



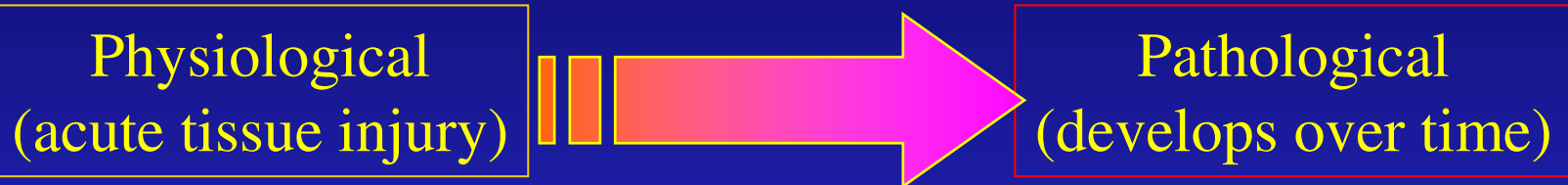
Chronic Pain & Substance Misuse

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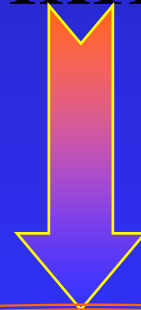
University of Edinburgh

Pain – acute or chronic?



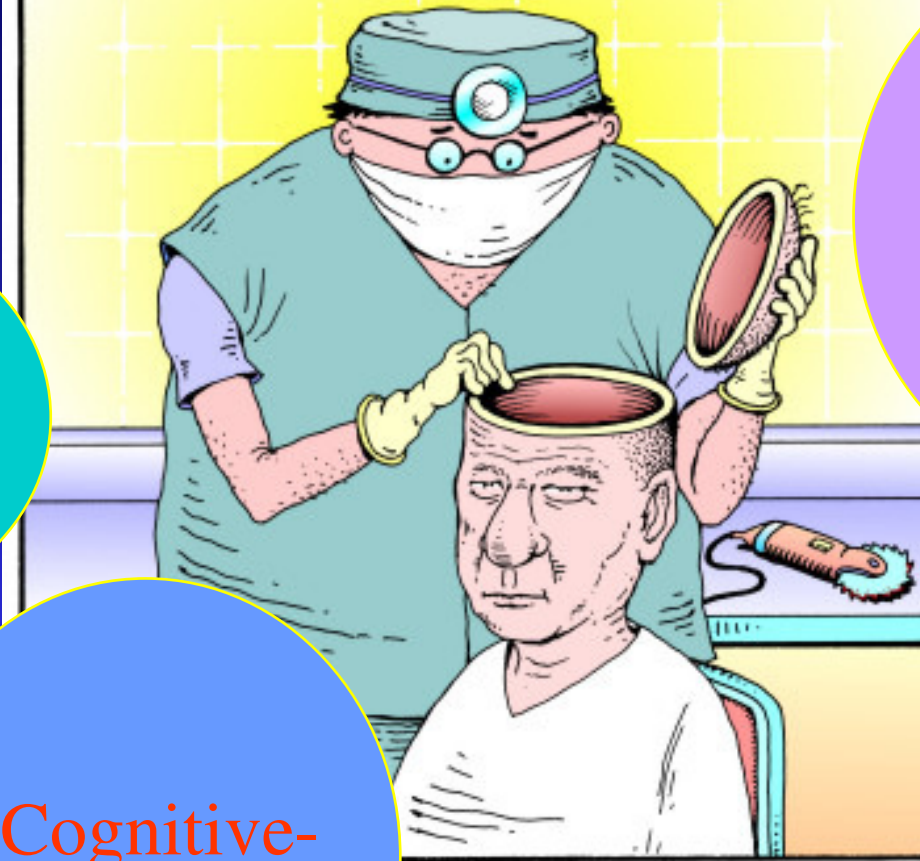
Nerve damage

+/- tissue inflammation



Peripheral & Central Nervous System
response

A NO-BRAINER



Sensory -
discriminative

Affective-
motivational

Cognitive-
behavioral

...Or “no brain, no pain??”

Pain & Opioid Dependency

- Physical Dependence
- Tolerance (side effects/analgesia)

NOT Addiction

- Opioid induce hyperalgesia

■ **Pseudoaddiction:** Aberrant drug-related behaviour in patients reacting to undertreatment of pain

Pain & Chemical Dependency

Task Force of APS, AAPM, and ASAM: New definition of addiction

- 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*
 - *craving*

Savage et al, JPSM, 2003

Addiction

Saliency	Drug & related stimuli increasingly important
Conflict	Intra-psychic; loss of control over use of substance
Tolerance	As above
Withdrawal	As above
Relapse	Rapid reinstatement of dependent use after abstinence
Mood modification	Substance may induce a pleasant +ve effect or remove -ve mood state

Background to drug use

- “Absolute sobriety is not a natural or primary human state”
- Mortality 14 x higher than for age matched individuals but good outcomes for many if kept alive: Harm Reduction Philosophy
- Often a chronic relapsing condition – similar to many others treated in primary care (chronic pain, depression, diabetes, arthritis)

Chronic Pain and Dependency the forgotten co-morbidity?

Chronic non-malignant
pain

Common: ~1 in 7

(~5 million in UK)

???

