

Dr. Peter Selby: Welcome back to ASAM's Practice Pearls. I'm Dr. Peter Selby and I am so excited to host this session with our esteemed expert, Dr. Andrew Smith. Andrew, welcome to our show, and we are so pleased that you're gonna be talking with us about pain and addiction in people with sickle cell disease.

Dr. Andrew Smith: Hey, Peter. Thanks so much. It's really fun to be here.

Dr. Peter Selby: Great. So, my interest in it goes back to residency, where I was struggling with this gentleman in my practice as a resident who would, depending on who was supervising me, would either say, this person with sickle cell disease was an addict, and they used that term, addict, or this person has poorly managed pain and prescribe them all the opioids they need. It became extremely confusing to me, and I always wondered about the patient as to how he navigated his pain management through this intermittent reinforcement program that we had set up where he would sometimes get meds and sometimes he wouldn't.

I took an elective in the addictions division at University of Toronto, and I went over to the Addiction Research Foundation, which was in existence at the time, then I had this experience of understanding that people were beginning to think about the co-occurrence of pain and addiction and that just because somebody has a pain disorder doesn't mean they can't have a substance use disorder or vice versa. So, that has always driven me and I owe it to – actually my career – to this person with sickle cell who really got me thinking, as these patients fall through the cracks or bounce between the pain system and the addiction system and other healthcare systems, that we need to do a better job.

So, today, I'm really pleased that we're gonna be able to talk about this intersection between sickle cell disease, pain, and addiction. We want to know what are some of the ways that we can do the best possible treatment plan and help people live full, productive lives, even if they have acute pain, chronic pain, or both, when they also have sickle cell disease?

Dr. Andrew Smith: That sounds great, Peter, and that anecdote is really right on because I think one of the reasons I like working with these patients is for similar reasons as you - I think there's so much to learn from them. They're highly complex, with so many different co-occurring conditions and that overlap between pain and chronic opioid therapy and use disorder, and how do we sort that all out? So, it's a really rich area of practice, I think.

Dr. Peter Selby: So, let's get back to the first part of this, which is – could you explain the nature of the pain that people with sickle cell disease will have during their life course?

Dr. Andrew Smith: Yeah, so it's pain, plural. There's different kinds of pain in individuals with sickle cell, and that's one of the things that makes it so challenging. And not just for us clinicians, but for them, themselves, people living with sickle cell disease. So, there's the acute pain, which is largely the result of vaso-occlusive crises, which, as we know, results from stressors put on the mutated hemoglobin molecule, which then kinks and polymerizes and causes red cells to sickle, which then adhere to the endothelium and smaller blood vessels and can cause occlusions and, essentially, ischemic injury to whatever tissue. That's the acute pain. And then, you know, over time, that can become more chronic. So, there's a couple of different kinds of chronic pain. There's chronic sickle cell-related pain that involves end-organ damage, if you will. So, individuals who've had recurrent bone involvement, avascular necrosis, for example, leg ulcers. There can be sort of chronification of that pain. But there's also sickle cell-related pain that doesn't necessarily have anything to do with an underlying

disease process or consequence and that is thought to be secondary to sensitization in the nervous system, so peripheral and then central. And then, really, the last category of pain is kind of a flare-up. So, there's the baseline chronic pain, which then can flare up and can feel an awful lot like a vaso-occlusive crisis and our patients will often talk about those flare-ups as a crisis. And when we hear crisis, we think, vaso-occlusive, but it's often a flare-up of the chronic pain.

Dr. Peter Selby: Wow. So, I'm hearing like almost four dimensions: acute pain, chronic pain, sensitization, and then acute and chronic flare-ups that are not necessarily vaso-occlusive. So, that's part of the way we need to think this through. I've also heard you in past, and just for disclosure, I've known Andrew for many years, you mentioned this "pain is pain is pain." Do you wanna just help the audience understand a little bit about how we should be thinking about "pain is pain is pain?"

