Chronic Pain Management: Taming the Opioid Dragon

Timothy A. Munzing, MD, FAAFP

ACTIVITY DISCLAIMER

The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. Please note that medical information is constantly changing; the information contained in this activity was accurate at the time of publication. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein by such individuals, whether these claims shall be asserted by a physician or any other person. Physicians may care to check specific details such as drug doses and contraindications, etc., in standard sources prior to clinical application. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.
DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

Timothy A. Munzing, MD, FAAFP

Physician, Kaiser Permanente Orange County, Santa Ana, California

Dr. Munzing has been a family physician with Kaiser Permanente Orange County for 31 years and has directed the family medicine residency program for 28 years. He is the 2017 recipient of the Nikitas J. Zervanos Outstanding Program Director Award and the California Academy of Family Physicians (CAFP) Hero of Family Medicine Award. In addition to serving on the Accreditation Council for Graduate Medical Education (ACGME) Review Committee for Family Medicine, he is on the core planning team for the developing Kaiser Permanente School of Medicine in Pasadena, California. Dr. Munzing is a national expert on appropriate opioid prescribing who has served as an expert reviewer for the U.S. Drug Enforcement Administration (DEA) and the Medical Board of California. He has been an invited speaker on the subject of appropriate opioid prescribing for the DEA and other state and federal law enforcement, as well as for prosecutors and physicians.
Learning Objectives

1. Assess patients with chronic pain to determine the mechanisms of pain.

2. Utilize appropriate/evidence-based clinical/specialty/regulatory guidelines and tools including State-based controlled medication utilization databases or prescription monitoring programs (PMP’s)

3. Develop collaborative treatment plans emphasizing physical and psychological modalities, prescription of non-opioid analgesics, treatment of comorbid mood disorders, and restoration of sleep utilizing patient-based and physician-based data collection and documentation tools/instruments

4. Establish plans to coordinate referral to a multidisciplinary team or pain specialist where first-line therapies are ineffective, complex patient management, and there is poor patient adherence to treatment plans.

Audience Engagement System

Step 1
Step 2
Step 3
Goals: Participants will be able to:

- Discuss and Apply Standards of Care for Controlled Substance Prescribing
- Identify and Analyze “Red Flags” for Potential Controlled Substance Abuse / Diversion
- Implement multimodal chronic pain management

Munzing Background

- Family Physician – 34 years – KP
- Family Medicine Residency Director – 31 years
- Medical Expert – opioid prescribing
  - >200 case reviews
  - >130 overdose deaths reviewed
  - >25 criminal convictions
Undercover states this is his “Back MRI”
What Do You See???

Conviction – 17 counts – 3 years in prison – September 2016

Stranger than Fiction: High Profile and Salacious Case

- Dr. Kim Case – ABC News Clip
- 17 Felony Convictions
- Sentence – 3 years
Dangerous / Common Combinations
Don’t Get on the Radar
• “Holy Trinity” –
  • Oxycodone, Benzodiazepine, Carisoprodol (or Stimulant)
• “Purple Drank, Sizzurp, Lean” –
  • Promethazine with codeine cough syrup, Jolly Ranchers candy or similar, fruit flavored cola – made popular by hip hop culture

Avoiding Falling off the Cliff:
Potential Consequences
• Patients
  • Addiction
  • Overdose
  • Death
• Physicians
  – Loss of Medical License
  – Prison
Outdated Information - WRONG

“The risk of addiction is much less than 1%”


Pain = 5th Vital Sign
1990’s Physicians encouraged to increase medications to eliminate pain (Assumed no harm)


Overdose Deaths

CDC Data: National Vital Statistics Reports

![Graph showing opioid overdose deaths from 2009 to 2017](image)

CDC Data: National Vital Statistics Reports

Overuse of Prescription Medications: Scope of the Problem

Nearly 2 million Americans, aged 12 or older, either abused or were dependent on opioids

