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## Opioid-Based Pain Management: Barriers, Guidelines, and Best Practices

Narrator:

You're listening to CME on ReachMD. The following activity, *Opioid-based Pain Management: Barriers, Guidelines, and Best Practices*, is provided in partnership with Prova Education and supported by an independent medical educational grant from Daiichi Sankyo, Inc.

Before beginning this activity, be sure to view the faculty disclosure statements as well as the learning objectives. Your host is Dr. William Fredette.

Dr. Fredette:

Chronic pain presents challenges both to patients—the majority of whom report failure to achieve adequate relief—and to physicians, who are increasingly reluctant to prescribe opioids because of concerns about tolerance, dependence, addiction and abuse.

I'm Dr. William Fredette. We're going to explore those issues and more, including current management strategies for chronic pain and abuse-deterrent formulations.

My guests are Dr. Charles Argoff and Jeffrey Gudin. Dr. Argoff is a Professor of Neurology at Albany Medical College, and he directs the Comprehensive Pain Center at Albany Medical Center in Albany, New York. Dr. Gudin is Director of Pain and Palliative Care and Englewood Memorial Hospital and Medical Center in Englewood, New Jersey.

Welcome to you both.

Dr. Argoff:

Thank you.

Dr. Gudin:

Thanks, Dr. Fredette.

Dr. Fredette:

Dr. Gudin, let's start with you. To give us a sense of scale, can you compare the prevalence of chronic pain in the US with that of, say, cardiovascular disease or diabetes or cancer?

Dr. Gudin:

Of course. I think this is going to come as a surprise to many of our audience today that chronic pain far outweighs, at least by numbers, the number of patients suffering from cancer, heart disease or diabetes. And the reason most people find that surprising is because if you think about where most of the dollars or the focus is in the United States, it's on these other major illnesses, but when you look at a report from our own Institute of Medicine that describes 100 million Americans suffering with pain, there are 20 million or so patients with each of those conditions—cancer, heart disease or diabetes—pain far outweighs that. And what becomes a challenge is that there are probably 20 or 30 million of those patients that require some type of advanced pain management, and many of those patients just aren't receiving the treatment that they need.

Dr. Fredette:

So there are huge numbers of people either undertreated or not treated at all for their pain. At the same time, though, the treatment of chronic pain, at least with opioids, has been labeled a public health crisis.

Dr. Gudin:

Yes, there's no question about it. I mean, we read in the newspapers and hear on the news every single day about the public health crisis of the opioid epidemic, but I'll tell you, it's just amazing that nobody talks about the public health crisis of the disease of pain. I'm not trying to minimize the fact that we have an opioid crisis in this country. Clinicians have tightened the reins, and we're doing a much better job at risk management, and that we are not contributing to this opioid epidemic as much as we were in the past. We can't forget about the millions of patients that fail conservative therapies and require advanced treatments like those with opioids.

Dr. Argoff:

I just want to add that there was an editorial, published in JAMA about a year ago which actually called to avoid using the term opioid epidemic. , the majority of people who use opioid therapy on a long-term basis actually do well enough to justify continuing such treatment, and so what you're saying to a person who is in pain, now being partially relieved by a particular treatment, that somehow they're part of an epidemic. we should really look at this as our quest to take care of people in pain as safely and appropriately as possible, at times using opioid therapy, and at the same time recognize that a significant percentage of our US population also suffers from disease of addiction, and treating people who need treatment for addiction in as nonstigmatized way as possible. But blanketly calling this an opioid crisis doesn't help serve either need very well.

Dr. Fredette:

And yet, unfortunately, in this era of 24-hour news cycles and sound bites, that's the phrase that tends to seep into the public imagination. And if that debate about treatment and the sheer numbers of patients who need help aren't daunting enough, what are some of the other challenges or barriers for physicians who are looking to do the right thing here?

Dr. Argoff:

there are many challenges—the inappropriate use of published guidelines, for example. The CDC guideline was recently published in order to help maximize safe use of opioid therapy, and this guideline is being used by payers and others to say you can't prescribe opiates. If you read the guidelines, that's not what it says. Essentially, you use the same evidence that was used in 2009 in a guideline published by the American Pain Society and the American Academy of Pain Medicine, which used information to say that opioids can be used safely and help many people if used with care, so clinicians are getting mixed messages about what they can do to help their patients.

clinicians are facing people with complex problems. They have limited amount of time to see people. They're being barraged by guidelines which are at times conflicting with each other, and they are facing situations from a practical point of view where they can't always implement. You send somebody for acupuncture; "Sorry, I can't do that because it's not paid for." I don't know what you think about that, Jeff.

