OPIOIDS FOR PAIN
INTERNAL MEDICINE
IMMERSION BLOCK 2015

David J. Tauben, MD, FACP
Clinical Professor
Chief, Division of Pain Medicine
Medical Director UW Center for Pain Relief
Department of Medicine
Department of Anesthesia & Pain Medicine
University of Washington

OUTLINE

1. Understand chronic ≠ acute pain
2. Opioids: some clinical pharmacology
3. Opioid selection approach
4. Opioid side effects and risks
5. Equianalgesia/MEDs and “rotations”
6. Opioid hyperalgesia
7. Evidence based COT effectiveness
8. Monitoring risk and adherence
9. Guidelines & resources
1. “It is an ethical and moral obligation for a physician to prescribe opioids, at times the most effective agent to treat pain, when they are called for.”

John Loeser, MD

2. Pain is not a state of opioid deficiency

3. Chronic pain is not nociception, even if it feels that way

**THE LOESER ONION**

- **PAIN BEHAVIOR**: What we observe during exam of our patients
- **SUFFERING**: Response to diminishment of one’s capacity
- **PAIN**: “Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (IASP 1979)
- **NOCICEPTION**: Nociceptors selectively respond to noxious stimulation
MULTIDIMENSIONAL BURDEN OF CHRONIC PAIN

- Performance of ADLs
  - Sleep disturbance
  - Work, Household chores
  - Leisure activities
  - Energy

- Socioeconomic consequences
  - Health care costs
  - Disability
  - Lost productivity

- Functional Activities

- Emotional Functioning
  - Irritable
  - Angry
  - Anxious
  - Depressed

- Social Consequences
  - Marital & Family relations
  - Intimacy
  - Social isolation

- Performance of ADLs
  - Sleep disturbance
  - Work, Household chores
  - Leisure activities
  - Energy

PREDICTORS OF ABNORMAL PAIN RESPONSE

- History and examination:
  - Demonstration of "non-anatomic" territory of pain
  - Depression or other preexisting mood disorder
  - Distressed socioeconomic status
  - Overall poor life coping status and satisfaction

- Active emotional distress
  - Particularly anxiety and fear (of the consequences or significance of an injury.)

- Preexisting pain processing disorders:
  - Like fibromyalgia
  - Prior persistent pain problems

- Prior surgical complications or failure to resolve pain after previous surgery

Von Korff M, Pain. 2005
Carroll LJ, Pain 2004
Carragee EJ, Spine J 2005
HEALTH PROFESSIONALS INVOLVED IN PAIN MANAGEMENT

1. Medical specialties
2. Nursing
3. Pharmacy
4. Physical therapy
5. Occupational therapy
6. Behavioral health
7. Social work
8. Chaplain
9. Addiction

DIAGNOSIS PRECEDES TREATMENT

“In order to treat something, we must first learn to recognize it.” -William Osler

1. Chronic pain though often a complex condition, when assessed following a structured approach, supports diagnostic accuracy
2. Thorough assessment of the common biopsychosocial domains also adds important diagnoses that require treatment
**Acute Pain**: a “symptom”
- Expected to resolve
- Goal is facilitation of recovery from the underlying injury, surgery, or disease

**Chronic Pain**: a “disorder”
- Illness or injury resolved but pain persists
- Goal is *improved function*

**Palliative Care**: end-of-life goals
- Support and treatment
- Goal of care is *comfort*

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**DETERMINE TREATMENT GOALS**

**MULTIDIMENSIONAL PAIN ASSESSMENT**

- Assess Pain, Function, Mood, Sleep, Risks, and Treatment adherence at every relevant encounter

- **7 Quick Tools**:
  1. Pain Intensity NRS
  2. Functional Interference NRS
  3. PHQ-4
  4. Sleep
  5. Opioid Risk Tool
  6. MED calculator
  7. UDTs, PMP
OPIOIDS

Any drug with significant pharmacologic activity as a “Mu” (µ) agonist

“Natural opiates”
- Derivatives of natural derived opium
  - Codeine, morphine, hydrocodone, hydromorphone

