European Society of Regional Anaesthesia & Pain Therapy
ESRA ITALIA

ESRA Italian Chapter
XXVIII CONGRESSO NAZIONALE

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DEL CONGRESSO
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Pharmachological pain therapy
Opioids, friends or enemies?

MZ EVENTS

Disclosures

Consultant for

- Abbott
- Boston Scientific

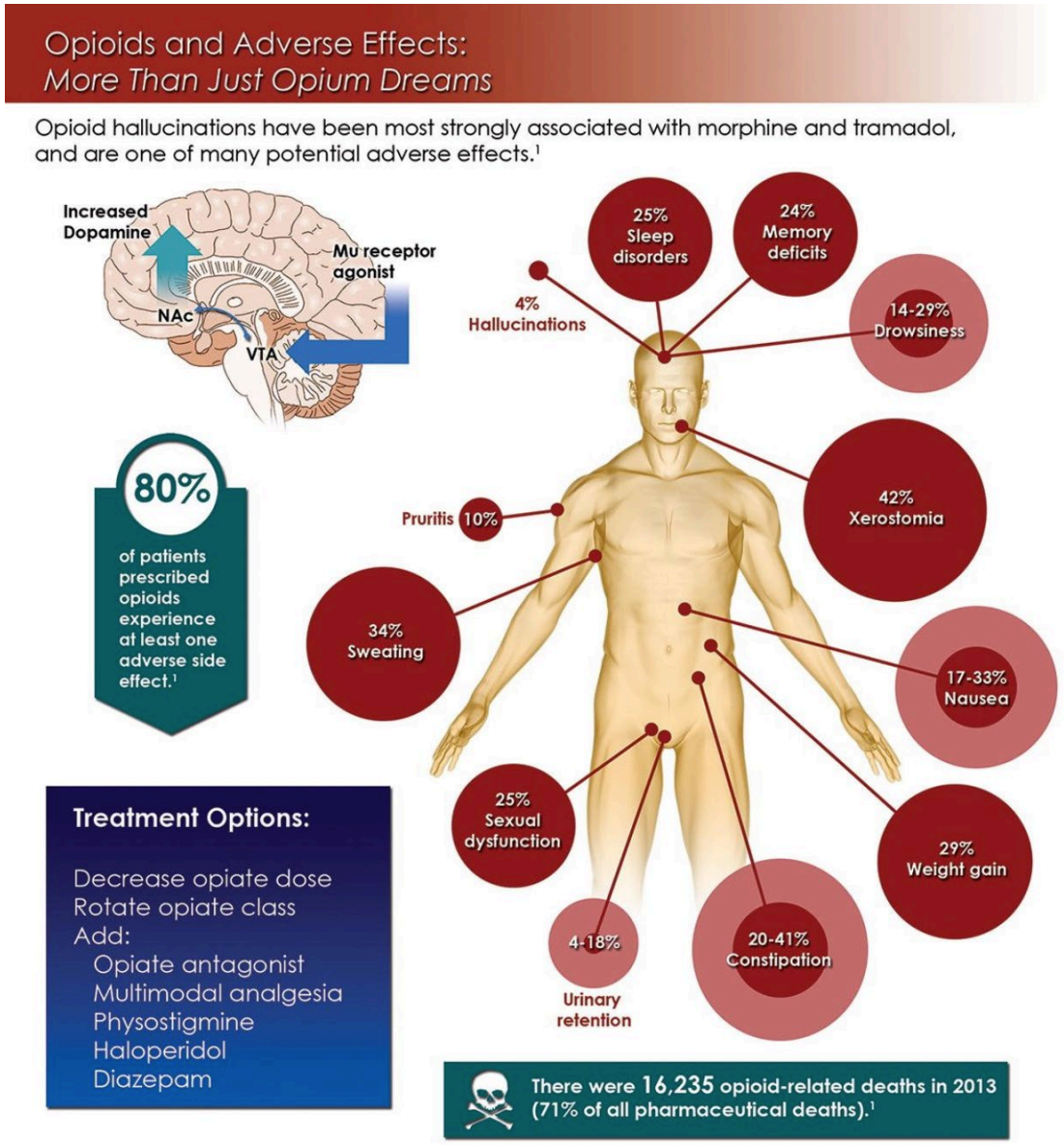
Pain control:
a need stressed only by pharmaceutical companies?

