Update on identifying and managing opioid-dependent pain patients

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Presentation Roadmap

A round up of the usual assumptions

Defining dependency

Different points of view

Opioids and saliency

Opioid Agonist Therapy

Is “How to identify & manage addiction?” the right question?

Emerging options to transform the moral arm-wrestle between analgesic provision & addiction

Some common assumptions

- Pain patients previously were only provided opioids if non-opioids were ineffective. Guidelines currently advise "only in exceptional circumstances".

Yet about 16% of Australian adults are dispensed opioids each year[1].
This is almost the prevalence of adult chronic pain (17% males & 20% females[2])

[1]Lalic 2019 Brit J Clin Pharm 85, 1, 202-15 [2] Blyth 2001 Pain, 89, 2, 127-34

- The key management imperative is the division into the opioid dependent and the opioid non-dependent. Some of the latter being at risk of opioid-related transgressions.
- The opioid analgesic dependent patient cannot have usual care; they need specialist addiction care.

What is this crazy little thing called dependency?

A definition of dependency may rely on:

- The International Classification of Diseases, either 10th or 11th Revision;
- The Diagnostic and Statistical Manual of Mental Disorders either version 4 or 5. If Version 5, is tolerance in or out? (the same goes for withdrawal)
- Any one of the varying state or territory health department definitions
- New conceptualisations eg “complex persistent opioid dependence”[1]

Well, how does the law decide? Let’s look defining pornography.
In 1964, US Supreme Court Justice Potter Stewart described how he determined whether a movie was hard-core pornography. “I know it when I see it, & the motion picture involved in this case is not that.”
Similarly, as clinicians we naturally rely on intuition. This could also be construed as a cultural ritual to exclude the Non-Genuine Other.

Excellent opioid management should not be set aside until a diagnostic threshold is crossed. It requires guidance based on the amount and pattern of use, adverse social effects, cravings or loss of control[2].

[1]Ballantyne 2017, Anesth Analg, 125, 5

[2] Room 2011 Addiction,106,5, 879-82

The patient or societal point of view

Addicts are bad and possibly dangerous.

In a WHO study of social disapproval regarding 18 conditions across 14 countries, ‘drug addiction’ ranked the worst. Addicts, the surveyed continued, should be given little priority in health care[1].

[1] Room 2011 Addiction 106, 5, 879-82

The regulator's point of view

<u>Plan One:</u>

Blame the doctors

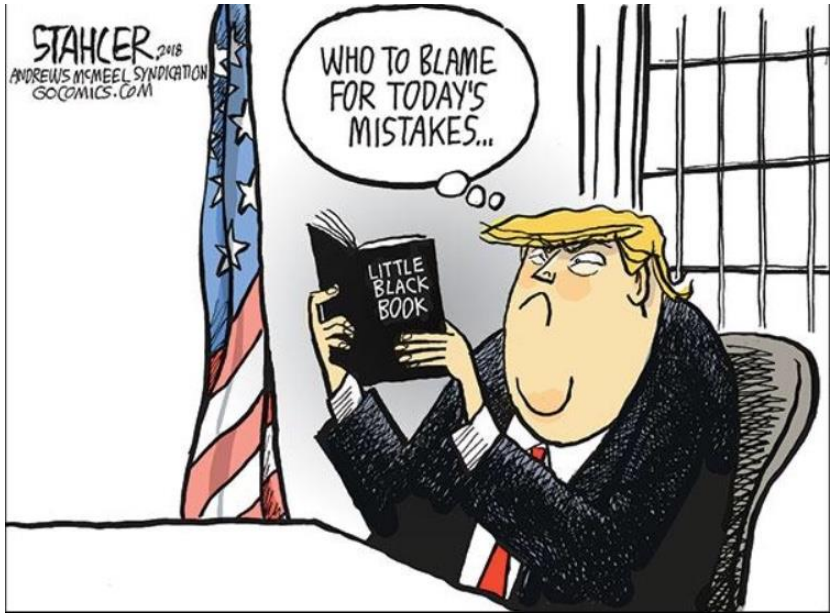
The 4 D's: Dated, Disabled, Dishonest or Duped.

Doctors need a whiff of sanction*

In 2018, the highest 20% opioid prescribers (~5,000 GPs) received de-registration threats.

