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."


1980 and Beyond

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

Can We Catch The Pendulum?

Avoidance
- Will not prescribe opioids for any reason - Driven by fear of regulatory action or antiquated views of addiction exaggerating the perception of risk

Balance
- Rational pharmacology, application of principles of addiction medicine
- Tailored therapy to risk in individual patients

Widespread Use
- Prescribing without recognition of dangers
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
Pain Assessment and Documentation Tool and Guidebook

Janseen Pharmaceutica Products, L.P. would like to thank you for your commitment to the management of chronic pain. Welcome to the Pain Assessment and Documentation Tool (PADT) Guidebook. This guide has been designed to explain the purpose of the PADT and clarify how to use it.

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## 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)

<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain as bad as it can be</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain as bad as it can be</td>
<td></td>
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</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th></th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical functioning</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>2. Family relationships</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>3. Social relationships</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>4. Mood</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>5. Sleep patterns</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>6. Overall functioning</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

* 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?  
   - Yes  
   - No

**Ask patient** about potential side effects:

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Vomiting</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>c. Constipation</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>d. Itching</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>e. Mental cloudiness</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>f. Sweating</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>g. Fatigue</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>h. Drowsiness</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>i. Other</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>j. Other</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

2. Patient’s overall severity of side effects?  
   - None  
   - Mild  
   - Moderate  
   - 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 (e.g., 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 (i.e., stockpiling) of medication
- Arrested by police
- Victim of abuse

Other: ___________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
Aberrant Behaviors ($n = 388$)

(Passik, Kirsh et al, 2003a)

- 55.4% of patients exhibiting behaviors ($n = 215$)
- 25.3% ($n = 98$)
- 8.6% ($n = 33$)
- 6.7% ($n = 26$)
- 4.1% ($n = 16$)

Number of Behaviors Reported:
- 0
- 2 to 3
- 3 to 4
- 5 to 7
- 8+

% of Patients exhibiting behs.
Aberrant Behaviors in Cancer and AIDS (Passik, Kirsh et al, 2003b)

![Bar graph showing the percentage of sample with different numbers of aberrant behaviors in cancer and AIDS. The x-axis represents the number of aberrant behaviors (0, 1 to 2, 3 to 4, 5 or more), and the y-axis represents the percentage of the sample (% of sample). The graph compares cancer and AIDS, with cancer shown in green and AIDS in blue.]
# AIDS Patients and Aberrant Behaviors

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