1. Chronic Opioids
9:05–9:50am

History and Presentation:
Ramana Naidu

Chronic Opioids in the Management of Non-Malignant Pain:
Ramana Naidu

Pain Assessment
- Nursing Perspective: Sarah Brynelson
- Physician Perspective: Scott Steiger
- Psychology Perspective: Jessica Pullins
- Socio-Economic and Cultural Differences: Chris Miaskowski

Case 1 Panel Discussion
Case 1 | Chronic Opioids | Disclosure Statements:

- **Ramana Naidu:** Pacira Pharmaceuticals, Pain Clinic of Monterey, Myoscience
- **Sarah Brynelson:** I have no financial disclosures to report
- **Scott Steiger:** I have no financial disclosures to report. Any off-label uses for buprenorphine will be clearly delineated as such.
- **Jessica Pullins:** I have no financial disclosures to report
- **Christine Miaskowski:** I have no financial disclosures to report
Case 1 | Chronic Opioids | History and Presentation

Ramana Naidu, MD
Assistant Professor, Director,
Acute Pain, Division of Pain Medicine,
Department of
Anesthesia and Perioperative
Care, Director, Pain
Services, UCSF Medical Center
Case 1 | Chronic Opioids | History

52 year-old gentleman with h/o failed back surgery syndrome, PTSD, opioid use disorder, scheduled for repeat spinal fusion due to progressing neurologic deficits.

PMHx:
• PTSD from a motor vehicle collision in 2001
• Failed Back Surgery Syndrome s/p Lumbar Fusion L3-S1
• h/o Substance Abuse – heroin
• Abuse of Prescribed Opioids

PSHx:
• Inguinal Herniorrhaphy – 1989
• Lumbar Fusion L3-S1 after trauma
Case 1 | Chronic Opioids | History

52 year-old gentleman with h/o failed back surgery syndrome, PTSD, opioid use disorder, scheduled for repeat spinal fusion due to progressing neurologic deficits.

Meds:
- OxyContin 60mg by mouth three times daily.
- Oxycodone 30mg by mouth every 4 hours as needed
  - Taking 4-6 every day.
- Duloxetine 120mg by mouth daily
- Nortriptyline 25mg by mouth at night
- Lorazepam 1-2mg every 12 hours as needed for anxiety
- Codeine
Case 1 | Chronic Opioids | History

52 year-old gentleman with h/o failed back surgery syndrome, PTSD, opioid use disorder, scheduled for repeat spinal fusion due to progressing neurologic deficits.

Soc:
• Divorced, living alone in an apartment
• 1 daughter (age 26y); 1 son (age 21y)
• Works as a wholesale distributor for a major grocery chain
• Occasional EtOH, non-smoker, 1-2 years of intermittent cocaine and heroin use in 1980s
Case 1 | Chronic Opioids | History

52 year-old gentleman with h/o failed back surgery syndrome, PTSD, opioid use disorder, scheduled for repeat spinal fusion due to progressing neurologic deficits.

PE:
• VS: HR: 88 BP: 142/91 RR: 18 SpO2: 99% NRS: 9/10
• Gen: In distress, irritable,
• MSK: 3/5 muscle strength of hip flexors on Left, 4/5 on Right.
• Psych: depressed mood, thought content normal
Case 1 | Chronic Opioids | History

52 year-old gentleman with h/o failed back surgery syndrome, PTSD, opioid use disorder, scheduled for repeat spinal fusion due to progressing neurologic deficits.

Rads:
• MRI Thoracic and Lumbar Spine:
  • L2-3 disc protrusion with >50% loss of height.
  • Grade III spondylisthesis of L2 on L3 (>50%)

Labs:
• Pre-Surgical Labs within normal limits
BIOLOGICAL
GENETICS

SOCIAL
ENVIRONMENT

PSYCHOLOGICAL
STRESSORS

HEALTH

1977
GEORGE ENGEL

UCSF
NOCICEPTION

PAIN

SUFFERING

PAIN BEHAVIOR

JOHN LOESER
Opioids in Chronic Non-Malignant Pain

**ACUTE**
- Surgery
- Trauma
- Acute Medical Conditions
- Acute Pain after Surgery and/or Trauma

**CHRONIC**
- Chronic Medical Conditions

**CANCER**
- Surgery
- Radiation Therapy
- Chemotherapy

“Transient pain that occurs within the expected period of healing.”
1990: "I’m worried about creating an addict"

