“Managing Chronic Pain in the Age of Opiate Aversion

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Faculty/Presenter Disclosure

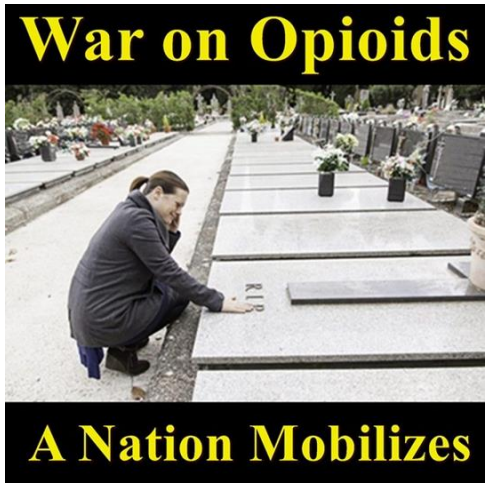
- **Faculty: Ted Rosenberg**
- **Relationships with commercial interests: none**
- **Commercial Support – none- RCI Stipend**
- **Conflict of Interest-**
  - **Care about my patients despite a " hostile environment"**
  - **20% of patients are on opiates**

Take Home Messages

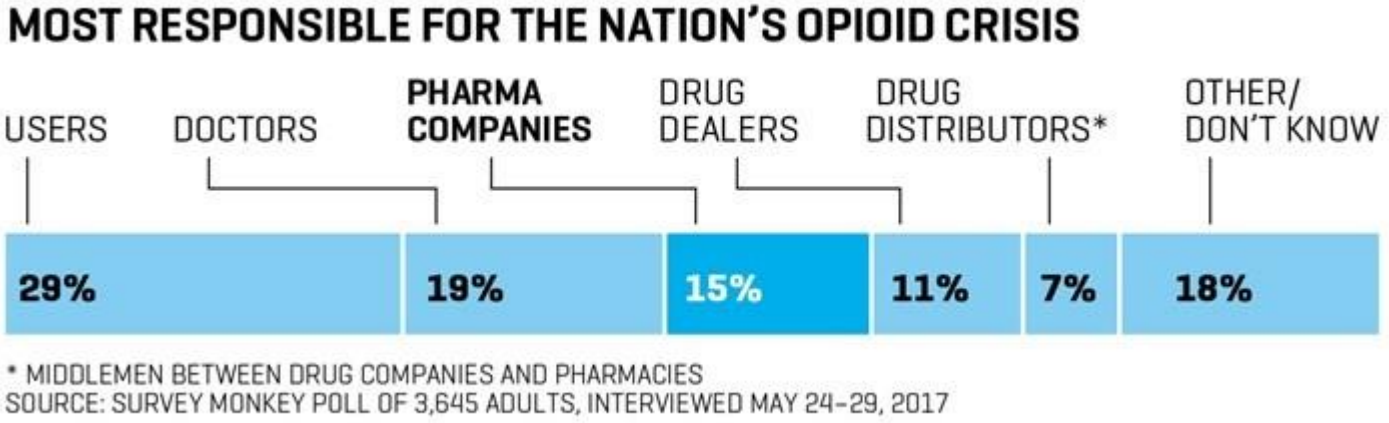
- **Treat Chronic Pain**
  - Comprehensive Assessment
  - Individualized Goals of Care
  - Judicious use of opiates for some people
- **Read and Don't be afraid of College Guidelines and Canadian Guidelines**
- http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf
- **Follow up regularly**
- **Document, Document, Document**
- **Think Prevention**

How Do We Reconcile These 2 Pictures?

