PRO 2026

ACUTE and CHRONIC PAIN:

Management issues for patients with SUD Relapse and Recovery

Ted Parran MD FACP FASAM
Isabel & Carter Wang Professor and Chair in Medical Education
Medical Director, Program in CME
CWRU School of Medicine
Medical Director, Glenbeigh Recovery Centers
Medical Director, Rosary Hall
tvp@case.edu

Disclosures and Learning Objectives

- Disclosures: none

- Learning Objectives: After this activity, participants will be able to:

1) Compare and contrast acute / malignant / chronic pain
2) Describe the differences between pts with “high risk” & “low risk” brains
3) Outline the implications of these different brains re: risks from opioids
4) Develop a structured approach to clinical reasoning & thus prescribing decisions regarding opioids and other medications in pain management

Pain by any other name … (is not the same pain)

- Acute Pain:
  - Etiology / Severity / Anticipated time course
- Malignant Pain:
  - Etiology / Severity / Anticipated time course
  - Malignant pain transitioning into chronic pain
- Chronic Pain:
  - Severity
  - Acute exacerbations on Chronic Pain (NOT "breakthrough" pain)

Why worry so much about the pain *type*?

Because they are different clinical syndromes, with different treatment goals and very different potential roles for opioids*

- Acute Pain:
  - Relieve pain, relieve pain, relieve pain; avoid side effects or adverse events; while waiting for the patient to heal
- Malignant Pain / palliative care:
  - Relieve pain, relieve pain, relieve pain; avoid side effects or adverse events; while waiting for the patient to pass away … or get better & become a chronic pain dx
- Chronic Pain:
  - Help patient manage their pain issues, maintain or improve function &/or QOL.

***Efficacy of opioids = reasonable in acute and malignant pain, questionable in chronic pain.**

Assessing Pain Complaints: the 5 basic questions

1. What is the major ***class*** of pain?
   - **Acute** self-limited pain / **Chronic** non-malignant pain / **Malignant** pain
2. What is the ***severity*** of the pain?
   - Mild / Moderate / Severe
3. What is the ***cause / etiology*** of the pain?
   - Nociceptive (musculoskeletal) / neuropathic / central / psychogenic
4. Are there ***pain generators*** present (especially in Chronic Pain)?
5. What are the appropriate treatments (based on 1-4 above)?
   - Efficacy of opioids highest in *acute* and *malignant*, ***much less in chronic***
   - Non-opioid meds / physical / psychological / complimentary
   - How do you decide?????? *(principals of clinical reasoning)*

The 4 Pain Generators (esp. in chronic pain)

- "Pain Generators" are clinical syndromes unrelated to the pain that act to intensify pain symptoms
- Classically there are 4 clinical entities that can magnify pain:
  1. Anxiety
  2. Depression
  3. Insomnia
  4. SUD Moderate-Severe
- ***MUST*** screen for, identify if present, assess and address pain generators to help with pain management (especially chronic pain)

Opioid Responsiveness & Opioid Resistance

- Concept of limits:
  - Effective opioid dose (>200MED Ballantyne, >/= 120MED Chou, 80 MED Ohio)
- "Opioid responsive" chronic pain responds rapidly & chronically to low doses
- There is variable tolerance to different opioid effects:
  - Rapid tolerance to euphoria / sedation / decreased vital signs (i.e. side effects)
  - ***Slow partial tolerance to analgesia (i.e. efficacy)***
  - Little if any tolerance to constipation / miosis
- Patients with SUD mod-severe can interpret loss of "high" as loss of efficacy
- Those without SUD interpret loss of "high" as a relief
- Those patients who require escalation to higher doses are higher risk

7

Conclusions as to "opioid efficacy in Chronic Pain":
Largely unproven … but widely accepted

- Opioids are a useful treatment for some patients with CNMP.
  - They are *never* sufficient
  - They almost never provide total lasting relief
  - They ultimately fail for many
  - They pose hazards to some patients and society
- It is not possible to accurately predict who ***will*** benefit from a trial of low dose opioid analgesics in chronic pain …
- *It easy to predict who is at high risk of* ***very real harm!***

Let's step back and review controlled drugs (including opioid analgesics of course)

Controlled drugs v. Non-controlled drugs

- Non-dangerous drugs: OTCs
- Dangerous drugs: RX drugs
- Controlled drugs (CRX):
  - RX REQUIRING A DEA# (CII, CIII, CIV, CV)
  - Non-RX (CI)
- *"What makes CRX a CRX?"* (DEA# of course)
- *"Why do they need a DEA#?"* (a CRX of course)
- And that's all folks!

- ACTUALLY … *it is the acute surge of dopamine from the VTA – NA – PFC*!!!!

