

“Managing Pain in Individuals with Serious Illness and Comorbid Substance Use Disorder”

Presented by:

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Webcast Questions and Answers

*(Answers are in **bold**)*

Objective: The goal/purpose of this activity is to provide strategies for safe opioid use in the hospital and after patient discharge.

Questions:

1. What about divided doses of buprenorphine for pain management in MAT? Is this done in practice, and do patients find this effective?
 - **Yes it has been done and patients have found it to be effective.**
2. What are the unique characteristics of methadone that contribute to increased risk for overdose?
 - **Methadone has a long half-life up to 150 hours but it only provides pain relief for 6-12 hours. It also has a lot of drug interactions. Part of the problem is lack of knowledge among clinicians about appropriate dosing – so someone may be started on it and be fine days 1-3 and dead day 4 due to the long half-life and accumulation.**
3. Do you think the risk stratification approach would be appropriate for non-palliative patients with past or present substance use disorder?
 - **The risk stratification approach is already what we are doing in the patient population with chronic pain – for those in our pain clinic if there was higher risk, there was more frequent visits, UDS, etc. The challenge is there are no ‘universally accepted’ guidelines.**

4. We have had multiple cases recently in which a patient was on >300mg of long acting opioids daily pre op and the MD would not reorder and only order two Percocet every 4 hours. How do you recommend we address these inpatient issues?
 - **The first thing to understand is why would the MD not 'reorder their outpatient medications' (I am assuming these were hospitalized patients?). It would be important to understand the rationale as in this case you are not only 'not treating' the acute pain, you are potentially putting the patient in withdrawal. If these are 'planned surgeries' then these types of issues should be addressed in the preoperative assessment. If you have a pain service it would be a good idea to get them involved prior to the surgery. If this is a trauma/unplanned surgery and you are meeting resistance from the surgeons and you do not have access a pain service, you may need to take this up the chain of command or even involve ethics. However – I would first try to 'understand' the rationale of the surgeon/hospitalist.**
5. Fentanyl submissions? What is that?
 - **The number of cases of overdose that involved fentanyl.**
6. Why do you think there are differences between the genders with heroin overdose deaths?
 - **In general more men use illicit drugs than woman according to the data. However the rates of addiction are the same and women may even be more at risk. There are some speculations that women may be introduced to heroin through partners and thus may be given lower doses and thus have decreased rates of death.**
7. What is the best pain med for pt with end stage liver disease?
 - **Opioids with the least toxicity would be fentanyl and hydromorphone. Alternatively you could use methadone. NSAIDs should be avoided. Because of the decreased metabolism dosing intervals should be increased (for example q6h instead of q4h PRN).**
8. Now the patients on MAT can go to a PCP and have them RX opioids because on the PDMP don't show that the patient is in treatment O persons in MAT on methadone can get opioids RX.
 - **You are correct that since MAT programs do not report to the PDMP patients could go to their PCP and obtain opioids. However if one is on chronic opioid therapy then universal precautions should be utilized and this includes urine drug screening. Prior to obtaining urine, I always ask patients if there is anything I may not know about that may be found in the urine.**