Dr. Andrew Smith: I use that kind of as a teaching point with patients. So, there's many different kinds of pain. On the physical end of things, there are those four kinds of categories of pain I just mentioned. But pain is a biopsychosocial construct and so human beings experience other kinds of pain beyond physical pain. It can be pain associated with a mood disorder or an anxiety disorder or trauma, either physical or psychological. It can be pain that you didn't sleep very well last night, or pain that you've just experienced, stigma in the emergency room, or pain that you don't have a job and have financial stressors. And all of those things contribute to the lived experience of pain. Those conversations are somewhat challenging in that some patients, if not approached sensitively and you don't take enough time to really explore all that with them, will sometimes hear that you're invalidating the physical pain or they think that you've just told them that it's in their head, but in fact, it's really trying to come at the lived experience in a holistic way.

Dr. Peter Selby: What you're touching upon is that this chronic condition, which has this undulated course, chronic course, there's no cure for sickle cell, it's there, and people are living with it, therefore, they have lots of experiences with the healthcare system. What advice would you have for clinicians of how to even start the approach with people who might have already had negative experiences, and how do we do the least harm when we are trying to engage and help people with sickle cell and pain and addictions?

Dr. Andrew Smith: Yeah. So, there's nothing particular about the approach to patients with sickle cell disease that we wouldn't apply to patients with other chronic pain conditions. It's just individuals with sickle cell have this kind of multidimensional pain complexity, different kinds of pain – acute, chronic, acute on chronic. And of course, the population tends to be people of color, marginalized communities who have experienced more stigma, more impact of their disease, more negative interactions with the health system. I think before we embark on an assessment of a patient with sickle cell, we just want to check in with ourselves and reflect on that. But then, maybe even express that we recognize some of those challenges that they may have already experienced in the health system and that our assessment is really a collaborative one. I strongly believe, especially in pain medicine, that narrative is an important part of treatment and allowing the patient to kind of own their narrative, tell their story, that we respect it, that we do so in a trauma-informed way, because often trauma is associated with these stories.

So, right up front, acknowledging that and allowing the patient to set boundaries around our conversation. And then doing that collaborative assessment, not being a curator of

information, we're not trying to extract, I mean, we are trying to know our patients, but again, honoring that narrative, reflecting back what we hear. Part of this is a motivational framework, too, and like with any chronic pain condition, so listening for readiness for change, listening for change talk in a very open way. Part of the assessment, like with any pain assessment, is screening for things that can increase risk and may point to an actual use disorder in patients who may be prescribed opioids or using alcohol or other substances to try to cope. So again, that's what we would call a universal precautions approach to assessing risk along with the rest of our assessment. And that we normalize that and really go out of our way to allow safe space for our patients to share sometimes difficult and maladaptive coping strategies with us.

Dr. Peter Selby: So, you're really talking about taking the time to build the rapport, make it safe, and you do that by using a motivational framework. You're trauma-informed, you're accepting that there are racial biases, because most people who have sickle cell are black, or a very, very small percentage could be from South America, but that's really small. But that's what we have. And so, you layer that on, if people are coming into a space, that space needs to be safe for them to be able to tell their story in a way that doesn't further traumatize them or diminish or invalidate their experience, and that takes time.

This is a good segue into the next part of my question, which is – we've come out through a point where pain management was managed with prescribing opioids, short-acting, long-acting opioids in high doses, and sometimes people will inherit patients who, because this is a condition that, you know, gets treated with pain in pediatric populations, and now come into the more adult sector. If we just broadly talk about how one should approach the issues of opioid use in people with sickle cell disease and what are some of the things we need to do to have good stewardship and help people function and live their best possible lives, even if they do need to take opioids.

Dr. Andrew Smith: I think, one thing again, too, that in our own process we should just check in around is to recognize, even before we meet with the patient, that they are gonna be very sensitized to questions around opioids. They will universally have experienced stigma and perceived, if not real, withholding of care or delay of care, really focused on opioids. And this is in spite of aggressive efforts on their behalf by the professional organizations like the American Society of Hematology with their 2020 guidelines and guidance around rapidly treating pain when somebody presents to the emergency department.

I think the discussion around opioids can be a very fraught one. I think, you know, that first of all, as part of our assessment, just checking in around how the pain is managed, what medications they're using, how and when they're using the opioids, what the opioids do, part of this is looking for tolerance and withdrawal-mediated pain. And I find that there's an easy way to gently inquire around aberrant use of the opioids, like "Are you taking extra? Are you running out early?" Sort of normalize it, starting with the pharmacology that tolerance happens, there can be a dose wear off, the medication isn't as effective as it used to be, some patients will find that they need to take more, they'll borrow some from their friend or whatever. So, again, and being really safe, non-judgmental, non-triggering as much as possible in those conversations and then again, reflecting back what you're hearing.