I tell you a story

MA, 56 aa, M
At 40 y age, diagnosis of eosinophilic granulomatosis for which he was prescribed high dose steroid
In 2010 vertebral fracture of T4 due to a minor trauma
Surgical treatment was excluded. To control pain, he was prescribed transdermal fentanyl and transmucosal fentanyl for incident pain …….
Now he refers no more pain in the thoracic region; he refers diffuse pain mainly in the lumbar region where he present disk and joint degenerative disiease no more controlled by pharmachological therapy:
Oxycodone 40 mg x 2, transmucosal Fentanyl 600 ug x 6!!!!
= 520 mg morphine equivalent/day

Side effects

- Sleep apnea
- Hypogonadotropic hypogonadism
- Hyperalgesia



INFOGRAPHIC: #Opioids and Adverse Effects - "More than Just Opium Dreams" journals.lww.com/anesthesia-ana... #meded #FOAMed

Research Paper
PAIN®

Sleep-disordered breathing decreases after opioid withdrawal: results of a prospective controlled trial

Andreas Schwarzer[a,*], Marie Aichinger-Hinterhofer[a], Christoph Maier[a], Jan Vollert[a], Jörg Werner Walther[b]

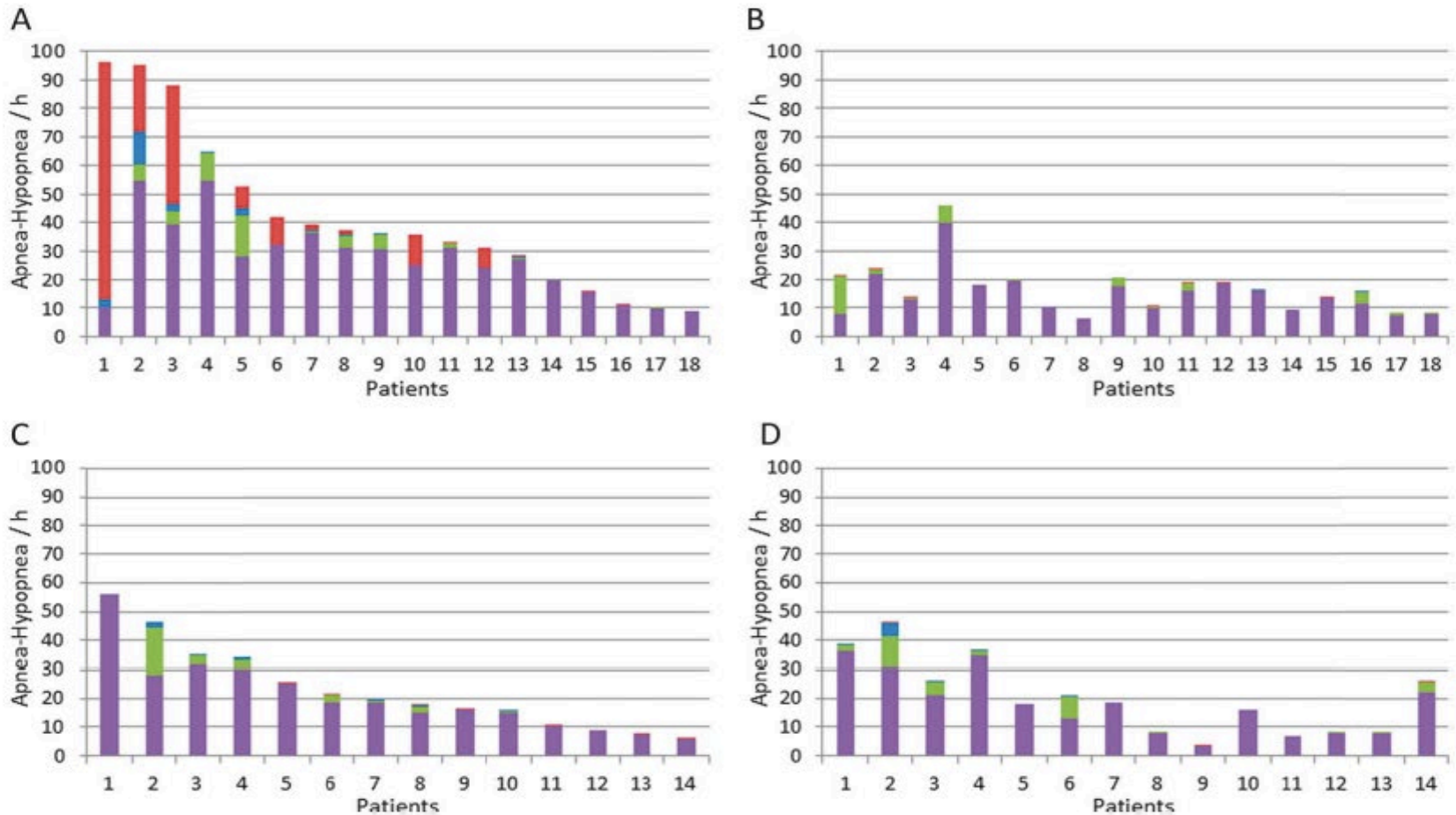


