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CHRONIC PAIN IN HIV PRIMARY CARE: A PRACTICAL, EVIDENCE-BASED APPROACH

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Chronic Pain in HIV Primary Care: A Practical, Evidence-Based Approach

[video transcript]

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I wanted to give you a little bit of a perspective of where I'm coming from. As you heard, I'm an ID physician, also a palliative care physician. I run a chronic pain clinic for patients with HIV that's embedded within our Ryan White clinic. And I run a research program also in this area, chronic pain and HIV and chronic pain in primary care populations in general. So, I'm right there with you in the trenches. And so, I look forward to a fun discussion about chronic pain in our patients.

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I'm not quite tall enough to see that screen. Okay, I'll have to go over here. So, the objectives for my talk are to develop an evidence-based approach to the overall evaluation and management of chronic pain in people living with HIV. And then I'm to talk a little bit about opioids as well, which I know probably when you saw the topic of this talk, you saw chronic pain and we're thinking opioids and we're certainly going to get to that in the discussion.

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And the way that we're going to structure this is first we're going to talk about chronic pain and HIV state of the science. I'm really going to focus mostly on epidemiology because I have such a limited amount of time but if people have more questions about pathophysiology or novel treatments, I'm happy to discuss that as well. And then we'll get right down to the practical stuff and talk about evaluation and then management. And then always, ooh opioids. We'll definitely talk about that.

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Okay. All right.

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So, what is chronic pain? So, chronic pain is pain that lasts for greater than three months beyond the period of normal tissue healing. And so, as you probably know, some people break their ankle, it heals. They don't have pain afterwards. Some people it goes on and on. So, what are some examples of this? So, as you all know, chronic low back pain, other regional musculoskeletal pain so knee pain, shoulder pain. There's an entity called chronic widespread pain, which is pain in the axial skeleton, so best to say back pain, pain on both sides of the body and pain above them below the diaphragm. So, somebody might have back pain, left knee pain, right shoulder pain. There's a subset of chronic widespread pain called Fibromyalgia where patients tend to feel flulike and hurt all over and also have other somatic symptoms, headaches, peripheral neuropathy. Chronic pain is very common in the general population. So, some of the more recent prevalence estimates suggest that it's at about a 15 percent prevalence in the general population. It has a unique neurobiologic basis, which I think is really important. I won't belabor this too much but I think, I hear oftentimes patients say and actually other providers say chronic pain is this weird mysterious thing that we don't totally understand and I want to just make sure people realize that that's not the case. I actually attended a week-long basic science conference on the basic

science of chronic pain. So, just not to go into that too much, but just to keep that in mind. And chronic pain we know is heavily influenced by biological, psychological, and social factors. So, in addition to that unique neurobiologic basis, we know that depression can make pain worse, pain and cause incident depression, social isolation can make pain worse and on and on.

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We know that chronic pain is associated with substantial disability. It can be difficult to treat. It affects really all aspects of patients' lives so it doesn't just-- it can cause patients to have difficulty with work, with close personal relationships, have difficulty earning income, having mood symptoms et cetera. We are going to talk about treatment quite a bit so I'll breeze by that for now. And you should note that the Institute of Medicine put out a report in 2011 called relieving pain in America that was followed up by a national pain strategy that came out about a year ago that identified chronic pain as a key area of research focused especially in populations most affected. So, this is really an important topic area.

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So, now a few moments about chronic pain in HIV. So, as you probably know, neuropathic pain is what's been classically identified and so this is due to the HIV virus itself, due to co-morbidities more commonly seen in patients with HIV such as alcohol use and due to some of the older drugs that we don't use anymore but they have lifetime side effects of neuropathic pain like the D drugs. However, more recent studies suggest a predominance of musculoskeletal pain. And by that I mean predominantly back pain but also other regional musculoskeletal pain and widespread pain. And in fact, multi-site pain in patients with HIV is very common. So, in one study from the REACH cohort at UCSF, they found in median number of locations of pain of five and in our SCENICS cohort, which is a large national clinical cohort, we found that the median number of locations of pain is three. So, I would imagine that probably jives with what you see clinically and I see some nodding heads there.

