Chronic Pain and Opiate Addiction

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Disclosures

* Nothing to Disclose – except I still sing for big bucks on occasion

Objectives

* Gain an understanding of the 12 steps as applied to Chronic Non Cancer Pain – not just addiction
* Learn a "Focus on function" paradigm
* Help the patient be proactive in own care
* Promote Self Managed Care
* Learn how to avoid Iatrogenic Relapse

Disease – Behavior and Stigma

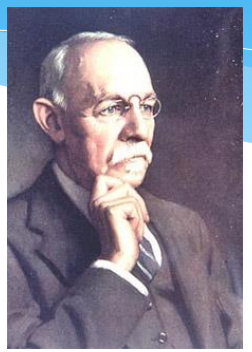
* STD's
* Obesity – Treatment vs Overtreatment
* Tobacco assisted CV - treatment
* HIV – coming around
* Alcoholism – treatment styles
* Iatrogenic Relapse – treatment before and after
* Heroin heart issues – denial of treatment?

Pain or Suffering?

* Nociception – associated with tissue damage
* Pain – unpleasant experience

* Suffering – deterioration of the quality of life

Lifetime Prevalence of Addiction



* 12-15% of Americans
* 30% of children of alcoholics
* 35% of people with chronic pain on opioids
* 80% of Heroin addicts began with prescription

NIDA; Boscarino JA et al. J Addictive Dis 2011; 30:185-194

Similarities of Chronic Illnesses

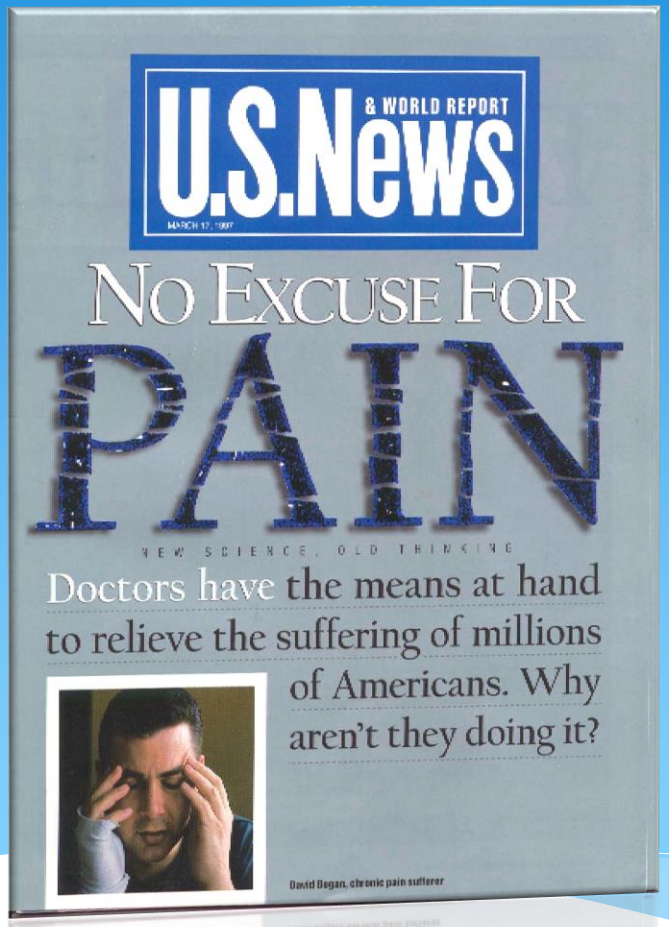
Addiction

* Continued use despite adverse or threatening consequences
* Isolation
* Loss of control
* Preoccupation with DOC
* Progression of disease process
* Tends to run in families

Chronic Non Cancer Pain

* Continued behavior despite adverse or threatening consequences
* Isolation
* Loss of Control
* Preoccupation with pain
* Progression of disease process
* Also runs in families

Source: Richard L. Reilly, D.O. "Living With Pain"



SO – What Happened?

How we got here from pain treatment to the largest opiate addiction epidemic in the country…

Opioid Research vs Usual Practice

She blinded me with SCIENCE!

