Session 19

Teresa Ainsworth: Epigenetics - studies so far elucidating the various genetic expression of alleles for EtOH metabolism, agree about the Asian anomaly. But re: northern Europeans: do they drink more and get drunk more d/t social/environmental cues, or are you aware of epigenetic data supporting variances in how they metabolize alcohol as a genetic subgroup?

Bruce Burns: We have even a higher percentage of prescription stimulants compared to the world.

- Dr. Salsitz: Agree. Probably all classes of controlled medications. e.g. benzodiazepines

Juliette: The book Dreamland also goes through a similar history of the opioid epidemic.

- Dr. Salsitz: Yes, agree.
- Kristen Belanger: Chasing the Scream is also a great Book

Dr Luther: I used to work in the ED. Pain scale used all the time. I would have patients look at me completely comfortable stating their pain was a "10". Led to so many ED docs resenting these patients and increasing use of "drug seeker" term. Unfortunately, this has extended to most patients with SUD.

Leslie Hayes: How much of a role do you think ACE's have in all of this, as they seem like they predispose to chronic pain, SUD, and mental illness?

- Dr. Salsitz: Couldn't agree more Leslie. BTW thought your presentation was really good.
- Leslie Hayes: Thank you! :-)

William Nickell: Have you ever prescribed over 24 mg of buprenorphine/dah

- Dr. Salsitz: I have not.
- Karl Wittnebel: Not outpatient
- Adam Lake: Agree with @karl wittnebel - only inpatient (post-op pain 8mg QID)

Laura Swain: adverse selection OMG!

Juliette: Any thoughts why the SOAPP-8 and Opioid Risk Tool do not include smoking in the assessment/screening?

- Dr. Salsitz: No. But eventually these tools have been questioned as to ability to predict misuse. An editorial a number of years ago was titled: "Risky Drugs, Not Risky Patients.
- Juliette: Appreciate the add'l context and reference. Like all screenings, they are not perfect tools but can assist with informing clinical decision-making.

Sean Leonard: LD50 for Ativan is 16 grams, benzos are dependent on endogenous GABA levels.

- Sean Leonard: I do only reserve benzos for anxiety refractory to all the other non-narcotic anxiolytics, and can count on one hand the number of patients I have on both a benz and buprenorphine or other opiate.

Carriedelle Fusco: READ Dopesick! IMO much better than dreamland. In Pain also an excellent look at how we manage pain.

- Juliette: Thanks for the suggestions.

Yngvild Olsen: The Empire of Pain is also a really interesting look at Purdue and the Sackler family

Denise Szczucki: What is an ACE?

- Leslie Hayes: Adverse childhood event
- Sunil Khushalani: adverse childhood experiences
- Pninit: Thank you. I was trying to figure out what ACE-i's had to do with pain management and mental health
- Dr Luther: Thanks for clarifying. I was thinking ACE inhibitors!
- Denise Szczucki: Thank you!

ST Weiss: Any thoughts about sigma receptor antagonists for pain and/or SUD tx?

- Dr. Salsitz: Above my pay grade
- ST Weiss: Haha, ok thanks. Maybe a future ASAM conference topic.

Erin Barnes: Tamper proof OPANA was like water in my area and that TTP syndrome was insane. Those patients were just SO sick.

Adam Lake: Marital status correlates with rx opioid misuse in NSDUH - Han, B., Compton, W. M., Blanco, C., Crane, E., Lee, J., & Jones, C. M. (2017). Prescription opioid use, misuse, and use disorders in US adults: 2015 National Survey on Drug Use and Health. Annals of internal medicine, 167(5), 293-301.

- Dr. Salsitz: Thanks. Will read and correct content
- Adam Lake: I still got the question right, as marital status isn't on the ORT :)

Juliette: There was a study that was published that most older adults are prescribed opioids prior to entering a geriatric age group and used them long-term.
https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13623

- Juliette: Ref: Opioid use in older adults and Medicare Part D. Adrienne H. Sabety PhD, Tisamarie B. Sherry MD, PhD, Nicole Maestas MPP, PhD. First published: 18 January 2021 https://doi.org/10.1111/1475-6773.13623
- Dr. Salsitz: Yes the older age groups receive the most prescriptions for opioids and benzos. They have lower rates of misuse, but often have serious adverse effects--falls, sedation, cognitive impairments.

