The Opioid REMS Advantage: Supporting Providers and Protecting Patients

CMEO Podcast Transcript

Johnathan Goree, MD:

Hello everyone. Welcome to the CME Outfitters webcast that's titled The Opioid REMS Advantage: Supporting Providers and Protecting Patients. We are in for a treat. I'm excited because I am moderating two amazing speakers that have become friends over the past few years. As I've worked with them on multiple projects, different research projects, different presentations, different education initiatives, and every time I hear them talk about this topic, I learn something because we all basically come at this topic from different perspectives. I also want to thank CME Outfitters for producing this program. CME Outfitters is dedicated to interprofessional continuing education and is jointly accredited by the ACCME, the ACPE, and the ANCC.

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I'll start by introducing myself. I'm Jonathan Goree. I am a professor of anesthesiology at the University of Arkansas for Medical Sciences. I'm an anesthesiologist and a chronic pain physician. I've been practicing interventional chronic pain for 11 years and been teaching fellows, residents and medical students about pain topics here in the good old state of Arkansas. And with that, I'll pass it on to Dr. Hyde to introduce herself.

Carrie Hyde, MD:

Thanks, Dr. Goree. I'm Dr. Carrie Hyde. I am a palliative care physician and internist. I am a Chief Medical Officer for a national palliative care program. Dr. Potru?

Sudheer Potru, DO, FASA, FASAM:

Hi, thanks for having me everybody. I'm Sudheer Potru. I'm a triple-certified anesthesiologist, pain medicine physician and addiction medicine physician at the Atlanta VA where I care for veterans who have very complicated pain, opioid use and mental health issues. I'm thrilled to be here for this talk.

Johnathan Goree, MD:

Our two speakers were really modest, but they carry a lot more titles and they're really amazing and so looking forward to a lively discussion. Here are our disclosures, so just wanted to leave those on the screen for a second and then I'm going to go through our learning objectives. Learning objective one is to identify physiologic and bio-cycle social factors that influence different etiologies of pain. The second one is to utilize pain assessment tools that reinforce approaches to the appropriate management of pain. The third is to implement strategies from the 2022 CDC guideline for prescribing opioids in the development of safe and effective pain management plans for patients with acute, subacute and chronic pain. Learning objective four, counsel patients on multimodal pain management to optimize safe and effective multimodal treatment plans as well as safe storage and disposal. And learning objective five, evaluate opioid non-medical use risk when developing multimodal pain

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management plans. And so, now that we're finished with all of our housekeeping, I'll pass it to Dr. Hyde who's going to start talking about the physiology of pain perception.

Carrie Hyde, MD:

Thank you, Dr. Goree. So we get to start off with a pretty heavy topic in basic pain mechanics. When we talk about pain, many people think it's a simple signal from the body to the brain, but it's actually a highly coordinated process with multiple checkpoints where pain can be amplified or dampened. It starts in the periphery where an injury triggers nerve endings to convert that stimulus to electrical signals. This is transduction. Those signals then travel through different nerve fibers. A delta fibers carry sharp fast pain. C fibers carry dull aching pain and a beta fibers usually carry touch but can modulate pain. Once those signals reach the dorsal horn of the spinal cord, the body can either boost or suppress them through modulation. From there, signals travel up the spinal cord through the ascending pathways into the brain where pain is finally perceived. But the brain doesn't just receive pain, it also sends descending signals back down to either turn the volume up or down.

This is why, and we're going to talk about this. Stress, emotion or even expectation can change how pain feels. Pain is not just what happens in the body, it's what the brain decides to do with that information. Now that we understand how pain is processed, let's talk about what happens when the system doesn't behave normally and when it becomes chronic. So real quick points here. Acute pain is a normal protective response that appears quickly after injury and typically resolves as the tissues heal. The nervous system calms down and the signals fade. That usually lasts about less than one month. That is the definition. Chronic pain is very different. When pain persists beyond three months, the nervous system can actually rewire itself, a process we call neuroplasticity. The spinal cord and brain become more sensitive to pain signals, which leads to concepts like wind-up where repeated stimulation makes pain feel more intense over time or hyperalgesia where normal pain feels exaggerated. Some people even experience allodynia or allodynia depending on where you trained, where non-painful stimuli like light touch can become painful.

The key takeaway here is that chronic pain is not just prolonged acute pain, its it's own disease process with changes in the central nervous system. Treating chronic pain requires us to target those neurobiological changes, not just the original injury. And this is exactly why treating pain requires a broader lens, one that includes more than just biology.

And this is where I get to put my palliative care hat on. This is called the biopsychosocial model of pain, and it reminds us that pain is influenced by three interconnected domains, biological, psychological, and social. Biologically we have factors like inflammation, nerve injury, genetic sensitization, but psychological factors like stress, depression, anxiety, coping style and catastrophizing can amplify or dampen the pain experience just as powerfully.

Then there's a social dimension, financial stress, family support or lack thereof, stigma, cultural beliefs, even job demands, these factors can increase pain-related disability more than the injury itself. I'm sure we can all relate to having patients with similar injuries and having a different perception of pain and how we treat it. What's the most important thing is that these domains constantly interact. For example, ongoing pain can lead to poor sleep and depression, which increases inflammation and pain perception, creating a cycle. If we only treat one area like prescribing medication for biology, we're missing two thirds of the picture. And so ultimately, the goal is not just to reduce pain scores, it's to improve quality of life and function. We're going to talk a lot about that

today. When we treat the whole person, whole care, outcomes improve and reliance on opioids often decrease naturally. So how do we apply this model in practice? We need to shift from a find-and-fix-it mindset to a holistic patient-centered approach.

So I want to dig into a couple of pain assessment tools here. When we ask a patient, what is your pain on a scale from zero to 10, we are only capturing a tiny piece of the story. That number does not tell us how pain affects their ability to work, sleep, move, or enjoy life. It doesn't tell us whether the pain is neuropathic, inflammatory or centralized. That's why we need validated assessment tools that look beyond intensity tools like the Brief Pain Inventory or BPI here. We're going to dig into that on the next slide. The Defense and Veterans Pain Rating Scale, the Michigan Body Map, Pain Detect for Neuropathic pain and the PROMIS Pain Interference scales that give us more complete picture. We're also seeing the growth, I think it's worth mentioning of ecological momentary assessments, the use of daily pain diaries or digital tracking to see how pain fluctuates in real life.

And these tools don't just improve documentation. They drive better treatment decisions. They help us match therapies to underlying mechanisms, track progress over time and justify multimodal care to payers. So in short, a better assessment leads to better outcomes. Again, all of these tools are really widely used, clinically useful, but I want to take a closer look at the Brief Pain Inventory, which is one of my favorite tools.

It starts by asking the pain intensity at its worst, least, average and current. It also includes a body map so patients can show where the pain is located, but where it really adds value is the interference section. I hope you can see it here. How much pain affects general activity, mood, walking ability, work, relationships, sleep and enjoyment of life, which can help us move from how much does it hurt to how much does it limit you? It also documents which treatments patients are using, medications, non-medication therapies, and how much relief those provide. This allows us to track effectiveness over time and adjust therapy. So overall, the BPI gives us a functional patient-centered lens that aligns perfectly with both the biopsychosocial model and the CDC guidelines emphasis on function over pain score, which is really important for this talk today.

Johnathan Goree, MD:

So before we go into the case, the benefit of being the moderator is I get to put these folks on the hot seat and they can't do it back to me. So, I wanted to pass it over to Dr. Potru who we haven't heard from yet, and we just talked about pain assessment tools. Are there any that you particularly love or that you use in your practice in the VA?

Sudheer Potru, DO, FASA, FASAM:

So I've used a lot of the things that Dr. Hyde mentioned. The DVPRS is specifically one that is used for veterans, so we use that one quite a bit. I think the brief pain inventory is probably, I really like that one because it covers a lot of ground within the context of a relatively short brief questionnaire. So that's the one that I try to go for. I'll also use various sort of disability indices like the Oswestry and things like this to get a sense of what the patient's function is looking like alongside their pain because we're really trying to assess all of that and care for people appropriately. So I would say those three are the ones that I'm looking at the most.

