

## Prescription Drug Abuse: What Indian Health Can Do\*

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## Disclosure

- Anthony Dekker, DO has presented numerous programs on Chronic Pain Management and Addiction Medicine. The opinions of Dr Dekker are not necessarily the opinions of the Indian Health Service or the USPHS. Dr Dekker has no conflicts to report.

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## Chronic Non-Malignant Pain (CNMP)

- Osteoarthritis
- Low back pain
- Myofascial pain
- Fibromyalgia
- Headaches (e.g., migraine, tension-type, cluster)
- “Central pain” (e.g., spinal cord injury, stroke, MS)
- Chronic abdominal pain (e.g., chronic pancreatitis, chronic PUD, IBS)
- CRPS, Types I and II, AI and AN have inc trauma
- Phantom limb pain
- Peripheral neuropathy
- Neuralgia (e.g., post-herpetic, trigeminal)

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## Treatment goals in managing CNMP:

- Improve patient functioning
- Identify, eliminate/reduce positive reinforcers
- Increase physical activity
- Decrease or eliminate drug use

**The goal is NOT pain eradication!**

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## CNMP:

### *The clinical challenge*

- **Be aware of the “Heart Sink” patient.**
- **Be aware of the borderline patient**
- **Remain within your area of expertise.**
- **Stay grounded in your role.**
  - **FIRST....Do no harm**
  - **THEN.....**
    - **Cure sometimes**
    - **Comfort always**

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## Non-pharmacologic treatments for CNMP

- ✓ Physical therapy – conditioning
- ✓ Pain Psychology – relaxation / counseling / expectations orientation
- ✓ Traditional Indian Medicine
- ✓ Massage therapy
- ✓ Osteopathic Manipulative Therapies
- ✓ Spinal manipulation
- ✓ Acupuncture, with and without stimulation
- ✓ TENS units
- ✓ Nerve blocks
- ✓ Pain management group

## Non-opioid medications for CNMP

- Non-steroidal anti-inflammatory drugs (NSAIDS)
- Tricyclics
- Anti-depressants/anxiolytics
- Anti-convulsants
- Muscle relaxants
- Topical preparations—e.g. anesthetics, aromatics
- Others (e.g., tramadol)

## Non-opioid medications (cont.)

- **Non-steroidal anti inflammatory drugs (NSAIDS) Inhibit prostaglandin synthesis:**
  - Works on Cyclo-Oxygenase (COX) COX-1 and COX-2
  - ↓ pain-minutes to hours
- **COX-1:**  
Aspirin, Ibuprofen, Naproxen, Ketoprofen, Indomethacin, Diclofenac, Piroxicam, Sulindac

### Non-opioid medications (cont.)

- **COX-2 Inhibitors:**
  - ↓ gastrointestinal effect
  - Normally not present but induced during inflammation
  - Celecoxib (Celebrex®);
  - Rofecoxib (Vioxx®); Valdecoxib (Bextra®) *withdrawn from market due to increased cardiovascular risk*

### Non-opioid medications (cont.)

- **Antidepressants:**
  - ↓ reuptake of serotonin & norepinephrine
  - ↑ sleep
  - Enhance descending pain-modeling paths
  - Tricyclics —amitriptyline (Elavil®)—most studied/most SE's and nortriptyline (Pamelor®)
  - SSRIs—not as effective
  - SNRI (venlafaxine, Effexor®; duloxetine, Cymbalta®) preliminary evidence of efficacy in neuropathic pain

### Non-opioid medications (cont.)

- **Antiepileptic drugs:**
  - ↓ neuronal excitability
  - Exact mechanism is unclear
  - Not due to antiepileptic activity e.g. phenobarbital is poor analgesic
  - Good for stabbing, shooting, episodic pain from peripheral nerves
  - Gabapentin (Neurontin®)
  - Pregabalin (Lyrica®)
  - Carbamazepine (Tegretol®)
  - Topiramate (Topamax®)

### Non-opioid medications (cont.)

- **Other drugs:**
  - **Tramadol (Ultram)**
    - Mixed mu opioid agonist & NE/serotonin reuptake inhibitor
    - Seizure threshold changes
  - **Corticosteroids**
    - ↓ inflammation, swelling
  - **Baclofen**
    - GABA receptor agonist
    - Used for spasticity
  - **Ketamine**
    - NMDA antagonist
    - Used in general anesthesia, neuropathic pain
    - Rarely used secondary to side effects

## Opioid therapy in CNMP:

**“To prescribe or not to prescribe ... that is the question!”**

When you are considering prescribing an opioid for CNMP, how do you decide?

- **Indications** – patient-specific and disease-specific
- **Contraindications** – Medical issues and history of or current addictive disease

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## Indications for opioid therapy

1. Is there a **clear diagnosis**?
2. Is there **documentation** of an adequate work-up?
3. Is there **impairment of function**?
4. Has **non-opioid multimodal therapy failed**?
5. Have **contraindications** been ruled out?

### Begin opioid therapy:

Document

Monitor

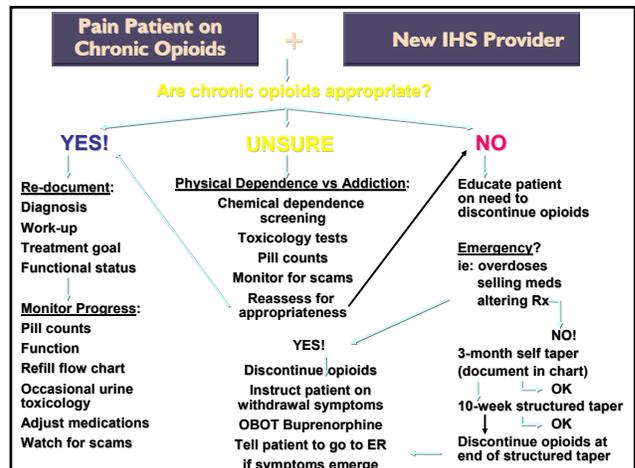
Avoid poly-pharmacy

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## Contraindications to opioid therapy

- Allergy to opioid medications ~ **relative**
- Current addiction to opioids ~ **??absolute**
- Past addiction to opioids ~ **?absolute**
- Current /past addiction, opioids never involved ~ **relative; ??absolute if cocaine**
- Severe COPD or OSA~ **relative**
- **Concurrent Sedative hypnotics~relative**

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## How to screen for addiction

- Perform an AUDIT and CAGE.
- Ask family or significant other the f-CAGE.
- Perform one or more toxicology tests.
- Ask prior physicians about use of controlled medications (f-CAGE).
- If history of current or prior addiction, has the patient ever abused opioids?
- Query the Pharmacy Board, PMP, NASPER

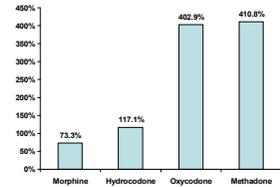
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## NASPER

National All Schedules Prescription Electronic Reporting Act

- Signed into law by President Bush August 2005
- Point of care reference to all controlled substances prescribed to a given patient
- Each state will implement it's own program
- Treatment tool vs. Law enforcement tool?

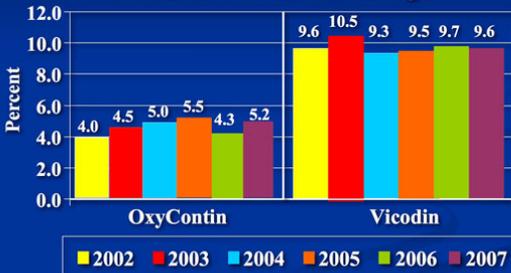
Sale of Opioids 1997-2002



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## Issues of Concern

Percent of 12th Graders Reporting Nonmedical Use of OxyContin and Vicodin in the Past Year Remained High



No year-to-year differences are statistically significant.

## The CAGE and f-CAGE

- **CAGE** =
  - Cut down on use?
  - Comments by friends and family about use that have Annoyed you?
  - Embarrassed, bashful or Guilty regarding behaviors when using?
  - Eye-openers to get started in the mornings?
- **f-CAGE** = Ask the patient's significant other the CAGE questions about the patient's use of alcohol, drugs or medications.

