WI Opioid Project ECHO 2018-2020

Pain Management in the Setting of MAT
Friday November 16, 2018
Ritu Bhatnagar, MD, MPH

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Physicians, Physician Assistants, Nurses, Social Workers, Pharmacists and Counselors.

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:

1. Review appropriate opioid prescribing and monitoring practices
2. Participate in office-based management of opioid use disorders
3. Seek overdose prevention education with greater frequency.
4. Identify the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD

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Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
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Wisconsin Opioid Project ECHO
Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

Joining by phone ONLY: +1 646 558 8656 or +1 669 900 6833 (US Toll)
Zoom Meeting ID: 156 261 634

For attendance purposes please text the following code: FUBNAR to 608-260-7097

Session Date: Friday November 16, 2018

Didactic Topic and Presenter: Pain Management in the Setting of MAT by Ritu Bhatnagar, MD, MPH

- 12:30 PM: Attendance text-in – Introductions
- 12:45 PM: Case #1 & discussion
  - Presenter: Elise Wessol, DO
- 1:00 PM: Case #2 & discussion
  - Presenter: Randy Brown, MD
- 1:15 PM Didactic Presentation
- 1:30 PM: End of Session

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

Date: 11/16/2018

Presenter: Elise Wessol

ECHO ID: 3912

Have you presented this patient during this teleECHO clinic before? ☑ Yes ☐ No

PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE:

The difficult patient

Demographic Information:

Age: 32

Housing: Lives with SO and 2 children with special needs

Gender: ☑ Male ☐ Female ☐ Transgender

Education/Literacy: unknown

Income source: inconsistent-various jobs in carpentry, painting, mechanic, mover

Insurance: MA

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Social History:	Patient began using heroin in 2013. First via insufflation then progressed to injecting. He presented to HPC in 8/2017 for MAT with buprenorphine. Financial strains, unstable relationship with SO, 2 young children with special needs
	Poor coping strategies, had self-increased Suboxone to cope with anxiety, anger
	near daily marijuana use. Cocaine metabolite consistently on urine drug testing. Smokes cigarettes 1-2 ppd
	SO with OUD in recovery who is on drug court.
	Patient had previously received MMT and Suboxone from NewStart. Reported child care issues as a barrier to continue daily MMT and missed too many appointments at NewStart.

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
contemplative to active stage of change Supportive family Children and SO	Poor coping Limited involvement in counseling, addiction treatment Financial strains

<u>Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc):</u>

n/a

<u>Substance Use History:</u>

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Nicotine 1-2ppd
Heroin injected
Cocaine

Behavioral Health Interventions that have been tried:

AA/NA, counseling (limited through BHC)

Medications Tried for Relapse Prevention? (Specify):

MMT, Suboxone, Vivitrol

Labs (as indicated): Include summary of urine testing or last urine drug screen

	Ref Range & Units	1mo ago (10/11/18)	1mo ago (9/25/18)	1mo ago (9/17/18)	3mo ago (8/14/18)	3mo ago (7/31/18)	4mo ago (7/17/18)
DRUGS OF ABUSE CLASS URINE (UWHC)	Below Detection	Below Detection	Below Detection	Below Detection	Detected !	Detected !	Detected !
BENZODIAZEPINE CLASS, URINE (UWHC)		Below Detection	Below Detection	Below Detection	Below Detection	Below Detection	Below Detection
OPIOIDS CLASS URINE (UWHC)		Detected	Below Detection	Below Detection	Detected	Detected	Detected
BUPRENORPHINE, URINE (UWHC)	ng/mL	High; >1000 ng/mL			Low; 10-300 ng/mL	Low; 10-300 ng/mL	Low; 10-300 ng/mL
NALOXONE URINE (UWHC)	ng/mL	High; >1000 ng/mL					

Consequences of Substance Use:

Social/occupational/educational: possession charges, discharge from HPC due to diversion

Physical (including evidence of tolerance/withdrawal): w/d

Current Medications: sertraline 100mg	**Medical/Behavioral Health Diagnosis:** anxiety

Prescription Monitoring Program Pertinent Findings:

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n/a

Proposed Diagnoses:

severe opioid use disorder

severe cocaine use disorder

anxiety

Patient Goals for Treatment:

abstinence from illicit substances

Proposed Treatment Plan:

MAT with MMT or buprenorphine at PAS or Madison East (daily visits), mental health counseling, residential addiction treatment likely not feasible, IOP?

