Essentials of … Chronic Pain Management and Addiction Medicine

What is it?

Chronic pain

Chronic pain is defined as pain lasting more than six months or longer than the time expected for tissue healing. Clinically, a distinction is made between cancer pain and non-cancer pain, because cancer pain usually worsens as the cancer spreads and increased medications are required for palliative care. Chronic non-cancer pain (CNCP), on the other hand, is a condition where pain perception is driven by persistent pain signals coming from specific areas of the body and/or there is amplification of pain perception in the central nervous system of the brain.

It is important to appreciate that pain is an inherently subjective experience and that the emotional state of an individual has a great effect on the perception of pain. Fear, anger and shame, for example, are commonly associated with amplification of chronic pain.

Addiction

Addiction, as defined by the Canadian Society of Addiction Medicine, is a primary, chronic disease characterized by impaired control over the use of substance(s) and/or behaviour(s). Clinically, manifestations occur along four dimensions: biological, psychological, social and spiritual.

Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s), continued use of the substance(s) and engagement in behaviour(s) despite adverse physical, psychological and/or social consequences. Like other chronic diseases, it can be progressive, relapsing and fatal.

Substance use and addictive behaviours aid individuals in numbing or escaping unpleasant feelings. 'Painkillers' or opioid medications commonly used to treat pain are often used by patients to escape unpleasant feelings. Not surprisingly, it is difficult to distinguish whether the chronic pain experienced and reported by an individual on prescribed opioids is part of addiction-related problems, represents a discrete condition (CNCP) with no overt addiction-related problems, or is a combination of CNCP and addiction. A specialized addiction medicine assessment is usually required—in addition to the initial comprehensive assessment—for cases where addiction-related problems co-exist in individuals seeking medical help for CNCP.

Chronic pain management

Chronic pain management involves an initial comprehensive assessment and a well-documented, ongoing review to ensure that:

- The pharmacotherapy, which may or may not include opioids, remains effective; and
- Non-pharmacological treatments are integrated to provide the maximum functionality and optimum quality of life for the patients.

A comprehensive assessment is essential to determine the correct diagnosis and develop an effective treatment plan. Two major challenges that require balance are the proper treatment of pain—especially when chronic opioid therapy is required—and the prevention of misuse and/or diversion of opioids, which causes harm to individuals and society.

How does chronic pain management work?

The focus for treatment must be to make the pain more manageable, improve function and optimize the quality of life.

Chronic pain has major debilitating effects that have significant repercussions on individuals, families and work productivity. It has been estimated that more than 18 percent of Canadians suffer from chronic pain (Canadian Pain Survey, 2009). To illustrate, the same survey found that employees with chronic pain miss an average of 28.5 workdays per year, which is more than four times higher than the national annual average of seven days for work absenteeism. Patients with chronic pain are often prescribed opioid medications in an effort to ease their discomfort. Unfortunately, this 'solution' can sometimes aggravate the problem, as opioids carry with them potential for abuse and dependence.

The *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* contains recommendations to guide physicians in treating pain and prescribing opioids in these situations.

In addition, the International Society of Addiction Medicine (ISAM) has adopted a framework for assessing chronic pain problems that outlines assessment for addiction potential in patients presenting with pain and requesting opioids and recommendations for interventions. According to this framework, patients can be assessed and classified generally into three categories:

- **Category A:** The patient seeks opioids for perceived pain. However, assessment reveals that addiction is the more pressing diagnosis and pain, although chronic, is manageable once addiction is effectively treated. For example, a patient with recurrent back pain develops chronic, mechanical back pain and rapidly starts to escalate the use of short-acting opioids, often using in a combination of regular excessive use and bingeing. Many Category A patients can taper off opioids and use non-opioid pharmacotherapy such as anti-inflammatories and/or acetaminophen. Some patients may require opioid agonist maintenance therapy, usually with methadone once daily or buprenorphine three times weekly, to address their addiction.
- **Category B:** The patient seeking opioids has clearly identifiable etiology for pain and does not have a past history of addiction or current active addiction issues. For example, a patient has chronic pain following knee surgery. This patient usually follows directions for treatment and does not change the medication or dosing schedule on their own accord. Aberrant behaviours common for Category A or Category C patients, such as hoarding medications and seeking more medication from multiple doctors, are minimal or non-existent in Category B patients. Some minor aberrant behaviours may occur, such as occasional excessive use to seek relief, and can be addressed through counselling.
- **Category C:** The patient not only has CNCP that requires ongoing opioid therapy, but also has a concurrent substance dependence. Medications such as methadone or controlled-release (CR) opioids, even though long-acting, are required multiple times daily. This severely contrasts treatment maintenance for Category A patients. Category C patients require very careful monitoring and structure to ensure that relapse to active addiction is prevented. Simultaneous use of recovery resources with agonist opioid therapy is essential, as persistent pain can be a trigger for 'out-of-control' drug use and reactivation of addictive behaviours and lifestyle.

