Comox Valley
Division of Family Practice
A GPSC initiative

COMOX VALLEY SAFE OPIOID PRESCRIBING ALGORITHM

RESOURCES & TOOLS

The Safe Opioid Prescribing Working Group was formed in November 2014 as part of the Comox Valley Division of Family Practice's work on developing a local approach to safe opioid prescribing practices and optimizing the coordination of care with community-based interdisciplinary care providers. It consisted of Dr. Charuka Maheswaran (physician lead), Dr. Barb Fehlau, Dr. Karen Nishio and Dr. John Bryant and pharmacist Dave Corman.

Revised February 2017

APPENDIX A: PATIENT & PHYSICIAN HANDOUTS

PAIN MANAGEMENT RESOURCES

LOCAL RESOURCES (COMOX VALLEY)

COMOX VALLEY NURSING CENTRE RESOURCES FOR PEOPLE LIVING WITH CHRONIC PAIN[1]: *615 Tenth Street, Courtenay Phone: 250.331.8502 Fax: 250.331.8503*

CHRONIC PAIN SUPPORT GROUP – PEOPLE IN PAIN NETWORK

This support group aims to help people living with chronic pain improve their lives through education, encouragement and fellowship. This meeting is co-facilitated by Heather Divine from the People in Pain Network and a Registered Nurse from the Nursing Centre on the third Tuesday of every month from 1:30 to 3:30 p.m. www.pipain.com twitter; https://twitter.com/Peoplepain and email is info@pipain.com .

GOOD VIBRATIONS - RELAXATION THERAPY

Facilitated by a Registered Clinical Therapist this open class meets weekly for 60 minutes to learn and practice relaxation skills. Thursdays 1:15PM to 2:15PM

CHRONIC PAIN EDUCATIONAL SERIES

A 5 week consecutive program (2hrs at each session) designed to assist people in exploring self-management strategies to enhance the quality of their lives. Chronic Pain Management Team members lead session(s), dedicated to their respective area. This program is run three (3) times per year. To Register call (250)-331-8502

SUPER 6 EXERCISE PROGRAM

A six week consecutive program with the focus on increasing strength, endurance and general fitness level. The Super 6 Exercise Program is run by a kinesiologist to re-introduce chronic pain clients to exercise. Must have a primary care nurse at the Nursing Center

1:1 APPOINTMENTS WITH A PRIMARY HEALTH CARE R.N.

Individual appointments can be arranged with a Registered Nurse at the Nursing Centre. We offer client-centered service. Clients do not need a referral. We encourage clients to take personal responsibility for their health through shared discussion, goal setting and problem solving. We support their decisions about their health and lifestyle by providing information and education, individual consultations and helping them find other resources in the community. We respect our client's active participation in managing their health effectively. It is basic to our partnership.

CHRONIC PAIN MANAGEMENT TEAM

Multidisciplinary team (Nursing, Physiotherapy, Pharmacy, Nutrition, Mental Health, GP Pain Consultations) in partnership with family MD. Goals of this team have been to provide a

[1] Descriptions of Services copied from Island Health (2013), Chronic Pain Resource Descriptions Flyer

multidisciplinary framework to assess, treat and to educate people experiencing chronic pain, and their families, as well as to increase our own knowledge and the knowledge of other health care professionals in this community. We have used existing community resources to provide a coordinated, multidisciplinary, and client centered approach.

NURSING CENTRE LIBRARY RESOURCES and COMMUNITY INTERNET ACCESS

This rich resource is located within the center and is managed by Nursing Center Volunteers. We have a broad selection of books, videos and audio tapes/CD's on Chronic Pain and many other health issues. A computer is also available for those who would like to access health related information via the Internet.

INTERVENTION PLUS PAIN CLINIC: (DR. BARBARA FEHLAU) *

1736 England Avenue
Courtenay BC V9N 2P6
250-871-1173 Phone
250-871-1946 Fax

Appointments are by referral only
http://www.interventionpluspainclinic.com

REGIONAL RESOURCES

NANAIMO REGIONAL GENERAL HOSPITAL PAIN CENTRE

For the treatment of patients who suffer from non-surgical pain that is not managed by conventional methods. No urgent concerns. Orientations every Tuesday from 4:00p.m. – 5:00 p.m.by scheduled appointment. *Phone: (250) 739-5978 Fax: (250) 739-5989 E-mail:* *NRGHPainClinic@viha.ca* for general inquiries only

VICTORIA ROYAL JUBILEE HOSPITAL PAIN PROGRAM

For the treatment of patients who suffer from non-surgical pain that is not managed by conventional methods. No urgent concerns. Orientations every Tuesday from 4:00-5:30 p.m.; no appointment necessary but attendance strongly recommended. Phone (250) 519-1836; Fax: (250) 519-1837; E-mail RJHPainClinic@viha.ca for general inquiries only.

UNIVERSITY OF VICTORIA CHRONIC PAIN SELF-MANAGEMENT PROGRAM

The Chronic Pain Self-Management Program (CPSMP) is a community program to help people live successfully with chronic pain. It is led by two trained leaders who successfully complete a four-day training workshop and is delivered in communities to groups of 10-12 persons, once a week for 2 1/2 hours, for six consecutive weeks. Participants receive two books: "Living a Healthy LIfe with Chronic Conditions" and the "Chronic Pain Self-Management Program Workbook"; the Workbook contains our "Moving Easy Program" CD which provides a set of easy to follow exercises which can be done in the comfort of your own home. For information about workshop dates and locations call our toll-free information line at 1-866-902-3767 or visit our website at www.coag.uvic.ca/cdsmp

VICTORIA BACKFIT PROGRAM

www.backfit.ca Phone (250)477-8143

ONLINE RESOURCES

1. Island Health has a webpage with a number of helpful videos to watch:
   - Understanding Pain in 5 minutes
   - Introduction to Pain
   - Accepting Your Chronic Illness

   http://www.viha.ca/comox_valley_nursing_centre/programs_and_services/chronic_pain.htm

2. University of Calgary Online Resources

   - Chronic Pain Management Online Lectures. Ten lectures covering Introduction to Pain, This is Your Body, Medications, The Role of Exercise in Managing Pain; Attention and Memory; Nutrition; Pacing in Pain Management; Anxiety, Depression and Chronic Pain; Sleep; and Understanding Medical Investigations & the Health Care System.

