CASE RECOMMENDATION FORM

Presenter Credential: PA-C

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Summary:

58-year-old male on Medicaid in long-term care. Has a history of alcohol use disorder and denies any psychiatric history. Has type II diabetes and had bilateral, above-knee amputation. Dependent on dialysis. Estranged from family. On disability for 20+ years. Little social support. Previously homeless. Resident has good medication adherence, but wants to stop buprenorphine and switch back to oxycodone. Primary concern is taste and efficacy and has refusals of buprenorphine. There is a concern that objective findings do not match subjective reporting. Resident is frequently playing cards and smoking with peers. Reports that pain is often 10/10, and never better than 7/10. Affect changes when speaking about pain. Calls 911 for transport to the ER for narcotics. We meet with residents every week about behaviors and going back on full mu-agonists. When we finish speaking with these residents, the situation is often worse. Current medications: Buprenorphine 2mg TID, Duloxetine, Cyclobenzaprine, Lyrica, Lidocaine Transdermal, Insulin, Amlodipine, Metoprolol, Trazodone, Atorvastatin.

Treatment Question(s):

Suggestions for how to work with a patient who refuses to continue using buprenorphine.

Recommendations:

Opioid Use Disorder (OUD) & Pain Management

- Diagnosis of OUD is probably appropriate based on his behaviors, such as having a history of alcohol use disorder and being physiologically dependent on opioids for a long period of time. If OUD is suspected, consider titrating buprenorphine to a higher dose, possibly increasing to 2 QID or 3 TID, if necessary.
- Consider utilizing topical NSAIDs or lidocaine gel for localized pain management (e.g., stump pain).
- Encourage functional improvement, such as physical therapy and movement, to help manage pain.
    - Encourage documentation of purposeful movement (such as on a calendar) to help track functional improvement and potentially manage pain better.
- Consider optimizing treatment for potential co-occurring conditions, like depression or insomnia, to improve pain management.

Other Considerations for Current Medications

- Reconsider the use of Lyrica and cyclobenzaprine, particularly in patients with kidney issues.
    - As he gets to be more tolerant to the buprenorphine itself, it will probably be less dangerous than the Lyrica might be because of his dialysis. Once he's at a higher dose of buprenorphine, he could potentially use a lower dose of Lyrica and taper off the cyclobenzaprine.
    - Be cautious with long-term muscle relaxants like cyclobenzaprine, as it's chemically similar to tricyclics and, combined with duloxetine, could increase the risk of serotonin-related issues.
- The manufacturer of duloxetine recommends avoiding the use of duloxetine in dialysis patients as the area under the curve is increased. This may increase the risk of adverse effects and drug-drug interactions. Some experts suggest that the use of 30-60 mg daily in dialysis patients may be used with caution with slow titration from 30 to 60 mg. Limited data exists for use of 60 mg of duloxetine in dialysis patients. The patient should be monitored closely for adverse effects.
- If he has insomnia, consider alternatives to Trazodone, as evidence of its efficacy in treating insomnia is limited.

Consider presenting follow-up for this patient case or any other patient cases at a future ECHO Clinic session.

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