SOMETHING FOR THE PAIN

EPISODE 24: Surveying Substance Use Disorder: Opioids

(30 mins)

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[cue guitar music]

[Sam Steffen]

This is *Something for the Pain*, a podcast produced by Project ECHO Idaho, made for Idaho's healthcare professionals working to prevent, treat, and facilitate recovery from opioid and substance use disorders throughout the Gem State. I'm your host, Sam Steffen.

[theme song]

Today we're continuing our theme of 'Surveying Substance Use Disorders' and are going to be talking about Opioids. This episode features a presentation by Alicia Carrasco, Addiction Medicine and Internal Medicine Physician at the VA Medical Center in Boise, titled "Complex Persistent Opioid Dependence." This lecture was recorded on June 9, 2022 as a part of ECHO Idaho's Opioids, Pain and Substance Use Disorders series. Here to introduce today's presenter is ECHO Idaho's Assistant Director, Katy Rodgers, formerly Katy Palmer.

[Katy Rodgers]

Hi, everyone! Welcome to Project ECHO's Opioids, Pain and Substance Use Disorders. My name is Katy Palmer and it is wonderful to see you all, thanks for joining. For today's session we are hearing from Dr. Alicia Carrasco, addiction medicine and internal medicine at the Boise VA Medical Center who will be talking about Complex Persistent Opioid Dependence. And then, Alicia, let's have you take it away!

[Alicia Carrasco]

So my name is Alicia Carrasco and I am an internal medicine and addiction medicine physician at the Boise VA. So today what I want to talk about is: I want you to be able to define at least the general concept of what complex persistent opioid dependence is and either refer these patients with complex persistent opioid dependence to specialty care or if you're comfortable or you want to practice kind of working with these patients, to really start doing it yourself and feel empowered to doing it yourself. And then to be able to differentiate between patients with clear-cut opioid use disorder and patients with complex persistent opioid dependence, because we think the trajectory of these patients and the underlying things that we need to help them with are probably a little bit different.

So I really like to start with just a history lesson because I think it's really important for us to see these things in a social and historical context. So way back in the '90s—wasn't that long ago—we started—and I say 'we' as like a medical profession—started really emphasizing this focus on pain, right? And saying, "Hey, you know what? We have this epidemic of pain, everyone's in pain, and we need to fix it." Right? And so, we were like "pain is bad and we know opioids are great for acute pain, right? They help when

people break their bones, they help post-surgically…" And so we made this cognitively—which turned out to be incorrect—but like: opioids are good for acute pain, therefore opioids are going to be good for chronic pain. And so we started putting a lot of people on these opioids. And what we found, you know, as we started doing that is like, this isn't working as well as we thought. You know, providers are looking at their own patients and they're saying, "You know, they're not really doing any better than they were before we started the opioids, you know? And I tried going up like you told me and I tried increasing the dose when their pain got worth and that's not working." And so we really started kind of questioning whether or not opioids were the right answer for chronic pain. And as we're questioning this we start looking at death rates and we start looking at outcomes and we're like, "Oh my goodness, we're in the middle of an epidemic." But it's not a pain epidemic anymore, it's an opioid epidemic, and people are dying and people are overdosing and people are becoming addicted. And we did this, right? And so we started to really go back and look and say is this the right thing? And really reversed course and said, "Hey, I don't think this is the right thing to do anymore." Right? And the CDC stepped in because they saw that the doctors had been starting all these prescriptions that we really had a huge role as providers in creation of this epidemic and said, you know, "Some of that's on us, we didn't really have great guidance for folks…" So they came up with the guidance on how to prescribe chronic opioids. And what it was intended to be was guidance on how to start opioids for patients that have chronic pain and kind of how to do the risk-benefit assessment and was probably mis-applied to a lot of patients that were already on opioids which is not what the guidelines were intended to be used for. But in any case, what happened is we prescribed a ton of opioids, we realized they weren't working and then we reversed course. And so what we started really focusing on, like what the CDC guidelines at least hopefully in theory is to do more of a risk-benefit calculation with all of our patients, so not to have our knee-jerk response be, hey you know the patient has pain so we're going to prescribe opioids for it, but to do like a real risk-benefit assessment. And you know doing those risk-benefit assessments, I think what a lot of us in medicine realized is that we had been overemphasizing the potential benefit, right? That like most patients don't actually get pain or functional improvement with long-term opioid therapy and that the risk was underemphasized. So we were not really thinking through all the consequences, right? And I'm talking about just the scary stuff like deaths and opioid use disorder but also just like risks of hey, invasive pneumococcal disease, or the risk of osteopenia, the risk of testosterone suppression, et cetera. So a lot of overemphasizing the potential benefits, underemphasizing the risks and so we kind of got ourselves in a conundrum right? Where we're like, "Well, holy moly, I have all these patients, I would never have started them on opioids…I'm doing my risk-benefit assessment and I don't think that the benefits outweigh the risks in this case…" but like what do we do for these patients that are already there, right? And is it better just to keep them on there because they've been kind of stable for a couple years or do I need to take them off? And I think these are like really hard and complicated questions, and for me it's helpful to ground it in an actual patient case which is what I hope to do next.

