Chronic Pain, Addiction Behavior Are Different

Giving shorter-acting opioids to those already taking long-acting formulations might create tolerance.

BY ALICIA AULT
Contributing Writer

WASHINGTON — Learning to differentiate between drug-seeking behavior and unmet pain needs can help emergency physicians cope better with chronic pain patients, who are frequent emergency department visitors, said Dr. James Ducharme at the annual meeting of the American College of Emergency Physicians.

It can be hard to determine when a patient is requesting medications for true pain as opposed to seeking them for diversion, he said.

However, if anything, patients are not given enough pain medication by emergency physicians—and, often, if they ask for a pharmaceutical by name, they are identified, usually incorrectly, as addicts, said Dr. Ducharme, who is professor of emergency medicine at Dalhousie University in Halifax, N.S., Canada, and clinical director of the emergency medicine department at Saint John Regional Hospital, N.B.

According to Dr. Ducharme, about 70% of people presenting to the emergency department have a pain complaint, but only about one-half of 1% are addicted.

When pain goes untreated, however, chronic pain patients, such as those with sickle cell disease, have behavioral traits that, taken alone, resemble those of addicts, he said. They see the ED as the place of last resort when they have not been helped elsewhere. Physicians often give these patients a short-acting opioid and then discharge them.

This is a mistake, though, because many chronic pain patients are already taking long-acting opioids. By giving them the shorter-acting formulations, the physicians may be creating tolerance.

Opioids also do not provide any long-term benefit to fibromyalgia patients or to those with neuralgic pain; myofascial pain syndrome; or chronic, stable, nonmalignant pain such as back pain. It is incumbent on the physician to explain this to patients, Dr. Ducharme said.

Migraineurs and others with recurrent conditions tend to know what works for them and will ask for the medication by name, but ED physicians may mistake that behavior for drug seeking, he said.

"It's not their fault if they know what they're talking about," Dr. Ducharme pointed out, adding that migraineurs also tend to visit an emergency department only once or twice a year.

However, migraine headaches, dental pain, back pain, and recurrent abdominal pain are common scenarios cited by drug takers to procure opioids, he said. Not surprisingly, many physicians doubt these patients' veracity.

But there are ways of treating pain without rewarding addicts, he noted.

If abuse is suspected, the suspicions should be voiced to the patient. If the issue is not resolved, give the patient an oral analgesic such as morphine, but only enough to last until a physician can be seen the following day. There are other options: a dental block with bupivacaine for dental pain, for instance. The patient should not get a prescription, Dr. Ducharme said.

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Physicians should not be confrontational with patients, but should suggest that they have a problem and then try to do whatever possible to treat the abuse. "If all we do is try to get them out of the ED and not address the abuse, we are ethically failing," Dr. Ducharme said.

Unfortunately, there are no evidence-based rules for identifying drug abusers, he said, adding that being objective is also difficult. The physician's own perceptions—of who is an abuser and of what pain should look like—can shape his or her judgment about who is truly in pain and who is seeking drugs for diversion, he said.

Dr. Ducharme gave some rules of thumb. Patients who aggressively complain about needing more drugs and who hoard during periods of reduced symptoms, request specific drugs, or openly acquire similar drugs from other medical sources may not be recreational drug takers or addicts, he said.

Patients who sell prescription drugs, steal them from others, and get them from nonmedical sources are much more likely to be drug takers, he said.

Another difficulty is treating addicts in pain, as they will need large doses of a medication. Physicians should accept that reality and consider alternatives to opioids, such as epidural or regional anesthesia, ketamine infusion, and NSAIDs, Dr. Ducharme said.

Most so-called drug takers, however, are patients whose pain is poorly controlled. ED physicians can help end the cycle by having good references for patients when they go back out into the community. And, he reiterated, drug abusers should get an objective assessment and good medical treatment, despite their history.

Dr. Ducharme disclosed that he has received a speaker honorarium in the past from Purdue Pharma, the manufacturer of painkillers such as MS Contin and OxyContin. ■

New Botox Wrinkle: Helping Frequent Migraine Sufferers?

BY DEBBIE LERMAN
Contributing Writer

PHILADELPHIA — Botulinum toxin type A was found to be an effective, well-tolerated prophylactic treatment for patients with transformed migraine, according to studies that were reported at the annual meeting of the American Headache Society.

