Opioids in the Treatment of Injured Workers

STEVEN D. FEINBERG, MD, MPH

Board Certified, Physical Medicine & Rehabilitation
Board Certified, Pain Medicine

Adjunct Clinical Professor, Stanford School of Medicine

Feinberg Medical Group
Functional Restoration Programs

stevenfeinberg@hotmail.com
www.FeinbergMedicalGroup.com

Topics to be Covered

- Chronic pain in America.
- Historical perspective: how did we get here?
- Extent of the opioid problem in workers' compensation.
- How did we get here?
- The problem with opioids.
- Opioid facts.
- Opioid in the treatment of injured workers for chronic pain.
- Opioid types & terminology.
- The opioid conundrum in the workers' compensation environment.
- Appropriate opioid use in treating injured workers with chronic pain.
- Risk factors for opioid use and warning signs of misuse.
- Detoxification and weaning of opioids in workers' compensation.
- Appropriate treatment approaches for chronic pain.

Chronic Pain As a Public Health Issue*

- Chronic pain affects at least 100 million American adults
  - more than the total affected by heart disease, cancer, and diabetes combined
- Cost Society $635 billion annually in medical treatment and lost productivity
- Chronic Pain
  - Reduces quality of life
  - Demographic disparities and prevalence and care
  - Chronic pain can be disease in its own right
  - Chronic pain is undertreated

*Institute of Medicine: Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research

- http://iom.nationalacademies.org/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-transforming-Prevention-Care-Education-Research.aspx

How Bad Is It?

- Drug overdoses are the leading cause of death for Americans under 50
- Overdoses killed more people last year than guns or car accidents
- Over 2 million Americans are estimated have a problem with opioids

Historical Perspective: How did we get here?

- < 1990s – Long term opioid therapy for chronic non-cancer pain (CNCP) essentially prohibited.
- 1990s – Assumption that opioids were safe and provided sustained benefit regardless of the dose (no ceiling).
- Pain advocacy groups and pain specialists successfully lobbied state Medical Boards and legislatures to change statutes and regulations to lift the relative prohibition on opioid use in the CNCP.

Historical Perspective: How did we get here?

- Joint Commission on Accreditation of Healthcare Organizations instituted screening for pain as the fifth vital sign.
- Big Pharma markets opioids to doctors (in a big way!)

What Happened?

- According to the CDC (https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm):
  - 1999-2014 – Drug overdoses nearly tripled
  - 2016 – 59,779 drug overdose deaths (Estimate, won't be confirmed by the CDC until this Fall)

What Happened in Workers' Compensation?

- Marked physician increase in opioid prescription
- Increased opioid use (especially at higher doses) associated with:
  - Decreased function
  - Increased medical costs
  - Lower return to work rates
  - Increased claim duration and costs

The Opioid Dilemma

- "To write prescriptions is easy, but to come to an understanding with people is hard"

  -Franz Kafka , "A Country Doctor"

- It is much easier to write an opioid prescription and spend 5 minutes with an IW (and it pays better) than to educate the person about better pain management over a 30+ minute appointment

  - Steven Feinberg, MD

The Opioid Epidemic

- Can lead to long-term health consequences, including limitations in daily activity, impaired driving, mental health problems, trouble breathing, overdose and death
- Prescription drugs, including opioids, have an appropriate use; however, there are risks
- Monitoring and vigilance by the physician are critical to ensure effective and safe use of opioids

Poll

- There is fairly good evidence that increased opioid use (especially at higher doses) is associated with:
  - Decreased function
  - Increased medical costs
  - Lower return to work rates
  - Increased claim duration and costs
  - All of the above

Poll

- There is fairly good evidence that increased opioid use (especially at higher doses) is associated with:
  - Decreased function
  - Increased medical costs
  - Lower return to work rates
  - Increased claim duration and costs
  - **All of the above**

Opioid Facts

- **Opioid analgesics decrease pain in <50% patients with chronic non-cancer pain**

Opioid Facts

- Opioid analgesics decrease pain in <50% patients with chronic non-cancer pain
- **Those who respond to opioids, report approximately 30% decrease in pain from baseline**

Opioid Facts

- Opioid analgesics decrease pain in <50% patients with chronic non-cancer pain
- Those who respond to opioids, report approximately 30% decrease in pain from baseline
- **Most studies show small to medium effect size for pain relief in the short term**

Opioid Facts

- Opioid analgesics decrease pain in <50% patients with chronic non-cancer pain
- Those who respond to opioids, report approximately 30% decrease in pain from baseline
- Most studies show small to medium effect size for pain relief in the short term
- **There is no convincing evidence on long-term efficacy of opioids**