Dr. Gudin:

Yes, , Charles brings up some really good points. There are a number of barriers to treatment, and the regulatory front is just one. These guidelines to guide practice are being adopted almost as laws or regulations by states and by CMS and by payers, and they are really making it challenging for clinicians on the front lines to try to use the therapies that we have in the past.

Dr. Fredette:

So you both touched on a couple of important points there. I want to go back just a little bit and talk about the guidelines that you mentioned. maybe you can talk a little bit more about the details and specifics about, for instance, the CDC guidelines or the APS guidelines.

Dr. Argoff:

the CDC guidelines are more recent guidelines, and they really summarize 12 steps, the 12 key points regarding any diverse issues, from considering non-opioid medical therapies, nonmedical therapies, ahead of opioid therapies, considering using the lowest effective dose of opioids and realizing that above certain doses the risk of harm increases, realizing that people need to be monitored for the good, the bad and the ugly about any treatment.

Let's keep in mind, , that more people die from the consequences of nonsteroidal anti-inflammatory drugs, which are sold at every over-the-counter aisle, than opioid therapy every year we need to realize that every therapy has harms associated with it. And the CDC guidelines try to outline some of the safety issues. It doesn't say, for example, that thou shalt never use a particular dose above a certain threshold. It says if you go past 50 or 90 morphine equivalent dose of milligram equivalence per day, then consider how much more carefully you have to monitor that person and understand why you're doing that. In many ways it used the same evidence—that was in

the APS and AAPM guidelines,. The VA guidelines and other guidelines all are associated with trying to reduce harm and consider other therapies.

But one of the weaknesses of the CDC guidelines—is that it doesn't mandate, for example, that anyone has to pay for nonmedical therapy or physical therapy, for example, or acupuncture, and so the clinician is left with a dilemma: How do I manage the person in front of me? So I just think those are some of the complexities of looking at and practicing guideline medicine.

Dr. Fredette:

All right, let's change focus now to the chronic pain patient. We know that millions are undertreated. Dr. Gudin, what are some of the consequences of that?

Dr. Gudin:

These patients have decreased productivity. They have financial issues. They have family discord. They have fatigue because they don't sleep. Their relationships are impaired. And if you look at the recent literature, there's even increased risk of suicide. So we talk about quality of life issues for pain patients—and believe it or not, if you look at the cancer pain literature, quantity of life. There's evidence to show that when we provide cancer patients better pain management, they live longer, so quality, quantity of life and functionality are really important goals in pain medicine.

Dr. Fredette:

If you are just joining us, this is CME on ReachMD. I'm Dr. William Fredette discussing opioid-based pain management with Drs. Charles Argoff and Jeffrey Gudin.

A little earlier we talked about the consequences of inadequate pain management and the dilemmas facing clinicians who are trying to treat. We've been focused on opioids, but those aren't the only tool in the drawer. So, Dr. Argoff, can you talk about a broader pain management paradigm?

Dr. Argoff:

I know that we've been focusing on opiates, but really, pain management a multimodal or multidisciplinary approach. There are many procedures that can enhance the value of medical strategies, rehabilitative strategies, physical therapy, therapeutic exercise at home, changes in lifestyle, complementary approaches that could include acupuncture; it could be hypnotherapy, cognitive behavioral approaches. And I would hope that the people would realize that while we're focusing on opiates, in the context of treating the whole person with a multidisciplinary effort, that's how we maximize best outcomes.

Dr. Fredette:

Dr. Gudin, addiction opioids gets all of the headlines, and it certainly has the attention of physicians, but if the fear of addiction can lead to undertreatment, are there tools to help clinicians estimate that risk and make some informed decisions about how best to proceed?

