Treating Acute Pain: It's not what it used to be

From the 1990's to today

Craig J. Uthe, MD FAAFP ASAM
Sanford Health, Chronic Pain and Addiction

MPATTC

Tuesday, July 23, 2024

Opioid Response Network

DISCLOSURE

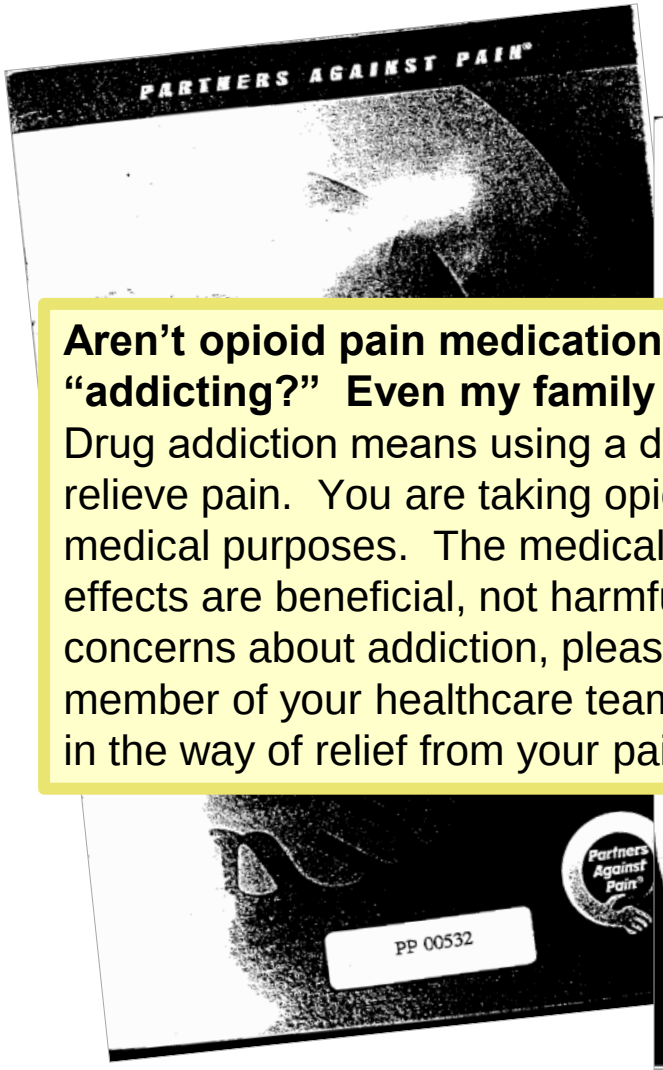
No conflicts of interest to disclose

OBJECTIVES

- ✓ Know the basic differences between acute pain and chronic pain
- ✓ Identify key elements in determining appropriate acute pain and post-op pain opioid management

- ✓ Explore challenges and opportunities in treating acute pain as it moves to chronic pain

PAIN MANAGEMENT – 1990s



Aren't opioid pain medications like OxyContin Tablets "addicting?" Even my family is concerned about this.
Drug addiction means using a drug to get "high" rather than to relieve pain. You are taking opioid pain medication for medical purposes. The medical purposes are clear, and the effects are beneficial, not harmful. If you or your family have concerns about addiction, please talk to your doctor or another member of your healthcare team. This fear should not stand in the way of relief from your pain

doctor. It may mean that your regular dose of OxyContin® (oxycodone HCl controlled-release) Tablets needs to be increased. It's a good idea to keep a diary of how many times a day you use your rescue medication and what caused the pain. Also

- **Do not** use your OxyContin® Tablets for your breakthrough pain.

PP 00539

Will it be easy to take OxyContin® Tablets?

OxyContin® Tablets are small (see actual size below) which makes them easy to swallow. They are also color-coded according to their strength. This is helpful for you and your physician.

OxyContin® Tablet Strengths

OxyContin® 80 mg and 160 mg Tablets for use only in opioid-tolerant patients requiring daily oxycodone equivalent dosages of 160 mg and 320 mg respectively.

Aren't opioid pain medications like OxyContin® Tablets "addicting?" Even my family is concerned about this.

Drug addiction means using a drug to get "high" rather than to relieve pain. You are taking opioid pain medication for medical purposes. The medical purposes are clear and the effects are beneficial, not harmful. If you or your family have concerns about addiction, please talk to your doctor or another member of your healthcare team. This fear should not stand in the way of relief from your pain.

What are the most important things to remember while I'm taking OxyContin® Tablets for my pain?

The single most important thing for you to remember is that you are the authority on your pain. Nobody else feels it for you so nobody else can describe how much it hurts, or when it feels better. Your healthcare team is there to help, but they need your help, too. Be sure to talk to them, ask them questions, tell them how you feel — whether that is better or worse. Together you can be *Partners Against Pain®*.

Additional Reminders

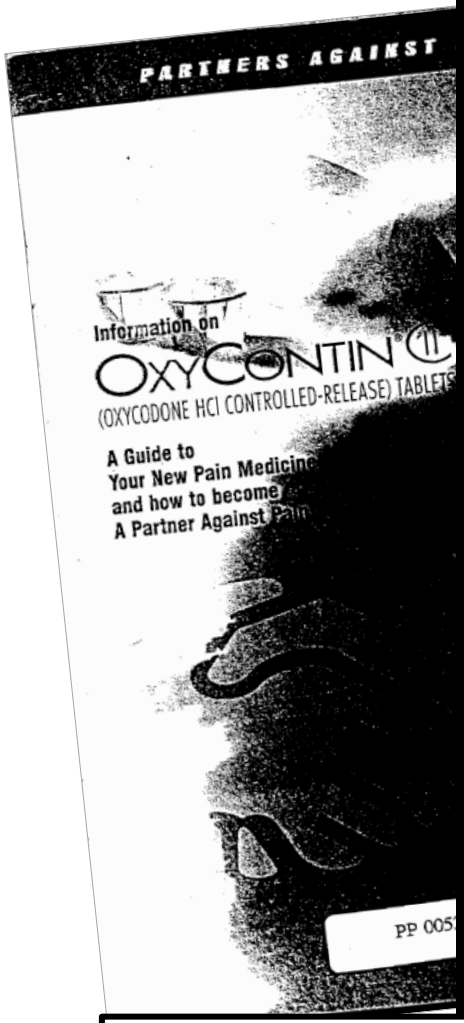
Make sure you always have enough medication.

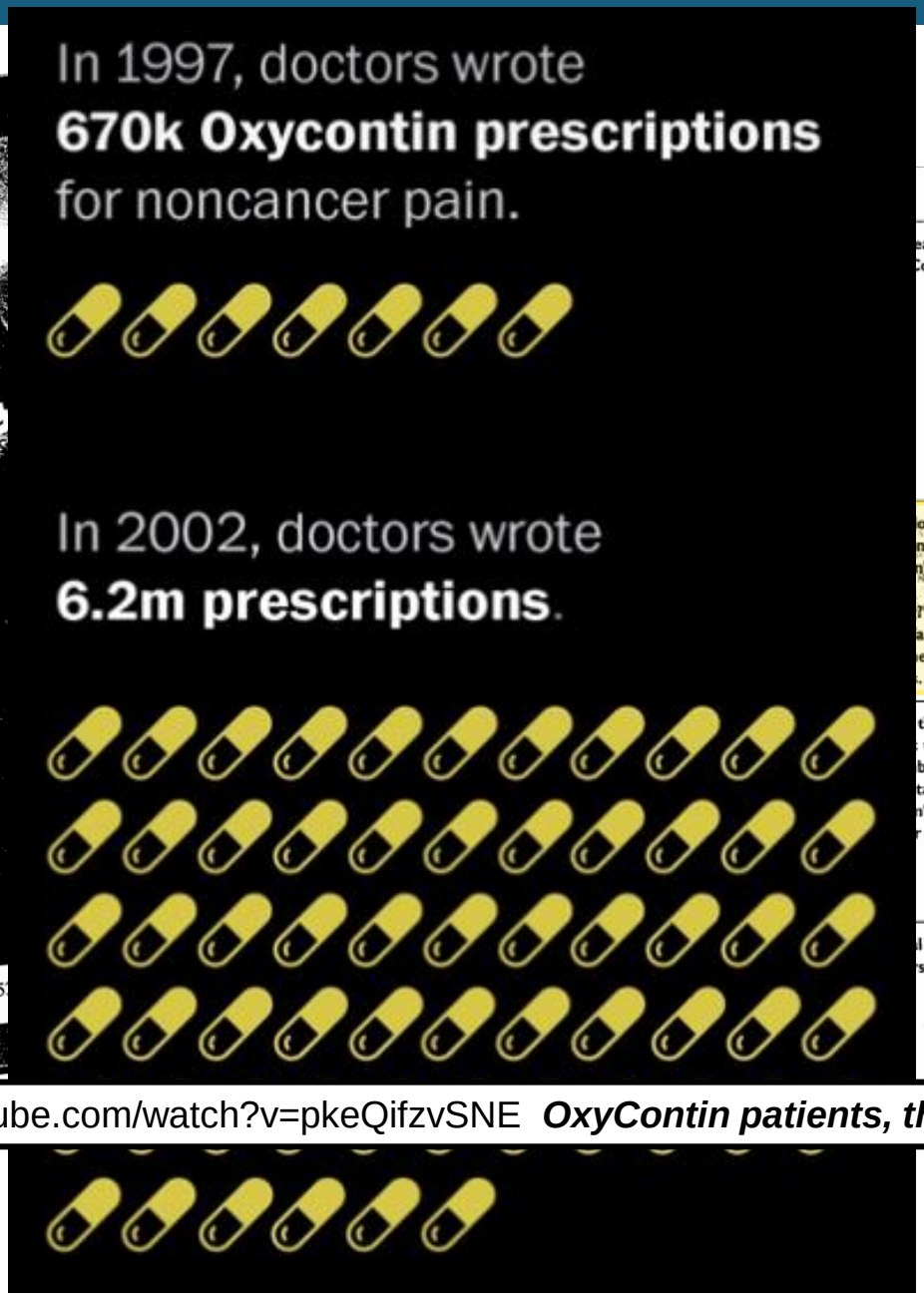
OxyContin® Tablets require a written prescription, so your doctor cannot call it into your pharmacy. Call or see your doctor at least one week before you run out of medication. Ask a family member to help you keep track if necessary.

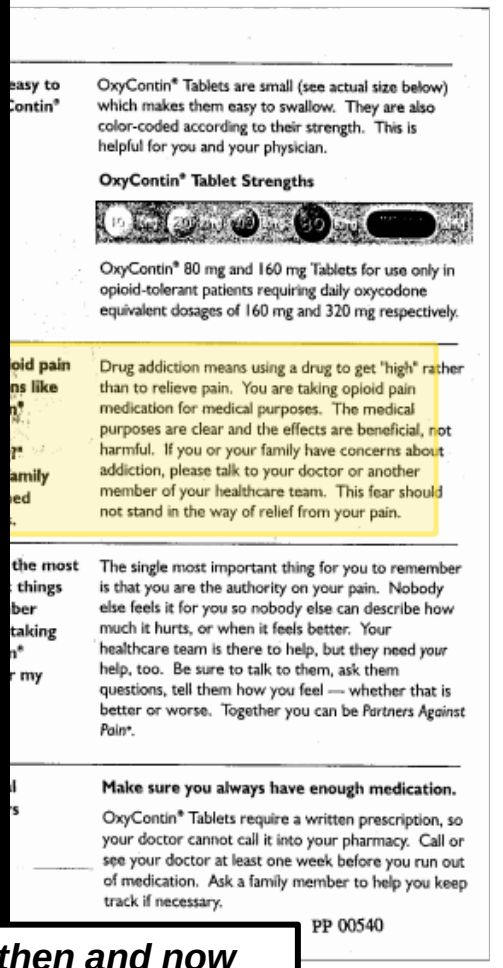
PP 00540

PAIN MANAGEMENT – 1990s

PAIN MANAGEMENT – 1990s

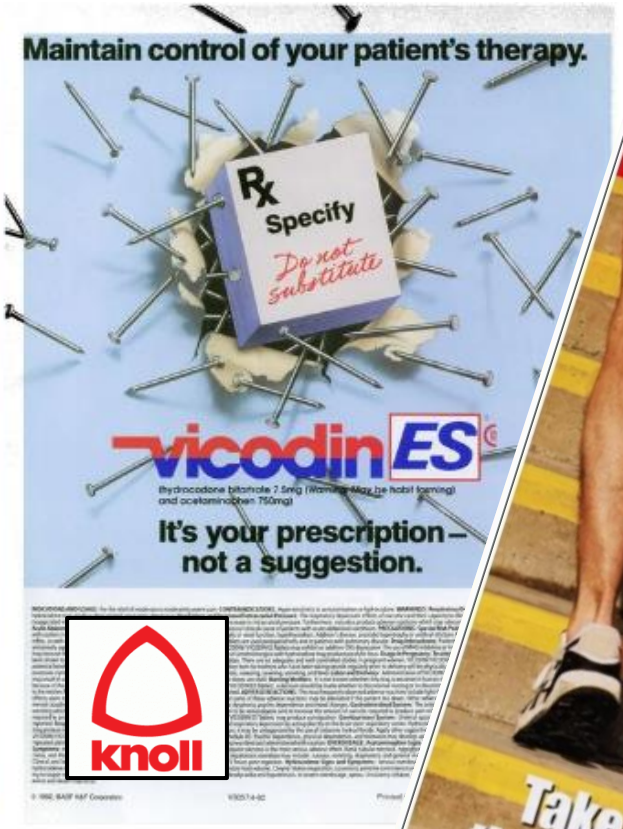






https://www.youtube.com/watch?v=pkeQifzvSNE ***OxyContin patients, then and now***

