WEBINAR VIDEO TRANSCRIPT

Opioid Addiction Treatment ECHO

Pain management in people who have OUD; acute vs. chronic pain

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INSTRUCTOR: So, those are the things that we're gonna focus on today. We'll talk first about the complexities of treating acute and chronic pain in patients who have Opioid Use Disorder, and then look at ways that our approach may need to be a little different when we're working with folks who have Opioid Use Disorder. And particularly if they're on agonist medication or for that matter if they're on antagonist medication.

The areas of pain and addiction have a fair amount of overlap, they often occur in the same people, and there are lots of opportunities for mistrust, misunderstanding, for people to feel like they're not being heard or having their needs met. For the medical provider, medical providers are often in sort of, they frequently experience being in a tug-of-war with patients, the patient wanting prescriptions for opioids, the provider saying no, for whatever reason. So they're use to sort of a polarized interaction. They may tend to perceive patients as drug seeking, namely manipulative for the purposes of getting opioid drugs, they may have difficulty telling whether someone has a substance-use disorder, versus physical dependence versus appropriate use of prescribed opioids, versus, are they really in pain, how do we assess what's going on, and that whole access of pain versus no pain, and Opioid Use Disorder versus not.

For the patient, most patients who have chronic pain and have been treated with opioids, and most patients who have Opioid Use Disorder, have experienced being treated in a non-empathetic way by the system, and they may anticipate being treated poorly, when they come into care. So, that can set up a bad dynamic from the beginning. The patient may wanna avoid talking about these issues, because they're afraid of being judged, of not having their needs met, and so there's kind of an environment of mutual fear and distrust. We know that when patients are physically dependent on opioids, they have less pain tolerance, and that is particularly true when they're on an agonist medication, like buprenorphine or methadone.

Studies have shown, for a lot of years, that for instance, a woman who's treated with methadone, who has a caesarian, a surgery for a caesarian delivery, will have less pain tolerance than someone who's not on opioid agonist therapy. An updated study by Dr. Meyer, who said it here, from 2007, she published another paper in 2010, looking at women who were treated with buprenorphine, and looking at what they experienced when they gave birth, and found just like with methadone, that women experience more pain, reported more pain during and after the caesarian, and needed more opioid agonist to control their pain. So, kind of a different profile that we're working with, when we're working with pain patients in this setting.

A really important thing to do, when you're working with a patient with pain and issues with opioids, is to take a deep breath, and think about your attitude and approach coming into the room. Developing a relationship with a patient that's characterized by mutual respect is absolutely key to having a successful interaction, and some of the ways to get there are to have and portray a non-judgmental attitude, and just as with other patients, to try and understand the patient's goals, and help the patient to reach those goals. So, in other words, a patient-centered approach.

Some of the skills that are needed, that are helpful, are certainly motivational interviewing, skills which help to elicit the patient's goals and strengthen the patient's motivation for health-goal activities that approaches, and reflecting the patient's perspective. So, instead of challenging or invalidating, to try to find ways to affirm and reflect what the patient is telling you, that he or she is going through. And finally, just knowledge of Substance Use Disorder and pain management. So, when you approach treating patients who have an opioid use disorder, it's helpful to have a really frank conversation about the potential for relapse, so patients are worried about this typically, they know that if they have an opioid use disorder, and they've been on agonist therapy, and now they're again being exposed to the acute effect of opioid full-agonist, that it can cause relapse. And talking with the patient about what are the options for management and what are the risks and benefits, and disclose different options. Setting up a treatment plan that you can agree to in advance. When I'm working with a patient, for instance, who is on buprenorphine treatment, or making a plan to treat them through a surgery, will actually establish timelines that we sort of agree on, for additional opioid agonist medications, and both sign off on that. It doesn't mean it can never be changed, but it sets a baseline expectation for what's going to happen. So that the patient isn't expecting that I am gonna continue to prescribe oxycodone for a month or two months, but instead we have a realistic sense of how long that's going to be. But everybody is better with social support and family involvement, when that's possible, can be really helpful. It's also, as with any other changes that we make when we're treating patients who have Opioid Use Disorder, it's really important to offer and encourage a soon follow-up. So if you sort of say, great, here's the plan, you're gonna have your surgery, here's the meds, and good luck, and I'll see you in a month in a half or two months, things may go very wrong and you ought to know about it. So, setting up early follow-up, even it's by phone, or other electronic means of communication, can be very, very helpful. And finally, multi-disciplinary approach is pretty key. Consulting and discussing things with surgeons when a surgical plan is involved, is pretty darn key to making sure that everybody's on the same page, and involving behavioral health support. And peer support workers, community health workers, can be super helpful. You probably all are aware that when pain is uncontrolled, it can lead to a whole cascade of unfortunate consequences. When someone has uncontrolled pain, they tend to do things to avoid exacerbating the pains, so if you have pain when you walk, you try not to walk. This decreases your mobility, it may slow or impede healing, your functional status may drop, you feel worse about yourself, you start to limit your social interactions, and you end up with more pain. So, avoiding this kind of cycle, is a really important goal, in all pain conditions, and it's an important one to keep in mind in patients who have a co-occurring Opioid Use Disorder. The difference between pain and suffering is an important distinction. The Buddha, 2,600 years ago, talked about how pain is inevitable, but suffering is not necessarily inevitable, but suffering is a lot about the overlay that we bring to the pain. The thoughts about, oh, this pain is making me miserable, and my life is never gonna be the same, or oh, what did I do to deserve this, or why is this happening to me. Or just obsessing about the pain and letting it take over your whole

consciousness, are all examples of suffering as opposed just to the indirect physical experience of pain. A lot of patients who have a Substance Use Disorder, have co-occurring conditions that make them more likely to experience pain as suffering, such as emotional trauma, particularly childhood trauma, which sets people up to have a lot of difficulty dealing with stressful events. Lack of effective coping skills, if you're somebody who has reached for a pill or a needle whenever you have a highly stressful event, and you don't have that available to you, or you're trying to avoid it as an option, it is another setup for feeling trapped, feeling hopeless, and helpless, when you have pain and are unable to deal with it. And people, certain subset of patients may have more dependent traits and not be prepared to problem-solve on their own. Another important issue to think about is, involvement of benzodiazepines. We've talked about this a number of different times in various contexts. Patients who have pain and an opioid use disorder, often present with a lot of anxiety, and so there can be a temptation to reach for a benzodiazepine prescription as a way of addressing that. This slide just illustrates the really marked increase in overdose risks for patients who are receiving opioid treatment and also benzodiazepines, compared with benzo alone, illustrating that this really is an unsafe combination, and so it's very important to avoid benzodiazepines as an option in patients who are being treated with opioids. Cognitive behavioral therapy, other psycho-social approaches and if you want to go with medication starting with SSRI's, are a few of the options that are available. It's good to think about alternative therapies for chronic pain, rather than that old opioid prescription, that is so commonly what we think of in primary care and medical practice in general. There are quite a lot of psychological interventions that have been shown to help patients to cope with pain. Cognitive behavioral therapy is a whole approach to pain and other problems that involves analyzing what you're thinking and trying to change the way you think about the situation. It can also involve ways of diverting yourself or distracting yourself from that obsessive focus on the pain stimulus. Behavioral therapy refers to a whole group of approaches that include trying to increase pleasurable activities, ways of engaging with the world that aren't just focused on the pain or avoidance of pain, stress monitoring, and stress reduction approaches, and setting realistic goals and achieving satisfaction from managing to achieve those goals. There's also lost of non-opioid approaches to pain management that involve medications or other medical interventions, so I think you're probably mostly aware that anti-inflammatory medications, anti-convulsants such as gabapentin, anti-depressants, and topical agents, such as lidocaine gel, can all be options. Non-pharmacologic physical interventions, like exercise, massage, acupuncture, ways of stabilizing a joint or changing the orientation of a joint, such as orthotics, can be helpful, and then more interventional-type things, like nerve blocks or steroid injections. So, it's quite helpful when you have a patient who has an opioid use disorder and is having pain, to really focus on these other strategies for addressing the pain, because they don't have the same kind of side effects and pitfalls that using opioids do in this population. When you're confronting a painful condition that a patient's having when they're on agonist treatment, our approach has kind of changed over time. In general, our approach now is to maintain the current agonist treatment, so keep going with the methadone and the buprenorphine, but a few tricks of the trade are first to recognize that the analgesic effect of these medicines is shorter than their effect in staving off withdrawal or craving. So, a patient may be okay taking their buprenorphine once a day, or their methadone once a day, just to prevent them from having withdrawal or craving or relapsing, but as a pain intervention, that analgesic effect only lasts a short amount of time. Typically, somewhere in the neighborhood of six to eight hours. So, when you think, oh my gosh, how can this

patient be having pain, she's on 80 milligrams of methadone, there are two fallacies to that. One is, she's already tolerant to the 80 milligrams of methadone, so she has acute pain on top of the baseline, that 80 milligrams of methadone is not going to do much for that. But secondly, she only gets that methadone once a day, and it's for treatment of an opioid use disorder, and so for most of the 24 hours, she's not receiving an analgesic opioid effect. Sometimes we do need to add opioids on top of the opioid agonist maintenance therapy that we're using for their opioid use disorder, and typically, you have to anticipate that the opioid analgesic doses will be higher, because of cross-tolerance and increased pain sensitivity, compared with patients who are not on opioid agonists. And as we've talked about, the risk of relapse is there, although the risk of relapse may be higher with inadequate pain management, and simply with adding an opioid agonist to the maintenance therapy. For methadone, the strategy is to continue their once-daily methadone dose, which is what they can get in an opioid treatment program. OTT's can typically divide up the dose, and give a smaller dose two or three times a day, and then adding a full agonist. So, if you have a patient who has a painful fracture, they're on methadone, you would had hydrocodone or oxycodone or some other opioid on top of the methadone. Again, the treatment agreement can be helpful to make a plan for how long that's gonna continue, and when its going to taper off, and post-monitoring is definitely indicated. For a patient who has chronic pain, we, as we all know, chronic opioid therapy, there's not a lot of evidence for its benefits in chronic pain conditions, but if you do decide that you need to add on an opioid, you do have to dose it more frequently than the methadone is dosed. Sometimes it can be hard to tell whether the patient's having a pain that is going to be relieved by adding a short-acting opioid, or is actually experiencing withdrawal, and it's causing them to have body pain. So, thinking about the timing of that is critical, because pain due to withdrawal will typically occur 24 hours or more after the last methadone dose. We've talked about how the methadone from an opioid treatment program is typically only discussed once a day, but you can run into problems if a patient is on methadone maintenance, and you add an additional opioid to that, because the patient's gonna get tested at the OTT, and is going to be confronted if their urine drug test shows another opioid in their system. So it is very important to communicate with the OTT providers, if you're prescribing an additional opioid agonist, and explain why and what the expected time course is. What about buprenorphine for treatment of pain? As you all may be aware, buprenorphine plus naloxone, the commonest brand name being Suboxone, was developed and marketed with approval for treatment of Opioid Use Disorder, not for pain. However, it is legal to use it for pain, and it's quite frequently used in an off-label fashion for treatment of pain, it's very effective. It's particularly wonderful for treatment of pain in someone who has an Opioid Use Disorder. Again, it's important to remember that you need to divide up the dose to TID or 2ID, three or four times a day, if you're using buprenorphine for pain as opposed to just treatment of the opioid use disorder. The other side is, the converse of that is not true. So there are some forms of buprenorphine that are only approved for pain, and you can't use those legally for treatment of Opioid Use Disorder, just because of the attitudes of our drug laws. So, for instance, Butrans is a patch that's approved for treatment of chronic pain, and it is not legal to prescribe that for treatment of Opioid Use Disorder. Strange but true. I think we've also emphasized the safety of buprenorphine. This is a pair of graphs from a study looking at the impact of increasing the dose of injected parenteral buprenorphine, used in an in-patient setting, and you can see that on the left, doubling the dose of buprenorphine didn't really produce any significant change in the slowing of breathing that occurs with a lower dose of buprenorphine. It's about the same with a higher

