

# PAIN TREATMENT TOPICS

# e-Briefing

Access to Clinical News, Information, Research, and Education

Spring 2006: Vol. 1, No. 1

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## In This Issue

From Editor: A New Concept for Learning About Pain & Its Treatment via the Internet .....	1
How Much Methadone Analgesia is Enough? Or...Too Much? .....	4
Methadone-Drug Interactions Affect Patient Response & Safety .....	6
Tapering Opioids: Patient Safety & Comfort Are Essential .....	7
Events Calendar .....	9
Pain: A Confounding Factor in Opioid-Addiction Treatment .....	10

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## Pain-Topics.com: A New Concept for Learning About Pain & Its Treatment via the Internet ...from Editor

Welcome to this debut edition of the “e-Briefing” from *Pain Treatment Topics*. This quarterly electronic publication provides busy healthcare professionals with a digest of selected news, information, research, and education in the pain management field. It is available for download at no charge from Pain-Topics.com in Adobe PDF format and optimized for easy reading right on your computer monitor, or it can be printed for sharing with colleagues.

### A Prevalence of Pain

More than a decade ago, pain was defined simply as, “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Mersky and Bogduk 1994). Yet, the varieties of pain, its possible causes, and available treatments are expansive.

As is commonly acknowledged, pain is a serious worldwide healthcare crisis, and many consider chronic pain a disease in itself that can and should be treated just as any other major illness (Porreca et al. 2006). Data vary; however, it appears from fairly recent surveys that at least half of Americans live with chronic or recurring pain (Poll 2005). Some authors claim that 20% to 30% of Americans [roughly 60-90 million persons] suffer specifically from *chronic* pain at any given time, with back and knee pain most common (Porreca et al. 2006). A third of all pain sufferers did not consult health professionals about their condition; and, among those who did, 4 in 10 say they achieved little or no pain relief (Poll 2005).

*It appears that at least half of Americans live with chronic or recurring pain.*

*A third have not consulted a healthcare professional about this.*

(Continued on page 2)

*(From Editor... continued from page 1)*

In response to the alarming prevalence of pain, there have been a number of recent local and worldwide initiatives. In January 2001, the U.S. Congress declared a “Decade of Pain Control and Research,” intended to stimulate progress in pain research, education, and clinical management. The International Association for the Study of Pain (IASP) proclaimed 2006 as its “Global Year Against Pain in Children,” and next year is proposed as the “Global Year Against Pain in Older Persons.” Still, the public and many healthcare providers remain unaware of these important movements.

### **A Flood of Information**

A large part of the problem is that the pain management field is flooded with information coming from many directions: associations, foundations, journals, news media, government agencies, and product manufacturers to name several. Busy healthcare providers simply do not have time to wade through, make sense of, and put into practice the overwhelming amount of information.

At the same time, the Internet has proven to be a rich source of such medical and healthcare information. In the United States, nearly 70% of the population has Internet access (about 210 million persons). Worldwide, more than 1 billion people have access to the Internet on a daily basis (IWS 2006).

However, a basic Google.com search on the word “pain” yields 373 million entries, ranging from the scientifically valid and useful to the quackish and dangerous. A more targeted search on “osteoarthritis pain” produces more than 153,000 results, and even a specific query like “osteoarthritis guidelines” garners 920 possible pages to visit. This presents an insurmountable, chaotic situation; consequently, while the Internet is awash with information on pain and its management, millions of persons remain untreated or undertreated for their pain disorders.

### **Making Sense of Chaos**

Clearly, to make the most of their time on the Internet, healthcare providers need one source, a clearinghouse of sorts, providing access to what they most need for a better understanding of current, evidence-based, clinical pain-management practices. *That is the mission of Pain Treatment Topics.*

In that regard, we are committed to providing scientifically valid, unbiased, accurate, non-commercial, and trustworthy content via the Internet for healthcare providers on the causes and effective management of pain. Our website – <http://www.Pain-Topics.com> – offers open-access to all contents; that is, they are available free of charge, *without* restriction or required registration, to site visitors.

To do this, *Pain Treatment Topics* relies on sponsor support in the form of unrestricted educational grants to fund the considerable costs of developing and providing this quality content to a worldwide audience. We would like to acknowledge and thank Mallinckrodt Pharmaceuticals, St. Louis, MO, for being a founding sponsor.