Johnathan Goree, MD:

Thank you. Dr. Hyde, in your work in the palliative care world, are there any specifically that you use that are either on the list or not on the list?

Carrie Hyde, MD:

I also like the BPI as I mentioned. We have an ESAS form which actually evaluates more than just pain symptoms. It actually assesses nausea, depression, anxiety, sleep, and it has a body map on it. So I don't know what it's called, but it's just our normal intake process. It incorporates a few different things on a scale from zero to 10.

Johnathan Goree, MD:

Yeah. I guess I'll answer my own question. We built in PROMIS scoring into every one of our visits, which was relatively labor-intensive, but the benefit of PROMIS scoring is it has scaled scores for not just pain interference, but also for sleep and depression and anxiety and other things that may affect someone in that biopsychosocial model of pain so that we can understand maybe someone really needs depression treatment before we really dive into their pain treatment or maybe those need to go side by side. And we can also track how all of those parts of the model improve with every piece of treatment. There's also been some work that's been done by colleagues of mine, Jason Pope in particular, that really look at what the chronic pain patient looks like on PROMIS scoring. So, all right, let's jump into the case and I see that we're starting to get some questions in which are really exciting and so we will try to weave those through, but at the end, we'll also have a question and answer period to make sure we get to every single one that we can.

So this is a longitudinal case. We're going to follow this patient, MJ, through the entire journey, but we're going to start with the beginning. So MJ is a 53-year-old man who presents with a work-related injury. He's a construction worker. He has shoulder and hip trauma after falling after scaffolding on a construction site and he has an acute injury. So we're going to talk about MJ and through his case as we move through, but we're going to start with how do we talk to patients about their pain? And I really always find this an important teaching point, especially for new trainees who are talking to pain patients for the very first time. And I like to make these conversations as goal-oriented as possible. So really understanding what someone's goals are and those can range from going to the supermarket or being able to pick up their grandchildren.

I had someone today with CRPS in the hand who was very frustrated because she just wanted to pick up her two-year-old grandson and couldn't do that anymore. But also, really understanding and explaining how someone's pain is A, what's happening in their body from a pain standpoint and explaining terms like central sensitization or acute pain, chronic pain and use lay terms like this is new pain and your pain has transitioned into a different disease process where actually, pain signals are actually easier to send than they were before, but also, making sure that you set realistic goals with those patients.

And also, I always think it's important as an anesthesiologist, and this is something I learned very early in my career, is that the longer you leave pain untreated, the more challenging it is to treat. And so, when we see acute pain, I always encourage physicians to be aggressive upfront, whether that's with opioids, whether that's with other modalities, obviously with other modalities first, but with acute pain, sometimes, it's the right time to go ahead and use opioids. If I get in a car accident today and any of you in the emergency room, I really hope you give me some morphine and don't try NSAIDs and other things first if I have a broken leg. Sometimes, we

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have to use opioids and treating that pain early and closing the pain gate as fast as we can is what we need to do. It's really the judicious long-term use of opioids that we need to be concerned about. So treat pain aggressively, titrate patients off medication and help them return to normalcy as much as possible.

Carrie Hyde, MD:

Yeah, I love that. Thank you for that really important reminder. And I think while analgesic therapies are important, it's most effective to use a combination of treatments. I like to call it a layering of therapy. You'll hear me refer to that in a little bit as well, or multimodal pain approach to adequately address the patient's pain. Some are listed on this slide and we're going to dive into a few non-pharmacologic strategies on the next slide. When a patient presents with acute pain, like our patient Mr. MJ, there's often a rush to reach for medication, especially opioids, but evidence shows that non-pharmacologic strategies are both effective and foundational and they should be part of nearly every acute pain plan. We start with simple self-care options. Hopefully, we all remember from our training, RICE, right? Ice, heat, rest, immobilization, elevation. I do it to my kids when they twist an ankle at baseball.

These are low risk, easy to implement, and often, underused. Rehabilitation therapies like physical or occupational therapy help maintain mobility and prevent deconditioning. Movement is medicine, even small amounts can interrupt the progression from acute to chronic pain like Dr. Goree was talking about. We also have complimentary therapies like acupuncture. A personal note, I'm a physician acupuncturist and I know how effective this can be for patients early in their disease course and throughout their disease course. Massage chiropractic care, and these are all excellent adjuncts when appropriately applied. Then let's not forget about the psychosocial intervention, CBT, cognitive behavioral therapy, ACT, which is acceptance and commitment therapy, which aims at increasing psychological flexibility and mindfulness practice because we know that thoughts and emotions strongly shape the pain perception even early on. So key takeaways, non-pharmacologic therapy isn't alternative, it's essential and the earlier we integrate it, the more likely we are to prevent chronic pain down the line. So now, let's talk about how we combine these strategies with medications using a step-wise approach.

So this slide highlights a very practical, patient-centered way to think about acute pain treatment and a step-wise approach. So step one, always start with non-pharmacologic interventions plus a non-opioid pharmacotherapy. Things like NSAIDs, acetaminophen, rest, ISPT, I've said this before, these cover the majority of acute pain cases. Step two, if your pain remains, if your patient's pain remains severe or limiting their function, we may add a short course of short-acting opioids and short-term really matters. The CDC, which we're going to talk about a little bit later, defines that as about three to five days in most situations, the goal is to use the lowest effective dose for the shortest duration while continuing multimodal therapy. So rather than opioid versus non-opioid, the real approach is that layered therapy approach always starting with the least risky, most supportive options and escalating only as needed. Before we dive deeper into the guideline-based prescribing, should we check on our patient, Dr. Goree?

Johnathan Goree, MD:

We should, but I'm going to bring in Dr. Potru one more time because we have a question that really is timely with what you just discussed and someone asked a question, it sounds like they have a pretty busy practice and their concern is if they see someone with a pain score of six to eight, so someone who has pretty severe pain,

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they ask if they're under treating if they don't prescribe an opioid and if they start with non-pharmacologic therapy? And their concern is sometimes, it's hard to get that patient back into their practice and sometimes patients don't respond to non-opioid therapy. So what are your thoughts there?

Sudheer Potru, DO, FASA, FASAM:

That's an important point. We want to make sure that we're balancing treating the pain but minimizing opioid exposure if possible. I think that in these types of acute situations, as Dr. Hyde has illustrated for us, the majority of times in the absence of really significant injuries and the options that have been outlined here, multimodal analgesia, physical therapy, weight loss, different types of non-opioid treatments, CBT, are really going to take care of most of these problems in an uncomplicated opioid-naive patient, you are going to get some here and there that will be more challenging and more complicated than that, but they're going to find their way back to your office anyway if they're still continuing to have issues.

So it's a balance of what Dr. Goree was saying about making sure you hit the pain hard and treat it aggressively to prevent it from chronifying and reduction in function and all that stuff, but at the same time, you really shouldn't need opioids, in my experience, for the majority of these types of acute injuries or situations.

So the problem with the pain score of course is it's very subjective. We know that pain is a subjective experience, meaning that it's difficult to say what a six out of 10 means to one person and it could be totally different for somebody else. I would say if you can, if it's possible, that patient comes in, you evaluate them, take a look, and then you could do something like you'd have them just follow up within a couple of weeks and see if you can get them back in. If you can't get them back in in a couple of weeks, what you could do is you could have an opioid prescription potentially if you're really worried about them not doing well, you could just have an opioid prescription that you send to the pharmacy and say, "You know what? They're going to pick this up after X number of weeks of trying non-opioid options and different things like this," so that they have something there if they need it. But at the same time, you're still making sure they're trying those non-pharmacologic and/or non-opioid options first.

Johnathan Goree, MD:

I think that was an absolutely excellent answer and I'll just add, I think sometimes, we just have to use our clinical judgment, the difference between, I've seen patients who've said they've had five out of 10 pain and they've had a broken femur, but I've also seen patients who are saying they have 10 out of 10 pain and they have a rash. And so, I think we have to understand what... There are certain patients where we may have to move through the chain rather quickly or use a combination of things and there's some patients where we have a little more time to try things that are non-opioid and I think that's when we can really lean on the literature and we'll jump into our patient and then continue to move through that.