PAIN MANAGEMENT – 1990s

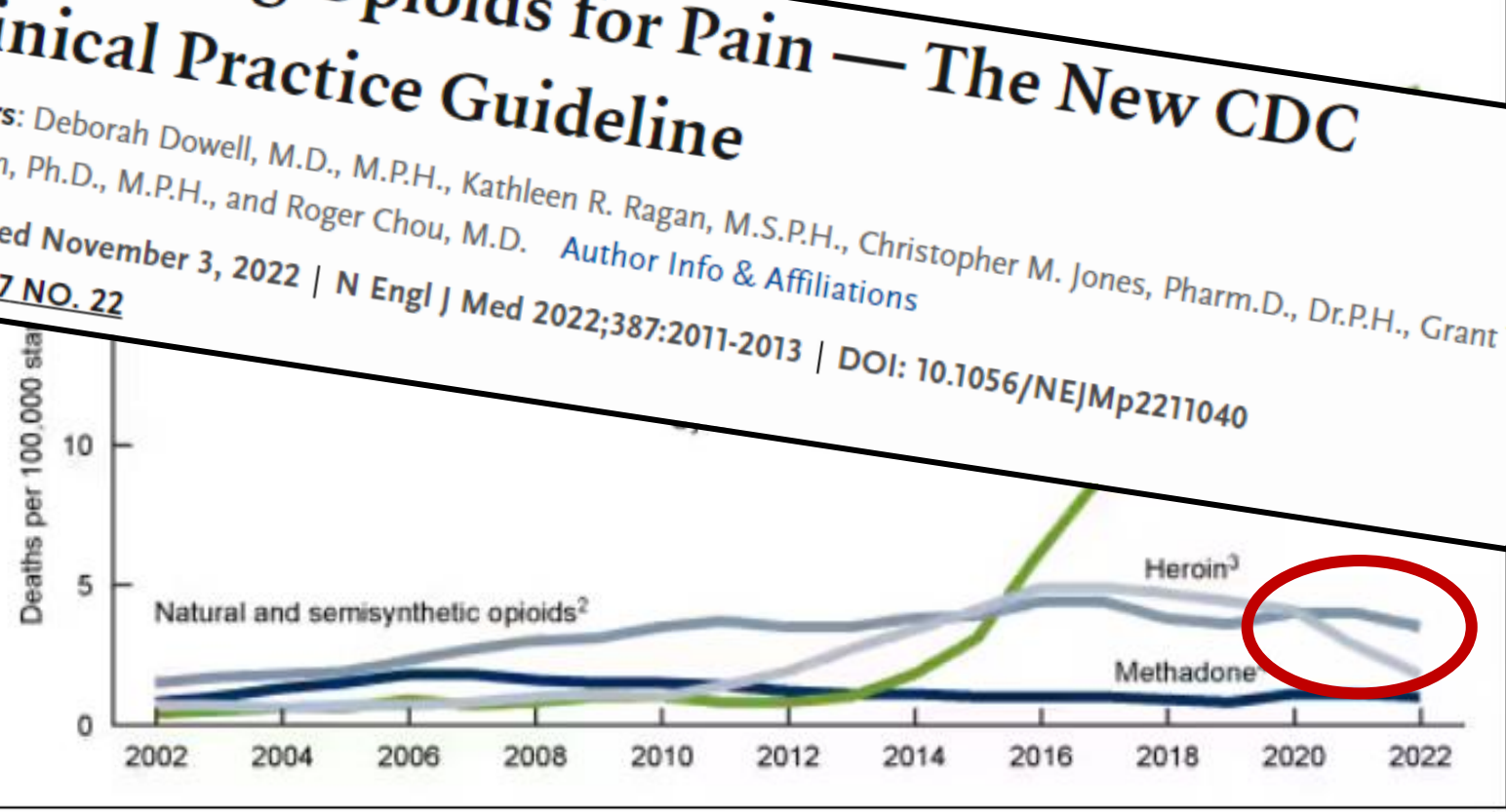


PAIN MANAGEMENT – 1990s

PAIN MANAGEMENT – 1990s

THE OPIOID EPIDEMIC – 2020s

Figure 4. Age-adjusted rate of drug overdose deaths involving
of opioid: United States, 2002–2022



Prescribing Opioids for Pain — The New CDC Clinical Practice Guideline

Authors: Deborah Dowell, M.D., M.P.H., Kathleen R. Ragan, M.S.P.H., Christopher M. Jones, Pharm.D., Dr.P.H., Grant T. Baldwin, Ph.D., M.P.H., and Roger Chou, M.D. Author Info & Affiliations

Published November 3, 2022 | **N Engl J Med 2022;387:2011-2013** | **DOI: 10.1056/NEJMp2211040**

VOL. 387 NO. 22

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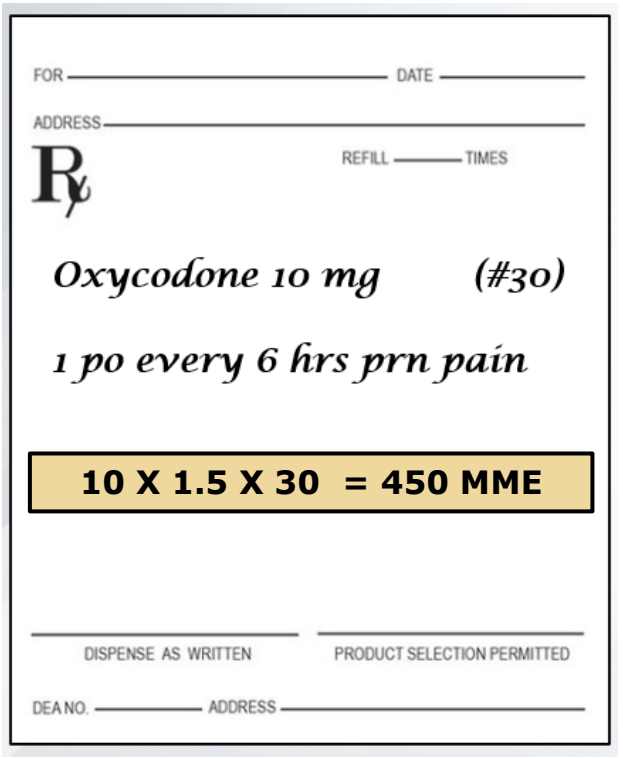
CASE STUDY – ACUTE PAIN

81 yo WF brought into ER by husband after syncopal episode around suppertime. She had Rt carpal tunnel surgery yesterday and has been sleeping most of the time since she got home.
She states feeling fine but groggy. Her Rt wrist is 3/10 pain, tolerable. She is on no Rx meds and has no chronic illnesses.
BP 100/55, HR 88reg, RR 16. Wt-101 lbs. No postural changes in VS.
Lungs clear. Heart reg. Neuro exam nl.

Meds: Oxycodone 10 mg 1 po q4h prn pain (#30) – given post-op after same-day surg.

Dx: Iatrogenic syncope, secondary to medication

Discontinue oxycodone.



Opioid dosage *x* conversion factor *x* # of pills = MME

TYPES OF PAIN

THREE MAIN TYPES OF PATHOPHYSIOLOGY
can be considered to result in chronic pain[1]

More than 1 type of pain may be present in a given patient

PATHOPHYSIOLOGY OF PAIN

3rd tier

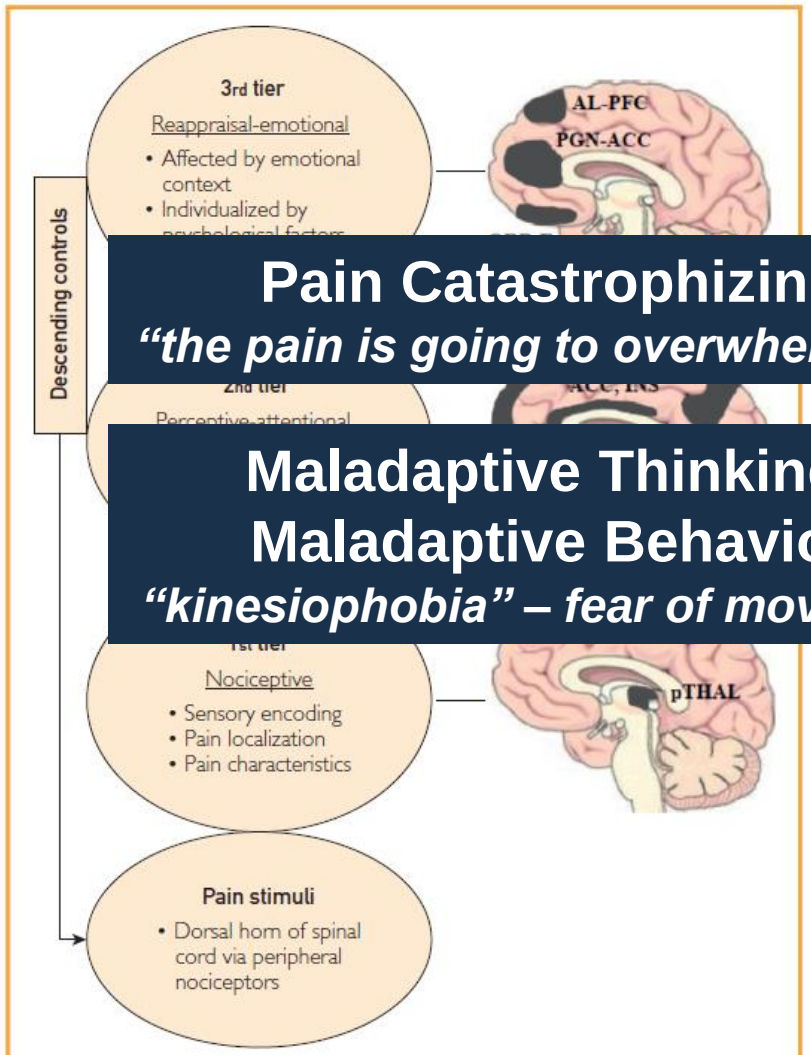
minutes to months

2nd tier

seconds

1st tier

milliseconds

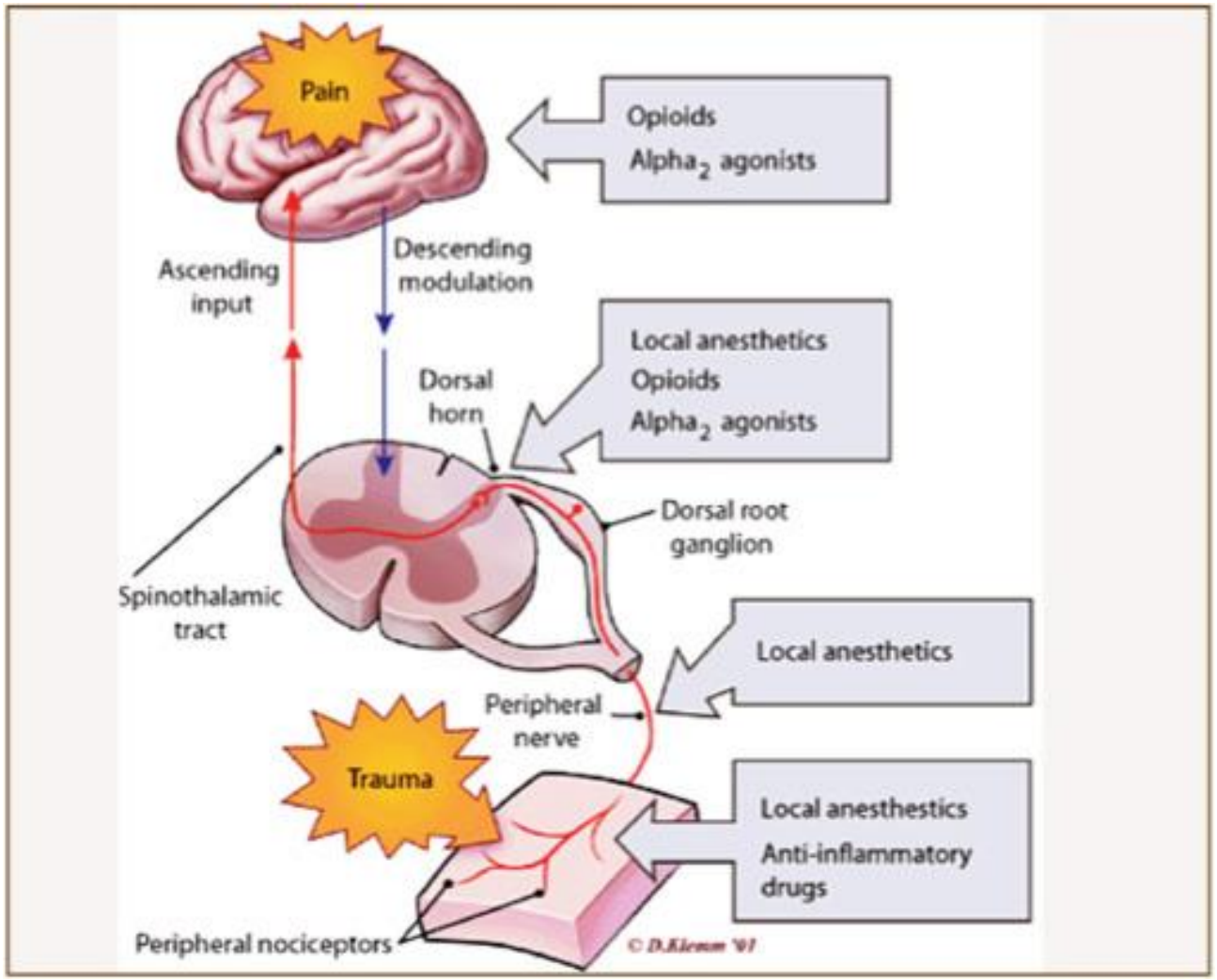


Pain Catastrophizing
"the pain is going to overwhelm me"

Maladaptive Thinking/ Maladaptive Behavior
"kinesiophobia" – fear of movement

FIGURE 1. Schematic representation of the 3-tiered pain matrix. ACC = anterior cingulate cortex; AL-PFC = anteriolateral prefrontal cortex; INS = insula; ORB-F = orbitofrontal; PFC = prefrontal cortex; PGN-ACC = perigenual anterior cingulate cortex; pPAR = posterior parietal cortex; pTHAL = posterior thalamus.

