Rhode Island Department of Health Academic Center Public Health Grand Rounds

Buprenorphine for Chronic Pain: Facilitated Panel Discussion

Jointly Provided By:

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These handouts are available as an additional educational guide to have in conjunction with the video.

Credit will not be awarded for reviewing the slides only.

Program Release: January 4, 2019
Expiration Date: January 4, 2021
Estimated time to complete: 75 minutes
There are no prerequisites for participation.

Method of Participation and How to Receive CME Credit.
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- Review the activity objectives, faculty information, and CME information prior to participating in the activity.
- View the CME presentations video in its entirety
- Complete the CME activity evaluation and post-test at the conclusion of the activity.
- A passing score of 75% must be achieved in order to receive a credit certificate.

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Disclaimer

This educational program is designed to present scientific information and opinion to health professionals, to stimulate thought, and further investigation.

Learning Objectives

At the conclusion of this session, attendees should be able to:

1. Describe cases of patients who have been prescribed and opioids for pain and how buprenorphine may be a safer alternative
2. Describe cases of patients who are on buprenorphine and need relief for pain with an opioid
3. Describe patients who have been prescribed buprenorphine who are affected by a transition of care to an ED or Inpatient unit and role of pain management

Target Audience

Primary Care Physicians, Physician Assistants, Advanced Practice Registered Nurse, Nurses, Medical Students, Residents & Fellows.

CME Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Warren Alpert Medical School of Brown University and the Rhode Island Department of Health Academic Center. The Warren Alpert Medical School is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation

Physicians: The Warren Alpert Medical School of Brown University designates this enduring material for a maximum of 1.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

RI Specific: This activity qualifies for 1.25 hours CME Credit in Opioid Pain Management/Chronic Pain Management, one of the required areas of section 6.0; 6.2.1 RI CME re-licensure requirements.

This training also meets the requirements set forth in RI Regulation 3.14 Prescriber Training Requirement for Best Practices Regarding Opioid Prescribing. This specific training requirement is required only once and must be completed before renewal of controlled substance registration or two (2) years (whichever is longer).

Other Health Professionals: Participants will receive a Certificate of Attendance stating this activity is designated for 1.25 hours *AMA PRA Category 1 Credits™*. This credit is accepted by the AANP, AAPA, and RI Pharmacy re-licensure.

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This activity may include discussion of off-label or investigative drugs uses. Speakers are aware that it is their responsibility to disclose to the audience this information. Individual Faculty Disclosure information may be found in the conference handouts.

Faculty Disclosure/Conflict of Interest

The following Speaker and Planning Committee* have indicated that they have no relevant financial relationships to disclose:

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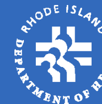
Buprenorphine for Chronic Pain: Facilitated Panel Discussion

Warren Alpert Medical School at Brown University
Providence, Rhode Island
October 25, 2018

Panel Members



Gary Bubly, MD
- Emergency Medicine

Laureen Berkowitz, PA
- Pain Management and Infectious Disease

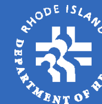
Todd Handel, MD
- Physical Medicine and Rehabilitation/Interventional Pain Management

Patient Bill

Patient Jessica

One Patient's Story

Second Patient's Story



Patient Case 1

55 yr old male police sergeant with chronic pain. Significant myofascial neck spasms with excellent relief from muscle trigger-point injections. Mild cervical spinal stenosis which he reports getting excellent relief from epidural steroid injections. Has participated in physical therapy and does a home exercise program.

- Using Neurontin 400mg TID
- Motrin 800mg QID
- Stable on Vicodin 5/325 TID; has been known to use more.
- Occasionally asks for Percocet 5/325 when he gets an exacerbation of symptoms.
- Mother passes away; he has been re-painting her apartment which increases pain. Pt requests more Percocet.

Patient Case 1 (continued)

- Multiple discussions with patient regarding pain versus dependency. Patient raised suspicion of dependency as having body discomfort when he decreased his dose.
- Started Belbuca 150mg SL BID. Increased to 300 mcg SL BID after one week. Then increased to 450 mcg BID is working great, significant improvement in pain and increased function. Pt took five Vicodin for breakthrough pain at first and is no longer needing Vicodin. Pt feels more stable.
- Pt had to wait a week for prior authorization when dose increased from 300 to 450 mcg.
- Pt used Vicodin for pain control when waiting for authorization.