[Sam Steffen]

Just a word here about this patient case. ECHO sessions typically feature real de-identified patient case presentations, delivered from practicing Idaho clinicians, physicians, social workers and other members of patient care teams. The case that Dr. Carrasco is presenting here is one such case. If you're a practicing clinician or physician, you can present your de-identified case to an interdisciplinary expert panel to help others learn and to receive free expert advice and feedback. Check out ECHO Idaho's website for more details. www.uidaho.edu/ECHO

[Alicia Carrasco]

And so this is like a patient—I've changed a couple of the things. We're going to call this patient Sam, and say they're a 74-year-old patient who's just had chronic pain for years, you know, and had been on some Norco and had generally done okay but then about 6 months ago had a back surgery and their opioids were increased after the back surgery and even after his body had healed from the surgical process itself, he was still on the same doses that he was on right after the surgery and his doctor was like, "Well—c'mon it's been six months, you know, like we don't need these higher doses. You already had the surgery six months ago. Let's go back onto what you were on before." So they tapered his medicine and the patient just started having uncontrolled pain, right? And so all of a sudden he'd gone from being fairly active, doing things around the house, painting, gardening, engaging with family members to starting to self-isolate, feeling like the pain is uncontrolled. And his mood really started really deteriorating. And so what the providers decided was, "Well, we're going to continue this." And so the patient was like, "My primary care doc cut me back to 4 pills a day but I was doing fine on 6 pills a day so I am going to take 6 pills a day, cause that's what I feel like I was doing well on." Sam felt that during that time, when they were taking 6 pills a day, they were doing much better—but they weren't prescribed 6 pills a day, so they ran out early and went through withdrawal. And then the provider noticed this, they did a refill and was like, "You know you can't do this? I'm writing for 4 pills a day." And the patient got the prescription but was like, "Well, my pain isn't controlled on 4, my pain was controlled on 6…" so they up-titrated on their own, ran out early again and the provider was like, "Hey, this isn't right. I think you might have opioid use disorder because you're not able to control what you're taking. And so I don't want to prescribe you this." So they stopped the opioids. And then even after the withdrawal—the physical withdrawal that happened—the patient just had severe worsening pain, basically no functional status whatsoever, like was barely getting out of bed, and then started becoming suicidal and was going into the emergency room to be evaluated for suicidal ideation because of the pain and just like intractable negative emotions that he was feeling. So do you think that Sam, the patient, has opioid use disorder, do you think Sam does NOT have opioid use disorder, or are you not sure?

—Musical interlude—

[Alicia Carrasco]

We're in a pickle, right? Cause I think all of us are like, "Well, something's not right." The average person who is on an opioid and is stopped, they're not going to kill themselves, right? The average person is not going to just stop functioning when they are tapered on their opioid. So something's not right and something's not normal, but this doesn't feel the same as our patients that are using their Oxycodone and like snorting it, right? This doesn't feel the same as people that are using heroin to get high. So this feels a little bit different even though we're meeting some of the OUD criteria. And so I think a lot of us are seeing this kind of stuff and we're wondering like, "Well, what is this?" right? Cause this is not our typical addiction, right? Where people are seeking the euphoric effects of the drug. In my mind the typical addiction of someone is like they're losing control to this drug. It's the drug that is really the dominant key factor that they're doing things for, and that they don't have control over the drug. So if you give them a prescription for 4 Norco a day, they're going to take 6 this week, they're going to take 8 next week, they're going to take 10 next week… it's something that gets worse over time and they're not generally controlled on just like a fixed schedule. So it's a little bit different. And then when you talk