     http://www.albertahealthservices.ca/2790.asp

3. Canadian Pain Coalition Pain Resource Centre. Information available about chronic pain conditions, management of chronic pain, accessing chronic pain care, pain associations, and more.

   http://prc.canadianpaincoalition.ca

VIDEOS

- "Pain and Role of Medications" www.aci.health.nsw.gov.au/chronic-pain/for-everyone/pain-and-role-of-medications
- "Adorable Animated Mice Explain Mediation in 2 Minutes" www.mindful.org/adorable-animated-mice-explain-mediation-in-2-minutes
- Evans Health Lab www.evanshealthlab.com (whiteboard health videos, e.g. stress, opioids)
- "Understanding Pain: What to do about it in less than 5 minutes?" You Tube

SMART PHONE / TABLET APPS

- Headspace: www.headspace.com [10 for free]
- MindShift: www.anxietybc.com/resources/mindshift-app [free]
- Insight Timer – Meditation Timer: www.insighttimer.com [free]
- Stop, Breathe & Think: www.stopbreathethink.org [free]
- Opioid Manager Apps: www.opioidmanager.com/apps.html [free for patients]

GOALS & HAZARDS OF OPIOID THERAPY

USE OF OPIOIDS FOR CHRONIC PAIN MANAGEMENT

GOALS OF USING OPIOIDS FOR PAIN MANAGEMENT

Goals of treating your pain with Opioid Medications are to reduce pain and improve your function. This will not completely take away your pain but hopefully will make your pain more manageable. If it does not after a reasonable trial, your doctor will likely be taking you off the opioid medications. There are many other medications or therapies that may be more appropriate than opioids for your particular type of pain.

WHAT ARE OPIOIDS?

Opioids are a very powerful kind of medication that reduces your moderate to severe pain. The most commonly used opioids include codeine (in Tylenol #2,3, or 4), morphine, Oxycodone, Tramadol, Hydromorphone, Fentanyl, BuTrans or Methadone. They come in different strengths.

If you are taking longer acting opioids such as Meslon, OxyNeo, Hydromorph Contin, BuTrans, Fentanyl or Methadone, you may not notice the same “kick” as you do for short acting opioids. This does NOT mean they are not working. Although they do not kick in as quickly as something like a Tylenol #3, it lasts longer so do not expect the same “feeling” when you take these.

RISKS OF ADDICTION

Your doctor will assess your risk of addiction. In the past, it was always thought that this is very rare, but with the current widespread use of opioids, we are seeing more addictions. It is still most common in people who have already had addiction challenges. If you have had challenges with addictions in the past or present, it is very important you discuss this openly with your physician who may either recommend other ways of dealing with your pain or suggest working with someone who has experience with working with people with addiction issues.

If you have no history of addiction but find that you “like” the escape feeling a bit too much, find your relationships with others deteriorating, lose jobs, have cravings for your medication or want or need more of the medication please discuss this with your doctor.

OVERDOSE OF OPIOIDS

If you experience grogginess, pinpoint pupils and lots of confusion, you may have overdosed on your medication. If so please seek help immediately – have someone keep you awake until you get help!

SIDE EFFECTS OF TAKING OPIOIDS

POSSIBLE SIDE EFFECTS

- **Sedation**
- **Nausea**
- **Constipation**
- **Dry Mouth**
- **Confusion**
- **Muscle Twitching**
- **Hormonal Disturbances**
- **Urinary Retention**
- **Allergic Reaction**
- **Heart Problems**
- **Pinpoint Pupils / Troubles Breathing**
- **Increased Pain / Sensitivity / Hyperalgesia**

SEDATION: Sedation is very common when you first start taking opioids, and this usually resolves after a few days of taking it. Avoid activities requiring mental clarity if you feel sedated such as driving or operating machinery. Sedation can also occur if you suddenly increase your dose or if you need less opioids or other factors in your illness occur leading to buildup of the medications in your bloodstream. If you are "nodding" out, being severely sedated or having troubles breathing, you are taking too much and this needs to be weaned, and you need to get help right away. Go to the emergency if necessary and you can't get in to see your family doctor.

NAUSEA: This occurs in about 60% of people when starting to take opioids, but this too usually goes away with ongoing use. Sometimes taking lower doses or *Dimenhydrinate* can help you through those first few days. Also sometimes taking ginger tea or peppermint tea can also help.

CONSTIPATION: This occurs with everyone taking opioids. Unlike normal constipation, more fiber will not help this, all you will end up with is concrete! You need to add something to stimulate your bowels, so taking something like *Senekot* 2 tablets at bedtime regularly or asking for help from your doctor, pharmacist or nurse can help.

DRY MOUTH: Opioids will cause dry mouth. Sometimes dry mouth can increase your risk of dental caries or cavities. It is important that you keep your mouth moist while taking opioids. This can be done by sucking a low sugar lemon candy or getting some saliva replacement available over the counter at your pharmacy.

CONFUSION: This is very common when starting to take opioids and often goes away if you keep taking them. Please do no drive if you feel this way or operate dangerous machinery until you feel clearer. If you have been on opioids for a while and this happens, please see your doctor right away, as there may be other things going on.

MUSCLE TWITCHING: This most often occurs after taking higher doses of opioids and is not harmful but often indicates the dose is too high, and may need to be reduced. These are not seizures.

HORMONAL DISTURBANCES: Taking opioids for a long time affects our hormones and the brain affecting hormone release and production. Therefore people may begin to have lower sexual desire or libido, weight gain, depression and cause changes in menstruation for women.

URINARY RETENTION: Sometimes people will have a hard time peeing when starting opioids. This effect may or may not go away with prolonged use. It may be necessary to get a urinary catheter inserted to get you started peeing again and hopefully this will be temporary.

ALLERGIC REACTION: Many people get dry itchy skin or hives that are not a "true" allergy but are a "false" allergy-like reaction. If this occurs, first try taking an antihistamine such as Benadryl or Reactine. If this does not go away, or you develop swelling or tightening of your throat please see your doctor immediately or if severe please go to the emergency department.

