Safe and Effective Opioid Prescribing for Chronic Pain

Case Study

October 23, 2010
DR. DANIEL ALFORD:: I’m going to present a case and because we’re running short on time, and I want to make sure there’s adequate time for the panel that occurs after the case, I’m going to ask the questions that are pertaining to this case to our expert panel and have them kind of play around with it a little bit so you can kind of hear how they would think through this case.
It’s a 45-year-old man who came to your office to establish primary care. He had a right ankle fracture after falling off a ladder one year ago.

He had several surgeries to restore relatively normal function. His orthopedist stated that he had well healed ankle with indwelling hardware and almost normal range of motion. The orthopedist had been prescribing oxycodone, 5 mg, 1 tablet every 6 hours, prn for pain, giving him 120 per month, and then told him that from now on your PCP needs to take over the pain management, which I actually think is appropriate, but it probably should have been done earlier, but that’s okay.

On this visit, the patient reports pain 5 to 6 on most days but up to 10 on bad days; pain relief with oxycodone, 5 mg, 3 to 6 times per day. The oxycodone is always needed at bedtime to help with sleep because that’s when the pain seems to be worse.
Case continued

- Drank alcohol “socially” and smokes 1 pack per day
- Smoked marijuana in his 20's, but denied any current illicit drug use
- Unemployed electrician and lives with his wife, no children
- Exam was normal except for multiple well-healed scars on R ankle and small areas of numbness and hyperalgesia on R forefoot

He reported drinking alcohol socially, smokes one pack per day, smoked marijuana in his 20’s, but denied any current illicit drug use, unemployed electrician, lives with his wife and no children. His exam is normal except for multiple well-healed scars on the right ankle and a small area of numbness and hyperalgesia, has increased sensitivity over the right forefoot.
Case Discussion Questions

1. Is this a good candidate for long-term opioid analgesics? Why or why not?
2. What additional information do you need?
3. If you decide to prescribe opioids at this visit will you change his regimen? If so, what changes will you make and why?
4. What will be your/his treatment goals?
5. What else will your pain/opioid management plan include?
6. What will you document at the initial visit?

The questions to our expert panel, is this a good candidate for long-term opiate analgesics? Why, why not? What additional information do you need?

DR. JEFFREY BAXTER: Do you want to ask specific people or do you want to....

DR. ALFORD: You can chime in. Go ahead, start.

DR. BAXTER: I'll jump in just because this reflects one of the questions that I got in the previous session and wasn’t able to respond to. What do you do when you are faced with people coming in requesting pain medications in a regimen that was started by someone else? The first thing I would say is you are never under the obligation of continuing a plan started by another physician. What I always recommend is starting over. You are all now that you’ve been here and probably before are well aware of what the treatment guidelines recommend in terms of assessment and screening and monitoring. You should start from scratch.

In terms of whether or not I would think this patient is a good candidate for long-term treatment, I don’t know. We’ve done some initial risk assessment. I think that just from screening the study, I ask the question, is there a potential that the benefits would outweigh the risks of continuing medications for a short-term treatment trial? I would probably be inclined to continue this patient as long as I’ve screened him appropriately, checked the prescription drug monitoring program, set up a monitoring plan, had him sign an agreement, and I had some really clear goals. Really clear goals.

What are we going to accomplish by continuing these medications? Is it that you are more functional at work, with your family? What do you want to be able to do by being on these meds? Then I would track that. That’s how I would feel confident stepping into this.

DR. ALFORD: Jane, do you want to add something?

DR. JANE LIEBSCHUTZ: No.
DR. ALFORD: If you decide to prescribe opioids at this visit, will you change his regimen? If so, what changes will you make and why and what will be your or his treatment goals? Jane?

DR. LIEBSCHUTZ: In terms of the regimen, I think I need to find out more information from the patient; how he takes the medication, what’s the pain like, really get more clinical information to figure out—it could be that when he’s more active, he’s in more pain at night and he takes it. It may not be that it’s chronic, the same all day long and it’s based on specific activities, in which case short-acting pain medications may make more sense. If it’s sort of chronic, all day long, unremitting, same kind of thing, then maybe a long-acting pain medication would make more sense.