### **Pain-Topics.com: A New Concept More Than a Decade in Development**

*Pain Treatment Topics* is new but actually has been in development for more than a decade, since it springs from a platform established in 1992 – *Addiction Treatment Forum*. *AT Forum* and the *ATForum.com* website, started in 1996, have become a leading educational program in the addiction treatment field worldwide.

There are many links between the addiction treatment and pain management fields, and both topics have been addressed for years in *AT Forum*. For example, pain often is a precursor of

*(Continued on page 3)*



*To make the most of their time on the Internet, healthcare providers need one source providing access to what they most need for a better understanding of current, evidence-based, clinical pain-management practices.*



*(From Editor... continued from page 2)*

substance abuse and complicates its treatment. Up to 80% of persons entering addiction treatment programs complain of pain disorders, with chronic pain in a third of them and most cases involving prescription opioid abuse to some extent. (See "Pain: A Confounding Factor in Opioid-Addiction Treatment" in this edition, page 11.)

Following months of design and testing, the Pain-Topics.com website was launched on January 2, 2006. Within the first month, we were pleased to have been awarded Health on the Net Foundation Code of Conduct (HONcode) certification as a source of health trustworthy information. This is consistent with our philosophy of adhering to the highest ethical standards and principles of medical/healthcare education, as advocated by: the PhRMA (Pharmaceutical Research and Manufacturers of America) Code on Interactions with Healthcare Professionals; the ACCME (Accreditation Council for Continuing Medical Education) Standards for Commercial Support; ACPE (Accreditation Council for Pharmacy Education) and ANCC (American Nurses Credentialing Center of the American Nurses Association) guidelines; and U.S. FDA (Food and Drug Administration) Guidance on Industry-Supported Scientific and Educational Activities.

### **Designed for Easy, Rapid Access**

Pain-Topics.com was specifically designed with the convenience and informational needs of busy healthcare providers in mind, allowing for intuitive navigation using tabs so visitors can easily and quickly find what they need.

One role of Pain-Topics.com is to logically organize links to other resources. Additionally, a significant amount of original content is developed on a continuing basis by *Pain Treatment Topics* associates and affiliated consultants, and reviewed for scientific accuracy and compliance with sound clinical practice by a team of expert Medical Advisors and Contributing Faculty.

*Among the many important features currently offered at Pain-Topics.com are:*

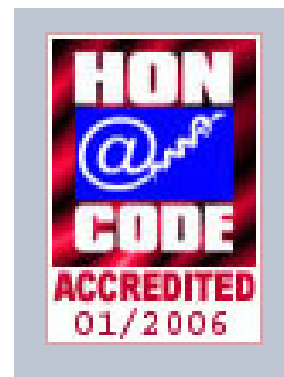
- The most comprehensive listings of related websites, events, and CME courses specific to the pain management field available anywhere on the Internet.
- Extensive links to guidelines, systematic reviews, and reports relating to diverse pain conditions and their treatment.
- Original, evidence-based reports on the application of opioids in pain management, some of which are discussed in this *e-Briefing* edition.

As we continue to grow Pain-Topics.com rapidly in the months ahead, let us keep you posted via e-mail of when this site is updated or there is news of importance. Register for "e-Notifications" at: <http://www.pain-topics.com/register.php>.

**Stewart B. Leavitt, MA, PhD; Publisher/Editor-in-Chief**  
Stew.Leavitt@Pain-Topics.com

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*Pain-Topics.com was specifically designed with the convenience and informational needs of busy healthcare providers in mind.*

*Register for e-Notifications to be alerted via e-mail of when Pain-Topics.com is updated.*

## How Much Methadone Analgesia is Enough? Or... Too Much?

According to James D. Toombs, MD, in his recent paper at Pain-Topics.com – “Methadone Dosing for Chronic Pain in Ambulatory Patients: A Clinician’s Perspective” – methadone is emerging as a good choice for the management of chronic non-cancer pain, both as a first line medication and as a replacement opioid. Toombs is a Staff Physician in the Division of Primary Care/Pain Medicine at the Harry S. Truman Memorial Veterans’ Hospital in Columbia, Missouri.



Particular cautions must be observed as methadone’s pharmacokinetics and pharmacodynamics are unique among opioids. Milligram-for-milligram methadone is much more powerful than morphine, although there is significant interindividual variability in the response to methadone. In the initiation of chronic opioid therapy with methadone or the transition from a different opioid, careful day-to-day monitoring is essential. Methadone has potential to interact with a large number of medications, and drug-drug interactions must be considered (*also, see “Methadone-Drug Interactions” on page 5 in this e-Briefing*). Finally, compared with other opioids, methadone offers significant cost advantages.

