Prevention in the Substance Abuse Patient

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Disclosures

- NONE

Objectives

- Identify the importance of addressing substance abuse in the primary care setting
- Identify useful screening tools for substance abuse
- Review common medical issues unique to patients with substance abuse and how we can address these issues in primary care
- List options for medical management of alcohol, opioid and nicotine dependence
- Review and discuss the treatment of chronic pain in the addicted patient

Background

- In recent years, a number of changes to the healthcare system have made the integration of primary care and substance use disorder treatment a more viable option
- More treatment options for substance use disorders in primary care
  - Buprenorphine
  - Naltrexone
  - Acamprosate
  - Disulfuram
  - Zyban
  - Chantix

Affordable Care Act 10 Essential Benefits

- ambulatory patient services
- emergency services
- Hospitalization
- maternity and newborn care
- mental health and **substance use disorder services**, including behavioral health treatment
- prescription drugs
- rehabilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care.

Substance Abuse Impacts Primary Care

- Infectious disease
  - A leading route of infection for HIV and Hepatitis
- Cardiovascular disease
  - 9 times greater risk of developing congestive heart failure
- Pulmonary disease
  - 12 times greater risk of developing pneumonia
- Liver disease
  - 12 times greater risk of developing cirrhosis

"SBIRT" MODEL

- **S**creening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- **B**rief **i**ntervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **R**eferral to **t**reatment provides those identified as needing more extensive treatment with access to specialty care.

Ask about substance use

- Many validated screening tools
- Tobacco use- now asked at every visit
- AUDIT-C
- AUDIT
- CAGE
- DAST-10
- “In the past year, how often have you used…?”

NIDA Quick Screen

In the past year how often have you used the following?	Never	1-2 times	Monthly	Weekly	Daily Or almost
Alcohol Men- 5 drinks per day Women-4 drinks per day					
Tobacco					
Prescription drugs for non-medical reason					
Illegal drugs					

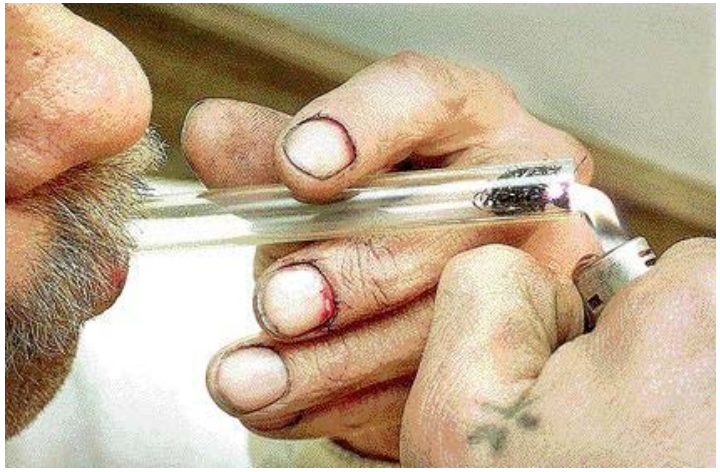
So what do we do next?

- Positive screen for abuse or misuse
  - Assess readiness for change
  - Offer treatment if interested
  - Not ready to quit?
    - DON'T JUDGE
    - TREAT THE PATIENT FOR GENERAL HEALTH

