Primary Care Approach to Treating Substance Use Disorders—a Webinar Series from the Montana Primary Care Association

- Session 5: March 20, 2024
- Managing Patients with OUD and Pain
- Dan Nauts, MD, FASAM
- CME approved by the American Society of Addiction Medicine (ASAM)

DISCLOSURE INFORMATION

Primary Care Approach to Treating SUD

March 20, 2024, Session 5

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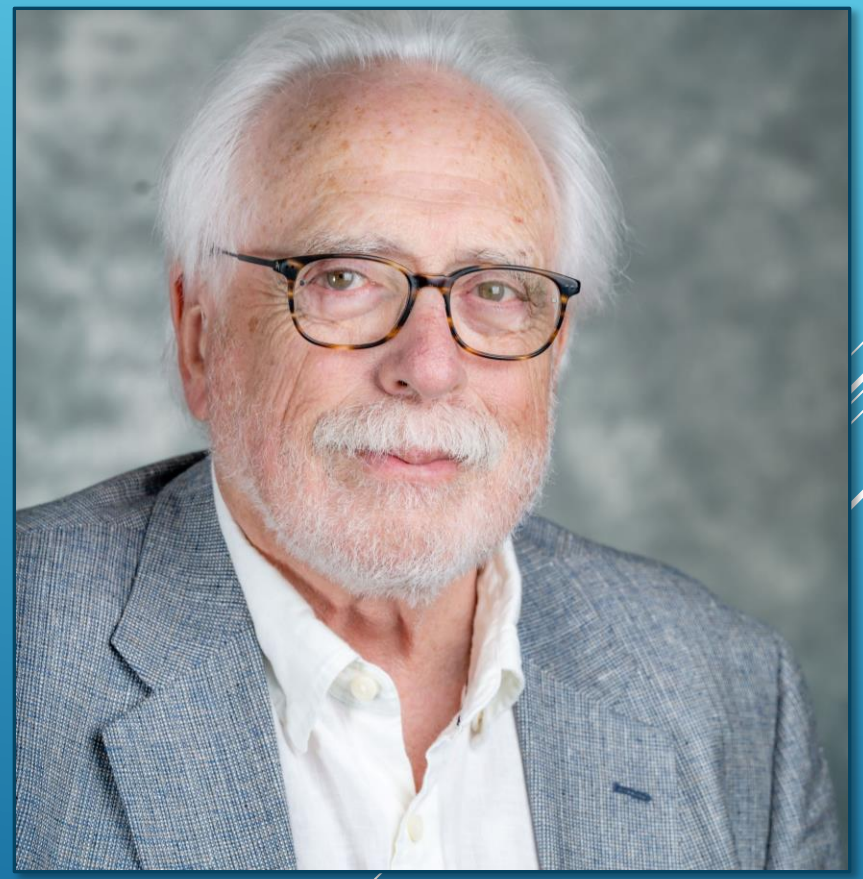
Managing Patients with OUD and Pain



- No disclosures

OUTLINE

- Approach to pain management
  - Acute, chronic and peri-operative
  - With and without OUD
- How to talk to patients about changing pain regimens
- When to prescribe Buprenorphine vs. full agonist opioids

OUD AND INCREASED PAIN SENSITIVITY

- Patients with OUD on opioid agonist treatment have **less pain tolerance** than matched controls (peer groups in remission or with siblings without an addiction history).
- Opioid agonist treatment (OAT) = buprenorphine or methadone

Slide credit: ASAM DATA 2000 Treatment of Opioid Use Disorder course,
Martin 1965, Ho 1972 90,2 Compton 1994, 2001

ACUTE PAIN MANAGEMENT OF PATIENTS ON BUPRENORPHINE OR METHADONE

- Patients who are **physically dependent** on opioids:
  - Must be maintained on daily equivalence ("opioid debt") before ANY analgesic effect is realized with opioids **(or nonopioids)** used to treat acute pain.
  - Often have higher opioid analgesic requirements due to increased pain sensitivity and opioid cross-tolerance.