Patient Case 1 (continued)

Why was buprenorphine a better choice for this patient?

Patient Case 2

- A 36-year-old male with the history of opioid use disorder currently on Suboxone presents to the emergency department after a six-foot fall from a ladder while painting a house.
- He is complaining of right wrist pain after the fall on an outstretched hand. He is slightly tachycardic, complaining of ten out of ten pain. He has a mildly displaced, closed Colle's fracture with no other injuries. He is neurovascularly intact.

Patient Case 2 (continued)

Questions:

1) How would you manage this patient's pain?
2) What are the risks of adding a full opioid agonist (e.g., hydrocodone) when a patient is taking buprenorphine/naloxone?
3) What are the risks of stopping his buprenorphine/naloxone suddenly?

Patient Case 3

HPI: 33 yo male with lower back pain that intermittently radiates into his B/L legs, with spasms. He has trouble sleeping and trouble picking up his young children. He was previously treated with oxycodone 5 mg QID x 4 years.

PMx: Asthma and liver disease.

Past Treatments: Oxycodone, ibuprofen 800 mg BID, Tylenol, and gabapentin 300 mg TID. Patient was referred to physical therapist; however, he was not compliant with treatments.

Plan: During the initial visit, Pt restarted on oxycodone 5 mg QID (epidural injection). He was non-compliant with pill counts and consistently over using his medication and running out early.

Patient Case 3 (continued)

- Changed to Morphine Sulfate ER 15 mg BID. Pt was noncompliant with dosage and over-using.
- Patient was then scheduled for a Suboxone induction and off all opioids for 24 hours. During the induction, Pt admitted to trying a friend's Suboxone when he ran out of Morphine. HPt mentioned that "*A half tab is all I needed*."
- Pt given ability to take Suboxone 8/2 tab BID for pain control. F/U one week later and one month later, Pt reports significant relief in his pain and symptoms and has been maintained on a half a tablet daily.
- Pt has been compliant with therapy and has full-time employment in construction since starting Suboxone; no aberrant behaviors exhibited.

Patient Case 3 (continued)

Questions:

- What do you make of the patient using diverted Suboxone?
- Why was Suboxone a better choice for this patient?

Patient Case 4

A 33-year-old presents as a level 1 trauma after a motor vehicle accident. The patient has three rib fractures, a pneumothorax on the left requiring chest tube, and a fracture of the left femur which is mildly displaced. This patient also has a history of opioid use disorder and is currently maintained on Suboxone 8 milligrams twice daily. He is in obvious severe pain.

Questions:

- After appropriate trauma evaluation and resuscitation, how would you manage this patient's pain?
- If the patient is admitted to the hospital, what advice do you give the hospitalists?

Patient Case 5

22 y/o male h/o anxiety, depression, ADD, Lyme disease, back pain on oxycodone 5mg TID. Had epididymitis age 20, afterward started having groin pain that eventually spread "*Up my spine to my arms and entire body*."

Questions:

1) What is appropriate strategy for this patient?
2) Does this patient have psychogenic pain?
3) Is this patient showing signs of dependence?
4) What was the long-term outcome?

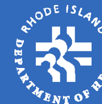
Patient Case 6: Visit 1

CC: "*I want to be able to sleep*."

HPI: Pt reports chronic pain in back, neck, b/l shoulder, and arm pain for last two years. Was taking Percocet and then progressed to Oxycontin 10 mg q eight hours. Tried to stop and experienced withdrawal. Went to ER and was referred to detox facility two years ago. Has been off all opioids since then and doesn't want to go back on them. Misses working and takes ibuprofen for pain. Biggest complaint is poor quality sleep.

PMHx: HTN, Spinal stenosis, OSA, opioid use disorder s/p treatment two years ago. Stopped drinking in his 30's on his own.

Patient Case 6: Visit 1



Continued…

Pt referred to a neurologist and then a surgeon. The surgeon wants to do Carpel Tunnel surgery, and then elbow/neck surgery. Pt reports he doesn't want to have surgeries since he will end up on more pain meds.

