Chronic Pain and Drug-Seeking in the Emergency Department

You are confronted by a hostile, distressed patient demanding refills of her opioid medications—and you suspect her medical needs go beyond pain control. How do you manage her behavior and proceed with her care? The authors outline a research-based, algorithmic approach.

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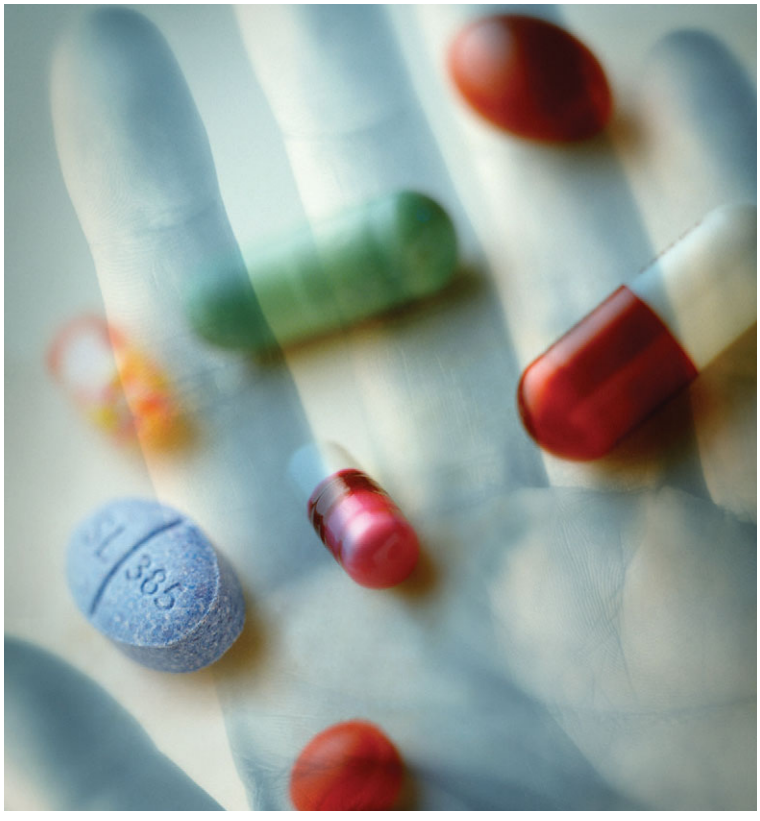

Toward the end of a busy overnight shift, the chart for Stacy S. is dropped into the rack where the files of waiting patients are held. Stacy is a frequent visitor to the emergency department, and most of the staff have cared for her before. The triage note reads as follows: "37-year-old female well known to ED with back pain, 10/10, for 3 years. Vital signs T 98.6, BP 130/70, HR 75, O_2 SAT 100% RA. Allergies: aspirin, ibuprofen, morphine, tramadol."

Stacy appears anxious as she recites the history of a lumbar spine injury she suffered in a car accident three years ago. Over the past several years she has seen several physicians and had an extensive workup with both computed tomography and magnetic resonance imaging. She previously participated in physical therapy but stopped because she felt it was not helping. This morning the issue at hand is that she has run out of pain medications and wants refills until she can make an appointment with a new primary care physician. Empty pill bottles show she has been taking hydromorphone and oxycodone, prescribed by a physician from your emergency department. The triage nurse asks that one of the physicians come and see Stacy to expedite her visit.

As inevitable a part of the human experience as happiness, sadness, love, and loss, pain is the single most common complaint among patients visiting the emergency department. It has been conservatively estimated that 60% to 70% of patients report pain at the time of triage. Emergency physicians must be able to manage patients with chronic pain since it is within of the scope of our practice as defined by the American College of Emergency Physicians (Table 1).[2]

In many patients with chronic pain and poor access to specialist care, history-taking and observation will reveal behaviors suggestive of prescription drug abuse and misuse. The goal of this article is to

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TABLE 1. ACEP Policy Statement on Pain Management

- Emergency department patients should receive expeditious pain management, avoiding delays such as those related to diagnostic testing or consultation.
- Hospitals should develop unique strategies that will optimize emergency department patient pain management using both narcotic and non-narcotic medications.
- Emergency department policies and procedures should support the safe utilization and prescription writing of pain medications in the emergency department.
- Effective physician and patient educational strategies should be developed regarding pain management, including the use of pain therapy adjuncts and how to minimize pain after disposition from the emergency department.
- Ongoing research in the area of emergency department patient pain management should be conducted.

