID USE DISORDER

- Brains reward center (pleasurable, remembered, ensures survival):
- 1) eating
- 2) drinking
- 3) sex
- Opioids highjack reward system due to Dopamine release
- COT can induce neuroanatomic changes in the brain



#### OPIOID USE DISORDER (OUD)

- Tolerance (100% > 90 days COT)
- Withdrawal if opioids stopped
- Higher doses over time than intended
- Unsuccessful at dose reduction or in controlling use
- More time spent obtaining, using and recovering
- Craving
- Impaired social/work demands
- Continued use despite knowing the physical/psychological harms



Diagnostic and Statistical Manual of Mental Disorders (DSM-V)

#### WHO'S AT RISK FOR OUD?

- History of substance abuse (nicotine, alcohol, THC, etc.)
- Other mental illness (depression, anxiety most common)
- Male
- Age 45-55 (opioids); 25-34 (Heroin)
- Non-Hispanic white
- History of psychological, physical, sexual abuse (? PTSD)
- Paulozzi L. Center for Disease Control. April, 2012



## PRESCRIPTION OF LONG-ACTING OPIOIDS AND MORTALITY IN PATIENTS WITH CHRONIC NON-CANCER PAIN

- Heart disease biggest risk from opioids:
- Pts on LA-COT are more likely to die prematurely from CV/resp. disease than due to accidental opioid OD
- 23,000 pts
- Rx LA opioid, pregabalin, gabapentin or low-dose anti-depressant
- After 4 months COT:
- 1) 185 deaths
- 2) Mortality rate 1.6x higher in opioid group

- 3) 89 CV/resp. deaths
- 4) 34 OD deaths

### PRE-OP OPIOIDS PROLONG POST-OP RECOVERY IN BACK SURGERY

- 140 Ohio Workman's' Compensation patients w/ degenerative LSS (Lumbar decompression)
- Outcome measurement = RTW
- Cohort: < 3 months pre-op opioids (short-term)</li>
- > 3 months pre-op (long-term)
- Outcome: short-term users had a higher RTW (42%) rate than long-term users (23%)
- > 3 months pre-op opioid use was a significant negative predictor of RTW
- Long-term opioid patients cost WC \$71,000 more than subjects on opioids < 3 months
- Tye EY et al., Spine. Feb., 2017

### NEW PERSISTENT OPIOID USE AFTER MINOR AND MAJOR SURGICAL PROCEDURES IN US ADULTS

- 36,000 pts Rx opioids after surgery in 2013-2014 (no prior opioid use in the year before surgery)
- 80% had minor surgery (VV stripping, CTR)
- 20% major surgery (bariatric, hysterectomy)
- No significant difference in pts who had major or minor surgery and their likelihood to continue COT
- Other risk factors for COT 3-6 months post-op:
- 1) Smokers 35% more likely to continue COT
- 2) Alcohol/substance abuse 34%

3) Anxiety 25%

- 4) Chronic pain pre-op 39%
- Brummett CM, Waljee JF and Goesling J. JAMA Surg. April, 2017

## CHARACTERISTICS OF INITIAL PRESCRIPTION EPISODES AND LIKELIHOOD OF LONG-TERM OPIOID USE-UNITED STATES, 2006-2015

Large sample of opioid-naïve, non-cancer patients who received 1<sup>st</sup> opioid Rx, likelihood of chronic opioid use increased w/ the following:

- 1) Each day the med was supplied beyond 3 days (especially 5<sup>th</sup> and 30<sup>th</sup> day)
- 2) A second Rx or refill
- 3) 1 in 7 pts w/ a refill or 2<sup>nd</sup> Rx were on opioids 1 year later
- 4) Initial 10 or 30 day supply
- 5) Use of LA opioid or Tramadol

Shah A, Hayes CJ and Martin BC. CDC Morbidity and Mortality Weekly Report. March 17, 2017

