Addiction in the Chronic Pain Patient:

Opportunities and pitfalls

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TPS Annual Meeting

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Michael Sprintz, D.O.

Dr. Sprintz has passionately committed himself to helping those patients suffering from chronic pain, addiction, or both. He is the founder of Sprintz Center for Pain and Dependency, an integrative chronic pain management practice focused on treating all aspects of a patient's pain experience, including opioid dependency.

Understanding the core issues surrounding both chronic pain and addiction, Dr. Sprintz built his practice model to ensure appropriate pain treatments remained available to appropriate patients, while offering help to those patients stuck in the quagmire of opioid dependency with or without chronic pain.

Dr. Sprintz received his Medical Degree from Midwestern University-Chicago College of Osteopathic Medicine and went on to a residency in Anesthesiology at Johns Hopkins Hospital and University of South Florida. Dr. Sprintz completed a Pain Medicine Fellowship at MD Anderson Cancer Center and is triple-board-certified in Anesthesiology, Addiction Medicine, and Pain Medicine.

Dr. Sprintz is also a consultant to the FDA's Analgesic and Anesthetic Drug Products Advisory Committee and was Past-President of the Texas Society of Addiction Medicine.

Dr. Sprintz is the founder of the healthcare software company, Cellarian Health.

Disclosures

- Cellarian Health, LLC
  - Founder/CEO
- Endo Pharmaceuticals
  - Chronic Pain Advisory Board
- Daiichi Sankyo
  - Consultant

Objectives

- Discuss issues impacting Texas pain management physicians, including addiction
- Illustrate the complex nature between pain and substance use disorders
- Discuss tools and techniques that can assist with managing pain, while also addressing co-occurring substance use disorders

THERE IS NO SIMPLE ANSWER

The Opioid Abuse Epidemic

- People are dying
  - Over 28,000 deaths in 2014[1]
  - >170 overdoses in 6 days in Cincinnati alone last month[2]
- Patients with untreated substance use disorders are very expense
  - Cost of nonmedical use of prescription opioids in US **> $72 Billion** annually[3]
  - 8x higher direct healthcare costs vs non-addict[4]
  - SUD-related diseases and accidents
  - Worsening of other chronic conditions

1) https://www.cdc.gov/drugoverdose/ 2) http://www.foxnews.com/us/2016/08/29/unprecedented-overdose-spike-in-cincinnati-seems-to-be-leveling-off.html 3) Ryan N. Hansen, PharmD, Gerry Oster, PhD, John Edelsberg, MD, George E. Woody, MD, and Sean D. Sullivan, PhD. "*Economic Costs of Nonmedical Use of Prescription Opioids*" **(***Clin J Pain* ***2011;27:194–202)*** 4) Source: ASTHO (Association of State and Territorial Health Officials). Prescription Drug Overdose: State Health Agencies Respond, 2008

Untreated Opioid Addiction is Costly

- **Mean excess annual cost per Florida privately insured patient over non-addict**

  - **$20,546**

- **Mean excess annual cost per Florida Medicaid patient over non-addict**

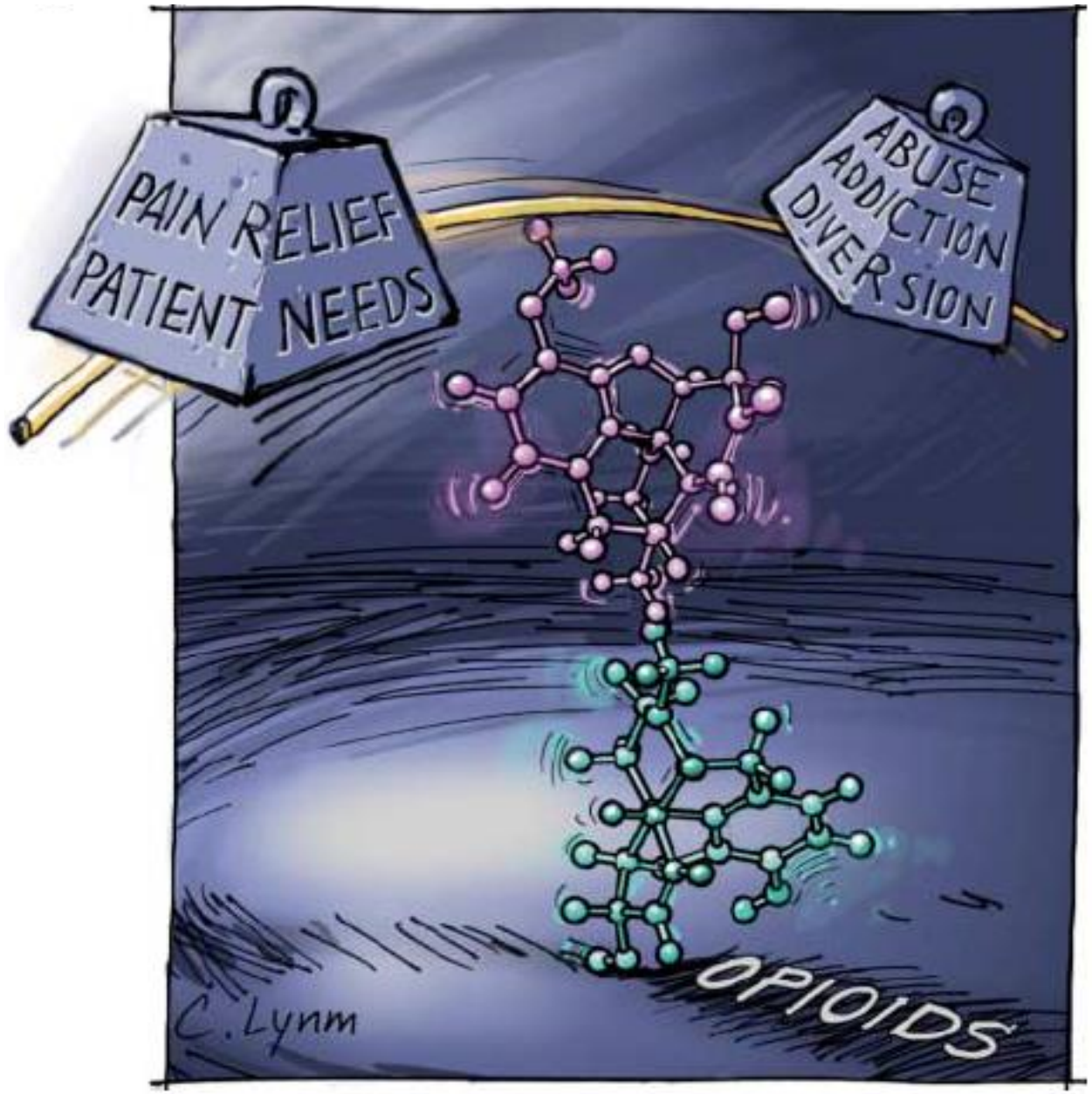
  - **$15,183**

Alan G. White, PhD; Howard G. Birnbaum, PhD; Matt Schiller, BA; Tracy Waldman, BA; Jody M. Cleveland, MS; and Carl L. Roland, PharmD. *Economic Impact of Opioid Abuse, Dependence, and Misuse.* Am J Pharm Benefits. 2011;3(4):e59-e70

