Team Based Approach

For the Patient Suffering with Chronic Pain

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Disclosures

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Where Do You Start?
“Pain is a uniquely individual and subjective experience that depends on a variety of biological, psychological, and social factors, and different population groups experience pain differentially.”

“For many patients, treatment of pain is inadequate not just because of uncertain diagnoses and societal stigma, but also because of shortcomings in the availability of effective treatments and inadequate patient and clinician knowledge about the best ways to manage pain.”

A quotation from a chronic pain patient (from a committee survey)

“I have a master’s degree in clinical social work. I have a well-documented illness that explains the cause of my pain. But when my pain flares up and I go to the ER, I’ll put on the hospital gown and lose my social status and my identity. I’ll become a blank slate for the doctors to project their own biases and prejudices onto. That is the worst part of being a pain patient. It strips you of your dignity and self-worth.”

Acute Pain:

➢ Is generally “a relatively short, time-limited experience that abates when the injury heals or the disease is cured.” (1)
  ❖ Is essential to survival
  ❖ Warns us of injury/disease.
  ❖ Encourages us to seek medical help
  ❖ Contributes to healing by promoting rest/recovery
  ❖ Its absence notifies us that is okay to resume activities
  ❖ Remembering acutely painful events helps as avoid future harm

➢ Without the capability of feeling pain, people typically do not live beyond childhood (2)

Chronic Pain or Persistent Pain (1, 2)

➢ Serves no adaptive purpose
➢ Persists past normal healing time
➢ When severe/intractable, it impacts the core of the person causing distress and suffering
➢ Associated with significant emotional distress and/or significant functional disability
➢ It ruins marriages and families
➢ Causes job loss, financial problems, social isolation, anxiety, worry, depression, and even suicide
➢ It is difficult to define:
  ❖ Time based definitions suggests:
    • Chronic nonmalignant pain is pain that persists 3-6 months
  ❖ Recent article separated chronic pain into 7 categories with multiple subcategories (2)

Societal Impact of Persistent Pain

Incidence in US (millions)

From: http://www.painmed.org/patientcenter/facts_on_pain.aspx#incidence

1. Institute of Medicine Report from the Committee on Advancing Pain Research, Care, and Education: Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research. The National Academies Press, 2011.

*Diagnosed and estimated undiagnosed
Financial Impact of Persistent Pain

• $530-$635 billion annually (about $2,000 for everyone living in the U.S.)
• More than the 6 next most costly problems (in billions)
  o Cardiovascular: $309
  o Neoplasms: $243
  o Injury/poisoning: $205
  o Endocrine, nutritional, and metabolic: $127
  o Digestive system: $112
  o Respiratory system: $112

1. Pain is experienced by a chronic pain patient as a somatic event. It may or may not be related to tissue damage.
2. The patient may or may not recall an actual event resulting in injury.
3. Injuries may result in pain, but the presence of pain does not necessarily mean that an actual injury has occurred.
4. We often erroneously assume that the greater the pain, the greater the degree of injury.
5. With acute pain, the correlation between the experience of pain and the degree of injury seems to be stronger. With chronic pain the relationship is much more variable.
6. We should reassure patients that their reports of pain are accepted as valid regardless of the results of medical testing.
Memories of previous experiences of pain and events related to the chronic-pain condition

Perceived coping alternatives

Expectations regarding implications of chronic pain for one’s general well being.

Attitudes and beliefs regarding oneself and others
Physical Thinking Emotions Behaviors

Pain diverting activities Vocal utterances
Restricting activity Taking medications
Facial grimaces Moaning
Withdrawing from others Seeking medical assistance
Overt Expressions of Pain Bracing
Limp
Physical

Thinking

Emotions

Behaviors

Environment

Spouse

Work

Social Environment

Living Conditions

Weather Changes

Finances
Pain

Usually thought of as sensation arising from the stimulation of nociceptors
This is an OVERSIMPLIFICATION!

