

Primary care perspectives on balancing pain relief and opioid risk reduction

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Disclosures

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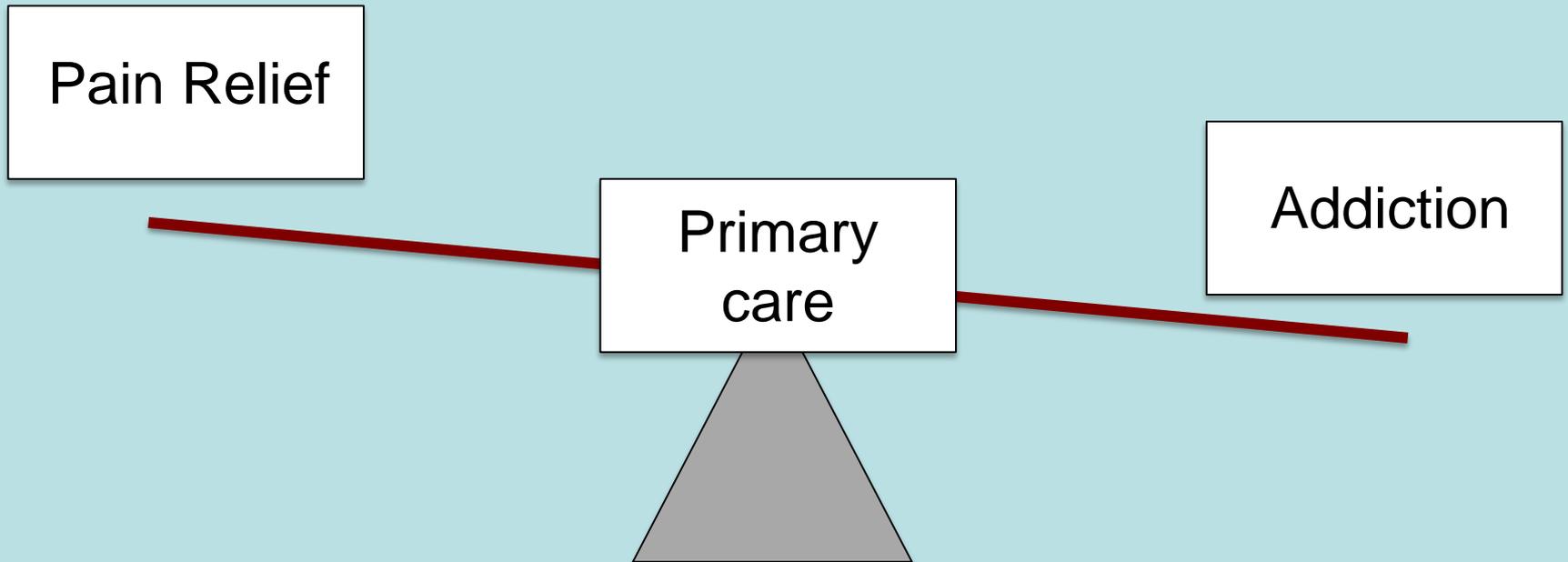
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Objectives

Illustrate challenges that primary care clinicians face when treating patients taking opioids for chronic pain.



Competing paradigms



Case 1– Ms. LB

62yo woman, established patient

CC: shoulder pain

HPI: Worsening shoulder pain; missed 1.5 days work last week

SHx: Lives in Clear Lake; works for Caltrans, no illegal drug history

PMHx: Low back pain, HTN, HIV



Case 1– Ms. LB

Pain history:

Chronic low back pain, worse in summer (works longer hours);

Norco 10/325 4x day

Soma 250mg at bedtime

Tylenol, ibuprofen PRN

Tried physical therapy in the past with limited success



Case 1– Ms. LB

Pain history (cont):

