Opioids
Pain & Addiction
Assessing and Managing Risk

Roman D. Jovey, M.D.
Physician Director
Addictions & Concurrent Disorders Centre
Credit Valley Hospital
&
Program Medical Director,
CPM Centres for Pain Management
Mississauga, Ontario

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**Opioid Risk Tool - Clinician Form**

*(including point values to score total)*

Mark each box that applies

<table>
<thead>
<tr>
<th>1. Family History of Substance Abuse:</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>□ 1</td>
<td>□ 3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>□ 4</td>
<td>□ 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Personal History of Substance Abuse:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>□ 3</td>
<td>□ 3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>□ 4</td>
<td>□ 4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>□ 5</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

| 3. Age (mark box if between 16 and 45) | □ 1    |

| 4. History of Preadolescent Sexual Abuse | □ 3    | □ 0  |

<table>
<thead>
<tr>
<th>5. Psychological Disease</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia</td>
<td>□ 2</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>□ 1</td>
<td>□ 1</td>
</tr>
</tbody>
</table>

**Scoring Totals:**

Low Risk = 0 – 3  Moderate Risk = 4 – 7  High Risk = >7

(Remove the scoring from the form if you plan to hand this out to the patient to complete!)

*Female / Male refers to the gender of the patient NOT the relative.

Webster LW. Pain Medicine 2005; 6(6): 432-442
Screener and Opioid Assessment for Patients with Pain (SOAPP-14Q)

Name: ____________________________ Date: __________________

Please answer each question as honestly as possible by circling the appropriate number. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How often do you have mood swings?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>2</td>
<td>How often have you smoked a cigarette within an hour after you wake up?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>3</td>
<td>How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>4</td>
<td>How often have any of your close friends had a problem with alcohol or drugs?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>5</td>
<td>How often have others suggested that you have a drug or alcohol problem?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>6</td>
<td>How often have you attended an AA or NA meeting?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>7</td>
<td>How often have you taken medication other than the way it was prescribed?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>8</td>
<td>How often have you been treated for an alcohol or drug problem?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>9</td>
<td>How often have your medications been lost or stolen?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>10</td>
<td>How often have others expressed concern over your use of medication?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>11</td>
<td>How often have you felt a craving for medication?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>12</td>
<td>How often have you been asked to give a urine screen for substance abuse?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>13</td>
<td>How often have you used illegal drugs (for example, marijuana, cocaine, etc) in the past five years?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
<tr>
<td>14</td>
<td>How often in your lifetime have you had legal problems or been arrested?</td>
<td>0 never 1 2 3 4 very often</td>
</tr>
</tbody>
</table>

Total SOAPP-R Score: _______

Positive = 7 or above  Sensitivity=0.91 Specificity=0.69  PPV=0.71 NPV=0.90

Ten Pearls for Prescribing Opioids for Chronic Pain

1. Take a good pain history
   - Pain locations, description, severity, aggravating and relieving factors
   - Symptoms of neuropathic pain (burning, shooting, tingling, numbness, swelling)
   - Pre-treatment functional assessment (go through a typical day with the patient) or use written tools (PDI)
   - **Screen for addiction risk** - Use the Opioid Risk Tool or SOAPP to risk stratify patients.
   - Screen for contributing psychosocial factors and concurrent medical problems

2. Do a relevant physical examination
   - Perform an MSK and neurological exam of the painful body locations
   - Look specifically for signs of neuropathic pain (hyperalgesia, allodynia, paraesthesia)
   - Look for secondary consequences of chronic pain (ie. stiffness, disuse muscle atrophy)
   - Document any physical stigmata of a substance use disorder (ie. skin tracks, spider nevi, etc)
   - Assess the patient’s pre-treatment mental status (ie. MMSE in older patients)

3. Try to establish a working diagnosis and differential diagnoses (or at least a pain mechanism)
   - Assemble a summary of previous investigations, consults and treatments
   - If gaps exist in the previous work-up, order appropriate investigations and consultations PRN
   - Rule-out serious, treatable causes of pain (ie. an occult cancer, PMR, aneurysm)
   - Is there a neuropathic component to the patient’s pain? Use the DN4 or LANSS
   - Is there psychosocial co-morbidity, which requires concurrent treatment? Use HADS to screen