Figure 2. Distribution of central (red), mixed (blue), and obstructive (green) apneas and hypopneas (violet) in the apnea–hypopnea index. (A) Apnea–hypopne index at baseline in the opioid withdrawal group; (B) Apnea–hypopnea index after treatment in the opioid withdrawal group; (C) Apnea–hypopnea index at baselir in the control group; (D) Apnea–hypopnea index after treatment in the control group.

And efficacy?

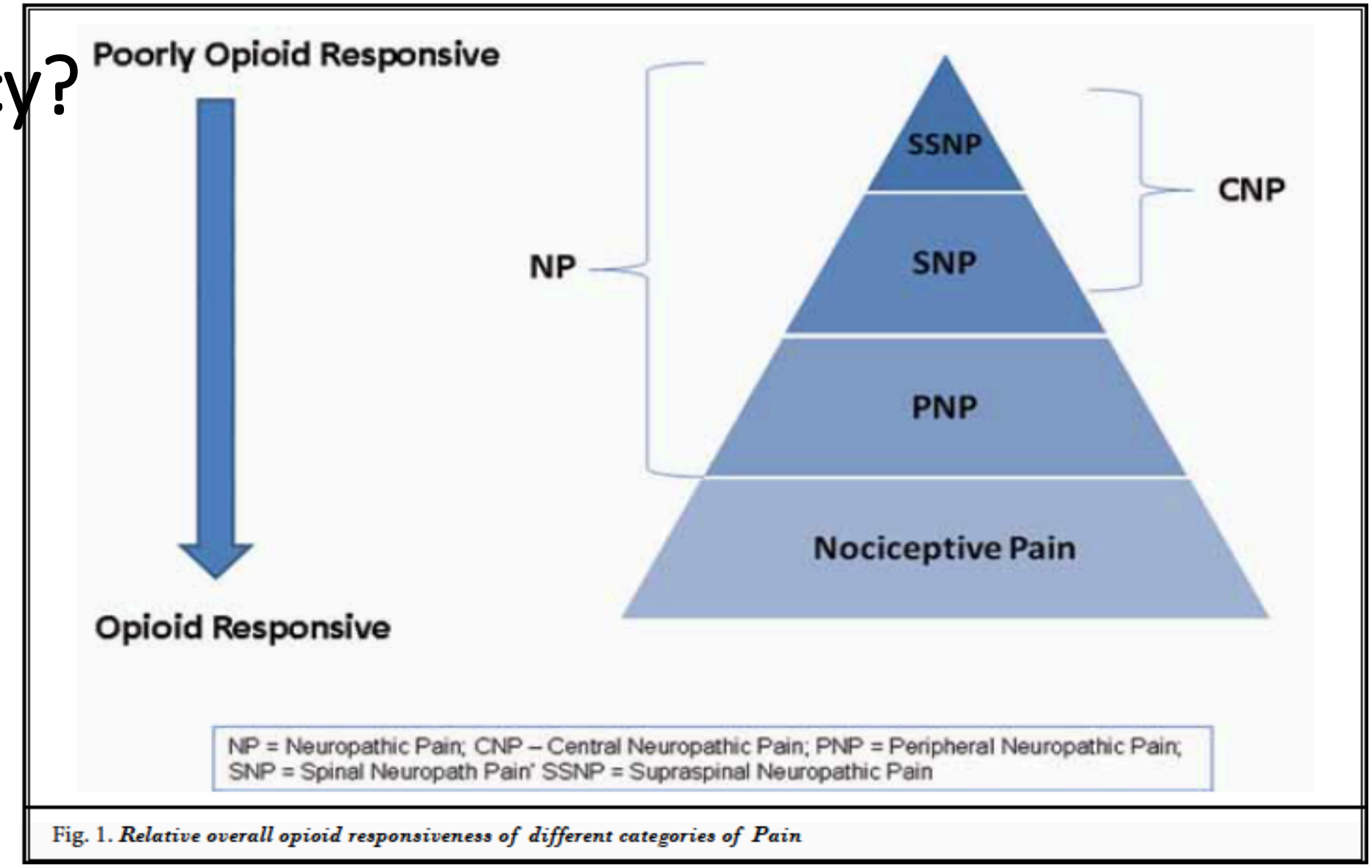
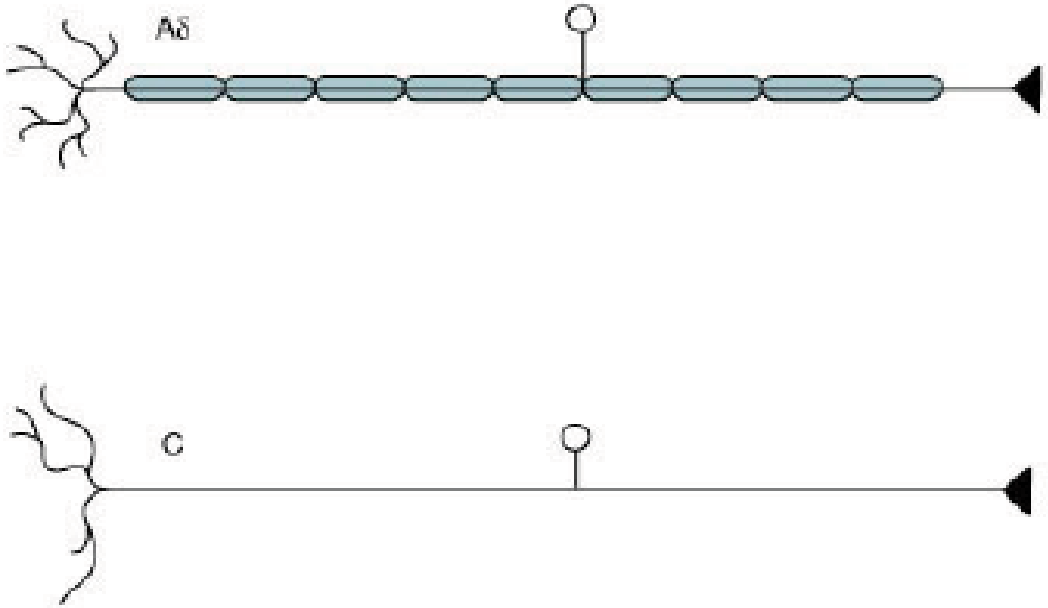
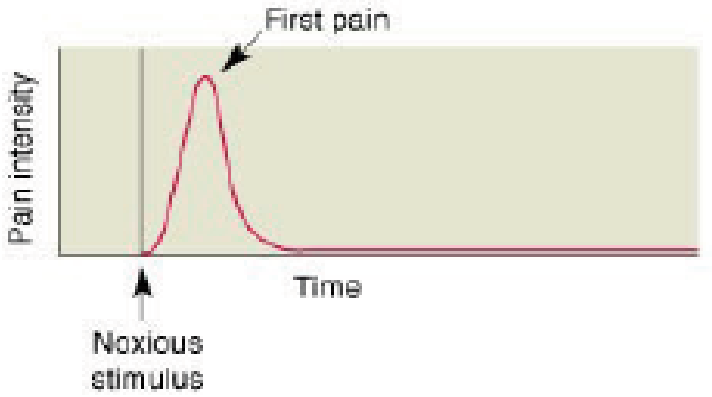