2005: "Patients deserve opioids ad infinitum"
Opioid-Related Adverse Effects

**ADVERSE EFFECTS WITH ACUTE USE**
- Respiratory Depression
- Nausea/Vomiting
- Pruritus
- Urticaria
- Constipation
- Urinary Retention
- Delirium
- Sedation
- Myoclonus
- Seizures

**ADVERSE EFFECTS WITH CHRONIC USE**
- Hypogonadism
- Immunosuppression
- Increased Feeding
- Increased Growth Hormone
- Osteopenia
- Withdrawal
- Tolerance, Dependence
- Abuse, Addiction
- Hyperalgesia
- Impairment While Driving
- Diversion
Case 1 | Chronic Opioids | Opioid-Induced Hyperalgesia (OIH)

“... a.k.a. the reason we have to undo everything we have done in the past 20 years in pain management”
Opioid-Induced Hyperalgesia

State of nociceptive sensitization caused by exposure to opioids paradoxical to the goal of this therapy


All full mu-agonist opioids are implicated to various degrees.

Clinical Features:
• Increased sensitivity to pain stimuli
• Worsening pain despite increasing doses of opioids
• Pain that becomes more diffuse, extending beyond the distribution of pre-existing pain

Opioid-Induced Hyperalgesia: Molecular Mechanisms

Glutamate-induced activation of the N-methyl-D-aspartate receptor


Increased release of the excitatory neuropeptide calcitonin gene-related peptide (CGRP) induced by increased levels of dynorphin A at the spinal level


Increased activity of the excitatory neuropeptides substance P and neurokinin1 (NK1) associated with chronic use of opioids


Increased activity of microglia and astrocytes reported to mediate the effect of pro inflammatory cytokines (IL-1β/IL-6)

O’Callaghan JP et al: Metabolism 2010; 59 (Suppl 1): S21-
Ketamine

Initiated at UCSF in 2012
Now acceptable for use on all acute care floors at UCSF

Goal #1: Reduce daily opioid consumption
Goal #2: Reduce the development of chronic pain after surgery
• NMDA-antagonist. Anti-Hyperalgesic.

• Limitation is in side effects.

• Evidence supports its use in several surgeries:
  Thoracotomy, Arthroplasty, Laparotomy, Spine, etc.

• Continuing evidence supporting its use as an antidepressant.

• Do not use in patients with h/o schizophrenia, schizoaffective disorder or 
  DSM-V Axis II, cluster A personality disorders
Why Use Long-Acting Opioids for Chronic Non-Malignant Pain?

Decrease peaks and troughs of short-acting opioids

Potentially can reduce the development of tolerance

Patient satisfaction gained with longer duration of relief, especially at night during sleep, or during the day while performing activities of daily living.
Evidence/Expert Opinion on the Use Long-Acting Opioids for Chronic Non-Malignant Pain…

Cochrane Review 2010: Many patients discontinue chronic opioid therapy due to adverse effects or ineffective relief. There is weak evidence that some patients benefit with long-term therapy of opioids.

Peri-Operative Management of Patients on Chronic Opioid Therapy

PATIENTS UTILIZING PCA

\[ n = 149 \text{ pairs; mean (SD); median (IQ) proportion (\%)} \]

<table>
<thead>
<tr>
<th>Variables</th>
<th>CPOC (^a)</th>
<th>Controls</th>
<th>Difference</th>
<th>95% CI</th>
<th>(P)-value</th>
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<tr>
<td>VRS (^b) at rest</td>
<td>5 [3]</td>
<td>3 [3]</td>
<td>2.5</td>
<td>(2.0, 3.0)</td>
<td>0.0001</td>
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<tr>
<td>VRS (^b) with stimulation</td>
<td>8 [2]</td>
<td>7 [3]</td>
<td>2.0</td>
<td>(1.5, 2.5)</td>
<td>0.0001</td>
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<td>Days on service</td>
<td>4 [4]</td>
<td>3 [2]</td>
<td>1.0</td>
<td>(0.5, 1.5)</td>
<td>0.001</td>
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<tr>
<td>Dose (^c) (mg MS in 24^\circ C)</td>
<td>135.8 (68.5)</td>
<td>46.8 (32.5)</td>
<td>89.5</td>
<td>(79.1, 99.9)</td>
<td>0.0001</td>
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<tr>
<td>Pruritis</td>
<td>46/148 (31.1%)</td>
<td>65/148 (43.9%)</td>
<td>-12.8%</td>
<td>(-23.4, -2.2)</td>
<td>0.03</td>
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<tr>
<td>Pruritis requiring medication</td>
<td>17/149 (11.4%)</td>
<td>20/149 (13.4%)</td>
<td>-2.0%</td>
<td>(-9.0, 5.2)</td>
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<td>Nausea/Vomiting (NV)</td>
<td>40/148 (27.0%)</td>
<td>59/148 (39.9%)</td>
<td>-12.8%</td>
<td>(-23.3, 2.3)</td>
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<td>N/V requiring medication</td>
<td>25/149 (16.8%)</td>
<td>38/149 (25.5%)</td>
<td>-8.7%</td>
<td>(-17.4, 0.1)</td>
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<td>Urinary retention</td>
<td>5/ 75 (6.7%)</td>
<td>9/ 75 (12.0%)</td>
<td>-5.3%</td>
<td>(-15.1, 4.5)</td>
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<td>Anxiolysis</td>
<td>24/137 (17.5%)</td>
<td>1/137 (0.7%)</td>
<td>16.8%</td>
<td>(10.2, 23.4)</td>
<td>0.001</td>
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<td>Sedation (^d)</td>
<td>74/147 (50.3%)</td>
<td>28/147 (19.0%)</td>
<td>31.3%</td>
<td>(20.7, 41.9)</td>
<td>0.0001</td>
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</table>

