

Managing Patients with Pain, Psychiatric Co-Morbidity & Addiction

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Prescribers' Clinical Support System for Opioid Therapies

Disclosure

I would like to disclose the following financial relationships with industry:

- Johnson & Johnson – stockholder
- General Electric – stockholder

I have no conflicts of interest relevant to the content of this presentation

Roadmap

- Prevalence of Co-Occurring Psychiatric Disorders in Chronic Pain Patients
- The Impact of Psychiatric Co-morbidity on Chronic Pain
- Assessment of Chronic Pain Patients with Co-Occurring Psychiatric Disorders
- Treating Co-Occurring Psychiatric Disorders in Chronic Pain Patients

Psychiatric Co-Morbidity & Chronic Pain

CONDITION	Current Incidence in Chronic Pain Patients	Incidence in the General Population
Depression	45 %	5 %
Anxiety Disorders	25%	3 % to 8 %
Personality Disorders	51%	10 % to 18 %
PTSD	2% civilian population 49% veteran population	1 % general population 20 % combat veterans 3.5 % to 15 % in civilians with trauma
Substance Use Disorders	15% to 28%	10 %
Somatoform Disorders	97 % in chronic low back pain patients in inpatient rehab programs	unknown

Psychiatric Co-Morbidity & Chronic Pain

CONDITION	Current Incidence in Chronic Pain Patients	Reference
Depression	45% (range: 33% to 54%*)	Cheatle M, Gallagher R, 2006 *Dersh J, et al., 2002
Anxiety Disorders	25% (range:16.5% to 50%*)	Knaster P, et al., 2012 *Cheatle M, Gallagher R, 2006
PTSD	49% veteran population 2% civilian population*	Otis, J, et al., 2010 *Knaster P, et al., 2012
Substance Use Disorders	19% (range: 15% to 28%*)	Polatin PB, et al. 1993 *Cheatle M, Gallagher R, 2006
Borderline Personality Organization	58% in Behavioral Medicine Pain Clinic	Fischer-Kern M, et al., 2011
Personality Disorders	51% (range: 31% to 81%*)	Polatin PB, et al. 1993 *Fischer-Kern M, et al., 2011

Psychiatric Co-Morbidity & Chronic Pain Summary – Prevalence of Co-Occurring Disorders

- The incidence of co-occurring psychiatric disorders is 2 to 3 times higher in chronic pain patients than in the general population
- The most common co-occurring disorders are depression, anxiety disorders and substance use disorders
- The incidence of PTSD is very high in combat veterans with chronic pain

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Is there a relationship between chronic pain and depression?

- Depression is the most common co-occurring psychiatric disorder in patients with chronic pain, occurring in 45% of such patients (Cheatle 2006).
- Among patients with Major Depressive Disorder (MDD), a significantly higher proportion reported chronic (i.e., non-disabling or disabling) pain than those without MDD (66% versus 43%, respectively).
- Disabling chronic pain was present in 41% of those with MDD versus 10% of those without MDD.

How are depressed chronic pain patients different from non-depressed pain patients?

Compared to pain patients without MDD, patients with co-morbid MDD and disabling chronic pain had the following characteristics:

- significantly poorer quality of life
- greater somatic symptom severity
- a higher prevalence of panic disorder
- a six-fold greater prevalence of anxiety

Is there a difference in treatment response in chronic pain patients with co-occurring depression?

- Poor adherence to treatment
- Worse satisfaction with treatment
- Higher likelihood for relapse
- Less chance for function improvement

How common are co-occurring depression and anxiety disorders in chronic pain patients?

- All depressed pain patients should be screened for an anxiety disorder
- There is a 16% prevalence of co-occurring disorders
- Most anxiety disorders are present before pain onset
- Most depressive disorders appear after onset of pain
- Psychiatric comorbidity is associated with increased pain intensity

How common is chronic pain and PTSD?

- PTSD is relatively infrequent in civilian patients with chronic pain, averaging about 2%
- The incidence in combat veterans can be as high as 49%. These patients often present with depression and other anxiety disorders
- Anticipate substance use disorders in these patients

PTSD, returning veterans and pain. What do we know?

