The Challenges of Managing Pain in Patients with HIV and Addictive Disorders

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DRUG-FREE AMERICA

AGE 0-4
AMoxicillin

4-12
Ritalin

12-18
Appetite suppressants

18-24
No-Doz

24-38
Prozac

38-65
Zantac

65-Everything else
HIV/AIDS Related Pain

- Studies since the early days of AIDS up to present time continue to indicate pain is common, neglected and undertreated in pts. with HIV/AIDS
  - (Parker, Stein & Jelsma, 2014)
- Pain control is essential throughout the course of the illness ranging from curative to palliative treatment
- Concept of Total Pain developed by Dame Cicely Saunders
  - Physical harm influenced by social, psychological and spiritual factors
HIV/AIDS Related Pain

- Prevalence rates range from 30-88% of PLWA at all stages of the disease
- Pain is of moderate to severe intensity w/ impact on function and PLWA report 1-2.5 sites of pain
  - (Parker, Stein & Jelsma, 2014)
- Pain in HIV/AIDS is associated with:
  - Disease progression- lower the CD4T cell count, the higher the risk of increased pain
  - Opportunistic infections- headache pain w/ cyptococcal meningitis; abd pain w/ mycobacterium; oral pain w/ candidiasis
  - Effects of HAART- neuropathy pain
HIV/AIDS Related Pain

- Common pain syndromes in HIV/AIDS
  - GI pain - oropharyngeal, esophageal, abdominal, biliary tract, pancreatic, anorectal
  - Chest pain syndromes
  - Neurological pain syndromes - headache, neuropathy
  - Rheumatological pain syndromes - arthritis, arthropathy, myalgias, myositis
  - Painful dermatological conditions
Neuropathy: Etiology

- HIV
- CMV
- Drugs, ie, didanosine, zalcitabine, isoniazid
- Mitochondrial toxicity
- Advanced immune suppression
- Comorbid TB infection and exposure to anti-TB medications (Nicholas, Corless & Evans, 2014)
HIV Neuropathy

- Prevalence is increasing globally
- In one study- 49 % of study population dx w/ neuropathy, w/ 30% of study population w/ symptomatic neuropathy, reporting moderate to severe pain symptoms
- Most common neurological complication in HIV
- Common symptoms include: Paresthesias in feet and lower extremities, also in hands and upper extremities, numbness, stinging, burning, hot or cold sensations, electric- shock sensations, difficulty bearing weight or wearing shoes
HIV/AIDS Related Pain

- Those at risk for even further undertreated pain in patients w/ HIV/AIDS:
  - Women
    - Increased pain frequency and pain intensity
  - Non- Caucasian groups
  - Patients w/ current or history of IVDU
  - Increased psychological distress and decreased emotional control is associated with increased pain
- Improvements in management of the virus have not resulted in improvements in pain management
  - (Breitbart, 1996; Newsham & Staats, 2013; Parker, et al., 2014)
Pain Definitions

- Pain:
- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life...It is unquestionably a sensation in a part or parts of the body but it is always unpleasant and therefore and emotional experience (International Assoc. for the Study of Pain, 1979)
Pain Definitions

• Pain
• “Whatever the experiencing person says it is, existing whenever s/he says it does”
• (McCaffery, 1968)
Important Definitions

• Physical Dependence-Adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist (AAPM, APS, ASAM, 2001)
Important Definitions

• “Tolerance—Normal neurobiological event characterized by the need to increase the dose over time to obtain the original effect
• Cross Tolerance—Normal neurobiological event of tolerance to effects of medication within the same class” (Alford et al. 2006)
Important Definitions

• Addiction- A primary chronic, neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving (AAPM, APS, ASAM, 2001)
Important Definitions

• Pseudoaddiction-An iatrogenic syndrome created by the under-treatment of pain. It is characterized by patient behaviors such as anger and escalating demands for more or different medications and results in suspicion and avoidance by staff. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated (Weisman & Haddox, 1989)
Hyperalgesia

