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Disclosures

- I have no actual or potential conflict of interest in relation to this presentation
- Previous speaker honorarium : AbbVie Pharmaceuticals, unrestricted educational grant
- No other consultant work/major shareholder/research support
- I will be discussing 'off-label' use of Buprenorphine/Naloxone (Suboxone)

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Outline

- Strategies for pain management and safely prescribing medications for pain
- Recognizing challenges for geriatric patients
- Diagnosis and treatment options of complex opioid use

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Mr. Sweetz

- 77 y/o male in your practice presenting with bilateral foot pain associated with numbness, 'burning' 'pins and needles' worse at night
- Medical Hx : HTN, Glaucoma, DMII on insulin, BPH
- Meds: Metformin, Insulin, Candesartan, Tamulosin
- No allergies
- No previous surgeries
- Sleeping very poorly at night with decreased mood
- Daughter accompanies him to appointment, 'Something HAS to be done, he can't go on like this'

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Pain Management Strategies

- 5 P's
  - Pathology – (IBD? RA? PMR? DMII?)
  - Pharmacology (Specific illness? Class of pain?)
  - Physical Modalities (Physio, Massage, TENS, etc.)
  - Psychology (Psychiatry/CBT/ACT/Mindfulness/Patient Education)
  - Procedures (Epidural Steroids, Nerve Blocks, Sympathetic blocks, Surgery, SCS)

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Pain Management Strategies

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Douleur Neuropathique en 4 (DN4)

Does the pain have the following characteristics?	
1. Burning (Branderig gevoel)	Yes/No
2. Painful cold (Pijnlijk koudegevoel)	Yes/No
3. Electric shocks (Electrische schokken))	Yes/No
Is the pain associated with one or more of the following symptoms in the same area?	
4. Tingling (Tintelingen)	Yes/No
5. Pins and needles (Prikken)	Yes/No
6. Numbness (Doof gevoel)	Yes/No
7. Itching (Jeuk)	Yes/No

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DN4

EXAMINATION OF THE PATIENT

Question 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

	Yes	No
8 - Hypoesthesia to touch	☐	☐
9 - Hypoesthesia to prick	☐	☐

Question 4: In the painful area, can the pain be caused or increased by:

	Yes	No
10 - Brushing	☐	☐

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Mr. Sweetz

- Mr. Sweetz DN4 score is 6/10, your physical exam reveals distal symmetric polyneuropathy in his feet
- Medical Hx : HTN, Glaucoma, DMII on insulin, BPH
- His goals would be to have better sleep, and to continue his daily walks with his partner Mrs. Sweetz
- You wonder how you can help him meet his goals. What medication would be best for him?

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Pain Management Strategies

- 5 P's
  - ~~Pathology – (IBD? RA? PMR? DMII?)~~
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  - ~~Procedures (Epidural Steroids, Nerve Blocks, Sympathetic blocks, Surgery, SCS)~~

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What is the perfect medication?

- Effective
- Easy to order/titrate
- No/few drug interactions
- Inexpensive
- No dependence
- No side effects

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Challenges with the elderly

- Multiple Comorbidities
- Polypharmacy
- Increased Sensitivities
- Organ dysfunction
- Risk of Falls

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Effective strategies

- Careful review of relative/absolute contraindications
- Start low and go slow
- Consider patient adherence/cognition
- Consider side effect profile
- One medication at a time

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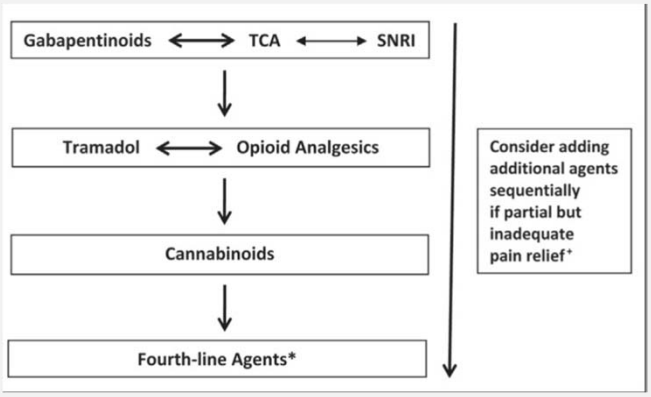
Canadian Neuropathic Pain Guidelines



