# Relief Without Addiction

## Opiates for Chronic Pain

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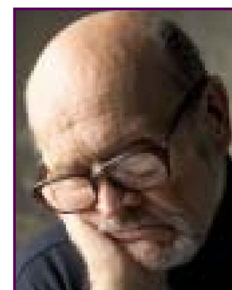
## *How is pain assessed?*

The most important part of the pain assessment is to start with a good pain history, so as to make as accurate a diagnosis of chronic pain as possible (Table 1). A pain inventory can be helpful in initial and followup assessments. Verbal or visual analog scales have been validated somewhat and are more reliable ways of assessing pain and function.

Screening for addiction should be considered for everyone. Screening is started with personal history of drug use. Past and family history of addiction and psychiatric illness are also important. A commonly used screening tool is the CAGE questionnaire (Table 2). A physical exam should be done to rule out serious and/or treatable causes of pain (*e.g.*, steroid injection for trochanteric bursitis), or to determine whether there is neuropathic pain (hyperalgesia, allodynia, paresthesias) present.

At the end of the assessment, it is important to determine the type of chronic pain (nociceptive, neuropathic, or both), as this directs the treatment strategy. Patients must understand that treatment for pain with analgesia is only one aspect of the whole management plan; there may be underlying dis-

### Carl's case



Carl, 60, has a seven-year history of stable Type 2 diabetes. He complains of intense burning in both feet. Nerve conduction studies have confirmed the diagnosis. He is having trouble with his activities of daily living, particularly his work, which requires a lot of walking. He also has trouble sleeping because of the pain.

He has a stable family life. He has no past or family history of psychiatric or addiction disorder. He never smokes or drinks, and denies the use of street drugs. There are no current stressors in his family.

**What is/are the acceptable trials of narcotic treatment to supplement other modes of therapy?**

a. Acetaminophen (Tylenol® #1, over the counter): Maximum of nine/day
b. Fentanyl patch, 25 µg/hour immediately without other trial of narcotics
c. Codeine, 50 mg, twice daily
d. Acetaminophen (Tylenol #3) during the day, one to two tablets every four hours as needed, or before prolonged walking
e. Acetaminophen (Tylenol #3) three times daily for a maximum of six tablets, with codeine, 50 mg, at bedtime

**Answer:** a, c, d, and e are correct.

**Table 1**

**What to look for when assessing pain**

- Onset
- Location
- Character
- Duration
- Intensity
- Severity
- Temporal characteristics
- Triggering/activating/relieving factors
- Underlying pathology
- Type (nociceptive, neuropathic, *etc.*)
- Unpleasantness scale (1-10)
- Psychologic symptoms (suicide risk)
- Treatment (duration, dosage, side-effects)
- Goals and expectations of treatment

**Table 2**

**CAGE Questionnaire**

**In the past, have you ever:**

1. Felt that you wanted or needed to **cut** down your drinking or drug use?
2. Been **annoyed** or **angered** by others complaining about your drinking or drug use?
3. Felt **guilty** about the consequences of your drinking or drug use?
4. Had a drink in the morning ("**eye-opener**") to decrease hangover or withdrawal symptoms?

ease or psychologic comorbidity that needs to be looked at as well. Thus, if narcotic analgesia is used, emphasize that it is a trial. If patients feel that the analgesia is not helpful, the trial can be stopped. I have set a policy to use a urine drug screen for every chronic pain patient. The frequency of screening depends on the risk of the patients. Table 3 outlines possible indicators of drug-seeking behaviour.

It must be remembered that physiologic dependence and tolerance without other symptoms or signs of addiction cannot be used alone to determine whether patients are addicted. There is always a dynamic balance between benefit and harm in using opiate analgesia in the treatment of non-cancer pain. The type of medication, dosage, frequency of monitoring, boundaries set, and requirement for formal addiction assessment will depend on initial and ongoing risk assessment. It is a good idea to have a written agreement with every patient who is taking narcotics. It serves to explain and educate the patients and give them some confidence that you know what you are doing. Spend time explaining the difference between pain- versus function-centred life. You may want to adopt the "5 As" approach in followup assessments (Table 4). If in doubt, refer the patient for an addiction assessment.