The Opioid Abuse Epidemic

- Unintended Consequences
  - Reactionary legislation
  - Many patients with legitimate medical need for opioids unable to get medication
    - Unnecessary acute opioid withdrawal
    - Forced to buy pills or illicit drugs on street
      - Increased risk for overdose or inadvertent ingestion of unknown or illicit substances
    - Increased healthcare costs- ER visits;

- <u>Left untreated, everyone loses</u>


PAIN RELIEF
PATIENT NEEDS
ABUSE
ADDICTION
DIVERSION
OPIOIDS
C. Lynm

Eliminating Opioids is NOT the Solution

- **Opioids play an important role** in acute and chronic pain management
  - Need to be available for patients with legitimate medical need
  - Need to be prescribed by healthcare providers that understand how to manage the entire continuum of chronic pain and recovery, including chemical copers and progressive addictive disease

- **Addiction is in the brain**, not the drug
  - Other drugs (especially in combination) are also problematic
    - Benzodiazepines (Xanax®, Valium ®, etc.); sedative-hypnotics (Ambien ®)
    - CNS Stimulants for "ADHD" (Adderall ®, Ritalin ®, amphetamine)
    - Barbiturates and Carisoprodol (Soma®)
    - Alcohol
    - Marijuana

Step Outside Your Comfort Zone

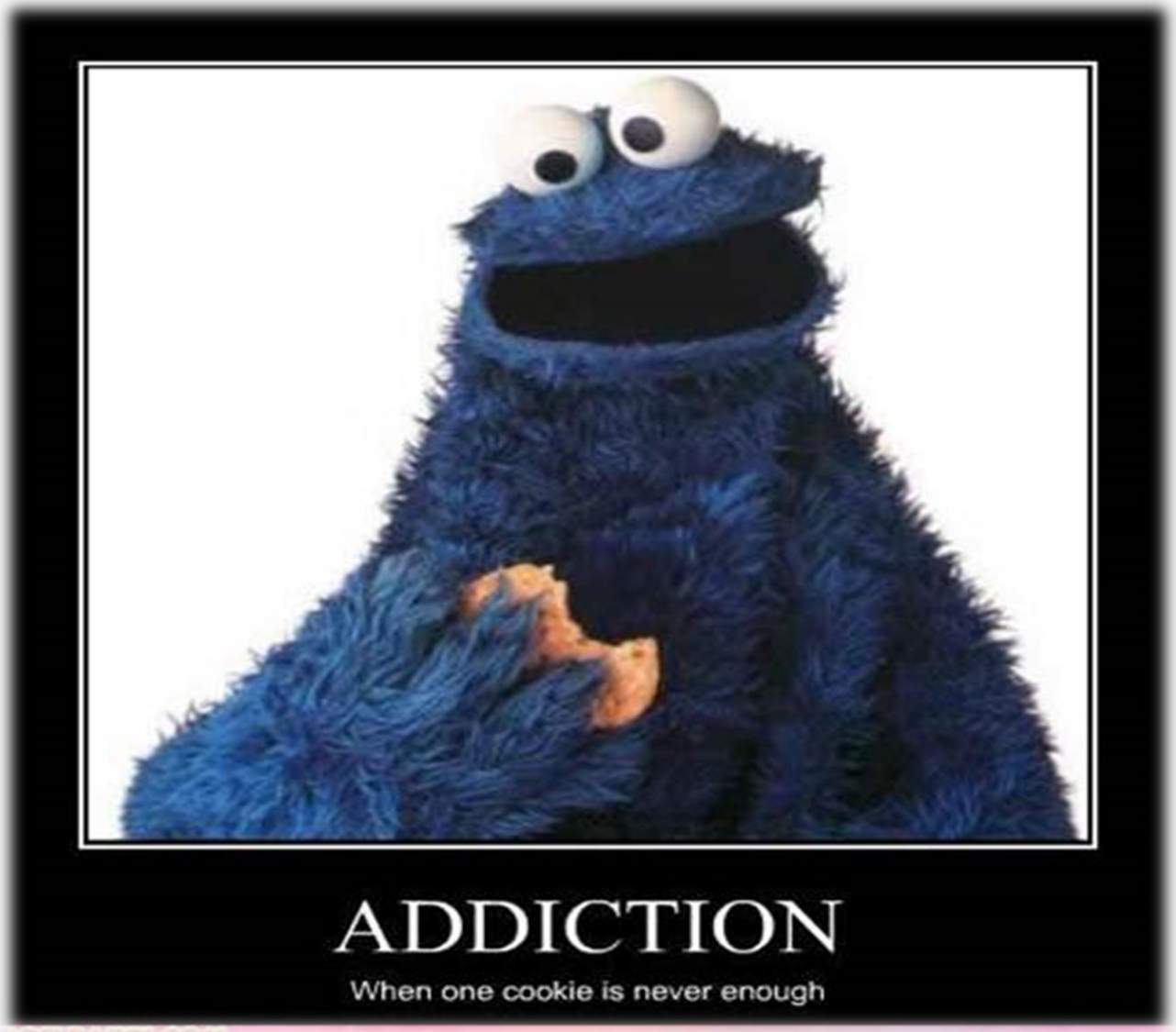
- Learn to identify and treat (or refer) patients with possible Substance Use Disorders (SUD) or chemical copers
- Adopt an integrative approach to pain management

- ***Discharging patients without any referral or guidance doesn't help the patient, doesn't help the doctor, and doesn't help society***