Uses extra Norco in summer;
occasional early refill requests

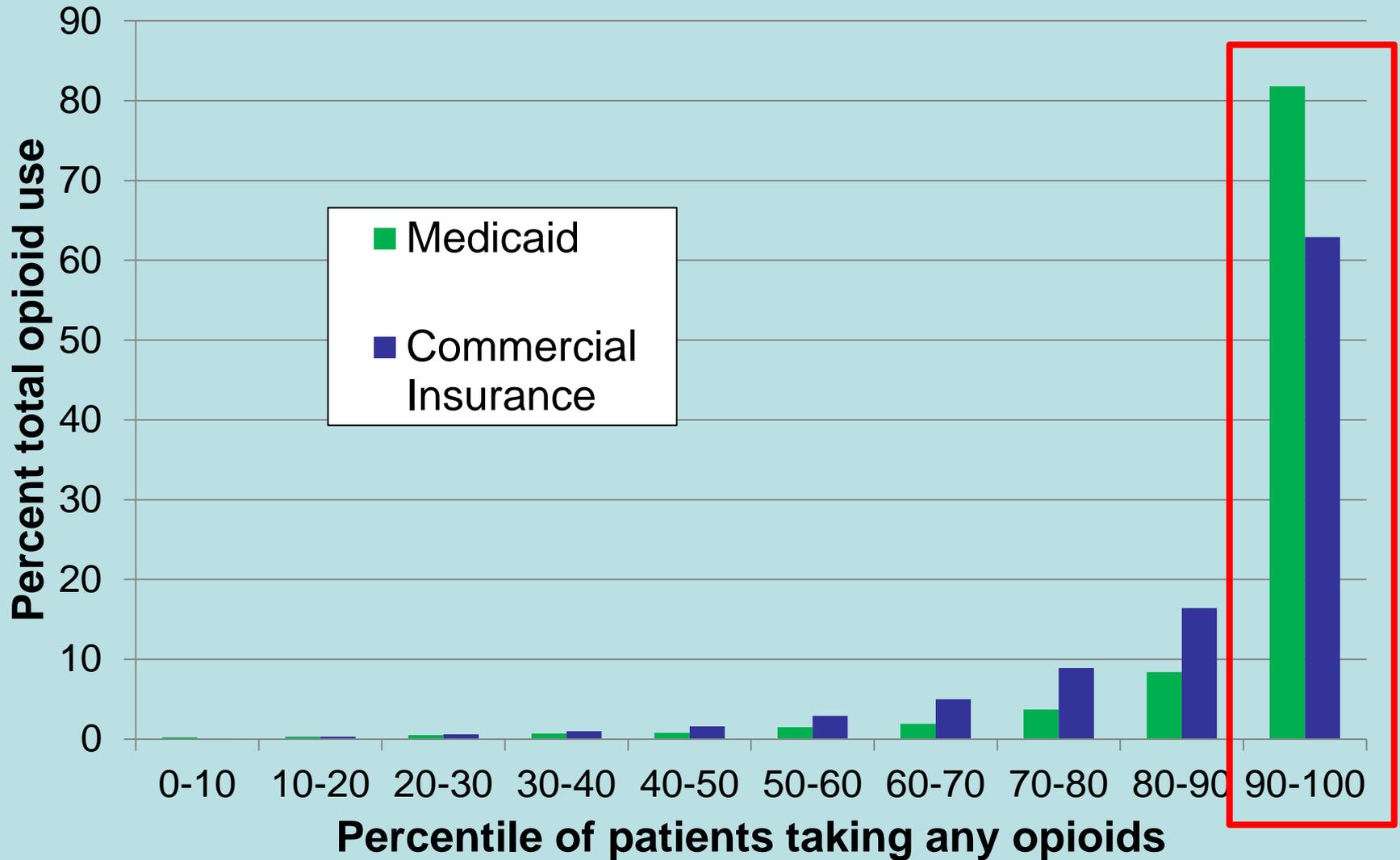
UDS & CURES report are congruent

Lives alone; moderate social support

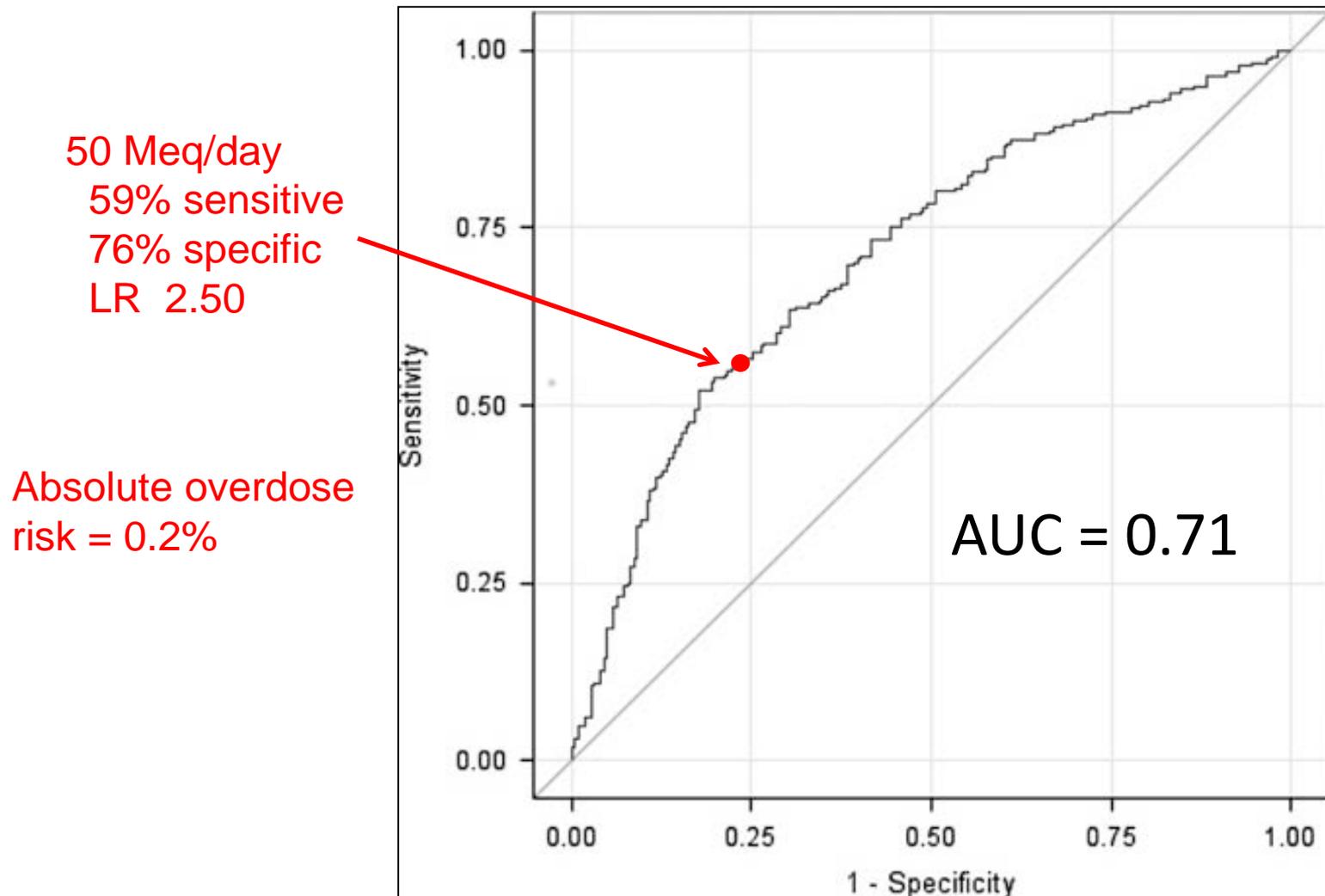
Pain goal: keep working until she can
