Balancing Relief and Risk:
Confronting the Duality of Chronic Pain and Opioid Addiction

Tabitha Davis Stellato, MD, FASAM, FAAFP
Associate Program Director
McLeod Family Medicine Residency

Financial Relationship Disclosures for

Tabitha Davis Stellato, MD

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Who am I?


1815
ALLEGHENY
COLLEGE


Jefferson


AxessPointe
Community Health Centers


McLeod Health
The Choice For Medical Excellence


WASHINGTON HEALTH SYSTEM

Objectives

- Diagnose Opioid Use Disorder (OUD) and begin treatment with support
- Discuss risks and benefits of opioids for chronic pain and how to mitigate such risks
- Understand the use of buprenorphine for chronic pain

First a patient...

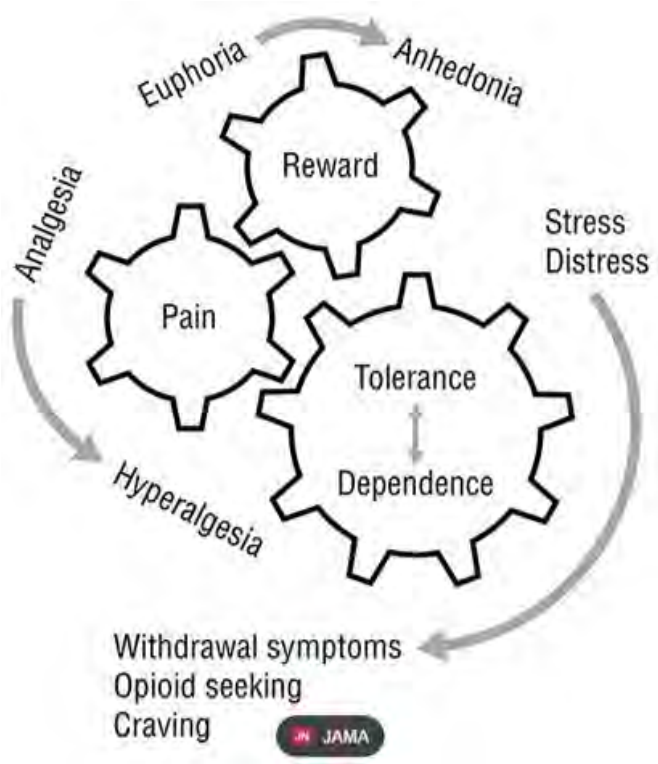
- 26-year-old female comes to you for suboxone therapy
  - Previously has used heroin, pills, fentanyl and even her late boyfriend's suboxone when he could spare one
  - Boyfriend died 2 months ago, and she went to rehab for the last 60 days
  - Hx of benzodiazepine use for sleep
  - Also smokes THC almost daily
  - Wants to get on meds so she does not return to use since leaving rehab

Opiate? Opioid?

- Opiates are naturally occurring – ie heroin, morphine, codeine
- Opioids include opiates and all the synthetic compounds
  - Includes oxycodone, oxymorphone, tramadol, fentanyl
  - Any many more

Opioids and Addiction

- Dependence: relying on the medication to live normally
- Tolerance: no longer responding to a drug and needing a higher dose to achieve the same effect
- Withdrawal: physical or mental symptoms when a drug is decreased or stopped
- Addiction: repeated, compulsive behavior driven by feelings of reward

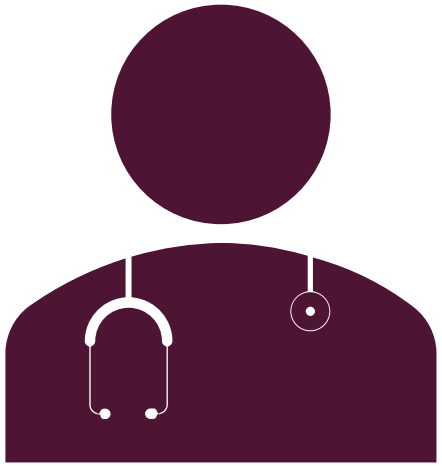


Opioid Use Disorder – DSM V Criteria

- A problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least 2 of the following occurring over a 12-month period:
  - Taking larger amounts or over a longer period than intended
  - Persistent desire or unsuccessful effort to cut down or control use
  - Great deal of time is spent obtaining, using and recovering from using opioid
  - Cravings or strong desires to use
  - Continued use despite interpersonal or social problems
  - Obligations at work, school or home are given up or reduced
  - Recurrent use where it is physically hazardous
  - Continued use despite knowing that there is psychological or physical problem
  - Tolerance*
  - Withdrawal*