4. Use rational polypharmacy: discontinue medications with more side effects than benefits
   - Taper and D/C sedating medications (ie. sedatives, muscle relaxants, sleeping meds)
   - Use tricyclics (amitriptyline, doxepin), trazodone, gabapentin, pregabalin, cannabinoid, tizanidine, quetiapine or olanzepine for sleep difficulties instead of benzodiazepines
   - If acetaminophen is helping, do not exceed 3.2 grams/day (10 regular strength tablets) long-term
   - For depression, use antidepressants with some proven analgesic effects (TCAs, SNRIs, buproprion)

5. Try adding adjuvant analgesics for neuropathic pain
   1. Start a TCA such as amitriptyline 10mg qhs and titrate q3-6 days to pain relief, maximum tolerated dose or at least 150mg. If too many anticholinergic side effects, switch to nortriptyline or desipramine.
   2. Next try the anti-epileptic drugs (AEDs) in a sequential fashion, starting at low dose and titrate to pain relief, maximum tolerated dose or, when available, to therapeutic blood levels. (Gabapentin and pregabalin have the lowest incidence of side effects and drug interactions and the lowest risk of serious organ toxicity.) Monitor LFTs and CBC with carbamazepine and valproic acid.
   3. If partial relief with either a TCA or an AED, then try combining.

6. For round-the-clock pain, start a trial of titrated, scheduled opioid therapy
   1. Provide informed consent and use a written agreement for high risk patients
   2. Start with IR/SA opioids dosed q 4h po and switch to CR/LA opioids when the dose is stable or;
   3. Start with CR/LA opioids dosed by the clock using IR/SA opioids for breakthrough (BT) pain
   4. Titrate CR/LA opioids q 3-7 days depending on patient tolerance for side effects
   5. Provide adequate breakdown (BT) pain medication given q4h prn during titration:
      a. 10 % of the total 24 hour opioid dose or,
      b. 20 % of the q12hourly dose
      c. Titrate CR/LA opioid to reduce BT meds to < 2 doses per day for activity-related pain

IR/SA = immediate release, short-acting; CR/LA= controlled-release, long-acting; TCA=Tricyclic antidepressant
7. Manage opioid-related side-effects:
   i) Distinguish opioid side effects from co-morbid conditions or other concurrent medication effects. Drowsiness and cognitive impairment due to opioids usually passes within 3-7 days. **Patients should not operate a motor vehicle or machinery during opioid titration.**
   ii) Try reducing the dose of the opioid if the pain is well controlled. If pain is not well-controlled:
      a. Add a non-opioid co-analgesic (ie.NSAID / COXIB for MSK pain)
      b. Add a specific adjuvant pain medication (ie.gabapentin/pregabalin for PHN; SNRI for DPN)
      c. Target the source of the pain (ie.hip replacement for severe osteoarthritis)
      d. Regional anesthetic or ablative neurosurgical techniques (ie. radio-facet neurotomy)
   iii) Treat adverse effect(s) symptomatically (see below) until tolerance develops
   iv) Switch to an alternate CR/LA opioid at ½ of the equianalgesic dose and titrate again to see if another opioid has a better balance of analgesia vs. adverse effects
   v) Manage constipation proactively and aggressively using dietary measures first (ie. bran, prunes, flax, 4-6 glasses water/day), adding stool softeners next (ie. docusate), then osmotic agents next (ie. Milk of Magnesia, lactulose, Pico-Salax) and finally adding stimulant laxatives (ie.senna) if the previous measures fail .

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Equianalgesic iv,im,sc dose</th>
<th>Equianalgesic oral dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10mg</td>
<td>60mg (acute dosing)</td>
</tr>
<tr>
<td>Codeine</td>
<td>120mg</td>
<td>200mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>(not available in Canada)</td>
<td>30mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2mg</td>
<td>8mg</td>
</tr>
<tr>
<td>Herin</td>
<td>5mg</td>
<td>60mg</td>
</tr>
<tr>
<td>Meperidine</td>
<td>75mg</td>
<td>300mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>(not available in Canada)</td>
<td>Variable</td>
</tr>
<tr>
<td>Fentanyl (td)</td>
<td>25 ug/hr = 45-60mg morphine/day</td>
<td></td>
</tr>
</tbody>
</table>

