

## Optimizing Opioids Reducing Risk in Pain Management

Roman D. Jovey, MD

## Learning Objectives

1. Assess and risk stratify patients with chronic pain for opioid therapy
2. Manage common opioid related side effects
3. Prescribe and monitor opioid therapy using Universal Precautions / Canadian Opioid Guidelines
4. Document key outcome measures to demonstrate benefit

## Conflict of Interest Disclosure Dr. Roman D. Jovey

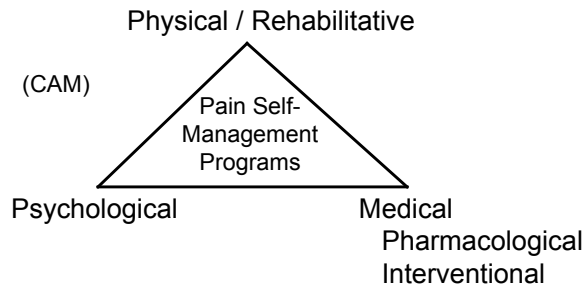
Program Title: Optimizing Opioids Reducing Risk

- Grants/Research Support: none
- Speakers Bureau/Honoraria/ Consulting Fees:
- Astra-Zeneca, Bayer, Biovail, Boehringer-Ingelheim, GlaxoSmithKline, Janssen, King, Lilly, Medical Futures Inc, Merck-Frost, Mundipharma, Nycomed, Palladin, Pfizer, Purdue-Pharma, Sanofi-Aventis, Tribute Pharma, Valeant, Wyeth

## Ralph: Back in your office

- complaining of insomnia / depressed mood
- severe low back pain that radiates up his back as well as part way down his right leg
- his wife is getting on his case - unable to do his household chores
- trouble meeting their monthly expenses (stress!)
- requesting something stronger for the pain and an MRI of his back
- a buddy had surgery for a "slipped disc" and is better
  - he also wants a referral to his buddy's surgeon

## Best Practice Treatment for Chronic Pain



**Opioids can be effective pain relievers at least for some types of chronic pain in some people for some period of time...**

## Unanswered Questions: Opioids

In which patients will opioids work?

.....for how long?

- Tolerance vs. hyperalgesia

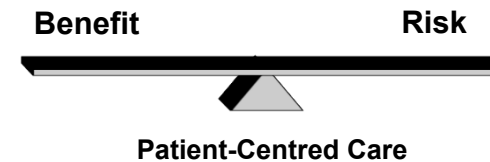
.....with what long-term side effects?

- Hormonal
- Sleep apnea

.....with what risks?

- Misuse / addiction
- Overdose deaths

## The Pain Management Challenge



# 1. Screening and Risk Stratification

Know your patient

## Screening for Opioid Misuse Risk

- Initial Screening Questions:
  - **Ask** in a routine, straightforward manner
  - Ask about number of drinks per day and per week and sedative use
  - CAGE, SOAPP-R, **Opioid Risk Tool**

**Opioid Risk Tool  
Clinician Form**  
(includes point values to determine scoring total)

Mark each box that applies:

|   | Female                     | Male                       |
|---|----------------------------|----------------------------|
| <b>1. Family History of Substance Abuse:</b>  |                            |                            |
| Alcohol   | <input type="checkbox"/> 1 | <input type="checkbox"/> 3 |
| Illegal Drugs   | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Prescription Drugs  | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| <b>2. Personal History of Substance Abuse:</b>  |                            |                            |
| Alcohol   | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 |
| Illegal Drugs   | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| Prescription Drugs  | <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| <b>3. Age (mark box if between 16-45)</b>   | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <b>4. History of Preadolescent Sexual Abuse</b>   | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| <b>5. Psychological Disease</b>   |                            |                            |
| Attention Deficit Disorder,<br>Obsessive-Compulsive Disorder,<br>Bipolar, Schizophrenia | <input type="checkbox"/> 2 | <input type="checkbox"/> 2 |
| Depression  | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |

Scoring Totals \_\_\_\_\_

The patient can be placed into one of three opioid risk categories based on their total score:

Low Risk = 0 - 3 points  
Medium Risk = 4 - 7 points  
High Risk = 8 points and above

Reprinted with permission: Lynsi R. Webster, MD

## Ralph– Risk Screening

- He admits he had a “wild” youth with drinking and heavy use of marijuana but settled down when he met his wife. Now occasional use of cannabis only on weekends (helps the pain) No other street drug use.
- His father and 2 paternal uncles had alcohol problems.
- Drinks alcohol (max 6-8 beers over a weekend). No interference with life
- Smokes 1 PPD. 1st cigarette within 1/2 hour of waking up. He quit for 2 weeks once.

