GUIDELINES FOR PAIN MANAGEMENT IN SUBSTANCE ABUSERS

1 Accept and respect the report of pain in spite of the possibility of being duped

A Withholding opioid analgesics from substance abusers has never been shown to increase the likelihood of recovery from addiction

2 Prevent or minimize withdrawal symptoms

A Distinguish between tolerance, physical dependency and addiction or abuse
B Avoid producing the syndrome of "pseudo addiction" through inadequate pain Rx
C Take a substance abuse history
D Distinguish between the *active* untreated drug abuser, the *former* addict and the patient in methadone maintenance.

3 Do a comprehensive pain assessment & provide treatment for both the underlying disorder(s) and the pain syndrome

A Provide adequate analgesia to allow diagnostic workup to take place

4 **Utilize World Health Organization "Analgesic Ladder"**

A NSAIDS
B Opioid analgesics (weak, strong opioids)
C Adjuvant analgesics (often have specific indications, i.e. neuropathic pain)
D Combinations of above

5 Apply appropriate pharmacological principles when using opioids

A Appropriate opioid (avoid agonist-antagonist)
B Use adequately titrated doses (consider tolerance / no pharmacologic ceiling)
C Use regular dosing schedule, at appropriate intervals, for constant pain-Avoid PRN dosing (prevents excessive medication-centered interactions with staff)
D Use appropriate route of administration
E Plan carefully with patient when route of administration is changed or opioids withdrawn

6 Provide non-opioid and non-pharmacologic therapies as indicated

A Use non-opioid analgesics-not as a substitute for opioids but as an adjuvant
B Use non-pharmacological therapies-physical rehabilitation, anaesthetic/neurosurg cognitive-behavioural approaches

7 Recognize specific drug abuse behaviours

A Detail expectations and define limits of acceptable behaviour
B Written rules agreed upon regarding prescription renewals, lost, stolen, altered prescriptions
C Set limits-Urine toxicology screens, tamper proof infusion pumps, restriction of visitors, frequent visits-one week supply of medication, search of hospital room
D Never use pain as a bargaining chip-Personal opinions about patients should not be allowed to obstruct therapy

8 Set realistic goals for pain therapy

A Know the limitations-Rehabilitation from addiction is not appropriate during an acute medical crisis or if patient unwilling
B Anticipate problems-prescription loss, early renewal. Avoid excessive negotiation by giving patient some control
C Define expected degree of pain relief
D Educate staff repeatedly-attitudes may not change but care must be provided

9 The care of the substance abusing patient with pain requires a team effort

A Early consultation with psychiatry, substance abuse, pain specialists, etc.

10 Evaluate and treat other distressing physical and psychological symptoms

11 Constant assessment and re-evaluation of the effects of pain interventions must take place in order to optimize care

Adapted from: *Pain Management of Patients with a History of Drug Abuse*, Passik et al at "Current Concepts in Acute, Chronic and Cancer Pain Management", Memorial Sloan-Kettering Cancer Centre, NY, 12/93; in "Comfort Care, Palliative Care Symptom Management of Cancer Patients, A Guide for Physicians", W.G. Carlyle Phillips, 2000.