



## Pain Management and Addiction: Achieving a Balance

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## 32 year old Female with Back Pain After Surgery

- Back injury at work while lifting patient
- Back and right leg pain without weakness
- Examination showed right foot weakness on inversion, plantar and dorsiflexion
- Positive straight leg raise and Lasegue's maneuver
- MRI showed right L5 disk

## Therapy

- Patient initially treated with NSAIDs and PT
- After 6 weeks had no improvement and has muscle relaxants added
- Patient has no relief and undergoes a trial of 3 LESI without relief
- Repeat imaging shows same disk herniation, now with disk fragment
- Patient undergoes decompressive laminectomy and discectomy with resolution of back and leg pain

- 6 weeks later she develops burning leg pain in the area of her previous leg pain. She has no back pain
- Repeat imaging reveals epidural fibrosis surrounding L5 root
- She has repeat ESI, tricyclics, AEDs attempted lysis of adhesions without relief
- She is referred back to PCP who starts Oxycodone 5mg q4h. She escalates to 14 tablets per day in 10 days

- She is referred to inpatient pain program but is denied coverage by insurer
- Referred to our clinic for "addiction management"
- Patient reports severe back pain and leg burning
- Examination shows local SI tenderness and hyperesthesia and allodynia along L5 dermatome
- Patient reports severe constipation and inability to sleep. She is taking Oxycodone/APAP every 2-3 hours with minimal relief
- MRI shows no new lesion

- Patient started on transdermal fentanyl patch 50ug and increased to 75ug q3d in addition to her adjuvant medications
- SI injection performed with good results
- Patient started on citalopram for depression and entered back into PT
- 2 months later she is reporting less pain in her back and leg. Fentanyl reduced to 50ug and then 4 weeks later to 25ug q3d
- Patient returns to work part time
- 2 months later she is off fentanyl and remains on

## 32 year old male with back pain

- History of heroin abuse. Detoxed 2 years ago
- Failed back syndrome after surgery
- Patient treated with oxycodone/APAP. Escalated to 10/d in 2 weeks
- Meds discontinued. Patient relapses.
- Patient referred to clinic
- Started on transdermal fentanyl 75ug q3d
- Heroin used stopped
- Patient returns to work

## The Four A's of Pain Treatment Outcomes

- Analgesia (pain relief)
- Activities of daily living (psychosocial functioning)
- Adverse events (side effects)
- Aberrant drug taking (addiction-related outcomes)

## Definitions

- **Pain**
  - an unpleasant sensory and emotional experience involving tissue damage or described in such terms
- **Addiction**
  - uncontrolled use of a substance even when it produces more harm than good
- **Dependence**
  - a physiological state produced by chronic administration of a neuroactive substance in which acute discontinuation results in autonomic and other physical reaction
- **Tolerance**
  - a state in which there is less activity per dose of agonist than during initiation of therapy due to receptor desensitization

## Myths About Pain and Opioids

- Opioids cause addiction in all patients
- All opioids are the same
- Opioids should never be given to patients with a history of substance abuse
- Dosing at the longest interval and only as needed will reduce likelihood of addiction
- Tolerance is inevitable

## What Do Studies Really Show About Opioid Therapy?

- Addiction is rare in chronic cancer patients and in acute pain treatment. (Kanner and Foley, 1981; Chapman and Hill 1989)
- Addiction is rare in patients without prior history. (Porter and Jick, 1980)
- Few cases of addiction or major dose escalation in chronic pain patients. (Jamison 1984; Portenoy 1993)
- No apparent increase in overdoses by prescribed medications despite marked increase in prescribing of opioids. (Joranson, 2000)

## What is the Impact of Under treating Pain

- No definitive studies
- Consequences are inferred by patients' behavior
- Several surveys suggest that untreated pain may lead to increased suicides among patients with advanced disease

## Some Examples

- 1985- (Levin et al) 69% of cancer patients surveyed indicated that they would consider suicide if their pain was not adequately treated
- 1988- (Helig) 57% of California physicians reported being asked by terminally ill patients to hasten death
- 1995- Death with Dignity Act
- 1996- Quill vs. Vacco

## Indications for Chronic Opioid Therapy

- Failure of other modalities
- Contraindications to other therapies
- Intractable pain of both somatic and neuropathic types

## Patient Selection

- Motivated patient with specific functional goals
- Lack of confounding psychological factors
- Lack of current substance abuse history
- Good support system

## Guidelines for Chronic Opioid Use in Non-malignant Pain

- Opioids should be used only after other treatments have failed
- Psychological causes for pain need to be adequately treated
- Baseline psychological profile to rule out underlying psychological issues
- Care must be centralized at one physician and one pharmacy
- Long acting opioids are preferred
  - Decreased conditioning
  - Decreased likelihood of tolerance
- Appropriate documentation entered in chart
- Drug free periods may be undertaken every 3-6 months

## Documentation

- Indicate specific diagnosis and supporting data being treated.
- Specify other modalities tried
- Specify failures/side-effects
- Specify effects on patient
- Indicate level of pain treated.
- Define functional goals
- Indicate attempts to centralize care
- Consent/contract

## Contract Elements

- Identifies participants
- Identifies risks and benefits
- Identifies consequences of lost medications, stolen prescriptions, etc

## Strategies for Minimizing Aberrant Use

- Pre-screen (CAGE questionnaire for example)
- Full records
- Use limited supplies
- Use tamper proof prescriptions
- Use hard to divert medications with low street value
- Random screens
- Work with pharmacists

## Identifying Aberrant Drug-Taking Behaviors

- **More predictive\***
  - selling prescription drugs
  - forging prescription
  - stealing or "borrowing"
  - frequent prescription "loss"
  - injecting oral/topical formulations
  - obtaining drug from non-medical source
  - concurrent abuse of related illicit drugs
- **Less predictive\***
  - aggressive demand for more drug
  - drug hoarding
  - unsanctioned dose escalation
  - unapproved use of drug
  - unkempt appearance

\*These are only some possible behaviors; others may be more or less predictive.

## Differential Diagnosis of Aberrant Drug-Taking Behaviors

- Substance use disorder (true addiction)
- Undertreated pain (pseudoaddiction)
- Other psychiatric disorders
  - depression
  - anxiety
  - cognitive dysfunction
  - personality disorder
- Family dysfunction
- Criminal intent (drug diversion)

## What To Do When You Find Aberrant Use

- Confirm
- Document
- Confront
- Taper
- Discontinue
- Refer
- Maintain treatment

*Blessed are those who treat pain- Galen*

