

TREATMENT OF CHRONIC PAIN

Current Evidence on Approach to Treatment

Addressing Related Issues of Prescription Medication
Addiction and Diversion

State of Maine Initiatives

- Health Professions Licensing Boards, Joint Rule Chapter 21, Use of Controlled Substance for Treatment of Pain (1999)
- MDEA Rule Chapter 1, Requirements of Written Prescription of Schedule II Drugs (Tamper-resistant scripts)
- L.D. 945 An Act to Facilitate Communication between Prescribers and Dispensers of Prescription Medication (P.L. 2003, Chapter 48; effective 9/13/2003) Prescription Monitoring Program
- State Office of Substance Abuse: Ongoing grants to MMA to educate prescribers, through NASPER (National All Schedules Prescription Electronic Reporting Act), and OSA PMP resources on its website
- Continuing work of the Office of the Chief Medical Examiner and the Margaret Chase Smith Policy Center of the University of Maine
- LD 1501
- Attorney General Summit: October 25, 2011, Point Lookout, Northport, ME

Resources on PMP Web

Resources for Prescribers: <http://www.maine.gov/dhhs/osa/data/pmp/prescriber.htm>

Resources for Dispensers: <http://www.maine.gov/dhhs/osa/data/pmp/dispenser.htm>

Resources for Patients: <http://www.maine.gov/dhhs/osa/data/pmp/patients.htm>

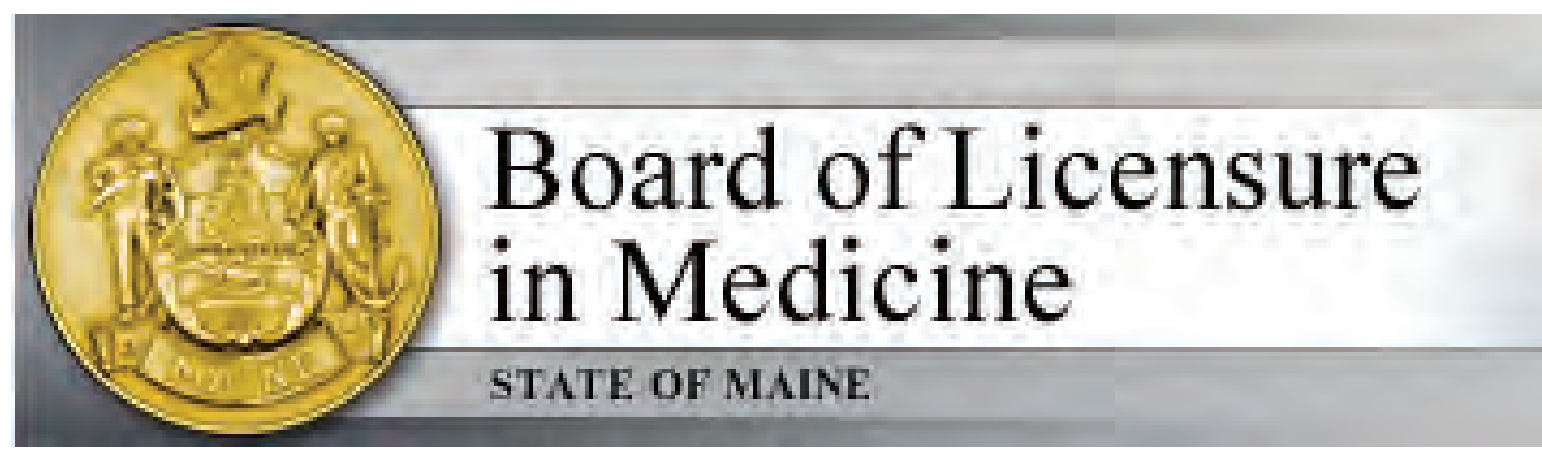
Reports: <http://www.maine.gov/dhhs/osa/data/pmp/reports.htm>

Federal Response and Resources:

- Management of Opioid Therapy of Chronic Pain. May 2010. Clinical Practice Guideline from Dept. of Veterans Affairs /Dept. of Defense. (This is a large document, 125+ pages)
- www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp
- Coming from the US Food and Drug Admin: REMS for Opioids. Expected date is early 2012. Current proposal makes this education voluntary for prescribers.
- Ongoing meeting with the US Attorney's Office
- Executive Office of the President: Epidemic: Responding to America's Prescription Drug Abuse Crisis. (2011, 10 pages)
- Institute of Medicine Report, June 29, 2011
- National Institute on Drug Abuse (NIDA)

MMA Initiatives

- Ongoing OSA-funded CME sessions on responsible opioid prescribing—see www.mainemed.com for details.
- MMA/BOLIM Chronic Pain Project—free, confidential in-office consultations available, along with CME Home Study materials. Contact Gordon Smith at gsmith@mainemed.com for details.
- Representation of Maine Physicians and Physician Assistants at all in-state meetings related to treatment of chronic pain, prescription medication addiction, diversion, and improvement of access to evidence-based therapies.
- Communication with MMA and DEAPA members regarding on-going initiatives, such as medical marijuana updates, participation in the PMP Advisory Committee, and communication with the BOLIM.
- In-office CME presentation through MICIS, the Maine Independent Clinical Information Service.



MMA/BOLIM Chronic Pain Project

September, 2011

From Spring, 2008 to Fall, 2010, approximately 250 Maine prescribers, along with their staffs, took advantage of consults offered by the Chronic Pain Project. The Project is funded by the BOLIM, administered by MMA, and available to all Maine prescribers and their staffs. About 1000 patient records were reviewed, with the goal of improving care of patients with chronic pain. An on-line or hard copy CME Home Study has also been part of the Project.

An updated CME Home Study will be available in late 2011. Consults will also again be available, on Fridays only. For further information on the Chronic Pain Project, please contact Gordon Smith, EVP of MMA, or Noel Genova, PA-C, Project Director, at noelpac@aol.com, cell phone 207-671-9076.

New Take Home Points—2011

- Evidence regarding the effectiveness of long-term opioids for treatment of chronic pain is weak, especially for headaches, fibromyalgia, and non-structural back pain.
- Risk of death with chronic opioid use, especially for doses higher than 100 mg/day morphine equivalent, is significant.
- According to the IOM's report, released in June, 2011, treatment of chronic pain presents a major public health challenge. Changes in culture, funding, and overall approach to the problem must be developed.
- Overall, medications alone are not effective. A multidisciplinary team approach must be used. Reimbursement for this approach is not always available.
- Many—but not all—patients currently on chronic opioid therapy will need to be tapered off of their medication. They may benefit from therapies such as Cognitive Behavioral Therapy and multidisciplinary functional restoration programs.
- Resources for chronic pain treatment will need to be developed in each community.

Old Take Home Points—2008, Still Valid in 2011

- Addiction to, and diversion of opioid medication intended for use to relieve chronic pain remains a major public health problem in Maine.
- Utilization of the Prescription Monitoring Program (PMP), use of drug screens, pill counts, and treatment agreements ("contracts") are all important, but cannot prevent unintended adverse outcomes associated with chronic opioid medication therapy.
- Effectiveness of treatments must be evaluated based on improvement of function.

WE WANT YOUR COMMENTS AND QUESTIONS

Please write comments and questions on the index cards provided, and place them in the box. We need to know about your challenges in treating patients with pain in your practice settings. We will use your input to develop the CME Home Study, and other MMA/BOLIM Chronic Pain Project materials. If you would like us to contact you for any reason, such as to arrange a confidential consult, or a phone conversation regarding treatment of patients with pain, please include your contact information on the card.

THANKS!

Evidence-Based Treatment of Chronic Pain

Pain remains an important public health concern in the US. While there is good evidence of benefit from the use of opioid medication short term in acute pain, and clinical practice and previous interpretation of the literature have suggested that opioid medication may be useful in treatment of chronic pain, new evidence shows:

- Reduced efficacy compared to older studies,
- Increased risk of drug-related death, especially with higher doses,
- Greater risk of addiction than is found in controlled trials, and
- Greater risk to the community because of diversion.

Improved treatment of chronic pain represents a public health challenge, as appropriate resources, and reimbursement for those resources, along with good research to guide treatment planning, is lacking.

Addiction and Diversion

- Studies consistently show low rates of addiction among patients treated with chronic opioid medication. However, most studies exclude patients with a history of substance abuse. Patients with a history of substance abuse, which may go unrecognized in primary care settings, are likely to show addictive behaviors around their use of prescription opioids.
- Use of “Universal Precautions”—checking the Prescription Monitoring Program (PMP), performing urine drug tests, requesting random pill counts, and utilizing treatment agreements (“contracts”) is a critical part of responsible opioid prescribing.
- Screening patients for addiction does not address the problem of diversion. Patients who divert their medication do not necessarily have an opioid addiction. They may trade their medication for other drugs or simply sell them.
- While many patients who die of prescription opioid drug-related death have never been prescribed an opioid medication, most opioids that are taken illicitly originated in a prescription. Collectively, prescribers may be able to impact on the number of drug-related deaths by altering their (our) prescribing patterns.

Drug-Related Death

- Recent studies show dramatic rises in both unintentional drug overdoses and drug-related deaths in the past 10 years. Maine’s rate of drug-related death is high (179 deaths in 2009), and the numbers of such deaths exceed the number of motor-vehicle accident-related deaths in some recent years.
- In Maine and nationally, the rise in drug-related deaths parallels a rise in prescription of opioids.
- Increased dose of opioid medication, as well as use with benzodiazepines or alcohol, are linked to increased chance of drug-related death.

Specialty Referral

- Although most patients with chronic pain are treated by Primary Care Providers, good communication with pain specialists and other members of the treatment team is essential.
- Patients who misuse their medication, or show signs of addiction, are best referred to an addiction treatment facility. Some medical pain management specialists treat the issue, but many do not.
- Interventional pain management specialists typically do not manage chronic opioid use, and do not address issues of potential aberrant medication use. Their area of expertise is in use of interventional strategies, such as injections, to reduce chronic pain.
- Patients who are not responding well to medication management, and are not candidates for interventional pain strategies, are best referred to medical pain management specialists. Opioid therapy in these patients usually should be discontinued, preferably by tapering.
- In many parts of Maine, access to appropriate pain and addiction medicine specialists is limited. Several advisors to the MMA/BOLIM Chronic Pain Project have made themselves available for phone discussions. Contact Gordon Smith, EVP of MMA, or Noel Genova, PA-C, Project Director, for further information.

Efficacy (or lack thereof) of Chronic Opioid Therapy

- Very few studies are long-term, lasting only up to 16 weeks.
- A cohort study showed that only 17% of patients who had shown response to long-acting oxycodone were still using the medication after 36 months.
- There is no evidence for efficacy for headache, non-structural chronic back pain, and fibromyalgia.
- Studies do not typically address the issue of opioid-induced hyperalgesia, which refers to increased sensitivity to painful stimuli, caused by use of opioid medication.
- High-dose chronic opioid therapy leads to difficulty in treating acute pain, such as post-surgery or associated with injury.

Chronic Pain in the Elderly

- Studies show that chronic pain is undertreated in the elderly. There are many options for treatment, including opioid medications, which may be a reasonable part of the therapeutic plan. However, bear in mind....
- Medication may be diverted by caregivers, thereby further undertreating the patient’s pain, and putting others at risk of adverse events due to medication misuse.
- Diminished cognition and increased risk of falls, along with constipation, may limit the use of chronic opioid medication.
- Risks increase with polypharmacy, especially with other sedating medications such as benzodiazepines.

The Challenge Ahead—A Team Approach is Needed

- The 2011 Institute of Medicine (IOM) Report on the treatment of chronic pain calls for a public health approach to this major medical issue.
- The treatment effect of medications is low.
- Comprehensive functional restoration programs, while found to be more effective than opioids when used alone, are not generally paid for by insurance.
- Incorporation of multiple strategies requires communication among clinicians in various professions, such as providers of CBT (cognitive behavioral therapy), pain psychologists, and Osteopathic Physicians who utilize Osteopathic Manipulative Therapy (OMT).
- Many patients benefit from fairly simple interventions, such as massage therapy or counseling with a Master’s level therapist, available in many communities.

References

- Bohnert AS, Valenstein M, Bair MJ, et al; Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths; *JAMA*; 305(13); 1315-1321.
- Chou R, Fanciullo GJ, Fine PG et al; Opioid Treatment Guidelines; *The Journal of Pain*; Vol. 10, #2; Feb, 2009; 113-130.
- Dunn KM, Saunders KW, Rutter CM et al; Opioid Prescriptions for Chronic Pain and Overdose; *Annals of Internal Medicine*; 2010; 152:85-92.
- Hall AJ, Logan JE, Toblin RL et al; Patterns of Abuse Among Unintentional Pharmaceutical Overdose Fatalities; *JAMA*; Vol. 300, #22; Dec. 10, 2008; 2613-2620.
- MMWR; Overdose Deaths Involving Prescription Opioids Among Medicaid Enrollees—Washington, 2004-2007; Oct. 30, 2009; 58(42); 1171-1175.
- Portenoy RK, Farrar JT, Backonja MM et al; Long-Term Use of Controlled-release Oxycodone for Noncancer Pain: Results of a 3-Year Registry Study; *Clinical Journal of Pain*; Vol. 23, #4; May, 2007.
- Helping the Hurt, Without Hurting the Patient: A Guide to Outpatient Management of Chronic Pain; The Alosa Foundation, July, 2011. Final materials not yet in print, but will be available through the Maine Independent Clinical Information Service (MICIS) in late 2011. Contact MMA for further details.
- Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research; Institute of Medicine; June, 2011. Available at www.iom.edu/relievingpain.

Helpful Links

- American Society of Addiction Medicine. www.asam.org.
- www.painjournalonline.com. Online access to the *Journal of the International Association for the Study of Pain*.