

Substance Abuse Issues in Pain Management

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Opioid Rhetoric: From Complete Avoidance to Complete Acceptance

1941

- "The use of narcotics in the terminal cancer patient is to be condemned if it can possibly be avoided... Dominant in the list of these unfortunate effects is addiction."

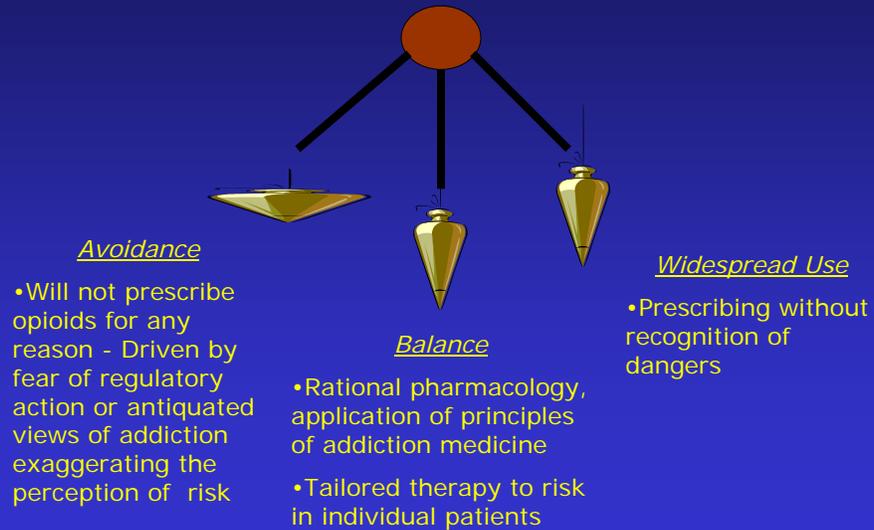
Lee, L.E. Jr. Medications in the control of pain in terminal cancer, with reference to the study of newer synthetic analgesics. *JAMA*. 1941; 116(3): 217.

1980 and Beyond

4 cases of addiction in 11,882 patients who received opioids during inpatient hospitalization

Porter J. and Jick H. Addiction rare in patients treated with narcotics. *N Engl J Med*. 1980 Jan 10;302(2):123 Letter (!)

Can We Catch The Pendulum?



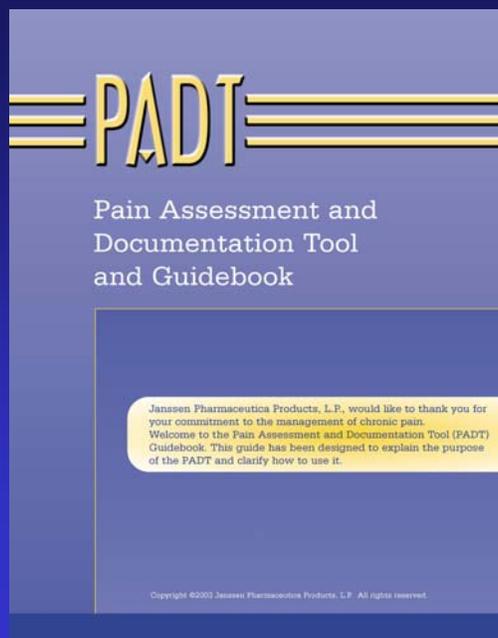
The New Rhetoric aka “What is the OxyContin Story”

- What does the household survey really tell us?
 - 19 million new drug abusers OR
 - 440k?
- Where is the diversion coming from?
 - Doctors and patients?
 - Theft from elsewhere in the pipeline?

