PAETC HIV LEARNING NETWORK

Didactic Series

Pain Management

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Learning Objectives

1) Describe background of pain issues in HIV infected patients

1) Identify pearls for the assessment and management of chronic pain

1) Review special issues with opioid pain meds

How comfortable do you feel in addressing chronic pain in your HIV-infected patients?

1. Great, it's like any other aspect of their care
2. I would prefer not to deal with it, but I can do it
3. I am uncomfortable, don't feel I do it well
4. I usually feel the patient is getting over on me

Why Pain Management is Hard

“To hear about pain is to have doubts, to experience pain is to have certainty.”

Elaine Scarry from The Body in Pain

LO1. Some Pain Concepts

Nociception – Process of conveying info about tissue damage to CNS

Transduction – Nociceptors translate stimulation or peripheral nervous system conveys pain

Transmission – Nerve impulses to the spinal cord & brain

Perception – awareness, unpleasant, negative emotion

Modulation – Attenuation of transmission by descending inhibition and facilitation from brain

LO1. Some Pain Concepts

Sensitization – Sensors turned on and lower threshold for activation after repeat or prolonged stimulus

Peripheral Sensitization Role in

Hyperalgesia - increased response to painful stimulus

Allodynia - pain by innocuous stimulus

Central Sensitization Results in

Spinal neuron hyperexcitability

With central sensitization there is brain, spinal cord remodeling resulting in hyperalgesia, allodynia, persistent and referred pain

Mechanism Based Pain Classification

Nociceptive Pain – Sensory neuron stimulation, autonomic response, withdrawal reflex

Inflammatory Pain – Tenderness can be protective, related to healing, risk for central hypersensitivity

Neuropathic Pain – Peripheral nerve damage, CNS injury, maladaptive central processing/ hypersensitivity

Dysfunctional Pain – Normal tissue and nerves, abnormal central processing

Simpson D, Koh-Knox C, Kappler J, - Chronic Pain in Primary Care

Background on HIV Pain

- **Early history of HIV was as a progressive, terminal illness**.
  - *Palliative and hospice care*

- **Aggressive approach to addressing pain**
  - *Multiple articles on untreated pain in HIV and other chronic disease* (1)
  - *1995 pain is "the 5th Vital Sign"*
  - CA *AB487 court case of under treatment of terminal pain*

- **Mid -1990's HIV began to evolve**
  - *Chronic disease, not terminal illness*

1.Onen NF et al. Pain Practice 2012 Jul; 12(6)

Pain Definitions

Acute pain - Clear onset, etiology often clear, autonomic responses, resolves with healing

Terminal or cancer pain – May be progressive, nociceptive and overlay of suffering, clear end point (death or remission)

Chronic or Chronic Nonmalignant Pain (CNMP) – Persists for 6 months beyond onset, temporal onset vague or faded, extends beyond period of healing, level of pathology low or insufficient to explain symptoms. Multifaceted disorder

Simpson D, Koh-Knox C, Kappler J – Chronic Pain in Primary Care Focus on Low Back Pain, Pain Clinician Report Feb 21, 2012

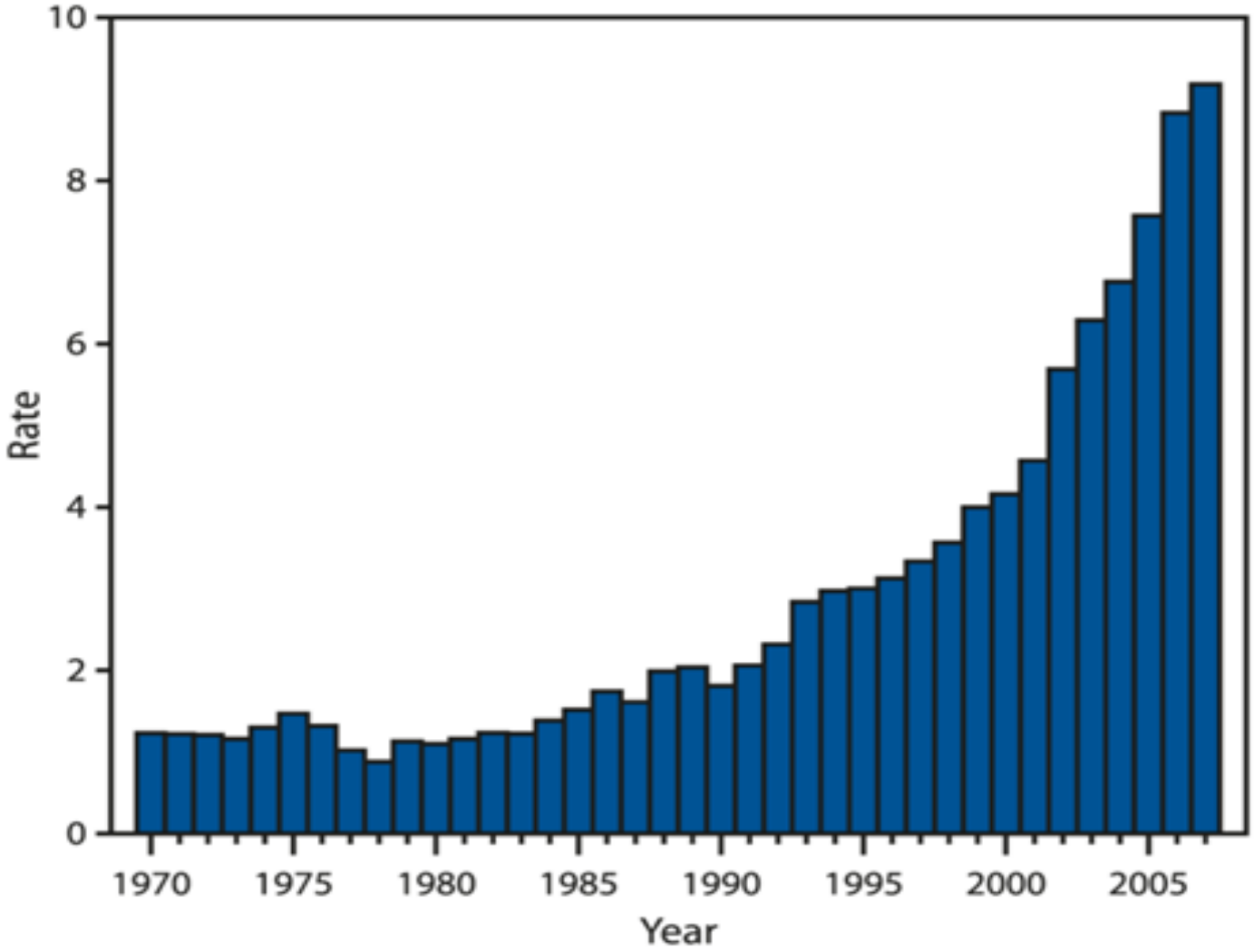
Pain Syndromes in HIV Disease

- Over 100 described pain syndromes
- Directly related to HIV infection or associated OI or neoplasm --- 50%
- Due to anti-HIV therapies or diagnostic procedures --- 30%
- Not related to HIV --- 20%

“Houston, we have a problem..”

