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Clash of the Titans: When Opioid Prescribing Meets Those Excluded from the Guidelines

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Disclosure

- Tanya Uritsky: Advisory Board: AcelRx
- Jessica Geiger: None

Learning Objectives

- Discuss considerations in opioid stewardship related to special patient populations
- Identify a pain management plan for a patient with sickle cell disease at high risk for misuse
- Describe key elements of opioid stewardship in a patient with active cancer
- Explain how to provide education to a palliative care patient worried about taking opioids for pain management

Opioid Stewardship

Stewardship

The responsible overseeing and protection of something worth caring for and preserving

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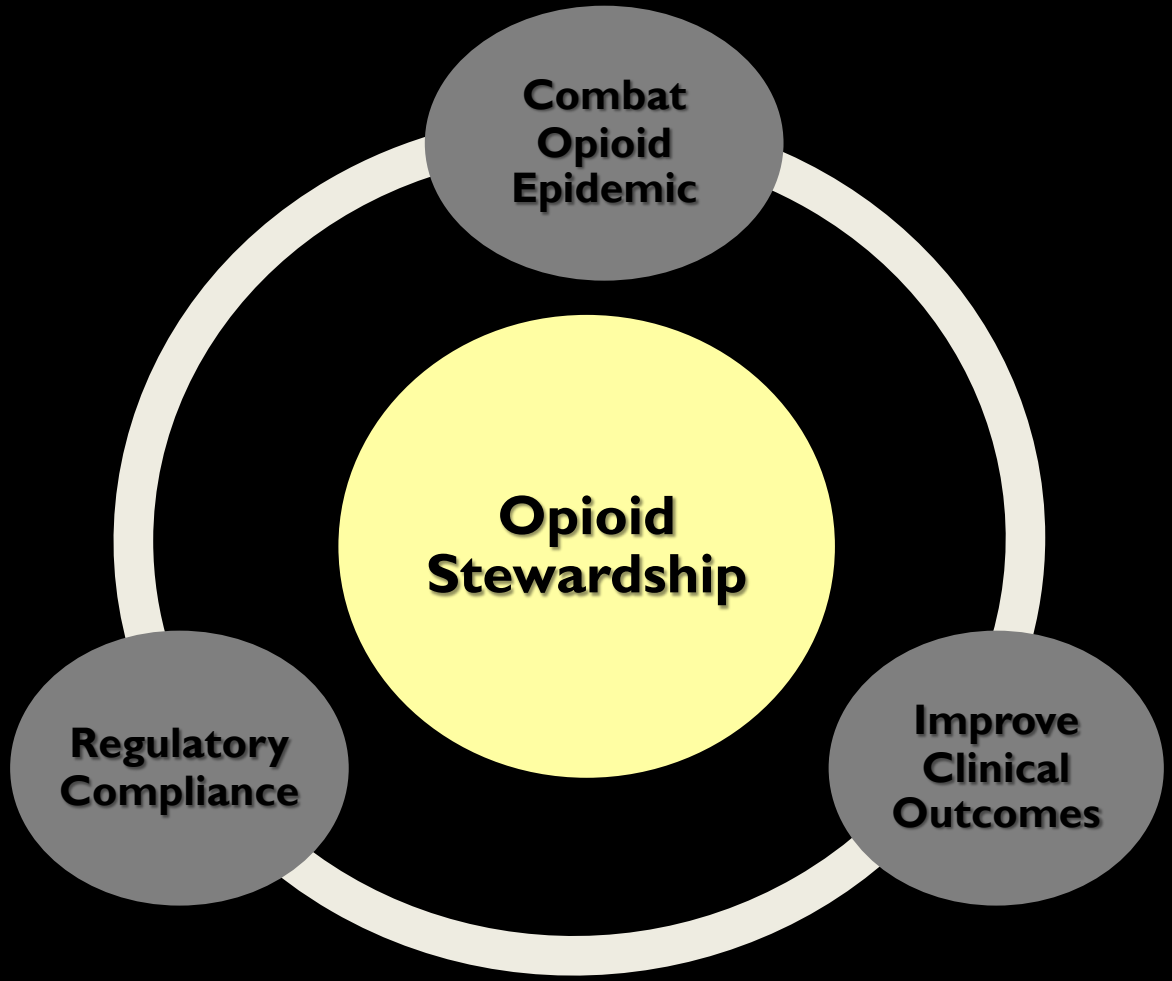
Brenn BR, et al. *Hospital Pediatrics*. 2016;6(9).

