The Anatomy of Chronic Pain and Opioid Misuse: Clarification of Diagnosis and Opioid Addiction

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Welcome!

Thank you for joining us for Paradigm’s 2012 webinar series. Replays of past webinars are available for viewing at www.paradigmcorp.com/webinars

The Anatomy of Chronic Pain and Opioid Misuse is a three-part series of pain-focused webinars

**Today:** Clarification of Diagnosis and Opioid Addiction

**May 2012:** Case Management, Treatment Decisions and Opioids

**August 2012:** Opioids and Cognitive Behavioral Therapy
First a few housekeeping points....

- Slides will advance automatically
- Question & Answer period at end
- You may submit questions at any time
  - Q&A Panel is on the lower right side (If you don’t see it, click the “Q&A” button in the upper right)
  - Type a question into the lower section of the Q&A panel that appears
  - Ask “All Panelists” and be sure to click “Send”
  - If we cannot answer during the session, we will e-mail you
- Replay will be available – look for our e-mail
- When the webinar ends, a short survey will pop up
  - There will be a CCMC section which must be completed to receive continuing education credits
- If you experience computer broadcast audio problems, please use the dial-in number posted in the Chat panel

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Chronic Pain—and Rx Abuse—are Chronic Problems

Pain medications are everywhere, and the potential for abuse is significant.

Pain medications are the most commonly prescribed drugs in the US\(^1\)

Hydrocodone is top prescribed medication in the U.S.\(^2\)

Admission rates for abuse of opiates other than heroin—including prescription painkillers—rose by 400% from 1998-2008\(^3\)

300,000 Americans a year go to the ER after overdosing on opioid painkillers\(^4\)

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The Line-Up: Pointing the Finger in the Right Direction

In the case of chronic pain and opioid misuse, who are the bad guys?

- Unclear Diagnosis
- Imprecise Treatment
- Confusing Definitions
Steven Moskowitz, MD
Senior Medical Director, Paradigm

• 28 years experience in physical medicine and rehabilitation and pain management
• 23 years experience in healthcare management and case management
• Clinical expertise in complex musculoskeletal and neurological conditions
• Practiced for 16 years at a large multispecialty clinic in MA in the neurology department
• Paradigm Medical Director for 15 years

Stephen Colameco, MD, MEd, FASAM
Medical Director, Volunteers of America Delaware Valley, Addiction Treatment Program
Medical Director, Paradigm

• Over 25 year practice in addiction medicine
• Certified by the American Society for Addiction Medicine in 1987, named a Fellow in 2003
• 2 years as a Paradigm Medical Director
Investigating Diagnosis and the Criteria for Opioid Use Disorders

Stephen Moskowitz, MD
Senior Medical Director, Paradigm
Investigating a Poor Outcome Case

Root Cause: Inaccurate Diagnosis

**FACT** Estimated 40-67% incidence of inaccurate or incomplete diagnosis in patient presenting to a pain treatment centers

**FACT** Commonly used physical diagnostic tests are imprecise at making a diagnosis for cervical or lumbar radiculopathy

**FACT** Opioids often not prescribed in accordance with universal guidelines

**FACT** Incorrect diagnosis leads to incorrect treatment
Impact of Treatment Decisions

Diagnosis impacts treatment decisions

Vague terminology leads to imprecise treatment

Radiculopathy

Epidural steroid injection, laminectomy, neuropathic pain meds, spinal cord stimulator, opioids

Discogenic pain

Discograms, IDET’s, spinal fusions, opioids etc.

Opioid tolerance

Escalating doses, ever-changing medications
Impact of Treatment Decisions

Diagnosis impacts treatment decisions

Vague terminology leads to imprecise treatment

**Fibromyalgia**
- Chronic pain syndrome, multiple complaints and body parts, polypharmacy (Cymbalta, Lyrica, Savella), opioids

**Sacroiliitis**
- Injections, radiofrequency ablation, fusion, activity avoidance, braces, opioids

**Complex regional pain syndrome**
- Injections, polypharmacy, spinal cord stimulator, lack of improvement, “spread”, opioids
54 year old female with chronic low back pain and leg pain

- Lumbar MRI negative; EMG/NCS negative; antalgic gait; reflexes and strength normal.

