Opioid Angst in the Pain Clinic:
Why This Is Hard-for Patients
and Clinicians

Disclosures

- Dr. Bicket reports consulting fees from Daniels Health which are ongoing

The Patients We're Talking About When Mental Models Collide

Opioids are the problem

→ Stopping = progress

Uncertainty • Risk management • Fear

Current practice reality

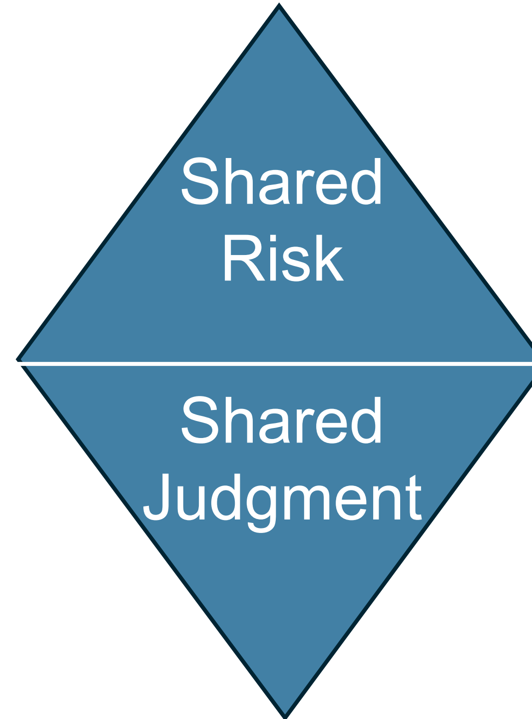
Opioids are the solution

→ Continuation = care

Manhapra *Subst Abus* 2018;39:152, 10.1080/08897077.2017.1381663

Good Intentions, Shared Risk

Patients
- Relief
- Function
- Stability



Clinicians
- Safety
- Scrutiny
- Responsibility

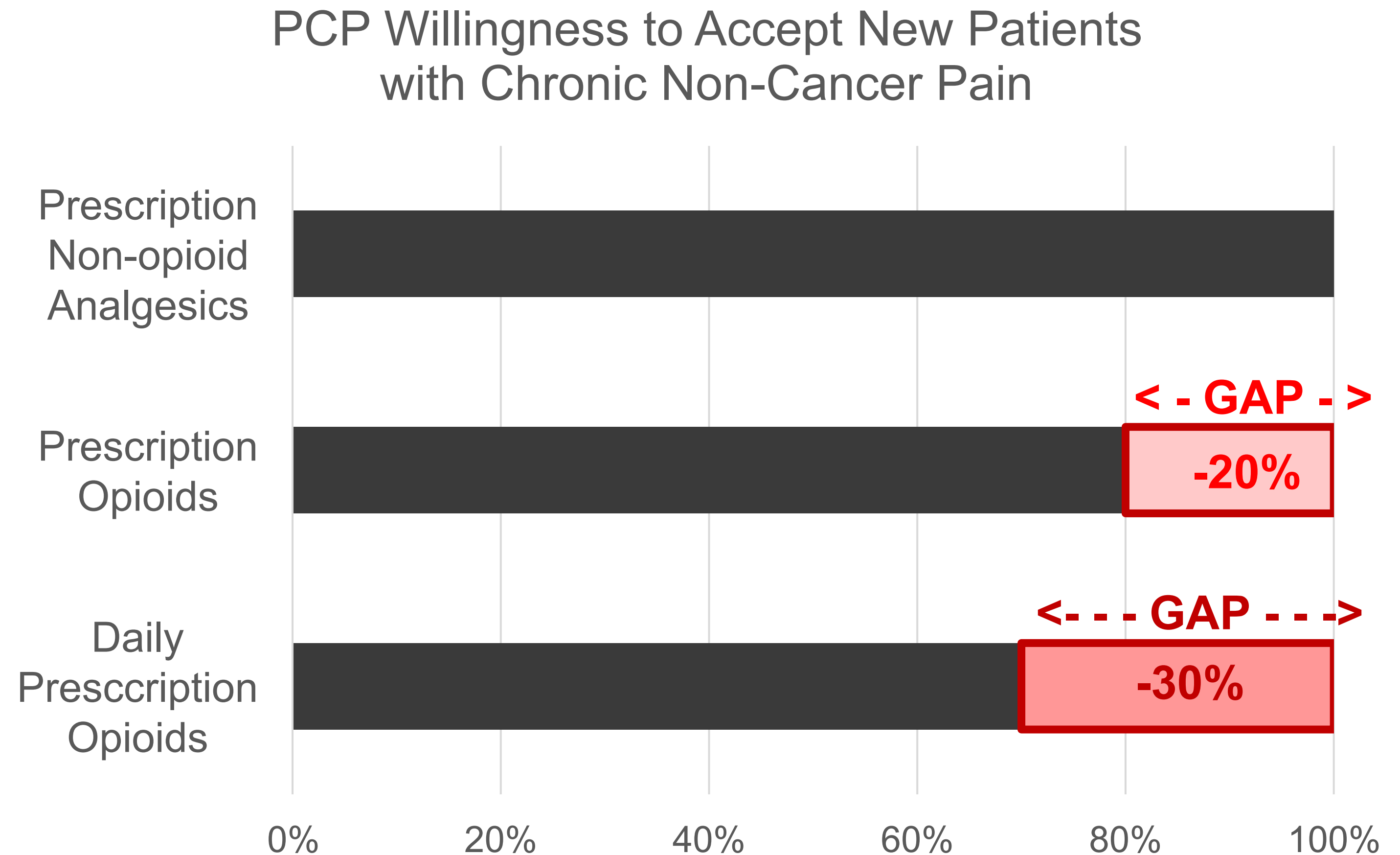
> *"I just want to get through my day …"*

> *"I don't want to hurt anyone."*

Matthias et al. *Patient Educ Couns* 2013;93:197, 10.1016/j.pec.2013.06.021

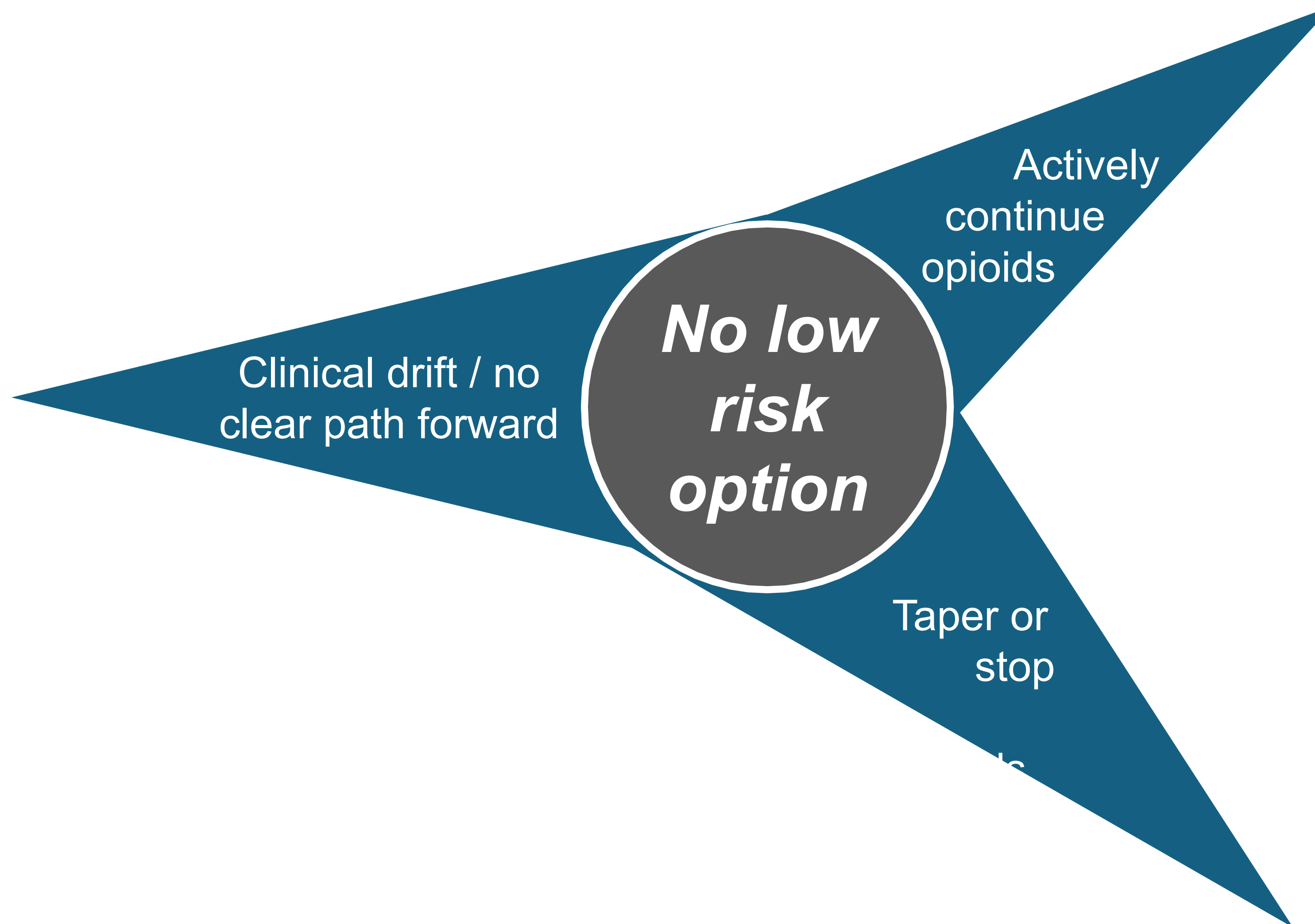
Prescription Opioids Now Carry Stigma

