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Use of Opioids in Patients with Cancer in North Carolina

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1

Disclosures

- None

UNC
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2

Learning Objectives

1. Explain factors and the current response of the opioid crisis over time
2. Identify best practices of opioid use for cancer-related pain
3. Describe alternative strategies and therapies for cancer-related pain

UNC
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3

Learning Objectives

1. Explain factors and the current response of the opioid crisis over time

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4

Prevalence of Chronic Pain in the US

- Low back pain-associated
- Diabetic neuropathy
- Shingles
- Cancer-related
- Spinal cord injury
- Causalgia and reflex sympathetic dystrophy
- HIV-associated
- Multiple sclerosis
- Phantom pain
- Poststroke
- Trigeminal neuralgia

-20% of the US population (50 million) with chronic pain
-8% with high impact pain
-Pain increases with age

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5

Chronic Pain & The Opioid Crisis

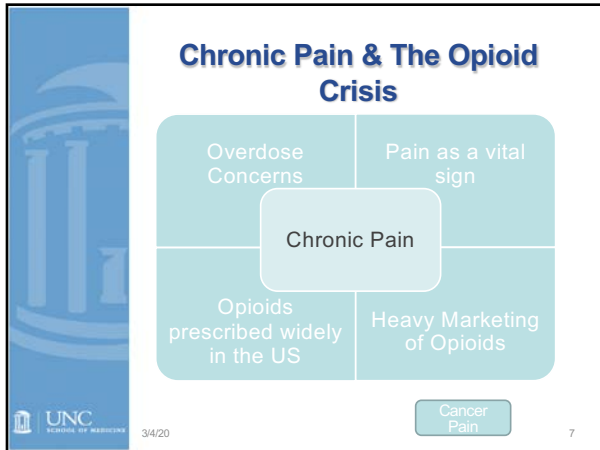
Overdose Concerns | Pain as a vital sign

Chronic Pain
Cancer Pain

Opioids prescribed widely in the US | Heavy Marketing of Opioids

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6



7

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Prevalence of Cancer-related Pain

1009 Journal of Pain and Symptom Management Vol. 12 No. 6 June 2016

Review Article

Update on Prevalence of Pain in Patients With Cancer: Systematic Review and Meta-Analysis

Martke H.J., van den Broek-van Groenou, MD, PhD, Laura M.J. Hooft-barb, MSc, Elbert A.J. Jonkers, PhD, Yvonne C.G. Tjan-Heijnen, MD, PhD, and Dain J.A. Jansen, MD, PhD
Center of Expertise for Palliative Care (M.H.J.v.d.B.-v.J., D.J.A.), Department of Anesthesiology and Pain Management (M.H.J.v.d.B.-v.J., E.A.J.), School for Public Health and Primary Care (SAPHO) (L.M.H.), Maastricht University Medical Center (UMC+), Maastricht, The Netherlands; Department of Health Services Research (L.M.H.), Maastricht University (UM), Maastricht, The Netherlands; School of Health Health and Neuroscience (M.H.J.), School for Imaging and Developmental Biology (SIB) (Y.C.G.T.-v.J.), Department of Medical Oncology (M.H.J.), Maastricht University Medical Center (UMC+), Maastricht, The Netherlands; Department of Research and Education (D.J.A.), Center of Expertise for Chronic Organ Failure (CEO+), Heer, The Netherlands

- 39% after curative treatment
- 55% during treatment
- 66.4% in advanced, metastatic, or terminal disease
- Overall, 30% with moderate to severe pain

3/4/20 8

8

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Concern about opioids?

