

PHYSICIAN'S WEEKLY UPDATES

PAIN MANAGEMENT



Quantifying Drug-Seeking Behaviors in the ED

Drug-seeking behavior is a common and growing problem in emergency departments nationwide. New research on drug-seeking patients in the ED has worked to quantify how frequently several strategies are used by drug-seeking patients to obtain medications.



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Pain is one of the most common reasons for patients seeking care in EDs, accounting for up to 42% of all emergency room visits. Emergency physicians vary widely in prescribing patterns and often have difficulty assessing patients'

level of pain. There may also be reluctance to provide pain medications due to concerns that patients are trying to obtain prescription drugs for non-therapeutic purposes. "These individuals—who are often labeled as drug-seeking—are a difficult group of patients to manage in the ED," says Casey A. Grover, MD. "They often present to the ED with conditions that are difficult to evaluate, and may also engage in deceptive behaviors in an effort to fool clinicians into giving them additional medications."

It is estimated that up to 20% of all ED visits may be due to drug-seeking behavior. "Drug-seeking

patients have been known to use large amounts of medical resources," says Dr. Grover. "They may occupy beds in EDs that would be more appropriately used for people truly in need of emergency care."

Prescription drug abuse and misuse is a growing epidemic throughout the United States, and more and more emergency physicians are encountering drug-seeking patients in daily practice. "Despite the magnitude of the problem," Dr. Grover says, "there is still much to learn about these patients, their patterns, and how best to manage them."

Intriguing New Data

Studies have been conducted on screening tools to identify drug-seeking behaviors in chronic pain patients, but few have provided quantitative data on such behaviors in the ED. With this in mind, Dr. Grover and colleagues performed a case-control study examining the relative frequency of various drug-seeking behaviors in drug-seeking patients as compared with all ED patients. The study was published in the *Journal of Emergency Medicine*. "Our goal was to provide emergency physicians with information as to which drug-seeking behaviors are most commonly used by drug-

seeking patients,” says Dr. Grover. “Identifying behaviors that are most commonly used by drug-seeking patients may help evaluations of patients suspected of drug-seeking behavior.”

A retrospective chart review of 152 drug-seeking patients and of age- and gender-matched controls was conducted, with the authors noting several drug-seeking behaviors that were exhibited over 1 year. Drug-seeking patients accounted for 2,203 visits to the ED, averaging about 14.5 visits per patient per year. For the control group, patients accounted for 315 visits to the ED, which is an average of 2.1 visits per patient per year. Patients in the drug-seeking arm reported their pain level as 10 out of 10 more often than control group patients (Table 1). Additionally, drug-seeking patients occasionally complained of pain levels greater than 10 out of 10, while the control group had no instances of these

Table 1 Percent of Patients Exhibiting Studied Behaviors

	Percent Experienced by Case Group (n=152)	Percent Experienced by Control Group (n=152)
10 out of 10 pain	75.0%	17.8%
Out of medication	59.9%	5.3%
Back pain	57.9%	9.2%
Request by name	55.9%	4.6%
Over 3 pain complaints	54.6%	3.9%
Headache	46.1%	7.2%
Three visits in 7 days	45.4%	2.6%
Chief complaint of refill	39.5%	3.3%
Requesting parenteral	30.3%	0.0%
Non-narcotic allergy	17.8%	5.9%
>10 pain	13.8%	0.0%
Dental pain	11.2%	2.0%
Lost or stolen medication	8.6%	0.7%

Source: Adapted from: Grover CA, et al. *J Emerg Med.* 2012;42:15-21.

Table 2 Odds Ratios for Studied Behaviors

	Odds Ratio	95% Confidence Interval
Requesting parenteral	-N	N/A
>10 pain	-N	N/A
Three visits in 7 days	30.8	10.84–87.30
Over 3 pain complaints	29.3	12.18–70.33
Out of medication	26.9	12.28–58.72
Request by name	26.3	11.54–59.86
Chief complaint of refill	19.2	7.42–49.52
Lost or stolen medication	14.1	1.82–109.37
10 out of 10 pain	13.9	7.98–24.19
Back pain	13.6	7.17–25.60
Headache	10.9	5.48–21.85
Dental pain	6.3	1.79–21.81
Non-narcotic allergy	3.4	1.55–7.57

Source: Adapted from: Grover CA, et al. *J Emerg Med.* 2012;42:15-21.

events. Drug-seeking patients were also significantly more likely to request medications parenterally.

