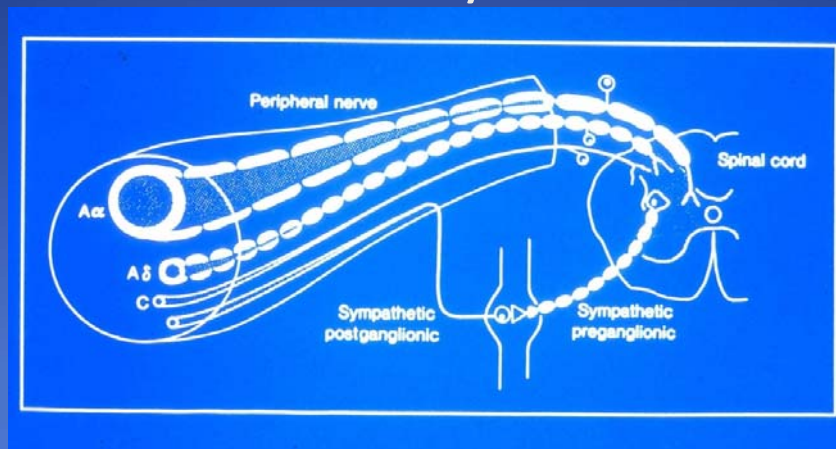


Opioid Prescribing 2018: Where Are We Now?

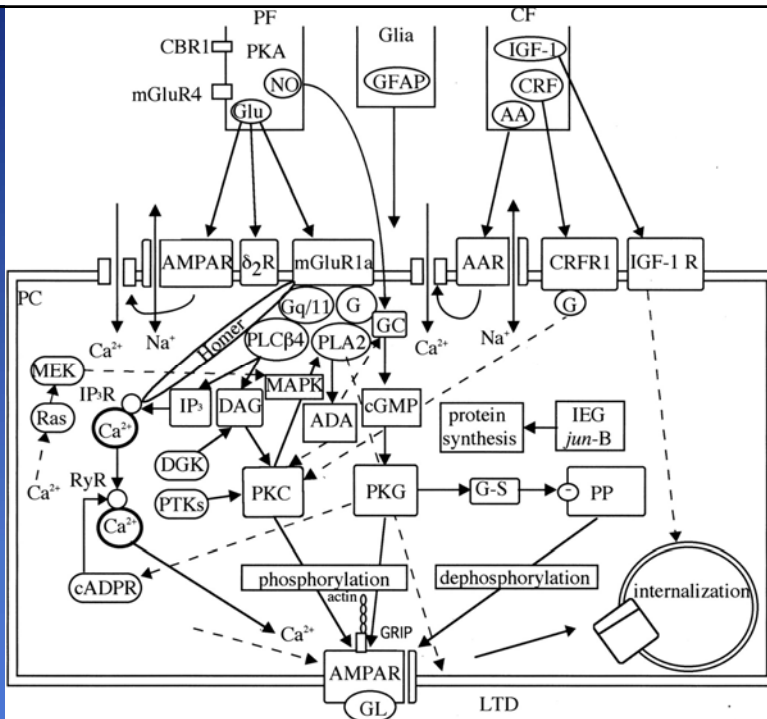
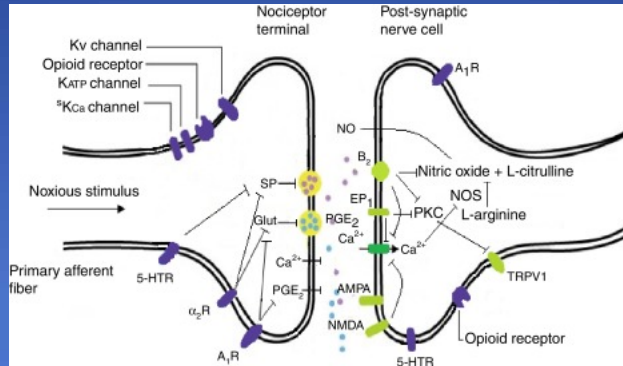
C. Scott Anthony, D.O.

