Chronic Pain and Opioid Use in People with HIV

R. Douglas Bruce, MD, MA, MS
Associate Chief of Clinical Affairs
Boston University School of Medicine
Boston, Massachusetts

Financial Relationships With Ineligible Companies

Dr Bruce has no financial relationships with ineligible companied to disclose. (Updated 06/16/21)

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Learning Objectives

After attending this presentation, learners will be able to:

- Describe the basic principles of addressing chronic, non-malignant pain in elderly people with HIV
- Appraise the role of urine toxicology in the management of chronic non-malignant pain
- Implement the basic principles of managing pain in people with HIV and opioid use disorders

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Background

- Depending on the study, 39% to 85% of people with HIV experience chronic pain[1]
- Greater rates of self-reported untreated or undertreated pain in people with HIV (80%) vs cancer[2]
- Having HIV, female gender, & history of injecting drugs decrease the likelihood patients will receive pain treatment services[3]

1. Merlin, J.S., et. al. (2012); JAIDS; 61(2):164-70
2. Pasvik, S.D., et al. (2006); The Clinical Journal of Pain; 22(2): 173-81.
3. Breitbart, W. et. al. (1996): Pain; 65(2-3): 243-9.

Pain is painfully complicated

- Even with an obvious organic cause for pain, that pain is perceived or experienced differently
  - like looking through different glasses
- Everyone has their own set, influenced by multiple factors[1]
  - depression, psychological distress, post-traumatic stress
  - drug abuse, sleep disturbance
  - reduced ART adherence, healthcare use, missed HIV clinic visits,
  - unemployment, and protective psychological factors

[1]Scott et al Pain 2018

Principles When Evaluating Pain

- Validate the complaint of pain
- Detailed history and physical examination and appropriate diagnostic work-up to ascertain the etiology of the pain – don't make assumptions.
- Psychiatric evaluation
- Risk of addiction evaluation
- Development of a treatment plan
  - multidisciplinary and comprehensive
- Ongoing pain assessments at regular intervals

You take a history

You take a history and find out that the patient has had a lumbar back pain for years, but that in the last six weeks he has developed a new pain. You ask him to point to where it is and he points to a region in his thoracic vertebrae.

On examination, he has pinpoint tenderness in his thoracic spine which prompts you to order a MRI which shows….

Yep, that is bad…



A Pain History - for ALL patients

- Acknowledge the report of pain; this is the first step to treatment. Pain is subjective.
- Thorough history of the pain
  - onset, location, duration, character, better/worse, impact on ADLs, other constitutional symptoms
- Past work-up at other sites, prior treatments, etc.
- If pt was in care elsewhere, why is the patient moving?
  - need for release of information to talk w/ prior providers

Pain is Subjective

- Patient presents to clinic with the complaint of back pain that is 8 out of 10. The patient is sitting comfortably and does not appear to be in distress. You think, this doesn't look like an 8.
- So you think about creating a frame of reference: "Do you have children?"
- "Yes"
- "If childbirth is a 10, what is your pain today?"
- "Oh! Compared to that, I'm only at a 2!"

More on History

- Inquire openly re: past personal & family substance use
  - Include use of alcohol and over the counter drugs
- Particular screening tools include: ASSIST, AUDIT, DAST, CAGE-AID
- Screen ALL patients for substance use to avoid profiling

Risk of Pain Rx Misuse Is Related to:

- Younger age
- Personal history of drug and alcohol use (this includes tobacco) – past and/or current.
- Family history of drug/alcohol problems
- Psychiatric history
- Prior history of motor vehicle collisions (likely due to link w/ drug/alcohol use & collisions).

- See Bruce, R.D., et al. (2017); CID65(10):e1-e37. https://www.idsociety.org/practice-guideline/hiv-chronic-pain-management/

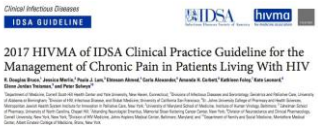
Pain Examination

- Direct observation & exam of the area (e.g., range of motion)
- Impact of pain on ADLs – if limited ability to walk, for example, have the patient walk in clinic to document
- During exam, ask re: goals of therapy (providing a realistic view of extent of pain & impairment upon ADLs)
- Next steps: Diagnostic work-up if needed

DOCUMENTATION

Critically important to document everything done to this point in the patient's medical record

Treatment information


Clinical Infectious Diseases
IDSA GUIDELINE

2017 HIVMA of IDSA Clinical Practice Guideline for the Management of Chronic Pain in Patients Living With HIV

See Bruce, R.D., et al. (2017); CID65(10):e1–e37. https://www.idsociety.org/practice-guideline/hiv-chronic-pain-management/

A patient walks into your office…

You have a 70 year old male patient with well controlled HIV who you have previously diagnosed with peripheral neuropathy likely related to prior d4T and ddI exposure. Patient has been on gabapentin 600 mg TID with unclear relief. The patient presents today wanting you to improve the pain control of the neuropathy. Assuming a good history and physical and the assessment that there is no other process going on, what do you do for the neuropathic pain?

Combination treatment

- Treatment for pain is multidisciplinary and multi-modal
  - In addition to medication, therapy (e.g., CBT*), acupuncture, and Yoga have been found to help improve chronic pain.
- *Remember that pain is NOT just biological/organic – one's perception of pain is critical to the experience of pain*
- In a chronic pain clinic, ALL patients should be referred to behavioral health for at least an evaluation.