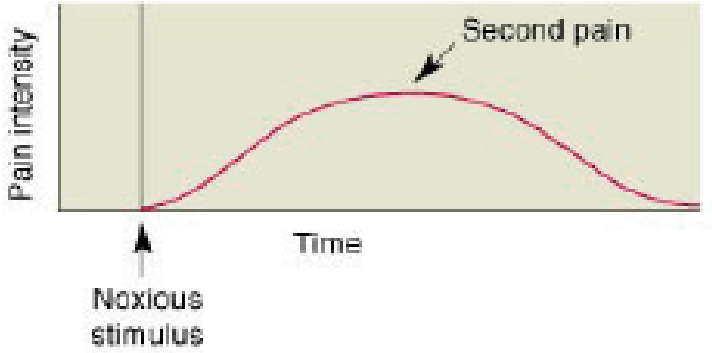
Fig. 1. *Relative overall opioid responsiveness of different categories of Pain*

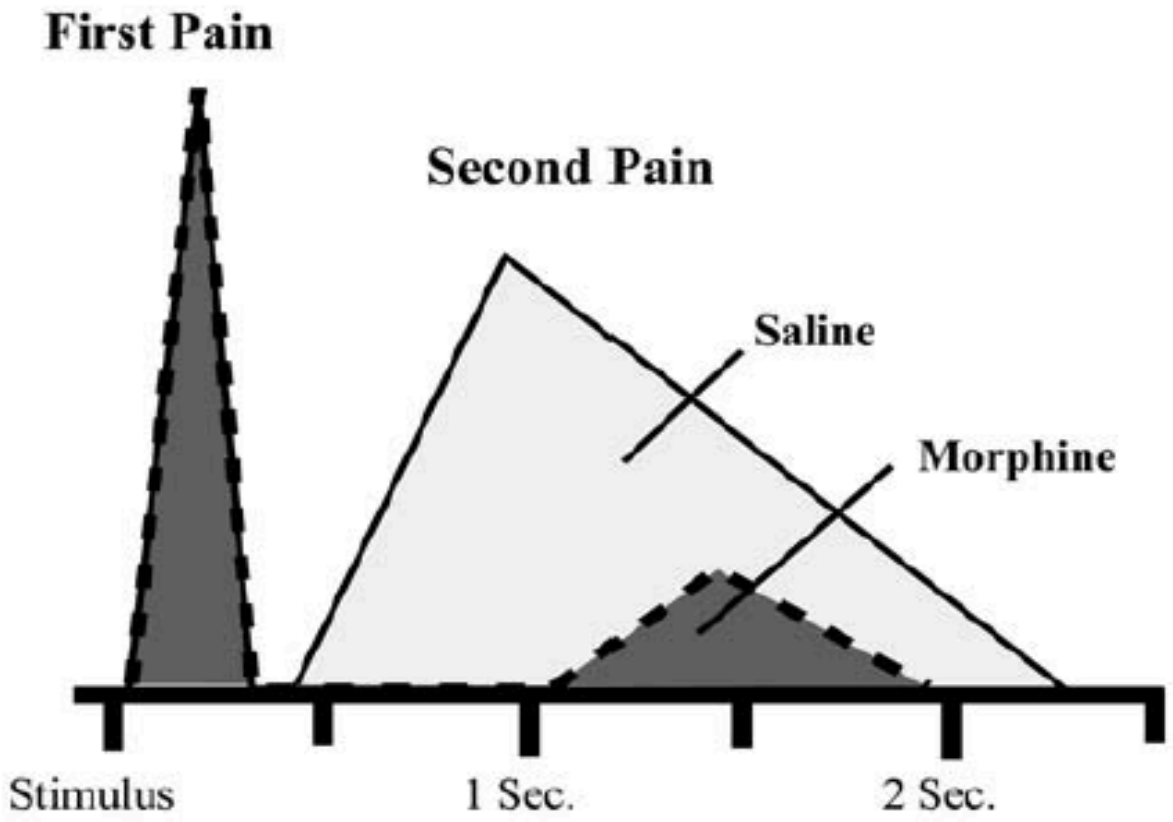
HS Smith. Opioids and Neuropathic Pain. Pain Physician, 2012.

Sensitive fibres and opioids









Opioids, Effects of Systemic Morphine on Evoked Pain, Figure 1 Average tracings of 6 subjects who followed the time-course and rated the magnitude of first and second pain elicited by 50~ms of electrocutaneous stimulation (1.28~mA/mm^2; 0.5~ms pulses at 200~Hz) delivered to one lateral calf. Time course estimates utilized a finger-span device attached to a potentiometer, and the magnitudes of first and second pain were rated verbally, using ► free magnitude estimation. Administration of 10~mg morphine sulphate 1~h before testing did not alter the magnitude of first pain. In contrast, second pain (dashed line) was delayed in onset and substantially reduced in magnitude and duration by morphine, relative to control measurements (solid line) (from Cooper et al. 1986).