Zeitgeist


War on Opioids
A Nation Mobilizes


The Opioid Crisis:
Epidemic By Design


MOST RESPONSIBLE FOR THE NATION'S OPIOID CRISIS
USERS
DOCTORS
PHARMA COMPANIES
DRUG DEALERS
DRUG DISTRIBUTORS*
OTHER/ DON'T KNOW
29%
19%
15%
11%
7%
18%
* MIDDLEMEN BETWEEN DRUG COMPANIES AND PHARMACIES
SOURCE: SURVEY MONKEY POLL OF 3,645 ADULTS, INTERVIEWED MAY 24-29, 2017

The Arguments: Opiate Crisis

- Opiate Related Deaths- Public Health Crisis
- Doctors are the only way to legally get Opiates
- Cavalier Prescribing Leads to:
  - Accidental Overdose
  - Diversion
  - Addiction
- Addiction leads to chronic misery and death
- Opiates and other Medical Rx for Chronic pain are not even effective

Recent Studies

- Risk of Addiction
- Efficacy for Chronic Non Cancer Pain (CNCP)

Risk for Addiction

Post Op Narcotic Use - *BMJ* 2018;360:j5790

- **Sample** 1 million Post –Op Opiate Naïve Patients
- **Outcome:** 1. Dependence 2. Misuse 3. Overdose
- **Risk** – 0.6%/Person Year
- **Related to Duration of Rx (*Not Dosage*)**
  - Adjusted Hazard Ration (AHR)- 20% /additional week
  - 3x risk if one refill compared to no refills
- **Conclusions**
  - Risk of Addiction is small but real
  - Can be mitigated by reducing the duration of use<5 days

Efficacy Opiates

- **Acute upper extremity pain in ER**
  - *JAMA*. 2017;318(17):1661-1667. doi:10.1001/jama.2017.16190
  - 5mg oxycodone/30mg codeine + acetamin = acetaminophen /NSAID
- **Chronic Back Pain** *JAMA*. 2018;319(9):872-882. doi:10.1001/jama.2018.0899
  - VA- n= 240 – Pain intensity of 5/10 affect function
  - RCT- opiate (stepped to 100mg of Morphine) vs non opiate – SRNI, Pregabalin , tramadol”
  - OA Back, hip knee
  - Efficacy – NS; increased SE -> in opiate group

Other Studies
Chronic MS and Back Pain

- **Pregabalin** – no benefit RCT for radiculopathy
  - N Engl J Med 2017;376:1111-20.
  - No Benefit at 8 weeks
  - Increased SE
  - Same as Gabapentinoids PLOS Medicine | https://doi.org/10.1371/journal.pmed.1002369 August 15, 2017
- **Epidural Steroids** – ineffective
- **Vertebroplasty** for Vertebral #- Conflicting Results
- **Acetaminophen** – ineffective Chronic back and OA lower extremity
- **NSAIDs**= Little benefit and dangerous

What Do I Do Now

Case Presentation

New Patient

- 84 retired baker living with her disabled husband
- Immigrated from Germany after the war
- Problems- initial assessment
  - Spinal Stenosis and general OA. Chronic pain
  - CHF, severe MR, borderline EF and unstable rhythm – Mobitz1
  - CKD –GFR 20, Creat 190, K+ 5.3
  - Hgb-100 , ferritin 20
  - Severe insomnia
  - Severe Constipation
  - Depressed, suicidal – “my mother starved herself to death”

Treatment History

- Meds – Tearful talking about meds
  - On 100 fentanyl for 8 years
  - Geriatrician warned GP to get in line with guidelines and together tapered her fentanyl to 50mcg over 6 weeks
    - GP"my hands are tied" you can get a new doctor if not happy."
  - Pain unbearable, problems with all transfers, walking down stairs, can't concentrate on TV
  - Furious and despondent that they wouldn't treat pain
  - Given T#3 as consolidation -12 a day –ineffective
  - Given Pregabalin- increased confusion and fall –ineffective
  - Duloxetine and amitriptyline - felt worse
  - Injections of epidural steroids ineffective as well as Acupuncture
  - Taking OTC
    - 8 ASA 375/Caffeine/codeine/day –only thing that give a shread of relief
  - Begging me to go back to 100 of fentanyl-
    - I would rather be dead than live with this pain
- Pain Clinic –"Injections almost killed me"
- PT- not helpful
- CBT/Minduflness – not going for counselling- Mobilty/costs