Information extracted from: American College of Emergency Physicians.[2]

review the best approach for working with patients who visit the emergency department with chronic nonmalignant pain and identify behaviors that may signify drug dependency or addiction.

DIFFICULT ASSESSMENT

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" and chronic pain as "pain that persists beyond normal tissue healing time, which is assumed to be three months."[3] The currently held theory about chronic pain is that NMDA (N-methyl-D-aspartate) receptor activation and the persistent release of substance P promote the development of new, maladaptive neural pathways that perpetuate chronic pain syndromes.[4]

Pain, often referred to as the fifth vital sign, is generally measured on a 0-to-10 visual scale. The value of an isolated pain scale score on a triage chart is often unclear because of differing individual pain thresholds and variable interpretation by both patient and physician. This method of assessing pain works best for acute episodes; it is problematic when treating a patient with chronic pain, in which scores often remain high despite treatment. Chronic pain severity is better measured by its functional impact, with improvement gauged by the patient's ability to carry out normal activities. The numeric rating can be used, but only in a limited way and with the understanding that a score of 0 is often not attainable in the acute care setting.

We often hear our own friends and family members say that someone "has a high threshold for pain"—an everyday reminder of the subjective nature of pain. A patient sitting quietly may be incorrectly presumed to be free of pain by a practitioner who underestimates the influence of psychosocial factors on the outward demonstration of discomfort. Many providers have seen patients with minor injuries screaming in pain while the patient with serious illness quietly suffers. Pain is not measurable by physiologic signs like heart rate and blood pressure, either, and relying on these to gauge pain intensity may lead to false assessments.[5] In general, searching for objective confirmation of a patient's description of pain is a common mistake that should be avoided.

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The literature demonstrates that oligoanalgesia (undertreatment of pain) is common in emergency medicine. These research findings have helped allay old fears about treating abdominal pain with narcotics and led to the publication of appropriate dosing regimens for morphine. There is less information available to guide the management of chronic pain in the acute care setting, perhaps due to the very

TABLE 3. Algorithm for Chronic Pain

- Attempt to provide analgesia in the emergency department.
- If discharging with an opioid prescription, use a long-acting formulation and provide quantity sufficient to last until next appointment.
- Document safety precautions discussed with the patient regarding the cognitive effects or sedation induced by opioids.
- If aberrant behavior is suspected, express concern for the patient and use screening tools.
- Offer resources for support if the patient is at high risk for an addictive disorder.
- Refer the patient to primary care or pain clinic and document discussion with patient on chart for next provider to see.

study also described the common practice of emergency physicians from different hospitals sharing information over the phone.[14] Generally, these lists lack a formal process for adding names or accessing information. Often a name may be added by a single staff member based on an isolated visit. There is little evidence to suggest that these lists help in the management of substance-dependent or addicted individuals. Furthermore, we must appreciate the high prevalence of undertreated chronic pain and pseudoaddiction in the emergency department and the consequent danger of subjecting patients suffering from chronic pain syndromes to a blacklist effect and denying them proper care. Ethically we cannot endorse a practice that may prevent the alleviation of suffering, unless it is proven to improve patient outcomes. Until a more standardized and evidence-based system of tracking patients with true substance addiction is developed, the informal use of habitual patient files should be abandoned.

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The first step in understanding patients you suspect of purely drug-seeking behavior is to consider offering an appropriate dose of analgesic.

MANAGING THE HOSTILE DRUG SEEKER

You are back at the nurses' station when you hear Stacy S. arguing loudly enough that the other patients in your ED are starting to take notice. As you approach Stacy's stretcher you notice the discharge instructions including the number and address of the local drug rehabilitation program lying on the floor, unsigned. She is asking the patients around her if they can believe that the doctor wants to send her home without any relief from her debilitating back pain.