“Synthetic opioids”
- Oxycodone, oxymorphone, fentanyl, methadone, buprenorphine, tramadol

OPIOIDS: CLINICAL SIMILARITIES

1. Analgesia
   1. Mu receptor(s) effect

2. Side-effects
   1. Nausea, constipation, pruritis
   2. Myoclonus, Hyperalgesia
   3. Confusion, Delirium
   4. Sedation, Hypoventilation
   5. Dependency, Addiction
OPIOID RX CHOICES

**Short-Acting**
- Codeine
- Hydrocodone
- Hydromorphone
- Oxycodone
  - Oxymorphone
- Morphine
- Fentanyl lozenge/buccal

**ER/LA**
- Extended release (“ER”)
  - Morphine
  - Oxycodone
  - Oxymorphone
  - Transdermal fentanyl
  - Transdermal buprenorphine
- Long Acting (“LA”)
  - Methadone
  - Levorphanol

“REMS”: Risk Evaluation and Mitigation Strategies
www.er-la-opioidrems.com

LONG OR SHORT ACTING OPIOID?

**Conventional wisdom:**
- Long-acting for Long-term use
  - Stable and scheduled dosing
  - Fewer pills
  - Trend toward worse outcomes: More deaths and misuse
- Short-acting taken regularly
  - Activity/function dependent dosing
  - Lower levels while asleep

**Current Approach:**
- Best patient function
- Least non-compliance
- Lowest “Morphine Equivalent Dose”
- Risk/harm reduction
**SHARED OPIOID ADVERSE EFFECTS**

**Vascular**
- Bradycardia
  - PVR

**Respiratory**
- hypoxic drive
  - CO2 threshold
  - cough reflex

**GI**
- peristalsis, relaxes
  - LES

**GU**
- Urinary retention, Hormonal Effects
  - estradiol & testosterone
  - Prolactin

**CNS**
- Sedation, delirium, tolerance, withdrawal, dependency/addiction risks

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**CALCULATE THE MED**

**Opioid Dose Calculator**

Instructions: Fill in the mg per day for whatever opioid your patient is taking. The web page will automatically calculate the total morphine equivalents per day. Learn how to add this calculator to your smart phone or desktop home screen here. Accessed on iPhone/iPad.

<table>
<thead>
<tr>
<th>Opioid (oral or transdermal)</th>
<th>mg per day</th>
<th>Morphine equivalents</th>
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<tbody>
<tr>
<td>Codeine</td>
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<tr>
<td>Fentanyl transdermal (in mg/hr)</td>
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<td>Hydromorphone</td>
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<td>0</td>
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<tr>
<td>Methadone</td>
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<tr>
<td>Morphine</td>
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<tr>
<td>Tapentadol</td>
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<td>0</td>
</tr>
<tr>
<td>Tramadol</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Methadone**
- <20 mg: 4x
- >20-40 mg: 8x
- >60-80 mg: 10x
- >80 mg: 12x

TOTAL daily morphine equivalent dose (MED) = 0

**NOTE:** All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mg per hour.

**CAUTION:** This calculator should NOT be used to determine doses when converting a patient from one opioid to another. This is especially important for fentanyl and methadone conversions. Equianalgesic dose ratios are only approximations and do not account for genetic factors, incomplete cross-tolerance, and pharmacokinetics.

AMDG on-line calculator
[www.agencymeddirectors.wa.gov](http://www.agencymeddirectors.wa.gov)
THE SO-CALLED “EQUIANALGESIC TABLE”

“Equianalgesic tables should only serve as a general guideline to estimate equivalent opioid doses.”

Recommendations derived from:
• Single dose studies
• Expert opinion
• Studies in cancer patients

Opioid rotation in chronic non-malignant pain patients
A retrospective study

A. B. Thomesen, N. Becker and J. Erik sen
Niels Højgaard Hospital, National Hospital, Copenhagen, Denmark

Background: The clinical advantage of opioid rotation is probably due to incomplete cross-tolerance favouring analgesia more and overdosing were relatively frequent in both groups. No significant dose changes were seen when rotating between different opioids. The opioid equianalgesic dose ratio may also be influenced by the actual dose level, as in the high dose range the equianalgesic dose might be several-fold different than expected.

