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Maryland Addiction Consultation Service

1-855-337-MACS

www.marylandMACS.org

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Maryland Addiction Consultation Service (MACS)

Provides support to primary care and specialty prescribers across Maryland in the identification and treatment of Substance Use Disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions, resources, and referral information
- Education and training opportunities related to substance use disorders and chronic pain management
- Assist in the identification of addiction and behavioral health resources that meet the needs of the patients in your community
- Administered by UMB School of Medicine and funded by Maryland Department of Health, Behavioral Health Administration

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It still hurts! Treating Pain in Patients with Opioid Use Disorder

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Maryland Addiction Consultation Service (MACS)

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Outline

- Opioid Use Disorder and Pain
- Treating Pain: Think Diagnosis & General Principles
- Three General Situations
- Special Considerations with Surgical Pain
- Take Home Messages

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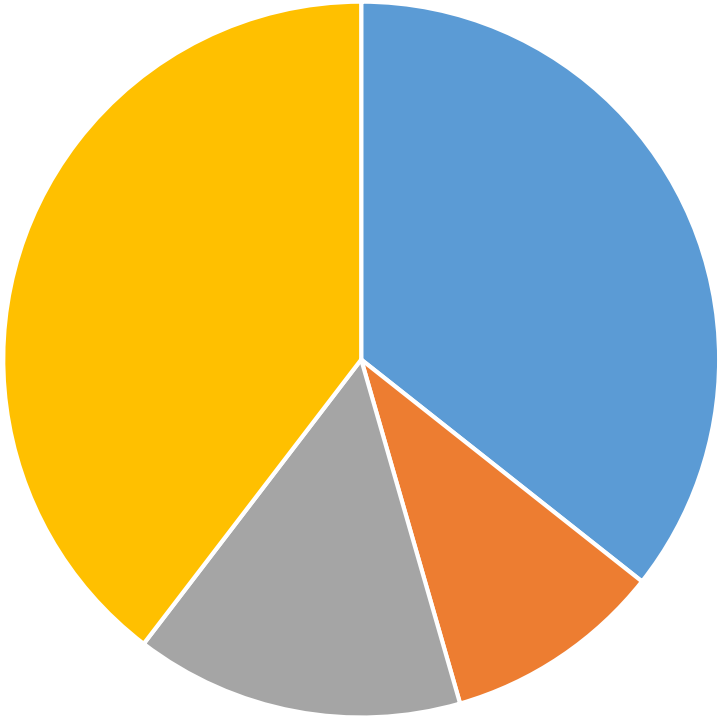
Chronic Pain and Opioid Use Disorder



Group	Description	%
No pain	No chronic pain	36%
OUD First	OUD prior to pain	10%
Same Time	OUD and pain at the same time	15%
Pain First	pain condition prior to OUD	40%

