Pain Plus: Challenges in Pain Management with Psychiatrically Unwell Patients

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Disclosures

• Relevant financial relationships
  • None

• Off label uses
  • None
Objectives

• Describe challenges of pain management with opioids in psychiatrically unwell patients

• Describe alternatives to controlled substance use for these patients
Primary Care Case

- 61 y/o, 3x divorced, disabled veteran
  - Chronic LBP, hip pain, chest pain
  - Panic attacks and fear of leaving his apartment
    - “I’m afraid I’ll stop breathing and flop around like a crappie.”
  - Chronic depressive symptoms
The problems

- On chronic stable oxycodone regimen...asks for more
- Nortriptyline hasn’t helped mood or pain
- Didn’t tolerate gabapentin; pregabalin too $$
- Cannabis – relaxation and sleep
- Cigarettes – “The only thing I enjoy”
- Chronic suicidality
  - Only reason for living is Ralph= 16 y/o dog
  - “When Ralph goes, I go.”
PMH

• Chronic LBP and bilateral hip pain
• CAD – first MI age 40
  • Multiple vascular interventions + medical therapy
• PFO with bidirectional shunt
  • On chronic warfarin
• Stage IV COPD
• Hypothyroidism
• Genital herpes
• Erectile dysfunction
ΨΗ

• Chronic depression, borderline personality disorder, PTSD, and chemical dependency
• 5 psychiatric admissions for suicide attempts
• Several antidepressant trials
• CD treatment in 2005 – left AMA
  • Amphetamines, cannabis, alcohol, tobacco
• No involvement in AA/NA
• No history of psychotherapy
Medications

• Aspirin
• Levothyroxine
• Lovastatin
• Metoprolol
• Nifedipine
• Nortriptyline 50 mg twice daily (therapeutic blood level)
• Oxycodone 10 mg/5 mg/5 mg/5 mg
• Omeprazole
• Warfarin
• Numerous pulmonary medications
Pain Inventory

- Widespread pain
  - 6/10 to 7/10
- 20% relief from oxycodone
- 7/10 interference
  - General activity
  - Mood
  - Sleep
  - Relations with other people
  - Enjoyment of life
“Oxycodone is the only thing that helps. If my pain gets worse, I’ll kill myself.”
What would you do next?

A. Continue oxycodone because he says he’s going to kill himself if his pain worsens

B. Taper oxycodone to discontinuation because he has multiple red flags and his pain is only 20% reduced with oxycodone

C. Refer to Pain Clinic

D. Refer to Pain Rehabilitation Program

E. Refer to Psychiatry
What would you do next?

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E. Refer to Psychiatry
Pain Clinic

- Reason for consult
  - Chronic low back pain. Patient on long-term oxycodone and requests dose increase.
  1. Underlying cause of pain?
  2. Treatment options?
  3. Appropriateness of escalating oxycodone dose?
Pain Clinic recommends

1. Avoid opioids
   • “He continues to state that these are the only medications that have been helpful and improve his quality of life, and he is dying anyway because of stage IV COPD.”
   • “He has multiple red flags and risks that put him at a higher risk of continuing this medication, including a PMH of significant cardiac comorbidities, advanced COPD, marijuana abuse and polysubstance overdose.”

2. Pain Rehabilitation
   • Says he cannot afford transportation to and from PRC

3. Meet with Pain Clinic CNS for wellness consult
   • Goals: Improve QOL, Cope with pain
   • “He does not seem very excited about this option, either.”
Psychiatry Consult

• Reasons for consult:
  1. Recommend medication to treat depression and chronic pain
  2. Is he okay for long-term opioid use with a Controlled Substance Prescribing Plan?
Psychiatry recommends

1. Pain Rehabilitation Program
2. Taper oxycodone to discontinuation
3. Avoid starting benzodiazepine for panic attacks
4. Replace nortriptyline with
   - Escitalopram or mirtazapine
   - *Duloxetine not recommended - trialed previously*
5. Referral to county mental health center for evidenced-based psychotherapy
6. Referral to county for supplemental health insurance and case management
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Drug ODs –
The leading cause of unintentional death in the United States

• Among pharmaceutical overdoses in 2010
  • 75% opioid-related
    • 29% with benzodiazepines
    • 13% with antidepressants
Opioid overdose deaths 2014

- 9 per 100,000 in 2014 vs 7.9 per 100,000 in 2013

- Age-adjusted rate of death involving
  - Methadone: unchanged
  - Natural and semisynthetic: 9%↑
  - Heroin: 26%↑
  - Synthetic other than methadone: 80%↑
Risks of Opioids –BZDS –Both

• Fall-related injuries due to oversedation
• MVAs
• Death due to respiratory depression
  • COPD, OSA
• ▲ risk of opioid-related death at Morphine Equivalent Daily Dose (MEDD) > 100 mg
• MEDD as low as 50 mg ▲ 4x risk of OD death with acute or chronic pain
Chronic pain and psychiatric disorders are commonly comorbid!

- Mood disorders
- Anxiety disorders
- Substance use disorders
- Personality disorders
Benzodiazepines

• “All guidelines and consensus statements recommend that this group of drugs should be used only to treat anxiety that is severe, disabling, or subjecting the individual to extreme distress…these drugs should be used at the lowest effective dose for the shortest period of time (maximum 4 weeks), while medium/long-term treatment strategies are put in place and with caution in patients with substance misuse. A very small number of patients with severely disabling anxiety may benefit from long-term treatment with a benzodiazepine.”

Case Outcome

- PCP told him she would not continue CSPP and would taper him off oxycodone
- Pain Rehabilitation Consult
  - Declined to participate - no motivation to taper off oxycodone → poor PRC candidate
- Pain Clinic
- Referral for case management and DBT
- Escitalopram trial
- Psych and PCP met with him together
Difficult patient population to treat

• Avoid initiating BZDs
• Taper patients off BZDS
• Taper off opioids
  • Pain Rehabilitation
  • Pain Clinic
• Multidisciplinary approach utilizing evidence-based therapies and interventions for pain and comorbid psychiatric disorders
  • Cognitive Behavioral Therapy
  • Dialectical Behavioral Therapy
  • Chemical Dependency Treatment
• Utilize Prescription Monitoring Databases
• Utilize Controlled Substance Prescribing Plans
References

- Jones CM et al. Pharmaceutical overdose deaths, United States, 2010. JAMA 2013; 309(7);657-9
Questions & Discussion

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