Safe Prescribing for Patients with a History of Substance Use Disorder

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Objectives

After participating in this webinar dental practitioners will be able to:

1) Implement treatment strategies that guide safe dental practices when performing procedures on patients with a history of substance use disorder (SUD)

2) Develop a safe and effective plan for acute pain management in patients receiving opioid maintenance treatment for addiction
Recent ADA Webinars

- Detection and Deterrence of Substance Use Disorders and Drug Diversion in the Dental Practice
- Interviewing and Counseling of Patients with Substance Use Disorders (SUDs) and Drug Seeking Behaviors
- Management of Controlled Substances in Dental Practice
Known vs. Unknown SUD History

Rules

1. Make the unknown known

2. Use the tools available:
   - Office assistants/hygienist screening patients
   - SBIRT, DAST, CAGE, AUDIT questionnaires
   - Prescription Drug Monitoring Programs

3. Physical Assessment/Exam
   - nose
   - mouth/teeth
   - arms

4. Disarm the patient first....then ask the patient about use, abuse, addiction

5. Protect the patient.....and yourself!
Assessing Abuse/Addiction History

- What was used?
- When was last use?
- How much was used?
- How was the substance abused? (IV, PO, nasal)
- How long have you been abusing?

- If in recovery.....how long?

Always congratulate the individual in recovery! They are accomplishing a monumental task!
**Definitions**

- **Pseudo-addiction** - a healthcare induced condition in which health professionals misinterpret a patient’s request for more medication due to inadequate treatment of a condition (e.g., pain, anxiety or sedation).\(^1\)

- **Opioid Maintenance Therapy (OMT)** - aka opioid substitution therapy (OST), office based opioid treatment (OBOT), opioid replacement treatment (ORT), medication assisted treatment (MAT) or methadone maintenance programs (MMT) are part of a comprehensive opioid addiction management strategy targeting illegal opioid abuse, the treatment of opioid addiction and other negative social consequences.

- **Hyperalgesia** may be defined as a patient’s increased detection or hypersensitivity to painful stimulus that previously was not perceived as painful without other known causes. This increased sensitivity to pain is most commonly associated with chronic opioid therapy for nonmalignant pain.\(^2\)

- **Cross-tolerance** is a pharmacological phenomenon that may be characterized as an inability to achieve a specific pharmacological effect due to prolonged exposure of a similar pharmacologic substance (8). Higher doses are required to achieve the same desired pharmacological effect. Cross-tolerance is most commonly associated with the sedative, analgesic, respiratory depressant, or euphoric effects of a substance.\(^3\)

References


Substance Use Disorders Discussed Today

- Alcohol
- Opioids (prescription and illicit)
Clinical Considerations and Treatment Goals:

1. Safely treat the dental pathology (e.g. abscess, extraction, implant, etc.)

2. Minimize the risk of relapse – exaggeration of cravings, compulsions, etc.

3. Recognize potential medications that may interfere with dental treatment

4. Provide support / encouragement to patient
Pharmacologic Cautions

Although little evidence based data exists, caution should be taken when administering NO, benzodiazepines or barbiturates to alcoholics in recovery since these agents *may* stimulate similar receptors in the brain that provoke cravings.
Naltrexone – ReVia®

- Opioid antagonist - blocks reinforcing properties of alcohol
- Usual daily dose is 50 mg orally
- Side effects - nausea, vomiting, headache, anxiety, fatigue, insomnia, elevated liver function tests (LFT’s)

Depo-naltrexone – Vivitrol®

- Opioid antagonist – blocks reinforcing properties of alcohol
- One injection of 380mg IM every month
- Side effects - nausea, vomiting, headache, anxiety, fatigue, insomnia, elevated LFT’s, pain or redness at injection site

Ask patients if you do not see it on the profile......monthly injections are frequently not reported
Considerations for Acute Pain Management in Patients Receiving Naltrexone

- Discontinue daily Naltrexone 72 hours before the procedure
- Reassure the patient the intent to adequately treat pain, NOT deny treatment of pain
- Establish specific post procedure pain management goals/expectations before the procedure (e.g., pain scores 1-3 not “0”)
- Educate and emphasize optimal nonpharmacological therapy post-procedure (ice packs, oral rinses, hygiene, compliance with eating instructions, etc.)
- Consider preemptive strike with NSAIDs then scheduled NSAID therapy
- Consider long acting topical anesthetics like bupivacaine prior to discharge from the office
- Use of combination analgesics with NSAIDS + acetaminophen may add additional analgesia. (Caution is recommended since these agents may be contraindicated for patients with a history of renal or hepatic impairment.)
- Consider adjunct corticosteroid therapy in cases with major inflammation (multiple extractions)
Does opioid analgesia work in patients receiving naltrexone products?
Clinical Considerations