Controlled drugs: DEA schedules

- All controlled drugs (scheduled drugs by the DEA) are BRDs / EPDs
  - CI: no legitimate medical purpose
  - CII: RX and considered to have the highest abuse or addiction potential, no refills
  - CIII: RX and lower abuse or addiction
  - CIV: RX and even lower abuse and addiction
  - CV: RX and lowest abuse and addiction
- CII-CV clinically is not very important … the alcohol example
- "What is a low abuse potential benzodiazepine / opioid / stimulant?"
  - (**HINT … NONE,** and that is actually the wrong question)
- "What is the relative abuse potential in the BRAIN that I am RXing to?"
  - (**THIS** is the right question! … more to come later)

Brain Reward Drugs (BRDs) or Euphoria Producing Drugs (EPDs)

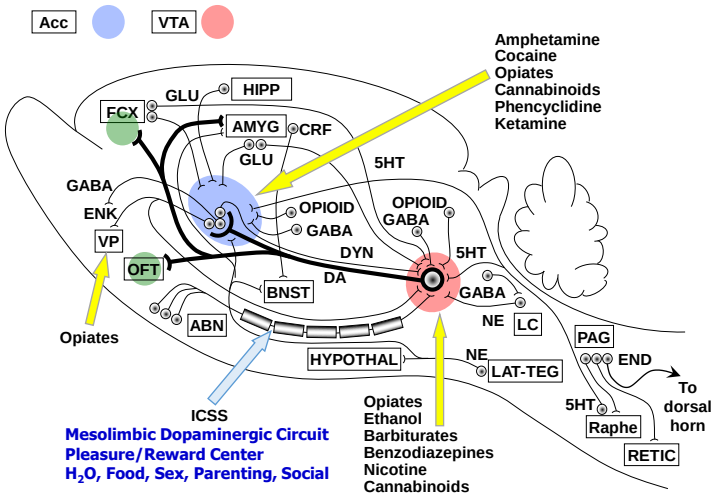
- BRDs or EPDs include "the FIVE families":
  - **Opioids**
  - **Stimulants**
  - **Sedative-hypnotics**
  - **Cannabinoids**
  - **Psychedelics / Hallucinogens**
- Very different substances
- Totally different primary brain effects
- ALL produce an acute surge of dopamine from the mid brain to the fore-brain
- ***Dopamine surges trigger addictive behavior***
- ***Dopamine surges mediate addictive disease***
- **High Risk Medications** (***sorry***, but they just are!)

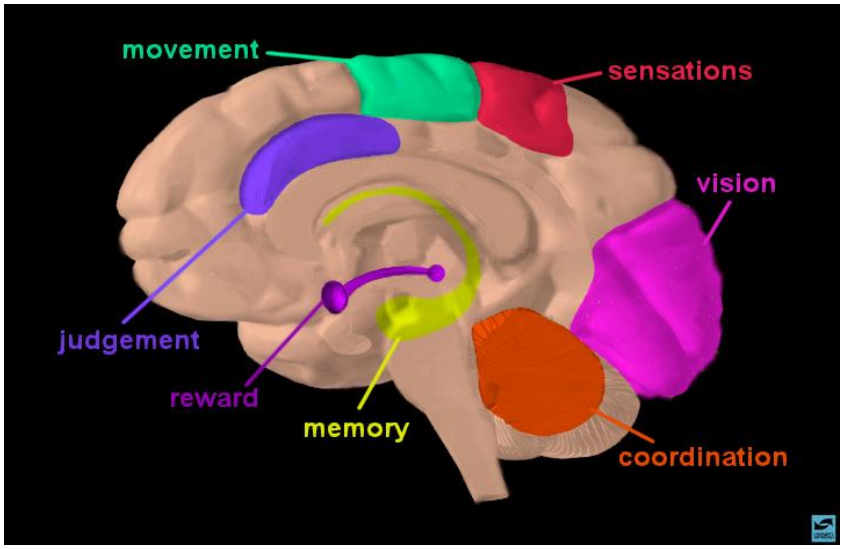
The FIVE families: primary brain effects

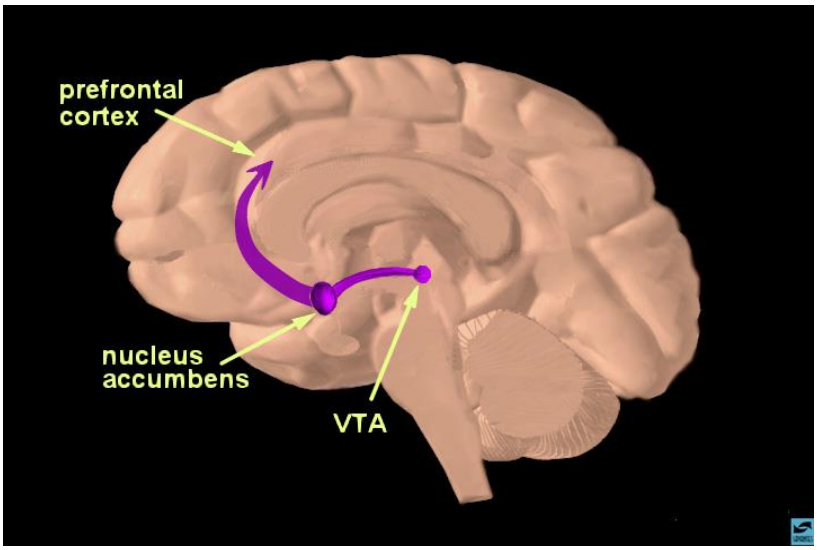
- Alcohol and Sedative-hypnotics
- Nicotine
- Cocaine and stimulants
- Opioids
- Marijuana and the endocannabinoids
- PCP and ketamine
- Classic hallucinogens
- ***ALL OF THEM***