A. M. Elliott et al. The
epidemiology of chronic pain in
the community. *Lancet*
354:1248-1252, 1999.

Substance misuse:
> 500 000 Europeans
receive substitution
treatment

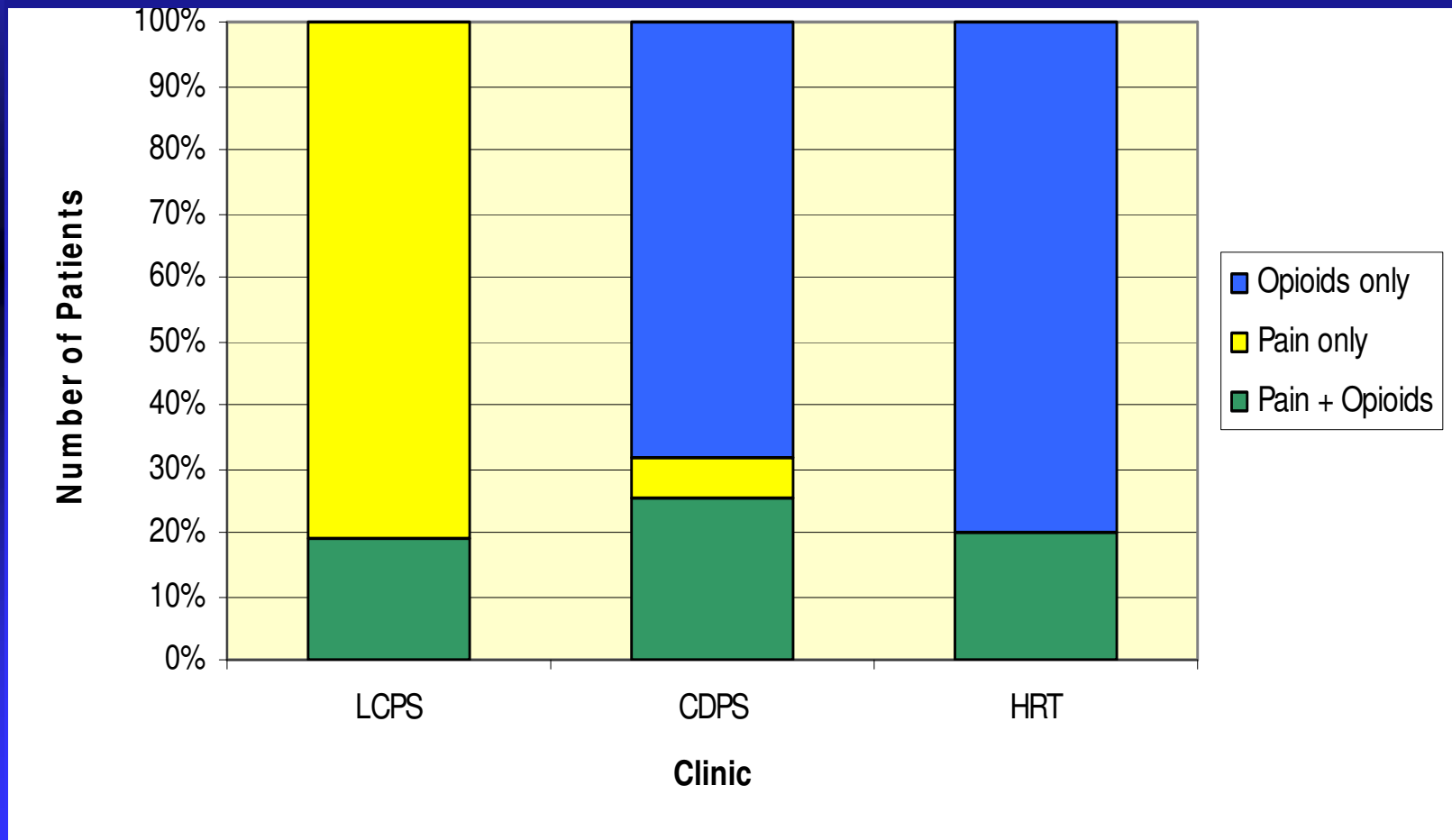
The National Drug Treatment Monitoring
System (2004/5)~160,450 people in drug
treatment services (England)

???

