Managing the Risks and Benefits of Pain Management with Opioid Analgesics

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Disclosures Joe DeLoach, OD, FAAO

I Have Received Honoraria From or Served as a Consultant for: (Partial Listing)

- Vision Source
- Alcon Laboratories
- Carl Zeiss Meditec
- Optos
- Diopsys
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- AllDocs
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- NVision
- Cleinman Partners
- Vision Trends
- Konan
- Essilor of America
- SNAPP
- AACO
- Vision West
- UHCO, NOVA, RSO, UAB, Berkley, *and other optometry schools*

Over half the state optometric associations in the United States

Practice Compliance Solutions, LLC – President, CEO & Shareholder

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Disclosures - Peter J. Cass, OD

- Optometrist, MyEyeDr Beaumont Texas
- Vice President, Practice Compliance Solutions
- Past President, Texas Optometric Association
  - Chair HIT Committee, AOA Health Information Exchange Workgroup
- Consultant/Speaker for ophthalmic companies:
  - Alcon, Bausch & Lomb, Crystal Practice Management, Diopsys, Solution Reach, Katena, Tear Science, Shire, BioD
- Lecturer for
  - Professional groups: Vision Source, Vision West, ECPN, PERC, Vision Trends, Vision West, TSO, etc.
  - Universities: RSO, UHCO, UAB, others
  - State associations: TOA, and over 20 others
- Working relationships with: Cleinman, CodeSafePlus
- Shareholder EKKDA, EDO labs, PCS

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Neither presenter has any ownership or other financial conflict with any product, company or organization discussed in this presentation

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Agenda

- History of opioid analgesic agents
- Issues with opioid over-use and addiction
- Definitions and mechanisms of pain
- Assessing patients in pain
- Creating an effective pain management plan
  - Non-pharmacologic management
  - Non-opioid analgesic management
  - Management with opioid analgesics

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Landmarks in History of Opioids

- It all started with opium – 3,400 BC. Sumerians labeled the opium poppy "the joy plant"
- Production and trading escalates after 15th century
- Before the 1800s, opioids used to treat everything from a toothache to pain at death
- 1806 – Friedrich Serturner isolates morphine from opium (named after Morpheus – "god of dreams").
- 1853 – hypodermic needle invented. Game changer spawned massive use esp. during Civil War
- 1898 – Bayer isolates heroin from morphine. Given as the "non-addictive alternative to morphine"

FROM THERE IT ALL STARTED DOWNHILL

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Opioids – 20th century and forward

- 1900-1985: Creation of Food and Drug Administration in 1906 and Harrison Narcotic Control Act in 1914 attempt to curb physician prescribing of opioids
- Around 1990, medical and scientific world focus on what as considered a "massive undertreatment of pain". **Use of opioid analgesics skyrockets** – considered a **standard of care** issue in pain management
- 2012 – FDA approves extended release opioid analgesics - opioid use peaks with consumption of 365,000 pounds in the US alone and widespread opioid addiction
- 2016 – medical community focuses on increased physician education and decreasing use of opioid analgesics

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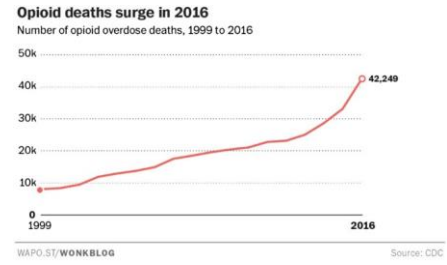
And Why???



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How Bad Is It?

National Institute on Drug Abuse

- 2018 – 128 people in US die from opioid overdose – **PER DAY**
- 21-29% of patients prescribed opioids for pain management mis-use them
- CDC estimates total cost burden to healthcare system of $78.5 billion
- Despite current efforts, opioid overdoses showed a 3.5% increase from 2018-2019

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How Do People Get Them

National Survey on Drug Use and Health (2016)

1. 53% from a friend or relative
2. 35% physician prescription (which obviously feeds #1)
3. 12% illegal acquisition

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Who Uses Them?

