ACTHIV 2017: A State-of-the-Science Conference for Frontline Health Professionals
Chronic Pain in HIV Primary Care: A Practical, Evidence-Based Approach

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Learning Objectives

Upon completion of this presentation, learners should be better able to:

• Develop an evidence-based approach to the overall evaluation and management of chronic pain in people living with HIV

• Assess the risks and benefits of long-term opioid therapy in HIV-infected individuals with chronic pain (including risks in those who are not yet on opioids and those in whom opioid continuation is being assessed)
Agenda

• Chronic pain in HIV: state of the science
• Evaluation
• Management
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Opioids
Agenda

• Chronic pain in HIV: state of the science
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What is chronic pain?

• > 3 months, beyond normal tissue healing
• Examples:
  – chronic low back pain, other regional msk pain, chronic widespread pain, headaches, neuropathy
• Common in the general population
• Unique neurobiologic basis
• Heavily influenced by biological, psychological, and social factors

What is chronic pain?

- Associated with substantial disability
- Difficult to treat
- IOM/National Pain Strategy: key area of research focus, especially in populations most affected

Epidemiology of Chronic Pain in HIV

- Neuropathic pain is classically described
- Recent studies: predominance of msk pain
- Multisite pain common

Epidemiology of Chronic Pain in HIV

• Chronic pain is an important comorbidity in HIV for two key reasons:
  – Prevalence (30-85%)
  – Impact on outcomes: Retention, function, healthcare utilization, suboptimal ART adherence, use of heroin and rx opioids

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Question 1:
I know my patient’s pain is real because:

a) The patient says so
b) The patient’s partner says so
c) The MRI says so
d) I have no idea, how should I know!?!
History and screening

• All that stuff you learned in school, plus:
• Impact of pain on function: PEG, how they spend their time
• Pain management history (get records!)
• Screen for:
  – mood symptoms: PHQ-2, GAD-7
  – etoh and substance use: NIDA quick screen
    https://www.drugabuse.gov/nmassist/
  – sleep problems
  (and ask about history of these in the past)
Note coping and self-management
Diagnostic Testing

• Evidence-based judicious use is best
• You can’t always see pain on an image or a blood test
• This is a challenge for both the patient and the provider

Expert opinion.
Agenda

• Chronic pain in HIV: state of the science
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Treating chronic pain is challenging because:

- Communication about chronic pain can be difficult
  - Patients and providers come with baggage, opioids rather than functional restoration become the focus
- Providers aren’t trained to do this
- Financial incentives to take a biomedical approach
- Commonly used medications have a limited evidence base and carry risk
- Patients may have mood disorders/addiction
- Best treatments are often inaccessible to patients

But...don’t despair. There are LOTS of things you can do.
General chronic pain treatment pearls

• Remember....first, do no harm!!
• Focus on evidence-based therapies, avoid unnecessary procedures, surgeries, medications
• Set concrete goals and timelines
• Be ready to discontinue therapies that don’t work
• If possible, treat psychiatric illness first

Expert opinion.
Learn some MI and CBT tricks
Pain Education

• What is chronic pain
• Patience
• Partnership and collaboration
• Pharmacologic and non-pharmacologic management
• Role of multiple team members
• Mind-body connection

• Functional goals
Non-opioid pharmacologic therapies

- Acetaminophen - OA, < 3g, consider relative contraindications
- NSAIDs - back pain, consider CV (naproxen), GI (cox-2/celecoxib), renal risk
- Muscle relaxants
- Benzodiazepines
- Anticonvulsants
- Antidepressants
- Topicals
  - Specific indications: e.g., lidocaine post-herpetic neuralgia, capsaicin post-herpetic/DSP, diclofenac-OA
Evidence-Based Non-Pharmacologic Strategies

- Behavioral approaches
- Physical therapy
- Exercise
- Interventional treatments
- Complementary and alternative therapies
- Surgery

My best advice to you

• Develop a team in your office:
  – Physician, nurse, social worker, pharmacist

• Develop a team in your community:
  – Physical therapist/PM&R physician
  – Anesthesiologist/interventionist
  – Psychologist
  – Psychiatrist
  – Addiction physician that prescribes bup, naltrexone
  – Methadone program
  – Addiction treatment program
(Don’t forget schools / training programs)
"We can give you enough medication to alleviate the pain but not enough to make it fun."
Opioids

Slide courtesy of Erin Krebs.
Opioids

Slide courtesy of Erin Krebs.
Question 2: Case

• 55 y/o male with HIV, on TDF/FTC/ral CD4 500 VL < 25 seeing you for routine follow-up
• Also has a history of depression on escitalopram 10mg daily, hypertension, diabetes, hyperlipidemia
• History of heroin and cocaine addiction in his 20s
• At the end of your 15 minute encounter... mentions he has had low back pain for past 6 months and asks for hydrocodone-acetominophen
• No red flags; unremarkable neuro exam; no personal history of malignancy
Question 2: Case cont’d
What do you do next?

a. Prescribe hydrocodone-acetaminophen, #90 per month with refills, and arrange follow-up in a year

b. Inform him that you do not prescribe opioids to patients with a history of addiction, and refer him to the local pain clinic

c. Tell him you will need an MRI to determine if he has pain, and depending on the results, you will consider an opioid

d. Perform a history and physical exam, consider whether additional workup is needed, and discuss pharmacologic and non-pharmacologic management options
Why? The perfect storm.

