



Is it pain or addiction?

The role of Methadone in handling
the tough ones.

The most difficult patients


- Strong family history of addiction
- No personal history of addiction
- Chaotic personal life
- History of childhood abuse
- Poor relationship history
- Problems with boundaries
- Relatively little visible pathology
- Poor stress coping mechanisms
- Poor emotional dealing skills

Pain Patient vs. Opioid Abuser

- Controls meds
 - Meds improve QOL
 - Complains of side effects
 - Concerned re: risk of addiction
 - Follows agreed upon treatment plan
 - Left over meds, does not run out of or lose meds
- Can't control meds
 - Meds decrease QOL
 - Wants meds despite S/E
 - Denies possibility of addiction
 - Does not follow treatment plan
 - Seldom has meds left over – excuses for lost meds



- Asking for more pain meds or specific meds
- Drug hoarding
- Openly getting meds from other MDs
- Occasional dose escalation or other non-compliance
- Treating another symptom with opioids
- Unintentional psychic effects
- Resistance to change in therapy that is working
- Intense anxiety about recurrent symptoms

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- Rx drug: selling, stealing, forgery
 - Injecting oral formulations
 - Obtaining Rx drugs from the street
 - Concurrent abuse of ETOH or illicit drugs
 - Repeated non-compliance despite warnings
 - Double doctoring
 - Drug-related deterioration in function
 - Resistance to change in therapy despite evidence of adverse drug effects



Addiction

A complex biopsychosocial disorder
with strong genetic factors.





Addiction

- Chronic
- Progressive
- Relapsing
- Often fatal





Characteristics

1. Loss of control
2. Continued use in presence of adversity
3. Reduction in function
4. Development of tolerance
5. Drug seeking behavior
6. Withdrawal
7. Physical effects
8. Behavioral changes. using or not



The 4 C's of Addiction

- Loss of Control
- Compulsive Use and Craving
- Consequences (Use Despite Harm)

Destroys

- Family
- Relationships
- Health
- Finances
- Job/career
- Reputation-morals
- Person
- Community---isolation



CHRONIC PAIN

1. Pain persisting after an initial insult
2. Doesn't respond to usual treatment modalities
3. Increased pain sensitivity (neuroplasticity)
4. Depression/anxiety
5. Frustration/anger
6. Pseudoaddiction
7. Family and financial issues
8. Loss of control
9. Behavioural changes

CHARACTERISTICS OF CHRONIC PAIN

1. Loss of Control
2. Behavioural changes
3. Physical changes
4. Family Problems
5. Relationship problems
6. Financial problems
7. Drug seeking behavior
8. Dose escalation
9. Progressive Isolation
10. Relapsing Nature of Pain





Characteristics of addiction

1. Loss of control
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Assessing Addiction Risk

- Screening – Ask the patient!
 - SISAP, CAGE, TICS
- FHx of ETOH, drug abuse, psych illness
- Significant psychiatric diagnoses
 - Bipolar, psychosis, borderline, anti-social PD
- HPH: physical, sexual, emotional abuse
- Previous impulsive / criminal behaviour
- High risk home environment
- Addiction consult

Urine Drug Screening

- Random witnessed urines are the ideal
- Know what the detection limits are for each substance in your local lab
 - Esp. oxycodone, fentanyl, and methadone
- Commonest way to fool a UDS is via dilution or adding a masking substance
 - Urine SG, Creatinine, pH
- Substituting some else's urine
 - Check for temperature after specimen provided
- Should UDS be a “universal precaution?”

<http://www.familydocs.org/UDT.pdf>



C.A.G.E. QUESTIONNAIRE

- Cut down on your drinking?
- Angry about confrontation?
- Guilty about your drinking?
- Early morning drinking?



Assessing Addiction Risk: TICS

- Two Item Conjoint Screening Tool (TICS)
- In the last year have you ever drank or used drugs more than you meant to?
- Have you felt that you wanted or needed to cut down on your drinking or drug use in the last year?

“Yes” to either = 80% sensitivity in diagnosing substance use disorder

Assessing Addiction

Risk: SISAP

- Consumes more than 5 drinks or more / typical day
 - Women: 4 drinks or more / typical day
- Consumes more than 17 drinks or more per week
 - Women: more than 13 drinks or more per week
- Smoked marijuana or hashish for recreational purposes in the past year
- Cigarette smoker
- Age 40 and under



Assessing Addiction Risk

- Both pain and addiction can co-exist in the same patient
- This does not necessarily preclude the use of opioid therapy



Opioid Therapy for the High Risk Patient ?

More assessment...

More structure ...

More monitoring...



Opioids for the Higher Risk Patient

. . .More Assessment

- More investigation/consultation
- More confirmation of previous history
- Collateral information from significant others
- More detailed assessment of function
- More attention to side effects and patient response

The Higher Risk Patient

. . . More Structure

- More use of concurrent treatments
 - Physical / Adjuvant analgesics / Cognitive Behavioural
- Written agreement
 - One prescriber
 - No replacement of “lost” scripts
- One pharmacist for all Rxs
 - Shorter dispensing intervals
 - No phone repeats for opioids
 - Preferential use of LA opioids
 - BID, once-daily or transdermal patch



Written Prescribing Agreements

Do they Change Patient Behaviour?

- No good evidence so far
- May help to demonstrate informed consent
- May also put an obligation on the doctor!

The main benefit of a written agreement is to the doctor NOT the patient.

Fishman S. 1999, 2000, 2002

Methadone

- A long-acting μ and Δ opioid agonist with NMDA blocking properties
 - a good option in neuropathic pain
 - opioid of choice in pregnancy
- Variable equianalgesic dose to other opioids
- Requires more careful initial titration
- Many drug interactions with CYP450 3A4
- Special authorization from Health Canada



Reasons for using Methadone

Opioid dependency: Reduction of craving

Palliative Care: Reduction of pain

Chronic non malignant pain: Improved function

Rapid opioid detoxication



CHARACTERISTICS OF ADDICTIVE DRUGS.

- EASE OF ADMINISTRATION
- RAPID ABSORTION
- SPEEDY ONSET OF ACTION
- GOOD HIGH
- FAIRLY RAPID EXCRETION
- MINIMAL WITHDRAWAL
- ABSENCE OF UNWANTED EFFECTS



METHADONE

- DIFFICULT ADMINISTRATION
- SLOW ABSORPTION RATE
- POOR HIGH
- LONG ACTING
- PERSISTENT SIDE EFFECTS
- PROLONGED WITHDRAWAL
- GOOD ANALGESIC





JUICE OR PILLS





METHADONE MAINTENANCE

A HARM REDUCTION PROCESS
USED WITH OPIATE
DEPENDENT INDIVIDUALS TO
ALLOW INDIVIDUALS TO
ACCESS TREATMENT
PROGRAMS WHILST
CONTROLLING CRAVING AND
DRUG SEEKING BEHAVIOR



Rough rules of thumb

The greater the addiction risk, the longer acting the opioid.

When in doubt as to the diagnosis. Is it pain or addiction, default to the most serious illness, addiction.

Addiction is about loss of control. YOU have to do the controlling.

Always trust the patient, NEVER trust the disease.

Using Methadone for ?Dual diagnosis Patients

Clean random urine screens (?THC)

Evidence of reduced alcohol intake

Very limited carries

One pharmacist

Regular appointments

Dosage titrated against function

Doses may be split if stable

Drug and alcohol counseling





What if?


Screens continue to be positive

Alcohol use continues to be a problem

Suspicion that Methadone is being sold

Patient becomes abusive

REFER TO OPIOID DEPENDENCY
PROGRAM



If all attempts to stabilise the Patient fail then rapid opiate withdrawal is appropriate. Daily decrease of 10%. Clonidine may be used to limit withdrawal symptoms.





Mr K.T.

Back Injury

Rest and analgesia

WCB

Orthopaedic surgeon---MRI

Surgery---percocet

Pain worse---more percocet

Second surgery

Pain worse----even more percocet

Early repeats,lost meds,

Mr K.T.

- Fired by physician
- Medicentres and ERs
- Refused analgesics
- Buys meds off the street.. Oxycontin the best
- Uses I/v.morphine SR.Develops septicaemia
- Develops abcess in cervical spine
- Lengthy stay in hospital and rehab
- Oxycontin used in hospital.
- Referred to Pain clinic



Mr K.T.

Initial assessment: at risk but ?pseudoaddiction

Addiction assessment: FH addiction, 3 impaired driving charges, history of poly substance use over the years. History of I/v drug use. CAGE, MAST, DAST positive. MMS 30/30. On AISH. No work for 5 years.

Team decided against the use of anything other than methadone. Initial screen pos for cocaine and Morphine and oxycodone(Rx).

Warned and rescreened twice weekly. Urines clear other than Rx oxycontin daily carries.

Mr K.T.

Methadone started and titrated daily carries
Dosage split bd then tid. screening continued.
Pain improved as did functionality. Stabilised and
over six months carries gradually increased to
weekly. Random screening over 4 years 4 cocaine
pos screens. Resulting in rapid appointment,
reduction in carries, increased screening. Then
gradual increase in carries with neg screens.
AA/NA encouraged, eventually discontinued.
Now involved in church group and works part
time to supplement AISH. Current screens neg.