Disclosures

- Dr Merlin has no relevant financial affiliations to disclose. (Updated 2/29/2016)
Educational Gap

- Many patients with HIV have chronic pain; chronic pain (including the use of long-term opioid therapy and other modalities) is rarely a focus of HIV provider training.

Objectives

After attending this presentation, participants will be able to:

- Identify a clinical approach to the evaluation and management of HIV-infected individuals with chronic pain
- Describe communication strategies that can be used when discussing chronic pain, including opioids, with patients with chronic pain

Expected outcome: increased provider comfort with chronic pain management
Outline

- What is chronic pain?
- What we know about chronic pain in HIV
- Clinical approach:
  - Evaluation
  - Communication
  - Management

Case – Mr. Smith

- 55 y/o HIV+ male on TDV/FTC/EFV
- CD4 490, VL < 20
- HTN, gout, hyperlipidemia
- History of cocaine addiction in his 20s
- At the end of your 15-minute encounter… mentions he has had low back pain for past 6 months and asks for hydrocodone-acetaminophen
What do you do next?

1. Prescribe hydrocodone-acetaminophen, #90 per month with refills, and arrange follow-up in a year
2. Inform him that you do not prescribe opioids to patients with a history of addiction, and refer him to the local pain clinic
3. Order an MRI to determine if he has pain, and depending on the results, consider an opioid
4. Perform a history and physical exam, consider whether additional workup is needed, and discuss pharmacologic and non-pharmacologic management options

Outline

- What is chronic pain?
- What we know about chronic pain in HIV
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Acute vs. Chronic Pain

- Acute pain: new pain, < 3 months
- Chronic pain: persists > 3-6 months, beyond the period of normal tissue healing
  - Examples: low back pain, other msk pain, fibromyalgia, neuropathy

Etiology

- Peripheral sensitization
- Central sensitization
  - Foundation for common co-occurrence of pain, mood disorders, and addiction
- Ongoing inflammation


**Figure 1: The effect and burden of chronic pain**

Chronic pain affects every aspect of a patient’s life, contributing to a loss of both physical and emotional function, affecting a patient’s levels of activity (ability to work at home and job and engage in social and recreational pursuits); additionally, there are often serious economic consequences as a result of health-care bills and potential loss or decrease in financial income.

Turk DC, Lancet, 2011; Institute of Medicine, 2012.
Outline

- What is chronic pain?
- What we know about chronic pain in HIV
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HIV and Chronic Pain in the Current Treatment Era

- Prevalence as high as 39-85%
- Often coexists with mood disorders and addiction
- Typically musculoskeletal
- Associated with key outcomes
- Can be challenging for HIV providers

Chronic pain in persons with HIV

Outline

- What is chronic pain?
- What we know about chronic pain in HIV
- Clinical approach:
  - Evaluation
  - Communication
  - Management
I know that my patient's pain is “real” because:

1. The patient says so
2. The patient’s partner says so
3. The MRI says so
4. I have no idea, how should I know!??
**Chronic pain history**

- Impact of pain on:
  - Function
  - Mood
  - Sleep

  - Ask: “Some people report that pain impacts X; is that true for you?”


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**Other key historical questions**

- Employment history, disability history
  - Specifically ask: How do you spend your day? What did you do before you had chronic pain? What would you like to be doing?

- Psychiatric and addiction history and symptoms

- During interview, note pain behaviors

Known Risk Factors for Disability

- Fear avoidance
- Catastrophizing
- Depression
- Anxiety
- Decreased function
- High initial pain levels
- Increased age
- Poor general health status
- Compensation dependency

ICSI Guideline for Management of Chronic Pain.

Etiology of Pain

- Try to determine, if possible
  - Neuropathic
    - Sciatica, post-herpetic neuralgia, etoh/dm neuropathy
  - Musculoskeletal
    - Myofascial pain syndrome
  - Inflammatory
    - Arthritis, tendonitis, chronic infections
  - Mechanical/compressive
    - Tumors, cysts, fractures

ICSI Guideline for Management of Chronic Pain.
Diagnostic Testing

- Evidence-based judicious use is best
- Pain may not have a radiographically identifiable cause
- This is a challenge for both the patient and the provider

ICSI Guideline for Management of Chronic Pain.