- Treating diagnosis: lumbar radiculopathy; she has had two back surgeries and is on Oxycontin 80 mg 3 times per day; she is asking for an increase in dose; pain is “excruciating”; MED is 360 mg.

- Oxycontin in the past has cut the edge off the pain. She had been on 10 mg BID.

- The MD states she has opioid tolerance.

What action is most appropriate?

A. MD should increase the dose by 25% since she has opioid tolerance
B. MD should immediately consider weaning off opioids
C. MD should begin process for a spinal cord stimulator trial
Inaccurate (or Unclear) Diagnosis

What does this mean?

- What is “inaccurate diagnosis”
  - Inaccurate physiological diagnosis
  - Over diagnosis /under diagnosis
  - Ignorance of the biopsychosocial model
  - Proliferation of diagnoses

- How does it occur?
  - Relying on subjective report
  - Over reading of diagnostic tests
  - Vague use of criteria
  - Conceptual bias: when all you have is a hammer, everything looks like a nail
Methods for Ensuring a Correct Diagnosis

Be systematic—Clarify the diagnosis

- **G**uidelines - access objective criteria for diagnosis (E.g., ODG, ACOEM, AMA, DSM)
- **O**bjective criteria for clinical assessment - do physical findings support diagnosis?
- **F**igure out if diagnostic testing is truly indicated
  - Are criteria met
- **I**nterpretation - careful interpretation of test results (Danger)
  - Know the common occurrence of incidental findings
  - Are test findings and physical findings concordant?
- **S**ocial and psychological factors impacting case
  - Impact of catastrophizing, fear avoidance, self efficacy, secondary gain defined?
- **H**elp the patient make good decisions

If need be, get your action team on the case
Case Example
Mr. C and the Ever-Increasing Morphine Equivalent Dose
Mr C


- Progressive escalation of opioids. Intrathecal pump with Dilaudid at 17 mg per day + oral Vicodin 120 mg per day MED: >20,000 mg. His physician continues to increase his dose.

- Continues to go to his pain physician with a complaint of lower back pain. Recent CT myelogram to look for surgical lesion. Recent increase in opioid dose. He continues to look for “relief” of his pain. He ambulates with a walker. Wife is very involved.

What is the likely reason for this high escalation opioid dose?

A. Addiction
B. Abuse
C. Physical dependence
On the Case: Clarifying Definitions and Defining Addiction

Stephen Colameco, MD, MEd, FASAM
Medical Director, Volunteers of America Delaware Valley, Addiction Treatment Program
Medical Director, Paradigm
The wrong term can mean the wrong diagnosis and wrong management approach.
Tolerance

Tolerance is defined by either of the following:

- A need for markedly increased amounts of a drug to achieve the desired effect \textit{or} markedly diminished effect with continued use of the same amount of the drug

- Don’t confuse:
  - Tolerance: Increased pain despite higher dose
  - Hyperalgesia: Increased pain because of higher dose

Neither is an excuse to continue escalating opioids
State of abnormal/unpleasant signs and symptoms that appears when a person stops taking a drug or chemical substance on which he or she has become physically dependent.

- Pain
- Sweating
- Diarrhea
- Restlessness

Excessive sweating can be a sign of withdrawal.
The body is constantly adapting to maintain a tight physiological balance (homeostasis).

Tolerance a way for the body to maintain that balance when exposed to daily doses of medications (opioids).

The body does so by various physiological adaptations aimed at compensating for the disturbances caused by the opioid.

When that opioid is removed or “wears off,” the prior biological adaptations are now needlessly in overdrive...the body must re-regulate.

Before and while it re-regulates a person feels the temporary symptoms of the various chemical imbalances. This includes the symptoms of withdrawal.

The body has become dependent.
A 60 year old woman is brought in the office by her 2 adult children who live with her.

