

Opioids in Pain and Addiction

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Pain and Addiction: Role of Opioids

Scope of the Talk

- Acute and chronic pain
- The clinician's dilemma: pain and addiction
- Assessing risks
- Adequate pain relief
- Opioids in chronic pain
- Managing chronic pain: other measures
- What if addiction occurs
- Documentation

Pain: “*Define yourself, then we shall converse*” --Voltaire



- **Pain:** An unpleasant *sensory* and *emotional experience* arising from the actual or potential tissue damage or described in terms of such damage.
- It is always *subjective*. Each *individual* learns the application of the word through *experiences* related to injury in *early life*.—IASP

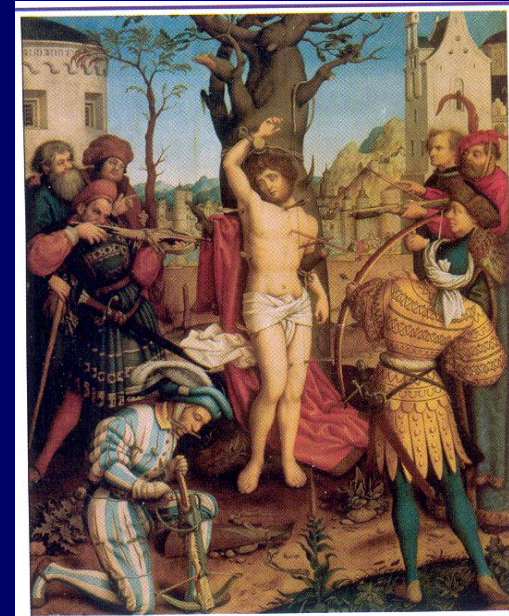
IASP = International Association for the Study

Early life -- historical

Experience--learned

Subjective--private

Individual--unique



Acute vs Chronic Pain:

Acute Pain

- Physiological; protective
- Causes external; obvious
- Tissue damage; resolution expected within days/wks
- Meds/big role vs self
- Symptom of illness
- Key issue: what pain?
- The devil outside

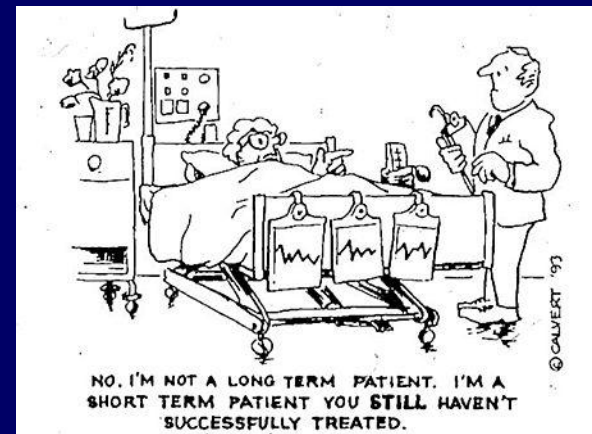
Chronic Pain

- Pathological; non-protective
- Causes internal; obscured
- CNS changes; resolution depends on mastery/control
- Meds/limited role vs self
- Disease & way of life
- Key issue: what patient?
- The demon within

The Acute pain patient is afflicted; the chronic patient is transformed. Chronic pain sufferer suffers for nothing

Chronic Pain: Risk Factors

- **Population level:**
 - old age; female gender; low socio-economic class, cultural background; life style; employment; hx of pain
- **Biological:**
 - Neural/pain threshold; endocrine/stress response, HPA axis, neuropeptides; genetics
- **Pain elsewhere:**
 - Type/ post-op, post-trauma, post-herpes; surgery/ nerve injury; radiation, chemo; prolong pain before surgery; inadequate analgesia
- **Disability:**
 - compensation, psychiatric co-morbidity
- **Patient attitude and belief**
- **Fact of pain becoming chronic**



Opioids for Chronic Pain: The Clinician's Dilemma

“What God hath joined together, can man put asunder?”

