MACS

MACS Webinar

Bridging the Gap: Practical Pain Management Across Primary & Specialty Care

Sarah Merritt, MD
MACS Pain Management Consultant
March 5, 2026

MACS

Maryland Addiction Consultation Service (MACS)

Provides support to prescribers and their practices in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance with addiction and behavioral health resources and referrals
- Technical assistance to practices implementing or expanding office-based addiction treatment services
- MACS TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning

1-855-337-MACS (6227) • www.marylandMACS.org

MACS

Pain Care in 2026: Why It Feels Harder Than Ever[1]

- 1 in 5 U.S. adults live with chronic pain
- Limited time, high complexity
- Opioid crisis reshaped prescribing culture
- Conflicting interpretations of guidelines
- Pain + depression + substance use frequently overlap
- $560–$635 billion annual economic impact

Pain in Baltimore: Why This Matters Locally

- High chronic pain and trauma exposure burden
- Persistent opioid-related morbidity and mortality
- Disparities in specialty access
- Primary care carries the front-line responsibility

Acute vs Chronic Pain: Different Problems, Different Clinician Goals

- Acute: protective, time-limited
- Chronic: persists beyond healing
- Acute goal: resolution
- Chronic goal: function + quality of life

Principles of Effective Acute Pain Management

- Treat early and adequately
- Match treatment to severity
- Use multimodal strategies first
- Reserve opioids for clear indications
- Always include an exit strategy

Post-Procedure Opioid Use: Data vs Assumptions[2]

- Soft tissue: ~5 tablets (2 days)
- Fractures: ~13 tablets (4–5 days)
- Joint procedures: ~14 tablets (5 days)
- **Most patients use far fewer opioids than prescribed**

When Opioids Are Appropriate for Acute Pain

- Major surgery or severe trauma
- Compound fractures
- Significant tissue injury
- Use IR formulations only
- Shortest effective duration

CDC Opioid Guidance: Clarifying Misinterpretations[34]:

Understanding what the guideline actually recommends.

- Non-opioid therapies first
- Lowest effective dose (<90 MME when possible)
- Reassessment and shared decision-making
- No mandate for abrupt discontinuation
- No 90 MME limit for MOUD dosing

Involuntary Opioid Taper[56]:
Emerging evidence on unintended consequences

- Associated with overdose risk
- Associated with mental health crises
- Increased emergency department utilization
- **Tapering decisions should be individualized and collaborative**

When Continuing Opioids Is Clinically Appropriate

- Documented functional benefit
- Stable dose without escalation
- No concerning behaviors
- Risk mitigation in place
- Ongoing reassessment

When Risks Likely Outweigh Benefits

- PEG consistently >5 (PEG = Pain, Enjoyment of Life, and General Activity Level)
- Dose escalation without function gain
- Opioid-induced hyperalgesia suspected
- High overdose risk factors present
- Central pain syndromes

Difficult Situaitons:
Acute Pain in people on opioids

- Baseline hyperalgesia in some
- Opioid tolerance in all
- Relapse risk if history of OUD
- However, pain complaints should be taken seriously
- Increase opioid and lean on non opioid treatments

Non-Opioid Therapies for Chronic Pain

- SNRIs (duloxetine, venlafaxine)
- TCAs (amitriptyline, nortriptyline)
- Gabapentinoids (selected neuropathic pain)
- Topicals (lidocaine, diclofenac)
- Physical therapy and exercise
- Cognitive behavioral therapy / pain psychology

Chou R et al. *Ann Intern Med.* 2017.

When to Consider Buprenorphine for Pain

Situations where a partial agonist may offer advantages

- **Chronic pain with opioid use disorder**
- **High risk of overdose** with full agonist opioids
- **Problematic long-term opioid therapy** (poor function or escalating doses)
- **Opioid-induced hyperalgesia suspected**
- Need for **more stable analgesia with lower misuse risk**
- **Partial agonist does not mean partial pain relief.**

Raffa RB, Haidery M, Huang HM, et al. The clinical analgesic efficacy of buprenorphine. *J Clin Pharm Ther.* 2014

Buprenorphine as an Analgesic:

Partial agonist does not mean partial pain relief

- *High-affinity partial μ-agonist with unique safety properties*
- Partial μ-opioid receptor agonist with **very high receptor affinity**
- Provides **clinically meaningful analgesia**
- **Ceiling effect for respiratory depression**, but not necessarily for analgesia
- May be useful for patients at **higher risk with full agonist opioids**

Chronic Pain:
Fundamentally different from acute injury

- Central sensitization
- Mood disorders
- Trauma exposure
- Social determinants of health
- **Chronic pain is not simply a problem of tissue damage.**

When Collaborative Specialty Care Is Indicated

- PEG >5 despite multimodal treatment
- Escalating dose without function
- Complex MOUD perioperative planning
- Significant psychiatric comorbidity
- You feel clinically stuck

A Common Pattern in Chronic Pain

When biology, experience, and stress interact.

