Best practices in the treatment of chronic non-cancer pain

Not Just a Prescription Pad

Mon Nov.14 | 6:30-8:00 pm PDT

November 14, 2022

WorkSafeBC

Agenda

Nov. 14
Part 2

- Case 2: Phillip: complex chronic pain requiring integration of pharmacological and non-pharmacological pain management strategies including opioid tapering; variations
- Putting it all together: James follow up
- Q&A

2

Disclosures

- Dr. Peter Rothfels
  - Salary paid entirely by WorkSafeBC
  - No financial interest or affiliations with any pharmaceutical, medical device, or communications company
- Dr. Launette Rieb
  - No financial interest or affiliations with any pharmaceutical, medical device, or communications company
  - Consultant for ActumHealth, and St. Paul's Hospital Rapid Access Addictions Clinic
  - Presents at accredited CME event; including those for WorkSafeBC
  - No perceived bias to mitigate

3

Learning objectives

1. Develop confidence to have **difficult conversations** related to broadening pain education and treatment options beyond the prescription pad
2. Apply key pharmacological principles including **tapering** of opioids, initiating **substitution therapy** and medication **exit** strategies
3. Identify community and regional **resources and supports**, including WorkSafeBC programs

4

Part 1 webinar: Recap

- Introduction: enacted scenario: James
- Persistent pain overview
- WorkSafeBC programs and community resources
- Case 1: Sue: demonstrating a bio-psycho-social approach
- Non-pharmacological modalities

To view the Part 1 webinar please visit:
ubccpd.ca/not-just-prescription-pad-multimodal-approach-chronic-non-cancer-pain-management

5

Pathways to Safer Opioid Use videos: Part 1 recap

- James Parker, previously a police officer with history of chronic back pain (currently taking prescribed pain medication for his back pain) overdosed
- One evening, James fell off the couch and sustained a corneal abrasion
  - He visited the ER to treat his eye, and was prescribed antibiotics eye drops and hydrocodone
- The following day, James had a pre-existing appointment with his family physician
  - Minimal information was shared between the health care team (nurse and physician)
- At the appointment, the doctor didn't take the time to make an informed decision together with James
  - He increased his opioid dosage (based on what James told him), and didn't seek alternatives
- On the health.gov website, you can choose to be one of four individuals (physician, nurse, pharmacist, or James) to decide on how to safely manage pain for James

6

Clinical case 2: Phillip

Phillip

54 yr old right hand dominant ironworker with chronic pain: thumb, hand, shoulder

- Sustained a work-related hyperextension injury of right thumb in 2008, seen in 2017
- Arthrodesis (volar plate at MCP joint)
- Carpal tunnel release
- Residual symptoms of neuropathic pain
- Surgeon said "avoid narcotics at all costs" yet on opioids
- Severe depression, nightmares, with PTSD from war experience in Iran as journalist
- Walking his dogs helps – not working

Your thoughts?

Phillip, cont'd

PMHx:

- Zoster (shingles) over left chest wall and back
- Herniated lumbar discs x 2, 2nd surgery "cured"

Meds:

- Opioid dose slowly crept up over many years
- Oxycodone ER 20 mg QID (MEDD 120mg = 122x risk for SUD)
  - Usually takes as directed
  - Gets generalized withdrawal pain if stops
  - He hates taking them and wants off
- Bupropion 150 BID for smoking, lifted mood
- Pregabalin 150 OD for zoster, eased hand pain
- Ibuprofen 400 mg Q4H – helps but getting stomachache
- Clonazepam 0.5 mg HS x years

Your thoughts?