Procedures should be postponed whenever possible in an impaired patient

1. Cross tolerance to sedation medication
   - Nitrous Oxide frequently the preferred agent
   - Benzodiazepines may have minimal effects
   - Opioids (e.g. morphine/fentanyl) *may* be helpful for mild sedation

2. Coagulopathies (end stage/cirrhosis)

3. Alcohol withdrawal
   - Can actually start within an hour of admission or treatment
   - Patients in withdrawal should be stabilized before treatment

4. Analgesia
   - NSAIDs and acetaminophen / or both preferred
   - Acetaminophen may still be used even in patients with liver disease but doses should not exceed 3 grams/day and consulting with the patients GI/IM doctor is always recommended
   - In end-stage liver disease NSAIDS and acetaminophen should be avoided
   - Opioids morphine/fentanyl are reasonable considerations
1) opioid addicts in recovery in abstinence-based programs (nonpharmacological management)

2) opioid addicts in recovery receiving OMT

3) opioid addicts in recovery receiving naltrexone therapy

4) opioid addicts still using.

While evidence-based studies are limited regarding acute pain management of dental patients with opioid addiction, there is ample evidence to support clinical considerations that are key when treating acute pain in patients with opioid addiction who are also receiving OMT.
Common Misperceptions Regarding Opioid Addiction with Acute Pain

- Addicts *in recovery* always lie about their pain
- Opioid medications used for chronic pain adequately treat acute pain
- Patients receiving opioid maintenance treatment with methadone or buprenorphine are adequately treated for acute pain
- Opioid addicts in recovery receiving opioids for acute pain have a higher risk of relapse than opioid addicts in recovery NOT receiving opioids
- Patients reporting high chronic pain scores (6+ on 0-10 scale) should be demonstrating visible symptoms such as increased HR, BP, grimacing or diaphoresis.
- Patients receiving chronic opioids for pain or OMT are “drug seeking” if they complain of inadequate analgesia.
NSAIDS and/or acetaminophen are always first line unless otherwise contraindicated.

Dentists are usually appropriately concerned about causing a relapse. “Relapse is a process not an instantaneous event”

If opioids are necessary, respect the patients right to deny opioid treatment.

The goal is to minimize pain...that doesn’t mean the patient should expect “0” pain.
## Checklist for Optimizing Acute Pain Management in Patients in Abstinence Programs

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
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<tbody>
<tr>
<td>Reassure the patient the intent to adequately treat pain, NOT deny</td>
<td>treatment of pain</td>
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<td>Establish specific pain management goals/expectations before the</td>
<td>procedure (e.g., pain scores 1-3 not “0”) to prevent prescriber-patient analgesia mismatch</td>
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<td>Respect a patient’s wishes to NOT receive or be prescribed opioid</td>
<td>analgesics or “extra doses” if they are adamant.</td>
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<td>Educate and emphasize optimal nonpharmacological therapy post-</td>
<td>procedure (ice packs, oral rinses, hygiene, compliance with eating instructions, smoking discontinuation or reduction, etc.)</td>
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<td>Document in chart all opioids and sedatives administered</td>
<td></td>
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<td>Consider preemptive strike with NSAID 1 hour before the procedure</td>
<td>then scheduled NSAID or NSAID + acetaminophen pain treatment around the clock and not as needed.</td>
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<td>Consider long-acting topical anesthetics like bupivacaine prior to</td>
<td>discharge from the office</td>
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<td>Use of combination analgesics with NSAIDs or acetaminophen may add</td>
<td>analgesia. (Caution is recommended since these agents may be contraindicated for patients with a history of renal or hepatic impairment. Doses of acetaminophen should not exceed 3.0 grams per day)</td>
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<td>Do not prescribe excessive doses of medications or in quantities</td>
<td>expected to be left over.</td>
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<td>Consider (with the patient’s consent) that a responsible family</td>
<td>member or friend control pain medications</td>
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<td>Encourage the patient to use their support services such as</td>
<td>counselors, narcotics anonymous/Alcoholics Anonymous groups if cravings increase</td>
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Buprenorphine – CIII

- generic mono-buprenorphine tablets (often referred to as “Subutex®” though brand name discontinued by manufacturer in 2011)

- Buprenorphine/naloxone tablets (4/1 ratio) – generic tablets, buprenorphine/naloxone film (4/1 ratio) – Suboxone®

- All forms of buprenorphine approved for opioid treatment are to be used sublingually.

