Warning Signs of Opioid Misuse and Treatment Options in Primary Care

Matthew Felgus MD FASAM

(1) BEFORE YOU START OPIOIDS:

- POLL QUESTIONS 1+ 2

Poll Question 1

- Which of the following are warning signs that your patient could become addicted to their opioid medication?
  - Family history of alcoholism
  - Drinking 7 or more drinks per week
  - High current life stressors (e.g. divorce)
  - History of high anxiety

Poll Question 2

- Which of the following are warning signs that your patient could become addicted to their opioid medication?
  - History of past trauma
  - Past history of alcohol dependence
  - Concurrent use of a benzodiazepine
  - Cannabis use 2-3x/week

(2) BEFORE YOU START OPIOIDS

- Past overuse of CNS depressants (alcohol or benzodiazepines) increase the risk of opioid overuse. Likely a greater risk than overuse of other substances (cocaine, cannabis) but both MD and patient must maintain awareness
- History of family members becoming ENERGIZED from opioid medication (more on this soon)
- Greater than 7 drinks per week (not rare in WI)

Standard Drink

Matthew Felgus, MD 8/16/18

Education not Punishment

- Higher risk factors does NOT mean your patient is intending to abuse their opioid medication
- Sometimes it is necessary to utilize opioid medication and this should be done as safely as possible
- Nobody starts using anything planning to develop an addiction
- Educating the patient that they are higher risk in a non-judgmental way can make a major difference

(1) ENERGIZED by Opioids

- Most people become tired, nauseous, cloudy after taking an opioid
- Some people become energized
- This appears to be a genetic variation (does run in families)
- This will likely occur at first exposure (including in children)
- Education to this risk factor is key to preventing addiction

(2) ENERGIZED by Opioids

- Positive Reinforcement: If it makes you feel good, you're going to do it again. And again
- This is a major risk factor for addiction to opioids
- Patients often say they had no idea this could happen to them (otherwise upstanding citizens)

<3 Min Conversation for ALL Patients Prior to Opioid Rx

- “If you (or your child) feel energized after taking this medication, you need to call the office and let us know. This shows you may have the brain wiring to develop an addiction to this type of pain medication. It is based on genetics and isn’t anything you are doing wrong. It is not about willpower or good character. It can happen to anybody with this type of brain wiring and most people don’t know they have it until they take this kind of prescription. However, this means you need to be very cautious with any opioids – never take extra and, if you can, have somebody else hold it for you.’’

Matthew Felgus, MD 8/16/18

Opioid Contract

- Never a bad idea
- Set parameters:
  - No early fills
  - Specific time frame of initial (1 week or less ideal; 1-2 weeks safer than longer) and subsequent rxs
  - Clarity of reasonable timeframe of rx for diagnosis
  - For more chronic condition, expectation of other modalities of pain control
  - No ‘doctor shopping’/no new controlled substances
  - Contact office for any abnormalities (lost, extra use, energy after use)
  - Breaking of agreement can lead to discontinuation

How to Minimize Abuse of Medication in a Substance Abusing Population

- Avoid meds with potential for abuse whenever possible
- Education
- Limited Use: e.g. small quantities (5 pills per month) for panic attacks

How to Minimize Medication Misuse a Substance Abusing Population

- PDMP as a source of information:

  Shorter time frames filled

  Other opioids in addition to yours

  Surprises (‘I forgot to tell you…’) regarding other controlled substances

ONCE YOU START OPIOIDS:

- POLL QUESTIONS 3 + 4

Poll Question 3

- Your patient returns for 1 month follow-up and requests renewal of their opioid Rx. Which of the following are risk factors?
  - Continued use of alcohol > 7 drinks per week
  - Reporting increased energy or ‘great’ mood
  - Complaining of depression
  - Ongoing Rx for a benzodiazepine