NQF Opioid Stewardship

Friedhelm S and Uppal R. The Time for Opioid Stewardship Is Now. *Jt Comm J Qual Patient Sf. 2019*;45:1-2.

Goals of Opioid Stewardship



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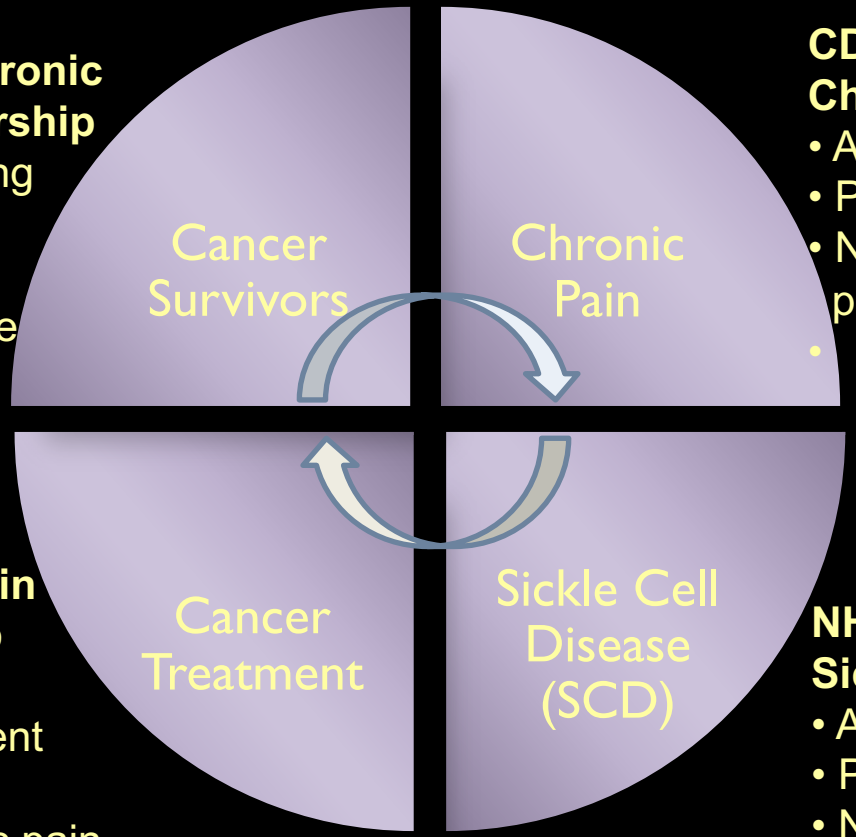
Current State of the Guidance

ASCO Guideline on Management of Chronic Pain and NCCN Guidelines for Survivorship
- Audience: Healthcare professionals caring for cancer survivors
- Population: Survivors with chronic pain
- NOT for acute diagnosis/treatment phase



CDC Guideline for Prescribing Opioids for Chronic Pain
- Audience: Primary care clinicians (PCPs)
- Population: Adults with chronic pain
- NOT intended for active cancer treatment, palliative care, end-of-life care.
- Refers NHLBI guideline for SCD

NCCN Guidelines for Adult Cancer Pain
- Audience: Healthcare practitioners who care for people with cancer
- Population: Cancer undergoing treatment with acute pain
- NOT intended for survivors with chronic pain