Route of drug use

- Ask about the route of use

Smoked drugs

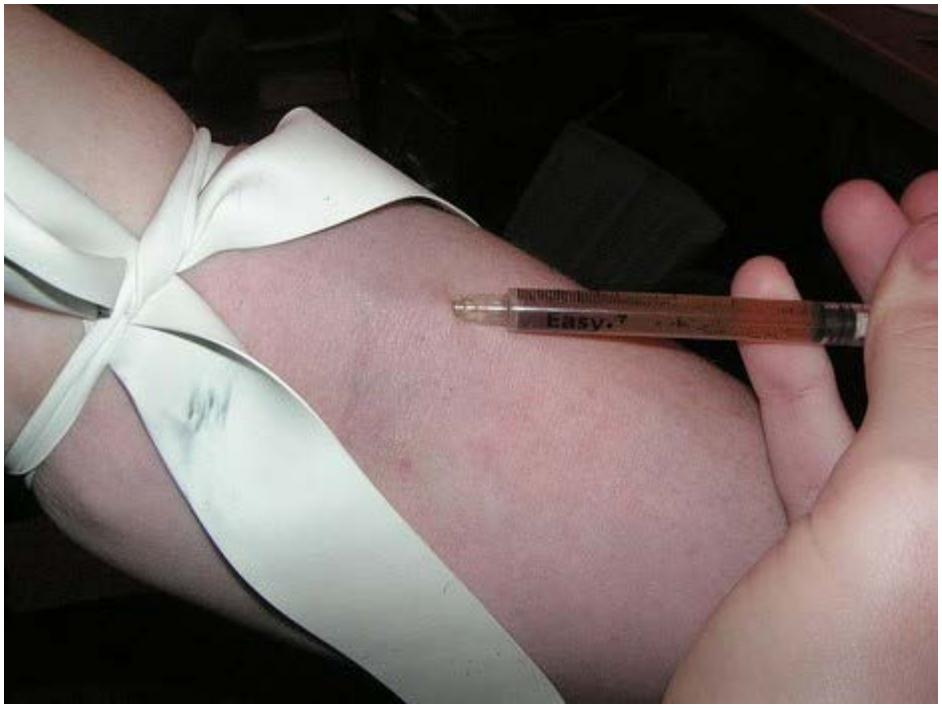


Intranasal

- Tobacco
- Heroin
- Cocaine
- Methamphetamines
- Opioid pills

Intravenous

- Heroin
- Cocaine
- Methamphetamines



Oral ingestion

- Alcohol
- Tobacco – chewing
- Marijuana
- MDMA/Ecstacy/GHB
- Cocaine
- Methamphetamines

Inhalants


RONSON
SPOT SHOT
Zippo
SPARKWHITE
WD-40
CoolWhip
Sharpie MAGNUM

Medical complications by route

- Smoking
  - Infection
    - Bronchitis
    - pneumonia
  - Pulmonary emboli
  - Pulmonary hypertension
  - COPD
  - Asthma
  - Respiratory suppression with opioids

Medical Complications by Route

- Inhalants
  - Similar to smoking
  - Toxins can affect all organ systems

- Intranasal use
  - Infections
  - Chronic sinusitis
  - Nasal septal defects
  - Can transmit HIV or Hepatitis C

Medical complications by route

- Oral
  - Gastrointestinal symptoms
  - GERD
  - Variation in intoxication
    - May have longer onset, but longer duration
- Intravenous
  - Skin infections
  - Pulmonary infections
  - Septic emboli
  - Endocarditis
  - HIV
  - Hepatitis C

Immunizations

- Tdap, Td
- Annual Flu
- Consider Pneumovax prior to age 65
  - Especially with smoking and inhaling
- Consider Hepatitis A and Hepatitis B vaccines
  - Especially in IV and intranasal drug use