- Not just attitudes
  → access
- Not just discomfort
  → exclusion



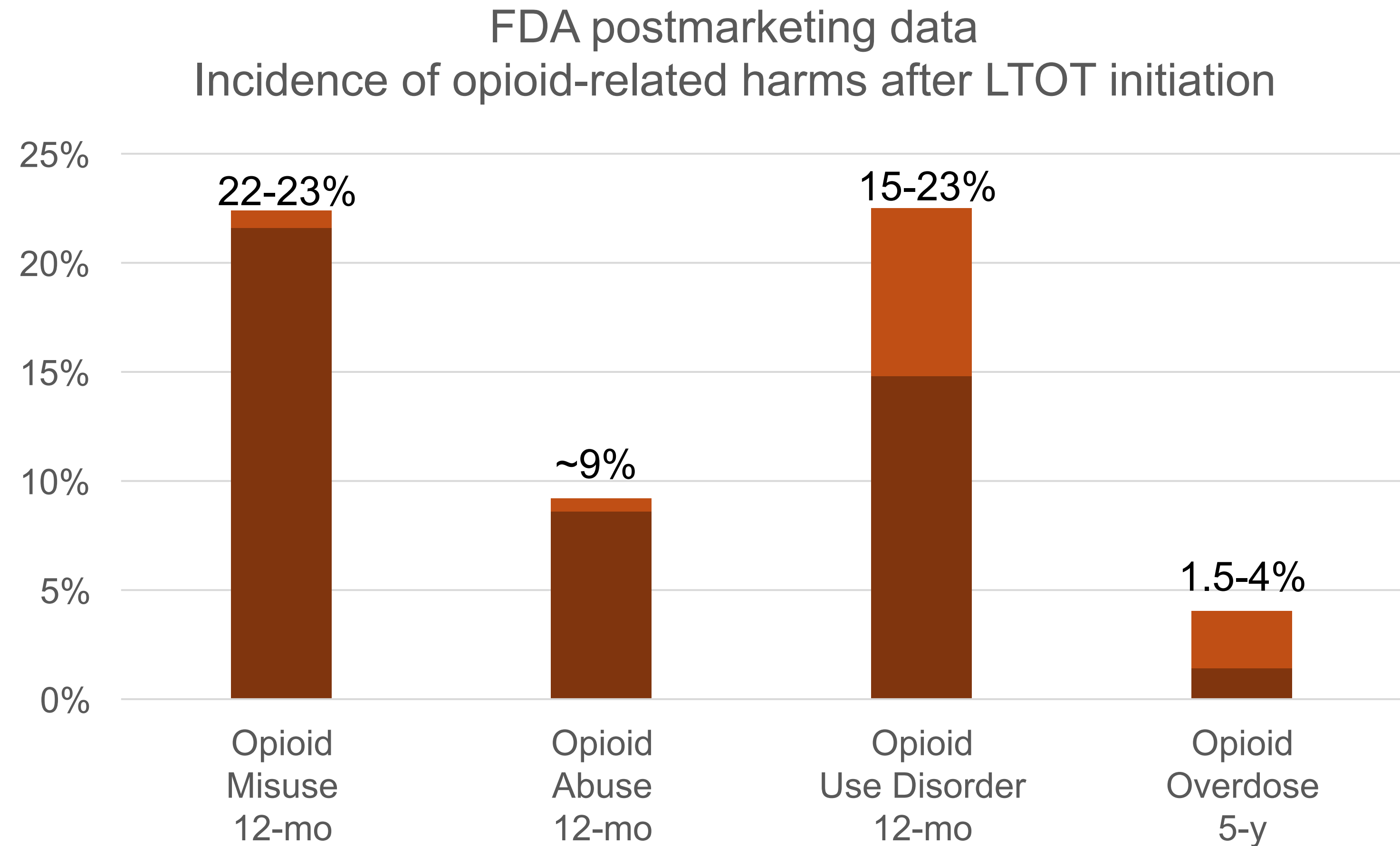
Bicket et al. *Health Aff Sch* 2024;12:6, 10.1093/haschl/qxae086

