CMEO
BriefCase

Personalizing Pain Care: Use of Opioid Risk Assessment Tools in Pain Management

Supported by an independent educational grant from Opioid Analgesic REMS Program Companies.

CME OUTFITTERS

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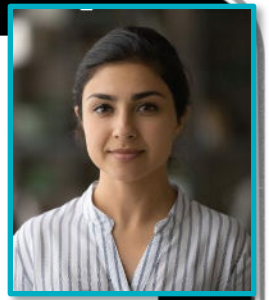
Learning Objective

Employ results from opioid risk tools as a resource to inform patient and clinician decision-making when considering use of opioid for pain management.

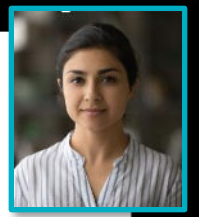
Patient case: Sandra R. visit to pain specialist



- 34 y/o woman with a history of fibromyalgia for 10+ years, symptoms well controlled with swimming and exercise and medications until the last year
- Has developed progressive numbness, burning and tingling below the knees bilaterally
- PMH: T2DM, depression, obesity, general anxiety disorder, chronic fatigue syndrome
- Current medications: duloxetine 30 mg + pregabalin 150 mg BID, tramadol 50 mg 4x per day as needed for pain, metformin 1000 mg BID
- Previously underwent a trial of amitriptyline, but did not tolerate it

BID = twice a day; PMH = past medical history; T2DM = type 2 diabetes mellitus; y/o = years old

Physical Exam and other history



- Musculoskeletal- 5/5 strength in all extremities, normal ROM, no swollen or erythematous joints
- Neurologic: Achilles reflex reduced bilaterally
  monofilament test: 5/10 right, 4/10 left
- Social history: drinks occasionally (1-2x/month), lives with husband and 2 kids, close to extended family that lives nearby
- Family hx: negative for SUD

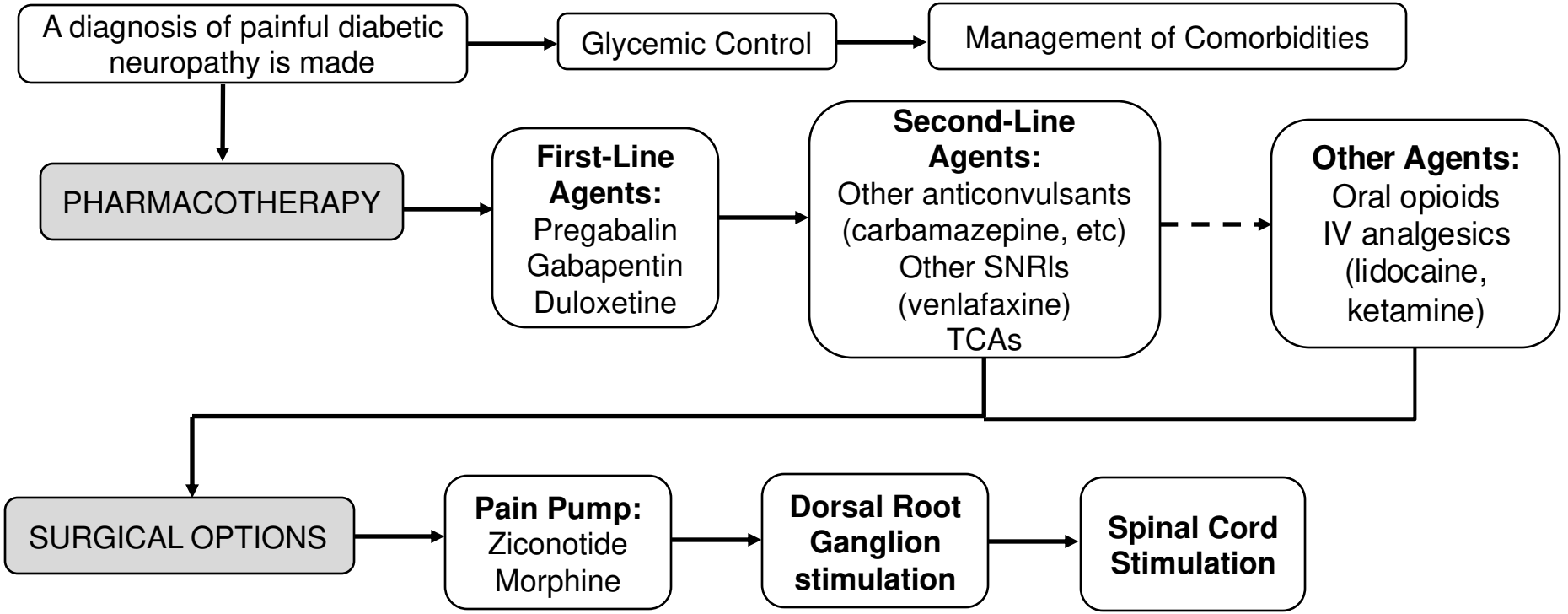
hx = history; ROM = range of motion; SUD = substance use disorder

Goals of Therapy: Diabetic Peripheral Neuropathy

- Pain modulation (30-50% reduction)
- Enhanced glucose control
- Restoration of function
- Patient education

Cohen K, et al. *P T.* 2015;40(6):372-388.

Painful Diabetic Neuropathy Management Options



SNRIs = serotonin and norepinephrine reuptake inhibitors; TCAs = tricyclic antidepressants

Snyder MJ, et al. *Am Fam Physician.* 2016;94(3):227-234.

Medication Options for Diabetic Peripheral Neuropathy

Drug Class	Dose (mg/day)	NNT	NNH
Tricyclic antidepressants (TCAs)	Amitriptyline 10–150	1-3	28 (major ADE) 6 (minor ADE)
Serotonin and norepinephrine reuptake inhibitor (SNRI)	Duloxetine 20–120 mg/day	5	17
	Venlafaxine 150–225 mg/day	3	16
	Desvenlafaxine 200 mg daily	9	6-14
Antiepileptics	Pregabalin 150–600 mg/day	5-8	9-16
	Gabapentin 900–3600 mg/day	3	4
Opioid-like medications	Tramadol 200-400 mg/day	4	8
	Tapentadol ER 200-500 mg/day	9-10	5
Mu-receptor partial agonist	Buprenorphine transdermal 5-40 µg/h	7	7 (ADR causing study withdrawal)
Opioids	Oxycodone CR 20-80 mg/day	6	13
Topical medications	Capsaicin patch or cream 0.075-8%	7	--
	Lidocaine 5% 1 patch every 12 hours	4	--

ADE = Adverse drug event; ADR = adverse drug reaction; CR = controlled release; ER = extended release; NNH = number needed to harm; NNT = number needed to treat

Snyder MJ, et al. *Am Fam Physician.* 2016;94(3):227-234. Staudt MD, et al. *J Diabetes Sci Technol.* 2022;16(2):341-352. Simpson RW, et al. *Diabetes Care.* 2016;39(9):1493-1500.

Audience Response

Which of the following is most important to assess before prescribing opioids for pain for this patient?

A. History of nausea with previous opioid exposure
B. OUD risk
C. Whether the patient has time to sleep for several hours each day after taking their opioid dose
D. I don’t know

Opioid Risk Tool (ORT)

Mark each box that applies		Female	Male
1.	Family Hx of substance use		
	Alcohol	☐ 1	☐ 3
	Illegal drugs	☐ 2	☐ 3
	Prescription drugs	☐ 4	☐ 4
2.	Personal Hx of substance abuse		
	Alcohol	☐ 3	☐ 3
	Illegal drugs	☐ 4	☐ 4
	Prescription drugs	☐ 5	☐ 5
3.	Age between 16 & 45 yrs	☐ 5	☐ 5
4.	Hx of preadolescent sexual abuse	☐ 3	☐ 0
5.	**Psychologic disease**	☐ 2	☐ 2
	ADD, OCD, bipolar, schizophrenia	☐ 1	☐ 1
	Depression		
	Scoring Totals:		

Presence/absence of one or more aberrant behaviors by risk category, computed from Opioid Risk Tool

Risk Category by Actual Outcome	Females	Males
Patients with no aberrant behaviors	71	38
Low (0–3)	12 (17%)	5 (13%)
Moderate (4–7)	56 (79%)	32 (84%)
High (≥ 8)	3 (4%)	1 (3%)
Patients with 1+ aberrant behaviors	37	39
Low (0–3)	0 (0%)	1 (3%)
Moderate (4–7)	17 (46%)	18 (46%)
High (≥ 8)	20 (54%)	20 (51%)

Remember: Risk prediction tools do *NOT* diagnose OUD

OUD = opioid use disorder

Webster LR, et al. *Pain Med.* 2005;6(6):432-442.

Treatment plan for Sandra

- Check HbA1c to review glucose control
- Change tramadol to longer acting agent
- Follow up in 1-4 weeks to assess efficacy and determine if dose change is needed
- Review need for psychotherapy referral
- Consider CBT or pain reprocessing therapy

CBT = cognitive behavioral therapy

Monitoring Opioid Use: Patient Education

Advise patients of PDMP monitoring that occurs at physician and pharmacy visits

- Check PDMP when starting opioids and with every new prescriptions or every 3 months

Advise patients of plans for urine drug screening

- Screening will be used to confirm adherence and identify use of illicit drugs or other medications that could interfere with treatment goals

Reinforce that monitoring strategies are designed to improve patient safety

- Patient should understand and agree to treatment and monitoring plans

PDMP = prescription drug monitoring program

Centers for Disease Control and Prevention [CDC] and Department of Health and Human Services [HHS]. *Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids.* National Archives Federal Register Journal Website. 2022. https://www.federalregister.gov/d/2022-02802.

Opioid Therapy for Chronic Pain

See patients at regularly scheduled intervals

Track pain and function at each visit

Evaluate for risk of harm or opioid misuse

Review non-opioid therapies for optimization

Discuss plan to continue, adjust, taper, or stop opioids

Monitor for development of hyperalgesia or tolerance

Dowell D, et al. *MMWR Recomm Rep.* 2022;71(3):1–95.

SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

- Reassess for changes in pain and function at every visit for patients with chronic pain
- Conduct regular opioid risk assessments for patients on long-term opioid therapy

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