retire (~3 more years)



Distribution of opioid use (2005)



ROC curve for morphine equivalent opioid dose

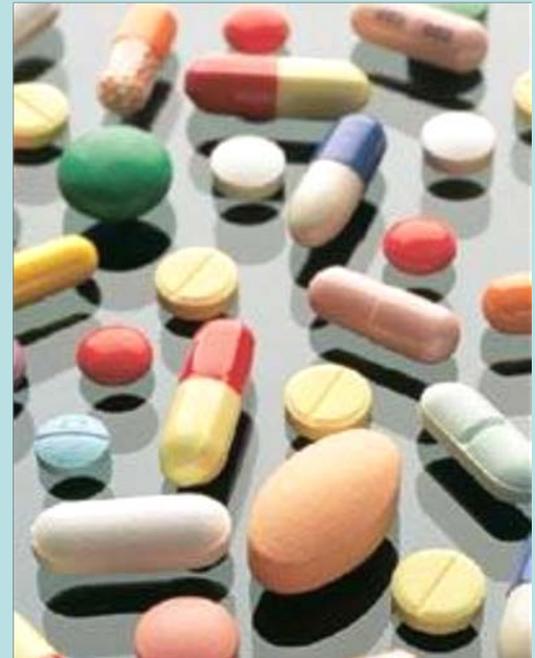


Overdose risk

5-10% of patients account for most drug-related overdoses.

Prescribed opioid dose is a moderate predictor of overdose risk (at best).

Most patients on long-term opioids are at low risk for overdose; other risks and benefits drive prescribing decisions.



Case 2 – Mr. GM

65yo man, establishing care

CC: fentanyl refill

HPI: Previously prescribed Vicodin and fentanyl by PCP. Weaned off Vicodin but couldn't wean off Fentanyl. Prior PCP recently arrested.

PMHx: Migraines, radicular LBP



Case 2 – Mr. GM

Pain history:

Radicular LBP x 5 years

Tried acupuncture & chiropractic with minimal relief

Fentanyl 50mcg every 48hours

Gabapentin 300mg TID

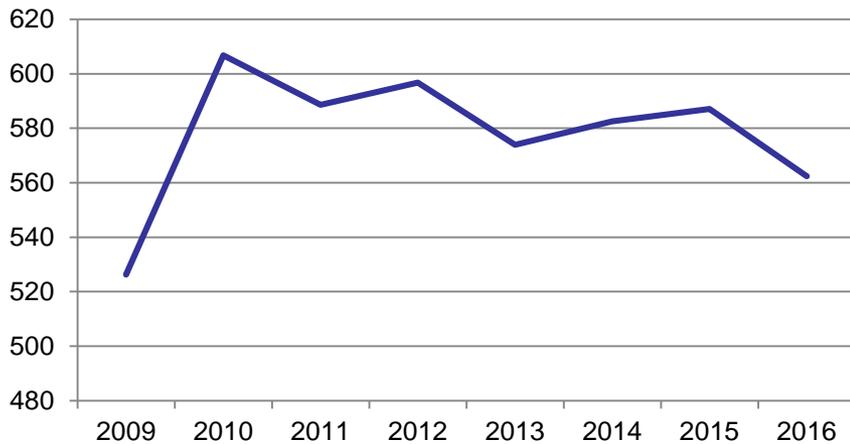
Sumatriptan PRN

Pain goal: get off fentanyl

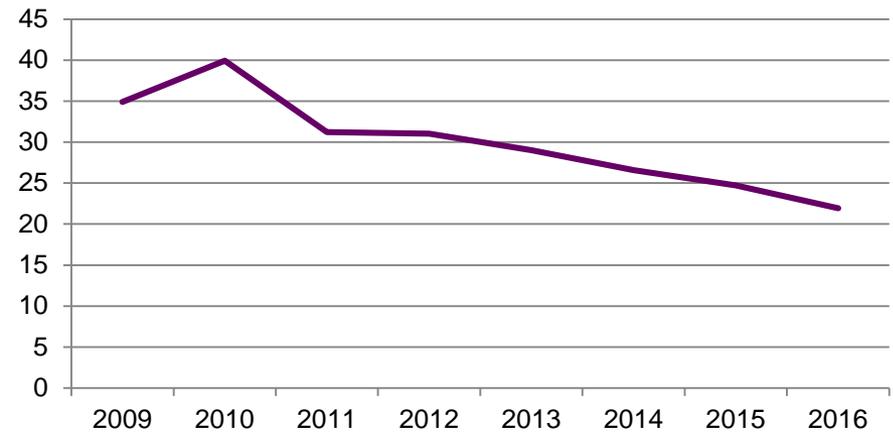


Opioid prescribing trends in California

Opioid prescriptions per 1000 California residents



Californians prescribed >90 Meq per 1000 residents



Data: California opioid overdose surveillance dashboard

DSM-V criteria for opioid use disorder

Problematic pattern of use leading to clinically significant impairment or distress, ≥ 2 of these criteria:

- Taken in larger amounts than intended
- Persistent desire /unsuccessful attempts to cut down
- A great deal of time spent obtaining opioids
- Cravings, or strong desire to use opioids
- Failure to fulfill major role obligations due to opioid use
- Persistent interpersonal or social problems due to opioids
- Social, occupational, or recreational activities given up
- Opioid use in situations where it is physically hazardous
- Continued use despite persistent physical or psychological problems likely caused by opioid use

Tapering vs MAT

Most patients on long-term opioid use can be tapered off, if you go slowly enough.