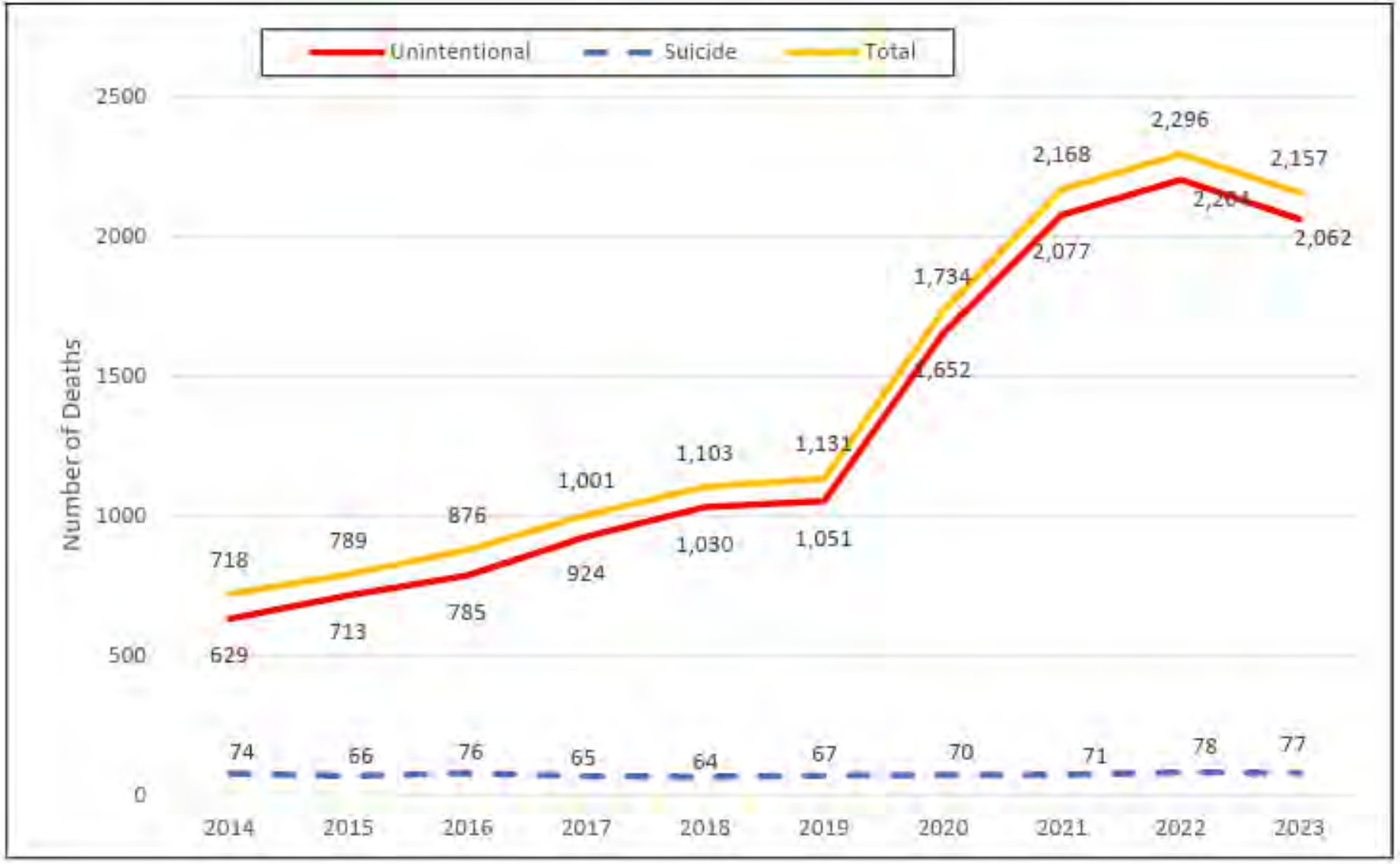
Opioid Use Disorder – DSM V Criteria

OUD = compulsion + lack of control + consequences + craving

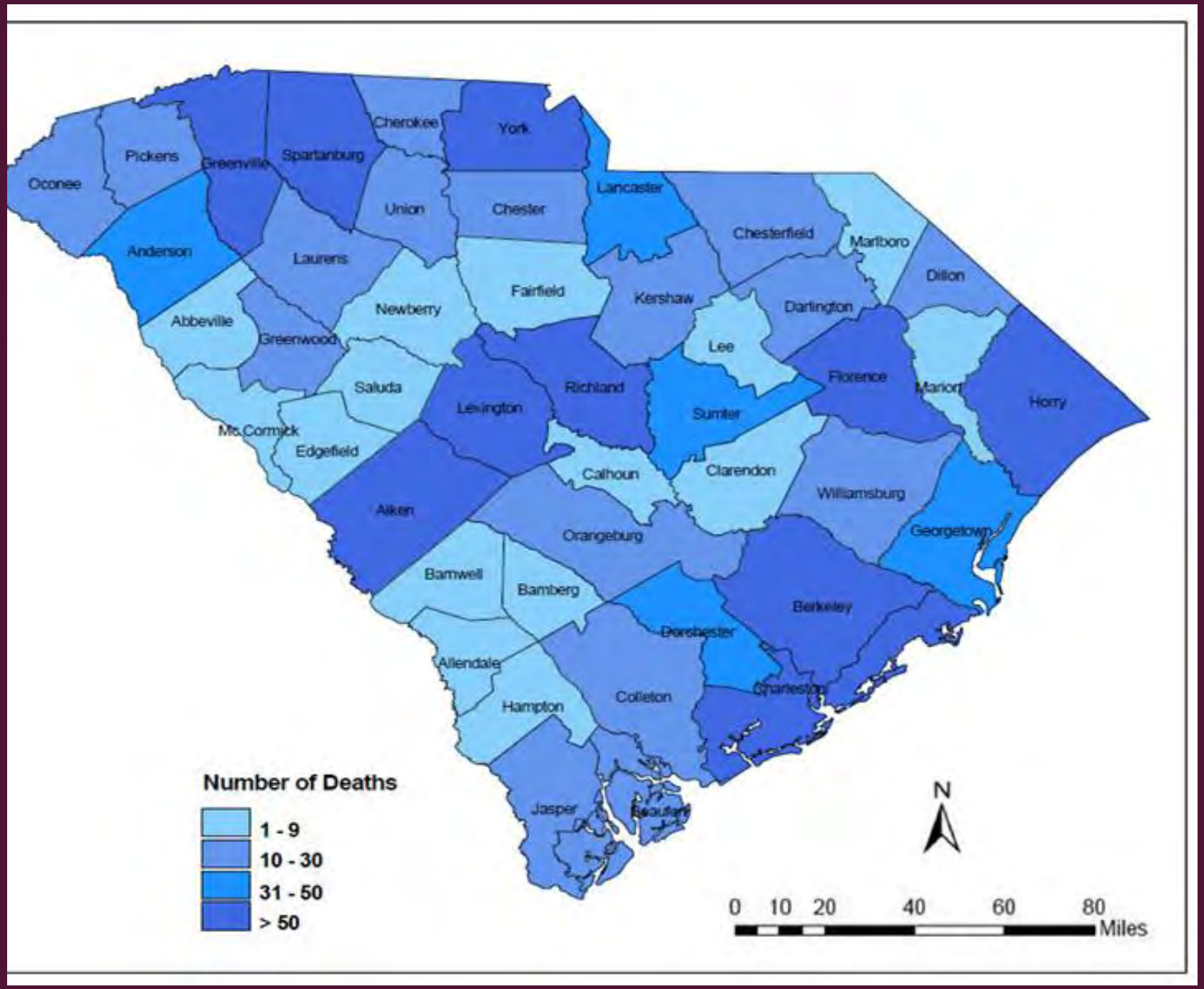


What do patients with OUD look like?

Number of Drug Overdose Deaths by Intent
South Carolina, 2014-2023
Occurrence Data