Hepatitis C

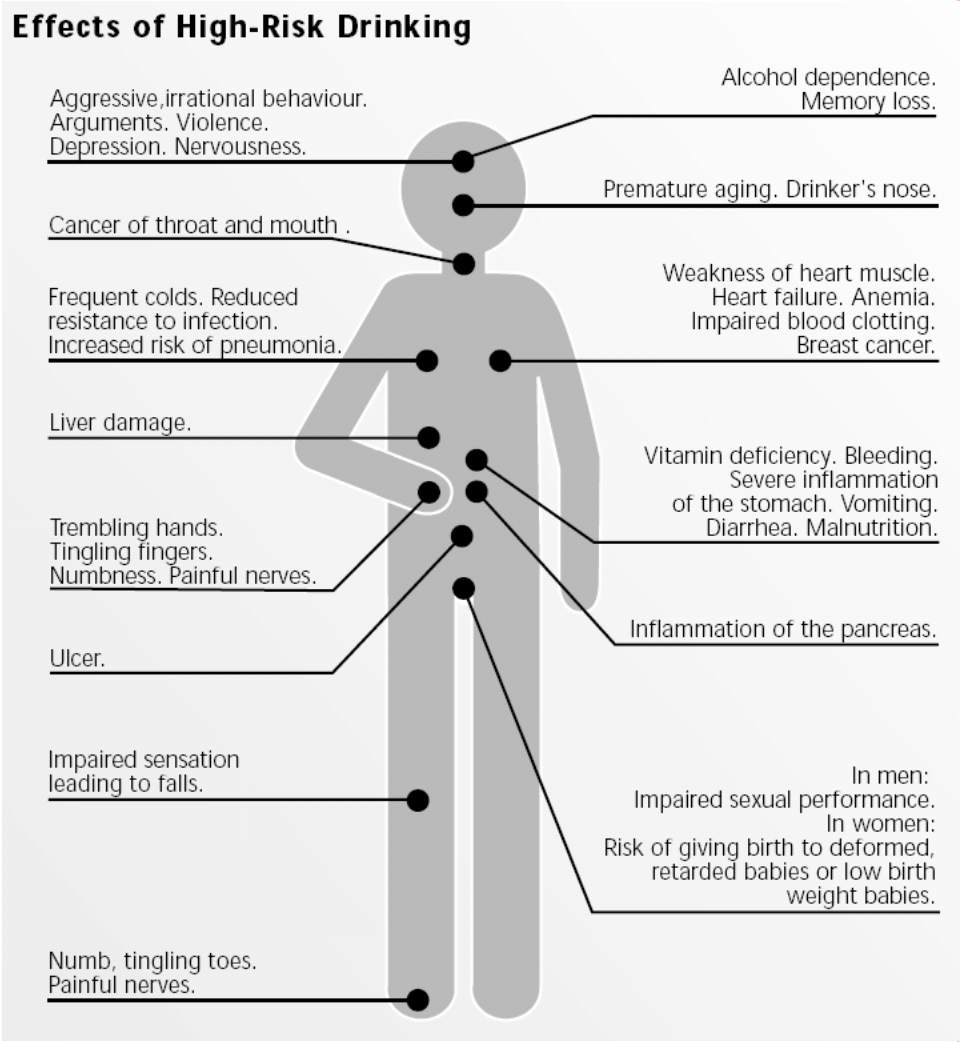
- Yearly monitoring of liver function
  - CBC, LFTs, vitamin D
- Immunizations
  - Hepatitis A and B
  - Pneumovax
  - Annual flu vaccin
- Control comorbidities
  - Diabetes
  - Obesity
- Referral for treatment
  - New treatments are making treatment options more promising
- Hepatocelluar carcinoma screening
  - Only if cirrhosis

Monitoring the drinker

- Standard Drink- 14gm alcohol
  - Beer 12 oz
  - Wine 5 oz
  - Liquor 1.5 oz
  - Microbrew 8-10 oz
  - Malt liquor 6-8oz
- At risk- at any time
  - Men > 4 drinks in a day
  - Women > 3 drinks in a day

Hazardous Drinking

- – All-cause mortality
- – Hypertension
- – Cardiomyopathy
- – Diabetes
- – Trauma
- – Stroke
- – More serious alcohol
- disorders
- – Cancers
- ~ particularly upper GI
- and breast cancers