- 42-year-old woman with chronic low back pain
- Initial injury lifting at work 8 years ago
- MRI: mild degenerative changes
- Pain worsened after divorce and financial stress
- Poor sleep, depressed mood
- Multiple medication trials with limited benefit
- **Pain is real — but the nervous system has become sensitized.**

MACS

Chronic pain is influenced by multiple interacting factors:

- **Biology** – injury, inflammation, nervous system sensitization
- **Psychological state** – depression, anxiety, stress
- **Social context** – trauma exposure, financial stress, instability
- **Prior experiences with pain and healthcare**
- **Pain is always real**
  But the nervous system can become **more sensitive over time.**

How the Nervous System Learns Pain

- Repeated injury or stress can **sensitize pain pathways**
- Trauma and chronic stress can **amplify nervous system responses**
- Depression and anxiety can **lower pain thresholds**
- The result is **real pain without ongoing tissue damage**
- **This is called central sensitization.**

Collaborative Models of Care

- Integrated pain, addiction, and mental health care
- Thoughtful opioid stewardship
- Multimodal therapies (opioids, non-opioids, interventions, PT)
- Open lines of communication
- **Referral is collaboration, not failure**

What I wish I knew sooner about chronic pain

- Pain intensity and tissue damage are often poorly correlated
- Chronic pain reflects changes in the nervous system, not just injury
- Mood, sleep, trauma, and stress can amplify pain signals
- Patients with chronic pain are often suffering in multiple domains
- Progress is measured in function and stability, not pain scores alone

Improving function is often a more realistic goal than eliminating pain.

Chronic pain is one of the most complex problems in medicine

- It affects more patients than almost any other condition
- It sits at the intersection of **biology, psychology, and social context**
- It often overlaps with **mental health and substance use**
- No single clinician can address all of it alone
- **Good pain care is collaborative care.**

Chronic pain is one of the most complex problems in medicine

- It affects more patients than almost any other condition
- It sits at the intersection of **biology, psychology, and social context**
- It often overlaps with **mental health and substance use**
- No single clinician can address all of it alone
- **Good pain care is collaborative care.**

References

1. Dahlhamer J, Lucas J, Zelaya C, et al. Prevalence of chronic pain and high-impact chronic pain among adults—United States, 2016. *MMWR Morb Mortal Wkly Rep*. 2018;67(36):1001-1006. doi:10.15585/mmwr.mm6736a2
2. Kim N, Matzon JL, Abboudi J, et al. A prospective evaluation of opioid utilization after upper-extremity surgical procedures: identifying consumption patterns and determining prescribing guidelines. *J Bone Joint Surg Am*. 2016;98(20):e89. doi:10.2106/JBJS.15.01290
3. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464
4. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC clinical practice guideline for prescribing opioids for pain—United States, 2022. *MMWR Recomm Rep*. 2022;71(3):1-95. doi:10.15585/mmwr.rr7103a1
5. Agnoli A, Xing G, Tancredi DJ, Magnan E, Jerant A. Association of dose tapering with overdose or mental health crisis among patients prescribed long-term opioids. *JAMA*. 2021;326(5):411-419. doi:10.1001/jama.2021.11013
6. Mark TL, Parish W. Opioid medication discontinuation and risk of adverse opioid-related health care events. *J Subst Abuse Treat*. 2019;103:58-63. doi:10.1016/j.jsat.2019.05.001
7. Goel A, Azargive S, Lamba W, et al. Perioperative pain and addiction interdisciplinary network (PAIN) clinical practice advisory for perioperative management of buprenorphine: results of a modified Delphi process. *Br J Anaesth*. 2019;123(2):e333-e342. doi:10.1016/j.bja.2019.03.044
8. Lembke A, Ottestad E, Schmiesing C. Patients maintained on buprenorphine for opioid use disorder should continue buprenorphine through the perioperative period. *Pain Med*. 2019;20(3):425-428. doi:10.1093/pm/pny019
9. Gaskin DJ, Richard P. The economic costs of pain in the United States. *J Pain*. 2012;13(8):715-724. doi:10.1016/j.jpain.2012.03.009
10. Hser YI, Mooney LJ, Saxon AJ, Miotto K, Bell DS, Zhu Y. Chronic pain among patients with opioid use disorder: results from electronic health records data. *J Subst Abuse Treat*. 2017;77:26-30. doi:10.1016/j.jsat.2017.03.006

Questions?

Type Questions into the chat or Raise hand

Additional questions:

1-855-337-MACS (6227)

MACS@som.umaryland.edu

MACS Services

Stay up to date: MACS Monthly Newsletter

www.marylandmacs.org/Contact-Us/

Prescribers: Sign up for MACS via phone or

https://bit.ly/2KE5nCT