The Opioid Epidemic: Is Your Practice Changing? - Frankly Speaking EP 26

Transcript Details

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Dr. Frank Domino
You've inherited a new patient into your practice as a PCP across town has recently retired. You see her on your schedule and you know that she's on chronic opioids for a low back pain injury she had three years ago. You suspect she's coming in for a refill today and wonder how to approach it. Joining me today is Jill Terrien and Susan Feeney, both Assistant Professors at the University of Massachusetts Medical School's Graduate School of Nursing. Welcome to the show, Jill and Susan.

Jill Terrien:
Thank you, Frank.

Susan Feeney:
Thanks, Frank.

Dr. Domino:
So I'm gonna start with you, Jill. This patient is not uncommon these days in our practice. What's your approach to inheriting a patient who's already on chronic opioids for chronic pain?

Jill Terrien:

Thank you, Frank. I think that the challenge is you don't know until she gets there, what you're gonna have. So my approach would be... Typical for any new patient would be some intake information. Hopefully we have her records with the visit, maybe I've even had a chance to review them before she got there so I have an understanding of what she is currently being treated with. Initially, it's introducing myself to the patient and to find out what her needs are during this visit specifically.

Dr. Domino:
Would you think about taking her off her opioids today or starting to wean her off?

Jill Terrien:
Yes, Frank. I think I need to first understand the mechanism of her injury, what she's had over these three years because that is a chronic state to be on opioids, and to see what I can do to offer a multi-modal approach to her pain.

Dr. Domino:
So it sounds like you wanna establish a little bit more of a relationship and then think about, going forward, how to address her pain best. Susan, just in general, what are your thoughts about the diagnosis and management of chronic pain today?

Jill Terrien:
So, Frank, is there an alternative to the artificial sweetener? Is it going back to sugar?

Susan Feeney:
It's very complex and very common in primary care, and it probably is the most vexing diagnosis that we see. The truth is that when people are in chronic pain, it affects their function and their ability. But what we do know is that opioids, in most cases, is an ineffective treatment. That people are often started on it possibly inappropriately or they're started... It should be a short term but it winds up not being managed. And so what Jill was saying is really important, is to figure out what's the injury, what have they done in the past, and to see if you can figure out if

it's a mechanical injury, would the multi-modal involve physical therapy or some sort of exercise therapy, but really working with the patient to have them understand that the opioid, most likely, is not treating their pain effectively. That it's more effective for an acute type of pain and that it's going to take a slow weaning off and a ramping up of other types of treatment, even something like acetaminophen or an inset if possible but also physical therapy and specifically about low back pain.

So it's managing, not only the patient's expectations but our own expectations because we feel frustrated, we want the patient to feel better. We also don't like to be in a position where we're prescribing medications we know aren't the best choice for the patient. But to understand that this is going to be a long term relationship with the patient working towards getting them in a functional state. That they're not gonna be completely pain free, but that they're going to be able, hopefully, to be less dependent on these medications and find something that really can be more efficacious.

Dr. Domino:
Well, thank you. That's great. Let's go back to Jill's patient. What tools do you recommend, Jill, that we, as providers use when we have to prescribe opiates?

Jill Terrien:
Yes, there are a number of validated tools that are available to us as providers. And I think that... First of all, there's many of them and so I think it's tailoring what works well in your practice. So, as prescribers, we use the Prescription Drug Monitoring database in Massachusetts, and around the country I believe, I wanna say, 48 states now have some sort of database that is similar. Not all of us talk yet, but many of us do so you can get... Especially being in Massachusetts we have many, many borders where patients can go to other states and receive medications. So the PMP is probably one of my primary tools, not only to validate what has been prescribed to this patient, but to have a discussion with them to see just what I'll be looking at every time they come for a visit. That's one tool. Other tools are I'm gonna be talking to the patient about an agreement on how we're gonna manage this pain, and that what our goals of care are, and that

we are gonna safely talk about how to decrease, wean, and ultimately I would like to see her off of her chronic opioid therapy.