- Illicit drug use was common among active duty troops in 1980, but dropped to low levels by 1992 and was reported as remaining low through 2005
- DOD guidelines recommending more aggressive treatment of acute pain may have led to more prescribing of potent opioids
- Lay press reports recent heavy prescription of opioids for pain. Will this lead to increased addiction rates?
- Survey of 28,546 active duty troops indicated 11% reported misuse of prescription medications

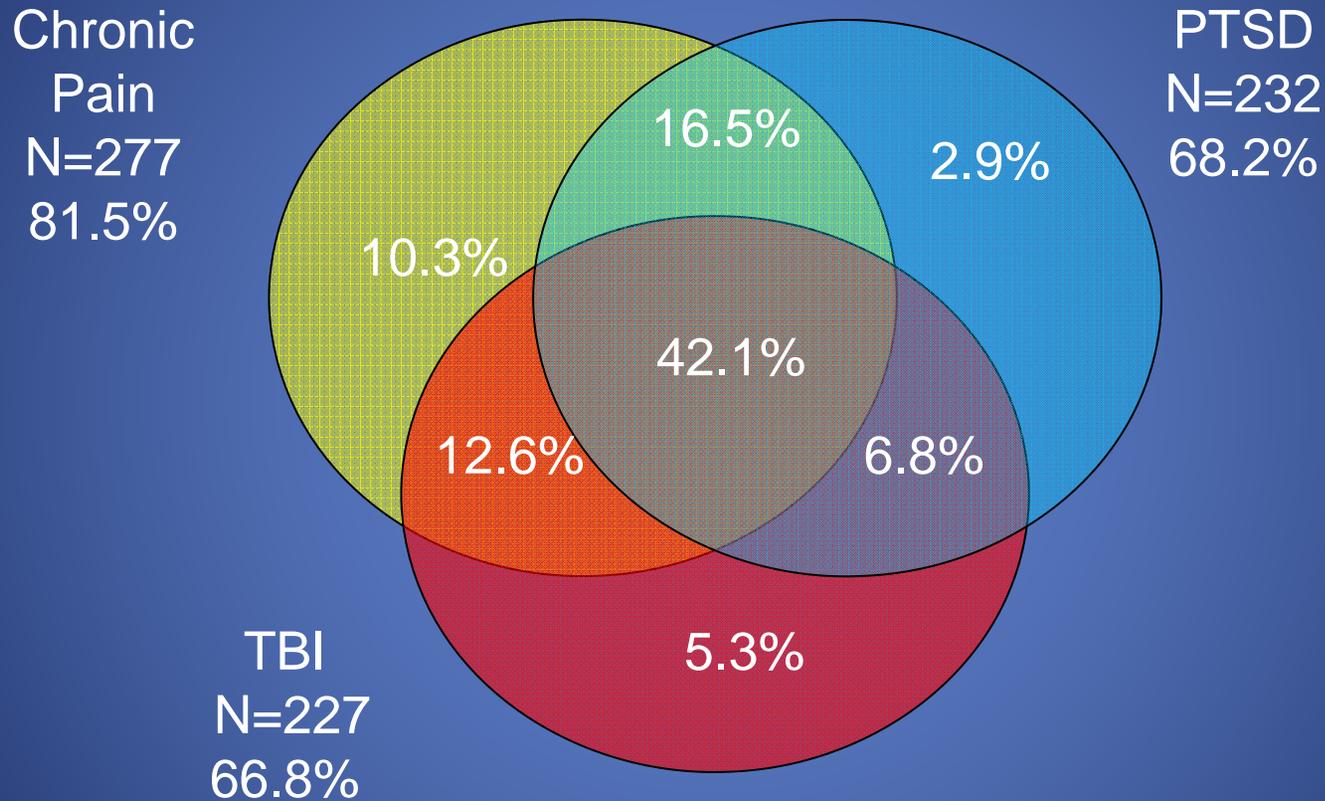
Does long-term treatment with opioids increase the risk for drug dependence?

- General population studies suggest up to 35% of individuals receiving long-term opioids for chronic pain meet criteria for opioid dependence
- Much higher than previous estimates (J Addictive Disease July 2011)
- Returning veterans may be at particular risk for pain syndromes with co-occurring substance abuse and other psychiatric disorders, including PTSD and Traumatic Brain Injury (TBI)

Dept of Defense 2008 SURVEY

- Prescription drug misuse
 - 2002 2%
 - 2005 4%
 - 2008 11%
- Types of misused prescriptions in 2008
 - Opioids 17%
 - Tranquilizers 6%
 - Sedatives 2.9%
 - Stimulants 2.3%
- “The strongest predictor of prescription drug abuse in the military is having received a prescription for pain medication within the past month or past year”

Prevalence of Chronic Pain, PTSD and TBI in a sample of 340 Iraq/Afghanistan veterans



Lew, Otis, Tun et al., Prevalence of Chronic Pain, Posttraumatic Stress Disorder and Post-concussive Symptoms in OEF/OIF Veterans: The Polytrauma Clinical Triad. (in press) *J Rehabil Res Dev*

What is the impact of PTSD on chronic pain?

