IOTOD improving outcomes in the treatment of opioid dependence

Demystifying complexities of opioid dependence related to chronic pain

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Disclosures

- Receipt of honoraria or consultation fees: Indivior, Martindale, Mundipharma, Bite Medical

Learning objective

After this presentation, participants should be able to:

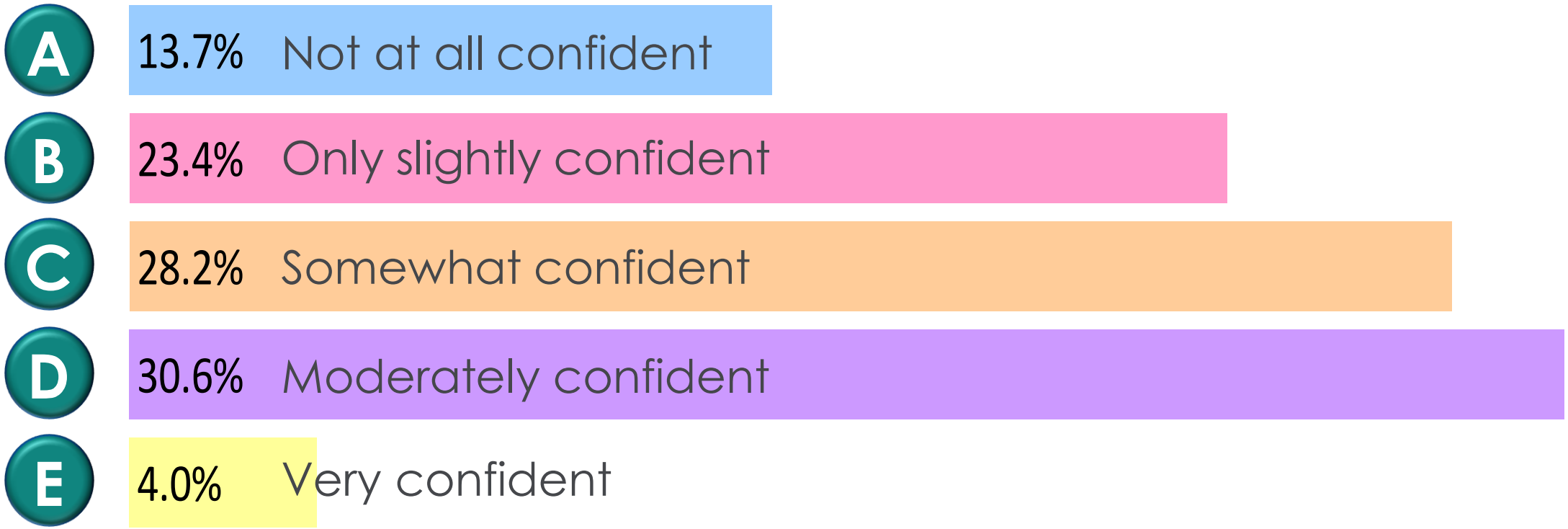
- **Discuss the challenges of identifying and managing patients with opioid analgesic dependence (OAD) and describe how these challenges can be overcome**

Interactive question

- On a scale of A–E, how confident are you in identifying individuals with OAD?

Interactive question

- On a scale of A–E, how confident are you in managing pain in individuals on opioid agonist therapy?



Two main groups impacted by chronic pain and opioid dependence in Europe

Chronic pain patients

Long-term opioid analgesia

Develop opioid dependence

Long-term heroin users

Ageing population

Develop chronic pain issues

Berterame S, et al. *Lancet*. 2016;387:1644–56; EMCDDA. European Drug Report. Trends and Developments. 2015.

Chronic pain patients who develop OAD

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Berterame S, et al. *Lancet*. 2016;387:1644–56.

But first, what is chronic pain?

