# The Appropriate Use of Opioids

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# Disclosures

- None

# Learning Objectives

- Create awareness of the current opioid epidemic
- List the current recommendations
- Identify current strategies to decrease opioid prescription in the perioperative area

# Background Info: From the beginning

- 1898: Bayer synthesized Heroin
  - Offered as a cough suppressant
  - “Non-addictive” alternative to morphine
- 1909: Opium Exclusion Act
  - Barred imported opium for smoking
- 1914: Harrison Narcotic Tax Act
  - Taxed/regulated opiates
- 1924: The Heroin Act

# FDA Approval

- 1950: Percodan approved by FDA
  - (oxycodone + aspirin)
- 1970: Controlled substances act
  - Consolidated narcotics into 5 separate "schedules"
- 1973: DEA formed
  - Nixon executive order
  - "War on Drugs"
  - U.S. had highest number of heroin addicts of any nation
- 1978: Vicodin introduced to U.S.

# Marketing of Opioids

- 1980’s: Fear of prescribing opioids
- 1984: MS Contin (Purdue Pharma) approved
  - Marketed for cancer pain
- 1990’s: Undertreatment of pain became a dialogue
- 1995: Oxycontin introduced by Purdue Pharma
- Heavily marketed
- Were told the chances of addiction were small because of the time release formulation

# Emphasis on pain management

## Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

- New standards in 2001
- Record pain as the 5th vital sign

Joint Commission on Accreditation of Healthcare Organizations. *Jt Comm Perspect*. 1999;19(5):6-8.
Sklar DP. *Ann Emerg Med*. 1996;27:412-413.

# CMS Removes Pain Management Questions from HCAHPS Survey

*11.07.16*

In a change supported by ASA, the Centers for Medicare and Medicaid (CMS) announced it will remove and revise questions assessing pain management from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. As part of the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule for calendar year (CY) 2017, CMS announced it was "finalizing the removal of the pain management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey for purposes of the Hospital Value-Based Purchasing Program to eliminate any financial pressure clinicians may feel to overprescribe medications." CMS indicated it was "continuing the development and field testing of alternative questions related to provider communications and pain."

**12. During this hospital stay, did you have any pain?**

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 15**

**13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?**

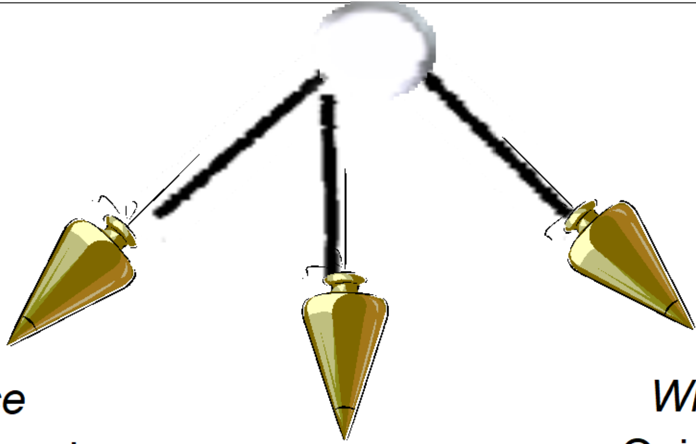
[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

**14. During this hospital stay, how often did hospital staff talk with you about how to treat your pain?**

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

- 2007:  Purdue and three executives plead guilty to misdemeanor charges of false branding of OxyContin; fined $634 million
- 2008:  Drug overdoses, mostly from opiates, surpass auto fatalities as leading cause of accidental death in the United States

# The Opioid Pendulum



*Avoidance*
Even dying people at risk of addiction

*Balance*
Risk stratification and principles of addiction medicine applied to opioid prescribing

regardless of the pain problem at hand

*Widespread Use*
Opiophobia must go

# Current Opioid Epidemic

- CDC: opioid drug related deaths quadrupled from 1999 to 2012; 1,4 deaths per 100,000 to 5.1 deaths, opioid sales quadrupled between 1999 and 2010
- 16,600 overdose deaths in the US in 2010, 45 deaths per day
- United States has the highest opioid use per capita in the world, consumes 80% of the world’s opioids.

# Decline of Oxycodone

- New interventions such as the PDMP
- New regulations on pain clinics
- Prescription drug-attributable mortality rate decreased by 23% from 2010 to 2012, also found to have declines in the prescribing rates of drugs associated with overdose deaths.