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## *Who should opiates be prescribed to?*

- Patients who have failed other forms of pain therapy.
- Patients who are not functioning well due to moderate or severe pain.
- Patients who are willing to achieve functional outcomes.
- Patients who are at high risk of developing chronic pain from acute injuries.

If a patient has used opiates before and the treatment worked, the same agent should be used. (An exception is for patients with addiction to medication with high street value.)

Long-acting medication is preferred if pain is continuous or causing a high degree of unpleasantness throughout the day (Table 5).

**Table 3**

**Possible indicators of drug-seeking behaviour**

- Out-of-town patient
- Hurried patient
- Allergic to weak opioid analgesics or non-opioid drugs, such as NSAIDs
- Knows clinical terminology
- Knows street nicknames for prescription drugs
- Reluctant to present identification
- Offers to pay cash instead of presenting identification

NSAID: Non-steroidal anti-inflammatory drug

**Table 4**

**Chronic pain: The five As**

- Analgesia (pain relief)
- Activities of daily living (physical and psychosocial functioning)
- Adverse effects (side-effects)
- Aberrant drug-taking behaviours
- Accurate medication log

## *What are the optimal dosing strategies?*

The most important advice is start low and go slow. It is not uncommon to take up to two to three months to titrate to the right dose and stabilize side-effects. I have learned to go even slower if the patient has higher addiction risk because it is hard to distinguish rapid dosage escalation from inadequate dosage.

It is advisable to start with short-acting opioids before switching to long-acting ones once the pain is stabilized. It is important to note that a fentanyl patch should not be administered to opiate-naïve patients. For these patients, begin with other analgesics and eventually switch them to fentanyl, using the equal analgesic equivalent table. The goal is to titrate the pain to a comfortable, manageable level, or until the patient experiences intolerable side-effects.

It is vital to prepare patients to handle some of the common side-effects (Table 6). Patients should be informed of various options, along with the pros and cons when selecting a medication.

Table 5
Pharmacologic characteristics of long-acting opiates

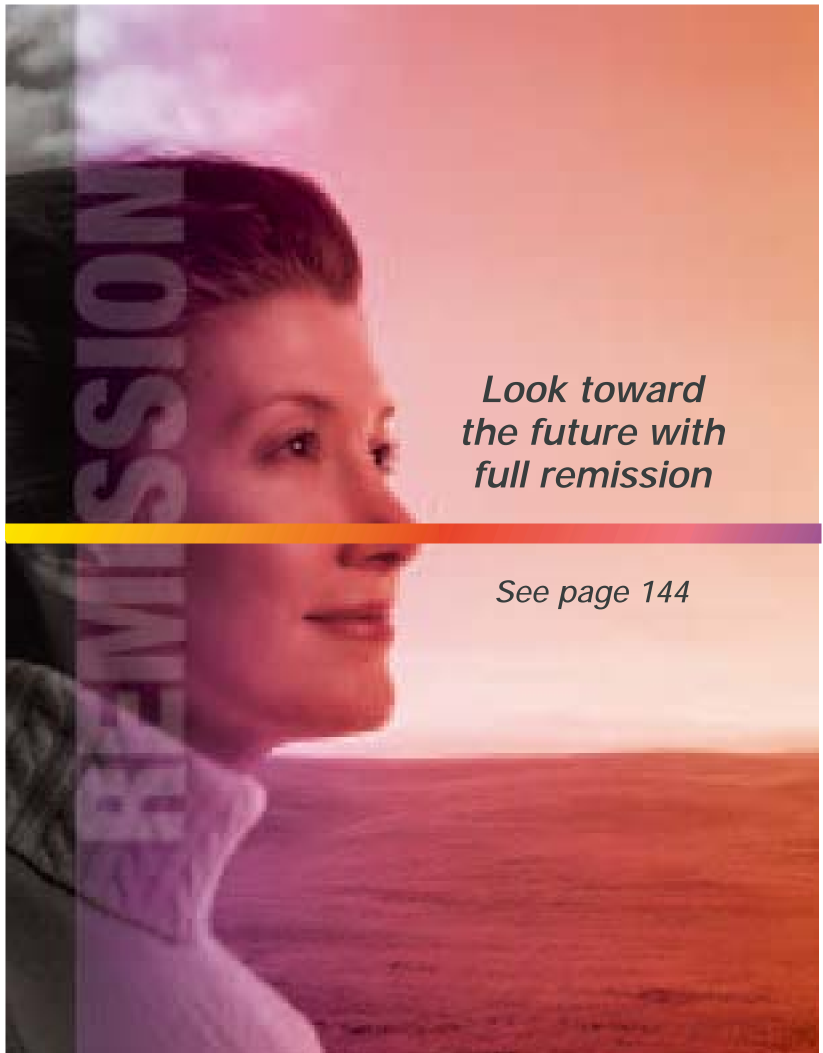
| Opiate | Trade names | Active metabolites | Bioavailability | Lipophilicity |
|---|---|---|---|---|
| Morphine | MS Contin® | M6G, M3G | 35% | Low (0.7) |
| Oxycodone | Oxycontin® | Oxymorphone, noroxycodone | 60-87% | Low (0.7) |
| Hydromorphone | Dilaudid®, Hydromorph Contin® | HM3G | 50% | Low (1.28) |
| Transdermal fentanyl | Duragesic® | None | 92% | High (717) |

