Pain medicine for older adults in a time of the "Opioid Crisis"

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University of Missouri-Columbia

"Diversion of prescription pills to the street market promotes the addiction to painkillers that leads to overdose deaths. We are focusing on charging doctors, pharmacists and the networks that are putting this poison on the streets."
- U.S. Attorney Barbara McQuade

New fix for opioid epidemic takes aim at doctors' Rx pads

Didn't the Docs promise meds are not addicting??
Why are we talking about this today?

- Statistics show prescription opioid-related overdose deaths are increasing
- Drug overdose is now the leading cause of injury death in U.S.
- Headline-grabbing stories have captured policymakers’ attention and spurred efforts to reduce abuse, misuse and diversion at the state and federal levels
- Some legislative and regulatory proposals pose serious risks to patients with legitimate need or allow for intrusion into medical practice.
Goals for this session

1. Understand the public health imperative to address prescription drug abuse and opioid-related death
2. Identify legislative and regulatory efforts to restrict opioid prescribing at the state and federal levels
3. Recognize when opioids may make sense for older adults

As patients and health care providers, we cannot ignore the numbers....

This means providers are doing a good job, right?

The problem is there has not been an overall change in the amount of pain that Americans report.
The 90’s: Older adults pain medication was NSAIDS, but GI bleeding risk

It’s not just young folk abusing

- 20 percent increase in opioid prescriptions over the last 5 years.
- 336,000 seniors were misusing prescription medications in 2012, “up from 132,000 a decade earlier.”
  - The Substance Abuse and Mental Health Services Administration
- over 50 percent increase in “emergency room visits by people 65 and over for misuse of pharmaceuticals” with overdose deaths nearly tripling to 9.4 per 100,000 people from 2007-2011
  - The Centers for Disease Control and Prevention
And not all coroners report opioid deaths

Big impact on young kids too

Peds opioid-related hospitalization

• Doubled between 2005 to 2015

And don’t forget that other epidemic

<table>
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<td>2015</td>
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<tr>
<td>2018</td>
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BENZODIAZEPINE
EPIDEMIC

9,000 benzo deaths in 2015
35,000 opioid deaths

I take so many prescription drugs every day that I’m surprised I don’t rattle when I walk.
HOWEVER... variation in painkiller prescribing between states, cannot be explained by state differences in health issues that cause people pain.

Statistics demonstrating abuse and misuse are just as sobering.
Midwest 30% Rise In ED Visits

Sources of Prescription Painkillers Among Past-Year Non-Medical Users

Overdose by risk group

Where you would like to see policymakers focus when they restrict prescribing?
And now the repercussions

42% of Missouri’s practicing physicians are flagged in the MO HealthNet database

Opioid Abuse and Chronic Pain: Not a Zero-Sum Game

Often, it feels like any attempt to prevent prescription opioid abuse must be accomplished by reining in prescribing, potentially increasing pain and decreasing function.

Similarly, it often seems as though any effort to improve pain management must involve increased prescribing, which could, in turn, lead to more adverse outcomes.

I believe this misstates the case, and that it is possible to address both problems without adversely affecting either—by providing balanced pain management.
Federal and State Pain Management Policy Issues

- Prescribing Guidelines
- Abuse-Deterrent Opioids
- Prescription Monitoring Programs
- Prior Authorization/Step Therapy/Specialty Tier
- Pain Clinic Regulation
- Mandatory CME/CE
- Availability of substance abuse treatment
- Good Samaritan/Naloxone Distribution and Administration
- Reimbursement for services other than prescribing and procedures

CDC Guideline Policy

- CDC issued an opioid prescribing guideline for PCPs treating chronic pain
  - Heavily criticized for process
  - Anticipated that this will be adopted as law/regulation/guideline by many states

CDC Guideline: Why Does It Matter?

- Because a guideline issued by CDC will carry considerably more weight, and will be considered as more valid, because it comes from CDC
- State health departments and licensing boards will move quickly to adopt this as official policy
- This guideline will find its way into court and will be seen as reflecting standard of practice
- Inflexible recommendations can tie our hands
- How would such a policy effectively be limited to PCPs?
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC’s Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Narcotic analgesic therapy and nonopioid (nonnarcotic) therapy as a single or combined approach. 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 nonopioid analgesic therapy and nonpharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should inform patients that if there is no clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patients and clinicians responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks and availability of nonopioid therapies with patient.
CDC Guideline: Clinicians concerns—Why Does It Matter?

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- Inflexible recommendations can tie our hands
- How do they operationalize cancer and palliative care is ok?
Back to the original pain management
Recommended Screening tools:

Opioid Risk Tool
This tool should be administered to patients upon initiation of therapy for pain management. A score of 0 or under indicates low risk, a score of 1 to 2 indicates moderate risk for opioid abuse, and a score of 3 or higher indicates a high risk for opioid abuse.