# Need for Opioid Prescribing Guidelines: CDC guidelines

- Previous opioid prescribing guidelines have been developed by several states and agencies but were inconsistent
- Most recent national guidelines are several years old and don't incorporate the most recent evidence
- Need for clear, consistent recommendations

# Organization of Recommendations

- The 12 recommendations are grouped into 3 conceptual areas:
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use

# Determining when to initiate or continue opioids for chronic pain

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

# Recommendation #1

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
  - Nonpharmacologic therapy: exercise and cognitive behavior therapy ( CBT)
- Nonopioid pharmacologic therapy: NSAIDs, acetaminophen, anticonvulsants, certain antidepressants ( ex. Duloxetine)
- Consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

# Recommendation #2

- Before initiating opioid therapy for chronic pain
  - Determine how effectiveness will be evaluated.
- Establish treatment goals with patients.
  - Pain relief
  - Function
- Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
  - 30% = clinically meaningful improvement

# Recommendation #3

- Be explicit and realistic about expected benefits
  - Emphasize goal of improvement in **pain and function.**
- Ensure patients are aware of potential benefits, harms, and alternatives to opioids
- Discuss:
  - serious and common adverse effects
  - increased risks of overdose:  when opioids are taken with other drugs or alcohol

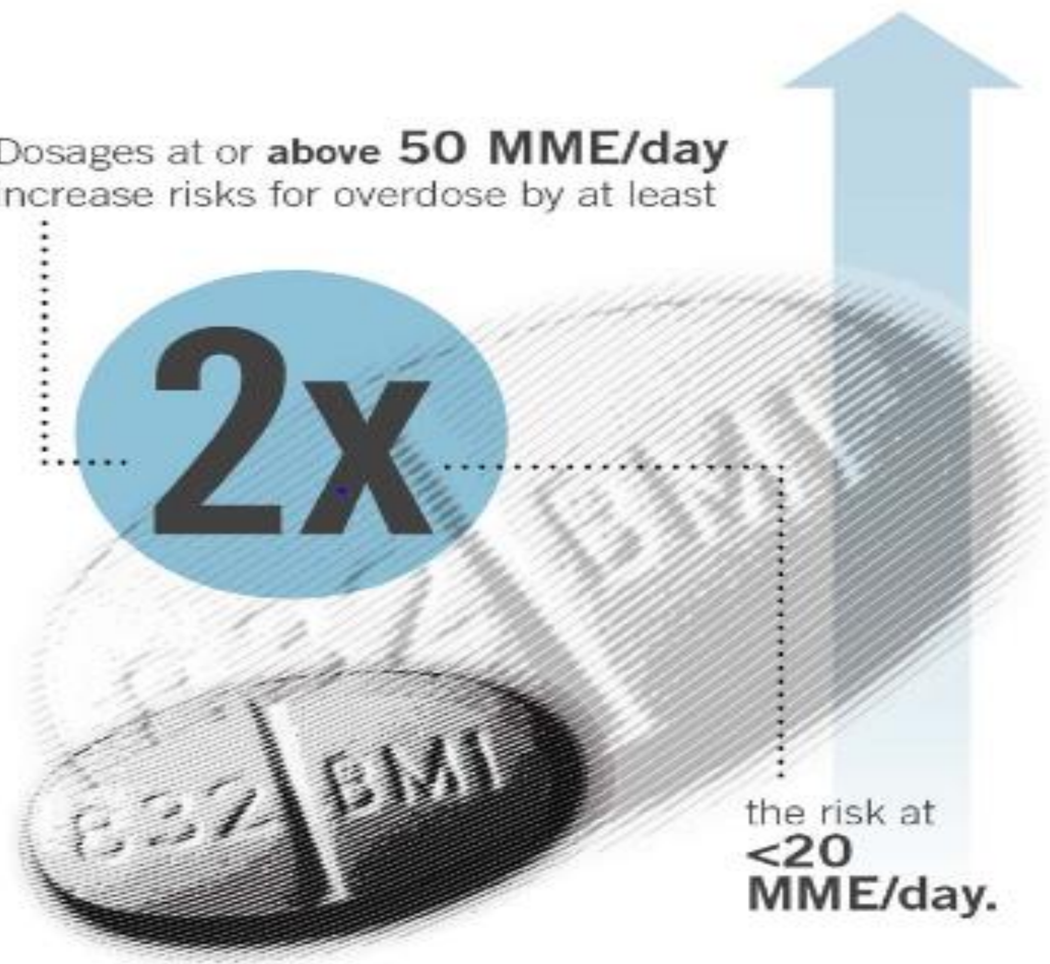
# Opioid selection, dosage, duration, follow-up, and discontinuation