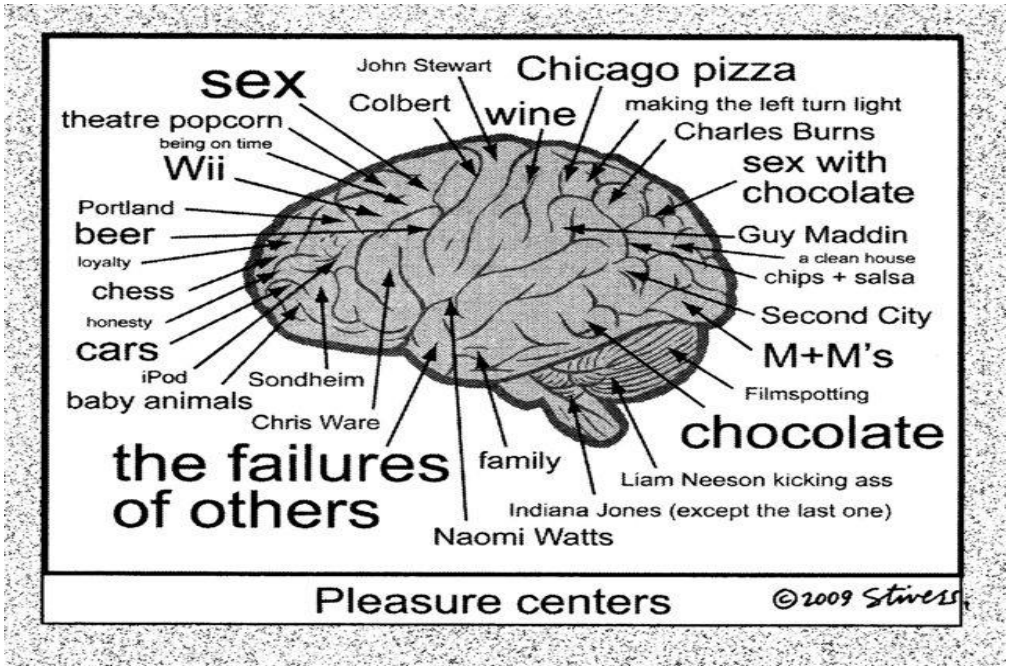
- GABA-A receptors
- Nicotinic & Acetylcholine receptors
- Dopamine receptors
- Endorphin opioid receptors
- CB1 and CB2 receptors
- NMDA-type glutamate receptors
- 5HT-2 serotonin receptors
- ***ACUTE DOPAMINE SURGE***

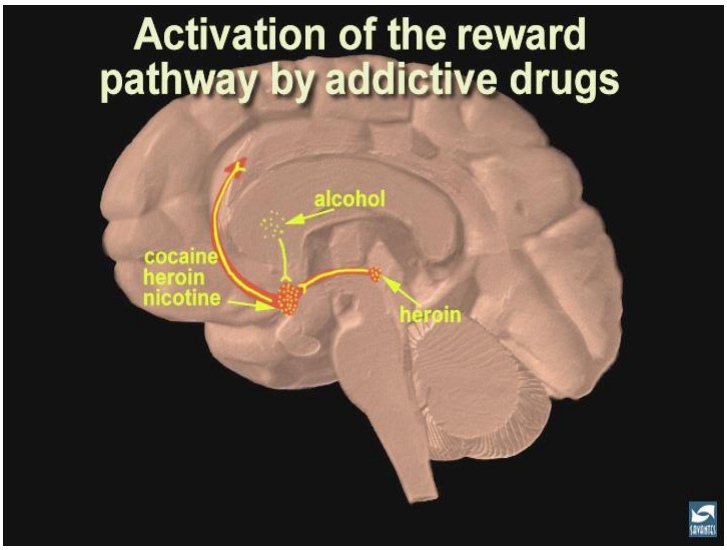
From Eliot Gardner




movement
sensations
vision
judgement
reward
memory
coordination


prefrontal cortex
nucleus accumbens
VTA


sex
John Stewart
Chicago pizza
Colbert
wine
making the left turn light
theatre popcorn
Charles Burns
being on time
Wii
sex with chocolate
Portland
beer
Guy Maddin
loyalty
a clean house
chess
chips + salsa
honesty
Second City
cars
M+M's
iPod
Sondheim
Filmspotting
baby animals
Chris Ware
chocolate
the failures of others
family
Liam Neeson kicking ass
Indiana Jones (except the last one)
Naomi Watts
Pleasure centers
©2009 Stivers


Activation of the reward pathway by addictive drugs
alcohol
cocaine
heroin
nicotine
heroin

Prescription Drug Abuse

The Drugs

Shopping List—Opioids		
Methadone	30 mg	$50
Hydromorphone	4 mg	$45
Morphine	30 mg	$15
Oxycodone	5 mg	$5-7
Hydrocodone	5 mg	$4-5
Tramadol	50 mg	$1-2
Buprenorphine	8 mg	$4 - 20+

Prescription Drug Abuse

The Drugs

Shopping List: Sedative Hypnotics		
Alprazolam	1 mg	$5
Diazepam	10 mg	$4
Lorazepam	2 mg	$3
Oxazepam	30 mg	50¢
Clonazepam	0.5mg	$4

The relative risk of the brain that is being prescribed to …

Brains by any other name … (are not the same brain)

- Regarding the risk to the patient when exposued to controlled drugs … there are 3 types of brains:
  - **LOW RISK BRAINS** (80% of the population, characterized by a history of low-risk use of brain reward drugs or "dopamine surge agonists").
  - **MIDDLE RISK BRAINS** (~10% of the population, SUD-MILD or "Substance abuse", and "Chemical Coping")
  - **HIGH RISK BRAINS** (~10% of the population, current or past SUD MOD-SEVERE)

Substance abusing / addictive brains = Higher Risk Brains (I am sorry, but they just are!!!)