Results: The main reason for opioid rotation was insufficient pain relief. Opioid rotations resulted in 59% in 40-70% of different LAO and 73% from SAO to LAO. During rotation the majority of the patients rotated from SAO to LAO obtained improved analgesia, but the cost was a near doubling of the opioid dose. The increased opioid dose may reflect not only the effects of changing an opioid but also an up-titration.

WHY?

1. Intractable side-effects
2. Temporal pattern of pain
3. Metabolites (accumulating M6G levels)
4. Route(s) of administration
5. Development of tolerance???

HOW?

1. Rotate ONTO 10-30% calculated dose of methadone
2. Do it low and slow, and with careful follow-up


OPIOID OVERDOSE RISK

- Non-user: 0.04%
- 1-19 mg.: 0.16%
- 20-49 mg.: 0.26%
- 50-99 mg.: 0.68% **
- 100+ mg.: 1.79% **

9-fold increase in risk relative to low-dose patients

Significant increment in risk p<0.05

Dunn et al., Annal Intern Med 2010
SLEEP DISORDERED BREATHING ON OPIOIDS


- Lack of evidence for sustained benefits
- Rebound insomnia
- Risk of over-sedation especially when combined with opioids
  - Complicating development of tolerance, dependency, and addiction.

**Use of benzodiazepines for sleep & anxiety are not recommended in chronic pain**
FRACTURE HAZARD RATIO AND MED

Saunders et al., JGIM, 2010

2-fold increase in risk relative to non-users

** p<0.05

ADVERSE SELECTION

PATIENTS ON ER OPIOIDS 35% CO-ADMINISTERED PSYCHIATRIC MEDICATIONS

Highest Risk Patients’ Receive Highest Opioid Dose

*Odds ratios adjusted for pain severity and patient characteristics

*Co-occurring psychiatric and addiction disorders

Merrill et al. 2011
Sullivan et al. 2012
Gustavsson A. et al. 2012
“ACUTE ON CHRONIC” OPIOIDS

Chronic high dose opioids (MED > 300 mg)
  • Difficult to achieve further analgesic effect with mu agonists
  • Often requires multimodal approach
    • Regional anesthesia, ketamine, gabapentinoids,
Account for tolerance
  • Higher doses for acute injury
  • Oral “basal” opioids often needed IV when NPO
Avoid dose-escalation “creep”
  • Get back to prior doses within 10 days

IDENTIFYING “MISUSE” DIAGNOSES

Misuse: Inappropriate use of prescription, whether intentional or unintentional, and regardless of motivation

Abuse: A maladaptive pattern of prescription opioid use leading to considerable impairment and/or distress

Addiction: Primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestation, characterized by one or more of the following behaviors:
  • impaired control over drug use
  • compulsive drug use
  • continued drug use despite harm
  • Craving

Incidence (Primary Care practice)
  • Up to 32% abuse
  • 3-18% chronic pain patients with SUD dx
### Assessing Opioid Misuse Risk

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<th>Mark each box that applies</th>
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<th>Male</th>
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<td>Illegal drugs</td>
<td>2</td>
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<tr>
<td></td>
<td>Prescription drugs</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal history of substance abuse</td>
<td>Alcohol</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Illegal drugs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Prescription drugs</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16-45 years)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>4. History of preadolescent sexual abuse</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>5. Psychological disease</td>
<td>Attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>1</td>
</tr>
</tbody>
</table>

Low (0-3) | Moderate (4-7) | High (≥8) | Scoring totals | | | |

**Administration**
- On initial visit
- **Prior** to LA Opioid Therapy

**Scoring**
- 0-3: low risk (6%)
- ≥8: high risk (> 90%)

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### Addiction Risk

**A SEMINAL LETTER TO THE EDITOR!!**

**Addiction Rare in Patients Treated with Narcotics**

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,546 hospitalized medical patients1 who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,1 Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