This Talk Assumes Addictive Disease Is Present

…but also consider chemical copers and medium-risk patients as well

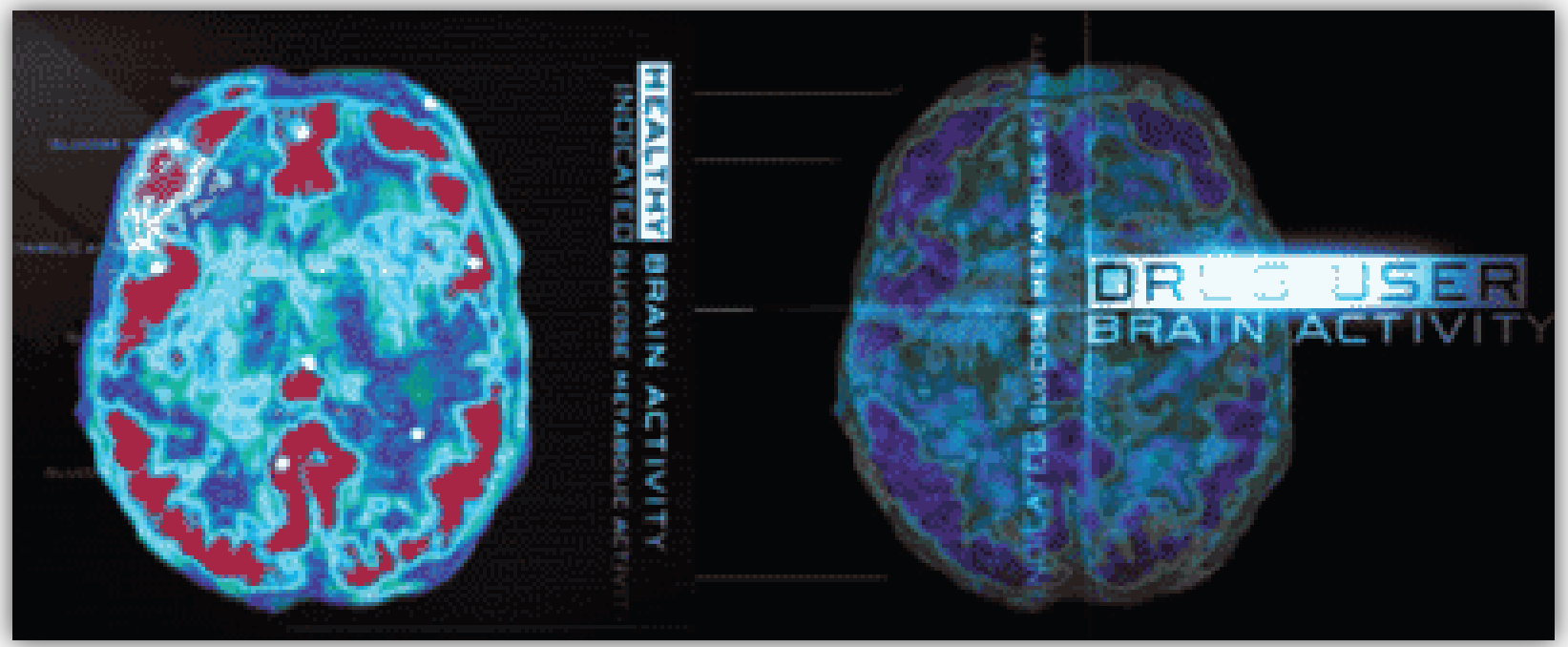
WHAT IS ADDICTION?


ADDICTION
When one cookie is never enough

Addiction is **NOT**:

- A moral deficiency
- Lack of willpower
- Only a disease afflicting the poor

Addiction is a Brain Disease



http://www.nida.nih.gov/scienceofaddiction/index.html

- A primary, chronic disease of brain reward, motivation, memory and related circuitry.
- **Dysfunction in these circuits** leads to characteristic biological, psychological, social and spiritual manifestations
  - Pathological pursuit of reward and/or relief by substance use and other behaviors

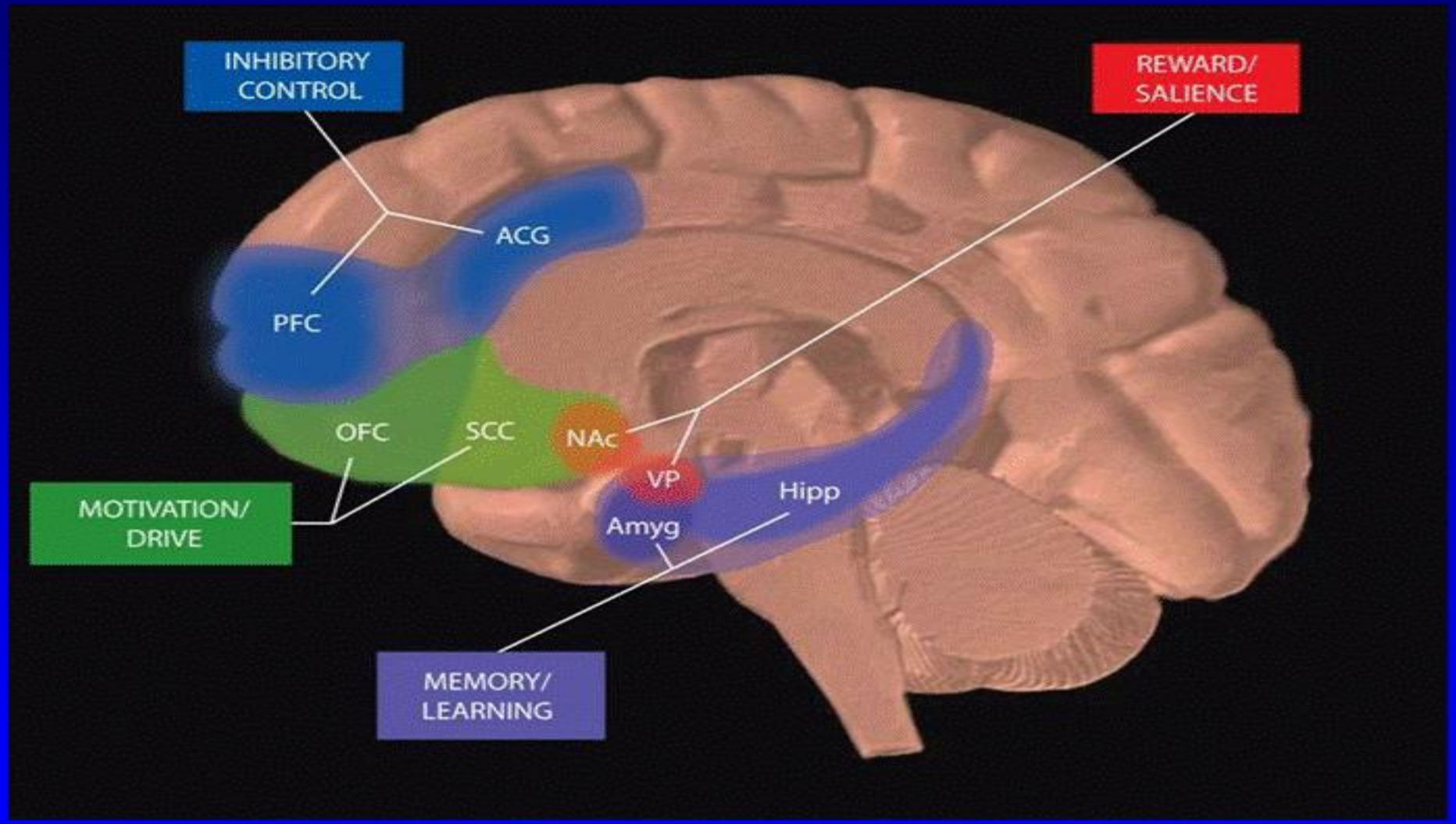
http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/the-definition-of-addiction

Addiction is characterized by 4 C's

- Impaired **C**ontrol;
- **Craving**
- **C**ompulsive use
- **C**ontinued use despite adverse consequences

- Denial
- Dysfunctional emotional response.