Pharmacological treatments for pain

Non-opioid analgesics

- Acetaminophen
- NSAIDs
  - Systemic
  - Topical

Co-analgesics

- Tricyclic antidepressants
- SNRIs
- Gapapentin/pregabalin
- Other anticonvulsants
- Capsaicin
- Skeletal muscle relaxants
- Cannabinoids

Opioids

- Buprenorphine
- Codeine
- Fentanyl
- Hydromorphone
- Methadone
- Morphine
- Oxycodone
- Tapentadol
- Tramadol

N.B. Benzodiazepines are not on this list

8 med classes in four common conditions

#	Drug	LBP	OA	FM	Neuropathic
1a	**Acetaminophen**		+		
1b	**NSAIDs**	+	+		
2a	**Tricyclics**			+	+
2b	**Muscle relaxants**	+		+	
3a	**Gabapentinoids**			+	+
3b	**SNRIs**	+		+	+
4a	**Tramadol**	+	+	+	+
4b	**Opioids**	?	+(*)		+ (**)
-	**Topical analgesics**	+	+		+/-

Slide courtesy of K. Kroenke – modified L. Rieb added notes: *SPACE trial showed opioids had greater side effects and no improved efficacy over non-opioid tx; **Cochrane review of neuropathic pain oxycodone was ineffective

Sleep/Mood Issues with SUD/Pain

- Education, cognitive therapy, exercise, social support
- For sleep cycle regulation +/- pain
  - Sleep hygiene
  - Sleep compression – reduce time in bed, wake same time every day
  - Caffeine elimination
  - Benzodiazepines contraindicated
  - Tricyclic or tetracyclic antidepressant can be helpful
  - Antipsychotics – can reduce pain (NNT* 3-4), and help sleep
- For pain +/- mood
  - SNRIs (duloxetine, venlafaxine)
- For primary mood issues
  - SNRIs or SSRIs (citalopram, paroxetine, sertraline)

*NNT: Number needed to treat is the number of patients that need to take a medication to get one to have the desired outcome beyond placebo

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH[1,2]; Amy Gravely, MA[1]; Sean Nugent, BA[1]; Agnes C. Jensen, MPH[1]; Beth DeRonne, PharmD[1]; Elizabeth S. Goldsmith, MD, MS[1,3]; Kurt Kroenke, MD[4,5,6]; Matthew J. Bair[4,5,6]; Siamak Noorbaloochi, PhD[1,2]

» Author Affiliations | Article Information

JAMA. 2018;319(9):872-882. doi:10.1001/jama.2018.0899

SPACE trial: Hypothesis and methods

Strategies for **P**rescribing **A**nalgesics **C**omparative **E**ffectiveness trial

- **Hypothesis 1**: Opioids will improve pain related function more than non-opioids
- **Hypothesis 2**: Opioids will cause more adverse side effects than non-opioids

N=240 veterans with LBP, OA knee or hip pain with >5/10 pain despite non-opioid current treatment were randomized to two groups:

1. Opioid medical management
2. Non-opioid medical management

SPACE Trial – Medication Protocol

Opioid group*:

- Step 1: Morphine IR, hydrocodone/acetaminophen or oxycodone IR
- Step 2: Morphine Sustained-release, or oxycodone sustained-release
- Step 3: Transdermal fentanyl

Non-opioid group

- Step 1: NSAIDS
- Step 2: Nortriptyline, amitriptyline, or gabapentin; AND a topical analgesic
- Step 3: Pregabalin, duloxetine, or tramadol

*If no response by 60 mg MEDD, rotation within a step was done prior to advancing

SPACE trial: Results

- Opioid therapy was not superior to non-opioid medication therapy over 12 months
- No difference in pain-related function
- Non-opioids improved pain intensity score slightly more than opioids
- Non-opioids had half as many bothersome side-effects
- **Results do not support long-term opioid therapy in patients with moderate to severe pain**

N.B. Elimination of tramadol responders from the "non-opioid" group does not change outcome

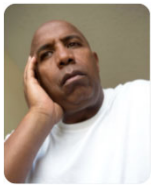
Back to Phillip

Substances:

- Coffee 2 cups, tea 5 cups/day
- Tobacco 1PPD to 3 bowls/day
- Occasional THC cookie/toke (he reports better sleep, less pain)
- No alcohol x 10 yrs since the accident, some binge drinking prior

What if he was still binging?