<u>Plan Two:</u>

Blame the patients**



*or more education

** far easier than making better care more accessible

THE HON TANYA PLIBERSEK MP

Minister for Health

MEDIA RELEASE

12 February 2012

New System to Crackdown on Prescription Painkiller Abuse

The Gillard Government will set up a new $5 million national electronic records system to combat abuse of controlled drugs including prescription painkillers, said Minister for Health Tanya Plibersek.

The Electronic Recording and Reporting of Controlled Drugs system will be made available to doctors, pharmacists and state and territory health authorities across Australia to monitor the prescribing and dispensing of addictive drugs in real time.

Big Pharma's point of view

Big Pharma know that clinicians' concern about addiction is a major barrier to the liberal prescription of opioids in chronic pain[1]. This led to long acting or "tamper-proof" formulations.

To re-direct our clinical culture, Big Pharma underwrote pain advocacy organisations, medical societies, medical education and guideline development.

Two of these guidelines were recently discontinued by the WHO due to the advisors' conflicts of interest [2].

In 2019, Mundipharma was fined $302,400 by our TGA for "misleading, imbalanced, and otherwise inaccurate" advertising of Targin ®.

[1] Potter 2001 J Fam Pract 50, 2, 145-151 [2] Dyer 2019, BMJ, 365, 8205, 4374.

The clinicians' point of view: barriers to identification and management

How often do we provide full informed consent on initiating opioids:

- they may be impossible to stop,
- they may increase pain,
- they may cause depression or death.

We don't want to look for dependency, because we might find The Other. We know if we ever found it, we couldn't manage it within our usual parameters of care.

We hate arguments about analgesia.

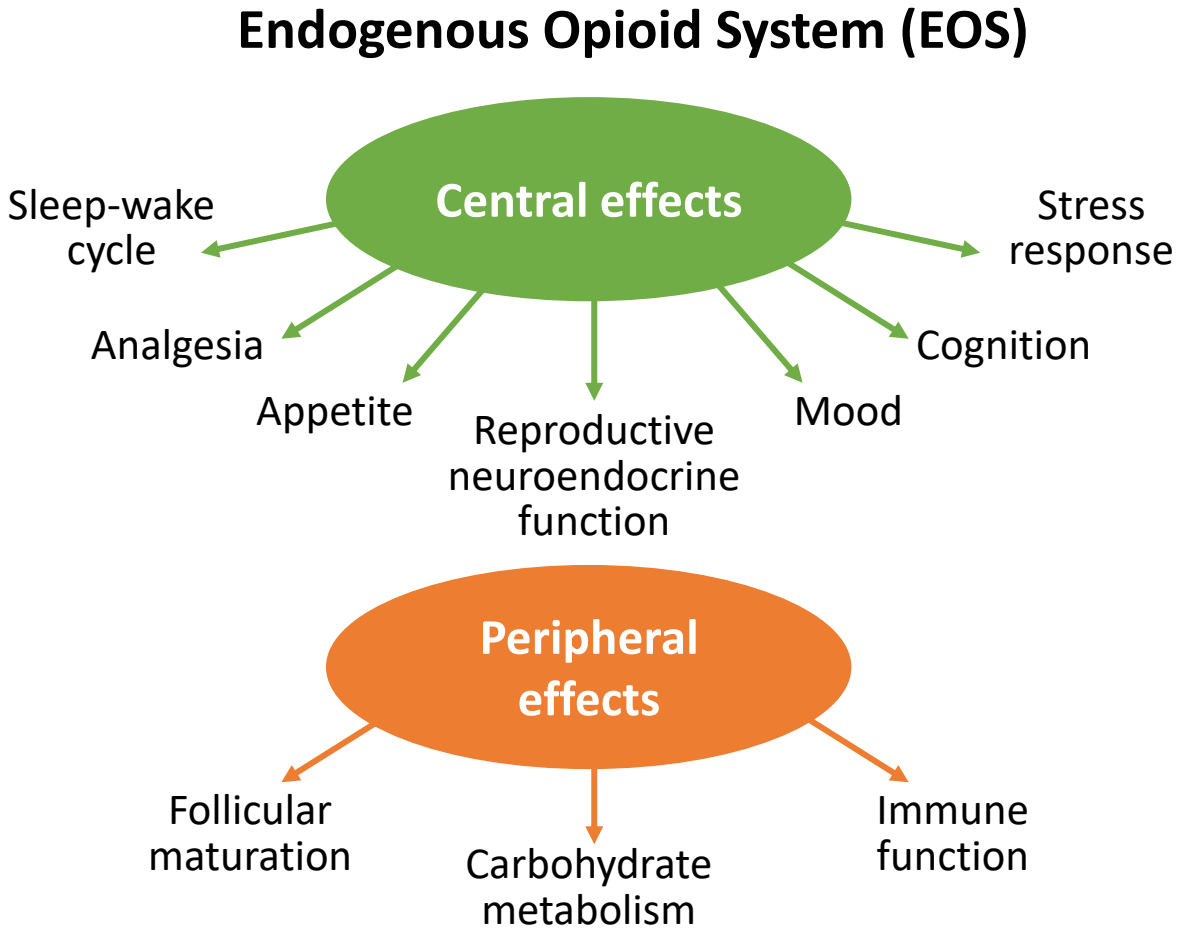
It is cost-effective to rely on previous management decisions (clinical inertia).

