



The truth about pain management: the difference between a pain patient and an addicted patient

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Pain is undertreated in all parts of the world. Multiple barriers exist that prevent valid treatment of the pain patient. This paper will provide definitions of pain, addiction, physical dependence, tolerance, and pseudoaddiction that health professionals need to understand in order to treat pain. It will address how to differentiate between a pain patient and an addict when evaluating the patient for treatment. The physiological benefits of using long- versus short-acting opioids will be presented. With proper education of the medical community, patients should receive humane and compassionate treatment of their chronic pain syndromes. © 2001 European Federation of Chapters of the International Association for the Study of Pain

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INTRODUCTION

Pain is one of the most common complaints of patients seeking medical attention (Foley, 2000). More than 70 million Americans suffer from chronic pain (Krames & Olson, 1997). In cases of moderate to severe pain, opioids may be required to treat the pain, in addition to adjunctive analgesics. However, patients face many barriers to the treatment of chronic pain, especially when opioids are indicated. These barriers include, but are not limited to, the health profession's inadequate education about pain and addiction medicine; misunderstanding of common definitions such as addiction, physical dependence and tolerance; and fear that patients may abuse or become addicted to the opioids.

Physicians need better education in pain and addiction medicine so they can evaluate and properly treat the pain patient.

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DEFINITIONS

Fishman (2000) gave the clinical definition of pain: 'It is whatever the patient states it is unless proven otherwise by poor adherence to the agreed upon medical regimen.' This clinical definition should be used, since one of the main complaints of patients seeking relief from their pain is that the doctor does not listen to them or believe them. It is better that 1% of patients obtain opioids for non-agreed upon medical use than to have 99% of patients suffer from pain when medications are readily available to treat them. Chronic pain has no positive physiological usefulness (Oaklander, 1999), therefore it must be treated.

Universal agreement on definitions of addiction, physical dependence and tolerance is critical to the optimization of pain treatment in order not to confuse the dependency on or tolerance of opioids with the disease of addiction. The terms addiction, physical dependency and tolerance are defined by a Joint Consensus Statement of the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine.

Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and

environmental factors influencing its development and manifestations. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical dependence is a state of adaptation that is manifested by a drug-class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. It must be strongly emphasized that physical dependence and addiction can coincide, but dependence does not equal addiction in all cases. Physical dependence is a neuropharmacological phenomenon as a result of neuroadaptation and neuroplasticity, while addiction is both a neuropharmacological and a behavioral phenomenon. A patient could become physically dependent on corticosteroids to treat asthma, but one would not call this patient addicted to steroids.

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time. What is key is that all other conditions remain constant. If a patient needs an increasing amount of opioids for his or her pain syndrome, generally two things are happening: (1) the disease is progressing (Weissman & Haddox, 1989), or (2) the opioid medications have increased the patient's functional activity and therefore the opioids have to be titrated to the new functional activity. The concept is the same as titrating blood pressure medicines or insulin to achieve the desired effect.

PAIN VERSUS ADDICTION

Many patients presenting to a doctor's office asking for pain medications are accused of drug seeking.

In reality, most of these patients may be under-treated for their pain syndrome. Weissman & Haddox (1989) used the term 'pseudo-addiction' to describe a patient's behavior that may occur when pain is undertreated. Pseudo-addiction can be distinguished from true addiction in that the behavior resolves when the pain is effectively treated. Portenoy & Savage (1997) stated that it is rare to produce addiction in the context of pain treatment in those with no history of addictive disorders.

Schnoll & Finch (1994) differentiated between a chronic pain patient and a patient with the disease of addiction (see Table 1).

Patients in recovery are often discriminated against in regard to the treatment of their pain. John N. Chappel, MD states that 12-step programs such as AA and NA are compatible with the treatment of all medical and mental disorders, including the use of opioids for the treatment of pain, and the treatment of pain should be considered essential as part of the treatment of addictive disorders (American Society of Addiction Medicine review courses).

LONG- VS SHORT-ACTING OPIOIDS

Research suggests that long-acting opioids such as methadone, morphine sulfate contin, and continuous-release oxycodone would be the medications of choice for the oral treatment of moderate to severe chronic pain. Long-acting opioids produce steady-state blood levels secondary to continuous occupation of the Mu receptor site. Pioneering work by Vincent Dole (1988) on methadone populations showed that methadone in the treatment of the disease of addiction prevents the on and off switch of fluctuating opioid blood levels that leads to euphoria alternating with cravings. Continuous occupation of the endogenous ligand Mu opioid receptor system

TABLE 1

Pain patient	Addicted patient
1. Not out of control with medication	1. Out of control with medications
2. Medications improve the quality of life	2. Medications decrease the quality of life
3. Aware of side-effects	3. Wants medications to continue or increase despite side-effects
4. Concerned about medical problems	4. In denial about medical problems
5. Will follow the agreed upon treatment plan	5. Does not follow the treatment plan
6. Has medications left over from the previous prescriptions	6. Does not have medications left over, loses prescriptions, and always has a 'story'

allows interacting physiological and behavior systems to become normal. The methadone patient becomes a normal functioning patient. These data again reinforce the idea that, in the pain patient, around-the-clock dosing reduces pain, increases function, minimizes the development of tolerance, and gives the patient a better quality of life (Dole, 1988; Savage, 1996).

CONCLUSION

Moderate to severe pain is undertreated across the world. All patients who have acute or chronic pain deserve to be believed, evaluated, and treated with the proper medications. In the case of moderate to severe pain, this treatment regimen can include opioids. Through education of medical students, residents, and practising physicians, pain management can improve as we enter this new century. If doctors follow the guidelines in this review, our profession can give pain patients the best quality of life possible given the reality of their clinical condition. This is consistent with the Hippocratic oath: 'I will prescribe a regimen for the good of my patient

according to my ability and my judgment and never do harm to anyone.'

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