**Jane Porter**

**Hershel Jick, M.D.**

Boston Collaborative Drug Surveillance Program

Waltham, MA 02154

Boston University Medical Center


**OPIOID EFFECTIVENESS FOR CNCP**

**A GAME CHANGING PUBLICATION**

**Case series 38 patients:** “adequate” pain relief in 37%; “partial” pain relief in 32%

“Few substantial gains in employment or social function could be attributed to the institution of opioid therapy”

“It must be recognized, therefore, that the efficacy of this therapy and its successful management may relate as much to **the quality of the personal relationship between physician and patient** as to the characteristics of the patient, drug, or dosing regime. ”


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**OPIOIDS FOR CHRONIC PAIN**

**THE CLINICAL CONUNDRUM**

**REVIEW**

*Annals of Internal Medicine*

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

**Conclusion:** Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.
**COT IS ALSO A COMMITMENT FOR LIFE**

Long-Term Chronic Opioid Therapy Discontinuation Rates from the TROUP Study

Bradley C. Martin, PharmD, PhD, Ming-Yu Fan, PhD, Mark J. Edlund, MD, PhD, Andrea DeVries, PhD, Jennifer Brennan Braden, MD, MPH, and Mark D. Sullivan, MD, PhD

**CONCLUSIONS:** Over half of persons receiving 90 days of continuous opioid therapy remain on opioids years later. Factors most strongly associated with continuation were intermittent prior opioid exposure, daily opioid dose ≥120 mg MED, and possible opioid misuse. Since high dose and opioid misuse have been shown to increase the risk of adverse outcomes special caution is warranted when prescribing more than 90 days of opioid therapy in these patients.

UW Medicine
PAIN MEDICINE

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**OPIOID INDUCED HYPERALGESIA**

C. 1870

“At such times I have certainly felt it a great responsibility to say that pain, which I know is an evil, is less injurious than morphia, which may be an evil. Here experience is needed. **Does Morphia tend to encourage the very pain it pretends to relieve?**

…in the cases in question, I have much reason to suspect that a reliance upon hypodermic morphia only ended in that **curious state of perpetuated pain.”**


UW Medicine
PAIN MEDICINE
OPIOID INDUCED HYPERALGESIA

Sensitized spinal dorsal horn neurons responding to abnormal descending pain facilitatory systems enhancing nociceptive inputs at the spinal (& trigeminal) levels

✓ Abnormal pain in areas different from original pain site seen in:
  • Addicts maintained on methadone
  • Patients post-op (somatic and visceral surgeries)
  • Experimental pain paradigms
  • Movement-evoked pain
  • Chronic medication overuse headache

✓ Retrospective studies showing consistent increases in MED
✓ CNCP patients receiving transdermal fentanyl showed dose escalation from 75-250 µg/h over 18 months with no improvement in VAS

Hojsted & Sjogren 2006
Angst & Clark 2006

CORRELATION OF OPIOID SALES/DEATHS/ABUSE

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)


UW Medicine
PAIN MEDICINE
QOL REDUCED WITH HIGH DOSE COT

Quality of Life Associated with Daily Opioid Therapy in a Primary Care Chronic Pain Sample

Kathryn Sullivan Dillie, PhD, Michael F Fleming, MD, MPH, Markon P. Mundt, PhD, and Michael T. French, PhD

Background: Daily opioid therapy is widely used in the treatment of chronic noncancer pain, yet there is limited empirical evidence on the relationship of opioid dosing and health-related quality of life (HRQol) in primary care settings.

Methods: An analysis was conducted to assess the relationship of opioid dose to quality of life. The sample consisted of 801 chronic pain patients who were prescribed daily opioids and 95 non-opioid users recruited from the practices of 215 primary care physicians. Eight HRQol domain scores were calculated and compared with US norms and across opioid use groups. A new modeling technique, propensity score matching analysis, was performed to adjust for potential confounding factors across a morphine-equivalent opioid dose groups (<20 mg, 20–40 mg, 41–105 mg, >105 mg).