Completing our folie à deux, patients are unlikely to disclose concerns if they fear stigmatisation, abandonment with loss of their desperately needed pain-killers.

Brain and opioid science

As pain becomes chronic, functional MRI shows brain activity shift to non-sensory areas such as the limbic system (motivations, emotional responsiveness, learning and memory).

Endogenous opioids modulate many similar functions: mood, stress responses and social bonding. The EOS unconsciously promotes pro-social behaviours buttressed by increased resilience to pain[1].



Carr 2017 Pain Medicine 18,2, 201-203

Adapted from Eyvazzadeh et al. Fertil Steril 2009; 92

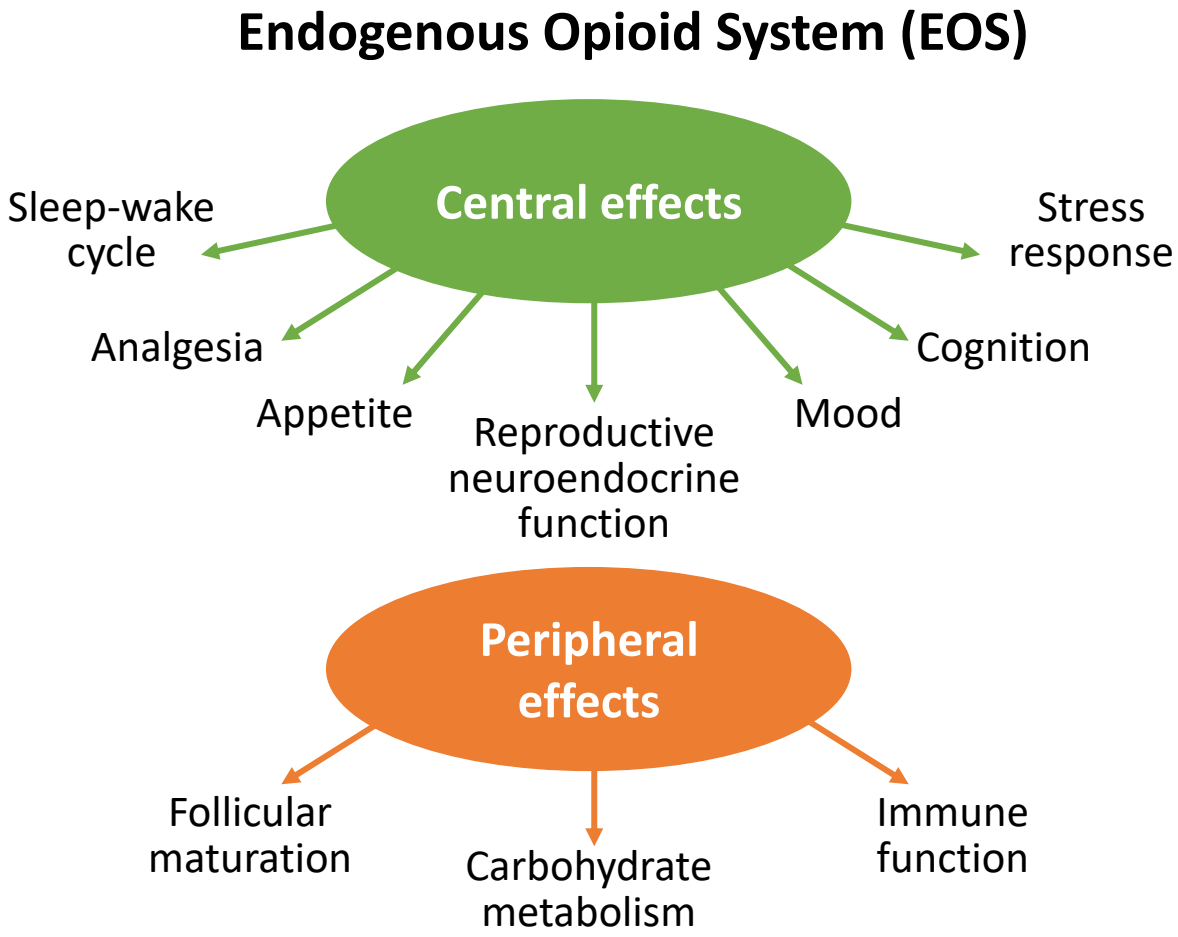
Drug or Medicine (or both)?