Functional Review

- Cognition– Intact – MOCA 26
- Mood - GDS- 4/5 – “Not depressed – just in pain”
- VAS -100mm
  - Back Pain 75
  - Fatigue -70
  - Dyspnea on exertion-80
- Frailty and Functional Markers
  - CFS-5
  - Gait Speed -0.73 ms (n>0.8-0.1)
  - Grip Strength -8kg (normal >20)
- Sleep Quality very bad-”used to be a great sleeper
- Severe painful constipation
- Supports – Daughter in-law, (retired nurse) checks in and bulk meals and heavy housework and supplies OTC ASA /Codeine. DIL stressed with care and worried about her pain

What would you do

- How would you handle her analgesia and problems and keep within the College Standards

Goals of Care

- **Symptom**s
  - Reduce Pain- VAS 75 – reduce to 50
  - Improve Sleep
  - Improve Constipation
- Function
  - Concentrate on TV
  - Transfer comfortably, Move in House
  - ADL/IADL – OK
- Reduce CG Burden
- Mortality/Health Directive – MOST 3
  - Want to live without pain- rather be dead than status quo
  - Hospital – if absolutely necessary
  - CPR- No

Changes

- **Titrated fentanyl to 100**
  - Aware of risk of death, OD, SE
  - No cognitive impairment
  - No balance problems or falls
- **Stopped: ASA/Caffeine /codeine- added Emtec 30**
  - -follow up renal function, hgb , Sleep- **Better**
  - PEG - constipation better
- **Trial of**
  - venlafaxine – Much worse
  - Tramadol/acet.- worse – cannot tolerate serotinergic agents
- **Repeat VAS**
  - VAS- 45/100
  - GDS – 1/5
  - Moca 26- no change
  - Gait Speed – 0.8 m/s

Summary
Do we meet College Standards?

#1 **Ethical Duty to treat Pain**

- The CMA *Code of Ethics* and the College standard *Access to Medical Care* prohibit discrimination based on medical condition and complexity. **Physicians must not exclude or dismiss patients from their practice based on their current use of, or request for, opioids or sedatives, or a suspicion of misuse of prescription medications.**
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#2- **Physicians must base decisions to prescribe opioids and sedatives on a *thorough understanding* of their patient.** This includes:

  - a. Conducting a well-documented, comprehensive assessment including patient history, physical examination, and relevant investigation results.
  - b. Conducting a comprehensive re-assessment at least every three months.
  - c. Basing decisions to continue long-term treatment with opioids and sedatives on objective evidence. Continuing to prescribe only because these medications were previously prescribed is not acceptable.

#3 "Informed Consent" and discussions of GOC

- When initiating treatment with an opioid or sedative medication, patients must be fully informed of the risks and benefits of such treatment. This includes holding and documenting a discussion about the rationale for a treatment regimen, expectations and goals of patient and physician, alternative treatment strategies, and a plan for the eventual possible discontinuation of the medication.

Did We meet the College Standards

#4 **Documentation**

- When considering continuing LTOT: a. Physicians must **document their discussion** with patients that non-pharmacologic therapy and non-opioid analgesics are preferred for chronic non-cancer pain (CNCP), and that the potential benefit of LTOT is modest and the risk significant.
- b. Physicians must **advise patients** that evidence points to risks outweighing benefits in providing LTOT for certain medical conditions including headache disorders, fibromyalgia, axial low back pain, and functional somatic syndromes.