Defined by the IASP as:

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” (1)

Suffering “can be defined as an affective or emotional response in the central nervous system, triggered by nociception or other aversive events, such as loss of a loved one, fear, or threat. Suffering is observed only in the indirect sense of the person's engaging in some behavior that is attributed to suffering.” (2)

Pain Behaviors (2)

• Things people do when they suffer or are in pain
• May arise because of nociception
• May arise from other reasons as well

Biomedical model/Disease Model

• Pain behaviors are seen as symptoms with a clear underlying cause.
• It is assumed that an “underlying cause” must first be corrected before symptoms - “pain behaviors” can abate.
• Results in an ongoing process of trying to find an answer to the question:
  o Why does this person have pain?
• The model is most useful in recent-onset pain problems
• The model begins to fail as time passes and chronicity is reached
  o Spectrum of phenomena influencing pain behavior will have broadened

Ways of Thinking about Pain

Disease or Biomedical Model
Assumes pain is a symptom of underlying body defect.

Vs

Biopsychosocial Model (1)
Suffering behaviors may occur for many reasons that may have substantial, little or no relationship to nociception.

(Biology, behaviors, thoughts, feelings, beliefs, and the environment all play a role).

Biopsychosocial Model

• With **chronic pain disorders** there is frequently a complex interaction between psychological, physiological and sociocultural factors.

• The **biopsychosocial model** of care acknowledges:
  ✓ Multiple influences shape the experience of pain and
  ✓ Contribute to how the patient acts and describes symptoms.

• **Ideally the assessment and management of pain** should:
  ✓ Go beyond a pure biomedical approach
  ✓ Address the various issues that are contributing to the overall suffering.
    (In complex situations, this is best done utilizing a team approach)
“pain is a subjective perceptual event that is not solely dependent on the extent of tissue damage or organic dysfunction.”

“The intensity of pain reported and the responses to the perception of pain are influenced by a wide range of factors, such as meaning of the situation, attentional focus, mood, prior learning history, cultural background, environmental contingencies, social supports, and financial resources, among others.”

“treatment should be designed not only to alter the physical contributors but also to change the patient’s behaviors regardless of the patient’s specific pathophysiology and without necessarily controlling pain per se.”

Best Setting? Multi-Disciplinary or Interdisciplinary Treatment?

The Blind Men and the Elephant
Seek First to Understand
Build the Therapeutic Alliance

• Loss of hope
• Marginalized
• Not taken seriously
• “My doctor thinks its all in my head.”
• Guilty

There is no greater disease than the loss of hope.

-Yisroel Salanter
Affective Contributions to the Chronic Pain Experience

Negative emotions are often associated with chronic pain.

- Around 50% of pts experiencing chronic pain have coexisting depression
  - The prevalence of **pain in depressed** cohorts and **depression in pain** cohorts are **higher than** when these conditions are **individually** examined (1).
  - **Depression** in chronic pain patients is associated with **increased disability** (2)
  - **Anxiety** is **commonly observed** in chronic pain patients and can be **associated with** maladaptive **pain behaviors** that reinforce both pain and disability (3)

Cognitive Contributions to the Pain Experience:

- **Pain catastrophizing** is basically an **irrational negative prediction** of future events (regarding the pain and its consequences).
  - Has been shown to be **associated with more intense pain and more disability** in patients with chronic pain. (1)

- **Patient expectations** influence the course of pain and treatment efficacy.
  - **Negative expectations** regarding pain persistence, disability and return to work can be **self-fulfilling**. (2)
  - **If patients believe** that a treatment is not going to work it probably won’t. (3)

The Patient’s Sociocultural Experience Impacts Pain

• Observing parents or others can affect pain and pain behavior. (1)

• Pain behaviors may be reinforced by how others react to those behaviors (attention, sympathy etc.).

• Pain may be expressed differently in different cultures. (2)

• Cultural differences also exist regarding beliefs about pain and how treatment is typically sought. (2)

Cognitive behavioral therapy (CBT).

- A central feature of interdisciplinary management of chronic pain. (1)
- Key purpose is to identify/replace maladaptive cognitions, emotions, and behaviors with more adaptive ones. (1)

- Hopefully results in:
  - Improved benefit from other interdisciplinary care components (such as physical therapy)
  - Enhanced functional capacity through improved coping

- Improves multiple psychological dimensions of chronic pain. (2)
  - Coping
  - Pain behavior
  - Social function

- Examples of cognitive areas addressed by CBT (3)
  - Catastrophizing
  - Acceptance of the pain condition
  - Avoidance of activity due to unrealistic concerns about harm
  - Expectations of pain treatment

We should:

• Educate the patient about how the nervous system processes, experiences, and responds to pain (from both a biological and a psychological perspective).