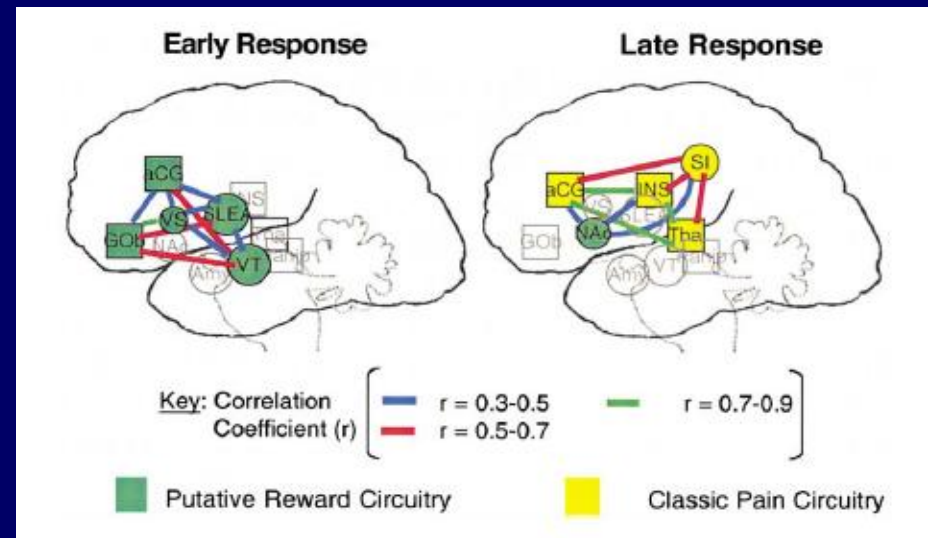
Separating analgesia from hyperalgesia and reward:

Substance p antagonists?

Canabinoid antagonists?

Glial cell inhibitors?

prevent development of
hyperalgesia and tolerance,
but preserve analgesia



Opioids for Chronic Pain: The Two Faces of Janus

What to do in the meantime?

Are opioids effective?

What risk addiction?

- Relieves pain
- Relieves suffering
- Relieves misery
- Makes you feel better
- Makes you feel good
- Makes you "high"



Diagnosing Addiction

Opioid-maintained Pain Patients

- No validated diagnostic criteria for addiction in pain patients; only “at risk” behaviors:
 - Control
 - Compulsive use
 - Continue use despite harm
 - Craving
- Identifying “at risk” patients:
 - History
 - Screening instruments
 - Behavioral checklists
 - Therapeutic maneuver



History and Screening

- **Predictive factors; as non-pain patients**
 - Personal or family history of drug abuse
 - Current addiction to alcohol or cigarettes
 - History of problems with prescriptions
 - Co-morbid psychiatric disorders
- **Screening instruments: SOAPP, ORT, SISAP**
 - Screened for non-compliant opioid use risks ²⁻⁴
 - Determine patient monitoring during opioid therapy ⁴
 - High risk of abuse scores aren't reasons to deny pain relief ⁴

Opioid Risk Tool (ORT)

Screeners and Opioid Assessment for Patients in Pain (SOAPP)

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:		_____	_____

14-item, self-administered form, capturing the primary determinants of aberrant drug-related behavior

Validated over a 6-month period in 175 chronic pain patients

Adequate sensitivity and selectivity

May not be representative of all patient groups

- **A score of ≥ 7 identifies 91% of patients who are high risk**

Administration

- On initial visit
- Prior to opioid therapy

Scoring

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

Butler, et al. *Pain*. 2004;112:65.

Webster, et al. *Pain Med*. 2005;6:432.

