Managing Active Injection Opioid Use: Severe Depression and Acute Pain

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Disclosures

• Jessica Gray, MD
  - Nothing to disclose

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  - Nothing to disclose

• John Renner, MD
  - Nothing relevant to this presentation
Target Audience

- The overarching goal of PCSS-O is to offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.

- Our focus is to reach providers and/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, and program administrators.
Educational Objectives

At the conclusion of this activity participants should be able to:

- Summarize treatment options for managing acute opioid withdrawal and acute pain on the inpatient service
- Explain how to manage chronic suicidality in a patient with opioid use disorder and pain
- Identify factors involved in safe discharge planning for patients with comorbid opioid use disorders, suicidality and pain
Overview

• The intersection of active illicit opioid use, acute pain and severe mental illness can be particularly challenging especially for generalist clinicians on the inpatient medical service.

• This case discussion reviews the challenges and approaches to:
  ▪ Managing acute pain in patients with an active opioid use disorder
  ▪ Managing patients with co-morbid depression with chronic suicidality and substance use disorders
Case Overview

- 45 year old male with chronic HCV, depressive disorder with suicidal ideation, PTSD, severe opioid use disorder on buprenorphine/naloxone (bup/nlx) and cocaine use disorder
- Recently relapsed to heroin, cocaine
- Developed purulent cellulitis and tendon necrosis after injecting heroin into his foot
- Admitted to hospital for IV antibiotics, wound debridement and pain control
Medical, Family and Social History

- Chronic hepatitis C
- HIV negative

- Substance use history
  - Heroin 1g/day IV, started in his 20s. Last use 2 days PTA
  - Cocaine 1g/day, IN and smoked, last use 2 days PTA
  - Daily tobacco
  - Denies ETOH, benzodiazepine or crystal methamphetamine

- Reports at least 1 opioid overdose
- Triggers: Pain, breakup with girlfriend, cocaine use
Medical, Family and Social History

- Prior substance use disorder treatment
  - History of detox, residential treatment
  - Methadone – never, “not interested”
  - Naltrexone - never
  - Bup/nlx: recently on clinic x 6 months at 8-2mg BID, successful while in residential treatment

- Family history: siblings with polysubstance use
- Social: homeless, stays with family, friends, shelters. Children with DCF
Psychiatric History

• Depressive disorder with chronic suicidal ideation, PTSD, SUD
• Multiple ED visits for suicidality, prior self harm, inpatient psychiatric care
• EMR alerts due to history of:
  ▪ Manipulative behavior
  ▪ Concern for medication seeking
  ▪ Concern for secondary gain e.g. housing

Medications

• Active medications:
  ▪ Olanzapine (Zyprexa) 10mg qAM/30mg qPM
  ▪ Mirtazepine (Remeron) 30mg qhs
  ▪ Divalproex (Depakote) 500mg bid
  ▪ Prazosin 2mg qhs for nightmares
  ▪ Bup/nlx 8-2mg BID (last dose >2 PTA)

• Outpatient psychiatric team
  ▪ Psychiatrist, therapist, community support worker
Discussion Questions

• 45 yo male w/ OUD, depression with chronic suicidality hospitalized for complications of heroin injection to foot

• What are the options for managing his opioid use disorder, opioid withdrawal and acute pain in the hospital?

• Should this patient remain on bup/nlx treatment during and after his hospitalization?
Hospitalization #1: Hospital Course

- Continued on outpatient psychiatric medications
- Violent outburst after a large knife in his possession is confiscated
- He endorsed suicidal ideation with plan for overdose

- Psychiatry consulted:
  - Safety concerns due to his report of suicidal ideation, history of depression, violent outburst
  - Concern for seeking secondary gain
Discussion Questions

• What is your assessment of this patient’s psychiatric issues?

• What additional information would you want?