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5424616/

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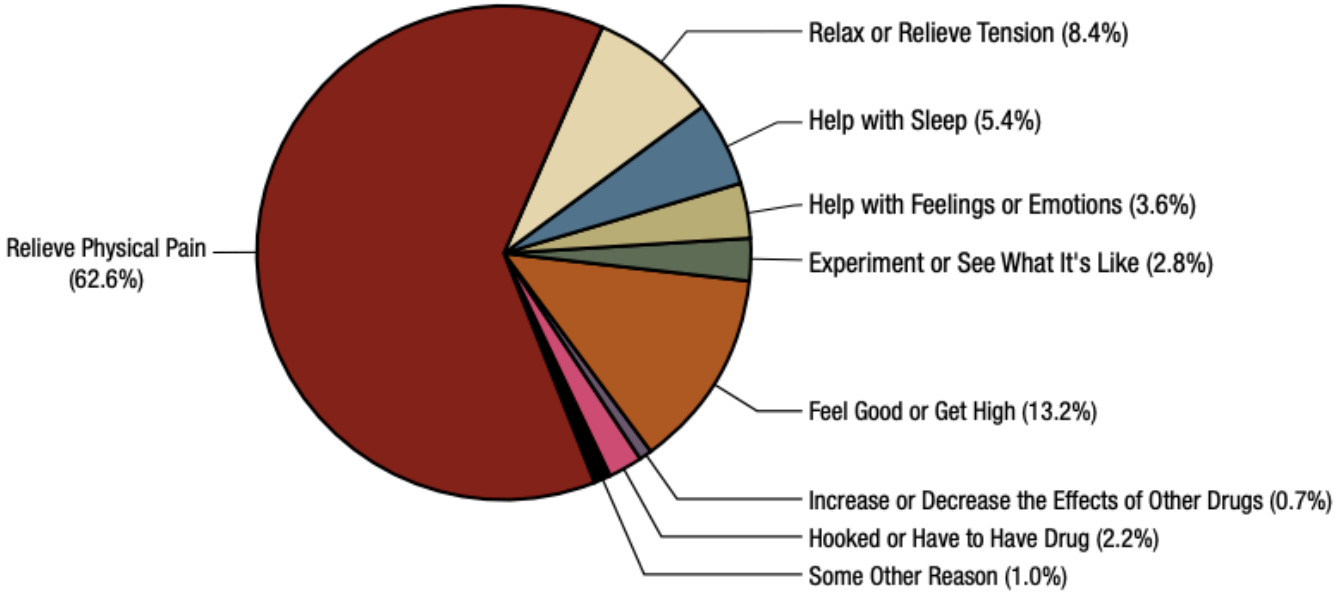
Most individuals who misuse opioids do so to relieve pain

Figure 25. Main Reason for the Most Recent Prescription Pain Reliever Misuse among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year: Percentages, 2017



11.1 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

Note: The percentages do not add to 100 percent due to rounding.

https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf

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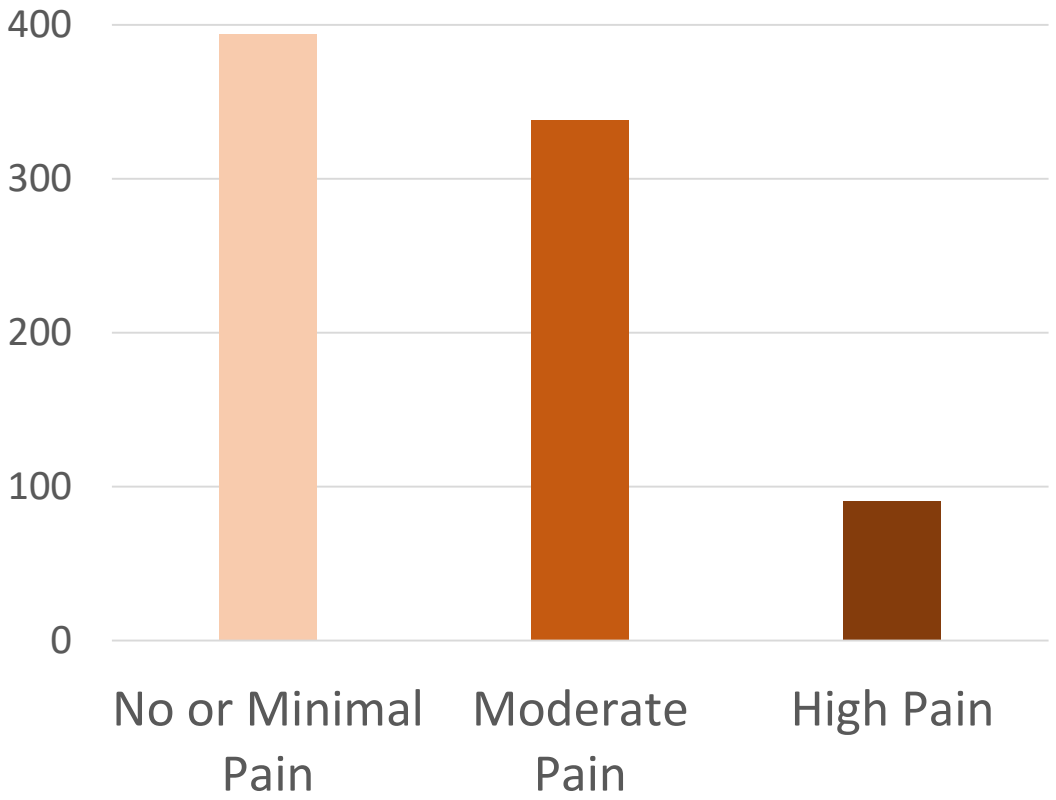
Pain is commonly reported among patients on Methadone Maintenance Treatment