Even the most compassionate emergency physicians who are experts in the field of pain management and aberrant drug related behaviors will find themselves on occasion calling for a security escort to remove a hostile, drug-seeking patient from a busy department. Our goal is to help providers recognize aberrant behavior early and apply an algorithmic approach (Table 3) in an effort to halt the escalation of hostile behavior and reduce the frequency of confrontations between staff and patients.

The first step in understanding patients you suspect of purely drug-seeking behavior is to consider offering an appropriate dose of analgesic. Regardless of your suspicions, the compassionate approach is to respect the patient's chief complaint. Keep in mind that many experts in the field believe that pseudoaddiction is the most common cause of behavior considered "drug-seeking" in the emergency department. In an article about the management of sickle cell disease in the February 2009 issue of EMERGENCY MEDICINE, Dr. Imoigele Aisiku, assistant professor in the departments of anesthesiology and emergency medicine at Virginia Commonwealth University, concluded that opioids are underprescribed in the emergency department for sufferers of chronic pain.

With these points in mind, be aggressive in attempting to alleviate pain early. If red flags begin to appear in a patient's behavior after adequate analgesia, remember that *continued on page 48*

opioids, and those seeking relief from chronic pain syndromes. There is no highly reliable way to distinguish among these groups. Their disease states often overlap, with as many as 40% of patients with diagnosed chronic pain disease also suffering from problems related to substance abuse.[11]

Those patients with pseudoaddiction will exhibit the same self-destructive behavior as true addicts until their pain is adequately treated. It is this group of patients that providers have the greatest ability to help—and the most potential to hurt. Most experts in the field of pain management will initially err on the side of treating pain in the setting of drug-seeking behavior, giving the benefit of the doubt to pseudoaddiction. If pseudoaddiction is the problem, this approach generally results in resolution of the behaviors and improved function.

Several screening tools exist to help providers identify those patients at greatest risk for substance abuse. Some are aimed at substance abuse in general and some, such as the Current Opioid Misuse Measure (COMM), are geared toward opioid abuse specifically. The 17-question COMM self-assessment has been validated in a population of 500 chronic pain patients on opioid therapy, and has been found to have a sensitivity of 0.77 and a specificity of 0.66 for identifying patients who are abusing opioids.[12] The behaviors consistently found to be suggestive of true addiction and abuse include prescription forgery, injecting oral formulations, concurrent alcohol abuse, rapid dose escalation, and drug related dysfunction at work, socially, or with the family. Table 2 lists behaviors that are highly suggestive of aberrant behavior and warrant further investigation.[13] Patients who are in fact suffering from undertreated pain may exhibit similar behavior such as aggressive interest in the need for more medication, drug hoarding, disclosing the fact that they have seen many other medical professionals for pain, and willingness to try other medications that may alleviate pain, but again, this is pseudoaddictive behavior that will subside once pain is under better control.

Screening tools can risk-stratify patients who may be abusing prescription drugs; however, they provide no information on the adequacy of their pain management, which ultimately is the most important aspect of their care in the emergency department.

What about attempting to track patients whose drug-related behaviors are of concern? One study in the state of Iowa found that 58% of emergency departments maintain a list of patients considered "drug abusers" or "problem patients." This same

TABLE 2. Differentiating Addictive and Pseudoaddictive Behavior

Red flags of addiction

- medication-related dysfunction at work or home
- concealing multiple visits to other providers in search of pain medication
- history of addiction to alcohol or an illicit drug
- selling prescription drugs
- forging prescriptions
- demanding intravenous formulations

Red flags of pseudoaddiction

- aggressive complaining for escalating doses
- openly visiting other doctors or emergency departments in search of pain relief
- drug hoarding
- reporting psychic side effects
- resistance to changing therapy associated with "tolerable" adverse effects, with expressions of anxiety about the possible return of severe symptoms

Adapted from Shalmi L.[13]

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The prevalence of substance abuse among patients in emergency departments vastly outweighs its prevalence in the general population.

complex nature of therapy for chronic pain—which, unlike acute pain, typically cannot be attributed to a single, verifiable pathology.