Diagnosis of opioid use disorder is often not helpful or meaningful in primary care.

Tapering patients is time consuming and generally left to primary care clinicians.



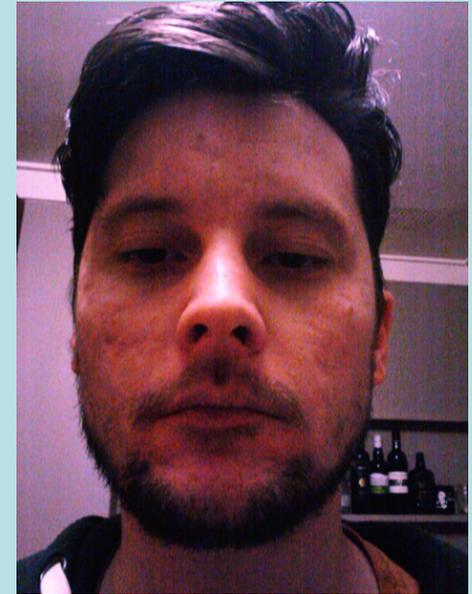
Case 3 – Mr. WB

47yo man, established patient

CC: Pain med refill

HPI: Back pain due to remote MVAs, recent rotator cuff injury

PMH: ESRD (on dialysis), stroke w residual R-sided deficits, HTN, diabetes



Case 3 – Mr. WB

Pain history

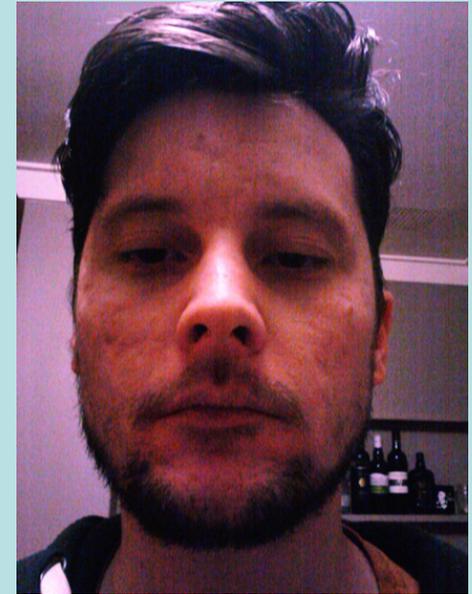
OxyContin 30mg BID

Norco 10/325 4-5x per day

Stable dose for ~5 years;
constantly asks for more pain meds;
reluctantly tries non-opioid treatment;
often disruptive/angry in clinic

CURES okay; UDS negative in 2015

Pain goal: kidney transplant



Case 3 – Mr. WB

Pain history (cont.)

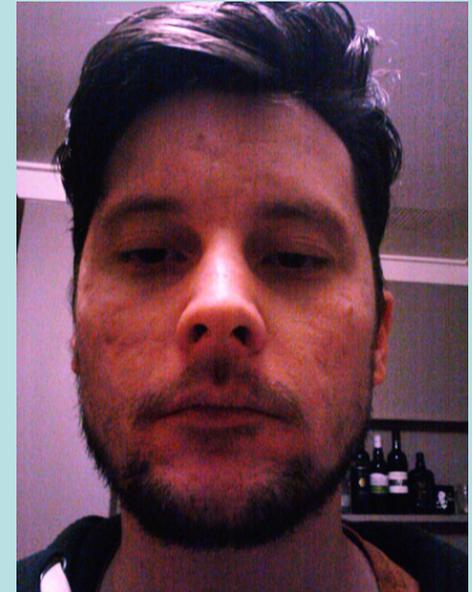
Insurance quit covering OxyContin

Did not tolerate Hysingla or Xtampza

Switched to Norco 10x per day

Changed insurance to get OxyContin

Left clinic when we insisted on tapering him off opioids



Evidence for pain and opioid tapering

Systematic review of studies examining dose reduction or discontinuing of long-term opioid therapy

