Emerging Solutions in Pain: The Interface of Pain and Addiction

The Dark Side of Pain Management and How to Become Enlightened

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Pain

"No kind of sensation is keener and more active than that of pain; its impressions are unmistakable."

— *"The 120 Days of Sodom"*
the Marquis de Sade

Barriers to Pain Management

- Addiction/misuse of controlled substances
- Diversion
- Regulatory issues

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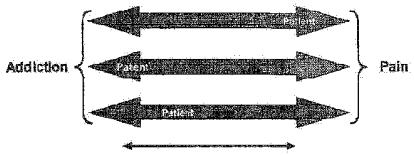
Treatment of Chronic Pain

- The prescribing of a controlled substance such as an opioid can be both the problem or the solution
  - There must be a clear exit strategy in addition to an entrance strategy before writing the first prescription

Heit HA, Gourlay DL. Pain and Addiction: Managing Risk Through Comprehensive Care Manuscript submitted for publication

Pain and Addiction Continuum (or Other Comorbid Condition)

- Failure to treat both conditions, when present, will undoubtedly lead to frustration and poor outcomes in both domains



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Pain and Addiction Continuum (or Other Comorbid Condition)

- One can treat **acute** pain in the face of an active addiction
- But one can not treat **chronic** pain with optimal results in the face of an active addiction
  - Patient must be willing to accept assessment and treatment of both pain and addiction

Gourlay DL, Heit HA, et al. Pain Med. 2006;8:107-112.

Addiction vs. Pseudoaddiction

- The diagnosis of addiction is made prospectively, over time
  - Aberrant behavior becomes apparent despite the best attempts of a rational treatment plan by the health care professional
- The diagnosis of pseudoaddiction is made retrospectively
  - Aberrant behavior normalizes with a rational treatment plan by the health care professional

Heit HA, Gourlay DL. Pain and Addiction: Managing Risk Through Comprehensive Care. Manuscript submitted for publication

"Can You Treat a Patient With Chronic Pain Who Has the Disease of Addiction With Controlled Substances Including Opioids?"

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. *Neuropsychopharmacology*. 2001;24(2):97-129.

All Opioid Medication/Controlled Substances (CS) Can Be Misused

Misuse of IR Opioids in Clever Delivery Systems

- Misused with destroying the CR/MR/SR delivery system
  - Now just IR opicid
- Cutting, crushing, or chewing the pill
  - Swallowing
  - Snorting
- Heating the pill in water or other solvents
  - Injecting
    - Risk of lung, vascular, and skin problems with IR opioids in a controlled-releasec delivery system

Misuse of the Fentanyl Patch

- Used fentanyl patches[1]
  - 28%-84% of drug remains in used patches
  - Leave old patches on
- Reverse roll patch
  - Insert in rectum
- Cut patch into four parts to make "Chiclets"

[1]Marquardt KA. *Am Pharmacother* 1996;29:959-971.

Misuse of the Fentanyl Patch

- Cut corner of patch
  - Place S/L
  - Use syringe to obtain drug for IV injection
- Obtain drug for smoking
- Abrade skin
  - Place heat over patch once applied

Prescription Drug Misuse

- Street value
  - Brand vs. generic
  - IR opioids
    - "Faster speed of dopamine elevation"
    - "Faster diminution of dopamine elevation."
      - *Positive reinforcement*
      - *In genetically susceptible individuals*
  - The drug can be injected or snorted successfully

Wise RA, Newton P, et al. Psychopharmacology. 1995;2010-20.
Volkow ND, Ding YS, et al. Arch Gen Psychiatry. 1995;52:456-463.

Benefits of Prescription Drug Diversion

- Oral use
  - No risk of HIV/Hep B or C
- Obtained from licit sources
- Often paid for by third party/welfare benefits
- Used/sold/bartered for illicit drugs

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Trends in Abuse of Oxycodone HCl Controlled-Release and Other Opioid Analgesics in the US: 2002-2004

- Prescription drugs easier to obtain than illicit drugs in a rural or suburban areas
- Illicit drugs are monitored more closely than prescription medication by the regulatory agencies
- Use/abuse of prescription medicines are more socially acceptable than illicit drugs
- Purity and the dosage of prescription medication is more highly predictable and consequently thought to be safer to misuse

Cicero TC, et al. J Pain. 2005;6(10):662-672.

Street Value of Drugs

- Darvocet® 100 mg: $0.50
- Tylenol® 3: $2-3
- Vicodin®: $6-8
- Percocet®: $6-8
- Demerol® 100 mg: $10
- Morphine 30 mg: $15
- Dilaudid® 4 mg: $48
- OxyContin®: $0.50 -1 per mg
- Duragesic Patch®: $1-2 per mcg
- Methadone 10 mg: $5-10
- Actiq® lozenges 200 and 400 mcg: $20
- Ativan® 2 mg: $2-3
- Xanax® 1 mg: $5-7
- Valium® 10 mg: $4-6
- Serax® 30 mg: $0.50
- Fiorinal®/butalbital: $3-5
- Ritalin® 10 mg: $10-12
- Soma®: $3-4

Goal

- Valid pain patients
  - The most prevalent category overall
- Addicted patients
  - The most common type of drug seeker
    - Prevalence of addiction in the general population
    - Approximately 10% (3%-16%)[1]
- Criminal drug seekers
  - The least common type of drug seeker

[1]Savage SR. J Pain Symptom Manage. 1996;11:274-286.

Strategies to Prevent Diversion: Preventing Telephone Scams

- No telephone prescriptions for unfamiliar patients
  - Including the vacationing/visiting pain patient
    - Forgot to bring his/her pain medicines
- Arrange to see in person
  - Not alone
- Do not permit office staff to authorize prescriptions renewals
  - Or designate one person for this office duty

Typical Scams

- Telephone scams
  - Calling after office hours or on weekends
  - My pharmacy is closed
- Garage sale
- Open house
- Workers in the house

Interval Prescribing

- Interval prescribing
  - New patients or patients with a history of addiction may do better with smaller quantities of medication

Contingency Prescribing

- Contingency prescribing
  - Prescribing the next script is contingent on…"
    - Bringing bottles in for 'pill counts'
    - Attendance mandatory at appointment
      - No telephone reports: if you're too sick to attend – yellow flag

"How Do You Provide Care While Preventing Misuse and/or Diversion of Opioid Medications?"

Goals of Treating Chronic Pain

- Decrease pain
- Increase function
- Use medications that do not have unacceptable side effects

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Hippocratic Oath

"I will prescribe a regimen for the good of my patients according to my ability and my judgment and never do harm to anyone"

Case Study: Mr. G

- Mr. G is a 40-year-old male who presents with documented failed back syndrome and myofascial pain syndrome secondary to auto accident
  - Reviewing past medical records documented all non-opioid treatments have failed to improve Mr. G's quality of life

Case Study: Mr. G

- He presents with:
  - Chronic pain
  - Depression
  - Alcohol dependency was present before and continues after the accident
  - Hydrocodone and heroin (IV use) was bought off the street to self-medicate his pain
  - Cocaine (snorting) is now being used to deal with stress secondary to family and economic problems
- Family history is positive for addiction

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Barrier to Opioid Pain Management?

- Can a pain patient who presents with an active addiction be treated if indicated with opioids?
- Fear of the regulatory agencies
  - If a doctor treats a chronic pain patient with opioids and that patient also has the disease of addiction, will he or she be a target of the regulatory agencies?
- Can I treat Mr. G's pain with opioids?

Alcoholics Anonymous (AA) 12-Step Program

- Variation on the 10th step
  - I will take a personal inventory of my knowledge and comfort to treat a patient with a pain syndrome and the disease of addiction
    - If I am uncomfortable or unsure with Mr. G's clinical problems, I should refer the patient to another doctor

The Physician's and Patient's Contributions to Misprescribing Opioids -- Four D's and Now the Five D's**

- Physician's contribution
  - Dated
    - Fails to keep current with prescribing practices or knowledge about drug abuse patterns
  - Disabled
    - Fails to exercise optimal judgment because of impairment
  - Defiant**
- Patient's contribution

DuPont IH... West J Med. 1990;152:600-603.

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The Physician's and Patient's Contributions to Misprescribing Opioids – Four D's and Now the Five D's**

- Physician's contribution
  - Dishonest
    - Subverts medical practice for personal financial gain
  - Duped
    - Fails to detect deception. Allows himself or herself to be manipulated into prescribing at variance with accepted medical practice
- Patient's contribution
  - Uses the physician as a drug dealer; not for medical care
  - Falsifies or withholds information

DuPont RL. *West J Med*. 1990;152:600-603.

Opioid Treatment of Chronic Pain

- Treatment of Mr. G is based on his
  - Mutual trust and honesty
  - Signing an opioid agreement
  - Starting or continuing a "program" for recovery for the disease of addiction
- Following Universal Precautions in Pain Medicine[1]
- Urine drug testing
  - Used, like all other diagnostic tests to improve patient care[2]

[1]Heit HA, Gourlay D. *J Pain Symptl Manage*. 2004;27(3):260-267.
[2]Gourlay DL, Heit HA. *Pain Medicine*. 2005;6(2):107-112.

