Back pain and opioid seeking behaviour

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This is the third article in a series of case files from general practice that explore treatment issues around substance use and commonly encountered general practice presentations.

BACKGROUND
Back pain is a common presentation associated with opioid seeking behaviour.

OBJECTIVE
This case study provides general practitioners with a practical approach to seeing patients with chronic pain whom they suspect of opioid dependence and describes a framework for managing chronic pain and dependence within the general practice setting.

DISCUSSION
Back pain, with or without opioid dependence, is commonly encountered in general practice. General practitioners frequently find themselves caught between the desire to treat and relieve symptoms, and not wanting to cause or exacerbate dependence. Clear guidelines and access to support are often lacking.

Case history – Callum

A practice colleague has had a stroke and is unlikely to return to work. Among his patients is Callum, 28 years of age, who, from his scant clinical notes, has been prescribed a variety of S8 drugs for at least 6 years. He first attended the practice after developing osteomyelitis from a compound fracture in his leg. Callum was discharged from hospital on opioids which your colleague continued to prescribe after the osteomyelitis had resolved. Callum tells you he has run out of his medications. He is using 3 x 30 mg oxycodone suppositories, 4 x 20 mg capsules of oxycodone hydrochloride, 3 x 100 mg MS Contin® and 1 x pethidine hydrochloride injection per day. He is not intoxicated, moves a little slowly, but doesn't appear to be in pain when sitting. You feel uncomfortable about the expectation to prescribe set by precedence in the practice.

What's achievable at the first appointment?

You wonder if Callum is:

- genuinely in pain and legitimately seeking analgesia
- in pain but opioid dependent and requiring assistance, or
- opioid dependent and playing the role of the pain patient to obtain opioid drugs.

Implicit in this is your concern for his safety and unwillingness to contribute to his problem, but also your wish to avoid the attention of local S8 drug regulatory authorities.

In theory, people with nongenuine pain demonstrate an exaggeration of the pain response, are inconsistent with movement and behaviour (eg. not apparently in pain when feeling unobserved, inconsistent in showing signs of pain with different movements), request specific drugs by name, and present at times when you are unable to check their story. However, none of these are by any means pathognomonic. People express their pain differently and pain can vary within the individual in different times and situations.[1] Pain and dependence lie on a continuum and are not mutually exclusive.[2]

So what are your options at this initial appointment? Given your uncertainty about this presentation you could refuse to pre-

Table 1. Assessment of pain and dependence

History
- History of the pain condition and contributing factors
- Past medical and psychiatric history
- Past and current treatment
- Past and current medication use

Examination
- Physical examination in relation to the site of pain
- Physical examination of other relevant areas
- Assessment of mental state, including response to pain and consistency of behaviours
- Signs of intoxication and withdrawal
- Signs of frequent intravenous or intramuscular injection

Investigations
- Previous investigations in relation to the cause of pain

scribe opioids. However, if Callum is genuinely in pain you would have failed in your duty of care. You have limited time to make a decision at this appointment and patients deserve the benefit of the doubt.[2]

Opioid use and chronic pain is a complex issue and determining an appropriate management plan is impossible in a single standard appointment. At a minimum, you need to manage the pain presentation between this and the next appointment and set up a framework for further action. This involves making an initial assessment of the areas outlined in *Table 1*. While you cannot assess all areas in depth, you will be able to elicit some preliminary information and undertake a more thorough assessment over time. You could contact your state/territory S8 drug regulatory authority to seek information about prescriptions for Callum. In this case, however, you know from clinical notes that Callum has indeed been prescribed S8 drugs and opt not to make the call.

From this brief assessment you have concerns about the mixture of medications and the reliance on short acting injectable analgesia, but continue the listed prescriptions for now. You inform Callum you plan to review his medications and discuss other available pain management techniques such as physiotherapy, TENS, psychological techniques such as cognitive behavioural therapy, various pharmacological approaches, and surgical and anaesthetic procedures. You ask Callum to keep a diary over the next few days documenting the time and date of any opioid and other medication use, activity, and the level of pain on a scale of 0–10.