Her pain doctor had recently increased her Lorcet from 10/650 mg every 6 hours, to every 4 hours. She also uses a 50 mcg Fentanyl patch. Her MED (morphine equivalent dose) is 180 mg per day.

The family states the opioid increase helped for a few days. But she is now asking for the medication more and more frequently, she is anxious, has run out of her prescription, and is restless.

The family is frustrated that no one will help her. They do not know what to do for her.

What is the best explanation for her complaints?
A. Tolerance
B. Physical Dependence
C. Withdrawal
D. All of the above
E. None of the above
As Opioid Doses Increase...

Tolerance
- Respiratory Depression
- Sedation
- Analgesia

Adverse Effects
- Increased pain sensitivity (hyperalgesia)
- Decreased pain threshold
- Endocrine Dysfunction

Addiction Risk
- Self-medication for negative mood states
- Developing cravings triggered by external or internal stimuli
Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.

- reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors
- often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

- American Society of Addiction Medicine
**What is Addiction?**

**Addiction made simple.**

**Addiction** is characterized by:

- Inability to consistently **Abstain**
- Impairment in **Behavioral** control
- **Craving**, or increased “hunger” for drugs or rewarding experiences
- **Diminished** recognition of significant problems with one’s behaviors and interpersonal relationships
- A dysfunctional **Emotional** response

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**Chronic pain makes diagnosing addiction much more difficult**

- 25% of people on opioids have a substance use disorder
- For many treating physicians, making a diagnosis of addiction is difficult
- Some addicts may exaggerate pain complaints to get opioids
- Patients with pain may have a “use disorder” even if it is not “addiction”
Addiction and Dependency are not DSM or ICD-9 diagnostic terms.

DSM-IV (currently used)

■ Substance abuse

■ Substance dependence (e.g. opioid dependence)

DSM-V (newly proposed)

■ Substance use disorders (e.g. opioid use disorder)

The term “addiction” may be more a distraction than a help
He entered an inpatient pain program: Despite some withdrawal symptoms, he detoxified from all opioids with good speed.

By week 2 he was ambulating with a cane. He progressed his exercise and posture. His wife had panic attacks and emerged as an obstacle to recovery.

Post discharge, he remained independent of opioids. He ambulated in the community and is not seeking medications.

What is the likely reason for this high escalation opioid dose?

A. Addiction
B. Abuse
C. Physical dependence
Summing it Up

Below are the key points you should know about understanding addiction terminology.

- The term “opioid dependence” means addiction in DSM and ICD language
- Terms denoting addiction are often misapplied to injured workers simply maintained on opioids (though they may be physiologically dependent)
- Even in the absence of “addiction,” high dose opioids are often problematic in many other ways including side effects, physiological dependence and problematic use
- Tolerance to analgesic effect is not a good reason for high-dose opioid treatment
- Distinguishing opioid misuse, abuse and addiction usually involves urine toxicology and evaluation of functional status
Paradigm’s Systematic Care Management Approach
Clarifying a diagnosis and understanding the definitions of substance abuse disorders are just the start to a better beginning.

The Diagnosis, Correct or Incorrect, Drives all the Care

Unclear, vague or inappropriate diagnosis related to injury

Early Signs of a Misdirected Case

- Escalation of opioids and polypharmacy
- Runaway procedures
- Excessively impaired function
Our next webinar, in May 2012, covers patient and provider behaviors that need to be addressed in management of substance use disorders in chronic pain.

What is the right treatment for tolerance, withdrawal, dependence, hyperalgesia, addiction?
Question and Answer Session

Please submit your questions for our panelists in the Q&A window on the right.

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Please use the toll-free dial-in number: 877-718-5092, pass code 1518438
Following are the leading guidelines for opioid use.

- APS/AAPM Clinical Guidelines
- ASIPP Guidelines
- VA/DoD Clinical Practice Guideline
- Universal Precautions in Pain Medicine
- Federation of Medical Boards -- Model Policy
- Cancer Pain Treatment Guidelines
- Other Guidelines
## How do they compare

### At a glance

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