The management of chronic pain requires an interdisciplinary approach including a strong psychosocial component. Given the physical and emotional deconditioning that occur with chronic pain, drug therapy alone is almost never an adequate treatment plan. Frequent follow-up by experienced pain specialists is the often unattainable goal. An experienced mental health practitioner is also important to help with management. There is a demonstrated correlation, for example, between borderline personality disorder and chronic pain.[6] If not treated properly, sufferers of chronic pain may cope by straying from the agreed dose range of prescribed medications (aberrancy).

The standard of care for patients suffering chronic nonmalignant pain involves a coordinated effort by a primary care physician and a chronic pain specialist or team. Many patients with chronic pain are candidates for chronic opioid therapy. Treatment regimens may include a combination of long-acting opioids with shorter-acting opioids for breakthrough pain in conjunction with physical therapy and an evaluation of psychosocial contributors to the overall health of the patient.[7]

PRESCRIPTION DRUG ABUSE: THE SOBERING REALITY

The use and abuse of prescription drugs is on the rise in the United States. In 2006, according to a federally funded "National Survey on Drug Use and Health," 16.2 million Americans ages 12 and older had taken a prescription pain reliever, tranquilizer, stimulant, or sedative for nonmedical purposes at least once in the year prior to being surveyed. On a lifetime basis, that number approached 50 million.[8]

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In an attempt to reduce the ambiguity associated with "substance abuse," a consensus document published in 2001 by the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine defined the terms *addiction*, *physical dependence*, *tolerance*, and *pseudoaddiction*.[9]

Addiction is a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm to self or others, and craving.

Physical dependence is a state of adaptation that often includes tolerance and 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, administration of an antagonist, or some combination of these.

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.

Pseudoaddiction is a term that has been used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may "clock-watch," and may otherwise seem inappropriately "drug-seeking." Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. In contrast to true addiction, the behaviors associated with pseudoaddiction resolve when pain is effectively treated.

Reviewing this spectrum of disorders serves as a reminder that substance abuse is a disease with biopsychosocial components. Therefore, simply writing a prescription for a patient without considering a differential diagnosis for drug-related aberrant behaviors may not address the underlying disease and may actually create more problems than it solves.

It is well documented that the prevalence of substance abuse among patients in emergency departments vastly outweighs its prevalence in the general population. Some studies have found the prevalence of substance abuse to be as high as 27% in this population.[10] This means most providers will encounter addicted patients regularly. Brief interventions in the emergency department have had success with alcohol abuse. Simply expressing concern and providing resources for sobriety such as support groups may be a good first step.

DRUG ABUSERS AND SUFFERERS OF CHRONIC PAIN

Patients who go to emergency departments in search of drugs fall into three general categories: those seeking medication for recreational use or profit, those with or without chronic pain who are addicted to

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short-acting opioids do not play a central role in the treatment of chronic pain, and referral to an outpatient pain management service is appropriate. It is helpful if you are knowledgeable about local drug rehabilitation services.

On occasion, despite all reasonable attempts at pain management, we will find ourselves in a confrontation with a patient who is seeking inappropriate pain therapies, such as intravenous formulations or large amounts of short-acting opioids. These confrontations often escalate and involve the entire department, interfering with the treatment of other patients. If you have provided early and aggressive pain control as well as referral to pain and addiction services, you can be firm in your resolve to deny further pain medication. Once this decision has been reached, avoid further arguments or bargaining and enforce your final decision, whether it be to admit for further pain management or discharge with outpatient follow-up.

STANDING READY

Sufferers of chronic pain syndromes and drug seekers are among the most difficult patients we care for as emergency physicians. We must be familiar with the prevalence of chronic pain syndromes and the concept of pseudoaddiction. With a better understanding of chronic pain as a disease, we can begin to identify the red flags of aberrant drug-related behavior. The approach to these often hostile patients should be algorithmic, based on the initial assumption that they truly are in pain.

It is imperative to be familiar with the full complement of medications we have at our disposal, including opioids and neuropathic pain medications. In addition to pharmacological relief, we should offer our patients access to pain management services, rehabilitation programs, and psychosocial support groups. Finally, as a specialty we should avoid the use of habitual patient files unless they can be maintained in a professional manner. Despite the frustrating nature of these cases, we must never forget that our ultimate duty is to relieve pain and suffering. □

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