Falling Down the Rabbit Hole: 
A Primer for Chronic Pain Management & 
Comorbid Substance Use Disorders

David Cosio, PhD

Biography

David Cosio, PhD, is the psychologist in the Pain Clinic and the CARF-accredited, interdisciplinary pain program at the Jesse Brown VA Medical Center, in Chicago. He received his PhD from Ohio University with a specialization in Health Psychology in 2008. He completed a behavioral medicine internship at the University of Massachusetts-Amherst Mental Health Services and a Primary Care/Specialty Clinic Post-doctoral Fellowship at the Edward Hines Jr. VA Hospital in 2009. Dr. Cosio has done several presentations in health psychology at the regional and national level. He also has published several articles on health psychology, specifically in the area of patient pain education.
Disclosure

- Nothing to disclose

DISCLAIMER:

Dr. Cosio is speaking today based on his experience as a psychologist employed by the Veterans Administration. He is not speaking as a representative of or an agent of the VA, and the views expressed are his own.
Learning Objectives

- Describe the circuitous journey the field of pain management has undergone
- Describe the high level of comorbidity between opioid use disorders and chronic pain
- Apply the new strategies underlined by the CDC guidelines for pain management
- Evaluate how to select candidates for opioid trials, assess for risk, and initiate opioid therapy, but only after exploring non-opioid and non-pharmacological strategies

The Circuitous Journey

- US attitudes have shifted repeatedly in response to clinical and epidemiological observations and events in the legal and regulatory communities

- The interface between legitimate medical use of opioids vs its abuse and addiction continues to challenge the clinical community
The Circuitous Journey (cont’d)

- Deemed a human right
- Believe entitled to opioids
- Providers feel pressured
- Reinforces patient’s beliefs and reliance on medication

The Circuitous Journey (cont’d)

- Widespread dissemination of opiates
- Lax safety measures placed on storage
- Dramatic rise in opioid misuse and deaths from OD
- Identified by CDC as “public health epidemic”
- CDC released guidelines in March 18, 2016
Rate of Overdose Deaths

- Prescriptions have increased by more than 300% since 1999
- In 2013, more than 16,000 people died in the US from opioid related overdose death
- Since 2009, leading cause of accidental death is drug overdose vs motor vehicle accidents
- High profile deaths of Heath Ledger, Brittany Murphy, Prince

New CDC Guidelines

- For initiation, selection, and assessment of opioid therapy risk
- Limited evidence supporting benefits of long-term opioid use outweigh the risks or improves functionality and QOL
New CDC Guidelines (cont’d)

- Indicate that nonopioid and nonpharmacological (ie, behavioral) strategies should be first option for treatment

- Require providers to assess for risk of overdose or development of a SUD

- To be keenly aware of their patients’ pain levels

- To be aware of their pain management strategies used when opioid medications are prescribed

Balancing Act

- The topic of opioid misuse and abuse (and the rising heroin epidemic) has dominated headlines lately

- What does this really mean for chronic pain specialists?

- How does one balance the needs of the legitimate pain patient, with those of society as a whole?
**Use Decision Tree**

**Decision Tree Steps 1 & 2**

**STEP 1:**
- Identify new or established patient with pain

**STEP 2:**
- Conduct comprehensive pain assessment:
  - A psychological evaluation
  - An assessment of risk for addiction
  - An appraisal of pain level and function
  - A diagnosis with appropriate differential
How Is A SUD Defined?

- APA (DSM-5) revised chapter of “Substance-Related and Addictive Disorders” includes substantive changes to the disorders
- Patient is diagnosed with a SUD if he/she exhibits a maladaptive pattern of substance use leading to clinically significant impairment or distress
- As manifested by 2 (or more) of the following, occurring within a 12-month period

How Is A SUD Defined? (cont’d)

- Impaired Control
  - Using more than intended or is prescribed
  - Persistent desire to use or unsuccessful attempts to quit
  - Increasing time spent using or getting
  - Craving or strong desire to use

- Social Impairment
  - Failing to fulfill major role obligations
  - Giving up important life activities due to use
  - Continuing to use despite knowledge of the negative effects
How Is A SUD Defined? (cont’d)

