Narcotic Addiction in Patients with Chronic Pain

John Roberts, MD
Medical Director
Pavillon
<table>
<thead>
<tr>
<th>Category</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic pain patients who may have addictive disorders</td>
<td>32% (Chelminski et al., 2005)</td>
</tr>
<tr>
<td>People ages 20 and older who report pain that lasted more than 3 months</td>
<td>56% (National Center for Health Statistics, 2006)</td>
</tr>
<tr>
<td>People experiencing disabling pain in the previous year</td>
<td>36% (Portenoy, Ugarte, Fuller, &amp; Haas, 2004)</td>
</tr>
<tr>
<td>People ages 65 and older who experience pain that has lasted more than 12 months</td>
<td>57% (National Center for Health Statistics, 2006)</td>
</tr>
<tr>
<td>Civilian, noninstitutionalized U.S. residents ages 12 and older who report nonmedical use* of pain relievers in past year</td>
<td>5% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007)</td>
</tr>
<tr>
<td>People ages 12 and older who report that they initiated illegal drug use with pain relievers</td>
<td>19% (SAMHSA, 2008)</td>
</tr>
<tr>
<td>People with opioid addiction who report chronic pain</td>
<td>29–60% (Peles, Schreiber, Gordon, &amp; Adelson, 2005; Potter, Shiffman, &amp; Weiss, 2008; Rosenblum et al., 2003; Sheu et al., 2008)</td>
</tr>
</tbody>
</table>

*Nonmedical use is use for purposes other than that for which the medication was prescribed.*
Epidemiology

• 6.8 million Americans reported nonmedical use of prescription drugs in the month in 2012
• Of these, 4.9 million abused pain relievers
• 30.7% received from a physician
• The number of Americans who abused prescription drugs exceeds those who have used cocaine, heroin, hallucinogens, ecstasy and inhalants combined. Only cannabis exceeds prescription drug abuse.
• 90% of US patients receiving pain management receive opiate medication
• 18-41% had abuse/addiction issues
DSM-5: The 11 Diagnostic Criteria

- Using larger amounts or for longer periods than intended
- Desire to cut down or stop using but not managing to do so
- Much time spent obtaining, using or recovering from use
- Cravings and urges to use substance
- Impaired function at work, home or school due to use
- Continued use despite problems in relationships
- Giving up important social, occupational, recreational activities due to use
- Using substance repeatedly despite resulting dangers
- Continued use despite physical or problems caused or made worse by use
- Needing increased amounts of substance to get desired effect (tolerance)
- Withdrawal symptoms when stopping or cutting down, relieved by use of more of substance
Continuum of Severity

- Mild - meets 2-3 criteria
- Moderate - meets 4-5 criteria
- Severe - meets 6 or more criteria
SUD Definition

- ASAM defines SUD as primary chronic brain disorder with genetic, psychosocial and environmental factors influencing its course
- Chronic relapsing disease characterized by impaired control, preoccupation with use, use despite adverse consequences, and distorted thinking, most notably denial
Relapse and Conditioning

- Repeated alcohol use has caused “conditioning” to occur in related circuits.
- Now “cues” associated with alcohol use can activate the reward and withdrawal circuit.
- This can evoke anticipation of alcohol or feelings similar to withdrawal that can precipitate relapse in an abstinence patient.

• Physical dependence. A state of adaptation that is manifested by a drug-class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing the level of the drug in the blood, or administration of an antagonist (a substance that opposes the action of the drug) (Savage et al., 2003)
• Tolerance. A state of adaptation in which exposure to a substance induces changes that result in a diminution of one or more of the substance’s effects over time (Savage et al., 2003).
• Pseudo-addiction. A controversial term coined to describe aberrant drug-related behaviors (e.g., clock watching, drug seeking), that resemble those of patients with addiction but that actually result from inadequate treatment of pain (Weissman & Haddox, 1989).
• PSEUDO-ADDICTION:
  • Physical dependence confused with psychologic dependence
  • Pain-relief seeking, not drug-seeking
  • When right dose used, patient functions better in life, whereas opposite true with the true addict
  • To help differentiate: one MD controls the drug under a specific contract with pt., one pharmacy, frequent visits, pill counts
Acute Pain

- Time limited - hours to weeks
- Related to damage
- “response to injury system”
- Damage heals and pain subsides
- Computer functions properly
Chronic Pain

• 24% male,
• 27% female,
• > 76 million in the US
• 22% of patients presenting to primary care
• Causes more disability than cancer and heart disease combined
• Common cause of suicide
• Direct cost- >$160 billion per year
Chronic Pain Syndrome

- Pain > 6 months
- Depression, anxiety, anger, fear
- Restriction in daily activities
- Excessive use of medications and medical services
- Multiple, *non-productive* tests, treatment, surgeries
- No clear relationship to organic disorder
5 Key Facts About Chronic Pain:

- All pain is real.
- Emotions drive the experience of pain.
- Opioids often make pain worse.
- Treat to improve function.
- Expectations influence outcomes.
Pain is influenced by:

- Culture
- Context
- Anticipation and previous experience
- Emotional and cognitive factors
Chronic Pain

• Pain persists long after healing has occurred and/or long after pain can serve a useful purpose
• No longer a symptom of injury or disease.
• A medical problem or syndrome in its own right.
Chronic Pain

• The original signs of injury may disappear or resolve to some minimal scar.
• There is a mismatch between the amount of pain and the amount of injury.
• Relatives and doctors begin to express their frustration
Chronic Pain

• Movement is restricted
• Thought is slow and attention to the outside world is limited
• Loss of appetite, constipation, loss of libido, change of sleep pattern, disturbance of family and social relations.
Chronic Pain

- Neural sensitization
- Lowered thresholds
- Amplified response (hyperalgesia)
- Normal stimulation becomes painful (allodynia)
- Spontaneous neural discharge occurs
Chronic Pain

• Patient’s behavior changes during the months after the onset of pain in the acute stage.
• Pain and complaint are unremitting and often a more and more elaborate search for treatment becomes a major activity.
• Deepening depression
Chronic Pain

• Pain, which is normally associated with the search for treatment and optimal conditions for recovery, now becomes intractable.
• Patients are beset with a sense of helplessness, hopelessness and meaninglessness.
• The pain becomes evil—intolerable and serves no useful function
Types of Pain

