Opioid Addiction

Defining Opioid Use Disorder (Addiction)

- DSM V criteria

Worksheet for DSM-5 criteria for diagnosis of Opioid Use Disorder			
Diagnostic Criteria (Opioid Use Disorder requires at least 2 criteria be met within a 12 month period)	**Meets criteria?** Yes	No	**Notes/Supporting information**
1. Opioids are often taken in larger amounts or over a longer period of time than intended.			
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.			
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.			
4. Craving, or a strong desire to use opioids.			
5. Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.			
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.			
7. Important social, occupational or recreational activities are given up or reduced because of opioid use.			
8. Recurrent opioid use in situations in which it is physically hazardous			
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.			
10. *Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid			
11. *Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms			

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Severity: Mild: 2-3 symptoms, Moderate: 4-5 symptoms. Severe: 6 or more symptoms.

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- 3 C's – compulsions
  - control (lack there of)
  - consequences

Identifying Opioid Addiction

- Self admission
- Red flags
  - control – lost meds, early refills, escalating dose, multidoctoring
  - compulsions – focused on opioids, unwilling to consider other tx, physician met with anger/guilt
  - negative consequences – employment, relationships, legal, health

Pharmanet

Urine drug testing – in office quick screen

Opioid risk tool

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

0–3: low
4–7: moderate
≥8: high

What next?

- Take a good history
- - drugs/etoh used/using, duration/age of onset, route of administration, overdose hx, hepatitis, hiv, cellulitis, endocarditis
- - psych hx
- - family hx
- - social hx – partner using/enabling, employment, income, housing, ?driving, ?childcare
- - legal hx

Time consuming – can bill 14043 chronic care code if primary care physician

What next?

- Physical exam
- - sedation/agitation
- - IV tracks, cellulitis, liver disease, endocarditis

Treatment Plan

- Treatment will require commitment from the patient and will not be short term. Success will likely require some form of behavioural/recovery therapy and not simply detox or another med
- Will the patient commit to such treatment or do they just want a quick fix solution.
- Do not try to assist by prescribing an opiate or bdz

Treatment Options

- Refer to inpatient detox – physician referral form, chest xray

  - aftercare essential and simple detox with no aftercare has relapse rate of > 85% after one year

  Refer to AOT clinic 1250 Quadra – self referral by patient, must show in person. Offer various outpatient tx and can refer for inpatient tx

  Recovery/12 step groups – participation even while using beneficial and may lead to abstinence

Refer for methadone/suboxone treatment

  - not short term, not for pain, commit to daily supervised administration of medication, frequent physician follow up

Methadone/Suboxone Treatment

- Opioid substitution – decreased IVDU and use of other opioids
- Reduction in crime, overdose, improved health
- Best combined with other recovery treatments
- Involves daily witnessed ingestion of methadone, frequent visits, urine drug monitoring, long term treatment
- Relapse rate >85% 1 year after cessation

Methadone/suboxone referral

- Physician or self referral
- Require urine drug screen, liver enzymes/function, hep/hiv serology and EKG
- Advise not to continue opioid prescribing but if so prescribe daily dispensing and no bdz/imovane

Key points for FP if patient on methadone/suboxone

Benzodiazepines/imovane/zolpidem contra-indicated due to risk of respiratory depression and death - do not prescribe

Do not prescribe another opioid to “help” a patient wean off methadone

Maintenance therapy (methadone/suboxone) does little for pain

Chronic pain – do not use opioids

Acute pain - opioids last choice, short duration only

Management of Pain in an Opioid Addict

- Chronic pain – risk of using an opioid extremely high and little evidence to show any benefit.
- Acute pain – Have firm diagnosis
  - use non opioid measures, opioids as last resort
  - if use opioids have opioid contract, sunset clause, use dosages and duration appropriate for patient with no hx of addiction
  - use urine drug screening and pharmanet before starting and during treatment

Resources

- Opioid screening tool/ Opioid contract – online download pdf
- Pharmanet – standard of care, college recommends using every time prescribing an opioid
- Urine drug testing – lab or in office
  - in office (dip) testing multipanel for op/oxy/bdz/amph/meth/ck
  - can bill 15040 for same
  - supplier – I use thermofisher scientific but there are others

Chronic non-cancer pain keypoints

- Evidence moving away from opioid efficacy
- Firm definitive diagnosis – avoid FM, chronic headache
- Before starting discuss risks and efficacy (1 in 4 at best)
- Screen with opioid risk tool, urine drug screen, pharmanet
- Opioid contract, ongoing urine drug testing
- Low dose as effective as high
- Max dose < 200mg morphine equiv per day
- BDZ/Imovane contra-indicated
- If not effective taper off do not continue to push up dose
- Document efficacy/benefits and goals of tx and re-evaluate