The odds ratios for both requesting parenteral medication and reporting pain levels greater than 10 out of 10 were significantly higher than all others observed in the study (Table 2). These were the most predictive of drug-seeking behavior, while a non-narcotic allergy was less predictive. However, the odds ratio for a non-narcotic allergy was greater than 1, and was still a behavior that was more commonly used by drug-seeking patients than the control group. For other studied behaviors, the confidence intervals were too wide to allow the authors of the study to meaningfully interpret the data.

Challenges Remain

According to Dr. Grover, chronic narcotic use can make patients more sensitive to pain. “These

“Identifying behaviors that are most commonly used by drug-seeking patients may help evaluations of patients suspected of drug-seeking behavior.”

— Casey A. Grover, MD

individuals may truly be suffering from the most severe pain possible. On the other hand, patients with narcotic abuse and dependency often exaggerate pain complaints in order to get their desired medication. Chemical dependency can become a major motivating factor for patients to seek emergency care. Unfortunately, it’s nearly impossible to definitively determine if they’re seeking care in an attempt to get medications for non-therapeutic reasons.”

The current literature on drug-seeking patients consists largely of small studies, according to Dr. Grover, and larger-scale studies are needed. “These efforts will hopefully help us gain a better overall picture of the frequency of these behaviors and eventually help us establish strategies to optimize how we manage drug-seeking patients.”

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Tackling Opioid Abuse & Preventing Drug-Related Deaths

Opioids are important medications for managing pain, but the potential for abuse and the increasing number of deaths attributed to the drug class are significant. Increasing understanding of the causes behind avoidable mortality and alternative pain treatments may help prevent future deaths.



The United States is experiencing a significant public health threat from overdose deaths involving prescription opioids for the treatment of pain. The number of fatal outcomes involving opioid analgesics more than tripled in the last decade (Figure). “The reasons for increased mortality relating

to opioid prescriptions are multifactorial,” says Lynn R. Webster, MD, FACPM, FASAM. “Prescriber behaviors, patient contributory factors, non-medical use patterns, and systemic failures are among the chief culprits. These factors—as well as others—all play a role in how opioids are viewed and utilized by physicians and may contribute to fears of prescribing these medications to patients in pain.”

The FDA has instituted risk evaluation and mitigation strategies for opioids, but mortality associated with opioid prescribing continues to increase despite these

efforts. Several risk factors have been identified for opioid-related overdose deaths. These include physician error due to knowledge deficits, patient non-adherence to medication regimens, and unanticipated medical and mental health comorbidities, including substance use disorders. Other risk factors include payer policies that encourage or mandate methadone as first-line therapy, the presence of additional central nervous system-depressant drugs (eg, alcohol, benzodiazepines, and antidepressants), and sleep-disordered breathing. “The analysis of risk factors is ongoing,” says Dr. Webster, “but pain care providers and public health officials must act now to prevent as many opioid-related deaths as possible.”

Causes & Risk Factors for Opioid Abuse

In the an issue of *Pain Medicine*, Dr. Webster and other experts in pain management had several articles published on the root causes and risk factors pertaining to opioid-related deaths. The issue, available for free online at <http://online.library.wiley.com>, also discussed the extent to which measures enacted to prevent these deaths have been successful and proposed recommendations to reduce mortality rates. “These analyses are intended to help craft quality medical education programs and other interventions relating to opioid use,” says Dr. Webster. “They’re also intended to identify needed research and to inform public discussion.”

Certain demographic trends emerged from the data published in the *Pain Medicine* supplement. Middle age was the most vulnerable time for opioid

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— Lynn R. Webster, MD, FACPM, FASAM

overdose. An increase in opioid-poisoning deaths was observed in non-metropolitan centers, which translated to death rates in rural areas that are now comparable with those in urban counties. More men than women also appear to die from opioid-related causes, but women are closing the gap in vulnerability to overdose. Dr. Webster adds that approximately 50% to 60% of patients who died while taking opioids had a history of drug abuse. “Another 60% to 70% of non-medical use of opioids starts when patients seeking treatment for acute pain receive unneeded opioids, sometimes for durations that are longer than necessary.”