• Opioid-induced abnormal pain sensitivity has been observed in patients treated for both pain and addiction (Brodner, 78; Taylor, 80; Savage, 96; Compton, 94; Doverty, 01; Schall, 96; Dyer, 99)

• “A neuroplastic change in pain perception resulting in an increase in pain sensitivity to painful stimuli, thereby decreasing the analgesic effects of opioids” (Alford et al., 2006)
Barriers to Pain Management

- Health Care Providers
  - Lack of knowledge
  - Myths and misconceptions
  - Cultural barriers
  - Fear of addiction
  - Fear of legal sanctions
  - Less of a priority in AIDS care than identifying other treatments
Barriers to Pain Management

- Patients/Family/Caregivers
  - Fear of addiction
  - Wanting to be “good” patients
  - Stoicism
  - Cultural barriers
- Social and Governmental Barriers
  - Stigma
  - Lack of access to care
  - Regulatory issues
  - Lack of accountability
Barriers to Pain Treatment

- Under-treatment of pain is usually the result of one of three factors:
  - Patient under-reporting of pain
  - Physician under-prescribing of pain medication
  - Nurses under-administering pain medication
Additional Barriers

• People with a substance abuse problem face additional barriers to pain management
  – Health care professionals often have:
    • Inadequate knowledge about pain management
    • Inadequate knowledge about addictive disorders
    • Fears of being “conned” or contributing to addictive problems
    • Stigma/Opiophobia
    • Concerns re: Legal issues
Consequences of Pain

- Immobility, Deconditioning, Sleep disorders, Immune dysfunction, Respiratory disorders, Anxiety, Falls, Malnutrition, Increased stress, Depression, Neurological changes

- Untreated or undertreated pain may lead to the development of a chronic pain condition – more difficult to treat!

All these consequences also are consequences of addictive disorders, so when a patient has both the consequences are greater
Risks of Addiction

Risk of addiction in chronic pain population -3.2- 18.9% (Portenoy, 86; Katon, 85; Fishbain, 86; Steele-Rosomoff, 90; Evans, 81; Fishbain, 92; Liebschultz, 2010)

Problem drug-taking behaviors identified in 40% of people in pain programs; 20% of those patients have behaviors suggestive of substance abuse and 2-5% of those patients have behavior indicative of addiction (Webster & Webster, 2005)

Known risk factors for addiction to any substance are predictors for prescription opiate abuse:

- Young age < 45
- History of substance use - illicit, prescription, tobacco, alcohol
- Family history of substance abuse
- Legal history
- History of mental illness
Psychiatric Co-morbidities of Pain and Addictive Disorders

- Depression 15-56 %
- Anxiety 17-50 %
- PTSD 20-34%
- Somatization disorders 20-31 %
- Personality disorders 31-81 %
- Substance Use disorders 15-28 %
- Sleep disorders (Trescott, 2008)
Additional Background Factors

- Relationship between traumatic injury and chronic pain and incidence of addiction
- Relationship between substance abuse and physical/sexual abuse in childhood and the development of chronic pain
  - 30-50% of chronic pain patients have experienced physical, sexual abuse or abandonment as children
  - Also high occurrence of physical/sexual abuse in substance abusing families
Comprehensive Assessment

- Patients assume that you don’t believe their pain complaints- BUILD TRUST
- Pain and Coping (identification of chemical copers)
- Collateral Information
- Function
- Substance Use History and Risk for Addiction
- Co-occurring medical and mental health conditions and disorders
- Physical Exam
- Mental Status Exam
- Thorough evaluation should be performed no matter how many times patient presents with pain
Assessment Tools

- Numeric Rating Scale- 0-10 scale; Visual Analog Scale
- Brief Pain Inventory
- Memorial Pain Assessment Card
- Patient Comfort Assessment Guide
HIV Neuropathy

- Risk factors for neuropathy include:
  - Exposure to ART
  - Older age
  - History of alcohol abuse
  - Advanced HIV disease

