

5-STEP INITIAL APPROACH TO CARING FOR *the Displaced Pain Patient on Chronic Opioid Therapy*

James Patrick Murphy, MD, MMM



Providing therapeutic continuity for patients who have abruptly lost access to their prescriber (e.g. pain clinic closure) can be a challenge, especially if the patient has been treated with opioids and other controlled substances.

A patient in pain, facing the possibility of worsening pain combined with medication withdrawal, can feel very stressed. In this potentially difficult scenario, the caregiver must convey an air of calmness and empathy. Providers may seize this clinical inflection point as an opportunity to redirect the course of treatment, or provide a therapeutic bridge to specialty care by way of referral or consultation.

While not meant as a substitute for more comprehensive guidelines, the following is a concise five-step initial approach to caring for the displaced pain patient on chronic opioid therapy.

Always exercise compliance with statutory requirements (<http://www.painpolicy.wisc.edu/database-statutes-regulations-other-policies-pain-management>).

FIVE STEPS

1. HISTORY AND PHYSICAL EXAM

- Establish a diagnosis**
- Assess for withdrawal symptoms** (Ref 1: Clinical Opiate Withdrawal Scale)
- Note behaviors indicative of drug abuse or diversion** (Ref 2: Knowing When to Say When: Transitioning Patients From Opioid Therapy, pg 19)

2. OBJECTIVE DATA:

- Check state Prescription Drug Monitoring Program** (e.g. KASPER - <http://operationunite.org/investigations/kasper>)
- Count the patient's current supply of pills**
- Review (and/or request) medical records and reports** (e.g. MRI)
- Do a urine drug screen** (<https://kbml.ky.gov/hb1/Pages/Considerations-For-Urine-Drug-Screening.aspx>)
- Screen for:**
 - Function** (Ref 3: PEG Scale: Pain, Enjoyment, General Activity)
 - Opioid abuse potential** (Ref 4: Opioid Risk Tool)
 - Mental health** (Ref 5: Patient Health Questionnaire, PHQ-4)
- Remain alert to signs of anxiety, depression, and opioid use disorder.** If signs of opioid use disorder, then offer or arrange for treatment. If signs of mental illness, then offer

or arrange for treatment (<https://findtreatment.samhsa.gov/>).

- If child bearing potential, order a pregnancy test.**
 - Immediately consult OB/GYN if pregnancy is confirmed.
 - Opioid withdrawal during pregnancy has been associated with spontaneous abortion and premature labor.

3. DOCUMENTS (MAY BE COMBINED INTO ONE)

- Informed Consent** (Ref 6: NIDA Sample Informed Consent)
- Treatment Agreement** (Ref 7: NIDA Sample Patient Agreement Forms)

4. PAIN TREATMENT

- Maximize use of nonpharmacologic and nonopioid pharmacologic treatments** as appropriate. (Ref 8: Treating Chronic Pain Without Opioids, CDC)
- Educational points in** <https://kbml.ky.gov/hb1/Pages/Considerations-For-Patient-Education.aspx> (Ref 9: CDC Opioid Factsheet for Patients, etc.)

5. DECISION: MAINTAIN, ALTER, TAPER OR DISCONTINUE

A decision regarding maintaining, altering, tapering, or discontinuing controlled substances must be made. Some stable patients might be well served by maintaining their current regimen, however you are under no obligation to prescribe or continue with a treatment plan you don't agree with.

- If the patient does not need a prescription** and still has some medication, advise on how to gradually taper (i.e. decrease 10 to 50 percent per week).
- To prescribe a taper** with controlled substances: Calculate the current Morphine Equivalent Daily Dose (Ref 10: Calculating Total Daily Dose of Opioids For Safer Dosage, CDC)
 - Initially prescribe zero to three days** of a reduced MEDD (e.g. decrease 10 to 50 percent)
 - Use immediate release medications**
 - Arrange follow up** early and often
 - Additional days of medications may be prescribed at follow up** if risk/benefit assessment is deemed acceptable by the prescriber
 - The CDC advises against a rapid taper** (e.g. three weeks or less) for people taking ≥ 90 MEDD
- Regardless of taper speed, withdrawal may still happen**
 - Advise on over-the-counter** medications for with-

drawal symptoms

(Ref 11: ASAM National Practice Guideline, Part 3, pg 29)

- ii. **Consider prescribing prescription medications for withdrawal** (Ref 11: ASAM)
- d. **If tapering benzodiazepines, do so gradually**
 - i. **No more than 25 percent** decrease every one to two weeks
 - ii. **Abrupt benzodiazepine withdrawal** can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death.
- e. **Risk mitigation topics** (<https://bit.ly/2eb0bYe>)
 - i. **Discuss with patients** undergoing tapering that, because their tolerance to medications may return to normal, they are at increased risk for overdose on abrupt return to previously prescribed higher doses.
 - ii. **Consider offering naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MEDD/day), or concurrent benzodiazepine use, are present (Ref 12: Opioid Reversal With Naloxone, NIDA)

REFERENCES:


1. Clinical Opiate Withdrawal Scale <https://bit.ly/1UITHV1>
2. Knowing When to Say When: Transitioning Patients from Opioid Therapy University of Massachusetts Medical School (Massachusetts Consortium) Jeff Baxter, M.D. April 2, 2014 <https://bit.ly/2w7jOHO>
3. PEG Scale (Pain, Enjoyment, General Activity) <http://https://bit.ly/2MqhB4n>
4. Opioid Risk Tool (ORT) <https://bit.ly/1Nnwj84>, <https://bit.ly/2Beoa5M>
5. Patient Health Questionnaire (PHQ 4) <https://bit.ly/2L05Z3y>
6. National Institute on Drug Abuse (NIDA) Sample Informed Consent Form <https://bit.ly/2MOBP4Q>
7. National Institute on Drug Abuse (NIDA) Sample Patient Agreement Forms <https://bit.ly/2CF0fFE>
8. CDC: Treating Chronic Pain Without Opioids <https://bit.ly/2Mk5ZAH>
9. CDC: Opioid Factsheet for Patients <https://bit.ly/2lvdeZ1>
Other Patient Education Resources: <https://bit.ly/2KTWqDa>, <https://bit.ly/2n-FHjnH>, <https://bit.ly/2nENcS3>
10. Calculating Total Daily Dose of Opioids For Safer Dosage (CDC) <https://bit.ly/2eY5bxw>
11. American Society of Addiction Medicine National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, Part 3: Treating Opioid Withdrawal, Summary of Recommendations (7), page 29. <https://bit.ly/2tbSGcj>
The Guideline Committee recommends, based on consensus opinion, the inclusion of clonidine as a recommended practice to support opioid withdrawal. Clonidine

is not US FDA-approved for the treatment of opioid withdrawal, but it has been extensively used off-label for this purpose. **Clonidine** may be used **orally** or **transdermally** at doses of **0.1–0.3 mg every 6–8 hours**, with a **maximum dose of 1.2 mg daily** to assist in the management of opioid withdrawal symptoms. Its **hypotensive effects** often limit the amount that can be used. Clonidine can be combined with other non-narcotic medications targeting specific opioid withdrawal symptoms such as **benzodiazepines** for anxiety, **loperamide** for diarrhea, **acetaminophen** or **NSAIDs** for pain, and **ondansetron** or other agents for nausea.

12. Opioid Reversal With Naloxone (NIDA) <https://bit.ly/2y0qLgy>

ADDITIONAL RECOMMENDED REFERENCES:

- a. CDC Checklist for Prescribing Opioids for Chronic Pain <https://bit.ly/2Lq3p-bV>
- b. Universal Precautions Revisited: Managing the Inherited Pain Patient by Douglas L. Gourlay, MD, MSc, FRCPC, FASAM,* and Howard A. Heit, MD, FACP, FASAM. Published in Pain Medicine Volume 10 • Number S2 • 2009 <https://bit.ly/2MMU5vw>
- c. SAMHSA Behavioral Health Treatment Services Locator <https://findtreatment.samhsa.gov/>
- d. University of Wisconsin Pain and Policy Studies Database of Statutes, Regulations, and Other Policies for Pain Management <https://bit.ly/2IClhc8>
- e. Knowing When to Say When: Transitioning Patients from Opioid Therapy University of Massachusetts Medical School (Massachusetts Consortium) Jeff Baxter, M.D. April 2, 2014 <https://bit.ly/2w7jOHO>
- f. The Pain Clinic Closure Survival Guide for Patients and Clinicians <https://bit.ly/2KWq2j5>
- g. **DROPBOX Link for Reference Materials:** <https://bit.ly/2vMW8lp>

Disclaimer: This is for informational purposes only, does not constitute medical advice or a patient/provider relationship. It is not meant to establish a standard of care. I have made every effort to cite references where applicable, however the opinions expressed are my own and have not been endorsed by any organization. Links to references or other materials are taken at your own risk. The content provided here is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read on this website. If you think you may have a medical emergency, call your doctor, go to the emergency department, or call 911 immediately. 

James Patrick Murphy, MD, MMM, FASAM is a board-certified pain medicine and addiction medicine specialist who represents the American Society of Addiction Medicine on the American Medical Association's newly formed Pain Task Force.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1–20 mg/day	4
21–40 mg/day	8
41–60 mg/day	10
≥ 61 –80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

Table 1: Recognizing Opioid Misuse and/or Addiction in Patients on Chronic Opioid Therapy

(Adapted from: Savage et al., 2008; Manchikanti et al., 2008)

Components of Addiction The “3 Cs”	Possible Expressions in Patients on Chronic Opioid Therapy
Loss of <u>C</u> ontrol	<ol style="list-style-type: none"> 1. Reports lost/stolen medications 2. Uses medication supply in short periods of time and calls for early refills 3. Seeks opioids from other sources 4. Exhibits withdrawal symptoms at appointments
<u>C</u> raving, preoccupation with use, compulsive use	<ol style="list-style-type: none"> 1. Recurring requests for increases in opioids 2. Increasing pain despite lack of progression of disease 3. Dismisses nonopioid treatments 4. Focuses on medications and not on other activities
Use despite negative <u>C</u> onsequences	<ol style="list-style-type: none"> 1. Significant side effects, such as sedation and cognitive impairment 2. Overdose 3. Decreases in activity, functioning, and/or relationships