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So, I would argue that chronic pain is an important co-morbidity in individuals with HIV for two key reasons. So, one is its prevalence. So, there have been no directly comparative studies of individuals with chronic pain with and without HIV but as I mentioned, the prevalence of chronic pain in the general population is around 15 percent and in patients with HIV, depending on the cohort study and the methodologies used, it ranges very widely but it's anywhere from 30 to 85 percent. So, even at the low end of that range chronic pain is much more common in patients with HIV than the general population. And there have been an increasing number of studies looking at the relationship between chronic pain and HIV outcomes. So, we know that from some recent work that some patients with chronic pain have worse retention in HIV primary care, they have up to 10 times greater odds of functional impairment, they utilize more health care resources, they can have suboptimal anti-retroviral treatment adherence, and they may be more likely to use heroin and other prescription opioids.

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All right. So, now on to evaluation.

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Okay. So this is the first audience response question. So, 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 or d) I have no idea, how should I know?! Please vote. Vote early and often.

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Music is great. They've matched it to the--

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Sorry, I didn't mean to do that. There you go. It was split between the patient says so and I have no idea, how should I know. So, it was about two thirds, one third. So, I love this question. I always include this in my talks because, you know, this is a real struggle, right? So, pain is subjective, right? And we rely on patient self-report. And so, I agree with folks who say I have no idea how should I know in the fact that there are some people who are malingerers. They're just going to tell you something that isn't true. But that's always a diagnosis of exclusion. And so the way that I think about this philosophically is only the patient can know if they have pain. That doesn't necessarily mean they did an opioid, which I think sometimes gets conflated with those question. Just because they say they have pain doesn't mean that opioids are the right way to address it. But I would argue that we should take our patients' pain at face value and then separately decide how to manage it.

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History and screenings. So, we all in school learned lots of stuff about how to evaluate our patients' pain but I wanted to give you guys some what I think are really practical pearls. So, really focusing on the impact of pain on function. So, in the pain world we care somewhat about how much pain somebody is in but way more about how much that pain impacts their life. Because it's a very different person who has severe pain but works a full time job versus somebody who has severe pain and is bed-bound and doesn't leave the house. So, there are standardized ways to do this so there is a 3-question questionnaire called the PEG and it stands for pain severity, enjoyment of life, and impact of pain on general activities and so if you just ask patients those questions on a scale of 0 to 10, that's something that can give you a sense of how much pain impacts their function. Another thing that I often do is ask people how they spend their time. So, I just say tell me a little bit about how you spend your day and it can be really, really informative because as you know, a lot of our patients may be on disability but even patients who are on disability can participate in lots of meaningful activities so it's important to flesh that out. And that helps you also get a baseline from which you can evaluate your treatment. Pain management history and of course getting records, so understanding what patients have been through before, understanding what medications may or may not have worked or what struggles patients may have had in the past with certain therapies. And then screen for a variety of things. We do these things systematically. We have patient-reported outcome questionnaires electronically in our clinic. But these are certainly things you can do just yourself in the room. And I always say screen for these things or else you'll miss them. They're so highly co-morbid with chronic pain and if you don't treat these things, often the pain does not get better. So, you want to screen for mood symptoms. I use the PHQ-9 but you can use that PHQ-2 for depression. GAD-7 for anxiety. There's a NIDA quick screen if you go to this website. It'll actually take you through questions you can ask your patient right at the point of care to help screen

for alcohol and other substance use and sleep problems. And asking about the history of these things in the past as well.

