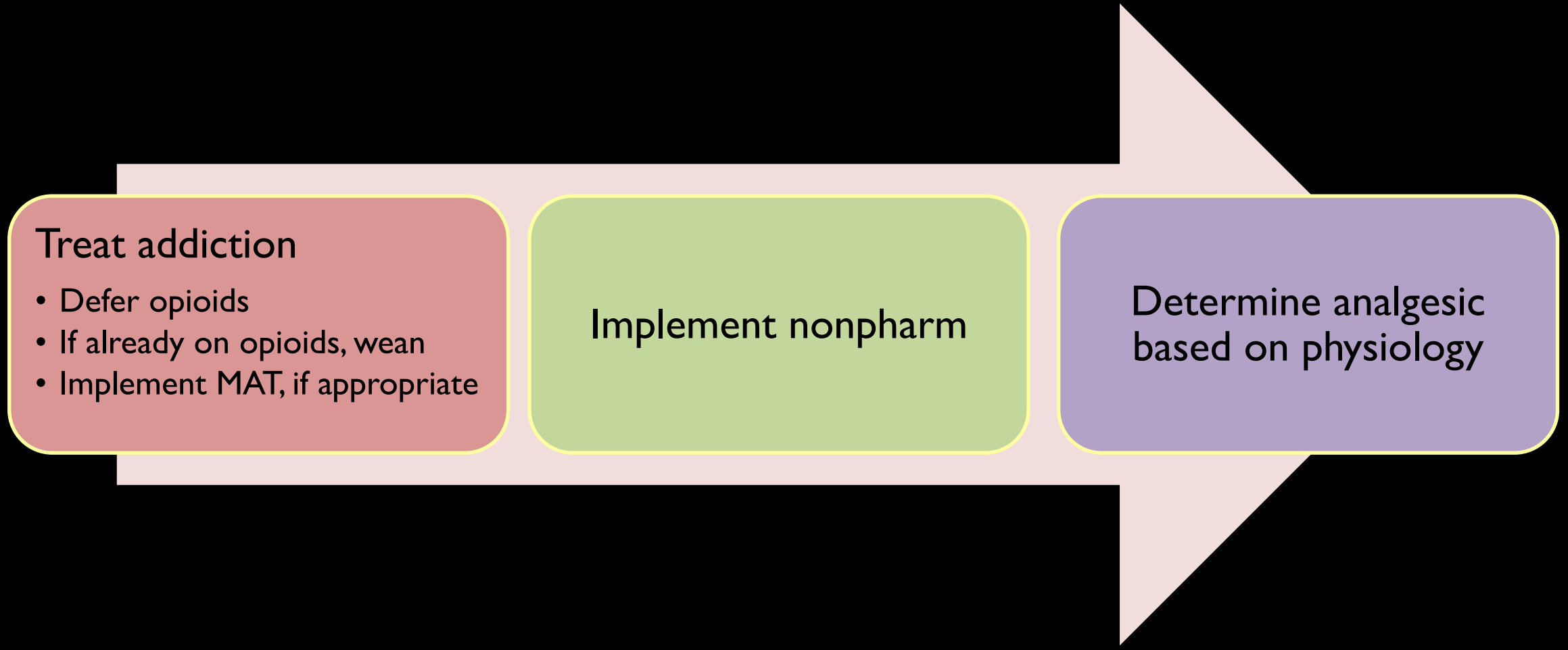
Pain Management in Comorbid SUD

Team Approach

Primary care provider	Addiction specialist	Pain clinician	Nurse
Pharmacist	Psychologist	Psychiatrist	Social workers
	Physical therapy	Occupational therapy	

Treatment Principles for Active Addiction



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Treatment Principles for Recovery

- Use nonpharmacological therapies
- Use nonopioid medications
- Treat comorbidities
- Periodic reassessment and monitoring
- Use opioids if benefits expected to outweigh risks for shortest period of time