By initialing here ___ew____ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by *maladaptive use* resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. **Taking the substance in larger amounts and for longer than intended**
2. **Wanting to cut down or quit but not being able to do it**
3. **Spending a lot of time obtaining the substance**
4. **Craving or a strong desire to use**
5. **Repeatedly unable to carry out major obligations at work, school, or home due to use**
6. **Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use**
7. **Stopping or reducing important social, occupational, or recreational activities due to opioid use**
8. **Recurrent use in physically hazardous situations**
9. **Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using**
10. ***Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)**
11. ***Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)**

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Opioid & Addiction Treatment ECHO Patient Case Presentation

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1-Date: 11/16/18

2-Presenter: Randall Brown

3-ECHO ID: 7840

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Opioid taper in setting of recent surgery + alcohol use disorder and history of high-dose opioids (use disorder?)

Demographic Information:

6-Age: 49

7-Gender: Male

8-Education/Literacy: HS

9-Income source: SSDI, VA

10-Insurance: VA

11- HPI:

- S/P liver transplant 3 wk prior to visit. Dc'd to physical rehab from hospital w/ regimen of oxy 5mg PRN and was using 15-20mg daily. Did not feel pain was adequately controlled and dosing was increased to 15mg q4 prn. Feels that provided best relief. Did not experience withdrawal Sx as peri-operative analgesics were reduced.
- Addiction medicine was consulted re: tapering plan w/ anticipated discharge to home in 2-3 days. Complicating factor is lack of current relationship with a PCP in area of residence (Appleton/Green Bay area).
- Pain medicine also consulted and recommended following pieces to multi-modal plan: transdermal lidocaine, abdominal binder, TENS unit trial
- Describes pain as "gnawing" and located in upper abdomen, deeply (less so superficially). Rates typical pain as 7/10, but intermittent increase to 9. When severe, has associated nausea, but generally no. Exacerbated primarily by movement. Denies relationship to oral intake. Denies abd cramping/diarrhea. In past has had h/o alc use d/o. Abstinent for 16 years, but use escalated subsequent to divorce and reduced contact with his son. Up to 1/3 of 1.75 L daily.
- ~10 yr ago began receiving opioid Rx for back pain pt attributes to injury sustained during service. He describes what he perceives as inappropriate prescribing by that MD with escalation of oxycodone Rx to 160mg TID. Had also been on trials of Opana, fentanyl.
- He switched MDs and was tapered off of opioid using methadone. He continued to experince w/d and craving, so sought out Suboxone, which he took for 5-8 yr prior to tapering off about 2-3 yr ago. Denies any opioid use during that time.
- Denies misuse or opioid-related consequences during Rx period (other than tolerance/withdrawal), but realizes that dosing was extreme

12-Social History:

- Mom and dad are his biggest supports; mom lives in Green Bay. Currently lives with father in Waupaca. One adult son that lives in Green Bay, has not seen in 2 years.
- Served in the Army-non-combat.

14- Substance Use History:

- As above. No other SU.

15- Consequences of Substance Use:

- Social/occupational/educational:
  Denies opioid related complications in last yr.
  Isolation, fairly sedentary
- Physical (including evidence of tolerance/withdrawal):
  Liver disease (alcohol)
  H/O opioid withdrawal. Currently denies Sx.

16- Behavioral Health Interventions that have been tried:

- Past residential treatment for AUD w/ 16 years abstinence thereafter.

