THE MANAGEMENT OF PAIN IN PEOPLE WITH A PAST OR CURRENT HISTORY OF ADDICTION

June 2013

“I felt I had come home”

- A recovering heroin addict, 18 months abstinent, affiliated with Narcotics Anonymous
- MVA, fractured tibia
- prescribed IV morphine in ED
- patient commented that he was an ex-addict;
- Reassured, given morphine
- “I felt I had come home” - after discharge, returned to heroin use
- After months of relapse, returned to residential rehabilitation.

Pain relief in current or former addicts

- The result of inappropriate or poorly managed pain relief in former addicts can be much more serious than in non-addicted people

Research team

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Steering Committee

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Process

1. Collate existing guidelines, identify and contact key stakeholders, locate guidelines in preparation (JW)
2. Literature review by KR and JB
3. Successive drafts discussed with steering group

Format

Resource for health professionals and patients:

1. Summarising guidelines
2. Identifying key issues
3. Identifying barriers to safe and effective analgesia - knowledge, attitudes, and skills of individuals, and policies for systems
4. Grounded in case studies
5. Divided into **acute** and **chronic** pain management

Guidelines

Source	Title	Year
The British Pain Society	Opioids for Persistent Pain	2010
Australian and of Anaesthetics (ANZCA)	Acute Pain Management: scientific evidence	2010
Substance Abuse and Mental Health Services Administration (SAMHSA)	Managing Chronic Pain in Adults With, or in Recovery From, Substance Use Disorders	2012
American Pain Society and the of Pain Medicine	Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non cancer Pain	2009
The British Pain Society, Royal College of Psychiatrists, Royal College of General Practitioners, Advisory Council on the Misuse of Drugs	Pain and Substance misuse; Improving the patient experience	
Guidelines in preparation		
The British Pain Society	Opioids for Persistent Pain	Due 2013
Royal College of Psychiatrists	Pain and Substance misuse; Improving the patient experience	Due 2013

Acute Pain Management

Relapse

Epidemiology

Most dependent users of drugs relapse repeatedly before achieving abstinence

The risk diminishes over time, but relapse has been observed after 15+ years of abstinence

Risk of relapse and chronicity of addiction is greater with opioids than with other drugs

Relapse II

Neurobiology

All drugs off misuse act on a common brain region, the "reward pathway"

Dependence produces lasting changes in neurotransmitters, causing vulnerability to relapse

Key triggers for relapse are re-exposure, and stress (such as pain)

Relapse III

How to manage severe pain in recovering addicts and minimise relapse?

There is no data on the risk of relapse if opioids are used. The risk is thought to be low.

There is no data on risk of relapse if pain is undertreated. It is considered to be a risk.

The role of self-help fellowships in recovery

Self-help fellowships provide:

- support and reinforcement to sustain abstinence
- A structured belief system to protect against risk of relapse

However, this may contribute to the "abstinence violation" effect

Acute Pain Management abstinent ex addicts

Source	Key Points / Recommendations
SAMHSA 2012	Patients in recovery may prefer to avoid opioids If given opioids, switch from short- to long-acting medications quickly Patients may benefit from recovery support during postoperative period
ANZCA 2010	The risk of abuse is considered to be very small, but there are no accurate data If on naltrexone, it should be stopped at least 24 hours before surgery Multimodal analgesic regimens (eg NSAIDs, paracetamol, ketamine, tramadol and regional analgesia) should also be employed.

Acute pain management in opioid-tolerant individuals

1. Currently using heroin

2. On Opioid Substitution treatment (OST)

Tears before bedtime

A heroin user was admitted for hand surgery

- Post-operatively, in pain

- When told his next scheduled dose of analgesia was not for several hours, he swore at the nurse

Resolution

Addiction nurse saw patient

- Recommended methadone be given, plus analgesia as needed

Once withdrawal relieved, addictions nurse suggested apology

Patient agreed, situation resolved

Opioid-tolerant individuals

1. Need management of withdrawal

   Withdrawal is associated with brain dysregulation:

   - increased pain
   - emotional distress

2. Need higher doses of analgesia to control pain

More tears

M 54, methadone 100mg/day, required thoracotomy

- Post-op morphine infusion
- Team felt also giving high dose methadone was unsafe
- Patient ill, in pain, begging for methadone
- Ward staff thought he was drug-seeking

Patient telephoned his GP, who rang the team

- Methadone continued - on methadone plus morphine, he had good pain relief

Guidelines – Hospitalised opioid-tolerant patient

1. If confirmed, the daily dose of methadone or buprenorphine should be continued, to prevent worsening pain symptoms (and behavioural problems) due to withdrawal
2. If patients are in pain, doses of morphine higher than would be required by non-tolerant subjects may be needed
3. If using heroin, or unable to confirm OST dose, initiate methadone in small doses to manage agitation and withdrawal, monitoring for toxicity

Barriers to safe and effective pain relief

1. Many health professionals have little knowledge or experience in dealing with addiction, little understanding of recovery

2. STIGMA

Stigma – health professionals

1. Fear opioid drugs – toxicity and misuse potential
2. Distrust addicts as manipulative

Stigma – current and recovering addicts

Internalised stigma – guilt, fear of judgment, mean many people are reticent or misleading about drug use

Fear of withdrawal and fear of pain mean that many current addicts may self-medicate when hospitalised, adding to distrust

Acute pain management in current or former addicts

Management requires knowledge, skill in empathic listening, and continuity of care

Listening to patients reduces anxiety and pain

In hospitals, specialists in pain management and addictions can support staff

Without this, interaction between addict and health system is often unhappy

Chronic Pain

Chronic pain in current and former addicts

- **This topic is complex and difficult. The SAMHSA Guidelines** "Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders" **is 129 pages long**
- **We have drafted a document built around stories, and a brief summary of guidelines and evidence synthesis**

The contemporary epidemics

http://www.drugabuse.gov/news-events/nida-notes/2012/11/qa-dr-david-thomas

100 million adult Americans have chronic pain

2 million Americans dependent on prescribed opioids (cf ~500,000 heroin addicts)

Response from NIDA

- "NIDA supports efforts to generate a medication that will provide effective pain relief but without the potential for abuse and addiction"

The key benefit of opioids is relieving the affective component of pain

Response from NIDA II

- NIDA is leading a major consortium initiative to foster the creation of NIH Centers of Excellence in Pain Education
- NIDA supports Pain Champions – people in teaching organisations to establish courses in pain management

Addiction consultant letter

- I saw this woman 10 years ago, at which time she was taking 160 hydromorphone tablets weekly for headache. I referred her to a pain clinic, where she was admitted to hospital, treated with a ketamine infusion (which temporarily relieved pain), and discharged with advice to reduce the amount of hydromorphone. She was recently referred again to our addictions service, now taking 270 tablets/week of hydromorphone. She is fixated on pain, and angry at being referred to Addictions

Prescription opioid Dependence

Addiction to prescribed opioids is not benign, and can contribute to pain, disability and distress

Opioids contribute to pain through

1. **Withdrawal**
2. **OIH (Opioid Induced Hyperalgesia)**

Withdrawal and operant pain

Short acting drugs (like hydromorphone) contribute to a cycle of withdrawal related pain, drug use and relief, then re-emergence of withdrawal pain

Transfer to a long-acting opioid may abolish this cycle and improve pain control

Opioid-induced hyperalgesia

Occurs with all opioids

Dose-dependent

Can be dramatic

To the extent that OIH is contributing to pain, dose reduction (or cessation) may improve pain control

Pain medicine and Addiction Medicine

Involve chronic disease management, attending to biological, psychological, and social factors

Use opioids as a mainstay of treatment

Pain medicine and Addiction Medicine

Pain medicine is supportive:

The pain is what the patient says it is

Addiction medicine is Structured

- Some addicted individuals are less than open
- Some have skills at manipulating doctors
- Scepticism and risk management are central

