Painkillers, addiction and primary care

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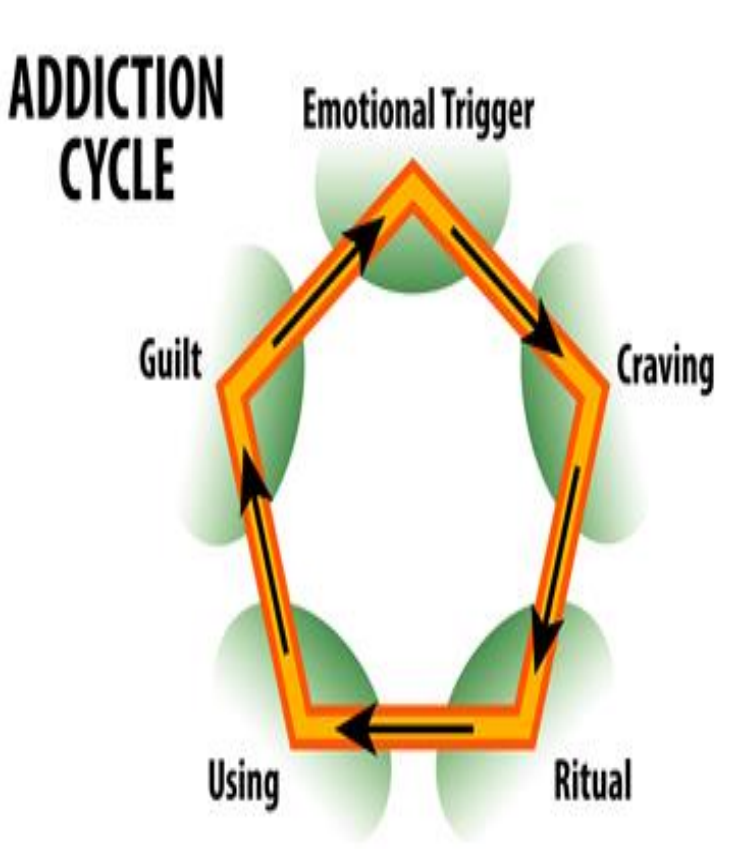
(GP with some knowledge about painkillers and addiction)

What is pain

- First attested in English in 1297, the word *pain* comes from the Old French *peine*, in turn from Latin *poena*, "punishment, penalty
- **Pain** is an unpleasant feeling often caused by intense or damaging stimuli, such as stubbing a toe, burning a finger, putting alcohol on a cut, and bumping the "funny bone".
- The International Association for the Study of Pain's widely used definition states: "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."
- Pain is the most common reason for physician consultation in the United States.

Addiction

- Evidence of dependence (tolerance and withdrawal) plus
- Impaired control over drug use
- Compulsive use
- Continued use despite harm
- Craving



PLEASURE

- Quick onset of action
- Smoking tobacco versus a nicotine patch
- Snorted oxycotin versus swallowed
- YOU CAN BECOME DEPENDENT ON LONG ACTING OPIATES, BUT ARE LESS LIKELY TO BE ADDICTED.
- You are much more likely to become addicted if you have a history of another addiction

What NICE say about the pain management (at the moment)

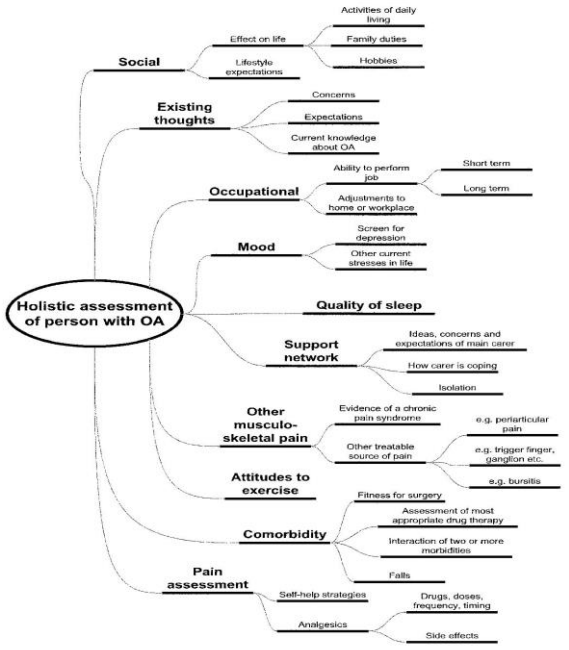


Figure 1 Holistic assessment of a person with osteoarthritis (OA)

