

PAIN TREATMENT IN ADDICTS

- It is not contra- indicated
- It needs to be carefully monitored
- It has been shown to reduce relapse rate
- It has been shown to not worsen psychological dependence
- Not treating pain has been shown to make patients more dysfunctional

Definitions and myths

- Physical dependence
- Mis-use
- Abuse
- Pseudo-addiction
- Addiction
- Tolerance
- Withdrawal

Addiction

Addiction is a primary, **Chronic**, neurobiologic **disease**, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired **C**ontrol over drug use, **C**ompulsive use, **C**ontinued use despite harm, and **C**raving (**5 Cs**).

Consensus Document:
The American Academy of Pain Medicine.
The American Pain Society.
The American Society of Addiction Medicine, 2001.

Five C's of the Disease of Addiction

- ◆ Chronic
- ◆ Control
- ◆ Compulsive
- ◆ Continued
- ◆ Cravings

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Tolerance

- ◆ **Tolerance** is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time
 - **Key to definition: All other conditions being constant**
 - BAD: Disease or syndrome is progressing
 - GOOD: Functional activity is increasing

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The American Society of Addiction Medicine, 2001.

Pseudoaddiction

- ◆ The patient who seeks additional medications appropriately or inappropriately secondary to significant undertreatment of the pain syndrome. When the pain is treated in the proper manner, all inappropriate behavior ceases.

Weissman, D.E. , J.D. Haddox,
Opioid pseudoaddiction—an iatrogenic syndrome.
Pain.
1989. 36(3): 363-6.

Addiction versus Pseudoaddiction in Pain Management

◆ Addiction

➤ Prospectively

- Patient's behavior and complying with the treatment agreement becomes *aberrant* despite "Rational Pharmacotherapy."

◆ Pseudoaddiction

➤ Retrorespectively

- Patient's behavior and complying with the treatment agreement *normalizes* with "Rational Pharmacotherapy."

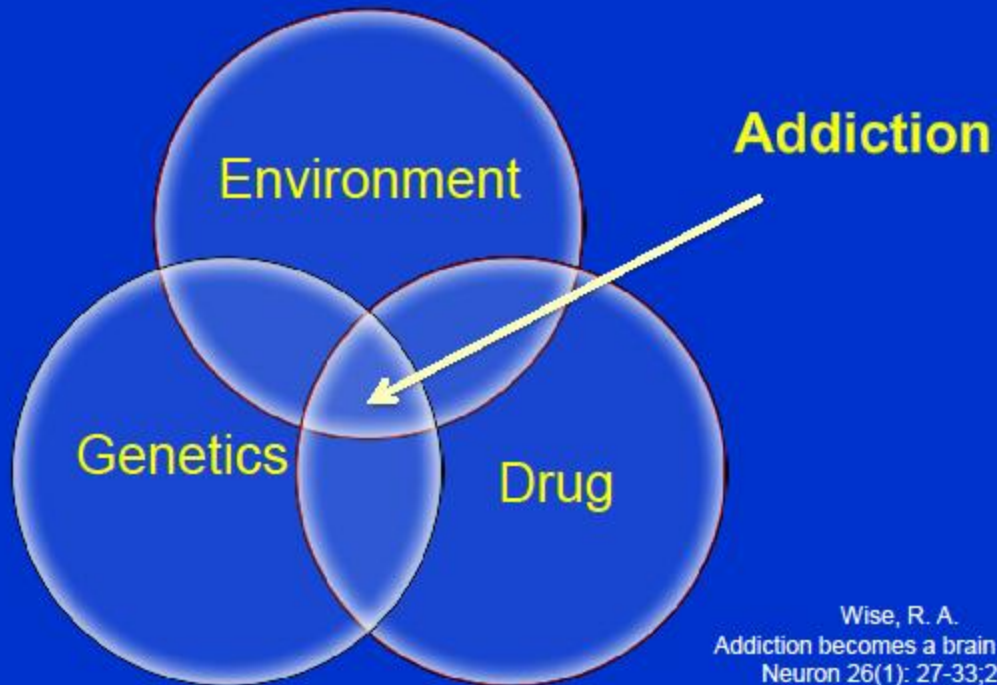
Gourlay D, Heit HA et al.
Pain Med.
2005;6(2):107-112