Pain Clinicians Practice Inside a Bind



What the Evidence Actually Says About LTOT

- We Can Quantify Risk, But Not Benefit
- Robust postmarketing evidence on misuse, OUD, overdose
- Little high-quality evidence for sustained functional benefit



JAMA

Bicket, Bateman. *JAMA* 2025;334:1057, 10.1001/jama.2025.13225

Clearly Labeling Prescription Opioid Risks

FOR IMMEDIATE RELEASE
July 31, 2025

Contact: HHS Press Office

202-690-6343

Submit a Request for Comment

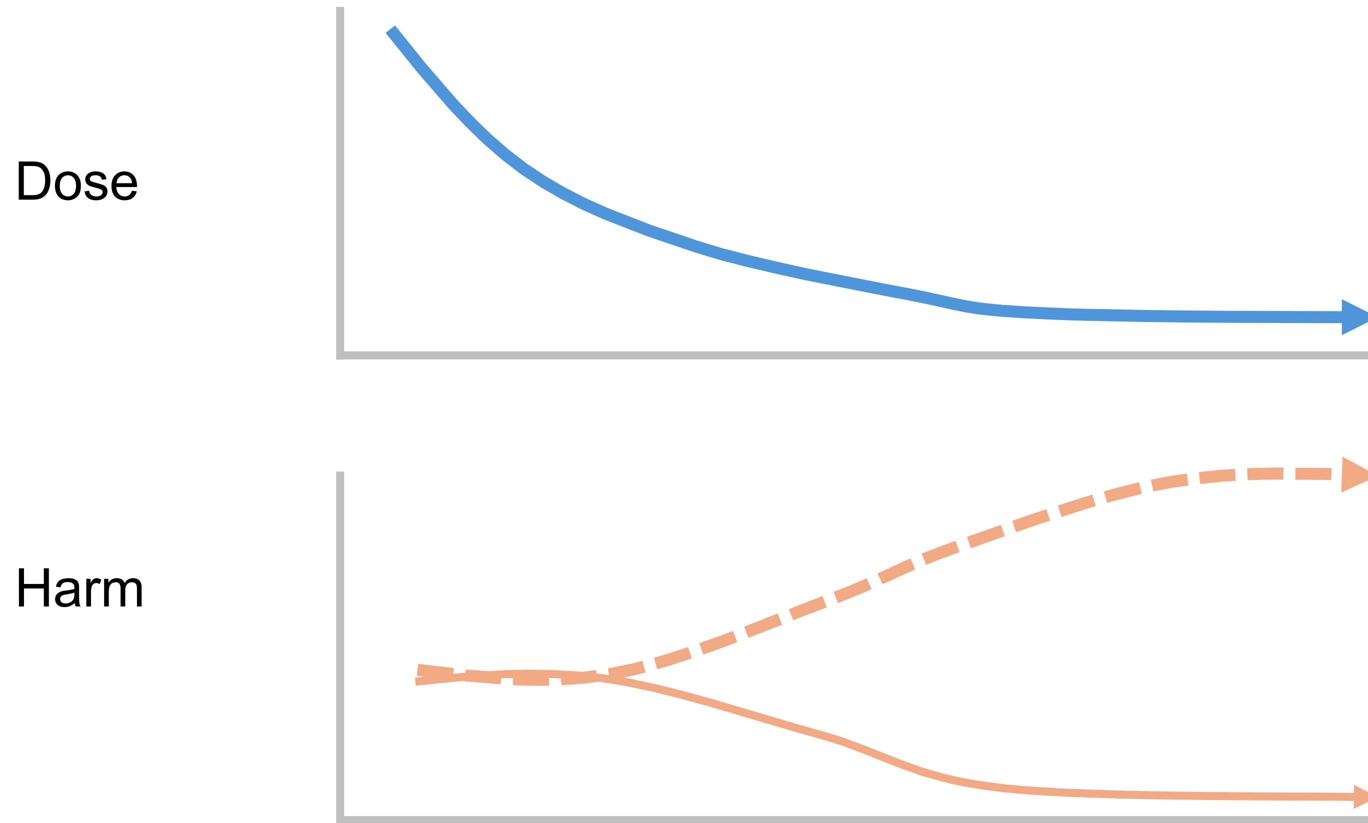
FDA Requires Major Changes to Opioid Pain Medication Labeling to Emphasize Risks

"The death of almost one million Americans during the opioid epidemic has been one of the cardinal failures of the public health establishment," said **FDA Commissioner Marty Makary, M.D., M.P.H.** "This long-overdue labeling change is only part of what needs to be done — we also need to modernize our approval processes and post-market monitoring so that nothing like this ever happens again."

