Pain Management and Opioids:

Mitigating Risks

PRESENTED BY

ASAM American Society *of* Addiction Medicine

UPDATED January 2022

FACULTY INFORMATION

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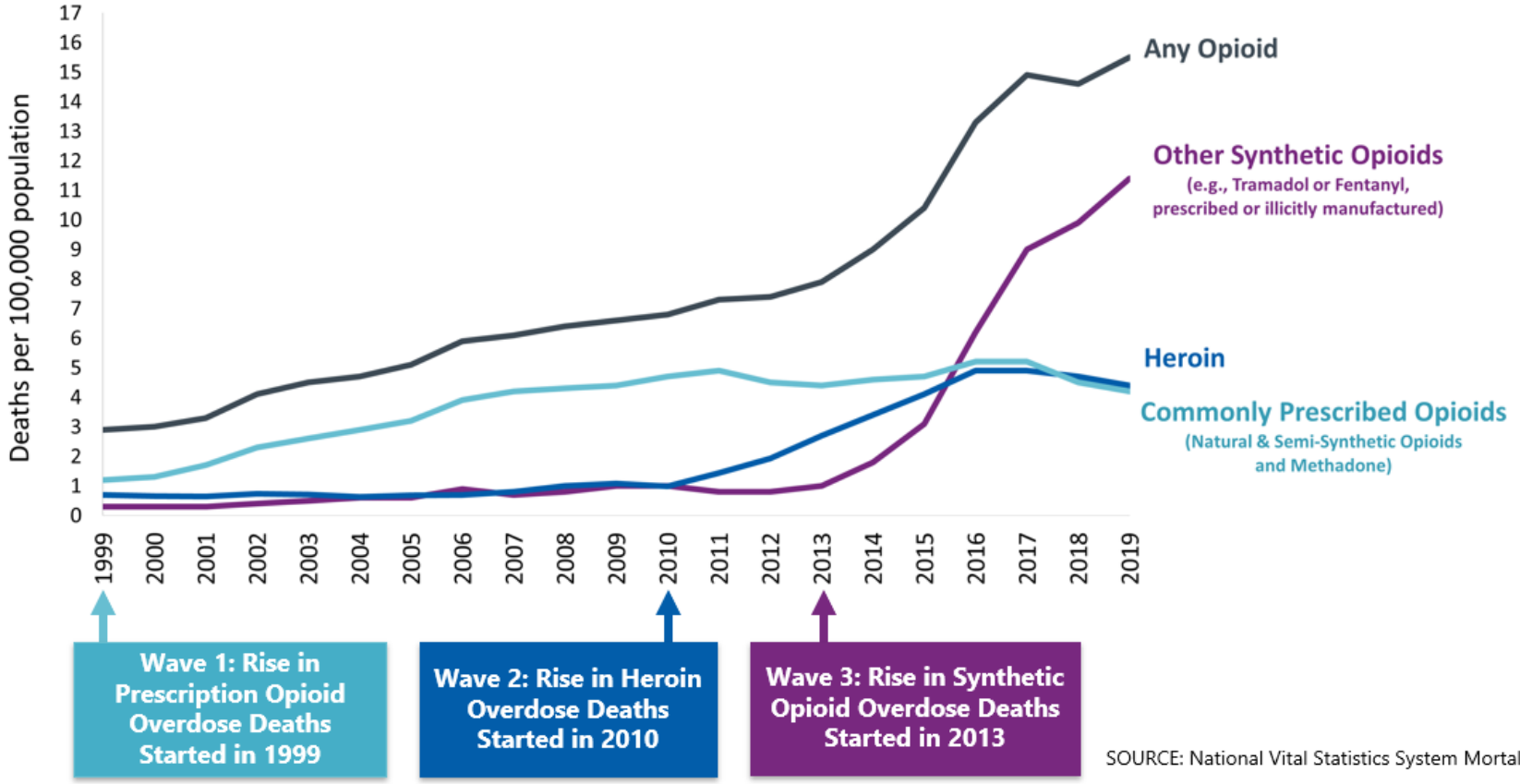
BY THE END OF THIS SESSION YOU WILL BE ABLE TO

- Describe the factors that led to the *Opioid Overdose Death Epidemic*.
- Use *non-stigmatizing language* to discuss pain and addiction.
- Describe the *pathophysiology of pain* as it relates to the concepts of pain management.
- Recognize behaviors that may be associated with *substance use disorder.*
- Accurately *assess* pain and addiction.
- Develop a safe and effective pain *treatment plan.*
- Identify the risks, benefits, and appropriate procedures for *opioid therapy.*
- Identify evidence-based *non-opioid options* for the treatment of pain.
- *Educate* patients and their caregivers about opioids.

WHY ARE WE HERE?

THREE WAVES OF THE RISE IN OPIOID OVERDOSE DEATHS



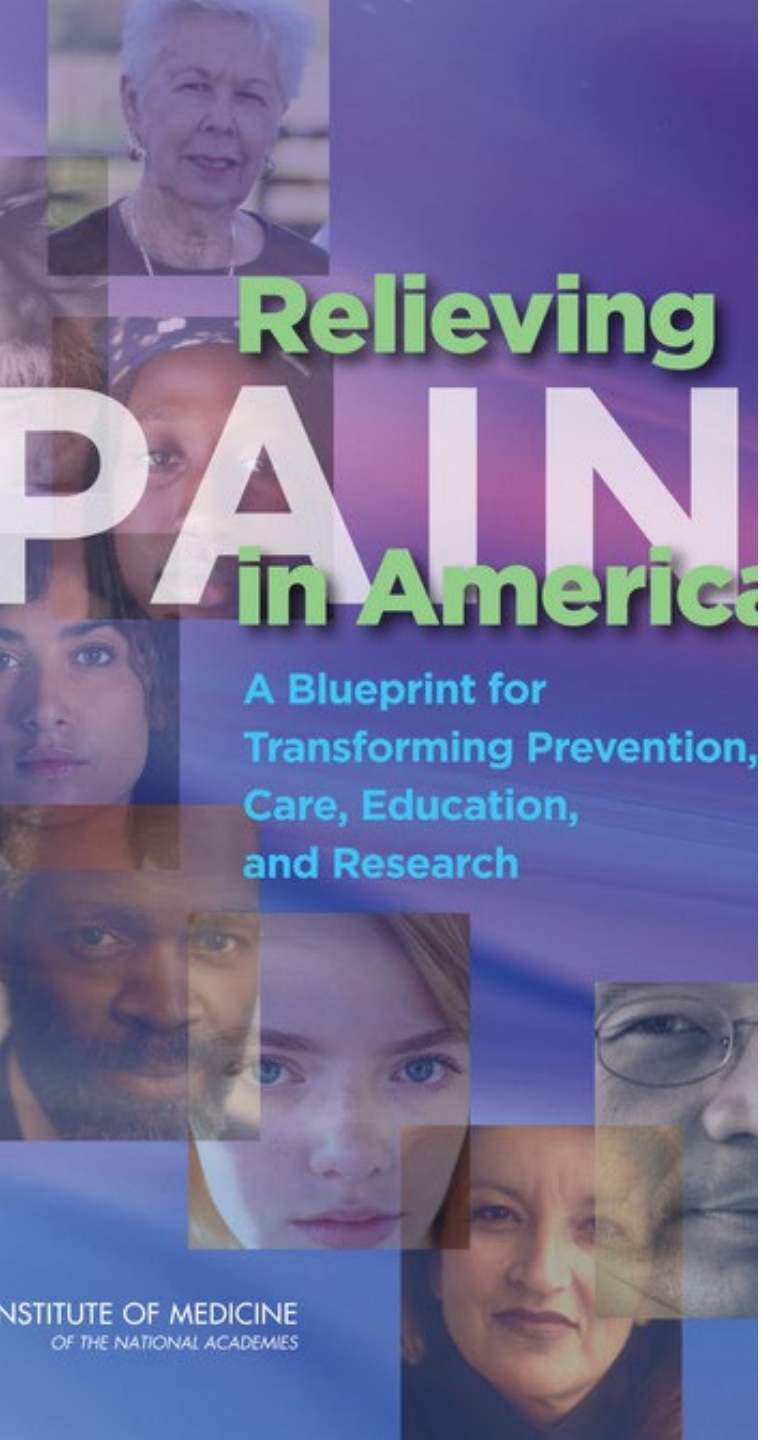
SOURCE: National Vital Statistics System Mortality File.

The Prescription Opioid Epidemic
The Rise of Heroin
The Ascent of Fentanyl

Opioid Overdose Death Epidemic

THE CLINICAL CHALLENGE

SOURCE: JAMA. 2016;315(17):1826

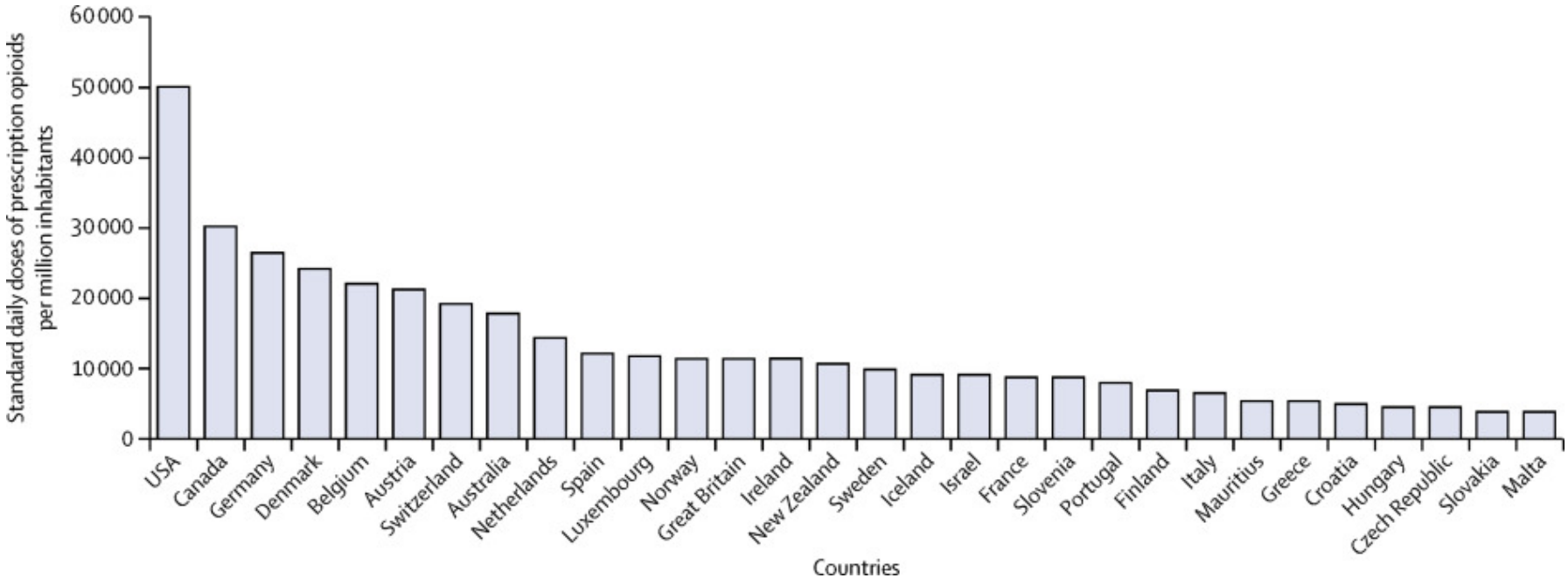


PAIN RELIEF IN THE USA

- 2011 IOM Report: **116 Million Americans have pain which persists for weeks to years**
- $560-$635 Billion per year
- Some physicians overprescribe opioids, while others refuse to prescribe
- Lack of education: Providers and Patients
- Primarily Chronic Non-Cancer Pain

SOURCE: NEJM 366:3 Jan 19,2012

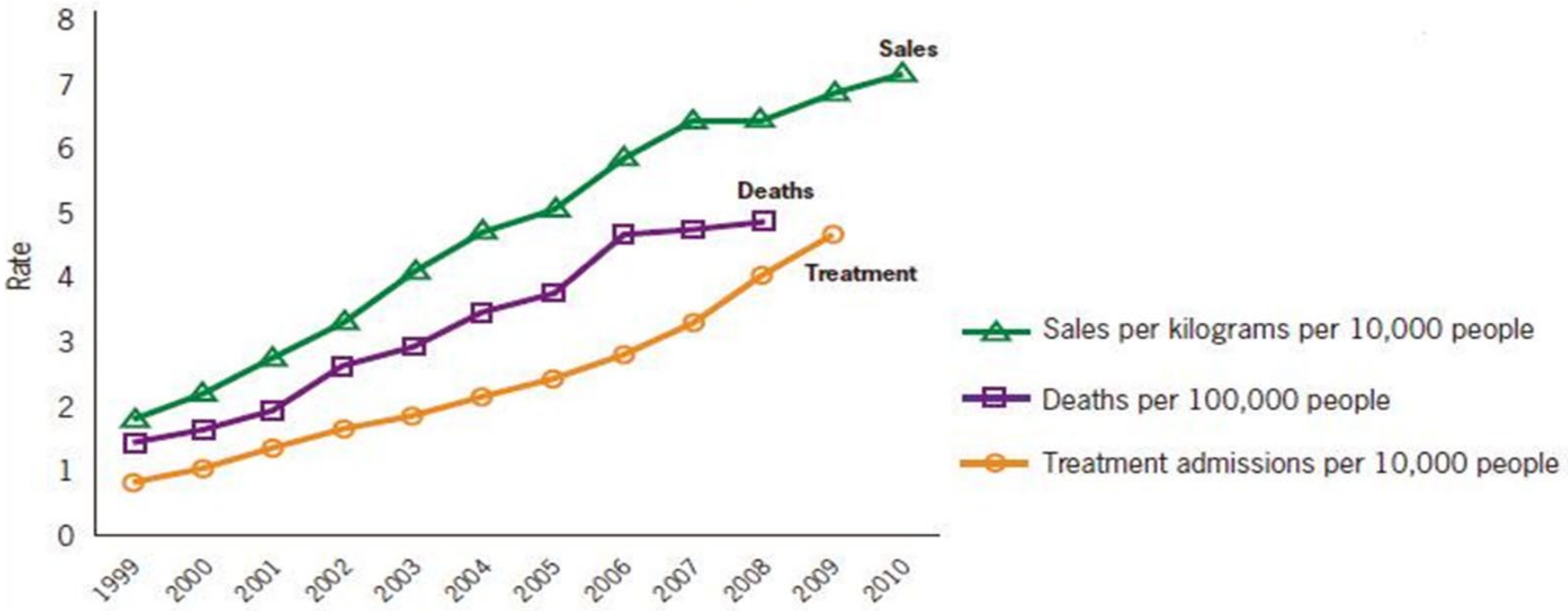
AVOIDING GLOBALIZATION OF THE PRESCRIPTION OPIOID EPIDEMIC



Top 30 Opioid-Consuming Nations 2012-2014

SOURCE: Lancet, Vol 390, 29 July–4 August 2017, Pages 437-439, Keith Humphreys

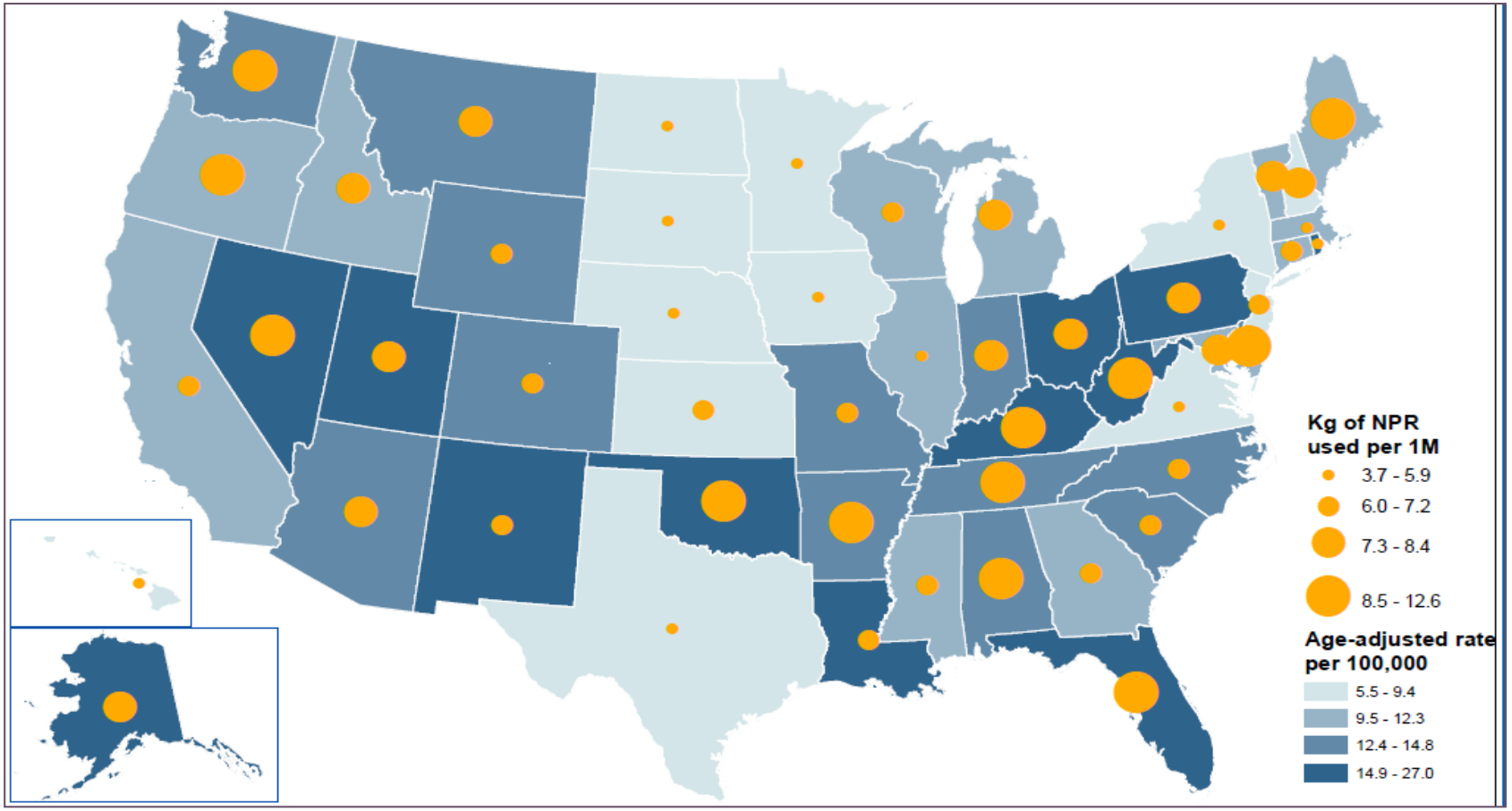
AVOIDING GLOBALIZATION OF THE PRESCRIPTION OPIOID EPIDEMIC



Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010

SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009.