HEART PROBLEMS: Irregular heart rhythms can occur with taking opioids. If you feel your heart pounding, beating very slowly or beating irregularly, either please see your doctor right away or if you feel very bad, please go to the Emergency Department. It is rare but there are some dangerous heart rhythms that can occur while taking these medications.

PINPOINT PUPILS/TROUBLES BREATHING: You may notice that you develop very small or pinpoint pupils. This may indicate that you have taken too much of your medication. Please see your health care provider right away if you also are groggy or feel confused. In addition if your breathing slows down dramatically you may also have taken too much opioids and should seek care immediately – do not drive, have someone drive you and keep you awake if this happens until you see a doctor.

INCREASED PAIN/SENSITIVITY/HYPERALGESIA: Occasionally, and especially on high doses of opioids, you may notice that your pain has changed and that it hurts all over whereas it only hurt in certain locations in your body before. It is often a very severe kind of all-over body burning pain. If this happens, you have probably developed "hyperalgesia" or increased pain sensitivity. It is important to start reducing your opioid medication if this happens, and ironically your pain will likely be less. "More" is not always "better". It is sometimes very disappointing to realize that your pain was not well controlled, but more will simply harm you. Remember, there are many reasons for your pain and many different ways of treating it, and opioids are only one of many different medications or approaches that can help it.

HOW TO SAFELY TAKE OPIOIDS

It is vitally important you work closely with your physician. He/she is trying to help you improve your life but in return they will expect the following:Take the medication as prescribed, do not change this without first talking with your doctor

1. Never take more medications than prescribed
2. When increasing the dose, be cautious of driving or doing tasks requiring concentration (BE SAFE)
3. KEEP YOUR OPIOIDS SAFE. Lock them up – studies are now showing that a surprising number of family members including teenagers help themselves to your opioids
4. NEVER give away to other people, even if they seem desperate, as this will leave you short of your prescription. It is other peoples' responsibility to have their own assessments and treatments.
5. NEVER forge or alter your prescriptions.
6. Document your progress.
7. Sign the opioid agreement we expect you to. It protects your prescriptions and our licenses to prescribe these medications. This will include random collection of urine drug screens.
8. Fill your prescriptions at only one pharmacy and see only one physician to help you manage your pain.
9. NEVER mix your medications with alcohol or other sedating medications unless your doctor is aware of this, the combinations of opioids and sedatives and alcohol have been found to be the biggest reason for patient deaths in recent years of using opioids.
10. Actively participate in your wellness including eating properly, sleeping well, pacing yourself and participating actively in exercise as much as you can. Do not expect the pain to go away first before increasing your activity. It is important that you challenge yourself even if you have pain. Opioids are not a magic answer to your pain but can help along with many other aspects to make your life better than it is now.

STOPPING OPIOIDS

If your pain is not helped with the use of opioids, or you have been found to be misusing your prescriptions, your physician will work with you to safely wean you off your medications. If you suddenly stop your opioids, you will go through physical withdrawal. This may or may not be associated with addiction, but it is more often a result of physical dependence. Slow reduction of the opioids or addition of a medication called clonidine will help.

Sudden discontinuation is uncomfortable but not life threatening. Symptoms most commonly feel like a bad "flu", with muscle and joint aches, runny nose, diarrhea and stomach cramps. These usually resolve within a few days.

We are truly wanting to help you help your pain and function. Please remember to work with us – we can work together to get the best possible management of your pain.

Dr. Barbara Fehlau, Dave Corman, et al., Safe Opioid Prescribing Working Group, Comox Valley Division of Family Practice, March 2015

• REFERRAL TO NURSING CENTRE CHRONIC PAIN CLINIC

To refer a client to the **Comox Valley Nursing Centre Community Pain Service Support**, please print and complete the referral form that is available in this package of resources (Appendix B).

DR. FEHLAU'S INTERVENTIONAL TREATMENTS

Dr. Fehlau offers a range of chronic pain management treatment options.
Visit the clinic's website for more information: www.interventionpluspainclinic.com

RESOURCES FOR PHYSICIANS

PAIN MANAGEMENT

WEBSITES

- **COMOX VALLEY NURSING CENTRE, COMMUNITY PAIN SERVICE SUPPORT: www.viha.ca/comox_valley_nursing_centre/programs_and_services/chronic_pain.htm**
- **ANXIETY B.C. www.anxietybc.com**
- **PAIN B.C. (Pain toolbox and more)** www.painbc.ca
- **Rx FOR HEALTH www.healthyfamiliesbc.ca/home/prescription-health**
- **PEOPLE IN PAIN NETWORK www.pipain.com**
- **UNIVERSITY OF CALGARY ONLINE RESOURCES** www.topalbertadoctors.org
  - Alberta's Toward Optimized Practice (TOP) Guidelines. Clinical practice guidelines available for low back pain, headache, and insomnia.
- **PAIN SOCIETY OF ALBERTA** www.painsocietyofalberta.org
- **CANADIAN PAIN SOCIETY.** www.canadianpainsociety.ca
- **INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN** www.iasp-pain.org
- **AMERICAN PAIN SOCIETY** www.americanpainsociety.org
  - Also see their link to "Subscribe to APS SmartBrief", a weekly email distribution of news for the pain professional.

VIDEOS

- "Pain and Role of Medications" www.aci.health.nsw.gov.au/chronic-pain/for-everyone/pain-and-role-of-medications
- "Adorable Animated Mice Explain Mediation in 2 Minutes" www.mindful.org/adorable-animated-mice-explain-mediation-in-2-minutes
- Evans Health Lab www.evanshealthlab.com (whiteboard health videos, e.g. stress, opioids)
- "Understanding Pain: What to do about it in less than 5 minutes?" You Tube

SMART PHONE / TABLET APPS

- Headspace: www.headspace.com [10 for free]
- MindShift: www.anxietybc.com/resources/mindshift-app [free]
- Insight Timer – Meditation Timer: www.insighttimer.com [free]
- Stop, Breathe & Think: www.stopbreathethink.org [free]
- Opioid Manager Apps: www.opioidmanager.com/apps.html [free for patients]

APPENDIX B: REFERRAL FORM FOR NURSING CENTRE CHRONIC PAIN CLINIC

REFERRAL TO

Comox Valley Nursing Centre
Fax 250.331.8503

Attention: Drop-in nurse of the day

Last Name (print)	First Name	Date of Birth (dd/mm/yyyy)	Telephone:
Address		PHN #: Sex: Male Female	

