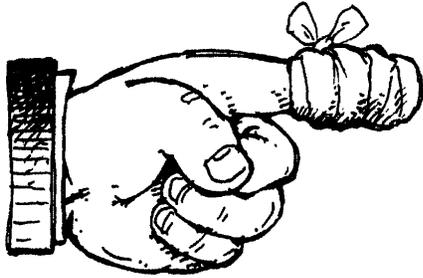


**AND THE
SUBSTANCE USER**

**A NYS OASAS CASAC
WORKBOOK**

PREPARED BY



OFFICE OF THE OASAS MEDICAL
DIRECTOR

STEVEN KIPNIS MD, FACP, FASAM

OASAS ADDICTION MEDCINE UNIT
JOY DAVIDOFF MPA, ASST DIRECTOR

MILDRED FIGUEROA
ROBERT HIGGINS, MA

NO KIND OF SENSATION IS KEENER AND MORE ACTIVE THAN
THAT OF PAIN, ITS IMPRESSIONS ARE UNMISTAKEABLE.

“THE 120 DAYS OF SODOM”
THE MARQUIS de SADE

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DEFINITIONS

PAIN :

- A NOUN
- A PENALTY
- BODILY SUFFERING
- DISTRESS
- ANGUISH



DRAWN BY SIR CHARLES BELL

DEFINITIONS

THE INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN DEFINES IT AS:

- UNPLEASANT SENSORY AND EMOTIONAL EXPERIENCE
- ASSOCIATED WITH ACTUAL OR POTENTIAL TISSUE DAMAGE*

*TISSUE INJURY OCCURS AT 45°C OR 113°F

DEFINITIONS

PAIN :

- UNIQUE AND COMPLEX EXPERIENCE INFLUENCED BY:
 - CULTURE
 - CONTEXT
 - ANTICIPATION
 - PREVIOUS EXPERIENCE
 - EMOTIONAL FACTORS
 - COGNITIVE FACTORS
 - AGE



DRAWN BY ANDREA VENTURA

DEFINITIONS

PAIN IS COMPOSED OF 3 HIERARCHICAL LEVELS:

I. SENSORY

- DISCRIMINATORY COMPONENT
 - LOCATION
 - QUALITY
 - INTENSITY

DEFINITIONS

PAIN IS COMPOSED OF 3 HIERARCHICAL LEVELS

II. MOTIVATIONAL

- AFFECTIVE COMPONENT
 - ANXIETY
 - DEPRESSION

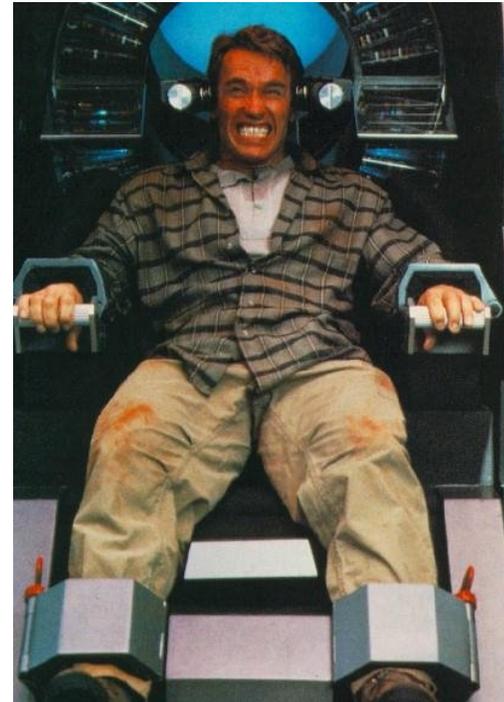
DEFINITIONS

PAIN IS COMPOSED OF 3 HIERARCHICAL LEVELS

III. COGNITIVE

- EVALUATIVE COMPONENT
 - THOUGHTS CONCERNING THE CAUSE AND SIGNIFICANCE OF THE PAIN

PAIN IS **ALWAYS** SUBJECTIVE
AND CAN NEVER BE PROVED
OR DISPROVED.



TOTAL RECALL

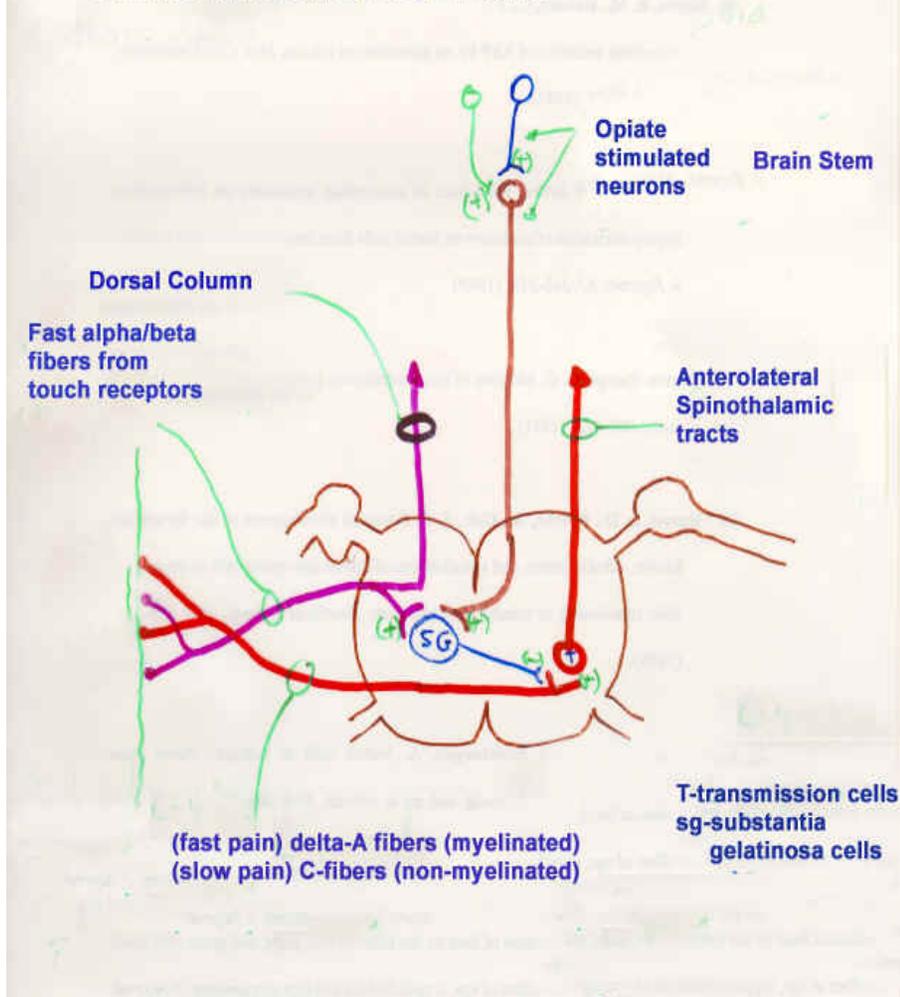
THERE ARE AT LEAST 26 AREAS OF THE BRAIN THAT ARE INVOLVED IN PAIN.

PAIN MODULATION IS INFLUENCED BY THE ENDORPHINERGIC (BRAIN MADE OPIATES) SYSTEM AND OTHER SYSTEMS.

CHRONIC PAIN CHANGES THE RECEPTORS, CIRCUITS AND TRANSMITTERS.

PATIENTS WITH CHRONIC PAIN ARE NOT EQUAL TO NORMAL SUBJECTS AS THE PAIN PATIENT'S SYSTEM IS **UPREGULATED** (HEIGHTENED SENSITIVITY TO PAIN STIMULI).