9. What do you suggest for chronic pain management for things like back pain in the primary care setting for patients with substance abuse histories or who are high risk due to family members substance abuse?
- **A multimodal approach to therapy is necessary – NSAIDs, MSK relaxants, anticonvulsants, PT, exercise, possible interventional therapy. Opioids should only be utilized for chronic non-malignant pain if all other modalities fail and it is deemed that the benefit outweighs the risk. So for example in the case of back pain the first thing to do is to determine the pathology. Is this an arthritis, a disk herniation involving nerves and radicular pain? Studies have shown that for general back pain disk degeneration (arthritis) one of the only effective therapies is conditioning (PT/Exercise). If there is concern about significant pathology consider a referral to physical medicine rehab or pain management.**
10. How do we deal with young patients who has history of ALL or malignancy who complain of pain? MRI, CT head/spine/thoracic and LP are negative. Giving IV Toradol make them appear high example their eyes roll as soon as you give them the Med. They're not EOL patients. They're on flexeril also.
- **The first thing to try to understand is what is the pain generator – this involves a good pain assessment as imaging may be negative for pathology. Have they had treatment for the malignancy that has caused a neuropathic pain syndrome? Have they had surgeries that could cause chronic pain? I don't understand why they would appear 'high' with Toradol as this is a NSAID. Flexeril is a muscle relaxer and can also cause sleepiness. In these cases a referral to pain medicine or palliative care may be helpful.**
11. What would be your suggestion in regard to having naltrexone available in a outpatient chemotherapy infusion center for patients with active heroin abuse and currently receiving chemotherapy in the outpatient clinic. Should it be available in case the patient come to the clinic with recent use and sign of overdose? Would we need consent to use the naltrexone in the patient prior to starting their treatment?
- **If a patient is receiving treatment of any kind in a clinical setting and becomes sedated with respirations less than 10, then this is an emergent clinical situation and would require you to utilize naloxone for reversal. You would not need consent if they are overdosed and sedated. You would not use naltrexone/naloxone on someone who was intoxicated but did not have respiratory depression. It would be important to look into whether your clinics have policies in place for this situation.**

12. I have a current hospitalized pt who may be discharged to a facility for care of recent BKA and severe PVD in R LE. He currently is receiving a Fentanyl patch at 50 mcg, Gabapentin recently increased to 800 tid, Cymbalta at 30 mg. The problem with this pt is he at first requested Dilaudid for BTP, but has requested oxycodone 15 mg q 4 hrs and takes q4 hrs and does not change his pain rating despite use of oxycodone of 75 mg to 90 mg/24 hrs. He is requesting to return home alone but this will not happen d/t safety. Pt dose admit to active ETOH hx when he is at home.

- **Without seeing the patient I can only make some general recommendations. In this case if his pain rating does not change with the use of oxycodone, then it should not be continued. You would want to maximize the non-opioids. If he has normal renal function and can tolerate it then you can try to further increase the gabapentin to 1200 mg q8h and duloxetine to 60 mg daily. Given that he may be at higher risk for abuse you may want to minimize breakthrough opioids which may require increasing the fentanyl patch**

13. What is the magnitude of renal risk with NSAIDs? Are any known to be less toxic?

- **I am not aware of any differences between NSAIDs and renal toxicity. Selective COX 2 may cause less gastropathy. In general one should avoid NSAIDs in patients with renal disease. In those without renal disease, one would use caution in the elderly, those with underlying cardiac disease and hypertension to minimize renal toxicity. If you plan to treat with chronic NSAIDs you should regularly check renal function.**

14. What do you suggest of someone (counselor) that works at a MAT program coordinating care with a provider that is not open to their mutual patients being in MAT programs, to help ensure that the patients care is not disrupted?

- **First it would be important to understand the provider's concerns about their patient being in MAT. If he/she is opposed to this type of treatment at all, then it may be necessary to find the patient another provider. If the patient has an addiction problem that is being treated in MAT then this is the priority.**

15. For acute pain in a patient on buprenorphine or methadone, do you typically discontinue the MAT drug or continue and use higher doses of opioids?
- **Generally methadone is continued and one treats with opioids for the acute pain. There are several different possibilities with buprenorphine. If it is a planned admission you could wean the buprenorphine and then treat the acute pain with opioids and if resolved you would then restart methadone. In the case of an unplanned admission you could stop the buprenorphine but know that for about 72 hours you may have to utilize higher doses of opioids to overcome the antagonism. In all cases multimodal therapy (nonopioids, nonpharmacologic, regional interventional techniques) should be used for the opioid sparing effect.**
16. Could you explain how you assess unexplained pain progression relative to unchanged pathology...given the relatively poor correlation of pathology and pain plus inability to restage/image to verify pathological progression?
- **The first thing to do is a comprehensive pain assessment. Has the nature of the pain changed? Are you seeing more neuropathic type components to the pain? Is there an increase in anxiety, depression, or insomnia? If you can discern no changes based on your assessment, you may have to assume there is either tolerance or opioid induced hyperalgesia. If escalating doses of opioids are not effective then it may be hyperalgesia. In either case you may need to evaluate if there are non-opioids that you can add to the regimen. You may need to consider rotation of opioids to possibly include methadone (if you are experienced with prescribing) that can possibly reverse tolerance.**
17. So how can we as inpatient nurses guide prescribing providers to an appropriate pain management program when they already have a preconceived bias towards a chronic pain patient who is now hospitalized and their pain is not being controlled?
- **It is important to have open communication with the provider to better understand their concerns. If this is a patient who is already on chronic opioid therapy now with an acute pain problem then the patient may not respond to standard doses of opioid therapy. It is important also to look at the pain management plan and ensure that multimodal therapy (nonopioids, adjuvant medications, nonpharmacologic modalities) are being utilized. One may also have to work with the patient on their expectations. Pain control should focus on function, not on a pain severity number as someone with chronic pain may always live at a higher pain severity, but yet be able to function.**