### Rx Medication Prices and Street Value

<table>
<thead>
<tr>
<th>DRUG</th>
<th>RETAIL PRICE</th>
<th>STREET VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schedule II</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone SR 40 mg (Brand)</td>
<td>$5.66 / tablet</td>
<td>$20 - $40 / tablet</td>
</tr>
<tr>
<td>Oxycodone 40 mg</td>
<td>$4.54 / tablet</td>
<td>$6 - $8 / tablet</td>
</tr>
<tr>
<td>Morphine 100 mg</td>
<td>$4.16 / tablet</td>
<td>$6 / tablet</td>
</tr>
<tr>
<td>Fentanyl Loz 400 mg</td>
<td>$26 / lozenge</td>
<td>$30 - $40 / lozenge</td>
</tr>
<tr>
<td>Fentanyl 50 mg</td>
<td>$24 / patch</td>
<td>$25 - $40 / patch</td>
</tr>
<tr>
<td>Methadone</td>
<td>$0.19 - $0.23 / tablet</td>
<td>$10 - $20 / tablet</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>$1.11 / tablet</td>
<td>$8 - $15 / tablet</td>
</tr>
<tr>
<td>Dextroamphetamine and Amphetamine</td>
<td>$4.23 / tablet</td>
<td>$5 - $7 / tablet</td>
</tr>
<tr>
<td><strong>Schedule III</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocodone/APAP (Brand)</td>
<td>$1.47 / tablet</td>
<td>$6 - $10 / tablet</td>
</tr>
<tr>
<td>Hydrocodone/APAP</td>
<td>$0.43 / tablet</td>
<td>$6 - $10 / tablet</td>
</tr>
<tr>
<td><strong>Schedule IV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td>$3.30 / tablet</td>
<td>$4 / tablet</td>
</tr>
<tr>
<td>Phentermine</td>
<td>$2.13 / tablet</td>
<td>$3 - $6 / tablet</td>
</tr>
<tr>
<td>Alprazolam 2 mg (Brand)</td>
<td>$3.28 / tablet</td>
<td>$4 / tablet</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>$0.42 / tablet</td>
<td>$4 / tablet</td>
</tr>
<tr>
<td><strong>Schedule V</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promethazine with Codeine</td>
<td>$3.35 / fluid ounce</td>
<td>$7.50 - $10 / fluid ounce</td>
</tr>
</tbody>
</table>

### Poll Question #1:
Which of the following predict misuse of prescription opioids?

- A. Race
- B. Disability
- C. Literacy
- D. Socioeconomic status
- E. All of the Above
- F. None of the Above
Cultural Competence

Do Not Predict
- Gender
- Race
- Literacy
- Disability
- Socioeconomic status

Predict
- Hx EtOH/drug abuse*
- Hx EtOH/drug-related criminal conviction
- FHx EtOH/drug abuse
- Psychiatric disorder
- Includes nicotine


Challenges for Physicians, Law Enforcement and Prosecutors
General Principles

- Act like a doctor
- 90-day cliff (or much shorter - 3-5 days???)
- Non-pharmacologic alternatives and adjunct treatments
- Start low and go slow – very limited prescription numbers
- Trust but verify
- Documentation – be thorough!

Pain Management Basics

- Multiple strategies
  - Non-pharmacologic
  - Pharmacologic
  - Procedures
  - Opioids
  - Devices
Poll Question #2 – Opioid Prescribing

A patient receives and takes an opioid prescription for an injury. Of patients taking the medication for 8 days, what percent will be on the medication one year later?

• A) 1.5%  B) 6.5%
• C) 13.5%  D) 20.5%

Likelihood of Chronic Opioid Use

• Increased - 3rd day of Rx and each additional day after the 3rd day
• Sharpest increase – after 5th and 31st day
• 2nd refill
• 700 morphine mg equiv. cumulative dose
• Initial 10-day or 30-day supply
• Opioid Use 1 year later
  • 1 day – 6%
  • 8 days – 13.5%
  • 31 days – 29.9%

CDC MMWR – March 17, 2017 / 66(10); 265-269
Poll Question #3

The 2016 CDC Guidelines are now the Standard of Care for prescribing opioid medications
A. Yes
B. No
C. Unsure

Poll Question #4

The 2016 CDC Guidelines recommend taking added precautions when prescribing opioids strengths with Morphine Milligram Equivalents (mg/day) over:
A. 20
B. 50
C. 75
D. 90
2016 CDC Guidelines for Controlled Substances

- Avoid benzodiazepines with opioids [increases risk of overdose death ten-fold versus only opioid use]
- Periodic benefit / risk evaluation, including PDMP and Urine Drug Screen
- Non-pharmacologic and non-opioid tx – first line
- Chronic pain – avoid opioids – risk outweighs benefits for most
- Discuss risk / benefits with patients and document

CDC Prescribing Guidelines (2016)- Published JAMA – March 15, 2016

2016 CDC Guidelines for Controlled Substances Con’t

- Establish realistic goals – prior to opioid starts
- Start immediate release – avoid Methadone as first line – higher risk
- Additional precautions if dose exceeds 50 MME mg /day
- “Generally avoid” increasing the dosage >= 90 MME mg/day

CDC Prescribing Guidelines (2016)- Published JAMA – March 15, 2016
2016 CDC Guidelines for Controlled Substances Con’t

- Should only give 3 days max for acute pain for most non-traumatic, non-surgical pain
- Avoid combinations – short and long acting opioids
- Concerns – may limit opioids for some for whom they may benefit

CDC Prescribing Guidelines (2016)- Published JAMA – March 15, 2016
Safe Prescribing Strategies

- Hardwire office safe prescribing
- Team commitments – patient well-being
- Pain agreements
- Multiple modalities
- Monitoring
- Referrals
- Tapering strategies
Poll Question # 5 – Red Flags

Which red flags confirm opioid abuse / diversion?