\(^a\) Chronic pain and opioid consuming patients.
\(^b\) Verbal rating scale where 0 = no pain and 10 = worst pain.
\(^c\) Milligrams of morphine equivalents.
\(^d\) Moderate or severe.

Rapp et al, Pain, 1995
How to Manage Long-Acting Opioids around Surgery

There is no evidence supporting opioid taper just prior to surgery. It can lead to withdrawals, and patients report unmanaged pain due to their tolerance.

Continue Extended-Release/Long-Acting (ER/LA) Opioids during the peri-operative period. A transition plan should occur with the PCP or pain physician after discharge.

If you have more than three months prior to surgery, suggest consultation with a pain physician to discuss an early and gradual taper, as well as a peri-operative pain management plan.

Rotation and use of unique opioids such as buprenorphine may be useful after surgery.
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<th>SOCIAL</th>
<th>PREP</th>
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<th>POST-OP</th>
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Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective

Sarah Brynelson, RN, MS
Clinical Nurse Specialist, Pain Management, UCSF Medical Center
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | Objectives

- Provide a broad overview of pain assessment in adult patients
- Outline specific strategies for managing a complex patient to include
  - Trust
  - Communication
  - Decision making
  - Goal setting
  - Education
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | Comprehensive Pain Assessment

Previous history of chronic pain
- Etiology of the pain
- Date of onset
- Pain locations
- Alleviating/aggravating factors
- Medication management history
  - Previous analgesics
  - Current analgesics
- Nonpharmacologic management strategies
- Effectiveness of current pain management plan
- Impact of pain on mood and function
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | Ongoing Assessment of New Pain Conditions

- Onset
- Duration
- Pain characteristics/qualities
- Location(s)
- Intensity/severity
- Aggravating/alleviating factors
- Effectiveness of current treatments
- Changes in functional status
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | Pain Assessment Tools

- First Line = Self-report
  - 0-10 numeric rating scale
  - Verbal descriptor scale (mild/moderate/severe)
  - FACES (ask the PATIENT to pick a face)
- Second Line = Behavioral assessment tools (adult)
  - Checklist of non-verbal pain indicators (CNPI)
  - Critical care pain observation tool (CPOT) (critical care only)
- “Assume pain present”
  - For unresponsive patients with conditions thought to be painful. May also use to pre-medicate before painful interventions/procedures (dressing changes, turning, etc.).
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | Case Specific Challenges

- High-dose opioid requirements
- Pain will be difficult to manage and treat
- Patient will be resource-intensive
- Providing adequate analgesia without over sedating the patient may be difficult.
Establish Trust

• Provide time for conversations about pain between nurse and patient
• Open and direct communication
• Believe the patient
• Listen to his frustrations and praises without judgment
• Demonstrate compassion and empathy regardless of personal beliefs or past experiences (work or life)
Involve Patient in the Decisions

- What assessment scale works best for him?
- Would he prefer to be awoken for pain assessment or be allowed to sleep longer intervals?
- Are there non-pharmacologic interventions that have worked for him?
- What are they and can we provide them?
- What is the best way to communicate with him about his pain management plan (whiteboard, journal)?
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | Strategies

Provide regular and direct communication about his pain management plan and course
• Timing of medications
• What pain interventions are currently underway
• What steps you take when pain is intolerable or unrelieved by current treatments

Education
• Use of the pain assessment tools (more than once if needed)
• Manage expectations about pain severity (i.e. may worsen after surgery, with ambulation).
Establish functional goals in addition to “acceptable levels” of pain

• Create a plan for pain management as the patient works toward function (i.e. timing medications before ambulation)
• Insure that the medical team and patient goals are in sync.
Case 1 | Chronic Opioids | Pain Assessment – Nursing Perspective | References

Case 1 | Chronic Opioids | What is the role of buprenorphine/naloxone in the treatment of co-occurring pain and substance use disorder?

