Chronic Pain and Opioid Substance Use Disorder:

An Overview

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Nothing to Disclose

Objectives

1. Describe the current state of pain in the US today with regard to approximate numbers of citizens affected and the cost of pain treatment yearly in the US.

2. Describe the differences between the traditional approach to chronic pain and the concept of the interdisciplinary pain team.

3. Describe significant challenges that primary care clinicians face when dealing with patients with chronic pain and co-occurring opioid substance use disorders.

Chronic Pain in the United States

- One of the major reasons adults seek medical – both urgently and in follow up
- Over 75% of ED visits – pain related (acute and chronic)
- Headache, Back Pain and Joint-related symptoms – major cause of absenteeism within American Labor Force
- Back Pain – leading cause of disability in US

Langworthy, 1993; Steward, et al, 2003

3 National Mandates for Pain Improvement in the United States

1. American Academy of Pain Medicine Position Paper- 2009
2. Department of Defense Pain Task Force, Office of Surgeon General - 2010
3. Institute of Medicine Report, “ Relieving Pain in America” - 2011

Department of Defense
Pain Management Task Force
Office of the Surgeon General – 2010 Report

- Department of Defense Pain Management Task Force Office of the Surgeon General – 2010 Report

PMTF Report finalized May 2010

- 109 Recommendations
- Available on Army Medicine website:

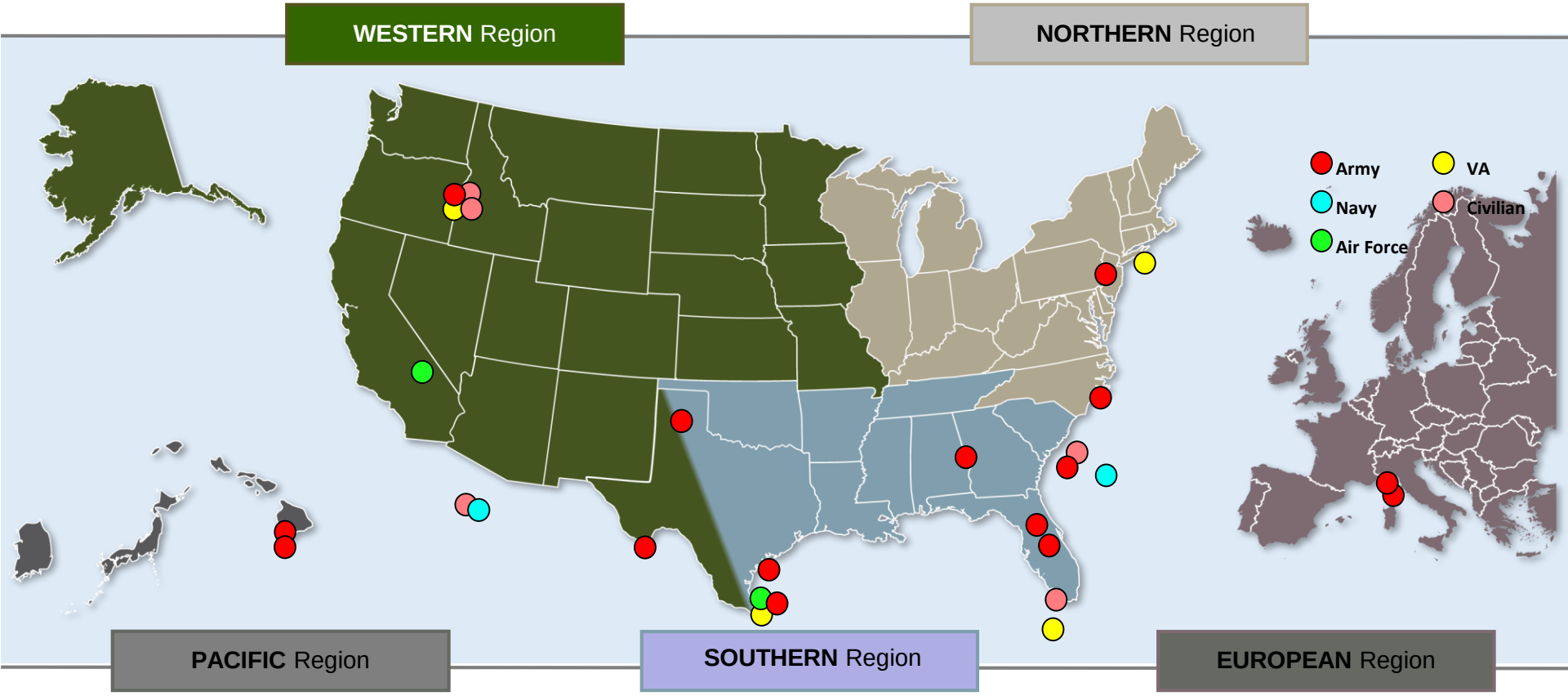
http://www.armymedicine.army.mil/

Incorporated strategies for many "pain" related issues

- Polypharmacy
- Soldier Suicides
- Medication Diversion / Abuse
- Substance Abuse