https://www.ncbi.nlm.nih.gov/pubmed/26101814

- 823 patients on MMT
- Higher reports of pain associated with:
  - Self-managing pain
  - Older age
  - Physical disability
  - Reporting a mental illness diagnosis
  - Marijuana use

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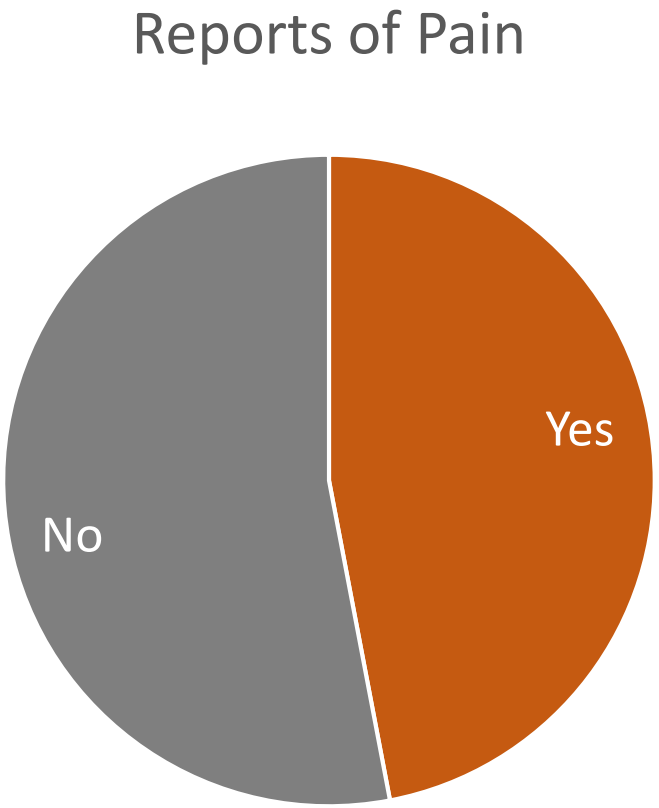
Pain is commonly reported among persons who inject drugs



- 702 adult PWID in San Francisco, California between 2011 and 2013
- 47% reported pain in 24 hours before using opioids
- Positive linear correlation between level of pain and nonmedical opioid use

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5450090/

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Treating Pain: Think Diagnosis

- What is the reason for the pain?
- A precise etiology should be identified
- Tailor treatments to the diagnosis

"Listen to your patient, she is telling you the diagnosis."

William Osler

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Treating Pain: General Principles

Non-pharmacological treatment

Analgesics
- Prescription
- Non-prescription

Psychology

Education

Rehabilitation

Interventions

Surgery

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Non-pharmacological treatments

Diagnosis	Examples of non-pharmacologic treatment
Chronic low back pain	Exercise, psychological therapies (primarily cognitive behavioral therapy [CBT]), spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation (MDR).
Chronic neck pain	Exercise, low-level laser, Alexander Technique, acupuncture.
Knee osteoarthritis:	Exercise, ultrasound.
Hip osteoarthritis:	Exercise, manual therapies.
Fibromyalgia:	Exercise, CBT, myofascial release massage, tai chi, qigong, acupuncture, MDR.
Chronic tension headache:	Spinal manipulation.

https://effectivehealthcare.ahrq.gov/topics/nonpharma-treatment-pain/research-2018