PATHOPHYSIOLOGY OF PAIN



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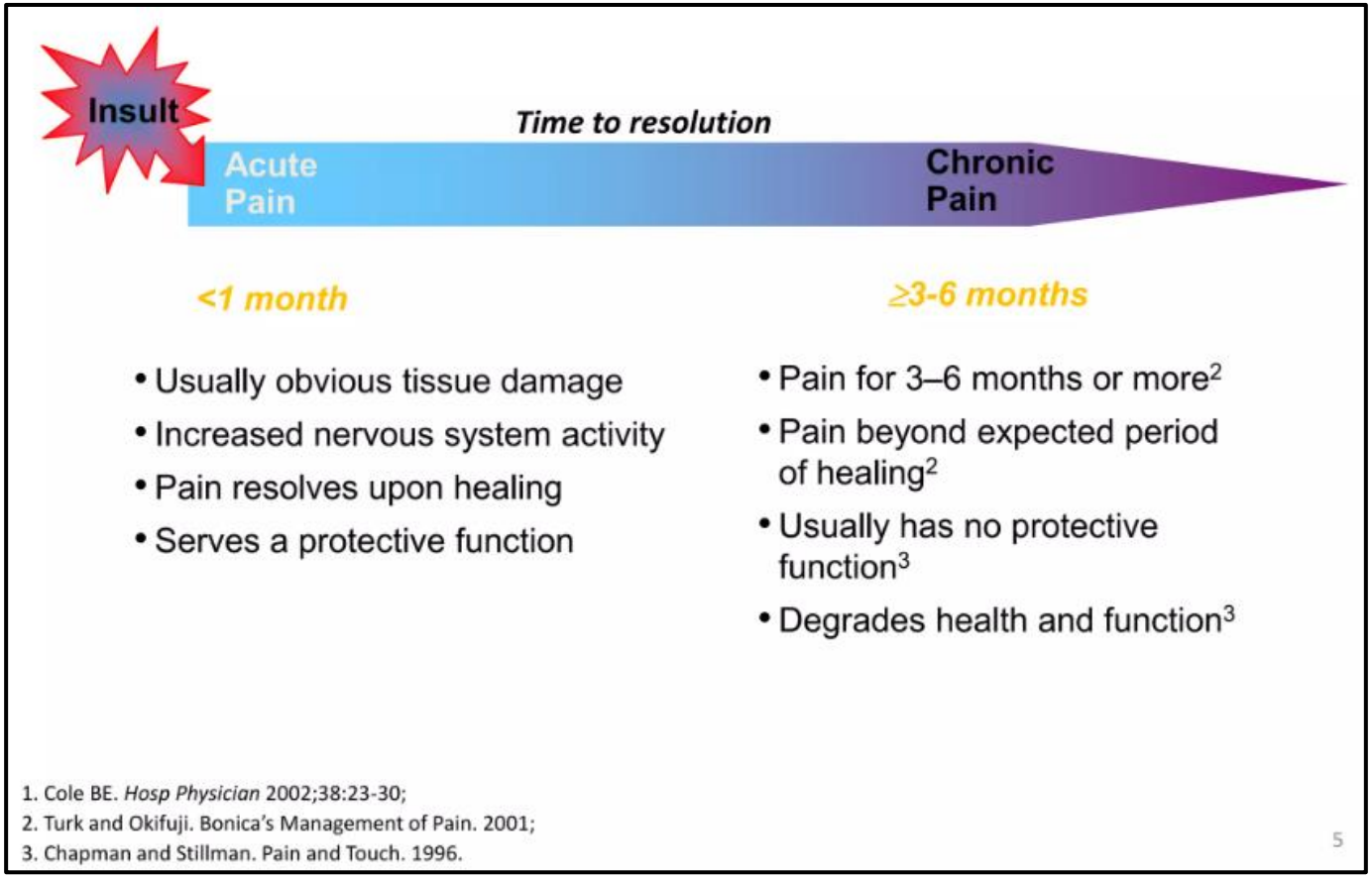

PAIN MANAGEMENT

Table C. Management Considerations Based on Pain Type: Acute vs. Chronic Pain		
Characteristics	**Acute Pain**	**Chronic Pain**
Duration	Normal healing duration; <3-6 months	Prolonged duration >6 months
Function	Physiologic (protective)	Pathologic (non-protective)
Cause	Acute illness, injury, trauma, surgery or other medical procedure	Injury, chronic illness, cancer, may have no indefinable pathology
Characteristics	Usually nociceptive; sharp, localized, sudden/gradual onset	Usually a combination of nociceptive and neuropathic, dull, aching, generalized, persistent
Treatment options (non-inclusive list no in any particular order)	Nonsteroidal anti-inflammatory drugs (NSAIDS), acetaminophen, opioids, nerve bocks, ketamine, muscle relaxants, pain-reducing modalities (e.g., immobilization, heat/cold, and elevation), graded exercise of the affected body area, physical therapy. Opioids are not recommended for acute low back pain.	Non-opioid analgesics, physical therapy, cognitive behavioral therapy, rehabilitation, exercise, integrative medical therapies (e.g., yoga, relaxation, tai chi, massage, and acupuncture), opioids on a case-by-case basis
Goals of treatment	Pain Resolution + Resolve underlying cause: - Facilitate recovery - Reduce pain - Minimize side effects - Prevent chronic pain	Pain Control + Restore function: - Restore function (physical, emotional, social) - Decrease pain (e.g., treat underlying cause, minimize medication use) - Correct secondary consequences (e.g., maladaptive behavior)

https://www.aafp.org/family-physician/patient-care/care-resources/pain-management/aafp-chronic-pain-management-toolkit.html

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Opioids for Acute Pain

- Opioids generally considered effective for acute pain
  - But, recent data indicates that opioids may be no more effective than an NSAID alone for acute pain
    - In LBP adding oxycodone/acetaminophen to an NSAID did not improve pain or function at 1 week (Friedman BW. JAMA 2015;314:1572)
- Use of opioids for “minor” pain associated with increased risk of long-term use
  - Versus no opioid use, opioid within 7 days of minor surgery associated with 44% increased risk of use at 1 year (Alam A. Arch Intern Med 2012;172:425)
- Prescribing excessive quantities of opioids for acute pain resulting in leftover opioids
  - Source of diversion and unprescribed use
- More judicious use of opioids for acute pain
  - If used, limit opioids to a 3-7 day supply for most acute pain

OPIOIDS IN PAIN MANAGEMENT

Generalizations to consider:

Chronic Pain: measure opioids in total MMEs per day.
*Recommend **< 90 MME/day*** in total Rx*

Acute Pain: measure opioids in total MMEs per prescription.
*Recommend **≤ 100 MME** in **total** prescription (Rx)*

Post-op Pain: measure opioids in total MMEs per prescription based upon a tiered system for severity of pain.
*Recommend **≤100 MME total** Rx in Tier 1 surgeries; up to **≤200 MME total** Rx in Tier 2 surgeries*

consider **<50 MME/day if co-occurring illness present*

OPIOIDS IN OUT-PATIENT ACUTE PAIN MANAGEMENT

Participating Groups and Measurable Goals

mnhealth COLLABORATIVE activated by icsi.

ICSI: Institute for Clinical Systems Improvement

- Three providing groups:
  - Ambulatory care clinics
  - Acute care clinics
  - Emergency departments

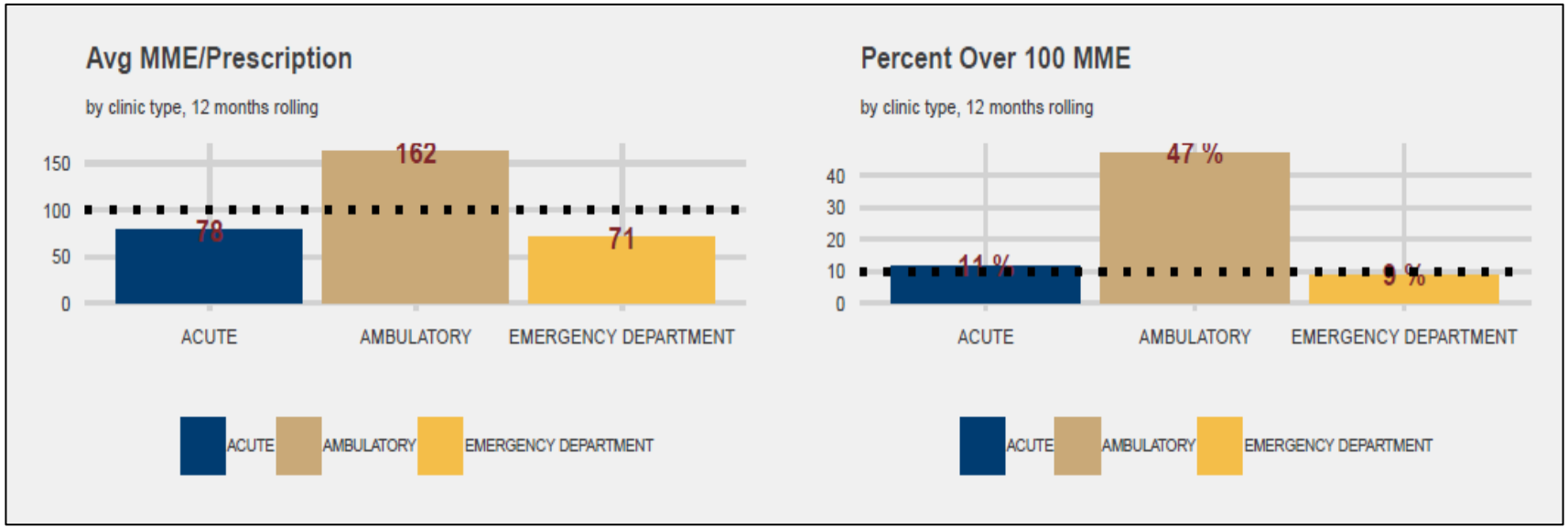
- **Goals:**
  - **90%** of all opioid prescriptions for opioid naïve patients will be **≤ 100 MME/prescription**
  - **Average** total MME/prescription will be **< 100 MME**
  - **Total** MME accumulative in all opioid Rx **≤ 700 MME**

OPIOIDS IN OUT-PATIENT ACUTE PAIN MANAGEMENT

mnhealth COLLABORATIVE activated by icsi.

GOAL: adequate pain relief without over-prescribing opioids which have potential for misuse or abuse

Measures opioids in total MMEs per prescription.
[Recommend ≤ 100 MME in total prescription (Rx)]



Avg MME/RX ≤ 100 MME

Less than 10% of all opioid Rx > 100 MME total

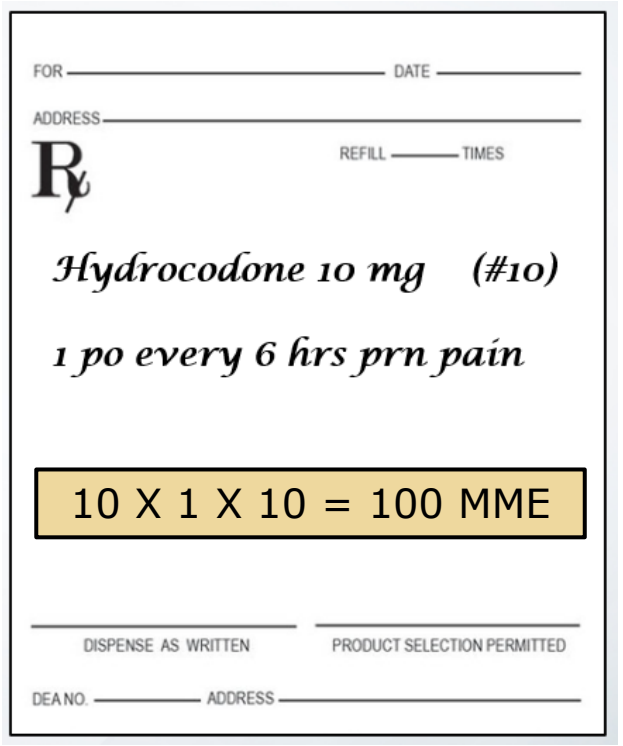
CASE STUDY – ACUTE PAIN

23 yo BM comes to ED with acute ankle injury playing football. He rates the pain as 8/10 and swelling, ecchymosis, and tenderness along his dorsal foot and lateral ankle along ligament lines, less over lateral malleolus. Bounding DP, PT pulses.

X-Ray of Rt foot and Rt ankle negative for fracture.

Dx: Grade 3 right ankle sprain

Plan:
Hydrocodone 10 mg 1 po q6h prn pain (#10)



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Generalizations to consider:

Brummett CM, Waljee JF, Goesling J et al. New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. *JAMA Surg*. 2017;152:e170504.

Zaveri S, Nobel TB, Khetan P, Divino CM. Risk of Chronic Opioid Use in Opioid-Naïve and Non-Naïve Patients after Ambulatory Surgery. *J Gastrointest Surg*. 2019

Alam A, Gomes T, Zheng H, Mamdani MM, Juurlink DN, Bell CM. Long-term analgesic use after low-risk surgery: a retrospective cohort study. *Arch Intern Med*. 2012;172:425–430.

Carroll I, Barelka P, Wang CK et al. A pilot cohort study of the determinants of longitudinal opioid use after surgery. *Anesth Analg*. 2012;115:694–702.

Sun EC, Darnall BD, Baker LC, Mackey S. Incidence of and Risk Factors for Chronic Opioid Use Among Opioid-Naive Patients in the Postoperative Period. *JAMA Intern Med*. 2016;176:1286–1293.

Alam A. **Arch Intern Med**. **2012** Mar 12;172(5):425. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8194057/

OPIOIDS IN PAIN MANAGEMENT

https://www.icsi.org/programs/mn-health-collaborative-opioids/
https://www.icsi.org/wp-content/uploads/2021/11/ICSI-Opioid-Postop-Toolkit.pdf

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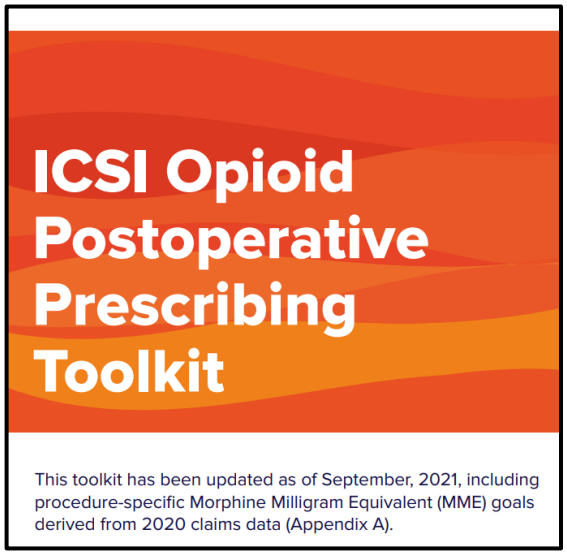
OPIOIDS IN POST-OPERATIVE PAIN MANAGEMENT

Participating Groups and Measurable Goals



- Surgical Departments:
  - OB/GYN
  - Orthopedics
  - General Surgery
  - Otolaryngology

https://www.icsi.org/programs/mn-health-collaborative-opioids/
https://www.icsi.org/wp-content/uploads/2021/11/ICSI-Opioid-Postop-Toolkit.pdf

- Goals:
  - Benchmark **25th percentile MME** in relation to surgical specialty's previous tabulated mean MME in total Rx
  - **Average** MME/prescription **tiered** at **< 100 MME, < 150 MME, or <200 MME**

OPIOIDS IN POST-OPERATIVE PAIN MANAGEMENT

GOAL: adequate pain relief without over-prescribing opioids available for potential misuse or abuse

