Managing Opioids with Acute Pain Patients

The Centre for Addiction and Mental Health OpiATE Initiative

David Mock, DDS, PhD, FRCD(C)
Professor, Oral Pathology/Oral Medicine, Faculty of Dentistry, University of Toronto
Professor, Laboratory Medicine & Pathobiology, Faculty of Medicine, University of Toronto
Wasser Pain Management Centre, Mount Sinai Hospital
Departments of Dentistry and Pathology, Mount Sinai Hospital
Disclosure

• Relationships with commercial interests:
  – **Grants/Research Support:** None
  – **Speakers Bureau/Honoraria:** None
  – **Consulting Fees:** None
  – **Other:** Proteocyte Diagnostics, Clinical Advisory Committee
    – preparing a cancer biomarker for commercialization. It has no application to the topic of this course.
Objectives:

- Learn to identify patients who are susceptible to opioid abuse
- Learn appropriate prescribing practices
- Understand how to advise patients on how to use opioid medication
- Become aware of resources to support your dental practice around patients with acute pain
Two “givens” before we proceed:
1. Truths are not eternal!
2. Practices are not acceptable in perpetuity!
General Principals

1. The dentist must exercise reasonable professional judgment in determining whether to, and when to prescribe any controlled substance, including opioids.
2. The dentist should only prescribe medication for treatment within his/her scope of practice and for conditions he/she is treating.
3. Prescriptions should be tailored to the patient and condition, not following a predetermined, routine practice.
4. A non-pharmacological approach, an OTC medication or a non-opioid should be used when it will satisfy the need.
5. A dentist is not obliged to prescribe any drug, including opioids, if they do not believe it is clinically appropriate, even if the patient has been prescribed them in the past.
6. The dentist must be alert to the potential for prescription drug abuse, misuse, addiction and diversion.
Patient Assessment

• The most valuable tool is the patient history:
  – Are there any contraindications to the medication in the medical history?
  – What other medication is the patient taking?
  – What related medication have they taken in the past? What was their experience?
  – Has another health practitioner prescribed anything?
  – Has another health practitioner refused to prescribe anything?
  – Is there a personal or family history of substance abuse (medical or non-medical)? (This includes alcohol, OTC medication)
Screening Tools

• Are to be used and interpreted by the clinician, not the patient
• One part of an objective and subjective evaluation of the patient
• None are foolproof!
Screening tools are available:

• Two short and simple ones are:
  – The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)
  – Opioid Risk Tool

  http://knowledgex.camh.net/primary_care/toolkits/addiction_toolkit/opioid_toolkit/Pages/faq_screening_patients_risk.aspx

• More information readily available from the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

  http://nationalpaincentre.mcmaster.ca/opioid/
Evaluation of Acute Pain

• Characteristics of the pain:
  – Severity of the patient’s pain? Constant or episodic? Frequency?
  – Nature of the pain – stabbing, burning, throbbing, pressure etc…
  – Can it be eliminated by the non-pharmacologic treatment?

• Will the treatment result in any post-operative pain?
  – Can that pain be controlled by non-pharmacological approaches?
  – Expected duration, under normal circumstances

• Associated symptoms
Principals of Pain Management

• Eliminate the source of the pain directly, as soon as possible, whenever possible
• All drugs carry an element of risk
• Individualize medication regimens
• Maximize the non-opioid (acetaminophen or NSAID) before adding or changing to an opioid
• Consider pre-emptive analgesia with non-opioid medication when post-operative pain is a concern
Principals of Pain Management cont’d

• Avoid long term use of any short acting analgesic in acute pain situations
• Reduce the dose in older patients and children
• Re-evaluate drug and dose for patients on other potentiating medication
• Generally, acetaminophen is sufficient for most mild to moderate acute oral pain
• Generally an NSAID is sufficient for most moderate to severe acute oral pain
Recommended Control for Acute Pain

• Assuming no contraindications, for mild to moderate pain, acetaminophen, adult dose 1000 mg q4h with a maximum daily dose of 4 g.
• If insufficient, (moderate to severe pain) and again assuming no contraindications, an NSAID q4h (e.g. ibuprofen, fluibuprofen, diflunisal, naproxen, ketorolac, ketoprofen, floctafenine or etodolac) up to maximum daily dose for that drug
• This should be adequate for most acute oral/dental pain situations
If Inadequate Analgesia or for Severe Pain