#### CHARACTERISTICS OF INITIAL PRESCRIPTION EPISODES AND LIKELIHOOD OF LONG-TERM OPIOID USE—UNITED STATES, 2006-2015

- Clinical Bottom Line:
- 1) Treat acute pain w/< 7 days opioids (Ideally < 3 d)</li>
- 2) After at least one day of initial opioid Rx, 6% on opioids at 1- year
- 3) After > 8 days on opioids, 13.5% on opioids at 1- year and,
  - 4) After > 31 days on opioids, 30% were still on opioids at 1-year
  - 4) Use caution when prescribing > 1-wk or authorizing a refill or 2<sup>nd</sup> Rx

Shah A, Hayes CJ and Martin BC. CDC Morbidity and Mortality Weekly Report. March 17, 2017

#### ASSOCIATION OF LONG-TERM OPIOID THERAPY WITH FUNCTIONAL STATUS, ADVERSE OUTCOMES, AND MORTALITY AMONG PATIENTS WITH POLYNEUROPATHY

- 3,000 pts w/ LE Peripheral neuropathy (neuropathic pain)
- Received COT > 90 days and compared to age-matched cohort not on opioids
- Those on COT:
- 1) Required more assistive devices to ambulate
- 2) No improvement in functional gains
  - 3) Higher rates of depression, opioid dependency and accidental OD
- <u>E. Matthew Hoffman, DO, PhD<sup>1</sup></u>; James C. Watson, MD<sup>1,2</sup>; Jennifer St Sauver, PhD<sup>3</sup>; <u>et alNathan P. Staff, MD, PhD<sup>1</sup></u>; <u>Christopher</u>
   <u>J. Klein, MD<sup>1</sup></u>
- JAMA Neurol. Published online May 22, 2017. doi:10.1001/jamaneurol.2017.0486

#### IMPACT OF PREOPERATIVE OPIOID USE ON TOTAL KNEE ARTHROPLASTY

- 156 Patients (62% female)
- Mean BMI 31.1 kg/m<sup>2</sup>
- Pre-op 23% received one or more opioid Rx's
- Outcomes:
- 1) Higher pain scores in opioid group
- 2) Pre-op Pain Catastrophizing Scale higher in opioid group
- 3) At 6 months post-op the opioid group had significantly less pain
  - reduction

Smith, Savannah R. BA1,\*; Bido, Jennifer BA2,\*; Collins, Jamie E. PhD1,2; Yang, Heidi MS, MPH1; Katz, Jeffrey N. MD, MSc1,2,3; Losina, Elena PhD1,2,4,a Journal of Bone & Joint Surgery - American Volume: <u>17 May 2017 - Volume 99 - Issue 10 - p 803–808</u>

#### NON-ADDICTING ADJUVANTS/ALTERNATIVES

- Exercise/PT
- Low-dose tricyclic antidepressants
- Anti-anxiety (non-benzo's): propranolol, clonidine, hydroxyzine
- Topical NSAID's
- Yoga
- CBT
- NSAID's
- Sleep hygiene
- HEP

Injections (TrP, ESI, RFA) Acupuncture (short-term) Chiropractic (short-term) Group psychotherapy TENS (LBP, NP) Anticonvulsants SSRI's/SNRI's Muscle relaxants (short-term)

#### OTHER SIDE EFFECTS OF COT



#### OPIOID INDUCED ENDOCRINOPATHY (OIE)

- Common but poorly recognized adverse consequence of COT
- Least often diagnosed
- Opioid use > 1 month:
- 1) blocks hypothalamic-pituitary-adrenal axis (HPA)
- 2) decreased testosterone, estrogen, progesterone, GH & cortisol

#### **OIE SYMPTOMS**

- Anemia
- Decreased libido (males on COT now commonly Rx sildenafil, tadalafil due to ED)
- Decreased muscle mass = loss balance leading to falls (females, elderly)
- Depression/anxiety/insomnia
- Fatigue
- Menstrual irregularities
- Osteopenia/osteoporosis
- Vasomotor instability (fainting)
- Weight gain
- Decreased response to stress