SURGICAL GROUPING: Gynecology Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Cesarean Section, Delivery Only	75	127	334	211	63%
Cesarean Section, Global	75	127	1323	881	67%
Colporrhaphy	75	104	35	26	74%
Conization Of Cervix	30	54	183	26	14%
Excision of Ovary/Ovarian Duct	75	99	160	139	87%
Hysteroscopy With Treatment	38	64	320	134	42%
Incision and Drainage Of Bartholin's Gland Abscess	0	98	37	2*	5%
Ligation of Fallopian Tube	75	126	62	38	61%
Removal of Ovary/Ovarian Duct	75	97	251	215	86%
Stress Incontinence Repair	50	79	93	69	74%
Supracervical Hysterectomy	75	114	76	60	79%
Total Abdominal Hysterectomy	98	140	64	49	77%
Vaginal Hysterectomy	75	124	616	516	84%
Vaginal Delivery**	0				

* < 10% of patient received Rx, benchmark changed to no routine opioids

** Benchmark derived from literature and expert opinion. *(Prabhu, 2018)*

OPIOIDS IN POST-OPERATIVE PAIN MANAGEMENT

GOAL: adequate pain relief without over-prescribing opioids available for potential misuse or abuse

SURGICAL GROUPING: Orthopedic Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Carpal Tunnel Surgery - Arthroscopic	45	73	154	102	66%
Carpal Tunnel Surgery - Open	50	78	717	453	63%
Joint Replacements (Hip)	200	253	708	545	77%
Joint Replacements (Knee)	250	317	880	739	84%
Joint Replacements (Knee Revision)	225	294	37	27	73%
Other Knee Arthroscopy with Treatment	100	165	340	298	88%
Other Open Surgery of The Knee	225	278	173	149	86%
Scopes (Knee Ligament Repair)	180	222	221	202	91%
Scopes (Knee Meniscectomy)	75	129	892	766	86%
Scopes (Rotator Cuff)	200	253	597	547	92%
Scopes (Shoulder)	150	218	361	329	91%
Therapeutic Arthroscopy of the Hip	150	242	140	125	89%
Total Shoulder Replacement	225	304	88	72	82%
SURGICAL GROUPING: Neurological/Orthopedic/Spine Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Spine Surgery (Cervical Fusion)	195	259	158	119	75%
Spine Surgery (Cervical Spine Laminectomy)	150	199	61	50	82%
Spine Surgery (Lumbar Fusion)	240	330	220	152	69%
Spine Surgery (Lumbar Herniated Disc, Decompression)	150	231	479	355	74%

OPIOIDS IN POST-OPERATIVE PAIN MANAGEMENT

GOAL: adequate pain relief without over-prescribing opioids available for potential misuse or abuse

SURGICAL GROUPING: General/ Gastroenterology/Hepatobiliary Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Appendectomy	68	96	127	92	76%
Colonoscopy, Diagnostic	0	226	9539	80*	1%
Endoscopic Retrograde Cholangiopancreatography with Treatment	75	316	132	33	24%
Esophagoplasty/Fundoplasty	50	93	105	79	73%
Gall Bladder	75	106	708	602	86%
GI Restrictive Procedure (Bypass)	60	107	44	27	55%
GI Restrictive Procedure (Sleeve)	50	68	150	84	57%
Hernia Repair, Inguinal	75	96	575	496	87%
Lower Gastrointestinal Endoscopy with Treatment	0	263	6782	53*	1%
Lower GI Removal	75	117	158	104	64%
Lumpectomy	40	74	197	150	76%
Mammoplasty	75	120	195	160	82%
Mastectomy	100	156	169	134	79%
Repair, Incisional or Ventral Hernia	75	119	175	143	81%
Repair, Umbilical Hernia	75	99	229	192	84%
Thyroidectomy	50	86	129	99	75%
Upper Gastrointestinal Endoscopy with Treatment	0	472	960	24*	2%

OPIOIDS IN POST-OPERATIVE PAIN MANAGEMENT

GOAL: adequate pain relief without over-prescribing opioids available for potential misuse or abuse

SURGICAL GROUPING: Otolaryngology Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Ear Tubes	0	163	202	3*	1%
Laryngoscopy with Treatment	50	287	80	37	46%
Myringotomy	0	0	60	0*	0%
Nasal Ablation	31	97	56	8	14%
Nasal Endoscopy with Treatment	53	93	172	128	74%
Nasal Vestibule Repair	100	126	43	29	67%
Septoplasty	75	133	321	276	86%
Tonsils and Adenoids	202	276	250	227	91%
Turbinate Excision	60	103	114	90	79%
Tympanoplasty	50	84	65	59	91%

SURGICAL GROUPING: Adolescent Otolaryngology Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Tonsils and Adenoids	150	209	82	68	83%

SURGICAL GROUPING: Pediatric Otolaryngology Procedure Description	Benchmark (2020 25th Percentile MME) MAX	2020 Mean MME	# procedures	# Rx	% Rx
Ear Tubes (General Anesth)	0	0	568	0*	0%
Tonsils and Adenoids	45	81	538	174	35%
Tympanic Membrane Repair	0	51	43	5*	2%
Tympanoplasty	0	49	32	8*	2%

* < 10% of patient received Rx, benchmark changed to no routine opioids

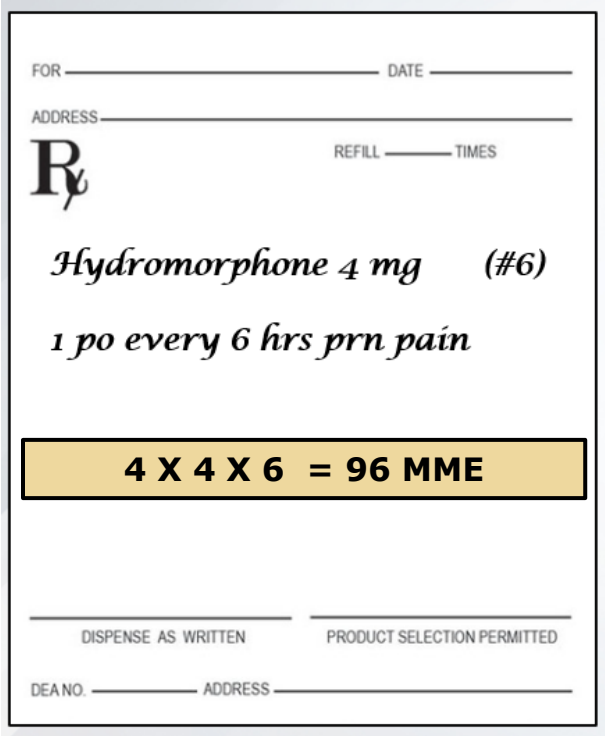
CASE STUDY – ACUTE PAIN

26 yo BF G3 P3003 in for elective C-section with term pregnancy of healthy male. She has had an uneventful pregnancy to date and only med is prenatal vitamins.
VS: BP-110/60. HR-78reg, BP-128/68. RR-16.

C-section surgery is uneventful with normal post-partum course and no complaints from the patient other than 6 to 7 out of 10 uterine and incisional pain.

Dx: Post-op Day # 2 post-partum multiparous female, stable

Plan: Hydromorphone 4 mg po q6 hours prn pain.



Opioid dosage *x* conversion factor *x* # of pills = MME

CASE STUDY – ACUTE PAIN

58 WM hospitalized for elective L4-L5 fusion with rods & pins. Has acute on chronic back pain and has been delaying surgery as long as possible.

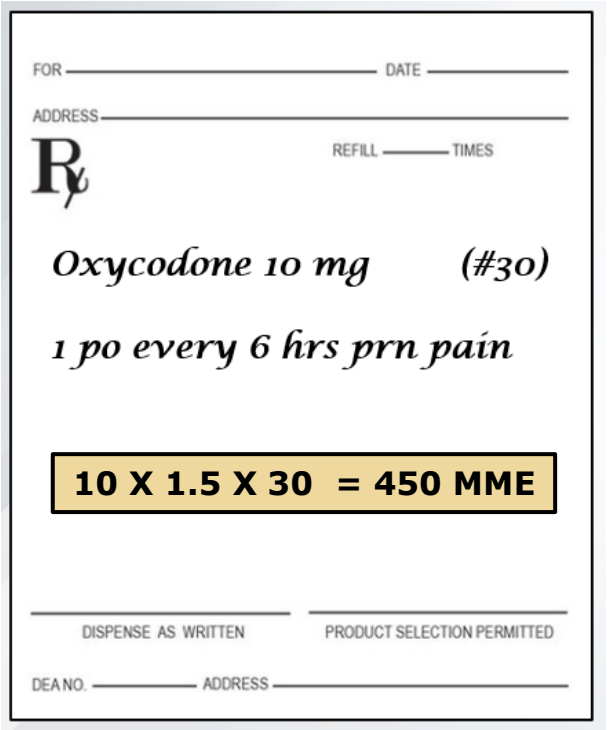
He is generally healthy but is unable to exercise regularly because of the pain. He is a non-smoker. He drinks 1-2 beers daily, 10-14 per week.

No prescription meds. Takes ibuprofen prn for his back pain.

Surgery is successful and pt. states the pain going down his back to his foot is gone. His incisional pain is 7-8 out of 10.

Dx: Post-op Day # , S/P L4-L5 laminectomy with spinal fusion

Plan: Oxycodone 10 mg 1 po q6hrs prn pain



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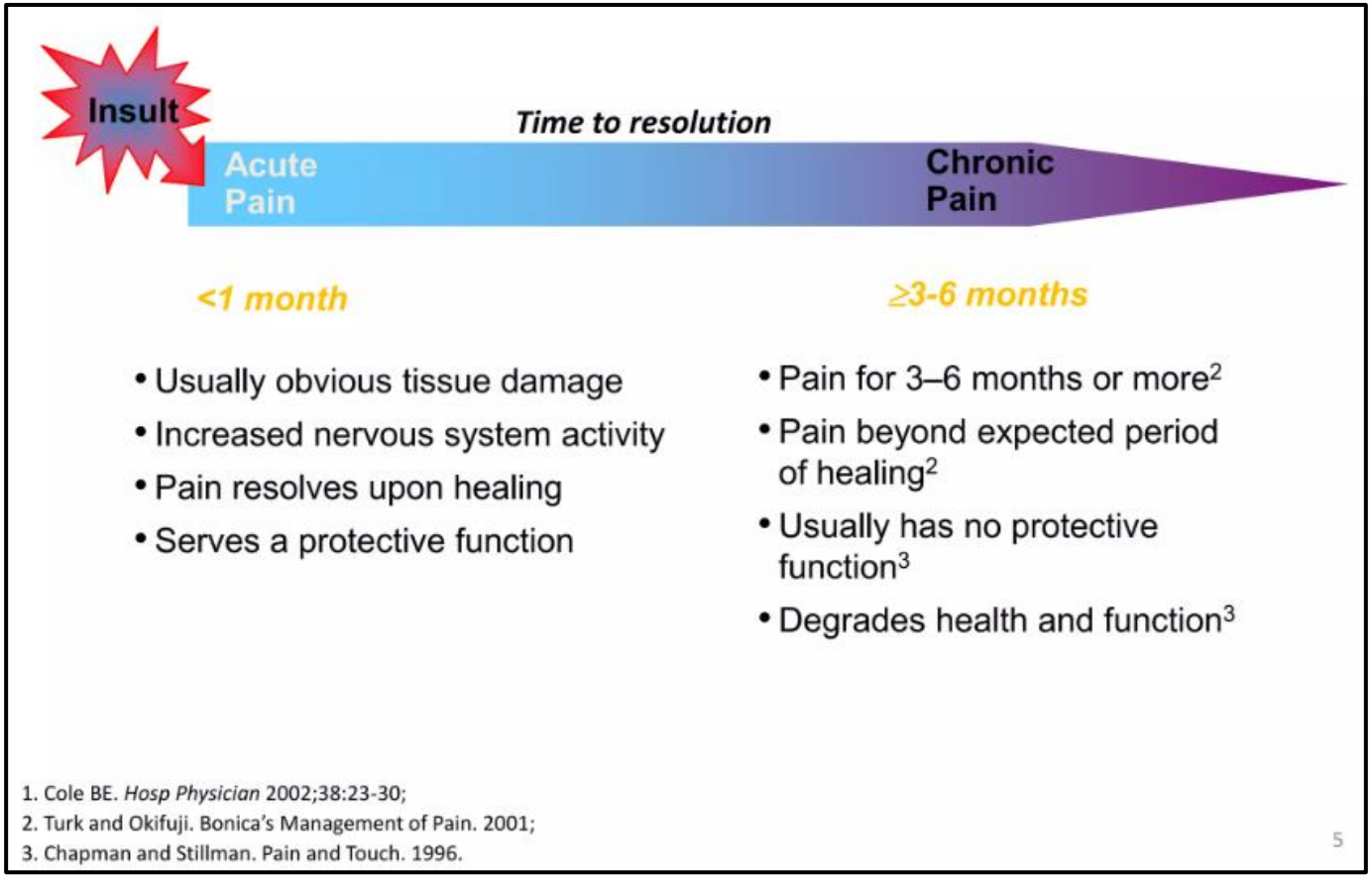
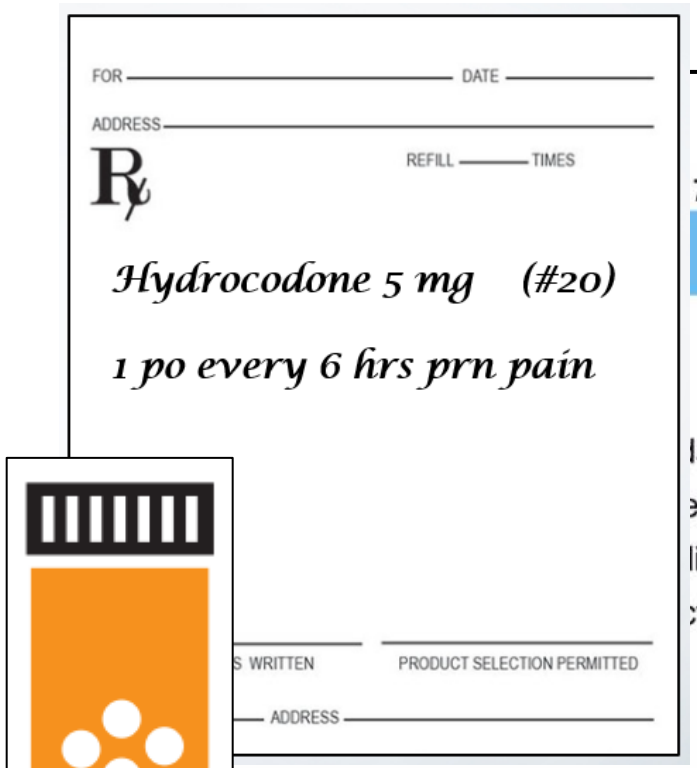
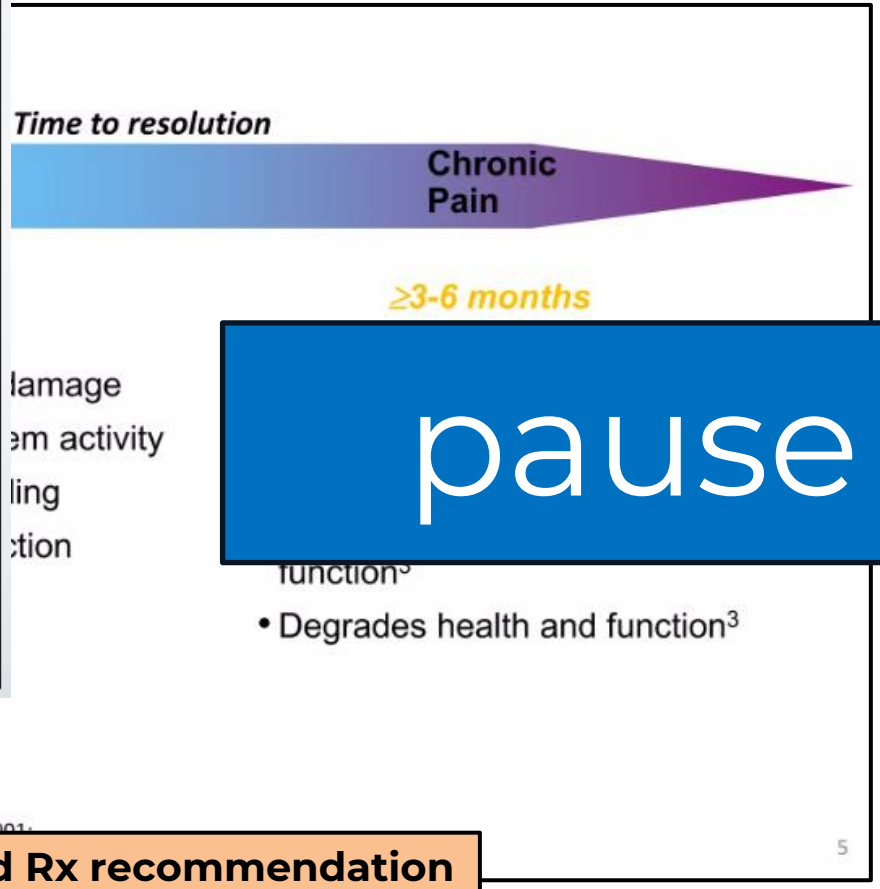
PATHOPHYSIOLOGY OF PAIN