- **Substance use disorder mild** (Substance Abuse) = planned binge – type use patterns
  - **Higher risk**
  - Phase or time of life - late adolescence / young adulthood
  - Behavior not a disease
- **Substance use disorder moderate or severe**:

"intermittent, inconsistent, unpredictable, repeated loss of control over the use of a euphoria producing drug ("high risk" drug / controlled prescription drug) resulting in repeated adverse consequences and craving for the substance when abstinent"

  - **Highest risk**
  - Brain disease, 50-60% genetic, 30% environment, 10-14% life-time prevalence
  - Higher in some groups (**level 1 trauma / psychiatric / chronic pain** populations)

Substance Use Disorder Moderate to Severe: predictable natural history

- A cascade of increasing dysfunction and disability in the following domains:
  1. ***Self image***
  2. ***Interpersonal***
  3. ***Social***
  4. ***Financial***
  5. ***Legal***
  6. ***Work***
  7. ***Physical***

SUD: from natural history to morbidity and mortality: the unspeakable toll

- Tobacco dependence – contributes to 20% USA annual mortality
- Tobacco dependence kills 1/3 and maims 1/3 of users
- Other addictions-
  - ***DEATH***: 700% increased annual mortality risk
  - ***FAMILIES***: 50% divorce, 70% domestic violence, 75% child abuse/neglect
  - ***SELF HARM***: 40-50% of successful suicides, 40-80% of level I trauma
  - ***FINANCIAL***: productivity
  - Not to mention all of the other medical complications / organ damage

EPDs / BRDs / CRX … … … and High-risk brains

- So … what does this mean for clinical prescribing practice?
  - **High Risk Brains + High Risk Drugs = *High Risk of Dangerous, Addictive, Out of Control Behaviors***
  - **SUD pt + *chronic* CRX = high risk of problem patient behaviors and patient / family / community / RXer & maybe Pharmacist *harm*.**
  - *"It is not surprising when a person with current or past SUD begins to develop aberrant behavior around their use of a controlled prescription drug … it is likely and even predictable. As part of their SUD, they have already demonstrated the inability to self-control their use of EPDs, so exposing them to additional EPDs via CRX is likely to be high risk for their health and safety … and maybe even life or liberty!"*

So … isn't this just *obvious*?
(and why spend a lovely morning going over it?)

"Like … don't prescribe long term outpatient addictive and abuse-able medications to patients who are abusers or addicted"

- Perhaps it is obvious … but haven't you seen it done?
- Several data points: ***over 60 years***!!!!

  1960s / 1992 / 1998 / 2007 / 2016 / today

1970 Controlled Substance Act (CSA)

- 1960s and early 1970s prescribing patterns
  - Prescribing of Dilaudid from primary care offices to "wean" patients with OUD … led to a surge in the abuse of RX opioids
  - Release of Talwin as *"low abuse potential"* kappa opioid led to IV Talwin and Benzedrine ("Ts & Bs") as a substitute for "Speedballs" (heroin & cocaine)
  - Massive national epidemic of RX amphetamine abuse and addiction (CII for amphetamines)
  - Cash weight loss clinics and RX amphetamines
  - Large volume barbiturate prescribing (Miltown, Placidyl, Seconal) and large numbers of fatal overdoses
- Triggered the passage of the CSA & CII Opioids and Amphetamines

Speaking of the 1960s: *a brief diversion into history*

- Cash for CRX visits, cash for CRX, cash for CRX (did I mention **CASH & CRX?**)
  - **SORDID HX:** **cash for TX covered by insurance plus CRX often attracting SUD pts**
    - 1970s-1980s CASH Weight-loss clinics and amphetamines
    - Late 1990s-2000s CASH Pain Management Clinics and huge MMEs of opioids
    - 2000s-2010s CASH Buprenorphine Clinics (and typically higher bup doses)
    - 2010s-2020s CASH "Medical MJ recommender" Clinics …
    - Today CASH Ketamine & Psilocybin Clinics …
    - Today CASH for "Men's Health" Clinics ("low T")
  - Other characteristics at times: requiring procedures in order to RX CRX (injections / blocks / etc) / high volume: > 15-20 patient follow-ups per provider per half day & CRX / Solo practice with no staff, no med-mal insurance and high volume / out of scope practice / extra-ordinary procedures (cost / volume / frequency / etc)
- **AKA PROBLEM CRX PRESCRIBING, $$$ & TROUBLED PRACTICES**

Late 1980s: "IV RITALIN ABUSE: prototype for prescription drug abuse"

- Case series of adults (parents of children with purported ADD/ADHD)
- Age 24-36 years
- Shooting IV Ritalin on the weekends in typical cocaine-like binge crash pattern
- Up to 2000 mg IV/d & referred to it as "poor person's cocaine" D/T filling on Medicaid R/T a drug dealer
- Most patients were ID'ed in MICU on vents D/T hypoxia from pulmonary HTN D/T IV use of meds intended for oral use
- ALL had prior SUD and "got turned on to Ritlins"

(today peer reviewed editorials: *"psychostimulants have low abuse potential")*

1992 Inner City Medical Clinic

- "Physician Failure to Record Alcohol Use History When Prescribing Benzodiazepines."

