

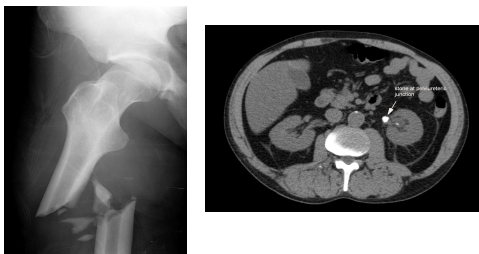
Pain, Suspicion and Substance Abuse in the ED

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Objectives

- By the end of this talk you will be able to:
1. Describe the degree of oligoanalgesia that exists in the emergency department (ED)
 2. Understand the complexities of pain management in the ED for 'drug-seeking' patients
 3. Brainstorm ideas about how pain management for this vulnerable group can be improved in your ED

Pain is common in the ED



<http://renovamedia.com/wp-content/uploads/2009/12/Fracture.jpg> <http://www.imagingpathways.health.wa.gov.au/includes/images/recode/ct1.jpg>

Pain and Emergency Medicine Initiative (PEMI)

- 842 patients aged 8 years and older
- Recruited from 20 US and Canadian settings
- Degree of pain on arrival to the ED was severe (median 8/10)
- Only 60% received analgesics
- Lengthy delays to first dose of analgesia (median 90 minutes, range 0 to 962 minutes)
- 74% of patients were discharged home in moderate to severe pain

Todd KH et al. "Pain in the Emergency Department: Results of the Pain and Emergency Medicine Initiative (PEMI) Multicenter Study" *Journal of Pain* 2007;8(6): 460-466.

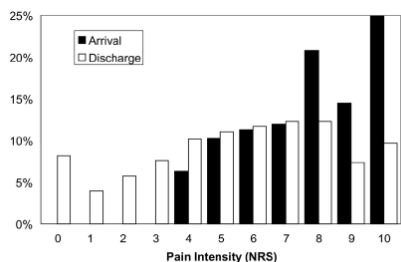
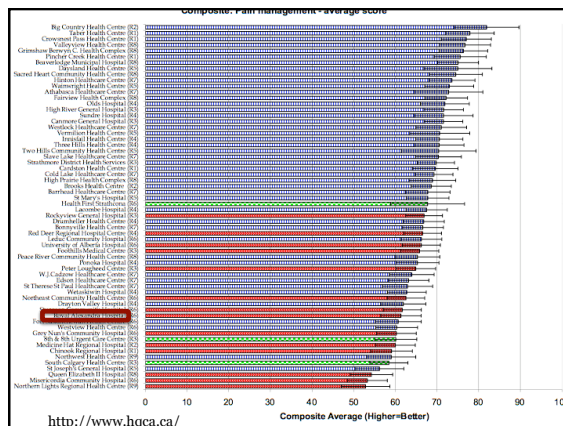


Figure 1. Pain intensity at ED arrival and discharge.



Barriers to Effective Pain Control

- Underestimation of pain
- Limited use of pain assessment tools
- Inadequate knowledge of or a reluctance to use effective pain management strategies (especially in subgroups like the elderly and pediatric patients)
- Perception that it may cloud clinical findings making diagnosis more difficult
- May compromise patient's decision making ability
- Multiple steps involved before pain medication can be given
- We are trained to search for diagnosis and pain is just a symptom
- Opiophobia – inappropriate fears of addiction
- Patient might be “drug-seeking”

Rupp TR, Delaney KA. "Inadequate Analgesia in Emergency Medicine" *Annals of Emergency Medicine* 2004;43(4): 494-503

On the Meaning of Drug Seeking

- Survey of three different nursing groups in an effort to define the term “drug seeking”
- Common themes:
 - Going to different ED's to get opioids
 - Telling inconsistent stories about their pain or medical history
 - Asking for a refill because the script was lost or stolen
- Very likely that the patient is addicted to opioids

McCaffery M, et al. "On the Meaning of 'Drug Seeking'" *Pain Management Nursing* 2005;6(4): 122-136.

Increasing Levels of Suspicion

- Allergies to multiple non-narcotic medications
- Request for a certain pain medication
- Complaints that are impossible to prove or refute (toothache, headache)
- Specialist or primary physician is on vacation
- Visiting from another city and ran out of regular medications

Wilsey BL, Fishman SM. "Prescription Opioid Abuse in the Emergency Department" *Journal of Law, Medicine & Ethics* 2005; Winter:770-782

Balance

Relieve true pain



Protect susceptible patients from the consequences of abusing or becoming addicted to drugs

Case #1: Roy

A 26 year old male presents to the ED on a Friday night complaining of a toothache. He is requesting Percocet to go. You examine his teeth and do not appreciate any abscess or abnormality.

What do you do?

- Give him Percocet to go and advise him to see his dentist on Monday.
- Give him Tylenol and Ibuprofen and tell him to see his dentist on Monday
- Not give him anything for pain and tell him to come back if it gets worse.

Case #2: Crystal

A 34 year old female presents to the ED complaining of pelvic pain. She has recently moved from Ontario and has run out of her regular medication. She is writhing in pain. You order some morphine and Gravol, and start investigations. An hour later the nurse tells you that she is still in pain and is requesting more morphine every five minutes.

What do you do?