Veterans with Chronic Pain & PTSD had:

- Higher levels of maladaptive coping strategies
- Greater catastrophizing
- Greater emotional impact of their pain
- Felt less control over their pain
- Poorer outcomes for injury recovery

Is there a relationship between TBI, PTSD & pain?

- 20% to 30% of recent vets may have a TBI
- Discharge rates for alcoholism or drug abuse were 2.6 times greater for mild TBI, and 5.4 times greater for moderate TBI
- Recently deployed soldiers with mild TBI are more likely to have PTSD and pain
- New Combat Veteran Syndrome:
 - Pain, PTSD, TBI & Substance Use Disorders

Psychiatric Co-Morbidity & Chronic Pain Summary – Impact of Co-Occurring Disorders

- Depression and anxiety are the most common psychiatric disorders seen in chronic pain patients
- These patients report more severe pain and disability, are less likely to adhere to treatment and have poorer outcomes
- Attention to assessment and treatment of chronic pain and concurrent psychiatric disorders is necessary to improve treatment outcomes
- Screen for PTSD, TBI, and addictive disorders in veterans with chronic pain

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Assessment for Psychiatric Disorders in Chronic Pain Patients

- The initial assessment of all chronic pain patients should include a review of psychiatric symptoms and previous treatment, and a mental status exam
- Be sure to include questions regarding:
 - Substance use and abuse
 - Early childhood abuse & current domestic violence
 - PTSD
 - Suicidal ideation
 - Medications from multiple providers
 - Any litigation or compensation involved?
- Assessment should include:
 - Urine toxicology
 - Review of state Prescription Drug Monitoring Program data
- If the diagnosis is unclear, refer for a psychiatric evaluation

Critical first steps in patient assessment:

- Screen for depression with suicidal ideation and plans for self-harm
 - Suicidal patients should be referred for psychiatric evaluation and/or hospitalization
- Screen for dependence on alcohol or illicit substances
 - Patients addicted to alcohol or sedatives may require inpatient detoxification before pain management can proceed
 - Patients abusing opioids may require detoxification or stabilization on methadone or buprenorphine

How to rule out substance-induced psychiatric disorders

- The high incidence of substance use and abuse in this population requires special attention to rule out substance-induced psychiatric disorders
- Substance-induced disorders can mimic:
 - Depressive disorders
 - Anxiety disorders
 - Psychotic disorders
 - Personality disorders

What are the DSM-IV Criteria for Substance-Induced Psychiatric Disorders?

- Symptoms occur during or within 30 days of intoxication or withdrawal
- Symptoms may be reasonably assumed to be substance-induced – examples:
 - Alcohol: depression, anxiety, hallucinations
 - Stimulants: depression, mania, paranoid psychosis
 - Psychedelics: psychosis, somatic delusions
 - Marijuana: psychosis
- Symptoms remit with sobriety

What criteria suggest that substance-induced psychiatric disorders are less likely (i.e.: that an independent psychiatric disorder is present)?

- Symptoms were present prior to substance use
- Symptoms are present during extended periods of sobriety (minimum 3 months)
- There is a family history of a similar disorder
- If symptoms are diagnosed while using the substance, or immediately following detoxification, reassess after 3-4 weeks sobriety

How to make the diagnosis of substance-induced psychiatric disorders

- Do not attempt to confirm the diagnosis while patient is intoxicated or within 3-4 weeks of substance use or detoxification treatment
- Verify drug-free state with laboratory tests and assess psychiatric status when sober
- Obtain a careful longitudinal history tracking both substance use and psychiatric symptoms – track parallel symptom courses
- Confirm history with relatives
- Review family history for psychiatric disorders

Completing the psychiatric assessment:

- If you are able to rule out a substance-induced psychiatric disorder, proceed on the assumption that current symptoms reflect an independent psychiatric disorder and that psychiatric treatment will be required (see following section)
- If symptoms are substance-induced, treatment for substance use/abuse or dependence must be part of the treatment plan
- A repeat psychiatric assessment should be part of the annual treatment plan review for all chronic pain patients