**Ralph Opioid Risk Tool Clinician Form**  
(includes point values to determine scoring total)

Mark each box that applies:

**1. Family History of Substance Abuse:**

|                    |                            |                                       |
|--------------------|----------------------------|---------------------------------------|
| Female             | <input type="checkbox"/> 1 | <input checked="" type="checkbox"/> 3 |
| Alcohol            | <input type="checkbox"/> 2 | <input type="checkbox"/> 3            |
| Illegal Drugs      | <input type="checkbox"/> 2 | <input type="checkbox"/> 3            |
| Prescription Drugs | <input type="checkbox"/> 4 | <input type="checkbox"/> 4            |

**2. Personal History of Substance Abuse:**

|                    |                            |                                       |
|--------------------|----------------------------|---------------------------------------|
| Female             | <input type="checkbox"/> 3 | <input type="checkbox"/> 3            |
| Alcohol            | <input type="checkbox"/> 4 | <input checked="" type="checkbox"/> 4 |
| Illegal Drugs      | <input type="checkbox"/> 3 | <input type="checkbox"/> 5            |
| Prescription Drugs | <input type="checkbox"/> 3 | <input type="checkbox"/> 5            |

**3. Age (mark box if between 16-45)**  1  1

**4. History of Preadolescent Sexual Abuse**  3  0

**5. Psychological Disease**

|   |                            |                            |
|---|----------------------------|----------------------------|
| Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia | <input type="checkbox"/> 2 | <input type="checkbox"/> 2 |
| Depression  | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |

Scoring Totals 7

The patient can be placed into one of three opioid risk categories based on their total score.

Low Risk = 0 - 3 points  
Medium Risk = 4 - 7 points  
High Risk = 8 points or above

Reprinted with permission: Lynn R. Webster, MD

## Screening for MH Disorders

- Screening for Anxiety
  1. Generalized Anxiety Disorder Score (GAD-7)  
Arch Intern Med. 2006;166:1092-1097
- Screening for Depression
  2. The Patient Health Questionnaire PHQ – 9  
<http://www.depression-primarycare.org/>
- Screening for Both
  3. Hospital Anxiety & Depression Scale HADs ←  
Acta Psychiatr Scand. 1983 Jun;67(6):361-70  
J Psychosom Res. 2002 Feb;52(2):69-77.

**HADS**

Please read each statement below and circle the number which best describes how true the feeling is for you.

|  | Yes definitely | Yes sometimes | No, not much | No, not at all |
|--|----------------|---------------|--------------|----------------|
| 1. I wake early and then sleep badly for the rest of the night.                  | 0              | 2             | 1            | 0              |
| 2. I get very frightened or have panic feelings for apparently no reason at all. | 3              | 2             | 1            | 0              |
| 3. I feel miserable and sad.   | 3              | 0             | 1            | 0              |
| 4. I feel anxious when I go out of the house on my own.                          | 3              | 2             | 1            | 0              |
| 5. I have lost interest in things.   | 0              | 2             | 1            | 0              |
| 6. I get palpitations, or sensations of 'butterflies' in my stomach or chest.    | 3              | 2             | 1            | 0              |
| 7. I have a good appetite.   | 0              | 1             | 2            | 3              |
| 8. I feel scared or frightened.  | 3              | 2             | 0            | 0              |
| 9. I feel life is not worth living.  | 3              | 2             | 1            | 0              |
| 10. I still enjoy the things I used to.  | 0              | 1             | 2            | 0              |
| 11. I am restless and can't keep still.  | 0              | 2             | 1            | 0              |
| 12. I am more irritable than usual.  | 0              | 2             | 1            | 0              |
| 13. I feel as if I have slowed down.   | 3              | 0             | 1            | 0              |
| 14. Worrying thoughts constantly go through my mind.                             | 3              | 0             | 1            | 0              |

A = 9  
D = 13

Anxiety: 2,4,6,8,11,12,14 total= \_\_\_ Depression: 1,3,5,7,9,10,13 total= \_\_\_  
Scoring: 0-7 = non-case; 8-10 = borderline case; >11 = definite case  
Zigmond AS, Snaith RP. Acta Psychiatr Scand. 1983;67(6):361-70.