Pseudotolerance

- ◆ Need to increase opioid dose that is not due to tolerance but due to other factors
 - Disease progression - **Yes**
 - New disease - **Yes**
 - Increased physical activity - **Yes**
 - Lack of compliance - **No**
 - Change in medication - **Maybe**
 - Drug interaction - **Maybe**
 - Addiction - **No**
 - Deviant behavior - **No**

Pappagallo, M
J Pharm Care Pain Symptom Control
1998;6:95-98

Addiction: A Complex Brain Disease



Wise, R. A.
Addiction becomes a brain disease.
Neuron 26(1): 27-33;2000.

Leshner, A. I.
Addiction is a brain disease, and it matters.
Science 278(5335): 45-7;1997

The Most Common Triggers for Relapse

- ◆ Stress
- ◆ Drug availability
- ◆ Re-exposure to environmental cues (sight, sounds, smells) previously associated with drug-taking

Koob GF, Le Moal M.
Drug addiction, dysregulation of reward, and allostasis.
Neuropsychopharmacology
2001;24(2):97-129.

Stages of Change

- ◆ Precontemplation
 - Not intending to change, unaware of problem, resists efforts to change
- ◆ Contemplation
 - Intending to act, aware of problem, not committed to action
- ◆ Preparation
 - Intending to act in the near future, has taken small action steps

Prochaska JO, DiClemente CC
Treating Addictive behaviors
Miller WR, Heather N, eds.
2nd ed. N.Y.:
Plenum Press
1998:37-49

Stages of Change [cont'd]

◆ Action

- Overt changes in behavior, overt effort to change

◆ Maintenance

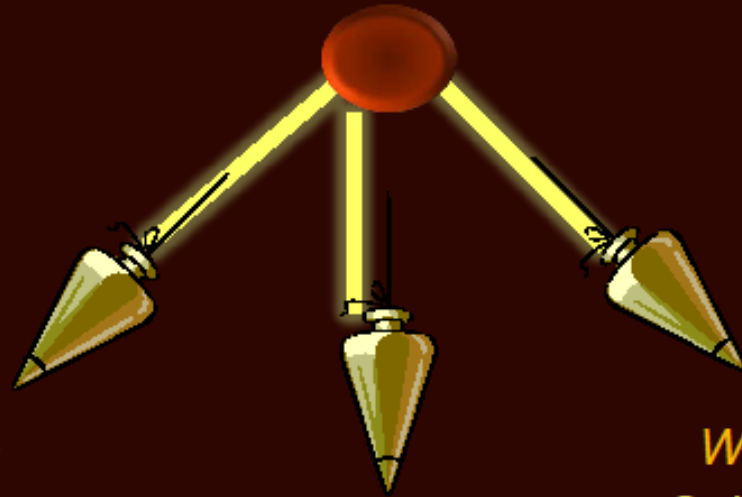
- Has sustained overt changes over time, working to stabilize change and avoid relapse

Prochaska JO, DiClemente CC
Treating Addictive behaviors
Miller WR, Heather N, eds.
2nd ed. N.Y.:
Plenum Press
1998:37-49

Chronic pain versus acute pain

- Acute pain serves a purpose, is a signal
- Chronic pain exists when the duration of pain exceeds the expected time for healing
-

