An Approach to Managing Chronic Non-Terminal Pain

Table 1. Opioid risk assessment tool

<table>
<thead>
<tr>
<th>Fxh substance abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Personal hx substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Age between 16 – 45</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hx preadolescent sexual abuse</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCD, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Scores:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 – 3</td>
<td>Low Risk</td>
<td></td>
</tr>
<tr>
<td>4 – 8</td>
<td>Moderate risk</td>
<td></td>
</tr>
<tr>
<td>≥8</td>
<td>High risk</td>
<td></td>
</tr>
</tbody>
</table>

Red flags that may ↑ risk: Asking for specific brand name opioids; frequent changing of PCPs or hospitals; coming from out of state; history of being taken off opioids by former provider.

- Review sleep hygiene

Box 1. Non-pharmacologic interventions

- MSK/inflammatory pain:
  - Ice or heat packs
  - Progressive exercise, stretching, yoga, relaxation, meditation
  - Physical therapy, TENS therapy, hypnosis
  - Manipulation (D.O., chiropractor)
  - Occupational therapy, work conditioning
  - Massage, acupuncture, biofeedback, Cognitive Behavior Therapy
  - Surgical evaluation (e.g. joint replacement for OA)
  - Interventional pain modalities
  - Self-care; new mattress, new shoes
  - Counseling (tobacco cessation, nutrition/weight loss)

- Visceral pain:
  - Dietary and other GI interventions

Box 2. Non-opioid medications for chronic pain

- MSK/inflammatory pain:
  - Acetaminophen (max. 3-4 g/day)
  - NSAIDs (in select nonelderly pts; monitoring GI/renal toxicity)
  - Topical anesthetics (lidocaine – cream, ointment, patch)
  - Anti-inflammatory creams (dicyclomine cream, gel)
  - Steroid injections
  - Muscle relaxants (cyclobenzaprine)

- Neuropathic pain:
  - Tramadol (weak opioid)
  - TCA’s (SOR-A): nortriptyline, desipramine
  - Topical anesthetics, Neuropathic creams
  - SNRI’s (SOR-A): duloxetine (Cymbalta®), milnacipran (Savella®)
  - Anticonvulsants: gabapentin (Neurontin®), pregabalin (Lyrica®)

- Visceral pain:
  - NSAIDs and/or acetaminophen
  - Antispasmodics (e.g. dicyclomine)

- Restore sleep:
  - Melatonin, TCA’s, trazadone

- Avoid BZD’s due to tolerance/abuse risk

Box 3. Urine Drug Monitoring (UDM)

- Obtain urine drug screen at start, then random testing ≥ once/yr
- List controlled substances that the patient is prescribed on lab requisition, including dose/frequency & time/date of last dose.

- “Opioids” reported on UDM are codeine and morphine only.
- Specific assay required for synthetic opioids (hydro/morphine).

Box 4. Opioid selection (augmenting other treatments)

- Lack of evidence for long-term benefit in chronic non-cancer pain (e.g. low back pain).
- Avoid use in chronic H/A, fibromyalgia, IBS.
- Begin with a short-acting opioid (e.g. hydrocodone/oxycodone → morphine) while titering up; transition to a single, long-acting form (e.g. MS Contin®) when a stable daily dose is established.
- When switching to a different opioid, calculate the Morphine Equivalent Dose (MED) and reduce by 25-50% initially for safety.
- Avoid MED > 50-100 mg/day dose to minimize overdose risk.
- Avoid concurrent use of multiple opioids or co-tx with BZD’s.
- Brand name formulations (e.g. Percocet®, Oxycodone®, Oxycontin®) have high street value and may pose increased diversion risk.
- Avoid methadone for safety (ADR’s, long variable T½, OD risk).

Gregory Eigner, MD

* See additional credits listed on page 2.
Discontinuing Opioids

Reasons to Discontinue Opioid Therapy

- 1) Lack of benefit in sx or function
- 2) Opioid-induced hyperalgesia
- 3) Excessive dose
- 4) Violation of contract, e.g. misuse of medications, inconsistent UDS, obtaining Rx from other providers, multiple requests for early refills or illicit substance use
- 5) Non-compliance with evaluation or treatment plan (tests, appt’s with consultants)
- 6) Workplace hazard (e.g. machine operator)
- 7) Medication diversion
- 8) Prescription forgery
- 9) Threats made by patient
- 10) Suicide attempt or ideation

Slow taper

- 1) Taper by 10% of the original dose every 1-2 weeks.
- 2) When 20% of the original dose remains, consider tapering by 5% every 1-2 weeks until off or at goal.

Rapid taper

- Taper by 20-25% every 3-5 days (with the lesser interval time for shorter half-life meds).

STOP NOW
- No further prescribing
- Refer patients with suspected or diagnosed opioid dependence (or substance use disorder) to an Addiction Medicine Specialist.
- Rescreen patients periodically for substance use/abuse and comorbid psychiatric conditions.

Medications that may be used to manage withdrawal symptoms (for patients that remain under your care):

1) Clonidine 0.1 – 0.2 mg q6h, or transdermal patch 0.1 mg/24h (monitor BP).
2) Promethazine 25 mg q6-8h, as needed for nausea.
3) Short term use of a non-BZD sleep aid for insomnia, if indicated.

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Thank-you to the Working Group of the State of Indiana’s Task Force on Prescription Drug Abuse for their valued input in the preparation of this document.

References

1. “Opioid Risk Tool” developed by Lynn Webster, MD (reprinted with permission)