Pain, Addiction & Methadone

A CHALLENGING INTERFACE

METHADONE AND SUBOXONE
OPIOID SUBSTITUTION CONFERENCE

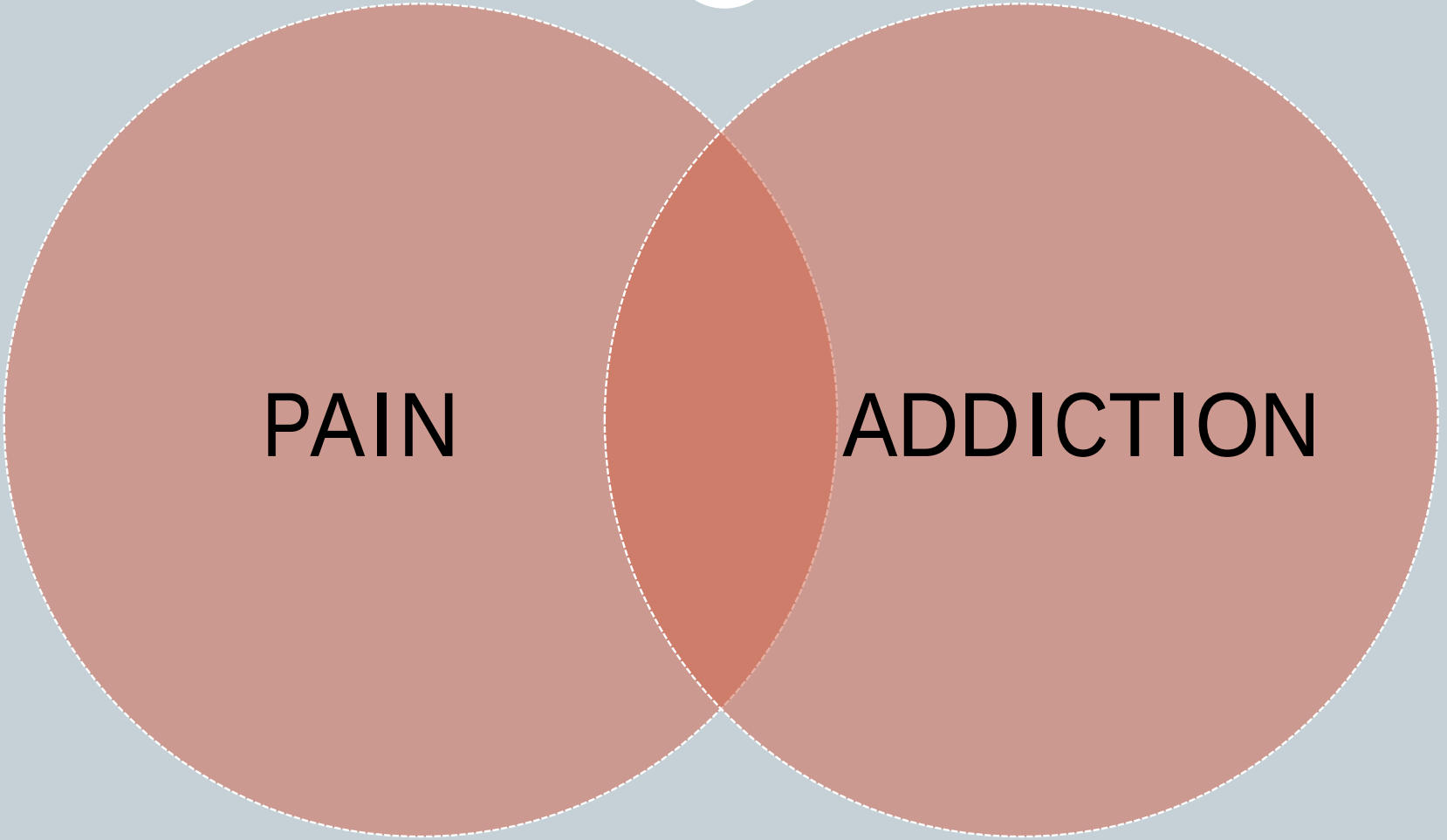
Objectives

- Explore the interface between concurrent pain and addiction.
- Appreciate the challenges for good concurrent care.
- Learn principles and evidence based options.

