QUESTIONS and ANSWERS from
Treating Chronic Pain with Prescription Opioids in the Substance Abuser: Relapse Prevention and Management

presented by

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Q: Hi Dr. Compton, It's nice to see you looking just like you did when I graduated UCLA's FNP program in 1998! Question: Twelve step programs are widely encouraged and incorporated into treatment & intervention strategies. Long-term data looks at continued sobriety among successful participants. What about non-12 step patients who remain sober? Is the data skewed on 12 step programs?

Answered during the presentation

Q: Also, can you make a concurrent treatment intervention of Detox & Substance abuse treatment AND initiation of opiod treatment for acute pain?

Answered during the presentation

Q: is newer terminology preferred to use "patient opioid agreement", not patient opioid contract?

Answered during the presentation

Q: I met a physician who treated depression with two substances way out of normal...Subutex and/or adderall. What are your thoughts?Q: No h/o of addiction

Answered during the presentation

Q: can you describe functional assessment?

Answered during the presentation

Q: if medication misuse does not equal addiction, how do we assess if our patients are who are misusing their meds are also becoming addicted?

A: Assess for, address and rule out the other sources of medication misuse (especially pseudoaddiction and psychiatric disease)

Q: Has anyone ever evaluated the effectiveness of use of lock boxes for some trusted person to keep for the addicted opioid patient with acute/chronic pain?

A: Not that I am aware of; we use the lock-boxes all the time in methadone maintenance, but not to control use, but to ensure that no one else can take it. Such limited access for the person with active addiction is likely to fail, as they will go elsewhere to obtain opioids.

Q: Are there additional issues with adolescent and geriatric patients?

A: With adolescents, we worry about the emergence of addiction because it not only is a strong predictor for later addiction problems, but because their brains are so vulnerable to drug effects. With geriatrics, we worry about the issues of polysubstance use (especially opioids + benzo or ETOH) and safety (i.e., falls)

Q: We have experienced an increase in patients who are admitted with chest pain demanding opioids after MI is ruled out. Patient satisfaction scores decrease when opioids not given. Have you had experience with other chest pain units having this problem?

A: Not specifically with chest pain, but certainly other types of pain as a means for drug-seeking. Scores on patient satisfaction scales will reflect their unhappiness at not being able to obtain drug; I wonder what would happen if the issue of addiction was broached during these encounters?

Q: In earlier chest pain question I asked I want be clear. These patients have repeated admissions with chest pain, then ruled out, continue to demand opioids.

A: Smells like addictive disease to me. See above.

Q: what are the reluctance in treating pregnant or postpartum women on methadone for pain management?

A: I am assuming you mean addition opioid analgesics on top of the daily methadone dose? Although there are not good data to support it, it may be due to physician fears about additional opioid exposure and neonatal withdrawal syndrome. Also, opioids are transmitted via breast milk, so should be avoided in nursing moms.

Q: Can you speak a little bit to patients on suboxone treatment with pain management issues

A: Little data exist to show how to provide pain relief to patients on suboxone, although as with methadone, additional opioid provision does appear to provide analgesia

Q: How does a nurse proceed in treatment of a chronic pain patient who demonstrates aberrant opioids use (loss of prescriptions, obtaining medications from other doctors) but will not admit to opioid abuse?

A: By providing objective evidence that he/she is not improving on the opioid regimen and not adhering to the treatment agreement, such that you are concerned that addiction may be a problem, and you'd like to have him/her see the addiction psychiatrist. Doing so helps move the patient from pre-contemplation to contemplation.

Q: I work at the VA with a lot of returning vets and there is a lot of anger that goes with giving people pain meds then taking them away then they are left with pain

A: Completely understandable – it sounds like the "taking them away" is the problem – I'd like to know more about why that happens.

Q: when relapse occur before 1 year or after a year of 12 step program. What is more frequently?

A: Relapse is more likely within the first year of treatment including 12-step treatment

Q: Why do some chronic pain patients report good pain relief from Suboxone and others find it ineffective?

A: EXCELLENT question – and so many variables to consider (i.e., genetics, pain type, addiction history, psychiatric overlay….), and the research has not been done.

Q: In my experience, many women with chronic pain continue to be treated with opiates for many years by pain management providers. What efforts are being made to educate or legislate the providers?

A: Thanks to REMS, big efforts are being just now being made to improve provider education – still much to be done, but at least it is now being acknowledged as a need