THE GREY AREA BETWEEN PAIN & ADDICTION

EVLOLVING STRATEGIES

Dr. Joel Bordman
FMF, 2015

Disclosure of Commercial Support

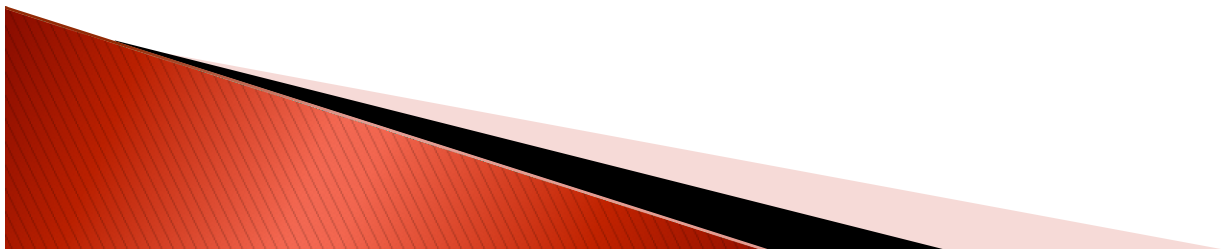
- **This program has received financial support from the following sponsors in the form of an educational grant:**
- **N/A**

Potential for conflict(s) of interest:

- Dr. Bordman has received funding from Purdue, Invidior and Astra Zeneca for consultation service and speaker's bureau
- Indivior produces and distributes a product that will be discussed in this program: Suboxone (Buprenorphine/Naloxone)

Faculty/Presenter Disclosure

- **Faculty:** *Dr. Bordman*
- **Relationships with commercial interests:**
  - Grants/Research Support: N/A
  - Speaker's Bureau: Purdue, Invidior
  - Consultant: Purdue, Invidior, Astra Zeneca



Mitigating Potential Bias

- The Planning Committee has reviewed the presenters' slides and ensured that they are unbiased and free of any inappropriate influence from industry.

Objectives

- review the differential diagnosis of addictive behavior in a chronic pain patient .
- explore treatment options for the patient with addictive behavior and chronic pain.
- to increased comfort in dealing with possible addiction in the chronic pain patient.

After this session participants will be able to:

- 1. Formulate the differential diagnosis of aberrant opioid behaviours in patients with chronic pain
- 2. Communicate effectively with patients when a diagnosis of addiction is being considered
- 3. Provide ongoing support to patients who require a referral for addiction treatment.
-

Before we start…

- Is there an issue with opioids in your community?
  - Excessive prescribing?
  - Illegal consumption (including Heroin)?
  - Diversion?
  - Pharmacy irregularities?

"Seriously babe, I can prescribe anything I want"

A common question:

- Is it pain or addiction?

A Better Question:

- For Someone on opioids:
- Are they **winning** their battle against chronic pain? Or….
- Do the risks outweigh the benefits to continuing opioid therapy?

Differential Diagnosis of Someone on opioids who is not winning their battle against chronic pain.

- Addiction (4 C's)
- Criminal Intent (diversion)

