One GP's Perspective on Chronic Pain and Opioids

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Objectives

- Identify impact of Chronic pain on Canadians
- Highlight barriers to effective pain treatment
- Discuss treatment options for chronic non-cancer pain (CNCP)
- To share with you my experience in managing chronic pain as an emergency medicine physician, an addiction medicine physician, and a family physician

What is Chronic Pain?

- Defined by National Institute of Health as: "pain lasting more than 12 weeks"[1]
- Chronic NON-CANCER pain (CNCP) is our focus
- 1 in 5 (20%) of Canadians suffer from CNCP[2]
- Prevalence of CNCP increases with age with as high as 65% of seniors reporting CNCP[3]
- Pain is the most common reason for seeking healthcare accounting for 78% of ER visits[4]
- Chronic pain associated with worse quality of life vs. chronic lung or chronic heart disease[5]

Chronic pain is a drain on productivity

- Low back pain prevalence estimated to be 15% in United States[6]
- Low back pain was the leading injured body part for WSIB, accounting for 17% of lost time claims[7]
- Osteoarthritis affects 10% of Canadians[8]
- 3% of Canadians live with neuropathic pain[6]
- Estimated cost for health care and lost productivity in Canada due to CNCP in 2011 was $56-60 billion[9]
- Living with chronic pain caries a 2 times risk of suicide vs. those without chronic pain[10]

Physician barriers to treating chronic pain[11]

- Gaps in knowledge/training in pain management
- Ethnic / racial / gender biases
- Reliance on behavioural cues in assessment
- Negative feelings towards pain patients (fear, suspicion, anger, resentment, denial)
- Concern for addiction / pseudoaddiction

Patient barriers to treating chronic pain[11]

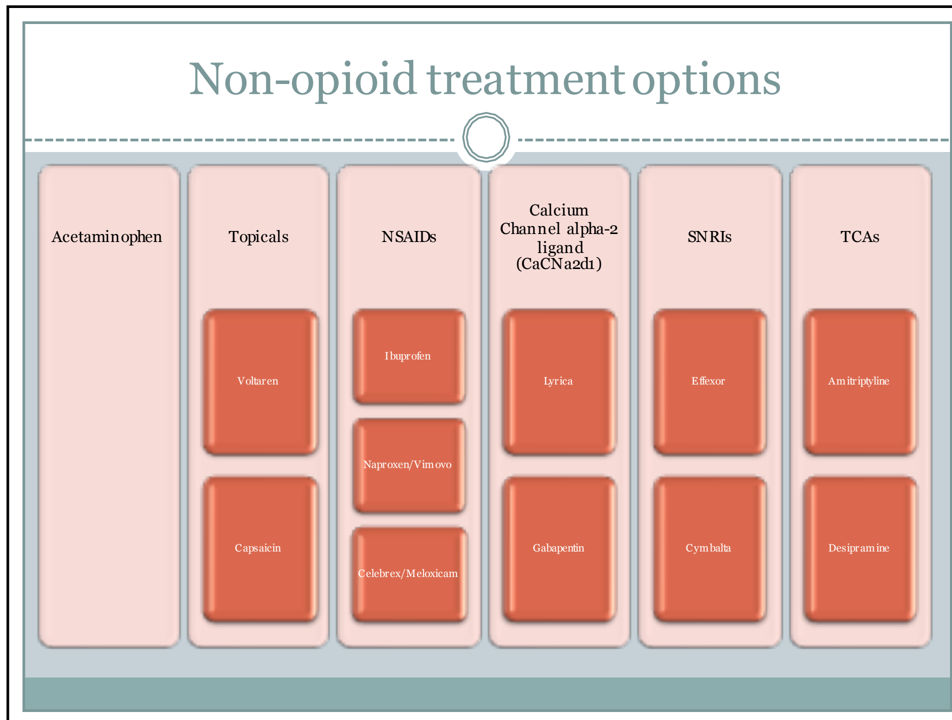
- Failure to report pain
- Thinking one can "see the pain through"
- Fear that pain portends a serious disease/diagnosis
- Concern about side effects of opioids
- Confusion about risks of opioids
- Unwillingness to take further medications

