Demystifying complexities of opioid dependence related to chronic pain

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Disclosures

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Learning objective

After this presentation, participants should be able to:

• Discuss the challenges of identifying and managing patients with opioid analgesic dependence (OAD) and describe how these challenges can be overcome
Interactive question

- On a scale of A–E, how confident are you in identifying individuals with OAD?

A: 4.8% Not at all confident
B: 16.8% Only slightly confident
C: 28.8% Somewhat confident
D: 32.8% Moderately confident
E: 16.8% Very confident
Interactive question

- On a scale of A–E, how confident are you in managing pain in individuals on opioid agonist therapy?

A  13.7%  Not at all confident
B  23.4%  Only slightly confident
C  28.2%  Somewhat confident
D  30.6%  Moderately confident
E  4.0%   Very confident
Two main groups impacted by chronic pain and opioid dependence in Europe

Chronic pain patients → Long-term opioid analgesia → Develop opioid dependence

Long-term heroin users → Ageing population → Develop chronic pain issues

Chronic pain patients who develop OAD

Chronic pain patients -> Long-term opioid analgesia -> Develop opioid dependence

Long-term heroin users -> Ageing population -> Develop chronic pain issues

But first, what is chronic pain?

A type of pain that has persisted beyond normal tissue healing time – usually ~3 months

Prevalence:
~19% of adults in Europe
~13% of adults in the UK

Opioid analgesics are often used to treat chronic pain

Weak opioids: Codeine, dihydrocodeine

Strong opioids: Morphine, buprenorphine, fentanyl, methadone, oxycodone, tapentadol, tramadol

The scale of the problem

OA use for pain management has dramatically increased worldwide over the last decade

OA, opioid analgesia; S-DDD, defined daily dose for statistical purposes

Incidence of OAD

Access to opioid analgesia is increasing in Western Europe, mirroring the trend seen in Australia and North America.

4.7% Incidence of OAD in those prescribed opioids for chronic care.

Important to remember: Majority of chronic pain patients using OA do not develop opioid dependence.

Why treat OAD?

OAD has social, psychological and physical consequences for the patient

**Physical**
- Vary with opioid intoxication, overdose or withdrawal
- Long-term effects
  - Endocrine changes
  - Immunological effects
  - Sleep disorders

**Social**
- Loss of employment
- Marital and family breakdown
- Loss of friendships
- Loss of interest in regular activities
- Financial problems

**Psychological**
- Mood instability
- Agitation
- Anxiety
- Depression

Risk factors for OAD

OAD may result from a combination of factors, including:

- Personal or family history of dependence
- Genetic predisposition
- Personal psychological profile
- Drug exposure
- Alterations in brain reward mechanisms

History of dependence is the strongest predictor

Studies have indicated rates of mental health issues in OAD individuals as high as 72.9%

Pathway to dependence

Opioid analgesia prescribed for pain

Use of prescription opioid analgesia for purposes other than pain control

Tolerance and ‘loss of control’ over life escalates

Dependence on opioid analgesia develops

Cheaper/alternative drugs e.g. heroin are sought

Opioid analgesics obtained from dealer

Prescription opioid analgesics from friends/family

Many people are treated successfully for their pain and do not progress past this point

This is not a set pathway for development of OAD. It is a complex progressive condition that may take many paths

Barriers and challenges of addressing OAD

**Engagement often suboptimal**

Patients often:
- do not seek help
- lack awareness of the problem
- fear being stigmatised

**OAD diagnosis often not made**

HCPs may lack awareness and knowledge of the issue

**Pathway of referral to a specialist may be unclear**

**Lack of integrated approach**

Success may be limited by lack of integration between opioid dependence and pain management

OAD prevention: safer prescribing of OAs initially

- Limit dose escalation if inadequate pain relief
- Regularly review analgesia use with patient
- Provide support for stopping if opioid trial not working
- Avoid treatments that are unlikely to be beneficial
- Avoid prescribing an opioid as ‘default’
- Consider non-pharmacological interventions
- Provide training and education among HCPs

Factors that may indicate possible addiction

**Adverse consequence:**
- Intoxicated/somnolent/sedated
- Decreased activity
- Irritable/anxious/labile
- Increased sleep disturbances
- Increased pain complaints
- Increased relationship dysfunction