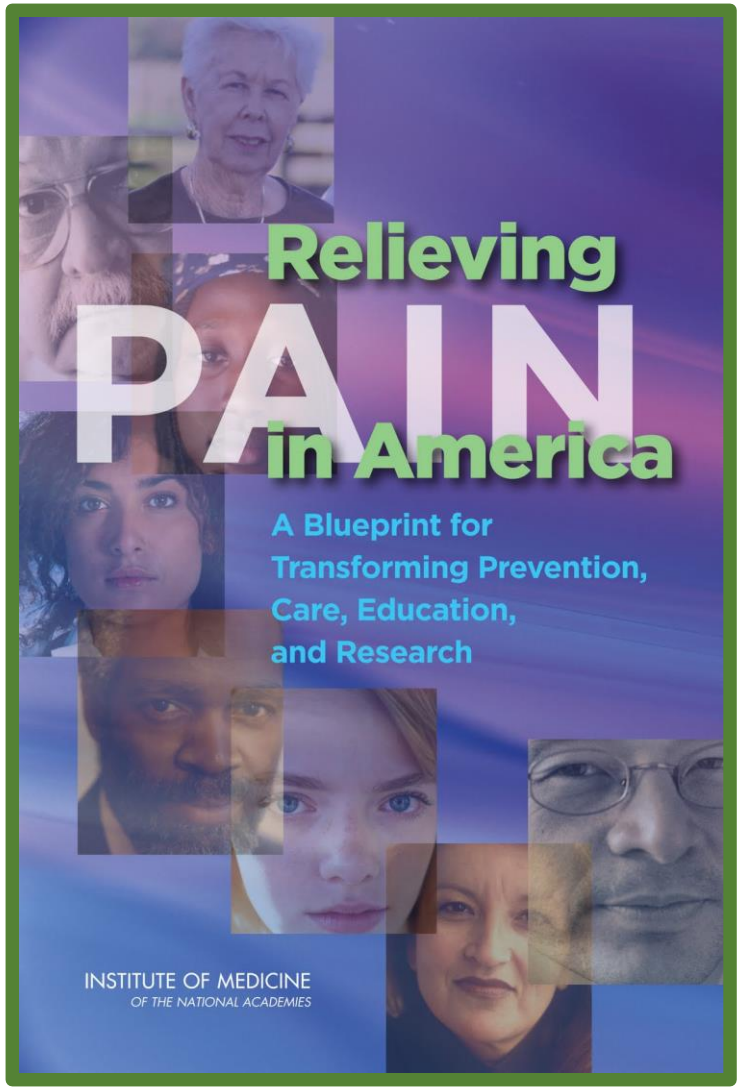
Highlighted requirements for integration/collaboration with other Army and DoD initiatives

PMTF Site Visit Map



1	Fort Lewis (MAMC) & Puget Sound VA & Univ of Washington & Swedish Hospital
2	Fort Drum (GAHC)
3	San Antonio VA,& Wilford Hall & Fort Sam Houston (BAMC)
4	Fort Carson (EACH)
5	Fort Bliss (WBAMC) & Fort Hood (CRDAMC)
6	Tampa VA & Univ of Florida
7	Balboa Naval Hospital) & Travis AFB & Scripps Center
8	Landstuhl (LRMC) & Baumholder AHC
9	Duke Univ & Camp Lejeune & Fort Bragg (WAMC)
10	Fort Campbell (BACH)
11	Honolulu (TAMC) & Schofield Barracks
12	Fort Gordon (DDEAMC) & Fort Stewart (WACH)
13	White River Junction VA
14	Walter Reed (WRAMC)

Institute of Medicine - 2011 Report "Relieving Pain in America: A Blueprint for Prevention, Care, Education and Research"



- Estimates that 100 million Americans are affected by chronic pain.
- The societal burden is estimated at 635 Billion dollars in treatment costs and lost productivity.
- Headache (all types), chronic back pain and other musculoskeletal pain are the main contributors to this burden.

Institute of Medicine: Relieving Pain in America, 2011

Institute of Medicine, “Relieving Pain in America” – 2011 Report

- Fostering a cultural transformation
- Pain is a public health challenge
- Educational challenges
- Research challenges
- Blueprint for action

Under treatment of Chronic Pain

- Public Health Crisis
- Fear of Opiate Prescribing, Diversion, Validity of Pain can lead to pseudoaddicition
- Legal Implications: NM Medical Board and NM Senate Memorial Bill
- Social Implications
- Psychiatric Implications

Why Chronic Pain ECHO in New Mexico?