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The other thing I'd recommend while you're evaluating the patient is really to note coping and self-management behaviors. And what do I mean by that? So, noting if the patient says, "I lay in bed all day because I'm afraid that if I get up I'm going to aggravate my back pain." So, that's a maladaptive coping strategy called fear avoidance that has been associated with negative functional outcomes and that's just something that you can note so that you may be able to work on that with them going forward. And you also want to note some more positive strategies when patients say, "Actually my pain is much better when I'm in church on Sundays," or "My pain is much better when I'm with my grandkids," or "I've found that if I'm walking, my pain actually is a little bit better. I'm distracted and I actually feel a little bit more mobile."

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So, diagnostic testing. So, of course the purpose of this talk is not to give you a long compendium of all possible chronic pain syndromes and diagnostic tests that you want to think about for each of those. But just to give you some general practical advice, which is that with diagnostic testing for chronic pain, evidence-based judicious use is best. So, what I mean by that is you can't always see pain on an image or a blood test. And if you, let's say, go to UpToDate or if you look at recent guidelines, for example, there's recent low back pain imaging guidelines from Chou et al. If you look at those guidelines and it says OK so for low back pain I should image if there are radicular symptoms, I should image of the patient's over 50, I should image if there's a history of malignancy, but the patient doesn't have any of those things and they've had back pain for 10 years and it hasn't gotten any worse, then you probably don't need to image. So, you want to think about what is evidence-based judicious use. And even if you do end up imaging, for example, or if somebody maybe has symptoms of fibromyalgia and you go onto UpToDate and you realize okay, there are a couple of tests I may want to send just to rule out other things. I may want to send to TSH, et cetera. You can't always see pain and an image or blood test and this can be really challenging, not only for us as providers, who are trained to want to find that smoking gun, but also for patients who really want a quote unquote answer. And so, it's really important to frame it to patients as we did these tests to rule out anything that might be scary or potentially harmful to you, things that we might want to treat in a very specific way. Luckily, we haven't found those things. What you have is something that's called chronic pain and we know how to handle that and we're going to work on that together. So, it's a really important matter of framing communication.

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Okay, on to management.

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So, treating chronic pain is challenging. How many of you would agree that treating chronic pain is challenging? Oh I have some friends in the audience. That's good. Okay. I agree. So, I think that there are several reasons for this. I'm sure we could think of many more but I just wanted to put these up here as

food for thought. So, first is the communication about chronic pain can be difficult. So, patients and providers often come with baggage, right? So typically, you're not the first provider that this patient has seen about their chronic pain. They've seen lots of other people and they may have been told some really harsh and untrue things, right? They may have been told that the pain is all in their head, they may have been told that chronic pain is this weird mysterious thing that we don't understand and doesn't have any neurobiologic basis and that there are no treatments for, they may have been told some-- or that they're just drug seeking, et cetera. But we're also human beings first and providers second, I would think. So, we may have had experiences with other patients in the past that may color the way that we interact with the person sitting in front of us. So, we may have had people who have diverted the medications that we have given them or people who have communicated with us in a way that makes us feel uncomfortable. And also, opioids rather than functional restoration have really become the focus of our conversations with patients and that's a real problem. Providers are not trained to do this. How many of you feel like you had really substantial formal training in chronic pain in the way that you had it in HIV or cardiology as a medical student or whatever? One person! That's awesome! I'm so glad. That's really cool. So, I did not and I managed to make it all the way to being an attending even after palliative care fellowship and did not really feel like I had adequate training in this. So obviously, providers have lower self-efficacy over things that they don't have training in as well. There's a financial incentive to take a biomedical approach. So, it's much easier to pull out your prescription pad or click on the prescription for an opioid than it is to talk about multi-modal treatment approaches as we heard about or have a long conversation with the patient, right? Commonly used medications have limited evidence and carry serious risks and we'll talk about that in a second. Patients may have mood disorders or addiction that color the way that they communicate with us as mood disorders and addiction are highly co-morbid with chronic pain. And unfortunately, the best treatments, and we'll talk about these in the second, like for example cognitive behavioral therapy, are often inaccessible to our patients. But don't despair. There are lots of things you can do.