The common analgesics I consider most helpful in patients with moderate to severe non-cancer pain are:

- Certain classes of tricyclic antidepressants;
- Trazodone for sleep;
- Valproic acid for neuropathic pain and daily headache;
- Gabapentin (high dose) for neuropathic pain;
- Topiramate and lamotrigine for headache prophylaxis and neuropathic pain; and
- Selective serotonin reuptake inhibitors and selective norepinephrine reuptake inhibitors for comorbid depression.

## *What are the recent advances?*

Choices of treatment for neuropathic pain have increased with newer, safer anticonvulsant and topical agents.



## Take-home message

***What should the general practitioner do?***

- Perform addiction screening and reassessment on all patients being prescribed narcotic analgesics.
- If in doubt, refer for a second opinion.
- Educate yourself and the patient repeatedly.

***What are the treatment options?***

- Opiate analgesics are an evidence-based option for patients with chronic non-cancer (musculoskeletal and neuropathic) pain (level II by The College of Physicians and Surgeons of Ontario [CPSO] November 2000 reference guide).
- Family physicians should learn how to convert patients from short- to long-acting analgesics for better pain control, thus reducing the risk of dependence (in accordance to the CPSO reference guide to minimize medico-legal implications).

Table 6

**Opioid side-effects**

- Nausea
- Constipation
- Sedation
- Pruritis/sweats
- Dysphoria
- Dry mouth/urinary retention
- Hyperalgesia
- Endocrine effects
- Reflux symptoms
- Opioid-induced edema

Newer oral transmucosal and transdermal opiates have been approved for chronic pain and breakthrough pain. Methadone has been shown to be effective in the treatment of chronic pain. There is some evidence suggesting that aggressive, comprehensive treatment of acute pain in selected patients may prevent the development of chronic pain. Evidence is mounting on what sort of comprehensive outpatient program is helpful and cost-effective for patients with chronic pain. Furthermore, societies and academies, as well as governing bodies (colleges) are recognizing the benefits and the issues that arise with the use of opiates for chronic pain patients. Dx

References available—contact *The Canadian Journal of Diagnosis* at **diagnosis@sta.ca**.

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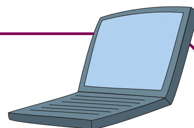
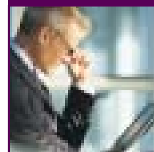


1. The Canadian Pain Society: *www.medicine.dal.ca*
2. The American Academy of Pain Medicine: *www.painmed.org*
3. The American Pain Society: *www.ampainsoc.org*

**www.stacommunications.com**



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