Morphine 0,1mg/kg

Opioids, Effects of Systemic Morphine on Evoked Pain

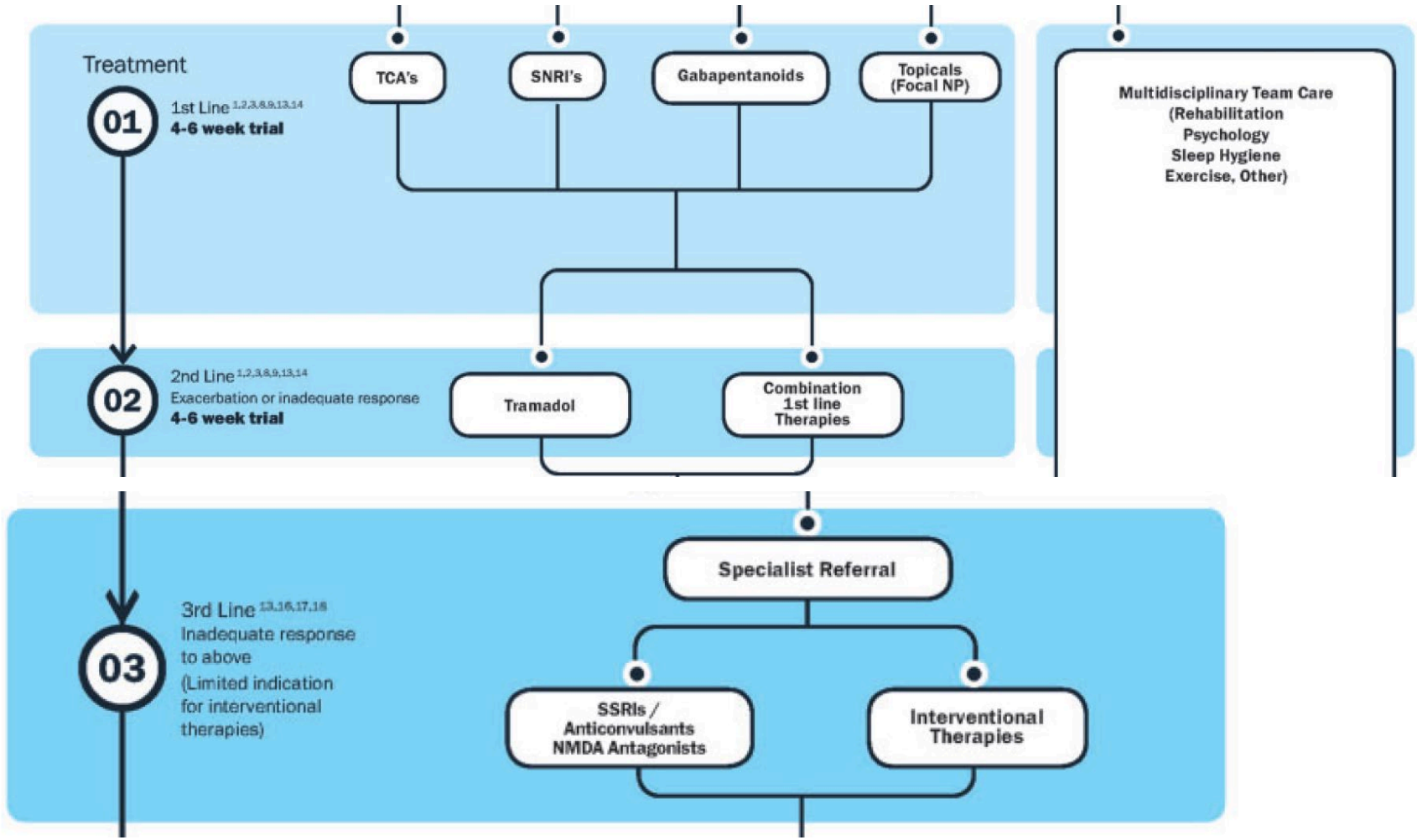
CJ Vierck Jr

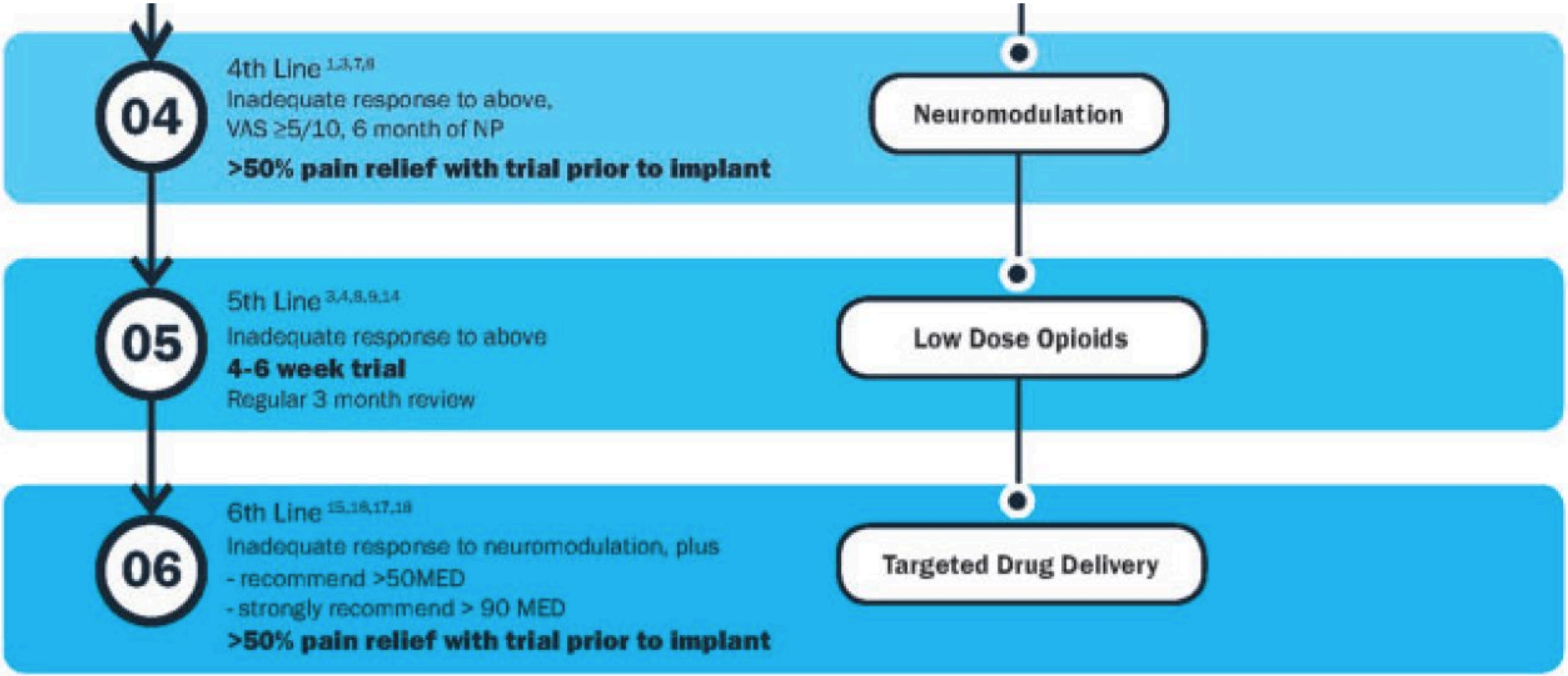
- Opioids (even endogenous) control the tonic component of pain at rest but not the phasic component evoked by movement and weight bearing in order to prevent further lesion to a damaged tissue
- But…
- High doses of a systemic opioid (minimum 3 mg/kg) are able to reduce nociceptive reflexes mediated by Aδ ϕιβερσ