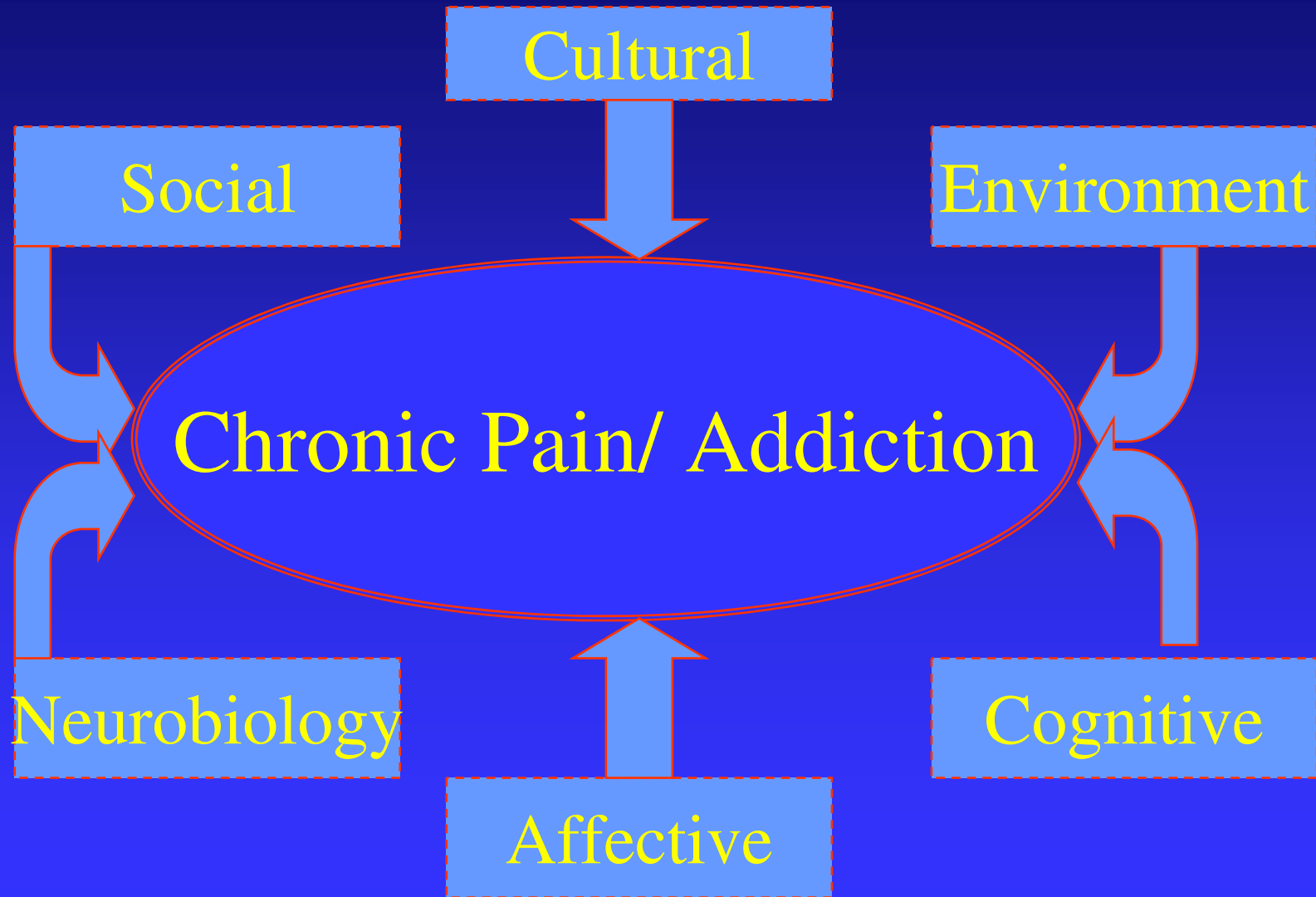
Chronic Pain and Dependency the forgotten co-morbidity?

- USA: 37% (severe) – 61% MMTP patients reported chronic pain Rosenblum: JAMA, 289, 2370-2378, 2003; Peles E et al, Pain 113:340-6, 2005; Jamison RN et al. J of Pain & Symptom Management. 19:53-62, 2000
- UK: 18% patients in Pain Service on opioids (mixed cancer/ non-cancer) (n=717) Evans PJ, Anaesthesia 36:597-602, 1981

Prevalence of opioid use & chronic pain



Assessment



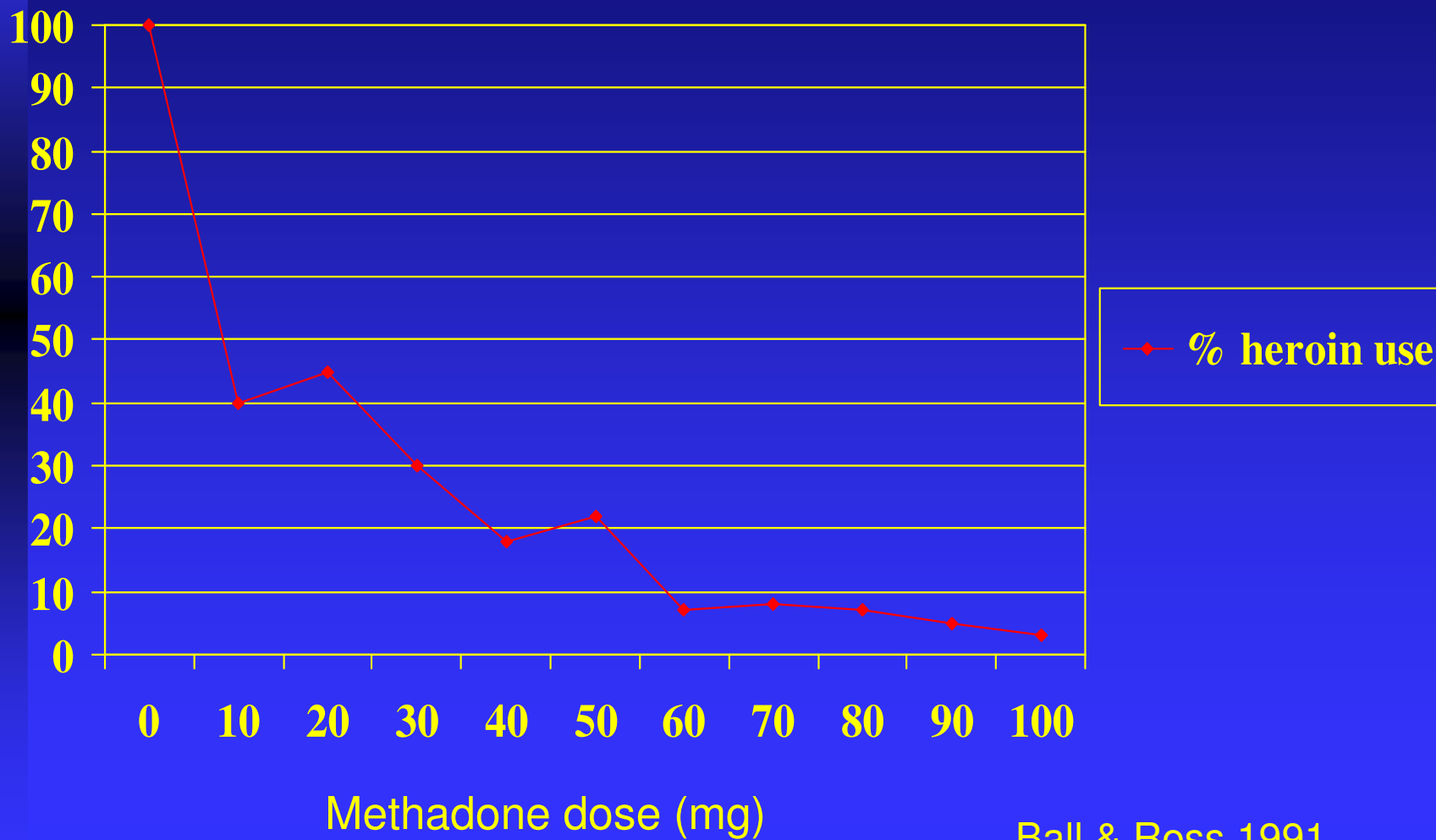
Methadone Maintenance Treatment Programmes

