Can We Identify Patients at Risk for Opioid Use Disorder when Beginning Opioid Analgesics for Pain from New or Ongoing Non-cancer Causes?

By Jan Klimas, PhD; Michee-Ana Hamilton, MSc; Malcolm Maclure, ScD; Rita McCracken, MD, CCFP, PhD (https://thischangedmypractice.com/opioid-use-disorder-opioid-analgesics-for-pain/) on August 24, 2021

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What frequently asked questions we have noticed

There is growing recognition that opioid prescribing can lead to prescription opioid use disorder (OUD).[1] It is estimated that nearly 115,000 British Columbians have become addicted to opioids.[2] This is mainly due to unsafe opioid prescribing and the fentanyl-contaminated street drug supply.[3] There is a need to safely reduce the volume of new opioid prescriptions for opioid naïve patients.

Rates of opioid prescribing and availability are strongly correlated with rates of opioid overdose death in British Columbia (BC).[4] Over 70% of men and nearly 50% of women who have died of a prescription opioid overdose death have not had an active prescription in the 60 days prior to their death.[5] This suggests there is significant diversion of prescription opioid medications in the Province.

Over 80% of people who use heroin say they initially started with prescription opioids.[6,7] Youth are often introduced to opioid use through diverted prescription opioid medications, which research has shown that these are incorrectly perceived as being safer than illegal street opioids like heroin.[8,9] As such, the optimal mechanism for prevention remains with the promotion of safer prescribing among physicians, dentists and other prescribers.

Opioid addiction is a large problem and some is due to unsafe opioid prescribing.[10-12] Although prescription opioid addiction or OUD is associated with substantial morbidity and mortality, most at-risk patients never develop this disorder. It is estimated that approximately 0.5-26% of persons prescribed opioids for pain develop physical dependency;[13-15] conversely, approximately 72-99.5% of individuals will not develop prescription OUD. Predicting its occurrence is important because the mortality rate is high when untreated.

Up to now, ways to screen and identify patients at high- versus low-risk of developing a prescription OUD have not been critically appraised. There appears to be a disconnect between the evolving evidence on prescribing opioids for pain and the standards in the College of Physicians and Surgeons of British Columbia (CPSBC), and Canadian pain guidelines.[16,17] A meta-analysis (96 trials of patients with chronic noncancer pain) showed opioid medications were of little added value in comparison to non-opioid alternatives.[18] High-quality studies showed that opioid use was associated with statistically significant improvements in pain and physical functioning, but the improvements were small and the risk of side effects compared with placebo increased. The benefit for pain and functioning may be similar to non-opioid approaches, although the evidence was from studies of only low to moderate quality.

There is a growing acknowledgement that some people develop prescription OUD when prescribed opioids while others do not. Several tools to screen and identify patients at high- versus low-risk of developing prescription OUD when opioids are prescribed have been developed. Nevertheless, can we identify patients at risk for OUD when beginning opioids for minor acute and chronic noncancer pain? What is the best (acceptable) practice when there is little or poor evidence?

Data that answers these questions or gaps

Evidence, or lack thereof, for opioid analgesics to treat minor acute and chronic noncancer pain

The BC Centre on Substance Use conducted a systematic review to analyze tools to safely reduce opioid use in opioid naïve patients, published in the *Journal of American Medical Association* Network Open.[19] Original studies that were included compared risk factors and risk assessment tools among patients who developed prescription OUD and patients who did not.

- 31 studies evaluated risk assessment tools for prescription OUD yet only two studies (of five individual tools) met the quality standards and thus were included.[20,21] Data were extracted and used to calculate likelihood ratios (LR), sensitivity and specificity.
- All screening tools, including the most commonly used tool in BC, the Opioid Risk Tool[22], have extremely poor diagnostic The Prescription Medication Questionnaire (PMQ) appeared useful for patients with pain disorders with a score above or equal to 30, though a score below 30 was not particularly useful for decreasing the likelihood.[20]
- Six other studies evaluated individual risk factors for prescription OUD, and four of them met the quality standards and thus were considered. These studies included 2,888,346 patients and 4470 cases that met the authors' definition of prescription OUD.[20,21,23,24] No individual symptoms, signs, or risk factors were amenable to meta-analysis (see Table).

What we recommend (practice tip)

Screening tools that are in widespread use for predicting risk of opioid addiction in opioid naïve patients are based on low quality studies and/or are not helpful. A history of opioid or other substance use disorders, certain mental health disorders and concomitant prescription of certain psychiatric medications (e.g., antipsychotics) may increase a patient's risk of prescription opioid addiction.

Only the absence of an affective disorder was modestly useful for patients at lower risk. Physicians currently have no valid way to identify opioid-naïve patients at high risk of OUD when beginning opioids. Given the scarcity of risk factors that have some evidence, patients should be warned about the risk of prescription opioid addiction and suggested instead other agents or approaches. In the absence of a valid way to identify opioid-naïve patients at high risk of OUD when beginning opioids, we recommend physicians to think twice, exercise caution and generally avoid making assumptions about patient risk of subsequent prescription OUD. A dedicated UBC Therapeutics Letter suggests that prescribers[25]:

1. assess pain in terms of effect on daily function, sleep, and quality of life
2. if appropriate, recommend non-pharmacological treatments (heat/ice, physiotherapy)
3. educate about benefit expectations and limitations of pain treatments
4. if non-pharmacological therapy is inadequate or not an option, start with nonopioid pharmacological treatments (e.g., acetaminophen, NSAIDs),
5. if a prescription for opioids is still indicated (e.g., very severe acute pain), prescribe at the lowest dose for the shortest duration (e.g., <1 week), and
6. follow-up post-opioid prescription to reassess daily function, sleep, and quality of life, and, if not addressed, do not continue with short duration of medications.