The Opioid Pendulum



Avoidance

Even dying people
at risk of addiction

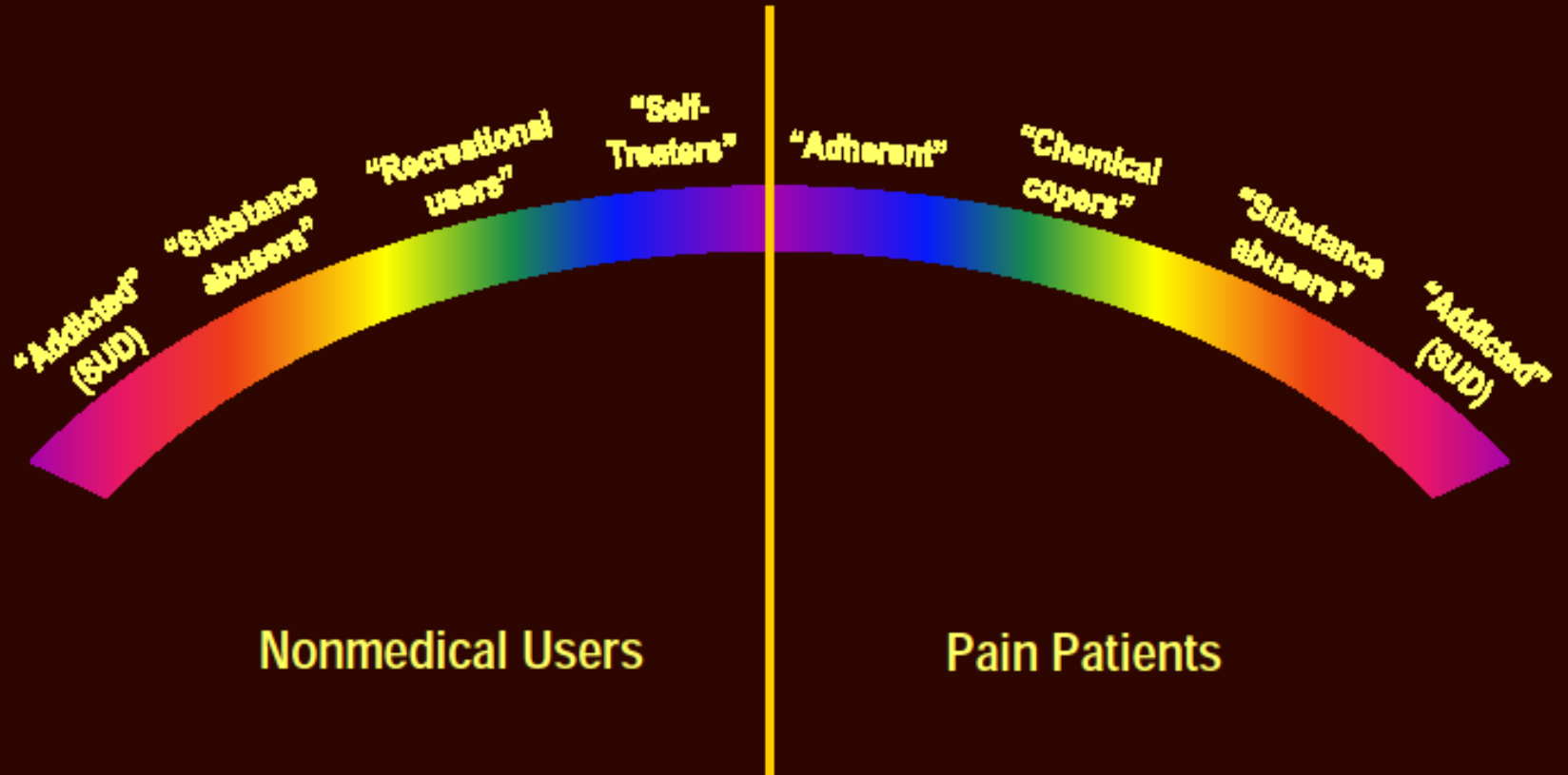
Balance

Risk stratification and
principles of addiction
medicine applied to
opioid prescribing
regardless of the pain
problem at hand

Widespread Use

Opiophobia must go

Population of Rx Opioid Users Is Heterogeneous



What Kind of a Rat am I?

Fisher 344	Abstinence	drug rejecting
Lewis	Polysubstance Abuse	drug seeking
Sprague-Dawley	Average	drug neutral



With Permission: Lynn Webster M.D., Lifetree Clinical Research and Pain Clinic
Salt Lake City, Utah.