This has been shown to result in:

• Improved function and quality of life (whether or not pain decreases).

A Team Based Approach May Help In Various Scenarios in Chronic Pain (Our Experience at UVPM)

- Fibromyalgia program
- Functional restoration program
- Co-management with psychology when there is a pain associated mood disorder (severe anxiety/depression).
- Particularly helpful in addressing:
  - Maladaptive cognitions, emotions, and behaviors commonly associated with a wide variety of chronic pain situations.
- As part of a universal precautions approach in managing patients who are prescribed opioid medications for pain
How Can A Team Based Approach Help in Managing the Chronic Pain Patient on Opioids?

- Can assist with opioid risk assessment by adding a psychological perspective.
- Provides input/help in management of aberrant behaviors that occur in conjunction with opioid therapy use.
- Support during tapering
- Increases the options available to these patients (i.e. adds more non-opioid strategies)
- Assists with management of associated mood disorders.
- May help in functional restoration as well as functional assessment in conjunction with opioid therapy.
- Co-management with psychology when simplifying polypharmacy (i.e. on both opioid medication and benzodiazepine medication).
- Psychological support in working a program in conjunction with on label use of buprenorphine
Statement Found in the Prescribing Information for Opioids:

5 points from this statement:
1. Assess each patient’s risk for opioid addiction, abuse, or misuse prior to prescribing.
2. Monitor all patients receiving opioids for the development of these behaviors and conditions.
3. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction).
4. Risks are increased with mental illness (e.g., major depression).
5. The potential for these risks should not, however, prevent the proper management of pain in any given patient.
Opioid Use Disorder Predictors

- A personal or a family history of alcohol or drug abuse is the strongest predictor of drug use disorder (1)
- History of physical, emotional or sexual abuse (2)
- Presence of a mental health disorder (3)
- Male gender (3)
- Younger age (3)
- Higher average daily dose (3,4)
- Longer duration of therapy (4)
- Prescriptions filled at more pharmacies (3)

Risk Stratification Before Prescribing Opioids

• Has become standard of care (1)
• Per 2017 FSMB Guideline (2)

❖ “Assessment of the patient’s personal and family history of alcohol or drug abuse and relative risk for substance use disorder also should be part of the initial evaluation”
  o Ideally completed prior to deciding to prescribe opioid analgesics
❖ Should inquire into history of physical, emotional or sexual abuse (known risk factors for substance use disorder)
❖ Validated screening tools for substance use disorder may be used for collecting and evaluating information and determining level of risk.

2. Federation of State Medical Boards (FSMB) 2017 Guideline for the Chronic Use of Opioid Analgesics
Also from the 2017 FSMB Guideline

• “Assessment of the patient’s personal and family history of mental health disorders should be part of the initial evaluation”
  ❖ Ideally should be completed prior to a decision as to whether to prescribe opioid analgesics.

• “All patients should be screened for depression and other mental health disorders, as part of risk evaluation.”
  ❖ Patients with untreated depression and other mental health disorders are at increased risk for misuse or abuse of controlled medications, including addiction and overdose.
  ❖ Additionally, untreated depression can interfere with the resolution of pain.
Risk Assessment Tools (per 2016 CDC guidelines)

• Type 3 evidence for accuracy (observational studies or randomized clinical trials with notable limitations).

• Insufficient evidence in reducing harms.

• Screening tools (ORT, SOAPP-R etc.) “show insufficient accuracy for classification of patients as at low or high risk for abuse or misuse”

• “Clinicians should always exercise caution when considering or prescribing opioids for any patient with chronic pain.... and should not overestimate the ability of these tools to rule out risks from long-term opioid therapy.”

• “Clinicians should ask patients about their drug and alcohol use”

Combining the SOAPP with the psychologist’s interview, lead to a marked increase in sensitivity (0.9) in predicting aberrant behaviors in conjunction with opioid use in chronic pain patients.

