Clinical Management Co-Occurring Alcohol and Opioid Misuse

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- Clinical context
- Paradigm of use-misuse
- Clinical concerns opioids and alcohol
- Current guidance opioids and alcohol
- Rational management strategies

Spectrum of Use and Misuse
Alcohol and Opioids

- Prescribed therapy
- Social-cultural-ritual
- Self medication
  - Sleep
  - Mood
  - Memories
  - Pain
- Reward-Euphoria
- Diversion for Profit

Spectra of Use-Misuse

Alcohol and Opioids

Purpose of Use

Prescribed therapy

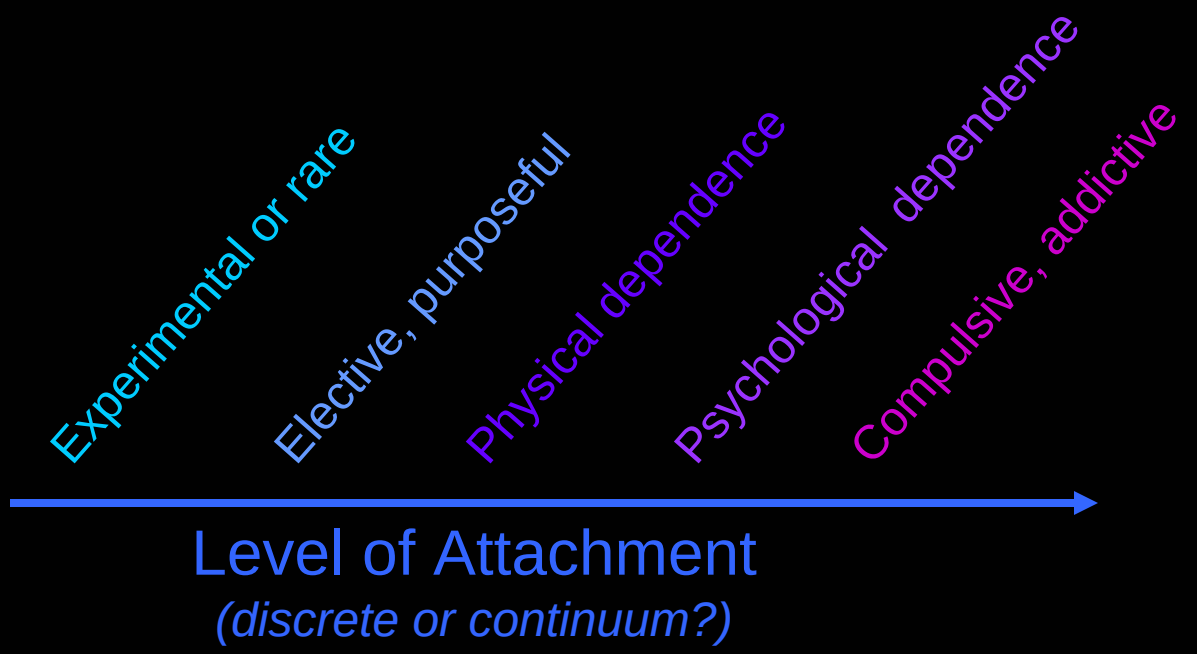
Social-cultural-ritual

Self medication:

- Sleep
- Mood
- Memories
- Pain

Reward-Euphoria

Diversion for Profit

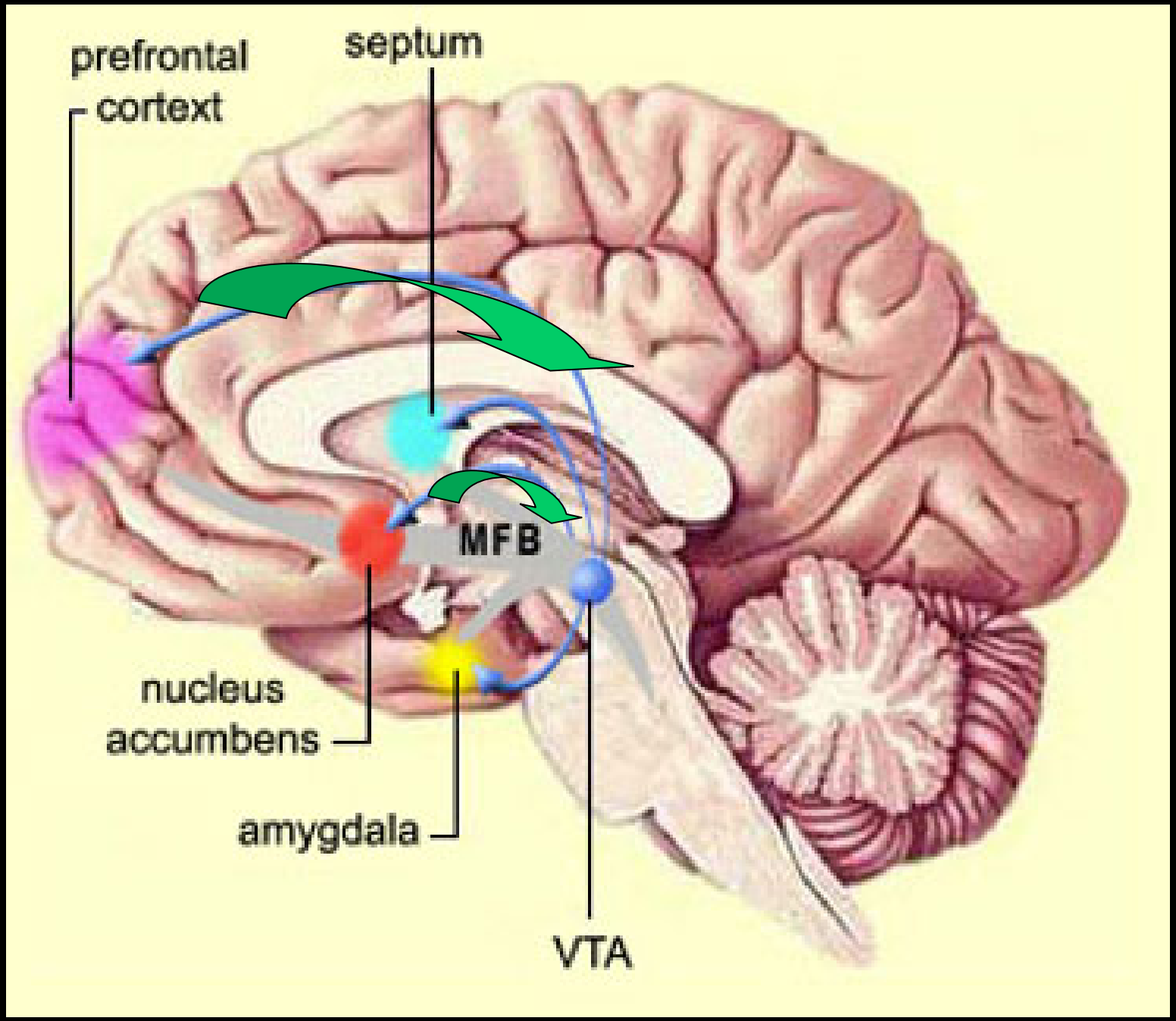


John M.

- 54 yo married male Veteran
- Painful neuroma post left AK amputation for PVD and LBP post surgery x 3 with fusion
- Relapsing alcoholism, history alcohol hepatitis. PTSD.
- Recovery program: “Support of recovering friends at the American Legion.”
- Minimal response to appropriate non-opioid treatment trials (continues on gabapentin, lidocaine patches)
- On Percocet 10/325mg 1-2 QID, continually runs out early, then binge drinks
- States
  - “I think I am in trouble with the Oxys”
  - “But it works for the pain”
  - “I never drink if I have the medication”