Scott Steiger, MD, FACP, ABAM Diplomate, Assistant Professor of Clinical Medicine, Division of General Internal Medicine, UCSF
Scott.Steiger@ucsf.edu
Case 1 | Chronic Opioids | Legal Options for Treating Opiate Use Disorder in the US

- **Methadone** (full agonist)
  - ONLY within the context of MMTP
- **Buprenorphine** (partial agonist)
  - ONLY with DEA-waiver (“x-number”)
- **Naltrexone** (antagonist)
  - Available as PO or depot
  - Avoid in advanced liver disease and pain
- **Abstinence-based counseling**
  - Relapse approaches 100% at 12 mo
Case 1 | Chronic Opioids | Buprenorphine is a partial agonist of the $\mu$-opioid receptor
Case 1 | Chronic Opioids | Buprenorphine is a partial agonist of the $\mu$-opioid receptor

*NABB.org
Case 1 | Chronic Opioids | Co-occurring Disorders Clinic

VA retrospective cohort of 143
• Referrals from PCP, pain management, hospital, substance abuse treatment
• Outcomes
  • Analog Pain Score (APS)
  • Retention
• Bup/nx discontinued if…
  • Uncontrolled pain on >28 mg bup/nx
  • Tox + 3x, miss 3+ visits, 3+ early refills

*Pade et al. JSAT 2012
Case 1 | Chronic Opioids | Change in Pain Scores and Retention

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<tr>
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<td>9 (75%)</td>
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<tr>
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Pade et al. *JSAT* 2012
Case 1 | Chronic Opioids | Initial Dose Must be Appropriate

Prospective cohort study NYC (n=12)

- 3 highest doses (>300 MS eq) and 3 lowest doses (<20 MS eq) quit at induction
- 4 who completed reported better pain control

Rosenblum *J Opioid Manag* 2012
Case 1 | Chronic Opioids | What is the role of buprenorphine/naloxone in the treatment of co-occurring pain and substance use disorder? | Summary

- Bup/nx’s pharmacology offers unique advantages compared to other opioids
- Rx bup/nx instead of other opioids
  - Opioid use disorder
  - Chronic pain with other SUD
- Consider bup/nx
  - Pain refractory to other opioids?
Case 1 | Chronic Opioids | What is the role of buprenorphine/naloxone in the treatment of co-occurring pain and substance use disorder? | Summary | Bup/nx Requires a DEA Waiver to Rx

- [www.buprenorphine.gov](http://www.buprenorphine.gov)?? For online training and list of 8 hour “live” courses
- “Half and Half” course coming to Mt Zion this fall!

Scott.Steiger@ucsf.edu
Case 1 | Chronic Opioids | Assessment: Psychology Perspective

Jessica Pullins, PhD
Clinical Psychologist,
UCSF Pain Management Center
Clinical Health Instructor, UCSF
Department of Anesthesia and Perioperative Care
Case 1 | Chronic Opioids | Psychological Assessment

Critical Areas

PMHx:
• PTSD from a motor vehicle collision in 2001
• Failed Back Surgery Syndrome s/p Lumbar Fusion L3-S1
• h/o Substance Abuse – heroin
• Abuse of Prescribed Opioids

• PTSD
• Substance Abuse
• Passive/Active Coping Strategies

PTSD, substance abuse, and passive coping → Poor prognosis

Develop a psychology treatment in concert with the interdisciplinary team, including the spine surgeon.
Case 1 | Chronic Opioids | Assess PTSD

**PTSD is associated with poor outcomes following elective lumbar fusion:**
“…Every measure of clinical outcome in this population of patients who underwent elective lumbar fusion showed statistically less improvement at 1 year for patients experiencing postoperative PTSD symptoms as compared with those who did not.” (Hart *et al*, 2013)

**PTSD leads to hypocortisolemia (e.g., Sherin *et al*, 2011):**
- He is likely locked in a chronic, pro-inflammatory response process now, and…
- He is at risk of a pro-inflammatory response following surgery.