Reason for Referral:

_____

_____

Requested Services: (Please check)

COMMUNITY PAIN SERVICES

Refer to Primary RN for:

1:1 consultation

Chronic Pain Management Team
GP Pain Consultation
Super 6 Exercise Program

Open Community Services

Chronic Pain Education Series
Chronic Pain Support Group
Relaxation Therapy Program

OTHER SERVICES AT THE NURSING CENTRE

General health consultation with RN
Chronic Disease Management
NI Regional Eating Disorders program (therapy,
nutrition services- Comox Valley only) Nurse Practitioner – Positive Wellness North Island
Men's Peer counselor (Thurs/Fri only)
Street Outreach

OTHER SERVICES

NI Regional Eating Disorders program (counseling services- Campbell River only)

Medical Diagnosis (attach relevant reports):

_____

_____

Current Medications (attach):

_____

_____

Has this client been informed of this referral? ☐ Yes ☐ No

Referred by: _____ Phone #: _____

Clinic or agency: _____ Patients' GP: _____

615 10th Street | Courtenay, B.C. V9N 1R2

Tel: 250.331.8502 | Fax: 250.331.8503
www.viha.ca/comox_valley_nursing_centre

APPENDIX C: OPIOID TREATMENT AGREEMENT

The following opioid treatment agreement was created by Dr. Barbara Fehlau. After your patient signs the agreement, please ensure you fax it to the pharmacist.

OPIOID TREATMENT **AGREEMENT**

FOR:_____

When opioids (narcotics) are prescribed, communication must be clear, because the College of Physicians and Surgeons monitors prescriptions closely.

- Opioids do not cure pain conditions and they may cause other problems.
- The main goal of opioid therapy is to help improve your physical and vocational functioning. If this does not improve your life, we will probably be weaning you off the opioids.
- During dosage adjustments, drowsiness may occur temporarily and during these times you agree not to perform tasks that could endanger you or others.
- Use of opioids to treat pain will result in physical dependence of the medication. Sudden decreases or discontinuation will lead to opioid withdrawal symptoms. These symptoms are uncomfortable but not physically life-threatening.
- There is a small risk that addiction may occur. Almost always, this occurs in patients with current or past drug abuse issues. If this occurs, treatment for addiction may be necessary.

Because of the controversy and concern surrounding opioid usage, we require that you:

1. Have only one physician or the locum physician covering for the physician prescribing these opioids while being treated for pain. This physician's name is:
   _____
2. Use only one pharmacy for medication and notify the treating physician of its name and phone number. Pharmacy name:
   _____
3. Give permission for your physician to access Pharmanet as needed.
4. Take your medications as prescribed including not increasing the dosage on your own. Do not lend, give or sell your medications to anyone. Keep your medication in a safe place. Lost, damaged or stolen medications will not be replaced until the next regularly scheduled visit.
5. Document your progress, and have a significant other also document your progress.
6. Know that forged or abused prescriptions constitute grounds for dismissal. Abusive behaviour to pharmacy, office staff or physicians will not be tolerated and are grounds for dismissal.
7. Know that treatment discussions will only occur within your appointments.
8. Allow random drug screens to be taken within reason. This means submitting the urine within 24 hours of request and may include witnessed collection.
9. Allow us to discuss your case with your caregivers and other health care providers.
10. Agree to refrain from use of any/all mood-modifying substances without prior agreement from your physician. These include tranquilizers, sleeping pills, illicit drugs such as cannabis, cocaine, heroin or hallucinogens, which can all interfere with opioid therapy.
11. Understand that if you do not follow the above requirements, you may be discharged from this treatment.

☐ **I have read and understand the goals and hazards of using opioid therapy** *(Check box)*

Patient's signature: _____ Date:_____

Physician's signature:_____ Date:_____

FAX to PHARMACY

Developed by Dr. Barbara Fehlau

APPENDIX D: RANDOM URINE DRUG SCREENING

TIPS FOR URINE DRUG TESTING COLLECTION

- ☐ An unusually hot or cold specimen, small sample volume or unusual color should raise concerns. Test temperature upon collection. The only reason for a cold specimen is that the patient is dead.
- ☐pH should be between 4.5-8
- ☐Can either be a) witnessed or b) unobserved
- ☐Random is best.

HOW TO FILL OUT REQUISITIONS

- ☐ Use a standard laboratory requisition (*see sample form on next page*)
- ☐ Synthetic/semisynthetic opioids are not easily detected in UDTs (like oxycodone, fentanyl) so need to ask specifically to confirm these
- ☐ Write "test is medically necessary" to ensure MSP coverage for test

BACKGROUND

- UDTs can detect parent drugs +/- metabolites. Most are done via a class-specific immunoassay. They can then be followed up by more specific testing like gas chromatography mass spectrometry (GCMS).
- In Chronic non cancer pain (CNCP), it is used to monitor compliance.
- Audits of medical records show that < 10% of physicians use UDTs.
- Reliance on aberrant behavior to trigger an UDT will miss more than 50% of those individuals using unprescribed or illicit drugs.

URINE VS. BLOOD TESTS: Blood testing is NOT more accurate than urine drug testing (UDT), as it has an increased window of detection (usually 1-3 days for most drugs) and only hours in serum. Urine drug tests are also less expensive.

INTERESTING FACTS ABOUT DRUGS / MEDICATIONS:

- Codeine turns into morphine but morphine does not turn back into codeine
- Heroin turns into 6- monoacetylmorphine and morphine
- Poppy seeds can result in a false positive morphine test
- Methadone tests test for methadone metabolites (if spiked see methadone only in the urine, not the metabolite)
- Cocaine testing is very specific – other topical "caines" DO NOT cause false positives
- Some OTC drugs such as decongestants and Parkinson's meds can give false positive amphetamine/ methamphetamine tests
- Nabilone does not result in a THC UDT being positive

***PLEASE NOTE**: If you need to ask for extra confirmation of tests appearing in the urine, the laboratory physicians are very helpful in supporting you to research any strange interactions with other medications or drugs.