## Primary Care Triage of Patients With Chronic Pain

- **Group III Tx by specialist or Primary Care (with a lot of help)**
  - Active addictive disorder, Hx of opioid addiction
  - Major untreated psychiatric disorder
- **Group II Tx by Primary Care (with some help)**
  - Increased risk patient, in recovery, positive family Hx
  - No active addictive disorder; No major untreated psychiatric disorder
- **Group I Tx by Primary Care (without help)**
  - Lack major psychiatric comorbidity
  - No history of substance related problems

Adapted from Gourlay D. & Heit H. Pain Med 2005

## 2. Manage Side Effects

Optimize Outcome

## Chronic Opioid Side Effects

- Constipation
- Sedation during titration (driving, work)
- Pruritis/sweats
- Dry mouth
- GE reflux symptoms

### Stable dose, scheduled, titrated, long-term opioid therapy should not cause clinically significant cognitive impairment

- Hendler N. et al. Amer J Psychiatr 1980
- Zacny JP. Exp Clin Psychopharmacol 1995
- Vainio A. et al. Lancet 1996
- Zacny JP. Addiction 1996
- Lorenz J. et al. Pain 1997
- Haythornthwaite JA, et al. JPSM 1998
- Sjogren P, et al. Pain; 2000
- Galski T, et al. JPSM 2000
- Chapman S. Clin J Pain 2002
- Sabatowski R. et al. JPSM 2003
- Tassain V. et al. Pain; 2003
- Fishbain DA. et al. JPSM 2003
- Meneffee, Pain Med 2004

#### REVIEW ARTICLE

### Systematic Review of the Quality and Generalizability of Studies on the Effects of Opioids on Driving and Cognitive/Psychomotor Performance

*Angela Mailis-Gagnon, MD, MSc, FRCPC (PhysMed),\*†; Shelma Fatima Lakha, MSc,\*†  
Andrea Furlan, MD, PhD,‡§; Keith Nicholson, PhD,\*† Balaji Yegneswaran, MD,\*  
and Rainer Sabatowski, MD\**

**Interpretation:** The commonly held concept that “chronic pain patients on stable opioids are safe to drive” cannot be generalized to all such patients in everyday practice, but may be applicable only to a subset who meet certain criteria.

Mailis-Gagnon, et al. Clin J Pain 2012; 28(6): 542-555

## Systematic Review of Studies on Opioids and Driving

Probably safe to drive:

1. No other meds / substance use
2. Do not have high levels of pain
3. Lack a substantial sleep disorder
4. Do not have sig. depression or anxiety

Mailis-Gagnon A. et al. Clin J Pain 2012; 28(6):542-555

## Driver Assessment-Medical Conditions

- DriveABLE: [www.driveable.com](http://www.driveable.com)
- DriveLab Inc: [www.wrigroup.ca](http://www.wrigroup.ca)

## Chronic Opioid Side Effects – “New”

- Hormonal effects
- Sleep apnea → ?CVS disease?
- Opioid induced hyperalgesia
- Immune dysfunction ??

**When the side effects are greater than the benefit → switch opioids**

Every patient responds uniquely to each opioid molecule.