You arrange a longer appointment for a more thorough assessment 4 days later. You explain that his continued treatment is contingent upon return for follow up assessment. You calculate – together with Callum – the supply of each medication required to last until the next appointment, and prescribe only that quantity. You make it clear that you will not prescribe to replace medication that is lost or depleted early.

The story unfolds

The next day you contact your local S8 drug regulatory authority at the department of health and discover that Callum has recently sought S8 medications from other GPs.

Callum returns 2 days early and asks to be seen urgently. He is not intoxicated although he has a degree of miosis. He says he was in terrible pain the day before and used all the pethidine.

You ask Callum if he has sought opioids from other sources. He admits to occasionally doing so, but avoids answering the question about recent visits to other GPs. You tell him you know about this and are concerned about the multiple sources of his medication and the associated risk of accidental overdose.

Callum admits his drug use has been getting out of control. He says the doses recommended don't help his pain anymore and he 'simply can't cope without using more'. He appears to be genuinely distressed.

You explain to Callum that pain and dependence can occur together, and that you are willing to work with him to achieve better control of both within a structured setting where you will prescribe opioids only if you can be sure he is not using other medications. This means he must agree to you discussing his case with the department of health and his pharmacist, and agree to seek pain medication only from your practice. This element of informed consent is an important part of the management of Callum's opioid medications (*Table 2*).

You make clear the ground rules:
- that you will treat him with respect and try your best to help him, and expect that he will attend appointments and treat the practice with respect
- that he will take responsibility for his medication and for planning appointments to avoid asking you to replace 'lost' scripts or respond to the need for 'urgent' appointments because medication has run out, and
- that you will both work together to resolve his opioid and pain management problems.

In addressing his request for more pethidine, you need to be consistent with your previous statement of not replacing medications depleted early.[2,4] You remind Callum of the previous agreement. As expected, Callum says: 'So what am I going to do for the next 2 days?' You indicate you are bound by government regulations to prescribe no more than 5 pethidine ampoules every month in addition to the MS Contin® and oxycodone. Callum tells you that his previous GP had

Table 2. A framework for managing opioid dependence and pain*

Establish ground rules: points for discussion	
Respect	• Mutually respectful behaviour including appointment attendance
Teamwork	• Management plans to be worked on together and agreed on
Expectations	• Clarify expectations. The absence of all pain and discomfort is not a realistic goal. Over time it will be possible to improve symptoms
	• Plan for after hours emergencies and agreed review after these occur
Responsibility	• Patient's responsibility for contributing to assessment and problem solving, participation in treatment (eg. physiotherapy) and care of own medications (ie. ensuring medications do not run out or lost)
Safety	• An agreement that medication will not be sought from other practices and consent for you to check on prescribing information from the authorities
	• Safety also requires that 'lost' medications cannot be replaced and this needs to be explained clearly from the beginning
Structure	• Consistency in words and actions is essential
	• Use a pain diary recording activities, pain and medications
	• Use pain clinics, drug and alcohol clinics and other allied health workers (*Table 3*)
	• Use your local S8 authority (state/territory department of health) as a resource
Consent	• Consent to start or continue treatment requires an understanding of drug side effects and sedation risks (especially in combination with other medication) dependence and withdrawal symptom potential, and confidentiality issues (with whom and what needs to be discussed)
Consequences	• Discuss consequences of lost medication, sale of medication, arriving earlier than agreed for medication, unacceptable behaviour (eg. demanding behaviour at reception desk)
	• If unable to control pain, medication cannot be continued under these arrangements. Alternatives range from more frequent dispensing of a limited amount of medication (eg. every second day) to mandating treatment through services for treating opioid dependence (eg. methadone maintenance which is much more restricted)
Points to clarify at each appointment	
Symptoms	• Review symptoms, activity and medication and encourage continued diary use to help gain control
Medications	• Review medication use, exact amounts of medication remaining, and work out together exactly when each medication is expected to finish
Documentation	• At each appointment document the presence/absence of intoxication or withdrawal, medications prescribed, agreements made and advice given

* A patient-doctor contract that includes these points is available on request from the author

always given him more. You explain that you do not feel comfortable breaching department of health regulations.

