Pain and Mood Sx, on Opioids, What am I going to do now?

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PAIN

International Association for the Study of Pain

"Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

Somatic Reality of Pain

Constant aversive message that your body is damaged or being harmed

- No other medical condition like it due to
  - Persistence
  - Intrusiveness
  - Behavior change unavoidable moment to moment
- Antithesis of the felt sense of control
- Struggling to regain somatic integrity
  - Maslow's Hierarchy

Optimal Approach is "Therapeutic"

- Be curious
  - Let them teach you what they are doing
- Normalize behaviors
  - Overuse, impulsivity
- Avoid playing "gotcha"
  - Patient hiding in response
- Share control
- Establish clear limits
  - Functional goals in pain
  - "Football field" analogy

Anxiety and Mood Disorders in Pain

- Pain alone, new onset sx's
  - Constant intrusion on consciousness
  - Catecholamine release
  - Loss of control
  - Role and relationship deterioration
  - Financial deterioration
  - Medication reactions
- Previous sx's enhanced by pain
  - Personality
  - SUD
  - Previous mood/anxiety disorder
    - Rumination, catastrophizing

Mood and Anxiety in Pain

- Depression rates in USA population
  - 5% current, 6.7-9.5 % yearly, 20.8% lifetime
- Depression rates in pain
  - 30-54% current, up to 65-80% lifetime
  - Increased suicidal thoughts in depressed pain patients, up to 3 fold in CPP.
- Anxiety disorders rates in USA population
  - 18.1% yearly, 28% lifetime
- Anxiety rates in pain
  - Overall prevalence in pain ranges from 16.5% to 50%

Fishbain 1999, Tang 2006, Raison 2009, Bair 2004, Knaster 2012

Substance Abuse Epidemiology

- Lifetime prevalence in USA 16.7%, with ETOH at 13.5% and other drug use at 7%
- Prevalence in PAIN PATIENTS is quite varied, 2.8-28% current and 23-41% lifetime. Most commonly cited range is 4-26%.
- Some ways to predict and contain this risk

Brown 1996, Cowan 2003, Michna 2004, ECA, Sehgal 2012,

Missed Opportunities

- Functional Pharmacology
  - Unexpected medication responses
- Opioid Stimulation Syndrome
- Misidentified sleep patterns
- Knowing safer opioids

Functional Pharmacology

- ”Junker” metaphor
  - Can’t fix your car
  - Attachment to a “fixed” car will drive potentially risky interventions
    - Procedural and pharmacologic
- Functional assessment
  - Know what their days and nights *actually* look like
  - Optimize somatic energy
- Pharmacologic assessment
  - What all medications are *actually* doing
  - Treating function, not just disease process

Unexpected Medication Responses

- Beneficial for disease, deleterious for function.
  - Neuropathic agents
    - Pregabalin, gabapentin, topiramate, etc
    - Lamotrigine?
  - Opioids
  - Benzodiazepines
- Atypical medication reactions
  - Expect sedation, get stimulation
    - Opioids, topiramate, pregabalin, benzodiazepines, etc
  - Expect stimulation, get sedation
    - Stimulants, NE agents, etc

Opioid Stimulation Syndrome

- Sleep disturbance
  - Sedative use/overuse
- Irritability
  - Discharge from clinic
- Impulsivity
  - Medication misuse
- Addiction
- Opioid induced hyperalgesia?

Prescription Opioid Use

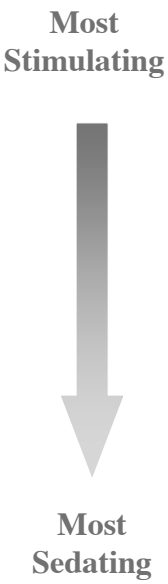
N=12 Men and Women (24 total)

- Route
  - 100% pill
  - 45% crush/snort
  - 62% chew
  - 29% inject
- Motive for use
  - 91% energy (100% women 83% men)
  - 83% pain (100% women and 66% men)
  - 82% euphoria/pleasure
  - 50% stress
  - 47% withdrawal

Back PhD 2011

Stimulation from Opioids

- Oxycodone
- Hydrocodone
- Fentanyl
- Buprenorphine
- Tapentadol (Nucynta)
- Tramadol (Ultram)
- Oxymorphone
- Morphine
- Hydromorphone
- Methadone



Sleep Pattern Detail

- Bed time, initiation time, out of bed time
  - Poor initiation?
    - Why and what doing.
  - Waking through night?
    - Why, when, how many times, re-initiate time
    - Clock watching and normal sleep
    - If actually out of bed, how long, what doing
  - Napping
- Somatic Energy is sum of hours slept in 24

"Horrible Sleep"

- Bedtime 11-12 pm
- Initiation: Does not initiate until 1am
- First wakes: 2am
- Later stages: Sleep an hour and wakes, initiates again in 30-60 min, does this 2-3 times and is then up for the rest of the day.
- Naps: unable to
- Total sleep 2-3 hrs maximum

"Horrible Sleep"

- Bedtime 11-12 pm
- Initiation: Does not initiate until 5am
  - Up watching TV, internet
- First wakes: 7am for family
- Later stages: Back to sleep at 9am, sleeps well to 3-4pm. Up for family. Up and down through evening.
- Naps: at times in the PM with TV
- Total sleep 8-9 hrs minimum

Safer Opioids

- Pain
  - Tramadol (Ultram)
    - SNRI primary
    - Opioid minimal, in metabolite only
  - Tapentadol (Nucynta)
    - NE and full agonist
    - 50-75mg = 10mg oxycodone ***clinically***
  - Buprenorphine
    - Partial agonist, ceiling effect
    - Transdermal Patch (Butrans)
    - Buccal (Belbuca)

Benzodiazepines when Pain Trumps

- Reduction or replacement of benzos
  - Risk assessment
    - SUD, pulmonary disease, sleep apnea, etc
  - What is a reasonable level?
    - Low vs high risk
    - True and limited PRN
  - Which benzo?
    - Long vs short half life
  - HS dosing removed?
  - Replace benzo with pain med? (two-fer)
    - Duloxetine, pregabalin, gabapentin, other neuropathic agent, TCA, etc

Optimizing Anxiety Treatment in Pain

- Are meds making them anxious?
  - Opioid stimulating, benzo stimulating, chronic steroids, etc
- AD optimization or augmentation
  - Dose adjustment
  - Rotation to other AD
  - Atypical antipsychotic
- Treat by other means
  - Buspirone
  - Beta blocker
  - CBT/DBT
  - Etc.

Benzodiazepines when Anxiety Trumps

- Reduction or Replacement of Opioid
  - What is a reasonable level?
  - Safer opioids
    - Bup, tapentadol, tramadol,
  - How to reduce
    - 5-20% per month
  - Sleep studies
  - Pain and function reassessment
    - Need opioid?
  - Interventional assessment
    - Injection, surgery, PT again, etc
  - Alternative pain tx
    - Yoga, PT, acupuncture, coping skills, etc
    - OTC medication

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Questions?