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## Medical issues in opioid prescribing

- Potential benefits
  - Analgesia
  - Function
  - Quality of life
  - Lower costs
- Potential risks
  - Toxicity
  - Functional impairment
  - Physical dependence
  - Addiction
  - Hyperalgesia

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## Review of opioid efficacy

- In short-term studies:
  - Single in vitro studies
  - Oral studies  $\leq$  32 wks
  - Both demonstrate that CNMP **can be** opioid responsive

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## Review of opioid efficacy (cont.)

- **In long-term studies:**
  - Usually observational – non randomized / poorly controlled
  - Treatment durations  $\leq$  6 years.
  - Patients usually attain satisfactory analgesia with moderate non-escalating doses ( $\leq$  195 mg morphine/d), often accompanied by an improvement in function, with minimal risk of addiction.
- The question of whether benefits can be maintained over years rather than months remains unanswered.

– Ballantyne JC: Southern Med J 2006; 99(11):1245-1255

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## Conclusions as to opioid efficacy

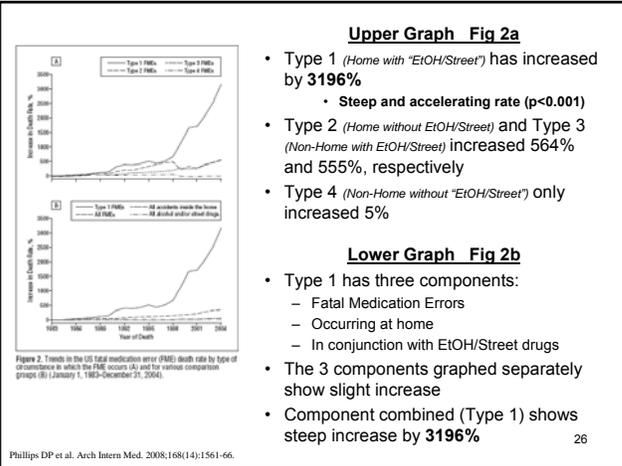
- Opioids are an essential treatment for some patients with CNMP.
  - They are rarely sufficient
  - They almost never provide total lasting relief
  - They ultimately fail for many
  - They pose some hazards to patients and society
- It is not possible to accurately predict who will be helped – but those with contraindications are at high risk

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## Conclusions as to opioid efficacy

- A trial (6 mo±) generally is safe (IF contraindications are ruled out)
- People who expect to take opioids and lie around the house while they get well, won't.
  - Push functional restoration, exercises
  - Lifestyle changes and weight loss
  - Make increased drugs contingent on increased activity

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## Desirable patient characteristics:

- No substance abuse disorder
- Reliable
- History of good medical compliance
- Willing to do their part to recover
- Recognizes that opioids are only a partial solution
- Good support (no substance abusers in the home)

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## Formulate a treatment plan:

- Goals
  - Pain
  - Function
    - What should the person do anatomically?
  - Quality of life
  - Affect?
- Opioids or not
- Other treatment components

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## Opioids – Often necessary, rarely sufficient

- Reconditioning program
- Physiological self-regulation
  - Yoga, biofeedback training, meditation, OMT
- TENS
- Adjunctive medications
  - NSAIDs and acetamenophen / antidepressants / AEDs / topicals

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## Educate the patient and family

Side effects - Risks - Drug interactions  
 – Start no new med, even OTC, without discussion

Pregnancy - Danger signs - What opioids can/can't do – Secure storage

- Risks to a teen who abuses / Child who takes inadvertently

Methadone variable T1/2, accumulation

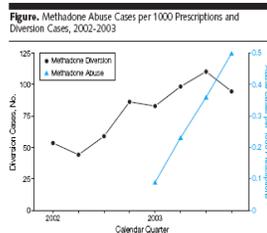
- Keep out of reach first week / administered by friend, family / Never by the bed or recliner

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## FDA Methadone Warning

### FDA ALERT [11/2006]: Death, Narcotic Overdose, and Serious Cardiac Arrhythmias

FDA has reviewed reports of death and life-threatening side effects such as slowed or stopped breathing, and dangerous changes in heart beat in patients receiving methadone. These serious side effects may occur because methadone may build up in the body to a toxic level if it is taken too often, if the amount taken is too high, or if it is taken with certain other medicines or supplements. Methadone has specific toxic effects on the heart (QT prolongation and Torsades de Pointes). Physicians prescribing methadone should be familiar with methadone's toxicities and unique pharmacologic properties. Methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours). Methadone doses for pain should be carefully selected and slowly titrated to analgesic effect even in patients who are opioid-tolerant. Physicians should closely monitor patients when converting them from other opioids and changing the methadone dose, and thoroughly instruct patients how to take methadone. Healthcare professionals should tell patients to take no more methadone than has been prescribed without first talking to their physician.



