AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens

Non-Opioid Treatment Options and Preventing Ineffective COAT

Andrew Friedman MD

AMDG Opioid Conference

June 12, 2015

Preventing Ineffective COAT

- What is “effective COAT”
  - 30% reduction in pain and improvement in function
  - Benefits are sustained over time needed
  - Minimal opioid-related adverse effects
  - No unintended drug-drug or drug-condition interactions
  - No dose escalation over time
  - No leakage of medicines into the community
  - No provider risk related to regulatory or legal exposure

In other words clear evidence that the benefits outweigh the risks and that the process for prescribing conforms to best practices

Long-Term Consequences of Starting Opioids:

- Efficacy of COAT is by no means clear. Consensus of evidence suggests no more than 30% reduction in pain scores and minimal if any benefit in function across large populations

- Patients who use prescription opioids for at least 90 days are more than 60% likely to still be on opioids in 5 years.

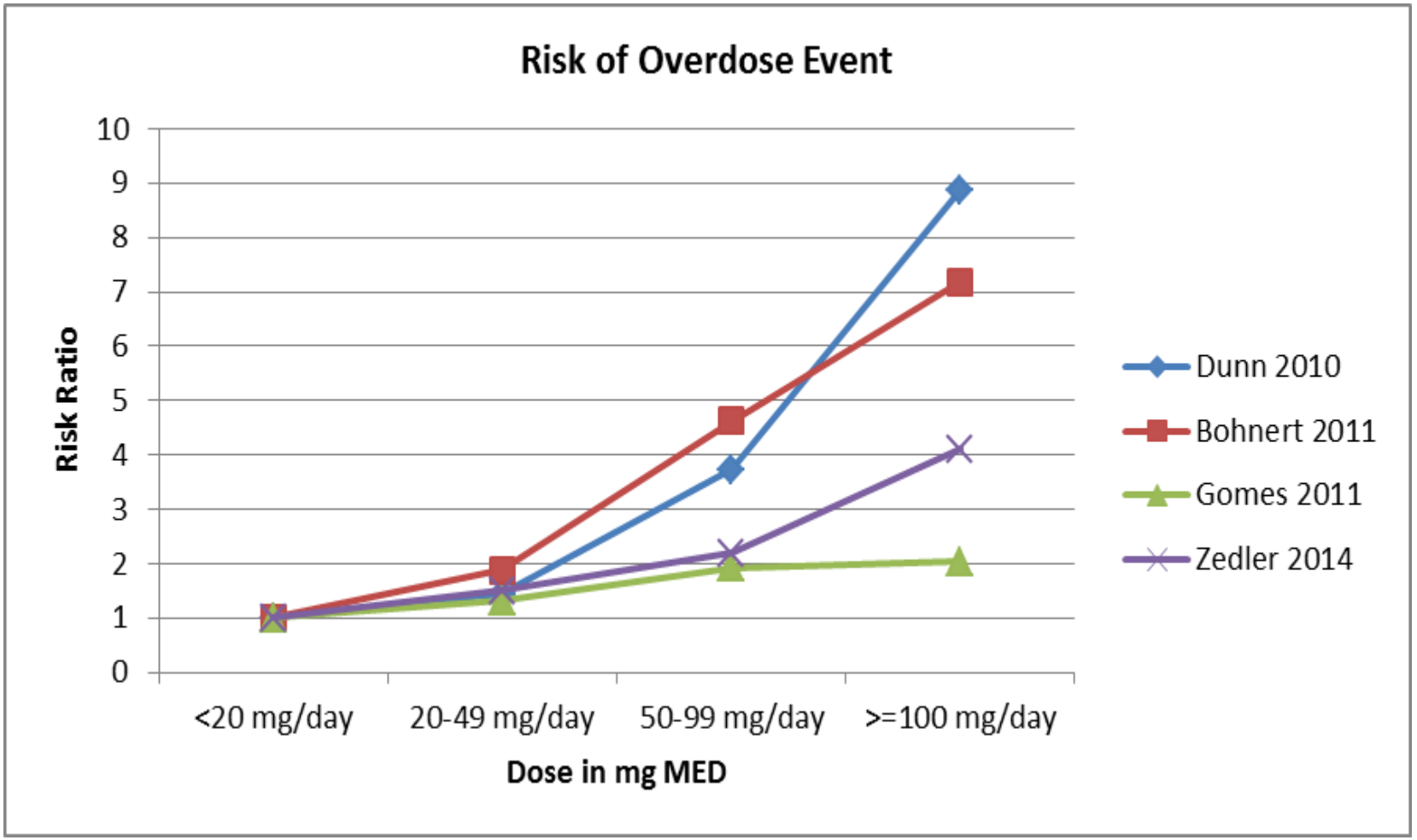
  --Martin et al 2011 Gen Int Med 2011;26:450-7

- Receiving > 1 week supply or 2 or more prescriptions for opioids after an acute back sprain doubles a patient's risk of disability at one year

  --Franklin et. al Spine 2008

AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens



So What Are Effective Alternatives?