Dr. Barbara Fehlau et al., Safe Opioid Prescribing Working Group, Comox Valley Division of Family Practice, revised Feb 2017

Last Name (From Care Card)	First	Initial	Date of Birth D M Y / Sex F M
Address	Postal Code		Phone Number
Bill to: ☐ MSP ☐ ICBC ☐ Non Resident of Canada ☐ WCB ☐ Other PHN# (Specify)			Copy to
Doctor Name / Address / Telephone / Practitioner # / Physician Signature			Antibiotics / Medications / Diagnosis

Patient Instructions: ☐ Fast for _____ hours prior to test.
☐ For therapeutic drug monitoring please report to the lab immediately prior to next dose.

HEMATOLOGY

- ☐ WBC ☐ ONLY
- ☐ HEMOGLOBIN ☐ ONLY
- ☐ DIFFERENTIAL COUNT
- ☐ HEMATOLOGY PANEL (Hgb, Hct, WBC, RBC, Indices and Differential when indicated)
- ☐ INR
- ☐ ESR - Provide

_____

CHEMISTRY

- ☐ GLUCOSE FASTING 8-10 HRS.
- ☐ 1 HR. POST 50g (PREGNANCY)
- ☐ GTT 100 G PREGNANCY
- ☐ 2 HR. GTT 75g (NON-PREG)
- ☐ PREGNANCY TEST ☐ urine ☐ serum (Qual)
- ☐ Therapeutic Drug Concentrations:
  - Specify Drugs _____
  - Last Dose _____
  - Next Dose _____
  - ☐ Toxicity suspected

MICROBIOLOGY

TEST: ☐ Bacterial Culture ☐ Gram Stain (list current antibiotics above)

SITE: ☐ Nose ☐ Sputum ☐ Throat ☐ Stool ☐ Other _____

TEST: ☐ Fungus Culture ☐ Fungus, direct exam 77 (KOH prep)

SITE: ☐ OTHER SOURCE

_____

_____

PROTOCOLS / GUIDELINES

Tests in this section should be ordered in compliance with the protocol or guideline

- ☐ Serum Ferritin ☐ * Special Case (if iron & binding capacity also requested)
- ☐ TSH ..... ☐ * Special Case (list additional tests)
- ☐ ESR ..... ☐ * Special Case Diagnosis _____

URINE ..... UTI NOT suspected ☐ Macroscopic
☐ Macroscopic → Microscopic if indicated
☐ Macroscopic & Microscopic * special case
..... UTI suspected ☐ Urinalysis → culture if pyuria or nitrite present
☐ Urine Culture: Source:

STOOL O & P..... ☐ Single Specimen ☐ HIGH RISK (Times x 2)

PSA ..... ☐ SCREENING (patient must pay) ☐ NOT FOR SCREENING

LIPIDS..... Major Risk Factor(s)/CAD
☐ No (patient must pay) ☐ Yes Major Risk Factors
☐ Total Cholesterol ☐ HDL Cholesterol
☐ Triglycerides ☐ LDL Cholesterol (calculated)

HEPATITIS SEROLOGY
- ☐ Acute Hepatitis Screen (HBsAg, anti-HCV, ANTI-HAV Igm) ☐ Immunity Hepatitis B (Anti-HBs)
- ☐ Immunity Hepatitis A (Anti-HAV total) ☐ Hepatitis B Carrier (HBsAG)
- ☐ Chronic Hepatitis (HBsAg, anti-HBc total, Anti-HCV) ☐ Needlestick (Source) (HBsAg, Anti-HCV, HIV)
- ☐ Needlestick (HCW) (HBsAg, anti-HBs, Anti-HCV) ☐ Other _____

ADDITIONAL TESTS OR INSTRUCTIONS

* Special cases must be justified

random urine drug screens prn x 2 years

Pt. is on _____ for chronic pain, test is medically required

☐ Needlestick (HCW) Phlebotomist
☐ Needlestick (HCW)

Patient has legal right to choose nominal or non-nominal reporting.

Date/Time of Collection

APPENDIX E: SUPPORT FOR WITHDRAWAL AND WEAN-DOWN MANAGEMENT

Tapering Patients off Opioids

WHEN TO TAPER PATIENTS OFF OPIOIDS

1. Inadequate analgesia – with severe pain and disability despite a high dose (greater than Morphine Oral equivalent dose of 200 mg/day)
2. Side Effects or medical complications – include sedation, sleep apnea, overdose, severe myoclonic jerking, constipation despite treatment and falls in the elderly
3. Opioid Misuse and addiction – those who are found to get opioids off the street, those who persistently have other drugs in their urine drug screens – they may be better served on the methadone/buprenorphine programs
4. Be careful if considering tapering pregnant patients as this may result in preterm labour and spontaneous abortion, they are better off on methadone
5. Warn patients that once they are off they are at increased risk of overdosing if they take their previous dose if they relapse

WHEN CAN OPIOIDS BE ABRUPTLY DISCONTINUED?

It is felt that if patients are obtaining most of their opioids from another source or diverting the prescriptions, it is reasonable to stop prescribing the opioids abruptly.

CLINICAL FEATURES OF OPIOID WITHDRAWAL

Physical signs/symptoms	lacrimation, rhinorrhea, yawning
	Dilated pupils, nausea/vomiting
	Diaphoresis, chills, piloerection, mild tachycardia, HBP
	Myalgias, abdominal cramps, diarrhea
Psychological symptoms	anxiety and dysphoria
	Cravings for opioids
	Restlessness, insomnia, fatigue

ONSET AND DURATION OF SYMPTOMS OF OPIOID WITHDRAWAL

<8 hours (peak 36-72h)	anxiety, fear of withdrawal, drug craving, diaphoresis, chills, lacrimation, rhinorrhea, yawning
12 hours on – peak 72 h	piloerection, anorexia, dilated pupils, anxiety, irritability, dysphoria, restlessness, insomnia, tremor, mild tachycardia, hypertension, abdominal cramps
24-36 h - peak 72 h	diarrhea, myalgias, muscle spasms, nausea, vomiting, diarrhea, severe insomnia, violent yawning

Physical withdrawal symptoms generally resolve by 5-19 days

Psychological symptoms may last weeks to months

Methadone withdrawal may start at 24 hours but the withdrawal symptoms are prolonged up to 3 weeks or more