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## Prescribing Practices Warranting Board Scrutiny

- Issuing prescriptions for large amounts of controlled substances and/or in excess of prescribed dosage
- Failing to keep accurate records
- Failing to evaluate/monitor patients
- Prescribing to drug-dependent persons without adequate consultation/evaluation and monitoring

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## Patient monitoring, using a systems approach

### Use a flow chart to monitor patient progress

- Assessment of function / pain assessment
- Medication(s) / Dose / Refills
- Toxicology test results (quarterly/random)
- Corroboration phone calls re: function / (quarterly)
- Info from your state's Pharmacy Board web-site query (twice yearly), NASPER
- Referral / Study / Test follow through
- Etc.

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## Monitor when initiating opioid treatment for CNMP

- Identify a clear diagnosis.
- Document an adequate work-up.
- Ensure that non-opioid therapy failed or is not appropriate (tx. rationale).
- Identify anticipated outcome (tx. goal).
- Use an Informed Consent Form
- ? Consult a physician with expertise in the part of the body / organ system involved

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## Monitor for side effects

### Short-term

- CNS: euphoria, anxiety, sedation
- Respiratory: respiratory depression & overdose
- CV: hypotension, edema
- GI: anorexia, vomiting

### Long-term

- Sleep disturbance including OSA
- Decreased testosterone, libido
- QTc prolongation
- Constipation
- Urinary retention
- Sweating
- Depression and other psychiatric co-morbidities

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## Monitor for use of other drugs

### Make access to opioids contingent on abstinence from illicit drugs / alcohol:

- Non-negotiable requirement for most
- Avoid arguments re "medical marijuana"

### If the patient is *unwilling or unable* to relinquish use of non-prescribed drugs:

- the pain problem most likely does not warrant chronic opioid therapy

### If the patient is *unable* to relinquish use of non-prescribed drugs:

- addiction treatment is indicated and pain treatment is jeopardized

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## Use of urine toxicology in monitoring

### Urine should contain the prescribed drug/s:

- If not, the patient may be diverting or providing a fake sample to cover other substances, make sure you know what your UDS is capable of detecting

### Urine should be free of non-prescribed substances:

- If the patient is unable to relinquish alcohol / recreational drugs in order to receive treatment, either treatment is not very important or the other drugs are overly important, and addiction assessment/RX is needed. (*Heit & Gourlay*)

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## Urine toxicology in monitoring (cont.)

### Test for what you're seeking:

- Immunoassays typically miss synthetics, semi-synthetics – SO ASK FOR THEM!
- GC/MS detects these but \$\$\$
- May need to specify compounds sought (e.g. methadone)

### Use “therapeutic drug monitoring” codes:

- e.g., treat the test clinically like a Digoxin or aminophylline level.

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## Urine toxicology in monitoring (cont.)

### Testing should be random

### Testing should be routine AND “for cause”:

- Open to biases (e.g., disproportionate testing of minorities),
- Misses 50% of those using unprescribed or illicit drugs.
  - Katz NP. American Academy of Pain Medicine 2001

### Excellent review of UDT available in online monograph:

- Gourlay D et al. 2002. ([http://www.alaskaafp.org/urine\\_test.htm](http://www.alaskaafp.org/urine_test.htm), accessed April 8, 2006)

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## Monitor for outcomes

- Analgesia – pain level – 0 -10 but subjective
- Affect – Beck Depression Inventory, Zung, Ham-D
- Activity level – Pain Disability Index, Oswestry
- Adverse effects – cognition, alertness, depression
- Aberrant behaviors – multisourcing, lost drugs

If not effective,



adapted from Passik & Weinreb, Adv Ther 2000

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### Summary: Monitoring strategy when prescribing chronic opioids

- Document functional improvement.
- Titrate opioids to improved function.
- Monitor medications (pill counts).
- Avoid non-planned escalation / early fills.
- Monitor for scams (informed consent form)
- Use toxicology tests (Q3-6months).
- Document, document, document!

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### Physical dependence

- Withdrawal syndrome when the drug is withdrawn acutely.
- May or may not be associated with increasing doses and increasing tolerance to the drug.
- May or may not be associated with abuse of the drug.

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### Abuse of Opioids

- Use of a medication outside the normally accepted standard for that drug.
- Recurrent problems in multiple life areas.
- Continued use in spite of negative consequences.
- Preoccupation with the drug, drug seeking behavior, loss of control of use.
- Tolerance or physical dependence may or may not be present.

Adapted from DSM IV, APA,1994

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### Aberrant behaviors that are less indicative of abuse

- Aggressive complaining about dose
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquisition of similar drugs from other medical sources
- Unsanctioned dose escalation 1-2 times
- Unapproved use of the drug to treat other symptoms
- Reporting psychic effects not intended by the clinician

Passik and Weinreb. 2002

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## Aberrant behaviors that are indicative of abuse

- Selling prescription drugs
- Forgery of prescriptions
- Stealing another person's meds
- Injecting / snorting oral preparations/ tampering with sustained-release preparations
- Obtaining from non-medical sources
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose escalations
- Recurring prescription losses

Passik SD, Weinreb HJ. Adv Ther. 2002

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## Recognize Drug-seeking behavior

- Pattern of calling for refills after hours.
- Prescriptions from multiple providers.
- Frequent visits to the Emergency Room
- Strong preference for specific drug ("allergic to everything but...")
- Repeatedly needing early refills.

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## What the clinician hears:

### Excuses:

- "I lost the prescription. I left it on the plane"
- "It was stolen out of my car/purse/bedroom."
- "The dog ate the prescription."
- "I spilled the bottle in the toilet."

### Fears / complaints:

- "That dose doesn't work anymore. I used a few of my mom's"
- "I can't sleep without it. I need it for my nerves"
- "I can't get through the day without it."

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## Aberrant medication use

### *Be prepared to intervene for:*

- **Inappropriate use or misuse**
- **Pseudoaddiction**
- **Chemical coping**
- **Physical dependence**
- **Abuse or addiction**
  - If the patient responds to intervention
  - If the patient is unwilling / unable to comply
- **Diversion**

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## Intervening for pseudo-addiction

- **Reassess medication management:**
  - adjustment of controlled drug therapy
  - adjunctive, lower risk medication
  - non-medication modalities
- **Referral/consultation:**
  - pain management
  - psych management
  - behavioral therapy
- **Restate or reframe therapeutic agreement and continue to monitor**

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## Intervening when abuse is suspected

- Express your behavior-specific concerns
- Ask further questions about drug use (how much, how often, increasing doses, need to supplement, symptoms of withdrawal)
- Ask about other drug or alcohol abuse
- Use urine drug screening and/or pill counts
- Include family members if available
- Look for a pattern: "rough guide"

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## Intervening when abuse is confirmed

### Express your specific concerns in terms of the patient's well-being:

"I know that you have a problem with pain...but I believe you also have a problem with how you are using your medication. These are the things I've noticed that worry me...."

"Do you agree that this is a problem for you?"

### Weigh the risks of continuing therapy with opioids or other controlled drugs.

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## Intervening when abuse is confirmed (cont.)

### Restructure the treatment agreement:

- Closer monitoring
- More tightly managed prescriptions
- Urine drug screening
- Pill counts

### Require a referral for addiction evaluation and treatment

### Consider the need for inpatient treatment

### If the patient is opioid-dependent, consider a referral for substitution or agonist treatment

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## Intervening when abuse is confirmed (cont.)

### Restructure the treatment agreement:

- Closer monitoring
- More tightly managed prescriptions
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## Intervening when abuse is confirmed (cont.)

"If you do not follow through with this referral and the consultant's recommendations, it will no longer be safe for me to prescribe this controlled medication.

In the meantime, we will have to manage your use of this medicine much more closely."

