The Unsanctioned Opioid Dose Escalation

SCOPE of Pain *Colleague to Colleague* Audio Short #10

Welcome back to the SCOPE of Pain Audio Shorts Series. This is Dr. Daniel Alford, Professor of Medicine and Course Director for the Boston University School of Medicine SCOPE of Pain Program.

Your patient, who you have been treating with chronic opioids for chronic painful diabetic neuropathy for the past 11 months calls the on-call service asking for an early refill. She states that her pain has worsened, and she took extra tablets and has run out early.

Eleven months ago, she had signed a patient-provider agreement stating that she would not self-escalate her dose. Why was the initial agreement signed by this patient ineffective in preventing this episode of opioid misuse, and how will you respond to this patient's request for an early refill?

The use of patient-provider agreements, while not evidence-based, help clarify provider and patient expectations regarding opioid prescribing. When used, they should include a treatment plan with realistic goals and informed consent regarding risks.

Although the elements of agreements have been defined, implementation remains a challenge. If having patients sign an agreement is viewed as just another administrative task, it misses the important opportunity to educate them about safe opioid use. Presenting agreements as tools to keep patients safe and to clarify expectations and responsibilities should be the goal.

Because of variations in patient health literacy, agreements should really be written at a sixth-grade reading level, and methods, such as teach-back, should be used to confirm comprehension. In one study, fewer than 20% of patients who had signed a pain agreement consistently remembered having done so. Therefore, agreements should be reviewed periodically; for example, annually.

The first step in this case is to assess the cause of her aberrant medication-taking behavior; that is unsanctioned dose escalation. Was her concerning behavior predominantly pain-relief-seeking or drug-seeking?

Well, pain-relief-seeking behavior may be due to disease progression or pain that is poorly opioid responsive, opioid-withdrawal-mediated pain, opioid/analgesic tolerance, or opioid-induced hyperalgesia.

Drug-seeking behavior may be due to an opioid use disorder or addiction, self-medicating some other psychiatric diagnosis or criminal intent that would be diversion. Or it could be a combination of both pain-relief-seeking and drug-seeking.

For example, the patient with chronic pain with comorbid addiction taking some opioid for pain and diverting some for income. Unfortunately, despite our best efforts, it may be difficult to diagnose the actual cause of her aberrant medication-taking behavior.

However, you don't need to prove with 100% certainty that the behavior is a result of addiction or diversion. You only need to assess and reassess the risk-benefit ratio. If the patient is unable to take the opioid safely or is nonadherent with monitoring, then discontinuing opioids is appropriate, even in the setting of benefits.

The key components of a patient-provider agreement and assessing and managing aberrant medication-taking behaviors are all discussed in detail in the SCOPE of Pain program. You're not alone in facing these challenging issues. Thanks for listening.

Be sure to check back often, as new Audio Shorts will be added throughout the year.
myCME.com/SCOPEofPain