Pain and Addiction

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InSight SBIRT Residency Training Program

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OBJECTIVES

Describe the prevalence of pain in patients with substance use disorders
Describe psychiatric co-morbidity in chronic pain patients
Summarize strategies for managing pain while minimizing risk of dependence
Identify and manage patients with non-medical use of prescription medications
Pain and Addiction – Two Views
Pain and Addiction – Two Views
Non-Medical Use of Prescription Drugs

2010 National Survey on Drug Use and Health (2009 data)
Drug Use Comparison

![Drug Use Comparison Chart]

- Marijuana
- Pain Relievers
- Cocaine
- Tranquilizers
- Heroin
- Stimulants
- Hallucinogens
- Inhalants
- Sedatives
Methods of Acquisition

- Free friend/relative
- Single physician
- Bought friend/relative
- Stole friend/relative
- Dealer
- Internet
Addiction in Patients with Chronic Pain

3.2% to 18.9% rate of addiction to prescription drugs, alcohol, illicit drugs

- Similar to rates of addiction in general population WITHOUT CHRONIC PAIN

Most common substances abused by patients with chronic pain

- ETOH
- Opioids

Houston Area DAWN Data

Percentage breakdown of ED visits associated with drug misuse

2008 Drug Abuse Warning Network-includes Ben Taub General Hospital EC
Houston Area DAWN Data

Between 2004 and 2007

ED visits involving non-medical pharmaceutical use with no other drug involvement rose 73%

ED visits involving non-medical pharmaceutical use and alcohol use rose 36%
Houston Area DAWN Data

Rates per 100,000

- Narcotic Analgesics: 68.6
- Hydrocodone: 51.1
- Methadone: 4.9
- Propoxyphene: 4.5
- Codeine: 3.8
- Oxycodone: 3.4
- Morphine: 2.8
Houston Area DAWN Data

Rates per 100,000

- Benzodiazepines: 122.5
- Alprazolam: 60.3
- NOS: 39.4
- Clonazepam: 9.9
- Diazepam: 9.1
- Lorazepam: 6
Case 1

46yo female cc b/l knee pain, right more severe
S/P right knee replacement complicated by infection and removal of hardware 1 year ago now awaiting revision
C/O pain 9/10
PMH: htn/dm/hyperlipidemia
Meds: Vicodin® with escalating use
How Common is Pain?*

60-80% lifetime prevalence of chronic pain

- 62-80% of MMTP patients
- 78% of patients getting inpatient SUD treatment
- 22% of primary care patients*

$61.2 billion lost productivity annually

Most common - headache, low back pain, arthritis, other joint pain

*Principles of Addiction Medicine, 4th Edition, Ries et al., 2009
# “Persistent pain and well-being: a WHO study in primary care.”
Gureje et al., JAMA 1998
Case 1 Continued

Belligerent in triage trying to get clinic appt when she runs out of Vicodin® early
12 PY history; quit 5 years ago
No other SUD history
Daughter with SUD
MDD diagnosed; stable on sertraline
Custody of teen grandson
On disability
Limited function, esp. shopping and laundry
Terminology

Aberrant medication-taking behaviors (AMTB) - May indicate abuse or addiction, less pejorative than ‘drug-seeking’

Chemical coping - Use/escalated use for secondary effects (i.e. sleep, anxiety, stress, mood)

Diversion - Not using medicine for self; typically to sell

Physical dependence - Usually present with normal chronic use as well as abuse or addiction

Pseudo addiction - Iatrogenic, under-treated pain

Tolerance - Sometimes present with normal chronic use as well as abuse or addiction

Addiction
(ASAM / APS / AAPM Criteria*)

A primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations; characterized by behaviors that include > 1 of the following:

– Impaired control over use
– Continued use despite harm
– Preoccupation with use
– Craving

* American Society of Addiction Medicine, American Pain Society, American Academy of Pain Medicine
What We Know And Don’t Know

We Know

Patients with opiate addiction often have increased pain sensitivity both in withdrawal and in recovery.

Opiates help modestly to relieve chronic pain.

Hyperalgesia

We Don’t Know

Longer acting/slower onset opiates

No validated screening tools

No validated treatment protocols

AMTBs common among individuals with and without addiction
The Single Question Screens

Validated single question screens for alcohol and drugs

- How many times in the last 12 months have you had 5 or more drinks (men) or 4 or more drinks (women) in a day?
- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Sensitivity</th>
<th>Specificity</th>
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<tbody>
<tr>
<td>Alcohol</td>
<td>82%</td>
<td>67%</td>
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<tr>
<td>Drug Screen Question</td>
<td>100%</td>
<td>73.5%</td>
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<tr>
<td>CAGE</td>
<td>77%</td>
<td>85%</td>
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Opiate Risk Tool (ORT)*