DSM-V Substance Use and Addictive Disorders

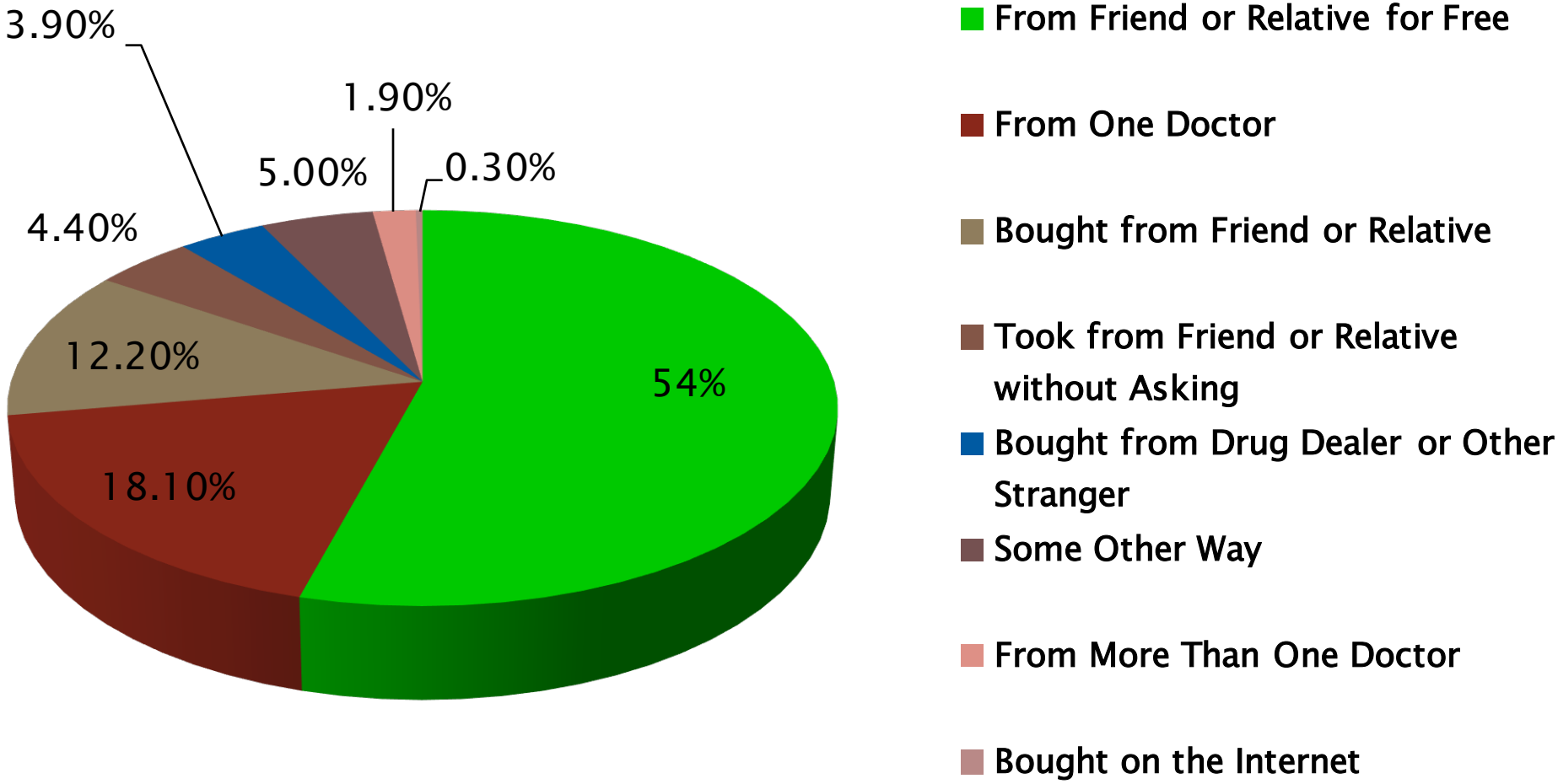
- Mild 2-3
- Moderate 4-5
- Severe 6-11

- *has to cause clinically significant impairment / distress

DSM-V Substance Use and Addictive Disorders

- Unsuccessful attempt to cut down
- Long periods spent obtaining drug or recovering
- Neglecting other life activities
- Use despite ongoing health consequences
- craving
- Consequences of use
- Repeated use in hazardous situations
- Repeated use despite interpersonal harm
- Tolerance
- Withdrawal
- Use for longer than was intended

Source Where Pain Relievers Were Obtained From for Most Recent Nonmedical Use (NSDUH)



Other includes sources "wrote fake prescription [illegible] from Doctor's Office/Clinic/Hospital/Pharmacy" and "some other way"

SAMHSA, Center for Behavioral Health Statistics and Qua[illegible]y the Office of Applied Studies), National Survey on Drug Use and Health, 2010-2011

Differential Diagnosis of Someone on opioids who is not winning their battle against chronic pain.

- Addiction (4 C's)
- Criminal Intent (diversion)

- Pseudo-addiction (inadequate analgesia)
- Opioid Induced Hyperalgesia
- Opioid unresponsiveness

- Other psychiatric diagnosis

Other psychiatric diagnosis

- Organic Mental Syndrome (confused)
- Personality Disorder (impulsive, entitled)
  - Cluster B: Narcissistic, hystrionic, borderline
- Chemical Coping (drug overly central)
- Self medicate for:
  - Depression
  - Anxiety
  - PTSD
  - Situational stressors

Pain treatment 2015

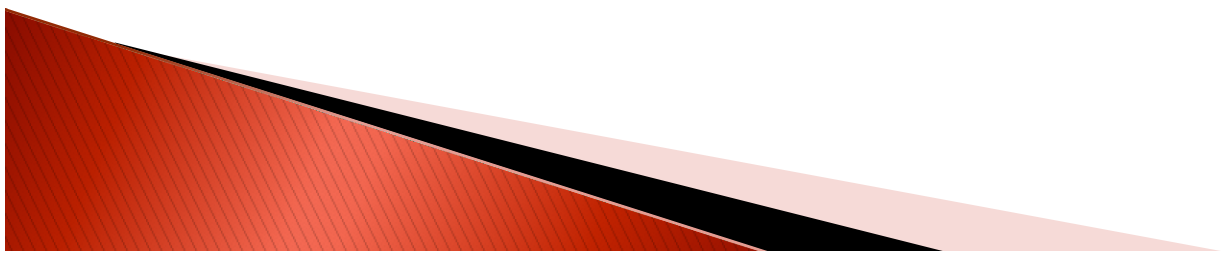
- *Primum non nocere*
- *First, do no harm*

PEARL. . .