In terms of the treatment goals, I think what Jeff said would be, what are the functional and pain benefits? What’s realistic to get, and then figure out some smart goals that we talked about; specific, measurable, actionable, realistic, and time sensitive goals that he and I can do. I would have him come back pretty quickly within maybe four weeks to assess, or even sooner if there’s some high risk things that come up on other testing. My treatment goals would be to make him more functional and not addicted or not diverting.

DR. ALFORD: Jeff, do you have anything else to add? I guess I’m reminded of one of the questions that came up and that is that we seem to be building a case for not doing this. That is, we’re telling you to create something that might not be doable in your practice, but I would argue that we do a lot of complicated stuff in primary care; in fact, taking someone from an oral hypoglycemic, from an oral agent to insulin, is quite complicated and we find a way to do it whether we use nursing assistants. We use somebody else to help with that transition, so I think it’s just something that we’re not used to doing and it’s something that we need to think about doing.

Again, I think some of the stuff that we’re talking about in terms of monitoring; you don’t need to do it all. I think there is a level of monitoring that you should do, kind of a minimal level around urines and pill counts, but I think we already talked about these random callbacks which might be hard or observed urines. We don’t generally do observed urines in our primary care practice. I’m just saying there are different levels and I think you have to see what you can do, but I think push yourself a little bit in terms of, don’t doubt your ability to implement some of this stuff.

DR. LIEBSCHUTZ: I think the other thing and there maybe some orthopedic surgeons in the audience, and I think most of the people in the audience are probably family medicine, internal medicine, or some sort of chronic specialty that you would be doing this, we have a very different way of interacting and thinking with patients than a surgeon might, not that there’s bad or good, but they’re focused on procedures and more short term things usually and we’re focused more on a different level.

I think engaging the patients and also seeing them back fairly quickly and showing them, as John said, that you’re not being arbitrary, but that you are kind of doing this in a systematic, thoughtful way, is really going to build a relationship with the patient so that whatever comes down the pike with this patient, you’ve got that established base so that if there are issues that come up, you’ve got that to fall back on.
DR. ALFORD: What else would your pain or opiate management plan include, and what will you document on the initial visit?

DR. JOHN RENNER: I’ll respond, at least to part of that Dan. First of all, I would make sure that part of that initial evaluation that Jeff described included a urine toxic screen just for other drugs, just to sort of verify that the history I’ve gotten is at least documented, correct or not. I’m just curious about why did this guy get discharged from the orthopedist? Is that just routine? Is there something about him and how he interacted with his prior doctor? Was it the doctor’s discomfort or is there something about the patient that we’re missing here? I think I probably would want to look for a more specific psychiatric eval if things have not gone real smoothly just to make sure there isn’t something that has been missed.

DR. ALFORD: And the social alcohol use, social drinking? Is that okay?

DR. RENNER: Well, he says social drinking. What does that mean? As Jeff says, how social is that? I think you need to really go beyond just taking the patient’s word for it. I think that earlier today we saw the screening test for problem alcohol drinking and this guy drinking more than five drinks in one day, some time in the last 12 months, that is a Red Flag for, at least, further evaluation and if not, an ongoing problem. I think I would just want more specific evaluation for that.

DR. ALFORD: One of the questions that I got that I don’t think we addressed was how do you know the patient is not lying to you when you ask him about substance use and alcohol and things like that?

DR. RENNER: You check his liver.

DR. LIEBSCHUTZ: You don’t. You just don’t. You don’t know.

DR. ALFORD: Right, you don’t, but that’s why I think it’s worth using validated questions. I think oftentimes we ask people these questions in a way that it’s easy to say no. Do you ever use cocaine or heroin, something like that? It’s easy to say no, but if you ask it in a more normative way, how often do you use your prescription, more than prescribed, if the person says once, that would be a positive as opposed to never. I think using the questions that Jeff showed, on those two single item questions, those have been validated yet they’ve been validated in small sample sizes and single populations, but it’s better than just picking your own questions. If you can memorize those questions, you’ll have a better chance of getting a truthful answer.

