

# The Intersection of Pain Management and Addictive Illness: Where Do We Start the Conversation?

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## Exercises

### 1. Ice breaker

Please go around the room and identify yourself and where your work. Then tell us one (and only one!) of three things about yourself and this topic:

- Why you are here
- A question you hope to have answered today
- A problem or issue you hope to have addressed today

### 2. How do you feel when you have to care for someone with an addictive disorder?

“I will pass out colored paper and crayon boxes—you can select whatever color you wish to have of both the paper and crayon. Clear your thoughts for a moment and consider this question: ‘How do you feel when you have to care for someone with an addictive disorder (especially someone with alcohol or drug addiction)?’ Now in your non-dominant hand I would like you to take about 5 minutes to write down those feelings—we are not sharing what you write with the group and we will not collect them—so you do not have filter your responses.” As participants complete the writing, ask them how was it to do this task . . . (easy, hard ??) Typically, a discussion does ensue - why did I have them do it- why write with crayons, why write in their non-dominant hand.

### 3. What is the same and what is different about managing pain with opioids vs managing some other condition with another class of drugs (ex., hypertension; diabetes; infection)? Given a condition such as hypertension—what therapeutic and side effects (including mental and behavioral changes) do we look for? When do we consider the possibility of poor adherence to the regimen? How do we decide to adjust the dose or change the medication? Are any of these parameters applicable to managing pain with opioids? What other conditions have behavioral components that may make treatment complex and difficult? When would we decide to “fire” the patient?

### 4. Some characteristics of opioids are shared by agents in other classes—can you identify examples?

- a. Physical dependence
- b. Tolerance
- c. “Dose-finding” via titration

- d. Potential for “abuse”
- 5. “Addiction” may or may not be well-defined legally, but it is certainly not well-defined medically. Let’s try to come up with a consensus definition of ‘addiction’—not necessarily an elegant textbook definition, but at least lets figure out what the elements are so that we can tell a clinician who never heard of this disease called addiction, how to do a differential diagnosis.
- 6. Assign a role called ‘devil’s advocate.’
- 7. Is there such a thing as ‘iatrogenic addiction?’
- 8. What are the clinical issues that arise when considering opioid management of pain?
- 9. Small group exercise  
Divide the larger group into smaller groups of 5-8 people. Assign one of the tasks below. Participants have 30-45 minutes to complete the task. At the end, each group reports back to the main group on their task, findings, and problems.

Develop guidelines, a protocol, an algorithm, or a policy applicable to MGH on one of the following areas:

- a. Longitudinal management of an opioid-tolerant patient preparing for major elective surgery (ex., hip arthroplasty)
  - b. Management of a patient with chronic pain in primary care that balances the imperative to relieve pain with the responsibility to protect the patient, society, the institution, and ourselves from inappropriate use of opioids.
  - c. Protocol to differentiate “drug seeking” from “pain relief seeking.”
- 10. Terminology: what do we mean by
    - a. “aberrant drug-taking behaviors?”
    - b. “drug seeking” [use the McCaffery questionnaire]
    - c. “over-dose” or “over-dosing”
    - d. opiophobia
    - e. pseudoaddiction
    - f. iatrogenic addiction
    - g. addiction/addictive illness/the disease of addiction
    - h. dependence
    - i. tolerance
  - 11. Let’s generate a list of “aberrant” drug-related behaviors that might raise concern about the possibility of abuse.

12. The comedian Jerry Lewis says he was addicted to Percocet for chronic back pain. His “proof”—he once bought a couple of tabs on the street when he ran out. Does this indicate “addiction?”
13. Have participants complete—then discuss—McCaffery’s “Drug Seeking” questionnaire from: McCaffery M, Grimm MA, Pasero C, Ferrell B, Uman GC. On the meaning of "drug seeking." *Pain Management Nursing*. 2005 Dec;6(4):122-36.  
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<http://www.painmanagementnursing.org/article/PIIS1524904205001475/journalimage?img=PIIS1524904205001475.gr1.lrg.gif&fig=&kwhquery=null>  
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<http://www.painmanagementnursing.org/article/PIIS1524904205001475/journalimage?img=PIIS1524904205001475.gr2.lrg.gif&fig=&kwhquery=null>
14. Consider a time (you don’t need to say it aloud) when they might have used a prescription or OTC medication not exactly as prescribed
- What induced you to do that?
  - Was that drug seeking or pain (symptom) relief seeking?
  - Can addicts also have "real pain" and not just be drug seeking?
15. Place in descending rank order (most important first) the populations in whom pain management is most important
- Trauma
  - Post-operative
  - Diabetes
  - Shingles
  - Morbid obesity/bariatric
  - Chronic low back
  - Addictive illness
  - HIV/AIDS
  - Cancer
  - Pediatric
  - Medically unstable ICU
16. Variation of #15: rank order the most to least “socially acceptable” diagnosis:
- Alcoholism
  - Diabetes
  - Drug addiction
  - HIV/AIDS
  - Lung cancer
  - Morbid obesity
  - Spinal cord injury sustained during bungee jumping

What features do these diagnoses have in common?  
What distinguishes the least from the most “socially acceptable?”

17. Cases (Appendices)

- a. Neuropathic pain
- b. Famous person, hidden pain and medication records
- c. “Aberrant” behavior in surgical patient with history of cocaine use.
- d. Use Haddox & Weissman’s index pseudoaddiction patient to initiate a conversation about potential alternative reasons for aberrant behaviors”
- e. Former heroin addict hit by car

18. What are the ethical dilemmas that come to mind when you consider caring for a patient taking opioid analgesics?

## Appendix A--cases

### Case #1

J is a 45 year old man who is college educated but has been out of the country most of the previous 20 years, studying in an ashram. He is under-employed, living in a borrowed apartment, and has MassHealth. He was discharged on Tuesday after a 5-day stay on the neuro unit following a neurological injury to his right arm sustained during an accident. He initially had partial paralysis and severe burning pain, but both were showing clear signs of improvement. At discharge his pain ranged from 3-6/10 depending on activity. He was discharged on gabapentin 900 mg BID and hydromorphone 2-6 mg q 4hr PRN. He was told to experiment to see what dose of hydromorphone worked best for him. J was very pleased with his inpatient treatment, but nervous about going home alone. He was given a follow up appointment one week later with the neurologist. J determined that the best dose of hydromorphone was 4 mg. He managed to stretch the interval between doses to an average of 6 hours, but had progressively worse pain for the final 3 hours, sometimes approaching 7/10 or even 8/10. By Friday evening J was running low on hydromorphone (2 mg tabs #30 had been dispensed) and it was clear he wasn’t going to make it to the following Tuesday. He called the neuro unit to ask for advice. The nurse, who happened to be one who had cared for him as an inpatient, told him he should be tapering his hydromorphone, using it only when necessary, and instructed him to increase the interval to 8 hours. Even this wasn’t going to make his last 8 tablets last until Tuesday afternoon, so J went to the ED on Saturday morning. He was given a new prescription with a sufficient number of tablets to get him through until Tuesday afternoon—but only if he reduced the dose to 2 mg.

- Was J (pharmacologically) treated appropriately as an inpatient?
- Were his discharge medications and instructions appropriate?
- Was the nurse who gave him advice on Friday evening on the right track?

- What factors/issues would the ED physician need to consider when evaluating and prescribing?

### **Case #2**

The patient had a plastic surgery procedure (rhinoplasty). He had a history of cocaine abuse (not sure if still using). Although this was initially planned as an ambulatory procedure, the surgeon decided that the patient should be kept over night with morphine PCA. The patient became adamant and unruly. He just wanted to go home. How should this patient be handled? Should he be sent home on opioids?

### **Case #3**

“A 17-year old man with acute leukemia and no prior history of drug or alcohol abuse was hospitalized with fevers and bone-marrow aplasia. Several days into his hospital course he began complaining of continuous chest-wall pain directly over a new pulmonary infiltrate associated with a pulmonary friction rub. Initially he was given 5 mg of intravenous morphine every 4-6 hours prn pain. Over the next several days he made repeated requests for pain medication prior to the 4-6 hour dosing schedule. This prompted discussion between nurses and physicians resulting in repeated one-time orders for additional intravenous morphine or meperidine. During this time he was also receiving 50 mg of intravenous meperidine to control shaking chills during amphotericin administration. After one week of continued chest pain he began requesting meperidine for relief of chills unrelated to fever, amphotericin, or blood product administration. He also began to complain of a variety of aches and pains for which he requested additional pain medication. The medical and nursing staff were not convinced that his pains were due to objective pathology and suggested (in written chart notes) that he was becoming addicted to meperidine and morphine. The house staff consulted the cancer pain management team for advice on how to manage the ‘addiction.’”

### **Case #4**

A person is hit by a car while intoxicated; he is a former heroin user. He survives the original vehicle-to-person assault and is begging for pain medications. Estimate the likelihood that this is “drug-seeking” behavior vs pain behavior.