NOVEMBER 29, 2018

Managing Chronic Pain and Addiction in Individuals with Serious Illness

JESSICA S. MERLIN, MD, PHD
ASSOCIATE PROFESSOR OF MEDICINE
DIVISION OF GENERAL INTERNAL MEDICINE
SECTION OF PALLIATIVE CARE AND MEDICAL ETHICS
SECTION OF TREATMENT, RESEARCH, AND EDUCATION IN ADDICTION MEDICINE
CENTER FOR RESEARCH ON HEALTHCARE

Introduction

Dr. Jessica Merlin, MD, PhD

MD, University of Pennsylvania

PhD, Health Behavior, University of Alabama at Birmingham

Fields of Practice:

- General internist
- Palliative care physician
- Infectious diseases physician
- Addiction physician
- Behavioral scientist

STREAM

Section of Treatment, Research, and Education in Addiction Medicine

Presentation Agenda

Definitions

State of the Science

Clinical Challenges

Definitions:

Chronic Pain

- > 3 months
- Common in the general population
- Can result from initial tissue injury, or not
- A chronic disease heavily influenced by biological, psychological, and social factors
- Optimal treatment is pharmacologic and non-pharmacologic, multidisciplinary

IOM, Relieving Pain in America, 2011; Interagency Pain Research Coordinating Committee, National Pain Strategy, 2016.

Definitions:

Addiction

AKA Substance Use Disorder

- Chronic, relapsing and remitting disease
- A brain disease
- Hijacking of pleasure-reward system resulting in compulsive use of:
    - Opioids
    - Alcohol
    - Stimulants
    - Marijuana
    - Multiple substances
- Treatment: medication ± psychosocial therapies

Definitions:

DSM-V Criteria for Substance Use Disorder

1. Taken in **longer amounts or over a longer period** than was intended.
2. There is a persistent desire or **unsuccessful efforts to cut down** or control use.
3. A **great deal of time** is spent in activities necessary to obtain, use, or recover from its effects.
4. **Craving**, or a strong desire or urge to use.
5. Recurrent use resulting in a **failure to fulfill major role obligations** at work, school, or home.

Definitions:

DSM-V Criteria for Substance Use Disorder

(Continued)

6. **Continued use despite having persistent or recurrent social or interpersonal problems** caused or exacerbated by the substance's effects.

7. Important social, occupational, or recreational **activities are given up** or reduced because of use.

8. Recurrent use in **situations in which it is physically hazardous.**

9. **Continued use despite knowledge of having a persistent or recurrent physical or psychological problem** that is likely to have been caused or exacerbated by the substance.

Definitions:

Serious Illness

- A health condition that carries **a high risk of mortality** AND either negatively impacts a person's **daily function or quality of life**, OR excessively **strains their caregivers**

- Examples include:
    - Cancer
    - Pulmonary disease (e.g., COPD, ILD)
    - Congestive heart failure
    - Renal failure
    - Dementia
    - Chronic liver disease
    - Vascular disease (CAD, PVD, DM)
    - ALS
    - Multimorbidity (≥ 3 chronic conditions)
    - Hip fracture, age ≥ 70

Kelley AS, Bollens-Lund E. *J Palliat Med,* 2018.