- Re-evaluate diagnosis
  - Add codeine 30 – 60 mg to the NSAID or acetaminophen (or use a codeine preparation)
  - Use an oxycodone combination drug

*After appropriate assessment and/or screening

Use lowest dose of opioid for the shortest time feasible
If an Opioid is Prescribed:

• For oxycodone preparations prescribe a maximum of 24 tablets
• For codeine 30 mg preparations prescribe a maximum of 24 tablets
• For codeine 15 mg preparations prescribe a maximum of 36 tablets
If Pain Unmanaged after 3 days:

- Reassess diagnosis
- Consider further non-pharmacological management, including direct clinical intervention
- Consider maximizing the non-opioid medication, possibly deleting the opioid if prescribed
- If an opioid was prescribed, consider repeating the opioid prescription unchanged, adding an NSAID/acetaminophen to reach maximal dosage
If Pain Still Unmanaged after another 3 days:

• Reassess diagnosis again

• Consider one of the approaches you didn’t take after the first 3 days
  – Further non-pharmacological management, including direct clinical intervention
  – Maximizing the non-opioid medication, possibly deleting the opioid if prescribed
  – Repeating the opioid prescription unchanged, adding an NSAID/acetaminophen to reach maximal dosage  BUT…
If Pain Still Unmanaged after 3 days (continued):

• If the prescription for an opioid is reissued for a second time:
  – consider the risk for diversion, misuse or abuse and if suspected consult with the family physician and/or pharmacist first
  – advise the patient that no further opioids will be prescribed after this without consultation with the patient’s physician or referral to an appropriate specialist (dental or medical) and/or with expertise in pain management
If the patient returns again with unmanaged pain:

• Refer back to the family physician or to a dental specialist either to reconsider the diagnosis or one with expertise in pain management

• Avoid prescribing any further opioid until after the consultations, if at all

• Consider maintaining the patient until the consultation with a non-opioid analgesic
An informed patient is the best safeguard

• Communicate the following:
  – Explain how the drug should be taken,
  – Tell the patient to only take it as directed and inform them of the maximum daily dose,
  – Warn the patient not to mix the medication with alcohol or other drugs unless approved by you or their physician
  – Forewarn regarding common adverse effects and explain discontinuing the medication
Informed Patient (continued):

– Remind them to never share prescription drugs with anyone else

– Advise them to store narcotics and controlled substances in a safe place, out of the reach of children and teenagers and keep track of amounts

– Instruct them to return unused medication to the pharmacy for safe disposal, in order to prevent diversion and to protect the environment (not keep it “just in case”),
### Aberrant Drug Related Activity


<table>
<thead>
<tr>
<th>Indicator</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altering the route of delivery</td>
<td>- Injecting, biting or crushing oral formulations</td>
</tr>
<tr>
<td></td>
<td>- Biting, chewing, swallowing or Injecting topical preparations (e.g., sustained-release analgesic patches)</td>
</tr>
<tr>
<td>Accessing opioids from other sources</td>
<td>- Taking the drug from friends or relatives</td>
</tr>
<tr>
<td></td>
<td>- Purchasing the drug from the &quot;street&quot;</td>
</tr>
<tr>
<td></td>
<td>- Double-doctoring</td>
</tr>
<tr>
<td>Unsanctioned use</td>
<td>- Multiple unauthorized dose escalations</td>
</tr>
<tr>
<td></td>
<td>- Blige rather than scheduled use</td>
</tr>
<tr>
<td>Drug seeking</td>
<td>- Recurrent prescription losses</td>
</tr>
<tr>
<td></td>
<td>- Aggressive complaining about the need for higher doses</td>
</tr>
<tr>
<td></td>
<td>- Harassing staff for faxed scripts or fit-in appointments</td>
</tr>
<tr>
<td></td>
<td>- Nothing else &quot;works&quot;</td>
</tr>
<tr>
<td>Repeated withdrawal symptoms</td>
<td>- Marked dysphoria, myalgias, GI symptoms, craving</td>
</tr>
<tr>
<td>Accompanying conditions</td>
<td>- Currently addicted to alcohol, cocaine, cannabis or other drugs</td>
</tr>
<tr>
<td></td>
<td>- Underlying mood or anxiety disorders not responsive to treatment</td>
</tr>
<tr>
<td>Social features</td>
<td>- Deteriorating or poor social function</td>
</tr>
<tr>
<td></td>
<td>- Concern expressed by family members</td>
</tr>
<tr>
<td>Views on the opioid medication</td>
<td>- Sometimes acknowledges being addicted</td>
</tr>
<tr>
<td></td>
<td>- Strong resistance to tapering or switching opioids</td>
</tr>
<tr>
<td></td>
<td>- May admit to mood-leveling effect</td>
</tr>
<tr>
<td></td>
<td>- May acknowledge distressing withdrawal symptoms</td>
</tr>
</tbody>
</table>
Control of Prescriptions

