

Same Pain,
New Game:
Updated
Guidelines for
Chronic Pain

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1

Disclosures

- The presenter has no actual or potential conflict of interest in relation to this presentation
- This presentation will include discussion of off-label use of buprenorphine

2

Objectives

Pharmacist:

- Identify recommendations from the CDC/VA guidelines for pain management
- Interpret recommendations in order to relate to patient care
- Compare buprenorphine to other opioids to provide informed care for patients

Technician:

- Recognize recommendations from the CDC/VA guidelines for pain management
- Define strategies for safe opioid use
- Recognize different opioid pain management strategies

3

Guideline Updates

- Initiation and continuation of opioids
- Dose, duration, and taper of opioids
- Screening, assessment, and evaluation
- Risk mitigation

4

Roadmap

Key categories:

- Assessing candidates for opioid use
- Considerations when starting opioids
- Opioid tapering suggestions
- Risk mitigation

Focus area:

- Buprenorphine use for pain

5

Recommendations not covered in detail (outside scope)

- VA Recommendation 4: No preferences between methadone, buprenorphine, or naltrexone for opioid use disorder.
- CDC Recommendation 1: Nonopioid therapies are at least as effective as opioids for acute pain.

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6

Definitions

- Acute pain – sudden onset, time limited, known causes
- Subacute pain – pain present for 1-3 months
- Chronic pain – pain present for >3 months

CDC Clinical Practice Guidelines for Prescribing Opioids for Pain – revised January 2022. Publication Number 2022

7



Patient: Tom (57 yo)
 PMH: Chronic low back pain, CKD, diabetes, high blood pressure
 Medications:
 -Metformin 5000 mg TID
 -Lisinopril 20 mg daily
 -Acetaminophen 500 mg TID PRN
 -Voltaren gel to knees 4 times daily

8

Roadmap

- Assessing candidates for opioid use**
 - VA Recommendations 1, 2, 3; CDC Recommendation 2
- Considerations when starting opioids
- Buprenorphine use for pain
- Opioid tapering suggestions
- Risk mitigation

9

Assessing patients prior to starting opioids:

For whom should I avoid opioids?

- Patients at higher risk for opioid use disorder (OUD) and overdose (OD):
 - Younger patients
 - Previous substance use disorder (SUD)
- Chronic non-cancer pain (VA guideline)
 - If considering daily opioids for chronic pain, consider buprenorphine instead of full agonist opioids

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10

Younger Patients

- Compared to patients >65 yo:
 - 18-30 yo had 11x risk of OUD and OD
 - 31-40 yo had 5x risk of OUD and OD
- Compared to 30-39 yo:
 - 18-29 yo patients had double the risk of OUD or OD

Previous SUD

- Study with >200K patients found patients with alcohol use disorder or other SUD had significantly higher risk of OD
- VA study of >150K patients found HR of 2.53 of OD death for patients with SUD and chronic non-cancer pain

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11

Assessing patients prior to starting opioids:

Alternatives to opioids

- Conduct bio-psycho-social assessment
- Establish treatment goals and functional goals
- Maximize nonpharmacologic therapies
- Nonopioid therapies are preferred for subacute and chronic pain
- Discuss realistic benefits and known risks of opioid therapy

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12




Bio-psycho-social assessment

- Complete pain assessment (PQRST)
- Previous treatments for pain and results
- Impact of pain on daily functioning and quality of life
- Evaluate psychological/behavioral factors (suicide risk, pain avoidance, pain catastrophizing)
- Evaluate social situation
- Assess co-occurring conditions and confirm diagnosis
- Physical exam
- Assess patient beliefs and understanding of cause of pain, treatment preferences, perceived efficacy of treatment options

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13

Functional Goal Setting

-  Setting functional goals can be effective in increasing motivation and functioning
-  Goals should be measurable
-  Include improvement in function in social, emotional, and physical aspects to improve quality of life

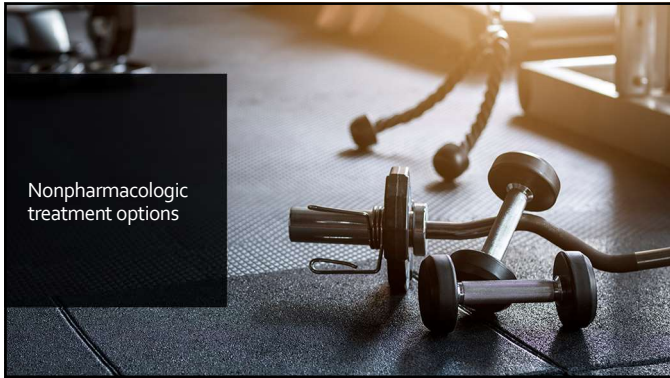
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14

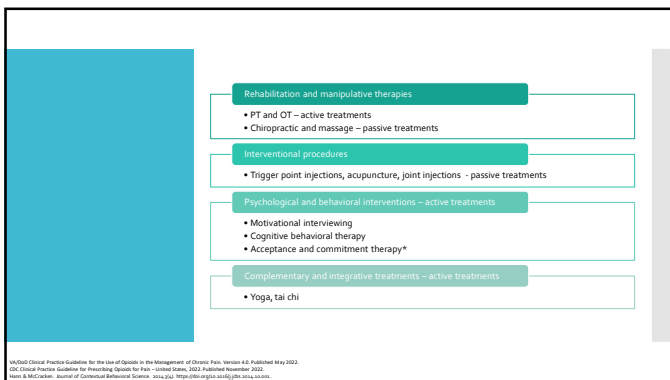
Functional Goal Examples

- I will walk to the mailbox and back every day this week
- I will practice breath work/meditation for 5 minutes on 4 days of the week for the next 2 weeks
- I will reach out to my mom 1 time each week for the next 4 weeks

15



16



17



18



**Patient Case:
Tom (57 yo)**

- PMH: Chronic low back pain, CKD, diabetes, high blood pressure
- Medications:
 - Metformin 3000 mg TID
 - Lisinopril 20 mg daily
 - Acetaminophen 300 mg TID PRN
 - Voltaren 4g 4 times daily
- Tom comes to you today complaining of worsening pain that is limiting his ability to play with his grandson. He is still able to work.
- Imaging shows degenerative disk disease at multiple levels in his spine
- What therapies are appropriate to offer Tom?

19

What therapy should Tom be offered?

- PMH: Chronic low back pain, CKD, diabetes, high blood pressure
- Medications:
 - Metformin 3000 mg TID
 - Lisinopril 20 mg daily
 - Acetaminophen 300 mg TID PRN
 - Voltaren 4g 4 times daily
- Imaging shows degenerative disk disease at multiple levels in his spine

What therapies are appropriate to offer Tom?

A. Start ibuprofen 200-400 mg every 8 hours as needed

B. Start oxycodone 5 mg every 4 hours as needed

C. Refer Tom to physical therapy

20

Roadmap

- ✓ Assessing candidates for opioid use
- ⊕ Considerations when starting opioids
 - VA Recommendations 5, 7-11; CDC Recommendations 3-7
- Buprenorphine use for pain
- Opioid tapering suggestions
- Risk mitigation

21

Recommendations for Starting Opioids

- Discuss risk vs benefits of opioid therapy with patients
- Use the **lowest effective dose**
- Use the **shortest duration** as indicated for expected duration of severe pain
- Recommend evaluation within **1-4 weeks (CDC)** or within 30 days (VA) and re-evaluate benefits and risks of opioids
 - Including opioid use disorder and risk of overdose
- Avoid increasing doses above levels that would yield diminishing returns

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22

Realistic Expectations of Opioid Benefits

- A 2018 study encompassed over 26,000 patients from 96 RCTs and found that, in patients with chronic non-cancer pain, opioids provided small and **not clinically significant improvements** in pain and physical functioning compared to non-opioid controls
- A different review study found benefit but did not include information on improvements in quality of life
- Lack of robust evidence that opioids improve pain or function with long term use and **complete elimination of pain is unlikely**
 - Function can improve without pain elimination

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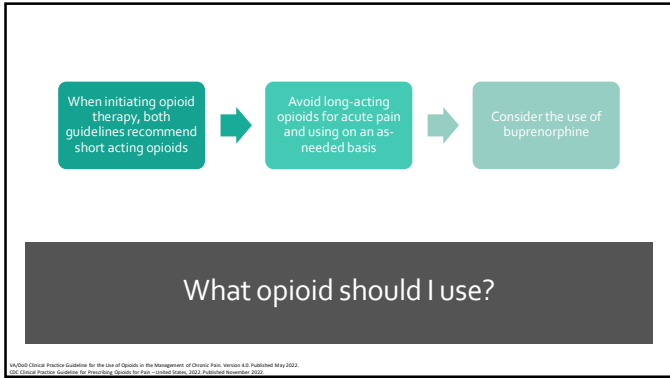
23

Risks of long-term opioid therapy

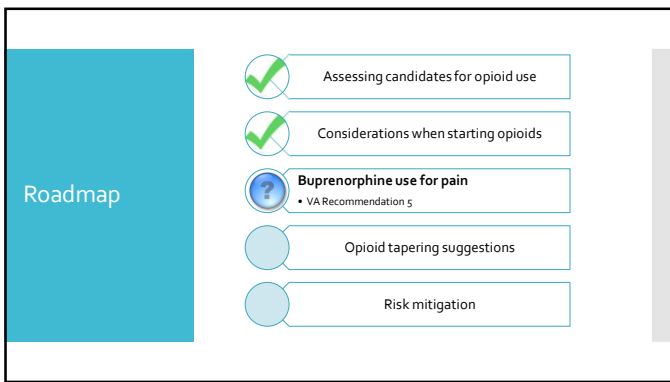
Higher doses have been shown to lead to a higher risk of OD and OUD	• Patients with > 100 oral morphine equivalents have anywhere from 4-12x increased risk for OD
Longer use has been shown to lead to higher risk of OD	• Use between 31-89 days have 4x risk of opioid related death • 90-379 days had 7x risk of opioid related death, increased risk of OUD
Increased risk of all-cause death	• Fractures, falls, myocardial infarction
Physiologic effects	• Hormone dysfunction, immune system effects, risk for hypoxemia, neurotoxicity

Patel A, et al. Pain Case. *Comparative Opioid Use*. 2022;14(3):101-114(10/20)

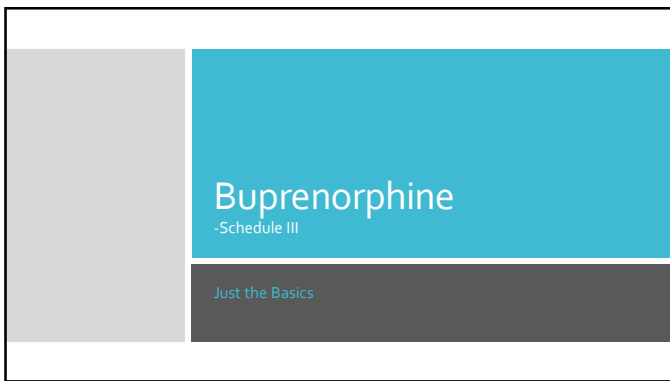
24



25



26



27

How comfortable would you be caring for someone with pain on...

- Buccal buprenorphine films?
- Transdermal buprenorphine?
- Sublingual buprenorphine tablet?
- Sublingual buprenorphine film with naloxone?

28

Basic Pharmacokinetics

- Actions on opioid receptors**
 - Mu – partial agonist
 - Delta – antagonist
 - Kappa – antagonist
- Bioavailability**
 - Oral – 10-15%
 - SL (tabs) - ~30%
 - Buccal – 45-65%
- Elimination/dosing in renal/hepatic disease**
 - Renal – no adjustments needed
 - Hepatic – no adjustments needed*

Pfizer & Wilkins. Bupren. 2013. P&G 1111-4.
 Smith et al. Drug. 2014. 40(1):11-18.
 Evaluation of the Pain Patch. 2014. 10(1):1-10.

29

	Available strengths	FDA Indications
Transdermal patch	5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr	Pain management
Buccal film	75 mcg, 150 mcg, 300 mcg, 450 mcg, 600 mcg, 750 mcg, 900 mcg	Pain management
Sublingual tablet/film	2 mg, 8 mg With naloxone: 2 mg-0.5 mg, 4 mg-1 mg, 8 mg-2 mg, 12 mg-4 mg	Opioid dependence

Formulation Differences

Buccal (package insert) Bupren, NC: EndoPharm Sciences International, Inc., 2015.
 Buccal (package insert) Bupren, CA: Purdue Pharma LP, 2016.
 Sublingual (package insert) Naxol, DavaPharm, VA: Mallinckrodt, Inc., 2016.

30

Will the buprenorphine block other opioids?

Buprenorphine Daily Dose	Mu Opioid Receptor Occupancy
1 mg	15-29%
2 mg	28-47%
4 mg	45-64%
8 mg	78-89%
16 mg	81-91%
24 mg	85-96%
32 mg	88-98%

Buprenorphine 20 mcg/hour patch delivers 0.48 mg per day

Chou & Cheng. Pain Med. 2013; 14(10):1071-1081

31

Buprenorphine Evidence for Pain

- Safety compared to traditional opioids:
 - 254 participants in a study of buprenorphine, there were no accidental overdoses
 - Ceiling effect on respiratory depression
- Efficacy compared to traditional opioids:
 - 2021 study compared pain reduction with buprenorphine to pain reduction with other opioids (hydrocodone, hydromorphone, morphine, oxycodone, oxymorphone, tramadol, and tapentadol), in most cases showing no difference

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32

Summary of Buprenorphine

<p>Benefits:</p> <ul style="list-style-type: none"> Maintained efficacy Decreased side effect profile Decreased development of tolerance, antihyperalgesic effects, decreased dysphoria and decreased cravings Decreased risk of overdose Flexible dosing for opioid naïve and tolerant patients 	<p>Drawbacks:</p> <ul style="list-style-type: none"> Formulation availability FDA approval based upon formulation Lack of understanding Potential stigma
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33

Assessment Question

Which of the following formulations of buprenorphine are approved for chronic pain and will not block other opioids from working?

- A. Transdermal buprenorphine
- B. Buccal buprenorphine (film, dosed in mcg)
- C. Sublingual buprenorphine (film or tablets dosed in mg)
- D. A and B
- E. All of the above

34

Roadmap

- Assessing candidates for opioid use
- Considerations when starting opioids
- Buprenorphine use for pain
- Opioid tapering suggestions**
 - VA Recommendations 12-13; CDC Recommendation 5
- Risk mitigation

35

Tapering Opioids

36

Taper of Opioids

- Suggest a collaborative, patient-centered approach to opioid tapering
- Opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages
- There is insufficient evidence to recommend for or against any specific tapering strategies

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37

The VA offers examples of statements to begin discussions:

- "Evidence shows that the best treatments for chronic pain are options such as behavioral interventions, rehabilitation therapies, and non-opioid medications."
- "Science has demonstrated that long-term opioid use can lead to multiple problems including loss of pain-relieving effects, increased pain, unintentional death, OUD, and problems with sleep, mood, hormonal dysfunction, and immune dysfunction. I am concerned about your health and safety."
- "While opioids were prescribed to you, we now understand in general that the risks outweigh the benefits when opioids are used long-term. Let's work on reducing your dosage of opioids and discuss other treatment options."

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38

Barriers to Tapering

- Patient and provider disagreement
 - CDC guidelines acknowledge this with the following statement: "clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner while avoiding patient abandonment"
- Symptoms of withdrawal
- Patient fear

39

Resources for Tapering

- VA Guide to Tapering Opioids: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P9682o.pdf
- Gives general information on appropriate dose reductions, how to treat withdrawal symptoms

40

Roadmap

- ✓ Assessing candidates for opioid use
- ✓ Considerations when starting opioids
- ✓ Buprenorphine use for pain
- ✓ Opioid tapering suggestions
- ⚠ **Risk mitigation**
 - VA Recommendation 6, 14-20; CDC Recommendations 8-12

41

Risk Mitigation

- Assess risks of opioid use and offer naloxone
- Suggest urine drug testing for patients on long-term opioids
- Clinicians should review the patient's history of controlled substance prescriptions
- Clinicians should use caution when prescribing opioids and benzodiazepines concurrently
- Suggest interdisciplinary care that addresses pain and/or behavioral health problems
- Suggest providing pre-operative opioid and pain management education to decrease the risk of prolonged opioid use for post-surgical pain
- Clinicians should offer or arrange treatment with evidence-based medications to treat patients with OUD

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42

Risk Assessments

Risk assessment to avoid harm:

- Contraindications to opioids:
 - SUD not in remission
 - Elevated suicide risk
 - Concomitant use of benzodiazepines
- If on opioids:
 - Self-escalation in doses
 - Early refills
 - Cravings
 - Interpersonal/social problems related to opioids

Checklist prior to prescribing opioids:

- Risks to not outweigh potential functional benefits
- Condition causing severe chronic pain, interfering with function, not responding to other treatments
 - Clear and measurable goals established
- Patient is willing and able to follow up
- PDMP and urine screen appropriate
- Patient is informed and consents to treatment

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43

Access to Naloxone

- Individual prescription
- Standing order
- Over the counter – approved and coming soon!
- Who should be offered / recommended to have naloxone?

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44

<h3>Urine Drug Screen</h3> <ul style="list-style-type: none"> • The VA guideline did not specify frequency • Annually recommended per CDC 	<h3>PDMP</h3> <ul style="list-style-type: none"> • Per law: before prescribing or dispensing a controlled substance • Recommendations: prior to initial opioid prescription, then every 3 months, at minimum
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How often do I check?

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45

Roadmap

- ✓ Assessing candidates for opioid use
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- ✓ Opioid tapering suggestions
- ✓ Risk mitigation

46

How does this look in practice?

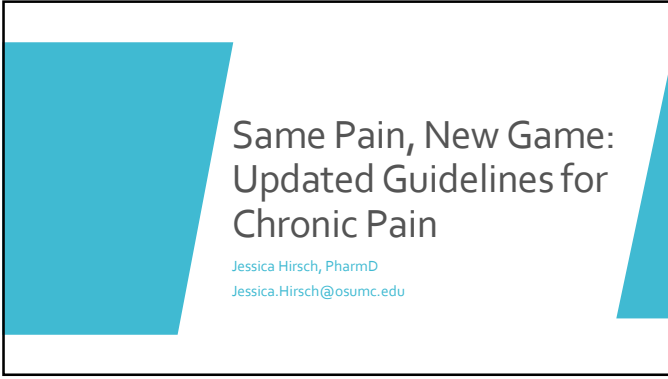
- Ohio State's Chronic Pain Team
 - MD, NP, pain psychologist, physical therapists, social workers, pharmacist, occupational therapist
- Initial appointment
 - 3-hour block to meet with each discipline for evaluation
 - Obtain baseline assessment
- Follow up appointments
 - Nearly always with social work/pain psychologist and PT
 - As needed with pharmacist and others
- Did not take over prescribing anything, recommendations made to PCPs and counseling and PT tailored to patients
- Grant funded

47

Key Take Home Points

- Assess patients and share risk vs benefits of opioid therapy
- If possible, explore nonpharmacologic options and nonopioid medications prior to starting opioids
- For patients on opioids, maximize other pain management modalities, assess risk vs benefit
- For tapering, take a patient centered approach and avoid discontinuing opioids suddenly
- Utilizing a team, close monitoring, and patient education can reduce risk surrounding opioid use
- Embrace buprenorphine as a viable option for chronic pain if opioids cannot be avoided

48



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49