This is important data to have, says Dr. Webster, because it highlights the need for physicians to

screen patients before prescribing opioids and to monitor them if they receive these drugs. “If patients are at risk for abusing these medications or for suicide, it’s important that physicians consider alternative treatments and medications. Not everyone will require opioids to manage their pain, and physicians must be educated on appropriate management strategies in cases when opioids are not utilized.”

A Need for Education on Opioids

Despite being one of the lowest-prescribed opioids on the market, methadone-related mortalities account for a disproportional number of deaths relative to the amount prescribed, says Dr. Webster

(Table). “About one-third of deaths associated from opioid use are related to methadone in particular. The reasons for this are two-fold. First, patients may be taking too much medication or mixing it with unauthorized substances. And second, patients may be started on too much medication or dosing may be escalated too rapidly. These findings highlight the need for physician education on pain management with opioids as well as on the use of multimodal treatment approaches. Clinicians who prescribe opioids long term should intensify efforts to assess and monitor patients.”

According to Dr. Webster, physicians need to ensure that opioids are being given to the right patients under the appropriate circumstances and within the confines of set parameters to truly benefit patients. “Much of the risk associated with opioid use comes through patients making mistakes that put them at grave risk. Patients may be driven to misuse opioids by their desire for greater pain relief or to self-medicate comorbid mental health problems or other issues. To improve care, we need to be specific and write pain drug prescriptions with explicit directions. We also need to consider alternative agents in patients who don’t require opioids. These steps are critical to decreasing the potential for abuse and associated mortality risk in the future.”

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Table Methadone Concerns

Data show that there appears to be a higher proportion of methadone-related deaths compared with other opioids when adjusted for the total number of prescriptions issued. Among recent findings:

Total prescriptions:

- Methadone represents less than 5% of total opioid prescriptions dispensed.
- However, methadone represents one-third of opioid-related deaths nationwide.

Toxic exposures (defined as non-administrative, non-information calls wherein the caller to poison centers was concerned about an exposure to a substance):

- Methadone was involved in fewer than 10% of all calls made to poison centers.
- The rate for methadone-related exposure calls was approximately 10 times greater than for hydrocodone and four times greater than for oxycodone.

Inclusion in reports of forensic drug items:

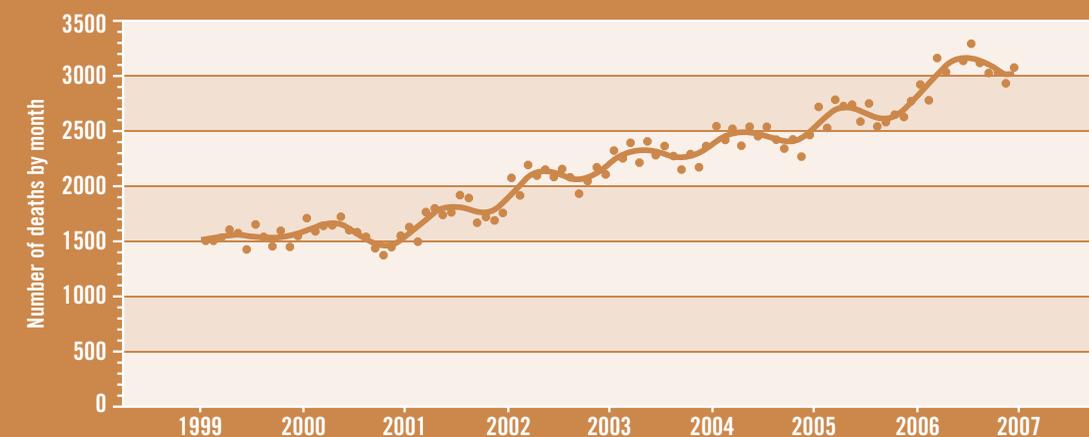
- Methadone represented about 12% of all drugs seized by law enforcement.
- The rate for methadone-related drug seizures was approximately 11 times greater than for hydrocodone and five times greater than for oxycodone.

