The Complex Pain Patient

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Disclosures

- None
Learning Objectives

- List 2 “behavioral addictions” that can complicate pain management
- Calculate the overall potency of an opioid regimen using a web-based tool
- Identify a rational method of simplifying a complex pain medication regimen

What Is a “Complex” Patient?

- COMPLEX: those patients who worry you the most. High doses of opioids (which you may have started, or are “inheriting”), multiple pain issues that “feed” off each other, social problems, mental health issues/personality issues that consume staff time
- Not BAD PEOPLE, in most cases, but rather BAD SITUATIONS that could have been avoided
- Session aimed to help you triage and treat
Pain Is Like Anything Else (Well…Sort of)

- Treating pain requires same skills you already have to use
- Example: not every diabetic patient is compliant (diet, exercise, meds)
  - Compliant = easier
  - Manipulative = harder
- Treating pain, as in other situations, requires risk management

Why Does Complexity Matter?

- Quite simply: $$$
- Complexity takes time, and time = $$$
- Primary care physicians identified 26% of their patients as “complex.”
  In younger patients, issues like mental health and substance use were the complicating factors; in older patients, multiple disease processes, medical decision-making, and coordination of care made them more complex
- Estimated “fully 80% of all medical expenses can be attributed to care of individuals with serious and complex conditions.”


Chrvela C, Sharfstein S (eds). Definition of serious and complex medical conditions. Washington, DC: Committee on Serious and Complex Medical Conditions, Division of Health Care Services, Institute of Medicine, National Academy Press; 1999.
Things Are Getting Tighter

- Regulations of practices are state-by-state, so be aware that not all places with “Pain Clinic” sign are on the same page

- Example: In my state, if opioid prescribed for >50% of patients for more than 90 days a year, state requires clinic ownership/oversight by board-certified physician

- Other regulations tightening further: specifying number of drug tests, referrals required based on dose, etc, CSMD automatically sending out warning memos


How Did We Get Here?

- ‘70, ‘80s, ‘90s – providers more broadly recognized impact of undertreated pain (veterans who survived, but injured/traumatized, instead of killed)

- Professional organizations dedicated to pain research formed (APS in the late ‘70s, AAPM in early ‘80s, ASPMN in early ‘90s)

- ‘80s, ‘90s, ‘00s: pharma began marketing LAOs for noncancer pain

- Aggressive outreach to prescribers led to rapid rise in prescriptions


How Did We Get Here? (cont’d)

- US Congress decreed 2001-2010 to be “The Decade of Pain Control and Research”
- Pharma companies recruited “Key Opinion Leaders” (KOLs) to spread the word
- The message was “no therapeutic limit”
- The marketing worked...REALLY worked


How Did We Get Here? (cont’d)

- Cash-and-carry “clinics” opened; sold pills (especially IR oxycodone) under the guise of “pain management”
- Even in “legit” pain treatment community, “no-limits” prescribing did not seem to be producing significantly better patient function
- States started instituting measures to help curb drug abuse and diversion by doctor/pharmacy shopping (eg, CSMD)
- PROP petitioned FDA to change the way opioids can be prescribed (eg, indicated for “severe” pain only, and called for limit to not more than 90 days of use)

“God gives the nuts, but He does not crack them.”

-Franz Kafka

Difficult Situations

- Variety of situations may bring complex patients to your office
- “Pain Clinic” closed, or prior prescriber retired (or arrested, or mysteriously died)
- Moved after natural disaster
- Can’t afford private-pay clinic any more
- Dismissed from prior practice
Difficult Situations (cont’d)

- PAIN DIAGNOSES: some painful situations “feed” off each other in an obvious way.
  Old traumatic injury to leg $\rightarrow$ gait disturbance $\rightarrow$ mechanical low back pain, or CTS from using walker, or DJD to opposite hip/knee/ankle

Difficult Situations (cont’d)

- COMORBID ILLNESSES: may complicate usefulness of treatments that might otherwise be very reasonable to order

  - Open wounds and urinary/fecal incontinence: no aquatic PT
  - Recent MI/stents, on anticoag: limits interventional options
  - Sleep apnea: both intermittent hypoxia and sleep fragmentation enhance perception of pain

Difficult Situations (cont’d)