Graham AV, Parran TV: Journal of Substance Abuse 1992. 4:179-185

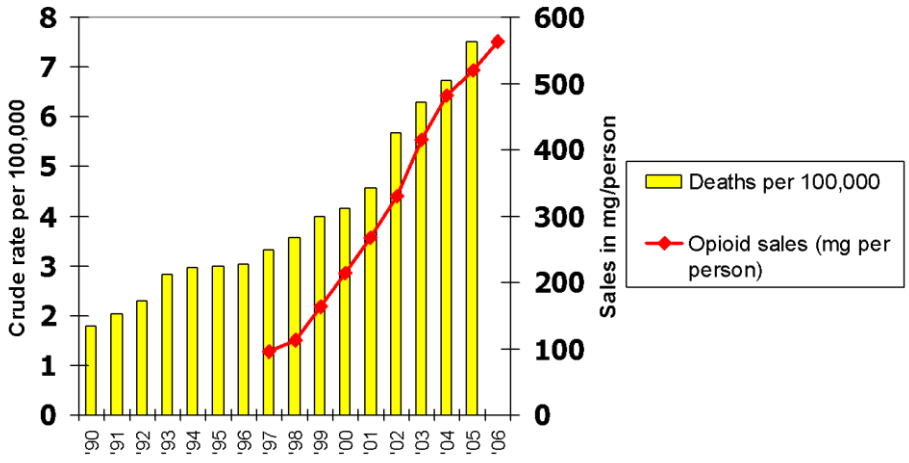
- Little evidence of SUD screening in medical records prior to initiating long term benzodiazepine prescription

1998 University Affiliated Large County Teaching Hospital

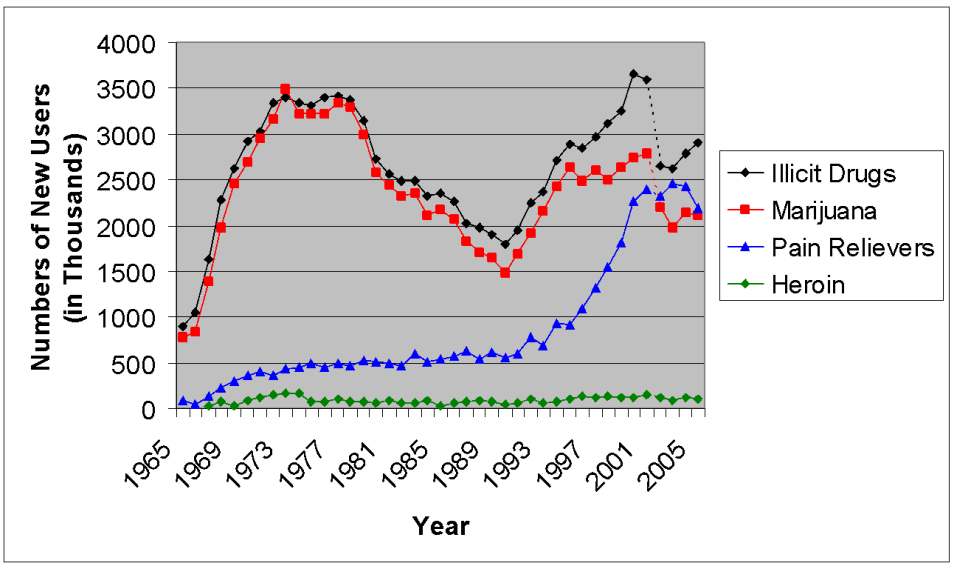
1. > 7000 Outpatients interviewed for SUD (alcohol problems)
2. Inpatient & Outpatient Medical Record Review for SUD DX documentation
3. Outpatient Medical Record Review for prescribing of CRX: ***patients with SUD DX were THE MOST LIKELY to get OPT CRX***
   - **Second strongest** predictor of receiving a CRX = having SUD documented in the medical record and having a Resident Physician as the doctor
   - ***Strongest predictor*** of receiving a CRX = having a SUD documented in the medical record and having an Attending Physician as the doctor
   - That is why this problem goes on and on and on and on over decades

Deaths / 100,000 from accidental RX opioid OD v. annual RX sales 1990 - 2006

Source: Paulozzi, CDC, Congressional testimony, 2007



NOT JUST ODs: New Drug User Patterns



January *2016 – Annals of Int Med*

- Large population-based study from MA
- *90% of patients **continued to receive** prescription opioids **after** an accidental overdose requiring treatment was recorded in the chart*
- >20% received a higher dose within 6 months following their OD
- Opioid discontinuation after overdose was associated with a lower risk for repeated OD

Annals of Internal Medicine • Vol. 164 No. 1 • 5 January 2016

March 2016 - JGIM

"Benzodiazepines are Prescribed More Frequently to Patients Already at Risk for Benzodiazepine-Related Adverse Events in Primary Care"

- Large population-based study
- Patients with SUD diagnosis / poor adherence / elderly / loss of cognitive function / OSA were more likely to get long term benzo RX than patients without these benzo related risk factors.

J Gen Intern Med. 2016;31(9):1027-1034 March 2016

TODAY: CRX prescribing trends 1989 ~ 2024

- 1985 - 2013 > 500% increase in opioid prescribing nationally
  - 5% of world population > 60% or world's opioid RX & > 80% of all H.C.
- 2013 – 2024 > 50% *decrease* in opioid prescribing from peak in 2012 nationally (still > 200% more than 1980s in mg/person)
- 2013-2022 > 30% *increase* in benzodiazepine prescribing … "remember the 1960s"
- 2013-2024 > 40% *increase* in psychostimulant prescribing … "remember the 1960s"
- So … CRX in the US is a teeter / totter of sorts!