Tragically, the new drug application for OxyContin was initially approved without study data supporting its long term use to treat pain in many patient populations for which it has been prescribed. The updated labeling change reflects robust data from two large FDA-required observational studies, called postmarketing requirements (PMR) 3033-1 and 3033-2, which recently provided new data on how long-term opioid use can lead to serious side effects. After reviewing those results, public comments, medical research and recognizing the absence of adequate and well-controlled studies on long-term opioid effectiveness, the FDA decided to require safety labeling changes to help health care professionals and patients make treatment decisions rooted in the latest evidence.

https://www.hhs.gov/press-room/fda-updates-opioid-risk-labels.html

Opioid Tapering Is Not a Neutral Intervention



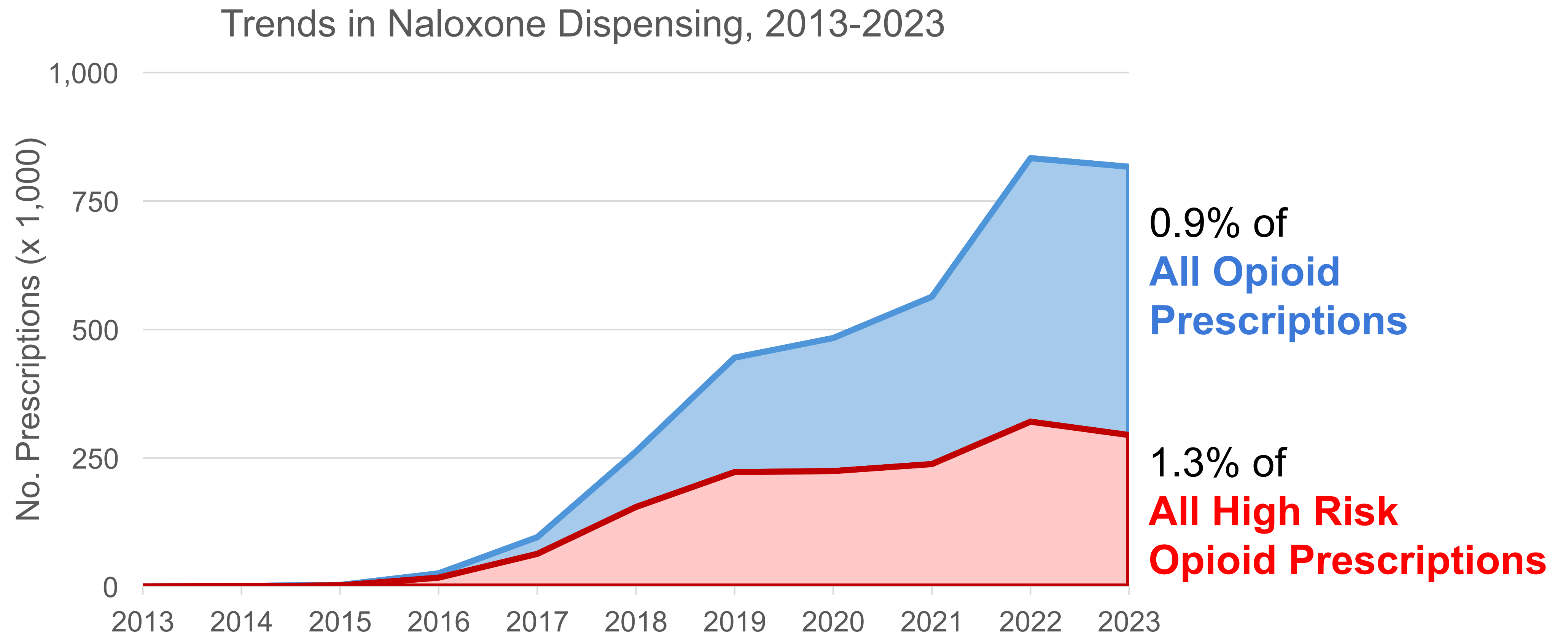
Dose ↓

does not always equal

Harm ↓

Coffin, Barreveld. *NEJM* 2022; ;386:611, 10.1056/NEJMp2115244

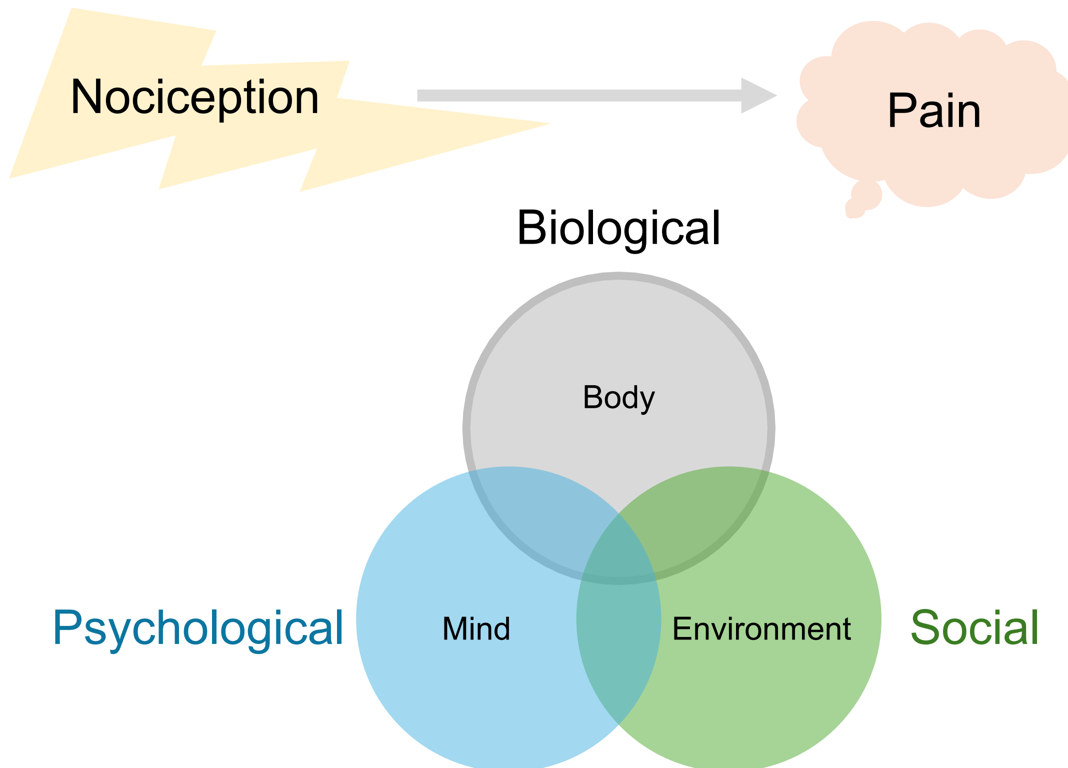
Overdose Prevention Still Fails LTOT Patients



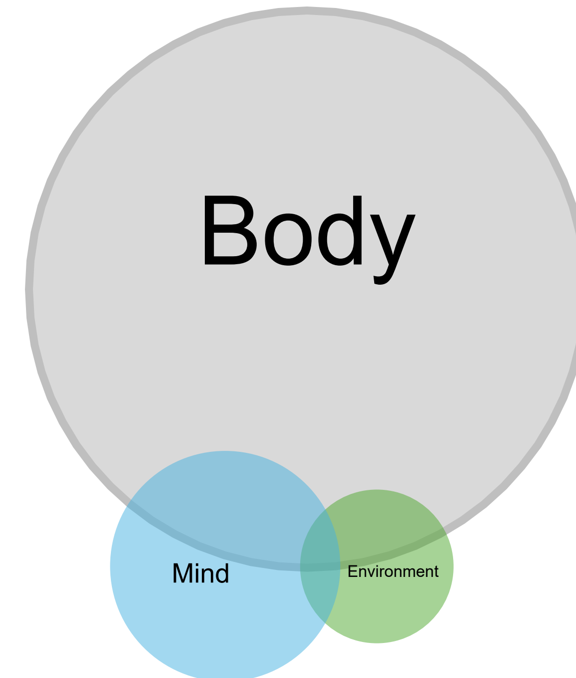
Beck et al. *Reg Anesth Pain Med* 2025, 10.1136/rapm-2025-106911

Pain Care Centered on Medications

Biopsychosocial Framework
What we aim to practice



The Bio, Bio, Bio Model
What our systems often deliver



Gatchel et al. *Psychol Bull* 2007;133:581, 10.1037/0033-2909.133.4.581

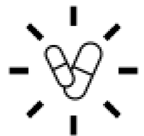
When DSM-5 Criteria Meet Pain Clinic Reality