- **MEDICATIONS**: patient report intolerances to medications (may be bogus)
- Nephrotoxicity of NSAIDs (or GI bleed, or anaphylaxis)
- Hepatotoxicity of APAP (especially if already taking lipid lower agents, antiviral meds, antifungal meds, hepatitis, or fatty liver issues)
- Seizure disorders (making SSRIs, tramadol, etc, more risky)
- Cardiac arrhythmias (making TCAs or methadone more risk due to potential for QTc prolongation)
- Taking high dose of opioids (100mg MED) +/- benzos

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Difficult Situations (cont’d)

**SOCIAL PROBLEMS:**

- Formulary limitations, “prior authorization” = waiting
- Transportation issues (requires a ride but family members not reliable; shared ride may take all day for someone with diabetes)
- Multiple generations in home
- Family resistance to treatments (eg, 6 hydrocodone tabs/day vs 2 morphine ER tabs/day)
Difficult Situations (cont’d)

ADDICTIVE PROBLEMS: chronic compulsive craving for something that causes harm, despite consequences)

- Substances: ETOH, nicotine, opioids, amphetamines, benzos are common potentially addictive substances
- Behavioral addictions: pathologic gambling, binge eating, compulsive sexual behaviors, compulsive technology use (eg, “binge watching,” Facebook, etc)


Difficult Situations (cont’d)

STATE/CORPORATE PROBLEMS:
- State law may preclude you from offering certain treatments
- Dose limits, quantity limits
- No 90-day supplies permitted, etc
- No early fills (even if going on trip)
- Pharmacies under intense scrutiny, so patient has to “play nice”

Why Does It Have to Be So Complex?

- Chronic pain is a perception (ie, inside the brain) phenomenon
- Treating pain involves addressing the intimate, dynamic interaction of physiologic processes (inflammation, nerve damage, etc) and emotion, as modulated by social/behavioral context. Not just WHAT hurts, but WHY and WHEN
- Break a leg? Cry. Dog gets run over? Cry. Same manifestation from physical damage as from emotional damage
- Some hurt a lot, but suffer little (childbirth). Some hurt a little, but suffer a lot (poststroke, with loss of independence)

It Is Not Easy

- Keys to good management are identifying pain generator, instituting/facilitating those treatment modalities most likely to improve function, and assessing, monitoring, and minimizing risk to individual and to society
- If it were EASY, there would not have been roughly 16,000 people dead from prescription opioid-related overdoses in 2015
- Many take medication not prescribed for them, or others fail to recognize/heed warnings of combinations with other CNS depressants given their individual health conditions (reduced excretion, OSA, ETOH, benzos, etc)

Let’s Play Fair

- Opioids are potentially lethal. Too much, too quickly → respiratory depression → death. Guaranteed
- However, as a class, they are VERY SAFE if prescribed, and taken, with some propriety
- Medical literature has plenty of case studies (1100mg/h IV morphine, 3400mcg/h transdermal fentanyl). Disease killed, not respiratory depression
- TRUTH: no theoretical therapeutic limit. Does not mean it will work, but means it can be titrated to effect/side effect


Let’s Play Fair (cont’d)

- Reasonably predictable side effects (eg, constipation, nausea, sedation), and other effects (eg, hormonal changes)
- Sedation precedes respiratory depression, every time. No one has succumbed to opioid-induced respiratory depression while awake
- DYNAMIC process: suddenly taking higher than the normal dose, excreting less, or even taking usual dose along with some other CNS depressant are all potentially lethal (eg, ETOH, “borrowed” benzo)

http://pcc.coh.org/pdf/Resp%20Dep-FF%2012-08.pdf
Let’s Play Fair (cont’d)

- Is there an epidemic of opioid related deaths?
- Prescribed opioids ("natural," “semisynthetic," plus methadone) involved in
  16,028 / 2,712,630 deaths in 2015 = ~0.6%
- Including fentanyl and heroin: 33,901 / 2,712,630 = ~1.2% of deaths
- TAKE HOME POINT: life is full of risks. Just requires fair assessment of
  risk-to-benefit ratio.