NHLBI Guidelines for Management of Sickle Cell Disease; ASH Guidelines 2020
- Audience: PCPs and other clinicians
- Population: SCD and acute/chronic pain
- NOT intended for patients with cancer

Adapted from Schatz AA, et al. J Natl Compr Canc Netw 2020; 18(4): 392-399

Common Ground

Common Themes Endorsed by All Guidelines
Use of nonpharmacologic therapy and nonopioid pharmacologic therapy
Assessment of an individual's likely benefit and risk prior to initiating opioid treatment
Development and implementation of strategies to maintain patient safety and minimize risk of opioid misuse based on patient history and risk factors
Continuous monitoring and regular evaluations of effectiveness and necessity of opioid therapy
Patient education on goals of treatment and safer use of opioid analgesics
Optimization of adjuvant analgesics, psychosocial support, and interventional therapies in conjunction with opioid therapy
Gradual opioid dose reduction, when indicated, to prevent withdrawal symptoms

Adapted from Schatz AA, et al. J Natl Compr Canc Netw 2020; 18(4): 392-399

Breaking It Down

Sickle Cell Disease

Patient Case - MJ

- 29 yo male with SCD and depression, (Hgb SC), chronic pain related to AVN
- Referred from Benign Hematology on high doses of opioids (> 90 MMED)
  - Oxycodone 20 mg PO q4h PRN, hydroxyurea 100 mg PO BID
  - Pain severity 8/10
- Lives at home with his mother, works part-time at local big box store
- Frequent ED/hospital admissions
  - Team is requesting a pain plan to manage pain as an inpatient for acute episodes

MJ - Quick Background Check

- ORT score = 6
- PDMP history
- Frequently requests early refills from Hematologist
- Urine toxicology congruent with oxycodone (oxymorphone) and hydromorphone metabolites
- Pill counts on target

Mark each box that applies	Female	Male
1. Family hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 1 ☐ 2 ☐ 4	☐ 1 ☐ 2 ☐ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 3 ☐ 4 ☐ 5	☐ 3 ☐ 4 ☐ 5
3. Age (mark box if 16-45)	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 3
5. Psychologic disease ADD, OCD, bipolar, schizophrenia Depression	☐ 2 ☐ 1	☐ 2 ☐ 1
Scoring totals:		

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

What do you do?!

- Do you:

A. Taper MJ's opioids over 3-4 weeks, don't they know the CDC Guideline?!
B. Recommend gabapentin 300 mg PO TID, how has he gotten so far without it?
C. Refer to Addiction Medicine, they will surely know what to do!
D. Refer him back to his Hematologist, he created this plan, after all…
E. Phone a Friend, this is a doozy!

I’m Your Friend!

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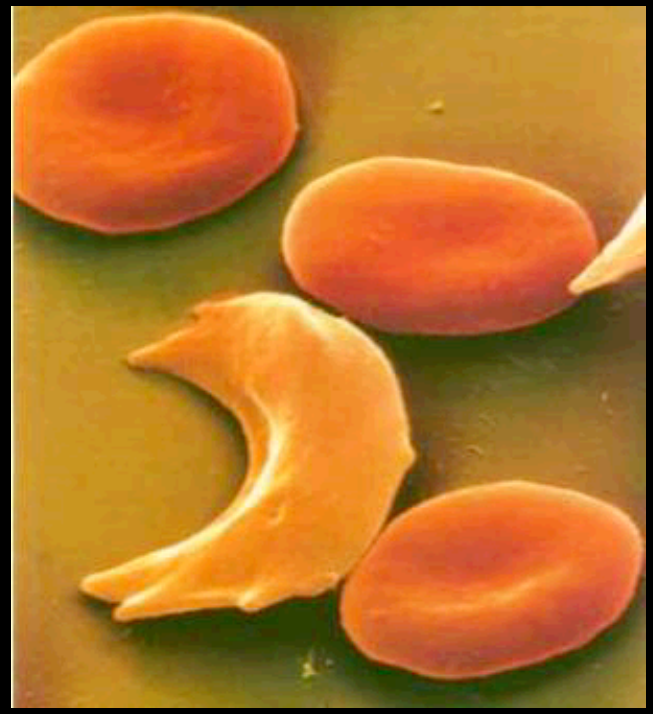
Sickle Cell Disease

