2020 Ryan White HIV/AIDS Program CLINICAL CONFERENCE

Chronic Pain and Opioid Use in People with HIV

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Financial Relationships With Commercial Entities

Dr Bruce has no relevant financial affiliations to disclose. (Updated 08/04/20)

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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 people with HIV
- Appraise the role of urine toxicology in the management of chronic non-malignant pain
- Implement the basic principles of caring for pain among people with HIV and opioid use disorders

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ARS Question 1

Please rate your current confidence in managing chronic, non-malignant pain in PLWH.

1. **Very Confident**
2. **Confident**
3. **Neutral**
4. **Little Confidence**
5. **Not Confident at All**

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Epidemiology

- 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]

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

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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

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Principles when Evaluating someone with 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

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A patient is referred to you…..

Jim is a 47 year-old male living with HIV who has a history of heroin injection, is on methadone maintenance, and is receiving opioids from his primary HIV provider for back pain.

He starts complaining of more back pain. Members of his care team believe this is drug seeking behavior, deny his request, and refer Jim to you to address his complaints.

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ARS Question 2: Your next step is…..

1. Pretend to be sick and avoid seeing the patient.
2. Take a history and do a physical examination.
3. Inform the patient that he already has someone giving him opioids, and to go see that person.
4. Because he is on methadone, regardless of the cause of pain, no additional medications are available.

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You take a history…

You take a history and find out that Jim 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…

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Yep, that is bad…



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History

- Acknowledge the report of pain; this is the first step to treatment. 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
- 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

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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
- Be aware: chronic pelvic and rectal pain may disguise a h/o sexual assault

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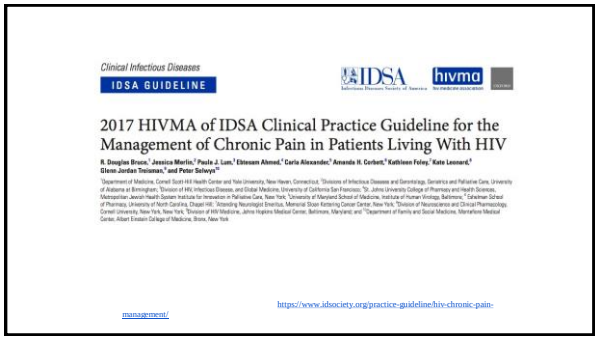
Pain examination

- 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

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DOCUMENT EVERYTHING

©IAS–USA



Combination, Team-Based 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 our pain clinic, ALL patients are referred to behavioral health.
- Team:
  - Prescriber
  - Mental health clinician (may include both therapist and prescriber)
  - Case management
  - Ancillary support services (e.g., Addiction treatment, Physical therapy)
  - Peer support – recovery coach, etc.

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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 to other providers involved in care
  - Urine tox & random pill counts (more on this later)
  - Active use → drug program

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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

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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

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Urine Drug Testing

- 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)

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"Why is this refill taking so long?????"

You inherit a new patient: Bob is a 45 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 there have been a few recent Emergency Department visits for methamphetamine intoxication.

Today, Bob is agitated, struggling to sit still, and wondering why the refill is taking so long….

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ARS Question 3: Your next step is…..

1. Curse the prior provider who left you a mess
2. Give the refill and find a way never to see the patient again
3. Call social work (or anyone) to try and diffuse the situation and get the patient into treatment
4. Talk with the patient about the ED visits and methamphetamine use to gauge interest in treatment, and refill the medication
5. #4 but do not refill the medication

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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

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It's Friday at 4PM…..

- Amanda is a 30 year-old female who comes into your clinic and, after much creative and interesting conversation, you conclude that the oxycodone you were giving for back pain is not in the urine toxicology, but morphine is…

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ARS Question 4: Your next step is….

1. Refuse to refill the medication and call someone else to deal with the upset patient
2. Agree with the patient that it was a one time thing and give all or some of the oxycodone
3. Discuss treatment for opioids and start buprenorphine
4. Discuss treatment for opioids and refer to methadone
5. Discuss treatment for opioids and start naltrexone

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Addiction

- A state in which a person engages in compulsive behavior
  - The behavior is reinforcing (that is, pleasurable or rewarding)
  - There is a loss of control in limiting the intake of the substance

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Why do people take drugs?