### More Bioavailable, Much Longer Half-Life Than Morphine

While methadone can be administered by a number of routes – orally, rectally, intravenously, intramuscularly, subcutaneously, epidurally, and intrathecally – it is most commonly given orally in either tablets or solution. Oral methadone is readily absorbed and very long-acting; by comparison, its bioavailability is nearly 3 times that of morphine and its half-life is about 10 times greater than morphine (see **Table**).

Methadone	
Bioavailability	~80% (79 ± 11.7%)
Half-life	~30 hrs. (30.4 ± 16.3)
Morphine	
Bioavailability	~30% (26 ± 13%)
Half-life	~3 hrs. (2.7 ± 1.2)

Although the half-life of methadone may be 30 hours, the duration of analgesia is much shorter. This mismatch of half-life and duration of analgesia is potentially life threatening if patients use methadone every 4 to 6 hours as they might use morphine, oxycodone, or hydrocodone. Analgesia is typically only 4 to 6 hours when methadone is initiated; however, as a rule, this will extend to 8 to 12 hours with repeated dosing, so adequate pain control is most often maintained with 2 or 3 daily doses, or 4 daily doses in some patients.

### Methadone Dosing: Opioid-Naïve Patients

With methadone, the general rule is to “Start Low and Go Slow.” For patients not currently using opioids regularly, the College of Physicians and Surgeons of Ontario recommends a starting dose of 2.5 mg po every 8 hours. While this is a conservative and typically safe starting dose, for a frail or elderly patient an initial dose of 2.5 mg po QD might be necessary.

Acceptable guidelines for methadone titration are lacking, so increases should be based on the patient’s response (see **Example Titration Table**). An increase of 2.5 mg per dose every 5-7 days has been recommended in the VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain.

Example: Methadone Titration Plan Opioid-Naïve Patient		
Wk	Dose	Total Dose/Day
1	2.5 mg po BID	5 mg
2	5 mg po BID	10 mg
3	7.5 mg po BID	15 mg
4	10 mg po BID	20 mg
5	10 mg po TID	30 mg
6	20 mg po BID (10 mg po QID)	40 mg

### Methadone Dosing: Opioid-Tolerant Patients

Most equianalgesic tables published to date indicate that a 15 mg oral dose of morphine is approximately equivalent to a 10 mg oral dose of methadone. For a single dose, this may be true; however, with repeated dosing, methadone may have a much greater analgesic effect. Relying on these “single dose tables” to transition a patient to methadone from one or more other opioids can result in a substantial methadone overdose that may not be apparent for days.

(Continued on page 5)

(Methadone Dosing continued from page 4)

The initial step in transitioning to methadone requires calculating the patient's daily oral morphine equivalent dose. For both long-acting and breakthrough opioid medications, the daily dosage of each is multiplied by the appropriate ratio of equianalgesic doses. The results are summed to produce the Total Daily Oral Morphine Equivalent Dose and, from this, the equianalgesic dose of methadone is calculated using an appropriate Equianalgesic Dose Ratio (EDR).

To simplify calculation of the *predicted* equianalgesic dose of methadone to be achieved during the titration process, a Methadone Conversion Nomogram was created (see **Graph**). This nomogram is used by locating the current morphine oral equivalent dose along the X-axis, moving up to the curve, and reading the corresponding methadone-dose value along the Y-axis.

Patients must be carefully monitored for side effects during the transition to methadone – sedation and respiratory depression are special concerns – as even correctly calculated doses of methadone may prove to be too high. Daily progress reports via telephone from the patient or family members can help assure both the physician and patient that the transition is being completed safely.

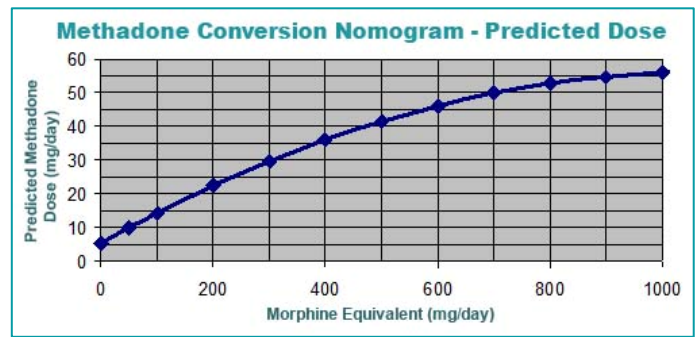
Transitioning patients on higher doses of opioids (>300 mg morphine) to methadone is most safely completed in a hospital setting. There are protocols for rapid transition to methadone that utilize loading doses, variable dosing intervals, and daily dose adjustments.

