Pain, Dependence and Universal Precautions: Working Smarter not Harder in Primary Care

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Declaration of Potential Conflict of Interest

• The content of this presentation is non commercial and does not represent any conflict of interest

• I have been compensated for my participation on various Advisory Boards for several Drug Companies
The Problem

• Pain and Addiction CAN coexist
• Addiction in General Population
  – Varies 3 – 16% prevalence
  – Varies with the drug, gender, economic status, race, age...
• Addiction in the Chronic Pain Population
  – We really have no idea
  – We use the same terms, with different meaning
• Lack of precision in definitions around abuse/dependency/addiction
Definitions

• **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 control over drug use, compulsive use, *continued use despite harm*, and craving. (LCPA)
Definitions

• **Physical Dependence:** Physical dependence is a state of adaptation that often includes tolerance and is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. (LCPA)
Definitions

• **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.

• Tolerance develops at different rates, in different people, to different effects
Definitions

- **Pseudoaddiction**: Iatrogenic, maladaptive behavior resulting from inadequate pain control

- Not to be used “instead of” addiction

- Unwise to diagnose in patient with history of addictive disorder, even in other substance
Addiction

Biology

Environment

Drug
Pain-Addiction Continuum
Diagnosis of Addiction in Chronic Pain

• When the drug is both the problem AND the solution in the patient at the same time i.e. problematic opioid use
  – DSM-IV is inadequate
  – Addiction is “diagnosis made prospectively, over time”
    • Pseudo addiction is “diagnosed retrospectively”
  – Careful limits and boundary setting will help to make the diagnosis
The Clinical Approach

• What is the nature of the problem?
  – Is this a pain problem alone, an addictive disorder or a bit of both?
    • If both, which is dominant?

• What is the nature of the pain?
  – Acute, chronic or acute-on-chronic

• Is the current pharmacotherapy rational?
  – Is it “doing more to the patient than for the patient?”

• Do I have the:
  – Experience to deal with this problem?
  – Resources to deal with it?
Do I have the Resources?

Integrated models of care create an opportunity to address problems that would be difficult or impossible to otherwise manage.
Basic Strategies

• Rationalize pharmacotherapy
  – Sometimes better to achieve pharmacologic stability than abstinence
    • Short-acting IR agonists can be problematic
      – “Agonist debt” can worsen pain
      – Higher abuse liability and greater street value?
  – Retry previously ineffective agents
    • NSAIDs, anticonvulsants, tricyclic antidepressants, etc.
  – Consider nonopioid therapeutics i.e. botulinum toxin
  – Avoid previous ‘drugs of misuse’
Basic Strategies

• Set limits carefully, from the outset
  – Easier to loosen limits than to tighten them later
  – Limits should be flexible and reasonable
    • If set too tightly, patient must step outside them

• Assess risk initially and periodically
  – Risk is dynamic in pain and addiction continuum

• Appropriate monitoring
  – Urine drug testing
  – Frequent follow-up
  – Interval/contingency dispensing
Urine Drug Testing

• Effective tool in patient monitoring BUT
  – More is not always better
    • You CAN monitor high risk patients too often!
    • Relying too heavily on UDT can change the focus from *therapeutic* to "the Gotcha Game"
  – There are MANY reasons why quantitative drug testing will NOT answer the questions you think they will
    • No reliable relationship between dose prescribed, amount taken and quantity recovered in UDT
 Boundary Setting

• 90%+ of patients don’t need strict boundary setting
  – Most patients have their own internal set
• For remaining ~10%, strict boundary setting is essential
• Treatment Agreements, Urine Testing, interval / contingency dispensing
Boundaries – Identification and Enforcement

Discharge Patient
Boundaries – identification and enforcement

Consultation with Addiction Medicine
Differential Diagnosis of Aberrant Behavior

- Comorbid psychopathology
  - i.e., antisocial personality disorder
- Pseudoaddiction
  - Behavior driven by inadequate relief of pain
- Active addictive disorder
  - With or without a primary pain problem
- Criminal intent
  - Drug diversion/trafficking
Motive vs. Behavior

- "I’m not using the drug to get high, I’m using it to relieve pain” or "I’m not an addict, I’m a pain patient”
  - Separate the 'motive' from the 'behavior'
    - "Why" the patient is behaving aberrantly is the motive; the real question is whether the patient is winning or not with the current regimen ie, "Is there a problem?"
  - Usually easier to get patient and the family to agree that there is a problem, even if they can’t agree why the problem exists
  - How easily the patient responds to a rational treatment plan may illuminate the nature of the problem
“The patient has no legitimate reason to be on opioids”

• It may be true that the original decision to trial opioids was ill advised –
  – If the patient has been on opioids for a prolonged period of time, they WILL be physically dependent
    • Physical opioid dependence IS a legitimate (and appropriate) reason to be on opioids
  – The challenge is how help the patient get from where they are to where they need to be
Not all aberrant patient behaviour is patient driven

- Running out of pills early, Hording medication, Symptom magnification
  - Can all be *driven* iatrogenically
  - Withdrawal, amplified pain etc can result from unreasonable treatment agreements (or their enforcement)

- *Treatment Plans must be*
  - *Defensible / Rational / Compassionate*
Clinical Pearls

• *Don’t do the same thing hoping for a different outcome*
  
  – If patient runs out early “because” you didn’t give them enough medication, consider increasing the dose but with tighter limits, ie, weekly dispensing
  
  • If patient is *‘borrowing from tomorrow to pay for today,’* you’ll see this with tighter prescribing intervals
Clinical Pearls

• *Don’t incur an ‘agonist debt’*
  – If patient is experiencing acute pain, basal opioids will do little to relieve it. They will need more, beyond what they normally use daily

• The acute setting is not the place to ‘solve’ a substance use disorder
  – *Identify, Stabilize and Refer*

• Don’t miss the ‘golden moment’ when a patient may see things as they are, not the way they wished they were
Clinical Pearls

• “You can’t solve a chronic pain problem in the context of an active, untreated addiction”
  – Doesn’t mean you can’t treat pain in a patient with substance use disorder
  – Unwise to assume that aberrant behavior is due to pain; it can represent a primary substance use disorder
Clinical Pearls

- “The diagnosis of addiction is made prospectively, over time”
  - What isn’t apparent on the first meeting will become obvious over time as long as you pay attention to details

- “The diagnosis of pseudoaddiction is made retrospectively”
  - Abnormal behavior that normalizes with rational treatment supports this diagnosis
Clinical Pearls

• "It takes 30 seconds to say 'yes' and 30 minutes to say 'no' to writing a prescription" — choose wisely!
  – If in doubt, don’t write the prescription
    • If you do write, write for a small quantity of drug
    • Use “Do Not Fill Until...” to reduce pill load
  – Make the prescription contingent on something
    • Pill counts; attendance at referrals; UDT samples
Clinical Pearls

• **Be careful interpreting urine drug tests**
  – Presence of an unprescribed drug *may* indicate a problem such as misuse/addiction
    • Beware of false positives
  – Absence of a prescribed drug *may* indicate a problem, ie, bingeing; not using as prescribed
    • Beware of false negatives
  – UDT is a clinical test for the benefit of the patient
    • It should not be used in an adversarial fashion
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
  - It’s about good medical care
Resources

- dgourlay@cogeco.ca
- www.asam.org
- www.udtmonograph.com
  - Urine drug testing monograph
- www.cpsm.on.ca/Publications/methpain.pdf
  - Methadone for Chronic Pain Guidelines