If At First You Don’t Prescribe

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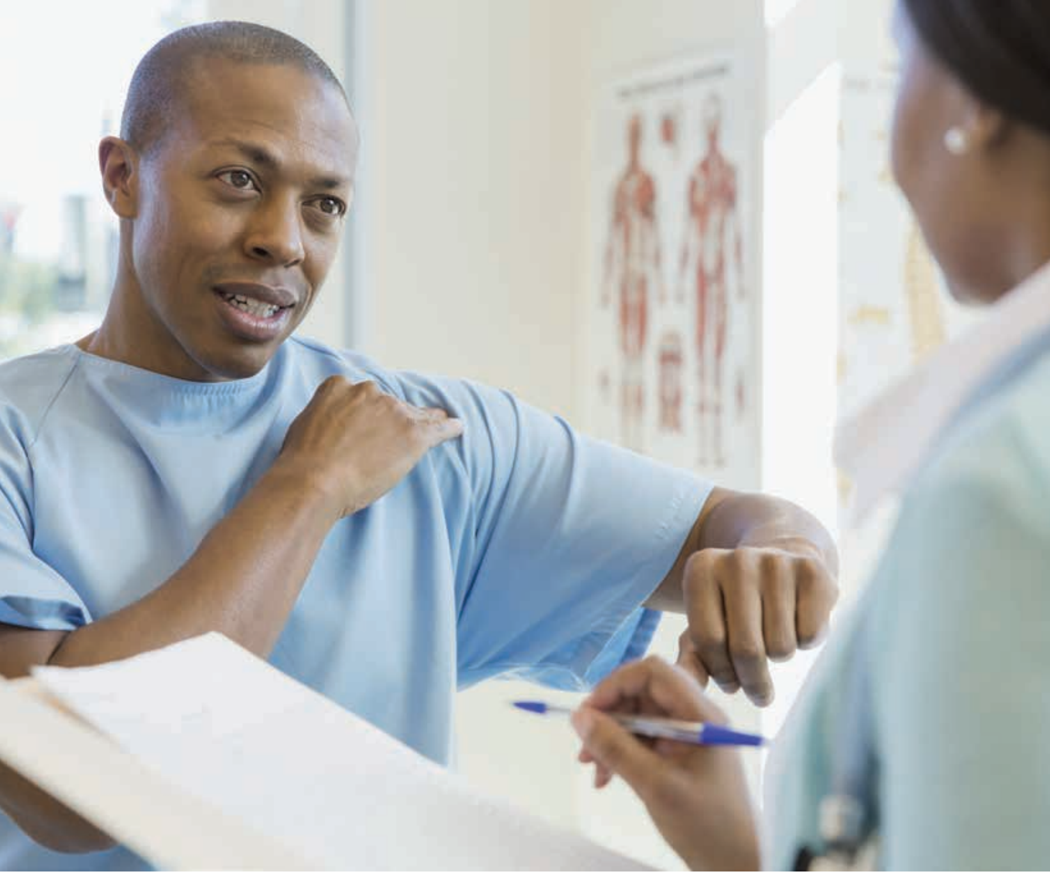


About this booklet

The current message in our mailboxes, inboxes, radio, television, and social media is to reduce or avoid prescribing opioids for our patients with non-terminal pain.

The opioid epidemic has received intermittent media attention as far back as 2008, yet, even as prescribing has gone down somewhat, it still remains alarmingly high, and the death rate continues to increase.

Some of the issues standing in the way of progress may be summed up as follows: as healthcare providers, we do not receive any formal training in pain management; time constraints, patient satisfaction surveys tied to bonuses, lack of coverage of alternative methods of pain management are additional issues that have been discussed as barriers to reaching our goals of improving healthcare outcomes for our patients as well as professional fulfillment as practitioners.

If At First You Don't Prescribe is intended to be a first step toward making real change in the way we think about and manage pain . . . and care for our patients.

A call to action

As medical practitioners, we are all familiar with the statistics:

- 52,000 Americans died from drug overdose in 2016 (33,000 from opioids).
- The United States accounts for only 5 percent of the world's population, but consumes 99 percent of the hydrocodone and 81 percent of the oxycodone.