to the patient it's different. They're not looking for the effects of the drug, they're looking for pain relief, right? They're looking for symptom relief. But it's also not normal to have such severe side-effects. And so you know what we're seeing in these patients—and I would say this patient probably has complex persistent opioid dependence—is, they're not tolerating getting off of the opioid. They have a dependence on it, right? Whether it's a long protracted withdrawal or like a psychological dependence or a physical dependence for pain, whatever it is, they aren't doing okay without their opioid. They have some sort of dependence on this opioid. But this is not classic addiction, right? These are patients who, maybe they are on a higher dose than they intended, maybe they didn't want to stay on opioids long term, but what's keeping them on it is not this craving or this desire for a euphoric effect. What's keeping them on this drug is pain. And potentially lack of ability to cope with the pain, right? Which kind of brings in some of the things that we can do to help these patients. But if you go through the opioid use disorder criteria with patients with complex persistent opioid dependence, they're not going to say "yes" to the criteria, right? If you ask them, "Are you spending a lot of time trying to get these drugs?" They're like, "No, I'm spending a lot of time trying to get my pain controlled." If you ask them, "Are these meds getting in the way of your relationships?"—I wouldn't ask in those words, right?—but they're gonna be like, "No, it's the pain. When my pain is controlled, I do well!" So we have these patients that have pain, they have some sort of dependence on these opioids, but they're not our classic opioid use disorder patients in that often they can be stable on a certain dose of a full agonist—and sometimes they can't, right? Because sometimes maybe it's just not safe for what they're on and you have the patient that they're on 3L of oxygen, they have COPD and they're on 200 morphine equivalents of you know, morphine, and you're like, "This isn't safe, we can't keep you on this and you're not tolerating the taper, so what do we do?"

We kind of talked about this already, so we need to treat it a little bit different and the first thing is: we need more research into this. Because I think right now I think we're clumping a lot of these patients together, and they're very different patients, right? The patient that has lost control to the opioid and the patient that has lost control to pain that has a dependence of some sort on opioids—that's not the same disease process and so you know trying to treat them exactly the same isn't going to be in the best interest. But I can't tell you that with a lot of evidence behind it because there really isn't a ton of good research into this yet and so we need more research.

But you know we have options with these patients, and so one is to really go back and to say, "hey, did we really need to taper?" Right? So, you know, is this pain just uncontrolled—is this patient's pain uncontrolled? So think back: like if the patient is decompensating during an opioid-taper did they need that taper to begin with, right? Or were we knee-jerking a response to kind of over-correcting because of what we did in the 90s and the early 2000s, like were they actually okay on the dose they were on and was I just tapering because I don't think this was a good idea to start? But they're already on it? Cause maybe we can just stabilize the patient by going back on the dose that they were on. And if not, like if the taper was appropriate, maybe they had aberrant behaviors, maybe they have respiratory issues. You know, buprenorphine can actually be super super helpful in these patients cause we're not going to see the same respiratory depression that we will with other agonists. You know if they do have OUD and it just hasn't been fully unmasked it's going to be treating that, so that's a great option as well. And I do, just to be really clear, you know, when we're doing buprenorphine for this, we really want to do three times a day dosing because the analgesic effects of buprenorphine only lasts for about six hours. And for these patients, you know, other things that can be really helpful is just to slow the taper

down. If they've been on certain meds for 20 years—eh, it's not an emergency to get them down, right? And then help provide like behavioral support because there's a lot of distress and catastrophization that tends to happen with these patients, so helping them learn how to self-manage some of that, those anxieties and behaviors, can be really helpful.

Okay, so again, this was just a very quick overview, but basically OUD and CPOD, as I call it—Complex Persistent Opioid Dependence—they're different types of opioid dependence; you know, they're both opioid dependence of sorts—the patient has some sort of dependence on them—but they're really clinically distinct. Complex Persistence Opioid Dependence, or CPOD, as I call it, is really characterized by worsening pain and loss of function when we're tapering opioids or trying to get opioids off; you know, whereas OUD is characterized by loss of control to the medicine itself. And buprenorphine—the great thing is that buprenorphine can be an appropriate treatment for both of these. And so these are the things that I hope you take away from it, and I'm happy to answer any questions that you all have.

[Neil Ragan]

I'm wondering about how you get patient buy-in on the transition from the typical short-acting or typical full-agonist, over to buprenorphine.

[Sam Steffen]

Speaking here is Dr. Neil Ragan, a physician at Health West in Pocatello and a regular participant at ECHO Idaho.

[Neil Ragan]

…What does that process sound like for you?

[Alicia Carrasco]

You know, it depends on the patient, and it depends on I think where they're coming from. Cause there are some patients where, you know, I'm like, "Hey, the Norco that you're on isn't working, you're not having functional benefit, let's try something safer, try something that I think will be better for you and will make it a little bit easier to taper…" And if they haven't had aberrant behaviors, I really try to encourage them and give them reasons and you know sometimes tell them stories about other patients I've had that have been really successful. There are other patients, though, that I'm like, "You kind of don't have a choice…" right? Like, "You keep running out early, you're not, you know, following the rules that we agreed upon. And, you know, at this point I think your options are either nothing or like Clonidine or Loperamide for withdrawal support or buprenorphine—and, which one would you like?" And with the latter, with the patients that have had more aberrant behaviors, I really think of it as a one-way street, because they've kind of lost the right to use a full opioid for at least now, cause they haven't been able to engage in the expectations that I have for them. But with the previous patients—patients that I just want to try bupe cause I think they might do better, it might help us taper, might help us stabilize—then sometimes I do say, you know, like, "Hey, let's try this. And if it doesn't work, we can go back, but I'd rather try this because it's safer and I think you'll do better." So my approach depends on whether they honestly have a choice or not. Cause sometimes patients, their primary care provider won't prescribe it anymore, and so it's, you know, "This is all I got for you. It's either buprenorphine or nothing." Which, I don't like forcing people's hands, but sometimes it happens.

[Todd Palmer]

I think a lot of it is convincing patients that buprenorphine works well for pain…

[Sam Steffen]

Speaking here is Todd Palmer, Addiction Medicine and Family Medicine physician and Geriatrician at Full Circle Health in Boise. He's also a panelist for ECHO Idaho's Opioids, Pain and Substance Use Disorders series.

[Todd Palmer]

You know, they'll read about it on the internet and they'll say, "Oh, this is only for addicts." But you know, telling them that buprenorphine was used for years and years in Europe for management of pain, and it's actually very effective. You know, it matches up very well to other opiates like morphine in controlling pain. So I think that's important to convince patients of that.

[Alicia Carrasco]

Yeah, and we have at the VA, we're lucky. We have resources that discuss buprenorphine for pain treatment and so I mention that. I tell them, like, "You know, in Europe, they've been using this a lot more, for years." So I think there is like a lot of evidence for buprenorphine for pain. I think that with time we're going to see more and more people starting with buprenorphine right off the bat. The reason that we don't tend to do it is, the lower-dose buprenorphine which is what an opioid-naive patient needs, so we're talking about the Butrans patch or the Belbuca, we're talking about micrograms, right? So we're talking about 20 micrograms an hour with the highest dose of the patch; we're talking about you know like 750 grams for the higher doses of the Belbuca. But that's like orders of magnitude lower than what you're going to be getting from a single Suboxone pill. So the problem in opioid-naïve folks is that the formulations that have the doses that people would need are really expensive and so it's just hard financially to justify it. And with insurance it can be really hard. But from a pharmacological and efficacy level, starting with buprenorphine makes a lot more sense. I think the greater question is: will it be any more effective than any full opioid agonist at chronic pain, right? Cause we don't have that data. We know it's safer but I can't tell you if in ten years we're going to be looking back and say that buprenorphine does the same thing that other full-agonist opioids do in terms of hyperalgesia and other side-effects.

[Cloeie Hood]

I have a question about Sam.

[Sam Steffen]

This is Cloeie Hood, LCSW, ACADC at Trivium Life Services in Boise and an ECHO Idaho participant.

[Cloeie Hood]

With Sam, putting him back on the buprenorphine or on something…is that going to reverse his depression and his quality of life?

