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Pain medicine: Why and when to call for the addictionologist and/or psychiatrist

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Substance abuse and psychopathology are frequently present in pain patients and often complicate pain treatment. Whereas the pain physician does not necessarily need to possess the tools needed to effectively treat these complicating conditions, it is incumbent on the pain physician to determine their presence and secure appropriate consultation. Aberrant drug behaviors may be present when patients manifest one or more of the following: continued use despite self harm, daily functionality deteriorates, impaired control over use (unable to take medications as prescribed), preoccupation with use of analgesics for non-analgesics purposes, inability to use non-opioid pain interventions, and/or preference for medications with high reinforcing characteristics (ie, achieve rapid plasma levels). The most common psychopathology is depression and anxiety. The clinical presentation of depression is commonly: persistent low moods ("feeling blue"/down, anhedonia), self-attitude changes (feeling of guilt, being a "bad" person), and/or changes in vital sense (changes in sleep, appetite, or energy levels). Anxiety is somewhat different and the clinical signs are: personality trait (ie, periodically becomes excessive), symptom of another disorder (eg, depression) or triggered by stressful situation (eg, chronic pain), worry out of proportion about negative results, kinesophobia, thoughts of serious illness, amplification of pain perception, muscle tension, sleep disturbances, restlessness, and/or fatigue. Depression and anxiety (most commonly Generalized Anxiety Disorder) are most effectively treated by Cognitive Behavioral Therapies in combination with pharmacologic means. Practicing in an interdisciplinary manner, with appropriate specialty consultation, is indicative of a comprehensive pain management program which is associated with the best possible patient results when dealing with patients manifesting comorbid addiction and/or psychopathology conditions.

Pain management has received increased attention from the medical community. This has been influenced by societal demands for more effective and comprehensive treatment. The Joint Commission on Accreditation of Health Care Organizations requires that their accredited health care organizations consider pain as "the fifth vital sign," requiring that pain severity be documented by using a standardized pain scale.

There has been a dramatic change in the medical management of pain over the past 10 years (Figure 1).[1,2] The threshold for prescribing opioids has decreased and is a function as much of scientific changes as societal ones. In the US in the early 1990s, there was a national debate regarding euthanasia as an alternative to pain and suffering. The debate centered on whether there was a constitutionally provided right to take one's life. In 1994, Oregon voters passed legislation legalizing the procedure of hastening the end of life to relieve pain and suffering (ie, Measure 16; Death With Dignity Act). In 1996, two separate Federal Circuit Court of Appeals struck down laws prohibiting euthanasia, ruling that there was no constitutional obstruction to that practice. This encouraged other states to seek changes in their laws addressing euthanasia/physician-assisted suicide. However, in 1997, the Supreme Court subsequently reversed the Federal Circuit Courts decision.[3] But Supreme Court opinions accompanying rulings are often more significant than the ruling itself. With a unanimous decision, Chief Justice Rehnquist delivered and Justices O'Connor and Stevens wrote (with Justice Souter concurring) that, although taking one's life was not protected by the Constitution, the citizenry had a right to relief from pain

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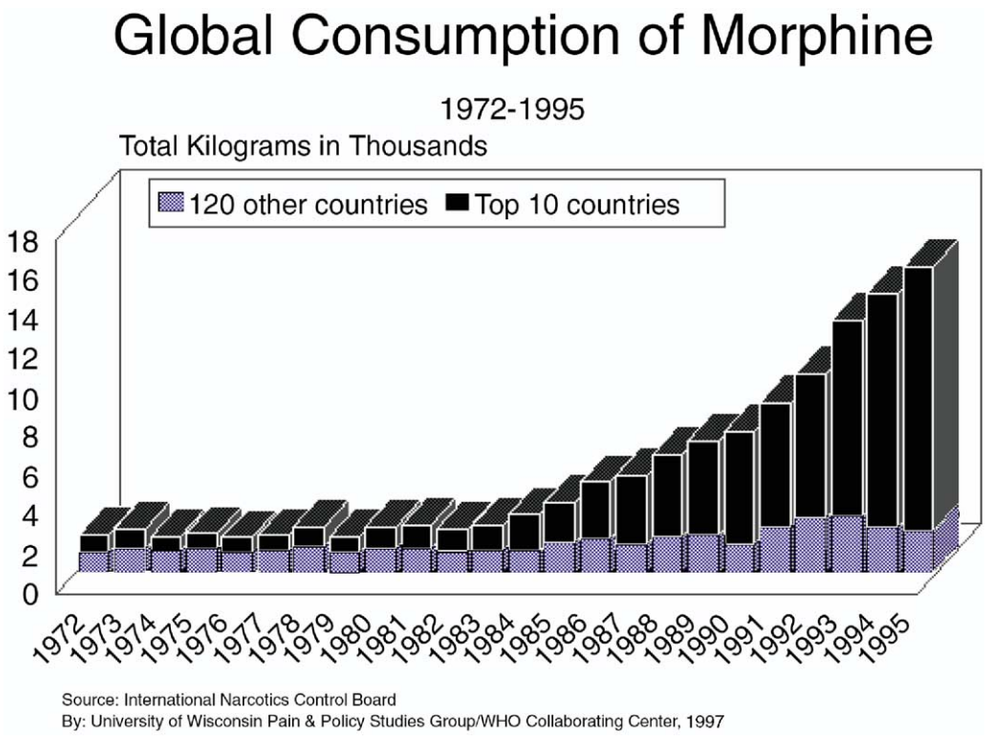

Figure 1 Global consumption of opioids from 1972 to 1995 (modified from Joranson and Gilson).[1]

and suffering, recognizing that the final effect in many cases will be the same. They addressed the need for laws and rules modification, which were seen as obstacles to effective pain relief, then the most common reason for selecting euthanasia as an option to life. Buoyed by this ruling, with its concomitant opinion, as much as the development of better medications to relieve pain, the use of opioids became commonplace.

The purpose of this monograph is to identify substance abuse and psychopathology as frequently present in pain patients. Furthermore, their presence complicates pain treatment and likely leads to treatment failures. It is beyond the scope of this paper (and the author's knowledge) to present an exhaustive treatise on the two topics, but that is the point of this manuscript. Although pain physicians are experts in treating pain patients, they are not necessarily experts in treating addicts and patients with psychiatric disorders. Pain physicians should be cognizant that these comorbid conditions are common in pain patients and be able to determine their existence and when they are affecting pain treatment negatively. These latter points should lead the prudent pain physician to seek and obtain prompt and appropriate specialty consultation.

Interdisciplinary versus multidisciplinary pain care

It is often stated that the multidisciplinary approach to pain management is the most effective. There is little to argue against that concept. A multidisciplinary approach with a "team" concept and practice allows for the evaluation of the pain patient by various team members, each of which is a specialist with varying skill sets. This allows for application of each member's expertise toward the patient's diagnosis and proposed treatment plan. Although this is undoubtedly an attractive option, it does present a series of formidable obstacles, which has prevented its widespread application. A multidisciplinary approach is often slow, difficult to organize and maintain, and poorly reimbursed.

The "standard of care" practice in the US is the interdisciplinary approach. In this system, the primary pain physician performs the initial consultation and establishes the treatment plan. This physician is charged with the responsibility of securing multispecialty consultations as appropriate. This method also appears to have room for improvement, primarily by education in identifying the patient in need of multispecialty pain care. Among the commonly voiced obstructions to the interdisciplinary practice are lack of dedicated specialists, most notably addictionologists, in many communities and, again, the reality of poor reimbursement for such care. Identification of such individuals should be made in advance of their need and, by establishing this relationship, access to care may be improved. Even if an addictionologist is not available, as may occur in some smaller communities, referral to a psychiatrist willing and interested in addiction medicine or regional referral center evaluation would suffice.

Cancer pain management is one of the most gratifying forms of pain management as patients less frequently are drug seekers, have secondary gains (eg, disability), and often equate reduced drug intake with an improvement in cancer status. However, effective treatment of cancer pain begins with assessing the severity, characteristics, and impact of pain. Emotional distress (especially anxiety, depression, and beliefs about pain) can easily complicate cancer