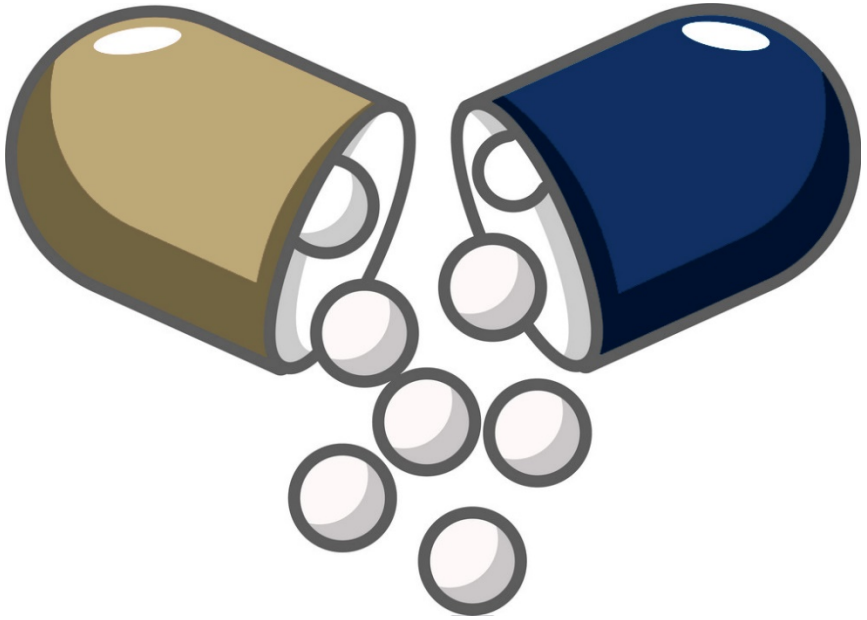
How chronic pain and addiction intersect in patients with serious illness:

- Chronic pain and addiction are common (pre-date serious illness)
- Pain and addiction often occur together
- Substances (opioids and others) can be used to treat pain
- Opioids are commonly prescribed for chronic pain (with or without serious illness)
- Pain is a common complication of serious illness
- People with serious illness are living longer
- Serious illness is a period of stress

*Excellent thought piece: Paice JA, Navigating Cancer Pain Management in the Midst of the Opioid Epidemic, Oncology, 2018.

Result:

Individuals with serious illness who have chronic pain *and* addiction.



Presentation Agenda

Definitions

State of the Science

Clinical Challenges

State of the Science:

Current Knowledge

- Focus is on patients with cancer in oncology and palliative care settings
- Most clinics do not screen patients for opioid misuse risk or substance use[1]
- When they do (in patients with cancer):
  - Elevated opioid misuse risk: 20-40%[2-4]
  - Unhealthy alcohol use: 10%[5]
  - Any substance use disorder diagnosis: 6%[6]
  - Concerning drug screen findings: 30-50% of those tested[7]
- Very little literature on management approaches

1. Tan PD et al, *J Palliat Med*, 2015. 2. Yennurajalingam S et al, *Cancer*, 2018. 3. Ma JD, *J Pain Palliat Care Pharmacother*, 2014. 4. Koyyalagunta D et al, *Pain Med*, 2013. 5. Guisti R et al, *Alcohol Alcohol*, 2018. 6. Ho P et al, *Psyhcosomatics*, 2018. 7. Rauenzahn S, *Supportive Care Cancer*, 2017. 8. Arthur JA, *Cancer*, 2016.

State of the Science:

Palliative Care

- “Palliative care … is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.”

- Therefore, individuals with serious illness who have pain and addiction often present in palliative care settings.

https://www.capc.org/about/palliative-care/

State of the Science:

Chronic pain in cancer survivors on long-term opioid therapy

- National palliative care provider survey
- Asked about cancer survivors with chronic pain NOT at end of life
- N=169, mostly physicians (83%) and nurse practitioners (15%)
- Opioid misuse/addiction:
  - Lots of time managing misuse behaviors (> 30 min/day in more than half)
  - Participants least confident in their ability to manage addiction (5/10)
  - 27% reported training/systems in place
  - 13% DEA waivered, 36% NO access to addiction specialist

Merlin JS et al, *J Pain Symptom Manage,* in press.

Given this limited evidence base, we need more research in serious illness on:

- Assessing opioid risks/harms vs. benefits
- Other analgesic approaches
- How to manage concerning behaviors, addiction
- Also need efforts in education, policy

Schenker Y, Merlin JS, Quill T. *JAMA*, 2018.

Presentation Agenda

Definitions

State of the Science

Clinical Challenges

Given this limited evidence base, we need more research in serious illness…

…What is a clinician to do?

Let’s look at some of the pressing clinical issues, and how our approach might be informed by the *general* chronic pain and addiction literatures.

Clinical Challenges:

What is the optimal treatment for chronic pain in individuals with serious illness? (with or without addiction?)

- How does a clinician decide who gets opioids and who doesn't?

- **From the chronic pain and general medical literatures:** Pharmacologic and non-pharmacologic, multidisciplinary

- **From the chronic pain and cancer literatures:** CDC, American Society of Clinical Oncology Guidelines, risk vs. benefit paradigm. Addiction is part of the risk side of the equation.

Clinical Challenges:

What about patients with "legitimate pain"/ "organic pain" / "real pain"?

- Is the distinction between "organic" and other pain a useful one?
- Does having "organic pain" mean that opioids are the best approach?
- **From the pain literature:** this terminology and distinction is disappearing. Chronic pain is not a symptom, but a disease in itself influenced by biological + psychological + social factors, regardless of the initial "pain generator".
- This means that "organic pain" ≠ opioids

Clinical Challenges:

Does the patient have pain, or do they have addiction?

- Are their behaviors indicative of untreated pain (pseudoaddiction), or addiction itself?

- **From the pain and addiction literatures:** Pain and addiction frequently coexist. Pseudoaddiction is a less than useful concept. Treat both pain and addiction together, realizing they are inextricably linked. Consider behaviors' differential diagnosis….

- We ALL must unlearn this

Clinical Challenges:

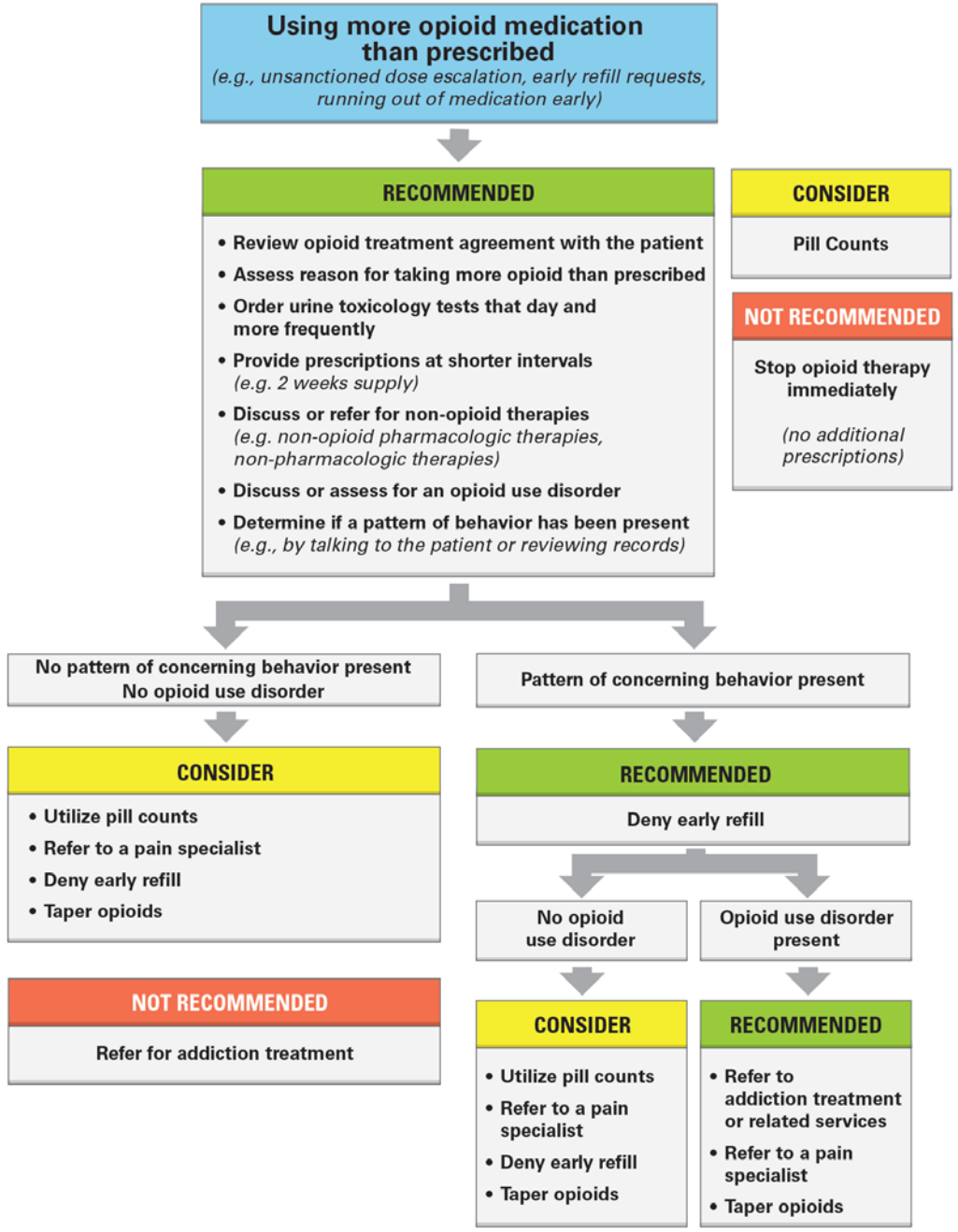
What is the best approach to management of concerning behaviors in individuals on long-term opioid therapy?

From the general medical literature:

- Missing appointments
- Taking opioids for symptoms other than pain
- Using more opioid medication than prescribed
- Asking for an increase in opioid dose
- Aggressive behavior
- Alcohol use
- Other substance use: stimulants, heroin; marijuana

Merlin JS et al, *J Gen Int Med*, 2018.

Clinical Challenges:



Merlin JS et al, *J Gen Int Med*, 2018.

Clinical Challenges:

How can you diagnose addiction in individuals on long-term opioid therapy?

From the addiction literature: some opioid misuse behaviors may fall into DSM-V categories:

DSM-V criteria	Misuse behaviors (examples)
Larger amounts/longer period	using more medication than prescribed, taking non-prescribed opioids
A lot of time spent to obtain, use, recover	ER visits, multiple prescribers, multiple pharmacies
Failure to fulfill role obligations	repeated failure to appear at appointments or other treatment recommendations
Interpersonal problems	fired by pain teams, arrests or legal issues, anger/aggression
Use in hazardous situations	MVAs
Continued use despite harm	Oversedation, overdosing, unwillingness to explore other medications despite adverse effects of opioids, falls

Young SR, Merlin JS et al, *under review*.

Clinical Challenges:

In the case

- First three hours of the day…. Can tell when it's 3pm….
- "Try to make 6 last" … "doesn't always work" … "doing the best with what I've got"
- Is this a **partially treated opioid use disorder?**
- Making the diagnosis is the first step

Clinical Challenges:

Powerful quotes from the case:

- “Sensitive issues”
- “Her history”
- When I “screw up”
- “Knowing when someone ‘screwed up’ but yet we want to take care of them”
- “Dirty urine”
- “Bad decisions” vs doing the “right thing”
- “Adversarial position”
- “Police the opioids” “be the cop”

What can we learn from this?

- **Stigma:** Stigmatizing language by patient and clinician
- **What's the diagnosis?** Naming the disease – opioid use disorder
- **It's a brain disease:** Framing opioid use disorder as good vs. bad and a choice that needs to be "policed"
- **Why does it matter?** Patient outcomes.

Clinical Challenges:

Positive and negative language

- Abuse
- Abuser, addict, alcoholic
- Drunk, junkie, IVDA
- Toxicology results: clean, dirty
- Relapse
- Binge

- Use disorder or addiction
- Person with substance use disorder
- Person who injects drugs (PWID)
- Person in recovery, drug free
- Toxicology results: positive, negative
- Return to use
- At risk, risky, hazardous use
- Unhealthy, excessive, heavy use

Slide adapted from slide by Dr. Rich Saitz.

Clinical Challenges:

How do you treat addiction in patients with pain and serious illness?

- Should this be any different than how we would treat addiction in patients:
  - With pain but without serious illness?
  - Without either comorbidity?

- **From the addiction literature:**
  - Treating addiction saves lives and reduces high-risk behaviors, improves QOL
  - Mainstays of treatment are medications (buprenorphine, methadone, naltrexone) and psychosocial treatments

Clinical Challenges:

In the case

- Methadone used to treat chronic pain
- Does the patient have an opioid use disorder? If so:
- Buprenorphine vs. methadone in patients with serious illness, pain, and addiction:
  - Efficacy for pain? Efficacy for addiction?
  - What is the safety, feasibility/acceptability, and effectiveness of office-based methadone treatment?

Clinical Challenges:

Where should addiction treatment occur?

- Addiction specialty care? Palliative care? Primary Care? Somewhere else?
- **From the addiction literature:** EVERYWHERE. There aren't enough addiction physicians to meet this need.
- **From the general medical literature:** more education of front-line clinicians on pain and addiction is needed.

Schenker Y, Merlin JS, Quill T. *JAMA*, 2018.

Clinical Challenges:

How should clinicians balance compassion with managing addiction?

- **From the addiction literature:**
  - Compassion ≠ opioids
  - Treating addiction is compassionate
  - Addiction = suffering

Clinical Challenges:

What's the harm of NOT treating addiction in patients with serious illness and pain?

- Especially in people who are at the end of life – if they want to drink, if they want to use drugs, if they want morphine, so what? Why stop them?
- **From the addiction literature:** addiction isn't pleasurable. It is a compulsion, with negative consequences.

Clinical Challenges:

"Why Bother?"

Table 1

Deleterious Impact of Addictions for Cases 1 and 2

Increased patient suffering
Increased stress and frustration for family members and caregivers
Masking of symptoms important to the patient's care
Family concern over misuse of medication
Reluctance by providers to provide adequate pain medications[a]
Poor patient compliance with medical regimen
Decreased quality of life

[a]Applies only to Case 1.

Passik S, *J Pain Symptom Manage*, 2000.

Clinical Challenges:

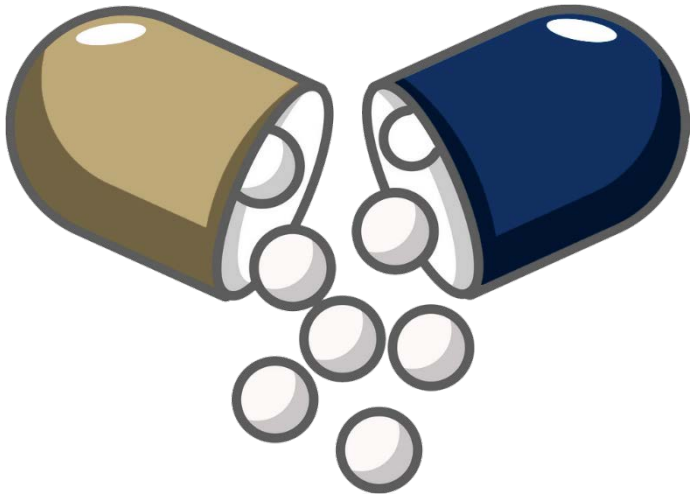
"Why Bother?"

(Continued)

"Why bother to assess and attempt to manage addiction in cancer patients? Those of us in psycho-oncology and palliative care have among our missions the limiting of suffering and the facilitation of adjustment to life with cancer.... Ignoring or being passive or fatalistic about drug use[sic] does not improve quality of life and runs contrary to our goals of care."

Passik S, *J Pain Symptom Manage*, 2000.

To sum it up…



- Managing chronic pain and addiction in individuals with serious illness is challenging, however:
- It is also IMPORTANT (and highly rewarding)
- We are here today because we are thought leaders in these issues
- Who better than us to find a way forward and improve care for these patients?