**Transcript Details**
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/prescribing-opioids-safely-for-patients-with-chronic-pain/3888/

**ReachMD**
www.reachmd.com
info@reachmd.com
(866) 423-7849

Prescribing Opioids Safely for Patients With Chronic Pain

**Treating pain is neither an absolute science nor risk-free. How can doctors safely prescribe opioids and what are the risks of addiction. You are listening to ReachMD XM160, The Channel for Medical Professionals. Welcome to The Clinician's Roundtable. I am your host, Dr. Mary Leuchars and joining me from Boston today is Dr. Daniel Alford who is Associate Professor of Medicine at Boston University School of Medicine and Director of Chief Resident Immersion Training in Addiction Medicine at Boston Medical Center. We are discussing the use of opioids for chronic pain and the risks of addiction.**

DR. MARY LEUCHARS:

Welcome, Dr. Alford.

DR. DANIEL ALFORD:

Thank you.

DR. MARY LEUCHARS:

Dr. Alford, let's talk about what opioid analgesics actually are.

DR. DANIEL ALFORD:

They are actually commonly prescribed medication. I think they are more commonly prescribed for acute pain and that is people who come in after an injury. I am really talking about morphine, codeine and then some of the medications that are synthesized from those like oxycodone, hydrocodone, or Vicodin and medications like that. I think medications of the opioid variety that are being used for acute pain started to also be used for chronic pain and namely pain that was a result of cancer and there was a fair amount of literature supporting the use of opioids chronically for cancer pain, but I think some of the problems have risen lately and that is the use of these medications chronically or over time **(01:30)** for chronic pain that's of non-cancer origin, chronic low back pain, nerve pain or neuropathic pain secondary to diabetes, and pain syndromes like that. I think there has been a lot of interest in research lately of these medications that not only are they great analgesics, but they carry a risk and the risk is of addiction. We don't really know exactly the perfect balance between using them to treat chronic pain and trying to minimize the amount of addiction as a result.

**DR. MARY LEUCHARS:**

How do you actually define chronic pain in a patient, what's the major hallmark?

**DR. DANIEL ALFORD:**

Chronic pain is defined in the literature and some sources we talk about at least 3 months and others at least 6 months. Usually, it's a chronic daily pain complaint that lasts at least 3 months. I think beyond that it is something we call chronic pain syndrome and that is beyond the pain complaint. There is a level of dysfunction, unable to work and unable to perform activities that were performed prior to the pain starting.

**DR. MARY LEUCHARS:**

Tell us about the history of these drugs being used for chronic pain initially in cancer patients. What are the new drug user patterns in order to abuse them?

**DR. DANIEL ALFORD:**

That's another difficult question and that is, you know, when this patient, who is coming to you as chronic pain on these medications, on opioids, asking for more. When are they drug seeking or addicted to these medications versus when are they pain relief seeking **(03:00)** and that is that their pain just isn't relieved and they are requiring more medications and I think from a physician standpoint, it is often hard to know the difference and I call it the primary care advantage and that is that as a primary care provider you are able to develop a relationship over time and so you can monitor somebody as opposed to someone who works in the emergency room or someone who works in urgent care setting where you see the patient once and it's hard to know whether they are drug seeking or they are just pain relief seeking. As a primary care physician over time, I will start to see patterns that will worry me and what do I mean by that, patients who are running out of their medications early, patients who you know are acting what's called aberrantly and that is they lost their prescription or they are just acting intoxicated when you see them and there are some monitoring strategies beyond just looking for these behavior changes, we pretty much check urine drug tests on everyone of our patients that is prescribed opioids for chronic pain, looking for 1 – the presence of the opioid that we are prescribing to make sure that it is being ingested, but also that they are on other drugs that could be abused concurrently like cocaine or other stimulants or other sedatives like benzodiazepine such as Valium or Klonopin and so I think there are monitoring strategies and I think the other thing that is useful to do is to monitor pill count and so when patients come in for their visits, they should bring in their pill bottle and you should count them to make sure that the patient is taking it as prescribed **(04:30)**. None of these strategies will diagnose addiction 100% of the time, but at least it's an effort on the physician's part to try to keep track of the patient, realizing that there is the risk of addiction with this medication and then if you are not monitoring and you are not paying attention, you will lose sight of the patient who does become addicted.

**DR. MARY LEUCHARS:**

How do you stop the problem of doctor shopping, if at all?