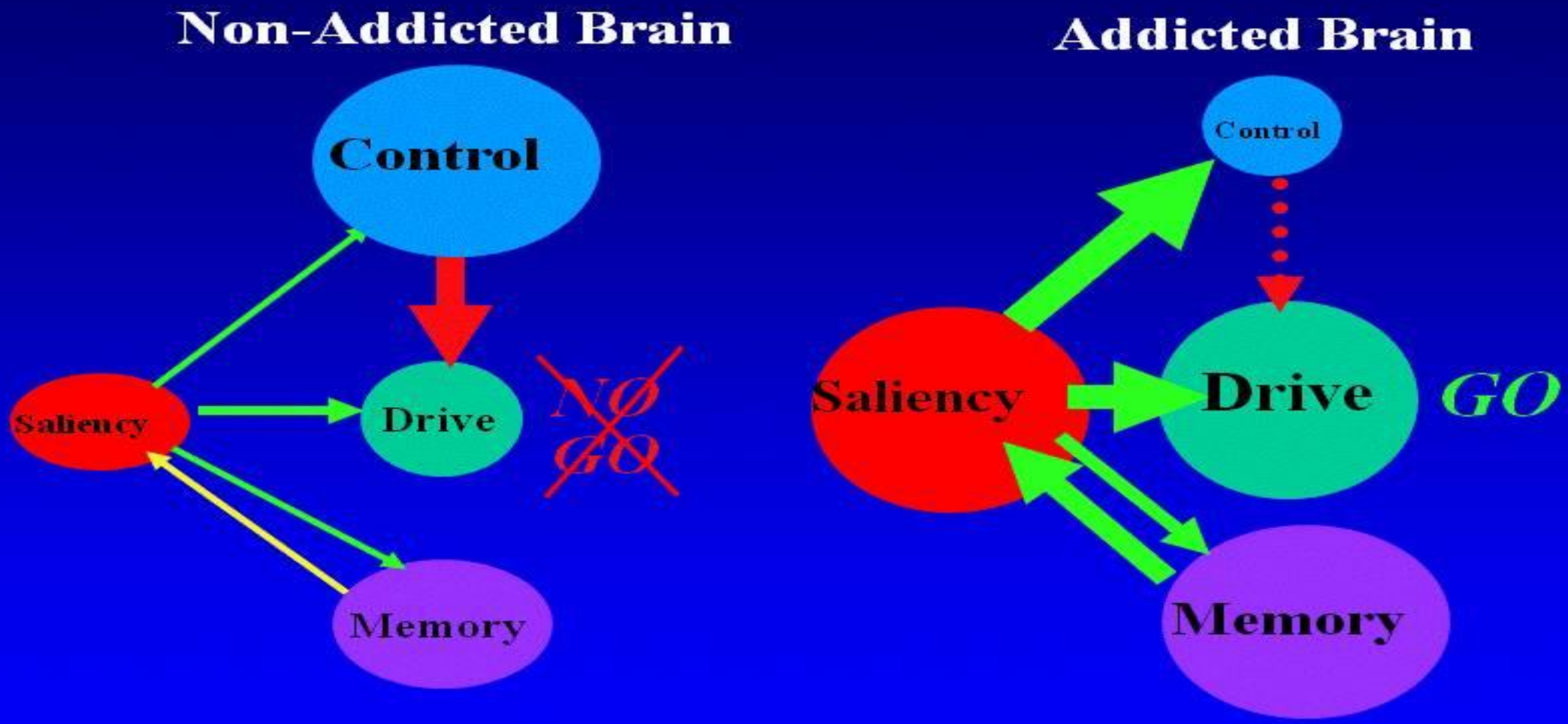
Circuits Involved In Drug Abuse and Addiction



All of these brain regions must be considered in developing strategies to effectively treat addiction

NIDA

Why Can't Addicts Just Quit?



Because Addiction Changes Brain Circuits

Adapted from Volkow et al., Neuropharmacology, 2004.