ED admissions related to prescription drugs:

- Methadone was involved in about 30% of all overdoses treated in EDs.
- The rate for methadone-related visits was approximately 23 times greater than for hydrocodone and six times greater than for oxycodone.

Source: Adapted from: Webster LR, et al. *Pain Med.* 2011;12(Suppl 2):S26-S35.

Figure A Growing Problem: Overdose Deaths Related to Opioids



Source: Adapted from: Webster LR, et al. *Pain Med.* 2011;12(Suppl 2):S26-S35.

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Chronic Pain: Analyzing the Public Health Burden

Chronic pain continues to be undermanaged, but following key principles, adhering to guidelines, and being cautious with pain medication prescriptions may help decrease the disease burden.



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There has been greater recognition over the past several decades of the pervasiveness of poorly assessed, poorly treated chronic pain, culminating recently in an Institute of Medicine report quantifying this healthcare issue. Evidence also suggests that the quality of and access to assessment and treatment of pain are poorer for racial and ethnic minorities. “This

is a very large public health problem,” says Perry G. Fine, MD. “The issue has become even more important because of its concurrent overlap with the liberalization of prescribing patterns for opioid analgesics to treat chronic, non-cancer pain.”

A Costly Problem

Well over 100 million people in the United States are living with chronic pain that has some debilitating effect on their daily lives, costing society over \$600 billion a year in direct medical costs and lost productivity. According to the American Pain Foundation, pain affects more Americans than diabetes, heart disease, and cancer combined (Table). The duration of pain in adults aged 20 and older who report

Table Incidence of Pain Compared with Other Major Conditions

• Pain: 26.0%
• Diabetes: 7.0%
• Coronary Heart Disease & Stroke: 6.0%
• Cancer: 0.4%

Sources: National Centers for Health Statistics, American Diabetes Association, American Heart Association, and American Cancer Society.

having pain is longer than 1 year for 42% of patients (Figure). As these health and economic tolls have made their mark, they have exposed training gaps for healthcare professionals in recognizing and treating chronic pain adequately.

“With some additional training and by adopting well-established practice guidelines, the risks of abuse can be managed and limited for both patients and physicians.”

“We have not established a systemic approach to comprehensively prevent and treat chronic pain,” says Dr. Fine, “and comorbid psychiatric disorders can further complicate issues of treatment selection and adherence. Physicians are doing their best to return their pain patients to optimal health and optimal function. One of the easiest tools they have appears to

be opioid analgesics. They’re highly efficacious in the short run and highly versatile, but they have serious problems attached to them with long-term use if these patients are not monitored well. The crux of the issue is how to treat, monitor, and manage chronic pain most appropriately without exacerbating potential issues of substance and chemical dependence (diversion, abuse, morbidity, and mortality) and without adversely restricting access to those drugs for patients who have appropriate and indicated needs for them.”

Although the parallel and occasionally overlapping public health quandaries of poorly treated chronic pain and prescription opioid abuse are visible and clearly present, their specific issues are only just being identified. Specialized education, including continuing medical education, and responsible prescribing guidelines continue to emerge. The hope is that these initiatives will alleviate pressure on physicians to automatically prescribe powerful analgesics when alternative treatment methods might be necessary. “The heavy focus on prescription drug abuse has created a great distraction from other things we can and should be doing to treat chronic pain,” Dr. Fine says. “Physician concern about opioid abuse can lead to undertreatment of chronic pain. However, with some additional training and by adopting well-established practice guidelines, the risks of abuse can be managed and limited for both patients and physicians.”

“With some additional training and by adopting well-established practice guidelines, the risks of abuse can be managed and limited for both patients and physicians.”

— Perry G. Fine, MD

Important Principles

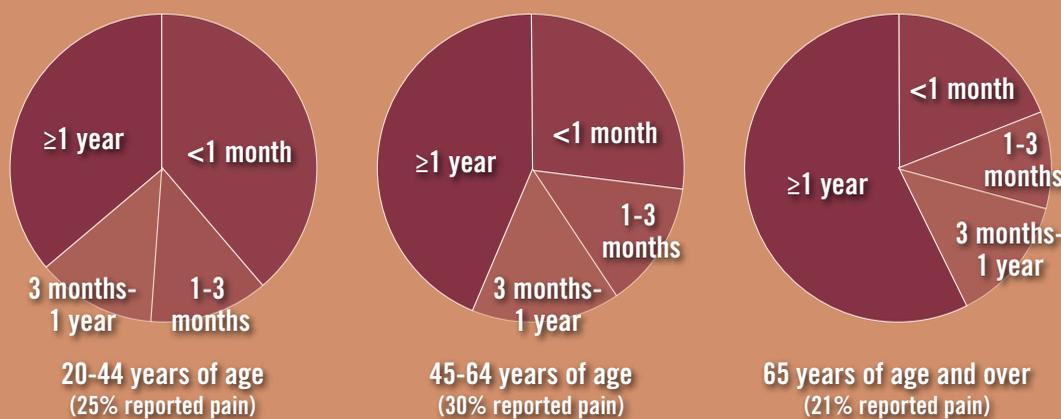
According to Dr. Fine, a key principle in managing chronic pain is to establish a truly professional relationship with patients. “This begins with a total history and physical examination, corroborative laboratory and imaging studies, or collateral medical records from other practitioners,” he says. “Know who you’re dealing with. Assess the social context of patients by finding out who they live with, their potential medical and social risk factors if a trial of opioid therapy is being considered and is appropriate, and how patients have historically handled other drugs of abuse.”

A formal risk assessment is another important consideration. Following a formal pain assessment and a diagnosis, physicians can determine the safest, most effective approaches to treatment. This can also lead to considering less risky alternatives to

opioid analgesics. Dr. Fine says if a trial of opioid therapy emerges as the only way to move patients forward in terms of function, sleep- and pain-related mood disturbances, and work and social restriction, then the key is to determine how much potential risk is there from exposing this person to opioids. “Moderate- and high-risk patients clearly require a different style of management than low-risk patients,” he adds. “Physicians need to determine whether the structure of their practice and their individual skill set have the means to manage patients throughout that spectrum of risk. The vast majority of people with chronic pain are being managed in the community by healthcare professionals who aren’t fellowship trained, board-certified pain medicine experts. This means that primary care and emergency physicians must step up their skills in order to manage more moderate- and high-risk patients.”

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Figure Duration of Pain, 1999-2002



Sources: CDC, National Center for Health Statistics, Health, United States, 2006. Figure 29. Data from the National Health and Nutrition Examination Survey.

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Acute Pain Management in the ED

Research has shown that ED physicians often fail to provide adequate analgesia to their patients. Pain management, particularly for acute pain, is a subject not often taught within most medical school programs.



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Pain has been identified as the most common reason for patients seeking care in emergency rooms. Considering the substantial impact that pain has on patients, ED physicians need to be well versed in its management, particularly in acute pain situations. Unfortunately, research has shown that ED physicians often fail to provide adequate analgesia to their patients. There are also challenges in meeting patients' expectations in treating pain and in changing prescribing patterns of opioid analgesics.

The Effects of "Oligoanalgesia"

We have more than 25 years of research on acute pain management as well as multiple guidelines on the topic. Despite this information, the phenomenon of "oligoanalgesia"—the undertreatment of pain—continues to persist in EDs. The following are major causes of oligoanalgesia in the ED:

- Lack of basic knowledge and formal education on acute pain management.
- Prejudice toward and irrational fear of using opioids in the ED.
- Lack of adherence to acute pain management guidelines and clinical pathways.
- Underuse of analgesics titration protocols.

Barriers preclude ED physicians from proper acute pain management that include ethnic, racial, and age bias as well as ED environment and culture.

Wanted: More Formal Pain Management Training

The lack of formal teaching of acute pain management in medical schools has had a profound effect on the gap in emergency physicians' clinical knowledge on the subject. There may also be a reluctance to change practice patterns or a prejudice toward using opioid analgesics in the ED. Pain management is a subject that is not taught within most medical school programs. Research has shown, however, that utilizing pain management educational programs can lead to substantial improvements. More efforts are needed nationwide in creating pain management curriculum in medical schools and residencies.