Opioid deaths by county in 2023

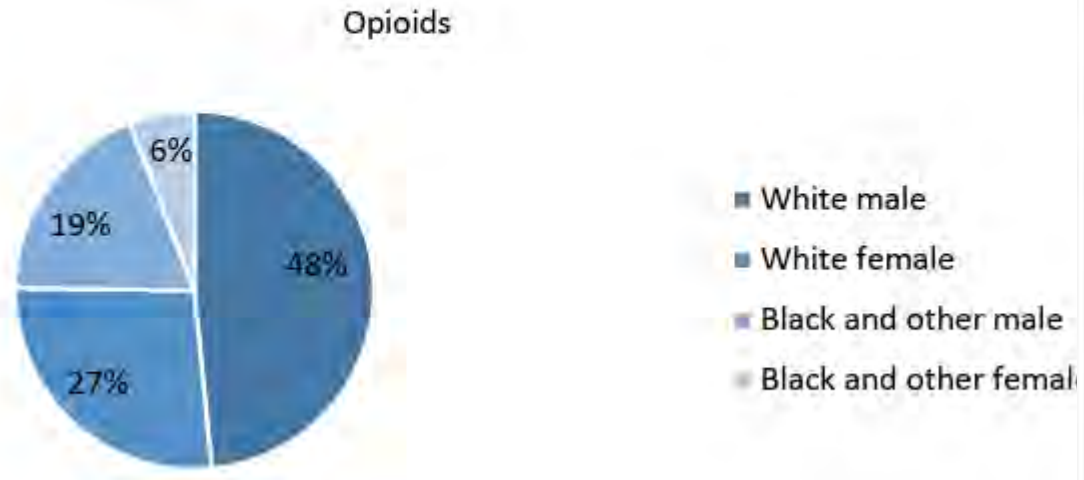


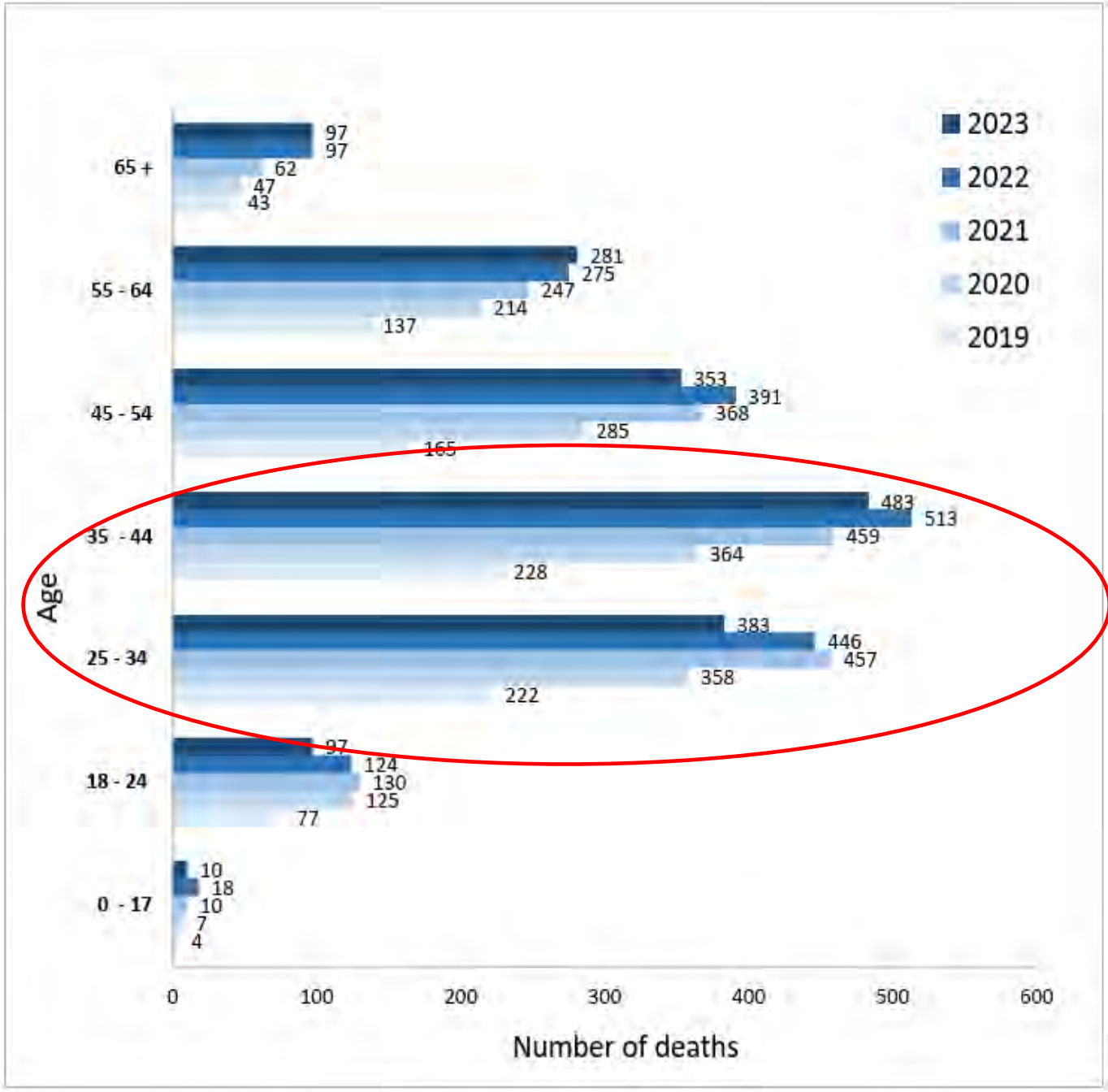
Drug Overdose Death by Substance

Table 2.
Number of Drug Overdose Deaths by Category and Selected Drugs
South Carolina, 2019-2023
Occurrence Data

Year	Total Drug Overdose	Prescription Drugs	Opioids	Psychostimulants with Abuse Potential	Fentanyl	Heroin	Methadone	Cocaine
2019	1,131	923	876	338	537	196	28	230
2020	1,734	1,463	1,400	551	1,100	244	46	352
2021	2,168	1,853	1,733	778	1,494	136	69	446
2022	2,296	1,982	1,864	794	1,660	54	58	562
2023	2,157	1,840	1,704	765	1,550	24	53	591

Select Drug Categories by Race/Sex
South Carolina, 2023
Occurrence Data





"Opioid Epidemic"

Declared a ***public health emergency*** in the US by the Department of Health and Human Resources and by Governor McMaster in the state of SC in December of 2017

