Fire the Molecule, Not the Patient!
From Irresponsible Prescribing to Universal Precautions

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Disclosure

- Nothing to disclose
Learning Objectives

- List strategies to set limits around medication prescribing that reduces the risk of addiction
- Explain how the three components of addiction (environment, biology, and drugs) each need to be examined to understand addiction
- Review the latest data on Universal Precautions in Pain Medicine
Good Intentions Gone Wrong

- From an anesthesiologists perspective, the treatment of chronic pain has had a chequered past
  - Typically a lost leader – managed reluctantly by some using the limited resources at hand – the nerve block
  - As time progressed, nerve blocks became more sophisticated encompassing neuroablative techniques and implantable devices
    - “There is nowhere in the human body an anesthesiologist can’t hit with an 18 ga needle of sufficient length” 😊
Specialty Training

- During anesthesia training, we learned little about oral pharmacotherapy
  - Chronic pain management was not a mandatory part of training
  - We learned even less about chronic disease management and ongoing patient care
  - We learned nothing about the disease of addiction
    - The common wisdom was that “if you had legitimate pain, the risk of addiction was negligible”
My First “Challenging” Patient

- 43 yo woman, diagnosed with bronchogenic CA
  - Referred by radiation oncologist due to excessive use of oral opioid analgesics (oxycodone with APAP)
    - MD stated “I’m concerned I’ve written scripts for over 600 tablets in this past month – can you please assess her and give me an opinion?”
  - I was actually quite good at identifying drug seeking behavior
    - My strategy was to set tight limits around medication prescribing and when the patient stepped out of bounds, they were discharged
  - This patient challenged my understanding of pain OR addiction
43 yo Cancer Patient

- Patient arrived for her appointment, in a wheel chair accompanied by a young man and woman
  - After the interview, the young man ‘volunteered’ to accept responsibility for his friends “Percs” to make sure she
    - “Takes ‘em just like you prescribed!”
  - During the physical exam, the patient confided that this couple cares for her, but only in exchange for Percocet®
    - I’d solved the problem but created a dilemma for myself
      - “legitimate pain didn’t make prescribing opioids appropriate”
All Pain Doctors Need to be Talented Amateurs in Addiction Medicine

▪ With this in mind, I completed a fellowship in Addiction Medicine at the Addiction Research Foundation in Toronto

— During this time, my goals were simple:
  • Integrate a body of knowledge I was unfamiliar with (addiction medicine) into a field I had considerable experience in (anesthesia)

— I attended a conference on Pain Management and Chemical Dependency in New York.
  • There were two clearly opposed factions of practitioners
Well attended by passionate practitioners from both camps:

- ~50% vilified the opioid class of drugs (and those who prescribed them)
- ~50% felt that opioids were obviously underutilized, with “literature” to support this position
  - Clearly the answer lies somewhere in between these two positions
Why Do We Use Opioids?

- Obviously this class of drug has risk associated with use
  - But we prescribe them because they work!
    - Unfortunately, they don’t work equally well for all patients, or all types of pain
      - And they certainly don’t seem to work sustainably for all patients
    - Patient selection is key (practitioner selection may also be important)
  - In the phrase “trial of opioid therapy,” the most commonly forgotten word is “trial”
The Pain World in Evolution

- In 1995, the APS declared that pain was “the 5th vital sign”
  - Pain was recognized as a significant public health concern
    - The public demanded better pain management
    - The pharmaceutical industry promised safe, effective medications
    - The government expected clinicians to take up this unmet challenge
  - In 2000, JCAHCO released new standards for assessment and management of pain
    - A few months later, Congress passed a law defining the next 10 years as the “Decade of Pain Control and Research” effective January 1, 2001
Pain and Chemical Dependency: Not an “Either Or” Proposition

- Pain and addiction CAN coexist

- Addiction in general population
  - Varies 3 – 16% prevalence
  - Varies with the drug, gender, economic status, race, age...

- Addiction in the chronic pain population
  - We really have no idea
  - We use the same terms, with different meaning

- Lack of precision in definitions around abuse/dependency/addiction

(Liaison Committee for Pain and Addiction 2001)
Definitions

- Addiction: Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. (LCPA 2001)
Definitions

- Physical Dependence: Physical dependence is a state of adaptation that often includes tolerance and is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. (LCPA 2001)
Definitions

- Tolerance: Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

- Tolerance develops at different rates, in different people, to different effects.
Definitions

- Pseudoaddiction: iatrogenic, maladaptive behavior resulting from inadequate pain control

- Not to be used “instead of” addiction

- Unwise to diagnose in patient with history of addictive disorder, even in other substance
What Was the Impact?