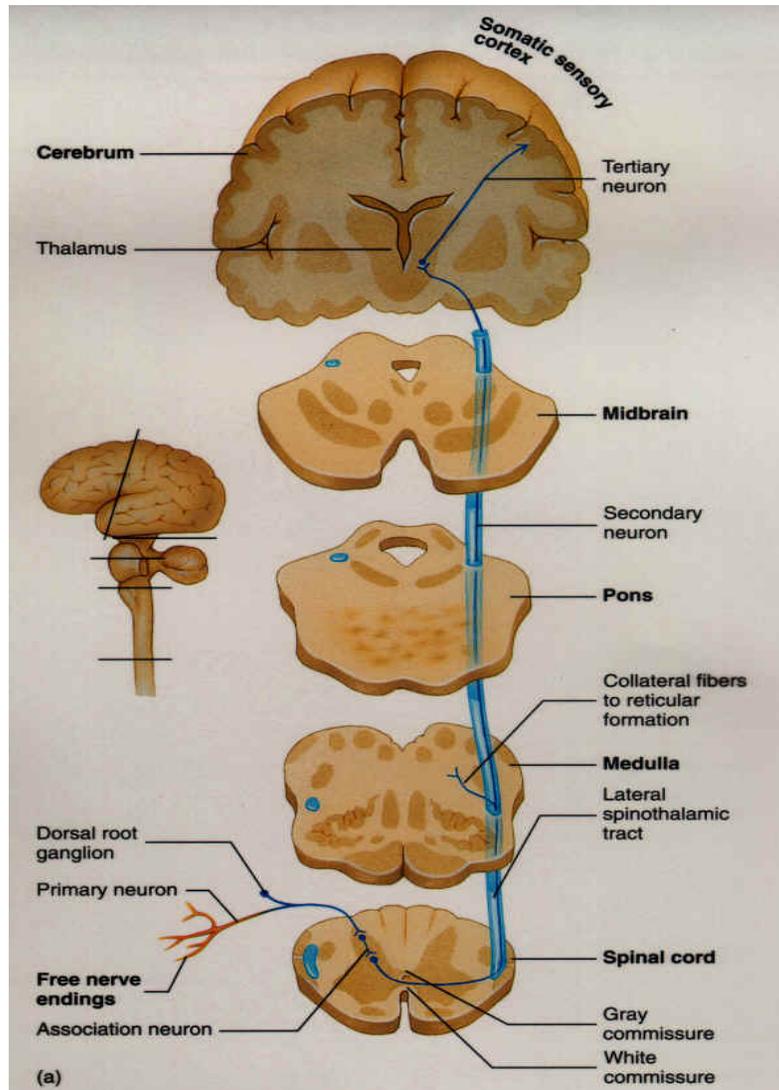
Transmission of Pain



PAIN IS TRANSMITTED FROM THE PERIPHERAL RECEPTORS TO THE BRAIN STEM (LOWER PORTION OF THE BRAIN – CONNECTS TO THE SPINAL CORD).

TYPES OF PAIN

- NOCICEPTIVE
- NEUROPATHIC
- SOMATOFORM (IDIOPATHIC)



ANTEROLATERAL SPINOTHALAMIC SYSTEM RESPONSIBLE FOR THESE SENSATIONS:

- COLD
- WARM
- PAIN SENSATIONS
- CRUDE PRESSURE AND TOUCH SENSATIONS
- TICKLE AND ITCH SENSATIONS
- SEXUAL SENSATIONS

TYPES OF PAIN

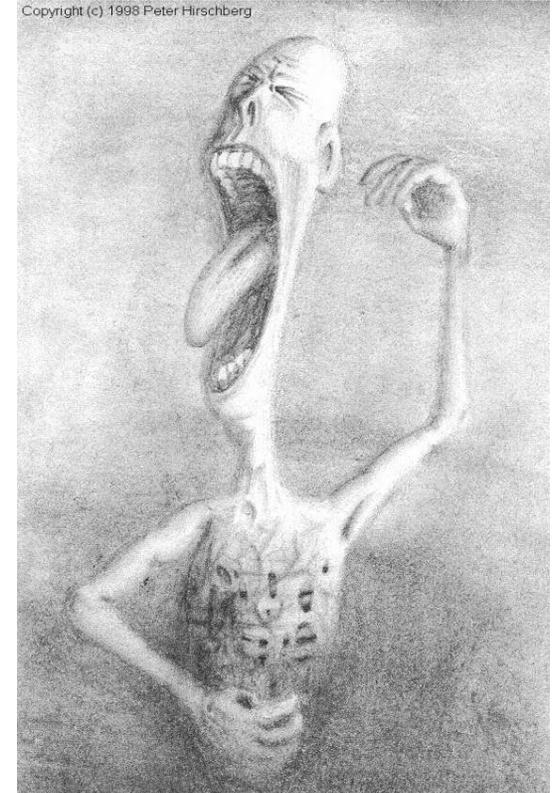
- NOCICEPTIVE
 - THIS PAIN PROCESS CAN BE INVOLVED IN BOTH ACUTE AND CHRONIC PAIN
 - SOMATIC: LOCALIZED, ACHY, SQUEEZING, STABBING, THROBBING
 - EXAMPLE: ARTHRITIS

TYPES OF PAIN

- NOCICEPTIVE
 - PRODUCED BY NOXIOUS STIMULI
 - SKIN, JOINT, ORGAN, MUSCLE PAIN
 - DUE TO TISSUE INJURY
 - INVOLVES
 - A-DELTA AND C FIBERS (NERVE FIBERS) RECEIVE PAIN STIMULI
 - ↓
 - DORSAL HORN OF THE SPINAL CORD WHERE THERE IS SIGNAL PROCESSING
 - ↓
 - NEURAL PATHWAYS GOING UP TO THE BRAIN (AFFERENT/ASCENDING PATHWAYS)
 - ↓
 - THALMUS AND OTHER PARTS OF THE BRAIN

TYPES OF PAIN

- NOCICEPTIVE
 - THIS PAIN PROCESS CAN BE INVOLVED IN BOTH ACUTE AND CHRONIC PAIN
 - VICERAL(ORGAN): GENERALIZED, CRAMPY, GNAWING
 - EXAMPLE: GALL BLADDER



TYPES OF PAIN

- NOCICEPTIVE
 - THIS PAIN PROCESS MAY INVOLVE ACUTE AND CHRONIC INFLAMMATION DUE TO THE ACTION OF VARIOUS SUBSTANCES AND NEUROTRANSMITTERS (NT) SUCH AS:
 - SEROTONIN (NT)
 - SUBSTANCE P
 - PAIN MESSENGER FROM AN INJURED AREA RELEASED INTO BLOOD AND CAN ACT ON VARIOUS BRAIN PAIN CENTERS
 - HISTAMINE
 - RELEASED ON INJURY, VESSEL DILATATION (VESSELS OPEN WIDER)
 - ACETYLCHOLINE (NT)
 - BRADYKININ
 - DILATES BLOOD VESSELS, INCREASES CAPILLARY PERMEABILITY
 - PROSTAGLANDINS
 - INVOLVED IN INFLAMMATORY RESPONSE

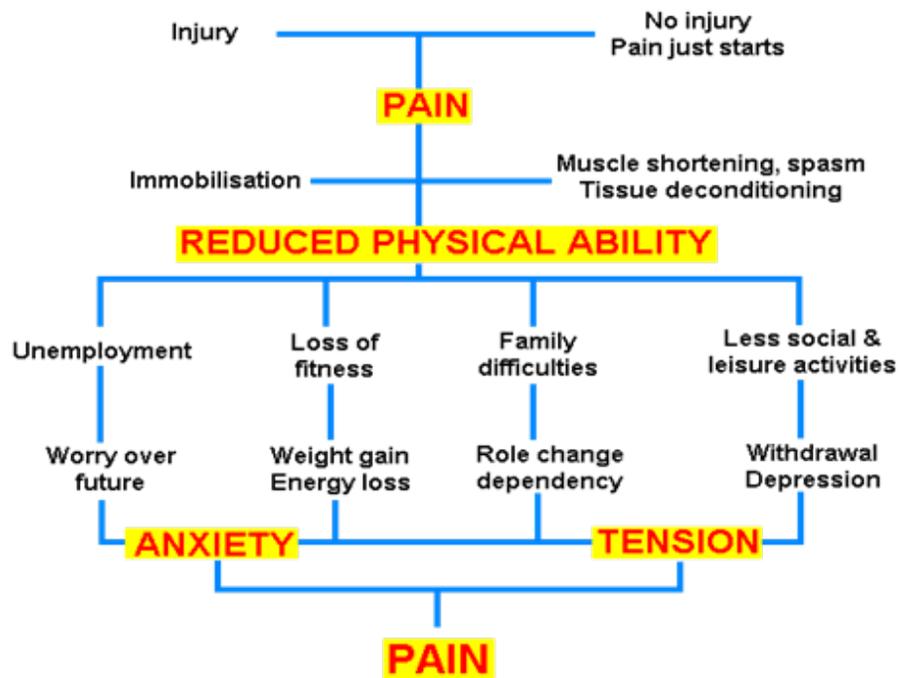
TYPES OF PAIN

- NEUROPATHIC
 - PRODUCED BY ALTERATIONS IN NOCICEPTIVE NERVE PATHWAYS OF THE PERIPHERAL OR CENTRAL NERVOUS SYSTEM
 - VARIED CHARACTERISTICS OF THIS TYPE OF PAIN
 - BURNING, “ELECTRICAL”
 - PERIPHERAL NEURITIS
 - PHANTOM LIMB
 - LOSS OF INFORMATION SO THERE IS AN INCREASE IN BACKGROUND ACTIVITY