#### Patient Cautions & Warnings Enhance Safety

Since methadone is different than other opioids in its onset and effect, patients (and their caretakers or families) should be advised of several strong cautions and warnings when starting methadone:

- A) Pain relief builds gradually over time, and it usually takes 5-7 days to see how a patient will react to a particular dose.
- B) Taking methadone as frequently as other opioids (such as Vicodin or Percocet) every 4-6 hours may produce a fatal overdose.
- C) Non-prescribed use of methadone in combination with other opioids, other drugs, or alcohol may be fatal.
- D) Patients should refrain from driving and other activities requiring balance or focused concentration until the effects of methadone are known, typically a week or longer.
- E) Other medical providers must be aware the patient is taking methadone. Adding medications or changing dosing of other medications can affect methadone and should be coordinated with the methadone prescriber.
- F) Methadone, like other opioids, can cause significant constipation. This should be anticipated and a laxative prescribed for the patient at the initiation of methadone therapy.

— SBL



*Patients must be carefully monitored for side effects during the transition to methadone, and they should be advised of several cautions and warnings.*

The above article was adapted from...

#### Methadone Dosing for Chronic Pain in Ambulatory Patients: A Clinician's Perspective

By: James D. Toombs, MD, February 2006.

To download the complete report, including author's examples and references, go to...



[http://www.pain-topics.com/pdf/Methadone\\_Dosing\\_Chronic\\_Pain\\_2006.pdf](http://www.pain-topics.com/pdf/Methadone_Dosing_Chronic_Pain_2006.pdf) (PDF 260 KB; 12 pp)

## Methadone-Drug Interactions Can Affect Patient Response & Safety

Each year in the U.S. there are innumerable adverse drug reactions, broadly defined as any unexpected, unintended, undesired, or excessive response to a medicine. Three-fourths of those adverse reactions relate to *drug interactions*, which occur when the amount or action of a drug in the body is altered – usually increased or decreased – by the presence of another drug or multiple drugs.

In an extensively peer-reviewed report, “Methadone-Drug Interactions,” Stewart B. Leavitt, MA, PhD, itemizes more than 100 substances – medications, illicit drugs, OTC products, and other substances – that can interact in some fashion to affect a patient’s response to methadone. Leavitt is Editor-in-Chief of *Pain Treatment Topics* and has researched and reported on methadone during the past 14 years.

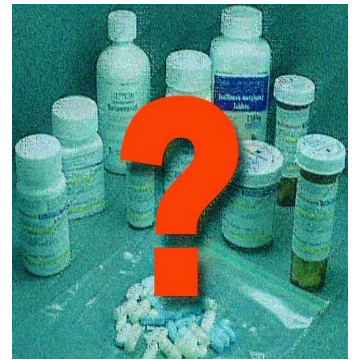
While multiple drugs often are necessary for treating complex or resistant conditions, side effects of the drugs themselves may induce symptoms rather than any pathological processes. This is of vital importance for patients receiving methadone analgesia regimens, since these individuals often have comorbid physical and/or mental disorders requiring multiple medications.

The most important enzymes in methadone metabolism are CYP3A4 and CYP2B6. Secondly, CYP2D6 appears to have a role, and CYP1A2 may possibly be involved. Another metabolic protein of some importance is P-glycoprotein (P-gp), which is found in the intestine, along the blood-brain barrier, and in other tissues.

Methadone works best when administered in *adequate* therapeutic doses; however, given the individual variability in methadone absorption and metabolism, it becomes difficult to accurately predict the effects of drug combinations in any one patient, or how methadone dosing may need adjustment to compensate for metabolic inducers or inhibitors. If a patient is responding unexpectedly or unfavorably to methadone – with signs/symptoms of under- or overmedication – a search for potentially interacting substances would be appropriate.