- Risk of overdose
- Risk of abuse/misuse

3/4/20 9

9

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CDC develops new guidelines March 2016, revised

- CDC developed and published the [CDC Guideline for Prescribing Opioids for Chronic Pain](#) to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.
- MMWR: [CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- Factsheet: [Calculating Total Daily Dose of Opioids for Safer Dosage](#)
- Mobile App: [CDC Opioid Guideline](#)

3/4/20 10

10

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CDC Guideline Overview

- The CDC Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the Guideline include:
 - **Determining when to initiate or continue opioids for chronic pain**
 - » Selection of non-pharmacologic therapy, nonopioid pharmacologic therapy, opioid therapy
 - » Establishment of treatment goals
 - » Discussion of risks and benefits of therapy with patients
 - **Opioid selection, dosage, duration, follow-up, and discontinuation**
 - » Selection of immediate-release or extended-release and long-acting opioids
 - » Dosage considerations
 - » Duration of treatment
 - » Considerations for follow-up and discontinuation of opioid therapy
 - **Assessing risk and addressing harms of opioid use**
 - » Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk
 - » Review of prescription drug monitoring program (PDMP) data
 - » Use of urine drug testing
 - » Considerations for co-prescribing benzodiazepines
 - » Arrangement of treatment for opioid use disorder

3/4/20 11

11

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What happened next?

3/4/20 12

12

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Revising Perspectives around Opioids

Seeking to Clarify Its Opioid Prescribing Guidelines, CDC Joins FDA in Decrying 'Mandated or Abrupt Dose Reduction'

The CDC's advice has been widely interpreted as requiring immediate tapering of medications as it does not exceed an arbitrary threshold.

APR 11, 2019 1:10 PM



Acknowledging the suffering caused by "misinterpretations" of the opioid prescribing guidelines is published in 2019, the U.S. Centers for Disease Control and Prevention

3/4/20 13

13

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Opioids in the Cancer Setting

NIH NATIONAL CANCER INSTITUTE

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Home > News & Events > Cancer Currents Blog

The Opioid Epidemic and Cancer Pain Management: A Conversation with Dr. Judith Paice

Subscribed

JUL 14, 2019, by Neil Gupta

Pain is a common symptom in cancer patients. It can be caused by cancer, its treatments, or a combination of factors. Although some pain lasts a relatively short time and will resolve on its own, cancer or the treatments can also lead to long-lasting chronic pain. Opioid medications are an important component of managing some types of long-lasting cancer pain.

In this interview, Judith Paice, MD, PhD, director of the Cancer Pain Program at North Carolina University's Packard School of Medicine, discusses the impacts of the opioid epidemic and how providers can address concerns about opioid misuse when managing cancer pain.



First of all, what types of medications or other approaches are used to manage pain in cancer patients and survivors?

Any of the prescription opioid medications can be used for people with cancer. Non-opioid agents, including medications like acetaminophen (Tylenol) and ibuprofen (Advil or Aleve), are also used for nerve pain, and may use anticonvulsant medications like gabapentin (Neurontin or Gralise) or antidepressant-type medications like duloxetine (Cymbalta).

The opioid epidemic is affecting people with cancer and we're on opioids to help manage their pain.

3/4/20 14

14

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Effects on Patients & Providers

Patients

- Fear
 - » Poor pain control
 - » Abuse potential
- Access

Providers

- Screening
- Assessment
- Monitoring
- Documentation



3/4/20 15

15

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Management of Chronic Cancer Pain

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Management of Chronic Pain in Survivors of Adult Cancers: American Society of Clinical Oncology Clinical Practice Guideline.

Chen J, Piantadosi S, Grunberg S, et al. *J Clin Oncol*. 2019;37(12):1271-1282. doi:10.1200/JCO.2018.8234

Abstract

PURPOSE: To provide evidence-based guidance on the optimum management of chronic pain in adult cancer survivors.

DESIGN: An ASCO sponsored expert panel conducted a systematic literature search of studies investigating chronic pain management in cancer survivors. Outcomes of interest included symptom relief, pain intensity, quality of life, functional outcomes, adverse events, misuse or diversion, and risk assessment or mitigation.