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<th>Male</th>
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<td>4</td>
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<td>Recent drug</td>
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<td>Age between 18-45 years</td>
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<tr>
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<td>1</td>
</tr>
<tr>
<td>Scoring total</td>
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<td></td>
</tr>
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</table>
And what are we really screening for?

Substance Use Disorder:
Patterns of symptoms resulting from the use of a substance that the individual continues to take, despite experiencing problems as a result.

American Psychiatric Association 2013: DSM-V

DSM-V defines substance use disorder as a clinical spectrum based on 11 criteria. The presence of two or more of these criteria may be indicative of substance use disorder.

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Presence of 2 out of 11

<table>
<thead>
<tr>
<th>DSM-V Substance Use Disorder Criteria</th>
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</thead>
<tbody>
<tr>
<td>1. Taking the substance in larger amounts or for longer than meant to</td>
</tr>
<tr>
<td>2. Wanting to cut down or stop using the substance but not managing to</td>
</tr>
<tr>
<td>3. Spending a lot of time getting, using or recovering from use of the substance</td>
</tr>
<tr>
<td>4. Cravings and urges to use the substance</td>
</tr>
<tr>
<td>5. Not managing to do what you should at work, home or school because of substance use</td>
</tr>
<tr>
<td>6. Continuing to use, even when it causes problems in relationships</td>
</tr>
<tr>
<td>7. Giving up important social, occupational or recreational activities because of substance use</td>
</tr>
<tr>
<td>8. Using substances again and again, even when it puts you in danger</td>
</tr>
<tr>
<td>9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance</td>
</tr>
<tr>
<td>10. Needing more of the substance to get the effect you want (tolerance)</td>
</tr>
<tr>
<td>11. Development of withdrawal symptoms, which can be relieved by taking more of the substance</td>
</tr>
</tbody>
</table>

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CAPC pearl for serious illness:

Key DSM-V criteria applicable to substance use disorder in the seriously ill patient:

- Continuing to use, even when it causes problems in relationships
AMA Task Force to Reduce Opioid Abuse

- >25 state, specialty and other health care associations
- “re-medicalize” the issues surrounding the epidemic of prescription drug misuse, overdose and death.
- prescribers of controlled substances accepting ownership of the issue and providing leadership in promoting solutions

AMA Task Force Goals

- Increase registration and use of PDMPs
- Ensure safe, evidence-based prescribing
- Support comprehensive pain care; reduce the stigma of pain
- Reduce the stigma of substance use disorder; increase access to treatment
- Increase access to naloxone to save lives from overdose; support broad Good Samaritan protections
So what do we do one on one with that patient in pain?

Who is really at risk from the opioid?
Key Points

**Question** Is prescription opioid use in one household member associated with increased risk of prescribed opioid use in other household members?

**Findings** In a study comparing 12,695,280 commercial insurance beneficiaries with a household member who started a new prescription of opioids, to 6,359,639 beneficiaries with a household member who started a new prescription of nonopioid pain relievers, the 1-year risk of subsequent opioid use was 0.71%, higher among individuals exposed to opioids through a household member’s prescription.

**Meaning** Prescription opioid use may spread within households.

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Lock Box

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Lock Box
In older adults pain is common
Risk is under treatment

Don’t underestimate the significance of disabling osteoarthritis pain at end of life

And pain in Nursing Home Hospice/Palliative patients?
- Cross-sectional data 2004 National Nursing Home Survey
- 1174 homes, 303 sampled patients of 33,413 receiving hospice or pall care
- Measure: faculty staff report of pain in last 7 days, Medication use and MDS info

— Hordon et al. JAMDA October 2010 p579
Undertreated pain even with hospice in the nursing home

- One of the first national studies of pain prevalence in nursing home hospice/palliative patients
- 1/3 of patients had pain in prior week
- (compared to 50% of NH residents)
- 15% received no analgesic

So Pain is common in older adults
But are Opioids safe in Older Adults?

Remember what the AGS pain guidelines say?

2002 Guideline

- (VIII) All patients with moderate to severe pain, pain-related functional impairment, or diminished quality of life due to pain should be considered for opioid therapy
  (low quality of evidence, strong recommendation).
- (IX) Patients with frequent or continuous pain on a daily basis may be treated with around-the-clock time contingent dosing aimed at achieving steady-state opioid therapy
  (low quality of evidence, weak recommendation).
- (X) Clinicians should anticipate, assess for, and identify potential opioid-associated adverse effects
  (moderate quality of evidence, strong recommendation).
- (XI) Maximal safe doses of acetaminophen or NSAIDs should not be exceeded when using fixed-dose opioid combination agents as part of an analgesic regimen
  (moderate quality of evidence, strong recommendation).
In Fairness the AGS guideline said some good things about opioid treatment

“In properly selected and monitored patients, opioid analgesics constitute a potentially effective and, for some patients, indispensable treatment as part of a multimodal strategy in the management of various types of persistent cancer and noncancer pain.”