A type of pain that has persisted beyond normal tissue healing time – usually ~3 months

Prevalence:
~19% of adults in Europe
~13% of adults in the UK

Opioid analgesics are often used to treat chronic pain

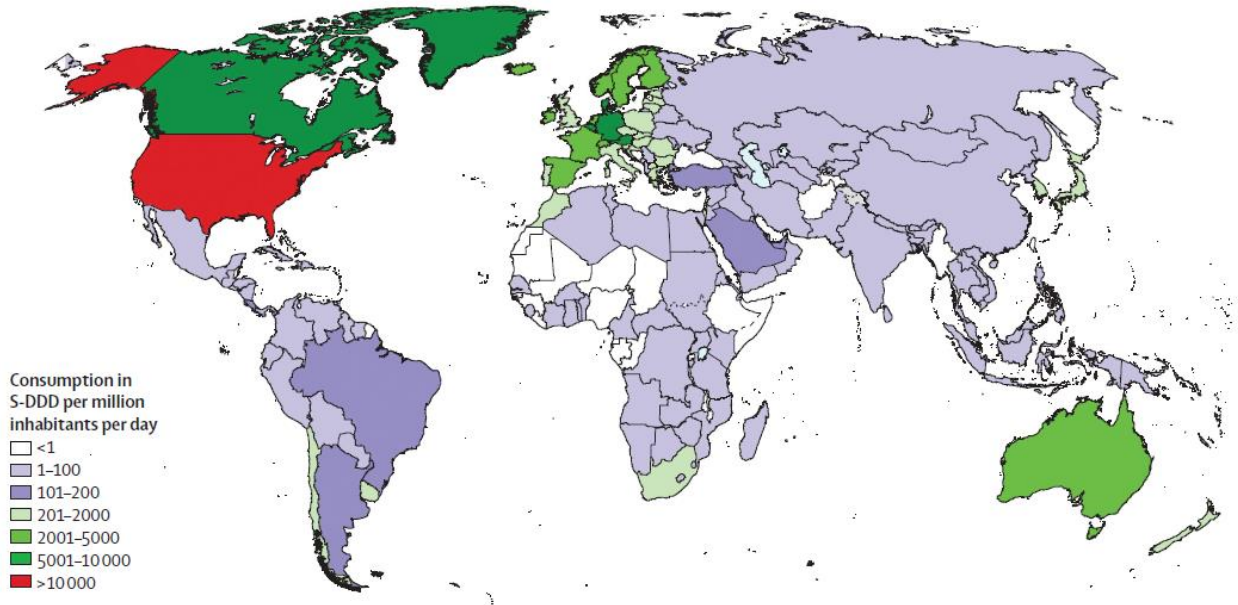
Weak opioids:
Codeine, dihydrocodeine

Strong opioids:
Morphine, buprenorphine, fentanyl, methadone, oxycodone, tapentadol, tramadol