## Switching Opioids – Abrupt Switch\*

1. Use opioid tables to calculate a total daily equianalgesic dose of the new opioid
2. Switch to 50-60% of the predicted dose of the new opioid and titrate to effect again
3. Provide adequate IR opioid to manage withdrawal or pain flare

\*Opioid switching worksheet available on the Canadian Opioid Guideline website and in the Opioid Manager App

## Equianalgesic Doses for Chronic Dosing\*

| MEDICATION            | P.O. DOSE                 |
|-----------------------|---------------------------|
| Morphine              | 30 mg                     |
| Codeine               | 200-300 mg                |
| Tapentadol            | 100 mg                    |
| Oxycodone             | 20 mg                     |
| Hydromorphone         | 6 mg                      |
| Fentanyl 12 mcg/hr    | ~30mg oral morphine/24hr  |
| Buprenorphine 15ug/hr | ~30mg oral morphine/ 24hr |

\* These are general guidelines only

\* Studies done in healthy volunteers, or post-op

\*Adapted from Opioid Manager, \*Courtesy of: "Toronto Rehabilitation Institute"  
Tapentadol product monograph

**Pain Medicine**

Pain Medicine 2012; 13: 571-574  
Wiley Periodicals, Inc.



### Case Report

## Overdose Deaths Demand a New Paradigm for Opioid Rotation

Lynn R. Webster, MD,\* and Perry G. Fine, MD<sup>†</sup>

Webster and Fine. Pain Medicine 2012; 13: 571-74

## “A New Paradigm for Opioid Rotation”

1. Decrease the the total dose of the old CR opioid 10-30% while starting the new CR opioid at the lowest dose for the formulation
2. Decrease the total daily dose of the old CR opioid 10-25% per week while titrating the dose of the new CR opioid weekly by 10-20% with a goal of switching over 3-4 weeks
3. Provide adequate IR opioid to manage withdrawal or increased pain

Webster and Fine. Pain Medicine April 2012

## Canadian Opioid Guidelines R17 Elderly Patients

- Opioid therapy for elderly patients can be safe and effective (Grade B) with appropriate precautions, including lower starting doses, slower titration, longer dosing interval, more frequent monitoring, and tapering of benzodiazepines (Grade C)

Available at: <http://nationalpaincentre.mcmaster.ca/opioid/>

29

Clinical Review & Education

Care of the Aging Patient: From Evidence to Action

Management of Persistent Pain in the Older Patient

A Clinical Review

Uma E. Makris, MD, Robert C. Abrams, MD, Barry Gurland, FRCPsychiatry, FRCPsychiatry,  
M. Carrington Reid, MD, PhD

- Optimize physical and psychological treatments
- Use complementary medication combinations
- A trial of acetaminophen
- Avoid long-term NSAIDs
- Trial of SNRIs or SSRIs when depression present
- Trial of opioids when 1<sup>st</sup> line treatments fail

JAMA 2014; 312(8):825-836

## Opioids for the Older / Fragile Patient

**START LOW  
GO SLOW  
MONITER CAREFULLY**

## 3. Prescribe Safely

Reduce Risks



McMaster University Faculty of Health Sciences  
 Michael G. DeGroot National Pain Centre  
 Department of Anaesthesia  
 Institute for Pain Research and Care  
 Toward Optimized Practice  
 Administration Login

MUGSI Quick Links Select  
 Faculty & Staff Directory Search GO  
 McMaster FHS NPC

Canadian Guideline for Opioid Use for Chronic Pain Feedback Contact Us

## Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Table of Contents  
 [Download Part A] | [Download Part B]

Please feel free to download the PDF files of the Canadian Guideline documents. The PDF versions posted on this website are the official Canadian Guideline documents. Web formatted content is the unofficial version of the Guideline. While best efforts have been made to ensure accuracy and consistency with the official documents, if any discrepancies exist in the web format, content of the PDF version shall apply.

Overview of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

|                            |  |            |                                      |            |                            |
|----------------------------|--|------------|--------------------------------------|------------|----------------------------|
| Summary of Recommendations | Part A: Executive Summary and Background | Appendix A | Part B: Recommendations for Practice | Appendix B | List of Figures and Tables |
|----------------------------|--|------------|--------------------------------------|------------|----------------------------|

April 30 2010 V5.6

### Summary of Recommendations

- Cluster 1: Deciding to Initiate Opioid Therapy
- Cluster 2: Conducting an Opioid Trial
- Cluster 3: Monitoring Long-Term Opioid Therapy (LTOT)
- Cluster 4: Treating Specific Populations with LTOT
- Cluster 5: Managing Opioid Misuse and Addiction in CNCP Patients

