What's New in Chronic Pain

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Objectives

- 1. Review resources for new recommendations – chronic pain with addiction disorder
- 2. Review ASAM 2026 chronic pain key concepts
- 3. Pearls from ASAM

Resources for Future Learning – What I Use to Keep on the Cutting Edge

- 1. Colorado Consortium for Drug Abuse Prevention - Coordinating Colorado's overdose crisis response - Colorado Consortium for Prescription Drug Abuse Prevention –
- 2. University of Washington
- 3. ASAM - new Implementation Guide for Hospitals and Emergency Departments – pain mgmt
- 4. MPCA – Addiction Medicine Network Meeting
- 5. ASAM Annual Meeting

Enduring Courses

Title
Caring for “Legacy Patients” on High Dose Opioids
Working Effectively Across Language Barriers
Anatomy of an Inpatient Addiction Consultation
2022 CDC Clinical Practice Guideline for Prescribing Opioids for Oral and Dental Pain
A Deeper Dive into the CDC Guidelines: Implementation and Practice
Benzodiazepine Induced Neurological Dysfunction (BIND)
Higher Dose Buprenorphine
Introduction to Substance Use Disorders & Medication-Assisted Treatment
Psychological Factors Influencing the Transition from Acute to Chronic Pain
Benzodiazepines: Appropriate Prescribing & Alternative Treatments
Deprescribing/Tapering of Prescription Benzodiazepines
Non-Opioid Pain Management
Physical Therapy for Pain Management

Rethinking Relief: Pain Management in a Changing Opioid Landscape

Speakers:
Joshua Blum, MD
Sarah Christensen, MD

Wednesday, May 20, 2026

Hosted on Zoom

This activity is jointly provided by Medical Education Resources, Colorado Consortium for Prescription Drug Abuse Prevention in collaboration with the Denver Center for Addiction Medicine.

