Acute pain management in patients with opioid use disorder

Substance Use Disorders in Hospital Care ECHO

November 11, 2019 PRESENTED BY: Lisa Whitmore NP and Jessica Gregg MD

Disclosures

Speakers: Lisa Whitmore and Jessica Gregg have nothing to disclose

Objectives

At the conclusion of this session, participants will be able to:

- Identify types of acute pain in patients with OUD
- Identify ways to appropriately address sources of pain

Case

30 yo female with a history of IV heroin use admitted to the hospitalist service with an epidural abscess, 1 week after beginning methadone maintenance treatment. Past medical history otherwise negative. Her chief complaint is severe pain and anxiety. Underwent two level spinal decompression (laminectomies) with orthopedic spine team.

Social history: homeless with her boyfriend, who is supportive, though still using heroin

Medications prior to admission: methadone 40mg

What are potential sources of her pain?

Withdrawal

Craving

Epidural abscess

Fear and anxiety

Case

On exam, she reports both cravings and withdrawal. Her withdrawal symptoms include restlessness, myalgias and irritability. She is terrified that her pain and withdrawal will not be treated and that her back pain is a sign that the infection is “eating her bones” and she will soon be paralyzed.

She asks for Ativan to treat her anxiety and Dilaudid for the back pain.

What do you do?

Acknowledge her pain (of all sorts)

Treat the withdrawal and craving

Manage her other sources of pain

Address the fear and anxiety

Acknowledge her pain

Are you in any withdrawal?

Are you experiencing cravings?

What else hurts?

What worries you (is there anything you are afraid of?) about this hospitalization?

Treat withdrawal and craving: why

Only once you have addressed the baseline opioid requirement, can you get clarity around what other sources of pain and discomfort may exist

Withdrawal is associated with increased pain sensitivity. It will worsen other painful conditions

Celerier et al. J Neurosci 2001
O'Brien CP. In The Pharmacological Basis of Therapeutics 2001

Treat withdrawal and craving: how

Either begin Methadone or buprenorphine or **continue them if the patient is already on them.**

Even if the patient is not interested in methadone maintenance, low dose methadone (20mg – 50mg) can help alleviate acute withdrawal/cravings and help manage pain

Recognize that while methadone and buprenorphine may provide some analgesia, they will need to be dosed differently for analgesic effects

Celerier et al. J Neurosci 2001
O'Brien CP. In The Pharmacological Basis of Therapeutics 2001

Treat withdrawal and craving: common misconceptions

1. Medications to treat OUD will also treat severe, acute pain
2. If patients on MOUD are given additional opioids they will overdose.
3. Full agonists won't work if a patient is on buprenorphine.

Treat withdrawal and craving: common misconceptions

1. Medications to treat OUD will also treat severe, acute pain

    They will help, but in cases of severe, acute, pain, are often insufficient

Treat withdrawal and craving: common misconceptions

2. If patients on MOUD are given additional opioids they will overdose.

   Patients on maintenance therapy develop tolerance to respiratory and CNS depressive effects of opioids.

   It is always important to monitor for respiratory depression or sedation, but most patients on MOUD tolerate additional agonists well

Alford et al. Annals of Internal Medicine 2009
McNicol et al J Pain 2003

Treat withdrawal and craving: common misconceptions

3. Full agonists won't work if a patient is on buprenorphine.

In experimental mouse and rat models, the combination of buprenorphine and full opioid agonists result in synergistic effects.

Accumulating research in humans shows good pain outcomes for patients maintained on buprenorphine with full agonists for pain control after cesarean sections and major abdominal and orthopedic surgeries

Kogel, B et al. European J of Pain 2005
Englberger W et al European J of Pharm 2006
Kornfeld H and Manfredi L Am J Therapeutics 2010
Oifa S et al Clin Ther 2009
Hoflich AS et al Eur J Pain 2011

Manage her other sources of pain

Approach to the opioid tolerant pt:

Start with a thorough med reconciliation.

Evaluate if medications are adding value to care

Baseline medications:

- antidepressants, anxiolytic and mood stabilizing medications
- other medications: stimulants, antihistamines, etc

- Prescribed opioids, PDMP review, if on bup or methadone consider alternative dosing. Over time, patients on MOUD develop tolerance to these medications and they are less effective for analgesia

How?

Methadone and buprenorphine are usually dosed daily.

However, the duration of action of analgesia of both medications is 6-8 hours. If used for analgesia, consider divided doses while maintaining the same total daily dose.

How?

Multimodal pain control- acetaminophen, NSAIDs when able, neuropathic agents, alpha 2 agonists, ketamine, topicals, heat, ice, local anesthetics

Ask: what is bothering you the most? The answer may be surprising.

Assess other measures of comfort: sleep, appetite, anxiety

Low dose melatonin

How?

Meet patients where they are, at times small more frequent visits are better tolerated.

Follow through, engage nursing and other staff when possible. Use pt advocacy if needed.

Engage PT/OT

Engage anesthesia if this is available for discussion on regional techniques. Can use nerve blocks whether single shot or catheters for limb trauma.

Address the fear and anxiety

Why?

It is the right thing to do.

Fear and anxiety increase pain.

- Post-breast cancer, patients who attribute pain to returning cancer report worse pain, regardless of the actual clinical cause
- The more information patients have about surgical procedures the less analgesia they require and the shorter the hospital stay

Smith WB et al Pain 1988
Kol E Pain Manag Nurs 2012

How?

Discuss the diagnoses and plans to address each one. Do it again.

Anticipatory guidance goes a long way. Set expectations that are realistic around function & comfort. Use pain scores only if they are meaningful. The good news is acute pain almost always gets better!

How?

Increase sources of support (Peer, SW, chaplain, supportive friends and family)

Treat PTSD if it is a contributor

Avoid benzodiazepines when possible. If absolutely necessary for procedures, start low.

Case

To address the patient's craving and withdrawal, the team increased her methadone dose by 10mg on the day of admission, and split the dose. Her dose was gradually increased throughout her stay. She also received clonidine, Vistaril and trazodone to help with withdrawal symptoms.

She worked with our SW and Peer to identify sources of anxiety and strategize around ways to address them. Nursing staff and physicians encouraged the presence of her boyfriend as long as he was not impaired.

Based on her history of homelessness and other trauma history as well as night terrors, she was give a presumptive dx of PTSD and began nightly prazosin and SSRI (or SNRI, or TCA)

Practices you can integrate today

Acknowledge pain

Ask about withdrawal – treat if present

Ask about craving – treat if present

Use opioid and non-opioid based interventions to treat acute somatic pain

Ask about anxiety and fear – address if present

Thank you

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