• Fully and clearly provide all necessary information on prescriptions including patient’s full name, date, name of drug, drug strength, quantity and instructions for use
• Include number of refills if any, noting also if none
• Printed name of prescriber and telephone number
• Either a clear signature or unique identifier
• If prescribing a monitored drug, the prescriber must provide their registration number and an identifying number for the patient (e.g. health card)
Control of Prescriptions (continued)

• Keep blank prescription pads/forms secure
• In the case of narcotics and controlled substances:
  – Write the prescription in words and numbers
  – Draw lines through unused portions of the prescription
• For desk-top prescription printing:
  – Use security features such as watermarks
  – Write a clear and unique signature
• If faxing:
  – Confirm destination and only fax directly to pharmacy
  – Destroy paper copy
Opioid Prescriptions

Dr. Family Doc
123 Main St. Anytown
(416) 555-1212
CPSO: 11111

Name: John Smith
Date: June 21/13

Rx

HC: 1234567890
Morphine SR 15mg
T bid
60 sixty

Signature:

Refills:

Name of Prescriber
CPSO or RCDSO Number
Full Name of Patient & Date
Health Card Number (or Other Identifier)
Drug, dose, instructions
Quantity
Signature
Refills

*It also can be helpful to add additional information for the pharmacists e.g. diagnosis, divided doses etc...
Pharmacists are responsible for confirming the authenticity of each prescription and thus may require direct confirmation with the prescriber.
The High Risk Patient

• A patient with a history of aberrant drug behaviour or a risk of such behaviour
• A patient unknown to you
  – Get identification from patient and record it in your records
  – Ask if they have received a comparable medication in the past 30 days
• Observe for suspicious behaviour such as the patient who:
  – Asks for a specific drug by name
  – Claims adverse reactions to all other medications you suggest
  – Refuses a complete assessment or indicated tests/imaging
  – Provides evasive responses
  – Refuses or insists on postponing direct treatment
Management of the High Risk Patient

– Consult with the family physician and/or pharmacist
  • Note in patient record

– Discuss instructions in detail with the patient and clarify the rules under which you are prescribing

– Consider prescribing divided doses
  • i.e. prescribe 12 tabs at once and 12 two days later

– If any doubt – do not prescribe an opioid
Narcotic Monitoring System

The NMS is a central database to enable reviews of monitored drug prescribing and dispensing activities within the community health care sector. The NMS will also have real-time Drug Utilization Review (DUR) capabilities. When a dispensing record is submitted by a pharmacy to the NMS, the system will conduct DUR checks. If potential issues, such as double-doctoring and poly-pharmacy visits are detected, the NMS will issue an alert to the pharmacy in real-time (i.e. at the time that the prescription is being dispensed).
Office Dispensing

Not generally a good policy for opioids or controlled substances but if you must for some reason:

• Store drugs securely and safely out of sight (locked)
• A drug registry must be kept, accounting for all drugs dispensed, including the patient’s name, quantity and name of drug and the date
  – Each entry must be initialed
• Include a notation in the patient’s record
• Any loss or theft must be reported
Prescriber
Resources for Guidance & Support

• Patient’s Family physician
  – Patient’s history, urine drug screening, physical signs, contraindications

• Pharmacist
  – Patient’s drug history with that dispensary, online sources

• Royal College of Dental Surgeons of Ontario
• Centre for Addiction and Mental Health (CAMH)
• Ontario College of Pharmacists
• College of Physicians and Surgeons of Ontario
Patient Resources

• About Percs, Oxys and other Pain Pills: https://knowledgex.camh.net/amhspecialists/resources_families/Documents/about_percs_oxys.pdf

• Youth and prescription painkillers- Parent Brochure: https://knowledgex.camh.net/amhspecialists/resources_families/Documents/YouthandMisure%20E.pdf
Questions?