MISCONCEPTIONS, MISUNDERSTANDINGS AND MISINFORMATION ON PAIN MANAGEMENT IN ADDICTIVE DISORDERS
Objectives

**Review** the common mis-beliefs about pain management in both addictive and psychiatric disorders

**Include** Include the dreaded triad of pain, substance abuse and psychiatric disease (depression / bipolar disorder)
Question

How does it start?
"At first, you may feel a slight tugging sensation, followed by a two-month addiction to Percocet."
PAIN MANAGEMENT IN ADDICTION

- 9.4% of population > 12 yrs old - 22 million with abuse or dependency
- 11.5 million with dependency (withdrawal)
- 2006 – 2.1 million illicit pain analgesic users
- 2005 – 4000 deaths from methadone; exceeds heroin and cocaine combined
- Prescription opioids now most rapidly growing class of abused drugs (NIDA, SAMHSA)
QUESTIONS AND MISCONCEPTIONS TO BE ADDRESSED

1. How do I know if my patient with chronic pain is addicted?
2. What approach should I take if I believe my patient with chronic pain is addicted to the medications I am prescribing?
3. In my patient with known addiction, can I prescribe opioids?
4. Methadone or buprenorphine (Suboxone) are medications that I can use in patients with or without addiction.

5. Physicians in ED or clinic are legally obligated to provide opioids or controlled substances for pain patients on demand.

6. Mood disorders, common in chronic pain patients, should be addressed when pain issues improve or resolve!
7. Do opioid withdrawal symptoms and escalation of dosage indicate addiction and/or dependency?

8. Chronic pain opioid dependent or addicted “frequent flyers” to ED and clinic are best managed with detoxification.
9. Soma (carisoprodol), Robaxin (methocarbamol), Ultram, (tramadol) Flexeril (cycloclobenzaprine) and Ambien are alternatives to opioids in patients with addictive disorders.

10. Since opioids should be provided when all other treatments have failed, discontinuation is never an option or of benefit to the patient.
11. Random urine drug screens (UDS) will allow me to detect when my patients are abusing drugs.
How do I know if my patient with chronic pain is addicted?
Quiz

– Who said this?
IDENTIFYING ADDICTION – CHARACTERIZED – 5 C’S

✓ Compulsive

✓ Craving

✓ Continued use – in spite of physical, psychological, social consequences

✓ Control

✓ Chronic
What approach should I take if I believe my patient with chronic pain is addicted to the medications I am prescribing?
“Your” discomfort

Their protection

Mutual Agreement = Opioid Contract
PAIN MANAGEMENT IN ADDICTION

• Can I prescribe opioids to my patients with known addiction?
  – YES.
    • Opioid contract
    • Limited supply
    • ?UDS (urine drug screen)
Methadone or buprenorphine/naloxone (Suboxone) are medications that I can use in patients with or without addiction.

Yes, BUT
Quiz
– Test your knowledge on Opioids
Buprenorphine – pharmacology
• Buprenorphine/naloxone (Suboxone) 2mg/0.5mg; 8mg/2mg
• Opiate – partial \((mu)\) agonist/antagonist \((k)\)
• sublingual
• High receptor affinity (limited intrinsic activity)
• Maximum effective dose \(~16mg\) (92% receptor occupancy)
• Ceiling effect – saturated receptors (high affinity)
• Larger doses extend duration of action
Physicians in ED or clinic are legally obligated to provide opioids or controlled substances for pain patients on demand.
Obligations:

- Appropriate and reasonable medical care
- Risks / Benefits
- Disposition
  - EMTALA
Mood disorders, common in chronic pain patients, should be addressed when the pain issues improve or resolve.
Quiz

–Mood Disorders
Mood Disorders (continued)

- Depression
- Bipolar disorder
- Substance abuse
Do opioid withdrawal symptoms and escalation of dosage indicate addiction or dependency?
Chronic pain, opioid dependent or addicted “frequent flyers” to the ED are best managed with detoxification.
Soma (carisoprodol), Robaxin (methocarbamol), Ultram (tramadol), Flexeril (cyclobenzaprine) and Ambien (zolpidem) are alternates to opioids in patients with addictive disorders.
Since opioids should be provided for chronic pain when all other treatments have failed, discontinuation is never an option or benefit for the patient.
Random urine drug screens (UDS) will allow me to detect when my patients are abusing drugs.
Thank You!