How Did We Get Here?

Maine Chronic Pain Collaborative
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Disclosures:

- I am employed by PCHC.
- PCHC gets reimbursed by MCPC for some of the time that I put into the MCPC (@ 2 hours/week).
- MCPC is funded by Physicians Institute for Excellence in Medicine (PIEM)
- PIEM has funding from this initiative from Pfizer Independent Grants for Learning and Change (IL&C).
How Did We Get Here?

"And with 10 being the highest, you're sure you're only at a 6?"
Poor Boundaries

Providers
Mostly well intentioned pain specialists and others wished to alleviate suffering and improve quality of life for those with chronic pain.

Industry
PhRMA wished to develop and market medications that served that interest and generated profits.
Fertile Ground

- Targeting of rural, poor states
- Targeting of unsophisticated (naive?) providers
- Knowledge vacuum
- Lack of physician and provider self efficacy
- Willing specialists leading the way
- Some corrupt physicians
Leading to the Birth of...

The American Pain Foundation:

• Heavily funded by Purdue, Cephalon and others
• No ceiling dose for opioids for chronic pain
• Shut down in May, 2012 after US Senate launched an investigation
“Pseudoaddiction”

- Coined by Dr. David Haddox and Dr. David Weissman
- Based on a single case of a 17 year old leukemia patient with pneumonia and chest wall pain being treated as an inpatient
- Embraced by APF and Federation of State Medical Boards (also receives funding from PhRMA)
“Pseudoaddiction”

“It led us down a path that caused harm. It is already something we are debunking as a concept.”

--Dr. Lynn Webster, President Elect of AAPM
And...

The American Academy of Pain Medicine & The American Pain Society

• In 1996 issued joint statement stating that chronic pain should be treated with opioids and the risk of addiction is low (<1%)

• Chair of group issuing the statement was Dr. David Haddox

• Statement was removed from AAPM website in fall of 2011

• APS now states that evidence for benefit of opioids in the treatment of chronic pain is low quality or insufficient.
And...

• In 2006 Purdue Pharma paid a $635 million fine for its deceptive marketing of Oxycontin.
• Purdue Pharma’s CEO paid $11 million personal fine.
• Purdue Pharma made over $3 billion from Oxycontin in 2010 alone.
• Dr. David Haddox is now VP of Health Policy at Purdue Pharma.
Where Are We?

"You say it's a sharp, stabbing pain. Hmmm... sharp... stabbing pain."
The Harm
The Harm

Percent Primary Admissions for Heroin/Morphine and Prescription Opioids 2000-2012 - (TDS 2012)
The Harm

Map showing kilogram of prescription painkillers per 10,000 people in different states of the USA with varying intensities of green shades.
The Harm

• Risk of addiction is 30 to 40% 
• 169 Mainers died of drug overdose in 2010. 
• 95% of those were prescription drugs. 
• 174 Mainers were admitted for prescription drug overdose in 2009. 
• 2 pharmacy robberies in 2008, 56 in 2012 
• Crime rates up 5.4% between 2010 and 2011 
• 40% of crime in Maine related to drug abuse
The Harm

• 779 babies born with NAS in Maine in 2012, over 900 in 2013
• Charges per baby over $50,000
• 15% of Maine high school students report non-medical use of prescription drugs in last year, 7% in last month.
• 265% increase in deaths from prescription opioid overdose in men since 1999, 400% in women
What is “High Dose?”

≥100 Morphine Equivalents

*Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.*
The Harm

- Opioid Induced Hyperalgesia (OIH)
  - State of nociceptive sensitization with paradoxical response
  - Increased sensitization to painful stimuli and pain from ordinary non-painful stimuli (allodynia)
  - Indication for weaning/discontinuing doses
The Harm

• We prescribe when there is no indication and when there are contraindications.
• We ignore recurring non-reassuring behaviors.
• We don’t consider the household or community environment into which we place these drugs.
• We devalue effective alternatives.
• We treat “pain” but not addiction.
• We use dangerous combinations of meds.
• We don’t like what we’re doing and we do little to change it.
How Do We Get Out of Here and Where Do We Want to Go?
Primum Non Nocere

We in primary care are uniquely positioned to make an immediate, positive and enduring impact on the quality of life and outcomes for our patients, for our providers and for our community. We have to solve this.
Where Do We Start?

• How about a definition of pain?

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. It is a subjective phenomenon.

*International Association for the Study of Pain (IASP)*
Pain Types

• Nociceptive pain is functional pain.
• Neuropathic pain is maladaptive pain.
• Chronic pain is dysfunctional pain with more widespread and ill-defined pathophysiology.
  o Associated with less insight into emotional component, worse outcomes and misapplication of acute treatments
  o People with high ACE scores have exaggerated inflammatory response to stress. High ACE is strongest predictor for chronic pain.
Where Do We Start?

• Open our minds and eyes.
• Recognize our personal and professional deficiencies and barriers.
• Improve our knowledge.
• Improve our self-efficacy.
• Develop an evidence based and reality informed approach to the management of chronic pain.
• Compassion!
Prescribers’ Barriers

- Complaints to the Licensing Board
- Withdrawal
- Uncertain of treatment alternatives (with little confidence in them)
- Lack of self efficacy
- Time constraints
- Emotional energy
- Conflict avoidance
- Empathy
# Prescriber’s Fears- Withdrawal