NICE clinical guideline 59 – Osteoarthritis 6

1.4 **Pharmacological management of osteoarthritis**

1.4.1 **Oral analgesics**

1.4.1.1 Healthcare professionals should consider offering paracetamol for pain relief in addition to core treatment (see figure 2); regular dosing may be required. Paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered ahead of oral NSAIDs, cyclo-oxygenase 2 (COX-2) inhibitors or opioids.

1.4.1.2 If paracetamol or topical NSAIDs are insufficient for pain relief for people with osteoarthritis, then the addition of opioid analgesics should be considered. Risks and benefits should be considered, particularly in elderly people.

What NICE will leave us after new guideline!!!

- NICE has warned GPs against prescribing paracetamol for patients with osteoarthritis after its experts said they were ‘extremely concerned’ about the links of higher doses to cardiovascular, gastrointestinal and renal adverse events. (Pulse, 15 August 2013)
- European Medicines Agency- Use Naproxen or ibuprofen short term (EMA 18.10.2012)


POPPY FIELD BY MASSIMO MERLINI WWW.CRESTOCK.COM

Why prescribe opioids?

- Opioids are prescribed to reduce the aversiveness of the experience of pain. Clinical trials of opioid efficacy suggest that the drugs can provide useful analgesia in the short and medium term. Data demonstrating sustained analgesic effectiveness in the longer term are lacking.
- Opioids can be effective in the management of somatic, visceral and neuropathic pain.
- Complete relief of pain is rarely achieved. The goal should be to reduce pain sufficiently to facilitate engagement with rehabilitation and the restoration of useful function.
- The management of persistent pain focuses not only on reduction in pain intensity but also on improvement in sleep, mood, and physical, vocational, social and emotional wellbeing. Data demonstrating improvement in these domains with opioid therapy are lacking, although improvement in sleep has been demonstrated in those for whom opioids provide useful pain relief.
- Opioids should not be used as primary hypnotics, anxiolytics, sedatives or antidepressants.
- In monitoring the effect of any opioid, clear identification of an analgesic effect is essential.
- Improvements in quality of life are unlikely to be achieved unless opioids are prescribed as part of a broader approach to improve patient function.

- Opioids for persistent pain: Good practice

A consensus statement prepared on behalf of the British Pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists

January 2010

Why do people use non-medically

- To feel good
- For various aches and pains
- Snorted or given IV for a real high
- To prevent withdrawal in those addicted to IV narcotics

History of Opiate Addiction/Dependence Déjà Vu All Over Again

- Sixteenth century-the first reports about addiction to opium throughout Europe, India and China.
- Early 1800s, the chemist Seturner was able to isolate and identify the active ingredient in opium, which he named Morphine after the Greek god Morpheus. This was touted as the solution to Opium Addiction.
- Throughout the early and mid-1800s, morphine was used during surgical procedures as a general anesthetic and as relief for chronic pain. By the end of the century there were just as many individuals addicted to morphine as there were to opium.
- Late 1800s- medical profession's creation of so many morphine addicts led to experiments with cocaine as a potential antidote.
- Current jargon- opiates, alcohol, benzo's- downers, cocaine- upper

A Brief History of Opiate Addiction

- Chemists believed they discovered a non-addictive form of opiate around the turn of the nineteenth century –Heroin. The Bayer Company started the production of heroin in 1898.
- Over the course of the next century, governments around the world, would begin to recognize the dangers of heroin, morphine and opium. Soon these drugs were outlawed for medicinal purposes, and pushed underground.
- Late nineteenth century Laudanum (a tincture of raw opium in 50 percent alcohol) was prescribed to women complaining of "female problems". Epidemiological studies conducted in Michigan, Iowa, and Chicago between 1878 and 1885 reported that at least 60 percent of the morphine or opium addicts living there were women.