### COMMONLY PRESCRIBED OPIOIDS AND ANDROGEN DEFICIENCY (AD) IN MEN

- 1,157 men (age 18-80)
- Single opioid for > 90 days (chronic non-cancer pain)
- Fentanyl, methadone, oxycodone or hydrocodone
- Increased AD in men taking fentanyl, methadone and oxycodone
- LA/ER opioids carry highest risk of AD
- AD least likely in men taking hydrocodone (but odds increase for every 10-mg increase in dose)

Rubinstein, RL and Carpenter, DM. Pain Medicine, 2017

- Pain assessment: pain drawing, NRS, other questionnaires (ORT, McGill)
- Comprehensive history and PE: location, character, chronicity, effect on mood/sleep, work & ADL's
- Patient expectations with COT in terms of analgesia and recovery of function
- Detailed psychosocial history (pre-existing depression, anxiety or other mood D/O)
- Past history of drug use/abuse (ETOH, tobacco, THC, other elicit substances)
- Past history of physical, psychological and sexual abuse
- Family history of drug/alcohol abuse
- Assess risk vs benefit with COT (is patient able to function and carry out psychosocial and work demands?)

• Fishman, SM. Responsible Opioid Prescribing: A Clinician's Guide, 2<sup>nd</sup> ed., 2014



- Informed consent (pain contract)
- Prescription monitoring program (PDMP)
- Assess risk for misuse before prescribing opioids (ORT)
- Create a treatment plan
- Establish functional goals

- Focus on functional outcomes and NOT analgesia:
- 1) Increased ADL's
- 2) RTW
- 3) Compliance with HEP
- 4) Increased social activities



- Frequent monitoring while on COT (4-6 week follow-up)
- Random pill counts
- UDS
- Plan for potential treatment discontinuation:
- 1) pain no longer a problem
- 2) intolerable side effects
- 3) lack of adequate pain relief or functional improvement
- 4) evidence of non-medical or inappropriate use of medication

#### INITIATING TREATMENT WITH OPIOIDS

- Initiating treatment should be individualized
- Do the patients subjective pain complaints correlate with the objective medical evidence?
- Exercise caution in patients with COPD, CHF, sleep apnea, mental illness, alcohol/substance abuse, elderly, renal and hepatic dysfunction
- Do not combine opioids with benzodiazepines or barbiturates unless there is a specific mental or psychiatric indication for combination use (strict monitoring required)



### OPIOID POTENCY

#### • <u>Opioid</u>

- 1) Morphine (MS)
- 2) Oxycodone
- 3) Hydrocodone
- 4) Hydromorphone
- 5) Fentanyl

#### Potency

IV MS 3X more potent than oral (10mg = 30mg)
1.5X more potent than MS (20mg = 30 mg)
Equipotent to MS (30mg = 30mg)
4-7X more potent than MS (7mg = 30mg)
80-100X more potent than MS (50mcg = 300mg)

Stanford School of Medicine Palliative Care Equivalency Table (palliative.stanford.edu)

#### COT AND DOSING

- THERE IS NO SAFE OPIOID DOSE!
- Low-dose COT < 20 mg/day MED
- Moderate-dose 20-49 MED
- High-dose 50-99 MED
- Very high-dose  $\geq$  100 MED



- OD risk increases 2X at doses between 20-49 MED
- OD risk increases 9X at doses > 100 MED

Interagency Guideline on Prescribing Opioids for Pain. June, 2015

#### TREATING WITH COT

- Dose titration: "go low and slow"
- Immediate release (IR) or short acting opioids are preferred
- Long-acting (LA) opioids may be required in combination with IR
- Combination therapy for chronic and breakthrough pain
- Anticipate potential opioid OD in high risk patient (i.e., COPD, apnea)
- Consider Rx intranasal naloxone in high risk patient who are on high-dose COT (>50 mg/d MED)
- Be prepared to manage opioid-related side effects

