All Party Parliamentary Group on Drug Misuse Inquiry

Response on behalf of the British Pain Society

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Risk of addiction to opioids prescribed for pain relief

Introduction

The prescription of opioids for the relief of pain has increased steadily over the past decade. Data from the US indicate that this increase is accompanied by a parallel increase in misuse of prescribed opioids. The use of opioids in the management of pain associated with cancer and for acute pain following trauma or surgery is well established. At the end of the 1980s it was thought that opioids might not be effective in the management of persistent non-cancer pain but subsequent clinical trials have demonstrated, and systematic reviews endorsed, the efficacy of opioids for the management of a variety of persistent pain conditions.in the short and medium term. More choice is available to prescribers with the availability of new opioid products coupled with technical advances in drug delivery. However, questions remain regarding the safety and efficacy of opioids in the long term and in particular the propensity of opioids to cause problems of tolerance, dependence and addiction. These concerns have particular relevance in the management of persistent pain syndromes because therapy is often continued over months or years.

Definitions

Evaluation of problem drug use in relation to prescribed opioids for pain relief has been hampered by confusion regarding the terms tolerance, dependence and addiction.

Existing diagnostic criteria relating to substance dependence have poor applicability when prescribing opioids for pain relief, and have acted as a source of concern to both prescribers and patients and their carers. The term substance dependence (accepted as being preferable to the term addiction) has a specific and distinct meaning when describing phenomena associated with prescribed drugs for pain relief (see below). The most commonly used criteria for substance dependence are the International Classification of Diseases Tenth Revision (ICD-10) and the fourth edition of the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (1994) (DSM IV). These criteria include the phenomena of tolerance and withdrawal as indicators of substance dependence which, if used to define addiction in the context of pain management would result in over diagnosis.

The confusion regarding terminology for patients in pain using opioids medicinally has been resolved by production of a clarifying consensus statement from the the American Pain Society. These definitions distinguish between expected sequelae of opioid therapy including physical dependence and tolerance and the more biologically and behaviourally complex syndrome of addiction.

Definitions related to the use of opioids for the treatment of pain.
American Academy of Pain Medicine, the American Pain Society and the American Academy of Pain Medicine 2001.

Addiction

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical Dependence

Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

Epidemiology

The estimated risk of iatrogenic addiction to prescribed opioids is variably reported. Most data are derived from studies of analgesic efficacy which are usually of too short a duration to identify problems relating to aberrant drug use. Longer-term retrospective and prospective data are available but these need caution in interpretation as the study

populations are not consistent with respect to diagnosis and previous history and reported prevalence varies depending on the criteria used to define addiction. Rates of addiction in non-cancer pain patients are reported as occurring in 0-50% patients and in cancer pain in 0-7.7% of patients being prescribed opioids.

Risk factors

A number of factors have been identified which are thought to be indicators of risk of addiction to prescribed opioids. These include:

- Current or past history of substance misuse including alcohol
- Family member with history of substance misuse
- Poor social support
- Co-morbid psychiatric disorders (this may be for a number of reasons including high levels of mental and substance abuse disorder co-morbidity and use of analgesic medications to alleviate symptoms of mental illness).

Prescribing safely – what the recommendations say

Concerns regarding long term safety and efficacy of opioid drugs, particularly in relation to problem drug use have prompted experts in a number of countries to produce recommendations for safe and effective prescribing of opioids. These include:

- Graziotti PJ, Goucke CR. The use of oral opioids in patients with chronic non-cancer pain. Management strategies. Med J Aust 1997;167:30–4.

- Kalso E, Allan L, Dellemijn PLI et al. Recommendations for using opioids in chronic non-cancer pain. Eur J Pain 2003;7:381–6.

- British Pain Society 2004 Recommendations for the appropriate use of opioids in persistent non-cancer pain. Available from: http://www.britishpainsociety.org/pub_professional.htm#opioids

- American Academy of Pain Medicine/American Pain Society 2006 The use of opioids for the treatment of chronic pain. Available from: www.ampainsoc.org/advocacy/opioids.htm

The UK guidance on behalf of the British Pain Society, The Royal College of General Practitioners, The Royal College of Psychiatrists and The Royal College of Anaesthetists is currently being revised and updated.

A number of common themes emerge from these recommendations including:

- Addiction should be discussed with all patients being considered for long term opioid treatment
- Opioids should be used only after other evidence based interventions have been tried
- Opioids should be prescribed as part of a broader management plan aimed at improving function in a number of domains
- Clear aims of therapy should be agreed with the patient before starting opioids
- Advice from specialists in pain medicine and addiction medicine should be readily available
- Patients should, where possible receive prescriptions from a one prescriber only
- Modified release opioid preparations are preferred in the management of persistent symptoms
- Injectable opioids play no role in the management of persistent pain
- Opioid therapy should be monitored regularly and adjusted appropriately

Minimizing risk of addiction to prescribed opioids

Predicting problems

Careful assessment of the patient being considered for opioid therapy may indicate that a patient is at risk of problem drug use.

NB There are no characteristics of a patient with a history of substance misuse that are pathognomonic. A worrisome pattern of may emerge on subsequent visits.

History

Patients should be asked about current or past history of substance misuse including alcohol. A sensitive explanation of why this information is necessary to support safe prescribing will usually encourage a patient to give information honestly. Patients should also be asked about substance misuse in family members. Co-morbid psychiatric orders should be identified. It is important to evaluate information from healthcare professionals with whom the patient has previously come into contact. It may be useful to involve the patient's carer or family in the assessment.

Examination

Current intoxication or opioid withdrawal should be obvious on presentation. Note should also be made of findings on examination suggestive of excessive use of alcohol or of intravenous drug use.

Special investigations

Laboratory tests (liver function tests, full blood count) may corroborate the clinical impression. Routine urinalysis for drug screening is recommended for patients at risk.

Screening instruments for addiction

A number of specialist tools are available to screen for the presence of an addictive disorder. Many of these are unvalidated. These should not be used to deny therapy for those with a pain syndrome that may be helped by the use of opioids but can guide the prescriber regarding the degree to which therapy should be supervised and can form the basis of a discussion with the patient about the types of behaviour which would prompt a review of therapy.

Recognising problems

Clinicians should be alert for behaviours suggestive of aberrant drug use Many authors have described problematic behaviours in patients prescribed opioids for pain. These may not be indicative of addiction but may be related to inadequate treatment of pain, physical dependence or an attempt by the patient to relieve distressing symptoms other than pain.

Some worrisome behaviours that have been described include:

- Simulating withdrawal symptoms when further supplies of the drug are refused or the dose reduced

- Simulating an exacerbation of the underlying medical condition if a prescription is refused or dose reduced

- Giving a history of inefficacy or poor tolerance of alternative medicines without misuse potential, or non-pharmacological treatment options

- Asking for prescriptions to be re-issued because of repeated unsubstantiated episodes of prescription loss; claiming that supplies have run out early; altering the quantity or identity of drugs to be supplied on a prescription; approaching a second doctor in order to obtain supplies if the first one refuses

- Stealing medication or prescriptions; buying supplies of medication from illicit domestic sources, from abroad, or via the Internet

- Making threats, or offering bribes, to prescribers or those supplying medication

Managing problems

The propensity for patients to use opioids problematically should be discussed before starting therapy. If concerns are noted these need to be discussed openly and non-judgmentally with the patient. The rationale for the concerns should be explained and the patient should be reassured that safe provision of analgesia remains the primary goal of therapy. The plan for evaluation of therapy may need to be modified. Frequency of assessments should be increased and drugs should be prescribed in small quantities. Problems should be discussed with other healthcare professionals involved in the patient's management. It may be helpful to ask the patient to be reviewed by a specialist in addiction medicine.

All discussions with the patient should be carefully documented and the patient should be given a copy of the written record of the discussion.

Managing pain in substance misusers

Individuals with a history of substance misuse are at risk of developing problems when prescribed opioids for pain relief, however there are a number of reasons why substance misusers have greater than usual pain management needs. If opioids are the most appropriate therapy they may be prescribed for these patients as part of a multidisciplinary treatment plan. Comprehensive assessment of both pain and addiction is mandatory and therapy should be closely monitored by professionals in both pain management and addiction medicine.

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What needs to happen?

Addiction to medicines prescribed for pain relief is a recognised problem which not only hinders successful pain management for the patient but imposes the additional burden of an addiction problem for the individual, his/her family and society. Steps to address this problem include:

- Gathering of epidemiological data relating to the scale of the problem in the UK.
- Effective promulgation of good practice recommendations in relation to opioid prescribing. All prescribers (medical and non-medical) should be aware of important addiction considerations when prescribing opioids for pain relief. Patients should also be aware of the potential pitfalls of using opioids for relief of painful symptoms.
- Support for collaborative working between primary care, specialist pain services and substance misuse professionals.

Reading

British Pain Society.2004 Recommendations for the appropriate use of opioids in persistent non-cancer pain. Available from: http://www.britishpainsociety.org/pub_professional.htm#opioids

British Pain Society 2004 Opioid medicines for persistent pain: information for patients. Available from: www.britishpainsociety.org/pub_patient.htm#opioidpatient

The British Pain Society 2007 Pain and substance misuse: improving the patient experience. Available from: www.britishpainsociety.org/pub_professional.htm#misuse

The British Pain Society 2007. Pain and problem drug use: information for patients. Available from: www.britishpainsociety.org/pub_patient.htm#misuse_patient

Ballantyne J and LaForge S Opioid dependence and addiction during opioid treatment of chronic pain
Pain 129 (2007) 235–255

Edlund MJ et al Risk factors for clinically recognized opioid abuse and dependence among veterans using opioids for chronic non-cancer pain
Pain 129 (2007) 355–362

Højsted J and Sjøgren P
Addiction to opioids in chronic pain patients: A literature review *European Journal of Pain* 11(2007) 490-518

Von Korff M and Deyo R Potent opioids for chronic musculoskeletal pain: flying blind?
Pain 109 (2004) 207–209

The British Pain Society is the largest multidisciplinary professional organisation in the field of pain in the UK. Our membership comprises medical pain specialists, nurses, physiotherapists, scientists, psychologists, occupational therapists and other healthcare professionals actively engaged in the diagnosis and treatment of pain and in pain research for the benefit of patients.

Our multidisciplinary nature is pivotal in making our society a uniquely relevant representative body on all matters relating to pain.

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