A Comprehensive Algorithm for Management of Neuropathic Pain

Pain Medicine, 20, 2019, S2–S12
doi: 10.1093/pm/pnz075
Review Article

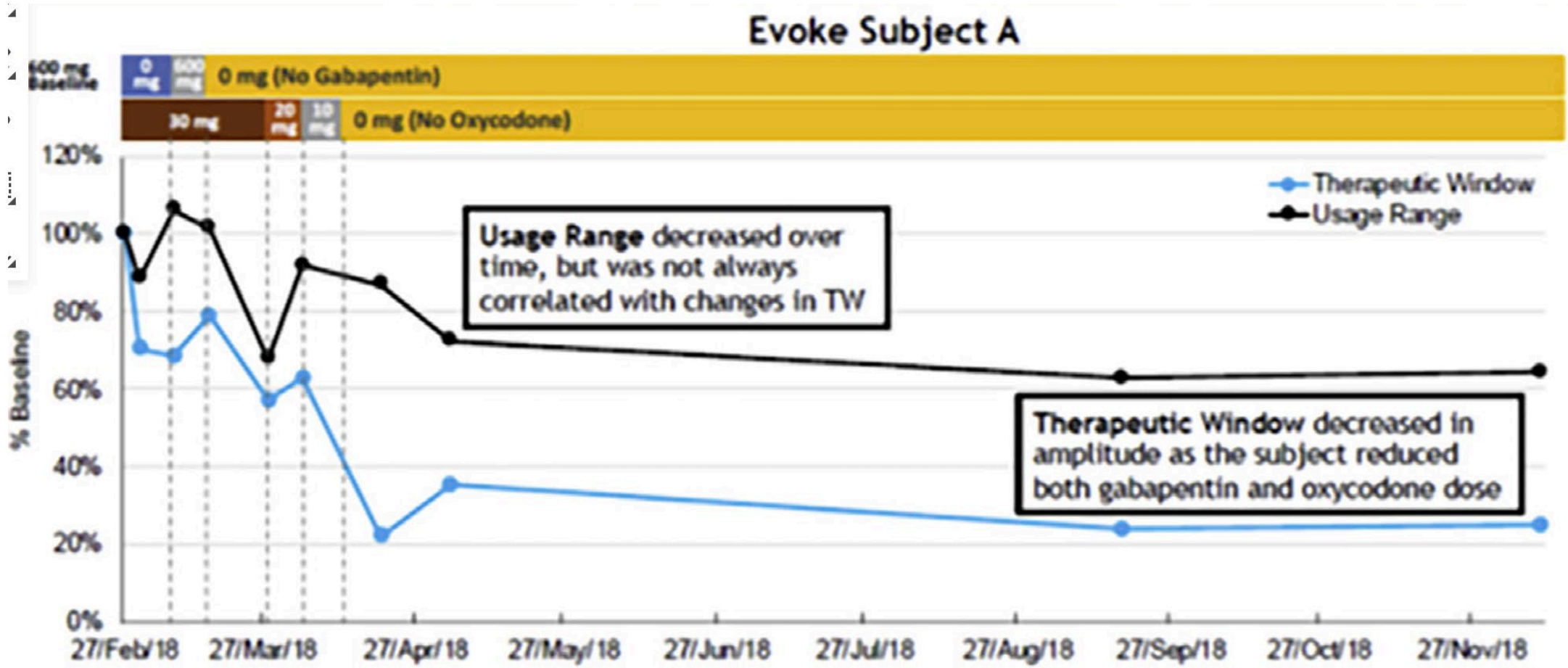
Daniel Bates, MD,* B. Carsten Schultheis, MD, PhD,† Michael C. Hanes, MD,‡ Suneil M. Jolly, MD,§,¶ Krishnan V. Chakravarthy, MD, PhD,‖,|||| Timothy R. Deer, MD, Robert M. Levy, MD, PhD,†† and Corey W. Hunter, MD‡‡**