The Challenge

- How do you manage pain in people with an established opiate addiction, demonstrated loss of control over opiates, compulsivity and lack of insight?

Pain and Addiction



Pain and Addiction

- Be prepared to manage both.
- Some basic principles apply, but the approach may vary with a patient entirely focused on their pain and resistant to any notion of addiction.

Pain and Addiction

- Some patients referred for methadone have a primary problem with chronic pain, and an acquired problem with opiate misuse, abuse or addiction.
- They may have no insight into their inappropriate use and feel medically entitled to an endless supply of opioids.
- The exemption to prescribe for both pain and addiction is often required.

Opioid Addiction & Pain

- Opiate Addiction with withdrawal is painful and predominately perceived as musculoskeletal. The pain stimulates continued use.
- Pain and craving can be indistinguishable.
- The chronic, relapsing, often chaotic course of addiction complicates central modulation of pain.
- There is a > 50% presence of concurrent mental illness. Somatization is common.

Addiction & Pain

- IDU is associated with painful and at times obscure complications (osteomyelitis, abscesses) requiring a high index of suspicion and clinical acumen.
- There is a higher incidence of chronic pain syndromes, fibromyalgia and complex regional pain amongst those with an addiction.
- These may be difficult patients with challenging patterns of behavior.

Chronic Pain Impact

- "Total Pain" or Bio-psycho-socio-spiritual with family, work & community consequences.

- Not unlike Addiction.

What if Addiction evolves during CNCP treatment?

HOW DOES COMPULSIVE USE, CRAVING , LOSS OF CONTROL AND NEGATIVE CONSEQUENCES PRESENT IN CLINICAL PRACTICE?

Aberrant Drug Related Behaviour (1)

- Altering delivery route *
- Accessing opioids from other sources *
- Unsanctioned Use
- Drug Seeking

From Passik, Kirsh et al 2002.

- Injecting, biting, crushing, snorting.
- Friends or relatives

  Street purchase

  Double-doctoring
- Multiple dose escalations

  Binge use
- Recurrent Rx losses

  Aggressive complaining for higher doses

  Harassing staff for faxed Rx or appointments.

  No non-0pioid solutions

Aberrant Drug Related Behaviour (2)

- Repeated Withdrawal Symptoms
- Accompanying conditions
- Social features

- Marked dysphoria, myalgias, GI symptoms, craving.
- Currently addicted to alcohol, cocaine, cannabis or other drugs.

  Underlying unresponsive mood disorder.
- Deteriorating or poor social function.

From Passik, Kirsh et al 2002.

Aberrant Drug Related Behaviour (3)

- Views on opioid medication

From Passik, Kirsh et al 2002.

- Sometimes acknowledges being addicted.
- Strong resistance to tapering or switching.
- May admit to mood-leveling effect.
- May acknowledge distressing withdrawal symptoms.

Pain Patient vs. Opioid Abuser

- Controls meds
- Meds improve QOL
- Complains of S/E's
- Concerned re: potential for addiction
- Cooperates with plan
- Has left over meds, does not run out or lose opioids

- Can not control meds
- Meds decrease QOL
- Unconcerned with S/E's
- Denies possibility of addiction
- Does not follow Tx plan
- No meds left over: many excuses for lost meds

(From Jovey)

Canadian Guidelines for Opioid Use for Chronic Pain

A STEPPED APPROACH TO PAIN, OPIOID MISUSE AND ADDICTION

Pain, Opioid Misuse and Addiction: 1

- Structured Opioid Therapy:
- Well defined pain condition
- Urine Drug Screens
- No illicit drug use
- Reasonable dose (< 200mg morphine) or
- Patch formulation with patch exchange

(Canadian Guideline for Opiate Use for Chronic Pain)

Pain, Opioid Misuse and Addiction: 2

- Methadone or Burprenorphine:

- Failed trial of Opioid detox or Structured Opioid Therapy.
- Alteration of delivery route.
- Illicit obtainment of opioids.
- Illicit drug use.

