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Psychiatry and Addictions Case Conference

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FROM PAIN TREATMENT TO OUD: THE ROLE OF OPIOID DEPENDENCE

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

✓None

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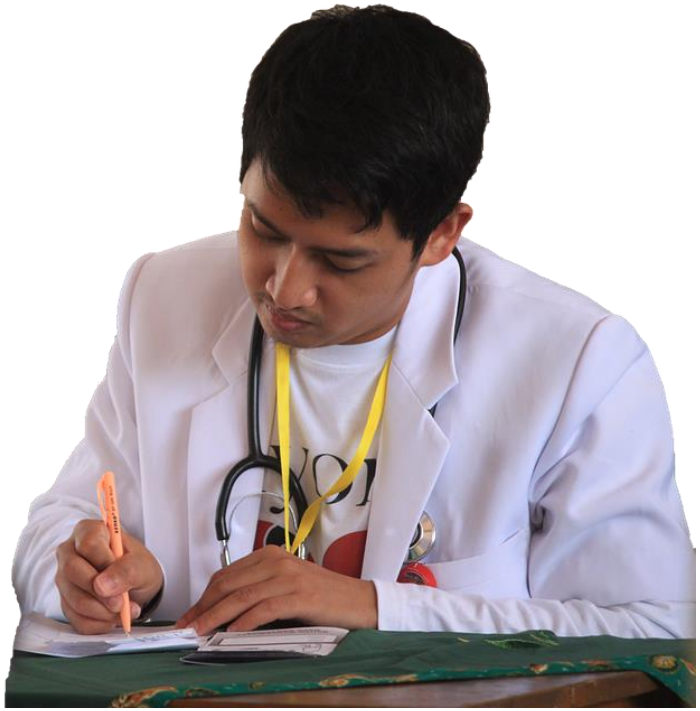
My patient on chronic opioid pain treatment is not doing well.

He may be addicted to opioids.

What should I consider doing next?



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How to tell your patient on LtOT is not 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)

How to tell your patient on LtOT is not doing well

- Are the goals of LtOT being met (on average):
  - 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)
    - Lower return to work rates for patients prescribed opioids (Carnide 2018)
  - Life improvement
    - Patients often acknowledge they are not doing well, but believe they would be worse off opioids

How to tell your patient on LtOT is not doing well

- Are the goals of LtOT being met (this patient):
  - 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. (couch time)
  - Life improvement
    - Patients often acknowledge they are not really happy with LtOT, but are fearful of losing access to opioids

Why might the patient not be the best judge of LtOT benefits and harms?

- Benefits: memory/ fear of overwhelming pain
  - Pain improved to unchanged in supported taper
  - Pain improved to worsened in unsupported taper
- Harms: Opioid therapy may impair perception
  - "No longer a zombie", confirmed by spouses
  - Hard to distinguish pain flare vs. withdrawal
- Distorting lens: opioid dependence
  - Is it as physical and temporary as alleged?

The nature of opioid dependence

- DSM-IV Opioid Dependence → DSM-V OUD
  - This is not my focus
- Psychological vs. physiological dependence
  - 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)

Our new view of opioid dependence

- Revealed by patients taking opioids *as prescribed* for years, esp. high doses who not doing well, but are unable to taper (Manhapra 2020)
  - Due to anxiety, insomnia, dysphoria, anhedonia, feeling "dead", and increased pain (original v. opioid)
- These patients may have engaged in no aberrant behaviors, but suffer from a form of persistent iatrogenic dependence
  - Often angry with addiction or OUD label

Biology and psychology of refractory opioid dependence

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

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 since priority given to pain over affect
- In ROD, salience of pain relief is enhanced and salience of other rewards is diminished
- In OUD, opioid reward overwhelms all other rewards

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, PTSD
    - (Fava 2018, Serafini 2018, Madison 2020)