He feels he can manage the pain during the day; however, as soon as he tries to go to bed the pain worsens. Pt tried marijuana, with no relief. Pt was on sleeping pills in the past; he shared that he chased his wife around the house and does not remember doing so. He stopped taking sleeping pills. Was on TCAs, trazodone, Seroquel, and many sleep meds in the past Gabapentin, Lyrica (mood problem).

Plan: Counseling and trial of Cymbalta.

Patient Case 6: Visit 2

- Visit two included both the patient and his spouse. Pt took Cymbalta for one month. Pt reports that "*It didn't do anything*."
- PMD gave Pt. mirtazapine; Pt. reports it felt like it helped a little, yet not consistently. Feels his pain is manageable, but that sleep is the problem. Goes to bed at 9 p.m. and cannot fall asleep until 2 a.m. Pt falls asleep around 2 a.m. and wakes up about 1.5 hours later. Feels better when he sits up and with hot showers.
- Reports he doesn't want to be dependent on medications but states, "*There has to be something I can take*." Spouse reports that they see advertisements on television for medications that say they work all the time.
- Feels Valium would work best as it has in the past.

Plan: Counseling and Butrans 5mcg

Patient Case 6: Visit 3

- Pt reports he has slept every single night since he was last seen at the office.
- Pain down to 3/10 with Butrans; Pt finds it a manageable level.
- When Pt puts the patch on, Pt experiences nausea the following day and feels it is too much.
- Pt requests a lower-strength.
- Pt. has been more active since last appointment and has lost 10 pounds.

Plan: Transferred to and maintained on buprenorphine 0.25 mg/day SL.

Patient Case 6: Visit 3

Questions:

1) Any challenges with third party payers?
2) Function and activities of daily living seemed important to this patient, do you address this in all of your patients?
3) Is buprenorphine a better choice than diazepam?

Patient Case 7

71 yo female with h/o obesity, OA of the spine, afib, hypothyroid, stage 3 kidney disease, depression/anxiety, R carotid aneurysm in 1999, s/p lap band. Pt previously smoked and social drank etoh. Pt quit after aneurysm in 1999.

Pt was on OxyContin 40 mg BID initially, and now on fentanyl 50 mcg patch and would like help weaning off. PMD retired and new PMD does not prescribe long-acting opioids.

Family Hx: Mother: deceased age 62, emphysema, COPD, pancreatic cancer. Father: Deceased age 82, lymphoma, lung cancer, COPD, emphysema **MGF**: Died age 62, CAD, DM. MGM: Died from peritonitis from childbirth. **PGF**: Died in late 50's from etoh and liver disease.

Patient Case 7 (continued)

Questions:

1) How do you approach a patient like this
2) What are the treatment options?
3) Does a genetic predisposition alter your approach to this patient?

Patient Case 8

A 39-year-old female with a prior history of opioid use disorder. Previously on Suboxone and now weaned-off and in recovery for the last five years.

Pt presents after a fall with fracture of her lateral malleolus.

Questions:

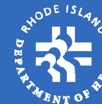
1) What are the overall treatment goals with this patient?
2) How would you manage pain in this patient?

Patient Case 9

HPI: 53 yo male with h/o HTN, osteoarthritis, tobacco dependence, L knee pain s/p b/l knee replacement. Pt had been on Percocet 15 mg po BID for many years from PMD and went in for knee replacements. Post-operative orthopedic stated weaning him off opioids.

Pt reports the knee pain has been worsening and he had to call orthopedic for Vicodin prescriptions every week. When he asks them what to do about his worsening knee pain the the response was, "*You can't have knee pain, you don't have knees*." Pt reports sometimes he couldn't get the pain meds and had withdrawal symptoms. Pt reports he got "aggressive" with secretary and they referred him here.

Patient Case 9



Current Meds: Clonazepam 1 mg TID (i.e., "*The only thing that works for my anxiety*"). In addition, patient is taking metoprolol 100mg and micardis 80mg/12.5mg.

Soc Hx: Pt does not drive since "*Maybe I got a DUI when I was young*."

Patient Case 9

Questions:

1) What are the risks of starting this patient on an opioid?
2) What are non-opioid treatment options for this patient?
3) What are opioid treatment options for this patient?
4) What are long-term goals for this patient?