(Canadian Guideline for Opiate Use for Chronic Pain)

Pain, Opioid Misuse and Addiction: 3

- Abstinent based treatment with
- Non-opioid chronic pain management.

(Canadian Guideline for Opiate Use for Chronic Pain)

Patient Referred for Pain, and Addiction

THE CHALLENGING ONES!

Evaluation Beyond Chronic Pain

- Explore the relationship of pain with substance misuse, abuse or addiction.
- Can they differentiate between pain and craving?
- Are they willing to explore alternatives to opiates?

Evaluation

- Summarize investigations, consults & treatments: some of this may not have been done due to their drug seeking behavior.
- Finish work-up, if required.
- Establish a working diagnosis (& differentials).
- Address treatable causes of the pain.
- Access concurrent treatment for psycho-social co-morbidity.

Treatment

- Establish and reinforce a primary focus on function, and functional recovery, rather than the elimination of pain or the use of a single drug.
- Frame this approach within the reality of their drug addiction.
- Emphasize the importance of a holistic approach.

Treatment

- Eliminate unnecessary & ineffective medications.
- Reinforce alcohol abstinence.
- Taper off sedatives.
- Explore non-pharmaceutical and non-opioid options.
- Access a multi-disciplinary pain clinic, if possible.

Follow-up

- Function
- Function
- Function (ADL)

- BPI / Opioid Manager (Rx Files)
- Analgesia: goal <4/10, or a 20% reduction.
- Medication, including OTC & herbal
- Adverse effects
- Aberrant alcohol or drug taking behaviour
- Holistic review
- DOCUMENTATION

Methadone

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PAIN AND ADDICTION

Methadone Initiation

- Ensure a complete pain assessment has been done.
- A therapeutic trial of methadone often requires a gradual withdrawal of their opiates with concomitant induction of methadone, rather than a straight conversion to methadone.
- Otherwise the use of methadone will be sabotaged with the patient expecting a return to their drug of choice.

Methadone Dosing

- Methadone is typically prescribed OD for addiction and TID or QID for pain.
- Clinically however many individuals with Chronic Pain Syndrome will be comfortable with OD or BID.
- Adjust the OD dose of methadone for pain management and monitor for objective improvement.

Pain, Opiate Abuse and Methadone

- Use methadone OD with non-opioid interventions if patient is not eligible for carries or more frequent dosing is not practical.
- Avoid opiates to maintain negative urine screens for substances of abuse.
- Progress to split dosed methadone, through carries, if both necessary and safe.
- Some people will stabilize in a holistic approach and can be tapered off methadone completely, with no subsequent opioid use.

Pain, Addiction and Methadone

- If legitimate, well-substantiated, pain syndrome is not methadone responsive at reasonable split doses, consider the use of transdermal fentanyl.
- Use patch exchange to diminish abuse.
- In theory, methadone should contain the euphoric & triggering effects of the fentanyl, or it may not be needed at all and can be tapered off.
- EDS coverage can be obtained if opiate addiction is verified.

References & Recommended Reading

- www.national paincentre.mcmaster.ca
- www.CCSA.ca
- www.CSAM.org.
- www.ASAM.org
- www.NIDA.org
- Project Create: www.addictionmedicine.ca
- Concurrent Disorder and Withdrawal Monograph, CPS-Sk
- Mate, Gabor. In The Realm of Hungry Ghosts. A.A.Knopf Canada. 2008

Questions?

THANK YOU