So when we look at MJ, a lot of the treatment for an acute injury would be PT and let's say that he had a great... Normally, I write patients for 16 sessions of PT, two times a week for eight weeks. During that time he lost some weight. We started him on NSAIDs and we started him and we referred him to cognitive behavioral therapy, which helped him with some coping mechanisms for his pain. And for this gentleman, multimodal management was really effective for him. Dr. Hyde, have you seen this patient before and has this regimen been effective for you?

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Carrie Hyde, MD:

Interestingly, I see people at a different life position. In palliative care, we're seeing very seriously ill patients, but they still have acute issues too. A fracture, a fall, physical therapy isn't as useful in the palliative care realm. A lot of my patients are very, very sick and so that may not be as important. NSAIDs also, most of them have organ dysfunction, so we have to be really careful, but I really like acetaminophen in these cases, under two grams so that we can do that. Cognitive behavioral therapy, hands down is one of my favorite things to use. Like we talked about in the biopsychosocial model, there's such a component like we talked about two thirds of a pain picture really can be not just biological pain. And so, really treating the patient holistically is really important and I think having support is really important in the patients that I see personally who may have an acute event on top of a serious illness.

Johnathan Goree, MD:

Thank you. I'm going to talk some about topical non-opioid medications. As Dr. Hyde said, this is the second step often in acute pain management and these slides are downloadable. You can go through these, but I want to highlight a couple. Topical NSAIDs have been very effective in my practice, especially for patients who have side effects to oral NSAIDs. One is topical diclofenac formulations, there are patches, gels, and you can also compound NSAIDs and avoid some of the systemic side effects. Lidocaine also very effective, often found over the counter. And then lastly, capsaicin, which I actually discussed with a patient today.

I saw a patient literally four hours ago who had basically post-herpetic neuralgia and unfortunately for her, it was right at the bra line, which is important because as her skin rubbed against her clothes, she was experienced severe pain and she wasn't able to get out of the house as much as she wanted to because she wasn't happy with her ability to wear the clothes that she wanted to wear. And she used topical capsaicin, which was really effective for her post-herpetic neuralgia. So even patients who have really severe disease, I've had shingles before, it hurts really bad. Sometimes non-opioids or topical medications can be really effective.

Other examples, and these are examples of oral non-opioid medications. I've heard Dr. Hyde present this many times and talk about how we can think of pain in really three different buckets. We have inflammatory pain for which anti-inflammatories like NSAIDs and steroids are really effective for. We also have somatic pain, which acetaminophen and we'll talk about the NaV1.4 pain signal inhibitors in a few slides, but basically, are traditional pain medicines and then even though we use them later on in the pathway, opioids are effective for that somatic pain.

And then the last one is neuropathic pain and we'll talk about that on the next slide, but antidepressants and anticonvulsants. So, for antidepressants, your typical primarily use SSRIs, your first line antidepressants don't often have much ability to treat pain or they're not as effective in pain management. While they may help in the biopsychosocial model because they can help with depression, they don't have primary indications for pain, whereas SNRIs and TCAs, which also have norepinephrine function have been shown in studies to be much more effective for neuropathic pain. So recently in my practice, SNRIs have really become the go-to for me when I treat antineuropathic pain. Anticonvulsants including gabapentin and pregabalin are also commonly used for antineuropathic pain. I wanted to check in with my colleagues and see is there anything that I'm missing so far?

Carrie Hyde, MD:

Pretty comprehensive in my opinion.

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Johnathan Goree, MD:

I did notice that we had one question where someone asked specifically about topical CBD and so I did want to make a couple of comments. One is that a lot of CBD formulations, because it's usually not as regulated, some of them may contain THC, and so you have to be very upfront with patients, especially if you suggest that. The second is that when I look at CBD without THC, CBD is normally more effective for inflammatory pain, whereas some of the other formulations of cannabis are often used for more neuropathic pain.

Sudheer Potru, DO, FASA, FASAM:

It's also important to note that we are still trying to build evidence in whether it's any cannabinoid for pain, where the jury is still out on precisely what we should be doing with regard to that. So it's useful in certain instances, but as Dr. Goree has alluded to, we have to be careful and cautious because this is still largely unregulated in a number of places.

Johnathan Goree, MD:

Yeah. One other question that we have in the chat and it's really a comment on payer status and there's a second part to the question that I know the two of you will address and it's about tramadol, but the first part of the question is really about how it's challenging for patients to get to physical therapy and two to three sessions per week can be too expensive, and I agree. I try to have a really open dialogue with patients about what they can afford. The way I approach that is I will often tell patients that my goal is to treat their pain, not to break their bank. And so, I'll often say that this may be the treatment for us and I never make assumptions, so I offer the treatments and then I ask patients if they think this is doable and if they say that it's challenging, then sometimes, we can change the plan some.

So, a good example of that would be to say, Mike, let's do two or three physical therapy sessions. Let's work with your therapist to modify quickly into a home program so that you can potentially continue the same therapy and exercises at home and not pay those co-pays that may be challenging for you to afford on a fixed income. And if the physical therapist, and if you have a good relationship with a therapist and the therapist knows that's the goal going into it, I find that that transition can be really easy and can be really helpful. Dr. Hyde, do you want to continue on with our case?

Carrie Hyde, MD:

Our poor Mr. MJ, guys, we got him all better after that fall at work and now, he's coming back in to see us and he has been in a multi-vehicle car accident, now has multiple rib fractures, which for anyone who treats rib fractures, they're terribly painful and he's got fractures in his left hip, lower leg and it is going to require surgery. We're going to come back a little bit later, but let's keep MJ in mind as we move forward in those next steps of the pain management cycle. He now has pretty severe acute pain and so Dr. Goree, I'll hand it back to you to talk through the CDC guidelines and then we'll get into opioids.

Johnathan Goree, MD:

Okay. This is a really important slide, so I'm going to spend a little time here, so bear with me. We all probably have heard about the CDC guidelines that were published in '22 or actually, the second iteration of the CDC

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guidelines, but really, a lot of them kept the spirit of the original CDC guidelines but with some changes so that we don't have hard floors and ceilings for the opioids that we should prescribe. So we really need to establish clear treatment goals as we talked about before, but also, make sure that opioids aren't the first line as we said, especially for chronic pain. Discuss risk and benefits and ensure that you have a real informative conversation just like we're taught to do in medical school about a procedure because opioids do have a lot of risk and benefits that we need to discuss and also make sure we're doing everything to keep patients safe.

That includes prescribing short durations for acute pain, but then also, checking the prescription drug monitoring program, using multimodal pain management. Use tools like urine drug screens when appropriate to make sure patients aren't mixing opioids with other psychoactive medications that may be dangerous or to make sure that patients are taking their opioids as appropriately or not mixing them with other opioids, etc. We should also of course try to prescribe the lowest effective dose if possible and incorporate risk mitigation strategies so, that include naloxone. I see a question about naloxone in the chat that we'll answer in a minute, but make sure that we basically are doing everything to keep patients safe and if we have to discontinue opioids for whatever reason, A, we need to be screening for opioid use disorder in all of our patients, but also, make sure that we taper and don't just stop opioids abruptly unless patients are doing something that's incredibly unsafe and it is just unsafe to continue opioids under any reason.

This is the second page and I talked about some of this again with the goals to make sure that we keep patients safe, patients use the least amount of medication necessary, make sure they're partnering with their physician and are really adherent to prescription drug regiments. We talked about making sure that they understand those most common side effects like falls and constipation and respiratory depression and all of those things so they understand how to treat them and when they need to give you a call as their provider if you're describing long-term opioids. How to handle missed dosages, which we should be doing for any medications. And our pharmacist colleagues, any of you are on the call, I know you do a great job of this as I also, as we all are also patients and I've been given that feedback of how to handle missed dosages at the pharmacy.

Lastly, we also need to discuss safe storage and disposal and make sure that our patients understand that opioid safety is not just about the patient, it's about really everyone in the household and honestly, everyone in our community because if the opioids that someone has been prescribed get into the wrong hands, they can be sold, they can be used, they can be abused, they can be misused. And so, safe storage is really important. I often have my patients give me their plan for how they're going to store their opioids and then talking to them about disposal, which we will have a little bit of, we have a slide on later on in the talk. Also ensuring they don't share their analgesic for those reasons and when and how to seek emergency medical treatment and how to report adverse events to the FDA.