Poll Question 4

- Your patient returns for 1 month follow-up and requests renewal of their opioid Rx. Which of the following are risk factors?
  - Pain is not improving
  - High anxiety
  - Going through a divorce or recent job loss
  - Feeling ‘withdrawal’ when they try to lower their medication

Things Can Change…

- Pain that is not improving may cause
  - An increase in mental health symptoms (mood, anxiety, sleep)
  - Inability to work, perform usual activities
  - Loss of social supports
  - Relying on the opioid for coping with any of the above

Depression

- Opioids are CNS Depressants
- Incapacitation, Isolation, Chronic Pain can lead to depression
- Opioids numb emotional pain as well as they numb physical pain
- It is important to screen for lowering of mood

Birth of An Anxiety Disorder

- Feeling Powerless (surgery, MVA, work accident)

+

- Previously High Functioning

=

- Risk of Panic Attacks/Generalized Anxiety

Opioids and Anxiety

- Opioids are wonderful numbing agents and individuals with anxiety, depression and past/present trauma want to be numbed

- Self-medication is a pathway to addiction although the individual is not trying to ‘get high’

(1) Warning Signs

- Anxiety causes increased perception of pain
- Depression causes increased perception of pain
- Trauma causes increases perception of pain
- Chronic insomnia causes increased perception of pain

(2) Warning Signs

- Per PDMP, fills consistently early (30 day Rx is filled every 26 days)
- A patient is calling for refills, then making excuses as to why they can't come in to the office
- Resistance to other modalities for pain treatment (including non-opioid medications)
- Resistance to lowering dose
- Using other drugs (random UAs are never a bad idea)

(3) Warning Signs

- The opioid epidemic would not have taken off as it did without patients selling their opioids.
- Patients are continuing to sell their opioids- it is a lucrative way to supplement one's income
- Other than being tipped off, there is no reliable way for an MD to know who is selling or fully prevent such selling
- THEREFORE, do not overprescribe and try not to refill without patient contact (ideally, in person)

