The Case of Orwell
What is Opioid Use Disorder and what it is not

April 2018 VIP Chat

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Noon-12:30

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A VISN 19 – VA SLC Initiative

The Discussant has no conflict of interests to disclose

Vulnerable Veteran – Innovative PACT (VIP) & VIP Chats

- **VIP Goal:**
  - The VISN 19 VIP (Vulnerable Veteran – Innovative PACT) Initiative's over-arching goal is to **improve the health of veterans who are particularly vulnerable due to medical disease and/or their social determinants in primary care environments**
  - Veterans served by this Initiative include those with unhealthy alcohol and drug use, co-occurring pain and/or addiction disorders, social determinants of health including homelessness, and those who frequently use health care services
- **VIP Chat Goal:**
  - **To provide education, mentorship, and foster a learning collaborative to improve the knowledge and skills of health care providers in VISN 19**
  - **The chats are generally scheduled for the *4th Wednesday of each month***
  - **All health care providers are welcome to join! – FUN!**

TODAY's GOALs

- Examine some common terminology regarding opioid use, misuse, and opioid use disorder

- Understand the difference between physical opioid dependence and opioid use disorder

youtu.be/dJ_8QmHlNPw
medicine.emory.edu/education/academy-of-medical-educators/bst-mode.html

AGENDA

- Introduction and Case (10 minutes)
- “Bite Sized Teach” (BST or “Beast Mode”) (10 minutes)
- Discussion (10 minutes)
  - Extended discussion (optional) (30 minutes)

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CASE: Orwell: Chief Complaint

- Orwell is a 28 year old male Veteran who presents to your primary care clinic.
- He is new to you.
- His chief complaint today is why is he feeling sick when he is coming off his pain medications.
- “Feels like the worst cold of my life and all my orifices are extruding their substances”

CASE: Orwell: Recent History

- Recent history
- 10 months ago, he suffered a motor vehicle accident, where he was t-boned by a semi-tractor trailer.
- He suffered multiple injuries including coma, multiple fractures (ribs, pelvis, both femurs), lacerated spleen requiring splenectomy, brain contusion, punctured lung, amputation of his left arm.
- He required multiple surgeries during a difficult 3 week ICU stay, additional 1 month hospital stay, and extended rehabilitation which he continues to work with physical therapy
- He has started to see mental health providers for family counseling, depression, anxiety, and “potentially PTSD”
- Since the accident he wakes up in “night sweats” with nightmares about the ICU stay
- He was arrested briefly due to alcohol intoxication when he had a bar fight 3 months ago.

CASE: Orwell

- **Past Medical History:**
  - Lower back pain – “mild, and gets bad when I am cutting logs in the backyard”
  - Nicotine use disorder - He smokes 1 pack per day, less than when he was in the
- **Social history:** Was in the marines, honorably discharged

  Prior to MVA he was a salesman, now on disability

  He is married, somewhat strained after the MVA

  He drinks alcohol only socially, but with further inquiry he mentions he drinks about 15 beers/week
- **Family history:** He is adopted. No known siblings. No children.

CASE: Orwell: Medications

- **Allergies:** None
- **Medications:**
  - Had been on MS Contin 120 mg twice a day
    - Just recently tapered over the course of 8 months
    - Stopped last week "Was feeling sick when I stopped these last week"
  - Intermittently uses Percocet 5/325 mg every 6 hours as needed
    - "I try to avoid these"
  - He has a spell after the hospitalization when he took a few more Percocets "to stave off the pain"
  - He had been on Xanax for the first 2 months after hospitalization
  - On Prozac (recent), consideration of prazosin for night terrors
  - On Motrin
  - On Colace
- **Labs/Studies:** Normal

Opioid Withdrawal
Want to avoid these…

- Severe flu-like symptoms
- Shaking chills
- Anxiety
- Hyperactivity
- Drooling
- Lacrimation/tearing
- Rhinorrhea
- Nausea and Vomiting
- Anorexia
- Diarrhea
- Myalgias and Muscle spasms

Not all people will have all these symptoms
Ask patients what THEY experience
Symptoms can be complicated by other medical conditions

CASE: Orwell – Diagnosis and Treatment?

- Your consideration: What does the patient have?

- What should we do?