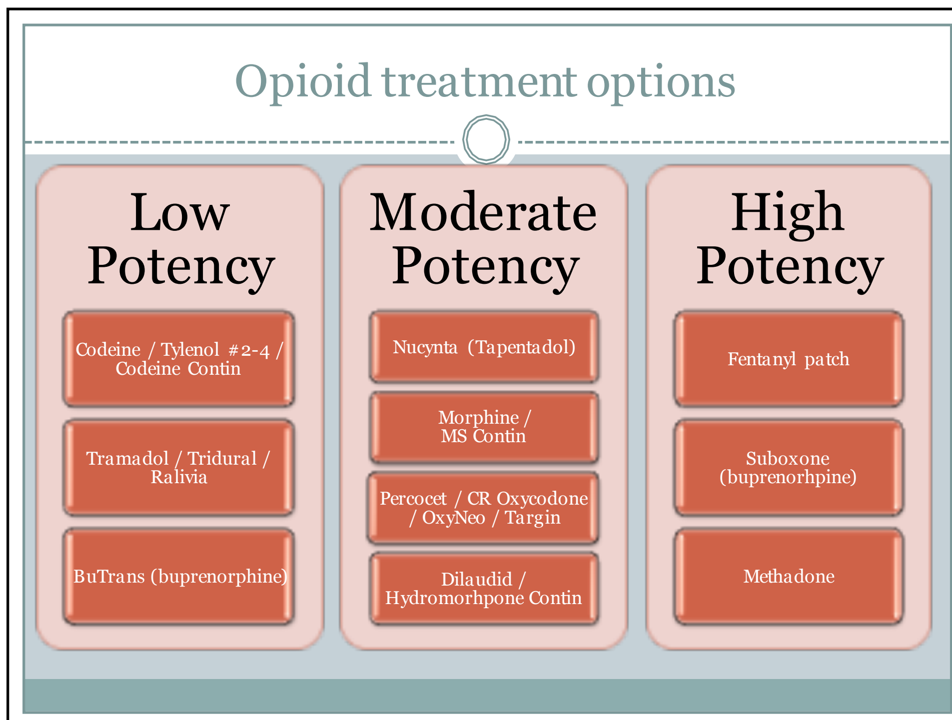
Opioid Misuse can lead to death

- In 2013, rate of past-year opioid use was 15% in Canada[12]
- Canadian self-reported abuse of opioids was 2% but was 6% in those aged 15-19[12]
- Opioid-related deaths in Ontario jumped from 12 in 1991 to 42 deaths per million residents in 2010[14]
- 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


Non-opioid treatment options
Acetaminophen
Topicals
Voltaren
Capsaicin
NSAIDs
Ibuprofen
Naproxen/Vimovo
Celebrex/Meloxicam
Calcium Channel alpha-2 ligand (CaCNa2d1)
Lyrica
Gabapentin
SNRIs
Effexor
Cymbalta
TCAs
Amitriptyline
Desipramine


Opioid treatment options
Low Potency
Codeine / Tylenol #2-4 / Codeine Contin
Tramadol / Tridural / Ralivia
BuTrans (buprenorphine)
Moderate Potency
Nucynta (Tapentadol)
Morphine / MS Contin
Percocet / CR Oxycodone / OxyNeo / Targin
Dilaudid / Hydromorhpone Contin
High Potency
Fentanyl patch
Suboxone (buprenorhpine)
Methadone

My life as an Emerg doc

- "My family doctor is on vacation …"
- "My family doctor can't see me until …"
- "My family doctor doesn't believe in fibromyalgia"
- "My teeth are killing me!"
- "I can't walk due to my back pain"
- "This is the worse headache of my life!"
- "I have abdominal pain & emesis, again …"

- Which medication is most "requested" in the ER?