- A congenital genetic chronic hemolytic disorder that is frequently interrupted by acute life-threatening events
- Incidence in newborn American Blacks: 1 in 400
- Sickle cell disease (SCD) includes many presentations
  - –HbSS, HBSC, HbS thalassemia, etc
- Acute complications
- Chronic complications



SCD and Acute Pain

- Average patient with SCD has 3 Emergency Departments (ED)/hospital admissions/year
  - Generate ~70,000 ED visits
  - > $1 billion in the U.S.
- American Society of Hematology (ASH), 2020
  - Use of standardized protocols to treat acute pain in the acute care setting
  - Nonopioid pharmacologic therapies for acute pain
  - Nonpharmacologic therapies for acute pain
  - Manage pain in SCD-specific hospital-based acute care facilities
  - Patient-controlled analgesia – no recommendation for or against a basal infusion

Field JJ, et al. J Pain 2019 20 (7):746-759.
Brandow AM, et al. Blood Adv. 2020 Jun 23; 4(12):2656-701.

Vaso-occlusive Episodes (VOE)

- Most frequent presenting complaint in adults with SCD
- Pathophysiology
  - Microvascular entrapment of red cells
  - Cycles of ischemia and reperfusion → inflammation, endothelial cell activation, WBC activation
- Peak incidence ages 19-39
- 30% of patients rarely have pain, and 30% are admitted > 6 x annually
- Precipitating factors
- Frequency of VOC predicts mortality
  - 22% of deaths in patient with SCD occur during an acute episode

Field JJ, et al. J Pain 2019 20 (7):746-759.

Management of VOE

- Rapid and effective pain control
  - Door to 1st dose of pain med: 30 min
  - Give SQ if IV access not available
  - Now is not the time to negotiate narcotic management

IV fluids if dehydrated

Broad-spectrum antibiotics if febrile or WBC elevated above baseline

Incentive spirometry reduces ACS episodes (42% → 5%)

Prophylactic anticoagulation

Transfusion in special cases (uncommon)

Supplemental O_2 in special cases

Inpatient Plan

- Analgesia:
  - Opioids - Patient Controlled Analgesia (PCA) - The tiered approach
  - Nonopioids around the clock – acetaminophen and NSAIDs
  - Adjuvants – continue home adjuvants, consider ketamine if pain is refractory
- Opioid-induced adverse effect management
  - Pruritus management: Antihistamines, opioid receptor antagonists
  - Sedation Monitoring: Pasero Opioid-induced Sedation Score (POSS)
- Discharge planning
  - Follow up within 1 week post-discharge
  - Check PDMP, inquire about home supply of opioids
  - Provide a tapering plan

Zassman SM, et al. Am J Health-Syst Pharm. 2019; 76:1965-1971

A Sample Inpatient Plan

Day 1 (First 24 hours of admission)