DR. LIEBSCHUTZ: The other thing, again, so somebody’s already on opiates. We heard about the SOAP, which are the five questions about when you’re thinking of starting somebody, there’s something called the COMM (C-O-M-M). You can write down if you want. You can Google it. The current opioid misuse measure, pain.edu, is a really good website by Flexion and they have that on there. That’s a much longer, 17 item questionnaire, but again, if patients are on opioids, it’s been shown to be helpful to distinguish patients who are higher risk for misuse than other patients. It has a lot of interesting questions that don’t sort of get right at the answer. They kind of go around it. It’s very useful.

DR. BAXTER: I just wanted to say that one of the benefits of having primary care, this kind of treatment being the purview of primary care, is that we are the experts in chronic illness management and we are
also used to not learning things on the first visit. I think it’s important to set the standard that you have
screened and have asked the questions, but it also gives you a framework to continue asking those
questions. I’m sure we’ve all had the experience that what we didn’t learn in the first visit, we often
learn down the line out of the longitudinal relationship that we have established with patients.

DR. ALFORD: There was a question from the audience about why is he unemployed? He’s unemployed
because of his pain but I think that’s an important point. He’s a young guy. He’s unemployed. Is it a
realistic expectation that he would be able to start working again? I think that’s a useful conversation to
have with patients. Oftentimes I’ll ask them, would you like to work again? Oftentimes they’ll say, yes,
but; and the but is, well, my pain hurts too much. I say, well, it does hurt right now but maybe we can
manage it so that you could work again. I think Jane mentioned, oftentimes I’ll give the number for
Mass Rehab out so that people can get potentially retrained. I think you want to get people to start
thinking about their life ahead of this initial visit in terms of what they potentially could do.

DR. LIEBSCHUTZ: Especially with men, money is always an issue for anybody who’s unemployed, but I
think he had a wife and some kids.

DR. ALFORD: A wife but no kids; unemployed electrician, lives with his wife.

DR. LIEBSCHUTZ: Nonetheless, that he may have injured himself on the job. He may have PTSD related
to sort of the injury and the opiate use may be for depression. I think it’s really important to build a
relationship and get to know the patient over time so that you can know what led into it and then your
differential diagnosis for helping him can really be more accurate.

DR. ALFORD: We’re going to move on.
He signed a controlled substance agreement stating that he’ll take his medication as prescribed. He’ll provide urines for drug testing and would adhere to pill counts at each visit. He was referred to a psychologist who specialized in chronic pain and also to physical therapy. He reluctantly agreed to go to the psychologist stating “my pain is not in my head and I don’t need to see a shrink.” He refused to go to physical therapy stating “last time I went to PT my ankle got worse and I couldn’t walk for weeks.”

Actually, before we get to the rest of the case, what do you guys think about that, his response to going to a behaviorist, his response to going to physical therapy?

DR. BAXTER: At risk of Dan and Jane thinking still that I come on too strong, I have in my experience found it very difficult to implement these things if they weren’t implemented at the beginning. I think that what I try to do in my conversations with patients is say, if you had cancer, you would not think it’s okay if I suggested that I was just going to treat you with one medication and not have you see an oncologist and a surgeon. These things are so important for total health and total recovery that I do think it’s beneficial to push them right upfront just out of respect for the patient in saying that this is the standard of care.

This is the gold standard. This is what’s going to help you get better. The pain medicine is only one part of a total program. I worry that we are not going to be able to achieve your goals if we don’t embrace the whole gamet of treatment that’s appropriate in this situation.

DR. ALFORD: John, do you want to address referring to a behaviorist?

DR. RENNER: First of all, I would support everything that Jeff said. I think it’s really important to sort of spell the ground rules out in the beginning, but unfortunately in the real world, you’re going to end up in a situation like this where the patient is doing half of what you’ve recommended or not. I think sometimes if you have problems down the road, things get worse or there are issues about his ability to control things or how the treatment plan’s working, that maybe the point where you can reinforce some of these other levels of care. You may have enough leverage at that point to say we’re not going to
continue this unless you do that because this isn’t working. Sometimes it’s hard to enforce that at the very beginning for treatment.