Theoretically, any drug or substance metabolized by the same CYP enzymes as methadone, or affecting their expression by inhibition or induction, might interact with methadone; although, some of these interactions might not be clinically important. The comprehensive tables in this report list drugs and substances *specifically mentioned in the scientific literature* that either: A) should definitely be avoided with methadone, B) may influence unexpected results or are themselves altered by their combination with methadone, or C) raise or lower serum methadone levels and increase or decrease methadone’s effects, respectively.

The report is thoroughly referenced, citing several levels of evidence: 1) Interactions demonstrated via published clinical studies and/or by the well-established and specific pharmacology of methadone metabolism; 2) Interactions based on published clinical case series reports and/or laboratory investigations in animals or tissues (in vitro); 3) Interactions proposed in the literature, but predicted from general pharmacologic principles and/or sporadic anecdotal cases. — SBL



*Theoretically, any drug or substance metabolized by the same CYP enzymes as methadone, or affecting their expression by inhibition or induction, might interact with methadone.*

*The above synopsis is of...*

### **Methadone-Drug\* Interactions** (\*Medications, illicit drugs, & other substances)

By: Stewart B. Leavitt, PhD, January 2006.

**To download the extensive report, including drug interaction tables and references, go to...**



[http://www.pain-topics.com/pdf/Methadone-Drug\\_Intx\\_2006.pdf](http://www.pain-topics.com/pdf/Methadone-Drug_Intx_2006.pdf) (PDF 700 KB; 33 pp)

## Patient Safety & Comfort Are Essential When Stopping Opioids

According to Lee A. Kral, PharmD, BCPS — author of “Opioid Tapering: Safely Discontinuing Opioid Analgesics” — guidance for starting medications is readily obtained from product package inserts and reference sources; however, it is more difficult to find information about switching or stopping opioid medications. Kral is a Faculty Member at The Center for Pain Medicine and Regional Anesthesia at The University of Iowa Hospitals and Clinics in Iowa City, IA.

## OPIOID TAPERING

Currently there is no standard protocol for tapering opioids; however, there are some suggested guidelines. Regardless of the reason for tapering opioids, the plan must be individualized to each patient’s needs, and close follow-up and psychosocial support are essential. The most important factor to consider is how acutely the taper or conversion is needed.

### Tapering Reasons, Settings, Duration

There are many reasons for considering opioid tapering, both from healthcare provider and patient perspectives. Patients may decide that they wish to stop their opioid therapy if they experience adverse effects. Opioid rotation is an option; however, patients may be wary to try another agent or may experience intolerable adverse effects with certain chemical classes of opioids. Their pain may not be opioid-responsive, their underlying disease process may have improved as a result of surgery or other interventions, or despite increasing their dose at regular intervals an adequate pain response may not be realized.

Tapering off opioids (often called detoxification or “detox”) may be done within a chemical-dependency treatment setting, specialty clinic, or primary care practice. Protocols vary between different institutions and outpatient centers.

The duration of the taper depends on its complexity and the patient’s needs. The universal goal is to taper as quickly as the patient’s physiologic condition and psychological status allow. The presence of multiple comorbidities, polysubstance abuse, female gender, and older age are among factors increasing the difficulty of tapering and tend to lengthen its duration.

Patients with a long history of taking chronic opioids or any centrally acting medication involving receptor pharmacology (e.g., dopamine agonists, SSRIs) are more likely to experience withdrawal during a taper that is too rapid and, therefore, may require a longer taper period to avoid such symptoms. Some patients may have a great deal of anxiety about the potential for increased pain or experiencing withdrawal symptoms. In all cases, it is important to make decisions about tapering therapy on an individual basis.

### Agents Used for Opioid Tapering

Depending on the situation, several options for tapering agents are available. The same opioid medication the patient has been taking may be used. This can be accomplished even with short-acting agents. The average daily dose should be spaced evenly throughout the day (and “prn” doses eliminated), usually with a frequency of every 4 or 6 hours. Once the patient has been stabilized on a scheduled dosing frequency, the tapering regimen may be implemented.

Short-acting agents may be replaced with another medication with a long half-life, such as methadone, or an extended release product such as MS Contin® or OxyContin®. Many programs use methadone, as it is less likely to produce euphoria and is inexpensive compared with the other long-acting agents.

Usually after a dosing conversion has been completed, a “test dose” or “test regimen” will be given with close monitoring. If the dose of the long-acting agent is too low, the patient may develop withdrawal symptoms; however, if the dose is too high, the patient may develop sedation.