Results: HRQol scores were significantly lower in chronic noncancer pain patients relative to the US general population regardless of opioid use. In unadjusted comparisons, those using up to 20 mg/d of opioids had the highest HRQol scores, whereas those using >105 mg/d had the lowest. After adjusting for potential confounders, those in the 20 mg to 40 mg/dosing group had significantly better HRQol scores than their non-opioid-treated or higher dosed counterparts.


MOST COT PATIENTS IN PRIMARY CARE ARE NOW MANAGED ON LOWER DOSE REGIMENS

Courtesy M. Von Korff, Source: CONSORT Survey (N=2119)
Group Health Cooperative and Kaiser Permanente N CA
## MENU OF CHRONIC PAIN TREATMENTS
### AVERAGE EXPECTED REDUCTION IN PAIN INTENSITY

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Average Reduction</th>
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<tbody>
<tr>
<td>Opioids</td>
<td>30%</td>
</tr>
<tr>
<td>Tricyclics</td>
<td>30%</td>
</tr>
<tr>
<td>Antiepileptics</td>
<td>30%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>10%+</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10-30%</td>
</tr>
<tr>
<td>CBT/Mindfulness</td>
<td>30-50%</td>
</tr>
<tr>
<td>Physical fitness</td>
<td>60%</td>
</tr>
<tr>
<td>Sleep restoration</td>
<td>40%</td>
</tr>
<tr>
<td>Hypnosis, Manipulations, Yoga</td>
<td>“some effect”</td>
</tr>
</tbody>
</table>

Turk et al. Lancet 2011; 337(2226-35)

## OPIOIDS ARE PART OF PLAN, NOT THE PLAN

“Avoid … primary reliance on opioid prescribing, which, when applied alone or in a non-coordinated fashion, may be inadequate to effectively address persistent pain as a disease process and, when employed as the “sole” treatment, is associated with significant societal expense and treatment failure.”

Use of combinations of analgesic R\textsubscript{x} with different mechanisms of action:

- Opioids
- NSAIDs
- Local anesthetics
- Antiepileptics
- Antidepressants
- NMDA antagonists

“MULTIMODAL ANALGESIA”

Cognitive, Behavioral & Coaching Interventions:

- Decreases anxiety
- Lessens pain intensity
- Reduces opioid utilization
- Improves treatment satisfaction
- Increases treatment adherence
- Reduces cardiovascular stress
- Improves respiratory indices
- Accelerates recovery

MULTIMODAL NON-DRUG ANALGESIA

Techniques

- Empathic listening
  - Communicated expectations
- Simple relaxation techniques
  - Imagery
  - Distraction
- Motivational coaching
  - Patient participation in transitional pain plan
- Physical strategies
  - Cold/heat
  - Progressive muscle relaxation
  - Exercise/mobilization
- Patient education

Cognitive, Behavioral & Coaching Interventions:

- Decreases anxiety
- Lessens pain intensity
- Reduces opioid utilization
- Improves treatment satisfaction
- Increases treatment adherence
- Reduces cardiovascular stress
- Improves respiratory indices
- Accelerates recovery

Courtesy Deb Gordon, DNP
METHADONE ACCIDENTAL OVERDOSES

- Typically occur early after Rx initiation
- Co-occurring Respiratory disorders
  - COPD
  - Sleep apnea
  - Restrictive lung disease
- Concomitant sedatives
  - Benzodiazepines
  - Carisoprodol
  - Alcohol
- QTc prolonging agents

METHADONE

✓ For Pain Treatment
  - Effective analgesic
  - Chronic Opioid Therapy
  - Long acting
  - Inexpensive

✓ For Addiction Treatment
  - Requires special DEA licensing and treatment support
  - Once daily liquid dosing eases administration
  - Reduces mortality among heroin users

Significant accumulation with repeat dosing

- Initial T½ 13-47 hrs up to 48-72 hrs
- 100% hepatic cleared
  - CYPs: 1A2, 2D6, 3A4

Inhibits its own CYP metabolism
Earlier review of case series and reports (Cruciano RA, 2008): Methadone dose range 65-1,000 mg, most doses >250 mg (>3000 mg MED)

**2014 American Pain Society Methadone Safety Guidelines**

- Obtain ECG prior to initiation of methadone in patients with risk factors for QTc prolongation, any prior ECG demonstrating a QTc >450 ms, or a history suggestive of prior ventricular arrhythmia.
- Recommend against use of methadone in patients with a baseline QTc interval >500 ms.
- For all patients perform follow-up ECG when the methadone dose reaches 30-40 mg/d in patients started at lower doses, and again at 100 mg/d.