TYPES OF PAIN

- SOMATOFORM (IDIOPATHIC)
 - PSYCHOGENIC
 - PART OF THE BRAIN FUNCTION
 - REAL

ADDICTION AND PAIN

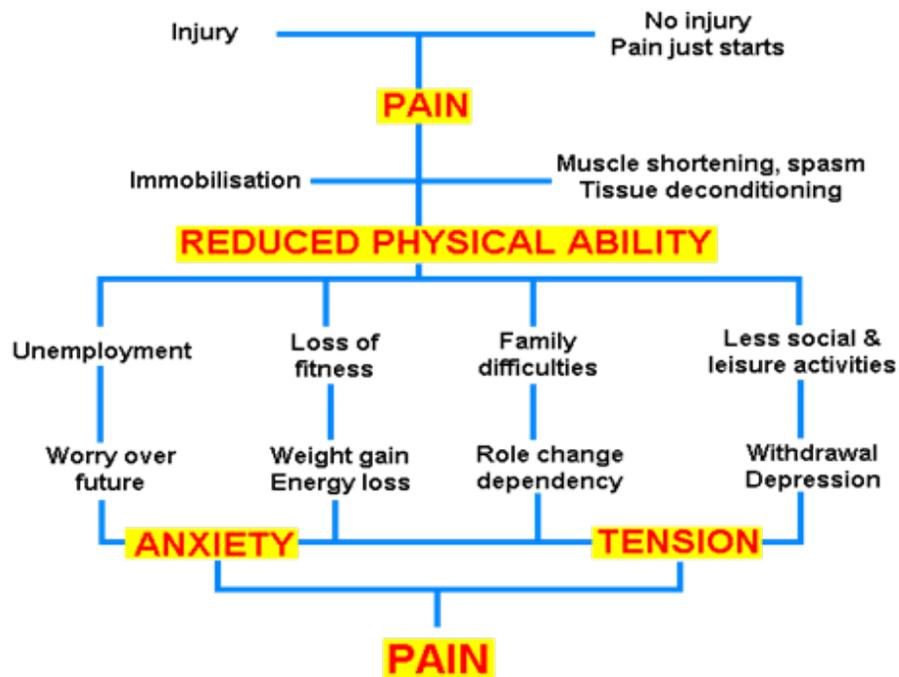


- CLINICAL PROBLEMS OF PERSISTENT PAIN AND ADDICTION ARE EACH COMPLEX ENTITIES WITH BIOLOGICAL, PSYCHOLOGICAL, SPIRITUAL, AND FUNCTIONAL COMPONENTS.

- **PHYSICAL DEPENDENCE DOES NOT EQUAL ADDICTION IN ALL CASES**
 - **PHYSICAL DEPENDENCE IS A NEUROPHARMACOLOGICAL PHENOMENON**
 - **ADDICTION IS BOTH A NEUROPHARMACOLOGIC AND A BEHAVIORAL PHENOMENON**

ASAM 2002

ADDICTION AND PAIN



- THE CHRONIC NON-CANCER PAIN PATIENT CAN EXHIBIT DEPRESSION AND ANXIETY WITH A DECREASE IN ACTIVITY LEVEL.
- THERE IS AN ASSOCIATED INSOMNIA AND FATIGUE .
- THE PAIN PATIENT LOOKS LIKE AN ADDICTION PATIENT

DEFINITIONS

- PSEUDOADDICTION :
 - INACCURATE INTERPRETATION OF CERTAIN BEHAVIORS
 - PAIN IS UNDERTREATED
 - PATIENTS APPEAR TO BE PREOCCUPIED WITH MEDS
 - PREOCCUPATION REFLECTS
 - A NEED FOR PAIN CONTROL
 - THIS IS NOT AN ADDICTIVE DRIVE

SEPARATE ADDICTION FROM PHYSICAL DEPENDENCE

ADDICTION

- LOSS OF CONTROL, CONTINUED USE DESPITE PROBLEMS CAUSED BY USE
- DENIAL, DISHONESTY
- RELAPSE IS COMMON
- A COMPLEX, PROGRESSIVE, MALIGNANT, BIOPSYCHOSOCIAL, POTENTIALLY FATAL DISEASE
- NOT A COMPLICATION OF MEDICAL OR PSYCHIATRIC TREATMENT.
- BEST TREATED BY SPECIFIC ADDICTION TREATMENT

PHYSICAL DEPENDENCE

- A CELLULAR ADAPTATION TO THE CONTINUOUS PRESENCE OF A BIOLOGICALLY ACTIVE COMPOUND
- WITHDRAWAL SYMPTOMS ON ABRUPT DISCONTINUATION
- BENIGN, TEMPORARY PROBLEM
- COMMON TO MANY SUBSTANCES USED IN MEDICINE
- NEUROADAPTIVE
- BEST TREATED BY GRADUAL DOSE REDUCTION

DEFINITIONS

- RELIEF :
 - A NOUN
 - EASE OR MITIGATION OF PAIN
 - SUCCOR
 - REMEDY

HOW EXTENSIVE IS THE PROBLEM ?

PAIN IS THE MOST FREQUENT REASON PATIENTS SEEK HELP FROM HEALTH PROFESSIONALS

- ALCOHOLISM IN U.S. HOSPITALS HAS A 3 -16 % PREVALENCE.
 - A PAIN SERVICE CAN EXPECT 25% OF THEIR PATIENTS TO HAVE A DIAGNOSIS OF ALCOHOLISM.
 - DRUG ABUSE/DEPENDENCE IN THE CHRONIC PAIN POPULATION RUNS 3.2 - 18.9%.

TYPES OF PAIN THAT WE COMMONLY DEAL WITH

- ACUTE PAIN
 - TRAUMA, ILLNESS
- CANCER - RELATED PAIN
- CHRONIC NON-CANCER PAIN
 - WHERE PAIN MAY OR MAY NOT BE DUE TO THE PRIMARY DISEASE, THOUGH IT BECOMES **THE PRIMARY PROBLEM**

FEATURES OF THE CHRONIC PAIN SYNDROME

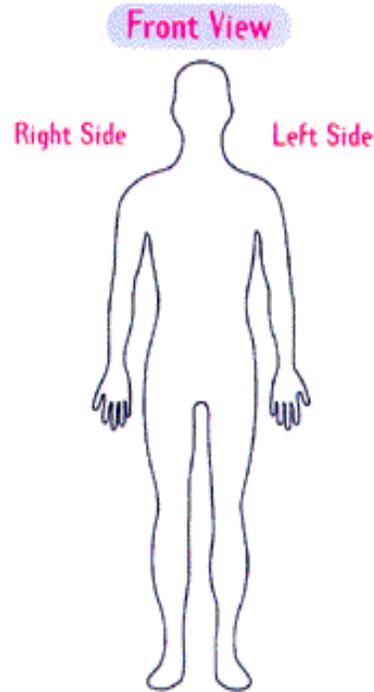
- INTRACTABLE PAIN FOR GREATER THAN OR EQUAL TO **6 MONTHS**
- MARKED **ALTERATION** OF BEHAVIOR
- MARKED **RESTRICTION** OF DAILY ACTIVITIES
- **EXCESSIVE** USE OF MEDICATIONS AND MEDICAL SERVICES
- NO CLEAR RELATIONSHIP TO ORGANIC DISORDER
- MULTIPLE, NON-PRODUCTIVE TESTS, TREATMENTS AND SURGERIES

THE WORK - UP

INITIAL PAIN ASSESSMENT

- HISTORY
 - DETAILED HISTORY INCLUDING ASSESSMENT OF PAIN CHARACTERISTICS AND INTENSITY
 - SEARCH FOR REASONS FOR PERSISTENT PAIN
 - IF HISTORY OF ALCOHOL AND DRUG ABUSE, OBTAIN HISTORY FROM PATIENT AND OTHER SOURCES IF POSSIBLE
 - QUANTIFY AND GRAPH PAIN (SEE NEXT 2 PAGES)
 - ADMINISTER CAGE AND/OR MAST
 - PSYCHOSOCIAL ASSESSMENT
 - LOOK FOR SLEEP AND MOOD DISTURBANCES

PAIN MAP



Quality:

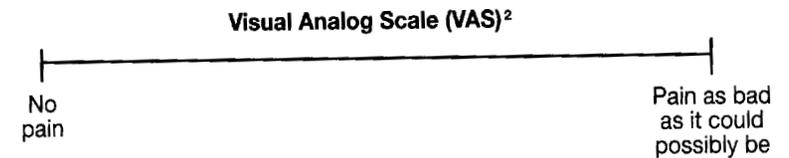
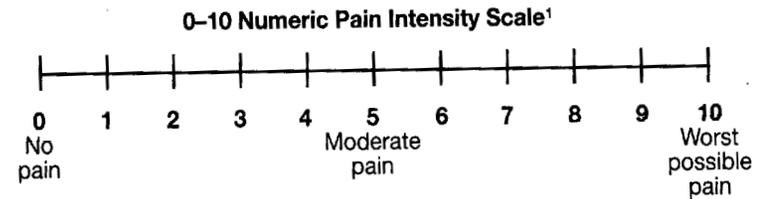
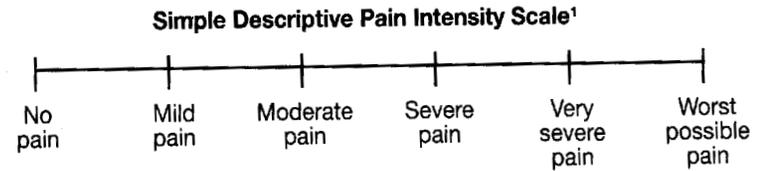
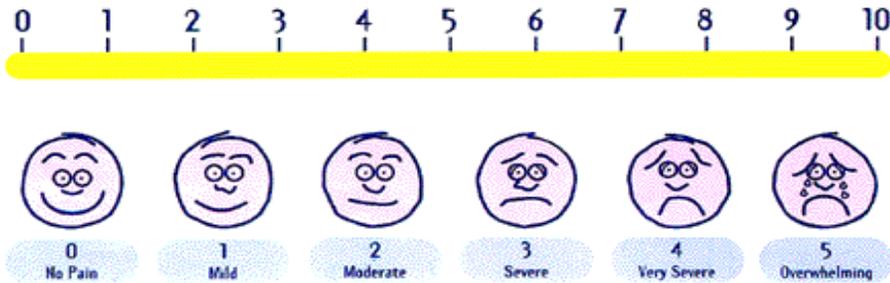
(What words describe the pain, indicate under each site of pain)

- 1 - Dull
- 2 - Aching
- 3 - Throbbing
- 4 - Burning
- 5 - Tingling
- 6 - Numbness
- 7 - Sharp
- 8 - Shooting
- 9 - Stabbing
- 10 - Other (Specify for each site)

- LOCATE AND DESCRIBE PAIN

PAIN INTENSITY SCALES

Figure 4. Pain intensity scales



¹If used as a graphic rating scale, a 10 cm baseline is recommended.

²A 10-cm baseline is recommended for VAS scales.

Source: Acute Pain Management Guideline Panel, 1992.

HISTORY

- LOOK AT PREVIOUS TAPERS OF PAIN MEDICATIONS
 - WAS THE TAPER TOO FAST??
- LOOK AT PAST WORK UP AND TREATMENT
- REALIZE THAT THERE ARE 3 TYPES OF CHEMICALLY DEPENDENT PATIENTS
 - ACTIVE CHEMICAL USERS
 - THOSE IN RECOVERY
 - THOSE WHO DENY USE, BUT HAVE OBJECTIVE FINDINGS OF USE

INITIAL PAIN ASSESSMENT

- PHYSICAL EXAM
 - EMPHASIS ON NEUROLOGIC AND MUSCULOSKELETAL EXAM
- REVIEW AND/OR ORDER APPROPRIATE TESTS
(RADIOLOGIC, EMG)

TREATMENT

- TREATMENT SIMPLY PUT HAS 2 GOALS
 - RELIEVE PAIN
 - IMPROVE FUNCTION

BEFORE STARTING TREATMENT: INFORMED CONSENT

- **EXPLAIN** THAT OPIOIDS MAY BE NEEDED.
- **RESPECT** THE RIGHT OF THE PATIENT TO DECIDE WHETHER OR NOT TO USE THIS CLASS OF MEDS.
- ALWAYS **EXPLAIN** ALTERNATIVE TREATMENTS.
- IF ON METHADONE MAINTENANCE, **EXPLAIN** THAT THE DOSE CAN BE MAINTAINED AND ADDED MEDICATION CAN BE USED.

WORK FROM A WRITTEN TREATMENT PLAN/CONTRACT

- **BE SPECIFIC** ABOUT MEDICATIONS
- **BE SPECIFIC** ABOUT AMOUNTS TO BE DISPENSED - USUALLY SMALL AMOUNTS
- **BE SPECIFIC** ABOUT REFILL POLICY
- **BE SPECIFIC** ABOUT REPLACEMENT OF “LOST” MEDICATIONS
- **BE SPECIFIC** ABOUT FREQUENCY OF OFFICE VISITS
- **BE SPECIFIC** ABOUT OTHER MD’S ORDERING MEDICATIONS
 - ONE MD AND ONLY ONE MD IS PRESCRIBING DOCTOR

WORK FROM A WRITTEN TREATMENT PLAN/CONTRACT

- SET REALISTIC GOALS
- PREVENT WITHDRAWAL
- ACCEPT AND RESPECT REPORT OF PAIN
- URINE DRUG SCREENS WEEKLY OR ON AN APPROPRIATE TIME SCHEDULE

ABCDE FOR PAIN ASSESSMENT AND MANAGEMENT*

ASK ABOUT PAIN REGULARLY, **ASSESS** PAIN SYSTEMICALLY

BELIEVE THE PATIENT AND FAMILY IN THEIR REPORTS OF PAIN AND
WHAT RELIEVES IT

CHOOSE PAIN CONTROL OPTIONS APPROPRIATE FOR THE PATIENT,
FAMILY AND SETTING

DELIVER INTERVENTIONS IN A TIMELY, LOGICAL AND COORDINATED
FASHION

EMPOWER PATIENTS AND THEIR FAMILIES, **ENABLE** THEM TO CONTROL
THEIR COURSE TO THE GREATEST EXTENT POSSIBLE

*AGENCY FOR HEALTH CARE POLICY AND RESEARCH

TREATMENT RULES

DUE TO THE OBSERVED PHENOMENON OF DRUG SUBSTITUTION, MANY ADDICTIONOLOGISTS RECOMMEND AVOIDANCE OF ALL POTENTIALLY INTOXICATING OR PHYSICAL DEPENDENCY PRODUCING MEDICATIONS IF POSSIBLE IN PATIENTS WITH A HISTORY OF ALCOHOLISM AND/OR SUBSTANCE ABUSE.

MOST WOULD AGREE, HOWEVER, THAT **NO MEDICATION IS CONTRAINDICATED WHEN IT IS THE ONLY REASONABLE OPTION FOR THE TREATMENT OF A PERSON'S PAIN.**

TREATMENT RULES

PAIN ASSESSMENT AND TREATMENT SHOULD ALWAYS BE
WELL DOCUMENTED

TREATMENT MODALITIES

- WHO* CLASSIFICATION
 - STEP I
 - NON-OPIOID MEDICATION PLUS ADJUVANT
 - STEP II
 - WEAK OPIOID, +/- NON-OPIOID, +/- ADJUVANT
 - STEP III
 - STRONG OPIOID, +/- NON-OPIOID, +/- ADJUVANT

* WORLD HEALTH ORGANIZATION

STEP I

- NON – OPIOIDS: THE NSAIDS (NON STEROIDAL ANTI – INFLAMMATORY MEDICATIONS)
 - CEILING EFFECT IN TERMS OF ANALGESIC EFFICACY
 - GENERALLY NO MOOD ALTERING EFFECTS
 - GI/KIDNEY TOXICITY CAN BE A PROBLEM
 - CAN BE USED WITH OPIATES IN STEP II, III
 - PRIMARY MECHANISM OF ACTION IS INHIBITION OF PROSTAGLANDIN FORMATION
 - PROSTAGLANDINS CAUSE INFLAMMATION IN THE BODY WHEN RELEASED

STEP I

- NON – OPIOIDS: THE NSAIDS
 - TYPES OF NSAIDS
 - SALICYLATE: TRISYALICYLATE DOES NOT BLOCK PLATELETS, UNLIKE ASPIRIN WHICH CAN INTERFERE WITH THE CLOTTING FUNCTION OF PLATELETS
 - PROPIONIC ACIDS: MOTRIN, NAPROSYN
 - INDOLES: INDOCIN, CLINORIL
 - COX 2 INHIBITORS: CELECOXIB (CELEBREX), VIOXX

STEP I: ADJUVANTS

PHYSICAL INTERVENTIONS

- THERMAL MODALITIES
 - COLD/HEAT PACKS
- PERIPHERAL COUNTERSTIMULATION
 - TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION), VIBRATION, TOPICAL AROMATICS
 - IN TENS, SKIN STIMULATION IS DELIVERED BY AN ELECTRICAL DEVICE (PULSE GENERATOR)
- MANUAL THERAPY
 - MASSAGE, MANIPULATION
- ACTIVE MOVEMENT
 - STRETCHING, CONDITIONING, STRENGTHENING
- ORTHOTICS
 - SPLINTS, BRACES, PILLOWS, SUPPORTS

PSYCHOLOGICAL INTERVENTIONS

- DEEP RELAXATION
- BIOFEEDBACK
- GUIDED IMAGERY
- TREATMENT OF ASSOCIATED MOOD DISORDER
- FAMILY/RELATIONSHIP THERAPY
- COGNITIVE - BEHAVIORAL THERAPY