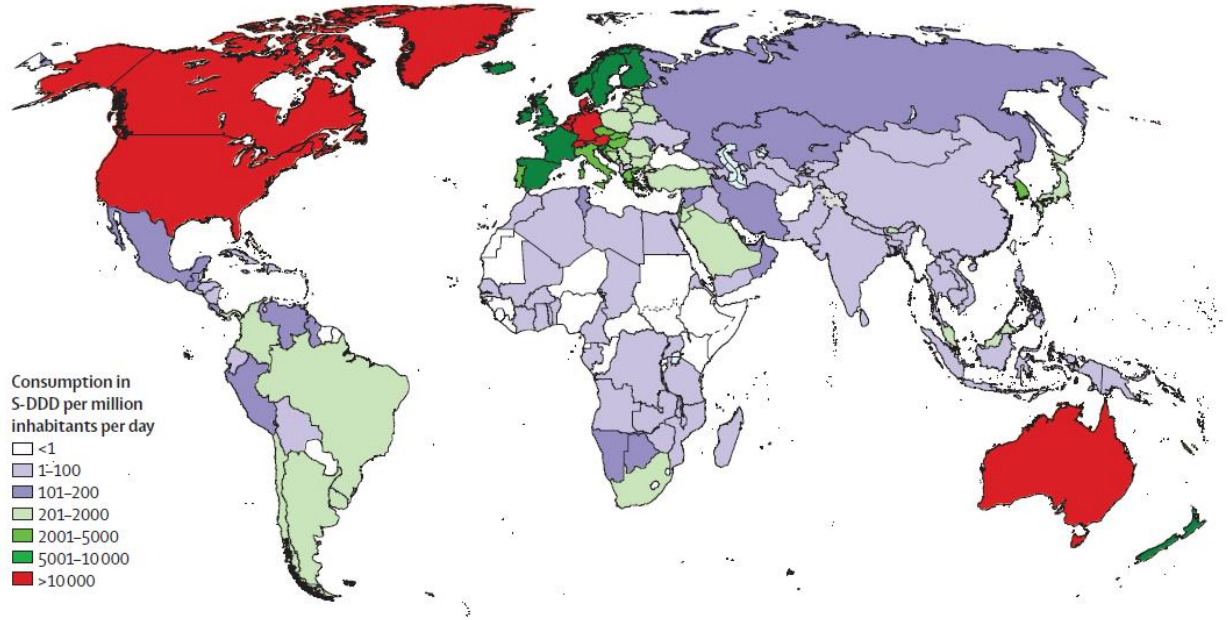
Breivik H, et al.. *Eur J Pain*. 2006;10:287–333;
British Medical Association. Chronic pain: supporting safer prescribing of analgesics. 2017.

The scale of the problem

OA use for pain management has dramatically increased worldwide over the last decade



2001–2003



2011–2013

OA, opioid analgesia; S- DDD, defined daily dose for statistical purposes

Berterame S, et al. *Lancet*. 2016;387:1644–56.

Incidence of OAD

Access to opioid analgesia is **increasing in Western Europe**, mirroring the trend seen in Australia and North America

4.7%

Incidence of OAD in those prescribed opioids for chronic care

Important to remember
Majority of chronic pain patients using OA do not develop opioid dependence

Berterame S, et al. *Lancet*. 2016;387:1644–56;
Higgins C, et al. *Brit J Anaes*. 2018;120:1335–44.

Why treat OAD?

OAD has social, psychological and physical consequences for the patient

Physical

- Vary with opioid intoxication, overdose or withdrawal
- Long-term effects
  - Endocrine changes
  - Immunological effects
  - Sleep disorders

Social

- Loss of employment
- Marital and family breakdown
- Loss of friendships
- Loss of interest in regular activities
- Financial problems

Psychological

- Mood instability
- Agitation
- Anxiety
- Depression

British Pain Society. Opioids for persistent pain: Good practice. 2010.

Risk factors for OAD

OAD may result from a combination of factors, including:

Personal or family history of dependence

Genetic predisposition

Personal psychological profile

Drug exposure

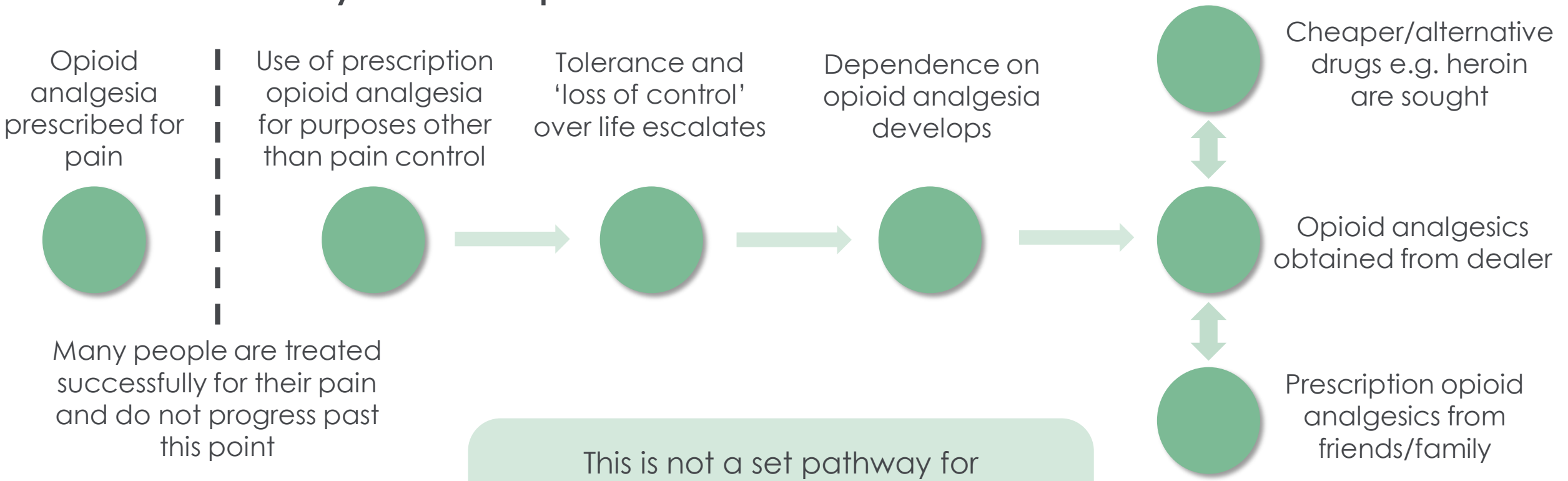
Alterations in brain reward mechanisms

History of dependence is the strongest predictor

Studies have indicated rates of mental health issues in OAD individuals as high as 72.9%

Ballantyne JC. *Pain Physician*. 2007;10:479–91; Ives TJ, et al. *BMC Health Serv Res*. 2006;6:46; Edlund MJ, et al. *Pain*. 2007;129:355–62; Conway K, et al. *J Clin Psych*. 2006;67:247–57.

Pathway to dependence



This is not a set pathway for development of OAD. It is a complex progressive condition that may take many paths

Canfield MC, et al. *J Addict Med*. 2010;4:108–13.

Barriers and challenges of addressing OAD

Engagement often suboptimal

Patients often:

- do not seek help
- lack awareness of the problem
- fear being stigmatised

OAD diagnosis often not made

HCPs may lack awareness and knowledge of the issue

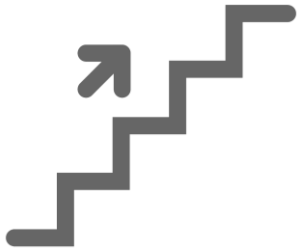
Pathway of referral to a specialist may be unclear

Lack of integrated approach

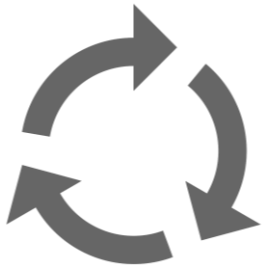
Success may be limited by lack of integration between opioid dependence and pain management

Kakko J, et al. *Subst Abuse Treat Prev Policy*. 2018:13:22.

OAD prevention: safer prescribing of OAs initially



Limit dose escalation if inadequate pain relief



Regularly review analgesia use with patient

Provide support for stopping if opioid trial not working

Avoid treatments that are unlikely to be beneficial

Avoid prescribing an opioid as 'default'
Consider non-pharmacological interventions

Provide training and education among HCPs

British Medical Association. Chronic pain: supporting safer prescribing of analgesics. 2017.

Factors that may indicate possible addiction

Adverse consequence:
- Intoxicated/somnolent/sedated
- Decreased activity
- Irritable/anxious/labile
- Increased sleep disturbances
- Increased pain complaints
- Increased relationship dysfunction

Impaired control/compulsive use:
- Repeated reports of lost or stolen Rx or Mx
- Frequent early renewal requests
- Urgent calls or unscheduled visits
- Misuse of other drugs and/or alcohol
- Withdrawal noted at clinic visits
- Observers report overuse or sporadic use

Preoccupation with use due to craving:
- Frequent missed appointments unless opioid renewal expected
- Does not try non-opioid treatments
- Cannot 'tolerate' most medications
- Requests specific medication/controlled drugs

Rx, prescription; Mx, medication.
Savage SR. *Clin J Pain.* 2002;18:28–38.

