Thinking about risk, and Buprenorphine for Pain: a Discussion

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ECHO

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Objectives

- Assess patients on opioids for pain for various kinds of risks
- Consider the use of buprenorphine to mitigate those risks
- Understand the process of tapering in patients who take opioids chronically for pain
- Understand the relationship between high risk opioid use and opioid use disorder

Case

- 68-year-old male, establishing care
- Chronic knee pain from osteoarthritis
- Chronic back pain from DJD, no surgeries
- PMHx: PTSD, MDD, HTN, COPD, tobacco (40 pack years), alcohol use disorder in remission 15 years
- Opioids:
  - MS Contin 30mg BID and oxycodone 5mg QID (MME 80-90)
  - 14 years slowly escalating dose on these meds
- Other meds:
  - Duloxetine, cyclobenzaprine, propranolol, lisinopril, lorazepam, inhalers

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Case Continued

- No PT in past 3 years, sedentary
- Does not see a psychologist
- Hospitalization last year for fall, femur fracture
- No UDS x 3 years
- UDS today: Opiates, oxycodone, benzos
- PMP - Several slightly early refills (3-5 days); 4 short rxs from dentist or ED/UC in past year
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Case Continued, patient reports

- The episodes of extra medication use are purposeful for pain flares, not impulsive or in reaction to cravings
- Other than during a pain flare opioids do not occupy his time
- He reports no medical or social consequences of being on opioids. (do you detect any from the case?)
- He reports meaningful activities ongoing in life
- No past quit attempts no desire to quit
- He believes he benefits from her meds and does not want to discontinue or change them

He has back DJD and knee OA. He is on 90 MME daily. By today's standard of care, does he have an indication to be on 90 MME opioid daily?

A. yes

B. No

C. Insufficient information to determine

What comorbidity worries you the most about this patient being on opioids (and benzos)?

A. History of alcohol use disorder in remission

B. PTSD and MDD - not in talk therapy

C. Falls - not in physical therapy

D. COPD – on inhalers

Thinking about opioid risk, we often focus on addiction and overdose.

How should we think about opioid risk in general?

68-year-old man on chronic high dose opioids plus benzos for a poor indication with substantial medical risks. Would you recommend to this patient switching to buprenorphine?

A. yes

B. No

If you said yes, why is buprenorphine a better fit for this patient?

If you said no, what doubts do you have that buprenorphine is better for this patient?

If you did switch this patient to buprenorphine, what is the most compelling reason to switch?

A. Improved ease of tapering

B. Improved pain control

C. Improved safety profile

D. Decrease likelihood of future opioid use disorder

E. Treatment of his current opioid use disorder

Discuss: Does buprenorphine provide better analgesic benefits than other opioids for chronic pain

(or more importantly, which chronic pain patients get better analgesic benefits from buprenorphine than from other opioids?)

Is buprenorphine less risky than full agonist opioids for chronic pain?

Which risks are improved?

Does buprenorphine improve tapering outcomes?

Which outcome?

If this patient were started on buprenorphine what would be the indication for it?

A. Chronic pain syndrome

B. Physiologic opioid dependence

C. Subclinical opioid use disorder

D. Pseudoaddiction

E. Moderate Opioid Use Disorder

How do we deal with diagnostic uncertainty when assessing for OUD?

- Is there “borderline OUD”?
- Is there pseudoaddiction?
- Is OUD on a spectrum?
- What do you do when patients are not candid during the diagnostic interview?
- What if you suspect OUD but cannot confirm it by interview?

If you started this patient on buprenorphine, what formulation would you use?

A. Buprenorphine/Naloxone films (Suboxone)

B. Buprenorphine monoproduct tablets (Subutex)

C. Buprenorphine patch (Butrans)

D. Buprenorphine sublingual film (Belbuca)

E. Injectable monthly buprenorphine (Sublocade)

Who should be prescribing buprenorphine for chronic pain?

- Buprenorphine waivered clinicians because they know how to prescribe bup
- Pain docs because they are trained to treat pain
- Primary care clinicians
- Why does question this matter?

Does switching to buprenorphine pose any risks to patients on opioids?

- More complicated pharmacology
- Switching to and from any opioid can cause problems
- Harder to calculate MME equivalence
- Is there stigma to being on bup?
- Do pharmacies create barriers to bup for pain (prior auths and requiring diagnostic codes)

If you could go back in time, would buprenorphine be a preferred drug for initiating opioid therapy for chronic pain in a patient such as this?

A. yes

B. No

Summary

- Patients with chronic pain on chronic opioids have many types of risks from the opioids
- Have diagnostic clarity about opioid use disorder vs patients without OUD who are high risk for opioids
- Reasonable providers disagree on the role of buprenorphine in treating chronic pain
- Buprenorphine may mitigate some of the risks of chronic opioids
  - Don’t count on buprenorphine to make tapers easy
  - Don’t count on buprenorphine to prevent addiction, or be preferred initial agent for pain

Thank you!
Questions?