• Nociceptive

• Neuropathic

• Mixed Nociceptive/Neuropathic

• Central
Nociceptive Pain

- Receptors stimulated by mechanical, thermal, chemical stimulation
- Dorsal Horn
- Somatosensory cortex – pain is evaluated
- Limbic system – emotional reactions mediated
- Autonomic centers
- Motor cortex? – behavioral response
- Musculoskeletal, inflammation, mechanical
Neuropathic Pain

• Results from lesion or dysfunction to sensory nervous system – injured nerve, metabolic diseases, infections
• Central and peripheral
• Diabetes mellitus, postherpetic neuralgia, CVA
Mixed Nociceptive/Neuropathic

- Combination of two types of pain
- Degenerative disc disease – mechanical (nociceptive) and radicular (neuropathic)
Central Pain

• Brain and nervous system are altered resulting in one feeling more pain
• Allodynia- pain from stimulus that does not ordinarily cause pain
• Hyperalgesia- an exaggeration or distortion of pain than would normally be expected
• Intensity of pain signal is turned up on high
Central Pain

- Sensitization of the brain and nervous system
- May affect nociceptors, spinal column, thought-processing centers
- Misunderstood - felt to be less than real
- Associated with emotional and psychological suffering – depression, anger, fear, frustration, hopelessness
- Real as any other chronic pain – not imagined
Referred Pain

• Information from nerves carrying pain signals from various organs or regions becomes confused
Chronic Pain

• Increasing signaling disconnected from nociceptive input becomes autonomous, self-sustaining and progressive, leading to continuous perception of pain even in the absence of ongoing tissues damage
• Tissue damage releases chemicals that sensitize nerve fibers, alter gene expression, causing changes in signaling
• These changes can enable non-pain-conducting fibers to trigger pain in the CNS
• Injured nerves regenerate in a neuroma – generates pain signal with no stimulation
• Injury occurs in pain processing CNS centers (dorsal horn, thalamus) signals interpreted as pain
• Degeneration of pain inhibitory cells
Acute Becomes Chronic pain

- Injury
- Injury doesn’t heal as expected
- Nociceptors continue to fire
- Transmission circuits become more efficient
- Neurotransmitters increase – (substance-P, enkephalins)
- Nociceptor treshold is lower – less stimulus required to discharge nerve
- Inhibitory signals decrease
How does acute pain become chronic pain?

Surgery or injury causes inflammation → Peripheral Nociceptive Fibers → Transient Activation → Peripheral Nociceptive Fibers → Sustained Activation → Sensitization → Peripheral Nociceptive Fibers → Sustained currents → Structural Remodeling → CNS Neuroplasticity → Hyperactivity → Acute Pain → Chronic Pain

Neuroplasticity

• Pain and emotion cause the brain to change
• Brain adapts and forms new pathways
• Altering behaviors can change the brain and the way one feels pain
Emotions

• Sensory components become less important
• Emotional components become more important
• Emotion and pain cause the brain to change
Biomedical Model

• Pain is entirely biological in origin
• Most effective treatment is medical in nature
• Real pain is “physical”
• Emotions discounted – psychosomatic, hypochondriacs, malingerers, addicts
• Emotional experience of pain determines perception of pain and suffering
Psychology of Pain

- Pain is variable
- Pain is modifiable
- Pain differs from person to person
- Pain differs from culture to culture
- Pain is a highly personal experience
- Pain cannot be defined simply in terms of particular kinds of pain
40% of all outpatient visits are related to pain\textsuperscript{1}

50% of male veterans and 75% of female veterans report presence of pain\textsuperscript{2,3}

More than half of all CNCP is managed by primary care providers \textsuperscript{4}


\textsuperscript{3}Haskell SG, Heapy A, Reid MC, Papas RK, Kerns RD. The Prevalence and Age-Related Characteristics of Pain in a Sample of Women Veterans Receiving Primary Care. \textit{J Women’s Health.} 2006;15(7):862-869.

Universal Precautions in Pain Medicine

- Reassessment of pain score and level of functioning
- Regularly assess the “Four As” of pain medicine: Analgesia, Activity, Adverse reactions, Aberrant behavior
- Periodically review pain diagnosis and co- morbid conditions, including addictive disorders
- Documentation
Contributing Factors

• Onset of drug abuse or addiction to other substances usually precedes abuse of prescription medication

• Drug Characteristics- rapidity of onset, route of administration, purity, brand name

• Hydrocodone abused far in excess of other opioids
Patient Characteristics

- Past or current SUD
- Use of meds in non-prescribed doses or routes of administration
- Use of meds for reasons other than indicated
- Younger age
- Health care workers
- Psychiatric dual-diagnosis
- Family history of SUD
<table>
<thead>
<tr>
<th>Risk</th>
<th>Characteristics of Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>No history of substance abuse</td>
</tr>
<tr>
<td></td>
<td>Minimal, if any, risk factors</td>
</tr>
<tr>
<td>Medium</td>
<td>History of non-opioid SUD</td>
</tr>
<tr>
<td></td>
<td>Family history of substance abuse</td>
</tr>
<tr>
<td></td>
<td>Personal or family history of mental illness</td>
</tr>
<tr>
<td></td>
<td>History of nonadherence to scheduled medication therapy</td>
</tr>
<tr>
<td></td>
<td>Poorly characterized pain problem</td>
</tr>
<tr>
<td></td>
<td>History of injection-related diseases</td>
</tr>
<tr>
<td></td>
<td>History of multiple unexplained medical events (e.g., trauma, burns)</td>
</tr>
<tr>
<td>High</td>
<td>Active SUD</td>
</tr>
<tr>
<td></td>
<td>History of prescription opioid abuse</td>
</tr>
<tr>
<td></td>
<td>Patient previously assigned to medium risk exhibiting aberrant behaviors</td>
</tr>
</tbody>
</table>
Drug Characteristics

- Rapidity of onset
- Magnitude of dopamine surge
- Route of administration IV>IN>IR>SR
- Purity – Trade named perceived as more potent and have higher street value
Clinician Characteristics

• Difficulty identifying high risk patient
• Dated clinical knowledge
• Deceived
• Distracted
• Defiant
• Disabled
• Dishonest
• Discomfort
Practice Characteristics

• Prescribing prior to obtaining complete clinical data (medical records, PE, SBIRT)
• Prescribing multiple controlled substances
• Prescribing for extended periods without reevaluating
• Lack of monitoring (UDS, prescription monitoring program)
• Failure to obtain consults
• Prescribing despite aberrant patient behavior
Pain Management

• Combined programs
  – Interdisciplinary Spine Program
  – Three prongs: Medical, Physical and Psychological
    • Medical: MRI, Neurosurgical evaluation
    • Physical: P.T., pool based, strength, flexibility, and conditioning
    • Psychological: Lifestyle change, motivational enhancement
Pain Management

Medically based

Surgery
Medications
Physical Therapy
Spinal Stimulator
Morphine Pump
Reasonable Goals of Pain Management Enhance Quality of Life!!