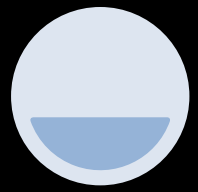
https://store.samhsa.gov/system/files/sma13-4671.pdf

Universal Precautions

- Diagnosis with appropriate differential
- Psychological assessment including of substance use disorder
- Informed consent
- Treatment agreement
- Conduct assessment of pain and function
- Appropriate trial of opioid
- Reassess pain score and level of function
- Regularly assess the 4As
- Periodically review pain diagnosis, co-occurring conditions
- Document

https://store.samhsa.gov/system/files/sma13-4671.pdf

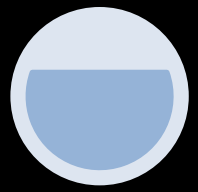
Risk of Developing Problematic Opioid Use



Low

No history of substance abuse

Minimal, if any, risk factors



Medium

History of non-opioid SUD

FH SUD

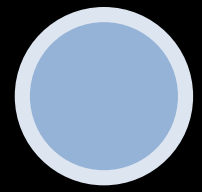
Personal or family history of mental illness

History of nonadherence to scheduled medication

Poorly characterized pain problem

History of injection-related disease

History of multiple unexplained medical events



High

Active SUD

History of prescription opioid abuse

Previously deemed medium risk

D.I.R.E., Diagnosis, Intractability, Risk, Efficacy Score; ORT, Opioid Risk Tool; PDUQ, Prescription Drug Use Questionnaire; SOAPP-R, Screener and Opioid Assessment for Patients with Pain-Revised

Risk Stratification Tools

Risk Tool	Indication	Question Format	Scoring	Advantages	Disadvantages
DIRE	Risk of opioid abuse and suitability of candidate for long-term opioid therapy	7 via patient interview	Numeric, simple to interpret	• 2 minutes to complete • Correlates well with patient's compliance and efficacy of long-term opioids therapy	Prospective validation needed
ORT	Categorizes patients as low, medium, high risk	5	Numeric, simple to interpret	• < 1 minute to complete • Simple scoring • High sensitivity and specificity for stratifying patients • Validated	• 1 question based on patient's knowledge of family history of substance abuse
PDUQ	Assess for presence of addiction in chronic pain patients	42 items via patient interview	Numeric, simple to interpret	• 3 items correctly predicted addiction or no addiction in 92% of patients	• 20 minutes to administer
SOAPP-R	Primary Care	24	Numeric, simple to interpret	• 5 minutes to complete • Cross-validated • Easy to interpret results	

Revised and reprinted with permission from paindr.com. (Accessed 5/5/2015, http://paindr.com/wp-content/uploads/2012/05/Risk-stratification-tools-summarized_tables.pdf)

Compton, P., J. Darakjian and K. Miotto (1998). "Screening for addiction in patients with chronic pain and "problematic" substance use: evaluation of a pilot assessment tool." J Pain Symptom Manage **16**(6): 355-363.

Fudin, J. (2012). Opioid Risk Stratification Tools Summarized.

Risk Mitigation

- Informed consent of risks, benefits, alternatives
- Opioid agreement
- Random UDM
- PDMP checks
- Monitoring for overdose and suicide potential
- Overdose education
- Prescribe naloxone

VA/DoD CPG Opioid Therapy for Chronic Pain, 2016.
https://store.samhsa.gov/system/files/sma13-4671.pdf

Examples of Aberrant Drug-related Behavior

- More interest in opioids
- Larger dose than prescribed or without provider authorization
- Insisting on higher dose
- Resisting UDM
- Resisting change to opioid therapy
- Pattern of lost or stolen medication or early refill
- Multiple phone calls about prescriptions
- Unscheduled visit after office hours
- Sedation
- Misuse of other substance
- Injecting or snorting oral formulation
- Obtaining medications illegally
- Threatening or intimidating behavior
- Unexpected UDM results
- Not adhering to nonpharm components of plan

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Tools to Assess Aberrant Drug-Related Behaviors