- No stimulants, no opium, or other illicit opioids
- Brother: alcohol use disorder – died of cirrhosis



Your thoughts?

Systematic review of systematic reviews for medical cannabinoids

Pain, nausea and vomiting, spasticity, and harms

G. Michael Allan MD CCFP Caitlin R. Finley MSc Joey Ton PharmD Danielle Perry Jamil Ramji Karyn Crawford MLIS Adrienne J. Lindblad ACPR PharmD Christina Korownyk MD CCFP Michael R. Kolber MD CCFP MSc

e78 *Canadian Family Physician | Le Médecin de famille canadien* ▸ Vol 64: FEBRUARY | FÉVRIER 2018

Conclusion: There is reasonable evidence that cannabinoids improve nausea and vomiting after chemotherapy. They might improve spasticity (primarily in multiple sclerosis). There is some uncertainty about whether cannabinoids improve pain, but if they do, it is neuropathic pain and the benefit is likely small. Adverse effects are very common, meaning benefits would need to be considerable to warrant trials of therapy.

Allen et al., 2018 – cont'd

- **Average pain reduction with cannabinoids:**
  - cannabinoids 1.5/10
  - placebo 1/10

N.B. This reduction **(0.5/10)** beyond placebo is about that of acetaminophen
— L. Rieb comment

- **NNT* for a 30% neuropathic pain reduction = 11–14**

N.B. This means we should be taking about 11 patients back off cannabinoids for every 12 we start, yet this rarely happens — especially if give 1 year authorization — L. Rieb comment

*NNT: Number needed to treat is the number of patients that need to take a medication to get one to have the desired outcome beyond placebo

19

Effect of cannabis use in people with chronic non-cancer pain prescribed opioids: findings from a 4-year prospective cohort study

Lancet Public Health 2018; 3: e341-50

Gabrielle Campbell, Wayne D Hall, Amy Peacock, Nicholas Lintzeris, Raimondo Bruno, Briony Larance, Suzanne Nielsen, Milton Cohen, Gary Chan, Richard P Mattick, Fiona Blyth, Marian Shanahan, Timothy Dobbins, Michael Farrell, Louisa Degenhardt

- Prospective, national cohort study of people (N=1,514) with CNCP being prescribed opioids in Australia followed for 4 years
- **Cannabis did not improve patient outcomes**, instead…
  - Greater pain
  - Lower self-efficacy in managing pain
  - No opioid-sparing effect
  - No functional improvement
- Thus, we cannot advise this substance for Phillip

20

Opinion

VIEWPOINT

Should Physicians Recommend Replacing Opioids With Cannabis?

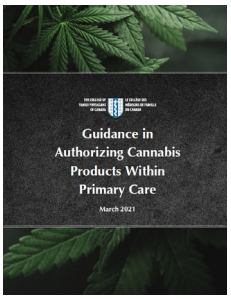
Humphreys K, Saitz R. JAMA Published online February 1, 2019

> "To date, no prospective evidence, either from clinical trials or observational studies, has demonstrated any benefit of treating patients who have opioid addiction with cannabis."

21

Cannabis resources

- The College of Family Physicians of Canada
  - Guidance in Authorizing Cannabis Products Within Primary Care, March 2021
  - cfpc.ca/CFPC/media/PDF/CFPC-Guidance-in-Cannabis-Within-Primary-Care.pdf
- College of Physicians and Surgeons of British Columbia
  - Practice Standard – Cannabis for Medical Purposes, February 2021
  - cpsbc.ca/files/pdf/PSG-Cannabis-for-Medical-Purposes.pdf



22

Dosing example for dried Cannabis

- Please specify dose, percent THC and CBD, days, total grams of dried product
- E.g. Dried cannabis 1-2 puffs q5-6h prn, 0.5 g/day maximum, 9% THC maximum, 9% CBD minimum, for 30 days, dispense 15 g
- And can add a ratio CBD:THC (20:1, 10:1, 5:1, 1:1)

"Average joint" = 0.5 g

Not this

What if considering "Edibles"?