Economic Impact

Economic Impact

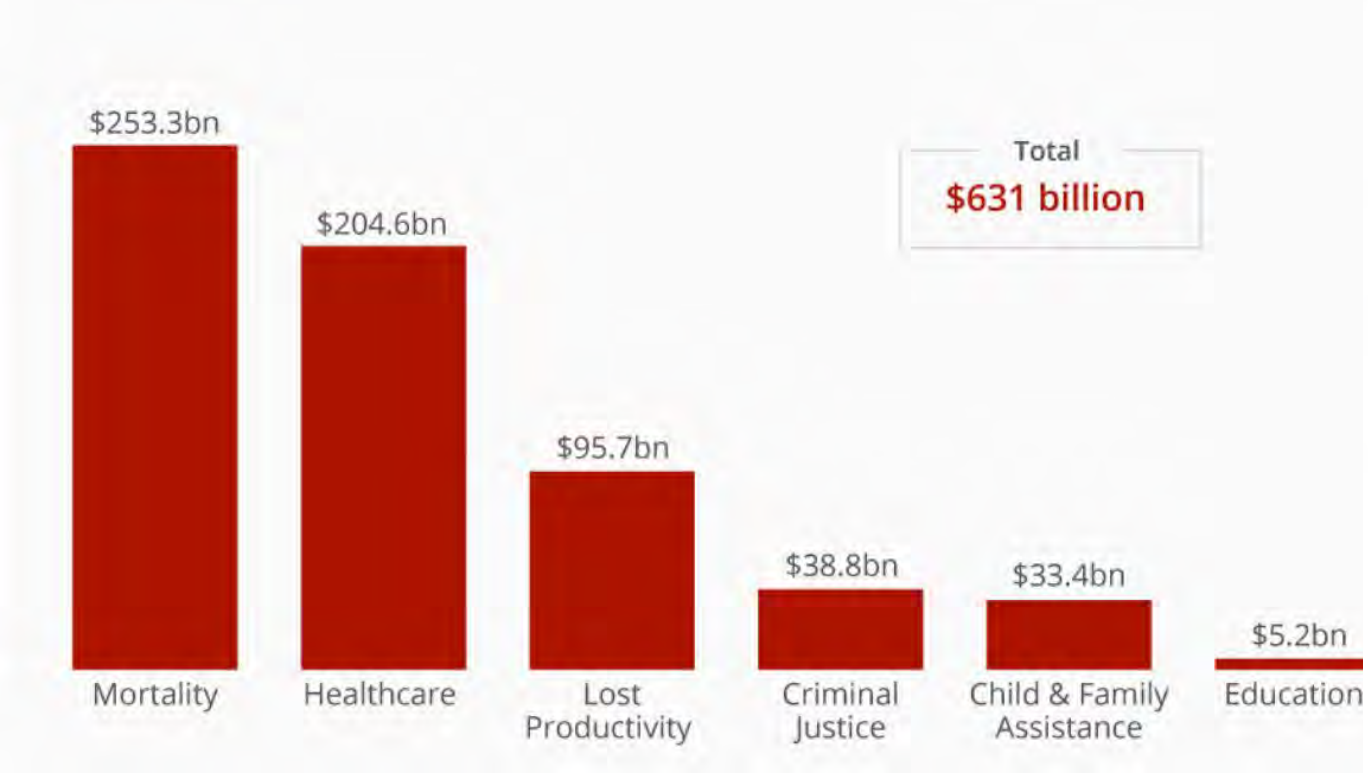
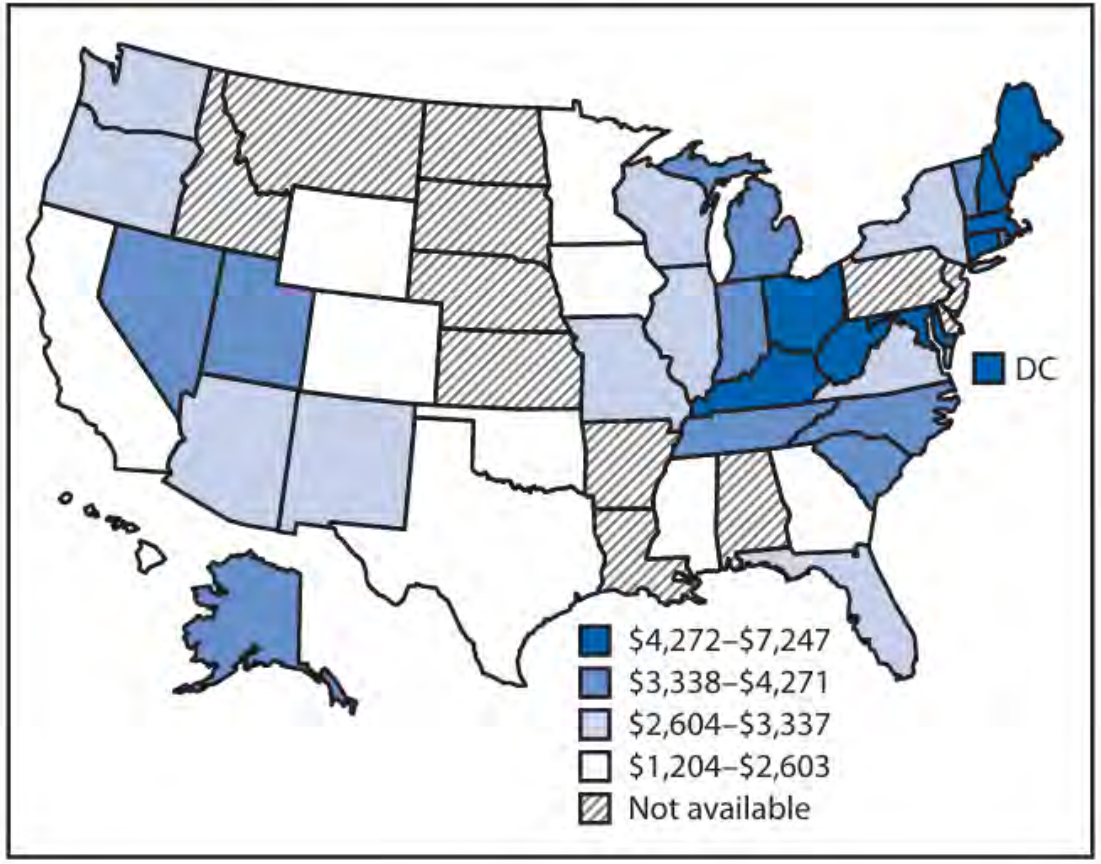


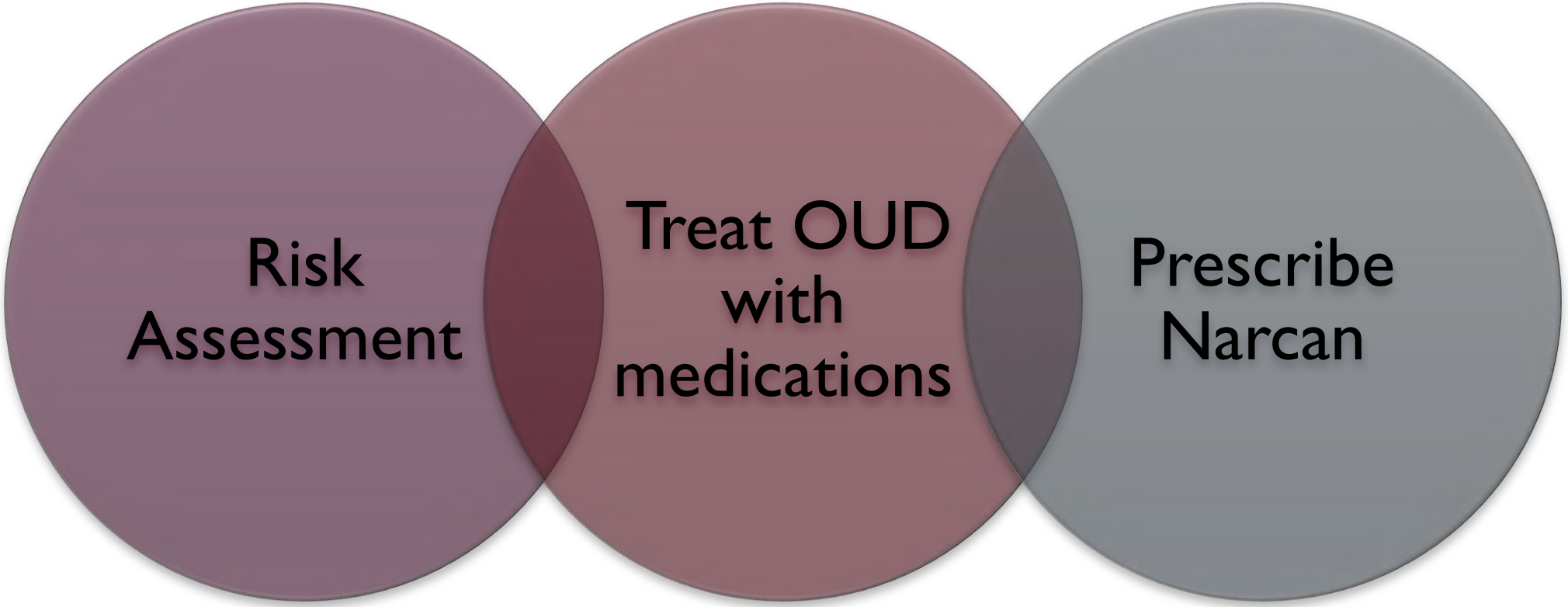
FIGURE. Per capita combined costs* of opioid use disorder and fatal opioid overdose — United States, 2017



We Have a Problem

- How do we fix it?
  - As a PCP? As a specialist?
  - As a health system?
  - As a community?