All practitioners who care for older patients—geriatricians, pain specialists, and primary care providers—must consider their own clinical experience along with published evidence when deciding whether and how they will prescribe opioids. Use of opioids in older patients with persistent pain should be prescribed on a trial basis with clearly defined therapeutic goals. The trial may involve serial attempts to titrate the opioid to an efficacious dose without intolerable adverse effects. It should be understood that opioids will be discontinued if the trial is unsuccessful. In most persistent pain conditions that warrant opioid therapy, optimum management requires a comprehensive treatment program that also involves functional restorative and psychosocial modalities. Patients and their caregivers must understand that opioids are not a panacea or substitute for nonpharmacological therapies.
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Is a strong pain medicine really better?

Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial

Andrew K. Cheng, MD, MS; Polly E. Byer, PhD; David Evans, MD; Douglas P. Barnaby, MD, MS; Jesse Bar, MD

Key Points

**Question** Do any of 4 oral combination analgesics (3 with different opioids and 1 opioid-free) provide more effective reduction of moderate to severe acute extremity pain in the emergency department (ED)?

**Findings** In this randomized clinical trial of 441 ED patients with acute extremity pain (mean score, 6.7 on the 11-point numerical rating scale), there was no significant difference in pain reduction at 2 hours. Mean pain scores decreased by 4.3 with ibuprofen and acetaminophen (paracetamol), 4.4 with oxycodone and acetaminophen, 3.5 with hydrocodone and acetaminophen, and 3.9 with codeine and acetaminophen.

**Meaning** For adult ED patients with acute extremity pain, there were no clinically important differences in pain reduction at 2 hours with ibuprofen and acetaminophen or 3 different opioid and acetaminophen combination analgesics.

Original Investigation

March 6, 2018

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain: The SPACE Randomized Clinical Trial

Eric L. Krohn, MD, MPH,1,2,3 Amy Grady, MA1 Sean Nagrent, MA1,2,3

Author Affiliations

But there is a moderate amount of positive evidence for Opioids in Older Adults


Papaleontiou

- 40 articles on safety/efficacy
- Age 63-73
- Patients with
  - DJD 70%
  - Neuropathy 13%
  - Other pain producing disorder 17%
Papaleontiou

• Take home: Short term use of opioid associated with reduction in pain intensity, better physical function, but poorer mental function.

So similar to the AGS guideline conclusion a decade prior.
But

• 1 in 4 discontinued treatment due to adverse event

• And note, the studies’ durations were short.
  – Mean duration 4 weeks
  – Only 5 studies were >12 weeks

Don’t opioids make you fall?

• Miller, et al. Opioid Analgesics and the Risk of Fractures in Older Adults with Arthritis.

• 2 statewide drug programs
• Patient starting either
  – Nsaid (4,874) or opioid (12,436)
  – 85% female
  – Most tx for DJD
  – New rx in last 180 days
  – Not in hospice or LTC
• Main outcome: fracture hip, humerus, wrist by ICD9 and procedure codes

• 587 fracture events among the participants
  – 587 fracture events in initiating opioids (120 fractures per 1,000 person years)
  – 38 fracture events in initiating NSAIDs (25 fractures per 1,000 person-years)
• Adjustment:
  – Fracture risk higher with higher opioid dose
  – Risk greater for
    • short acting opioid HR 5.1 95% CI 3.7-7.1
    • Vs long acting opioid HR 2.6 95% CI 1.5-4.4
  – Risk is apparent in first 2 weeks of starting opioid but not thereafter

Problem?
• Well, 5,552 of the opioids were for propoxyphene 45%
• Opioid initiators were more likely to be taking Benzodiazepines, antidepressants, PPIs, steroids, thiazides and osteoporosis medications
• High initial doses (37 mg morphine/day)
• No adjustment for pain and functional assessment!!!!!

Bertha
• 84 year old
  Hip pain is disabling
  Not a surgical candidate
  Goals: to be able to care for her disabled son
One way to think about opioids:

Three Pain Populations
Goals for opioid use are individualized depending on both the type of pain and the patient population.
1. Cancer pain
2. Non-cancer pain and concurrent serious illness
3. Non-cancer pain with no concurrent serious illness (Caution: Evidence of opioid efficacy for this population is limited and is associated with risk of substance use disorder and unintentional overdose.)

