

GreeneStone Muskoka www.greenestone.net

Host: Detailing Addiction on America's Web Radio

Ethics Issue for Today

- Dilemma of treating patients with cooccurring DX of Addiction and Pain
- Use of Pain Medication vs. Abstinence model of recovery
- Balance the Risk of Relapse from pain and depression vs. the Risk of Relapse from pain medications.
- <u>EVERYONE</u> in Recovery or Monitoring <u>WILL</u> face this dilemma in their <u>LIFE</u>

Case Study: Buddy

- 36 year old male recovering Opiate addict
- Got into treatment at age 24 after about 7 years of use
- Had a few slips, but with the aid of a good sponsor, has done well
- Injured in MVA-fractured pelvis, both legs and injury to lower back
- Surgery and Rehab went well
- 6 months post op still in pain......

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Questions: Buddy

- Do you put him on opiates for pain?
- Tell him he has to just learn to deal with the pain?
- Which is the greater risk to his sobriety?
- Untreated pain?
- Exposure to opiates?



Case Study: Mary

- 45 year old homemaker
- No previous history of addiction
- Some family history, but vague
- Pain Management for L4-5 degenerative disc
- Recent change from short acting hydrocodone to long acting oxycodone
- Broke her medication contract, began to increase the dose of medication

Questions: Mary

- Does Mary have addiction?
- Tolerance?
- Poor response to oxycodone?
- Is she diverting medications?



JCAHO Pain Standards

- Minimize meperidine use
- Minimize DPT use (Demerol, phenergan, thorazine)
- Reduce use of IM route and PRN orders
- Reduce procedure pain, e.g., use of EMLA and **buffered lidocaine**
- Pain ratings > 2/10 require intervention; >4/10 consider opioid
- Side effects of opioids are to be prevented, constipation (no tolerance develops) Nausea/Vomiting and sedation (tolerance develops)

The Ten Commandments of Pain Management



- 1. Thou shalt believe the patient's report of pain.
- Thou shalt assess and reassess the patient's response to pain interventions.
- Thou shalt not be afraid of prescribing or administering opioid analgesics.
- Thou shalt not prescribe inadequate amounts of any analgesic.

ed from Twycross, R: Practical Palliative Care Today. Spring 2000, Vol. 2. Center for Palliative Studies at San Diego Hospice, San

The Ten Commandments of Pain Management, (cont'd)

- 5. Thou shalt not use the abbreviation PRN for continuous pain, but ATC (around the clock).
- 6. Thou shalt reassure the patient and family that risk of opioid addiction is rare.
- 7. Thou shalt provide support for the whole family.
- 8. Thou shalt not limit thy approach simply to the use of analgesics, but also adjuvant drugs and "mind-body" techniques.

Modified from Twycross, R: Practical Palliative Care Today. Spring

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The Ten Commandments of Pain Management, cont'd



- 9. Thou shalt prevent or treat side effects of opioids.
- 10. Thou shalt not be afraid to ask colleagues' advice.

Modified from Twycross, R: <u>Practical Palliative Care</u>
<u>Todav</u>. Spring 2000, Vol. 2. Center for Palliative
Studies at San Diego Hospice, San Diego.

Screener and Opioid Assessment for Patients with Pain (SOAPP®)

- Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R) The Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R) is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require
- SOAPP-R is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy.

The Current Opioid Misuse

- The COMM™ examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medicationrelated behaviors over the course of treatment. The COMM™ ic:
- • A quick and easy to administer patient-self assessment
- • 17 items
- • Simple to score
- • Completed in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.

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Patient Care Contract

I agree to begin ambulatory medication taper under the care of Susan Blank, MD and staff at GreeneStone Muskoka , on _____under the

following conditions of treatment:

following conditions of treatment:

a grace to take all medications as directed, not skipping
doses or escalating doses.

a understand that I may NOT operate a motor vehicle
while on medications or until otherwise advised by
Foundations Atlanta medical staff.

a gree to attend ALL scheduled appointments.

will abstain from ALL Drug, illicit substances and alcohol

 will not obtain any medications from other physicians or other sources.

I will submit to random urine drug screens when

requested. I agree that if I do not abide by the above conditions of treatment, or if I become medically unstable at any point during the ambulatory tapering process, as determined by the medical staff, I will enter inpatient detoxification.

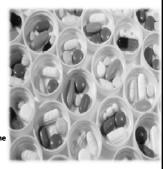
 I agree that if I do not abide by this agreement, I may be terminated as a patient. I agree that GreeneStone is not a pain management program and that following my medication taper, I will resume care with my pain doctor and other health care professionals.

I have read and understand this agreement.

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Non-Opiate Non-Benzo Options

- Anticonvulsants
- SSRI
- SSRI/NE
- NSAIDS
- Clonidine
- Ultram??? Topicals.
- Lidoderm
 - Gabapentin / Clonidine
- Piroxicam Tablet Triturates
- Ibuprofen Suppositories
- Ketoprofen / Cyclobenzaprine Topical
- Ketamine Gel



Herbal Therapies for P

- Arnica Montana: 2/4 studies + for osteoard and post surgery
- Capsaicin: 11/14 studies + for post surgical, osteoarthritis, DM neuropathy
- Omega 3: 2/3 studies + for musculoskeletal pain
- Devil's Claw: 3/4 studies + non-radicular back pain, muscular pain
- Epsom Salt (Mg++): 7/7 + potentiates opiates, Infusion, topical, Oral formulations

Every Patient with Addiction:

- Must have a discussion with their treatment team/monitor about Pain.
- Must develop a protocol fo dealing with planned procedures that may be painful.
- Must discuss how to handle acute pain in crisis
- Must know to come back to discuss medical management of illness requiring injections

Drugs We Hate for Patients with Addiction

- Xanax
- Actiq



Formulation may make the Difference



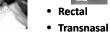
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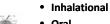


- Intraventricular
- Intravenous
- Intramuscular
- Subcutaneous









- Oral
- Sublingual
- Topical



Safe Guards			
✓ Addictionologist consul	Sponsor/Family/SO		
✓ Get Board/Monitoring entity approval	/Monitor aware of Rx Plan, signs of relapse		
	Consider supportive experience for acute or post- op pain		
	Consider surgery, pain pump		

Safe Guards

Do not Use Drug of Choice

Prevention Contract

"Pre-Treat" with medications:

- Campral
- Antabuse
- Provigil?
- Wellbutrin?
- Not Naltrexone

✓ One provider write all medications

or SCS sooner rather than later

✓ Encourage alternate Rx

- ✓ Small amounts of medications at one time
- ✓ Expanded UDS and increased frequency of UDS
- ✓ NO PRN's, Meds on Schedule with Pain Journal

Ethics of Pain Management

- No Easy Answers
- Either Treating or Not Treating pain presents a relapse risk
- Care Monitoring and relapse prevention plan are musts
- Pt should be in active recovery program
- Damned if you do, Damned if you don't

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Useful Web Sites:

- American Society of Addiction Medicine <u>www.asam.org</u>
- American Society of Pain <u>www.ampainsoc.org</u>
- Pain Education Resources www.painEDU.org
- American Academy of Pain Management <u>www.painmed.org</u>
- Calloway Labs (drug tests pain/addiction) www.callowaylabs.com