Carrie Hyde, MD:

Great. And so with that, we're going to jump into opioids. To use opioids safely and effectively, I think we need to first understand how they work. Opioids primarily act on mu-opioid receptors in the brain and spinal cord, reducing pain signal transmission and changing how the brain perceives pain. But opioids don't all behave the same. Each drug has unique potency, receptor affinity and pharmacokinetics. That's why morphine, oxycodone, fentanyl and methadone can all relieve pain but with very different dosing, onset and duration profiles. Some opioids have active metabolites that can accumulate, especially in renal or hepatic dysfunction, which I see a lot in my practice. Others are more lipophilic and cross the blood brain barrier quickly leading to faster onset and

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sometimes, higher misuse potential for that reason. Understanding these differences can help us choose the right opioid at the right dose, for the right patient and anticipate safety concerns.

So let's carry that forward. We've got a few examples here on this screen and let's go into some more specific opioid classes. This slide really reinforces that pharmacodynamics and pharmacokinetics matter just as much as receptor activity. So, we need to consider, when choosing a medication onset and duration, metabolism, active metabolites for safety, formulation, immediate release versus extended release depending on stability of pain and opioid tolerance. Ceiling effects, things like partial agonist and individual variability including pharmacogenomics, which can dramatically change how a patient responds. So bottom line is opioids really are not interchangeable. We need to have a thoughtful understanding of their characteristics to help prevent both undertreatment and overuse.

So with that, I'd like to point out a couple of these immediate release formulations. Again, remember from the CDC guidelines that Dr. Goree just went over. Immediate release formulations should be used first for safety, consider the onset and duration again to match the clinical situation. I'm thinking about our Mr. MJ and he probably does need some pretty quick and potent medications too, he has multiple fractures.

And then one other note here is just to be aware of combination products like hydrocodone, acetaminophen. So I personally, my practice is I don't usually prescribe those medications because I want to separate those out so I can control how much acetaminophen a patient is getting. And as we all have horror stories from our training, I had multiple patients who were taking hydrocodone not having relief from pain, they took acetaminophen and came in with liver failure and some actually passed away.

This is where we get really gritty and we look at morphine milligram equivalents. MMEs is how I'm going to refer to these in this slide. This is a tool to help compare opioid potency across different medication. It's not perfect and it changes often, but it is useful for estimating relative risks. So for example, when I look at this chart, 10 milligrams of oral oxycodone is roughly equivalent to 15 milligrams of oral morphine. 10 milligrams of oral hydrocodone is roughly equivalent to 10 milligrams of morphine. I think we have to be really careful and we put some stars here next to a few that we need to be really mindful of, that methadone and fentanyl require extra caution due to nonlinear conversions.

So what's really important is that MME matters. So morphine milligram equivalents, this is a skill that every practitioner needs to have. Overdose risk increases significantly above 50, 5-0 MMEs per day and the CDC guidelines recommend avoiding or carefully justifying doses above 90 MMEs per day. This is really important in documentation, so be able to calculate your MMEs, be able to justify why you're using the dose you're using, and then certainly for treatment decisions like rotating opioids, we would need to consider reducing the calculated dose for cross tolerance. We won't get into all of that today, but MMEs aren't just a number, it's safety. So what about long-acting opioids? We've talked about short-acting opioids, but it's really important that we talk about long-acting opioids, when to use them-

Johnathan Goree, MD:

Dr. Hyde, before you do that, can I jump in real quick?

Carrie Hyde, MD:

Oh, sure. Yeah.

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Johnathan Goree, MD:

Because we've gotten two questions about tramadol and so I just wanted to give you guys a chance to get on your high horse for a second or get on your platform. How effective is tramadol or acetaminophen with codeine for moderate pain?

Carrie Hyde, MD:

Dr. Potru, I'll give it to you on this one.

Sudheer Potru, DO, FASA, FASAM:

So I think that using those things in an acute situation is reasonable to do. Tramadol is not a medication that I am a fan of using chronically. I feel like the dose tends to build up very quickly. We know about the risks of serotonin syndrome. If I had to choose between those two, assuming generally speaking that I don't have an ultra rapid metabolizer, which is potentially always a concern with those two particular drugs acetaminophen with codeine as well as tramadol. I would personally would prefer the acetaminophen with codeine because I feel like it may be a little bit more reliable in the way that it acts and it typically doesn't end up escalating the doses of... I've seen patients on 12, sometimes 15 tramadol pills a day, which is not really great and sets them up for a disaster. So that's just been my experience. I also don't think it's the cleanest drug in the world metabolism wise, and so I try not to use it if I can avoid it, but I can see an argument for using it in certain acute situations.

Carrie Hyde, MD:

Yeah. We know that certain enzymes are not present in a large part of the population, so it's a gamble to give someone tramadol. It does work for a portion of the population, but there are so many risks and side effects to tramadol. I agree with you, Dr. Potru, I think the pharmacokinetics on it are a little bit rough because it has so dependent on that cytochrome P450 system that we need intact to metabolize the medication. So it's a little bit risky.

Johnathan Goree, MD:

Yeah, I'm going to say one quick thing because there was a question about muscle relaxants as I was going through non-opioid medications. I find that they're effective for muscle spasm or muscle pain in very acute situation, but I don't think that they are great long-term medications for back pain or muscle pain. So let's go back to long-acting opioids.

Carrie Hyde, MD:

Yes, long-acting or extended release opioids are something we have to be very careful with and I'm going to go quickly again for the sake of time, I really want to hear Dr. Potru speak today. So a few guiding principles here is never start long-acting opioids in opioid naive patients, only after maximizing non-opioid and short-acting opioids should you even consider these, they have longer half lives and accumulation and overdose are real concerns. I would also put a special note next to methadone. It has very unique pharmacokinetics and should only be used by experienced prescribers. They're not inherently stronger, they're just longer lasting. I don't know if any of you on the call have had this happen, but my patient that said, "Oh, I took six of my morphine,

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they didn't work." And I'll say, "These were extended release. They didn't work the same way as your short-acting." So it's really important to educate your patients on how these are to be used and how they can control background pain.

So regardless of formulations, they do carry side effects. I want to jump into side effects really quickly. These are often what determine whether therapy is safe or sustainable. So they don't just reduce pain, they affect almost every other major organ system. We have a comprehensive list here. One special note is that constipation is nearly universal. It does not improve with tolerance. So you have to always put someone on a bowel regimen when you put patients on opioids. So please do not forget that, how many times I've had patient call in after hours to say I hadn't pooped in four days. I say, "Yeah, I know I hear you. We should have put you on an opioid or a bowel regimen with this medication at any given time."

And now that we've covered the pharmacology and risk of opioid, let's talk about creating individualized management plans that can balance benefit and safety. And then I'm going to hand it off and let these other experts talk. When developing the pain plan, there's no single template that fits everyone. Each patient's story biology and goals are different. We need to start with identifying the type of pain, look at the comorbidities, their functional goals, and start with that multimodal therapy. Combining non-drug and non-opioid options first and if medication's needed, match the class to the mechanism. So again, Dr. Goree, you know I love this, but if they have neuropathic pain, let's use duloxetine for neuropathic pain. For inflammatory pain, let's use NSAIDs. And finally, just always reassess the patient's function and pain. These change over time and our plans should change with them. Shared decision-making keeps patients engaged and improves adherence. And ultimately, individualized care plans really mean balancing efficacy, safety and quality of life, not just prescribing a pill.

Once we've built that personalized framework, sometimes opioids are appropriate. Let's review how to start safely and when that decision is made. I keep clicking on the wrong arrow, guys. So when considering opioid therapy, we really need to ask ourselves, have all reasonable non-opioid options been tried? And if the answer is yes and pain remains severe, here's the roadmap for a safe initiation. So reserve opioids for cases where other treatments are inadequate. Use tools like the opioid risk tool, which I know Dr. Potru is very good at, and he'll probably talk about and always check the state's PDMP or prescription drug monitoring program to identify risk before we prescribe. Again, start with immediate release formulations at the lowest effective dose in the shortest duration possible. Remember, three to five days is that key CDC guideline. Think about comorbidities and interaction. Educate and consent your patient. And I'll hand it to, Dr. Goree, I know we had a question about naloxone, so would love to hear your thoughts on when to prescribe naloxone.