Pain Management of Tulsa

The Basic Pain Pathway



Dorsal Horn Synapse





The Adverse Effects of Uncontrolled Pain

- Severe deconditioning
- Loss of aerobic capacity
- Weight gain
- Catecholamine surges
- Sleep disturbances
- Depression and suicide
- Persistent pain is a potent stressor
- CDC asks: does the potential harm outweigh the risks

Opioid Prescribing:

- Chronic pain is highly complex
- Opioids alone are often inadequate
 - 25-50% improvement in pain scales
- Opioid therapy can be highly beneficial in select patients who demonstrate compliance and function
- Often the only remaining option for some patients
- Worries about the “collateral damage” to chronic pain patients who require opioids to function and live a quality life

Controversies Abound

- Concerns about the CDC guidelines
- Are chronic opioids even effective?
- Are opioids a “gateway” drug?
- Is the reduction in prescribed opioids harmful?
- Getting help for opioid addiction and abuse
- Palliative care and chronic pain
- The legitimate patient with pain

National Issues

- President Trump initiative to decrease opioid prescribing by 33-50% in 3 years
- CMS actions
- DEA reducing manufacturing of opioids 25% in 2017 and a further 20% in 2018
- Pharmacy chains with varying policies
- Numerous states capping at <90 MED's
- National Committee for Quality Assurance
 - Links "best practices" to MED,s

Oklahoma Issues

- Rise in illicit opioids and methamphetamine
- Reduction in prescribed opioids
- Treatment of addiction and abuse
- Naloxone initiative
- Overdose tracking
- Electronic prescribing
- PMP strengthening
- Initial opioid prescriptions

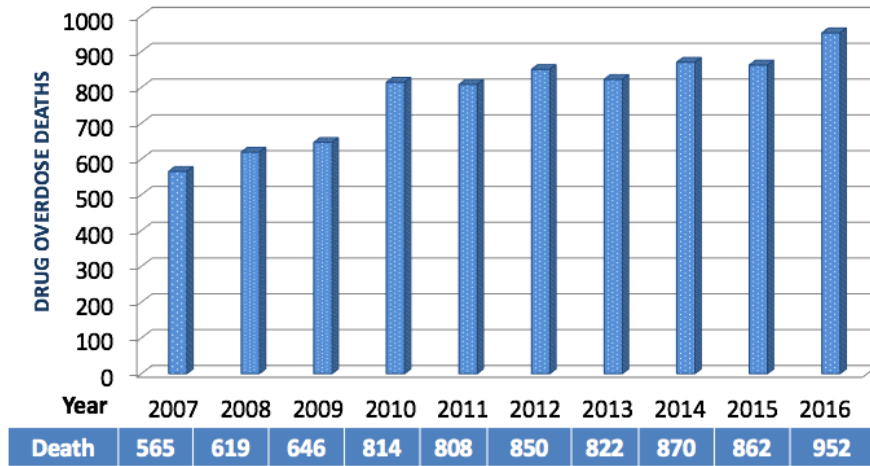
Opioid Deaths

- Major reason for CDC involvement
- Significant escalation in illicit opioids
- Diversion: most deaths are from “non-prescribed” opioids
- Lethal combinations especially with benzodiazepines
- Illegal opioids outpacing prescribed opioids
- Without question the number one reason for governmental intrusion

CDC Overdose Death Rates From Prescription Opioids

- April 2018: *American Journal of Public Health*
- Prescription opioid overdose death rates are “*significantly inflated*”
- Illicitly manufactured fentanyl
- Exact drug in 20-25% of overdose deaths unknown
- 50-90% of deaths involve multiple drugs
- Number of deaths due to diverted opioids unknown
- Prescription opioid overdose deaths have been overestimated by 50% and likely more in 2016

STATE OF OKLAHOMA DRUG OVERDOSE DEATH 10 YEAR COMPARISON



My Practice Observations

- Definite change in referral patterns
- CDC guidelines have changed my practice
 - Try to get to the most effective dose
 - Emphasis on drug combinations
 - Medication assisted treatment for addiction/abuse
- Frightened patients
- Frightened physicians
- Pain management: “worst of the worst”

CDC: Pro's and Con's

- Has been generally helpful in decision making
- But, has become a “flashpoint”
- Evidence across the board is lacking
- Much legislation is tied to “guidelines”
- High emphasis on “dose” and not case by case
 - Insurers
 - CMS
 - Legislation
 - Press

Opioids for Chronic Pain

- Broad spectrum of opinions
 - “Life saving therapy”
 - “Legalized heroin”
- CDC study controversy
- Long term outcome studies are sparse
 - “The absence of evidence is not the evidence of absence”
- Short term outcome studies show benefit
- Most all guidelines and medical societies show support for appropriate prescribing of opioids

Are Opioids Efficacious for Chronic Pain?

