Chronic Pain:

to prescribe or not to prescribe

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Disclosure of Conflict of Interest

• No conflicts to report
• No:
  – Grants
  – Consulting fees
  – Other
Objectives

1) Recognize the role of medication in chronic pain management;

2) Comprehend the current situation within Alberta (both regarding medical marijuana and the prevalence of prescription drug abuse/misuse);

3) Identify patients that would benefit from de-prescribing and alternatives.
The Chemistry of Pain

Tissue damage
Inflammation
Nerve compression

5-HT, Bradykinin, Cytokines, Histamine, Prostaglandins

EAAs $\rightarrow$ NMDA receptors
SubP / NGF / NK1 / CGRP / NO

Descending Excitation / Inhibition

Dynorphin A / CCK
5HT / NE / GABA

Neuronal Plasticity

Attention
Expectation
Affect

Peripheral $\leftarrow$ Sensitization $\rightarrow$ Central
WHO Analgesic Ladder for Cancer Pain Management

**Strong Opioid + Nonopioid**

If pain persists or increases

**Weak Opioid + Nonopioid**

If pain persists or increases

**Nonopioid**

If pain persists or increases

Acetaminophen
NSAIDs
COXIBs

Buprenorphine
Tramadol

Codeine
Morphine
Oxycodone
Hydromorphone
Fentanyl
Methadone

Antidepressants

Anticonvulsants
Cannabinoids
Canada 753mg/capita
US 693 mg/capita
Local context

- 30 million high dose Rx dispensed in Canada/year
- Alberta 2\textsuperscript{nd} highest MEDD in Canada
- Calgary has the highest overdose rate in Alberta
In 2015, more Calgarians have died from fentanyl use than traffic collisions and homicides combined.

Your next dose of fentanyl may be your last.

#FentanylKills

Fentanyl awareness ad from Calgary police and Alberta Health Services.

Prescribed opioid difficulties, depression and opioid dose among chronic opioid therapy patients

Joseph O. Merrill, M.D., M.P.H. a, *, Michael Von Korff, Sc.D. b, Caleb J. Banta-Green, M.S.W., M.P.H., Ph.D. c, Mark D. Sullivan, M.D., Ph.D. d, Kathleen W. Saunders, J.D. b, Cynthia I. Campbell, Ph.D., M.P.H. e, Constance Weisner, Dr.P.H. e

Problems and concerns of patients receiving chronic opioid therapy for chronic non-cancer pain

Mark D. Sullivan a, *, Michael Von Korff b, Caleb Banta-Green c, Joseph O. Merrill d, Kathleen Saunders b

Trends in opioid use and dosing among socio-economically disadvantaged patients

Tara Gomes, David N. Juurlink, Irfan A. Dhalla, Angela Mailis-Gagnon, J. Michael Paterson, Muhammad M. Mamdani
Do they work?

Efficacy

- Meta-analysis of 15 RCTs; duration 4-6 weeks; pain intensity (including NeP) reduced by about 30%
  - Kalso et al, Pain 2004

- Meta-analysis of 8 RCTs in NeP; duration <28 days; significant benefit
  - Eisenberg et al, JAMA 2005
Efficacy

Meta-analysis of 41 RCTs; duration 16 weeks; pain intensity reduced with strong opioids, not with weak or non-opioids; more than 1/3 abandoned treatment for lack of efficacy

- Furlan et al, CMAJ 2006

Meta-analysis of 6 RCTs in LBP; duration <16 weeks; no significant reduction in pain intensity

Efficacy

✧ In OA, research demonstrating long-term improvements in pain/function is lacking.
✧ In elderly patients with OA, the risk of opioids may be even greater than the risk of NSAIDs.
✧ Opioids should not be routinely used in OA; if necessary, they should be used for short-courses in carefully selected patients.

✧ Ivers, Dhalla, Allan, TFP ACFP 2012
Less well-suited for COT | Well-suited for COT


Smith, HS. Pain Physician, 2012;15:ES1-ES7
The down side
BAD IDEAS
We All Have Them
the patient may have no other tools to use
The patient isn’t alone
We do have some influence
Opioid tapering

- Explain Pain and role of medications
- Motivational interviewing approach to change
- Team support, plan
- Slow, structured taper
WHAT IS THE BEST ADVICE FOR PEOPLE ON, OR ABOUT TO START, OPIOID MEDICATIONS?
Understanding Pain: Brainman stops his opioids
| Reinforce patient’s motivation |
| Make sure the patient knows what to expect – and troubleshoot ahead of time |
| Try to avoid alternative Rx |

### Medication Tapering Plan

- **Date:**
- **Prescribing Physician Responsible for Taper:**

| Medication that is being tapered and current dose: |
| Target dose after taper: |

| Physician’s reason for taper: |
| Patient’s reason for taper: |
| Benefits to taper: |
| Barriers to taper: |

| Sleep |
| Mood |
| Nutrition |
| Bowel |
| Work |
| Exercise/Activity |
| Social/Relationships |

- **Flare-up**
  - Mild
  - Moderate
  - Severe
Opioid tapering

- Scheduled, ideally low dose tablets
- Blister pack, weekly dispensing
- 10% per week to start
- Agree to plateau if needed, but not go back up
Authorizing Dried Cannabis for Chronic Pain or Anxiety

PRELIMINARY GUIDANCE

September 2014
Clearly proven
risks and benefits for pain patients

Neuropathic pain
Fibromyalgia
Back pain
HIV neuropathy
MS pain
Muscle spasm
Myofascial pain
Pelvic pain
Migraine
Migraine
Tension headache
CFPC guidance

- There is no evidence to support use of marijuana for fibromyalgia, back pain, OA.
- Should be considered only for neuropathic pain that has failed to respond to standard treatments, including pharmaceutical cannabinoids.
- Should not be used for sleep or anxiety.
Evidence to date


Evidence to date

- Average N=30
- Duration of studies ≤5 days
- All previous smokers of marijuana
- Amounts ranging 25mg-900mg
- THC ≤9.4%
  - One study 20% not an efficacy study, n=8
- Smoking or vapourizing
- Reduction in pain ranging from 0.7 to 3 points on the NRS
Evidence of risks


Evidence of risks

- Cannabis Use Disorder
- Mood
- Cognitive impairment
  - Driving
  - Pregnancy
  - Children and adolescents
- COPD
- Cardiovascular/hepatic
- Hyperemesis
CFPC guidance

Do not authorize:
- Under age 25
- Personal or strong family history of psychosis
- Current or past cannabis use disorder
- Cardiovascular or respiratory disease
- Pregnant or breastfeeding

? Hepatic disease
CFPC guidance

- Use caution:
  - Active mood or anxiety disorder
  - Smoke tobacco
  - Risk factors for cardiovascular disease
  - Heavy users of alcohol or taking high doses of opioids or benzodiazepines or other sedating medications
Lay the groundwork

- Document consent discussion and patient education
- Document risk assessment, UDT and cannabis treatment agreement
- Document concrete, measurable functional goals
- Agree that treatment will be stopped if function does not improve
Ongoing monitoring

- Function
- Adverse effects
- Evidence of cannabis use disorder
- (as best you can) Aberrant medication behaviour
Process (very briefly)

- Be familiar with CPSA Standard of Practice
- Email CPSA to let them know you will be authorizing
- Ask patient to choose a licensed producer
- Complete the Medical Document and send it directly to the LP
- Patient registers with the LP and purchases their product, which is couriered to them directly
References


