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
KEY POINT

IT’S ALL ABOUT THE RELATIONSHIP and COMMUNICATION!
HIV/AIDS Related Pain

- Studies from 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)
- Concept of Total Pain developed by Dame Cicely Saunders
  - Physical harm influenced by social, psychological and spiritual factors
  
  Focus for presentation is on chronic pain
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
- 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
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)
Differences in Definitions

PAIN ≠ Dependence
Tolerance Addiction
CASE EXAMPLE

- George is a 64 yr old man w/ AIDS- diagnosed for 12 years and doing well on HIV meds w/ high CD4 count and undetectable VL
- Multiple pain sites- lower back pain x 5 yrs, hip and wrist pain of longstanding nature. Currently has new pain in abdomen and is being worked up for lymphoma
- Long history of IVDU- main drug was Heroin but also used alcohol and marijuana. No drug use for almost 10 years. Was active in NA but has stopped going to meetings.
- Recent increase in irritability with angry outbursts and his partner relates being afraid of his temper. He denies recent drug use and refuses referral for therapy.
- Where would you begin in your assessment? What are your concerns?
Barriers to Pain Treatment

• Stigma or opiophobia
• Under-treatment of pain is affected by patient, family and provider concerns
• Provider concerns include:
  • Fear of contributing to addiction, legal issues, fear of being “conned”
Consequences of Un-treated or Under-treated 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!
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)

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
Older Adults and Pain

- Key to pain management in older adults:
  - An understanding of the pathology of the underlying disease
  - An understanding of age-related changes in how pain presents and how the older patient perceives and tolerates it
  - Changes in pharmacokinetics of analgesic medications in the older adults due to changes in aging liver and kidney
Older Adults and Pain

- Mistaken belief that analgesics are not safe for older adults
- Pain is NOT a normal part of aging, but is commonly thought to be and is therefore often under-treated
- Importance of drug-drug interactions
Comprehensive Assessment

- Patients assume that you don’t believe their pain complaints - BUILD TRUST
- Pain and Coping (identification of chemical copers)
- 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
- Use of Rating tools
Communication

- The difficult conversation w/ George
  - Rating
  - Realistic appraisal
  - Expectations
  - Contribution of medication
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

5 A’s- Analgesia, ADLs, Affect, Adverse effects, Aberrant drug taking
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

- Probably less predictive
  - Aggressive complaining about need for higher doses
  - Drug hoarding during periods of reduced symptoms
  - Requesting specific drugs
  - Unsanctioned dose escalation 1-2 times
  - Unapproved use of the drug to treat another symptom
  - Reporting psychic effects not intended by the clinician

(Passik & Portenoy, 1998)
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
Approach to Care

- Coordinated, individualized 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
Approach to Care

- Behavioral intervention plan - change of patient expectations from cure to functional improvement
- Serious discussion re: risks of treating w/ opiates vs. non-treatment of opiates
- 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