- Maintain function.
- Improve function.
- Reduce discomfort by 50%.
Standards of Practice

• A complete medical history and a physical examination should be conducted before beginning any treatment and must be documented in the medical record.

• The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse.
Standards of Practice

• The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.
• Each provider should develop a written plan for assessing each patient’s risk of aberrant drug-related behavior, which may include patient drug testing.
• Each provider should assess each patient’s risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.
Standards of Practice

- Each provider should develop an individualized treatment plan for each patient.
- The treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned.
- After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient.
Pain Assessment and Documentation Tool (PADT)

- Areas covered:
  - Analgesia
  - Activities of daily living
  - Adverse events
  - Aberrant drug-related behavior
Pain Assessment

• Patients may be describing suffering in addition to pain intensity
• Physicians tends to believe pain is lower than patient reports
• Physicians especially more likely to underestimate pain in women, elderly, minorities, low economic status, SUD’s
Pain Scale

• 0- Pain free
• 1- Very minor annoyance, minor twinges
• 2- Minor annoyance, brief strong twinges
• 3- Annoying enough to be distracting
• 4- Can be ignored if involved in work
• 5- Can’t be ignored more than 30 minutes
Pain Scale

• 6- Can’t be ignored but still go to work and social activities
• 7- difficult to concentrate, interferes with sleep, can function with effort
• 8- Physical activity severely limited, can read and converse with effort
• 9- unable to speak, crying or moaning
• 10- Unconscious
Pain Assessment Scale

Clinical definition of pain:
“Whatever the patient states it is unless proven otherwise.”

No Pain
Moderate Pain
Worst Pain

0 1 2 3 4 5 6 7 8 9 10
Chronic Pain Treatment

• Medication are most prevalent – easiest method
• “Fifth vital sign” – measure pain and treat it
• 90% of pain management patients receive opiate medications
• Chronic opiate therapy only reduced pain by 30% beyond 18 months
ADJUVANTS TO SOMATIC PAIN

Non-pharmacologic:
- Ice, heat
- Physical therapy
- Chiropractic/osteopathic manipulations
- Massage
- Acupuncture
- Yoga
- Topical agents (Ben Gay/Icy Hot – with menthol, salcylates, Capcaicin)
- Local injections (steroids, lidocaine)
- Glucosamine shown to help with osteoarthritis

Pharmacologic:
- NSAIDs
- Cox 2 inhibitors
- Steroids
- Muscle relaxants
NEUROPATHIC PAIN

- Tricyclic antidepressants
- Anti-epileptics
- Anti-arrhythmics
- Topical agents – lidocaine, capsicain
- Steroids for spinal radiculopathies
- Others – RT for spine mets, TENS/PENS units and also spinal electrical stimulators
- CAM - Acupuncture, massage, PT, yoga, healing touch
Pharmacologic Non-Opioid

- NSAID’S, COX 2S
- Tricyclics, SNRI’S
- Anticonvulsants
- Muscle Relaxants— (AVOID SOMA/carisoprodol)
- Topicals
Pharmacologic Non-Opioid

- NSAID’S, COX 2S
- Tricyclics, SNRI’S
- Anticonvulsants
- Muscle Relaxants—(AVOID SOMA/carisoprodol)
- Topicals
### Exhibit 3-2 Summary of Non-Opioid Analgesics

<table>
<thead>
<tr>
<th>Analgesic</th>
<th>Addictive</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>No</td>
<td>Should normally not exceed 4 g/day; in adults with hepatic disease, the maximum dose is 2 g/day. Potentiates analgesia without potentiating respiratory and sedative side effects.</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>No</td>
<td>Are used to relieve numerous types of pain, especially bone, dental, and inflammatory, and enhance opioid analgesia. May cause gastrointestinal bleeding and renal insufficiency.</td>
</tr>
<tr>
<td>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</td>
<td>No</td>
<td>Are used to relieve several nonstructural types of pain (e.g., migraine, fibromyalgia, low back pain) and probably others.</td>
</tr>
<tr>
<td>Analgesic</td>
<td>Addictive</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tricyclic Antidepressants</td>
<td>No</td>
<td>Have demonstrated efficacy in migraine prophylaxis, fibromyalgia, many neuropathic pains, vulvodynia, and functional bowel disorders. Watch for anticholinergic side effects and orthostatic hypotension (fall risk in older people).</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>No</td>
<td>Some have demonstrated efficacy in relieving fibromyalgia, migraine prophylaxis, and neuropathic pains.</td>
</tr>
<tr>
<td>Topical Analgesics</td>
<td>No</td>
<td>Comprise several unrelated substances (e.g., NSAIDs, capsaicin, local anesthetics). Work locally, not systemically, and therefore usually have minimal systemic side effects.</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>No</td>
<td>Have no demonstrated analgesic effect, except to abort migraine/cluster headache. Risks include extrapyramidal reactions and metabolic syndrome.</td>
</tr>
<tr>
<td>Muscle Relaxants</td>
<td>Carisoprodol (Soma) is addictive. Some others have significant abuse potential.</td>
<td>Have not been shown to be effective beyond the acute period. Some potentiate opioids and are not recommended.</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Yes</td>
<td>Not recommended (see discussion).</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>Yes</td>
<td>Not recommended (see discussion).</td>
</tr>
</tbody>
</table>
Chronic Opioid Treatment

- Can be quite appropriate for some patients
- Is pain totally or mostly relieved?
- Is function maintained or improved?
- Are side effects absent or tolerable?
What about patients who are actually prescribed opioids?

