

Opioid Prescribing: Chronic Opioid Therapy

Updated: October 7, 2019

Assessment

The following assessment will likely entail a substantial commitment of time; therefore, both appropriate reimbursement for such a complex assessment, as well as a staged approach over several visits, may be necessary

- **Patient history.**^{1,2} Complete a history including details on opioid use. The history of prescription opioids should detail prescribed opioid use from the very first prescription of opioids to the present. Include in the history the amount (≥ 50 MED, ≥ 90 MED) and frequency of opioid use. **Some factors may be associated with increased risk of opioid overdose.**
 - History of all pain related interventions, including all spine and extremity surgery, all injections, any integrative health interventions and their impact on pain and function.
 - Ask if withdrawal symptoms occur when a usual dose is taken as directed (e.g., Q12 extended release opioid), decreased or if several doses are missed. Ask about whether or not any changes in mood accompany these symptoms.
 - Review and document the current treatment agreement if one is in place.
- ~~Using EHR data, screen for the following. Risk of opioid overdose and problematic opioid use increases with the number of indicators that are present.~~
 - ~~Chronic opioid therapy average daily dose (greater than 50 mg. MED)~~
 - ~~Chronic opioid therapy average daily dose (greater than 90 mg. MED)~~
 - Alcohol or other drug use or alcohol or drug use disorder diagnosis
 - Other behavioral health diagnosis, see section below
 - Use of ER/LA opioids
 - Use or chronic use of sedatives/benzodiazepines
 - Opioid use disorder diagnosis
 - Document relevant co-morbidities (e.g., diabetes, COPD)
 - Document all adverse events related to chronic opioid use (see [Table on page 38 of the AMDG Interagency Guideline on Prescribing Opioids for Pain](#)).
- **Physical exam.** Complete physical exam including a detailed examination of all pain-related regions; for patients with any history of neuropathic pain of any kind, including that following failed surgery that may have affected nerves (e.g., failed back surgery syndrome). Document a detailed neurological examination
- **Assess pain and functional status.**³
 - Using a pictorial representation of the body, fill in all the parts of the body affected by chronic pain to determine which parts of the body are affected.
 - Assess pain and functional status with PEG pain intensity and interference scale.
- **Prescription Monitoring Program.** Query the Prescription Monitoring Program over the past 6 months and document all findings to determine if use and refill intervals have been stable.
- **Urine drug screen.**⁴ Conduct a urine drug screen. If results are not consistent with what is being prescribed or suggest the concurrent use of other substances, discuss this with the patient.
- **Co-occurring behavioral health conditions.** Screen for co-occurring conditions including depression, anxiety, suicidality, and alcohol, marijuana, and illicit drug use. Use validated instrument(s) such as:

Opioid Prescribing: Chronic Opioid Therapy

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- **Depression** (e.g. Patient Health Questionnaire-2, PHQ-3 and/or PHQ-9) and **anxiety** (e.g., Generalized Anxiety Disorder-2), follow guidelines within the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#), or more recent if available.
- **Suicidality** (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts). If suicide risk is detected, follow guidelines within the 2018 Bree Collaborative [Suicide Care Report and Recommendations](#), or more recent if available.
- **Alcohol misuse** (e.g., AUDIT-C) and **drug use** (e.g., single-item screener, ASSIST, DAST-10, single item cannabis and other drug use questions). If alcohol misuse is detected, follow guidelines within 2015 Bree Collaborative [Addiction and Dependence Treatment Report and Recommendations](#), or more recent if available.
- **Post-traumatic stress disorder** (e.g. PTSD Checklist)
- **Adverse childhood experiences**. More information [here](#).
- **Evaluate for opioid abuse.**⁵ Evaluate the patient for behaviors that may indicate the presence of opioid abuse.
 - If there are indications of opioid misuse, or concomitant illicit drug use, evaluate the patient for the presence of an opioid use disorder. The DSM-5 criteria for the diagnosis of Opioid Use Disorder can be found in Appendix 1. If a number of symptoms are found as a result of this evaluation, the patient may have an opioid use disorder that ranges from mild to severe.
 - Tolerance and withdrawal are expected physiologic phenomena associated with chronic opioid use. The physical symptoms of withdrawal occur with the cessation of opioids prescribed for chronic use and in persons who have an opioid use disorder. Their presence alone does not define the presence of an opioid use disorder or addiction.
- **Evaluate for opioid use disorder.** If a person with chronic pain is also found to meet the criteria for an opioid use disorder as defined in the DSM-5, and the primary provider does not have the capacity to provide medication assisted treatment for opioid use disorder, a referral to an addiction medicine provider or another provider who can provide medication treatment should be made.
- *More recently, experts have suggested that the definition of opioid dependence be expanded to describe both the physical and negative emotional symptoms that occur with withdrawal from prolonged opioid use, a concept not reflected in either the DSM IV or DSM-5. This 'complex, persistent' dependence is not the same as opioid use disorder or addiction. While the neural changes that lead to complex, persistent dependence are similar to those seen in persons with addiction, persons with 'complex, persistent' dependence do not exhibit the full range of behaviors that define opioid use disorder, though some overlap may occur..*
 - *Refs Koob & Volkow Lancet Psychiatry 2016;3:760, Ballantyne, Sullivan and Koob, 2019 (in press)*
 - *Characteristics of this 'complex' opioid dependence can includes any/all of the following characteristics,*
 - *No uncontrollable craving or compulsive use*
 - *No harmful use that is not medically directed (patient takes opioid exactly as described)*