17-Medications Tried for Relapse Prevention? (Specify):

- None for alcohol
- Suboxone in past for OUD

18-

Current Medications:	Medical/Behavioral Health Diagnosis:
Lidocaine transdermal Oxycodone 15mg Q 4 PRN Fluoxetine 40mg QD Multiple past psychopharm trials SSRI, SNRI, atypical anti-psychotics, buprenorphine, benzodiazepines Meds for GER, htn	PTSD Depressive disorder

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19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Supportive family Motivation VA community	No ACE identified Marginal social support Unemployed/financial Co-morbid MH (PTSD, MDD) *h/o opioid w/d and related anxiety

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):

- Veteran

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

- Normocytic anemia
- AST/ALT 72mg/dL (10-37)/304mg/dL (10-65); albumin 3.1; nl bilirubin and INR
- No recent BAC/UDS

22-Prescription Monitoring Program Pertinent Findings:

- Clonazepam 1mg TID last Rx 3 mo prior
- No recent opioids

23-Proposed Diagnoses:

- Post-operative pain—incisional + functional +/- neuropathic
- H/O AUD
- Physical opioid dependence (?)

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Pain Management with Buprenorphine: Updates

r. Ritu Bhatnagar, M.D., M.P.H.
Medical Co-Director, Addiction Psychiatrist
UnityPoint Health- Meriter/ NewStart
November 16, 2018

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- No financial disclosures for Dr. Bhatnagar
- Some off-label uses of medications may be discussed in this presentation

Overview

- Review of pain management options, historical
- Pain management with buprenorphine:
  - Planned
  - Unplanned, emergent

- Long recognized as an important concern because of properties of buprenorphine:
  - 30x as potent as morphine, effective analgesia at low doses
  - Pharmacokinetics
  - High affinity for mu receptor, slow dissociation
  - Long half-life: 24 to 60 h, varies from patient to patient
  - Norbuprenorphine also has long half-life (57 h)
  - At 16 mg dose, 79-95% opioid receptor occupancy

- Can make pain management challenging

Tip 40 (little clinical experience documented at the time of printing):

1. Use non-opioid medications
2. Don't give bupe and opioids at the same time
3. Pain mgmt. challenging until bupe leaves the body

http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf

Tip 54, on Chronic Pain

- Buprenorphine is not great for acute pain
- Give buprenorphine 3x/day when pain reduction is goal
- PCAs with agonists ok for acute pain, with high bolus doses and short lockout intervals- monitor closely for side effects

http://atforum.com/documents/TIP54QuickGuide.pdf

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- Case: a person stable on buprenorphine is going to have surgery.
- Surgeon calls to discuss pain management peri-operatively.
- What do you suggest the person does?
  - stop buprenorphine
  - continue buprenorphine, increase dose
  - stop buprenorphine and add opioids
  - continue buprenorphine and add opioids
  - it depends on the type of surgery

Elective Surgery

Preoperatively: Surgical team should assess anticipated postoperative pain and opioid requirements

Minimal to No Pain

Ask patient if he or she is still taking buprenorphine and establish total daily dose#

Yes →

Still Taking Buprenorphine

- Continue buprenorphine
- Do NOT routinely prescribe supplemental opioids
  Do NOT change the buprenorphine dose
- Consider adjuncts – NSAIDs, membrane stabilizers, acetaminophen, local anesthetic agents, regional anesthetic techniques

No →

Off Buprenorphine

- Surgical team should contact buprenorphine providers and confirm they are aware of surgery and have a plan to reinstitute therapy
- Assess amount of time since last dose. If the following dose/time intervals are met, treat with traditional opioids using opioid-tolerant dosing:
  - 0-4 mg per day – stop x 24 h before surgery
  - >4-8 mg per day – stop x 48 h before surgery
  - >8-12 mg per day – stop x 72 h before surgery
  - >12 mg – requires preoperative management plan with buprenorphine provider

Moderate to Severe Pain

Ask patient if he or she is still taking buprenorphine and establish total daily dose#

Yes →

Still Taking Buprenorphine

- Cancel surgery – Maybe better: postpone or schedule surgery such that the following requirements can be met
- Patient should return to buprenorphine provider and be placed on short-acting opioid or be weaned off before surgery. A plan for follow-up and reinstitution of therapy should be established.
  - 0-4 mg per day – stop x 24 h before surgery
  - >4-8 mg per day – stop x 48 h before surgery
  - >8-12 mg per day – stop x 72 h before surgery