PSYCHOLOGICAL INTERVENTIONS

- COGNITIVE - BEHAVIORAL THERAPY
 - CATASTROPHIZING
 - IMMEDIATE AND AUTOMATIC INTERPRETATION OF EVENTS AS CATASTROPHIC
 - OVERGENERALIZATION
 - ARRIVE AT A BROAD CONCLUSION BASED ON A SINGLE PIECE OF DATA
 - SELECTIVE NEGATIVE ABSTRACTION
 - ATTEND ONLY TO THE NEGATIVE ASPECTS OF A SITUATION
 - PERSONALIZATION
 - MISINTERPRET BEHAVIOR OF OTHERS AS A NEGATIVE REACTION TO YOU

PROCEDURES

- **TRIGGER POINT INJECTION** TREATS FOCAL, INTRACTABLE MUSCLE SPASM
- **TENDON, BURSAL OR INTRA-ARTICULAR STEROID INJECTIONS** ARE USED FOR THE TREATMENT OF NON INFECTIONOUS INFLAMMATION
- **PERIPHERAL NERVE BLOCK** IS USED TO TREAT PERIPHERAL NEURITIS

PROCEDURES

- SYMPATHETIC BLOCK
 - COMPLEX REGIONAL PAIN SYNDROME, ISCHEMIC PAIN, VASOSPASM
- SPINAL INFUSION
 - POST - OP PAIN CONTROL, CANCER PAIN, INTRACTABLE SEVERE NON-CANCER PAIN
- IMPLANTED PERIPHERAL NERVE STIMULATION
 - FOR THE TREATMENT OF INTRACTABLE PERIPHERAL NERVE PAIN

STEP I

- ADJUVANT MEDICATIONS (NON OPIOID)
 - ANTIDEPRESSANTS
 - ANTICONVULSANTS
 - TOPICALS
 - MISCELLANEOUS

ANTIDEPRESSANTS

- TCA (TRICYCLIC ANTIDEPRESSANTS)
 - PAIN ASSOCIATED WITH DEPRESSION??
 - LOW ABUSE POTENTIAL
 - SOME PROMOTE SLEEP
 - DOXEPIN, NORTRIPTYLINE, AMITRIPTYLINE
 - MAY GET “HANGOVER”
 - EXCELLENT FOR DIABETIC AND POST - HERPETIC NEUROPATHY (NOT AIDS NEUROPATHY)
- SSRI’S (SELECTIVE SEROTONIN REUPTAKE INHIBITORS)
 - UNCLEAR IF USEFUL

ANTICONVULSANTS

- LOW ABUSE POTENTIAL
- NEURONTIN® 100 - 3600 MG/D USED FOR:
 - PAIN*
 - SLEEP*
 - COCAINE CRAVING *
 - SEIZURES

*Off-Label Use

TOPICALS

- CAPSAICIN
 - DERIVATIVE OF OIL OF RED PEPPER
 - USED FOR POST - HERPETIC NEURALGIA AND ARTHRITIS
 - DEPLETES SUBSTANCE P AT NOCICEPTIVE TRANSMITTER SITE
 - 3 - 4 TIMES PER DAY FOR 4 WEEKS BEFORE PAIN RELIEF

MISCELLANEOUS

- ANTISPASM AGENTS
- NMDA ANTAGONISTS
 - KETAMINE
 - DEXTROMETHORPHAN
 - 30 - 240 MG/D MAY CAUSE DECREASE IN NEED FOR OPIATES

STEP II/III OPIATES

OPIATES IN GENERAL

THERE IS A **DEFINITE STIGMA** ASSOCIATED WITH OPIOID MEDICATIONS, ESPECIALLY IN THE ADDICTION UNITS.

HOWEVER, IN LARGE SURVEYS OF NON ADDICTED PATIENTS, 40% OF CANCER PATIENTS AND UP TO 80% OF HIV PATIENTS WERE UNDERTREATED FOR PAIN.

THE STIGMA CROSSES ALL CLASSES OF PATIENTS.

STEP II/III OPIATES

- WORK THROUGH CENTRAL AND PERIPHERAL OPIATE RECEPTORS WHICH INHIBIT TRANSMISSION OF THE PAIN INPUT
- ALTER THE LIMBIC SYSTEM IN THE BRAIN

STEP II/III OPIATES

- OPIATES CAN BE ADMINISTERED BY VARIOUS ROUTES
 - ORAL
 - SUBLINGUAL (UNDER THE TONGUE)
 - INTRAVENOUS
 - SUBCUTANEOUS (BENEATH THE SKIN)
 - RECTAL
 - TRANSDERMAL (PATCH)
 - TRANSMUCOSAL (ACROSS THE MUCOUS MEMBRANE, I.E. MOUTH, NASAL)
 - INTRATHECAL (SPINAL)

STEP II/III OPIATES

- OPIATES CAN BE ADMINISTERED BY VARIOUS ROUTES
 - INTRAMUSCULAR (IM) NOT RECOMMENDED DUE TO
 - PAINFUL ADMINISTRATION
 - UNPREDICTABLE ABSORPTION
 - FORMATION OF TISSUE FIBROSIS (SCAR) AND ABSCESSSES
 - RAPID DECLINE IN ANALGESIC EFFECT

STEP II/III OPIATES

- OPIATES CAN BE ADMINISTERED BY VARIOUS ROUTES
 - MYTH
 - IV IS MORE EFFECTIVE THAN ORAL
 - TRUTH
 - TAKES LONGER TO REACH MAXIMAL EFFECT BUT IS AS EFFECTIVE

OPIOID ANALGESICS

COMPARISON TABLE OF DOSING

ORAL/RECTAL DOSE (MG)	ANALGESIC NAME	PARENTERAL DOSE – IM, IV OR SUBCUTANEOUS (MG)
30	MORPHINE	10
20	OXYCODONE	NOT AVAILABLE
4	LEVORPHANOL	2
8	HYDROMORPHONE	3
NOT AVAILABLE	FENTANYL	0.2
30	HYDROCODONE	NOT AVAILABLE
20	METHADONE	10
200	CODEINE	120
300	MEPERIDINE	100

AVOID ANTAGONISTS WITH ALL OPIATE USE (CAN CAUSE WITHDRAWAL):

- TALWIN (PENTAZOCINE)
- STADOL (BUTORPHANOL)
- BUPRENEX (BUPRENORPHINE)
- NUBAIN (NALBUPHINE)

STEP II/III OPIATES

- ADVERSE EFFECTS
 - CONSTIPATION IS THE MOST COMMON
 - DUE TO BINDING OF THE OPIATE TO THE OPIATE RECEPTOR – μ_2 IN THE GI TRACT. BINDING TO THIS SUBSET OF RECEPTORS CAUSES INHIBITION OF PERISTALSIS AND RESULTANT CONSTIPATION
 - SEDATION
 - NAUSEA

WEAK OPIATES

- CODEINE, OXYCODONE, HYDROCODONE, DEMEROL
 - CEILING (MAXIMUM DOSE) IS DUE TO SIDE-EFFECTS, USUALLY NAUSEA AND VOMITING
 - USUALLY IN COMBINATION WITH ASPIRIN OR TYLENOL

WEAK OPIATES

- DEMEROL
 - ACTIVE METABOLITE IS NORMEPERIDINE
 - NORMEPERIDINE IS A CNS STIMULANT WHICH CAN CAUSE:
 - TREMOR
 - JITTERS
 - SEIZURES

WEAK OPIATES

- TRAMADOL (ULTRAM®)
 - CODEINE/ACETAMINOPHEN COMPOUND (30 MG CODEINE AND 300 MG ACETAMINOPHEN) IS EQUIVALENT IN ANALGESIC EFFECT
 - DO NOT USE DOSES GREATER THAN 400MG PER DAY AS THIS CAN CAUSE SEIZURES ESPECIALLY IF THE PATIENT IS ON:
 - SSRI ANTIDEPRESSANTS
 - TRICYCLIC ANTIDEPRESSANTS
 - OTHER SEIZURE PRODUCING MEDICATIONS

WEAK OPIATES

- TRAMADOL (ULTRAM®)
 - CAN GET WITHDRAWAL IF STOPPED ABRUPTLY AS IN OTHER OPIATES
 - PATIENTS CAN DEVELOP OPIATE DEPENDENCE
 - NOT TO BE CONFUSED WITH TORADOL®
 - KETOROLAC IS GENERIC NAME
 - NON – STEROIDAL ANTI – INFLAMMATORY FOR SHORT TERM RELIEF OF ACUTE PAIN (5 DAYS)
 - ORAL DOSE – 40MG MAX PER DAY
 - IM/IV DOSE – 120 MG MAX PER DAY

STRONG OPIATES

- DILAUDID, MORPHINE, METHADONE, FENTENYL
- WHY GOOD?
 - NO CEILING
 - NO EFFECT ON ORGANS
 - MANY ROUTES OF ADMINISTRATION AVAILABLE

IF YOU WANT TO TRANSITION FROM
ONE OPIATE TO ANOTHER, “**ROLL OVER**”
TECHNIQUE (DECREASE ONE AND
INCREASE THE OTHER).