### Figures

- Figure 01: Recommendations Roadmap

### Figure 01. Recommendations Roadmap

nationalpaincentre.mcmaster.ca/opioid

### Summary of Recommendations

Cluster 5: Managing Opioid Misuse and Addiction in CNCP Patients

| No.  | Recommendation   | Keyword                               |
|------|--|---------------------------------------|
| R2.1 | For patients with chronic non-cancer pain who are addicted to opioids, three treatment options should be considered: methadone or buprenorphine treatment (Grade A), structured opioid therapy (Grade B), or abstinence-based treatment (Grade C). Consultation or shared care, where available, can assist in selecting and implementing the best treatment option (Grade C). | Addiction treatment options           |
| R2.2 | To reduce prescription fraud, physicians should take precautions when issuing prescriptions and work collaboratively with pharmacists (Grade C).   | Prescription fraud                    |
| R2.3 | Be prepared with an approach for dealing with patients who disagree with their opioid prescription or exhibit unacceptable behaviour (Grade C).  | Unacceptable behaviour                |
| R2.4 | Acute or urgent health care facilities should develop policies to provide guidance on prescribing opioids for chronic pain to avoid contributing to opioid misuse or diversion (Grade C).  | Acute care opioid prescribing ability |

### Appendix B

- Appendix B-1: Examples of Tools for Assessing Alcohol and other Substance Use
- Appendix B-2: Opioid Risk Tool
- Appendix B-3: Urine Drug Screening (UDS)
- Appendix B-4: Opioid Information for Patients
- Appendix B-5: Sample Opioid Medication Treatment Agreement
- Appendix B-6: Benzodiazepine Tapering
- Appendix B-7: Example of Documenting Opioid Therapy
- Appendix B-8: Opioid Conversion and Brand Availability in Canada
- Appendix B-9: Brief Pain Inventory ©
- Appendix B-10: Aberrant Drug-Related Behaviours Resources
- Appendix B-11: SOAP®-R and COMM-B
- Appendix B-12: Opioid Tapering
- Appendix B-13: Meta-analysis Evidence Table

# The Canadian Opioid Guidelines

- Practice Toolkit:
  - Opioid Manager\*
  - Recommendations Roadmap
  - Recommendation Highlights
  - List of Recommendations
  - Tools to Use Before You Prescribe Opioids
  - Tools to Select the Right Opioid and Titrate Effectively
  - Tools to Monitor for Safety and Effectiveness
  - Opioid Tapering

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

<http://nationalpaincentre.mcmaster.ca/opioid>

**PRACTICE TOOLKIT**

Practice Tool Kit Available at: <http://nationalpaincentre.mcmaster.ca/opioid/>

# The Opioid Manager

- Is designed to be used as a point of care tool for providers prescribing opioids for CNCP
- It condenses key elements from the Canadian Opioid Guideline and can be used as a chart insert
- Revised February 2011

CNCP = Chronic Non-Cancer Pain  
 \*Courtesy of: "Toronto Rehabilitation Institute" Available at: <http://nationalpaincentre.mcmaster.ca/opioid/>

**OPIOID MANAGER**

Healthcare Professionals  
Patient  
Terms and Conditions

App Availability:  
Android  
Apple iTunes

EMRs:  
Accuro (Optimed)  
Microquest  
MOIS  
OSCAR  
Practice Solutions  
Xwave  
York-Med

**A. Before the First Script**  
Overdose Risk  
Initiation Checklist  
Stepped Approach to Opioid Selection  
Opioid Risk Tool

**B. Initiation Trial**  
Suggested Initial Dose and Titration  
Initiation Trial Chart

**C. Maintenance & Monitoring**  
Switching Opioids  
Opioid Conversion Tool  
Maintenance & Monitoring Chart

**D. Decreasing & Stopping Opioid**  
When to Stop Opioids  
How to Stop  
Aberrant Drug Related Behaviour

37

McMaster University

Faculty of Health Sciences  
Michael G. DeGroote  
National Pain Centre  
Chairman of

MUGSI  
Quick Links | Search  
Faculty & Staff Directory  
Search  
McMaster PHS NPC

McMaster NPC Home About NPC Guidelines News Links Feedback Patient Information Contact NPC

**Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain**

Table of Contents  
[Site Map] | [Guideline PDF Files] | [Opioid Manager] Collaboration and Acknowledgments | Provide Feedback

**200 mg morphine equivalent = "watchful dose"**

[www.nationalpaincentre.mcmaster.ca/opioid/](http://www.nationalpaincentre.mcmaster.ca/opioid/)

## Conducting an Opioid Trial – Watchful Dose

### R10 Recommendation Statement

Chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent (Grade A).