**DR. DANIEL ALFORD:**

There are strategies out there and I think there are prescription monitoring programs that a lot of states are now using and that is that when a new patient comes to you, you are able to check their prescription history by logging in using your special ID to see you know

where a patient has been prior. I think also pharmacists are getting much more comfortable talking to physicians and calling up prescribers and saying you know this patient has gotten multiple prescriptions from multiple different doctors and you know some times that's doctor shopping and it's a sign of addiction and a sign of patient losing control. Other times, it's just the sign that your practice like mine has 26 other doctors and when I am not in clinic another doctor will okay the prescription that I would have written if I was there and so I think it's actually nice to have this open dialogue now with pharmacists because I think they see another piece of, you know, patient profile that we don't necessarily have access to.

**DR. MARY LEUCHARS**:

How do you define dependence versus addiction?

**DR. DANIEL ALFORD**:

This was one of the first things that we cover when training doctors about this issue **(06:00)** and that is the difference between physical dependence and addiction and that is when a patient takes opioids for any length of time, they become physically dependent and that's just a biological property of the medication and there are lots of medications that we prescribe that cause physical dependence and physical dependence is when a patient stops taking the medication, they go through some type of withdrawal and with opioids, the withdrawal is nausea, vomiting, diarrhea and as if they had a viral syndrome and that's physical dependence and that's not addiction because again it's just a biological property. Addiction on the other hand though is a behavioral maladaption to the opioid and that is they are no longer taking it for the purpose of what you prescribed it for, but they are now living an addiction. The way it presents is kind of a loss of control, compulsive use, and really continued use of the medication despite harm. You know what happens, some times patients will get in car crashes or they are falling sleepy in the middle of the day because they have too much medications on board yet they still want more and this is just kind of drug craving or hunger that goes on and that's you know the behavioral aspects of addiction as opposed to the physical dependence that patients get from this. It's a little confusing because the DSM IV, which is the textbook that describes various psychiatric diagnoses, describes opioid dependent and they don't use the word addiction **(07:30)**. They talk about opioid dependence and the word dependence gets confused with physical dependence, but opioid dependence by this textbook includes both the biological properties that I have described to you, but also the behavioral pieces. Again, that's loss of control and compulsive use and so it gets really confusing for the practitioner, but I think it's important for people to realize that physical dependence does not equal addiction.

**DR. MARY LEUCHARS**:

You've talked about the 4 phases of addiction; can you just run through those?

**DR. DANIEL ALFORD**:

Sure, it's loss of control, compulsive use, continued use despite harm, and craving or drug hunger the patient describes.

**DR. MARY LEUCHARS**:

Do we know the likely percentage of patients who will develop an addiction or dependence to opioid medication when they are taking it for chronic pain?

**DR. DANIEL ALFORD:**

That's a great question and <_____> **(08:18)** worded and that is when a patient comes to you with chronic pain and you give them an opioid for that chronic pain what's the likelihood that they are going to develop an addiction and unfortunately we don't really know that number. So, when you look at population studies, the patients who are getting chronic opioids for chronic pain, the rates are about 3 to 19% n the literature and what's interesting is that that's pretty much the same percent of the US population that has addiction to other substances whether it be alcohol or other drug and so it's not surprising that the risk factors for developing addiction to an opioid analgesic for pain **(09:00)** are the same risk factors for developing addiction to alcohol, cocaine, or any other drug of abuse and that really is prior history of addiction or lifetime history of addiction disorder or family history of substance abuse or a history of legal problems or other social problems and so I think you know you can look at the risk of anyone who is coming to you asking for opioids for chronic pain has a same risk of addiction to any substance that they might get exposed to. Now, the way I use that in clinical practice is that I tell the patient that they are at higher risk. It doesn't mean it's an absolute contraindication and that I wouldn't try to treat their chronic pain with opioids if I thought it was indicated. It's just that I will forewarn the patient that they are at higher risk for developing a problem and that I am going to be monitoring them closely so that if they develop another problem, namely addiction, that I am going to you know help them work through it.

**DR. MARY LEUCHARS:**

How significant is the family history in evaluating the patient who is most likely to become dependent on these drugs?

**DR. DANIEL ALFORD:**

It is about a 4-fold risk in someone who doesn't have a family history.

**DR. MARY LEUCHARS:**

And what is biologically attributed to, is there a genetic marker or?