Psychiatric Co-Morbidity & Chronic Pain Summary - Assessment

- All chronic pain patients should be screened for psychiatric disorders, including PTSD and substance use disorders
- Suicidal ideation requires a careful psychiatric assessment
- A patient with a current addiction may require detoxification before pain treatment can proceed
- It is important to distinguish substance-induced disorders from independent psychiatric disorders

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General Principles: How to manage psychiatric disorders in chronic pain patients

- The basis for the successful management of chronic pain and co-occurring psychiatric disorders is a Biopsychosocial Treatment approach.
- If screening identifies the presence of an active substance use disorder and/or any substance-induced psychiatric disorder, patients must first be referred for detoxification (if required) and ongoing addiction treatment must be integrated into the ongoing chronic pain management program

What is Biopsychosocial Treatment?

- The biopsychosocial model for chronic pain management includes:
 - Evidence-based pharmacotherapy for both chronic pain and any co-occurring psychiatric disorders
 - Cognitive-behavioral therapy (CBT) – this should address pain issues and any relevant psychiatric symptoms, including substance use disorders
 - A graded exercise program

What is Chronic Pain Self-Management?

Treatment should always begin with a Chronic Pain Self-Management Program:

- Careful patient education on the physiologic mechanisms underlying their pain and the efficacy of recommended treatments
- Patients must take responsibility for compliance with any recommended pharmacotherapy. This includes medications for pain and any psychiatric disorder.
- Patients must take responsibility for implementation of any graded exercise program.

What is the evidence for the efficacy of self-management treatment programs?

- This approach has been effective for diabetes and asthma
- Data for chronic pain self-management is marginal and compliance can be a problem
- A successful chronic pain self-management program requires strong support from family and the primary pain treatment clinician

Warsi A, et al., Arch Int Med 2004; 164(15):1641-1649

Kawi J, Pain Manag Nurs 2012 Dec 8. pii: S1524-9042(12)00147-6

What is the role of Cognitive-Behavioral Therapy?

- CBT is well established as an effective evidence-based therapy for chronic pain, depression, anxiety, PTSD and substance use disorders.
- CBT typically includes skill acquisition:
 - Relaxation therapy
 - Cognitive restructuring
 - Effective communication
 - Stress management
- This is followed by skill consolidation and rehearsal:
 - Training to generalize new skills
 - Maintenance of behavioral change
 - Strategies to avoid relapse

What are the benefits of early implementation of CBT in chronic pain treatment?

McCracken & Turk reviewed comprehensive program outcomes and reported that patients who complete a pain program based on the biopsychosocial/CBT model demonstrate:

- Improved return to work
- Pain reduction
- Increased activity
- Reduced medication use
- Benefits were maintained at 5 year follow-up

Can pain be managed without opioids?

Optimized antidepressant therapy and pain self-management in depressed primary care patients with musculoskeletal pain: A randomized controlled trial

- Optimized antidepressant therapy along with a pain self-management program produced significant reductions in depression severity and moderate reductions in pain severity and disability at 12 months
- Reductions in depression and pain were seen early (1 month) and were sustained

What are the evidence-based pharmacotherapies for chronic pain?

- For neuropathic pain:
 - Topical analgesia (lidocaine patch)
 - Anticonvulsants (gabapentin, valproate, carbamazepine)
 - Tricyclic antidepressants (nortriptyline, desipramine)
 - SSRIs
 - SNRIs (venlafaxine, duloxetine)
 - Oxycodone
 - Tramadol
 - Baclofen
- In general, opioids are reserved for the treatment of acute, nociceptive, inflammatory pain, not for chronic pain.

What are the guidelines for pharmacotherapy of psychiatric disorders in chronic pain patients?