The Four “A’s” of Pain Treatment Outcomes

- Analgesia (pain relief)
- Activities of Daily Living (psychosocial functioning)
- Adverse effects (side effects)
- Aberrant drug taking (addiction-related outcomes)

Passik & Weinreb, 1998



Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.) _____

4. Is the amount of pain relief you are now obtaining from your current pain relievers enough to make a real difference in your life?
 Yes No

5. **Query to clinician:** Is the patient's pain relief clinically significant?
 Yes No Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Social relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sleep patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

Adverse Events				
1. Is patient experiencing any side effects from current pain relievers? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Ask patient about potential side effects:				
	None	Mild	Moderate	Severe
a. Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental cloudiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient's overall severity of side effects?				
<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe				

Aberrant Drug-taking Behaviors: The Model

- Probably more predictive
 - Selling prescription drugs
 - Prescription forgery
 - Stealing or borrowing another patient's drugs
 - Injecting oral formulation
 - Obtaining prescription drugs from non-medical sources
 - Concurrent abuse of related illicit drugs
 - Multiple unsanctioned dose escalations
 - Recurrent prescription losses
- Probably less predictive
 - Aggressive complaining about need for higher doses
 - Drug hoarding during periods of reduced symptoms
 - Requesting specific drugs
 - Acquisition of similar drugs from other medical sources
 - Unsanctioned dose escalation 1 – 2 times
 - Unapproved use of the drug to treat another symptom
 - Reporting psychic effects not intended by the clinician

Passik and Portenoy, 1998

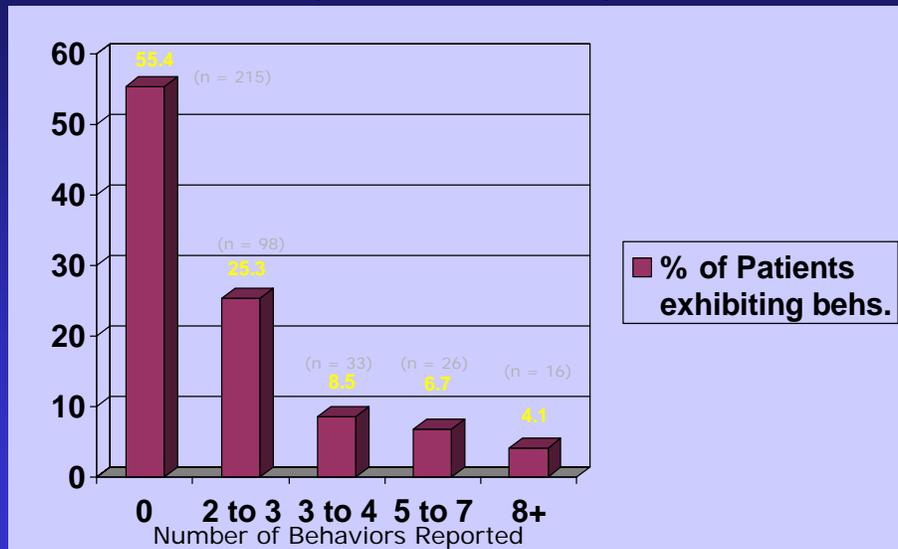
Potential Aberrant Drug-Related Behavior

Please **check** any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

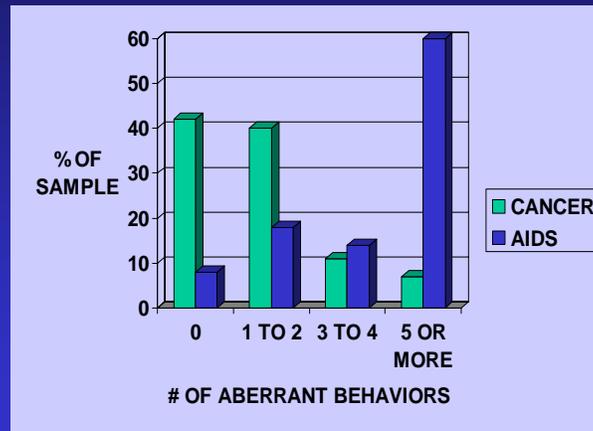
- Purposeful over-sedation
 - Negative mood change
 - Appears intoxicated
 - Increasingly unkempt or impaired
 - Involvement in car or other accident
 - Requests frequent early renewals
 - Increased dose without authorization
 - Reports lost or stolen prescriptions
 - Attempts to obtain prescriptions from other doctors
 - Changes route of administration
 - Uses pain medication in response to situational stressor
 - Insists on certain medications by name
 - Contact with street drug culture
 - Abusing alcohol or illicit drugs
 - Hoarding (ie, stockpiling) of medication
 - Arrested by police
 - Victim of abuse
- Other: _____