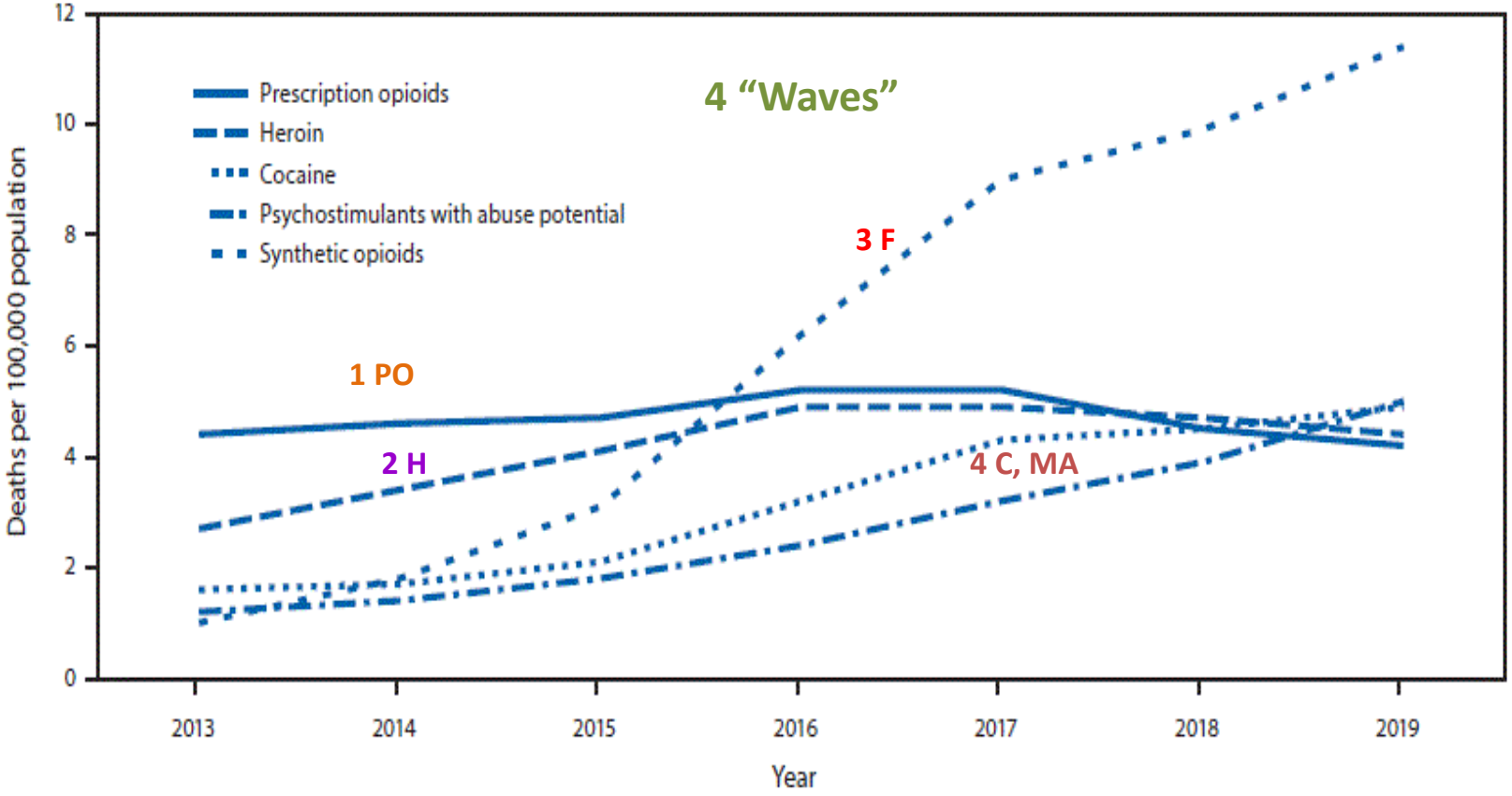
RELATIONSHIP BETWEEN OVERDOSE DEATHS & OPIOID SALES



Drug Overdose Death Rate, 2008, and Opioid Pain Reliever Sales Rate, 2010

SOURCE: National Vital Statistics System, 2008; Automated Reports Consolidated Orders System, 2010.

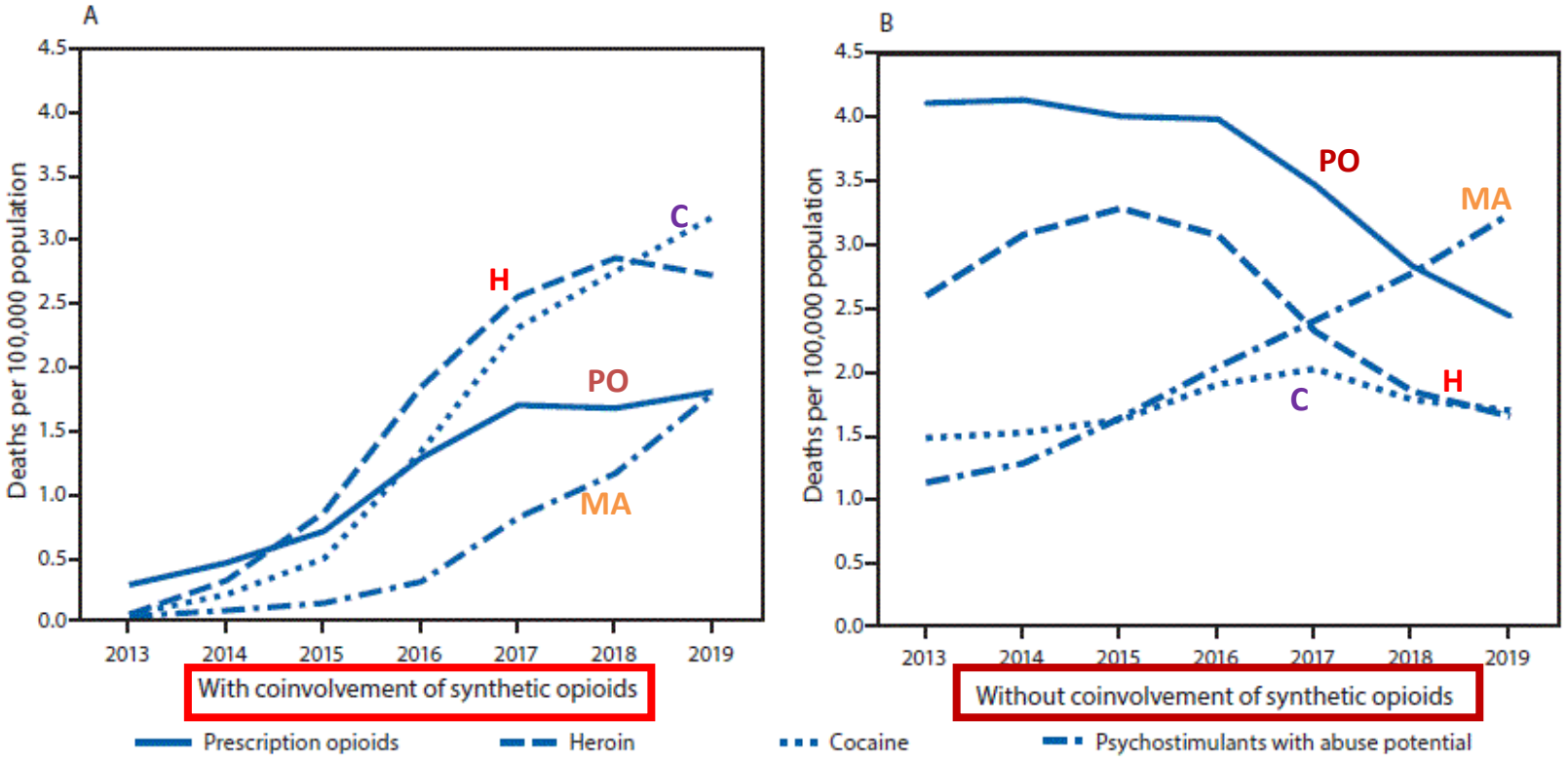
THE 4 "WAVES" OF DRUG OVERDOSE DEATHS



Age-Adjusted Rates of Drug Overdose Deaths Involving Prescription Opioids, Heroin, Cocaine, Psychostimulants with Abuse Potential, and Synthetic Opioids Other than Methadone— United States, 2013–2019

SOURCE: MMWR Morb Mortal Wkly Rep 2021;70:202–207

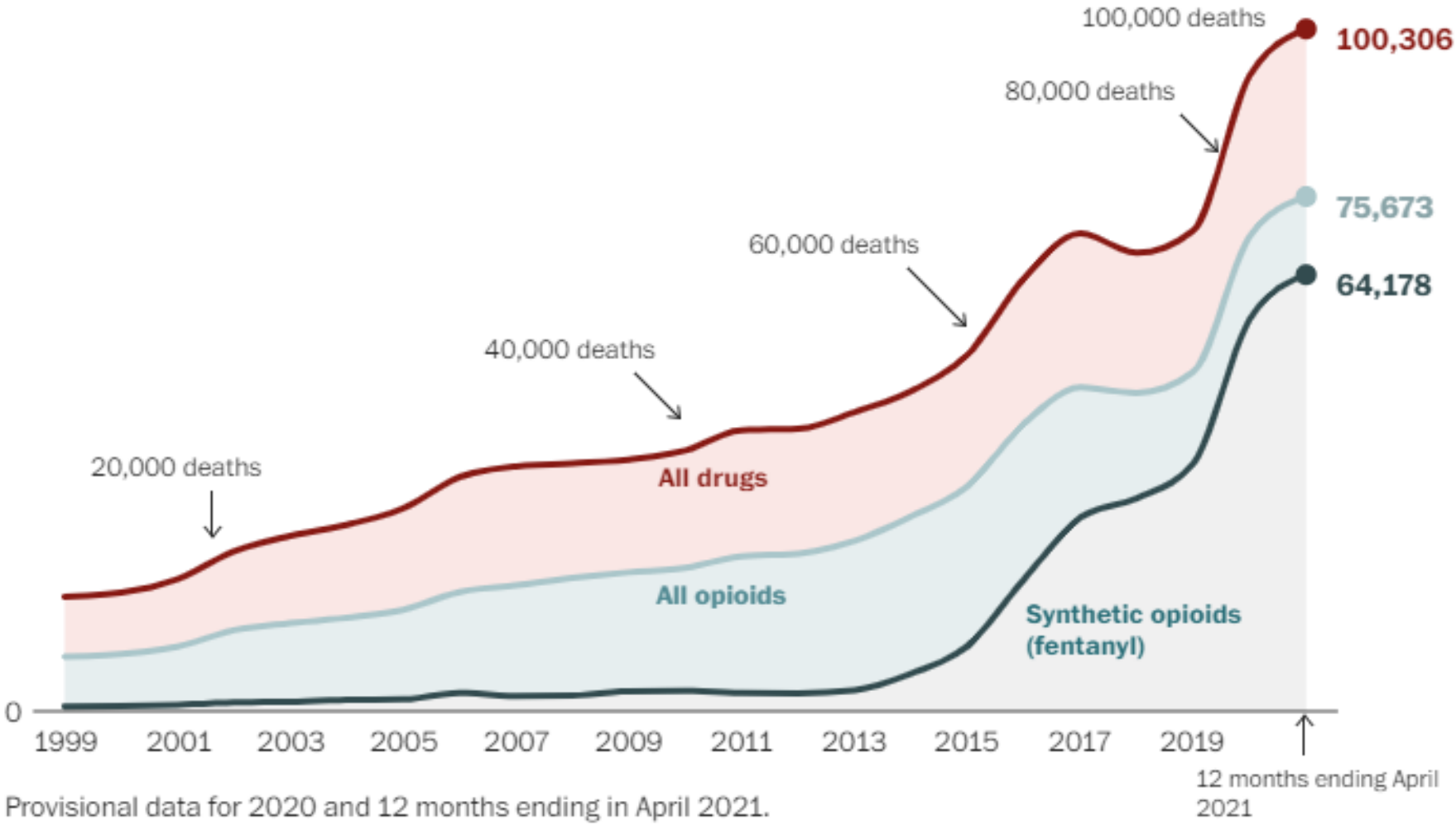
OVERDOSE DEATHS & SYNTHETIC OPIOIDS



Age-adjusted rates of drug overdose deaths involving prescription opioids, heroin, cocaine, and psychostimulants with abuse potential, with (A) and without (B) synthetic opioids other than methadone — United States, 2013–2019

SOURCE: MMWR Morb Mortal Wkly Rep 2021;70:202–207

US DRUG OVERDOSE DEATHS PER YEAR



SOURCE: CDC, National Center for Health Statistics

“PERFECT STORM”

1995: Introduction of Oxycontin

1995: Pain is Fifth Vital Sign

Publications indicating low risk of addiction

Thought Leaders with Financial/ Pharma Conflicts

Patient Satisfaction Surveys: “…staff did everything they could to help you with your pain”

Physicians successfully sued for not treating pain

No Evidence

Long Term Effectiveness COT → CNCP

Physical Dependence (ease of tapering) vs Addiction

INTENDED/UNINTENDED CONSEQUENCES TO PRESCIPTION OPIOID EPIDEMIC

INTENDED

- Prescription Drug Monitoring Programs: PDMP
- Limits on the quantity and dosage prescribed
- UDTs (Saliva) becoming standard of care
- Naloxone Overdose Prevention Programs
- Education of prescribers: FDA REMS Opioid Course
- CDC Guidelines
- Tamper Resistant/Abuse Deterrent Formulations

UNINTENDED

- HEROIN: Cheaper(10:1 Oxy:H), Readily Accessible
- Fentanyl and Fentanyl Analogues

FENTANYL AND FENTANYL ANALOGUES

Overdose deaths from street fentanyl and fentanyl analogues, such as carfentanil, have increased 540% in three years.

Street fentanyl is illegally manufactured; it is generally NOT a diverted pharmaceutical product.

Two causes of fentanyl OD death: opioid-induced **respiratory depression** and **rigid chest wall syndrome**; higher or repeated doses of naloxone are required to reverse a fentanyl overdose.

Fentanyl is also unknowingly mixed with heroin, cocaine, and methamphetamine, which contributes to OD deaths.

Photo source: New Hampshire State Police Forensic Laboratory

RISKS VERSUS BENEFITS OF PRESCRIBED OPIOIDS

RISKS

- Misuse, diversion, and addiction
- Abuse by patient or household contacts
- Interactions with other meds and substances
- Risk of neonatal abstinence syndrome
- Inadvertent exposure/ingestion by household contacts, especially children
- Life-threatening respiratory depression
- Overdose, especially as ER/LA formulations contain more MME than IR

BENEFITS

- Analgesia
  - Reliable pain control
  - Quick analgesia (particularly with Immediate Release)
- Continuous, predictable (with Extended-Release/Long-Acting) Improved function
- Improved quality of life

SOURCE: Nicholson, B. Pain Pract. 2009;9(1):71-81. http://onlinelibrary.wiley.com/doi/10.1111/j.1533-2500.2008.00232.x/abstract

CHAPTER 2
TERMINOLOGY

WORDS MATTER: LANGUAGE CHOICE CAN REDUCE STIGMA

"If you want to care for something, you call it a flower; if you want to kill something, you call it a weed." —Don Coyhis

Stigmatizing Term	Preferred Term
Abuse	Use, misuse, low-risk, unhealthy, harmful use
Drug-seeking, aberrant/problematic behavior	Using medication not as prescribed
Addict, drug user, alcoholic, crack head	Person with substance use disorder (SUD)
Clean/dirty urine	Positive/negative urine drug screen
Fix, binge, relapse	Dose, use, heavy drinking episode, return to use
Detoxification	Withdrawal management

SOURCES: Saitz, R., Miller, S. C., Fiellin, D. A., & Rosenthal, R. N. (2021). Recommended use of terminology in addiction medicine. Journal of Addiction Medicine, 15(1), 3-7.

WORDS MATTER: DEFINITIONS

Misuse	Use of a medication in a way other than the way it is prescribed
Tolerance	Increased dosage needed to produce a specific effect
Diversion	Transfer of a legally controlled substance, prescribed to one person, to another person for illicit (forbidden by law) use
Withdrawal/ Physical Dependence	Occurrence of uncomfortable symptoms or physiological changes caused by an abrupt discontinuation or dosage decrease of a pharmacologic agent
MME	Morphine milligram equivalents; a standard opioid dose value based on morphine and its potency; allows for ease of comparison and risk evaluations
Chronic non-cancer pain (CNCP)	Any painful condition that persists for ≥ 3 months, or past the time of normal tissue healing, that is not associated with a cancer diagnosis

SOURCES: SAMHSHA Resource: https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf
World Health Organization, Ensuring Balance in National Policies on Controlled Substances.
https://www.who.int/medicines/areas/quality_safety/GLs_Ens_Balance_NOCP_Col_EN_sanend.pdf

CLEAN URINE

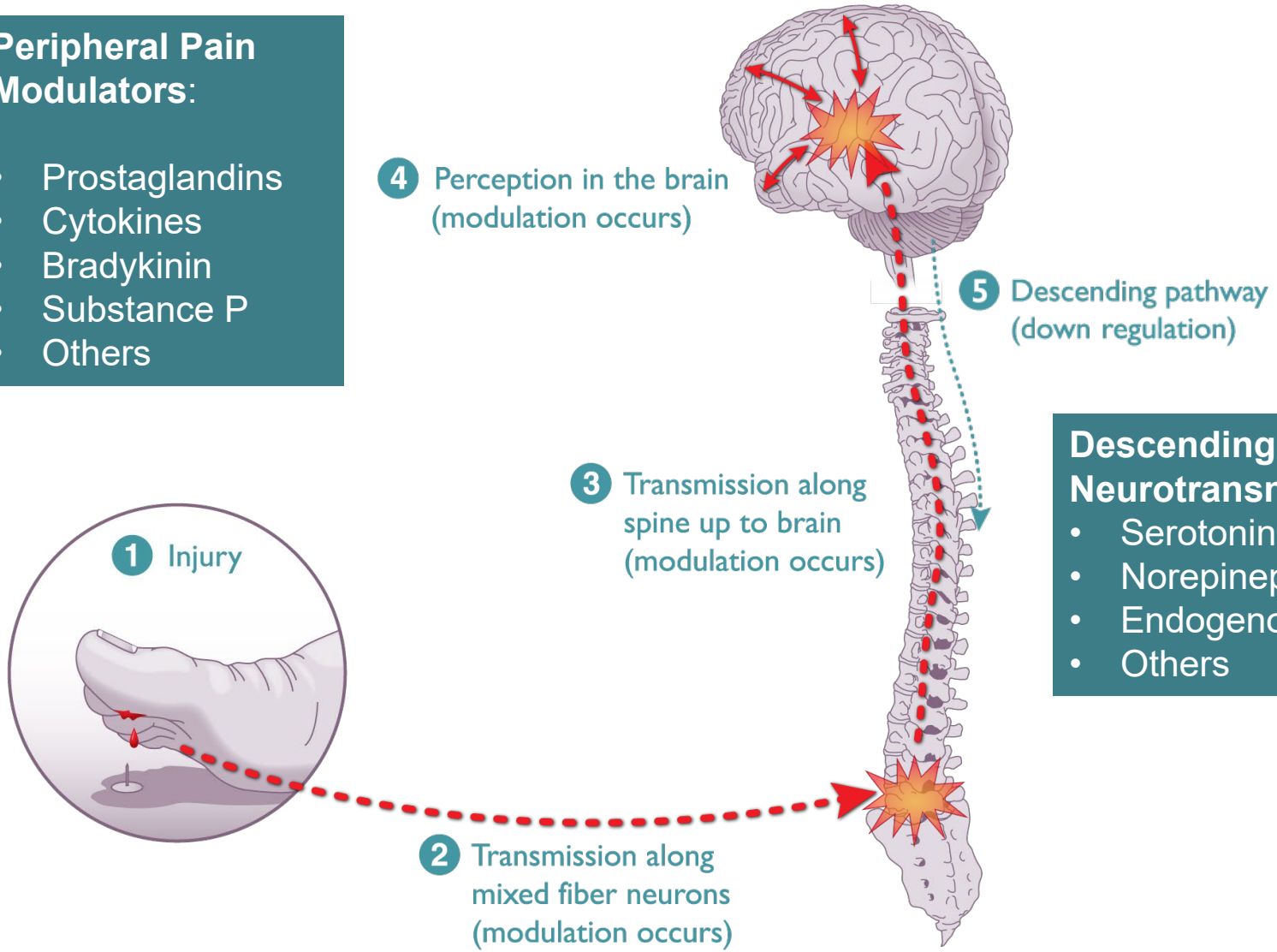
DIRTY URINE

CHAPTER 1
PAIN

THE NEUROMECHANISMS OF PAIN

Peripheral Pain Modulators:

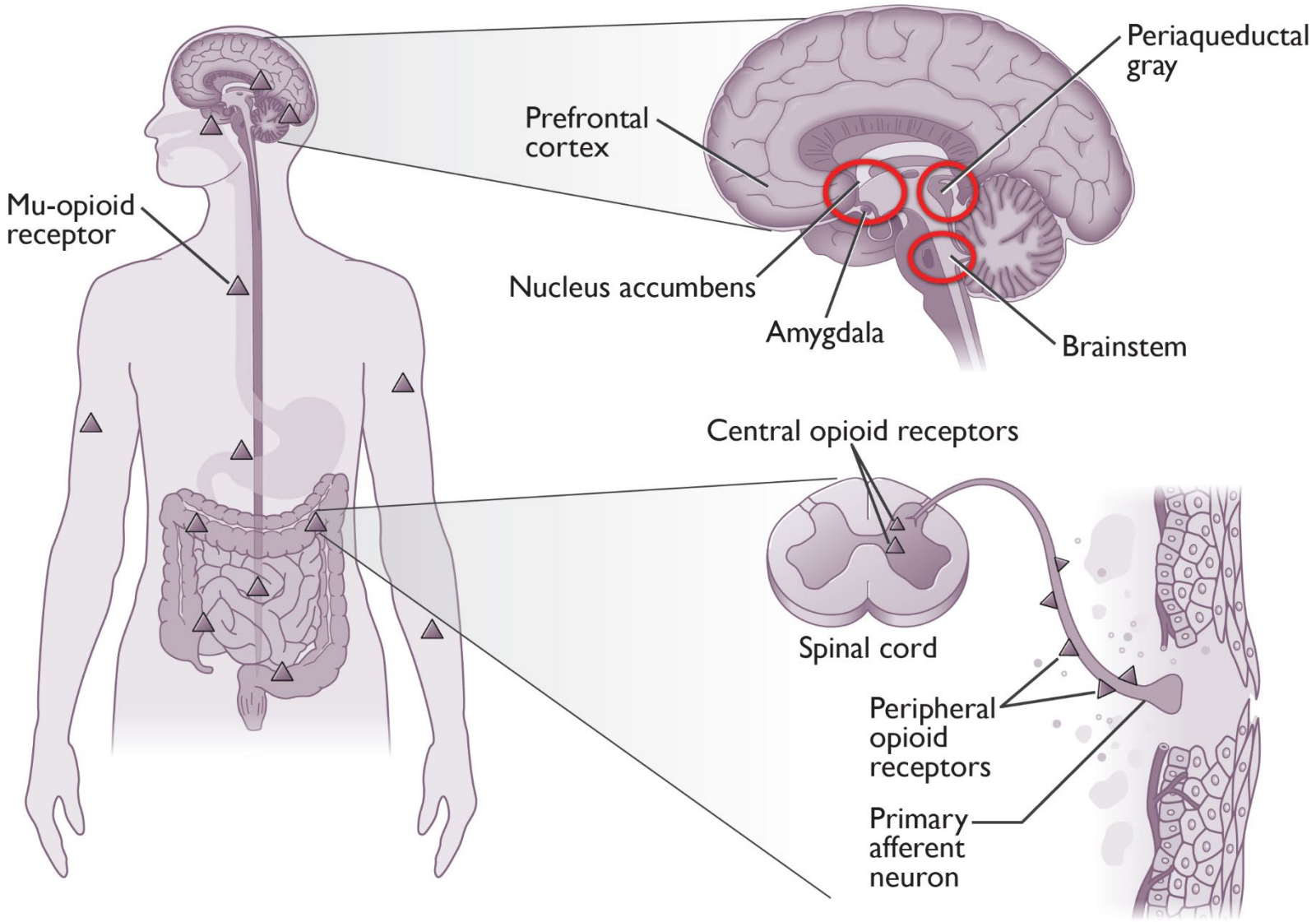
- Prostaglandins
- Cytokines
- Bradykinin
- Substance P
- Others



Descending Neurotransmitters:

- Serotonin
- Norepinephrine
- Endogenous opiates
- Others

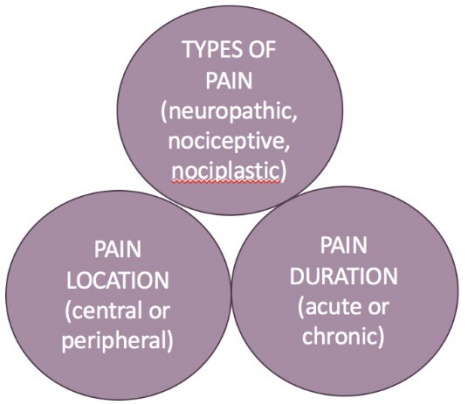
OPIOID RECEPTOR LOCATIONS



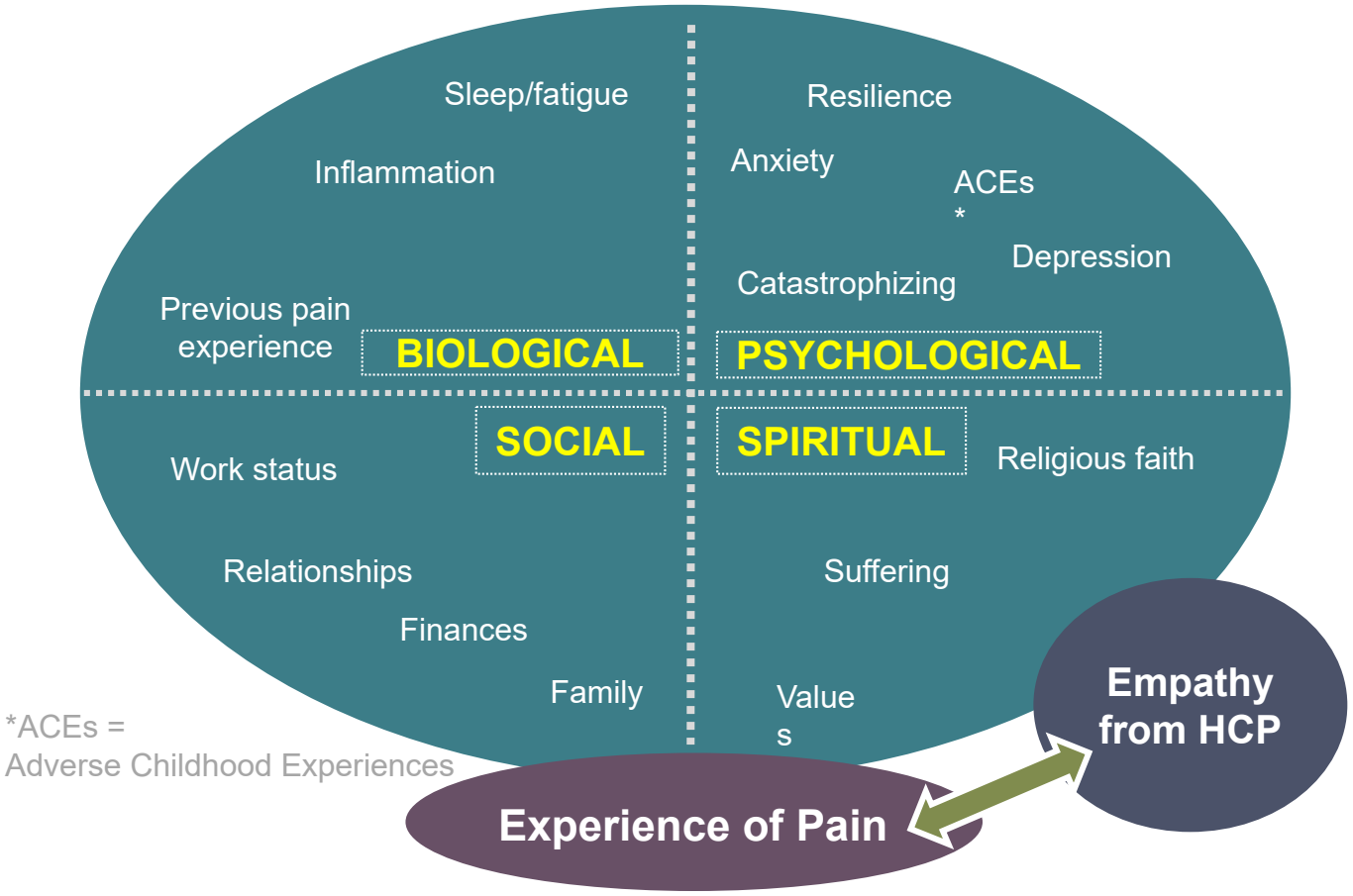
TYPES OF PAIN

NOCICEPTIVE / INFLAMMATORY	NOCIPLASTIC	NEUROPATHIC	MIXED TYPES (NOCICEPTIVE / NEUROPATHIC)
Pain in response to an injury or stimuli; *typically* acute	Pain that arises from altered nociceptive function; *typically* chronic	Pain that develops when the nervous system is damaged; *typically* chronic	Primary injury and secondary effects
Postoperative pain, sports injuries, arthritis, sickle cell disease, mechanical low back pain	Fibromyalgia, irritable bowel syndrome, non-specific low back pain	Post-herpetic neuralgia, trigeminal neuralgia, distal polyneuropathy, CRPS, neuropathic low back pain	

Possible development of chronic pain after an acute injury.



THE BIOPSYCHOSOCIAL SPIRITUAL CONTEXT OF PAIN

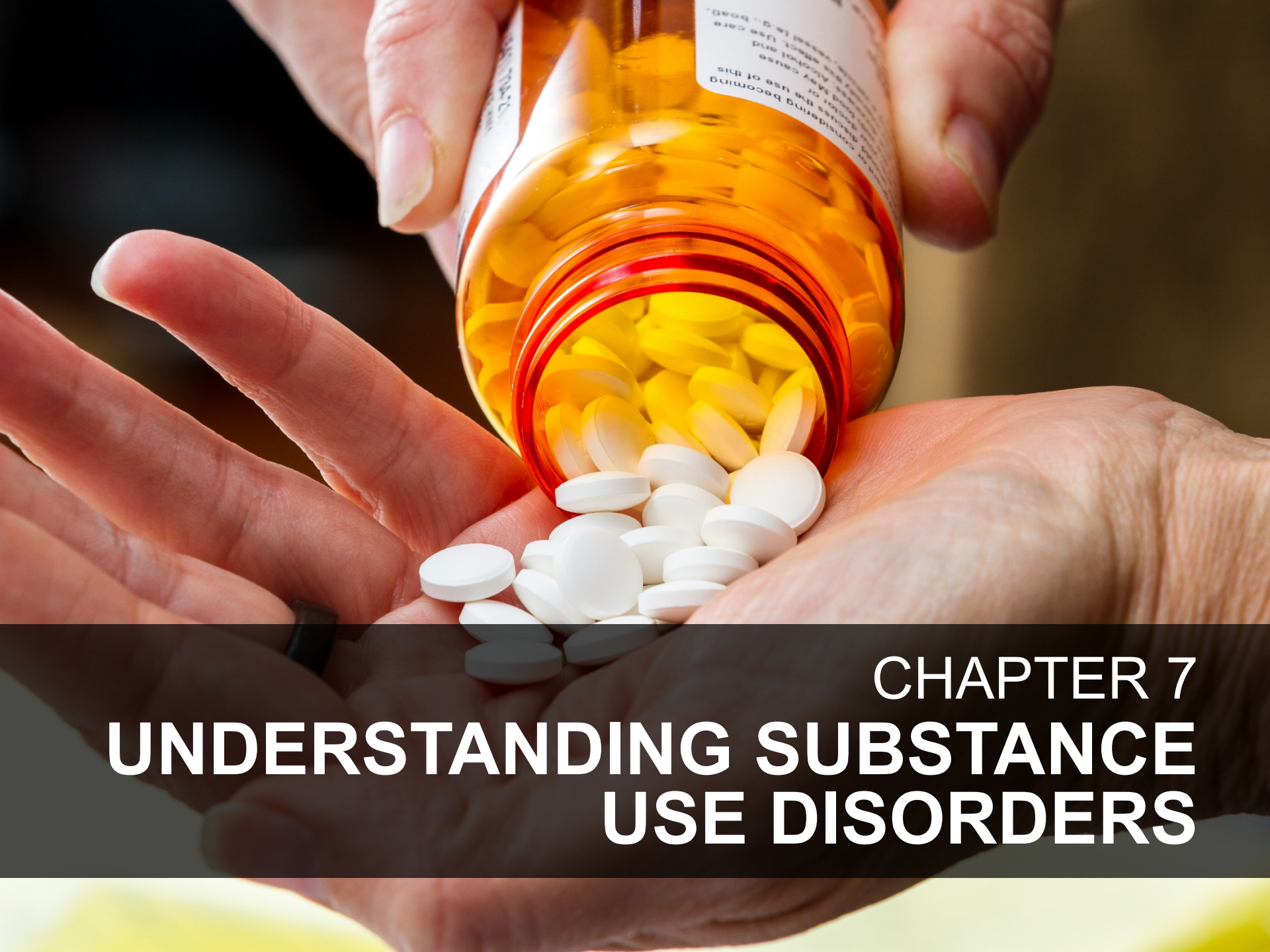


PAIN CATASTROPHIZING

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

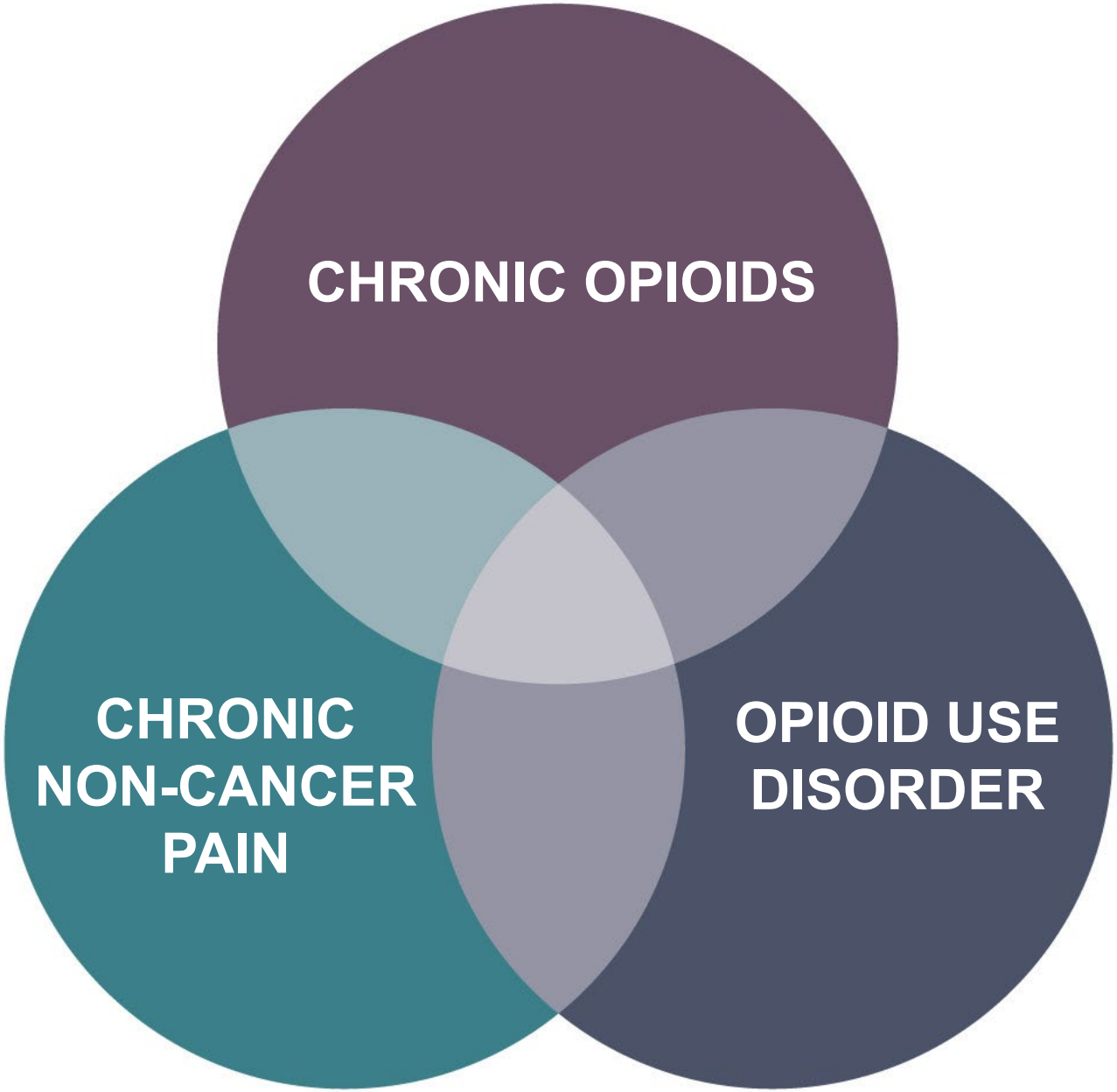
SOURCE: Pain Catastrophizing Scale © 2009 Dr. Michael JL Sullivan
Mapi Research Trust, Lyon, France. Internet: https://eprovide.mapi-trust.org

- "*Tell me about your pain…*"
- Listen for rumination, feelings of hopelessness, or anticipation of negative outcomes.
- These feelings are important to identify because they can prolong and intensify pain; or lead to higher levels of suffering and altered perception of pain.
- If identified, shift to "*tell me about your life.*"
- Consider a pain psychologist referral



CHAPTER 7

UNDERSTANDING SUBSTANCE USE DISORDERS


CHRONIC OPIOIDS
CHRONIC NON-CANCER PAIN
OPIOID USE DISORDER

OPIOIDS

WHAT IS THE RISK FOR MY PATIENT?

- Risk of opioid use disorder in patients on chronic opioid therapy (COT) for chronic non-cancer pain (CNCP) is up to **36.3%**
- Risk is always highest with past history of substance use disorder (SUD) or psychiatric comorbidity

SOURCE: Jantarada C, Silva C, Guimarães-Pereira L. Pain Pract. 2021;21(6):715-729. doi:10.1111/papr.13001

WHAT IS ADDICTION?

PRACTICAL DEFINITION:

Addiction is the continued use of drugs or activities, despite knowledge of continued **harm** to one's self or others.

OFFICIAL ASAM DEFINITION:

Addiction is a **treatable**, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. **Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.**

SOURCE: Ann Quinlan-Colwell, PhD, PCSS-O Webinar 2011

SUBSTANCE USE DISORDER: DSM-5 CRITERIA

Be alert to these factors in your patients on long-term opioid therapy

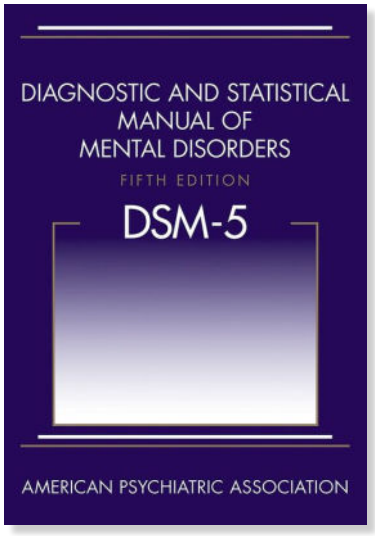
1. Tolerance *
2. Withdrawal *

LOSS OF CONTROL

3. Using larger amounts and/or for longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using, or recovering
6. Craving/compulsion

USE DESPITE NEGATIVE CONSEQUENCES

7. Role failure at work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm



- 2 – 3 = mild
- 4 – 5 = moderate
- ≥6 = severe

*** Not valid if opioid is taken as prescribed**

SOURCE: APA. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 2013

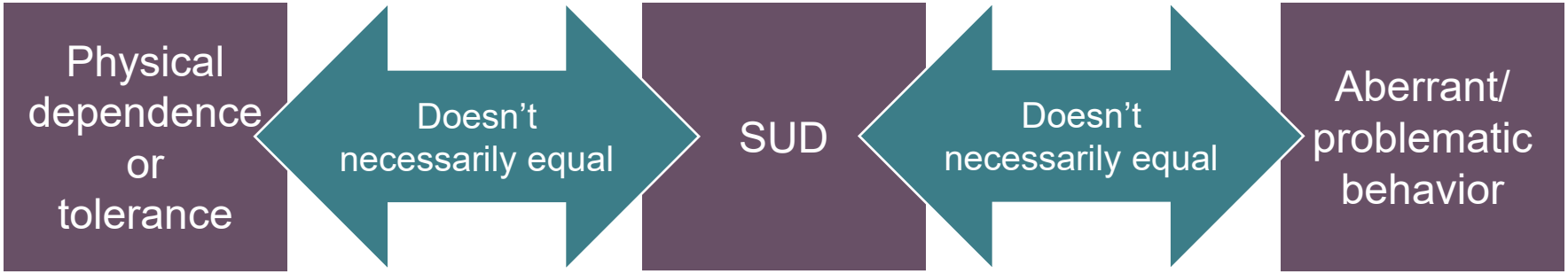
PAIN, OUD, AND OPIOIDS

The DSM-5 criteria for opioid use disorder may be misleading in the context of *prescribed opioids* for the treatment of pain.