Tool	Indication	Question Format	Scoring	Advantages	Disadvantages
ABC	Ongoing assessment of patients on COT	20	≥ 3 indicates possible inappropriate opioid	• Concise • Easy to score • Studied at VA	• Needs validation outside VA
COMM	Assess aberrant medication-related behaviors in chronic pain	17	Numeric	• 10 minutes to complete • Useful for adherence assessment	• Unknown reliability long-term
PADT	Streamline assessment of chronic pain outcomes using the 4 A's	N/A	N/A	• 5 minutes to complete • Documents progress • Complements	• Not intended to predict drug-seeking behavior or positive/negative outcomes

- **ABC, Addiction Behaviors Checklist; COMM, Current Opioid Misuses Measure; PADT, Pain Assessment and Documentation Tool**

Revised and used with permission from paindr.com. (Accessed 6/27/2019, http://paindr.com/wp-content/uploads/2012/05/Risk-stratification-tools-summarized_tables.pdf)
Fudin, J. (2012). Opioid Risk Stratification Tools Summarized.

Relapse Prevention

- Identify environmental cues and stress
- Identify and manage negative emotions
- Balanced lifestyle
- Tools to identify and manage craving
- Recovery support system

The American Society of Addiction Medicine Handbook on Pain and Addiction. New York, NY; Oxford: 2018.

Relapse Response

- Lapse vs. relapse
- Intensify treatment
  - Level of care
  - Frequency of visits
  - Dose of medication
- Modify treatment
- Re-engage
- Address underlying causes of relapse

- Determine if safe to continue opioids
  - If safe
    - Close monitoring
    - Limited supply
    - Frequent UDM
  - If unsafe
    - Taper off
    - Assess for OUD and initiate MAT if appropriate

https://store.samhsa.gov/system/files/sma13-4671.pdf
The American Society of Addiction Medicine Handbook on Pain and Addiction. New York, NY; Oxford: 2018.