- Risky Use
  - Using in physically hazardous situations
  - Continuing to use despite knowledge of the negative effects
  - Pharmacological criteria
    - Tolerance, needing to use more to get the same effect
    - Withdrawal symptoms from detoxing (nausea, insomnia, anxiety, sweating, trembling)

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>RANGE</th>
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<tbody>
<tr>
<td>Mild</td>
<td>2-3/11</td>
</tr>
<tr>
<td>Moderate</td>
<td>4-5/11</td>
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<tr>
<td>Severe</td>
<td>6+/11</td>
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Comorbidity of SUD

- There is a wide range in prevalence rates reflected in studies

- Makes it difficult to know what the true incidence of SUD is among chronic pain patients

- In 2005, study indicated that (before the current opioid epidemic) approximately one-third (32%) of chronic pain patients may have comorbid substance use disorders (SUDs)
Comorbidity of SUD (cont’d)

- In 2008, among 5,814 patients with chronic pain who were also prescribed chronic opioid therapy, 19.5% had a current SUD diagnosis documented in their medical record
  - Alcohol (73%)
  - Cannabis (16%)
  - Prescription and/or illicit opioids (15%)
  - Stimulants (cocaine 11% and amphetamines 8%)

- In 2011, a review found anywhere from 4% [primary care setting] to 48% [AIDS clinic] of patients with chronic pain have a current SUD

Increased Risk

- Patients with SUD’s have been found to be at greater risk for aberrant medication related behaviors

- Eg, if prescribed an opioid, there is an increased risk for prescription opioid misuse and abuse

- Patients with comorbid SUD (past and present) are potentially more difficult to treat and are at higher risk for comorbidities (depression, anxiety, sleep disturbances)
Opioid Misuse vs Addiction

<table>
<thead>
<tr>
<th>Table 1. Clinical Features Used to Identify Opioid Misuse and Addiction</th>
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<tbody>
<tr>
<td>Clinical Features</td>
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<tr>
<td>Compulsive drug use</td>
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<tr>
<td>Crave drug (when not in pain)</td>
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<tr>
<td>Obtain or purchase drugs from nonmedical sources</td>
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<tr>
<td>Procure drugs through illegal activities</td>
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<tr>
<td>Escalate opioid dose without medical instructions</td>
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<tr>
<td>Supplement with other opioid drugs</td>
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<tr>
<td>Demand specific opioid agents</td>
</tr>
<tr>
<td>Can stop use when effective alternate treatments are available</td>
</tr>
<tr>
<td>Prefer specific routes of administration</td>
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<tr>
<td>Can regulate use according to supply</td>
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Decision Tree Step 3

STEP 3:

- Determine whether pain is acute or chronic and educate the patient about difference
- Acute pain has sudden onset, lasts no more than 3-6 months, and resolves when the underlying cause is treated
- Chronic pain persists beyond the “normal” time of healing—even if from trauma, injury, or infection—and affected by both physical symptoms and emotional problems
Decision Tree Step 4

STEP 4:
- Outline treatment expectations and review options

- Consider an array of evidence-based therapies
  - NO evidence that one treatment is better than another!
  - Decide based on intensity and how invasive.
  - Use pain treatment ladder

- Review empirically validated CAM therapies
  - Expand conversation from solely pain reduction to effective functioning with continued pain
The Goldilocks Effect

- Providers in the field tend to be eclectic and flexible treatment methods and try until find something that suits patient

- Research has shown that the overall treatment effectiveness for chronic pain remains inconsistent and fairly poor

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Figure 1: Pain treatment ladder

<table>
<thead>
<tr>
<th>Neuroablative (chemical or surgical)</th>
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<tbody>
<tr>
<td>IMPLANTABLE THERAPY</td>
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<tr>
<td>Intrathecal Drug Infusion</td>
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<tr>
<td>IMPLANTABLE THERAPY</td>
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<tr>
<td>Spinal Cord Stimulation</td>
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<tr>
<td>Long-Term Oral Narcotics</td>
</tr>
<tr>
<td>Corrective Surgery</td>
</tr>
<tr>
<td>Behavioral Programs*</td>
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<tr>
<td>Nerve Blocks</td>
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<tr>
<td>Physical Therapy**:</td>
</tr>
<tr>
<td>Manipulation/TFE/ Muscle Relaxants</td>
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<tr>
<td>NSAID/NSP</td>
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<tr>
<td>Over-the-Counter Drugs</td>
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The Manumea Effect

- Research results presented are disheartening
- The best evidence for pain reduction averages around 30%
- Clinical trials have indicated comparable efficacy of numerous diverse treatments
- The Manumea is a cousin to the Dodo bird reference to the “Dodo bird effect”

Patient-Provider Shared Responsibility

- Patients with rewarding relationships have:
  - Better outcomes
  - Less likely to seek assistance from other sources
  - Reduces the risk of conflicting treatment plans
  - Reduces risk of further confusion
When Should I Consider Opioids?

