Pain management in patients with a history of opioid dependence

Information for health professionals

Managing pain in patients with a history of opioid dependence can pose substantial challenges. There is a lack of clinical consensus and research-supported guidance.[1] In addition, pain in these patients is often underestimated and undertreated.[2]

People with current or past problems of opioid dependence are at higher risk of serious harm from treatment with opioid analgesics. These harms include relapse to addiction, risk of overdose, and inappropriate use. However, history and/or risk of opioid use or abuse should not automatically, or necessarily, preclude opioid treatment for a patient. Careful use of opioids together with risk management tools and techniques can reduce the potential harms.

Prescribing principles for such patients include:

- taking a thorough drug history and making a comprehensive assessment of pain and risk
- implementing multimodal treatment therapies that maximise non-opioid analgesics, adjuvant medicines and non-drug therapies and avoid sole reliance on opioids
- never continuing claimed previous treatment without independently verifying the claims directly with the previous prescriber, and making your own thorough assessment of the patient
- using risk management strategies that monitor compliance, aberrant behaviour, and supply and diversion, and include specialist support
- providing patient communication and information that is non-judgemental and empathic, framed as your concern about the patient's safety.[3]

Assessing patients with a history of substance use disorder

Before prescribing an opioid it is essential to take all reasonable steps to ensure that a therapeutic need does exist. For pain control, this involves a comprehensive pain assessment as well as a complete understanding of the patient's current and past drug-related behaviours, social pressures and psychological state. Patient subjective reporting of pain is the gold standard for assessing pain in patients with or without opioid-dependence history. Requirement for analgesia, including opioid medicines, should be led by this assessment.

An opioid risk tool can help identify individuals at risk of developing aberrant drug-related behaviours, who may require more intense monitoring. These behaviours can include deliberate misuse with the aim of experiencing non-therapeutic effects and/or on-selling the medicines for profit.[4]

Risk factors most predictive of development of a substance use disorder (SUD) include personal or family history of alcohol or other drug abuse, and comorbid psychiatric disorders. Research strongly suggests smoking is also a predictor of more frequent and problematic use of opioids.[5]

Patients with SUDs may not disclose drug use, either current or historical.[6] Consider drug use screening when assessing acute pain in patients with a history of dependence.

Look for signs of drug use, including intoxication, withdrawal and injection-site marks, and conduct a urine drug screen;[6] this screen is not confirmatory and should always be used in conjunction with clinical signs and history (see the RACGP guidelines).[13]

Aberrant drug behaviours

Adapted from Passik & Portenoy 1998

YELLOW FLAGS	RED FLAGS
• Few unsanctioned dose escalations • Occasionally acquiring from multiple doctors • Aggressive complaining about need for higher dose or specific drug • Drug hoarding during periods of reduced symptoms • Unapproved use of drug to treat other symptoms (eg, sleep, mood) • Reporting psychic effects not intended by clinician	• Many unsanctioned dose escalations • Often acquiring from multiple doctors • Recurrent prescription loss • Obtaining prescription drugs from nonmedical sources • Concurrent substance abuse (alcohol, other drugs) • Injecting oral formulations • Selling prescription drugs • Prescription forgery

Medicare Australia's Prescription Shopping Information Service (Tel: 1800 631 181) can provide a means for assessing new patients, and those being treated, who are at risk of drug abuse or misuse through doctor shopping. You may also contact Drugs and Poisons Regulation (Tel: 1300 364 545 or email: dpcs@dhhs.vic.gov.au) to check if permits have been issued or notifications of drug dependency have been received in relation to a patient you intend to treat. While these resources can assist with patient assessment, it is important to be aware that not all patients who have a history of drug-seeking or aberrant drug behaviours will be identified through these services, so universal precautions should always be taken when considering treatment.

Universal precautions

With patient safety paramount, apply the principles of universal precautions to pain management for all patients, as it is impossible to identify all patients engaged in drug-seeking behaviour.