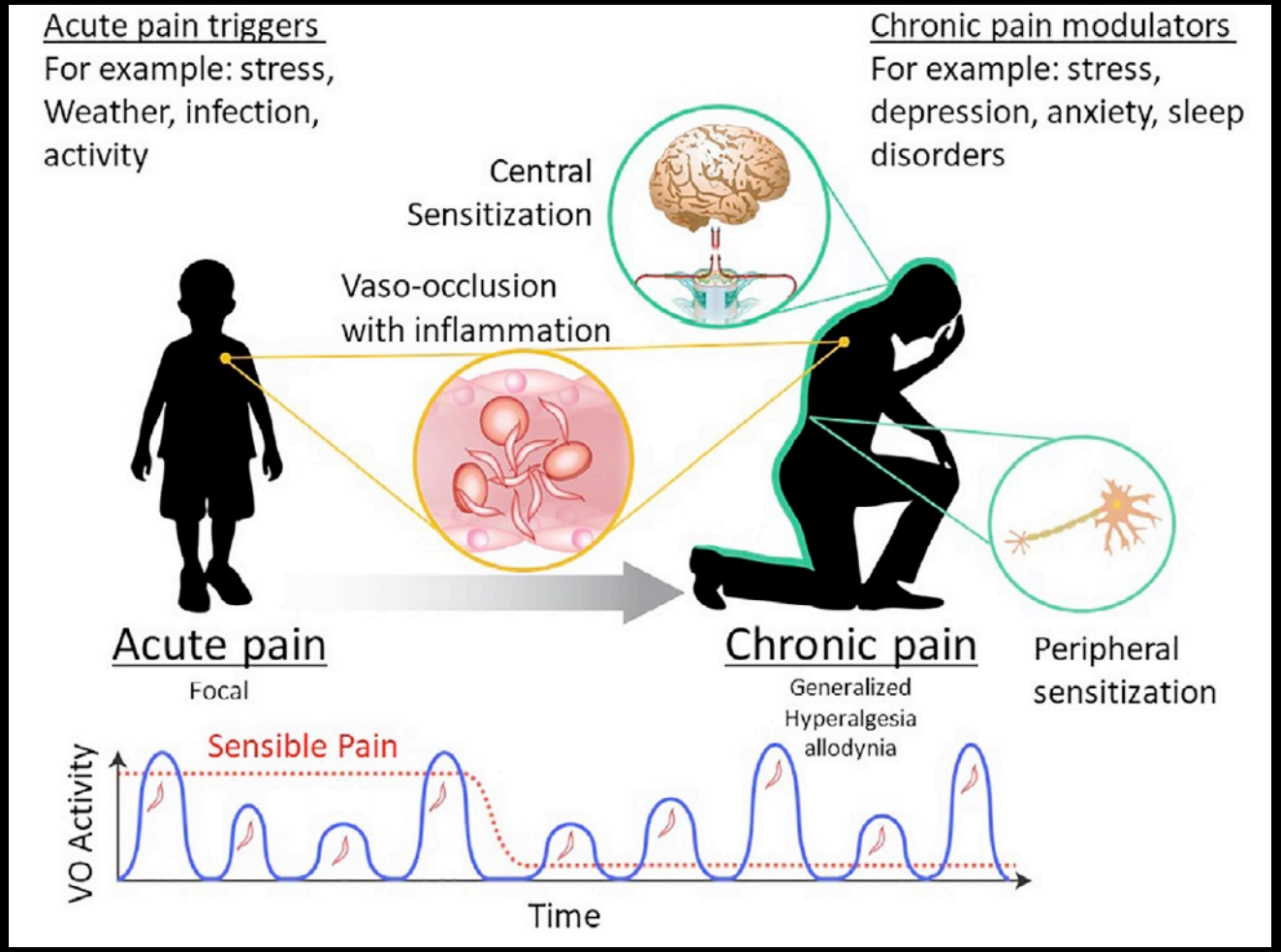
- Hydromorphone PCA 0 mg/hr; 0.4 mg demand, 15-min lockout; load 0.8 mg; 4-hr max: 3.2 mg
- Oxycodone 20 mg PO q4h (home med)
- If pain is intolerable on PCA on Day 1, increase demand dose 50-100%
- Scheduled Ketorolac 15 mg IV q6h

  Contraindications: eGFR < 45 ml/min, CHF, Plt <75, Hx GIB, allergy
- Scheduled Acetaminophen 1000 mg PO q6h
- Naloxone 0.04 mg IV x 1 PRN

Day 2 (24-48 hours into admission)

- Hydromorphone PCA – 30-min lockout; 4-hr max: 2 mg - **ONLY for pain refractory to PO meds**
- Oxycodone 20 mg PO q4h
- Oxycodone 20 mg PO q3h PRN moderate pain
- Oxycodone 30 mg PO q3h PRN severe pain
- Ketorolac 15 mg IV q6h as above (if no CI)
- Scheduled Acetaminophen 1000 mg PO q6h

SCD and Chronic Pain - Etiology



Field JJ, et al. J Pain 2019 20 (7):746-759.