“The most effective programmes are those that provide higher doses of methadone as part of a comprehensive treatment programme with maintenance rather than abstinence as the treatment goal”

Methadone Maintenance: the Guidelines

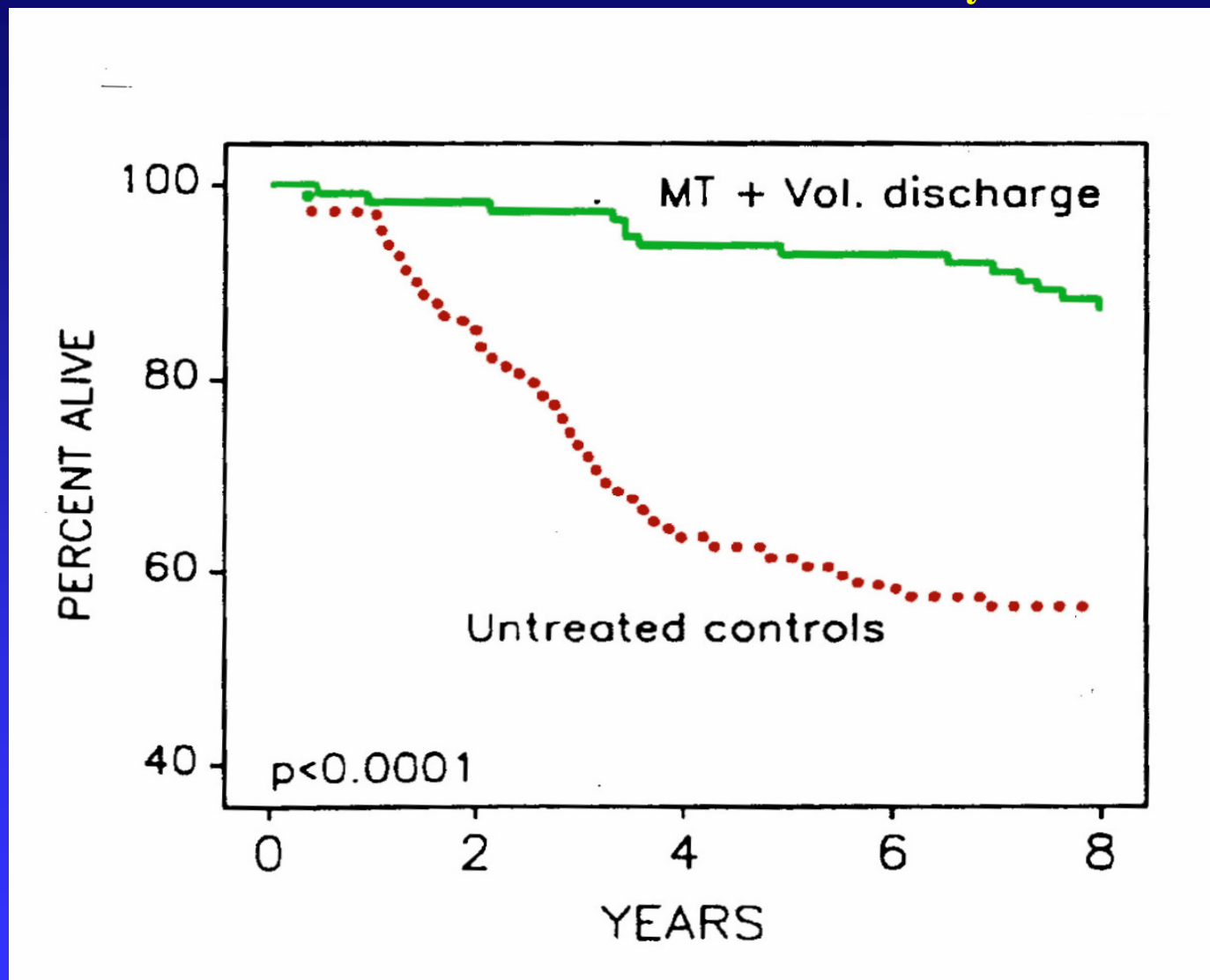
- Prescribe for DAILY SUPERVISED CONSUMPTION initially
- Incremental dose increase \Rightarrow patient is comfortable (no withdrawal nor intoxicated)
- Aim to reach maintenance dose as soon as safely possible to prevent further illicit drug use (don't \uparrow daily dose by $> 20\text{-}30\text{mg/wk}$)
- **Supervised consumption** recommended for ≥ 3 months - Return to supervision if relapse
- Do **not** start patients on tablets or injectables