SSRI, Methadone, Topical Lidocaine, Lamotrigine, Lacosamide, Tapentadol, Botulinum toxin A

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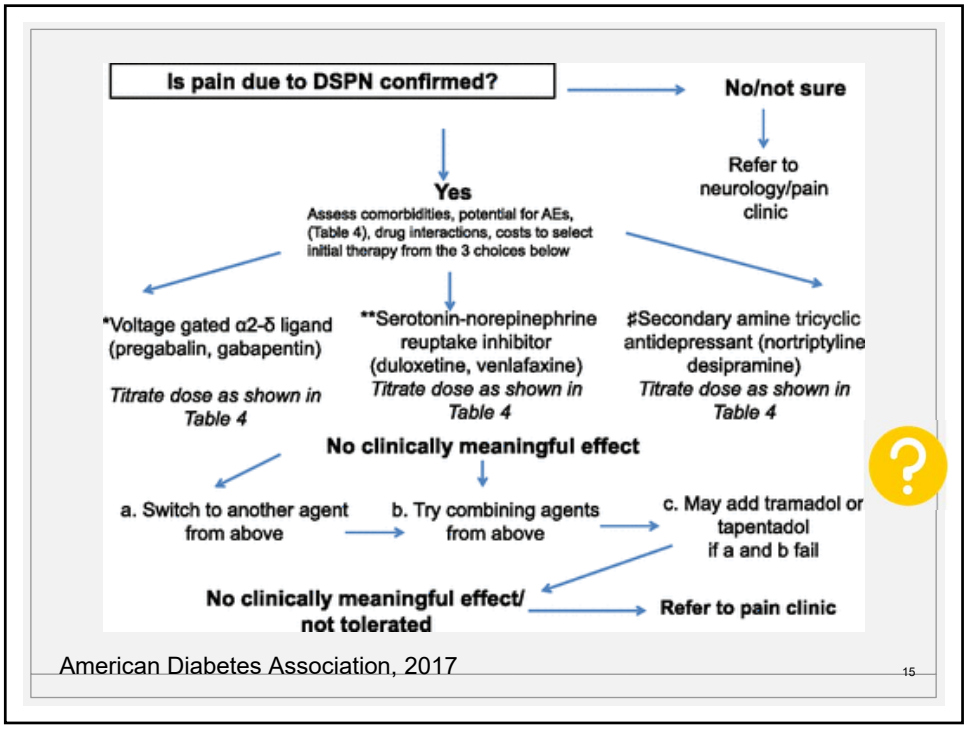

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Mr. Sweetz

- You consider co-morbidities, and decide against a TCA (Glaucoma, BPH) or Duloxtine (can be activating, HTN)
- Pregabalin 25mg PO qhs, with instructions to increase by 25mg q weekly until he reaches 75mg for reassessment. You decide to optimize the nightly dose to meet his goal of better sleep and to maintain alertness during the day and decrease fall risk
- He returns in two months with a partial response and asks about opioids

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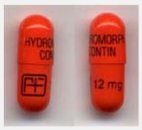
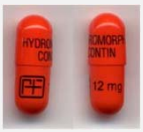
Physician views

Role	No Role
	
	