Observed Behaviors

Early refills

Dose escalation

Running out

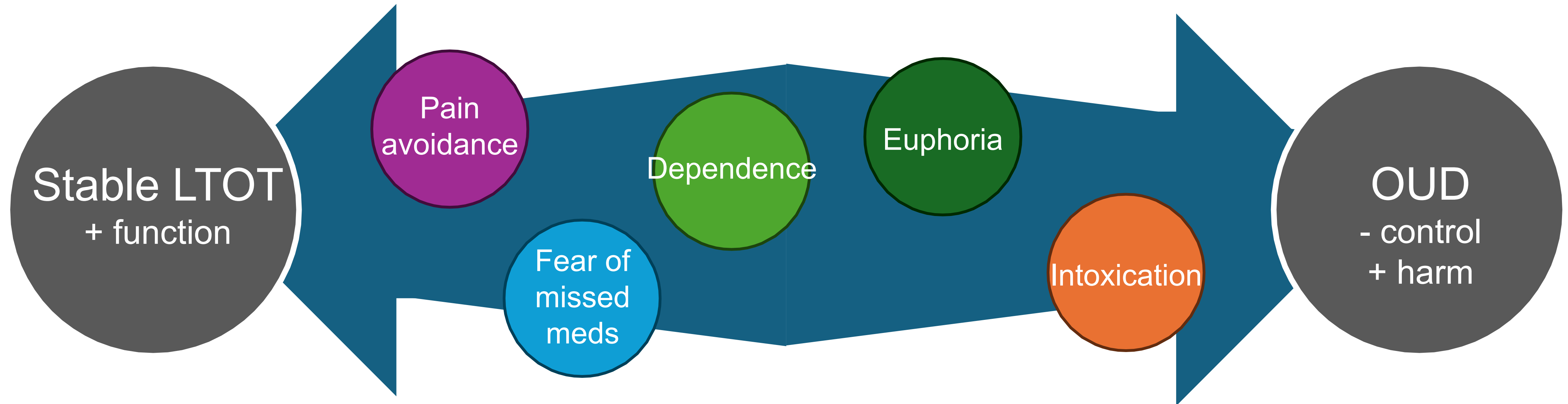

Medication focus

Multiple Mechanisms

- Uncontrolled pain
- Avoiding withdrawal
- Anxiety, catastrophizing
- Disorganized systems
- Biomedical focus on pain

Diagnostic Interpretation?
-> OUD
-> Physiologic dependence
-> Overlap

Opioid-Related Risk Exists on a Spectrum



Complex Persistent Opioid Dependence CPOD As An Evolving Concept

CPOD describes patients who have:

- Long-term opioid exposure
- Physiologic dependence
- Functional or emotional reliance on opioids
- Instability with dose reduction
- That does not firmly map to OUD

What CPOD Is and Is Not

CPOD is:

- Descriptive, not diagnostic
- Clinically pragmatic
- Focused on stability and safety

CPOD is not:

- A DSM diagnosis
- A way to avoid diagnosing OUD
- A moral judgment

Manhapra et al. *JGIM* 2020 Dec;35:964, 10.1007/s11606-020-06251-w

Why Some Find CPOD Clinically Useful

What CPOD Changes in Practice

- Creates room to adjust the plan before labels harden
- Allows pain clinicians to stay engaged rather than deferring or referring prematurely
- Helps patients hear concern without accusation or redefining