**Impaired control/compulsive use:**
- Repeated reports of lost or stolen Rx or Mx
- Frequent early renewal requests
- Urgent calls or unscheduled visits
- Misuse of other drugs and/or alcohol
- Withdrawal noted at clinic visits
- Observers report overuse or sporadic use

**Preoccupation with use due to craving:**
- Frequent missed appointments unless opioid renewal expected
- Does not try non-opioid treatments
- Cannot ‘tolerate’ most medications
- Requests specific medication/controlled drugs

Screening tools to assess risk of misuse

A single-question screening test

‘How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?’ (positive answer >0)[1]

ORT
Opioid Risk Tool

Assesses risk of aberrant behaviours — low-, moderate- or high-risk user. 5 items. Approx. 1 min to complete[2]


SOAPP
Screener & Opioid Assessment for Patients with Pain

Assesses suitability of long-term opioid therapy from chronic pain patients. Different versions: 8, 14 or 24 items[3][4]

http://nationalpaincentre.mcmaster.ca/documents/soapp_r_sample_watermark.pdf

SISAP
The Screening Instrument for Substance Abuse Potential

Identifies individuals with a possible substance abuse history and at risk of misusing opioids. 5 items. Approx. <1 min to complete[5]

https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs

DAST-10
Drug Abuse Screening Test

Assesses degree of problems related to drug abuse. 10 items. Yes/no self-report instrument. Should take <8 mins to complete[6]

https://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf
Survey of OAD awareness among mental health professionals

Respondents thought patients presenting with the following problems are misusing or have developed OAD:

- Long-term Rx of OA for chronic pain (37%)
- Resolved pain but still needs OA (63%)
- Poorly managed pain requesting more OA (29%)
- Intermittent clinic attendance requesting OA (15%)
- Patient on OST requesting OA (15%)
- All of the above (26%)

OAD treatment options

First step is usually tapering opioid analgesia

If this does not work

Opioid agonist treatment is recommended

Key points
✓ Choice of OAT medication should be tailored to each individual
✓ Intensive monitoring is required
✓ Adjustments of dose may be necessary
✓ Consider role of psychosocial support
✓ Certain individuals with complex comorbidities may benefit from an in-patient setting
✓ Cessation of OAT should be guided by clinical response and not stopped prematurely
Long-term opioid users who develop chronic pain

Chronic pain patients → Long-term opioid analgesia → Develop opioid dependence

Long-term heroin users → Ageing population → Develop chronic pain issues

Long-term heroin users with chronic pain

- Increasing due to an ageing population
- At risk of undertreatment due to misconceptions
  - OAT alone provides enough analgesia
  - Use of OA may result in relapse

Management recommendations

✓ Have realistic goals
✓ For patients on OAT experiencing pain, consider dividing daily dose into every 8 or 12 hours
✓ Consider non-opioid analgesia where they have demonstrated efficacy for the pain condition reported
✓ Consider non-pharmacological options

May only be able to achieve reductions in pain intensity and not complete relief

For example, physical rehabilitation, exercise and psychological treatments
Case example

- 38-year-old white British male
- Works for emergency services
- Had an accident 8 years ago
  - Slipped and fractured wrist
- Continued to have ‘pain’ for 2 years
- Prescribed analgesia by GP
- When prescription stopped, began buying analgesia OTC
  - Took 68 tablets of 8/500 mg codeine/paracetamol both in the morning and at night for 3 years
- Referred by GP to our service after they failed a codeine-only taper
- We stabilised the patient on low-dose methadone (20 mg/day) with psychosocial interventions
- Within 6 months, the patient was referred for in-patient detox as he struggled reducing it at home
- Patient then completed a successful detox
- He is now abstinent and back at work

GP, general practitioner; OTC, over the counter.
Case example

**Previous medical history**
Nil

**Past psychological history**
Drank alcohol excessively 10 years ago but had since reduced and stopped – still abstinent. No previous psychological diagnosis but had underlying low mood

**Family history**
Father had ‘alcohol issues’. Mother and brother diagnosed with GAD

**Personal history**
He had been working for the emergency services for 14 years. Had a partner and two children (14-year-old boy and 8-year-old girl)
Integrated and multidisciplinary approach is key

Primary care physicians

Pain specialists

Addiction specialists