PARADIGM OUTCOMES

The Anatomy of Chronic Pain and Opioid Misuse

Case Management, Treatment Decisions and Opioids

While the financial and societal impact of prescription opioid misuse has concerned carriers and providers for years, choosing the best setting and manner for detoxification remains unclear to many.

Statistics about opioid misuse illustrate the scope of this problem: in recent years, deaths from drug overdose have outstripped deaths by car accident,[1] and for every unintentional death caused by prescription opioids there are 9 patients admitted to substance abuse programs and 35 patients who visit an emergency room for treatment.[2]

The right setting for a particular patient depends on many factors, including dose of opioids and other concurrent medications, geographic availability of treatment options, and family and social supports already in place for that patient. Also important is the reason why he or she has chosen the route of detoxification.

Widespread Use and Hazards

Though opioids have become the standard of care in many pain clinics and primary care settings, this standard has been driven more by habit than by strong medical evidence. Numerous sources, including the American Pain Society, have noted that long-term high-dose opioid use in chronic non-cancer pain has not been proven effective. In fact, the data is piling up about the potential harm of opioids, even with judicious use.

Americans have a troubling relationship with psychoactive drugs, consuming nearly 2/3 of the world's illegal narcotics.[3] When looking specifically at the illicit use of prescription opioids, the American appetite is equally problematic. About 56% of people using prescription pain medication non-medically obtained the drug for free from a friend or relative.[4] A combination of misleading marketing efforts, misconceptions about effectiveness, liberal prescribing patterns and loosening regulation has resulted in an unprecedented number of Americans dependent on opioids.

Side Effects and Withdrawal

Separate from the misuse issues, opioids cause significant side effects that must factor into an understanding of detoxification efforts. According to data from the American Pain Society, over 60% of people taking opioids for chronic non-malignant pain suffer side effects. These include nausea and vomiting, constipation, fatigue, hormone imbalance, urinary retention and immune suppression. Additionally, there are side effects such as sedation and euphoria that might appeal to some users and motivate them to keep using the drug.

While many side effects are unpleasant, withdrawal symptoms can be acutely severe during the early stages of detoxification. Reducing drug intake may cause apathy, agitation, nausea, anxiety, sweating and diarrhea. These can be managed with judicious weaning speed and should fully resolve upon the completion of a detoxification program.

Weaning and Detoxification

When prescription opioid use for non-cancer pain becomes problematic, one must help a patient find the

right setting to wean in a safe and effective manner. Abrupt cessation of opioids can trigger severe withdrawal symptoms caused by physiological drug dependence and is not recommended.

The challenge with detoxification from opioids in the context of chronic pain is that the issues relating to pain symptoms and medication use become entangled. The cause-and-effect relationship between pain, medication side effects and withdrawal symptoms may become blurred for the patient. Particularly impacted will be those patients with suboptimal pain coping skills, which may be a significant population of users of prescription painkillers. It is necessary to blend weaning with pain rehabilitation to give the patient new skills or replacement strategies that are more adaptive and active than simply taking medications.

Selecting Among the Options

The best setting for opioid weaning depends on the specific needs of a given patient. The information below is meant as a guide, not a treatment protocol.

The major factors one must consider when choosing a setting for weaning include:

- desired speed of weaning
- medical and psychosocial complexity of the case
- amount of structure needed

The factors that determine speed of weaning include total dose of opioids and the specific opioid being eliminated. When developing a full picture of the complexity of a case, one must consider the number and doses of other medications the patient is taking as well as his or her ability to manage exacerbated pain symptoms. The amount of structure needed is determined by community supports available to promote weaning and the potential for aberrant behaviors that may require intense psychosocial response.

Next are outlined some general guidelines about what the different weaning settings can provide.

Outpatient Weaning

Outpatient weaning can be performed in a physician's office as part of an outpatient drug weaning program or as part of a comprehensive outpatient program. Weaning is often slower than inpatient settings, with opioid doses lowered by approximately 20-25% every 10-14 days or more slowly, depending on dose of medication and response to weaning.

