How to get your patient off “Pill Island”

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Where did the opioid experiment get us?

FOUR POPULATIONS OF PATIENTS PRESCRIBED CHRONIC OPIOID THERAPY FOR NON-MALIGNANT PAIN

- “Nociceptive or neuropathic pain from tissue injury” population
- Substance abuse population
- Diversion population
- “Pain for psychological reasons w/o tissue pathology” population
3 Types of Pain

- Nociceptive
- Neuropathic
- “Pain without tissue pathology...for psychological reasons”

A combination of these is often the case

“Pain without tissue pathology...for psychological reasons”

What is that???
WHAT IS PAIN: PAIN WITHOUT TISSUE PATHOLOGY
(No tissue injury. No tissue pathology. No activation of nociceptors.)

Pain Stimulus

Altered sensory processing of all sensory stimuli (Everything hurts). Altered motor control.

Central nervous system changes

Emotional processing of pain stimulus

Emotional distress and unpleasantness

Pain and DISABILITY

DEPRESSION, TRAUMATIC EXPERIENCE (WAR, ABUSE, DISASTER), ETC

DIGITAL PAIN

MULTIPLE SOMATIC COMPLAINTS THAT ARE DIFFICULT TO EXPLAIN (OFTEN GI)

LOTS OF OPIOIDS BUT NOT WORKING

COGNITIVE AND PHYSICAL DEVELOPMENTAL DELAYS

WHEN ACE >5/10, 20 YEAR SHORTER LIFE SPAN

MORE LIKELY TO BE OBESE, or other eating disorder

DIFFUSE PAIN "OUT OF PROPORTION TO OBJECTIVE EVIDENCE OF TISSUE PATHOLOGY"

(ramped up emotional processing, AKA FMS)

INCREASED RISK OF DIABETES, COPD, CAD, AUTOIMMUNE DISORDERS

AUTONOMIC DYSREGULATION

http://www.cdc.gov/violenceprevention/acetstudy/
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The two pain pathways

SENSORY PAIN PATHWAY

EMOTIONAL PAIN PATHWAY

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Please fill in the "Pain Diagram" below to let us know where your pain is and where it hurts the worst. Shade or color the areas on your body where you feel pain. Mark Severe Localizations with "O"'s and use an "X" where it is the Worst.

Here I hurt, but I try to organize them.

My back and neck hurt too. My legs hurt as bad it seems.
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Some signs of ramped up emotional pain processing

- Depressive symptoms and signs/high score on test such as BDI
- Anxiety symptoms and signs/high score on tests such as GAD-7
- Diffuse pain without clear pathological explanation
- Multiple somatic complaints
- Patient report of disability seems out of proportion to physical pathology
- Pain behaviors out of proportion to pathology, such as grimacing, groaning, crying out, protected movement
- Patient reports high job stress and or dissatisfaction
- Patient grieving a loss (of a relationship, family member, etc)
- Patient chooses emotionally charged language to describe pain
  - "I am crying in pain"
  - From the McGill pain Questionnaire: Tiring/exhausting; sickening/suffocating; fearful/terrifying; punishing/cruel

What is Pill Island?

- Patient using analgesics for pain, but...
- Function is not good, even when dosage increased
- It is not clear that pain meds are helping
- Patient is often not engaged in self care
- Patient often has behavioral health issues that are not addressed and which undermine the rescue effort
- Concerning yellow flag behaviors may be present
  - Running out early, lost meds
How did the patient get there?

- **Patients whose pain is psychologically driven, and opioid is desirable to the patient for its psychotropic properties**
  - Developmental trauma, anxiety, depression, etc
  - Emotional pain processing predominates
- Patient (and maybe provider) has unrealistic expectations for treatment and kept ramping up the medications
- Opioid was titrated past the “maximum effective dose” and now the pt is on more than is needed
- Addiction – patient was and is an addict
- Diversion – patient is selling the pills

When you suspect diversion
When you suspect addiction

- Stop prescribing controlled substances
- Refer to addiction medicine
- Halt active pain treatment until addiction treatment is established and pt is engaged

Treatment of Opioid Withdrawal Symptoms

- Clonidine. 0.1-0.2 q4-6 hours, or 0.1 mg patch/wk
- Lomotil (diphenoxylate, for diarrhea)
- Bentyl (dicyclomine, anticholinergic for muscle spasm)
- Hydroxyzine 25-50 mg HS
When the medication hasn’t met expectations
When the dose has been escalated too far
and psychosocial factors aren’t significant

- Slow wean: 10-30% decrease each month,
  slower as dose gets < 60mg/D MS, 30mg/D oxycodone, 30mg/D methadone
- Fast wean: 10-30%/D until limits above reached
  then 10-20% of the limit dose every 3-5 days.