*(Continued on page 8)*

*The duration of the taper depends on its complexity and the patient’s needs.*

*The universal goal is to taper as quickly as the physiologic and psychological status of the patient allows.*

*(Opioid Tapering continued from page 7)*

During the first week, the dose of the long-acting agent should be adjusted to control any withdrawal symptoms. After the patient has been stabilized, the tapering regimen may be implemented.

Individual patients may have differing responses to the tapering regimen chosen. As noted above, for those who have been on long-term opioid therapy, there may be fear and anxiety about reducing and/or eliminating their opioid medication. Or, patients may be concerned about the recurrence or worsening of pain. They also may be concerned about developing withdrawal symptoms.

Typically, the last stage of tapering is the most difficult. The body adapts fairly well to the proportional dosage reduction to a point, and then (at less than 30-45 mg of opioid/day) the body cannot adapt as well to the changes in concentration and receptor activity, which precipitates withdrawal if the tapering regimen is not slowed.

### Advising Patients on Emergency Tapering

Following the Katrina Hurricane in 2005, the National Pain Foundation offered some recommendations for what patients can do when all access to continuing pain medications is unexpectedly cut off, as during an emergency or other crisis. These are adapted below, and a version of this might be provided to patients whenever chronic opioid analgesics are prescribed.

*Individual patients may have differing responses to any chosen tapering regimen.*



— SBL

## Patient Instructions – Stopping Opioid Painkillers in an Emergency

If you are unable to refill or get your opioid medications, symptoms of withdrawal will vary depending on how long you were on the opioid medication and what type you were taking. People taking morphine, hydro-morphone, or oxycodone may experience withdrawal symptoms within 6 to 12 hours of the last dose while those taking methadone or controlled-release opioids will experience symptoms 1 to 4 days after the last dose. Typically, withdrawal from morphine takes 5 to 10 days while withdrawal from methadone or other long-acting opioids takes longer.

Ideally, discontinuing the medication would be a slow tapering process under the care of a physician or other appropriate medical provider. If this cannot be accomplished, it is important to make an effort to taper the dose on your own as slowly as possible.

The best way to avoid serious withdrawal symptoms is to reduce the amount of medication you are taking or how often you are taking it before you run out. Reducing the amount by 25% per day, or by 25% every other day,

may result in some withdrawal symptoms, but it is better than having to suddenly stop the medication when you run out entirely.

If you are taking any of the extended release versions of opioids, such as OxyContin® or Kadian® or fentanyl patches, do not tamper with them in any way. Breaking or opening these capsules, or cutting patches, can release the entire dose at once, causing overdose and possible death. Instead, take the whole tablet or capsule or use the whole patch, but take or use the medication less often to reduce the dosage.

Drink a lot of fluid, try to stay calm, and keep reassuring yourself that any withdrawal reaction will pass and you will eventually feel better. One of the symptoms during opioid withdrawal is a state of sensitized pain, meaning your pain may feel more intense or severe. This also will pass with time.

**Remember:** Always seek professional healthcare assistance as soon as you can — if possible, before running out of medication.

*The above article was adapted from...*

### Opioid Tapering: Safely Discontinuing Opioid Analgesics

By: Lee A. Kral, PharmD, BCPS, March 2006.

**To download the complete report — including tapering schedules, author's examples, and references — go to...**



[http://www.pain-topics.com/pdf/Safely\\_Tapering\\_Opioids.pdf](http://www.pain-topics.com/pdf/Safely_Tapering_Opioids.pdf) (PDF 140 KB; 7 pp)

# EVENTS CALENDAR

For a complete listing of event see: [http://www.pain-topics.com/events\\_calendar/index.php](http://www.pain-topics.com/events_calendar/index.php)



## June 2006

### ASCO Annual Meeting

Sponsor: American Society of Clinical Oncology (ASCO)

**June 2-6-2006**

Atlanta, Georgia

Contact: <http://www.asco.org>

### Pain Management and End of Life Care

Sponsor: University of California San Francisco

**June 4-5, 2006**

San Francisco, CA

Contact: 415-476-4251; <https://www.cme.ucsf.edu/cme/>

### UCD Review & Updates of Pain & Palliative Care Medicine

Sponsor: UC Davis Health System

**June 10-11, 2006**

Contact: Vickie Hidalgo, 916-734-5774;

E-mail: [vickie.hidalgo@ucdmc.ucdavis.edu](mailto:vickie.hidalgo@ucdmc.ucdavis.edu);