<table>
<thead>
<tr>
<th>Opioid Withdrawal</th>
<th>Benzodiazepine / Alcohol Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOT deadly</strong></td>
<td><strong>Potentially Deadly</strong></td>
</tr>
<tr>
<td><strong>Mainly Cholinergic Effects:</strong></td>
<td><strong>Mainly CNS Effects:</strong></td>
</tr>
<tr>
<td>• Yawning</td>
<td>• Delirium,</td>
</tr>
<tr>
<td>• Lacrimation</td>
<td>• Increased reflexes</td>
</tr>
<tr>
<td>• Rhinorrhea</td>
<td>• Disorientation,</td>
</tr>
<tr>
<td>• Pupilary dilation</td>
<td>• Psychosis</td>
</tr>
<tr>
<td>• Piloerection</td>
<td>• Anxiety</td>
</tr>
<tr>
<td>• Nausea/Vomiting</td>
<td>• Seizures</td>
</tr>
<tr>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td>• Abdominal Cramping</td>
<td></td>
</tr>
<tr>
<td>• NO Seizures</td>
<td></td>
</tr>
<tr>
<td><strong>CV:</strong></td>
<td><strong>CV:</strong></td>
</tr>
<tr>
<td>Rare tachycardia from agitation, hypovolemia</td>
<td>Hyperthermia, Hypertension, Hyperventilation, Tachycardia</td>
</tr>
<tr>
<td><strong>Myalgias /arthralgias</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dysphoria , Restlessness, Irritability, Agitation, Tremors</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Comfort Packs

<table>
<thead>
<tr>
<th>Withdrawal Symptom</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea/Vomiting</td>
<td>Antiemetics</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide or Octreotide</td>
</tr>
<tr>
<td>Cholinergic Overload</td>
<td>Clonidine</td>
</tr>
<tr>
<td>Spasms/ Twitching</td>
<td>Muscle Relaxants</td>
</tr>
<tr>
<td>Aches</td>
<td>NSAIDS</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Low-Abuse Sleeping Agents (trazodone)</td>
</tr>
</tbody>
</table>
Other Treatments

“No, this won’t help your back, but I’m getting great reception for the big game!”
“But Nothing Else Works”

- SNRI, TCA, SSRI
- RA: DMARDs
- Anticonvulsants
- NSAID
- CBT
- Physical Therapy
- OMT
- Support Groups
- Exercise
- Weight Loss
- Acupuncture
- Massage
- Chiropractic
- Tai Chi
“I’m the one with the medical degree. I’ll determine if your back is bothering you or not.”
Where Do I Start?

- Compassionate language
- Intentional management of acute prescriptions
- Strengthen knowledge of risks/benefits of all treatment options
- Don’t be fatalistic
- Know the meds you do prescribe.
- Don’t use opioids in circumstances when they shouldn’t be used.
- Gain your proper role in the management of this important problem.
- Educate patients and caregivers (and staff and colleagues and public)
- If chronic opioids are part of the treatment plan use drugs and doses that limit risks and use tools to properly assess risk, monitor use and evaluate for important adverse effects/toxicities.
- Don’t work in isolation.
Communicate Risks of Opioids

“There are very significant risks associated with opioids.”

- Accident
- Injury
- Accidental overdose
- Premature death
- Driving
- Becoming the victim of a crime
- Dependence
- Addiction
Compassion

“I’ve been thinking a lot about your care. As new information becomes available it is more and more apparent that these medications are not the right ones for your problem, and I think we need to move to a safer and more effective treatment plan. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together.”
Or...

“I’ve been thinking a lot about your care. As new information becomes available it is more and more apparent that your dose is unsafe, offers no benefit and may be making your pain worse. I think we need to reduce your dose to a safer level. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together.”
## Tapering Plan for Client with Chronic, Non-Cancer Pain

Please Fax to: Narcotic Review Program (360) 725-2122

### Client's Name: [ ]  Client ID#: [ ]

Short and long acting narcotics should be tapered separately, first taper the short acting agent, then taper the long acting.

**Tapering short acting narcotics:** As a general rule, if the % of total MED is < 10% of the initial total MED of all narcotics, taper by 10% of the initial total dose (milligrams) every 3 days. If the % of the total MED is > 10% of the initial total MED, taper by 10% of the initial total dose (milligrams) every week.

**Tapering long acting narcotics:** As a general rule, taper by 10% of the initial total dose (milligrams) until down to 50% of the initial total dose (milligrams). Then, taper by 10% of the remaining 50% of the initial dose (milligrams).


According to the Agency Medical Directors Opioid Guidelines, symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1-0.2mg orally q6hours or Catapress-TTS 1 patch/weekly. Sleep problems can be treated with zolpidem and/or low dose tricyclic agents, such as doxepin 10-50mg qhs. **DO NOT TREAT WITHDRAWAL SYMPTOMS WITH ADDITIONAL OPIOIDS OR BENZODIAZEPINES.**

### Initial Total Dose

<table>
<thead>
<tr>
<th>Opioid Type</th>
<th>Baseline Opioid</th>
<th>Current mg/Day</th>
<th>Current MED/Day</th>
<th>% of Total MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Acting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Acting</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Opioid Dose Calculator

**Instructions:** Fill in the mg per day* for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day. For more information on how to this calculator to your smartphone or tablet home screen, visit: [Android](https://play.google.com/store/apps) or [iPhone/iPad](https://appstore.apple.com).

<table>
<thead>
<tr>
<th>Opioid (oral or transdermal)</th>
<th>mg per day: *</th>
<th>Morphine equivalents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Methadone</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Morphine</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Pain Matrix

- Very sensitive to context
- Can be activated by emotional stimuli
- Activated by descriptions of other’s pain
- Activated by rejection (also increases inflammatory response)
- Can reduce pain if properly stimulated
- Improving insight on emotional component improves outcomes
Resources

• Best Advice for People Taking Opioids – Dr. Mike Evans
• AMDG Guideline on Opioid Dosing for Non-cancer Pain
• Physicians for Responsible Opioid Prescribing (SUPPORTPROP.ORG)
• MCPC
• nnesin@pchc.com
Discussion