- Begin with Chronic Pain Self-Management
- Add CBT and a Graded Exercise Program
- In most cases, standard psychiatric medications for depression, anxiety disorders and PTSD can be used
- There is little research available to guide medication choices in chronic pain patients
- Avoid medications with an abuse potential
- Side effect profile can guide medication choice
- Monitor for medication compliance

How to manage the pharmacotherapy of psychiatric disorders in chronic pain patients

- Begin with non-abuseable medications - the SSRI's are a good choice to treat BOTH depression and anxiety
- Adequate doses for an adequate time (6 to 8 weeks)
- If no response consider nefazodone, SNRI's, or dual action agents
- CBT will improve the response to medications
- Benzodiazepines have no role as a primary treatment for depression or PTSD
- Benzodiazepines can be used with caution, and short term, for some anxiety disorders if the patient has not responded to CBT and/or antidepressant medications and has no history of abuse of benzodiazepines

Pharmacotherapy recommendations for psychiatric disorders in patients with chronic pain

- Depression – SSRIs; Venlafaxine, Duloxetine, Nefazodone, Bupropion
- Generalized Anxiety Disorder – SSRIs; Buspirone, Duloxetine, Escitalopram
- Panic Disorder – SSRIs; Nefazodone
- Social Anxiety – Paroxetine
- PTSD – SSRIs, Venlafaxine ER & Prazosin
- Bipolar Disorder – Valproate

What are the risks for substance abuse in depressed patients on chronic opioid therapy?

- Patients with moderate to severe depression are 1.8 and 2.4 times more likely, respectively, to misuse opioid medications to relieve these symptoms (Grattan 2012)
- Such patients will benefit from pharmacotherapy with standard antidepressant meds
- There are no clear guidelines to guide choice of medication, though consideration should be given to venlafaxine and duloxetine because of their efficacy in chronic pain management (Cheatle 2006)

Grattan A, et al., 2012, Annals Family Med 10(4):304-311

Cheatle MD, Gallagher RM, 2006, Current Psych Reports 8:371-376

What are the evidence-based pharmacotherapies for anxiety disorders?

A recent systematic review of randomized controlled trials, including the Cochrane Database, reported on data from trials demonstrating a $\geq 50\%$ reduction from baseline score on the Hamilton Anxiety Scale in generalized anxiety disorder:

- Fluoxetine was ranked first for response and remission
- Sertraline was ranked first for tolerability

In a subanalysis for generalized anxiety disorder:

- Duloxetine was ranked first for response
- Escitalopram was ranked first for remission
- Pregabalin was ranked first for tolerability

What are the risks for using benzodiazepines in the treatment of other anxiety disorders?

- Comprehensive literature review
- Efficacy demonstrated for: Generalized Anxiety Disorder, Panic Disorder and Agoraphobia
- Probable efficacy for: Social Phobia
- Little evidence of added risk for medication abuse or increased relapsed BUT avoid use in primary sedative-hypnotic addicts or in other addicted individuals

Treating co-occurring pain & PTSD

- 12 session integrated treatment for chronic pain and PTSD
- Includes CPT for PTSD & CBT for chronic pain:
 - Relaxation training
 - Activity goal setting
 - Cognitive restructuring
 - Relapse prevention (J Otis et al. 2009 *Pain Medicine*)
- CBT for PTSD is not recommended until patients have achieved stable sobriety

Pharmacotherapy for chronic pain in the presence of co-occurring PTSD

- Avoid opioids whenever possible
- Preferred pharmacotherapy options for chronic pain with co-occurring PTSD:
 - NSAIDS
 - Anticonvulsants
 - Tricyclic antidepressants

Treating co-occurring pain, PTSD and TBI

- CBT for pain management
- Prolonged Exposure Therapy and Cognitive Processing Therapy for PTSD
- TBI may make it more difficult for veterans to invest in these cognitive approaches, however these highly structured approaches may also aid individuals with TBI

VA / DOD Practice Guidelines for PTSD Pharmacotherapy, 2010

Biopsychosocial approach recommended:

- SSRIs and SNRI Venlafaxine are first line medications
 - Venlafaxine ER may be more tolerable because of fewer /less intense side effects
- Prazosin for nightmares, off label, (1 mg QHS gradually increased to 20 mg, as needed)
- Add CBT if no response to medications alone:
 - Prolonged Exposure; Cognitive Processing Therapy
- Second line medications: mirtazapine, topiramate, amitriptyline, imipramine, phenelzine, nefazodone
- Cautions against using benzodiazepines

Psychiatric Co-Morbidity & Chronic Pain Summary - Treatment

- Develop a Biopsychosocial Treatment plan
- Begin with a Chronic Pain Self-Management Program
- Incorporate Cognitive Behavior Therapy
- Standard pharmacotherapy for depression, anxiety, & PTSD
 - Choose non-abusable medications
 - Adequate doses for an adequate time
- Warn patients that psychiatric medications are unlikely to work if combined with illicit drugs and that the combination can be lethal

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