Acute Pain Management in Patients on MAT for OUD

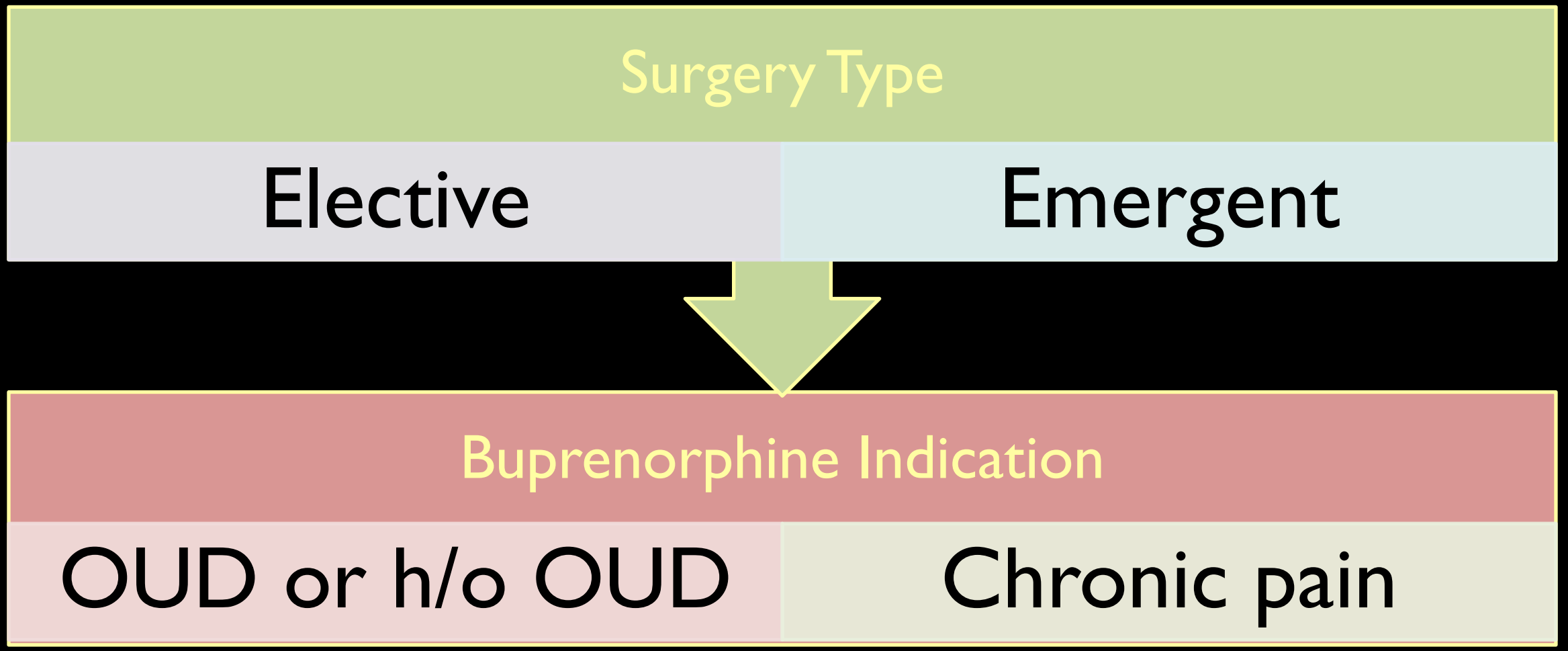
PAINWEEK®

Buprenorphine

- Partial opioid agonist
- High binding affinity and long half-life
- Out compete opioids for receptors; slow dissociation rate from receptors
- Fail to disclose illicit buprenorphine use
  - Assessed as high tolerance → Given high doses of opioids → respiratory depression in 2-3 days when buprenorphine is cleared from the system
- Multiple formulations available
  - OUD vs. chronic pain

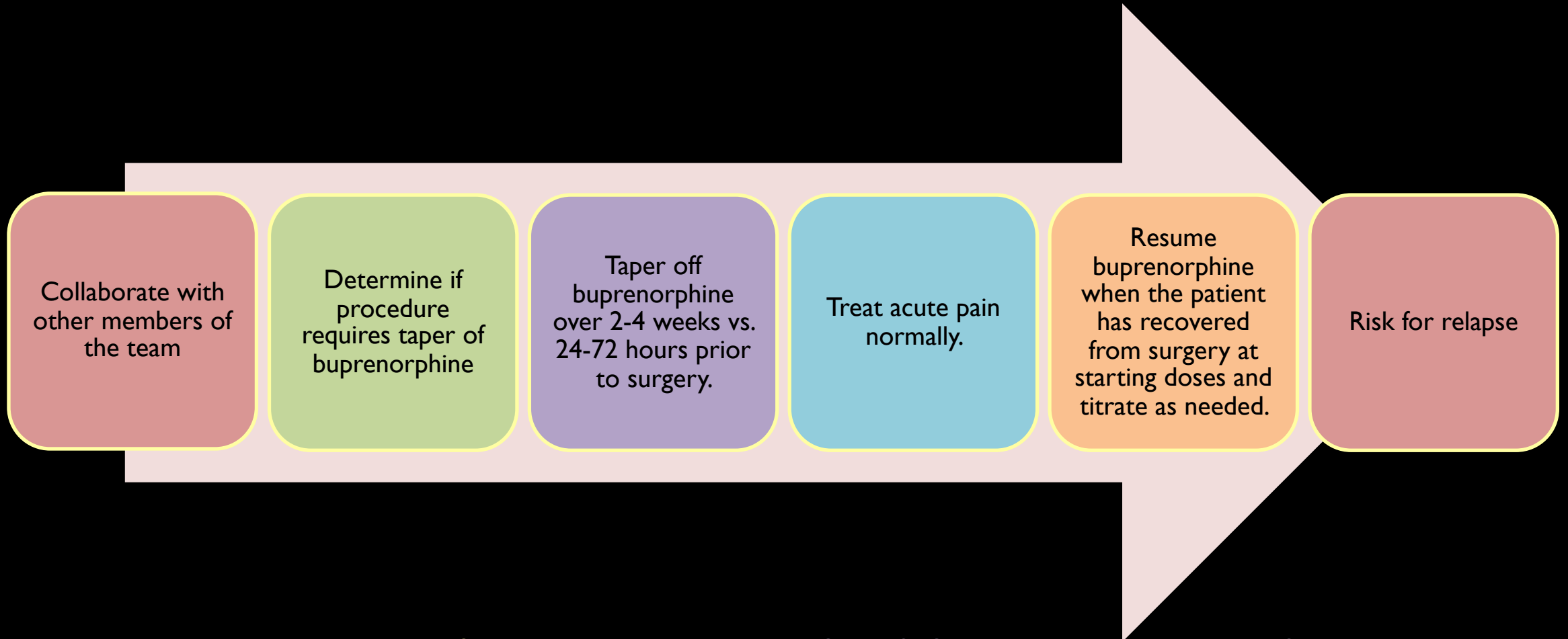
VA National PBM-MAP-VPE. Perioperative pain management guidance for patients on chronic buprenorphine therapy undergoing elective or emergent procedure: Supplemental Information. April 2019.