- Screen patients to identify those at risk of aberrant drug-related behaviours and problematic drug use.
- Prescribe opioids on a limited trial basis to establish efficacy, and review pain scores and level of function regularly.
- Routinely assess at each visit the five As of pain medicine:
  - has the pain reduced (**Analgesia**)?
  - has the level of function improved (**Activity**)?
  - are there significant **Adverse** effects?
  - is there evidence of **Aberrant** substance-related behaviours?
  - what is mood of the individual (**Affect**)?

If treatment goals are not met, consider tapering or discontinuing opioids while using other methods to manage pain. (See fact sheet 'Recommendations for deprescribing or tapering opioids' for further information.)

Lost prescriptions or drugs, or claims they were stolen, should flag that either the patient is misusing or trafficking the drug, or that there is a risk to others from these potentially dangerous medicines. Consider limiting supply to every day or two, or tapering and discontinuing – outcomes that should be signalled in the patient agreement. Failure to comply with non-opioid treatment appointments or recommendations may signal that the patient is drug-seeking or focused inappropriately on opioids to the exclusion of other effective treatment modalities.

Adopting a cautious approach – one that includes regular monitoring and reassessment – may prevent problematic opioid use or identify it early, enabling appropriate referral into specialist care, including pain and drug and alcohol addiction specialist care with input from mental health specialists as needed.[4]

Treatment considerations

Treating chronic pain in patients with SUD is complex. Chronic pain is a biopsychosocial phenomenon, and all aspects should be assessed and treated. Many patients, including those with high-risk drug behaviours, receive insufficient pain relief.[6,7] The effective treatment of acute pain may reduce the risk of developing a chronic pain condition.[8]

Adopt a multidisciplinary approach with a focus on appropriate combinations of physical, psychological and pharmacological therapies. Optimise non-drug and non-opioid drug treatments either to avoid opioid use or implement opioid-sparing treatments.

Only consider prescribing an opioid over a 4-week trial period after confirming all of the following:

- a comprehensive assessment and patient history has been undertaken, providing a differential pain diagnosis with baseline pain score and functional ability, as well as a mental health history including drug and alcohol use
- a treatment plan has been agreed to and includes improved function and activity as a goal, not just pain relief
- a trial of non-opioid analgesia and non-drug treatments has occurred, including corroboration of treatment history confirming this for patients who report starting treatment elsewhere
- the patient has acute pain, cancer pain and palliative care, or in the case of non-cancer pain, a diagnosis consistent with nociceptive or neuropathic pain.

Start low and go slow

Limit the prescribed opioid to the lowest effective dose for the shortest effective duration (for both acute and chronic pain) without compromising effective analgesia.[1] With acute pain, prescribe no more than needed for the expected duration of the pain – 3 days or less will often be sufficient; more than 7 days will rarely be needed.[9] (See fact sheet 'Safe prescribing and supply of opioid medicines' for further information.)

Withdrawal management

In addition to maximising pain relief through non-opioid analgesics, preventing withdrawal syndromes is an important aim of management. Clonidine may be useful for this purpose.

Note that for patients abusing other recreational drugs, there is no cross-tolerance between opioids and most other drugs of abuse (eg, alcohol, benzodiazepines, cannabis, cocaine, amphetamines).

For moderate pain that is unresponsive to non-opioid analgesia and other intervention, consider prescribing a trial of tramadol, as it has a lower potential for abuse compared with other opioids.

Tramadol may not provide sufficient pain relief for patients with severe pain or those who are opioid-tolerant.

Choose drugs and administration routes with lower reinforcing properties (eg, morphine over pethidine, oral rather than parenteral).

Consider adjuvants such as clonidine, antidepressants and anticonvulsants.

Opioid replacement therapy

Patients with an opioid dependency who are not suitable for a controlled trial can be offered opioid replacement therapy (ORT) with methadone or buprenorphine. Health professionals and patients may contact DirectLine (1800 888 236, 24 hours, 7 days) for the nearest prescriber and pharmacy trained to provide opioid replacement therapy services.

Alternatively, all medical practitioners in Victoria may prescribe buprenorphine/naloxone for up to five patients without the requirement for formal training. Further information on how to safely prescribe buprenorphine/naloxone or how to attend a free ORT training course is available at: www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy

Risk management

Research recommends intensive monitoring and management of patients at high risk of opioid misuse. This may include:

- close supervision of opioid supply, including interval dispensing every day or more
- additional non-pharmaceutical strategies such as psychotherapy
- monitoring via appointments, random urine drug screens, and pill counts.[7,10]

High abuse risks are indicated by:

- current alcohol and/or drug abuse
- significant, poorly controlled psychiatric comorbidity
- repeated problems adhering to an opioid management treatment plan, such as
  - frequent early refill requests
  - escalating doses without consultation with a physician
  - obtaining opioids from multiple prescribers
- use, or detection by urine drug screen, of illicit drugs or other sedating medicines
- diversion to others, suggested by the absence of the prescribed drug in the urine drug screen.

Intense monitoring is recommended for patients

- taking > 120 mg morphine-equivalent dose (MED) per day
- taking methadone or buprenorphine for the treatment of opioid dependency
- who have a history of either high dose opioids or treatment for opioid dependency.

Tailored patient management plans can include:

- patient education and treatment agreements based on informed consent
- compliance monitoring
- pill counts
- urine drug tests
- referral to addiction medicine specialists.

This approach has potential for prevention and early identification of problematic opioid use, and facilitates appropriate referral into specialist care, including pain and drug and alcohol addiction specialist care with input from mental health specialists as needed.[4,11]

An initial referral to specialists is typically considered before prescribing for patients with:[12,13]

- a history of or current alcohol or drug dependence
- previous opioid use that was problematic
- a comorbid psychiatric or psychological disorder
- indeterminate pathology (undifferentiated or non-specific pain)
- a relatively young age.

During the course of pain management, even when an optimal regimen and monitoring approach has been implemented, advice may be warranted for the following reasons:[12,13]

- unexpected drug dose escalation
- ceiling drug dosages reached
- suspected abuse or misuse (eg, drug diversion)
- change in risk category
- high levels of patient distress or exacerbation of psychiatric or psychological disorder.

Be prepared to refer a patient for hospital admission if you consider them to be a risk to themselves or others or if your patient is at risk from others.

Communication strategies

Patients prescribed opioids respond best when conversations are framed as protecting them from potential opioid-related harms.

> Use a benefit-to-harm framework to make and communicate decisions about starting, continuing and discontinuing opioids for managing chronic pain. This focuses decisions and discussions on judging the treatment rather than the patient, and promotes a therapeutic alliance and shared decision making.[3]

Presenting risk management as a strategy for protecting the patient from medication harms enables treatment agreements to become an important communication tool rather than just a practice policy, and helps the patient distinguish between acceptable and unacceptable drug-taking behaviours. It also provides a means for justifying the decision, if necessary, to terminate opioid treatment.[3,11]

Prescribing tips to deter abuse[13]

Reduce risk by restricting access and decreasing temptation to overuse by:

- enabling only small quantities of opioids to be dispensed – prescribe only enough medicine to carry through to the next appointment
- writing out the number of tablets to be dispensed in letters and numerals (ie, 14 and fourteen) to prevent forged alteration of the prescription to obtain larger amounts.
- drawing a large 'Z' at the bottom of the prescription to avoid other items being added to paper prescriptions.
- arranging more frequent follow-up.

Discourage doctor shopping by informing patients that opioids should be obtained from one practice and preferably only one prescriber, including being dispensed through one pharmacy. GPs are under no obligation to continue another prescriber's drug regimen; ultimately the decision to prescribe rests with the individual health professional.

Review your prescribing habits in relation to opioids and other drugs of dependence. The RACGP has generated a list of common 'prescribing traps' associated with prescribing drugs of dependence: RACGP Prescribing drugs of dependence in general practice. Part A: Prescribing traps

A Schedule 8 permit must be obtained from the Department of Health & Human Services before prescribing an opioid to a patient who is drug dependent. Evidence that recent supportive advice has been obtained from a specialist may be necessary for a permit to be issued. See Policy for issuing Schedule 8 permits for further information.