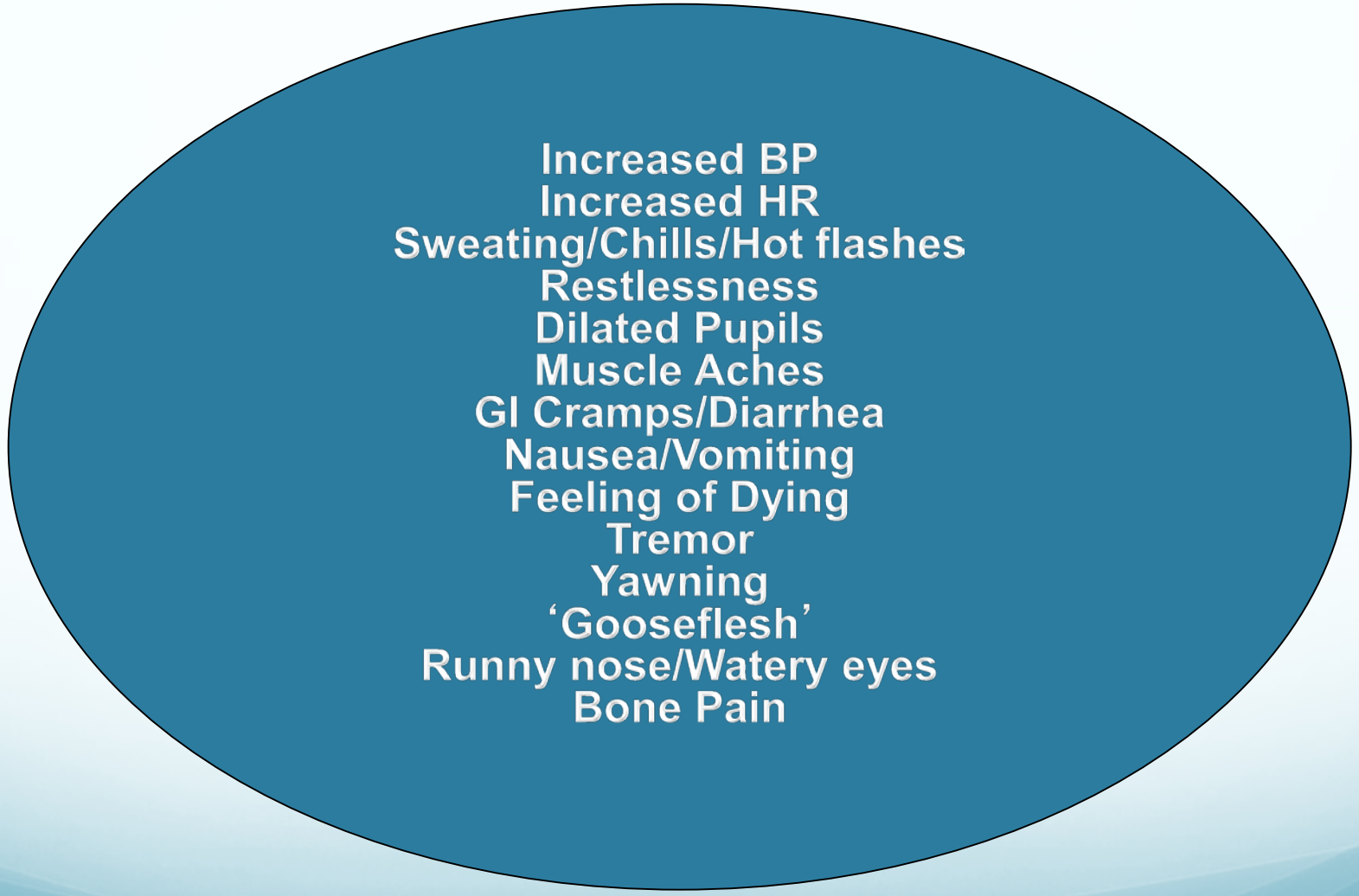
(4) Warning Signs

- “Doc, I’m trying to cut down my pain pills but I’m going into withdrawal…”

Withdrawal or Anxiety?