• What are your management recommendations?
Hospital Course (17 Days) and Discharge

- **Cellulitis and tendon necrosis**: IV antibiotics, debridement in OR x 2
- **Opioid use disorder**: Restarted bup/nlx 8-2 BID
- **Pain control**: Started on PRN oxycodone, requiring 15mg q4h
- **Depression and suicidality**: Olanzapine decreased to 20mg qhs and linked to outpatient treatment once mood stabilized
- **Discharged** on Hospital Day 17 to girlfriend’s house
  - Given a limited amount of oxycodone for acute pain management (#12)
  - 30 days of PO antibiotics
  - VNA for wound dressing changes
  - Close follow up with podiatry
  - No prescription or linkage back to bup/nlx provider
2 Weeks Post-Discharge

- Did not follow up with podiatry, seen in ED
- Unable to refill bup/nlx, used IN heroin for pain after running out of oxycodone within days
- Actively using cocaine
- SI with plan to step in front of car or overdose on fentanyl
- Worsening infection despite adherence to oral antibiotics
- Sent to the ED by VNA for 4 days of fever and worsening pain
**Hospitalization #2: Hospital Course (28 Days)**

- **Readmitted** for worsening infection requiring debridement x 2
  - Completed 14 days of IV antibiotics
  - Plan for 4-6 weeks of wound vac as tissue not ready for graft

- **Psychiatric evaluation for SI:**
  - Denied suicidal plan when seen by psychiatry
  - Symptoms felt consistent with substance use worsening chronic SI
  - Recommend continue current medications
Discussion

- 45 yo male w/ OUD, depression with chronic suicidality hospitalized for complications of heroin injection to foot

- What is your reaction to his ongoing suicidal statements?
Hospitalization #2: Hospital Course (28 Days)

• **Pain and substance use disorder:**
  - Restarted on bup/nlx 8-2mg BID
  - Due to repeated instrumentation and significant pain with wound vac ordered oxycodone sliding scale at 5-15mg q 4h PRN
    - Received oxycodone 15 mg ~q4-6h (60-90 mg per day) x 28 days

• **Discharge planning:**
  - Patient requires 4-6 weeks of wound vac treatment due to slow healing
  - Physical Therapy initially recommended subacute rehab
Hospitalization #2: Discharge Planning Challenges

- Unable to be placed in subacute rehab due to behavioral issues and treatment with bup/nlx
- His outpatient bup/nlx prescriber would not continue prescribing if patient remained on additional opioid analgesics (i.e., oxycodone)
- Unable to taper oxycodone due to persistent pain from wound vac
- Addiction consult service called 21 days into the hospitalization when primary team unable to make safe discharge plan
Discussion

• 45 yo male w/ OUD, depression with chronic suicidality hospitalized for complications of heroin injection to foot

• Without access to a monitored setting, what are some options for outpatient acute pain management in this patient with active opioid use disorder?
High Risk Discharge Plan, Hospital Day #28

- Discharged to his brother’s house with VNA, home PT and transportation arranged for podiatry, psychiatry and primary care follow-up

- Due to concerns about outpatient safety with prescription opioid pills, transitioned to fentanyl patches for pain control
  - Bup/nlx discontinued
  - Prescribed fentanyl patches with taper schedule q3 days
    - Plan: d/c wearing 50 mcg → 37.5 mcg → 25 mcg → 12 mcg
    - Due to insurance issues: only able to pick up 25 mcg and 12 mcg patches
    - Limited number of oxycodone PRN dressing change (#20)

- Referred to outpatient addiction clinic to resume bup/nlx after fentanyl taper
Hospitalization #3: Psychiatric Evaluation (3 Days)

- **Re-presented to the ED 6 days later** in setting of increased drainage from wound and suicide attempt with psychiatric medications
- Continued fentanyl taper per last hospitalization

- Psychiatry: chronically elevated suicide risk
  - Initially required 1:1 monitoring, outreach to primary psychiatrist
  - No change in medications
  - Cleared 1:1 suicide risk, returned to baseline
  - Offered crisis stabilization placement but he declined