The phase II botulinum toxin type A (Botox) trials were intended to identify a responsive patient population and the most appropriate dosing as well as to determine efficacy end points to guide phase III studies. Transformed migraine was defined as 16 or more headache days per month, 50% or more of which were migraines.

Dr. Benjamin Frishberg and Dr. David Dodick, who presented these studies at the meeting, said they found significant improvement with Botox compared with placebo in terms of number of headaches, number of headache days, and use of acute medications. The improvements were most notable in patients who were not on any other type of prophylactic treatment.

Dr. Frishberg is a neurologist in La Jolla, Calif., and Dr. Dodick is a neurologist at the Mayo Clinic in Scottsdale, Ariz. Their studies of Botox were supported by Allergan Inc., which is the drug's manufacturer.

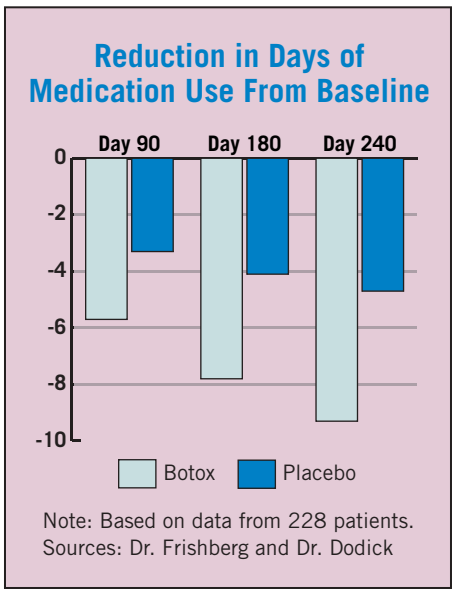
Dr. Frishberg and Dr. Dodick reported on a randomized, double-blind, placebo-controlled study in which 1,200 patients were screened based on 30 days of self-reported headaches entered in an electronic diary.

Of these, 702 patients who reported chronic daily headache (CDH, defined as 16 or more headaches a month) were enrolled in a 30-day, single-blind placebo run-in period.

After this period, patients were classified as either placebo responders, or placebo nonresponders.

The mean age of patients was 43.4 years and 82.9% (582) of them were female. All of the patients had at least one migraine or probable migraine during the 30-day baseline period.

Of the 702 patients, 52% were receiving one or more prophylactic headache treatments, in addition to the treatment given in the trial.



Note: Based on data from 228 patients.
Sources: Dr. Frishberg and Dr. Dodick

The researchers then conducted a subanalysis that looked at 355 patients in the placebo nonresponse group, of whom 228 (64%) were not using prophylactic headache medications. This subset of 228 patients was aged 19-65 years (mean age of 42.4 years), and 86% female. All of these patients had CDH with 50% or more migraine days per month, which the researchers defined as transformed migraine.

The patients in the subset were randomized to receive injections of Botox (117) or placebo (111). Those in the Botox group received between 105 U and 260 U (average 190 U) over six to seven head and neck muscle areas using a modified follow-the-pain injection paradigm. the investigators said.

No significant differences were found between Botox and placebo in the predetermined primary efficacy end point, which was defined as mean change from baseline in the frequency of headache-free days at day 180 in placebo nonresponders, Dr. Frishberg and Dr. Dodick reported.

Several secondary end points were successfully met. The following statistically significant reductions from baseline were observed:

- Headache frequency in placebo nonresponders with 225 U and 150 U of Botox vs. placebo at day 240 (reductions in headache frequency of –8.4, –8.6 and –6.4, days respectively).
- Headache days in placebo nonresponders who received Botox vs. placebo at day 180 (40% vs. 20% reduction in headache days).
- Number of days of use of acute headache pain medications at day 90 in Botox users, compared with placebo (reduction from baseline of –5.7 vs. –3.3 days), as well as at day 180 (–7.8 vs. –4.1), day 210 (–8.5 vs. –4.0), and day 240 (–9.3 vs. –4.7).

Only 27 of the 702 placebo nonresponders (3.8%) discontinued the study due to adverse events. The most commonly reported adverse events in patients treated with Botox vs. placebo were muscular weakness (22% vs. 0%) and neck pain (13.3% vs. 0.5%).

Based on these results, Botox would seem to show the most promise in treating transformed migraine in patients who are not using other prophylactic medications, Dr. Frishberg said in an interview with this newspaper. Phase III trials were scheduled to begin late last year at 100 sites, he said. ■

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