Buprenorphine Considerations



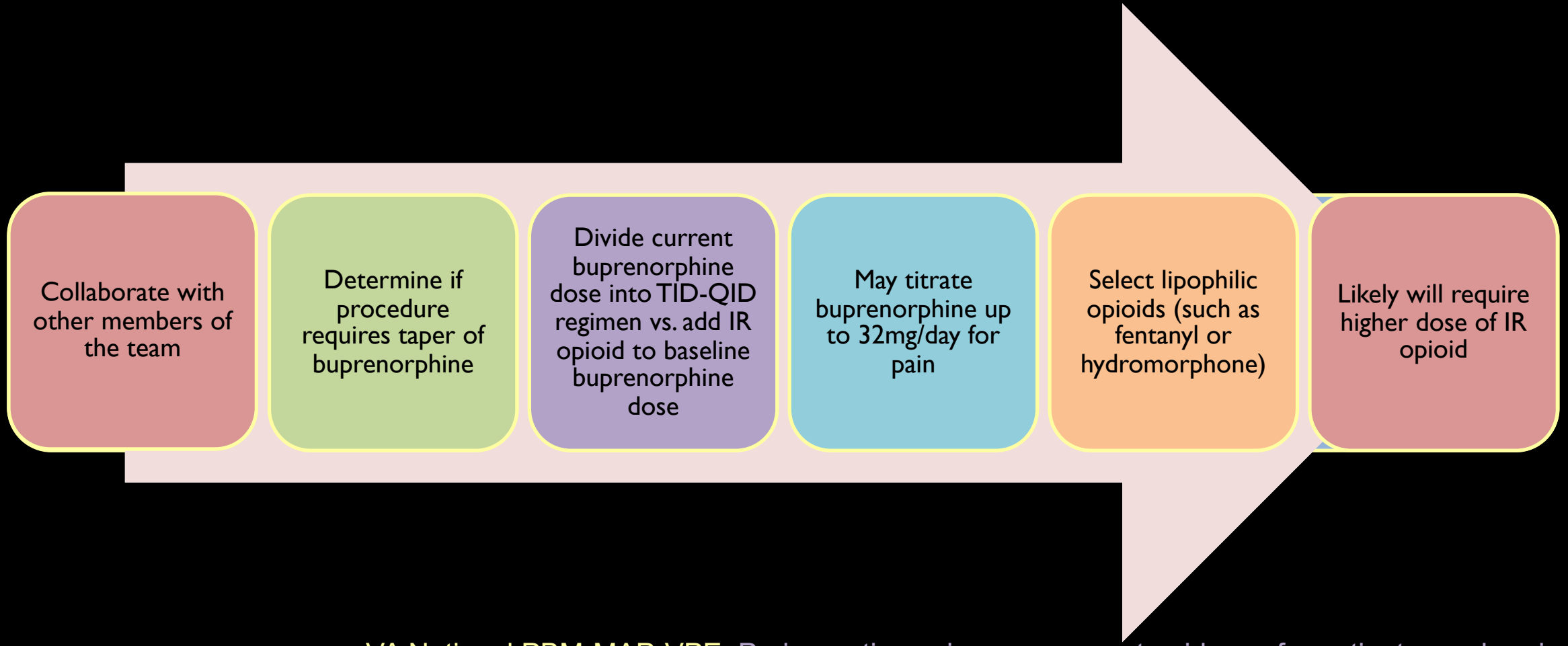
VA National PBM-MAP-VPE. Perioperative pain management guidance for patients on chronic buprenorphine therapy for opioid use disorder undergoing elective or emergent procedures: Buprenorphine for opioid use disorder. March 2019.