- Cohort study of 10,000 patients
  - Followed for 42 months average
  - 61% with full follow up

- Risk of overdose and death increased with higher dose of opiates:

<table>
<thead>
<tr>
<th>Opiate Dose</th>
<th>Annual Overdose Risk</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20 mg</td>
<td>0.2%</td>
<td>1</td>
</tr>
<tr>
<td>50-99 mg</td>
<td>0.7%</td>
<td>3.7</td>
</tr>
<tr>
<td>&gt;100 mg</td>
<td>1.8%</td>
<td>8.9</td>
</tr>
</tbody>
</table>

FDA Amendments Act (FDAAA) - 2007

REMS

Risk Evaluation & Management Strategy

OpioidREMS@fda.hhs.gov
REMS Program

1. Requires manufacturers to submit REMS with drugs or biologics that have a known or potential safety risk.

2. May include any medication or class of medication

3. May include medication guides, communications to healthcare providers, elements to assure safe use, implementation systems to assure safe use

4. Goal of opioid REMS
Opioid Analgesics Required to Have a REMS

- All extended-release oral opioids:
  1. Hydromorphone
  2. Morphine
  3. Oxycodone
  4. Oxymorphone
- Methadone
- Transdermal fentanyl
Patients and providers need reasonable expectations

- Opiates can be expected to work in about 40% of patients
- Opiates may lower pain by about 30-35%
- 40-50% of patients will drop out on their own
- If no response after 3 months, further treatment unlikely to be helpful
Opioid Contracts

- No prospective studies to support their use
- Are commonly used in specialty pain clinics
- Opinion differs slightly on when to use:
  - Some recommend these for all patients on chronic therapy, others only for patients felt to be at high risk for abuse or with relative contraindications to opioids
Opioid Contracts

- Typically address the following areas:
  - Effects and side effects of narcs, including probability of physical dependence and consequences of withdrawal
  - Compliance with dosing regimen
  - Compliance with follow up, specialty appts
  - Monitoring for substance abuse
  - Need to get all meds from single doctor and pharmacy
  - Need to meet with physician before any dose changes or before taking any new medicines
  - Consequences of failure to meet the stipulations
Exhibit 5-6 Sample Pain Treatment Agreement

Patient: Irene Simpson  
Doctor: Dr. Miller  
Date: 1-19-10

This treatment plan has been developed to manage neck pain and tension headaches. It is open to changes when both the doctor and I agree that the changes are in my best interest and are likely to improve my pain management or overall health. A primary goal of the plan is to protect my recovery from addiction.

1. My daily medications:
   - gabapentin, 1,200 mg three times daily.
   - duloxetine, 90 mg every morning.
   - topiramate, 100 mg at bedtime.

2. At the first indication of a headache, I will take ibuprofen (600 mg).

3. If possible, I will lie down in a darkened room with an ice pack to my neck and shoulders for 15 to 20 minutes to give the medication time to work; if the headache is still present in 30 minutes, I will take acetaminophen (500 mg). Use of opioid medications can be considered if this plan is unsuccessful. However, under no circumstances will I seek these medications from other doctors, friends, or the Internet. Instead, I will discuss my cravings and sense that the plan is not working with Dr. Miller, Joan Small, and my sponsor.

4. I will see Dr. Wong weekly or as recommended for acupuncture treatments.

5. I will walk 15 to 30 minutes daily.

6. I will attend the pain management group with Joan weekly and see Joan for individual sessions as indicated.

7. I will obtain all prescriptions for headache or other pain and for addiction recovery from Dr. Miller, and I will fill all prescriptions at the Main Street Pharmacy.

8. I will not visit other physicians or the emergency department without first talking to Dr. Miller or to the doctor who is covering for him.

9. I will attend my home group (Tuesday Night Women’s Group) weekly, plus two other weekly Narcotics Anonymous (NA) meetings of my choice; I will talk with my sponsor at least weekly and will call her when I feel despondent or have cravings to drink or take opioid pills.

10. My daily meditation will focus on removing myself from conflicts where I do not have a direct role to play. I will try to remind myself when “I don’t have a horse in this race” at work or at home.

Important Phone Numbers:

- Dr. Miller’s Office .......................... 222-3800
- Dr. Miller’s Answering Service .......... 222-9000
- Main Street Pharmacy .................... 380-2000
- Joan Small’s Office ...................... 380-2132
- NA Hotline ................................ 234-0081
- Abby (sponsor) ............................ 382-9970

Patient: ___________________________  
Doctor: ___________________________  
Date: ___________________________
Urine Drug Screen

• Urine drug screens typically check for evidence of opiate, alcohol, benzodiazepine, cocaine, marijuana, amphetamine and barbiturate use

• Some opiates may need to be specifically requested such as oxycodone, fentanyl, and methadone
Length of Time Drugs of Abuse Can Be Detected in Urine

• Alcohol 7-12 hours
• Amphetamine 48 hours
• Barbiturate 24 hours to 3 weeks
• Benzodiazepines 3 days to 1 month
• Cocaine 3 days
• Marijuana 3 days to over 1 month
• Opioids 48 hours to 4 days
Urine Toxicology Pearls

- Unless patients are on Morphine, methadone, or high-dose codeine, do not rely on utox to confirm that the patient is taking his/her medication.
- Use urine tox testing to detect illicit drug use: simply asking patients if they’re using drugs is inadequate.
  - Patients are likely to hide illicit drug use.
  - Studies have shown that urine toxicology may frequently be positive even in patients who don’t give off the ‘vibe’ of abuse.
Benefit of Urine Toxicology?

