Cases to Assess Understanding - Barbara and Olivia

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CASES TO ASSESS UNDERSTANDING - BARBARA AND OLIVIA

Goal:

The learner will be able to minimize risk of addiction when prescribing opioids and other controlled substances for treatment of common pain conditions.

After completing this module participants will be able to:

- Apply what was learned in the training program about screening for substance abuse or risk of substance abuse to cases with common pain conditions
- Apply what was learned in the training program about using first-line treatments first, and prescribing opioids appropriately only when needed in treating common pain conditions
- Apply what was learned in the training program about ordering urine drug testing in a patient being considered for chronic opioid therapy
- Apply what was learned in the training program about stratification of risk for patients with chronic pain conditions being treated with chronic opioid therapy
- Demonstrate clinical skills in how to manage a common pain condition

Professional Practice Gaps

Back pain, acute pain, osteoarthritis, headache, neuropathy, and fibromyalgia are the most common chronic conditions for which opioids are prescribed in primary care (Fleming et al., 2007; Reid et al., 2002). Physicians studied in a teaching hospital did not use a standard approach to common issues in addiction medicine and pain management[1]. First-line, usually non-opioid therapies need to be tried before using opioids for these common conditions. However, the standard first-line therapies are often not used even though they may be as effective as opioids. For example, despite evidence-based guidelines for back pain, the most common form of chronic pain, approaches to treatment vary widely and have similar outcomes[2].

General gap: Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain to reduce risk of addiction and other substance abuse were developed by professional organizations of pain specialists, the American Pain Society and the American Academy of Pain Medicine, based on an extensive review of the literature by a multidisciplinary panel[3]. According to national surveys, physicians do not follow key elements of the plan recommended by the guidelines including screening for risk of addiction/abuse, assessing substance abuse, communicating effectively about opioid use and risks, and reducing the risk of prescriptions drug overdose and diversion[4,5]. The need for education/skills training in order to be able to follow the guidelines in these areas is evident from national physician surveys[4,6,7]. Based on the overall results of their physician survey on the problem of drug diversion, CASA concluded that physicians should receive more continuing medical education related to prescribing and administering controlled substances and identifying, diagnosing, and treating substance abuse and addiction[4].

INTRODUCTION

Meet the Patients
We will follow the stories of these patients in order to assess understanding:

MS. JENSEN
Ms. Jensen is on NSAIDs for moderately severe knee pain but takes them irregularly due to adverse effects on her stomach. She also regularly takes acetaminophen. Ms. Jensen's orthopedic surgeon said she'll probably need a knee replacement some day. Ms. Jensen is staying with a sister and does not know anyone in the area.

MS. BURCH
Ms. Burch finds that oral NSAIDs do not control all of her arthritis pain and wants a prescription for opioids. She recently took opioids that were prescribed for her husband and found that her pain was nearly gone. She has had osteoarthritis, confirmed by radiographs, for around 17 years, in her hands, knees, elbows, hips. Rheumatoid arthritis has been ruled out.

Review each case and make the requested clinical choices to manage their pain safely and effectively. Be sure to follow the guidelines for prescribing opioids, should your patient qualify for that type of treatment[8].

MS. JENSEN - CASE PART 1

Patient: Ms. Barbara Jensen, 40 years old
Chief Complaint: Knee pain
History of Present Illness: Ms. Jensen is on NSAIDs for moderately severe knee pain, but takes them irregularly due to adverse effects on her stomach. She also regularly takes acetaminophen. Ms. Jensen's orthopedic surgeon said she'll probably need a knee replacement some day. Ms. Jensen is staying with a sister and does not know anyone in the area.

Patient Interview:

Provider: *What would you rate your pain at its worst on a scale of one to 10?*

Ms. Jensen: *An 8 at its worst and it's usually at least a 6. It was an 8 all the time before I started getting the Hyaluronate injections twice a year and using topical NSAIDs.*

Provider: *That sounds intense. [Looking at the intake form] So you have stomach problems when taking oral NSAIDs. What other pain medications or treatments have you tried?*

Ms. Jensen: *Only acetaminophen. It helps a little, but not enough. I do exercises I got from a physical therapist and I use acupuncture as often as I can afford it.*

Provider: *Does your knee pain prevent you from doing anything in your day-to-day life?*

Ms. Jensen: *I don't get around as much. I have to limit any walking I do to things that are absolutely necessary, like getting groceries.*

Provider: *How long has this been going on?*

Ms. Jensen: *In the past 3 years I haven't been able to take NSAIDs every day. That's when it started getting bad.*

Question 1: Is Ms. Jensen's pain severe enough to consider evaluating her further for chronic opioid therapy?

Choose one

1. Yes.
    - Feedback: Correct
    - Opioids are recommended for moderate to severe pain, with a functional impairment that has not responded to first-line therapies. Ms. Jensen does have moderate to severe pain and has some functional impairment. First line therapies have been tried.
2. No.
    - Feedback: Incorrect
    - Opioids are recommended for moderate to severe pain, with a functional impairment that has not responded to first-line therapies. You do know that Ms. Jensen does have moderate to severe pain and has some functional impairment. First line therapies have been tried.
3. Not enough information.
    - Feedback: Incorrect.
    - Opioids are recommended for moderate to severe pain, with a functional impairment that has not responded to first-line therapies. You do know that Ms. Jensen does have moderate to severe pain and has some functional impairment. First line therapies have been tried. All of these conditions have been met.

Question 2: Do the benefits of chronic opioid therapy outweigh the risks in Ms. Jensen's case?

Response: Possibly

- Decreased pain of up to a few points on a pain scale and improved function are likely. Constipation is likely for all patients on chronic opioid therapy but can be managed.

Risk of addiction, abuse, and overdose appear low so far, but a complete screening and assessment for opioid risk and current substance abuse should be completed.

MS. JENSEN

Continuation of the Provider-Patient Dialogue:

Provider: *How are you doing emotionally as you cope with this pain?*

Ms. Jensen: *It's lonely, because I'm new here. Sometimes, I feel like I am at my wits end with the pain. I don't know how to cope with it anymore.*

Provider: *Counseling can be helpful for coping with pain. How would you feel if I referred you to someone for some counseling?*

Ms. Jensen: *I could try that.*

Question 3: What type of counseling specialist is likely to be most effective in Barbara's case?

Choose one

1. Psychoanalysis
    - Feedback: There isn't much evidence supporting the effectiveness of psychoanalysis for coping with pain.
2. Cognitive behavioral
    - Feedback: Correct. Cognitive behavioral therapy has been shown to be effective in coping with pain.

      A form of CBT, Acceptance and Commitment Therapy (ACT), has been effective in pain management by using a mindfulness approach to facilitate acceptance?[9]
3. Behavioral
    - Feedback: There is little evidence on the effectiveness of behavioral therapy for pain.

MS. JENSEN

Continuation of Patient-Provider dialogue:

Provider: *Because NSAIDs hurt your stomach and because opioids haven't been tried yet, I'm going to prescribe a low dose of a prescription opioid pain reliever. I believe this will provide the best pain relief without hurting your stomach. How does that sound?*

Ms. Jensen: *That sounds good.*

Provider: *I recommend a prescription for a low dose of an opioid that is commonly used in these situations. Please continue to use the acetaminophen and topical NSAIDs. I encourage you to continue the exercises that your physical therapist provided. This should help you maintain strength in your knees and legs and help prevent things from getting worse.*

Ms. Jensen: *Okay.*

Provider: *We'll try this prescription for a week and then I want to see you and hear how this is working for you.*

Assuming chronic opioid treatment was indicated, the following **prescribing strategies** minimize the risk of pain medication abuse or addiction before prescribing opioids. So far, the provider used the following:

1. Set goals for treatment.
   The provider did mention the goal of pain relief but was not clear about the fact that opioids are likely to provide relief of only a few points on a scale of 1 to 10 and not likely to completely relieve the pain. The provider did not mention a realistic description of the likely improved functioning as a goal.
2. Use first-line medications for treating pain condition before prescribing opioids. This is appropriate and has been tried in this case. NSAIDs, acetaminophen, injections, and physical therapy had already been tried. The provider added counseling to help with coping.
3. Recognize the infrequent situation in which opioids are indicated for the treatment of chronic pain. In most cases of knee arthritis, opioids are not indicated, but it does appear that they might be considered for Ms. Jensen after further evaluation.
4. Prescribe the lowest dose that will adequately manage the pain. A low dose is being tried.
5. Prescribe opioids in combination with other effective medications and non-pharmacological treatments. The provider did recommend continuing topical NSAIDs and acetaminophen in addition to providing the prescription.
6. Prescribe opioids in short time intervals. The first prescription is for just one week.
7. Plan to re-evaluate the effectiveness of pain treatment periodically and change medication if needed. A one-week initial followup is planned.

Other steps the provider could use to minimize risk of addiction include:

1. Check patient history in a prescription drug monitoring plan. Checking a prescription drug monitoring database is a good idea for all new patients to look for possible excessive prescriptions.

2. Consult with specialists as needed (pain, addiction, mental health). It would be appropriate to obtain records from the orthopedist to confirm the history, diagnosis and whether other treatments have failed.

3. Choose the least addictive drug formulation that will adequately manage the pain. We don't know what was prescribed in this case.

4. Identify a treatment "home" for the patient, that is, the provider who will oversee and coordinate treatment. This has not been done yet but should be discussed. There should be coordination of care with the orthopedic surgeon since she is moving back there.

5. Identify a single prescribing provider if possible and single dispensing pharmacist. This has not been done yet in this case and should be discussed.

POLL: I WOULD PRESCRIBE AN OPIOID FOR BARBARA JENSEN WITH THIS MUCH INFORMATION

Poll Results:

1. Yes
    - 32% (160 votes)
2. I would need some more information
    - 63% (312 votes)
3. No - I do not think opioids are indicated
    - 4% (22 votes)

Total votes: 494

MRS. BURCH - CASE

New Patient

Name: Mrs. Olivia Burch

Age: 77 years old

Chief Complaint: Finds that NSAIDs are not sufficient to manage her arthritis pain completely. She wants to try opioids, because they helped her pain when she used her husband's supply.

History of Present Illness: Mrs. Burch has had osteoarthritis for around 17 years, in hands, knees, elbows, hips. This has been confirmed with radiographs and rheumatoid arthritis has been ruled out. She reports that she still has some pain with the NSAID she takes. She tried oxycodone that her husband had left over from elbow and back injuries and thought it worked "marvelously." She requests a prescription for oxycodone.

***Please review the interactive online version of this case**

SUMMARY

Here is a summary of recommended skills that were added in this module:

- Use first-line therapies first for common pain conditions; first-line therapies are generally not opioids.
- When opioids are used, generally use along with adjuvant therapies as part of a multimodal plan to treat pain.
- Document reasons for using chronic opioid therapy in patient record, including pain severity and functioning.
- Consider the huge psychogenic component often involved in suffering from chronic pain and consider offering a referral for counseling to develop coping skills.

RESOURCES AVAILABLE THROUGH THIS MODULE:

- CDC Guideline for Prescribing Opioids for Chronic Pain
  Clinical guidelines, literature review, and analysis of the evidence on the use of opioids for chronic pain. Recommendations are also made for prescribing opioids for acute pain.
- NSAIDs Beyond the Basics. Up to date. Available at: https://www.uptodate.com/contents/nonsteroidal-antiinflammatory-drugs-nsaids-beyond-the-basics
- Mayo Clinic. Arthritis. 3/7/18 https://www.mayoclinic.org/diseases-conditions/arthritis/diagnosis-treatment/drc-20350777
- Cleveland Clinic. When You Can't Stomach NSAIDs. May 2015. https://www.arthritis-advisor.com/issues/14_5/features/When-You-Cant-Stomach-NSAIDs_1092-1.html

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