Monitoring the drinker

- Screen for hypertension regularly
  - Coronary Artery Disease
  - Cardiomyopathy
  - Arrhythmias
- Gastrointestinal Disorders
  - GERD
  - Gastric and Peptic Ulcers
  - Pancratitis
- Renal
  - Electrolyte disturbances
  - Hepatorenal syndrome
  - Rhabdomyolysis

Monitoring the drinker

- Psychiatric disorders
  - Anxiety
  - Depression
  - PTSD
- Sleep disorders
  - Insomnia
  - Sleep cycle disturbance
- Nutritional deficiency
  - Vitamin deficiencies
- Liver disease
  - Alcoholic hepatitis
  - Fatty liver
  - Cirrhosis

Medical Management- Alcohol

- Naltrexone
  - 50mg daily
  - Monitor liver function
  - Cannot use with opioid medications
- Acamprosate
  - 666mg three times daily
  - Monitor renal function
- Disulfuram
  - 250mg – 500mg daily
  - Monitor liver function
  - Avoid all alcohol containing items
    - Medications
    - Foods
    - toiletries

Cirrhosis

- High risk complication in patients with substance abuse
- Progression of disease
  - 20% with alcohol alone
  - 20% with hepatitis C alone
  - 90% with hepatitis C and concurrent alcohol use
  - Marijuana may also worsen risk of fibrosis in hepatitis C

Complications of Cirrhosis

- Variceal hemorrhage
- Ascites
- Spontaneous bacterial peritonitis
- Hepatic encephalopathy
- Hepatocellular carcinoma
- Hepatorenal syndrome
- Hepatopulmonary syndrome

Monitoring Cirrhosis

- Monitor liver function every six months
  - CBC, LFTs, vit D, PT/INR, Chem 10
- Hepatocellular carcinoma screening every six months
  - AFP
  - RUQ ultrasound
- Esophageal variceal screening
  - EGD annually

Management of Cirrhosis

The major goals of managing patients with cirrhosis include:

- Slowing or reversing the progression of liver disease
- Preventing superimposed insults to the liver
- Identifying medications that require dose adjustments or should be avoided entirely
- Managing symptoms and laboratory abnormalities
- Preventing, identifying, and treating the complications of cirrhosis
- Determining the appropriateness and optimal timing for liver transplantation

Monitoring the opiate user

- Harm reduction
  - Education
  - Needle exchanges
  - Narcan programs
- Medical complications
  - Gastrointestinal
    - Constipation
    - Laxative misuse
  - Pulmonary
    - Respiratory suppression
    - Pulmonary hypertension

Medical Management- Opioids

- Methadone
  - Must be treated in a site specifically qualified to treat with methadone
- Buprenorphine (Suboxone)
  - Office based treatment
  - Primary care can make the biggest impact
  - Requires special training and DEA wavier
- Naltrexone
  - Opioid antagonist
  - Blocks opioid from receptor
  - Compliance is an issue

Monitor the nicotine user

- Tobacco use is the leading cause
  - Coronary Artery Disease
  - Cancer
  - Chronic bronchitis
  - Chronic Obstructive Pulmonary Disease
  - AAA screening in all men age 65-75 who have ever smoked
- Tobacco and Nicotine also causes
  - Gastroesphageal reflux disease
  - Peptic ulcer
  - Sleep disturbance
  - Mouth cancers

Medical Management - Nicotine

- Nicotine replacement
  - E-Cig is not nicotine replace

- Buproprion
  - Initial dose 15mg daily
  - Maintenance dose 150mg BID
  - Continue for at least 7 weeks after quit date
- Varenicline
  - Taper dose 0.5mg daily x 3 days, then 0.5mg BID x 4 days
  - Maintenance dose 1mg BID
  - Continue 12 weeks
  - Monitor for suicidality

Monitoring the stimulant user

- Monitor for hypertension
- Acute coronary syndrome
- Increased progression of atherosclerosis
- Rhabdomyolysis
- No specific guidelines on these patients
- Suggest echocardiogram to monitor
  - Cardiomyopathy
  - Pulmonary hypertension
  - Interval unknown