SCD and Chronic Pain - Guidelines

- American Society of Hematology (ASH), 2020
  - Nonopioids for chronic pain with another identifiable cause besides SCD
    - Avascular necrosis (AVN) of bone (adults): duloxetine, NSAIDs; Children – no recommendation
  - Nonopioids for chronic pain with no identifiable cause (adults)
    - Selective Serotonin-Norepinephrine Reuptake Inhibitor (SNRI), tricyclic antidepressants (TCA), gabapentinoids
  - Nonpharmacologic therapies for chronic pain
    - Cognitive and behavioral pain management strategies
    - Integrative approaches as available, tolerated, and by patient preference and response
    - No recommendation for or against exercise, PT, or medication/movement programs
  - Chronic Opioid Therapy (COT) for chronic pain
    - Not recommended unless pain is refractory to multiple other modalities
    - If receiving COT, evaluate function and perceived benefit

Brandow AM, et al. Blood Adv. 2020 Jun 23; 4(12):2656-701.

Outpatient Plan

- Standardized approach when prescribing
  - ORT
  - Nonopioids and nonpharmacologic interventions
  - Pain Contracts
  - PDMP check
  - Random Urine Toxicology
  - Functional goals
  - Naloxone prescribing
- Additional risk stratification
  - Pill counts
  - Smaller day supply/Rx
  - Consider Buprenorphine
  - Pain psychologist support

Common Pitfalls

- Communication breakdown within and between teams
- Discharge opioid prescribing
- The Visual Analogue Scale
- IV versus PO administration
- Psychosocial barriers
- Psychological barriers
- Cost/Access issues
- Stigma

The Stigma


mistrust
isolation
insomnia
shame
different
drug-seeking
fatigue
difficulty concentrating
emotionally draining
pain
crisis
bullying
disrespect
anxiety

Back to MJ

- Required Strategies
  - Small Rx supplies
  - Pain contract
  - Random urine toxicology
  - Risk assessment, discussion, referrals as appropriate
  - Inpatient pain plan, including expectation setting
  - Prescribe naloxone

- Approaches
  - Attempt to taper opioids
  - Opioid rotation – role of methadone or buprenorphine?
  - Trial of long-acting opioid only
  - Add on and optimize adjuvants

Active Cancer/Palliative Care

Patient Case - CP

- 42 yo female with active breast cancer.
- Referred to palliative care from primary oncologist due to uncontrolled pain.
  - Current regimen
    - Morphine 30 mg PO q4h PRN
    - Pain severity 8/10
    - Using 6 doses/day of the morphine
- Lives at home with husband and 2 sons, worried about having opioids in the home/addiction
- Increasing pain needs due to disease progression (bone and liver mets)
  - Oncology team is uncomfortable with prescribing over 90 OME
- No concerns for opioid misuse

CP - Quick Background Check

- ORT score = 1
- PDMP history is appropriate

Mark each box that applies	Female	Male
1. Family hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 1 ☐ 2 ☐ 4	☐ 1 ☐ 2 ☐ 4
2. Personal hx of substance abuse Alcohol Illegal Drugs Prescription drugs	☐ 3 ☐ 4 ☐ 5	☐ 3 ☐ 4 ☐ 5
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Scoring totals:		

Scoring (Risk)
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4-7 Moderate Risk
≥ 8 High Risk

What do you do?!