Buprenorphine for OUD and Elective Procedure – Discontinue Method



1. Fudin J, Srivastava A, Atkinson TJ, Fudin HR. Opioids for Surgery or Acute Pain in Patients on Chronic Buprenorphine. In Aronoff G, ed., Medication Management of Chronic Pain: What you Need to Know. Trafford Publishing, 2017.
2. VA National PBM-MAP-VPE. Perioperative pain management guidance for patients on chronic buprenorphine therapy for opioid use disorder undergoing elective or emergent procedures: Buprenorphine for opioid use disorder. March 2019.

Buprenorphine for OUD and Elective Procedure – Continue Method



VA National PBM-MAP-VPE. Perioperative pain management guidance for patients on chronic buprenorphine therapy for opioid use disorder undergoing elective or emergent procedures: Buprenorphine for opioid use disorder. March 2019.

Buprenorphine for OUD and Emergent Surgery

- Emergent surgery
  - –Multimodal plan
  - –Determine level of anticipated pain from procedure
    - Minimal to no pain
      - –Continue on buprenorphine and use nonopioids
      - –Switch to IV buprenorphine if on less than 8 mg/day of Suboxone, Zubsolv, Bunavail, or Subutex
      - –Increase buprenorphine dose, taper to previous dose before discharge (if waivered provider available)

1. Fudin J, Srivastava A, Atkinson TJ, Fudin HR. Opioids for Surgery or Acute Pain in Patients on Chronic Buprenorphine. In Aronoff G, ed., Medication Management of Chronic Pain: What you Need to Know. Trafford Publishing, 2017.
2. VA National PBM-MAP-VPE. Perioperative pain management guidance for patients on chronic buprenorphine therapy for opioid use disorder undergoing elective or emergent procedures: Buprenorphine for opioid use disorder. March 2019.

Buprenorphine for OUD and Emergent Surgery

- Determine level of anticipated pain from procedure
  - Moderate to severe pain
    - Continue buprenorphine (preferred)
      - Nonopioids
      - Switch to IV buprenorphine except > 8 mg/day of Subozone, Zubsolv, Bunavail, or Subutex
      - Increase buprenorphine dose, taper to previous dose before discharge (if waivered provider available)
      - IR opioids, taper off before discharge
    - Discontinue buprenorphine (immediately on admission)
      - High-dose, short-acting mu-opioid receptor agonist
      - Titrate IR opioid carefully; likely need reduction as receptor sites become unoccupied
      - Remain hospitalized for 3-5 days after stopping buprenorphine
      - Taper dose of opioid to average dose
      - Convert back to buprenorphine prior to discharge

1. Fudin J, Srivastava A, Atkinson TJ, Fudin HR. Opioids for Surgery or Acute Pain in Patients on Chronic Buprenorphine. In Aronoff G, ed., Medication Management of Chronic Pain: What you Need to Know. Trafford Publishing, 2017.
2. VA National PBM-MAP-VPE. Perioperative pain management guidance for patients on chronic buprenorphine therapy for opioid use disorder undergoing elective or emergent procedures: Buprenorphine for opioid use disorder. March 2019.