Resources

Urine Drug Testing: www.racgp.org.au/your-practice/guidelines/drugs-of-dependence-a/appendix-h-urine-drug-testing/appendix-h-urine-drug-testing

Sample opioid treatment agreement, Hunter New England Area Health Service: www.hnehealth.nsw.gov.au/Pain/Documents/Opioid%20treatment%20agreement_Mar%202013.pdf

Drug and Alcohol Clinical Advisory Service (DACAS): Tel: 1-800 812 804 (24-hour service) or go to www.dacas.org.au

Prescription Shopping Information Service: Tel: 1 800 631 181 or go to www.medicareaustralia.gov.au/provider/pbs/prescription-shopping

Drugs and Poisons Regulation (DPR): Tel: 1300 364 545 or go to www.health.vic.gov.au/dpcs/reghealth

DirectLine – free, confidential alcohol and drug counselling and referral service available 24 hours, 7 days a week: Tel: 1800 888 236 or go to www.directline.org.au

References

1. Volkow ND, McLellan AT. Opioid abuse in chronic pain – misconceptions and mitigation strategies. NEJM 2016;374:11. http://www.nejm.org/doi/full/10.1056/NEJMra1507771.
2. Mehta V, Langford RM. Acute pain management for opioid dependent patients. Anaesthesia 2006;61:8. http://www.ncbi.nlm.nih.gov/pubmed/26525109.
3. Nicolaidis C. Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. Pain Medicine 2011;12:8. http://www.ncbi.nlm.nih.gov/pubmed/21539703.
4. Nicholas R, Lee N, Roche A. Pharmaceutical drug misuse in Australia: Complex problems, balanced responses. Flinders University Adelaide: National Centre for Education and Training on Addiction (NCETA) 2011. http://nceta.flinders.edu.au/files/6113/2823/3742/EN448_Nicholas_2011.pdf (accessed 11 May 2016).
5. Skurtveit S, Furu K, Selmer R, et al. Nicotine dependence predicts repeated use of prescribed opioids. prospective population-based cohort study. Ann Epidemiol 2010;20:8. http://www.ncbi.nlm.nih.gov/pubmed/20627770.
6. Roberts L. Managing acute pain in patients with an opioid abuse or dependence disorder. Aust Presc 2008;31:3. http://dx.doi.org/10.18773/austprescr.2008.074.
7. Passik SD, Kirsh KL. Opioid therapy in patients with a history of substance abuse. CNS Drugs 2004;18:1. http://www.ncbi.nlm.nih.gov/pubmed/14731056.
8. Webster LR, Brennan MJ, Kwong LM, et al. Opioid abuse-deterrent strategies: role of clinicians in acute pain management. Postgrad Med 2016;128:9. http://www.ncbi.nlm.nih.gov/pubmed/26631936.
9. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. JAMA 2016;315:22. http://www.ncbi.nlm.nih.gov/pubmed/26977696.
10. Morasco BJ, Gritzner S, Lewis L, et al. Systematic review of prevalence, correlates, and treatment outcomes for chronic non-cancer pain in patients with comorbid substance use disorder. Pain 2011;152:10. http://www.ncbi.nlm.nih.gov/pubmed/21185119.
11. Passik SD. Issues in long-term opioid therapy: unmet needs, risks, and solutions. Mayo Clin Proc 2009;84:8. http://www.ncbi.nlm.nih.gov/pubmed/19567713.
12. Hooten WM, Timming R, Belgrade M, et al. Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain. 2013. https://www.icsi.org/_asset/bw798b/ChronicPain.pdf (accessed 29 April 2016).
13. Expert Group for Analgesics. eTherapeutic Guidelines: Analgesic. 2012. http://online.tg.org.au/ip/desktop/index.htm (accessed 29 April 2016).

© 2016 NPS MedicineWise. Published May 2016. ABN 61 082 034 393 Level 7/418A Elizabeth St, Surry Hills NSW 2010. Independent. Not-for-profit. Evidence based. Developed with funding from the Victoria State Government, Department of Health and Human Services. Reasonable care is taken to provide accurate information at the time of creation. This information is not intended as a substitute for medical advice and should not be exclusively relied on to manage or diagnose a medical condition. NPS MedicineWise disclaims all liability (including for negligence) for any loss, damage, or injury resulting from reliance on, or use of this information. Any references to brands should not be taken as an endorsement by NPS MedicineWise.