John M. Clinical Issues

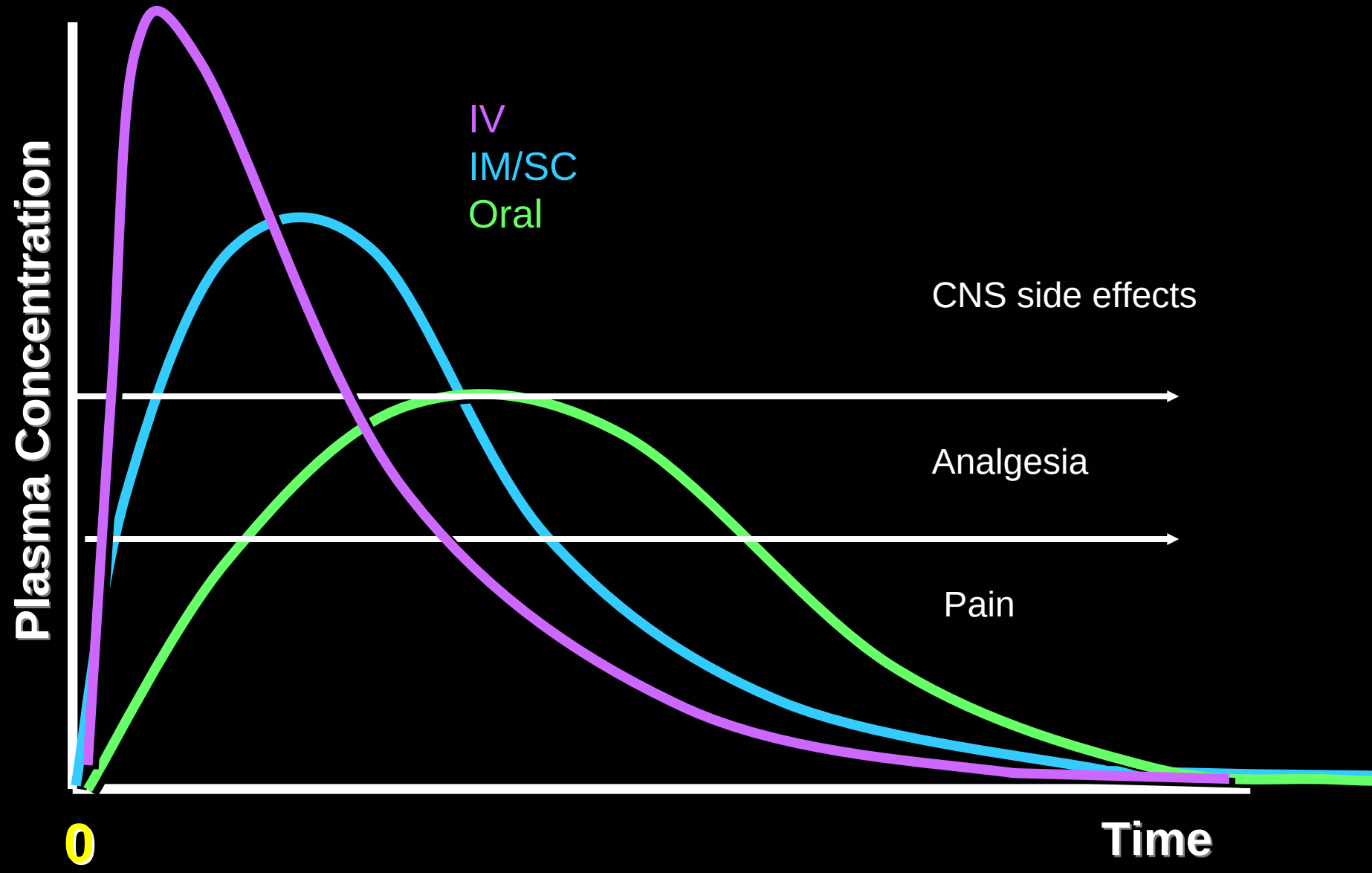
- Pain limits function and quality of life
- PTSD flares with pain
- Relapsing alcoholism
- Overuse of therapeutic opioids (uncertain cause)