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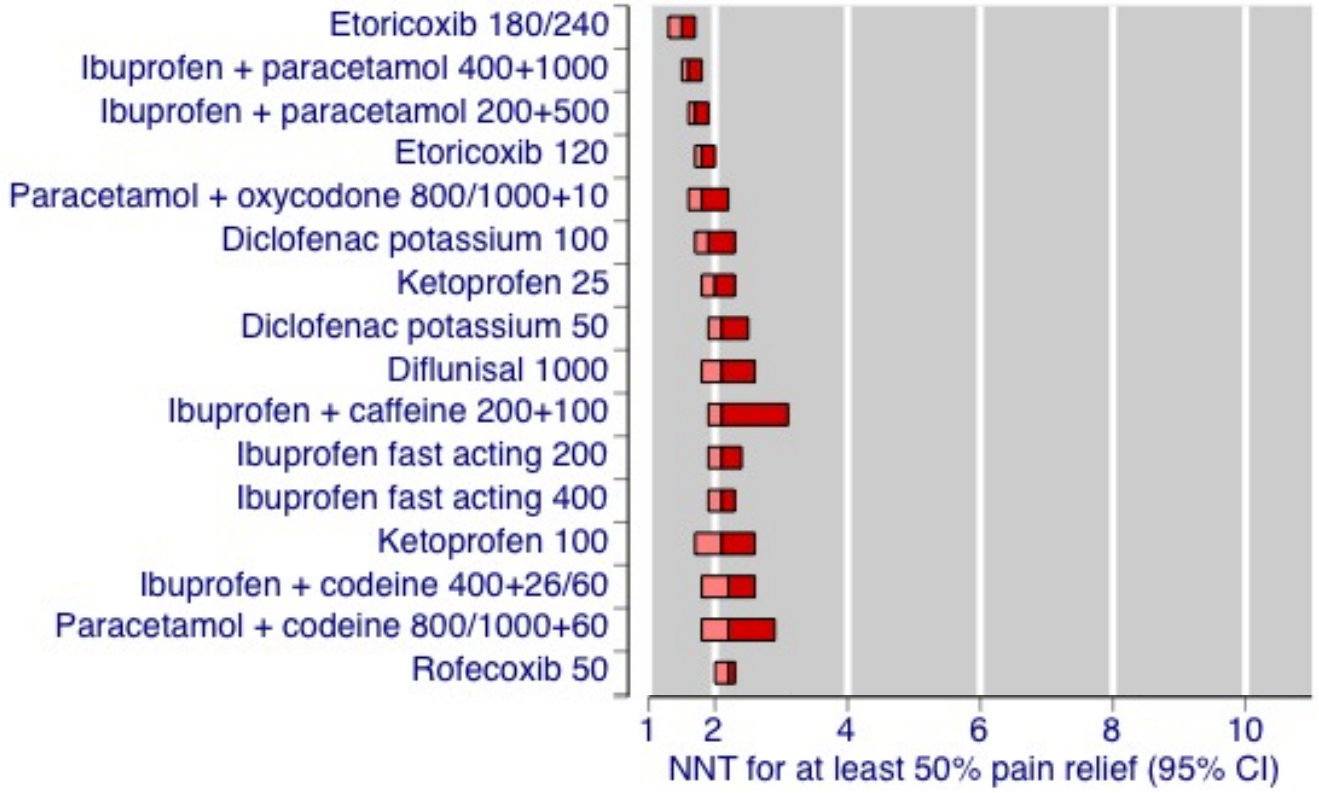
Pharmacologic Analgesics

- Start with non-opioids
  - Acetaminophen
  - NSAID such as ibuprofen
- Combine the two for lowest NNT



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6485441/

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Pharmacologic Analgesics

- Consider other non-opioids based on diagnosis
- Tricyclic Antidepressants (TCA)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- Anticonvulsants

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Using Opioids to Treat Pain in Patients with Opioid Use Disorder

Often encountered in treating acute pain from surgery

3 general situations

1. Pain in patients with an untreated and active opioid use disorder
2. Pain in patients with active treatment for OUD with opioid agonists
3. Pain in patients with active treatment for OUD with naltrexone