[Alicia Carrasco]

Well, it's not a panacea. This is an actual patient that we're working with now, you know, and they've been having a hard time tolerating the buprenorphine but are doing better and aren't suicidal anymore, so a lot of times it will help. There's like this whole protracted withdrawal syndrome that probably lasts like a year and so—we don't really know because there's not a lot of data and like research on it yet—but we do think that it will help reverse a lot of that. And then there's the theoretical effects, too, of the kappa-antagonism that buprenorphine does, so most full-opioid receptors are mu-agonists which are getting the pain under control, but you also get kappa-agonism and kappa causes dysphoria. And buprenorphine is a kappa-antagonist, so it blocks the dysphoric properties and we think that that might help some with the mood. But yeah, generally patients do stabilize on buprenorphine.

[Todd Palmer]

Yeah, one other thing I'll mention is, you know there's some thinking that there's a lot less risk for hyperalgesia with buprenorphine than a full mu-agonist, which, you know—the hyperalgesia can be a big problem with opiates, where they have more pain over time.

[Amy Jeppesen]

So, as a behavioral health specialist working in a substance abuse treatment center, one of the issues that we struggle the most with is folks with chronic pain.

[Sam Steffen]

Speaking here is Amy Jeppesen, LCSW, ACADC, social worker at Trivium Life Services in Boise and panelist for ECHO Idaho's Opioids, Pain and Substance Use Disorders series.

[Amy Jeppesen]

And I think there's two pieces going on there. There's that addictive property of the opiate and sort of fear of change, right? We hear a lot of times with our chronic pain people, "No, no, no, I've tried Suboxone before—it doesn't help with the pain," or, "I've tried something different before, it doesn't help with the pain." And I don't know that we can really tease it out, but it's so hard to tell like, okay, is this really that their pain level is where it's at? Or is it that they weren't on the right level of Suboxone before? And so one of the things that we've found quite challenging, and maybe you have some ideas around this, is like our folks that aren't particularly using drugs for chronic pain, it's a little bit easier—not much—but, to get them to consider Suboxone. But our chronic pain folks? Man, that is a struggle. Because they have had that chronic pain, right? And we also know just like you mentioned that opiates can provide pain, if they're on opiates long-term it can actually increase their pain or they can have more pain. So do you have any advice on that? Like there's this huge fear around, "I can't switch over to Suboxone or methadone," or "it's not going to cover my pain—this is the only thing that works—it's the only thing that works for me and I can't do anything else!" So I'd love to hear any advice that anyone has on maybe ways you can address that conversation or maybe things that you've found that we're successful with clients that are so afraid that they're going to have that chronic pain again?

[Alicia Carrasco]

Yeah, I will say that for my patients that have chronic pain, I pretty much exclusively do micro-dosing protocols and low-dose buprenorphine initiation, because it's a really hard sell to have someone go into withdrawal. Right? I'm like, "hey this might be better but it's going to be a few days of misery." And

that's a really hard sell. So with the micro-dosing protocols, you know, you just—basically the theory is you start at such a low dose and kind of increase so that people aren't going into withdrawal cause you're just displacing a small amount of the full-opioid as you build up with the buprenorphine. That also helps because people are scared of change, which, Amy, I think is like, a lot of what you're saying, right? Like, people just don't like change and it's scary and so like if they feel like they still have the medicine that they're used to for a while we start the buprenorphine then it's an easier sell as well. And then you know depending on how anxious they are, maybe I'll do the micro-dosing over a week, maybe I'll do it over two weeks. You know and then once I feel like they're stable, then we can get them off the buprenorphine and make sure that their pain is kind of controlled the whole time. Cause I find that people tolerate that transition better because in their mind they're getting twice as much med, you know, during the transition—even though I know that their Norco isn't actually working when their receptors are full of the buprenorphine.

[Todd Palmer]

You know, Amy, I've had quite a few patients where buprenorphine is the answer, you know I'll have them on one or two, three, four times a day, and it does it for them. The other thing I always tell them is, you know, this is a trial. Let's just give it a shot because what's been happening so far with your other meds isn't going well. Let's try this different approach. If it doesn't work, we'll stop it. And I also—you know, the other principle here is that—with buprenorphine dosing—there's a plateauing effect when it comes to respiratory depression and euphoria, but when it comes to pain, there's really not a plateauing effect, so you can go up on the dose and keep going up and you get further pain control because you don't get the plateauing when it comes to pain control.

