

Strategies for pain management and complex opioid use in the elderly

**Dr. Matthew Sheppard, FRCPC
(Anesthesia and Pain Medicine)
Nov. 1st, 2019**

Disclosures

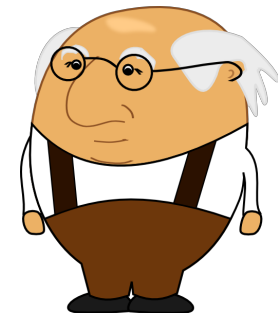
- I have no actual or potential conflict of interest in relation to this presentation
- Previous speaker honorarium : AbbVie Pharmaceuticals, unrestricted educational grant
- No other consultant work/major shareholder/research support
- I will be discussing 'off-label' use of Buprenorphine/Naloxone (Suboxone) and Fluticasone (skin)

Outline

- Strategies for pain management and safely prescribing medications for pain
- Diagnosis and treatment options of complex opioid use
- Review resources and services

Mr. Sweetz

- 77 y/o male in your practice presenting with bilateral foot pain associated with numbness, 'burning' 'pins and needles' worse at night
- Medical Hx : HTN, Glaucoma, DMII on insulin, BPH
- Meds: Metformin, Insulin, Candesartan, Tamsulosin
- No allergies
- No previous surgeries
- Sleeping very poorly at night



Pain Management Strategies

- 5 P's
 - Pathology – (IBD? RA? PMR? DMII?)
 - Pharmacology (Specific illness? Class of pain?)
 - Physical Modalities (Physio, Massage, TENS, etc.)
 - Psychology (Psychiatry/CBT/ACT/Mindfulness/Patient Education)
 - Procedures (Epidural Steroids, Nerve Blocks, Sympathetic blocks, Surgery, SCS)

Pain Management Strategies

- 5 P's
 - **Pathology** – (IBD? RA? PMR? DMII?)
 - Pharmacology (Specific illness? Class of pain?)
 - Physical Modalities (Physio, Massage, TENS, etc.)
 - Psychology (Psychiatry/CBT/ACT/Mindfulness/Patient Education)
 - Procedures (Epidural Steroids, Nerve Blocks, Sympathetic blocks, Surgery, SCS)



Douleur Neuropathique en 4 (DN4)



Does the pain have the following characteristics?

- | | |
|---|--------|
| 1. Burning (Branderig gevoel) | Yes/No |
| 2. Painful cold (Pijnlijk koudegevoel) | Yes/No |
| 3. Electric shocks (Electrische schokken) | Yes/No |

Is the pain associated with one or more of the following symptoms in the same area?

- | | |
|-------------------------------|--------|
| 4. Tingling (Tintelingen) | Yes/No |
| 5. Pins and needles (Prikken) | Yes/No |
| 6. Numbness (Doof gevoel) | Yes/No |
| 7. Itching (Jeuk) | Yes/No |



PINT



DN4



EXAMINATION OF THE PATIENT

Question 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

	Yes	No
8 - Hypoesthesia to touch	<input type="checkbox"/>	<input type="checkbox"/>
9 - Hypoesthesia to prick	<input type="checkbox"/>	<input type="checkbox"/>

Question 4: In the painful area, can the pain be caused or increased by:

	Yes	No
10 - Brushing	<input type="checkbox"/>	<input type="checkbox"/>



Mr. Sweetz

- Mr. Sweetz DN4 score is 6/10, your physical exam reveals distal symmetric polyneuropathy in his feet
- Medical Hx : HTN, Glaucoma, DMII on insulin, BPH
- His goals would be to have better sleep, and to continue his daily walks with his partner Mrs. Sweetz
- You wonder how you can help him meet his goals. What medication would be best for him?



Pain Management Strategies

- 5 P's
 - ~~Pathology — (IBD? RA? PMR? DMII?)~~
 - **Pharmacology (Specific illness? Class of pain?)**
 - Physical Modalities (Physio, Massage, TENS, etc.)
 - Psychology (Psychiatry/CBT/ACT/Mindfulness/Patient Education)
 - ~~Procedures (Epidural Steroids, Nerve Blocks, Sympathetic blocks, Surgery, SCS)~~

What is the perfect medication?

