

The fear of enabling

MISUSE OF PRESCRIPTION OPIOIDS:

How to distinguish pain from drug-seeking behaviour



Steve's story – a true account of prescription medicine misuse

Eight years ago, Steve, a 43-year-old technician, injured his back during a strenuous session lifting weights at the gym. Later on that evening, in serious pain, Steve called an ambulance and was transported to hospital. At the emergency department, Steve was given a dose of morphine and told he had a stress fracture in the lumbar region of his spine. He was given a prescription for 50 mg tramadol and 5 mg diazepam, twice daily, and sent home with instructions to rest in bed. Almost immediately, Steve decided to double the dose of both the tramadol and diazepam “to take the edge off the pain”. The pain eventually resolved and Steve returned to full activities.

Several years later Steve injured his back again while carrying wood. He went to his GP who suspected the injury was a slipped disc and prescribed 50 mg tramadol, twice daily, as specifically requested by Steve. The GP also referred Steve for a diagnostic scan.

The next day Steve returned to his GP, as he claimed that the tramadol was not effective for his pain, and requested something stronger. The GP prescribed 20 mg oxycodone, twice daily. Again, Steve decided to adjust the dose himself and he increased to 60 mg oxycodone per day and then to 80 mg per day. During this time Steve saw a neurosurgeon who advised him that surgery was not required. Although his back pain slowly improved, Steve continued to take 80 mg oxycodone for several months, receiving repeat prescriptions from his GP. Steve was also concurrently taking diazepam. At this point, Steve admits to becoming dependent on the benzodiazepine and required assistance from his GP to withdraw. He continued to intermittently take oxycodone doses throughout this time and hoarded supplies to use in the future. Steve also returned to the gym to lift weights, despite advice against this from the neurosurgeon.

Last year Steve was planning an overseas holiday and was concerned about pain he may potentially experience. His original GP had left so he visited a new

GP and convinced her to prescribe him oxycodone as he said that was the only analgesic that worked for his pain and that other opioids made him feel nauseous. Steve again hoarded pills from this prescription and took doses whenever he felt the need. He continues to push himself with weight lifting, and when asked if his experiences have changed the way he views pain he says; “I have definitely changed my perception of opioids, I know now that I would always go for something strong and go in at the maximum dose”.

Is Steve’s behaviour worrying or is this a normal response to pain?

It is possible that Steve’s aberrant behaviour, i.e. modifying the dose and medicine-hoarding, was a result of under-treated pain. However, Steve’s addiction to benzodiazepines and somewhat manipulative behaviour with his doctors suggests that oxycodone addiction or general drug seeking behaviour has played a role.

On further investigation into Steve’s history, he reveals that he has previously taken steroids and admits to a cavalier approach to drug-taking – perhaps in part explaining his willingness to increase medicine doses, without fear of adverse effects. Steve also reveals a history of mental health issues and use of antidepressants.

What lessons can be learnt from Steve’s story?

- Drug seekers can be of any age, ethnicity, occupation or education level
- A history of addictive or risk-taking behaviour should be a red-flag when prescribing strong opioids for pain relief
- Prescribe the lowest effective dose for the shortest possible time and regularly enquire about pain levels
- Prescribe the right opioid for the right level of pain
- Step-down the dose or type of opioid as the pain subsides
- Apply caution when prescribing benzodiazepines concurrently with strong opioids

Reports that misuse of prescription opioids is increasing

There is growing concern among New Zealand health professionals about the perceived increase in misuse of prescription opioids – especially oxycodone. Many GPs have become reluctant to prescribe these medicines and fear that with each prescription, they are contributing to a rising drug problem.

A considerable proportion of the use of oxycodone appears to stem from discharge prescriptions from secondary care which may then be continued by GPs. There is no published evidence of an oxycodone misuse epidemic in New Zealand, but prescription numbers are increasing at a significant rate each year. In the 2007/08 New Zealand alcohol and drug use survey, it was reported that 3.6% of adults (aged 16 to 64 years) had used an opiate for recreational purposes at some stage of their life. The most common type of opiate used was prescription analgesics such as morphine or oxycodone.¹ In the latest report from the Illicit Drug Monitoring System (IDMS), it is confirmed that the main source of illicit opioids in New Zealand is “street morphine”, sourced from pharmaceutical prescriptions.² “Homebake heroin”, made from codeine, is also popular among drug users. Pharmaceutical opioids are obtained by theft of supplies from pharmacies, forging or altering prescriptions, deception or manipulation of prescribers, “doctor shopping”, “pharmacy hopping” and using legitimate prescriptions belonging to others.² The level of use of street morphine has remained stable between 2008 and 2009.² However, in the latest IDMS publication, it was reported that oxycodone misuse was an emerging trend.² The percentage of injecting drug users that used oxycodone increased from 9% in 2008 to 18% in 2009.

There is more evidence of the growing problem of oxycodone misuse in other countries, where oxycodone has been available for longer. Americans represent 4.6% of the global population, yet they consume 80% of the opioid supplies.³ Retail sales of oxycodone in the United States increased by 866% between 1997 and 2007.³ As a

result, reports of prescription opioid misuse, overdose and unintentional deaths have risen steadily.³ In a survey of non-medical users of prescription opioids, 18% obtained the medicine from their own doctor and 56% obtained it from a friend or relative – of which 84% obtained the prescription from their doctor.