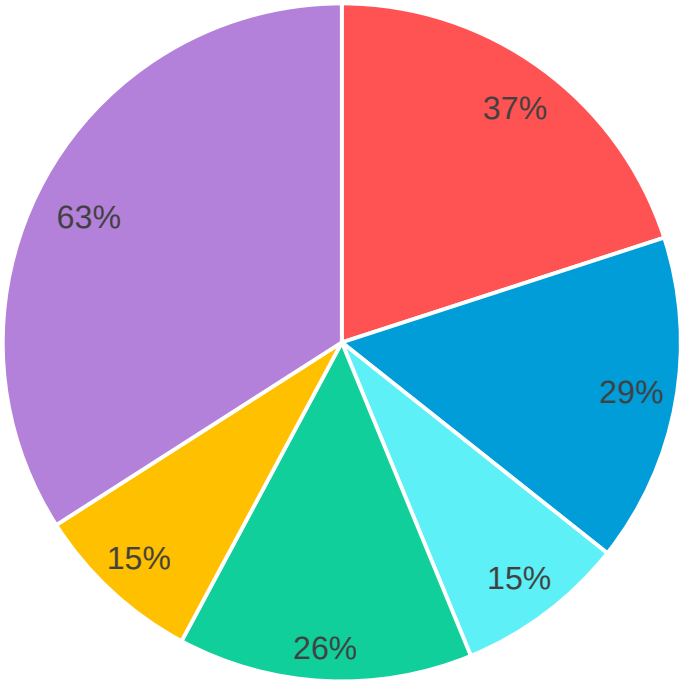
Screening tools to assess risk of misuse

A single-question screening test	'How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?' (positive answer >0)[1]
ORT **Opioid Risk Tool**	Assesses risk of aberrant behaviours — low-, moderate- or high-risk user. 5 items. Approx. 1 min to complete[2] http://www.agencymeddirectors.wa.gov/files/opioidrisktool.pdf
SOAPP **Screener & Opioid Assessment for Patients with Pain**	Assesses suitability of long-term opioid therapy from chronic pain patients. Different versions: 8, 14 or 24 items[3][4] http://nationalpaincentre.mcmaster.ca/documents/soapp_r_sample_watermark.pdf
SISAP **The Screening Instrument for Substance Abuse Potential**	Identifies individuals with a possible substance abuse history and at risk of misusing opioids. 5 items. Approx. <1 min to complete[5] https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs
DAST-10 **Drug Abuse Screening Test**	Assesses degree of problems related to drug abuse. 10 items. Yes/no self-report instrument. Should take <8 mins to complete[6] https://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf

Smith PC, et al. *Arch Intern Med*. 2010;170:1155–60; Webster LR, et al. *Pain Med*. 2005;6:432–42; https://www.inflexxion.com/questions-soapp-8/ [Accessed May 2019]; https://www.nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf [Accessed May 2019]; Coambs RB, et al. *Pain Res Manag*. 1996;1:155–62; http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs. [Accessed May 2019]

Survey of OAD awareness among mental health professionals

Respondents thought patients presenting with the following problems are misusing or have developed OAD