Johnathan Goree, MD:

Yeah, that answer has been taken out of my hands because it's Arkansas law that you have to prescribe it for any patient who's taking chronic opioids. So you have to make sure you're following the laws of your state, not just the guidelines that we've followed as a medical community.

But I also want to answer a few questions in the chat that are very similar to this and it's really around stigma. So the stigma around talking about depression or anxiety or naloxone or urine drug screens or the easiest way is just to be very honest and upfront and do it on everyone. So by doing PROMIS scoring, I can say, "I looked at your scores and I'm concerned about depression and I know that depression can contribute to your chronic pain. And so, I want to ask you and start asking..." And then go into a conversation around depression for naloxone, I just prescribe it for everyone and I say, "I prescribe naloxone for everyone who is on chronic opioids. I think it is

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important to have this in your cabinet, not just for you, but if someone in your house unfortunately gets into your opioids because it's a life-saving medication." So it's how I handle all of those stigma conversations. I'm just very upfront and then I give the patient the honest truth about how I use those things.

Carrie Hyde, MD:

Yeah. I think normalizing the discussion is really important. I agree with you. Okay, let's go back to MJ. So we have given him multimodal pain care in the hospital and he was discharged home on hydrocodone acetaminophen 5/325, 1 tablet every eight hours as needed for pain and it's alternating with ibuprofen over the counter. For the sake of time, we can discuss that regimen or we can keep moving, Dr. Goree?

Johnathan Goree, MD:

I think we should keep moving. Let's move on to general principles on ongoing long-term opioid management.

Sudheer Potru, DO, FASA, FASAM:

All right. Awesome. So I think it's really important to frame this if we are going to have a patient who's on ongoing opioid therapy, that we're viewing each time that we prescribe it sort of, not exactly, but like a trial because you want to make sure that whatever you're doing is improving pain and improving function every single time you prescribe it. So when the patient comes in, you want to make sure you're reviewing those pain and function goals on a regular basis to ensure that they're still getting improvement. Obviously, you're looking into adverse effects, you're reviewing the PDMP, all of those things. For those of you who aren't familiar, these are state prescription drug monitoring programs that track, as a database, all those controlled substances that are filled within the state. And so pharmacies have to report this information to the state so that this is accessible.

All 50 states have PDMPs, Missouri's I believe, recently became functional in sometime at the end of 2023. So every state has them, so we have to make sure that we really try to use them. We want to make sure that we are reassessing need, like I said, on a regular basis. At the same time, we're monitoring also to make sure that the disease process itself, if you're looking at long-term management to make sure that you're not potentially developing what we call OIH, which is opioid induced hyperalgesia as well as potentially opioid use disorder versus a progression of the actual disease process itself. Because we can't ignore the medical factors that may be related to the pain that is ultimately being caused. We're screening for various new psychiatric and/or medical conditions and utilizing other non-pharmacologic and non-opioid therapies as well as we already discussed.

So, as we are thinking about the context in which to taper opioids, and this is a decision by the way, if you are thinking about tapering an opioid, whether it's in the acute setting or in the chronic setting, you really should be discussing this at length with the patient and making sure that you have buy-in because there is actually a lot of data unfortunately, showing that involuntary opioid tapers, particularly in patients who have been in opioids for a long time or on high doses, unfortunately the taper increases their risk of overdose, of hospitalization, and unfortunately, of suicide attempts. So you really have to be pretty confident about what you're doing, why you're doing it, and making sure that there is some support on board. If this is the plan.

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So, in the acute setting, we can taper a little bit faster because generally, a lot of these patients are going to end up being opioid naive. You can typically get patients off within a few days and usually obviously, only for acute pain, you're typically only prescribing for a few days anyway, three to five days. So the reality is that this is usually not an issue. If it is an issue, then it's time to reevaluate and see if there's something else happening. If there's resistance to that or the patient's having withdrawal symptoms, then we need to treat those things.

In the more sort of chronic opioid tolerant patient, which is really more the patient that I see, these are patients who may require tapers for months or possibly even years. There's one guy that I started tapering two years ago that I'm still working on, to be honest. He's doing okay. But in the process of tapering, what you'll actually find when you do it really slowly, and this is, you're taking away 5% each month or maybe even less depending on the situation, what you may actually find is that you may start to discover other things. You may start to discover worsening of pain situations. You may start to discover decompensating mental health. You may start to discover signs and symptoms of a substance use disorder. And it's important to make sure you're providing ongoing support as you're doing that because you are less likely to be successful if you're not insuring checking in with your patient regularly. So that's seeing them on a regular basis or at least having somebody call them from your clinic to see how they're doing and sort of what's going on.

You want to make sure that you're not just taking something away but you're offering something else. So other non-pharmacologic therapies for pain, other different medications. Multimodal analgesia, as we've already talked about, is going to be really, really important in this context.

In thinking about how we store and dispose of opioids, and we've talked about this a little bit. I think it's really, really important to make sure that these things are stored safely. And this obviously goes without saying, but keeping things locked up and particularly away from children is maybe the most important thing because you never know what little Johnny is going to do when he gets into grandma's medicine cabinet. It's really important to avoid sharing medications because you don't necessarily know what's going to happen. And there may be individuals who are using other non-medical opioids that they got from other sources and they may get mixed in with things. They get a fentanyl inside and could be lethal. It's important to keep that in mind.

The DEA and other organizations have what they call drug take-back days where they will actually take medications back without any questions asked and dispose of them appropriately. There also are other things you can buy out there, products you can get even on Amazon that are using activated charcoal or other different types of things like that that will actually disintegrate your medication for you and you won't even necessarily need to take it anywhere. But take-back programs are very useful I think, in the community.

So looking at our patient, MJ, who has already been through so many things, but here, now, he sustains a back injury because he went bowling with the son and was trying too hard for that strike and unfortunately, tweaked his back. So he's given 20 tablets of hydrocodone, 10/325 every eight hours by an urgent care. And so he decides to ask his primary care physician to continue those opioids and he gets referred to a pain specialist. The pain specialist perhaps, fortunately or unfortunately, depending on how you might view the situation, decides to initiate treatment with long-acting oxycodone, 10 milligrams every 12 hours. And I think we'll discuss this a little bit moving forward.

So what I want to do before we get into more stuff is really talk about opioid risk assessment tools, which we haven't necessarily discussed too much of, but I'm curious to see what you guys think. When do you use one? So, I use one in initiation of opioid prescriptions and periodically thereafter. I use one when patients receiving opioids are displaying concerning behaviors. I've used one inconsistently and don't have a reliable process in

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place. Rarely, this is a difficult tool to implement in my practice setting. I've never used an opioid risk assessment tool, but I'm open to using one.

All right. So here we are. We see that 42% of people are using it as initiation, 10% with inconsistent behaviors. 11% say inconsistent use, 4% say they're rarely using it and 32% say they've never used one. So hopefully, we're going to go through one here that hopefully will be helpful for you guys as you're thinking about this process. This is the one that's most commonly used and it is validated. It's called the opioid risk tool. And the reason why it's helpful is because it assesses obviously a family history of substance use disorder. There is personal history of substance use disorder. Age is important because of the brain development time frames as well as pre-adolescent sexual abuse and psychological disease. So it's a good tool. It is validated and it is helpful. It is a little bit controversial and I'm interested to hear what my colleagues have to say about their experience with the ORT.

Johnathan Goree, MD:

Yeah, I use it. I think the main thing is I use it as an assessment tool. I don't use it to make my opioid decisions or a risk tool. So I know that patients who score high, I may watch them a little more closely and by that, I may have them return to clinic more often than patients who score low. But still, I think we should be vigilant with all opioid patients.

Carrie Hyde, MD:

Yeah, I agree. We use this in my outpatient palliative care clinic and I think it's just a good awareness. It doesn't capture all of the risk as you have mentioned, and I think that's the key there. It's like everyone is at risk. And I think that I actually have had a lot of people answer no to the history of pre-adolescent sexual abuse because it's a very sensitive question. If you're doing a screening tool and that's your first question, I think it harms the relationship in some instances. So would be curious about... Most of my patients aren't forthcoming with that question and that's heavily weighted on this score and we know why. But it's an interesting observation I've made.