04
4th Line [1,3,7,8]
Inadequate response to above,
VAS ≥5/10, 6 month of NP
>50% pain relief with trial prior to implant
Neuromodulation
05
5th Line [3,4,8,9,14]
Inadequate response to above
4-6 week trial
Regular 3 month review
Low Dose Opioids
06
6th Line [15,16,17,18]
Inadequate response to neuromodulation, plus
- recommend >50MED
- strongly recommend > 90 MED
>50% pain relief with trial prior to implant
Targeted Drug Delivery

LONG-TERM OPIOID-SPARING EFFECTS OF ECAP-CONTROLLED CLOSED-LOOP SPINAL CORD STIMULATION: EVOKE AND AVALON STUDY RESULTS

Steven Rosen, MD[1], Todd Bromberg, MD[1], Shrif Costandi, MD[2], Michael Sprintz, MD[3], Marc Russo, MBBS[4], Lalit Venkatesan, PhD[5], Mena Mekhail, MD[5], Nathan Taylor, BSc (Hons)[6]



CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Deborah Dowell, MD[1]; Kathleen R. Ragan, MSPH[1]; Christopher M. Jones, PharmD, DrPH[2]; Grant T. Baldwin, PhD[1]; Roger Chou, MD[3]

- Recommendations for opioid prescription for chronic pain by general practioners, apart from cancer pain and palliative care
- Guidelines on:

1. When begin with opioids;
2. Opioid selection, dosage, time, follow-up, stop;
3. Evaluation of risks and prevention of side effects

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Among the 12 recommendations in the Guideline, there are three principles that are especially important to improving patient care and safety:

- ☑ Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- ☑ When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- ☑ Clinicians should always exercise caution when prescribing opioids and monitor all patients closely.

PATIENT CARE AND SAFETY IS CENTRAL TO THE GUIDELINE

Before starting opioids to treat chronic pain, patients should:

- Make the most informed decision with their doctors
- Learn about prescription opioids and know the risks
- Consider ways to manage pain that do not include opioids, such as:
  - Physical therapy
  - Exercise
  - Nonopioid medications, such as acetaminophen or ibuprofen
  - Cognitive behavioral therapy (CBT)

1. OPIOIDS ARE NOT FIRST-LINE THERAPY
2. ESTABLISH GOALS FOR PAIN AND FUNCTION
3. DISCUSS RISKS AND BENEFITS
4. USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING
5. USE THE LOWEST EFFECTIVE DOSE

Reconsider alternative options before increasing the dose over 50 MME
Do not prescribe over 90 MME

6. PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

Usually 3 days therapy is enough

7 **EVALUATE BENEFITS AND HARMS FREQUENTLY** Evaluate the patient al least every 4 weeks

8 **USE STRATEGIES TO MITIGATE RISK** Eventual use of naloxone

9 **REVIEW PDMP DATA** Prescription Drug Monitoring Program

10 **USE URINE DRUG TESTING**

11 **AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING**

12 **OFFER TREATMENT FOR OPIOID USE DISORDER**

It is not true that an early prescription of opioids can prevent chronic pain

Opioids are very useful drugs

but prescription appropriateness and monitoring are fundamental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Podcast
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PILLOLE ALGOLOGICHE