RESULTS: A total of 53 studies met eligibility criteria and comprise the evidence-based basis for the recommendations. Studies tended to be heterogeneous in terms of specific sites and populations. Primary outcomes also varied across the studies, and in most cases, were not directly comparable because of different outcomes, measurement, and methods used of different time points. Because of a paucity of high-quality evidence, many recommendations are based on expert consensus.

RECOMMENDATIONS: Clinicians should screen for pain at each encounter. Recurrent disease, second malignancy, or late-onset treatment effects in any patient who reports new onset pain should be evaluated, treated, and monitored. Clinicians should determine the need for other health professionals to provide comprehensive pain management care to patients with complex needs. Systemic nonopioid analgesics and adjuvant analgesics may be prescribed to reduce chronic pain and/or to improve function. Clinicians may prescribe a trial of opioids to carefully selected patients with cancer who do not respond to more conservative management and who continue to experience distress or functional impairment. Risks of adverse effects of opioids should be assessed. Clinicians should clearly understand terminology such as tolerance, dependence, abuse, and addiction and be ready to the use of opioids and should incorporate rational practices to minimize abuse, addiction, and adverse consequences. Additional information is available at www.asco.org/clinical-practice-guidelines and www.asco.org/painmanagement.

3/4/20 16

16

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Learning Objectives

2. Identify best practices of opioid use for cancer-related pain

3/4/20 17

17

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Opioid Screening & Mitigating Risk



OPIOIDS & SCREENING

3/4/20 18

18

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Selection and Risk

MAKING DECISIONS ABOUT PATIENT SELECTION —
WHAT ABOUT RISK?

Opoid Treatment Guidelines
Clinical Guidelines for the Use of Chronic Opoid Therapy in Chronic Noncancer Pain

Recommendations
1. Patient Selection and Risk Stratification
Recommendations
1.1 Before initiating COT, clinicians should conduct a history, physical examination, and appropriate testing, including an assessment of risk of substance abuse, misuse, or addiction (strong recommendation, low-quality evidence).
1.2 Clinicians may consider a trial of COT as an option if CNCP is moderate or severe, pain is having an adverse impact on function or quality of life, and potential therapeutic benefits outweigh an increased risk of potential harms (strong recommendation, low-quality evidence).
1.3 A benefit-to-harm evaluation including a history, physical examination, and appropriate diagnostic testing, should be performed and documented before and on an ongoing basis during COT (strong recommendation, low-quality evidence).
Major patient selection in critical and requires a comprehensive benefit-to-harm evaluation that weighs the potential positive effects of opioids on pain and function against potential risks. Thorough risk assessment and stratification is appropriate in every case. This approach is justified by estimates of aberrant drug-related behaviors (see Appendix B, Opioid), drug abuse, or misuse

American Pain Society, 2009

3/4/20 19

19

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Screening and Monitoring

Prevention of Opioid Abuse in Chronic Non-Cancer Pain: An Algorithmic, Evidence Based Approach

Chronic Pain

Screening Tools

- Low Risk**
Opioid use < 80 morphine milligram equivalents (MME) per day
No history of abuse
No history of substance use disorder
No concurrent psychiatric or medical conditions
No concurrent medications that may interact with opioids
No concurrent alcohol or benzodiazepine use
No concurrent driving or operating heavy machinery
- Medium Risk**
Opioid use 80-160 MME per day
History of abuse
History of substance use disorder
History of concurrent psychiatric or medical conditions
History of concurrent medications that may interact with opioids
History of concurrent alcohol or benzodiazepine use
History of concurrent driving or operating heavy machinery
- High Risk**
Opioid use > 160 MME per day
History of abuse
History of substance use disorder
History of concurrent psychiatric or medical conditions
History of concurrent medications that may interact with opioids
History of concurrent alcohol or benzodiazepine use
History of concurrent driving or operating heavy machinery

3/4/20 20

20

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Pain Contract / Pain Treatment Agreement

- Provider name
- Patient name
- Patient signature
- Date (updated yearly)
- 1 pharmacy
- 1 prescribing physician/clinic
 - For exception, approval beforehand
 - Following emergent hospitalization, alert within 48 hours of discharge
- Update all medications including opiates with other providers
- Keep all appointments, no-show policy
- Take all medications exactly as prescribed
- Self escalations not permitted
- No early refills
- Bring all opiate medications with original prescription bottle to each clinic visit
- Will not abuse alcohol or use illicit drugs
- Agree to urine, blood or other drug screenings
- Provider may perform criminal background check and track pharmacy prescriptions
- Refill not provided if lost or stolen (police report)
- Medication not continued if lost or stolen >1x
- If arrested or incarcerated related to legal or illegal substances, medication refills will be denied
- Refills require clinic visit
- Follow recommendations regarding multimodal pain management strategies (AT, PT, exercise prescriptions, pain psychology, MH follow up)

3/4/20 21

21

Part 3 – Identifying at Risk Behavioral Aberrant behaviors



Most Common

- Preference for short acting medication
- Running out of medications early/unsanctioned dose escalations
- Obtaining pain medication from other physicians
- Borrowing pain medication from others


More Severe

- Obtaining prescription drugs from nonmedical sources (i.e. on the street)
- Concomitant abuse of related illicit drugs (marijuana or other)
- Recurrent prescription losses
- Injecting or inhaling oral formulation
- Prescription forgery

3/4/20 22

22

PSYCHOSOCIAL RISK FACTORS FOR OPIOID MISUSE – AT A GLANCE



- **Personal history of substance abuse**
- **Prior drug and/or alcohol rehabilitation**
- **History of criminal activity and/or legal problems including DUIs**
- **Regular contact with high risk people or high risk environment**
- **Problems with past employers, medical providers, family members, and friends**

- Risk-taking or thrill seeking behavior
- Heavy tobacco use
- **History of psychopathology including severe depression, suicidality, bipolar I disorder, severe anxiety, psychotic disorders, somatization, personality disorder**
- Psychosocial stressors
- Family history of substance abuse
- Poor social support

3/4/20 23

23

Opioid Screening Tools

*UNC School of Medicine
Pain Research and Treatment
Research and Practice, 17 pages
https://doi.org/10.1016/j.pain.2019.08.014*

Review Article
Assessment and Treatment of Abuse Risk in Opioid Prescribing for Chronic Pain

Robert N. Jamison, Juliana Scerrifelli, and Edward Mickus
Pain Management Center, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, Harvard Medical School and Boston Children's Hospital, 02115, USA
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*Specialty medicine provides effective treatment for numerous pain, but some physicians have concerns about adverse effects, tolerance, and addiction. Abuse of opioids is common in patients with chronic back pain and early recognition of abuse can avoid high prescription abuse, prevent or reduce harm, and improve patient outcomes. This review discusses the assessment of abuse risk in patients with chronic pain, the use of assessment tools, and the use of pain management strategies for patients with chronic back pain. High quality medical practice and addiction are essential for the effective management of chronic pain. The authors are grateful for the support, guidance, and resources of the authors' institutions. Although there is no "gold standard" for opioid abuse risk assessment, several validated measures

1. Opioid Risk Tool (ORT)
2. Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R)
3. Current Opioid Misuse Measure (COMM)

3/4/20 24

24

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Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16–45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

3/4/20 25

25

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SOAPP10-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Cutoff 18+ for high risk

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3/4/20 26

26

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Current Opioid Misuse Measure

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are uncertain how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or not being able to perform?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. In the past 30 days, how often do people around you think that you are not managing your pain? (i.e., they think that you are not taking or using your pain pills, or you are not taking or using your pain pills correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get another prescription for pain medication? (i.e., another doctor, emergency room, friends, street market)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In the past 30 days, how often have you taken more medication than you were supposed to take? (i.e., more than your doctor prescribed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the past 30 days, how often have you been worried about abusing your medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In the past 30 days, how much of your time is spent thinking about opioid medication? (e.g., how often you think about taking or using your pain pills, or how often you think about not taking or using your pain pills correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. In the past 30 days, how often have you been in an argument with people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. In the past 30 days, how often have you been worried about your medication? (i.e., how often you think about not taking or using your pain pills correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. In the past 30 days, how often have you used more medication than you were supposed to use? (i.e., more than your doctor prescribed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. In the past 30 days, how often have you had trouble with your thinking or concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3/4/20 27

