CAPTASA

PAIN MANAGEMENT
ALTERNATIVES TO OPIOIDS

January 25, 2019
Lexington, KY
This presentation is only for use at this conference.

No other use is authorized.
But this is not a new talk- I’m just saying what I have been for awhile.

BEFORE THE CDC AND OTHERS CAME OUT AGAINST OPIOIDS FOR CHRONIC NON-CANCER PAIN...
"But Doc, I Really Hurt "

Interventions Where Chronic Pain is an Issue
CAPTASA 2012

NON-OPIATE MANAGEMENT OF CHRONIC PAIN

January 28, 2012
Lexington, KY
ADDICTION AND CHRONIC PAIN CONFERENCE

CHRONIC PAIN TX WITHOUT ADDICTIVE SUBSTANCES

St. Luke’s Hospital
Sioux City, Iowa
April 5, 2013
Opioid Therapy: Risks vs. Rewards - Operation Unite Symposium 2013

Greg L. Jones, MD
Medical Director
Kentucky Physicians Health Foundation
So Here we go ...

I added all of the product features that each of you demanded.

Now our product is a worthless hodgepodge of complexity.

I appreciate your input. I couldn't have failed without you.

Teamwork!
Learning Objectives:

❖ Learn the difference between Acute and Chronic Pain
❖ Summarize Opioid Induced Hyperalgesia
❖ Look at alternatives to Opioids
The Face of Pain
Activation of the reward pathway by addictive drugs

cocaine
heroin
nicotine

alcohol

heroin
Pain Management vs. Patient Management

- Acute Pain
- Chronic Pain
- The Patient with the Pain
Sir William Osler

“It is more important to know what kind of patient has a disease... than what kind of disease a patient has”
Pain is subjective in nature and is defined by the person experiencing it.
Brain in Pain

How Pain Works

1. Cerebrum
2. Cerebral
3. Medulla
4. Spinal
5. Medulla

Descending pathways from the somatosensory cortex travel through the medulla and spinal cord and inhibit ascending pain pathways to produce analgesia (pain relief).

- Hypothalamus
- Descending Pathway
- Ascending Pathway
- Nociceptor Nerve Ending
Acute vs. Chronic Pain
Porter & Jick letter

a single paragraph printed in the January 10, 1980, issue of the New England Journal of Medicine:

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS
WHO 3-step ladder

1 mild
- ASA
- Acetaminophen
- NSAIDs

2 moderate
- A/Codeine
- A/Hydrocodone
- A/Oxycodone
- A/Dihydrocodeine

3 severe
- Morphine
- Hydromorphone
- Methadone
- Levorphanol
- Fentanyl
- Oxycodone
± procedures
That was an Old slide

Lead to big problems
JCAHO Pain Standards (2001)

❖ Include pain treatment in patient bill of rights.
❖ Screen all patients for pain on admission and regularly thereafter.
❖ Ensure competency of staff and physicians in pain assessment and management.
Institutionalization of Pain

Pain Rating Scale

- No Pain
- 0: No Hurt
- 2: Hurts Little Bit
- 4: Hurts Little More
- 6: Hurts Even More
- 8: Hurts Whole Lot
- 10: Hurts Worst

- Worst Possible Pain

- None
- Mild
- Moderate
- Severe
Those two also old and also...

Lead to big, Big problems
Mark Twain: (Smart Man)

"It ain't what you don't know that gets you into trouble. It's what you know for sure that just ain't so."
An Average American Watches 16 Hours Of Drug Ads A Year!
Direct to Patient Ads work!

A good morning after a sleep-through night

That’s how a patient feels after a restful night’s sleep provided by Quaalude-300 (methaqualone).

He wakes up alert and ready to face the demands of the day. Quaalude patients usually awaken easily and without evidence of “hangover” ... because he slept well all night (Quaalude usually helps produce 6 to 8 hours of restful sleep) ... and he didn’t have to lie awake for a long period of time before he went to sleep (Quaalude can induce sleep in 10 to 30 minutes). Now the physician has one less tired, sleepy and apprehensive patient to contend with.

Non-barbiturate Quaalude-300 is chemically unrelated to other sedative-hypnotics. Its therapeutic value has been established in controlled clinical studies and by wide usage of methaqualone throughout the world.

Side effects reported have been mild, transient, and have often proved to be statistically insignificant when compared to placebo effects. (See brief summary on last page of advertisement.)

For these reasons, maybe the prescribing physician sleeps a little better, too.

a non-barbiturate
Quaalude®-300 (methaqualone)

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

For additional prescribing information, please turn page.
New Non-medical Users of Pain Relievers 1965-2002

Thousands of New Users

Source: 2003 NSDUH, SAMHSA
Opioid Prescriptions Soar

Between 1999 and 2002:

❖ Oxycodone Rx’s increased 50% to 29 million
❖ Fentanyl Rx’s increased 150% to 4.6 million
❖ Morphine Rx’s increased 60% to 3.8 million
Opioid Prescriptions Soar

❖ In 2004, the United States used 99% of the world’s supply of hydrocodone.