3 Ways to Combat Opioid Epidemic



Opioid Prescribing

Figure 2. Number of controlled substances dispensed by drug class, 2019 - 2023

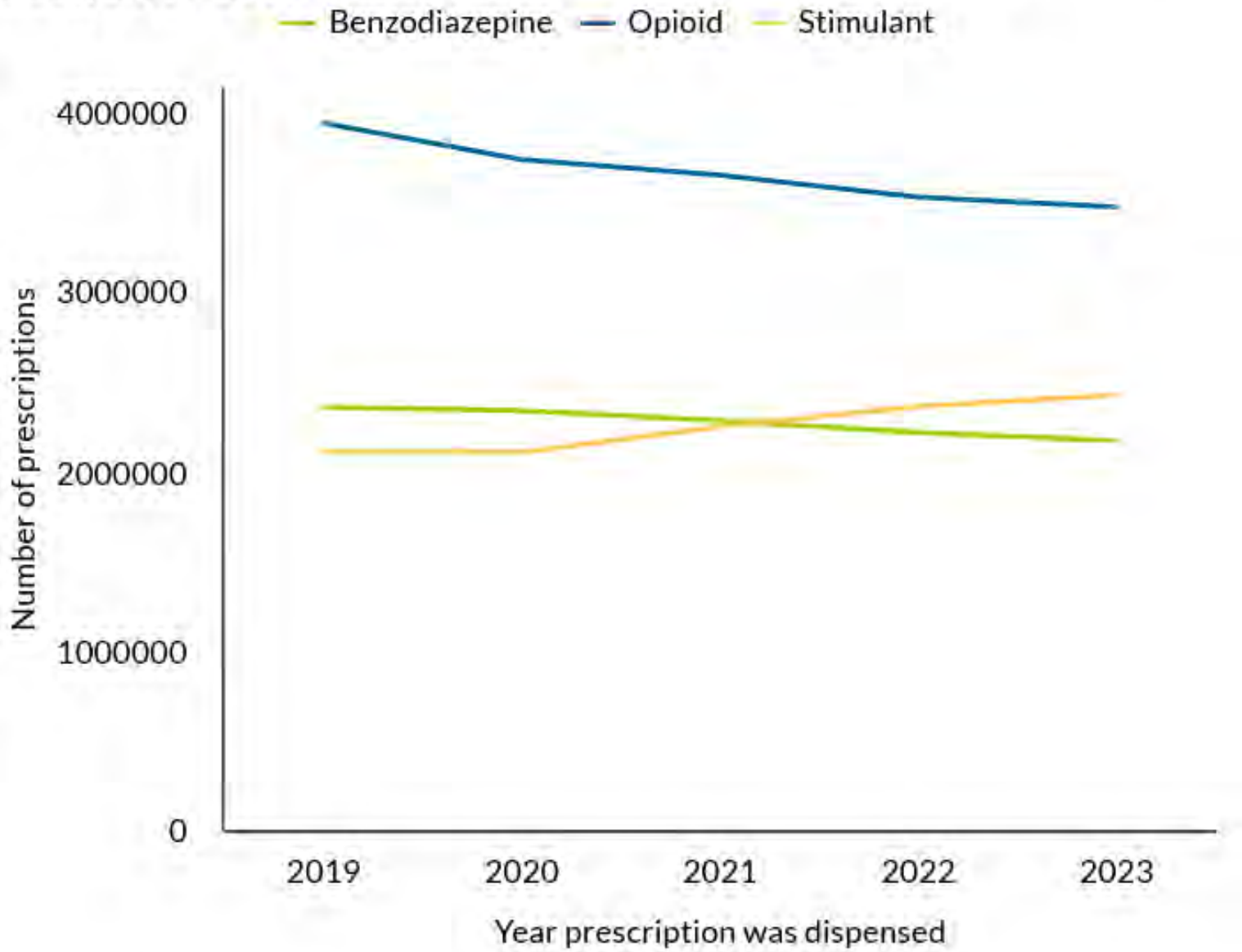
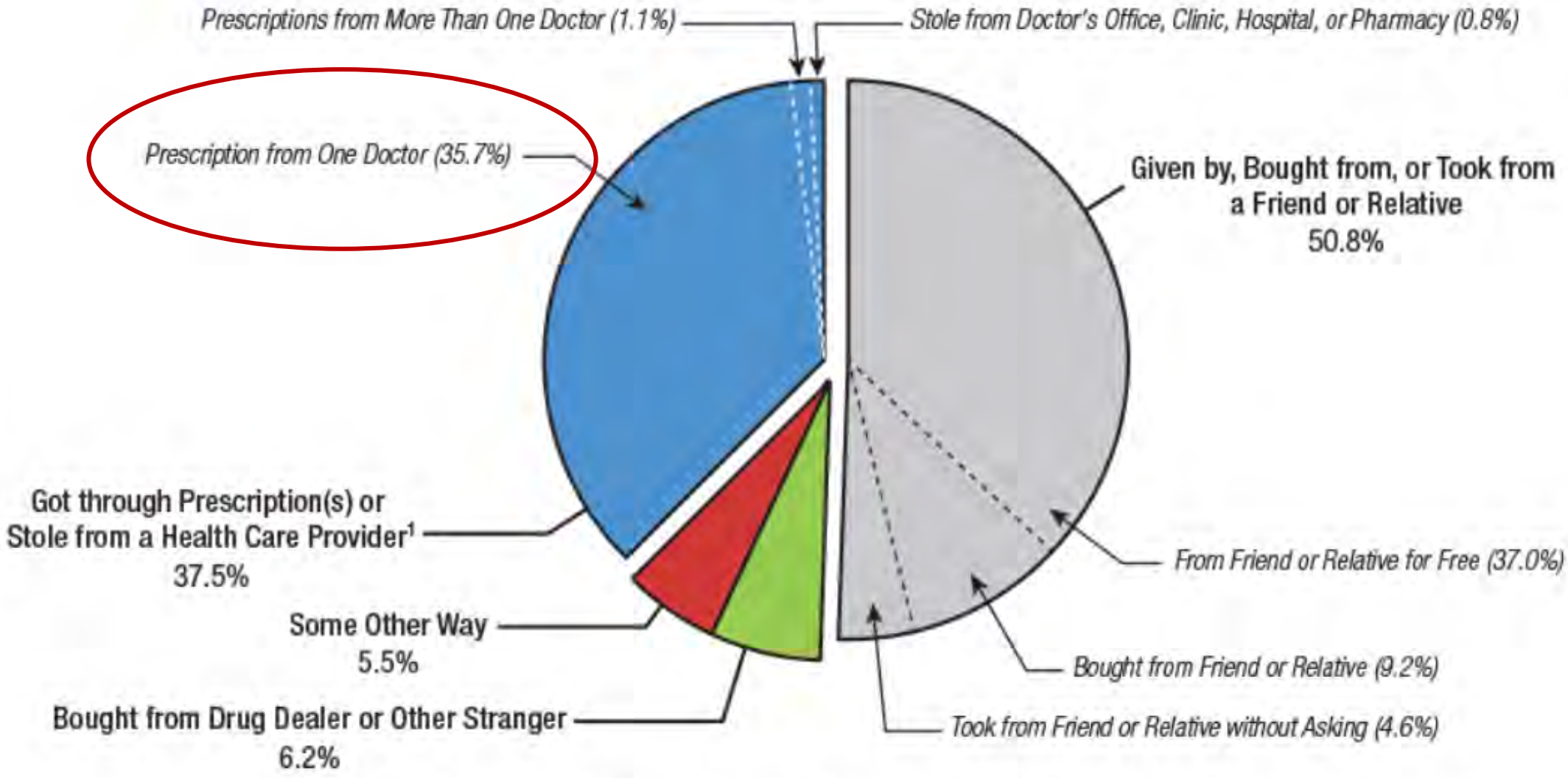


Figure 23. Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Pain Relievers in the Past Year: 2019



Clinical Tools for Primary Care Providers

The Guideline for Prescribing Opioids for Chronic Pain is intended to help providers determine when and how to prescribe opioids for chronic pain, and also how to use nonopioid and nonpharmacologic options that are effective with less risk. The clinical tools below have been developed with you, the primary care provider, in mind, to help you carry out the complex task of balancing pain management with the potential risks that prescription opioids pose.