Consideration of higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes (Grade C).

39

Adapted from: <http://nationalpaincentre.mcmaster.ca/opioid/>

## "Watchful Dose"

Considerations before titrating dose  
>200 mg/day of morphine equivalent (ME)

- Is the pain diagnosis correct?
- Is the pain problem responsive to opioids?
- What is the patient's risk of misuse?
- Is further investigation and/or consultation required?
- Are non-opioid treatment options available?
- Is there an inadequately treated concurrent mental health disorder?

**Prescribe all opioids  
at all doses  
with consideration and care**

## Written Treatment Agreements

- Low cost, low tech strategy
- Helps to demonstrate informed consent
- Effective boundary setting tool
- Must be readable, reasonable and have some flexibility

Fishman S. 1999, 2000, 2002  
Wallace LS et al. Jour of Pain, 2007; 8(10):759-766

## Urine Drug Testing

- Only small % of FDs in Canada include this as part of pain management
- Not funded in all provinces, technology varies
- Confusion re: interpretation of results
- Limitations using urine as a test substance
  - UDT “games” → ? Saliva drug testing

## Incorporating Risk Level into Pain Management

### **Group III – Co-management with specialist (if available)**

Written agreement, random UDTs 1-2x per month, pill counts  
Exhaust all other options before considering opioids  
Dispensing daily → weekly, choose opioids carefully

### **Group II – Tx by Primary Care with consultation (if available)**

More assessment and focus on functional goals  
Written agreement, UDT 3-4x per year, collateral information  
Follow-up monthly, dispense q 2 wks, choose opioids carefully

### **Group I – Treatment by Primary Care**

Utilize all Tx options, including opioids, focus on S/E  
Verbal or written agreement, UDT 1-2x per year  
F/U q 2-3 months, meds dispensed q 4 weeks

## What to do with a +ve UDT

- FIRST – confirm the results
- Discuss with pt – ask re: addiction problem
  - Offer to refer for help
- Tighten boundaries
  - More frequent dispensing (1-2x weekly prn)
  - Decrease or D/C break through meds
  - More frequent random UDTs
  - Collateral information
- If persists, taper off of opioids

## Opioids are not a panacea for all pains in all patients

There is always an individual  
risk / benefit ratio

## When to Stop Opioid Therapy

- No meaningful pain relief
- Persistent adverse effects
  - ? Opioid hyperalgesia
- Does not achieve therapeutic goals, even with effective pain relief
  - ie. improved physical or social functioning

Ballantyne JC et al, 2003; Benyamin R et al, 2008; Chou R et al, 2009; Porreca F et al, 2009; Slatkin NE, 2009

## When to Stop Opioid Therapy

- Not cooperating with treatment plan
- Persistent out-of-bounds behaviours
  - unable to follow the treatment agreement
- Is diagnosed with an addiction disorder and refuses referral for treatment

Ballantyne JC et al, 2003; Benyamin R et al, 2008; Chou R et al, 2009; Porreca F et al, 2009; Slatkin NE, 2009

## Don't abandon your patient simply because of opioid-related behaviours...

...but you can abandon a treatment that is not helping

## Tapering a patient off of opioids because of repeated ADRBs

- “I am sorry, I can no longer safely Rx opioids from this office for your problem.”
- “I am going to taper you off of the opioids over the next \_\_\_ days or weeks, but I am still willing to work with you on other treatments.”
- “The only place I think that you can safely obtain opioids at this time is a methadone program. I will be happy to refer you.”

## Tapering Opioid Therapy

1. Discuss and document (with significant other?) :
  - Withdrawal is not dangerous
  - Typical withdrawal symptoms & time course hand-out
2. We may both be surprised that your pain is no worse or possibly even better
3. Discuss alternative treatment options
4. Careful with sedatives - withdrawal is more risky

Patients who are diverting or addicted may refuse to comply and leave your practice

## Tapering Opioids

- Fast or slow
  - 10% per day, daily pharmacy dispensing
  - 10% q 1-2 weeks
- Use pharmacological aids
  - Clonidine, imodium, NSAID, nabilone, GPN, PGN
- Methadone (buprenorphine) taper
- Educating the patient is the most effective treatment!

