Pain Care for People who have Opioid Use Disorder

Mi-CCSI Pain and Addiction Series

Your Speaker

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Objectives

1. Participants will be able to state the basic differences between the three FDA approved medications used to treat opioid use disorder.
2. Participants will have improved confidence in treating acute pain in patients also being treated for opioid use disorder.
3. Participants will be able to state at least one treatment recommendation for chronic pain that is nociceptive, neuropathic, and nociplastic.
4. Participants will be able to state at least two other professionals who might serve their patients with addiction and pain

Three Parts

1. **Part 1:**
   - **Definitions**
   - **Types of treatment for opioid use disorder**
   - **Case presentation of someone with acute pain**
2. Part 2:
3. Part 3:

Some definitions

- Opioid Use Disorder (OUD)
- Acute Pain
- Medication for Opioid Use Disorder (MOUD)
- Methadone
- Buprenorphine
- Naltrexone

Opioid Use Disorder

- 11 Criteria per the DSM-V
- 2-3 Symptoms = Mild
- 4-5 Symptoms = Moderate
- 6 + Symptoms = Severe

  - *Opioids taken longer or larger amounts*
  - *Unable to cut back*
  - *Time investment to obtain the opioids*
  - *Craving*
  - *Failure to fulfill obligations*
  - *Continued use despite negative consequences*
  - *Missing out on social events and work*
  - *Use in hazardous situations*
  - *Use despite exacerbations of physical or psychological problem due to the opioids*
  - *Tolerance*
  - *Withdrawal*

Acute Pain

Usually caused by an injury, surgery, illness, or painful procedure

Has an end-point once healed

Shorter duration

Medication for Opioid Use Disorder MOUD

- Previously known at MAT (medication assisted therapy)
- 3 drugs are FDA approved to treat opioid use disorder
  - Methadone
  - Buprenorphine
  - Naltrexone

Methadone as MOUD

- Mu agonist
- Synthetic opioid
- Good
    - Easy to initiate after mu agonist use
    - Long ½ life allows for once daily dosing
- Bad
    - QTc interval prolongation and risk of Toursades de Pointes
    - Respiratory depression
    - Sexual problems (hypogonadism)
    - Weight gain
    - Sedating

More about Methadone MOUD

- There are no elements of blocking the effects of opiate use
- Very high morphine equivalency at low-ish doses (20 mg = 80 MME and 30 mg = 240 MME)
- Must be dosed at a specialty clinic and not in a primary care office
- Slightly better retention rates than treatment using other medications
- Often daily dosing with daily trips to a clinic
- Can be difficult to earn “take-homes”
- Recognize the burden of care

- https://www.cdc.gov/opioids/providers/prescribing/pdf/calculating-total-daily-dose.pdf

Buprenorphine as MOUD

- Partial agonist at the mu receptors and antagonist at the kappa receptors, but low intrinsic activity at the mu receptor
- High affinity
- About 20-50 times the MME of Morphine (no exact conversion – but it's STRONG)
- Good
  - Long half life allows for once daily dosing
  - Blunting effects for opioids used
  - Ceiling effect of respiratory depression making overdose deaths rare
  - Can be prescribed by anyone licensed to prescribe schedule III drugs and filled at commercial pharmacies
- Bad
  - Affinity can cause withdrawal if given too closely after mu agonists
  - Difficult to transition from mu agonists to buprenorphine (fentanyl and methadone)
  - SE include constipation, sexual side effects, GI issues sometimes

https://psychiatry.uams.edu/clinical-care/cast/buprenorphine/

Naltrexone as MOUD

- Mu receptor blocker
- Not a controlled medication
- Comes in a once monthly injection (Vivitrol) or pills
- Efficacy on par with buprenorphine
- Must be 100% off opioids prior to initiation
- Effectively treats OUD and AUD
- Low burden of care, pills are cheap, injection is expensive
- SE: GI issues, headache, anxiety, trouble sleeping

Representative Case Study

- This is not a real person, but a representative case
- All the material here is made up and any similarity to an actual person is accidental and coincidental

Meet Charlene

- 62-year-old female patient who developed opioid use disorder due to long-term opioid prescribing after a lumbar surgery 20 years ago
- She was treated with SL buprenorphine for 9 years and then changed to XR injectable buprenorphine 2 years ago
- Her ongoing chronic pain is managed through physical activity, occasional NSAIDs, steroid injections, occasional acetaminophen, Medrol dose pack every 12-18 months for flares in her pain

