Workers' Comp

Pain Management: Pharmacologic Alternatives to Opioids

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Event Details

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In this webinar, we will learn about the pain pathway and the different types of pain as well as review the efficacy and adverse event profile of opioids. We'll also learn pharmacologic alternatives to opioids and their recommended use, associated risks, and guideline-supported place in the treatment of work-related pain conditions, and gain a deeper understanding of the available interventions that will help injured workers recover function and manage pain.

Webinar Questions & Answers

Q: What is your take on spinal cord stimulators for chronic pain?

A: Looking at the evidence, there is some guidance within the official disability guidelines that shows for certain conditions, there is clinical support for the use of a spinal cord stimulator. The guidelines outline several stipulations recommending spinal cord stimulators as a treatment option for complex regional pain syndrome or for filled back surgery syndrome particularly in the low back when certain criteria are met. One of the prerequisites they recommend is when there's a lack of improvement with conservative therapy meaning other medications other treatment modalities like stretching and exercise etcetera for at least six months prior to considering the device. So, the short answer is that there is a place for these as an option, but it depends largely on the patient, confounding factors, and the type of pain that we're looking to treat.

Q: Only a few years ago doctors were giving Hydrocodone 10 mg like candy for any and all painful injury. Now doctors in my region are providing no pain meds, yet I have multi-injury cases. They say they cannot

prescribe pain meds unless a person has surgery. How is it good that we stopped treating acute pain during early stages of healing from significant injury? Makes little sense to me and significantly increases patient anxiety while decreasing patient satisfaction with all involved.

A: I have to agree that in some cases the pendulum has swung too far in the opposite direction. We still certainly have a pain problem in the U.S. and coming up with viable treatment options is critical. Sometimes the best treatment is an opioid, especially as you've identified in the management of severe acute pain conditions, such as short-term immediate post-procedure or surgical intervention. I often go back to the pain ladder adapted from the World Health Organization's analgesic ladder for treating cancer pain where the initial approach is to start with a non-opioid and work up to a stronger analgesic including opioids if pain persists or increases. However, when we anticipate high pain immediately say with surgery, it is completely appropriate to start with a stronger opioid and to back off depending on the level of pain expected. There's certainly still is a place for opioids within the pain treatment continuum. The best balance is to analyze each patient individually and consider the goals of treatment as well as to outline clear and specific timelines for opioid use and to pull from the grab bag of all of the other supportive measures and or medications that might be used either adjunctively or in place of opioids when and where it makes sense for that patient. We have a lot of different things that we can do to help patients address pain, so whether or not to use an opioid becomes a careful balancing act.

Q: Why doesn't any patient of mine ever have relief of pain using tramadol?

A: That's an interesting question. Tramadol is considered by many in general practice to be a weaker opioid analgesic. I can tell you that it works through a slightly different mechanism of action versus some of its other counterparts within the class. It's actually been identified as one of the more useful agents for patients who are suffering from chronic or nerve-related pain because of this unique mechanism of action. Both tramadol and Nucynta achieve analgesic effects by binding to and activating mu opioid receptors within the body, similar to other opioid analgesics on the market, but they also have activity with some of the other neurotransmitters involved in the pain response such as serotonin and norepinephrine. There isn't necessarily a clinical reason why tramadol would be expected not to produce a pain relief response where other opiate analgesics would, I think again it just has so much to do with individual patient variability and what works best for them.

Q:If we have cut down the amounts of opioids prescribed then why do we still use 80% worldwide.

A: I can't tell you that definitively. The stats are somewhat shocking, but it's intended to show the scope of the issue and where we've been. Comparatively we in the U.S. are heavy users of, in general, prescription medications overall compared to the rest of the world, but in particular our opioid use is above and beyond. We are making strides in the right direction with overall prescribing of opioids decreasing as well as decreasing the days supply prescribed with each prescription, so it is entirely possible that those statistics have decreased slightly. I haven't looked for updated numbers since these results were published, so it's possible we've been gaining ground and improving that statistic as a nation. Here's one study citing those stats, it's from 2008: https://pubmed.ncbi.nlm.nih.gov/18443641/

Q: Do you believe we have alternative methods to treat pain that are helpful?

In general, yes, we do have a number of alternative methods to treat pain that have been shown to be clinically beneficial and have borne out in evidence-based research as useful options for pain. Beyond medications, some

of these include mindfulness exercises, cognitive behavioral therapy, physical therapy and stretching exercises, increased activity and strength-training where possible, adjustments to diet/nutrition, acupuncture, yoga, breathing exercises, the list goes on.

A: What are some examples of comorbid psychiatric conditions?

Comorbid psychiatric conditions can include anything within the DSM-5 that's considered a mental health condition. Those in particular that we commonly see presenting along with pain complaints which may actually contribute to the pain cycle and/or essentially feed one another or that are associated with an increased risk of developing opioid use disorder are major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. Other mental health factors can be risk indicators showing a higher likelihood to turn to substance abuse or addiction: characteristics such as chronic stress, past or present trauma like a childhood event, even with subclinical symptoms where we don't necessarily have a diagnosis, can play a role. Part of the thinking is that individuals with these histories may be more likely to self-medicate with a substance in order to cope with some of these mental health battles. This is why one of the recommendations is to do a psychological screening prior to initiating an opioid and is why these metrics are also included on several of the questionnaires and screening tools that are available to clinicians to help anticipate or identify abuse and misuse of an opioid.