Aberrant Drug-Taking Behaviors

Probably more predictive

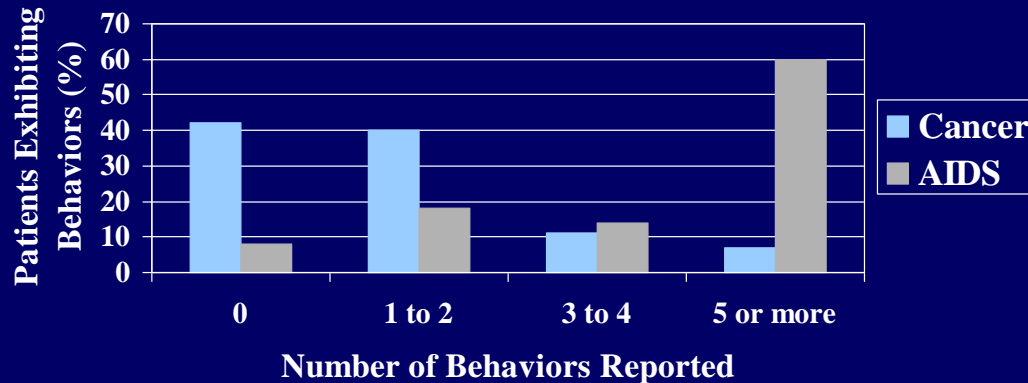
- Selling prescription drugs
- Prescription forgery
- Stealing or borrowing another patient's drugs
- Injecting oral formulation
- Obtaining prescription drugs from non-medical sources
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose ↑ s
- Recurrent prescription losses

Probably less predictive

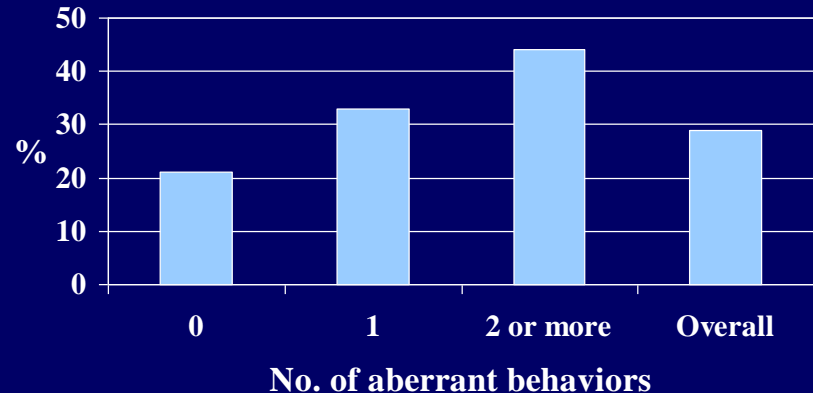
- Aggressive complaining about need for higher dose
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquisition of similar drugs from other medical sources
- Unsanctioned dose escalation 1 – 2 times
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician

Aberrant Behaviors in Cancer and AIDS Patients

Aberrant Behaviors in Cancer and AIDS:
SUD a Risk Factor?



Probability of positive urine toxicology by number of aberrant behaviors



Higher prevalence of SUD among pts on opioids for chronic pain than general population
(8.1 % current users)

Therapeutic Maneuver: Is the Pain Patient Addicted?