The Surgeon General's Turn the Tide campaign correctly pointed out that healthcare professionals were encouraged in the 1990s to be more aggressive about treating pain (pain as the fifth vital sign) – in most cases without formal training in pain management. These attitudes may have also been communicated to patients. This combination may be responsible for the unintended consequence that is our current nationwide epidemic.

Real-life examples of the problem

- An oral surgeon routinely prescribes 40 Vicodin or Percocet to teenagers after wisdom teeth extraction (often a teen's first exposure to opioids)
- A general surgeon writes a prescription for an opioid at discharge after a low pain procedure and encourages the patient to fill it "just in case."
- A primary care, emergency, or urgent care physician, NP, or PA treats acute back injury, ankle sprain, or dental pain with opioids.

Did you know?

- Over half of people using prescription opioids for non-medical reasons obtained them from friends or family (e.g., taken from medicine cabinets)
- The highest risk of overdose is in the first 24-48 hours of therapy

These are just a few examples of the current state of affairs in our community. We are asking you to lead the change. This toolkit is intended to help guide you on how to do that.

Facts about opioids

Opioids bind to the same brain systems (CNS and PNS) as heroin and morphine (mu, delta, and kappa receptors). These receptors are present in the brain, GI tract, spinal cord, and other organs. They suppress the chemoreceptor response to hypercapnia, which leads to cardiac dysrhythmia, arrest and death. When they're used post-op for low-pain procedures, opioids increase the risk of long-term use by 44 percent at one year after surgery.

Did you know?

Opioids:

- Suppress the body's endorphin production with repeated use
- Can induce hyperalgesia (increased sensitivity to pain)*
- Do not increase function
- Do not address the cause or amplifying factors of pain

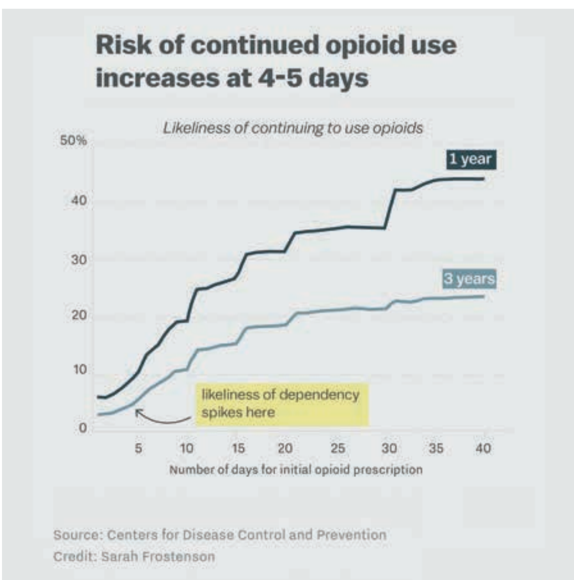
*This is strongly suggested by reviews, but evidence is experimental

Efforts to stem the tide

First Fill Limit, an executive order signed by Arizona Governor Doug Ducey on October 24, 2016, took effect on April 1, 2017. It limits the initial fill of any prescription opioid for non-cancer, non-terminal pain to no more than a seven-day supply.

The data from the Centers for Disease Control and Prevention (CDC), however, show that the likelihood of continuing opioids at one year begins to spike after only four to five days of use.

Sometimes, it takes only one pill.



So . . . what about not starting opioids at all?

Pain is a symptom of unidentified pathology. The onus is on us as practitioners to determine and address the pathophysiology of the pain, especially in the acute setting. Caveat: identification of pathology does not necessarily prove it is the cause of the pain experience.

100% pain relief is anesthesia!

We need to educate ourselves about realistic expectations for pain management so we can in turn educate our patients.

It's important to remember that 35 percent of people on opioids for chronic pain develop substance abuse disorder.

As pain becomes chronic, central sensitization plays a more dominant role than peripheral stimulation, regardless of the underlying diagnosis, and is accompanied by fatigue and slower cognition.

Opioids act on the central and peripheral nervous system, whereas non-opioids address inflammatory mediators (i.e., the underlying cause).

For chronic non-cancer pain, systematic reviews show opioids only moderately improved pain, function and disability as compared with placebo.

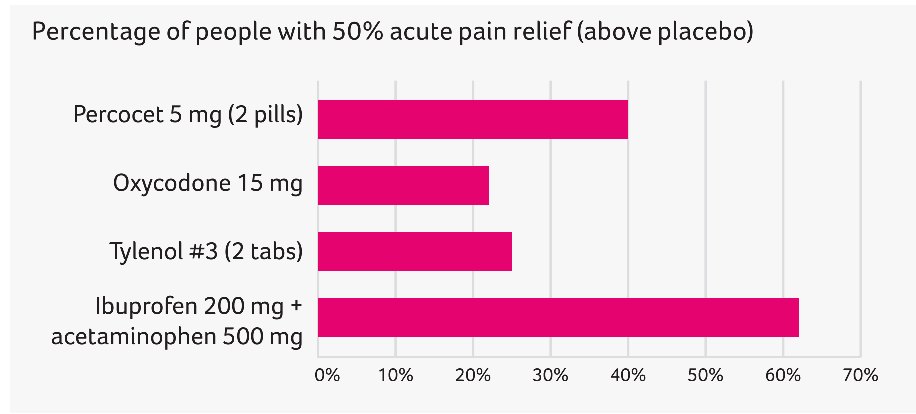
All pain is not created equal

Just as all infections are not the same, all pain is not created equal. You wouldn't treat a UTI the same way you would treat pneumonia. Likewise, nerve pain is not treated the same way as musculoskeletal or other types of pain.

- **Nerve (neuropathic) pain**, such as diabetic nerve pain, postherpetic neuralgia
  - — Opioids are not effective
  - — Best treated with gabapentin (well-studied and very effective for acute post-op and zoster pain), Neurontin, Lyrica, tricyclics, SNRIs (e.g., Cymbalta, Savella), topical anesthetics (lidocaine) and capsaicin
- **Dental pain** (post-procedure)
  - — Can be managed with NSAIDs, acetaminophen, and/or a long-acting anesthetic (i.e., bupivacaine), which lasts up to eight hours, or 72 hours, when used in liposomal form post-procedure. This could also potentially be used in the emergency department or urgent care for acute dental pain pending referral for definitive treatment. A recent review in the *Journal of the American Dental Association* concluded that ibuprofen and acetaminophen in combination is the best treatment for dental pain.
- **Psychogenic pain** (pain with psychological overlay)
  - — Most effectively treated with antidepressants, anxiolytics, atypical antipsychotics
- **Nociceptive inflammatory and mechanical pain** (e.g., rheumatoid arthritis)
  - — Best treated with NSAIDs, corticosteroids, DMARDs
- **Bone pain**
  - — Better treated with NSAIDs, corticosteroids, bisphosphonates, salmon calcitonin
- **Muscular pain**
  - — More responsive to muscle relaxers, diazepam

Treating acute pain

Studies show that non-narcotic medications are **superior** to opioids for acute pain



- The first completed randomized, controlled trial of opioids vs. non-opioid for chronic back pain and osteoarthritis took place at the Minneapolis Veterans Administration Hospital. It was presented at the annual meeting of the Society of General Internal Medicine in Washington, D.C. in April 2017. Among 240 veterans over 12 months, more patients in the non-opioid group had significant improvement, and those in the opioid group had more side effects.
- Several Cochrane Reviews have shown that ibuprofen 200 mg + acetaminophen 500 mg is MORE effective for acute pain than any opioid used alone or in combination with acetaminophen:
  - — A review of 20 studies (2,641 participants) of oxycodone 15 mg for post-op pain: the number needed to treat (NNT) for at least 50 percent pain relief was 4.6 vs. 2.7 for oxy 10 mg + paracetamol [acetaminophen systemic] 650 mg. (Gaskell, Derry, Moore, and McQuay, 2009). The NNT for ibuprofen/acetaminophen as above, in a separate study, was only 1.6. (CJ Derry, Derry, and Moore, 2013)
  - — Naproxen for post-op pain-NNT for at least 50 percent pain relief for 4-6 hours was 2.7 (95 percent CI 2.3-3.2) (C. Derry & Derry, 2009)
  - — Renal colic: In 2009, 20 trials from 9 countries (1,613 participants) showed NSAIDs provided pain relief EQUAL to opioids, with fewer side effects. (Holdgate & Pollock, 2004).
- Post-operative pain may also be treated with long-acting liposomal bupivacaine (FDA approved October 2011). A single dose infiltrated into the surgical site at closure is associated with both pain relief for 72 hours and a 45 percent reduction in total opioid consumption at 72 hours (Formulary. 2012; 47:212–226.)

Non-drug therapies to consider

- Diet – alpha lipoic acid, acetyl-L-carnitine. Not well studied, but potentially important.
- Cognitive behavior therapy (CBT)
- Exercise regimens
- Neurofeedback – promising results in altering pain perception. Patients learn to regulate specific regions in the brain via feedback from real-time EEG. Provided by psychologists, family therapists, and counselors.
- CAM (complementary and alternative medicine) approaches
- Stimulators (e.g., TENs)
- Nerve blocks
- Osteopathic manipulation

If all else fails, and you decide treatment with opioids is needed

Once all efforts have been made to diagnosis and treat pain and opioids are considered the last option, it's important to:

- Assess risk using a standardized tool:
  - ORT (www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf)
  - DIRE (integratedcare-nw.org/DIRE_score.pdf)
- Recognize that, according to Veterans Affairs, approximately 15-35 percent of people with chronic pain have post-traumatic stress disorder (PTSD). These patients are largely under-identified, but would be picked up with proper screening. Helpful risk assessment tools are ACE, BPI, GAD 7, and PHQ9. The test of your choosing could be completed by your patient with the help of a nurse or medical assistant before you enter the room, in the interest of time.
- Obtain a baseline urine drug screen and repeat periodically (two-four times per year, randomly)
- Check the CSPMP (may be state-specific) at baseline and each time you write a new prescription to see what other controlled substances prescriptions the patient may have filled. Coordinate care with other treating physicians.
- Explain the risks and benefits of treatment with opioids to the patient and obtain a signature acknowledging their understanding documented in a patient-provider opioid agreement (www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf)
- Coordinate care with the patient's other providers, where appropriate.

What not to do

- Do not "fire" or abandon your patient who is using opioids. Some educational resources about strategies to help these patients are available in the links below. These patients may need your help more than ever.
- Opioid withdrawal can present as acute pain or GI symptoms. You should refer these patients to a treatment or detox center, not treat them with additional opioids.

Where to go for more information

- Project ECHO
  www.weitzmaninstitute.org/project-echo
- The Pain Project: Chronic Pain Treatment and Opioid Alternatives
  ww.thepainproject.com
- SAMHSA Treatment Locator
  1-800-662-HELP
- Free CME-American Academy of Pain Medicine
  www.painmed.org
- Virtual Lecture Hall
  www.vlh.com
- Arizona drug drop-off sites
  www.acpa.net/arizona_drug_disposal_locations.aspx

Pain management providers and resources

- National Institute on Drug Abuse
  www.drugabuse.gov
- Arizona Governor's Office of Youth, Faith and Family
  substanceabuse.az.gov
- Advocates for Opioid Recovery
  www.opioidrecovery.org

Preventing or reducing opioid abuse and overdose

Selected resources

- www.samhsa.gov/capt/sites/default/files/resources/preventing-reducing-opioid-abuse-overdose.pdf
- AZ Criminal Justice Commission Initiative Strategies
  azcjc.gov/ACJC.Web/Rx/toolkit.aspx
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Prescription Drug Misuse and Abuse
  www.samhsa.gov/prescription-drug-misuse-abuse/samhsas-efforts
- Prescription Drug Monitoring Program (PDMP) Training and Technical Assistance Center www.pdmpassist.org/content/resources-products

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Researched and written by Elisa S. Mashal, M.D.

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