prefrontal
cortext
septum
MFB
nucleus
accumbens
amygdala
VTA

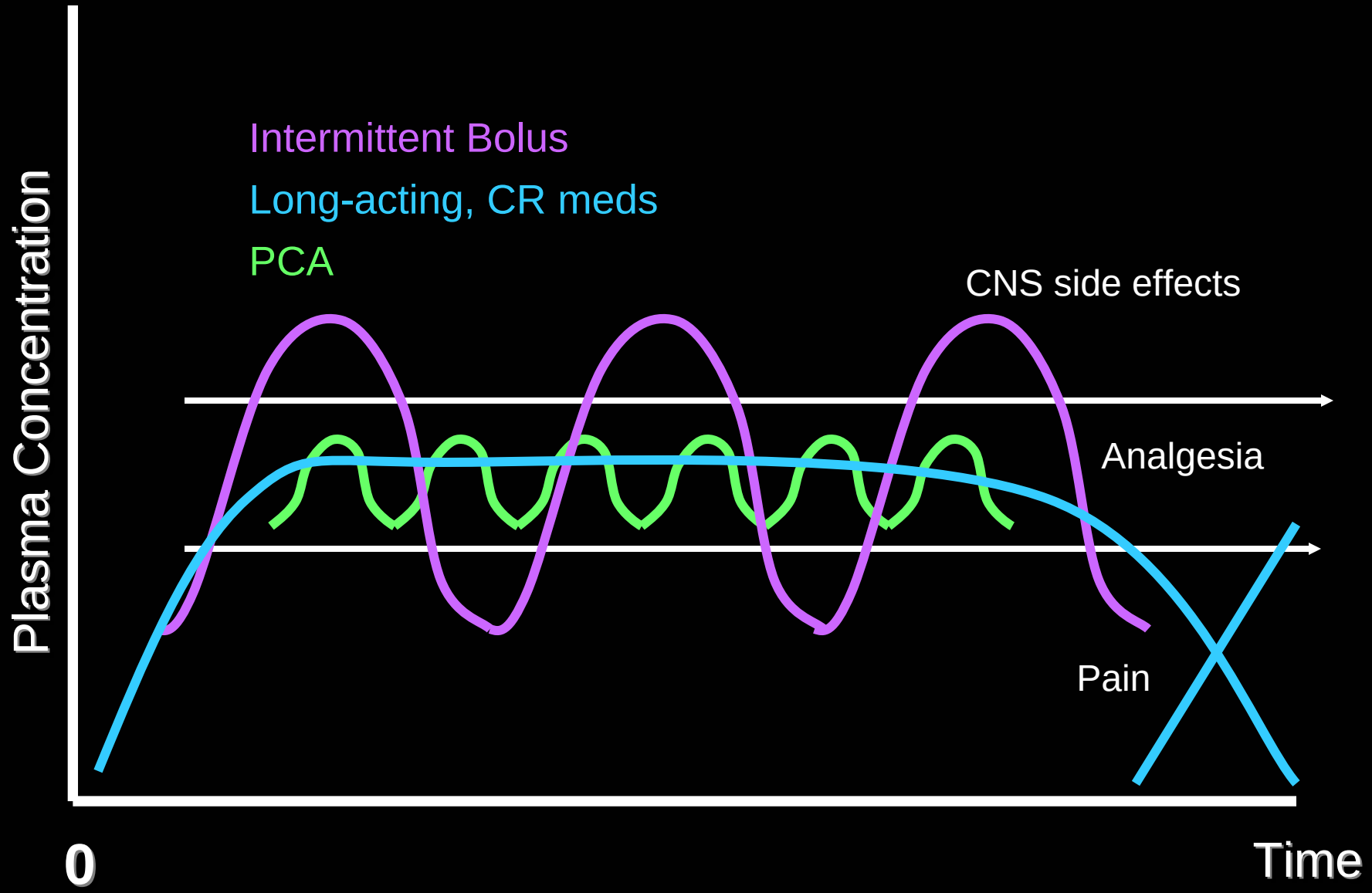
Drug Reward

- Poly drug use common
- Most patients have drug class of choice
- Some drugs and dosing regimens induce greater reward than others
  - Rapidity of increase in blood level
  - Magnitude of blood level
  - Specific receptor effects
  - Periodicity of effects: intermittent vs stable

Routes of Administration



Schedule of Administration



Opioid Reward Effects

- Do not occur in all individuals
- Pain may attenuate reward
- Strategies to minimize
  - Slow onset drugs (methadone, levodromoran)
  - Stable blood levels (sustained release meds: oxycodone, morphine, fentanyl)
  - Small increments (PCA)
  - Kappa agonists (pentazocine, butorphanol)
    - Note mu antagonism, can’t use mu agonists
  - Partial mu agonists (tramadol, buprenorphine)