Universal Precautions (UP) Approach When Prescribing Opioids

➢ We need to use a universal precautions (UP) approach when prescribing opioids in pain management

  o This has been emphasized by pain societies, pain specialists, and government agencies (1-6)

➢ This is a familiar concept to medical professionals (i.e. the blood of all patient should be treated as potentially infectious)

➢ With opioid prescribing, we need to apply a uniform set of practices for all patients who are being considered for long-term opioid therapy.

4. Webster LR, Fine PG. J Pain. 2010
Before Prescribing an Opioid:

Assess the patient

• Detailed history
  ❖ Medical history
  ❖ History of the pain problem (include review of prior workup/testing)
  ❖ History of substance abuse
  ❖ Psychological history
  ❖ Family history (especially history regarding substance abuse and mental health disorders)

• Thorough physical examination
• Arrive at differential diagnosis for causes contributing to the pain and suffering.
(UP) Before Prescribing an Opioid:

**Perform a risk assessment**

- Includes an attempt to predict risk of future aberrant behaviors
  - Take into account history of previous aberrant behaviors and a personal or family history of substance abuse
    - Baseline drug screening (typically urine)
    - Review state monitoring program
    - Consider psychological factors (including input from psychology in our situation)
    - Use validated instruments in this assessment (i.e. SOAPP-R, ORT etc.)
    - When appropriate, communicate with previous prescribers or review their records
    -Dosage of medication

- Includes an assessment of risk for potential medical complications of opioid therapy—including overdose and death
  - Help the patient understand that they can be taking the opioid as prescribed and still overdose/develop respiratory depression/die.
  - Try and quantify this risk for the patient (Zedler et al., Pain Medicine, 2017)
Before Prescribing an Opioid:

**Educate the patient (Be specific)**

- **Risks** of opioid medication
- **On the limited benefits** of opioid medications

**A team based approach can help with this educational process**

- Team members can talk about opioids from their unique perspectives (i.e. prescriber, psychology).
- A team member can reinforce the education given by other team members
If the decision is made to prescribe consider the following general principles:

- Prescribing should be done on a trial basis.
- Prescribing should continue only if the trial is successful and if benefits continue to outweigh risks/side effects.
- Consider the patient’s medical status, psychological status, prior opioid use history, and history of substance abuse.
- Take into account the patient’s dose (as dose increases, risk increases)
- Sometimes tapering is necessary even if the decision to prescribe is made.
- Discuss treatment expectations, potential risks/side effects, and benefits (i.e. informed consent)
  - This should include a discussion about functional goals
- Include a discussion about compliance monitoring (medication counts, random drug screens, securing medication).
- As part of this discussion, review the medication management agreement and have the patient sign that agreement.
Regularity monitor the patient:

➢ More frequent follow-up may be necessary in higher risk situations.
➢ Prescribing is not a one-time decision
➢ This is an ongoing process. The decision to prescribe should be made at every visit after counseling with the patient.
➢ Regularly assess “5 A’s” and act on this reassessment
  ❖ Analgesia: Is the pain better managed because of the opioid?
  ❖ Activity: Is he/she more functional and reaching treatment goals because of the opioid?
  ❖ Adverse effects:
    o Does the patient report sedation, constipation, nausea, vomiting, itching etc.
    o Is there evidence for respiratory depression.
    o Has the situation changed from a risk standpoint (for example has the patient developed a new problem with their lungs etc.)
  ❖ Aberrant behaviors:
    o Is there any evidence for misuse or abuse?
    o Is there any evidence for diversion?
  ❖ Affect: How is the patient’s mood?
Possible Tapering/Discontinuation Needs to Be Considered Regularly (UP cont.)

Potential Reasons to Taper/Discontinue

❖ Lack of efficacy
❖ Intolerable side effects
❖ Pain has resolved
❖ Failure to improve quality of life despite reasonable titration
❖ Failure to achieve pain relief or functional improvement or
  ✓ Deterioration in physical, emotional, or social functioning attributed to opioid therapy
❖ Persistent nonadherence with medication management agreement
❖ Development of opioid use disorder
❖ Aberrant behaviors
❖ Opioid hyperalgesia
❖ Other medical situations resulting in unacceptable risk for opioid-induced respiratory depression/death
❖ Other harms (falls, motor vehicle etc.) that could reasonably be attributable to the opioid medication
❖ Cognitive impairment (either from the opioid or separate from the opioid) or mental health issues resulting in an increased and potentially unmanageable risk for unintentional or intentional misuse

Patients should continue to be treated with non-opioid options for their chronic pain.
Other Reasons Why Tapering/Dose Reduction Be Considered (UP cont.)