Research

* Perfect patients
* ~ 6 months rx
* Low-moderate doses
* No additional controlled substances
* Tightly controlled rx by experts

Typical Practice

* Comorbid substance use,
* Psychiatric illness, poorly explained pain
* Years of rx
* Moderate – high doses
* Combined with benzodiazepines, Soma, sedatives, stimulants
* Loose supervision by non experts in addiction

Chronic Opioid Therapy

* Summary of existing data
    * At 18-24 months, 50% will have stopped opioids
* Loss of efficacy
* Adverse effects
    * 20% will have developed problems
    * 30% will have 30% pain reduction
    * A few will have sustained, significant benefit but they typically can't be identified in advance

Covington, 2014

In Practice

* Patients at Highest Risk Receive the Most Drugs
  - 4,000,000 customers; Kaiser Permanente of Northern California & Group Health Cooperative of Seattle
* Substance use disorder pts
  - Higher dose regimens
  - More days supply
  - More likely to receive short- and long-acting Schedule II opioids
  - More likely to receive 180+ days of sedative-hypnotics

*Similar patterns were seen when comparing persons with an opioid use disorder to those without an opioid use disorder. ($p<0.0001$) Constance M et al. Pain 145 (2009) 287–293

Barriers to Lifestyle Change

* We live in a “fix me now” mindset
* We tend to forget the chronicity of chronic illness
* ELOC vs ILOC in the patient population
* The real world of patient satisfaction
* It’s good business to prescribe – 15B in opiate sales in 2015

Contributing Environmental Factors for Both Illnesses

* Raw Nerves
* Anxiety
* Turmoil
* Living with people with a defeatist attitude
* Living with people who wait on them because of their pain

Contributing Environmental Factors (Continued)

* Living with someone who discourages physical exercise.
* Living with someone who encourages obesity.
* The use of drugs.
* Physicians who prescribe just about anything.
* Lack of spiritual support.

Abstinence Based Pain and Addictions Treatment with 12 Steps

Groups are better than one on one.

- Group support.
- Allows members to unburden themselves.
- Share triumphs and defeats.
- Need a supportive program that they can sink their teeth into.
- Need an action based and self managed philosophy.
- Groups stifle “terminal uniqueness.”