OPIOIDS IN PAIN MANAGEMENT





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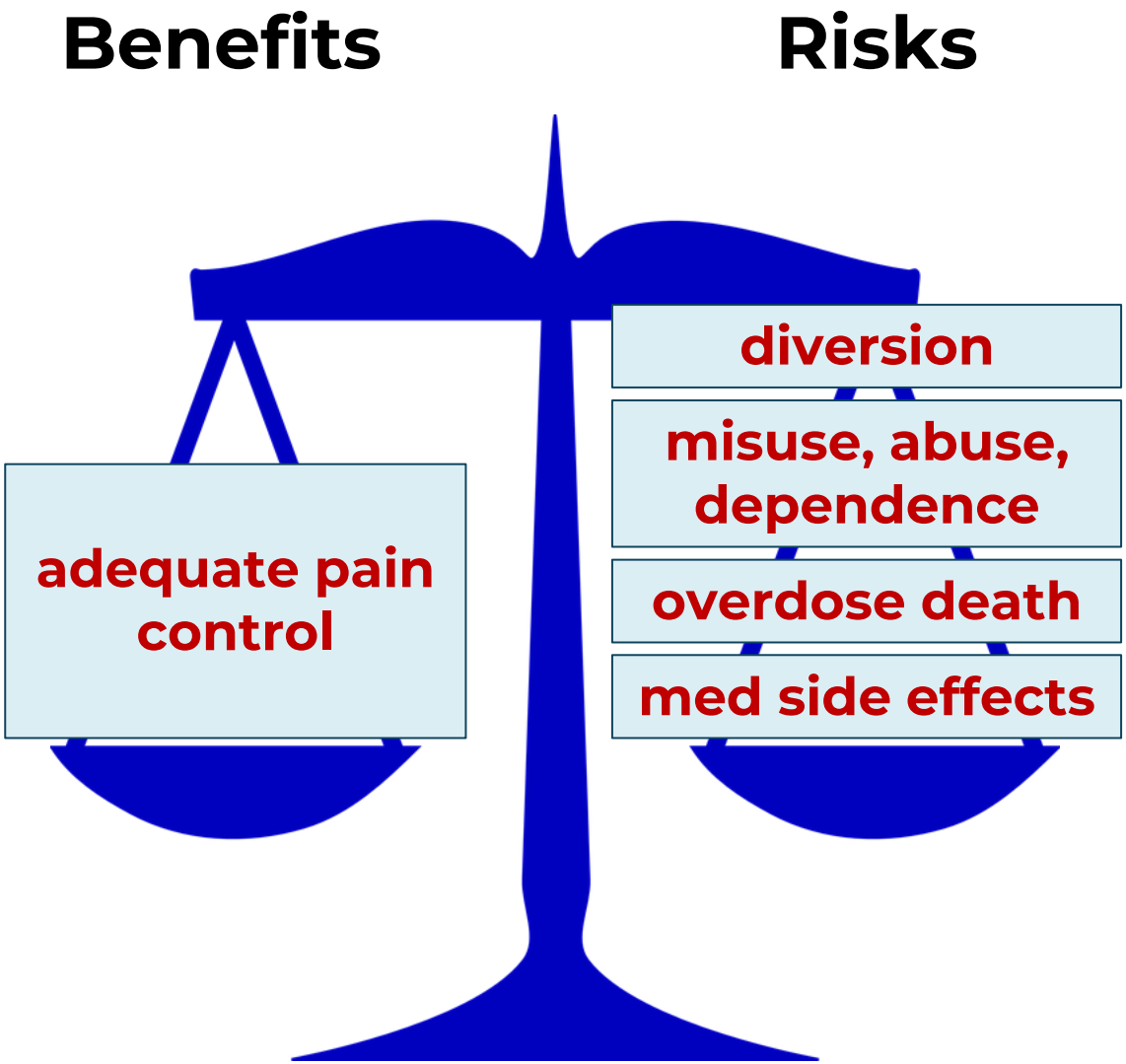
For ACUTE PAIN, general opioid Rx recommendation is ≤ 100 MME <u>total course</u> of illness

Strategy for treating acute pain in the out-patient setting



Strategy for treating acute pain in the out-patient setting

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose.

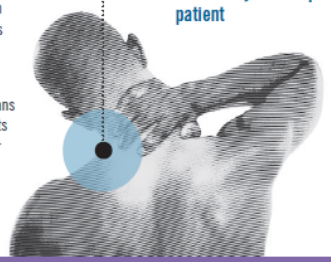
The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Strategy for treating acute pain in the out-patient setting

NNR.24

- First consider non-medication, non-opioid alternatives
- Try to identify patients at-risk for opioid dependence
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- Discontinue opioids after acute pain episode (3 to 7 days)
- Have a disposal method for leftover pills

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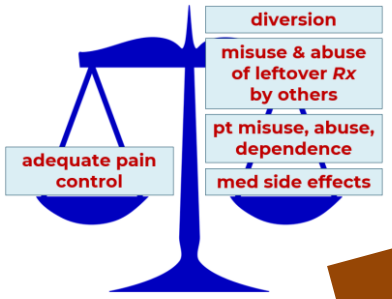
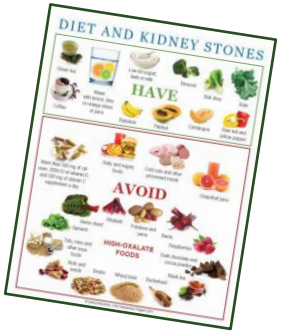
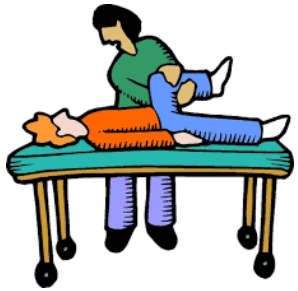
Strategy for treating acute pain in the out-patient setting

