

CHRONIC PAIN AND SUBSTANCE USE DISORDERS

Telling the Difference and Caring for
Patients

YOUR SPEAKER

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DISCLOSURES

- ▶ I have no financial interests to disclose

OBJECTIVES

1. Participants will learn ways to recognize and identify substance use issues in patients who have pain
2. Participants will learn ways to communicate with pain patients about substance dependence and use disorders
3. Participants will learn about the spectrum of substance use disorders
4. Participants will learn how to treat pain in patients while keeping them as safe as possible

SCREENING TOOLS

Instrument	Population	Description	Link
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	Adults & Adolescents	8-item screening tool developed by WHO to screen for multiple substances	https://www.who.int/management-of-substance-use/assist/

SCREENING TOOLS

Instrument	Population	Description	Link
Alcohol Use Disorders Identification Test (AUDIT)	Adults and Adolescents	10-item screening tool developed by WHO for hazardous alcohol use	https://www.who.int/substance_abuse/activities/sbi/en/
AUDIT-C	Adults	First 3 questions of AUDIT	https://www.hepatitis.va.gov/alcohol/treatment/audit-c.asp

SCREENING TOOLS

Instrument	Population	Description	Link
CAGE (Cut down, Annoyed, Guilty, Eye-opener)	Adults (people older than age 16)	4-item, non-confrontational questionnaire for alcohol use disorders	file:///C:/Users/evagn/AppData/Local/Temp/CAGE_questionnaire.pdf
CRAFFT (Car, Relax, Alone, Forget, Family or Friends, Trouble)	Adolescents	6-item screening covers alcohol and drugs and situations relevant to adolescents	https://med.dartmouth-hitchcock.org/documents/CRAFFT-adolescent-substance-use-screen.pdf

SCREENING TOOLS

Instrument	Population	Description	Link
Drug Abuse Screening Test (DAST)	Adults	20- and 28-item adaptation of the Michigan Alcohol Screening Test (MAST) to detect consequences related to drug abuse without specifying the drug	20-item https://adai.uw.edu/instruments/pdf/Drug_Abuse_Screening_Test_105.pdf

SCREENING TOOLS

Instrument	Population	Description	Link
DAST-A	Adolescents	28-item DAST for adolescents	http://www.socialworkerstoolbox.com/drug-abuse-screening-test-for-adolescents-dast-a/

SCREENING TOOLS

Instrument	Population	Description	Link
Fagerstrom Test for Nicotine Dependence	Adults	6-item test evaluating cigarette consumption	http://www.pharmacists.ca/cpha-ca/assets/File/membership/Fagerstrom%20Tolerance%20Scale.pdf

SCREENING TOOLS

Instrument	Population	Description	Link
Michigan Alcohol Screening Test (MAST)	Adults, Adolescents, Seniors	24/5-item instrument providing a general measure of lifetime alcohol problem	<p>https://www.anitamcleodcounseling.com/userfiles/4702580/file/MAST%20updated.pdf</p> <p>Geriatric MAST (MAST-G): https://www.ncbi.nlm.nih.gov/books/NBK64829/#A46031</p>

SCREENING TOOLS

Instrument	Population	Description	Link
NIDA Drug Use Screening Tool	Adults	A 1- to 7-question screening tool adapted from the WHO's ASSIST	https://www.drugabuse.gov/sites/default/files/pdf/screening_qr.pdf

SCREENING TOOLS

Instrument	Population	Description	Link
TWEAK (Tolerance, Worried, Eye- openers, Amnesia, [K] Cut Down)	Adults and pregnant women	A 5-item scale to screen for risky drinking	https://adai.uw.edu/instruments/pdf/TWEAK_252.pdf

SCREENING TOOLS

- ▶ Many are embedded in electronic health record
- ▶ The best screening tools are the ones that get used
- ▶ Simple is better
- ▶ Longer gives more information
- ▶ Self evaluation vs provider directed questioning
 - ▶ Think about literacy, privacy, timing, and time spent

WHAT DO WE SCREEN FOR?

- ▶ What is the deadliest substance?
 - ▶ Tobacco?
 - ▶ Alcohol?
 - ▶ Opiates?
 - ▶ Stimulants?

HARMFUL SUBSTANCES

- ▶ Tobacco

- ▶ The top causes of death in the United States are directly connected to tobacco use (heart disease and cancer) (CDC)

- ▶ Alcohol

- ▶ The third leading cause of death in the United States, killing about 88,000 Americans in a year (NIH.gov)

- ▶ Opioids

- ▶ Killed about 47,000 people in 2017 (CDC), but I think this number is under-represented

- ▶ Benzodiazepines

- ▶ Stimulants

SIGNS AND SYMPTOMS

- ▶ Amount
 - ▶ Take the substance in larger amounts and for longer than intended
- ▶ Control
 - ▶ Want to cut down or quit, but unable to
- ▶ Time
 - ▶ Spend large amounts of time obtaining the substance
- ▶ Cravings
 - ▶ Experience cravings or strong desires to use the substance
- ▶ Obligations
 - ▶ Repeatedly unable to carry out major obligations at work, school, or home due to substance use

SIGNS AND SYMPTOMS

▶ Social

- ▶ Continuing to use the substance despite persistent or recurring social or interpersonal problems or harm to relationships.

▶ Activities

- ▶ Stopping or reducing important social, occupational, or recreational activities due to substance use.

▶ Hazard

- ▶ Continually using the substance in physically hazardous situations such as driving under the influence.

▶ Harm

- ▶ Consistently using the substance, despite knowledge of the substance causing persistent or recurrent physical or psychological problems.

SIGNS AND SYMPTOMS

- ▶ Tolerance
 - ▶ Building a tolerance – the need for markedly increased amounts of the substance to achieve the desired effect or a markedly diminished effect with continued use of the same amount of the substance.
- ▶ Withdrawal
 - ▶ Feeling withdrawal symptoms as either a characteristic syndrome or when the substance is used to avoid withdrawal.

MILD MEETS 2 to 3 CRITERIA	MODERATE MEETS 4 to 5 CRITERIA	SEVERE MEETS 6 or MORE CRITERIA
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CLINICALLY SPEAKING...

- ▶ There are folks who display behaviors that may trouble providers
- ▶ I call these “non-reassuring behaviors”
- ▶ These behaviors don’t prove anything, but may cause unease for the provider
- ▶ Any of these behaviors should be explored and evaluated

NON-REASSURING BEHAVIORS

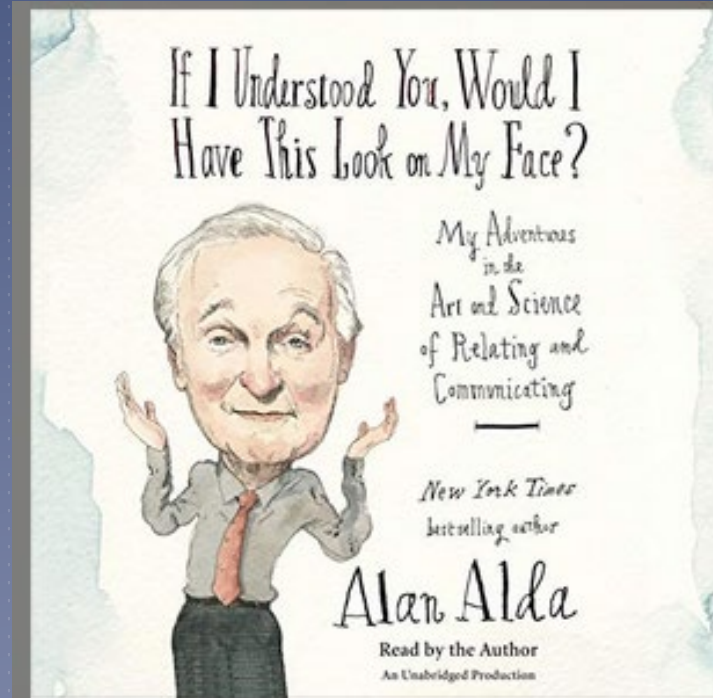
- ▶ Early refills/running out of controlled medications early
- ▶ Reports of lost or stolen controlled medications
- ▶ Trouble with the law
- ▶ Failure to have a urine screen or medication count
- ▶ Treating staff poorly, yelling, demanding
- ▶ Threats of self harm
- ▶ Threats to buy medications “from the street”
- ▶ Coming to appointments impaired
- ▶ Using substances that are not safe with controlled medications
- ▶ More

PSEUDOADDICTION

- ▶ This was an article by Dr. Haddox written in 1989
- ▶ It was a single case observation of an adolescent hospitalized for leukemia with chest wall pain
- ▶ His behavior (in the eyes of Dr. Haddox) were similar to people with opioid addiction
- ▶ The patient's behavior improved when opioids were provided
- ▶ This single case study became a giant game of “telephone” and used by pharmaceutical companies to demonstrate how giving MORE opiates would calm these symptoms
- ▶ This is no longer routinely accepted as a medical condition

COMMUNICATION

Recommended reading



COMMUNICATING WITH EMPATHY

- ▶ Cognitive Empathy

- ▶ The ability to understand what someone else might be thinking and feeling

- ▶ Emotional Empathy

- ▶ The ability to share the feelings of another person

- ▶ Compassionate Empathy

- ▶ Sharing in the feelings of another person and taking time to helping take practical steps to reduce another's emotional pain

DEMONSTRATING EMPATHY

- ▶ Give your full attention
 - ▶ Tune in without barriers
 - ▶ Pay attention to not only what is being said, but how
- ▶ Consider other's perspectives
 - ▶ Put aside your own opinions and perspectives
- ▶ Take action
 - ▶ Work to help the other person set and meet some goals

USE DISORDER SPECTRUMS

- ▶ Think back to our signs and symptoms
- ▶ There are patients who meet 2 criteria
- ▶ There are patients who meet criteria for severe use disorders

CASE STUDY #1

A 33 year old female patient comes into your office and is 90 minutes late for her scheduled appointment. You have a no-show and decide that you will see her.

Her primary concern is that she is having pain in her legs and she is feeling sick. She says that she started feeling sick 3 days ago and doesn't know what to do. She also wants you to fill out some paperwork for her housing.

Your physical examination reveals a thin female patient with multiple open skin lesions on her forehead, her cheeks, and her chin. She is wearing pajama pants and a large sweatshirt with the hood up. Her fingernails are bloody presumably from picking at her face. Your medical assistant did not get VS because the patient could not tolerate the blood pressure cuff.

CASE STUDY #1, CONT.

She sits in the exam room chair, then gets up and paces in the room. She is crying and tells you that she just wants her pain to stop.

What do you say?

- A. Oh my God! What happened to your face?!
- B. I am hearing that you want your pain to stop. Can you tell me more about your pain?
- C. Are you using drugs?
- D. Please make this quick, you are late for your appointment.

CASE STUDY #1, CONT.

You respond with B and she tells you that she had a scheduled visitation with her children and when she went to see them, she finds that the state had removed the children from the care of her ex-husband because he had relapsed with drugs.

She then asks you if you can give her something to make her feel better. She is crying.

You respond:

- A. There is nothing I can give you to make this better.
- B. What were you thinking, maybe some Valium to help you calm down?
- C. Before I prescribe medications, I really want to know what happened after you tried to see your kids

CASE STUDY #1, CONT

You respond C and she tells you that when she realized the kids were gone, she then started using methamphetamines with her ex-husband. She says that she didn't sleep for 3 days until she was able to get some heroin to help her come down and get some sleep. She says that she has not taken any drugs for 2 days and she is feeling sick, restless, and hopeless. Your response:

- A. I am so glad that you came in to see me today. Thank you for telling me what happened to you
- B. I am so sorry, would you like me to call the police on your ex-husband
- C. You will need to get off drugs if you ever want to see your kids again

CASE STUDY #1, CONT

You respond A. She tells you that she is ashamed of her relapse and she doesn't know what to do.

You talk with her about substance use disorder and treatment options. She decides that she would like to go back on suboxone (has been on it in the past). You write a prescription and schedule her for the following week. You decide to get her paperwork finished next week when she is feeling better.

CASE STUDY ANALYSIS

- ▶ Very clear cut of severe substance use disorder not in remission. This patient came to you with a pain concern but through empathic and non-judgmental interactions, she was able to enter early recovery.

CASE STUDY #2

You receive a phone call from your local interventional pain management office about a 65 year old patient. The pain providers have been tapering this patient from chronic opioids prescribed to him due to a work place accident which led to complex regional pain syndrome. He overused his medications and is out of medications 2 weeks early. He is in the interventional pain office in active withdrawal.

You have an opening in your schedule and since the pain office is less than 10 minutes away, you ask if the patient can come to your office right away.

CASE STUDY #2, CONT.

15 minutes later, a 65 year old male patient arrives at your office Roland. Roland brings his wife, Betty with him.

VS: BPI 52/98, RR 16, P 108, O₂ sats 99% on room air

Roland tells you that 15 years ago, he had a crushing injury of his right foot and needed surgery. He had continued pain after the surgery, so 6 months after the first surgery, the hardware was removed. Subsequently, he had swelling, a bluish discoloration, and intense pain in the foot. He got so he couldn't wear a sock or a shoe. He was diagnosed with CRPS and treated with high dose oxycodone.

CASE STUDY #2, CONT.

He had had numerous procedures including lumbar sympathetic blocks, extensive physical therapy, cognitive behavioral therapy and most recently had a spinal cord stimulator placed. The spinal cord stimulator seemed to work better than anything and he is now walking better and has better function.

His pain provider, Dr. Zeigler has been working with him to taper him off high dose opioid medications considering his pain is so much better.

CASE STUDY #2, CONT

Roland tells you that he initially tolerated tapering just fine, but then started really struggling 2 months ago. Last month, he says that he spent most of his time thinking about oxycodone and was watching the clock for his next pills. He felt anxious about the medications all the time and just couldn't seem to stay within the limits prescribed to him. A couple of times, he thought about calling his pain provider to beg for more medications, but he was too proud to do that.

At this point, Betty reminds Roland that he stayed home instead of going to their daughter's house to celebrate his grandson's birthday. Roland told Betty that he just didn't feel up to being around other people.

CASE STUDY #2, CONT.

Roland says that he filled his most recently oxycodone prescription 2 weeks ago. “I just don’t know what happened, but I started just not keeping track and took an oxycodone whenever I started to feel anxious about it. Next thing I knew, I was all out of medications.” He then called Dr. Zeigler because he started feeling sick since being out of medication now for about 48 hours. “I don’t know what’s wrong with me, my pain is a lot better, but I can’t stop taking the oxycodone. I hope you will write me a prescription.”

CASE STUDY #2, CONT.

You respond:

- A. NO way! I can't give oxycodone to an addict!
- B. You sound like you're feeling pretty bad right now. Is it ok if I talk to you about your options?
- C. If you want oxycodone, you will have to talk Dr. Zeigler into that, he's the one who got you in the mess to begin with.
- D. You just need to go home and sleep it off and you will feel better in a couple of days.

CASE STUDY #2

You respond B and Roland gives you permission to present options.

You show Roland the DSM5 criteria for substance use disorder and discuss that due to being on opioids he has developed an opioid use disorder.

After a long discussion, Roland and Betty feel that it would be best for Roland to be on suboxone in order to stabilize. Roland says that he wants to eventually get off “that stuff” and you reassure him that when the time feels right, you will work with him to help him taper.

DISCUSSION CASE #2

Roland's case is much more subtle than case #1. He still has a substance use disorder and appropriate for treatment.

Imagine this case if Roland became angry that “you called me an addict!”

Imagine this case if Betty became angry and tried to force Roland to leave the appointment, but he wanted to stay and see about treatment.

How could you use your empathy skills to help you in these situations?

TREATING ACUTE PAIN

Let's go back to our 2 case studies and imagine how we might help them with severe acute pain!

Our patient from case #1 has been on suboxone and off other drugs for 2 months. She has continued concerns about fatigue and shortness of breath. You find out that she does have a history of endocarditis. Her primary care provider puts her through a cardiac workup and it is determined that she needs a heart valve replacement. She calls you in a panic and asks to come see you.

CASE #1 ACUTE PAIN

Your patient asks you how she can stay in her recovery if she has to get heart surgery. She says that she is scared that having pain medications will cause her to relapse.

You tell her:

- A. You will need to go off your suboxone to have this surgery
- B. Your surgeon will have to figure out how to treat your pain. I have no idea how he's going to do that.
- C. I will talk with your surgeon and we will develop a plan for your surgical pain

CASE #1, CONT.

You answer C. You talk with her cardiac surgeon and ask how painful the surgery will be. You find out that your patient will be in the hospital 1-2 days after surgery. He normally gives people 2-3 Percocet a day while in the hospital and usually provides a prescription for 15 pills when a patient is discharged.

After doing some reading, you decide that it's best to leave your patient on suboxone through the surgical period. You then instruct her surgeon that treating with percocet will be fine on top of the suboxone although he may need to make the dosing a little more generous to get better pain relief.

CASE #1 CONT.

You then advise the surgeon to not prescribe any percocet for her to take home.

You call your patient and let her know the plan. You instruct her to call you when she gets out of the hospital to tell you how she is feeling. You agree that if she is having a high degree of pain, you will prescribe a small amount of supplemental suboxone to be used PRN for her pain. She was comfortable with this plan.

CASE #1 DISCUSSION

- ▶ Using mu agonists in addition to suboxone – considerations
- ▶ What if she wanted mu agonists at discharge
- ▶ What if the prn suboxone doesn't help her pain
- ▶ What adjunct medications could you use to help with this

CASE #2 ACUTE PAIN

1 year after you first met Roland, he was able to successfully taper off suboxone. He no longer has cravings and is doing quite well. He hadn't been into your office to see you for many months and he called you because he is planning to have a total knee replacement.

He says that he is afraid to get "hooked" on pain pills again. You bring him in for a discussion.

Roland tells you that it crossed his mind that he might get oxycodone and would be able to achieve the relaxation that he used to get from this medication. He is scared that this will get out of hand.

CASE #2 CONT.

You ask Roland if he talked with his surgeon about this and he says that he “sort of” told him that he “used to be on a lot of oxy, but had to get off it.” He says that the surgeon expects him to be discharged either the day of surgery or the next day. His surgeon usually gives his patients #20 oxycodone pills at discharge. You ask Roland’s permission to coordinate his care with his surgeon. Roland tells you that he would feel more comfortable if he only get prescriptions from you because he trusts you to not “make a mess.” You tell Roland that you will talk with the surgeon and then will have a discussion with him.

CASE #2 CONT.

You call the orthopedic surgeon and discuss Roland's case. You let the surgeon know a little about Roland's difficulty with oxycodone in the past. You explain that Roland is a little nervous about pain pills and want to find out if there are options.

You and the surgeon discuss that the use of pain pills while Roland is in the hospital will be low risk to Roland. The surgeon explains that the block in the knee usually wears off in about 4-6 hours after surgery, but he does have a device that he can leave in the surgical wound for another 2 days that will infuse Marcaine to the site. This will require prior authorization with the insurance company.

CASE #2 CONT.

You discuss this option with Roland and he feels that this would be better than going home with pain pills. You write a letter for the insurance company and they approve the Marcaine infusion for his post-surgical pain.

CASE #2 DISCUSSION

- ▶ What if you did not have the option of a Marcaine infusion, how would you help Roland to be safe?
- ▶ What if his surgical course gets complicated with infection and an open wound to heal by secondary intention?
- ▶ What adjuncts would you employ to help maximize his pain control, function, and his safety?

THE ULTIMATE QUESTION

QUESTION:

How do you tell the difference between a patient with pain and a patient with addiction?

ANSWER:

You don't and you don't really have to. You compassionately evaluate the situation in front of you and treat based on your assessment, experience, and modern guidelines. Never fear making a phone call to someone who can help you think through these situations.

NON-PRESCRIBER SUPPORTS

- ▶ Patients have a variety of care providers
- ▶ The best support you can give a patient is to open empathetic communication between the patient and the team
- ▶ Be aware of any potential pitfalls a patient might face when moving between providers
- ▶ Be sure that the patient understands how each person fits in their team
- ▶ Express any concerns to the provider
- ▶ Support the provider when engaging in difficult conversations
- ▶ Shared appointments!

QUESTIONS?