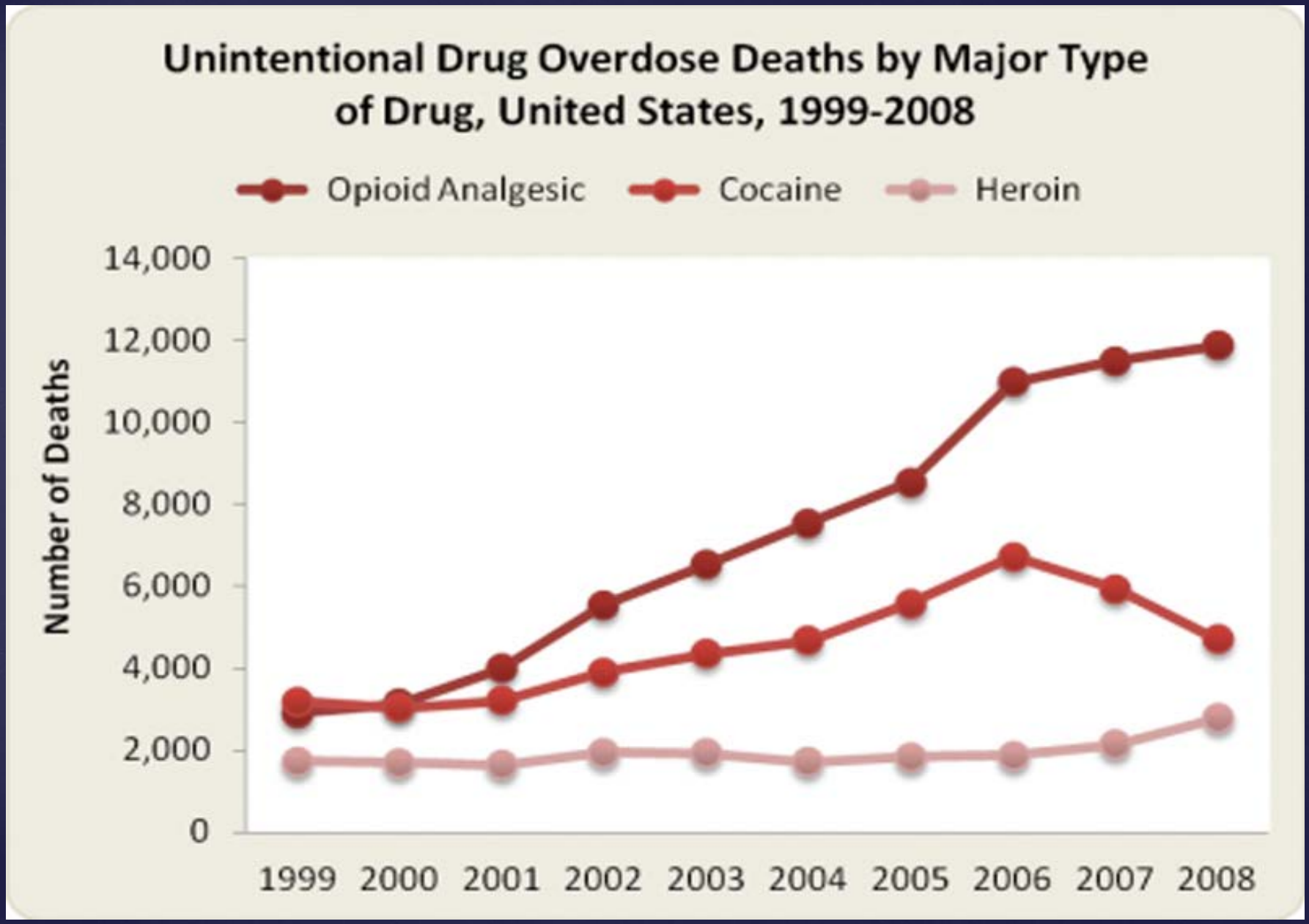
Rise in opioid pain prescriptions with subsequent (and disproportionate) rise in opioid related problems…

FIGURE. Rate* of unintentional drug overdose deaths — United States, 1970–2007



Source: National Vital Statistics System. Available at http://www.cdc.gov/nchs/nvss.htm.

* Per 100,000 population.



CDC. Policy Impact: Prescription Painkiller overdoses. 2011

With OD Risk, Dose Matter

- 80% prescribed < 100mg morphine Eq/day = 20% OD
- 10% prescribed > 100mg morphine Eq/day = 40% OD

The rest are higher doses, multiple providers ==

OD risk,

diverting risk

Dunn KM, et al Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Int Med 2010;152(2)
Bohnert AS et al. Association between opioid prescribing patterns and opioid overdose deaths. JAMA; 2011;305(13)
Hall AJ, Logan JE et al. Patterns of abuse among unintentional pharmaceutical overdose fatalities. JAMA. 2008;300(22).