HOW COULD THIS BE?
Perpetuation of status quo
(for over 60 years!!!!)

- **HRB's** REALLY REALLY REALLY **want** high risk drugs
  - Dr-Pt relationship / communication challenge
- Screening for HRB **poorly & rarely** done
  - Good Screens are incompletely / rarely used
- Un-appreciated contraindications (h/o or current SUD)
- Blurring of basic ethical tenants of doctoring
  - "Above all, first do no harm … **then** comfort always"
  - Not "comfort at all costs even if you hurt the patient in the process"

Perpetuating CRX Problems: “6 Ds”

- The AMA has described mechanisms by which prescribers become involved in RxDA: “the 4-D’s + 1 +1”
  1. Dated
  2. Duped
  3. Disabled
  4. Dishonest
  5. Defiant
  6. Distracted

Perpetuating CRX Problems: beyond the 6 Ds

- CWRU School of Medicine: 3 decades of teaching safer CRX prescribing
  - Medication mania
  - Confrontation phobia
  - Hypertrophied enabling

Safer CRX Solutions

HOW CAN WE CHANGE THE STATUS QUO? … … …

WITH APPROPRIATE CLINICAL REASONING
COMBINED WITH A STRONG KNOWLEDGE BASE OF AND RESPECT FOR THE NATURE OF ADDICTIVE DISEASE OF COURSE

CRx Prescribing Decisions:

How to Avoid Mixing High Risk Drugs with High-Risk Brains!!!

- Any and every prescribing decision involves:
  - Indications – establishing the reason to RX
  - Contraindications – screening for reasons not to RX
  - Clinical reasoning – comparing risks v. benefits
- Contraindication screening re CRX requires **K,A,S**.
  - ***Knowledge = clinically understanding contraindications***
  - ***Attitude = respecting the gravity of contraindications***
  - ***Skill = using screening tools to ID contraindications and communication skills to maintain your boundaries***
- **K,A,S** are ***ALL*** needed for safe CRx prescribing
- Most prescribers lack ***at least one*** of them

Chronic OPT Prescribing of CRX

- Who **TO** prescribe long term CRX to?
  - **Presence** of **Indications** – pt and disease specific
    AND
  - **Lack** of **Contraindications** - pretty uniform
- Who **NOT TO** prescribe long term CRX to?
  - Lack of **indications**
    OR
  - Presence of **contraindications** **(even if indications exist)**

Contraindications to chronic CRX TX: it's a short list

- Highest Risk Brains (HRB)***:
  - **Current SUD mod-severe = strong contraindication**
  - **Past SUD mod-severe = strong contraindication**
  - **History of diversion = strong contraindication**
- Risky Brains (SUD MILD) = relative contraindication
- Significant nonadherence = relative contraindication
- Substantial active psychiatric co-morbidity = relative contraindication
- COPD &/or Obst Sleep Apnea = relative contra to opioids or sed hyp

***** Prescribe chronic C RX to HRB's only with expert advice and support (i.e. a methadone or buprenorphine clinic)**

Indications for *possible* *chronic* CRX

Use Universal Precautions

ASK THE 5 QUESTIONS OF CWRU SOM

1. Is there a clear diagnosis (in your scope or area of expertise)?
2. Is there documentation of an adequate work-up?
3. Is there impairment of function or quality of life?
4. Have non-CRX multi modal therapy been tried & failed?
5. Are contraindications to CRX therapy ruled out?

- IF "yes to ALL 5" then ***consider*** CRX TX …
- **Always** use an Informed Consent Form!
- Be sure to **Document** & **Monitor**!
- Avoid poly-pharmacy *of controlled substances*

Prescribing Controlled Drugs: Screening for SUD(**Team** WORK)

- Perform an AUDIT (questionnaire) and CAGE-AID with pt
- Ask family or sig. other the f-CAGE (Informed Consent)
- Do an initial toxicology screen
- Inquire of prior prescriber re: use of controlled prescriptions, general adherence patterns, etc.
- Check the "retail pharmacy" print-out (CRX and non-CRX)
- Check the PMP report (CRX)

If screen is + for current or prior addiction = High Risk Brain … so the decision *should* be obvious!

The "Family / Significant Other Interview"

- Requires a **TEAM** and **Systems** approach:
  - Somebody gets consent to call (Informed Consent Form)
  - Somebody calls and asks the "6 Functional Assessment ?'s"
    1. What can __ do now?
    2. What could ___ do before this DX (pain/anxiety/insomnia/ADD)?
    3. What does the family hope ___ will be able to do if we can help?
    4. Has ___ **C**utback on use of alcohol or other drugs?
    5. Has ___ been **A**nnoyed by comments re: alc / drug use?
    6. Has ___ felt **G**uilty or embarrassed about actions/words when using?

Monitoring strategy when prescribing OPT CRx – Team Work = *"universal precautions"*

- Informed Consent Form – require adherence with TX Plan
- Document functional improvement / QOL – pt and family
- ROI for ANYONE you think is needed (What if they say NO?)
- Titrate RX to improved function
- Monitor medications (pharmacy profile printout, OARRS)
- Avoid non-planned escalation – "nonadherence"
- Monitor for scams (***NO early refills***)
- Perform occasional toxicology tests
- Document, document, document! (**Flow sheet**)

OK … lets get back to opioids and pain management decisions with and without SUD!!!!!