Dr. Gudin:

Yes, this is an area where we've made quite a bit of headway in the last, I'd say, 10 to 15 years with risk management strategies and using certain assessment tools. Charles and I talk about the 4 As of pain medicine, an easy way for clinicians to screen their patients: analgesia, what's your pain like on the current therapies; your activities of daily living, a measure of function; any adverse events, and the fourth A is aberrant behaviors. So that's one of the more simpler screening tools that docs can use is remembering those 4 'A's. There are some psychometric tools that can be scored, a tool called the Opioid Risk Tool, a 5-question assessment tool which asks patients about the greatest risk factors associated with abusing prescription drugs—a previous history of substance abuse, a family history of substance abuse, history of major psychiatric illness, any history of PTSD-like activities, and they screen for age thinking that 18- to 45-year-old age range is probably at the most risk for substance abuse.

There are some even better ones for those who are familiar with using tools, one called the SOAPP-RIt's called the Screener and Opioid Assessment for Pain Patients. It tries to find the red flags that patients might display which would make them at risk for misusing prescription drugs. And the other tools that I don't want to forget about are 2 very important ones, urine drug testing and using your state's prescription drug monitoring program. And if you're not using it, I'd recommend to everyone tuned in to today's program to learn about your own state's prescription drug monitoring program.

Dr. Fredette:

So if I as a physician use these tools, I determine that the risk of addiction is too great in my estimation, what are some alternatives? And specifically, what are abuse-deterrent formulations?

Dr. Argoff:

Even if someone is at a high risk for opioid use, it doesn't mean that if it's the right treatment to consider for that person they can't be considered. The practitioner, the provider, needs to be comfortable in following and monitoring that person the way that a person at high

risk would need to be followed. We now have many agents that are considered abuse deterrents. Actually, there are a number of them, more than some people might realize, and there are those which are formulated to reduce crushing, or they are extraction-resistant. There are those that are combined with an opioid antagonist, like naloxone or naltrexone, so that if somebody did try to crush it, the opioid antagonist would be released and deter one from doing so because you're not going to get any benefit from that. So there are oxycodone-, morphine-, hydrocodone-based, extended-release or long-acting, abuse-deterrent agents, and there's actually an immediate-release-based, abuse-deterrent opioid that's oxycodone-based and that's resistant to crushing and grinding. But it's deter, it's not abuse-proof, and I really want to make that point because they are, , a tool in helping us to use this class of treatment opioid therapy more safely and effectively,.

Dr. Fredette:

All right. Let's change gears now and talk about the role of public policy in all of this. Dr. Argoff, what's happening at the federal level?

Dr. Argoff:

Well, there are many things that are happening at the federal level. And please, Jeff, chime in as well. I mean, multiple agencies within the Federal Government—the FDA, SAMHSA, NIDA... If one looks at NIDA's website, there's so much information. The FDA has so much information and education. SAMHSA has offered so much information and education. Health and Human Services... I wouldn't tell you that I know they are working together, but they are working in so many ways to help reverse the opioid misuse and abuse situation and to help ensure—and I hope help ensure—safe use of opioids for those who need them.

Dr. Fredette:

Before we wrap up, are there any takeaways you'd like to stress here? Dr. Gudin?

Dr. Gudin:

Yes, sure. let me just remind our audience members, between Charles and I, we probably have 50+ years in the pain space. We've seen the good, the bad and the ugly of opioid therapy. Patient selection is key, educating yourselves about risk mitigation strategies, some of which we've talked about today, documenting each and everything you do, and perhaps even product selection. There are newer opioids available that have abuse-deterrent technologies. You should arm yourself with some of these. Educate yourselves about the attributes of a few of them. And in addition to your prescription drug monitoring program, urine drug testing and screening tools, consider adding abuse-deterrent formulations to your arsenal.

Dr. Argoff:

Taking care of people in pain is particularly challenging because it's a very dynamic situation. People's medical situation changes, their mental health state changes, and so it really does suggest to us as clinicians that we need to actively manage our patients. always take the risk-averse approach, meaning that when you do have choices of medications to consider, consider those that have more deterrent for bad outcomes as possible, and consider that—aain, 2 different substances, same opioid substance—one may have built-in abuse-deterrent features, one may not, and it does make a difference,.

Dr. Fredette:

And on that note, thanks to Drs. Charles Argoff and Jeffrey Gudin for a great conversation.

Dr. Gudin:

Thank you for having us.

Dr. Argoff:

Thank you.

Narrator:

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