DR. LIEBSCHUTZ: I would also say, and John can pipe in, is that a lot of people don’t want to see a psychologist. If you have PTSD, one of the hallmark signs of PTSD is avoidance, so sending somebody to a psychologist to unearth painful issues maybe really difficult. Working with the patient before you send them there about the goals of the treatment is really important. I’m not saying this is in your head. I’m not saying you’re crazy, but I do think that look at this, you’re unemployed for a year. You’re financially in difficult straits. You’re relying on a very strong medication to kind of make it through the day. I think that these are important factors and the psychologist sometimes can help you manage how to work in your life and how to deal with the changes that you’ve dealt with. Really focusing on what the goal is of the therapy may be a useful way to move forward.

DR. RENNER: I would just add that you need to really locate psychiatrists and psychologists in your community who have some expertise working with these types of patients. Just like with addictions in the beginning, you want a therapist who’s going to sort of build coping skills and not sort of dig into past trauma. It’s sort of timing when you get into this material is a really important skill, so you need someone who knows how to do that, not just anyone who happens to be available.

DR. ALFORD: We’re lucky that we have a behaviorist who’s interested in managing—we’re doing CBT with patients with chronic pain, but I learned very quickly that I wasn’t doing a very good job of making those referrals because I had a patient who came back to me and said, you know, I’m not going back to that guy because he didn’t even examine me. I said, believe me, if he examined you, that would be a problem. I think I think of it along the lines of when I’m referring one of my paranoid patients to a psychiatrist. I’m not saying I’m sending you because you’re paranoid. I’m saying I’m sending you because you seem incredibly stressed out and anxious about these people who are waiting outside your door, the people who are hiding in your closet.

These things are making you incredibly uptight and not sleep, so I want you to see someone to help with the anxiety this is causing you. I’m not discounting this person’s reality because they won’t go. I do tell them, listen, I’m not saying your pain isn’t real. I’m just saying that we’re trying a proven therapy, and that is CBT for the treatment of chronic pain. I think it’s useful to send people to that; the same thing with the physical therapist. The way I deal with that is, not all physical therapists are the same. Your pain probably isn’t the same as the last time you went. Things are changing and so it’s worth going to a different physical therapist and it’s worth trying it again if it didn’t work before.

This is when I start to think, am I getting the sense that the patient is less interested in pain relief and more interested in getting more drug? If I’m starting to recommend lots of different stuff and explaining myself as to why I’m recommending these different things and the patient still focuses on no, no, no, I just want more drug; to me that’s a problem. That’s a problem that they’ve really started to lose the focus.
Over the next four months, due to inadequately controlled pain, you increased his oxycodone or I did over multiple visits to an average of six, 10 mg tablets per day. He was switched to Sustained Release morphine, 30 mg b.i.d. with a standing dose of acetaminophen, 500 mg t.i.d. giving that synergy. He stated the morphine kept his pain to a “5-6”, had about a 2-3 point improvement on all 3 PEG (pain, enjoyment in life, general activity) questions but remained unemployed. He remains unemployed however, was adherent with leaving urine drug tests and there was only morphine in it and that’s exactly what I would have expected, but he forgot to bring his pills in half the time, but when he did, the count was correct. 

The way I deal with this now is I used to say, okay, you forgot, that can happen to anybody, don’t forget next time. Then the patient would forget the next time, and they forget the next time. Now I say, okay, you forgot, what’s convenient for you in the next week to come in and see my nurse with your pills. Please bring them in just for a quick pill count and that will be the end of it. They don’t usually forget after that. If they don’t show up even though they said Tuesday morning is convenient for me and they don’t show up with the pills, that means something to me. That’s a problem. Not that they’re selling them or diverting them, maybe they’re just taking more than prescribed and they haven’t talked to me about it, but I’m going to bring that up to them that I’m very concerned about what’s going on.

Patient denied opiate side effects including constipation, sedation, or decreased sexual function;
Case continued

- He surprised you by running out of his morphine early and demanded an early refill and increased morphine dose.
- “I needed to use more pills because my pain is “15” all the time.” “The morphine doesn’t last 12 hours so I have been taking it more often.” “My body has gotten used to the morphine and I need a higher dose.”
- Also took hydrocodone/acetaminophen that his wife had left over from prior gallbladder surgery.
- When he ran out early, he got very sick which resolved after taking wife’s hydrocodone.
- His exam was unchanged.
- He only went to the psychologist once and did not follow up because it was “a waste of time” and did not go to PT.
- He asked about acupuncture because he heard that it helps pain.