A Brief History Opiate Addiction

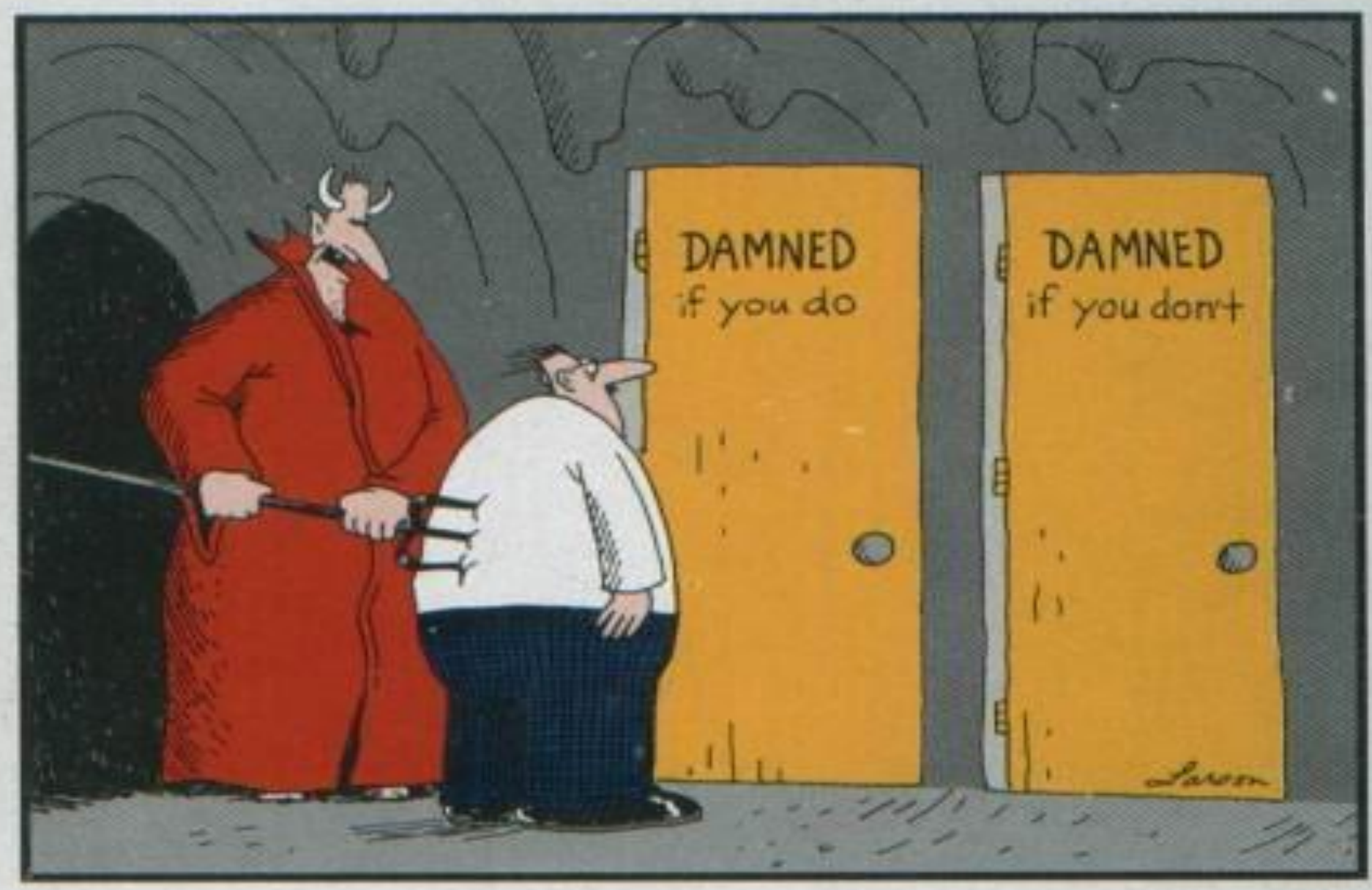
- Huge numbers of men and children, too, complaining of ailments ranging from acute pain to colic, heart disease, earaches, cholera, whooping cough, hemorrhoids, hysteria, and mumps were prescribed morphine and opium.
- A survey of Boston's drugstores published in an 1888 issue of Popular Science Monthly -of 10,200 prescriptions reviewed, 1,481, or 14.5 percent, contained an opiate.
- During this period in the United States and abroad, the abuse of addictive drugs such as opium, morphine, and, soon after it was introduced to the public, cocaine constituted a major public health problem..