Q: I have seen Gabapentin being given a lot, is it a good alternative or should we keep an eye on long term use?

A: Recent evidence has shown that caution is warranted with the use of gabapentin. It has been tied to an increased likelihood of risk of overdose when used alongside an opioid, and it does have its own risk of abuse potential. It still remains one of the first-line adjunctive, non-opioid treatment options for a patient dealing with pain, especially chronic or nerve-related pain, however. I would still recommend keeping an eye on it and considering it as part of the patient's overall picture of risk.

Q: Why don't typical pain medications relieve Fibromyalgia pain?

A: Fibromyalgia is one of those tricky chronic pain conditions where it's difficult to identify a source or a direct "cause" of the pain. There are so many confounding factors, and clinicians and researchers still aren't really sure what drives pain complaints in these patients other than they exhibit an increased sensitivity to pain. In general, chronic pain is difficult to pinpoint or manage, so the typical approach is to turn to medications that have been shown to be useful for chronic or nerve-related pain, which fall outside of traditional analgesics in most cases.

Q: Is a neuropathic medication like gabapentin a good alternative to opioids?

A: The clinical evidence we have available today supports the use of medications like gabapentin or pregabalin as first line options in patients with neuropathic pain complaints, and they would represent a more clinically appropriate alternative versus an opioid for this type of pain.

Q: What is the best antidepressant for chronic pain?

A: It's difficult to point to any one drug in particular as individual patient response may vary, but the clinical evidence does show us that tricyclic antidepressants as a therapeutic class, including drugs like amitriptyline, nortriptyline, and others, are some of the most efficacious when it comes to chronic or nerve-related pain management. However, that class is also associated with a number of side effects that many patients find intolerable. The next best class of antidepressants for chronic pain are the selective norepinephrine reuptake inhibitors or SNRIs including drugs like duloxetine or venlafaxine. There really isn't a lot of evidence to support the use of traditional antidepressants in the selective serotonin reuptake inhibitor (SSRI) family for chronic pain.

Q: Is there a difference in effectiveness of the name brand topicals vs an over-the-counter (OTC)?

A: If we're talking about the costly brand name private-label topical analgesics (PLTAs) that often include the same or similar active ingredients as those available OTC, then no, there is no evidence of which I am aware that has proven PLTAs to be more effective than over-the-counter formulations for the treatment of pain.

Q: While we follow Official Disability Guidelines (ODG) what are your thoughts on compounded creams?

A: My thoughts on compounded medications in general are that there is a place in practice, and it is a valuable science and service that pharmacist can provide, however, the practice should be reserved and has very limited, patient-specific uses. The evidence does not support the benefit of these products over other commercially available options on the market in most cases. We just don't have the research and evidence of safety and efficacy to support the use of a number of the ingredients that are used topically. For example, often these creams will incorporate medications we have available in oral form today such as gabapentin which does not have good evidence to support that it's absorbed through the skin to even have an effect.

Q: How do you propose we address long term prescribing of muscle relaxants? Are there resources available to assist with limiting these to the timeline recommended?

A: One approach is to point back to the clinical guidelines that are available based on lack of evidence for efficacy beyond the generally recommended treatment timeline of 21 days or less as well as evidence of increased risk or harm with long-term use. I don't really have a simple answer or resource to point you to other than to recommend provider engagement, injured worker and provider education, and partnering perhaps with a nurse case manager to do outreach to that end to have those discussions. Working with a pharmacy benefit manager (PBM) can help identify opportunities for outreach through flagging long-term muscle relaxant fills for intervention.

Q: What is the length of time you recommend muscle relaxers (eg. flexeril or tizanidine) as I have MD's prescribing them for months on end.

A: The guidelines support use for up to 21 days for pain. In practice, you're correct that we do see long-term prescribing of these medications, but that isn't considered best practice according to the evidence we have available.

Q: Are joint injections recommended for elbows?

A: I believe this is referring to intra-articular hyaluronic acid derivative injections. The products I covered in the presentation are only indicated for the knee joint, and they are typically utilized in an effort to prolong or prevent the need for a total knee replacement.

Q: Should a doctor avoid prescribing opioids completely if the patient admits to cocaine use?

A: That is an individual patient-clinician determination. It certainly would be a risk factor and something that needs to be considered as part of the patient's overall treatment plan, but there are really no black and white answers when it comes to patient care. Most of the time, those precautions should be considered and it's up to that individual provider to use his or her best clinical judgment to determine how to proceed.

Q: Are lidocaine patches approved for regular/frequent use?

A: Lidocaine patches are only indicated/approved by the Food and Drug Administration (FDA) for a very specific type of nerve-related pain following herpes zoster virus infection (a.k.a., Shingles) known as post-herpetic neuralgia. All other use is considered off-label. We don’t have a lot of sound clinical guidance as far as other uses or duration of treatment.

Q: Does the 80% U.S. opioid consumption include both opioids that are prescribed legally as well as those obtained illegally?

A: It's been a while since I've looked at the research, but I believe it is referring to the world's opioid supply considering legal channels/medical-use opioids. I'm not 100% positive, but the article references illicit substances separately (where it indicates the U.S. consumes two thirds of the world’s illegal drugs).

This information is meant to serve as a general overview, and any specific questions or concerns should be more fully reviewed with your health care professional such as the prescribing doctor or dispensing pharmacist.

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