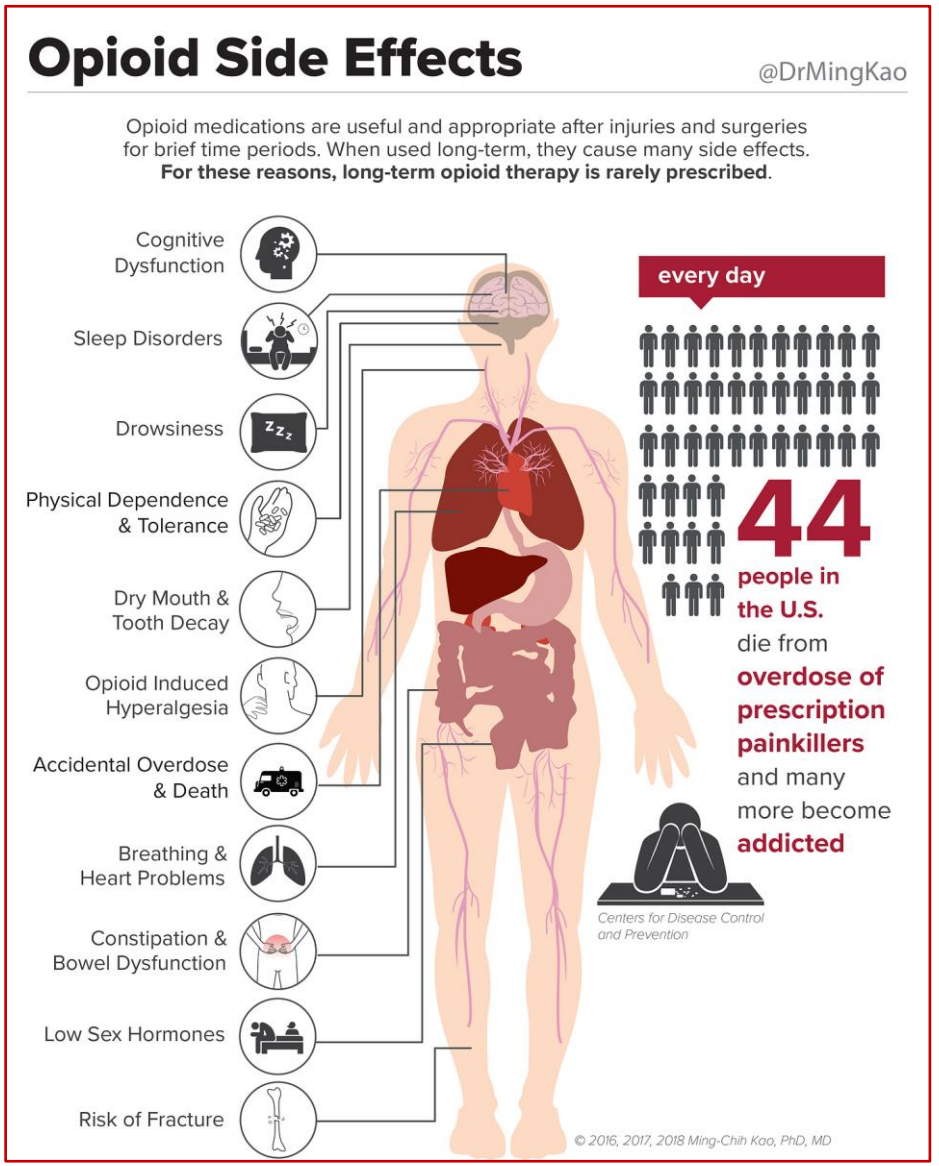


CBT: Cognitive Behavioral Therapy

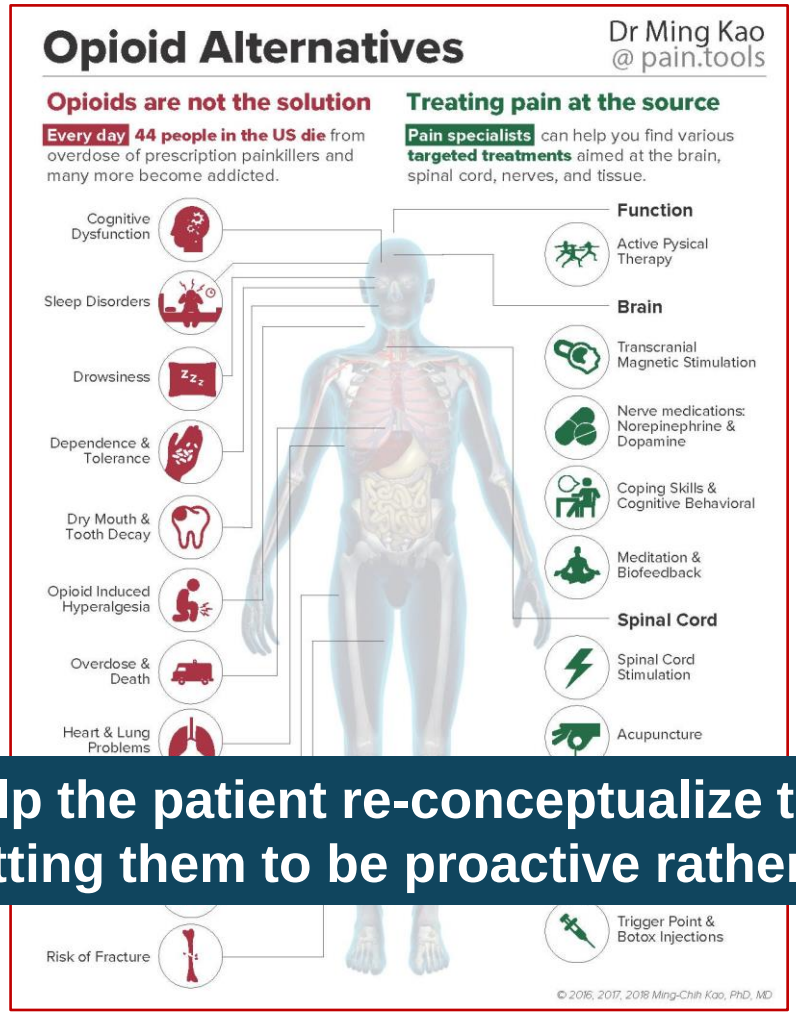
ACT: Acceptance Commitment Therapy

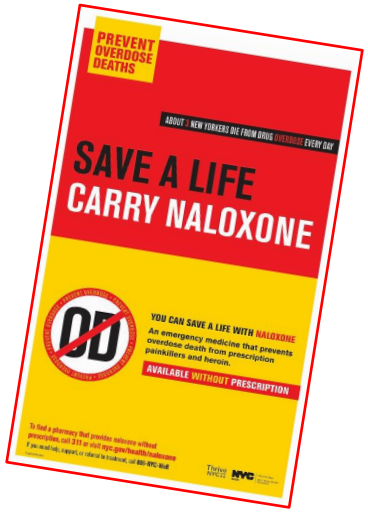






Strategy for treating acute pain in the out-patient setting

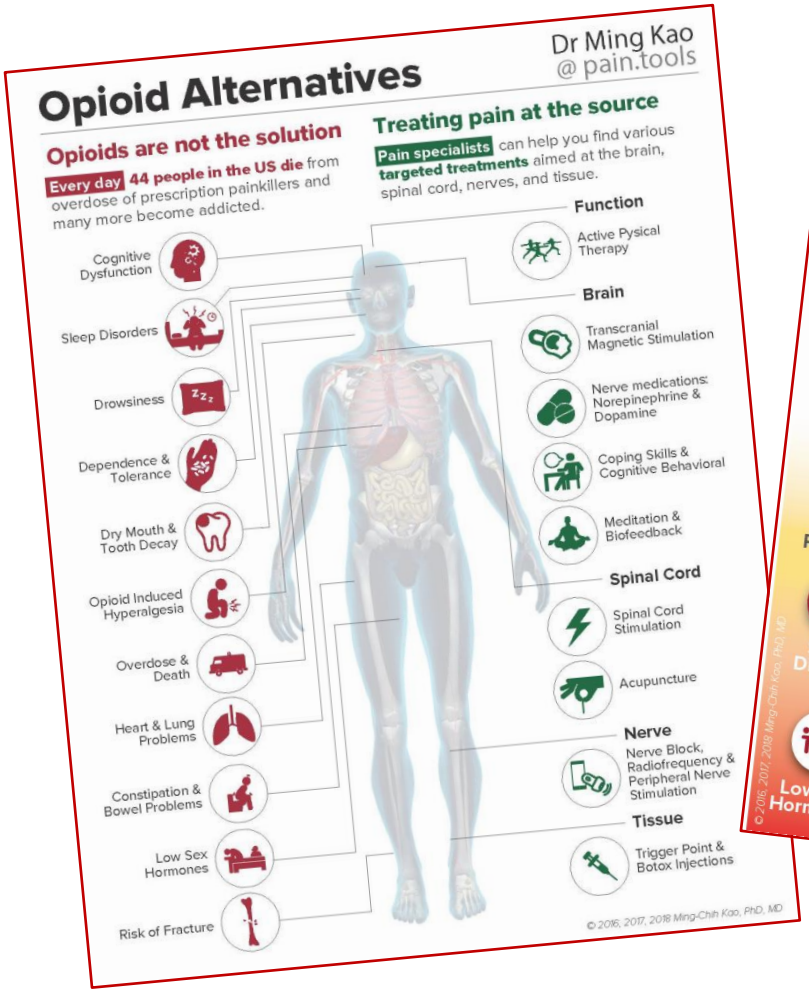


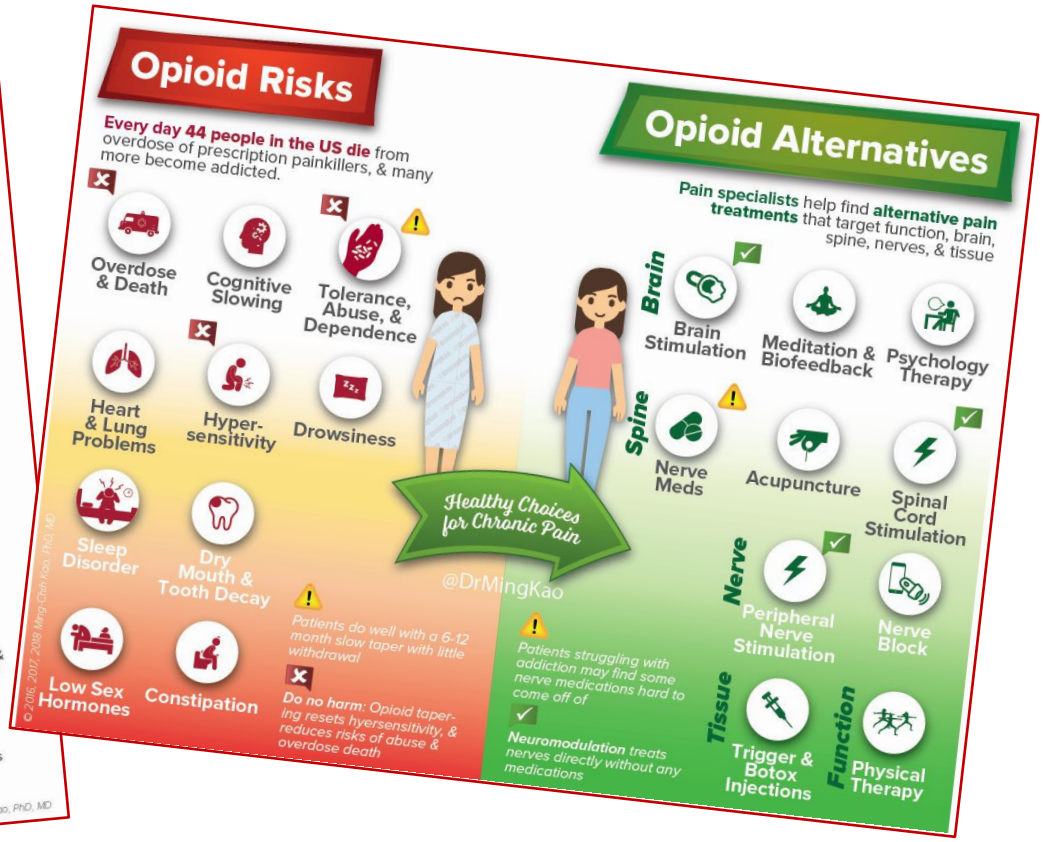


Narcan: automatically recommended Rx for opioid prescriptions > 100 MME total

Help the patient re-conceptualize their pain, their role in healing, getting them to be proactive rather than reactive.

Strategy for treating acute pain in the out-patient setting





Visual tools in the toolbox:

Mindfulness Based Stress Reduction
Cognitive Restructuring
Assertiveness Training

Strategy for treating acute pain in the out-patient setting

NNR.24

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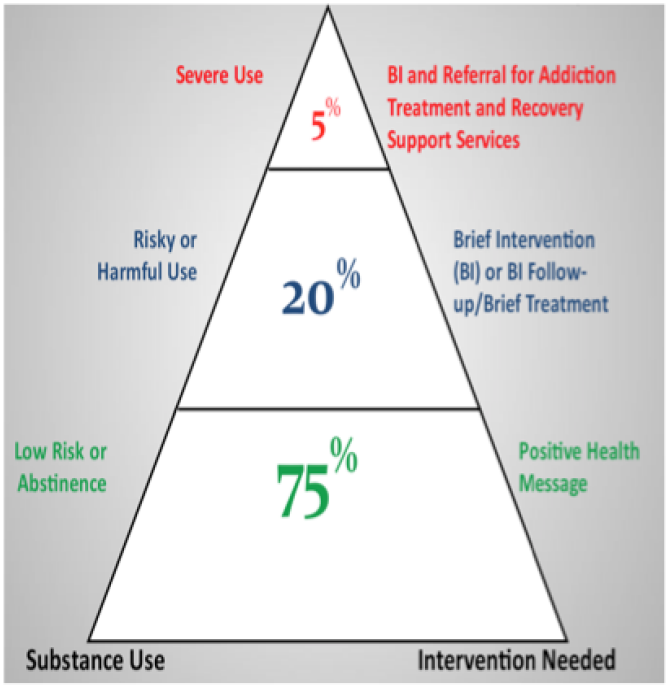
Risk categorization of substance use among the general population and the appropriate intervention



Before REFILLING an opioid for acute pain…

Ask about recent opioid use

↓

Check PDMP for controlled substance prescription history

YES → **Consider DAST-10**

NO → **Consider ORT**

Screening for at-risk opioid use

Drug Abuse Screening Test (DAST – 10)

In the past 12 months…		Circle	
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you use more than one drug at a time?	Yes	No
3	Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes")	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use? (If never use drugs, answer "No")	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Score	Risk Level	Intervention
0	Zone 1: **No risk**	Simple advice: Congratulations this means you are abstaining from excessive use of prescribed or over-the-counter medications, illegal or non-medical drugs.
1-2	Zone 2: At Risk Use - "low level" of problem drug use	Brief Intervention (BI). You are at risk. Even though you may not be currently suffering or causing harm to yourself or others, you are at risk of chronic health or behavior problems because of using drugs or medications in excess.
3-5	Zone 3: "intermediate level"	Extended BI (EBI) and RT – your score indicates you are at an "intermediate level" of problem drug use. Talk with a professional and find out what services are available to help you to decide what approach is best to help you to effectively change this pattern of behavior.
6-10	Zone 4: Very High Risk, Probable Substance Use Disorder	EBI/RT- considered to be at a "substantial to severe level" of problem drug use. Refer to specialist for diagnostic evaluation and treatment.

Screening for at-risk opioid use

Alcohol Use Disorder Identification Test (AUDIT – 10)

12 fl oz of regular beer	=	8–9 fl oz of malt liquor	=	5 fl oz of table wine	=	1.5 fl oz shot of 80-proof spirits

Unhealthy Drinking:

The **STOP, START, CONTINUE** Exercise:

What do I want to **STOP** doing?
What do I want to **START** doing?
What do I want to **CONTINUE** doing?

9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Screening for at-risk opioid use

Opioid Risk Tool (ORT)

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool, Lynn R. Webster, MD, and Rebecca M. Webster, PAIN MEDICINE, Volume 6, Number 6, 2005

Opioid Misuse Risk Screening Tools

ORT: Opioid Risk Tool

SOAPP: Screening & Opioid Assessment for Patients with Pain

COMM: Chronic Opioid Misuse Measure

STAR: Screening Tool for Addiction Risk

SISAP: Screening Instrument for Substance Abuse Potential

PDUQ: Prescription Drug Use Questionnaire

No "gold standard"

Lack rigorous testing

Strategy for treating acute pain in the out-patient setting

NNR.24

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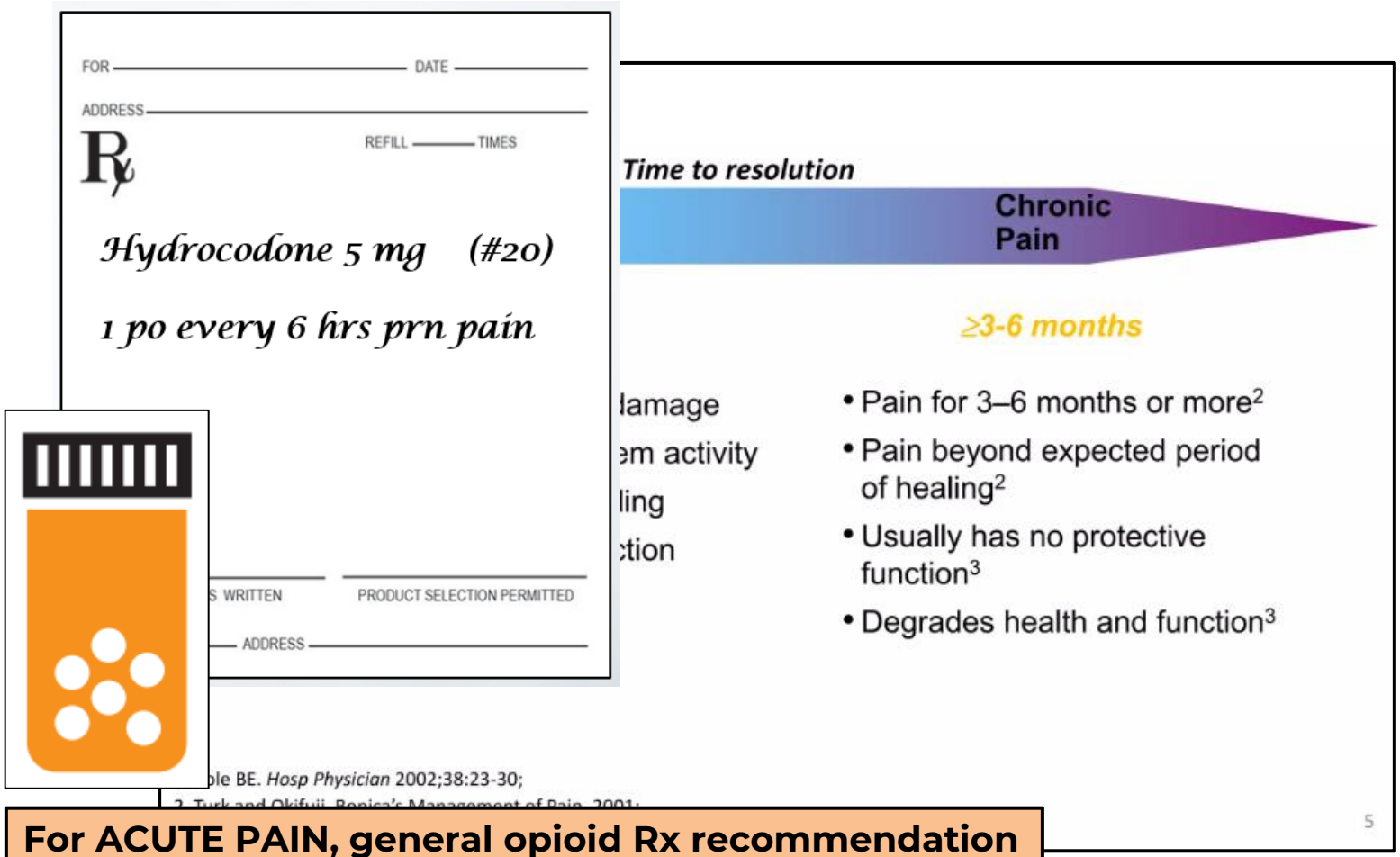
- Have a disposal method for leftover pills

OPIOIDS IN PAIN MANAGEMENT



For ACUTE PAIN, general opioid Rx recommendation is ≤ 100 MME <u>total course</u> of illness

OPIOIDS IN PAIN MANAGEMENT

Calculating total dosage of opioids: Morphine Milligram Equivalents (MME)

Hydrocodone : Morphine (1:1)
(Lortab, Norco, Vicodin)

- Hydrocodone 5 mg = Morphine 5 mg (5 MME)
- Hydrocodone 7.5mg = Morphine 7.5mg (7.5 MME)
- Hydrocodone 10 mg = Morphine 10 mg (10 MME)

Hydromorphone : Morphine (4:1)
(Dilaudid, Exalgo)

- Hydromorphone 2 mg = Morphine 8 mg (8 MME)
- Hydromorphone 4mg = Morphine 16 mg (6 MME)
- Hydromorphone 8 mg = Morphine 32 mg (32 MME)
- Hydromorphone 16 mg = Morphine 64 mg (64 MME)

OPIOID CONVERSION TABLE

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr.)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1 – 20 mg/day	4
21 – 40 mg /day	8
41 – 60 mg/day	10
≥ 61 – 80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Oxycodone : Morphine (1.5:1)
(OxyContin, OxyIR, Percocet, Percodan)

- Oxycodone 5 mg = Morphine 7.5 mg (7.5 MME)
- Oxycodone 7.5mg = Morphine 11.25mg (11.25 MME)
- Oxycodone 10 mg = Morphine 15 mg (15 MME)
- Oxycodone 20 mg = Morphine 30 mg (30 MME)

Codeine : Morphine (0.15:1)
(Phenergan w/ Codeine Cough Medicine)

- Each 5 mL (1 tsp) of cough medicine contains promethazine 6.25 mg & Codeine phosphate 10 mg. (3 tsp = 1 Tsp)
- 1 tsp = Codeine 10 mg = Morphine 1.5 mg
- 1 Tsp = Codeine 30 mg = Morphine 3 mg
- 2 Tsp = Codeine 60 mg = Morphine 9 mg (9 MME)

Tramadol (0.1 : 1)
(Ultram, Ultram ER)

- Tramadol 50 mg = Morphine 5 mg (5 MME)
- Tramadol 100 mg = Morphine 10 mg (10 MME)
- Tramadol 300 mg = Morphine 30 MME)

OPIOIDS IN PAIN MANAGEMENT

Recommended Opioid Rx Dosing Limits For Acute Pain

Acute Pain: measure opioids in total MMEs per prescription.