**Treatment Goal:** Treat the PTSD using an empirically-supported therapy to reduce or alleviate symptoms prior to the surgery.
Substance abuse is associated with poor outcomes following back surgery. (Epker & Block, 2001)

Very limited research on treating comorbid opioid use disorder and PTSD. “Combining opioid substitution therapy with evidence-based behavioral intervention designed for individuals with comorbid PTSD (e.g., Seeking Safety) may improve the treatment outcomes in this population.” (Ayman et al, 2013)

Treatment Goal: Develop behavioral plan with pain specialist and addictionologist to reduce opioid dose and eliminate abuse of prescribed opioids.
Case 1 | Chronic Opioids | Assess Pain Coping Strategies

**Passive pain coping**
Withdrawal of activity; giving up control to an external agent or force
- Guarding
- Resting
- Asking others for assistance
- Reliance on medications, medical interventions, and/or surgeries *with no functional improvement*

**Active pain coping**
Initiating an instrumental action to manage pain
- Task persistence
- Activity pacing
- Coping self-statements
- Socialization
- Relaxation/meditation

**Treatment goal:** Transition from passive to active pain coping.
PTSD:


Case 1 | Chronic Opioids | References | Substance Abuse | Pain Coping

Substance abuse:


Pain coping:
Case 1 | Chronic Opioids | Assessment of Socioeconomic and Cultural Differences

Christine Miaskowski, RN, PhD, FAAN
Professor – Department of Physiological Nursing
American Cancer Society Clinical Research Professor
Sharon Lamb Endowed Chair in Symptom Management Research
Case 1 | Chronic Opioids | Sociocultural Dimension

Original conceptualization of this dimension of chronic pain focused on an assessment of:

- Age
- Race/ethnicity
- Gender
- Religion/spirituality
Case 1 | Chronic Opioids | Sociocultural Dimension

Current conceptualization is focused on:

- Impact of chronic pain on the patient’s ability to carry out normal roles and social interactions
- Attitudes, beliefs, and knowledge about chronic pain
  - Patients and clinicians
- Contribution of family caregivers to the patient’s pain experience and the impact of chronic pain on the family
Case 1 | Chronic Opioids | Assessment of Sociocultural Dimension

- Avoid stereotyping patients
  - Need exists for clinicians to examine their own attitudes and beliefs about co-occurring pain and substance use
- Assessment of the sociocultural dimension of pain takes time
  - Need to develop a trusting relationship with the patient
**Case 1 | Chronic Opioids | Assessment of Sociocultural Dimension**

- Specific areas for assessment
  - Understanding of the chronic pain condition and its effect on the patient and their family
  - Meaning of the pain to the patient and their family
  - Patient’s typical coping responses to stress or pain
  - Patient’s concerns about using controlled substances
  - The economic impact of chronic pain
Case 1 | Chronic Opioids | Co-occurring Chronic Pain and Substance Use

• Uninsured, low income patients are more likely to be diagnosed with co-occurring chronic pain and substance use (Busch et al. 2013, Edlund et al. 2010)

• Until recently, patients with co-occurring chronic pain and substance use were prescribed opioids for pain management (Vijayaraghavan, et al. 2012, Edlund et al. 2010)

• Clinicians face ongoing challenges with the assessment and management of these patients:
  • Chronic pain
  • Substance use
  • Chronic use of opioid analgesics
  • Psychological problems (depression, anxiety, PTSD)
“I think most of my patients who are seeking narcotics, who have a history of substance abuse, definitely are in pain, are suffering….”

“Most of my patients lead incredibly difficult lives, many of whom have had trauma in the past, and I think in their minds these pain meds are the only things that make them feel better…..”
“I think some of them just have poor insight into how their other medical conditions and other things in their life may be contributing to their pain.”

“So when I, as a provider try to treat their chronic medical diseases or try to use non-opiate adjunct treatment or try to get them to physical therapy or surgery, I think not all of them realize that those things may help them even.”

“I think in their mind it’s very dichotomized. Oh, this provider is just not willing to treat my pain and is not willing to prescribe these medications…”
“I mean, it’s the chicken and the egg, right? Like I think a lot of people have very unstable social lives, very poor social support, …in terms of friends and family in their immediate lives, and that leads to comorbid depression and anxiety and a lot of psychosocial stressors… which then exacerbates their chronic conditions….”

“They have real pain… but until we get them housing and a way to take medicines every day where they’re not stressed out and fighting with a significant other….it – it will be difficult to manage their pain.”