**2014 APS GUIDELINES: BASELINE ECGs**

Prior to initiation of methadone in patients with risk factors for QTc interval prolongation, any prior ECG demonstrating a QTc >450 ms, or a history suggestive of prior ventricular arrhythmia.

“Consider” an ECG within the past 3 months with a QTc <450 ms in patients without new risk factors for QTc interval prolongation can be used for the baseline study (strong recommendation, low-quality evidence).

ECG within the past year with a QTc <450 ms in patients without new risk factors for QTc interval prolongation can be used for the baseline study (weak recommendation, low-quality evidence).

RISKS FACTORS FOR QTc PROLONGATION

- Electrolyte abnormalities ie. hypokalemia or hypomagnesemia
- Impaired liver function
- Structural heart disease (ie. congenital heart defects, history of endocarditis or heart failure);
- Genetic predisposition ie. congenital prolonged QT syndrome or familial history of prolonged QT syndrome
- Use of drugs with QTc-prolonging properties

QTc prolonging Rx
- Ca++ blockers, propafenone, quinidine
- Tricyclics, SNRIs, and SSRIs
- Erythromycin, azithromycin, clarithromycin, quinilones, pentamidine
- Ondansetron, resperidone


SOME METHADONE DRUG DRUG INTERACTIONS

<table>
<thead>
<tr>
<th>DRUG</th>
<th>EFFECTS ON METHADONE LEVELS*</th>
<th>EFFECTS ON QTc INTERVAL</th>
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<tr>
<td>Antibiotics</td>
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<tr>
<td>Ciprofloxacin</td>
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<tr>
<td>Erythromycin</td>
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<tr>
<td>Itraconazole</td>
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<td>Carbamazepine</td>
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<td>Phenytoin</td>
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CYP 3A4 inhibitors RAISE methadone levels
CYP 3A4 Inducers LOWER methadone levels

## HIGH RISK METHADONE DDIs

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Effects on Methadone Levels</th>
<th>Effects on QTc Interval</th>
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<td>Flurazepam</td>
<td>↑</td>
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</tr>
<tr>
<td>Lorazepam</td>
<td>↑</td>
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<tr>
<td>Midazolam</td>
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<tr>
<td>Triazolam</td>
<td>↑</td>
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<tr>
<td>Zopiclone</td>
<td>↑</td>
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</tr>
</tbody>
</table>

Increased lethality when combining methadone with sedatives!!!

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## …AND A BIT ABOUT SUBOXONE®

μ receptor activity: Full, Partial, vs. Antagonist

![Graph showing μ receptor activity](image-url)
**BUPRENORPHINE**

Partial mu-agonist
- Competitively high affinity

Partial κ-antagonist

Poor PO absorption

Equianalgesia\(_{max}\) ? 60-100mg MED

DEA waiver needed for addiction Rx
- Not needed, for“off-label” for pain

Suboxone® or Subutex®

Transdermal: 5, 10, 20 µgm/week

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**...AND A WORD ON MU-SNRI AGENTS**

Tramadol
- Low affinity mu
- 2D6, 3A4
- Max dose 400 mg/24\(^0\)

Tapentadol
- MS 18x > tapentadol
- Max dose 600 mg/24\(^0\)
TREATMENT ADHERENCE MONITORING
INTERPRETATION OF URINE DRUG TESTING

Dipstick (immunoassay)
• Point of Care: 10-40\% False positive and False negative

Chromotography/Spectroscopy “confirmation testing”
• Codeine ➞ Morphine
• Codeine ➞ Hydrocodone ➞ Hydromorphone
• Morphine ➞ Hydromorphone

YOUR expert judgment needed when unexpected negatives/positives
• Document and track aberrancies
• “4 strikes and you’re out”?