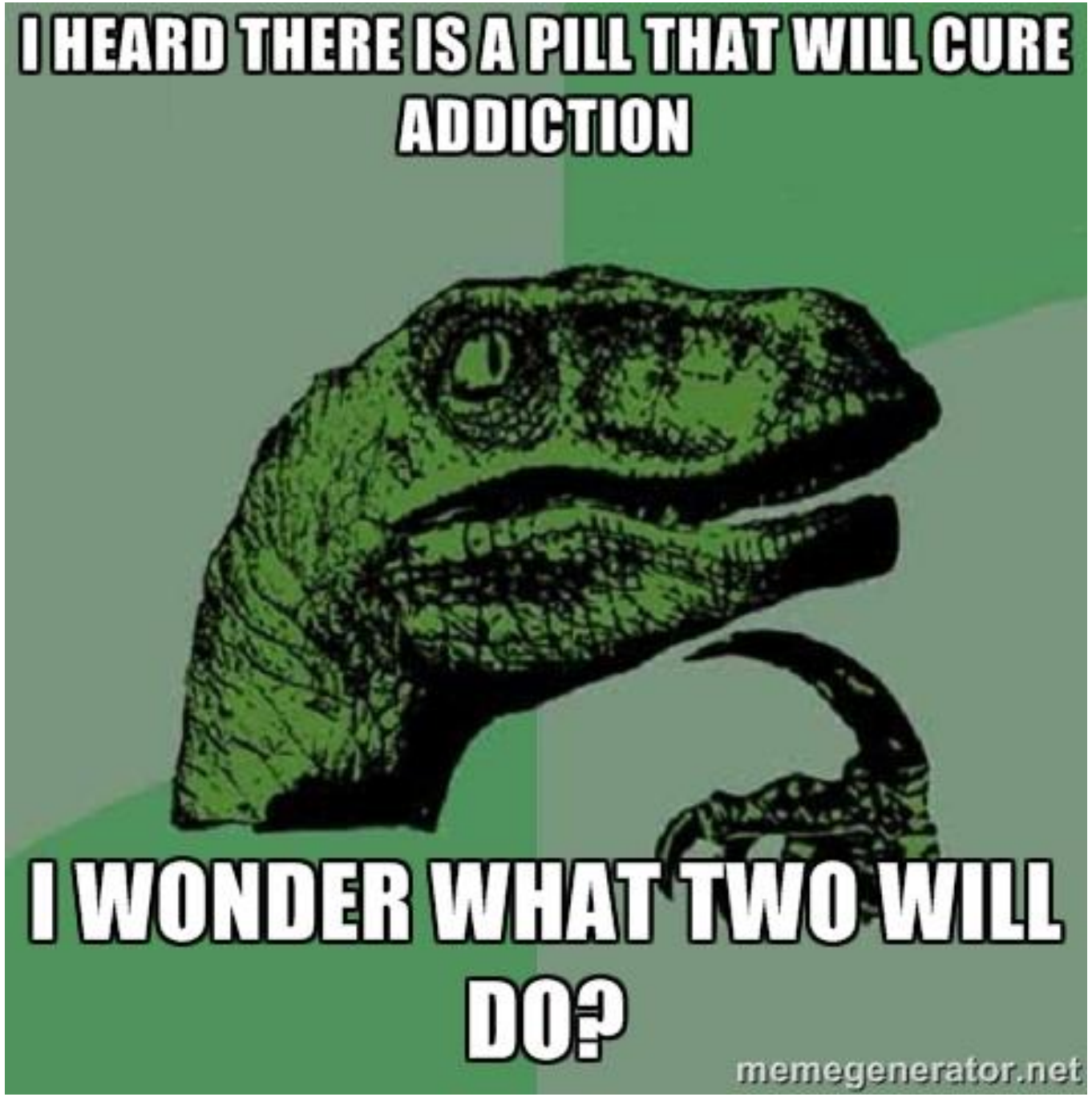
NIDA

Confirmed in Animal Studies…

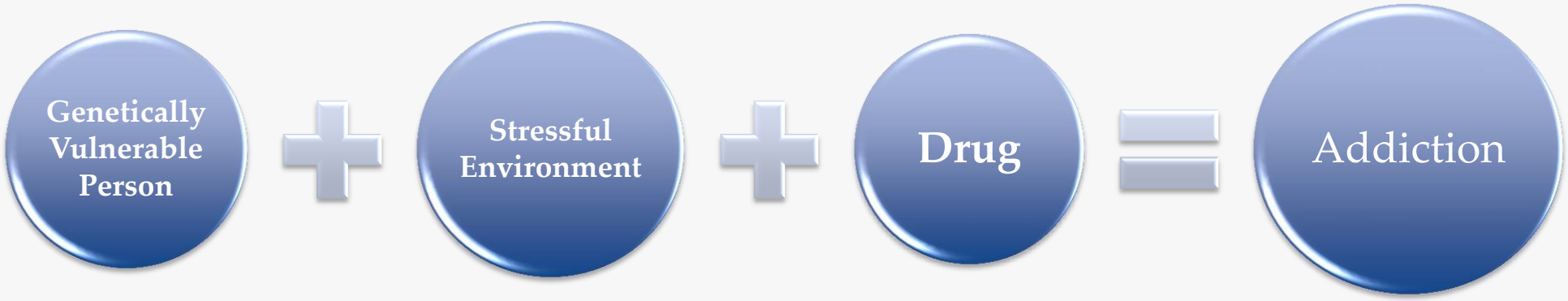

Internet
Food
Shopping
Addiction
Gambling
Work
Sex


DEALER


SEX


I HEARD THERE IS A PILL THAT WILL CURE ADDICTION
I WONDER WHAT TWO WILL DO?
memegenerator.net

How to Develop Addiction



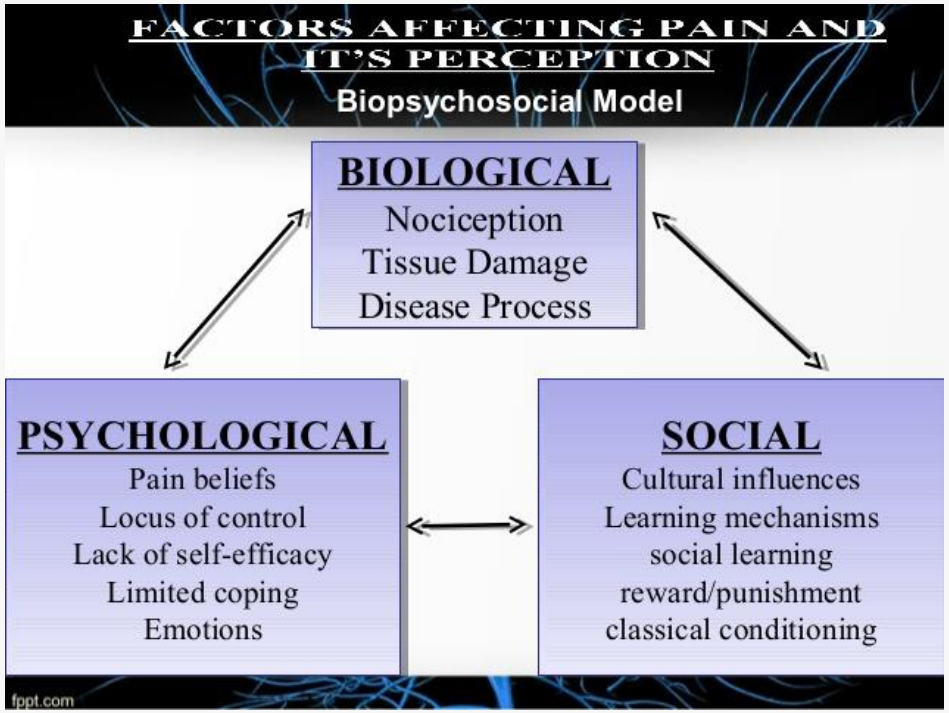
Chemical Co-Dependents

- Chronic pain patients who occasionally use their medication in non-prescribed ways to cope with stress
  - Depression, anxiety, PTSD, other life stressors
  - Overly focused on obtaining drugs for pain
  - Inflexibility about non-drug components of care

Passik, Steve and Kirsch, Kenneth. "Chemical Coping: The Clinical Middle Ground." Clinical Management of Pain in Chemical Dependency. Pg 299-300