No →

Off Buprenorphine

- Anticipate patient's opioid requirements will be similar to opioid-tolerant or highly-tolerant patient
- Surgical team should ensure appropriate outpatient follow-up with buprenorphine provider
- Consider adjuncts – NSAIDs, membrane stabilizers, acetaminophen, local anesthetic agents, regional anesthetic techniques

Urgent/ Emergent Surgery

Preoperatively: Surgical team should assess anticipated postoperative pain and opioid requirements

Minimal to No Pain

Ask patient if he or she is still taking buprenorphine

Yes → Still Taking Buprenorphine

- Surgeons should contact the physician prescribing buprenorphine and ensure that he or she is aware of surgery
- Continue the buprenorphine for postoperative pain
- Do NOT routinely prescribe supplemental opioids
- Consider adjuncts – acetaminophen and/or NSAIDs

No → Off Buprenorphine

- Assess the amount of time since last dose of buprenorphine
- If ≥5 days off buprenorphine, treat with traditional opioids; may require tolerant or highly-tolerant doses
- Surgeons should contact the physician prescribing buprenorphine and ensure that he or she is aware of surgery
- After postoperative pain normalizes, the patient may work with his or her physician to reinstitute buprenorphine therapy

Moderate to Severe Pain

Ask patient if he or she is still taking buprenorphine

Yes → Still Taking Buprenorphine

1. Discontinue buprenorphine
2. Start PCA – Will likely require high doses; may require some continuous opioid infusion. However, would avoid high-dose, continuous opioids and *instead allow* the patient to use PCA. Consult APS, PCA to be managed by Acute Pain Service (APS).
3. Patient should be in a monitored setting with close nurse monitoring (ICU, or monitored/moderate care setting)
    - Duration of ICU/monitored setting time will vary
    - Acetaminophen around the clock (ATC)
    - Consider gabapentin or pregabalin
4. Regional anesthesia – consider continuous catheters
5. Maximize adjuncts
    - Dexemedetomidine for ICU patients used according to ICU protocols
    - Acetaminophen around the clock (ATC)
    - Consider gabapentin or pregabalin
6. Continue traditional opioid therapy for postoperative pain after discharge. Coordinate follow-up with pain physician prescribing buprenorphine for eventual opioid wean and reinstitution of buprenorphine therapy.

No → Off Buprenorphine

- Anticipate patient's course to be similar to tolerant patient
- Surgeons should ensure appropriate outpatient follow-up

Updated Recommendations:

1. Preoperative pain management planning when possible
   - Addresses the psychological aspects of pain

2. Perioperative use of validated pain assessment tool

3. Multi-modal analgesia, both pharmacologic and non-pharmacologic

4. Oral preferred over IV opioids
   - Often need doses 150-200% of usual opioid doses

5. PCA analgesia when systemic analgesics are necessary

6. Avoid basal opioid infusions

7. Where regional analgesia not appropriate, high dose opioids should be anticipated.

Updated Recommendations Continued:

8. Non-opioid options: NSAIDs, gabapentinoids, ketamine, alpha 2 agonists, NMDA receptor antagonists

9. Continuous regional anesthesia techniques where appropriate
   - May not need to discontinue buprenorphine
   - May not need additional analgesics for post-op pain

Anderson et al (2017). To Stop or Not, That is the Question. *Anesthesiology*, 126:6: 1180-1186.

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Conclusions

- Pain management a manageable concern
- Needs planning and coordination
- Provide reassurance for patient
- Develop a plan for post-operative pain management as well as safe distribution of opioids
- Recognize relapse risk
- Schedule frequent follow-ups, maintain counseling contacts

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References:

- Anderson T et al (2017). To Stop or Not: That is the Question. Anesthesiology, 126: 6, pp 1180-1186.

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DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

Project ECHO®
Wisconsin Department of Health Services