What are we using it for?
- To detect the presence of prescribed opioids?
- To detect other opioids or illicit drugs?
Role of Urine Toxicology Part 1

- Can urine toxicology screening be used to confirm that patients are taking the medications that they are prescribed?
Bottom Line of Urine Toxicology: Part 2

- Checking for aberrant behaviors alone will miss many (50%) problem patients
- Opiate prescription can be harmful to patients with active addiction issues
- Many experts recommend routine urine toxicology recommended for all patients on chronic opioid therapy
## Retention Times of Common Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Retention time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10 hrs</td>
</tr>
<tr>
<td>Heroin</td>
<td>2.5 hrs</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>10-15 hrs</td>
</tr>
<tr>
<td>Methadone</td>
<td>3-8 hrs (not incl metabolites)</td>
</tr>
<tr>
<td>Meperidine</td>
<td>15-20 hrs</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>15-20 hrs</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>20-25 hrs</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20-25 hrs</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>20-30 hrs</td>
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## Urine Drug Screens

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Diluted</th>
<th>Adulterated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine</td>
<td>Less than 20</td>
<td></td>
</tr>
<tr>
<td>ph</td>
<td></td>
<td>Less than 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater than 11</td>
</tr>
<tr>
<td>s.g.</td>
<td>Less than 1.003</td>
<td></td>
</tr>
<tr>
<td>nitrite</td>
<td></td>
<td>Greater than 500</td>
</tr>
</tbody>
</table>
Pill Counting

- No studies demonstrating accuracy or effectiveness of pill counts in reducing aberrant behaviors
- Labor intensive
Monitoring Tools: Summary

- Tools available for pre-treatment risk stratification and ongoing monitoring
  - None are well-validated
  - None are considered standard of care - yet
  - May help with defense of personal decision-making and with documentation
  - This is the future of opioid prescribing: individualized risk:benefit assessment and ongoing systematic monitoring
Prior to initiation of therapy: Tools to predict opiate abuse

- Opioid Risk Tool (ORT)
- SOAPP and SOAPP-R
- Studied in small, selected groups only
- Results have not been validated in larger studies
- Modest positive and negative likelihood ratios
COMM and ABC

■ COMM
  ■ 17-item, self-administered
  ■ Score ≥ 9 detected opioid misuse with
    ■ LR- of 0.08
    ■ LR+ of 3.48
    ■ Sensitivity 77%, Specificity 66%

■ ABC
  ■ 20-item, yes/no questionnaire, staff-administered
    ■ Sensitivity 88%, Specificity 86%
Ongoing monitoring

- Monitoring for efficacy
  - PADT

- Monitoring for abuse
  - PADT
  - Current Opioid Misuse Measure (COMM)
  - Addiction Behaviors Checklist (ABC)
Ideal Opioid Prescribing, 2010

- Discuss risks/benefits with patient
- Set goals for therapy and time limit of trial
- Use an initial screening tool (SOAPP, ORT) to determine if patient is likely to be at high risk for abuse
- Perform informed consent/sign contract
- Use moderate dose opioids, generally <100 mg/day and max 180 mg/day morphine equivalents
- Monitor frequently with a follow up tool (PADT, COMM), urine toxicology screening, and PDMP
- Titrate off therapy if poor response or major misuse/abuse
Opioid Selection

• Select opioids with minimal rewarding properties to reduce euphoric effects - tramadol?
• Ovoid Supratherapeutic doses
• Avoid Underdosing
• Select slow onset opioids with longer duration
• Consider delivery mechanism – transdermal patches?
Opioid Selection

• “That one doesn’t work for me”- may be accurately reporting
• Start low but titrate rapidly unless using methadone
• May require higher than average doses secondary to tolerance
Problems with Opioids

- Side Effects
- Tolerance and physical dependence
- Loss of function
- Perceive emotional pain as physical pain (chemical copers)
- Hyperalgesia
Opioid Adverse Effects

- Hyperalgesia
- Hypogonadism
- Sedation
- Cognitive Impairment
- Constipation
- Nausea/Vomiting
- Pruritis
- Respiratory Depression
- Central Sleep Apnea
Opiate Induced Hyperalgesia

• Long-term use of opioids may also be associated with the development of abnormal sensitivity to pain, and both preclinical and clinical studies suggest that opioid-induced abnormal pain sensitivity has much in common with the cellular mechanisms of neuropathic pain.

• Opioid induced abnormal pain sensitivity has been observed in patients treated for both pain and addiction.
Opioid Hyperalgesia

Reported Pain Level

Optimum dose

Increasing dose of opioid

NEJM, Ballantyne & Mao
Nov 2003
Opioid Hyperalgesia

- **Distinct from tolerance**
  - Tolerance is a pharmacologic *desensitization*
  - Opioid-induced pain sensitivity is a *sensitization* process

- Hyperalgesia first noted in opioid-dependent subjects during withdrawal phase
Opioid Hyperalgesia

- Tolerance to opioids and hyperalgesia from opioids may be modulated by the NMDA receptor and central glutamatergic system.
- Use of NMDA receptor antagonists to prevent or treat opioid hyperalgesia has been disappointing.
- Hyperalgesia and analgesia may be present simultaneously.
Opioid Hyperalgesia

- How can you differentiate from tolerance?
  - Increasing the opioid dose should improve pain control in the tolerant patient, but may have no effect or worsen pain in the hyperalgesic patient

- What to do for hyperalgesia?
  - Opioid reduction/discontinuation
  - Opioid rotation
Criteria for Problematic Opioid Use

- Overwhelming focus on opiate issues during visits that impede progress with other issues (>3 visits into care)
- ≥3 early refills or escalating use in absence of change in medical condition
- Multiple calls or visits associated with pain Rxs
- Prescription problems including lost, spilled, or stolen meds
- Supplemental sources of opiates (multiple providers, ER’s, or illegal sources)
DDx of Problematic Opioid Use/Drug-seeking Behaviors

- Psychological or physical dependence
- Inadequate pain treatment (pseudoaddiction)
  - Tolerance
  - Opioid hyperalgesia
  - Progression of underlying disease process
- Use of opioids to relieve a comorbid condition (depression, anxiety)
- Search for sympathy, preoccupation with being unwell (“professional patient”)
- Addiction
• Being more interested in opioids (especially immediate-release and nongeneric) than in other medications or in any other aspect of treatment.
• Taking doses larger than those prescribed or increasing dosage without consulting the clinician.
• Insisting that higher doses are needed.
• Resisting UDT, referrals to specialists, and other aspects of treatment.
• Resisting changes to opioid therapy.
• Repeatedly losing medications or prescriptions or seeking early refills.
• Making multiple phone calls about prescriptions.
Aberrant Behavior

• Early refills – lost or stolen meds, shorted by pharmacy
• Urgent unscheduled visits
• Multisourcing – multiple MD’s, recruiting surrogates, illicit dealers or internet
• Intoxicated behaviors – slurred, disinhibited calls, presenting to pharmacies under the influence, ER visits, falls, accidental overdose
• Pressuring behavior – pleading, excessive compliments, breaching boundaries, threats to harm self or others
Explanations for Aberrant Behavior