Opioid Facts

- **Opioids are not superior to NSAID, acetaminophen, tricyclic antidepressants e.g., amitriptyline, etc.) or anticonvulsant drugs (e.g., gabapentin, etc.) in decreasing pain or disability**

Opioid Facts

- Opioids are not superior to NSAID, acetaminophen, tricyclic antidepressants e.g., amitriptyline, etc.) or anticonvulsant drugs (e.g., gabapentin, etc.) in decreasing pain or disability
- **Opioid analgesic efficacy is not always sustained during continuous and long-term opioid therapy, even in patients with stable disease and despite dose escalation**

Opioid Facts

- Opioids are not superior to NSAID, tricyclic or anticonvulsant drugs in decreasing pain or disability
- Opioid analgesic efficacy is not always sustained during continuous and long-term opioid therapy, even in patients with stable disease and despite dose escalation
- **Evidence for improved physical, emotional or cognitive function with long-term opioid therapy is inconclusive**

Opioid Facts

- Opioids are not superior to NSAID, tricyclic or anticonvulsant drugs in decreasing pain or disability
- Opioid analgesic efficacy is not always sustained during continuous and long-term opioid therapy, even in patients with stable disease and despite dose escalation
- Evidence for improved physical, emotional or cognitive function with long-term opioid therapy is inconclusive
- **There may be a greater risk for driving related accidents and psychomotor impairment in patients who have recently begun opioid therapy or who have recently increased their opioid dose**

Opioid Facts

- Opioid therapy is associated with high rates of multiple side effects in majority of patients
  - Nausea and vomiting
  - Constipation
  - Drowsiness, lethargy and cognitive impairment
  - Depression
  - Hormonal changes
  - Sexual dysfunction
  - Urinary retention
  - Hypotension and peripheral edema
  - Respiratory depression & death
- A strong association is reported between daily opioid dose and mortality, even at intermediate doses

CDC Study

- The longer the opioid prescription, the greater chance of being on opioid a year later
  - One-day prescription of opioids had a 6 percent chance of being on the drug a year later
  - Those who took opioids for 12 days had an almost 25 percent chance of still being on the drug a year later
  - Those with a monthlong prescription had a worrisome 30 percent chance of continuing to be on prescription opioids a year later

Poll

- Opioids are not superior to NSAIDS, tricyclic or antidepressant drugs:
  - True
  - False

Poll

- Opioids are not superior to NSAIDS, tricyclic or antidepressant drugs:
  - **True**
  - False

Opioids

- Types
  - Agonists & Antagonists
- Morphine equivalent dose (MED)
- Important terms
  - Physical dependence
  - Withdrawal
  - Tolerance
  - Addiction

Morphine Equivalent Dose (MED)

- Treatment with high daily doses (>120 mg/day MED), greater day supply of prescription opioids and use of short-acting schedule II drugs increases risk of opioid misuse

Opioids Types

- Opioid agonists
  - Short Acting
  - Long Acting
- Opioid Partial Agonists/Antagonists
  - buprenorphine (Buprenex®, Subutex®)
  - buprenorphine and naloxone (Suboxone®)

Important Terms

- Physical dependence
- Withdrawal
- Tolerance
- Addiction

Dependence

- Physical dependence is a normally induced state such that abrupt stopping medication results in withdrawal symptoms
- Psychological dependence occurs when the individual becomes emotionally tied to taking a specific drug and develops anxiety with planned drug cessation

Withdrawal

- Withdrawal is defined as a set of normal physiologic consequences (things that happen to your body) that occur as a response to abrupt cessation of a drug
- Symptoms consistent with withdrawal include increased heart rate, sweating, body aches, nausea, vomiting, diarrhea, and abdominal pain and mood changes

Tolerance

- Tolerance is a simple observation of requiring larger opioid doses to produce the same effect
- In other words, it takes more pills to get the same or less pain relief
- Increase dose may lead to side-effects & dependence

Addiction

- Addiction is an abnormal behavioral syndrome induced by a certain medication or drug in a susceptible patient
- Findings necessary to make a diagnosis of addiction include:
  - Abnormal behavior focused on acquiring the offending drug
  - Evidence of harm with the use of the drug
  - Continued drug use despite the individual's awareness of harm with use

Poll

- Findings necessary to make a diagnosis of addiction include:
  - Abnormal behavior focused on acquiring the offending drug
  - Evidence of harm with the use of the drug
  - Continued drug use despite the individual's awareness of harm with use
  - a & c
  - All of the above