TAPERING PROTOCOL

Formulation	Sustained release opioids until lowest does is reached
Dosing Interval	Scheduled doses rather than prn until lowest dose is reached
Rate of Taper	Taper slowly: 10% every two to four weeks The longer the patient has been on opioids the longer the taper Taper even more slowly when patient is on 1/3 of starting dose
Frequency of pharmacy dispensing	If patient runs out early then dispense weekly, alternate daily or daily
End point of taper	Less than 200 mg. equivalent morphine oral dose as long as goals of treatment are being met. Wean off if there is no benefit (*See table on next page for equivalent doses information*)
Frequency of visits	If possible, prior to each patient dose decrease
Approach at each visit	Ask about withdrawal symptoms, pain, benefits such as alertness, less fatigue and less constipation

Use of other medications to ease withdrawal

Nausea and vomiting	Dimenhydinate 25-100 mg po/pr q4h prn
	Prochlorperazine 5-10 mg po q4h prn
Diarrhea	Loperamide 2-4 mg po prn max dose 16 mg/24
Myalgias	Acetaminophen 500 mg po bid prn
	Naproxen 500 mg po bid prn with meals
Anxiety, lacrimation, rhinorrhea	Hydroxyzine 25-50 mg po tid prn
Insomnia	Trazodone 50-150 mg po qhs prn
Other general withdrawal	Clonidine 0.1 m,g po x 1 dose – If BP greater than 90/60 proceed to use – use 0.1 mg po qid prn for up to 14 days

EQUIANALGESIC OPIOID CONVERSION FOR CHRONIC PAIN

DRUG	ORAL (PO)	PARENTERAL (IV,IM,SC)
Morphine	10 mg	5 mg*
Codeine	100 mg	65 mg
Hydromorphone	2 mg	1 mg*
Oxycodone	5 – 7.5 mg	---
Methadone	1 mg but highly variable ratio & complex**	Not readily available
Fentanyl	25 mcg patch ≈ 60 – 134 mg total oral Morphine Equivalent Daily Dose (MEDD)*** e.g. morphine 10 mg po q4h = 25 mcg patch	
* Common ratio PO:IV/IM/SC is 2:1, but some patients may be 3:1		
** Rotation to methadone from morphine is complex, including delayed accumulation to steady state. Ratio varies from morphine:methadone 5:1 at low doses to 10:1 or up to 20:1 at higher doses. Must be individualized.		
*** Manufacturer suggests a range of possible doses. See Table below.		

***Recommended Initial Dose Conversion to Fentanyl Patch	
Oral 24-Hour Morphine Equivalent Daily Dose (mg/day)	Fentanyl Dose Equivalent (mcg/hour)
60 – 134	25
135 – 179	37
180 – 224	50
225 – 269	62
270 – 314	75
315 – 359	87
360 – 404	100

The above table is designed to be conservative when switching to a fentanyl patch. It must therefore be used with great caution when switching **from** a fentanyl patch **to** another opioid. Use of this table for such a conversion could overestimate the dose of the new agent and over dosage may occur.

Note: The 12 mcg/h dose is not included in this table because it generally should not be used as the initiating dose, except in the case of patients for whom clinical judgment deems it appropriate. Fentanyl transdermal systems are contraindicated in opioid-naïve patients.

The above information is copied, unaltered, from the following source: ***Authors:*** *Dr. Greg McKelvie, Pharm D, Pharmacy Practice Council and End of Life Quality Council, Island Health Interprofessional Practice & Clinical Standards.*

REFERENCES

1. Medical Care of the Dying, 4th edition, page 195
2. Health Canada Bulletin. Important Changes to the Dose Conversion Guidelines for Fentanyl Transdermal Systems. Authorized by Janssen-Ortho Inc., Cobalt Pharmaceuticals Inc., Novopharm Limited, Ranbaxu Pharmaceuticals Canada Inc., Ratiopharm Inc., January 2, 2009

APPENDIX F: SAMPLE MISUSE LETTER FROM R.C.M.P.

The Safe Opioid Prescribing Practices working group has collaborated with the Comox Valley R.C.M.P. in order to better understand the extent of the misuse and diversion of prescription opioids in our community. If your patients' medications are seized by the R.C.M.P., the prescribing physician and dispensing pharmacy will receive this letter. Please note that this only identified a portion of the total seizures, as many seized medications are not found in their original packaging.

Royal Canadian Mounted Police
Comox Valley Detachment
Telephone: (250) 338-1321
800 Ryan Road Courtenay, British Columbia V9N 7T1
FAX: (250) 338-6781

Date:_____
File Number: _____

Misuse of Prescription Medication

Dear Dr. _____

Please be advised that a quantity of prescription medication prescribed by you was seized pursuant to a criminal investigation on _____

These medications were seized as they were being misused in the following manner:

- **Being bought or sold illegally;**
- **Not found in the possession of the intended patient;**
- **Other:** _____
  _____

The medication in question is believed to be:_____

Prescribed on:_____ Quantity prescribed:_____
The intended patient is listed as:_____
A total of _____ were seized and will be destroyed.
If you have any questions, please do not hesitate to contact the investigating officer at (250) 338-1321.

PHARMACY _____ NOTIFIED

Investigating Officer:_____ Date:_____

ADDITIONAL TOOLS AND RESOURCES

The following tools and resources are from the General Practice Services Committee (GPSC) Practice Support Program (PSP) Chronic Pain Algorithm. GPSC (2009) Tools and Resources website and are available in fillable pdf format through PSP.

In order to create a complete library of resources for physicians, we have also included them here.

RED, YELLOW FLAGS

Red Flags for Consideration when Pain Present

Summary

1. Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention. Red flags were designed for use in acute low back pain, but the underlying concept can be applied more broadly in the search for serious underlying pathology in any pain presentation.

Red Flags Possible fracture	Possible tumour or infection	Possible significant neurological deficit
From history		
• Major trauma • Minor trauma in elderly or osteoporotic	• Age >50 or <20 years • History of cancer • Constitutional symptoms (fever, chills, weight loss) • Recent bacterial infection • IV drug use • Immunosuppression • Pain worsening at night or when supine	• Severe or progressive sensory alteration or weakness • Bladder or bowel dysfunction
From physical examination		
• Evidence of neurological deficit (in legs or perineum in the case of low back pain)		

References

1. New Zealand Low back Pain Guide. Accident Rehabilitation and Compensation Insurance Corporation of New Zealand and the National Health Committee. Wellington 1997.