- We have other non-cannabinoid medications with better efficacy
- Instead of edibles, try nabilone and nabiximols (Sativex)
- If pure CBD is desired – consider hemp products
- Virtually no literature on edibles – outside all guidelines
  - = oral cannabis products off prescription
- Many formulations exist from Licensed Producers (LPs)
- Often very concentrated – check dose and concentration – calculate mg/d
- For example:
  - **THC/CBD studied for pain typically 5 to 40 mg/day (one 65 mg/day)**
  - **Remember nabiximols (Sativex) max THC and CBD = 32 mg/d**
  - Patients sometimes take **2-200x** beyond what is medically indicated or studied so are using beyond our knowledge of benefit and side effects

Table 3. Dosing of cannabis oils: Using the percentage of THC or CBD and volume to determine the milligrams dosage (1 millilitre = 1 gram = 1,000 milligrams of oil)

Volume in mL or cc of Oil (mg of CBD or THC)	1% THC or CBD	5% THC or CBD	10% THC or CBD	15% THC or CBD	20% THC or CBD	25% THC or CBD
0.2 (200)	2 mg	10 mg	20 mg	30 mg	40 mg	50 mg
0.3 (300)	3 mg	15 mg	30 mg	45 mg	60 mg	75 mg
0.5 (500)	5 mg	25 mg	50 mg	75 mg	100 mg	125 mg
1 (1,000)	10 mg	50 mg	100 mg	150 mg	200 mg	250 mg
10 (10,000)	100 mg	500 mg	1,000 mg	1,500 mg	2,000 mg	2,500 mg
20 (20,000)	200 mg	1,000 mg	2,000 mg	3,000 mg	4,000 mg	5,000 mg
30 (30,000)	300 mg	1,500 mg	3,000 mg	4,500 mg	6,000 mg	7,500 mg
40 (40,000)	400 mg	2,000 mg	4,000 mg	6,000 mg	8,000 mg	10,000 mg
50 (50,000)	500 mg	2,500 mg	5,000 mg	7,500 mg	10,000 mg	12,500 mg
100 (100,000)	1,000 mg	5,000 mg	10,000 mg	15,000 mg	20,000 mg	25,000 mg

What if considering "edibles"?

- Virtually no literature on edibles – outside all guidelines
- Many formulations exist from Licensed Producers (LPs)
- Often very concentrated – **check dose and concentration**

- **Start with high CBD: THC ratio:**
  - One LP told me they can label "no THC" if under ~1.5% THC
  - "All CBD" or "20:1" oral solution are examples

- **Start with just one dose at night, titrate slowly**
- Introduce more THC cautiously, typically just at night and keep amounts low (avoid high THC low CBD products)

- **MD should monitor** if involved with the document
- Warn about driving – no authorization if safety sensitive or critical work (even driving their own vehicle is a risk)

(L. Rieb – clinical experience)

26

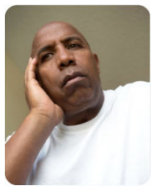
Edible calculation

- The base oil is written as 1 mL = 1 g
- 1 mL of a 20:1 ratio CBD:THC does not provide enough information to calculate the dose
- 1 mL of CBD 20 mg/mL = 20 mg
- 1 mL of CBD 20% = 200 mg
  - So, 0.2 - 0.3 mL/day max is appropriate
  - Divide this 0.1 mL BID – TID
  - Look at their dropper
- Consider starting with topicals

Phillip

Px:

- Looked exhausted and bit sad, full range of affect
- Right shoulder AC joint impingement signs
- Myofascial trigger and tender points
- Neurologically intact aside for decreased sharp sensation in median nerve distribution from wrist distally
- UDS + oxycodone + benzodiazepine + THC
- Family physician worried about "drug abuse"



28

Guidelines for opioid prescribing for chronic non-cancer pain

- CPSBC practice standard, 2022 cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf
- Canadian guideline for opioid therapy and chronic noncancer pain, 2017 cmaj.ca/content/189/18/E659
- US CDC guideline for prescribing opioids for chronic pain – United States, 2016 cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- Draft US CDC guideline for prescribing opioids for chronic pain – United States, 2022 cdc.gov/media/releases/2022/s0210-prescribing-opioids.html

29

When to suggest opioid taper?

- On opioids **without significant improvement** in pain and function
- Suspect **tolerance** and **opioid induced hyperalgesia (OIH)**, including spread of pain in the absence of disease progression
  - Allodynia, hyperalgesia, withdrawal symptoms
- Active **substance use disorder** where opioid maintenance therapy is not viable
- **Safety sensitive and decision critical activities**
- **Patient requests to taper or discontinue**
- On **over MEDD 90 mg** and not trialed a taper

30

Where to start?

- **First make a diagnosis**
  - Use? Substance Use Disorder?
- **Is there physiologic dependence?**
  - Is a withdrawal syndrome present?
  - How severe? Life threatening?
- **What is the patient's circumstance?**
  - Support setting? Mental and physical health?

31

Opioid withdrawal

Withdrawal is not life threatening

- Unless patient is pregnant, has a history of seizures, gets dehydrated, or is suicidal – then careful monitoring is needed

Warn patients of the elevated risk of overdose post detox due to loss of tolerance if they reinitiate opioids

32

Opioid lowering options

1. Convert to long-acting opioid – taper
2. Taper with short-acting opioid
3. Opioid substitution/rotation – taper

33

Typically…opioid tapering is not an emergency!

- Some can drop 5-10% every 1-2 weeks, sometimes slowing to every 2-4+ weeks for the last 20%
- **For patients on LTOT for many years who have failed more rapid tapering, just slow it down to drop 5% every 1–3 months**
- In a year they will be down 20-60%, and by 2 years 40-100%. But this is ridiculously slow if they have only been on a year or less
- **Adverse effects of opioids are dose dependent, so lower dose**

34

Opioid tapering – from long-acting

Convert short-acting opioids to long-acting then taper:

- **Week 1** — Convert 75% of the short acting into long acting and give the remaining 25% as short-acting PRN dosing — warn to use as little as possible
- **Week 2** — See what PRN used, and convert this to long
- **Once on just long acting** — begin taper as per previous slide

N.B. Do not taper so fast that the patient has unmanageable withdrawal and seeks illicit opioids

35

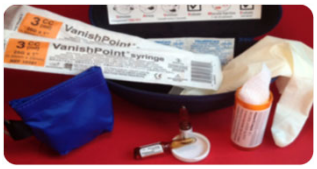
Phillip: Tx recommendations

- Trial of **opioid tapering** — pain education, PT, OT, psych, pharmacist, MD
- Taper oxy to elimination, try 10% reduction every 7d
- Trial of **prazosin** 1 mg HS titrated up to max 9mg HS
- Retry **trazodone** (no side effects with one dose)
- Move **pregabalin** to HS, and add small daytime doses
- Add **rabeprazole**
- Change ibuprofen PO to topical **diclofenac gel 10% with menthol 4%**
- Slow **clonazepam taper** — compounded into 5ml, drop 0.1 mg Q2-4+ weeks, keeping the volume the same for each drop
- Stop cannabis (unless a "pure" CBD product)

36

WorkSafeBC will cover naloxone

Recommend take-home **naloxone** to all patients who are on opioids for pain or due to an opioid use disorder



37

Contracts and collateral assessment

- **Opioid manager** – healthsci.mcmaster.ca/npc/opioid-manager
- **Opioid contracts** — e.g., CPSBC, WorkSafeBC, or write your own
- **PharmaNet** — prescription monitoring
- **Urine drug screening** — baseline before starting any addictive substance, then random every 4-12 weeks, name synthetic opioids
- **Pill counts** — call back by MD or pharmacist
- With permission **ask relatives and/or friends** about sedation, sleep apnea, behaviour

38

Back to Phillip

- **Prazosin** titrated to 4 mg HS — first time in years the nightmares subsided substantially in frequency and content
- He did well for the **first 30 % drop of oxy** — 10% every 2 weeks — opioid withdrawal symptoms and injury site pain would escalate after each drop, then settle
- **When trying to go lower, he had trouble** with withdrawal symptoms, his mood started to drop, nightmares increased, limb pain increased, and the post herpetic neuralgia pain returned

39

Back to Phillip

- We had to slow the oxy taper to 5% every 2 weeks to then drop to 5% per 3 weeks, then 5% every 4 weeks until off
- The taper off opioids and benzos took 5 months
- Daytime pregabalin made him too dizzy so kept at HS

40

Phillip – at end of PMMP and follow up

- **Calmer, happier, mentally clearer**, in tears when speaking about how much his life has improved
- Pain "about the same or a **bit less**" off opioids
  - How common is this? Very! Most studies show pain the same or less after opioid detox, only 10% have more pain once withdrawal symptoms over
- **His wife really happy with the change — had him "back"**
- Sleep was **nightmare free** on some nights, and reduced frequency and intensity on other nights
- **Function increased** — started volunteer dog walking

41

Phillip Summary

He had a complex pain experience:

- Premorbid: possible genetic predisposition, binge drinking, and trauma history
- Injury and local pathology
- Chronic pain - central sensitization?
- Depression
- Disabled lifestyle
- Pain from opioid use and w/d:
  - OIH, WIH, WISP and general w/d pain
- **Overall, he felt better and more functional once active and off opioids and benzos**

Your thoughts?

42

Key things to remember

- Adequate trial of suitable non-opioid analgesics +/- adjunct agents is recommended before considering opioids
- "I've tried that and it didn't work!" Assess dose and duration to determine if trial was adequate
- "The drug had too many side effects!" Start low, go slow and counsel that side effect often diminish within 1 to 2 weeks
- Try alternate drugs within a therapeutic class before determining that the class is ineffective
- Combine medications with different sites of action for synergistic effect
- **Pain reduction and improved function, not pain elimination, is the goal**

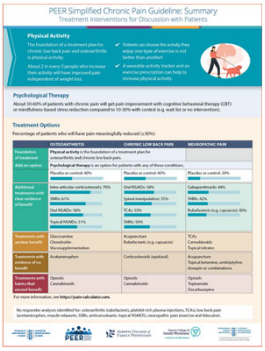
43

Medications are a fantastic tool, but if they are not working…

- Review the diagnosis – Repeat Hx/Px
- Tolerance, opioid induced hyperalgesia, substance dependence or diversion?
- Screen for depression, anxiety, and PTSD
- Explore perception of disability & meaning
- Consider somatoform disorders
- **Avoid iatrogenic pain and suffering**

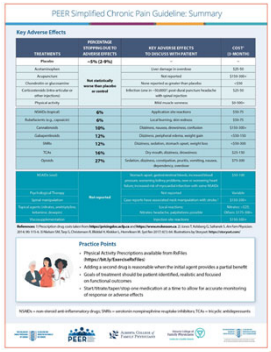
44

Peer Simplified Chronic Pain Guideline: summary



Canadian Family Physician, Vol.68, Issue 3 Mar.1, 2022 *PEER simplified chronic pain guideline*
www.cfp.ca/content/68/3/179

Peer Simplified Chronic Pain Guideline: summary continued



Canadian Family Physician, Vol.68, Issue 3 Mar.1, 2022 *PEER simplified chronic pain guideline*
www.cfp.ca/content/68/3/179

Grade quality-of-evidence for all recommendations

Canadian Family Physician, Vol.68, Issue 3 Mar.1, 2022 *PEER simplified chronic pain guideline*
www.cfp.ca/content/68/3/179

Advanced presentation: Clinical case 2: Phillip - variations

48

Poll question
Advanced NJAPP presentation topics and content

A. What if Phillip had trouble getting off high dose opioids?
B. What if Phillip had trouble getting off the last 10–20% of opioid?
C. What if he could not get off opioid?
D. What if Phillip had an opioid use disorder?
E. What if Phillip was drinking heavily and/or doing cocaine?
F. How could Phillip's situation have been prevented?