Talk with Patients

Talk with patients about their pain management options and risks of opioid treatments using Conversation Starters.

Quick Reference for Healthcare Providers

Quick Reference for Healt

Urine Drug Testing

Urine Drug Testing [PDF]

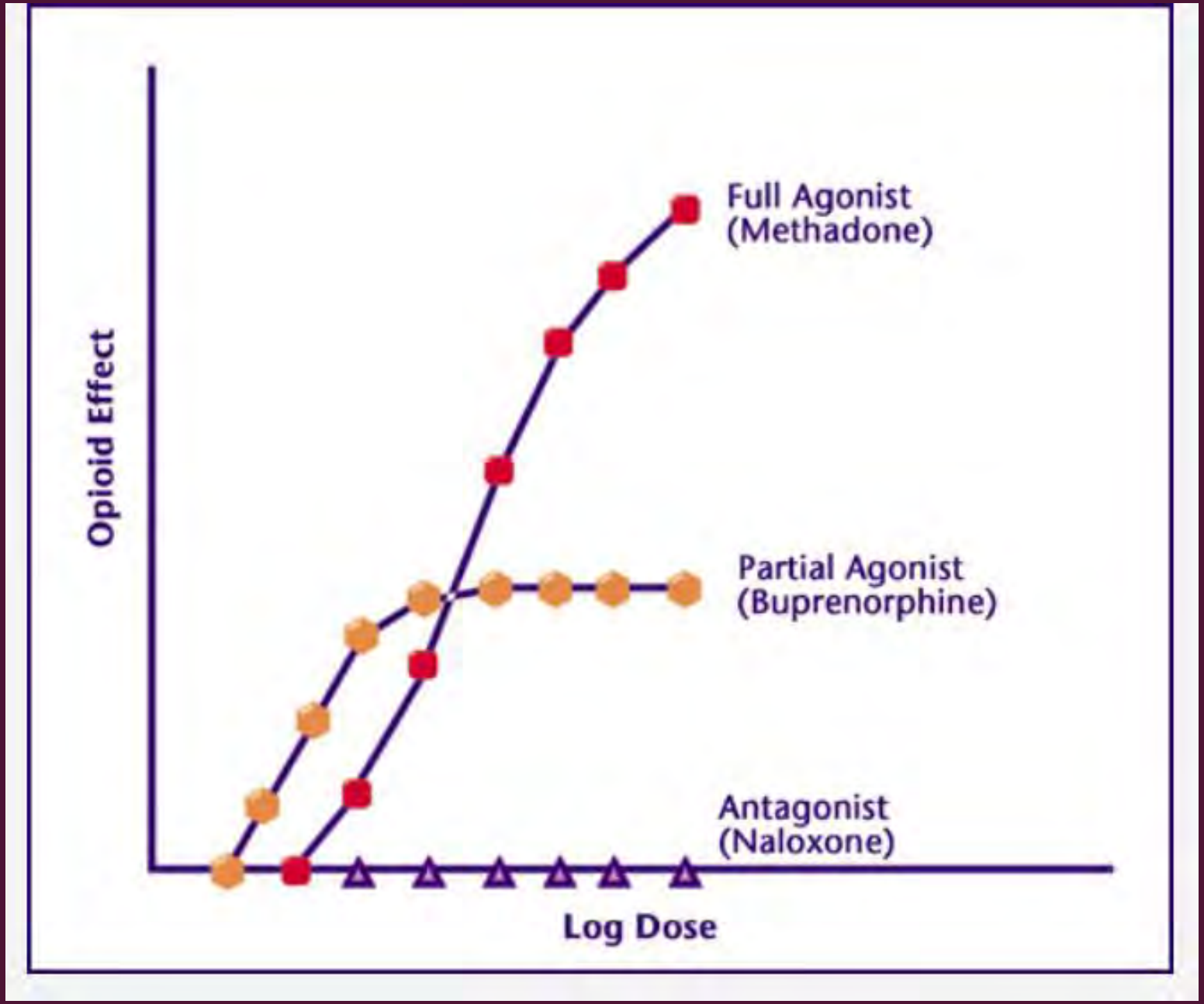
Mobile App

Opioid Prescribing Guideline Mobil

Medication for Opioid Use Disorder

- There are 3 medications that are FDA approved for treating OUD
  - Methadone
  - Naltrexone
  - Suboxone

Pharmacology



Methadone

- Full agonist
- Long and variable half-life – up to 160hrs
- Lots of drug interactions
- Must be in treatment program and go daily to get medication/dose

Naltrexone

- Full antagonist
- Available as daily tablet (50mg) or monthly injection (380mg)
  - XR-Naltrexone = Vivitrol
- Patient must abstain from opioid use for 5-7 days before starting

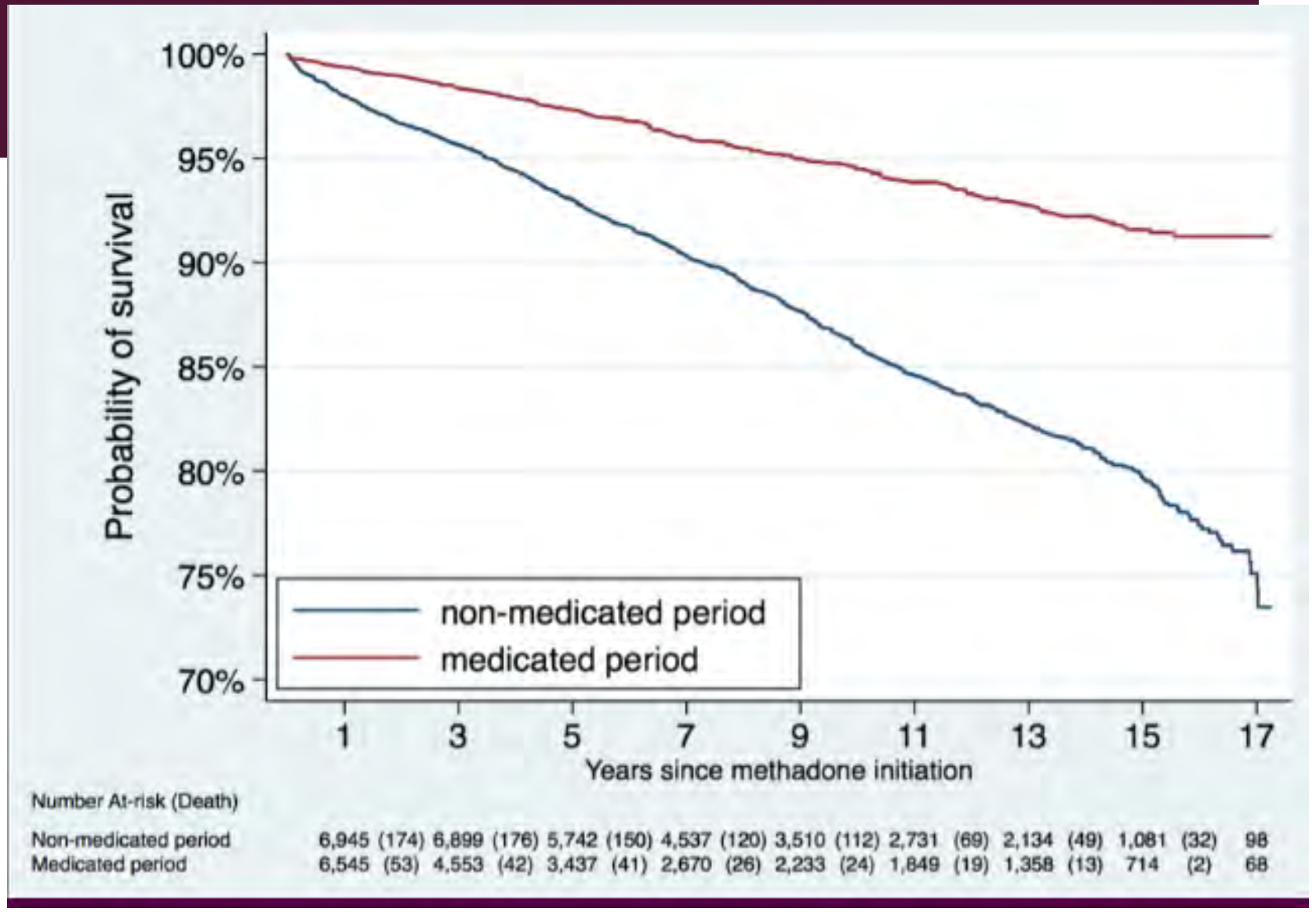
Buprenorphine-Naloxone aka Suboxone

- Partial agonist
- Available as combo or mono product, usually in 8mg, 4mg, and 2mg doses
- DEA X Waiver NO LONGER REQUIRED!

Benefits of Medications

- Buprenorphine and methadone have been shown to:
  - Reduce return to illicit drug use
  - Retain patient in treatment program
  - Decrease HIV infections
  - Decrease HCV infections
  - Improved pregnancy and neonatal outcomes
- XR-Naltrexone has been shown to:
  - Reduce return to illicit drug use
  - Increase treatment retention
  - Reduce opioid craving

Benefits of Medications

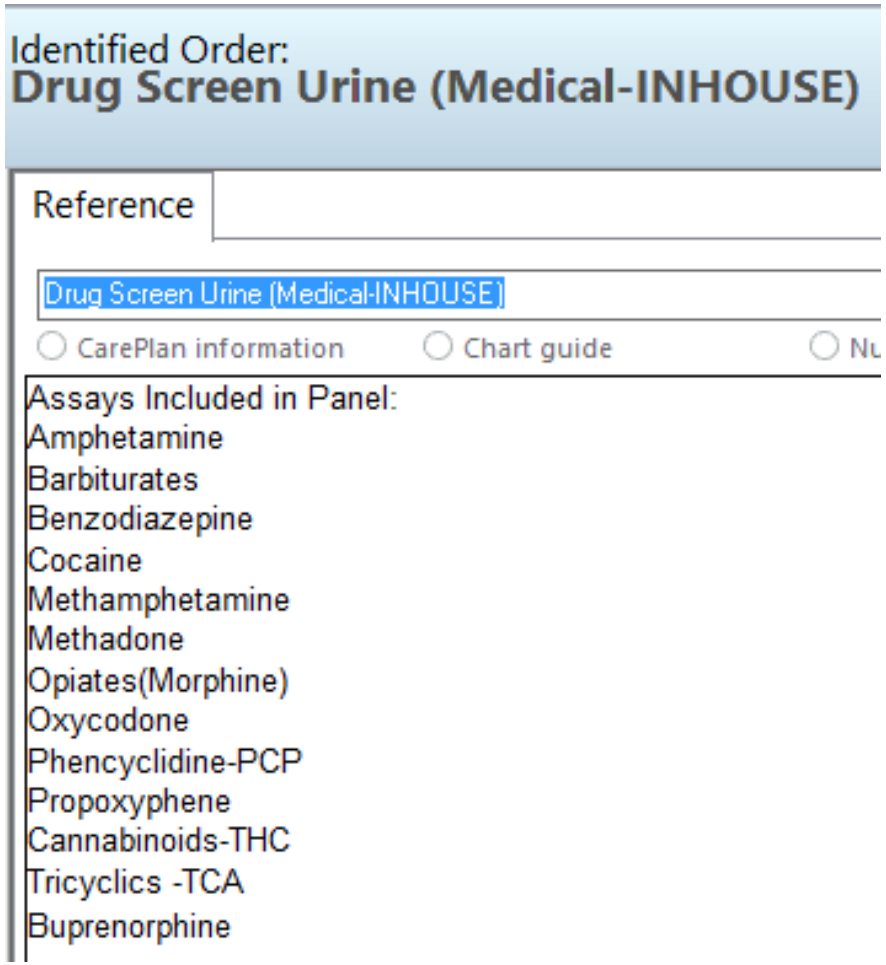


Suggested Laboratory Studies

- HIV
- Hepatitis Panel
- CMP
- CBC
- UDS + urine fentanyl
  - Once in treatment add on norbuprenorphine --> metabolite in urine
- Alcohol level
- Pregnancy test

A Word About Urine Drug Screens

- Check to ensure treatment drug is present
  - Also gives information about their current use
  - Do not use it to penalize the patient
- False positives do happen
  - Wellbutrin = meth
  - Phenobarb = barbituarates



Inpatient Considerations

- Physicians in inpatient settings can legally order buprenorphine
- This is also true for methadone!

What about Acute Pain?

- Patient with OUD still get ACUTE PAIN!
- Suboxone:
  - Ok to use opioids on top of their stable suboxone dose if needed peri-operatively
  - Fentanyl, dilaudid and morphine bind the mu opioid receptor with higher affinity so use these
  - Ok to split buprenorphine to TID dosing as you taper other opioids to help with pain control
- Methadone:
  - Continue home methadone dose
  - Ok to add on short acting opioids to control acute pain

Access to Medication Improves Link to Treatment

Results of a Randomized Control Trial on ED-initiated Buprenorphine for OUD Treatment

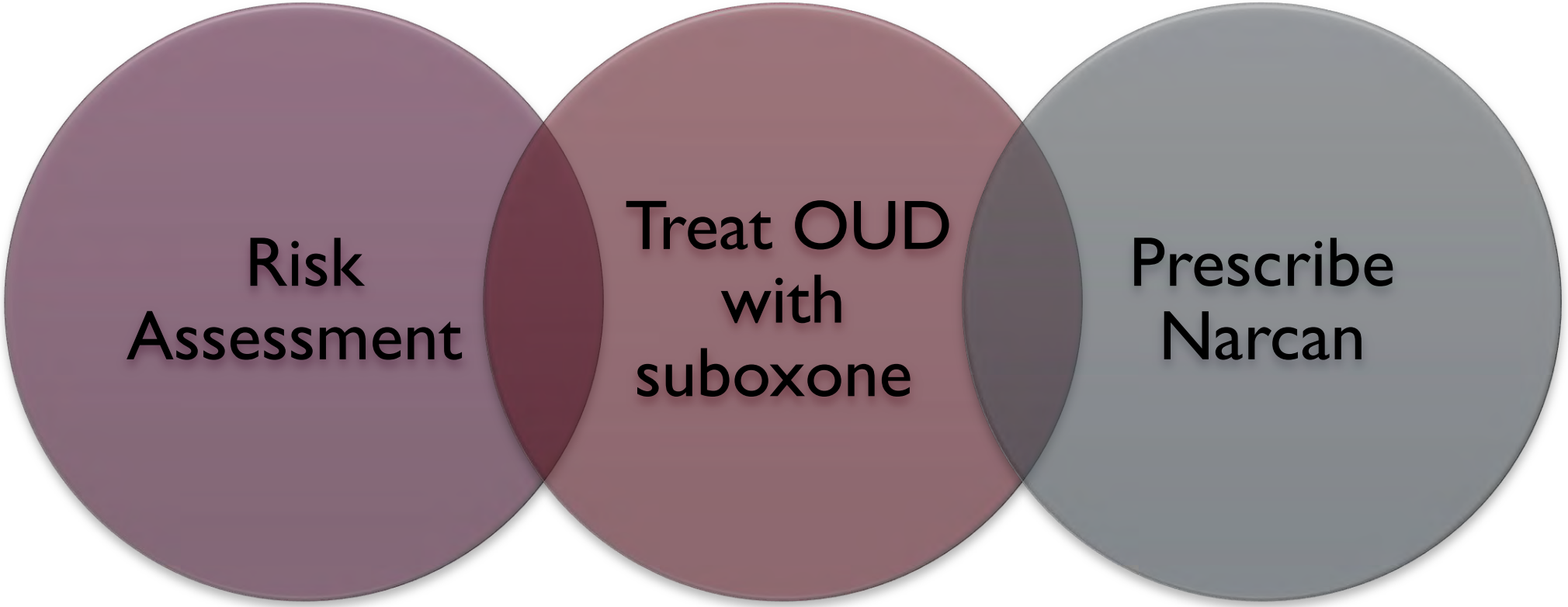
Dose	ED-initiated Buprenorphine	Brief Intervention with Facilitated Referral	Referral Only
Engaged in treatment at 30 days	78%	45%	37%
Self-reported past 7-day opioid use at 30 days	0.9 days	2.4 days	2.3 days

Source: D'Onofrio, G., O'Connor, P.G., Pantalon, M.V., Chawarski, M.C., Busch, S.H., Owens, P.H., Bernstein, S.L., and Fiellin, D.A. (2015) Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. Journal of the American Medical Association, 313, 1636-1644.

Narcan

- Please prescribe nasal narcan to:
  - Patients on chronic high dose opioids or co-prescribed benzos
  - Patients on MOUD
  - Patients recently released from incarceration
  - Patients who have suffered non-fatal overdose
  - Patients' families as interested
- Usually covered by insurance
  - About $70-$100 without insurance

3 Ways to Combat Opioid Epidemic



COWS Score

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute

Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Buprenoprhine-Naloxone Therapy for OUD: In-Office Induction

12 hours for short acting drugs

24 hours for intermediate acting drugs

Appropriate off time for medication withdrawal

72 hours for methadone (see methadone decision support))

Patient presents for induction appointment 12-24 hours after last opioid use

Clinic Opioid Withdrawal Scale (COWS) and UDS

Defined by COWS score of at least 5

Withdrawal Symptoms Present

No

Reschedule induction

Yes

Administer 4/1 mg and observe 1 hour and repeat COWS

Consider starting at 2 mg/0.5 mg for patients on methadone or who may be at higher risk for precipitated withdrawal

Withdrawal Symptoms Present (COWS > 5)

No

Yes

Repeat 4/1 mg dose and observe 1 hour and repeat COWS

Continue total amount administered as maintenance dose. Schedule follow-up for one week

Consider splitting into twice daily dosing

Withdrawal symptoms present (COWS > 5)

No

Yes

Repeat 4/1 mg dose

Prescribe 8/2 mg twice daily and follow-up by phone in 24 hours for further dose adjustment if needed

BUPRENORPHINE SELF START

SETTING YOURSELF UP FOR A SUCCESSFUL INITIATION

When did you last use opioids?

- Keep track of the **day** and **time** you last used opioids
- Plan a break between your last opioid use and first dose of buprenorphine to avoid precipitated withdrawal.

Take a break

The opioid you're using impacts when you can start buprenorphine:

- **Fentanyl** OR if you aren't sure if fentanyl is in your supply: wait **at least 24 hours**
- **Short-acting opioids** (like heroin, oxycontin, morphine): wait **12-16 hours**
- If you take **60 mg or less of methadone daily**: wait **48-72 hours**
- If you take **more than 60 mg of methadone daily**: talk to your healthcare provider for guidance

What are your four worst withdrawal symptoms?

Withdrawal symptoms indicate opioids are leaving your body. Generally having 4 or more withdrawal symptoms is a sign you're ready to start buprenorphine.

- Yawning
- Body aches
- Goosebumps
- Restlessness
- Enlarged pupils
- Sweating or chills
- Anxiety or irritability
- Runny nose or tearing eyes
- Twitching, tremors, or shaking
- Stomach cramps, diarrhea, nausea, or vomiting

Before you start...

1. Ask your healthcare provider for **medications for opioid withdrawal symptoms.**
2. Have the **clinic phone number** if you need to contact your healthcare team.

You are ready to start buprenorphine when you...

1. **Have taken a long enough break from using opioids** **AND**
2. **Have at least four or more withdrawal symptoms.**

How to start buprenorphine...

Step 1: Take a low dose (2 mg) to see how you feel and wait 30 minutes.

Step 2: If after 30 minutes you feel...

THE SAME OR BETTER

Continue taking 2-4 mg every 2-4 hours until your withdrawal symptoms are managed OR you reach your prescribed total daily dose.

WORSE

If you feel worse, you may have taken buprenorphine too soon and are in precipitated withdrawal. Take your withdrawal meds and wait 2-4 hrs before your next buprenorphine dose. If needed, call your healthcare team or go to the nearest ER.

How to start:

- COWS > 8
  - Start with 4mg buprenorphine
  - Reassess in 1 hour, if COWS >8, dose again with 4mg
  - Repeat COWS q6hrs or PRN
  - Max dose 16mg

26yo woman looking to start suboxone...

- What dose would you start?
- When would you follow up?
- What about if UDS is positive for THC?
- What about the chronic benzos?

56yo woman admitted after total hip replacement...

- She takes 16mg suboxone per day at home
- What dose would you start?
- When would you follow up?
- What about if UDS is positive for THC?

QUESTIONS?

Let's take a break!

Thank you!