The importance of dose: Methadone dose & heroin use



Ball & Ross 1991

Graph showing deaths, comparing untreated patients with those in Methadone maintenance treatment in Swedish study



(Gronbladh et al)

Factors influencing outcome

+ve



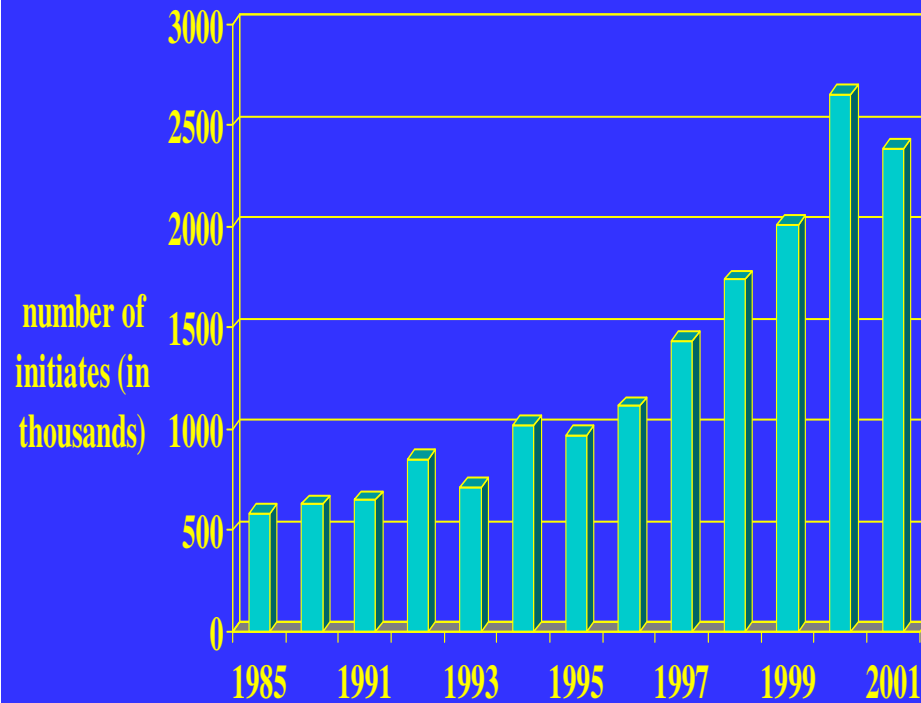
Reduce barriers to entry
Optimal daily dose
Good medical/ psychosocial services
Social rehab
Treatment duration sufficient
Detox only if willing

-ve

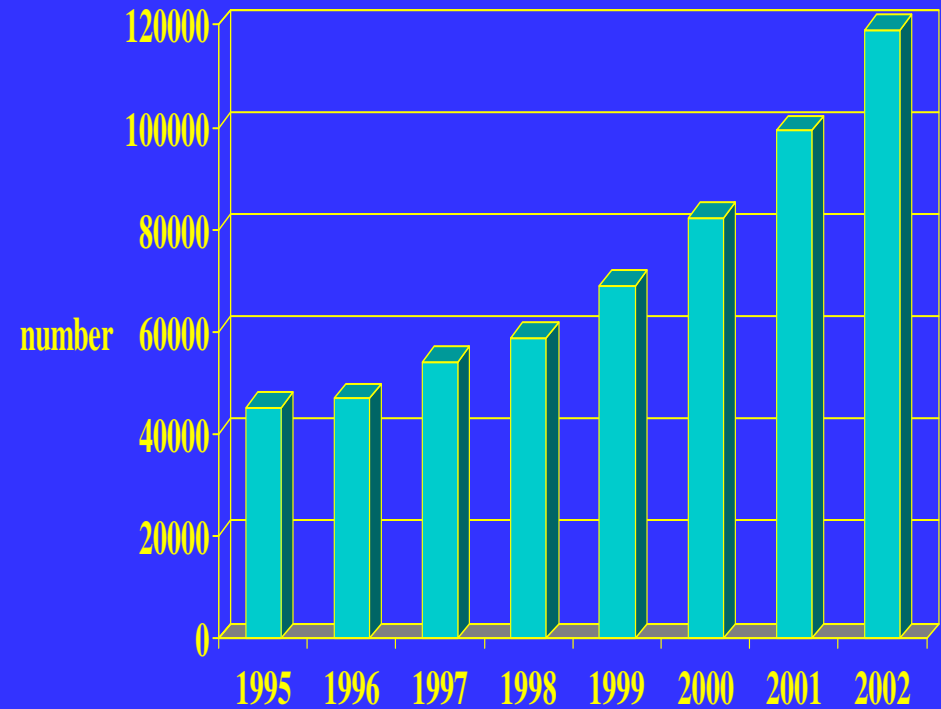


Difficult access to treatment
Daily dose restricted
Untrained staff/ -ve attitude
Controlling/ punitive
Treatment duration limited
Pain ; anxiety; depression