Poll

- Findings necessary to make a diagnosis of addiction include:
  - Abnormal behavior focused on acquiring the offending drug
  - Evidence of harm with the use of the drug
  - Continued drug use despite the individual's awareness of harm with use
  - a & c
  - **All of the above**

The Opioid Conundrum

- Ever increasing problem of increasing deaths and dysfunction from the inappropriate use of prescription opioids

- versus -

- Needs of patients for adequate pain control to facilitate comfort, activity, function, and return to work

Conundrum: Opioids for Chronic Pain

- Short-term use of opioids is rarely worrisome
  - Exceptions
    - History of substance abuse
    - Delayed recovery factors
      - Psychiatric comorbidity
      - Adverse childhood experiences (ACE)
- Prolonged use increases side-effect risks
- opioids for treating chronic pain in and of themselves can cause a disability (and impairment) and a decrease in the ability to function in life

Measuring Opioid Usefulness

- Ultimate outcome of the use of opioid medication must be viewed in terms of:
  - Pain relief/reduction
  - Objective gains (function or increased activity including return to work)
  - Manageable side-effects
- It is not about the drug but about the benefit from use
- A small, select group benefits from chronic opioids, with resultant pain reduction and improved physical and psychological functioning
- Most do poorly with chronic opioids, especially with escalating doses

Strategy for Prescribing Opioids

- Careful assessment and formation of an appropriate diagnosis
- Does the physical pathology support opioid prescription
- Psychological assessment including risk of addictive disorders
- Treatment agreement
- Opioids as a trial
- Assessment and reassessment of pain and level of function

Risk Factors for Opioid Abuse

- History of addiction to opioids, alcohol and/or other drugs
- Personal or family substance abuse history
- Adverse childhood experiences (ACE)
  - Neglect
  - Physical, emotional, sexual abuse
- Comorbid psychiatric disorders

Risk Assessment Tools

- **ORT:** Opioid Risk Tool
- **SOAPP:** Screener and Opioid Assessment for Patients with Pain
- **DIRE:** Diagnosis, Intractability, Risk, Efficacy
- **COMM:** Current Opioid Misuse Measure
- **PMQ:** Pain Medication Questionnaire
- **DAST-10**: Drug Abuse Screening Test

Warning Signs of Substance Use Disorder

- Intoxication & aberrant behavior
- Reports of lost or stolen prescriptions
- Failure to achieve pain reduction
- Failure to improve in function
- Acquisition of opioid prescriptions from multiple physicians
  - Prescription Drug Monitoring Program (PDMP)
- Failed urine drug testing (UDT)

Pain & Opioid Treatment Guidelines

- State specific guidelines
- Medical society specific guidelines
- ACOEM
- ODG
- CDC Guideline for Prescribing Opioids for Chronic Pain, 2016

Pain & Opioid Treatment Guidelines

- Identify justifiable EBM treatment
  - Education of prescribers
  - Protecting consumers
- Recognize importance of psychosocial factors
  - Identifying risk factors for delayed recovery
- Treatment focused on education and functional restoration
- If prescribed, should be short-term on a trial basis

Guidelines for the Use of Opioids

- Focused on reduction/elimination of opioids
- Opioid medications are not the first line of treatment for pain and should not in general be used for mild injuries
- They should only be prescribed at the lowest dose that provides pain relief, for a limited time, and with no refill, prior to re-assessment
- Patient should be educated about opioids and adverse possible adverse events – expectation should be clear for short-term use
- Opioid agreements recommended & random urine drug testing
- Prescription Drug Monitoring Program (PDMP)

Weaning - Detoxification

- Should never be abrupt
- Best done slowly
- Consideration for conversion to buprenorphine
- Patients who have been on long-term chronic opioids may be difficult to completely wean
- Provide pain treatment alternatives

What Do Chronic Pain Guidelines Recommend?

- Functional Restoration
- Treat with a biopsychosocial functional restoration approach
  - Physical (Pathophysiology)
  - Psychological state
  - Consider all factors including IW belief and expectations and childhood and life experiences
- Focus of treatment
  - Medication optimization with weaning/detoxification of opioids and psychotropic medications
  - Increased function with return to life and work activities

Thank You for Participating in This Webinar

STEVEN D. FEINBERG, MD, MPH

Board Certified, Physical Medicine & Rehabilitation
Board Certified, Pain Medicine

Adjunct Clinical Professor, Stanford School of Medicine

Feinberg Medical Group
Functional Restoration Programs
Palo Alto, California 94301
stevenfeinberg@hotmail.com
www.FeinbergMedicalGroup.com