Simplifying Complex Cases

- Complexity may mean multiple painful areas, multiple medications (opioid, or not), or comorbidities (eg, mental health)
- Not unusual to see a patient who is taking 10+ meds a day, for multiple chronic diseases
- Each specialty may be practicing “evidence based medicine” for each condition, but it amounts to HUGE burden, danger, and cost


Simplifying Complex Cases (cont’d)

- Historical changes in past 50 years
- Better at delaying death, but that just means more time spent with chronic issues
- EBM from various fronts adds to medication complexity
- DTC advertising preys on ego
- Promotion of “lifestyle drugs” over behavior change (rapid weight loss, something to sleep, something to wake, etc)
Simplifying Complex Cases (cont’d)

- REDUCING NUMBER OF DIFFERENT MEDS is one of easiest ways possible to simplify care, not to mention cost of care
- Takes time to really go over medication regimens, and time = $$
- Study from VA from 2001 (results just as useful now):
  - Calendar format of days/times → avg of >2 doses/day LESS
  - Plain list of medicine → avg of >3 doses/day MORE
- Survey in 2013 of over 1,000 patients who take meds for chronic health issues found weak adherence (avg grade: C+)


Reducing Number of Different Meds

- Discuss meds in terms of FUNCTIONAL BENEFITS
- Medicine added during hospitalization but patient/family have no idea why
- Example: Already on corticosteroid for UC. Has knee pain from advanced DJD. Hospitalist prescribes celecoxib. Risk of GI bleed/nephrotoxicity likely outweighs benefit
- Example: Already taking amitriptyline sleep; PCP adds duloxetine for fibromyalgia; likely therapeutic duplication of SSRI/SNRI effects. Leave off most potentially toxic one, unless patient can REALLY tell a difference
Reducing Number of Different Meds (cont’d)

- Same principle applies with opioids
- If possible in your practice setting, do conversion to long acting to simplify dosing for around the clock pain
- MSIR 15 mg q4h → MSER 30 mg q8h (same dose, half the pills)
- Tapering benzos greatly reduces risk, but even more time-consuming/challenging than tapering opioids


Case Study: Reducing Dose

- 59 yo woman moves in from out of state
- Hx of multiple spinal surgeries for scoliosis; old SCS for radicular pain, but wire broke
- Diffuse thoracic and lumbar pain
- Mainly c/o “sharp” pain near right SI joint
- Brings in current meds in bottles: oxycodone 30 mg QID, MSER 30 mg at HS, hydrocodone/APAP 10 mg QID prn; only other med is estrogen tab
- Records obtained from prior provider clearly document improved function (better ADL performance, better walking, better sleep)
Case Study: Reducing Dose (cont’d)

- PMHx: hysterectomy and BSO; spinal surgeries as above
- Social: married, lives with husband. Retired/disabled teaching assistant. No kids in the home. Quit smoking in her 30s; glass of wine with dinner a few times a year
- Diagnostics: lumbar X-ray study from prior year shows no fusion instability, just fracture SCS wire
- UDT: in-office screen positive for oxycodone and opiates (appropriate)
- Risk assessment screening tool: low-medium risk
- Exam: alert, conversant, pleasant demeanor; exquisite tenderness over right SI joint; spastic lumbar musculature

Where do you start in deciding if/how you will take over her meds?

- Most states allow providers to prescribe at least some opioids, but may limit certain schedules, or certain quantities, or certain durations (eg, for NPs, 8 states do not allow C-II prescriptions for pain)
- Whatever opioid prescribing is permitted in your state, you need to know the relative potency of what the patient is taking
- “Morphine equivalent dose” (MED). Various states calculate via CSMD to see who is prescribing what

Case Study: Reducing Dose (cont’d)

- Why calculate in terms of morphine equivalent dose?
- WA has had a guideline in place since 2007 to track total opioid doses prescribed and associated complications (especially overdose deaths), with specific recommendations against high dose prescribing (defined as 120 mg MED or more)
- Between 2009 and 2010 (after guidelines had time to get rolled out and providers educated on it), deaths from opioid overdoses cut by 50% (agencymeddirectors.wa.gov/calculator/dosecalculator.htm)
- NOT intended for dose conversion, just dose calculation


Case Study: Reducing Dose (cont’d)

- Calculating MED using the AMDG calculator reveals the following:
  - Oxycodone 30 mg QID = 120 mg oxy = MED 180 mg
  - MSER 30 mg/day = MED 30 mg
  - Hydrocodone 10 mg QID = 40 mg hydro = MED 40 mg
- Total MED = 250 mg
- That dose level may or may not be within what you can prescribe in your state (or your practice’s protocols, even with C-II privileges)
- Even if it is, your state’s department of health may frown on the complexity (eg, >4 doses per day of short acting opioids)

Case Study: Reducing Dose (cont’d)

