Opioids and chronic pain management

Michael Fingerhood MD FACP DFASAM AAHIVS
Associate Professor of Medicine and Public Health
Johns Hopkins University

DISCLOSURES

No financial ties

No commercial interests

Objectives

- Increase ability to effectively diagnose opioid use disorder in the older adult
- Be able to recommend effective treatment options for the older adult with pain
- Be able to recommend effective treatment options for the older adult with opioid use disorder

Patient vignette 1

- **EB is a 72 F seen for initial visit. She has a history of HIV and chronic pain in hips and knees. Her previous provider will no longer prescribe oxycodone as for the past 2 months her 30 day script ran out after 2 weeks. Tearful and fearful that providers won't help her. Cannot take NSAIDs. She admits that she often takes oxycodone when she is upset.**
- **She lives alone in senior housing apartment; 2 daughters- both with difficulties (medical and social). Non-smoker; no alcohol.**

Patient vignette 1 outcome

- After spending a great deal of time building rapport and making sure she knew my goal was to work with her, I explained I would not prescribe her oxycodone.
- She was open to undoing isolation, treating mood and trying buprenorphine
- Almost immediately, physically more active (no longer dwelling on when next dose of pain medication is and does she have enough), remains on low dose buprenorphine, never running out before she should, with improved pain.

Patient vignette 2

- KL is a 65F with longstanding stable HIV who had right total knee replacement complicated by joint infection requiring prolonged course of antibiotics, hardware removal with spacer and finally replacement of hardware. She has been on oxycodone 15 mg four times daily for 4 months.

- She sees orthopedics in f/u and is told she should not be on any further opioids as she is now 2 weeks out since the last surgery. She is told to take ibuprofen.

Patient vignette 2 outcome

- I receive a call from the police that KL had died from an apparent opioid overdose
- I find out from her son that she had gone into severe opioid withdrawal and bought opioids on the street.

Patient vignette 3

- JL is a 67M seen to establish primary care. His only complaint is severe back pain. He has had many ER visits for pain and on review of PDMP has opioid scripts from many different providers. He also had on ER visit for opioid overdose. He is insistent on receiving a script for oxycodone

Patient vignette 3 outcome

- It is clear that he has opioid use disorder.
- He is offered help and a naloxone script.
- He refuses both and leaves the office without making a follow-up appointment.

Patient vignette 4

- CG is a 78F with HIV, CAD, CHF and severe DJD both knees; uses walker with difficulty. She would qualify for joint replacement very high risk
- She is receiving oxycodone 15mg four times daily and on this dose can make it around her apartment and sleep at night

Patient vignette 4 outcome

- She has remained on this dose of oxycodone for the past 5 years with no ER visits/hospital admissions
- She remains mostly homebound, using walker to ambulate, but always shows up to see me and her cardiologist

American Geriatrics Society Beers Criteria

- Avoid NSAIDs, muscle relaxants and tramadol (added 2019)
- Avoid opioids if history of falls or fracture
- Avoid tricyclics- amitriptyline

Other pharmacologic agents?

- Gabapentinoids
- SSRIs- duloxetine
- Topicals

Non-pharmacologic tools?

- Exercise/water therapy/yoga
- Massage
- Chiropractor
- Acupuncture

DSM5- Opioid Use Disorder

- No longer abuse versus dependence
- Need at least 2 of 11 criteria with clustering in groups

DSM5- Opioid Use Disorder

- Group 1- **Impaired control**- larger amounts and longer; desire to cut down; great deal of time spent related to using; craving
- Group **2-Social impairment**- failure to fulfill obligations; interpersonal problems; reduction in social, occupational or recreational activities

DSM5- Opioid Use Disorder

- Group 3- **Risky use-** use in hazardous situations; continued use despite negative consequences
- Group 4- **Pharmacologic dependence**- tolerance; withdrawal with cessation

Themes in older adults with opioid use disorder

- Living alone
- Sense of isolation (despite family)
- Opioid as a “friend”
- Shame
- Fear of how to live without opioid

Who are the older patients with opioid use disorder?

- Lifelong opioid use disorder with survival to older age (more common than realized)
- Entry via opioid prescription later in life

Epidemiology of opioid use disorder in older adults

- **Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS) System- between 2006 and 2014, rates of unintentional prescription opioid misuse and serious medical outcomes were higher for adults who were 60 years of age or older than for those who were 20 to 59 years of age and this was especially true if suicide intent**

How did my patient get here?

