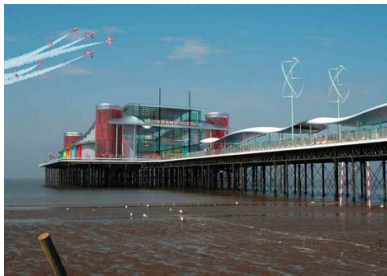


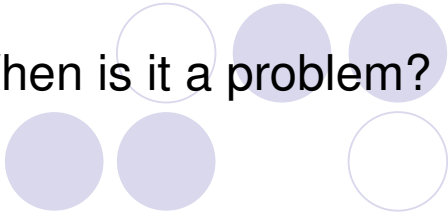
Pain Relief and Drug Use –
the forgotten dual diagnosis ?

- Dr Jonathan Garstang
 - GP Principle
 - Weston-Super-Mare





When is it a problem?



Strong Opiates

- Buprenorphine
- Methadone
- Heroin/Diamorphine
- Pethidine
- Tramadol !!



Weak Opiates

- Dihydrocodeine
- Codeine
- Tramadol
- Meptazinol
- Dextropropoxyphene



Weak Opiates

- Codeine 240mg = Morphine 20mg
- Dihydrocodeine 240mg = Morphine 25mg
- Tramadol 400mg = Morphine 80mg

Is it a problem?

- Incidence of chronic pain in methadone patients – 37-48%
- In general population approx 15%

Is it a problem?

- Practice Population 9,600
- Current or Past History of Opiate/Drug Addiction 181
- Requiring Analgesia = 87 (48%)
- Req Reg Analgesia = 23 (12%)
- Req Reg Strong Opiates = 7 (3%)
- Req Chronic Pain Meds = 4 (2%)

Is it a problem?

- Chronic Non-malignant Pain Patients
 - 0-50% have addiction to opiates

Workshop

- Case studies
 - Causes of pain
 - Assessing/initiating
 - Inheriting/Monitoring
- Strong Opiate
 - Benefits, risks, getting off them
- Acute/Prison setting



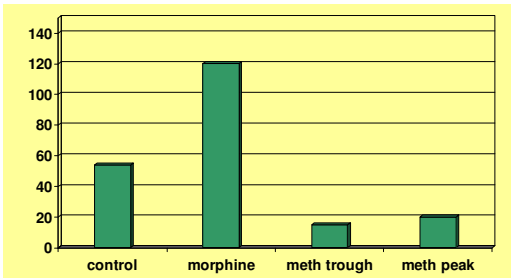
CASE 1

- DG 44yr old male
- Past History Opiate addiction and Alcohol Dependence
- In residential home
- Fracture R Humerus Feb 2008
 - Non-union, mobile
 - 'painless'
- DHC 120mg bd, amitriptyline 10mg, paracetamol, Buprenorphine Patch 30mcg
- Requesting fentanyl patches

Pain – bio-psycho-social perspective

- Environmental factors
- Perceptions
- Mood
- Coping skills
- Beliefs
- ?doctor patient relationship

Hyperalgesia – cold pressor test



Addiction

Pain Society 2004

- Compulsive use of opioids
 - Preoccupation
 - Impaired control
 - Craving
 - Detriment to Health
- Pseudo-addiction

Case 2

- 44yr old male
- Recently joined practice
- Chronic severe body pain post RTA
- Old notes
 - Under previous Drug Clinic
 - Under Pain Specialist
 - Under Psychiatrists
- Requests Methadone

Waddell Signs

- **Superficial tenderness** – skin discomfort on light palpation.
- **Nonanatomic tenderness** – tenderness crossing multiple anatomic boundaries.
- **Axial loading** – eliciting pain when pressing down on the top of the patient's head.
- **Pain on simulated rotation** - rotating the shoulders and pelvis together should not be painful as it does not stretch the structures of the back.
- **Distracted straight leg raise** - if a patient complains of pain on straight leg raise, but not if the examiner extends the knee with the patient seated (e.g. when checking the [Babinski's reflex](#)).
- **Regional sensory change** - Stocking sensory loss, or sensory loss in an entire extremity or side of the body.
- **Regional weakness** - Weakness that is jerky, with intermittent resistance (such as cogwheeling, or catching). Organic weakness can be overpowered smoothly.
- **Overreaction** - Exaggerated painful response to a stimulus, that is not reproduced when the same stimulus is given later.