Universal Precautions in Pain Medicine

1. Diagnosis with reasonable differential
2. Detailed psychological assessment including risk of addictive disorders
3. Informed Consent
4. Treatment Agreement
5. Pre and Post Assessment of Pain Level and Function
6. Appropriate Trial of Opioid Therapy +/- adjuvants
7. Reassessment of Pain Score and Level of Function
8. Regularly assess the “Four A’s” of Pain Medicine
9. Periodically reassess Pain Diagnosis and comorbidity including substance use disorders (SUD)
- 10. Document Appropriately**

Gourlay DL, Heit HA et al Universal Precautions in Pain Medicine: a rational approach to the management of chronic pain. Pain Med 2005; 6(2): 107-112

Opioid Risk Tool (ORT)

Mark each box that applies:

	Female	Male
1. Family history of substance abuse		
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Prescription drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
2. Personal history of substance abuse		
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
3. Age (mark box if between 16-45 years)	<input type="checkbox"/> 1	<input type="checkbox"/> 1
4. History of preadolescent sexual abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
5. Psychological disease		
ADO, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Scoring totals:	_____	_____

Administration

- On initial visit
- Prior to opioid therapy

Scoring

- 0-3: low risk (6%)
- 4-7: moderate risk (28%)
- ≥ 8 : high risk (> 90%)

Primary Care Triage of CNCP Patients

- **Group I** Primary Care
 - Lack major psychiatric comorbidity
 - No history of substance related problems
- **Group II** Primary Care with consultation
 - Increased risk patient, in recovery, family Hx
 - No active addictive disorder; No major untreated psychiatric disorder
- **Group III** Referral to tertiary clinic
 - Active addictive disorder
 - Major untreated psychiatric disorder

Teaching About Medication Storage and Sharing

- Sharing prescription meds seen as safe by “self-treaters”
- Need to educate patients about medication storage
- New devices being developed to help only the patient have access and on a schedule programmed in by the MD or RN



New Technology for Urine Screening

Tests for 12 Drugs

- ▶ Amphetamine
- ▶ Barbiturates
- ▶ Benzodiazepines
- ▶ Buprenorphine
- ▶ Cocaine
- ▶ Methadone
- ▶ Methamphetamine
- ▶ MDMA (Ecstasy)
- ▶ Opiates
- ▶ Oxycodone
- ▶ THC
- ▶ Propoxyphene



Results you can see in less than 5 minutes.

Split Chamber

Monitoring Standards

- Consider urine drug testing (UDT) in all patients
 - Especially those starting opioid therapy
 - When making major changes in therapy
 - When pain persists despite reasonable opioid therapy
 - In response to aberrant behavior
- Cheap, effective and well tolerated by pts
 - Only patients 'philosophically opposed' to UDT are those patients with problems who don't want help
- Use for advocacy, motivate/support behavioral change, identify abuse/addiction: Avoid "gotcha" syndrome

Aberrant Drug-taking Behaviors: The Model

- Probably more predictive
 - Selling prescription drugs
 - Prescription forgery
 - Stealing or borrowing another patient's drugs
 - Injecting oral formulation
 - Obtaining prescription drugs from non-medical sources
 - Concurrent abuse of related illicit drugs
 - Multiple unsanctioned dose escalations
 - Recurrent prescription losses
- Probably less predictive
 - Aggressive complaining about need for higher doses
 - Drug hoarding during periods of reduced symptoms
 - Requesting specific drugs
 - Acquisition of similar drugs from other medical sources
 - Unsanctioned dose escalation 1-2 times
 - Unapproved use of the drug to treat another symptom
 - Reporting psychic effects not intended by the clinician

Summary

- By consistently applying a basic set of principles to CNCP patients
 - Patient care is improved
 - Stigma is reduced
 - Overall risk is contained
- Universal Precautions is not about opioids –its about good medical care