Surgery and Risk of Post-op Pain

Intermediate or moderate

- Laparoscopic procedures
- Video-assisted thoracoscopic procedures
- Arthroscopic procedures
- Open neurosurgical procedures

Severe

- Open intra-abdominal surgery
- Open intra-thoracic surgery
- Orthopedic procedures

Jonan AB, Kaye AD, Urman RD. Pain Phy. 2018;21:E1-E12.

Methadone

- Full mu-opioid receptor agonist
- Contact methadone maintenance clinic
- Continue usual methadone dose
  - This is not adequate to manage pain
- Treat pain as usual
  - May need higher doses

https://store.samhsa.gov/system/files/sma13-4671.pdf

Naltrexone

General

- Opioid antagonist
- Will displace opioids from receptors

Elective

- Delay procedure until levels are low enough

Emergent

- Consider alternatives
  - Regional analgesia
  - Conscious sedation
  - Nonopioids
  - General anesthesia
- High doses of short-acting opioids in hospital setting
- Close monitoring of respiration

1. Vivitrol package insert. Accessed 6/28/19.
2. The American Society of Addiction Medicine Handbook on Pain and Addiction. New York, NY; Oxford: 2018.
3. https://store.samhsa.gov/system/files/sma13-4671.pdf
4. https://store.samhsa.gov/system/files/sma14-4892r.pdf

Conclusion

- Pain and addiction often co-occur and treatment for either condition should not be done in a silo
- Identify and monitor for risk factors for developing SUD or potential relapse
- Utilize standardized assessment tools when feasible
- Incorporate risk mitigation into all aspects of clinical practice
- Treatment of comorbid pain and SUD typically requires a team approach and non-opioid treatment (pharmacological and non-pharmacological options) should be explored/offered
- Patients prescribed buprenorphine, methadone, or naltrexone for OUD will likely require more coordinated care and planning in the setting of acute pain
- The CPS provider can serve in key clinical roles providing direct patient care, including but not limited to OEND, risk mitigation, and pharmacotherapy management

Acknowledgements

- We thank the following people for allowing us to present several of their slides
  - Norman Hooten, PharmD
  - Terri Jorgensen, RPh, BCPS

PainWeek®

Which Came First…Pain or Substance Abuse Disorder?

Abigail Brooks, PharmD, BCPS
Courtney Kominek, PharmD, BCPS

Question #1

- Which of the following are risk factors for developing problematic opioid use?

a. History of SUD
b. FH SUD
c. Poorly characterized pain problem
d. History of adherence to medication regimen
e. All of the above
f. A, B, and C only

Question #2

- Which of the following tools would be most appropriate to use for screening a patient being admitted to your hospital's psychiatric unit for a suspected SUD requesting detox?

a. AUDIT or AUDIT-C
b. UDM
c. PDMP query
d. TAPS
e. NIDA-modified (NM-) ASSIST
f. Some combination of the above

Question #3

- Mr. Wood is a 62 YOM prescribed buprenorphine for OUD. He has been in remission from opioid use for ~5 years. He is scheduled to undergo a right total knee replacement in 2 months and presents to your clinic for pre-op clearance. Which option below offers a reasonable plan in terms of post-op pain management and risk mitigation?

a. Discontinue buprenorphine now and initiate oxycodone IR 10mg PO QID PRN until surgery, then adjust oxycodone IR dose while admitted and at time of hospital discharge
b. Discontinue buprenorphine 72 hours prior to surgery, then utilize oxycodone IR PRN post-op pain for a defined period of time before converting back to buprenorphine
c. Continue buprenorphine and add-on liberal doses of IR opioid for PRN use post-op
d. No treatment planning is required – continue buprenorphine as prescribed with no changes required for post-op pain