Callum says: 'Are you telling me I have to go and find other people to give me what I need?' You reply: 'I can't stop you from doing what you choose to do. But if you go to other GPs it's only a matter of time before the department of health speaks with them and you'll find your supply cut'. Offering choices is better than simply making a statement about refusal to prescribe; so you offer Callum the choice of nonsteroidal anti-inflammatory drugs, Panadeine Forte® or tramadol to tide him over next 2 days. Callum accepts tramadol but is clearly not satisfied.

Setting a plan

Callum doesn't return for 4 months. He looks sheepish and says he would like you to take over his care if you're still willing to. He says he doesn't want to continue the cycle of lying and fear of discovery.

You agree on the condition that he agrees to the ground rules (*Table 2*). You call your local department of health in Callum's presence and confirm he has had scripts from various

Table 3. State/territory alcohol and drug advisory services for GPs

Western Australia	08 94425042 or 1800 688847
Northern Territory	1800 111092
South Australia	1300 131340
Tasmania	1800 630093
Victoria	03 94163611 or 1800 812804
New South Wales/ACT	02 93618006 or 1800 023687
Queensland	07 36367098

GPs who have now been instructed to stop prescribing to him. You tell them that you are taking on Callum's care and intend to seek a pain specialist's assistance.

You explain to Callum that pain is better controlled with long acting opioids at regular intervals.[1] You outline that short acting drugs such as pethidine can result in increased pain – as the analgesia wears off, pain recurs quickly increasing anxiety and fear, which in turn increases pain.[4] Once again, you give Callum self monitoring 'homework' and ask him to bring his pain medication supply to the next appointment.

You stress that you are only allowed to prescribe opioids for pain and not dependence. This means that active pain assessment and management strategies must take place. If opioid use becomes out of control you will have to refer him to a drug treatment service where it is likely he would be offered either methadone or buprenorphine dispensed in a daily supervised manner. If that happened Callum would lose the flexibility of having his own supply of medication. You want Callum to understand his part in defining how his pain is managed and tell him it is up to him to use his medications responsibly to avoid this scenario.

Gradual stabilisation

Before the development of osteomyelitis, Callum had been on a disability pension for back pain. Opioids used for his osteomyelitis eased his back pain and this became his reason for continued use.

You re-assess Callum's back, arrange investigations and physiotherapy and get him on a pain management clinic waiting list. Over time, you shift Callum toward long acting opioid medications, increasing his dose of regular MS Contin® and eventually ceasing oxycodone capsules and pethidine. Sustained release morphine preparations are the drugs of choice in patients with chronic noncancer pain, as they result in more stable blood concentrations.[1] In addition, you prescribe naproxen suppositories to be used on days of increased pain.

This shift has required good communication between you, as the primary GP, and other practice colleagues. Your clearly documented treatment plan has been important in ensuring consistency occurs.

There have been times that Callum has

accused you of being uncaring and unconcerned about his pain. You have responded by asking him what he expects you to do. When he tells you that he wants you to prescribe more medications, you ask him: 'How would the health authorities respond to this?' In this way you encourage Callum to recognise that asking you to prescribe outside government guidelines would jeopardise his current relationship with you and your ability to continue to prescribe for him.

Conclusion

The management of chronic pain is an important responsibility of the GP. Inappropriate management not only results in significant patient distress through pain and associated reduced mobility, but encourages the inappropriate use of medications resulting in opioid tolerance and eventually dependence. The use of appropriate pain management strategies outlined in this article will assist in preventing the development of this scenario, or re-dressing it where it has occurred. Good pain management, like other areas of medical practice, requires a systematic approach to avoid complications and optimise clinical outcomes.

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