Pain Physician, Volume 5, Number 1, pp 110-113
2002, American Society of Interventional Pain Physicians®
ISSN 1533-3159

Letters to the Editor

Prevalence of Opioid Abuse

To the Editor:

The article by Manchikanti et al (Pain Physician 2001; 4:358-365) on Opioid abuse in pain medicine should more accurately been titled "Prevalence of opioid contract violations in the interventional pain practice as measured by outside prescription acquisition."

The definition of drug abuse in the article was "obtaining a prescription (ata minimum of at least 30 tablets) of a controlled substance . . . [excepting emergencies]." No differentiation between opiate and sedative hypnotics is made. A more conventional definition of substance abuse is the taking a controlled substance for other than its intended purpose, such as to get psychological affects in a sociopathic manner. The definition is important because the definition of addiction builds upon this as the uncontrollable compulsion to abuse a substance despite the known potential harm. Could the prevalence measure within the article fit more adequately with pseudoaddiction in that many of the patients required more medication than the opioid contracted prescriber was providing?

I am further puzzled by the groups 1 and 2 formed. As the only defined abuse identifier in the article is "frequent abuse" as noted above, I would expect by definition of group 2 for 100% to be positive for frequent abuse and by definition of group 1 for 0% to be positive for frequent abuse.

The article is more important to point out that opiate contracts will be violated by patients seeking prescriptions from another provider 25% of the time. If this is for opioids it is particularly more relevant. Inclusion in the contract of permission for the prescriber to contact all other physicians and pharmacies may be of value as it helped identify such violation in this study.

Why is the patient obtaining outside prescriptions? Is the prescriber inadequately dosing the patient? Is access to prescription refill too difficult? Is true abuse or addiction present? Were urine toxicity screens by Gas Chromatography performed to bolster assurance that the pills were not being diverted? These are the questions that must now be answered.

The debate pro and con opioid use will continue but should not be further fueled by a mistitled article.

Joseph F. Jasper, MD

Advanced Pain Medicine Physicians, PLLC
1628 South Mildred Street #105-110
Tacoma, WA 98465-1613

In Response:

We would like to thank Dr. Jasper for his comments on our article entitled Prevalence of opioid abuse in interventional pain medicine practice settings: A randomized clinical evaluation (1). Dr. Jasper claims that this article should have more accurately been titled: "Prevalence of opioid contract violations in the interventional pain practice as measured by outside prescription acquisition." In addition, he also states that the debate of pro and con use will continue but should not be further fueled by a mistitled article. We would like to point out that this is neither a mistitled article, nor would a more appropriate title be the one suggested by Dr. Jasper. We contend that Dr. Jasper has failed to understand the purpose, the methodology, results and conclusions of this study.

It is well known that if it walks like a duck and talks like a duck, it is a duck. By the same token, if it looks like abuse and smells like abuse, it is abuse. Notwithstanding Jasper's own definition and characterization of a more conventional definition of substance abuse and addiction, DSM-IV (2) characterizes substance abuse as:

- A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.
- An individual has resorted to illegal sources of supply
- Legal difficulties may arise as a result of behavior while intoxicated with opioids.
- Persons who abuse opioids typically use these substances much less often than do those with

dependence and do not develop significant tolerance or withdrawal.

Further, when problems related to opioid use are accompanied by evidence of tolerance, withdrawal, or compulsive behavior related to the use of opioids, a diagnosis of opioid dependence, rather than opioid abuse, should be considered.

DSM-IV criteria (2) for substance abuse are as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period.

   (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (eg, repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
   (2) recurrent substance use in situations in which it is physically hazardous (eg, driving an automobile or operating a machine when impaired by substance use)
   (3) recurrent substance-related legal problems (eg, arrests for substance-related disorderly conduct)
   (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (eg, arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

   DSM-IV criteria (2) for substance dependence are as follows:

   A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

   (1) Tolerance, as defined by either of the following:

      (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
      (b) markedly diminished effect with continued use of the same amount of the substance

   (2) Withdrawal, as manifested by either of the following:

      (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances)
      (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

   (3) The substance is often taken in larger amounts or over a longer period than was intended
   (4) There is a persistent desire or unsuccessful efforts to cut down or control substance use
   (5) A great deal of time is spent in activities necessary to obtain the substance (eg, visiting multiple doctors or driving long distances), use the substance (eg, chain-smoking), or recover from its effects
   (6) Important social, occupational, or recreational activities are given up or reduced because of substance use
   (7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (eg, current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

DSM-IV (2) also describes various opioid use disorders such as opioid dependence; opioid abuse; opioid intoxication; opioid withdrawal; opioid intoxication delirium; opioid-induced psychotic disorder with delusions; opioid-induced psychotic disorder with hallucinations; opioid-induced mood disorder; opioid-induced sexual dysfunction, opioid-induced sleep disorders; and opioid-related disorder, not otherwise specified. DSM-IV does not mention addiction as one of the disorders.

As five blind Indians in a forest touching an elephant and coming to different opinions, various medical professionals have designed their own definitions. Basically, prescription of opioids for the treatment of non-malignant pain raises questions about appropriate definition of terms (3). The traditional definitions of DSM-IV have been argued by practitioners to be somewhat inappropriate for pain pa-

tients taking opioids (4). Robinson et al (3) state that most patients on opioids develop tolerance to their medication, and undermedicated for their pain, they demonstrate drug-seeking behaviors. They also state that these patients may not be diagnosable according to the same criteria based on non pain populations. Thus, convenient criteria and clinical terminology have been developed that supposedly highlight the difficulty in defining dependence for chronic pain patients resulting in terminology such as pseudoaddiction and therapeutic dependence. Robinson et al (3) believed that currently, in the literature, the component of the DSM-IV definition of abuse and dependence that appears most applicable to chronic pain patients centers on the criterion that the patient used the drug (in this case, the opioid) despite negative and harmful effects or despite any decrease in pain level. Similar to many drug companies and a multitude of guidelines provided by the sponsorship of the makers of opioids, the American Society of Addiction Medicine also has proposed its own set of guidelines to help clinicians decide whether a patient is addicted to opioids. Based on this, screening instruments also have been developed (5). However, the major differences between all the terminology and practices is that this article emphasizes practices in interventional pain medicine settings, not in opioid pain medicine settings, methadone clinics, psychiatric, or behavioral pan management settings. The practices are different in that opioids are administered in conjunction with interventional techniques in a multidisciplinary setting. Further, patients are also different from the one end of neurosurgical and orthopedic practices, with organic and acute pain, to the other end of behavioral management programs with chronic pain syndrome. However, these once again do not apply if the practicing physician is an organic or behavioral purist or reductionist. The criteria developed by the American Society of Addiction Medicine, the American Academy of Pain Medicine and the American Pain Society provide the following definitions and recommendations for addiction, physical dependence and tolerance, not withstanding that the term addiction is not utilized by DSM-IV.

Addiction is a primary, chronic, neurobiological 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
Craving

Our article was meant to highlight opioid abuse in interventional pain medicine practice settings. It can also be used to evaluate violations of opioid contracts. However, this study did not focus on other controlled substances. The purpose of the study was not to identify why patients have obtained outside prescriptions and determine if the dosing was adequate. That would sound more like a sales pitch from a pharmaceutical company, rather than interventional pain medicine practice. Any deviation, except for acute emergencies, was considered as abuse in this study. Further, frequent abuse was defined as occurrence of obtaining a prescription (of a minimum of at least 30 tablets) of a controlled substance at least once a month from another physician without approval of the pain physicians signing the controlled substance contract. Jasper also misunderstood with his belief that all the patients in Group II were frequent abusers. In contrast, all patients in Group II are abusers, whereas 50% of the patients are frequent abusers.

More importantly than the above criticism, it is imperative for interventional pain physicians to understand the present day risks associated with opioid abuse for over-prescription, as well as underprescription. In addition, physicians should consider their own licenses, malpractice, and potential for liability for overdosing, and also, potential for the abuse by the individuals, and not become victims of emerging terminology: pseudoaddiction and opiophobia, etc. We believe that physicians have been blamed enough for under-treating pain without remedy for the liability associated with patient abuse and dependence.

Laxmaiah Manchikanti, M.D.
Bert Fellows, MA
Pain Management Center of Paducah
2831 Lone Oak Road
Paducah KY 42003

REFERENCES

1. Manchikanti L, Pampati V, Damron K et al. Prevalence of opioid abuse in interventional pain medicine practice settings: A randomized clinical evaluation: *Pain Physician* 2001; 4:358-365.
2. *Diagnostic and Statistical Manual for Mental Disorders*. Fourth Edition (DSM-IV). American Psychiatric Association. Washington, 1994.
3. Robinson RC, Gatchel RJ, Polatin P et al. Screening for problematic prescription opioid use. *Clin J Pain* 2001; 17:220-228.
4. Sees KL, Clark HW. Opioid use in the treatment of

chronic pain: Assessment of addiction. *J Pain Symptom Manage* 1993; 8:257-264.
5. Compton P, Darakjian J, Miotto K. Screening for addiction in patients with chronic pain and "problematic" substance use: Evaluation of a pilot assessment tool. *J Pain Symptom Manage* 1998; 16:355-363