Further to these recommendations, the physicians could consider using an Electronic Medical Records (EMR) template/ script like the statements:

- I advised the patient of the risk of opioid addiction and suggested not to give opioids unless as a last resort.

- I advised patients that our screening tools for predicting risk of opioid addiction in opioid naïve patients are based on low quality studies and/or are not helpful.

Prescriber heal thyself

In early 2020, the Portrait program to improve safety of opioid prescribing in primary care has been launched in BC by the Therapeutics Initiative (www.ti.ubc.ca/portrait (http://www.ti.ubc.ca/portrait)), with our assistance: mailing individual prescribing portraits to an 'early group' of 2604 Family Physicians (December 2020), followed six months later in June 2021 by a mailing to 2553 Family Physicians in the 'delayed group'. The program invited physicians to re-consider opioid prescription to primary care patients who are opioid naïve presenting to their primary care clinics with pain from new or ongoing non-cancer causes, such as: new or chronic MSK issue (e.g., ankle sprain), mechanical low back pain, osteoarthritic knee pain, rotator cuff pain, dental pain, etc.

The Portrait contains a graphical illustration of the number of opioid naïve patients initiated on prescription opioids in the past 3 years, a breakdown of opioid prescriptions to opioid naïve patients in 2020 and a graph showing the typical new opioid prescription strength for opioid naïve patients in 2020 in morphine equivalents daily (MED) dosage for the individual prescriber compared with the median BC primary care prescriber. To view this sample Portrait in PDF format view: Portrait Opioid Updated (https://www.ti.ubc.ca/wordpress/wp-content/uploads/2021/06/Portrait_Opioid_Updated-Logos.pdf) . This sample Portrait contains fictional individual physician data.

If you are a BC family physician, and wish to sign up for (or opt out of) receiving Portrait click on the REGISTER https://flex.redcap.ubc.ca/surveys/?s=4TT4RFNY48 (https://flex.redcap.ubc.ca/surveys/?s=4TT4RFNY48) button. You are also offered a low-barrier chance to "opt out" of receiving Portrait, at any time using phone, fax, or email. Researchers are currently looking at the impacts of the Portrait program in a randomized controlled trial (REDONNA).[26]

For more information, check out the Portrait program at this link: Sparing-opioid-prescription-to-opioid-naive-patients (https://www.ti.ubc.ca/2021/06/02/sparing-opioid-prescription-to-opioid-naive-patients/) .

Or, attend an interactive and free webinar for Family Physicians (licenced to practice in BC), and Nurse Practitioners, to learn more about the evidence, or lack thereof, for opioid analgesics to treat minor acute and chronic non-cancer pain.

- Sep 15 at 5.30PM http://bit.ly/REDONNA1 (http://bit.ly/REDONNA1)
- Sept 29 at 5.30PM http://bit.ly/REDONNA2 (http://bit.ly/REDONNA2)
- Oct 13 at 12PM http://bit.ly/REDONNA3 (http://bit.ly/REDONNA3)

Once registered, you will receive a link for the session by email. If you have indicated interest in participating in the focus group discussion following the webinar, you will receive an email with more information about this. For more information or assistance please contact the Research Coordinator: michee.hamilton@ubc.ca (mailto:michee.hamilton@ubc.ca) .

Table. Characteristics of opioid risk assessment tools from high quality studies included in quantitative synthesis. * (PDF (http://med-fom-tcmp.sites.olt.ubc.ca/files/2021/08/Risk-for-Opioid-Use-Disorder-Table.pdf))

Instrument[a]	Study	No. of Items	Scope	Response Format	Before or during opioid therapy	Score Range	Usual Cutpoint	Literacy Level	Administration or Completion Time, min	Quality score
PMQ	Jones 2015[21]	26	Specific to prescription opioids in chronic pain care	0="Never"/ "Disagree" to 4="4+ times" / "Agree"	During	0-104	<20.5: low risk 20.5-30.0: moderate 33.3-66.7: high	easy	~10 min	3
ORT	Jones 2015[21]	10	Specific to prescription opioids	Yes or No	Before	0-26	0-3: low 4-7: moderate ≥8: high	easy	<1 min	3
BRQ	Jones 2015[21]	12	Specific to prescription opioids for chronic pain	Yes or No and Rating Scales	During	0-24	≥3	easy	unclear	3

BRI	Jones 2015[21]	12	Specific to prescription opioids for chronic pain	Rating Scales from low- to very high risk	During	n/a	At least 1 area with the highest risk rating	easy	6-12 min	3
SOAPP	Akbik 2006[22]	14	Specific to prescription opioids in chronic pain care	0="Never" to 4="Very Often"	Before	0-56	≥8	easy	<8 min	3

[a]See eTable 2 for full list and description of all available screening tools. PMQ = Prescription Monitoring Questionnaire; ORT = Opioid Risk Tool; BRQ = Brief Risk Questionnaire; BRI = Brief Risk Interview; SOAPP = Screener and Opioid Assessment for Patients with Pain.

[*]Published with permission from JAMA Network Open (2019;2(5):e193365-e193365). Quality scores range from 1-5 (5 = highest quality)

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