The cognitions, feelings and behaviours of the EOS are re-directed by exogenous opioids.

"Usurping" or "hijacking" of the EOS[1] may look like aberrant behaviours or DSM V SUD criteria.

As many nonpharma pain treatments work by strengthening the EOS [1], exogenous opioids may render these ineffective.

In 2010, the US FDA was well advised, "These opioids are essentially (like) legal heroin…. We need to think about how we would construct a Risk Evaluation and Mitigation Strategy if we were going to be marketing heroin." [2]



[1] Clauw 2017 Pain 158,12 2283-2284 [2] Okie 2010, NEJM 363, 21

Adapted from Eyvazzadeh et al. Fertil Steril 2009; 92

Medicinal opioids and the clinical relationship

Starting or continuing opioids obliges both doctors and their patients to dance the analgesia tango.

We become (unhappily) locked, potentially for decades, in the psychosocial twirls of addictive pharmacotherapy.

There is more similar than different between my GP chronic opioid analgesic clientele and my opioid dependency clientele.

Opioid Agonist Therapy (OAT)

OAT is an evidence-based model of care designed for harm minimisation. It usually involves methadone or buprenorphine and strategies as outlined in the box. Therapeutic boundaries are titrated to progress; with a spectrum of provision styles from repressive to liberal.

As with pain clinics, patients often present on high doses of opioids and our treatment aim is to improve function. Unlike pain care, higher doses and lengthier treatment programmes improve outcomes.

I have been referred, or asked to consult with, many patients on long-term opioid analgesics. Formal OAT may be appropriate for some, especially the more chaotic. However, in my experience, the vast majority do not need formal OAT. However, every single one needs titration of some OAT strategies.

OAT strategies:
. a single prescriber
. a single pharmacy
. no early prescriptions
. no replacement of lost medications
. daily dispensing
. supervised doses
. inspection of potential injecting sites
. urine drug testing
. Tapering or ceasing is risky

Have we been asking the wrong question?

"How to identify and manage addiction?" assumes that to be liberal with opioids for genuine pain patients, we must catch the addicts. However, when we find chaos, most clinicians lose direction & confidence.

Taking a more integrative approach with pain and addictions would include [1]:

- non-initiation of opioids
- normalising attention to iatrogenic cognitive, affective and behavioural changes
- long term opioid analgesics are like de facto OAT. Tapering this risks chaos emerging[2].
- Providing take-home naloxone and education for family or friends
- reducing polypharmacy
- prioritising of non-pharmacological therapies (or non-addictive medications)
- managing co-morbidities