Bertha
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CAD, Stage 4 CKD
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3/27/2018

**When CONSIDERING long-term opioid therapy**
- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (e.g., addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (e.g., PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

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**4 steps to opioid prescribing**

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
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<tbody>
<tr>
<td>STICK substance use history</td>
<td>Screens using risk assessment tool and risk stratify patient</td>
<td>Develop management strategy based on risk</td>
<td>Monitor for or risk behavior</td>
</tr>
</tbody>
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**Opioid Risk Tool**

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 0 or lower indicates low risk for future complications, a score of 1 or 2 indicates moderate risk for opioid abuse, and a score of 3 or higher indicates a high risk for opioid abuse.

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<tr>
<td>Injuries</td>
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<td>Injuries</td>
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<td>Age between 18–45 years</td>
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<td>History of somatoform or sexual abuse</td>
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<tr>
<td>Psychological disease</td>
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Scoring totals

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How to know you are doing well??????

Not Patient Satisfaction Report Cards!

FUNCTIONAL STATUS!

What do you watch for to know you are doing well??????

Not Patient Satisfaction Report Cards!

FUNCTIONAL STATUS!

**ASSESSING PAIN & FUNCTION USING PEG SCALE**

**PEG score** = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

- **Q1**: What number from 0–10 best describes your pain in the past week?
  - 0 = “no pain”, 10 = “worst you can imagine”

- **Q2**: What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
  - 0 = “not at all”, 10 = “complete interference”

- **Q3**: What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
  - 0 = “not at all”, 10 = “complete interference”
When REASSESSING at return visit

- Assess pain and function (eg, PED); compare to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
  - If yes, taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (age, difficulty controlling use).
- If yes, refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If <30MME/day total (<10mg hydrocodone, <33 mg oxycodone),
    increase frequency of follow-up; consider offering naloxone.
  - Avoid >30MME/day total (<50 mg hydrocodone, <150 mg oxycodone),
    or carefully justify consider specialist referral.
- Schedule reassessment at regular intervals (≤3 months).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

Please Join Missouri PDMP
False signs of opioid misuse in PDMP

Patients who are receiving care in a group practice or an academic teaching hospital, where doctors commonly cover for each other, should not be confused with patients who are doctor-shopping.

Patients who are receiving prescriptions for limited quantities (e.g., a two-week prescription as part of an opioid taper) should not be confused with patients who are getting early refills.

Opioid Pearls for Older Adults

- Think in terms of 24 hour totals and Morphine Equivalent Dosing (MED)
- Increase dose by no more than 50-100% 24 hour total
- Opioid rescue dosing= 10-15% of 24 hour total
Barriers to Effective Opioid Therapy

- **Patient Barriers**
  - Save for “when it’s really bad”
  - Fear of addiction
  - Stigma of morphine
  - Side effects
  - Reluctant to report pain

- **Physician Barriers**
  - Fear of addiction
  - Knowledge deficits
  - Regulatory oversight
  - Analgesia low priority compared to cure

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**Equianalgesic Doses of Opioid Analgesics (in mg)**

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<td>Hydrocodone</td>
<td>-</td>
<td>-</td>
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<tr>
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<tr>
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<td>Morphine</td>
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<td>20</td>
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<td>-</td>
<td>Fentanyl</td>
<td>0.1-0.25</td>
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**Opioid Rescue Doses**

- Used for breakthrough pain.
- **Dose:**
  - Approximately 10% of daily dose equivalent.
- **Frequency:**
  - Oral: every 1 - 2 hours
  - Parenteral: every 15 - 30 minutes
Start Low and Go Slow

- Reduced volume of distribution

Watch out for Reduced Renal Clearance!

Remember how is morphine metabolized?

Metabolites
Final Take Homes

• Use the Opioid Risk Screening Tool
• Use the 3 item functional pain scale PEG
  – Surgeon General’s Turn the Tide is one place to find them
• Think about three pain types:
  1. Cancer pain- Use opioids
  2. Pain with serious illness- opioids as second line option
  3. Chronic pain without serious illness- avoid opioids

Resources

AAHPM

State Pain Policy Advocacy Network [https://sppan.aapainmanage.org/]
- Policy news
- Legislation & regulations by state

American Medical Association [www.ama-assn.org/go/endopioidabuse]
- Education resources by state
- Links to each state PDMP for registration
- State naloxone and Good Samaritan laws

CDC Pain Guideline [http://www.cdc.gov/drugoverdose/prescribing/resources.html]
- Surgeon General’s Turn the Tide Rx [http://turnthetiderx.org/]

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