Diligent follow-up is essential for all three categories of patients listed above. Over time, Category C patients may achieve sufficient stability in recovery to become Category A patients, where they may become opioid-free or able to tolerate once-daily opioid agonist maintenance therapy. For example, a patient is initially stabilized on CR opioids for chronic knee pain and receives concurrent addiction treatment. After months of making sustained lifestyle changes (such as losing weight, increasing exercise tolerance, attending individual and/or group psychotherapy and developing a strong mutual support network), these patients may be able to decrease or even eliminate the need for opioid maintenance pharmacotherapy.

Proactive, ongoing assessment and monitoring also helps to identify a Category A or Category C patient who may have been initially classified as a Category B patient. For example, a patient who is very compliant and comes for their medications regularly, yet is found later to be hoarding and bingeing on opioids with a significant number of days in between when no opioids are used (Category A); or a patient who was stable on a twice-daily opioid maintenance therapy but starts to run out of their opioids early under stressful and/or ambiguous circumstances, indicative of impaired control over their substance use (Category C). In both of these examples, further assessment and addiction treatment is essential.

There may be an assumption that giving the patient more medication will eliminate aberrant behaviours such as seeking more pain medications from multiple doctors, hoarding medications or bingeing on medications with a conscious motivation to eliminate pain. In fact, giving the patient more medication can impede appropriate intervention and harms the patient, who may be denied needed addiction treatment.

Concurrent emotional issues and/or psychiatric disorders require further assessment and treatment for all patients in all three categories. Physical therapy, surgical possibilities and counselling/psychotherapy (individual and group)—together with mutual support—are expected to address the issues in all four dimensions of health (i.e., biological, psychological, social and spiritual). Family involvement is recommended in cases where the patient's recovery may be hampered by family behaviours that encourage dysfunctional behaviours.

In addition to pharmacotherapy, it is essential that physical and psychological interventions be considered to alleviate pain, improve function and ultimately focus on enhancing the quality of life.

Implications for health care providers

All health care providers, especially those dealing with mental health and/or addiction problems, need to be conversant with pain as an acute or chronic concurrent disorder. The treatment of chronic pain with opioids, especially in the acute setting, is necessary and no one need be deprived of pain relief in those circumstances, regardless of their psychiatric and/or addiction-related co-morbidities. An individualized treatment plan is needed in every case to ensure that patients are tapered off the opioids as soon as feasible in acute situations.

If chronic opioid agonist maintenance therapy is needed, initial and ongoing evaluations are required to ensure that medications that are expected to help do not become part of the problem by either misuse on the part of the patient or by indiscriminate prescribing on the part of the physician. Familiarity with the ISAM framework would ensure that Category B patients are not inappropriately labelled as 'addicts', and that Category A and Category C patients are provided concurrent addiction treatment.

Documentation of assessment and ongoing care is critical. The following 6 A's are considered a working standard for documentation:

- Accurate medication record (list of all medications together with dosing schedule);
- Adverse effects (side effects of medications and/or drug interactions);
- Analgesia (pain relief);
- Activities (functionality);
- Aberrant behaviours (together with any consequences); and
- Affect (comments regarding feelings expressed, appearance and overall demeanour).

The benefits of pharmacotherapy with specific medications must always be balanced with the risks of adverse side effects and/or drug interactions. Co-administration of benzodiazepines or other sedatives can become especially dangerous as synergistic effects can cause respiratory depression, which can be fatal.

Health care providers must move beyond focusing on finding the right medication to relieve pain. Effective treatment is holistic and tailored to each individual, taking into account all medical, surgical and psychiatric co-morbid illnesses. The focus for treatment must be to make the pain more manageable, improve function and optimize the quality of life.

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