



UW PACC

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

- ✓ Expert witness for Maryland Attorney General

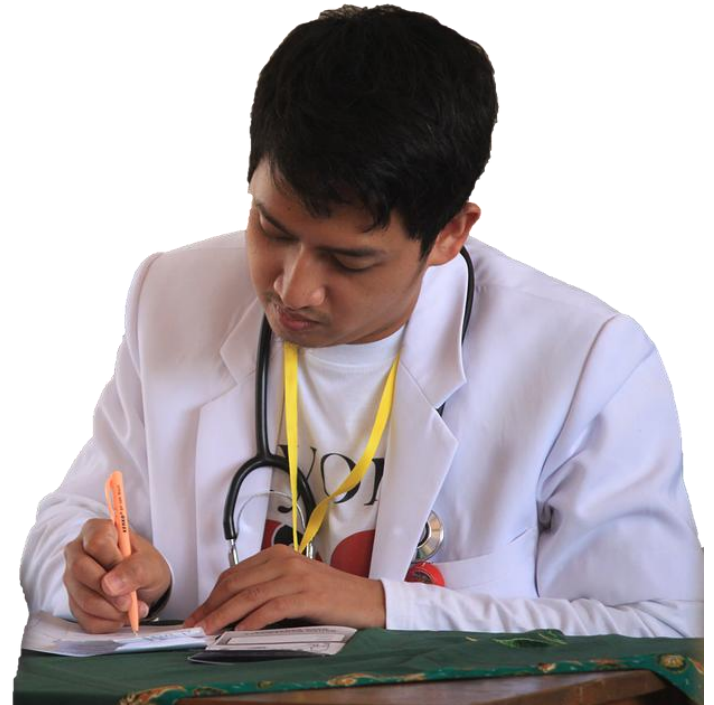
OBJECTIVES

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

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

He may be addicted to
opioids.

What should I
consider doing next?



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)

MUST PAIN REDUCTION HAPPEN AS FIRST STEP IN CHRONIC PAIN IMPROVEMENT?

- It is commonly assumed that pain intensity must be reduced before improvements in other pain outcomes are possible
- Cross-lagged models using retrospective clinical data examined relationships between average pain intensity and symptoms of psychological distress, difficulties with sleep initiation and maintenance, and disability in 666 treatment-seeking patients with chronic pain who demonstrated improvement in pain intensity (≥ 1 -point reduction on 0-10 numeric rating scale) over a 1-year span.
- Results indicated that decreased difficulties with sleep initiation, depressive and anxious symptoms, and disability predicted later improvement in pain intensity, whereas greater pain intensity predicted only later difficulties in sleep initiation and maintenance.
- These results suggest that pain reduction is NOT a necessary first step in successful chronic pain treatment

Sturgeon JA, Langford D, Tauben D, Sullivan M. Pain Intensity as a Lagging Indicator of Patient Improvement: Longitudinal Relationships With Sleep, Psychiatric Distress, and Function in Multidisciplinary Care. J Pain. 2021 Mar;22(3):313-321

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 (Manhappa 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

CHANGE IN NSDUH SURVEY HIGHLIGHTS IATROGENIC OPIOID DEPENDENCE

- Until 2021, NSDUH did not ask questions about DSM5 OUD criteria to respondents who denied opioid misuse
- Including non-misusing persons in the survey, increased estimated prevalence of OUD from 1.6M to 6.1M
- 62% of the 4.8M people on LTOT with OUD did NOT misuse their opioids

Biology and psychology of prescription opioid dependence syndrome (PODS)

- 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

Prescription Opioid Dependence (PODS) vs OUD

- Role of reliable source of prescribed opioids
 - PODS may start looking like OUD with opioid DC
- In PODS, withdrawal may look like pain flares since priority given to pain over affect
- In PODS, 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 PODS or OUD?

- PODS 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

UNDERSTANDING PODS AS A PRE-ADDICTIVE STATE

- Opioid need for pain may be hard to distinguish from withdrawal in patients on LTOT
- This arises from the interaction of pain relief with opioid reward, which changes the motivations for continued opioid use in ways not always obvious to patients or prescribers.
- Recognition of a prescription opioid dependence syndrome (PODS) allows for a more nuanced approach to the treatment of failed opioid pain treatment
- PODS is a pre-addictive state that can exist even as opioids are used exactly as prescribed

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

- Buprenorphine best choice for PODS 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)

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