Drug-seeking or increased requests for pain medication

Detailed pain work-up

↑ Pathology / pain of new source

No new pain pathology

↑ Opioid dose

Unimproved functioning
Presence of toxicity

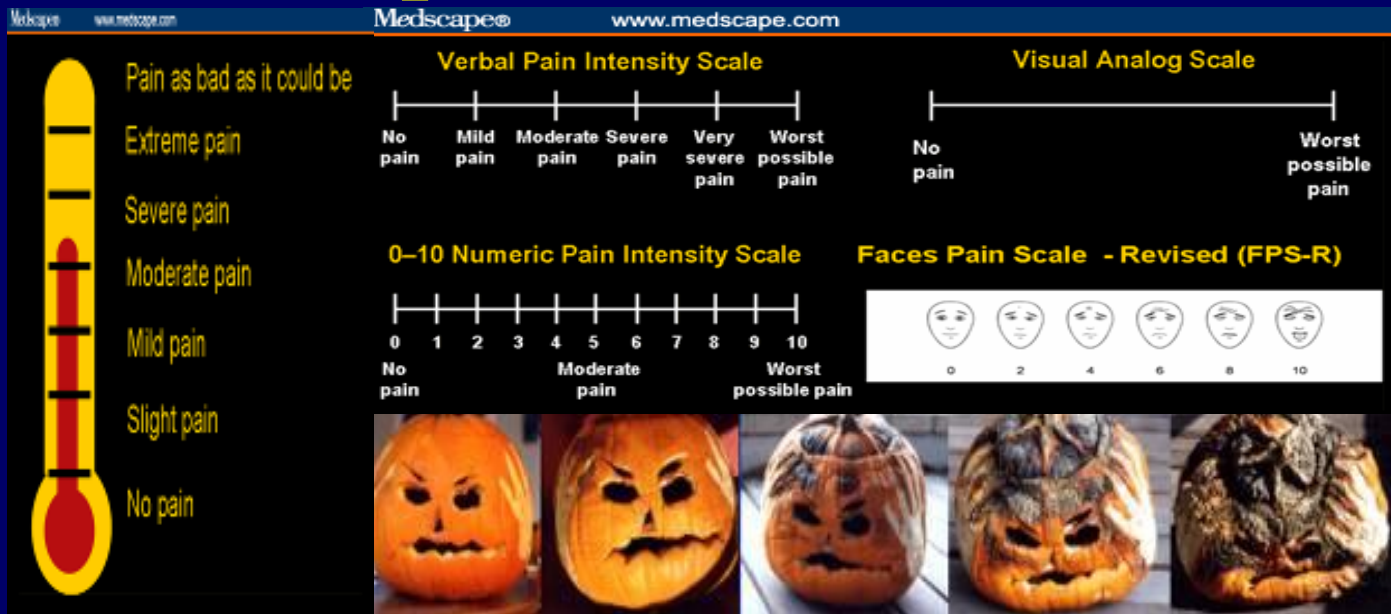
Improved functioning
Absence of toxicity

Addictive disease

Pseudoaddiction

Therapeutic dependence

Meaningful Pain Reduction & Acceptable Side Effects



- VAS / Numeric scale 0 – 10: (4 – 6 = mod pain; 7 – 10 = severe pain)
- Moderate pain (mean = 6): Meaningful reduction = 2.4 (40 %)
 - Very much better = 3.5 (45%)
- Severe pain (mean = 8): Meaningful reduction = 4.0 (50 %)
 - Very much better = 5.2 (56 %)

Meaningful Functional Improvement: My Favorites

- **Patient perspective of “improvement”**
 - Used to do, can’t do now, would like to do again
 - Could be physical, social, recreational
 - With friends, family, church
- **Achievable, enjoyable and meaningful**
 - Hobbies
 - Volunteer work