<http://cme.ucdavis.edu>

### 53rd Annual Anesthesiology Review Course

Sponsor: Dannemiller Foundation

**June 10-16, 2006**

San Antonio, TX

Contact: <http://www.dannemiller.com/meetings.cfm>

### Canadian Pain Society 2006 Annual Meeting

**June 14-17, 2006**

Edmonton, Alberta, Canada

Contact: 905-668-9545; <http://www.canadianpainsociety.ca>

### 17th Annual Meeting of the AACPI: "The Politics of Pain"

Sponsor: American Alliance of Cancer Pain Initiatives

**June 15-17, 2006**

Phoenix, AZ

Contact: <http://www.aacpi.wisc.edu/events.htm>

### 48th Scientific Meeting: American Headache Society

**June 22-25, 2006**

Los Angeles, CA

Contact: 856-423-7222, ext. 223; <http://www.ahsnet.org>

### ASIPP 8th Annual Meeting and Legislative Visits

Sponsor: Association of Interventional Pain Physicians

**June 24-28, 2006**

Washington, DC

Contact: <http://www.asipp.org/meetings.htm>

### 7th International Symposium on Pediatric Pain

Sponsor: International Association for the Study of Pain

**June 25-29, 2006**

Vancouver, Canada

Contact: 604-681-2153; <http://www.ispp2006.com>

## July 2006

### AJAO National Conference

Sponsor: American Juvenile Arthritis Organization

**July 13-16, 2006**

Atlanta, Georgia

Contact: 404-965-7538; E-mail: [kbitner@arthritis.org](mailto:kbitner@arthritis.org)

### NHPCO 5th National Conference on Volunteerism and Family Caregiving

Sponsor: The National Hospice and Palliative Care Organization

**July 28-30, 2006**

Denver, CO

Contact: <http://www.nhpc.org>

## August 2006

### An Intensive Review of the Specialty of Pain Medicine

Sponsor: Dannemiller Foundation

**August 26-30, 2006**

Chicago, IL

Contact: <http://www.dannemiller.com/meetings.cfm>

## September 2006

### AAPM Annual Clinical Meeting

Sponsor: American Academy of Pain Management

**September 7-10, 2006**

Orlando, Florida

Contact: <http://www.aapainmanage.org/>

### "Pain in Europe V" Triennial Meeting of EFIC

Sponsor: European Federation of IASP Chapters

**September 13-16, 2006**

Istanbul, Turkey

Contact: +41 22 908 0488; <http://www.kenes.com/efic>

### ACA Annual Conference

Sponsor: American College of Apothecaries

*Pain Treatment Topics Affiliate Organization*

**September 27 – October 1, 2006**

Palm Beach, Florida

Contact: <http://www.acainfo.org>

### Regional Anesthesia & Pain Medicine 2006

Sponsor: The Canadian Pain Society

**September 29-October 1, 2006**

Toronto, Canada

Contact: 416-603-5118; <http://www.canadianpainsociety.ca>

To have your organization's event listed at Pain-Topics.com,

send an e-mail with the details to:

[Info@Pain-Topics.com](mailto:Info@Pain-Topics.com)

# Pain: A Confounding Factor In Opioid-Addiction Treatment

Pain and addiction share some common physiologic pathways in the brain, especially those involving opioids, and each may affect the other. That is, the presence of pain may influence the development and course of opioid addiction, and vice versa. That's the premise of "Pain in Opioid-Addicted Patients Entering Addiction Treatment," an article by *Pain Treatment Topics* editor, Stewart B. Leavitt, MA, PhD, and based on research first reported by Leavitt in *Addiction Treatment Forum* (ATForum.com; Vol 13, No1).

These interactions of pain and addiction may be a confounding factor during therapy for opioid addiction. For example, some opioid-addicted persons may have lower tolerance for and greater sensitivity to pain (hyperalgesia), and this may continue during addiction treatment. Sleep disorders and psychiatric illness often associated with addiction may increase the experience of pain and decrease the effectiveness of pain-relief interventions.

## High Prevalence of Pain in Opioid Addiction

In a sizeable investigation (n=390), researchers reported on the prevalence and characteristics of pain in patients attending a methadone maintenance treatment (MMT) program for their opioid addiction. Surprisingly, pain was experienced during the prior week by 80% of those surveyed. More than a third of all patients suffered from chronic, severe pain, defined as pain of moderate to severe intensity persisting for more than 6 months.

Among those patients with chronic, severe pain, nearly two-thirds said their pain greatly disrupted physical and psychosocial functioning. About one-third reported having used illicit drugs (primarily opioids) and/or alcohol to self-medicate their pain, and a majority of them also had been prescribed pain medications at some point by physicians. Many reported that pain was a motivation behind their abuse of drugs in the first place.

Factors that seemed to significantly contribute to the patients' pain conditions included age, chronic illness, lifetime psychiatric illness, psychological distress, and time in addiction treatment. The study did not explain why increasing time in treatment correlated strongly with persistent pain complaints; although, methadone medication underdosing might have been a factor.

Where does all the pain come from? Some experts have suggested that patients in addiction treatment programs may have high rates of acute and chronic pain resulting from injuries associated with past intoxication episodes or risk-taking behaviors. Additionally, studies have suggested that arthritis, headache, and lower back pain are prevalent pain diagnoses in persons addicted to opioids.

Body aches and pains, depression, and anxiety frequently coexist. Furthermore, dual diagnoses of psychiatric disorders and substance abuse/addiction are common. Therefore, *triple-diagnoses* – pain, psychiatric disorder, and addiction – might be expected in many patients entering addiction treatment programs and should be considered in the diagnosis and treatment plan.

## Rx Opioids Play a Major Role

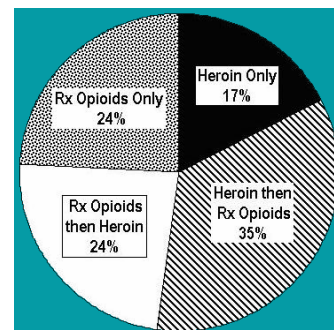
In another study, a Canadian group of investigators reported on prescription opioid abuse among patients entering MMT (n=178). At admission most patients (83%) had been abusing prescription opioids, taking them at higher than therapeutic dosages and with or without heroin.

Four groups were identified (see **Pie Chart**): a) those using heroin only, b) heroin first, plus prescription opioids subsequently, c) prescription opioids initially, then heroin later, d) prescription opioids only. Although heroin was involved to some extent in 76% of cases, there was still a



*Surprisingly, pain was experienced during the prior week by 8 out of 10 patients in treatment for opioid addiction.*

*More than a third suffered from chronic, severe pain.*



*(Continued on page 11)*



*(Pain in Addiction Treatment continued from page 10)*

sizeable proportion of patients in MMT exclusively due to prescription opioid addiction. The majority of patients dependent on prescription opioids, as well as most who used prescription opioids initially then heroin, were more likely to have started opioid use due to ongoing pain problems. Most of them (61%) had received at least some opioids via prescription and also

were engaged in psychiatric therapy at some time.

Of interest, patients who used prescription opioids exclusively or initially exhibited significantly greater retention in addiction treatment during a two-year period. This is consistent with the observation that patients with genuinely chronic pain may be reluctant to leave addiction treatment when faced with the likelihood of drug relapse and the challenge of daily “hustling” for drugs illicitly. Denying opioid analgesics to patients who might benefit from them could subvert the goals of addiction treatment by discouraging retention and precluding achievement of a more functional, pain-free life.

Those patients who initially or exclusively abused prescription opioids also were considerably older and started opioid abuse later in life, compared with those who used heroin only or initially. They also had significantly higher rates of chronic pain prior to entering MMT.

### **Barriers to Pain Management During Addiction Treatment**

The undertreatment of pain is an important concern in persons with addiction, and barriers to effective pain management in these patients include misguided institutional practices, inadequate physician training, reluctance to provide adequate pain medications (especially opioids) to chemically dependent persons, an unwillingness by these patients to seek care due to stigma and fear of drug relapse, and clinicians’ fears of regulatory sanctions.

Clearly, there is a need for competent pain management in addiction-treatment populations. In some cases, however, it seems possible that patients might have been referred to such programs for problems that could be described as “pseudoaddiction” — that is, aberrant opioid-seeking behaviors due more to the unavailability of adequately prescribed pain medication than to a true neurobiological addictive disorder.

Unfortunately, many pain specialists have little understanding of addiction or how to manage pseudoaddiction. And, addiction medicine practitioners often have limited training in the assessment and management of persistent pain. Certainly, efforts to improve cross-training and communication between pain management and addiction treatment specialists should be encouraged.

— SBL

*The above was excerpted from...*

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By: Stewart B. Leavitt, MA, PhD, December 2005.

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