- Long term outcome studies are lacking
- CDC insights based on available evidence
 - Opioid use may be the most important factor impeding recovery of function
 - Opioids may not consistently and reliably relieve pain and can decrease quality of life
 - The routine use of opioids cannot be recommended
- Appropriate only for selected patients with moderate-severe pain that significantly affects quality of life

CDC Emphasis: High Dose Opioids

- Providers should prescribe lowest possible dose
- Additional precautions at > 50 MED's
- Should avoid > 90 MED's
- Risks of fatal and non-fatal overdoses
- Demands documented increase in function and no adverse side effects
- Recommend consultation over 90 MED's
 - Closer follow-up
 - Consideration of other risk factors

Some Concerns with MED's

- Sudden dose escalations
- Non-prescribed opioids
- Errors with opioid rotations
- “Start low, go slow”
- Data is retrospective
- What about cohort of healthy functioning patients?
- Does not take into account:
 - Tolerance, weight or pain syndrome
 - Genetics/pharmacology

Recent CDC Comments

- Patients deserve safe and effective pain management
- Taper and reduce dosage only when harm outweighs risk
- The guideline is not meant to be a rule, regulation or law
- It is not intended to deny access to pain medication
- Not intended to take away from physician discretion and decision making
- The ultimate goal of the guideline is to ensure patients who need opioids have access to them

CDC Summary Comments

- Recommendations are based on the best available evidence
- The scientific evidence is low in quality
- Much left to be learned about opioid therapy
- Need research leading to safer and more effective care
- Strong evidence for many pain therapies is lacking
- Does the potential harm outweigh the risks

Are High Dose Opioids “Bad” Practice?

- It is an “MED, MED, MED world”
- Ongoing reduction in what is termed “high dose”
- Comments from national leaders
- Anecdotal evidence over 23 years of practice that there is benefit in select patients
- Roughly 20% of patients abuse their prescribed opioids
- What about the roughly 80% who take appropriately?
- Will opioid therapy be an option in coming years?

“Forced” Dose Reductions

- There is really no evidence on this approach
- A vulnerable population of patients
- Does this lead to more harm?
- Rupture of patient-physician relationship
- Increased disability
- Risk of illicit drug use
- Suicide

CDC Emphasis: First Line Approach

- Non-pharmacological approach
- Non-opioid approach
- Emphasis on
 - Behavioral therapies
 - Functional therapies
 - Adjunctive medications
 - Patient and provider expectation
 - Opioids are a “last resort” option

Chronic Opioid Therapy (COT)

- Consensus agreement that it can be useful in carefully selected patients with moderate to severe pain
- Absolutely demands:
 - Compliance: As with any medical problem
 - Documentation
 - Close monitoring through follow up
 - Vigilant monitoring for abuse and diversion
 - Assessment of opioid related side effects
 - Understanding of opioid use in chronic pain

Expectations

- Patient and physician usually have a different view
- Perhaps the best way to avoid problems
- Explain:
 - Your expectations
 - Listen to the patients expectations
 - Come to a middle ground of understanding
 - Develop a “trust”
 - Explain the rationale for your decision
 - Have available a print out of the CDC guidelines

Patient Selection and Risk Stratification

- History, physical examination and diagnostic testing
- Psychosocial risk assessment
- Expectations: physician and patient
- Risk assessment is an underdeveloped skill for most clinicians
- CDC: COT should be viewed as a treatment of last resort
 - Consider other modalities prior to initiation
 - Use opioids in addition to a multidisciplinary approach to pain

CDC: Initiation of COT

- Informed consent and discussion of risk vs. benefit
- Therapeutic trial of 4-6 weeks
- Exhaustion of other modalities
- Insufficient data on starting dose
 - “Start low go slow”
 - Conversion tables
- Ongoing monitoring and assessment of benefit vs. risk, expectations and alternative modalities
- Consider a taper or wean even in functional patients

CDC Emphasis:

- IR vs. ER/LA opioid therapies
 - Little mention of abuse deterrent medications
- Benzodiazepine use with opioids
 - Significant increase in deaths and ER visits
- Acute pain leading to chronic therapy
- Methadone
- Offering naloxone to patients at risk
- High dose opioids