#### **INFORMED CONSENT FOR OPIOID PAIN THERAPY**

- Before initiating a trial of opioid analgesic therapy, obtain informed consent to
- establish:
- Analgesic and functional goals of treatment
- Prescriber and patient expectations
- Potential near-term and long-term risks of opioid therapy
- Alternatives to opioids
- The potential for and management of adverse effects

#### TREATING WITH COT

- Screen for endocrine dysfunction (depression, fatigue, insomnia, falls commonly seen but not recognized)
- Is the patient developing OIH?
- Consider DEXA to r/o osteopenia, osteoporosis
- Opioid rotation due to tolerance
- Consider pain, psychiatry or addiction medicine consult
- Taper off opioids if no significant change in analgesia and or agreed upon functional goals

#### IDENTIFY NON-COMPLIANT/HIGH RISK PATIENTS

- Requesting name-brand opioids ("oxycodone is the only one that works")
- Demanding or manipulative behavior
- Acquiring opioids from multiple providers (PDMP)
- Frequently running out of Rx prior to scheduled refill
- "Lost" or "Stolen" prescription
- UDS screen negative for opioid being Rx
- Inaccurate pill count



 Frequent requests to increase dose despite no antecedent cause for pain escalation (OIH?)

#### COMMON TRAITS IN PATIENTS MISUSING OPIOIDS

- Deteriorating appearance/hygiene
- Looks intoxicated or acts euphoric
- Appears sedated or confused (slurred speech)
- Increasingly negative moods or frequent mood swings
- Lack of interest in therapy or other non-opioid interventions
- Victim of abuse
- Misuses alcohol, tobacco or other illicit drugs
- Involved in MVA or other accidents
- Frequent complaints about co-workers, family or friends
- Fishman, SM *Responsible Opioid Prescribing: A Clinician's Guide*, 2<sup>nd</sup> ed. 2104



#### EFFICACY OF COT FOR CHRONIC NON-CANCER PAIN

- Low evidence that COT is efficacious in treating LBP
- Little to no evidence that COT improves chronic non-cancer pain
- Most opioid trials < 6 weeks</li>
- No studies comparing opioids to other treatments looking at long-term outcomes for pain, function or quality of life
- No effect on functional outcomes
- No more than a 5-10 point benefit on function (100-point scale)
- Incidence of pain increases and function declines with high-dose COT
- cdc.gov
- American Pain Society: Clinical Practice Guidelines in the Treatment of Chronic Non-cancer Pain, 2014

#### METHADONE-IS IT SAFE?

- High incidence of OD deaths
- Major causal factor in OD occurs when switching from another opioid to methadone
- Short duration of action (4-8 hr) with a long half-life (up to 60 hr)
- Commonly Rx when other opioids fail to relieve pain
- Lower affinity for mu-opioid receptors resulting in fewer side effects (i.e., constipation, nausea)
- Binds to NMDA receptor (reduced opioid tolerance)
- Better for neuropathic pain compared to other opioids?
- Fishman SM. *Responsible Opioid Prescribing: A Clinician's Guide*, 2<sup>nd</sup> ed., 2014

#### METHADONE-IS IT SAFE?

- Requires special prescriber knowledge and patient education for safe use
- Prolonged and variable elimination half-life resulting in higher risk of unintended drug-drug interactions
- Tobacco accelerates elimination
- Alcohol increases methadone toxicity and accelerates metabolism with chronic use
- Must be carefully titrated to avoid OD ("start low and go slow" vital)
- Methadone appears to be more potent in pts on higher doses of other opioids
- Dosage escalation more frequently than every 5-7 days increases risk of accumulation
- Fishman SM. Responsible Opioid Prescribing: A Clinician's Guide, 2<sup>nd</sup> ed., 2014



#### METHADONE-CARDIAC WARNINGS

- Methadone can cause:
- 1) QT prolongation
- 2) *Torsades de Points (*fatal ventricular arrhythmia)
- Cardiac conduction abnormalities can occur at <u>ANY</u> dose
- Prescribers should possess a Cardiac Risk Management Plan
- Methadone can be physically and psychologically addicting



