PAIN AND ADDICTION – Assessment Framework and Appropriate Treatment

Chronic non-cancer pain (CNCP) continues to be a challenge for suffering patients and doctors who are called upon to prescribe effective treatments. Chronic opioid therapy has been increasingly recognized as an appropriate approach but problems continue to exist related to improper assessment and clarification of diagnoses. Patients are often denied benefit of opioids because of being labeled 'drug seeker' or 'drug addict'; or conversely, may be enabled in their addiction by prescription of potentially dangerous medications (opioids, benzodiazepines, stimulants etc.) under the guise of treatment of pain. This latter group of patients is denied the benefit of addiction treatment and ancillary supports of mutual help meetings, while they face worsening of their disease ofaAddiction

Every patient presenting with acute or chronic pain deserves an appropriate assessment for their pain and screening for addiction. Routine use of CAGE-AID (Fig 1) and a urine drug screen will quickly identify people who require a more detailed assessment. Bloodwork is usually a part of the assessment of a complex problem like chronic pain, hence, obtaining an MCV and a liver profile (AST, ALT, GGT and bilirubin) also allow for a quick screen for any compromise of the physiology because of alcohol and/or other drugs.

Figure 1: CAGE-AID Questions (5)

1. Have you ever tried to ***C***ut down the use of alcohol and/or other drugs?
2. Have you ever been ***A***nnoyed by someone criticizing your alcohol and/or other drug use?
3. Have you ever felt ***G***uilty about the use of alcohol and/or other drugs?
4. Have you ever used alcohol and/or other drugs as an ***E***ye-opener to get yourself going in the morning?

Even one 'yes' answer to any of the CAGE-AID questions means further evaluation for addiction. Further, if there are other hints in the history of alcohol and/or other drug related problems; a more complete assessment is needed to ascertain whether the person meets the criteria for substance dependence (DSM IV) or addiction, as defined by the International Society of Addiction Medicine. A diagnosis of addiction may be made where there are problems related to pathological gambling, eating disorders and/or other addictive behaviours where impaired control is clearly identifiable.

A categorical framework (Fig 2) is useful in conceptualizing how a patient may be primarily an addiction patient (Category A) who would benefit from a trial off opioids and non-opioid therapy for pain; or primarily a pain patient (Category B) who is unlikely to exhibit persistent aberrant behaviour in relation to opioid therapy; or a complicated pain and addiction patient (Category C) who requires chronic opioid therapy in addition to addiction treatment. Category A patients may require agonist therapy in the form of methadone or buprenorphine maintenance, if opioids were their drug of choice and repeated relapses have occurred in trying to follow total abstinence. Category B patients may exhibit aberrant behaviour that is sometimes called 'pseudoaddiction' and mostly

falls under the diagnostic category of substance abuse. This can be managed with appropriate boundary setting and education. Substance dependence or addiction must be recognized as a more serious problem, which is more challenging to treat in Category C patients. However, simultaneous utilization of recovery resources with agonist opioid therapy is far more beneficial than trying to avoid the addiction diagnosis because of pain being present. Diligent follow-up is essential for all three categories of patients. Category C patients over time may achieve sufficient stability in recovery to consider becoming opioid-free similar to a Category A patient who tapers off methadone after some years of maintenance. Proactive ongoing assessment and monitoring also helps identify Category C patients who may have been initially classified as a Category B patient. Labeling aberrant behaviour in these patients as 'pseudoaddiction' impedes appropriate intervention and harms the patient in being denied addiction treatment.

Figure 2: Categorization of patients seeking opioids for pain

- A. Addiction unmasked... -> opioid-free or agonist maintenance (e.g. Methadone)
- B. No addiction
- C. Addiction and Pain that is unmanageable without opioids

- ALL REQUIRE A BIO-PSYCHO-SOCIAL-SPIRITUAL APPROACH TO TREATMENT
- CATEGORY B PATIENTS INVARIABLY HAVE PSYCHO-SOCIAL-SPIRITUAL ISSUES – ADJUSTMENT DISORDER/CO-DEPENDENCY

In summary, it is essential that every physician learns to appreciate that having pain does not preclude addiction; and patients with a ddiction may require chronic opioid therapy for CNCP. Assessment for pain routinely needs to include judicious screening for addiction related problems; and recovering addicts need to be considered for chronic opioid therapy for CNCP with appropriate monitoring and boundary structures.

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