Effective Alternatives Include:

- Accurate Diagnosis and Recovery Expectations
- Presence, Listening and Empathy
- Identification of the drivers of persistent pain—depression, anxiety, PTSD
- Recommendations regarding safe activity
- Identification of patient goals
- Non-opioid medication
- Cognitive, motivational and behavioral interventions
- Management of sleep disturbance
- Multimodal rehabilitation programs

Accurate Diagnosis and Recovery Expectations

- Screen for red flags
  - Avoid imaging in the first six weeks of presentation unless red flags
  - In msk pain, the absence of red flags is strongly predictive of the absence of serious pathology—even in older patients
    - Jarvik et. Al JAMA 2015
- Provide reassurance and recovery Expectations
  - Elevated fear-avoidance beliefs among otherwise similar practitioners can effect outcomes adversely
    - Darlow et. Al Eur J Pain 2012
- Encourage general activity and graded exercise as appropriate
  - Patient adherence to activity may be particularly important in regard to outcome. Activity diaries, telephone apps as well as various other kinds of motivation may be useful.

Accurate Diagnosis/Recovery Expectations

- Consider multiple dimensions of pain presentations and use validated instruments to measure depression, anxiety, PTSD.
  - See appendix B of AMDG guides for tools

- Schedule return visits for patients who appear to be at high risk of atypical recovery. Tools such as the FRQ and STarTBack tool can help identify patients at higher risk. These patients benefit from augmenting usual interventions with cognitive, behavioral and motivational approaches.

Initiating Treatment

- Identify treatment goals
- Consider assistance with activation/PT
- Consider non-opioid analgesics
- Address sleep if needed
- Consider cognitive and behavioral tx
- Tailor follow up plan based on patient/progress

Physical Therapy

- In acute LBP not shown superior to advice to remain active however…
- Consider PT when specific structural issues identified
- Consider PT when high levels of fear avoidance
- Use PTs who are focus on education, graded exercise and incorporate cognitive and behavioral approaches to treatment.
- Average # of PT visits for LBP in PNW 9/episode of LBP

Evidence for Other Therapies for LBP

- Superficial heat and cold + evidence of benefit
- Massage therapy—conflicting evidence
- Traction for LBP –no evidence of benefit
- Lumbar Supports –no evidence of benefit
- Interferential therapy –no evidence of benefit
- Diathermy –no evidence of benefit
- Ultrasound-no evidence of benefit
- TNS—good evidence that it is ineffective for LBP

Consider Non-Opioid Analgesics

- **NSAIDs**
  - NNT analyses of naproxyn 500 mg and of ibuprofen 200 mg +apap 500 mg have shown favorable pain relief when compared to oxycodone 15 mg
- **TCAs/SNRIs** may be effective first line agents for neuropathic pain
- **Gabapentin** and **pregabalin** have been shown to have efficacy in chronic neuropathic pain conditions though generally not superior to the ADs
- "**Muscle Relaxants**"—limited evidence of benefit. Avoid carisoprodol (SOMA) and benzodiazepines
- See appendix F for diagnosis-based recommendations

Sleep

- Restorative sleep can help predict reduction in pain
- Lack of REM sleep associated with hyperalgesic states
- Trazodone, TCAs, melatonin and other non-controlled substances are the preferred agents for sleep if patient requires pharmacotherapy.*
- Benzodiazepines are not recommended due to disturbance of REM sleep and potential for development of tolerance, dependency and addiction.*
- While the “Z” drugs are FDA approved for insomnia they can potentially produce cognitive and psychomotor impairments as well as rebound, risk of falls and parasomnias. *

*Tauben, D—Rehab Clinics of N. America 2015—in press.

There is good evidence that CBTs are effective in reduction of subacute or chronic LBP, FM, IBD, orofacial pain and pain in children.

Cognitive: Address distressing negative cognitions and beliefs, catastrophizing

Behavioral approaches: Mindfulness, relaxation, biofeedback

Physical: Activity coaching, graded exercise

Spiritual: Identify existential distress, seek meaning and purpose in life

Education (patient and caregivers): Promote patient efforts aimed at increased functional capabilities

--Adapted from Argoff 2009 and Tauben 2015

Structured Intensive Multidisciplinary Pain Programs

- Involve physical rehabilitation +
  - Psychosocial interventions
  - Behavioral interventions
  - +/- other pain relieving or function enhancing interventions

  - Evidence clearly supports the value of multimodal programs in improving pain and function and reducing disability.

Preventing Ineffective COAT

- Evaluate each patient individually
  - Assess medical and non-medical risks
  - Assess non-opioid options and consider that these may be more effective
  - Avoid starting opioid therapy for non-specific or generalized chronic pain
  - If starting opioid tx in the acute phase assess pain and function at baseline and provide expectations for recovery and discontinuing opioids
  - Discontinue opioids if patient has recovered or if there has not been CMIF
  - The Acute Phase provides a big opportunity for eliminating problems associated with ineffective or harmful COAT

Preventing Ineffective COAT

- Avoid the “compassion reflex”

  --prescribing opioids because you are not comfortable offering “only” empathy and credible reassurance and advice to stay engaged in life.

- Consider:

  1. Patients with FM, Chronic HA, Chronic myogenic lbp are not likely to have sustained CMIF. Patients with specific pain c/o but also widespread pain are unlikely to benefit in the long-term.
  2. Physicians who offer empathy, credible reassurance and advice to remain engaged in life activities ARE helping their patients cope with chronic pain
  3. Reflexively prescribing opioids, particularly when doses escalate over time or if the patient is not doing well in terms of engagement in life activities is not good medicine.

     --Michael Von Korff

AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens