Managing drug-seeking behavior

Miriam Komaromy, MD
Medical Director
UNM Project ECHO Addiction Treatment Program
The $10,000 question…

Why is the patient seeking the drugs?
The problem:

- Only the patient knows whether she or he is truly having pain.
- There is no external way of verifying or disproving this subjective experience.
Implications

Don’t waste too much time trying to decide whether the patient is in pain.

Instead focus on:

- Using non-addicting pain treatment when possible
- Preventing diversion
- Detecting diversion
- Treating addiction when it is present
Case 1

35 year old man with a history of a hip injury from a fall at work treated with Lortab chronically for pain. Requesting stronger medication because his pain has increased while doing construction work. Exam is unchanged, and shows some pain with external rotation. How would you decide whether to increase his medication?
Case 2

42 year old woman who has been on methadone maintenance for 5 years, in recovery from heroin addiction. She had extensive gum surgery yesterday, and comes in reporting pain and insomnia from the surgery. Her oral surgeon had recommended naproxen. How would you decide whether to prescribe opiates?
Case 3

A 23 year old woman has a history of multiple documented kidney stones for which she often presents to the emergency room for additional pain medication on top of what you usually prescribe. She has an appointment with a renal specialist next week for further evaluation. She reports at a routine medical visit that she is having increased pain and thinks she has a new stone. She has run out of the opiate pain medication you have prescribed, and asks you for an early refill. How would you decide whether to prescribe opiates?
A 55 year old man with metastatic prostate cancer is prescribed large quantities of Percocet and Oxycontin by you. He comes in asking for an increase in his medication. His urine drug screen shows oxycodone, morphine, and THC. How would you decide whether to prescribe more opiates?
Why is it so hard to manage chronic pain?

- Pain is unmeasurable, unverifiable
- We’re the gatekeepers for opiates
- Tolerance, dose escalation
- Lack of permanent remedy for pain
- Potential for abuse
- Difficulty detecting abuse
- Monetary (“street”) value of meds
- Opiate-induced hyperalgesia
21/23 patients detoxified off opioids after \( \geq 1 \) year of rx for chronic pain reported that their pain was significantly less after detox off opioids, suggesting that:

“high-dose opioids may contribute to pain sensitization via opioid-induced hyperalgesia, decreasing patient pain threshold and potentially masking resolution of the preexisting pain condition.”

Baron, MJ. J Opioid Management, 2006;2(5).
Almost all primary care practices involve some treatment of chronic non-malignant pain with opioid medications.
Opioid addiction: pain pills
Misuse of prescribed opioids is common.....

Heroin users (past year) 380,000

Prescription opioid users (non-medical use past month) 7,000,000

SAMHSA Nat Survey Drug Use and Health 2005, 2006
US deaths from prescription opioids, by year, 2001-05

National Drug Intelligence Center, National Prescription Drug Threat Assessment 2009, April 2009
% of 12th graders reporting non-medical use in past year, 2007

NIDA Monitoring the Future Study 2007
Figure 1. Percentages of Reported Method** of Obtaining Prescription Pain Relievers for Their Most Recent Nonmedical Use in the Past Year among Persons Aged 18 to 25: 2005 NSDUH

- Got Them from a Friend or Relative for Free: 53.0%
- Prescriptions from One Doctor: 12.7%
- Bought from a Friend or Relative: 10.6%
- Bought from a Drug Dealer or Other Stranger: 4.8%
- Took from a Friend or Relative without Asking: 3.8%
- Got Them Some Other Way: 2.9%
- Prescriptions from More Than One Doctor: 1.3%
- Other Unknown or Invalid Source: 10.0%
What options are available to deter misuse/addiction?
Sites of Diversion

1. Joranson, David. Diversion of Prescription Opioids. PPSG
Safer opioid prescribing

- Carefully consider duration, quantity
- Initial risk assessment
- Structured monitoring and documentation for all patients
- Single prescriber and pharmacy
- Treatment agreements
- Patient maintains secure medication storage
- Urine toxicology
- PMP data
- Tamper-proof prescriptions
- Brief intervention and referral
- Exit strategy
- Abuse-deterrent opioids
- Office-based treatment for opioid addiction
How to decrease diversion

- Try to avoid widely-abused medications: Oxycontin, Xanax, Valium
- Keep prescription pads locked up or on your person
- Give small amounts more frequently
- Always write out numbers on prescriptions, including numbers of refills
- Discuss diversion of meds with your patients:
  - Unacceptable; cause for potential dismissal
  - Avoid unintentional diversion by disposing of leftover meds promptly and properly
Predictors of opioid misuse

- Smokers, hx/Fhx addiction, psych d/o

- SOAPP-R: Screen and Opioid Assessment for Patients with Pain, Revised

- 10-minute paper screen for likelihood of “aberrant medication-related behaviors”

- Sensitivity .81, specificity .68

- Uses: adjust intensity of monitoring/treatment agreement; refer to specialty clinic

Sample questions: SOAPP-R

How often.....

- do you have mood swings?
- do you feel bored?
- do you feel impatient with your doctors?
- have you taken more medication than you were supposed to?
- Have you felt craving for pain medicine?
Urine toxicology

- When and how often?
- Observed, temperature monitored?
- What won’t show up as “opioid positive?”
  - oxycodone
  - methadone
  - buprenorphine
- What to do with the result?
Prescription Monitoring Programs (PMPs)

- Used in 38 states
- Effective in decreasing supply of abusable drugs
- Some states proactively alert prescribers if their patients have multiple prescribers of controlled drugs
- All allow prescribers to query activity of an individual patient

http://www.rld.state.nm.us/pharmacy/monitoring.html

1. www.deadiversion.usdoj.gov/faq/rx_monitor.htm
Less-Abusable Opioids

**Agonist/Antagonist:**
- Buprenorphine (Suboxone)
- Embeda (in development): morphine + naloxone

**Aversive:**
- Niacin + opioid

**Extraction-resistant:**
- Remoxy (in development): oxycodone in a high-viscosity matrix
- Depot formulations

Passic, Mayo Clin Proc 2009
What can you do if you suspect your patient is addicted to opiates?
You can treat opioid addiction in your primary care practice
What is buprenorphine?

- Newer medication (2002) for opioid replacement therapy (pain pills and heroin)\(^1\)
- Low abuse potential
- Detox or maintenance
- About as effective as methadone\(^2, 3\)
- Several advantages over methadone

---

1 TIP Series # 40, SAMHSA, 2004
2 Mattick RP, Cochrane Database Systemic Review 2004
3 Mattick RP et al, Addiction 2003
Why isn’t buprenorphine abused?

- When patients abuse a drug, they usually crush it and inject it
- Buprenorphine is sold as Suboxone®, a pill that contains both buprenorphine and naloxone (Narcan®)
- When taken under the tongue, the naloxone is not absorbed and so is not active
- When injected or snorted, the naloxone is active and causes withdrawal
Suboxone 8 mg and 2 mg tablets
Why is overdose potential low with buprenorphine?

Opioid Effects

Log dose

Respiratory suppression, death

Partial Agonist: Buprenorphine

Antagonist: Naltrexone

Agonist: Methadone, Heroin, etc.
Observational data on Buprenorphine effectiveness

- Increasing use of buprenorphine in France associated with \(^1,^2\)
  - Decrease in arrests for heroin (77% decline since 1995)
  - Decrease in overdose deaths (81% decline since 1995)

Overall Overdose Mortality

French population in 1999 = 60,000,000

No. of deaths


Years

120

564

Rapport OCRTIS, 1998
M. Auriacombe, Université Victor Ségalen Bordeaux 2, Bordeaux, France
# Buprenorphine treatment outcomes at 6 months

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Heroin users</th>
<th>Pain pill users</th>
<th>Methadone (data from literature review)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention in treatment</td>
<td>67% *</td>
<td>77%</td>
<td>53-63%</td>
</tr>
<tr>
<td>Abstinence (self-reported)</td>
<td>70%</td>
<td></td>
<td>73%</td>
</tr>
<tr>
<td>30 day illicit drug use (self-reported)</td>
<td>1.2 days</td>
<td></td>
<td>3-7 days</td>
</tr>
</tbody>
</table>

*14% of pts reported they had already completed treatment by 6 months

Criminal Activity past 30 days in buprenorphine-treated patients (self-reported)

<table>
<thead>
<tr>
<th></th>
<th>Street drug acquisition</th>
<th>Drug dealing</th>
<th>Prescription fraud</th>
<th>Other crimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>13 days</td>
<td>16%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>After 6 months of treatment</td>
<td>1.7 days</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

RCT of buprenorphine

- 40 Heroin addicts
- Buprenorphine 8mg/day vs taper + placebo
- All received counseling, groups
- Followed for 1 year

<table>
<thead>
<tr>
<th></th>
<th>Buprenorphine</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained at one year</td>
<td>70%</td>
<td>0</td>
</tr>
<tr>
<td>Died</td>
<td>0</td>
<td>20%</td>
</tr>
</tbody>
</table>

Kakko et al, Lancet 2003
Buprenorphine vs Methadone

Like Methadone…
• Reduces IDU
• Retains pt in treatment
• Decreases craving
• Stops withdrawal
• Costs $ 5-13 per day

Unlike Methadone….
• Low potential for OD
• Little street value
• Prescribed in MD office
• No sedation
• Easy taper/detox
What about my patient’s pain?
Buprenorphine for pain

✔ Effective analgesia
✔ (relatively) Non-abusable
✔ (virtually) No risk of respiratory suppression/OD
✔ Low street value
✔ No tolerance/dose-escalation
✔ No hyperalgesia
✔ Can’t be combined with other abusable opiates

1 Johnson RE, J Pain & Symptom Manage 2005;29
2 Cowan, Br J Pharmacol 1977;60
Effectiveness for chronic pain

- 95 pts on opiates > 1.5 years for chronic pain
- All had increasing pain, declining functional status
- 8% had clear addiction
- All underwent buprenorphine induction
- Maintained on doses of 4-16 mg for a mean of 8.8 months

95 chronic pain patients transferred to buprenorphine from other opiates

- 86% had moderate-to-substantial pain relief with improved mood and functioning
- 6 patients dropped out because of side effects or increase in pain
- Addicted patients benefited as much as non-addicted

Regulatory Issues for buprenorphine prescribing

- Must be buprenorphine-certified to prescribe
- 8-hour federally-mandated training
- Special DEA #, “X” number
- Only physicians can prescribe (MD or DO)
- Maximum 30 patients in year one, 100 simultaneous patients thereafter
- Is it OK to use buprenorphine for pain when it is only licensed for opioid replacement?
Miriam Komaromy, MD
505-715-0394
miriamkomaromy@gmail.com