A. Early Refill
B. Escalating Dosing
C. Multiple pharmacies used
D. Driving a long distance for the appointment
E. All of the above
F. None of the Above

Identify Potential Red Flags

- Early Refills
- MED > 100 mg / day
- Multiple concurrent prescribers
- Multiple pharmacies
- Combinations (i.e. Opioid, Benzodiazepine, Soma)
- Escalating dosing by provider
- Escalating prescriptions by patient
Additional Potential Red Flags

- Inconsistent UDT results
- Younger age - <45 years old
- Patients driving a long distance for care
- Multiple family members – identical or similar meds
- Drug overdoses
- Buy/ give / sell meds
- Use of THC – even with Marijuana Card

High Dose Opioids

- Dosing > 100 mg Morphine Equivalent Dosing per day
  - Overdose increases 8 fold
  - Annual overdose risk ~ 2% per year
- Specific informed consent
- Close monitoring – UDS, PDMP
- Subspecialty consultation
- Weigh potential benefit / risk ratio

Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study”; Annals of Internal Medicine, Kate Dunn, PhD, et al; January 19, 2010 [MED dosing information / risks]
Morphine Milligram Equivalent (MME) / Morphine Equivalent Dosing (MED)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand</th>
<th>Relative Strength</th>
<th>100 mg/d MED Equiv</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Methadose</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Norco, Vicodin</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>OxyCodone Roxycode</td>
<td>1.5</td>
<td>66</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>Opana</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Dilauid</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td>4 to 12</td>
<td>10</td>
</tr>
<tr>
<td>Fentanyl (transdermal)</td>
<td>Duragesic</td>
<td>100</td>
<td>42</td>
</tr>
</tbody>
</table>

Adapted from Opioid Calculator - Available at http://agencymeddirectors.wa.gov/mobile.html

Poll Question # 6
Physician Drug Monitoring Program (PDMP)

PDMP review is required in my state?
- A) Yes
- B) No
- C) Sometimes
- D) Unsure
Poll Question #7
MED Calculation Challenge

Calculate the MME / MED (mg/day)
- Oxycodone 30 mg – 4 times/day
- Hydrocodone-Acet 10/325 mg – 4 times/day

• A) 180 mg/day  B) 220 mg/day
• C) 240 mg/day  D) 260 mg/day

Physician Drug Monitoring Program (PDMP)

• Information includes:
  • Date
  • Physician prescriber
  • Drug, strength, dosage, quantity, refills
  • Pharmacy
  • Patient address
  • Payer type
How to Say “NO”

- Doctor – Patient therapeutic relationship
- Risks – Benefits
- Alternatives
- It’s worth the time and effort

Opioids Are Ineffective For ...

- Fibromyalgia
- Headaches
- TMJ
- Many chronic pain syndromes
Special Circumstances & Topics

• Naloxone – High risk patients
• Patients with substance use disorder
• Response to potential aberrant behavior
• Renal, liver, lung co-morbidities
• Dangerous drug combinations
• Tapering strategies

Benzodiazepine and Opiate Tapers

• Taper at the appropriate speed
• Negotiate with patient: what rate are they willing and able to tolerate; 5%-10% per week can be preferable
• Successful tapers are similar to healthy weight loss strategies; any abrupt physiologic change forced too quickly on the body will likely result in failure due to body’s ability and evolutionary drive to sustain homeostasis
• Real, sustained change takes ongoing effort and gradual reductions over time
Practice Recommendations

- Thorough evaluation prior to prescribing – Document well
- Individualize treatment – Function > Pain Improvement – Multi-modal tx
- Avoid opioid and benzodiazepine combination
- Document MME, UDS, PDMP

[*** All Above Expert Consensus ***]

Improving Patient Safety and Outcomes
References

• Centers for Disease Control and Prevention (CDC) – Guideline for Prescribing Opioids for Chronic Pain, 2016 - https://www.cdc.gov/drugoverdose/prescribing/guideline.html
• Opioid Prescribing for Chronic Pain; AAFP Clinical Practice Guidelines, April 2016
• Medical Board of California Guidelines for Prescribing Controlled Substances for Pain: 2007, and 2014
• Washington State Agency Medical Directors’ Group – in conjunction with the Interagency Guideline on Opioid Dosing for Non-cancer Pain

References

• World Health Organization – Guidelines for Pain Management
• American Pain Society – Guidelines for Pain Management
• American Academy of Pain Medicine Pain Management Guidelines
• Drug Enforcement Administration
• Centers for Disease Control - Overdose and Overdose death statistics
• “Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study”; Annals of Internal Medicine, Kate Dunn, PhD, et al; January 19, 2010 [MED dosing information / risks]
Opioid Prescribing Review

• “Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain”, The Permanente Journal
  • Author – Timothy Munzing, MD
  • https://doi.org/10.7812/TPP/16-169

Tim Munzing, M.D.

• Tim.a.munzing@kp.org
• Kaiser Permanente
  1900 E. 4th Street
  Santa Ana, CA. 92705
• Medical Expert Reviewer
  • Medical Board of California
  • DEA, FBI
  • Multiple other law enforcement agencies
Associated Sessions

- (PBL) Chronic Pain Management: Taming the Opioid Dragon

Questions