The “Ideal” Patient

- Well defined pathology
- Good insight and desire to improve
- Willing to “work hard” to improve
- Interested in other modalities and work-up
- Not focused on opioids but desire to improve
- Good understanding that opioids will provide “some” relief to help them improve
- Examples

The “Wrong” Patient

- Diffuse and poorly localized pain
- No interest in work-up or other modalities
- Focus is on opioids alone
- Poor insight and unrealistic expectations
- Poorly motivated with no desire to “work hard”
- Poor functionality
- Examples

Patients at Risk

- Psychosocial issues
- History of addiction
 - Risk of relapse, harm and treatment failure
- Adverse Childhood Experience (ACE)
 - Abuse, neglect, household dysfunction and traumatic stressors
- Poor motivation and lack of insight
- Disability, Medicaid and even prior criminal activity
- Unrealistic expectations

Opioid Use Disorder

- 3-26% incidence
- Significant impairment or distress
- Inability to reduce opioids
- Inability to control use
- Decreased function
- Social function reduced
- Failure to fulfill work, home or school obligations
- Commonly referred to as “abuse” in the literature

Risk Factors for OUD

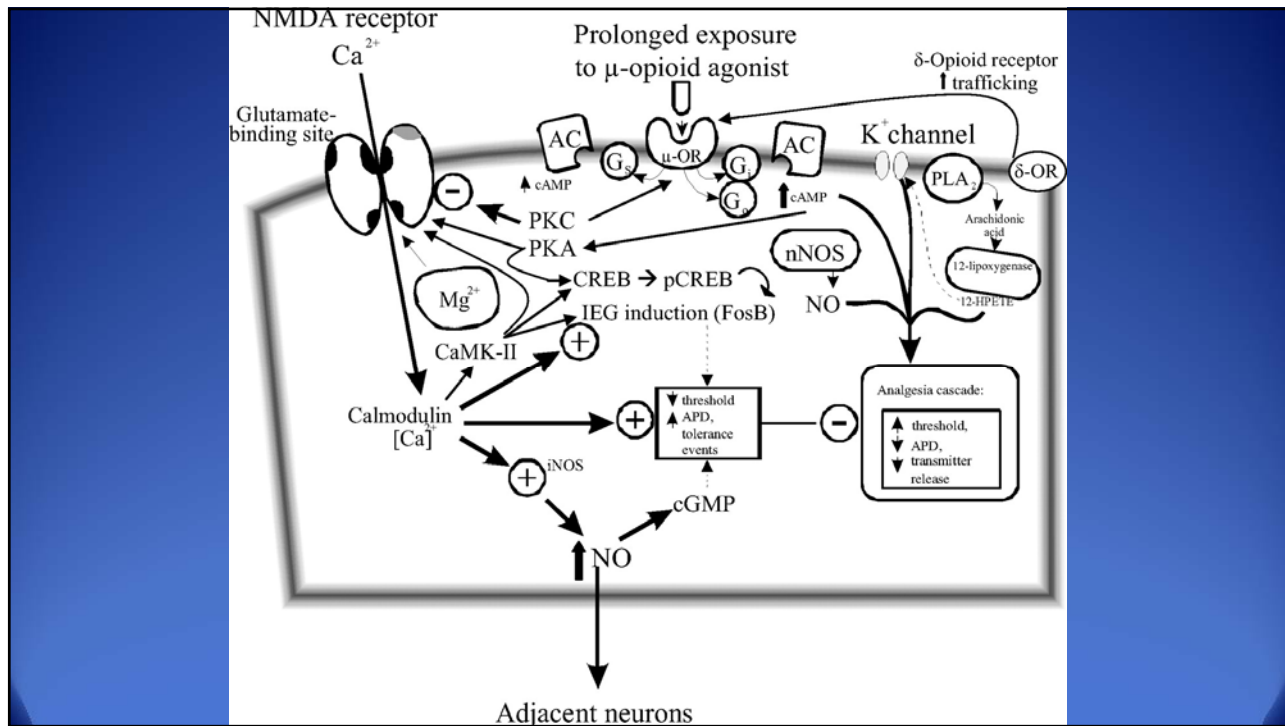
- Younger age
- Previous substance abuse
- Poor insight
- Poor social structure
- Back pain, headache and non-specific pain
- Co-existing depression and anxiety
- Greater than 90 MED's a day