- Effective
- Easy to order/titrate
- No/few drug interactions
- Inexpensive
- No dependence
- No side effects



Challenges with the elderly

- Multiple Comorbidities
- Polypharmacy
- Increased Sensitivities
- Organ dysfunction
- Risk of Falls

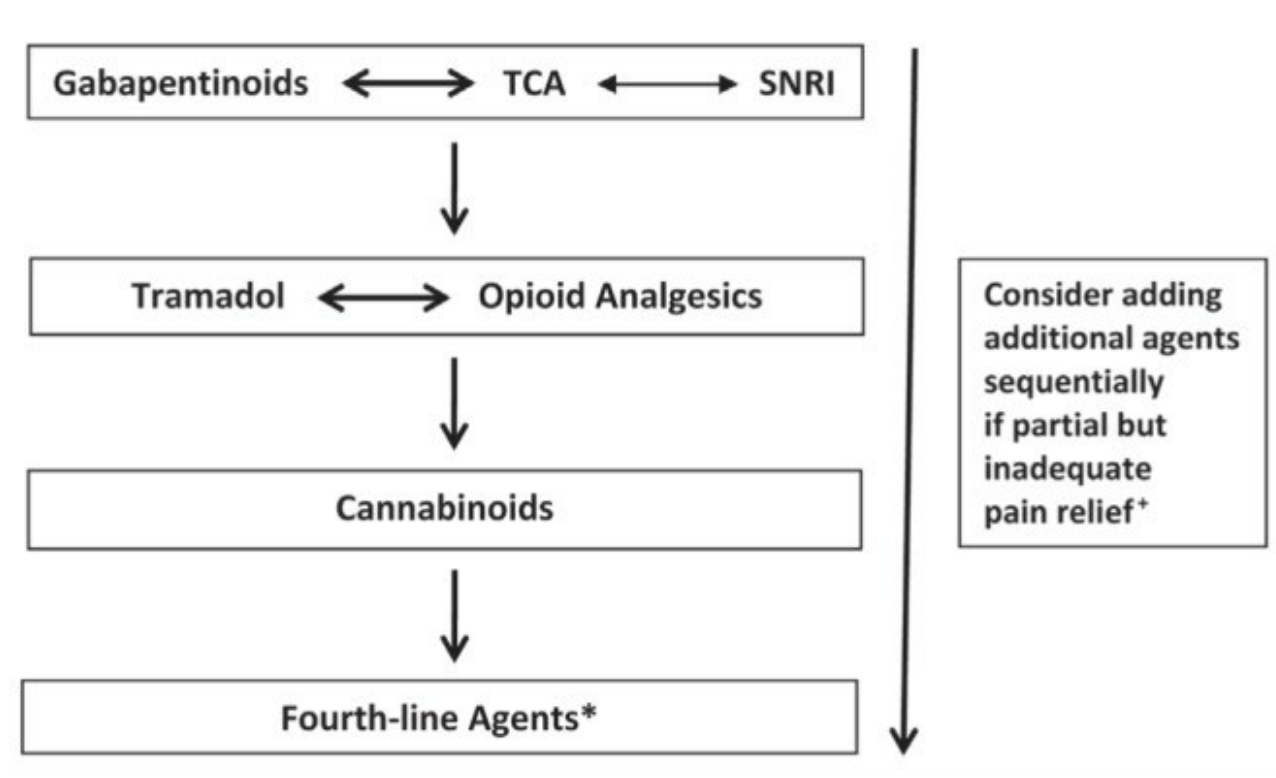


Effective strategies

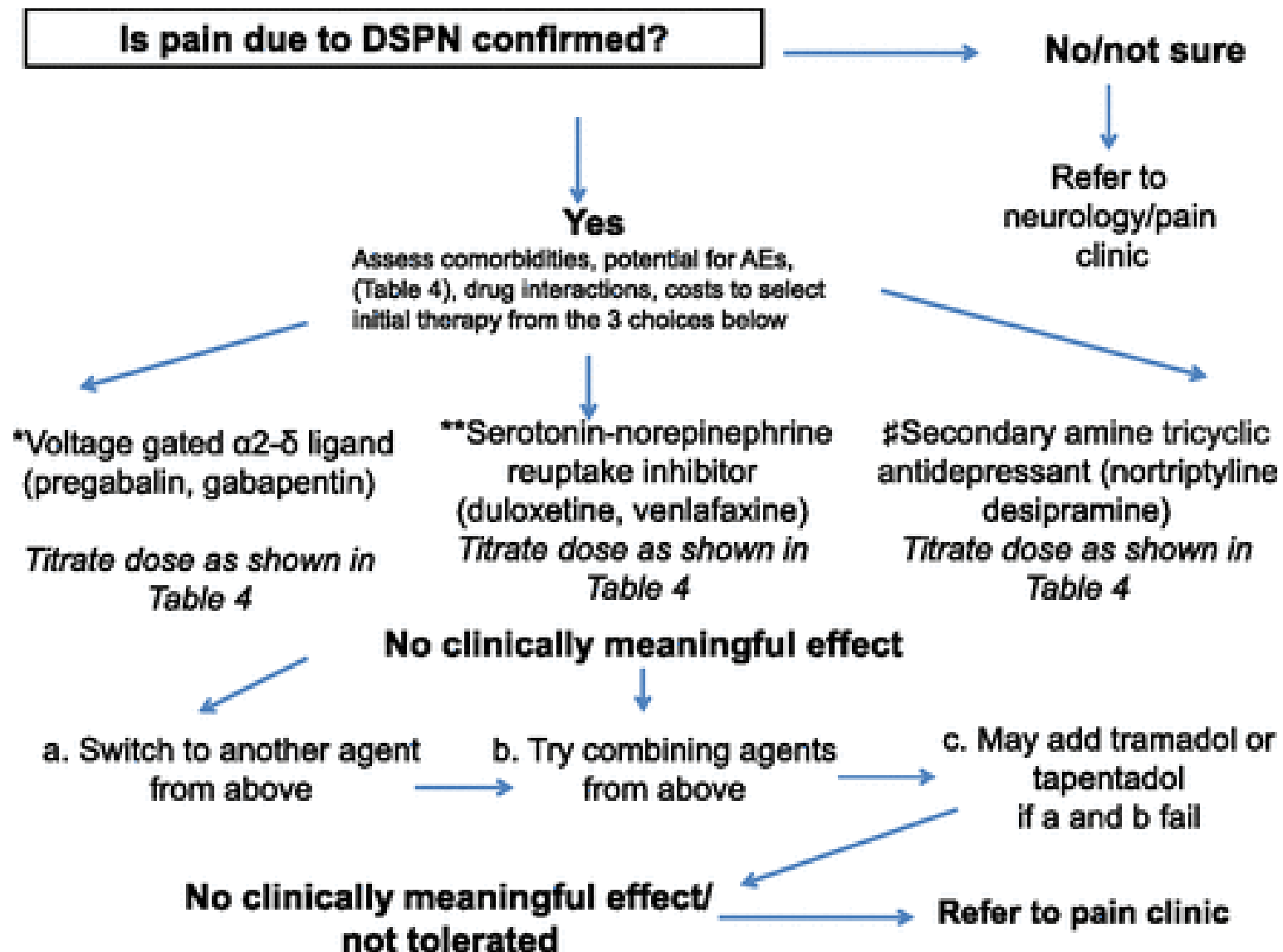
- Careful review of relative/absolute contraindications
- Start low and go slow
- Consider patient adherence/cognition
- Consider side effect profile
- One medication at a time



Canadian Neuropathic Pain Guidelines



**SSRI, Methadone, Topical Lidocaine,
Lamotrigine, Lacosamide, Tapentadol,
Botulinum toxin A**



Mr. Sweetz

- You consider co-morbidities, and decide against a TCA (Glaucoma, BPH) or Duloxetine (can be activating, HTN)
- Pregabalin 25mg PO qhs, with instructions to increase by 25mg q weekly until he reaches 75mg for reassessment. You decide to optimize the nightly dose to meet his goal of better sleep and to maintain alertness during the day and decrease fall risk
- He returns in two months with a partial response and asks about opioids



Physician views

Role



No Role



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

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART A

— Executive Summary and Background —

Published by the
National Opioid Use Guideline Group (NOUGG)
a collaboration of:

- Federation of Medical Regulatory Authorities of Canada
- College of Physicians & Surgeons of British Columbia
- College of Physicians & Surgeons of Saskatchewan
- College of Physicians & Surgeons of Manitoba
- College of Physicians and Surgeons of Ontario
- Collège des médecins du Québec
- College of Physicians and Surgeons of New Brunswick
- College of Physicians and Surgeons of Nova Scotia
- College of Physicians and Surgeons of Prince Edward Island
- Government of Nunavut
- Yukon Medical Council

April 30 2010 Version 4.5

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

CMAJ

REVIEW

Opioids for chronic noncancer pain: a new Canadian practice guideline

Andrea D. Furlan MD PhD, Rhoda Reardon Dip(PBOT), Clarence Weppler BSc Pharm, for the National Opioid Use Guideline Group (NOUGG)

Underestimated chronic noncancer pain and growing misuse of opioids are two challenges presented by opioid therapy. A new Canadian guideline addresses these challenges with recommendations and tools for safe and responsible selection, prescription, titration and monitoring of opioids.

Chronic noncancer pain is a substantial public health problem in many societies,^{1,2} where it has immense negative impact both socially and economically. The most potent analgesics available, opioids have been shown to reduce pain in functional outcomes has been less obvious.³ Their efficacy in functional outcomes has been less obvious.³ Their efficacy in functional outcomes has been less obvious.³

Canadian medical regulators (i.e., colleges of physicians and surgeons) have recognized a growing need for guidance in opioid use for chronic noncancer pain. In November 2007, they formed the National Opioid Use Guideline Group to collaborate in developing the Canadian guideline for safe and effective use of opioids for chronic noncancer pain.⁴ Their aim was to oversee the development and implementation of a guideline to help physicians manage patients with chronic noncancer pain in a safe and effective manner.

The guideline is intended to help physicians make decisions to start trials of opioid therapy for chronic noncancer pain and to guide them in the management of patients on opioid therapy, including the detection of situations. The guideline was not intended to be a training manual for physicians prescribing opioids for chronic noncancer pain that persists for more

Key points

- In patients with chronic noncancer pain, opioids may be effective and should be considered.
- Opioid therapy should begin with setting of realistic goals with the patient, a monitored trial of dosage titration, and follow-up to ensure opioid effectiveness.
- Prescribers and dispensers can minimize potential harms associated with opioid use by assessing risks, educating patients, monitoring use over time, and reducing or stopping opioids when indicated.
- Good communication and collaboration between health care providers and patients, across clinical disciplines, and between primary care and specialty care, is important when treating patients with chronic noncancer pain.

Development

Leadership

Three groups were instrumental in developing the Canadian guideline for safe and effective use of opioids for chronic noncancer pain. These groups were the National Opioid Use Guideline Group, a research group, and a national advisory panel. The role of the National Opioid Use Guideline Group was to oversee the development and implementation of the guideline; the group's members were appointed by medical regulatory bodies. The research group comprised a research librarian, a physician-epidemiologist and four physician-researchers. This group was responsible for literature review,

from the Institute for Work and Health, Toronto Rehabilitation Institute and the Department of Medicine, University of Toronto (Furlan); Quality Management Division, College of Physicians and Surgeons of Ontario (Reardon); Toronto, Ont; and the Physician Working Practices Department, College of Physicians & Surgeons of Alberta (Weppler). Edmonton, Alta.

CMAJ 2010; DOI:10.1503/cmaj.090877

© 2010 Canadian Medical Association or its licensors

2017 Canadian Opioid Guideline

- Consider once non-opioid alternatives have been exhausted, if pain not optimized a trial of opioids is reasonable
- Opioids for chronic non-cancer pain are to be avoided in patients with current or past substance use d/o's and active psych d/o's
- Suggest max dose between 50-90 MDE, likely less in the elderly

Opioid Risk Tool Clinician Form

(includes point values to determine scoring total)

Mark each box that applies:

1. Family History of Substance Abuse:

Alcohol

☐ 1☐ 3

Illegal Drugs

☐ 2☐ 3

Prescription Drugs

☐ 4☐ 4

2. Personal History of Substance Abuse:

Alcohol

☐ 3☐ 3

Illegal Drugs

☐ 4☐ 4

Prescription Drugs

☐ 5☐ 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

☐ 2☐ 2

Depression

☐ 1☐ 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

Recommendation #2 (Canadian Opioid Guideline)

- For patients with chronic non-cancer pain, without current or past substance use disorder and without other active psychiatric disorders, who have persistent problematic pain despite optimized non-opioid therapy, a trial of opioids rather than status quo is suggested



What is a trial of opioids/medications

- Opioid Chosen, e.g. Hydromorphone
- SMART goals
- 3-6 months
- Regular assessments
- Constant monitoring for benefits/harm
- Safety



Brief Pain Inventory (BPI)

Diagram

VAS (Visual Analogue Scale)
pain scores

Treatments, % relief

Interference Score (/70)

General Activity, Mood,
Walking, Work, Relationships,
Sleep, Enjoyment of Life

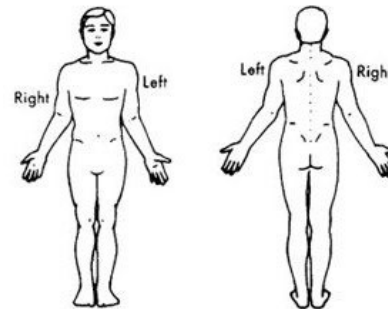
FORM 3.2 Brief Pain Inventory

Date: ____ / ____ / ____ Time: ____

Name: _____
Last First Middle Initial

- 1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

- 2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.



- 3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

- 4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

- 5) Please rate your pain by circling the one number that best describes your pain on the **average**.

0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

- 6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

- 7) What treatments or medications are you receiving for your pain?

- 8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received

0% 10 20 30 40 50 60 70 80 90 100%
No relief Complete relief

- 9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:
A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

Effective Opioid prescribing strategies

- Careful review of risks and side effects (Sleep Apnea, Hormone dysregulation, Opioid induced hyperalgesia, constipation, falls, cognitive changes)
- Start low doses and increased interval
- Frequent assessments and titrate slowly
- Short dispensing intervals
- Avoid long acting in elderly***

Long acting opioids

- Classic teaching to consolidate short acting opioids to decrease risk potential and increase analgesia
- Pederson (2014) performed a systematic review which found no difference in pain relief, improved sleep, amount of rescue analgesics or improved function
- Altered pharmacokinetics decreases drug clearance
- Butrans patch (Buprenorphine) could be considered - easy administration and decreased resp depression, however expensive and skin reactions (Symbicort)
- Can start at 5mcg dose and q2-4 weeks increase by 5 mcg to 20mcg patch max (<50MDE)

What to do when opioids don't work or aberrancy behaviour?

Complex Opioid Use

- Dependence? Addiction? Substance Use d/o? Improper use?
- Options :
 - 1. Weaning/Discontinuation (5-10% weekly reduction)
 - 2. Continued structured opioid therapy
 - 3. Opioid Agonist Therapy (Buprenorphine/Naloxone or Methadone)

Practical Considerations

- Document, document, document
- Opioid Agreements
- Urine Drug Screens
- Close communication with pharmacy
- Methadone can be challenging, few pain prescribers and many patients do not wish to go to Methadone clinics
- Buprenorphine/Naloxone can be a challenging induction, but no specific training for prescription
- Consider expert opinion

CPSO

CPSO OPIOID INVESTIGATIONS

POSTED TO PUBLIC REGISTER

NOT POSTED

36

Mandated Remediation

2

Prescribing Restrictions

22

No Action

8

Mandated Remediation
and a Caution

1

Prescribing Restrictions
and a Caution

6

Advice

3

No Longer in Practice

1

Referral to Discipline

2

Remedial
Self-Study

SUBTOTAL

81

Investigations in progress

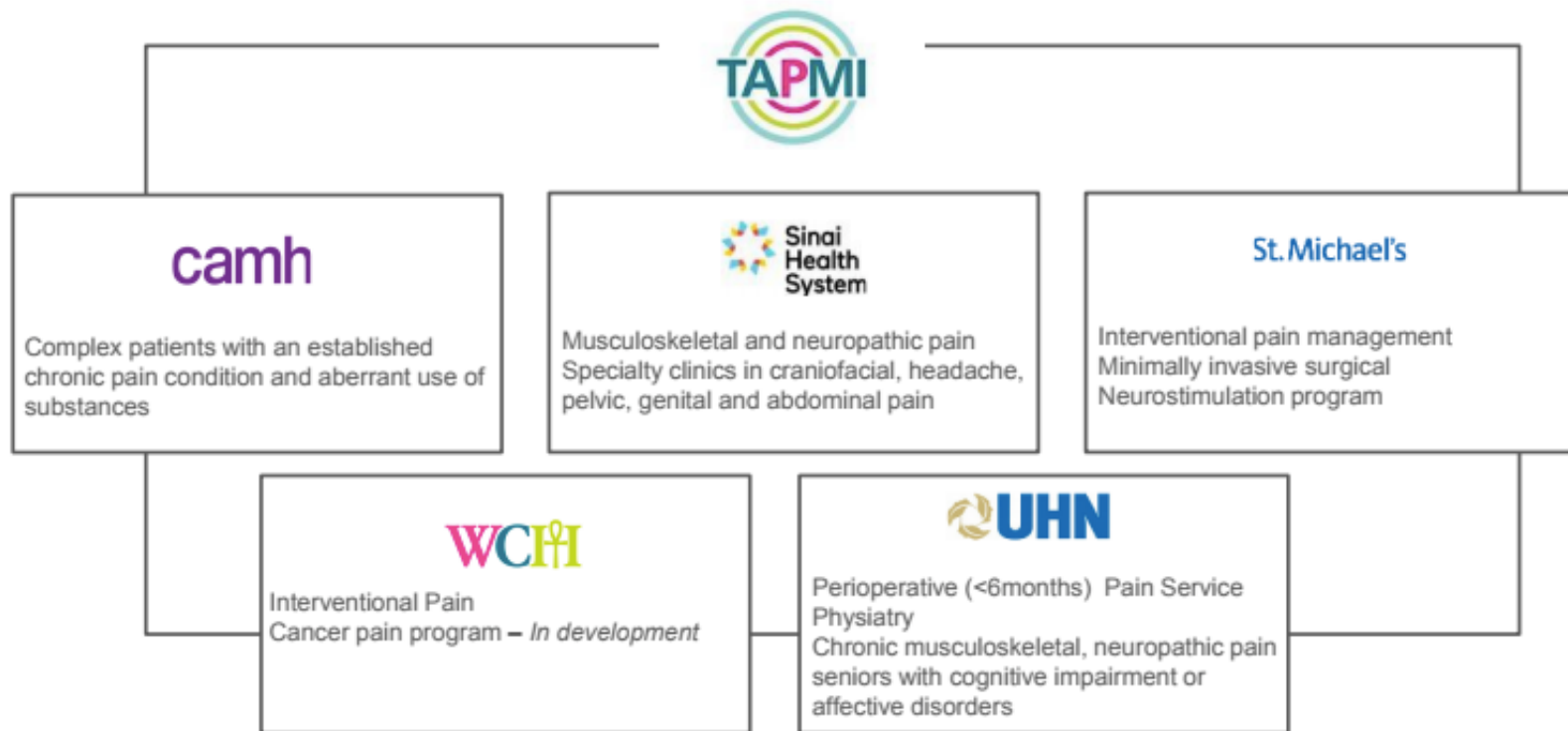
3

TOTAL

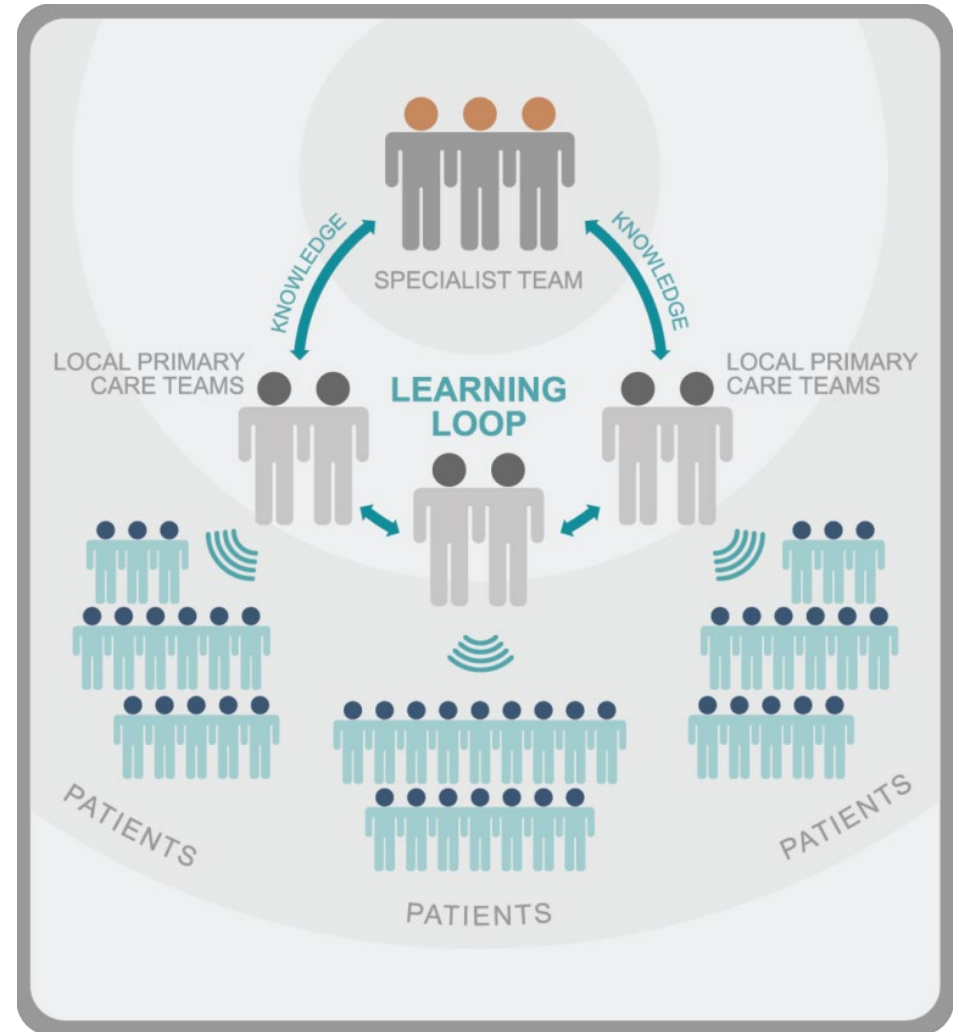
84

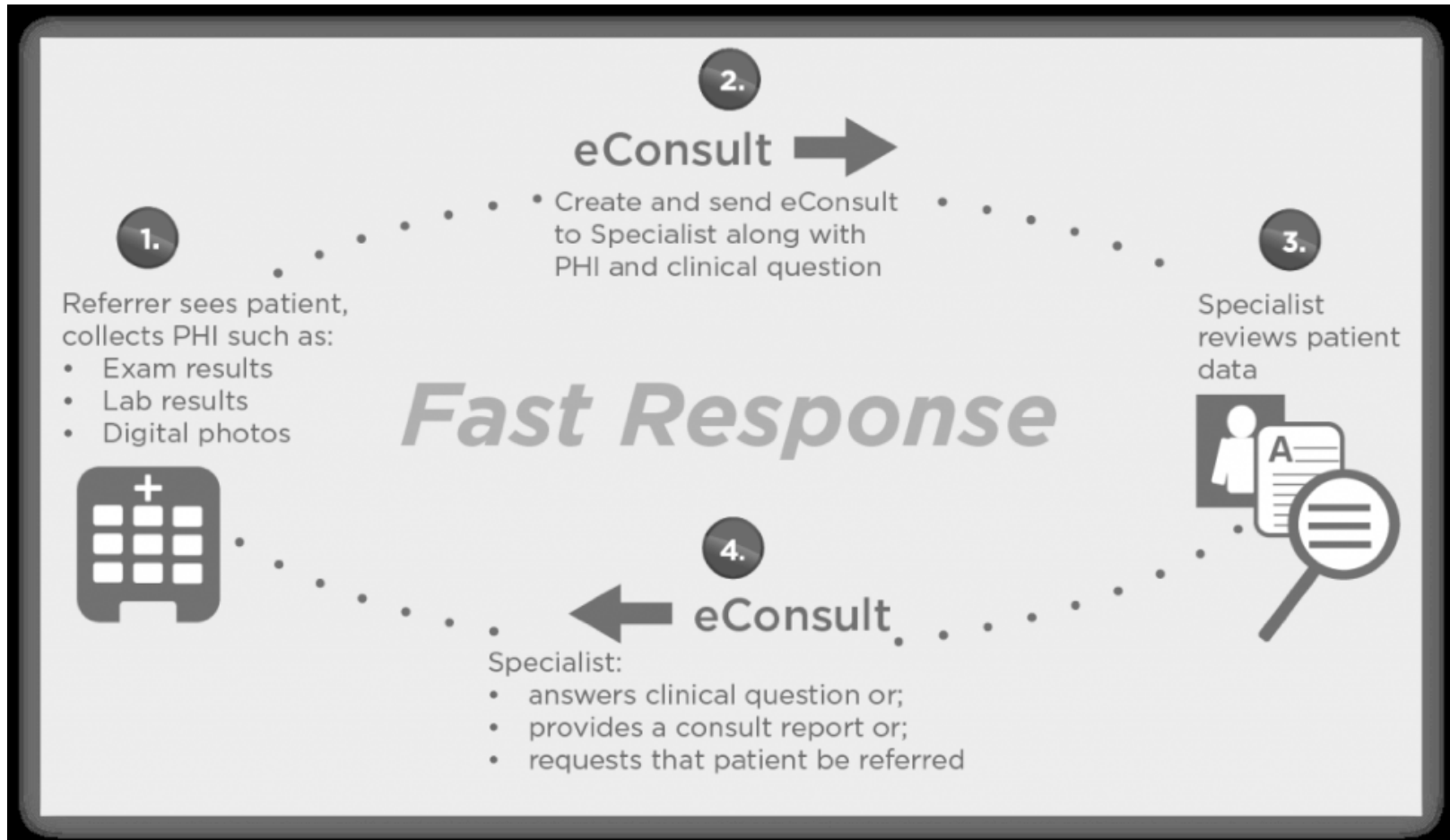
Dialogue, 2018,
Volume 14, Issue 1

TAPMI (tapmipain.ca)



Learning Opportunities





Thanks! Questions?



@Msheppard08

matthew.sheppard@
sinaihealthsystem.ca

ICONS

For other colour options

Choose your image:

1. Right Click the image
2. Select “Size and Position”
3. Click on “Reset” button
4. Click on “Format” tab above, choose the “Crop” icon and re-crop the image to the desired colour