Pain consultant letter

I reviewed H today. She has had severe back and leg pain, and just wants the pain to stop. She has come off lorazepam, which is remarkable, but is taking oxycodone 10mg, clonazepam 1mg, Zopiclone 15mg, all 2-3 times per day until she falls asleep. She has increased baclofen to 85mg. I injected further trigger points today and will review in 3 weeks

From addictions perspective

Diagnosis – dependence on opioids and benzodiazepines

Objectives of treatment – improve function (NOT pain free)

Current medication is not helping

Structured care

1. Diagnosis
2. Agreed realistic objectives
3. Good communication between all treatment providers
4. Monitoring and review
5. Appropriate dispensing and supervision

Guidelines

There are many published guidelines and evidence reviews on use of opioids in chronic pain

Most guidelines identify substance misuse as a contraindication to prescribing opioids

Five guidelines were identified dealing with pain management in current or past addicts

Guidelines

Source	Title	Year	Topics covered
The British Pain Society	Opioids for Persistent Pain	2010	Consensus statement and recommendations on opioids and problem drug use (Ch 7)
Australian and of Anaesthetics (ANZCA)	Acute Pain Management: scientific evidence	2010	Systematic review and recommendations: *Acute pain management in heroin users (11.7) *Acute pain management in opioid tolerant patients (and OST patients) (11.8)
Substance Abuse and Mental Health Services Administration (SAMHSA)	Managing Chronic Pain in Adults With, or in Recovery From, Substance Use Disorders	2012	Consensus document and supporting evidence: * Treating patients in recovery (p35) *Treating patients in medication-assisted recovery (p43) *Acute pain episodes (p46)
American Pain Society and the of Pain Medicine	Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non cancer Pain	2009	Systematic review and recommendations: * High-risk patients including patients with a history of drug abuse (Section 6).
The British Pain Society, Royal College of Psychiatrists, Royal College of General Practitioners, Advisory Council on the Misuse of Drugs	Pain and Substance misuse; Improving the patient experience	2007	Consensus statement and recommendations on good practice for the management of pain and in the prescription of opioid drugs: *Pain control in the addicted patient (Section 4) *Acute pain management (Section 5)

Guidelines in preparation

The British Pain Society	Opioids for Persistent Pain	Due 2013	Consensus statement and recommendations on opioids and problem drug use (Ch 7)
RCP Psych	Pain and Substance misuse; Improving the patient experience	Due 2013	Consensus statement and recommendations on good practice
PHE	Management of Persistent Pain in Secure Environments	Due 2013	Consensus statement and recommendations on good practice

Observations

1. Concerns over risk of diversion, overdose, and of maintaining addiction are not trivial, and make prescribing analgesia for addicts more difficult.

2. Many opioid-tolerant individuals experience chronic pain

Findings

There is no high-grade evidence on which to recommend chronic pain management in recovering or current opioid addicts

Findings

Treatment requires support + structure

- Long acting opioids
- Monitoring
- agreed, realistic objectives

There is a better evidence for opioids for addiction than for chronic pain

Conclusions

Conclusion

There is often no "right answer" in a given situation – managing pain, and managing risks, are processes

Managing pain in current or former addicts requires competence

Elements of competence

1. Knowledge –
   - opioid pharmacology
   - opioid dependence and withdrawal
   - structured treatment planning
   - management of opioid dependence
   - risk management (eg supervised administration, urine testing)

Elements of competence

2. Skill

- communicate effectively with patients (elicit history empathically, contain distress, discuss risks)
- collaborative treatment planning – set limits, provide options, monitor and ensure follow-up

- Communicate effectively with other professionals

In practice

GPs (and patients) need:

- Access to addictions specialist consultation
- Access to pain clinic consultation

Preferably in a one-stop comprehensive assessment.

Hospitals need:

- protocols
- Pain team
- Addictions consultation-liaison service

In practice

Pain clinics need

- Basic grasp of addiction medicine
- Access to addictions consultation

Addictions services need:

- Basic grasp of chronic pain Mx
- Access to pain clinic consultation

Engaging consumers

- In a health system creaking under increasing demand and diminishing resources, how do we achieve more individualised, comprehensive care?

- Encourage patients to ask, to express their concerns, and to ask for specialist input if they feel they need it