Response: Providing Relief, Avoiding Euphoria

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Roger Weiss: I learned a lot from this article (Savage, Kirsh, and Passik, 2008). It provides a very comprehensive, soup-to-nuts review of the relationship between pain and substance abuse, describes the mechanisms of pain, and details which kinds of opioids cause euphoria and under what circumstances. Most valuably, the authors present a rational approach to clinically evaluating and treating people who have chronic pain and suspected or known substance abuse.

Maria Sullivan: Many substance abuse clinicians are uncomfortable with this comorbid population, and, conversely, pain management specialists often feel unprepared to handle substance issues. For those professionals in particular, the authors' presentation of concrete clinical tools and a structured differential diagnosis of opioid misuse should be very helpful.

Dennis Paul: No less important is the reminder that addicts deserve humane pain treatment just like everyone else. We have an ethical obligation to treat their pain.

Universal precautions, individual assessments

Sullivan: The challenge in treating pain in patients who have been addicted to opioids is to meet their therapeutic needs without encouraging a relapse to substance misuse. The authors' recommendation for universal precautions in prescribing opioids recognizes that, even when a patient does not have such a history, the potential for misuse is always there. As the authors set them forth, the main precautions are, with every patient, to have clear treatment goals, be attentive to psychological and substance use issues, and conduct recurrent assessments of function as well as pain level. This strategy is analogous to the use of protective measures, such as always wearing gloves when handling blood and disposing of needles safely, whether or not a patient has been diagnosed with an infectious disease.

Weiss: There are obstacles to substance abuse patients getting pain treatment and vice versa. Substance abuse programs generally are happy to refer patients to pain programs, but some pain programs are reluctant to accept those patients. On the other hand, patients in pain programs typically resist the idea that addiction is their problem. They believe that chronic pain is their problem.

Sullivan: It would be very useful for pain management programs to establish working relationships with addiction psychiatrists, who can provide specialized assessments of patients with potential substance abuse issues. As the article points out, some of an addiction professional's skills, such as cognitive-behavioral intervention, can be brought to bear in pain management.

Paul: I have encountered physicians who felt that addicts gave up their right to be treated for pain and wouldn't give them opioids. In the past, everyone who came into the major public hospital in New Orleans with a complaint of pain was suspected of seeking opioids. That was the mindset that the medical staff were instilling in students. We had to fight the mentality that everyone was looking for their next fix.

Weiss: Giving up your right to treatment—I've never quite heard that phrase before. However, I think that is essentially what happens when people with substance abuse issues get thrown out of a pain clinic. It's obviously a bad situation when that occurs.

Sullivan: Most clinicians feel fairly comfortable treating acute pain in addicted individuals. It's when the pain becomes chronic that there's often a struggle or a difference of opinion over whether opioid use needs to continue. I'm aware of a number of patients who have been placed on enforced tapers by their pain management physician, despite continuing analgesic requirements and no current misuse of the medication.

Weiss: Clinicians in pain treatment centers and primary care settings are the ones who most often give opioids for chronic pain. They are likely to suspect misuse when patients ask for refills sooner than scheduled or say they have lost prescriptions, or if an unexpected positive finding comes up on a urine screen, or if a family member reports that there is trouble. There are lots of reasons, though, why these things might occur.

Sullivan: A common clinical response in those scenarios would be to curtail the supply of medication and require the patient to present at more frequent intervals. That way, care providers can get a better understanding of what dosing schedule the patient can adhere to and whether sufficient analgesia is being achieved.

Paul: At Louisiana State University, we have a similar procedure. We have the patients sign a contract, which states the exact consequences of testing positive. Patients can't get additional medication if they take more than they're supposed to or run out too soon.

Sullivan: At Columbia, patients who test positive for drugs of abuse are warned that they must discontinue any illicit substance use to remain in the program. Patients who misuse their medications receive a similar

warning. The key to making such policies work is systematically assessing the cause of the abuse or misuse. Perhaps the patient's pain isn't being sufficiently alleviated. I've seen cases, such as the authors mention, where patients simply misunderstood dosing instructions. Or a patient may be unable to abstain from illicit drugs if he's not receiving adequate substance treatment.