Medical Education Resources

UW TelePain

Pain Medicine

Center for Pain Relief at UW Medical Center – Roosevelt

Fred Hutchinson Cancer Center Pain Clinic

Connect with us

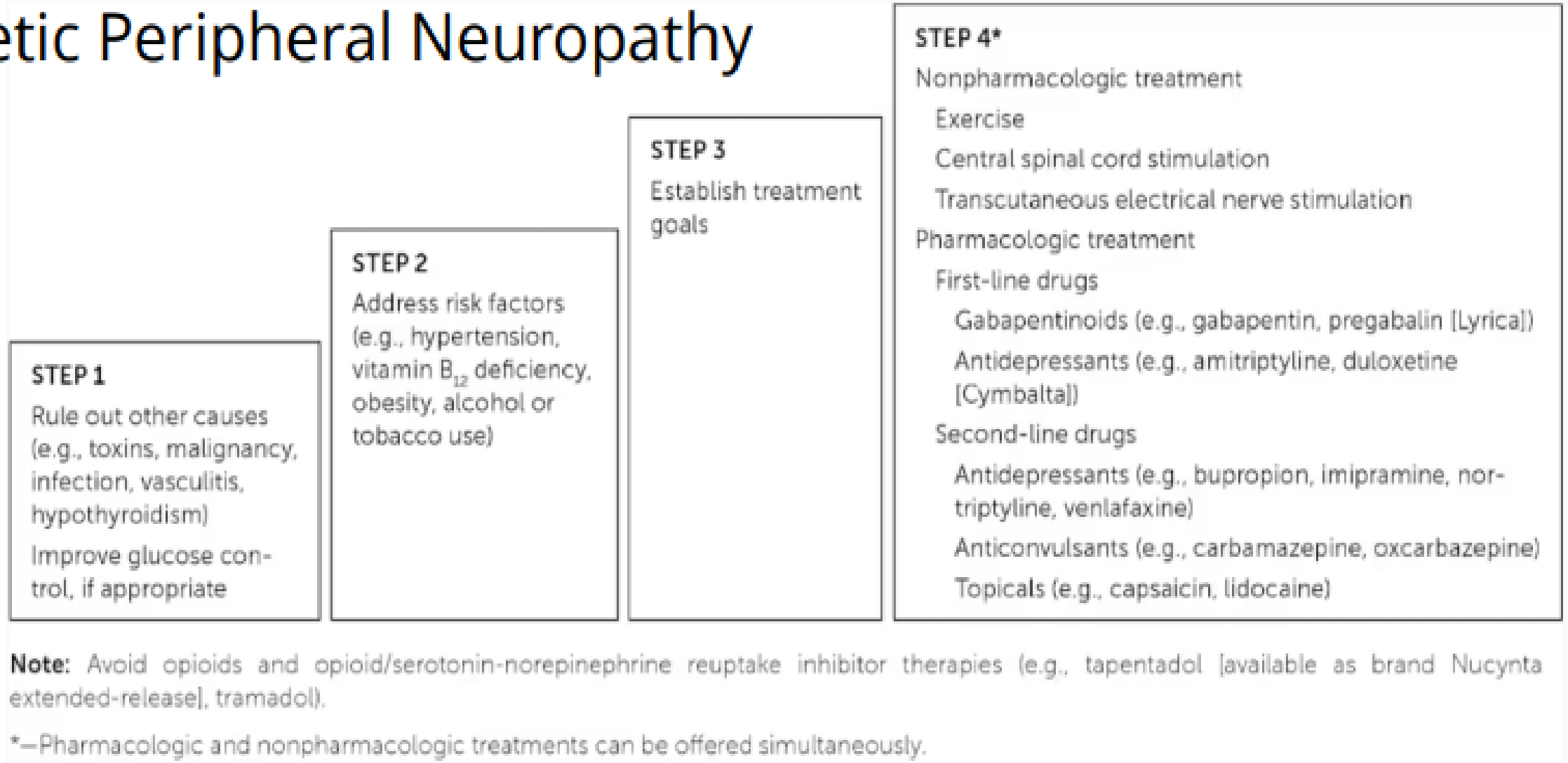
Questions about registering, connecting, presenting, or CME? Send us an email at **telepain@uw.edu**.

Overview of Chronic Pain – What's Not New

- Treat like any other chronic medical problem
- History, physical exam, collateral information, labs as indicated, differential diagnosis, use a PEG Scale – measure fxn, adl's, pain
- Address chronic medical conditions (including mental health)
- Treatment – oral or topical nsaids, acetaminophen, topicals, SNRI (duloxetine), consider risks and benefits of gabapentin or pregabalin
- Consideration of opioid therapy if above is not achieving functional improvement

onsider periodic literature review

t: Diabetic Peripheral Neuropathy



Note: Avoid opioids and opioid/serotonin-norepinephrine reuptake inhibitor therapies (e.g., tapentadol [available as brand Nucynta extended-release], tramadol).

*—Pharmacologic and nonpharmacologic treatments can be offered simultaneously.

Managing pain from diabetic peripheral neuropathy.

Scott Bragg, PharmD, Sarah Tucker Marrison, MD
American Family Physician. 2024;109(3):226-232.

Rethinking Problematic Opioid Use
J Addict Med – March/April 2026 -UW

- Prior DSM-5 OUD criteria supported a dichotomy definition – you have it or you don't
- The reality - is it is not that simple
- Recent discussions suggest a newer classification of prescription opioid dependence syndrome
- Complex interaction of pain relief and reward, neuroadaptation
- Pre-addictive state

What defines PODS – Delphi Study

- No objective evidence of improvement in pain or function
- Strong belief that opioid is needed despite lack of objective evidence of improvement
- Deterioration in pain and function
- Craving
- Continued use despite being informed that risk exceeds benefit
- Difficulty tapering
- Tolerance
- Recurrent acute and protracted withdrawal