The NEW ENGLAND JOURNAL of MEDICINE
Flood of Opioids, a Rising Tide of Deaths
n engl j med 363;21nejm.orgnovember 18, 2010

- Prescription opioids caused 11,499 of the deaths in 2007 — more than heroin and cocaine combined
- Admissions to substance-abuse treatment programs increased by 400% between 1998 and 2008
- Prescription painkillers are the second most prevalent type of abused drug after marijuana
- In almost every age group, men have higher death rates from drug overdoses than women
- About half of those who died had a medical history of pain treatment

Patients at Highest Risk

- Patients over 65
- Patients on 100 mg of Morphine or equivalent per day
- Patients with underlying lung disease
- Patients with underlying liver disease
- Patients with comorbid substance use disorder
- Patients with comorbid Mental Health Disorder
- Patients on Benzodiazepines



"C'mon, c'mon — it's either one or the other."

Behaviors More Suggestive of an Addiction Disorder

- Selling prescription drugs (Old grannies on 100 caps of 30/500 co-codamol a month)
- Prescription forgery (still happens)
- Stealing or “borrowing” drugs from others (just had couple of my mum’s/ wife’s painkillers as I was in agony)
- Injecting/ snorting oral formulations (Oxycodone etc)
- Obtaining prescription drugs from non medical sources (World Wide Web Pharmacy)
- Concurrent abuse of alcohol or illicit drugs

Behaviors More Suggestive of an Addiction Disorder

- Multiple dose escalations or other noncompliance with therapy despite warnings
- Multiple episodes of prescription “loss”
- Recent trend in my practice Diarrhea and Vomiting
- Repeatedly seeking prescriptions from other clinicians or from A&E without informing prescriber
- Evidence of deterioration in the ability to function at work, in the family, or socially that appear to be related to drug use
- Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug (Long acting formulations do not work, Rashes from the plasters, too dopey from tryciclics, NSAID bad for your heart etc)

Behaviors More Suggestive of an Addiction Disorder

- Aggressive complaining about the need for more drug
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Openly acquiring similar drugs from other medical sources
- Unsanctioned dose escalation or other noncompliance with therapy on one or two occasions
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician
- Resistance to a change in therapy associated with “tolerable” adverse effects with expressions of anxiety related to the return of severe symptoms

Explanations for Aberrant Behavior

- Pseudoaddiction – Addictive behavior primarily motivated by poor pain control
- Addiction –Loss of control, compulsive use, continued use despite harm, and craving.
- Tolerance – Decreased effect from previously effective opioid dose. (Can a safe opioid dose be used?)
- Diversion

Explanations for Aberrant Behavior

- Self medication of underlying Psychiatric Symptoms
- Hyperalgesia – The opioid has caused a worsening of pain control and the dose may need to be decreased or the opioid tapered and discontinued
- Disease progression with the need for reevaluation

Opiate Induced Hyperalgesia

- Long-term use of opioids may also be associated with the development of abnormal sensitivity to pain, and both preclinical and clinical studies suggest that opioid-induced abnormal pain sensitivity has much in common with the cellular mechanisms of neuropathic pain.
- Opioid induced abnormal pain sensitivity has been observed in patients treated for both pain and addiction.

Chronic Pain

- A complex process requiring time and frequent follow-up appointments.
- Patient education is crucial for success.
- Coordination of care with multiple specialties may be necessary.
- Treatment works. Do not give up.
- Treating addiction with ongoing opiate therapy will create more problems and eventually take more time.
- Pain treatment and opiates are not necessarily the same thing.
- Functional improvement is critical to ongoing success.

