Opioid Therapy, Pain, and Addiction at the Crossroads

Steven D. Passik, PhD

Learning Objectives
Following this presentation participants will be able to:

• Discuss the recent history of opioid abuse and understand its connection to pain management
• Critically evaluate and discuss the concept of hyperalgesia and understand its roots in opioophobia
• Apply management strategies to accompany opioid therapy in chronic pain management

An Extremely Important N of 1 Case Study

• Slipped on ice on Feb 14th
• Torn supraspinatus tendon
• 6+ months of episodic, severe pain
• New understanding and empathy for the experiences of those with chronic pain
• Resulted in rotator cuff surgery

An Extremely Important N of 1 Case Study

• “Acute” post op pain with anticipated exposure to opioids of up to 3 months
• The humanity of opioid availability?
• No risk assessment

Disclosure
Steven D. Passik, PhD

• Vice President, Clinical Research and Advocacy
  Millennium Health

• Principal Investigator
  Millennium Research Institute

The Opioid Pendulum


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Nearly 20 years of expanded opioid prescribing: What have we learned?

- Something fundamental about the clinical use of opioids?

  OR

- Something fundamental about what our healthcare system is bad at?

What is our healthcare system bad at?

- Chronicity
- Conditions with major motivational or psychiatric component
- Communication among professionals
- Ongoing risk assessment
- Conditions that intersect badly with SES
- Stigmatization

Two Commonly Used Classes of Medications

- PPIs
- Opioids

Pushing the Pendulum Towards Opiophilia

- Trivialization of risk and overstatement of benefits
  - To individual patients
  - To society
- Pain management is easy, just follow the numbers
- Pain patients vs addicts
- The delivery system will deliver us

Base Rates of Addiction and Abuse: Vulnerabilities in the Population

- 8.7% Illicit Drugs
- 6.2% Alcohol
- 26.5% Nicotine

Pseudoaddiction?

Weissman and Haddox

- N of 1 case study
- Inpatient
- Became surly and uncooperative
- Pain management improved, behavior improved

Passik, Kirsh, and Webster

- Failures to demonstrate it empirically
- Use of illegal drugs covered?
- Overuse of prescribed medications by outpatients covered?
- Primary vs secondary alcoholism as a better model
AIDS Patients and Aberrant Behaviors

<table>
<thead>
<tr>
<th>Adequate Analgesia (n=49)</th>
<th>Inadequate Analgesia (n=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of aberrant behaviors</td>
<td>305 (6.2)</td>
</tr>
<tr>
<td>Aberrant behaviors “probably less predictive of addiction”</td>
<td>239 (78%)</td>
</tr>
<tr>
<td>Aberrant behaviors “probably more predictive of addiction”</td>
<td>66 (22%)</td>
</tr>
</tbody>
</table>


Nonmedical Use of Psychotherapeutic

<table>
<thead>
<tr>
<th>Year</th>
<th>Pain Relievers</th>
<th>Stimulants</th>
<th>Sedatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>1.3</td>
<td>0.5</td>
<td>1.5</td>
</tr>
<tr>
<td>2003</td>
<td>1.4</td>
<td>0.6</td>
<td>1.5</td>
</tr>
<tr>
<td>2004</td>
<td>1.5</td>
<td>0.7</td>
<td>2.0</td>
</tr>
<tr>
<td>2005</td>
<td>1.6</td>
<td>0.8</td>
<td>2.5</td>
</tr>
<tr>
<td>2006</td>
<td>1.7</td>
<td>0.9</td>
<td>3.0</td>
</tr>
<tr>
<td>2007</td>
<td>1.8</td>
<td>1.0</td>
<td>3.5</td>
</tr>
</tbody>
</table>


Illicit Drug Use (2013)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Past Month Users, Age 12 or older (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any illicit drug</td>
<td>24.6</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.5</td>
</tr>
<tr>
<td>Inhalants</td>
<td>0.5</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>1.3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.5</td>
</tr>
<tr>
<td>Psychotherapeutics</td>
<td>4.5</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1.3</td>
</tr>
</tbody>
</table>

2 million people used pain relievers, tranquilizers, stimulants, or sedatives nonmedically for the first time in 2013 (average 5,500 new initiates/day).


What Makes News?

- Sex
- Drugs
- Rock and Roll

Doctors on Trial: Pain Docs or Drug Dealers?

This?
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Or This?

What Constitutes Functional Improvement, Anyway?

Slowing the rate of decline?

Pushing the Pendulum Toward Opiophobia

- Opioid strawman
- Addiction is resident in drugs
- Hyperalgesia

The Opioid Strawman

Where does Addiction Live?

