

Acute and Chronic Pain Management in the Opioid Dependent Patient

Douglas Gourlay, MD, MSc, FRCPC, FASAM
Wasser Pain Management Centre
Mount Sinai Hospital

Outline

- Demographics
- Pain and Chemical Dependency
 - The Problem
- Acute/Chronic and Acute-on-Chronic Pain
- Treatment Strategies
- Special Concerns

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Demographics I

- Patients with CNCP on long-term opioid therapy
 - Most are not complicated by addiction
 - Triage Group I (of I, II, III)
 - Commonly multiple medications
 - Not only opioid agonists i.e. BZD
 - Often have some degree of tolerance
 - ? hyperalgesia / withdrawal mediated pain

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Demographics II

- Office-based agonist therapy (NTP)
 - Clearly established addiction history
 - Typically polysubstance users
 - On either methadone OR buprenorphine
 - Once daily dosing is the rule
- Often in various stages of recovery
 - Very sick ← [patient] → very healthy

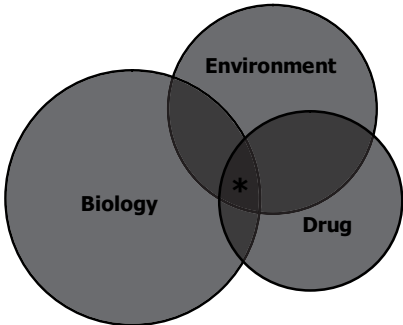
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The Problem

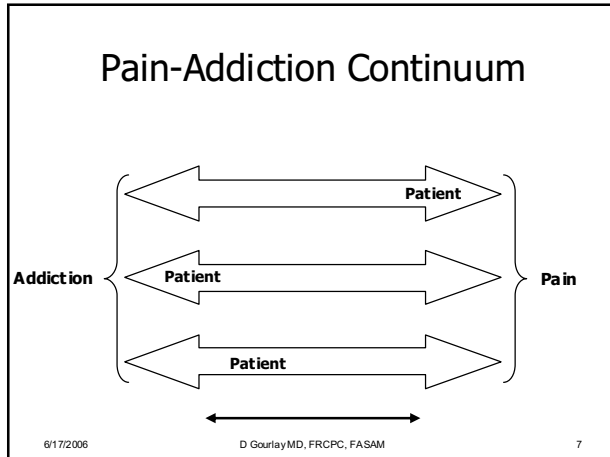
- Pain and Addiction CAN coexist
- Addiction in General Population
 - Varies 3 – 16% prevalence
 - Varies with the drug, gender, economic status, race, age...
- Addiction in the Chronic Pain Population
 - We really have no idea
 - We use the same terms, with different meaning
- Lack of precision in definitions around abuse/dependency/addiction

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Addiction *



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- ### Types of Pain
- Acute
 - Anticipated (Planned Surgery, Physiotherapy)
 - Unanticipated (Trauma, surgical emergency)
 - Chronic
 - Stable
 - Progressive
 - Acute-on-Chronic
 - Trauma
 - Breakthrough / Withdrawal mediated?
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- ### Treatment Approach
- Is there Pain/Addiction or Both?
 - Is the addictive disorder dominant?
 - Never dismiss or minimize the pain complaint.
 - Is the pain likely opioid responsive?
 - Have non-opioid modalities been tried?
 - Do you have the resources to treat this?
 - Get a pain/addiction doctor in to co-manage
 - *"You can't solve CNCP in context of untreated active addiction"*
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- ### Treatment Strategies
- In methadone patient
 - Take once-daily dose and split in three/four
 - Titrate the TID/QID doses to effect
 - Consider 5-10mg unit doses for breakthrough
 - Advantages
 - Urine drug screens remain interpretable
 - Cost effective, Easily tolerated, easier to return to OD dosing
 - Disadvantage
 - Potentially unstable pts need take-home doses
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- ### Treatment Strategies
- In buprenorphine patient
 - Split dosing TID or QID
 - μ effect linear up to 6-8mg (per dose?)
 - 40:1 MS : buprenorphine
 - Advantages
 - Urine drug screens remain interpretable
 - Able to remain on buprenorphine program
 - Disadvantages
 - High receptor affinity may make other μ agents less effective
 - Ceiling effect may limit use to mild/moderate pain
 - Caution with benzodiazepine use / diversion risk
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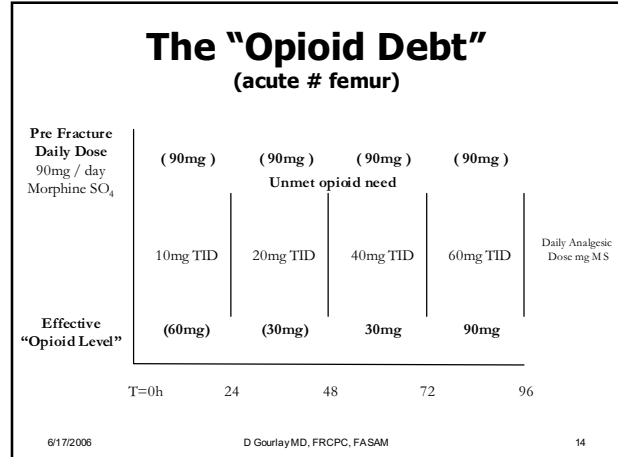
- ### Treatment Strategies
- Use alternate opioid (maintain OAT)
 - Avoid prn dosing
 - NEVER use partial μ agent in μ dependant
 - Start with IR agents and switch to CR agents once dose known
 - Advantages
 - Patients more readily accept this approach
 - Disadvantage
 - May be hard to interpret Urine Drug tests
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Treatment Caveats I

Do Not incur an opioid debt!

- Partial μ agents are contraindicated in acute pain management
 - BUT you can always add a pure μ agent to a partial μ without risk of withdrawal
- Previously ineffective agents may now work
- PCA pump NOT contraindicated in addictive disorders

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Treatment Caveats II

- Avoid PRN dosing, don't avoid opioids
 - Time limited prescription of oral opioids on discharge
 - Avoid combination products
 - Avoid polypharmacy
- Increase recovery-oriented activities including Urine Drug Screening
- Relapse is more often due to inadequate pain relief than too much medication

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Treatment Caveats III

- Maintain tight boundaries
 - Formal treatment agreement
 - One prescriber/one pharmacy
 - Limited prescription quantities
- Be alert to aberrant behavior
- Pain treatment typically involves multiple daily dosing schedules

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Special Concerns

- Perioperative strategies
 - Regional or combined technique if possible
 - Consider indwelling epidural/intrathecal catheter for procedure/post-op period
 - Anticipate venous access problems
- Postoperative Analgesia
 - Opioid dependent patients may be more pain sensitive – they often need more, and need it more frequently

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Special Concerns

- Caution regarding 'first dose (s)' in hospital setting
 - First sign of drug diversion may be opioid overdose
 - Split doses and reassess prior to next dose
- Positive UDS
 - +ve cocaine is more concerning than THC
 - -ve UDS does NOT (always) mean diversion

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Dental Analgesia

- Dental Procedures
 - Speak with dentist prior to procedure
 - Maintain status quo with daily opioids
 - Post procedure analgesia as for any other patient BUT avoid past drugs of abuse
 - NSAIDs are usually the best agents for dental pain
 - Positive urine drug screens are common after dental procedures – assess behavior NOT just the screen

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Obstetrical Analgesia

- Speak with attending OBGYN in advance
- Maintain status quo with daily opioids
- At time of delivery, regional analgesic techniques are preferred
- In case of methadone, total daily dosing requirement will drop in first 1-2 weeks
- Breast feeding not contraindicated

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What about Buprenorphine?

- High receptor affinity may interfere with effectiveness of other analgesics
 - Advise discontinue and switch to alternative agent (pure μ) if time permits
 - Fentanyl may be a better choice for acute pain management with buprenorphine on board
 - not easily reversed with antagonist agents

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Buprenorphine cont.

- Like all partial μ agonists, contraindicated in opioid dependent patients
- BUT as an agent for chronic pain management has many enviable qualities
 - Potent (40:1 MS over linear range)
 - Long duration of action (>24h) as an opioid substitution agent – BUT q6-8h analgesic duration

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Summary

- Chronic opioid users often have lowered pain thresholds
- Usually require opioid dose increase (if opioid responsive pain) and more frequent dosing of opioids for analgesic effects
- Relapse is a risk, but poorly managed pain may be a greater risk than the rational use of prescribed analgesics

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