BALANCE
CHRONIC PAIN MANAGEMENT
AND RESPONSIBLE OPIOID
PRESCRIBING

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April 27, 2011
Overview

• Frame the dilemma
• Federation of State Medical Boards
• Discussion and questions
United States Statistics

- 70 - 100 million adults have chronic pain\textsuperscript{1}
- 5 -33% of outpatient visits to primary care clinics\textsuperscript{2}
- Unrelieved pain is a public health epidemic
- 2003 JAMA published overall costs to society of $61 billion\textsuperscript{3}, similar to that of cancer and CVD\textsuperscript{4}
It’s the law!

2005 - WHO
“...relief of pain is a basic human right...”

JCAHO “....Patients have the right to appropriate assessment and management of pain....”

Pain Relief Act NM January 20, 2003, “....every New Mexican shall receive appropriate treatment for pain,” further, “....health providers have an obligation to treat chronic pain....including the use of controlled substances...”
Categories of Pain Treatment

- **Psychological approach** - CBT, Biofeedback, hypnosis
- **Injection** - TPI, ESI, joint
- **Neural blockade** - celiac plexus block
- **Implants** - intrathecal pump, nerve stimulator
- **Surgical** - cordotomy, neurotomy
- **Non-opioid drugs** - NSAIDS, acetaminophen
- **Adjuvant analgesics** - antidepressants, anticonvulsants
- **Rehabilitative approaches** - hot/cold packs, nerve stim, PT/OT
- **CAM** - acupuncture, chiropractic, massage
- **Lifestyle changes** - Etoh, tobacco, sedentary life, wt loss
- **Opioids** - morphine, oxycodone, fentanyl, methadone
Fear influences us

Last week’s JAMA: Opioid overdose is now the second leading cause of unintentional death in the USA

The 'Oxy Express': Florida's Drug Abuse Epidemic


"If you're a clinic owner or a doctor or an employee knowingly working at one of these pill mills, we have probably bought dope from you. And we are probably coming to see you soon."
<table>
<thead>
<tr>
<th>Drug Deaths in New Mexico</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Drug</th>
<th>2002</th>
<th>2003</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total drug overdose deaths</td>
<td>253</td>
<td>307</td>
<td>21</td>
</tr>
<tr>
<td>Rx drug overdose deaths</td>
<td>66</td>
<td>108</td>
<td>64</td>
</tr>
<tr>
<td>Illicit drug overdose deaths</td>
<td>187</td>
<td>199</td>
<td>6</td>
</tr>
<tr>
<td>Morphine/heroin</td>
<td>133 (55%)</td>
<td>121 (44%)</td>
<td>-9</td>
</tr>
<tr>
<td>Cocaine</td>
<td>94 (39%)</td>
<td>110 (40%)</td>
<td>17</td>
</tr>
<tr>
<td>Alcohol</td>
<td>76 (31%)</td>
<td>78 (28%)</td>
<td>3</td>
</tr>
<tr>
<td>Methadone</td>
<td>28 (11%)</td>
<td>34 (12%)</td>
<td>21</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>14 (6%)</td>
<td>26 (9%)</td>
<td>86</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>11 (5%)</td>
<td>21 (8%)</td>
<td>91</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>10 (4%)</td>
<td>18 (6%)</td>
<td>80</td>
</tr>
<tr>
<td>Diazepam</td>
<td>12 (5%)</td>
<td>16 (6%)</td>
<td>33</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>18 (7%)</td>
<td>15 (5%)</td>
<td>-17</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>8 (3%)</td>
<td>14 (5%)</td>
<td>75</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>2 (1%)</td>
<td>8 (3%)</td>
<td>300</td>
</tr>
</tbody>
</table>

Table 1. The Most Common Drugs Causing Death Among Total Drug Overdose Deaths in New Mexico, 2002-2003
DILEMMA

How do we responsibly prescribe opioids and balance management of chronic pain?
A New Approach

You will no longer cringe, hide head in the sand

Rewarding for patient and provider
Opioid history

1. One of the oldest known drugs - opium

2. Appeared in Europe and US in 1800s,
   — 1890’s 1st Congressional Act--opium taxed
   — 1914 Harrison Tax Act--criminalized non-clinical use

3. Where we are today:
   — Controlled Substances Act 1970’s (CSA)
   — Schedule classification (Class I - V)
1. Mechanism of action: mu-opioid receptor
   – Highly variable receptor with a range of responses - producing wide inter-individual variations
2. Types: short, long, rapid-acting
3. Common side effects
   – nausea
   – sedation
   – constipation
   – pruritus
Which one to choose?