Chronic Pain and Addiction

- Chronic pain is common in substance abuse patients
- Many patients self medicate with other substances or purchase opioid medications off the streets
- Tolerance may be complicating the picture

Managing pain in the addicted patient

- Complicated
- Generalized fear of prescribing opioid medications to an addict
- Scrutiny by governing entities and uncertainty about laws and regulations
- Moral vs. social views on addiction
- Clinical concerns about causing or contributing to addiction

Prescribing opioids to the addicted patient

Potential risks of prescribing

- Prescribed opioid may serve as a trigger for relapse
- Difficulty controlling use
- Patient may feel pressure to "supply" friends
- Patient may be tempted to sell meds to supplement income

Potential risk of NOT prescribing

- Continued addiction and self-medication of pain
- Unsuccessful detox due to pain with withdrawal
- Increased distress leads may trigger relapse to use alcohol or drugs

Addiction alters the pain experience

- Both stimulant and opioid abuses have less pain tolerance than peers in remission or matched controls
- Former opioid abusers have decreased pain tolerance to pain compared to non-addict siblings
- HIV infected patients with h/o substance abuse required higher doses of opioid analgesics than patients without a hx of substance abuse
- Therefore, patients with a history of addiction may be more pain sensitive and require higher doses

- Martin J (1965), Ho and Dole (1979) Compton (1994, 2001) Swica (2002)

Can opioid medications be used?

- Opioids can be effective and safe in an addicted patient
- Patients on chronic opioid medications should be assessed for risk of misuse
- Predicting and diagnosing addiction in patients with chronic pain can be challenging
- Patients with a history of opioid dependence, including those on maintenance therapy (methadone, buprenorphine), have a lower pain tolerance
- Acute management of pain requires continuation of maintenance opioid, with addition of higher doses of opioid

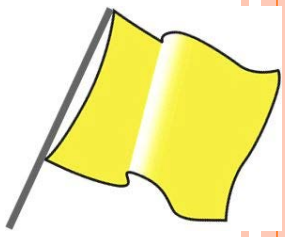
How do I do this in my practice?

- Take a thorough pain history
- Take a thorough social history
- Take a thorough substance use history
- Used opioid risk screening tools
- Use nonopioid medications and adjunctive therapies
- Don't judge the patient based on their substance use, treat them as a person with pain

Monitoring for misuse

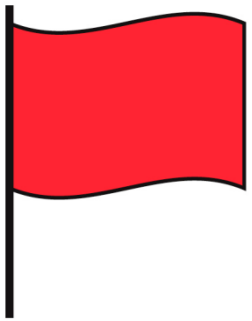
- Universal Precautions
  - Agreements/Contracts
  - Monitor for aberrant behavior
  - Monitor for adherence, addiction, and diversion
    - Urine drug screens
    - Pill counts
  - Initial small quantities and frequent visits
  - Establish a refill and cross coverage system
  - Prescription monitoring program

Aberrant Behaviors
Less Predictive of Addiction



- Complaints about need for more medication
- Drug hoarding
- Requesting specific medications
- *Openly* acquiring similar medication from other providers
- Occasional unsanctioned dose escalation
- Non-adherence to other recommendations for pain therapy

Aberrant Behaviors
More predictive of addiction



- Deterioration in functioning at work or socially
- Illegal activities- selling, buying, forging
- Injecting or snorting medications
- Multiple episodes of “lost” or “stolen” medication
- Resistance to change therapy despite adverse effects
- Refusal to comply with random drug screens
- Concurrent use of alcohol or illicit drugs
- Use of multiple physicians and pharmacies

When enough is enough!

- It is okay to discontinue the opioid medications and offer other medical therapies
- Refer to treatment for addiction if indicated
- Express concern, not what you may really feel inside…

If we all help treat this population, there is hope

- Questions?
- Comments?