Overall low quality of evidence; 16 (of 67) studies were of fair or good quality

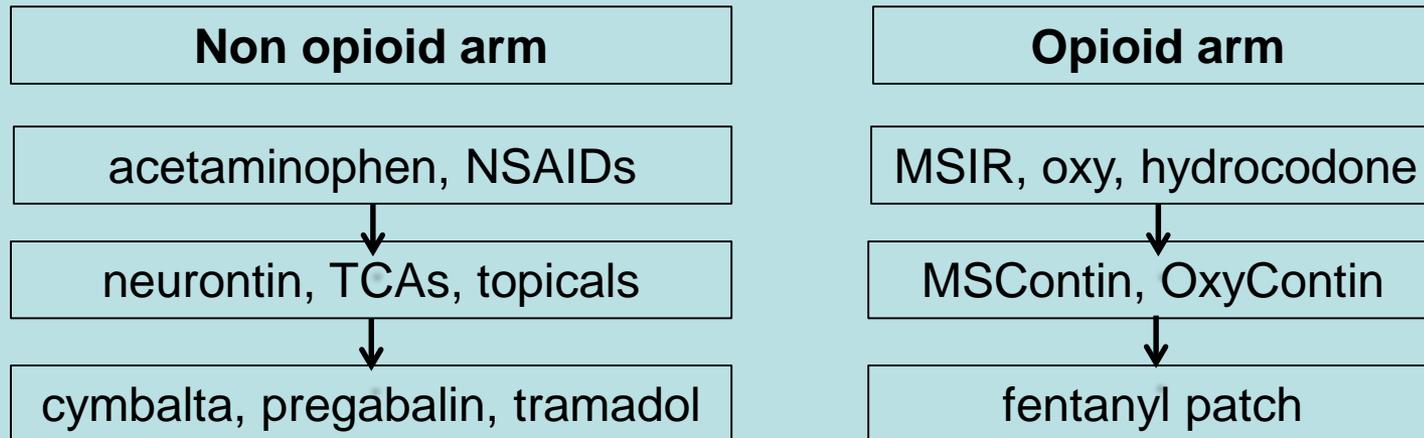
Dose reduction / discontinuation associated with

- Less severe pain (8 of 8 studies)
- Improved function (5 of 5 studies)
- quality of life (3 of 3 studies)

The SPACE Trial

Pragmatic RCT of opioid vs non-opioid analgesics

Randomized 240 veterans with chronic back, knee or hip pain for >6 months with $\geq 5/10$ pain despite analgesic use



The SPACE Trial

Medications managed by one clinical pharmacist

Non-pharmacological therapies allowed

Excluded patients on opioids or with active SUD

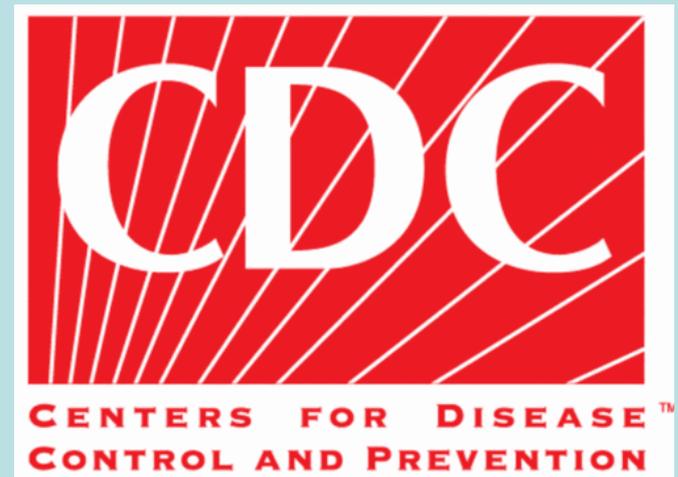
12-month follow up results:

- No difference in pain-related functional impairment ($p = 0.58$)
- Lower pain in non-opioid arm (3.5 vs 4.0; $p = 0.03$)
- Worse anxiety in non-opioid arm ($p = 0.02$)
- No significant differences in other outcomes

Looking forward

Opioids are not as effective for chronic pain as originally thought (but some patients benefit).

“Weaponization” of CDC prescribing guidelines is solving yesterday’s problems.



Questions

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