Misuse of oxycodone has been identified as a major health issue in Canada. In a study based in a large addiction centre in Toronto, it was found that the number of admissions related to controlled-release oxycodone increased significantly from 4% of the total admissions for opioid addiction to 55% four years later.⁴ The majority of these addictions were sourced through prescriptions from doctors.⁴

1. Do not fear prescribing opioids when use is justified

Most people with chronic pain, who are treated long-term with opioids, will not develop an addiction to the medicine. Addiction occurs as the result of two factors; the pharmacological properties of opioids that cause them to become addictive and the psychological, social and physiological factors of a person which predisposes them to addiction.⁵

It was estimated, in an evidence-based review of multiple studies, that 3% of people who take opioids for chronic non-malignant pain develop misuse or addiction problems and 11% develop “aberrant drug-related behaviours” such as aggressively requesting medicines, self-directed dose escalation or inappropriate use of the medicine, e.g. injecting. However, after removing people with history of drug misuse or addiction, these numbers reduce to 0.2% and 0.6% respectively.⁶

A history of serious mental illness, including major depressive disorder, is also associated with a higher likelihood of illicit drug use or substance dependence.³

These findings suggest that if there is appropriate screening of patients for addictive behaviours and risk for

substance misuse prior to prescription, the risk of opioid misuse and addiction is very low.

There is good evidence for the use of opioids in short-term relief of acute pain, but less evidence of their effectiveness in long-term treatment of non-malignant pain. Opioids should be used at the appropriate strength (i.e. following the WHO analgesic ladder), for the shortest possible time and stepped down when the pain resolves. Use in chronic, non-malignant pain should only be considered if the patient has not responded to other treatment or analgesia options.

2. Do not under-treat pain

Behaviours such as dose escalation, medicine hoarding and medicine sharing are suggestive of opioid addiction. However, in some cases, these behaviours occur as a result of under-treatment of pain and ineffective pain coping strategies – termed pseudo-addiction. In contrast to addiction, the behaviours resolve when adequate pain relief is prescribed.⁷

Patients whose reports of pain are not accepted, may resort to behaviours which raise suspicion of opioid misuse.⁷ The difference between people with genuine pain and people with opioid misuse problems are that the latter group use opioids in the absence of pain or in an attempt to alter their mood or reduce symptoms other than pain.⁷

It is important to prescribe medicine for breakthrough pain in addition to the usual daily opioid dose and regularly enquire about pain levels, and adjust the dose accordingly, whether the pain is increasing or decreasing.

3. Be vigilant for drug-seeking behaviour

Pain is not always obvious and prescribers must rely on a subjective report from the patient about the level of pain they are experiencing. This makes it easier for people with ulterior motives to gain access to pain medicines such as morphine or oxycodone.

Drug-seekers do not fit any particular stereotype but there are some behavioural aspects which may help to identify them, such as:^{8,9}

- Requesting a specific medicine and refusing all other suggestions – the patient may claim that other medications do not work, they have an allergy to them, a high tolerance to drugs or report losing prescriptions
- Inconsistent symptoms that do not match objective evidence or physical examination
- Manipulating behaviour which may include comparing one doctor's treatment opinions against another's, offering bribes or making threats
- Assertive personality, often demanding immediate action
- Unusual knowledge of medications and symptoms or evasive and vague answers to history questions
- Reluctance to provide personal information such as address or name of regular doctor
- Use of multiple doctors

- Presenting near closing time without an appointment
- Reporting a recent move into the area, making validation with a previous practitioner difficult
- Signs and symptoms of intoxication or withdrawal

If you suspect that a patient is seeking opioids for reasons other than legitimate pain relief, some suggested strategies are:⁹

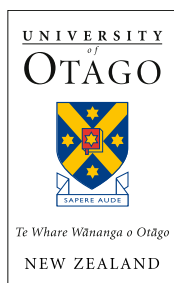
- Outright refusal to prescribe
- Prescribing for a limited time, e.g. two to three days
- Supervised daily dosing
- Prescribing a medicine appropriate for the reported symptoms but different from the one requested by the patient
- Seeking a second opinion from a colleague

 For further information see: "Prescription drug misuse", BPJ 16 (Sep, 2008).



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Division of Health Sciences

Complementary Medicine – its place in primary care – GENX 826

Semester Two – 2011

Commences with the first residential in Dunedin on August 27 & 28 and finishes with a residential on November 26 & 27.

Study of this paper will equip GPs with the knowledge base to help their patients make informed health care choices in relation to complementary therapies.

STUDENTS WILL GAIN:

- An overview of non-conventional treatment options available in the primary healthcare sector and of reasons patients give for using them.
- Understanding of the different health care perspectives that underlie complementary practices and how they fit with general medical practice.
- Knowledge about existing research of complementary therapies, how to access evidence-based information and what the specific challenges are for research in this field.
- Understanding of the legal and regulatory environment for complementary practices in NZ.



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