- A) Tell the nurse not to give her any more analgesia and discharge her as soon as her investigations come back normal.
- B) Tell the nurse to give her more morphine and to titrate every 15 minutes, until she is comfortable.
- C) Switch her pain medication to Dilaudid.

Case #3: Tony

A 43 year old male presents to the ED complaining of shortness of breath. He is drowsy, but still quite tachypneic. You ask and he tells you that he injected a 'grey' before coming to the ED. His CXR shows a left lower lobe infiltrate and his oxygen saturations are borderline at 90-91% on room air. He complains of chest pain and asks for morphine.

What do you do?

- A) Order him morphine and tell the nurse to give him as much as he wants.
- B) Tell him you won't prescribe narcotics but you will give him Tylenol and Ibuprofen.
- C) Order some morphine but put a limit on the total dose that he can be administered.

Case #4: Barb

A 41 year old female presents to the ED complaining of abdominal pain. She has a longstanding history of Crohn's disease. She tells you that she is followed by the local pain clinic, but that she is out of her morphine pills. You call the clinic and they tell you that she recently broke her pain management contract and that they have discharged her.

What do you do?

- A) Tell her that she has burned all her bridges and not to come to the ED anymore.
- B) Give her resources on Narcotics Anonymous and the local detoxification facility.
- C) Give her a prescription for an opioid taper.

All these patients could be considered 'drug seekers', but their underlying motivations and problems are very different.

It may help to think about this group of patients in four different categories.

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Recreational Drug User

Recreational Drug Users

- Looking for a "high" but are not addicted or chronic users
- May also have been sent to the ED to try and procure drugs for drug trafficking
- Minority of the patients that we see

Hansen GR. "The Drug-Seeking Patient in the Emergency Room" *Emerg Med Clin N Am* 2005; 23: 349-365

Case #2: Crystal

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Pseudoaddiction

Pseudoaddiction

- Behavior similar to addiction that results from poorly managed pain
- Patients appear focused on obtaining medications and "clock-watch"
- Escalating analgesic demands associated with behavioral changes to convince others of the pain's severity
- Behaviors resolve when the pain is managed

Hansen GR. "The Drug-Seeking Patient in the Emergency Room" *Emerg Med Clin N Am* 2005; 23: 349-365

Case #3: Tony

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Chronic Opiate User with an Acute Medical Issue

Chronic Opioid Users With Acute Medical Issues

- At risk for poor analgesic outcomes¹
- Opiate addiction, while important and relevant, may be a secondary issue to their acute medical needs
- ED and inpatient setting can be a place to further address addiction issues

O'Connor AB et al. "Outcomes after Intravenous Opioids in Emergency Patients: A Prospective Cohort Analysis." *Academic Emergency Medicine* 2009; 16:477-487.

High Risk Patient

- Poor treatment of his pain
- Constant threat of withdrawal
- Unfamiliar environment
- Talked about as a "drug user"
- Belongings taken away



Leaving Against Medical Advice

If too sick to leave, drugs brought in by friends

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Chronic Opioid User with Addiction

Chronic Opioid Users

- Difficult problem to manage
- Ideally one primary care provider, one narcotics dispenser

What can we do better?

There are many things that can be done to improve pain management in the ED!

Educational Programs

"There is a large arsenal of analgesic choices available to emergency physicians. Similarly, the range of painful afflictions seen by emergency physicians spans the scope of all medical specialties. One is left to wonder why everyone receives the same doses of morphine, and why discharge options are limited to short-acting combination narcotics and ibuprofen."

Fraschetti DE et al. "Changing Attitudes About Pain and Pain Control in Emergency Medicine." *Emerg Med Clin N Am* 2005; 23: 297-306.

Pain Management Protocols

- Nursing initiated analgesia
- Standardize the pain medications provided in the ED
- More consistent for staff and for patients

Better Discharge Planning

“Percocet 15 tabs to go”

- For the patient in significant pain this will last about 1.5 days
- Belief that the primary care physician should prescribe more opioids or that limiting the amount prescribed will “ensure follow-up” are poor excuses

Fosnocht DE et al. "Changing Attitudes About Pain and Pain Control in Emergency Medicine" *Emerg Med Clin N Am* 2005; 23: 297-306.

Managing Frequent Users

- Try to set up appropriate outpatient services
- Routinely assess patients for problematic drug use and refer to appropriate services
- Consider a “frequent flier program”
- Consider compassionate refusal

Hansen GR. "The Drug-Seeking Patient in the Emergency Room" *Emerg Med Clin N Am* 2005; 23: 349-356

No Easy Solutions

“Cathedrals were places of sanctuary. In violent, turbulent times, they were places of safety and refuge. In hungry times, they were places where the destitute could get a meal. In times of ignorance, they were places where knowledge was preserved. In desperate times, they provided a place where hope lived and kindness and solace could be found.”

Waldman, M "There are still cathedrals in Toronto" *Journal of Emergency Medicine* 12(3): 707-708

Take Home Points

- Pain is inadequately managed in the ED
 - We are under-treating most people
 - We are stigmatizing another group of patients with a chronic illness who are vulnerable and in need of our assistance
- Next time you think a patient is ‘drug-seeking’ consider:
 - Are they looking for recreational drugs?
 - Are they showing signs of pseudoaddiction?
 - Do they have an opioid addiction with a concomitant medical problem?
 - Do they have an unmanaged addiction problem?