[1] Manhapra 2018 Substance Abuse 39, 2, 152-61

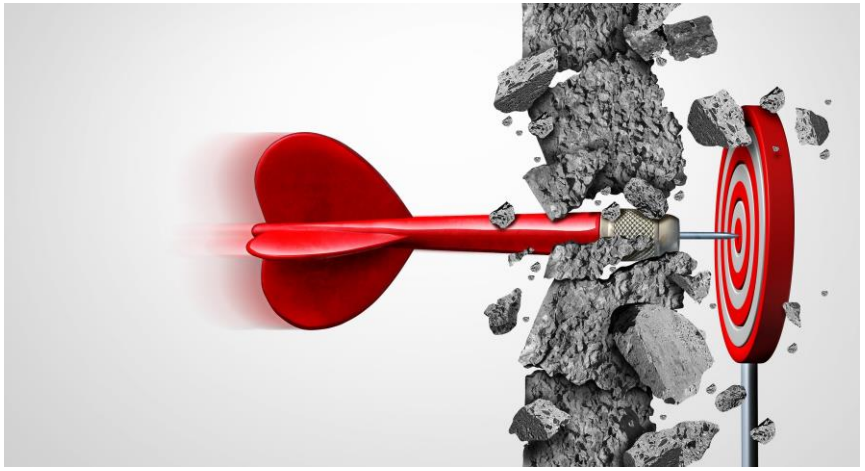
[2] Manhapra 2018 Med Clinics North America 102, 4, 745–63

Emerging options to transform the moral arm-wrestle between analgesic provision & addiction

Buprenorphine is relatively forgiving in overdose because as a partial opioid agonist it gives less respiratory depression. It is said to have antihyperalgesic properties [1].

A new development is depot buprenorphine (weekly or monthly). This revolutionizes the challenges of long-term opioids. It stabilises serum levels and side-steps aberrant behaviours such as doubling up or diversion. It is simple to use, un-demanding of workforce and relatively COVID-safe.

The main challenge, if you don't start off on bupe, is the transition[1]. Changing from full to partial opioid agonists risks withdrawal, either slow or precipitated.



So if you and your patients decide to take that opioid road trip together, buprenorphine is safer. If things go awry, depot buprenorphine provides a relatively low-risk safety option.

Urits 2020 The utilization of buprenorphine in chronic pain Best Prac & Res Clin Anaesth 34, 3, 355-368

Surgical to palliative to chronic to addictive care

In **2018**, I first met Phil, a 46yo surveyor.

Since teens, gastro-oesophageal reflux disease

2008 Oesophageal cancer Rx: Transthoracic oesophagectomy (replaced with colon)

On opioids since stricture surgery 2013. Currently 225mcg fentanyl patches every 2 days + daily 35mg methadone + esomeprazole.

Unable to eat due to vomiting and severe pain lasting days. Severe dental decay from waterbrash. So ashamed that his kids have to watch him writhe in pain.

Uses cannabis during chemotherapy and when unable to eat for days.

Alcohol: binged as a teen. No other past or current alcohol or drug problems

PEG score 26/30. Mood depressed. An odd indurated area on thigh without puncture marks.

Plan: As vomiting up methadone, we ceased this and advised that he should stay on Fentanyl

Fentanyl patch exchange at chemist twice a week.

Bystander Naloxone

Liaison with GP/Pain physician/PRU (NSW Health)

Surgical to palliative to chronic to addictive care

In **2020**, Phil returned as he couldn't get into his GP & had left his scripts on the train. All local pharmacies had refused to deal with him because he would request every script early with a new excuse. **Not** identified by Doctor shopper Information line. Using 4 cones a night for sleep.

Cachexic, multiple thigh ulcers but denied injecting fentanyl.

I rang his GP to prescribe his medications.

During the bushfires, he re-presented in extreme withdrawal as unable to access scripts or his GP. Had run out 2 days prior.

We commenced s/l buprenorphine 1mg (with melatonin, metoclopramide and dispersible piroxicam) increasing to 32mg over a week.
He reported no cravings, better sleep, but still pain on eating.
We switched to depot buprenorphine (Buvidal®) weekly and then monthly 128mg. Reported severe pain on injecting subcutaneously (no adipose tissue). For 3 weeks unable to eat due to pain. Panendoscopy arranged.
After 3 months, switched to monthly Sublocade® 300mg x 3. After 6 months, now on Sublocade® 100mg improved without chaos but still pain on eating.
At review this week Phil was gaining weight, was less pale and was eating better (after accessing some THC:CBD).