Opioid Prescribing: Chronic Opioid Therapy

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- *Withdrawal drug opposite effects: somatic withdrawal symptoms, hyperalgesia, hyperkatefeia, dysphoria*
- *Potential difficulty tapering*
- *Stress-like symptoms*
- *Reward deficiency (i.e. anhedonia or difficulty experiencing pleasure in life) and social withdrawal*
 - *Refs: Ballantyne & LaForge, Pain 2007;129:235*
 - *Ballantyne et al, Arch Int Med 2012;172:1342*
 - *Nestler, Nature Rev Neurosci 2001;2:119*
 - *Koob & LeMoal Annu Rev Psychol 2008*
 - *Koob & LeMoal 2001*
 - *Shurman et al Pain Med 2010*
 - *Koob & Volkow Lancet Psychiatry 2016*
 - *Ballantyne et al Pain 2019*

While physiologic changes that occur in 'complex' opioid dependence and opioid use disorder occur in the same part of the brain, they are not the same conditions.

Interventions for complex opioid dependence can include:

- *Transition to Buprenorphine should be offered to persons with complex dependence as a safer alternative with less overdose risk. As a partial opioid agonist, buprenorphine is quite effective for pain.⁶⁷⁸ if a*
- *By taking the time to clarify whether someone has complex dependence or an opioid use disorder, an incorrect diagnosis, stigma, discrimination, employment implications and possible child custody implications of OUD can be avoided.*

Opioid Prescribing: Chronic Opioid Therapy

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Appendix X:

The following brief simple questions can be used to inquire about substance misuse. Any use of an illegal drug or use of a prescription drug for a non-medical reason indicates increased risk of opioid overdose and opioid use disorder.

How many times in the past year have you used an illegal drug or used a prescription drug for non-medical reasons?

Never Once More than once

IF MALE under age 65, Ask:

In the past year, how many times have you had 5 or more drinks in a day?

Never Once More than once

IF FEMALE or over age 65, Ask:

8B. In the past year, how many times have you had 4 or more drinks \ in a day?

Never Once More than once

Have you more than once tried to give up or cut down on your use of opioid pain medicines and been unable to do so?

No Yes

Have you ever felt a strong urge or desire to take opioid pain medicines?

No Yes

Have you ever continued to use opioid pain medicines despite emotional or physical problems related to their use?

No Yes

Medical Risks of Long-term Opioid Use

Medical risk	How common?	Description and information
Respiratory depression		
Opioid overdose	< 1% per year but increases with dose	<ul style="list-style-type: none"> - Caused by severely slowed breathing, which you may not notice - Severe cases are treated in the hospital - Can cause death
Breathing problems during sleep	Not known	<ul style="list-style-type: none"> - Opioids may cause or worsen sleep apnea - You may not notice breathing problems
Injuries		
Falls & fractures	Not known	
Motor vehicle crashes	Not known	
Gastrointestinal problems		
Constipation	30 - 40%	<ul style="list-style-type: none"> - It helps to use stool-softeners or drugs that stimulate bowel movements
Serious intestinal blockage	<1% per year	<ul style="list-style-type: none"> - Caused by severe constipation - Severe cases are treated in the hospital
Hormonal effects		
Hypogonadism, impotence, infertility, osteoporosis	25% - 75%	<ul style="list-style-type: none"> - <i>Hypogonadism</i> = lowered sex hormones, which can worsen sexual function - <i>Osteoporosis</i> can make you more likely to fracture or break a bone
Cognitive and neurophysiologic effects		
Sedation	15%	<ul style="list-style-type: none"> - Can cause difficulty driving or thinking clearly
Disruption of sleep	Not known	
Hyperalgesia	Not known	<ul style="list-style-type: none"> - <i>Hyperalgesia</i> = being more sensitive to pain
Psychosocial		
Depression, anxiety, de-activation, apathy	Not known	<ul style="list-style-type: none"> - Depression can worsen pain, while pain can worsen depression. Opioids can cause loss of interest in usual activities, which can increase depression.
Addiction, misuse, and diversion	5 - 30%	<ul style="list-style-type: none"> - Common signs of prescription opioid addiction are preoccupation with opioid use or craving, unsuccessful attempts to discontinue use or cut down, cutting down or giving up activities due to opioid use, and using more medication than prescribed.
Oral Health		
Dry mouth that may sometimes cause tooth decay	Dry mouth is common	<ul style="list-style-type: none"> - Brush your teeth and rinse your mouth often - Chew sugarless gum and drink water or sugar-free, non-carbonated fluids
Myoclonus	Not Known	<ul style="list-style-type: none"> - <i>Myoclonus</i> = muscle twitching

Long-term opioid use can cause diverse adverse effects that differ across patients. A brief, simple information sheet like that shown above can be used with patients to review common medical risks of opioids to identify problems that patients may not realize are being caused by their use of opioid analgesics, while educating patients about opioid-related risks.

Reference: Baldini A, Von Korff M, Lin EHB. A review of potential adverse effects of long-term opioid therapy: A practitioner's guide. *The Primary Care Companion for CNS Disorders* 2012; 14(3): pii: PCC.11m01326. doi: 10.4088/PCC.11m01326.

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 - ⁴ Argoff CE, Alford DP, Fudin J, et al. Rational Urine Drug Monitoring in Patients Receiving Opioids for Chronic Pain: Consensus Recommendations. *Pain Med*. 2018;19(1):97–117.
 - ⁵ http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b10.html
 - ⁶ Arendt-Nielsen L, Andresen T, Malver LP, Oksche A, Mansikka H, Drewes AM. A Double-blind, Placebo-controlled Study on the Effect of Buprenorphine and Fentanyl on Descending Pain Modulation: A Human Experimental Study. *Clin J Pain*. 2012;28(7):623-7.
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