ER docs try hard not prescribe opioids

- For acute pain, most ER docs provide only a small quantity of opioid medication (i.e. less than 30)
- Generally speaking, ER docs do not renew opioid medications for chronic pain
- I have recommended or prescribed an NSAID/CaCNa2d1/SNRI to provide additional pain relief
- We do see patients with repeat request for opioids and generally they have low back pain or teeth pain
- If you have a concern for a particular patient's drug-seeking behaviour in your office, LET US KNOW!

Family doctor experience

- I have an Addiction Medicine practice of 75 patients in North Bay
  - Many are marginalized and as such I assume the role of their family physician
  - Roughly 30% are mixed chronic pain / addiction
  - Roughly 60% have concurrent psychiatric illnesses with anxiety and depression toping the list
  - On history, number one prescribed medication leading to addiction was Oxycodone (Percocet and OxyContin)
- I recently took over care of Dr. Chilvers' patients
  - 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 re-addressing the treatment of their chronic pain

Here's a snap-shot of my FHO practice

- 203 (7.5%)patients on chronically renewed opioids:
  - 45 (1.7%) Percocet (**30** of which are not on a long-acting opioid)
  - 45 (1.7%) Tridural (long-acting tramadol)
  - 38 (1.4%) Dilaudid (**16** of which are not on a long-acting opioid)
  - 20 (0.7%) Tramadol
  - 17 (0.6%) Hydromorphone Contin
  - 14 (0.5%) Nucynta (long-acting tapentadol)
  - 12 (0.4%) BuTrans (long-acting buprenorphine)
  - 11 (0.4%) OxyNeo (long-acting oxycodone)
  - 10 (0.4%) Tylenol #2-4 (**10** of which are not a on long-acting opioid)
  - 9 (0.3%) Codeine Contin
  - 7 (0.3%) Fentanyl Patch (average age 68)
  - 5 (0.2%) Targin (long-acting oxycodone with naloxone)

My attempts to convert short-acting to long-acting opioids has met with mixed results

Mrs. Smith	Mr. James
• 74 year old lady with osteoarthritis • Taking 6 Percocet per day • Also on a benzodiazepine for sleep • No long-acting opioid	• 34 year old male with chronic low back pain • A bulging disc without stenosis on MRI • Taking 6 Tylenol #3 per day • No long-acting opioid

My goals for the next 6 months

- Re-evaluate each patient with chronic pain & build therapeutic trust
- Re-sign "Triple One" opioid treatment agreements
  - One patient – One doctor – One pharmacy
  - Concurrent use of non-prescribed opioids & benzodiazepines, cocaine, amphetamines, or methamphetamines will result in contingency management
  - Urine drug testing and pill-counting call-backs will occur
- Ensure that no reversible conditions exist
- Move patients from short-acting to long-acting opioids
- Taper high dose opioids (>200mg of daily morphine equivalent)
- Implement Urine Drug Testing to ensure compliance, assess for illicit drug use, and determine possible diversion
- Implement pill-counting call-backs to either office of pharmacy to assess for diversion and compliance

Urine Drug Testing is essential in the office

- Immunoassay test strips relatively inexpensive but higher rates of false positive/negative
  - Oxycodone often a false negative -> send for chromatography
- Measure temperature and Creatinine to reduce risk of tampering by dilution
- Can have supervised testing if concern for tampering
- Assess if patient is taking prescribed medication
- Assess if patient is taking illicit drugs
  - Non-prescribed opioids & benzodiazepines most concerning
  - Cocaine, amphetamines, methamphetamines

Contingency Management strategies to build therapeutic relationship

- Systemic use of reward for positive behaviours and consequence for negative behaviours to help align patient behaviour with therapeutic treamtent plan
- Applying to chronic pain treatment compliance this may include
  - Reducing or increasing dispensing interval
  - Reducing or increasing frequency of Urine Drug Testing
  - Reduction in allocated short-acting opioid doses
  - Reduction in benzodiazepine doses
  - Stopping of all opioid scripts in cases of fraudulent behaviour

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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