Massachusetts Consultation Service
MCSTAP
for Treatment of Addiction and Pain

MCSTAP Learning Case: Use of Buprenorphine for Patient with Chronic Pain and OUD

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Brief Description of Clinical Case

A 35-year-old female with history of major depressive disorder (MDD), generalized anxiety disorder (GAD), fibromyalgia, and reflex sympathetic dystrophy (RSD) of the right lower extremity (RLE). She's been on oxycodone maintenance for five years (max 90 mg daily). The patient has recently been noted to run short at times given worsening pain. She reports intermittent complaints of opioid withdrawal symptoms when she was transitioned to tramadol by her PCP, with doses up to 500 mg daily with inadequate pain relief. The patient is now referred to you by her PCP for consideration of buprenorphine transition.

She has past and current pain history diagnoses of fibromyalgia, chronic pelvic pain, and RSD s/p RLE injury. No known substance use history. Her past and current mental health history include MDD and GAD. She had therapy in the past as a teen.

Drug test results have been as expected (oxycodone when prescribed), with no non-prescribed or illicit results. She has been running short of meds with consequential opioid withdrawal, taking them for mood benefit as well. Recently the patient's boyfriend gave her one of his buprenorphine pills (2 mg/low dose). The patient noted it was very helpful and seemed to help all of her symptoms

Pertinent Current and Past Medications

Tramadol 100 mg TID
Tizanidine 4 mg bid
Nortriptyline (100 mg)
Gabapentin (800 mg TID)

Caller Questions

1. Is the differential diagnosis OUD, or pain with dependence, "pseudo-addiction" and aberrant behavior re: non-prescribed buprenorphine?
2. Is tramadol an opioid that would respond to buprenorphine maintenance?
3. Can a PCP prescribe medications for pain without a waiver?
4. Does the patient need to go to an IOP or need behavioral support in order to start buprenorphine? What if she refuses?

Treatment Plan

1. Do an assessment using DSM 5 OUD criteria.
2. Buprenorphine trial prescription makes sense; the patient has already tried and found great relief of withdrawal symptoms, as well as pain relief, even in low dose.
3. Refer the patient to a buprenorphine-waivered provider because she met criteria for OUD.
4. Don't force behavioral intervention, especially if the patient is not interested.

(continued)

Learning Points

1. Chronic pain and SUD overlap; review the differential diagnosis and DSM-5 criteria for OUD.
2. Meet the patient where she is. PCP and coach team-based care makes sense because the patient is not interested in further programming at this time. There is no clear data that mandating it improves outcomes: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5474206/
3. Tramadol dependence does occur. Tramadol is a synthetic, centrally active analgesic with weak mu opioid agonist activity and can cause dependence and use disorder.
4. Buprenorphine treats opioid withdrawal/use disorder and pain as above.
5. The PCP can prescribe buprenorphine off label without X license if "for pain," but this patient does meet criteria for OUD.

Notes/References

Tramadol Physical dependence does occur – Lainier et al

1. Randomized, placebo-controlled, crossover study: phases consisting of 60 mg daily morphine and 200 mg or 800 mg tramadol dosing.
2. Results: overall, naloxone precipitated withdrawal occurred, and effects were similar for subjects taking 60 mg daily morphine and 200 mg or 800 mg daily tramadol.
3. Results also suggested that physical dependence can occur at doses typically prescribed for pain (200 mg/day to 400 mg/day).
4. Physical dependence appears dose-related and sustained dosing regimens are similar to other mu agonists.
5. Withdrawal symptoms are consistent with opioid withdrawal: anxiety, goose flesh, lacrimation, yawning, rhinorrhea, sweating, abdominal cramps, restless legs, and depression.

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