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Ready? We'll talk about them. So, general treatment pearls. So, remember. First, do no harm. You want to focus on evidence-based therapies and avoid unnecessary procedures, surgeries and medications. These are patients that are at very high risk for polypharmacy, for having five back surgeries without ever having their severe depression treated. So, you want to avoid contributing to that problem as much as you can. You want to set concrete goals and timelines. So for example, if you are going to start somebody on opioids, which I would say is becoming less and less common in this day and age, but if you are, you want to say, "Okay, I will start you on opioids. We'll go up to a certain dose that's reasonable and we'll talk about what that dose might be, but if it doesn't work after a few months we're going to stop it because you don't need to be on a medicine that does not work." And then the flip side of that is be ready to actually follow through on that and discontinue therapies that don't work. And if possible, treat psychiatric illness first. So, there is no randomized trial that will tell you treat depression versus not treat depression in patients with chronic pain and see what happens. You don't need an additional rationale to treat somebody's depression adequately, or their anxiety adequately, or what have you. However, I will say anecdotally that when patients have severe mood disorders, when you treat those mood disorders first, their pain often goes into the background and is not the major issue anymore and so that's typically our treatment approach is to focus on that first. It doesn't mean they

can't also be going to physical therapy or we can't pick a medicine like Duloxetine that has an indication for chronic pain. But you really want to focus on that psychiatric illness upfront.

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The other thing, and I'm happy to talk to folks offline about this because it's a longer discussion, but learning some tricks from our psychologists and other mental health colleagues. So, the book I'm on the left, Managing Pain Before it Manages You is a cognitive behavioral therapy self manual if that's a word. So basically, if you have a patient with a very high literacy level, they could buy this book and go through it themselves but I've actually read it and it's helped me think about how I might talk to my patients about reframing some of their less helpful thoughts. For example, related to chronic pain, setting goals related to increasing physical activity etc. So, those are some tricks from CBT that you can use. And then how many of you have training in motivational interviewing? Yeah, a lot. That's good. So, maybe a third of the room. So, motivational interviewing is just a great way to help patients who who may benefit from some behavioral change and so that could be increased antiretroviral medication adherence, smoking cessation, but it might also be more adaptive pain coping behaviors like increasing their physical activity and decreasing some of their less helpful thoughts related to their chronic pain. So, that's a technique that I think can be very useful and I use it a lot in my practice.

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Pain education. So, early in my time with the patient, usually during the first visit, I have a very concrete discussion with them about what is chronic pain. So, I even talk about the neurobiologic basis of chronic pain and I talk to them about how sometimes patients' peripheral receptors get hypersensitized when they've had a trauma in the past and that can cause them to have pain that lasts longer than other people's pain. I talk about this concept called central sensitization whereby even when there's no inflammation in the peripheral receptors, the brain gets this strong signal of pain and that that process is closely related to the processes in our brain that control depression and anxiety and substance use. So, I don't use those fancy terms but I try to explain that we know this about chronic pain. I talk about patients, so I say, "I know that you've had this problem for a long time and I know you wish it could go away overnight. And I know that you know better than I do that it's not going to go away overnight. It's going to take a lot of patience on your part and patience on my part. But with partnership and collaboration we can work on this together." I set an upfront expectation about both pharmacologic and non-pharmacologic management because both are very important. I talk about the role of multiple team members, so like the presenter before me, I'm very fortunate to be on a, I lead a multi-disciplinary team. It's me and a nurse practitioner, social worker, pharmacist, physical therapist. I know I'm leaving someone out. That's probably it. So, it's really-- everybody brings something different to the table and I'm very fortunate to work on a team like that. But even if you don't have a fully assembled team in your office, even if you know that a patient has complex chronic pain and you want to bring your social worker colleague who also has a counseling background into the room and you know introduce that person to say, "Hey, we're going to work on this with you together." I talk about the mind body connection. So, as I mentioned before, I talk about how chronic pain can make mood worse. For example a mood, you know, if somebody is depressed that can make their chronic pain worse, so that then when I may introduce medications like antidepressants to treat their pain or talk about treating

their depression or anxiety aggressively, they understand why. And then I talk about functional goals. I always emphasize functional goals. Asking people what they would like to be doing if their pain was better managed and we work on that together.