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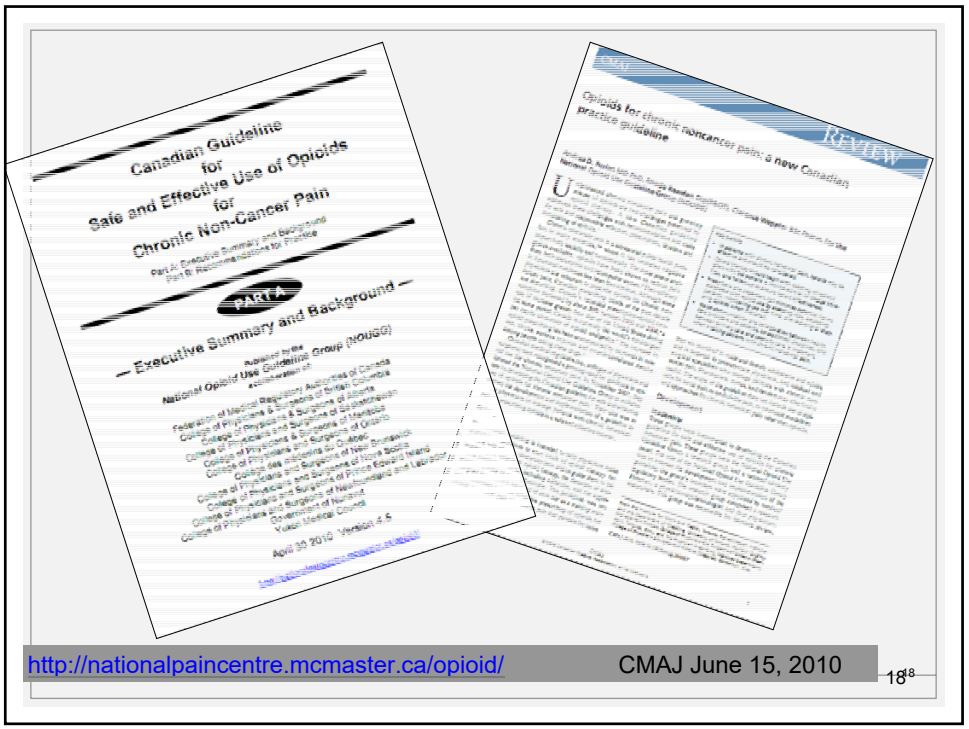

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2017 Canadian Opioid Guideline

- Consider once non-opioid alternatives have been exhausted, if pain not optimized a trial of opioids is reasonable
- Opioids for chronic non-cancer pain are to be avoided in patients with current or past substance use d/o's and active psych d/o's
- Suggest max dose between 50-90 MDE, likely less in the elderly

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Opioid Risk Tool
Clinician Form

(includes point values to determine scoring total)

	Mark each box that applies: Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
2. Personal History of Substance Abuse:		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription Drugs	☐ 5	☐ 5
3. Age (mark box if between 16-45)	☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse	☐ 3	☐ 0
5. Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals	_____	_____

The patient can be placed into one of three opioid risk categories based on their total score.

Low Risk = 0 - 3 points
Medium Risk = 4 - 7 points
High Risk = 8 points and above

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Recommendation #2 (Canadian Opioid Guideline)

- For patients with chronic non-cancer pain, without current or past substance use disorder and without other active psychiatric disorders, who have persistent problematic pain despite optimized non-opioid therapy, a trial of opioids rather than status quo is suggested

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What is a trial of opioids/medications

- Opioid Chosen, e.g. Hydromorphone
- SMART goals
- 3-6 months
- Regular assessments
- Constant monitoring for benefits/harm
- Safety

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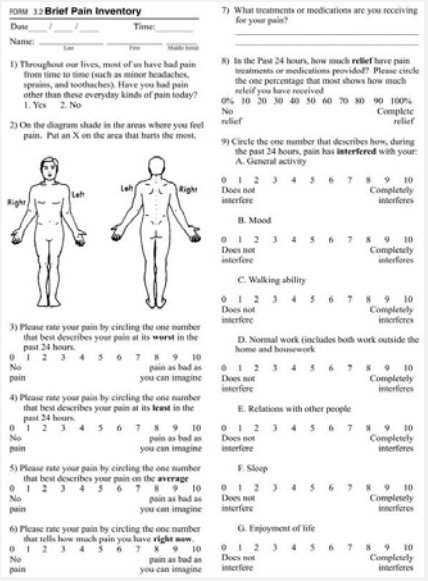
Brief Pain Inventory (BPI)

- Diagram
- VAS (Visual Analogue Scale) pain scores
- Treatments, % relief
- Interference Score (/70)
- General Activity, Mood, Walking, Work, Relationships, Sleep, Enjoyment of Life



FORM 3.2 **Brief Pain Inventory**

Date ___/___/___ Time:_____

Name: _____ _____ _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.