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24

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1. Pain in patients with an untreated and active opioid use disorder

- ASAM Guidelines
  - Consider buprenorphine, methadone for OUD and pain treatment in those not already on treatment
- Methadone metabolism may be variable
- Buprenorphine has wider safety profile

https://pcssnow.org/wp-content/uploads/2014/02/PCSS-MATGuidanceOff-label-bup-for-pain.Gordon.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/23707283/

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  - Consider buprenorphine, methadone for OUD and pain treatment in those not already on treatment
- Methadone metabolism may be variable
- Buprenorphine has wider safety profile

- In patients with OUD and chronic pain, sublingual Bup/Nx maintenance doses:
  - Reduce pain scores
  - Show dose response for analgesia
    - Greater analgesia with higher maintenance doses

https://pcssnow.org/wp-content/uploads/2014/02/PCSS-MATGuidanceOff-label-bup-for-pain.Gordon.pdf
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2. Pain in patients with active treatment for OUD with opioid agonists

Methadone

- Methadone dose for OUD usually inadequate for analgesia
- For acute pain, other opioids on top of daily methadone
- Tolerance is likely, so higher doses

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24

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Buprenorphine

- For acute pain
  - Temporary increase in dosing
  - Split dosing
- For chronic pain
  - Split dosing

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24

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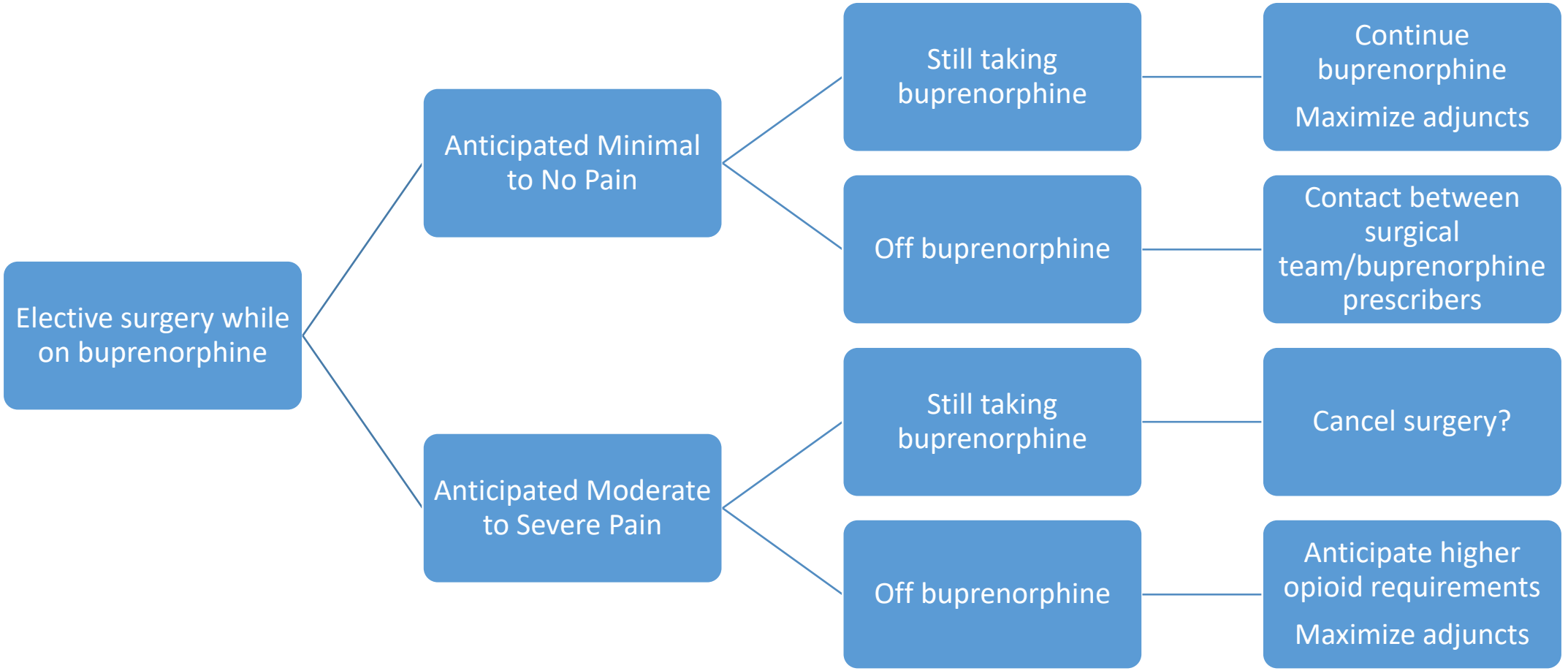
2. Pain in patients with active treatment for OUD with buprenorphine