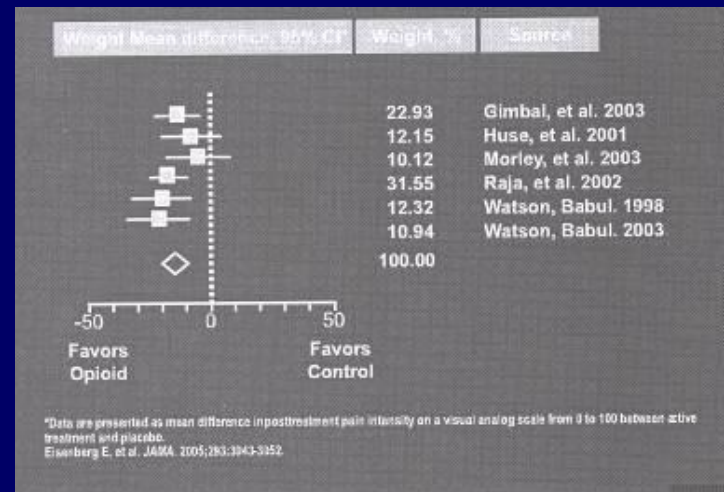
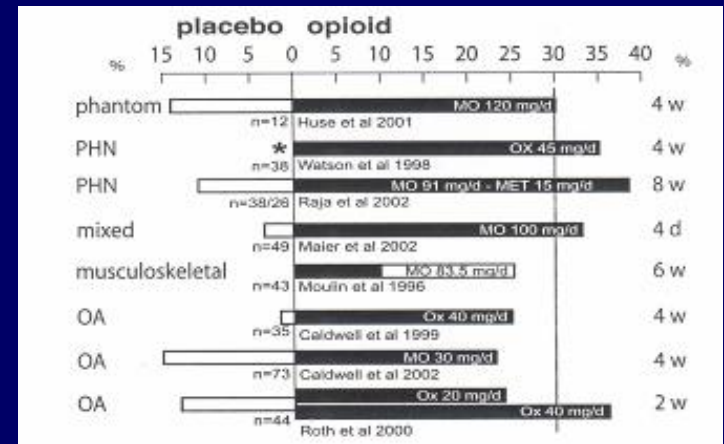
Pharmacologic Management of Neuropathic Pain: Evidence-based Recommendations

- **First-line medication:**
 - TCA's :nortriptyline, amitriptyline
 - SSNRI's: duloxetine, venlafaxine
 - Calcium channel α_2 -d ligands:Gabapentin, pregabalin
 - Topical lidocaine
- **Second-line may be used as first-line:**
 - Opioids
 - Tramadol
- **Gen. third-line:**
 - Anticonvulsants: carbamazepine,lamotrigine,oxcarbazepine
 - Antidepressants
 - Mexiletine, NMDA antagonists, topical capsaicin

Robert H. Dworkin et al: Pain 132 (2007)237-251

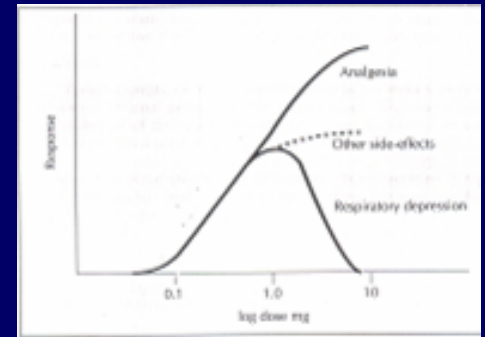
Opioids for CNMP: How Effective?⁵⁻⁸

- Effective, especially strong opioids
- Meaningful pain ↓ (1/3)
- Acceptable side effects
- Improved function & QOL
- Most data short term (< 3 m)
- Exclude “addict” patients



Buprenorphine for Neuropathic Pain

- Thought limited by its ceiling effect
 - not borne out clinically
- Tight binding & prolonged receptor occupancy thought to limit ability to combine with other agonists
 - not borne out clinically
- Previously recommended to D/C or substitute with full agonist one week before surgery
 - not borne out clinically
- May prove to be best treatment for chronic pain in opioid-dependent patients ¹⁶





Adjunct Analgesics & Behavioral Strategies

- Neuraxial analgesia: intrathecal MS (100 x) and epidural (10 x)
- Opioid rotation esp methadone switch
- Regional analgesia (blocks)
- Indwelling catheters
- α -2 adrenergic agonist dexmedetomidine
 - dextromethorphan;
 - gabapentin;
 - ketamine;
 - nitric oxide;
 - transdermal nitroglycerine
- What it is and isn't
- Pain vs. suffering
- Hurt vs. harm
- Not acquired from outside but transformed
- Not to cure or do away with once and for all
- To conquer, triumph over, manage and master
- To rid of chronic pain is to rid of the self; *it is against the law in all civilized countries.*