❖ Between 1999 and 2002, in the United States, there has been a 91.2% increase in deaths due to opioid overdose.
Growth of Pain Clinics

![Growth of pain clinic 1990-2008](image)

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Figure 2
Deaths per year 2001-2006 Unintentional with Opiates
CDC statistics

Year:
- 2001: 3994
- 2002: 5547
- 2003: 6524
- 2004: 7547
- 2005: 8541
- 2006: 11001
Kentucky Drug Overdose Deaths 2006-2017

Sources: 2015-2017 Data: Overdose Fatality Reports. Kentucky Justice and Public Safety Cabinet, June 2017 and July 2018. 2006-2014 Data: U.S. Centers for Disease Control, Multiple Cause of Death Data (CDC Wonder Online Database)
$634.5M settlement for OxyContin maker

The firm and the current and former executives, including the CEO, pleaded guilty in U.S. District Court...to a felony charge of misleading doctors and consumers about the drug's risks of abuse and addiction... CNN
Risk to Society

“The diversion of prescription opioids has become a major public health hazard”

-Paulozzi, et.al., 2006

ED visits for nonmedical use of opioid analgesics increased 111% from 2004-2008
Nearly 40% of all pt’s had no opiates on UDS
11% tested positive for illicit drugs
Unprescribed opiates in 29% of samples
Dr. Leider “startling results”

Jefferson School of Population Health and Ameritox
Long-term Safety Has Not Been Demonstrated

Despite absence of direct organ-specific toxicity, opioids nonetheless produce many adverse effects

- Hyperalgesia - Mao, Pain, 2002
- Respiratory depression associated with chronic use of opioids has simply not been studied - Farney, et.al., Chest, 2003
Long-term Safety Has Not Been Demonstrated

- Hormonal Imbalance - Ballantyne & Mao, NEJM, 2003
- Sleep disorders
- Adrenal suppression
- Decreased testosterone in males - Daniell, J. Pain, 2002
- Erectile dysfunction
- Depression
ADVERSE EVENTS AND DEATH HAVE BEEN DEMONSTRATED

- Opiates associated with fourfold higher hip Fx risk
- 70% higher risk for hospitalizations
- Doubling of all-cause mortality compared with NSAID’s

Solomon et al. Arch Internal Med Dec. 2010
CDC says Opioids to be avoided in chronic non-cancer pain -March 2016

Neurology agreed- they had published a position paper in Sept 2014
So now there are lots of folks saying this
Risk Factors for opioid abuse

❖ History of drug abuse
❖ History of physical/sexual abuse
❖ History of depressive or anxiety disorder
❖ Current chaotic living environment
❖ History of criminal activity
Risk Factors for opiate abuse

- Prior failed treatment at a pain management program
- Heavy tobacco use
- Regular alcohol use
- Multiple injuries or surgeries
- Family history of drug abuse
Definitions

Acute Pain

❖ Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.
Acute Pain
Acute Pain

❖ Broken bones
❖ Incisions
❖ Burns
❖ Kidney Stones
❖ Childbirth
❖ Damaged or disrupted tissue and functional injury
Definitions

Chronic Pain

- Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
Chronic Pain

- Low back pain more than 3 months in duration
- Neuropathy- Diabetic, Post Herpetic, Alcoholic ...
- Arthritis
- Chronic Non-Cancer Pain
- Several relatively new Syndromes invented to cover a set of Sx’s
Palliation

- Pain - do something
- Measure the pain
- Don’t measure the function
- Conditioned responses expected - “breakthrough medication”
- Pain behavior is expected and rewarded - phone in a Rx
- Opiates may be effective
- Behavioral Medicine is optional
Rehabilitation

❖ Pain - do something else
❖ Measure the function
❖ Don’t measure the pain
❖ Conditioned responses are avoided - only scheduled medication
❖ Pain behavior is ignored and ultimately extinguished
❖ Self-administered opiates are usually ineffective
❖ Behavioral Medicine is essential
Opioid Induced Hyperalgesia
What we know about opioid induced Hyperalgesia?

❖ It occurs more frequently in the young
❖ It is probably on the same receptor that produces euphoria
❖ It occurs rapidly and is exacerbated by each subsequent dose
❖ If the pain condition is stable and the pain is worse, the opioids are not the solution, they are the problem
Opioid Induced Hyperalgesia

DRUG ADDICTION & OPPONENT PROCESSES

THE FIRST TIME

THE 100TH TIME

ALONE AGAIN, NATURALLY
Opiate induced Hyperalgesia

❖ “…apparent opioid tolerance is not synonymous with pharmacological tolerance, but may be the first sign of opioid-induced pain sensitivity suggesting a need for opioid dose reduction….”

❖ “…repeated opioid administration could lead to a progressive and lasting reduction of baseline nociceptive thresholds, hence an increase in pain sensitivity….”

Acute vs. Chronic Pain
Non-opioid management strategies

❖ NSAID’s and Acetaminophen
❖ Antidepressants, some other meds
❖ Massage and Acupuncture
❖ Meditation and Mindfulness - (Jon Kabat-Zinn)
❖ Exercise and Sunshine
❖ PT and OT
Non-Opioid Management

Sometimes, just thinking of something nicer makes the pain go away!
Non-Opioid Management
Thanks to my friend - Dr. Michael Kaufman (Medical Director Emeritus OMA PHP)

Five Fundamentals Of Civility

1. Respect Others and Yourself
   Treat everyone in the workplace, regardless of role, with respect — even those we barely know, disagree with, or dislike. Respect for others requires inclusivity while observing healthy boundaries. Self-respect is key.

2. Be Aware
   Civility is a deliberate endeavour, requiring conscious awareness of oneself and others. Mindfulness and reflective practice enhance awareness.

3. Communicate Effectively
   Civil communication is more about how we say it as much as what we say. Or do. Effective communication is critical at times of tension or when the stakes are high.

4. Take Good Care of Yourself
   It’s hard to be civil when personally stressed, distressed, or ill.

5. Be Responsible
   Understand and accept personal accountability. Avoid shifting blame for uncivil behavioural choices. Intervene when it’s the right thing to do.
Greg L. Jones, MD

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