* cognitive behavior therapy

Combination Treatment - the Team

- Prescriber
- Mental health clinician (may include both therapist and prescriber)
- Case management
- Ancillary support services
  - Addiction treatment
  - Physical therapy
  - Yoga
- Peer support – recovery coach, etc.

Pain Management Structure

- Agreement for ALL patients on opioids
  - Only ONE provider in ONE clinic provides pain medication for that patient
  - This should include non-opioid issues like psychiatric evaluation, PT/OT, etc.
  - Release of info for other providers involved in care
  - Urine tox & random pill counts (more on this later)
  - Active use → drug program

Opioids and Virologic Failure

- Merlin and colleagues[1] reported on chronic pain, long term opioid treatment (LTOT) & virologic failure
  - N=2334 mainly from Alabama and San Diego.
- Patients with chronic pain and not on LTOT had 2x higher rates of virologic failure (aOR 1.97, 95% CI 1.39 to 2.8)
- LTOT did not impact retention in patients with pain

[1] Merlin, J.S., et. al (2018); JAIDS, 79(1):77-82.

Monitoring Treatment

- Resolution of pain is *not* the goal
  - improvement in ADLs is the goal.
- Periodic assessments on
  - Progress on functional goals (e.g., ADLs),
  - Documentation of quality of life,
  - Adverse events,
  - Adherence to treatment
- Opioid treatment agreements
- Urine drug testing

Urine Drug Testing (UDT)

- One study revealed 62% of the 173 HIV+ patients screened had problematic drug use[1]
  - So, UDT on all patients prescribed opioids
  - While there is no current standard of frequency, at each refill is generally recommend and at any time the provider is concerned about use or diversion.
- Be aware of limitations – what UDT can and cannot do
  - e.g., oxycodone screen, buprenorphine, fentanyl
  - common causes of false positives (e.g., ciprofloxacin and opiates)

"Why is this refill taking so long?"

You inherit a new patient: A 65 year old male comes in for his refill of oxycodone of 30 mg tablets, two tablets every 6 hours for a total of 240 tablets for the month. You notice there hasn't been a urine toxicology in 5 years, but notice that there have been a few recent Emergency Department visits for methamphetamine intoxication. The patient today is agitated, struggling to sit still, and wondering why the refill is taking so long….

People Who Use Drugs

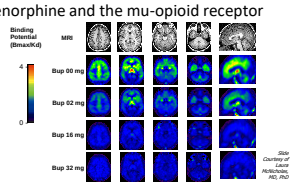
- When the Urine Drug Testing does not match what is prescribed, consider plausible etiologies:
  - Patient ran out early due to increased pain and UDT is negative due to washing out.
  - Patient had a false positive or false negative UDT
- Problematic behavior in clinic could mean many different things:
  - Inadequately treated pain
  - Poor coping skills
  - Relapse to drug use

It's Friday at 4 PM….

A 60 year old comes into clinic and, through much creative and interesting conversations, you conclude that the oxycodone you were giving for back pain is not in the urine toxicology, but morphine is…..

Pain treatment with Opioids

Buprenorphine and the mu-opioid receptor



What to do with the UDT?

- Positive for illicit drugs
  - Could be due to relapse or self-medication of pain
  - Ongoing treatment contingent on entering addiction treatment services
- Positive for other prescribed drugs
  - Could be false positive (e.g., cipro and opiates)
  - Self-medication of undertreated pain
- Negative for prescribed drugs
  - When did you last take the medication? If over 5 days ago, could be patient ran out due to increased pain
  - Medication diversion

Mental Health Disorders

- Baseline mental health evaluations for HIV patients with chronic pain because:
  - High prevalence of mental health disorders in HIV clinical settings
  - Mental health disorders can complicate pain and pain treatment (e.g., depression – PHQ-9).
- Of particular concern:
  - Recent grief/loss
  - History of physical/sexual violence
  - Mood disorders
  - History of suicidal ideation

2 disorders, NOT 1

- Pain and addiction can be overlapping, but are distinct disorders with disparate treatments.
  - For example, smoking crack - addiction vs. methadone - pain. Removing methadone for a cocaine positive urine does not improve the pain treatment and does not enhance treatment for cocaine.
- In parallel, clinicians don't stop diabetic meds b/c the patient didn't take anti-hypertensives appropriately.
- Active use should lead to enrollment in addiction services as part of ongoing pain treatment stipulation (should be in contract).

Consultation

- The provider should have established referral systems to assist w/ complex patients requiring evaluations for:
  - Addiction
  - Mental health
  - Pain management
- Where these services are not available locally, providers may work to establish contacts with larger referral hospitals or academic centers.

Conclusion

- Pain is prevalent in HIV clinical settings
- Patients with a complaint of pain should have a thorough history and physical examination to rule out pathology.
- Treatment should be multi-modal & multi-disciplinary
- Treatment should be monitored
- Mental health and substance use come with the territory and should be addressed as they are identified.

Questions?

My contact info: rdbruce@bu.edu

Useful websites

- American Pain Society has resources available online: http://www.americanpainsociety.org/resources/content/primary-care-practitioner.html
- American Academy of Pain Medicine resources: http://www.painmed.org/library/main.aspx
- Providers Clinical Support System (PCSS) for MAT at https://pcssnow.org/resources/clinical-tools/
- Buprenorphine training: https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training


Question-and-Answer Session