Opioid Prescribing: Pain Management in a New Era

Frequently Asked Questions:

1) In some states, cannabis available has been observed to decrease opioid overdose deaths by 25%. Does cannabis have a role in decreasing opioid abuse and potential abuse?

*Recent articles in popular press have discussed the potential for cannabis (medical marijuana) as a potential alternative to opioids. There is currently no medical/healthcare literature on this subject. There is also no current standard of care that reflects an evidence-based consensus on this topic.*

*Public/ Lay Articles focused on this topic include:*

*http://time.com/4419003/can-medical-marijuana-help-end-the-opioid-epidemic/*

*https://www.sciencealert.com/93-of-patients-prefer-cannabis-over-opioids-for-managing-their-pain-according-to-new-study*

*https://www.drugrehab.com/2016/09/20/study-finds-medical-marijuana-may-reduce-opioid-use/*

*http://online.liebertpub.com/doi/full/10.1089/can.2017.0012*

*https://mmjcanada.ca/can-marijuana-save-current-opioid-crisis/*

*In the experience of our experts, "chemical coping" is fairly common among patients who are taking opioids and it could be conceivable that cannabis served this role of "chemical coping" (i.e. treating anxiety, not pain) and thus reduced opioid use*

2) What is the percentage of patient who cannot use topical medications for pain management?

*Very small—as there are multiple vehicles to choose from, and multiple meds, can generally find a tolerated combination. Tape allergies are an issue with patches, but that leave open option for creams, gels, etc.*

*With respect to transdermal Fentanyl, there is a very small percentage that cannot use this medication. Cachexia is not a contra-indication for use of transdermal Fentanyl, but we do know from a few small studies, that people with little adipose tissue requiring slightly higher doses of TD Fentanyl.*

*Lidoderm patches are usually well tolerated but over-utilized. They are indicated only for neuropathic pain, yet are often placed over any area of discomfort (arthritic joints, for instance) where they have no proven efficacy (and are very costly).*

## 3) When discharging a patient from your practice, do you taper the medications over 30 days? This could be a challenge since it can take 60-90 days to get an appointment with another pain management clinician. What do you recommend?

- *Some of our experts don't usually discharge for failed urine tests (UDS), but do discontinue the opioid prescribing. Discharge a patient for a failed UDS is not the most professional approach to this patient situation.*
- *Offer non-controlled treatment alternatives: muscle relaxants, NSAID, PT, AEDs.*
- *If the urine is completely negative for the prescribed drugs, the prescribing provider can just stop the medication.*
- *When tapering opioids, the prescribing clinician can more rapidly reduce dosing for the first 75% or so of the dose, but when the doses begin to diminish, this is when the withdrawal symptoms often occur and recommend slowing the taper… so the timing of a taper is somewhat dependent on the starting dose and the tolerance of the taper.*
- *If the patient tests positive for prescribed meds and other non-prescribed drugs, then recommendations for weaning are by 10-20% at a time.*
- *If there are real safety issues you can wean by 20%/day and provide clonidine, antiemetic to cover symptoms*
- *If less concerned re. Overdose risk, then can decrease the dosage by 10% every 3-7 days.*
- *If you think that an addiction issue is present, offer a referral for addiction treatment.*
- *If patient is not in clinic, which is often the case when UDS comes back, the experts recommend sending a certified letter with return receipt with the instructions for weaning, and instructions to call for clonidine, etc.*
- *If there is abusive or threatening behavior, they get discharged on the spot. Provide written directions for med weaning, make sure they have at least a 30 day supply of non-controlled substances*
- *Provide suggestions for alternative physicians, but also weaning instructions for even things like gabapentin in case they don't get in soon enough to cover.*
- *Provider the patient with a release of med info with a sticker on it (if they're in the clinic) so they can request records for the new physician.*

## 4) Is there a better way to pass off a difficult patient when a physician/clinician elects to discontinue care rather than potentially overburdening urgent and emergency medicine providers?

*The most important factor that has emerged is to help with this situation has been the implementation of the Physician monitoring programs. The expert panel recommends documenting concerns about abuse, misuse or diversion clearly in the patient's chart. Of course, HIPAA prohibits our sharing that information without patient consent.*

## 5) What is the process for disposing of unused opiates? Patients often return and ask what to do with them?

*This varies from state to state. See re. Local take back days/ options Virginia has "prescription take back dates". Some of the bigger healthcare and pharmacy chains were working on having disposal containers on site. There have been efforts to establish high security disposal bins in police stations. Doctors and hospices are not allowed to receive unused controlled substances. We do not recommend flushing them, but disposing them in kitty litter or coffee grinds. There are references on line re. How to dispose, including used kitty litter, plaster of Paris, etc. Developing a simple handout to go with the treatment. Would be a good practice.*

## 6) When should providers/clinicians think about testing rapid metabolizers? Is this recommended only when they are high MMED?

*I use genetic testing sparingly. (Medicare will only pay for it once in a lifetime) Most often, it's for people with multiple adverse reactions to multiple meds, or in patients on increasing MMED (can't give you a number, but depends on behavioral pattern and when I start getting uncomfortable) who are not receiving benefit.*

## 7) What clinical pearls are recommended for patients on chronic narcotics who are resistant to change?

*You, as the prescribing clinician, need to assess whether the patient is exhibiting the benefits re: function, then you can choose to wean. There is no obligation to continue an unsuccessful treatment. Think of it as an antihypertensive—not working? Change the therapy. If the patient is resistant, explore the possible reasons (fear? Addiction? Diversion paying the bills?) but your obligation is to provide the best medical care and proceed accordingly. If the patient chooses, they can find another provider. If not weaning b/c of aberrant behavior, then you can wean more slowly, like 10%/week. Many patients will actually stick it out, and come back and be appreciative once they're off the opioids, because they actually feel better. Be brave! Primum non nocera!*

*Firm boundaries: some of these patients respond to this approach. The patients, who don't respond, tend to move on to a different doctor.*

*It is also important to continue to treat their pain, but with non-opioid strategies (adjuncts, PT, TENS, nerve blocks, etc.)*

## 8) Are there any risks to non-benzodiazepine sleep aids (Ambien, Lunesta) for patients on narcotics?

*Yes. Any depressants increase risks of OD. They can potentiate the sedating qualities when used with opioids and thus pose an increased risk This includes muscle relaxants, AEDs, alcohol, etc. They also should be used with caution.*

*Overdose data supports that most often polypharmacy is involved.*

*Though patients are often not happy, things like melatonin, better sleep hygiene (including decreased caffeine…..), relaxation exercises, are reasonable, low risk options.*