An opioid trial is the only way a clinician can determine the efficacy and tolerability of a particular agent in a particular patient.
What are barriers to prescribing?

Patient\textsuperscript{14}

Doctor\textsuperscript{14}

Regulatory\textsuperscript{15}
Barriers

Patient barriers

• Patient: Fear if adverse affects
• Fear that pain is irreversible and inevitable
• Fear of addiction
• Fear of focusing on symptoms and not cause
Barriers

Doctor barriers = opiophobia

– Lack of education about opioids and current standards
– Fear of toxicity
– Fear of addiction
– Fear of being “scammed or had” by patient
– Fear of regulatory scrutiny
Regulatory Barriers

1. States laws restrict Schedule II
   – prescription quantity or duration
   – prescription validity period

2. Prescription series

3. Triplicates/duplicates

4. Prescription monitoring programs
Federation of State Medical Boards (FSMB) 2005

Seven Step Process
1. Patient evaluation
2. Treatment plan
3. Informed consent and agreement (contract)
4. Periodic review
5. Consultation
6. Documentation
7. Compliance with controlled substances laws and regulations
Step 1

Patient evaluation

– Document H & P

– Comorbidities - anxiety, depression, cancer

– History of substance abuse - CAGE, ORT

– Document the indication for opioid use
Step 2

Treatment plan

– Objectives
– Adjust over time
– Don’t forget other modalities
Step 3

Informed consent and agreement contract

– Discuss
– Document
– Contract
– Violation
Step 4

Periodic review

– Evaluate progress toward treatment objective
– FOUR A’s - analgesia, activities, adverse effects, aberrant behaviors
– Satisfactory response
– “Zero pain” vs improved quality of life
Step 5

Consultation

– Be willing to refer patients at risk
  • Misuse, abuse, or diversion
  • Substance abuse
  • Psychiatric disorder
Step 6 - Documentation

Accurate and complete medical records

- Treatment objective
- Discussion of risks and benefits
- Informed consent
- Treatments
  - Past tried, why failed; Current; Future ideas
- Medications:
  - Date, type, dosage, and quantity
- Instructions and agreements
- Periodic reviews
Step 7

Regulations

– Licensed in the state you are prescribing
– Federal regulations www.usdoj.gov/dea
– State regulations www.nmmb.state.nm.us

https://www.pmp.state.nm.us/pmp/webcenter
Physical Dependence - a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of antagonist, physical dependence, by itself, does not equate with addiction
Vocabulary

**Pseudoaddiction** - iatrogenic syndrome from the misinterpretation of relief seeking behavior as though they are drug-seeking behaviors that are commonly seen in addiction.

BUT

relief of seeking behavior resolves with the institution of effective analgesia
Vocabulary

Substance Abuse - use of a substance for non therapeutical purposes or use of medication for purposes other than those it was prescribed for

Tolerance - a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect or a reduced effect is observed with a constant dose over time.

Tolerance may or may not be evident during opioid treatment and does not equate with addiction.
Finally

Multiple focus areas for scholarly project/publication
Websites

2005 National survey on drug use and health
www.oas.samhsa.gov

University of Wisconsin – Pain Policy
www.painpolicy.wisc.edu

New England Journal of Medicine – Opioid
http://www.nejm.org/search?q=opioid+therapy+for+chronic+pain&asug=opio

National Alliance Of Advocates - Buprenorphine Treatment
http://www.naabt.org/laws.cfm
References

1. Gottlieb S. Speech before the American Pain Foundation. Remarks by the Deputy Commissioner for Medical and Scientific Affairs, Food and Drug Administration to the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health; December 8, 2005; Washington, DC.


