CHAPTER 11
OPIOID THERAPY IN SUBSTANCE ABUSERS

A history of serious drug abuse or addiction complicates treatment that incorporates potentially abusable drugs, including opioids. However, it is not a contraindication for such therapy. Short-term opioid therapy for acute pain, particularly in a monitored setting, usually can proceed without difficulty. Indeed, undertreatment is widely considered to be a serious challenge among these patients and may relate to both the reticence to prescribe on the part of clinicians and nonadherence with therapy on the part of the patient.

Long-term opioid therapy presents a more challenging issue. A trial of opioid treatment for pain related to serious medical illness, such as cancer or AIDS, is generally appropriate. Treatment of patients with severe nonmalignant pain syndromes is best considered on a case-by-case basis. In all situations, the decision to implement a trial must be based on a careful evaluation, which must be clearly documented. Treatment requires ongoing assessment and skillful adaptation of the principles that have proved essential in the optimal management of patients with no history of drug abuse. Although there are very few data pertaining to the outcome of long-term therapy in populations with drug abuse or addiction, the observations of specialists suggest both that the risks are increased, particularly among patients with recent or active drug abuse, and that many patients have the ability to respond favorably.

Assessment issues

History taking that reviews substance use should be part of every pain assessment and must be detailed whenever a patient has a suspected or known history of drug abuse. Highly comprehensive, structured interviews have been developed for this assessment but are used only in research settings. Clinicians should ask nonjudgmental questions about past and present drug use, both licit and illicit. These questions should attempt to clarify the nature of this use and its impact on varied domains of function. Questions about the nature of use should focus on quantity and frequency of drug intake and the extent to which it appears controlled or compulsive and out of control. Those focused on the impact of use should explore physical effects (such as hospitalizations or visits to the emergency department),

legal problems, trouble at work, interference in relationships, and other pertinent outcomes.

Extensive experience suggests that matter-of-fact questioning usually yields openness and responses that appear accurate over time. Some patients dissemble, of course, and when it is crucial to be sure, confirmatory information should be sought. Generally, however, this substance use history yields information sufficient to categorize the patient in terms of current risk and to clarify the type of structure that will be needed should treatment with a controlled substance be pursued.

Categories of substance abusers

To help categorize patients according to risk, it is worthwhile to broadly distinguish into 3 groups those with a history of substance abuse.

Drug-free recovery

The first group, patients in an established drug-free recovery, often appears clinically to present more of a problem with undertreatment than abuse. If opioids are necessary, such as after surgery or trauma, or if long-term treatment is considered for chronic pain, a history of abuse may increase both the risk of inadequate prescribing and a reluctance of the patient to accept the therapy.

Notwithstanding the risk of undertreatment, these patients also should be viewed as being at relatively higher risk of aberrant drug-related behavior than those without such a history. For this reason, consideration must be given to creating a more defined structure for prescribing at the start of therapy (see chapter 10). This structure may be reassuring to both the treating clinician and the patient and may assist the at-risk patient in maintaining control. The specifics depend on the assessment. For example, the patient who has been in recovery from a primary alcoholism for more than 20 years and still attends daily peer support meetings probably requires less structure than a patient with a polysubstance abuse history whose recovery spans less than a year.

History of opioid abuse

The second group includes patients with a history of opioid abuse who are currently in substitution therapy with methadone or buprenorphine. These patients also are at high risk for undertreatment. Negative attitudes of the clinician may combine with some degree of analgesic tolerance to limit the efficacy of therapy. Assessment of a patient who requires substantially higher

starting doses than most and complains about persistent pain may be very challenging. At times, an empirical approach centered on a therapeutic trial of higher doses and close monitoring of subsequent behavior is the only reasonable, and humane, strategy. This may be a jusifiable indication for inpatient care.

There are important differences between the use of methadone as an analgesic and its use as a substitution therapy for opioid addiction. In pain management, doses of methadone must be titrated according to patient response; there is no predefined appropriate dose range, and most patients require doses 3 to 6 times per day to maintain consistent analgesia. The latter observation is supported by studies that demonstrate a duration of analgesia that is typically much briefer than would be expected from the half-life of this drug. When methadone is used to block craving in addiction, a once-daily dose is sufficient, and most patients require doses less than or equal to 120 mg per day.

Methadone can be used to treat pain in patients receiving methadone maintenance, but the clinical distinctions and the parallel regulatory issues must be understood. Any clinician can prescribe methadone for pain, but maintenance for addiction treatment requires a federal license. If methadone is used for pain management in the patient receiving methadone maintenance, clear documentation is required that describes this use and distinguishes it from addiction treatment. If it is used as an analgesic, dosing frequency should be increased and the dose should be titrated against pain.

Patients with a history of opioid addiction who are given long-acting opioids, including methadone, for pain do not also need substitution therapy with methadone or buprenorphine to block drug craving. Nonetheless, some patients prefer to continue in a program during pain treatment with an opioid. The reasons for this are varied and may involve support systems provided by some programs or a persistent fear of relapse into addiction. Patients can remain in programs and also receive an opioid for pain as long as the 2 treatments adhere to regulations and the various clinicians are communicating.

Office-based buprenorphine therapy is beginning to be used in the United States. Although many of the issues surrounding pain management are likely to mirror those encountered in the methadone-maintained population, there are several unique considerations. Buprenorphine has an affinity for the opioid receptor that far exceeds the affinity of other agonist opioids. To treat acute pain, and presumably chronic pain, it will probably be necessary to use doses of another opioid that are substantially higher than those required by patients who are not receiving

buprenorphine. Experience is yet too limited to develop guidelines for this treatment, but the known pharmacology suggests that clinicians must be prepared to titrate the dose of a second opioid agonist aggressively or risk undertreatment. Substitution therapy with buprenorphine may pose additional challenges for pain treatment, because it is an office-based treatment and depends largely on the efforts of a single clinician. If these patients are referred for pain management, the need for communication and documentation is apparent.

Ongoing abuse

The third group of drug abusers broadly includes patients with an active ongoing abuse problem. This is obviously a highly diverse population that includes addicts and nonaddicts, single-drug abusers and polydrug abusers, and those with various medical and psychiatric comorbidities. In varied subpopulations, comorbid psychiatric disease and adverse situational factors may be profound enough to undermine any effort to implement an effective pain management strategy.

Management strategies for opioid therapy

Clinicians who learn to implement strategies to manage risk should be comfortable implementing a necessary opioid regimen for acute pain or chronic pain in severe medical illness. They also may feel empowered to consider opioid therapy in other patients with chronic pain. The specific management strategies must be individualized on the basis of patient assessment. A broad framework that recognizes the special challenges that might be posed by a patient with a known history of substance abuse includes the following considerations.

Accept the patient's self-report of distress

The dictates of humane and compassionate care should support a bias that patients generally should be believed. Although addiction, other psychiatric disorders, and psychosocial factors can profoundly influence pain presentation, malingering and factitious pain complaints appear to be rare even among patients with a history of substance abuse. Unless the evidence is compelling, it is more productive simply to believe the patient's complaint and thoughtfully assess the degree to which it can be explained by physical and psychologic determinants.

Consider opioids within a multimodality approach

A multimodality approach should be considered for all patients with chronic pain. When the risk of problematic drug-related

behavior is relatively high, the need to consider alternative strategies or concurrent therapies that may reduce the opioid requirement is especially important.

Define and use a treatment team

A treatment team typically is developed ad hoc depending on the complexity of the problems posed by the patient. The team may involve a specialist in addiction, the patient's sponsor, a pharmacist, the patient's spouse or significant other, and various clinicians who can address different pain management approaches. Agreement on the treatment plan by the entire team enhances patient care, and communication among the team is essential to prevent mixed messages, duplication of prescriptions, or inadvertent violations of the opioid treatment plan. If the treatment plan includes continued attendance at peer support meetings, the clinician can demand from the patient signed slips that document attendance.

Consider pharmacologic issues

Patients with a history of active opioid abuse or ongoing substitution therapy may require higher doses or more rapid titration. Specifically, drug tolerance and the higher opioid receptor affinity of buprenorphine may alter dosing expectations when prescribing opioids for pain in patients taking buprenorphine substitution therapy.

Structure therapy based on the perceived level of risk

As discussed in Chapter 10, a variety of strategies can be implemented to increase the likelihood that the therapy will be controlled and to enhance the opportunity for monitoring outcomes. Consideration of these strategies is essential in the population of known drug abusers. Treatment of chronic pain often requires more intensive elements, such as the use of a written agreement, urine drug screens, and prescriptions for small amounts with frequent visits. Similar to the management of the patient without a drug abuse history, the structure of prescribing can be made less strict over time should a patient demonstrate consistently responsible drug use.

Suggested reading

Portenoy RK, Payne R. Acute and chronic pain. In: Lowinson JH, Ruiz P, Millman RB, eds. Substance abuse: a comprehensive textbook. 3rd ed. Baltimore: Williams & Wilkins, 1997:563-90