Johnathan Goree, MD:

Well also to add that it's weighted for women and not weighted for men, which is something to point out. And here's a name-drop. I was on a panel with Dr. Webster what? About five weeks ago, and he even says that, speaks that this tool has gotten a little too out of control. So I think we should use it as a risk tool, but we shouldn't use it to say that no patients shouldn't get opioids because they score higher.

Carrie Hyde, MD:

Yeah, I agree with you.

Sudheer Potru, DO, FASA, FASAM:

I fully agree. This is a risk stratification tool and every situation is different. So I think it's great to be vigilant based on it, but also, not necessarily deny care when you think it would actually benefit the patient. Just maybe watch them more carefully. So, the reality is that when we think about a substance use disorder, there are some people who develop them and some people who don't. Lots of people drink alcohol, lots of people use opioids,

some people even use cocaine. And many people never develop substance use disorders. So what causes it in some, but not all? We know that about genetics results in to 60% of your vulnerability to a substance use disorder. And that's a big component. So that's a first degree relative. So environment obviously plays a big role in this. We think about these people, low socioeconomic status, poor parental support, physical psychological abuse as we've discussed. And of course, mental illness plays a significant role here as well.

So in defining what we call an opioid use disorder, there are 11 criteria in the DSM-V, which is the psychiatrist's manual. And basically, all these 11 criteria go for any substance. So an opioid use disorder, alcohol use disorder, cocaine use disorder, etc. But you can break those 11 questions, I should say, down into these four categories. So you have impaired control, which means cravings or strong desire to use, failed attempts to cut down, social problems, meaning that you have failure to complete major tasks at work, school, or home, you're giving up leisure activities, things like this. Risky use would be used in a risky setting. So that would be, for instance, somebody who has ongoing liver cirrhosis, continuing to drink alcohol or the use of a dirty needle when you're injecting drugs or a used needle I should say. And potentially, tolerance and withdrawal effects as well.

So these are the criteria that basically, for opioid use disorder, you can see all 11 of them there. On the left is the actual criterion itself. On the right is in bold, some of the things that some of my patients have said to me. I tried to stop using a few times before, but I start when I do it, I start again. Persistent desire, craving. I wanted to use so badly, I couldn't think about anything else. I keep having trouble at work and I've lost the trust of friends and family, etc. So these are the situations that we encounter where these are true problems and true substance use disorders.

So when should you refer to a pain management or addiction medicine specialist? Here, we should be thinking about specific situations where these are things that are difficult for you as a clinician to handle, right? So if there are side effects that you don't know how to deal with for pain management that is, there's an interventional procedure that you feel like a pain specialist can offer and you feel uncomfortable with the situation, with a medication situation or pain situation, whatever that might be.

With an addiction medicine specialist, really what I'm looking at or thinking about is a situation where the patient needs possibly medications for treatment as well as potentially wraparound psychosocial treatment for their substance use disorder, which you may not be able to provide in a primary care or other... Even a behavioral health clinic depending on the situation. So, we'll get into those treatments specifically, exactly what that looks like, but those would be good situations to refer.

So our patient, MJ, he scores 11 on the current opioid misuse measure and the positive is greater than or equal to nine. He's run out of medications a few times and when we've tried reducing his dose, he has cravings and withdrawal symptoms. So his physician diagnoses him with opioid use disorder and gets him into a medication assisted treatment, MAT or MOUD medication for OUD treatment program. And the resolution here, the buprenorphine treatment is perfect. TBT is perfect. Peer recovery groups and/or other outpatient substance use disorder treatment is excellent. As well as the physical therapy for his underlying treatment. Do you guys have any other thoughts on this one?

Johnathan Goree, MD:

No, I'm just happy that somebody recognized the fact that he had opioid use disorder. I think that's the most important point here. I think the other point to look at with these two cases is the difference between part one and two and part three and how important it is to set expectations and discuss risk and benefits of opioids. I

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think the physician didn't have that discussion and just prescribed him opioids in an urgent care and that led him down this path to eventually develop opioid use disorder. When before, he had used non-opioid options and even used opioids and was able to titrate off probably because the physician's set expectations really helped him understand how to use them, when to use them, when to not stop using them.

Sudheer Potru, DO, FASA, FASAM:

Perfect. So there are three FDA approved medications for opioid use disorder, and I don't want to necessarily belabor this too much, but basically, they're methadone, buprenorphine and naltrexone. Methadone may be the one that you guys are most familiar with. It has to be prescribed within the context of a federally regulated opioid treatment program, which you might know better as a methadone clinic. Where somebody shows up, they get methadone physically administered to them while they're there. So it's usually a liquid, an oral methadone, and then they leave and they go to work or they go home or they go on to their daily lives. Buprenorphine, which is in its milligram dosing because buprenorphine is in both microgram and milligram dosing, in milligram dosing, we use it for treatment of opioid dependence. That's what the label says. And microgram dosing the patch or the buccal formulation, we're using it typically to treat chronic pain.

So it is safer than methadone for any number of different reasons, but it is really nice that you can prescribe it in an office-based setting and this is probably the reason why for MJ, his physician ended up giving it to him.

Naltrexone is also a good choice. It's a helpful drug. It's a mu-opioid antagonist. The unfortunate thing about it is that in order to prescribe it for somebody who has opioid use disorder, they have to be opioid-free for about seven to 10 days. The opioids have to wash out of their system to initiate it, otherwise you will almost certainly, precipitate withdrawal. In the case of buprenorphine, the old way of doing it was to induce withdrawal basically, withhold opioids and have the patient then be "induced" onto buprenorphine. Induction really just means starting, prescribing the medication and so it's a little bit less stigmatizing to some extent, to not have to have them withdraw and there are many strategies to use this now.

Many of you may be familiar with something called the X-Waiver, which is based on really, really old legislation indicating that you had to undergo a special training in order to prescribe buprenorphine for opioid use disorder because of the concern about precipitated withdrawal. Because that concern has largely gone away, to be frank, as well as the concern regarding the opioid crisis and the number of opioid overdoses we were experiencing as a nation every year, that was ultimately sunset at the end of 2022 and no longer exists. So anyone with a DEA number and license can prescribe buprenorphine for opioid use disorder as well as these other medications as well.

So, as I alluded to previously, there are non-pharmacological treatments for substance use disorders. Specifically what we're talking about is psychosocial interventions, behavioral interventions that include all the many things that you see here. And it is really, really an important portion of substance use disorder treatment because if it's not properly initiated and they're not really looking at the other things other than just taking medications, the medications will help with the physical symptoms, the cravings and withdrawal, even some of the psychological symptoms. But what these non-pharmacological treatments do, the behavioral treatments, they're really helping patients understand their triggers, understanding the things that made them use drugs in the past, teaching them to drive a different route that's not past the bar that they love going to where they met their friends to drink or not past the corner where they used to use injectable drugs with friends, different things like this. Getting rid of people from your lives, getting rid of places from your lives, all that stuff is the important part

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of relapse prevention models to make sure that patients do better and that's just one example of the many, many things that exist here.

Johnathan Goree, MD:

Dr. Potru, as you go into the next slide, I just want to say that the next part of the case is really going to answer probably like five questions in the chat. So I'm really excited to see you discuss it.

Sudheer Potru, DO, FASA, FASAM:

Let's do it. So our final portion, so unfortunately, poor Mr. MJ now is requiring a complex back surgery, decompression infusion for bad spondylosis, severe spinal stenosis and neurogenic claudication. He has opioid use disorder and he's been on buprenorphine eight milligrams three times a day. He is doing well in recovery, has not used illicit opioids, goes to regular CBT sessions, is in 12 step groups and is in a really, really great situation overall in his ongoing recovery.

Johnathan Goree, MD:

Can I throw in one question real quick before you finish?

Sudheer Potru, DO, FASA, FASAM:

Of course.

Johnathan Goree, MD:

There was a question about what dose of bup would you start on a patient like this if you were treating them for opioid use disorder?

Sudheer Potru, DO, FASA, FASAM:

So for opioid use disorder, you want to make sure that you're giving them milligram dose buprenorphine. The microgram products are not going to be sufficient because they're not going to block enough receptors to actually block those cravings and withdrawal symptoms and also to block the effects of other opioids. So, I would say typically at minimum, I'm looking at two to four milligrams for patients who I think have at least a mild to moderate opioid use disorder. Generally speaking, I'm usually landing in around the eight to 16 range with most of the patients that I see. In patients who are actively using fentanyl, sometimes you need more than that because fentanyl is a powerful opioid with very, very high affinity for the mu-opioid receptor just like buprenorphine has.

Johnathan Goree, MD:

Thank you.

Sudheer Potru, DO, FASA, FASAM:

Sure. So thinking about post-surgical pain, and we're not going to spend a ton of time on this, we know that acute post-operative pain is typically, we call it about a week out from surgery, chronic or persistent post-

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surgical pain, CPSP, which is a big topic of discussion in the anesthesia and pain circles is pain that lasts more than three to six months after surgery. And that wide range that you see there of 10 to 50% is obviously substantial. We do know that several people are at risk for persistent post-operative opioid use or new persistent opioid use depending on the term that you use. These conditions that you see here, we know that our patient has a history of remote opioid use. We know he has chronic pain. I don't know if we talked about tobacco with him. I think he might've had some tobacco problems. I wouldn't be surprised if he's developed some anxiety issues surrounding his falls and traumas and different things like this. So he's definitely at risk and obviously he has clear opioid use disorder in this situation.

So when we think about how we're looking at long-term opioid therapy, that's what LTOT is and OUD treatments for perioperative pain, we know that these patients are going to be more complicated. They're going to require multimodal analgesia. You are best served if you are, whether you're the primary care physician, if you are the surgeon, if you're the whoever, to make sure that you're doing really good multidisciplinary care here. The anesthesia team should be involved in the discussion. If the patient has opioid use disorder and is seen by an addiction practitioner, they should be involved in the discussion. The surgical team should be involved in the discussion and there should be a clear plan for what you're going to do.

Generally, routinely speaking, we want to continue medication treatment for OUD in the perioperative period with the exception of Naltrexone and most of the patients who have chronic pain and opioid use disorder hopefully are on methadone or buprenorphine, which are going to continue perioperatively and then utilize all the other non-pharmacologic techniques that we have available in addition to other opioids for the acute postoperative pain that they may experience. And I don't want to delve too deeply into this. If you guys have further questions on this at the end, we can talk about that a little bit more.

Johnathan Goree, MD:

Dr. Potru is being very modest. He was one of the authors on the paper that elucidated that plan.

Sudheer Potru, DO, FASA, FASAM:

Yeah. And I'm happy to discuss that in more detail later. So, we know that MJ here, these are perioperative considerations. He had had his back surgery, we maintained his buprenorphine perioperatively, we can do infusions in the operating room for him, if any for anesthesiologists, we would probably do a ketamine infusion and a lidocaine infusion, maybe a magnesium infusion if you were really concerned about blocking the NMDA receptor. So, IV acetaminophen and ketorolac are great options here. Potentially, there is a relatively new drug out there called suzetrigine, which is used for acute pain management and could certainly be a choice here as well.

So, we postoperatively decided to continue his buprenorphine, which is great. We use short-acting IV fentanyl for breakthrough pain, which is totally fine because fentanyl will still get to the mu-opioid receptor but will not really cause a lot of substantial euphoria because the buprenorphine is specifically blocking you from doing that. We gave him some nice adjuvant medications, pregabalin for potential neuropathic pain, spine surgery, obviously that's a good idea. Tizanidine for muscle spasms, which we see all the time after spine surgery, acetaminophen is a great choice and if your spine surgeons are okay with it, potentially ibuprofen or ketorolac, but that would be something that you would have to discuss with them because there is some old data showing

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that fusions may not set as well with anti-inflammatory. So certain spine surgeons feel some way about it versus others.

So, I'm intentionally not going to go through this slide because it's really honestly out of the scope of this talk, but keep in mind that patients who are on MOUD treatments usually do better continuing on those medications as much as possible, whether that's in the chronic setting or in the peri and post-operative settings. So do your best to continue that if possible, if you find yourself in those circumstances.

Johnathan Goree, MD:

Yeah, I just wanted to conclude before we get into questions that it's really important that we do all of this as a team. And I've played sports growing up, I particularly played football and everyone played different roles, but we all had to work together to get to the goal of getting to the touchdown or getting to the quarterback if we were on defense. And so, including all of the different members of the health team, pharmacists, physicians, nurse practitioners, nurses, even MAs and front desk staff who are often the first person that meets a patient when they walk into an office, they often set the tone for the visit and sometimes, if the MA's in a bad mood, then all the patients who come in are going to be in a bad mood.

So I really think it's important to make sure that we include everybody as a part of the team and as we go through the questions, all of you are going to be a part of our team and we're going to talk about some different topics in chronic pain for the next 10 to 12 minutes. And so, one question that I saw that I thought was rather interesting was a question that talks about patients who are either resistant to tapering or who come in and say that opioids are the only thing that works. So, can one of you talk about how you handle that and how you handle the conversations with those patients.

Sudheer Potru, DO, FASA, FASAM:

So, the way I'm framing that discussion is, so they come in and they say they've tried X, Y, Z, it's the only thing that works. It's the only thing that's helping them. They don't want to taper because they think this is the thing that's assisting them. So I'm doing two things in that context. I want to understand exactly what working for them means. I want to know what percentage of their pain is getting better. I want to know how their function is improving. I want to know if they're able to walk around the supermarket better. I want to know if they can sleep more hours. I want to know if can go back to work. I want to know specifically what that means, it's working for me. Because the reality is when they've gone through X, Y, Z, 10,000 different kinds of medical treatments for pain and none of those things are helping and the opioid is helping, you wonder if there is some component of treating physical pain as well as potentially emotional suffering.

One of the things that we didn't talk about is that a significant number of people, 51% of the opioids prescribed in the United States of America as of the year 2017, went to patients with mood disorders, meaning that they're probably treating physical pain as well as emotional suffering. It's time to look at all of those things. When the patients say that, they say this is the only thing that works. Okay, well, why didn't the other things work? It's time for us to start expanding our differential to other things.

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The Opioid REMS Advantage: Supporting Providers and Protecting Patients

Carrie Hyde, MD:

Yeah, I like that. And I think through the palliative care lens, a lot of these patients maybe felt like that was there raised an emotional connection to that medication. It was something that, they were struggling with pain. It was the one thing that maybe alleviated their pain and there's a fear of removing that without some sort of alternative plan. And so, I think saying, "I'm going to continue taking care of you," and giving them a sense of control. I think that a lot of our patients actually feel a lack of control in their medical care these days. And I like to say, "We're going to taper you. Would you like to take your long acting or your short-acting down?" It still reduces that MME by 5%, but it gives them control and the buy-in on their own plan, which you alluded to earlier, so nicely, Sudheer.

So I think that giving them control, acknowledging that I see that this probably helped you at a time. It may not be helping you any longer, but I'm going to take care of you. So those three things are some strategies I used to align with them in ways that can move the needle for the patient.

Johnathan Goree, MD:

Yeah. I would also add it's similar. There's another question about what to do when a patient refuses a referral to addiction specialists when you think that they have opioid use disorder? And I think it's just open and honesty and just say that... And I think it's being honest about what you're comfortable with, just like any relationship or relationship with... The patient physician relationship is just like any other relationship. And sometimes, you have to say, "These are my non-negotiables and this is what I feel comfortable with and this is what I don't feel comfortable with." And then leave all the cards on the table and just be... And so I think honesty is the most important thing in any relationship.

Sudheer Potru, DO, FASA, FASAM:

One other thing that I've had success with is to say something along the line of, if you don't want to prescribe something, you think it's inappropriate treatment, to say, "In my professional medical opinion, this is not indicated for you." And the reason why those words are so powerful is because it sums up all of your training. It sums up all of your experience. It sums up everything that you've done, right? Because at the end of the day, that patient is there. They might think they're there to get something, but what they're actually for is your medical opinion. And your medical opinion might differ from other people's medical opinions and that's totally fine. If they go to enough prescribers, they go to enough clinicians, eventually, someone will give them what they want. But at the end of the day, as Dr. Goree has alluded to, you have to do the thing that you feel is medically in the best interest of the patient because you have to first do no harm.

And so, if you think that you are going to do something that causes harm, you have to tell the patient, "I think the risks outweigh the benefits for this for you in this particular instance, and this is not an appropriate thing to do in my opinion." And that usually ends the discussion because once you say that, it's a medical decision, not some other feeling or you DEA-based or government-based decision, when it's a medical decision, how can they argue?

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Carrie Hyde, MD:

Yeah, I like that. And I also like to say this is part of the care plan and it has everything to do with your safety and you getting better. So, I always like to anchor too in safety because that's hard to argue with, is that I want you safe and I want you well, and this is part of the care plan. If that's not something you're interested in, then this relationship may not continue. And that's okay to say too.

Johnathan Goree, MD:

Yeah. I'm going to answer a couple of the questions and I'm going to toss out some rapid fire ones because I want to make sure we cover a few things. How do I typically handle a patient who calls saying their opioids are lost or stolen? In my office, we normally ask them to get a police report, which is often helpful. Having patients actually... If they feel like their family members are stealing their opioids and they actually make sure that that's documented and then if somebody is... And then also reminding them how to keep their opioids safe, help them make sure that they are able to articulate a plan to make sure that that doesn't happen anymore. One question for you guys. We'll make this a one word answer. Do you prescribe opioids to patients or do you routinely check for marijuana when you are prescribing opioids for patients and how do you handle it? 10 words or less.

Sudheer Potru, DO, FASA, FASAM:

Go ahead, Dr. Hyde.

Carrie Hyde, MD:

I don't care about marijuana in my population.

Sudheer Potru, DO, FASA, FASAM:

I care a lot about marijuana in my population.

Johnathan Goree, MD:

That's the difference between practicing in the VA and then practicing palliative care. I'm somewhere in the middle. I normally don't stop prescribing if someone has marijuana in a urine drug screen, but I do tell them that I don't want them to mix those medications long-term. We have a lot of questions about opioid use disorder when it comes to buprenorphine dosing and also, can you talk just a little bit quickly about how you dose and escalate buprenorphine?

Sudheer Potru, DO, FASA, FASAM:

For opioid use disorder specifically?

Johnathan Goree, MD:

Yeah, for opioid use disorder specifically.

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Sudheer Potru, DO, FASA, FASAM:

Yeah, so generally, there are a lot of ways to do this, to be honest. Like I said, within, usually... If you have a patient who has opioid use disorder, you want to get them ideally on eight to 12 milligrams of buprenorphine, almost as quick as you can within a couple of weeks, ideally. Buprenorphine is a powerful, powerful, potentially sedating opioid, so if you're going to use it, you can't just give them 12 milligrams off the bat. There's some people who do that, some ERs that do that actually. But generally speaking, I'm titrating this usually two to four milligrams a day for a few days until I get them to the point where I'm getting their cravings and withdrawal symptoms. They feel better, they feel like they're controlled, stuff like this. And you are titrating to effect, in this case, you're titrating to those cravings and withdrawal symptoms. So generally speaking, your therapeutic range is going to be between eight and 16 milligrams. Sometimes a little bit less than that, sometimes a little bit more, but that's probably the best advice I can give from a numbers' standpoint.

Johnathan Goree, MD:

Thank you. There were a couple of questions I'll answer really quickly. There was one about how do you taper 5% when patients are on lower doses? I think you do the best you can. For example, if someone's on hydrocodone five TID, then I would taper down to... Sometimes you're can have them break pills in half. I wouldn't for that. I would just bring them down to two pills, then one pill, then off, which is larger, but when you get to those lower doses, sometimes you have to be a little more inventive.

There's another question about patients showing up in the PDMP with prescriptions from another clinic. How do you interpret that without assumptions? Again, I'm just open and honest and I just tell patients, "Hey, I see you're getting opioids from Dr. so-and-so, can you tell me a little bit about that and what you got those opioids for?" And just ask the question and just be honest and don't make assumptions because sometimes, the answer can really be elucidating and sometimes somebody will say it's a dentist and I had dental work or whatever.

But I think the main thing is to make sure that when you are prescribing long-term opioids to our patients, I just tell them all, if you get opioids somewhere else for some other reason, call my office. If you have dental work or whatever, I totally understand, but call my office so that we understand, so we can discuss whether you should be on those opioids, whether you should take them, whether you should fill them, etc. There is a question about metastatic cancer history in patients who are on buprenorphine. Dr. Hyde, do you want to speak to that really quickly?

Carrie Hyde, MD:

Yeah, I think Sudheer and I can both do this. I think that buprenorphine is a great pain medication. It's really great if you have coexisting substance use disorder, but I would use it. I think it hits the right receptors in a lot of these patients and sometimes, you can use that medication for pain management and get people's pain really well controlled with that. Sudheer, I don't know if you have another thing to add?

Sudheer Potru, DO, FASA, FASAM:

Yeah. No, I think buprenorphine, it's a very, very powerful analgesic and it's gotten this bad rap because it's a partial opioid agonist so, its not being a good drug for pain. It was created as a for pain. Many people don't know that, and then eventually later on the SUD world adapted it for use in opioid use disorder, but it's a fantastic

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drug for pain. Depending on what source you read, it's 10 to 30 times the strength of morphine. It's great in a bunch of surgical models that I've seen, so I think it's a great option if you have a patient who has really, really bad cancer-related pain, particularly obviously if they have a substance use disorder.

Johnathan Goree, MD:

Yeah. I just wanted to give you guys a shout-out that a really good friend of ours with the same initials as mine just said that you guys did a great job as always, so just wanted to say hi. There are a couple of really challenging patients that were discussed in the questions. One in particular, a patient with nerve impingement who's tried a number of things. I would say oftentimes, this is showing my bias, I do a lot of neuromodulation. That may be a particular option for that patient, but I do think that continuing with the interventional pathway may be particularly helpful. We're about to go into our closing, but any closing thoughts from either of you in the last 15 seconds? Parting words? Parting pieces of advice?

Sudheer Potru, DO, FASA, FASAM:

I think just in general try to believe your patients about their pain, whatever the situation is, but at the same time, be compassionate but firm and practice medicine the way you want other people to be treated.

Johnathan Goree, MD:

Dr. Hyde?

Carrie Hyde, MD:

I'm going to say ditto to that.

Johnathan Goree, MD:

Awesome. Well, I just want to thank you all for joining us. To help you put this information into action, we have some smart goals that you may want to try into your practice as appropriate over the next three months. Here those are on the slide, and remember that you can download these slides and look at all this information and read it after the talk.

If your colleagues missed today's live programming and you want them also to take advantage of the information that was shared today, the recording will be available on the CME Outfitters Pain Management Hub, along with resources for both clinicians and patients. The Hub also offers tools to help you build your skills for creating a welcoming and inclusive environment. Again, I want to thank everyone who contributed to this program. I want to thank our funding source. I want to thank CME Outfitters, which has always been great to work with, and they put on some really quality education program, not just in the chronic pain space, but in multiple other spaces, multiple other specialties, multiple other disease processes, so, be sure to check out some of their oncoming sessions.

I'd also like to thank our panel. I think the two of you were absolutely amazing, and I agree, I learn something from both of you every time that we put on an education program. I also learned a lot from you out there, who were our learners, who asked a lot of really awesome questions, and also, many of you had comments and being the moderator, I got to read them and I didn't read out a lot of the comments because I wanted to make sure

that we focused on the questions, but I learned a lot from you and things that you do in your practices and also little tips and tricks that you shared with us, and I tried to work some of those in as we were going through the rest of this program.

So, again, I want to thank you for joining us today. Thank you for spending your evening with us. I think it was a great program. I hope all of you have a wonderful evening and be sure to remember that you can download these slides and continue to go through this content. Thank you very much.

Carrie Hyde, MD:

Thanks everyone.

Sudheer Potru, DO, FASA, FASAM:

Thanks guys.

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