- Usually dosed daily or bid

Methadone – CII

The average daily oral dose of methadone is 70mg-120mg/day
Opioid Addicts in Recovery in Opioid Maintenance Programs (methadone/buprenorphine)

Common Questions

- How do these medications work?
- Are we replacing one addiction for another?
- Are my patients impaired?
- Do these daily doses treat acute pain?
## Checklist for Optimizing Acute Pain Management in Patients Receiving OMT

| Reassure the patient the intent to adequately treat pain, NOT deny treatment of pain |
| Establish specific pain management goals/expectations *before the procedure* (e.g., pain scores 1-3 not “0”) to prevent prescriber-patient analgesia mismatch |
| Respect a patient’s wishes to NOT receive or be prescribed opioid analgesics or “extra doses” if they are adamant. |
| Confirm doses of buprenorphine/methadone or chronic opioid doses with the treatment facility or patient’s primary pain specialist and discuss *preferred* plans of treatment with treatment providers. |
| Educate and emphasize optimal nonpharmacological therapy post-procedure (ice packs, oral rinses, hygiene, compliance with eating instructions, smoking discontinuation or reduction, etc.) |
| Document in chart all opioids and sedatives and report information to the OMT treatment center or primary pain specialist as soon as possible. |
| Consider preemptive strike with NSAID 1 hour before the procedure then *scheduled* NSAID or NSAID + acetaminophen pain treatment around the clock and not *as needed*. |
| Consider long-acting topical anesthetics like bupivacaine prior to discharge from the office |
| Use of combination analgesics with NSAIDs or acetaminophen may add analgesia. *(Caution is recommended since these agents may be contraindicated for patients with a history of renal or hepatic impairment. Doses of acetaminophen should not exceed 3.0 grams per day)* |
| Do not prescribe excessive doses of medications or in quantities expected to be left over. |
| Consider (with the patient’s consent) that a responsible family member or friend control pain medications |
| Ideally, the OMT prescriber or the chronic pain medication prescriber should manage all pain medications |
The dental practitioner should discuss with the OMT prescriber options such as addition of higher dose traditional short acting oral opioid analgesics or combination analgesics (e.g., hydrocodone/apap, hydrocodone/ibuprofen, oxycodone/apap, hydromorphone) in addition to their current maintenance dose of methadone.

Addition of higher dosage, short-acting opioids should be limited to the anticipated duration of acute pain.

Codeine products should be avoided since it is dependent on its demethylation to morphine to produce its major analgesic effects. Only about 10% of codeine is metabolized to this active form. Also, many common antidepressants compete with codeine metabolism which may reduce codeine’s effectiveness.

In clinical practice, emergency dental events may be managed with higher traditional doses of short acting oral opioids. Medications should be titrated daily by phone if possible to manage the acute event.

The dental practitioner should document all medications administered or prescribed and notify the patient’s OMT prescriber due to potential patient contract violations such as positive urine drug screens.

Another option is to have the OMT prescriber add supplemental oral methadone doses every 4-6 hours for analgesia in addition to their daily OMT methadone.

Minimal data exists regarding post-op or post-procedural acute pain management in patients receiving buprenorphine (29). Patients receiving buprenorphine for OMT may benefit by dividing the total daily dose of buprenorphine into 3-4 doses throughout the day to provided better analgesic coverage.

Having the OMT prescriber add additional low dose sublingual buprenorphine (e.g. 2mg) at 4-6 hour intervals) is also an option.
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- Consider long acting topical anesthetics like bupivacaine prior to discharge from the office
- Use of combination analgesics with NSAIDS + acetaminophen may add additional analgesia. (Caution is recommended since these agents may be contraindicated for patients with a history of renal or hepatic impairment.)
- Patients usually require higher dose opioids if opioid therapy is definitely warranted. Fentanyl or hydromorphone may be preferred agents due to their high affinity for opioid receptors.
### Additional Considerations for Active Addicts Requiring Acute Pain Management

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<td>After adequate analgesia has been achieved, the dental practitioner should encourage the patient to receive SUD treatment and should be prepared with address and phone numbers of local treatment options.</td>
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<td>To minimize the risk of misuse or abuse of the total prescription at once, the prescriber may write more than one prescription but limit the prescription to a 24-48 hour supply.</td>
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<td>Writing specific hour dosing schedules may benefit some patients.</td>
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<td>The dental practitioner can have the patient sign an opioid treatment agreement warning the patient that loss, theft or overutilization of opioid medication may result in discontinuing of treatment.</td>
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Summary
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
Twitter: @PCSSProjects

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Webinar Evaluations (Post and 30-Day)

- Each PCSS-O partner organization that provides CE credit to participants is asked to submit a post and 30-day evaluation to participants for completion.
- Participants in today’s webinar will receive their evaluation by email at the completion of today’s webinar.
- These questions have been developed and approved by SAMHSA.
- By completing the evaluations, you are helping us improve PCSS-O resources!
Have an idea for future ADA PCSS-O webinars?

Submit your feedback to Alison Siwek at SiwekA@ada.org