Challenges of Treating Chronic Pain in People with Opioid Dependence

By Celia Vimont | June 24, 2011 | 11 Comments | Filed in Addiction, Drugs, Healthcare & Prescription Drugs

As headlines about opioids focus on misuse of the drugs, physicians who treat patients with chronic pain are grappling with how to deal with opioid dependence. At the recent American Psychiatric Association meeting, pain specialists said that treating patients in pain who are dependent on opioids involves a delicate balance between managing pain relief and risk of drug abuse.

“One of the challenges is that we don’t have good estimates of how common it is for chronic pain patients to develop problematic opioid use” says Jennifer Potter, PhD, MPH, in the Department of Psychiatry at the University of Texas Health Science Center in San Antonio.

“The vast majority of people with chronic pain do not go on to develop an opioid addiction, so it’s important for patients to understand that if this medication benefits you, it’s not necessarily a concern. We can’t let our response to the rise in prescription drug abuse to be denying access to all people in pain who can benefit from opioids. We need to build our understanding so we can manage our risk of drug abuse effectively.”

Rates for co-existing chronic pain and opioid addiction vary depending on where you look, Dr. Potter says. “For patients in a pain clinic, addiction rates are relatively low, but in a methadone or buprenorphine population, between 34 to 40 percent will have a chronic pain complaint,” she says.

A doctor treating a person for pain needs to look for potential risk factors for substance abuse, such as a personal or family history of other types of substance abuse or psychiatric disorders, Dr. Potter says. “If a person has one of these risk factors, they shouldn’t automatically be denied opioids, but they should be informed of the risk of dependence and be monitored for potential abuse.”

For some people with chronic pain, medication isn’t always the answer, says Dr. Potter, who is studying the treatment of opioid dependence and chronic pain through a grant from the National Institute on Drug Abuse. “There’s a false assumption that giving medicine makes pain go away, but in chronic situations that doesn’t always work,” she says. “Many people only get some reduction in pain.”

Non-Opioid Pain Treatments

Patients with substance abuse issues can be treated for pain in a variety of ways that don’t involve opioids, says Sean Mackey, MD, PhD, Chief of the Pain Management Division at Stanford University and Associate Professor of Anesthesia and Pain Management. “A multidisciplinary approach is needed to treat patients in pain who have substance abuse issues,” he says.

There are non-opioid drugs such as anti-epileptic drugs, antidepressants and anti-arrhythmic drugs, which can be effective in treating pain, Dr. Mackey says.

Patients can also be treated with psychological therapies, as well as physical and occupational
therapy, he says. Many patients, however, do not receive a multidisciplinary approach to treating chronic pain because it generally requires the resources of an academic medical center. “Doctors who are treating patients without these resources need to collaborate with others who have the knowledge they don’t, either in addiction medicine or pain medicine,” Dr. Mackey advises.

If a doctor weighs all the options and determines that opioid treatment will work best for an opioid-dependent patient in pain, buprenorphine or methadone may be good options, he says. “Buprenorphine and methadone have strong analgesic benefits, and we commonly use them in this situation,” he says.

For a patient using methadone, one approach is to use a “blinded pain cocktail” in which methadone is ground up and mixed in with baclofen as a binding agent, with cherry syrup as a base. “We tell the patient what’s in it, but not how much,” Dr. Mackey says. “We closely track their quality of life measurements, and we can go up or down on the methadone accordingly. If we have a patient with clear control issues we only give out small doses at a time, or we hand it over to a trusted family member.” Mackey does acknowledge that the use of this tool is time and staff intensive and may be more than a small community practice can handle.

When treating patients with both chronic pain and a substance abuse disorder, Dr. Mackey advises making sure that they are receiving psychological counseling, either in a group or individually. “Many treatments we use in substance abuse overlap with chronic pain treatment—the psychological and behavioral skills are the same,” he says.

He also suggests an opioid contract for some patients, which establishes an understanding between patient and doctor that the patient will only receive opioids from that doctor, and from only one pharmacy. The patient may be asked to submit to urine drug screening, and is told that if their medication is lost it will not be replaced, and stolen medication will only be replaced if the person brings a police report.

“While even the most careful clinical pain management cannot eliminate risk of opioid misuse in patients with a history of addiction, good communication, knowledge of non-opioid treatment alternatives and appropriate monitoring and care in structuring opioid management can reduce risk significantly,” Dr. Mackey says.

---

**Comments**

Clicky