- Do you:

A. Taper opioids to below 90 OME
B. Recommend addition of dexamethasone
C. Refer back to oncology team
D. Get her off the opioids because she is worried
E. Phone a Friend, this is a doozy!

CDC Guideline review

- Stressed appropriate assessment, dosing, treatment duration and risk/benefit.
- Suggested morphine milligram equivalent (MME) thresholds
  - ≥ 50 MME – careful reassessment
  - ≥ 90 should be avoided without justification
- Suggested time frames for treating acute pain
  - Limiting prescriptions to no more than 1 week

Dowell D, et al. MMWR Recomm Rep; 2016

Current State

- Unintended consequences for patients with active cancer
  - Delay in patient care
  - Disruptions in treatment plans
  - Insurance red tape
  - Increased workload on providers

Cancer pain

- Affects:
  - 30-50% of those receiving active treatment
  - >70% of those with advanced disease
- Can require high doses
- Generally a mixed pain presentation
  - Nociceptive
  - Neuropathic
  - Inflammatory

NCCN Guidelines

- Set goals
- Comprehensive assessment
  - PDMP review
  - Opioid contract (as appropriate)
  - Pain assessment
- Multimodal approach
- Use the lowest effective dose
- Use scheduled and breakthrough doses based on 24 hour use
- Decrease if able

NCCN. Adult Cancer Pain; 2020

Back to CP

- New plan
  - Initiate extended release morphine 90mg Q12H
    - This is based on the current use of 180mg morphine/day
  - Allow for breakthrough doses
    - Morphine 15mg PO Q4H prn
  - Add multimodal therapies
    - Dexamethasone?
    - Gabapentin/pregabalin?
    - Nortriptyline?
    - SNRI?
  - Follow up in 1-2 weeks

Education

- Remember that CP is nervous about having opioids in the home…

- Education on safe storage and disposal
  - Lock box
  - Don't keep them in the medicine cabinet
  - Drug take back days
  - Drug disposal systems
- Understanding the difference between addiction and dependence
  - She might become "dependent" but that does not mean she is "addicted"

Cancer Survivorship

Patient Case - TH

- 42yo male with a history of rectal cancer.
  - S/P chemotherapy and radiations
  - Scans have been free of cancer for the past year
- Still reports pain and wants an increase in his oxycodone
  - Describes burning pain in the rectal area and stabbing pain in the abdomen
- Current regimen includes:
  - Oxycodone 30mg Q4H prn pain, uses 6 doses per day
  - Gabapentin 300mg QHS
- Labs are WNL

ASCO Guidance

- Used 35 systemic reviews, 9 RCTs and 19 comparative studies
  - Focus on adult cancer survivors
  - Focus on chronic pain rather than acute
- Developed by an expert panel

ASCO Guidance

- Comprehensive pain assessment:
  - Screen for chronic pain syndromes that result from cancer treatments
  - Evaluate for recurrent disease
- Multimodal pain therapies
  - Pharmacologic AND non-pharmacologic
  - Opioids should only be used when non-responsive to other treatments
- Important to conduct risk vs benefit analysis
- Taper opioids if no longer warranted

What should we do for TH?

A. Titrate the opioid
B. Increase gabapentin to 300mg BID with a plan to continue to titrate
C. Stop prescribing the opioid
D. Taper TH off of the opioid

New Plan

- Increase gabapentin
- Add topical lidocaine to the rectal area
- Do not adjust the opioid…may even consider a taper depending on responsiveness to the above changes
- Involve an interdisciplinary team
  - Physical therapy
  - Counselling services
  - Interventional therapies?

Summary

- Don’t forget about the outliers
  - Sickle Cell
  - Active Cancer treatment
  - Cancer survivorship
  - Palliative Care
- Patient specific regimens are important
- Ongoing risk benefit analysis
- Opioids aren’t always the answer…but sometimes they are

References

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