What works for OUD and POUD -----

- Buprenorphine has emerged as a useful tx for both
- Good analgesic efficacy, in part due to long half life
- Good safety profile – ceiling effect for respiratory depression
- May be a poor choice for end of life care or acute pain (trauma)

Buprenorphine – Unique Properties

- Partial mu opioid agonist (receptor occupancy – not analgesic efficacy)
- Kappa antagonist – bolters mu opioid agonism and reverses opioid induced hyperalgesia that occurs during opioid dependence.
- Kappa antagonism has useful andtidepressant effects
- Kappa antagoinism has useful anti-hyperkatifeia effects (*increased sensitivity to pain and emotional distress to those in early recovery)*

Buprenorphine Pharmacology

- Duration of action 20-73 hours, half life is 38 hrs
- Duration of action for analgesia – 6 hrs
- Low risk for overdose and misuse
- Strong binding affinity to mu receptor – greater than oxycodone, heroin, methadone, naloxone, fentanyl
- Microinduction techniques can help convert patients with OUD to buprenorphine without precipitated withdrawal

How/why to use Buprenorphine and treat times of acute/increased pain

- Buprenorphine is occupying 80% of mu receptors at 16mg/day
- Adding short acting opioids to buprenorphine can provide some added analgesia – especially useful in hospital settings. Dose based on tolerance – breakthrough doses should be 10-20% of the total daily opioid dose
- Increasing the total daily dose of buprenorphine provides more analgesia
- More frequent dosing improves pain control
- Duration of analgesia – 6hrs
- 4mg QID better than 8mg bid
- Continue MOUD in the hospital and peri-operatively

Effective Pain Control requires a multi-modal approach

- Acetaminophin
- NSAID's
- Neuropathic agents
- Muscle relaxants for acute pain with spasm
- Ketamine (hospital) for refractory pain
- Regional anesthesia for focal pain

ASAM 2026 PEARL – Opening Session Resilience – Michael Unger PhD

- In exposure to adversity – capacity to navgigate to resources to sustain wellbeing and
- Negotiate for these resources to be provided in culturally meaningful ways.

- We need many different resilience enabling resources at many different system levels to thrive

- Yoga at lunch is not going to do it – its not enough and its not for everyone


POSITIVE THINKING
FINANCIAL WELLBEING
STRUCTURE
PHYSICAL WELLBEING
ACCOUNTABILITY
BASIC NEEDS
LOVE FROM OTHERS
RIGHTS & RESPONSIBILITIES
SUPPORTIVE RELATIONSHIPS
BELONGING/ CULTURE
A POWERFUL IDENTITY
SENSE OF CONTROL
SOURCE: Ungar, M. (2019). Change Your World: The Science of Resilience and the True Path to Success.

Low Dose Naltrexone

Mechanism	Anti-inflammatory effect via antagonism of Toll-like receptor 4 on microglial cells reducing neuroinflammation and central sensitization Upregulation of endogenous opioid signaling
Dose	Starting 1-1.5mg daily, titrated to 4.5-9mg daily (Compounded) Low dose IS different form regular dosing (transient blockade of opioid receptors allows rebound upregulation of receptors and endogenous opioids)[31]
Side effects	Vivid dreams, nausea, fatigue
Special considerations	Modest effect in fibro, but limited and mixed evidence. 2024 meta-analysis of 4 RCTs (222 patients) showed significant reduction in pain scores, but less impact on Fibro Impact Questionnaire and catastrophizing[28] Some low level evidence in neuropathic pain, CRPS[29] FINAL trial showed memory improvement, not statistically significant pain improvement[30] INNOVA trial in progress (following patients for 1 year) Generally not covered by insurance, ~$30-$50/month

Bottom Line

LDN represents a promising, low-cost, non-opioid option for refractory chronic pain, particularly fibromyalgia and neuropathic pain conditions. However, the evidence base remains limited by small sample sizes, methodological heterogeneity, and a lack of large, well-powered RCTs. Current reviews consistently call for further high-quality trials before definitive efficacy conclusions can be drawn.