An effective opioid trial, as most of us understand, reduces pain, but also more importantly, improves function and quality of life. And again, if we're not hearing that from our patients, then we want to say that and put forward other options. So, I think, just coming in and saying,

"Oh my goodness," especially inheriting a patient, "Wow, you're on a boatload of opiates and what are we gonna do about that?" is not gonna go very far, as opposed to really spending the time to get their experience of the opioid, hearing about side effects. And again, in that motivational framework, with establishing rapport, you'll begin to hear how it's not working for them and, together with them, make a case for thinking about different options.

Dr. Peter Selby: Right. It's more about describing the phenomenon of what the drug is doing to them versus for them, and then rather than jumping on labels or absolute amounts, it's really keep your eye on the person, their function, and then you can bring that into focus and come along with the patient is what I'm hearing you say to us.

And, can I ask just a point of clarification, in terms of the role of rating scales and in those other practices that we use in chronic pain management in the face of addiction, are there things that you do differently? Do you have different kinds of approaches to that? Anything in particular you're looking for?

Dr. Andrew Smith: Not really. In our clinic, we use the same scales in patients with sickle cell as with other chronic pain conditions. So, brief pain inventory, we look at catastrophizing and self-efficacy, we screen for mood and anxiety and trauma, and also, we use different measures of opioid misuse.

Dr. Peter Selby: So, coming back to now, let's say this person is actually meeting criteria for an opioid use disorder. What are some of the ways in which you approach that, both in communicating it to the patient and then engaging and what kind of treatment options do you use in OUD treatments, and how do you manage both the pain and addiction?

Dr. Andrew Smith: Yeah. It's enormously challenging to diagnose a use disorder in these patients. And I'm speaking as a white male physician, those discussions are enormously challenging, because they can be very triggering. And like many of our chronic pain patients, there's a certain sense of entitlement to the opioid because, "This is to manage my pain," and there can often be less insight into the downside and the problematic use. I try to stay away from labels so much and really just talk about the idea of dependency. Physical dependency can sometimes be an easy way to enter into that discussion and the pharmacology and that "it's not really working for you" and moving into sort of a reflection of kind of the maladaptive use. And again, normalizing that – nobody ends up wanting to have a use disorder. It is a risk of prolonged exposure to an opioid. We think of opioids a little bit like radioactivity. So, the higher the dose, the longer the exposure, the higher the risk of developing a use disorder, and these patients will often have other risk factors for that as well. So, to speak to that, but then provide some options. It's not an all-or-nothing conversation. I think that's an important thing. "We're gonna continue to manage your pain and probably with opiates. It's just this particular opiate seems to be more," as you said, Peter, "doing more to you than for you." We can then leverage some of the tools that we use in the treatment of opiate use disorder really effectively in this population as well. In our locale, hydromorphone is often what's most frequently escalated and a problem to say sustained release oral morphine or certainly buprenorphine. And there's really nice emerging data, specifically in the sickle cell population, that the buprenorphine is quite effective in treating the chronic pain associated with sickle cell and improving function and quality of life.

Dr. Peter Selby: In divided doses or as individual single dose?

Dr. Andrew Smith: Either or both.

Dr. Peter Selby: Both. Okay. So, there are ways in which we can use safer opioids, less risk of overdose in that situation. Here's the other dilemma that we have in people who are on opioid agonists and shows up in emerg, in a crisis, what are some of the options that person has, and how does the ER doc, who may or may not have much experience in managing people on opioid agonist treatments, manage this one?

Dr. Andrew Smith: Yeah. Educating our patients is, I think, really important and empowering them for whatever contingency may arise. So, I think, our patients with sickle cell and [those] who have a use disorder are gonna land in the emergency department at some point or another. So having conversations, "How are we gonna deal with that?" One tool that we use, and there is some literature in this that is quite effective, is essentially providing, we call it a "care passport." So, it's essentially a letter that outlines a brief summary of the pain condition and the pain formulation really and concurrent disorders. It's done collaboratively, obviously with the patient, so we're not revealing all kinds of, you know, extraneous details, but there can be contingencies outlined in that care document and then contact information that the ER doc could access to be able to reach somebody like me or somebody who can provide further support to their care acutely.

