



Pain & Dependence Issues in General Practice

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Prescription Opioid Dependence

- 700% increase in consumption 1991 – 2006 (TAS use is approx 50% higher c.f national average)
- Oxycodone use 2001 – 128,288 scripts
- Oxycodone use 2007 – 1,306,152 scripts
- Estimated 20-30 deaths/year in TAS assoc with use of opioids
- Tasmania S59 requests increase '04/05 – 2500; in '07/08 – 5000.



Prescription Opioid Dependence

- Lack of multidisciplinary pain unit in the North and North West
- Apart from transfers, all OST patients in Launceston have prescription opioid dependence, many with BZD dependence as well (esp alprazolam)



Discussing the Problem

- some considerations

■ Can I say 'No'?

- “You are asking me to prescribe Endone but I don't think that is in your best interests”
- “I am not prepared to prescribe that medication for you today. However, I am concerned and would like you to come back when we have more time to explore the problem & discuss how I might help you”



Drug Seeking Behaviour Clues - Yellow Flags

- Only a specific drug will do the job - “allergies”
- Last patient of the day
- Vague, poorly defined problem that is difficult to confirm eg back pain, migraine, insomnia
- Visiting (usual GP cannot be contacted for verification)
- Letter from other GP recommending addictive med'n
- Lost or otherwise misplaced scripts
- Over-friendly or threatening, abusive, hostile (sudden change if demands not met)
- Resistance to alternative strategies or med's



Drug Seeking Behaviour Clues - Red Flags

- History of alcohol abuse or illicit drug use
- Script forgery
- Injecting medication – check arms (feet, inguinal region)
- Obtaining drugs from non-medical sources
- Seeking medications through multiple prescribers
- Attends appointments intoxicated
- Repeated lost or otherwise misplaced scripts



Pain & Dependence

- Dependence is inevitable with administration of opioid medication longer than 4 weeks
- Aberrant behaviours (“addiction behaviours”) are not inevitable
- “a pattern of thinking and behaviour in which drug use and drug seeking becomes an end in itself, dominating and displacing other activities or behaviours, and ultimately causing harm to the individual”.
- “impairment”, “distress”, “dysfunctional behaviours”




Dependence Criteria

- Tolerance
- Withdrawal
- Using larger amounts, for longer than intended
- Desire to reduce intake, failed attempt at reduction
- Much time used in pursuit or recovery from substance use
- Other activities (social, occupational) neglected in favour of substance use
- Use is continued despite knowing it is causing harm in some way




Is it Chronic Pain or Dependence?

- “My pain is worse, I need more” - tolerance?
- “Without my tablets, my pain goes through the roof” - withdrawal?
- Many patients end up using more medication for longer than they intended
- Some withdraw from social/work roles
- Some have tried and failed to cut back on medication due to exacerbation of pain



How to manage problem behaviours when treating chronic pain


- Discuss objectives of treatment eg pain decrease Vs elimination
- Conduct a dependence risk assessment*
- Consider using an opiate medication agreement
- Watch for problem behaviours
 - Non prescribed dose escalation
 - Early request for script renewals
 - Refusal to consider non opioid medication nor non medication treatment modalities
 - Injecting medication



How to manage problem behaviours when treating chronic pain

The Treatment Agreement

- Treatment goals (as measured by function not pain)
- Frequency of appointments & scripts
- Non replacement for “lost” scripts / “stolen” med's
- Rules regarding use of medication
 - Eg take as directed
- Single prescriber and pharmacy only
- Pt responsibilities eg safe storage
- Behaviour expectations eg aggression or intimidation
- Consequences if contract is breached




How to manage problem behaviours when treating chronic pain

Avoid:

- Short acting opioids
- Benzodiazepines
- Joining the patient in catastrophisation of the situation

Seek:

- Time to reflect & consider options
- To discuss case with a colleague, addiction consultant, pain service
- Referral to physiotherapy and/or psychologist



How to manage problem behaviours when treating chronic pain

When problem behaviours are present:

- “Daily supervised dosing at Smiths Pharmacy”
 - Addiction correlates with lack of control, hence external controls need to be placed
- Transfer to transdermal patch
- Random urine drug screen
- Discuss with addiction consultant or PSB pharmacist
- Refer to ADS for review
- In extreme cases, transfer to Opioid Substitution Treatment (OST) ie methadone or buprenorphine



Opiate Dependence Treatment options

Detoxification

- inpatient or outpatient

Relapse prevention

- counselling and psychosocial support
- naltrexone

Opioid substitution therapy

- methadone & buprenorphine



Principles of opioid substitution

- Replacement of injected illegal opiate with regulated supervised oral dose of licit opiate
- reduction in drug use
- reduction in death
- improvement in health
- reduction in criminality and improvement in social outcome
- reduction of spread of BBV



Principles of opioid substitution

➤ Methadone

- Once daily, liquid, 30+ yrs experience
- Preferred treatment during pregnancy

➤ Buprenorphine (Suboxone, Subutex)

- Daily to 3rd daily dosing (long acting)
- Sublingual
- Safety features (bup-naloxone combo)
 - Blocks effect of additional opioid use



Resources

- **DACAS 1800 630 093**
 - 24 hour line to medical officer
 - clinical advice for health professionals
- **ADIS 6222 7511**
 - 24 hour line to drug counsellor
 - confidential counselling on drug related issues
 - Information on specific drug issues
- **ADS North 6336 5577**

Intra-arterial injection of alprazolam