Basic Clinical Reasoning re: Opioids in Pain

- Short term prescribing: ACUTE
  - ACUTE PAIN IN A LOW-RISK PATIENT
  - ACUTE PAIN IN A HIGH-RISK PATIENT
- Long term prescribing: CHRONIC
  - The proverbial can of worms

ACUTE Pain Mgmt in a Low-Risk Patient

- Clear acute pain diagnosis? Y/N
- Dx in your are of expertise / scope of practice? Y/N
- Pain (type/intensity) warrants consideration of opioid tx? Y/N
- Non-opioid tx inappropriate or failed? Y/N
- Consider prescribing opioids
  - SMBO rules re: #, follow-up, etc
  - DOCUMENT

Acute pain IN HIGH-RISK PATIENT (SUD Moderate - Severe)

- Clear acute pain diagnosis? (YES)
- Pain (type/intensity) warrants opioid tx? (YES)
- Non-opioid tx inappropriate or failed? (YES)
- Then “Consider prescribing opioids”

Acute pain and SUD: **consider opioids** …

(what does consider opioids in SUD mean?)

- Assess SUD
  1. **Remission?**
  2. **Relapse?**
  3. **Opioids ever as drug of choice?**
- Consider consultation
  - Pain management specialist
  - Specialist in the involved organ system
  - Addiction medicine/psychiatry specialist (ASAM/AAAP)

Acute pain-active opioid SUD

(SUD consult or refer for SUD TX of course)

- Estimate tolerance - provide bid opioid-SR.
- ID “typical D&D” of analgesia needed (with consultation).
- Rx “typical D&D” PLUS tolerance dose.
- Remember, self report of analgesia may not be helpful re: pain sx & relief
- Assess level of analgesia via observation
- Avoid “opioid of prior abuse” & that class of opioids if possible (mu/kappa)
- (BEWARE of switching from mu to kappa *if current physical dependence*.
- Avoid poly-pharm of CRX, small RXs with refills, frequent tox screens.
- After stabilization, consider transition to sl-bup/NX

Acute pain - active non-opioid SUD

- Refer to SUD treatment (active SUD).
- ID “typical dose and duration” of analgesia (with consultation).
- Rx “typical dose and duration” of analgesia.
- Small supply / short duration of opioid Rx (with refills if needed), close monitoring / reassessment and toxicology tests.

Acute pain - h/o SUD with opioids … but now sober (aka OUD in remission)

- Probably *the highest of high-risk situations* … prescribing a mu agonist in these circumstances is in some ways analogous to giving alcohol to a person in recovery from Alcohol Use Disorder.
- Discuss indications with patient.
- ID and Rx “typical” dose and duration.
- Avoid pt’s prior drug or even class (mu/kappa/partial agonists)
- ID surrogate to dispense medications.
- Self report of efficacy not helpful.
- Limit supply, no CRX poly-pharm, frequent toxicology.

Acute pain - h/o SUD never involving opioids*

- Discuss indications with patient.
- ID and Rx “typical” dose and duration.
- Control access (surrogate dispenser).
- Avoid poly-pharmacy.
- Close monitoring with toxicology.

***probably quite low risk situation**

How About Opioids in Chronic Nonmalignant Pain?

No SUD

Yes SUD

REVIEW: Chronic OPT Prescribing of ANY CRX

- Who **TO** prescribe to?
  - **Presence** of **Indications** – patient and disease specific
    AND
  - **Lack** of **Contraindications**

- Who **NOT TO** prescribe to?
  - Lack of **indications**
    OR
  - Presence of **contraindications** **(even if + indications)**

REVIEW: Indications for *possible* ***chronic*** CRX
Use Universal Precautions: *ASK THE 5 QUESTIONS OF CWRU SOM*

1. **Is there a clear diagnosis … and is it in your expertise or scope of practice?**
2. **Is there documentation of an adequate work-up?**
3. **Is there impairment of function?**
4. **Has non-CRX multi modal therapy been tried & failed?**
5. **Are contraindications to CRX therapy ruled out?**

- IF ***"yes to ALL 5"*** then ***consider*** CRX TX … as a therapeutic ***trial***
- **Always** use an Informed Consent Form!
- Be sure to **Document** & **Monitor**!
- Avoid poly-pharmacy *of controlled substances*

Alternatives to Opioids in CNMP

- Remember the 1980s - CNMP is NOT an opioid deficiency disorder!
- The BIO-BEHAVIORAL APPROACH rather than the Biomedical one
  - Bio-psycho-social-spiritual-family TX
  - Chronic pain is mostly a “movement” problem
    - Reconditioning / “pain informed” PT-OT / stretching / massage
    - “Pain informed” psychology / counseling
  - Meds are less efficacious
    - NNT is best with TCAs >>> SNRIs or Gabapentinoids
    - NSAIDS / Aceta / topicals / anti-seizure
    - Opioids decrease help-seeking behavior and are pro-inflammatory

Using TCAs in CNMP

- Amitriptyline best data:
  - 10 mg QHS … increase Q2weeks to AEs and then decrease by 25-50 mg.
- No evidence for Trazodone, little for other TCAs

Tips for chronic opioid RX in CNMP (no SUD)

Question: Why did we prescribe opioids for CNMP in the early 2000s the way that we did?