Pregabalin Vs Gabapentin – Does it matter

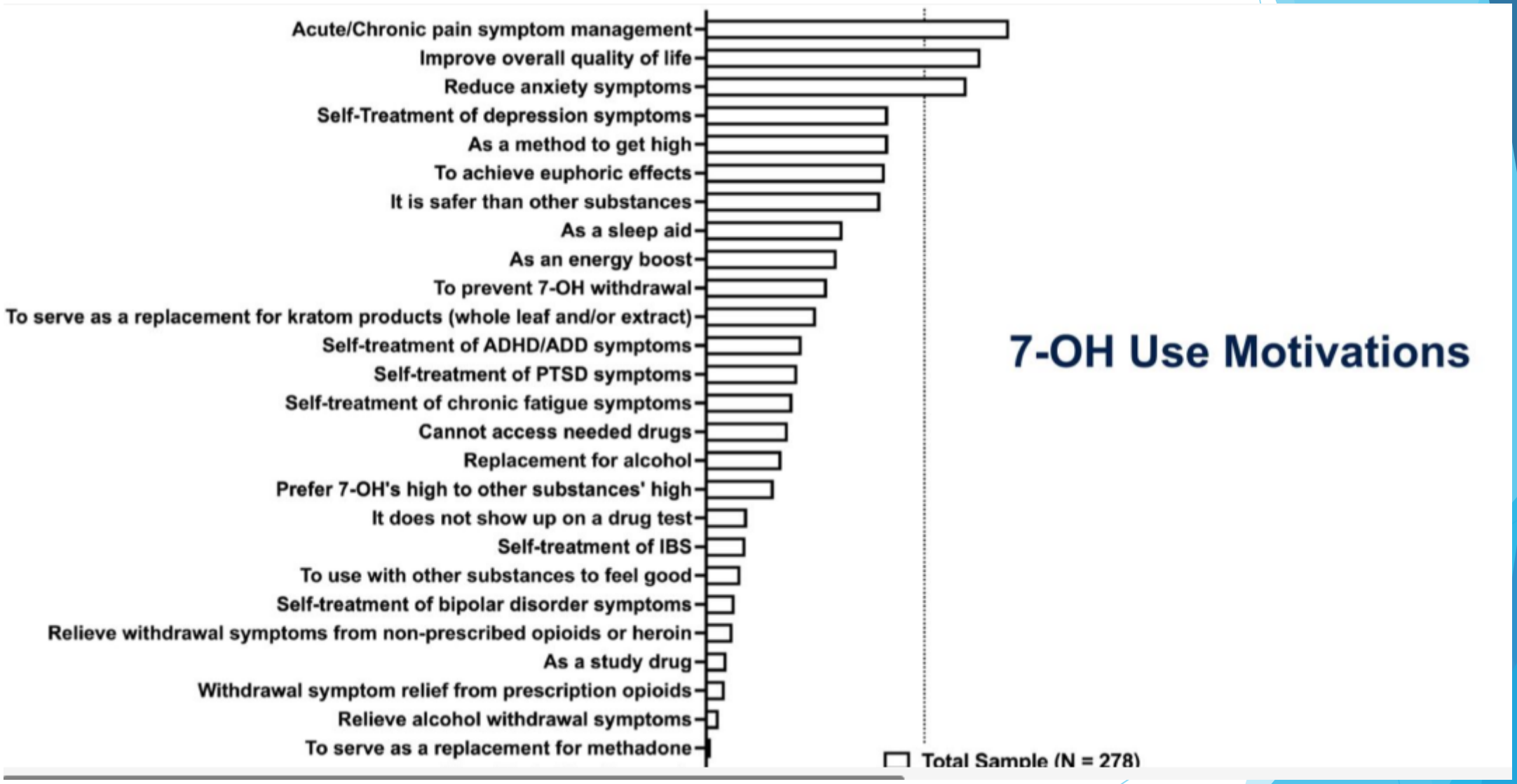
- Neuropathic pain – not bones/joints
- Poorly understand and little evidence for best practice, lots of expert opinion
- Increased diversion of gabapentin – known to potentiate opioid euphoria
- Lyrica has higher potency, BID dosing, linear absorption
- FDA approval for both drugs limited – major of clinical use off label