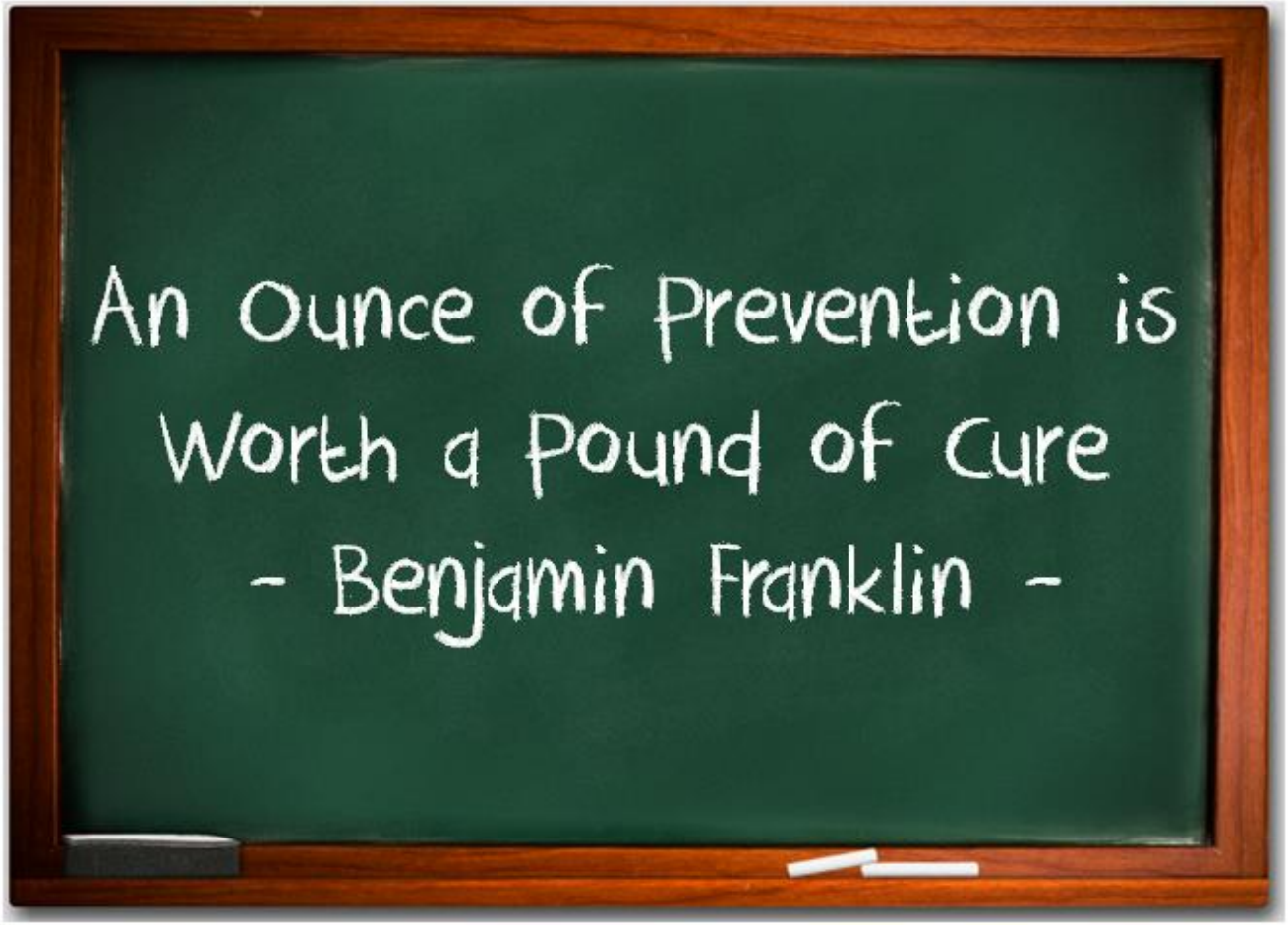
#7 **Opiate Dose <90Morphine equivalents**

- For patients on LTOT, physicians must always prescribe the lowest ***effective*** dose of opioid medication
- Physicians must be confident, and document, that there is **substantive evidence of exceptional need and benefit** for doses >90 morphine equivalent daily dose (MEDD) of prescribed opioids.
- b. For all patients on LTOT, but particularly those on >90 MEDD, the merits of tapering to the lowest effective dose must be emphasized. The decision to taper must be made collaboratively. Such tapers must be slow to minimize patient discomfort. Patients attempting a taper need supportive counselling and frequent follow-up. **The College recognizes that these attempts may not always be successful.**
- c. Even if an attempt at tapering fails, patients must regularly be offered the option of tapering their medications.