The Opioid Risk Tool (ORT)

- Five-question clinical interview or patient questionnaire to assess patients at risk prior to treatment initiation
- Specifically developed to screen patients with chronic pain who will be using opioids as part of their treatment plan
- Quantifies the level of risk for patient
- Easy to use format

Webster LR, Webster RM. *Pain Med*. 2005;6:432-442.

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The ORT Form

Mark each box that applies

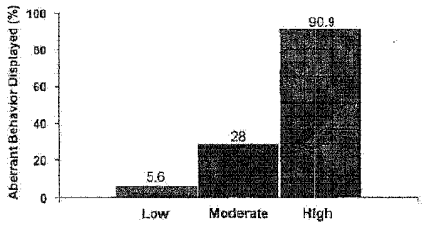
	Female	Male
1. Family history of substance abuse		
Alcohol	[ ] 1	[✓] 3
Illegal drugs	[ ] 2	[ ] 3
Prescription drugs	[ ] 4	[ ] 4
2. Personal history of substance abuse		
Alcohol	[ ] 3	[✓] 3
Illegal drugs	[ ] 4	[✓] 4
Prescription drugs	[ ] 5	[✓] 5
3. Age (mark box if between 16-45)	[ ] 1	[✓] 1
4. History of preadolescent sexual abuse	[ ] 3	[ ] 0
5. Psychological disease		
Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	[ ] 2	[ ] 2
Depression	[ ] 1	[✓] 1
Scoring Totals		17

Scoring the ORT

- Total score is calculated by adding the point values for each of the risk factors
- Three risk categories
  - Low: 0 - 3 points
  - Moderate: 4 - 7 points
  - High: 8 points and above

Webster LR, Webster RM. *Pain Med.* 2005;6:432-442.

Validation Study Results



Webster LR, Webster RM. *Pain Med.* 2005;6:432-442.

Breath Alcohol Concentration (BAC)

- Equal in alcohol content
  - 12 oz of beer
  - 5 oz of wine
  - 1.5 oz of liquor (80 proof)
    - Metabolized by the liver by zero order kinetics

Breath Alcohol Concentration (BAC)

- Male
  - Rise in BAC/drink
    - 0.020 g/dL
  - Fall in BAC/hour
    - 0.010 g/dL
    - Equal to ½ of a drink
- Female
  - Rise in BAC/drink
    - 0.025 g/dL
  - Fall in BAC/hour
    - 0.0125 g/dL
    - Equal to ½ of a drink

Mr. G will also submit to random BAC or UDT testing. Results will be correlated with his clinical status

The Clinical Use of an Agreement for Opioid Maintenance Therapy for Noncancer/Cancer Pain

Creating and Implementing Opioid Agreements

- Opioid agreements
  - Can improve the therapeutic relationship
  - Must be based on mutual trust and honesty between patient and physician that is initiated with the first visit
  - Must be part of an environment of care that emphasizes truthful, open dialog

Heit HA, *Care Management: Disease Management Digest.* 2003;7(1):2-3

Opioid Agreements

- Purpose of agreement
  - To facilitate informed consent
  - Patient education
  - Compliance
- Establishes the responsibilities of physician to patient and patient to physician
- It delineates the treatment plan to manage pain

Heit HA, *Care Management: Disease Management Digest.* 2003;7(1):2-3

Opioid Agreements

- Gives informed consent about side effects and risks of opioids
- Establishes boundaries and consequences for opioid misuse or diversion
  - Noncompliance with the agreement can aid in the diagnoses of the disease of addiction or substance abuse relapse
    - This would require a change in the treatment plan
- Agreement should be reasonable, readable, and flexible

Heit HA, *Care Management: Disease Management Digest.* 2003;7(1):2-3

Mr. G Required Evaluation and Treatment of Two Medical Problems

- The pain syndrome
- The disease of addiction
  - The pain doctor should know addiction medicine
  - The addiction medicine doctor should know pain medicine

Conclusion

Health care practitioners can prescribe scheduled controlled substance (CS) to give their patients the best quality of life possible given the reality of their medical condition.

Future Solutions and Thoughts

- Medical schools and post medical school training and all health professional schools
  - Must make addiction medicine and pain management part of the core curriculum
  - Board certification

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AA Serenity Prayer

"God, grant me the Serenity to accept the things I cannot change; Courage to change the things I can; and the *WISDOM* to know the difference."