• Pseudoaddiction – Addictive behavior primarily motivated by poor pain control
• Addiction – Loss of control, compulsive use, continued use despite harm, and craving.
• Tolerance – Decreased effect from previously effective opioid dose. (Can a safe opioid dose be used?)
• Diversion
Behaviors More Suggestive of an Addiction Disorder

- Multiple dose escalations or other noncompliance with therapy despite warnings
- Multiple episodes of prescription “loss”
- Repeatedly seeking prescriptions from other clinicians or from emergency rooms without informing prescriber or after warnings to desist
- Evidence of deterioration in the ability to function at work, in the family, or socially that appear to be related to drug use
- Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug
Behaviors Less Suggestive of an Addiction Disorder-But Need to Be Addressed

• Aggressive complaining about the need for more drug
• Drug hoarding during periods of reduced symptoms
• Requesting specific drugs
• Openly acquiring similar drugs from other medical sources
• Unsanctioned dose escalation or other noncompliance with therapy on one or two occasions
• Unapproved use of the drug to treat another symptom
• Reporting psychic effects not intended by the clinician
• Resistance to a change in therapy associated with “tolerable” adverse effects with expressions of anxiety related to the return of severe symptoms
Patients Who Will Need Extra Monitoring if Opioids are Prescribed

• **Drug and medication use history**
  – History of medication mismanagement or nonadherence
  – Evidence of recent illicit substance use, e.g., positive urine screen
  – Substance abuse/dependence history or current substance use disorder under treatment
  – No benefit from well-crafted prior opioid trials for the same clinical problem
Approach to the Patient with High Opioid Risk

• Be nonjudgmental in all interactions
• Take a risk vs benefit approach in explanations for further treatment options
• Show a commitment to continue to work with the patient for pain control whether opioids are used or a non opioid approach will be taken
• Make appropriate referrals and schedule careful follow-up
Pain Management in SUD

- More frequent visits
- Recommend a lock box
- Have family hold and administer medication
- UDS
- State prescription monitoring program
Assessment in SUD

• Patients may overreport pain secondary to fear of being under-treated
• May underreport pain to avoid medications that may cause relapse
• May exaggerate to obtain opiate pain medications for other reasons
### Exhibit 2-7 Steps Following Substance Abuse Assessment

<table>
<thead>
<tr>
<th>If</th>
<th>Then</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse is remote and patient is in long-term recovery</td>
<td>Verify and support recovery efforts</td>
</tr>
<tr>
<td>Patient is on buprenorphine or methadone maintenance therapy (MMT)</td>
<td>Verify and continue buprenorphine or MMT</td>
</tr>
<tr>
<td>Abuse appears active</td>
<td>Refer patient to substance abuse specialist for further evaluation</td>
</tr>
</tbody>
</table>

Adapted from Passik & Kirsh, 2004.
## Exhibit 2-15 ORT

<table>
<thead>
<tr>
<th>Item</th>
<th>Mark Each Box That Applies</th>
<th>Item Score if Female</th>
<th>Item Score if Male</th>
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<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>□</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>□</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>□</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal history of substance abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>□</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>□</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>□</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16–45)</td>
<td>□</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of preadolescent sexual abuse</td>
<td>□</td>
<td>3</td>
<td>0</td>
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<tr>
<td>5. Psychological disease</td>
<td></td>
<td></td>
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<tr>
<td>Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia</td>
<td>□</td>
<td>2</td>
<td>2</td>
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<tr>
<td>6. Depression</td>
<td>□</td>
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<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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</tr>
<tr>
<td><strong>Total score risk category</strong></td>
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<td>Low risk: 0–3</td>
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<tr>
<td>Moderate risk: 4–7</td>
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</tr>
<tr>
<td>High risk: ≥ 8</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

SUD’s

- “Cross-addiction” may lead to relapse
- Determine recovery status – those in good recovery will be forthcoming and some may be in denial
Acute Pain Episodes

- Non-pharmacological modalities
- Change to long acting medications as soon as possible
- Bolster recovery support
- Maintain patients on agonist therapy and supplement with additional medications
- Patient controlled analgesia
- Do not detox from benzodiazepines for acute pain treatment
- Prescribe small number of pills with more frequent refills if needed
Treating patients in Recovery

• Assess level of recovery – refer unaddressed SUD to SUD specialist
• Treat with non-opiate analgesics as determined by pathophysiology
• Prescribe non-pharmacological therapies
• Treat comorbidities
• Assess treatment outcomes
• Initiate opioid therapy only if benefits outweigh the risk and only for as long as unequivocally beneficial
• Suboxone, Methadone
Relapse

- Minor relapses with quick stabilization – may refer to addiction counselor
- Closely monitor opioids
- Short interval dosing
- Major relapse – refer to methadone maintenance program or consider Suboxone
- Discontinue if patient harm and public safety outweigh benefits
- Offer to treat with other modalities – don’t fire the patient
- Be aware of naltrexone especially IM
Active Addiction

• Successful treatment in a primary care setting is improbable
• Refer to formal addiction treatment program
• If patient refuses treatment, do not prescribe chronic opioid medications and use as leverage to move patient into treatment
• Motivational Interviewing
Methadone Pearls

- No active metabolites, no renal concerns
- Excellent oral bioavailability
- Cheap
- Theoretical benefit of NMDA receptor antagonism
- Can be followed separately on tox screen
- Potent in rotation
How to Switch to Methadone

- Probably reasonable to use a ratio of 5:1 morphine equivalents in patients on low-moderate doses
  - Example: MS Contin 120 mg/day would convert to 24 mg methadone ≈ 20 mg starting dose
- Use 10:1 ratio for morphine doses ≥ 180 mg/day
- Increase by no more than 25% of total dose every 5-7 days
Methadone: Pitfalls

- Drug-drug interactions (rifampin, phenytoin)
- Unclear equianalgesic ratio
- Highly variable metabolism; very dangerous when diverted and misused
- Risk of Torsades de Pointes
- Dose adjustments (either up or down) may be necessary later in course
- Stigma of use for heroin addicts
Routine EKGs too Aggressive?