Dr. Peter Selby: Wow. So, I can see how you're suggesting that we need to come to this really in this holistic way, making sure not only when they come to see us, but how they engage with others, that there's a care plan that goes with them. And I love that idea of your passport. I think it's a really interesting one; it empowers people, you co-create it with them.

So, I think what I'm hearing is that if we situate our management in a motivational state, this is going to really help move this forward and minimize the amount of stigma, minimize the defensiveness that might come when you're trying to have that difficult conversation. We all shy away from it, but you've just given us an idea of how we can approach it. So, I really appreciate that.

Dr. Andrew Smith: Yeah. And actually, there's some really interesting qualitative literature looking at the most recent paper was done out of the Johns Hopkins Sickle Cell Clinic program and the experience was of patient autonomy. And these were patients with and without sort of problematic use of their opioids, but the idea was the experience of transitioning to buprenorphine in particular, and what worked and what didn't. The patient feedback was really strongly about information, being informed about having options. So, it's not just, "Here's the choice or else," having autonomy in the choice and being able to have follow up, connect with a team, to sort of support the transition and a lot of the reservations up front were around, "Well, how's my pain going to get managed?" Stigma, "What happens?" "I know about 'bupe' and I'm gonna land in the ER," and so addressing that proactively.

Dr. Peter Selby: Right. The time has flown by and I have just one last one that I'd like to get your thoughts on - if you have a case with somebody with sickle where you've had to work through that inspired you to continue to work in this space as well.

Dr. Andrew Smith: Yeah. I was thinking about that. It's actually a case I had, I think I was just barely out of my clinical fellowship, and it was a young woman who has sickle cell disease. She had an older brother with sickle cell, grew up raised by a single mom, a

tumultuous childhood, some adversity, and she had episodes of acute vaso-occlusive crises, was able to come on and off the acute opioids. But then, she was sexually assaulted in her late teens and then it became increasingly more challenging to get her off the opioids from the crises. And this developed into a use disorder.

When I saw her initially, and this was pre-pandemic, and I do have to say that, at least, I know in the United States as well, but here in Canada, our practice around rigidity in opioid prescribing, we've become a bit more flexible in some ways. But my own practice was like, "Oh, here's aberrancy and the plan is we're going to make a couple of recommendations or do a structured taper." And she was not at all ready to hear that; she was not at all ready to make the change. And we essentially had an impasse in our therapeutic alliance. And she was able to actually voice to me why she wasn't ready and the role that the hydromorphone, in her case, played and asked, "Are there other things we can do?" And of course, we were trying to engage her and interest her in trauma therapy and other things. Ultimately, when she was offered more options and more autonomy in the choice, and we were able to together discuss in a more open, accepting way, in a safer way, perhaps more trauma-informed way on my part, the choice was easier and then it became a really productive relationship. She ultimately decided to rotate to buprenorphine and did some addiction counseling treatment and trauma work and has done fabulously well. She now teaches at our patient support group for patients with sickle cell disease. She's become a nurse and is very interested in this field. So, there are good outcomes, but for me that was the case that made me reflect on how to win.

Dr. Peter Selby: Amazing. That's really amazing and it really shows you that when you see people at their worst that doesn't ever tell you where they can be at their best. And so, really, thank you for that. And I think our key takeaway is that – pain is real, validate people, build rapport, understand, and use judicious use of medications. But it's not just about medications. It's about all those other things that have happened to them. And then using a collaborative model, you really help them control the narrative but also help them see that they may be getting into difficulty. So, by reaching an impasse, which then creates that sort of space for change, is really the way you're talking about it.

I can't thank you enough for joining us and sharing our wisdom with us, Andrew.

Dr. Andrew Smith: Thanks, Peter.

Dr. Peter Selby: Absolutely. And thank you to all our listeners today for listening to this ASAM Practice Pearls. And for more information, check out our show notes. And of course, don't forget to subscribe and share this episode with colleagues who might find this information helpful. Lastly, we'd love to hear your thoughts, what challenges you have faced in treating individuals with sickle cell disease and how do you overcome them? And be sure to join in on the conversation on our social media sites. Thanks for listening, and we'll see you next time on ASAM Practice Pearls.