Biopsychosocial Model and Pain

http://www.healthy-back-and-neck.com/images/bps2.jpg



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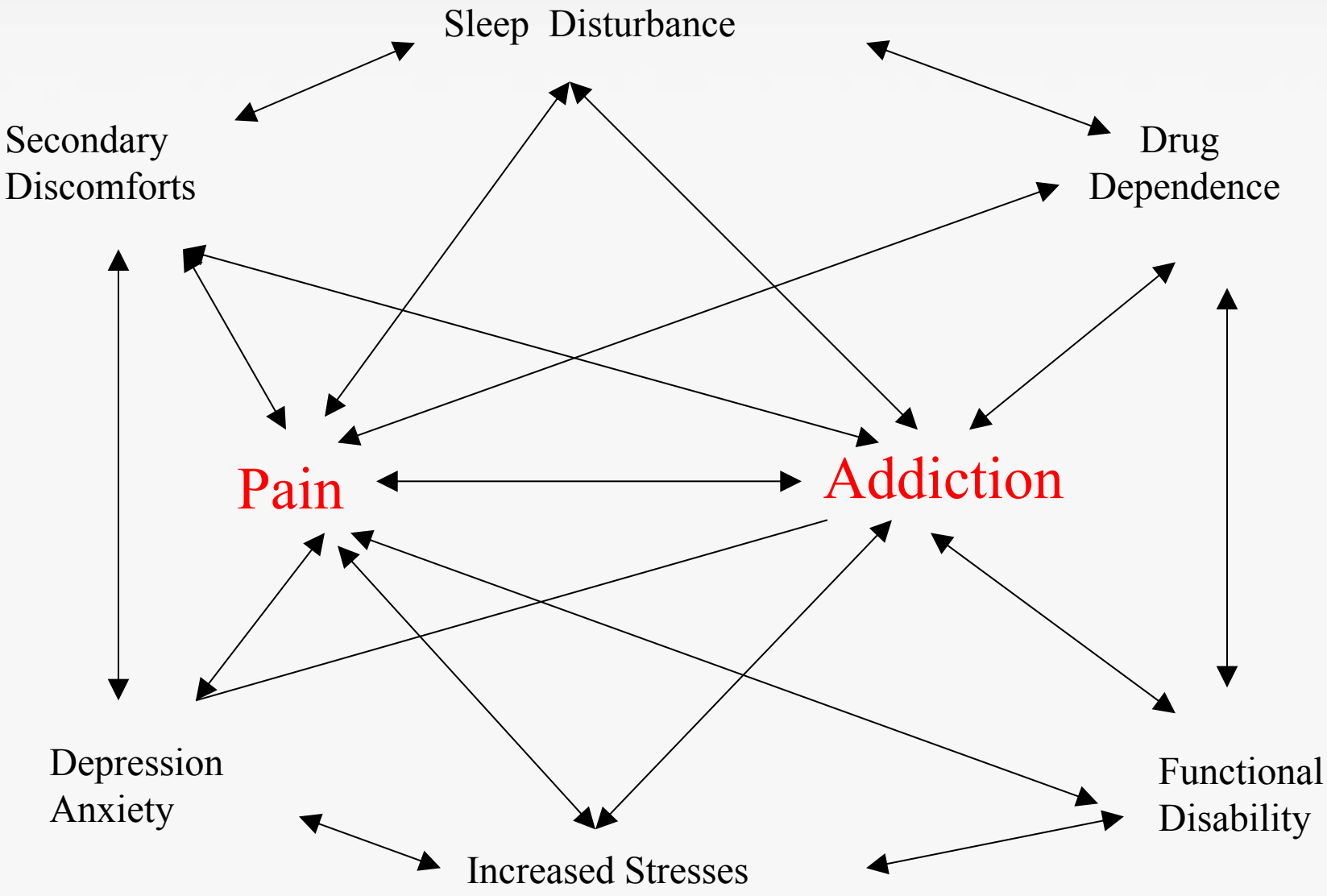
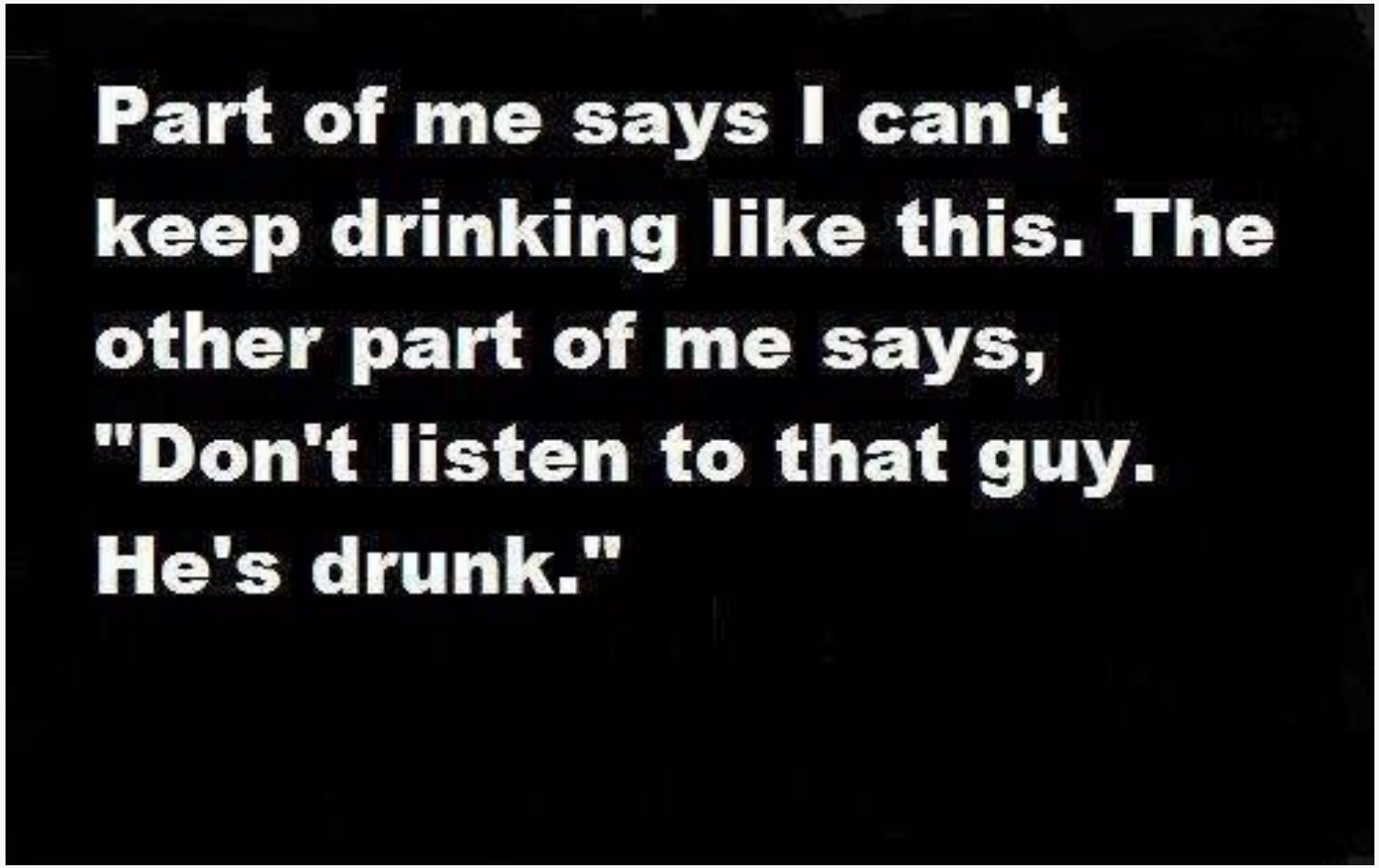
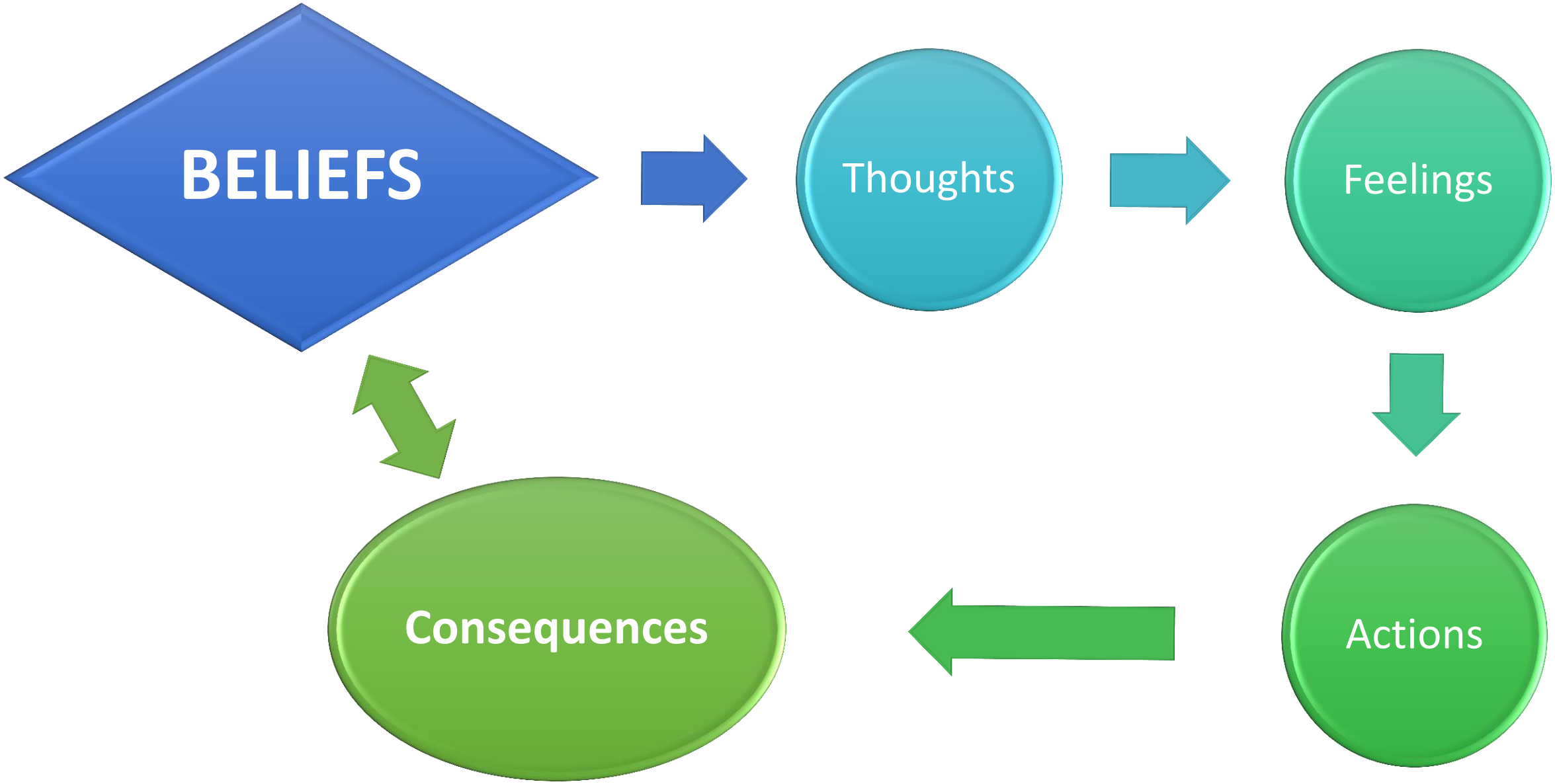