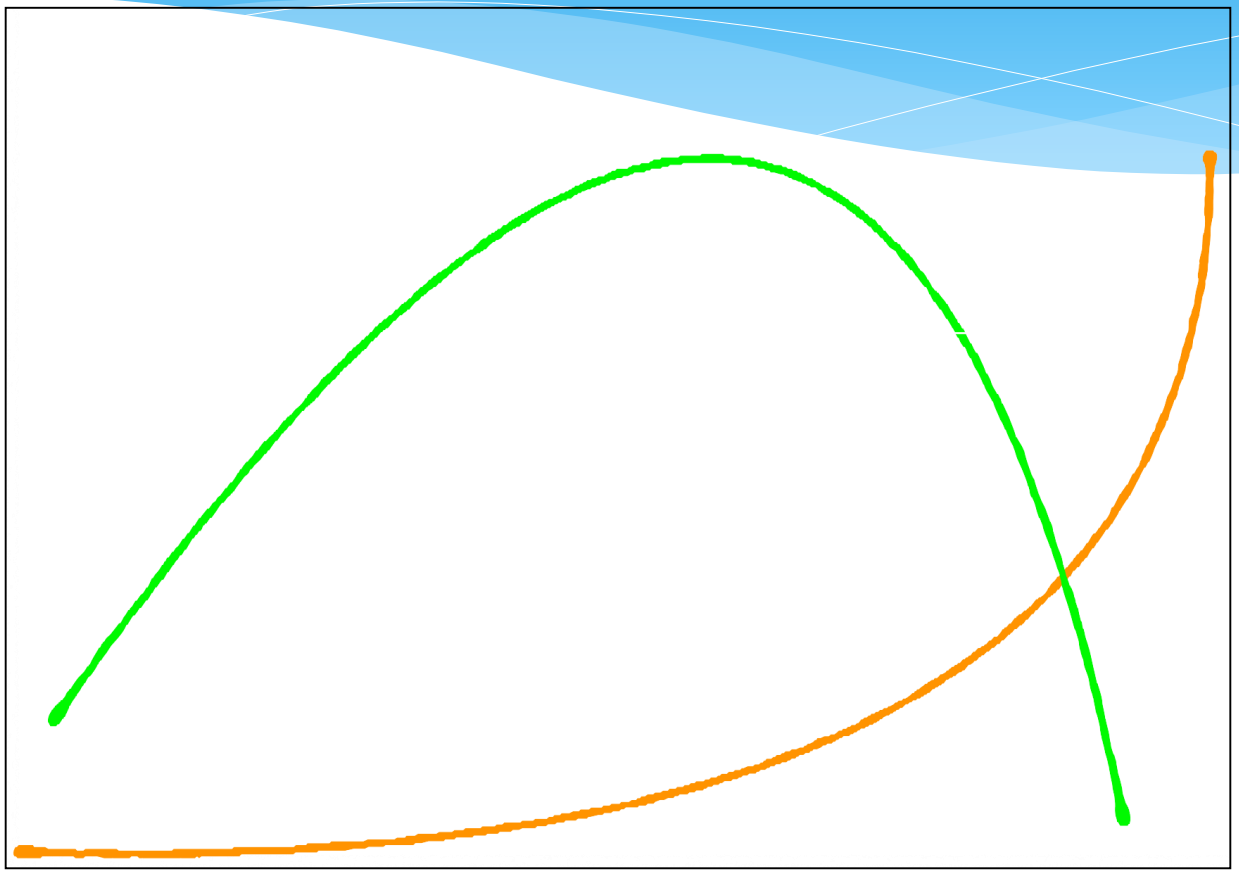
12 Steps and Chronic Pain

* Powerlessness over the pain perception
* Dr. Shopping for a cure – too much medicine?
* Learning a new lifestyle
* Exercise is STILL the best medicine

There is no medicine that can make up for lack of exercise…

Moses Maimonides

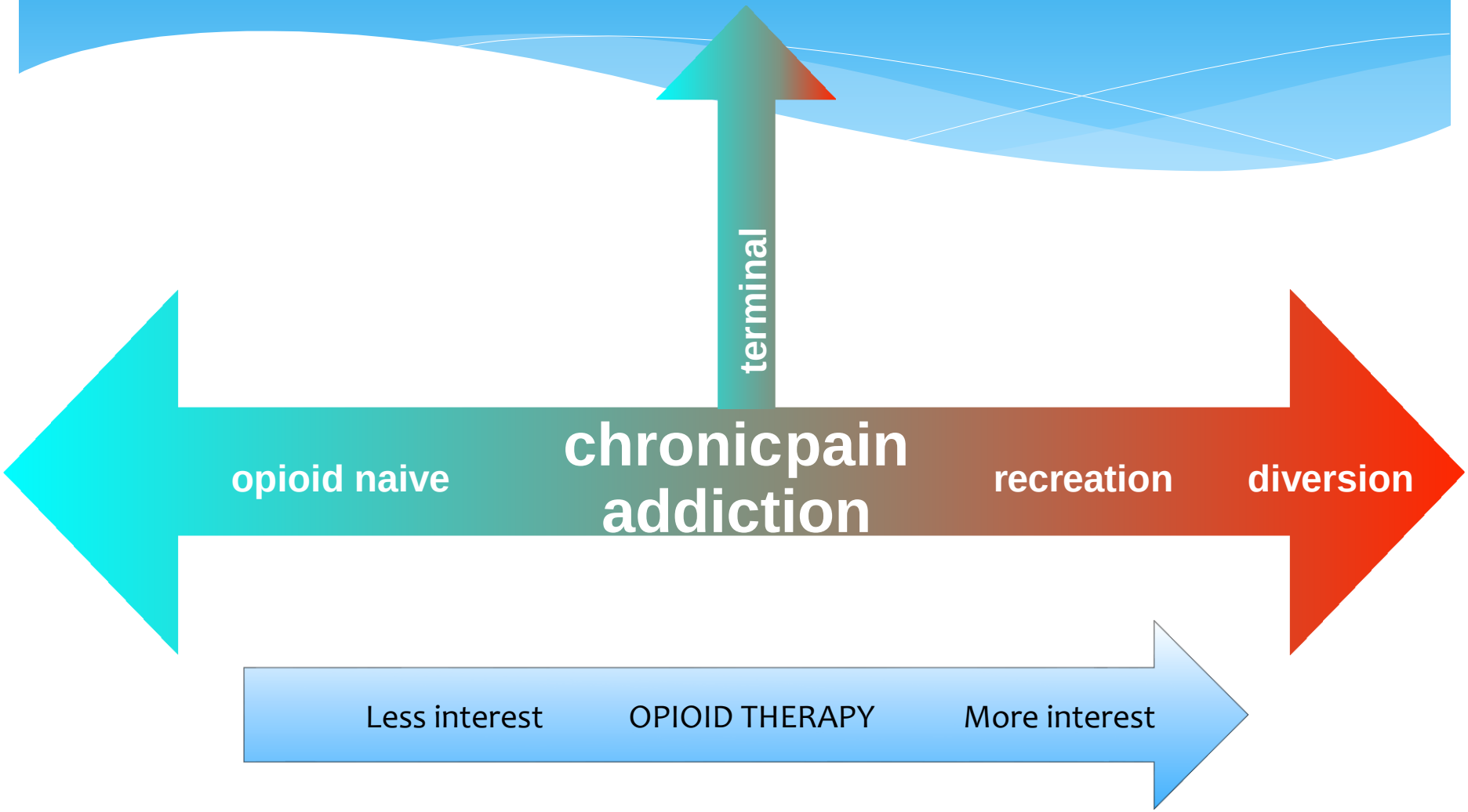
chasing zero pain



Our Part as "Chemical Coddlers"