Charlene

- You receive a phone call from Charlene on the day she is supposed to come in the office for a routine visit & XR Buprenorphine injection
- She says that on her way to her car, she slipped and fell on the ice in her driveway
- She says that she did not hit her head and was able to get herself back onto her feet, but her back is very sore and she says that she cannot stand up straight
- She apologized for not coming in that day, but she plans to go back in the house and rest
- She asks if you are going to give her anything for her pain from the fall

What next?

A) You reassure yourself that Charlene does not need emergency care and tell her that since she has addiction, you cannot prescribe anything for this injury

B) You ask Charlene a few more questions to make sure that she does not need emergency care; then prescribe her 10 Vicodin, 5 Valium, and 30 Flexeril

C) You reassure yourself that Charlene does not need emergency care and you reschedule her to be seen next week. You instruct her to take 200 mg ibuprofen + 500 mg acetaminophen (up to 6 doses/day) and to use ice on her back for 15 minutes 2-3 times today. You educate her about red-flag symptoms that should prompt her to report to the emergency department (saddle anesthesia, foot drop, etc.)

D) You reassure yourself that Charlene does not need emergency care and you prescribe her a Medrol dose pack to help her with her back pain

Option “A”

- You reassure yourself that Charlene does not need emergency care and tell her that since she has addiction, you cannot prescribe anything for this injury

- This makes Charlene angry and she tells your medical assistant that she is “being treated like an addict!”
- She hangs up on staff and does not make a follow up appointment

Is it possible to make this right? How?

Option “B”

- You ask Charlene a few more questions to make sure that she does not need emergency care; then prescribe her 10 Vicodin, 5 Valium, and 30 Flexeril
- You receive a phone call from the pharmacy asking if you are sure you wish to prescribe these agents considering Charlene is on buprenorphine
- The following day, you receive a phone call from Charlene’s husband stating that he is having a hard time waking her up and wants to know what he should do

Option “C”

- You reassure yourself that Charlene does not need emergency care and you reschedule her to be seen next week. You instruct her to take 200 mg ibuprofen + 500 mg acetaminophen (up to 6 doses/day) and to use ice on her back for 15 minutes 2-3 times today. You educate her with red-flag symptoms that should prompt her to report to the emergency department

- Charlene comes in the following week for her XRB injection
- She says that she is still sore, but feeling much better and says that she was happy to have your reassurance on the day that she fell
- She is having some trouble taking her daily walk, so you offer to send her for a few sessions of physical therapy given her chronic pain history

Option "D"

- You reassure yourself that Charlene does not need emergency care and you prescribe her a Medrol dose pack to help her with her back pain

- Charlene comes in the following week for her XRB injection
- She says that she really struggled to sleep while on the Medrol, but she toughed things through and is feeling a little better on the day of her injection
- She says that she was very anxious about the fall and considered going to the emergency department, but did not
- She is having some trouble taking her daily walk, so you offer to send her for a few sessions of physical therapy given her chronic pain history

Let’s Clarify some things

- Patients in recovery are sensitive to being treated as “less than”
- Option A really made her feel stigmatized and did not employ what we know about treating acute back pain
- Option B would not be considered all that safe for ANYBODY and would not be a first line effort in treating acute pain
- Option C appears to be a treatment plan that you would offer anyone with acute onset of back pain from a fall on the ice, also giving reassurance goes a long way in these circumstances
- Option D although not a bad treatment plan might not have been necessary if she utilized OTC medications and some physical medicine (rest and ice)

Self-Reflection Questions

What were your initial thoughts regarding her question of prescribing “something” for her acute pain? Did you think that she might have been seeking controlled medications? Would you have felt different if she wasn’t a person in recovery?

Did you think that her buprenorphine would “cover” her pain?

What is your confidence level in helping any of your patients in a similar situation?

Summary: Part I

We defined terms commonly used and heard in the context of substance use disorder.

We discussed the multiple medications used for opioid use disorder and how they differ and potential impact on the treatment of pain.

We were introduced to our sample patient: Charlene who presented to your clinic with an acute pain problem.