Universal Precautions in Pain Medicine

- Why person is in pain- DIAGNOSIS???
- Patient's expectations (West Kent Guidelines- Optimal dose is when patient experiences analgesic efficacy (10-30% pain reduction))
- Psychological assessment (somatisation, addictive personality)
- Informed consent (Side effects, addiction)
- Treatment agreement (compliance using one source for painkillersrather than running between various GP's and Hospital
- Pre/Post Interventions Assessment of Pain level and Function
- Appropriate TRIAL of opioid therapy with adjunctive therapy

Universal Precautions in Pain Medicine

- Reassessment of pain score and level of functioning
- Regularly asses the “Four As” of pain medicine: Analgesia, Activity, Adverse reactions, Aberrant behavior
- Periodically review pain diagnosis and co- morbid conditions, including addictive disorders
- Documentation (not only yours to make colleagues life easy but also your colleagues documentation to make your life easy)

Should you treat chronic nonmalignant pain with opioids?

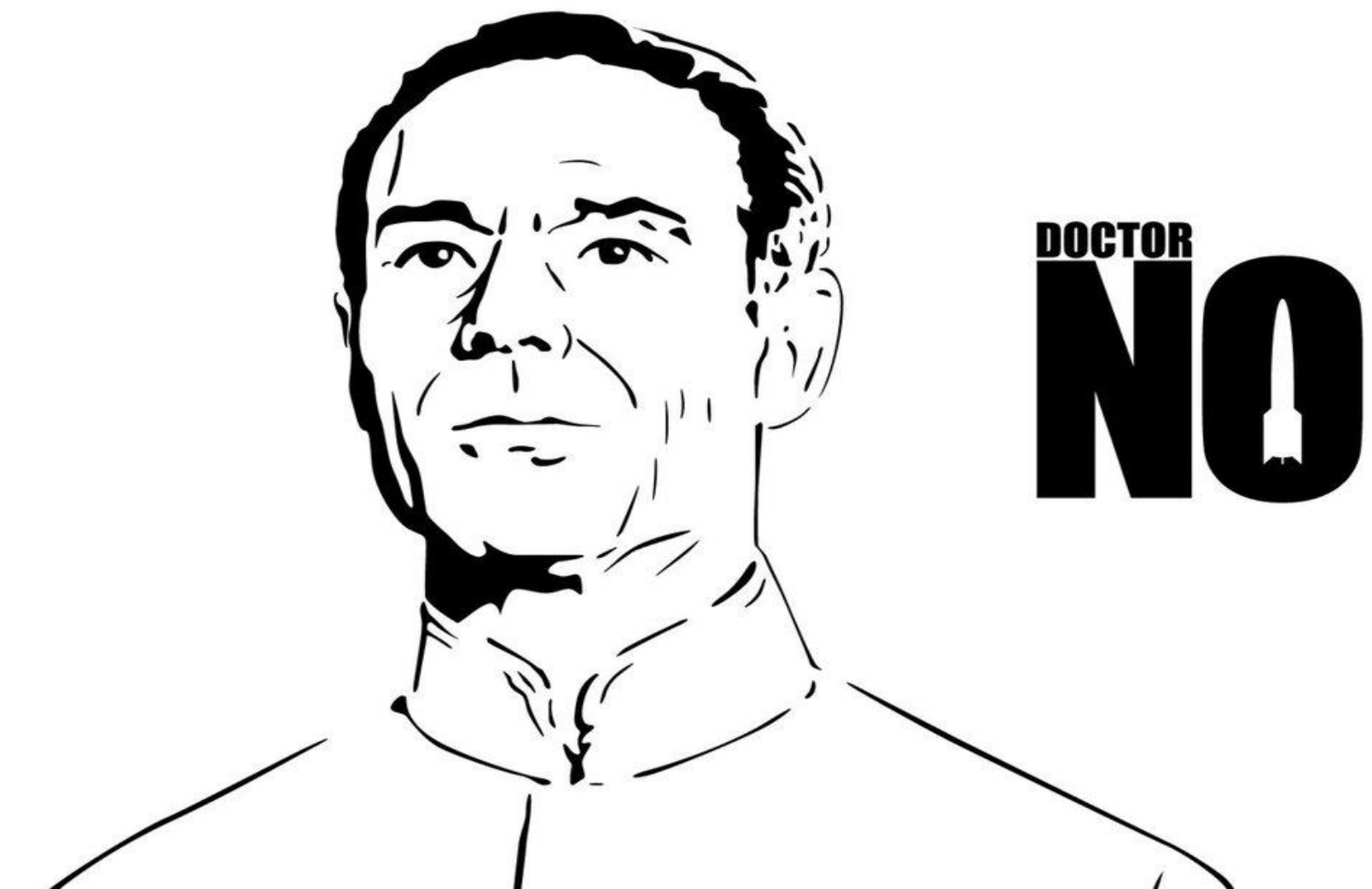
Few studies of long term use. Most show little or no long term benefit.

