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BUPRENORPHINE PRESCRIBING FOR BEGINNERS: TAILORED TRAINING FOR CHRONIC PAIN

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Buprenorphine Prescribing for Beginners: Tailored Training for Chronic Pain
[video transcript]

00:10
Okay, so let's talk about this clinical case. So I'm going to talk about chronic pain and OUD and when would you consider transitioning to buprenorphine in a patient who has chronic pain, and counseling patients about chronic pain management. Okay, so we have a very interesting case. This is Ms. AC. She's a 35 year old with a history of bipolar disorder and nephrogenic sclerosis and rheumatoid arthritis. She's currently taking a long acting oxycodone, 30 milligrams twice a day. And then she's taking short acting oxycodone, which she's taking three times a day. She's also on clonazepam and Depakote. She continues to have pain, and then you assess her function in the clinic. And what is the PEG scale? The PEG scale is a three question scale, which assesses function, and you find out it's 8, 9 and 8, which is high. She's sobbing in the clinic as she feels the current regimen is not helping her.

01:06
So my first question, as part of your assessment, what is your next step? Do you take a pain and prior treatment history? Do you assessor for OUD? Do you review her current pain treatment program? Or all of the above? I'm going to give you a short time because we are very near ending this presentation. So let's see what everyone says. Oh my god, that's amazing. So 100%, I completely agree, you will use all of that. And why is that important? Because you really need to know the pain history. You need to evaluate with a pain focused history. Find out about the opioids, how do they take their opioids? It's not just enough to say, 'Oh, I take my oxycodone three times a day.' What does that mean? Do you combine two pills in the morning? Do you take one pill at night? Do you sometimes skip doses? Do you have any left overs? So it's really important to know how they take their opioids, even if it's been prescribed in a certain way.

02:07
And I can tell you a little story, because I have a chronic pain clinic. There were a large proportion of patients, we simply tapered opioids by asking them how they were taking their opioids, because they were taking less, but no previous provider asked them how they were taking. So they were just refilling opioids what the previous provider did. But if you really sit down and talk to the patient, we were able to go down on the opioids simply by asking them how they're taking. That's it.

02:42
Okay, so this patient, we did a DSM five criteria, this is very important, do they have OUD or not? And regardless if chronic pain patient has OUD or does not have OUD, if you leave this presentation with one thing regarding chronic pain, it will be this multimodal pain care, there is no magic pill. Chronic pain treatment is hard, and that's why making sure they have multiple modalities to bank on is important. What is this multiple modalities? It means making sure they're getting physical therapy, they're getting mental health and anything else, which I'm going to go into in a little bit. So she does not meet the criteria for OUD, you want to optimize the other non opioids also. So in her case, she was already taking Tylenol. She cannot take naproxen or

NSAIDs because she has CKD 4. She has tried physical therapy in the past, but did not find it helpful. And she is following religiously with a rheumatologist and getting treatment for her rheumatoid arthritis. So these are some of the things, so let's say if somebody has a reason for the chronic pain, you want to make sure they're getting treatment for that reason. In her case, it's rheumatoid arthritis.

03:57
Second question, what should you advise her? Now you know she's using some of the multiple modalities. Should you assess her pain and taper opioids? Or hey, it is not working, maybe increase her opioids? Or maybe we can suggest an alternative opioid? Okay, let's see what the answers are. Okay, so I think there's no wrong answer, per se, in this. And I'm going to go over this, but what I would have chosen is assessing her pain and taper, and I'll tell you in a second why. So I assessed her pain, and then I used something called a risk benefit ratio for continuing opioids. What does that mean? It means really, for all patients who aren't prescribed opioids, really getting at the risks of the opioids and the benefits of opioids. So in her case, she was on high doses of opioids. So remember high doses of opioids have a high risk. She's taking 180 milligrams of morphine. So I'm converting the oxycodone to morphine equivalents, and she's on 180 milligrams, 90 is considered high dose. So she's beyond high doses. She's also co-prescribed benzos. And what are the benefits that she's getting? How do I find out that she's benefiting from this? Well, she's getting low benefit. And the reason why I know this is because her function scale is high. If her function was good, the PEG scale would have lower numbers. So now in my head, I'm like, the risks of these medicines are higher, while the benefits are low. So in such situations, you would recommend tapering opioids.