- Assessment
  - Complete history and physical
  - Use of screening tools - Brief Peripheral Neuropathy Screening Tool ((BPNS))
    - (Nicholas, Corless & Evans, 2014)
Assessment Concerns

• Any factor that interferes with or diminishes the communication with patients poses a threat to the adequacy of the assessment and appropriate treatment of pain

  Under-treated/underserved populations:
  
  IV drug users, women (esp. African-American women), the very poor, very ill, very old and very young
Assessment Concerns

- Failure to recognize, identify and treat the co-morbid problems of mental illness, addictive behaviors and pain compromises the ability to adequately treat any of these issues.
- Behavioral patterns of substance intoxication and/or withdrawal can lead to immediate labeling on the part of providers, resulting in inadequate assessment of the problem.
- Patient distrust of providers can lead to poor outcomes, delay in seeking treatment, failure to follow recommendations or lack of follow-up in care.
- EMPATHY is key to delivering good care.
Principles and Goals of Pain Management

- Listen to the patient
  - Pain is subjective – there is no objective measure of pain-only what the patient tells us
  - However, patients’ unrealistic expectations must be addressed
- Reassessment
  - After treatment is initiated, pain should be regularly reassessed to determine the efficacy of the intervention
- Optimal functioning with least side effects
  - The right dose of pain medication is the dose it takes to relieve the pain with the fewest side effects
  - Functioning is usually more of a priority in patients who are not end-stage
WHO 3 Step Analgesic Ladder

Pain Management

• **Step 1:** Mild pain
• **Step 2:** Moderate pain
• **Step 3:** Severe pain
Optimal Use of Analgesics
World Health Organization Step Ladder

1) Begin with non-opiate, nonsteroidal anti-inflammatory agents (NSAIDS)
2) Add a “weak” opiate, such as codeine or hydrocodone (with or without an adjuvant)
3) Move to a stronger opiate, such as oxycodone, morphine (with or without an adjuvant)
4) Opioid efficacy in chronic pain
   Limitations of current evidence - RCTs short duration, industry sponsored, no NIH home or funding
Methadone

- See new guidelines (handout)
- Educate patient about safety issues
- Mitigation of serious risks of OD and cardiac arrhythmias
- Careful dose initiation and titration - equal analgesia
- Diligent monitoring and follow-up
- Long half life
- Multiple drug interactions
- EKG
Treatment for Neuropathy

- First line treatment- NSAIDS and acetaminophen for mild pain, or throbbing pain
- Moderate pain- Gabapentin -300 mg at hs increasing to 1200 mg/d in divided doses q 6-8 hrs; 2-3 Gm max
- Nortriptyline 10 mg at hs increasing to 75 mg, Amitryptiline or Desipramine 25 mg, increase q 3 days
- Lamotrigine 25 mg q 12 hrs, increase up to 150 mg q 12 hrs
- Topical capcaicin, Lidocaine patches
- Severe pain- long acting opiate- MS Contin, transdermal Fentanyl, Methadone (Sax, Cohen, Kuritzkes, 2012)
Treatment for Neuropathy

- CAM
  - Massage
  - Acupuncture
- Use anti-embolic stockings
- Encourage exercise, such as cycling, walking
- Use topical capsaicin P ointment if only small areas like toes or fingers are affected – takes several days to be effective, must be applied tid-qd
- Discontinue the causative drug if possible
- B6 and B 12 supplements
Complementary and Non-Pharmacological Therapies

These therapies have research to support that they reduce pain. Most research done in non-HIV patients

- Acupuncture
- Hypnotherapy
- Massage
- Magnet Therapy
- Nutriceuticals (dietary supplements such as glucosamine chondroitin)
- Music
- Therapeutic touch
- Aromatherapy
- Heat/ice
- Distraction (tv, reading)
Interventional Strategies

- Plays a small role in pain management in HIV/AIDS
- Usually done by anesthesiologist
- Nerve blocks, using anesthetics, corticosteroids or neurolytic drugs
- Implanted epidural pumps or intraspinal drug delivery – cautious use with persons with AIDS due to risk of infection
  - (Newsham, & Staats, 2013)
Case

- 43 year old Caucasian male with HIV disease, peripheral neuropathy and alcohol abuse. Also severe back, hip, wrist and epigastric pain of several years, hypertriglyceridemia, hypercholesterolemia. S/p CVA.
- No prior psychiatric history
- VL suppressed, CD4 858
- Referred for severe depression, pain management
Management of Adverse Drug Effects

- Most common side effect????

- Patients discontinue treatment due to ADEs

- Unique problems with Meperidine (Demerol) has resulted in recommendation to NOT use for chronic pain conditions
Case

Pam is a 42 year old married Caucasian woman, mother of an 11 year old girl. Has advanced HIV disease with poor immunologic functioning and poor virologic control on her current regime of Abacavir, Tenofovir and Kaletra. She has multiple resistance mutations -pan-resistance to NNRTI’s and minor PI and RT mutations.

- She also has Chronic Hep C and has had 3 courses of treatment with sustained remission for 6 years and developed HIV rebound during her last treatment.
- Also history of osteochondritis, lower abdominal pain, pelvic discomfort, diarrhea, cervical spine disease and significant weight loss. Is currently being worked up for malignancy with abdominal lymph node biopsies.
Case

- She has a past history of heroin and cocaine abuse but has not used drugs for 12 years. She has had a diagnosis of major depressive disorder and was treated for years with Zoloft. She wanted to stop treatment with Zoloft about three years ago and after a very slow taper of the Zoloft has had no recurrent episodes of depression.

- Does have major complaints of pain and has been managed with Oxycontin for the last two years with no difficulty. New complaints of anxiety and irritability in the past year related to increase in her medical problems. Has refused to go back on antidepressants. With current medical issues have increased therapy sessions again and anticipate further need for support and antidepressants as medical condition is deteriorating.

- Presents today in your office screaming and demanding more medication for pain and “I need Valium too!”
Pain management is not just “nice to do”. Nurses and physicians have been held legally accountable for inadequate pain management.
Dealing with the Pain/Addiction Issue in 2014

- The problem of pain and addiction has challenged providers for the last two plus decades, but has become more challenging in the last year.
- This has resulted in rethinking many approaches to pain management and the pendulum is swinging...
- The following slides include approaches to the problem that attempt to deal with the needs of people in pain while not contributing to the very real challenges of addictive disorders and use/abuse of opiate medications.
Approach to Care

- Coordinated care approach is essential
- Rational, informed approach to care based on evidence when available
- Management of provider fears/biases
- Tight control of medications dispensed, especially opioids (recommendation is for one prescriber only)
- Escalating requests for opioids results in review of overall treatment plan
- Behavioral intervention plan- change of patient expectations from cure to functional improvement
Approach to Care

- Increased Communication and Coordination with PCP
- Serious discussion re: risks of treating w/ opiates vs. non-treatment of opiates
- Involvement of patient in treatment program
- Realistic expectations of role of opiates
- Patient role in treatment and participation in care
- Respect for patients and providers alike
  - Forum to discuss varying points of view
- Support and supervision for staff
Screening Tools used in Pain Programs

- The Opioid Risk Tool (ORT) (Webster & Webster, 2005) - handout
- The Screening Instrument for Substance Abuse Potential (SISAP) (Coombs et al. 1996)
- The Screener and Opioid Assessment for Patients with Pain (SOAPP) (Butler, et al. 2004)

Other resources:

http://www.partnersagainstpain.com/printouts/Pain%20Management%20Quick%20Kit.pdf
Additional Tools that have been added to our “tool kit”

- Universal precautions
- Monitor benefit/harm w/ frequent face to face visits
- Use of medication agreements “our clinic policy is”
- Use of urine toxicology screens
- Pill counts
- Prescription Monitoring Programs- MA. State program