## Know info re: your local Methadone (Buprenorphine) Clinic

## Safe Opioid Prescribing for All:

- One doctor, one pharmacist
- Tamper-evident or multiple copy pads
  - Keep Rx pads in your pocket
- Utilize Rx monitoring data where available
- Ask about the home milieu
- Limit the amount dispensed (part-fills)
- Discuss security of meds (lock them up!)



Search this site:

Home About Us Appointments Referral Requests Online  
References & Testimonials Resources & Links Upcoming Events & Media Coverage Who

### Now available for ordering online: Lockmed(TM) Boxes

Wellbeings Pain Management and Dependency Clinic is pleased to announce that LockMed™ Boxes are now available for purchase through this website, and may be ordered securely online. Available in three sizes, LockMed™ Medication Boxes are the ideal way to keep strong medications secure and safe at home.



[Click here to order!](#)  
Clinic News

[www.wellbeings.ca](http://www.wellbeings.ca)

## Prescription Drug Return Initiatives in Canada

| Table of Contents   |
|---|
| • <b>1. Introduction</b>  |
| • <b>2. Prescription Drug Return Initiatives</b>                        |
| • 2.1 <a href="#">U.S. Drug Enforcement Administration</a>              |
| • 2.2 <a href="#">Niagara Region Drug Drop Day</a>                      |
| • 2.3 <a href="#">Ministry of Environment (Ontario) Regulation</a>      |
| • 2.4 <a href="#">Medi Drop (Cornwall)</a>                              |
| • 2.5 <a href="#">Ottawa Public Health Medication Clean-Out Project</a> |
| • 2.6 <a href="#">Medications Return Program</a>                        |

CBCnews | Windsor

Home World Canada Politics Business Health Arts & Entertainment Technology & Science Trending Weather

Canada Windsor Photo Galleries

## Fentanyl 'patch-for-patch' program growing in Ontario

CBC News Posted: May 12, 2015 8:05 AM ET | Last Updated: May 12, 2015 8:34 AM ET

63 shares Ontario communities

Facebook Twitter Reddit Google

Stay Connected with CBC News



# PATCH4PATCH INITIATIVE

Fentanyl Abuse Prevention – A Shared Responsibility  
Ontario Association of Chiefs of Police – Substance Abuse Committee 2014

THE GLOBE AND MAIL



## New opioid standards to tackle widespread, serious abuse in Canada

KELLY GRANT  
HEALTH REPORTER — The Globe and Mail  
Published Monday, Jul. 07 2014, 2:00 AM EDT  
Last updated Monday, Jul. 07 2014, 6:30 AM EDT

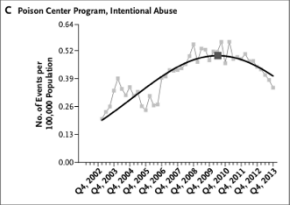
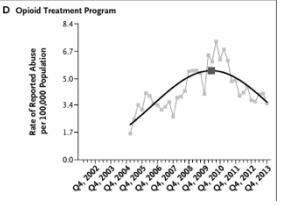
In a bid to curb Canada's widespread prescription-drug abuse problem, Ottawa is moving to force the makers of all opioids – not just the well-known painkiller oxycodone – to render their products resistant to crushing, snorting or injecting for a quick high.

THE NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

## Trends in Opioid Analgesic Abuse and Mortality in the United States

Richard C. Dart, M.D., Ph.D., Hilary L. Surratt, Ph.D., Theodore J. Cicero, Ph.D., Mark W. Parrino, M.P.A., S. Geoff Severson, Ph.D., Becki Bucher-Bartelson, Ph.D., and Jody L. Green, Ph.D.