Slide credit: ASAM DATA 2000 Treatment of Opioid Use Disorder course,
Peng 2005, Ahlford 2006

Management of Acute Pain

- **Patients with OUD, especially those in recovery and on opioid agonist therapy or naltrexone, deserve pain relief on par with patients without OUD**
  - Novel approaches required due to pharmacology of their OAT
    - Buprenorphine: high affinity partial agonism
    - Methadone: full agonism
    - Naltrexone: high affinity full antagonism

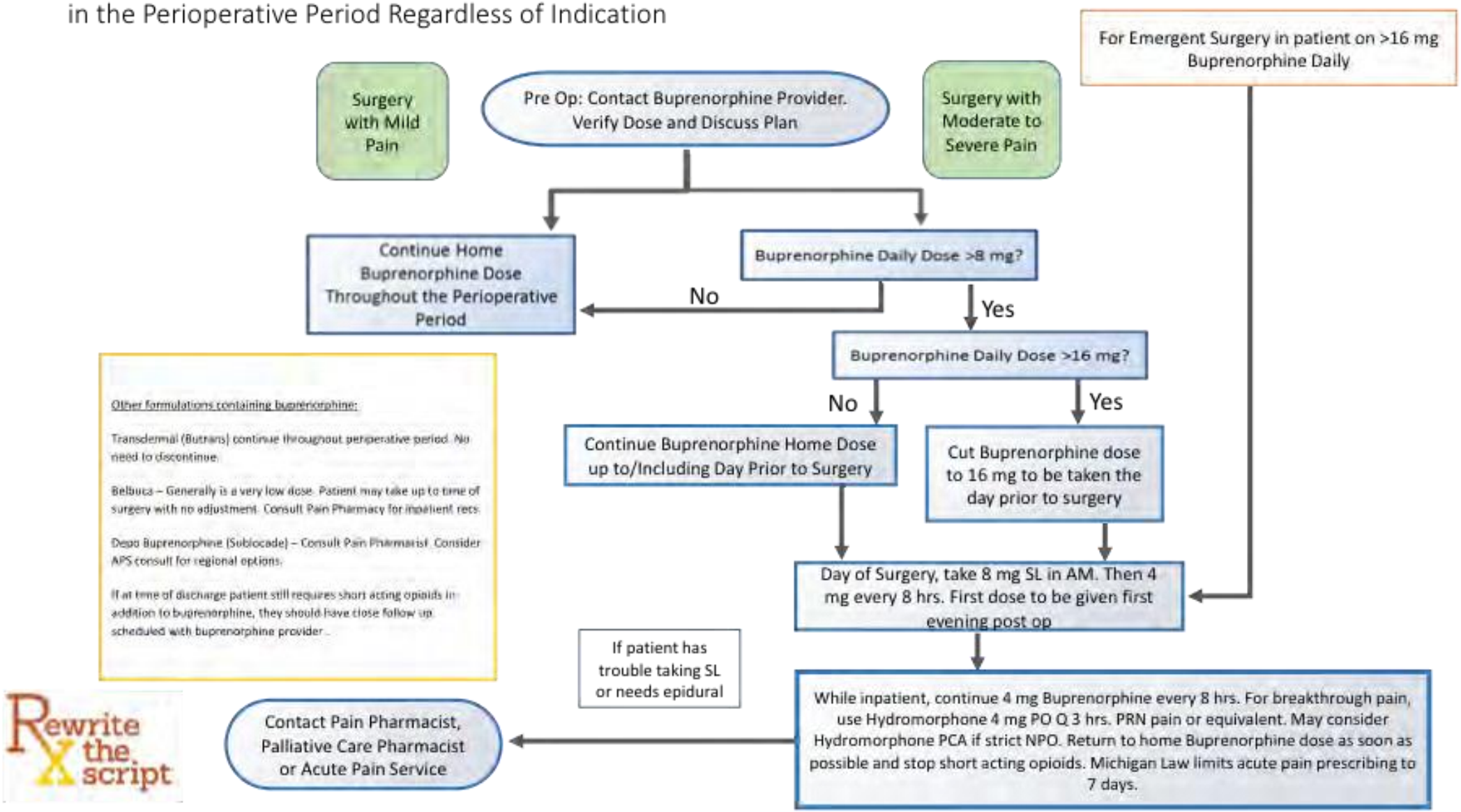
ACUTE PAIN MANAGEMENT OF PATIENTS ON BUPRENORPHINE OR METHADONE

- Trial of non-opioid analgesics and nonpharmacologic management
- If opioids needed for patient with OUD on bup, usually dose 1.5x usual amount and continue baseline dose of buprenorphine
- Split buprenorphine dosing TID or QID
  - Buprenorphine analgesic effect q6-8 hours
- Outpatient management: consider increasing buprenorphine dose by 25% and advising TID or QID frequency x one week, then reassess