- Pharmacogenetic Testing
Aberrant Drug-taking Behaviors: The Model

- Probably more predictive
  - Selling prescription drugs
  - Prescription forgery
  - Stealing or borrowing another patients’ drugs
  - Injecting oral formulations
  - Obtaining prescription drugs from non-medical sources
  - Concurrent abuse of related illicit drugs
  - Multiple unsanctioned dose escalations
  - Recurrent prescription losses (Passik & Portenoy, 1998)

- Probably less predictive
  - Aggressive complaining about need for higher doses
  - Drug hoarding during periods of reduced symptoms
  - Requesting specific drugs
  - Acquisition of similar drugs from other medical sources
  - Unsanctioned dose escalation 1-2 times
  - Unapproved use of the drug to treat another symptom
  - Reporting psychic effects not intended by the clinician
The Five “A’s” of Pain Treatment Outcomes

• Analgesia (pain relief)
• Activities of Daily Living (psychosocial functioning)
• Affect- emotional and mood evaluation
• Adverse effects (side effects)
• Aberrant drug taking (addiction-related outcomes)  (Gourlay & Heit, 2005)
Recommendations for Pain and Addictive Disorders

• Pain Management for all Patients with addictive disease:
  – Team of providers to assess both pain and addiction
  – Enhance support systems
  – Involve patient in planning, use non-judgmental approach
  – Provide verbal and written explanations and information – contracts, agreements and contingency plans*
  – Educate
Recommendations for Pain and Addictive Disorders

• Explain and discuss any plan to use psychoactive substances as part of treatment
• Explain risks (health and quality of life) of unrelieved pain, including risk of relapse
• Explain risks of treatment w/ opiates and side effects/dependence, tolerance, risks of drug interactions, risk of abuse, addiction, overdose
• Legal responsibilities- disposing, sharing, selling
• Involve family, S/O, supports in conversation where appropriate and patient gives permission
• Respect the patients’ wishes
• Use of opioids as a test or trial
Recommendations for Pain and Addictive Disorders

- Encourage active participation in recovery programs
- If relapse occurs, intensify recovery efforts, do not necessarily terminate pain care
Dealing with Prescription Drug Abuse Issue - Clinician Concerns

- Routine questioning of all patients- “If I opened your medicine cabinet, what would I find in it?”
- Review methods of proper disposal of unused medications with all patients
- Use of strategies (recommendations to be covered-contracts, agreements, urine toxicology screens, multidisciplinary team, referral to addiction services, PMPs)
- Consults
- Support for staff
- Document, document, document
Attitude is a little thing that can make a big difference

Winston Churchill
Language Matters

- Terms used when describing people with pain- “she doesn’t look like she’s in pain”
- Terms used when describing people with addictive disorders- “junkie”, “dirty urine”
- Research at MGH revealed that trained professionals were susceptible to the effects of stigmatizing language
- Survey comparing response to patient scenario- substance abuser vs. substance use disorder- terms were the only difference in the scenarios
Language Matters

- Results of survey:
- Respondents to survey using term substance abuser were more likely to blame pt for his problem and thought that the patient should be punished for not adhering to the treatment, compared with respondents whose surveys described him as someone with a substance abuse disorder.
- One phrase conveys a treatable medical disorder, the other may convey that the pt. is responsible for his or her disorder  
  (Kelly & Westerhoff, 2010)
Attitudes

“The longer I live, the more I realize the impact of attitude on life. Attitude, to me, is more important than facts. It is more important than the past, the education, the money, than circumstances, than failure, than successes, than what other people think or say or do. It is more important than appearance, giftedness or skill. It will make or break a company...a church... a home. The remarkable thing is we have a choice everyday regarding the attitude we will embrace for that day. We cannot change our past... we cannot change the fact that people will act in a certain way. We cannot change the inevitable. The only thing we can do is play on the one string we have, and that is our attitude. I am convinced that life is 10 % what happens to me and 90 % of how I react to it. And so it is with you... we are in charge of our ATTITUDES”.

Charles R. Swindoll,
American writer and clergyman
Questions

- The Pain/Addiction problem in our country is not going to go away without a lot of work.
- .... So what role do you want to have in changing the care our patients receive???

- Thanks for your interest in this challenging topic!