Addiction is not Simply a Disease of Exposure

**Burroughs:**
Exposure

**Current:**
Exposure is necessary, not sufficient.
- Exposure to drug
- Vulnerable person
- Vulnerable time

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Does Drug Selection Matter?
Long-acting Opioids vs Short-acting Opioids

Fentanyl Patch  Fentanyl TIRF

Risk Management is a Package Deal

- Screening and risk stratification
- Use of PMP data
- Compliance Monitoring
  - Urine screening
  - Pill/patch counts
- Education regarding drug storage and sharing
- Psychotherapy and highly "structured" approaches
- Abuse-deterrent formulations

Population of Rx Opioid Users Is Heterogeneous

Assessment of Addiction Risk

- Measures for screening for addiction risk
  - STAR/SISAP
  - CAGE AID
  - Opioid Risk Tool (Emerging Solutions in Pain)
  - SOAPP (see painedu.org)
- Psychiatric interview assessment of risk
  - Chemical
  - Psychiatric
  - Social/familial
  - Genetic
  - Spiritual

How do Different Risk Measures Compare?

- A recent study at a pain practice in Tennessee
  - A retrospective study of discharged patients
  - N=48
  - Risk rating of each patient with all four measures:
    - Clinical semi-structured interview by a psychologist
    - DIRE (Belgrade et al, 2006)
    - ORT (Webster and Webster, 2005)
    - SOAPP (Butler et al, 2004)
- "Medium" or "High" risk rating = Accurate prediction
- This measure assesses sensitivity (not specificity)
Accuracy in Predicting Discharge (Aberrant Drug-related Behaviors)

<table>
<thead>
<tr>
<th>Measure</th>
<th>% Accuracy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>77%</td>
</tr>
<tr>
<td>SOAPP</td>
<td>73%</td>
</tr>
<tr>
<td>ORT</td>
<td>45%</td>
</tr>
<tr>
<td>DIRE</td>
<td>17%</td>
</tr>
</tbody>
</table>


The Growth of Prescription Monitoring Programs

- 2003
  - 14 states had prescription drug monitoring programs
  - 36 states had no prescription monitoring programs
- 2012
  - 41 states had prescription drug monitoring programs
  - 9 states had no prescription monitoring programs


Aberrant Behaviors Versus Urine Toxicology Testing

<table>
<thead>
<tr>
<th>Urine Toxicology</th>
<th>Aberrant Behaviors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Yes</td>
<td>10 (8%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>26 (21%)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>36 (29%)</td>
</tr>
<tr>
<td>Negative</td>
<td>Yes</td>
<td>17 (14%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>69 (57%)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>86 (71%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>122</td>
</tr>
</tbody>
</table>

53/122 (43%) of patients had “problems” (positive urine screen or behavioral issues)


Unexpected UDT Results Chronic Opioid Therapy

- Normal: 55%
- Missing opioid: 14.5%
- Additional drug: 17.6%
- Illicit substance: 2.6%
- Adulterated: 2.6%


Teaching about Medication Storage and Sharing

- Sharing prescription meds seen as safe by “self-treaters”
- Need to educate patients about medication storage
- New devices being developed to help only the patient have access and on a schedule programmed by the MD or RN


Substance Misuse Treatment for High Risk Chronic Pain Patients on Opioid Therapy: A Randomized Trial

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Opioid Renewal Clinic

**Procedure**
- Consult from PCP
  - Workup & pain dx
  - Opioid Treatment Agreement
  - Baseline urine drug test
- PCP CONTINUES TO BE RESPONSIBLE TO PRESCRIBE OPIOIDS

**Strategy**
- Opioid Treatment Agreement
  - Second change agreement
  - Frequent visits
  - Prescribed opioids on short-term basis
  - Random UDT
  - Pill counts
  - Co-management with additional services

Referred for addiction treatment
- Aberrant behavior = 171
- Self-discharged = 38%
- Aberrant behavior resolved = 45%
- No aberrant behavior = 164

NIDA Study: Adherence Therapy for Opioid-abusing Pain Patients

- 40 pain patients at 2 sites in Virginia and New York
  - Evidence of opioid efficacy for diagnosis
  - Greater than 6 month duration, constant, moderate-severe intensity (VAS greater than 7 despite daily opioids)
- Substance abuse comorbidity
  - Opioid abuse dependence, greater than 2 on "problems with pain meds", no current substance dependence, and lifetime dependence or current abuse permissible
- Psychiatric comorbidity
  - No unstable major psychiatric disorders, current suicidal or homicidal ideation, or medication dose considerations
- Medical comorbidity
  - No unstable or severe medical conditions or planned surgery within study period; no meds that interact with methadone

We Are All Stakeholders

- Patients
- Professionals
- Law enforcement
- Media
- 3rd Party Payors

Trends in Opioid and Non-Opioid Use

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- Frequent visits
- Urine screens
- Psychological care
- Abuse deterrent opioids
- Less drug per prescription