Environment & Culture Affect Pain Management

Crowding, interruptions, and break-in tasks are common problems in the ED that can lead to delays in treatment as well as delivery of pain medications. Other cultural factors that affect pain management include poor doctor-patient communication, stereotyping and prejudices, patient mistrust issues, and patient dissatisfaction. These factors must be regularly assessed and altered, if need be, based on characteristics unique to each ED setting so that pain management protocols can be developed to improve outcomes.

We have a great responsibility to relieve pain by all possible appropriate means in a timely, efficient, and effective manner. More than a decade ago, the RELIEF approach to pain management was introduced by Turturro et al (Table). The take-

Table The RELIEF Approach

R: Record the pain score on the patient's chart before and after treatment.
E: Ease patients' concerns. Inform them that pain control is a goal of care.
L: Look & Listen to patients because they will be the best judges on their level of pain and pain relief.
I: Inquire if patients need pain medications.
E: Educate ED staff on proper analgesic techniques.
F: Facilitate multidisciplinary protocols with nursing and other specialties to manage common painful conditions in the ED.

Source: Adapted from: Turturro MA. *Emerg Med Prac.* 1999;1:1-16.

home messages of the RELIEF approach should be applied in order to positively impact acute pain management in the ED. Oligoanalgesia will persist unless each physician assumes leadership in pain management. As we see improvements in pain assessment and documentation and progress in knowledge and research, the hope is that emergency physicians will more effectively manage acute pain in the ED. 

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Pain Management: A Look at Provider Perspectives



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It has been well established that pain is the most commonly reported symptom in primary care and a leading cause of disability. Primary care providers (PCPs) face numerous challenges in caring for patients with chronic pain. Pain is subjective, and there are no objective tests that confirm the level of pain people experience. One patient might rate

pain as a 4 on a 1-to-10 pain scale while another might label the same degree of pain as a 6 or 7. The successful treatment of chronic pain is challenging, especially in cases for which no sure cause of the pain can be identified. Alleviating pain can be elusive, which becomes frustrating to both patients and PCPs. It can also put a strain on the patient-provider relationship, which can ultimately impact the well-being of both parties.

Elucidating the Provider's Perspective

Many studies have looked at the treatment of chronic pain from the patient's perspective, but there has been little research on those who provide

care for these patients. In a study published in *Pain Medicine*, my colleagues and I surveyed 20 PCPs with open-ended questions to elicit their perspectives on experiences in caring for patients with chronic pain.

A central theme from our investigation was that chronic pain takes a real toll on PCPs and their patients. Three other broad themes also emerged from our analysis. First, providers emphasized the importance of the patient-provider relationship, asserting that productive relationships with patients are essential for good pain care. Second, providers detailed the difficulties they encountered when caring for patients with chronic pain. These included:

- Feeling pressured to treat chronic pain with opioids.
- Believability of patients' reports of pain.
- Worries about secondary gain or diversion of opioids.
- "Abusive" or "difficult" patients.

Third, providers described the emotional toll they sometimes felt with chronic pain care. Oftentimes, PCPs reported feeling frustrated, ungratified, and guilty. Many criticized themselves because they felt unable to treat chronic pain effectively, others internalized their negative feelings.

Negative feelings were also compounded by hostile interactions with some patients. Suspicion and distrust were prevalent, especially in cases in which it was perceived that individuals were seeking pain medications for uses other than pain control. PCPs dreaded seeing these individuals' names on their clinic schedule, because they knew the interaction would likely be unsuccessful at best and difficult or hostile at worst. These challenges added to feelings of providing ineffective and unsuccessful care for chronic pain patients.

Important Clinical Implications

Based on our findings, there are two important clinical implications to consider for PCPs. First, we cannot ignore the needs of PCPs in the context of pain care. PCPs need instrumental and emotional support throughout their care for patients with chronic pain. New strategies are needed to ease frustrations and defuse potential hostility in clinical interactions. Second, improving patient-centered communication skills for PCPs is promising for alleviating some of the strain and burden that has been reported. This includes demonstrating empathy and encouraging shared decision making with patients. We must remember that potential solutions to difficulties in chronic pain care extend beyond the individual provider. By finding new strategies that address challenges for clinicians and patients alike, we may ultimately improve patient care. 

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Readings & Resources

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