- Based on clinical experience, significant cardiac toxicity risk likely small
- Prolongation of QTc usually < 40 ms over baseline
- TdP not described in prospective studies
- Consider simply having a low threshold for EKG, especially in patients on >100 mg/d, substrates or blockers of Cyp 3A4 or 2D6, hERG blockers or in patients with hypokalemia
- Stop methadone for QTc >450
Buprenorphine for CNTP: the future for high-risk patients

- Partial μagonist, κantagonist
  - Minimal respiratory depression
  - Ceiling effect
- Combined with naloxone to prevent using a different route of administration
- High receptor affinity; prevents the high from other opiates
Buprenorphine for CNTP

- DEA Schedule III; CSAT waiver required to prescribe for opiate addiction
- Waiver NOT required to prescribe off-label for pain
  - Write “for chronic pain” or “off-label use”
- Good for moderately severe pain
- Dosed up to 32 mg/day divided TID/QID
- Further experience needed
Can One Use S/L Buprenorphine with or without Naloxone for Pain Management?

◆ The off-label use of the sublingual formulations of buprenorphine (Suboxone®/Subutex®) for the treatment of pain is not prohibited under DEA regulations.
  ➢ One does not need a waiver from CSAT but a valid registration to prescribe a Schedule III controlled substance
    – Under these circumstances one does not place an X before one’s DEA number
    – Personally, I recommend writing on prescription: “Pain patient, off label use”

Heit HA, Covington E, Good PA
(Former Chief Liaison and Policy Section Office of Diversion Control):
Dear DEA,
S/L Buprenorphine and the Treatment of Pain

- Effective analgesia is achieved at relatively low μ receptor occupancy\(^1\)
  - 5-10 %
- Degree of analgesia is *not* related to plasma concentration of the drug\(^2\)
  - The dissociation from the μ receptor site will lag behind plasma concentration
- 0.4 mg of buprenorphine = 10-12 mg of morphine
  - At least 30 times more potent than morphine\(^3\)
- Analgesic effects – 0.1- 8 mg

S/L Buprenorphine

◆ Chronic pain management
  ➢ 6-8 hour analgesic duration
    – As with methadone
  ➢ tid or qid dosing
    – **Always follow “Universal Precautions in Pain Medicine” in all cases of pain management**

◆ OAT
  ➢ Stabilizing drug
  ➢ Long duration of action ( >24 h)
  ➢ qd dosing

D Gourlay, HA Heit, A Almahrezi
Universal Precautions in Pain Medicine:
A Rational Approach to the Treatment of Chronic Pain.

HA Heit, DL Gourlay.
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds). Pain and Chemical Dependency.
S/L Buprenorphine and the Treatment of Pain

- Elective procedure/surgery (mild-to-moderate pain and not NPO)
  - S/L Buprenorphine with or without naloxone
  - Take the total qd dose of buprenorphine
    - Give the total dose divided in tid or qid doses
- Titrate to effect with a maximum dose around 8 mg/dose
  - If breakthrough medication is needed, use one with high receptor site affinity and potency
    - Oral transmucosal fentanyl lozenges/tablets
    - Hydromorphone
    - PCA

HA Heit, DL Gourlay.
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds). Pain and Chemical Dependency.
S/L Buprenorphine and the Treatment of Pain

- Elective procedure/surgery (moderate-to-severe pain and not NPO)
  - Discontinue S/L buprenorphine around three days before surgery
  - Use full μ agonist such as methadone/MR/SR/CR opioid
    - Titrate the μ agonist to effect to prevent withdrawal and to treat the pain
  - If breakthrough medication is needed, use a IR full μ agonist

HA Heit, DL Gourlay.
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds). Pain and Chemical Dependency.
S/L Buprenorphine and the Treatment of Pain

- Elective procedure/surgery (NPO)
  - Discontinue S/L buprenorphine
  - PCA with full μ agonist
    - Titrate to effect to prevent withdrawal
    - Then treat the pain with an opioid with high receptor site affinity and potency
      - Fentanyl
      - Hydromorphone
        - Second choice
      - Avoid meperidine

HA Heit, DL Gourlay
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds). Pain and Chemical Dependency.
S/L Buprenorphine and the Treatment of Pain

- Acute pain patient on buprenorphine agonist therapy (mild-to-moderate pain and not NPO)
  - Divide S/L buprenorphine dose to tid or qid schedule
  - Titrate to effect
    - Up to 8 mg tid to qid of buprenorphine
    - Limit of dose for pain?

- Alternative is to discontinue S/L buprenorphine
  - Switch to full μ agonist if time permits
    - Titrate the μ agonist to limit withdrawal
    - Titrate to effect to treat the pain

HA Heit, DL Gourlay.
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds). Pain and Chemical Dependency.
S/L Buprenorphine and the Treatment of Pain

- Acute moderate-to-severe pain treated with IV opioids (NPO)
  - Discontinue S/L buprenorphine
  - PCA analgesic
    - Titrate to effect to prevent withdrawal
    - Then titrate to treat the pain
      - Fentanyl
        » High receptor site affinity and potency
        » May be easier to titrate
      - Hydromorphone
    - Avoid meperidine

HA Heit, DL Gourlay
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds), Pain and Chemical Dependency.
S/L Buprenorphine and the Treatment of Pain (Mild-to-Moderate Pain)

- Acute pain superimposed on chronic pain
  - Assumes S/L buprenorphine in divided doses was controlling pain
    - Add IR/RO opioid with high receptor site affinity and potency
      - Hydromorphone
      - Oral transmucosal fentanyl lozenges/tablets
  - Titrate to effect

HA Heit, DL Gourlay.
Buprenorphine in Pain and Addiction.
In H Smith and SD Passik (eds). Pain and Chemical Dependency.
Deciding Whether to Maintain or Terminate Opioid Treatment

What are the criteria for success or failure?
- Pain relief
- Sense of well-being
- Improved function
- Improved quality of life

Any of these may be considered reasonable goals; failure to reach any or deterioration in the physician-patient relationship
Psychiatric Comorbidities

- SNRIs
- TCAs
- Trazodone
- Remeron
- Anticonvulsants - pregabalin, gabapentin, lamotrigine, valproic acid
- Baclofen
- Beta blockers - propanolol
- SGA’s - Abilify, Seroquel, Geodon, Latuda
Mood Affects Pain

• Depression-
• Chronic pain - >30% have depression
• Depression - %75 may have pain
• Increase in depression results in increase in pain – need to treat both
Emotions

• Negative emotions increase pain
• Positive emotions decrease pain
• Resisting pain increases pain
• Relaxing into pain and less resistance decreases pain
Emotions and Thoughts

• Need to pay attention to thoughts and emotions to eventually modify them
• Patients may be initially resistant (it’s all in my head)
• Majority of pain experience and ability to reduce pain lies with thoughts and emotions
• Need to address the suffering in addition to the sensation
Patient with Pain
Patient with Pain
Reasonable Goals of Pain Management: Enhance Quality of Life!!