Examine some common terminology regarding opioid use, misuse, and opioid use disorder

Common terms

TERM	DEFINITION	Implications
Opioid Use	Any use of opioids	Good or bad
Intermittent opioid use	Use of prescribed opioids over the course of the year, no more than 3 months continuously	Okay
Chronic opioid use	Use of prescribed opioids for more than 3 months	Okay
Opioid Misuse/Non-Medical Use (NMPO)	Patient use of *prescribed* opioids contrary to medical instructions	Not good
Opioid Abuse	DSM4: met 1 of 4 criteria	A disease (old)
Opioid Dependence	DSM4: met 3 of 7 criteria	A disease (old)
Opioid/Physical Dependence	Patient has physical or psychosocial withdrawal of a substance	Drug effect Not necessarily bad
Opioid Use Disorder	DSM5: meet at least 2/11 criteria	A disease (new)

Cochran G, et.al. Defining Non-Medical Use of Prescription Opioids within Health Care Claims. Subst. Abus. 2015.

Opioid Misuse/Non-Medical Use of Prescription Opioids (NMPU): Harms

- Those engaged in NMPO are likely to have
  - mental and behavioral health comorbidities
  - post-traumatic stress
  - Mood
  - Anxiety
  - Personality disorders
  - substance use disorders
- Other common health problems include
  - Hepatitis
  - overall poorer health
- The most severe health consequence resulting from the rapid escalation of NMPO has been the increase in opioid-related overdose deaths

Cochran G, et.al. Defining Non-Medical Use of Prescription Opioids within Health Care Claims. Subst. Abus. 2015.

Opioid Use Disorder (DSM5)

Criteria:
2-3 (mild)
4-5 (moderate)
6 or more (severe)

1. Failure to fulfill role obligations at work, school, or home
2. Recurrent use in hazardous situations
3. Continued use despite substance-related social or interpersonal problems
4. Tolerance to a substance
5. Withdrawal/physical dependence
6. Loss of control over amount of substances consumed
7. Preoccupation with controlling substance use
8. Preoccupation with substance use activities
9. Impairment of social, occupational, or recreational activities
10. Use is continued despite persistent problems related to substance use
11. Craving or a strong desire to use a substance

Important – no more legal criteria

Opioid Use Disorder (DSM5) - APPLIED

Criteria:
2-3 (mild)
4-5 (moderate)
6 or more (severe)

1. Failure to fulfill role obligations at work, school, or home
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Common terms: Pseudoaddiction?

- Pseudoaddiction, a concept coined in 1989, has frequently been cited to indicate that under-treatment of pain, rather than addiction, is the more pressing and authentic clinical problem in opioid-seeking patients.
- Empirical evidence supporting pseudoaddiction as a diagnosis distinct from addiction has not emerged.
- Nevertheless, the term has been accepted and proliferated in the literature as a justification for opioid therapy for non-terminal pain in patients who may appear to be addicted but should not, from the perspective of pseudoaddiction, be diagnosed with addiction.

Green MS, Chambers RA. Pseudoaddiction: Fact or Fiction? An Investigation of the Medical Literature. Curr Addict Rep. 2015

Perhaps a cascade of use?

- **Intermittent use or chronic use**
  - Use with potential risks
  - Risks not necessarily all do to dose or amount

- **Opioid Misuse/Non-Medical Use of Prescription Opioids**
  - Most difficult patients
  - Often do not qualify for addiction or pain services
  - Many have other substance use disorders or other mental illnesses
  - Vexing to many providers

- **Opioid Use Disorder**
  - Treatable

Understand the difference between physical opioid dependence and opioid use disorder

Physical opioid dependence does not equal DSM4 opioid dependence diagnosis.

- Simple!
- Physical opioid dependence is almost expected!
  - It occurs with a HOST of medications (not just opioids)
    - It applies to people with other substance use – alcohol, caffeine, cupcakes….
  - It occurs often when people are exposed to long term medication use
  - It can be treated symptomatically or with specific medications
  - It can also be avoided by tapering medications slowly over time
  - It is just ONE criteria for opioid use disorder
    - Must be “maladaptive pattern of use” which causes the criteria to activate
  - It is NOT bad

CASE: Orwell – Diagnosis and Treatment?

- **Your consideration: What does the patient have?**
  - Likely physical dependence of opioid medications
  - No real history of opioid misuse
  - Does not meet DSM5 criteria for opioid use disorder (not close)
  - Likely tapered too fast off of MSCONTIN (see VIP Chat in March 2018)
  - At-Risk Alcohol Consumption
    - >14 standard drinks over a week – meets the criteria
    - Does NOT meet the criteria for alcohol use disorder
  - Nicotine Use Disorder
- **What should we do?**
  - Symptomatic relief of opioid withdrawal syndrome.
  - Treat pain, rehab could continue
  - Mental health and possibly TBI? Care

DISCUSSION

Next VIP CHAT!

Wednesday, MAY 23, noon-12:30 PM **(ALWAYS 4th Wednesday of the month)**

The Case of Betty – Buprenorphine Treatment in a Nurse Care Management Model: One model of care