Non-CME Webinar Series
designed with the trainee in mind
first Tuesday of the month

ASRA PAIN MEDICINE
THE ASSOCIATION OF PAIN PROGRAM DIRECTORS

Opioids: Indication-Getting On-Staying On-Getting Off

Tuesday, November 1, 2022

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Opioid Therapy

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ADVANCING EDUCATION IN MULTIDISCIPLINARY PAIN MEDICINE

Disclosures:

- None

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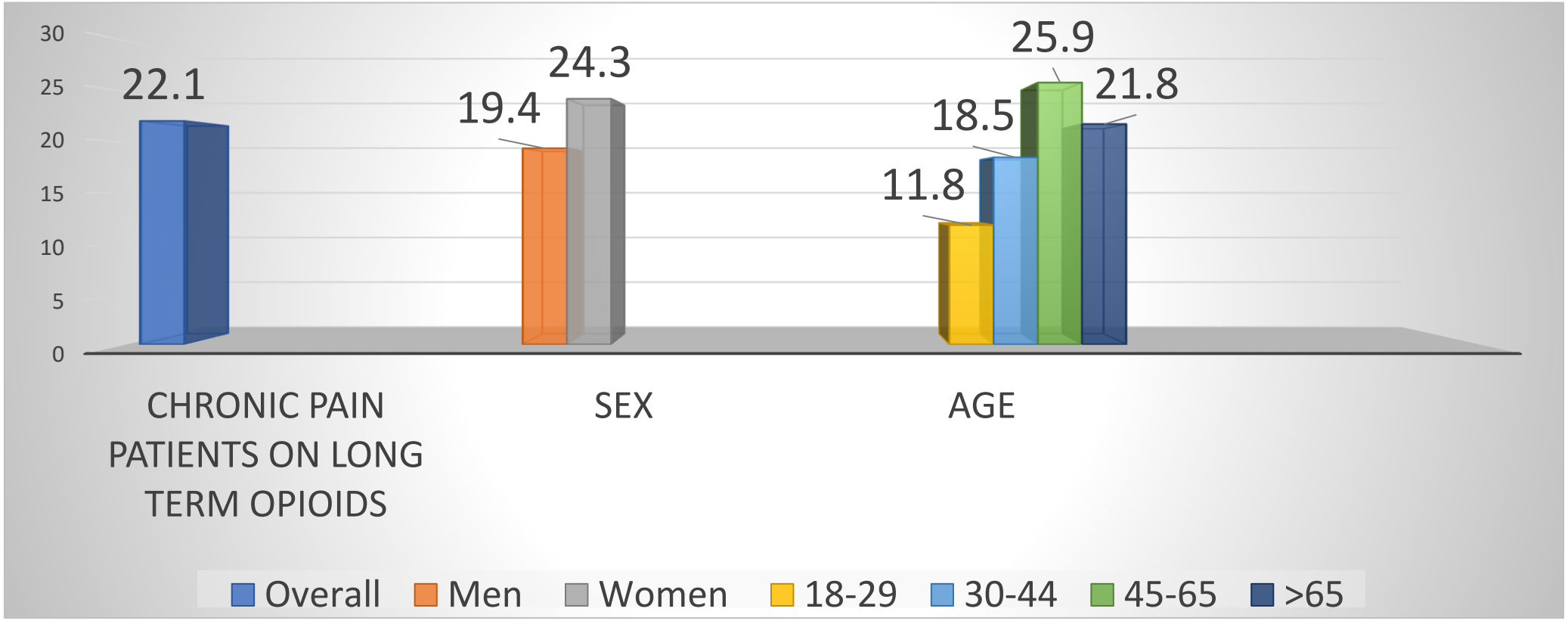
Objectives:

- Opioid Initiation
- Maintenance of opioid therapy
- Challenges
- Opioid rotation

Percentage of adults on opioids for chronic pain



Dahlhamer JM, Connor EM, Bose J, Lucas JL, Zelaya CE. Prescription Opioid Use Among Adults With Chronic Pain: United States, 2019. Natl Health Stat Report. 2021 Aug;(162):1-9. PMID: 34524076.

What CDC says…

- Opioids are not first line or routine therapy for chronic pain

  - ❑ Every attempt should be made to maximize non pharmacologic and non opioid pharmacologic therapy
  - ❑ Establish goals for pain and function

www.cdc.gov/drugoverdose/prescribing/guideline.html

What CDC says…

- Considering Opioids
  - ❑ Benefit > Risk
  - ❑ Establishment of treatment goals, opioid contract
  - ❑ Selection of immediate vs long acting opioids
  - ❑ Start low and go slow
  - ❑ Reassess – pain and function
  - ❑ Evaluate risk of harm and discontinuation of therapy

www.cdc.gov/drugoverdose/prescribing/guideline.html

Opioid contract Should Include:

- Treatment goals – pain and function
- Patient's responsibility - safe medication use
- Secure storage and safe disposal
- Opioids from only one clinician or practice and one pharmacy
- Patient's agreement to periodic drug testing
- Clinician's responsibility to be available or to have a covering clinician available to care for unforeseen problems and to prescribe scheduled refills
- Renew yearly

Start with short-acting opioid

- Initiate any opioid trial with ≤ 2 weeks of short-acting opioid
  - Easier to stop if adverse effects
  - Will know within a few doses if adequate relief
  - Starting with ER/LA product had greater risk of overdose
  - No difference between short vs. long-acting product on pain or function
- May transition to long-acting opioid if successful trial and appropriate daily dose is determined

Periodic Review of Plan

- At each visit assess for the 5 A's:
  - Analgesia
  - Activities of daily living
  - Adverse effects
  - Aberrant drug-seeking behaviors
  - Affect

What CDC says…

-Assessing risk and addressing harms of opioid use

- ❑ Evaluation of risk factors for opioid related harms and ways to mitigate risk to patient
- ❑ Review PDMP data
- ❑ Urine drug testing
- ❑ Consideration of co-prescribing of benzos
- ❑ Arrangement of treatment for OUD

www.cdc.gov/drugoverdose/prescribing/guideline.html

Risk factors for opioid misuse

- Family/personal history of substance abuse
- Young age
- Mood/personality disorder
- History of criminal activity, childhood abuse
- Regular contact with others who misuse substances
- Risk taking behavior
- Use of substances which lead to dependence
- Psychosocial stressors

Benzon et al. Practical management of pain. 6th edition

Risk assessment tools

- Screen and opioid assessment for patients with pain – revised (SOAP – R)
- Current opioid misuse measure (COMM)
- Pain Medication Questionnaire (PMQ)
- Opioid risk tool (ORT) – popular as lists only 5 items

Benzon et al. Practical management of pain. 6th edition

Urine drug testing (UDT)

- Importance
  - Establish prescription compliance
  - Identify use of other undisclosed substances
  - Uncover diversion
- When
  - Before initiating opioid therapy
  - Stable patients screened randomly or at every visit

Gourlay DL, et al. Urine Drug Testing in Clinical Practice, 4th Ed.

Urine drug metabolites

Opioid	Metabolites
Codeine	Morphine, hydrocodone, norcodeine
Heroin	6-Monoacetylmorphine, morphine, normorphine
Morphine	Normorphine, Hydromorphone, morphine-6-glucuronide, morphine-3-glucuronide
Hydrocodone	Hydromorphone, norhydrocodone, dihyrocodeine
Hydromorphone	Hydromorphone-3-glucuronide
Oxycodone	Oxymorphone, noroxycodone
Oxymorphone	Oxymorphone-3-glucuronide
Fentanyl	Norfentanyl
Methadone	2-Ethylidene-1, 5-dimethyl-3, 3-diphenylpyrrolidine
Buprenorphine	Norbuprenorphine

Nagpal G et al. JAMA. 2017 Nov

Concerns with opioid therapy

- Short term adverse effects
  - Constipation, nausea, vomiting
  - Sedation, confusion
  - Respiratory depression
  - Itching, rash
- Long term effects
  - Hypogonadism
  - Osteoporosis
  - Immunosuppression (T cells)
  - HPA axis suppression
- Tolerance
- Opioid induced hyperalgesia
- Risk of abuse/ dependence

Concerns with opioid therapy

Tolerance

- Receptors are down-regulated
- Location of pain consistent
- Occurs in all pts
- Waning efficacy of opioid over time
- Improved analgesia with dose increase

Hyperalgesia

- Receptors are upregulated
- Increasing distribution of painful area
- Not symptomatic in all pts
- Waning efficacy of opioid over time
- Analgesia same or worse with dose increase

Opioid rotation

- Switch from one opioid to another in an effort to improve clinical outcomes (benefits or harms).
- Selection of a new drug at a starting dose that minimizes potential risks while ideally maintaining analgesic efficacy.
- Indications- Lack of efficacy, tolerance, side-effects, financial/ formulary constraints

Clinical considerations for opioid rotation

- Consider patient characteristics to identify the opioid to switch to
- Convert to the equianalgesic dose of current opioid
- Clinically adjust equianalgesic dose of new opioid to minimize risk of overdose

Fine PG, Portenoy RK; Ad Hoc Expert Panel on Evidence Review and Guidelines for Opioid Rotation. Establishing "best practices" for opioid rotation: conclusions of an expert panel. J Pain Symptom Manage. 2009 Sep;38(3):418-25. doi: 10.1016/j.jpainsymman.2009.06.002. PMID: 19735902; PMCID: PMC4065110.

418 Journal of Pain and Symptom Management Vol. 38 No. 3 September 2009

Special Article

Establishing "Best Practices" for Opioid Rotation: Conclusions of an Expert Panel

Perry G. Fine, MD, and Russell K. Portenoy, MD, for the
Ad Hoc Expert Panel on Evidence Review and Guidelines for Opioid Rotation
Department of Anesthesiology, Pain Research Center (P.G.F.), University of Utah School of Medicine, Salt Lake City, Utah; and Department of Pain Medicine and Palliative Care (R.K.P.), Beth Israel Medical Center, New York, New York, USA

- Window to apply to most switches is a **reduction of 25-50%** of the **calculated equianalgesic dose**
- Exceptions: Methadone, Transdermal fentanyl, transmucosal fentanyl

Fine PG, Portenoy RK; Ad Hoc Expert Panel on Evidence Review and Guidelines for Opioid Rotation. Establishing "best practices" for opioid rotation: conclusions of an expert panel. J Pain Symptom Manage. 2009 Sep;38(3):418-25. doi: 10.1016/j.jpainsymman.2009.06.002. PMID: 19735902; PMCID: PMC4065110

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Fine PG, Portenoy RK; Ad Hoc Expert Panel on Evidence Review and Guidelines for Opioid Rotation. Establishing "best practices" for opioid rotation: conclusions of an expert panel. J Pain Symptom Manage. 2009 Sep;38(3):418-25. doi: 10.1016/j.jpainsymman.2009.06.002. PMID: 19735902; PMCID: PMC4065110

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Benzon et al. Practical management of pain. 6th edition

Nagpal G, Heiman H, Haymond S. Interpretation of Urine Drug Screens: Metabolites and Impurities. JAMA. 2017 Nov 7;318(17):1704-1705. doi: 10.1001/jama.2017.10910. PMID: 29114811.

Parts of this presentation have been adapted from prior work of Dr. Bhavvana Yallmuru and Lee Kral

Questions?