

VERACT INTRACTABLE PAIN AND PALLIATIVE CARE CLINIC

OPIOID AND COST REDUCTION PROGRAM

FEBRUARY 2018

ISSUE

Although all patients accepted into our clinic for on-going care are already on high dose opioids and have failed conventional and standard treatments as outlined by the World Health Organization 3-Step Analgesic Ladder, reduction and minimization of opioids has always been a goal for every patient. The exception has been those patients who are in palliative care and likely will not live longer than a year. In contrast to the usual step-down or withdrawal methods to reduce opioids (we do use these), we have found that the treatment of neuroinflammation and specific causative diseases markedly reduces the total opioid need. In addition, some new non-opioid alternatives are helping to reduce opioid demands. The high cost of opioids in recent years has required that cost reduction be combined with opioid reduction as 3rd party payers will no longer finance the cost of high-priced opioids.

RESULTS

Since 2015-2016, our overall opioid prescribing has reduced about 40-50%, and this figure is continuing to go down. Some patients who previously took very high opioid dosages now take zero or low opioid dosages. Our goal is to bring every patient, except those who are in palliative care with a life expectancy of less than a year without treatment, down to Centers for Disease Control (CDC) levels – 90 mg morphine equivalence. By use of the new neuroinflammation treatment protocol, new patients rarely require ultra-high opioid dosages.

MAJOR METHODS USED FOR OPIOID REDUCTION

1. IDENTIFICATION AND DIAGNOSTIC LABELING OF THE UNDERLYING, CAUSATIVE DISEASES OF PAIN

Six causes are responsible for about 90% of severe intractable pain:

1. Adhesive Arachnoiditis
2. Ehlers-Danlos Syndrome
3. Reflex Sympathetic Dystrophy (RSD)/Complex Regional Pain Syndrome (CRPS)
4. Traumatic Brain Injury
5. Post-Viral Encephalopathy/Neuropathy
6. Systemic Lyme Disease

Some treatments are directed at the specific disease; these include special exercises, spinal fluid flow measures, antibiotics, anti-virals, vasodilators, and anabolic tissue agents.

2. COST REDUCTION MEASURES

In the past 2 years we have progressively made the following changes:

1. Stopped name-brand opioids
2. Stopped TIRF-REMS products

3. Substituted several non-opioid, low-cost analgesics: ketorolac, oxytocin, ketamine, clonidine, anti-seizure agents, stimulants, antidepressants, select corticoids.

3. SUPPRESSION OF NEUROINFLAMMATION

Two profound scientific breakthroughs of the past decade have made this possible: (1) the microglial cell in central nervous system (CNS) is activated by severe pain and produces neuroinflammation which is responsible for “intractability”; and (2) the CNS itself makes a set of neurohormones that it uses to suppress and control neuroinflammation. These same hormones or their analogues can be administered to suppress neuroinflammation.

Treatment of neuroinflammation has been the MOST EFFECTIVE MEASURE to bring down opioid dosages. A clinical protocol has been developed for neuroinflammation and it contains the following elements: (1) neuroinflammatory agents that cross the blood brain barrier; (2) neuroregenerative agents; and (3) neuroinflammatory diet.

4. OPIOID ALTERNATIVES

Two new opioid alternatives that we have helped develop (dosage, formulation) are oxytocin and ketamine. Most patients are now instructed to take these 2 agents (sometimes together) before they resort to an opioid.¹ Another opioid alternative that we were among the first to advocate is clonidine, and we are increasingly using this agent.²

5. USE OF FORMULATED OPIOIDS FOR FLARES

We have found that the use of formulated injectable or sublingual drops of high potency opioids for severe pain flares and crises reduces the need to escalate the routine, daily oral dosages of oxycodone, hydromorphone, and hydrocodone; therefore,¹ the overall opioid dosage declines.

6. CESSATION OF TIRF-REMS AND LONG ACTING OPIOIDS

All TIRF-REMS products have been stopped because the new protocols keep the severity of baseline and breakthrough pain low enough that they are no longer needed. The same goes for long-acting opioids such as Oxycontin and methadone. The long-acting opioids (including intrathecal opioids) block out short-acting opioids, so the short-acting dosages of such opioids as hydrocodone, morphine, hydromorphone, and oxycodone escalate.

GOALS: (1) Bring the opioid dose of patients down to a level that they can be transferred to continued care by their local physicians.
(2) Develop low-cost, effective protocols that can be implemented by primary care practitioners.

¹ Tennant F. Sublingual Oxytocin and Ketamine for Pain Relief. PainWeek, Las Vegas, 2017.

² Tennant F. Use of the Clonidine Patch in High Dose Methadone Maintenance Patients Who Don't Satisfactorily Maintain. American Society of Addiction Medicine, 1998.