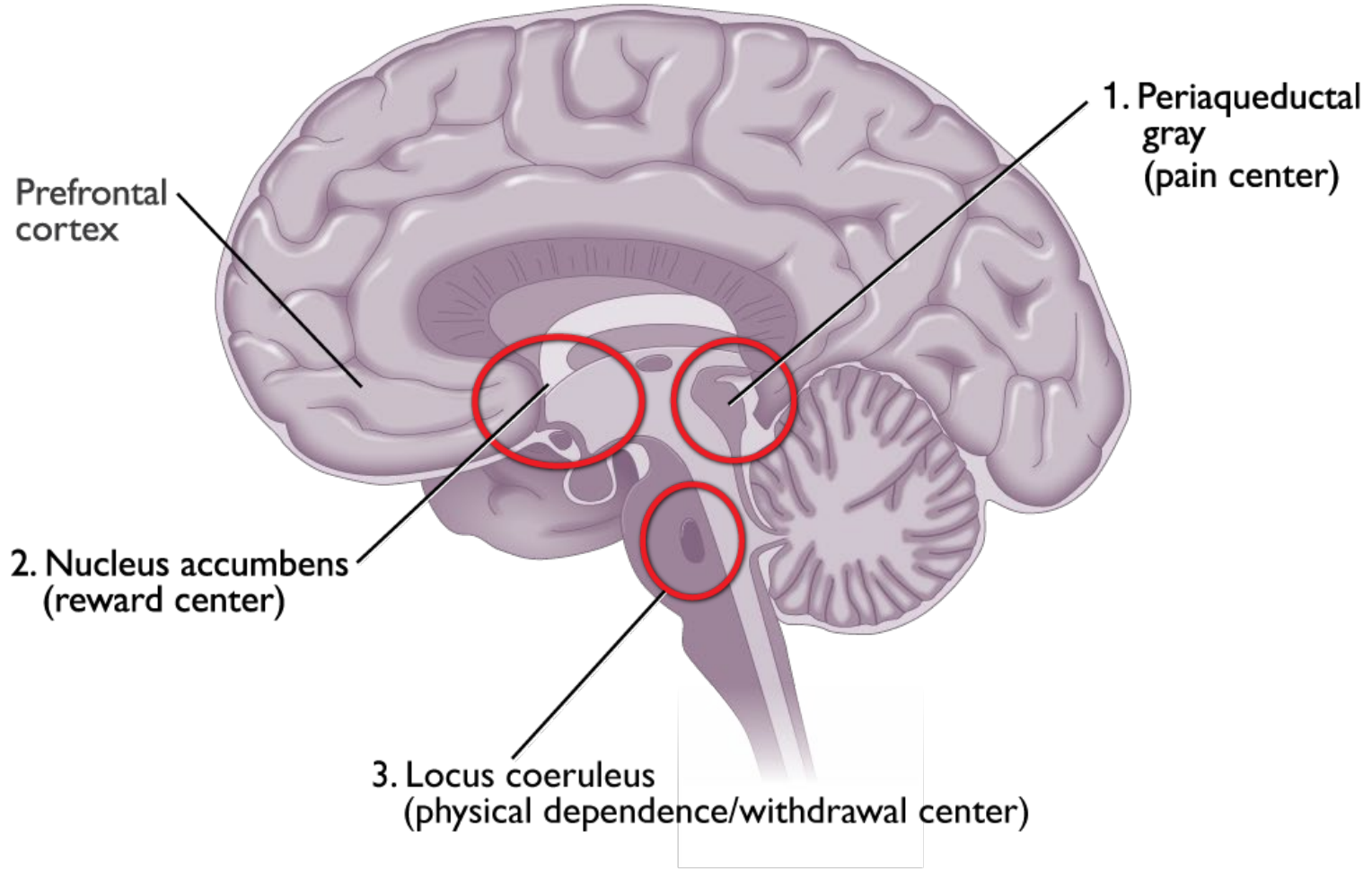
Harm may be masked under these conditions.

Clinical judgement is key.

WORDS MATTER



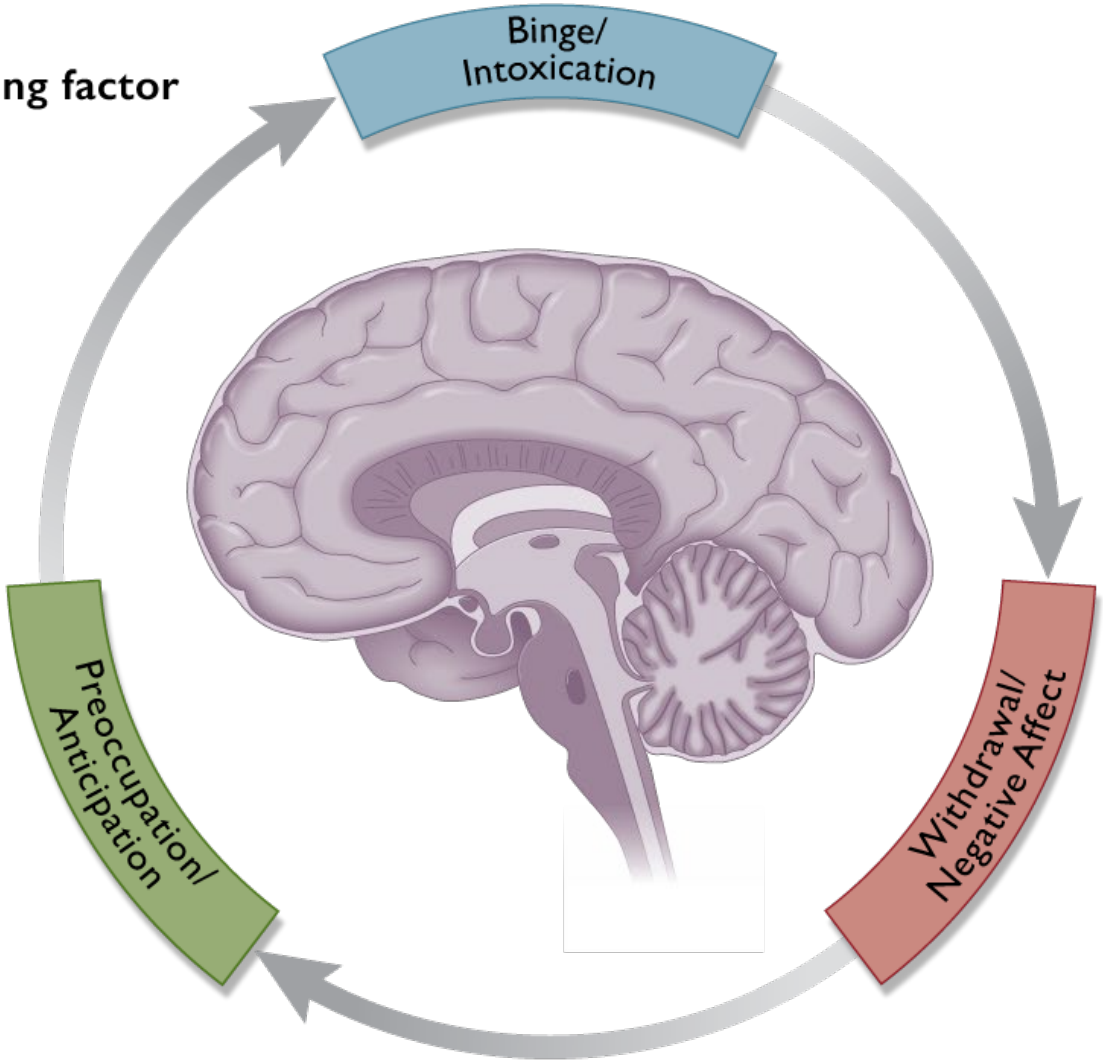
OPIOID RECEPTORS IN THE BRAIN: RELATIONSHIP TO ANALGESIA, OUD, AND WITHDRAWAL



THE CYCLE OF SUBSTANCE USE DISORDER

NEUROTRANSMITTERS

- Dopamine
- Opioid peptides
- Corticotropin-releasing factor
- Dynorphin
- Glutamate



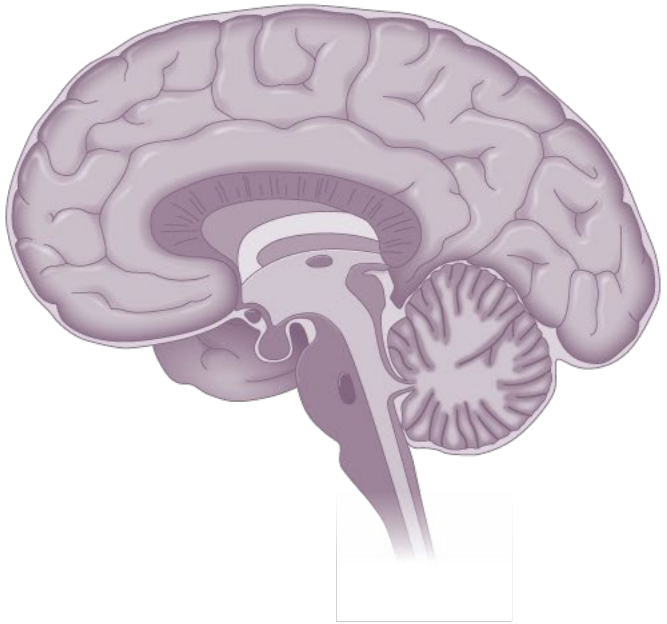
EVERYONE IS VULNERABLE, BUT WHO IS *MOST* VULNERABLE TO OPIOID MISUSE OR OUD OR SUBSTANCE USE DISORDERS?

Those with low hedonic tone

Those with psychiatric comorbidities

Those with a genetic predisposition to substance abuse (family history)

The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after 5 days or 1 month of opioids has been prescribed.



TREATMENT OF OPIOID USE DISORDER

- Medication options for addiction treatment
  - Methadone (Schedule II)
  - Buprenorphine (Schedule III)
  - Naltrexone (not a controlled substance)
- Supplementary psychosocial and recovery support services
  - Housing, childcare, support groups, employment services
- Temporal considerations
  - Frequency of administration (daily versus long-acting formulations)
  - Length of treatment
    - No recommended time period for treatment
    - Patients who discontinue medications and resume street opioids risk overdose and death

TREATING PAIN IN THE PATIENT WITH OUD

- Remember that untreated pain is a trigger for relapse
- Must address *both* pain and opioid use disorder
- Avoid other potentially problematic medications
- Consider a multidisciplinary pain program

- Consider buprenorphine for both pain and OUD
- Consider using opioids that do not metabolize to other prescribed medications
- Enlist patient's family/ significant other to secure and dispense opioids
- Recommend an active recovery program
- Remember to use UDT, PDMP, pill counts, PPA

SOURCE: Bailey J, et al. Pain Med 2010;11:1803-1818.

BUPRENORPHINE

- If using for pain, you **do not** need a Buprenorphine waiver
- If using to treat OUD, you **do** need a waiver
- The most commonly prescribed pharmacotherapy for the treatment of OUD
- Partial mu-agonist with “plateau effect” for respiratory depression
- Good efficacy and safety profile
- FDA-approved buprenorphine products for pain:
  - Butrans: 7-day transdermal patch
  - Belbuca: buccal mucosal film; BID dosing

BUPRENORPHINE ROTATION

In this systematic review, *buprenorphine was associated with reduced chronic pain intensity* without precipitating opioid withdrawal in individuals with chronic pain who were receiving long-term opioid therapy (LTOT).

These findings suggest that *buprenorphine rotation may be a viable option for mitigating the harms of LTOT in individuals with chronic pain* who were receiving unsafe opioid analgesic regimens.

JAMA Network | Open

Original Investigation | Substance Use and Addiction

Evaluation of Buprenorphine Rotation in Patients Receiving Long-term Opioids for Chronic Pain
A Systematic Review

Victoria D. Powell, MD; Jack M. Rosenberg, MD; Avani Yagantl, BS; Claire Garpestad, MD; Pooja Lagisetty, MD, MSc; Carol Shannon, MPH; Maria J. Silveira, MD, MA, MPH

Abstract

IMPORTANCE Individuals with chronic pain who use long-term opioid therapy (LTOT) are at risk of opioid use disorder and other harmful outcomes. Rotation to buprenorphine may be considered, but the outcomes of such rotation in this population have not been systematically reviewed.

OBJECTIVE To synthesize the evidence on rotation to buprenorphine from full μ-opioid receptor agonists among individuals with chronic pain who were receiving LTOT, including the outcomes of precipitated opioid withdrawal, pain intensity, pain interference, treatment success, adverse events or adverse effects, mental health condition, and health care use.

EVIDENCE REVIEW PubMed, CINAHL, Embase, and PsycInfo were searched from inception through November 3, 2020, for peer-reviewed original English-language research that reported the prespecified outcomes of rotation from prescribed long-term opioids to buprenorphine among individuals with chronic pain. Two independent reviewers extracted data as well as assessed risk of bias and study quality according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guidelines. Quality of evidence was assessed with the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.

FINDINGS A total of 22 studies were analyzed, of which 5 (22.7%) were randomized clinical trials, 7 (31.8%) were case-control or cohort studies, and 10 (45.5%) were uncontrolled pre-post studies, which involved 1616 unique participants (675 female [41.8%] and 941 male [58.2%] individuals). Six of the 22 studies (27.3%) were primary or secondary analyses of a large randomized clinical trial. Participants had diverse pain and opioid use histories. Rationale for buprenorphine rotation included inadequate analgesia, intolerable adverse effects, risky opioid regimens (eg, high dose and/or sedative coprescriptions), and aberrant opioid use. Most protocols were adapted from protocols for initiating treatment in patients with opioid use disorder and used buccal or sublingual buprenorphine. Very low-quality evidence suggested that buprenorphine rotation was associated with maintained or improved analgesia, with a low risk of precipitating opioid withdrawal. Steady-dose buprenorphine was better tolerated than tapered-dose buprenorphine. Adverse effects were manageable, and severe adverse events were rare. Only 2 studies evaluated mental health outcomes, but none evaluated health care use. Limitations included a high risk of bias in most studies.

CONCLUSIONS AND RELEVANCE In this systematic review, buprenorphine was associated with reduced chronic pain intensity without precipitating opioid withdrawal in individuals with chronic pain who were receiving LTOT. Future studies are necessary to ascertain the ideal starting dose, formulation, and administration frequency of buprenorphine as well as the best approach to buprenorphine rotation.

JAMA Network Open. 2021;4(9):e2124152. doi:10.1001/jamanetworkopen.2021.24152

Key Points

Question Is rotation to buprenorphine from full μ-opioid receptor agonists associated with improved pain-related outcomes and acceptable adverse effects in patients with chronic pain and long-term use of opioids?

Findings In this systematic review of 22 studies that addressed prespecified outcomes of rotation to buprenorphine, low-quality evidence suggested that buprenorphine rotation was associated with reduced pain without precipitating opioid withdrawal or other serious adverse effects.

Meaning These findings suggest that buprenorphine rotation may be a viable option for mitigating the harms of long-term opioid therapy in individuals with chronic pain who were receiving unsafe opioid analgesic regimens; further studies are needed to examine the best way to accomplish buprenorphine rotation.

+ Supplemental content

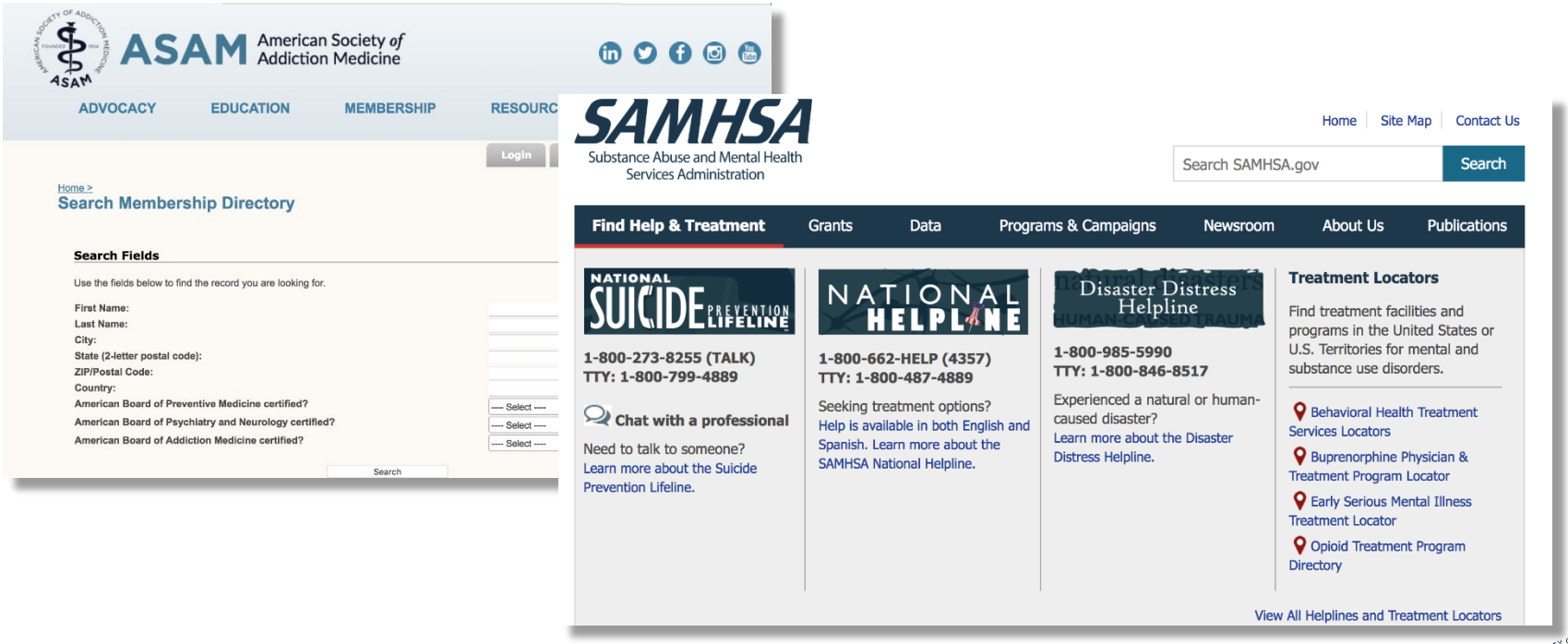
Author affiliations and article information are listed at the end of this article.