- There were more than 33,000 **opioid** overdose deaths in 2015 (includes heroin and prescription opioids). (1)

- **Higher doses** are also associated with increases in the following:
  - Overdose risk (2-4)
  - Opioid use disorder (5)
  - Depression (6)
  - Fracture (7)
  - Motor vehicle accidents (8)
  - Suicide (9)

- Decreasing the dose or discontinuing the opioid obviously may lower risks.

1. Rudd RA, Seth P, David F, Scholl L. 2016,
3. Dunn KM, Saunders KW, Rutter CM, et al. 2010
4. Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink, DN. 2011
8. Gomes T, Redelmeier DA, Juurlink DN, Dhalla IA, Camacho X, Mamdani MM. 2013
Be Aware!

“Clinicians should remain alert to signs of anxiety, depression, and opioid use disorder that might be unmasked by an opioid taper and arrange for management of these co-morbidities” (1)

Tapering May Be Difficult

- Expert guidelines suggest tapering when benefits are outweighed by risks. (1,2)

- The challenges of tapering:
  - In clinical practices, discontinuation of long-term opioid therapy (LTOT) is uncommon ranging from 8-35%. (3,4)
  - Over half of pts receiving high doses of opioids want to cut down or stop their medication--yet 80% are still receiving high doses one year later. (5)
  - 91% of patients on LTOT who experience a nonfatal overdose continue using opioids following that overdose. (6)
  - There is not a lot of evidence guiding clinicians in the process of opioid tapering
  - There are risks associated with tapering (withdrawal symptoms, possible increased pain, and losing the patient to follow-up).

- Some patients do report improved function and improve quality of life after tapering. (7)

2. Department of Veterans Affairs; Department of Defense; Opioid Therapy for Chronic Pain Work Group. 2017
When Discontinuing an Opioid (UP cont.)

• Physical dependence can occur with even short term exposure to an opioid. This is manifested by withdrawal.

• It is generally agreed the patient should gradually be tapered off of opioids.
  o There is a lack of evidence in terms of determining the optimal weaning strategy.
  o A taper of less than 25% dose reduction per week minimizes withdrawal symptoms in most cases.
  o Slower tapers of 10% per week have also been recommended.
  o Some have proposed rapid tapers initially that are slowed as doses reach lower levels.
  o According to the CDC 2016 guideline, “patients tapering opioids after taking them for years might require very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosage”

• When opioids are discontinued because of an opioid use disorder, patients may require inpatient treatment with detoxification.

• Psychological support/CBT can be helpful
Tapering Considerations with Concurrent Benzodiazepine and Opioid Use.

• Per CDC: “because of greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and because tapering opioids can be associated with anxiety, when patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first.” (1)

• Though the above is obviously very important:
  ❖ There are situations where anxiety is the bigger issue and other situations where pain may be the bigger issue and each situation should be considered individually
  ❖ My opinion--In addition to the CDC statement above, the prescriber should consider multiple additional factors before deciding which to taper first:
    - Patient’s input
    - Psychology input
    - The medical situation (both from a pain perspective and a psychological perspective).

If Tapering a Benzodiazepine, the CDC Guideline (1) Suggests:

• Taper benzodiazepines gradually because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death.

• A commonly used tapering schedule that has been used safely and with moderate success is a reduction of the benzodiazepine dose by 25% every 1–2 weeks.

• CBT increases tapering success rates and may help patients struggling with the taper.

• If benzodiazepines are tapered/discontinued, or if patients receiving opioids require treatment for anxiety, the following option should be offered:
  o Evidence-based psychotherapies (e.g., CBT) and/or
  o Specific anti-depressants or other nonbenzodiazepine medications approved for anxiety

“Alone we can do so little; together we can do so much.”

--Helen Keller--
Thank You!