College Guidelines

- #4-7, 8-11- Risk Mitigation

Case
Part 2


An Ounce of Prevention is
Worth a Pound of Cure
- Benjamin Franklin -

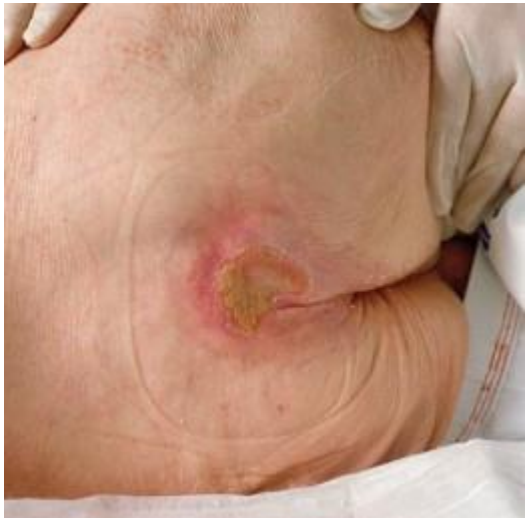
Part 2a

- **Pain is getting worse**
  - Wrists and hands numb and painful
  - “My bum is killing me”

Risk of Carpal Tunnel Syndrome with walkers

- Walker Height- neutral ht. Ulnar styloid
- Pad Handles
- Splints

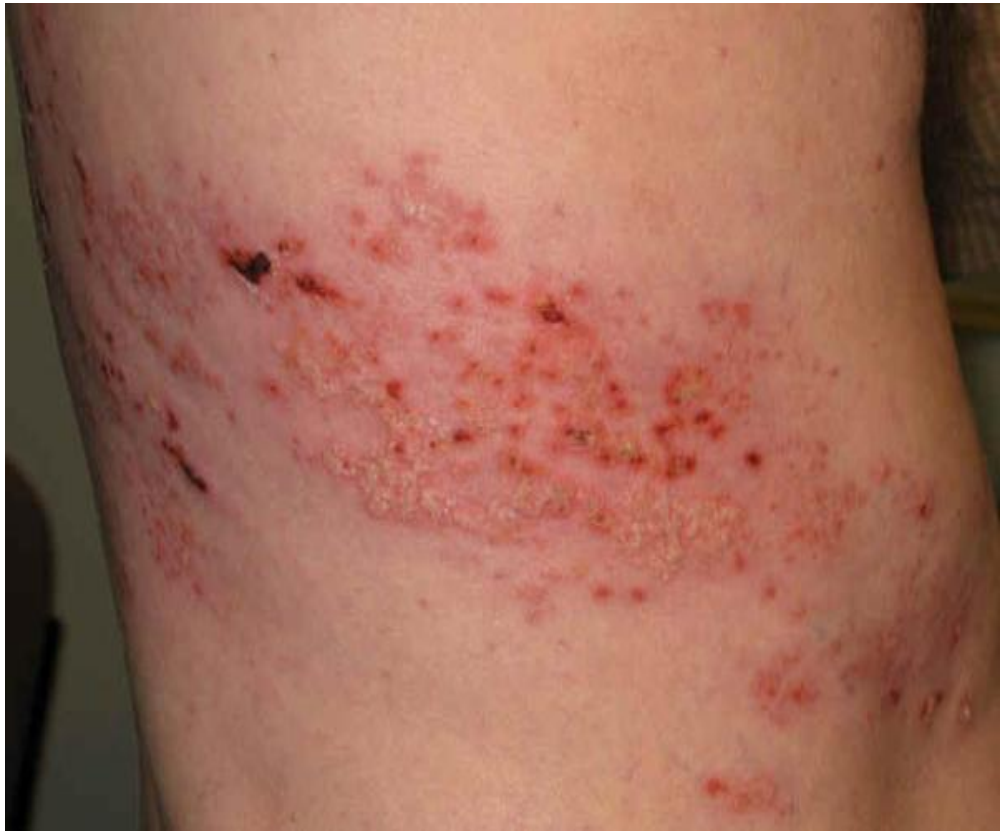
Decubitus Ulcers



Decubitus Prevention

Prevention
Part 2b

- Call Dec 2017
  - Severe pain stabbing pain back and flank



Rx of Post Herpetic Neuralgia in Elderly

- Compounded Spray
  - 2-5% Ketamine
  - 2-5% Lidocaine

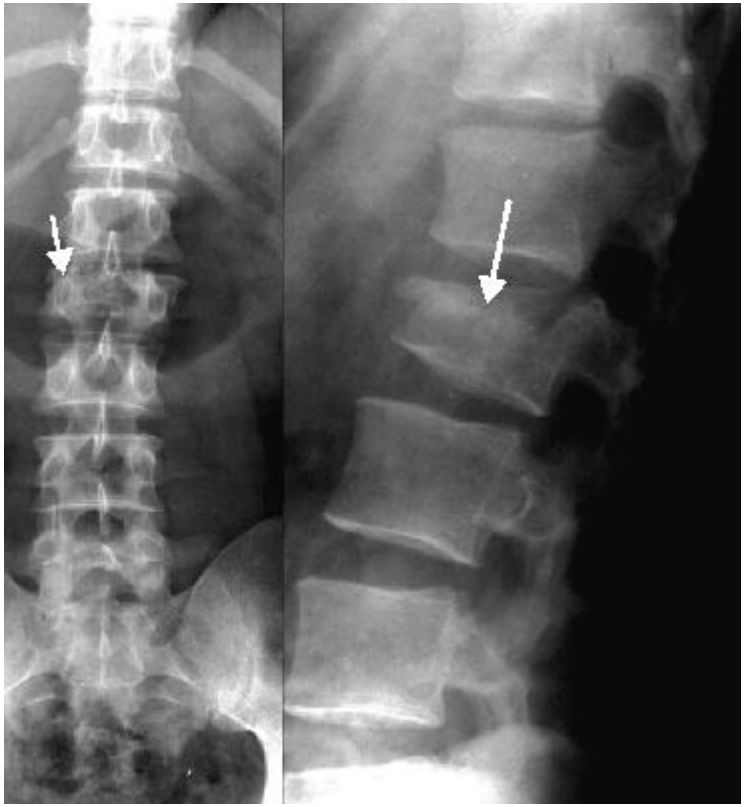
Adjuvant Zoster Vaccine

CDC+P recommendations
https://www.cdc.gov/shingles/vaccination.html

- Risk of Shingles -30%
- Increases with age
- Adjuvant Vaccine
  - Efficacy - 97% >70
    - 90% –age>80
  - Safe- Sore arm/Malaise
  - $ 150/dose x2
  - Duration – 4+ years
  - Use even if live virus vaccine or previous shingles

Prevention
Part 3

- Now my back is really killing me!



Prevention of Osteoporotic #'s

- Anti Resorptive agents – 40-50% effective
  - Bisphosphonates
  - Denosumab
- Anabolic agents PTH- very expensive
- Vitamin D – people who are shut in and don't see much daylight and deficient diet
- Ca++ - very little benefit.
  - Increase constipation
  - Increased Coronary calcifications?

Other Useful Treatments

- CBT- Group Therapy for elderly- Effective Meta Analysis
  - *JAMA Intern Med*. doi:10.1001/jamainternmed.2018.0756
- Mindfulness- RCT effective acute pain
  - J Gen Intern Med
  - DOI: 10.1007/s11606-017-4116-9
- Acupuncture- meta-analyses effective
- TENS
- PT/OT

Conclusions

- **Treat Chronic Pain**
  - Comprehensive assessment
  - Establish GOC
  - Start with Non-opiates when possible
  - Include Team/PT etc
- **Trial of Opiates**
  - Informed Consent
  - Documentation
  - Adequate Follow up
- **Think about Prevention** when dealing with Frail elderly people
- **Share the Care**- improves the efficacy and outcomes