**DR. DANIEL ALFORD:**

There only isn't 1 gene that's responsible for this, but multiple genes and it's probably more of a genetic predisposition and that is you might be predisposed for developing an addiction to any substance of abuse, but if you don't get exposed to it, that is you don't have the environmental key, then you we will never express **(10:30)** that genetic predisposition. Multifactorially, I think the genetic predisposition is to be there, but also the environmental exposure needs to be there as well.

**DR. MARY LEUCHARS:**

How is the best way to talk to patients about stopping their opioid tablets for chronic pain, how do you go about that?

**DR. DANIEL ALFORD:**

The first thing you need to do is monitor people over time not only in terms of are they losing control and all other things you look for addiction, but are the opioids actually helping them and we look for pain relief and we look for improvement in function and if they are not getting clinical benefit over time, regardless of whether or not they develop signs of addiction, then it's really time to make a change and so I think it's important to give the patients feedback and that is - over the last few months I haven't noticed any improvement in your pain symptoms or in your ability to function, therefore I don't think this is a good medication for your problem, we will try something else or if you think the person actually has developed addiction, again I think it's important to give them feedback and that is by saying – you know, you have lost your prescription, you have come early even though I have told you that you can't run out early and you need to take them as prescribed and if your pain is worse, then you do let us know so that we can make adjustments, you haven't complied with your pill count or your urine drug screen showed cocaine and what have you by giving the patient feedback and so there is some rationale for why you say – I think you have a new problem and that is addiction and you may agree to disagree on this point, but as your physician, I think it's time that **(12:00)** we need to make the changes and one change will be to stop giving you this medication that I think you are addicted to, but also importantly is to offer them addiction treatment, offer them a referral to addiction treatment and hopefully you have that available to you in the clinical practice.

DR. MARY LEUCHARS:

Well, thanks very much Dr. Alford for being our guest today. We have been discussing the risks of prescribing opioids to patients

**I am Dr. Mary Leuchars, you have been listening to the Clinician's Roundtable on ReachMD XM160, The Channel for Medical Professionals. To listen to our on-demand library, visit us at www.reachmd.com. Register with promo code radio and receive 6 months of free streaming to your home or office. Thanks for listening.**

**Welcome to doctor's Digest, a feature of ReachMD Radio on XM160. Doctor's Digest - bridging the gap between the business of the medicine and the practice of medicine.**

**So, on physicians working more hours than others but the average clocks are a lot more than the standard 40-hour week. Dermatologists, emergency medicine physicians, and pathologist clock in at around 46 hours a week and those in anesthesiology, obstetrics and gynecology, general surgery, or urology average over 60 hours a week.**

**Not surprisingly, many physicians decide to go part time at some point during their career. Toping the list of reasons for going part time are caring for children, easing into retirement, taking some courses, or exploring new business ventures.**

**But there will be some challenges. Earning less money is one; another is your colleague's reaction when you decide to cut back. You may have to ignore judgments about what a physician supposedly should do. Once you decide to go part time (13:30), you may need to be creative to come up with a plan. If you have a full patient load, consider reducing your hours gradually to avoid overloading your colleagues. If you are solo physician or in a small group, you might start by closing the practice to new patients or giving notice that you will stop participating in some insurance plans.**

**If you are a husband and wife team, consider job sharing and if more than 1 physician in your office is going part time, try to work out a cross-coverage plan with each other. If you are looking for a new physician, look beyond what the employment ad in the back of the**

journal says. A place that really needs physicians may be willing to consider part time even if they prefer to have you full time.

Before you take the plunge, put your financial house in order. Take a look at taxes, insurance, debt management, retirement planning, and college savings and if possible, pay down any debts before you go part time. If you are not paying off credit card balances each month, reassess your spending habits.

Finally set aside funds for emergencies. Financial experts recommend having at least 6 months living expenses on hand and saving money market account.

You have been listening to Doctor's Digest, a feature of ReachMD Radio on XM160. To learn more about effective communications and to receive free access to back issues, visit us at www.doctorsdigest.net. Click on e-subscription and enter promo code ReachMD. Doctor's Digest, Your Guide to Practice Management.

Hello, my name is Maureen Corry. I am executive director of childbirth connection, a national not-for-profit organization that works to improve the quality of maternity care and you have been listening to ReachMD.

You are listening to ReachMD XM160, The Channel for Medical Professionals.