* We *want* to help.
* Immediate "help" may exacerbate past problem.
* Even conservatively, if there was a 5% chance of a person developing a fatal complication based on adding hydrocodone, would we still prescribe it?
* Opiate OD deaths have TRIPLED since 2001
* Shift of thought process for pain types – acute, acute on chronic, EOL, CNCP, Palliative, Cancer.

Opioid Misuse Spectrum



Iatrogenic Relapse

* We should treat pain even in those with opiate addiction
* Opioids are best indicated for acute nociceptive pain
* Clinicians worry about whether they will cause addiction
* Rarely are we worried about relapse
* We should be

Advanced Directives for the Prevention of Iatrogenic Relapse

Advance Directives for Addiction in Remission and to Ensure Continued Recovery

Patient Last Name		Patient First Name	Middle Initial
Birth Date		Medical Record Number	Date Prepared
A	In event of my inability to speak for myself, I am recovering from addiction to ( ) Alcohol ( ) Opioids ( ) Benzodiazepines ( ) Amphetamine ( ) Cocaine ( ) Other		
B	I would request if any mood altering medications are to be given that they are used sparingly and in amounts and formulations designed for my personal recovery to minimize iatrogenic relapse. Signed document allows for permission to use INSPECT at any time		
C	USE: Long acting ( ) morphine ( ) oxycodone ( ) methadone ( ) oxymorphone ( ) other USE: Short Acting ( ) morphine ( )oxycodone ( ) hydrocodone ( ) other		
D	Responsible Party for post procedural take home medications		
E	Scheduled ( ) Every [ ] hours for [ ] days no longer than [ ] days		
F	Responsible prescribing clinician/Pharmacy (one of each only)		
G	Copy of current treatment agreement attached		
H	Sponsor/Recovery Coach		

So What Do We Do?

* Treat the pain
* Watch for observed intoxication and refer
* If on chronic opioids, these are considered baseline – use additional short acting for BTP
* Opioid Rotation
* Know your own reaction
* Other clinician challenges “WHAT ARE YOU GONNA DO FOR ME?”

What NOT to Do

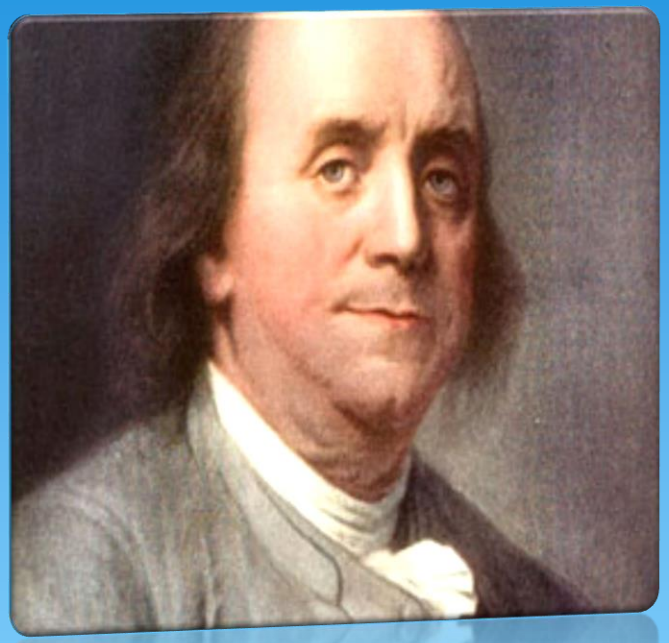
* Send them off with a 30 day supply and a letter of discharge – THIS fuels the illicit trade
* Use short acting opioids for weaning
* Trust the addicted or non addicted patient to wean himself/herself
* Assume that ANY patient will disclose an addiction diagnosis

Conclusions

* Opioids are quite helpful for many patients with chronic non Cancer Pain
* They are useless or harmful for many
* It is difficult to predict benefit/harm
* Harm to society is substantial, and increases with the use of higher doses

Conclusions

* Most societal harm likely occurs with people who never had a prescription
* With meticulous prescribing, those who benefit from opioids can get them safely, and those who do not benefit can be protected from them
* It is unclear the extent to which physicians can adequately protect society



Nothing is more fatal to health, than an over care of it…

Benjamin Franklin

Thank You… Questions?