# Recommendation #4

- When starting opioid therapy: prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.
- Choose opioids with predictable pharmacokinetics and pharmacodynamics to minimize overdose risk
  - Methadone should not be the first choice for an ER/LA opioid.
  - Prescribe transdermal fentanyl only if familiar with the dosing and absorption properties and prepared to educate patients about its use.
- Avoid the use of immediate-release opioids combined with ER/LA opioids.

# Recommendation #5

- Start low and go slow
- Prescribe the lowest effective dosage
- Reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day
- Avoid increasing dosage to ≥90 MME/day
- Carefully justify a decision to titrate dosage to >90 MME/day.



Dosages at or above 50 MME/day
increase risks for overdose by at least
2x
the risk at
<20
MME/day.

# Recommendation #6

- When opioids are used for acute pain
  - prescribe the lowest effective dose of immediate-release opioids
  - **prescribe no greater quantity than needed** for the expected duration of pain severe enough to require opioids.
    - Do not prescribe additional opioids “just in case”
- Often <3 days and rarely more than 7 days needed
- Do not prescribe ER/LA opioids for acute pain treatment

# Recommendation #7

- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
- Evaluate benefits and harms of continued therapy with patients every 3 months or more frequently
- If benefits do not outweigh harms of continued opioid therapy
  - Optimize other therapies and psychosocial support
  - Taper/Discontinue opioid therapy
    - Decrease 10% per week

# Assessing risk and addressing harms of opioid use

# Recommendation #8

- Evaluate risk factors for opioid-related harms
- Mitigate risk by offering naloxone when:
  - History of overdose
  - History of substance use disorder,
  - Higher opioid dosages (>50 MME/day)
  - Concurrent benzodiazepine
- Increase risks for opioid-associated harms
  - >65 years old
  - Pregnancy
  - Moderate or severe sleep-disordered breathing

# Recommendation #9

- Review patient's PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.
- Review PDMP data at least every 3 months

# Recommendation #10

- Use urine drug screen (UDS) before starting opioid therapy and consider UDS at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs

# Recommendation #11

- Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible

# Recommendation #12

- Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder
- Assess for OUD using DSM-5 criteria
- If present, offer or arrange Medication-Assisted Treatment (MAT)
  - Buprenorphine
  - Methadone maintenance therapy
  - Oral or long-acting injectable formulations of naltrexone (for highly motivated non-pregnant adults)

# Opioid-Related Case Questions

Case #1

- 23-year-old intubated male arrives in the trauma ICU with multiple traumatic injuries following a motorcycle accident. A family member discloses that he struggle with an active heroin addiction. What is the best approach in treating this patient's pain during his stay in the ICU?

A. Avoid treatment with any opioid medication

B. Initiate a methadone titration for the treatment of pain as well as addiction maintenance

C. Treat heroin withdrawal with IM buprenorphine and IV clonidine according to the COWS protocol

D. Anticipate the need for an increased opioid requirement due to his chronic heroin use and opioid tolerance

# Case Study #2

- 56-year-old Caucasian female with fibromyalgia, degenerative disc disease with chronic back pain
- Treated with opioids in the past  - Oxycontin 80mg bid, oxycodone 15mg 6x/day
- Other mediications: zolpidem 10mg QHS, alprazolam 1mg bid, sertralline 100mg daily
- •No history of early refills, nonsmoker, chronic depression and anxiety.
- •5-Q SOAPP score is 2 (no illegal drug use, nonsmoker, no legal hx or meds over prescribed amounts)
- •ORT score is 2 (no family or personal history of substance abuse, >45yo, + history of
- sexual abuse and psych disease)
- •Complains of severe pain, and wants to restart medications as previously.

# Which of the following would be an important first step prior to starting any new medication?

- A.Obtain a comprehensive urine toxicological screen
- B.Send the patient for a full psychiatric evaluation
- C.Do a comprehensive pain history and physical examination
- D.Tell her opiates are bad and we need to focus on her depression
- E.All of the above