STEP 5:
- Only after other treatment options have been exhausted should an opioid trial be considered
- Careful risk-benefit analysis is required
- Routine assessment of Analgesia, Activity, Adverse effects, Aberrant behavior, and Affect will help to direct therapy
- If risks outweigh benefits, a referral to pain specialist or interdisciplinary rehab program indicated
- If benefits outweigh risks and clinician’s practice able to provide adequate patient support and f/u, an opiate trial may be appropriate

Decision Tree Step 6

STEP 6:
- Sign opioid agreement
- Random urine tox screens
- Prescription state monitoring
- Opioid risk tools (SOAPP)
- Schedule frequent f/u appointments
Case Study #1

- Patient presents with increasing pain complaints and requests for dose increases while decreasing activity. There is no indication the opioid is helpful.
  - Make sure no new evidence of pathology
  - Review pain agreement—role of opioid hyperalgesia
  - Check urine drug screen
  - Set up more frequent visits
  - Refer to PT for an assessment
  - Offer nonpharmacological options
  - Refer to pain education school

Case Study #2

- Patient comes to your clinic as a walk-in and is reporting lost or stolen medications.
  - Review pain agreement—police report—“one and done policy” vs “zero tolerance”
  - Determine cognitive impairment/neurological evaluation
  - Determine if impaired by other substances being used
  - Determine if misusing medication, running out early, gave it away, or sold it?
    - Withdrawal symptoms?
  - Unsafe environment—shared responsibility
  - Discuss non-opioid and nonpharmacological options
  - Refer to pain education school
Case Study #3

- Patient urgently calls you with increased pain and then shows up to your clinic for an unscheduled appointment and asking for an early refill.
  - Review pain agreement—“NO early refills”
  - Reason for early request
  - Refer to ED or Urgent Care
  - May have to wait until the next available appointment
  - Unscheduled visits should NOT be used for opioid increases
  - Stress to the patient they “deserve to have a full visit”
  - Set up for frequent visits and pill counts
  - Address behavior if starts to become a pattern
  - Do not treat patients with opiates if you cannot follow adequately

Case Study #4

- You ordered a urine screen during your patient’s last visit and it comes back:
  - Negative for a substance you are prescribing
  - Positive for a substance you did not prescribe
  - Review pain agreement
  - Send out for a confirmatory test—rapid metabolizer?
  - Determine if diversion, sharing, or unsanctioned dose escalation—use pill counts, increase visits, etc
  - Use state prescription monitoring programs
  - Opiates may have to be tapered or d/c if repeat offender
  - Refer to addiction services
  - Offer nonopioid and nonpharmacological options
**Case Study #5**

- Patient is upset and is making SI/HI threats after being told d/c opiates at this time.
  - Make sure you are safe
  - Speak softer/lower so patient decreases volume
  - Recognize patient is angry and goal is pain improvement
  - Remind patient that making threats is in pain agreement
  - Express to patient that making SI/HI threats is serious
  - Call for police backup/refer to ED/refer to MH Intake
  - Document this behavior in chart and outline steps taken
  - Consult/debrief with other providers for support
  - Recognize that setting boundaries is important work!

**Case Study #6**

- Patient comes to your visit appearing intoxicated or somnolent/overmedicated. They also continue to report taking their opiates as prescribed.
  - Ask to speak to a family member
  - Determine if drug interaction, overdose, or underlying medical problem—over-the-counter?
  - Use urine screen—if presence of alcohol, medications not prescribed to them, or illicits—d/c opiate related adverse events
  - Refer to addiction services and offer detox?
  - Refer to ED or Urgent Care
References


References (cont’d)

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