UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

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WELCOME!

Today's Topic:

Pain and Opioid Treatment

My patient on chronic opioid pain treatment is not doing well, and I think they are addicted to them. What should I consider doing next

Mark Sullivan, MD, PhD

PANELISTS:

MARK DUNCAN, MD, RICK RIES, MD, KARI STEPHENS, PHD AND BARB MCCANN, PHD

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FROM PAIN TREATMENT TO OUD: THE ROLE OF OPIOID DEPENDENCE

MARK SULLIVAN, MD, PHD

UNIVERSITY OF WASHINGTON

GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- ✓ Research grants: Pfizer, Purdue
- ✓ Consulting: Chrono Therapeutics, Revon Systems
- ✓ Expert witness: States of MD and WA

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OBJECTIVES

1. Learn how to decide a patient on long-term opioid therapy is not doing well
2. Understand why patients on opioids may not be the best judge of whether they are doing well
3. Learn about the various facets of opioid dependence

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My patient on chronic opioid pain treatment is not doing well.

He may be addicted to opioids.

What should I consider doing next?

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How to tell your patient on LtOT is <u>not</u> doing well

- Consider goals of LtOT
  - Pain reduction (intensity, interference)
  - Functional improvement (physical, emotional, social, role)
  - Life improvement (HRQL, reduced disability, love/work/play, life moving forward again)

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How to tell your patient on LtOT is <u>not</u> doing well

- Are the goals of LtOT being met (<u>on average</u>):
  - Pain reduction
    - High rates of pain intensity and interference in LtOT clinical practice (Hoffman 2017, Dobscha 2016, Eriksen 2006)
    - Especially patients on high opioid doses (Morasco 2010, Merrill 2014, Hauser 2018)
  - Functional improvement
    - Low functional status, very low rates improvement (Webster 2007, Krebs 2018)
  - Life improvement
    - Patients often acknowledge they are not doing well, but believe they would be worse off opioids

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How to tell your patient on LtOT is <u>not</u> doing well

- Are the goals of LtOT being met (<u>this patient</u>):
  - Pain reduction
    - Pre-opioid pain scores rarely available
    - Patients (self-selected) report improvement compared to pre-opioid pain levels, but may overemphasize opioid initiation and discontinuation experiences
  - Functional improvement
    - Patients report improved function, though spouses often contradict this. Function remains low for most.
  - Life improvement
    - Patients often acknowledge they are not really happy with LtOT, but are fearful of losing access to opioids

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Why might the patient not be the best judge of LtOT effectiveness?

- Memory and fear of overwhelming pain
  - Pain improved to unchanged in supported taper
  - Pain improved to worsened in unsupported taper
- Opioid therapy may obscure harm perception
  - "No longer a zombie", confirmed by spouses
  - Hard to distinguish pain flare vs. withdrawal
- Opioid dependence
  - Is it as physical and temporary as alleged?

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The nature of opioid dependence

- DSM-IV Opioid Dependence → DSM-V OUD
  - This is not my focus
- Formerly psychological vs. physiological depen
  - But psychological dependence discarded as part of focus on addiction as brain disease
  - This left physiological dependence, which is seen:
    - Inevitable with opioid exposure (unlike addiction)
    - Physical (somatic, bodily symptoms)
    - Temporary (resolves within a week or two of opioid DC)

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Our new view of opioid dependence

- Revealed by patients taking opioids *as prescribed* for years, esp. high doses who are unable to taper
  - Due to anxiety, insomnia, dysphoria, anhedonia, feeling "dead"
  - Also increased pain (unmasked v. withdrawal)
- These patients may have engaged in no aberrant behaviors, but suffer from a form of iatrogenic dependence
  - Often angry with addiction or OUD label

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Biology and psychology of refractory opioid dependence

- Biology
  - Related to opioid-induced hyperalgesia
  - May be similar to second phase of addiction-Koob
    - Binge-intoxication *(basal ganglia)*
    - Withdrawal-negative affect *(extended amygdala)*
    - Preoccupation-anticipation *(prefrontal cortex)*
- Psychology
  - Opioid-induced deactivation → depression
  - Incentive salience, anti-reward

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Refractory opioid dependence (ROD) vs OUD

- Role of reliable source of prescribed opioids
  - ROD may start looking like OUD with opioid DC
- In ROD, withdrawal may look like pain flares
- In ROD, salience of pain relief is enhanced and salience of other rewards is diminished
- In OUD, opioid reward overwhelms all other rewards

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Does your patient on LtOT have ROD or OUD?

- ROD probable
  - Minimal aberrancies, unable to taper, very high salience of pain relief
  - Deactivated, impaired social/emotional function
- OUD probable
  - Aberrancies common, illicit polysubstance use
  - Non-oral administration, severe social harms

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How to treat a patient receiving LtOT who develops ROD or OUD?

- Buprenorphine best choice for ROD and OUD
  - Safer than high-dose full-agonist opioids
    - (Wolff 2012, Pergolizzi 2016)
  - Provides adequate or improved analgesia
    - (Daitch 2014, Gimbel 2016)
  - Does not induce and may treat depression
    - (Fava 2018, Serafini 2018)

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