8. Regular follow-up at least every 2 months - even for stable, low risk patients. Document the 4+2 A’s:
   1. Analgesia (pain relief) using a numerical rating scale +/- percentage pain relief with treatment
   2. Activities (physical functioning) note specific examples, or use paper tools (ie. BDI Interference)
   3. Adverse effects - both the patient’s complaint and your response
   4. Ambiguous drug-related behaviours (document the details along with your response)
   5. Affect (mood and psychologic status) depression, anxiety
   6. Accurate medication records according to federal laws (name, strength and amount of drug + dosing info)

9. Decrease the risk of drug diversion with careful prescribing and monitoring:
   -Fax prescriptions (where legal) Witnessed dose of medication Random medication counts
   -Use “tamper-evident” Rx pads Fill up all empty space on the Rx Write out numbers and words
   -Part-fills in high risk patients Limit IR/SA opioids in high risk pts Avoid phone prescribing
   -Random urine drug screening Collateral sources of information Written prescribing agreements

10. Use extra care and monitoring especially when…
   -prescribing large amounts of short acting opioids – especially in a patient at higher risk for addiction.
   -the patient’s prescription for opioids repeatedly is “lost” or runs out earlier than the expected time.
   -prescribing injectable opioids for home use (only in very exceptional circumstances with expert consultation).
   -prescribing two or more drugs with abuse/dependence potential, (i.e. opioids and benzodiazepines).
   -a patient abuses alcohol or illicit drugs while on long-term opioid therapy.
   -a patient reports improved pain relief but whose function declines on opioids.
   -the patient’s report of functional improvement is very different from the report of a collateral source.
Opioid Prescribing Agreement - 1

This agreement is being undertaken between __________________________,(the patient), and

Dr___________________ (the doctor) regarding treatment of a chronic pain problem using long-term opioid therapy.

1. The patient hereby agrees that this treatment has been explained to him/her in terms of the purpose, the side
effects of the medication and the risks involved. During dosage adjustments (titration) drowsiness can be a temporary side
effect. During these times the patient agrees not to drive a vehicle or perform other tasks that could involve danger to self or
others. The doctor will advise the patient when these activities are safe to perform again.

2. The patient understands that using long-term opioids to treat chronic pain may result in the development of a
physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the
symptoms of opioid withdrawal. The patient understands that opioid withdrawal is uncomfortable but not life threatening.
Physical dependence by itself does not mean the same thing as addiction to opioids.

3. The patient agrees not to change the dose or the frequency of taking their medication without first consulting the
doctor, and also agrees to follow-up with the doctor, as required by the doctor, for monitoring of this treatment.

4. The patient agrees to keep the prescribed medication in a safe and secure place. Lost, damaged or stolen
medication will not usually be replaced until the next regularly scheduled office visit.

5. The patient agrees not to give, sell, lend or in any way provide his/her medication to any other person, and
agrees to obtain all of his/her medication from only one licensed pharmacist. The patient consents to open communication
between the pharmacist and the doctor on any matter related to the patient’s medications.

6. The patient agrees not to seek, obtain, or use ANY mood-modifying medication, especially pain medication,
sleeping pills or tranquilizers, from ANY other physician, without first discussing this with the doctor. The patient gives the
doctor consent to provide a copy of this document to any other physicians, Emergency Departments or walk-in clinics.

7. In patients taking long-term opioid therapy, there is a small but definite risk that opioid addiction can occur.
Almost always, this occurs in patients with a current or past history of other drug or alcohol abuse. Therefore, the patient
agrees to refrain from the use of ALL other mood modifying drugs, including alcohol, unless agreed to by the doctor. The
moderate use of nicotine and caffeine are an exception to this restriction. The patient agrees to submit to timely, random
urine, blood, saliva or hair testing, at the doctor's request, to verify compliance with this. At any time during treatment, the
patient agrees to be assessed by an addiction specialist if requested by the doctor.

8. The patient understands that one of the main measures of successful treatment is significant improvement in the
patient's function. The patient agrees to open communication between the doctor and those close to the patient, such as
family members, to help determine function and adverse effects due to treatment.

9. The patient agrees to attend and participate fully in any other reasonable assessments or pain treatment programs
which the doctor may recommend at any time.

The patient understands that ANY deviation from the above agreement may be grounds for the doctor to discontinue opioid
therapy at any time and prescribe other treatments instead.

Signed at ___________________________ on ______________, 200

 ________________________________  ________________________________
 (patient)                                      (doctor)
Opioid Prescribing Agreement - 2

This is an agreement between Dr. _______________ and me regarding my pain medicines.

1. I will ONLY get my pain medicine from the doctor named above.
2. I will take my pain medicine as advised by the doctor.
3. I will tell my other doctor(s) that I am taking pain medicine from the doctor.
4. I will tell my doctor about ALL of my health problems.
5. I will tell the doctor about ALL of the medicines (over-the-counter, herbs, vitamins, those ordered by other doctors) I am taking.
6. I will allow the doctor to talk with other doctors about my health problems.
7. I will tell the doctor right away if I get pain medicine from any other doctor or emergency room.
8. I will keep my pain medicine locked in a safe place AND away from children.
9. I will bring all of my leftover pain medicine in their pharmacy bottles every time I come to see the doctor.
10. The doctor or nurse may count the number of pills left in my bottle(s).
11. I will allow the doctor to check my urine (pee) or blood to see what drugs I am taking.
12. I will NOT share, sell, or trade my pain medicine with anyone.
13. I will NOT use someone else's pain medicine(s).
14. I will NOT ask the doctor for an early refill if I lose or misplace or run out of my pain medicine early.
15. I will NOT use illegal drugs (such as crystal meth, marijuana, cocaine) and I will not drink alcohol without the doctor's permission.
16. I know if I drive while taking pain medicine, I could be charged with driving under the influence (DUI) by the police. If I am charged with DUI while taking pain medicine, the doctor is not to blame.
17. I will only ask for refills during an office visit (Monday to Friday from 9:00 AM to 5:00 pm).
18. I will call the doctor's office at least 24 hours in advance if I need to cancel my appointment.
19. The doctor and my pharmacy may talk to the police if they think I am misusing or selling my pain medicine.
20. If I do not do all of the things listed above, the doctor may take me off of pain medicine.
21. If I do not do all of the things listed above, the doctor may send me to a drug treatment clinic.

____________________   ___________________   ____________________
Patient Signature       Doctor Signature       Date
Urine Drug Testing
A Summary

<table>
<thead>
<tr>
<th>Prior to UDT</th>
<th>Limitations of immunoassay (IF)</th>
<th>Limitations of chromatography (HPLC)</th>
</tr>
</thead>
</table>
| - Inform the patient. (“I do this for all of my patients”)  
- Take careful history of medication use in past week.  
- Collect the sample in physician office; ensure proper labeling. | - Doesn’t distinguish between different opioids.  
- Often misses semisynthetic and synthetic opioids e.g. oxycodone, fentanyl, methadone, hydromorphone, hydrocodone, meperidine, buprenorphine. | - Identifies individual opioids, including heroin and monoacetylmorphine  
- Codeine metabolized to morphine.  
- Morphine can be metabolized to hydromorphone  
- False negatives can occur (but more accurate than immunoassay). |

<table>
<thead>
<tr>
<th>Drug</th>
<th>Immunoassay (IF)</th>
<th>Chromatography (HPLC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of days drug is detectable</td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>2-5</td>
<td>1-2 (may show up as morphine.)</td>
</tr>
<tr>
<td>Morphine</td>
<td>2-5</td>
<td>1-2</td>
</tr>
<tr>
<td>Meperidine</td>
<td>1 (often missed)</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2-5</td>
<td>1-2</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>2-5</td>
<td>1-2</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Often missed</td>
<td>1-2</td>
</tr>
<tr>
<td>False positives for opioids</td>
<td>Poppy seeds, quinolones</td>
<td>None</td>
</tr>
<tr>
<td>Cocaine + metabolite</td>
<td>3-7</td>
<td>1-2</td>
</tr>
<tr>
<td>Benzodiazepines (regular use)</td>
<td>20+ days for regular diazepam use. Immunooassay does not distinguish different benzodiazepines. Intermediate-acting benzodiazepines such as clonazepam are often undetected.</td>
<td>Does not distinguish different benzodiazepines. May miss clonazepam.</td>
</tr>
<tr>
<td>Cannabis</td>
<td>20+</td>
<td></td>
</tr>
</tbody>
</table>


If a urine drug test result is confusing order confirmatory testing by GC/MS on the same urine specimen. This is the most sensitive (and most expensive) test which identifies individual opioids as well as a large list of illicit and other prescription and some OTC meds.

**Random Urine Drug Tests** - For high risk patients try to use random urine drug screens:
Identify a number of random days on a calendar at the next office visit. Write these dates on a note to your receptionist to call the patient first thing in the morning of these dates, asking him/her to come in for a UDT that day. For patients who are employed, allow them 24 hours to come to the office to provide a UDT. Advise patients to always bring in all of their meds in original pill bottles when they come for a UDT and periodically ask your staff to do a random pill or patch count.
Interpretation of Abnormal Urine Drug Test Results

Diversion

- Diversion should be suspected when the urine drug screen is repeatedly negative for the prescribed medication, and the patient insists that they are taking the medication as prescribed.
- Repeatedly negative UDTs can also occur when patients binge on their opioids and run out several days prior to the test; or in patients who are non-compliant with their medication for any reason.
- The presence of the prescribed opioid doesn’t rule out diversion, because the patient may take a portion of the prescription prior to the test. Random pill or patch counts or a witnessed dose in the office can be helpful.

Accessing opioids from other sources

- This should be suspected when a non-prescribed opioid is present in the UDT.
- Remember that some opioids are metabolized to others. For example:
  - Codeine $\rightarrow$ morphine + occasionally to hydrocodone
  - Heroin $\rightarrow$ morphine
  - Hydrocodone $\rightarrow$ hydromorphone
  - Morphine (high dose) can $\rightarrow$ hydromorphone (Cone EJ. J Analy Tox. 2006)
- UDT will not detect patients who are double doctoring with the prescribed opioid, or buying that opioid off the street

Presence of non-opioid drugs (e.g. cocaine, cannabis, benzodiazepines)

- If cocaine or benzodiazepine addiction is suspected, opioid tapering should be considered as well as referral to an addiction or methadone treatment program.
- There are several potential problems with ongoing opioid prescribing in the presence of a current addiction:
  - Increased drug toxicity (i.e. benzodiazepine and opioids)
  - Diversion (i.e. selling or trading opioids to purchase cocaine)
  - Increased risk of opioid misuse and dependence

Urine Tampering

The most common form of tampering is adding water to the urine sample. This dilutes the concentration of the drug to below detection threshold. Tampering should be suspected when:

- The sample is cold. (Could be someone else's urine but remember that urine samples cool within minutes.)
- Urine specific gravity or creatinine is low. The latter is more accurate. A urine creatinine of $< 2-3$ mmol/L is non-physiologic and suggests dilution.
- Adding an acid $\rightarrow$ detect by ordering urine pH
- Various adulterants - some office lab sticks and some labs can test for common adulterants
WHAT IF MY PATIENT DEMONSTRATES “OPIOID MISUSE” BEHAVIOURS?

- Review the patient behaviours that are causing you concern. Use the attached page on Opioid Misuse Behaviours to help decide if these are more or less suggestive of addiction and to help you form a differential diagnosis.
- Obtain collateral information from other professionals dealing with the patient.
- Have a meeting with the patient and “family” to ask for their observations and to assess for any new psychosocial factors. Discuss your concerns with the patient and family. Note their reaction.
- Consider an opinion from an addiction medicine consultant and/or psychologist.
- If not already done have the patient read and sign a written “Opioid Prescribing Agreement”
- Try to minimize or eliminate the amount of short-acting, prn opioid in favour of scheduled, long-acting opioids.
- In very high risk patients, use a signed and dated fentanyl patch, which is exchanged for a new one every 3 days, or daily dispensing and witnessed administration of once-per-day opioid from the pharmacist.
- Make your prescriptions as forgery-proof as possible: Include the patient’s name and address, the pharmacy name, the name of the drug and strength, the dosing instructions, the number of dosing units to dispense in numbers and words. Fill in all blank area of the script to prevent any additions. Where legal, fax prescriptions directly to the pharmacist to prevent tampering.
- In a group practice, have a written medication plan in the chart for your absences.
- Shorten the dispensing interval for medications and increase the frequency of follow-up appointments. Advise the patient that you will not normally replace lost or stolen meds or if the patient uses up the medication before the next renewal date.
- Have the patient keep more detailed written diaries of medication use, degree of pain relief and function.
- Ask the patient to bring in all of their medication in the original bottles at each visit for you to review. Make sure that the doctor’s name on the bottle is yours! Note when the script was filled compared to date in your notes. Prescribe a 3-day “emergency supply” of opioids the first time and advise the patient to not touch these unless you cannot see them on the usual renewal day. Count these meds periodically when seeing the patient to ensure they still have a 3-day supply.
- If suspicious of diversion, witness the patient taking one of his/her prescribed doses of opioid and observe in the office for 3 hours to note their response. (Have a consent form, an emergency plan to handle potential overdose and some naloxone injectable available if you want to try this!)
- Perform random urine screens for the opioid prescribed and for drugs of abuse. Know the detection limits for the labs in your area. Fentanyl, oxycodone and methadone usually do not show up on most immunofluorescence (IF) urine drug screens. A “Broad Spectrum Urine Toxicology” (HPLC) urine screen will detect most opioids except fentanyl. GC/MS will detect all drugs but is more costly.
- If the drug misuse behaviours continue, consider a “Termination of Opioid Prescribing” letter. Offer to give him/her one more chance and allow them to see you tuck this letter into their chart.
- If the behaviours continue, taper the patient off of the opioid using a humane opioid withdrawal protocol. An example is included in this handout. **DO NOT ABANDON THE PATIENT.** Offer to treat their pain with non-opioid alternatives or to refer them to an addiction treatment program or a methadone program for help. Those who do not want help will simply not return to see you.
OPIOID MISUSE BEHAVIOURS

More Suggestive of Abuse/Addiction

Selling Rx drugs / Prescription forgery
Stealing drugs from others
Injecting oral formulations
Obtaining Rx drugs from non-medical sources
Concurrent abuse of alcohol or illicit drugs (esp. cocaine)
Repeated dose escalation or other non-compliance despite multiple warnings
Repeated visits to other ERs or MDs without advising prescribers
Drug-related deterioration in function at work, in the family or socially
Appears intoxicated at office visits or at pharmacy
Repeated resistance to change in therapy despite evidence of adverse drug effects
Repeated “losses” of medication / requests for early refills
Repeated failure to keep appointments
Involvement with the law (MVCs, DWI, arrests, etc)

Less Suggestive of Abuse/Addiction

Aggressive complaining about need for more pain meds
Drug hoarding during periods of reduced symptoms
Requesting specific drugs
Using SR medication as prn meds
Openly acquiring pain meds from other doctors
Frequent visits to ER for pain flares
Occasional unsanctioned dose escalation or other non-compliance
Unapproved use of the drug to treat another symptom
Reported psychic effects not intended by the clinician
Reluctance to try previous treatments again
Resistance to change in therapy that is working
Intense expressions of anxiety about recurrent symptoms
Negative mood change
Supplementing prescribed meds with OTC pain meds

Portenoy and Passik, 1994

Differential Diagnosis of Aberrant Drug-Related Behaviours

Addiction
Pseudoaddiction / Inadequate titration
Psychiatric disorder / Chemical coping
Mild Encephalopathy / Confusion
Family / Social disturbance
Criminal Intent
Managing Opioid Withdrawal – Information for Patients
Dr. Roman D. Jovey, M.D.

Opioid withdrawal symptoms are unpleasant but very rarely life threatening. The exceptions to this could be someone with a serious medical condition, such as poorly controlled angina or poorly controlled high blood pressure or someone with a severe psychiatric condition where the risk of self-harm is high. In such cases, you should seek medical supervision when stopping your opioid medication through your own family doctor or, if necessary, at the Emergency Department of your local hospital.

You may experience any or all of the following: sweats, chills, headaches, muscle aches, joint aches, abdominal cramps, nausea, vomiting, diarrhea, anxiety, fatigue, malaise, "goose flesh". These symptoms are similar to a severe flu-like illness. They usually begin within 12 - 36 hours of reducing the dose of your opioid medication, are most severe for the next 24 - 72 hours and then begin to fade away over the next 3-7 days*. Some people report feeling tired and mildly unwell for 1 - 2 weeks after completely stopping opioids. After this you may feel a temporary flare up of your previous pain, but some people actually report less pain once this temporary pain flare is finished.

There are 3 main methods of stopping your opioids:

1) Fast – You can simply stop taking your opioids immediately. This will mean that your withdrawal may be more severe, as described above, but the worst will be over in 7-10 days.