Scoring:
 < 9 low adherence risk
 ≥ 9 elevated adherence risk

27

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Helpful Online Resources for Psychometrics

3/4/20 28

28

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Opioid Dependence – Opioid Use Disorder (OUD)

- F11.10 - Mild: 2–3 symptoms
- F11.20 - Moderate: 4–5 symptoms
- F11.20 - Severe: 6 or more symptoms

Specifiers

- » Early Remission: no criteria for 3-12 months#
- » Sustained Remission: no criteria for 12+ months#

1. Using more & for longer
2. Difficulty controlling/cutting down
3. Obtaining & using
4. Craving
5. Problems at work, school, home
6. Problems with people
7. Less time with functional /pleasurable activities
8. Continued in dangerous situations
9. Continued use despite MH and/or health problems
10. Tolerance
11. Withdrawal

29

29

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Opioid Contract & Behavioral Adherence Plan

Standard Opioid Agreement

Vs.

Extra behavioral goals that are considered mandatory -mitigating risk

3/4/20 30

30

Case Example 1

- **Tanya**
 - » 56 yo AA female with breast cancer
 - s/p mastectomy and currently undergoing chemotherapy
 - Pmhx + for type 2 DM
 - » Possible sources of pain
 - From cancer
 - Post surgical pain – post acute vs. chronic (nerve damage)
 - Chemotherapy
 - DM neuropathic pain

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31

Case Example 2

- **Charles**
 - » 75 yo C male with h/o oropharyngeal cancer
 - s/p surgery and radiation therapy
 - 6 years in remission
 - » Possible sources of pain
 - From surgery
 - From radiation
 - » Other symptoms or concerns?

UNC SCHOOL OF MEDICINE 3/4/20 32

32

Case Example 3

- **Dennis**
 - » 35 yo C male with metastatic breast cancer
 - diagnosed years after pain started (stage III)
 - palliative radiation therapy for metastases to his skull, spine, and mediastinum
 - chemotherapy x 7 years
 - Hospice care x 2 with PCA and port
 - Fentanyl 150 mcg/hr and dilaudid 4mg q4 hr prn
 - » Diversion potential
 - Port
 - » Intrathecal pump?

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33

Opioid Dosing

Overages at or above 50 MME/day increase risks for overdose by at least **2x** the risk at **<math><20</math> MME/day.**

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004-2009, patients who died of opioid overdose were prescribed an average of 59 MME/day, while other patients were prescribed an average of 48 MME/day.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

www.cdc.gov

3/4/20 34

34

Opioid Dose Calculator

Opioid (oral or transdermal):	mg per day**
Codone	0
Fentanyl transdermal (in mcg/hr)	0
Hydrocodone	0
Hydroxyzine	0
Morphine†	0
Morphine	0
Oxycodone	0
Oxycodone	0
Oxycodone	0
Tegaserod	0
Tramadol	0
Total	0

**NOTE: All doses expressed in mg per day, with exception of fentanyl transdermal, which is expressed in mcg per hour

<http://www.agencymeddirectors.wa.gov/Calculate/DoseCalculator.htm>

3/4/20 35

35

Opioid Dose Calculator

Hypothetical case example:
Oxycodone 5mg q6 hr, up to 4x/day = 30 mme

Opioid (oral or transdermal):	mg per day**
Codone	0
Fentanyl transdermal (in mcg/hr)	0
Hydrocodone	0
Hydroxyzine	0
Morphine†	0
Morphine	0
Oxycodone	30
Oxycodone	0
Oxycodone	0
Tegaserod	0
Tramadol	0
Total	30