[Amy Jeppesen]

Thanks, that's definitely helpful. You know, we're a substance abuse and mental health provider and so a lot of times when they end up here, not only have they been taking opiates for chronic pain, but they've moved into heroin or there's also methamphetamine that's going along with it, and so, yeah, that's a big struggle with us for the pain clients. Cause it's like you talked about, it's so tricky because a lot of these folks that come in, they had a legitimate injury that they started taking opiates for and they were being prescribed the opiates and maybe they couldn't get the opiates any more so they moved to heroin, and so it's a really tricky—like helping them understand like, "Yes, we totally recognize that you needed this for your pain control, this was something that was prescribe to you, but you sort of crossed that threshold into, like when you started using meth and getting street heroin—you crossed that threshold over into the addiction properties of what happened to you, so it's totally unfair that this happened, that you had this injury, that you got…felt dependent upon these drugs…" I've found that working with some folks that have chronic pain issues, it can be really difficult as the behavioral health provider to help them see, you know, "You sort of crossed that threshold a little bit and now in order to fix that not only is Suboxone or those types of things going to help you, but you also need to work on your thinking…" and I find that when the chronic pain folks do engage in therapy, they actually do pretty well because they learn some skills that not only help them with the addictive thinking piece, but they actually learn some skills around how to manage that chronic pain piece, too, cause a lot of times with chronic pain comes a lot of anxiety. So, a couple things that…just some thoughts that I had.

[Todd Palmer]

Yeah, I think it's also important that opioids are not the only answer, in fact they're not a good answer at all. You know, there are other modalities, I mean there's the Clofen ectopical, there's Duloxetine. You know there's a lot of other treatments out there, it's not just switching from opioids to bupe. I think the most important thing for me with my patients is assuring them that I'm not going to abandon them regarding their pain; I mean, I still acknowledge their pain, I'm still going to address it, but I want to get to something that's safer and something that works better.

[Amy Jeppesen]

And I think, too, Todd, it's the behavioral health side and the medical side working better together, right? Cause obviously here we do Suboxone, but most of the people that come in, their addiction is their main issue and mental health issues. So I think it's us as a community starting to work better, too, like, because really, you guys are the experts in pain management and we're the experts in addiction. And I think in the past those two things have kind of butted heads a little bit, like some people that work with addiction are like, "Oh, you can't be using anything," and "the fact that you're doing this means you're still addicted." And I think everybody's got to come forward and work together as a community so that we as a treatment provider can refer them out into the community to a pain specialist and have that communication to be like hey, here's what they're working on in their addiction part, here's what they're working on in the pain part, you know? Working together to help that client heal I think would…and predominantly I think the two fields have been separate and I think we've got to make some more progress in that way.

Music

[Sam Steffen]

That again was Alicia Carrasco, Addiction Medicine and Internal Medicine physician at the VA Medical Center in Boise presenting "Complex Persistent Opioid Dependence." That lecture was recorded live on June 9, 2022 as a part of ECHO Idaho's Opioids, Pain and Substance Use Disorders series.

If you'd like to watch the Zoom recording of that presentation, that video is currently available on the ECHO Idaho YouTube channel, which you can access through our website. The PowerPoint slide deck as well as information about how to contact some of the organizations and services mentioned in that talk, are available in our podcast show notes, on our podcast webpage: www.uidaho.edu/echo-podcast

Banjo music

If you're interested in joining our free, live ECHO sessions to receive Continuing Education credit, learn best practices, ask a question or grow your community—please visit our website at www.uidaho.edu/ECHO where you can register to attend, sign-up to receive announcements, donate, and find out more information about our programs.

[Fade out banjo music]

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[cue guitar strum and guitar theme w/ lyrics in background]

We here at ECHO also want to hear your feedback. We welcome your questions, comments and suggestions and invite you to email us at echoidaho@uidaho.edu. And don't forget to subscribe to Something for the Pain using your podcast app. And if you have a moment, write us a review!

[bring up theme song lyrics and chorus until first "echo Idaho", then drop volume and continue playing]

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The contributing voices on today's episode were those of: [Katy Rodgers, Alicia Carrasco, Neil Ragan, Cloeie Hood, Todd Palmer, Amy Jeppesen].

We'd also like to thank all of our listeners, without whom none of this would be possible. Without you, we'd just be talking to ourselves.

[Continue to theme chorus, fade]