• Pain is the 5\textsuperscript{th} vital sign = pain is always an emergency
• Palliative care’s early successes
• Misinterpretation of early studies
• Marketing of long-acting oxycodone
• Professional organizations, key individuals
My take on opioids

• They ARE NOT first-line therapy for chronic pain
• They work for some people
• However, evidence of benefit is limited
• What we know about their risk is growing
• If started:
  – They should always be considered a “time-limited trial”
  – Find lowest effective dose

• The recent CDC Guideline for Prescribing Opioids for Chronic Pain is a good starting place:

https://www.cdc.gov/drugoverdose/prescribing/guideline.html
Lack of evidence of benefit

• “No study of opioid therapy versus placebo, no opioid therapy, or nonopioid therapy evaluated long-term (>1 year) outcomes related to pain, function, or quality of life.....Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function.”

Lots of evidence of risks/harms

• “Evidence supports a dose-dependent risk for serious harms.”
  – Decreased function/return to work
  – Induced depression (duration > dose)
  – Motor vehicle accidents (OR 1.2-1.4 ≥ 20mg equivalents of morphine compared to < 20)
  – Falls (especially soon after initiation)
  – Addiction (~10%)
  – Overdose (worse with dose > 100 mg equivalents of morphine, co-rx benzos)

What to do when you have a patient sitting in front of you

Image courtesy of: www.pilladvised.com
Whether to start (less common case)

• “Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).”

CDC, MMWR, 2016.
Whether to continue (more common case – “inheritting”)

• “Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).”

CDC, MMWR, 2016.
How to “evaluate for harms”

• “Universal precautions” approach
  – Opioid Treatment Agreements
  – Urine Drug Testing
  – Practitioner Database Monitoring Programs
  Limited evidence, but can be very useful, becoming standard of care. Know your state’s requirements.

• Be alert to concerning behaviors that can arise

Opioid Treatment Agreements

• NOT contracts
• Informed consent; you and your patient’s responsibilities
  – One prescriber, one pharmacy
  – Take as prescribed, no changes on one’s own
  – Urine drug testing
  – How medicines are refilled, replacement rxs
  – Conditions for stopping opioids
Urine Drug Testing

• Useful for checking for adherence to rx’d drugs and for presence of substances not rx’d
• “A tool not an oracle”: lots of pitfalls
• Send screening immunoassay; discuss unexpected results; if still unclear, send confirmatory test (GCMS/LCMS); if still unclear, consider ddx
• Know your toxicologist
• Be mindful of cost
• Consider POC

• Decision support: Mytopcare.org

Prescription Drug Monitoring Programs (PDMP)

• State-by-state, lots of variability
• Tells you three things that predict OD:
  – Dose
  – multiple rx’s
  – opioid and benzo co-rx
Concerning Behaviors

• Examples include:
  – Unexpected urine results
  – Running out early/other rx problems
  – Multiple prescribers
  – Belligerent behavior
• All have a differential diagnosis
• Tips for evaluating these behaviors:
  – Detailed exploration with patient
  – Re-education
  – Closer monitoring, small prescriptions (is this a pattern? does the patient have an opioid use disorder?)
  – Involvement of psychiatry/addiction colleagues
Pearls about harms

• Try to decide whether the patient has an opioid use disorder (so you can refer to tx)
• This can be HARD
• Regardless: you may determine that the risks of opioid rx > benefits
Recognizing Opioid Use Disorder (1/2)

1. Opioids are often taken in longer amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.

4. Craving, or a strong desire or urge to use opioids.

5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

DSM-5.
Recognizing Opioid Use Disorder (2/2)

6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.

8. Recurrent opioid use in situations in which it is physically hazardous.

9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
Treating Opioid Use Disorder

• Three evidence-based, FDA-approved medications:
  – Buprenorphine (on WHO list of essential meds*)
  – Methadone (on WHO list of essential meds*)
  – Naltrexone

Naloxone

- $85 for a two-pack
- Covered by many insurances
- Consider in all patients, especially high dose
- Know local laws
Question 3:
You should routinely tell patients with chronic pain that:

a. If they “break” their pain “contract,” you will get angry and fire them from the practice

b. The goal of pain management is improvement in physical function, rather than being “pain-free”

c. Their pain is “mostly psychological”

d. If they go to their initial visit with their pain doctor, they will get opioids
This is complicated!
Maybe I can just avoid it...

• The bad news: there aren’t enough pain specialists to see patients with chronic pain

• So:
  – Whether you’re in primary care, psychiatry, neurology, palliative care, or another subspecialty....
  – Whether you’re a doctor, NP, PA, RN, social worker, pharmacist....

• Patients will look to you for help. You will be their best chance of getting help

• It is *so rewarding*
How to make this as easy as possible

• Develop systems in your practice
• Utilize unique skills of team members
• Develop policies and agreed-upon approaches
• Utilize resources
  – Those mentioned today
  – CDC materials
  – Conferences: AMERSA, ASAM, regional APS
  – Providers’ Clinical Support System (PCSS)
In sum

• Chronic pain is a major problem
• We have a lot more to offer than opioids
• If you do prescribe opioids (and you will), use a universal precautions approach
• Diagnose and facilitate addiction treatment
• Utilize available resources

My contact information: jmerlin@uabmc.edu
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