- If someone is displaying signs of addiction, the biggest way we can HELP them, is to accept this as a possible diagnosis and explore treatments

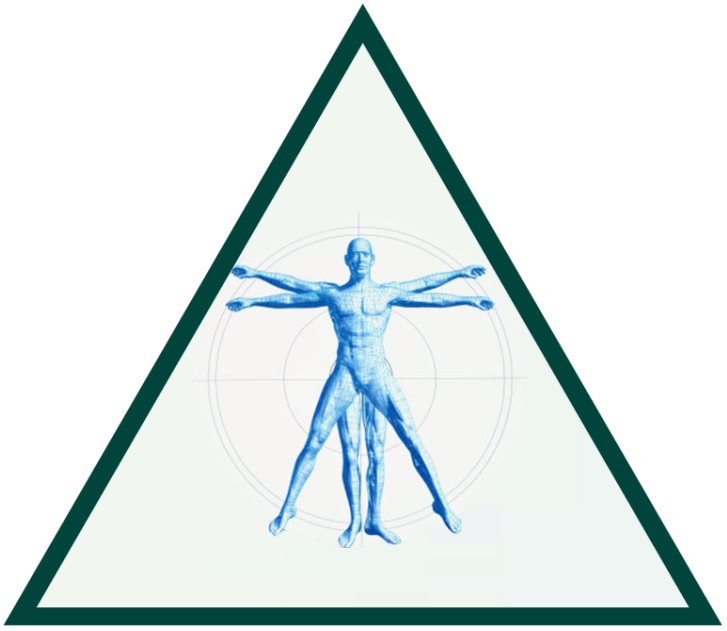
- In addition, remember that DENIAL and AMBIVALENCE TO TREATMENT are a part of the illness

- Complex problems rarely have simple solutions.



TRIAD OF CHRONIC PAIN TREATMENT

Physical / Rehabilitative



Psychological

Medical

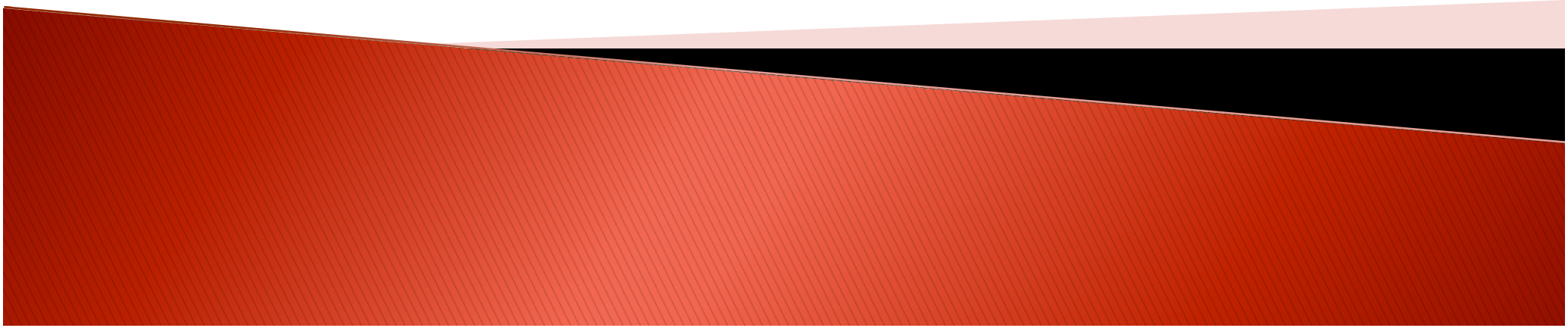
- Pharmacological
- Interventional

Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guidelines

www.camh.net

Principle author: Dr. Curtis Handford

October, 2011



Buprenorphine/Naloxone Indication

- Buprenorphine/Naloxone is indicated for the substitution treatment of opioid dependence in adults

- Suggested training:
  - www.suboxonecme.ca

  www.camh.net (Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guidelines)

  It should NOT be used as part of a opioid rotation in patients without opioid dependence

BuTrans®: Specific Features

- BuTrans®…

  Is specifically indicated for persistent moderate pain lasting an extended period

…due Pharma Canada. BuTrans® Product Monograph, July 2010.

- How is buprenorphine different than other opioids?

Terminology

- AGONIST
  - A ligand the binds to the brain receptor and activates cellular signaling
- ANTAGONIST
  - A ligand the binds to a brain receptor and blocks other ligands from binding; it does not activate any cellular signaling
- PARTIAL AGONIST
  - A ligand that binds to a brain receptor and activates cellular signaling, but only at a fraction of that receptors capacity to signal

A confusing combination

- Buprenorphine
  - Partial mu agonist
  - Kappa antagonist
- Naloxone
  - Mu antagonist

HOW IT WORKS

Combines buprenorphine and naloxone in one pill.

Recommended:
Taken as Directed
by Your Doctor
Under the Tongue

NOT Recommended:
Misused by injecting

Acts like buprenorphine alone.

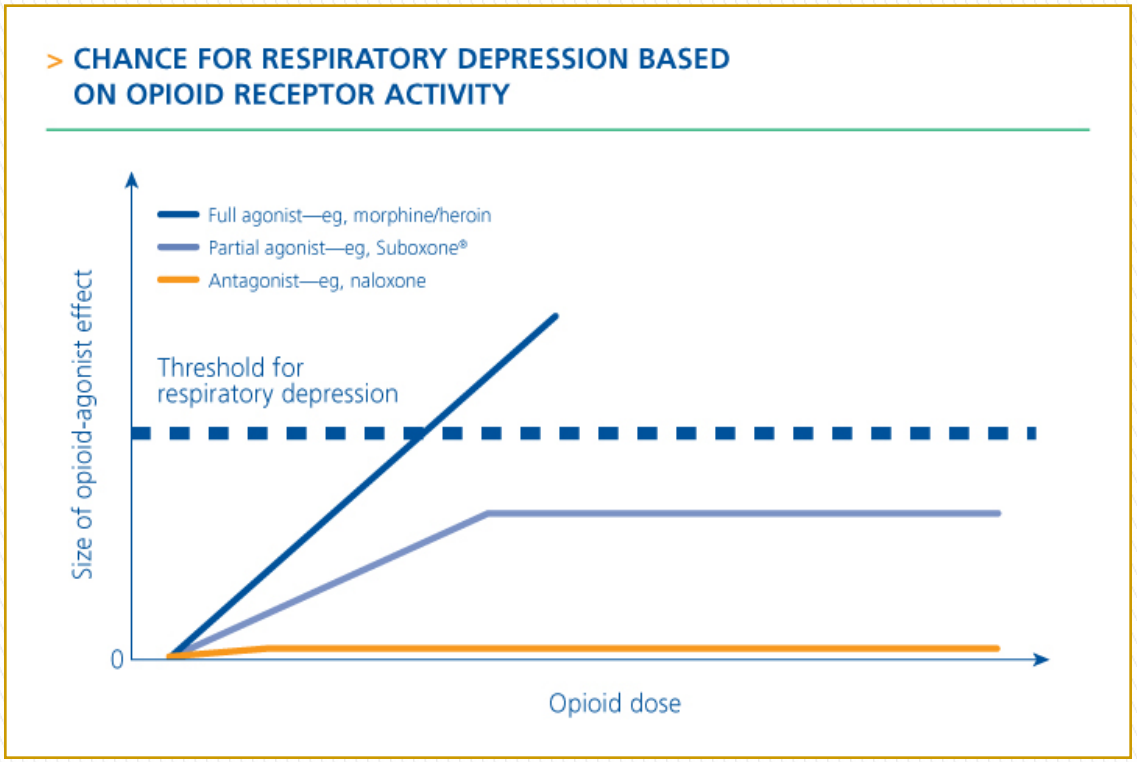
When taken
under the tongue, as directed,
the naloxone is silent…
it has no effect.

Acts like naloxone.

Naloxone will cause
withdrawal symptoms for
opioid-dependent people who
have heroin or methadone
(full agonists) in their bodies
at the time of injection.

BUPRENORPHINE: A "SAFE CEILING"

- Unlike full agonists, agonist effects of buprenorphine reach a ceiling[1]
- Less likely to cause respiratory depression in overdose
  - Ceiling can be compromised by concomitant alcohol or other central nervous system depressants, or when buprenorphine is misused[2]



[1]Johnson RE, et al. *Drug Alcohol Depend*; 2003.
[2]Suboxone™ Product Monograph.

Safety

- Diversion: Patients who use methadone non-medically have higher hospitalization rates, greater ICU utilization rates, and considerably worse medical outcomes when compared with patients who use buprenorphine non-medically

Lee S, Medical outcomes associated with nonmedical use of methadone and buprenorphine, J Emerg Med 2013

Pain Medicine 2014

- Conversion from high dose full opioid agonists to sublingual buprenorphine reduces pain scores and improves quality of life for chronic pain patients
- Daitch, et al

Daitch, et al

- Subjects:
  - 35 chronic pain patients (age 24-66)
  - MEDD 200-1370mg (mean 550mg)
  - Average buprenorphine dose 28mg
- Methods:
  - Retrospective chart analysis QoL scores and numerical pain levels
  - 2 months

Daitch, et al

- Results:
  - Mean pain scores decreased at 2 months from 7.2 to 3.5
  - QoL scores improved from 6.1 to 7.1

THANK YOU