Dr. Domino:
Okay. How do you know if the patients at high risk to develop dependency or even abuse of these drugs?

Jill Terrien:
Well, we know, with opioids anyways that patients do build up a tolerance just because of the nature of the drug. So we do have a tool that's been out there called the Opioid Risk Tool, although the questions... The Opioid Risk Tool which is not something that you would hand to a patient and have them check off, but it is a scoring system to look at anything in their background and when they were younger, if they had any issues with pre-adolescent sexual abuse, if they have any anxiety, depression, bipolar disorder, and anxiety, and anything like that that could lend themselves to having a problem with opioids, be more apt to misuse opioids. And how you ask those questions is really part of your interview. You weave it into your interview and history of the patient, coming from the stance that, "I need to know more about you so I can help you with your chronic pain management 'cause we know that there are certain things in a patient's life that can contribute to making them more dependent on these types of medications."

Dr. Domino:
Well, thank you. Susan, you mentioned a multi-modal approach, can you tell us a bit about non-opioid treatments for chronic pain?

Susan Feeney:
Sure. There was a systematic review done by the CDC just this year and it was pretty amazing. What they showed was that many of the studies that were looked at didn't look at long term outcomes, but they looked at mainly six weeks or shorter. But what they found was what we know, that long term opioid use causes distress, impairment, and decreased function, and that

there's also tolerance and increased association with misuse, addiction, and overdose. So when they compared various different alternatives, they found that many of them were just as efficacious or more efficacious. There is the cognitive behavior therapy, helping people deal with pain and understanding the ideology of the pain. It had a positive effect on function and attitude. Exercise therapy, through physical therapy and an exercise program, improved function with people with chronic low back pain, osteoarthritis of the knee and hip, and many guidelines have incorporated the use of acetaminophen and NSAIDS for pain of osteoarthritis of the hip and knee and of low back pain and have found them to be just as efficacious, understanding that NSAIDS have its own risk but certainly, that needs to be addressed.

And that for neuropathic pain, that the anti-convulsive meds, like Pregabelin and Gabapentin, the tricyclic antidepressants, and the SNRIs, the serotonin-norepinephrine re-uptake inhibitors, have shown great efficacy in dealing with neuropathic pain without getting someone dependent on an opioid. So it really talks to the provider as understanding the ideology of the pain and helping the patient come up with a treatment plan from the beginning and going down that route, than to start with dealing with something like an opioid.

Dr. Domino:
Jill, what if your patient wants to come off their opioids? Can you talk a little bit abut a medication assisted therapy?

Jill Terrien:
Sure, Frank. So let's just say our patient in the case came in today and said, "I don't wanna be on these anymore." Well, there has to be a discussion first about, "How much are you on?" And to look at a calculation of how, first of all, you can wean off and wean off safely. Meaning that you wanna avoid symptoms of withdrawal. They can be very, very uncomfortable and very, very unsafe. If the patient felt that she had a propensity to misuse the medicine and was worried about that, another safe way of weaning is medication assisted therapy. That would be something like Suboxone or Vivitrol. And as I was thinking of Susan and her multi-modality therapies that she talked about, I'm thinking of sometimes this is a team support, so you might

be referring out to your behavioral health, psychiatric colleagues as well, depending on how the visit goes with the patient and what the needs are. So I think that it's not all on you, but it's more that it's a connection with the patient gaining their trust and working as a team, and bringing in others as necessary.

Dr. Domino:
Great, thank you both very much. Practice pointer, taking a multi-modal approach to patients with chronic pain will lead to the best outcome and lower the risk of an opioid related death. Jill and Susan, thank you so much for bringing this topic forward and helping us understand how to handle this challenging new patient.

Jill Terrien:
Thank you, Frank.

Susan Feeney:
Thanks, Frank.

Dr. Domino:
Join us next week where we look at the role of saturated fat and the American Heart Association's position on dietary consumption.