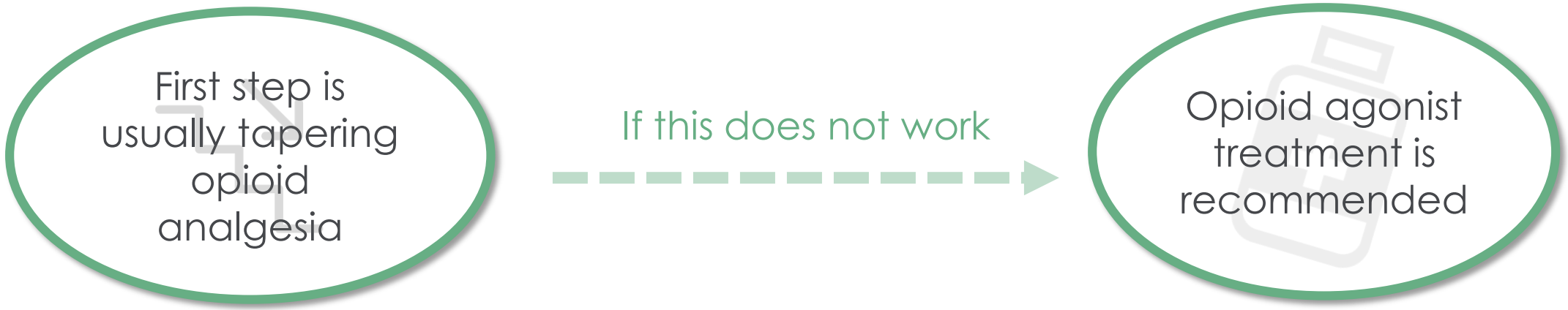


- Long-term Rx of OA for chronic pain
- Resolved pain but still needs OA
- Poorly managed pain requesting more OA
- Intermittent clinic attendance requesting OA
- Patient on OST requesting OA
- All of the above

Rx, prescription.

Abbasi Y, et al. Poster presented at SSA Annual Symposium 2016.

OAD treatment options



Key points

- ✓ Choice of OAT medication should be tailored to each individual
- ✓ Intensive monitoring is required
- ✓ Adjustments of dose may be necessary
- ✓ Consider role of psychosocial support
- ✓ Certain individuals with complex comorbidities may benefit from an in-patient setting
- ✓ Cessation of OAT should be guided by clinical response and not stopped prematurely

Kakko J, et al. *Subst Abuse Treat Prev Policy*. 2018:13:22.

Long-term opioid users who develop chronic pain

EMCDDA. European Drug Report. Trends and Developments. 2015.

Long-term heroin users with chronic pain

Increasing due to an ageing population

At risk of undertreatment due to misconceptions

EMCDDA. European Drug Report. Trends and Developments. 2015;
UK guidelines on clinical management. Drug misuse and dependence. 2017; Scottish Drugs Forums. Final report. 2017.

Management recommendations

- ✓ Have **realistic** goals
- ✓ For patients on OAT experiencing pain, consider **dividing daily dose** into every 8 or 12 hours
- ✓ Consider **non-opioid analgesia** where they have demonstrated efficacy for the pain condition reported
- ✓ Consider **non-pharmacological** options

May only be able to achieve reductions in pain intensity and not complete relief

For example, physical rehabilitation, exercise and psychological treatments

UK guidelines on clinical management. Drug misuse and dependence. 2017.

Case example

- 38-year-old white British male
- Works for emergency services
- Had an **accident** 8 years ago
  - Slipped and fractured wrist
- **Continued** to have **'pain'** for 2 years
- **Prescribed analgesia** by GP
- When prescription stopped, began **buying analgesia OTC**
  - Took 68 tablets of 8/500 mg codeine/paracetamol both in the morning and at night for 3 years
- Referred by GP to our service after they failed a codeine-only taper
- We stabilised the patient on **low-dose methadone** (20 mg/day) with **psychosocial interventions**
- Within 6 months, the patient was referred for **in-patient detox** as he struggled reducing it at home
- Patient then completed a successful detox
- He is **now abstinent** and **back at work**

GP, general practitioner; OTC, over the counter.