Patient Case 10

- **CC**: Low back pain with radiculopathy into the left leg. Also inquiring about Suboxone on her first visit today.
- **HPI**: Pt is a 67 yo female s/p lumbar fusion in 2011 and cervical fusion in 2002 reporting chronic low back pain that radiates into her left leg, with numbness, tingling, and intermittent weakness. Pt has been treated with OxyContin, dilaudid, morphine, and fentanyl over the years, and was tapered down to oxycodone 10 mg QID by her previous provider. Pt reports she went through withdrawals in addition to inadequate pain control. Pt is on SSDI.
- **PMH**: Anxiety, depression, hypercholesterolemia, OA, Hepatitis C, hypothyroidism, and anemia.

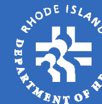
Patient Case 10 (continued)

Past Treatments: Cervical and lumbar sx, physical therapy, chiropractic care, epidural steroid injections, acupuncture, and aquatic therapy.

Plan: Pt was scheduled for Suboxone induction with the office in October of 2016. She has been well-maintained on Suboxone 8-2 SL film BID with gabapentin 800 mg TID, cyclobenzaprine 10 mg QD PRN spasms, and naproxen 500 mg BID. In addition, three spine injections/year help control the radicular pain.

Take Home Message: Patients know that they are dependent and fear the withdrawal. When they are stable, the pain tends to be stable; however, not pain-free.

Patient Case 11



CC: Female with lower back pain and radiculopathy into the left leg. She is also having trouble sleeping due to the pain.

HPI: Patient is a 54 yo female s/p lumbar fusion x 2 reporting low back pain radiating into the left leg that did not improve following her second surgery in 2014. Pt reports left leg pain with numbness and weakness.

PMH: Anxiety treated with 1 mg clonazepam QD and GERD.

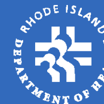
Patient Case 11

Past Treatments: Spine injections, lumbar fusion x2, physical therapy, aquatic therapy, NSAIDS, and Tylenol.

Plan: Pt has had been treated with Nucynta ER 150 mg BID from 2016 to 2018, in addition to receiving one to two spine injections yearly.

In January of 2018, Pt presented reports of inadequate pain control in addition to tolerance to the Nucynta ER. Pt was changed to Belbuca 150 mg and then titrated up to 450 mcg BID over four weeks. Pt has been well-maintained on the dosage for the last 10 months.

Take Home Messages



- Patients are complex and require a compassionate, thoughtful, and individualized approach – **pain is often multifactorial**.
- Stopping opioids suddenly- buprenorphine included- is not advised and places patients at risk.
- Buprenorphine doses may be significantly lower for chronic pain than for the treatment of opioid use disorder.
- Buprenorphine is a long-acting, mixed opioid antagonist in various forms that might be a better choice for some patients for chronic pain.

Take Home Messages

- Patients may have psychiatric co-morbidities that need to be treated.
- Communicating with the PCP or ED treatment provider is ideal and sometimes the best approach to increasing the buprenorphine/naloxone for a short time.
- The DATA-waiver course is available from multiple organizations: https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

Take Home Messages

- For the patient on Suboxone with sudden acute pain, strongly consider increasing the Suboxone dosing to three times daily for pain management. Coordinate with the Suboxone prescriber.
- For patients on Suboxone with severe trauma requiring parenteral pain relief strongly consider fentanyl.

Resources

1) Chen, Kelly Yan, et al. “Buprenorphine–Naloxone Therapy in Pain Management.” Anesthesiology:
The Journal of the American Society of Anesthesiologists, The American Society of Anesthesiologists, 1 May 2014, anesthesiology.pubs.asahq.org/article.aspx?articleid=1917779

2) Rolley E. Johnson, PharmD , Paul J. Fudala, PhD, Richard Payne, MD, Buprenorphine: Considerations for
Pain Management, Journal of Pain and Symptom Management, March 2005 Volume 29, Issue 3, Pages 297–326

3) Alford, Dan. “Managing Acute and Chronic Pain with Patients on MAT.” PCCS, pcssnow.org/wp-content/uploads/2015/12/Alford-Acute-Chronic-Pain-MAT-FINAL3-12-22-15.pdf

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