Chronic Pain and Opioids Follow-Up Discussion

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Conflict of Interest Disclosure

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Objectives

- Identify impact of Chronic pain on Canadians
- Identify impact of Opioid Addiction on young Canadians
- To share with you my experience in managing chronic pain / addiction / pseudoaddiction as a family physician
- Revisit our Action Plan from last meeting
- Open forum to discuss our concerns surrounding chronic pain treatment, dispensing, and community impact

Chronic Pain & Opioid Addiction

- National Institute of Health defines Chronic Pain as "pain lasting more than 12 weeks"[1]
- 1 in 5 (20%) of Canadians suffer from Chronic NON-CANCER pain (CNCP)[2]
- Canadian self-reported abuse of opioids was 2% but was 6% in those aged 15-19[12]
- 1 in every 170 deaths in Ontario related to opioids[14]
- Ages 25-34: **1 in every 8** deaths related to opioids[14]
- Most patients had seen a physician in the preceding 10 days prior to their death with a pain or psychiatric complaint[15]

High doses of opioids correlated with death

- Daily dose of morphine equivalent greater than 200mg was associated with a **3 times** increased risk of mortality vs. lower doses[17]
  - 1300mg of Codeine
  - 130mg of Oxycodone
  - 40mg of Hydromorphone
  - 50mcg/h of Fentanyl

Family doctor experience

- 9 months ago I took over a fully rostered family practice
- 7% of my patients were on chronically-renewed opioids
- Unique opportunity for a new physician to re-evaluate patients with chronic non-cancer pain
- A BIG challenge to build therapeutic trust to engage patients on the treatment of their chronic pain

Update on my goals from 6 months ago

- Re-evaluate each patient with chronic pain & build therapeutic trust
  - I have met with every patient and continue trust-building
- Re-sign "Triple One" opioid treatment agreements
  - 100% of patients have signed opioid treatment agreements
- Ensure that no reversible conditions exist
  - Completed; ordered 40 MRIs, 10 patients referred to a spine surgeon
- Move patients from short-acting to long-acting opioids
  - Nearly all patients on a long-acting opioid as opposed to only short-acting
- Taper high dose opioids (>200mg of daily morphine equivalent)
  - This is proving to be a time-intense challenge
- Implement Urine Drug Testing to ensure compliance, assess for illicit drug use, and determine possible diversion
  - Initial phase started with plan to expand to all patients on opioids
- Implement pill-counting call-backs to either office of pharmacy to assess for diversion and compliance
  - Not yet initiated

Change in Opioid Prescriptions

Opioid	September 2015		April 2016	
	Total	**IR Only***	**Total**	**IR Only***
Tylenol #3	10	10	4	4
Oxycodone IR	45	30	7	4
Hydromorphone IR	38	16	24	9
Tramacet	20	20	15	15
Fentanyl	7		7	
Patients on Chronic Opioids	**203**	80	**181**	32

*"IR Only" refers to immediate release only; i.e. not on a long-acting opioid

Some Cases for Discussion

Mrs. DilaudidOnly

- 62 year old female new to practice
- On transfer record, "Hydromorphone 8mg TID (not contin)" for "chronic pain"
- Pt stated that long-acting doesn't treat my pain
- "Intolerant" of NSAIDs, Lyrica, Gabapentin, Cymbalta, …
- Attempts to engage in discussion of switching to long-acting opioid met the fierce resistance

Mr. CantHandlePain

- 34 year old male with chronic back pain
- Previous car vs. pedestrian collision resulting in head injury, spinal fractures, and femur fracture 10 years ago
- "Was using my father's Dilaudid until he died"
- History of IV drug use (denies recent use)
- "If you don't give me Dilaudid you are forcing me to buy it off the street"

Action Plan Revisited

- Physician agreement to limit the amount of opioids being prescribed. Less pills/patches leaves less room for diversion.
- Pharmacy medication disposal program should be more often if "Patch for Patch" program is to be implemented.
- All clinics should be implementing a pain protocol. NOUGG guidelines are an excellent source of information to help physicians.

Action Plan Revisited

- Ask all patients if they have private coverage or are willing to pay for medication. This allows the patient to have access to newer medications that may have abuse deterrent formulation.
- Revisit medical charts to see if any patients are candidates to be converted from short acting to long acting medication. Less pills in the household, longer duration of pain control.
- Law enforcement officials to start visiting physician offices and pharmacies to update stakeholders on local concerns.

Action Plan Revisited

- Improved partnership between pharmacist and physician. Increase communication about concerned prescriptions. All opioid agreements should be faxed to the pharmacy with the pharmacy's name on the form. "If another pharmacy is used to fill prescription than the physician's office must be notified within 24hrs."
- NMS – pharmacy call ladder if there are issues related to misuse. Would like to see pharmacies contact physician who issue is related to.

Your turn …

- Questions about treatment of chronic pain?
- What concerns to do you have about opioid abuse in our community?
- What challenges have you faced in implementing our action plan?
- How is the Fentanyl Patch-to-patch program working?
- Any questions about Opioid Replacement Therapy (methadone, Suboxone)?

Resources

- This talk and specific resources related to chronic pain management can be found on my website:

  www.drpeterson.ca/pain

- THANK YOU!!

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