Framing a Pain Approach

History including

- Diagnostic assessment
- Impact on life and function
- Response to past and current therapy
- Risk for addiction/substance use disorder

Trial of therapy

- Emphasis on “trial” with time course and outcomes
- Multimodality (can be hard to access non prescription resources)

Ongoing assessment

- One example : PEG

Ongoing Functional Assessment - PEG

Using 1-10 Scale – What number best describes….

1. …PAIN on average in the past week.
2. …how, in past how, during the past week, pain has interfered with your ENJOYMENT
3. …during the past week, pain has interfered with your GENERAL ACTIVITIES

The Medications

NSAIDS – 5 classifications worth trial of different categories

Acetaminophen – lowest dose for safety +/- effect

Opioids – Consider short acting and long acting

Antiepileptic – corner stone for neuropathic pain (data for gabapentin and pregabalin)

Antidepressants – adjuvant therapy

WHO Analgesic Ladder/Platform 1986 for Cancer Pain Adapted

When to stop a patients opioids?

In the chat box or audio, what's your experience been like?

A word about ART drug interactions

NNRTI (efavirenz and nevirapine) can increase the metabolism of some opioid medications

--*May need increases based on withdrawal (more than increased pain?) symptoms as much as 30%*

Other ART drug interactions reported, seem more variable

**Starting and stopping drugs that interact with pain meds are periods when close monitoring needed.

Treatment Failure

Lack of effect on targeted goal – (Think PEG)
--- Taper off or rotate to other medications/opioids

Safety issues - Role for rapid initial decrease, then taper off based on withdrawal symptons

Diversion issues – Careful assessment of need to taper versus abrupt stop *

* Story of Ms. K - chronic pain, cocaine dependence and the negative urine drug toxicity screen

Rules of Thumb for Tapering Opioids

1. The longer on opioids the slower you go
2. Medications not used daily can be stopped without a taper
3. Use only one “small currency” opioid
4. Down is easier than off
5. First 1/3 is easier than 2/3
6. Last 1/3 is hard and last 10% is really hard
7. Most patients tolerate 10% reductions
8. Virtually no one tolerates 25% reductions well
9. Going slowly is always better than stopping or giving up
10. The best taper is the one that works

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Tapering and Discontinuing Opioids

This factsheet accompanies the 2010 VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain. It was created to aid with treatment of adult populations. Department of Veterans Affairs (VA) and Department of Defense (DoD) employees who utilize this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.

- Methadone:
- Decrease dose by 20-50 percent per day until you reach 30 mg/day
- Then decrease by 5 mg/day every three to five days to 10 mg/day–
- Then decrease by 2.5 mg/day every three to five days

- Morphine SR/CR:
- Decrease dose by 20-50 percent per day until you reach 45 mg/day
- Then decrease by 15 mg/day every two to five days

- Oxycodone CR:
- Decrease dose by 20-50 percent per day until you reach 30 mg/day
- Then decrease by 10 mg/day every two to five days

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Summary

- Managing pain, especially CNMP is a major part of care of HIV infected patients
- Its hard, but possible, to do it well
- Safety and effectiveness are key ongoing considerations
- Guidelines and protocols for partnering with patients will continue to evolve.
- Check out the SCOPE OF PAIN web site

References

1.Onen NF et al. Pain Practice 2012 Jul; 12(6)

2. Krebs E et al. Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference J Gen Intern Med. Jun 2009; 24(6): 733–738

3. Simpson D, Koh-Knox C, Kappler J. Chronic Pain in Primary Care Focus on Low Back Pain, Pain Clinician Report Feb 21, 2012

4. Dunn KM, et al Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Int Med 2010;152(2)

5. Bohnert AS et al. Association between opioid prescribing patterns and opioid overdose deaths. JAMA; 2011;305(13)

6. World Health Organization . Traitement de la douleur cancéreuse. Geneva, Switz: World Health Organization; 1987

7. Fishman S – Responsible Opioid Prescribing, A physician's guide FSMB Foundation, 2007 w/ revision in 2013.

8. Videos with vignettes and specific guidelines - https://www.scopeofpain.com/tools-resources/****