2) Slower – If you have tried the fast method and cannot cope, and you have a doctor willing to work with you, you could gradually taper the amount you take by 5-10% every day. This would mean that you are off of opioids by 10-20 days. Your withdrawal symptoms will be milder but will last a longer time (2-4 weeks). In this case, the doctor may choose to write a prescription instructing the pharmacist to dispense only a limited amount of medication at a time. Also he/she may substitute a long-acting, once-daily opioid to simplify the taper.

3) Methadone taper – This method is probably the most gentle way to come off of opioids but also results in the longest total period of withdrawal symptoms*. A doctor prescribing methadone requires a special approval from the Federal Government and usually works at a special clinic. Your doctor can refer you to the closest clinic in your community. The doctor at the clinic has to follow a specific protocol involving daily dispensing of the medication from a specific pharmacy.

There are some medications you can take to decrease opioid withdrawal symptoms but no medication, other than an opioid, will take withdrawal symptoms away completely. Clonidine is an older blood pressure medication, which can help to decrease some of the anxiety, jitters, sweats, and chills associated with opioid withdrawal. The most important side effect of clonidine is light-headedness when getting up suddenly from bed or a chair. Clonidine comes in a 0.1mg tablet. Start by taking one to see how well you tolerate the drug. Then take one or two tablets every 4-6 hours as required. Do not exceed 6 tablets per day without speaking to your doctor. When stopping clonidine, taper the dose off over 3 days to decrease the risk of a temporary blood pressure increase. Muscle and joint aches can be treated with an over the counter NSAIDs, such as ibuprofen (ie. Advil©, Motrin©). If diarrhea and stomach cramps become severe, use Imodium©, available over the counter at your pharmacy. Finally, for severe anxiety, the doctor may prescribe an antiepileptic drug such as carbamazepine, gabapentin or pregabalin for 1-2 weeks after stopping your opioid medication.

*Methadone withdrawal symptoms are typically less intense initially but may last up to 4-6 weeks in some people.
Managing Opioid Withdrawal – Information for Physicians

1. Reassure the patient that withdrawal from opioids is **uncomfortable but not life threatening**. Each dosage reduction may result in symptoms similar to a severe, flu-like illness beginning within 12 - 36 hours and peaking at 48 - 72 hours and then tapering off after 1 week. Some people experience a period of vague dysphoria for 1 - 2 weeks after withdrawal. (Methadone withdrawal may peak later with less intensity but can go on for 4-6 weeks in some people.)

2. The patient can choose to withdraw abruptly and experience a more severe but shorter overall period of symptoms, or to taper over 10 to 14 days and experience milder but a more prolonged withdrawal. You can provide a 10% reduction daily over 10 days. Use frequent (even daily) pharmacy dispensing for the tapering process in high-risk patients. Once-daily opioid formulations (ie. Kadian) may make the withdrawal process simpler. A methadone taper allows for a less intense but longer period of withdrawal symptoms but requires a methadone prescribing authorization. Buprenorphine is a more recent alternative to methadone in Canada and may result in less severe withdrawal symptoms.

3. Clonidine has been used the longest to decrease some of the autonomic symptoms of opioid withdrawal. The main side effects are orthostatic hypotension and sedation.
   
   *Prescribe 0.1-0.2 mg po q6h prn maximum 6 tabs per day. The dose may have to be lowered if the patient reports orthostatic symptoms or has a BP less than 90/60 mmHg, 1 hour after a dose. Continue clonidine until off of opioids for 3-5 days then taper over next 3-5 days.*

4. One of the symptoms of opioid withdrawal is pain – usually arthralgias and myalgias - which may persist longer than other withdrawal symptoms, but will eventually settle. NSAIDs or acetaminophen or tramadol may be helpful. If attempting to re-evaluate a patient’s pain off of opioids, the opioids need to be discontinued for at least 4 weeks to get through withdrawal-mediated pain and allow opioid receptors to “reset.”

5. Loperamide (Imodium), which can be purchased OTC at the pharmacy, can help decrease abdominal cramping and diarrhea if these occur.

5. Acupuncture or TENS have been shown in some studies to decrease symptoms of opioid withdrawal.

6. Short-term use of an antiepileptic such as carbamazepine or gabapentin or pregabalin, or an antipsychotic such as quetiapine for the first 1-2 weeks may help with sleep and anxiety. Short term use of clonazepam is also an option. Try to avoid prolonged benzo use especially in high risk patients.

References: