Opioid Treatment Guidelines

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• Chronic opioid therapy to treat “chronic non-cancer pain” (CNCP) is controversial

• Opioid prescriptions have increased substantially over the last 20 years
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• An increase in prescription opioid misuse and mortality associated with opioid use has also been observed

• A balanced approach to opioid use while recognizing the serious public health concerns is needed
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- The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) commissioned a multidisciplinary panel to develop evidence-based guidelines for chronic opioid therapy for CNCP
- Published 14 guidelines in 2009
#1 Patient Selection and Risk Statification

- Before initiating COT, clinicians should conduct a history, PE, appropriate testing and do an assessment of risk of substance abuse, misuse, or addiction.

- Consider a trial of COT if CNCP is moderate to severe and impacts quality of life.
#1 Patient Selection and Risk Statification

- Determine that the potential therapeutic benefit outweighs any potential risks/harm
#2 Informed Consent and Opioid Management Plans

- When starting COT, informed consent should be obtained.

- Ongoing discussion with the patient regarding COT includes goals, expectations, potential risks, and alternatives to COT.
#3 Initiation and titration of COT

- Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine whether COT is appropriate

- Opioid selection, initial dosing, and titration should be individualized
#4 Methadone

- Methadone is characterized by complicated and variable pharmocokinetics and pharmacodynamics.

- Should be initiated and titrated cautiously by clinicians familiar with its use and risk.
#5 Monitoring

- Reassess patients on COT periodically and as warranted by changing circumstances

- Monitoring should include documentation of pain intensity, level of functioning, progress toward therapeutic goals, adverse events, and adherence
• Collect periodic urine drug screens or other information to confirm adherence with all patients
#6 High-Risk Patients

- Consider COT for patients with CNCP and a history of drug abuse, psychiatric issues, or serious aberrant drug-related behaviors only if they are able to implement more frequent and stringent monitoring parameters.
#6 High-Risk Patients

• Consider consultation with a mental health or addiction specialist

• Evaluate patients engaging in aberrant drug-related behaviors for appropriateness of COT, need for restructuring therapy, referral for assistance in management, or discontinuation of COT
When repeated dose escalations occur in patients on COT, clinicians should evaluate potential causes and reassess benefits relative to harms.
#7 Dose Escalations, High-Dose Opioid Therapy, Opioid Rotation, and Indications for Discontinuation of Therapy

- In patients who require relatively high doses of COT, evaluate for unique opioid-related adverse effects, changes in health status, and adherence to the COT treatment plan on an ongoing basis, and consider more frequent follow-up appointments.
#7 Dose Escalations, High-Dose Opioid Therapy, Opioid Rotation, and Indications for Discontinuation of Therapy

- Consider opioid rotation when patients on COT experience intolerable adverse effects or inadequate benefit despite dose increases
#7 Dose Escalations, High-Dose Opioid Therapy, Opioid Rotation, and Indications for Discontinuation of Therapy

- Taper or wean patients off of COT who engage in repeated aberrant drug related behavior or drug abuse/diversion, experience no progress towards meeting therapeutic goals, or experience intolerable adverse effects.
#8 Opioid-Related Adverse Effects

- Clinicians should anticipate, identify, and treat common opioid-associated adverse effects
#9 Use of Psychotherapeutic Cointerventions

- CNCP is often a complex biopsychosocial social condition

- Clinicians who prescribe COT should routinely integrate psychotherapeutic interventions, functional restoration, interdisciplinary therapy, and other adjunctive non-opioid therapies
#10 Driving and Work Safety

- Counsel patients on COT about transient or lasting cognitive impairment that may affect driving and work safety

- Encourage them not to engage in potentially dangerous activities when impaired
#11 Identifying a Medical Home and When to Obtain Consultation

- Pursue consultation, including interdisciplinary pain management, when patients with CNCP may benefit from additional skills or resources that you cannot provide.

- Patients on COT should identify a clinician who accepts primary responsibility for their overall medical care.
#12 Breakthrough Pain

- In patients on around-the-clock COT with breakthrough pain, consider as-needed opioids based upon an initial and ongoing analysis of therapeutic benefit versus risk.
#13 Opioids in Pregnancy

- Counsel women of childbearing age about the risks and benefits of COT during pregnancy and after delivery.

- Encourage minimal or no use of COT during pregnancy, unless the potential benefits outweigh risks.
#13 Opioids in Pregnancy

• If COT is used during pregnancy, clinicians should be prepared to anticipate and manage risks to the patient and newborn
#14 Opioid Policies

- Clinicians should be aware of current federal and state laws, regulatory guidelines, and policy statements that govern the medical use of COT for CNCP
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Opioid Approach
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• Medication Agreement

• Sent out before the appointment

• Sets the “rules” before there can problems
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- Urine Drug screens
- Always done at first appointment
- Done randomly and when issues arise or changes occur
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• Utilize the Nevada Task Force Inquiry
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• Only prescribe medications you feel comfortable with

• I personally avoid Methadone, Oxycontin, Soma, the D’s and Benzodiazepines
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• Try to manage pain with as little medication as possible

• This includes the number of medications and the number of pills
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• Consistency
• Consistency
• Consistency
Questions?