Laura Swain: Are heroin users on Naltrexone Vivitrol, using Methamphetamine use because they can still get High? MANY Methamphetamine users in Colorado were Heroin-opioid dependennt.

- Dr. Salsitz: A recent article, reviewed in the stimulant talk showed a study using NTX and bupropion to treat methamphetamine use disorder.
- Dr. Salsitz: As far as I know, NTX does not block the effects of methamphetamine; ?attenuates as in alcohol use disorder?
- Erin Barnes: We have same problem. It is the problem of cross addiction- they still are at base substance users with a substance user brain. Meth is now VERY available nad they haven't built

up their coping strategies that are non-drug based strategies enough so meth then becomes the coping drug

- Erin Barnes: There is NO medication with high level evidence of efficacy for meth treatment. The naltrexone bup study was better but if you look at absolute rates it is still REALLY pitiful with the majority still not responding. So worth a shot but meth is now just a hot mess

Madhuri Gadiyaram: Any thoughts on microdosing of Bup for pain

- Karl Wittnebel: Same as for everyone else.
- Anthony Ekwo: I thought Methadone may be prescribed for opioid use disorder in a methadone clinic

Leslie Hayes: Any tips on how to get patient buy-in on non-pharmacologic treatment from patients who have already been treated with opioids? I find they are often uninterested in anything that is not a pill.

- Dr. Salsitz: Yes, often difficult. Education, education.
- Leslie Hayes: Thanks!
- ST Weiss: Focus on making it a "both-and" and not an "either/or". Meaning, it's not opioids or nothing, it's opioids (if needed) AND whatever nonpharmacological adjuncts they're willing to also use. And preferably multiple ones. Also, resetting expectations. Everyone has SOME pain. It's not realistic to go through life and never have any pain at all.
- Sean Leonard: I work in an FQHC, my patients don't have access to yoga programs, pain counseling etc. I do move my patients through the system i.e. physical therapy, x-rays, mris, referrals to neurosurgery or orthopedics, +/- pain management for back injections.

Sean Leonard: insurance won't cover lidocaine patches or diclofenac patches in my area..

- Dr. Salsitz: Yes, this is a significant problem. The misused schedule 2 opioids are always covered, but safer, more rationale therapy is not.

Mark Fuller, MD: The new book EMPIRE OF PAIN does a great job of going inside the Purdue Pharma empire and describing the marketing of Oxycontin.

Avani Sheth: Can you please provide the studies of individuals on chronic opioid rx transitioning to illicit use? Local experience (in urban setting) is that chronic opioid rx plays a much smaller role in driving the OUD/OD epidemic and concerned about the disproportionate emphasis on opioid prescribing

Sean Leonard: Gabapentin 100mg to 400mg comes in capsules and patients have been known to snort the contents.

Karl Wittnebel: The likelihood of getting Narcan during your admission for spine surgery is about 50% higher if you receive gabapentin in one series.

- Dr. Salsitz: Interesting, since naloxone does not antagonize gabapentanoids. But using gabapentanoids plus opioids increases overdose risk.

ST Weiss: Anybody have any references on the mechanism of how gabapentin potentiates opioid effects? Anecdotally there are lots of cases and case reports stating that it does, but I've never seen a good pharmacological explanation for why it happens.

- Dr. Salsitz: Gabapentanoids can cause respiratory depression.
- ST Weiss: Yes, I know. But that's not why the OUD patients are taking them. They're taking them to potentiate the euphoric effects of the opioids. I would like to understand why gabapentin potentiates the euphoric effect. All I've seen about this is anecdotes.

Stephen Gibert: If 30-40% of chronic pain opioid users, what are the other 60-70% doing? Obviously that in itself is evidence of the utility of opioids in chronic pain.

Andrea Leigh Lubeck: wy are more doctors not given warnings by states for over prescribing allowed to over prescribe. the is a doctor in my area\

- Leslie Hayes: One problem I see is that there is no intervention until the provider is so far over the line that there is no hope. I wish they might notify providers and say, Hey, your prescribing habits are concerning. Can we talk and offer some suggestions?
- Leslie Hayes: For patients already stable on chronic, long-term opioids, are there any studies about whether it is more risky to continue or stop? I seem to see a lot of patients who started heroin after being cut off. Does it matter if the dose was high?
- Dr. Salsitz: Yes, if a patient is doing well, continue with proper monitoring and reviewing risk/benefit. If the provide "fires" an opioid physically dependent patient, they might turn to illicit opioids.