- No evidence of wound infection
  - Discharged with follow up wound care
Hospitalization #4: SI, OUD and Pain (4 Days)

- **Readmitted 5 days later** for SI and pain control
  - Delay in getting lower fentanyl dose due to insurance issues
  - Did not follow up with PCP
  - Actively using heroin for pain

- Psychiatry: Desire to kill himself via strangulation and IVDU
  - Passive SI w/ concern for secondary gain
  - Once medically cleared needs psychiatric admission

- Wound vac discontinued with no sign of infection
Hospitalization #4: SI, OUD and Pain (4 Days)

- Fentanyl plan discontinued due to insurance complexities
- Restarted bup/nlx given ongoing heroin use
  - 16mg bup divided TID for pain control
  - Continued to require high dose oxycodone PRN
- Discharged to crisis stabilization unit and then respite care to complete oxycodone taper
- Scheduled for follow up in new **opioid urgent care** clinic for bup/nlx refill
What is an opioid urgent care clinic?

FASTER PATHS TO TREATMENT

Faster Paths to Treatment, is BMC’s substance use disorder urgent care center. It is a judgment-free home for people suffering with addiction. Staff members help individuals overcome their addiction by rapidly evaluating, motivating, and referring patients with substance use disorders to a network of care including inpatient and outpatient detox, treatment, and aftercare services.

Individuals who come to Faster Paths to seek help receive:

- Referral to addiction treatment
- Assessment for medication assisted treatment including prescriptions for induction and stabilization on buprenorphine/naloxone (Suboxone) and naltrexone pills or injection (Vivitrol) for blocking cravings
- Opioid overdose education including Naloxone (Narcan) rescue kits
- Follow-up from a licensed alcohol and drug counselor
- Access to BMC case management, which can help with overcoming common barriers to health including transportation and acquiring a Massachusetts Identification Card
- Access to a BMC primary care doctor
- Access to community-based support services from the recovery specialists with Boston Public Health Commission’s PAATHS (Providing Access to Addiction Treatment Hope & Support)
In Retrospect

• 4 hospitalizations in 4 months - total of 52 inpatient days
  ▪ What could have been done differently to avoid the multiple readmissions?
  ▪ Are these discharge challenges (patient declined by multiple rehabs) similar across the country?
Follow Up

• Administratively discharged from respite care after 1 week for behavior
• Not engaging with primary care despite repeated encouragement
• Repeated no show with plastic surgery (attended 1/5 scheduled visits)

• Walking in to wound clinic for dressing changes PRN
• Intermittent follow up in FASTER PATHS clinic for short bup/nlx prescriptions
  ▪ Utox: +cocaine, opiates, norfentanyl, and intermittent +buprenorphine
  ▪ Continues to complain of pain, awaiting wound graft
  ▪ No further opioid prescriptions (other than bup/nlx)
  ▪ Plan for up-titration of bup/nlx q8 hour for pain if able to attend follow up appointments

• Working on getting back into respite care
  – Remains depressed, suicidal thoughts, considering residential program
  – Remains out of hospital for 6 weeks
Take Home Messages

• Active substance use and mental illness are the underlying cause of severe infection and are contributing to the ongoing complications

• Outpatient management of acute pain in patients with active OUD is extremely challenging
  ▪ Early involvement in addiction/pain specialist is recommended

• Patients with passive suicidality have chronic elevated risk of self harm and require continued vigilance and coordination with psychiatry
References


PCSS-O Colleague Support Program and Listserv

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.

- PCSS-O Mentors comprise a national network of trained providers with expertise in addiction medicine/psychiatry and pain management.

- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

- The mentoring program is available at no cost to providers.

For more information on requesting or becoming a mentor visit: www.pcss-o.org/colleague-support

- Listserv: A resource that provides an “Expert of the Month” who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcsso@aaap.org.
PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: www.pcss-o.org  
For questions email: pcss-o@aaap.org  
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