John B. Goals of Treatment

- Manage baseline and incident pain
- Control PTSD symptoms
- Avoid overuse of opioids
- Avoid alcohol relapse

Options for Management

- Discontinue opioids
  - To be beneficial
    - Requires intensive treatment, engagement, recovery support
    - Effective non-opioid management of pain
  - Risks of opioid discontinuation
    - Uncontrolled pain
    - Uncontrolled use of street sources opioids
    - Relapse to alcohol to control distress and pain
- Consider opioid agonist therapy of opioid addiction
  - Incidental effects on pain
  - Incidental effects on alcohol craving?
- Continue highly structured opioid therapy of pain

Treatment Structure Variables

Beyond Universal Precautions

- Setting and specialization of care
- Selection of treatments
- Supply of medications
- Supports for recovery
- Supervision and monitoring

Savage,Passik & Kirsch

NIDA Addiction Science and Clinical Practice, 2008

Setting of Care

Primary vs Specialist Care

- Primary care contributions
  - Broad medical expertise
  - Longitudinal knowledge of patient
  - Integrates pain care with other medical problems
- Specialist contributions
  - Depth of focused expertise
  - Breadth of pain/addiction experience
  - System of care for complex pain/addiction management
  - Relatively limited knowledge of patient

Setting of Care

- Primary Care
  - Lacks major psychiatric comorbidity or major stressors
  - No or remote history of substance related problems
- Primary Care with consultation
  - Increased risk patient, in recovery, family Hx
  - No active addictive disorder; No major untreated psychiatric disorder or stressors
- Referral to tertiary clinic
  - Active addictive disorder
  - Major untreated psychiatric disorder

Note: Guidelines subject to clinical judgment and resource availability
Setting may change over time with stability.

Gourlay and Heit, 2004 (modified)

Selection of Treatment

Goal: reduce reward in vulnerable individals

- Availability of non-rewarding alternatives
- Reward potential of meds used as prescribed
- Reward potential of medications if misused
- Schedule of medications
  - As needed
  - Scheduled only
  - Scheduled and prn
- Active vs passive patient role
- Efficacy of treatment

Supply of Medications
Goal: assist in control of medication use

- Weekly to monthly typical for initiation
- Some may advance to every 3 months
- Some may continue at initiation level
- Some may require tighter control
  - Frequent dispensing, small quantities
  - Signed and dated patch
  - Dispensing by trusted other

Supports for Recovery
Goal: reduce relapse risks

- Substance treatment
  - Confirmation of AA/NA attendance
  - One on one or group counseling
  - Opioid maintenance for relapsing opioid addiction
- Toxicology screens
- Psychiatric care for co-morbidities
- Multidisciplinary pain care

Supervision

Goal: optimize pain treatment and identify/address concerns early

- Frequency of visits
- Pain and medications diaries
- Observation of others
- Urine screens
- Pill counts
- Opioid challenge

John M. Initial Plan

Setting	Pain/addiction specialist
Selection treatment	Transition to long acting opioid (morphine 30mg q12h)
Supply of meds	Dispensed daily by wife.
Support Recovery	Resume AA. Engage with counselor
Supervision	Call in one week

John B. One Month Later

- “New man.” “Everyone notices!”
- Pain manageable
- More stable, PTSD quiescent
- Function improved
- No loss of control over opioids
- No use of alcohol


No

But wait! John B. Two months later

- “Stealing” meds from wife, overusing opioid sand running out,
- Reports drinking on three occasions, once requesting detox after a bender
- Now states the morphine created mood swings, “did better on short acting opioid”
- Tox screen shows no illicit substances
- If no pain relief, “Jack Daniels here I come”

Considerations

- Primum non-nocere
  - Which is the greater risk?
    - Withhold opioids and risk
      - Protracted alcohol relapse?
      - Use of street opioids?
    - Restructure/tighten opioid prescribing with possibility that patient will still misuse opioids?
- How to further tighten care. Options:
    - Intensive addiction treatment
    - Pharmacologic tx alcohol
    - Dispensed model of opioid prescribing