Martell, Bridget et al Annals of Internal Medicine: January 16, 2007

Barriers to Pain Management in Primary Care

1. Inadequacies in education and training
2. Lack of consultant support
3. Psychosocial Complexity
4. Time Pressures
5. Skepticism
6. Systems Limitations

Suggestions from my own experience

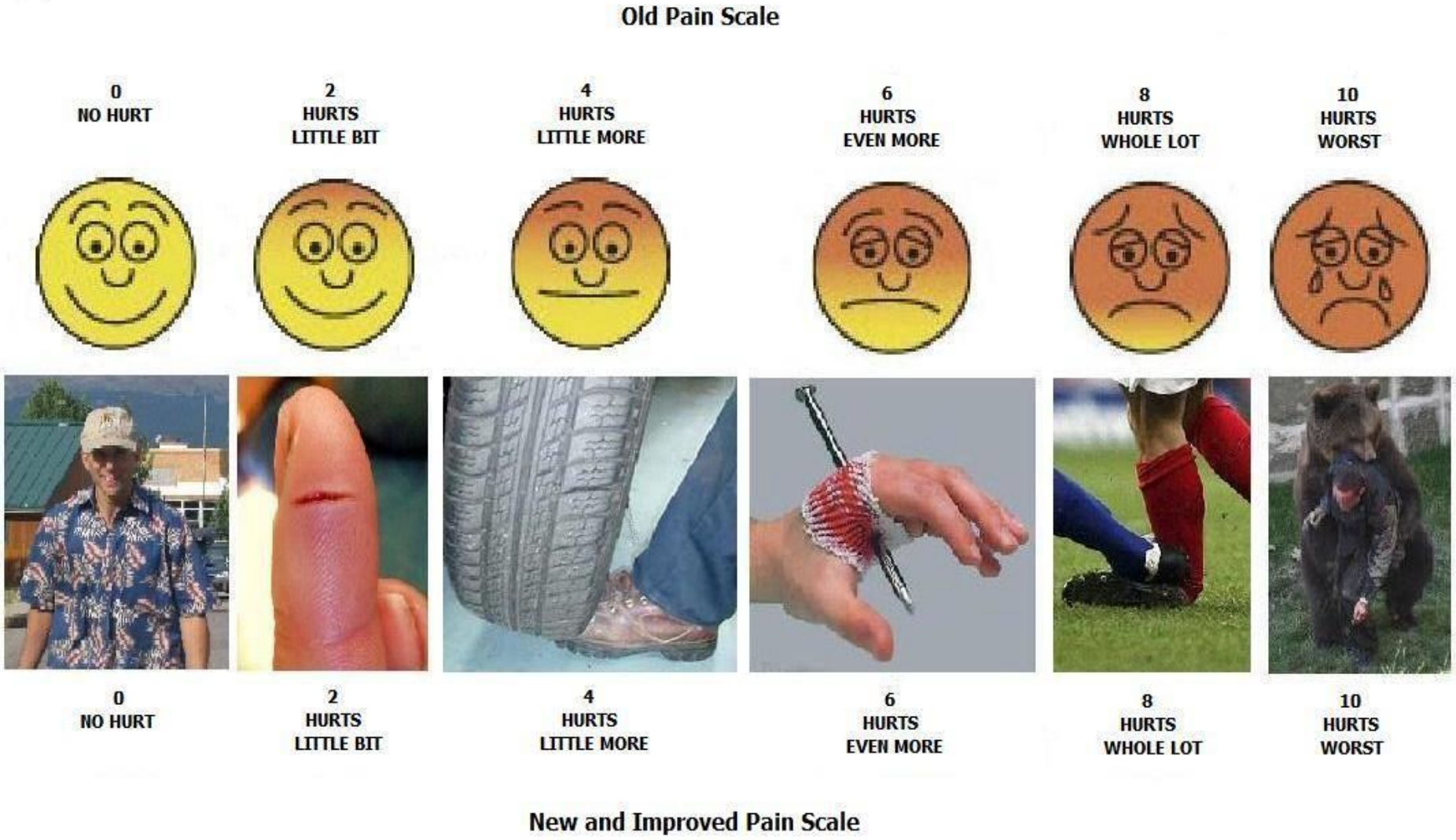


1. For all new patients asking for opioids- contact previous GP or Pain Team or at look for any evidence suggesting start or increase of opiates, preferably by telephone on the first visit

Patient assessment

1. The Pain: Subjective pain scale, patient's description, how it effects his/her life
2. The Pain: Objective
   - What is causing this pain?
   - What diagnostic tests have been done?
   - What treatments have been tried and how did they work?
   - Can it be fixed? Your opinion and patient's opinion
   - You need to obtain this information
3. Is the pain from the medical condition or secondary to depression or the stress of life?

How severe is the pain?



The minefield

- Some people are trying to obtain opioids for reasons other than pain - for their addiction, to sell, to treat their depression or life stresses.
- Some people are at risk for developing addiction.
- In some individuals the narcotics will not really relieve the pain. If the patients continue on the opoiods, it will be difficult for them to stop, even though they are no better.

BUT SOME PEOPLE MAY GET PAIN RELIEF AND GET THEIR LIFE BACK!!!!

Preparing for the Voyage

- Where are you going?
  - To improve functional status, not just lessen pain
- How will you know if you are off course or lost?

  - The pain gets no better
  - The dose needs continual increases
  - The patient isn't taking the medication you prescribe

Pill counts

Educate the patient

The use of medication is to reduce pain and increase function

2. The medicine does not always work, and so would be stopped to prevent problems
3. Sharing the medication could result in criminal charges
4. Do not leave medication where others, including teenagers, can find it.

If you don't have the time, don't prescribe the opioids!

- Spending 10 or 20 minutes obtaining a careful history, including a detailed SA history, contacting previous physicians and pharmacists, and another 10 minutes carefully reviewing old charts might save you future hours and many future headaches