PERI-PROCEDURE MANAGEMENT FOR PATIENTS TAKING BUPRENORPHINE

- Do **not** recommend discontinuing buprenorphine
  - Consider tapering bup dose prior to procedure? No expert consensus, but not recommended based on clinical experience.
  - Dose TID-QID post-op if daily SL bup is prescribed for OUD
- Refer to guidelines and/or contact MOC for guidance

Perioperative Buprenorphine Management: This Protocol Applies to all Patients Taking Buprenorphine in the Perioperative Period Regardless of Indication



https://michiganopioidcollaborative.org/wp-content/uploads/2021/05/Perioperative-Bup-Mgmt-2019.pdf

OPEN
Prevention. Treatment. Recovery.

STEPS FOR APPROACHING CHRONIC PAIN

- Identify/treat any local pain generators
- Find and treat comorbid psychiatric illness
- Understand the continuum from pain to opioid use disorder in these patients
- Restore sleep
- Promote increased physical activity and decreased fear of movement

CHRONIC PAIN: A ROLE FOR OPIOIDS?

Figure. Evidence-Based Opioid-Sparing Pain Management Strategy

Wood 2019

WHEN SHOULD I CONSIDER TRANSITIONING MY PATIENT ON FULL OPIOID AGONISTS TO BUPRENORPHINE?

- When intermittent daily opioid dosing results in a real, but only intermittent benefit
- Your patient is in trouble:
  - High opioid dose; signs/symptoms of opioid adverse effects
  - Patient asks for more (tolerance or misuse)
  - Severe SUD hx

HAVING "THE BUPRENORPHINE TALK" WITH PATIENTS PRESCRIBED CHRONIC OPIOID AGONISTS

- Patients with and without a hx of OUD may be hesitant to consider buprenorphine (or any regimen change) to treat their chronic pain
  - Patients need to *understand* why this choice is preferred.
- Conversations can take time, be patient
- Buprenorphine is an effective, FDA-approved pain medication

Trust is essential. Listen to your patients.

BENEFITS OF BUPRENORPHINE VS. FULL AGONIST OPIOIDS IN PHARMACOLOGIC PAIN MANAGEMENT

- Lower risk for overdose
- Lower side effect profile
- Lower misuse risk
- Little or no tolerance seen
- Schedule III vs II drug
- Disadvantage- Cost/insurance issues, initiation?

INITIATION TIPS

- Converting from short or intermediate-acting opioid formulations to buprenorphine – how long to wait? 16 hours
- Converting from long-acting (fentanyl, methadone): bridging with short-acting opioids avoids lengthy withdrawal.
    - Illegal to prescribe full opioid agonist if patient has hx of OUD

FDA-APPROVED FOR PAIN ONLY: TRANSDERMAL BUPRENORPHINE (BUTRANS® OR GENERIC)

- TD bupe is rarely adequate for patient's taking > 80 MME
- Start patch. During the first day, taper off and d/c any other opioid
- Titrate dose after one week
- Yes, you can cut them
- $$$; often not covered

Choosing an initial dose:

MME	Patch dose
< 15	5 mcg
15-30	7.5 mcg
> 30	10 mcg
Max recommended dose is 20 mcg	

FDA-APPROVED FOR PAIN ONLY: BUCCAL BUPRENORPHINE (BRAND NAME BELBUCA® ONLY)

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- Rarely adequate for > 150 MME
- No induction protocol. Start strip; d/c any other opioid after 1or 2 doses
- Yes, you can cut them as well!
- Many patients prefer TID dosing over BID
- $$$; often not covered

Choosing an initial dose:

MME	Dose
< 30	75 mcg BID
30-89	150 mcg BID
90-150	300 mcg BID
Maximum recommended dose 900 mcg BID	

WHAT IF IT ISN'T WORKING?

- Obtain history of what patient thinks isn't working: less functional (focus on function vs pain severity), transient relief
- Consider increasing dose or frequency of dosing (for SL)
- Review proper SL admin technique
  - Have a wet mouth
  - No smoking 30 min before dosing
  - Hold film under tongue for 5-10 minutes
  - Do not eat, drink or talk while film is dissolving

DSM-5 DIAGNOSIS OF OPIOID USE DISORDER

- Use in larger amounts/longer periods than intended
- Unsuccessful efforts to cut down
- Excessive time spent taking drug
- Failure to fulfill major obligations
- Continued use despite problems
- Important activities given up
- Recurrent use in physically hazardous situations
- Continued use despite social consequences
- Craving
- **Tolerance***
- **Withdrawal***
    - **No guidelines when tolerance and withdrawal can be counted in a person prescribed opioids chronically and**

Mild: 2-3
Moderate: 4-5
Severe: 6 or more

(OFF-LABEL) BUPRENORPHINE/NALOXONE FOR PAIN

- No expert consensus how formulations of buprenorphine indicated for pain only compare to bup/naloxone films in terms of serum levels
- Insurance may not cover for non-OUD diagnosis (off-label use)

< 50	0.5-3 mg
50-150	3-6
> 150	6-8
Use divided dosing (TID-QID) – cut films/tabs	

NALTREXONE AND PAIN TREATMENT

Naltrexone Blockade

- Analgesic effects of opioids blocked at conventional doses.
- Can be overcome by 6-20x usual analgesic dose without significant respiratory depression or sedation under close observation.

Urgent/acute procedures

- Will need to overcome naltrexone blockade of opioid receptors, so need setting equipped and staffed for resuscitation.
- Consult anesthesia, consider nonopioids and regional anesthesia

Perioperative Management

- Oral naltrexone blockade 50% diminished after 72 hours.
- XR-naltrexone blockade begins to decline at day 14
- If possible, schedule elective surgery to time with day 28-30 after receiving XR-naltrexone

Slide credit: ASAM DATA 2000 Treatment of Opioid Use Disorder course, 2021

Dean 2008, Vickers 2006

PAIN MANAGEMENT RESOURCES

- Perioperative Buprenorphine Management
- Michigan Medicine Ambulatory Pain Management Guidelines
- Nonnarcotic Methods of Pain Management (NEJM article)
- Things we do for no reason™: Discontinuing Buprenorphine when treating acute pain

GENERAL RESOURCES

- Michiganopioidcollaborative.org Resources
- PCSSnow.org
- SAMHSA Medications for Opioid Use Disorder Manual
- BMC OBAT Policy and Procedure Manual
- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder – *2020*
- *Bridgetotreatment.org*
- *CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022;MMWR/ Nov 4 2022/ Vol. 71, pg54.*
- *VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, May 2022.*
- *Stigma video, shatterproof.org*

After Hospital Admission

- Opioids Not Required on Admission
  - Start buprenorphine when withdrawal develops

- Opioids Continued on Admission
  - Cannot use a standard induction

Hospital is Critical Opportunity

- OUD in hospitalized patients quadrupled
    - Annual rate of hospital discharges documenting OUD without opioid overdose quadrupled during 1993–2016

- OUD in hospitalized pts increased 8% annually
    - During 2003–2016.

Peterson, C., Xu, L., Florence, C., & Mack, K. A. (2019). Opioid-related US hospital discharges by type, 1993–2016. *Journal of substance abuse treatment*, *103*, 9-13.

Management of Acute Pain

- Buprenorphine is a high affinity partial agonist
  - ”Out-competes” most other opioids
- When possible, use non-opioid analgesia
  - Nerve blocks
  - NSAIDS
  - Acetaminophen
  - Immobilization
  - Ketamine

Management of Acute Pain

- If opioids are required
  - Select those also with high affinity
    - Fentanyl
    - Hydromorphone
  - Expect to use large doses
    - Not due to tolerance, although this contributes
    - Only a small amount of the opioid provided will outcompete buprenorphine
    - Titrate to effect