- Accidental OD deaths are more frequent with concurrent use of alcohol or benzodiazepines
- Fishman SM. Responsible Opioid Prescribing: A Clinician's Guide, 2<sup>nd</sup> ed., 2014



#### METHADONE-RELATED DEATHS

- Risk of OD death highest in the first two weeks of treatment:
- 1) Initial dose is too high
- 2) Rapid dose escalation
- 3) Drug-drug interactions (Benzo's, anticonvulsants, antidepressants)

• Krantz MJ, et al. Annals of Internal Medicine, 2009

### METHADONE VS. BUPRENORPHINE

- Buprenorphine is a partial mu-opioid agonist-antagonist
- Less euphoria than methadone
- Withdrawal less severe than w/ methadone
- Longer acting
- Buprenorphine available in tablet, injectable, sub-lingual and transdermal
- Buprenorphine should be used as maintenance therapy related to recovery from opioid addiction and NOT as a treatment for chronic pain
- Caution in the elderly
- Check liver enzymes before starting buprenorphine
- Avoid alcohol and benzodiazepines as with other opioids



#### COT: THE GOOD NEWS

- Effective analgesia can prevent morbidity and psychosocial distress
- Unrelieved pain is associated with increased M/M
- Careful monitoring can prevent management problems related to tolerance and dependency
- Addiction is rare w/o pre-existing history of substance abuse or other risk factors such as mood disorder(s)
- In stable and active pts receiving COT who request dose escalation, often times it is due to progression
  of their disease and not tolerance

Aronoff, GM. North American Pain and Disability Group. January, 2017

#### COT: CANDIDATES?

- Nociceptive pain is opioid responsive (i.e., fractures/trauma, post-op)
- Neuropathic and central pain not generally responsive to opioids
- Psychologically maintained pain unresponsive to opioids and contraindicated
- Hypersensitivity states (i.e., Fibromyalgia) in the absence of identifiable injury or tissue damage are not appropriate candidates for COT and generally should be avoided

#### IDEAL CANDIDATE ON COT

- Pain is stable on COT w/o exacerbations or change in dose
- Independent in ADL's
- Working
- Compliance with treatment & HEP
- No mood disorder(s)
- No pre-existing drug/alcohol misuse
- Non-smoker
- Active outside of work and home (hobbies)



### GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN-WHEN TO INITIATE OR CONTINUE OPIOIDS

- Opioids are not fist-line or routine therapy for chronic pain
- Establish and measure goals for reduced pain and increased function
- Discuss benefits and risks of COT and availability of non-opioid adjuvants
- Educate patient on the relative risks and benefits with COT
- cdc.gov
- mtguidelines.com

## GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN-OPIOID SELECTION, DOSE, DURATION, FOLLOW-UP AND DISCONTINUATION

- Use immediate release opioids when starting
- Start low and go slow
- Prescribe no more than needed w/ acute pain (< 7 days)</li>
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risks of harm
- Reduce dose or taper and discontinue if needed
  - cdc.gov

mtguidelines.com

#### GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN-ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and Rx from other providers
- Use UDS to identify opioids prescribed and other undisclosed meds or illicit drugs
- Avoid combining benzodiazepines w/ opioids
- Coordinate referral for treatment of opioid use disorder if needed
- cdc.gov
- mtguidelines.com

#### SUMMARY

- COT is challenging
- Comprehensive pre-opioid evaluation/follow-up critical to avoiding long-term adverse effects
- Exhaust all non-opioid therapy before considering COT
- Use the lowest dose possible to reduce risk of OUD and accidental OD
- Carefully reassess risk/benefit when increasing dose to 50 mg/d MED (33 mg oxycodone)
- Avoid doses of 90 mg/d MED or more (60 mg oxycodone)
- Be able to recognize and treat potential multiple adverse side effects

### THANK YOU