OPIOID RISK TOOL
Mark each Item Score Item Score
box that applies If Female If Male
1. Family History of Substance Abuse Alcohol [ ] 1 3
   Illegal Drugs [ ] 2 3
   Prescription Drugs [ ] 4 4
2. Personal History of Substance Abuse Alcohol [ ] 3 3
   Illegal Drugs [ ] 4 4
   Prescription Drugs [ ] 5 5
3. Age (Mark box if 16 – 45) [ ] 1 1
4. History of Preadolescent Sexual Abuse [ ] 3 0
5. Psychological Disease Attention Deficit [ ] 2 2
   Disorder,
   Obsessive Compulsive
   Disorder,
   Bipolar,
   Schizophrenia
   Depression [ ] 1 1
TOTAL _______ _______

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk > 8
Reprinted by Permission: Lynn Webster, MD
Opiate Risk Tool (ORT)*

Measure to identify AMTB risk

Study information
- Opiates prescribed for chronic pain
- N = 185
- Single Pain clinic
- Results
  - Low risk (0-3 points): 94.5% without AMTB
  - High risk (≥ 8 points): 90.9% with AMTB

* Webster and Webster, Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool*. Pain Medicine, 2005
## Appropriate Treatment Setting

### CONTINUUM OF CARE

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### Primary Care

- Uncertain
- Stable
- In recovery
- Modest
- Modest

### Multi Specialty (Pain, Addiction, Psychiatry)

- Unknown
- Unstable
- Active use
- Isolated
- Minimal engagement
Universal Precautions in Pain Medicine

Goals: Reduce Stigma, Contain Risk, Improve Patient Care

Diagnosis with reasonable differential
Psychological assessment including addictive disorder risk
Informed consent
Treatment agreement
Pre, post-intervention pain level and function assessment
Appropriate trial of opioid therapy ± adjuvant meds
Reassessment of pain score, level of function
Regularly assess the “4 A’s” of pain medicine
Periodically review pain diagnosis, co-morbid diagnoses
Document

Universal Precautions in Pain Management – A Rational Approach to Management of Chronic Pain Douglas Gourlay, MD, FRCPC, FASAM
Four “A’s” of Pain Treatment

Analgesia
– Modest but meaningful

Activities of Daily Living (psychosocial functioning)
– 80% rated as improved overall

Adverse effects (side effects)
– Common but tolerable

Aberrant Medication-Taking Behaviors
– May be indicative of addiction

Adapted from “Aberrant Drug-taking Behaviors in Pain Patients”, presentation by SD Passik, 2003
Case 1 Conclusion

Trial of long acting opiate: Morphine Sulfate Controlled-Release (MS Contin®)
Modest relief on 30mg BID, reported increase in shopping/laundry ability
Good relief on 60mg BID with no sedation, reported/observed, and fully functional
Drug seeking behaviors cease
Minimal AMTBs over last 4 years
Case 2

65yo male with stage IV lymphoma
C/O pain 10/10 mostly in legs
CT shows tumor compressing multiple pelvic and retroperitoneal nerves as well as vascular structures
PMH: COPD/MDD
Meds: Ipratropium bromide/albuterol sulfate (Combivent®), duloxetine (Cymbalta®) 60mg qday, naproxen (Naprosyn®, Aleve®)
All: NKDA
Case 2

Lives alone but good community support
No longer shops/runs errands outside of home except medical appointments
Has friend tidy apartment
Able to make microwave meals from wheelchair and sponge bathe self
Left long time wait staff job due to pain/mobility issues. What to do for pain?
Further Questions

Substance History:

– Alcohol Dependence in recovery for 4 years
– History of prescription drug problems 30 years ago (hydrocodone/APAP [Vicodin®] drug of choice then)
– 12 step involvement; supportive sponsor
– Church helping with rent pending SSD
– Family distant; father was alcoholic
– Patient declined opiates pending workup of leg pain/swelling due to fear of addiction
WHO Step Ladder

- **Mild Pain**
  - ASA, Acetaminophen, NSAIDS

- **Moderate Pain**
  - A/Codeine, A/Hydrocodone, A/Oxycodone, Tramadol

- **Severe Pain**
  - Morphine, Hydromorphone, Methadone, Levorphanol, Fentanyl, Oxycodone, AND ASA/Acetaminophen/NSAID, consider procedures

All levels: Co-analgesics as needed for neuropathic pain and other symptoms
Case 2 Continued

Addressing his pain

- Tried long acting morphine
- Patient liked hydromorphone (Dilaudid®) and Vicodin® better
- Patient skipped follow up appointments
- Got more Vicodin® and Dilaudid®
- Brought to EC after neighbor noted pt with AMS opiate overdose (filled 120 Vicodin® script, had 43 left 2 days later) AND + BAC in EC (albeit low)
- Patient acknowledged ETOH slip “just one beer” but also acknowledged not being sure of slip as thought he might have been hallucinating it
## Aberrant Medication-Taking Behaviors