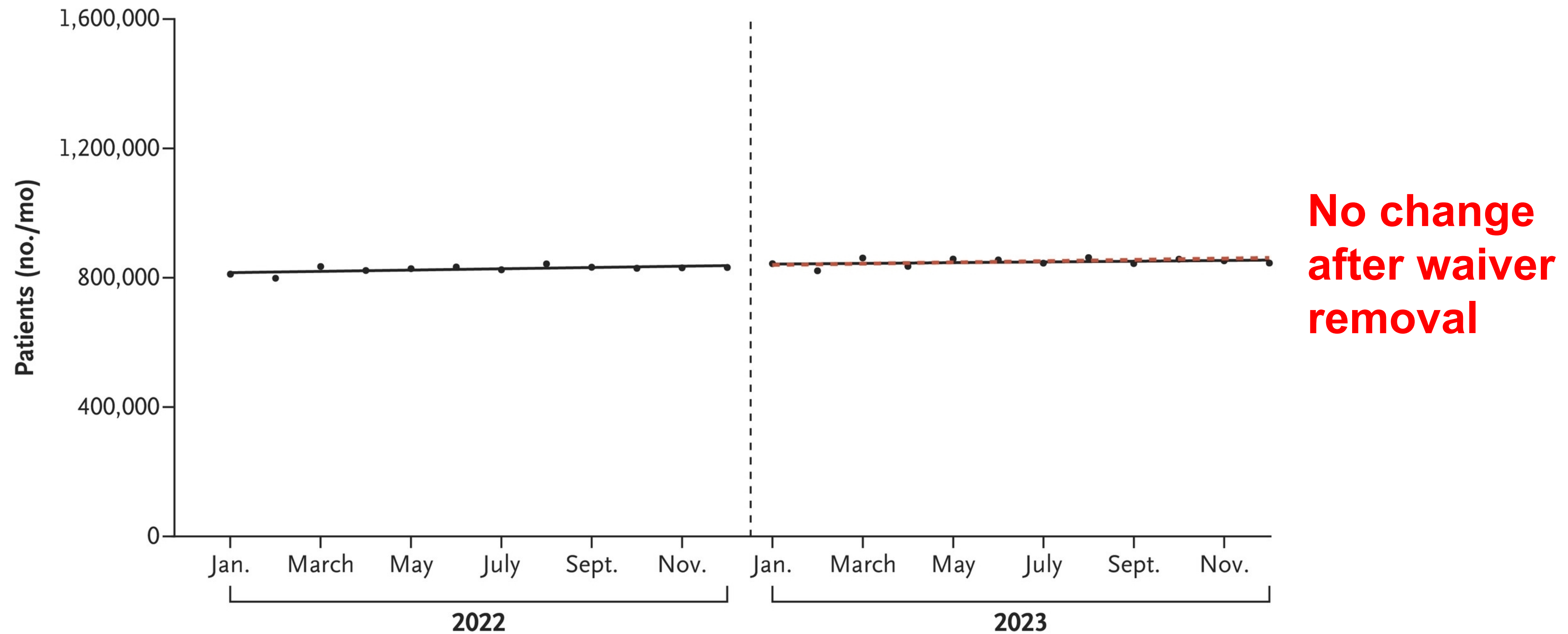
What CPOD Does Not Claim

- That action should be delayed until a diagnosis is fully settled
- That opioid use disorder isn’t present or possible
- That addiction medicine principles don’t apply

Manhapra. *Curr Treat Options Oncol* 2022;23:921, 10.1007/s11864-022-00985-x.

Setting the Stage for Safer, More Stable Care

Monthly No. of Patients Filling Buprenorphine



The NEW ENGLAND JOURNAL of MEDICINE

Chua et al. *NEJM*. 2024;390:1530, 10.1056/NEJMc2312906

Case Study: Tony

"I've been stable on these meds for a long time."

"Isn't Suboxone that stuff for addicts? I have real pain ."

66-year-old male with h/o alcohol use disorder in remission for over 10 years, now on chronic opioid therapy for past 6 years for lumbar DDD with right L5 radicular leg pain and bilateral knee DJD.

Case Study: Tony

- History: 3 lumbar surgeries including L3-S1 fusion in 2019
- Low back and right leg pain shooting to calf
- *“I have bad lumbar nerve scarring. Worst the surgeon had ever seen.”*

Medications

Oxycodone 10 mg, 1 Q4-6 hrs, max 6/ day x 10 years
#180/30 days

Alprazolam 1mg QHS x 3 years

Social

ETOH: past “problem,” none

Tobacco: quit in treatment 10 yrs

Wife supportive, no SUD hx

Case Study: Tony

- Though historically he has been adherent without red flags over 5 years working together, PCP recently became concerned about *multiple requests for early refills* reportedly due to unplanned out of town trips.
- His prescribed opioid, oxycodone, which is Rx'd at 10mg q4h as needed for pain (max 6/day), is *absent on urine tox screen* the next time seen, confirmed by GC/MS testing → PCP refers him to pain/addiction medicine.
- We discuss case hx and records in detail, do PE. Tony admits that he has been using 8/day recently because he needs to take 2 tabs in the AM to get adequate pain relief, and at least one dose overnight to avoid withdrawal. He therefore not surprisingly has been *running out several days early*.

Review Case Study

Review Tony 's history of chronic opioid therapy and alcohol use disorder as well as some of the red flags involved in his case.

Discussion Questions

- *Based on the information provided, does Tony's case align more with OUD, CPOD, or both? Why?*
- *How does this difference inform next steps?*

Time Allocated:

5 minutes