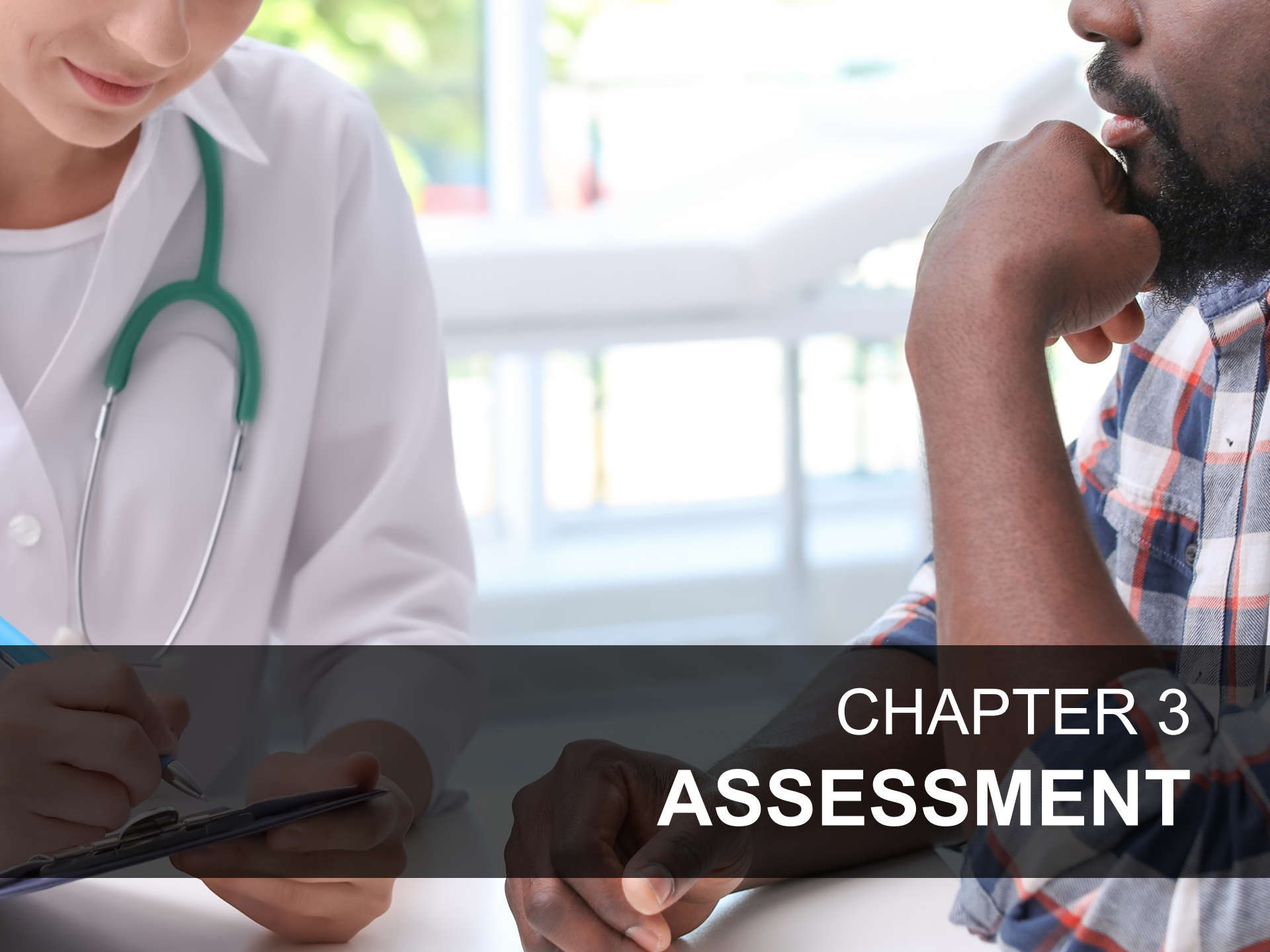
SOURCE: Powell VD, et al. JAMA Netw Open. 2021;4(9):

REFERRALS AND TREATMENT CENTERS

ASAM, SAMHSA, and AAAP are all helpful referral resources.

ASAM resources: https://www.asam.org/resources/resource-links
SAMHSA locator: https://findtreatment.samhsa.gov/locator
AAAP locator: https://www.aaap.org/patients/find-a-specialist/



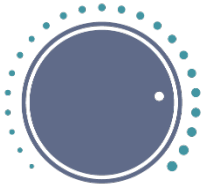


CHAPTER 3
ASSESSMENT

PAIN ASSESSMENT

DESCRIPTION OF PAIN

Location



Intensity

Quality

Onset/
duration

Variations/
patterns/rhythms

WHAT RELIEVES THE PAIN?

WHAT CAUSES OR INCREASES THE PAIN?

EFFECTS OF PAIN ON PHYSICAL, EMOTIONAL AND PSYCHOSOCIAL FUNCTION

PATIENT'S CURRENT LEVEL OF PAIN AND FUNCTION

SOURCES: Heapy A, Kerns RD. Psychological and behavioral assessment. In: Raj's Practical Management of Pain. 4th ed. 2008:279-295; Zacharoff KL, et al. Managing Chronic Pain with Opioids in Primary Care. 2nd ed. Newton, MA: Inflexion, Inc.;2010.

PAST MEDICAL AND TREATMENT HISTORY

NONPHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

RELEVANT ILLNESSES

PAST AND CURRENT OPIOID USE

- Query your state's Prescription Drug Monitoring Program (**PDMP**) to confirm patient report
- Contact past providers and obtain prior medical records
- For opioids currently prescribed, note the opioid, dose, regimen, and duration
- Determine whether the patient is **opioid-tolerant**

GENERAL EFFECTIVENESS OF CURRENT PRESCRIPTIONS

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

PDMPs are state-run, electronic databases that track controlled substance prescriptions in a state.

PDMP DATABASES	BENEFITS
• Provide a full accounting of the controlled substance prescriptions filled by a patient • Nearly all are available online 24/7 • Required in most states; know your state laws	• Identify potential drug misuse/abuse • Discover existing prescriptions not reported • Opportunity to discuss with patient • Determine if patient is using multiple prescribers/pharmacies • Identify drugs that increase overdose risk when taken together (such as benzodiazepines and opioids)

*** Multiple prescriptions from different providers is most predictive of opioid abuse or misuse.**

OBTAIN A COMPLETE SOCIAL AND PSYCHOLOGICAL HISTORY

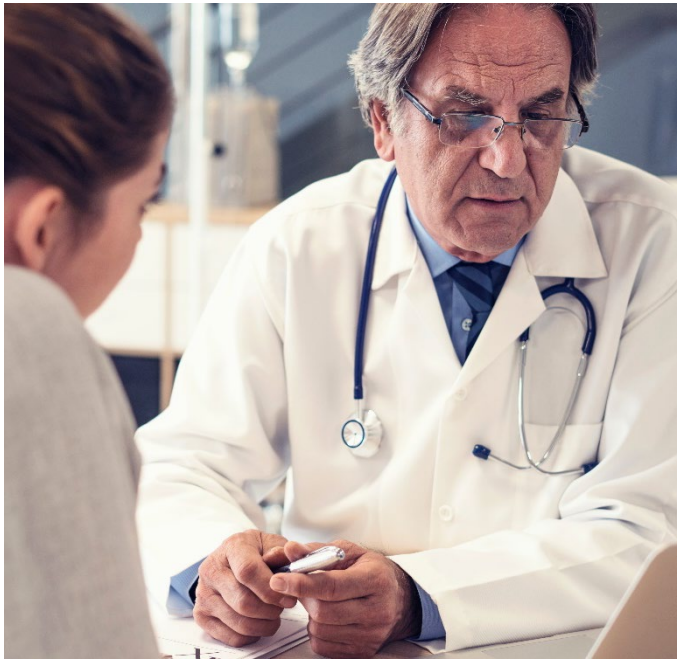
SOCIAL HISTORY

Employment, cultural background, social network, relationship history, legal history, and other behavioral patterns

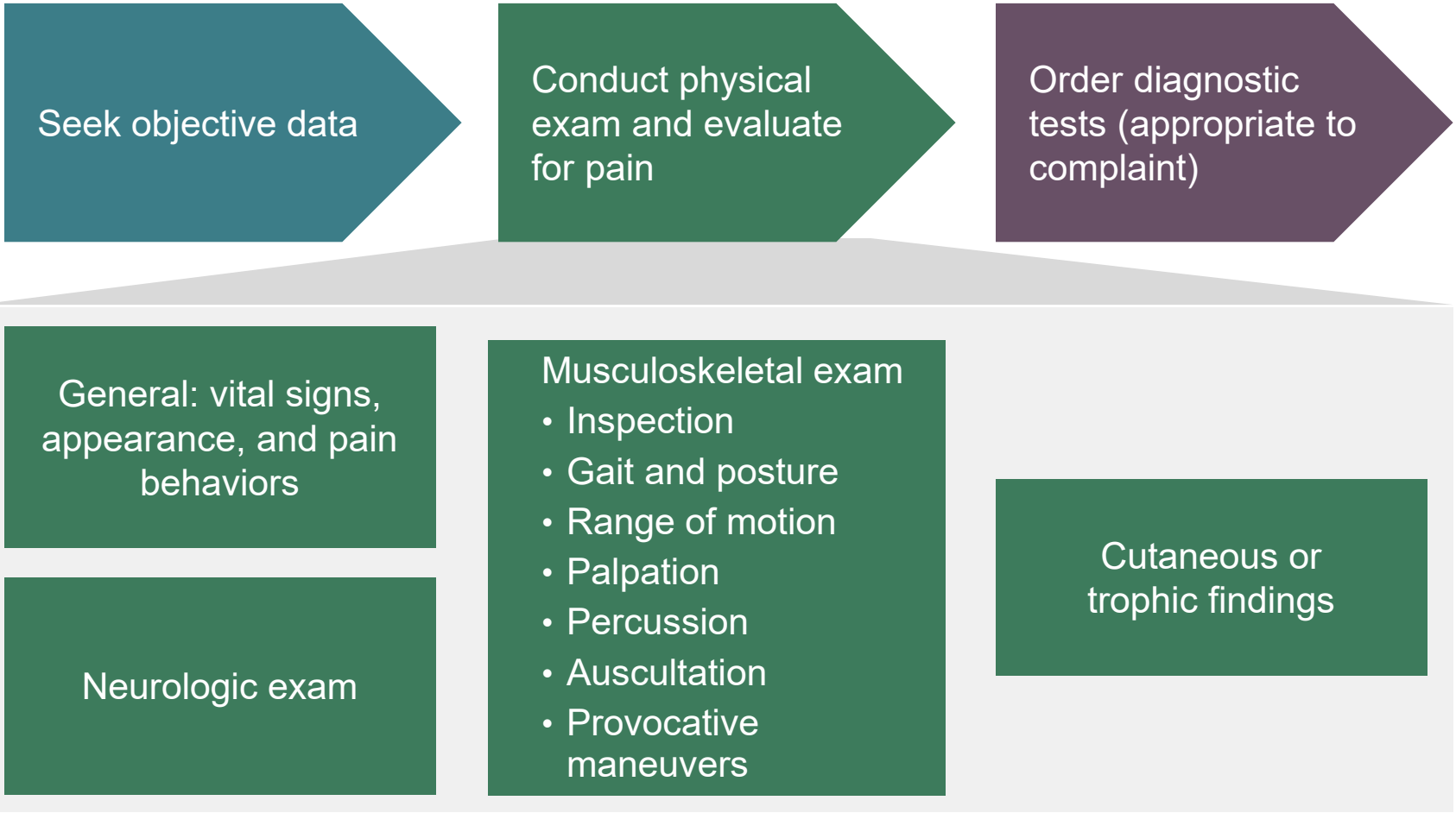
PSYCHOLOGICAL HISTORY

Screen for:

- Mental health diagnoses, depression, anxiety, PTSD, current treatments
- Alcohol, tobacco, and recreational drug use
- History of adverse childhood experiences
- Family history of substance use disorder and psychiatric disorders
- Depression and anxiety can be predictors of chronic pain



PHYSICAL EXAM AND ASSESSMENT



SOURCES: Lalani I, Argoff CE. History and Physical Examination of the Pain Patient. In: Raj's Practical Management of Pain. 4th ed. 2008:177-188; Chou R, et al. J Pain. 2009;10:113-130.

PAIN ASSESSMENT TOOL BOX

http://core-rems.org/opioid-education/tools/

Pain Assessment Tools

BPI or 5 A's

Functional Assessment

SF-36, PPS, Geriatric Assessment

Pain intensity, Enjoyment of life, General activity

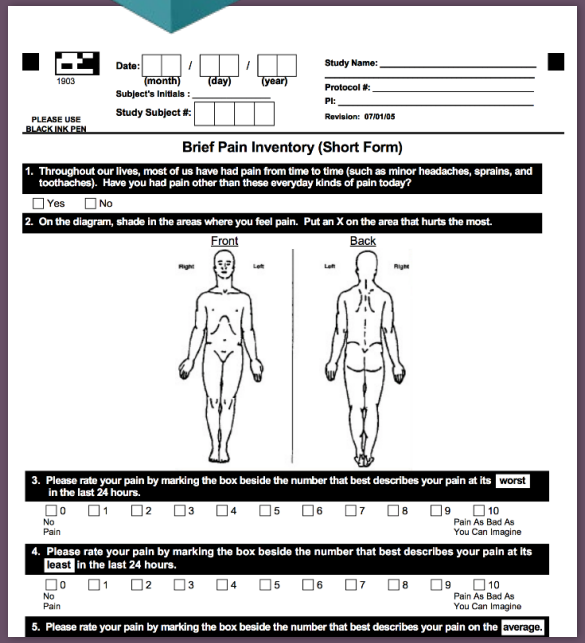
PEG

Adverse Childhood Experience Questionnaire

ACE

Assessment in Advanced Dementia

PAINAD



1903

Date: (month) / (day) / (year)

Study Name:

Protocol #:

PI:

Revision: 07/01/05

Subject's Initials :

Study Subject #:

PLEASE USE BLACK INK PEN

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

Front Back

Right Left Left Right

3. Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the **average**.

Brief Pain Inventory (BPI)

Psychological Measurement Tools (PHQ-9, GAD-7, etc.)

OPIOID MISUSE RISK ASSESSMENT TOOLS

http://core-rems.org/opioid-education/tools/

TOOLS FOR PATIENTS CONSIDERED FOR OPIOID THERAPY
ORT-OUD Opioid Risk Tool
SOAPP® Screener and Opioid Assessment for Patients with Pain
DIRE Diagnosis, Intractability, Risk, and Efficacy score

TOOLS FOR SUBSTANCE USE DISORDER
CAGE-AID Cut down, Annoyed, Guilty, Eye-Opener tool, Adapted to Include Drugs
RAFFT Relax, Alone, Friends, Family, Trouble
DAST Drug Abuse Screening Test
CTQ Childhood Trauma Questionnaire
ACEs Adverse Childhood Experiences

A CLOSER LOOK AT THE ORT-OUD

Opioid Risk Tool – OUD (ORT-OUD)

This tool should be administered to patients upon an initial visit prior to beginning or continuing opioid therapy for pain management. A score of 2 or lower indicates low risk for future opioid use disorder; a score of >/= 3 indicates high risk for opioid use disorder.

Mark each box that applies	YES	NO
Family history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Personal history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16-45 years	1	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
Scoring totals		

SOURCE: Cheatle, M., et al. JPain 2019; Jan 26.

Substance use disorder history does not prohibit treatment with opioids, but may require additional monitoring and expert consultation or referral.

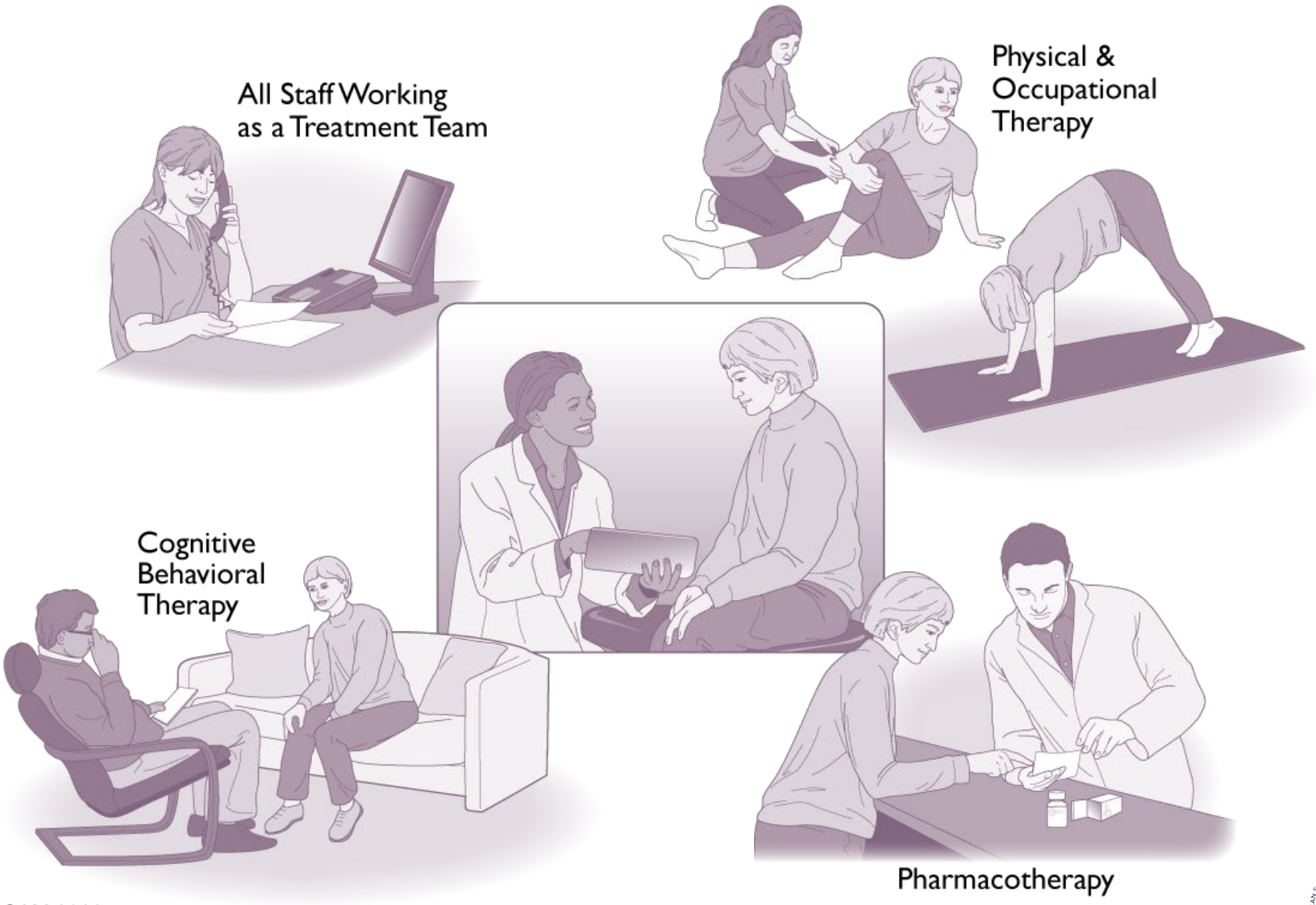
Scoring:

- **≤ 2: low risk**
- **≥ 3: high risk**

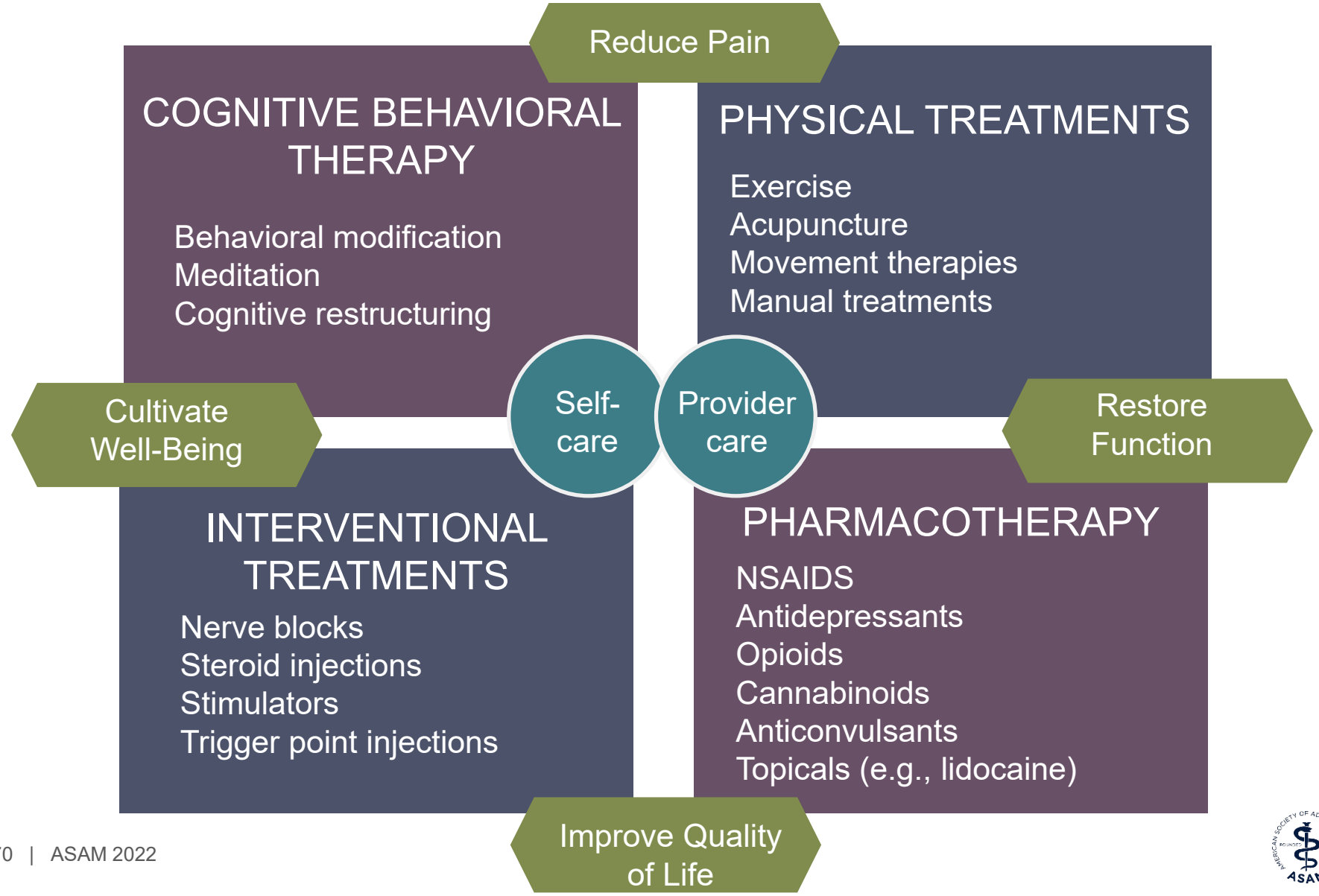
CHAPTER 4

CREATING THE PAIN TREATMENT PLAN

COMPONENTS OF A MULTIMODAL TREATMENT PLAN FOR PAIN



PAIN MANAGEMENT GOALS AND TREATMENT OPTIONS: A MULTIMODAL APPROACH



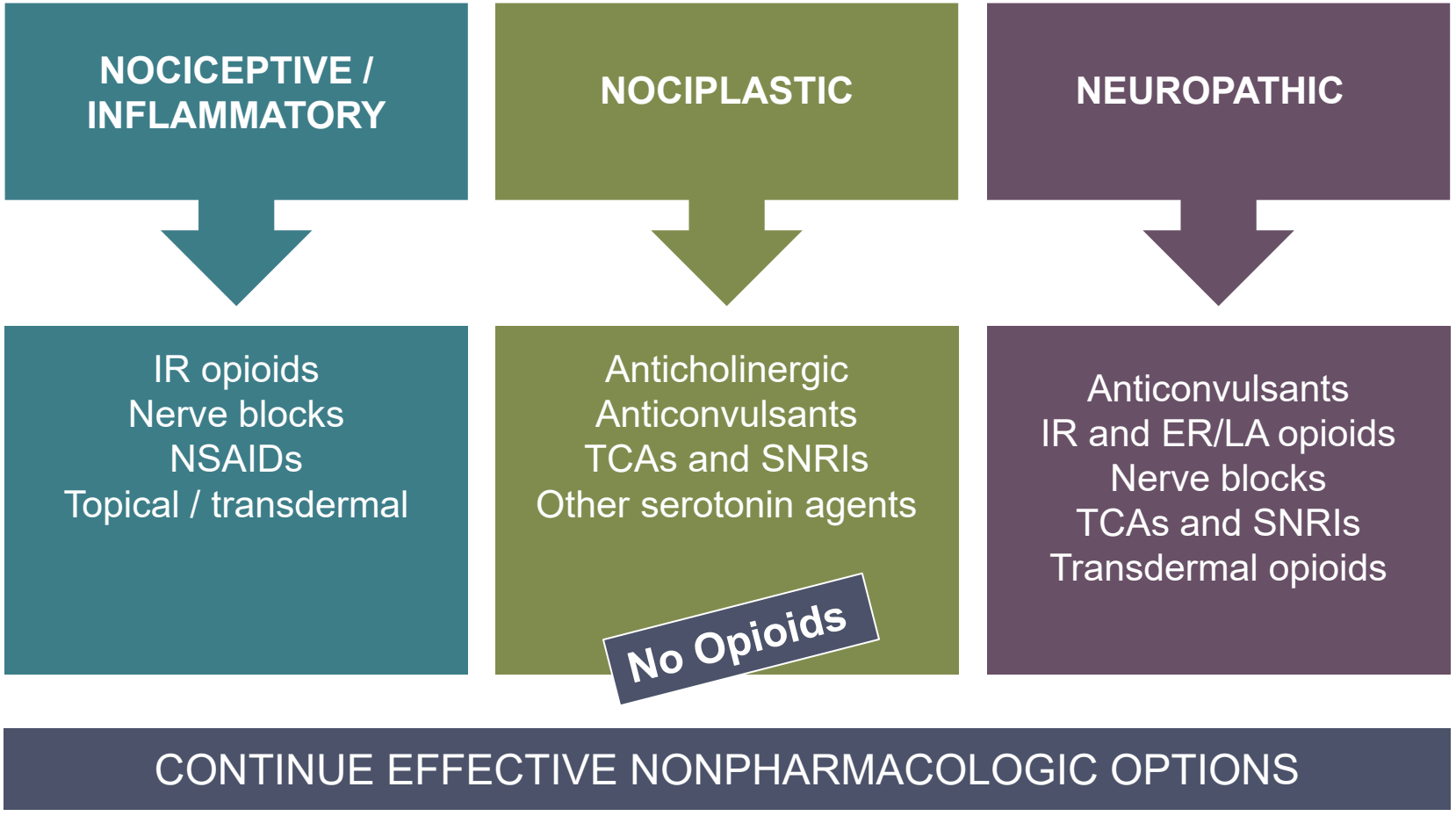
EVIDENCE-BASED NONPHARMACOLOGIC TREATMENTS

What is appropriate for your patient?

- Tai Chi
- Yoga
- CBT and ACT
- Acupuncture
- PT/OT/aquatic
- Mindfulness meditation
- OMT
- Massage therapy
- Chiropractic
- Neuromodulation or surgical approaches (in some situations)

CBT = cognitive behavioral therapy; ACT = acceptance commitment therapy; OMT = osteopathic manipulative therapy

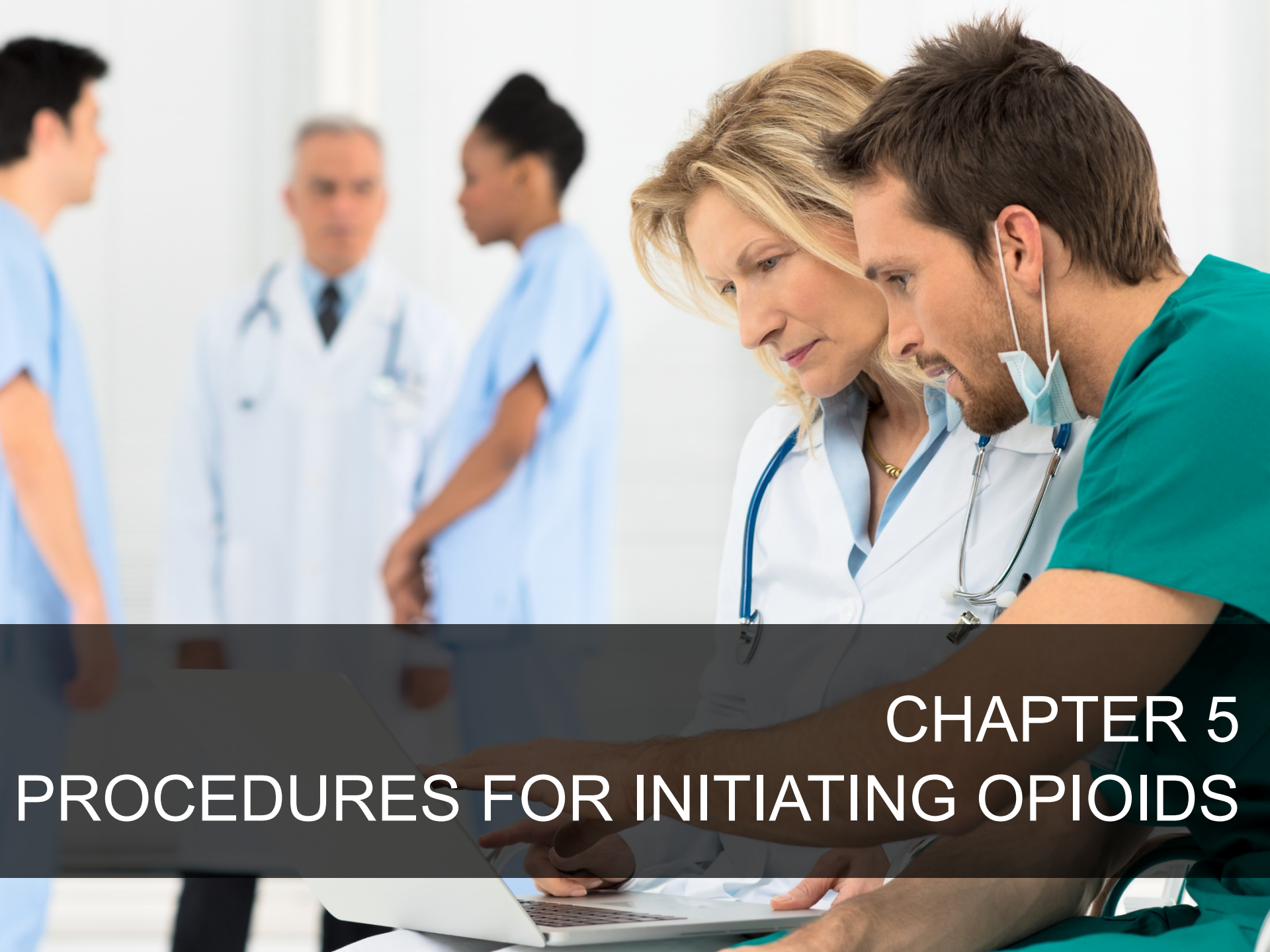
PHARMACOLOGIC TREATMENTS BY TYPE OF PAIN



DRUG CHARACTERISTICS TO CONSIDER BEFORE PRESCRIBING

Route of administration	Formulation	Strength	Dosing interval
Key instructions (indications, uses, contraindications)	Specific drug interactions	MOA*	Product-specific safety concerns
Specific information about product conversions, if available		Use in opioid-tolerant patients	Relative potency to morphine

*MOA = Mechanism of action
Opioid product information available at
https://opioidanalgesicrems.com/RpcUI/products.u



CHAPTER 5
PROCEDURES FOR INITIATING OPIOIDS

CONSIDER AN OPIOID ONLY WHEN:

- Potential benefits are likely to outweigh risks
- Patient has failed to adequately respond to non-opioid and nonpharmacological interventions
- Patient has moderate to severe nociceptive or neuropathic pain
- Begin as a therapeutic trial

SOURCES: Chou R, et al. J Pain. 2009;10:113-130. Department of Veterans Affairs, Department of Defense. VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. 2010.

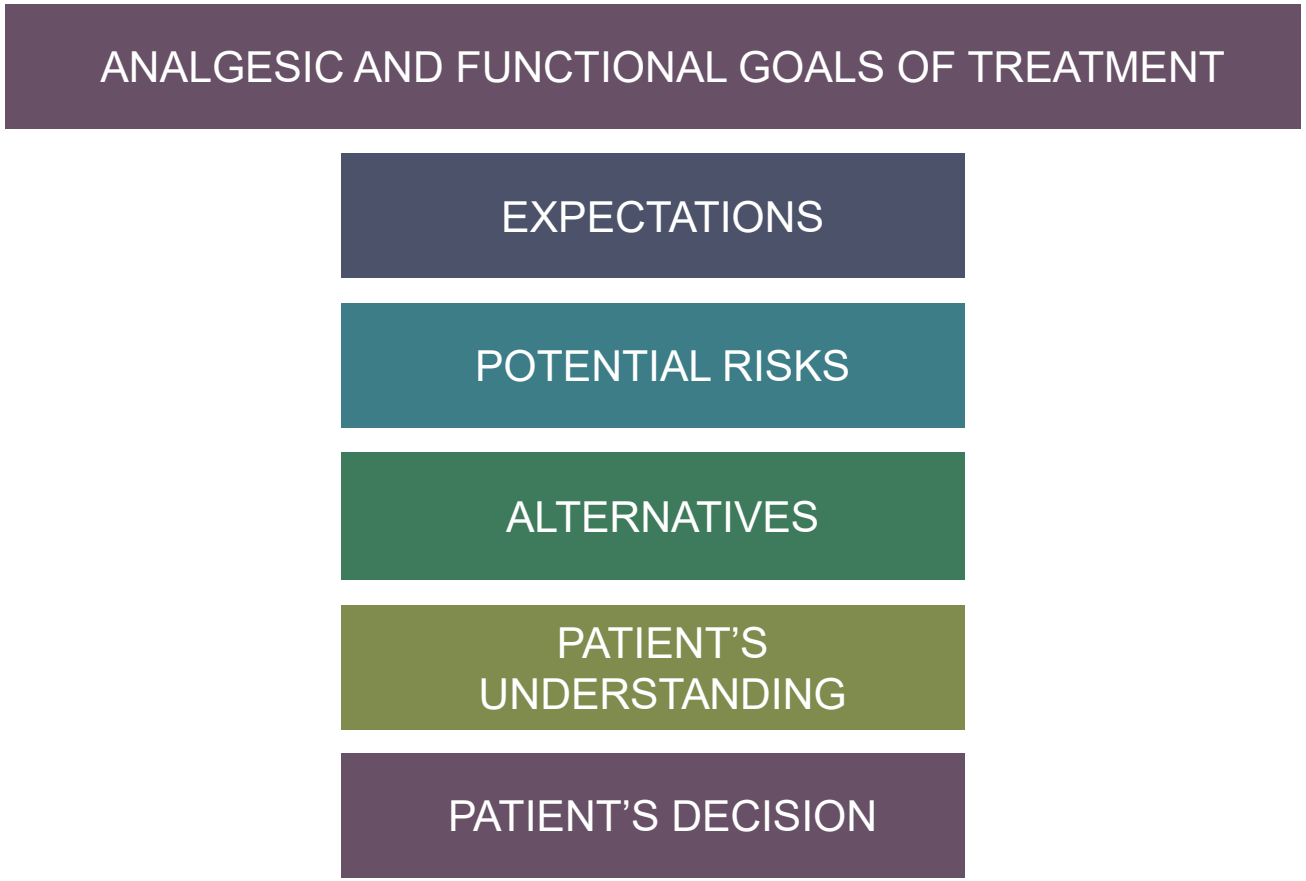
OPIOID SIDE EFFECTS AND ADVERSE EVENTS

SIDE EFFECTS	ADVERSE EVENTS
Respiratory depression	Death
Opioid-induced constipation (OIC)	Addiction
Myoclonus (twitching or jerking)	Overdose
Sedation, cognitive impairment	Hospitalization
Sweating, miosis, urinary retention	Disability or permanent damage
Allergic reactions	Falls or fractures
Hypogonadism	
Tolerance, physical dependence, hyperalgesia	

Prescribers should report serious AEs and medication errors to the FDA:
https://www.fda.gov/media/76299/download
or 1-800-FDA-1088

INFORMED CONSENT

When initiating a pain treatment plan, confirm patient understanding of informed consent to establish:



PATIENT PROVIDER AGREEMENT (PPA)

REINFORCE EXPECTATIONS FOR APPROPRIATE AND SAFE OPIOID USE

- Clarify treatment plans and goals
- One prescriber
- Consider one pharmacy
- Safeguards
  - Do not store in medicine cabinet
  - Keep locked (medication safe)
  - Do not share or sell
- Instructions for disposal when no longer needed
- Prescriber notification for any event resulting in a pain medication prescription
- Follow-up plan
- Monitoring
  - Random Urine Drug Test (UDT) and pill counts
- Refill procedure
- Identify behaviors indicating need for discontinuation
- Exit strategy
- Signed by both

PATIENT PROVIDER AGREEMENT (PPA) NONADHERENCE

Behavior outside the boundaries of agreed-on treatment plan

- Unsanctioned dose escalations or other noncompliance with therapy on 1 or 2 occasions
- Unapproved use of the drug to treat another symptom
- Openly acquiring similar drugs from other medical sources
- Multiple dose escalations or other noncompliance with therapy despite warnings
- Prescription forgery
- Obtaining prescription drugs from nonmedical sources

Any of these behaviors merits **investigation**: proceed with caution

OPIOID-INDUCED RESPIRATORY DEPRESSION

MORE LIKELY TO OCCUR:

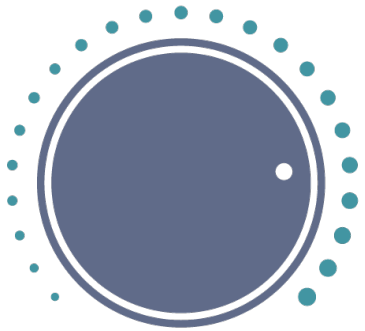
- In elderly, cachectic, or debilitated patients
- If taken concomitantly with other drugs that depress respiration (eg., benzodiazepines*, other sedatives, and alcohol)
- In patients who are opioid-naïve or have just had a dose increase
- Opioids are **contraindicated** in patients with respiratory depression or conditions that increase risk

HOW TO REDUCE RISK:

- Ensure proper dosing and titration
- **Do not overestimate** dose when converting dosage from another opioid product
  - Can result in fatal overdose with first dose
- Avoid co-prescribing sedatives
- Instruct patients to swallow tablets/capsules whole
  - Dose from cut, crushed, dissolved, or chewed tablets/capsules may be fatal, particularly in opioid-naïve individuals

*Greatest risk of respiratory depression

EMERGENCE OF OPIOID-INDUCED HYPERALGESIA



- An increased sensitivity to pain
- Usually occurs at high MME dosages and over long periods of time
- A physiological phenomenon that can happen to anyone
- Consider this explanation if:
  - Pain increases despite dose increases
  - Pain appears in new locations
  - Patient becomes more sensitive to painful stimuli
  - Patient is not improving in the absence of underlying cause progression

SOURCE: Yi P, Pryzbylkowski P. Opioid induced hyperalgesia. Pain Medicine 2015; 16: S32-S36

FOR SAFER USE: KNOW DRUG INTERACTIONS, PHARMACODYNAMICS AND PHARMACOKINETICS

CNS depressants can potentiate sedation and respiratory depression
(e.g. benzodiazepines)

Some ER/LA products rapidly release opioid (dose dump) when exposed to alcohol
Some drug levels may increase without dose dumping

Opioid use with MAOIs may increase respiratory depression
Certain opioids with MAOIs can cause serotonin syndrome (e.g. Tramadol)

Opioid use can reduce efficacy of diuretics
Inducing release of antidiuretic hormone

Many opioids can prolong QTc interval, check the PI; methadone requires extra caution

Drugs that inhibit or induce CYP enzymes can increase or lower blood levels of some opioids

OPIOIDS AND CYP450 ENZYME INTERACTIONS

Metabolism of several commonly used opioids occurs through the cytochrome P450 system

Be aware of potential inhibitors (e.g., macrolides, azole antifungals) and inducers (e.g., carbamazepine)

Genetic and phenotypic variations in patient response to certain opioids

Refer to product-specific information in the drug package insert before prescribing

SOURCE: https://dailymed.nlm.nih.gov/dailymed/index.cfm


SPECIAL
POPULATIONS

OLDER ADULTS

RISK FOR RESPIRATORY DEPRESSION

- Age-related changes in distribution, metabolism, excretion; absorption less affected

ACTIONS

- Monitor
  - Initiation and titration
  - Concomitant medications (polypharmacy)
  - Falls risk, cognitive change, psychosocial status
- Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients
- Start low, go slow, but GO
- Routinely initiate a bowel regimen
- Patient and caregiver reliability/risk of diversion

SOURCE: American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons. J Am Geriatr Soc. 2009;57:1331-46. Chou R, et al. J Pain. 2009;10:113-30.

PEOPLE OF CHILDBEARING POTENTIAL

Neonatal opioid withdrawal syndrome is a potential risk of opioid therapy

GIVEN THIS POTENTIAL RISK, CLINICIANS SHOULD:

- Discuss family planning, contraceptives, breast feeding plans with patients
- Counsel people of childbearing potential about risks and benefits of opioid therapy during pregnancy and after delivery
- Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks to fetus
- Refer to a qualified provider who will ensure appropriate treatment for the baby

A pregnant person should not stop buprenorphine before delivery as it will create the potential for term withdrawal and return to use.

Opioid agonist pharmacotherapy with methadone or buprenorphine is endorsed by ACOG as the optimal treatment for OUD during pregnancy.

ACOG = American College of Obstetricians and Gynecologists

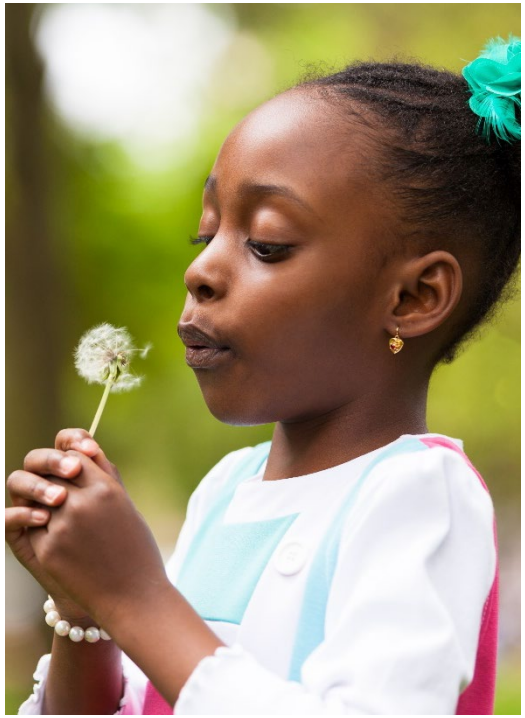
SOURCES: Chou R, et al. J Pain. 2009;10:113-30; ACOG Committee on Obstetric Practice, August 2017

CHILDREN AND ADOLESCENTS

HANDLE WITH CARE: JUDICIOUS & LOW-DOSE USE OF IR FOR BRIEF THERAPY

THE SAFETY AND EFFECTIVENESS OF MOST OPIOIDS ARE UNESTABLISHED

- Pediatric analgesic trials pose challenges
- Transdermal fentanyl approved in children ≥ 2
- Oxycodone ER dosing changes for children ≥ 11



ER/LA OPIOID INDICATIONS ARE PRIMARILY LIFE-LIMITING CONDITIONS

WHEN PRESCRIBING ER/LA OPIOIDS TO CHILDREN:

- Consult pediatric palliative care team or pediatric pain specialist or refer to a specialized multidisciplinary pain clinic

SOURCES: Berde CB, et al. *Pediatrics.* 2012;129:354-364; Gregoire MC, et al. Pain Res Manag 2013;18:47-50; Mc Donnell C. Pain Res Manag. 2011;16:93-98; Slater ME, et al. Pain Med. 2010;11:207-14.

OTHER POPULATIONS NEEDING SPECIAL TREATMENT CONSIDERATIONS

Persons with…

- Sleep disorders or sleep-disordered breathing (sleep apnea)
- Dementia/ nonverbal patients
- Obesity
- Renal/ hepatic impairment
- Psychiatric disorders
- At end-of-life
- Substance use disorder

WHEN TO CONSIDER A TRIAL OF AN OPIOID

60-YR-OLD WITH CHRONIC DISABLING OA PAIN

- Non-opioid therapies not effective
- No psychiatric/medical comorbidity or personal/family drug abuse history
- High potential benefits relative to potential risks
- Could prescribe opioids to this patient in most settings with routine monitoring

30-YR-OLD WITH FIBROMYALGIA AND RECENT ALCOHOL USE DISORDER

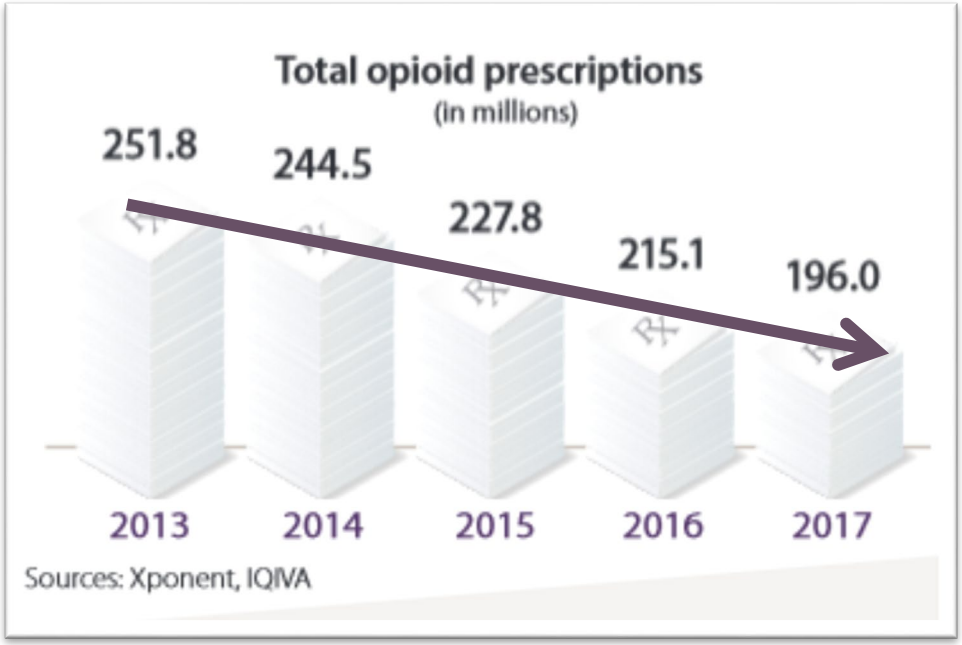
- High potential risks relative to benefits (opioid therapy not first line for fibromyalgia)
- Requires intensive structure, monitoring, and management by clinician with expertise in both addiction & pain
- *Not a good candidate for opioid therapy*

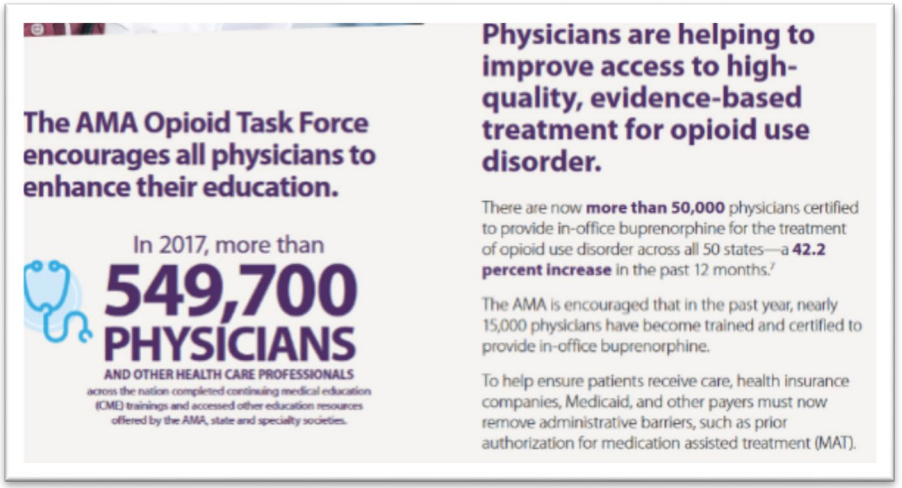
CDC CHRONIC NON-CANCER PAIN GUIDELINE

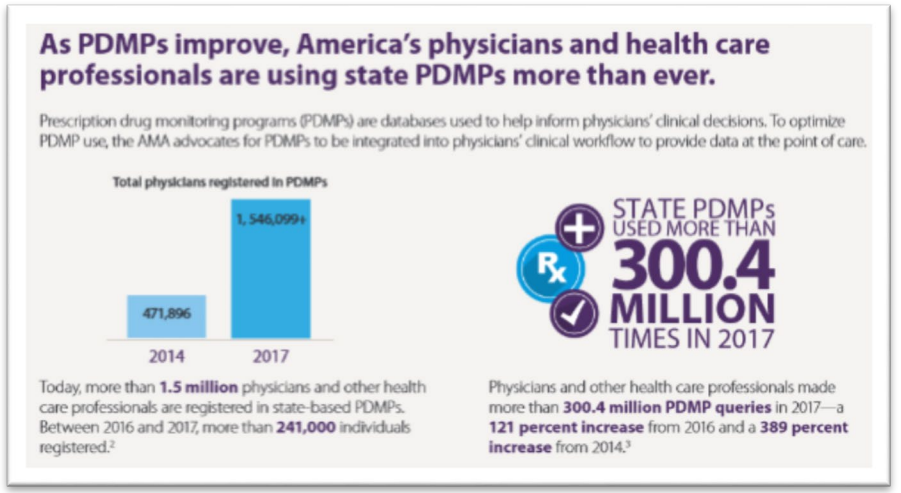
Guideline	Evidence
Non-Pharmacologic and **Non-Opioid** therapy is preferred	**3**
Before starting opioid therapy, **Establish Realistic Treatment Goals**	**4**
Before starting and periodically during opioid therapy, discuss **Risks, Benefits** and responsibilities for managing therapy	**3**
Immediate Release Opioids should be used when starting therapy	**4**
When opioids are started, **Lowest Effective Dose** should be used**50/90 MME**	**3**
Quantity prescribed: **Acute Pain < 3 days supply, Rarely >7 days**	**4**
Evaluate Benefit vs Harm in patient within 1-4 weeks of starting opioids	**4**
Before starting and during therapy, **Evaluate Risk Factors**	**4**
Review patient's history of controlled substance use by using the state's automated **Prescription Drug Monitoring System (PDMP)**	**4**
When prescribing opioids for chronic pain, clinicians should use **Urine Drug Screens (UDS)**	**4**
Avoid prescribing opioid medications with **Benzodiazepines**	**3**
Offer **Substance Use Disorder Treatment** for patients when needed	**2**

Type 1 evidence: Randomized clinical trials or overwhelming evidence from observational studies
Type 2 evidence: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.
Type 3 evidence: Observational studies or randomized clinical trials with notable limitations
Type 4 evidence: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations

PHYSICIANS' PROGRESS TO REVERSE THE NATION'S OPIOID EPIDEMIC







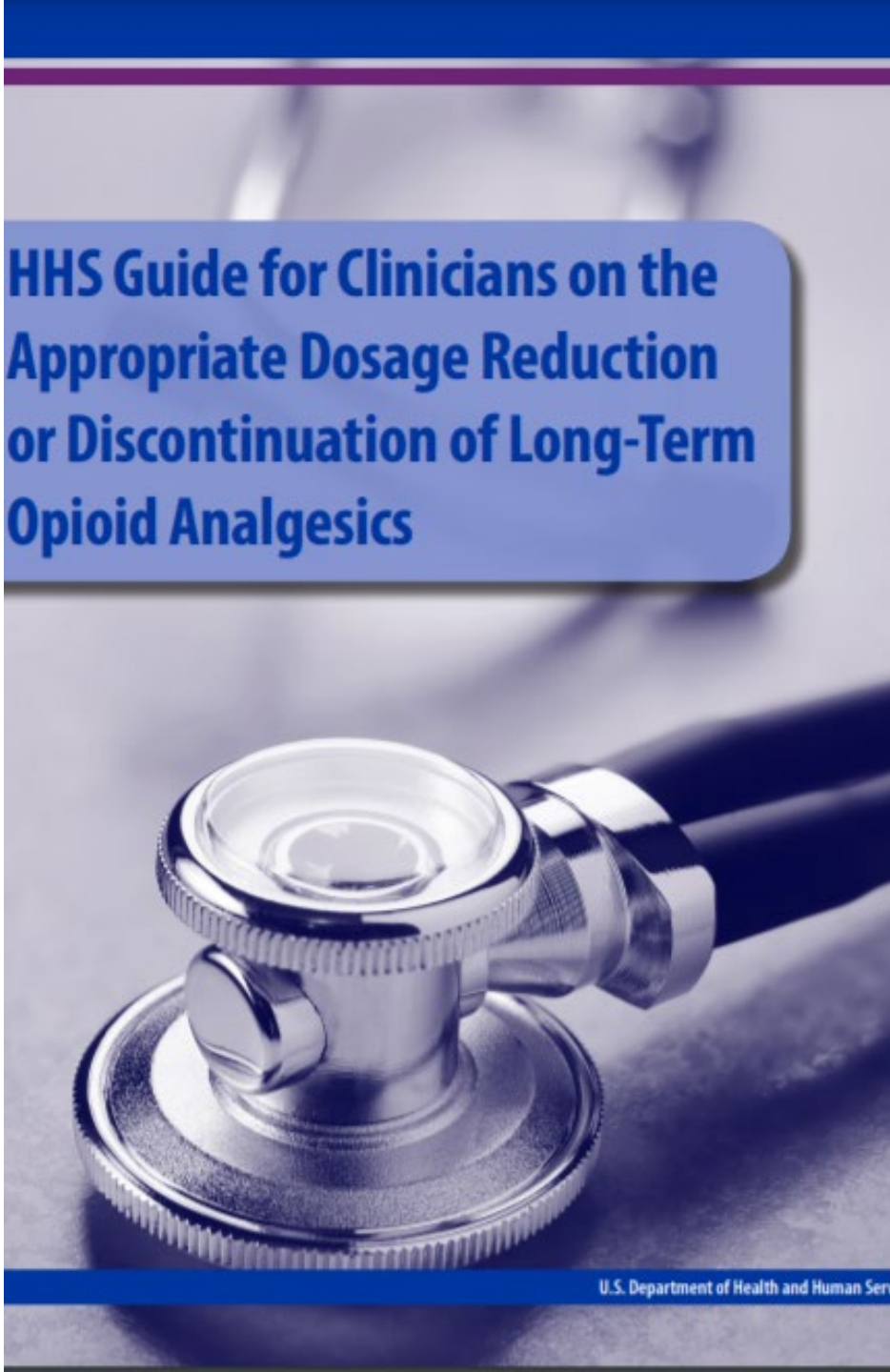
SOURCE: AMA Opioid Task Force 2018 Progress Report.

KEY POINTS:

The CDC Guideline for Prescribing Opioids for Chronic Pain **does not recommend opioid discontinuation when benefits of opioids outweigh risks.**

Avoid misinterpreting cautionary dosage thresholds. Guideline recommends avoiding or carefully justifying increasing dosages **above 90 MME/day, it does not recommend abruptly reducing opioids from higher dosages.**

Avoid dismissing patients from care.



CHAPTER 6

MANAGING PATIENTS ON CHRONIC OPIOID ANALGESICS

ONGOING AND LONG-TERM MANAGEMENT OF PATIENTS ON OPIOID ANALGESICS

PERIODIC REVIEW OF PAIN

- Is the patient making progress toward functional goals?
- Reset goals if required or indicated; develop reasonable expectations
- Monitor for breakthrough pain
- Review adverse events/side effects at each visit
  - Evaluate bowel function
  - Screen for endocrine function as needed
  - Report adverse events to the FDA website
  - Implement opioid rotation, as indicated

Prescribers should report serious AEs and medication errors to the FDA:
https://www.fda.gov/media/76299/download
or 1-800-FDA-1088

ONGOING AND LONG-TERM MANAGEMENT OF PATIENTS ON OPIOID ANALGESICS

MONITORING FOR SAFETY

- Check Prescription Drug Monitoring Program (PDMP)
- Use urine drug testing (UDT)
- Reassess risk of Substance Use Disorder (SUD) and/or OUD
- Monitor adherence to the treatment plan
  - Medication reconciliation
  - Evaluate for nonadherence

DISCONTINUING AND TAPERING

- When is opioid therapy no longer necessary?

WHEN TO MOVE FROM IR TO ER/LA OPIOIDS

PRIMARY REASONS

- Maintain stable blood levels (steady state plasma)
- Longer duration of action
- Multiple IR doses needed to achieve effective analgesia
- Poor analgesic efficacy despite dose titration
- Less sleep disruption

OTHER POTENTIAL REASONS

- Patient desire or need to try a new formulation
- Cost or insurance issues
- Adherence issues
- Change in clinical status requiring an opioid with different pharmacokinetics
- Problematic drug-drug interactions

OPIOID ROTATION

DEFINITION

A change from an existing opioid regimen to another opioid with the goal of improving therapeutic outcomes or to avoid AEs attributed to the existing drug

RATIONALE

Used when differences in pharmacologic or other effects make it likely that a switch will improve outcomes

- Effectiveness and AEs of different mu-opioids vary among patients
- Patient tolerant to first opioid might have improved analgesia from second opioid at a dose lower than calculated from an Equianalgesic Dosing Table (EDT)

SOURCES: Fine PG, et al. J Pain Symptom Manage. 2009;38:418-425; Knotkova H, et al. J Pain Symptom Manage. 2009;38:426-439; Pasternak GW. Neuropharmacol. 2004;47(suppl 1):312-323.

START WITH AN EDT FOR ADULTS

	EQUIANALGESIC DOSE		USUAL STARTING DOSE	
DRUG	SC/IV	PO	PARENTERAL	PO
Morphine	10 mg	30 mg	2.5 – 5 mg SC/IV q3 – 4hr (1.25 – 2.5 mg)	5 –15 mg q3 – 4hr (IR or oral solution) (2.5 – 7.5 mg)
Oxycodone	NA	20 mg	NA	5 –10 mg q3 – 4hr (2.5 mg)
Hydrocodone	NA	30 mg	NA	5 mg q3 – 4hr (2.5 mg)
Hydromorphone	1.5 mg	7.5 mg	0.2 – 0.6 mg SC/IV q2 – 3hr (0.2 mg)	1– 2 mg q3 – 4hr (0.5 – 1 mg)

MU-OPIOID RECEPTORS AND INCOMPLETE CROSS TOLERANCE

MU-OPIOIDS BIND TO MU RECEPTORS

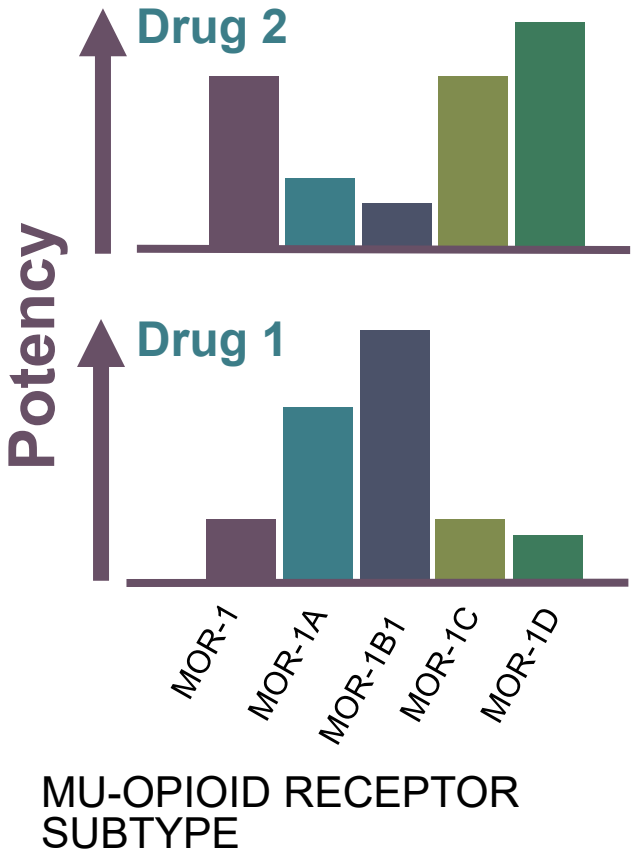
MANY MU RECEPTOR SUBTYPES

Mu-opioids produce **subtly different** pharmacologic responses based on distinct activation profiles of mu receptor subtypes

MAY HELP EXPLAIN:

Interpatient variability in response to mu-opioids

Incomplete cross tolerance among mu-opioids



GUIDELINES FOR OPIOID ROTATION

Calculate equianalgesic dose of new opioid from EDT

REDUCE CALCULATED EQUIANALGESIC DOSE BY 25% – 50%*

SELECT % REDUCTION BASED ON CLINICAL JUDGMENT

CLOSER TO 50% REDUCTION IF PATIENT

- Is receiving a relatively high dose of current opioid regimen
- Is elderly or medically frail

CLOSER TO 25% REDUCTION IF PATIENT

- Does not have these characteristics
- Is changing route of administration

*Equianalgesic dose tables are not to be used for rotation to methadone- *always start low and go slow*

BREAKTHROUGH PAIN (BTP)

PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP

- Due to disease progression or a new or unrelated pain
  - Target cause or precipitating factors
- Dose for BTP: Using an **IR, 5% – 15%** of total daily opioid dose, administered at an appropriate interval
- **Never use ER/LA for BTP**

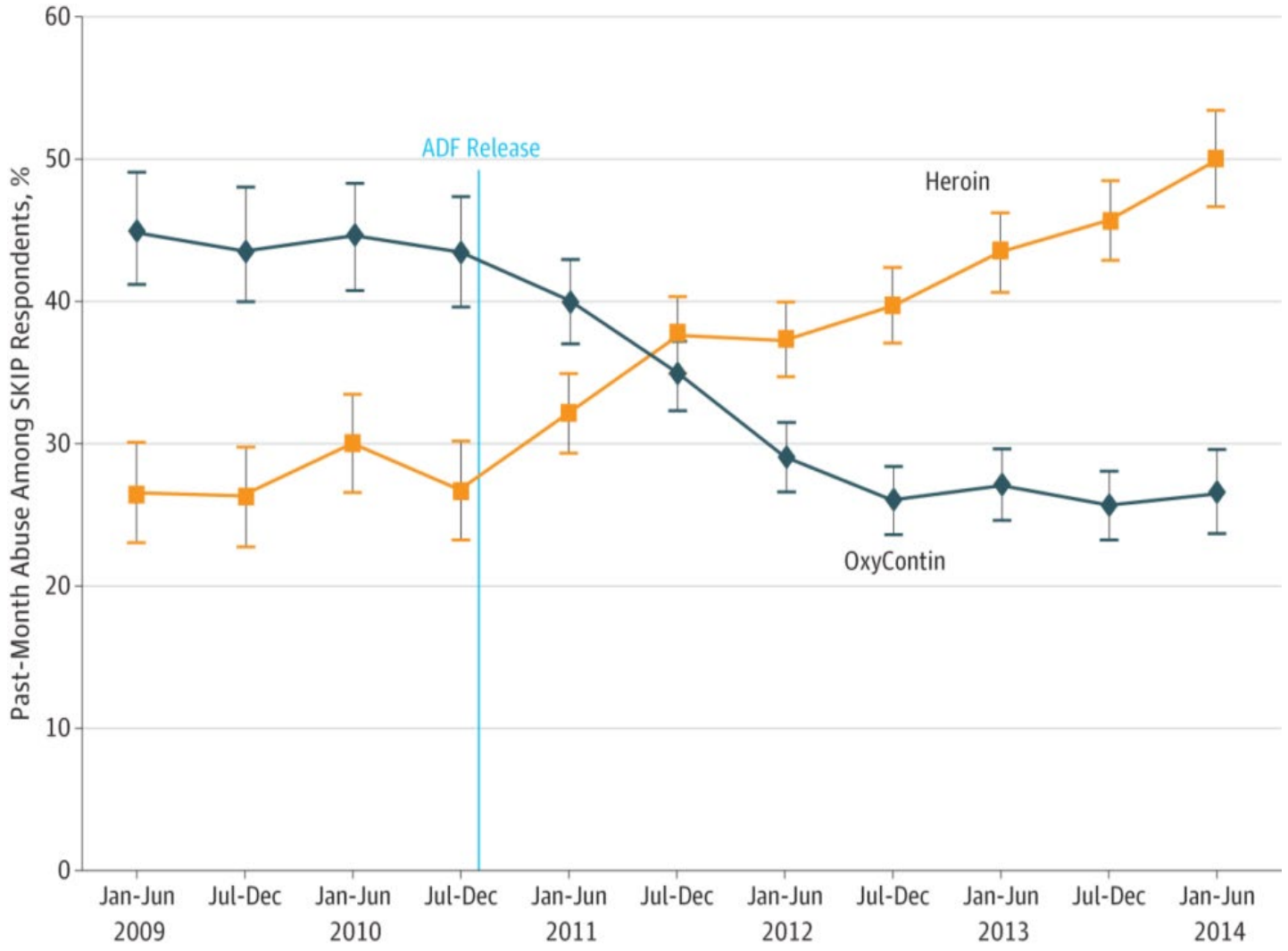
CONSIDER ADDING

- PRN IR opioid trial based on analysis of benefit versus risk
  - There is a risk for aberrant/problematic drug-related behaviors
  - High-risk: Add only in conjunction with frequent monitoring
  - and follow-up
  - Low-risk: Add with routine follow-up and monitoring
- Consider non-opioid drug therapies and nonpharmacologic treatments

ABUSE-DETERRENT FORMULATION (ADF) OPIOIDS

- Response to growing non-medical-use problem
- An ER/LA opioid with properties to meaningfully deter abuse, even if they do not fully prevent abuse
  - Less likely to be crushed, injected, or snorted
- Consider as one part of an overall strategy
- Mixed evidence on the impact of ADF on misuse
- Overdose is still possible if taken orally in excessive amounts
- These products are expensive with no generic equivalents

UNINTENDED CONSEQUENCES OF THE INTRODUCTION OF ADF



SOURCE: JAMA Psychiatry. 2015;72(5):424-430.

URINE DRUG TESTING (UDT)

- Urine testing is done **FOR** the patient, not **TO** the patient
- Helps to identify drug misuse/addiction
- Assists in assessing and documenting adherence

CLINICAL CONSIDERATIONS

- Recommend UDT before first prescription (baseline) then intermittently, depending on clinical judgment and state regulations
- Document time and date of last dose taken
- Be aware of possible false positives or negatives
- Clarify unexpected results with the lab before confronting patient to rule out poor specimen or error

SCREENING VERSUS CONFIRMATORY UDTS

	SCREENING (Office-based)	CONFIRMATORY (Send to lab)
Analysis technique	Immunoassay	GC-MS or HPLC
Sensitivity (power to detect a class of drugs)	Low or none when testing for semi-synthetic or synthetic opioids	High
Specificity (power to detect an individual drug)	Varies (can result in false positives or false negatives)	High
Turnaround	Rapid	Slow
Cost/Other	Lower cost. Intended for a drug-free population, may not be useful in pain medicine	Higher cost. Legally defensible results

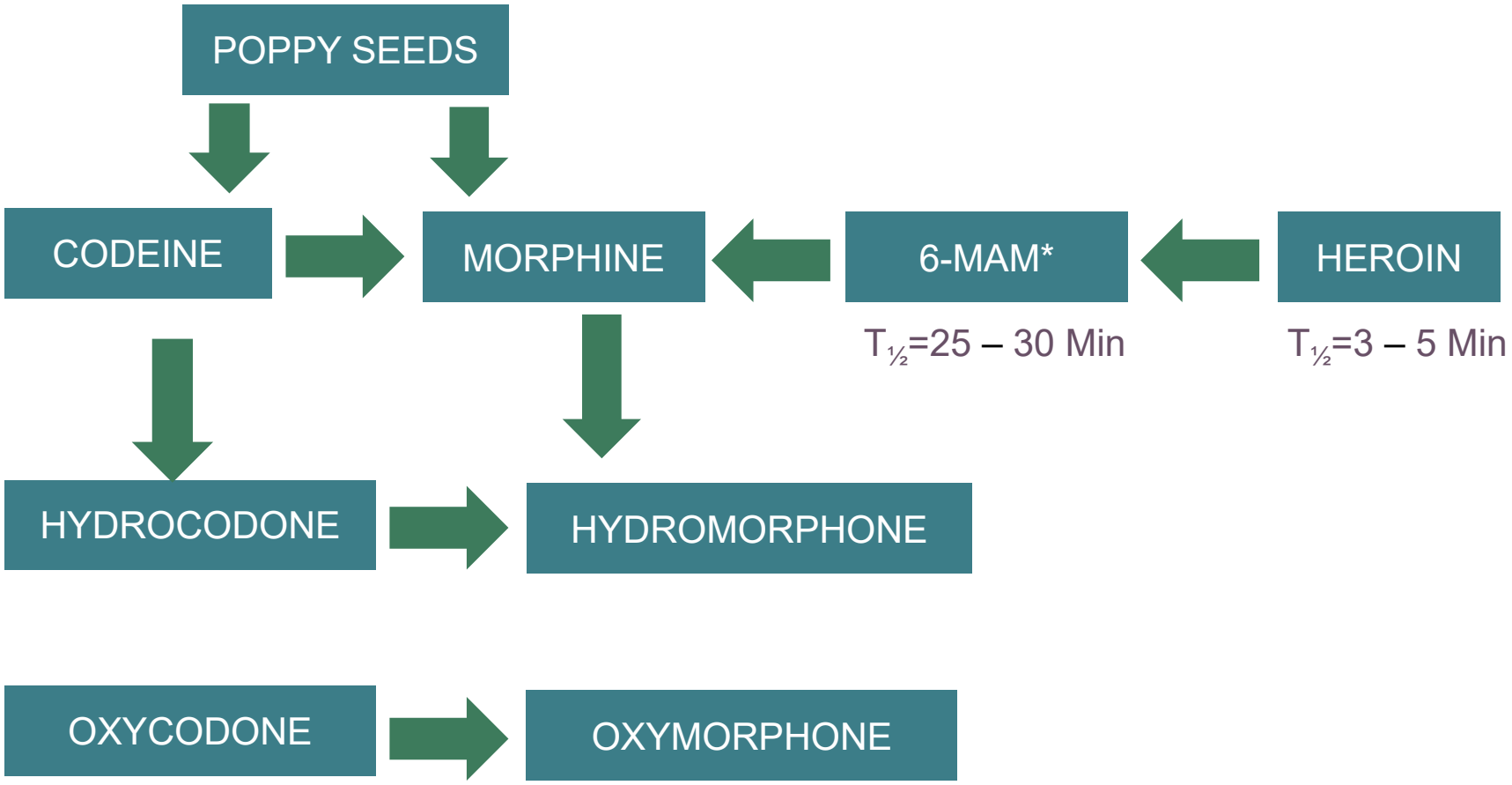
GC-MS = gas chromatograph-mass spectrometry; HPLC = high-performance liquid chromatography

WINDOWS OF SPECIFIC DRUG DETECTION

Drug	How soon after taking drug will there be a positive drug test?	How long after taking drug will there continue to be a positive drug test?
Cannabis/pot	1 – 3 hours	1 – 7 days
Crack (cocaine)	2 – 6 hours	2 – 3 days
Heroin (opiates)	2 – 6 hours	1 – 3 days
Methamphetamine	4 – 6 hours	2 – 3 days
Angel dust/PCP	4 – 6 hours	7 – 14 days
Ecstasy	2 – 7 hours	2 – 4 days
Benzodiazepine	2 – 7 hours	1 – 4 days
Barbiturates	2 – 4 hours	1 – 3 weeks
Methadone	3 – 8 hours	1 – 3 days
Tricyclic antidepressants	8 – 12 hours	2 – 7 days
Oxycodone	1 – 3 hours	1 – 2 days
Fentanyl/norfentanyl	1 – 3 hours	*up to 28 days

SOURCE: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/DrugsofAbuseTests/ucm125722.htm

EXAMPLES OF OPIOID METABOLISM



*6-MAM=6-Monoacetylmorphine

REASONS FOR DISCONTINUING OPIOIDS

PAIN LEVEL DECREASE IN STABLE PATIENTS

INTOLERABLE AND UNMANAGEABLE ADVERSE EFFECTS

NO PROGRESS TOWARD THERAPEUTIC GOALS

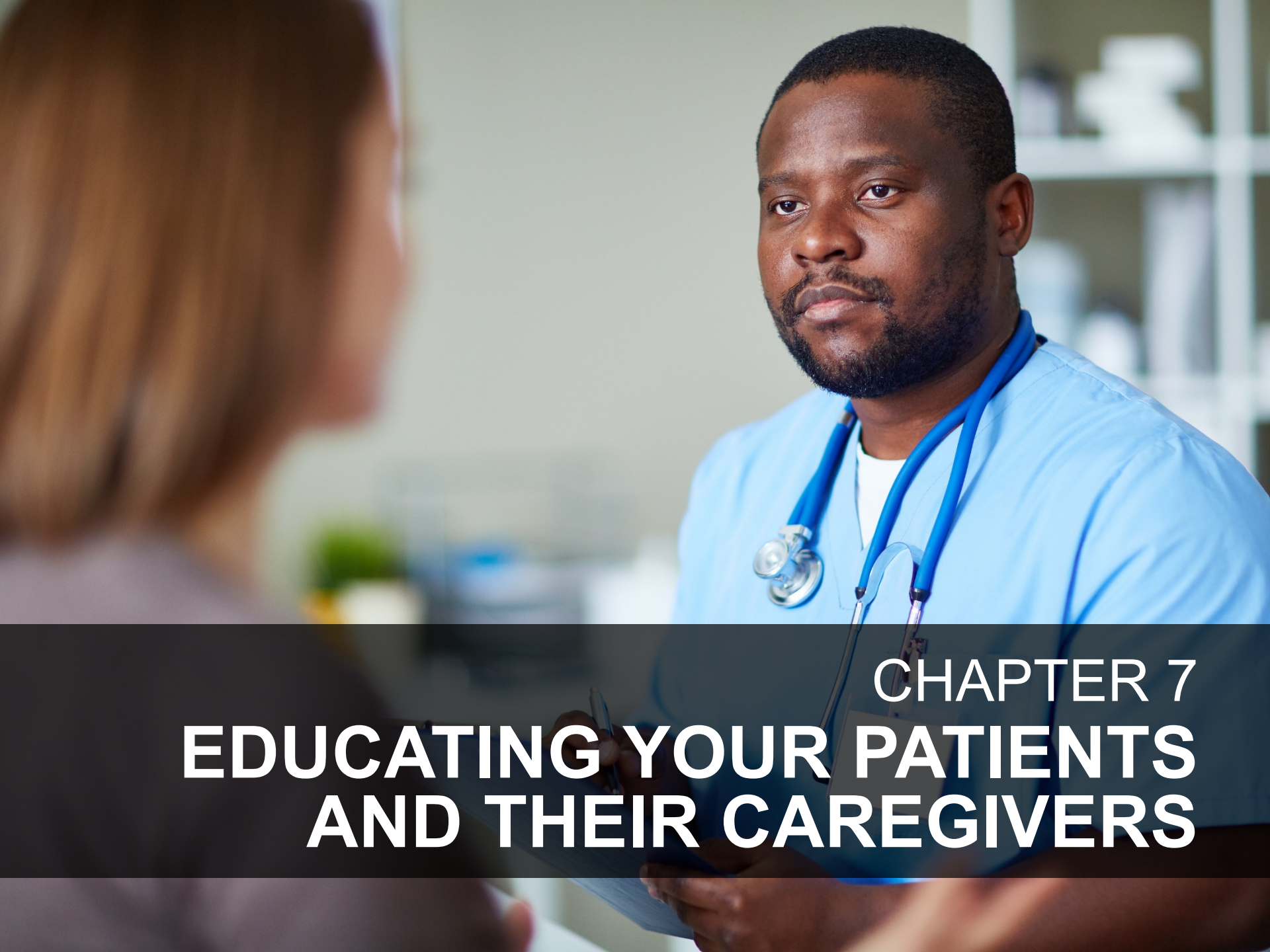
MISUSE OR ABERRANT BEHAVIORS

- One or two episodes of increasing dose without prescriber knowledge
- Sharing medications
- Unapproved opioid use to treat another symptom (e.g., insomnia)
- Use of illicit drugs or unprescribed opioids
- Repeatedly obtaining opioids from multiple outside sources
- Prescription forgery
- Multiple episodes of prescription loss
- Diversion

TAPER DOSE WHEN DISCONTINUING

- No single approach is appropriate for all patients
- May use a range of approaches from a slow 10% dose reduction per week to a more rapid 25% – 50% reduction every few days
- To minimize withdrawal symptoms in patients physically dependent on opioids, consider medications to assist with withdrawal (clonidine, NSAIDs, antiemetics, antidiarrheal agents)
- If opioid use disorder or a failed taper, refer to an addiction specialist or consider opioid agonist therapy
- Psychosocial treatments such as CBT are helpful

DOCUMENT, DOCUMENT, DOCUMENT!



CHAPTER 7

EDUCATING YOUR PATIENTS AND THEIR CAREGIVERS

COUNSEL PATIENTS ABOUT PROPER USE

- Take opioid as prescribed
- Adhere to dose regimen
- Use least amount of medication necessary for shortest time
- Do not abruptly discontinue or reduce dose; taper safely to avoid withdrawal symptoms
- Properly handle missed doses
- Notify HCP if pain is uncontrolled
- Manage side effects
- Inform HCP of ALL meds being taken
- Never share or sell opioids: can lead to others' deaths, against the law
- Use caution when operating heavy machinery and driving

Read the opioid **drug package insert** received from the pharmacy **every time** an opioid is dispensed

WARN PATIENTS

Never break, chew, crush, or snort an opioid tablet/capsule, or cut or tear patches or buccal films prior to use

- May lead to rapid release of opioid, causing overdose and death
- If patient is unable to swallow a capsule whole, refer to drug package insert to determine if appropriate to sprinkle contents on applesauce or administer via feeding tube

Use of CNS depressants or alcohol with opioids can cause overdose and death

- Use with alcohol may result in rapid release and absorption of a potentially fatal opioid dose, known as “dose dumping”
- Use with other depressants such as sedative-hypnotics (benzodiazepines), anxiolytics, or illegal drugs can cause life-threatening respiratory depression

TRANSDERMAL/TRANSMUCOSAL DOSAGE FORMS

Do not cut, damage, chew, or swallow

Prepare skin: clip (not shave) hair and wash area with water

Rotate location of application

Do not apply buccal film products if film is cut, damaged, or changed in any way -- use the entire film

Note that metal foil backings are not safe for use in MRIs

Monitor patients with fever for signs or symptoms of increased opioid exposure

Note that exertion or exposure to external heat can lead to fatal overdose

SIGNS OF OVERDOSE POISONING CALL 911

- Person cannot be aroused or awakened or is unable to talk
- Any trouble with breathing, heavy snoring is warning sign
- Gurgling noises coming from mouth or throat
- Body is limp, seems lifeless; face is pale, clammy
- Fingernails or lips turn blue/purple
- Slow, unusual heartbeat or stopped heartbeat

NALOXONE

What it is:

- An opioid antagonist administered intranasally (most common) or parenterally
- Reverses acute opioid-induced respiratory depression but will also reverse analgesia; may precipitate acute opioid withdrawal
- No abuse potential

What to do:

- Discuss an overdose plan with patients
- Consider offering a naloxone prescription to all patients prescribed opioids; some states *require* co-prescribing
- Involve and train family, friends, partners, and/or caregivers in the proper administration of naloxone
- Check to see if pharmacy dispenses it
- Check expiration dates and replace expired naloxone
- In the event of known or suspected overdose **call 911** and administer naloxone

SAFE OPIOID STORAGE AND DISPOSAL

STEP 1: MONITOR

- Note how many pills are in each prescription
- Keep track of dosage and refills
- Make sure everyone in the home knows (if appropriate)

STEP 2: SECURE

- Keep meds in a safe place (locked cabinet or box)
- Store away from children, family, visitors, and pets
- Encourage parents of your teen's friends to secure their prescription

STEP 3: DISPOSE

- Discard expired or unused meds
- Consult drug package insert for best disposal method

SOURCE: McDonald E, Kennedy-Hendrick A, McGinty E, Shields W, Barry C, Gielen A. Pediatrics. 2017;139(3):e20162161

WHERE AND HOW TO DISPOSE OF UNUSED OPIOIDS

Authorized Collection Sites

- Use the DEA disposal locator website to find sites near you: https://apps.deadiversion.usdoj.gov/pubdispsearch
- Search Google Maps for ”drug disposal nearby”

Options

- Drug take-back days (local pharmacies or local law enforcement)
- Flush
  - Follow the FDA’s “flush list”
  - Fold patch in half so sticky sides meet, then flush
- Trash (mix with noxious element like kitty litter or compost)

Mail-Back Packages

- Obtain from authorized collectors

SOURCES. Department of Justice, Diversion Control Division, Disposal Act: General Public Fact Sheet (June 2018), https://www.deadiversion.usdoj.gov/drug_disposal/fact_sheets/disposal_public_06222018.pdf;
FDA. Where and How to Dispose of Unused Medicines, https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm

Our session stops here, but your review continues…

PRESCRIBING INFORMATION

- **DailyMed** www.dailymed.nlm.nih.gov
- **CORE-REMS Tool Repository** http://core-rems.org/opioid-education/tools/
- **CDC Opioid Prescribing Guideline Resources** https://www.cdc.gov/opioids/providers/prescribing/index.html

ADDITIONAL EDUCATION

- **ASAM's Pain & Addiction Education** https://elearning.asam.org/PainAddictionCourses
- **The ASAM Treatment of Opioid Use Disorder Course including the buprenorphine waiver training** https://elearning.asam.org/buprenorphine-waiver-course

THANK YOU!