Savage, S. Pain and Addiction, Common Threads VI at ASAM Med Sci Conf. 2005

Beliefs


Part of me says I can't keep drinking like this. The other part of me says, "Don't listen to that guy. He's drunk."

Beliefs Create Reality


BELIEFS
Thoughts
Feelings
Actions
Consequences

http://media.carbonated.tv/124602_story__FutureBabe.jpg

Multidisciplinary Care is Essential for Success

- Mange addiction risk
- Identify problems early
- Treat the pain
  - The pain experience is multi-faceted
  - Optimal treatment should be multi-modal

Remember,

- if you only treat the pain, the addiction gets worse
- If you only treat addiction, the pain gets worse
- **YOU MUST ADDRESS BOTH**

Tools And Techniques To Identify Possible SUD

- Urine drug screens
- Prescription Drug Monitoring Programs
- Psychological assessment and testing
  - Many validated risk-assessment tools for addiction
    - Not just opioids
  - Rule out/ID other co-occurring psych disorders

Techniques To Identify Possible SUD

- Spend time with patient
  - First visit
  - Subsequent visits
  - Talk with family
- Communication with other healthcare providers
  - (Yes…talk with each other!!!!)

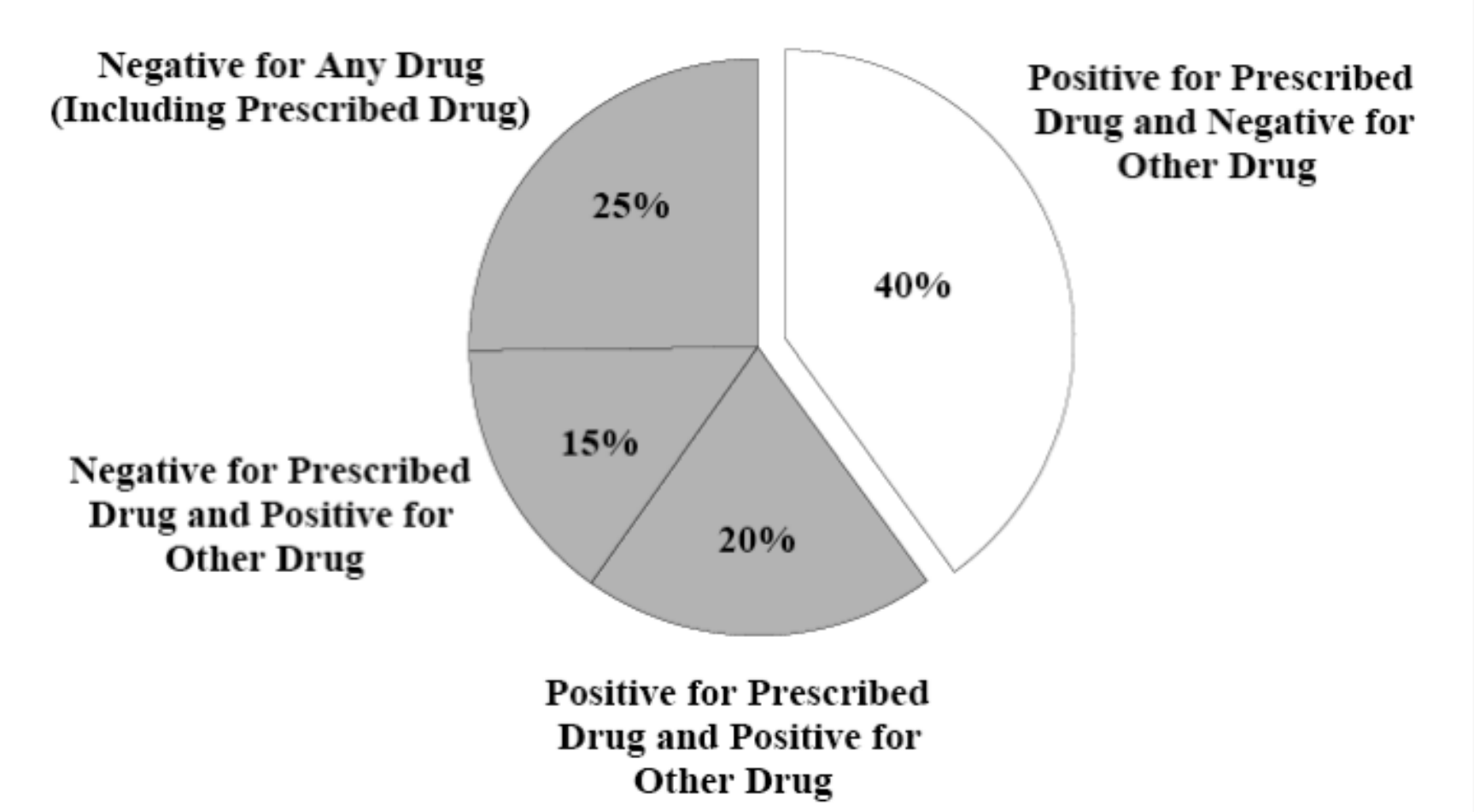
Most Physicians Can Intuitively Tell Which Patient Is Abusing Or Diverting Drugs.

A. True

B. False

C. I don't know

Clinical "Hunch" Is Often Wrong



Percentage of Patients Referred to Quest Diagnostics Laboratories for Drug Testing by Their Physicians Testing Positive and Negative for Drugs Prescribed for Them, 2012

Center for Substance Abuse Research. (2013, June 3). Lab test results suggest majority of patients do not take prescription drugs as prescribed. *CESAR Fax, 22*(22).

Clinical Drug Testing Saves Lives

…But you MUST know how to use it

The Importance of Clinical Drug Testing

- A valuable tool to use as part of a comprehensive evaluation of patients
  - Improve diagnosis
  - Improve treatment
  - Improve outcomes
- Save billions in healthcare costs
- Improve public health
- Save YOU time, money, and your license

Drug testing is done ***for*** the patient,
not ***to*** the patient

-Gourlay and Heit 2013

Prescription Drug Monitoring Program (PMP's or PDMP's)

- State-run programs that collect prescription data on dispensed controlled substances
- Operational in 49 states in US and 2 in Canada
- Vital tool for prescribers, healthcare systems, pharmacies, law enforcement, and third-party payers to prevent prescription drug abuse and diversion
  - Great potential, poor utilization

The Beauty of PMPs

- They *can* help providers identify patients with possible addiction and get them help early
- They *can* empower pharmacists to draw boundaries
- They *can* open a dialogue with your patient
- They *can* open a dialogue with your colleague
- They *complement* drug testing to better care for your patients

The Current PMP "Solution" Doesn't Fit Well into Clinical Practice

- Time consuming
- No analytics
- No clinical guidance
- ***Laws in >30 states mandating*** either enrollment or its use

The Good News….

- There are software solutions from third party vendors that deliver PMP data in an intuitive format that fits into the clinical workflow
  - Enables more informed clinical decisions before prescribing or dispensing
  - Decreases risk of inappropriate prescribing/dispensing
  - Improves compliance and confidence when prescribing opioids to appropriate patients

= BETTER PATIENT CARE

Management


I HAVE NO IDEA
WHATS GOING ON
memegenerator.net

Goals for Treatment

- Reduce impact of pain (suffering) on daily life
- Identify and address beliefs that keep patient stuck
- Learn skills for coping better with pain
- Improve physical and emotional coping
- Reduce pain and reliance on pain medication
- ***Minimize risk for addiction or relapse***

Be Honest with Yourself

...It's ok.

An Integrative Approach To Managing Pain

- Treat the whole patient
- Identify psychological issues/BELIEFS hindering recovery
  - Not just addictive disease- think chemical copers
    - Depression
    - Anxiety
    - Dysfunctional social structure
- Treat the pain
  - The pain experience is multi-faceted
  - Optimal treatment should be multi-modal

Assess For Appropriateness Of Opioid Therapy

- RISK vs BENEFITS
- Diagnose underlying addictive disease
  - Gastric bypass, etc.
- Just because your patient has a history or is at risk for SUD does not mean they should suffer
- High-risk patients-
  - Structure and accountability

Management-Cheat Sheet

- Learn your patient's beliefs
- Define treatment goals
- Foster realistic expectations
- Communicate with other providers
- Engage family and support network
- Multi-modal therapeutic interventions

Sprintz Center for Pain and Dependency

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The Woodlands, TX

CDC Opioid Prescribing Guidelines

1. Opioids not first-line therapy
2. Establish goals for pain and function
3. Discuss risks and benefits
4. Use IR opioids
5. Use lowest effective dose
   - Problems with using MME
6. Short duration for acute pain
7. Assess risk/benefits frequently
8. Use strategies to mitigate risk
   - Hx of SUD
   - No benzos
   - Naloxone
   - Low dose opioids
9. Review PDMP data
10. Urine drug testing
11. No benzos
12. Refer for tx of Opioid Use Disorder