Patient Agreement

Include the fact that use of opioids is a trial, to be stopped if it is not working or if there are problems

Include information on how the medication is prescribed -- need to come to the surgery to see the same doctor and take it to the same pharmacy

Include the side effects of medicine, dangers of overdose or driving if tired.

Opioid Agreement

- Patients agree to comply fully with all aspects of the treatment program including behavioral medicine and physical therapy if recommended
- A prohibition on use with alcohol, other sedating medications or illegal medications
- Agreement not to drive or operate heavy machinery until medication-related drowsiness is cleared (Must inform DVLA or if not sure get consent for you to contact DVLA)

Opioid Agreement

- Opioid prescriptions are provided by only ONE DOCTOR!!!
- Patients agree not to ask for opioid medications from any other doctor without the knowledge and assent of the provider
- Patients agree to keep all scheduled medical appointments
- Urine drug screens will be obtained as indicated (WISHFUL THINKING ☹)

Repeat prescribing

- There is no ethical obligation to prescribe or continuing prescribing narcotics for chronic pain.
- Stop if they are not working or if the patient is unable to take them as prescribed. (At each review, you should confirm that the patient is taking their medicines as directed, and check that the medicines are still needed, effective and tolerated),

(http://www.gmc-uk.org/guidance/ethical_guidance/14325.asp)

- Do not treat pain with benzos
- Use long acting. Avoid short acting for breakthrough pain, or if used, only prescribe a few.

Monitor Medications

- Count Pills: Tell patient that you are doing a quality assurance project and that you are calling patients and having them bring in their bottles of all pills to make sure it is what you have in your records.
- Prison experience implemented in the general community- daily/ bi- weekly pickup

Increasing doses without improvement

Tolerance: usually increase is small

2. Pain was not narcotic responsive:
   neuropathic pain, pain due to depression and psychosocial causes
3. Narcotic hyperalgesia
4. Diversion
5. Addiction

Thank You