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So, I'm going to spend a very brief minute on non-opioid pharmacologic therapies because I think people generally are aware of these. But it's always important to remember these and to utilize them when they're appropriate. So, acetaminophen, best studied in osteoarthritis. There's now a 3 gram limitation and you want to consider relative contraindications like hepatitis C and alcohol use. NSAIDs, best studied and back pain. Remember that NSAIDs have a class effect of having cardiovascular, GI, and renal risk, and so even though there are some that may be friendlier than others in various ways, with our patients with so many co-morbidities, these are often not good medications for people to be on forever. Maybe fine initially while they're getting good with physical therapy or something, but just be mindful of indefinite use. It may shock you to learn that muscle relaxants and benzodiazepines have no evidence base in chronic pain even though all of our patients seem to be on them. So, what I would recommend is not adding them. So, if your patient is not already on them, I would say don't add them. If they are already on them, what I typically do is the muscle relaxant is usually the easiest thing to address first, so I usually ask patients what they think of their muscle relaxant. A lot of times people will say, "Yeah it makes me sleepy. It helps because it makes me sleepy," and I say, "But we just talked about those functional goals. You're too busy to be sleepy. So, why don't we try decreasing or getting off of that?" and usually people tolerate that well. Benzos can be much more challenging to get off of. But I usually try to understand exactly what the diagnosis is that caused the patient to be on the benzo and then work with the person who started that medication to consider if that really continues to be necessary. Anti-convulsants for specific indications, for example Gabapentin for peripheral neuropathy. Anti-depressants. We already heard about Duloxetine, TCAs like amitriptyline, can be effective for neuropathic pain. And then don't forget topicals. So, lidocaine for post-herpetic neuralgia, capsaicin for post-herpetic neuralgia or distal sensory polyneuropathies or peripheral neuropathy, topical diclofenac for OA.

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Evidence-based non-pharmacologic strategy. So, it's a pity that there's just one slide on this because honestly, the behavioral approaches, which include cognitive behavioral therapy, pain self management programs that sound like they may be in the same vein as some of the holistic treatments that were talked about a moment ago, really have the best evidence base. They're really some of the safest most effective interventions for chronic pain. Physical therapy, best studied in low back pain. Graded exercise. Interventional treatments for specific indications. So, a lot of people will use low back injections for radicular pain. The evidence on that is poor at best but it's commonly used. Acupuncture is the best-studied complementary therapy. Regular acupuncture is better than sham acupuncture and sham acupuncture is better than placebo, so there's probably some placebo effect, but it's better than, both are better than nothing. And so if you have access to it, that's great. And surgery for very specific indications like spinal stenosis.

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So, with all of that having been said, my best advice to you is develop a team in your office if you can. So, utilize the skills of the people in your office. So, a team of a physician, nurse, social worker, pharmacist is a great team to tackle some of these most difficult patients. And if you have, for whatever you don't have in your office or immediately at hand, develop a team in your health system or your community. So, get to know a physical therapist or a PM and R physician who likes to work with patients with chronic pain, an anesthesiologist, an interventionists who's good, psychologists, psychiatrists, addiction physician, very important, methadone program addiction treatment programs. And don't forget schools and training programs like counseling schools and things like that that can offer low-cost treatments.

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Okay, so in the 10 minutes, five minutes that remain, I'm going to talk to you guys about opioids. I'm sorry that I'm running a little short on time.

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Okay. So, what is this? Humor me. It's the sun at the center of the solar system. And what is in it? Oxycodo-- right, oxy. Okay. Very good.

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And what's this? Black hole! Good job. Okay. So, opioids-- these are not my slides. I wish they were but I borrowed from a colleague. So, oxycodone or opioids tend to be at the center of our conversations with patients, right? And it can really be a black hole and this is a pity because we've already spent 26 minutes talking and we haven't even gotten to opioids so these are really not our best treatments. But they're common and they have challenges, so here we go.

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So, 55 year-old with HIV, well-controlled on therapy, history of depression. He's on a escitalopram for that. Hypertension, diabetes, hyperlipidemia, history of addiction in the past. At the end of your 15-minute encounter, as you're shaking his hand and reaching for the door, he mentions he's had low back pain for six months and asks for hydrocodone acetaminophen. And all the usual, like, no red flags, unremarkable neuro exam, no personal history of malignancy, blah blah blah.

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Okay. So what do you do? Do you prescribe hydrocodone acetaminophen #90 per month with refills and arrange follup-up in a year? Do you-- don't laugh because you know people do this, okay? You may not admit that you do this, but inform him that you do not prescribe opiates to patients with a history of addiction and refer him to the local pain clinic, if you're lucky enough to have one? Tell him you'll need an MRI to determine if he has pain and depending on the results, you will consider an opioid? Or do you perform a history and physical, consider whether additional workup is needed, and discuss pharmacologic and non-pharmacologic management options? Please vote.

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We'll just do this one quickly. All right. You guys are great test takers. So, let's just quickly talk though about these other options.

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So, the new CDC guideline on opioid prescribing recommends follow up at least every three months. So, these are not people that you just want to throw opioids at and send to the wolves. You really need to monitor them frequently for reasons we'll talk about in a second. You can successfully prescribe opioids to patients who have a history of addiction. They just need more monitoring. I often will see people using MRIs as a litmus test or other imaging test as a litmus test to see whether a patient deserves opioids or really has real pain. Most pain does not show up on an imaging test and so this is really irrelevant in the opioid decision. And of course, the last one is correct.

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So, why is this happening? Why are we so focused-- how did how do we get here with opioids? So, pain is the fifth vital sign. Pain is always an emergency. It was a well-intentioned strategy that is not good, right? Because if you have chronic pain and you're always in a state of emergency, you're really not meeting those functional goals. It's more appropriate for acute pain. As a palliative care physician, I will say palliative care's early success is we really fought to make opioids not just something that you use in somebody's last dying breath, but they're also not something you use for every hangnail and wart. Misinterpretation of early studies, so there were some early big case series, really one early largish case series, that suggested that people on long-term opioids for nonmalignant pain did not develop opioid use disorders. And that was really overgeneralized. Marketing of long-acting oxycodone, for which people went to federal prison. It was marketed as not addictive and other professional organizations and key individuals propagated these things.

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So, here's my take on opioids. I think when people give a talk on opioids it's important for them to kind of say what their personal synthesis of the literature is on this. But now that the CDC guideline has come out and it's the same as my personal synthesis, I feel like I have to defend this a little bit less. So, opioids are not first-line therapy for chronic pain. Are not. They work for some people. I'm not a nihilist, I don't believe that opioids should never be used for anybody ever under any circumstances. However, the evidence from their benefit is limited. And what we know about their risk is growing. So, if started, they should always be considered a time-limited trial and you want to use the lowest effective dose. You don't escalate forever and ever. And if you want to read anything about this, and hopefully some of you have seen this already, here's the link to the CDC guidelines. It does a beautiful job of something synthesizing the literature in this area and summarizing some of these points.

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So, it may also surprise you to know that there's really a lack of evidence of benefit of opioids, which is why this is so problematic. So, this is from a systematic review from 2015, the most recent one. And it says, "Evidence is insufficient to determine the effectiveness of long term opioid therapy for removing chronic pain and function," because we really don't have outcomes beyond a year. Not good.

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But we do have lots of evidence of risks and harms and here are some of the most important ones. So, decreased function/return to work, induced depression, which is thought to be more of a duration than a dose effect, motor vehicle accidents, even at what we would consider lower doses like 20 milligram equivalents of Morphine a day, falls, addiction, and overdose. And if you remember one thing about overdose, it's that it's worse with above between around 90 or 100 milligram equivalents of morphine a day, although that curve starts going up around 50 milligram equivalents of morphine a day. And in people who are co-prescribed benzodiazepines.

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So, then what do you do when you have a patient sitting in front of you? You have to weigh these risks and benefits.

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So, one scenario is whether to start, right? This is less common these days because oftentimes hopefully we're reaching for other things first because we know about these problems. But what the CDC says about this is, "Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if the expected benefits for both pain and function are anticipated to outweigh the risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy."

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Okay. This is the more typical situation, righ? Whether to continue-- the "inheriting" scenario. So, what I say is every time you have a patient who is on long term opioids in front of you, you need to reassess the opioids. So, about every three months or more frequently, you assess the benefits and harms of the opioid for the individual patient. And if the benefits do not outweigh the harms, the clinician should optimize other therapies and work with patients to taper. And I'm happy to answer questions about how you might do that.

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So, I know I'm like a minute over. I'm going to go through this really quickly. So, how to evaluate for harms. So, I mentioned you know you want to look at what benefits they're getting, so are they doing more, are they more physically active, that sort of thing, but how do you evaluate for harms? So, you want to use a universal precautions approach. Treat everybody the same because evidence has suggested that when we don't treat everybody the same, when we don't just do this universally, we use subconscious racial biases etc. to do this. So, you want to look at opioid treatment agreements, urine drug testing and practitioner database monitoring programs. Understand that these things have a limited evidence base. However, they're becoming a standard of care. And you need to know what your state's policies are for this, so different states have different rules about how often you're supposed to do these things.

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And the other thing you want to do, I had on that last slide, is be alert concerning behaviors that arise. We're going to talk about each of these just quickly. Opioid treatment agreements. So, how many of you use these in your practice? Great. So, this is best used as an informed consent type of document where you say to the patient, "Okay. These medications have risks. Here the risks, the benefits, the alternatives. Here are my responsibilities as your provider. Here are your responsibilities as your patient. And then there are a few things to keep you safe. Use one prescriber, one pharmacy, take them as prescribed, don't escalate your dose. We may need to do, you know, we'll do urine drug testing, how we do refills." And then the conditions for when we would stop opioids.

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Urine drug testing. So, the bottom line with urine drug testing is a tool, not an oracle. This is what I always tell my fellows. So, they can be relatively complicated to interpret. So, a negative result does not mean diversion. A negative result might mean somebody ran out early, it might mean somebody has low health literacy and didn't understand how to take it, it might mean that they're on a medication like evafirenz that increases the metabolism of something like Oxycodone. So, there is a decision support tool that I highly recommend at mytopcare.org that can help you walk through this. This is a whole separate topic.

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Prescription drug monitoring programs. There's lots of state-by-state variability but it tells you the three things that predict opioid overdose: dose, multiple prescriptions, and opioid and benzo co-prescription.

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We all know about concerning behaviors that can arise. I'll let you guys ask questions about those if you have questions.

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Diagnose opioid use disorders if they are there and that can be challenging. I'm going to skip these. I'm sorry I'm so over, I usually when I give this talk, I do not read this far over but I must have been having fun up here. And we can talk about opioid use disorder treatment if you're interested.

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Okay. We can do this last question. 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 or d) if they go to their initial visit with their pain doctor, that's me, they will get opioids. Don't do that. I'll be very mad at you. Especially after this talk.

00:33:30

Good. You guys learned something or maybe you knew that coming in. All right. I'm going to stop there.

[Video End]