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## Intervening when the patient is unwilling or unable to comply

- Express your concern in terms of patient's well-being
- State that the particular medication is no longer safe or indicated and you will not continue to prescribe it (arrange taper or referral)
- Explore other therapeutic options
- Assess for withdrawal risk
- Refer for specialized addiction treatment

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## Non-emergency contraindications to continued opioid prescribing

1. Note in chart the reason for discontinuing opioids, non-emergency situation, outline of taper, end date for prescribing, referral to OTP or OBOT.
2. Have patient read and initial the note. (needed in EHR)
3. Prescribe 10% fewer opioid analgesics each week
4. Reassess on week #8 or earlier:
  - If going well, continue.
  - If not going well, plan detoxification
5. **At Week 10:** Stop prescribing and educate patient about withdrawal symptoms. Urge the patient to consider OBOT or to go to the ER if withdrawal is severe and treat for detoxification.

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### Emergency contraindications to continued opioid prescribing

1. Altering a prescription = *Felony*
2. Selling prescription drugs = *Drug dealing*
3. Accidental/intentional overdose = *Death*
4. Threatening staff = *Extortion*
5. Too many scams = *Out of control*

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### Emergency contraindications to continued opioid prescribing

#### *What is a provider to do?*

- Identify the contraindicated behavior.
- State that prescribing is inappropriate.
- Educate the patient about withdrawal symptoms.
- Instruct the patient about what to do if in withdrawal (OBOT, OTP, or ER).
- Offer care without an opioid, and/or a referral (OBOT/OTP).

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### Possible Interventions

- Weaning or tapering (avoid the term “detoxifying”)
- Referral for substance abuse treatment while tapering
- Substitution or agonist therapy with methadone or buprenorphine (OBOT)

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### Legalities

- **Only specifically licensed programs / physicians can treat addiction with agonist therapy.**
- **Any physician licensed to prescribe controlled substances is licensed to taper them when they are contraindicated, no longer needed or effective**

– Heit HA, Covington EC, Good PM, Pain Medicine 2004;5(3):303

- *Note: PDR recommendations support this stance.*

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## Three phases of weaning

- **Establish a baseline**
  - Opioids
  - Sedatives
- **Dose reduction**
  - There are numerous ways to do it
  - None is demonstrably superior
  - Excellent summary: Fishbain DA et al., *Annals of Clinical Psychiatry*, 5:53-65, 1993)
  - Sedatives
- **Treatment of protracted / post-acute withdrawal** with OBOT or OTP

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## Opioid withdrawal

Hours after use	Grade	Symptoms / Signs
	<b>0</b>	Anxiety, Drug Craving
4-6	<b>1</b>	Yawning, Sweating, Runny nose, Tearing eyes, Restlessness, Insomnia
6	<b>2</b>	Dilated pupils, Gooseflesh, Muscle twitching & shaking, Muscle & Joint aches, Loss of appetite
8-12	<b>3</b>	Nausea, extreme restlessness, elevated blood pressure, Heart rate > 100, Fever
12-72	<b>4</b>	Vomiting / dehydration, Diarrhea, Abdominal cramps, Curled-up body position

## Medications for opioid withdrawal

- **Buprenorphine (OBOT)**
- **Alpha-2 agonist: Clonidine**
  - 0.1 mg prn if systolic BP  $\geq$  120
  - Consider transdermal
- **Sedation / tranquilization**
  - Trazodone
  - Doxepin
  - AEDs given for pain also reduce the anxiety component
  - Others
- **Loperamide (Imodium)**
- **Anti-emetics**

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## Substitution or agonist therapy: Opioid addiction or dependence

Appropriate for illicit or prescription opioid abuse with associated physical dependence

### Rationale for agonist therapy:

- Cross-tolerance
- Prevents withdrawal
- Relieves craving
- Blocks euphoric effects of other opioids

### Available alternatives:

- Methadone
- Buprenorphine (Subutex)
- Buprenorphine/naloxone (Suboxone)

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## Finding a resource for referral

- *On the web:* The electronic, searchable version of SAMHSA's updated ***National Directory of Drug and Alcohol Abuse Treatment Programs*** is available on the Web at <http://FindTreatment.samhsa.gov/>
- [www.buprenorphine.samhsa.gov](http://www.buprenorphine.samhsa.gov)
- *In the community:* Contact ASAM See [www.asam.org](http://www.asam.org) for addiction Rx information.