18. What would you recommend for patient admitted to hospital reporting high methadone or Suboxone dosage as home regimen when unable to verify outpatient Rx.
- **Individuals on methadone maintenance usually have an ID card from the clinic. When you can not verify the dose (such as a weekend), you may give a dose of methadone daily (generally up to 30 mg daily) until able to verify the dose. If it takes several days to verify the dose you may have titrate slowly back up to the outpatient dose if the patient has received a lower dose in the hospital for several days. In the case of Suboxone, if the patient is being admitted for pain you may want to just discontinue the Suboxone while hospitalized and treat with an opioid. Since Suboxone is dispensed by the pharmacy through a prescription written by a physician you should be able to contact the pharmacy or have the patient /family bring in the prescription bottle to verify.**
19. Do you have any experience with sickle cell patients and if so any advice for prescribing to this population when there may be substance use issues?
- **Yes I have experience and one would use the same guidelines – starting with an accurate assessment to determine the source of pain. Is it an acute pain due to vaso-occlusive crisis or a chronic pain secondary to a pathology such as avascular necrosis? One would treat based on the characteristics of the pain and use multi-modal analgesia. I would use caution utilizing high dose clinician administered IV boluses of opioids and recommend PCA in the inpatient setting where the patient may have severe pain and require IV analgesia to prevent triggering of the reward system.**
20. Is there a tool whether that be the ORT or the SOAPP that you recommend as more reliable?
- **These tools have been validated in the population of chronic nonmalignant pain but not cancer related pain. The SOAPP has been demonstrated to be more sensitive than the ORT. The clinical interview is the most sensitive. The ORT may be easier to administer in some cases as only 5 questions.**
21. If someone is getting vivitrol injections, how is acute pain managed?
- **It will be necessary to utilize as many nonopioid options possible such as regional blocks, adjuvant therapies. In the cases where opioids may be required you may need to use up to 20 times the usual dose to overcome the opioid antagonist effects of Vivitrol. In these cases the patient should be in a monitored setting.**

22. What are the "unique characteristics of methadone" that lead to increased risk for overdose?
- **Half-life of 24-150 hours and many drug/drug interactions that can increase the serum levels of methadone may increase risk for overdose. Analgesic effect may only be 6-12 hours but accumulation of drug may lead to oversedation**
23. What advice would you give to clients in recovery for SUD regarding how to talk to their PCP about their pain management while advocating for their recovery.
- **The most important thing for the patient is to be honest with their PCP about their addiction and their current efforts to be active in recovery. There are PCPs who may also have waivers to provide buprenorphine treatment so alignment with this type of provider may be helpful.**
24. Michigan does not delegate any non-physician access of MAPS (Michigan version of PDMP). Is there a recommendation for nurses to be allowed to access that program?
- **Consider contacting the program to find out what the plans are for non-clinicians to be able access programs. In the three states where I have been practicing, as a NP I could delegate non-clinicians to access the PDMP as well as RNs. This type of access will be important as many prescribers may not be willing to check the PDMP prior to prescribing.**
25. In our chronic pain practice, our patients bring back unused opiates and they destroy them in front of the staff in kitty litter once the med is dissolved in hot water by the patient.
- **I would be cautious about this practice. Health care providers are not allowed to 'take back' opioids so although it is being done by the patients in the office, I would be concerned that it may be misconstrued that the provider is involved in this practice. In addition, this type of disposal is not consistent with the FDA guidelines for disposal.**
26. Out of the assessment tools mentioned for screening for opioid risk, which do you recommend?
- **We are currently utilizing the SOAPPR in our clinic for initial screening and the COMM for those on therapy. Both of these tools have been cross-validated. As I said, they have not been validated in patients with cancer related pain, but we hope that the use of the tool may allow us to better predict which patients may have higher risks.**