- Limited Access to Chronic Pain Specialists
- Rural State, # 1 prescription opioid overdoses
- No interdisciplinary pain teams available
- Desire to shape demand, provide best practices
- Educated Primary Care providers

Interdisciplinary Team

- Best Practices for **Effective**, **Long-Term** Management of Patients with **Moderate** to **Severe** Chronic Pain
- Neurology, Psychiatry, Physical Medicine, Interventional Pain, Psychology, Rehabilitation Services, Pharmacy

Flor, Fydrich, and Turk, Pain, 1992
Chelminski, Ives, et al, BMC Health Services Research, 2005

Educational Challenges in Chronic Pain

- No **single** medicine specialty "owns" chronic pain
  - Headaches: Primary Care, Neurology
  - Back Pain: Primary Care, Physical Medicine, Orthopaedics, Neurosurgery, Interventional Pain
  - Fibromyalgia: Primary Care, Rheumatology, Neurology

- **No residency training dedicated** to chronic pain (yet)---ABPM (requires primary residency)

- **Variable** residency requirements for chronic pain **education**

Education Required for Effective Chronic Pain Treatment

- Documentation
- Address Biases of Providers related to "drug-seeking" and "real pain"
- Enhance comfort with use of opioids
- Decrease opioid phobia and pseudoaddiction
- Educate regarding over-prescribing and medication overuse

Bennet, and Carr, J. Palliative Care, 2002, 16:105-109

Psychiatric and Behavioral Overlap with Chronic Pain

- Greatest Challenge with Chronic Pain Treatment—strong psycho-social connection
- 5th Vital Sign/ TJC Mandate—"difficult to quantify/ even more challenging to treat"
- Blessing= More experts can help patient: (Psychiatry, Psychology, CBT, Biofeedback, MBSR)
- Curse= Anxiety and Depression negatively impact Chronic Pain Management

Diagnostic and Treatment Challenges of Major Depressive Disorder with Chronic Pain

- Patients with Major Depressive Disorder (MDD) 4 times more likely to complain of Chronic Pain
- 2-fold Increase in Work Missed in Patients with co-morbid MDD and Painful Somatic Symptoms
- Pain predicts time to remission in recurrent depression
- Painful somatic symptoms decreases chance of recovery in MDD

Bair, Arch Int. Med, 2003, 163, 20, 2433
Greelins, et al, Soc Psych Psychiatric Epid., 2002

Anxiety and Migraines

" Disproportionate number of migrainers suffer from one or more co-morbid anxiety disorders, which are associated with migraine **intractability and progression**".

Smitherman TA, et al, Current Pain Headache Rep, 2008

PTSD and Migraine

- Prospective Study----60 Adult Patients
  - 60 Adult patients
  - 53% Episodic Migraine (EM)
  - 47% Chronic Migraine (CM)
- Results:
  - Relative Frequency of PTSD reported on PTSD check-list:
    - Chronic Migraine-43%
    - Episodic Migraine- 9%
    - P=.0059
- Adjusted for Depression

Peterlin, et al, Headache, 2008

Anxiety and Behavioral Dependence on Headache Medication

- Cross-sectional
- 247 patients with MOH
- Majority (> 83%) had previous diagnosis of Episodic Migraine
- Opioids- 43%, Triptans- 46%, OTC- 28%
- Sedatives and Anxiolytics- Less Common

Rad, et al, Headache 2008

Management of Fibromyalgia and Comorbid Psychiatric Disorders

- Lifetime Prevalence of:
- MDD with FM=62% vs. with RA=28%
- All Anxiety D/O with FM=60% vs. with RA=25%
- PTSD with FM=23% vs. with RA=5%
- Social Phobia with FM=21% vs. with RA=5%

Arnold, et al. J.Clin Psychiatry 2006: 67: 1219-1225

Addiction

- **Fishbain Review - Risk of Opioid Addiction with Chronic Opioid Therapy?**

- Addiction Rates
- **3.27%** - rate of opioid abuse/addiction developed among 2,507 chronic pain patients

- **0.19%** - rate of abuse/addiction among pre-selected patients with no history of abuse/addiction

- <2% with opioid risk screening tools and careful psychosocial history

- Iatrogenic Opiate Addiction - Poorly Defined

- Addiction Rates - Quite low with monitored program

- Multidisciplinary team

  -careful patient selection

  -opiate contract

  -regular office visits

  -document improvement in function

  -use of adjunctive meds

Fishbain et al. Pain Medicine 2008

Rate of Opioid Misuse in the United States

- For Americans 12 years and Greater:

4.2% US Average

4.9% Hispanic Population

6.9% American Indian Population

Medication Assisted Treatment(Buprenorphrine, Methadone, Vivitrol) and Harm Reduction Measures, such as Naloxone, now FDA-approved can save lives for thousands of patients suffering with opioid substance use disorder.

Opioid Prescribing After Nonfatal Overdose and Association With Repeated Overdose: A Cohort Study

Marc R. Larochelle, MD, MPH; Jane M. Liebschutz, MD, MPH; Fang Zhang, PhD; Dennis Ross-Degnan, ScD; and J. Frank Wharam, MB, BCh, BAO, MPH

- 2848 patients aged 18-64 who had a non-fatal overdose during long term therapy for chronic non-cancer pain
- In the 2 months before the index overdose, the mean daily dose for the cohort group ranged between 152-164 MED, and rapidly increased to 187 MED the day before the overdose.
- 56% were dispensed a benzodiazepine in the 2 months prior to the index overdose
- 91% of those with a non-lethal opioid overdose were continued on opioid medications.
- 71% continued to receive the medication from the same doctor.

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