Your thoughts?

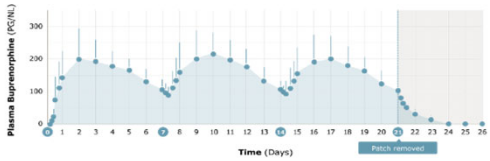
49

What if Phillip had trouble getting off the last 10–20% of opioid?

Your thoughts?

50

Buprenorphine Transdermal Patch



- Use buprenorphine (BuTrans) patch every 5mcg/h = 10-20mg MEDD
  - Substitute in BuTrans 5 mcg/H, and drop habitual opioid 10-20mg MEDD every week until converted over
- Can even use in opioid naïve as well as tolerant patients, unlikely to precipitate withdrawal from other opioids unlike using Suboxone

51

Bup patch induction for CNCP

- If morphine equivalent daily dose (MEDD) is 80–100 mg or less, you can use a buprenorphine patch
- BuTrans 5 mcg/h = MEDD 20 mg
- BuTrans 10 mcg/h = MEDD 40 mg
- BuTrans 20 mcg/h = MEDD 80 mg
- Start with 5 mcg/h, and remove 20 mg MEDD of their current other opioid
- Changed every 7 days — increase patch, while removing other opioid until only on BuTrans
- N.B. — Patch too low a dose to show bup in UDS

52

What if he could not get off opioids?

Your thoughts?

53

- Check for sleep apnea – CPAP if needed
- Check for testosterone suppression – replace if needed
- Check liver and renal function
- Assess risk for falls
- Assess risk for MI
- Assess for safety sensitive work or recreation
- Assess mood and cognitive function
- Is there demonstrable functional benefit to opioid use?
- Is opioid use integrated with non-medication and non-opioid strategies?
- Is the opioid dose at 90 MEDD or below? Or, if above has there been a trial of slow opioid tapering in recent years? Rotation?
- Is the worker on buprenorphine at any dose?
- **If answers are favorable then maintenance can be considered**

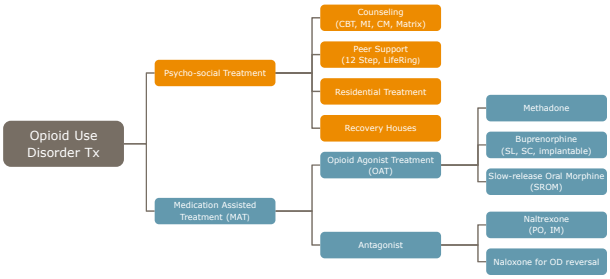
54

What if Phillip had an Opioid Use Disorder?

Your thoughts?

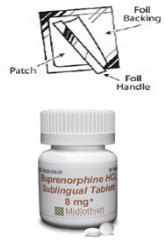
55

Opioid use disorder Tx



56

Buprenorphine in Canada



Suboxone
(buprenorphine HCl/naloxone HCl dihydrate)

57

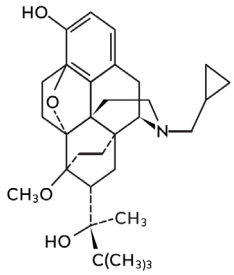
Buprenorphine

High receptor affinity

Marketed as a mu opioid receptor "partial agonist" based on in vitro studies, BUT…

In Vivo – as good as morphine for analgesia with a ceiling for respiratory depression

Kappa opioid receptor antagonist



• HCl

58

Buprenorphine Points

- Converting from other opioids to **buprenorphine** for detoxification or maintenance for opioid use disorder:
  - No longer need a methadone exemption first
  - Additional training is recommended
- Converting from other opioids to **buprenorphine** for detoxification or maintenance for chronic noncancer pain (CNCP) is currently off label in U.S. and Canada