*[Recommend **< 100 MME in total** prescription (Rx)]*

Hydrocodone : Morphine (1:1)
(Lorcet, Lortab, Norco, Vicodin, Vicoprofen)

Hydrocodone 5 mg (100 mg = 20 pills)
Hydrocodone 7.5 mg (<100 mg = 14 pills)
Hydrocodone 10 mg (100 mg = 10 pills)

Oxycodone : Morphine (1.5:1)
(OxyContin, OxyIR, Percodan, Percocet, Roxicet)

Oxycodone 5 mg (<100 mg = 13 pills)
Oxycodone 7.5 mg (<100 mg = 8 pills)
Oxycodone 10 mg (<100 mg = 6 pills)

OPIOID CONVERSION TABLES

Morphine Milligram … IE)

Morphine is the **standard** from wh… asured.

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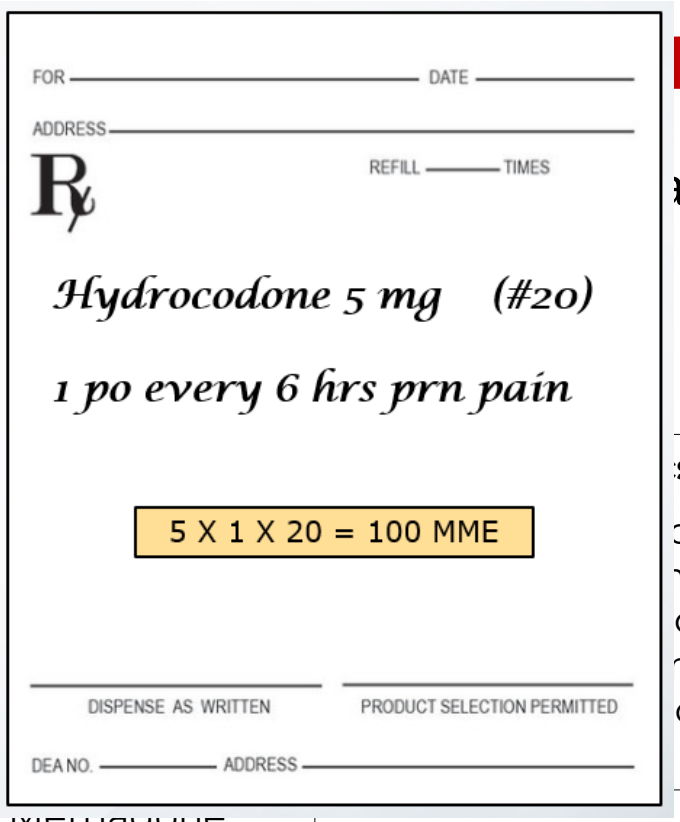
Oxycodone	1.5
Oxymorphone	3



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…s (Opioids):

…odone
…morphone
…one
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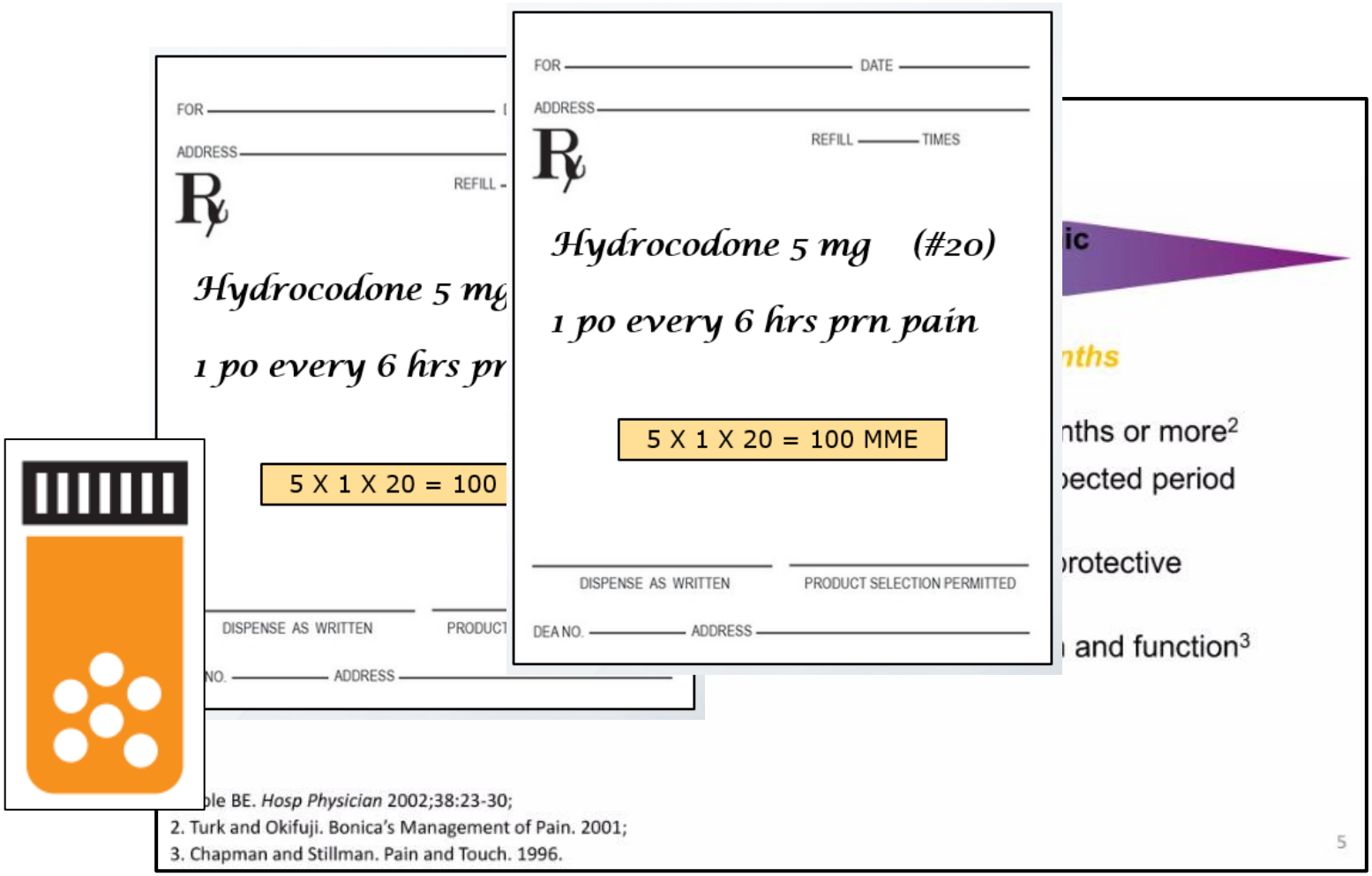
…orphine

Synthet…

- …
- …Methadone
- Fentanyl

opioid dosage X conversion factor X # of pills = MME

OPIOIDS IN PAIN MANAGEMENT



For ACUTE PAIN, general opioid Rx recommendation is ≤ 100 MME <u>total course</u> of illness

OPIOIDS IN PAIN MANAGEMENT

If opioid Rx ≥ 100 MME, it is recommended to prescribe NALOXONE

Naloxone can trip severe & unpleasant withdrawal symptoms.

Several doses of naloxone may be required to reverse an overdose. The reversal effect of naloxone does not outlast the sedating effect of many opioids.

Naloxone should be made available to patients and those around them…

- **≥ 100 morphine milligram equivalents (MME) total for acute pain**
- **≥ 50 MME daily for chronic pain**

Strategy for treating acute pain in the out-patient setting

NNR.24

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- **Have a disposal method for leftover pills**

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U.S. Department of Justice ★ Drug Enforcement Administration

Diversion Control Division

DEA Diversion Control Division News (June 3, 2024)

DEA and its Partners Remove more than 670,000 Pounds of Unused Medications from Homes Across the Country

DEA special agents, diversion investigators, and law enforcement partners teamed up for DEA's 26th National Prescription Drug Take Back Day on April 27, 2024. The community emptied 670,136 pounds of unneeded medications from their medicine cabinets. More than 4,600 law enforcement partners teamed up with DEA at close to 5,000 sites nationwide.

Since the program's inception in 2010, National Prescription Take Back Day has removed more than 18.6 million pounds of unneeded medications from communities across the country.

Complete results for DEA's spring National Prescription Drug Take Back Day are available at: https://www.dea.gov/takebackday#results

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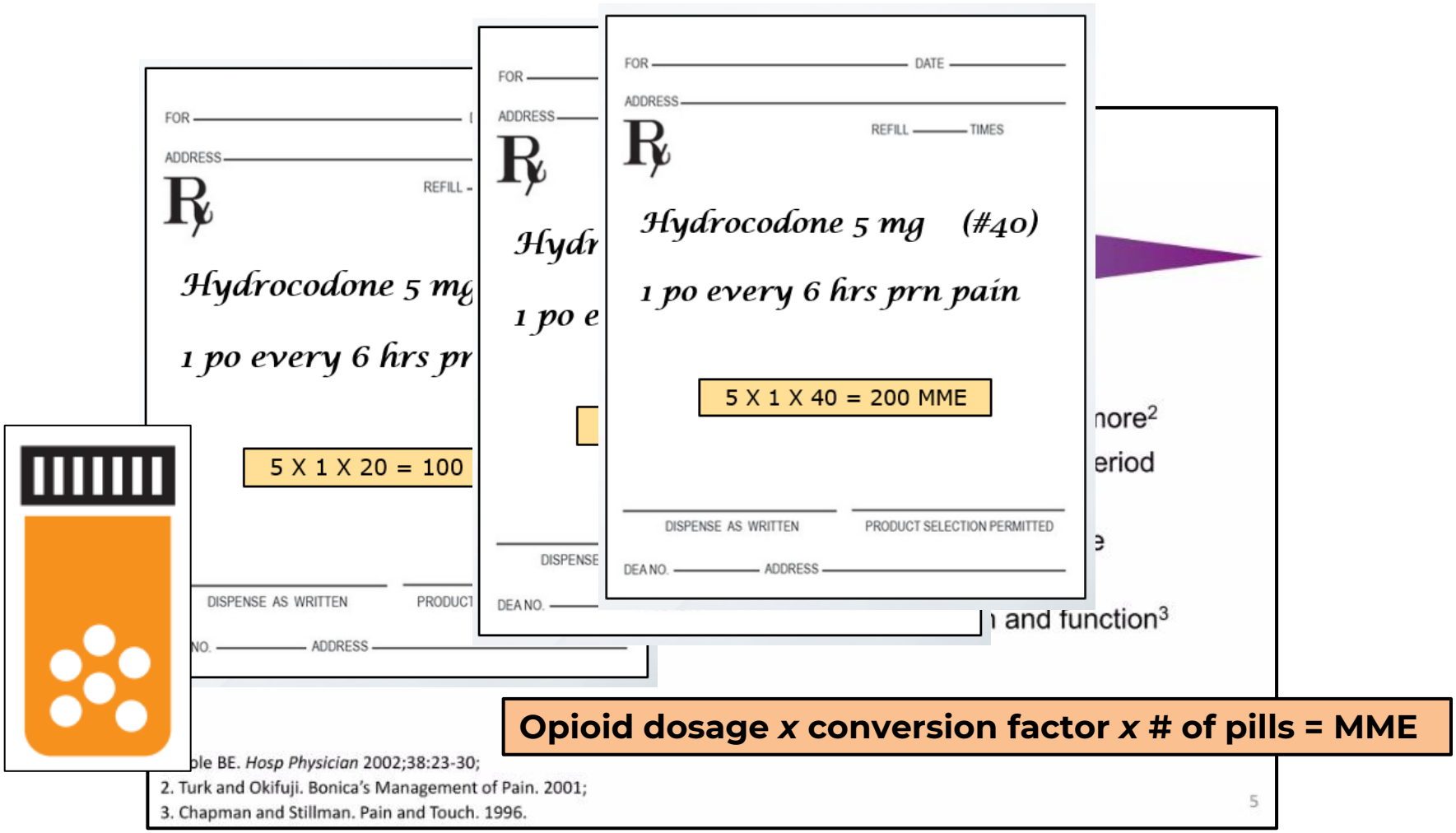
OPIOIDS IN PAIN MANAGEMENT