Case example

Previous medical history

Nil

Past psychological history

Drank alcohol excessively 10 years ago but had since reduced and stopped – still abstinent. No previous psychological diagnosis but had underlying low mood

Family history

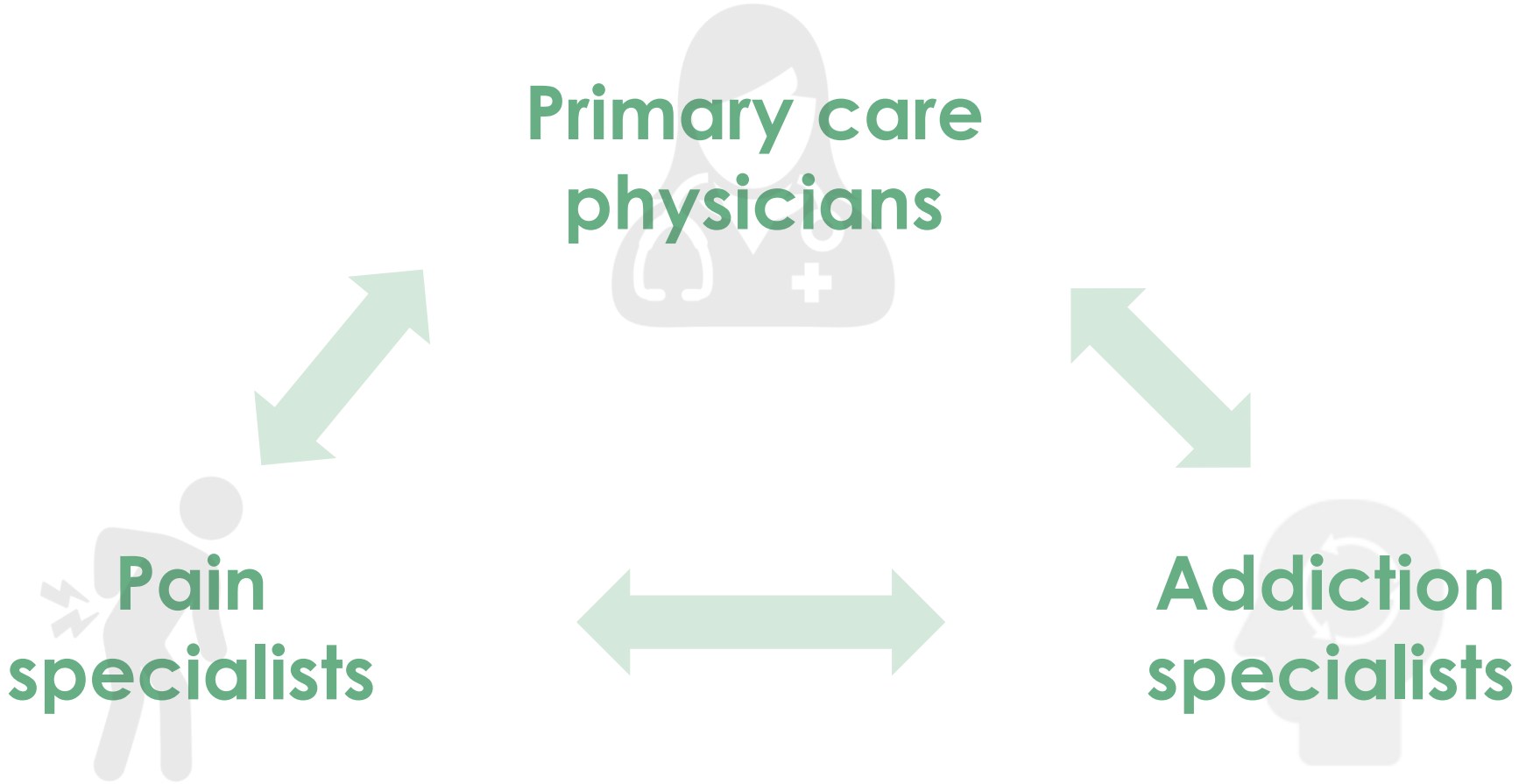
Father had 'alcohol issues'. Mother and brother diagnosed with GAD

Personal history

He had been working for the emergency services for 14 years. Had a partner and two children (14-year-old boy and 8-year-old girl)

GAD, generalised anxiety disorder.

Integrated and multidisciplinary approach is key



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