- Risk was ignored
- Opioid prescriptions skyrocketed
- Adverse outcomes increased

- Interestingly, several key opinion leaders published data suggesting that despite the dramatic increase in the prescription use of opioids, there was no evidence of a causal relationship between opioid prescribing and misuse
Universal Precautions in Pain Medicine

- In 2002, at the World Congress on Pain in San Diego, CA, I listened to one more angry colleague asking why I didn’t believe my patients had real pain:
  - “You wouldn’t do a urine drug test on a cancer patient, would you?”
    - To her surprise, my answer was “Yes, if I thought the information might be helpful. What actions I’d take might differ in a palliative setting . . . .”
  - It was that day I considered a new way of approaching pain patients that respected the uncertainty of risk assessment . . .
Universal Precautions in Pain Medicine

- A Universal Precautions Approach to the assessment and management of chronic pain (Gourlay / Heit 2005)
  - Which was borrowed from the infectious disease model by the same name
    - “The question shouldn’t be ‘Is there risk?’ If you’ve got a pulse, you have a risk…. the real question is ‘What is the risk – and how can it best be managed?’”
    - The 10 point approach has been widely adopted in most chronic pain guidelines in the USA and Canada
Universal Precautions Concept

▪ How do we implement it?
  — Thoroughly inquire into drug and alcohol history
    • ORT/CAGE/etc
  — Set boundaries around medication use
  — Identify aberrant behavior

▪ Triage
  — Group I: CNCP patients managed by primary care
  — Group II: Those managed with specialist support
  — Group III: Tertiary level CNCP patients

▪ Assess opioid responsiveness through rational trials of opioid therapy
Pain-Addiction Continuum
Diagnosis of Addiction in Chronic Pain

- When the drug is both the problem AND the solution in the patient at the same time i.e. problematic opioid use

  - DSM-V is inadequate
  - Addiction is “diagnosis made prospectively, over time”
    - Pseudoaddiction is “diagnosed retrospectively”
  - Careful limits and boundary setting will help to make the diagnosis
  - “A legitimate indication for a drug does not (always) make it’s use appropriate”
Universal Precautions in Pain Medicine

1. Diagnosis with appropriate differential
2. Psychological assessment including risk of addictive disorders
3. Informed consent (verbal v. written/signed)
4. Treatment agreement (verbal v. written/signed)
5. Pre trial assessment of pain/function
6. Appropriate trial of opioid therapy +/- adjuvants
7. Reassessment of pain score and level of function
8. Regular assess the “Four A’s” of pain medicine
9. Periodically review pain diagnosis and comorbid conditions including addictive disorders

10. DOCUMENT, DOCUMENT, DOCUMENT

Gourlay, Heit et al 2005
Where Are We Today?

- The pendulum is again in motion
  - Opiophobia is being replaced by opiophobia
    - Clearly, neither extreme is a rational position
    - How do we achieve balance?

- State regulators are introducing legislation that serves to severely curtail availability of the opioid class of medications
  - Legislation is often well intended, but no mechanism in place to assess both “intended” as well as “unintended” consequences
Challenges for Today

- We still have an aging population with poorly managed chronic pain
  - But we also have a large population of patients who are now chronic prescription opioid users
    - Some are relatively stable; some are struggling
      - It’s a heterogeneous group
    - Virtually all are physically dependent on opioids
      - Most do not have access to clinicians who can help them manage these drugs, safely OR rationally
Managing the Inherited Pain Patient

- What does a patient do when their prescriber
  - Retires?
  - Dies?
  - Loses their licence?
    - What does the medical community do?

- Whether the patient was ever a good candidate for a trial of opioid therapy, most now have a legitimate reason for being on this class of drug...at least in the short term
Exit Strategies From Opioids

- First, not all patients who struggle to get off opioids are “addicted”
  - “If they don’t need opioids, they come off them easily” is, for the most part, nonsense
- Similarly, not all patients whose pain gets worse with opioid discontinuation are best served by continuation of opioids
  - even if they seem to improve somewhat with reintroduction of the class
  - Pain often gets better without, rather than with opioids
Where to Go From Here?

- First, don’t accept the status quo
  - Change is a process, for both the patient AND the prescriber
    - Beware the phrase “best of a bad situation.” It’s usually just a bad situation.
  - Pain patients and their treatment providers may benefit more from carefully set limits and boundaries than well intentioned labels that may or may not apply

- As pain medicine clinicians, you have a lot to offer your pain management colleagues
  - Try to get involved before the wheels fall off – not after!
Resources

- [http://drug-interactions.com](http://drug-interactions.com)
  - For UDT monograph
- [dgourlay@cogeco.ca](mailto:dgourlay@cogeco.ca)
  - Email for Dr Douglas Gourlay