PCA (PATIENT CONTROLLED ANALGESIA)

- GOOD IN ADDICTION PATIENT
- GOOD FOR POST-OP AND POST-TRAUMA PAIN
- SELF - ADMINISTER (IV, SC)
- AVOIDS PEAKS
 - SEDATION AND INTOXICATION
- AVOIDS VALLEYS
 - PAIN, ANXIETY, CRAVING
- CONTROLLED BY THE PATIENT WITH THE PHYSICIAN CONTROLLING THE SIZE OF THE DOSE

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- SUPPORT THE INDIVIDUAL IN ACHIEVING AND SUSTAINING ADDICTION RECOVERY
 - DO NOT WITHDRAW OPIOIDS FROM SOMEONE IN ACUTE PAIN, BUT CONSIDER ADDICTION INTERVENTION/COUNSELING WHEN PAIN IS CONTROLLED
 - WHEN NECESSARY FOR SAFETY, MAKE OPIOID ANALGESIA CONTINGENT ON ACTIVE INVOLVEMENT IN RECOVERY ACTIVITIES
 - PROVIDE FREQUENT DRUG SCREENS DURING LONG – TERM OPIOID USE TO SUPPORT RECOVERY AND IDENTIFY RELAPSE

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- PROVIDE MEDICATIONS IN MANAGEABLE AMOUNTS TO OUTPATIENTS
 - SMALLER QUANTITIES (BUT ADEQUATE DOSES) AT MORE FREQUENT DISPENSING INTERVALS
 - CONSIDER DAILY DISPENSING BY A TRUSTED INDIVIDUAL, IF NEEDED, TO MAINTAIN SAFETY IN THE PRESENCE OF IMPAIRED CONTROL OVER DRUG USE

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- USE SPECIFIC OPIOIDS IN SCHEDULES THAT TEND TO CAUSE LESS EUPHORIA OR REWARD WHEN THEY ARE EFFECTIVE
 - ORAL PREFERRED OVER PARENTERAL (IV,IM)
 - PCA (SMALL BOLUS) PREFERRED OVER LARGER PARENTERAL DOSES
 - BETTER THAN PRN ADMINISTRATION FOR ACUTE PAIN
 - PRN CAN BE USED THE FIRST DAY OR TWO UNTIL DOSING IS CORRECT
 - THE PATIENT DOES NOT HAVE TO ASK FOR MEDS
 - DECREASES FEELINGS OF “DRUG SEEKING” BEHAVIOR
 - DELAYS ARE AVOIDED

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- USE SPECIFIC OPIOIDS IN SCHEDULES THAT TEND TO CAUSE LESS EUPHORIA OR REWARD WHEN THEY ARE EFFECTIVE
 - SCHEDULED DOSES PREFERRED OVER PRN DOSING (PROMOTES DRUG SEEKING BEHAVIOR)
 - LONG ACTING MEDICATIONS THAT PROVIDE STABLE BLOOD LEVELS WITH SLOWER ONSET PREFERRED OVER QUICK ONSET SHORT ACTING MEDICATIONS

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- NOTE POTENTIAL FOR ADULTERATION AND ABUSE OF EXTENDED – RELEASE MEDICATIONS
 - USE BY IV, INTRANASAL, OR IMMEDIATE – RELEASE ORAL USE (CHEWING)
- CONSIDER A WRITTEN TREATMENT AGREEMENT SIGNED BY BOTH PATIENT AND PROVIDER

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- OBTAIN PERMISSION FOR COMMUNICATION AS APPROPRIATE WITH SIGNIFICANT OTHERS
 - ADDICTION TREATMENT TEAM
 - OTHER MEDICAL CARE PROVIDERS
 - FAMILY AND FRIENDS
 - CAREGIVERS (NONPROFESSIONAL)
- SEE PATIENT FREQUENTLY AND ASSESS ADDICTION RECOVERY AS WELL AS PAIN CONTROL AT ALL VISITS

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- IF RELAPSE OCCURS, INCREASE FACE TO FACE APPOINTMENTS AND TIGHTEN STRUCTURE TO MAINTAIN SAFETY
- IF SAFETY CONCERNS OUTWEIGH PAIN BENEFITS AND OPIOID THERAPY MUST BE DISCONTINUED, ADDRESS PAIN WITH NON – OPIOID APPROACHES AND CONTINUE TO ENCOURAGE RECOVERY

* INFORMATION ON THE PREVIOUS 7 SLIDES TAKEN FROM AMA PAIN MANAGEMENT SERIES.

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- IF MEDICATION CAN NOT BE WITHDRAWN, STABILIZE DOSE EARLY IN TREATMENT
- USE OF LONG TERM OPIATES IS ACCEPTABLE WHEN ALL OTHER TREATMENTS FAIL
- ALWAYS WEIGH PAIN RELIEF AND IMPROVED FUNCTION AND QUALITY OF LIFE VS. PHYSICAL DEPENDENCE

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- MONITOR FOR LOST OR STOLEN PRESCRIPTIONS
- USE ADJUNCTIVE MEDICATIONS AS NECESSARY
- KNOW HOW TO WITHDRAW THE PATIENT FROM THE MEDICATION
- KNOW THE PHARMACOLOGY OF THE MEDICATIONS BEING PRESCRIBED
- DOCUMENT ALL ACTIONS TAKEN

THE ADDICTED PATIENT WITH PAIN – PRINCIPLES AND STRATEGIES FOR OPIOID USE

- IF PAIN PERSISTS BEYOND APPARENT HEALING TIME
 - PATIENT MAY HAVE AN UNDETECTED PHYSICAL PROBLEM
 - PATIENT MAY BE PHYSICALLY DEPENDENT ON ANALGESIC MEDS AND EXPERIENCING WITH-DRAWAL PAIN
 - PATIENT MAY BE USING MEDS TO OBTAIN RELIEF FROM OTHER SYMPTOMS (DEPRESSION, ANXIETY)
 - THE PATIENT MAY BE ADDICTED TO THE PAIN MEDICATIONS AND A CONSULTATION WITH AN ADDICTION SPECIALIST SHOULD BE CONSIDERED

COMPLEMENTARY MEDICINE

- EVENING PRIMROSE OIL
- OMEGA FATTY ACIDS
- FRANKENSENSE HERB
 - DECREASES INFLAMMATION
- BROMALIA (PINEAPPLE ENZYME)
 - HEALS SCARS
- GLUCOSAMINE SULFATE

COMPLEMENTARY MEDICINE

- FEVERFEW
 - PREVENTS MIGRAINES
- GINGER
 - ANTI-INFLAMMATORY
- CONDROTEN SULFATE
 - ARTHRITIS RELIEF?

COMPLEMENTARY MEDICINE

- ACUPUNCTURE
 - NIH APPROVED FOR MYOFASCIAL PAIN, CARPAL TUNNEL, LOW BACK SYNDROME AND ARTHRITIS
 - MAY INCREASE ENDORPHINS

SPECIAL POPULATION CONCERNS

WHAT WE THINK ABOUT ADDICTION VERY MUCH DEPENDS
ON **WHO** IS ADDICTED.

DAVID COURTWRIGHT - “DARK PARADISE”

THE ADDICTED PATIENT WITH PAIN

- THE GOAL IS NOT UNLIKE THAT IN THE NON - ADDICTED PATIENT:
 - **REDUCTION** OF PAIN
 - **IMPROVEMENT** IN ASSOCIATED SYMPTOMS
 - INSOMNIA, DEPRESSION, ANXIETY
 - **RESTORATION** OF FUNCTION
 - **ELIMINATION** OF UNNECESSARY DEPENDENCE OR MEDICATIONS

THE ADDICTED PATIENT WITH PAIN

- INDIVIDUALS WITH ADDICTIVE DISORDERS ARE AT INCREASED RISK OF RECEIVING INADEQUATE PAIN MANAGEMENT
 - PHYSICIAN FACTORS
 - PHYSICIANS DO NOT GET ENOUGH TRAINING IN PAIN MANAGEMENT
 - FEAR OF CONTRIBUTING TO ADDICTION THROUGH THE USE OF OPIATES
 - PHYSICIANS DO NOT GET ENOUGH TRAINING IN RECOGNIZING ADDICTION SIGNS AND SYMPTOMS
 - PHYSICAL DEPENDENCE, TOLERANCE
 - FEAR OF REGULATORY SANCTIONS
 - SOCIETAL PREJUDICES AGAINST PERSONS WITH ADDICTIONS

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ALCOHOL AND OPIATE USERS
- SICKLE CELL DISEASE
- HIV/AIDS PATIENTS
- PHYSICAL/SEXUAL ABUSE
- RACIAL/ETHNIC GROUPS
- ELDERLY PATIENTS
- METHADONE MAINTAINED PATIENT
- BUPRENORPHINE MAINTAINED PATIENT
- REVIA MAINTAINED PATIENT
- DENTAL PROCEDURES
- OBSTETRICAL PROCEDURES
- CANCER PATIENT

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ALCOHOL DEPENDENT PATIENTS
 - PAIN IN THIS GROUP CAN BE CAUSED BY VARIOUS FACTORS
 - TRAUMA AS A RESULT OF FALLS DUE TO INTOXICATION OR SEIZURES
 - 49% OF RECENT SPINAL CORD INJURIES TESTED POSITIVE FOR ALCOHOLISM.
 - OF 313 PATIENTS PRESENTING TO THE ER FOR FALLS, 53% HAD A POSITIVE BAC OF GREATER THAN .2MG%.
 - INFECTIONS DUE TO IMPAIRMENT OF THE IMMUNE SYSTEM
 - POLYNEUROPATHY
 - PARESTHESIAS (BURNING, TINGLING PAIN)
 - MUSCLE WEAKNESS

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ALCOHOL AND OPIATE USERS
 - “PREVALENCE AND CHARACTERISTICS OF CHRONIC PAIN AMONG CHEMICALLY DEPENDENT PATIENTS” ROSENBLUM, JOSEPH, FONG, KIPNIS, CLELAND AND PORTENOY JAMA; MAY 14, 2003 VOL 289:2370-2378
 - 390 PATIENTS AT 2 MMTP’S
 - 531 PATIENTS FROM 13 NYS ATC’S

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ALCOHOL AND OPIATE USERS
 - PREVALENCE OF CHRONIC PAIN (> 6 MONTHS DURATION)
 - 37% OF METHADONE PATIENTS C/O CHRONIC PAIN WITH 80% HAVING PAIN IN THE LAST WEEK.
 - 24% OF INPATIENTS C/O CHRONIC PAIN WITH 78% HAVING PAIN IN THE LAST WEEK
 - INPATIENTS USED MORE ILLICIT DRUGS (51% V 34%) AND MMTP PATIENTS USED MORE PRESCRIPTION MEDICATIONS (67% V 52%)

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ALCOHOL AND OPIATE USERS
 - USE OF OTC MEDICATIONS DID NOT VARY BETWEEN THE 2 GROUPS (75% MMTP, 72% INPT)
 - MOTRIN WAS USED MOST FREQUENTLY, FOLLOWED BY ACETAMINOPHEN
 - 65% OF MMTP PATIENTS AND 48% OF INPATIENTS REPORTED THAT PAIN INTERFERED IN THEIR PHYSICAL AND PSYCHOSOCIAL FUNCTIONING

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- THE ENDOGENOUS OPIOID SYSTEM (ENDORPHINS) IS RELATED TO BOTH PAIN AND OPIOID DEPENDENCY.
- CENTRAL ALPHA RECEPTORS PLAY A ROLE IN PAIN AND ADDICTION
 - CLONIDINE (A MEDICATION WHICH WORKS AT THE ALPHA RECEPTOR) IS EFFECTIVE FOR SPINAL ANESTHESIA
 - CLONIDINE IS EFFECTIVE FOR OPIOID WITHDRAWAL SYMPTOM INHIBITION

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- INDIVIDUALS WITH CHRONIC PAIN OF NONMALIGNANT ORIGIN HAVE HAD THEIR PAIN IMPROVED FOLLOWING DETOXIFICATION FROM OPIOIDS.
 - THE EXPLANATION IS THAT THERE MAY BE A SUBTLE WITHDRAWAL SYNDROME OCCURRING IN THE PRESENCE OF OPIATES RESPONSIBLE FOR MAINTAINING THE PAIN AND IF THE PATIENT CAN GET OFF OF OPIATES, THE PAIN ACTUALLY IMPROVES

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- DEPRESSION IS SEEN WITH ALCOHOL AND COCAINE USE.
- DEPRESSION IS SEEN IN CHRONIC PAIN.
 - IS THERE A LINK???

* ALWAYS LOOK FOR DEPRESSION IN YOUR ASSESSMENT

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- SICKLE CELL DISEASE
 - PAINFUL CRISIS
 - DUE TO LACK OF OXYGEN RESULTING IN TISSUE INJURY (CAUSED BY OBSTRUCTION OF BLOOD FLOW BY SICKLED RED BLOOD CELLS)
 - BONE AND ABDOMINAL PAIN ARE FREQUENTLY SEEN
 - NO LABORATORY OR CLINICAL TEST TO CONFIRM A CRISIS

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- HIV/AIDS PATIENTS
 - 25% PREVELENCE OF PAIN IN THIS GROUP WITH SIGNIFICANT NEUROPATHIC PAIN
 - PAIN IS RELATED TO:
 - HIV INFECTION AND COMPLICATIONS
 - NEUROPATHY, KARPOSI'S SARCOMA, ARTHRITIS, INFECTIONS (HERPES, CMV)
 - MEDICAL TREATMENT AND SIDE - EFFECTS

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- PHYSICAL/SEXUAL ABUSE
 - ENGEL THEORY
 - DOES PHYSICAL OR SEXUAL ABUSE IN CHILDHOOD LEAD TO THE DEVELOPMENT OF A “PAIN-PRONE” PATIENT.
 - 30 - 50% OF CHRONIC PAIN PATIENTS HAVE A HISTORY OF SEXUAL AND/OR PHYSICAL ABUSE.

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- RACIAL/ETHNIC GROUPS
 - NUMEROUS STUDIES SHOW RACIAL AND EHTNIC DISPARITIES IN PAIN MANAGEMENT
 - PAIN PERCEPTION IS CULTURAL; RACIAL/ETHNIC DESCRIPTION OF PAIN IS DIFFERENT
 - HEALTHCARE PROVIDERS CONCERN ABOUT POTENTIAL DRUG ABUSE IN MINORITY PATIENTS
 - FEWER RESOURCES TO PAY FOR ANALGESIA
 - DIFFICULTY IN ACCESSING CARE AND FILLING PRESCRIPTIONS
 - 25% OF PHARMACIES IN MINORITY NEIGHBORHOODS HAD ADEQUATE SUPPLIES OF OPIOID MEDICATIONS TO TREAT SEVERE PAIN, COMPARED TO 72% OF PHARMACIES IN PREDOMINANTLY WHITE NEIGHBORHOODS*
 - LANGUAGE AND CULTURAL BARRIERS

*MORRISON ET AL, “WE DON’T CARRY THAT” – FAILURE OF PHARMACIES IN PREDOMINANTLY WHITE NEIGHBORHOODS TO STOCK OPIOID ANALGESICS NEJM 2000;342:1023-1026

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ELDERLY
 - 25% TO 50% OF COMMUNITY DWELLING SENIORS ARE ESTIMATED TO HAVE PAIN THAT INTERFERES WITH NORMAL FUNCTION*
 - 59% TO 80% OF NURSING HOME RESIDENTS HAVE PAIN THAT INTERFERES WITH NORMAL FUNCTION**
 - THE MOST COMMON CAUSE OF CHRONIC PAIN IN THE ELDERLY IS MUSCULOSKELETAL PAIN

*HELME ET AL, 8TH WORLD CONGRESS ON PAIN 1997

**FERRELL ANNALS OF INTERNAL MEDICINE 1995

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ELDERLY
 - BURNING, DISCOMFORT, ACHING AND OTHER TERMS MAY BE SUBSTITUTED FOR “PAIN”
 - COGNITIVE AND LANGUAGE IMPAIRMENTS ARE COMMON
 - DETAILED EVALUATION OF ACTIVITIES OF DAILY LIVING (ADL’S) ARE NEEDED
 - USE AGE SPECIFIC SCALES TO EVALUATE PAIN’S EFFECT ON MOOD AND PSYCHOLOGICAL FUNCTION (GERIATRIC DEPRESSION SCALE FOR EXAMPLE)
 - EVALUATE ALL CHRONIC MEDICAL PROBLEMS AND MEDICATIONS

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- ELDERLY
 - AMERICAN GERIATRICS SOCIETY RECOMMENDATIONS FOR CHOOSING MEDICATIONS
 - USE THE LEAST INVASIVE ROUTE TO GIVE MEDICATION
 - START LOW AND GO SLOW
 - NONSTEROIDAL ANTI – INFLAMMATORY MEDICATIONS SHOULD BE USED WITH CAUTION DUE TO SIDE EFFECTS
 - OPIOID ANALGESICS ARE EFFECTIVE FOR RELIEVING MODERATE TO SEVERE PAIN
 - PHARMACOLOGIC THERAPY IS MOST EFFECTIVE WHEN COMBINED WITH NONPHARMACOLOGIC THERAPY

* ALWAYS DETERMINE NEED FOR SUPERVISION TO MONITOR TAKING THE MEDICATION AND REPORTING PROBLEMS

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- IN THE METHADONE MAINTAINED PATIENT
 - CONTINUE BASELINE DOSE AND PROVIDE ADDITIONAL TREATMENT FOR PAIN