Opioid Risk Score
Chou 2009

- The biggest identified risk factors are:
- Personal or family history of aberrant alcohol and drug-related behaviors
- History of physical or sexual abuse
- Co-occurring psychiatric conditions

Date _____

Patient Name _____

OPIOID RISK TOOL

	Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol <input type="checkbox"/>	1	3
	Illegal Drugs <input type="checkbox"/>	2	3
	Prescription Drugs <input type="checkbox"/>	4	4
2. Personal History of Substance Abuse	Alcohol <input type="checkbox"/>	3	3
	Illegal Drugs <input type="checkbox"/>	4	4
	Prescription Drugs <input type="checkbox"/>	5	5
3. Age (Mark box if 16 – 45)	<input type="checkbox"/>	1	1
4. History of Preadolescent Sexual Abuse	<input type="checkbox"/>	3	0
5. Psychological Disease	Attention Deficit Disorder <input type="checkbox"/>	2	2
	Obsessive Compulsive Disorder <input type="checkbox"/>		
	Bipolar <input type="checkbox"/>		
	Schizophrenia <input type="checkbox"/>		
	Depression <input type="checkbox"/>	1	1
TOTAL	<input type="checkbox"/>		
Total Score Risk Category		Low Risk 0 – 3	Moderate Risk 4 – 7
		High Risk ≥ 8	

Reproduced with permission from Lynn Webster²⁷

Case 3

- JF 38yr old female
- Depression, abdo pains late teens
- Operations including hysterectomy
- Frequent admissions to hospital
 - Discharged on high dose pethidine
 - Up to 1000mg daily, injectable
- Under care of local D+A services
 - Pethidine 300mg daily injectable, +top ups
 - Methadone 70mg daily

Case 3 cont

- Stable currently
- In past frequent entries in notes re needing additional analgesia
 - For pain
 - When low mood

Case 3 cont.

- Evidence of addiction?
- Evidence of misuse?

Prescription Opioid Misuse Index
(+ score is more than one +) Knisely et al 2008

1. Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you?	Yes	No
2. Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages, than is prescribed for you?	Yes	No
3. Do you ever need early refills for your pain medication?	Yes	No
4. Do you ever feel high or get a buzz after using your pain medication?	Yes	No
5. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?	Yes	No
6. Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication?	Yes	No

Case 3 cont.

- Inheriting a patient like this... how would you manage?
- Monitoring

Monitoring: the 4 'A's (Chou et al)

- Analgesia and use of medications
- Activity Levels
- Adverse Events
- Aberrant Drug Behaviours

Problem Drug Use

AAAP 2009

- Intoxication
- Signs of illicit drug use
- Lost / stolen prescriptions
- Escalation of need for opiates
- No improvement in pain
- No improvement in function
- More than one source of scripts

Aberrant drug behaviours

Passik & Portenay 1998

Probably more predictive

- Selling prescription drugs
- Prescription forgery
- Obtaining prescription drugs from non-medical sources
- Injecting oral formulations
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose escalations
- Recurrent prescription loss

Probably less predictive

- Aggressive complaining about need for higher dose
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquiring from multiple Drs
- Unsanctioned dose escalations 1-2 times
- Unapproved use of drug to treat other symptoms
- Reporting psychic effects not intended by clinician

Strong Opiates for Chronic Pain

Do they Work?

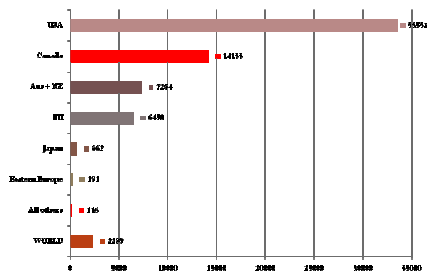
- Trials
- Functioning, Pain scores
- Massive increase in use

Dangers?

- Mortality
- Hyperalgesia
- Addiction behaviour
- Immunosuppression

Global Consumption of Narcotics (2003-2005)

(defined daily doses/million inhabitants/day)



Courtesy of Dr. Jayadeep Patra, Centre for Addiction and Mental Health, University of Toronto, under review.

Strong Opiates for Chronic Pain

- Getting Off Strong Opiates

- Problems
- Benefits
- How to?

Acute Pain

Hospitalised Patients
Cold Pressor Studies
Discharging back to community

Summary

- A dual diagnosis
 - Is it relevant?
 - Is it forgotten?
- Evidence for hyperalgesia
- Validated tools to help manage patients
- Pros and Cons of using strong opiates

References

- Will be available on-line.....

CAGE-AID

Brown and Rounds 1995

- Cut Down
- Annoyed
- Guilt
- Eye-opener /steady nerves first thing in morning