Increasing Prescription Drug Abuse



National Household Survey
On Drug Use and Health



Drug Abuse Warning
Network

Portenoy, Beth Israel, New York

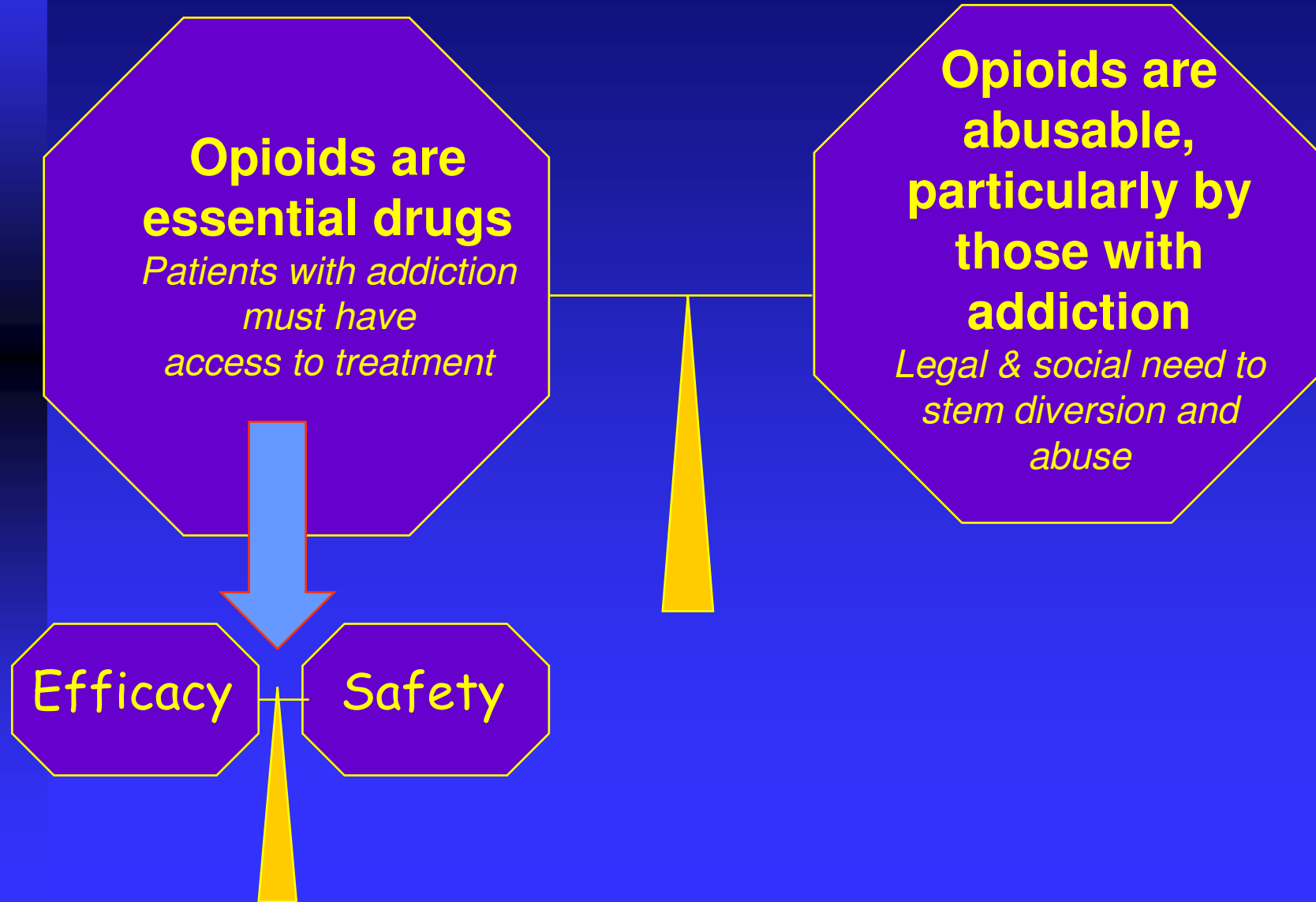


What influences opioid prescribing (GPs)?

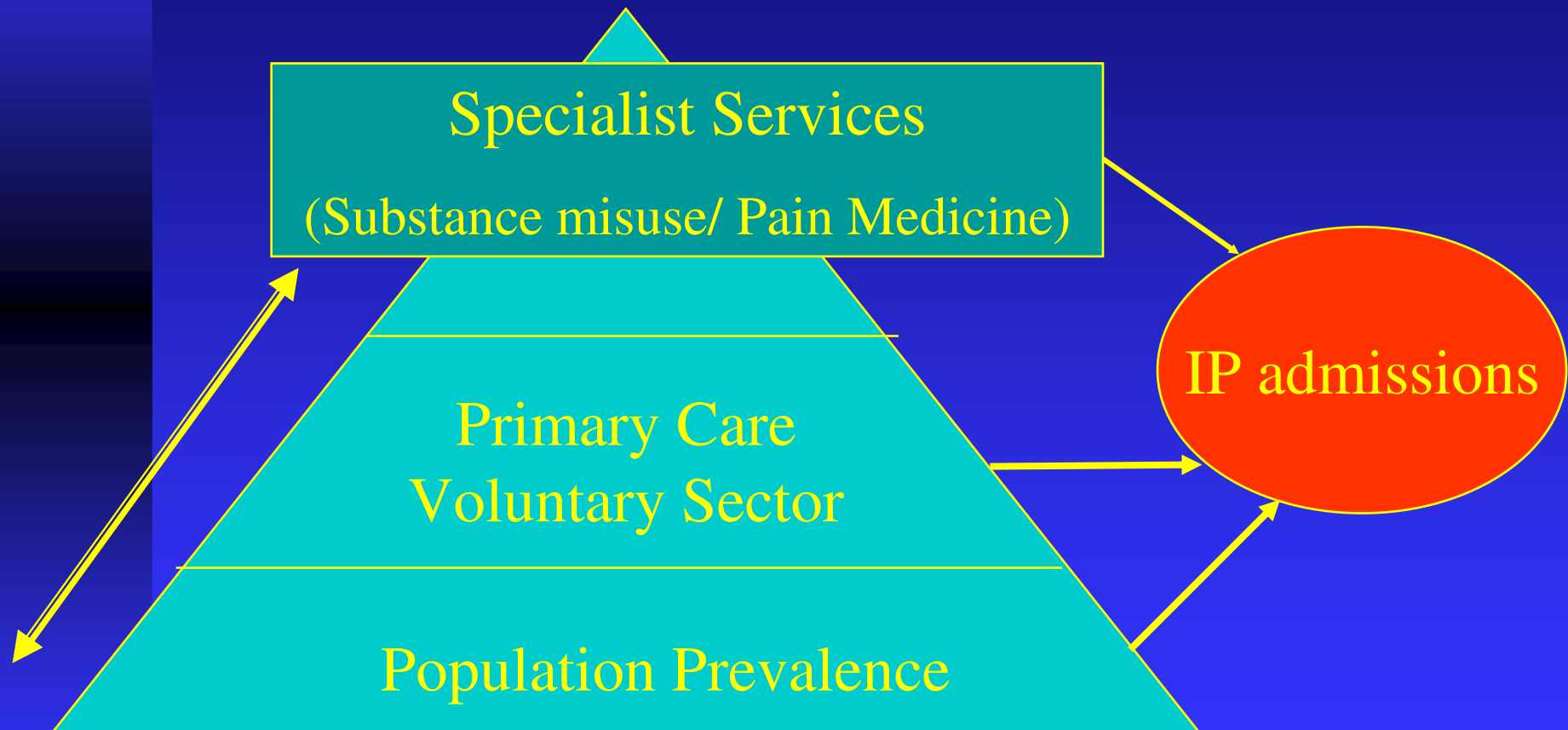
- Concern about lack of pain training
- Few had prescribing guidelines
- Neither training nor guidelines influenced prescribing