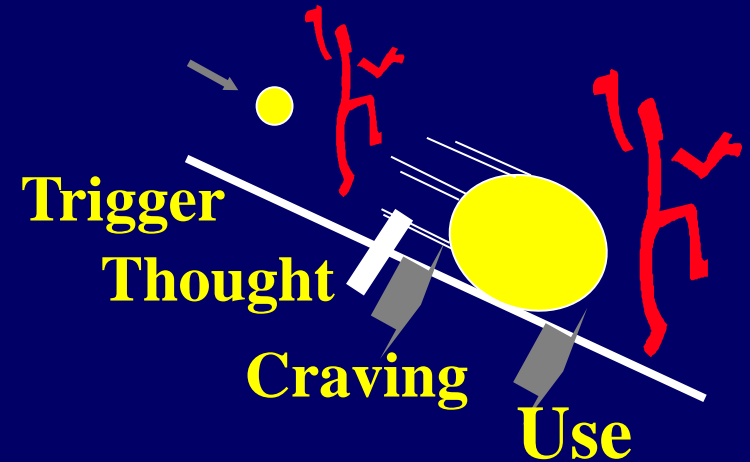


What If Addiction Occurs?



"Addiction is not taking a lot of drugs; it's taking drugs and acting like an addict." – Alan Leshner

- Integrated concurrent approach
- Control over medication supply
- Observed dosing and "call backs"
- Use of contingencies and "contracts"
- Urine testing
- Setting goals before start
- Family involvement
- Intensifying "recovery"
- Exit strategies
- Treatment guidelines
- Consultations



Motivational Style

Documentation

- Why opioids are prescribed in this case
- What reduction in pain has been achieved
- What functional improvement has occurred
- Document acceptable side effects
- Document responsible medication use and absence of aberrant behaviour



Remember:

1. What is not written down didn't happen.
2. Your record will testify in public not what patients you have but what doctor they have

In Summary

1. Chronic pain is not something that happens to you, it is “you” transformed. It cannot be gotten rid of; it can only be managed.
2. Opioids are powerful and legitimate tools for chronic pain patients; they are effective in relieving suffering and pain.
3. The risk for addiction is small; it’s reflected by behavior that must be assessed early and monitored throughout treatment

One for the Doc

1. Before you start

- Learn what chronic is and isn't; differentiate between suffering and pain, hurt and harm
- Assess the level of risk; decide if formal agreement needed
- Pick an opioid, learn its effective use, dose escalation and opioid induced hyperalgesia

2. During treatment

- Monitor for behavior indicative of misuse, abuse and addiction; use adjunct medications and behavioral treatment; use common sense.

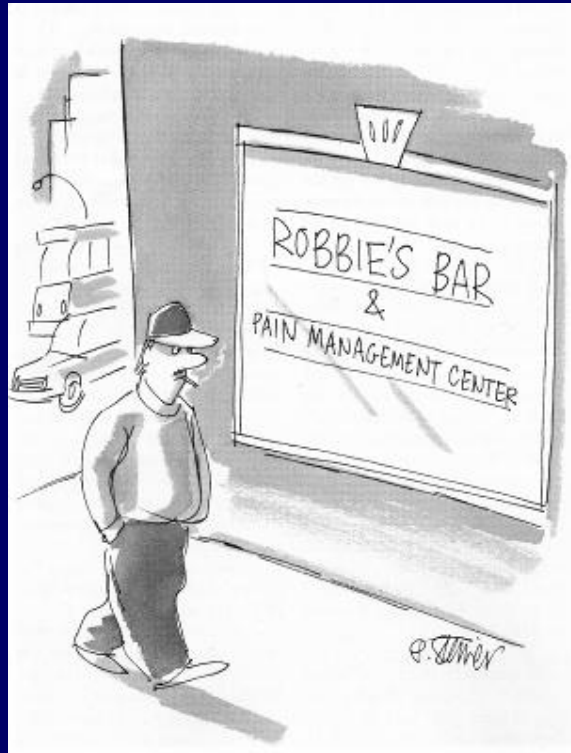
3. If addiction happens, treat and get help

4. Document what you do and why

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Thank you, thank you



and thank you...