This setting is best for patients on lower doses of opioids without significant additional medications requiring concurrent detoxification as well as those patients who cope relatively well with pain symptoms and have good social and/or family supports. Withdrawal symptom management needs can be met over the phone or in scheduled visits, while pain management needs can be met in an outpatient setting.

Outpatient programs are not recommended for patients who are expected to have difficulty managing symptoms or who are found to exhibit drug seeking behavior or extreme pain behaviors. Some outpatient interdisciplinary pain programs do not have a detoxification program. All patients require a rehabilitative approach since their pain symptoms and medication use are often entangled.

Inpatient Interdisciplinary Pain Programs

Inpatient weaning and highly structured programs offer the ability to provide constant monitoring and quick intervention for patients who cannot tolerate withdrawal symptoms or perceived exacerbation of symptoms. With these types of programs, weaning can be accomplished at rates of 20-25% every 3 days, depending on medication and dose. Weaning from multiple medications can be done simultaneously or in rapid sequence.

Though detoxification in unidisciplinary inpatient settings may be possible, pain exacerbation often

cannot be managed or becomes unstable upon discharge. Inpatient or tightly coordinated outpatient interdisciplinary programs target pain behaviors, provide modalities to manage withdrawal symptoms, and teach alternatives to pharmacotherapy to manage pain symptoms and restore function.

Replacement Therapies

Therapies such as methadone and buprenorphine preparations can provide a helpful bridge to those weaning off high-dose opioids, but may prove difficult to wean off of in their own right. Their pain-relieving properties have been over-promoted: these are medications to treat addiction, not to reduce pain.

Methadone has some concerning side effects and potential for serious complications. Any replacement therapy requires an "end game": a plan for detoxification and functional rehabilitation is still necessary. Patients with significant addiction or aberrant use may benefit from transition to one of these medications but will still require separate pain rehabilitation and de-emphasis on medication use.

Rapid Detoxification

At this time, rapid detoxification is not recommended to reduce or eliminate opioid use. ODG TWC 2012 Guidelines note that data supporting the effectiveness of rapid detoxification is limited and that the safety of this method has not been established. The guidelines also note that the adverse events are potentially life threatening.

Case Management Pointers

There are many paths to overuse of prescription opioids, and many paths to treatment. For those patients on high doses who have not benefitted or who suffer from significant side effects, safe weaning or detoxification is indicated.

The choice to embark on the route to detoxification is difficult and often courageous. Opioids are highly addictive, and physiological dependence is almost guaranteed at higher doses. The detoxification process can be painful, difficult, and embarrassing.

Pre-planning is vital in order to establish a safety net and support system for the patient once the detoxification process is complete. Case managers must help coach patients to envision life without pain medications. The ability to manage pain symptoms without medications is vital. Follow-up with a provider who will support the non-opioid treatment regimen is perhaps the most important intervention, so that the patient does not risk a quick return to opioids and escalating negative effects.

Lastly, the least costly detoxification option may not be the most effective in patients with dual diagnosis of chronic pain syndrome and opioid dependence. Effective treatment requires a program comprehensive enough to manage both diagnoses. No matter the setting that proves most effective for a particular patient, close case management and planning for the post-detoxification period is vital.

For more information on Paradigm's Systematic Care Management approach to these cases, please review the webinars related to chronic pain on our website at www.paradigmcorp.com.

1. Von Korff, M., et al. Long-Term Opioid Therapy Reconsidered. *Annals of Internal Medicine*, 2011; 155 (325-328).
2. CDC Grand Rounds: Prescription Drug Overdoses – A U.S. Epidemic, January 13, 2012.
3. Wang J, Christo PJ. The influence of prescription monitoring programs on chronic pain management. *Pain Physician*. May-Jun 2009;12(3):507-15.
4. SAMHSA, Office of Applied Studies. Results from the 2006 National Survey on Drug Use and National Findings. 2007.