- **WORST CASE SCENARIO:** If state/protocol does not permit to that high of a dose, patient needs counseled on risks of abrupt discontinuation
- Discuss ways to taper current meds to make them last longer (e.g., going down on the oxycodone and hydrocodone to make them last longer)
- Patient may request tapering prescription from prior provider, if the patient left on good terms
- Otherwise, may need outpatient or inpatient management of withdrawals

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Case Study: Reducing Dose (cont’d)

- **MORE LIKELY SCENARIO:** patient willing to “work with you”
- Prescribing >120 mg MED is not doable in your state, and your Dept of Health recommends minimal short-acting doses
- She had been on OxyER in the past, and oxycodone already represents the bulk of her MED
- Lower oxy 30 mg and hydro 10 mg to TID each, and one MSER 30/day = 185 mg/day until finished. Then rotate to abuse-deterrent oxycodone ER 40 mg q12h = MED 120 mg
- Leave off opioid for “breakthrough pain”; can still take OTCs

Case Study: Reducing Dose (cont’d)

- **SNAFU**: she comes back to your office from the pharmacy after finding out her responsibility for the OxyER 40 mg q12h (which is not available in a generic formulation, since reformulated) is going to be over $200. Can’t afford it. What do you do?

[NOTE: When she was on oxycodone ER in the past, it was under her spouse’s old insurance plan; now, she has Medicare. Copay cards from pharma manufacturers in your sample closet can’t be used with government-funded medication plans]

Case Study: Reducing Dose (cont’d)

- Option 1: she obviously tolerates morphine, so you could switch her to MSER 60 mg q12h
- Option 2: she tolerates oxycodone, which is partially metabolized to oxymorphone. Oxymorphone has much longer half-life than morphine, plus available in extended release form, so could switch to oxymorphone ER 20 mg q12h which may work well
Case Study: Reducing Dose (cont’d)

- While her back looks terrible overall, it’s important to remember the MAIN COMPLAINT
- The BULK of her pain complaint is over the right SI joint (a frequent source of pain in patients with lumbosacral fusions)
- May benefit from a referral to an interventional specialist for a trial of SI joint injection therapy
- Can be done with plain anesthetic for truly diagnostic effect; if confirmed, can be followed by RFA of the lateral branch nerves


Case Study: Reducing Dose (cont’d)

- She calls back after a week on the morphine ER 60 mg q12h. Aggravated by itching and nausea, but no rash and no vomiting, and nowhere nearly satisfactory analgesia
- Willing to try rotating to the oxymorphone ER 20 mg q12h as had been discussed previously, so you make the conversion
- Comes back a few weeks later; itching is better, nausea is better. While pain control is not quite as good as on prior regimen, she is glad to be on much simpler regimen
- One prescription instead of 3, 2 doses instead of 9
Patient Education Is Paramount!

- Large percentage of patients in our practice who take LAO do not take any SAO (although they may have neuroadjuvant meds)
- More patients than you might think respond favorably to this greatly simplified method
- If SAO is prescribed, discuss in terms of use for “incident pain” (activity-related pain, not end-of-dose failure)
- Unless there is concrete description of activity-related pain (standing to or cook, bending at sink for ADLs) no obvious need for a SAO. Then, maybe 1 or 2 doses a day

Reasonable Expectations

- Pain treatment: much more than physical
- Behavioral, emotional, and functional components of “pain experience”
- Complex patients deserve a fair shake, but you have to follow the guidelines to which you are held accountable
- You may not have all the tools available in your practice setting, but you can help coordinated services (referring for mental health services, referring for occupational therapy, referring for eval for suitability of interventional therapies)

## Accountability

- Hold patients accountable! Not fair for them to “ask for help” but expect you to pull all the load
- Not fair to ask for a sleep aid while consuming a lot of caffeine/nicotine
- Not fair to ask for appetite-suppressing stimulant when diet modification actually works
- Not fair for a patient to ask you to prescribe opioid analgesics (especially high doses) without evidence of functional improvement

## Closing Thoughts

- Most of the controversy in chronic pain management comes down to this: are opioids appropriate, or not? If so, how much, and for how long?
- The answers to these questions are never set in stone. Management is a DYNAMIC process. A patient may be a fine candidate for opioid therapy at one point, only to have physical, emotional, or social factors change to the point that their options become much more limited
- Assess risk of opioid therapy first; if opioids instituted, assess function on an ongoing basis
- Do not continue a treatment when there is no clear indication of significant functional improvement
Thank You!