- Ease the burden
  - Accupuncture
  - Clonidine patch
  - Hydroxyzine, trazadone HS

When opioid is a “psychotropic adjuvant” for a
patient with psychological pain: patience, integration
of BH, and one-step-at-a-time approach

- Patients are on guard about being told the
  pain is “in your head”
- Patients may be very resistant to
  behavioral health approaches and lifestyle
  changes
- Patient’s life circumstances can be very
  challenging, interfering with lifestyle
  change and access to care
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- CBT, & Trauma tx if there is developmental or adult trauma hx
- Aggressive pharmacologic tx of depression, anxiety
- Frame up the effort in terms of re-regulating the nervous system
- Alternative medicine
- Physical therapy and exercise, when ready
- Interventional pain treatment if indicated, when ready
- Lifestyle change, when ready
- Wean opioid slowly, when ready

Patient engagement: getting them onto the bridge

- Focus on the customer. Meet them where they are at and plan the journey to health ownership from there.
- Always frame the discussion around the patient’s best interests
- “It’s in your nervous system”, not in your head. Use the phantom limb pain example.
- Outstanding customer service throughout the office is key to gaining the patient’s respect and trust
Patient engagement: getting them onto the bridge

- Leverage the "we get you" effect
  - Integration of behavioral and medical so that you can show the patient you understand their life context
    - Barriers to care
    - Cultural issues related to care
    - Previous (good or bad) experience with healthcare
    - What the pain feels like to them, psychologically
  - Function - provider must know what a day in the life of the patient is like and the patient must know you know

Patient engagement: getting them onto the bridge

- Honesty
- Go the extra mile
  - Care coordination (we need help from payers and practice administrators on this one – and not just for pain issues)
- Peer pressure
  - Groups for CBTI
- Leverage pharmacotherapy
  - Continuing opioid makes sense only if...
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Framing the discussion in terms of “the nervous system”

The MIND
Perceiving
• Psychiatrist
• Therapist
• Neuropsychologist
• PCP adapting treatment to the appropriate cultural context, doing mental health screening, etc.

The Nervous System
Modulating and transmitting
• Health psychology
• Neurology/Pain Medicine
• PCP screening for nervous system sensitization/dysregulation (signs of classical neuropathic pain or ramped up emotional processing of pain)

The BODY
Sensing
• Physical Therapy
• Orthopedics
• Neurosurgeons
• Rheumatologists
• Pain Medicine Spec.
• PCP implementing and coordinating treatment algorithms

How to get it done – the opioid taper

• In general, the longer the patient has been on opioids, the slower the taper should be 10-20% per week to per month.
• Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
• Patients taking opioids on a non-daily, as-needed basis can typically have their medication discontinued without tapering.
• Take into consideration patient-specific factors when deciding what rate. Consider risk of precipitating withdrawal, patient’s level of anxiety about discontinuing opioids, duration of opioid therapy, medical and psychological comorbidities and access to treatment, and clinical need for rapid taper.
• The goal is to minimize adverse/withdrawal effects. The rapid detoxification literature indicates that a patient needs 20 percent of the previous day’s dose to prevent withdrawal symptoms.
• Consider using adjuvant agents such as antidepressants and clonidine.1mg bid to tid to manage irritability and sleep disturbance, or antiepileptics for neuropathic pain.
• Fentanyl CAN be rotated to a different opioid, either long-acting morphine or methadone. Once the patient is converted, the same guidelines will apply. Alternately, with the availability of transdermal fentanyl 12 mcg/hr patches, some patients may be tapered down on fentanyl patches and then given a brief supply of oral short-acting opioids to complete the taper.