This is the differential diagnosis, and this is where pain programs can draw on the expertise of addiction specialists. An addiction counselor can help patients distinguish between therapeutic and inappropriate uses of pain medications, and can work with patients to identify any psychological factors driving inappropriate use. Counselor and patient can discuss the role that pain plays in the substance problem and whether the patient believes that the substance abuse is ameliorating the pain. There are many possibilities to be considered before rejecting a patient for opioid therapy.

Paul: The differential should also consider family and social dynamics, which also can promote pain behaviors and addictive behaviors. In a course that we teach on pain management, we include a section on the social setting of pain. We emphasize that, for some patients, not having to go back to work reinforces them for continuing to have pain. Others, particularly children or young adults, receive reinforcement for pain because their parents pay more attention to them, take care of them, and clean their room for them. With constant attention and reinforcement, the pain behavior continues.

Sullivan: Sometimes, problems arise when the family has trouble relinquishing its caregiver role after the patient recovers from addiction. I treated a woman who, while abusing opioids in her 30s, had regressed to very infantile behaviors. When she started feeling better, her parents couldn't accept her autonomy and independence. In another case, a husband who became unemployed because of his overuse of prescription opioids adopted a very dependent role relative to his wife. When he regained the ability to work and ceased the abuse, the couple required marriage counseling.

Weiss: A very interesting, controversial question is whether opioids themselves can contribute to some patients' pain, especially when they are abused. I do not know the answer, but I have certainly seen some of my addiction patients have their pain get better when they stopped using opioids.

Sullivan: In my addiction psychiatry practice, I've also seen patients being maintained on opioids for pain attributed to gastrointestinal complaints or chronic myalgias. In some cases, the pattern of pain in these patients bore a strong resemblance to opioid withdrawal syndrome and indeed remitted when they were taken off the opioid.

Potential new medical tools

Sullivan: Currently, I'm evaluating the use of buprenorphine for patients with histories of prescription drug abuse who need an opioid-strength analgesic to control pain. I must say that this population is very grateful to encounter clinicians who are alert to both their analgesic needs and their struggle with addiction. They've often had conflicts with pain management specialists who distrust their reports of pain. They also tend not to feel they belong in typical substance abuse programs because, although they acknowledge a number of aberrant behaviors around drugs, they argue that they are only trying to achieve adequate pain relief.

Our early results suggest that the patients in the study, who all have moderate pain, are achieving good relief and also having fewer cravings for other opioids. Also, buprenorphine does not seem to alter the analgesic effects of other opioids, so it should be feasible to administer additional medications for episodic acute pain, for example, in case of traumatic injury.

Paul: I suspect that's true of other mu opioids and nonopioid analgesics. However, I suspect that buprenorphine alters the analgesic effect of kappa-agonist opioids, such as butorphanol and pentazocine.

Sullivan: We haven't studied those specifically, but I suspect you're right. Another observation we've made is that chronic pain patients are receptive to having some degree of control over their analgesic medication. During the outpatient phase of this study, we provide *pro re nata* dosing of 2 mg of buprenorphine, on top of the 16-mg/day maintenance dose. On a fixed dosing regimen without this measure of control for acute flareups of pain, patients can sometimes get into trouble and find themselves ahead of the count in the pill bottle.

Weiss: We are studying buprenorphine's ability, in conjunction with counseling, to help people stop abusing prescription opioids. Many of our study participants have pain, and we are monitoring, along with their substance abuse outcomes, how their pain responds to our treatment. I know that buprenorphine is used outside the United States for treating pain, and I'll be interested to see Dr. Sullivan's results.

Paul: My group is experimenting with combinations of morphine and low-dose antipsychotics, such as methotrimeprazine, which is currently unavailable in the United States. We've already shown that a low dose of methotrimeprazine can potentiate morphine's analgesic effect.

REFERENCE

Savage, S.R.; Kirsh, K.L.; and Passik, S.D., 2008. Challenges in using opioids to treat pain in persons with substance use disorders. *Addiction Science & Clinical Practice* 4(2):4-25.