- Maintain function
- Improve function
- Reduce discomfort by 50%
Addiction

Physical Problems

Sleep Disturbance

Substance Abuse

Depression

Functional Disability

Increased Stresses

Anxiety

Seddon Savage, M.D.
Chronic Pain

- Physical Problems
- Sleep Disturbance
- Depression
- Anxiety
- Increased Stresses
- Substance Abuse
- Functional Disability
Sleep Disturbance

Physical Problems

Substance Abuse

Depression

Increased Stresses

Anxiety

Functional Disability

Seddon Savage, M.D.
Pain Recovery – Develop Balance

- Mental
- Emotional
- Physical
- Spiritual

RESULTING CHANGES
- Relationships
- Positive actions and behaviors
Treatment Implications

• Surrender
• Utilize body awareness
• Develop “relaxed attention”
• Involved with others
• Pain Recovery – Develop Balance
Emotional Intensifiers

- Fear
- Guilt
- Anger - Resentments
- Loneliness
- Helplessness
Cycle of Uncontrolled Pain and Fear

- Pain
- Avoidance Behaviors
- Decreased Mobility
- Social Limitations
- Diminished Self-Efficacy
- Altered Functional Status
Reversal of Cycle of Fear and Pain

- Pain
  - Exercise
  - Increased Mobility
- Less Pain
  - Improved Function
  - Enhanced Self-Efficacy
  - Enhanced Self-Efficacy

Non-Medication Treatments at LVRC

- Exercise – Physical Therapy
- Chiropractic Treatments
- Therapeutic Massage
- Reiki
- Acupuncture
- Individual + group therapy
- Mindfulness-Based Stress Reduction (Kabat-Zinn)
- Yoga - Chi Gong
Treatment Implications

- Surrender
- Utilize body awareness
- Develop “relaxed attention”
- Involved with others
- Pain Recovery – Develop Balance
Ways to reduce pain intensity

- Cognitive/Behavioral Therapies
- Attention/Distraction
- Control/Placebo effect
- Fear reduction
Daily Log of Exposure Therapy

Daily measures of pain-related fear and pain of Mr. A during baseline (A-B) and exposure treatment (B-C).

Vlaeyen et al., 2002. In Psychological Approaches to Pain management. (Turk & Gatchel, eds.)

LAS VEGAS RECOVERY CENTER
Pain Recovery – Develop Balance

- Mental
- Emotional
- Physical
- Spiritual

RESULTING CHANGES

- Relationships
- Positive actions and behaviors
Pain Outcome Profile (POP)

20 questions, multiple measurements across treatment

- Pain intensity right now (0-10)
- Pain on average past week (0-10)
- Mobility (5 questions)
- ADL's (4 questions)
- Negative affect (5 questions), fear (2 questions)
- Vitality (3 questions)
Exhibit 3-1 Algorithm for Managing Chronic Pain in Patients With SUD

Evaluation sufficient to confirm:
• Diagnosis of chronic pain (pain does not result from a health-threatening or correctable pathology)
• Functional impairment
• Psychological comorbidity

Active addiction
• Start addiction treatment
• Defer opioids/analgesia
  (Patient already on opioids should have trial of opioid weaning. Opioids may be continued only if the patient immediately initiates SUD treatment.)
• Analgesic determined by pain physiology
• Implement non-pharmacologic treatment

In recovery
• Without medication
• On agonist therapy
  • Non-opioid analgesics as determined by pain physiology
  • Continue agonist; may increase dose as required for analgesia

Concurrent
• Nonpharmacologic pain treatments
• Reconditioning as determined by functional impairment
• Treatment of psychiatric/sleep comorbidities

Successful outcome
Inadequate benefit

Initiate opioid trial if risk is warranted
• Relapse
• Failure
• Success
  • Wean opioid
  • Continue other therapies
  • Continue strategy
  • Monitor for demonstration of continued benefit
### Exhibit 5-3 Reliable Web Sites With Information on Chronic Pain and Pain Treatment

<table>
<thead>
<tr>
<th>Organization</th>
<th>Web Site</th>
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<tbody>
<tr>
<td>Aetna Intellihhealth</td>
<td><a href="http://www.intellihhealth.com">http://www.intellihhealth.com</a></td>
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<tr>
<td>Agency for Healthcare Research and Quality</td>
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</tr>
<tr>
<td>American Academy of Family Physicians</td>
<td><a href="http://www.familydoctor.org">http://www.familydoctor.org</a></td>
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<tr>
<td>American Academy of Pain Medicine</td>
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<tr>
<td>American Cancer Society</td>
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<td>American Chronic Pain Association</td>
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<tr>
<td>Emerging Solutions in Pain</td>
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<tr>
<td>Komen Foundation</td>
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</tr>
<tr>
<td>National Cancer Institute</td>
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<td>National Institutes of Health</td>
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<td>Veterans Affairs</td>
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<tr>
<td>National Institute on Alcohol Abuse and Alcoholism</td>
<td><a href="http://www.niaaa.nih.gov">http://www.niaaa.nih.gov</a></td>
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<tr>
<td>National Institute on Drug Abuse</td>
<td><a href="http://www.drugabuse.gov">http://www.drugabuse.gov</a></td>
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<tr>
<td>Parents. TheAntiDrug.com</td>
<td><a href="http://www.theantidrug.com">http://www.theantidrug.com</a></td>
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<tr>
<td>Partnership for a Drug-Free America</td>
<td><a href="http://www.drugfree.org">http://www.drugfree.org</a></td>
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<tr>
<td>Substance Abuse and Mental Health Services Administration</td>
<td><a href="http://www.samhsa.gov">http://www.samhsa.gov</a></td>
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</table>
Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders

TIP 54

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-7277)