- As expected, most prevalent in Metropolitan and fringe areas
- Problem in all age groups, all ethnicities, all genders, all socio-economic backgrounds
- Tendency toward lower income groups
- Groups with largest death rate - African descent 45-65 years old and non-Hispanic whites 25-35 years old
- WebMD – 14% age 12-17 stated had used opioid narcotics

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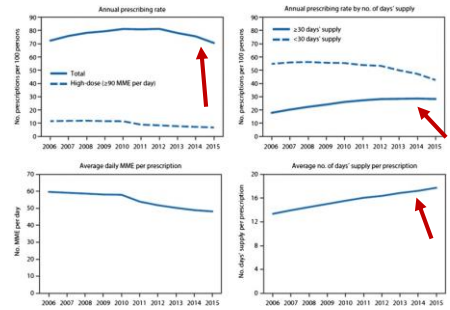

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Pain Terminology

OLD TERMINOLOGY	NEW TERMINOLOGY
Addiction	Substance use disorder
Addict	Person with substance use disorder
Drug Seeker	Using drug in altered manner
Misuse	Using drug not as prescribed
Abuse	Use with intent of high/euphoria
Tolerance	Increased dosage needed for desired effect
Dependence	Cannot function outside presence of drug

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One Very Significant Term

Chronic, non-cancer pain (CNCP)

- Defined as chronic pain lasting >2-3 months NOT the result of cancer or cancer treatment
- A major issue contributing to opioid use crisis

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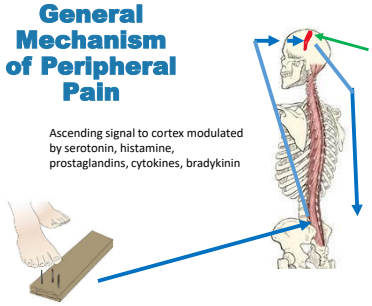
General Mechanism of Peripheral Pain



Ascending signal to cortex modulated by serotonin, histamine, prostaglandins, cytokines, bradykinin

Somatosensory cortex interprets location, severity and intensity. Usual response is to send blocking signals to site of pain

Descending signal to site of injury modulated by serotonin, norepinephrine, **andogenous opioids (via Mu receptors)**

SIGNIFICANT individual variation in these responses to all kinds and levels of pain

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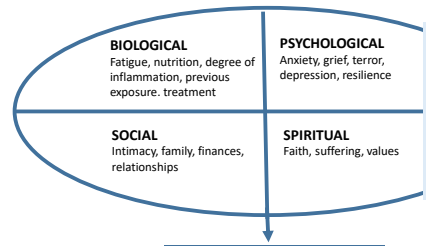
Biopsychosocialspiritual Context of Pain



The ultimate response through help in any of these areas can be influenced by doctor's actions and empathy

PAIN EXPERIENCE

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Travel partners…

Depression and chronic pain travel together – chronic pain causes depression and depression feeds chronic pain

Pain. 2016 Jul; 157(7): 1472–1479

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Pain Classification

By Type

NOCICEPTIVE	NOCIPLASTIC	NEUROPATHIC	MIXED
Usually inflammatory mediation often from injury	Usually nociceptive pain that is altered to a chronic state	Usually injury directly to or inflammation at a central nerve	Severe chronic pain where the pain becomes the disease itself
ACUTE	**CHRONIC**	**ACUTE OR CHRONIC**	**CHRONIC**

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Pain Classification

By Characteristics

- Duration
- Underlying pathophysiology
- Central sensitization (now called "tolerance")

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Pain Classification

In General

- Acute
  - Most common ocular pain
- Chronic
  - Most common opioid problem

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Assessing Pain – History is King

- Description – location, intensity, quality, onset, duration
- What makes it worse?
- What makes it better?
  - Non-pharmacologic
  - Pharmacologic
    - If opioids, must use Prescription Drug Monitoring Program
- Relevant co-morbidities
- Social and psychological factors

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Five tips to spotting the "addicted" patient

✓ Inconsistencies in reported symptoms or history

Over-rated explanations of injuries; symptoms persisting well beyond injury; over-rated pain in relation to cause

✓ Unusual behaviors

Patient is obsessive, agitated, irritable, fails to keep appointments then wants in for "emergency" care, overly complimentary of physician

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Five tips to spotting the "addicted" patient

✓ Lack of correlation between symptoms and signs from examination

✓ Failure to accept non-narcotic recommendations ("I tried that before, it didn't work…but Vicodin did!")

✓ Request for dosages or refills in excess of the problem – losing prescriptions

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Texas Prescription Monitoring Program (PMP)

➢ Implemented in 2008 – only for Schedule I and II reporting

➢ Amended in 2016 to include all Schedules with required reporting requirements for all Texas pharmacists and any physician prescribing opioid derivatives, benzodiazepine (many sedatives), barbiturate or carisoprodol (Soma) – regardless of the Schedule

➢ This means under current law we are required to use the PMP with any prescription for codeine or tramadol containing medications

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Then….

IT'S JUST THAT EASY….

- Effective September 1, 2019, before writing any applicable prescription you must login and check the registry regarding the patient's history
- Then make a determination if you want continue with the prescribed medication based on:
  - ✓ The prescription data and history related to the patient, if any, contained in the Prescription Monitoring Program
  - ✓ A determination whether the planned decision would constitute a potentially harmful prescribing pattern or practice.

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Side point…

Every licensed practitioner has a profile in PMP accessible by any pharmacist in Texas. Your prescribing patterns are being recorded and monitored whether you elect to participate in the PMP program or not.

More information on the Texas Prescription Monitoring Program can be found at: www.pharmacy.Texas.gov

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Assessing Patients in Pain

- Pain is one of the most common reasons a patient will present for care
- The ability to decrease or eliminate pain is considered one of the most significant powers of a physician
- Failure to provide options for pain control, which may include many things, will often result in loss of patient confidence

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Assessing Pain – Physical Examination

- Physical exam
  - Especially specific to site of pain / injury
  - In eye care, this can be an extensive binocular evaluation
- General neurologic evaluation
- MOST IMPORTANT – Observe the patient!

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Pain Management Plans

Key Points

- Organism's recognition of ACUTE pain is vital for survival
- CHRONIC pain serves no beneficial physiologic or psychologic function
- Common problem with pain, especially chronic, is the ***"fix it NOW"*** expectation
- People experience pain – health care providers must offer solutions

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Ocular Pain

- Acute pain due to injury – cornea most common site
- Acute or chronic presentations due to:
  - Dry eyes or other chronic external eye disease
  - "Eyestrain"
  - Ocular presentation from external disease
  - Ocular manifestation of remote disease

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Pain Management Plan - Options

INTERVENTIONAL
- Surgery
- Nerve blocks
- Steroids
- Stimulators

PHYSICAL
- Exercise
- Physical therapy
- Manipulation (chiropractic)
- Acupuncture
- Hot / cold therapy

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Pain Management Plan - Options

COGNITIVE / BEHAVIORAL
- Meditation
- Behavior modification
- Counseling

PHARMACOLOGIC
- NSAID
- Opioids
- Anti-depressants
- Cannabinoids
- Topical anesthetics

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Pain Management Plan - Options

ALTERNATIVE
- Tai chi
- Yoga
- Meditation
- Massage / manipulation
- Specific herbs, botanicals
- Neuromodulators

ALL of these recognized by the American Society of Addictive Medicine as effective alternatives for pain management

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General Options by Pain Type

NOCICEPTIVE	NOCIPLASTIC	NEUROPATHIC	MIXED
Antihistamines	Anticholinergics	Anticonvulscents	Definite multi-specialty approach involving pain management specialists
Opioids	Serotonin agonists	Nerve block	
NSAID	Antidepressants	Opioids	
Nerve block		Alternative	
Topical			
Alternative			

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So, a word about corneal pain

- Corneal and ocular pain can be / is often VERY severe
- Pain medications, even Schedule II narcotics, can have minimal effect on curbing this pain
- Bandage lenses have far more pain controlling power than narcotics

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Non-Opioid Pain Medications

- tramadol
- gabapentin
- antihistamines
- Topicals (anesthetics, capsaicin)
- Non-steroids
  - acetaminophen
  - ibuprofen
  - naproxen
  - Does the acetaminophen/ibuprofen bomb work?

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Opioid Narcotic Choices

- meperidine (Demerol)
- Methadone
- fentanyl ← 2015-2019: 540% increase in overdose deaths
- **oxycodone (OxyContin)**
- Hydromorphone (Dilaudid)
- Percocet, Percodan
- hydrocodone (Vicodin, Norco, Lortab, Lorcet, Norcet, Lorcet)
- codeine

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Long-Acting Opioids – The Big Problem

- Morphine ER (Kadian)
- Morphine SR (MS Contin)
- Buprenorphine (Sublocade, Suboxone) ←
- Fentanyl patch (Duragesic)
- Methadone (Metadol)
- Oxycodone controlled release (OxyNeo, Targin)
- Hydromorphone (Hyrdomorph Contin)

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When To Consider Opioids

- *Typically* ONLY in moderate to severe nociceptive or neurologic pain
- *Typically* ONLY after non-opioid alternatives have failed to produce desired response
- **ALWAYS** only when the benefits outweigh the risks

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General Opioid Prescribing Guidelines for Ocular Pain Management

- First, consider if this level of intervention is warranted
- Consider the **smallest dosage possible for the least amount of time possible**
- Extended release options RARELY indicated
- Consider "at risk"
  - Pregnant
  - Adolescents
  - Sleep disorder
  - Dementia
  - Obesity
  - Renal / hepatic compromise

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Common Opioid Side Effects

INTERESTING - Incidence of side effects common but actual percentage unknown. May include:

- Respiratory depression (esp. with alcohol)
- Constipation
- Myoclonus
- Sedation / cognitive impairment
- Allergic reaction
- Tolerance / dependence

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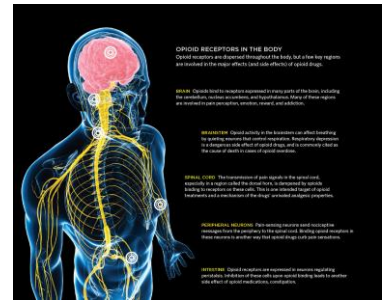

Opioid (Mu) receptors found ALL over the body but concentrated in the brain, spinal cord, peripheral neurons and intestine

A receptor is a receptor is a receptor…

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Managing Patients on Opioid Therapy

PREVENT PROBLEMS THROUGH PATIENT EDUCATION

- Discuss side effects
- Emphasize adherence to prescription instructions
- Avoidance with alcohol
- Discuss safe storage and disposal
- Emphasize NEVER sharing with anyone else
- Discuss need for emergency care – respiratory depression, GI obstruction, allergic reaction

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Monitoring Patients on Opioid Therapy

- Demand a REALLY good reason to break this rule – ***"lowest dosage possible for shortest duration possible"***
- If Rx > 7 days, consider co-prescription bowel regimen
- Re-evaluate 7-10 days then every three months – LET THE PATIENT KNOW YOU ARE MONITORING THEM – consider telling them you will know if they get additional Rx from another provider
- Work with the pharmacist
- Consider abuse-deterrent formulation (ADF Opioids) – cost factor but may become standard of care

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Opioid Misuse

It's common…look for it!

Risk assessment tools (http://core-rems.org/opioid-educational/tools/)

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Remember the tips to spotting the "addicted" patient

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Texas Medical Association position on physician self-prescribing

There is no prohibition on physicians treating themselves or members of their family

BUT…

"Physicians are prohibited from prescribing controlled substances for themselves or immediate family member unless it constitutes an immediate need. Even in that case, the prescription dosing is limited to a 72-hour supply."

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Thank you

QUESTIONS?

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