Aberrant Behaviors (n = 388)

(Passik, Kirsh et al, 2003a)



Aberrant Behaviors in Cancer and AIDS (Passik, Kirsh et al, 2003b)



AIDS Patients and Aberrant Behaviors

	Adequate <u>Analgesia</u> (n = 49)	Inadequate <u>Analgesia</u> (n = 24)
<u>Total # aberrant behaviors</u>	305 (6.2)	152 (6.3)
Aberrant behaviors “probably less predictive of addiction”	239 (78%)	116 (74%)
Aberrant behaviors “probably more predictive of addiction”	66 (22%)	40 (26%)

Differential Diagnosis of Aberrant Drug-Taking Attitudes and Behavior

- Addiction (out of control, compulsive drug use)
- Pseudo-addiction (inadequate analgesia)
- Other psychiatric diagnosis
 - Organic Mental Syndrome (confused, stereotyped drug-taking)
 - Personality Disorder (impulsive, entitled, chemical-coping behavior)
 - Chemical Coping (drug overly central)
 - Depression/Anxiety/Situational stressors (self-medication)
- Criminal Intent (diversion)

(Passik & Portenoy 1996)

Surprise Urine Drug Test (Katz and Fanciullo, CJP, 2002)

Issues--→ UDT Results	Yes (%)	No (%)	Total (%)
+	10 (8)	26 (21)	36 (29)
-	17 (14)	69 (57)	86 (76)
Total	27 (22)	95 (78)	121

A total of 53 (43%) had a “problem” so identified

Assessment of Addiction Risk

- Measures for Screening for Addiction Risk
 - STAR/SISAP
 - CAGE AIDD
 - Opioid Risk Tool (Emerging Solutions in Pain)
 - SOAPP (see painedu.org)
- Psychiatric Interview Assessment of Risk
 - Chemical
 - Psychiatric
 - Social/Familial
 - Genetic
 - Spiritual

Tailoring The Approach

- The uncomplicated patient: Minimally Monitored Drug Only Pain Therapy
- The Vast Middle Ground: “Chemical Copers”
- Addicted patients:
 - The actively abusing
 - The patient in drug free recovery
 - The patient on methadone maintenance

Minimally Monitored Drug-Only Pain Therapy

- Who qualifies for minimally structured approach?
 - None or minimal co-morbid psych
 - None or minimal substance abuse
 - None or minimal contact with addiction subculture
- Managed via optimization of opioids and side effect management – ie, routine medical management
 - 30 day supplies of meds
 - liberal rescues
 - brief monthly follow-up

The Vast Middle Ground: The “Chemical Coper”

- Opioid use characterized by:
 - Being overly drug focused
 - Always on the fringes of appropriate drug taking
 - Not progressing towards goals
- Related characteristics:
 - Somatization
 - Alexythymia
 - “Accidental” overmedication
- Decentralize pain medication – focus on rehabilitation and psych interventions

Outpatient Management of the Chemically Dependent Pain Patient/or Patient with Aberrant Drug-taking

- Maximally structured approach includes:
 - Frequent visits
 - Limited supply of meds
 - Managed primarily with long-acting opioids with low street value – judicious use of rescues
 - Urine Toxicology/pill counts/patch counts
 - Recovery program/psychotherapy
 - Opioid agreement
- Applied to:
 - High risk patients
 - All patients at the beginning of therapy (Universal Precautions: Heit and Gourlay)?

Summary

- There is a difference between addiction and the complex issues of noncompliance and aberrant behavior during pain management that has been poorly articulated
- The pain population is diverse – the application of opioid therapy to this diverse population requires careful assessment and tailored approaches that recognizes this diversity