However, he surprised you by running out of his morphine early and demanded an early refill and increased morphine dose. “I needed to use more pills because my pain is 15 all the time. The morphine doesn’t last 12 hours so I’ve been taking it more often. My body has gotten used to the morphine and I need a higher dose.” He also took some hydrocodone/acetaminophen his wife had left over from gallbladder surgery. When he ran out early, he got very sick which resolved after taking his wife’s hydrocodone.

His exam was unchanged. He only went to the psychologist once and did not follow up because it was a waste of his time, and he didn’t go to physical therapy. He asked about acupuncture because he had heard that that helps pain, so he is thinking about other ways of managing his pain.
The questions are: Is this patient benefiting from his current therapy; why, why not?

DR. BAXTER: Well, he thinks he is, but I think the more important question is whether or not the risks are starting to outweigh the potential benefits. So you want to just put up your next question? I'll just chime in first again very briefly. I think this is a perfect opportunity to enhance his care, to review the treatment agreement that he signed; specifically, the parts about managing the medications safely, and how to manage refills, to challenge him in a positive way to say I know that you can do this and if we're going to continue with this and know that it's safe, I need you to be able to adhere to this set of guidelines. Use it as an opportunity to reintroduce the other therapies that should help in this situation, and talk about the what ifs. What if we can't do this safely? What will come next?

I would say that, for me, I wouldn't stop. This isn't an emergency termination situation. I would not feel like I have to stop his treatment today. I would see him more frequently and put other systems in place to make sure that he can bring this back under control. I've had quite a few examples of patients who have gotten out of control but been able to successfully bring it back under control with guidance and increased support - -.

DR. ALFORD: Again, is this drug seeking and addiction or is this pain relief seeking. You'd want to know what else is going on in his life. I've had patients where you told me to do more activity and I'm doing more activity and my pain got worse. Okay, you're right, but the one thing that I don't tolerate anymore and I think this is an important point. I don't tolerate unsanctioned dose escalation anymore. I really don't. I don't tolerate it with other medications that I prescribe unless it's a clear plan of action; that is, you can take sliding scale insulin based on the following formula, but I don't expect people are just going to start titrating their blood pressure medicines and whatever else I'm prescribing, so I don't want them titrating.

This is a foreign concept for a lot of patients who are getting treated by other prescribers who were prescribing prn. They were supposed to take 1 or 2 tablets depending on their need, but when you
starting to get into chronic pain management, where you’re on long-acting opioids and there’s a risk for overdose, especially as you start to get to higher dosages and risk for getting into car accidents and so forth, when you’re changing doses, I don’t tolerate patients escalating their dose anymore. I’ll allow it once and then I’ll reeducate them, but after that, to me that’s a problem and it’s time that the risk has gotten too out of hand.

So this guy I need to tell him you cannot do this anymore and if you do it again, then the risk is too great and either you’ve got an addiction or you just are unable to maintain control of this medication for whatever reason, but we can’t do this. I think you can do that.

DR. LIEBSCHUTZ: I think that one other thing to think about is the cause of the pain. I have patients with ongoing connective tissue diseases, rheumatoid arthritis, etc., in which the actual underlying disease waxes and wanes, but this guy had his injury a year and a half ago and it shouldn’t theoretically be getting worse unless his activity changes or something like that. You’ll find out when you talk to him. The Red Flags are even higher in this case; that there’s either underlying depression for which he’s self treating with more medication or whether there is an actual addiction that’s been triggered or retriggered or whatever by the medications.

DR. ALFORD: Someone had posted on one of these cards; what about trying low dose Gabapentin based even on the trial that I told you about that you can get away with lower doses of the morphine and better pain control. Is there some neuropathic component to this pain, and there probably is. I think that’s a good suggestion. Again, he had been on morphine and acetaminophen but you certainly could add an NSAID. You certainly could add some adjuvant therapies. If he’s having terrible pain at night, which is what he described initially, you could use a tricyclic to help him with sleep but also help his pain at night, so there are lots of things that were not done pharmacologically that could have been done in this case.

DR. BAXTER: What I don’t want to see happen in this situation is: (A) Give him more medication. Oh, you took more so let me give you more. No, I think the challenge is to see if you can control your behavior at the dose that you agreed on; and (B) Please don’t give him a month’s worth of this medication; a few days to see if he can pull it together. A month’s worth is more than enough to kill you. A few days still has a safety margin, so when I talk about a trial of enhancing his therapy, I’m talking about a short trial, a week, two weeks, something very controlled to see if he can pull it together or not. I’ve had patients do it, but I’ve had others not do it.

MALE VOICE AUDIENCE: New dose or same dose?

DR. BAXTER: I think unless you have some new pain generator; the question was new dose or same dose. I don’t think in this situation you increase the dose. I think you go back to the dose that you agreed on and make sure that they can control their behavior at that dose.

DR. ALFORD: We’ve already been talking about should you continue opioids, why, why not; if not, how would you manage him? What will you document in your visit note? Is there anything else you would add?
DR. LIEBSCHUTZ: I would document exactly the conversation, and I would document specifically what you told him and that you’re sending him for urine tox screen.

MALE VOICE AUDIENCE: Where would you send that tox screen?

DR. LIEBSCHUTZ: We have a certain panel in our hospital, so I usually send—we’ve like a urine tox that includes cocaine, opiates, benzos, barbiturates, and then I would also send specific for some of the synthetics that are around.

DR. ALFORD: The key is to know what you’re getting when you do send urine and then have the capacity, or know if you have the capacity to ask for other things, like oxycodone, like some of the semi-synthetics as well. I think the documentation piece is important just like it is for anything else we do. There have been studies where you can get docs. You can get providers to ask about pain. You can get them to send urine drug testing. What happens, though, oftentimes is there is nothing that follows. There’s no assessment of what it all means when the person reports something or when the urine comes back in a way that needs to be interpreted.

There isn’t enough documentation about what it means and what you’re going to do about it. So if you start to monitor, that’s great and we think you should, and I think that should be standard of care, but make sure you respond to it. It might be that this is aberrant behavior. I’ve talked to the patient. I’m not convinced that they’ve developed an addiction yet, but I’m thinking its unrelieved pain, so I’m going to do the following or whatever, but give some assessment as to what you think is going on and then have a plan.

DR. BAXTER: Can I say one last thing? What I think people also might be worried about is what if I do another 3-7 day trial and this patient’s out of control. I’m just going to put in a little plug for my own programs. Here in Central Massachusetts we do not have a wait for entrance into opioid treatment. Please communicate a lot and send records and talk to us, but we do walk-in admissions 2 days a week. Patients walk in and they start treatment that same day as long as there is no direct contraindication to it. So if your patients need addiction treatment, please call us.

DR. LIEBSCHUTZ: I think with the advent of Buprenorphine over the last number of years, the lines for addiction treatment for methadone has really, really gone down and they’re generally very short waits, if any, not just in Central Mass but I think in the Boston area. I don’t know what’s in Western Mass but I do think you should—it’s tougher in Western Mass.

DR. BAXTER: Yeah, very tough.

DR. ALFORD: We got a comment from the crowd about are the discussions really focused on giving or not giving opioids—I wouldn’t use the word narcotics, but opioids, so we really didn’t get into what’s the cause of this pain. I think that’s an excellent point. Last time when we presented this case in June, we had an orthopedist in the crowd who stood up and commented on what he thought was going on. He was surprised that this person had this outcome based on the history. I think this is when you do need to make referrals to a specialist and get an opinion about, could there be something else going on?
Could this be regional sympathetic, regional pain syndrome? Is there a role for an interventionist? Is there a role for a nerve block or some other kind of intervention that could help this patient?

We are focused on opioids here because that’s the focus of this entire half day, but you’re right, there are other pain therapies. There are other pain specialists. Along with thinking about whether or not opioids should be continued or not or increased or not, you should be thinking about, do I have the right diagnosis? Has something changed? Can a specialist out there help me with either diagnosis or doing some other therapy? The opioid piece, I think, we own. Thanks.

[Applause]