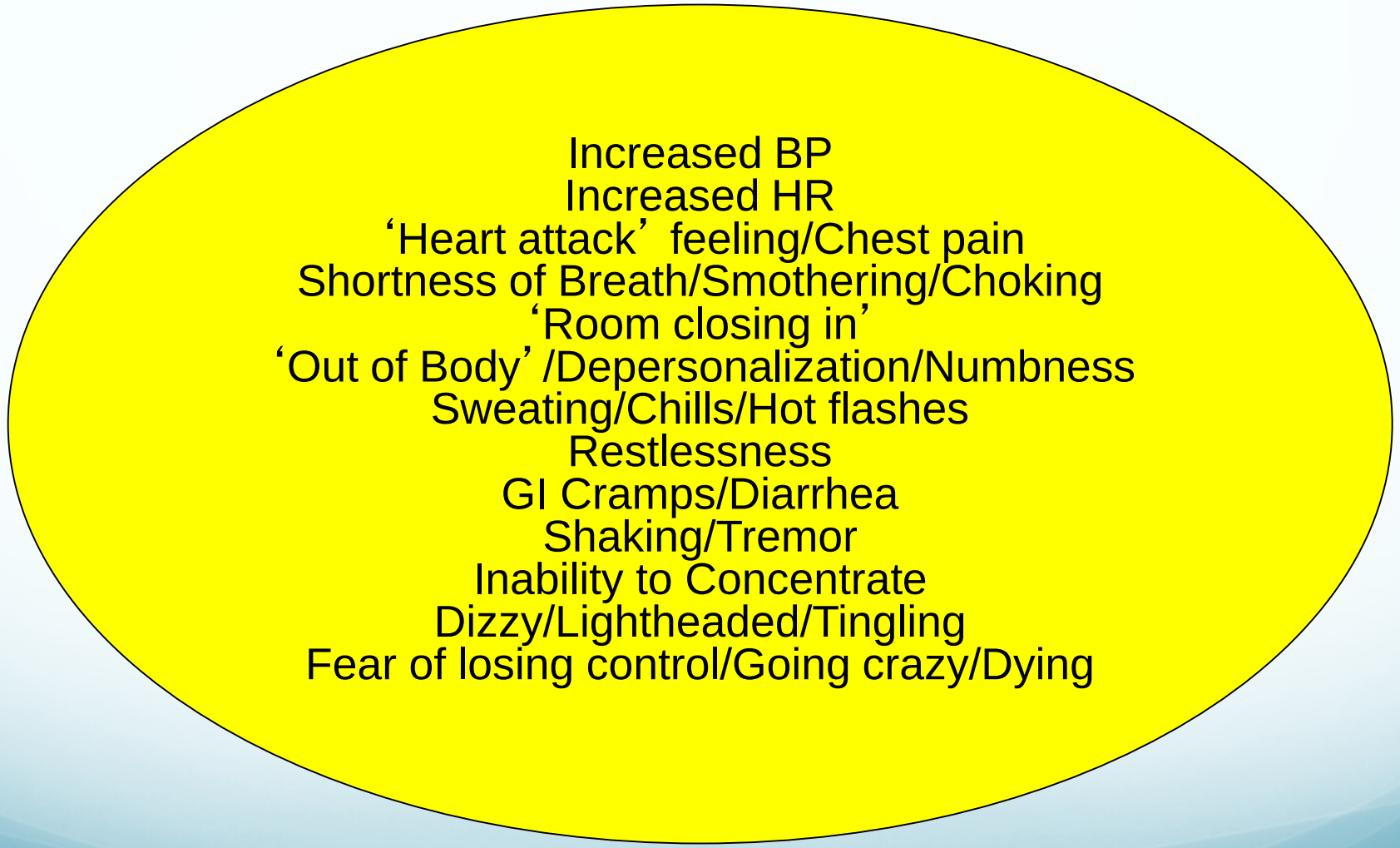
- Extremely common presentation
- High degree of overlap between withdrawal and anxiety sxs
- While anxiety isn't responsible for the opioid epidemic, it is a major barrier for individuals to stop using

Opioid Withdrawal



Matthew Felgus, MD 8/16/18

Anxiety


Increased BP
Increased HR
‘Heart attack’ feeling/Chest pain
Shortness of Breath/Smothering/Choking
‘Room closing in’
‘Out of Body’ /Depersonalization/Numbness
Sweating/Chills/Hot flashes
Restlessness
GI Cramps/Diarrhea
Shaking/Tremor
Inability to Concentrate
Dizzy/Lightheaded/Tingling
Fear of losing control/Going crazy/Dying

Anxiety Vs. Opioid Withdrawal

- Take a good history
- Corroborate with family and friends
- Symptoms when abstinent
- Symptoms prior to use
- Look for physical evidence (e.g. gooseflesh, runny eyes/nose)

(1) Your Patient May Be Addicted to Opioids

- Now What?

(2) Your Patient May Be Addicted to Opioids

- Encourage Honest, Open Dialogue
  - Running out early
  - How much are they taking (could be supplementing)
  - Do NOT cut off their prescription at the first sign of a problem, they will often turn to the street for pills or heroin

(3) Your Patient May Be Addicted to Opioids

- Screen for ‘The Big 4’:
  - Anxiety
  - Depression
  - Trauma
  - Insomnia
- There are available screens (PHQ-9, GAD, HAM-D)

(4) Your Patient May Be Addicted to Opioids

- Refer to Pain Treatment
  - ‘Alternative’ therapies: Neuromuscular Tx, Massage, Acupuncture
- Refer to Counseling
- Good Boundaries and a Pain Contract (if not already in force)
  - No early refills under any circumstance
  - Slowly lowering doses