2. Low Back Pain: Rational use of opioids in chronic or recurrent non-malignant pain. NSW Therapeutic Assessment Group: Prescribing guidelines for primary care clinicians. Published 1998. Revised 2002.

The above information is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.

RED, YELLOW FLAGS

Yellow Flags

Yellow flags indicate psychosocial barriers to recovery. Identifying yellow flags in patients can be challenging. Yellow Flags indicate psychosocial barriers to recovery that may increase the risk of long-term disability and work loss. Identifying any Yellow Flags may help when improvement is delayed. Yellow Flags include:

Yellow Flag	Intervention
Belief that pain and activity are harmful	Educate and consider referral to active rehab
"Sickness behaviors" (like extended rest)	Educate and consider pain clinic referral
Low or negative moods, social withdrawal	Assess for depression and treat
Treatment beliefs do not fit best practice	Educate
Problems with claim and compensation	Connect with stakeholders and case manage
History of back pain, time-off, other claims	Follow-up regularly refer if recovering slowly
Problems at work, poor job satisfaction	Engage case management through disability Carrier
Heavy work, unsociable hours (shift work)	Follow-up regularly refer if recovering slowly
Overprotective family or lack of support	Educate patient and family

Psychosocial Yellow Flags: Helping Someone at Risk - Suggested steps to better early behavioral management of low back pain problems

- Be directive in scheduling regular reviews of progress. When conducting these reviews shift the focus from the symptom (pain) to function (level of activity). Instead of asking "How much do you hurt?" ask "What have you been doing?"
- Keep the individual active and at work if at all possible, even for a small part of the day. This will help to maintain work habits and work relationships.
- Acknowledge difficulties with activities of daily living, but avoid making the assumption that these indicate all activity or any work must be avoided.
- Help to maintain positive cooperation between the individual, an employer, the compensation system, and health professionals. Encourage collaboration wherever possible. Please refer to the template letter to employers – Return to Work as an example of collaboration.
- Make a concerted effort to communicate that having more time off work will reduce the likelihood of a successful return to work. At the 12-week point consider suggesting vocational redirection, permanent job changes.
- Be alert for the presence of individual beliefs that he or she should stay off work until treatment has provided a 'total cure'. Watch out for expectations of simple 'techno-fixes'.

The above information is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.

RED, YELLOW FLAGS

Yellow Flags cont'd

- Promote self-management and self-responsibility. Encourage the development of self-efficacy to return to work.
- Be prepared to ask for a second opinion, provided it does not result in a long and disabling delay. Use this option especially if it may help clarify that further diagnostic work is unnecessary.
- Avoid confusing the report of symptoms with the presence of emotional distress. Exclusive focus on symptom control is not likely to be successful if emotional distress is not dealt with.
- Avoid suggesting (even inadvertently) that the person from a regular job may be able to work at home, or in their own business because it will be under their own control. Self employment nearly always involves more hard work.
- Encourage people to recognize, from the earliest point, that pain can be controlled and managed so that a normal, active or working life can be maintained. Provide encouragement for all 'well' behaviors—including alternative ways of performing tasks, and focusing on transferable skills.

The information presented here is taken entirely, without any content modification from: Kendall, N A S, Linton, S J & Main, C J (1997). Guide to Assessing Psycho-social Yellow Flags in Acute Low Back Pain: Risk Factors for Long-Term Disability and Work Loss. Accident Compensation Corporation and the New Zealand Guidelines Group, Wellington, New Zealand. (Oct, 2004 Edition).

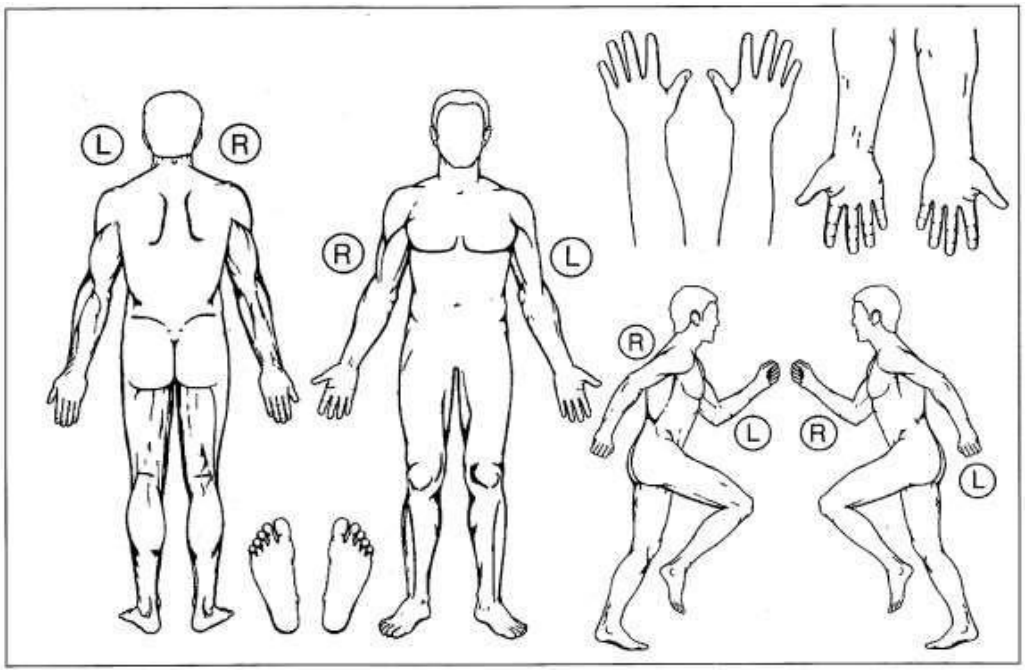
The above information is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.

Brief Pain Inventory

Date: _____ Time: _____

Patient name: _____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these everyday kinds of pain today? ___ Yes ___ No
2. On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Source: Pain Research Group, MD Anderson Cancer Center, 1997 *The above tool is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.*

7. What treatments or medications are you currently receiving for your pain:

_____

_____

_____

_____

_____

_____

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows most how much RELIEF you have received.