Right Left Left Right

3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **average**
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received
0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:
A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

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Effective Opioid prescribing strategies

- Careful review of risks and side effects (Sleep Apnea, Hormone dysregulation, Opioid induced hyperalgesia, constipation, falls, cognitive changes)
- Start low doses and increased interval
- Frequent assessments and titrate slowly
- Short dispensing intervals
- Avoid long acting in elderly***

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Long acting opioids

- Classic teaching to consolidate short acting opioids to decrease risk potential and increase analgesia
- Pederson (2014) performed a systematic review which found no difference in pain relief, improved sleep, amount of rescue analgesics or improved function
- Altered pharmacokinetics decreases drug clearance
- Butrans patch (Buprenorphine) could be considered - easy administration and decreased resp depression, however expensive
- Can start at 5mcg dose and q2-4 weeks increase by 5 mcg to 20mcg patch max (<50MDE)

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What to do when opioids don't work or abherrant behaviour?

Bridgepoint Active Healthcare | Circle of Care | Lunenfeld-Tanenbaum Research Institute | Mount Sinai Hospital Joseph & Wolf Lebovic Health Complex

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Complex Opioid Use

- Dependence? Addiction? Substance Use d/o? Improper use?
- Options :
  - 1. Weaning/Discontinuation (5-10% weekly reduction)
  - 2. Continued structured opioid therapy
  - 3. Opioid Agonist Therapy (Buprenorphine/Naloxone or Methadone)

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Practical Considerations

- Document, document, document
- Opioid Agreements
- Urine Drug Screens
- Close communication with pharmacy
- Methadone can be challenging, few pain prescribers and many patients do not wish to go to Methadone clinics
- Buprenorphine/Naloxone can be a challenging induction, but no specific training for prescription
- Consider expert opinion

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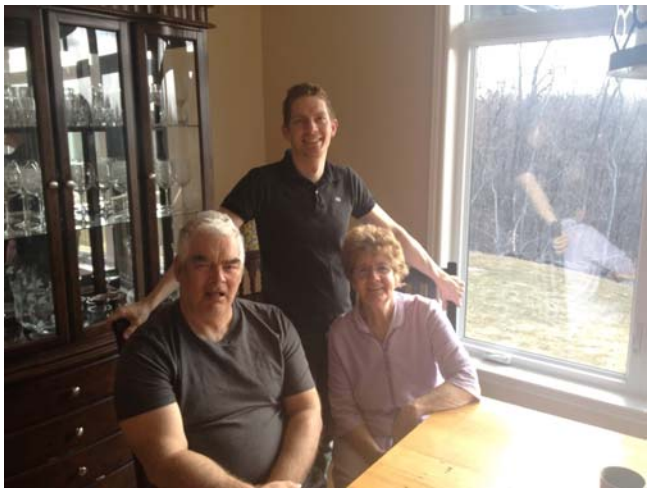

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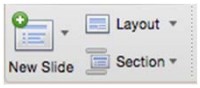

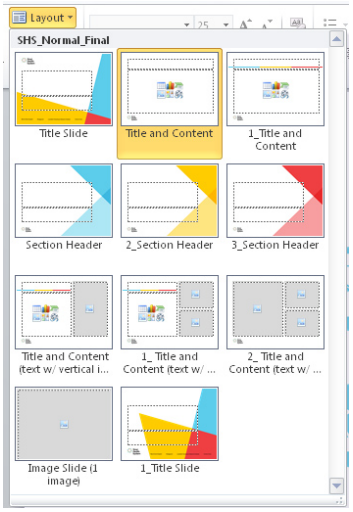

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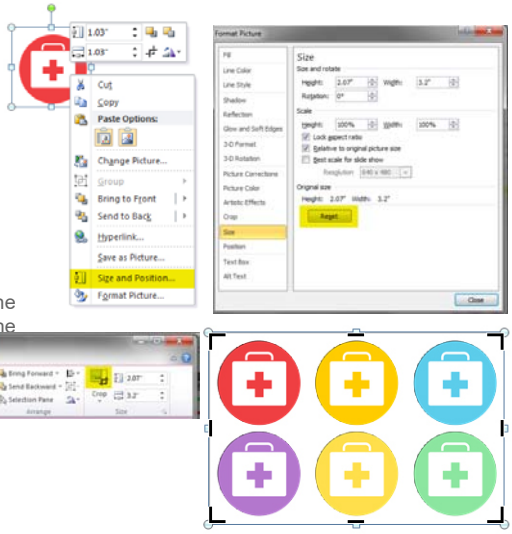

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