To feel good
To have novel:
feelings
sensations
experiences
AND
to share them



To feel better
To lessen:
anxiety
worries
fears
depression
hopelessness

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Drugs Are Usurping Brain Circuits and Motivational Priorities

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General Principles

- Treat all patients with dignity and respect
- People who use drugs are people
- Malingering, manipulation, etc. are all survival mechanisms people who use drugs use for survival. Don't take it personally.

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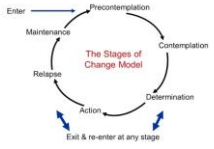
Practical Steps

- Screening
  - How many times in the past year have you had 5 or more standard drinks in a day?
  - How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons?
- Think About Systems
  - Provision of low threshold, rapid access, appropriately dosed treatment (e.g., buprenorphine, methadone, or other treatments)?
  - Culturally appropriate counseling for addiction [can be simple (NA) to more complex (CBT)]
- Treat Everyone
  - Provide naloxone
  - Treatment of the medical issues associated with addiction (e.g., HIV, HCV, HBV, and TB)
  - Treat substance use disorders (more below)

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"But it isn't really a problem" – change is a process

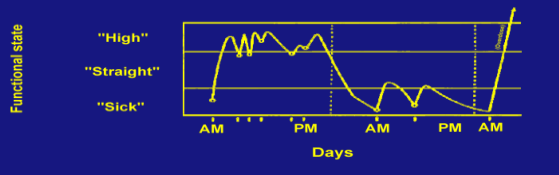
- Transtheoretical Model of Change:
  - Helping patients to move along the stages of change
  - MI – "Roll with resistance"
- Harm Reduction
  - Syringe exchanges
  - Naloxone
- When helping hurts
  - Enabling vs. boundaries



Graphic by Wayne LaMorte, MD, PhD, MPH

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Why isn't it a problem? The Lifecycle of a Heroin User



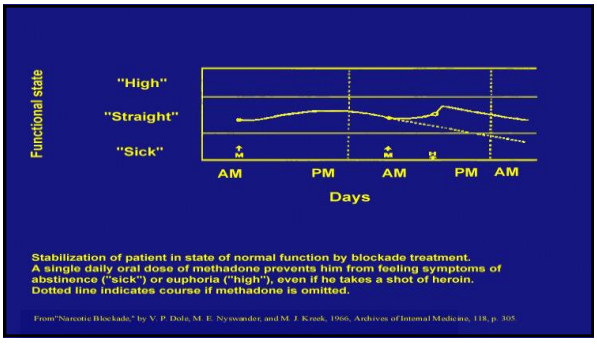
Diagrammatic summary of functional state of typical "mainline" heroin user. Arrows show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that the addict is hardly ever in a state of normal function ("straight").

From "Narcotic Blockade," by V. P. Dole, M. E. Nyswander, and M. J. Kreek, 1966, Archives of Internal Medicine, 118, p. 305.

Medications to treat opioid use disorder

- Methadone
  - Only in OTP
  - Efficacious, best retention
- Buprenorphine
  - Office based
  - Efficacious, retention less than methadone
- Naltrexone
  - Office based
  - Efficacious
  - Retention less than methadone & buprenorphine

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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

https://www.idsociety.org/practice-guideline/hiv-chronic-pain-management/

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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

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Pain and Addiction

- 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).

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ARS Question 5: "Aberrant Behavior"

- The healthcare team is poor at predicting abuse of medication. Hence, routine urine toxicology as part of treatment is recommended.
- Which of the following are a cause of aberrant behavior?
  1. Addiction
  2. Pseudo-addiction
  3. Metabolic condition (e.g., encepahlopathy)
  4. Infectious (e.g., Neurocog of HIV/HCV)
  5. Mental health Axis I (e.g., depression)
  6. Mental health Axis II (e.g., borderline PD)
  7. Social stressors/poor coping skills
  8. All of the above

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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.

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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

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Question-and-Answer Session

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