dose, and in neither case does it cause dangerous respiratory suppression. On the other hand, look at the difference in analgesia, or pain effect. So, the doubling of the buprenorphine dose on the right, in the clear circles, shows you that you get a lot more pain relief, or analgesia, from the higher dose of the buprenorphine, without the greater respiratory suppression. And this is just emphasizing the point, that buprenorphine doesn't really cause people to stop breathing, unlike other opioids. So it's much, much safer in that way. When you're working with a patient who is on buprenorphine maintenance, who has acute pain, the first rule is to approach stabilization, if that pain was non-medication methods and secondly, was not opioid methods. You wanna split up that buprenorphine dose and you can certainly prescribe a higher dose, temporarily, with buprenorphine. That can be very effective for oral surgery, for all kinds of acute pain stimulus, just, increasing the buprenorphine dose to do it. But, unlike what we used to think, you can also add a regular opioid, a non-buprenorphine opioid on top of the buprenorphine, and it will still have pain-relieving effects. This is quite contrary to what we taught and believed for years, but it appears to be absolutely true. Both from studies, and from my experience with patients. So you don't have to stop the buprenorphine in order to get the additional opioid agonist pain-relieving effect from the opioid that you prescribed on top of it. So they can continue their buprenorphine, and if you choose too, you can add oxycodone or hydrocodone for instance, and get pain-relieving effect from that. In the face of surgery, there's, sort of the old approach, was to stop the buprenorphine before someone had surgery, move them over to a full opioid agonist, whatever that was gonna be, whether it's oral or parenteral, and then resume the buprenorphine after a few days. Now, we're really moving to a different approach, because it's been found that continuing your buprenorphine right through the surgery, day of surgery, day after surgery, the whole thing, you don't stop it, actually results in better pain control for the patient. Most studies have shown that you have to use higher additional doses of the full opioid agonist on top of the buprenorphine. Some studies show you actually don't use much more at all, if any more, that the same opioid dose that can be used on someone else is effective in the patient who's on the buprenorphine. And overall, the patient who's maintained on their buprenorphine, does better. They return to functional status more quickly, and get out of the hospital more quickly, compared with a patient that has the buprenorphine stopped, goes on full opioid agonists alone, and then has to restart the buprenorphine. What about if you're working with a pain patient who doesn't have an opioid use disorder? These patients also can actually really benefit from buprenorphine if you're thinking about an opioid for treatment of pain. A study that I love by Herbert Malinoff from 2005, is still relevant, even though it's getting to be an old study. He took, I think, 85 patients who had chronic pain and poor functional status, who were prescribed opioids, but very few of whom apparently met criteria for opioid use disorder, and he tried changing them over to buprenorphine to see what happened to them, and the vast majority actually reported that their pain was better, and were observed to have better functional status on the buprenorphine, compared with the chronic full-opioid agonist medications. So, I do this fairly often. Medical providers will send patients to me in this situation and switching them over to buprenorphine often results in a significant improvement in their functional status along with a decrease in risk, because they're no longer at such high risk of opioid overdose. What about starting someone on buprenorphine for pain, if they're not opioid tolerant or opioid dependent? You have to be pretty careful here. You do not wanna do the same thing you would do if you're introducing a patient on buprenorphine, when they have active Opioid Use Disorder, that are tolerant, cause you'll make them wicked sick. So, you wanna aim more for one or two

milligrams, two or three times a day, as opposed to eight or 16 or 24 milligrams a day. So start very slow. You'll often get very adequate pain relief with those very small doses. You may have to creep up a little bit over time, but in general, someone who was opioid naive, you're not gonna have to get up into the super high doses. There's a little bit of controversy or varying outcomes about whether chronic pain in general worsens outcomes for patients who are on medication treatment of opioid agonist treatment for Opioid Use Disorder. Some studies have shown worse outcomes, and some haven't, basically. Just a little bit on extended release naltrexone. This is the injectable opioid antagonist. So remember, all the other medications we've talked about, activate the opioid receptor. Almost all the ones we've talked about that are full activators, full agonists of the opioid receptor, whereas buprenorphine is a partial activator, it turns it on partway, and naltrexone is an opioid blocker. So it grabs ahold of that new opioid receptor and it holds on like crazy, and it doesn't let anything else come along and attach to it. When it's, you use the injectable, it's active for a month, so, it can block the effects of opioids for a full month, and it has been shown to help reduce the risk of relapse. And these patients, again, you wanna start with either non-pharmacological therapies, or non-opioid therapies, and it's kind of all the same medications that we looked at earlier as a patient. If you do have someone who has a really severe painful stimulus while they're on naltrexone, it can be pretty hard to manage, because opioid treatment is not gonna be effective, unless they're real close to the end of that month, when their opioid buffer starts to wear off. And oftentimes, they actually have to be put in the intensive care unit and given extremely high doses of opioids to try and overcome the naltrexone blockade. So, not something to try at home, needless to say. In elective surgery, you wanna stop oral naltrexone, pill naltrexone, at least three days prior to the surgery, and if they're on the injectable naltrexone, and you can schedule the surgery, you wanna wait until you're a month out from the last dose, in order to have that blocking effect wear off. So, in summary, it's definitely true that opioid use disorder makes it a little more complicated to manage acute and chronic pain, but we now know that it's best to actually maintain patients on their agonist therapy, while they're being treated for intercurrent pain, and it's really clear that taking a multi-disciplinary approach to treatment is important in managing patients in this situation, just as it is in so many patients with whom we work. So, let me stop there.