Or

- TAKE ONCE DAILY DOSE AND SPLIT INTO 3 OR 4 DOSES
 - TITRATE DOSE TO RELIEVE PAIN
 - CONSIDER 5 – 10 MG DOSE FOR BREAKTHROUGH PAIN
 - ADVANTAGES
 - URINE DRUG SCREEN REMAINS INTERPRETABLE BECAUSE NOT ON DIFFERENT MEDICATIONS
 - COST EFFECTIVE AND EASILY TOLERATED
 - EASIER TO RETURN TO ONCE DAILY DOSING IN THE FUTURE
 - DISADVANTAGES
 - MUST GIVE TAKE HOME DOSES

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- IN THE METHADONE MAINTAINED PATIENT, DO NOT MAKE THESE COMMON ERRORS
 - METHADONE DOSE LOWERED IN HOSPITAL AND PATIENT THEN EXPERIENCES WITHDRAWAL
 - PAIN MEDICATION WAS DENIED BECAUSE PATIENT WAS ON METHADONE MAINTENANCE AND THIS WAS THOUGHT TO PROVIDE ADEQUATE ANALGESIA
 - WHEN ANALGESICS WERE PRESCRIBED, DOSES WERE INADEQUATE DUE TO FEAR OF CAUSING RESPIRATORY DEPRESSION

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

(Continued)

- IN THE METHADONE MAINTAINED PATIENT, DO NOT MAKE THESE COMMON ERRORS
 - PATIENT IS TOLD TO WITHDRAW FROM METHADONE PRIOR TO SURGERY (THOUGHT WAS THAT IT WOULD INTERFERE WITH THE PROCEDURE)
 - INCREASING METHADONE TOO HIGH IN THE HOSPITAL
 - OPIOID ANTAGONISTS WERE ADMINISTERED AND INDUCED SEVERE WITHDRAWAL
 - PATIENTS CONCEAL THEIR METHADONE HISTORY DUE TO PERSUMPTION OF STIGMA

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

(Continued)

- IN THE METHADONE MAINTAINED PATIENT, DO NOT MAKE THESE COMMON ERRORS
 - METHADONE CAN BE GIVEN OUT IN A PRIVATE PHYSICIANS OFFICE ONLY FOR THE TREATMENT OF PAIN, NOT ADDICTION. IF USED FOR OPIATE DEPENDENCE TREATMENT CAN ONLY BE GIVEN BY A LICENSED METHADONE PROGRAM OR A MEDICAL MAINTENANCE PHYSICIAN

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- IN THE BUPRENORPHINE MAINTAINED PATIENT
 - CONSIDER SPLIT DOSING (TID OR QID)
 - ADVANTAGE
 - URINE DRUG SCREEN REMAINS INTERPRETABLE
 - ABLE TO REMAIN ON BUPRENORPHINE REGIMEN
 - DISADVANTAGES
 - HIGH RECEPTOR AFFINITY OF BUPRENORPHINE MAKES OTHER OPIOID AGENTS LESS EFFECTIVE
 - CEILING EFFECT OF BUPRENORPHINE MAY LIMIT ITS USE TO MILD/MODERATE PAIN
 - CAUTION WITH BENZODIAZINE USE AND DIVERSION RISK

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- IN THE BUPRENORPHINE MAINTAINED PATIENT
 - IF SEVERE PAIN, HIGH RECEPTOR AFFINITY WILL INTERFERE WITH EFFECTIVENESS OF OTHER OPIOID ANALGESICS
 - CONSIDER SWITCHING TO ALERNATE (PURE MU) OPIOID MEDICATION IF TIME ALLOWS
 - FENTANYL MAY BE A BETTER CHOICE FOR ACUTE PAIN MANAGEMENT WITH BUPRENORPHINE ON BOARD
 - BUPRENORPHINE IS NOT EASILY REVERSED WITH ANTAGONIST AGENTS (NARCAN)

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- PAIN MANAGEMENT FOR PATIENTS ON REVIA® (NALTREXONE) – REMEMBERING THE REVIA® EFFECT ONLY LASTS 72 HOURS
 - IF ELECTIVE SURGERY
 - DISCONTINUE REVIA® 72 HOURS BEFORE THE PROCEDURE, DUE TO THE FACT THAT IT CAN BLOCK THE EFFECT OF OPIOID PAIN MEDICATION
 - TREAT PAIN AS USUAL
 - IF OPIOIDS ARE USED FOR PAIN RELIEF, A NARCAN CHALLENGE(SEE THE PDR) OR A NEGATIVE URINE DRUG SCREEN FOR OPIOIDS SHOULD BE PREFORMED PRIOR TO RESTARTING REVIA®
 - IF UNANTICIPATED ACUTE PAIN (TRAUMA, ACCIDENT)
 - FOR MODERATE PAIN
 - USE NON-STEROIDAL ANTIINFLAMMATORY MEDICATIONS
 - IF SEVERE PAIN
 - DISCONTINUE REVIA®
 - TREAT WITH REPEATED SMALL DOSES OF INTRAVENOUS SHORT ACTING OPIOIDS AND GRADUALLY TITRATE DOSE OF NARCOTIC UNTIL PAIN RELIEF
 - MONITOR FOR SIGNS OF RESPIRATORY DEPRESSION

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- DENTAL ANALGESIA IN OPIATE DEPENDENT PATIENTS
 - SPEAK TO DENTIST PRIOR TO PROCEDURE
 - MAINTAIN STATUS QUO WITH DAILY OPIOIDS
 - POST PROCEDURE ANALGESIA AS FOR ANY OTHER PATIENT BUT AVOID PAST DRUGS OF CHOICE
 - NSAID'S ARE USUALLY THE BEST AGENTS FOR DENTAL PAIN
 - POSITIVE URINE DRUG SCREENS ARE COMMON AFTER DENTAL PROCEDURES – ASSESS BEHAVIOR AND NOT JUST THE SCREEN

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- OBSTETRICAL PROCEDURES IN OPIATE DEPENDENT PATIENTS
 - SPEAK WITH ATTENDING OB/GYN IN ADVANCE
 - MAINTAIN STATUS QUO WITH DAILY OPIOIDS
 - AT TIME OF DELIVERY, REGIONAL ANALGESIC TECHNIQUES ARE PREFERRED
 - IN CASE OF METHADONE MAINTAINED PATIENT, TOTAL DAILY DOSING REQUIREMENT WILL DROP IN FIRST 1 – 2 WEEKS AFTER DELIVERY
 - BREAST FEEDING IS NOT CONTRAINDICATED

SPECIAL POPULATIONS WITHIN THE SUBSTANCE USING GROUP

- CANCER PATIENTS
 - IF THE PATIENT HAS CANCER RELATED PAIN
 - TREATMENT IS SIMILAR TO OTHERS

THE PATIENT'S COMFORT IS THE PRIMARY GOAL.

THE ADDICTED PATIENT WITH PAIN

- AVOID PITFALLS OF TREATMENT
 - PSYCHOACTIVE DRUGS WITHOUT ANALGESIC EFFECT
 - PLACEBOS
 - PAIN RELIEF AS A BARGAINING CHIP
 - USE OF NALOXONE (AN OPIOID ANTAGONIST WHICH WILL INDUCE WITHDRAWAL IN AN OPIOID DEPENDENT PERSON) PUNITIVELY

THE ADDICTED PATIENT WITH PAIN

- AVOID PITFALLS OF TREATMENT
 - INDIVIDUALS WITH DISABLING, CHRONIC PAIN OF NON-MALIGNANT ORIGIN, WHO HAVE NOT HAD A TRIAL FREE OF OPIOIDS, BENZODIAZEPINES OR OTHER DEPENDENCY PRODUCING MEDICATIONS, SHOULD HAVE A TRIAL FOR AT LEAST 6 WEEKS DURATION.
 - MUST PROVIDE THE PATIENT WITH OTHER TOOLS TO DEAL WITH THE PAIN

THE ADDICTED PATIENT WITH PAIN

- IN ALL PATIENTS
 - ASSESS AND DOCUMENT OUTCOME OF THERAPY
 - 4 A'S TO MONITOR
 - **ANALGESIA** (PAIN RELIEF, IMPAIRED SLEEP AND MOOD)
 - **ADVERSE** EVENTS (CONSTIPATION, SEDATION, NAUSEA, ETC.)
 - **ACTIVITIES** OF DAILY LIVING
 - **ABERRANT** DRUG TAKING BEHAVIOR (EARLY REFILL REQUEST, LOST – STOLEN PRESCRIPTION, MISSED APPOINTMENTS)

THE ADDICTED PATIENT WITH PAIN

- REFERENCES
 - IF NOT STATED ELSEWHERE
 - “PAIN AND ADDICTION – COMMON THREADS” ASAM 2002
 - “PAIN MANAGEMENT” PART 1, 2, 3, 4 AMA CME PROGRAM FOR PRIMARY CARE PHYSICIANS