Gabapentin Dosing Evidence

- Clinical trials demonstrated efficacy across **1800–3600 mg/day**, though additional benefit above 1800 mg/day was not clearly demonstrated in the FDA's clinical studies.

Kratom and Chronic Pain – Use in the USA

- In Southeast Asia – primary use is the plant mitragyna – leaves for chewing and tea from leaves
- In the US – dried powder, concentrates, 7-OH products
- Few to no studies to support use for chronic pain
- Typical opioid dependence and withdrawal occurs with regular use
- Significant adverse effects – liver toxicity, seizures, respiratory depression, coma, death have been reported
- Drug drug interactions with patient's other medications
- Lack of consistent products – no FDA regulation


Acute/Chronic pain symptom management
Improve overall quality of life
Reduce anxiety symptoms
Self-Treatment of depression symptoms
As a method to get high
To achieve euphoric effects
It is safer than other substances
As a sleep aid
As an energy boost
To prevent 7-OH withdrawal
To serve as a replacement for kratom products (whole leaf and/or extract)
Self-treatment of ADHD/ADD symptoms
Self-treatment of PTSD symptoms
Self-treatment of chronic fatigue symptoms
Cannot access needed drugs
Replacement for alcohol
Prefer 7-OH's high to other substances' high
It does not show up on a drug test
Self-treatment of IBS
To use with other substances to feel good
Self-treatment of bipolar disorder symptoms
Relieve withdrawal symptoms from non-prescribed opioids or heroin
As a study drug
Withdrawal symptom relief from prescription opioids
Relieve alcohol withdrawal symptoms
To serve as a replacement for methadone
7-OH Use Motivations
Total Sample (N = 278)

ASAM DAY 2 – KeyNote Address – Coming Challenges

- Changing landscape, again, in compensation for addiction medicine
- Medicaid work requirements, six months reenrollment, staff to support this work.
- Those with substance use disorders – again – will be most affected
- Employment can be challenging for those in early recovery
- Breaking down bundled services and what is allowed when we know wrap around services are needed.

ASAM Pearls

- Early buprenorphine long acting injectables – many centers adopting, access to the medication at point of care continues to be challenging.
- Enhancing dental care in patients on sublingual buprenorphine products – topical fluoride, dental screening exams, specific education.
- Although ASAM guidelines describe benzodiazepines as standard of care for alcohol use disorder, many are shifting to phenobarbital – particularly in the ED and hospital setting.
- Research funding continues to be a big unknown
- Lots of passion for improving/collaborating for best practices in ED and hospital care.

THC Products and Chronic Pain – Is There any Real Evidence

- Summary of RCT's available reveal modest but consistent analgesic effect, primarily in neuropathic pain
- Low NNH – 6
- CBD products do not appear to be effective
- Not a first line treatment, avoid smoking/inhaling the product
- Avoid in adolescents, frail, pregnant, those with SUD's, those with serious mental illness
- Discussing alternative therapies, if patient is intent on using discuss safe use

Pain Contracts -

- Change to opioid treatment agreements – implies therapeutic collaboration rather than a punitive approach.
- Include what to expect: UDS, access to provider, off hour medication needs, expectations about engaging in other forms of treatment, expected behavior in clinic – a map to success.
- Use a behavioral contract if possible if patients have “difficult behavior”
- Make recommendations if patient is not best cared for in your practice