Juliette: What about the evolving use of rotation to buprenorphine for pain mgmt?

Bezalel Dantz: Can you talk about treating pain in patients on buprenorphine or naltrexone

- Dr. Salsitz: I will discuss on the panel at 1:30PM

Juliette: Also, will updated slides be included in the ASAM resources? Thank you.

Sadie Knott: Please comment on deprescribing strategies for patients resistant to taper.

Avani Sheth: How effective is bup/nlx in treating chronic pain and what guidelines do you recommend (ie split dosing, higher dosing, etc)

Erin Barnes: How do you prepare patients on high dose buprenorphine for upcoming elective surgeries. Do you have a set kind of guide you use to decrease the bup with increased full opioid to help them be more sensitized? Do you reach out to the anesthesiologist to warn them they may need different strategies for anesthesia and pot op pain?

- Karl Wittnebel: Our limit is 12mg/day suboxone or 300 BID for belbuca. We are continuing it for major orthopedic and spine procedures.
- Karl Wittnebel: Postop management is buprenorphine plus a regular mu agonist.

Erin Barnes: Also my understanding is split dose buprenorphine does better for pain than daily type dosing. Confirm?

Charles Plummer, MD: What is the effect of genetic polymorphisms on overall efficacy and safety of opioid therapy and why do we not evaluate routinely for these polymorphisms?

Leslie Hayes: One frustration I have with post-op pain opioid prescriptions is that there is a huge variation in the amount of opioids patients need. However, many of the surgeons I work with give the same amount for everyone and don't ever refill. It seems like it would be better to give a small amount, then give refills for the patients who need them.

Mathew Sean McCarthy: Is there a role for buprenorphine in pain management?

- Erin Barnes: Yes. It is being increasingly used. There are patch and other formulations only approved for pain management which are at much lower doses than the doses used for treating SUD.
- Adam Lake: I've had good success and I think the literature backs me up. Lower doses (75-900mcg BID SL tabs or 5-20mcg/hr patches) are approved for pain

RJ: It is not recommended to flush opioids or other medications down a toilet. This results in measurable levels of medications in drinking water. It is a standard pharmacy recommendation to NOT flush meds down a toilet.

- Adam Lake: don't the drugs end up there after people take them?
- Sean Leonard: @ adam LOL

Bezalel Dantz: buprenorphine-samidorphan was recently rejected by the FDA as a proven treatment option for Major Depressive Disorder. There is evidence to support buprenorphine for depression. Can you comment on the data and the FDA's decision against approval?

Jeffrey Rosen: do not agree about first dose liking affect. Almost all my palliation patients describe first dose "magic carpet ride" to quote one 78 yo

Terry Horbal: Method to transition off and back on to bup when post op pain relief is needed

- Adam Lake: I few people have brought up microdosing - Ahmed S, Bhivandkar S, Lonergan BB, Suzuki J. Microinduction of Buprenorphine/Naloxone: A Review of the Literature. Am J Addict. 2021;30(4):305-315. doi:10.1111/ajad.13135

Bezalel Dantz: How often should stable patients on buprenorphine be seen by clinician?

- Dr. Salsitz: Clinical judgment. Can refill up to 5 times.

Dr Luther: If treating pain and OUD with bupe in the same patient, do you need a waiver?

- Sharon Stancliff: Get a waiver, it is so easy now that, for 30 patients you only need to send a notice of intent.

Laura Swain: which meds are approved for Medicaid patients?

Bella: The pain approved are much more expensive.

Marc Simmons: the question is not correct. Many pts come in to EDs and get methodone because they can not get their methodone for what every reason

- Adam Lake: is this the dispensing or prescribing?

Helene Alphonso: Is there future interest to approve more IM versions of buprenorphine for SUD?

Marcie Bockbrader MD PhD: Please comment on the cost/insurance coverage of buprenorphine for pain compared to cost/insurance coverage for full agonist opioids/opiates for pain.

Mark Chambers: Are those formulations of buprenorphine for pain available here in the US? I was under the impression buprenorphine was NOT DEA approved for chronic pain here in this country

- Jeffrey Rosen: yes. butrans. belcucca

Karl Wittnebel: Most insurers want all patients to switch to suboxone from Belbuca if the medication is continued beyond 1-2 months when prescribed for pain.

Gamwo: so methadone can not be prescribed in primary care only for pain management right?