Outline

- What is chronic pain?
- What we know about chronic pain in HIV
- Clinical approach:
  - Evaluation
  - Communication
  - Management
You should routinely tell patients with chronic pain that:

1. If they “break” their pain “contract,” you will get angry and fire them from the practice
2. The goal of pain management is improvement in physical function, rather than being “pain-free”
3. Their pain is “mostly psychological”
4. If they go to their initial visit with their pain doctor, they will get opioids

Communicating About Chronic Pain

- Not easy, because:
  - Patients come with “baggage”
  - Providers come with “baggage”
  - Pain is the 5th vital sign, pain is an emergency
  - Medications come with risk
  - Patients may have active psychiatric illness/addiction
  - Patients’ behaviors may evoke severe negative countertransference
Initial Discussion

- What is chronic pain
- Patience
- Partnership and collaboration
- Pharmacologic and non-pharmacologic management
- Mind-body connection
- Functional goals
- Motivational interviewing can be very useful

Outline

- What is chronic pain?
- What we know about chronic pain in HIV
- Clinical approach:
  - Evaluation
  - Communication
  - Management
Evidence-Based Management

- Remember….first, do no harm!!
- Focus on evidence-based therapies, avoid unnecessary procedures, surgeries, medications
- Set concrete goals and timelines
- Be ready to discontinue therapies that don’t work
- If possible, treat psychiatric illness first

Evidence-Based Non-Opioid Pharmacologic Therapy

- Acetaminophen - OA, < 3g, consider relative contraindications
- NSAIDs - back pain, consider CV (naproxen), GI (cox-2/celecoxib), renal risk
- Muscle relaxants
- Benzodiazepines
- Other: anticonvulsants, antidepressants, topicals
  - Specific indications: e.g., lidocaine post-herpetic neuralgia, capsacin post-herpetic/DSP, doclofenac-OA
“We can give you enough medication to alleviate the pain but not enough to make it fun.”

Opioids

Slide courtesy of Erin Krebs.
My take on opioids

- They ARE NOT first-line therapy for chronic pain
- They work for some people
- However, evidence of benefit is limited
- What we know about their risk is growing
National Institutes of Health Pathways to Prevention Workshop

- “Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.”
  - Chou R et al Annals Intern Med 2015; 162 (276-86)

Slide courtesy of Mark Sullivan.

Risks of long-term opioid therapy – to patients

- Decreased function/return to work (cohorts)
- Hyperalgesia
- Tolerance
- Dependence (lifelong?)
- Addiction (10%)
- Evidence for increased mortality with doses > 100-200 mg equivalents of morphine per day
- Highest risk is combination of opioids and benzos


Slide adapted from material courtesy of Mark Sullivan.
Risks of long-term opioid therapy - to patients

- Hypogonadism (infertility, low libido)
- Induced depression (duration > dose)
- Overdose, death, ED visits (>700,000 in 2012)
- Motor vehicle accidents, dose-dependent (OR=1.2-1.5)
- Falls (worse early on)

Slide adapted from material courtesy of Mark Sullivan.

Risks of long-term opioid therapy - to family and friends

- Misuse (12th graders: 10% 2010 → 6% 2014)
- Accidental overdose, death (2010-2,2x heroin)
- Addiction
Risks of long-term opioid therapy - to culture

- Inability or unwillingness to manage pain in non-medical ways
- Once a medical pain treatment is available, it ceases to be noble to endure pain and it becomes just stupid

Slide adapted from material courtesy of Mark Sullivan.

Benefits of long-term opioid therapy

- Preservation of mobility
  - In older patients with osteoarthritis and intermittent use
  - In patients with progressive rheumatological or autoimmune disease
- Palliation of severe intractable chronic pain
  - Patients who have failed all other multi-modal therapies, including psychiatric therapies
  - Patients who would otherwise not be able to live at home, avoid hospitalization, ED visits

Slide courtesy of Mark Sullivan.
How to decide (to start or continue)

- Assess risk/benefit ratio of opioids
  - Risk factors for misuse: personal or family history of substance use disorder, younger age, history of sexual abuse, depression
  - Evidence of harm: concerning behaviors, side effects, hyperalgesia
  - Evidence of benefit: physical and emotional function, not only pain self-report


Opioid Risk Mitigation Strategies

- Opioid treatment agreement
  - Includes patient education and informed consent
- Practitioner database monitoring programs
- Urine drug testing

Different states have different policies for the above (know yours!), but in general, routine use of the above is becoming standard of care
Opioid Misuse Behaviors

- Examples include:
  - Unexpected urine results (including substance use)
  - Running out early/other rx problems
  - Multiple prescribers
  - Belligerent behavior
- All have a differential dx
- Approach usually combines careful exploration of the ddx, re-education, clos(er) monitoring and small rx’s, involvement of psychology/addiction colleagues; and if warranted tapering and/or addiction treatment

Addiction in patients prescribed long-term opioid therapy

- Loss of control
- Compulsive use
- Craving
- Continued use despite harm

Other Opioid Pearls

- Regular office visits q3-6 mo are becoming standard of care
- Long acting vs. short acting vs. both
- Avoid indefinite dose escalation
- Urine drug tests are deceptively difficult to interpret
- Document your thinking!!

Evidence-Based Non-Pharmacologic Strategies

- Behavioral approaches
- Physical therapy
- Exercise
- Interventional treatments
- Complementary and alternative therapies
- Surgery

Key Points

- Chronic pain is common in patients with HIV, and causes substantial *functional* impairment
- You know a patient has pain if they say they have pain
- We have a lot more to offer than opioids
- Pay attention to psychiatric symptoms