ADHERANCE MONITORING

Prescription Monitoring
• State level programs capturing all scheduled medication prescribing, including cash purchased
• Goals are diversion reduction while maintaining access to pain treatment
• Operational as of January 2012
https://wapmp-provreg.hidinc.com

Emergency Department Information Exchange
• Electronic health information exchange
• Sacred Heart in WA linked providers and emergency rooms
• Able to save $70-100,000/year in reduced admissions, labs, excessive exposures to CT imaging in emergency rooms by utilizing this system

GET SIGNED UP!!
GUIDELINES
INTERAGENCY GUIDELINE ON OPIOID DOSING FOR CHRONIC NON-CANCER PAIN

www.agencymeddirectors.wa.gov/guidelines.asp

> 120mg/day MED dose threshold:

• No pain management consultation needed if the prescriber is documenting sustained improvement in both function and pain

• Specialty consultation needed if frequent adverse effects, high risk, and/or lack of response

• Includes: acute pain, surgical pain, pediatric pain, pain in older adults, misuse and addiction management, cancer survivor pain

JULY 2015
UPDATED GUIDELINES

WA STATE OPIOID RULES (AKA “2876”)
MEDICAL QUALITY ASSURANCE COMMISSION CHAPTER 246-919 WAC: 850 -863

1. Specifies education and guideline use
   ➢ Should obtain 4 hrs CME on ER/LA opioids

2. Requires access to specialty care when pain/ function not improved, or high risk

3. Requires measurement-based care:
   ➢ Pain, Function, Mood, Risk, Adherence

   ➢ Excludes: acute pain, surgical pain, palliative care, cancer pain
“BENDING THE CURVE” OF THE OPIOID CRISIS

WA State only state in US with decline in opioid related adverse events

![Prescription Opioid Involved Overdoses Washington State](chart)

Source: Jennifer Sabel PhD Epidemiologist, WA State Department of Health, April 18, 2014

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**OPIOID RULES**

**DOCUMENTATION REQUIREMENTS**

1. **Pain diagnosis and indications** for chronic opioid treatment
2. **Abuse risk assessment**
3. **Psychiatric status**
4. **Medical co-morbidities**
5. **Treatment effect** on Pain, Physical and Psychosocial function
6. **Aberrancy monitoring**: urine toxicology screens, periodic review of available Emergency Department information and Prescription Drug Monitoring programs

Source: Jennifer Sabel PhD Epidemiologist, WA State Department of Health, April 18, 2014
PATIENT EVALUATION
WAC 246-840-467

Shall obtain, evaluate and document in the health record prior to treating for CNCP

- History & Physical examination
- Current & past treatments for pain
- Effect of pain on physical & psychological function
- Risk screening for potential comorbidities, should address history of addiction, aberrant behaviors related to opioids
- Regular use of benzos, alcohol or other CNS drugs
- Receipt of opioids from more than one provider/group
- Repeated visits to ED seeking opioids
- H/o sleep apnea

Health record should include: diagnosis, tx plan, objectives, indications for pain medication, results of periodic review, instructions to the patient

OPIOID AGREEMENTS AND INFORMED CONSENT

Makes explicit all expectations
Reinforces risks of chronic opioids
Supports structured management

- No call-ins
- No lost Rx
- No on-call requests
- One prescriber
- UDTS
- Regular appointments

"When starting COT, informed consent should be obtained. A continuing discussion with the patient regarding COT should include goals, expectations, potential risks, and alternatives to COT."

- APS/AAPM Guidelines

http://www.painmed.org/clinical_info/guidelines.html
IMPROVED ACCESS TO PAIN SPECIALISTS

UW TELEPAIN

Contact Information: Cara Towle RN MSN ctowle@u.washington.edu


or search: uw telepain

Sessions every Wednesday noon-1:30
KEY LINKS

UW Pain Provider Toolkit
search: uw pain toolkit

Washington State “AMDG” Guidelines
&
Opioid Dose Calculator
search: AMDG opioid

UW TelePain
search: uw telepain, or, uw pain toolkit

SELECTED REFERENCES (1)

SELECTED REFERENCES (2)