05:54
So the other answers about increasing opioids, because there are many times that I've wondered, you know, I should increase opioids. But the idea is, if somebody is already on 180 milligrams of morphine, increasing the dose will not give them any more benefit. Now switching to alternative opioid, we're going to hold that thought because you guys were not wrong. I just want to clarify one thing, in the past there was a lot of talk about opioid rotation, 'oh, this patient is on oxycodone, maybe if I transition to another opioid, it will be better, their pain will be better?' But we're going to talk about switching to another opioid, which is not methadone or anything else, which I'm going to tell you in a second. Ms. AC does not understand the reasons behind opioid taper, especially when her pain is not well controlled. And this is what I get 'my pain is not controlled, and you're asking me to reduce my pain medicine further? That doesn't make sense.' But you have to explain to the patients that opioids for chronic pain are not helpful because patients develop opioid induced hyperalgesia. So eventually, after a lot of talk talking, you convince her and she wants to give it a try. And the regimen that you come up with is, so remember the short acting opioid was 20/20/20. And all you do is you want to change that afternoon dose from 20 to 10. So taper, if you ever decide you want to taper patients, it has to be slow taper. Rapid tapers are associated with bad patient outcomes. Okay, so any taper should be slow and should have patient engagement and you should motivate the patient to do it. It shouldn't be forced. So you follow up with her in one month and she's miserable. She does not want to go ahead with it anymore. Now what do you do? Do you stop the dose reduction

and increase the opioid? Do you stop the opioid dose reduction and continue her current regime? Or do you stop the opioid dose and discuss switching to buprenorphine?

07:58
Okay. Let's see the answers. So, this is the buprenorphine talk. So yes, this would have been the right answer. Okay, great. I agree with you. That is the correct answer. And why is that the correct answer, and I'm going to go into this a little bit. So buprenorphine and chronic pain, there are more and more case reports that have described this phenomenon. And this is where I say it has to be off label for chronic pain. So buprenorphine sublingual is only approved for OUD, but we can use it off label for chronic pain. And in somebody who is on high doses of opioids, you try to taper them, it doesn't work, you increase opioids, it doesn't work. They're on high doses. What do you do? And in those patients, buprenorphine can be offered as an alternative. Now, if somebody is on 180 milligrams of morphine, how do you switch to buprenorphine? Imagine telling them, you have to be off your opioids for 24 hours. Many of my patients who have underlying chronic pain will not agree to that. And that's where the microinduction comes in. And the philosophy behind a microinduction is if you give them in really, really small quantities, the buprenorphine, it doesn't trigger a precipitated withdrawal. But this is a whole, you know, another talk in itself. And we have another talk through the CEI on this, how to actually do this. And then buprenorphine, especially in patients who have chronic pain, it's safer in older patients, it has a ceiling effect. It is better for a safety profile also.

09:41
So key points, discuss with patients reasons for transition. This is very, very important, because some of my patients will be like 'you know what, I've heard that buprenorphine is only for people who are addicts.' This is the word they use. 'They're for addicts. I'm not an addict, why are you giving it to me?' So I have to really educate them, and sort of like, tell them why I'm using. 'This is more for chronic pain, not for OUD.' And this happens over multiple visits. It's not like the first time I'm seeing a patient and I offer this, they're gonna agree to this. This requires patience and this happens over time. And I always provide a contact number for patients.

10:18
So take home points in regards to chronic pain, always risk benefits analysis in patients who are on long term opioid therapy. If risks are high, I would recommend the first thing you should do is a slow taper, develop a multimodal pain treatment program. And then let's say the taper doesn't work and your other multimodal strategies don't work, then you can offer transition to buprenorphine to help improve their pain.

10:46
So now I have three minutes for questions. But I see something, the form asks about the required 24 hour training, I have not completed it. So if you do the notice of intent, it should not, the notice of intent basically means that you can prescribe up to 30 people without this training. So you will be able to prescribe up to 30 without the 24 hour training. I hope there's an option for that.

11:19

I have a potential patient on biweekly take [inaudible] should I work with them? So now this patient, Abigail, this is a really good question, so this patient is getting has probably been on methadone for a long time, that's why they're getting it every two weeks. My first question is does the patient want to transition to Bup, or maybe they're just happy with the methadone? If somebody is happy in the methadone treatment program, they can continue the methadone treatment program. It's only if they want to transition to buprenorphine. So yes, I would try to microdose, you can call the methadone program with the, what do you say, you can ask permission from the patient. And then you can tell them, 'hey, I will be microdosing. This is my aim. I'm going to do this over this long, you know, whatever, 10 days or seven days, and so this patient will be on buprenorphine and methadone at the same time.' So yes, you will have to involve the methadone program.

12:18
Any other questions? And then, Janine, if you're still unable to apply for the form, just email us, we can figure that out. So anyone who has a problem can email us and we'll figure this out. Okay, any other questions? Okay. I know we went over the case real fast. So you know.

12:43
Everyone likes to have it as reference. Well, thank you so much. This was an amazing presentation.

[End]