

MACS Webinar

Bridging the Gap: Practical Pain Management Across Primary & Specialty Care

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Maryland Addiction Consultation Service (MACS)

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Pain Care in 2026: Why It Feels Harder Than Ever¹

- 1 in 5 U.S. adults live with chronic pain
- Limited time, high complexity
- Opioid crisis reshaped prescribing culture
- Conflicting interpretations of guidelines
- Pain + depression + substance use frequently overlap
- \$560–\$635 billion annual economic impact

Pain in Baltimore: Why This Matters Locally

- High chronic pain and trauma exposure burden
- Persistent opioid-related morbidity and mortality
- Disparities in specialty access
- Primary care carries the front-line responsibility

Acute vs Chronic Pain: Different Problems, Different Clinician Goals

- Acute: protective, time-limited
- Chronic: persists beyond healing
- Acute goal: resolution
- Chronic goal: function + quality of life

Principles of Effective Acute Pain Management

- Treat early and adequately
- Match treatment to severity
- Use multimodal strategies first
- Reserve opioids for clear indications
- Always include an exit strategy

Post-Procedure Opioid Use: Data vs Assumptions²

- Soft tissue: ~5 tablets (2 days)
- Fractures: ~13 tablets (4–5 days)
- Joint procedures: ~14 tablets (5 days)
- **Most patients use far fewer opioids than prescribed**

When Opioids Are Appropriate for Acute Pain

- Major surgery or severe trauma
- Compound fractures
- Significant tissue injury
- Use IR formulations only
- Shortest effective duration

CDC Opioid Guidance: Clarifying Misinterpretations³⁴: Understanding what the guideline actually recommends.

- Non-opioid therapies first
- Lowest effective dose (<90 MME when possible)
- Reassessment and shared decision-making
- No mandate for abrupt discontinuation
- No 90 MME limit for MOUD dosing

Involuntary Opioid Taper⁵⁶: Emerging evidence on unintended consequences

- Associated with overdose risk
- Associated with mental health crises
- Increased emergency department utilization
- **Tapering decisions should be individualized and collaborative**

When Continuing Opioids Is Clinically Appropriate

- Documented functional benefit
- Stable dose without escalation
- No concerning behaviors
- Risk mitigation in place
- Ongoing reassessment

When Risks Likely Outweigh Benefits

- PEG consistently >5 (PEG = Pain, Enjoyment of Life, and General Activity Level)
- Dose escalation without function gain
- Opioid-induced hyperalgesia suspected
- High overdose risk factors present
- Central pain syndromes

Difficult Situations: Acute Pain in people on opioids

- Baseline hyperalgesia in some
- Opioid tolerance in all
- Relapse risk if history of OUD
- However, pain complaints should be taken seriously
- Increase opioid and lean on non opioid treatments

Non-Opioid Therapies for Chronic Pain

- SNRIs (duloxetine, venlafaxine)
- TCAs (amitriptyline, nortriptyline)
- Gabapentinoids (selected neuropathic pain)
- Topicals (lidocaine, diclofenac)
- Physical therapy and exercise
- Cognitive behavioral therapy / pain psychology

When to Consider Buprenorphine for Pain

Situations where a partial agonist may offer advantages

- **Chronic pain with opioid use disorder**
- **High risk of overdose** with full agonist opioids
- **Problematic long-term opioid therapy** (poor function or escalating doses)
- **Opioid-induced hyperalgesia suspected**
- **Need for more stable analgesia with lower misuse risk**
- **Partial agonist does not mean partial pain relief.**

Buprenorphine as an Analgesic:

Partial agonist does not mean partial pain relief

- *High-affinity partial μ -agonist with unique safety properties*
- Partial μ -opioid receptor agonist with **very high receptor affinity**
- Provides **clinically meaningful analgesia**
- **Ceiling effect for respiratory depression**, but not necessarily for analgesia
- May be useful for patients at **higher risk with full agonist opioids**

Chronic Pain:

Fundamentally different from acute injury

- Central sensitization
- Mood disorders
- Trauma exposure
- Social determinants of health
- **Chronic pain is not simply a problem of tissue damage.**

When Collaborative Specialty Care Is Indicated

- PEG >5 despite multimodal treatment
- Escalating dose without function
- Complex MOUD perioperative planning
- Significant psychiatric comorbidity
- You feel clinically stuck

A Common Pattern in Chronic Pain

When biology, experience, and stress interact.

- 42-year-old woman with chronic low back pain
- Initial injury lifting at work 8 years ago
- MRI: mild degenerative changes
- Pain worsened after divorce and financial stress
- Poor sleep, depressed mood
- Multiple medication trials with limited benefit
- **Pain is real — but the nervous system has become sensitized.**

Chronic pain is influenced by multiple interacting factors:

- **Biology** – injury, inflammation, nervous system sensitization
- **Psychological state** – depression, anxiety, stress
- **Social context** – trauma exposure, financial stress, instability
- **Prior experiences with pain and healthcare**
- **Pain is always real**

But the nervous system can become **more sensitive over time.**

How the Nervous System Learns Pain

- Repeated injury or stress can **sensitize pain pathways**
- Trauma and chronic stress can **amplify nervous system responses**
- Depression and anxiety can **lower pain thresholds**
- The result is **real pain without ongoing tissue damage**
- **This is called central sensitization.**

Collaborative Models of Care

- Integrated pain, addiction, and mental health care
- Thoughtful opioid stewardship
- Multimodal therapies (opioids, non-opioids, interventions, PT)
- Open lines of communication
- **Referral is collaboration, not failure**

What I wish I knew sooner about chronic pain

- Pain intensity and tissue damage are often poorly correlated
- Chronic pain reflects changes in the nervous system, not just injury
- Mood, sleep, trauma, and stress can amplify pain signals
- Patients with chronic pain are often suffering in multiple domains
- Progress is measured in function and stability, not pain scores alone

Improving function is often a more realistic goal than eliminating pain.

Chronic pain is one of the most complex problems in medicine

- It affects more patients than almost any other condition
- It sits at the intersection of **biology, psychology, and social context**
- It often overlaps with **mental health and substance use**
- No single clinician can address all of it alone
- **Good pain care is collaborative care.**

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