27. Do you know of any Fed and state law, which prohibits hospice nurse to pick up opioid med for hospice pt at a local pharmacy?
- **You should check with your state laws and board of nursing. If you work for a hospice, they should also have policies in place with regards to this issue. From my limited understanding, it may be against the law but may be state by state specific.**
28. How do you prevent some of the "doctor shopping" since patients may not tell you the other doctors they have visited?
- **Checking the PDMP and utilizing a patient provider agreement which states that analgesics will only be obtained through one provider (or clinic setting) are some measures to prevent 'doctor shopping.'**
29. Would you recommend increase of fentanyl patch when pt is comfortable at 50 mcg and reports he takes oxy for pain "just in case"? And perhaps convert to morphine tabs q 6 hrs?
- **There is no need to titrate the fentanyl patch if patient is not consistently utilizing 3 or more doses of breakthrough opioids daily. If you are concerned about the 'likeability component of oxycodone, you could rotate to morphine which may have less likeability.**
30. Great fast pace. We had a palliative care SUD patient who sold her Fentanyl patches to a teenager (so she could buy her drug of choice) and the teen died.
- **Sad case – we have to try to do the best we can to safeguard the patient and the general public.**
31. I have successfully managed severe pain with buprenorphine by increasing the dose in patients on maintenance for opioid use disorders. It is a good option for high risk cases.
- **Thanks for the information. I agree it can be useful if one is comfortable with the use of buprenorphine. It would be important to ensure that the MAT prescriber is aware and that you (if you do not have DEA waiver) are clear in your documentation that you are prescribing for pain management**
32. What is your experience with confronting pts with substance use issues within the context of treating them for legitimate chronic or acute pain issues?
- **It is always difficult to have these conversations. If you have evidence from a urine drug screen or PDMPs then this can be the basis for your conversation. I always try to emphasize that I want to treat the pain, but need to do it in a safe way.**

33. Do you think the risk stratification approach would be appropriate for non-palliate patients with past or present substance use disorder?
- **Yes I think one could utilize some stratification approach as most of the tools will also give you guidance of the relative risk. You would then add the clinical indicators and the MEDD to your evaluation.**
34. The last conference I attended last month reviewed that use of opioids with benzos is no longer recommended. I have been converting to Cymbalta when benzos have been present with opioid use. What do you suggest?
- **Yes the use of opioids and benzodiazepine can increase the risk of oversedation and increased morbidity. If someone has an underlying anxiety disorder that is not currently treated with an SSRI/SNRI then starting one would be an option. Duloxetine (Cymbalta) may be a consideration especially if there is concurrent neuropathic pain or MSK pain. Other SSRIs such as escitalopram, paroxetine, etc. may also be effective but in all cases may take 3-4 weeks to take effect. However in some cases with people with advanced disease I have continued to prescribe benzodiazepines but I educate patients and families of the risks associated with co-morbid use.**
35. We have a patch for patch Fentanyl exchange program in Ontario Canada and people have been busted for making fake patches to return to their pharmacy.
- **Individuals can always find ways to abuse. All we can do is try our best to minimize the harm.**
36. What about divided doses of buprenorphine for pain management in MAT? Is this done in practice, and do patients find this effective?
- **Yes there are cases where this is done and it can be effective. It is very important to have clear documentation.**