No relief	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete relief

9. Circle the one number that describes how, during the past 24 hours, your pain level has interfered with your:

General Self-Care Activities (e.g., dressing, bathing, etc.):

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Mood:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Walking Ability:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Normal work (includes both work outside the home and housework):

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Relations with other people:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Sleep:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Enjoyment of life

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

Source: Pain Research Group, MD Anderson Cancer Center, 1997 The above tool is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.

PAIN DISABILITY INDEX

Name: _____ Date:

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the seven categories of life activity listed, please circle the number on the scale which describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/home responsibilities: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self-care: This category includes activities that involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support Activities: This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Reprinted with permission from Pollard CA. The relationship of family environment to chronic pain disability. (Doctoral dissertation, California School of Professional Psychology—San Diego) Dissertation Abstracts International *1981;42,2077B.*

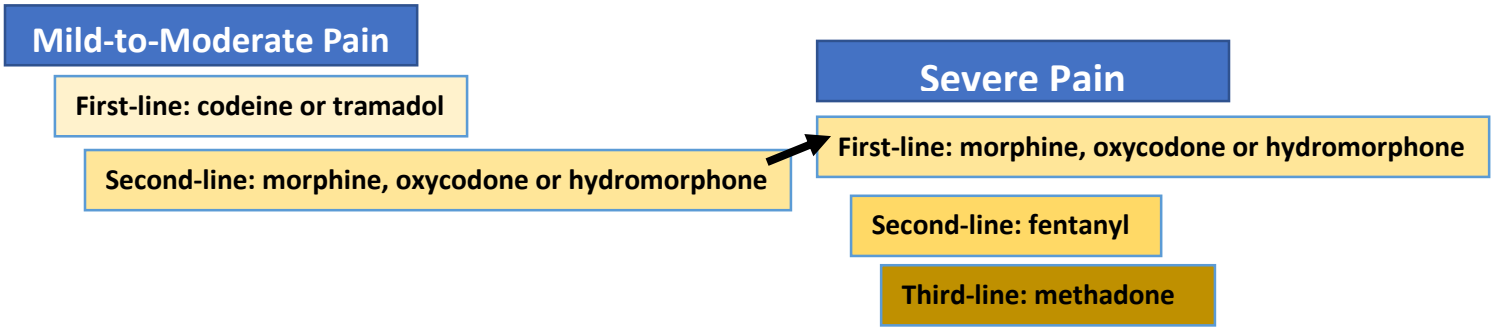
Goals decided with patient:

1.
2.
3.
4.
5.
6.
7.

Overdose Risk	**Patient Factors**	**Opioid Factors**	
Provider Factors -Incomplete assessments -Rapid titration -Combining opioids and sedating drugs -Failure to monitor dosing -Insufficient information given to patient and/or relatives	- Elderly - On benzodiazepines - Renal impairment - Hepatic impairment - COPD - Sleep apnea - Sleep disorders - Cognitive impairment	-Codeine & Tramadol - lower risk -CR formulations - higher doses than IR **Prevention** -Assess for Risk Factors -Educate patients /families about risks & prevention	-Start low, titrate gradually, monitor frequently --Careful with benzodiazepines -Higher risk of overdose - reduce initial dose by 50%; titrate gradually -Avoid parenteral routes - Adolescents; elderly - may need consultation -Watch for Misuse

Initiation Checklist	Y	N	Date
Are opioids indicated for this pain condition			
Explained potential benefits			
Explained adverse effects			
Explained risks			
Patient given information sheet			
Signed treatment agreement (as needed)			
Urine drug screening (as needed)			

Stepped Approach to Opioid Selection



The above tool is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.

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
PSYCHOLOGICAL 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
>7: high

The above tool is copied from the General Practice Services Committee (GPSC) Practice Support Program Chronic Pain Algorithm. GPSC (2009) Tools and Resources website.

Aberrant Drug Related Behaviour *(Modified by Passik,Kirsh et al 2002).*

Indicator	Examples
***Altering the route of delivery**	• Injecting, biting or crushing oral formulations
***Accessing opioids from other sources**	• Taking the drug from friends or relatives • Purchasing the drug from the "street" • Double-doctoring
Unsanctioned use	• Multiple unauthorized dose escalations • Binge rather than scheduled use • Recurrent prescription losses
Drug seeking	• Aggressive complaining about the need for higher doses • Harassing staff for faxed scripts or fit-in appointments • Nothing else "works"
Repeated withdrawal symptoms	• Marked dysphoria, myalgias, GI symptoms, craving
Accompanying conditions	• Currently addicted to alcohol, cocaine, cannabis or other drugs • Underlying mood or anxiety disorders not responsive to treatment
Social features	• Deteriorating or poor social function • Concern expressed by family members
Views on the opioid medication	• Sometimes acknowledges being addicted • Strong resistance to tapering or switching opioids • May admit to mood-leveling effect • May acknowledge distressing withdrawal symptoms

Aberrant Opioid Use

Red Flags

- Prescriptions from multiple physicians
- Frequent visits to emergency room requesting opioids
- Requests from patients from outside of local area
- Stolen or modification of prescriptions
- Extensive polypharmacy with CNS depressants and/or non-prescribed habituating substances
- Forgery, selling, stealing, or using other person's medications; tampering with prescriptions.
- Injecting oral or chewing LA formulations

Reassess Regimen and/or Treatment Agreement

- Rapid escalation of dose in CNMP
- Frequent excuses for running out of medication
- Frequent loss of prescriptions and/or medications
- Frequent changes of the opioid prescribed
- Aversion to concurrent recommended treatments
- Request for Brand-name versus generic product
- Lack of request for adjunct analgesic refills
- Unsanctioned noncompliance with the regimen
- Missed follow-up visits

Definitions

Addiction:
Loss of control over substance use WITH compulsive continued use despite harm

Pseudoaddiction:
Drug seeking behavior mimicking addiction resulting from under-treatment of pain.

Dependence, physical:
A state of adaptation resulting in drug class-specific withdrawal symptoms upon abrupt dose reduction, decreasing drug levels or antagonist administration (not to be confused with addiction).

Tolerance:
Decreasing effect of a drug over time.