- Personal beliefs about appropriateness of opioids main factor

Opioids for Chronic Pain



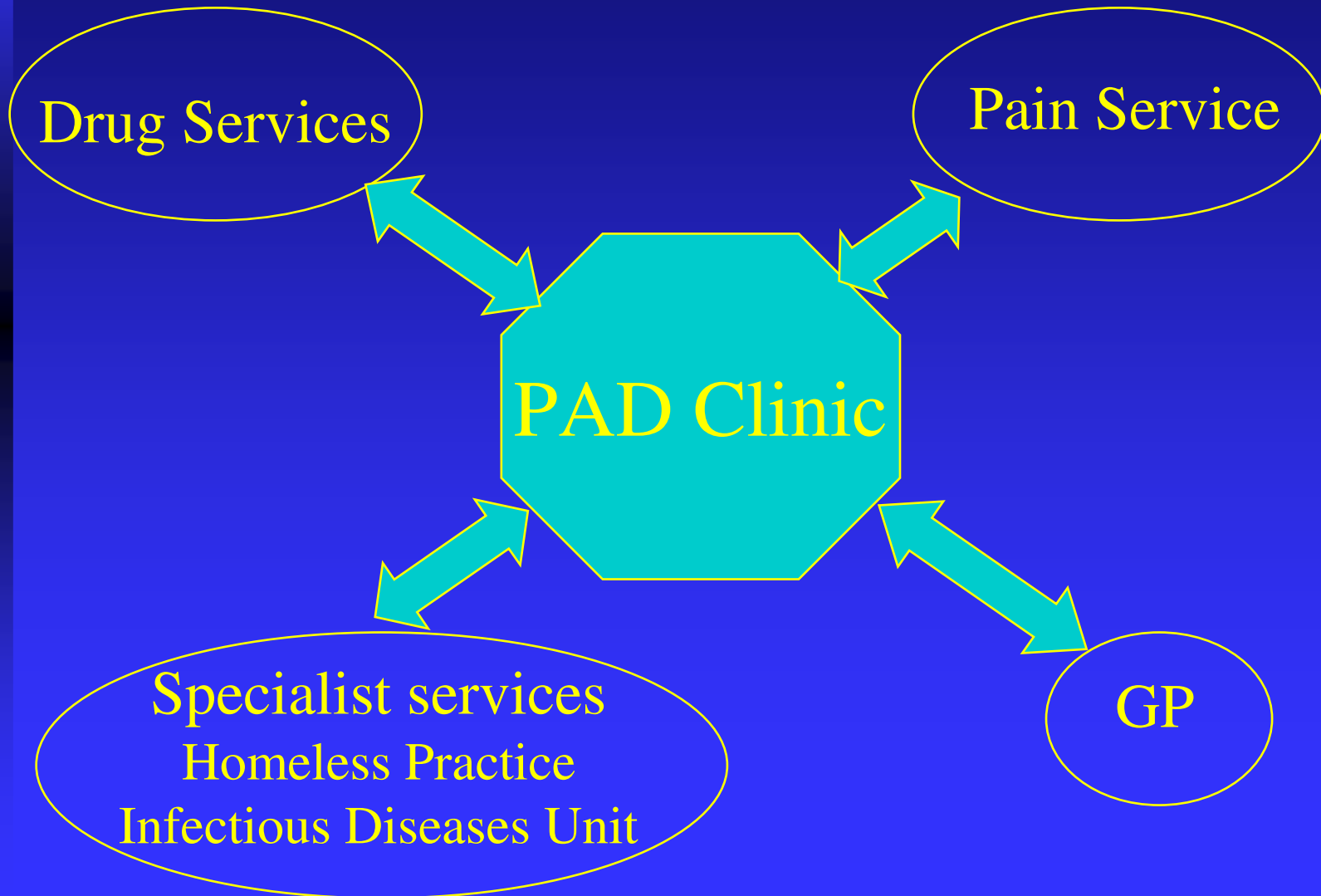
The Edinburgh Experience: Current Management