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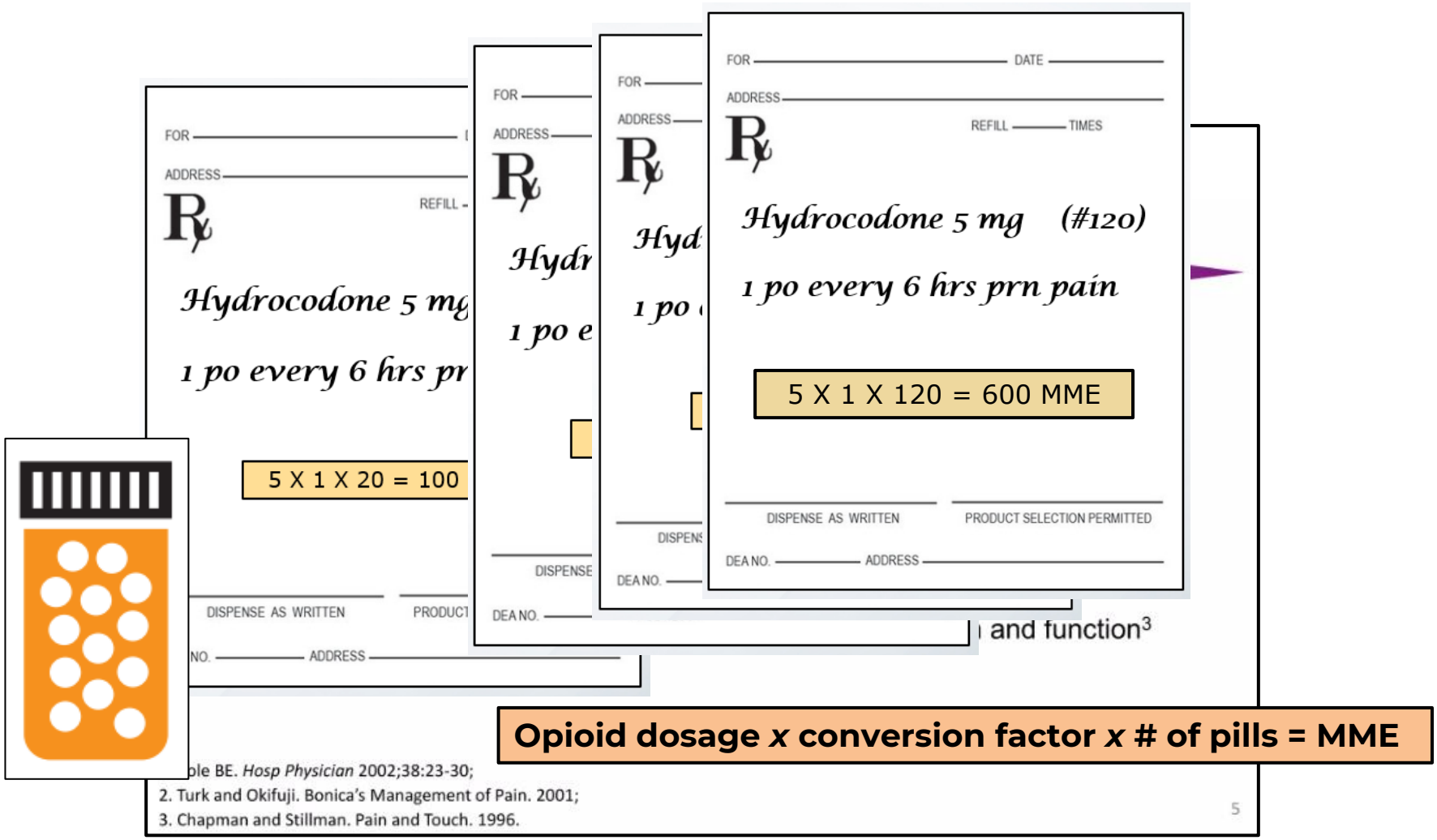


For ACUTE PAIN, general opioid Rx recommendation is ≤ 100 MME <u>total course</u> of illness

DSM-5: Substance Use Disorder

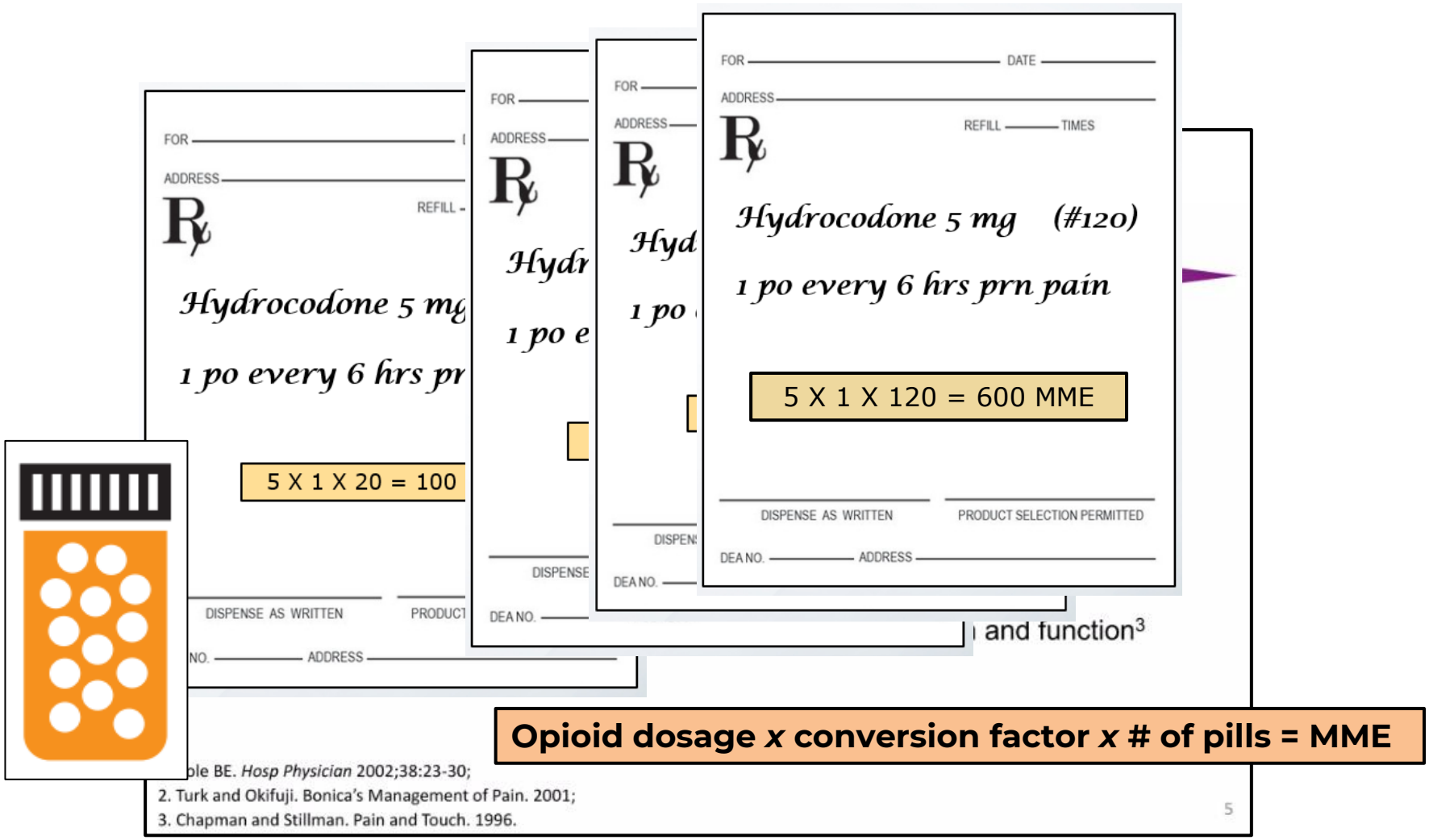
DSM-5 Substance Use Disorder: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Severity of Substance Use Disorders:

- **Mild:** Presence of **2-3** symptoms
- **Moderate:** Presence of **4-5** symptoms
- **Severe:** Presence of **6 or more** symptoms

OPIOIDS IN PAIN MANAGEMENT



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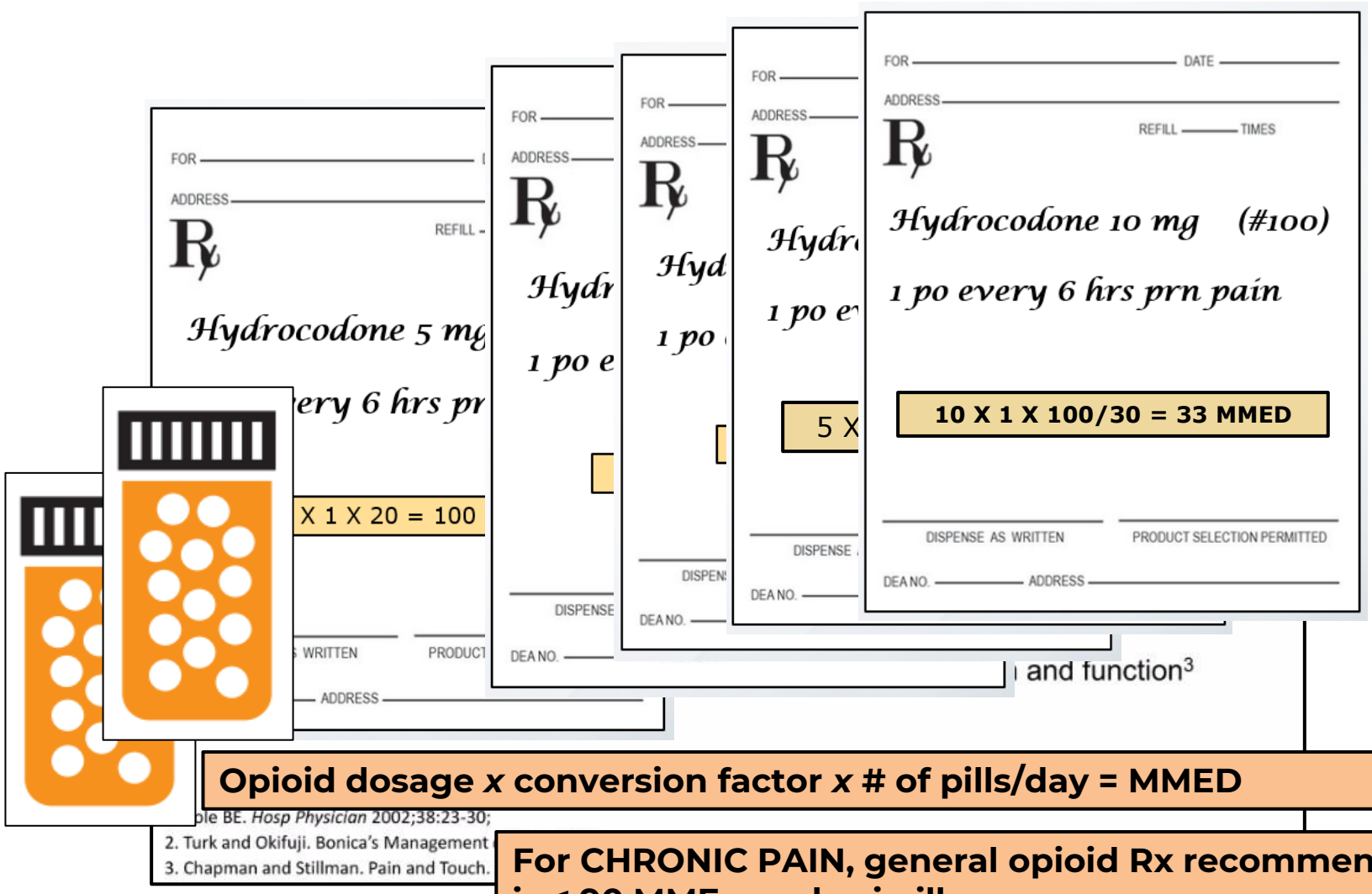


Opioid dosage *x* conversion factor *x* # of pills/day = MMED

For CHRONIC PAIN, general opioid Rx recommendation is ≤ 90 MME <u>per day</u> in illness

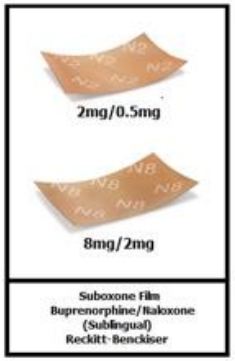
For ACUTE PAIN, general opioid Rx recommendation is ≤ 100 MME <u>total course</u> of illness

OPIOIDS IN PAIN MANAGEMENT

Should we consider...
Buprenorphine for acute pain?

Suboxone
Buprenorphine/Naloxone
(Sublingual)
Reckitt-Benckiser

Subutex
Sublingual Buprenorphine
Reckitt-Benckiser



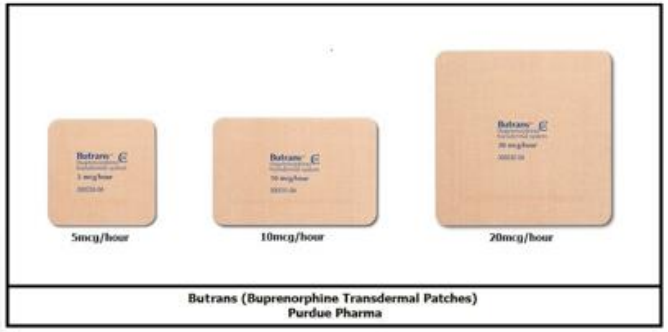
Suboxone Film
Buprenorphine/Naloxone
(Sublingual)
Reckitt-Benckiser

Buprenorphine:

- Semi-synthetic partial opioid agonist
- 2002: Opioid Replacement Therapy for persons addicted to opioids
- Much higher affinity for brain μ receptor
- Some significant euphoria – first few doses
- Some "upper"-like effect
- Some addicts take to prevent extremely uncomfortable sx of withdrawal
- Will cause "precipitated withdrawal" in person with notable opioid in system

Buprenorphine/Naloxone
(Sublingual)
Amneal Pharmaceuticals

Sublingual Buprenorphine
Roxane Laboratories



Butrans (Buprenorphine Transdermal Patches)
Purdue Pharma

is ≤ 90 MME <u>per day</u> in illness

For ACUTE PAIN, general opioid Rx recommendation is ≤ 100 MME <u>total course</u> of illness

Questions

Working with communities.

- The SAMHSA-funded *Opioid Response Network (ORN)* assists states, tribes, organizations and individuals by providing the resources and technical assistance they need locally to address the opioid crisis and stimulant use.
- Technical assistance is available to support the evidence-based prevention, treatment, recovery and harm reduction of opioid use disorders and stimulant use disorders.

Working with communities.

- The *Opioid Response Network (ORN)* provides local, experienced consultants in prevention, treatment, recovery and harm reduction to communities and organizations to help address this opioid crisis and stimulant use.
- *ORN* accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Contact the Opioid Response Network

- To ask questions or submit a technical assistance request:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org

Substance Abuse and Mental Health Services Administration (SAMHSA)

Funding for this initiative was made possible (in part) by grant no. 1H79TI085588-02 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Approach: To build on existing efforts, enhance, refine and fill in gaps when needed while avoiding duplication and not "recreating the wheel."

Overall Mission

To provide training and technical assistance via local experts to enhance **prevention**, **harm reduction**, **treatment** (especially medications like buprenorphine, naltrexone and methadone) and **recovery** efforts across the country addressing state and local - specific needs.