Medication Assisted Treatment

- Emphasized with patients who display OUD
- Buprenorphine: Partial agonist
- Methadone
- Behavioral therapies
 - Help maintain retention
 - Help reduce relapse rate
- CDC emphasis on:
 - Availability
 - Cost

Opioid Induced Hyperalgesia

- Increased sensitivity to noxious or non-noxious stimuli
- Sensitization of pro-nociceptive mechanisms
- Hypersensitivity and allodynia
- Confused with tolerance
- Caused with rapid escalation and high dose therapy?
- Activity at the NMDA receptor in dorsal horn
- Novel medications now and future



Contributing Factors to Inadequate Treatment and Prescribing

- Physician lack of knowledge in best clinical practice
- Inadequate research
- Poor understanding of risk mitigation
- Poor utilization of PMP and UDS
- Conflicting clinical guidelines
- Physician misunderstanding of dependence/addiction
- Complete relief may not be an attainable goal

Common Mistakes

- Continued escalation of opioids despite no evidence of improvement
- Opioids used in pain syndromes known to be poorly responsive
- Failure to document
- Not addressing psychosocial issues
- Not using medication assisted treatment options
- Lenient with abuse behaviors
- Failure to use monitoring systems

Drug Seeking?

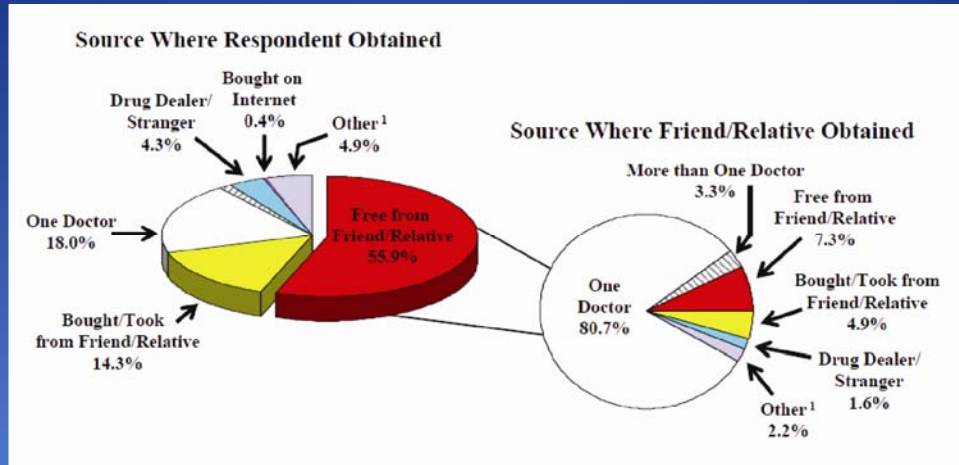
- Even a skilled physician can be “duped”
- Common scenarios patient request for opioids or opioid increase
 - Progression of disease
 - New painful diagnosis
 - Psychological issues
 - Poor understanding of pain and opioids
 - Failure to use adjunctives or other therapies
 - Addiction, abuse or diversion

Risk Mitigation

- Pay attention to a pattern of activity that suggests abuse and address
- Monitor closely through follow up and documentation
- Use available tools:
 - PMP database
 - UDS and pill counts
 - Opioid risk tools
- Obligated to protect yourself, your patient and society from opioid abuse and diversion

Prescription Monitoring Program

- Powerful tool
- Mandated in Oklahoma first visit and every 180 days
- Physician and staff friendly
- Helps with determining MED's
- Helpful to determine other scheduled drugs like benzodiazepines
- Good “teaching moment” with the patient
- Unfortunately a high percentage of overdoses are from non-prescribed opioids



Don't Forget Documentation

- A patient problem requires a documented response and action
 - UDS result
 - PMP result
 - Non-fatal overdose
 - Lost or stolen prescription
 - Phone calls

Medical Marijuana

- CB₁ and CB₂ receptors
 - Neuropathic pain and spasticity
 - Microglial activity: neural inflammation
 - Pharmaceutical advances
- Reduced opioid deaths?
- Reduced opioid utilization?
- Increased risk of abuse of opioids?
- CBD vs THC

Conclusion: Key Points

- We are facing a public health crisis
- We need more mental health treatment
- Training physicians to provide MAT
- Responsible prescribing
- Risk mitigation
- We cannot forget the patient who does suffer with chronic pain