**NOTE: All doses expressed in mg per day, with exception of fentanyl transdermal, which is expressed in mcg per hour

<http://www.agencymeddirectors.wa.gov/Calculate/DoseCalculator.htm>

3/4/20 36

36

Opioid Dose Calculator

Case example 3 (metastatic/palliative):
Fentanyl 150 mcg/hr + dilaudid 4mg 4x/day = 520 mme

Opioid (oral or transdermal):	mg per day**	mme
Codone		0
Fentanyl transdermal (in mcg/hr)	150	360
Hydrocodone		0
Hydromorphone	40	160
Mefenbutol		0
Morphine		0
Oxycodone		0
Oxycodone/acet		0
Tapentadol		0
Tramadol		0
Total		520

<http://www.agencymeddirectors.wa.gov/Calculate/DoseCalculator.htm>

3/4/20
37

37

Dosing Guidelines

Guideline Resources: CDC Opioid Guideline Mobile App

Prescribe with Confidence

CDC's new Opioid Overview App designed to help providers apply the recommendations of CDC's Guideline for Prescribing Opioids for Chronic Pain without practice by using the app's guideline, tool, and resources in the palm of their hand. Including chronic pain in complex, but evidence-informed practice has never been easier.

The application includes a Morphine Milligram Equivalent (MME) calculator, summaries of key recommendations and links to the full guideline, and an interactive medication monitoring feature to help providers practice effective communication skills and prescribe with confidence.

Free Download

The new CDC Opioid Guideline App is now available for free download on Google Play (3/23/20) and in the Apple Store (3/23/20).

Download **Free Download**

3/4/20
38

38

CDC Resources

Quick Reference for Prescribing Opioids for Chronic Pain
(PDF - 1.3MB)

Urine Drug Testing (UDT)
(PDF - 95KB)

Opioid Prescribing Guideline Mobile App
(PDF - 63.7KB)

Pharmacists' Brochure
Prescribing Opioids for Chronic Pain
(PDF - 1.8MB)

Pocket Guide: Tapering
Tapering Opioids for Chronic Pain
(PDF - 2.3MB)

Fact Sheet
Guideline for Prescribing Opioids for Chronic Pain: Recommendations
(PDF - 725 KB)

Checklist*
Checklist for Prescribing Opioids for Chronic Pain
(PDF - 814KB)

Nonopioid Treatments
Nonopioid Treatments for Chronic Pain (PDF - 2MB)

Assessing Benefits & Harms
Assessing Benefits and Harms of Opioid Therapy (PDF - 2MB)

3/4/20
39

39

Learning Objectives

3. Describe alternative strategies and therapies for cancer-related pain

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40

The Evolution of Behavioral Therapies

1st wave
Classical conditioning and operant learning

2nd wave
Cognitive Therapy and Cognitive Behavioral Therapy (CBT)

3rd wave
Addresses metacognition, acceptance, mindfulness, dialectics, spirituality, and personal values

Acceptance and Commitment Therapy (ACT) and Mindfulness Based Stress Reduction (MBSR)

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41

Empirically Validated Therapies
(for chronic pain, depression, anxiety disorders)

Main Approaches

1. Cognitive Behavioral Therapy (CBT)
2. Acceptance and Commitment Therapy (ACT)
3. Mindfulness Based Strategies

Also Helpful

- Dialectical Behavior Therapy – for BPD and stress reactivity
- Behavioral sleep hygiene, CBTi – for sleep
- Trauma – CPT, EMDR, Prolonged Exposure
- MAT + behavioral therapies above – OUD and SA

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42

NC Drug Addiction Resources

- North Carolina Harm Reduction Coalition (NCHRC)
 - <http://www.nchrc.org/>
- Free naloxone overdose/rescue kits
- Since the Overdose Prevention Project (OPP) started in Aug 2013 NCHRC has dispensed over **101,000** free overdose rescue kits, and **13,394** confirmed reports of life saving use of naloxone (data as of 1/20/2019)
- Main Office: Raleigh
- Secondary Office: Wilmington
- NCHRC engages in grassroots advocacy, resource development, coalition building and direct services for people impacted by drug use, sex work, overdose, immigration status, gender, STIs, HIV and hepatitis
- NCHRC also provides resources and support to the law enforcement, public health and provider communities

3/4/20 46

46

Alcohol/Drug Counsel of North Carolina

www.alcoholdrughelp.org

1-800-688-4232

- 24/7 Help Available
- Confidential Information and referral
- Referral specialists available Mon-Sat 8am-6pm
- Live crisis services available All Nights and Sunday

National Suicide Prevention Lifeline
1-800-273-8255

Levels of Care

- Outpatient services (9 hrs/week)
- Intensive outpatient treatment (9+ hrs/week)
- Partial hospitalization (psychiatric, medical & lab services)
- Clinically managed low intensity residential (Eg, halfway house (5 hrs of addiction services))
- Clinically managed medium intensity residential therapeutic rehabilitation facility (to address more severe medical, emotional, cognitive, and behavioral problems)
- Clinically managed high-intensity residential Substance Abuse Non-Medical Community Residential Treatment (24 hr recovery env)
- Medically monitored intensive inpatient surface Substance abuse medically monitored community residential treatment
- Medically managed intensive inpatient services Acute care general hospital, psychiatric hospital, psychiatric unit in an acute care hospital

3/4/20 47

47

Mental Health & Substance Abuse Referrals

- Medicaid
 - LMEs
 - MCOs
- Medicare
 - www.medicare.gov
 - Find doctors
 - Psychologist
 - Psychiatrist
 - Mental health counselor
- Private Insurance
 - Direct through insurance website or referral number
 - Psychology Today Database**
 - Find a therapist, psychiatrist, treatment facility
 - www.psychologytoday.com

3/4/20 48

48

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Referrals for Mental/Behavioral Health and Substance Abuse Treatment in North Carolina

****MEDICAID AND SELF PAY OPTIONS****

LME / MCO
These LME/MCO contacts connect patients with MH/Substance Abuse treatment facilities within their counties/region.

All Medicaid and uninsured patients must go through this route. These are also options for individuals with other insurance



Based on NC County

Cardinal Innovations Healthcare Solutions Office
Phone: 704-939-7700
Crisis Line: 800-939-5911
Counties Served: Alamance, Cabarrus, Caswell, Chatham, Davidson, Davie, Forsyth, Franklin, Granville, Halifax, Mecklenburg, Orange, Rockingham, Person, Rowan, Stanly, Stokes, Union, Vance and Warren

Alliance Behavioral Healthcare Office
Phone: 919-651-8401
Crisis Line: 800-510-9132
Counties Served: Cumberland, Durham, Johnston, Wake

<https://www.ncdhhs.gov/providers/lme-mco-directory>

49

49

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Referrals for Pain Psychology at UNC

- Ambulatory Referral to Pain Psychology
 - » Order for full evaluation with pain psychologist - Outpatient
 - Amy Goetzinger, PhD
 - Seema Palidar, PhD
 - Skye Margolies, PhD
 - » Coverage at UNC Southern Village Pain Clinic and Hillsborough outpatient
 - » Pain Psychiatrist – Dr. Rebecca Bottom
- Inpatient Medical Center Referrals
 - » To chronic pain service
 - Dr. Palidar available for behavioral health assessment and treatment Wednesday mornings only
 - Dr. Goetzinger available for OUD behavioral health assessment and treatment at UNC Hillsborough hospital on Friday mornings beginning Jan 2020

UNC Pain Management
Phone: 984-974-6688
Fax: 984-974-6793

3/4/20 50

50

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3/4/20 51

51