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<td>Selling prescription drugs</td>
<td>Complaining about need</td>
</tr>
<tr>
<td>Prescription forgery</td>
<td>Drug hoarding</td>
</tr>
<tr>
<td>Stealing or borrowing other’s drugs</td>
<td>Requesting specific drugs</td>
</tr>
<tr>
<td>Injecting oral formulation</td>
<td>Acquisition of similar drugs from other medical sources</td>
</tr>
<tr>
<td>Obtaining prescription drugs from non-medical sources</td>
<td>Unsanctioned dose escalation 1 – 2 times</td>
</tr>
<tr>
<td>Concurrent abuse of drugs</td>
<td>Unapproved use of the drug to treat another symptom</td>
</tr>
<tr>
<td>Multiple unsanctioned dose escalations</td>
<td>Reporting psychic effects not intended by the clinician</td>
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Adapted from "Aberrant Drug-taking Behaviors in Pain Patients", presentation by SD Passik, 2003
Differential Diagnosis of AMBTs

Tolerance
Worsening of underlying disease
New disease process
Chemical Coping
Pseudo addiction
Addiction
Diversion
Patient Discussions

**AMTB**
- Express concern, ask open-ended questions, listen for flexibility when addressing behavior

**Addiction**
- Benefits no longer outweigh risks, taper, offer referral, commit to ongoing care with alternatives

**Diversion**
- STOP prescribing, focus on patient responsibility of safeguarding medication
Case 2 Continued

What next?

– Patient switched to methadone for pain
– Pain 9/10 but functional status modestly improved and no nodding out
– Patient still preferred Dilaudid® or Vicodin® but acknowledged problematic use and risk
– Back in touch with 12 step sponsor
– Back to weekly visits with doctor
– Only enough meds given to get to next appointment
– Added amitriptyline for neuropathic pain/insomnia
– 12 step sponsor concerned pt on methadone
Case 2 Continued

Other avenues

– May consider change to fentanyl patch
– Patient considering sub acute or skilled nursing facility placement
– Interventional options?
How Common is Insomnia?

35% of all adults within past 6 months
10-20% of primary care patients report chronic insomnia
Increased rates reported in patients receiving residential drug treatment services and highly variable
Insomnia, Opiates and Benzodiazepines*

Opiates shorten sleep latency, reduce total sleep time, sleep efficiency, slow wave sleep (SWS) and REM
Tolerance to some affects esp REM within several weeks of chronic use
Opiates improve RLS and PLMS
Benzodiazepines reduce sleep latency and nocturnal arousals, increase total sleep time with little effect on REM
Tolerance to sleep effects can occur within 2 to 3 weeks
Withdrawal from either causes significant and often long term sleep disruption

Insomnia in Patients with SUD

Take careful history of sleep and onset of sleep problem
Assess and treat any medical/psychiatric confounders
Assess and treat for intrinsic sleep disorders: OSA/RLS/PLMS
Discuss sleep hygiene
Medication therapy with lower abuse potential:
  – Trazodone (Désyrel®)  Quetiapine? (Seroquel®)
  – Amitryptiline (Elavil®)  Ramelteon (Rozerem®)
  – Melatonin

Case 3

23 yo male presents to triage/urgent/new patient appt for “med renewal”
PMHx: none
PSHx: s/p ex lap for gsw 2 years ago
Meds: Zolpidem (Ambien®)
All: NKDA
Case 3 Continued

Any further questions?

– Substance Hx: in treatment facility x 2 weeks for methamphetamine dependency; on Ambien® for 3 years took prescribed plus street up to 10 pills as needed help come off meth; occ MJ (last use 3 months ago, weekly use in high school)

– Family hx: no SUD

– HS grad, works construction prn
Case 3 Continued

Last took Ambien® 2 weeks ago
Awakes at 6am per treatment program requirements
Not falling asleep until 1 or 2 am
No napping
Other than snoring roommate, sleep environment conducive
Drinks 6 to 10 caffeinated beverages daily
Case 3 Continued

Treatment recommendations

– Cut back caffeine; none after 4pm
– Earplugs
– Ambien® alternatives if above insufficient:
  • Trazodone, Amitryptiline, Quetiapine?, Ramelteon, Melatonin
Prescription Access Texas

Texas’ online prescription drug monitoring program run by the Department of Public Safety (DPS)


Searches available in real time
Data updated within last 30 days
Lists controlled prescriptions, date prescribed, prescriber, date filled, pharmacy used, dose and quantity both prescribed and dispensed
Tips for Ethical Practice

Check DPS PAT prior to prescribing and ongoing
Obtain UDS prior to prescribing and ongoing
Utilize pain contracts / informed consent / pill counts/
Focus on functional improvement and setting pain relief goals realistically – 4 A’s
Use adjunctive treatment modalities / team approach
Know referral resources for both pain and addiction
Additional Resources


www.painedu.org

http://www.bu.edu/aodhealth/ealerts

www.drugabuse.gov

www.samhsa.gov
InSight SBIRT Residency Training Program

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SBIRT: Brief Intervention