59

Buprenorphine Advantages

- Respiratory ceiling effect — **decreased OD** risk
  - Protection lost with benzodiazepine co-ingestion
- When given as buprenorphine/naloxone SL AKA BUP-NX 4:1 — injection can precipitate withdrawal thus **discouraging diversion** for IV use
- Kappa antagonism acts as an **antidepressant**
  - In Europe BUP-NX is used with oral naltrexone to treat depression (the naltrexone cancels the mu opioid agonist effect)

60

Daitch, 2014

Pain Medicine
Pain Medicine 2014; ·: ··–··
Wiley Periodicals, Inc.

Conversion from High-Dose Full-Opioid Agonists to Sublingual Buprenorphine Reduces Pain Scores and Improves Quality of Life for Chronic Pain Patients

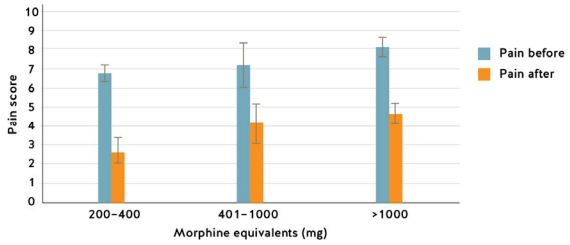
(Daitch et al. 2014)

Retrospective chart review of CNCP patients on over 200 MEDD converted from other opioids to BUP-NX

- **Pain scores averaged 8/10 pre-conversion**
- **4/10 post conversion**

61

Pre- and post-conversion pain scores by pre-conversion morphine equivalents dosage



Daitch, 2014

62

What if Phillip was drinking heavily and/or doing cocaine?

Your thoughts?

63

Poly-substance use

- Residential treatment is recommended if opioids are being used in combination with cocaine or alcohol (or other significant non-nicotine-based drug use) that is not responding to advice alone, outpatient treatments, and is (or may) cause harm
- Also recommend residential tx or hospitalization if there is a significant risk of harm to self or others, or there is severe co-morbid psychiatric issues

64

How could Phillip's situation have been prevented?

Your thoughts?

65

Analgesic Efficacy of Opioids
(Ballantyne, 2006)

- Only **1 out of every 3 or 4** patients get some pain relief with opioids initially, the others should be taken off right away, not left on with other medications added
- Average just **20–30% analgesia**
- Fantasy that endless dose escalations will provide further reductions in pain
- NB. Busse 2018 — **only 1 in 7-11 get relief** this level of relief for CNCP
- **So TAKE PHILLIP OFF early if not responding**

66

Putting it all together

Reintroducing James

From: Pathways to Safer Opioid Use, created by the Office of Disease Prevention and Health Promotion (health.gov)

68

Poll question

What would you do?

A. Double his opioid medication and let him know this is the best way to reduce his pain right now.

B. Assess his risk for misuse, then discuss the bio-psycho-social nature of pain and his integrated care plan.

69

James

From: Pathways to Safer Opioid Use, created by the Office of Disease Prevention and Health Promotion (health.gov)

70

James

From: Pathways to Safer Opioid Use, created by the Office of Disease Prevention and Health Promotion (health.gov)

71

Remember to...

- Offer **Hope**
- Encourage self-efficacy
- Work together
- Attempt first to do no harm

72

> To the love of his profession the physician should add a love of humanity
>
> — Hippocrates, 460 BCE-370 BCE

> To the love of their profession the health care provider should add a love of humanity
>
> — Dr. Peter Rothfels, 2022

73

Summary

- Chronic pain is not acute pain
- Remember the biopsychosocial (spiritual) approach
- Be willing and prepared to engage in a difficult conversation
- Engage in goal setting and action planning
- Exercise/Activity is crucial
- Staying at work or returning to work is therapeutic
- Use a ladder approach to treatment

74

Questions

Thank you
for attending