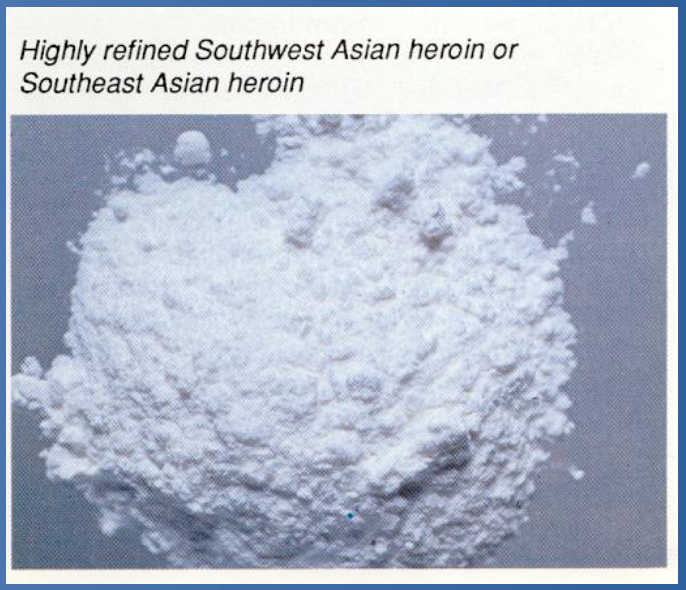
- Pain as vital sign
- Using pain scores rather than assessing function
- Pharmaceutical industry
- Society guidelines for treating pain
- Availability of opioids- family, friends and street

“Escalate opioids to maximum dose”

- Portenoy R et al. The nature of opioid responsiveness and its implications for neuropathic pain: new hypotheses derived from studies of opioid infusions. Pain 1990 Dec;43(3):273-86.

- “Both the clinical use of opioids and paradigms to investigate opioid responsiveness should include dose escalation to maximally tolerated levels and repeated monitoring of analgesia and other effects”

The sap is extracted by slitting the pod



Opiates & Opioids

Opiates **= naturally present in opium**

- **morphine, codeine, thebaine**

Opioids **= manufactured**

- **Semisynthetics are derived from an opiate**
  - **heroin from morphine**
  - **oxycodone and buprenorphine from thebaine**
- **Synthetics are completely man-made to work like opiates**
  - **methadone, fentanyl**

Effects of Opioids

- Euphoria/analgesia
- Nausea/vomiting/stomach turning
- Abdominal pain with withdrawal
- Drowsiness/poor sleep
- Respiratory depression
- Other- constipation, osteoporosis, hypogonadism

Screening/Diagnostic Tools- Utility in older adults?

- Ask about pain and impact on life
- Ask about use of opioids that were not prescribed
- Note that patients may not realize the difference between re-emergence of pain and withdrawal

Psychosocial Contributors to Assess in Older Adults

- Stigma/Shame – “addict”
- Bereavement and grief issues
- Social isolation/loneliness
- Reduced self-regard or self esteem
- Family conflict and estrangement
- Problems in managing time/boredom

“Despair”

Identifying

- Ask
- Survey/screening tools
- Clinical assessment
- Local medical record
- CRISP/PDMP
- Search criminal record?

But here is my bias:

SBIRT

vs

SIT (screen, intervene and treat)

Intervention- “I have joined your fan club”

- Interventions and education are effective
- Interventions should emphasize health and relationship benefits
- Use family/friends in a positive way
- Avoid threats- “If you use, you will die”
- Give hope that life can improve
- Acknowledge reasons for use, but…
- Work together to define the benefits of change

Treatment approach for older adults

- Don’t enable
- Confront with compassion
- Remove shame
- Build self-esteem
- Give encouragement/hope
- Undo isolation
- Work on coping skills
- Facilitate finding new ways to stay busy with use of peers

So now how do I deal with pain?

- Expectations are crucial
- Non-opioid pharmacologic options
- Non-pharmacologic options
- Safer opioid options?

Pharmacologic treatment for opioid use disorder?

- Buprenorphine/naloxone
- Methadone
- Naltrexone
- Naloxone for emergency

JOHNS HOPKINS MEDICINE

MEDICATIONS

NOT MAT

Buprenorphine's Properties

- Modest μ agonist activity with ceiling
- Long half life
- Precipitated withdrawal if taken after full agonist
- Sublingual route of administration
- "Combo" tablet with naloxone limits abuse by injection

Buprenorphine Safety

- No alteration of cognitive functioning
  - feel “normal”
- No organ damage
  - Early concern of hepatic toxicity unconfirmed
  - No evidence of QT prolongation
- Ceiling prevents respiratory depression/overdose
- No clinically significant interactions with other drugs

Stop using this term:

But don't I need to provider a counselor?

- **Multicenter randomized clinical trial- n=653**
- **Patients randomized to standard medical management(SMM) or SMM plus counseling**
- **Separate counseling did not change outcomes**

Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence:*A 2-Phase Randomized Controlled Trial*
Roger D. Weiss, MD; Jennifer Sharpe Potter, PhD; David A. Fiellin, MD et. al. Arch Gen Psych 2011; 68:1238-1246

Support groups?

JOHNS HOPKINS MEDICINE

"You're not in recovery if you're on medication"

Summary- What should we do?

- Assess function and goals for daily life
- Partner with patients to remove shame if opioid use disorder present
- Offer concern, hope and guidance to patients so that their lives can improve
- Integrate evidence based treatment for opioid use disorder into geriatric care

References

- Mattson M, Lipari RN, Hays C, Van Horn SL. A day in the life of older adults: Substance use facts. The CBHSQ Report: May 11, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

- Lehman S, Fingerhood M. Substance use disorders in later life. New England Journal of Medicine 2018; 378:2351-60.