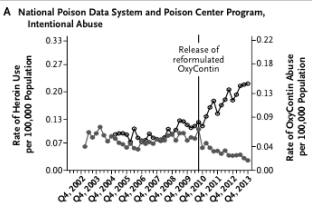
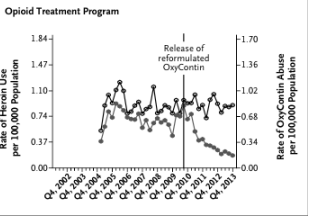
Dart R.C. et al. NEJM 2015;372(3):241-248

THE NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

## Trends in Opioid Analgesic Abuse and Mortality in the United States

Richard C. Dart, M.D., Ph.D., Hilary L. Surratt, Ph.D., Theodore J. Cicero, Ph.D., Mark W. Parrino, M.P.A., S. Geoff Severson, Ph.D., Becki Bucher-Bartelson, Ph.D., and Jody L. Green, Ph.D.

Dart R.C. et al. NEJM 2015;372(3):241-248

For every complex problem there is a simple solution...

...and it is usually wrong.

H.L. Mencken

## Management of Opioid Risk Is a “Package Deal”

- Multimodal approaches
- Screening & risk stratification
  - Rx agreements
- Use of online PMP data
- Adherence monitoring
  - Urine drug screening ( ?oral screening)
  - Pill/patch counts
- Education re safe drug storage & no sharing of meds
- Abuse-deterrent formulations



PMP=Prescription Monitoring Programs

Adapted from Passik, 2008

## 4. Document Effectively

Demonstrate Positive Outcomes

## Ralph– Follow-Up

- Physio for flexibility and core work
- Seen by the psychologist who used ACT to help him develop coping strategies
- TrPt injections weekly x 6
- Tried TCAs then Duloxetine – could not tolerate S/E
- Tramadol → nausea and H/As ; Acetaminophen + Codeine → too constipating
- Started Bup TD at 5ug/hr titrated weekly to 20ug/hr with adequate relief and mild constipation – managed diet
- WSIB agreed to fund a work-hardening program with a goal of gradual return to work
- Eventually agreed to reduce / taper his opioid



## BPI Ralph: Follow-up Visit

|  |  |  |
|--|--|--|
| <p><b>Now</b><br/>6/10</p> <p>2/10</p> <p>4/10</p> <p>3/10</p> <p>60%</p> <p>22/70</p> | <p>Please rate your pain by circling the one number that best describes your pain at its <b>WORST</b> in the past 24 hours.</p> <p>No. pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine</p> <p>Please rate your pain by circling the one number that best describes your pain at its <b>LEAST</b> in the past 24 hours.</p> <p>No. pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine</p> <p>Please rate your pain by circling the one number that best describes your pain on the <b>AVERAGE</b>.</p> <p>No. pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine</p> <p>Please rate your pain by circling the one number that tells how much pain you have <b>RIGHT NOW</b>.</p> <p>No. pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine</p> <p>In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much <b>RELIEF</b> you have received.</p> <p>No relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Completely relieved</p> <p>Circle the one number that describes how, during the past 24 hours, pain has interfered with you:</p> <p><b>A. General Activity:</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><b>B. Mood:</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><b>C. Walking Ability:</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><b>D. Normal Work (includes both work outside the home and housework):</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><b>E. Relations with other people:</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><b>F. Sleep:</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><b>G. Enjoyment of Life:</b><br/>Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interfered</p> <p><small>WPI permission: Pain Research Group, MD Anderson Cancer Center, 1997</small></p> | <p><b>Initially</b><br/>8/10</p> <p>6/10</p> <p>7/10</p> <p>7/10</p> <p>10%</p> <p>52/70</p> |
|--|--|--|

## Essential Follow-up Documentation The "6A s"

1. Analgesia (pain relief) ✓
2. Activities (physical and psychosocial functioning) ✓
3. Adverse Effects (and your advice) ✓
4. Ambiguous Drug Taking Behaviours (and your response) ✓
5. Accurate medication record ✓
6. Affect ✓

Jovey R, et al. Managing Pain, 2002 p. 121  
Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: A rational approach to the treatment of chronic pain. Pain Medicine 2005;6:107-112.

## Pain Management Goals

- Decrease pain
- Improve function
  - Physical
  - Psychological
  - Social
- Minimize risk
  - Patient
  - Physician
  - Society

drjovey@bell.net