Take Patient’s Word in Judging Chronic Pain

BY FRAN LOWRY
Orlando Bureau

ORLANDO — Do not confuse addiction with physical dependence when prescribing opioids for your chronic pain patients, Dr. Jennifer P. Schneider advised at the annual clinical meeting of the American Academy of Pain Management.

“Doctors are un-comfortable with this.”

The field of chronic pain management is full of misconceptions, she added. For example, cancer pain is more likely to get treated than noncancer pain, because practitioners falsely believe patients will become addicted to their pain medications; some physicians may not be concerned about the risk for addiction in this population because they perceive these patients as being close to death.

“This is faulty thinking. Addiction is not the same as physical dependence or tolerance. We’ve got to get that message across to clinicians,” she said.

Sometimes physicians get suspicious when patients complain that their original dose either relieves pain less effectively than before or has stopped altogether, Dr. Schneider said. “When this happens, ask patients about their function. Maybe they are having more pain because they are no longer just sitting on the sofa, like they used to. If they are now able to get up and walk the dog or do gardening, they will need more medication. So don’t just assume it’s tolerance, or worse, that they are drug seeking. If you don’t want them to get back to lying on the sofa, prescribe more.”

Long-acting opioids are preferable over shorter-acting agents, because they produce even blood levels and more stable pain relief. Short-acting drugs are more likely to cause a “buzz” as they get taken up by the brain. Patients also have to get in the middle of the night to take short-acting opioids to keep their blood levels constant.

Short-acting drugs are useful for acute pain, however, and can also be used for rescue dosing, Dr. Schneider said.

There is no evidence for major organ toxicity with opioids. However, constipation is a problem for virtually all patients, and they should be aware of the importance of adequate hydration to minimize this. A stool softener also may be of benefit, she said.

Opioids lower testosterone levels in men, which can put them at risk for osteoporosis. Dr. Schneider advised replacing the testosterone to prevent the loss of bone and to give men more energy and muscle strength.

“The big buzzword” of opioid prescribing is diversion. “Are patients selling their drugs on the street? We all worry about this,” she said. To help guard against diversion, Dr. Schneider recommended doing routine drug screening with an additional screen for any special drugs that patients may be taking.

“A regular urine drug screen will pick up codeine, morphine, and heroin only, but not methadone, fentanyl, oxycodone, or hydrocodone,” he said. “Use an urine drug screen, make sure you test for other drugs, if you suspect the patient is taking other substances.”

A drug screen is also good to make sure patients are using the drugs as prescribed, she added.

Dr. Schneider reported that she also has her patients sign a contract with her, in which they attest they will not engage in illegal or diversional activity and will take their medication in a responsible manner. “If you do all these things and are victimized by someone who is a drug seeker, at least you have documented your efforts and have done everything you can,” she said.

Dr. Schneider advised treating opioid addiction with a “medical treatment model” that includes medication-assisted treatment and behavioral modification.

“Don’t forget about the dogs,” she said. “Pet owners addicted to opioids often get drug-seeking dogs. If you take the dogs away, they will complain of pain and counsel them to get more medicine. So don’t just assume it’s tolerance, or worse, that they are drug seeking. If you don’t want them to get back to laying on the sofa, prescribe more.”

This approach is effective, Dr. Schneider said. “When I do this, patients tell me they feel much better.”

Dr. Jennifer P. Schneider advised at the annual clinical meeting of the American Academy of Pain Management.

Transdermal Postoperative Pain Control Device Approved

BY ELIZABETH MECHCATIE
Senior Writer

A patient-activated transdermal product for short-term management of acute postoperative pain in adults requiring opioid analgesia has received Food and Drug Administration approval.

The fentanyl iontophoretic transdermal system, marketed under the trade name IONSYS by Alza Corp., was approved for use only in hospitalized patients.

In an interview, Dr. Eugene R. Viscusi, director of regional anesthesia and acute pain management, Thomas Jefferson University, Philadelphia, described IONSYS as a compact, preprogrammed, needle-free system that provides an alternative to administering morphine via intravenous patient-controlled analgesia (PCA). Each unit is about 2 by 3 inches, with adhesive backing and a dosing button.

The patient double clicks the button when analgesia is needed, and 40 mcg of fentanyl is delivered over 10 minutes.

The approval of IONSYS and of DepoDur, a sustained-release injectable morphine for epidural use approved in 2004, illustrate the movement of postoperative analgesia into this realm of less invasive and less burdensome technologies that are more user friendly and less cumbersome for patients and nursing staff, Dr. Viscusi noted. He has served as a scientific advisor to Alza, which has provided research support to Thomas Jefferson University.

IONSYS is applied to intact, nonirritated, nonexcoriated skin on the chest or upper arm, and is replaced every 24 hours or when 80 doses have been administered. A maximum of 6 doses per hour and 80 doses over 24 hours can be administered; no more than 1 dose every 10 minutes can be released. Patients should be titrated to comfort before starting treatment, the label says.

VIGILance Key to Avoiding Hassles in Opioid Prescribing

BY FRAN LOWRY
Orlando Bureau

ORLANDO — When opioids are prescribed for chronic pain patients, following the step-VIGIL system can lessen the threat of being scrutinized by the Drug Enforcement Agency.

The acronym stands for verification, identification, generalization, interpretation, and legal and ethical considerations. It was developed by David B. Brushwood, at the annual clinical meeting of the American Academy of Pain Management.

“The old advice that doctors will be okay as long they practice good medicine and document their actions thoroughly is wrong. I don’t agree with it. These things may get you out of trouble once you are in it, but I want to teach you how to stay out of trouble in the first place,” said Mr. Brushwood, who is a professor of pharmacy health care administration at the University of Florida, Gainesville.

Verification. This is the first step in staying out of legal trouble and involves using brief questionnaires, such as the Drug Abuse Screening Test (DAST) and the Screen and Triage Assessment for Patients with Pain (SOAPP) tests.

“When you interpret the results of these tests, you can ask yourself whether you now feel comfortable allowing the patient to have controlled substances,” Mr. Brushwood said.

This step also will help differ- entiate between the chronic pain patients and the “fakers and liars.”

Legal. This final step means staying squeaky clean with regard to meeting your legal requirements,” he said.

Follow state and federal laws for controlled substances, and make no exceptions.