https://www.ncbi.nlm.nih.gov/pubmed/28511196

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2. Pain in patients with active treatment for OUD with buprenorphine

- The risks and benefits of continuing or stopping buprenorphine perioperatively is limited by a lack of high-quality evidence

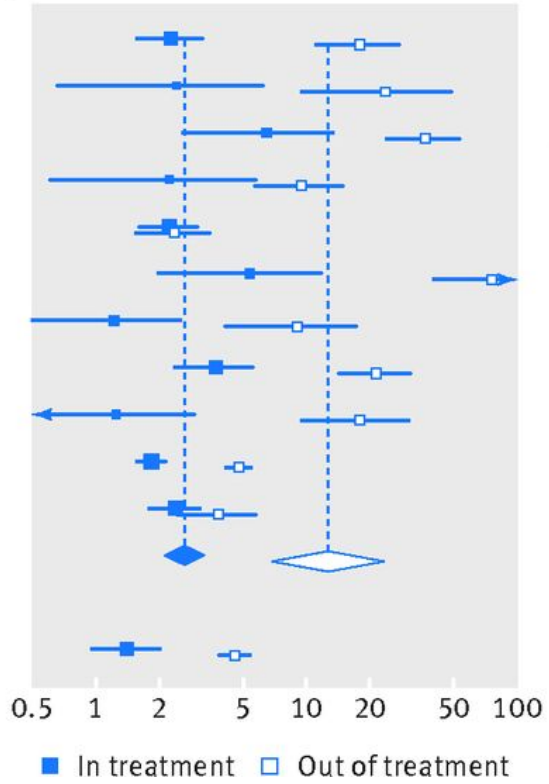
- Consider continuing buprenorphine perioperatively, especially when the dose is < 16 mg SL daily

    - No evidence against doing so from observational studies and case reports

https://www.ncbi.nlm.nih.gov/pubmed/30484167

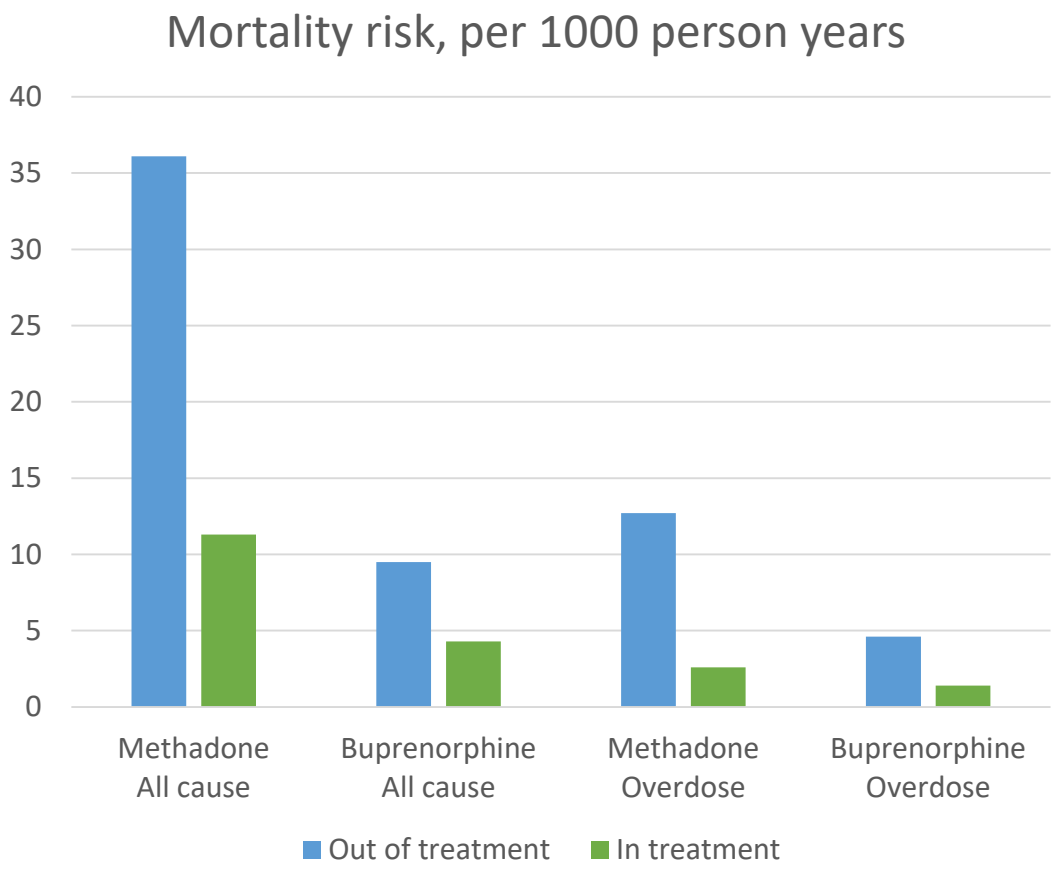
Death from overdose is less likely while in treatment

	No of deaths/ person years		Overdose mortality rate/ 1000 person years (95% CI)		Overdose mortality rate/ 1000 person years (95% CI)	
	In treatment	Out of treatment			In treatment	Out of treatment
Methadone						
Gearing et al 1974	33/14 474	21/1170			2.3 (1.6 to 3.2)	17.9 (11.1 to 27.4)
Cushman 1977	4/1655	7/297			2.4 (0.7 to 6.2)	23.6 (9.5 to 48.6)
Grönbladh et al 1990	7/1085	27/740			6.4 (2.6 to 13.3)	36.5 (24.0 to 53.1)
Caplehorn et al 1996	4/1792	19/2004			2.2 (0.6 to 5.7)	9.5 (5.7 to 14.8)
Buster et al 2002	42/18 747	26/10 983			2.2 (1.6 to 3.0)	2.4 (1.6 to 3.5)
Scherbaum et al 2002	6/1114	13/172			5.4 (2.0 to 11.7)	75.6 (40.2 to 129.2)
Davoli et al 2007	7/5751	9/998			1.2 (0.5 to 2.5)	9.0 (4.1 to 17.1)
Clausen et al 2008	24/6450	28/1303			3.7 (2.4 to 5.5)	21.5 (14.3 to 31.1)
Peles et al 2010	5/3985	13/727			1.2 (0.4 to 2.9)	17.9 (9.5 to 30.6)
Kimber et al 2015	169/91 792	216/45 265			1.8 (1.6 to 2.1)	4.8 (4.2 to 5.4)
Cousins et al 2016	54/22 648	24/6247			2.4 (1.8 to 3.1)	3.8 (2.5 to 5.7)
Overall					2.6 (2.1 to 3.3)	12.7 (6.9 to 23.4)
Buprenorphine						
Kimber et al 2015	31/21 936	143/31 239			1.4 (1.0 to 2.0)	4.6 (3.9 to 5.4)



https://www.bmj.com/content/357/bmj.j1550

2. Pain in patients with active treatment for OUD with buprenorphine



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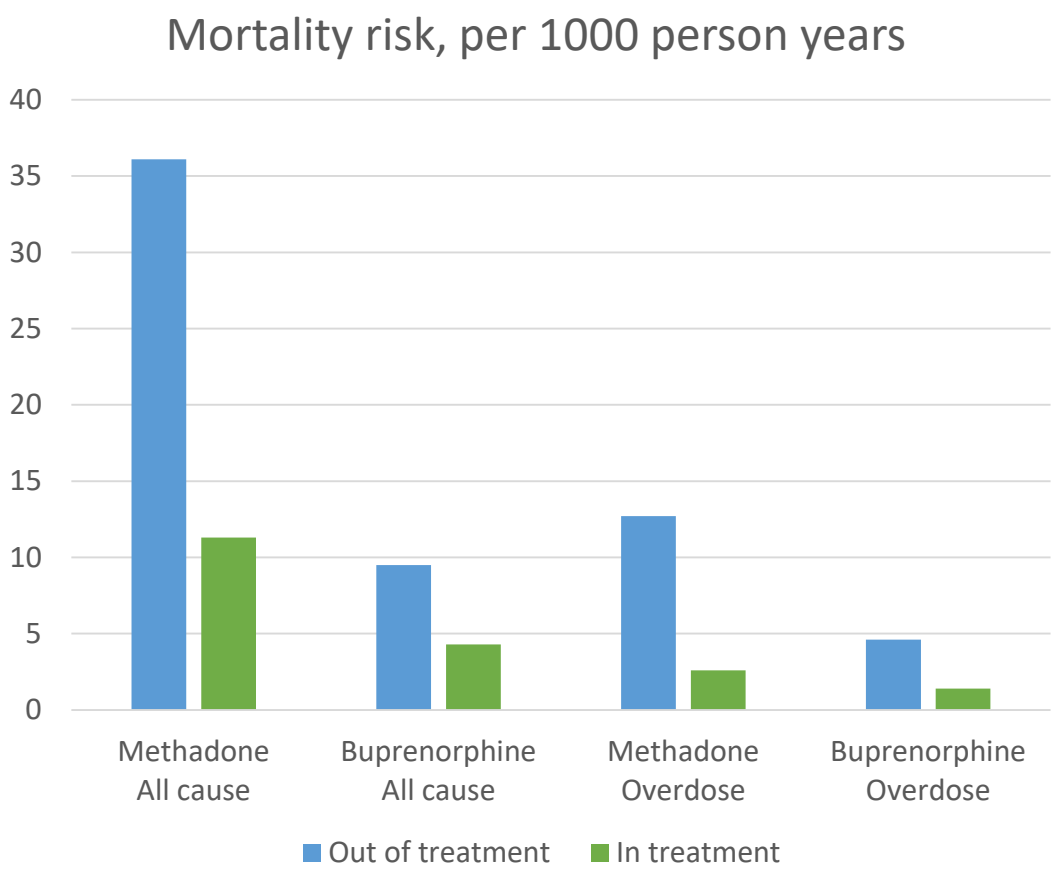

- Retention in treatment →
  - substantial reductions in risk for all cause, overdose mortality
- Time immediately after leaving treatment is a period of increased mortality risk

https://www.bmj.com/content/357/bmj.j1550

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3. Pain in patients with active treatment for OUD with naltrexone

- Patients will not respond to opioids in usual manner
- For mild pain – NSAIDs
- For moderate or severe pain –
  - Ketorolac (risk of gastritis)
  - Consult specialist

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24

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3. Pain in patients with active treatment for OUD with naltrexone

- Patients will not respond to opioids in usual manner
- For mild pain – NSAIDs
- For moderate or severe pain –
  - Ketorolac (risk of gastritis)
  - Consult specialist
- For surgery
  - Discontinue naltrexone >72 hours before elective surgery
  - Discontinue extended release naltrexone 30 days before surgery
  - Wait 3-7 days before resuming naltrexone
    - May consider naloxone challenge

https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24

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Take Home Messages

- Pain is common in patients with opioid use disorder regardless of their treatment status
- Establishing a diagnosis for pain is a critical first step
- Utilize the full spectrum of non-opioid treatments
- Understand the power of combining non-opioid pharmacologic
- Opioid prescribing for acute pain needs monitoring, close follow up, and expertise

Questions?

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