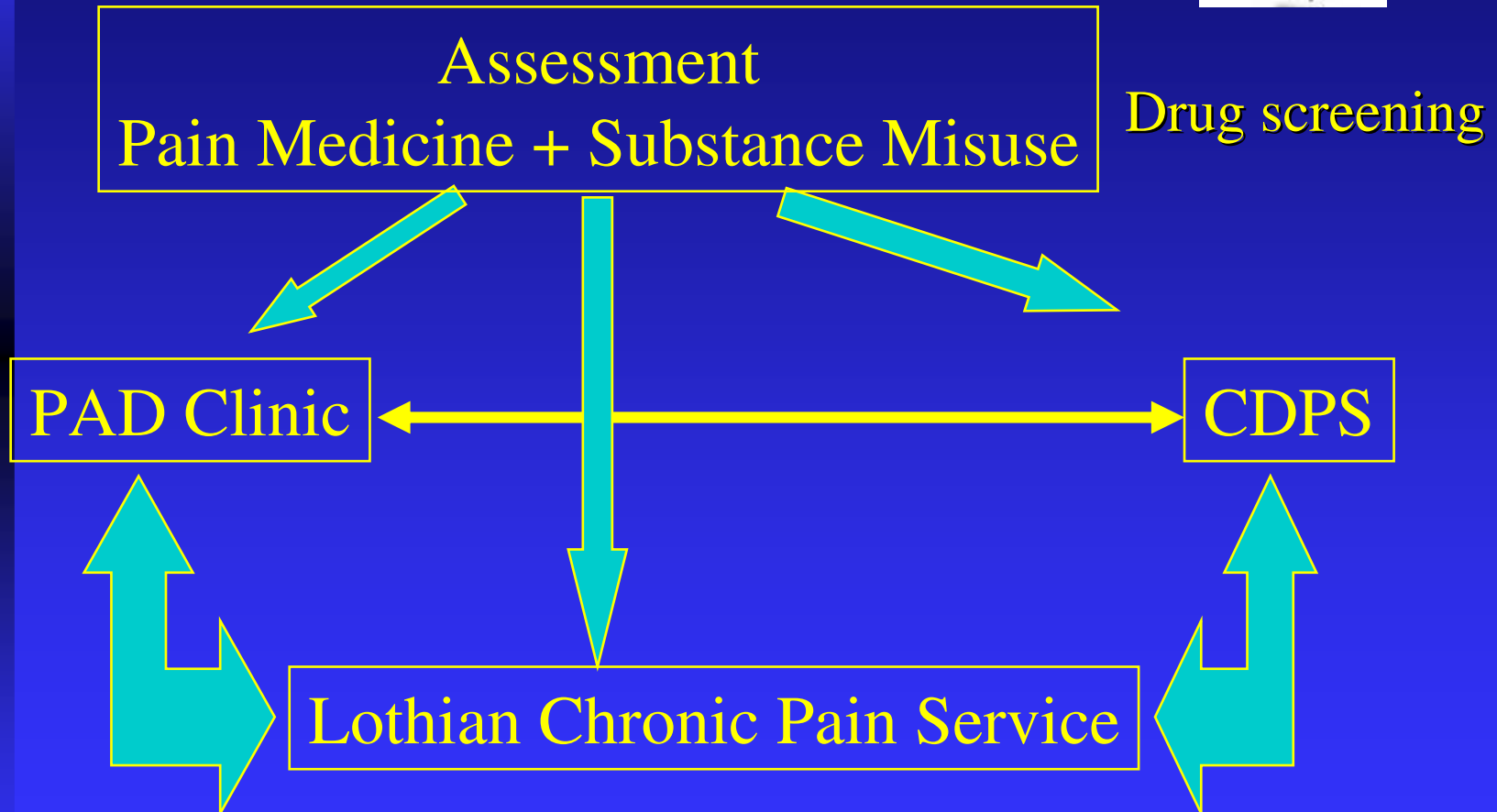
Pain & Dependency – the Edinburgh experience: Service design issues

- Development of combined Pain & Dependency (PAD) Clinic
 - Patients with drug dependence should not be denied adequate pain relief
 - Access to specialised services with experience in managing this patient group is essential

Referral Pathways to PAD Clinic



PAD Clinic



PAD Clinic



Ongoing review

- Key worker/ GP
- Telephone
- Voluntary agencies

Liaison with other specialties

- Verify past assessment
- Initiate further assessment/ investigations
- Inadequate history from patient

PAD Clinic – potential problems

- Waiting times
 - Lothian Chronic Pain Service (18 weeks)
 - Lothian Drug Services (14-20 weeks)
 - PAD Clinic: Pressure to see patients outwith PAD clinic setting (24 weeks)
- Difficult to engage population
 - High DNA rate
 - Best time to change is when patient is ready
- Interferes with multidisciplinary working
 - If no key worker – problems with safe pharmacological manipulation

British Pain Society

Pain & Substance Misuse, 2007

Key points

- Additional problems assoc with substance misuse – increased risk of conditions requiring pain management
- Clear understanding of terms (tolerance, dependence etc)needed
- Primary purpose of opioid prescribing is *pain relief* – complete relief of symptoms rarely achievable
- Comprehensive assessment & specific management needed