Answer: Because that is what we were taught.

Question: Who taught us to prescribe longitudinal opioids in CMNP syndromes in the late 1990s?

Answer: Palliative care physicians

Tips for chronic opioids in CNMP (no SUD)

- ***NOT*** supported by strong (or even moderate) evidence
- **THUS**, in an increased risk patient … probably a bad idea!
- Factor in tolerance (already on opioids).
- Start low/go slow (not already on opioids).
- Slow release OR fast acting
- Fixed dosing OR prn's
- **Avoid *opioids*** for "breakthrough" pain.
- Avoid poly-pharmacy involving controlled drugs!!!

Tips for chronic opioids in CNMP (no SUD)

- Factor in tolerance – physical tolerance
- Low & Slow - use equi-analgesic tables
  - Morphine : Methadone = 4:1 – 6:1 - 8:1 – 12:1 depending on dose
  - Use T½ for fixed dose intervals – *hold the line*
  - T½ for pain may NOT be T½ resp. depression (aka methadone)
  - Titrate up only AFTER steady state (5 X T½) at a minimum, and *most safe after full respiratory depression physical tolerance (15 T½)*

Tips for chronic opioids in CNMP (no SUD)

- Tolerance – minimizing tolerance ***is*** a legitimate tx. goal
  - Malignant v. chronic pain model
  - Differential tolerance to pain relieving v. euphoria producing v. other effects
  - Change in tolerance to pain effects *may* be more related to peaks and troughs.
- Take home points:
  - Opioids maintain pain efficacy over time and thus the dose OFTEN is not needed to be increased unless there is a change in the underlying pathophysiology – therefore there should be a reassessment prior to a dose increases (the clinical "time-out")
  - Additional opioids PRN for BTP *DO clearly* drive tolerance cycle

Tips re: Chronic opioids in CNMP (no SUD)

- BTP is a totally legitimate concept in Acute and Malignant pain management
- BTP is *not* a useful concept in most CNMP
  - Why does the person always need the same # of BTP meds every month?
- It is a "Bad Day" not Break Through Pain (BTP) in CNMP
  - Malignant Pain v. Chronic Pain – NOT same
  - Chronic pain tx goal? To improve function or QOL … not necessarily pain score!
  - If *not* on daily opioids, then give opioids only on "Bad days" to maintain QOL
  - If *on* daily opioids consider adding in PRN aceta / nsaids / tramadol for Bad Days
  - Keep pain log re: # day/wk of Bad Days – *re-titrate* if too many Bad Days / month

Predictors of OD's and fatal ones

- Patients with **current/past SUD** = bingeing
- Not verifying prior dose (tolerance)
- Early in course of RXing (titration)
- Soon after a major change in treatment
- Soon after extended absence (loss of tolerance)
- Poly controlled drugs – benzo/barb/alcohol/gabapentinoids
- Inaccurate dose equivalence tables – methadone
- Mental health dual diagnosis
- Historical non-adherence

Problematic Prescribers + Problematic Patients = Community harm?

- Problematic prescribers rarely **consistently** follow the above principles.
- Their prescribing tends to **attract** patients with SUD / diverters to the practice.
- Their lack of requiring medical follow through often **keeps** patients who are out of control with SUD in their practice.
- This **can** result in "doing harm" to patients with SUD and in excessive "diversion" of drugs to the community.

Above All: First do no harm

Revisiting ***Absolute / Strong*** Contraindications to chronic opioid prescribing in CNMP:

AKA in Patients with SUD

"Let's Make a Deal"

Door #1: Non-opioid TX of CNMP in SUD-M/S

1. Aggressive detox with buprenorphine (comfort)
2. Address "pain generators": Addiction / Depression / Anxiety / Insomnia
3. Non-CRx analgesics: TCA / aceta / nsaid / muscle relaxants / topicals / anti-seizure medications / smoke and mirrors / "Reagan-omics" /
4. Pain Psychology: meditation / counseling / relaxation / addressing expectations.
5. Physical Tx: PT / stretching / re-conditioning
6. Addressing SUD = "sobriety" (a bio-psycho-social-spiritual- family rec. prog)

- THIS **REALLY REALLY REALLY** works!

Chr. Pain + Active opioid addiction: Door 2, 3 & 4

- **Door #2**: BUPRENORPHINE
  - Buprenorphine OBOT ***+ CD TX + CNMP TX (aka Door #1)***
  - Divide dose of buprenorphine into BID or TID dosing (1-4 mg SL TID)

- **Door #3**: METHADONE OTP
  - Methadone OMT + CD TX + CNMP TX (aka door #1)
  - Earn "take home doses" (THD)
  - Split the THD to BID or TID dosing

- **Door #4**: "LETS JUST PRETEND YOU DON'T HAVE SUD"
  - Don't EVER "pretend" with patient care
  - Difficult but necessary conversations!!!!!

SUMMARY: Opioids & Pain Mgmt: Addiction and Recovery

- Balancing ***indications*** and ***contraindications:***
  - Increase comfort with prescribing controlled and non-controlled drugs as part of multi-modal tx
  - Assess for SUD and avoid **all** controlled drugs … especially long-term
- FIRST do no harm, THEN comfort always and cure sometimes.
- Target opioid prescribing towards low-risk / away from high-risk patient populations.
- High-risk patients needing opioids = OMTP with methadone or buprenorphine!

Questions, comments, cases