(1) Opioids and Depression

- Depressed opioid users often can not maintain sobriety if depression is not treated
- Opioids may “depress” medications for depression

(2) Opioids and Depression

- Opioid abusing depressed individuals often have their use brought to attention before their depression

ANTI-ANXIETY

- BENZODIAZEPINES
  - Immediate relief
  - Tolerance, mental dependence can result if used long-term in a susceptible individual
  - Binds in the same area of brain as alcohol
  - Numerous studies have stated contraindicated in PTSD as can be disinhibiting
  - Respiratory Depression risk with opioids
  - THEREFORE, NOT RECOMMENDED

ANTI-ANXIETY: non-addicting (prn or sched)

- **Gabapentin**
- **Clonidine**
- **Propranolol (situational anxiety)**
- **Quetiapine**
- **Tiagabine**
- **Trazodone**
- **Hydroxyzine**
- **Buspirone**

Insomnia: non-addicting

- **Trazodone**
- **Clonidine**
- **Quetiapine**
- **Hydroxyzine**
- **Diphenhydramine**
- **Doxepin**
- **Mirtazepine**

Medication Assisted Tx for Opioid Dependence

- Buprenorphine (e.g. Suboxone®)
- Naltrexone (oral or IM- Vivitrol®)
- Methadone

Buprenorphine: Why?

- Effective, proven treatment in reducing use
- Keeps clients in treatment (carrot)
- Blocking agent for other opioids
- Less likely to be abused (but not impossible)

Buprenorphine: Why Not?

- Over reliance on medication vs. recovery tools
- Opioid Replacement may be started at a higher relative dose than amount used and patients may appear ‘stoned.
- It is possible to abuse opioid replacement medications
- Belief among some prescribers that this is lifelong treatment

Opioid Replacement Therapy: Buprenorphine

- Dosage Range: O.25-24+ mg./day
- Research shows receptors saturated at 16mg
- Manufacturer does not recommend >24 for any reason
- Quick detox vs. slow (3+yrs.) detox vs. maintenance

(1) Buprenorphine/Naloxone

- Half-life is 22-40 hours (average 35 hrs.) so only needed once daily
- Safer in OD since less respiratory depression than other opioids
- Best if used as past of a treatment program

(2) Buprenorphine/Naloxone

- Yes, you can get high….if not opioid dependent
- Diversion of prescription
  - Party drug for those without an opioid habit
  - Prevention of opioid withdrawal in those using
  - Self detox for those trying to quit

Injectable Naltrexone (Vivitrol®)

- Blocks effects of opioids for 1 month
- More residential treatment programs offering this option at discharge and jails/prisons
- Alternative to Replacement Therapy as can not be combined with opioids including suboxone
- Good option for motivated individuals

Inj Naltrexone: Why?

- It’s not an opioid
- It can not be abused (no high)
- No street value
- It saves lives –
  - Injection as leaving incarceration or rehab does help prevent overdose

Inj Naltrexone: Why Not?

- Injection is expensive ($800-1200/vial)
- Not an opioid and does not numb (still can have cravings)
- May be done under duress
- Patients may try to overcome block as injection wears off and overdose
- Pain medication will not be as effective (accident or emergent surgery)

Almost always underlying substance use….

- Anxiety
- Trauma
- Depression
- Insomnia

(1) In Summary:

- Addiction is a disorder of brain wiring
- Shame is a part of addiction
- We can not make anybody ready for treatment
- We can offer compassion along with good boundaries

(2) In Summary:

- Each patient has to walk his/her path
- Their success or failure is not our responsibility

Final Thoughts…

- Nearly all individuals who become addicted are trying to numb something, and need our help to learn to feel again
- Medication alone will not solve the issue of substance abuse and addiction but may be one piece of the puzzle

Final, Final thoughts…

- Healing is a s-l-o-w process and relapse is the rule rather than the exception
- The medical profession has a lot to learn about the above, and the majority of MDs are not trained in treating addictions